Hospital Quality Institute
2016 Vanguard Award Application

Providence Little Company of Mary Medical Center Torrance

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Application Title: **RX for Safe Medication Therapy Across Care Transitions (M TACT)**

Topical Area(s):

☒ Patient Safety
☒ Quality Improvement
☒ Patient Experience

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Thursday, August 11, 2016

Hospital Quality Institute
1215 K Street, Ste 930
Sacramento, CA 95814

RE: 2016 Vanguard Award

To Whom It May Concern:

Please accept this letter in support of the enclosed submission for the Hospital Quality Institute's 2016 Vanguard Award for Providence Little Company of Mary Medical Center Torrance.

The Medication Therapy Across Care Transitions (M TACT) project that is described in the attached documents represents a collaboration amongst many stakeholders that is in line with the journey that this organization has committed to in becoming a High Reliability Organization.

The cross functional team that worked on this project, lead under the vision and direction of our Administrative Director of Pharmacy Services, Muno Bholat, cultivated a commitment to improve a process that has a wide reach across so many patients as addresses a critical patient safety issue. This work is not only in line with the vision of the Hospital Quality Institute to become highly reliable with zero defects in care, but it is also in line with our Providence Health & Services promise to, *together, we answer the call of every person we serve: know me, care for me, ease my way.*

The work that was done at Providence Little Company of Mary Medical Center Torrance has also been translated to our other acute care hospital in the South Bay, Providence Little Company of Mary Medical Center San Pedro allowing us to address such a critical component in the care of a patient across a wider spectrum.

On behalf of the executive team at Providence Little Company of Mary Medical Center Torrance, I thank you for your time and consideration for recognizing this important work that has been done.

Best Regards,

Richard Glimp, M.D.
Chief Medical Officer
South Bay Community Services

Executive Summary

The Institute of Medicine 2006 reports that 40% of medication errors occur due to inadequate reconciliation during admission, discharge, and transfer of patients. Of these errors, 20% result in patient harm. With a goal to prevent these errors, we developed a four phased model called M TACT (Medication Therapy Across Care Transitions) focused on pharmacy technicians and pharmacists ensuring accurate medication history across transitions. Phase I eliminated admission medication defects (58% to 0%) for 100% of adult medical patients. With the implementation of the electronic medical record, we found that medication errors were introduced at discharge in 72% of patients. This lead to phase II requiring pharmacist review of medication reconciliation at discharge. Currently we review 70% of patient's discharges with a goal of 100%. Phase III aimed at improving patient adherence by ensuring patients go home with their medications. Since inception, an average of 72% of patients had their discharge prescriptions filled by our pharmacy. In Phase IV we recognized a need to manage patients on complex drug therapies during their transition to home and established the pharmacist managed Center for Drug Therapy Management outpatient clinic. Our program delivers a sustainable and scalable model to ensure safe medication therapy across care transitions.

Background and Relevance

Care transitions are error-prone processes that are filled with patient safety risks; medication reconciliation being an important component during those care transitions. Without a comprehensive approach to medication reconciliation, that is viewed much more broadly then just an accreditation function, errors can arise as a result of numerous challenges that can be faced when attempting to get an accurate list of patient's medications. This project focused on utilizing pharmacy subject matter expertise as a component of medication reconciliation to reduce errors with the latter phase of addressing ways to minimize out of pocket expenditures to the patient and assisting with discharging the patient with medications in hand easing the transition to the next level of care.

Description of Effort

Scope

Initially stakeholders were identified for the pilot which included RN leaders from the pilot unit, a representative from performance improvement, medical staff, and pharmacy. Upon successful completion of the pilot, metrics were provided on a quarterly basis.

Customers included everyone involved in the medication reconciliation process: nursing, physicians, pharmacists, and patients. The stakeholders helped to define the desired outcome by creating current status process maps, identifying delays in service, and categorizing defects of the process. Pharmacy & Therapeutics Committee, Medical Executive Committee (MEC), Medication Safety Team, and physician support helped develop the protocols and practice.

Process

Pharmacy technicians with experience in outpatient pharmacy are deployed to the emergency department, adult medical units, and conduct pre-admission phone calls for scheduled surgeries and procedures to obtain patient medication history as early as possible during admission through direct interview of patient, family, caregiver, or external pharmacy.

Pharmacists in patient care areas review prior to admission medication histories and perform admission medication reconciliation reviewing for accuracy, completeness, and appropriateness and utilize the MEC approved pharmacist medication reconciliation protocol to efficiently resolve any medication discrepancies.

Pharmacists in adult medical units review discharge medication reconciliation and resolve defects to ensure patients go home with a correct medication list and instructions to ensure discharge prescriptions are accurate and complete.

Outpatient pharmacy technicians ease the patient's way to ensure they go home with their prescribed discharge medications by removing any barriers to non-covered or non-formulary medications, minimizing out of pocket expenses, and obtaining prior authorizations for critical medication. They help the poor and vulnerable by connecting them with the community outreach programs for low cost or no cost medication.

The implementation of the M TACT has allowed for organizational and employee learning and growth. The expansion of the pharmacy technician role has allowed them to be an integral part of the health care team with direct patient interaction. Unit based technicians are now deployed outside of the pharmacy to patient care areas. The presence of pharmacy in the emergency department by staffing a pharmacy technician and pharmacist in the unit which has allowed for subject matter experts to be more closely integrated in the interdisciplinary team caring for the patient. The organization's new service of having the pharmacist run Center for Drug Therapy Management clinic helps patients transition from discharge to home.

To reduce unnecessary variation and create a reliable process/system standard work was developed for both unit based and emergency department pharmacy technicians to minimize variation. Pharmacists and pharmacy technicians underwent training on the standard work and necessary competencies to fulfill the tasks. Clinical documentation by both the pharmacist and pharmacy technician in EPIC, our electronic medical record, was standardized to provide for safe hand-offs at transitions. Daily and monthly metrics are reviewed by pharmacists and pharmacy technicians for quality assurance and allow for real-time ongoing modification to the program as needed.

Results of the Effort

Chart review was performed to determine the percentage of patients with a medication error occurring at discharge to home. Charts for 67 patients were reviewed. Forty-eight (48) of those patients, translating to 72%, had a discharge medication reconciliation error corrected by a pharmacist with the top two error types being prescribing error and improper dose error. A total

of 73 errors were found for 48 patients (1.5 errors per patient). An average of 935 patients per month have their discharge medication reconciliation reviewed by a pharmacist (70%) of all discharges to home as of May 2016 with the target goal by the end of 2016 to be at 100%.

Appendix A: Evidence of Lower Costs/Expenses

- Discharge RXs: revenue & 340B Cost Savings show the upward trajectory increase in 340b prescription savings from 2013-2015 of over a quarter million dollars.

Appendix B: Evidence of Scalability

- Deployment at San Pedro shows increase in percent of total patients with pharmacy resolved medication reconciliation from 77% in November 2015 to 100% as of July 2016. Compliance at 100% has been sustained over seven (7) consecutive months.

- Percentage of After Visit Summaries (AVS) completed by pharmacy increase from 0% in November 2015 to 81% in July 2016.

Appendix C: Evidence of Higher Quality

- Pharmacy Resolved Medication Reconciliation on Admission (PTA) sustaining at 100% for twelve consecutive months as of April 2016.
- Rx filled for discharged patients based on new discharge Rx being written showing increase from baseline.

Appendix D: Evidence of Improved Patient Safety

- Number of defective admission medication reconciliations **AVOIDED** with pharmacy review greater than 500 per month.
- Number of medication errors **AVOIDED** due to Pharmacy resolved Medication reconciliation at Discharge near or exceeding 1,000 events per month since the start of 2016.

Appendix E: Evidence of Patient Experience

- Steady and sustained increase in Top Box percent from May 2015 to April 2016.

Sustainability & Scaling

To ensure sustainability of this program and results standard work and competencies were develop to provide structured foundation. Daily huddles with visual management boards and monthly review of key metrics allows for ongoing refinement and update of processes as needed.

Providence Little Company of Mary Medical Centers San Pedro & Torrance have overlapping geographical service areas which have allowed the organization to create a South Bay Community model where services are shared amongst the organization and further supports the sharing of best practices. Phase I of the project was translated from Torrance to San Pedro with admission medication reconciliation being completed by ED based pharmacists and unit based pharmacists and pharmacy technicians. Phase III was kicked off in conjunction with admission medication reconciliation to ensure patients leave with their medications at discharge. Providing discharge medications has been well received by both the executive team and physicians as being

a valuable service to the patients. Phase II of the discharge medication reconciliation was recently deployed at San Pedro and has already shown marked increase in the number of patients.

Key Lessons/Advice

Overall, we have found that having standard training, competencies, and defined standard work has led to an ease in translating these phases to other ministries. Support from the executive team in supporting leveraging subject matter experts in pharmacy and involving them in the medication reconciliation process as an integrated member of an interdisciplinary team working with the patient in the forefront has been a great asset to the success of the project. One of the greatest lessons learned and advice that could be provided is that by addressing the errors in the early steps of a workflow not only reduces the harm that could be experienced by a patient, it also has positive downstream effects reducing the amount of rework to correct defects/errors.