Taking Aim: Measurement Strategies in Capturing Adverse Drug Events (ADEs)

Session 1
May 23, 2017
Today’s Presenters

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Executive Director, Medication Safety and Quality
Health Services Advisory Group (HSAG)

Kim Werkmeister, BA, RN, CPHQ, CPPS
Clinical Improvement Educator
Hospital Quality Institute (HQI)

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Objectives

1. Introduce the ADE Sprint and the aim of the Sprint.

2. Describe the six measures for ADEs and their specifications.

3. Help hospitals formulate strategies for finding and measuring ADE data.

4. Examine the model for improvement, with a focus on formulating an aim statement for ADEs.
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Who Are We?

Mary Andrawis-Refila, PharmD, MPH  
Executive Director, Medication Safety and Quality, HSAG

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Clinical Improvement Educator, HQI

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HSAG HIIN Technical Director, HSAG

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Analytics Manager, Data Science & Advanced Analytics, HSAG
The HSAG HIIN ADE *SPRINT*

**Aim:**
To reduce adverse drug events as measured by international normalized ratios (INRs) greater than 5, glucose less than 50, and naloxone for opioid reversal by 20% compared to a baseline year of 2015 by December 31, 2017, in all HSAG HIIN hospitals.

**How will we accomplish this?**
By creating a community of medication safety leaders sprinting together toward a rapid, tangible, reduction in specific ADEs over a short period of time by implementing small tests of change.
Who Are YOU?

• Polling Question: Who is in the room? Are you a:
  A. Pharmacist, Clinical?
  B. Pharmacist, Leadership?
  C. Nurse, Clinical?
  D. Nurse, Leadership?
  E. Quality Director?
  F. Other (type into chat)
  G. Secure Data Portal Administrator?

(check all that apply)
Does your hospital have a program to monitor and reduce ADEs, including a policy defining ADEs, high-risk drugs, and high-risk patient factors?

- No: 2.74% (6)
- Yes: 97.26% (213)

Percent based on 219 respondents. 7 hospitals did not respond to the question.
ADE Data Reporting: Current State

Percent of Hospitals

<table>
<thead>
<tr>
<th>Collection and Monitoring Period</th>
<th>Monthly</th>
<th>Quarterly</th>
<th>Semi-Annually</th>
<th>Annually</th>
<th>None</th>
<th>No Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warfarin</td>
<td>59.43%</td>
<td>27.36%</td>
<td>0.94%</td>
<td>0.00%</td>
<td>8.02%</td>
<td>2.36%</td>
</tr>
<tr>
<td>Insulin and Other Anti-Diabetic Agents</td>
<td>65.57%</td>
<td>20.28%</td>
<td>1.42%</td>
<td>0.00%</td>
<td>11.32%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Opioids</td>
<td>63.68%</td>
<td>26.89%</td>
<td>0.47%</td>
<td>1.42%</td>
<td>8.49%</td>
<td>0.47%</td>
</tr>
</tbody>
</table>

Percent based on 212 respondents.
Hospitals included in 'No Answer' selected a response for one of the medications, but not the one specified.
14 hospitals did not respond to the question.
ADE Data Reporting: Current State

• Polling Question: Who do you report ADE data to?
  A. Staff
  B. Leadership
  C. Patients
  D. Externally to a regulatory agency
  E. Externally to an organization
  F. Not sure
  (Check all that apply)

• Chat in: What measures do you use, and how do you find these data?
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Inpatient Anticoagulation Safety

• FIRST FOCUS: **Daily INR checks for patients on warfarin**

• OUTCOME MEASURE: INR > 5 per 1,000 patient days for patients receiving warfarin

• PROCESS MEASURE: Percentage of daily INR on patients receiving warfarin
## INR Patient Days

<table>
<thead>
<tr>
<th>INR &gt; 5 per 1,000 Patient Days</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator</strong></td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
</tr>
<tr>
<td><strong>Rate Calculation</strong></td>
</tr>
<tr>
<td><strong>Data Source(s)</strong></td>
</tr>
<tr>
<td><strong>Data Submission Time Period</strong></td>
</tr>
<tr>
<td><strong>Baseline Period</strong></td>
</tr>
<tr>
<td><strong>Measure ID</strong></td>
</tr>
</tbody>
</table>

*If a hospital is unable to limit the denominator to patients on Warfarin, then submit patient day counts as a proxy.

INR: International Normalized Ratio
# Percentage of Daily INR

<table>
<thead>
<tr>
<th>Percentage of Daily INR on Patients Receiving Warfarin</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator</strong></td>
</tr>
<tr>
<td>Number of patient days with INR lab result for adult patients on Warfarin</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
</tr>
<tr>
<td>Number of patient days for adult patients (18 years of age or older) on Warfarin, excluding the emergency department*</td>
</tr>
<tr>
<td><strong>Rate Calculation</strong></td>
</tr>
<tr>
<td>( \left( \frac{\text{Numerator}}{\text{Denominator}} \right) \times 100 )</td>
</tr>
<tr>
<td><strong>Data Source(s)</strong></td>
</tr>
<tr>
<td>EHR</td>
</tr>
<tr>
<td><strong>Data Submission Time Period</strong></td>
</tr>
<tr>
<td>Monthly</td>
</tr>
<tr>
<td><strong>Baseline Period</strong></td>
</tr>
<tr>
<td>Calendar year 2015</td>
</tr>
<tr>
<td><strong>Measure ID</strong></td>
</tr>
<tr>
<td>ANTICOAG_DAILY_INR</td>
</tr>
</tbody>
</table>

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Inpatient Glycemic Management

- **FIRST FOCUS:** Use of basal-bolus correction insulin on all patients prescribed insulin and eliminating sliding scale insulin as sole means of glycemic control

- **OUTCOME MEASURE:** Blood glucose < 50 mg/dL per 1,000 patient days for patients on insulin

- **PROCESS MEASURE:** Percentage of use of basal-bolus insulin alone for glycemic control for patients on insulin
## Blood Glucose Patient Days

<table>
<thead>
<tr>
<th>Blood Glucose &lt; 50 per 1,000 Patient Days</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator</strong></td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
</tr>
<tr>
<td><strong>Rate Calculation</strong></td>
</tr>
<tr>
<td><strong>Data Source(s)</strong></td>
</tr>
<tr>
<td><strong>Data Submission Time Period</strong></td>
</tr>
<tr>
<td><strong>Baseline Period</strong></td>
</tr>
<tr>
<td><strong>Measure ID</strong></td>
</tr>
</tbody>
</table>

*If a hospital is unable to limit the denominator to patients on insulin, then submit patient day counts as a proxy.*
# Insulin: Percentage of Use

## Percentage of Use of Basal-Bolus Insulin for Glycemic Control

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator</strong></td>
<td>Number of patient days with basal-bolus insulin given for adult patients on any insulin</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>Number of patient days for adult (18 years of age or older) patients on any insulin, excluding the emergency department*</td>
</tr>
<tr>
<td><strong>Rate Calculation</strong></td>
<td>( \left( \frac{\text{Numerator}}{\text{Denominator}} \right) \times 100 )</td>
</tr>
<tr>
<td><strong>Data Source(s)</strong></td>
<td>EHR</td>
</tr>
<tr>
<td><strong>Data Submission Time Period</strong></td>
<td>Monthly</td>
</tr>
<tr>
<td><strong>Baseline Period</strong></td>
<td>Calendar year 2015</td>
</tr>
<tr>
<td><strong>Measure ID</strong></td>
<td>DIABETIC_INSULIN</td>
</tr>
</tbody>
</table>

*If a hospital is unable to limit the denominator to patients on any insulin, then submit patient day counts as a proxy.*
Inpatient Opioid Safety

• FIRST FOCUS: Use of standard, validated tools for assessing patients’ response to opioid administration both after each dose and before subsequent dose

• OUTCOME MEASURE: Naloxone use for reversal of opioid over sedation in patients on an opioid agent

• PROCESS MEASURE: Percentage of opioid risk assessment in patients on an opioid agent
# Naloxone Use

## Naloxone Use for Reversal of Opioid Over Sedation per 1,000, Patient Days

<table>
<thead>
<tr>
<th><strong>Numerator</strong></th>
<th>Number of patient days where Naloxone administration was required for adult patients on an opioid agent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Denominator</strong></td>
<td>Number of patient days for adult (18 years of age or older) patients on an opioid agent, excluding the emergency department and operating room*</td>
</tr>
<tr>
<td><strong>Rate Calculation</strong></td>
<td>( \left( \frac{\text{Numerator}}{\text{Denominator}} \right) \times 1,000 )</td>
</tr>
<tr>
<td><strong>Data Source(s)</strong></td>
<td>EHR</td>
</tr>
<tr>
<td><strong>Data Submission Time Period</strong></td>
<td>Monthly</td>
</tr>
<tr>
<td><strong>Baseline Period</strong></td>
<td>Calendar year 2015</td>
</tr>
<tr>
<td><strong>Measure ID</strong></td>
<td>OPIOID_NARCAN</td>
</tr>
</tbody>
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*If a hospital is unable to limit the denominator to patients on an opioid agent, then submit patient day counts as a proxy.*
## Percentage of Opioid Risk Assessment in Patients on an Opioid Agent

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td><strong>Numerator</strong></td>
</tr>
<tr>
<td>Number of patient days where an opioid risk assessment (e.g., Pasero Opioid-Induced Sedation Scale [POSS] or Richmond Agitation Sedation Scale [RASS]) was used for adult patients on an opioid agent</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
</tr>
<tr>
<td>Number of patient days for adult (18 years of age or older) patients on an opioid agent, excluding emergency department and operating room*</td>
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<td><strong>Rate Calculation</strong></td>
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<td>Calendar year 2015</td>
</tr>
<tr>
<td><strong>Measure ID</strong></td>
</tr>
<tr>
<td>OPIOID_RISK</td>
</tr>
</tbody>
</table>

*If a hospital is unable to limit the denominator to patients on an opioid agent, then submit patient day counts as a proxy.
Key Messages

• All hospitals should submit data (self-report) on all six ADE measures for baseline period calendar year (CY) 2015 and monthly beginning with January 2016

• Hospitals should create own process for generating monthly reports that allow reporting of the ADE measures

• ADE measures are not meant to be PERFECT but are GOOD ENOUGH to drive improvement
HSAG HIIN Secure Data Portal Users’ Guide:  

Data Submission Instructions:  

Data Submission Template: 
http://hiin.hshapps.com/DataInput/DownloadC ontent?filename=DataSubmissionTemplate.xlsx
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Guide to Finding Your Hospital’s ADE Rates

Step-by-Step Data Collection Guide for Collecting the Six ADE Measures
Anticoagulation Outcome Measure

• INR >5 per 1,000 Patient Days for Patients on Warfarin
  – **Numerator:** Count the number of days an INR reading is > 5. Throw out repeat same-day INRs > 5. In other words, a patient with multiple INRs above 5 on a single day is only counted once. A patient with multiple INRs above 5 on different days is counted once for each day the INR is elevated. Any INR above 5 after admission should count (exclude the emergency department).
  – **Denominator:** Count the number of inpatient days (i.e., length of stay) for patients on warfarin. The entire length of stay is counted for the patient even if warfarin is administered only on a subset of days. For example, if a patient received warfarin once during their 10-day stay, this would count as 10 patient days.
    • ALTERNATIVE: Count the number of total inpatient days.
  – **Calculate the rate** by taking numerator/denominator *1,000. Numerators can be obtained from the lab or electronic health record (EHR), denominators can be obtained from the EHR, and the resulting rate can be calculated using the aforementioned formula.
  – For example, we can use the EHR/lab to find that, in the month of January, we had 50 INR readings > 5, but 10 of those were repeat same-day INRs > 5. So 40 is our numerator. Then we look at the number of inpatient days for patients on warfarin. We find that there are 500 patient days for patients that received warfarin. So the rate is 40/500 *1000 = 80 INR > 5 per 1,000 patient days for patients on warfarin.
  – **Helpful Hint:** Very few situations other than warfarin can cause an INR > 5, so assuming all excessive INRs are from warfarin can eliminate the need to cross-check.
Anticoagulation Process Measure

• Percentage of Daily INR for Patients on Warfarin
  – **Numerator:** Count the number of days any INR lab result is available. Throw out repeat same-day INRs; in other words, a patient with multiple INRs on a single day is only counted once. Any INR available should count (can include the emergency department).
  
  – **Denominator:** Count the number of inpatient days (i.e., length of stay) for patients on warfarin. The entire length of stay is counted for the patient even if warfarin is administered only on a subset of days. For example, if a patient received warfarin once during their 10-day stay, this would count as 10 patient days.

    • **ALTERNATIVE:** Count the number of total inpatient days.

  – **Calculate the percentage** by taking the numerator/denominator * 100.

  – For example, we can use the EHR/lab to find that, in the month of January, we had 200 INR lab results, but 45 were repeat same-day INRs. So 155 is our numerator. Then we look at the number of inpatient days for patients on warfarin. We find that there are 500 patient days for patients that received warfarin. So the percentage is 155/500 * 100 = 31% daily INR for Patients on warfarin.
Hypoglycemia Outcome Measure

- **Blood Glucose (BG) < 50 per 1,000 Patient Days for Patients on Insulin**
  - **Numerator:** Count the number of days blood glucose value is < 50 mg/dL. Throw out repeat same-day BGs < 50; in other words, a patient with multiple values below 50 on a single day is only counted once. A patient with multiple BGs below 50 on different days is counted once for each day the BG is low. Any BG below 50 should count (exclude the emergency department).
  - **Denominator:** Count the number of inpatient days (i.e., length of stay) for patients on any insulin. The entire length of stay is counted for the patient even if insulin is administered only on a subset of days. For example, if a patient received insulin once during their 10-day stay, this would count as 10 patient days.
    - **ALTERNATIVE:** Count the number of total inpatient days.
  - **Calculate the rate** by taking numerator/denominator * 1,000. Numerators can be obtained from the lab or EHR, denominators can be obtained from the EHR, and the resulting rate can be calculated using the aforementioned formula.
  - For example, we can use the EHR/lab to find that, in the month of January, we had 100 BG readings < 50, but 15 of those were repeat same-day values. So 85 is our numerator. Then we look at the number of inpatient days for patients on insulin. We find that there are 600 patient days for patients that received insulin. So the rate is 85/600 * 1000 = 141.6 BG < 50 per 1,000 patient days for patients on insulin.
  - **Helpful Hint:** Very few situations other than insulin can cause BG <50, so assuming all are from insulin can eliminate the need to cross-check.
Hypoglycemia Process Measure

- Percentage of Use of Basal-Bolus Insulin for Glycemic Control in Patients on Insulin
  - **Numerator**: Count the number of days a basal-bolus insulin regimen (which means a long/intermediate-acting insulin is included) was given. Throw out repeat same-day doses; in other words, a patient with multiple doses of basal insulin on a single day is only counted once. A patient with multiple doses of basal insulin on different days is counted once for each day the basal insulin is given. Any insulin that is not short/fast-acting should count in the numerator.
  
  - **Denominator**: Count the number of inpatient days (i.e., length of stay) for patients on any insulin. The entire length of stay is counted for the patient even if insulin is administered only on a subset of days. For example, if a patient received insulin once during their 10-day stay, this would count as 10 patient days.
    - ALTERNATIVE: Count the number of total inpatient days.

- **Calculate the percentage** by taking the numerator/denominator *100.

- For example, we can use the EHR/lab to find that, in the month of January, we administered 200 doses of basal-bolus insulin, but 80 were repeat same-day doses. So 120 is our numerator. Then we look at the number of inpatient days for patients on any insulin. We find that there are 500 patient days for patients that received insulin. So the percentage is 120/500*100 = 24% use of basal-bolus insulin for patients on insulin.
Opioid Outcome Measure

- Naloxone Use for Reversal of Opioid Over-Sedation per 1,000 Patient Days
  - **Numerator:** Count the number of days where naloxone was given. Throw out repeat same-day doses; in other words, a patient with multiple doses of naloxone on a single day is only counted once.
  - **Denominator:** Count the number of inpatient days (i.e., length of stay) for patients on any opioid. The entire length of stay is counted for the patient even if an opioid is administered only on a subset of days. For example, if a patient received an opioid once during their 10-day stay, this would count as 10 patient days.
    - ALTERNATIVE: Count the number of total inpatient days.
  - **Calculate the percentage** by taking the numerator/denominator * 100.
  - For example, we can use the EHR/lab to find that, in the month of January, we administered 90 doses of naloxone, but 30 were repeat same-day doses. So 60 is our numerator. Then we look at the number of inpatient days for patients on any opioid. We find that there are 600 patient days for patients that received an opioid. So the percentage is 60/600*100 = 10% naloxone use for patients on opioids.
  - Helpful Hint: Although naloxone is also used for reversal of opioid over-sedation after procedures, the effort required to identify and eliminate those situations would create an unnecessary burden. This measure is “good enough” to track improvement over time.
Opioid Process Measure

- Percentage of Opioid Risk Assessment in Patients on an Opioid Agent
  - **Numerator:** Count the number of days where an opioid risk assessment (e.g., Pasero Opioid-Induced Sedation Scale [POSS] or Richmond Agitation and Sedation Scale [RASS]) was used for adult patients on an opioid agent (exclude the emergency department and operating rooms).
  
  - **Denominator:** Count the number of inpatient days (i.e., length of stay) for adult patients on an opioid agent, excluding the emergency room and operating rooms. The entire length of stay is counted for the patient even if an opioid is administered only on a subset of days. For example, if a patient received an opioid once during their 10-day stay, this would count as 10 patient days.
    
    • ALTERNATIVE: Count the number of total inpatient days.
  
  - **Calculate the rate** by taking numerator/denominator * 1,000. Numerators and denominators can be obtained from the EHR and the resulting rate can be calculated using the aforementioned formula.
  
    - For example, we can use the EHR to find that, in the month of August, we had 280 risk assessments completed, so 280 is our numerator. Then we look at the number of inpatient days for patients on opioids. We find that there are 1,300 patient days for patients that received opioids. So the rate is 280/1,300 * 1,000 = 215 naloxone use for reversal of over sedation per 1,000 patient days for patients on opioids.
ADE Frequently Asked Questions

Questions and Answers

Q1: What are patient days for DBR = 1, days that refer to actual patient days per patient at any number of patients?

- A. When looking at the DBR > 1, the denominator is the number of patient days for the adult (19 years of age or older), patients in the hospital for 7 days or more, the numerator is the number of hospital days for the patient for the prior year.

Q2: What are patient days for DBR = 1, days that refer to actual patient days per patient at any number of patients?

- A. HSAG-HIN only looks for the patient days since they are mapped to the patient's emergency department to eliminate any denominator that is included.

Q3: What are patient days for DBR = 1, days that refer to actual patient days per patient at any number of patients?

- A. HSAG-HIN only looks for the patient days since they are mapped to the patient's emergency department to eliminate any denominator that is included.

Q4: What are patient days for DBR = 1, days that refer to actual patient days per patient at any number of patients?

- A. HSAG-HIN only looks for the patient days since they are mapped to the patient's emergency department to eliminate any denominator that is included.

Q5: What are patient days for DBR = 1, days that refer to actual patient days per patient at any number of patients?

- A. HSAG-HIN only looks for the patient days since they are mapped to the patient's emergency department to eliminate any denominator that is included.
Q1: When collecting patient days for INR > 5, does that refer to actual patient days per patient or any number of patients?

A: When looking at the INR > 5, the denominator is the number of patient days for adults (18 years of age or older) patients on warfarin, excluding the emergency department. For example, your hospital has Patient A who was in the hospital for 7 days total, the patient was on warfarin for 5 days, and 3 of those patient days they had an INR > 5. Using the example, the denominator would be 7 days for that patient. Your hospital would sum that up across all the incidents, and get the number of total patient days for the patients that are on warfarin for the time period in question. For the numerator, no matter how many times there was an INR > 5 on those days, even if it was more than once a day for 3 days, the numerator would be 3. This logic can be applied for all the ADE measures located in the Compendium of Measures (CoM).

Q2: What if the patient was on warfarin before they were admitted? Is the INR > 5 measure only referring to patient days once they are inpatient or before they were admitted?

A: HSAG HIIN is only looking for the patient days once they are inpatient at your hospital.
Q3: When submitting data for INR > 5 per 1,000 patient days, should patients currently transitioning to Coumadin from another medication be included?

A: The denominator is the number of patient days for adults (18 years of age or older) on warfarin, excluding the emergency department. Any patient who has received warfarin, or has an order for warfarin (this can be used as a proxy for administration to reduce data collection burden), should be included in the denominator.

Q4: Should inpatient days be included for patients who use their own insulin pump (which are self-administered) be included in the denominator?

A: Patients using their own insulin pump can be excluded. Given the inconsistencies in how hospitals document self-administered or patient's own medications, this will be challenging to universally exclude from the measure for all facilities, but each facility can choose to manage these circumstances in the least burdensome way.

Q5: What drugs are considered an “opioid agent”?

A: HSAG HIIN considers the following opioid agents to be included in the Naloxone User of Reversal of Opioid Over-Sedation per 1,000 Patients Days: codeine, fentanyl, hydrocodone, hydrocodone/acetaminophen, hydromorphone, meperidine, methadone, morphine, oxycodone, oxycodone and acetaminophen, and oxycodone and naloxone.
Q6: Should the metrics be grouped by month based on the discharge date of the visit or the date of that specific inpatient day?

A: Patient days should be grouped by the date of the specific inpatient day.

Q7: What type of patients are to be included in the measure, or what are the specifications on the numerator and denominator?

A: For the ADE measures, the patient type, numerator and denominator specifications are located in the Compendium of Measures. For example, the measure Naloxone Use for Reversal of Opioid Over Sedation, the patient type is an adult (18 years of age or older) on an opioid agent. The numerator for this measure is the number of patient days where naloxone administration was required for adult patients on an opioid agent. The denominator for this measure is the number of patient days for adult patients on an opioid agent, excluding emergency department and operating room.

Q8: Are the patients to be included only inpatients and are there any exclusions?

A: The patients to be included are only inpatients. Any exclusions are outlined in the Compendium of Measures.

Q9: What are the deadlines for ADE self-reported data submissions?

A: Deadlines are detailed in the Data Submission Instructions on the Secure Data Portal. HSAG HIIN encourages all participating hospitals to submit their ADE data by June 16.
Technical Assistance

Measure Support

contact via email: measurehelp@hsaghiin.org
or via telephone at: 844.472.4269
Objectives

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Improvement 101

How do we make changes?

How do we know that a change is an improvement?

“Every system is perfectly designed to achieve exactly the results that it gets” —Paul Batalden

“How all change is improvement but all improvement is change” —Don Berwick
The Improvement Process

- Form a team
- Set AIM
- Establish Measures
- Select Change
- Test Change

REPEAT
Forming a Team

• Patient safety is a TEAM SPORT

• Consider all of the roles in your organization that may contribute to the gap in care you are attempting to change, and also consider the roles that may contribute to improving the situation.
Team Members

- Clinical Leader
- Technical Expertise
- Day-to-Day Leadership
- Project Sponsor
Team Members

Clinical Leader

- Teams need someone with enough authority in the organization to test and implement a change that has been suggested and to deal with issues that arise.

Technical Expertise

- A technical expert is someone who knows the subject intimately and who understands the processes of care.
Team Members

Day-to-Day Leadership
• The leader is the driver of the project, assuring that tests are implemented and providing oversight of data collection.

Project Sponsor
• A successful improvement team needs a sponsor with executive authority who can serve as a liaison with other areas of the organization.
Example ADE Team

**Clinical Leader:** ____, MD, Chair, Pharmacy and Therapeutics Committee, Patient Safety Officer

**Technical Expertise:** ____, RPh, Director, Clinical Pharmacist

**Day-to-Day Leadership:** ____, RN, Manager, Medical/Surgical Nursing

**Additional Team Members:** Risk Manager, Quality Improvement Specialist, Staff Nurse, Staff Education, and Information Technology

**Sponsor:** ____, MD, Chief Medical Officer
What Is Our Aim?

*What* are we trying to accomplish?

By *when*?

*How much?*

*Who* will be included?

In other words.....*why* are we testing a change to our process?
Effective Aim Statements

“Who is going to do what, by how much, and by when?”

Example:
The cardiac intensive care unit (CICU) of St. Elsewhere Hospital will decrease catheter-associated urinary tract infections by 20% by September 30, 2017.
But How Will We Do That?

Model for Improvement

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?

Aim
Measure
Small Tests of Change

Plan
Do
Act
Study
Where Do I Start?
Next Steps/Homework

- Develop a process for generating monthly ADE performance reports on the ADE measures
- Write an aim statement for the ADE work
- Register for the next webinar on Tuesday, June 6
- Make sure your hospital has identified an ADE lead on the self-assessment (contact your clinical improvement advisory [CIA] to confirm/change/add)
Discussion/Questions

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For continuing education credit (1), please complete the evaluation at:

https://goo.gl/n3vEOQ

If you registered online for this event, you will also receive the link via email.

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