Maintaining Medication Quality

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I have had the privilege of serving on the Pharmacy and Therapeutics (P&T) committee at Thomas Jefferson University Hospital for nearly a quarter of a century, and I serve as Chair for its Medication Quality subcommittee. I have enjoyed my longtime service on both committees, and have reported on their work to readers of American Health & Drug Benefits.1 I am confident that tying the work of the P&T committee to the overall delivery of high-value healthcare is an important annual exercise. As such, at the close of 2014, it would be beneficial to review the recent annual report from the subcommittee and make some broad recommendations for 2015 and beyond.

The work of the Medication Quality subcommittee is divided into several discrete segments. The first involves a detailed review of adverse drug events, from surveillance and prevention perspectives. The second involves a critical review of medication through a standardized process, sometimes called Medical Use Evaluation (MUE). The third is the day-to-day work of reviewing protocols and policies regarding medication use in our healthcare system, and finally, critical activities that ensure regulatory compliance. Let us examine each of these in turn.

Regarding adverse drug event prevention and surveillance, our committee worked hard in this past academic year to examine the quarterly medication events and adverse drug reaction reports. We made specific recommendations, as appropriate, and reviewed the logs for the documentation of system improvements that were made in response to events. Our adverse drug reaction reports reveal a stable system, with very little perturbation throughout the year. Sometimes our work leads to a root cause analysis on a department-specific basis. For example, house officers in the Department of Medicine did a root cause analysis this past year relating to medication reconciliation—clearly a critically important issue. Finally, we also reviewed and evaluated reports from the Chemotherapy Event Review committee. Clearly, we want to deliver these toxic medications in the safest way possible. Vigilance and ongoing system evaluation are important tools in ensuring patient safety.

With regard to MUE, 2014 was a busy year. We reviewed quarterly reports of, for example, proton pump inhibitors, parenteral nutrition, and related medications. We routinely compared our performance in the use of proton pump inhibitors and parenteral nutrition with our colleagues across the membership of UHC (formerly known as the University HealthSystem Consortium). We are lucky to have this national comparative data set on hospitals similar to ours, because it provides ongoing benchmarks to help in evaluating our performance. We also reviewed quarterly reports of the use of rescue drugs. For example, how often do we need to use dextrose for insulin overdose or naloxone for an opioid overdose? We compared favorably with the UHC members in these subcategories.

Within the MUE category, we also sometimes pose difficult questions. For example, how can we more appropriately dispense drugs such as zolpidem, which, by all accounts are overly prescribed by physicians? This is one of our more difficult tasks as we seek to choose wisely and create higher value for our patients. We also hope to avoid increasingly common drug interactions. Through one MUE review, we discovered that our use of combination antifungal medications for invasive fungal infections was not in compliance with nationally recommended guidelines, which led us to make recommendations to our colleagues in the Infectious Disease subcommittee and up through the chain of command to various clinical department chairs. We revisit these issues months, and sometimes years, later to see how we are doing. In short, self-evaluation, measurement, and closure of the feedback loop are the critical tools that characterize the MUE process.

Of course, in a place of our scope and size (an urban academic medical center with 3 sites and 957 acute care beds), the annual review of standing policies and protocols is always a good idea. It is incredible to consider the number of policies that are under our purview, including investigational drugs, controlled substances, deletion of drugs from the formulary, documentation of vaccine administrations, policies on verbal orders, and policies for educating patients on drug interaction. Any time a clinical department alters a standing protocol...
involving the administration of a pharmaceutical agent, our subcommittee swings into action and must give final approval to a standing protocol-driven, evidence-based guideline anywhere in the institution.

I am curious about your P&T committee and its subcommittee structure. How does your organization review adverse drug events, MUEs, and standing policies and procedures?

Finally, regarding activities that ensure compliance with regulatory requirements, we respond on a regular basis to scores of external requests for information. At any moment, our hospital could be inspected by officials from the city, state, Medicare, or accrediting bodies. One of the many areas I am most proud of is our ongoing compliance with what we refer to as “double signatures”—the requirement that 2 people sign off—for certain high-risk medications. This is especially critical in the chemotherapy arena. It turns out that compliance with the medication reconciliation monitors remained high this past academic year, and we are constantly tinkering with this system to ensure the highest possible level of medication safety.

Looking back on my nearly 25 years of service on both committees, I am proud of our team. I want to especially note the tremendous support that our committee gets from Craig Senholzi, RPh, MBA, and Brian Swift, PharmD, MBA. I am grateful to these 2 leaders, as well as to many unnamed others who contribute their time, energy, and expertise on a monthly basis to help ensure that our patients are safe. Of course, safety is a cornerstone of delivering value; I see it as central to the mission of our complex academic medical center.

I am curious about your P&T committee and its subcommittee structure. How does your organization review adverse drug events, MUEs, and standing policies and procedures? As always, feel free to reach out to me at david.nash@jefferson.edu. We can all continue to learn from one another.

Reference