



October 3, 2013

Yael Harris, Director
Director Division of Health Care Quality
Department of Health and Human Services
Office of Disease Prevention and Health Promotion
1101 Wootton Parkway
Suite LL100
Rockville, MD 20852

VIA ELECTRONIC SUBMISSION:

Attention: Draft National ADE Action Plan

Dear Dr. Harris

The American Society of Health-System Pharmacists (ASHP) is pleased to submit comments on the Draft National Action Plan for Adverse Drug Event (ADE) Prevention as published in the September 4, 2013 Federal Register.¹ ASHP is the national professional organization whose 42,000 members include pharmacists, pharmacy technicians, and pharmacy students who provide patient care services in acute and ambulatory care settings, including hospitals, health systems, and ambulatory clinics. For over 70 years, the Society has been on the forefront of efforts to improve medication use and enhance patient safety.

We applaud the Department for their work on this draft plan. ASHP supports the four-pronged approach, which is more comprehensive than previous attempts to address this issue. We believe that incorporation of research to identify knowledge gaps is especially valuable. The plan's focus on engaging stakeholders, including professional associations, will be especially useful in obtaining real-world perspectives. It will also assist in marketing and uptake of the initiative. The identified disease states and populations are appropriate and reflect high-impact, high return-on-resource-investment areas. As the program matures, it will be useful to expand to other at-risk populations and medications. Given the extent of care that is provided in the outpatient setting, it will be essential to explore additional strategies that address ADEs in this setting. While ADE occur across the spectrum of care, more sophisticated programs (including IT) support better reporting and prevention in the inpatient setting. As such, the

¹ Vol. 78, No. 171, Pages 54469 – 54470.

TOGETHER WE MAKE A GREAT TEAM

burden of any new programs will be heavily weighted to inpatient settings, who are already experiencing substantial challenges. The following are ASHP's comments on the draft plan, identified by section, subsection, and page number.

Executive Summary

Page 1

ASHP fully supports the use of an enhanced, specific, and consistent definition of adverse drug event. There is neither standardization of, nor universal agreement on, the terminology that should be used to describe adverse drug events, which hinders analysis of aggregate ADE data. Establishing these definitions is essential in identifying effective prevention strategies and collecting meaningful data on progress in reducing the rate of ADEs.²

Although it is important to target these high risk and high impact areas, life threatening ADEs can occur from a variety of classes of agents and can result from improper formulation and administration of agents. The accompanying broad and general plan should address mechanisms to assist entities in preventing harm should be highlighted.

Page 2

The Society would like HHS to make available an aggregated and indexed list of approved, vetted, and validated tools that can help health-systems identify and prevent ADEs in a prospective manner.

ASHP supports the proposed approach, which is described as "sharing" which implies use of already existing resources. The Center for Medicare and Medicaid Innovation Center at the Centers for Medicare and Medicaid Services (CMS) has done significant work in the identified therapeutic areas of interest, and their private sector networks, including the Health Engagement Network, should be tapped for resources. While the draft plan focuses on Federal agencies, it is imperative that the program scan the private sector for resources, where many substantial and effective tools have been developed.

Under incentives and oversight, the Society acknowledges and supports the value of these mechanisms, but it is important to recognize that not all ADEs are not preventable. The Agency for Healthcare Research and Quality (AHRQ) notes that "anywhere from 28 percent to 95 percent of ADEs can be prevented by reducing medication errors through computerized monitoring systems." This indicates that 5 to almost 30 percent of ADE may not be preventable. Therefore, penalty-based programs are especially concerning. In addition, it is challenging to

² Institute of Medicine. Introduction; Definitions, pp 35-38, in Preventing medication errors: Quality Chasm Series. Washington, DC: National Academy Press, 2006.

determine causal relationships for many ADE. This is addressed to an extent on page 25 (see comment below).

Introduction

Pages 9 - 10

On pages 9 through 10, the draft plan notes that ADE programs may be more challenging to implement in rural settings – which is an important fact that should be examined further. The plan goes on to state that critical access hospitals (CAH) are already exempt from some Hospital Care and other reporting programs (page 9, 3rd paragraph), which will be especially important if penalty-based programs are implemented. However, there are a significant number of small and rural facilities that are not CAHs, but are not large enough to have the resources of larger facilities. They will face substantial staffing, IT and other challenges with incentive and oversight programs.

Throughout the document, specific professions are stated. We suggest consistent use of the terms “clinician” or “health-care practitioner” throughout the document so that it is clear this important effort applies to the entire health-care team involved with patient care, including pharmacists, physicians, nurses, and other providers

Section 1: National Action Plan Scope and Development

Development process for the national action plan for ADE prevention

Page 19

ASHP commends HHS on the systematic method used in the development process of the draft National Action Plan for ADE prevention

Organization for the NAP for ADE prevention

Page 20

ASHP suggests expanding the incentives beyond the “meaningful use” of electronic health information technology. Health-Systems with limited resources should be further supported to implement needed changes and develop interoperable systems within their communities

Table 1 identifies areas where HIT can support action plan goals. While this information is accurate, it is also aspirational. For example, incorporation of clinical guidelines in clinical decision support to aid in prevention aspects of the program is currently in its infancy. ASHP is a member of the Pharmacy HIT Collaborative which submitted comments to the ONC on June 26, 2013 about the *Request for Comments on the Development of a Risk-Based Regulatory*

*Framework and Strategy for Health Information Technology.*³ We support their efforts in achieving the use of electronic health information exchange across providers and patients, as well as strategies that are effective and feasible to further advance and promote interoperability and health information exchange and ensure the protection of patient data collected and shared through electronic means, including mobile devices and mobile medical apps.

The Office of Disease Prevention and Health Promotion cites CMS' Meaningful Use (MU) EHR Incentive Program as supporting the goals of the proposed plan. While ASHP fully supports and recognizes the meaningful use of EHRs, AHRQ should be cognizant of the fact that pharmacists are not recognized as eligible providers under the MU EHR Incentive Program and are therefore ineligible for EHR incentives. In this context, the requirements of meaningful use essentially exist as unfunded mandates on pharmacists which limit optimal participation and subsequent improvements in patient health outcomes and cost reductions. We urge the Secretary to allow pharmacists the opportunity to receive EHR incentives which would lead to adoption of these EHR standards at a level that improves care transitions and health outcomes.

Section 2: Surveillance Resources

Considerations for Choosing Surveillance Data Sources and Metrics; General Surveillance System Considerations; Active Surveillance vs. Passive Surveillance (Voluntary Reporting)

Page 24

ASHP is very supportive of focusing on active surveillance systems described in the second paragraph. However, the Society would also encourage incorporation of existing plans to enhance spontaneous (passive) surveillance, which has limitations but is still important to a comprehensive surveillance program. For example, plans to provide e-reporting for passive surveillance may be especially valuable in outpatient settings.

Considerations for Choosing Surveillance Data Sources and Metrics; Considerations Specific to ADE Surveillance

Page 25

The challenges in using administrative claims (e.g., underuse of these codes) are acknowledged in paragraphs 2 and 3. Significant education and training would be needed before programs of this nature could be implemented. The third paragraph describes strategies for easing the burden of manually reviewing clinical documentation, including algorithmic detection methods.

³ *Comments on the Development of a Risk-Based Regulatory Framework and Strategy for Health Information Technology*, June 26, 2013, submitted by Pharmacy e-Health Information Technology Collaborative, Alexandria, VA.

These strategies do decrease burden, as demonstrated in pilot studies. However, broad implementation on the scale at which that these three target conditions occur would be resource intensive.

Section 3: Prevention Approaches

Key determinants of ADEs

Pages 33 – 35

The Society believes that this section should be expanded to include a comprehensive list of tools and prevention approaches. Examples may include re-engineered discharge planning, and The Institute of Healthcare Improvement’s Trigger tool for measuring adverse drug events.⁴

While this section accurately describes key determinants of ADEs, it would be improved by clarifying that not all ADEs are preventable and that prevention approaches only address preventable events.

Adverse drug reactions (ADRs) a subset of ADEs, are defined by the WHO as unintended and occurring at normally used doses and therefore are not preventable. ADRs should not be a focus of prevention approaches nor should they be included in surveillance data that is used to track progress on preventable ADEs.⁵

A key and expanding area of knowledge is the contribution of pharmacogenetics to ADE prevention, yet this aspect is touched on only briefly on page 35 and is not included in Figure 5. FDA-approved drug labeling for more than 100 therapies now provides information on drug use based on the patient’s genetic profile, with much of the information focused on safety aspects (i.e., prevention of ADEs). This information is expected to expand substantially in the coming years as this action plan is implemented.

⁴ Classen DC, Resar R, Griffin F, et al. “Global trigger tool” shows that adverse events in hospitals may be ten times greater than previously measured. *Health Aff (Millwood)*. 2011;30(4):581–589. doi:10.1377/hlthaff.2011.0190.

⁵ Definition of adverse drug reaction. World Health Organization. Glossary of terms Used for Pharmaceuticals and Pharmaceutical Policies in Low- and Middle-Income Countries <http://apps.who.int/medicinedocs/en/d/Jh2934e/14.html> (accessed 25 Sept 2013)

Section 5: Anticoagulants

Surveillance

Page 59

ASHP agrees with the actions that can potentially advance surveillance strategies for anticoagulant ADEs. Specifically the promotion of consistent definitions for major and minor bleeding episodes, and ensuring pharmacy data is linked to laboratory tests.

Evidence-based Prevention Tools; Federal agencies that provide direct patient care play an important role in advancing evidence-based strategies for anticoagulant ADE prevention

Pages 64 – 65

ASHP recommends contacting the Department of Veterans Affairs (VA) to confirm the accuracy of Table 3 as several recommendations may have been updated.

- “Provide heparin in dosage forms that are as close as possible to what is ordered (e.g. 5000 U)” **may no longer be applicable as current guidelines recommend rarely recommend subcutaneous administration of unfractionated heparin. Vials would not be dispensed.**⁶
- “Establish a food and drug interaction program/policy which addresses enteral feedings and warfarin administration” **is narrowly focused on enteral feeding, but should include all foods that affect warfarin therapy.**⁷
- “Include drip charts on the infusion bags to improve the ability to adjust rates without mathematical errors” **Intelligent infusion devices with dose error reduction systems have nearly eliminated the need for rate calculations at the bedside.**

Evidence-based Prevention Tools; Federal agencies that provide direct patient care should continue to lead the path in exploring ways to further improve uptake of evidence-based, systematic, and coordinated models of oral anticoagulation management associated with reductions in anticoagulant ADEs and health care costs

Page 70

ASHP is pleased to see support for anticoagulation clinics for this high impact area where pharmacists can provide much expertise in the area of medication therapy management for

⁶ Antithrombotic Therapy and Prevention of Thrombosis, 9th Ed: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines| February 2012. Subcutaneous heparin: <http://journal.publications.chestnet.org/article.aspx?articleid=1159399> (accessed 25 Sept 2013)

⁷ Walter Ageno, MD; Alexander S. Gallus, MBBS; Ann Wittkowsky, PharmD, FCCP; Mark Crowther, MD; Elaine M. Hylek, MD, MPH; Gualtiero Palareti, MD. Oral Anticoagulants. Antithrombotic Therapy and Prevention of Thrombosis, 9th ed: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines. <http://journal.publications.chestnet.org/article.aspx?articleid=1159432> (accessed 25 Sept 2013)

chronic disease states. These clinics would advance prevention strategies by serving as central points of the management process.⁸

Evidence-based Prevention Tools; Federal agencies should explore ways to incorporate anticoagulation-specific targets in ADE prevention strategies in long-term care and care transitions settings; Long-term Care Settings

Page 74

ASHP agrees with the promotion of real-time actionable data interchange strategies that combine medical, laboratory, and pharmacy, medication data to prevent harm in long-term care settings

Section 6: Diabetes Agents

Magnitude of the problem

Page 97

ASHP commends the FIW for diabetic ADEs on the use of a general broad term to encompass hypoglycemic events without the definition of a threshold serum glucose value. This will enhance efforts to control symptomatic hypoglycemia and help prevent and alleviate harm to a broad base of patients.

Surveillance; Increased reporting of these events in current national surveys along with use of standardized definitions will help advance the ability to track ADEs associated with hypoglycemic agents

Page 103

ASHP strongly supports the listed items to advance surveillance strategies for hypoglycemic ADEs. However similar to the section on anticoagulants the document should list specifically endorsed measures on glycemic safety, and provided recommended toolkits for surveillance and vetted implementation strategies to reduce these events in a variety of care settings.

Evidence based Prevention Tools; Inpatient Settings

Page 108

The ASHP Research and Education Foundation has recently released insulin-use recommendations for health-systems that provides strategies for ensuring safety and appropriate use in the inpatient setting. These recommendations have been endorsed by the American Association of Clinical Endocrinologists, the American Association of Nurse

⁸ Witt DM, Sadler MA, Shanahan RL, Mazzoli G, Tillman DJ. Effect of a centralized clinical pharmacy anticoagulation service on the outcomes of anticoagulation therapy. *Chest*. 2005;127(5):1515–1522. doi:10.1378/chest.127.5.1515.

Anesthetists, the American Academy of Pediatrics, and The Endocrine Society and are supported by the American Academy of Clinical Toxicology, the American College of Emergency Physicians, the Institute for Safe Medication Practices and the Society of Hospital Medicine. ASHP recommends review of these recommendations for inclusion in the action plan.⁹

Section 7: Opioids

Magnitude of the problem

Page 129

ASHP recommends consideration of the new FDA announcement regarding indication change for long-acting/extended release opioids may be added for inclusion and support in this background section.¹⁰

Page 130

The Society agrees that respiratory depression and over-sedation should be higher priority than other ADEs of opioids. We recommend considering further clarifying that death can result from respiratory depression and other ADE's are generally treatable/reversible.

The undertreatment of pain remains an important problem in the US – Efforts to minimize opioid abuse have to be implemented in parallel with efforts that ensure patients suffering from pain receive the most effective and safest available treatment

The phrase which starts "in pain care, clinical decisions..." should be rewritten to compare benefit and risk – that is that benefit of pain relief versus risk of individual treatments. As stated, it seems safety and risk are not distinguishable, and this does not account for other considerations clinicians and patients may have

Evidence – Based Prevention Tools

Page 139

While opioid dose conversion tables are important tools, clinician judgment is still needed to modify doses safely, (e.g., patient has allergy or side effects and also had inadequate pain control). A pure conversion based on table guidelines alone is often not sufficient for assessing a new agent and/or dosage.

⁹ Cobough DJ, Maynard G, Cooper L, et al. Enhancing insulin-use safety in hospitals: Practical recommendations from an ASHP Foundation expert consensus panel. *American Journal of Health-System Pharmacy*. 2013;70(16):1404–1413. doi:10.2146/ajhp130169

¹⁰ <http://www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/ucm363722.htm>

Incentives and Oversight

Page 145

Quantity limits at point of sale may prevent patients who have developed tolerance and require high doses for palliation from obtaining adequate amounts of drug. The draft is targeted towards non-cancer chronic pain, but limits such as these may be detrimental to other patients, such as cancer patients on chronic therapy, or sickle cell patients who may have short bouts of very severe pain.

Page 146

State Medicaid drug utilization review (DUR) may be helpful in reviewing Medicaid patients, but non-Medicaid patients will not be addressed. This contributes to a gap in assessment. ASHP suggests identifying potential sources for non-Medicaid DUR.

The Society appreciates this opportunity to provide comments. Please contact me if you have any questions on ASHP's comments on the Proposed Rule. I can be reached by telephone at 301-664-8806, or by e-mail at ctopoleski@ashp.org.

Sincerely,



Christopher J. Topoleski
Director, Federal Regulatory Affairs