Partnership for Patients
Hospital Engagement Network
All Hospital Event

Focusing on Eliminating ADE as a Strategic Imperative for Hospitals

April 1, 2013
3:00 – 4:15pm ET
WELCOME AND OVERVIEW

Fred Butler Jr., MPH, MBA
Partnership for Patients
Partnership for Patients Objectives

• 40% reduction in hospital-acquired conditions:
  – Adverse Drug Events
  – Catheter-Associated Urinary Tract Infections
  – Central Line Associated Blood Stream Infections
  – Injuries from Falls and Immobility
  – Obstetrical Adverse Events
  – Pressure Ulcers
  – Surgical Site Infections
  – Venous Thromboembolism
  – Ventilator-Associated Pneumonia
  – Readmissions

• 20% reduction in hospital readmissions compared to 2010.

  *Participants aim to reach these goals nationwide within 3 years.*
Our Infrastructure: 26 Hospital Engagement Networks (HENs)

- American Hospital Association / Health Research & Educational Trust
  - 31 State Hospital Associations
- Ascension Health
- Carolinas - HealthCare System
- Dallas-Fort Worth Hospital Council Foundation
- Dignity Health
- Georgia Hospital Association Research and Education Foundation
- Healthcare Association of NYS
- Hospital & Healthcare System of Pennsylvania
- Intermountain Healthcare
- Iowa Healthcare Collaborative
- Joint Commission Resources, Inc.
- LifePoint Hospitals, Inc.
- Michigan Health and Hospital Association
- Minnesota Hospital Association
- National Public Health and Hospital Institute
- Nevada Hospital Association
- New Jersey Hospital Association
- North Carolina Hospital Association
- Ohio Children’s Hospital Solutions for Patient Safety
- Ohio Hospital Association
- Premier
- Tennessee Hospital Association
- Texas Center for Quality and Patient Safety
- UHC
- VHA
- Washington State Hospital Association
What to Expect Today

• A National “Call to Action” to eliminate ADEs
• A Patient’s Story highlighting the significance of ADE monitoring and tracking
• Success Stories from a large and small hospital system to generate improvements and results in ADE
• Requests of commitment for all hospitals
How to Participate on This Call

In order to ask a question or provide a comment:

– Via Phone
  • Please press “*” followed by the “1” to be placed in the queue.
    – When you are satisfied with the response to your question, please press “1” again.

– Via the “Ask a Question” Box
  • Please type your question or comment in the “Ask a Question” box located directly under the slides on this platform.
ADE: A NATIONAL MOVEMENT

Dr. Tom Evans
Iowa Healthcare Collaborative
Prevention of Adverse Drug Events (ADEs): A National Priority

Don Wright, M.D., M.P.H.
Deputy Assistant Secretary for Health
Director, Office of Disease Prevention and Health Promotion (ODPHP)
ADES—OPPORTUNITY FOR IMPACT
ADEs – Opportunity for Impact

INSIDE the hospital

- Most common causes of inpatient complications → prolong length-of-stay and increase costs
  - Affect ~1.9 million hospital stays annually
  - Add 1.7 to 4.6 hospital days
  - Cost $4.2 billion USD annually

ADEs as Causes of Inpatient Complications

- ~63% of ADEs:
  1. Excessive bleeding (anticoagulants)
  2. Delirium or change in mental status (opioids, benzodiazepines)
  3. Hypoglycemic event (insulin, oral hypoglycemics)

- ~50% of ADEs judged to be preventable
Data Draws National Attention

- ADEs responsible for ~100,000 emergent hospitalizations in older Americans, annually
  - ~ Two-thirds resulting from just four medication classes (anticoagulants, insulin, oral hypoglycemics, antiplatelets)
  - ~ Two-thirds resulting from unintentional overdoses (or supratherapeutic effects)
ADEs Gain Federal Interest

- Data sparked interest of Federal stakeholders
  - Interest from Congress
  - Interest from Secretary of HHS

- ODPHP charged with developing National Action Plan for ADE Prevention
  - Modeled after the National Action Plan to Prevent Healthcare-Associated Infections
NATIONAL ACTION PLAN FOR ADVERSE DRUG EVENT PREVENTION
The Charge

- Marshal extensive and diverse resources of the Department and its federal partners
- Form interdepartmental, public, and eventually public-private partnerships
- Initiate discussions that identify coordinated approaches to ADEs in the areas of:
  - Prevention
  - Surveillance
  - Incentives & Oversight
  - Research (Unanswered Questions)
- Incorporate approaches into National Action Plan for ADE Prevention
  - Build framework for future targets
The Targets (Phase 1)

- Inpatient and outpatient harms resulting from:
  1. Anticoagulants (orals, injectables)
  2. Diabetes agents (orals, injectables)
  3. Opioids (oral, injectables)
     - Acute pain
     - Non-malignant, chronic pain
PARTNERSHIP FOR PATIENTS:
TURNING ADE GOALS INTO ACTION
PfP: A Call to Action

- Partnership for Patients: Two Aims
  - 40% Reduction in Preventable Hospital Acquired Conditions over three years
    - ADEs constitute more than 30% HACs
  - 20% Reduction in 30-Day Readmissions in Three Years
    - Two-thirds of adverse events within 30 days of discharge in Medicare Beneficiaries are from drug events
PfP: Steps to Success

- Every hospital has a medication safety challenge

- Committing to ADEs requires:
  - Strategic priority in improving Harm Across the Board
  - Leadership to build a common vision and generate results
  - Bold commitments from all hospital staff
Thank You

Prevention of Adverse Drug Events (ADEs):
A National Priority

U.S. Dept of Health & Human Services (HHS)
Office of the Assistant Secretary for Health
Office of Disease Prevention and Health Promotion
http://www.hhs.gov/
http://www.hhs.gov/ash/
http://odphp.osophs.dhhs.gov/
Missing the Forest for the Trees

Helen Haskell
Mothers Against Medical Error
www.advocatedirectory.org
Haskell.helen@gmail.com
Lewis Blackman
1985-2000
An Adverse Event

Healthy 15-year-old develops severe upper abdominal pain while on NSAID and narcotic pain regimen following elective surgery.

Nurses and residents fail to act upon increasing signs of instability, including 24 hours with no urine output and four hours with no BP.

Four days post-op, Lewis dies. Autopsy shows a giant duodenal ulcer and 2.8 liters of blood and gastric secretions in the peritoneal cavity.
Two medication errors

- Incorrect IV fluids
- Inappropriate prescribing of Toradol

Compounded by

- Diagnostic error
- Communication errors
- Failure to rescue
Underlying Causes

- Unfamiliarity with medication contraindications
- Unfamiliarity with pediatric dosing
- Unfamiliarity with medication side effects
- Inability to recognize problems caused by the side effects (i.e., sepsis and shock)
- No one thought of the drug when the patient began experiencing unexpected symptoms
The Overriding Problem

Lack of respect for the power of medications:

☞ Physicians overprescribe and do not recognize side effects
☞ Patients do not exercise skepticism
☞ Patients are willing to bankrupt themselves for drugs they may not need
Drugs Involved in Adverse Medication Events
N=271

- Antibiotics: 23%
- Narcotic pain medications: 19%
- Psychiatric medications including antidepressants and ADD drugs: 12%
- Blood thinners (Heparin, Warfarin, etc.): 10%
- Drugs used in anesthesia: 8%
- Diuretics: 3%
- Steroid medications: 6%
- Benzodiazepines (e.g., Valium, Ativan): 4%
- Insulin: 3%
- Sleep medications: 3%
- NSAID pain medications: 3%
- Other diabetes medications: 2%
- Heart medications: 1%
- Chemotherapy medications: 2%

185 respondents/271 responses
Source of Medication Event (N=494)
Cultural Issues in Medication Safety

- Knowledge deficit - Not knowing what you don’t know
- Labeling - “Noncompliance,” “anxiety,” “drug-seeking”
- Respect for the knowledge of the patient and family
- Teamwork - Flattening the hierarchy
- Flexibility - The ability to respond proactively to changes in the patient’s condition
The Continuum of Medication Safety

- Knowledge
- Prescribing
- Administration
- Vigilance
- Recognition
- Rescue
The desire to take medicine is perhaps the greatest feature which distinguishes man from animals.

☞ Sir William Osler, quoted by Harvey Cushing
SUCCESSFUL HEN/HOSPITAL ADE STORY

What to listen for...
Why to listen for it...
Efforts of PremierHEN in Medication Safety

Monica Barrington, RPh, MPH, FASCP
VP Partnership for Patients
Premier, Inc.
Assessment of medication safety best practices

PremierHEN Percent Compliance to Best Practices In Medication Safety

Interview Guide Results Not Currently being Implemented by Question

<table>
<thead>
<tr>
<th>PHASE</th>
<th>Percent of Interventions Not Currently Implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment/Documentation</td>
<td>8.97%</td>
</tr>
<tr>
<td>Area of Harm</td>
<td>11.49%</td>
</tr>
<tr>
<td>ADE</td>
<td>3.39%</td>
</tr>
<tr>
<td>Regular monitoring</td>
<td>41.56%</td>
</tr>
<tr>
<td>Monitoring insulin</td>
<td>1.68%</td>
</tr>
<tr>
<td>Adjusting dosage</td>
<td>15.45%</td>
</tr>
<tr>
<td>Monitor patients</td>
<td>1.80%</td>
</tr>
<tr>
<td>Evaluate medication history</td>
<td>13.57%</td>
</tr>
</tbody>
</table>
Hypoglycemia focus

- (40%) Eliminate the use of sliding insulin dosage scales
- (53%) Implement one standard glucose control protocol
- (58%) Regular monitoring of hypoglycemia in diabetic patients
- (69%) Daily clinical review of all BG for protocol adjustments
- (75%) Coordinate meal and insulin times
- Education of nursing staff to identify symptoms of hypoglycemia and protocols that allow for BS testing on demand
- Move to eliminate oral hypoglycemics from hospital use

Percentage of BG Results below facility thresholds

<table>
<thead>
<tr>
<th>Month</th>
<th>Aug-12</th>
<th>Sep-12</th>
<th>Oct-12</th>
<th>Nov-12</th>
<th>Dec-12</th>
<th>Jan-13</th>
<th>Feb-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>BG Results</td>
<td>1.6</td>
<td>2.0</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
A Systems Approach to Reducing Adverse Drug Events

Steve Meisel, Pharm.D., CPPS
Director of Patient Safety
Fairview Health Services, Minneapolis, MN
Fairview Health Services

- 6 hospitals, ranging from rural to academic
- 50+ primary care clinics
- Home care/hospice, home infusion, long term care, retail pharmacy, Pharmacy benefits management company
- 20,000 employees, 3,000 physicians
- 73,000 annual admissions; 175,000 ED visits; 1 million clinic visits
- $3 billion gross revenue
- > 8,000,000 annual inpatient doses dispensed
- 1.7 million annual retail pharmacy prescriptions
Why the passion?

A story
Measuring Progress
Fairview’s ADE Measurement System

• 100% real-time review of triggers for harm from high hazard drugs:
  – Naloxone use (narcotics)
  – Flumazenil use (sedatives)
  – Blood sugar $<40$ mg/dl (antidiabetic agents)
  – INR >5 (warfarin)
  – PTT >200; anti-Xa level > 1.6 (heparin)
  – prothrombin complex concentrate and coagulation factor VIIa (rivaroxaban and dabigatran)
Trigger Review Criteria

- Is the trigger legitimate?
- If yes, was it associated with the drug?
- If yes, was there harm, defined at a minimum as requiring intervention?
- If all 3 questions are “yes”, it is coded an ADE
ADE: 5 Fairview Hospitals, all 4 Drugs

22.5% reduction
ADE: 5 Fairview Hospitals, antidiabetic agents

27.2% reduction
ADE: 5 Fairview Hospitals, anticoagulants

Note: threshold changed 2Q 2012

No improvement
ADE: 5 Fairview Hospitals, narcotics

56.1% reduction
ADE: 5 Fairview Hospitals, sedatives

No improvement
Organizational Approach to Safety
Strong Organizational Leadership & Culture

Patient Safety

Training

Measurement

Resources

Deploy Known Best Practices & Design New Best Practices

Build Adaptability, Resilience, & Teamwork
Leadership/Culture

• Safety as a true priority of the organization
  – Executives actively promote the efforts and engage with the improvement teams and front-line clinicians
  – Targets are set and are included in manager/leader performance reviews
  – Active, routine agenda item at the Board level
• People know how to raise concerns
  – When they do, something happens
• Sharing of stories widely: both internal and external
• Just culture
Adaptability/Resiliency

- Anticipate and expect problems
- Failure mode and effects analysis
- Avoid complacency
- Rapid response teams
  - Patient activated
- Simulation training
- TeamSTEPPS
Designing reliable systems of care

Prevent

Detect

Mitigate
Prevent

- Order sets
- Computer flags
- Minimize floor stock
- Look-alike strategies
- Double-checks
- Smart-pumps
- Epidural pumps
- Pharmacist review & oversight
- Dose equivalency tools

- Medication reconciliation
- Bar coding
- Handoff communication
- Protocols
- Specialty consults
- Patient education
- Effective transitions
- Failure mode and effects analysis
- Competency assessment
- Formulary/drug use choices (low molecular weight heparin vs heparin)
Detect

- Computer flags
- Double-checks
- Smart-pumps
- Epidural pumps
- Pharmacist review and oversight
- Critical value management

- Medication reconciliation
- Bar coding
- Handoff communication
- Patient education
- Post-discharge follow-up
- Monitoring protocols
- Monitoring equipment
Mitigate

- Protocols for recovery: prior to calling physician
- Rapid response teams
Technical vs. Adaptive Change
Minnesota Hospital Association
Roadmap to Prevent Adverse Drug Events
SAFE Structure

- **S**afety Teams and Organizational Structure
- **A**ccess to Information
- **F**acility Expectations
- **E**ngagement of Patient, Client, Resident and Family
Drug-Specific Gap Analyses

• Narcotic oversedation
• Anticoagulants
• Antidiabetic agents

• A compendium of 50-100 best practices for each topic
• Organized around the framework of prevent, detect, and mitigate
• Intended to be completed in an interdisciplinary manner
Engaging Providers and Stakeholders
You will hear (and we have heard):

• These events are uncommon.
• These events are an expected cost of doing business (“that’s why naloxone is on the market!”).
• These events are unpredictable.
• Human beings aren’t machines; the complexity of illness and physiology defies perfect outcomes.
• It’s a tradeoff. If we do away with narcotic oversedation we will have more people with unrelieved pain.
• Well, that case was a problem but it was an isolated event caused by single inattentive practitioner.
Your (our) responses

• If aviation approached safety in that manner, would any of you ever get on an airplane?

• Other health care organizations have achieved excellence in all of these domains without sacrificing clinical quality.

• If one of your family members experienced one of these events, how would you feel?
Quantitative data are of limited value in engaging stakeholders; they tend to depersonalize the issue. On the other hand, the power of story can be enormous.
Group Processing

What is one big insight that you got from Fairview?

What did you just hear from Fairview?
Number of Hospitals Measuring Adverse Drug Events, by Level of Engagement

- Engaged
- Committed to Reporting
- Submitting Data
- Improving/Sustaining High Perf.
Polling for Hospitals Only

Please indicate the response below that best describes your hospital’s action on ADE:

1. Like Fairview, we are actively involved in this area already and have ADE results.

2. We are actively involved in this area already and we will work with our HEN to document our results.

3. We are NOT YET actively involved in this area and need to be working with our HEN.
SUCCESSFUL HEN/HOSPITAL ADE STORY

What to Listen For...
Why to Listen for It...
Patient Safety: Adverse Drug Event Monitoring

Monitoring Blood Glucose Levels at a Small Rural Hospital

Gayle Mayer, RPh, BPharm
Director of Pharmacy
Spencer Hospital
Spencer, Iowa
It’s All About OUR Patients!

It’s Knowing and Accepting Who You Are: No facility is too small to “do” something!
# Blood glucose <50 by Primary Diagnosis Category

<table>
<thead>
<tr>
<th></th>
<th>4/11 to 1/12</th>
<th>4/12 to 1/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection</td>
<td>1.5%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Medical</td>
<td>0.5%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Surgical</td>
<td>0.2%</td>
<td>0.1%</td>
</tr>
</tbody>
</table>

- # BG readings <50 / total number BG readings
- 4/12 we educated on and made available a Basal Bolus Insulin protocol
Who are we? Why us? **Why NOT us?**

- We are not large – we are a big, small hospital
- We have no official studies, run charts or published papers on this topic
- We travel the daily journey with our patients and physicians – we have a story with each patient
- We **recognize the detours** – as we move to our goal we find areas to stop and take the time to improve, we adapt often – our journey may never reach a specific destination!
Who are we? Why us?

Why NOT us?

• We have a systematic plan to build on each step and keep up the progress – it will never end
• We are not afraid to go step by step and celebrate accomplishments and measured growth
• We are willing to provide the very best care we can to our patients – together - part of a healthcare team
• Our patients are us - our neighbors and families, our friends and co-workers, our communities
Blood Glucose Values Less Than 50 per number of readings

<table>
<thead>
<tr>
<th></th>
<th>Apr 12</th>
<th>May 12</th>
<th>Jun 12</th>
<th>Jul 12</th>
<th>Aug 12</th>
<th>Sep 12</th>
<th>Oct 12</th>
<th>Nov 12</th>
<th>Dec 12</th>
<th>Jan 13</th>
</tr>
</thead>
<tbody>
<tr>
<td>%BG &lt; 50 /readings</td>
<td>0.24</td>
<td>0.92</td>
<td>0.32</td>
<td>0.34</td>
<td>0.38</td>
<td>0.43</td>
<td>0.34</td>
<td>0.19</td>
<td>0.81</td>
<td>0.14</td>
</tr>
<tr>
<td># of Patients</td>
<td>80</td>
<td>45</td>
<td>35</td>
<td>49</td>
<td>40</td>
<td>40</td>
<td>47</td>
<td>50</td>
<td>55</td>
<td>51</td>
</tr>
<tr>
<td># patients BG&lt; 50</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Total Readings</td>
<td>822</td>
<td>436</td>
<td>486</td>
<td>581</td>
<td>592</td>
<td>529</td>
<td>539</td>
<td>534</td>
<td>614</td>
<td>722</td>
</tr>
<tr>
<td># Readings under 50</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>1</td>
</tr>
</tbody>
</table>
Where Did We Start?

- Pharmacy recognized need for increased patient safety via improved BG monitoring and review of diabetic order sets with a goal of increased diabetic control for all patients
- The high readings (>180) were our initial concern – this continues to be a primary focus
- Pharmacy began a data collection process on every patient with BG readings
- After about a year of data and a basic analysis pharmacy brought together an interdisciplinary task force including members from nursing, clinical nursing, lab, dietary and quality services. We also identified a physician “champion.”
  - (This task force is separate from our Diabetic Education Group)
## Data Collection Metrics

<table>
<thead>
<tr>
<th>Basic Data</th>
<th>Medical Group</th>
<th>Infection Group</th>
<th>Surgical Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, Gender</td>
<td>Cardio</td>
<td>Pneumonia</td>
<td>General</td>
</tr>
<tr>
<td>Prescriber</td>
<td>Endocrine</td>
<td>Skin</td>
<td>GI</td>
</tr>
<tr>
<td>Unit</td>
<td>General</td>
<td>Urology</td>
<td>Ortho</td>
</tr>
<tr>
<td>BBI, SSI, TPN, Drip...</td>
<td>GI</td>
<td>General</td>
<td>Urology</td>
</tr>
<tr>
<td>Type of insulin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metformin</td>
<td>Hematology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Oral Diabetic Med</td>
<td>Mental Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Steroid Therapy</td>
<td>Neurology</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>OB</td>
<td></td>
</tr>
<tr>
<td>Diagnosis Group</td>
<td>Oncology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Notes</td>
<td>Ortho</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pulm</td>
<td></td>
<td>Urology</td>
</tr>
</tbody>
</table>

Data collected daily by clinical pharmacist as part of a larger complete review of each patient. We do utilize a technician to do data entry onto a spreadsheet for the BG measurement program.*
|    | YYMM | Age | Gen | ABC | prsbc # | Unit | BBI | Met# | Other Oral Meds | Steroid | Diagnosis | Notes | First Date | 1.1 | 1.2 | 1.3 | 1.4 | 2.1 | 2.2 | 2.3 | 2.4 | 3.1 | 3.2 | 3.3 | 3.4 | 4.1 |
|----|------|-----|-----|-----|---------|------|-----|------|----------------|---------|-----------|-------|------------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|
| 59 | 120415 | 74f | bc  | 24 | med     |       |     |      | s-ortho        |         | rt knee    | arthritis | 4/17/12 | 93  | 168 | 140 | 169 | 131 | 111 |
| 60 | 120419 | 85f | tm  | 24 | med     |       |     |      | s-ortho        |         | hip pain   |         | 4/22/12 | 132 | 108 | 150 | 142 | 111 | 131 |
| 61 | 120427 | 61f | eh  | 24 | med     |       |     |      | s-ortho        |         | r shoulder | rotator cuff | 3/23/12 | 131 | 149 | 133 | 101 |     |     |
| 62 | 120428 | 68f | mc  | 22 | med     |       |     |      | s-ortho        |         | right hip |         | 3/27/12 | 97  | 130 | 149 | 133 | 101 |     |
| 63 | 120429 | 54f | mz  | 22 | med     |       |     |      | s-ortho        |         | blat knee | OA       | 3/26/12 | 144 | 115 | 162 | 188 | 170 | 138 | 166 | 151 |
| 64 | 120452 | 70m | rm  | 24 | med     |       |     |      | s-ortho        |         | severe OA | left hip | 3/7/12  | 157 | 268 | 206 | 250 | 163 | 206 | 173 | 259 | 159 | 227 | 176 |
| 65 | 120462 | 93f | md  | 6  | icu     | s-ortho |     |      | hip fx         |         |           |         | 4/27/12 | 287 | 281 | 287 | 181 | 184 | 187 | 236 | 136 |
| 66 | 120465 | 64f | dm  | 23 | med     | s-ortho |     |      | thoracic discitis |     |          |         | 4/12/12 | 108 | 92  | 92  |     |     |     |     |     |
| 67 | 120466 | 83f | pv  | 11 | med     | s-ortho |     |      | rt hip fracture |         |           |         | 4/12/12 | 111 | 107 |     |     |     |     |     |     |
| 68 | 120470 | 75m | bt  | 47 | med     | s-ortho |     |      |           |         |           |         | 4/12/12 | 141 | 141 | 130 | 142 | 115 |     |     |     |
| 69 | 120471 | 81f | rh  | 25 | med     | s-ortho |     |      |           |         |           |         | 4/12/12 | 141 | 141 | 130 | 142 | 115 |     |     |     |
| 70 | 120474 | 93f | md  | 6  | med     | s-ortho |     |      |           |         |           |         | 4/12/12 | 141 | 141 | 130 | 142 | 115 |     |     |     |
| 71 | 120411 | 76f | af  | 51 | med     | s-urol |     |      | uro          |         |           |         | 4/17/12 | 155 | 128 |     |     |     |     |     |     |
| 72 | 120423 | 82m | gm  | 51 | med     | s-urol |     |      | BPH-PSA own  |         |           |         | 4/24/12 | 127 | 184 | 130 | 52  | 151 |     |     |     |
| 73 | 120430 | 69f | ds  | 45 | med     | s-urol |     |      | abd px, urin   |         |           |         | 3/2/12  | 146 | 241 | 171 | 170 | 122 | 131 | 147 | 135 | 114 |
| 74 | 120441 | 77m | cr  | 51 | med     | s-urol |     |      | retention     |         |           |         | 4/3/12  | 77  |     |     |     |     |     |     |     |
| 75 | 120480 | 61m | ld  | 6  | med     | s-urol |     |      | tnp-dcd S-4   |         |           |         | 4/29/12 | 174 |     |     |     |     |     |     |     |
| 76 | 120510 | 87m | mc  | 7  | med     | s-urol |     |      |             |         |           |         | 3/7/12  | 97  | 108 | 112 | 110 | 104 | 97  | 178 | 135 | 90 | 106 | 153 |
| 77 | 120479 | 78m | cw  | med | 146d   | s-urol |     |      |             |         |           |         | 5/1/12  | 186 | 111 | 168 |     |     |     |     |     |
| 78 | 120513 | 65m | rf  | 1  | med     | s-urol |     |      | l-gen         |         |           |         | 5/9/12  | 148 | 117 | 99  |     |     |     |     |     |
| 79 | 120533 | 72m | re  | 6  | lcu     | l-gen  |     |      |             |         |           |         | 5/20/12 | 307 | 231 | 155 | 201 |     |     |     |     |     | 79  | 74  | 72  |
Looking forward:

- Moving to wireless BG meters in May
- Continue to improve the numbers
- Continue our **connection** in transitions of care:
  - With our community pharmacies – outpatient outreach & follow-up
  - With our medical staff
  - With our off site clinics
- Pharmacy– maximizing our resources.
  - Expansion of Advanced Certified Pharmacy Technician* program
  - Redistribute pharmacists time to additional clinical and cognitive services

*Data entry, Tech check Tech, Medication Reconciliation, Sterile Oncology compounding
Lessons Learned

- BG monitoring by pharmacy with active, daily communication to physicians via clinical involvement of pharmacists improves safety and outcomes.
- Although not all patients are candidates for the Basal Bolus Insulin protocol, the roll out and education during this implementation process heightened awareness of all diabetic treatments, also improving outcomes for all patients.
- Always do what you can – small steps are better than no steps. Be patient!
Spencer Hospital is an acute care facility in NW Iowa with:

- 2 Medical/Surgical floors
- Inpatient Mental Health
- Intensive Care Unit
- Emergency Department
- Two Dialysis Units (one on campus & one in Spirit Lake, Iowa)
- Two family practice clinics located in Sioux Rapids and Milford, Iowa
- We have both a central pharmacy (7 days/week) and a pharmacy located in our Abben Cancer Center wing (5 days/week)

- Surgery Center
- Obstetrics
- Ambulance Service
- Radiation Oncology and Medical Oncology
Thank You!

- We would love to share with you
- We would love for you to share with us
- Contact me!

- gmayer@spencerhospital.org
Group Processing

What is one big insight that you got from Spencer Hospital?

What did you hear from Gayle?
Polling for Hospitals Only

Please indicate the response below that best describes your hospital’s action on ADE:

1. Like Spencer Hospital, our hospital has similar ADE tracking procedures in place.

2. Our hospital does not have an ADE tracking procedure in place yet, but we are working to incorporate a process.

3. Our hospital is NOT engaged in tracking ADE and we need our HEN’s assistance to put a process in place.
Call to Action

Paul Moore,
HRSA

Tom Evans,
Iowa Healthcare Collaborative
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