MSOS Member Briefing
January 2020

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January 2020

Moderated by: E. Robert Feroli, PharmD, FASHP

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MEDICATION SAFETY OFFICERS SOCIETY

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Modern Patient Advocacy: engaging a family after a healthcare system breakdown

Liz Hess, PharmD, MS, FISMP, CPPS
Pharmacy Program Coordinator, Medication-Use Safety & Quality
UK HealthCare

UK HealthCare

Objectives

- Identify methods for establishing a positive relationship between a patient's family and healthcare institution

UK HealthCare

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Post Event

Mourn → Show compassion → Disclose the event → Provide a contact

HealthCare

Establish a Relationship

- Let them vent about what occurred
- Learn about the family
- Understand personal values

Alltech

HealthCare

Brainstorm & Scope

- Define the **mission** of the partnership
- Put all **ideas** on the table
- Determine **scope** of partnership
  - Medication safety and music therapy
- Identify **key roles** and content experts

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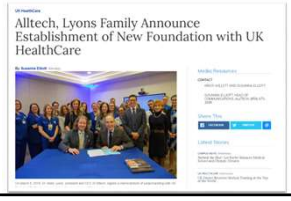
Formalization of Agreement

- Sign a memorandum of agreement
- Be ready for the Press
- Establish official documents and transfer of funds



UK HealthCare

Get To Work!

Protect time	Establish contracts
Study the intervention	Engage the family

UK HealthCare

Questions?

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Lions and Tigers and Opioids, Oh My!

Ambulatory Care Opioid Stewardship Amidst a National Crisis

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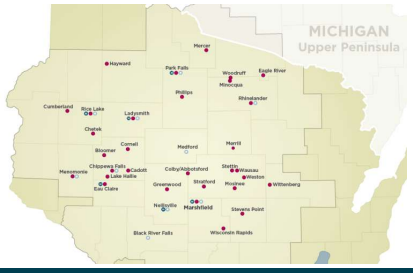
Luanne Sojka, PharmD, BCPS and Jenny Panić, PharmD, BCPS

Marshfield Clinic Health System

Marshfield Clinic Health System Controlled Medication Workgroup



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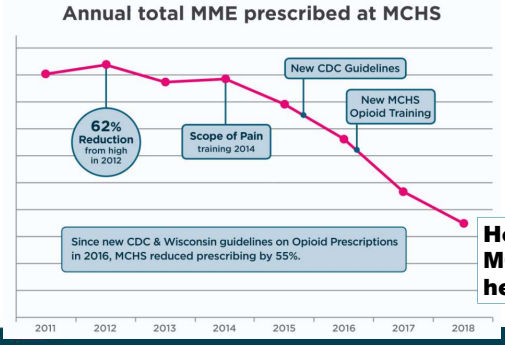
Annual total MME prescribed at MCHS



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Strategies we will discuss

- Leadership and prescriber champions
- Provider education and training
- Standardized opioid agreements
- Identification of prescribing practices, system leader engagement and peer discussion
- Identification of higher risk patients, case reviews, system and prescriber engagement

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Provider education and resources regarding opioid stewardship

Provider education:

- External opioid training program from 2014 to 2017
- MCHS-specific CME opioid training program offered first in 2017
- Policy and Resource guide for prescribing opioids
- System experts

Resources:

- PDMP link in prescribing platform
- Toolkit on intranet
  - Direct access to all resources

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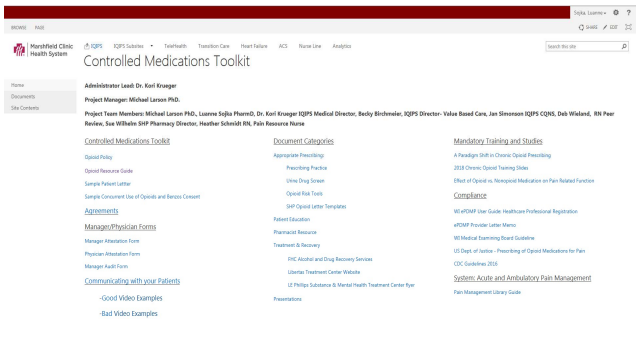

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Resource guide

3.11. Discontinuing Opioid Therapy: If the lack of efficacy of opioid therapy is determined, discontinuation of therapy should be performed.

a. Opioid weaning can be performed by reducing the MED by 10% weekly until 5-10mg MED remain at which time the opioid can be fully discontinued. The opioid weaning schedule can also be slower that may allow patient to tolerate this more effectively. When possible allow for a slower weaning schedule of 10-15% of total daily dose every 4 weeks. This will likely reduce the need for additional medication for opioid withdrawal related symptoms.

b. Prescription of clonidine 0.2 mg po BID or tizanidine 2 mg po TID can be provided to patients complaining of opioid withdrawal related symptoms. If evidence of increased risk develops, weaning or discontinuation of opioid should be considered.

c. Optional: Opioid weaning can be performed by reducing the MED by 25% weekly until 5-10 mg MED remain at which time the opioid can be fully discontinued. This faster weaning schedule should be reserved for those individuals that have:

- ☐ A health risk that requires faster wean for safety;
- ☐ A violation of the opioid / prescriber agreement due to misuse of the prescribed medication OR use of some other illicit substance OR use of another medication that was not prescribed directly to them;

Definition of Outliers

Patient outliers

- ≥100 milligrams of morphine equivalents (MMEs) per day
  - ≥400 MME/day
  - ≥200 MME/day + benzo
- Opioid agreement signed
- Urine drug screen completed at least annually
- Naloxone prescribed

Prescriber outliers

- Comparisons within peer groups
- >2 standard deviations above the mean MMEs prescribed in 6 months

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Excerpt from opioid monitoring communication to service line medical director

To: [redacted] MD
From: Kori Krueger, MD, Mike Larson, PhD, Opioid Monitoring team and Peer Review
Re: Quarter 3, 2019 opioid monitoring reports

We appreciate all of the attention and time you and your team has dedicated to conscious opioid prescribing in our system, thank you!

Your Service Line summary: [redacted]

1. Patients:
   a. Number of patients: **3**
      i. Number of patients missing both Opioid Agreement and Urine Drug Test: **0**
      ii. Number of patients missing one either Opioid Agreement or Urine Drug Test: **1**
      iii. Number of patients ≥ 200 MME and benzodiazepine: **1**
      iv. Number of patients ≥ 400 MME: **2**
   b. Number of prescribers managing these patients: **3**
2. Prescribers identified as outliers: **4**

Marshfield Clinic Health System (MCHS) currently monitors all patients with a calculated average morphine milligram equivalent (MME) ≥1
benzodiazepine/naloxone use for these patients. MCHS also includes opioid prescribing in its Ongoing Professional Practice Evaluation (OP
Opioid Prescribing Rate Indicators: IQIPS/Peer Review/OPPE-FPPE Opioid Prescribing Rate Indicators

You are receiving this information to keep you informed regarding the prescribing of opioids within your service line. If you would like an
hesitate to contact us.

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Description of duties of service line medical directors

- Assess data provided on quarterly basis
- Determine if provider outliers are reasonable based on provider practice volume
  - If not, request more data
- Communicate with prescriber any patient outliers identified and ways to improve compliance

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Focus Professional Practice Evaluation (FPPE) strategies

- Monitors any patient missing opioid agreement
- Reviews all patients with MME ≥ 400 MME/day
- Assess all patients with MME ≥ 200 with benzodiazepine
- Communication with provider and service line medical director

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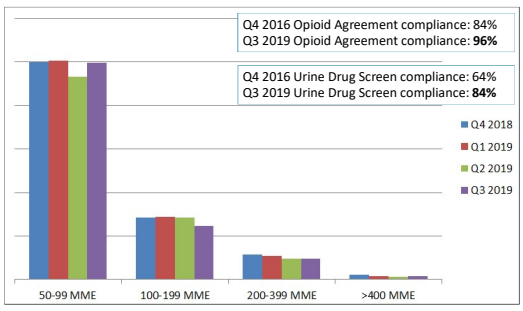
Total patients by MMEs per day



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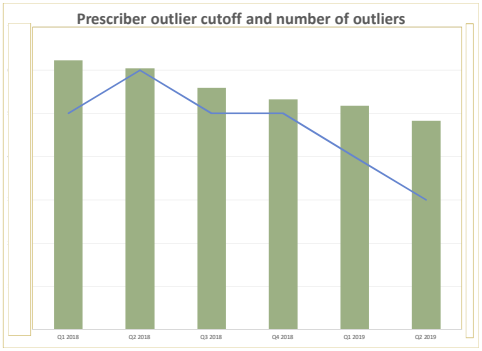

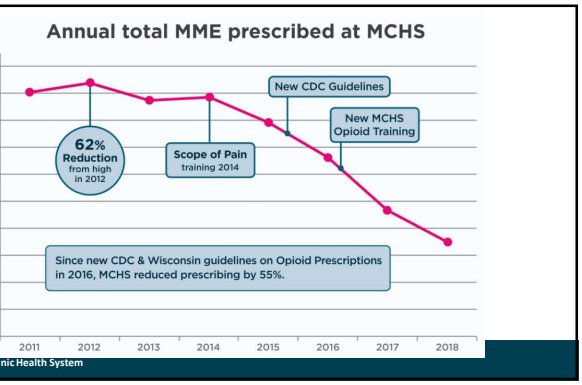

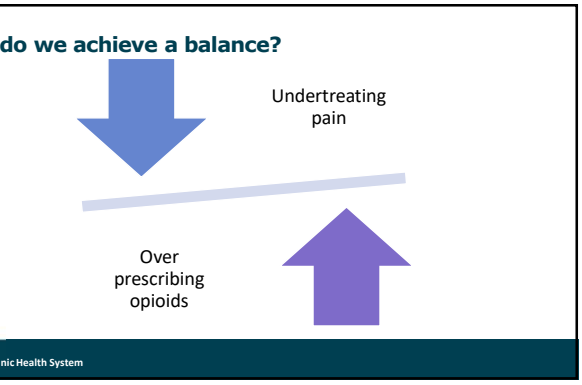

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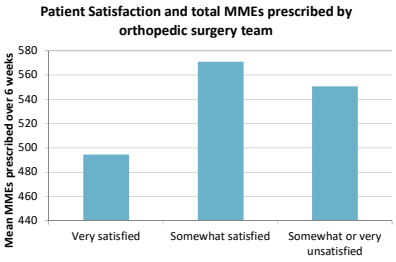
Postoperative survey of MCHS TKA patients

n=64

Question: "Please rate your satisfaction with post-operative pain management using the scale below."

Kruskall-Wallis test, $p = 0.722$



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Strategies you could try

- Create an interdisciplinary team to define outliers
- Recruit prescriber champions
- Identify, communicate, and monitor your patient population
- Assess outlier prescribers and ask why
- Design and implement CME for all providers and staff
- Provide a controlled substances toolkit on the health system's website

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Questions?

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JOHNS HOPKINS MEDICINE
THE JOHNS HOPKINS HOSPITAL

Documentation dilemma: When a medication is given in error

Meghan M. Rowcliffe, PharmD, BCPS, BCPPS
Medication Safety Officer, Pediatrics
The Johns Hopkins Hospital

Objectives

- Describe a strategy to document a medication given in error

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History

- Patient in ED ordered ibuprofen and cyclobenzaprine for back pain. Prescriber then noted that patient was taking citalopram at home and due to potential DDI with cyclobenzaprine, changed order to methocarbamol within a few minutes of placing the original orders.
- RN approached prescriber and stated that cyclobenzaprine had already been administered and needed the order to be re-entered.
- Prescriber was hesitant to place the order since he did not authorize it.

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Response

- Medication safety team advocated for developing a way to document this error in the EMR
  - Order vs. progress note?

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Rationale for an order

- Patient-centered
- Visible to other clinicians
- Monitoring

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Process

1. Nurse notifies provider of medication given in error
2. Nurse enters “medication given in error” order

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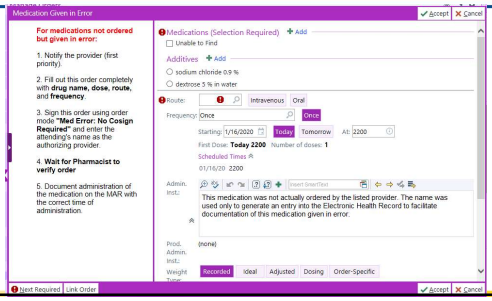
Process



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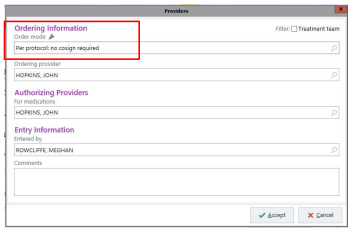
Process

3. Nurse signs order



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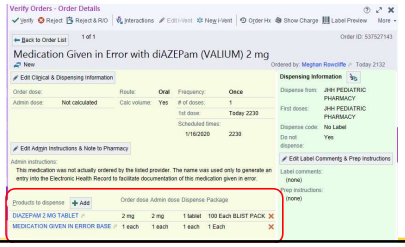
Process

4. Pharmacist verifies the order



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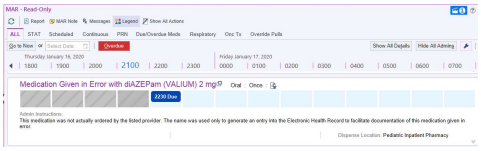
Process

5. Nurse documents administration on the MAR



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When to use this order?

Active medication order	Discontinued medication order or no order exists
• Document the error in the comment section of the order on the MAR	• Nurse will use "medication given in error" order
• Example: wrong dose of medication administered	• Example: medication given to different patient, medication differs from what was ordered

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Conclusions

- Documentation of a medication given in error is a challenging dilemma
- To facilitate patient-centered care, the unintended administration should be documented in the MAR
- Ensure real-time communication with RNs to avoid medications given in error

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Questions?

ISMP Update

Institute for Safe Medication Practices
An ECRI Institute Affiliate

Michael R. Cohen, RPh, MS, ScD (hon.), DPS (hon), FASHP
President, ISMP

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Questions?

- A copy of today's slides will be posted on our website
- Next MSOS Briefing date – March 26, 2020.

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