ISSUE BRIEF

NATIONAL QUALITY FORUM
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National Quality Forum Action Team: Person-Centered Medication Safety

Today's healthcare system inadequately addresses the risks of complex medication regimens, resulting in a serious public health problem that poses a substantial threat to patient safety. Patients, families, and caregivers are often missing from key conversations and decisions around their medications.

Medications (also often referred to as medicines or drugs) are any substance that affects a person's health, including prescription, over-the-counter, homeopathic, and illegal substances.[1] Suboptimal medication safety can have a profound effect on a person's health and quality of life, and its impact can range from no effect to severe injury or death.[2] Each year in the United States (U.S.), adverse drug events (ADEs) cause approximately 1.3 million emergency department visits and 350,000 hospitalizations.[3] While the occurrence of an ADE does not necessarily indicate an error or poor quality of care, it is estimated that about half of ADEs are preventable.[4] The cost of medication is a major barrier that creates safety risks, and certain racial and ethnic groups face additional obstacles to safe medication use, such as cultural differences, systematic biases, and distrust in medical advice.[5] Polypharmacy, inadequate medication reconciliation during transitions of care, and person-specific risk factors, such as limited English language proficiency and health literacy, are topics that, if properly addressed, can improve medication safety.

Person-centered medication safety is a bottom-up approach that focuses on actively empowering patients, family members, and caregivers as partners in understanding medicines, choosing the best treatment plan, identifying potential problems, and preventing ADEs. It differs from traditional top-down approaches, which rely on healthcare professionals to prevent medication errors and have shown limited effectiveness.[3] While a bottom-up approach does not diminish the responsibilities of healthcare professionals, it creates new opportunities to both engage the people who live with the medications on a daily basis and encourage them to become informed advocates for their health. The goal of person-centered medication safety is to strengthen an individual's capacity to obtain, process, understand, and use basic health information and services. This understanding can lead to improved knowledge about medications, treatment aims, and the reasons for taking medications as prescribed. Individuals have different needs, capacities, cultures, and values. By adopting a person-centered perspective, a diverse group of healthcare stakeholders, including clinicians, administrators, and staff at health systems, pharmacies, and health plans, can embrace these differences in ways that empower patients and caregivers to advocate for their safety.

To amplify the need to share best practices and recommendations to improve patient safety, the National Quality Forum (NQF) convened the Action Team on Person-Centered Medication Safety over a nine-month period beginning in May 2021. The Action Team brought together 26 NQF member organizations that represent multistakeholder groups, including patients and caregivers, health systems, pharmacists, physicians, professional societies, research organizations, health plans, and federal agencies. The Action Team identified challenges and shared actionable strategies to improve medication safety. Healthcare organizations and clinicians should work with their local patient population to understand which improvements would be most beneficial and to assist in implementing strategies. Technology improvements, such as improved interoperability and automated workflows, should also be used to optimize care and take burden off clinicians. While healthcare organizations and clinicians are the main audience for this Issue Brief, it can also be used by stakeholders across disciplines, including health system administrators, community health workers, payers, policy-makers, and especially patients, families, and caregivers, to understand the challenges of person-centered medication safety and opportunities for improving care.

The Action Team identified the following set of priority challenges for stakeholders to assess and address in the pursuit of improving person-centered medication safety:

- **Complicated medication regimens** impede the ability of patients, caregivers, and clinicians to appropriately understand and manage medication, particularly for people with multiple complex medical conditions.
- **A lack of care coordination and communication** between care teams at various institutions and sites of care results in potentially harmful medication regimens, inaccurate medication lists, and confused patients and caregivers.
- **Limited time and resources** in clinical settings lead to insufficient discussion, education, and support for patients and caregivers on understanding and correctly using medication.
- **Lack of access to resources and/or contacts** for questions and guidance limits the ability of patients and caregivers to ensure their needs, goals, and questions are adequately addressed.
- **Misaligned financial incentives** do not typically reimburse for clinical pharmacist time, extensive education, care coordination, or other resource-intensive best practices that reduce ADEs, empower patients, decrease health disparities, and increase person-centered medication safety.

To support person-centered medication safety, the Action Team recommends that stakeholders across disciplines partner together to accomplish the following objectives:

1 BUILD AN ACCURATE, BENEFICIAL, AND COMPREHENSIVE MEDICATION LIST

- Clearly discuss and document patients' goals, priorities, and obstacles to informed and effective medication management, and use this information to create accurate, readily available, and comprehensive medication lists that provide maximum benefit to every stakeholder, including patients, caregivers, clinicians, and health plans
- Discuss all medication information, including purpose, usage instructions, benefits, potential risks, patient experience, and cost/coverage information, with patients and caregivers and document it in a comprehensive, clear, and personalized medication list that is available in customizable formats for the different users of the information
- Champion policies and procedures that promote information exchange between healthcare stakeholders within and outside of your organization, and advocate for practices that support timely exchange of information
- Integrate ongoing evaluation of medication lists to reconcile, simplify, and measure the success of prescribed treatment
- Incorporate pharmacists as part of the core care team to help reconcile and optimize patients' drug regimens

2 PROVIDE CLEAR, READABLE, AND UNDERSTANDABLE MEDICATION INSTRUCTIONS

- Ensure clinical staff have ongoing training and robust systems to provide medication information in a method that aligns with patients' goals, education, language, and culture
- Establish standard practices that ensure patients, particularly those who have complicated medication regimens, complex comorbidities, and multiple specialists, receive clear and useful educational materials and know whom to contact with medication questions
- Encourage regular and ongoing access to and communication with the care team to support patients' changing needs (e.g., ongoing discussions about medications with patients and caregivers throughout a hospitalization instead of only during discharge)
- Incorporate health navigators (i.e., professionals who help patients and caregivers to understand confusing issues related to clinical care or insurance coverage) to answer questions, provide guidance, and support patients as they navigate the healthcare system

3 EDUCATE AND EMPOWER PATIENTS AND CAREGIVERS TO BE PARTNERS IN THEIR CARE

- Elicit, share, and use person-specific factors (e.g., health goals and beliefs, ability to manage medications, financial background, health literacy and numeracy, and any other unique consideration) to create care plans and provide care
- Simplify drug regimens where appropriate, provide tools (e.g., pillboxes) to help patients and caregivers with medicines, and ensure patients and caregivers understand the purpose of every medication and agree with the treatment plan
- Create policies, procedures, and protocols that encourage shared decision making, mutual target setting, and frequent judgment-free communication between patients and caregivers and care teams
- Fund and use demonstration projects, research, and data that incorporate diverse populations to address prominent gaps in care
- Encourage patients and caregivers to report adverse drug reactions to the FDA and/or drug manufacturers

4 PRIORITIZE AND INVEST IN PERSON-CENTERED MEDICATION SAFETY

- Incentivize and encourage change by advocating for payment mechanisms that promote quality and outcomes across all payment models, including fee-for-service and value-based payment programs
- Invest in and reimburse medication safety efforts, including medication reconciliation and transitions of care, that focus on patient safety and understanding; incorporation of pharmacists as part of the core healthcare team; and availability of health system navigators
- Collaborate with payers to build reimbursement models that support effective medication management as part of delivering value, and incorporate diverse members of the healthcare team to better address patients' medication-related needs, including but not limited to clinical pharmacy services and social work resources
- Reduce barriers to person-centered medication safety by incorporating activities that foster health equity, such as access to language translation services at every point of contact (including medication education and pharmacy services)

Healthcare stakeholders must create meaningful partnerships with patients, families, and caregivers to both achieve medication safety goals and facilitate optimal health outcomes. Healthcare organizations must foster person-centered practices that put patients and caregivers at the forefront of their own care. Opportunities exist to educate and empower patients and caregivers in managing their medication therapy plan and to support clinicians in maximizing patients' health. Optimizing person-centered medication safety has the potential to improve medication management across the continuum of care.

ACTION TEAM ON PERSON-CENTERED MEDICATION SAFETY

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ENDNOTES

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2 Rodziewic TL, Housaman B, Hipskind J. Medical Error Reduction and Prevention. Last accessed September 2021.

3 Centers for Disease Control and Prevention (CDC). Adverse Drug Events. https://www.cdc.gov/medicationsafety/adult_adversedrugevents.html. Last accessed August 16, 2021.

4 Agency for Healthcare Research and Quality (AHRQ). Medication errors and adverse drug events website. https://psnet.ahrq.gov/primer/medication-errors-and-adverse-drug-events. Last accessed September 2021.

5 Kogut SJ. Racial disparities in medication use: imperatives for managed care pharmacy. J Manag Care Spec Pharm, 2020 Nov;26(11):1468-1474.