Preventing Adverse Drug Events: Tools and Updates

In Partnership with the Indiana Hospital Association

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Center for Medication Safety Advancement
Objectives

The objectives for today’s webinar include:

• Provide an overview of the *Partnership for Patients* and *Coalition for Care* initiative
• Discuss toolkits and resources available through the Purdue University College of Pharmacy Center for Medication Safety Advancement
• Review *Partnership for Patients* ADE aligned measures and strategies for gathering the data
Partnership for Patients

The 40/20 Goal

Keep patients from getting injured or sicker.
Reduce preventable hospital-acquired conditions by 40%.
1.8 million fewer injuries to patients, with more than 60,000 lives saved over the next three years.

Help patients heal without complication.
Reduce all hospital readmissions by 20%.
1.6 million patients will recover from illness without suffering a preventable complication requiring re-hospitalization within 30 days of discharge.
Ten Priority Areas of Focus

Hospital Engagement Network hospitals are required to address ten harms/areas of focus (or as many as are relevant to the organization):

• Adverse Drug Events
• Catheter-Associated Urinary Tract Infections
• Central Line Associated Blood Stream Infections
• Injuries from Falls and Immobility
• Obstetrical Adverse Events (and EED focus)
• Pressure Ulcers
• Surgical Site Infections
• Venous Thromboembolism
• Ventilator-Associated Pneumonia
• Reducing Readmissions
Partnership for Patients AIM statement: Four Calls to AHA/HRET Hospitals

• **Reduce harm across the board.** It is a call for hospitals to produce reductions in every type of harm.

• **Take a systemic approach.** It is a call to transform the organization and its practices to eliminate all the causes of harm. “Using every means at our disposal.”

• **Make your safety transparent to all.** It is a call for hospitals to define themselves by their safety performance; define themselves to their employees, doctors, patients and the community.

• **Make safety personal & compelling.** Make every incident of harm a personal patient story that propels the institution to higher levels of performance.
Evaluation

• Webinar funded by CMS through the Partnership for Patients
• CMS reviews results and wants 80% of participants to evaluate educational sessions
• Please complete the simple three question evaluation by June 25, 2014.
  https://www.surveymonkey.com/s/2014_06_17_ADEResourcesCoaching
Outline

• Medication Safety Alliance review
  – Measures initiative
• ADE Change Package overview
• Anticoagulation tool-kit
• Standardized IV concentrations
• Medication Safety Essentials continuing education
• Questions and answers
About CMSA

• Center for Medication Safety Advancement
  – Division of Purdue University College of Pharmacy
• Discovery and delivery of safe medication practices
• Innovation and collaboration
  – Healthcare practitioners
  – Faculty and staff
  – Students and learners
  – Patients, families, and caregivers
• Research, education and outreach
Indiana AHA-HRET HEN Summary

• 119 Indiana hospitals aligned with IHA/HRET

• Includes:
  - 26 critical access hospitals
  - 7 psychiatric hospitals
  - 5 rehabilitation hospitals
  - 4 long term acute hospitals

• Represents opportunities for statewide engagement
  - Leverage state resources, including academic partners
Medication Safety Alliance (MSA)

- Purpose
- Framework
- Partnerships
  - Over 30 hospitals
  - More than 45 health-professionals
- Pharmacist’s Role
  - Path for involvement
MSA Structure

Educating

Medication Safety

Sharing

Supporting
Educating

• Medication Safety Essentials Courses
  – On-line, on-demand course
  – 15 CE hours for physicians, nurses and pharmacists
• Live lectures
• Coaching calls
• The “road show”
  – Visits to regional coalitions
Sharing

• Nationally and locally
• Today’s webinar!
  – Opportunities to learn from others’ successes
  – Share best practices
• Create a forum for medication safety-related improvement efforts
• MSA web portal
  – Members only
Supporting

• Self-assessment tool
  – Focused on high-risk medications leading to readmissions
  – Help identify areas for additional research and root-cause analysis
• Coaching calls, and...
• New webinars rolling out in 2014
  – Focus on gaps identified by the Alliance
  – Self-assessment data
• Continued work and alignment with statewide patient safety coalitions
State Measures Initiative

• Nationally, ADE reporting is lowest of all harm categories

• Measures adopted as statewide areas of emphasis for reporting adverse drug events as part of the MSA
  – Focus on outcomes

• Purpose is to identify best practices and share improvement strategies throughout Indiana

• Make it simple to report
  – Provide a pathway
  – Ensure the value proposition is clear for members
<table>
<thead>
<tr>
<th>Indicator Name</th>
<th>Definition</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Sources</th>
<th>EOM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excessive Anticoagulation with Warfarin - Inpatients</td>
<td>All inpatients who had excessive anticoagulation with warfarin</td>
<td>Inpatients experiencing excessive anticoagulation with warfarin (INR greater than 6)</td>
<td>Inpatients receiving warfarin anticoagulation therapy</td>
<td>AHA/HRET EOM; CMS ISMP Trigger Alert List</td>
<td>ADE 12</td>
</tr>
<tr>
<td>Manifestations of Poor Glycemic Control</td>
<td>Inpatients who experienced manifestations of poor glycemic control during hospitalization</td>
<td>Patients experiencing the following CC/MCC codes as a secondary diagnosis: 250.10-250.13 250.20-250.23 251.0 (CC) 249.10-249.11 249.20-249.21</td>
<td>All acute care inpatient discharges</td>
<td>AHA/HRET EOM; CMS Hospital Acquired Conditions</td>
<td>ADE 110</td>
</tr>
</tbody>
</table>
# Process Measures

<table>
<thead>
<tr>
<th>Heart Failure Discharge Instruction (HF-1)</th>
<th>Heart failure patients discharged home with written instructions or education material given to patient or caregiver at discharge or during the hospital stay</th>
<th>HF patients with documented D/C instructions, addressing: activity level, diet, weight monitoring, medications, appointments, and other relevant info</th>
<th>HF patients discharged home</th>
<th>AHA/HRET EOM; National Hospital Quality Measures; The Joint Commission</th>
<th>ADE 9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintenance of Active Medication Allergy List (CMS MU)</td>
<td>Number of patients with a medication allergy or indication of No Known Allergies (NKA) recorded</td>
<td>Number of patients with at least one entry or an indication of NKA recorded on a medication allergy list</td>
<td>Number of unique patients admitted to the hospital</td>
<td>AHA/HRET EOM; CMS Meaningful Use</td>
<td>ADE 7</td>
</tr>
<tr>
<td>Automated Dispensing Cabinets Override Rates</td>
<td>Automated dispensing cabinets (ADC) medication withdrawals occurring without review</td>
<td>Number of medication withdrawals from an ADC that were removed by “override”</td>
<td>All medication removal activity from ADCs</td>
<td>ASHP Best Practices</td>
<td>Indiana specific</td>
</tr>
</tbody>
</table>
Targeting Anticoagulation Harm
The Plan

• Leverage Medication Safety Alliance
  – Communication
  – Best practice sharing/storytelling
  – Coaching/webinars

• Resource development
  – Toolkit
  – Checklists
  – Tip sheets

• **Deliberate** focus on data tracking and transparency
Anticoagulation Toolkit

Anticoagulation Safety Toolkit

Table of Contents

- Introduction
- Chapter 1: Self-Assessment
- Chapter 2: Improving Anticoagulation Processes
- Chapter 3: Measuring Performance
- Additional Resources

Improving Safety through Anticoagulation Therapy Management
Tip Sheets

Coalition for Care
Indiana Adverse Drug Event (ADE) Measures

**Indicator Name:** Excessive Anticoagulation with Warfarin (Inpatients)

**Type:** Outcome

**Definition:** All inpatients experiencing excessive anticoagulation with warfarin. Excessive anticoagulation is determined when the International Normalized Ratio (INR) is greater than 6. Patients are at greater risk for bleeding complications.

**Inclusion Criteria:** Inpatients experiencing excessive anticoagulation with warfarin. Patients must have received at least one dose of warfarin while admitted.

**Exclusion Criteria:** Patients admitted from the Emergency Department (ED) and observation patients (less than 24 hours).

**Calculation:**
- **Numerator:** Inpatients experiencing excessive anti-coagulation with warfarin (INR>6)
- **Denominator:** Inpatients receiving warfarin anti-coagulation therapy

**Related Articles:**
Continued Focus: Anticoagulation

- Toolkit
- Previously recorded webinars on IHA website
- Ongoing support

**Anticoagulants**

*Indicator Name:* Excessive Anticoagulation with Warfarin - Inpatients (ADE-12)

*Numerator:* All patients experiencing excessive anticoagulation with warfarin (“excessive” is organization-defined).

*Denominator:* Inpatients receiving warfarin anticoagulation therapy.
Next Focus: Hypoglycemia and Opioids
ADE Change Package

- New, narrower focus on warfarin, opioids, and insulin
- Incorporates 2013 ADA standards of diabetes care
- Provides expanded change ideas, especially regarding opioids
- Tools and updated references
  - CMSA will provide additional resources!
Next Focus: Hypoglycemia

Insulin

Indicator Name: Hypoglycemia in Inpatients Receiving Insulin (ADE-13)

Numerator: Hypoglycemia in inpatients receiving insulin or other hypoglycemic agents (e.g. hypoglycemia defined as plasma glucose concentration of 50 mg per dl or less).

Denominator: Inpatients receiving insulin or other hypoglycemic agent.
Next Focus: Opioids

Opioids

Indicator Name: ADE’s due to Opioids (ADE-11) = EOM ADE - 111

Numerator: Number of patients treated with opioids who received naloxone during the review period.

Denominator: Number of inpatients and patients in hospital outpatient departments who received an opioid agent during the review period. Exclusion: ED patients; naloxone use for nausea or pruritus.
Measurement Questions?
Anticoagulation Toolkit

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John B. Hertig, PharmD, MS, CPPS
Purdue University College of Pharmacy
Center for Medication Safety Advancement
Anticoagulation ADE Webinar

• October 2013
  – Pharmacists Role in Anticoagulation
  – Best Practices in Care of Transitions of Anticoagulation
  – Medication Reconciliation and Health Literacy
Chapter 1: Self Assessments

• Warfarin Management
• Health Literacy
# Self-Assessment – Warfarin Mgmt

## Warfarin Management Self-assessment

<table>
<thead>
<tr>
<th>Element of Performance</th>
<th>Safe Practices</th>
<th>Tool</th>
<th>Self-assessment Score*</th>
<th>Level of Implementation Difficulty**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use approved protocols for the initiation and maintenance of anticoagulant therapy</td>
<td>- Warfarin Dosing protocol</td>
<td>A, B, C</td>
<td>3</td>
<td>I</td>
</tr>
<tr>
<td></td>
<td>- Tracking form for managing patients on warfarin is used and provided to patient and patient’s outpatient provider</td>
<td>C,D</td>
<td>4</td>
<td>L</td>
</tr>
</tbody>
</table>

*Self-Assessment of Safe Practices Self-scoring Scale

1. There is no discussion around this activity
2. This activity is under discussion, but there is no implementation plan
3. This activity is partially implemented in some or all areas of the organization
4. This activity is fully implemented in some areas of the organization
5. This activity is implemented in all areas of the organization

N/A This activity is not applicable

**Level of Implementation Difficulty

Low (L)= Safe practice recommendation is in place with few adjustments needed to meet expectation.
Intermediate (I)= Safe practice recommendation may or may not be in place.
High (H)= Safe practice recommendation is not in place.
# Self-Assessment - Health Literacy

## 1. Improve Spoken Communication

<table>
<thead>
<tr>
<th>Importance</th>
<th>Tools to Help*</th>
</tr>
</thead>
<tbody>
<tr>
<td>*</td>
<td>1-Form Team</td>
</tr>
<tr>
<td>**</td>
<td>3-Raise</td>
</tr>
<tr>
<td>***</td>
<td>Awareness</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Doing Well</th>
<th>Needs Improvement</th>
<th>Not Doing</th>
<th>Not Sure</th>
<th>or N/A</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

1. Staff members have received awareness and sensitivity training about health literacy issues.

2. All levels of practice staff have agreed to support changes to improve patient understanding.

Please select one answer that most accurately describes your practice:

<table>
<thead>
<tr>
<th>Doing Well</th>
<th>Needs Improvement</th>
<th>Not Doing</th>
<th>Not Sure</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our practice is doing this well</td>
<td>Our practice is doing this, but could do it better</td>
<td>Our practice is not doing this</td>
<td>I don’t know the answer to this question</td>
<td>This is not applicable to our practice</td>
</tr>
</tbody>
</table>

Importance:  
* Beneficial  ** More Beneficial  *** Most Beneficial

Adapted from AHRQ Universal Precautions Health Literacy Toolkit
Chapter 2: Improving Anticoagulation Processes

• Project Plan
• Developing AIM Statements
• Model for Improvement
# Project Plan

<table>
<thead>
<tr>
<th>Project Timeline-Activity</th>
<th>Month 1</th>
<th>Month 2</th>
<th>Month 3</th>
<th>Month 4</th>
<th>Month 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review Toolkit</td>
<td></td>
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<tr>
<td>Understand Anticoagulant Safe Practices</td>
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<tr>
<td>Conduct Self-assessment of Current Practices</td>
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<tr>
<td>Assess your current practices (Self-assessment)</td>
<td></td>
<td>●</td>
<td></td>
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<tr>
<td>Validate assessment results by observation and/or interview</td>
<td>●</td>
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<tr>
<td>Review baseline data if available</td>
<td>●</td>
<td></td>
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</tr>
<tr>
<td><strong>Improving Anticoagulant Process</strong></td>
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<td></td>
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<tr>
<td>Select Project Team Members</td>
<td>●</td>
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<tr>
<td>Develop Project Plan</td>
<td>●</td>
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<tr>
<td>Develop Communication Plan for project milestones</td>
<td>●</td>
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<tr>
<td>Formulate AIMs statements for identified gaps in performance</td>
<td>●</td>
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<tr>
<td>Determine ongoing measures to support the AIMs statements</td>
<td>●</td>
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<td></td>
</tr>
<tr>
<td>Develop ideas to create new processes</td>
<td>● →</td>
<td>→</td>
<td>→</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Run tests of change using Plan, Do Study, Act worksheets</td>
<td>● →</td>
<td>→</td>
<td>→</td>
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<td></td>
</tr>
<tr>
<td><strong>Measuring Performance (Chapter 3)</strong></td>
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</tr>
<tr>
<td>Collect and display data/results for self-assessments, FMEAs, Tests of Changes tired,</td>
<td></td>
<td>● →</td>
<td>→</td>
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<td></td>
</tr>
<tr>
<td>overall AIMs for improvement</td>
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</tr>
<tr>
<td>Use tool for measuring harm from ADE’s and display results</td>
<td>● →</td>
<td>→</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Spreading and Sustaining Improvement</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Determine plan for spreading improvement</td>
<td>● →</td>
<td>→</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Determine plan for sustaining improvement</td>
<td>● →</td>
<td>→</td>
<td></td>
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</tr>
</tbody>
</table>
Developing AIM Statements

• **State the Team AIMS**
  – Be clear, concise, targeted. The team will make better progress if the AIM is specific.

• **Include Numerical Goals**
  – A numerical goal will help the team measure improvement and progress. Quantify the aim by marrying the AIM to a Baseline Measure, which over time will indicate improvement and with planning rapid tests of change using the PLAN-DO-STUDY-ACT cycle.
  – Do not accept minimal improvement- strive for success.
  – Maintain focus on the goal
  – Fifty-percent improvement can easily slip to 40% or 30%, but only if the team choses to accept less.

• **Example:**
  – Reduce the number of ADE associated with warfarin by x% Unit A within 6 months
# Model for Improvement

## Cycle for Learning and Improvement

<table>
<thead>
<tr>
<th><strong>PLAN</strong></th>
<th><strong>DO</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ask Questions:</strong>&lt;br&gt;• Will protocol be acceptable for use at this hospital?&lt;br&gt;&lt;br&gt;<strong>Make Predictions:</strong>&lt;br&gt;• MDs will find it easy to use?&lt;br&gt;<em>(Y or N)</em></td>
<td><strong>Carry out the change or test, collect data and begin analysis</strong>&lt;br&gt;• Ex: Team asks one MD, RN, PharmD to stimulate use of protocol on one pt by next Tuesday. Group meets to review pt chart and list recommended modifications</td>
</tr>
<tr>
<td><strong>Plan for collection of Data:</strong>&lt;br&gt;• Who? When? Where?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>STUDY</strong></th>
<th><strong>ACT</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Complete analysis of data</strong>&lt;br&gt;• Summarize what was learned</td>
<td><strong>Determine if you are ready to make the change</strong>&lt;br&gt;• Ex: modify protocol based on test of change</td>
</tr>
</tbody>
</table>
Chapter 3: Measuring Performance

• Process Measures
• Outcome Measures
Process Measure

• Examples of Process Measures
  – Percentage of Warfarin patients receiving correct meal plan (to assure that Nutrition Services are informed of all patients on Warfarin therapy)
  – Time frame for receipt of lab results by care providers over time.
  – Time to therapeutic levels
  – Percentage of patients receiving warfarin with INR outside protocol limits
Outcome Measures

Measurement: Reduction in Warfarin Related ADEs

- Initiation of Warfarin Dosing Protocol
- Full implementation of Warfarin dosing protocol
- Initiate Discharge Counseling program

Goal
### Outcome Measures

<table>
<thead>
<tr>
<th>Goal</th>
<th>Recent Activity</th>
<th>Status</th>
<th>Stakeholder</th>
<th>Projected Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce percent of patients with INR &gt;5 by 20%</td>
<td>Updated warfarin dosing protocol (10/4/13)</td>
<td>Yellow</td>
<td>KEB</td>
<td>12/31/13</td>
</tr>
</tbody>
</table>

Factors used to determine current status: Goal clarity (are there clear objectives and direction) and goal timeline. If a goal is on time and on target then it should be **green**. If the goal timeline is at risk or if there are some questions as to objective, the goal should be **yellow**. If the project is past the goal completion date or if progress has ceased due to a roadblock, the project is **red**.
# Additional Resources

<table>
<thead>
<tr>
<th>Source</th>
<th>Website</th>
<th>Information Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Warfarin Management</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Warfarin Dosing               | www.warfarindosing.org                                                 | - Dose Calculator  
  - Considers many factors such as genetics and medications                                                              |
| My Blood Thinner              | www.mybloodthinner.org                                                 | - Resources for patients, providers, and caregivers  
  - Information in Spanish is available                                                                                     |
| America’s Anticoagulation     | www.ptinr.com                                                          | - Patient education  
  - Great for at home INR testing’                                                                                         |
| Resource                      |                                                                        |                                                                                                                        |
| University of Michigan        | http://www.med.umich.edu/cvc/prof/anticoag/dose.htm                    | - Guidance on dose adjustment                                                                                           |
|                               | Consensus-Statements/Antithrombotic-Guidelines-9th-Ed                  |                                                                                                                        |
| Spectrum Health               | http://www.spectrumhealth.org/anticoagulationtoolkit                   | - Patient education  
  - Dosing algorithms  
  - Point-of-Care Testing  
  - Documentation  
  - Anticoagulation competency                                                                                           |
| **Pharmacist Run Clinic**     |                                                                        |                                                                                                                        |
| AZCERT, INC                   | http://www.credibleds.org/files/2113/7961/4352/Patient_Agreement.pdf  | - Patient Contract                                                                                                      |

*Note:* The table provides a list of additional resources related to warfarin management and anticoagulation. Each resource is associated with a website link and a description of the information it provides.
Development of a Statewide Standardized List of Drug Concentrations

Indiana Hospital Association
Patient Safety Coalitions

John B. Hertig, PharmD, MS, CPPS
Dan Degnan, PharmD, MS, CPPS
Purdue University College of Pharmacy
Center for Medication Safety Advancement
Standard IV Concentrations

• San Diego Council for Patient Safety
  – Work published as toolkit in 2009
  – Replicated by others in Indiana

• 3 of 11 Patient Safety Coalitions
  – Developed standardized list of concentrations
  – Southwest, Northeast and Indianapolis
  – Interest in expanding work
    • Standardization among coalitions recommended
    • Why not a Statewide list?
The Need to Standardize

• Improved safety as a result of reduced variation and complexity

• Elevated risk awareness among healthcare clinicians
  – Patients and healthcare professionals move across settings
  – Some hospital nursing staff turnover rate can be as high as 28%

• Enhanced ability to benchmark and compare med related technology (BCMA, Smart Pumps, etc)

• Enhanced compliance with external accrediting bodies
  – Thoughtful process vs. Traditional methods
Process to Develop the List

• Comparison of lists of standard IV concentrations
  – Northeast, Southwest and Indianapolis coalition lists
  – Published literature
    • Work from San Diego Patient Safety Council
    • Published survey results from USP expert committee on medication safety
  – Publicly available IV concentration lists
    • Organizations with concentration lists identified through an internet search engine
    • Non-pediatric hospitals were included

• Initial compiled list contained 69 concentrations
  – Represented 37 different medications
Process to Develop the List

• Initial list of 69 concentrations pared down to 34 concentrations
  – Based on existing coalition lists
  – Consensus existed around 19 concentrations

• Meeting of statewide panel of physicians and pharmacists
  – Represented regional coalitions and major health-systems
  – Consensus developed around 9 additional concentrations

• Final statewide list contains 28 IV concentrations
Initial list of 69 IV concentrations are compiled from Indiana coalition members, published literature, and publicly available hospital lists.

34 of the 69 concentrations are on at least one of three Indiana regional coalition lists.

19 of the 34 concentrations among the three Indiana regional coalitions are already the same.

A group of pharmacists and physicians representing various major health-systems and patient safety coalitions meet to discuss consensus around the remaining 15 concentrations from the list of 34.

Consensus is established for a final list of 28 concentrations for use on the statewide IV concentration list.
**Recommended list of IV concentrations for the State of Indiana**

Alternate concentrations of dobutamine may be required in procedural areas of healthcare facilities for short term diagnostic purposes.

The standardized concentration of magnesium sulfate is intended to describe the use of the medication for obstetric patients. Other concentrations may be used for electrolyte imbalance.
Next Steps

• Adding additional drugs to the list
  – hydromorphone, nicardipine, norepinephrine, epinephrine, dopamine are next to be reviewed

• Evaluating units of measure for each concentration
  – Several issues identified by participants

• Add members to group
  – Expertise, geography and organization represented

• Publish work within Indiana
# Current Participants

<table>
<thead>
<tr>
<th>Current Participants</th>
<th>Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gary Brazel, St. Vincent</td>
<td>St. Vincent</td>
</tr>
<tr>
<td>Tara Jellison, Parkview</td>
<td>Parkview</td>
</tr>
<tr>
<td>EJ Last, IU Health</td>
<td>IU Health</td>
</tr>
<tr>
<td>Jen Reddan, IU Health</td>
<td>IU Health</td>
</tr>
<tr>
<td>Jim Fuller, Indy Safety Coalition</td>
<td>Indy Safety Coalition</td>
</tr>
<tr>
<td>Heather Jackson, Eskenazi</td>
<td>Eskenazi</td>
</tr>
<tr>
<td>Sonja Damjanoski, Fransican</td>
<td>Fransican</td>
</tr>
<tr>
<td>Vernon Mass, St. Mary’s</td>
<td>St. Mary’s</td>
</tr>
<tr>
<td>Don Julian, St. Mary’s</td>
<td>St. Mary’s</td>
</tr>
<tr>
<td>Todd Walroth, Eskenazi</td>
<td>Eskenazi</td>
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<td>John Hertig, Purdue</td>
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<td>Betsy Lee, IHA</td>
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<tr>
<td>Laura Stock, Deaconness</td>
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<td>Amy Hyduk, Lutheran</td>
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If you are interested in participating in the development process moving forward, please contact Dan Degnan at ddegnan@purdue.edu or 317-275-6087.
Other Offerings through Purdue/IHA

• Medication Safety Essentials (MSE) 1.0 and 2.0
  – Online CE webinars targeting healthcare staff
  – Up to 15 hours of accredited medication safety continuing education available for physicians, pharmacists and nurses

• Medication Safety Certificate
  – Anticipated to be available late 2014
  – Will incorporate CE hours from MSE and case based project completion
## Other Offerings through Purdue/IHA

**MSE 1.0 Topics**
- Medication Errors and Safety Practices
- Errors in Prescribing and Transcribing
- Errors in Dispensing
- Errors in Administration and Monitoring
- Continuous Quality Improvement
- Metrics, Scorecards and Dashboards
- Leading for Safety

**MSE 2.0 Topics**
- Effective Interpersonal Communication
- Establishing a Culture of Safety
- Technology
- Medication Transitions of Care and Medication Reconciliation
- Storytelling
- Anticoagulation
- Medication Safety of Antihyperglycemics
- Management of Opioids (coming soon)
Other Offerings through Purdue/IHA

- Medication Safety Portal (i.e. enhanced website)
  - Published toolkits
  - Medication Safety News
  - Sample policies and procedures
  - Relevant journal club reviews
  - Regular medication safety blog entries
  - Difficult to find medication safety resources
    - Official FDA Tall Man lettering list
    - All 52 TJC sentinel event alerts
    - Official REMs transcript approvals
Questions?
Preventing Adverse Drug Events: Tools and Updates

In Partnership with the Indiana Hospital Association

John B. Hertig, PharmD, MS, CPPS
Associate Director
Purdue University College of Pharmacy
Center for Medication Safety Advancement
Save the Date: July 30

- ADE Mini-Collaborative
  - HRET/Cynosure/IHA/CMSA
  - Morning session
  - Prior to the in-person Improvement Leader Fellowship in Indianapolis
  - Location TBD
Evaluation

• Webinar funded by CMS through the Partnership for Patients
• CMS reviews results and wants 80% of participants to evaluate educational sessions
• Please complete the simple three question evaluation by June 25, 2014.
  https://www.surveymonkey.com/s/2014_06_17_ADEResourcesCoaching
Thank you