APRN Professional Practice Evaluation

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Associate Nursing Officer, Advanced Practice
Vanderbilt University Medical Center
Objectives:

- Understand the purpose and requirements for Focused and Ongoing Professional Practice Evaluation
- Identify a basic framework of FPPE and OPPE assessment.
- Explore effective methods and tools used to measure performance.
With a national imperative for cost effective, quality healthcare, APRNs are considered a provider of choice.

As billing providers, APRNs generate revenue; however, far greater value is gleaning through clinical coverage and quality outcomes.

Professional practice evaluation can be a means to assess quality and contributions of APRN practice.

Professional growth and development can be optimized with an effective performance evaluation program.
2010 Institute of Medicine Report

- Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
- Nurses should be full partners with physicians and others in redesigning U.S. health care.
- Effective workforce planning and policy-making require better data collection and an information infrastructure.
- Nurses should practice to the full extent of their education and training.

Transform nursing field to prepare nurses to lead change and advance health for all Americans.
IOM – Six Aims of Quality Healthcare

- Safe
- Effective
- Patient-centered
- Timely
- Efficient
- Equitable
Costs associated with longer length of stay and hospital complications have been shown to be decreased after the addition of APRNs to the service (Sise, et al., 2011).

Many APRN practices utilize creative means, such as telephone outreach and home visits, for ensuring patient care beyond the hospital stay, thereby decreasing readmission rates (Enguidanos, Gibbs, & Jamison, 2012).

Over utilization of resources can be decreased by the addition of APRNs and consistent application of resource reducing guidelines in ordering diagnostics, treatments and medications (Chen, McNeese-Smith, Cowan, Upenicks, & Afifi, 2009).
The majority of APRN associated outcomes studies have focused on consistency in adherence to evidence based practice standards with the associated cost savings via reduced complications and decreased length of stay (Kleinpell, 2009).

Comparisons of APRN outcomes to traditional providers and have shown either no difference or a reduction in morbidity and mortality (Gershengorn et al., 2011, Skinner et al., 2012, Scherr, Wilson, Wagner & Haughian, 2012).
<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Methodology</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burns, et al., 2002</td>
<td>Comparison of ventilator days, LOS and per-patient cost after adding an outcomes management-NP (OM-NP) as compared to before OM-NP was added. postNP n=125, 5 adult ICUs over one quarter, as compared with, preNP n=575.</td>
<td>Mean ventilator days post NP=11, pre NP=17. Mean LOS post NP=23, pre NP=32. Per patient cost post NP= $69,118, pre NP=$85,411.</td>
</tr>
<tr>
<td>Burns, et al., 2003</td>
<td>Retrospective comparison of baseline pre-outcomes-management NP (OM-NP), 18 months, to prospective 12 months where OM-NPs were added to 5 adult ICUs. Clinical and financial data compared.</td>
<td>Post addition of OM-NP showed decreased ventilator days by 1 day, ICU LOS by 3 days, hospital LOS by 2 days and mortality rate from 38% to 31%. Over $3,000,000 in cost savings in the OM-NP group.</td>
</tr>
<tr>
<td>Butler et al., 2011</td>
<td>Prospective analysis of NP documentation and charge capture. NPs used standardized templates for documentation in 3 ICUs over 3 years.</td>
<td>Increase in charge capture by 48%.</td>
</tr>
<tr>
<td>Chen et al., 2009</td>
<td>Retrospective data analysis of drug utilization and costs of NP-led care compared to usual care. Experimental group n=581 patients and control group n =626 patients.</td>
<td>Total drug costs per patient for NP=$636, control =$844; Average daily drug costs for NP=$89, control=$96; Average drug days for NP=66, control=80.</td>
</tr>
<tr>
<td>Cowan, et al., 2006</td>
<td>Quasiexperimental design comparing NP-led group to control group of usual care. LOS and hospital profit determined from cost savings.</td>
<td>Average LOS of NP group=5 days, usual care=6. Hospital profit NP group=$1591 per patient, usual care=$639 per patient.</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Methodology</td>
<td>Outcomes</td>
</tr>
<tr>
<td>------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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<tr>
<td>Ettner, et al., 2006</td>
<td>1207 patients randomized to either an NP/MD group or and MD only group. Comparison regression-adjusted costs between groups.</td>
<td>NP/MD group had net cost savings of $978 per patient over MD only group.</td>
</tr>
<tr>
<td>Meyer, et al., 2005</td>
<td>Retrospective comparison of one year of patient and economic outcomes of postoperative cardiovascular care before NPs added and another year after NPs added.</td>
<td>After NPs added, LOS decreased by 1.91 days and total cost decreased by $5039 per patient.</td>
</tr>
<tr>
<td>Russell, et al., 2002</td>
<td>Prospective analysis of LOS, rates of urinary tract infections and skin breakdown pre and post addition of NPs to the practice. The baseline included randomized sample of 122 patients admitted to Neuro ICU over 12 months as compared to 402 patients admitted in first six months of the following year after NPs added.</td>
<td>LOS post NP=8 days vs. baseline=11. UTI NP=2% vs. baseline 6%; Skin breakdown NP=0 vs. baseline=2%. Patient days showed 2306 fewer days than baseline group with total cost savings of $2,467,328.</td>
</tr>
<tr>
<td>Sise et al., 2011</td>
<td>Prospective analysis of adding NPs to Level 1 Trauma center. Analysis of demographics, injury severity scores, length of stay, complications, total direct costs of care and outcomes.</td>
<td>Post addition of NPs, decrease in complications by 28.4%, LOS by 36.2%, costs of care by 30.4%</td>
</tr>
</tbody>
</table>
APRNs and PAs can make a difference!

APRN/PA Impact on Surgical Infections

Scope of Surgical Infections
- 14-16% of all HAI
- 2nd Most common HAE
- Mortality rate doubles
- 60% more time in ICU
- Adds $1,398 - $26,019 per patient
- Adds $130-$845 million per year
- 5X more likely to be readmitted
- 40-60% are preventable
APRN/PA Impact on Avoidable Events

Scope of venous thromboembolic events
- Most common preventable cause of death, 10% of all deaths
- Incidence after major procedures 20-50%
- 100X greater in hospitalized patients
- 2nd most common cause of increased LOS
- 3rd most common cause of mortality
- $18,310 - $27,089 per patient
- 50% reduction in fatal PE with appropriate prophylaxis
Vanderbilt Trauma

- High acuity, high volume with seasonal surges.
- Transition area of 17 beds experiencing delayed throughput
- Hypothesized that by adding experienced Trauma NPs, we could improve throughput and quality in care.
- 1 year, compared with 2 years prior
- Results:
  - Increased volume of cases by 14.3%
  - 1.0 reduction in ALOS for entire trauma service
  - 27.8 million reduction in hospital charges.
  - Increased direct discharges by 21%.
  - MD/RNs found the addition of ACNPs beneficial, improved patient care, improved workflow, improved communication and throughput.
NPs on RRT DATABASE

- 898 calls Jan-Dec
- Average time of call 31.8 minutes
- 303 transfers to ICU
- 317 encounters generated critical care billing
- NP unique interventions - 3056
- 341 lab tests
- 454 medications
- 257 x-rays, 257 EKGs
- 26 procedures
- 860 education events
ACNPs added Jan. 2011

REDUCTION IN OUT OF ICU ARRESTS
Professional Practice Evaluation

✓ Joint Commission Standards
✓ MS.08.01.01 and MS.08.01.03
The Joint Commission

- Ongoing Professional Practice Evaluation (OPPE), MS.08.01.01
  - To move from cyclical to continuous evaluation of a practitioner's performance to identify practice trends that impact quality, patient safety and determine whether a practitioner is competent to maintain existing privileges or needs referral for a focused review.

- Focused Professional Practice Evaluation (FPPE), MS.08.01.03
  - To verify competency, when applying for new privileges (ie. new hire) and whenever questions arise regarding the practitioner's professional performance.
Focused Professional Practice Evaluation - FPPE
Focused Professional Practice Evaluation

• Clearly defined and consistently applied program to identify and outline competency or competencies for review, assign proctor, outline comprehensive plan for improvement, timeline for evaluation and associated measures.

• Approved through Joint Practice Committee, Credentials Committee and Medical Center Medical Board.
What is FPPE?

- A period of focused review (JC standard MS.08.01.01).
- Clearly defined performance monitoring process
- Time or volume limited
- Consistently implemented
- Assigned proctor, usually a peer
- Outlined plan for improvement
When is an FPPE completed?

- When a practitioner has the credentials to suggest competence, but additional information or a period of evaluation is needed to confirm competence in the organization’s setting.
- If questions arise (clearly defined triggers) regarding a practitioner’s professional practice.
When is an FPPE completed?

- Implemented for all newly requested privileges
  - Practitioners new to the organization
  - Existing practitioners applying for new privileges

- When practice issues are identified that affect the provision of safe, high-quality patient care
  - Triggered from an ongoing evaluation or clinical practice trends
  - Triggered by a single incident or sentinel event
FPPE can include …

• Chart review
• Monitoring clinical practice patterns
• Simulation
• Peer Review (Internal and/or External)
• Discussions with other individuals involved in patient care
• Direct Observation
Critical Care Advanced Practice - Focused Professional Practice Evaluation

Name of Practitioner being evaluated: ____________________________________________

This practitioner is undergoing a Focused Professional Practice Evaluation for the following reason:

____ Six month evaluation for newly hired practitioner, confirmation of competence as an Advanced Practice Provider. *See attached Delineation of Privileges List "Domains and Core Competencies for Nurse Practitioners"
____ Application for new privileges, confirmation of competence in new privilege(s)
____ Referred for focused review after Ongoing Professional Performance Evaluation. Date of OPPE: ______________________
____ Referred for focused review for other reason, please specify: ________________________________

The practitioner has satisfactorily demonstrated competence in practice and applicable privileges within his/her scope of practice and is recommended to be released from the focused monitoring period.

The practitioner has not yet demonstrated competence in certain areas of the privileges/scope of practice requested and has agreed to further evaluation as outlined below and within the determined time frame.

Assigned Proctor: ___________________________ Delineation of Privileges List made available to Proctor: ________

Time limit for further review (if indicated): __________ Date of follow up evaluation (if indicated): ______________

Specific competencies for review (if indicated):

________________________________________________________________________

________________________________________________________________________

Plan for improvement as determined in collaboration with proctor, practitioner and others as appropriate (if indicated):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

*Methods for measurement of improvement include but not limited to: direct observation, retrospective medical record review, overreads, review of surgical/procedure case lists and informal interviews with peers, house staff, nursing staff, patients and others as appropriate.

Practitioner: ___________________________ Date: ___________________________

Proctor (if other than Supervising MD): ___________________________ Date: ___________________________

Supervising MD: ___________________________ Date: ___________________________
Ongoing Professional Practice Evaluation - OPPE
Ongoing Professional Practice Evaluation

- Professional, practice management, procedural and clinical competencies identified for each APRN specialty.
- Quantifiable tools (i.e. dashboards, surveys) used to collect and display APRN associated performance indicators and outcomes.
- Qualitative reviews conducted twice yearly and included peer review, self-assessment and proctor assessment.
Why OPPE?

• To move away from the procedural, cyclical process in which practitioners are evaluated when privileges are initially granted and every 2 years thereafter.

• To continuously evaluate a practitioner’s performance

• To identify professional practice trends that impact on quality of care and patient safety.

• To decide whether a practitioner is competent to maintain existing privileges or needs referral for FPPE
What is OPPE?

- Clearly defined quality review process to evaluate each practitioner’s practice.
- Type of data collected may be general but also must include data that is determined by individual departments and be individual practice specific.
- Can include both subjective and objective data.
- Must occur more than once a year, usually every 6-8 months.
### Qualitative

- Professionalism
  - Behavior
  - Involvement/Commitment to Practice
  - Leadership
- Communication
  - Patients/Families
  - Health Care Team
  - Oral/Written
- Tools
  - Questionnaires
  - Surveys
  - Evaluation forms
  - Discussions
  - Direct observance
  - Confidential reporting methods
  - Chart audits

### Quantitative

- Performance Indicators
  - Blood transfusion patterns
  - Ventilator days
  - Hand hygiene
  - Protocol adherence
- Outcomes Data
  - Length of stay
  - Readmission rates
  - Nosocomial infection rates
- Technical performance
  - Complication rates
  - Frequency of procedures performed
  - Performance indicators (protocol, time out)
- Tools
  - Dashboards
  - Scorecards
  - Graphs
  - Reports
  - Checklists
Professionalism
Patient Care
Interpersonal communications
Medical/Clinical knowledge
Systems based practice
Practice based learning and improvement
Scientific Foundation
Leadership
Quality
Practice Inquiry
Technology and Information Literacy
Policy
Health Delivery Systems
Ethics
Independent Practice
Neurocritical care
Trauma
Glucose management
Surgical ICU
Cardiology arrhythmia
Inpatient medicine
Cardiothoracic ICU
Medical ICU
Hematology
✓ Provides patient care that is compassionate, appropriate and effective for the promotion of health, prevention of illness, treatment of disease and care at the end of life.
Medical and Clinical Knowledge

✔ Demonstrates knowledge of established and evolving biomedical, clinical and social sciences and the application of knowledge to patient care and the education of others.
Practice Based Learning and Improvement

✔ Able to use scientific evidence and methods to investigate, evaluate and improve patient care practices.
Interpersonal and Communication Skills

✓ Demonstrates interpersonal and communication skills that establish and maintain professional relationships with patients, families, co workers and other members of the healthcare team.
Professionalism

✓ Demonstrates behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity* and a responsible attitude toward patients, profession and society.
Systems Based Practice

✔ Demonstrates both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.
Updates to Professional Portfolio
Completed by Self (Advanced Practice Provider)

Chart Audit
Completed by External or Internal Peer

Privileged Procedure Review
Electronically Imported

Compliance CATs Database Information
Electronically Imported

Competency Review and Goals
Completed by All

Credo Evaluation
Completed by Self and Administrator

Ongoing Professional Practice Evaluation
February - April

New hire 6 month evaluation of core competencies
** Click here to review Delineation of Privileges, "Domains and Core Competencies for Nurse Practitioners"

Focused review for new privileges

Focused review required as a result of OPPE

Other need for focused review

Ongoing Professional Practice Evaluation – Mid Year
August - October

Update s to Professional Portfolio
Completed by Self (Advanced Practice Provider)

Chart Audit
Completed by external or internal Peer

Privileged Procedure Review
Electronically Imported

Competency Review and Goals
Completed by All

Credo Evaluation
Completed by Self and Administrator
OPPE – Secure Data Capture
<table>
<thead>
<tr>
<th>Professionalism</th>
<th>Poor</th>
<th>Needs improvement</th>
<th>Proficient, meets expectations</th>
<th>Advanced, experienced</th>
<th>Expert, consultant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
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<tr>
<td>Medical/Clinical Knowledge</td>
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<td>Interpersonal Communication</td>
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<td>Systems-based Practice</td>
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<td>Practice-based Learning and Improvement</td>
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<tr>
<td>Quality</td>
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<tr>
<td>Leadership</td>
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This practitioner meets expectations required for the following quality indicators:

- Inpatient NP/PA Bundle (O/E LOS, Blood transfusion rates, DC before noon, CAUTI, CLABSI, Hand Hygiene)
- SCIP Measures (BG control, DC periop abx, BB for CABG)

Please review the attached core competencies for practice (click on unit tab) and indicate whether these are all met or whether there are some competencies that can be improved.

Attachment: [VUH NP PA Core Competencies for Practice.xlsx](attachment://VUH NP PA Core Competencies for Practice.xlsx) (0.03 MB)

Please comment on practitioner’s accomplishments, strengths and opportunities for improvement.

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<table>
<thead>
<tr>
<th>Practice Management</th>
<th>O</th>
<th>REQ</th>
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<tbody>
<tr>
<td>History &amp; Physical (EMR)</td>
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<td>Daily Progress Note (EMR)</td>
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<td>Death Report &amp; Summary (EMR)</td>
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<td>Team Summary/Handover (EMR)</td>
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<tr>
<td>IMPAX Training</td>
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<td>Star Panel Training</td>
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<td>WIZ/HEO Training</td>
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<tr>
<td>Rx Star/Discharge Wizard</td>
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<tr>
<th>Procedures</th>
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<tbody>
<tr>
<td>Chest tube removal</td>
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<tr>
<td>Tracheostomy downsize/exchange</td>
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<td>Tracheostomy decannulation</td>
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<tr>
<td>Enteral feeding tube placement</td>
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<tr>
<td>Complex wound management</td>
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<tr>
<td>Percutaneous drain removal</td>
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<thead>
<tr>
<th>Clinical Practice</th>
<th>P</th>
<th>REQ</th>
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<tbody>
<tr>
<td>Anemia</td>
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<td>Bronchial hygiene</td>
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<tr>
<td>Cervical spine immobilization</td>
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<tr>
<td>Chest wall injury management</td>
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<tr>
<td>Deep vein treatment; Pulmonary embolism</td>
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<tr>
<td>Fever</td>
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<tr>
<td>Fluid/electrolyte replacement</td>
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<tr>
<td>Glycemic control</td>
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<tr>
<td>Open fracture management</td>
<td></td>
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<tr>
<td>Splenic vaccinations</td>
<td></td>
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<tr>
<td>Spinal fracture management</td>
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</tbody>
</table>
Please indicate updates to your professional portfolio (check all that apply).

- Committees involvement
- Publications
- Presentations
- Special projects
- Continuing education
- Lectures/Teaching responsibilities
- Precepting students
- Research
- Process improvement initiatives
- Abstracts in review
- Boarding
- Protocol development
- Orientation development
- Elected office
- Honors and awards
- Other

Please share more details regarding your updates to your professional portfolio (you may copy and paste these directly from your CV).

Please list your professional goals for the upcoming year (please list at least 2).

Have you completed the yearly required amount of contact hours for your area of work? Check all that apply.

- 40 CME credits for Department of Medicine providers
- 20 CME credits for Department of Anesthesiology providers
- 20 CME credits for Department of Surgery providers
- 20 CME credits for Department of Neurology providers

Must be able to provide evidence of continuing education requirement if applicable.

Stroke Education: All NPs/PAs who care for patients with stroke (as primary or secondary dx) must have at least 8 hours of related education (stroke, cardiac, diabetes) per year. These hours can include journal articles, lectures, conference sessions, etc. (does not have to be formal contact hours). Please list your 8 hours of education here:

- [ ] Must provide value

Have you completed the 2 contact hours of controlled substance education as required by the Tennessee Board of Health?

- [ ] Yes
- [ ] No

For ICU and Trauma NPs/PAs, have you completed annual "Violent Restraint" education?

- [ ] Yes
- [ ] No
- [ ] Does not apply

- Restraint policy and Face to Face documentation

Have you completed the webinars required for faculty appointed practitioners?

- [ ] Yes
- [ ] No

https://medapps.mc.vanderbilt.edu/toto

https://medapps.mc.vanderbilt.edu/toto

Please indicate your current licensure and certifications (check all that apply).

- ACNP-BC
- AG-ACNP-BC
- FNP-BC
- ANP-BC
- APRN/Master's in Nursing
- DNP/PhD
- PA-C
- RN
- DEA
- ACLS
- BLS
- FCCS Instructor
- Other

Do not list expired licenses/certification

Which procedures do you currently hold privileges for? Check all that apply.

- Central line placement
- Central line change over wire
- Intubation
- Arterial line placement
- Lumbar puncture
- Moderate sedation
- Chest tube insertion
- Thoracentesis
- IABP removal
- Arterial sheath removal
- Other

- Only list current privileges procedures

Have you completed the 2 contact hours of controlled substance education as required by the Tennessee Board of Health?

- [ ] Yes
- [ ] No

- Must provide value

- Journal Article: "Stroke in Elderly Patients" (30 minutes or .5 hour)
Competency Assessment – Adherence to Best Practices
Click HERE for NCU NP Quality Metrics

**QUALITY METRICS:**

- Foley Insertion Date: 05/25/2011
- Removal Date: ___________________________
- CVC 1 Insertion Date: 05/29/2011
- Removal Date: ___________________________
- CVC 2 Insertion Date: ____________________
- Removal Date: ___________________________
- 7 Day Disposition Update Date: 06/01/2011 (Patient cannot transfer due to critical illness)
- Nutrition Start Date: 05/25/2011
- PT/OT Ordered Date: 05/27/2011
- ST - Swallow Study/Cognitive Screen Date: 05/26/2011
- DVT Prophylaxis: Lovenox
- Stress Ulcer Prophylaxis: H2 blocker
- Mechanical Ventilation: Yes
- SAT Performed: Yes
- SBT Performed: Yes

Billing Hours can be placed here.

Billing Hours can be inserted here!
### NP MICU Mechanical Ventilation patients with Stress Ulcer Prophylaxis

**MICU Quality Measure - MICU : MICU**

#### 9/30/2012

<table>
<thead>
<tr>
<th>Provider</th>
<th>% Mech Vent Pts with SUP</th>
<th>% Mech Vent Cases FYTD</th>
<th>% Mech Vent Pts with SUP FYTD</th>
<th>Mech Vent Cases FYTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHASSAN, CHERRY S, APNP, NURSE PRACTITIONER</td>
<td>92%</td>
<td>13</td>
<td>90%</td>
<td>41</td>
</tr>
<tr>
<td>CLEVELAND, CHRISTINA M, NURSE PRACTITIONER</td>
<td>100%</td>
<td>25</td>
<td>98%</td>
<td>51</td>
</tr>
<tr>
<td>DAVIDSON, STEPHANIE, NURSE PRACTITIONER</td>
<td>100%</td>
<td>24</td>
<td>100%</td>
<td>59</td>
</tr>
<tr>
<td>EVANS, EMILY, NURSE PRACTITIONER</td>
<td>100%</td>
<td>16</td>
<td>98%</td>
<td>54</td>
</tr>
<tr>
<td>FLEMINGS, LISA N, NURSE PRACTITIONER</td>
<td>100%</td>
<td>10</td>
<td>96%</td>
<td>41</td>
</tr>
<tr>
<td>FELLERLY, SUSAN, NURSE PRACTITIONER</td>
<td>94%</td>
<td>18</td>
<td>94%</td>
<td>54</td>
</tr>
<tr>
<td>HOLCOMBE, EMILY, NURSE</td>
<td>74%</td>
<td>19</td>
<td>74%</td>
<td>49</td>
</tr>
<tr>
<td>LANSPIRISIR, JANNA S, NURSE PRACTITIONER</td>
<td>75%</td>
<td>4</td>
<td>97%</td>
<td>31</td>
</tr>
<tr>
<td>WILLIAMS, KRISTINA JILL, NURSE PRACTITIONER</td>
<td>96%</td>
<td>28</td>
<td>90%</td>
<td>75</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>84%</strong></td>
<td><strong>157</strong></td>
<td><strong>96%</strong></td>
<td><strong>426</strong></td>
</tr>
</tbody>
</table>

11/13/2012

This document is confidential and privileged pursuant to the provisions of Section 63-6-219 of the Tennessee Code Annotated, the contractual obligations of Vanderbilt University to its insurance companies, the attorney-client privilege and other applicable provisions of Law.
Practice-Specific Quality Indicators

- NP RBC Utilization
- NP Service O/E LOS
- NP Unit O/E LOS
- NP Discharges by noon
- NP Readmissions
- CLABSI
- CAUTI
- Hand hygiene
- Practice specific metrics for clinical practice standards and processes
RBC to RESERVE (will obtain type&screen/crossmatch as needed)

- Do not reserve any blood

<table>
<thead>
<tr>
<th>Units: 1)</th>
<th>2)</th>
<th>4)</th>
<th>6)</th>
<th>10)</th>
<th>Other:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milliliters:</td>
<td></td>
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RBC to TRANSFUSE

- Do not transfuse any blood

<table>
<thead>
<tr>
<th>Units: 1)</th>
<th>2)</th>
<th>4)</th>
<th>6)</th>
<th>10)</th>
<th>Other:</th>
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<tbody>
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<td>Milliliters:</td>
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REASON for TRANSFUSION (REQUIRED):
- Acute blood loss with hemodynamic instability
- Symptomatic anemia
- Severe hemolytic anemia (hct < 18 or hgb < 6)
- Anticipation of Hematopoietic failure
- Pre-op transfusion for anticipated blood loss
- Red cell exchange via apheresis (Dialysis Unit only)
- Sickle cell disease

--- Authorizing attending/provider: (required)

### SPECIAL PREPARATION for RBC Products: Check all relevant & give reasons

- Use Irradiated RBC for REASON:

- Use Washed RBC for REASON:

### Order Urgency/Start Time:

(Click the link to view RBC Turn-Around-Times)
- Routine
- STAT - If patient condition requires blood within 15 min, order trauma blood by calling the blood bank 322-2233

### Delivery of blood product:

- Nurse will enter a "send" order when ready to receive and hang product. (MOST COMMON in the Emergency Department and all areas. DO NOT use for OR or for exchange transfusion)
- Blood bank to send ALL product to current patient location via tube system as soon as available. (Primarily used by OR or in emergent situations)
- Blood bank to prepare cooler with product for pick-up. (RESTRICTED to select procedural areas, i.e. OR, dialysis, ECMO, cath lab)
OPPE – Tracking non-billing productivity
What metrics will you measure?

- What are outcomes valued by your practice?
- What are outcomes valued by the institution?
- Are any of your outcomes clinical and if so, are they evidence-based?
- Are any of these outcomes (clinical and other) directly affected by APRNs?
- How do the outcomes chosen measure your APRN core competencies?
OPPE – Setting goals in line with Institutional Goals
Getting started…

- Define your outcome and goal.
- How will the outcome be measured?
- Is there data already being collected on this metric? If so, how can the data be mined and presented in a meaningful reader format?
- Can informatics be created to automatically collect the data? If not, how can the APRN collect the data?
- If the APRN is collecting the data, can the collection process be integrated into the current workflow?
- What is your target value? Reach value? Unacceptable value?
- How will you address unacceptable values consistently?
- How will the APRNs and others in your practice be able to monitor this data?
“...performance...of clinical microsystems is often hidden from view because of a lack of metrics, data or benchmarking information to reveal whether or not everything is done every time in the right way at the right time in the best way for the best possible results...Continuous nurturing of (APRN practice) to be information rich is essential....
References


Bringing the New Joint Commission Standards for Credentialing and Privileging Within Reach of the Community Hospital, An Institute for Health Metrics White Paper 2008

DeMilt, D, Fitzpatrick, J, McNulty, R. 2010. Nurse Practitioners job satisfactions and intent to leave current positions, the nursing profession and the nurse practitioner role as a direct care provider. Journal of American Academy of Nurse Practitioners, 10, 1-8

References


References


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