Introduction

- University Hospitals Health System (UHHS)
- University Hospitals Specialty Pharmacy (UHSP) is a part of an integrated health-system delivery network within UHHS
- UHSP is dually accredited by URAC (Utilization Review Accreditation Commission) and ACHC (Accreditation Commission for Health Care)
- Compliance with accreditation measures is necessary for optimizing patient care, improving patient outcomes, and reducing overall healthcare burden and costs
- There are 5 mandatory measures that must be reported to URAC on an annual basis, in order to meet the specialty pharmacy accreditation requirements.
- 2 of the 5 mandatory measures focus on dispensing accuracy and distribution accuracy

Methods

- The UHSP team reports clinical interventions, near misses, and errors to the UHSP intervention email outbox or to a physical log on-site, which is then recorded into the Pharmacy Event Log (PEL) on SharePoint
- The results for all of the errors documented between 10/7/2019-3/31/2020 in the intervention log has been extracted and analyzed
- Inclusion:
  - All errors and clinical interventions reported within this time frame
- Exclusion:
  - Interventions that pertained to labs being ordered for treatment
  - Information collected from the Interventions Log:
    - Patient name
    - Date of birth
    - Fill Type (Refill or Initial Fill)
    - Type of Insurance
    - Event Type
      - Complaint
      - Shipping Error
      - Cold Chain
      - Adverse Event
      - Dispensing Error
    - Near Miss/Internal Error
    - Prescriber Error
    - Error/External Error
    - Equipment Error
    - Malfunction
    - Billing Error
    - Other
    - Description of Issue
    - Description of Resolution
    - Outcome
      - Patient satisfied
      - Escalated to Pharmacist
      - Quality Audit initiated
      - Date Resolved
      - Rx Number
      - Service Line
      - PA Only Script (Y/N)
      - Dispensing Accuracy

Objectives

- **Primary Objective**: Determine the dispensing and distribution accuracy of University Hospitals Specialty Pharmacy by the percentage of different types of errors reported
- **Secondary Objective**: Describe the percentage of external prescriber error by service line

Results

<table>
<thead>
<tr>
<th>MEASURE (QUALITY ID #)</th>
<th>URAC DOMAIN</th>
<th>DOCUMENTATION DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compounding Accuracy</td>
<td>Safe Care</td>
<td>MANDATORY URAC MEASURES</td>
</tr>
<tr>
<td>Dispensing Accuracy (MP 2012-06)</td>
<td>Safe Care</td>
<td>- Six-part measure to assess the percentage of prescriptions that the organization dispenses inaccurately. Measure includes: (A) Incorrect Drug and/or Product Dispensed B) Incorrect Recipient C) Incorrect Strength D) Incorrect Dosage Form E) Incorrect Instructions F) Incorrect Quantity</td>
</tr>
<tr>
<td>Distribution Accuracy (MP 2012-07)</td>
<td>Safe Care</td>
<td>- Assesses the percentage of prescriptions delivered to the wrong recipient. Measure includes: A) Prescriptions mailed with an incorrect address B) Prescriptions mailed with a correct address to the incorrect location</td>
</tr>
</tbody>
</table>

Discussion

- Total number of prescriptions during this time period was 15,524 prescriptions. 707 of these 15,524 prescriptions were reported to contain errors. The error rate during this time period was 4.5%
- Out of 707 total errors that were reported within this time frame, 53% of these errors were reported external prescriber errors
- There were a total of 264 external prescriber errors, the majority (51%) of these errors were from the oncology service line

Strengths

- Ease of error reporting and documentation to encourage UHSP to report all errors and clinical interventions encountered
- Implementing URAC measures into intervention log questions

Limitations

- Not all errors and clinical interventions are forwarded to the interventions email outbox or are documented onto the physical log on-site
- Types of Error are not mutually exclusive categories. For example, an error that is categorized as a “near miss” could also potentially be a result of a prescriber error
- Manual process requiring human interpretation
- Categories are not well defined and there is a lack of subcategories within the intervention log

Next Steps

- URAC criteria discussed and implemented into the design of the intervention log questions

Future Steps

- Add additional questions onto the intervention log:
  - Severity of error
  - Prescriber of Rx
  - Add subcategories within the intervention log

Create Clinical Interventions Subcommittee

- Retail pharmacists meet once a month to discuss actionable items in a manner similar to ISMP

Anticipated Barriers

- Data Collection: time consuming documentation
- Data Integrity: lack of automation in error reporting process, consistency in reporting, unintended omissions of error reporting, and consistency of interpretation of collected data

Disclosure/References

The researchers report no potential or actual conflicts of interest relevant to this poster or research.


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