In June 2001 ASHP created the ASHP Vision Statement for Pharmacy Practice in Hospitals and Health Systems. Essential themes in the vision are that health-system pharmacists will help make medication use more effective, scientific, and safe; and they will contribute meaningfully to public health. Based on the vision and with significant input from members, ASHP has established some ambitious and measurable goals and objectives for pharmacy practice in health systems to be achieved by the year 2015. By focusing practitioner and ASHP energies on a manageable number of crucial and achievable targets, this initiative can be an effective lever in advancing patient care and pharmacy practice in health systems. Meaningful progress in achieving the goals and objectives will speak powerfully about health-system pharmacy practitioners’ commitment to high quality patient care and their collective, national resolve to improve medication use throughout health systems. The University of Kentucky Chandler Medical Center Pharmacy Services considers the ASHP Health-System Pharmacy 2015 Initiative an important document and strategic plan with which it should align for continued success and leadership in assuring that patients make the best use of their medications. This 2015 initiative is viewed as a “Best Practice”, therefore it reflects a model in which UK should make assessments and goals for the future.

THE MODEL

The ASHP Health-System Pharmacy 2015 Initiative (the “2015 Initiative”) is patterned after the Healthy People 2010 project of the HHS Office of Disease Prevention and Health Promotion. As in the Healthy People 2010 project, the 2015 Initiative is organized this way:

- There are overarching goals.
- There are specific objectives related to those goals.
- There are baselines against which progress in meeting the objectives can be measured.

HOW THE GOALS AND OBJECTIVES WERE DEVELOPED

Using the Healthy People 2010 model and based on the themes in the ASHP Vision Statement for Pharmacy Practice in Hospitals and Health Systems, the development of the 2015 Initiative goals and objectives began in early 2002. The goals and objectives were developed with input from the ASHP Board of Directors, state society leaders, and members’ comments. The following aims guided the effort.

- The number of goals and objectives should be “manageable.”
- Each objective should have a plausibly high relationship to practice advancement and achieving the ASHP vision for practice.
- Each objective should have a quantified target.
- ASHP should have the ability to measure progress related to each objective. ASHP does not have to be the data collector; any reliable source can be used. Baseline data will be collected about the extent to which each activity now occurs, and ongoing surveys will be conducted to measure how well each objective is being achieved over time.
- Members should believe that, if they work to achieve the goals and objectives, the level of health-system pharmacy practice will be advanced.
A guiding aim in establishing the target percentages for the objectives was to set targets that would represent substantial, realistically achievable improvement by the year 2015. These initial chosen percentages were based on member input. Good baseline numbers are not available yet for most of the objectives. Establishing the baselines will be a high priority for ASHP. Once baseline numbers are determined, the target percents may be modified.


**THE INTENT OF ADDING UK Assessments and Goals for University of Kentucky (UK) Chandler Medical Center Pharmacy Services will be to align strategic directions of UK with those items identified in the ASHP 2015 Initiative. Assessments and Goals will be reviewed and revised annually (January/February of each year until 2015 starting in 2005). The UK Scope of Pharmacy and the UKCMC Pharmacy and Therapeutics Committee will review and approve this document on an annual basis. All pharmacy personnel, hospital and medical staff are welcome to provide feedback and comments regarding this initiative at any time to John Armitstead, Director of Pharmacy Services at <jaarmi2@email.uky.edu>.


**Goal 1. Increase the extent to which pharmacists help individual hospital inpatients achieve the best use of medications.**

**Objective 1.1**

Pharmacists will be involved in managing the acquisition, upon admission, of medication histories for 75% of hospital inpatients with complex and high-risk medication regimens.

ASHP baseline: A baseline has not been established. Once determined, this may lead to a revision of the target percentage.

**UK 2010 Goal:** To effectively implement electronic medication reconciliation. Define a process to target complicated patients and medication regimens (ie monitorable drugs) to ensure that medication histories and reconciliations are completed accurately.

**UK 2009 Assessment:** Obtain audit data from Kimberly Hite. Timeline for implementation of electronic med rec and Rx Writer has been defined for fall 2009.

**UK 2008 Goals:** Establish baseline expectation of all pharmacy residents, students and pharmacists to perform a medication history/reconciliations on all high priority patients. Further define/clarify the high risk patients and medication regimens to support pharmacist prioritization of services provided. Perform medication histories in 100% of BMT, TXL, CT, and HIV patients. Move towards med histories/reconciliation for 100% of ED patients to be admitted. Clarify our metrics to measure. Recommend evaluating a proprietary medication reconciliation product to identify high priority patients. Advocate medication histories being received from UK clinics.

**UK 2007 Assessment:** Med histories/reconciliations are being performed on all CT, BMT, TXP, and HIV patients. Medication reconciliations are being recorded in WORx at a rate of 10% of total admissions.
**UK 2006 Goals**: Documented medication histories performed on 10% of all inpatient admissions, including 100% of BMT and 100% of solid organ transplant patient admissions.

**UK 2005 Assessment**: Documented medication histories were performed for 2.2% of all inpatient admissions. The top documenting services included SGB, Medicine, FM, HO and BMT; 100% of all HIV admissions have documented medication histories.

**Objective 1.2**
The medication therapy of a majority of hospital inpatients with complex and high-risk medication regimens will be monitored* by a pharmacist in 100% of hospitals.

ASHP baseline: A baseline has not been established. Once determined, this may lead to a revision of the target percentage.

**UK 2010 Goal**: To identify high risk regimens and services most associated with them. To define and assess current process for identifying high risk patients with complex medication regimens.

**UK 2009 Assessment**: Recruited PICU pharmacist. Expanded service coverage including TDM/anticoagulation on below services (GYN/ONC, PLA, SGG, SGR, SGO)-ICU) with use of clinical-staff pharmacists.

**UK 2008 Goal**: Identify additional services that need a rounding Pharmacist: GYN/ONC, (PLA, SGG, SGR, SGO)-ICU, FM, PICU

**UK 2007 Assessment**: Hired one Emergency Department pharmacist, still recruiting the second pharmacist. Emergency department coverage is nearly 100%, Pharmacokinetic services have been reinstated. All services are covered by a primary pharmacist.

**UK 2006 Goal**: Reinstate the pharmacokinetics service (100% inpatient coverage) and expand to include anticoagulation services (100% of inpatients). Expand pharmacist monitoring involvement to include the emergency department. Define the expectations of pharmaceutical care monitoring (“covered service”)

**UK 2005 Assessment**: Based on average daily inpatient census, 60% of medical services are routinely covered by a pharmacist 5 to 6 days a week. Therapeutic drug monitoring is provided to 100% of inpatients. NICU and Pediatric HO monitoring expanded. Currently the Therapeutic Drug Monitoring (pharmacokinetics) position is being recruited to be refilled as a hospital-based position.

**Objective 1.3**
In 90% of hospitals, pharmacists will manage medication therapy for inpatients with complex and high-risk medication regimens*, in collaboration with other members of the health-care team.

Baseline: A baseline has not been established. Once determined, this may lead to a revision of the target percentage. (Note: Managing medication therapy may include: initiating, modifying, and monitoring a patient’s medication therapy; ordering and performing laboratory and related tests; assessing patient response to therapy; counseling and educating a patient about medications; and administering medications.)

**UK 2010 Goal**: To identify high risk regimens and services most associated with them. To assess outcomes in patients with pharmacist involvement in management of targeted medications. To advocate through the P&T committee for pharmacists to function within their scope of practice under “per protocol” orders.

**UK 2009 Assessment**: We are well established on services where pharmacists are present, but we need further action on the services without full-time pharmacy coverage.

**UK 2008 Goal**: No further action is required.

**UK 2007 Assessment**: We have a well established, integrated pharmacy practice within the medical teams. No further authority is needed.

**UK 2006 Goal**: Obtain the Pharmacy and Therapeutics Committee authority to obtain lab studies necessary for therapeutic drug monitoring. Research other areas for expansion of organization authority to collaboratively manage medication therapy.

**UK 2005 Assessment**: Only a few therapeutic interchanges formally approved by the Pharmacy and Therapeutics Committee. Collaboration exists primarily at the individual practitioner level.

**Objective 1.4**
75% of hospital inpatients discharged with complex and high-risk medication regimens will receive discharge medication counseling managed by a pharmacist.

Baseline: A baseline has not been established. Once determined, this may lead to a revision of the target percentage.

**UK 2010 Goal**: During their inpatient stay, patients should receive medication counseling for complex and high risk medication (ie warfarin) regimens. Identify patients who could benefit from PharmacistCare follow-up appointment after discharge and refer. Use educational tools (patient education booklets) for patients on warfarin therapy during their hospitalization. Complete medication action plan on all HIV patients prior to discharge. Advocate the pharmacist’s role in medication counseling with the nursing staff during patient hospitalization.

**UK 2009 Assessment**: We are continuing to address the professional role of the pharmacist in participating in discharge medication counseling. Medication action plan (TXP, BMT, CARDS) made prior to discharge.

*Pharmacists helping people make the best use of medicines*
UK 2008 Goal: Design a plan and identify the professional role of the pharmacist in participating in discharge medication counseling. Determine which meds are prioritized and target select discharge pharmacist med counseling. Advocate a discharge education documentation is part of the ICIS clinical documentation. Identify the functional discharge processes already in place that are model practices.

UK 2007 Assessment: Pharmacy has participated in the interdisciplinary Discharge Task Force. Currently our role is poorly defined and is a range of involvement.

UK 2006 Goal: Documented discharge counseling will be performed on 10% of all inpatient admissions, including 100% of BMT and solid organ transplant patients. All patients discharged on anticoagulation will be provided with discharge counseling.

UK 2005 Assessment: Less than 2% of all discharges.

Objective 1.5
50% of recently hospitalized patients (or their caregivers*) will recall speaking with a pharmacist while in the hospital.
Baseline: 23% (2002 survey conducted by the ASHP Public Relations Division). (* i.e. Family members)

UK 2010 Goal: To add a question regarding pharmacist interaction on hospital patient satisfaction survey.

UK 2009 Assessment: Select areas with defined patient populations or identified need have made significant progress in patient-pharmacist interaction.

UK 2008 Goal: Define a standardized approach. Conduct an audit of current practice. Get business cards for pharmacists who will use them. Incorporate pharmacy contact info into the std discharge packet. Add the pharmacist coverage to the patient room white board.

UK 2007 Assessment: Pharmacists have heightened their interactions with patients/families this year participating with medication reconciliation.

UK 2006 Goal: Develop a standardized department approach to pharmacist-patient introduction. Promote 24-hour pharmacy services and instruct patients how to contact a pharmacist during the pharmacist-patient interactions. Actively support objectives targeting medication histories and discharge counseling.

UK 2005 Assessment: Estimate less than 5% at UK. Objective will not be measured at UK.

Objective 1.6
In 90% of hospitals, pharmacists will ensure that effective medication reconciliation* occurs during transitions across the continuum of care.

New ASHP 2015 objective in 2008

UK 2010 Goal: To review the medication reconciliation at admission, transfer and discharge and identify risk points. Implementation of electronic medication reconciliation will require physicians to act on each order at transfer.

UK 2009 Assessment: Medication reconciliation processes are in place during transitions, although utilization is variable.

Goal 2. Increase the extent to which health-system pharmacists help individual nonhospitalized patients achieve the best use of medications.

Objective 2.1
In 70% of health systems providing clinic care, pharmacists will have organizational authority to manage medication therapy for patients with complex and high-risk medication regimens, in collaboration with other members of the health-care team.
Baseline: A baseline has not been established. Once determined, this may lead to a revision of the target percentage. (Note: Managing medication therapy may include: initiating, modifying, and monitoring a patient’s medication therapy; ordering and performing laboratory and related tests; assessing patient response to therapy; counseling and educating a patient about medications; and administering medications.)

UK 2010 Goal: Successful completion of the Internal Medicine Refill Authorization Service pilot and expansion to OBGYN clinic and neurology clinic. Expand pharmacy presence to include a consistent presence in Women’s Health and Internal Medicine clinics. Expand emergency department pharmacy services from 10 hours/day to 16 hours/day seven days a week. Expand the role of emergency department pharmacists and KY Clinic pharmacists to facilitate outpatient prescription services. Expand pharmacy services to KY Clinic South and Good Samaritan Hospital. Expand pharmacy services in hematology/oncology clinics to include more oncology-specific services, possibly via institution of an APPE experience, and creation of an outpatient satellite pharmacy. Expand cardiology clinic services to heart failure patients. Obtain a dedicated pharmacist for the infusion center and formalize his/her role and responsibilities. Define pharmacists’ privileges in the ambulatory care setting.

UK 2009 Assessment: Bluegrass Women’s Health Clinic involvement not materialized. Gill Heart Institute involvement expanded (cardiology pharmacotherapy clinic with collaborative care agreement pending). Markey
Objective 2.2

In 95% of health systems providing clinic care, pharmacists routinely counsel clinic patients with complex and high-risk medication regimens.

Baseline: A baseline has not been established. Once determined, this may lead to a revision of the target percentage.

UK 2010 Goal: Determine method for measuring pharmacists’ involvement in patients’ clinic visits. Formalize infusion center patient counseling procedures. Utilize results of KY Clinic patient counseling practice evaluation. Quantify pharmacist MTM/counseling activities in PharmacistCARE. Refine and formalize the place of PharmacistCARE within ambulatory care services as a means to integrate all services. Document clinical activities via Rx writer/additional technology to improve continuity of care.

UK 2009 Assessment: Continuing to counsel patients in the transplant, hematology/oncology, pediatric hematology/oncology, Gill Heart anticoagulation, Bluegrass HIV, Women’s health, cardiology pharmacotherapy clinic. Commissioned 25% FTE to review methods of patient counseling in the KY Clinic pharmacy. PharmacistCARE MTM and counseling for patients. Documentation of activities via WORx AC.

UK 2008 Goal: Strive to extend patient counseling activities in the Kentucky Clinic Pharmacy to patients who fax or electronically transmit prescriptions to the pharmacy. Target counseling for patients on complex or high-risk medication regimens, including warfarin. Encourage and empower poly-pharmacy patients to carry a current medication list with them to healthcare appointments/admissions. Continue counseling for transplant and hematology/oncology patients. Counseling should be documented in the WORx AC system.

UK 2007 Assessment: Pharmacists are actively counseling high risk patients in the transplant, hematology/oncology and pediatric hematology/oncology clinics, Gill Heart Institute cardiology anticoagulation clinic, etc. Monthly staff development programs to enhance counseling skills in pharmacists at Kentucky Clinic Pharmacy. Counseling for Kentucky Clinic Pharmacy walk-in patients and high risk patients (pediatric compounded prescriptions and injectables) is achieved.


UK 2005 Assessment: Counseling is offered to Kentucky Clinic Pharmacy patients and/or their representatives 100% of the time. The reality may be that patients do not know to request information and pharmacists may not readily provide it to patients (considering the volume of phone/fax prescriptions).

Objective 2.3

In 90% of home care services, pharmacists will manage medication therapy for patients with complex and high-risk medication regimens*, in collaboration with other members of the health-care team.

Baseline: A baseline has not been established. Once determined, this may lead to a revision of the target percentage. (Note: Managing medication therapy may include: initiating, modifying, and monitoring a patient’s medication therapy; ordering and performing laboratory and related tests; assessing patient response to therapy; counseling and educating a patient about medications; and administering medications.)

UK 2010 Goal: Consistently provide medication reconciliation documents to subsequent providers in a timely manner.
manner (prior to follow-up appointment). Implement an electronic orders reconciliation program. Decrease time to medication reconciliation for new admissions.

**UK 2009 Assessment:** Medication reconciliation focus is now both admission and discharge. Not up to our goal of communicating medication therapy to the subsequent provider at discharge.

**UK 2008 Goal:** UK will meet the expanded expectation from the NPSG 8, which requires discharge medications to be communicated to the next healthcare provider and patient.

**UK 2007 Assessment:** The medication reconciliation process usually focuses on admission rather than discharge. UK is striving to meet the expanded expectation from the NPSG 8 which requires discharge medications to be communicated to the next healthcare provider and patient. Pharmacy is actively involved in the discharge task force to develop an effective process.

**UK 2006 Goal:** Establish a communication model for pharmacists at UKH to communicate pertinent patient care issues on individual patients to pharmacists at select home care providers, based upon the Cardinal Hill Hospital model developed (see Objective 2.4).

**UK 2005 Assessment:** Objective 2.3 is not directly applicable to UKH since we do not provide pharmacy home care services, although we currently provide continuity of care services only upon request.

**Objective 2.4**

In 90% of long term care facilities, pharmacists will manage medication therapy for patients with complex and high-risk medication regimens*, in collaboration with other members of the health-care team.

**Baseline:** A baseline has not been established. Once determined, this may lead to a revision of the target percentage.

(Note: Managing medication therapy may include: initiating, modifying, and monitoring a patient’s medication therapy; ordering and performing laboratory and related tests; assessing patient response to therapy; counseling and educating a patient about medications; and administering medications.)

**UK 2010 Goal:** Investigate provision of clinical and distributive pharmacy services for Kentucky correctional facilities.

**UK 2009 Assessment:** Not currently providing services to long-term care settings.

**UK 2008 Goal:** See Objective 2.3

**UK 2007 Assessment:** See Objective 2.3

**UK 2006 Goal:** Establish a communication model for pharmacists at UKH to communicate pertinent patient care issues on individual patients to pharmacists at Cardinal Hill Hospital, our primary rehabilitation transfer site.

**UK 2005 Assessment:** Objective 2.4 is not directly applicable to UKH since we do not provide long term care, although we currently provide continuity of care services only upon request.

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**Goal 3. Increase the extent to which health-system pharmacists actively apply evidence-based methods to the improvement of medication therapy.**

**Objective 3.1**

In 90% of hospitals, pharmacists will be actively involved in providing care to individual patients that is based on evidence, such as the use of quality drug information resources, published clinical studies or guidelines, and expert consensus advice.

**Baseline:** A baseline has not been established. Once determined, this may lead to a revision of the target percentage.

**UK 2010 Goal:** Reformation of MUE committee as the MOA Committee (Medication Outcome Assessment). Establish standards for clinical expectations/performance. Refine competency assessments and develop defined levels of competency. Continue to advocate for pharmacist provider status, and inpatient credentialing.

**UK 2009 Assessment:** All inpatient services have a pharmacist assigned for rounding or screening coverage. Some but not all pharmacists are developing more experience in evidence-based practice; addressing by implementation of Clinical Development Series but may need additional activities to promote knowledge. Resources are readily available (clinical specialists and electronic sources) to advance evidenced-based practice.

**UK Goal 2008:** Improve coordination of resources for patient coverage. Integrate MUE process into the daily pharmacist practice. Establish minimum of pharmacy services and provided to all patients and the manageability of other pharmacy services based on the volume and acuity. Pharmacists are actively involved in the documentation of the core measures. Utilize the concepts of 3.1 in the programming and development of the SCM clinical documentation, link to the evidence. Push for the pharmacist provider status. MUEs planned to be conducted in 2008: Crotalidae antivenin-assessment usage, medication reconciliation - policy adherence and safety, Broad-spectrum antimicrobial therapy de-escalation, antibiotic adverse events in patients with hematologic malignancies, enteral nutrition in neurocritical care, factor VII.

**UK 2007 Assessment:** Heparin FMEA, Cardiology core measure, reviewing oncall reports, evidence based medicine is routinely utilized in patients that we round on, supports the ACLS algorithm during codes. Pkine and anticoag monitoring, med error investigation?, MUE s conducted in 2007: ICU Intensive Insulin nomogram, neutropenic fever guidelines, albumin supplementation inliver transplantation, ACE Inhibitor/ ARB Use Post-Renal
transplantation, flumazenil for reversal of benzodiazepine-induced sedation/respiratory depression, protamine for reversal of heparin-induced anticoagulation, metronidazole and oral vancomycin for C. difficile, ventilator-associated pneumonia treatment pathway, anti-fibrinolytic prophylaxis for on-pump cardiac surgery, enoxaparin for venous thromboembolism prophylaxis in trauma patients, itraconazole fungal prophylaxis in heart and lung transplant.

**UK 2006 Goal:** Implement evidenced based medicine guidelines in the pediatric population. Standardize neuromuscular blocking agents. Define the role of 5HT3 antagonists in post-operative nausea and vomiting.

**UK 2005 Assessment:** Currently, pharmacists are involved in the implementation of evidence based medicine in a number of areas including the Antimicrobial Management Team (AMT), stroke team with TPA evaluation and dosing, Xigris evaluations, and the pharmacist immunization protocol. Other areas with evidence based guidelines or pathways include acute MI, CHF exacerbations, neutropenic fever protocol, ICU anemia protocol.

**Objective 3.2**
In 90% of hospitals, pharmacists will be actively involved in the development and implementation of evidence-based drug therapy protocols and/or order sets.

Baseline: A baseline has not been established. Once determined, this may lead to a revision of the target percentage.

**UK 2010 Goal:** As a key member of a multidisciplinary team, pharmacists should lead in the creation and revision of all order sets/guidelines involving medications; a pharmacist can be assigned to take ownership of order sets. Review and update of the order sets/guidelines should be performed regularly. Encourage increased utilization of order sets/guidelines by providers.

**UK 2009 Assessment:** Pharmacists have been involved in the review of the SCM Clinical Documentation guidelines: smoking cessation, contrast nephropathy, admit order sets, DVT prophylaxis, sedation of non-emergent pediatric intubation, pediatric pain control guidelines, antifungal use in BMT/neutropenic fever, and implementation of the ED CAP order set. We will need to focus on areas that are not covered by a pharmacotherapy specialist.

**UK Goal 2008:** Smoking cessation, contrast nephropathy, admit order sets, DVT prophylaxis. Pharmacists will be involved in the review of the SCM Clinical Documentation guidelines. Pharmacists routinely utilize Zync Health or better standards available to implement the evidence in practice. Sedation of non-emergent pediatric intubation. Pediatric pain control guidelines. Antifungal use in BMT.

**UK 2007 Assessment:** Standardized drip concentrations in the pediatric units, cardiology updated the order sets, Pharmacists are routinely involved in the development and continual review of 100% of the SCM order sets (NICU, oncology, pediatric pulmonary, cardiology, Vaccine protocol, smoking cessation, hyperglycemia, heparin).

**UK 2006 Goal:** Continue to work collaboratively with health-care professionals to development and implement evidence-based protocols specifically targeting patients on the cardiology service.

**UK 2005 Assessment:** Currently pharmacists have been involved in the development and implementation of evidence-based medicine in a select group of areas with ICIS including infectious diseases and CTICU order sets.

**Objective 3.3**
In 90% of hospitals, pharmacy departments will actively participate in hospital-wide efforts to ensure that patients receive evidence-based medication therapies required by the CMS hospital quality initiative, Joint Commission Core Measures, and/or state-based quality improvement and public reporting efforts.

**New ASHP objective for 2008**

**UK 2010 Goal:** Continue active involvement and improvement of performance indicators. Petition nationally the active involvement of pharmacist in the core measures and furthering the development of evidence behind the core measures. Need to consider Good Samaritan compliance with core measures.

**UK 2009 Assessment:** Actively involved in CMS hospital quality initiative, Joint Commission Core Measures, and/or state-based quality improvement and public reporting efforts.

**Former Objective 3.3**
90% of hospital pharmacies will participate in ensuring that patients* hospitalized for an acute myocardial infarction or congestive heart failure will receive angiotensin-converting enzyme inhibitors at discharge.

Baseline: A baseline has not been established. Once determined, this may lead to a revision of the target percentage. A related baseline is that, at discharge, these medications are prescribed for 74% of Medicare patients hospitalized for acute myocardial infarction and for 68% of Medicare patients hospitalized for congestive heart failure. (Jencks S, Huff ED, Cuerdon T. Change in the quality of care delivered to Medicare beneficiaries, 1998-1999 to 2000-2001. JAMA 2003; 289:305-312). However, the percentage of hospital pharmacies engaged in this is to be determined.

**UK 2008 Goal:** To improve the documentation, goal to gain pharmacist provider status to document. Continue to work with CSP and MDs to ensure consistent assessment of HF & MI patients hospital wide, beyond the CAR services.

**UK 2007 Assessment:** 87% HF and 84% for MI

**UK 2006 Goal:** Strive to ensure that 90% of patients admitted for acute myocardial infarction and congestive heart failure receive angiotensin-converting enzyme inhibitors upon discharge. Develop an evidence-based protocol or pathway for patients admitted for congestive heart failure including implementation of angiotensin-converting enzyme inhibitors.

**UK 2005 Assessment:** Currently, approximately 50% of patients admitted for an acute myocardial infarction or congestive heart failure and approximately 75% CABG of patients are discharged on angiotensin-converting enzyme inhibitors.

**Former Objective 3.4**

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90% of hospital pharmacies will participate in ensuring that patients hospitalized for an acute myocardial infarction will receive beta-blockers at discharge.

**Baseline:** A baseline has not been established. Once determined, this may lead to a revision of the target percentage. A related baseline is that, at discharge, aspirin is prescribed for 86% of Medicare patients hospitalized for an acute myocardial infarction. (Jencks S, Huff ED, Cuerdon T. Change in the quality of care delivered to Medicare beneficiaries, 1998-1999 to 2000-2001. JAMA 2003; 289:305-312). However, the percentage of hospital pharmacies engaged in this is to be determined.

**UK 2008 Goal:** Know our noncompliance by service.

**UK 2007 Assessment:** 97% for beta blockers at discharge.

**UK 2006 Goal:** Evaluate 100% of patients admitted for an acute myocardial infarction for a prescription for a B-blocker upon discharge. On all services (uncovered-Cards/non-covered—FM, CT, Int Med), ensure that pharmacists are involved in discharge counseling.

**UK 2005 Assessment:** Based on 2004 data, 35% of patients with a DRG for chest pain and myocardial infarction have received B-blockers as UCKMC inpatients.

**Former Objective 3.5**
90% of hospital pharmacies will participate in ensuring that patients hospitalized for an acute myocardial infarction will receive aspirin at discharge.

**Baseline:** A baseline has not been established. Once determined, this may lead to a revision of the target percentage. A related baseline is that, at discharge, aspirin is prescribed for 86% of Medicare patients hospitalized for an acute myocardial infarction. (Jencks S, Huff ED, Cuerdon T. Change in the quality of care delivered to Medicare beneficiaries, 1998-1999 to 2000-2001. JAMA 2003; 289:305-312). However, the percentage of hospital pharmacies engaged in this is to be determined.

**UK 2008 Goal:** Maintain, ensure appropriate dose of aspirin is provided.

**UK 2007 Assessment:** 100%

**UK 2006 Goal:** Encourage and implement aspirin therapy in patients suffering from and acute myocardial infarction on uncovered and non-covered services upon discharge. In addition, increase efforts to provide discharge counseling to patients suffering from an acute myocardial infarction.

**UK 2005 Assessment:** Approximately 31% of patients admitted with a DRG of chest pain and/or myocardial infarction have received aspirin and/or clopidogrel while being admitted as an inpatient.

**Former Objective 3.6**
90% of hospital pharmacies will participate in ensuring that patients hospitalized for an acute myocardial infarction will receive lipid lowering therapy at discharge.

**Baseline:** A baseline has not been established. Once determined, this may lead to a revision of the target percentage.

**UK 2008 Goal:** Obtain data from the CEQS.

**UK 2007 Assessment:** No data available.

**UK 2006 Goal:** Increase compliance with baseline by a minimum 10% above baseline for 2005.

**UK 2005 Assessment:** Approximately 37% of UCKMC of patients with a DRG for chest pain and/or myocardial infarction have received a lipid lowering agent (statins, bile acid sequestrants, ezetimibe, niacin, fibrates) as an inpatient.

**Former Objective 3.7**
90% of nonhospitalized patients under the care of health-system pharmacists and who are receiving medications to decrease blood glucose levels will be assessed annually with a HbA1c test.

**Baseline:** A baseline has not been established. Once determined, this may lead to a revision of the target percentage. A related baseline is that this assessment occurs for 78% of Medicare patients. (Jencks S, Huff ED, Cuerdon T. Change in the quality of care delivered to Medicare beneficiaries, 1998-1999 to 2000-2001. JAMA 2003; 289:305-312). However, the percentage of non-hospitalized patients for whom this assessment occurs under the care of health-system pharmacists is to be determined.

**UK 2008 Goal:** Obtain SCM/SCV access to lab values. Identify PharmacistCARE patients to access their records.

**UK 2007 Assessment:** Education program provided by KCP to outpatients, KCP and Pharmacist CARE participated in health fairs; PharmacistCARE CARE participated in health fairs and before discharge from UKCMC.

**UK 2005 Goal:** Obtain data from the CEQS.

**UK 2007 Assessment:** No data available.

**UK 2006 Goal:** Increase compliance with baseline by a minimum 10% above baseline for 2005.

**UK 2005 Assessment:** Approximately 37% of UCKMC of patients with a DRG for chest pain and/or myocardial infarction have received a lipid lowering agent (statins, bile acid sequestrants, ezetimibe, niacin, fibrates) as an inpatient.

**Objective 3.4**
In 70% of hospitals, pharmacists will actively be involved in medication- and vaccination-related infection control programs.

**New ASHP Objective for 2008**

**UK 2010 Goal:** Need to improve performance and outcome measures of medication- and vaccination-related infection control programs through order set utilization and revision, active consultation and monitoring. Promote effective use of Immunization Manager. Target AMT activities at improving this indicator.

**UK 2009 Assessment:** Pharmacist are actively involved in medication- and vaccination-related infection control programs.

**Objective 4.1**
90% of health systems will have an organizational program, with appropriate pharmacy involvement, to

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Pharmacists helping people make the best use of medicines
**UK 2006 Goal:** Provide nursing education on sterile preparation of medications (e.g. use of alcohol swabs), create and implement a nursing competency CBL on sterile product preparation. Address medication compounding activities on floor, NICU identified as a target problem area. Assess ability of enlarging oncology and pediatric pharmacy satellites or closure of these areas. Replace IV hoods with new hoods in compliance with USP 797. Obtain 100% IV pump admixture training for technicians. Train 100% of new pharmacy residents on TPN preparation. Continue annual sterile product compounding preparation assessment of staff.

**UK 2005 Assessment:** See USP 797 gap analysis. Pharmacy staff is assessed annually on correct sterile compounding procedures. Inaccurate Baxter admixture machine replaced.

**Objective 4.3**

80% of hospitals have at least 95% of routine medication orders reviewed for appropriateness by a pharmacist before administration of the first dose. (*Not including doses required in the context of emergencies or immediate procedures such as surgeries, labor and delivery, cardiac catheterization, etc.)

Baseline: A baseline has not been established. Once determined, this may lead to a revision of the target percentage. (*Not including doses required in the context of emergencies or immediate procedures such as surgeries, labor and delivery, cardiac catheterization, etc.)

**UK 2010 Goal:** Address the pharmacist review of contrast media orders. Implement a limited ED Pyxis profile, address the review of all medications for ‘boarders’ regardless of location, specific areas of concern are PACU, ED.

**UK 2009 Assessment:** Expanded SCM order entry to include dialysis, Gill Heart, CAS, and women’s bluegrass. Developed a collaborative relationship with radiology.

**UK 2008 Goal:** Address the pharmacist review of contrast media orders. Implement a limited ED Pyxis profile, address the review of all medications for ‘boarders’ regardless of location, specific areas of concern are PACU, ED.

**UK 2007 Assessment:** Sporadic review of Pyxis override medications is being done, looking for what medications are being overridden, user access and trends. ED has implemented CPOE and all medication orders are review. We are not reviewing Transplant Clinic, Bluegrass High Risk. KCN review of vaccines now has a process for a pharmacist/physician review prior to administration.

**UK 2006 Goal:** Monitor doses and time frame when Pyxis override function (routine or critical) is utilized. Assume pharmaceutical responsibility for boarding emergency department patients.

**UK 2005 Assessment:** 90-95% of medication orders are reviewed by a pharmacist prior to administration. Gaps exist (~5%) in specialty units (ED, OR, ENDO, PACU, LDR) and Pyxis override situations.

**Objective 4.4**

90% of hospital pharmacies will participate in ensuring that patients receiving antibiotics as prophylaxis for surgical infections will have their prophylactic antibiotic therapy discontinued within 24 hours after the surgery end time.

Baseline: A baseline has not been established. Once determined, this may lead to a revision of the target percentage.

**UK 2010 Goal:** Please insert comments here

**UK 2009 Assessment:** Active pharmacy participation in SCIP core measures. Meet or exceed the goals as publicly reported. AMT to provide an update for the 2008 Assessment and develop goals for 2009. 92.5% of patients are estimated to receive appropriate selection, time to administration and therapy duration of antibiotic prophylaxis for surgical infections.

**UK 2008 Goal:** Meet or exceed the goals as publicly reported. AMT to provide an update for the 2007 Assessment and develop goals for 2008.

**UK 2007 Assessment:** Prophylaxis has improved but core measures are still not met. Obtain the existing data, report it to our pharmacists. Some OCTOR orders still exist.

**UK 2006 Goal:** 100% of patients undergoing surgery will receive appropriate antibiotics for surgical infection prophylaxis within 1 hour of incision. The antimicrobial team will continue monitoring selection and duration of treatment of antibiotic surgical prophylaxis. Creation of SCM order sets which implement 24 hour automatic stop time of prophylactic antibiotics for surgical infections.

**UK 2005 Assessment:** 70% (infection control % to replace estimate with exact data) of patients are estimated to receive appropriate selection, time to administration and therapy duration of antibiotic prophylaxis for surgical infections. Anesthesia department currently holds responsibility of antibiotic administration time and records information. An approved algorithm has been approved by P&T with a goal for hospital-wide implementation.

**Objective 4.5**

85% of pharmacy technicians in health systems will be certified by the Pharmacy Technician Certification Board. Baseline: 38% (2002 ASHP National Survey of Pharmacy Practice in Hospital Settings).

**UK 2010 Goal:** 100% state registration for pharmacy technicians. Only hire certified technicians for full-time positions. Develop policy for all technicians practicing in a specialty area (IV room, etc.) to be certified.

**UK 2009 Assessment:** Inpatient 71%, KCP and peds heme/one 59%. New technicians are expected to become certified within 12 months. This expectation would exclude technicians who have been employed at UK for greater than 10 years.
UK 2008 Goal: Inpatient 75%, KCP maintain 90%. New technicians are expected to become certified within 12 months. This expectation would exclude technicians who have been employed at UK for greater than 10 years.

UK 2007 Assessment: KCP is at 90%, excluding on call technicians. Inpatient is at 60%

Some outliers where they exceed the grade ceiling. This will be investigated to see if this can be corrected.

UK 2006 Goal: 50% (or 20% increase from current status) inpatient technicians will become board certified. 75% of inpatient technicians with ≥ 3 years UK tenure will become certified; 85% of KCP technicians with ≥ 3 years UK tenure will become certified. Exception: technicians who are pharmacy interns are excluded.

UK 2005 Assessment: 30% inpatient technicians are board certified. 70% KCP technicians are board certified.

Objective 4.6
50% of new pharmacy technicians entering hospital and health system practice will have completed an ASHP-accredited pharmacy technician training program*. New ASHP Objective for 2008

UK 2010 Goal: Develop a proposal for in-house ASHP-accredited pharmacy technician training program. Implement initial training program that meets a minimum of the ASHP requirements. Explore incremental salary advancement with completion of ASHP training.

UK 2009 Assessment: Hired one technician who completed an ASHP-accredited pharmacy technician program.

Objective 4.7
90% of new pharmacists entering hospital and health-system practice will have completed an ASHP-accredited residency. New ASHP Objective for 2008

UK 2010 Goal: Increase the number of ASHP-accredited residents we train. Implement an extended PGY 1 residency.

UK 2009 Assessment: Residency training was advertised as highly valuable but not required for the requirement of CSPs. Currently produce 7 to 10 ASHP accredited residents per year. Investigating an extended PGY 1 residency.

Goal 5. Increase the extent to which health systems apply technology effectively to improve the safety of medication use.

Objective 5.1
75% of hospitals will use machine-readable coding to verify medications before dispensing. Baseline

Objective 5.2
75% of hospitals will use machine-readable coding to verify all medications before administration to a patient.

UK 2010 Goal: 5.1 - At least 90% of medications will be bar coded by January 2010. Barcode refill for Pyxis will be operational by January 2010. 5.2 – Selection of BCMA product, preparation for implementation in 2011.

UK 2009 Assessment: Talyst AutoCarousel™ was implemented in July 2007 which automates the drug storage and retrieval process while providing up to a 50% space reduction for medication storage and ushered in the bar code era for inpatient pharmacy services. eMAR was implemented in November 2007 and currently in 90% of patient care areas (exceptions are chemotherapy administration, pediatrics, outpatient clinics). BCMA project timeline pending. Autopack and Barcode labeler target date extended. Talyst implemented 2007. KY Clinic Pharmacy is fully barcoded. SRx will be implemented in July 2009; need to confirm that SRx printing will allow for barcoding for labels (IV admixtures); barcode refill for Pyxis in June 2009; determine percent of current medications that are bar coded. ASHP SELF ASSESSMENT TOOL: 5.1: Fully Implemented for Some Areas; 5.2: Formally Discussed/Considered

UK 2008 Goal: Implementation of the Autopack and Barcode labeler is scheduled for June 2008 (opted to not purchase the packing instrumentation versus using Shamrock, pre-bar coded packaging. BCMA project has been submitted for FY09 (hospital is still determining priority, funding). eMAR will be implemented in Fall 2007.

UK 2007 Assessment: Budget submitted for Bar Code equipment, Autopack and Barcode labeler. It would put us in position to dispense doses ready for BCMA. In order to move toward BCMA, the SCM-WORx bidirectional interface or integrated SCM Pharmacy module will need to be in place to allow the BCMA “system” to “know” what pharmacy has dispensed to be administered.

UK 2006 Goal: Continue to explore market and research institutions demonstrating best practice with this technology. Resubmit capital equipment request for FY07 budget.

UK 2005 Assessment: The concept has been introduced and presented to the Integrated Clinical Information Systems (ICIS) project executive committee and hospital administration. A capital equipment request for FY06 has been submitted but is not of high organizational priority at this time. Tentative scheduling of concept has been made for FY07 consideration.

Pharmacists helping people make the best use of medicines
Objective 5.3
For routine medication prescribing for inpatients and clinic patients, 70% of hospitals will use computerized prescriber order entry systems that include clinical decision support.

UK 2010 Goal: Assess electronic documentation of medications administered during code situations (post event) as part of electronic code record. Expand pharmacy’s role in Medical Logic Module (MLM) clinical decision support. Chemotherapy will be included in CPOE in 2010. Expand pharmacy involvement in SCM order set design and maintenance including promotion/education and utilization review.

UK 2009 Assessment: SCM 5.0 upgrade will be implemented in March 2009 and will enhance functionality including use of order filters. SRx will be implemented in July 2009 and will allow bidirectional communication from CPOE and Pharmacy Systems. Outpatient Medication Profile and Prescription Writer™ will be implemented in Fall 2009 which will allow electronic medication reconciliation. CPOE at UK HealthCare not functional in following areas: Chemotherapy orders, Outpatient – intravenous infusion clinic, OR, Codes, and outpatient clinics. Enhanced functionality added to allow drug interaction severity pairings to be modified to reduce alert fatigue. Added MLM functionality (anticoag, completed orders, hyperglycemia). E-prescribing, electronic medication reconciliation to be implemented Fall 2009. CPOE continues to expand in outpatient clinic. ASHP SELF ASSESSMENT TOOL: 5.4: Fully Implemented for Some Areas

UK 2008 Goal: Further enhance the decision support rules. SCM 4.5 upgrade has enhanced functionality that allow drug interaction severity pairings to be modified to reduce alert fatigue.

UK 2007 Assessment: CPOE was initiated in 2004 and now has been implemented for all inpatients and ED. Chemotherapy and investigation orders are currently excluded. CPOE is also implemented in procedural areas (i.e. endoscopy, etc). CPOE has not been implemented in the majority of clinic/outpatient areas. Bluegrass Women’s Health clinic is the first clinic area. ICIS Steering committee meets monthly and advances the decision support rules. Evidenced based order sets are in place for all services thereby providing clinical decision support.

UK 2006 Goal: In FY05 implementation is scheduled for chemotherapy, BMT, pediatrics, NICU, OR, PACU, MCC outpatients and ED. Further development of the medical logic modules and evidence based order sets/treatment protocols.

UK 2005 Assessment: Implementation initiated in FY04 with 70% of inpatient orders managed via the CPOE system. Outlying patient groups and orders include: chemotherapy, BMT, pediatrics, NICU, OR, PACU, ED, and clinic patients.

Baseline: A baseline has not been established. Once determined, this may lead to a revision of the target percentage. (* Clinical decision support may include, for example, medication interaction screening, dose checking, allergy checking, IV compatibility checking, and expert decision rules)

Objective 5.4
In 65% of health systems, pharmacists will use medication-relevant portions of patients’ electronic medical records for managing patients’ medication therapy.

UK 2010 Goal: Increase utilization of order filters by all pharmacists, residents, and PY4 APPE students. SRx will be fully implemented including off site verification. Implement integrated documentation system of pharmacy services utilizing SCM Clinical Documents and SRx including documentation of pharmacotherapy consults, patient education, and method to assess productivity.

UK 2009 Assessment: Increased utilization of filters in provision of pharmacy service including TDM, anticoagulation, VTE prophylaxis, antimicrobials, completed orders, renal dosing, vaccines etc. Active Medication Reconciliation Reference List was created in 2008 to facilitate medication reconciliation. Access to documents, charting, I&O, vitals, labaratory data, patient profile, eMAR, and immunization manager are currently available. Integration between eMAR and SRx will be available; utility being developed. All services have assigned pharmacist coverage with access to electronic medication record. SRx relevant results will available during order verification. ASHP SELF ASSESSMENT TOOL: 5.4: Fully Implemented Throughout

UK 2008 Goal: Monitor and update the renal dosing program to reflect coverage assignment and formulary medications. The kinetic service filters for all assigned patients on TDM and anticoagulation drugs. Extend the filter utilization covered by other pharmacists. Electronic notification of Critical value is being discussed.

UK 2007 Assessment: Renal dosing program was revised outlining the procedure. All services have been assigned for pharmacist coverage. SCM filters and WORx Infomaker reports are generated to facilitate identification of specific patients’ drug therapy issues.

UK 2006 Goal: Assess the renal dosing program. Explore opportunities in the CPOE system for tools to aid pharmacist management of medication therapy.

UK 2005 Assessment: Daily reports are reviewed by a pharmacist related to therapeutic drug monitoring (pharmacokinetics and anticoagulation), patient allergies, and the renal dosing program.

Baseline: A baseline has not been established. Once determined, this may lead to a revision of the target percentage. (Note: Managing medication therapy may include initiating, modifying, and monitoring a patient’s medication therapy; ordering and performing laboratory and related tests; assessing patient response to therapy; counseling and educating a patient about medications; and administering medications.)

Pharmacists helping people make the best use of medicines
Objective 5.5
For 70% of patients with complex and high-risk medication regimens pharmacists will be able to access pertinent patient information and communicate across settings of care * to ensure continuity of pharmaceutical care.

UK 2010 Goal: Outpatient Medication Profile and Prescription Writer™ will be implemented in Fall 2009 and will allow increased utilization of medication reconciliation for high risk medications. Need to assess potential physician portal use for pharmacist continuity of care and improve access to patient information from GSH, KCP database.

UK 2009 Assessment: Increased utilization of filters to identify high-risk medication regimens. SCM for Clinical documentation with electronic medication reconciliation implemented. Digital discharge summaries were available in Clinical Documentation in Spring 2008 which improved dissemination of patient information throughout UK HealthCare including medications. Medication Reconciliation pilot (new paper form) completed with revised format to improve discharge process including communication to hospital course/new medications to primary care provider. ASHP SELF ASSESSMENT TOOL: 5.4: Fully Implemented Throughout

Objective 6.1
60% of pharmacies in health systems will have specific ongoing initiatives that target community health.

Baseline: A baseline has not been established. Once determined, this may lead to a revision of the target percentage. One baseline measure is that 52.4% of hospitals offer wellness programs (2002 ASHP National Survey of Pharmacy Practice in Hospital Settings).

UK 2010 Goal: Increase awareness and knowledge of Gardasil vaccination (however, only nurses may administer) in hopes of increased rates of vaccination to prevent cervical cancer. Pharmacy will explore avenues to increase vaccination in the community, specifically family members. Improve compliance with patient screening and identification of patients in need of pneumococcal vaccination. Encourage and make note of volunteerism amongst staff and work with those individuals to identify/create a volunteer network (contact between members to be done through commonly accessed medium such as SharePoint). Expand roles in the disease-state management of FMC and KCP. Anticoagulation note available via UK server to be utilized by FM, internal med clinics. Online med reconciliation is in development.

UK 2006 Goal: Increase access to electronically available data to pharmacists in the Kentucky Clinic pharmacies, specifically SCM, SCV, and WORx. Eliminate use of the “pink” chemotherapy production card and convert to electronic documentation via SCM and WORx.

UK 2005 Assessment: Inpatient pharmacists have electronic access to laboratory data, dictation summaries, and medication profiles. Outpatient pharmacists do not have access to these data. Pharmacists in the BMT, Liver/Kidney/Pancreas transplant and Pharmacotherapy clinics have access to clinical medical records. Baseline: A baseline has not been established. Once determined, this may lead to a revision of the target percentage. (* For example, among hospitals, clinics, home care operations, and chronic care operations)

Goal 6. Increase the extent to which pharmacy departments in health systems engage in public health initiatives on behalf of their communities.

UK 2008 Goal: Campaign for patient involvement in health-carrying own med sheets; flu and pneumococcal immunizations by appt in KCP; Continue herpes zoster vaccination program; Program integration of PharmacistCare and Kentucky Clinic activities (pt who pick up Rx at KY clinic receive brochure for PharmacistCare); Vaccinations in hospital lobby (for pt family members); provision of medication information in KCP lobby area; Expansion of Medication Therapy Management (MTM) services for Medicare part D in the KCP.

UK 2007 Assessment: Continuing flu vaccine drive-through. REACH program evolvement to PharmacistCare, diabetes day, cardiac health day, offered flu vaccines in H110 (multiple sessions offered to staff), health fair KAPS, Pharmacists helping people make the best use of medicines.
continued participation in “ask the pharmacist”, zoster vaccinations (#8-10/week); MTM services for Medicare Part D.

**UK 2006 Goal:** Continue with annual influenza vaccine drive-thru program, increase pharmacist involvement in immunization through the pneumococcal vaccination program and enhance provision of health and medication information in the Kentucky Clinic pharmacy lobby.

**UK 2005 Assessment:** Existing programs targeting community health include REACH (diabetes, women’s health, smoking cessation), UK Wellness Program (weight loss, cardiovascular health, smoking cessation), annual influenza vaccine drive-thru, annual UK College of Pharmacy “Ask a Pharmacist” television show and Faith pharmacy participation (free pharmacy services and medications for indigent population).

**Objective 6.2**
50% of pharmacy departments in health systems will be directly involved in ongoing immunization initiatives in their communities.

Baseline: A baseline has not been established. Once determined, this may lead to a revision of the target percentage.

**UK 2010 Goal:** Work to increase lobby presence (KCP, Hospital, MCC, ED etc.) by pharmacy to increase vaccination of public patrons. This will involve an increase or formalize the promotion and utilization of vaccination programs within the UK HealthCare system and its patrons (possible through UK becoming an Operation Immunization Site). These efforts will also look to expand the number and type of vaccinations offered (i.e. meningococcal, hepatitis A & B, Tetanus/Pertussis). Awareness program for patients (i.e. “When was your last vaccination”).

**UK 2009 Assessment:** KCP offering vaccinations year around (Zoster, influenza), extensive program for influenza. Continued annual drive-thru influenza vaccination program initiated in 2003 has 50% of pharmacists and/or pharmacy students providing vaccine administration.

**UK 2008 Goal:** Continue vaccination administration recertification program for UK hospital pharmacists. See goal 6.1.

**UK 2007 Assessment:** Met goals from 2006.

**UK 2006 Goal:** Continue current level of pharmacy involvement in influenza vaccination program and encourage other pharmacists to be involved.

**UK 2005 Assessment:** Annual drive-thru influenza vaccination program initiated in 2003 has 50% of pharmacists and/or pharmacy students providing vaccine administration.

**Objective 6.3**
85% of hospital pharmacies will participate in ensuring that eligible patients in health systems receive vaccinations for influenza and pneumococcus.

Baseline: A baseline has not been established. Once determined, this may lead to a revision of the target percentage. A related baseline is that 72% of Medicare patients receive influenza vaccine, and 65% receive pneumococcal vaccine. (Jencks S, Huff ED, Cuerdon T. Change in the quality of care delivered to Medicare beneficiaries, 1998-1999 to 2000-2001. JAMA 2003; 289:305-312). However, the percentage of hospital pharmacies involved in this is to be determined.

**UK 2010 Goal:** Increase nursing utilization of immunization manager for all eligible patients identified in the health system as well as increase pharmacists access to immunization manager. Increase education of healthcare providers in regard to importance of patient evaluation and vaccination (use of vaccination protocol) as well as documentation of administration in immunization manager. Remove barriers to use of vaccination protocol (i.e. schedule vaccination for the day of discharge to prevent fever work-up)

**UK 2009 Assessment:** ~80% of CAP patients are being evaluated for vaccination. Currently pharmacists are members of an interdisciplinary team working on vaccination core measures. Immunization manager currently being implemented through SCM.

**UK 2008 Goal:** Assess and document vaccination history in greater than 50 % of eligible patients. Improve vaccination follow-up data collection.

**UK 2007 Assessment:** In 2006, 10-70% of patients were administered pneumococcal vaccinations- however, no data is available since implementation of the admission protocol. In 2005, 2% of patients were administered pneumococcal vaccinations. There has been an increase in the number of pneumococcal vaccines dispensed (30 pneumococcal vaccines/month 2005- 150 pneumococcal vaccines/month 2007- 5 fold increase). Influenza and pneumococcal vaccinations are part of the admission order sets. Pharmacists are regularly involved in data collection on this initiative.

**UK 2006 Goal:** Expand application of vaccination protocol to all adult patients admitted to hospital. Create and implement a standing admit vaccination order with nursing eligibility of patient immunization status assessment. Measure utilization of vaccination protocol through SCM tracking and explore MLM tracking procedures for accessing vaccination history (both inpatient and outpatient) when SCM goes live.

**UK 2005 Assessment:** Vaccination protocol approval obtained from P&T. Approximately 40% of at-risk population admitted to IM and FM services are assessed for immunization eligibility.
Objective 6.4
80% of hospital pharmacies will participate in ensuring that hospitalized patients who smoke receive smoking-cessation counseling.

Baseline: A baseline has not been established. Once determined, this may lead to a revision of the target percentage. A related baseline is that 43% of Medicare patients hospitalized for an acute myocardial infarction receive such counseling. (Jencks S, Huff ED, Cuerdon T. Change in the quality of care delivered to Medicare beneficiaries, 1998-1999 to 2000-2001. JAMA 2003; 289:305-312). However, the percentages of hospital pharmacies engaged in this and doing this for all hospitalized patients who smoke are to be determined.

UK 2010 Goal: Increase education and pharmacist utilization of nicotine replacement order sets (inpatient). Design and implement a web-based educational resource for pharmacists and staff members to use in smoking cessation efforts.

UK 2009 Assessment: Currently UK meets this objective in 100% of all Core Measures. Ongoing involvement of pharmacy members in health-system committees.

UK 2008 Goal: Coordinate and promote KCP smoking cessation products with Human Resource benefits/policies; continued support of Cooper-Clayton smoking cessation program for employees

UK 2007 Assessment: Designation of a smoking cessation pharmacist champion at UK hospital. Pharmacists have been actively involved in interdisciplinary initiatives to achieve these goals. In and out-patient pharmacy staff have supported the Cooper-Clayton smoking cessation program for employees.

UK 2006 Goal: Contribute support to hospital staff in smoking cessation efforts and participate when appropriate.

Tobacco status will be identified and evaluated in 10% inpatients and 100% inpatients admitted to BMT and TXP services.

UK 2005 Assessment: 70% patients receive smoking cessation information in pamphlet form upon discharge; 0-5% patient receive verbal smoking cessation counseling.

Objective 6.5
90% of pharmacy departments in health systems will have formal up-to-date emergency preparedness programs integrated with their health systems’ and their communities’ preparedness and response programs.

Baseline: To be determined.

UK 2010 Goal: Create a simulation exercise for pharmacy involvement in disaster response/emergency preparedness. Work with PPD to outfit common pharmacy areas with notification system or loud-speaker system to increase awareness of emergency notification/alarms.

UK 2009 Assessment: Competency survey (performed annually) is ongoing to assess pharmacists baseline knowledge of disaster preparedness. Increased presence of pharmacy services members in the emergency department. Clinical development series topic/discussion regarding Chempack utilization/protocols.


UK 2007 Assessment: University of Kentucky hospital is the Metropolitan Medical Response System (MMRS) contact for central and eastern Kentucky. Chempack is stored and maintained at UK counter terrorism. Medication supply is available at UK and its distribution will be coordinated throughout the city and county region. CE programs on viral, bacterial and chemical exposure are available online.

UK 2006 Goal: Update pharmacy HEICS website, encourage other pharmacists to obtain continuing education in emergency preparedness and obtain 50% CE credit for pharmacists employed by UK and 100% CE credit for pharmacy residents.

UK 2005 Assessment: Involvement currently exists in Kentucky Bioterrorism Pharmacy Program (performance assessment of mock disaster drills), the city-wide emergency response program and also with the CDC for emergency preparedness.

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