Leaving Med Wreck In the Dust

Cyndy Clegg, BS Pharm, MHA, FASHP
Director of Pharmacy, Swedish Edmonds

March 17, 2016
Housekeeping Items

- Webex Chat
- Line Muting
- Copy of slides
- Evaluation
Visit the WSHA Medication Safety Homepage!


Resources for:
- Anticoagulant ADEs
- Hypoglycemic ADEs
- Opioid verdose ADEs
- Antimicrobial Stewardship
Data Submission

• All hospitals in Washington state joined Partnership for Patients!

• What’s in it for your facility to submit data to WSHA?
  • Data is **power** and information to **improve patient safety**!
  • Receive **monthly reports and graphs** regarding ADE rates.
  • Understand how your **hospital compares** to like hospitals.
  • Understand your hospital’s **trend over time** to predict areas of opportunity for improvement.
  • Use these reports to drive **root cause** and **continuous improvement**.
  • Share best practices as you **collaborate** with others.
# January 2016 Summary Results

<table>
<thead>
<tr>
<th>Category</th>
<th>Opportunity</th>
<th>Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmissions</td>
<td></td>
<td>20.2%</td>
</tr>
<tr>
<td>OB Early Elective Delivery</td>
<td></td>
<td>83.5%</td>
</tr>
<tr>
<td>OB Preeclampsia</td>
<td></td>
<td>84.6%</td>
</tr>
<tr>
<td>OB Episiotomy</td>
<td></td>
<td>63.4%</td>
</tr>
<tr>
<td>CAUTI ICU Rate</td>
<td></td>
<td>60.7%</td>
</tr>
<tr>
<td>CAUTI Hospital-wide Rate</td>
<td></td>
<td>47.5%</td>
</tr>
<tr>
<td>ADE Opioids</td>
<td></td>
<td>43.6%</td>
</tr>
<tr>
<td>Sepsis</td>
<td></td>
<td>36.3%</td>
</tr>
<tr>
<td>SSI Total Hip</td>
<td></td>
<td>31.1%</td>
</tr>
<tr>
<td>OB Trauma w/o Instrument</td>
<td></td>
<td>27.4%</td>
</tr>
<tr>
<td>SSI Cardiac</td>
<td></td>
<td>22.1%</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td></td>
<td>22.0%</td>
</tr>
<tr>
<td>OB Trauma w/ Instrument</td>
<td></td>
<td>21.0%</td>
</tr>
<tr>
<td>ADE Anticoagulants</td>
<td></td>
<td>20.0%</td>
</tr>
<tr>
<td>SSI Hysterectomy</td>
<td></td>
<td>19.7%</td>
</tr>
<tr>
<td>SSI Total Knee</td>
<td></td>
<td>17.6%</td>
</tr>
<tr>
<td>Pressure Ulcers</td>
<td></td>
<td>16.9%</td>
</tr>
<tr>
<td>Falls</td>
<td></td>
<td>13.6%</td>
</tr>
<tr>
<td>CLABSI Hospital-wide Rate</td>
<td></td>
<td>10.4%</td>
</tr>
<tr>
<td>CLABSI ICU Rate</td>
<td></td>
<td>9.6%</td>
</tr>
<tr>
<td>OB Induced C-Sections</td>
<td></td>
<td>7.5%</td>
</tr>
<tr>
<td>OB NTSV</td>
<td></td>
<td>6.6%</td>
</tr>
<tr>
<td>SSI Colon</td>
<td></td>
<td>1.5%</td>
</tr>
<tr>
<td>Venous Thromboembolism</td>
<td></td>
<td>0.0%</td>
</tr>
<tr>
<td>C.diff</td>
<td></td>
<td>-7.3%</td>
</tr>
<tr>
<td>ADE Hypoglycemic</td>
<td></td>
<td>-16.9%</td>
</tr>
<tr>
<td>Ventilator Condition</td>
<td></td>
<td>-67.3%</td>
</tr>
</tbody>
</table>

- Looking good!
- We’re getting there.
- How do we move this?
ADE Rate Visual - Example

Definition: Number of patient events with an INR >3 after any warfarin administration (for patients cared for in an inpatient area) over the number of patients (cared for in an inpatient area) on warfarin. A patient that has multiple elevated INRs will be counted as one event until it drops below 3.0 and rises above 3.0 again. Exclusions: emergency department readings, patients admitted for trauma, patients with liver failure diagnosis, and patients given argatroban before warfarin.

Data Source: Washington State Hospital Association (WSHA) Quality Benchmarking System.
Questions?

Meg Kilcup, PharmD
Director, Medication Safety Practices
253-740-1383  I  MegK@wsha.org

Thank you!
Objectives

Webinar participants will be able to:

• Describe the benefits of doing a pilot to test a medication reconciliation process

• Leverage the benefits provided by the MARQUIS Implementation Manual

• Understand the importance of good storytelling
What is the Opposite of Wreck?

- Aid
- Assist
- Build
- Construct
- Create
- Cure
- Enable

- Fix
- Grow
- Heal
- Help
- Improve
- Mend
- Repair
- Strengthen
Define Medication Reconciliation

A formal process of identifying the most complete and accurate list of medications a patient is taking and using that list to provide correct medications for the patient anywhere within the health care system.

Sounds easy, doesn’t it? 😊
History of Med Recon

Joint Commission Requirements

2005 National Patient Safety Goal #8

• “Accurately and completely reconcile medications across the continuum of care.”
• Unfunded mandate
• Processes required to be in place 2006
• Revoked goal in 2009
• Revised requirement in 2011
• Whose job is it, anyway?
Where Do We Begin?

Medication reconciliation is not simply a regulatory requirement that is someone else’s job. It is doing what it takes to make sure each patient is ordered the right medications in the hospital and after discharge.

Errors in the medication reconciliation process can undo a lot of otherwise excellent medical care.
Swedish Edmonds

- Daily census: 145
- 450+ physicians
- 1,400+ staff
- Full scope of medical and surgical services, including Level IV Trauma emergency medicine, diagnostic, treatment and support services
- 2015: 8200 admissions
The Beginnings

• Quality and Safety Council
  • Composed of physicians and senior leadership
  • Charge by President of Medical Staff
    • “Fix medication reconciliation”
    • Discussion the following month
  • Discussion with Committee
    • “Do you trust the medication list?”
    • How can we ensure accurate medication handoffs?
    • Cost avoidance and FTE requirement from literature (2004)
    • Information gathering about prior history
    • Two months for detailed plan

• Research best practice
MARQUIS

- The Society of Hospital Medicine
- Funded by AHRQ grant
  - Best practices around MR
  - Examples
  - Lit review
  - Tools for staff
  - ROI
MARQUIS Checklist

• Pre-Implementation Checklist
  • Learn about best practices
  • Analyze current care delivery
  • Collect baseline data
  • Choose reliable interventions
  • Gain organizational support
  • Identify key stakeholders
  • Create a multidisciplinary team
  • Set general goals and timeline
  • Turn general aims into specific aims
  • Follow a framework for improvement
  • Complete the MARQUIS pre-intervention site assessment
Learn About Best Practices

- MARQUIS
- ASHP (American Society of Health System Pharmacists) [www.ashp.org](http://www.ashp.org)
- Peers
Analyze Current Care Delivery

• What is the current state?
  • Ask questions of a variety of physicians, nurses, pharmacists
  • What is going on in different areas of the hospital?
  • Do we have a standard approach at all touch points?
Collect Baseline Data

• Decide on data points
  • Just a few metrics
  • Easy to get and track
  • What matters
    • Readmissions? Drug related readmissions?
    • Return ED visits?
    • ADEs?
    • LOS?
    • Number of MR?
    • Number of discrepancies?
Choose Reliable Interventions

• What interventions make sense for your organization?
  • What? Med histories?
  • Where? ED, pre-admit, discharge, post-discharge?
  • When? Days? Hours?
  • How? What is the role of IT?
Interventions: What?

Medication histories, reconciliation, and education for high-risk patients
Interventions: Where?

Admission (Emergency Department) and Discharge
Interventions: When?

Peak times for admission
Interventions: Who?

Pharmacists
Gain Organizational Support

Identify the underlying reason for leadership’s interest in MR

• Financial?
  • Return on investment calculator

• Quality and Safety?
  • Literature

• Ownership?
  • Staff satisfaction?

*The average hospital patient is subjected to at least one medication error per day.*
What About a Pilot?

- Test of an idea or process
- Provides an “out” for leadership
Identify Key Stakeholders

- Physicians
  - Hospitalists
  - ED
  - PCP
- Pharmacists
- Nursing
- Case management
- Quality and Safety personnel
Now What?

Best practices
Documentation plan
EMR
Input from stakeholders
Identify Ideal State
MARQUIS Resources
Phasing Implementation

- Unit, Floor, or Service
- Timing (Admission or Discharge)
- Patient Risk
- Component (Educational Efforts First)
Fragmenting the process by admission or discharge is not ideal because it artificially separates a process that by definition is attempting to achieve seamless care across a continuum.

Similarly, focusing only on certain medications is of limited utility because in the end it is the patient, not the medication, who should be the focus of your interventions.
The Swedish Edmonds Plan

• Using pharmacists to focus on admission AND discharge MR
  • Recommendation for knowledge, skills, and behaviors – not a specific clinician
    • Do they have the knowledge, skills and behaviors needed to complete the task?
    • Who else in the organization has these skills?
    • Is the “best” person for the task the person who is completing the task?
  • Pharmacists are the medication experts
Commitment:
• 3 months
• Pharmacist in ED 4 hours per day, M-F
• Pharmacist for discharge 4 hours per day, M-F

Metrics:
• #MR
• Time spent
• Impact on readmissions
• Stories
• # discrepancies per patient
The Ask

- Formally present plan to larger stakeholder group for support
- Proposed metrics
  - ROI
- Description of process
- CEO
Results of the Pilot

- High risk medications missing or wrong
- Adherence/lack of understanding
- Financial barriers

- 4 discrepancies per patient on average
- Overwhelming physician support
The Power of Storytelling

“Audiences forget facts, but they remember stories. Once you get past the jargon, the corporate world is an endless source of fascinating stories.”

- Ian Griffin
Admission Stories

- Pradaxa duplication, carried through to inpatient orders
- Amiodarone discrepancy
- Dx/treatment of diabetes revealed
- Presenting diagnosis of “dizziness” patient on 12 medications, over 20 meds on med list, dosages in disarray, 9 potentially causing “dizziness”
Discharge Stories

- Warfarin dose restarted (INR of 8)
- Not using inhaler due to $, admission for asthma exacerbation
- Patient taking quetiapine post discharge, stopped in hospital due to prolonged QT
- Diabetes – non-adherence
- Levitiracetam non-adherence
- Insulin injections are “a pain”
Hello?
What’s Next?

• Communication to next provider of care

• Additional inputs for admission:
  • Trial with orthopedic surgeon to meet with patients before surgery
  • Direct admissions
Connect and Collaborate with Your Peers

“We need to play each others instruments.”

- Steven Johnson
Ask to Pilot Your Process

“Great things are done by a series of small things brought together.” -Vincent Van Gogh
Just Get Started!

“If everyone waited to become an expert before starting, no one would become an expert. To become an EXPERT, you must have EXPERIENCE. To get EXPERIENCE, you must EXPERIMENT! Stop waiting. Start stuff.” — Richie Norton
Action / Next Steps

• Ask yourselves…
  • “Do we trust our med lists we receive from others?”
  • “Do others trust the meds lists they receive from us?”

• If not, what steps in the med recon process could be improved?
  • Getting medication history on admission
  • Reconciling historical to current meds
  • Reconciling meds prior to discharge/transfer
  • Transmitting reconciled med list to next provider

• Is there a pilot intervention we could try?
• Join the WSHA Partnership for Patients
Contact

Jeff West MPH RN
Quality Improvement Consultant
jeffwe@qualishealth.org
206-288-2465

Martha Jaworski, MS, RN, CIC
Quality Improvement Consultant
marthaj@qualishealth.org
(208)383-5944

For survey:
https://www.surveymonkey.com/r/8FT5FF2

For more information:
www.Medicare.QualisHealth.org/ADE