

# Riverside County Regional Medical Center

Department of Pharmacy Services



**Sam Ho, Pharm. D.**  
Pharmacy Management Project Director

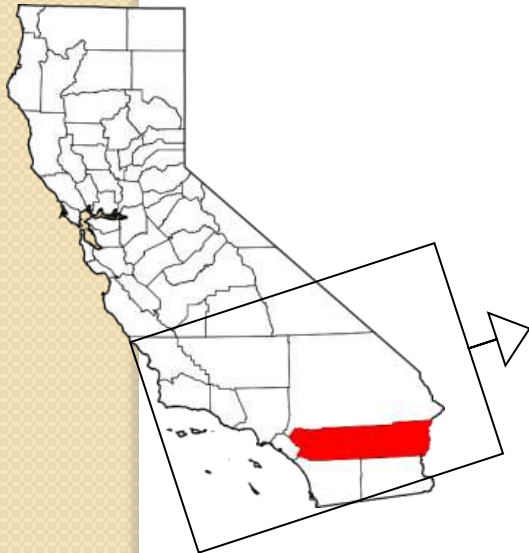
**Youbin Kim, Pharm. D.**  
Vice Chair – Specialty Acute Care

# Objectives

- Understand concepts in creating a pharmacist-driven Core Measures compliance models.
- Utilize available resources to develop your own core-measures program.
- Identify target outcome measures to assess effectiveness of the programs.
- Learn key lessons in implementing your core-measures program successfully.



# Background



- **Riverside County**
  - 7,200 square miles
  - shares borders with Orange, San Bernardino, San Diego, and Imperial counties
  - extends from within 14 miles of the Pacific Ocean all the way to Arizona
  - topographically, mostly desert

## Riverside County, California


[i](#) Further information

Want more? [Browse data sets for Riverside County](#)

<b>People QuickFacts</b>	<b>Riverside County</b>	<b>California</b>
<a href="#">i</a> Population, 2010	2,189,641	37,253,956
<a href="#">i</a> Population, percent change, 2000 to 2010	41.7%	10.0%
<a href="#">i</a> Population, 2000	1,545,374	33,871,648
<a href="#">i</a> Persons under 5 years old, percent, 2009	7.9%	7.5%
<a href="#">i</a> Persons under 18 years old, percent, 2009	29.0%	25.5%
<a href="#">i</a> Persons 65 years old and over, percent, 2009	11.5%	11.2%
<a href="#">i</a> Female persons, percent, 2009	50.0%	49.9%
<hr/>		
<a href="#">i</a> White persons, percent, 2010 (a)	61.0%	57.6%
<a href="#">i</a> Black persons, percent, 2010 (a)	6.4%	6.2%
<a href="#">i</a> American Indian and Alaska Native persons, percent, 2010 (a)	1.1%	1.0%
<a href="#">i</a> Asian persons, percent, 2010 (a)	6.0%	13.0%
<a href="#">i</a> Native Hawaiian and Other Pacific Islander, percent, 2010 (a)	0.3%	0.4%
<a href="#">i</a> Persons reporting two or more races, percent, 2010	4.8%	4.9%
<a href="#">i</a> Persons of Hispanic or Latino origin, percent, 2010 (b)	45.5%	37.6%
<a href="#">i</a> White persons not Hispanic, persons, 2010	39.7%	40.1%
<hr/>		
<a href="#">i</a> Households, 2005-2009	645,185	12,187,191
<a href="#">i</a> Persons per household, 2005-2009	3.11	2.91
<a href="#">i</a> Per capita money income in past 12 months (2009 dollars) 2005-2009	\$24,642	\$29,020
<a href="#">i</a> Median household income, 2009	\$55,151	\$58,925
<a href="#">i</a> Persons below poverty level, percent, 2009	13.9%	14.2%



- **Level II Adult & Pediatric Trauma Center**
- **362 Single Patient Rooms (Hospital)**
- **77 Licensed Beds (Psychiatric Treatment Facility)**
- **12 Operating Rooms**
- **Intensive Care Units (Adult, Pediatric and Neonatal)**
- **Pharmacy with Clinical Pharmacist on Site**
- **Complete Radiology Services including MRI & CT Scans**
- **Occupational & Physical Therapy Services**
- **Complete Clinical Laboratory Services**
- **Complete Pulmonary Services including Hyperbaric Oxygen Treatments**
- **Complete Diagnostic Services including EEG, EKG and Echo**
- **Full Pediatric Services**
- **Birthing Rooms**
- **Emergency Room and Trauma Center**
- **24 Hour Physician Staffing**
- **Adjacent Helipad**
- **Immediate OR Access**
- **Abuse Services**
- **Child Assessment Team (CAN Team)**
- **Elder Abuse**
- **Drug Endangered Children**
- **SART (Sexual Assault Response Team)**
- **Childhood Injury Prevention Center**



*A successful man is one who can lay a firm foundation with the bricks others have thrown at him.*




# System Change

- Transactional Change
  - Individual tasks, skills, abilities
  
- Transformational Change
  - Altered paradigm
  - Shift in values
  - Reform in beliefs



**Cost Control is Transactional**

**Quality Improvement is Transformational**



**“Transformed means that when times are tough, we invest more in quality”**

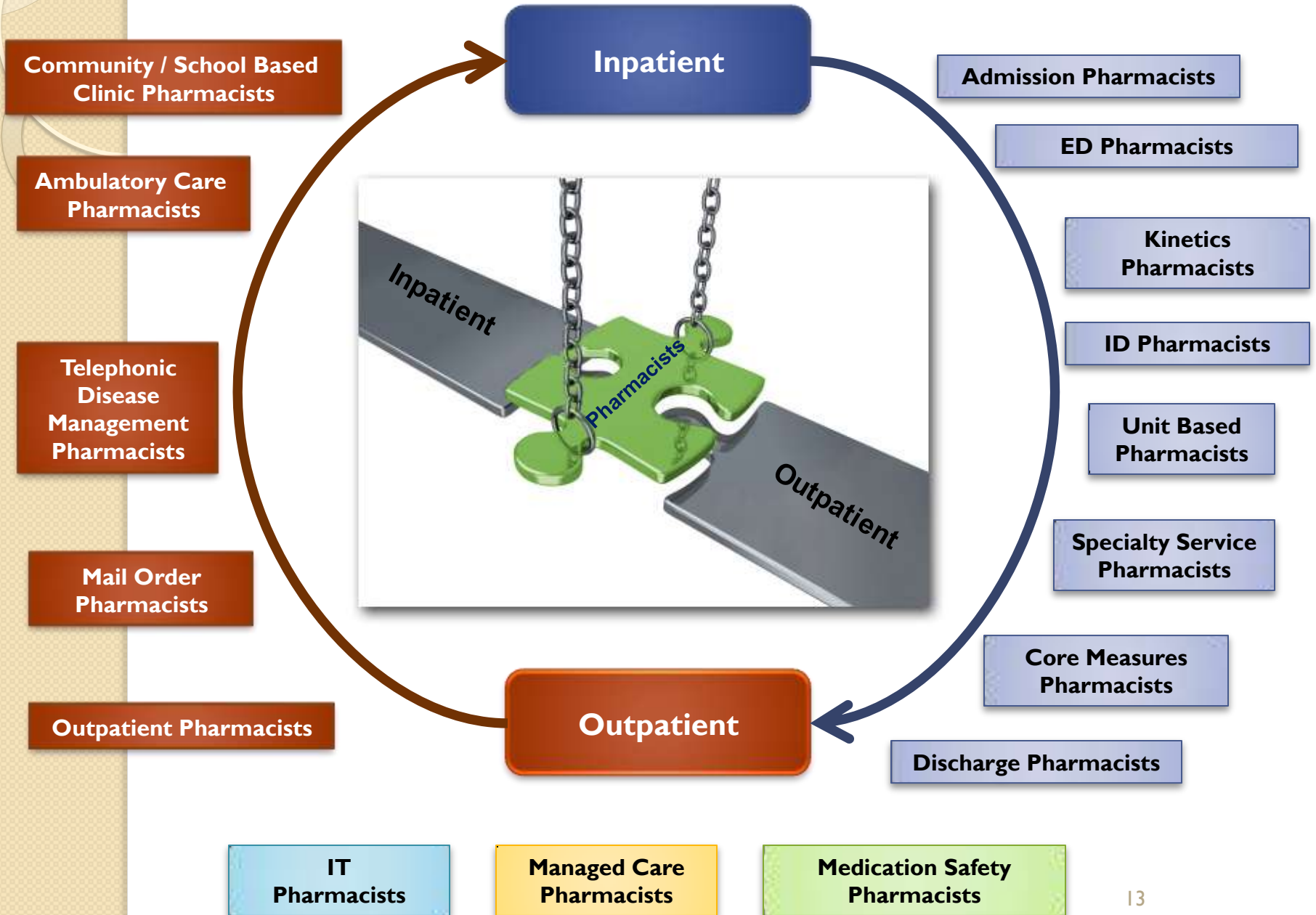
**Charles Buck**

**– retired GE executive**

# Hospital Quality

- CMS Core Measures
- NCQA HEDIS Measures
- HITECH Act – meaningful use
- Value-Based Purchasing
- HAI payment adjustment
- HCAHPS

# Roles of the RCRMC Pharmacists



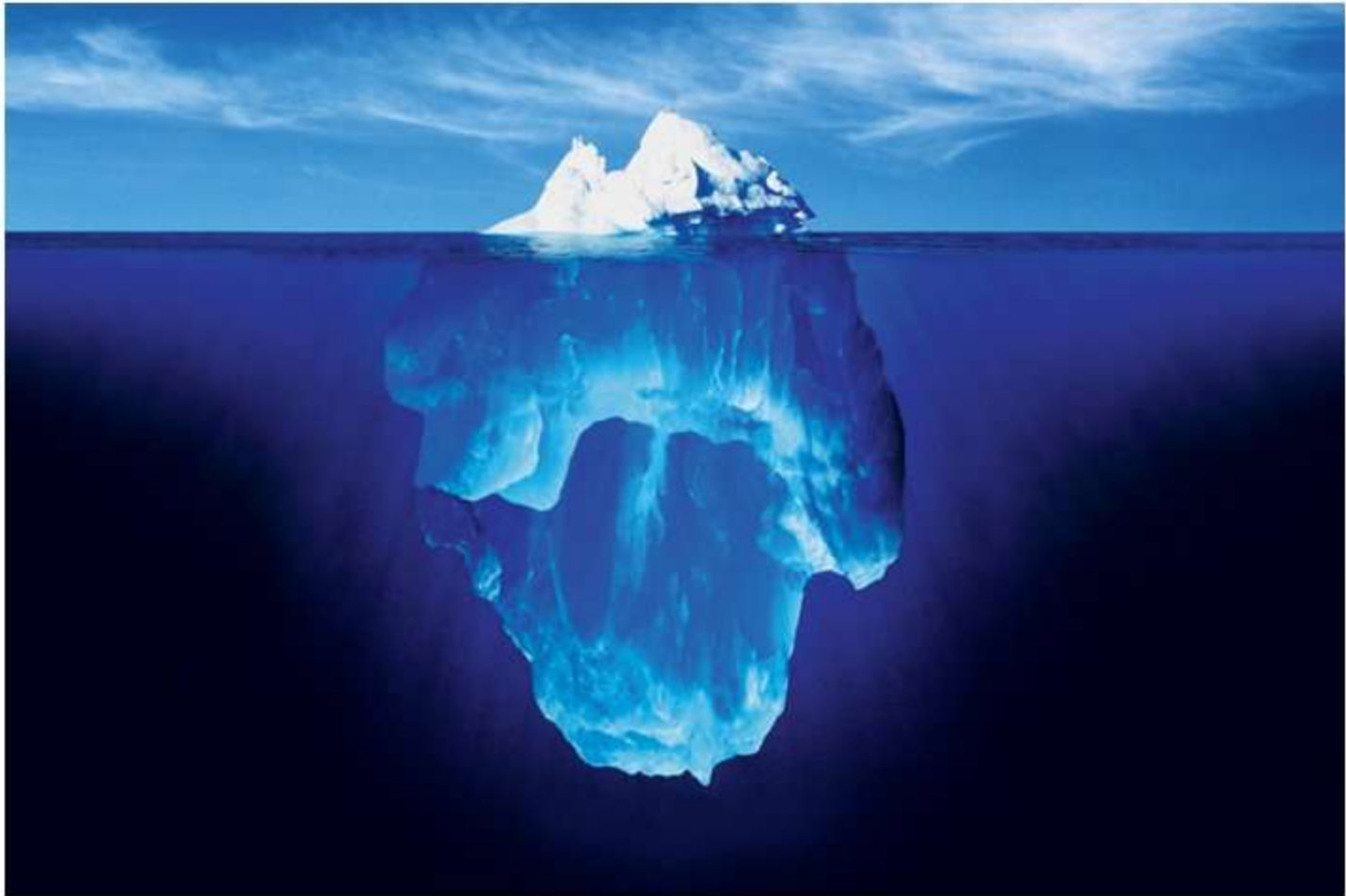
# Continuity of Care

**Traditional = Snap Shot**



# Continuity of Care

**Continuity of Care = Whole Picture**





# ACHIEVEMENT

YOU CAN DO ANYTHING YOU SET YOUR MIND TO WHEN YOU HAVE VISION,  
DETERMINATION, AND AN ENDLESS SUPPLY OF EXPENDABLE LABOR.

[www.despair.com](http://www.despair.com)

# Strategic Quality Initiatives

- Improve quality of care
  - Continuity of care
  - Coordination of services
- Integrate multidisciplinary teams
  - Vertical & Horizontal integration
- Efficient use of resources
  - Cost savings

**2005 - 2007**

- Pre-printed orders
- Standardize hospital abbreviations
- Standardize concentration
- Smart pumps with guardrails
- Labs online
- Computerized pharmacy system (Cerner)
- Pyxis 3000 system
- Med Safety Hotline
- Monitor use of "trigger" drugs
- Pediatrics and ICU Pharmacists
- Ambulatory Care Coumadin Clinic

**2005 - 2007**

- Jan 2010**
- Respiratory Medication Monitoring

- March 2010**
- Improve pharmacy organization structure
- Ketorolac & metformin BBW Monitoring Program

- April 2010**
- Pharmacy Peer Review Program
- Pharmacy On-call Program
- Arlington Campus Revamp
- Unit Based Clinical Pharmacy Program (4100/4200)
- Ambulatory Care Program (Women's Health Clinic)

- May 2010**
- Pharmacist-driven Heart Failure Program
- Pharmacist-driven Antimicrobial Stewardship Program
- Pyxis 4000 Upgrade, Pyxis Anesthesia

- July 2010**
- Pharmacist-driven PCA & Infusion Monitoring Program
- REMS Compliance Program
- Unit based pharmacist (2500)
- Fentanyl BBW Monitoring Program

- August 2010**
- Pyxis PARx bar code scanning

- September 2010**
- Pharmacist-driven Immunization Program
- Unit based pharmacist (3500)

- 4th Quarter 2011**
- Medication carousel
- Automatic unit dose packager
- Pharmacist-driven Pneumonia Program
- Ambulatory Care Program (Surgical Clinic)
- Pharmacy Emergency Department Services

- 2012**
- Computerized Prescriber Order Entry
- Electronic MAR
- Bar code medication administration
- Wireless smart pump monitoring

**2008 - 2010**

- November 2009**
- Ambulatory Care Program (CBC)
- Pharmacy Therapeutic Drug Monitoring Service
- Metabolic, K+, and Electrolyte Monitoring

- July 2009**
- Weekly pharmacist education session and competency exams
- Ambulatory Care Program (Internal Medicine)

- June 2009**
- Nutrition pharmacist
- Pharmacist-driven SCIP & VTE Prophylaxis Program
- Acetaminophen Usage Monitoring Program

- October 2008**
- Antibiotics pharmacist
- Improve handling of high risk/alert medications

- September 2008**
- Medication safety pharmacist
- Segregation of LASA, adult/pediatrics medications
- Ambulatory Care Program (Family Medicine)
- Clinical Pharmacist Monitoring of Black Box Warning Medications

- June 2008**
- Information technology pharmacist
- Pharmacist-driven Anticoagulation Program

**2011 -**

- 2nd Quarter 2011**
- Unit based pharmacist (3100)

- 1st Quarter 2011**
- Pharmacist-driven Stroke Program
- Pharmacist-driven Sepsis Program
- Automated TPN Compounder
- Pharmacist-managed Titration Clinic

- January 2011**
- MERP Restructure
- Pharmacist-driven Glycemic Control Program
- Unit based pharmacist (4500)
- General Pharmacist Educator (GPE)

- December 2010**
- Oncology / Palliative Care Pharmacist

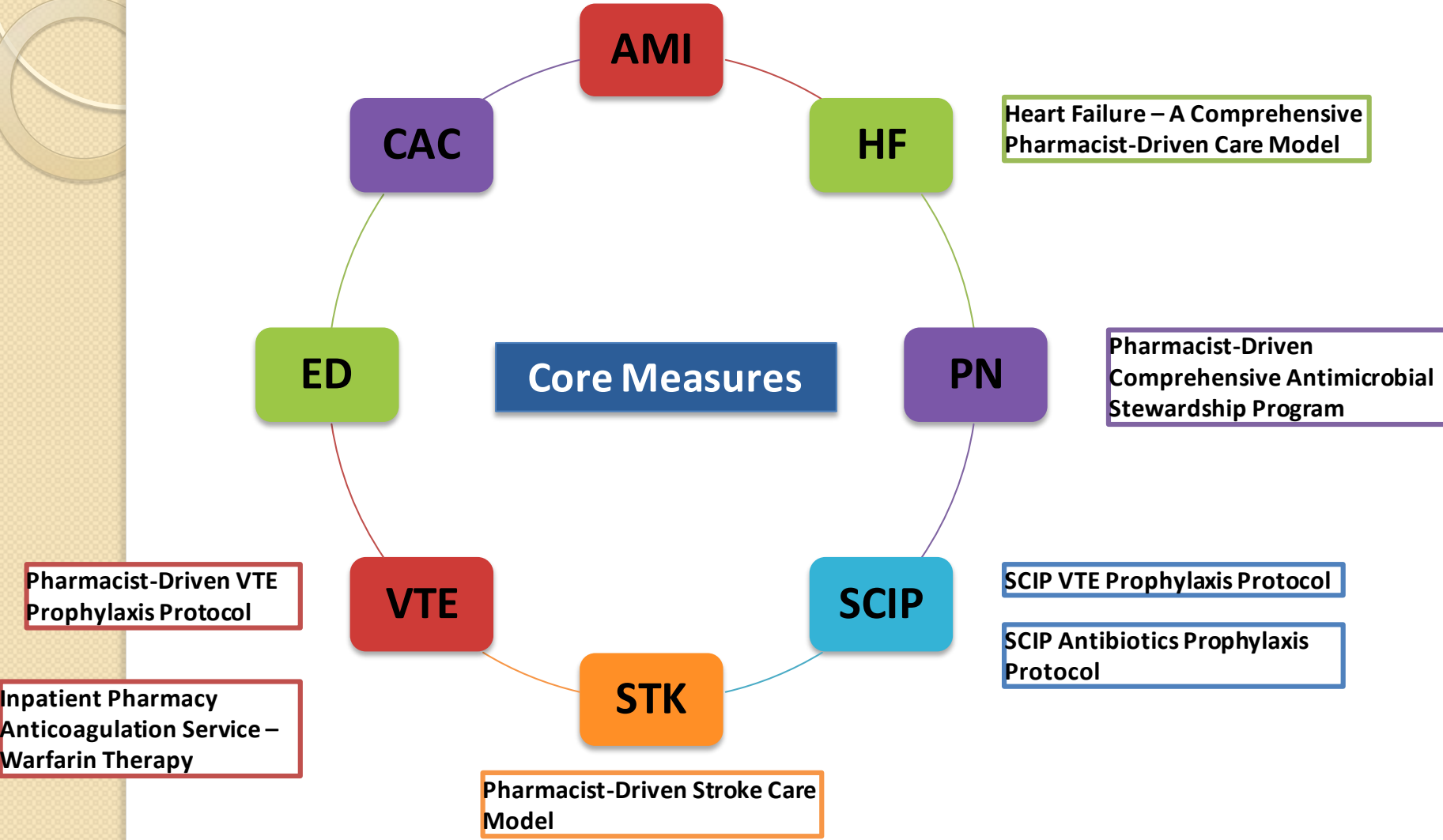
- November 2010**
- Medication Management Telephonic Model
- Medication distribution workflow improvement

- October 2010**
- Hospital Information System Upgrade (Siemens)
- Psychiatric Pharmacy Services



# Pharmacist-Driven Core Measures Program

# Core Measures and Pharmacist-Driven Programs





# VTE prophylaxis

# Background

- Between 200,000 and 300,000 US patients die of VTE each year (surgery-related and non-surgery-related)—more deaths than from AIDS, breast cancer, and traffic accidents combined\*
- VTE causes an approximate 10% hospital readmission rate by day 90 post surgery and results in substantial resource utilization and excess charges
- Each hospital-acquired DVT represents an incremental inpatient cost of \$10,000, while each PE represents \$20,000.

\*<http://www.vteconsultant.com/VTE-prophylaxis-initiative.html>

# RCRMC Goals for VTE Prophylaxis Program

1. Standardized VTE risk assessment
2. Ensure safe and effective use of pharmacologic VTE prophylaxis
3. Improve patient outcome/Avoid preventable VTE/PE
4. Avoid unnecessary cost associated with preventable VTE/PE

**May 2009**

Start protocol development

**October 2009**

Start reporting progress to Quality Management

## Implementation Time Line

Program Initiated

**August 2009**

Program goals achieved

**April 2010**

# RCRMC VTE Prophylaxis Program

- Pharmacist evaluates patient's risk for VTE within 24 hours of admission or surgery using standardized risk assessment form
- Pharmacist consults physician when changes in VTE prophylaxis regimen is recommended
- Pharmacist monitors relevant lab values daily for possible Heparin-Induced Thrombocytopenia (HIT)
- All patients who are on pharmacological VTE prophylaxis have CBC drawn at least every 3 days per Pharmacy Protocol

# Quality Improvement

- Review of any incidence of potentially preventable VTE
- Quarterly review of core measure fall outs

## Identified:

- Many times due to lack of documentation of administration of prophylactic agents (Mechanical/Pharmacological) → Now included in pharmacy assessment/documentation
- Falling out of time window → Twice daily reviewing of surgical cases. Working with nursing to ensure proper administration time



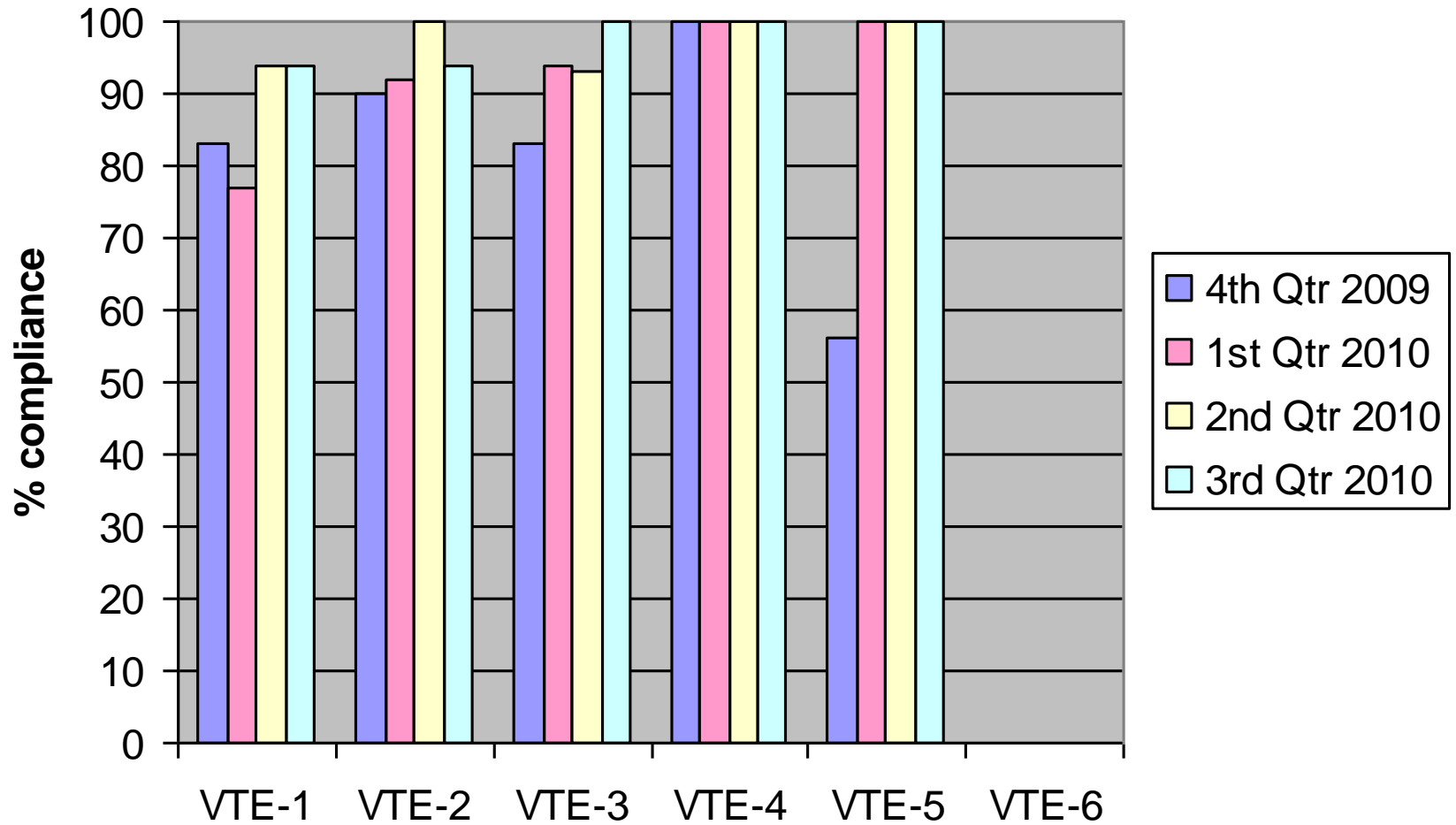
Table 1. DVT PROPHYLAXIS (ADULT) RISK SCREEN

Allergy:	SCr:	CrCl:
1. Assign risk score using criteria below		
<b>A. Risk Factors (RFs) with value of 1 point</b> <input type="checkbox"/> Age >40 – 60 years <input type="checkbox"/> Family history of DVT or PE <input type="checkbox"/> Leg swelling, ulcers, stasis, varicose veins <input type="checkbox"/> Inflammatory bowel disease <input type="checkbox"/> Central line <input type="checkbox"/> Bed confinement /immobilization > 24 hours <input type="checkbox"/> Pregnancy, or postpartum < 1 month <input type="checkbox"/> Obesity (>20% over IBW) <input type="checkbox"/> Minor Surgery <input type="checkbox"/> Estrogen therapy/ SERM <input type="checkbox"/> Erythropoiesis-stimulating agents <input type="checkbox"/> Nephrotic syndrome  # RFs point= _____	<b>B. RFs with value of 2 points</b> <input type="checkbox"/> Age 61 - 70 years <input type="checkbox"/> Major surgery <input type="checkbox"/> Malignancy <input type="checkbox"/> Multiple trauma <input type="checkbox"/> Spinal cord injury with paralysis <input type="checkbox"/> COPD/asthma exacerbation  # RFs point= _____	<b>C. RFs with value of 3 points</b> <input type="checkbox"/> Age over 70 years <input type="checkbox"/> Prior history of DVT/ PE <input type="checkbox"/> Acute MI/CHF <input type="checkbox"/> Severe sepsis (Sepsis w > 1 organ failure) <input type="checkbox"/> Stroke with paralysis <input type="checkbox"/> Hyperviscosity syndromes <input type="checkbox"/> Hip and Knee replacement <input type="checkbox"/> Inherited thrombophilia <input type="checkbox"/> Acquired thrombophilia <input type="checkbox"/> Paroxysmal nocturnal hemoglobinuria  # RFs point= _____
2. TOTAL RISK SCORE (A+B+C)= _____ Low Risk = 1 point    Moderate Risk = 2 points    High Risk = 3 – 4 points    Very High Risk > 4 points		
3. Early ambulation for all patients when possible, with assistance if necessary.		
4. <input type="checkbox"/> Patient is on therapeutic anticoagulation. Additional pharmacologic thromboprophylaxis is not required		
5. <input type="checkbox"/> Patient has contraindication to pharmacologic therapy: _____		
Order for thromboprophylaxis:		
<b>Low Risk (1 pt)</b>	<b>Moderate Risk (2 pts) Choose One of the following</b>	<b>High Risk/Very High Risk (≥3 pts) Choose one of the following</b>
<input type="checkbox"/> Sequential compression device (SCD) <input type="checkbox"/> Early Ambulation	<input type="checkbox"/> Sequential compression device (SCD) <input type="checkbox"/> Enoxaparin 40mg SubQ q 24 hr <input type="checkbox"/> Enoxaparin 30mg SubQ q 24 hr (Dosing for CrCl < 30 ml/min) <input type="checkbox"/> Heparin 5000 units SubQ q 8hr	<input type="checkbox"/> Sequential compression device (SCD) <b>AND</b> <input type="checkbox"/> Enoxaparin 40mg SubQ q 24 hr <b>OR</b> <input type="checkbox"/> Enoxaparin 30mg SubQ q 24hr (Dosing for CrCl < 30 ml/min)  <b>Hip and Knee-replacement alternatives</b> <input type="checkbox"/> Enoxaparin 30mg SubQ BID
Other Orders:		
<b>Contraindication to Pharmacological Prophylaxis</b>		
<b>Relative</b> <ul style="list-style-type: none"> <li>History of cerebral hemorrhage</li> <li>Craniotomy within 2 weeks</li> <li>GI, GU hemorrhage within the last 6 months</li> <li>Thrombocytopenia (Platelet &lt; 100 k/uL)</li> <li>Coagulopathy (INR &gt; 1.5)</li> <li>Active intracranial lesions/neoplasm/monitoring devices</li> <li>Diabetic Retinopathy</li> <li>Vascular access/biopsy sites inaccessible to hemostatic control</li> </ul>	<b>Absolute</b> <ul style="list-style-type: none"> <li>Active hemorrhage</li> <li>Heparin, enoxaparin, or warfarin use in patient with heparin-induced thrombocytopenia</li> <li>Warfarin use in the first trimester of pregnancy</li> <li>Severe trauma to head, spinal cord or extremities with hemorrhage within last 4 weeks</li> <li>Indwelling epidural/spinal catheter- placement or removal</li> </ul>	
Pharmacist signature/ Print	Phone #	Date/Time

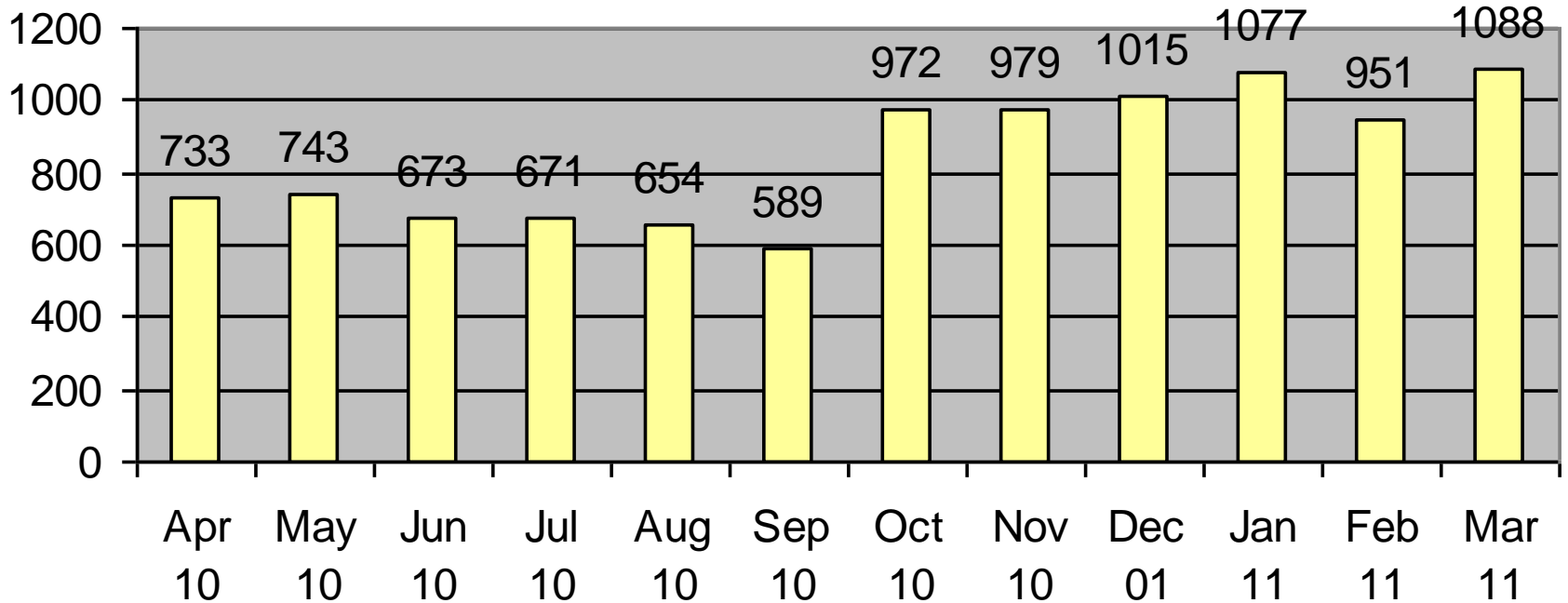
# VTE Core-Measures

- VTE-1:VTE Prophylaxis
- VTE-2: Intensive Care Unit VTE Prophylaxis
- VTE-3:VTE patients with anticoagulation overlap therapy
- VTE-4:VTE patients receiving unfractionated heparin with dosages/platelet count monitoring by protocol
- VTE-5:VTE discharge instructions
- VTE-6: Incidence of potentially-preventable VTE

## VTE Core-Measure Data

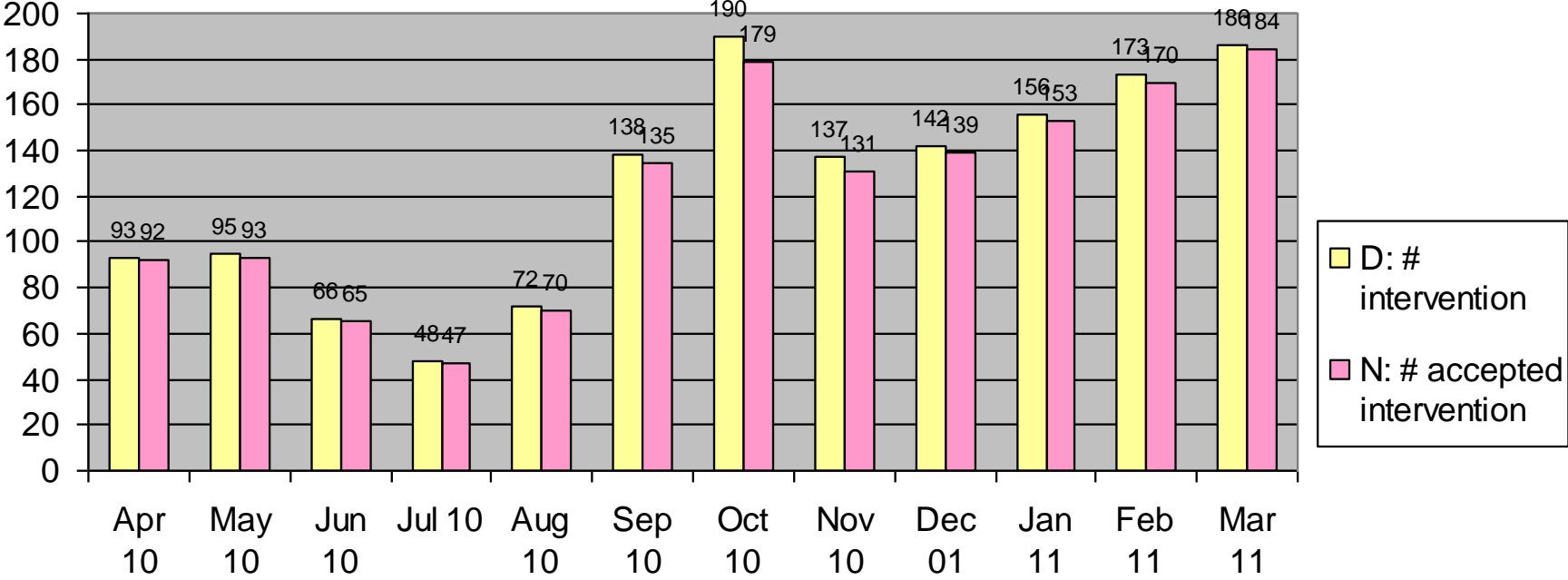


## # of Patients Assesed by Pharmacist for VTE Prophylaxis 12-Month Data



\*Medical Patients

# Interventions by Pharmacist



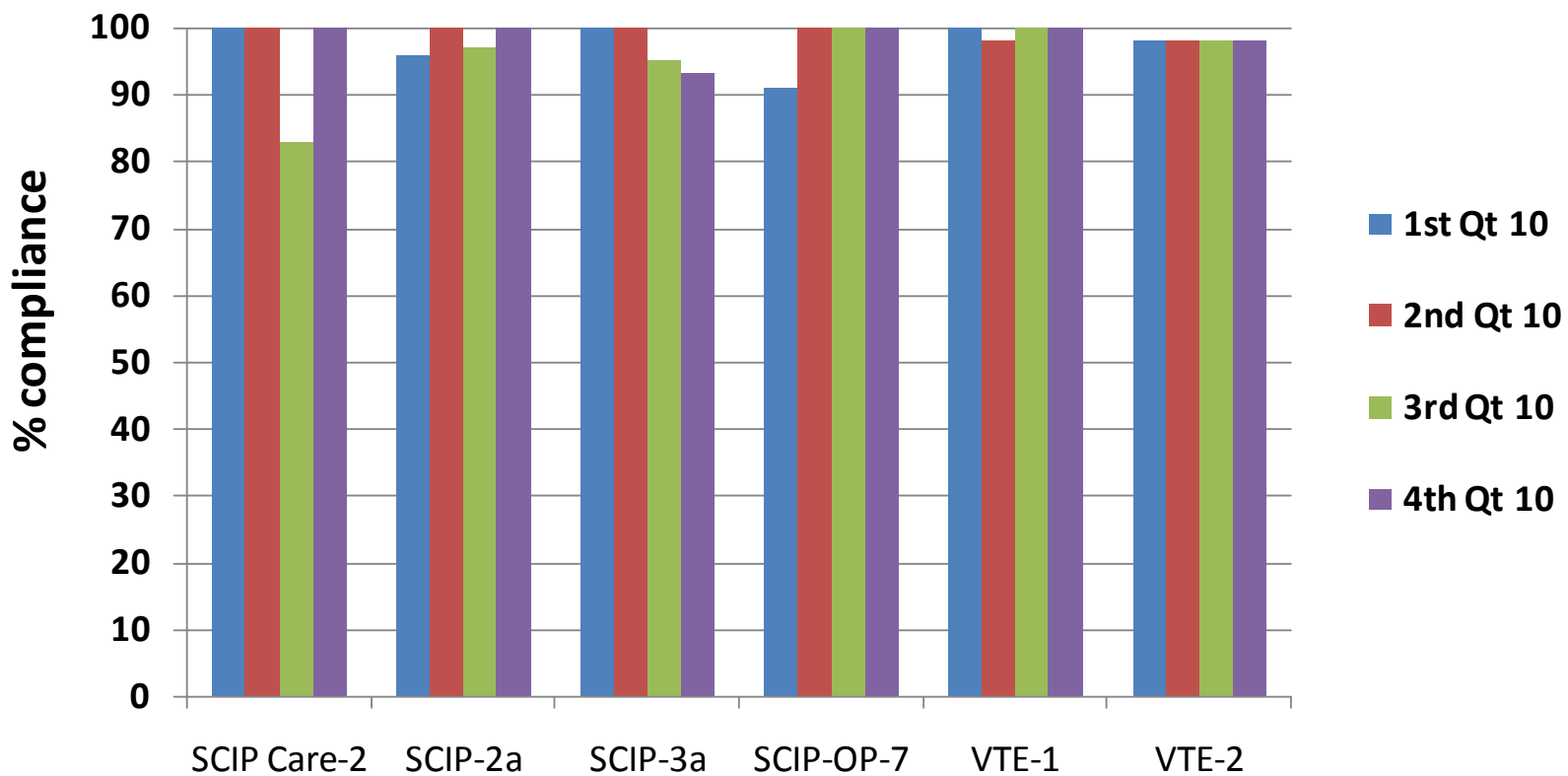


# **Surgical Care Improvement Projects (SCIP)**

# Pharmacist Driven SCIP Program

- VTE Prophylaxis (VTE 1 & 2)
- Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time
- Surgery Patients on Beta-Blocker Therapy Prior to Arrival Who Received a Beta-Blocker During the Perioperative Period : pharmacist review prior medication history and ensure BB is continued during perioperative period

# Core Measures - SCIP



P = Problem (In terms of Patient Care Diagnosis)  
 I = Intervention (Include: short term goals, education)  
 P = Plan (Evaluation of interventions, response to treatment, change in patient status, chronological documentation of patient's clinical course)

Date/Time	Discipline	
	Pharmacy	<b>SCIP Performance Measure Reviewed by the Pharmacist</b>
		Post-Surgical VTE Prophylaxis Per Pharmacy Protocol
		<u>S/O</u>
		Past Medical History:
		Past Surgical History:
		Labs: PE:
		<u>A/P</u> VTE risk factors include:
		<input type="checkbox"/> Patient is at low risk for VTE
		Contraindication to pharmacological anticoagulants
		<input type="checkbox"/> Yes →
		<input type="checkbox"/> No
		Patient currently has VTE prophylaxis orders for:
		<input type="checkbox"/> TED/SCD <input type="checkbox"/> Heparin 5000units subcut q8h
		<input type="checkbox"/> None <input type="checkbox"/> Lovenox 40mg subcut q24h
		<input type="checkbox"/> Lovenox 30mg subcut q24h (Renal Dose)
		<input type="checkbox"/> Patient does not require pharmacological or mechanical VTE prophylaxis
		<b>Prophylactic Antibiotics Discontinuation Per Pharmacy Protocol</b>
		<input type="checkbox"/> Patient received prophylactic antibiotics perioperatively.
		<input type="checkbox"/> Prophylactic antibiotics is discontinued 24 hours post anesthesia end time
		Pharmacist will monitor and discuss with the physician if there is any change.
		SCIP performance measure completed 24 hours post anesthesia end time.
		Pharmacist: PharmD. Ext 30248

**DISCIPLINE LEGEND:**

MD/DO	Physician	RT	Respiratory Therapy	R.D.	Registered Dietician
RN	Nursing	PT	Physical Therapy	S.W.	Social Service
RPH	Pharmacist	OT	Occupational Therapy	SP	Speech Pathology

Riverside County Regional Medical Center

ADDRESSOGRAPH

**INTERDISCIPLINARY PATIENT PROGRESS NOTES**

P.I.P. Charting



# Heart Failure

# Heart Failure Program

- Patients admitted with diagnosis or history of HF are automatically enrolled in Pharmacist-Driven HF program
- Clinical Pharmacist provides initial consultation within 24-48 hours of admission: medications, diet, exercise, smoking cessation, symptoms of worsening heart failure...
- Pharmacist conducts medication reconciliation and reviews current medications: Review for optimized of therapy

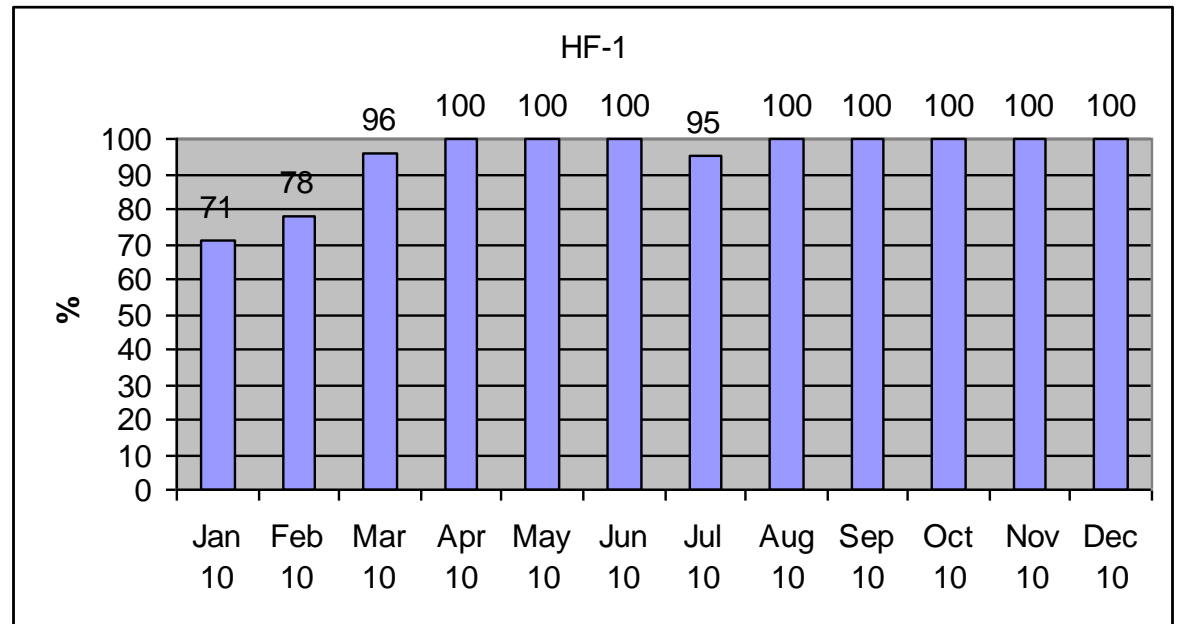
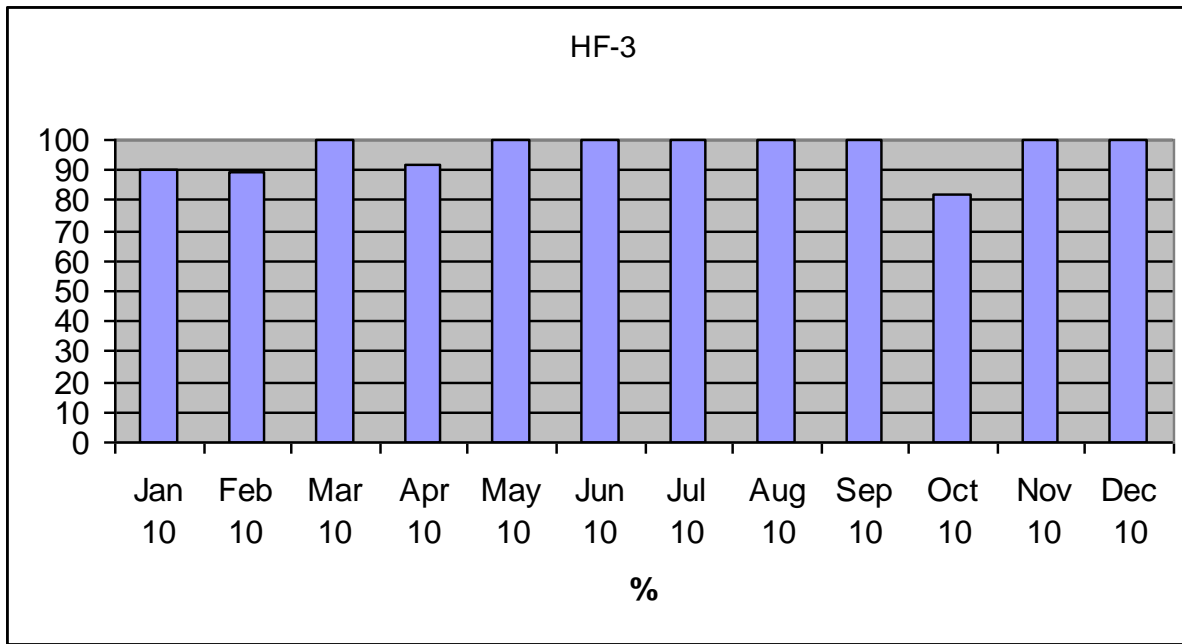
# Heart Failure Program

- Upon discharge, Pharmacist conducts discharge medication reconciliation and provides discharge consultation regarding any changes, discontinuation or addition of medications
- Pharmacist ensures patient will obtain 30 day supply of medications.
- Pharmacist ensures all core-measures are met before discharge.
- Upon discharge, Clinical Pharmacist will refer patient to outpatient pharmacy services (Medication Management Telephonic Model, ambulatory clinics) as appropriate → in collaboration with case management. Currently in process of expanding pharmacist service

# Heart Failure Core-Measures

- HF-1: Discharge Instruction
- HF-2: Evaluation of LVS function
- HF-3: ACEI or ARB for LVSD
- HF-4: Adult smoking cessation advice/counseling
- Best practice: Beta blocker





Date/Time	Discipline	
	Pharmacy	<b>HF Initial Progress Note EF: _____%</b>
		PMH:
		<input type="checkbox"/> If patient is diagnosed with HF or admitted for HF exacerbation or has a history of HF w/ ↓ LVEF (<40%), recommend patient be discharged with the following:
		<input type="checkbox"/> <b>ACEI/ARB</b>
		<input type="checkbox"/> Benazepril (Lotensin)
		<input type="checkbox"/> Losartan (Cozaar)
		<input type="checkbox"/> <b>Beta-Blocker</b>
		<input type="checkbox"/> Carvedilol (Coreg)
		<input type="checkbox"/> Metoprolol XL (Toprol XL)
		<b>NOTE: If patient cannot be discharged with these medications MUST document the reason (ie. contraindication, allergy, etc)</b>
		<b>Patient Consultation:</b>
		<input type="checkbox"/> Discussed low-salt diet, fluid restriction, healthy life-style, activity level, smoking cessation, avoidance of EtOH & illicit drugs, daily weight monitoring.
		<input type="checkbox"/> Educated patient on s/sx of worsening HF and what to do if symptoms worsen.
		<input type="checkbox"/> HF verbal and written education given to patient addressing 1. Activity level, 2. Diet 3. Follow-up monitoring 4. Weight monitoring, 5. What to do if symptoms worsen
		<input type="checkbox"/> Educated patient on HF medications, proper use, expected effects, significant ADRs, and potential drug interactions
		<input type="checkbox"/> Spanish translation provided if Spanish-speaking
		<b>Intervention:</b>
		<input type="checkbox"/> Recommend considering alternate agent for NSAID _____. NSAID can cause sodium retention and peripheral vasoconstriction and can attenuate the efficacy and enhance the toxicity of diuretics and ACE inhibitors.
		<input type="checkbox"/> Recommend considering alternate agent for antiarrhythmic agent _____. Antiarrhythmic agent can exert important cardiodepressant and proarrhythmic effects. Only amiodarone and dofetilide have been shown not to adversely affect survival.
		<input type="checkbox"/> Recommend considering alternate agent for Calcium Channel Blocker _____. Calcium channel blockers can lead to worsening HF and have been associated with an increased risk of cardiovascular events. Only the vasoselective ones have been shown not to adversely affect survival.
		<input type="checkbox"/> Other recommendation:
		Please feel free to contact with any questions.
		Pharmacist: PharmD. Ext 30222 -

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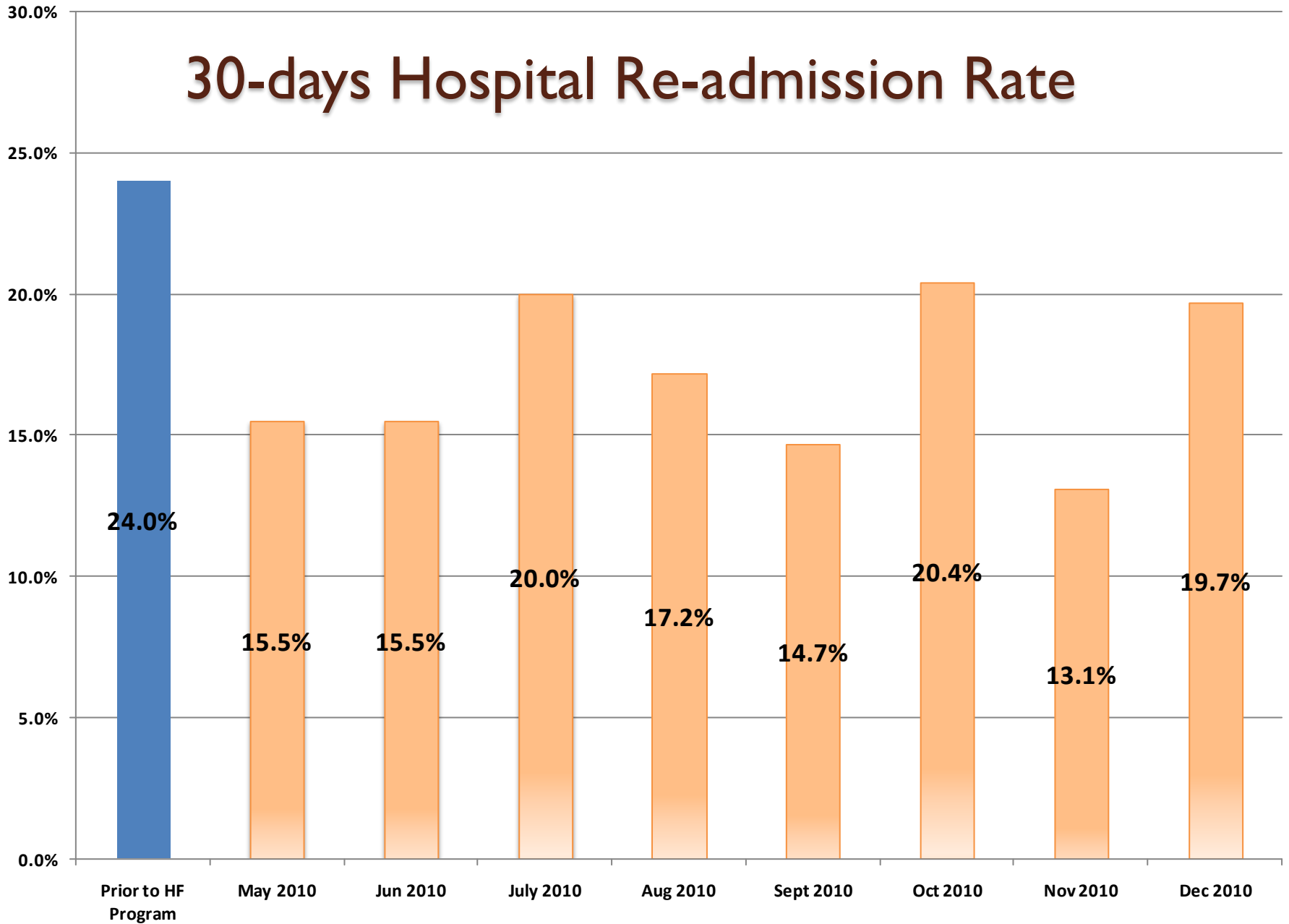
ADDRESSOGRAPH

INTERDISCIPLINARY PATIENT PROGRESS NOTES

04



# 30-days Hospital Re-admission Rate



\*Data collected based on patients followed by pharmacists



# Vaccination

# Pharmacist-Driven Hospital-wide Immunization

- **Employee Flu Drive**
  - 89% (vs. 50%)
- **Admitted Patients**
  - Influenza
    - 96% Screened and Immunized
  - Pneumonia
    - 99% Screened and 89% Immunized
- **Core Measures**
  - PNA-2, PNA-7, Prev-Imm-1, Prev-Imm-2
  - Improve quality of vaccination screening and overall patient care



# Financial Impact of Pharmacist-Driven Core Measures Program

# Risk of Deep Vein Thrombosis in Hospitalized Patients

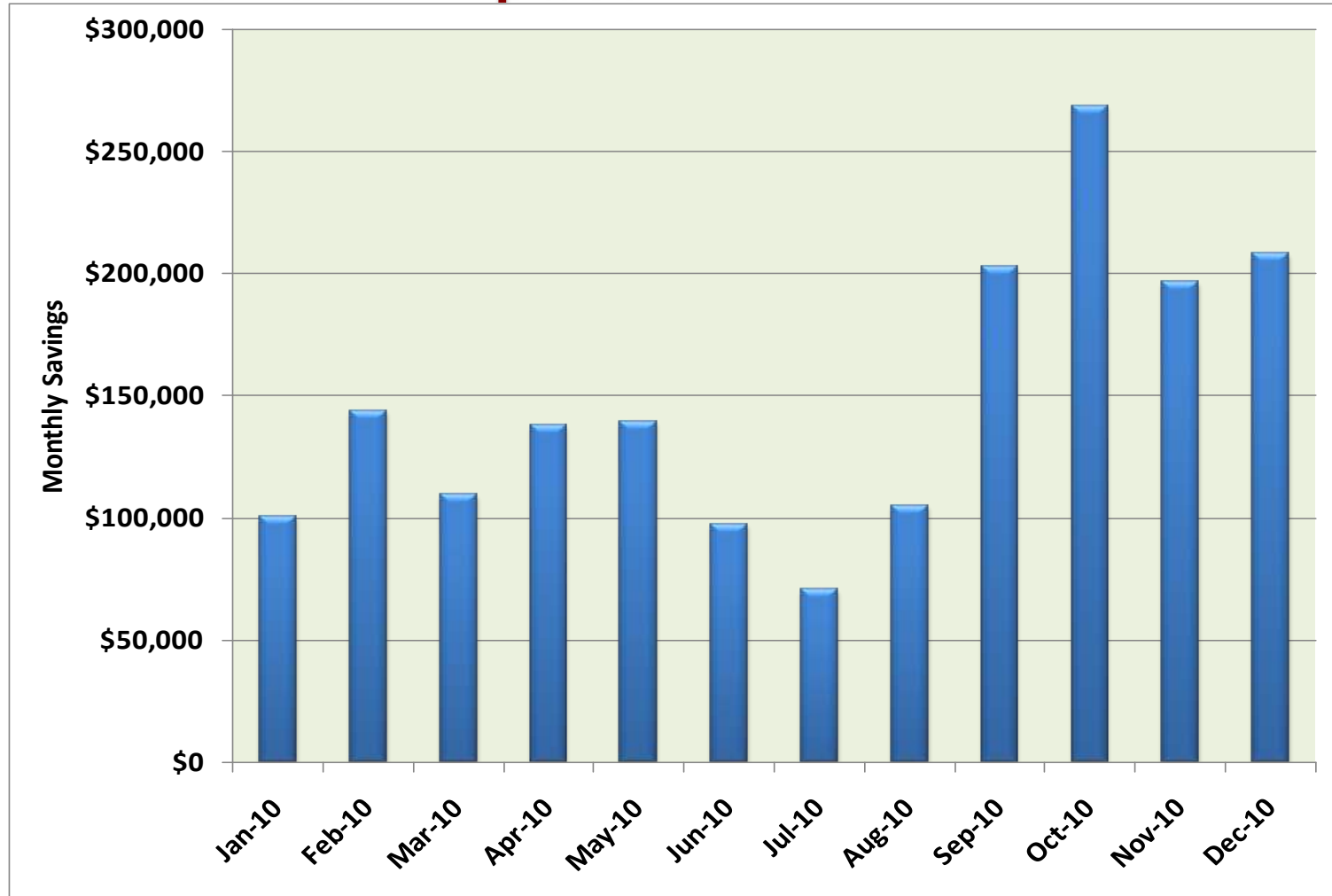
No prophylaxis + routine objective screening for DVT

Patient Group	DVT incidence (%)
Medical Patients	10-26
Major gynecological, urological, or general surgery	15-40
Neurosurgery	15-40
Stroke	11-75
Hip or knee surgery	40-60
Major trauma	40-80
Spinal cord injury	60-80
Critical care patients	15-80

Reference: [www.ahrq.gov](http://www.ahrq.gov)

Each hospital-acquired DVT represents an incremental inpatient cost of \$10,000, while each PE represents \$20,000.

# DVT/VTE Prophylaxis Interventions - Financial Impact



Assumption: 15% prevalence rate, \$10,000 / incident

**Total savings/cost avoided to date = \$1.8 million**

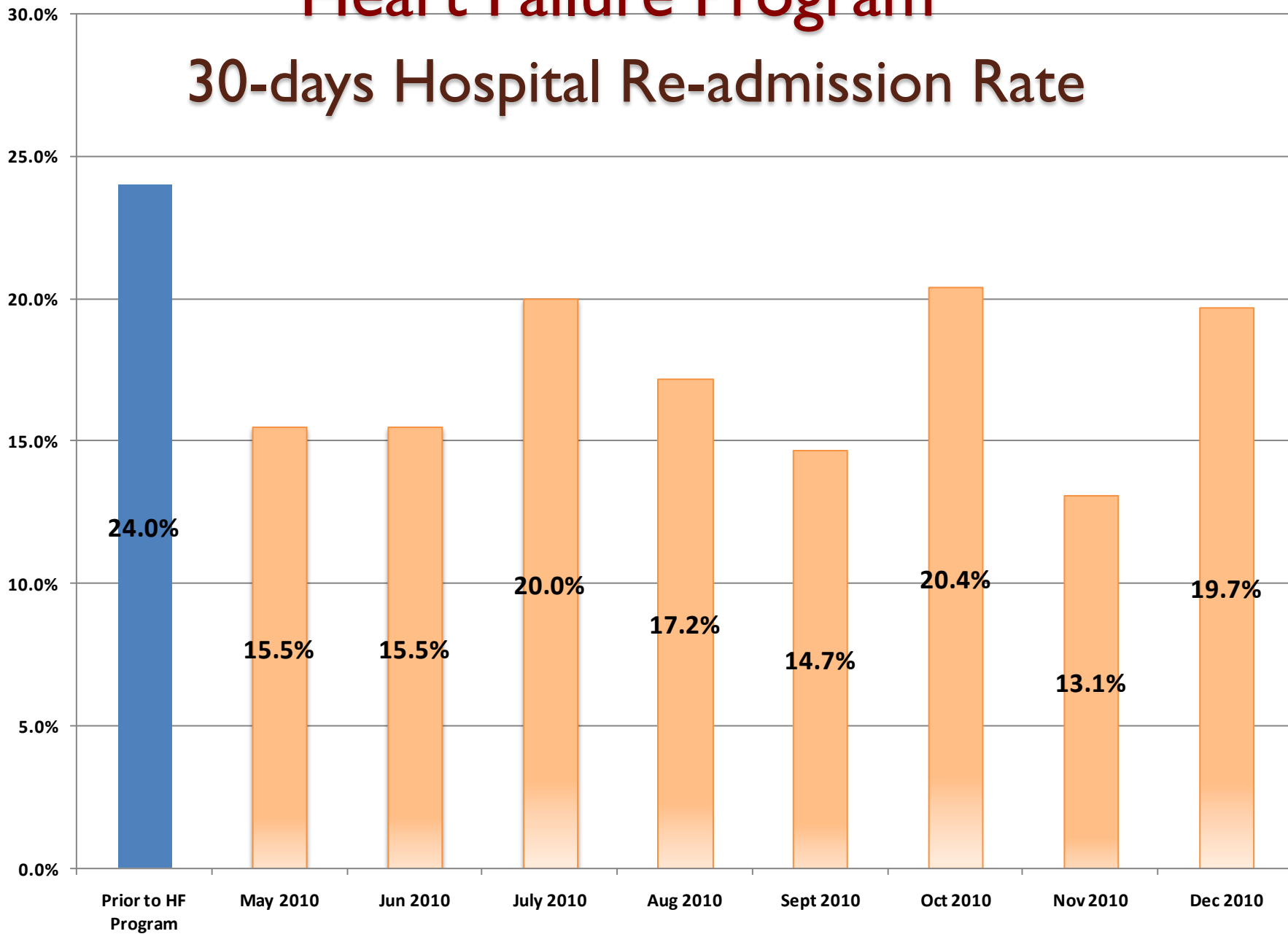
- **Total savings/cost avoided to date = \$1.8 million**

Return on Investment (ROI) = 10.6



# Heart Failure Program

## 30-days Hospital Re-admission Rate



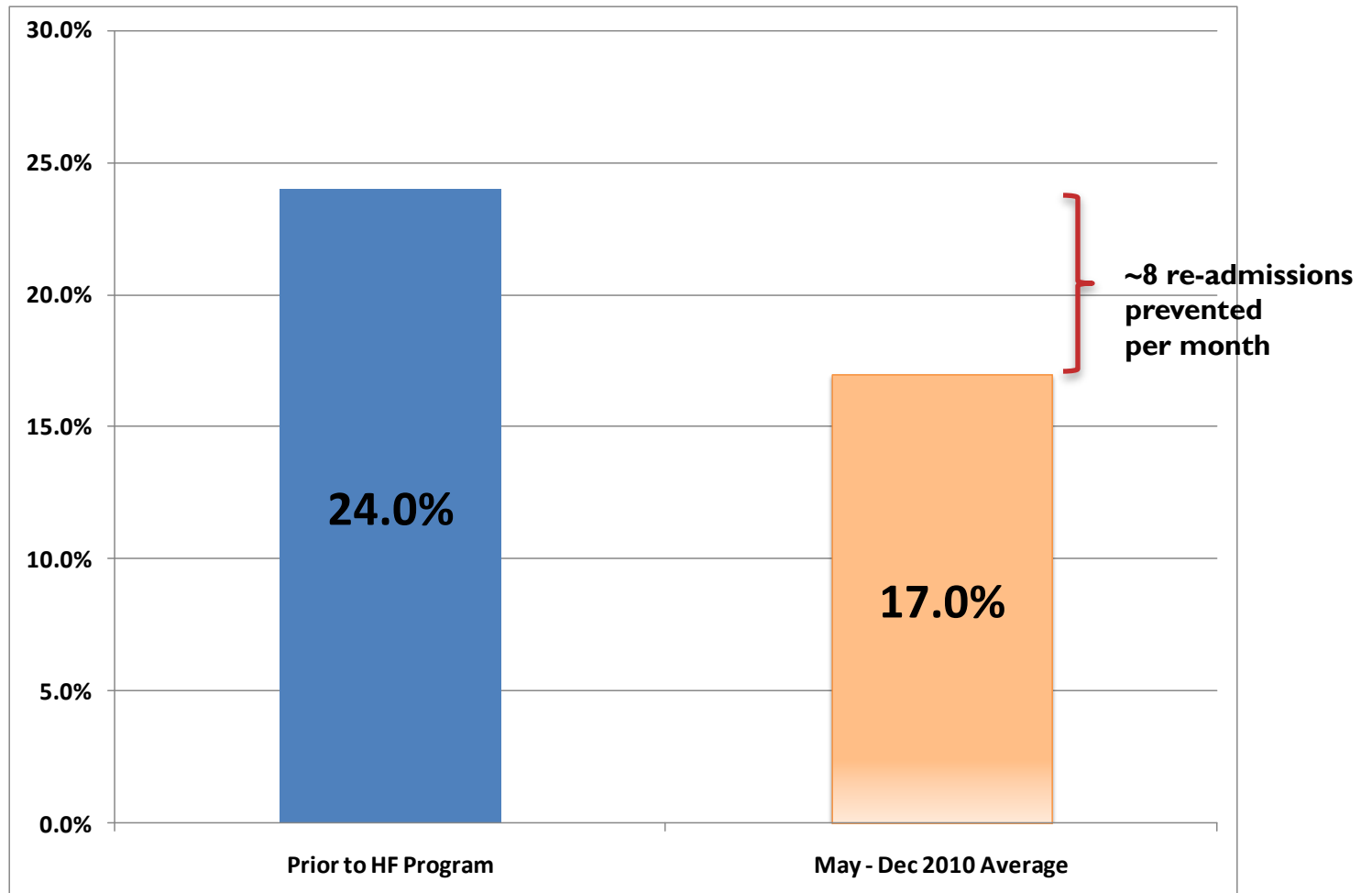
\*Data collected based on patients followed by pharmacists

\* based on article by Peacock ,2003

# Financial Impact

$$8 \times \$15,293^* = \$122,344 / \text{month}$$

$$= \$1.46\text{M} / \text{year}$$



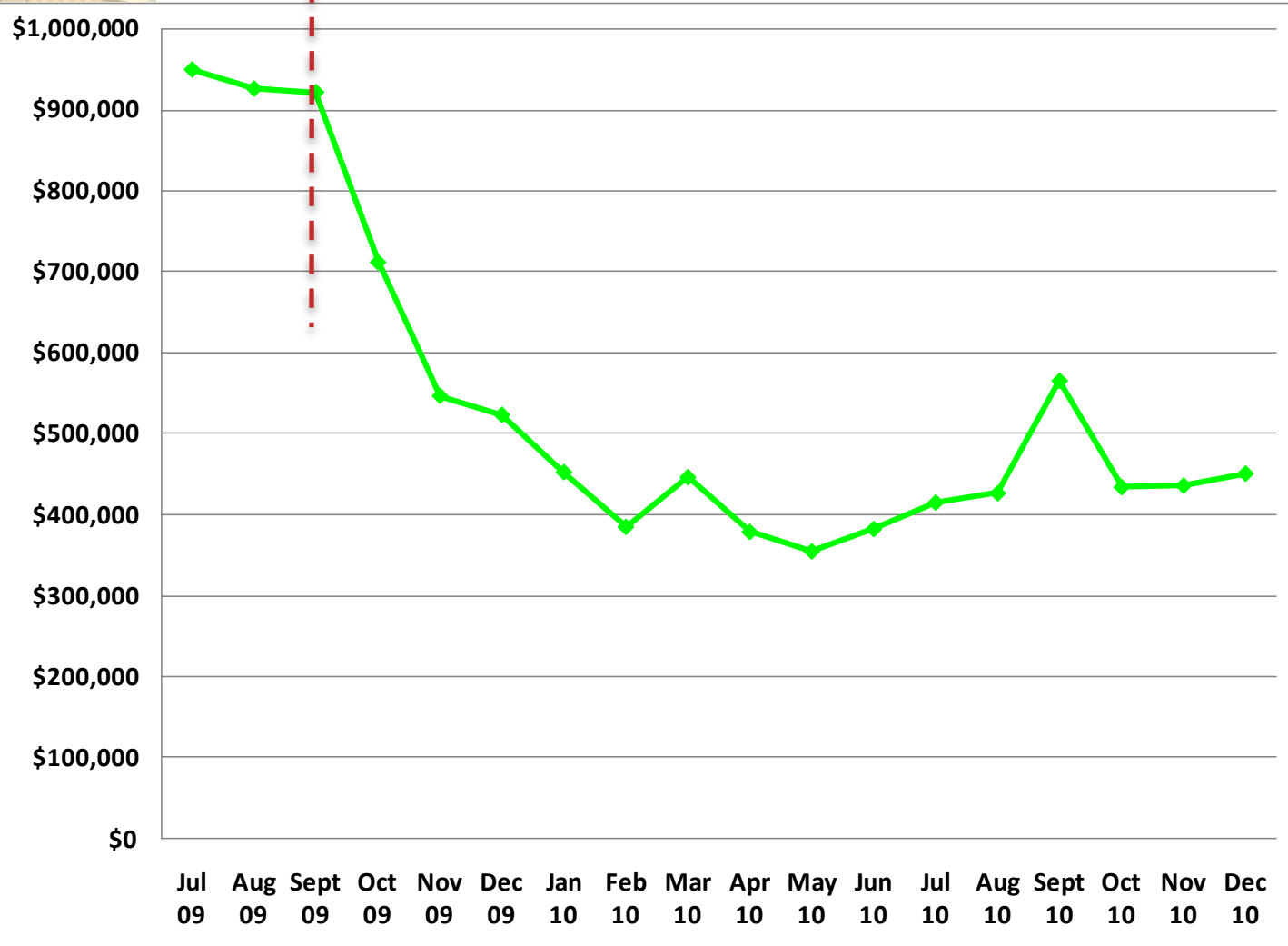


# Managed Care

# Medically Indigent Service Program (MISP)

- Sept 2009
- Formulary management
- Disease management
  
- Pharmacist coordinated care
- Vertical & horizontal integration
- Improve quality
  - Reduction of poly-pharmacy, poly-prescribers,
  - Standardization of care

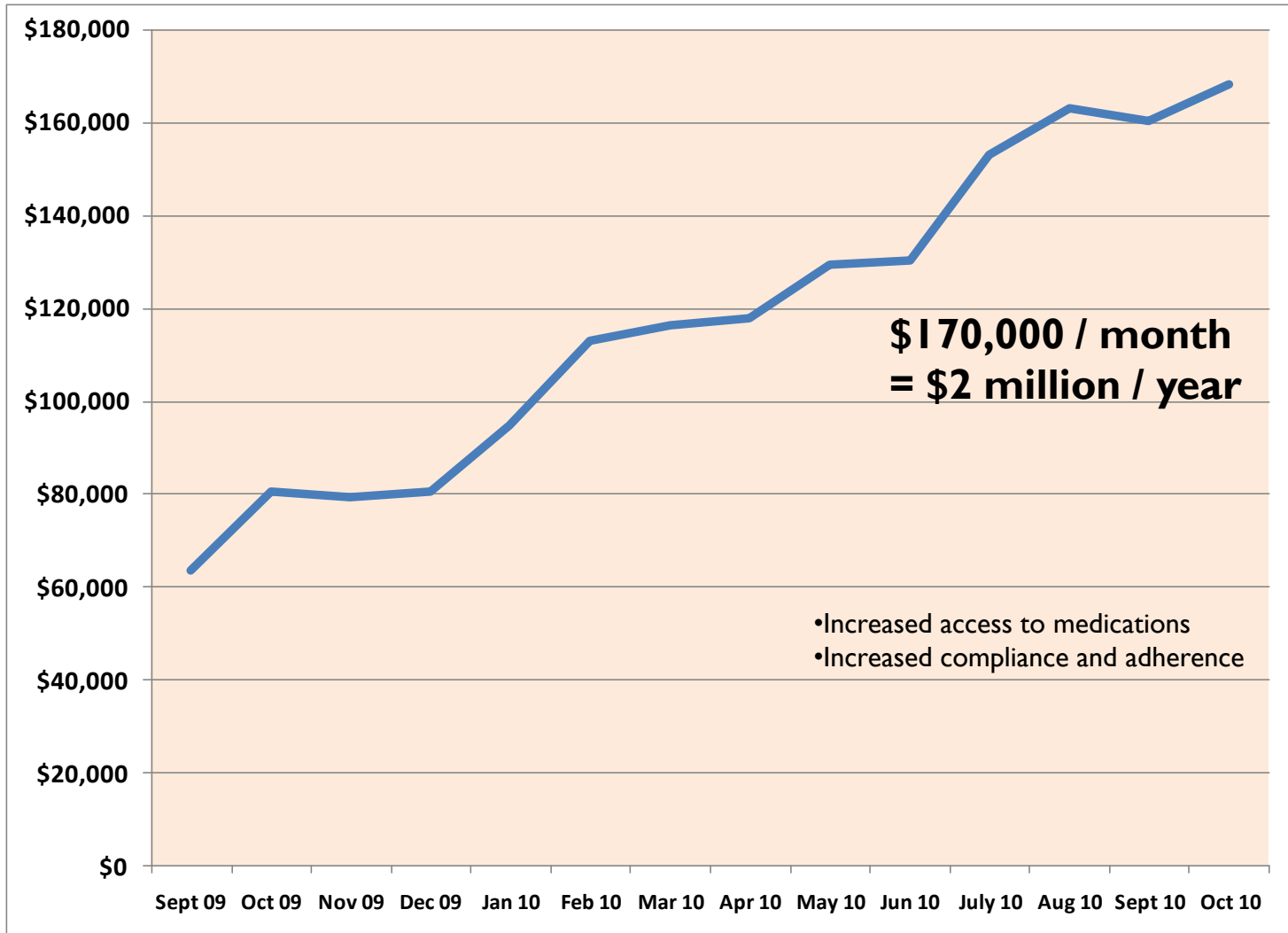
# Pharmacist-Managed Medically Indigent Service Program



~ \$450,000 / month

= ~\$5.4 M / year

# Pharmacist-Managed Patient Assistance Program



# Pharmacist-Driven Strategic Quality Initiatives

- Improve overall **QUALITY** and outcomes
- Enhance safe use of medications
- Efficient use of resources



# Take home message



- I) Research
  - Data collection
  - Hospital statistics
  - Current practice and quality measures
  - Expected outcomes/impacts



- 2) Institution support
  - Administrators
  - Physicians
  - Nurses
  - Pharmacists



- 3) Develop collaborative practice protocol
  - Evidence based practice
  - Best practice standards (tailored to your institution)



- 4) Implementation
  - Staffing requirement
  - Workflow
  - Staff training – getting out of the comfort zone



- 5) Quality assurance
  - Monitoring mechanism
  - Data collection and reporting
  - Re-evaluate program and modify



