

The Case for Implementing a VTE Prophylaxis Process¹ for Hospitalized Patients Now

It's the Right Thing to Do

- More than 2 million Americans suffer from venous thromboembolism (VTE—which includes deep vein thrombosis [DVT] and pulmonary embolism [PE]) each year, with over half of these individuals developing their VTE in the hospital or in the 30 days post-hospitalization.
- One in ten of those who develop a VTE go on to die from PE. These 200,000 patient deaths represent more annual deaths than those from breast cancer, AIDS, and traffic accidents combined.
- VTE is the #1 cause of preventable death among hospitalized patients: an estimated 10 percent of inpatient deaths are secondary to PE. Patients who survive the initial diagnosis of PE face a mortality rate of 17.5 percent at 90 days.
- Over one year, a 300-bed hospital that lacks a systematic approach to VTE prevention can expect roughly 150 cases of hospital-acquired VTE. Approximately 50 to 75 of those cases will be potentially preventable because of missed opportunities to provide appropriate prophylaxis. Approximately 5 of those patients will die from potentially preventable PE.
- Not only do patients with VTE suffer a 30 percent cumulative risk for recurrence, they are also at risk for the potentially disabling post-thrombotic syndrome.
- Most hospitalized patients have at least one risk factor for VTE.
- Medical patients probably account for more than half of all hospital-acquired VTE events. In a typical hospital, it is estimated that fewer than 5 percent of medical patients could be considered at low risk for VTE.
- VTE prophylaxis is rated by Agency for Healthcare Research and Quality (AHRQ) as #1 out of 73 Patient Safety Practices, based on their impact and effectiveness.

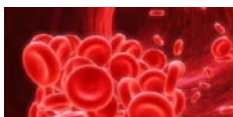
We Can't Afford Not To

- Cost-effectiveness of VTE prophylaxis has been repeatedly demonstrated. Pharmacologic prophylaxis reduces the incidence of VTE by 50 percent to 65 percent.
- The incremental length of stay and costs of treating a preventable VTE event are substantial. The Agency for Healthcare Research and Quality (AHRQ) Healthcare Cost and Utilization Project's estimates of incremental cost are \$10,000 per DVT and \$20,000 per PE.
- The Centers for Medicare & Medicaid Services (CMS) has included VTE related to total knee replacement and hip replacement (when not present on admission) among the hospital-acquired conditions for which it will no longer pay, effective October 1, 2008.

Our Future Performance Will Be Publicly Compared to Other Hospitals' Performance

- Two VTE measures have already been included for public reporting as part of the CMS Surgical Care Improvement Project (SCIP) quality measures set.
- Six VTE measures (related to both medical and surgical patients) endorsed by the National Quality Forum (NQF) have been approved as part of a core measure set for use in The Joint Commission's ORYX program and may be included for public reporting on the *Hospital Compare* Web site and as components of the CMS Reporting of Hospital Quality Data for Annual Payment Update (RHQDAPU) program in 2012.

¹ Adapted from *Preventing Hospital-Acquired Venous Thromboembolism: A Guide for Effective Quality Improvement*. Maynard G, Stein J. (2008). Prepared by the Society of Hospital Medicine. AHRQ Publication No. 08-0075. Rockville, MD: Agency for Healthcare Research and Quality. Available at <http://www.ahrq.gov/qual/vtguide/>.



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Translating VTE Guidelines Into Practice

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