

## Attachment 5

### **Subject: Invitation to participate in national Evaluation of Venous Thromboembolism Prevention Practices in U.S. Hospitals**

RE: Hospital Name: \${e://Field/Hospital%20Name}

Dear \${m://FirstName} \${m://LastName}

Your hospital is being invited to participate in a randomly selected, nationally representative evaluation of venous thromboembolism (VTE) prevention practices. This project aims to evaluate the extent to which U.S. hospitals utilize VTE risk assessment in VTE prevention. This information is needed to help guide efforts to reduce the incidence and burden of VTE.

The project is supported by the Centers for Disease Control and Prevention (CDC), National Center on Birth Defects and Developmental Disabilities, Division of Blood Disorders and is being implemented by the Department of Research at The Joint Commission. Please read this information sheet [insert hyperlink] which describes the project background, target respondent, content areas as well as how information will be de-identified and safeguarded.

We greatly appreciate it if you would complete the online questionnaire using the link below. Your participation in surveys like this is important, since this is one of the few ways content experts can learn about the range of current practices in the field. If would like to print a copy of the questions prior to answering it online, you can access it here [insert hyperlink....]

By completing the questionnaire, you will provide insight into the current state of VTE prevention activities nationally and significantly contribute to future efforts to improve VTE prevention, patient safety and outcomes.

Thank you very much for considering this important opportunity. If you have any questions, please contact Salome Chitavi PhD at 630-792-5977 or email [schitavi@jointcommission.org](mailto:schitavi@jointcommission.org) or Barbara Braun PhD at 630-792-5928 in the Joint Commission Department of Research.

Sincerely,

...tbd

**Follow this link to complete the online questionnaire:** \${l://SurveyLink?d=Take%20the%20Survey}  
**Or copy and paste this URL into your internet browser:** \${l://SurveyURL}

By clicking this link you are indicating you have read the information sheet and agree to participate in this project.

## Evaluation of Venous Thromboembolism Prevention Practices in U.S. Hospitals

### Project Information Sheet

**Background:** Venous thromboembolism, which includes deep vein thrombosis (DVT) and pulmonary embolism (PE), is an important and growing public health problem. Each year in the U.S., it is estimated that VTE affects as many as 900,000 people, is responsible for up to 100,000 deaths, and is associated with healthcare costs of approximately \$10 billion (CDC, 2019a). Recurrence after a VTE is common and complications include post-thrombotic syndrome and chronic thromboembolic pulmonary hypertension (CDC, 2019b).

Healthcare-associated venous thromboembolism (HA-VTE) is often preventable but venous thromboembolism (VTE) prevention strategies, including risk assessment and appropriate prophylaxis, are not applied uniformly or systematically across U.S. hospitals and healthcare systems (Kahn et al., 2013).

Several organizations have led efforts to prevent the development of VTE related to hospitalization. These include CDC Division of Blood Disorders, the Anticoagulation Forum, Agency for Healthcare Research and Quality (AHRQ), National Quality Forum (NQF), and professional societies such as the American College of Chest Physicians (ACCP), the American Society of Hematology (ASH), Society of Hospital Medicine and others (Maynard, 2016; Anticoagulation Forum, n.d.). The Joint Commission has had a role in improving safety for patients receiving anticoagulation therapy through both standards and performance measurement. Regarding performance measurement, The Joint Commission is the measure steward for two electronic clinical quality measure (eCQM) options available for CMS Inpatient Quality Reporting (IQR) (and Joint Commission hospital accreditation) since 2016. Both eCQMs are VTE prevention measures that address the initiation of prophylaxis in a limited timeframe, but the measures do not assess the patient's level of VTE risk or evaluate the appropriateness of prophylaxis.

The framework for improving VTE prevention includes protocols with VTE and bleeding risk assessments linked to risk-appropriate prophylaxis options. Several VTE risk assessment tools and models have been published but there is no standardized risk assessment tool currently in use across U.S. hospitals and healthcare systems. Implementation of risk assessment varies in terms of the model, patient population, time frames, method of administration, person/s performing the risk assessment, linkage to a clinical decision support tool for VTE prophylaxis, and monitoring adherence to a VTE prevention protocol. An evaluation of the extent to which U.S. hospitals utilize VTE risk assessment is needed to better understand the landscape around VTE prevention practices to reduce the incidence and burden of VTE.

**Purpose:** The overall goal of this project is to support a framework for improving VTE prevention practices through the evaluation of current VTE prevention practices in U.S. hospitals. This project aims to:

- Implement a questionnaire in a nationally representative sample of U.S. hospitals that characterizes VTE prevention practices occurring in general medical units and general surgical units, and
- Analyze and describe the extent to which U.S hospitals utilize standardized risk assessment and related practices in their VTE prevention activities.

It is important to note that the questionnaire is focused on providing an accurate snapshot of current activities in U.S. hospitals. There are no right or wrong answers and the questions are not intended to suggest hospitals should be doing certain activities. It is therefore most helpful to be candid about what is happening at your hospital.

**Topics addressed:** It consists of two major sections: hospital-level VTE prevention practices and VTE prevention practices for patients on general medical and general surgical units. The practices of interest relate to the use of VTE policies and protocols, VTE data collection and reporting, VTE prevention teams, VTE risk assessment, VTE prophylaxis safety and monitoring, VTE ambulation protocols and VTE prevention education for general medical and general surgical patients. Additional detail is provided at the end of this document.

**Target respondent:** The preferred person to complete the questionnaire is the person(s) closest to VTE prevention activities. In many cases, this is the Director of Patient Safety and Quality, the Chairperson of the Patient Safety Committee, other quality improvement professionals, or the physician/clinical champion(s) for VTE prevention at your organization. If your hospital has no specific person coordinating VTE prevention efforts, the target respondent is the individual(s) with the most knowledge of VTE prevention efforts or leading the general medical or general surgical department(s) at the hospital.

**Estimated time to complete the questionnaire:** The questionnaire has approximately 50 questions including skip logic and no questions are mandatory. Based on pilot testing the online questionnaire at nine hospitals, the average time to complete the survey was 61 minutes (min=20; max=150, median=60, range=130, standard deviation=37). No additional activities are requested beyond completing the questionnaire.

**Confidentiality and participation risks and benefits:** The CDC has determined this project to be public health practice surveillance and not human subjects research. No patient information is requested. Research findings will be de-identified to protect the privacy and anonymity of participating hospitals and staff. Data will be stored in a password-protected electronic format securely accessed only by research project staff. We believe there are no or minimal risks associated with this project; however, a slight risk of breach of confidentiality always exists.

No compensation will be provided for completing the questionnaire and there are no direct benefits to participants. Participants will, however, have the option of receiving an aggregated report upon study completion which allows comparison of their hospital's practices to the larger group. Most importantly, participants will be significantly contributing to future efforts to improve VTE prevention, patient outcomes and safety.

**Unrelated to accreditation:** This project is being implemented by the Department of Research at The Joint Commission. The sample includes hospitals that are accredited by The Joint Commission as well as hospitals that are accredited by other organizations or not accredited by

any group. Participation in this project is in no way related to an organization's accreditation process nor is it a requirement for accreditation. At the Joint Commission, there is a firewall between data received for research and the accreditation-related areas such that organization-specific information received in research studies is not shared with persons other than those directly involved in the research.

**Project funding:** The project is funded by the Centers for Disease Control and Prevention (CDC), National Center on Birth Defects and Developmental Disabilities, Division of Blood Disorders. The Joint Commission has a sub-award with the Association of University Centers on Disabilities (AUCD) (#2-20-8813). The period of performance is xxx TBD.

**Questions:** For additional information, please contact Salome Chitavi PhD, Co-Investigator, 630-792-5977, [Schitavi@jointcommission.org](mailto:Schitavi@jointcommission.org) or Barbara Braun PhD, Principal Investigator, 630-792-5928, [bbraun@jointcommission.org](mailto:bbraun@jointcommission.org) in the Department of Research, The Joint Commission.

### **References:**

CDC (2019a). "Learn About Healthcare-Associated Venous Thromboembolism". Retrieved on January 29, 2020 from: <https://www.cdc.gov/ncbddd/dvt/ha-vte.html>

CDC (2019b). "Deep Vein Thrombosis & Pulmonary Embolism". Retrieved on January 29, 2020 from: <https://wwwnc.cdc.gov/travel/yellowbook/2020/travel-by-air-land-sea/deep-vein-thrombosis-and-pulmonary-embolism>

Kahn, S.R., Morrison, D.R., Cohen, J.M., Emed J., Tagalakis, V., Roussin, A., and Geerts, W. (2013). Interventions for implementation of thromboprophylaxis in hospitalized medical and surgical patients at risk for venous thromboembolism. *Cochrane Database of Systematic Reviews*, 7(CD008201). DOI: 10. 1002/14651858.CD008201.pub2.

Anticoagulation Forum (n.d.). "About Us". Retrieved on January 29, 2020 from: <https://acforum.org/web/about-us.php>

Maynard G. (2016). *Preventing hospital-associated venous thromboembolism: a guide for effective quality improvement (2<sup>nd</sup> ed.)*. AHRQ Publication No. 16–001-EF. Rockville, MD: Agency for Healthcare Research and Quality.

## **Examples of questionnaire content**

### **Section I. Hospital-level VTE Prevention Practices**

#### **A. VTE prevention policy and protocol in your hospital**

- Does hospital have a VTE prevention policy?
- Does the VTE prevention policy apply to all patients?
- Barriers to establishing a VTE prevention policy
- Does hospital have VTE prevention protocol?

- Is the VTE prevention protocol unit specific for general medical or general surgical units/wards?

#### B. VTE prevention team

- Does hospital have a VTE prevention team?
- How many people are on the team?
- Whether the VTE prevention team includes representation across more than one department
- Healthcare professionals represented on the VTE prevention team
- How often the VTE prevention team meets

#### C. VTE data collection and reporting

- What data and measures do you collect related to VTE prevention practices?
- Whether hospital reviews hospital-associated VTE events
- Whether hospital reviews adverse events and complications from anticoagulant prophylaxis
- Whether hospitals report VTE data externally and to whom?

### **Section II. VTE Prevention Practices for Patients on General Medical and General Surgical Units**

In this section, each of these questions will be asked separately for general medical and general surgical units.

#### A. VTE risk assessment

- Whether patients in general medical or general surgical units are routinely assessed for VTE risk
- Who conducts VTE risk assessment?
- Which units use a standardized VTE risk assessment?
- Timing for VTE risk assessment and whether it is mandatory
- Use of externally developed qualitative and quantitative VTE risk assessment tools
- How VTE risk assessment is implemented
- Monitoring of risk assessment activities

#### B. VTE prophylaxis safety considerations

- Whether patients in general medical or general surgical units are routinely assessed for bleeding risk
- Who conducts bleeding risk assessment?
- Use of standardized bleeding risk assessment tools
- Documentation of contraindications to anticoagulation prophylaxis

#### C. Ambulation protocol and VTE prevention education

- Whether hospital has an ambulation protocol for general medical and/or general surgical patients
- If VTE prevention education is provided to clinicians or patients

D. VTE prophylaxis monitoring and support

- Which order sets address prophylaxis
- Use of clinical decision support systems, checklists, audit and feedback
- Documentation of missed doses