



American Society of
Health-System Pharmacists
7272 Wisconsin Avenue
Bethesda, Maryland 20814
(301) 657-3000
Fax: (301) 664-8877
www.ashp.org

October 10, 2008

The National Quality Forum
601 Thirteenth Street, NW
Suite 500 North
Washington, DC 20005

Re: NQF Member Pre-voting Review for Safe Practices for Better Healthcare – 2009

The American Society of Health-System Pharmacists (ASHP) is pleased to have the opportunity to comment on the proposed 2009 Safe Practices for Better Healthcare. Overall, we find the practices to be comprehensive, timely, and accurate. ASHP believes that these practices will most certainly have an effect on reducing the risk of harm to patients and enhancing the quality of healthcare by promoting the harmonization of evidence-based standards with daily practices of patient care. Suggested changes or added text is noted below in capital letters.

Identification and Mitigation of Patient Safety Risks—Safe Practice 4

ASHP believes pharmacists should exert leadership in the development, maintenance, and ongoing evaluation of adverse drug reaction (ADR) reporting programs. Our [Medication Errors and Risk Management Policy](#) establishes that pharmacists should be included in healthcare organizations' risk management processes for the purposes of (a) assessing medication-use systems for vulnerabilities to medication errors, (b) implementing medication-error prevention strategies, and (c) reviewing occurrences of medication errors and developing corrective actions.

ASHP suggests adding an additional strategy of progressive organizations after line 484:
“OTHER PROGRESSIVE ORGANIZATIONS PROVIDE FEEDBACK TO STAFF ON IMPROVEMENTS AND ENHANCED PERFORMANCE THAT RESULTED FROM ADVERSE EVENT REPORTING.”

ASHP suggests adding to line 490 “AND FACILITATE DIALOG USING AIDS SUCH AS ONLINE OR HOTLINE REPORTING SYSTEMS.”

Disclosure—Safe Practice 7

Regarding malpractice insurance and disclosure policies, professional liability policies in general do not permit the insured to disclose. The business model of insurance carriers does not consider the disclosure practices or preferences of individual healthcare institutions. Disclosure is proscribed by some insurance carriers; if the insured engages in any prohibited activities such as

TOGETHER WE MAKE A GREAT TEAM

admitting liability without the carrier's consent, the coverage is null and void. ASHP recommends that further study is needed as it is not clear how successful organizations will be in negotiating these agreements with insurance carriers.

Order Read-back and Abbreviations—Safe Practice 13

ASHP supports NQF's efforts to minimize the use of abbreviations and verbal orders in healthcare. [ASHP's Guidelines on Preventing Medication Errors in Hospitals](#) states that verbal orders "should be reserved only for those situations in which it is impossible or impractical for the prescriber to write the order or enter it in the computer."

Medication Reconciliation—Safe Practice 17

ASHP fully supports Safe Practice 17 on medication reconciliation. The Society describes medication reconciliation as "the comprehensive evaluation of a patient's medication regimen any time there is a change in therapy in an effort to avoid medication errors ... as well as to observe compliance and adherence patterns. This process should include a comparison of the existing and previous medication regimens and should occur at every transition of care in which new medications are ordered, existing orders are rewritten or adjusted, or if the patient has added non-prescription medications to their self-care." Research is needed to evaluate the effectiveness of various approaches to medication reconciliation to improve outcomes of medication use.

Furthermore, ASHP [policy](#) supports that pharmacists, because of their distinct knowledge, skills, and abilities, should provide leadership of interdisciplinary efforts to establish medication reconciliation systems to ensure the accuracy and completeness of all medication lists taken at admission and for communication of a reconciled list of medications at any change in level of care. ASHP provides resources to support pharmacist leadership in coordinating medication reconciliation initiatives.

Pharmacists also have a responsibility to educate patients and caregivers on their responsibility to retain an up-to-date and readily accessible list of medications that the patient is taking and should assist patients and caregivers by assuring the provision of a personal medication list as part of patient education and counseling efforts.

As noted in lines 1474 to 1485, implementation of medication reconciliation is still in the early stages; there are five overarching limitations that can lead to delays in implementation:

1. competing priorities for caregivers' time;
2. perceived value of medication reconciliation—value of services needs to be demonstrated to get the financial resources needed to fully implement strong and successful programs;
3. workforce capacity to handle new work above existing models;
4. availability of data—can be facilitated by use of technologic advancements, namely, a national electronic health record; and
5. non-incremental change—perception that institutions will get penalized on an "all-or-nothing" basis for medication reconciliation program implementation.

Under Applicable Clinical Care Settings, ASHP recommends that “ambulatory care” be further defined to ensure community care and retail pharmacy settings are included as applicable settings for this safe practice.

ASHP recommends adding as a specification: “ADHERENCE TO PROCEDURES THAT ENSURE AN ACCURATE CURRENT MEDICATION LIST BEFORE, DURING, AND AFTER EPISODES OF CARE IS AN EXPECTATION OF ALL MEMBERS OF THE HEALTHCARE TEAM.” The Society believes that participation of all disciplines involved in medication use is essential to solve the complex challenges of medication reconciliation.

In regards to line 1518, which states “medications ordered for the patient while under the care of the organization are compared to those on the list created at the time of entry to the organization or admission,” ASHP recommends clarification. As written, this statement can be interpreted to mean that all medications that are ordered during an inpatient stay are reconciled to the admission list. The Joint Commission has clarified this by differentiating between the “home medications” list and the dynamic document of the patient’s current medication list (see page 5 of the Joint Commission FAQ document available at http://www.jointcommission.org/nr/rdonlyres/9ecf1ed6-e04e-41de-b7bc-174590cedf33/0/07_npsg_faqs_8.pdf).

ASHP recommends generalizing line 1525 by replacing “from the ICU to a floor” with “TO A LOWER OR HIGHER LEVEL OF CARE.”

Line 1549 states that there should be a complete medication reconciliation process whenever “there is a prescription change for any of the patient’s current known long-term medications.” ASHP recommends inclusion of an exception for the temporary hold of a chronic medication during an inpatient stay.

ASHP strongly supports NQF in encouraging patients to carry an accurate medication list (line 1582) and recommends including a link to the My Medication List™ that has been developed with multidisciplinary efforts (available at <http://www.safemedication.com/MedTool.pdf>).

Line 1591 states that “high performing organizations have required second check systems to validate patient medication home lists.” A clarification or an example of this second check system may be helpful.

Secure online electronic medication lists to which patients may designate access by caregivers in the health system or community, such as Google Health (www.google.com/health) or Microsoft’s HealthVault (www.healthvault.com/), should also be included as an area for future research.

Pharmacy Leadership Structures and Systems—Safe Practice 18

ASHP commends NQF on the proposed revisions of Safe Practice 18: Pharmacy Leadership Structure and Systems.

ASHP strongly acknowledges the importance of pharmacy leadership to a successful medication safety program; we recommend revising line 1678 as follows: “EFFECTIVE pharmacy

leadership is CRITICAL TO a successful medication safety program. Pharmacy leadership structures and systems SHOULD ensure a multidisciplinary focus...”

Background information in line 1702 contains data from 2001 regarding outpatient prescription medicine spending. Newer data according to AHRQ shows that in 2004 spending had increased to 191 billion dollars
(http://www.meps.ahrq.gov/mepsweb/data_files/publications/st168/stat168.pdf).

ASHP commends NQF’s recognition of the role of pharmacy leaders on the administrative team and recommends revising line 1754 to strengthen this statement as follows: “Pharmacy leaders should have an INTEGRAL role on the administrative leadership team...”

ASHP recommends addition of a specification to Leadership and Culture of Safety after line 1764 as follows: “ENSURE SAFE AND EFFECTIVE MEDICATION USE ACROSS THE CONTINUUM OF CARE AS PATIENTS MOVE FROM ONE SETTING TO ANOTHER (E.G., AMBULATORY CARE TO INPATIENT CARE TO HOME CARE).”

ASHP recommends integration of the medication safety committee described in this safe practice with the interdisciplinary patient safety committee described in Safe Practice 1. To accomplish this, line 1781 could be revised as follows: “Establish a medication safety committee...to report data and prevention strategies to senior leadership, THE INTERDISCIPLINARY PATIENT SAFETY COMMITTEE, AND THE patient safety officer.”

ASHP supports the importance of a sound formulary system (see [ASHP Statement on the Pharmacy and Therapeutics Committee and the Formulary System](#)). ASHP recommends expanding the proposed definition of a formulary on line 1797 to include: “...medications chosen for safety, effectiveness, AND COST, AS WELL AS MEDICATION-ASSOCIATED PRODUCTS OR DEVICES, MEDICATION USE POLICIES, IMPORTANT ANCILLARY DRUG INFORMATION, DECISION SUPPORT TOOLS, AND ORGANIZATIONAL GUIDELINES.”

ASHP encourages health systems to adopt bar-code enabled medication administration (BCMA) technology to improve patient safety and the accuracy of medication administration and documentation, as stated in [ASHP policy](#). The Society suggests rewording line 1829 to: “Machine-readable coding should be considered in compounding, stocking, and dispensing procedures to facilitate accuracy.” In addition, ASHP recommends that an additional medication administration specification should be added after line 1834 as follows: “ORGANIZATIONS SHOULD CONSIDER THE USE OF MEDICATION ADMINISTRATION TECHNOLOGIES SUCH AS BAR-CODE ENABLED MEDICATION ADMINISTRATION (BCMA) AND INTELLIGENT INFUSION DEVICES AS PART OF ITS MEDICATION SAFETY STRATEGY.”

ASHP applauds the example implementation approaches. We believe that the example implementation approach outlined in lines 1879-1880 should be expanded as follows: “Seek pharmacists with experience, EXPERTISE, AND TRAINING in management and clinical services to lead and oversee clinical pharmacy operations. SKILLS SHOULD INCLUDE

COMMUNICATION, CONFLICT RESOLUTION, NEGOTIATION, AND COLLABORATION.”

In addition, ASHP believes that the implementation approach described on line 1896 confuses two separate issues: credentialing and professional development. ASHP suggests clarification with the following changes. Line 1896 should be focused on credentialing as: “REQUIRE pharmacists TO COMPLETE CREDENTIALING CONSISTENT WITH THEIR SCOPE OF PRACTICE SUCH AS RESIDENCY TRAINING OR board certification.” Following this line, the additional implementation approach of continuing development should be inserted as: “ENSURE THERE IS A MODEL AVAILABLE, SUCH AS CONTINUING PROFESSIONAL EDUCATION, FOR CONTINUING PROFESSIONAL DEVELOPMENT FOR PHARMACISTS.”

ASHP supports the involvement of pharmacy leadership in senior administration such as through a Chief Pharmacy Officer as described in lines 1904–1906. ASHP recognizes that various models of doing this have been shown to be effective regardless of titles used and recommends adding to line 1906: “REGARDLESS OF THE TITLE, HAVING A PHARMACY EXECUTIVE REPORT AT A HIGH LEVEL OF ADMINISTRATION HAS BEEN SHOWN TO BE EFFECTIVE.”

ASHP believes the methods of providing 24/7 pharmacist coverage discussed in lines 1907-1909 should be developed into a separate strategy bullet as follows: “Some organizations have developed 24/7/365 pharmacist coverage with combinations of REMOTE ORDER ENTRY, telephony, streaming video, and scanning technologies that enable the clear evidence-based practices of PROSPECTIVE PHARMACIST ORDER REVIEW AND FACE-TO-FACE PATIENT COUNSELING.”

ASHP believes the section on Strategies of Progressive Organizations can also be enhanced through the addition of the following three strategies:

- Adoption of a pharmacy practice model where pharmacists are positioned to promote the safe and effective use of medications while technologies and technicians are used for preparation and dispensing processes.
- Continually reevaluating and redesigning the medication-use system to improve error-prone steps through the use of technology.
- Utilizing pharmacy technicians with standardized training and certification to improve the efficiency and safety of medication preparation and dispensing.

Care of the Ventilated Patient—Safe Practice 23

It is stated that peptic ulcer disease (PUD) prophylaxis should be implemented based on patient risk assessment. However, the evidence showing that PUD prophylaxis prevents ventilator-associated pneumonia (VAP) remains questionable. While some studies have demonstrated that use of select therapies provides benefit in reducing VAP, others studies have found conflicting results. Some evidence has shown that organisms causing VAP cannot be tracked back to the stomach, implying that the stomach may not be an important source for VAP. We suggest

considering the need for research that evaluates the usage of PUD prophylaxis and its relation to VAP.

VTE Prevention—Safe Practice 28

This safe practice is consistent with the Venous Thromboembolism (VTE) measures that were recently endorsed by NQF. Although provider education is addressed, patient education is not currently addressed in the specifications. We suggest considering inclusion of the following (based on a NQF-endorsed measure) as an additional specification for this safe practice:

“PROVIDE AND EXPLAIN TO VTE PATIENTS OR THEIR CAREGIVERS, AT THE PATIENT-APPROPRIATE READING AND HEALTH-LITERACY LEVEL, WRITTEN DISCHARGE INSTRUCTIONS OR OTHER EDUCATIONAL MATERIAL ADDRESSING ALL OF THE FOLLOWING: 1) FOLLOW-UP/MONITORING, 2) COMPLIANCE ISSUES, 3) DIETARY RESTRICTIONS, AND 4) POTENTIAL FOR ADVERSE DRUG REACTIONS/INTERACTIONS.”

Anticoagulation Therapy—Safe Practice 29

ASHP applauds the inclusion of monitoring of heparin and especially of low-molecular weight-heparin (LMWH). ASHP strongly encourages that platelet monitoring be required for LMWH, in addition to the current requirement for unfractionated heparin (UFH). Our recommendation is consistent with the Eight American College of Chest Physicians Conference on Antithrombotic and Thrombolytic Therapy guidelines, which indicate that postoperative patients receiving prophylactic LMWH and medical patients who receive LMWH after receiving UFH should have platelet counts monitored every 2 or 3 days within days 4 and day 14 of therapy, or until the heparin therapy is discontinued. While the ACCP guidelines indicate this is a Grade 2 recommendation, there is growing evidence that the incidence of heparin-induced thrombocytopenia may be underestimated in patients receiving these therapies.

Contrast-Media Induced Renal Failure Prevention—Safe Practice 30

ASHP encourages the use of evidence-based protocols for the prevention of contrast media-induced nephropathy and recommends the rewording of line 3935 for clarity as follows: “USE EVIDENCE-BASED PROTOCOLS DEVELOPED BY A MULTIDISCIPLINARY TEAM THAT INCLUDES A PHARMACIST AND THAT ARE APPROVED BY THE MEDICAL STAFF FOR THE PREVENTION OF CONTRAST MEDIA-INDUCED NEPHROPATHY.”

For clarity, ASHP recommends rewording line 3939 as, “MONITOR AND DOCUMENT USE OF EVIDENCE-BASED PROTOCOLS, INCLUDING VARIANCES AND RATIONALE.”

ASHP suggests the addition of a specification as follows: “SPECIFY QUALIFICATIONS FOR STAFF WHO ARE AUTHORIZED TO INITIATE PROTOCOLS FOR IMAGING THAT INCLUDE CONTRAST MEDIA AND SCREEN PATIENTS AT RISK FOR CONTRAST MEDIA-INDUCED NEPHROPATHY.”

Glycemic Control—Safe Practice 32

The controversy on tight glycemic control in critically ill patients is well-noted; however, line 4291 as written applies to all patients. The NQF should consider that application of tight glycemic control to all patients may be overly broad in light of the evolving evidence. Individual

guidance documents based on patient type or practice setting may be preferred compared to the current document that addresses all of these areas. In addition, recent evidence demonstrates that the target level of glycemic control may be less important than the controlling the extent of variability in glucose levels in some patient populations in the intensive care unit setting. New devices, including implantable insulin devices that allow for more accurate and continuous monitoring of blood glucose, may also impact practice recommendations.

Falls Prevention—Safe Practice 33

ASHP believes that a pharmacist should be involved in fall reduction programs described in line 4464 to develop medication assessment strategies for patients at risk for falls. The assessment of medications in fall risk evaluation is critical (see data at http://www.psa.state.pa.us/psa/lib/psa/advisories/v5n1march_2008/mar_2008_v5_n1_article_medication_assessment_falls.pdf).

The specifications discuss assessing fall risks in populations but do not address the assessment of individual patients, which is crucial due to the compounding effect that risk factors exhibit. ASHP recommends the addition of the individual assessment of patients that are within the at-risk populations identified. This practice is described in the example implementation approaches but should also be listed as a specification.

ASHP commends the NQF on observing the importance of “regular review of patient medications that may predispose patients to falls, especially psychotropic medications.” ASHP suggests also adding “DIURETICS, AND OTHERS.”

ASHP supports the use of tools to assess an individual’s fall risk; as currently written this safe practice describes two such tools. It is important to note that the Morse assessment does not consider patient medications that might increase the patient’s risk for falls. The Hendrich tool does give consideration to the use of certain central nervous system medications, but the list is limited and does not include other medication classes, such as diuretics, that also have the potential to increase a patient’s risk of falls. For this reason, a pharmacist’s involvement in fall reduction efforts is preferred.

Thank you for the opportunity to provide feedback on the proposed Safe Practices for Better Healthcare for 2009. If you have any questions concerning the Society’s comments, please contact me by phone at (301) 664-8815 or via e-mail at mandrawis@ashp.org.

Regards,



Mary Andrawis, Pharm.D., M.P.H.
Medication-Use Quality Improvement Associate
American Society of Health-System Pharmacists