Ambulatory Patient Safety Toolkit 2020

A resource for clinicians and staff provided by HealthPartners Ambulatory Safety Program
HealthPartners is committed to eliminating harm due to error in the delivery of medical care. The HealthPartners Ambulatory Safety Toolkit provides practical tools and suggestions that you may wish to incorporate into clinical operations or adapt to create your own initiatives. We include links to national and local safety resources and protocols, organized by topic. A complete listing of HealthPartners administrative policies can be found on the Provider Portal at http://www.healthpartners.com/provider-public/administrative-policies/.

To date, relatively little research has focused on patient safety in the ambulatory setting. Yet most care is delivered in these settings. Although the ambulatory setting might seem less intense (and less “dangerous”) than an inpatient setting, lapses in safety can and do occur, with adverse consequences.

A “culture of patient safety” is an essential ingredient of the safe health care organization. “Culture” can be understood as habits, attitudes, and beliefs that live in the minds of the people who work in the organization and guide the work that they do. Concepts closely related to “culture” are “environment” and “mindset.”

The knowledge, skill and judgment of the clinician are essential, of course. In the modern group practice, clinic, and outpatient center, the clinician operates through organizational systems and processes, which together produce the desired clinical outcome.

Research has shown that serious errors occur more often from a failure of process and systems, rather than the action of a single individual. Well-designed systems and processes allow the organization to deliver care with reliability, consistency, and resiliency (the ability to detect and quickly recover from an error, before harm occurs).

Our goal with this toolkit is to promote these sorts of systems and processes. Together, we can improve the safety of care delivered in the ambulatory setting. We welcome comments and feedback. We are committed to continually improving this toolkit. Please feel free to contact us by email at quality@healthpartners.com.

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Clinic Assessment of Safety Culture

Identify the Safety Risk

Evaluation of a culture of safety refers to measurement components such as management behaviors, safety systems and employee perceptions of safety. A variety of survey tools is available to identify potential gaps and improvement initiatives concerning patient safety. While there are many surveys that address the safety climate, we endorse the Institute for Clinical Systems Improvement (ICSI) survey and HealthPartners Ambulatory Site Survey (see sample forms).

Suggestions for Improvement

- Clinics should track errors that occur within the standard practice of medicine.
- A standard error report should be used by all of the staff. All staff must be comfortable in reporting errors.
- Consider providing a thank you note and/or “kudos” when someone submits an error report.
- Culture surveys assist in identifying comfort in this area. A safety officer, committee, or leader could review the reports and monitor for trends to prioritize improvement projects. If a clinic is large enough, the detail could be entered into a database to track and assist in analysis.
- Clinics should have guidelines in place for hand hygiene and infection control. The Center for Disease Control and Prevention (CDC) guidelines are available at http://www.cdc.gov/handhygiene/Guidelines.html and the MDH guideline is available at http://www.health.state.mn.us/handhygiene/hcp/index.html

Sample Forms & Article

Figure 1: ICSI Survey on Patient Safety

Figure 2: HealthPartners Medical Group (HPMG) & Clinics Policy and Medication Event/Incident Report

Figure 3: Medication Safety Culture Meter

Figure 4: Clinic Safety Assessment Survey and Ambulatory Site Survey form

Figure 5: Creating and Sustaining a Culture of Safety Free From Harm - Eight Recomendations (NPSF)

Other Resources -Links

- Agency for Healthcare Research and Quality (AHRQ) Safety Tools and Resources
- AHRQ Medical Office Survey Toolkit
- AHRQ Patient Safety Toolkit
- AHRQ Surveys on Patient Safety Culture
- Institute for Safe Medication Practices Assessment Tool
- Harvard Education-Culture of Safety
- Patient Safety and Quality Healthcare
- Flex Monitoring Team: Promoting a Culture of Safety
- Workplace Violence Prevention

Works Cited

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Safety Learning Reports

Identify the Safety Risk

Clinics should have systems in place to track and trend errors, “near misses” and “good catches” that occur with the standard practice of medicine.

Describing them as safety learning reports may minimize the negative connotation of incident reports and promote open dialogue and review of an event from a systems perspective. Even near misses could be tracked and collected.

Review of incident reports and near misses through safety learning reports can help identify things that may be wrong with the system that lead to errors, or may provide detail on what was right with the system that helped to prevent an error.

Suggestions for Improvement

- Establish and utilize a survey tool to assess your clinic’s safety culture (see Clinic Assessment of Safety Culture and Systems for sample forms).
- Use the safety culture results to assess the team’s comfort level in reporting incidents and in reviewing learning reports, near misses and good catches.
- If survey results indicate improvement, develop an education toolkit and schedule team building around reporting incidents, near misses, good catches and safety learning.
- If you do not have a current safety learning report format (or report for incidents), obtain samples and form a committee to review and select one, or use one and implement updates to it specific to your clinic.
- Establish a protocol for safety learning reports. Make sure that the protocol addresses learning reports, near misses and good catches.
- Have a safety representative review and compile data on the safety learning events that are identified through reports each quarter. Enter details into a database and monitor for trends.
- Use this analysis to identify and prioritize areas for improvement.

- Develop action plans around the outcomes seen.
- Continue ongoing monitoring of safety culture (Gunderson 15)

Other Resources – Links

- National Quality Forum Resources
- ICSI
- Minnesota Alliance for Patient Safety
- Minnesota Hospital Association

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**Patient Registries as a Monitoring Tool**

Registries are becoming increasingly important to support patient care, ensure adherence to clinical guidelines, assess provider performance and to help improve the quality and safety of patient health outcomes. “A computerized disease registry is a software application for capturing, managing and providing access to condition-specific information for a list of patients to support organized clinical care.” (California HealthCare Foundation publication, *Using Computerized Registries in Chronic Disease Care*). Developing, using and maintaining a Registry is a standard in NCQA’s Medical Home recognition program.

HealthPartners maintains a registry of members who are in need of preventive or chronic care treatment and/or testing. These lists may be utilized independently or may augment processes and/or Registries that you already have in place for your entire clinic.

Registries at HealthPartners are updated quarterly. Registry data updates are currently available for Preventive Services, Asthma, Chronic Obstructive Pulmonary Disease (COPD), Diabetes, Cardiovascular Disease (CVD), Coronary Artery Disease (CAD), Heart Failure (HF), Child and Teen Check-ups (C & TC) and Hypertension.

**Suggestions for Improvement**

- Develop a protocol on registry use in your clinic using HealthPartners registry, your own clinic registry, or both.
- Identify your target population(s). Choose a population of patients with certain chronic diseases. It may be practical to start an improvement process with one area of focus from the registry.
- Identify who will be responsible for one (or each) registry list and how the work will get done.
- Develop base line data using established measures, and evidence based guidelines to define target goals.
- Audit at least 20 patient records for completion of the required elements.
- Track your efforts to provide the needed services through the registry.
- Identify your interventions, evaluate these over time and modify them as needed.
- Use the registry for visit planning to work with patients when they are seen in the clinic.
- Assist patients in receiving the services they need such as mammograms, immunizations, lab tests and eye exams by communicating the needs to the patient through some form of outreach.
- Validate the data provided and update quarterly.
- Evaluate your success and refine your process where needed.
- Continue ongoing monitoring of patient populations and expand improvement efforts to other focused areas in patient care.

**Other Resources - Links**

- [National Quality Forum (NQF)](https://www.qualityforum.org/)
- [AAFP: Registries Made Simple](https://www.aafp.org/afp/2003/0201/p354.html)
- [HealthPartners Registry](https://www.healthpartners.com/)

Secured Provider Portal access to registry data is available at [healthpartners.com](http://healthpartners.com). Contracted providers can obtain access by registering at [Provider Portal](https://www.healthpartners.com/provider_portal). For current registry users: Provider Electronic Commerce support center at 952-883-7505 can help with password issues and questions.
Health Literacy

Identify the Safety Risk

Effective communication is the heart of health care relationships. At least 50 percent of the US population cannot understand and use the information provided by their clinicians.

Health Literacy is defined as an individual’s ability to read and comprehend prescription bottle labels, appointment slips and other essential health-related materials required to successfully function as a patient.

Research shows literacy is a stronger predictor of health status than age, income, employment status, education level or racial and ethnic group. Health literacy barriers lead to misunderstood health care instructions, prescriptions and appointment slips (no-shows), poor health outcomes and medical errors.

It is now recommended that a universal precautions approach be taken. This means approach all patients the same – i.e., all patient education materials, forms and letters are at a 7th grade reading level and all explanations are in plain (non-medical) language. Health Literacy affects a person’s ability to engage in self-care and chronic disease management. See the “Patient Engagement Section” of this toolkit for additional ideas.

Suggestions for Improvement

- When giving instructions or educating the patient about their medical condition, use plain, non-medical terminology, focus on one to three key messages, show or draw a simple picture.
- Ask patients to recall and restate what they have been told about medication, what they are to do when they get home, etc.
- Focus on one topic and/or one ethnic group and review all patient education materials used in this area. Compare the materials to a Reading score tool (e.g., Flesch Reading Ease or grade level, SMOG, etc.) and access tools that have already converted education materials to different languages. Convert those materials that are identified as more complex into a lower reading level that is easier to understand and

into the primary language that you have prioritized.
- Several resources have education materials available in multiple languages that also provide detail on cultural appropriateness.
- Bring in a focus group and a translator to test the materials you have converted.
- Create a calendar to continue to covert materials by topic in your clinic over time. Create a shame-free environment and use patient friendly and culturally appropriate materials.

(Gunderson 26)

Six steps to improve interpersonal communication with patients

1. Slow down
2. Use plain, non-medical language
3. Show or draw pictures
4. Limit the amount of information provided and repeat it
5. Use the teach-back or show-me technique
6. Create a shame-free environment and use patient friendly and culturally appropriate materials

Sample Forms

Figure 6: Teach-Back supported by research
Figure 7: Teach-Back Self-Evaluation & Tracking Log
Figure 8: Resource List
Figure 9: Clear Communication Checklist

Other Resources - Links

- Health literacy and patient safety: help patients understand (AMA Video)
- Using Health literacy to improve patient outcomes (Discovery Channel Video)
- Joint Commission "What Did the Doctor Say?"
- CDC Communication Strategies Cultural Competence
• Stratis Health
• AHRQ Health Literacy Universal Precautions Toolkit
• Ethnomed
• CDC Plain Language

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Patient Engagement (motivational interviewing)

Identify the Safety Risk

A critical component of ongoing medical care is having the patient engaged in self-care. Assess the patient’s interest level in their own care. Remove health literacy barriers to support your patient/family engagement efforts. Informed patients are more engaged and actively involved in their therapy. Patient partnering will involve providing patients with tools to help them become more informed. What efforts has your clinic made to involve patients in their own safety?

Suggestions for Improvement

When providing patients with written materials, be sure that they are at the 7th grade reading level and are in plain language. When explaining medical conditions or educating patients, use the “Teach Back Method”. See Health Literacy section of this toolkit for additional ideas.

- Provide all patients with an understanding of the roles of the clinicians, nurses and pharmacists in their care.
- Use a tool to assess the underlying knowledge, skills and confidence of a patient’s own health and healthcare needs such as the Patient Activation Measure (PAM).
- Have patient brochures available in the clinic to engage them in actively managing their care with their providers.
- Create an agreement for patients and providers to review and sign regarding roles and responsibilities. Address prevention, healthy lifestyles, illness, and medication management. Keep the agreement in the front of the medical record and provide a copy for the patient.
- Address active patient responsibility at each clinic visit and give examples related to the visit and follow up. Health Literacy tip – use Teach Back Method, e.g., “What are you going to do when you get home?”
- Engaged patients may want additional help when faced with multiple options for care of certain conditions/diseases. Shared decision making tools address this need. See “Other Resources” for more information.
- Discuss the patient’s role in checking their medication carefully and the need to report any side effects to their care providers.
- Provide each patient with copies of their medication lists. There are “apps” that will show a picture of the medication for people with low health literacy.
- Patients should be instructed to update the clinic with any medications they are taking that are prescribed by other physicians or any other medication changes i.e., discontinued medications, dosage changes, etc.
- Urge patients who are unsure about medications to bring in a bag with all of their medications. Take the time to help clarify the labels and explain the different medications to them. Health literacy tip – ask the patient to identify each pill, when they take it and what the pill is for.
- Consider implementing a pill box distribution system or develop a pill card for patients who take multiple medications and/or for those at highest risk of missing medications.
- Create a protocol for the use and distribution of the pill boxes (Figure 11).
- Engage patient family members or, if appropriate, assist the patient in engaging home health resources for medication distribution.
- The medication reconciliation tool can help to coordinate improvement efforts (Figure 10).
- Make it a routine part of your care process, to create an after visit summary regarding patients self-care and medication safety.
- Include Motivational Interviewing in the scripting (ICSI)
Sample Forms

**Figure 10:** My Medicine List Tool

**Figure 11:** Sample Pill Box Distribution policy

**Figure 12:** *Medication Therapy Management:* article, ROSE Resource 2Q 2008 newsletter published by ING Reinsurance.

**Figure 13:** Pill Card Template

Other Resources - Links

- [CDC Health Communication Strategies](#)
- [What Did the Doctor Say?](#)
- [AHRQ Consumer Site](#)
- [National Cancer Institute Fact Sheet](#)
- [IHI: What is Motivational Interviewing?](#)
- [AHRQ Pill Card and Instructions](#)
- [Shared Decision Making](#)
- [Ottawa Patient Decision Aids](#)
- [The PAM® Survey](#)
- [Patient Engagement Framework and Assessment Tool Encourages Patient Engagement](#)

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Compliance, Security and Privacy

Identify the Safety Risk

With the growth and usage of electronic medical records and the internet maintaining compliance requirements are becoming more challenging for facilities and providers.

A Compliance Program is one of the ways to make sure that your providers and facilities are complying with all appropriate legal, professional, and ethical standards.

In 2000, The U.S. Department of Health and Human Services (HHS) issued a Privacy Rule to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 known as HIPAA. The rules address the use and disclosure of protected health information with the assurance an individual’s health information is properly protected and secured.

Suggestions for Improvement

- Develop tools that help keep your entity in compliance with the laws and other standards. Ensure technology is safe and optimized to improve patient safety and care.
- Establish written standards of conduct such as a Code of Conduct and organizational policies, procedures and standards.
- Proper Oversight to ensure personnel in all areas and at all levels of the organization are appropriately informed about, and accountable for, the Integrity and Compliance program.
- Conduct education and training annually to help communicate to all personnel what is expected of them under an Integrity and Compliance program.
- Establish reporting and complaint channels to ensure the organization keeps lines of communication open so all personnel are able to voice their compliance concerns in a safe, non-retaliatory environment.
- Develop Self-Assessment Activities, such as auditing and monitoring to help verify commitments made to compliance and other standards of conduct.
- Establish an appropriate discipline process to ensure non-compliant activities are addressed in a fair and consistent manner.
- Take Corrective Actions promptly when it is determined that organizational or individual conduct is inconsistent with the laws, policies, and other standards.

Other Resources – Links

- HealthPartners Code of Conduct
- Minnesota Patient, Resident and Home Care Bill of Rights
- U.S. Department of Health and Human Services (HHS): Health Information Privacy
Safe Driving

Identify the Safety Risk

Advanced age should not automatically be equated with dangerous driving. Many older drivers are quite capable drivers.

Safe elderly drivers require the complex coordination of many different skills. Physical and mental changes that occur with aging can diminish the abilities of elderly drivers.

Telling elderly drivers that it may be time to stop driving can be one of the most difficult milestones for caregivers. Support and assistance from the patient’s physician can help make this transition less difficult.

Discussions about safe driving should also be talked about with teenagers. Injury from motor vehicle accidents is the leading cause of death among people 15 to 24 years of age, according to recent data from the Centers for Disease Control and Prevention (CDC).

Suggestions to Assess and Counsel the Older Driver:

- Open communication with the patient and family in the office setting can help physicians assess the patient’s risk for a driving accident.
- Working with family and involving community resources regarding alternative forms of transportation may be necessary.
- Patient with suspected driving difficulty needs to be interviewed and examined thoroughly by the physician.
- Determine the importance and uses of driving in the patient’s life.
- Provide resources to the patient regarding a formal driving evaluation program or community program such as the Checkpoints Program.
- If an elderly patient needs to stop driving, present the news slowly and sensitively.
- Acquaint yourself with state laws regarding the reporting of a patient with disease or illness that interferes with driving.
- Your recommendations should be provided to the patient in writing.

Sample Forms

Figure 14: AARP elder driver checklist

Other Resources - Links

- HelpGuide: How Aging Affects Driving
- AAA Roadwise Review
- Teenage Driving MN
- Checkpoints Program
Falls Prevention

Identify the Safety Risk

Preventing falls is an important issue, especially for the well-being of older adults. Research has demonstrated falls in adults over the age of 65 can result in hip fractures and head injury. Once an elderly patient is hospitalized from a fall, many never return home or live independently again. It is imperative to identify and assess patients at high risk for a fall in the ambulatory setting. This includes appropriate access points in the clinics, use of assistive devices, cameras in public areas, appropriate rooming procedures such as a family member or staff member staying with the confused patient during their visits.

Suggestions for Improvement

- Create a partnership committee to focus on fall prevention. Include physicians, nursing, pharmacy, physical therapy staff and administration.
- Identify that falls can happen from aging and balance problems, environmental hazards, and impairments to vision, hearing, sensory and motor skills, medication effects, toileting requirements and poor judgment.
- Falls can be prevented through thoughtful strategies designed for individuals.
- Create a falls assessment sheet to identify if a patient is at risk for falls and include: history of previous falls, motor or sensory impairment, orthostasis, dementia, delirium, sedation, elimination (bowel and bladder needs).
- Create a protocol that identifies that the team working with patients can recognize, diagnose, evaluate, treat and prevent patient falls.
- Create or use an education sheet on patient falls. Make sure to address each of the areas identified as potential risks and provide a key prevention recommendation.
- Audit the records of patients who have been seen in clinic and/or admitted to the hospital in the last quarter due to a fall.
- Present a case study of the fall description to the partnership committee to prevent falls.
- Have a brainstorm session to identify causes and possible prevention for the case presented.
- Come to a conclusion for the cause of the fall, and intervene with an education program for the patients.
- Engage the patient in your quality improvement attempt to prevent future falls.
- Provide additional resource tips such as physical therapy, safety tips for use of crutches, walkers, wheelchairs, etc.
- Intervene and document education and have the patient teach back or explain what was learned.
- Monitor the patient for future falls and audit records twice a year for two years post falls.
- Evaluate and intervene if fall occurs post improvement initiative. Make changes if necessary.
- Create a falls assessment and falls prevention check list for every patient over the age of 65 years of age – also include any patients who may be at risk for falls.
- Keep the check list posted on the admit page for clinic visits. Provide educational handouts for falls prevention to these patients.

Sample Forms

Figure 15: Fall Safety Checklist

Other Resources - Links

- NIH Senior Health
- CDC Falls Fact Sheet
- MN Falls Prevention
- AHRQ Fall Prevention Toolkit
- The Joint Commission: Preventing falls and fall-related injuries in health care facilities
- Healthwise-Fall prevention
Child Injury Prevention

Identify the Safety Risk

Majority of injuries are preventable. According to the CDC, unintentional injuries remain the leading cause of death in 0-19 year olds. Recent data from the United States Consumer Product and safety Commission (CPSC), identified an estimated 80,000 emergency visits involving pediatric poisoning and chemical burns. The top ten products included acetaminophen, blood pressure medications, antidepressants, narcotic medication, bleach, ibuprofen, sedatives/anti-anxiety medication and Diphenhydramine.

Children and Adolescents aged 0 to 14, are among the greatest risk for concussion. Concussion is the most common type of traumatic brain injury (TBI). Every year TBI results in an estimated 3000 deaths, 29,000 hospitalizations and 400,000 visits to the emergency department. ¹

Access to guns and unsafe storage practices creates risk of serious unintentional injury and death. 20,000 children present to EDs for firearm-related injuries annually. 90% of those ED visits are by children ages 12-19. 4,500 children under 21 died from firearm violence in 2015. ²

Suggestions for Improvement

- Incorporate and promote a child injury/safety prevention program within your facility
- Create a checklist to educate staff, providers and parents regarding safety in the home and medication
- Include child safety education for new parents and at all pediatric visits
- Increase awareness and education regarding concussions. Develop and provide fact sheets for parents, athletes and coaches. [http://www.cdc.gov/headsup/resources/custom.html](http://www.cdc.gov/headsup/resources/custom.html)
- Utilize patient assessment tools such as [Acute Concussion Evaluation (Ace) Forms](http://www.cdc.gov/headsup/resources/custom.html) in clinical setting. Identify barriers for receiving appropriate services for TBI patients and make appropriate referrals
- Discuss the importance of helmet safety
- Discuss the importance of safe gun storage with parents or gun owners within the household
Other Resources – Links

- CDC “Heads Up” Series
- CDC Concussions
- Minnesota Youth Athletic Services
- Helmet Safety
- Safe Kids: Medication Safety Checklist
- Safe Kids: Home Safety Checklist
- Prevent Child Injury
- Child Safety Network
- Bright Futures: Health and Safety Promotion
- American Academy of Pediatrics
- Project Childsafe: Firearm Safe Storage
- Healthy Children: Firearm Safety
- Protect Minnesota: Public Health Conference on Gun Violence

Works Cited


Medication Safety: Sampling

Identify the Safety Risk

The use of samples leads to prescribing and use which may not be the most effective or efficient for patients: sample drugs represent potential risks as pharmacists are eliminated from the dispensing process. There is an increased risk of documentation errors, use of non-formulary drugs, outdated medications and drug interactions.

It is recommended that clinics eliminate sampling of all prescription pharmaceutical products supplied by manufacturers. Clinics choosing to stock and dispense sample medications must follow safe medication practices consistent with JCAHO standards. HealthPartners identifies sampling of prescription pharmaceuticals as inconsistent with the six aims of quality, primarily due to concerns for patient safety.

Suggestions for Improvement

- Eliminate sampling.
- Review or implement a sample drug protocol in your clinic. Form a work group to assess the protocol (providers, nurses, medical assistants).
- Implement protocol. If sampling is not yet eliminated, set a future date and goal for elimination.
- Determine which samples should be maintained, where they should be maintained and the level of security necessary. All samples should be locked in a secure place.
- Eliminate drug samples from exam rooms and doctors’ offices and store them in a secure location in clear view of a nursing station.
- Create a written documentation and monitoring system for samples and include duplicate written instructions to keep in the log and to give to the patient. Include expiration date and drug details.
- Track the total starting number of samples per drug, the number distributed with the date distributed and the number of sample drugs remaining with a date.
- Create labels for the samples and attach them prior to giving to the patient.
- Provide educational handouts on each drug within the sample space and make sure adequate copies are available and easily obtainable for each sample. Place a copy of the education piece given to the patient in the log and in the medical record.
- Make pharmaceutical representatives aware of your protocol and their roles in ensuring safe sample distribution. Consider a sign in/out log for pharmaceutical representatives to use during every visit. Enter a name, medication(s) delivered, lot numbers, quantity and expiration date. Clinic staff who removes samples should sign them out on the same log.
- Assessments for hidden caches of samples within physician offices or exam rooms should be done regularly, perhaps every quarter to every six months.

(Gunderson 22)

Sample Forms

Figure 16: Pharmaceutical Sampling Policy

Other Resources - Links

- American Pharmacists Association-Safety First: The latest updates from The Joint Commission

Works Cited

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**Medication Safety: Therapeutic Monitoring**

**Identify the Safety Risk**

Certain medications require annual monitoring due to increased risk of harm from drug side-effects and drug toxicity. Therapeutic monitoring of patients is essential to prevent avoidable adverse drug events related to specific high-risk drugs (e.g., Warfarin and Amiodarone monitoring).

Ongoing provider monitoring will include the Healthcare Effectiveness Data and Information Set (HEDIS) measure Annual Monitoring for Patients on Persistent Medications. Performance information will provide meaningful and useful information to clinicians for therapeutic decision making and management.

This measure now includes

- ACE inhibitors and combination products
- ARBs and combination products
- Digoxin
- Diuretics

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### HealthPartners Commercial HEDIS Rates

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**Suggestions for Improvement**

- Create or implement a protocol on therapeutic monitoring for patients on persistent medications.
- Incorporate the protocol to align with your use of the HealthPartners registry monitoring system. Access to the registry data is available through [healthpartners.com](http://healthpartners.com), Via the provider portal.
- Form a work group to assess the policy and include providers, nurses, and medical assistants.
- Evaluate HEDIS results for this measure.
- Review the HealthPartners measurement summary of the HEDIS Annual Monitoring for Patients on Persistent Medications.

**Sample Forms**

**Figure 17:** HPMG & Clinic Amiodarone & Warfarin protocol (example only – HealthPartners health plan does not endorse this specific protocol)

**Other Resources -Links**

- [American Association for Clinical Chemistry](https://www.aacc.org)
- [U.S. Food and Drug Administration Safety and Drugs](https://www.fda.gov)
- [MA Coalition for the Prevention of Medical Errors](https://www.macoalition.org)

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Medication Safety: Do Not Use Abbreviations

Identify the Safety Risk
HealthPartners and Regions Hospital are part of a metro area-wide effort to eliminate unsafe prescribing practices and reduce medication errors. Our efforts are part of the Safest in America (SIA) and JCAHO initiatives to eliminate dangerous abbreviations, acronyms and symbols. We provide this information to encourage the elimination of unsafe prescribing practices in all clinical settings.

Suggestions for Improvement

- Establish a protocol and try to eliminate all handwritten prescriptions.
- Perform an audit of prescriptions written and e-prescribed in the clinic on 20 records to monitor for compliance with your clinic’s protocol. If 100 percent compliance is not seen, share results with providers and set goals for improvement.
- Continue to monitor for compliance. Consider additional initiatives with providers if 100 percent compliance is not seen.
- Obtain examples of poor prescription writing from pharmacies and have them block out the names to protect patient confidentiality. You can show these to providers as examples.
- Assess prescription writing or e-prescribing practice by assigning a nurse to review all of the prescriptions written or e-prescribed in a day as patients exit the clinics.
- Collaborate with a pharmacy and provide them with standards and a chart to track a clinic’s prescriptions. Ask them to assess every prescription for one week or one month and give feedback. Review at least 20 prescriptions. Generate provider specific data and give feedback with suggestions for improvement. We suggest monitoring every 3 to 6 months once standards are in place.
- If a medical practice has an electronic medical record, an electronic prescription writing platform may already be in place. Create a monitoring system (through EMR data reports) to check for accuracy.
- Member interviews and pharmacy reports are additional resources to use in monitoring and validation checks. (Gunderson 10)

Other Resources - Links

- Joint Commission Do Not Use List

Works Cited

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Medication Safety: Medication Reconciliation

Identify the Safety Risk

Medication reconciliation is the process of comparing a patient’s medication orders to all of the medications that the patient has been taking. This reconciliation is done to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions. It should be done at every transition of care in which new medications are ordered or existing orders are rewritten.

HEDIS instituted a measure regarding Medication Reconciliation Post-Discharge (MRP). The specification from CMS requires that medication reconciliation occur within 30 days post-discharge from an inpatient facility. Even though this measure has a restricted population, the standard of care should apply to any member with complex medical care needs on multiple medications.

Suggestions for Improvement

- Establish a spot in the medical record where the current medication list is stored. This should be accessed upon opening a medical record or on the encounter page in an electronic medical record (EMR).
- Implement a process for obtaining and documenting a complete list of each patient’s medications upon admission/discharge to clinic and hospital using member’s preferred pharmacy. Establish a communication method (fax or EMR) where an inpatient facility provides the patient’s current list of medications upon discharge from an inpatient facility. Include a statement in scripting about how the patient’s provider gives recognition of legitimate authority. For example, “Dr. X wants to know your medications and would like you to know them too”.
- Consider personal reciprocity in your scripts - be nice to people and they will feel obligated to be nice to you. Use words like “will you please...”, and always give the patient the opportunity to respond.
- Once you have developed the medication reconciliation script with input from front line staff, test it in a small group. Make changes as needed.
- Assign a nurse/medical assistant to choose 20 patients over several days each quarter to review their medication list tool and compare it to the list in the chart. (Gunderson 4)
- Develop scripting messages around medication reconciliation to promote consistency, assure a high level of service, help staff to handle difficult situations, and set clear expectations. Scripts also promote a verbal commitment and compel people to follow through. Commitment influences behavior and may increase compliance.
- Establish a spot in the medical record where the current medication list is stored. This should be accessed upon opening a medical record or on the encounter page in an electronic medical record (EMR).
- Implement a process for obtaining and documenting a complete list of each patient’s medications upon admission/discharge to clinic and hospital using member’s preferred pharmacy. Establish a communication method (fax or EMR) where an inpatient facility provides the patient’s current list of medications upon discharge from an inpatient facility. Include a statement in scripting about how the patient’s provider gives recognition of legitimate authority. For example, “Dr. X wants to know your medications and would like you to know them too”.
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- Consider personal reciprocity in your scripts - be nice to people and they will feel obligated to be nice to you. Use words like “will you please...”, and always give the patient the opportunity to respond.
- Once you have developed the medication reconciliation script with input from front line staff, test it in a small group. Make changes as needed.
Sample Forms

Figure 18: My Medicine List Tool
Figure 19: Sample Pill Box Distribution Policy
Figure 20: HEDIS 2015: Medication Reconciliation

Other Resources - Links

- AHRQ & Patient Safety Network(PSNET)
- Medication Reconciliation Pitfalls
- NIH Seniors and Medication
- Medication Reconciliation Roadmap
- Joint Commission Alert/Medication Reconciliation

Works Cited

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Medication Safety: Protocols for Use of Hazardous Drugs and Controlled Substances

Identify the Safety Risk

Coumadin, Amiodarone, Insulin and controlled substances such as Opioids are the most common potentially hazardous drugs prescribed in the outpatient setting. Research demonstrates that standardized prescribing of these medications may improve safety and potentially prevent misuse or abuse.

Protocols for a Coumadin prescription, along with standing orders for INR determination are available through multiple sources, including the product manufacturer. Clinics should have standing orders that allow nurses or pharmacists to renew or alter doses based on lab test results or changes in the patient’s circumstances. Standing orders that require regular assessment of INR should also be in place.

Sliding scales for Insulin have improved care by allowing those at the actual point of contact with the patient to modify medication orders based on point of care testing. Protocols, guidelines and standing orders should be developed to allow nurses, Medication Therapy Management (MTM) pharmacists or Certified Diabetes Educators (CDE) to provide the greatest level of patient care in the safest manner.

Use of chronic Opioid therapy for chronic nonmalignant pain (CNMP) has increased substantially; therefore effective management is considered a major problem in both primary care and out-patient medicine. It presents a major challenge for both the patient and health care provider. Opioids are associated with potentially serious harms, including adverse effects and outcomes related to the abuse potential and diversion.

Does your clinic have protocols in place and standing orders for Coumadin, Amiodarone, Insulin and controlled substances (CS)? Are CS locked in a safe place with a sign out procedure? How complete are the protocols for hazardous drugs?

Have you compared them to guidelines? How well are the protocols and standing orders followed in your clinic? Does your clinic have a protocol for disposing of controlled substances or hazardous medications?

Suggestions for Improvement

- Establish protocols for the use of hazardous drugs in your clinic. Make sure that the protocol addresses standardized daily dosing algorithms, monitoring and management plans. Include details on lock up and sign out procedures for certain medications.
- Form an improvement/quality group of providers to review the current methods of providing safe care to patients who are on controlled substances. Evaluate the results and implement change if improvement is needed.
- Update protocols and standing orders as needed to be in compliance with guidelines.
- Perform a sample audit of records (such as 20 records) to compare with each of the medication guidelines and orders in your protocol(s). Review compliance outcomes with your clinic’s quality team.
- Continue to monitor for compliance against the clinic protocols for hazardous drugs.
- If you use an electronic medical record, and as computers become more common in exam rooms, incorporate the guidelines, standing orders and other safety tools into the work flow of patient care.
- Review the HPMG & C Amiodarone policy & Warfarin protocol (Figure 17)

(Gunderson 25)

Sample Forms

Figure 17: Amiodarone Monitoring Policy &Warfarin Therapy Protocol
Figure 21: Provider Letter: Controlled Medication
Figure 22: Focus on Controlled Substances: Retrospective Drug Use Evaluation
Other Resources - Links

- **ICSI: Antithrombotic Therapy Supplement**
- **ICSI Guidelines: Diabetes**
- **AHRQ**
- **American Academy of Emergency Medicine Position**
- **Occupational Safety Health Administration list of hazardous medications**
- **MN Pharmacy Board: Prescription Monitoring Program**
- **Journal of Pain Clinical Guidelines for Opioid Therapy**
- **Controlled Substances Act**
- **ICSI Guideline: Acute Pain Assessment and Opioid Prescribing Protocol**
- **American Pharmacists Association: Patient Outreach Tools**

**Works Cited**

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Medication Safety: Antibiotic Prescribing

Identify the Safety Risk

To reduce risk, monitor the overuse (multiple dispensing) of antibiotics and/or inappropriate use of antibiotics. Some potent antibiotics, while very effective against certain types of infections, have a high risk for toxicity. This risk is even greater with patients who have impaired renal function.

When using antibiotics that have a high risk of toxicity, such as Aminoglycosides and Vancomycin, use protocols or other standardized dosing guidelines to assist prescribers in selecting appropriate doses based on clinical condition and renal function.

Ongoing provider monitoring completed by Minnesota Community Measurement includes the following measures:

- Appropriate Treatment for Children with Upper Respiratory Infections
- Appropriate Testing for Children with Pharyngitis
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

Performance information will provide meaningful and useful information to clinicians for therapeutic decision making and management.

Suggestions for Improvement

- Develop a protocol to follow with antibiotic prescriptions.
- Review the Minnesota Community Measurement provider monitoring for the measures listed above.
- Use existing guidelines and protocols with appropriate criteria to meet before ordering an antibiotic. If possible, implement these guidelines into your EMR or patient work flow to use when prescribing antibiotics.
- Consider creating a tool with criteria to check for quarterly chart audits on children and adults who have received antibiotics. Review results and try to identify if greater action is needed for appropriate use of antibiotics.

Other Resources - Links

- [AHRQ Antibiotic Report](#)
- [American Academy of Pediatrics Guidelines Article](#)
- [Pediatric Abstract article](#)
- [NY Dept of Health](#)
- [ICSI Guideline: Respiratory Illness](#)
- [HealthPartners and Flu Shots](#)
Medication Safety: Prescription Refills

Identify the Safety Risk

All providers will have a process for prescription refills to insure patients receive approvals in a timely and safe manner. Providers should develop a standing order policy and procedure regarding frequent medication refills.

Research studies have proven the effectiveness of automated or electronic prescription writing programs to reduce errors in handwritten prescriptions. Examples of electronic prescription tools include palm pilots, intranet, electronic formulary, or online drug information database. E-Prescribing allows for clear, concise, and legible instructions. HealthPartners encourages the adoption of E-prescribing in all clinical settings.

Electronic prescribing can offer enhanced safety features for patients. Prescriptions are legible, and pharmacists can eliminate worries over misunderstood phone messages for a prescription or refill of a medication consisting of a sound alike name.

Online prescription refills is another technology that can reduce errors and improve prescription processing efficiency. With online refills, patients can submit their refill requests electronically.

Suggestions for Improvement

- Convert your refill process into an e-prescribing system.
- Create or implement a protocol on prescription refills for your clinic. This could be incorporated into an electronic medical record or an on-line refill system.
- Create an assessment sheet for auditing purposes. The assessment could include how the refill was provided, by what provider, who picked up the order, what pharmacy refilled the prescription, did the member need to be seen prior to the refill, and, if so, was the member seen?
- Integrate the clinic protocol parameters into the assessment. Complete a random audit of 20 members with refills. Use the assessment sheet to track audit results.
- Form a work group to assess the audit data (providers, nurses, medical assistants). Compare data to the policy parameters. If parameters were not met, evaluate if changes are needed in the policy.
- Review and analyze the other data results. Is there an area where improvement is needed in the refill process? If so, have the work group develop an improvement initiative.
- Once the initiative is implemented, evaluate quarterly until improvement is seen, or until other changes are made.
- Continue to monitor for compliance with your clinic’s prescription refill protocol on an ongoing basis.
- Consider implementing a refill reminder system to increase compliance.

(Gunderson 34)

Sample Forms

**Figure 23:** Medication Refill (Behavioral Health) Standing Order policy.

**Figure 24:** Medication Refill (Non-Behavioral Health) Standing Order policy.

**These policies are for reference only. Please review and adapt to make your own policy.**

Other Resources - Links

- [AHRQ Article](#)
- [NPSF Pharmacy Safety and Service Facts](#)

Works Cited

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Medication Safety: Generic Prescribing

Identify the Safety Risk
Generics are a safe, effective alternative to many branded drugs. Generic drugs, because they have been on the market for a long time, have well known side effects and a longstanding record making them a more reliable and safe choice compared to newly introduced drugs.

Prescription drugs can be a costly medical expense, especially for older people and those who are chronically ill. However, each state has a law that lets pharmacists substitute less expensive generic drugs for many brand-name products. Generic drugs are less expensive because generic manufacturers don't have the investment costs that the developer of a new drug has.

New drugs are developed under patent protection. The patent protects the investment - including research, development, marketing and promotion - by giving the company the sole right to sell the drug while it is in effect.

As patents near expiration, manufacturers can apply to the FDA to sell generic versions. Because those manufacturers don't have the same development costs, they can sell their product at substantial discounts. Also, once generic drugs are approved, there is greater competition, which keeps the price down.

Generic Drug Use in Primary Care and in Specialty Care are Clinical Indicator measures. The rate represents the percentage of all prescriptions filled with generic drugs for HealthPartners members with a drug benefit. For prescriptions filled the first half of 2011, the generic drug use rate for primary care is 81.7 percent. The generic drug use rate for specialty care ranged from 75.7 percent to 93.6 percent.

Suggestions for Improvement
• Identify patients and target to move them toward generic conversion from the brand name drug to the equivalent generic.
• Perform an audit to identify patients who are on the drugs and run a cost summary of the past year. The summary should include cost of the drug and cost to the patient.
• Create a generic education sheet and describe the medication conversion you are focusing on.
• Identify 20 patients and flag their medical record to focus on conversion to a generic equivalent on their next office visit.
• Make a follow-up phone call to the patient three to five days after the prescription was written for conversion.
• Submit a questionnaire to check on satisfaction and send to patients two months after conversion. Review the satisfaction outcomes and determine if you can broaden the conversion program.
• Re-run the cost analysis data in three to six months and again in one year and compare that to the brand cost data.

Other Resources - Links
• FDA Generics
• HealthPartners.com/formulary
• HealthPartners Clinical Indicators Report

• Create a generic drug protocol in your clinic.
• Choose one common brand name drug to focus on in your clinic.
Reporting Results: Follow up from Tests and Procedures

Identify the Safety Risk

All providers will have a process and written protocol to identify abnormal diagnostic results, reporting abnormal results to clinicians and actions taken.

Suggestions for Improvement

- Examine your practice and review your current “results reporting” process. Is there a protocol in place? If not, form a work group to establish a clinic wide results reporting policy. Questions to answer may include: What critical values require phone calls?
- What tests require a written letter from the provider?
- What is the turnaround time required for a test to be completed and reported initially?
- What is the turnaround time goal for reporting the results to the patient?
- Is there a difference between a turnaround time or type of notice given for normal versus abnormal results?
- Is there a provider back up plan to notify patients of results if the provider who ordered them is not available to get back to the patient?
- Is there a rule about leaving information on results on answer machines or with other people?
- What documentation needs to occur in the notification process and who is responsible for this?
- Try to address all of these issues and define parameters for the notification process in your clinic policy.
- Develop a form letter for reporting normal results to the member to simplify reporting normal results to the patient.
- If your clinic uses patient e-mail notification, consider adding detail in the protocol to address reporting results through this process.
- Perform a random audit of normal and abnormal result notifications under your current process. Use this as baseline data.
- Implement the new process and policy. After one month, perform a random survey of charts. Document results and evaluate if any changes need to be made. Resurvey compliance on a regular basis.
- If failure to notify patients in a timely manner is rare, an annual evaluation should be sufficient. If you are seeing problems, try to perform a gap analysis, adjust the process and update the policy. If problems are noted, a quarterly audit for compliance may be required.

(Gunderson 31)

Other Resources

- **MA Coalition for the Prevention of Medical Errors: Implementing the Communication Critical Test Results Recommendations**

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# Staff Survey on Patient Safety

**Occupation:**
- Nurse
- Medical Assistant
- Other
- Provider/Clinician
- Patient Services (Receptionist, Scheduler)

Please fill in the best answer for each statement. If you do not have the experience to answer a question please answer NK (not known), but please try to answer as many as possible.

**Definitions:**
- Near miss – errors that are caught before they reach the patient
- Adverse event – injury caused by medical treatment rather than by underlying condition of the patient.

<table>
<thead>
<tr>
<th></th>
<th>SD – Strongly Disagree</th>
<th>D – Disagree</th>
<th>A – Agree</th>
<th>SA – Strongly Agree</th>
<th>NK – Not Known</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>At my clinic, there is a formal way to report incidents related to medical errors (near miss, unsafe act, adverse event).</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2.</td>
<td>My clinic acts on reported information related to medical errors (near miss, unsafe act, adverse event) to improve patient safety.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>At my clinic, anyone may report medical errors (near miss, unsafe act, adverse event) without fear of disciplinary action.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>4.</td>
<td>At my clinic, individuals are not blamed when an unintentional medical error (near miss, unsafe act, adverse event) occurs.</td>
<td></td>
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<tr>
<td>5.</td>
<td>I feel comfortable reporting medical errors (near miss, unsafe act, adverse event) made by my peers.</td>
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<tr>
<td>6.</td>
<td>The error reporting process at my clinic is easy to use.</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>7.</td>
<td>The error reporting process at my clinic protects the confidentiality of reporters.</td>
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<td></td>
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</tr>
<tr>
<td>8.</td>
<td>I believe that a medical error (near miss, unsafe act, adverse event) is the result of a provider mistake, or lapse in judgment.</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>I believe that most medical errors are due to patient behaviors, such as non-adherence to medications or not following medical advice.</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>10.</td>
<td>Staff receives information on the number and type of reported medical errors (near miss, unsafe act, adverse event).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>My clinic views every medical error (near miss, unsafe act, adverse event) as an opportunity to improve safety.</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>I work in an environment where patient safety is a priority.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>13.</td>
<td>In the past year, I have reported one or more near misses (errors I catch before they reach the patient) and other accidents waiting to happen.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What factors will help you and what factors will get in the way of reporting possible patient safety concerns in your job?

Return to:
Medical Error/Potential Medical Error/Incident Reporting

When should the form be completed?

Whenever a medical error, potential medical error or incident is identified, it should be reported. We define these as follows:

Medical Error - failure of a planned action to be completed as intended or use of a wrong plan to achieve an aim.

Incident - occurrence which happens to a patient, visitor or property which is inconsistent with proper procedure or routine operations, inconsistent with intended care or injurious or has potential to result in injury, property harm or negative consequences.

How can I report these events?

To report it, you can either call the Medical Error Hotline (952-883-6222) or complete this form. The call or form should be completed immediately.

Who should complete the call or the form?

Any HPMG employee or medical staff member who witnesses or becomes aware of an event should report it.

What should I do if the event involves injury to the patient/visitor?

The first and most important thing to do is ensure the patient/visitor is treated by a physician. Additionally you should immediately notify your supervisor of this type of event and on the form indicate the appropriate class for the outcome of the event.

Where should this form be sent?

Send the completed, original form in reroute to:

Care Innovation & Measurement
21101D

How can I get help if I have questions?

Talk with your clinic manager, chief or supervisor or call Care Innovation & Measurement at 952-883-7779.
## Medical Error/Potential Medical Error/Incident Form

**Name:** ___________________________________________________

**MRN #:** _________________________________________________

**DOB (if MR # missing):** ________________________________

<table>
<thead>
<tr>
<th>Check one</th>
<th>Clinic:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>Date of event:</td>
</tr>
<tr>
<td>Visitor</td>
<td>Time of event:</td>
</tr>
<tr>
<td></td>
<td>Specific location of event:</td>
</tr>
</tbody>
</table>

### 1. Describe what happened  
(Be concise, objective, factual, and include any statements of patient/visitor in quotes. Include details surrounding the event and other extenuating circumstances)

___________________________________________________________________________________________________________

___________________________________________________________________________________________________________

___________________________________________________________________________________________________________

___________________________________________________________________________________________________________

___________________________________________________________________________________________________________

___________________________________________________________________________________________________________

___________________________________________________________________________________________________________

___________________________________________________________________________________________________________

___________________________________________________________________________________________________________

### 2. Outcome of Event

**Check one**

- **Class I – Emergent, Harm** *
  - Unexpected, event involving death or serious injury.

- **Class II – Urgent, Harm** *
  - Event resulting in injury or change in condition.

- **Class III – Non-urgent, No harm**
  - Event not resulting in injury or change in condition.

*Class I & II require immediate attention and response. Contact your supervisor immediately.*

**Check all that apply:**

- Abrasions/bruise/contusion
- Allergic reaction
- Burn
- Cardiac / Respiratory arrest
- Death
- Delayed treatment / Diagnostic test
- Dental related
- Dizzy, nausea, headache
- Fracture / dislocation
- Infection
- IV infiltration
- Laceration
- Mental status changes
- Sprain / Strain
- Unplanned admission to hospital
- Unplanned ER visit
- Unplanned surgery
- Other: _____________________
- No change in condition or outcome
- Property damage
- Repeat test / Procedure

---

**CONFIDENTIAL – NOT A PART OF THE MEDICAL RECORD**  
This report is directed to HealthPartners Care Innovation & Measurement Department.  
The contents of this report are confidential in accordance with Minnesota statutes.
MEDICATION RELATED

- Prescribing – RX w/incorrect med/dose/freq. (provider only)
- Dispensing – Incorrect product (pharmacy only)
- Dosage – Incorrect strength (pharmacy only)
- Distribution – Pt. receives another’s Rx (pharmacy only)
- Medication – Incorrect med or dose administered
- Reaction – Adverse reaction to meds

Possible Causes of Event – Check all that apply

- Lack of training
- Verbal miscommunication
- Illegible handwriting
- Transcription incorrect
- Order missed
- Order not sent to Pharmacy
- Order sent to Pharmacy but not in stock
- Confusing abbreviation
- Order misread

PATIENT CARE RELATED

Check all that apply

Diagnostic
- Error or delay in diagnosis
- Failure to employ indicated tests
- Use of outmoded tests or therapy
- Failure or delay in acting or results of test

Treatment
- Error in performance of operation, test, procedure
- Error in administering the test/treatment
- Delay in treatment or responding to abnormal test
- Inappropriate or not indicated care

Preventive
- Failure to provide prophylactic treatment
- Inadequate monitoring or follow up

Other
- Failure of communications
- Documentation error
- Computer system error
- Record availability
- Other: ____________________________

FALL RELATED

Check one

- Exam room
- Public area
- Other: __________

Check all that apply

- Floor wet/slippery
- Needed help – did not call
- Staff with pt/visitors at time of incident
- Patient impaired at time of incident

TRAUMA RELATED

Check one

- Burn
- Self-injury
- Interpersonal altercation

Check all that apply

- Was patient impaired
- Staff involved
- Equipment involved
- Struck by an object
- Struck an object
- Other: ________________

MISCELLANEOUS

Check all that apply

- Equipment failure, damage, contamination
- Facility/property damage
- Departure before seen
- Missing article
- Other: ____________

CONFIDENTIAL – NOT A PART OF THE MEDICAL RECORD
This report is directed to HealthPartners Care Innovation & Measurement Department.
The contents of this report are confidential in accordance with Minnesota statutes.
3. Person Completing Form

<table>
<thead>
<tr>
<th>Name</th>
<th>(Please print)</th>
<th>Date</th>
<th>Dept/Unit</th>
<th>Phone/Extension</th>
</tr>
</thead>
</table>

Witnesses:

<table>
<thead>
<tr>
<th>Name</th>
<th>(Please print)</th>
<th>Date</th>
<th>Dept/Unit</th>
<th>Phone/Extension</th>
</tr>
</thead>
</table>

Others (Please print name(s))

4. Physician Report

Condition of Patient and Plan of Care:

_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________

Signature of Physician Examining Patient _______________________________ Date/time ____________

Refused treatment/care? □ Yes □ No □ N/A

5. Management Follow-up:

_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________

Other Dept(s) CI needs to follow up with: ____________________________

Signature of Supervisor ____________________ Date _______________ Time ____________________

6. Other Department Follow-Up:

_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________

7. CARE INNOVATION & MEASUREMENT USE ONLY:

<table>
<thead>
<tr>
<th>DATE RECEIVED:</th>
</tr>
</thead>
<tbody>
<tr>
<td>FOLLOW-UP NECESSARY:</td>
</tr>
</tbody>
</table>

CONFIDENTIAL – NOT A PART OF THE MEDICAL RECORD
This report is directed to HealthPartners Care Innovation & Measurement Department. The contents of this report are confidential in accordance with Minnesota statutes.
**Gundersen Lutheran Medication Safety Culture Meter**

*How are we doing?*

Last year, Gundersen Lutheran began a systems initiative regarding medication safety. We need your input in how we are doing. Please rate the following statements. Circle one number for each item. **NOTE:** An “event” is defined as ADR's (adverse drug reaction) both preventable and non-preventable, medication errors and near misses. If you have any additional comments after completing this survey, please write them on the back of this form. Thank you

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I am aware of the Medication Safety initiative at Gundersen Lutheran.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. Leaders and managers at Gundersen Lutheran communicate to me that medication safety is a high priority.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. I fear there will be negative consequences associated with reporting medication events.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. I feel comfortable reporting medication events made by coworkers.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. A &quot;potential&quot; event relating to medication use that has been caught and corrected before it reaches the patient should be reported</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. The process of reporting medication events at Gundersen Lutheran is easy to do.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. I am familiar with Gundersen Lutheran’s policy regarding medication event and ADR reporting.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. I have reported an Adverse Drug Reaction that I became aware of within the last 3-6 months.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9. I believe that a medication event is the result of a failure of a complex system.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10. I work in an environment where I can openly communicate my opinions about patient care practices.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11. I see changes occur when I report an event.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

**Job Title:**

Department: □ hospital/ unit □ clinic/ dept □ other →

Please return this form by December 9th via inter-departmental mail to Kim Weber- mail stop H03-007.
# AMBULATORY SITE SURVEY FOR ONE CLINIC

## Contact Information

<table>
<thead>
<tr>
<th>Medical Group Name:</th>
<th>Surveyor Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Survey:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinic Site Name &amp; Address:</th>
<th>Medical Group Representative &amp; Title:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Records Contact:</th>
<th>Quality Contact:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

## Accreditation (circle)

<table>
<thead>
<tr>
<th>Joint Commission</th>
<th>NCQA</th>
<th>Other (list)</th>
<th>Accreditation effective date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*If clinic has accreditation, obtain a copy of the survey report that indicates the survey includes the physician’s office and meets HealthPartners quality assessment criteria. If these qualifications are met, the rest of this document does not need to be completed.*

## Site Survey

### External Access/Appearance

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1. Building is easily identified and accessible to persons with disabilities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Practitioner’s names are listed near entrance/reception area or printed information is available to patients (i.e., brochure, business cards)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Hours of operation and after hours care are posted near entrance/reception area or printed information available to patients (i.e., brochure with hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Adequate parking is available, including parking for persons with disabilities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Parking areas and clinic entrance are well lit and well maintained</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

### Internal Access/Appearance

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. Adequate signs/directions to patient care, business office and administrative areas</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. Reception/waiting areas are adequate to accommodate patient flow and volume</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8. Exam/treatment rooms are adequate to accommodate appointment scheduling, patient privacy, etc.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>9. Patient care areas accessible to persons with disabilities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10. Reception/waiting areas and exam/treatment rooms are clean and well maintained</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>General Safety Management</td>
</tr>
<tr>
<td>---------------------------</td>
</tr>
<tr>
<td>11. Fire safety procedures and systems are in place (i.e., unobstructed fire exits/doors, alarms, sprinkler systems)</td>
</tr>
<tr>
<td>12. Supplies with potential for abuse are appropriately secured (i.e., are not in exam rooms - drugs, syringes, prescription pads)</td>
</tr>
<tr>
<td>13. Hazardous waste containers and Sharps containers are present</td>
</tr>
<tr>
<td>14. Sample medications are kept in a locked area and logged out when provided to patients and routinely checked for expiration date</td>
</tr>
<tr>
<td>15. Medical coverage is available 24-hours/day</td>
</tr>
<tr>
<td>16. Written policy exists for appointment availability</td>
</tr>
<tr>
<td>17. Preventive care appointments can be obtained within four weeks</td>
</tr>
<tr>
<td>18. Non-Urgent, symptomatic appointments can be obtained within 48-72 hours</td>
</tr>
<tr>
<td>19. Urgent Care appointments can be obtained within 24-36 hours</td>
</tr>
<tr>
<td>20. Policy exists for answering and returning phone calls</td>
</tr>
<tr>
<td>21. Compliance with answering and returning phone calls is monitored</td>
</tr>
<tr>
<td>22. Infection control procedures in compliance</td>
</tr>
<tr>
<td>Medical Record-Keeping</td>
</tr>
<tr>
<td>22. Medical records are stored in a secure area that is inaccessible to unauthorized individuals. Area is locked or someone present at all times during open hours</td>
</tr>
<tr>
<td>23. Written policies exist for confidentiality, release of information, and advanced directives</td>
</tr>
<tr>
<td>24. Written policy exists for medical records standards. Compliance with medical record organization and documentation requirements is monitored</td>
</tr>
<tr>
<td>25. Written policy exists for chart availability between practice sites</td>
</tr>
<tr>
<td>26. Written policy exists for continuity &amp; coordination of care with other practitioners and providers (i.e., hospitals, home cares, nursing homes, specialists)</td>
</tr>
<tr>
<td>27. Review paper medical record or provide a copy of a list (chart order) showing what is included in the medical record (i.e., problem list, immunizations, medication flow sheet).</td>
</tr>
<tr>
<td>28. Has an electronic medical record (EMR) system been implemented? If yes, provide either a copy of the policy and procedure manual’s Table of Contents or a list of what is included (i.e., problem list, immunizations, medication flow sheet, advance directives).</td>
</tr>
<tr>
<td>29. Clinic physicians participate in one or more of the NCQA Physician Recognition Programs (circle all that apply): 2) Diabetes 3) Heart/Stroke 5) Patient –Centered Medical Home 6) Government Recognition Initiative</td>
</tr>
</tbody>
</table>

If you answered No to any of the above questions please explain/comment:
Office Site Criteria

Physical Accessibility

External
1. Building is easily identified and accessible
2. Building is accessible to persons with disabilities
3. Adequate patient parking is available, including parking for persons with disabilities

Internal
1. Patient care areas are easily identified and accessible
2. Waiting rooms are accessible to persons with disabilities
3. Examining rooms are accessible to persons with disabilities
4. Restrooms are accessible to persons with disabilities

Physical Appearance/Conditions

1. Building is kept in good repair
2. Building signage is adequate to direct patients to appropriate departments
3. Parking areas and clinic entrance are well lit and well maintained
4. Reception/waiting areas are clean and well maintained
5. Exam/treatment rooms are clean and well maintained
6. Climate/environment is comfortable (e.g., air quality, lighting, safety)
7. Infection Control Procedures in place

Adequacy of Waiting-and Examining-Room Space

1. Waiting rooms are adequate to accommodate patient flow and volume
2. Waiting rooms provide adequate patient privacy
3. Exam/treatment rooms are adequate to accommodate patient care, patient privacy, etc.

Medical/Treatment Record-Keeping Criteria are addressed in QUI Policy: Medical Records Standards (QA 10)
Ambulatory Safety Survey 2020

Safety Culture Assessment

* 1. Has your medical group developed and completed an assessment of the current safety culture?

☐ 1-No assessment
☐ 2-An assessment of safety culture has been completed; includes a reporting system of incidents and near misses
☐ 3-Assessment completed AND action plan(s) have been implemented, based on analysis of reported incidents

A culture of safety addresses management behaviors, employee perceptions of safety and safety systems—including a reporting system of incidents, near misses and good catches. See HealthPartners Ambulatory Safety Toolkit.

* 2. Has your medical group established a protocol for dispensing sample medications?

☐ 1-No protocol
☐ 2-If samples are provided to patients, a protocol has been established and implemented at clinic sites
☐ 3-Sampling has been eliminated at all clinic sites

It is recommended clinics eliminate sampling of all prescription pharmaceutical products supplied by manufacturers. Clinics choosing to stock and dispense sample medications must follow safe medication practices consistent with HealthPartners Pharmaceutical Sampling provider policy. See HealthPartners Ambulatory Safety Toolkit.

* 3. Has your medical group established a protocol for members on chronic anticoagulation therapy?

☐ 1-No protocol
☐ 2-Protocol established and implemented at clinic sites
☐ 3-Protocol implemented AND compliance with protocol is monitored and documented; 100% of all patients on chronic anticoagulation therapy are managed by protocol
☐ NA-We do not manage patients on anticoagulation therapy

A written standard protocol within practice must address standardized daily dosing algorithms, monitoring and management. Therapeutic Monitoring in HealthPartners Ambulatory Safety Toolkit.
4. Has your medical group established a protocol for safe use of abbreviations?

- 1-No protocol
- 2-Protocol established and implemented at clinic sites
- 3-Protocol implemented AND compliance is monitored and documented

A written standard protocol within practice must address safe medication practices consistent with the HealthPartners Do Not Use Abbreviations provider policy. This policy incorporates recommendations from the Institute for Safe Medication Practices. See Do Not Use Abbreviations in the Ambulatory Safety Toolkit.

5. Has your medical group established a protocol for medication refills?

- 1-No protocol
- 2-Protocol established and implemented at clinic sites
- 3-Protocol implemented AND compliance is monitored and documented

A written standard protocol within practice must address standing order policies and procedures regarding frequent medication refills.

6. Has your medical group established a protocol for use of controlled substances?

- 1-No protocol
- 2-Protocol established and implemented at clinic sites
- 3-Protocol implemented AND compliance is monitored and documented

A written standard protocol within practice must address members taking controlled substances on a long term basis. The protocol includes care plans, member contracts and referrals to 1:1 programs as appropriate. Care plans identify the approved medications, quantities, dosage ranges, approved pharmacies and providers. See Protocols for Use of Hazardous Drugs in the Ambulatory Safety Toolkit.

7. For accurate reporting, please complete information below

Respondent name

Job title

Medical Group/Clinic

Email

Phone
8. Are there other topics you would like to see included in the Ambulatory Patient Safety Toolkit and survey?
Creating and Sustaining a Culture of Safety

By Stephen W. Harden

Healthcare consumers are increasingly aware of medical error and publicly reported quality measures. Additionally, the Centers for Medicare and Medicaid Services' (CMS) pending refusal to pay for certain "never events," the advent of the Hospital Consumer Assessment of Healthcare Providers Survey (HCAHPS), and the work of the Institute for Healthcare Improvement (IHI), the National Patient Safety Foundation (NPSF), and Joint Commission have combined to produce conditions where creating and sustaining a culture of safety is a priority for many healthcare organizations. That was the case for The Nebraska Medical Center (TNMC) in Omaha. The academic medical center realized in 2004 that their patient safety efforts needed a boost to move from very good to great. A focus on quality and safety was one of four CEO leadership priorities, and the focus on quality and safety was incorporated into the hospital's strategic plan with full approval of the Board.

Chief Medical Officer Steve Smith, MD, spearheaded the effort to change TNMC's culture: "We want a safer place to practice medicine with the confidence that all steps necessary to ensure our patients' safety to the highest degree are taken into account for all cases." Based on a recommendation from the chief of surgery, Smith elected to join forces with LifeWings, a consultancy group that works with clients to create a culture of safety by adapting the best practices of aviation and other high reliability organizations.

TNMC chose to follow a five-point plan for creating and sustaining an improved culture of safety. In a 6-month period of 2005 and 2006, the first four steps of the plan were conducted in perioperative services as proof of concept with follow-on implementation planned for other areas after success in the OR.

Step 1. Develop change-initiative skills for key leadership positions and an organizational structure that will support the new culture. Realizing no change would occur without partnership with the institution's physicians, TNMC recruited physician champions, briefed all physicians in perioperative services through monthly meetings and surgery Grand Rounds, and made sure each physician understood the methodology, potential results, and "what's in it for you" for supporting the initiative. This was an important step, as TNMC already had very high levels of patient safety in other areas. Next, key leaders at both the institutional and departmental level were trained on leading change initiatives. Skills learned included:

- responding to difficult questions about the initiative,
- recruiting champions and coaching low performers, and
- conducting rounding for patient safety.

Organizational development to support the initiative included:

- a project oversight and steering committee,
- revisions to policy and procedure manuals,
alignment of leadership assessment systems to support the culture,
a data collection and analysis plan for project measurement, and
making the training and new safety tools mandatory for all physicians and staff — including consequences for non-compliance.

Step 1 was perhaps the most important part of the methodology as research shows that "end user" adoption of culture changing behaviors and tools is primarily a function of effective leadership action.

Step 2. Provide training in teamwork and communication to support desired culture-changing behaviors. Following a site visit, a thorough patient care processes review, and preparation of a teamwork scorecard as part of their needs analysis, LifeWings prepared customized courseware targeting the needs of TNMC and presented it to physicians and staff. The training was interdisciplinary, experiential, and based on healthcare case studies. It provided evidence-based teamwork skill sets based on team training from the aviation industry — called Crew Resource Management (CRM) — and adapted for the needs of the OR team. CRM is based on the best science and research on high performing teams.

Step 3. Create and implement site-specific safety tools to hardwire the teamwork behaviors into daily work life. Using a process based on Lean, a small work group of physicians and staff met to 1) identify points in their workflow where improvements in patient safety were most needed and 2) create safety tools such as checklists, structured handoffs, protocols, and communication scripts to facilitate the needed improvements. An education and implementation plan was created for each tool. Tools were implemented over a period of weeks. The first tool completed and implemented was a Pre-Procedure Briefing (Figure X) for surgical cases that incorporated the elements of the Universal Protocol (which is available online at www.psqh.com/xxx. It also included checklist items to ensure all staff and needed equipment were available and operational, and that the patient was completely ready for the procedure to begin.

Step 4. Collect and analyze data to document results. TNMC created a measurement plan to analyze results by examining safety measures including safety climate surveys, teamwork and communication issues, and process reliability and efficiency.

Step 5. Conduct training for "master trainers." TNMC wanted to bring the culture-changing initiative in-house as quickly as possible and avoid an extended engagement with an outside consultant. To develop their internal capacity, three trainers were chosen in 2006 to learn to provide the teamwork skills training and to create and implement the safety tools. Two trainers were from the Six Sigma department and one was hired externally. Once qualified by LifeWings, these trainers assumed responsibility in 2007 and 2008 for the roll out of Steps 1 through 4 in the emergency department, the cardiac catheterization and electrophysiology labs, and the obstetrics and gynecological services department. TNMC continues to roll out the system in its critical care areas with plans to implement the culture change in its entire hospital.

Results
The culture of safety has improved at TNMC. Results of the safety-climate survey administered after the implementation in the areas listed above show dramatic improvement in the perception of staff, physicians, and residents on those indicators related to patient safety in their area (Figure 1). Additionally, the culture has produced multiple examples of "good catches" by the staff as they have intercepted potential errors that might have affected patient safety. In addition to improved patient safety, TNMC has seen an improvement in cases without significant events, reducing unexpected delays (Figure 2). As a result of their culture-changing efforts, TNMC recently won the "Quest for Excellence" award given each year by the Nebraska Hospital Association. The award represents "the highest level of professional acknowledgement in
Nebraska's hospital quality improvement arena.”

TNMC has proved that though disciplined leadership action, effective interdisciplinary skills training, use of site-specific safety tools that hardwire behaviors, and program-guiding measurement, the safety culture can be changed and improved.

**Figure 1: Safety Climate Survey Results**

<table>
<thead>
<tr>
<th>Culture of Patient Safety Survey Results Cath/EP</th>
<th>Pre-CRM: August 2006 (n=24), Post CRM: July 2007 (n=16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>We are actively doing things to improve patient safety.</td>
<td>73%</td>
</tr>
<tr>
<td>Staff will freely speak up if they see anything that may negatively affect patient care.</td>
<td>63%</td>
</tr>
<tr>
<td>Staff feel free to question the decisions or actions of those with more authority.</td>
<td>29%</td>
</tr>
</tbody>
</table>

**Figure 2: Percentage of Procedures without Delays**

<table>
<thead>
<tr>
<th>Cath Lab 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>July (N=36)</td>
</tr>
<tr>
<td>Sept (N=92)</td>
</tr>
</tbody>
</table>

*Stephen Harden* is the co-founder and president of LifeWings Partners LLC. He is co-author of *CRM: The Flight Plan for Lasting Change in Patient Safety* (published by HC Pro) and is a nationally known speaker on creating a culture of patient safety. He can reached at sharden@SaferPatients.com.
FREE FROM HARM: ACCELERATING PATIENT SAFETY IMPROVEMENT FIFTEEN YEARS AFTER TO ERR IS HUMAN

TO ERR IS HUMAN FRAMED PATIENT SAFETY AS A SERIOUS PUBLIC HEALTH ISSUE (1999 ESTIMATES)

<table>
<thead>
<tr>
<th>Annual Deaths</th>
<th>Source(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>44,000 - 98,000</td>
<td>(a)</td>
</tr>
<tr>
<td>43,458</td>
<td>(a)</td>
</tr>
<tr>
<td>42,297</td>
<td>(a)</td>
</tr>
<tr>
<td>16,516</td>
<td>(a)</td>
</tr>
</tbody>
</table>

Annual deaths from medical error among hospitalized patients. (a)
Annual deaths from car crashes. (a)
Annual deaths from breast cancer. (a)
Annual deaths from AIDS. (a)

BY SOME MEASURES, HEALTH CARE HAS GOTTEN SAFER SINCE TO ERR IS HUMAN

1.3 Million
Estimated reduction in hospital-acquired conditions (2011-2013) as a result of the federal Partnership for Patients initiative. (b)

TO UNDERSTAND THE FULL IMPACT OF PATIENT SAFETY PROBLEMS, WE MUST LOOK AT BOTH MORTALITY AND MORBIDITY

1 in 10 patients develops a health care acquired condition (such as infection, pressure ulcer, fall, adverse drug event) during hospitalization. (b)

BUT WE MUST LOOK BEYOND HOSPITALS TO THE FULL CARE CONTINUUM

ADVANCEMENT IN PATIENT SAFETY REQUIRES AN OVERARCHING SHIFT FROM REACTIVE, PIECEMEAL INTERVENTIONS TO A TOTAL SYSTEMS APPROACH TO SAFETY (d)

1. Ensure that leaders establish and sustain a safety culture.
2. Create centralized and coordinated oversight of patient safety.
3. Create a common set of safety metrics that reflect meaningful outcomes.
4. Increase funding for research in patient safety and implementation science.
5. Address safety across the entire care continuum.
7. Partner with patients and families for the safest care.
8. Ensure that technology is safe and optimized to improve patient safety.

1.3 Million
Estimated reduction in hospital-acquired conditions (2011-2013) as a result of the federal Partnership for Patients initiative. (b)

1 Billion
Roughly 1 billion ambulatory visits occur in the US each year. (c)

35m
About 35 million hospital admissions occur annually. (c)

To read the full report and detailed set of recommendations, visit www.npsf.org/free-from-harm

1. Ensure that leaders establish and sustain a safety culture

Improving safety requires an organizational culture that enables and prioritizes safety. The importance of culture change needs to be brought to the forefront, rather than taking a backseat to other safety activities.

2. Create centralized and coordinated oversight of patient safety

Optimization of patient safety efforts requires the involvement, coordination, and oversight of national governing bodies and other safety organizations.

3. Create a common set of safety metrics that reflect meaningful outcomes

Measurement is foundational to advancing improvement. To advance safety, we need to establish standard metrics across the care continuum and create ways to identify and measure risks and hazards proactively.

4. Increase funding for research in patient safety and implementation science

To make substantial advances in patient safety, both safety science and implementation science should be advanced, to more completely understand safety hazards and the best ways to prevent them.

5. Address safety across the entire care continuum

Patients deserve safe care in and across every setting. Health care organizations need better tools, processes, and structures to deliver care safely and to evaluate the safety of care in various settings.

6. Support the health care workforce

Workforce safety, morale, and wellness are absolutely necessary to providing safe care. Nurses, physicians, medical assistants, pharmacists, technicians, and others need support to fulfill their highest potential as healers.

7. Partner with patients and families for the safest care

Patients and families need to be actively engaged at all levels of health care. At its core, patient engagement is about the free flow of information to and from the patient.

8. Ensure that technology is safe and optimized to improve patient safety

Optimizing the safety benefits and minimizing the unintended consequences of health IT is critical.

To read the full report and detailed set of recommendations, visit www.npsf.org/free-from-harm

This project was made possible in part through a generous grant from AIG in support of the advancement of the patient safety mission. AIG had no influence whatsoever on report direction or its content. The views and opinions expressed herein are those of the author(s) and do not necessarily reflect those of American International Group, Inc. (AIG) or its subsidiaries, business units or affiliates.
Teach-back is Supported by Research

- “Asking that patients recall and restate what they have been told” is one of 11 top patient safety practices based on the strength of scientific evidence.”

  AHRQ, 2001 Report, Making Health Care Safer

- “Physicians’ application of interactive communication to assess recall or comprehension was associated with better glycemic control for diabetic patients.”

  Schillinger, Arch Intern Med/Vol 163, Jan 13, 2003, “Closing the Loop”
Teach-Back Self-Evaluation and Tracking Log

Name: ___________________________ Start/end date: _____/_____  

<table>
<thead>
<tr>
<th># Items to do or remember</th>
<th>Teach back used?</th>
<th>Results – Clarification needed? Patient perceptions?</th>
<th>Your assessment?</th>
<th>What to do differently next time</th>
</tr>
</thead>
</table>
| 1. Increase evening insulin dose to 26 units.  
2. Start Enalapril 5 mg. take 1 pill every morning. | X | I asked the patient to tell me his medication changes. He understood the addition of Enalapril and the dose, but he forgot how much I asked him to increase his insulin dose by. I clarified, and he actually expressed his appreciation for my confirmation. | | If I find that many patients can’t recall their medication changes, I may use a form to write them down for all patients. |

FIGURE 7
Resource List

Health Plan Organizational Assessment of Health Literacy Activities

Many questions in the organization assessment inquired about the use of guidelines. To help health plans implement and use guidelines in the future, each guideline topic covered in the assessment is listed below. The guidelines and suggestions listed are resources that have been developed and may be used or built upon to improve existing health literacy initiatives.

Please Note- All pages numbers listed refer to the page of the actual document as indicated in the lower right or left corner. The page numbers may or may not correspond to individual pdf file page numbers.

Reading level goals and testing


Font/Size


Clear/Plain Language

- **Checklist for use of plain language**
Web specific

- **Document Checklist of Plain Language on the Web** - This webpage provides some brief guidelines for writing information specifically for web viewing.
  

White space

- **Simply Put** - CDC Communication Guide. Brief layout and design guidelines (Page 17)
  

Graphics/Illustrations

- **Simply Put** - CDC Communication Guide. Discusses the use of graphics/illustrations generally as well as putting some focus on cultural appropriateness (Pages 11-16).
  

Verbal Communication (strategies for good communication as well as indications for difficulty understanding)

- **Quick Guide to Health Literacy** - Includes information on teachback and examples of the use of this technique (Page 4.5).
  

Identification of organizational words and phrases

- **Simple Words and Phrases**
  

Regulation of acronyms or nicknames

- **Keep it Jargon-Free** - Lists suggestions for regulating the use of acronyms/abbreviations at the bottom of the page.
  
Development of forms

- *Simple Words and Phrases*- Word suggestions- much of this is the type of language that would be used in forms [http://www.plainlanguage.gov/howto/wordsuggestions/simplewords.cfm](http://www.plainlanguage.gov/howto/wordsuggestions/simplewords.cfm)

Training Resources


The resources listed above provide basic guidance for the use of health literacy guidelines in your health plan. If you are looking for more in depth, additional, or specific information, there is a comprehensive guide to available resources on Health Literacy available for download at [https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthliteracytoolkit.pdf](https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthliteracytoolkit.pdf)
Checklist for Creating Easy-to-Read and Easy-to-Understand Communications

Planning the Communication

- Know your audience
- Know your objectives
- Limit content to what’s needed
- Focus on the reader, not on HealthPartners
- Focus on what the person must do
- Always let the reader know how to get more information

Writing Style – Make it Easy to Understand

- Write the way you would tell it to someone (use living room language)
- Write to the person, not about the person (use “you” and “we”)
- Use short words rather than longer ones when possible
- Use short sentences (10-15 words) with one idea in each
- Use active voice when possible
- Use medical, technical and industry terms and jargon sparingly (define if used)
- Avoid acronyms (spell out if must use)
- Avoid elements like “i.e.” “e.g.” “<” “>”
- Keep it simple and friendly
- Avoid using long names for staff positions and phone lines (for example Obesity Patient Counseling Nurse)

Format – Make it Look Easy to Read

- Use serif font for body copy (Times New Roman)
- Can use sans serif font (such as Arial) for heads, subheads, etc.
- Use 12-point font
- Use upper and lower case text
- Be strategic with using bold type – don’t overdo it
- Break content into chunks – don’t use large blocks of copy
- Use bulleted lists when possible
- Provide “road signs” to help people navigate the document (headings, font style, color, etc.)
- Use plenty of white space
- Provide sharp contrast – text should be dark; background white or very light
- Set up flush left – don’t justify type (don’t make it fill the line left to right)

Review your work

- Read it out loud
- Ask someone who’s not close to your subject to read it and make suggestions to clarify
- Check the reading level (aim for 7th grade or lower).

Visuals (illustrations, photos, charts, diagrams)

- Only use visuals to help readers understand the message, not just be decorative
- Charts should be very simple and limited to what readers need to know
- Clearly label all parts of a chart or graph
**My Medicine List**
Fold this form and keep it with you

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date of Birth:</th>
<th>Allergic To: <em>(Describe reaction)</em></th>
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<tr>
<td>Emergency Contact/Phone numbers:</td>
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<td>Doctor(s):</td>
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<tr>
<td>Pharmacies, other sources:</td>
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**Immunization Record** *(Record the date/year of last dose taken)*

<table>
<thead>
<tr>
<th>Flu vaccine(s):</th>
<th>Pneumonia vaccine:</th>
<th>Tetanus:</th>
<th>Hepatitis vaccine:</th>
<th>Other:</th>
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List all medicines you are currently taking. Include prescriptions (examples: pills, inhalers, creams, shots), over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, gingko). Include medications taken as needed (example: nitroglycerin, inhalers).

<table>
<thead>
<tr>
<th>START DATE</th>
<th>NAME OF MEDICATION</th>
<th>DOSE</th>
<th>DIRECTIONS <em>(How do you take it? When? How often?)</em></th>
<th>DATE STOPPED</th>
<th>NOTES <em>(Reason for taking?)</em></th>
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Directions for My Medicine List

1. ALWAYS KEEP THIS FORM WITH YOU. You may want to fold it and keep it in your wallet along with your driver’s license. Then it will be available in case of an emergency.

2. Write down all of the medicines you are taking and list all of your allergies. Add information on medicines taken in clinics, hospitals and other health care settings — as well as at home.

3. Take this form with you on all visits to your doctor, clinic, pharmacy and hospital.

4. WRITE DOWN ALL CHANGES MADE TO YOUR MEDICINES on this form. When you stop taking a certain medicine, write the date it was stopped. If help is needed, ask your doctor, nurse, pharmacist, or family member to help you keep it up-to-date.

5. In the “Notes” column, write down why you are taking the medicine (Examples: high blood pressure, high blood sugar, high cholesterol).

6. When you are discharged from the hospital, someone will talk with you about which medicines to take and which medicines to stop taking. Since many changes are often made after a hospital stay, a new list may be filled out. When you return to your doctor, take your list with you. This will keep everyone up-to-date on your medicines.

How does this form help you?

- This form helps you and your family members remember all of the medicines you are taking.

- It provides your doctors and other providers with a current list of ALL of your medicines. They need to know the herbals, vitamins, and over-the-counter medicines you take!

- With this information, doctors and other providers can prevent potential health problems, triggered by how different medicines interact.

For copies of the My Medicine List and a brochure with more tips, visit the Minnesota Alliance for Patient Safety’s Web site at www.mnpatientsafety.org or call (651) 641-1121.
SAMPLE POLICY

Policy for Pill Box Distribution

Purpose: Increase compliance with prescribed therapeutic regime and reduce the potential for medication errors by distribution of medication boxes to those patients determine to be high risk.

Definition: A person considered being high risk if two or more of the following conditions are identified or present:

- Greater than 5 prescriptions.
- Greater than 12 doses of medications per day.
- Four or more medication changes in the past 12 months.
- More than 3 concurrent disease states.
- On a medication that requires therapeutic monitoring (narrow therapeutic index).
- History of non-compliance.

Policy:

After evaluation by a physician, pharmacist, or nurse, those patients meeting the above criteria of high risk will be offered a medication box to aid in the correct administration of their medications.

Education of the proper use of the medication box will be provided for the patient/surrogate/or designated person by the physician, pharmacy, or nurse.

The person providing the medication box should note this either in the discharge note or on the patient profile at the pharmacy.

The patient or the patients surrogate will need to designate the person responsible for filling and monitoring the medication boxes.

It is the patient or the patients’ surrogate responsibility to monitor the status of medication refills and notify the patient’s attending physician when refills are needed.
Medication Therapy Management (MTM) services help address this urgent public need for the prevention of medication-related morbidity and mortality. This service can enhance patients’ understanding of appropriate drug use, increase adherence to their medication therapy, and empower patients to take an active role in management of their medications and health care.

MTM services are currently being delivered in both the public and private sectors. In the public sector, some state Medicaid programs and Medicare D plans are utilizing MTM services. For Medicare Part D, the Centers for Medicare and Medicaid Services (CMS) have mandated that any patient that has $4,000 per year in actual or anticipated drug expense is eligible for MTM services. State Medicaid programs vary widely in eligibility criteria, but generally a patient must have at least two chronic disease states and be on at least four or more medications to receive these services. In the private sector, MTM programs are beginning to emerge and are providing services for traditional insured organizations, self-insured employers, managed-care groups, and self-paying individual patients nationwide. Retail pharmacy organizations are developing capabilities for MTM in anticipation of patient needs and payer requirements.

What is Medication Therapy Management (MTM)?
Medication Therapy Management is a standards driven service. It is a patient-centered service encompassing an assessment of the patient’s medication-related needs, the development of a care plan to meet these needs and follow-up evaluations in order to optimize outcomes. Drug therapy problems are identified, resolved and prevented with the patient and the patient’s care providers. This service is designed to facilitate collaboration and enhance communication between the pharmacist, patient, physician, and other healthcare workers to promote safe and effective medication use by the patient.

The pharmacist or qualified provider takes a complete medication history, gathers patient-specific information about the patient’s medical conditions, and assesses the medication therapies to determine if there are problems. This assessment can help determine if any of the medications are inappropriate, ineffective, unsafe or inconvenient for the patient to take as intended. Interventions may include working with the patient or
collaborating with physicians or other healthcare workers to resolve the problem. When drug therapy problems are identified, they can be resolved by changing products, doses, or educating the patient on how to maximize the effectiveness of the medication. MTM services are provided to the patient in a private or semiprivate area, as required by the Health Insurance Portability and Accountability Act (HIPAA), and in accordance with evidenced-based guidelines.²

Which patients may benefit from MTM services?
All patients who are taking medications or should be taking medications can benefit from MTM services. Patients taking multiple prescription and nonprescription medications, patients who may be experiencing a drug therapy problem, regardless of the disease-state, all benefit from MTM services. Patients who may be having difficulties taking their medications, patients who are taking medications that need close evaluation (for example, warfarin, phenytoin, methotrexate), or patients who are receiving care from more than one prescriber, can all benefit from this service.

Patients with chronic conditions requiring them to take complex regimens throughout the day can benefit from these services. Some of the medical conditions which are most commonly associated with non-adherence include diabetes (27%), hypertension (15%), hyperlipidemia (14%), osteoporosis (12%), and depression (6%). Other conditions include gastroesophageal reflux disease, (GERD), asthma, allergic rhinitis, generalized pain, and COPD/emphysema. The most frequent causes of patients being unwilling or unable to take their medications as intended are that the patient: 1) cannot afford to purchase the medications or make the co-payment; 2) did not understand the instructions for use; 3) has a significant number of co-morbidities and is taking a large number of medications.³

Patients with a potential need for MTM services can be identified by pharmacists, physicians, nurse practitioners, case managers or other healthcare workers, and even by the patients themselves, when medication-related problems are identified or suspected. For example, case managers work closely with patients that have chronic conditions and diseases to counsel and teach about their specific diagnoses and medication regimen. They develop care plans and goals with the patient that encourage active participation in their care. They collaborate with the patient providers and other healthcare workers to promote adherence to the plan of treatment and medications. Case managers can help with early identification of patients who can benefit from MTM services, including those patients who continue to demonstrate non-adherence, or continue to have medication-related problems, despite the teaching and efforts of the case manager.

Health plans and provider systems can use triggers such as diagnoses, number of prescriptions, or financial expenditures to identify patients out of larger populations that could benefit from these services.

Examples of the benefits of MTM services
The literature supports the patient benefits of MTM services when provided in a comprehensive and systematic
manner. In one study, qualified pharmacists provided MTM services for eleven months to 1122 diabetic patients in ambulatory practice settings. The majority of the practices were clinic-based and the services were provided in close proximity to, and in collaboration with, the prescribing physician. The patients saw the pharmacist an average of 2.5 visits in a year for MTM services. They were being treated for an average of eight medical conditions including hyperlipidemia, hypertension, depression, osteoporosis, pain, GERD, and medication therapy for stroke or myocardial infarction, in addition to their diabetes treatment. The average number of medications being taken by these patients was 13.

Seventy-seven percent (77%) experienced one or more drug therapy problems, 39 percent had three or more and 17 percent had five or more drug therapy problems identified and resolved during the study period.

The drug therapy problems were resolved by evaluating each medication for appropriateness, effectiveness, and safety. When these issues were resolved, the patients were more willing and able to take their medications, thus improving adherence to their medications. For this group of patients, a return on investment (ROI) of approximately 3:1 was achieved. For every dollar invested in providing MTM services three dollars was saved.

The Minnesota State Medicaid Program recently reported that pharmacists providing MTM services to Medicaid patients improved diabetes quality indicators six-fold over statewide averages.

A federal study which included about 160 ambulatory patients over the age of 65, who were prescribed at least four medications daily, also demonstrated the value of MTM services. Pharmacists provided education regarding their medications, and performed assessments of adherence and refills. Researchers found that after six months in an MTM program, medication adherence increased in these patients (from 61.2 percent to 96.9 percent), resulting in clinically significant improvements in blood pressure and LDL levels.

MTM services are demonstrating positive clinical and economic healthcare outcomes. Reductions in emergency room visits, hospital days, physician visits and overall healthcare costs have resulted from pharmacists providing MTM services in various settings.

Summary
To prevent medication-related problems, The Institute of Medicine advocates that healthcare should be safe, effective, patient-centered, and patients should be active participants in the healthcare process. Pharmacists, practitioners, nurse case managers and other healthcare workers can partner to ensure that patients are educated and informed healthcare consumers, and are aware of the tools and resources available to promote safe medication practices and reduce risk. Because medications play a major role in over 80 percent of treatments, improving their effectiveness and safety may be the largest opportunity to improve care.

MTM services can improve clinical outcomes, medication safety and adherence, and reduce healthcare expenditures. Patients who receive MTM services achieve their goals of therapy fifty-two percent (52%) more often than when they do not. They are on fewer unnecessary medications, have fewer adverse reactions, and experience less toxicity when they receive these services, avoiding costly treatment failures. These services also help patients use more affordable medications and be more compliant. When patients with numerous medications are well managed, they will achieve better therapeutic outcomes, compliance, and ownership of their healthcare.

Linda M. Strand, Pharm. D., Ph.D. is a Distinguished Professor in the College of Pharmacy, at the University of Minnesota.

Sources:

Because medications play a major role in over 80 percent of treatments, improving their effectiveness and safety may be the largest opportunity to improve care.
# Pill Card Template

<table>
<thead>
<tr>
<th>Name</th>
<th>Used For</th>
<th>Instructions</th>
<th>Morning</th>
<th>Afternoon</th>
<th>Evening</th>
<th>Night</th>
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AHRQ Publication No. 08-M016
February 2008
Elderly Drivers
Is your loved one driving safely?

Are elderly drivers safe? Yes ... for the most part. The same can be said for teen drivers.

Do driving skills of decline with age? Yes, but just like other age groups, driving skills vary from one person to another. Telling elderly drivers that it may be time to stop driving can be one of the most difficult milestones for caregivers. Driving represents freedom and independence for the elderly ... the ability to visit friends, go to the movies and shop ... without relying on anyone else.

Revoking an elderly person’s drivers license over a certain age is not an acceptable solution. Driving skills vary widely at all ages. It is unfair to punish most elderly drivers for problems caused by only a few drivers.

When the question of declining driving abilities becomes personal, the issues involved become very emotional. Elderly drivers might get defensive ... even angry ... when the subject of their driving abilities is raised. Thus, include the elderly person in the decision-making process if at all possible, rather than dictate a decision to them. It can also be very helpful if both you and your loved one discuss the matter together with other family members, doctors, and other people they respect, such as clergy and friends. But, despite your best efforts, you may still have to make the decision to stop for them for their own safety ... and the safety of other drivers and pedestrians.

How does aging affect the abilities of elderly drivers?

Safe elderly drivers require the complex coordination of many different skills. The physical and mental changes that accompany aging can diminish the abilities of elderly drivers. These include:

- A slowdown in response time
- A loss of clarity in vision and hearing
- A loss of muscle strength and flexibility
- Drowsiness due to medications
- A reduction in the ability to focus or concentrate
- Lower tolerance for alcohol

Taken separately, none of these changes automatically means that elderly drivers should stop. But caregivers need to regularly evaluate the elderly person’s driving skills to determine if they need to alter driving habits or stop driving altogether.

A checklist on safe elderly driving

Watch for telltale signs of decline in the elderly person’s driving abilities. Do they:

- Yes  No Drive at inappropriate speeds, either too fast or too slow?
- Yes  No Ask passengers to help check if it is clear to pass or turn?
- Yes  No Respond slowly to or not notice pedestrians, bicyclists and other drivers?
- Yes  No Ignore, disobey or misinterpret street signs and traffic lights?
- Yes  No Fail to yield to other cars or pedestrians who have the right-of-way?
- Yes  No Fail to judge distances between cars correctly?
Become easily frustrated and angry?
- Yes - No

Appear drowsy, confused or frightened?
- Yes - No

Have one or more near accidents or near misses?
- Yes - No

Drift across lane markings or bump into curbs?
- Yes - No

Forget to turn on headlights after dusk?
- Yes - No

Have difficulty with glare from oncoming headlights, streetlights, or other bright or shiny objects, especially at dawn, dusk and at night?
- Yes - No

Have difficulty turning their head, neck, shoulders or body while driving or parking?
- Yes - No

Ignore signs of mechanical problems, including underinflated tires? (one in 4 cars has at least one tire that is underinflated by 8 pounds or more; low tire pressure is a major cause of accidents.)
- Yes - No

Have too little strength to turn the wheel quickly in an emergency such as a tire failure, a child darting into traffic, etc.?
- Yes - No

Get lost repeatedly, even in familiar areas?
- Yes - No

If the answer to one or more of these questions is “Yes,” you should explore whether medical issues are affecting their driving skills.

Medical issues to consider

Caregivers need to know if the elderly person:

- Yes - No  Has had their vision and hearing tested recently?

- Yes - No  Has had a physical examination within the past year to test reflexes and make sure they don’t have illnesses that would impact their driving?

- Yes - No  Is taking medications or combinations of medications that might make them drowsy or confused while driving?

- Yes - No  Has reduced or eliminated their intake of alcohol to compensate for lower tolerance?

- Yes - No  Has difficulty climbing a flight of stairs or walking more than one block?

- Yes - No  Has fallen - not counting a trip or stumble - once or more in the last year?

- Yes - No  Has had a physician told them that they should stop driving?

Adapting to change

Driving is not necessarily an all-or-nothing activity. Some programs exist to help elderly drivers adjust their driving to changes in their physical condition:

AARP (the American Association of Retired Persons) sponsors a Driver Safety Program, which helps older people deal with issues such as how to compensate for vision problems associated with aging. And, the Association for Driver Rehabilitation offers referrals to specialists who teach people with disabilities, including those associated with aging, how to improve their driving.

There are many ways for elderly drivers to adjust so they are not a danger to themselves or others. Among them are:
- Avoid driving at night and, if possible, at dawn or dusk
- Drive only to familiar locations
- Avoid driving to places far away from home
- Avoid expressways (freeways) and rush hour traffic
- Leave plenty of time to get where they are going
- Don’t drive alone

**Other forms of transportation**

Encourage your loved one to rely more on public transportation. This will reduce their time behind the wheel and help prepare them for the day when they can no longer drive. Many cities offer special discounts for seniors on buses and trains, and senior centers and community service agencies often provide special transportation alternatives.

**How to get them to stop**

If you feel strongly that your parent cannot drive safely, you have little choice but to get them to stop driving. If they agree without an argument, wonderful. If not, you have several options:

- **Stage an intervention.** This approach, commonly used with substance abusers, involves confronting the elderly driver as a group of concerned caregivers. The group should include family members, health care workers and anyone else respected by the senior. The intervention needs to be handled firmly but with compassion in order to break through the senior’s denial of the issue.

- **Contact the local Department of Motor Vehicles and report your concerns.** Depending upon state regulations and your senior’s disabilities, it may be illegal for them to continue to drive. The DMV may do nothing more than send a letter, but this might help convince your parent or loved one to stop.

- **Take the keys, disable the car or move it to a location beyond the elderly person’s control.** Leave the headlights on all night or disconnect the battery to disable the car. But if your loved one is likely to call AAA or a mechanic, you have no choice but to eliminate all access to the car. While this may seem extreme, it can save the lives of seniors, other drivers and pedestrians.

**Related resources**

AARP offers the highly recommended Driver Safety Program for older people. To find a class near you, visit the AARP Web site at www.aarp.org/drive/home.html, call toll-free at 1-888-227-7669, or write to them at 601 E Street NW, Washington, DC 20049.

The Association for Driver Rehabilitation offers referrals to professionals trained to help people with disabilities, including those associated with aging. Visit their Web site at www.driver-ed.org and click on “Directory” in the left hand menu, or contact them at: P.O. Box 49, Edgerton, Wisconsin 53534, 1-608-884-8833.

The USAA Educational Foundation, AARP, and the National Highway Traffic Safety Administration developed a very informative booklet, “Driving Safely While Aging Gracefully.” (To view it online, visit their Web site at www.nhtsa.dot.gov/people/injury/olddrive/booklet.html.) It describes many of the physical changes associated with aging, and includes tips on coping with them so that older people can remain safe drivers.
Fall Prevention
Home Safety Checklist

What YOU Can Do To Prevent Falls
Falls are a serious public health problem among older adults. In the United States, one of every three seniors over 65 years fall each year, and falls are the leading cause of injury death for seniors 65 and over. Simply making changes to the home does not reduce falls. However, certain risk factors in the home environment may contribute to about half of all home falls. Homes that were perfectly convenient one year can cause problems in later years. Changing physical abilities can make daily routines more difficult. It makes sense, then, to make changes to existing homes, or build in features in new construction that will help create a safer environment.

For specific recommendations to prevent falls, complete the Fall Prevention Checklist for every room in your house.

**Entrance**

**Do you have tile or linoleum floors at your front or back doors?**

Yes: Whenever you’re moving from one kind of floor surface to another, the change in surface texture can put you at risk for falls. (Especially if it’s raining or snowing outside and your feet bring some of that moisture inside to a slick surface.) Have solid, non-stick areas inside any entrance to help secure footing.

**Do you have a small deck landing (less than 5’ square) at the front or back entrance?**

Yes: Small landings can cause awkward turns to make room for an outward swinging door. This is a fall risk. You want to have enough room to the side of your door to avoid the door swing. Add to your deck or remount the door to minimize this kind of clumsy entrance.

**Bathroom**

**Is the path from the bedroom to the bathroom dark?**

Yes: Install nightlights along the hallway—even every outlet. Let them light your way.

**Do you use towel racks for balance or to grab onto while getting in or out of the bathtub/shower?**

Yes: Towel racks may not be mounted well enough to support a person's weight. Install grab rails next to and inside the tub and next to the toilet. Sometimes a bathroom wall needs to be reinforced to make sure the grab rails can support a person's weight. If you’re planning a bathroom redo, consider the convenience of a walk-in shower.

**Is it difficult to stand during a shower?**

Yes: A shower seat allows you to shower without getting tired or risking a fall because of dizziness. It can also eliminate bending to wash feet or shave legs.
Bathroom (continued)

No: Sometimes the heat and humidity in the shower can make you light headed unexpectedly. Or an occasional virus might leave you temporarily weak. You may still want to consider a shower seat or grab bars in the shower for extra security.

Is the shower floor or bathtub slippery? Is there water on the floor? Are there leaks from the tub or shower? □ YES □ NO

Yes: Install non-skid strips or a non-slip mat. Patch leaks with caulk or other appropriate material. Wipe up spills immediately. Get a plumber to check fixtures and seals.

Is it necessary to reach far or turn around to get towels, shampoo, and soap? □ YES □ NO

Yes: A shower/bath storage unit that attaches to the side of the tub or shower wall can reduce the need to reach or turn around to get things. You may find that liquid soap in a dispenser is more convenient. Fishing for that slippery bar of soap that fell in the tub can be dangerous.

Is it difficult to get on and off the toilet? □ YES □ NO

Yes: It may be helpful to raise the seat and/or install handrails.

Kitchen

What’s cooking in the kitchen? Don’t let it be a fall! But if you’re preparing meals or cleaning up, you might be doing several things at once. Slow down! Move deliberately. Take an extra trip rather than load up your arms. Wipe up any spills you might step in. Close cabinets and drawers when you’re not using them.

Are the things you use often on high shelves? □ YES □ NO

Yes: Move items around in your cupboards. Keep things you use often on the lower shelves (about waist high). Do not put heavy items on shelves where you have to reach up. Installing sliding shelves or lazy susans in corner cupboards can help you make your most convenient shelves hold more of what you use the most.

Is your step stool unsteady? □ YES □ NO

Yes: Get a new, steady step stool with a bracing bar to hold on to. Most of them fold up for easy storage, and have sturdy, non-skid steps and legs that grip the floor to help keep you steady. Retire the old one. An old step stool is not an heirloom, it’s a safety hazard!

Do you use chairs, boxes or makeshift items to reach high shelves? □ YES □ NO

Yes: Get a new sturdy step stool.

Is it necessary to reach far or bend over to get commonly used items and foods? □ YES □ NO

Yes: Rearrange cupboards. Put items you use every day in your most convenient cupboard.
Is there liquid, food or grease or other clutter on the floor?  
Yes: Sweep often and wipe up spilled liquids immediately to reduce the chances of slipping.

Bedroom

You’re tired. You’re getting ready for bed, or perhaps you’ve just gotten up. You’re not wearing your glasses. It’s dark. Make sure your bedroom is an oasis of safety—not an obstacle course.

Is there a long reach from the bed to a light switch?  
Yes: It’s good to have a light switch within easy reach of where you sleep. Move the lamp closer to the bed or attach a small lamp to the headboard to reduce the risk of falling—either from over reaching or from moving about in the dark.

Do you need to get out of bed or reach far to answer the telephone?  
Yes: A longer phone extension cord can help bring the phone closer to the bed. Even better, a cordless phone within easy reach of the bed means you can just move the handset close to the bed.

Cords are a tripping hazard. Reroute cords so they don’t cross where you walk. That might mean getting a longer extension cord so it can travel along a wall instead of across the room. Or consider getting an electrician to install additional outlets.

Don’t fasten cords to the wall with staples or nails. Use tape designed for this purpose.

Is there clutter (clothes, shoes, newspapers, books, etc.) on the floor?  
Yes: Pick-up clutter from walkways to reduce the chances of tripping. Do you have to reach up to pull cords to lights or ceiling fans? Have a phone close to the floor in order to call for help in the event of a fall.

Do you need to wear glasses to see?  
Yes: Make sure you put your eyeglasses within easy reach.

Are there telephone, light or television cords running along the floor or the walkways?  
Yes: Install longer cords or link ceiling lights/fans to a light switch on the wall to eliminate the need to look and reach up.

Do you get up many times during the night to use the bathroom?  
Yes: Place a portable commode near the bed to eliminate nighttime trips to the bathroom.
**Living Areas**

Do you have to walk around furniture to walk through a room?

**Yes:** It’s best to have a straight path through any and every room. Consider rearranging the furniture to clear a path and provide an obstacle-free walk. It might even mean having less furniture in a room. It will look bigger, and be safer!

Do carpets, rugs or floor coverings have frayed corners or rolled-up edges?

**Yes:** Remove damaged floor coverings or secure them well with double-sided tape, or nails. It is important to have a flat, sturdy walkway.

Do you have throw rugs or runners in walkways?

**Yes:** It is best to throw away the throw rugs. They can slip easily and cause a fall. Or you could try double-sided tape on them so they do not slip. If you use double-sided tape, get special purpose carpet tape and check it regularly to make sure it is holding all edges of the rug securely.

Some throw rugs have rubber or non-skid backing. Check them regularly—sometimes the backing comes off after frequent laundering.

Are chairs and couches low to the ground?

**Yes:** Higher chairs and armrests are helpful for easing into a sitting position. Sometimes adding a throw pillow on the cushion can help.

**Stairs and Steps**

Even if you are very familiar with the stairs, lighting is an important factor. You should be able to turn on the lights before you use the stairway from either end. Don’t carry loads that block your vision. Instead, make several trips with smaller loads.

Are papers, shoes, books or other objects on the stairs?

**Yes:** Always keep objects off the stairs. It’s easy to ignore loose items on the steps and lose your footing. An extra kitchen chair can be placed near a stairway to collect things that are heading to another floor—just make sure the chair is not blocking a walkway.

Do you walk around the house in slippers or socks?

**Yes:** Try to avoid wearing socks or smooth-soled shoes or slippers, especially on the stairs.

Are some steps broken or uneven?

**Yes:** Fix loose or uneven steps. Even a small difference in step surfaces or riser heights can lead to falls. Wooden steps off your porch or deck outside can rot or weaken over time and may need to be replaced. Stair treads should be deep enough for your whole foot—at least 8 inches, but 10 to 11 is better. A stair rise should be no higher than 7 inches from one step to the next; a smaller rise is even better.
Are you missing a light over the stairway?
Yes: Have a handyman or an electrician put in an overhead light at the top and bottom of the stairs.

Has the stairway light bulb burned out?
Yes: Have a friend or family member change the light bulb. Use newer style bulbs that have longer life than traditional bulbs.

Do you only have one light switch for your stairs (only at the top or at the bottom of the stairs)? Or do the switches at the top AND the bottom of the stairs both have to be on for the light to work?
Yes: Have a handyman or an electrician put in an independent light switch at the top and bottom of the stairs. Light switches that glow can help.

Are the handrails loose or broken? Is there a handrail on only one side of the stairs?
Fix loose handrails or put in new ones. Make sure that the handrail is secured into the studs in the wall—you may need to hire a handyman to help. Make sure handrails are on both sides of the stairs and are at least as long as the stairs.

Is the carpet on the steps loose or torn?
Yes: Make sure the carpet is firmly attached to every step or remove the carpet and attach non-slip rubber treads on the stairs.

Outside
Are outdoor steps slippery, depending on the weather and time of year?
Yes. Paint outside steps with a paint that has a rough texture, or use abrasive strips.

Is the path from your garage to your door dark or poorly lit?
Yes: Installing a path of lights or overhead light will help reduce the chance of falling. Sensor lights (“motion lights”) mounted on the house or garage are helpful too, because they turn on and off automatically. You can’t avoid what you can’t see.

Are there hoses, weeds or other obstacles on your sidewalks?
Yes: Remove clutter and keep walkways weeded to eliminate tripping hazards.
Are your steps or walkways icy?  
Yes: Shovel immediately after a storm and/or apply salt or sand on ice to reduce the chance of slipping.

Are hallways and passageways between rooms darker than the other rooms in your house?  
Yes: Use the maximum wattage bulb allowed by the hall fixture. If you do not know the correct wattage, use a 60-watt bulb. Consider adding more lamps or light fixtures in dark hallways. You don’t want lighting to produce glare or shadows. If this is a problem, try frosted bulbs, indirect lighting, or lampshades.

Have you fallen before? Were you injured when you fell?  
Yes: People who have fallen before are more likely to fall again. Think about the factors that led to your last fall. Take action to reduce those factors. Consider using a personal emergency response service (such as LifeLine) to help you if you fall again.

Have you stopped doing any daily activities because you are afraid of falling? Do you avoid exercise because you are afraid of falling?  
Yes: Fear of falling can be helpful if it causes you to take reasonable precautions, but it can be harmful when it causes you to avoid exercise and other daily activities that keep you active, strong and healthy. Start slowly to build your confidence in exercise and daily activities. Start with chair exercises, then move to standing exercises, and then moving exercises. If you are afraid of exercising alone, consider joining a group or class.

Has your hand strength decreased?  
Yes: Decreased hand strength can put you at greater risk for falling because you may have difficulty catching yourself or carrying objects safely. Avoid carrying things in your hands when walking. Put them in a pocket or purse instead. You may benefit from strength training for your hands. Talk to your health care provider about recommended exercises.

Has your eyesight diminished? Do you have trouble seeing depth or seeing at night?  
Yes: Problems with eyesight can make it difficult to see things you can trip over. Get your eyes tested by an optometrist or an ophthalmologist to see if you need glasses or a new prescription. Place nightlights throughout your house. For depth of field problems, place tape or paint a line at the edge of stairs so you can see the edge when walking.
Personal Risk Factors (continued)

Have you experienced hearing loss?

Yes: Hearing is closely associated with balance. Get your hearing tested by your health care provider or by an audiologist. Wear a hearing aid as needed.

Do you have foot ulcers, bunions, hammer toes or calluses that hurt or cause you to adjust your steps?

Yes: Painful foot problems can cause you to walk slowly and differently, increasing your chance of falling. If you have reduced feeling in your feet, make sure to watch your step and be aware of foot placement. Attend a foot care clinic or ask your doctor to treat your feet problems. A strong stride and good balance are key to preventing falls. Consider using a cane or other assistive devise to help you feel steadier. Your doctor can help you decide which device is best for you. Carry a cordless phone with you so you don't have to rush to answer the phone and so you can call for help if you do have a fall. You can also ask your doctor to give you a balance assessment or recommend physical therapy.

Do you feel unsteady on your feet? Do you shuffle when you walk?

Yes: Arm and leg weakness can make it harder for you to navigate your environment. You can build muscle strength by exercising regularly. Join an exercise class or learn exercises that you can do at home.

Do you feel weaker than you used to? Do you have less strength in your arms and legs?

Yes: Arm and leg weakness can make it harder for you to navigate your environment. You can build muscle strength by exercising regularly. Join an exercise class or learn exercises that you can do at home.

Do you experience incontinence?

Yes: Incontinence can increase your chances of falling if you are anxious and rush to get to the bathroom. Check with your doctor about incontinence treatments. If nighttime incontinence is an issue, consider getting a bedside commode. Make sure the path to your bathroom is well lit and free from clutter.

Do you feel dizzy when you stand up?

Yes: Dizziness increases your chance of falling because it causes disorientation and even fainting. Dizziness can have many causes so you should ask your doctor to test you for postural hypotension (decreased blood pressure). Take time to stabilize yourself before changing positions.
Personal Risk Factors (continued)

Do you take four or more medications? Do you take high blood pressure medications?  □ YES □ NO

Yes: Certain medications can increase your chance of falling because of side effects such as dizziness, confusion and low blood pressure. Have your doctor or pharmacist review all of your medications and dosages. Make sure you understand the medications you are on and how to take them correctly.

Do you take sleeping pills regularly?  □ YES □ NO

Yes: Sleeping pills can cause dizziness, confusion and a “hang-over” feeling that increase your chance of falling. Meet with your doctor to discuss sleeping tips. Avoid drinking alcohol while taking sleeping pills.

Do you ever wear high heels?  □ YES □ NO

Yes: High heels are more likely to get caught in the carpet and in holes. They are also unsteady. Well-fitting shoes with low, flat, and wide heels provide the sturdiest footing.

Do your clothes (dresses, robes, etc) have long cords or ties?  □ YES □ NO

Yes: Shorten ties and cords to prevent tripping on them.

Do you ever wear socks only? Or slippers without rubber soles?  □ YES □ NO

Yes: Shoes should also have non-skid soles. Slippers and socks with rubber tread bottoms are more likely to prevent slipping.

Do you wear athletic shoes?  □ YES □ NO

Yes: Avoid wearing athletic shoes with large soles and deep treads in the soles.

Who Can Help?

Do you have questions about fall prevention in your home? Do you know where to turn for information about improving your health and safety?

Check with your doctor or HMO, and your city or county public health department. On the Web, look up:

Minnesota Safety Council (interactive fall prevention checklist) at http://www.mnsafetycouncil.org/seniorsafe/falls/
“Fall Prevention Home Safety Checklist” (PDF) at http://www.mnsafetycouncil.org/seniorsafe/fallcheck.pdf


“The Practical Guide to Universal Home Design” at Minnesota Housing Finance Agency (info on home accessibility remodeling design and funding) at http://mhfa.state.mn.us/accessibility
Sources:
Senior Fall Prevention Task Force, Hennepin County Community Health Department, “Fall Prevention Home Safety Checklist” from Senior Fall Prevention Screening Kit: Identifying fall risk factors in older adults
Minnesota Safety Council
Consumer Product Safety Commission
Centers for Disease Control
East Metro SAIL (Seniors Agenda for Independent Living)
I. **PURPOSE**  
To define a process for the control, accountability, security and safety of pharmaceutical samples throughout the HealthPartners organization.

II. **POLICY**  
Individual clinics or care units wishing to continue or initiate storage and distribution of prescription pharmaceutical samples must apply to the HPMG Pharmacy Committee for pharmaceutical sampling privileges. Applications will include a detailed written plan for compliance with the procedures outlined below. Applications will be reviewed upon initial request and approved or denied by the Pharmacy Committee. The Chief of Professional Services or Department Head will be responsible for the implementation and compliance of the Pharmaceutical Sampling Policy for his/her clinic and/or department.

The management of pharmaceutical samples will adhere to this policy and be compliant to laws, regulations and standards (eg. Joint Commission, Board of Pharmacy and FDA) regarding the storage, prescribing, dispensing and documentation of prescription pharmaceuticals and will be consistent with other organization policies and procedures for medication use.

This policy does not pertain to NON-prescription pharmaceutical items.

III. **PROCEDURE(S)**  
A. For approval of the approval of sampling of prescription pharmaceuticals complete the application requesting the use of pharmaceutical samples, including the elements listed below.
   1. The designated requesting physician and chief or department head.
   2. Clinic location.
3. Purpose for providing pharmaceutical samples. Include how the proposed pharmaceutical sampling practice will satisfy the following principles for drug dispensing/distribution:
   i. **Safety**—the use of pharmaceutical services/agents within our systems will not pose a threat to our patients/members.
   ii. **Effective**—patients/members will receive the most appropriate pharmaceutical interventions, avoiding underuse and overuse.
   iii. **Equitable**—pharmaceutical services/agents will be consistent and fair to all patients/members. Individual personal characteristics will only guide pursuit of optimal outcomes.
   iv. **Patient Centered**—pharmaceutical services/agents will be respectful of individual patient/member needs, preferences and values.
   v. **Timely**—the delivery of pharmaceutical services/agents will eliminate unnecessary waits and harmful delays to both patients/members and providers.
   vi. **Efficiency**—pharmaceutical services/agents will be guided by wise stewardship of resources, avoiding waste and inefficiencies.

4. A designated coordinator who is responsible for oversight of the sample inventory and compliance with this policy.

5. A list of prescription pharmaceuticals that will be maintained in the sample inventory.

6. A specific location where:
   i. Samples can be securely stored with access limited to authorized staff,
   ii. Storage conditions such as temperature, light and moisture according to manufacturer recommendations.
   iii. Samples are organized so as to reduce the risk of a dispensing error. This includes the requirement of samples to be within the expiration date.
   iv. Cytotoxic agents are stored separately from other medications, if applicable.

7. Identity of individuals or staff roles authorized to access, prescribe and dispense sample prescription pharmaceuticals.

8. Log of all prescription pharmaceuticals signed into the sample inventory with lot numbers and expiration dates.

9. Clear process to identify outdated, damaged, discontinued and recalled medications and remove from the sample inventory. (removal from inventory must be documented on the inventory log)

10. Clear pharmaceutical waste disposal plan that prevents unusable medications from being dispensed and properly disposes of sample medications as hazardous waste (black bins).

11. A clear dispensing process that outlines who is authorized to prescribe and dispense samples, the labeling of samples, any information that will be provided to patients, and appropriate documentation in the patient’s medical record (in the Active Medication List).
   i. A medication for sampling, can be appropriately entered into the “Active Medication List” of Epic, without generating a prescription, by the following process:
      1. Go to the “Order Entry” tab of Epic
      2. Enter the prescription information as normal
      3. In the “Class” section of “Order Entry”, click “No Print/No Fill” button.

12. Log the pharmaceutical sample that was dispensed to the patient in the inventory log, including patient information, medication name and lot number.

13. A process to monitor patients for the effects of the dispensed sample medication, and how to respond to adverse drug events/reactions and medication errors.

14. A monthly audit process to monitor compliance with this policy and ensure quality control of samples. Each month will require that sample inventories are verified and ensure that samples are not expired.

15. Communication plan to notify all staff of sample policy, procedures and expectations.

B. Send completed request/application to the Chair of the HPMG Pharmacy Committee.
C. Any additions/deletions/changes to the Sample List must be provided to the Pharmacy Committee at least yearly. Normally this can be communicated at the time of the “Annual Sampling Audit”. Additions for sample drugs utilized must be approved in advance by the Pharmacy Committee.

D. Attestations and audits must be resubmitted annually.

E. Clinics who sample agree to participate and respond to the annual sampling audit as distributed by the Pharmacy Committee.

F. Documentation must exist that samples were provided to patients. Documentation of the patient should be listed in the inventory log or dispensing log as well as in the medical record.
   1. Samples will be logged out of the sampling inventory if inventory is removed or destroyed.
   2. All dispensed pharmaceutical samples will be documented in the sampling log.
   3. All pharmaceutical samples dispensed to the patient must be documented in the patient medication record (Epic).
   4. All sampling logs will be kept on site for a minimum of 2 years.

IV. DEFINITIONS  n/a

V. COMPLIANCE
Failure to comply with this policy or the procedures may result in disciplinary action, up to and including termination.

VI. ATTACHMENTS  See Medication Sampling Log

VII. OTHER RESOURCES
Internal HealthPartners Safety Toolkit at Healthpartners.com/quality

Other    Joint Commission Standard, TX.3.17

VIII. APPROVAL(S)

Nancy McClure           Brian Rank, MD
Chief Operating Officer, Care Group    Executive Medical Director, Care Group

IX. ENDORSEMENT  n/a
## Sampling Log

**Medication:** __________________________

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<th>Lot #</th>
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<th>Staff Initial</th>
<th>Patient Name</th>
<th>MRN</th>
<th># Samples Dispensed</th>
<th>Lot #</th>
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Pharmaceutical Sampling. GHI EC HPMG Ops 03 11.15_eab8924f-ce95-4a7c-98e9-a3097420ca77.doc
I. PURPOSE
To provide a uniform and consistent policy for monitoring patients on low-dose amiodarone. Amiodarone is a medication typically used for the treatment of heart arrhythmias.

II. POLICY
All HPMG patients on amiodarone should be monitored per this amiodarone policy (these are minimum expectations). RNs can use the Medication Refill Standing Order to order monitoring lab tests and procedures. If laboratory or other monitoring tests are abnormal, the RN will consult the prescribing physician. The physician assumes responsibility for monitoring until the values are within established parameters.

This policy focuses on monitoring low-dose amiodarone (< 400mg/ day) - additional monitoring may be recommended during initiation and for higher doses of amiodarone. Unless otherwise agreed upon, the prescribing physician is responsible for this monitoring. If other arrangements are made for follow-up, this plan should be documented in the medical record.

III. PROCEDURE(S)
Amiodarone toxicities that need monitoring are:
1. Pulmonary toxicity
   • Pulmonary function tests should be completed at baseline, including diffusion capacity.
   • Chest x-rays should be done at baseline and yearly.
   • Patients should be referred to prescribing physician for additional testing if symptoms of pulmonary toxicity occur (unexplained cough, dyspnea).
2. Liver toxicity
   • AST (SGOT) or ALT (SGPT) should be monitored at baseline and every 6 months.
3. Thyroid abnormalities
   • Thyroid function, using TSH and free T4, should be assessed at baseline, 3 months and every 6 months.
   • Refer to the prescribing physician for more frequent monitoring if thyroid abnormalities are
suspected.

4. Ophthalmic side effects
   - An ophthalmologic exam, including funduscopy and slit-lamp examination may be completed at baseline for patients with significant visual issues.
   - Refer to an ophthalmologist if the patient has with visual changes.

5. Cardiac effects
   - EKGs should be done at baseline and yearly.
   - Refer to the cardiologist if the patient has new-onset arrhythmias or bradycardia.

6. Renal function
   - Serum creatinine, Bun and electrolytes (K, Mg, Na) should be done at baseline.

7. Interacting medications
   - In the event of amiodarone dose changes, monitoring protocols should be followed for interacting medications like warfarin (Coumadin) and digoxin. Referrals may be made to anticoagulation nurse, cardiologist, or prescribing physician.
   - Caution should also be used with simvastatin (increased risk of myopathy), sildenafil (increased levels), cyclosporine (increased levels), antiarrhythmic medications (additive effects), quinolones (increased risk of arrhythmias), antidepressants (increased risk of arrhythmias), azithromycin (increased risk of arrhythmias) and grapefruit (inhibits conversion of amiodarone to the active metabolite).

IV. DEFINITIONS

V. COMPLIANCE
Failure to comply with this policy or the procedures may result in disciplinary action, up to and including termination.

VI. ATTACHMENTS Amiodarone Monitoring worksheet

VII. OTHER RESOURCES
   Internal – Medication Refill Standing Order
   Other

VIII. APPROVAL(S) Robert H. VanWhy, Sr. Vice President, Primary Care and Practice Development

IX. ENDORSEMENT
Open boxes are required monitoring, shaded boxes indicate routine monitoring is not required but can be completed if clinically indicated.

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* Monitoring values are not needed if amiodarone monitoring is done by consultants outside of HPMG. This can be noted with a check mark or the name of the group assuming responsibility for monitoring.
** Patients should be asked about symptoms, both for efficacy and for side effects. Specific questions should address respiratory symptoms, vision problems, thyroid abnormalities, cardiac symptoms, and GI pain.
*** Patients should be evaluated for visual impairment/symptoms and considered for annual eye exams. No monitoring values are needed on this sheet.
**** Pulmonary function testing is recommended at baseline and for otherwise unexplained dyspnea, particularly in patient with underlying lung disease, and for abnormalities on chest x-rays.
***** Serum creatinine and electrolytes are recommended at baseline and as necessary.

Providers also need to be aware of multiple drug interactions, which include warfarin (Coumadin), and digoxin.
This policy focuses on monitoring low-dose amiodarone (≤ 400mg/ day) - additional monitoring may be recommended during initiation and for higher doses of amiodarone.
SUBJECT: MAINTENANCE PROTOCOL FOR PATIENTS ON WARFARIN

EFFECTIVE DATE: 3/19

APPROVED FOR USE AS A POPULATION BASED STANDING ORDER BY:
Beth Averbeck, MD Senior Medical Director, Primary Care
Mark Sannes, MD Senior Medical Director, Medical Specialties
Doug Olson, MD Division Medical Director, HPMG Lab
Rae Ann Williams, MD Department Chair, Internal Medicine
Art Wineman, MD Department Chair, Family Medicine

CONTACT: Beth Averbeck, MD Senior Medical Director, Primary Care
Jo McLaughlin, RN Director, Nursing and Nutrition Services
Lindsey Colbert, RN Manager, Patient Care Support Services
Abby Head, CDS, Patient Care Support Services

SUPERSEDES: 8/18

REVIEW DATE: 3/20

PURPOSE
To provide a population based standing order for Anticoagulation Center Registered Nurses to manage anticoagulation maintenance therapy for established and stable patients who are on anticoagulation medication (Coumadin).

POLICY
To provide in a safe, efficient manner, guidelines for the Anticoagulation Center RNs to manage patients’ dose therapy for their anticoagulation medication. To be used when the patient has an established weekly dose. References to percentage dose changes are based on patient’s weekly dose. An INR variance of 0.1 above or below therapeutic range may be acceptable and require no change to dosing plan or return date.

Tablet strengths:
Anticoagulation Center RNs may therapeutically substitute warfarin tablet strengths in order to more accurately manage warfarin dosing for enhanced time in therapeutic range. New prescription orders will be given refills to last as long as remaining original prescription, and in concordance with Medication Refill Standing Orders.

Resuming parenteral anticoagulation:
If INR drops below 1.8 within the first four weeks of therapy and patient was taking parenteral anticoagulation, restart LMWH at same dose until INR is therapeutic for one day.

To determine dose
Take Total weekly mg and multiply that number by the desired percent change (.10 = 10%) to determine the total amount of mg per week to increase or decrease.
To determine percentage change
Calculate the total number of mg the patient had in the last 7 days (ie. 20mg)
Calculate the weekly total you intend on advising (22.5mg)
Take the difference between the two weekly averages (2.5mg) and divide by what the patient had in the last 7 days (20mg). **Answer: 13%**

Maintenance Dose Adjustment Considerations:
- Expect a 15% dose adjustment will result in an approximate 1.0 INR change.
- A 10% dose adjustment will result in an approximate 0.7 – 0.8 INR change.
- Be cautious of frequent adjustments in the weekly dose. When possible, avoid a second adjustment after a short time period.
- Do not keep increasing or decreasing without searching for cause. Consider permanent dose change if INR is abnormal x 2.
- INR Trend = A detectable change in the general movement of the INR over time (either up or down), while still potentially remaining within the target goal range.

High INR Values: Inform Anticoagulation Clinician of prolonged or markedly elevated INR values.
- Hemorrhagic risks significantly increase with INR > 4.0.
- Patients with high bleeding risks should be treated more aggressively.

Low INR Values: Inform Anticoagulation Clinician of prolonged or markedly low INR values.
- Thromboembolic risks increase with INR below 1.8.
- Essentially no protective anticoagulant effect is observed at INR < 1.5.
- Patients with high thromboembolic risks should be treated more aggressively.
- For patients with atrial fibrillation if the INR drops below 1.7, the risk of stroke doubles. A further decline in the INR to 1.5 results in more than a three-fold increase in the risk of stroke.

Isolated Subtherapeutic INR: Defined as an INR result below therapeutic range preceded by two INRs within or above range, measured at least two weeks apart.

Per CHEST guidelines: For patients with stable therapeutic INRs, presenting with a *single* subtherapeutic INR value, we suggest against routinely administering bridging with heparin. This recommendation is only for a single subtherapeutic INR, not for multiple low INR values or patients who are off of their medication.

Prolonged Subtherapeutic INR: Defined as an INR result below therapeutic range for at least 3-5 days and did not respond to previous dose increases.
**Dosing Protocol for Therapeutic Range of 1.5 – 2.5**

INR range 1.5-2.5 can be used for patients who have bleeding complications at INR 2.0-3.0 range and has been reviewed by anticoagulation specialist for appropriate use.

<table>
<thead>
<tr>
<th>INR</th>
<th>ADJUSTMENT FOR TARGET INR 2.0  (Range of 1.5 – 2.5)</th>
<th>Recheck INR</th>
</tr>
</thead>
</table>
| 1.0-1.2 | • Search for cause and document.  
          • If no trend, give one-time dose increase of 0-12%.  
          • For other factors or trend, increase weekly dose 0-12%.                                                                 | Repeat INR in 1 week |
| 1.3-1.4 | • Search for cause and document.  
          • If no trend, consider one-time dose increase of 0-10%.  
          • For other factors or trend, increase weekly dose 0-10%.                                                                 | Repeat INR in 1 week |
| 1.5-2.5 | • No change.                                                                                                            | 4-6 weeks            |
| 2.6-3.0 | • Search for cause and document.  
          • If no trend, consider one-time dose reduction of 0-10%.  
          • For other factors or trend, reduce weekly dose by 0-10%.                                                           | Repeat INR in 1-2 weeks |
| 3.1-3.5 | • Search for cause and document.  
          • If no trend, give one-time dose reduction of 5-15%.  
          • For other factors or trend reduce weekly dose by 0-15%.  
          • Holding one day may be an option.  
          • For two consecutive elevated INR’s of unknown origin, >4.0 ask patient to open Warfarin pill bottle and read what the pill says as well as verifying color.  
          • Consider sending note to ordering clinician.                                                                          | Repeat INR in 1 week |
| 3.6-4.0 | • Search for cause and document.  
          • If no trend, give one-time dose reduction of 10-20%.  
          • For other factors reduce weekly dose by 10-20%.  
          • Holding one dose may be an option.  
          • For two consecutive elevated INR’s of unknown origin, >4.0 ask patient to open Warfarin pill bottle and read what the pill says as well as verifying color.  
          • Consider sending note to ordering clinician.                                                                          | Repeat INR in 1-5 days |
<table>
<thead>
<tr>
<th>INR</th>
<th>ADJUSTMENT FOR TARGET INR 2.0</th>
<th>Recheck INR</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1-6.0</td>
<td>- Search for cause and document.</td>
<td>Repeat INR in 1-3 days before further doses are recommended</td>
</tr>
<tr>
<td></td>
<td>- Assess/document any signs and symptoms of bleeding.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Hold one or more doses until next INR.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- For two consecutive elevated INR’s of unknown origin, &gt;4.0 ask patient to open Warfarin pill bottle and read what the pill says as well as verifying color.</td>
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</tr>
<tr>
<td></td>
<td>- Consider sending note to ordering clinician.</td>
<td></td>
</tr>
<tr>
<td>6.1-9.9</td>
<td>- Search for cause and document.</td>
<td>Repeat INR in 1-3 days before further doses are recommended</td>
</tr>
<tr>
<td></td>
<td>- Assess/document any signs and symptoms of bleeding.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Hold one or more doses until next INR.</td>
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</tr>
<tr>
<td></td>
<td>- For two consecutive elevated INR’s of unknown origin, &gt;4.0 ask patient to open Warfarin pill bottle and read what the pill says as well as verifying color.</td>
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</tr>
<tr>
<td></td>
<td>- Consider sending note to ordering clinician.</td>
<td></td>
</tr>
<tr>
<td>≥10.0</td>
<td>- Speak with the patient, search for cause and document.</td>
<td>Repeat an INR in 1 day</td>
</tr>
<tr>
<td></td>
<td>- Assess/document any signs and symptoms of bleeding.</td>
<td></td>
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<tr>
<td></td>
<td>- Hold Warfarin</td>
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<td></td>
<td>- Advise patient to go to the ED for assessment and possible Vitamin K administration.</td>
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<tr>
<td></td>
<td>- Ask patient to take all Warfarin pill bottles with them.</td>
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</tr>
<tr>
<td></td>
<td>- Send note to ordering clinician as FYI</td>
<td></td>
</tr>
</tbody>
</table>
# Dosing Protocol for Therapeutic Range of 2.0-3.0

<table>
<thead>
<tr>
<th>INR</th>
<th>ADJUSTMENT FOR TARGET INR 2.5 (Range of 2.0 – 3.0)</th>
<th>Recheck INR</th>
</tr>
</thead>
</table>
| 1.0-1.4 | • Search for cause and document.  
          • If no trend, give one time dose increase of 10% -20%.  
          • For other factors or trend, increase weekly dose by 10-20%.  
          For the following **high risk** situations, when initial isolated subtherapeutic INR ≤ 1.5. Dose patient aggressively and recheck INR in 3 days.  
          1. Recent (≤ 3 months) VTE  
          2. Recent (≤ 3 months) CVA/TIA, LMWH may be contraindicated in larger strokes due to bleed risk. Consider LMWH if patient received heparin product upon initiation.  
          3. Mechanical Mitral Valve Replacement with lower range, consider bleed risk and discuss with clinician for recommendation.  
          4. Bjork Shiley or Starr Edwards AVR with INR <2.0.  
          If INR is not near therapeutic after 3 days of aggressive warfarin dosing, **send note to clinician recommending therapeutic LMWH until therapeutic x 1 day**. If on LMWH, check INR daily until therapeutic x 1 day.  
          For all other prolonged subtherapeutic INRs, increase warfarin dose 10-20%. Recheck INR in 3-5 days. If INR is not near therapeutic after 5 days of aggressive warfarin dosing, **send note to clinician with recommendation based on individual risk.** | Repeat INR in 3-7 days for **low risk** patients  
Repeat INR in 1-3 days for **high risk** patients |
1.5-1.9

- Search for cause and document.
- If no trend, consider one-time dose increase up to 0-12%.
- For other factors or trend, increase weekly dose by 0-12%.

For the following high risk situations, when initial isolated subtherapeutic INR 1.5-1.7. Dose patient aggressively and recheck INR in 3-5 days.

1. Recent (< 3 months) VTE
2. Recent (< 3 months) CVA/TIA, LMWH may be contraindicated in larger strokes due to bleed risk. Consider LMWH if patient received heparin product upon initiation.
3. Mechanical Mitral Valve Replacement lower range, consider bleed risk and discuss with clinician for recommendation
4. Bjork Shiley or Starr Edwards AVR with INR <2.0.

If INR is not near therapeutic after 3-5 days of aggressive warfarin dosing, send note recommending therapeutic LMWH until therapeutic x 1 day. If on LMWH, check INR daily until therapeutic x 1 day.

For all other prolonged subtherapeutic INRs, increase warfarin dose 0-12%. Recheck INR in 3-5 days. If INR is not near therapeutic after 5 days of aggressive warfarin dosing, send note to clinician with recommendation based on individual risk.

### ADJUSTMENT FOR TARGET INR 2.5

<table>
<thead>
<tr>
<th>INR</th>
<th>(Range of 2.0 – 3.0)</th>
<th>Recheck INR</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.0-3.0</td>
<td>No change.</td>
<td>4-6 weeks</td>
</tr>
<tr>
<td>3.1-3.5</td>
<td>Search for cause and document.</td>
<td>Repeat INR in 1-2 weeks.</td>
</tr>
<tr>
<td></td>
<td>If no trend, consider one-time dose reduction up to 12%.</td>
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</tr>
<tr>
<td></td>
<td>For other factors or trend, reduce weekly dose by 0-12%.</td>
<td></td>
</tr>
<tr>
<td>3.6-4.0</td>
<td>Search for cause and document.</td>
<td>Repeat INR in 5-10 days</td>
</tr>
<tr>
<td></td>
<td>If no trend, give one-time dose reduction of 10-15%.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>For other factors or trend, reduce weekly dose by 10-15%.</td>
<td></td>
</tr>
<tr>
<td>4.1-4.5</td>
<td>Search for cause and document.</td>
<td>Repeat INR in 1-5 days</td>
</tr>
<tr>
<td></td>
<td>Assess/document any signs and symptoms of bleeding.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Holding one or more doses may be an option.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Alternately, give one-time dose reduction of 10-20%.</td>
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<tr>
<td></td>
<td>For two consecutive elevated INR’s of unknown origin, &gt;4.0 ask patient to open Warfarin pill bottle and read what the pill says as well as verifying color.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Consider sending note to ordering clinician.</td>
<td></td>
</tr>
<tr>
<td>INR</td>
<td>ADJUSTMENT FOR TARGET INR 3.0 (Range of 2.5 – 3.5)</td>
<td>Recheck INR</td>
</tr>
<tr>
<td>------</td>
<td>--------------------------------------------------</td>
<td>-------------</td>
</tr>
</tbody>
</table>
| 4.6-6.0 | - Search for cause and document.  
           - Assess/document any signs and symptoms of bleeding.  
           - Holding one or more doses may be an option  
           - If able, repeat INR next day  
           - If not able to repeat next day, hold one dose and give a one-time dose reduction of 10-30%  
           - For two consecutive elevated INR’s of unknown origin, >4.0 ask patient to open Warfarin pill bottle and read what the pill says as well as verifying color.  
           - Consider sending note to ordering clinician. | Repeat INR in 1-3 days |
| 6.1-9.9 | - Search for cause and document.  
           - Assess/document any signs and symptoms of bleeding.  
           - Hold one or more doses until next INR.  
           - For two consecutive elevated INR’s of unknown origin, >4.0 ask patient to open Warfarin pill bottle and read what the pill says as well as verifying color.  
           - Consider sending note to ordering clinician. | Repeat INR in 1-3 days before further doses are recommended |
| > 10 | - Speak with the patient, search for cause and document.  
       - Assess/document any signs and symptoms of bleeding.  
       - Hold Warfarin  
       - Advise patient to go to the ED for assessment and possible Vitamin K administration.  
       - Ask patient to take all Warfarin pill bottles with them.  
       - Send note to ordering clinician as FYI. | Repeat INR in 1 day |
### 1.0-1.4
- Search for cause and document.
- If no trend, give one time dose increase of 10-25%.
- For other factors or trend, increase weekly dose by 10-25%.

For the following **high risk** situations, when initial isolated subtherapeutic INR ≤ 1.5.

Dose patient aggressively and recheck INR in 3 days.

1. Recent (< 3 months) VTE
2. Recent (< 3 months) CVA/TIA, LMWH may be contraindicated in larger strokes due to bleed risk. Consider LMWH if patient received heparin product upon initiation.
3. Mechanical Mitral Valve Replacement consider bleed risk and discuss with clinician for recommendation
4. Bjork Shiley or Starr Edwards AVR with INR <2.0.

If INR is not near therapeutic after 3 days of aggressive warfarin dosing, **send note to clinician recommending therapeutic LMWH until therapeutic x 1 day**. If on LMWH, check INR daily until therapeutic x 1 day.

For all other prolonged subtherapeutic INRs, increase warfarin dose 10-25%.

Recheck INR in 3-5 days. If INR is not near therapeutic after 5 days of aggressive warfarin dosing, **send note to clinician with recommendation based on individual risk**.

### 1.5-1.9
- Search for cause and document.
- If no trend, give one-time dose increase up to of 10-20%.
- For other factors or trend, increase weekly dose by 10-20%.

For the following **high risk** situations, when initial isolated subtherapeutic INR 1.5-1.7.

Dose patient aggressively and recheck INR in 3-5 days.

5. Recent (< 3 months) VTE
6. Recent (< 3 months) CVA/TIA, LMWH may be contraindicated in larger strokes due to bleed risk. Consider LMWH if patient received heparin product upon initiation.
7. Mechanical Mitral Valve Replacement lower range, consider bleed risk and discuss with clinician for recommendation
8. Bjork Shiley or Starr Edwards AVR with INR <2.0.

If INR is not near therapeutic after 3-5 days of aggressive warfarin dosing, **send note recommending therapeutic LMWH until therapeutic x 1 day**. If on LMWH, check INR daily until therapeutic x 1 day.

For all other prolonged subtherapeutic INRs, increase warfarin dose 10-20%.

Recheck INR in 3-5 days. If INR is not near therapeutic after 5 days of aggressive warfarin dosing, **send note to clinician with recommendation based on individual risk**.

<table>
<thead>
<tr>
<th>INR</th>
<th>ADJUSTMENT FOR TARGET INR 3.0 (Range of 2.5 – 3.5)</th>
<th>Recheck INR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Repeat INR in 1-3 days</td>
</tr>
<tr>
<td>1.0-1.4</td>
<td></td>
<td>Repeat INR in 1-4 weeks for upper end of range</td>
</tr>
<tr>
<td>1.5-1.9</td>
<td></td>
<td>Repeat INR 3-5 days for <strong>high risk</strong> patients</td>
</tr>
<tr>
<td>INR Range</td>
<td>Instructions</td>
<td></td>
</tr>
<tr>
<td>-----------</td>
<td>-------------</td>
<td></td>
</tr>
</tbody>
</table>
| 2.0-2.4  | • Search for cause and document.  
• If no trend, consider one-time dose increase 0-12%.  
• For other factors or trend, increase weekly dose by 0-12%.  
| Repeat INR in 1-2 weeks |
| 2.5-3.5  | • No change.  
| 4-6 weeks |
| 3.6-4.0  | • Search for cause and document.  
• If no trend, consider one-time dose reduction 0-12%.  
• For other factors or trend, reduce weekly dose by 0-12%.  
| Repeat INR in 1-2 weeks |
| 4.1-4.5  | • Search for cause and document.  
• At lower end of range, consider a one-time dose reduction 5-15%.  
• At upper end of range holding one dose may be an option.  
• For other factors or trend, reduce weekly dose by 5-15%.  
• For two consecutive elevated INR’s of unknown origin, >4.0 ask patient to open Warfarin pill bottle and read what the pill says as well as verifying color.  
• Consider sending note to ordering clinician.  
| Repeat INR in 1-7 days |
| 4.6-6.0  | • Search for cause and document.  
• Assess/document any signs and symptoms of bleeding.  
• Holding one or more doses may be an option.  
• Alternately, give dose reduction 15-25%  
• For two consecutive elevated INR’s of unknown origin, >4.0 ask patient to open Warfarin pill bottle and read what the pill says as well as verifying color.  
• Consider sending note to ordering clinician.  
| Repeat INR in 1-3 days |
| 6.1-9.9  | • Search for cause and document.  
• Assess/document any signs and symptoms of bleeding.  
• Hold one or more doses until next INR.  
• For two consecutive elevated INR’s of unknown origin, >4.0 ask patient to open Warfarin pill bottle and read what the pill says as well as verifying color.  
• Consider sending note to ordering clinician.  
| Repeat INR in 1-3 days before further doses are recommended |
| ≥10.0    | • Speak with the patient, search for cause and document.  
• Assess/document any signs and symptoms of bleeding.  
• Hold Warfarin  
• Advise patient to go to the ED for assessment and possible Vitamin K administration.  
• Ask patient to take all Warfarin pill bottles with them.  
• Send note to ordering clinician as FYI.  
| Repeat INR in 1 day |
**Dosing Protocol for Therapeutic Range of 3.0 – 4.0**

INR range 3.0-4.0 can be used for patients who have had an embolic event at INR 2.5-3.5 range and has been reviewed by anticoagulation specialist for appropriate use.

<table>
<thead>
<tr>
<th>INR</th>
<th>ADJUSTMENT FOR TARGET INR 3.5 (Range of 3.0-4.0)</th>
<th>Recheck INR</th>
</tr>
</thead>
</table>
| 1.0-1.9 | • Search for cause and document.  
• Give one-time dose increase of 15-30%.  
• Send Anticoagulation Encounter to Clinician using dot phrase .hirisk to review need for LMWH | Repeat INR in 1-2 days       |
| 2.0-2.5 | • Search for cause and document.  
• If no trend, give one-time dose increase of 10-15%.  
• For other factors or trend, increase weekly dose by 10-20%.  
• Send Telephone encounter to clinician using dot phrase .hirisk to review need for LMWH | Repeat INR in 5-7 days.      |
| 2.6-2.9 | • Search for cause and document.  
• If no trend, consider one-time increase of 0-15%.  
• For other factors or trend increase weekly dose by 0-15%. | Repeat INR in 1-2 weeks.     |
| 3.0-4.0 | • No change                                                                                               |                             |
| 4.1-4.9 | • Search for cause and document.  
• If no trend, consider one-time dose reduction of 0-12%.  
• For other factors or trend reduce weekly dose by 0-12%. | Repeat INR in 1-2 weeks for INR 4.1-4.5  
Repeat INR in 3-7 days for INR 4.6-4.9 |
| 5.0-6.0 | • Search for cause and document.  
• Assess/document any signs and symptoms of bleeding.  
• If no trend, give one-time dose reduction of 15-25%.  
• Holding one dose may be an option.  
• For two consecutive elevated INR’s of unknown origin, > 5.0 ask patient to open Warfarin pill bottle and read what the pill says as well as verifying color.  
• Consider sending note to ordering clinician. | Repeat INR in 1-3 days.       |
### 6.1-9.9
- Search for cause and document.
- Assess/document any signs and symptoms of bleeding.
- Hold one or more doses until next INR.
- For two consecutive elevated INR’s of unknown origin, > 5.0 ask patient to open Warfarin pill bottle and read what the pill says as well as verifying color.
- Consider sending note to ordering clinician.

Repeat INR in 1-3 days before further doses are recommended.

<table>
<thead>
<tr>
<th>INR</th>
<th>ADJUSTMENT FOR TARGET INR 3.5 (Range of 3.0-4.0)</th>
<th>Recheck INR</th>
</tr>
</thead>
</table>
| ≥10.0 | - Speak with the patient, search for cause and document.  
- Assess/document any signs and symptoms of bleeding.  
- Hold Warfarin  
- Advise patient to go to the ED for assessment and possible Vitamin K administration.  
- Ask patient to take all Warfarin pill bottles with them.  
- Send note to ordering clinician as FYI. | Repeat an INR in 1 day |
# My Medicine List
Fold this form and keep it with you

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date of Birth:</th>
<th>Allergic To: (Describe reaction)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency Contact/Phone numbers:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Doctor(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Pharmacies, other sources:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

## Immunization Record
(Record the date/year of last dose taken)

<table>
<thead>
<tr>
<th>Flu vaccine(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Pneumonia vaccine:</th>
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<tr>
<th>Tetanus:</th>
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<thead>
<tr>
<th>Hepatitis vaccine:</th>
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<table>
<thead>
<tr>
<th>Other:</th>
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</table>

## List all medicines you are currently taking.
Include prescriptions (examples: pills, inhalers, creams, shots), over-the-counter medications (examples: aspirin, antacids) and herbs (examples: ginseng, gingko). Include medications taken as needed (example: nitroglycerin, inhalers).

<table>
<thead>
<tr>
<th>START DATE</th>
<th>NAME OF MEDICATION</th>
<th>DOSE</th>
<th>DIRECTIONS (How do you take it? When? How often?)</th>
<th>DATE STOPPED</th>
<th>NOTES (Reason for taking?)</th>
</tr>
</thead>
<tbody>
<tr>
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Directions for My Medicine List

1. ALWAYS KEEP THIS FORM WITH YOU. You may want to fold it and keep it in your wallet along with your driver’s license. Then it will be available in case of an emergency.

2. Write down all of the medicines you are taking and list all of your allergies. Add information on medicines taken in clinics, hospitals and other health care settings — as well as at home.

3. Take this form with you on all visits to your doctor, clinic, pharmacy and hospital.

4. WRITE DOWN ALL CHANGES MADE TO YOUR MEDICINES on this form. When you stop taking a certain medicine, write the date it was stopped. If help is needed, ask your doctor, nurse, pharmacist, or family member to help you keep it up-to-date.

5. In the “Notes” column, write down why you are taking the medicine (Examples: high blood pressure, high blood sugar, high cholesterol).

6. When you are discharged from the hospital, someone will talk with you about which medicines to take and which medicines to stop taking. Since many changes are often made after a hospital stay, a new list may be filled out. When you return to your doctor, take your list with you. This will keep everyone up-to-date on your medicines.

How does this form help you?

- This form helps you and your family members remember all of the medicines you are taking.

- It provides your doctors and other providers with a current list of ALL of your medicines. They need to know the herbals, vitamins, and over-the-counter medicines you take!

- With this information, doctors and other providers can prevent potential health problems, triggered by how different medicines interact.

For copies of the My Medicine List and a brochure with more tips, visit the Minnesota Alliance for Patient Safety’s Web site at www.mnpatientsafety.org or call (651) 641-1121.
# SAMPLE POLICY

## Policy for Pill Box Distribution

**Purpose:** Increase compliance with prescribed therapeutic regime and reduce the potential for medication errors by distribution of medication boxes to those patients determine to be high risk.

**Definition:** A person considered being high risk if two or more of the following conditions are identified or present:

- Greater than 5 prescriptions.
- Greater than 12 doses of medications per day.
- Four or more medication changes in the past 12 months.
- More than 3 concurrent disease states.
- On a medication that requires therapeutic monitoring (narrow therapeutic index).
- History of non-compliance.

**Policy:**

After evaluation by a physician, pharmacist, or nurse, those patients meeting the above criteria of high risk will be offered a medication box to aid in the correct administration of their medications.

Education of the proper use of the medication box will be provided for the patient/surrogate/or designated person by the physician, pharmacy, or nurse.

The person providing the medication box should note this either in the discharge note or on the patient profile at the pharmacy.

The patient or the patient’s surrogate will need to designate the person responsible for filling and monitoring the medication boxes.

It is the patient or the patients’ surrogate responsibility to monitor the status of medication refills and notify the patient’s attending physician when refills are needed.
Medication Reconciliation

Medication reconciliation is the process of comparing a patient's medication orders to all of the medications that the patient has been taking. This reconciliation is done to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions. It should be done at every transition of care in which new medications are ordered or existing orders are rewritten.

Hospital discharge is a critical transition point for all patients. High-risk patients with multiple medical issues and elderly patients are especially vulnerable to the consequences of ineffective discharge handoffs that leave the individual without clear understanding of discharge instructions that likely includes changes or additions to their pre-hospital medication list.

HEDIS Measure:

HEDIS instituted a new measure in 2009 regarding “Medication Reconciliation Post-Discharge”. This measure continues as one of a select number of measures addressing the special needs of Medicare members enrolled in Special Needs Plans (SNPs). The specification from CMS requires that medication reconciliation occur within 30 days post-discharge from an inpatient facility. Even though this measure has a restricted population, the standard of care should apply to any member with complex medical care needs on multiple medications.

HealthPartners Quality Improvement:

HealthPartners, Inc., as part of their 2014 Medical Record Documentation review, assessed the occurrence of medication reconciliation using the HEDIS specifications for a sample of Medicare members at multiple clinics that serve our members. Of the charts reviewed, results indicated post-discharge medication reconciliation was completed within 30 days post discharge.

In 2011, HealthPartners entered a collaborative arrangement with other major health plans on a Performance Improvement Project (PIP) for our seniors. Each health plan partnered with a hospital and provider group to increase the number of members who are discharged from hospital to home that have a follow-up visit with their Primary Care Provider (PCP) within 15 days after discharge. The purpose of this visit is to promote a safe recovery and prevent readmission. An extremely important component of that is the inclusion of a thorough medication review and reconciliation.
Dear Prescriber:

In the last month, your patient has been identified through pharmacy claims as obtaining six or more controlled substances, by at least three different prescribers and filled by at least three different pharmacies.

In an effort to ensure your patient is getting appropriate, safe and high quality care, a subset of the patient’s prescription profile representing only the prescriptions you have prescribed has been attached. State privacy laws prevent us from disclosing the full prescription history.

What can you do?

- Review the complete patient profile for this patient’s controlled medications by using the Minnesota Prescription Monitoring Program. Minnesota law requires all pharmacies to report the dispensing of all controlled substances to the Minnesota Prescription Monitoring Program. To access this data please visit http://pmp.pharmacy.state.mn.us/. Registration is required.
  - Many states have similar programs.
- If you believe that this patient would benefit from case management services, you can contact HealthPartners Connect (HealthPartners Case Management program) to make a referral at 952-883-5469.

If you have questions or suggestions regarding this communication, please contact Pete Marshall, PharmD, at Peter.S.Marshall@HealthPartners.com or directly at (952) 967-5807.

Thank you for your attention and partnership in providing appropriate care for this member.

Sincerely,

Virginia Kakachek, MD
Associate Medical Director for Medical Policy & Clinical Relations
HealthPartners Health Plan
To ensure members are getting appropriate, safe and high quality care, HealthPartners focused on a controlled substances program called the Retrospective Drug Use Evaluation for controlled substances. The evaluation identifies members who received six or more controlled substance medications prescribed by three or more unique prescribers and dispensed by three or more unique pharmacies.

The member is identified through pharmacy claims; we send a letter to the most recent prescriber describing the Drug Utilization Review (DUR) Program and identifying the controlled substance prescriptions written by that provider. Prescribers can re-evaluate the treatment plan and if they need a complete patient profile they can call HealthPartners Pharmacy Benefits Manager, or refer the member to our HealthPartners Connect (Case Management) Program. Minnesota prescribers can log on to the Minnesota Prescription Monitoring Program. Minnesota law requires all pharmacies to report the dispensing of all controlled substances to the Minnesota Prescription Monitoring Program. Some states have similar programs.


Seven states (Alaska, Florida, Kansas, New Jersey, Oregon, South Dakota and Wisconsin) and one U.S. territory (Guam) have enacted legislation to establish a PDMP, but are not fully operational. <http://www.deadiversion.usdoj.gov/faq/rx_monitor.htm> accessed 1.28.2011.

Reports are compiled monthly and are reviewed for trends. Any member that recurs three times in a rolling 12-month period is automatically forwarded to our Case Management Program for investigation.

If misuse is identified, HealthPartners can request system limitations that restrict the patient to a particular pharmacy or prescriber. In a case of prescriber or pharmacy misuse, HealthPartners can restrict that prescriber or pharmacy and potentially remove them from our network.
SUBJECT: MEDICATION REFILL (Behavioral Health) STANDING ORDER
EFFECTIVE DATE: 12/18

APPROVED FOR USE AS A DEPARTMENT POPULATION BASED STANDING ORDER BY:
Amy Nygaard, MD Medical Director, Behavioral Health Outpatient Department

CONTACT: Behavioral Health Dept. Care Delivery
Amy Nygaard, MD Medical Director, Behavioral Health Outpatient Department

SUPERSEDES: 7/18
REVIEW DATE: 7/20

PURPOSE:
To provide a process for RNs working in Behavioral Health to review and approve maintenance prescription refill requests for designated medications.

POLICY:
To provide in a safe, efficient manner, approval for a supply of medication for patients. The RN is the agent of the prescriber delegated to refill medications as per the following procedure. The prescription must clearly originate with HPMG physicians or other HPMG authorized prescribers.

PROCEDURE:
1. Obtain information from the requesting pharmacy: patient’s name, medical number or date of birth, pharmacy, pharmacy phone number, medication requested, amount requested and the last date the medication was ordered. Document the information in an EpicCare Refill Encounter or phone message. A 24 to 48 hour turn-around time on a medication request may be necessary.
2. Review the patient’s medical record for the following areas:
   a. Review the record for visit compliance. In order to refill medications, a patient needs to be seen “current” defined as seen within the past 12 months or as indicated in the plan of the last visit. If the patient is due for a visit, contact the patient by phone to schedule a follow-up appointment. If unable to contact the patient to schedule an appointment, the pharmacy is notified that the patient needs to contact his/her provider’s clinic to schedule an appointment so that a refill can be authorized. All communications and outcomes are documented in the patient’s medical record.
   b. Verify the medication and dosage. This may require call to patient and/or pharmacy.
   c. Verify that no lab testing/monitoring is required before ordering refills. (See #5.) If patient is due for testing/monitoring, a month refill may be provided to allow the patient the opportunity to see his/her provider/complete tests or monitoring. Place orders as per #5.
3. The following medications are excluded from this policy. Refill requests must be sent to a licensed prescriber:
   a. Controlled Substances (see details in #6)
   b. Medications excluded per careplan
   c. Indications of non-compliance, including overuse or underuse
   d. Indications that the patient may be experiencing a side effect or drug interaction
   e. Specific medications as noted by the ordering prescriber
Behavioral Health Department Specific
Standing Order

f. Requests to change from a brand name medication to a generic when a physician specified the brand name to be used, unless brand name was ordered to meet requirements for insurance coverage and that need has changed.

g. Medications not considered chronic and requiring review of clinician’s plan:
   - Medication dosing change requested by patient

4. Criteria Required for Refills
   a. If the patient has been keeping his/her appointments per careplan and is not overdue for a visit, refills of non-controlled drugs may be given to last until the patient is due for his next visit, not to exceed one year from the last visit.
   b. Adjusting to meet patient quantity request:
      - If the patient has been keeping his/her appointments and is not overdue for a visit, RNs may adjust to meet patient’s quantity requests up to a 12 month supply (i.e. changing 90 day refill x3 to a 30 day refill x 12) to the equivalent dosing.
      - If the patient has been keeping his/her appointments and is not overdue for a visit, RNs may change tablet/capsule strength and quantity to the equivalent therapeutic dose for immediate release medications (i.e. Fluoxetine 10 mg x2 can change to Fluoxetine 20 mg daily).
   c. Mail order: If a patient has not received mail order prescription, a 30 day supply can be sent to a local retail pharmacy.

5. Medication Monitoring
   a. All antipsychotics
      - If no results in EPIC in the past 12 months place order for lipids and HgA1c
   b. Clozaril-ANC monitoring per Clozaril REMS guidelines
   c. Depakote-If no results in EPIC in the past 12 months place order for valproate (Depakote) level, CBC with platelets, AST
   d. Tegretol- If no results in EPIC in the past 12 months place order for CBC with diff and platelets, ALT, AST, tegretol level
   e. Lithium- If no results in EPIC in the past 6 months place order for Lithium level and BMP.
      - If no results in EPIC in the past 12 months place order for TSH, Lithium level and BMP
   g. Naltrexone- If no results in EPIC in the past 12 months place order for LFTs

6. Controlled Medication: For controlled substances, check the MN Prescription Monitoring Website as per clinic workflow.

7. Refills are routed to or called into the pharmacy of the patient’s choice.

8. Document that the medication was refilled per standing order (PSO).

9. The RN may question any medication refill and refer to an ordering provider for review.
**Prepared Practice Team Medication Monitoring Protocol**

**NOTE:** This is not an all-inclusive list. The RN may refill any maintenance medication, and may utilize the standard of care medication monitoring protocol in addition to the parameters in the standing order refill policy.

### Antipsychotics

| All Antipsychotics | • AIMS or DISCUS annually (atypical) or bi-annually (typical)  
|                    | • Height and weight annually  
|                    | • Labs at start, 4 months after start, then annually:  
|                    |   ■ Fasting (preferred) lipid and HgA1c  
|                    |   ■ Fasting lipid profiles; if LDL level ≥ 130 mg/dl refer for treatment, repeat within 6 months  
| Clozaril           | • AIMS or DISCUS annually  
|                    | • Height and weight annually  
|                    | • Labs at start, 4 months after start, then annually:  
|                    |   ■ Fasting plasma glucose level or HgA1c  
|                    |   ■ Fasting lipid profiles; if LDL level ≥ 130 mg/dl refer for treatment, repeat within 6 months  
|                    | • WBC and ANC (PMNs in “WBC with differential”) at baseline and every week for 6 months. Then if WBC is at least 3500/mm³ and ANC is at least 2000/mm³ for 6 months, decrease to every two weeks. If maintains WBC > 3500/mm³ and ANC > 2000/mm³ for 6 months, decrease WBC and ANC to every 4 weeks.  
|                    | • If WBC <3,000/mm³ or ANC<1,500/mm³: re-increase frequency of monitoring.  
|                    | • When discontinuing Clozaril, weekly WBC and ANC at least 4 weeks and until WBC = 3500/mm³ and ANC = 2000/mm³  

### Antidepressants

| Selective Norepinephrine Reuptake Inhibitors:  
| Venlafaxine (Effexor)  
| Duloxetine (Cymbalta)  
| Desvenlafaxine (Pristiq)  
| Levomilnacipran ER (Fetzima) | • Blood pressure at all visits when the medication was started or raised (if not already performed in another clinic).  
| Levomilnacipran ER (Fetzima) Annual Creatinine level.  
| Mirtazapine (Remeron) and Tricyclic Antidepressants | • Weigh at each visit for one year then annually (if not already performed in another clinic within past 2 months).  

### ADHD Medications

| Stimulants (Refer to controlled substance section above.) | • Blood pressure at all visits where the medication was started or raised at the last visit and every 6 months (if not already performed in another clinic).  
• Weigh every visit under age 16  
• Height every 6 month under age 16 |
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<tr>
<td>Strattera</td>
<td>• Weigh every visit under age 16</td>
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### Mood Stabilizers

| Depakote | • Weigh at each visit for one year then annually (if not already performed in another clinic within past 2 months).  
• Labs at one month after start, 6 months after start then annual:  
  ■ HEMOGRAM/PLTS  
  ■ AST  
  ■ Valproate level |
|---|---|
| Tegretol | • Weigh at each visit for one year then annually (if not already performed in another clinic within past 2 months).  
• Labs at one month after start, 6 months after start then annual:  
  ■ HEMOGRAM/PLTS/DIFF  
  ■ ALT  
  ■ AST  
  ■ Tegretol level |
| Lithium | • Weigh at each visit for one year then annually (if not already performed in another clinic within past 2 months).  
• Labs every 6 Months:  
  ■ Lithium level  
  ■ Basic Metabolic Panel  
• Annual Labs:  
  ■ TSH |
| Topamax/topiramate | Labs at 3 months and 6 months after start then annually  
  ■ Basic Metabolic Panel (look for hypercalcemia)  
  ■ UA with micro  
Annual eye exam for glaucoma screening |

### Substance Use Deterrents

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<th>Naltrexone (Vivatrol)</th>
<th>• LFT’s at baseline and then annually.</th>
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| Disulram (Antabuse) | • Baseline LFT’s and Renal Function  
• Monthly LFT’s for first 6 months |
SUBJECT: MEDICATION REFILL STANDING ORDER

EFFECTIVE DATE: 6/19

9/19 UPDATE: Policy addition for RNs and Pharmacists to follow added procedure step #4 related to blood glucose meters and testing supplies.

Addition of step #4: Diabetes Supplies.

7/19 UPDATE: #3 updated to remove the following meds from the exclusion list: 1) Vit. D; 2) Calcium and phosphorus binders; and 3) Iron

APPROVED FOR USE AS A POPULATION BASED STANDING ORDER BY:

Jason Maxwell, MD Department Chair, Pediatrics & Adolescent Medicine
Art Wineman, MD Department Chair, Family Medicine
Rae Ann Williams, MD Department Chair, Internal Medicine
Beth Averbeck, MD Senior Medical Director, Primary Care

CONTACT: Abby Head, Manager Centralized Services

SUPERSEDES: 11/17

REVIEW DATE: 11/20

PURPOSE:
To provide a process for RNs and Pharmacists to review and approve maintenance prescription refill requests.

POLICY:
To provide in a safe, efficient manner, approval for a supply of medication for patients (this would also include supplies for maintenance medications, for example, insulin syringes). The RN or Pharmacist is the agent of the prescriber delegated to refill medications ONLY for medications listed within the attached Operations Alpha Med Refill List document following the procedure steps below. RNs and Pharmacists can also refill, initiate new orders or change orders for blood glucose meters and testing supplies (meters, lancets, test strips/disks) that are not listed within the attached Operations Alpha Med Refill List, to match a patient’s insurance formulary following procedure step #4 below. Prescriptions must clearly originate with HPMG physicians or other HPMG authorized prescribers.

PROCEDURE:
1. Obtain information from the requesting pharmacy: patient’s name, medical number or date of birth, pharmacy, pharmacy phone number, medication requested, amount requested and the last date the medication was ordered. Document the information in a phone message or an EpicCare Refill Encounter. A two business day turn-around time on a medication request is necessary.
2. Review the patient’s medical record for the following areas:
   a. Review the record for compliance.
      i. In order to refill medications, a patient needs to be up to date on lab tests pertaining to the medication being requested and seen annually (primary care, phone visit, hospital physician or Well at Work visit for any reason within the last 12 month; emergency room, urgent care and E-visits are not considered primary care).
      ii. If a dose change has been made on the requested medication, follow the clinician’s plan of care. If there is no dose change and patient meets the standing order, refill until next office visit or lab work is due.
      iii. If prescription is started or has a dose change by a diabetic nurse specialist or MTM, refills can be approved per standing order.
      iv. Medication orders placed with refills for one year that expire on day 364-365 are an active order and okay to refill per protocol.
v. If prescription is entered on medication list by an authorized prescriber as no print/no fill it can be refilled according to the standing order.

vi. If a prescription is started during a hospitalization by an HPMG hospitalist, refill as per protocol if a primary care follow-up visit has taken place since that hospitalization. If a primary care follow-up visit has not taken place, send request to clinician refill pool to approve.

vii. If the patient is overdue for a visit, a refill (up to three months) is approved to allow the patient the opportunity to be seen by his/her clinician. If it is more than 15 months since the last office visit, route the request to Clinic Assistant to schedule patient. If patient schedules appointment and is between 15-18 months overdue, RN can provide a courtesy refill to last until appointment. Contact the patient by phone, mail or online patient services to explain the need for a follow-up appointment. All communications and outcomes are documented in the patient’s medical record.

b. Verify that lab testing/monitoring is not required before ordering refills. (See Attached: Operations Alpha Med Refill List). If patient is due for testing/monitoring, a refill (up to three months) may be provided to allow the patient the opportunity to see the clinician/complete tests or monitoring. If it is more than 15 months since the last testing/monitoring, route request to Clinic Assistant to schedule patient. If patient schedules testing/appointment and is between 15-18 months overdue, RN can provide a courtesy refill to last until the appointment. The RN, LPN, RMA, CMA or Pharmacist will order the appropriate lab tests in Epic and will ensure communication of needed tests to patient.

c. If the PCP field is listed as “Unassigned” or “No primary”, route refill request to the clinic to assign PCP and to review/order medication.

d. Verify the medication and dosage. The clinician must be informed if any discrepancies are noted, for example, a medication is being refilled too frequently for the way it is prescribed. Also, the clinician must be informed for any p.r.n. medications that are being used with increased frequency, for example, sublingual nitroglycerin, migraine medications or narcotics. Identified problems are clearly documented in the medical record.

e. If a medication alert appears when the refill order is placed, verify that the patient has had a previous order for this medication and history of tolerating the medication, and then proceed to refill. If there are any questions or concerns, forward to the ordering clinician.

3. The following medications are excluded from this policy. Refill requests including but not limited to the following list must be routed to a licensed prescriber. RN or Pharmacist use “.no standing order” or “narcotics” for narcotic medications, to document that the request is being routed to a licensed prescriber.

a. Controlled Substances, including pseudoephedrine-containing products
b. Oral Steroids
c. Cox II inhibitors
d. Chemotherapeutic agents
e. Antibiotics
f. Antipsychotics
g. Multaq® (dronedarone)
h. Accutane® (isotretinoin)
i. Indications of non-compliance, including overuse or underuse
j. Indications that the patient may be experiencing a side effect or drug interaction
k. Requests to change from a brand name medication to a generic when a physician specified the brand name to be used

4. Diabetic Supplies.
a. The RN or Pharmacist can adjust the quantity of diabetes supplies to match the Rx day supply (i.e. twice per day blood glucose monitoring if filled for 30 days would have a quantity of 60).
b. When diabetes is on the patient’s problem list, the RN or Pharmacist can initiate new orders or change the orders for requested blood glucose meters or testing supplies to match what is available on the patient’s insurance formulary. Discontinue the outdated order of the meter or diabetes testing supplies.
   • Diabetes supplies smartset (EPIC ID 951) can be used for ordering supplies.
c. The co-sign function needs to be used when ordering blood glucose meters or diabetes testing supplies (lancets and test strips/disks) for patients ≥ 65 years of age.
d. This does not apply to Continuous Glucose Monitoring (CGM). CGM requests require clinician signature.

5. Refills may be given to last until the patient is due for his next visit or needs monitoring lab tests, not to exceed one year from the last visit. One three month extension may be allowed, see 2 a. & b.
a. RNs or Pharmacists may increase the quantity from 30 to 90 days supply per patient request or to meet the mail order benefit.
b. This excludes scheduled medications (II – V) and antipsychotic drugs and any medication excluded from this standing order (per section 3).

6. If a refill request has been signed and approved by a clinician, diabetic nurse specialist, MTM, or RN and the medication has refills remaining, the RN can resend the prescription with the amount of refills that the patient has remaining without sending back to clinician. This excludes controlled substances.

7. If the patient requests capsule instead of tablet form, verify that the patient is taking the dosage form requested if it differs from original orders. Verify that the products are therapeutically equivalent. If yes, the change in form can be provided.

8. The DISPENSING PHARMACIST may change the quantity and days supply dispensed on maintenance medications, up to a 3-month supply, to meet patient requests or a mail order benefit. This policy excludes all scheduled medications (II – V), psychotherapeutic drugs and any medication ordered by a behavioral health clinician.

9. Refills are returned to or called into the pharmacy of the patient’s choice.

10. Document that the medication was refilled per standing order (PSO).

11. The RN or Pharmacist may question any medication refill and refer to an ordering clinician for review. If the medication cannot be filled per the standing order, the request should be routed to the clinician refill pool for review.