Lost in Translation: Improving Med Rec Through Collaboration

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Conflict of Interest

- We have no actual or potential conflict of interest in relation to this activity.

Illinois Council of Health-System Pharmacists 2015 Annual Meeting

Pharmacist Objectives

- Describe key metrics to evaluate the effectiveness of a Discharge Medication Review program.
- Identify opportunities to optimize the Electronic Health Record to improve efficiency of a Pharmacist Discharge Medication Review program.
- Explain the "life-cycle" of an order and how other facilities and/or encounters are impacted by transitions of care into or out of an acute care setting.

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Technician Objectives

- Define the difference between performing discharge medication reconciliation and discharge medication review.
- Recognize common defects when a patient experiences a transition of care.
- Explain the "life-cycle" of an order and how other facilities and/or encounters are impacted by transitions of care into or out of an acute care setting.

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OSF Saint Francis Medical Center

- 616 bed tertiary care medical center located in Peoria, Illinois
  - 124 beds in Children's Hospital of Illinois
  - Midwest St. Jude affiliate
- Teaching affiliate of the University of Illinois College of Medicine at Peoria
- Level 1 Adult and Pediatric Trauma Center
- Currently 80+ pharmacists on staff

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Medication Reconciliation[1]

- A formal process for identifying and correcting unintended medication discrepancies across transitions in care

1. Pronovost P, Weast B, Schwarz M, Wyskiel RM, Prow D, Milanovich SN, Berenholtz S, Dorman T, Lipsett P. Medication reconciliation: a practical tool to reduce the risk of medication errors. J Crit Care. 2003 Dec;18(4):201-5.

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Medication Reconciliation: Why is it important? [1]

- Up to 67% of patients admitted to hospitals have unintentional medication discrepancies
- Reported rates of discrepancies having the potential to harm are as high as 59%

1. Kwan JL, Lo L, Sampson M, Shojania KG. Medication reconciliation during transitions of care as a patient safety strategy: a systematic review. Ann Intern Med. 2013 Mar 5;158(5 Pt 2):397-403.

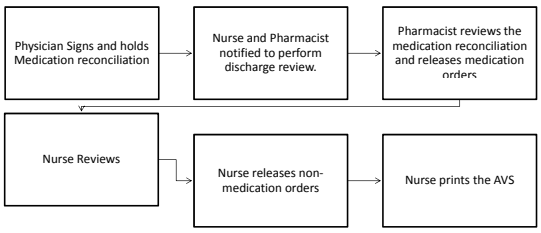
The Circle of Med Rec Life

- Discrepancies on PTA med list become discrepancies on inpatient list
- Discrepancies on inpatient list become discrepancies on outpatient list
- Changes made after leaving the facility do not always get resolved in our EMR
- These changes may become discrepancies on PTA med list next time

Medication Reconciliation vs. Medication Review at OSF

- Medication Reconciliation
  - Provider function
  - Process of determining what meds to order from PTA med list and other meds at a transition of care
- Medication Review
  - Performed by a pharmacist prior to patient discharge
  - Review appropriateness of provider order choices

Discharge Order Workflow



Discharge Med Rec Review at SFMC

- Centralized area where pharmacists perform reviews
- Auto-consult is sent to pharmacy in-box with each order in the discharge workflow
- Pharmacists work out of in-box in the order the consults are received

Case Study

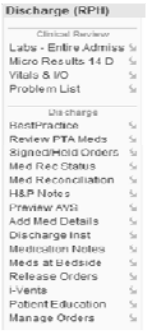
Pharmacist Discharge Procedure

- RPh Discharge Navigator
- Checklist
- Documentation

Discharge Medication Review Workflow

- Pharmacist performs the discharge medication review
  - Will review the patient's discharge after visit summary (AVS) for any medication discrepancies
    - In addition will review:
      - Prior-to-admission (PTA) medication list
      - Inpatient medication list
      - Culture results
      - Lab results
      - Vital signs
      - Progress notes

RPh Discharge Navigator



Pharmacy Discharge Review Checklist

Discharge Med Review Consult Checklist: / /

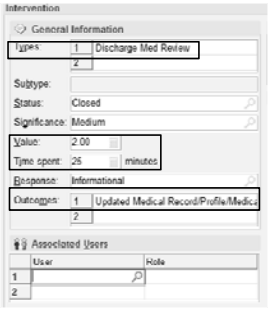
Patient Name		Patient Name	
	Is Med Rec Complete?		Is Med Rec Complete?
	✓AVS including instructions		✓AVS including instructions
	Review D/C Med Rec		Review D/C Med Rec
	Release D/C Meds		Release D/C Meds
	Send NUR 1113 order		Send NUR 1113 order
	Create i Vent		Create i Vent
	Complete Consult		Complete Consult
	Done in-basket message		Done in-basket message

Discharge Medication Review Documentation

- Pharmacist documents completion of discharge medication review
- Documents interventions made on discrepancies of critical or high severity

Intervention Documentation

- Example of discharge medication review with defects
- Because there were defects, additional documentation is needed if they are critical or high severity



Metrics – What We Measure

- Time
  - Average time per review
  - Average time review in queue
- System Score card
  - % Patients reviewed prior to discharge
  - % Defect free reviews
- SFMC
  - % High and Critical Interventions
  - Average # defects per review requiring intervention

Collaborating with Nurses

- Pharmacists found medication discrepancies at discharge that originated on admission
- Determined that nurses were not documenting the PTA med list in a consistent way
  - Confirmed with Simulation Exercise
- Established a new position called "Medication History Specialist (MHS)" Nurse
  - Responsible for timely completion of PTA med list and allergy documentation

Collaborating with Nurses

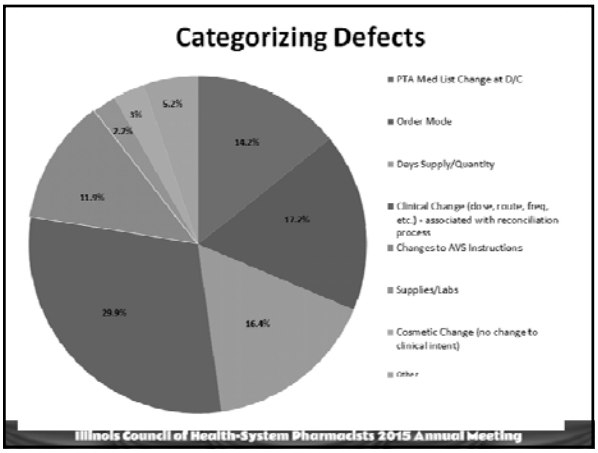
- MHS nurses were trained with 2 hour "in the seat" training sessions
  - Pharmacist assisted with training
  - Didactic as well as hands-on
  - Patient scenarios with real-life examples
- Mechanism created to allow documentation of events related to inaccurate PTA medication lists
- Pharmacists met with MHS managers to discuss events and learning opportunities

Collaborating with Nurses

- Eight different "tip sheets" created to assist MHS nurses
- Pharmacists also given updated training and tip sheets for updating PTA medication lists
- Collaborated with nurses on presentation to Magnet surveyors

Collaboration with Providers

- Individual phone calls
- Medication event follow up with Med Staff events
- UHATS/Hospitalist scorecard
  - Department meeting education created
- QSB / System feedback
- Education for Medical Residents and Attendings



Collaborating with Other Facilities

- Local LTACH was finding discrepancies on their admissions from our facility
- Worked with the hospitalists to find a process to resolve issues
- LTACH pharmacists called our Med Rec Office for every admission
- After 3 months of collaboration, phone calls no longer needed

Collaborating with Other Facilities

- Within our own system, we recognized that our data was not comparable from facility to facility
- Facilities reviewed different information during a review
- Facilities "counted" different things as defects
- As a system, we didn't know where to focus our efforts with the non-standard data
- A survey was created in order to establish a baseline

Difference in Defect Definitions

Incorrect quantity or days supply	68.75%	11
Incorrect/improper dose, route, and frequency of a prescription medication	100.00%	16
Incorrect start date	68.75%	11
Incorrect Order mode (escribe, normal, fax, OTC, etc)	31.25%	5
Missing dose or tablet size on OTC	31.25%	5
Non-ideal product selection (no change in clinical intent; ie.change in tablet size, neb consolidation, etc)	50.00%	8
Presence of multiple prescriptions when only one is needed as outpatient (ie. steroid taper, warfarin different doses, etc)	68.75%	11
Lack of order for follow labs (ie. INR, Vanco level, etc)	50.00%	8
Updates to the typed discharge instructions on the AVS	50.00%	8
Dug-drug mismatch	50.00%	8
Medication discrepancy at discharge that is caused by a discrepancy on the PTA med list	100.00%	16
Lack of supplies ordered (ie. New diabetes diagnosis without needles, lancets, etc)	18.75%	3
Un-reconciled inpatient orders at discharge (ie. Maintenance fluids in a patient going home)	75.00%	12
Incorrect pharmacy chosen for the E-scribe/Fax	25.00%	4
Other (please specify)	25.00%	4

Responses

Collaborating With Other Facilities

- We worked with the CNOs and CMOs of each of our system facilities
- Recognized needs for standard definition of a defect
  - Establish a new baseline
  - Determine which portion of the process to allocate resources

Lessons Learned

- Logistics considerations
  - When resources are needed
  - What resources are available
  - Where discharge med review occurs
- Documentation
  - Justification of service
  - Process improvements
  - Scorecard/Outcomes data

Lessons Learned

- Collaboration
  - Do it early and often
  - Include all players who touch medication reconciliation, inpatient and outpatient
  - Include the C-Suite
- Medication reconciliation is a fluid process
  - Process improvement should not be done in a silo

Question 1

- What is the difference between discharge medication reconciliation and discharge medication review?
  - A. Discharge medication reconciliation is a pharmacist function
  - B. Discharge medication review is performed by a panel of providers when issues are identified post-discharge
  - C. Discharge medication reconciliation is a provider function to determine discharge medications and pharmacists review their actions taken during discharge medication review
  - D. Discharge medication reconciliation and discharge medication review are synonymous terms

Question 2

- Which of the following are common defects identified when a patient experiences a transition in care?
  - A. Inappropriate medication frequency
  - B. Medication duplication
  - C. Medication omission
  - D. All of the above

Question 3

- Which of the following key metrics can be used to evaluate the effectiveness of a discharge medication review service?
  - A. HCAHPS scores
  - B. % of defect free discharge medication reviews
  - C. Average # of meds reviewed per discharge
  - D. Average time to perform a discharge medication review

Question 4

- Discharge medication review workflow was streamlined at OSF by addition of which of the following?
  - A. Collaborative practice agreement for pharmacists to reconcile medications
  - B. RPh discharge navigator in the EHR
  - C. Pharmacy Technicians obtaining medication histories
  - D. Patients having complete and up-to-date medication lists

Question 5

- Which of the following is correct for the "Life Cycle" of a medication order?
  - A. Inpatient and outpatient medication lists are exclusive to reduce potential discrepancies
  - B. Patients' medication lists change little after discharge, and a medication history is not needed for a bounce back re-admission
  - C. When not identified and corrected, medication discrepancies will flow from the outpatient to the inpatient setting
  - D. Medication discrepancies are infrequent

What questions do you have for us?