Quality Assessment of Drug Therapy
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March 3, 2016
# Patient Concerns

<table>
<thead>
<tr>
<th>Concern</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug-Drug interaction</td>
<td>70%</td>
</tr>
<tr>
<td>Wrong medicine</td>
<td>69%</td>
</tr>
<tr>
<td>Cost of treatment</td>
<td>69%</td>
</tr>
<tr>
<td>Complications from procedure</td>
<td>69%</td>
</tr>
<tr>
<td>Cost of prescription medicines</td>
<td>67%</td>
</tr>
<tr>
<td>Hospital acquired infection</td>
<td>49%</td>
</tr>
</tbody>
</table>

ASHP Survey: May 1 and 5, 2002
IOM Report:
Preventing Medication Errors

IOM study estimated 1.5 million preventable adverse medication events per year

One medication error per patient per day

Photograph of the cover of the report.

Deaths From Medication Accidents

Line chart showing the ratio of deaths to 1979 levels by year of death from 1979 through 1998. Chart compares deaths from prescription medicines to railway, motor vehicle, water transport, and air transport accidents. Over time the number of deaths from medication accidents has greatly increased and now greatly exceeds deaths from those other accidents.

## Drug Related Morbidity and Mortality Costs

<table>
<thead>
<tr>
<th>Category</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>$121 billion</td>
</tr>
<tr>
<td>Long Term Care</td>
<td>33 billion</td>
</tr>
<tr>
<td>Physician visits</td>
<td>14 billion</td>
</tr>
<tr>
<td>Emergency visits</td>
<td>5 billion</td>
</tr>
<tr>
<td><strong>Added prescriptions</strong></td>
<td>3 billion</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$177 billion</strong></td>
</tr>
</tbody>
</table>

Medication Use Quality

Medication use process/system

Organizational interests in med use

Monitoring and improving med use quality & outcomes

Identifying and reducing med errors
Adverse Drug Events
Adapted from Bates et al.

Adverse Drug Event:
preventable or unpredicted medication event---with harm to patient

Graphic illustration showing a large circle entitled “Medication errors (preventable)” with a smaller half-overlapping circle entitled “Adverse Drug Events (ME & ADR)”.

Cost Impact of ADE’s

<table>
<thead>
<tr>
<th></th>
<th>Increased LOS</th>
<th>Increased Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADE</td>
<td>2.2</td>
<td>$3,244</td>
</tr>
<tr>
<td>Preventable ADE</td>
<td>4.6</td>
<td>$5,857</td>
</tr>
</tbody>
</table>

Incidence of Preventable Drug Related Admissions

Meta-analysis of 15 studies (1980-99)

4.3% (2.5-19%) of all admissions were drug related

>50% of drug related admissions are preventable

Winterstein AG, Sauer BC, Hepler CD, Poole C,
Preventable Drug-Related Hospital Admissions.
Ann Pharmacother 2002; 36:1238-48
Impact of Preventable Drug Related Admissions

158 ADR related admissions over 11 months (24% life threatening)

67% inappropriate monitoring of therapy (80% lab abnormality)

26% drug-drug interactions

595 hospital days (6.1 day LOS)

McDonnell PJ and Jacobs MR. Hospital Admissions Resulting from Preventable Adverse Drug Reactions. Ann Pharmacother 2002; 36:1331-6
Medication Errors

Any preventable event that may cause or lead to inappropriate medication use or patient harm while medication is in the control of the health care professional, patient or consumer

National Coordinating Council for Medication Error Reporting and Prevention
Decision to Treat

Flow chart that begins with decision to treat followed by order written and the various stages that the order goes through while being monitored by various health professionals and the patient once it reaches the patient.
Medical Management Process

Where Adverse Drug Events* Originate
Source Adapted from Bates et al.: JAMA 1995;274:29-34

Flow chart

As Published in Computerized Physician Order Entry: Costs, Benefits and Challenges, Feb 2003, AHA
Medication Use Process

Complex system

Opportunities for error

Impacts patient care and research
Process Improvement

Focus on systems
Data driven
Iterative Cycle Concept
Shewhart Cycle in Quality Improvement

A circle is shown with arrows showing clockwise motion and numbers 1, 2, 3, 4 evenly spaced inside the circle. The following explains this graphic illustration.

**Step 1:** Planning stage (identify objectives, define data which may be available, define new data needs, plan change or test)

**Step 2:** Implementation or pilot stage (complete the planned changes or test)

**Step 3:** Observation stage (collect information on the effect of the planned changes which have been implemented)

**Step 4:** Evaluation stage (study the results of the changes implemented during this cycle)

The Shewhart cycle is repeated multiple cycles with expected improvements implemented in each new cycle.
Organizational Interests

What to use
When to use it
How to use it
Is it cost-effective
Will it be used safely
Pharmacy and Therapeutics Committee

Focus for medication related activities within a health care organization
P&T Committee Overview

Medical Staff Committee

Oversight of medication use in the organization

Staff experts in the medication use process
P & T Committee Role

Medication related policies
Formulary drug selection and review
Evaluate medication use and improve performance
Educate
Medication Policy Issues

Medication selection and quality
Medication prescribing
Medication administration
Formulary

A continuously updated list of medications and related information representing the clinical judgment of physicians, pharmacists, and other experts...

Principles of a Sound Drug Formulary System, 2000

Drug Selection

Safety
Clinical Effectiveness
Cost Impact
Preventable ADE’s

Flow chart showing the steps an order goes though including reaching the patient. Specifically, it starts with a order written (56% of errors), then it is interpreted by a nurse and a pharmacist, then it is transcribed to MAR (6% of errors), then prepared and dispensed (4% of errors) and finally administered to the patient (34% of errors).

Bates DW, Cullen DJ, et al., JAMA 1995; 274: 29-34
Error Location in Medication Use Process

MedMARx 2000 Report

Bar chart indicating the percent of errors that occur in medication administration (42%), documentation (27%), dispensing (17%), prescribing (13%) and monitoring (1%).
Errors in Medication Administration

Total Error Rate = 19%
Excluding Wrong Time = 10%
Barker et al, Arch Int Med 2002

Bar chart indicating the percent that a medication is given at the wrong time (43%), omission (30%), wrong dose (17%), and wrong drug (4%).
Errors in ICU Medication Administration

Med Administration Errors (3.3%)
Vasoactive Drugs (33%)
Sedative / Analgesics (26%)
Wrong Infusion Rate (40%)
Pharmacist Involvement cited in low rate

MEDICATION ERROR DEATHS

FDA Adverse Events Reporting System
1993-98

<table>
<thead>
<tr>
<th>Error Type</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wrong dose</td>
<td>41</td>
</tr>
<tr>
<td>Wrong drug</td>
<td>16</td>
</tr>
<tr>
<td>Wrong route</td>
<td>9.5</td>
</tr>
</tbody>
</table>

Sources of Errors and Elements of Defense Against Them

Graphic illustration

# Proximal Causes of Medication Errors*

<table>
<thead>
<tr>
<th>Lack of knowledge of the drug</th>
<th>Faulty dose checking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of information about the patient</td>
<td>Infusion pump and parenteral delivery problems</td>
</tr>
<tr>
<td>Violation of rules</td>
<td>Inadequate monitoring</td>
</tr>
<tr>
<td>Slips and memory lapses</td>
<td>Drug stocking and delivery problems</td>
</tr>
<tr>
<td>Transcription errors</td>
<td>Preparation errors</td>
</tr>
<tr>
<td>Faulty checking of identification</td>
<td>Lack of standardization</td>
</tr>
<tr>
<td>Faulty interaction with other services</td>
<td></td>
</tr>
</tbody>
</table>

Latent Medication System Errors  
**Latent Errors**

Drawing of a square with round holes of various sizes in it and lines leading from the holes to the following captions:

- **Handwriting**
- **incomplete information**
- **order transcription**
- **unclear labeling**
- **high workload**
- **etc**
Workload and Outcomes

Average census
Admissions on admission day
Discharges on admission day
Admissions on discharge day
Discharges on discharge day
Team admissions per month
Number of teams
Number of interns on the admitting team
## Workload and Outcomes

<table>
<thead>
<tr>
<th>Team admissions that day</th>
<th>IP Mortality</th>
<th>30-day Re-admit</th>
<th>LOS</th>
<th>Total Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.09*</td>
<td></td>
<td>3.09*</td>
<td>2.31*</td>
</tr>
<tr>
<td>Average Census</td>
<td></td>
<td></td>
<td>-5.30*</td>
<td>-5.11*</td>
</tr>
</tbody>
</table>

*Significant Multivariate House Staff Effects

Prescribing Errors
by Medication Category

Antimicrobials  40%
Cardiovascular  18%
Gastrointestinal  7%
Narcotic analgesics  7%

Lesar et al. JAMA, 1997
MedMARx Reports of Actual Error or Harm

MedMARx 2000 General

Bar chart showing % of errors involving insulin (9%), heparin (5%) morphine (4%), Warfarin (4%) and potassium Chloride (3%)

MedMARx 2006 Pediatric

Bar chart showing % of errors involving Opioids (11.5%) Antimicrobial (7.5%), Anti-diabetic (4.5%) and fluid & elec (4.4%)
Specific Factors Related to Errors in Medication Prescribing

Decline in renal or hepatic function  13.9%
History of medication allergy  12.1%
Use of abbreviations  11.4%
Incorrect dose calculation  10.8%

Lesar et al. JAMA, 1997
MEDMARX® Reports of Harmful Errors

MEDMARX 2002 Report

Bar chart showing percent overall medication errors (1.5%), and medication errors in Geriatric medicine (3.5%) of which 55% were fatal.
Safeguard Against Errors in High-Risk Drugs

Build in System Redundancies
Use Fail-Safes
Reduce Options
Use Forcing Functions
Externalize or Centralize Error-prone Processes
Store Medications Appropriately
Screen New Products
Standardize and Simplify Order Communication
Limit Access
Use Constraints
Use Reminders
Standardize Dosing Procedures
Use Differentialization
Screen New Products
Standardize and Simplify Order Communication
Limit Access
Use Constraints
Use Reminders
Standardize Dosing Procedures
Use Differentialization

Total Medication Errors by Month

Line chart showing these errors that crept up in numbers over time beginning with approximately 12 errors in June 2001 up to approximately 45 in June 2005.
Use of High Level Data

Shows interesting trends

Better for global evaluation

No detail to work with
Pitfalls of High Level Data

Cause unclear

Potential false conclusions
Medication Errors by Quarter

Chart detailing the errors including wrong drug, wrong dose, duplicate dose, wrong route, wrong time, wrong fluid, wrong rate, wrong device, and wrong IV infiltration by quarter. The total number of errors increased over time from 68 in June 2002 to 81 in March 2005.
Broad-based
Information Sources

Near misses

Patient specific events

Aggregated hospital-wide occurrence data

External medication error data

Hospital quality improvement data

Therapeutic trends & changes

Hospital programmatic information
Epidemiology of Medication Errors

Collect the numbers
Read between the lines
Look for common threads
Try to link together
Admission Order
Medication Omissions

Review of ongoing meds not ordered by MD at admission

53% of patients had at least 1 unintended discrepancy

37% had potential for harm

Cornish, Arch Intern Med 2005; 165:424-429
**Admission Order**

**Medication Omissions**

<table>
<thead>
<tr>
<th>Type</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Omission</td>
<td>65</td>
</tr>
<tr>
<td>Dose</td>
<td>35</td>
</tr>
<tr>
<td>Frequency</td>
<td>24</td>
</tr>
<tr>
<td>Incorrect drug</td>
<td>16</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>140</strong></td>
</tr>
</tbody>
</table>

Cornish, Arch Intern Med 2005; 165:424-429
IOM Recommendations on: Preventing Medication Errors

Stronger consumer role (self-management)
Enhance consumer information sources
Complete patient-information & decision support tools
Improved drug labeling
Standardize drug-related health information technologies
Broad research agenda on safe and appropriate med use with funding
Medication Use Evaluation

A performance improvement method that focuses on evaluating and improving medication-use processes with the goal of optimal patient outcomes

American Society of Health-System Pharmacists, 1996
## Selection of MUE Projects

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>known or suspected to cause adverse reactions or drug interactions</td>
<td>used in patients at high risk for adverse reactions</td>
</tr>
<tr>
<td>affects large number of patients or medication is frequently prescribed</td>
<td>critical component of care for a specific disease, condition, or procedure</td>
</tr>
<tr>
<td>potentially toxic or causes discomfort at normal doses</td>
<td>most effective when used in a specific way</td>
</tr>
<tr>
<td>under consideration for formulary retention, addition, or deletion</td>
<td>suboptimal use would have a negative effect on patient outcomes or system costs</td>
</tr>
<tr>
<td>expensive</td>
<td></td>
</tr>
</tbody>
</table>

A chart is shown that indicates that during FY 01 through FY 05 the amount spent on anti-infective agents went from $1,612,016 in FY 01 to $5,287,206 in FY 05. In addition, the chart indicates that in FY 01 $1,226,067 was spent on Antineoplastic agents and by FY 05 the amount spent on those agents was $1,866,450.
<table>
<thead>
<tr>
<th>Review Category</th>
<th>Data Collection Model(s)</th>
<th>Typical Application</th>
<th>Comments</th>
</tr>
</thead>
</table>
| Retrospect      | Data is collected for a fixed period which may be archival or accumulation of new patients for a fixed period of time | Data archive search for prescribing patterns of patients on serotonin antagonist antiemetic drugs | Supports large scale epidemiologic approach  
No active intervention to change medication use patterns occurs due to the post-hoc data collection process |
| Concurrent      | Each new order generates an automatic review of previously approved criteria for use within a specified period of the initiation of therapy | Review of naloxone to investigate possible nosocomial adverse medication event          |                                                                                             |
|                 | Laboratory or other monitoring criteria are reported for all patients on the drug       | Digoxin monitoring based upon daily review of digoxin serum levels (49).               |                                                                                             |
|                 | Abnormal Laboratory or other monitoring criteria are reported for all patients on the drug on a regular basis. | Regular review of serum creatinine for patients on aminoglycosides                     |                                                                                             |
|                 | Each new order for the drug is evaluated for compliance with previously approved criteria for use. Variance to the criteria require intervention prior to initiation of therapy | Medication use guidelines (ketorolac) (50); Restricted antibiotics                  |                                                                                             |
Evidence Based Guidelines

Photograph of a Fact Sheet on Beta-Blockers for Acute Myocardial Infarction dated April 27, 2005

www.guidelines.gov
Benchmarking

Primary Indication for NovoSeven™ Use

37.8% (119/315) of patients received NovoSeven for prevention of bleed

62.2% (196/315) of patients received NovoSeven for treatment of active bleed

Primary Indication for NovoSeven Use by Institution

Bar chart showing % of cases. The numbers above the bars represent the number of complete cases submitted by each institution.
Benchmarking

Chart showing C6- Medication until first dose of antifungal medication – Page 1 of 2
Benchmarking

Photograph of a document called Key Indicator Report – Sample Hospital, July-September 2005 (Q3)
Photograph of a Quality Report for a Hospital.

National Quality Improvement Goals. Condition: Heart Attack Care

Reporting Period: July, 2004 – June, 2005
Computerized Laboratory Alerts

Flashing Computerized Alert for low Potassium

Increased follow-up monitoring

Increased K+ intervention rate

Decreased hypokalemia at discharge

Paltiel, Arch Intern Med 2003; 163:200-204
Computerized Order Entry

Taylor (Pediatrics, 2008)
Feldstein (Arch Intern Med, 2006)
Mekhjian (JAMIA, 2002)
Nightingale (BMJ, 2000)
Bates (JAMA, 1998; JAMIA, 1999)
Raschke (JAMA, 1998)
Computer Facilitated Order Errors

Computerized prescriber order entry error opportunities

22 types of errors facilitated by CPOE system

Many can be corrected by investigation and improvement

Koppel, JAMA 2005; 1197-1203
Computer Facilitated Errors

20% of MedMARx reports involved computer related interaction

71% did not reach patient

0.74% did actual harm

Automated dispensing machines

MedMARx 5th Anniversary Data Report, 2005
Simulation of Technology Impact

Computer simulation of integrated medication use system

Concluded 1,226 days of excess hospitalization

$1.4 million associated costs

Anderson, JAMIA 2002; 9: 479-90
Drug Name Selection

Lambert (Drug Safety, 2005)
Lambert (AJHP, 1997)
Lambert (Medical Care, 1999)
Summary of Medication Use Quality Issues

Complex process prone to error
Drug use can be improved
ADE risks can be reduced
Photograph of various medications (tablets, capsules, and vials).