Safer Healthcare Now! MedRec National Teleconference

Making a case for medication reconciliation in primary care

Speakers:

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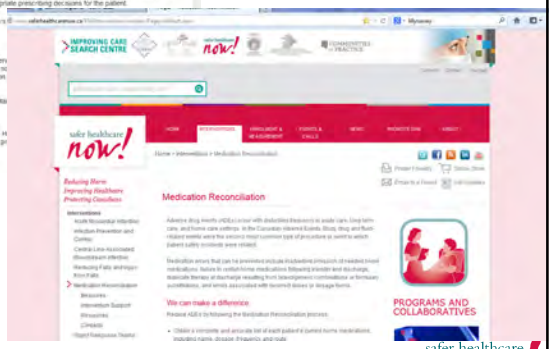
Reducing Harm | Improving Healthcare | Protecting Canadians

Resources

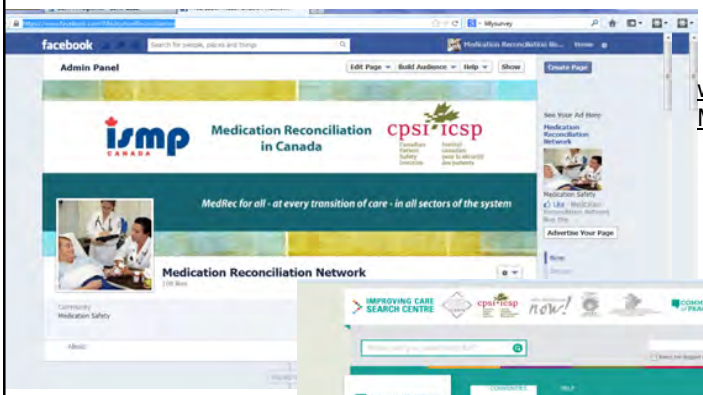
www.ismp-canada.org/medrec



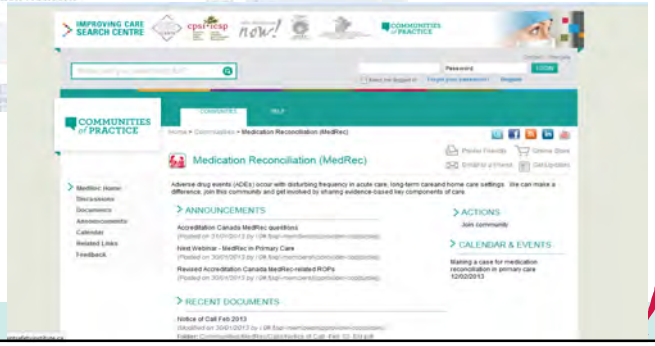
http://www.saferhealthcarenow.ca/EN/Pages/default.aspx

www.saferhealthcarenow.ca

Resources



www.facebook.com/Medicationreconciliation



http://tools.patientsafetyinstitute.ca/Communities/MedRec/default.aspx

Cross Country MedRec Check-Up

- **Updated and revised to incorporate direct links** to Canadian research papers, articles, tools and resources
- **Canadian MedRec Map will be directly linked to a new World MedRec Map** currently being developed. This will increase our global visibility for MedRec.

http://www.ismp-canada.org/medrec/map/

Consumer Awareness and Products

iPhone, iPad, iPod Touch App

- Allows consumers to keep an up-to-date list of their medications + more on their phone
- Available on iPhone, iPad and iPod Touch only from the **iTunes Store** at: https://itunes.apple.com/ca/app/mymedrec/id534377850

Objectives:

1. Raise awareness about medication safety issues - specifically medication reconciliation - in primary care.
2. Highlight the need for better communication and connectivity between hospitals, pharmacies, primary care and patients. (And how we can help each other.)
3. Suggest primary care take on leadership role in medication safety - we can (and should!) "own" the list.
4. Stress the importance of medication reconciliation as a continuous, interdisciplinary, and collaborative activity.

Who is in our audience today?

- Do you work in primary care?

1. Yes
2. No

Who is our audience today?

- I am a(n):

1. Physician
2. Nurse
3. Pharmacist
4. Allied health professional
5. Administrator
6. Other

A case from primary care…

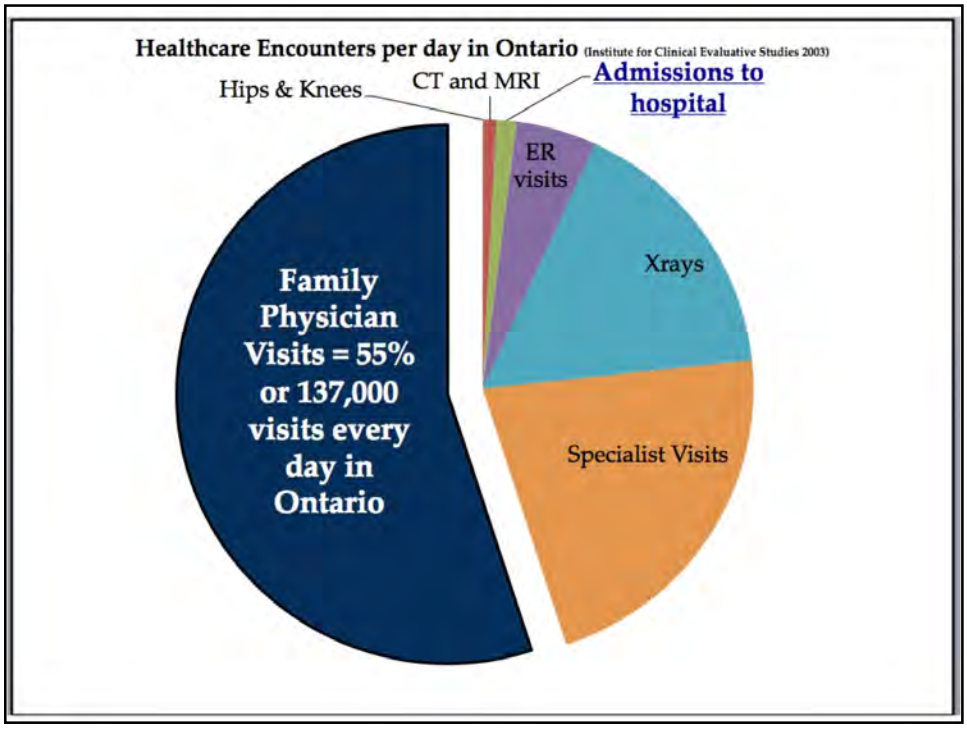
- An ER report informs you that 80 year old Jane Smith (whom you saw last Monday on call) was admitted with lower GI bleed 4 days later and an INR of 10.2
- You had prescribed azithromycin for her pneumonia
- ER notes list states that Jane is on warfarin but her EMR med list does not.
- Inquiry reveals that Jane was started on warfarin by cardiology & is followed by their INR Clinic.
- Somehow this info never made it to Jane's clinic medication list

A case from primary care…

Her misadventure occurred due to her inaccurate clinic medication list.

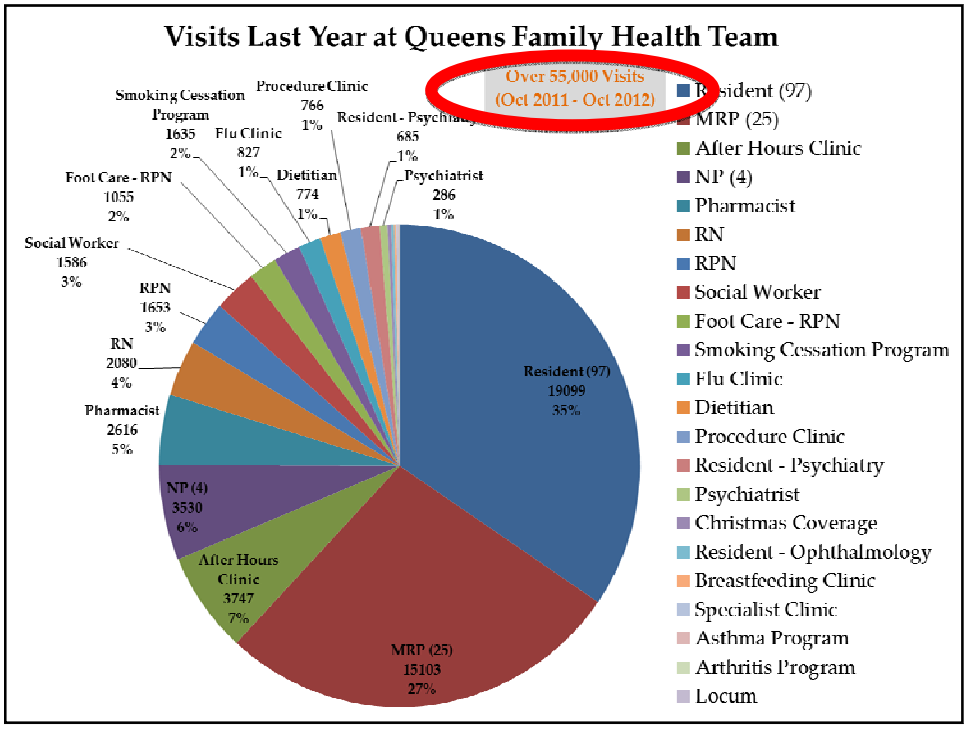
Has this sort of incident ever happened in your world?

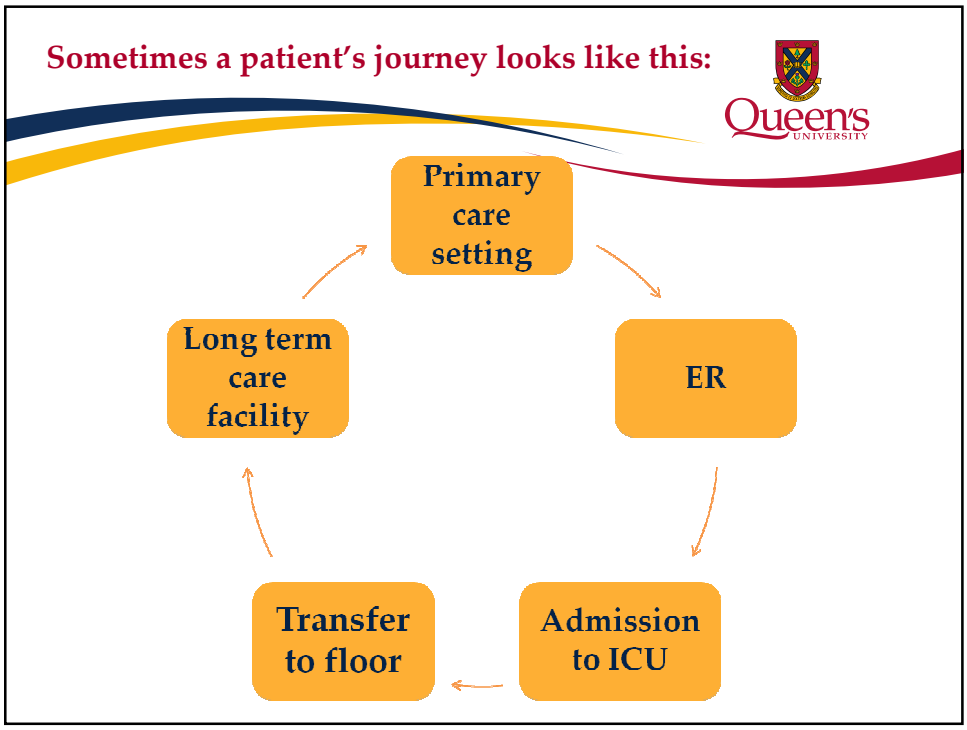
1. Never
2. Once or twice
3. Often
4. Hate to think about it…



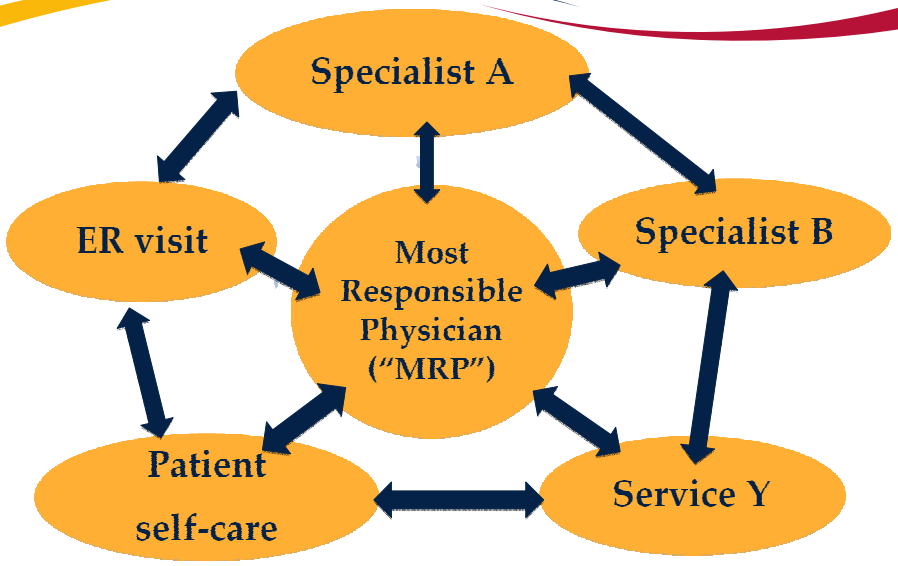
We are…

- Academic inter-professional family health team in Kingston, Ontario ("Queen's Family Health Team" or QFHT)
- A team of 23 physicians, nurses, nurse practitioners, social work, dietitian, pharmacist and administrators
- Train 50 family medicine residents per year
- 14,000 active patients


Visits Last Year at Queens Family Health Team
Over 55,000 Visits
(Oct 2011 - Oct 2012)
Resident (97) 19099 35%
MRP (25) 15103 27%
After Hours Clinic 3747 7%
NP (4) 3530 6%
Pharmacist 2616 5%
RN 2080 4%
RPN 1653 3%
Social Worker 1586 3%
Foot Care - RPN 1055 2%
Smoking Cessation Program 1635 2%
Flu Clinic 827 1%
Dietitian 774 1%
Procedure Clinic 766 1%
Resident - Psychiatry 685 1%
Psychiatrist 286 1%
Resident (97)
MRP (25)
After Hours Clinic
NP (4)
Pharmacist
RN
RPN
Social Worker
Foot Care - RPN
Smoking Cessation Program
Flu Clinic
Dietitian
Procedure Clinic
Resident - Psychiatry
Psychiatrist
Christmas Coverage
Resident - Ophthalmology
Breastfeeding Clinic
Specialist Clinic
Asthma Program
Arthritis Program
Locum


Sometimes a patient's journey looks like this:
Queen's University
Primary care setting
ER
Admission to ICU
Transfer to floor
Long term care facility

But more often than not it looks like this:



Medication Safety and Reconciliation

There are innumerable causes of error under the umbrella of medication safety.

We are focusing on the lack of emphasis on medication reconciliation in transition points of *primary care*, as compared to what typically occurs in institutional settings.

Reconciliation…what?

An accurate medication list is essential to safe prescribing - *in any setting* - to reduce medication errors and improve clinic efficiency

Goal: creation of **"Best Possible Medication List"**

Reconciliation versus Assessment

- **Reconciliation** – "getting two things to correspond; *e.g. the reconciliation of her cheque book and bank statement*" Synonym: balancing, or leveling
- It is *not* the act of recommending different medications. It is simply the act of matching up two lists and making them equal

(However it is the starting point for medication optimization: one can't set the family budget until it is known how much money is in the bank account.)

Reconciliation… when?

Medication reconciliation prevents errors at patient ***transition points.***

We propose these encounters with primary care such as:

- face-to-face office visits
- incoming ER records & consultant letters
- fax refill requisitions or pharmacist phone calls

are transition points where **two medication lists should be compared and reconciled**.

Reconciliation….why?

1. **Literature**
2. **'Rules'**
3. **Our observations & propositions**

Literature

Literature typically discusses medication reconciliation in context of institutional settings

rather than in primary care.

Literature

- Hospital-based medication error research is well reviewed but…
- Community-based safe medication use remains relatively unstudied…
- Despite 422 million outpatient pharmacy prescriptions dispensed per year in Canada

Sears 2011

Literature

- 185,000 of 2.5 million annual hospital admissions were due to adverse events - ***37% were potentially preventable***.[1]
- In a review of adverse events for 1 year: 61% occurred **before** hospitalization and ***32% of these were preventable***.[2]
- 1 in 9 ER visits are due to drug related adverse events. 6**8% of these were thought to be preventable.**[3]
- Substantial percentage of patients with chronic diseases experienced medication errors. 4/5 occurred in community settings.[4]

[1] *Canadian Adverse Events Study. Baker, CMAJ. May 25 2004*
[2] *Ottawa Hospital Patient Safety Study. Forster, CMAJ. April 13 2004*
[3] *Preventable medication errors as related to ER visits. Zed, CMAJ. June 3 2008*
[4] *Patient-related risk factors for self-reported medication errors in hospital and community settings. Sears, CPJ. March 2012*

Rules

College of Physicians and Surgeons of Ontario

- *Prescribing Practices Policy*: "the primary care provider …be aware of all the patient's prescriptions"
- *The Medical Records Policy Statement* states that "physicians should actively maintain the information contained in Cumulative Patient Profile (CPP)" and includes current medications

College of Physicians and Surgeons of Ontario. "Policy #2-05 Drugs and Prescribing: Prescribing Practices." c2005 [cited 2008 Aug 09]
College of Physicians and Surgeons of Ontario. "Policy Statement #5-05 Medical Records." c2006 [cited 2008 Aug 09]

Expert recommendation regarding poly-pharmacy

"Ensure you have a complete drug list when writing an Rx.

Ensure patients are not getting previously stopped meds."

Rx Files 9th Ed

Observations: expectations

"My family doctor knows what I am on."

"Call the family doctor's office to find out what the patient is on."

Observations: office efficiency

A significant amount of time in primary care is spent on managing refills:

J Am Board Fam Med Jan 2006 31-38

- 42 to 71% of visits to physicians result in at least one medication prescription
- Refills account for ~14% of all telephone calls
- Therefore, it follows, that there are positive 'spin-off' benefits of paying attention to accuracy of office medication lists

Observations: errors and inaccuracies

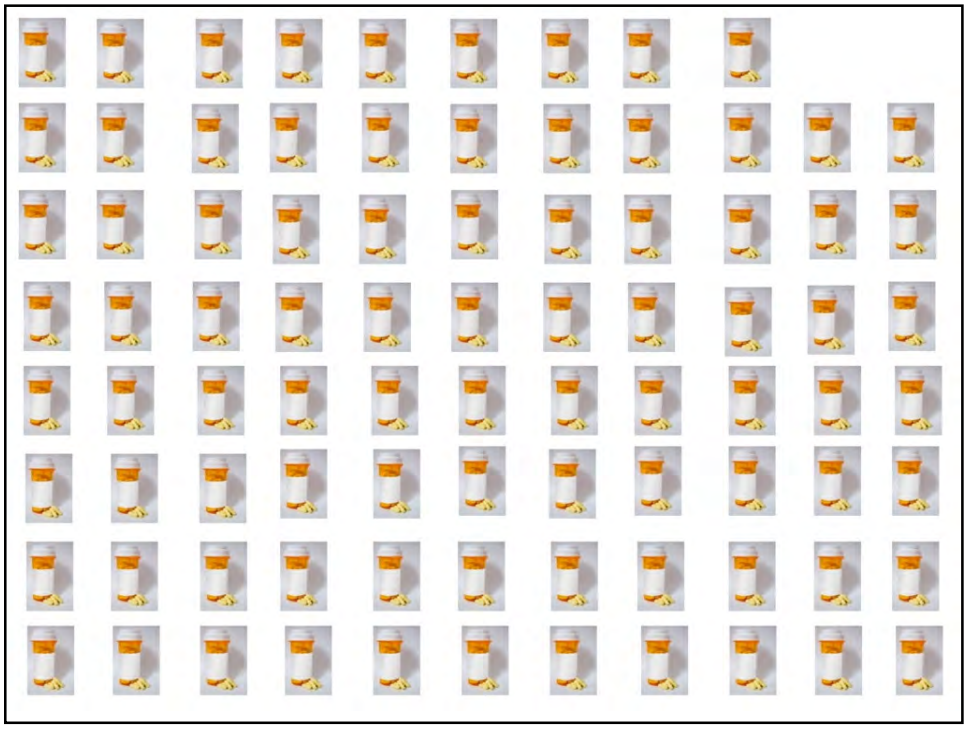
We have recorded medication list inaccuracies including "big ticket" drugs that are not on our patient medication lists:

- warfarin,
- methotrexate,
- digoxin,
- prednisone,
- insulin,
- ACEI,
- NSAIDS,
- DMARDs, etc.

These have potentially major adverse outcomes.

Journey of developing medication reconciliation program at QFHT

1. ***Observation***: Our medication lists are a mess.
2. ***Question:*** How accurate are they?
3. ***Measurement:*** A baseline audit of patients on 4 or more medications:
   - Ahead of scheduled appointments we asked patients to bring in their 'shoebox' of home medications and meet with a medical student who compares it with the computer chart list.
   - Comparison of their shoebox of home meds with our EMR list showed that out of the 86 medication lists reviewed…



Only 1 out of 86 medication lists was accurate.

Types of Medication List "Errors"

1. **Commission Discrepancies**
   - Medications that were previously discontinued were still listed as active (e.g. metoprolol was stopped 2 months ago and it was not physically 'discontinued' from the med list).
2. **Omission Discrepancies**
   - Meds started elsewhere were missing (eg. warfarin started by a specialist).
3. **Internal Discrepancies within the medication record**
   - Incorrect dose, strength, frequency or route listed in our record.

Physician feedback regarding discrepancies

Causes of errors as reported by physicians:

1. Cumbersome software
2. Too time consuming to update/correct
3. Non-EMR clarifications of meds – i.e. verbal orders given to nurse or patient, handwritten 'fax backs' to pharmacies, etc
4. Multiple providers for patient e.g. External physicians prescribing for patient
5. **Culture: **Medications not routinely reviewed at office visits*****

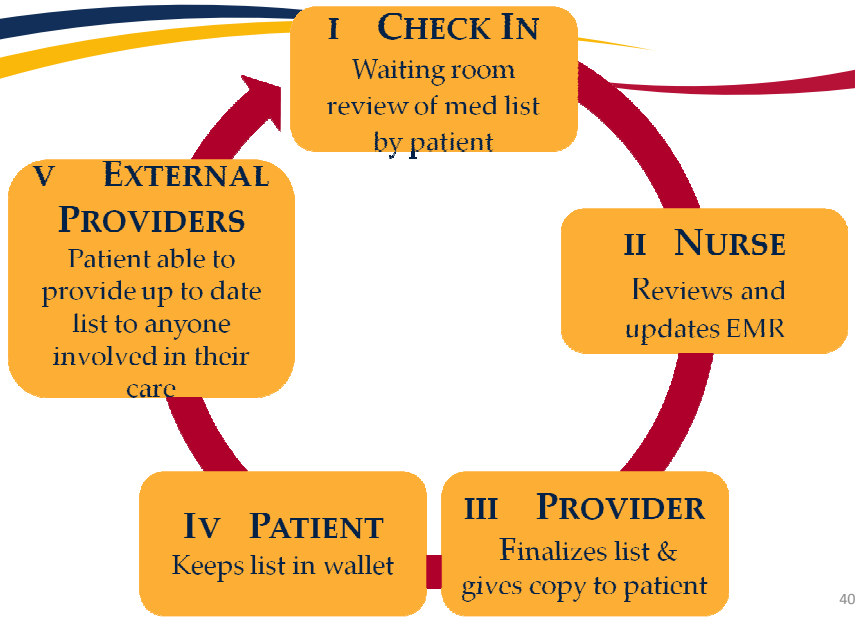
Medication reconciliation *in primary care*

- Medication reconciliation is essential in primary care
- Primary care should drive improved accuracy for medication lists
- But how?

Discovering a 99% inaccuracy rate we…

- Formed a Pharmacy and Therapeutics Committee to developed medication reconciliation policy
- Criteria for our medication reconciliation program:
  1. Sustainable
  2. Include everyone in the patients' circle of care (including the patient and patients' pharmacy)
  3. Must result in a perpetually accurate medication list (rather that a one time blitz that would quickly come out of date)

Create processes that include patients' entire circle of care



Re-audit Summer 2010

- We found that ~ 50% med lists reviewed were accurate
- The errors were due to:
  - changes from other providers
  - software issues
  - changes made by the patient

Re-audit Observations

- We are still having software issues.
- Culture shift is emerging: opening the medication list at every visit is improving.
- Discrepancies between how medications were prescribed and how patients were actually taking them persist.

Implementation & Process Pearls:

- Devise a process that is inclusive of everyone in the circle of patients' care – including the patient!
- Focus on creating a **sustainable and continuous process** that will maintain your lists rather than update them in a one time blitz.

Get "buy in"

- Find a CHAMPION – ideally in a leadership position
- Track results – set parameters, pick a goal report progress and get feedback
- Be tenacious: follow up with folks who are not on board with focused help
- If a list is too messy, consider booking a special visit for meds rec, or a consult with a pharmacist

Enable & Educate Support Staff

- Train staff to train patients
- Anticipate questions and push-back – provide tools for front-line staff: FAQs, talking points, verbiage, etc.
- Train how to use the EMR – provide "how-tos" and training sessions

Enable & Educate Support Staff

- Make it easy: "ASAP"
  - **A**ctive medications are confirmed
  - **S**topped medications are removed
  - **A**llergies are updated
  - **P**rint off medication lists to give to patient

Enable & Educate Patients

- Explain what you are doing and why.
- Explain that inhalers, drops, creams, & over-the-counter pills are medications to be recorded on their chart – bring in everything, at every visit!
- Use the opportunity to educate in general about medication safety and to notify us if another physician changes their medications. Give them a copy of the list.

Reduction in Medication Errors Goals:

- Improved tracking of medication errors that leave our practice such as prescription clarifications required from pharmacies or patient ER visits from medication misadventures
- Optimize and standardize medication reconciliation processes ultimately with formalized written policies

Blue sky dreaming…

What we are doing is hopefully a temporary remedy until:

- Medication reconciliation software is refined and required in EMRs
- Centralized medication list repositories are developed for patients' healthcare providers to access regardless of where patient is (eg ER, in office, at specialist)
- There is a shift in medical culture such that medication reconciliation in primary care is deemed as essential as vitals signs

Questions/Comments?

Making a case for Medication Reconciliation in Primary Care

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Mark Your Calendar
for the next national MedRec Webinar

Accreditation Canada and the 2014 ROPs for MedRec

Date: March 5, 2013
Time: 12 noon ET

Kindly take a few minutes to reply to the poll!

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