IPRO

Moderator: Sara Butterfield
February 6, 2014
3:00 PM ET

Operator: Good day, ladies and gentlemen, thank you for standing by, and welcome to IPRO Medication Consultation and Medication Management Collaborative Prework Session Conference Call. At this time all participants are in a listen-only mode. Later we'll conduct a question-and-answer session, and instructions will follow at that time. If you require operator assistance, you may press star then zero on your touchtone telephone. I would like to turn the conference over to our host, Vicky Agramonte, you may begin.

Vicky Agramonte: Thank you so much, Olivia, and good afternoon, everyone, and thank you for joining us. Just some ground rules as we get started. If you cannot pronounce the Collaborative, you can't be part of it. Just kidding, just want folks to feel very comfortable with what we're doing here. We'd like to welcome all of you to this call this afternoon. I know you've been waiting with bated breath to jump into your audits and to really dive deep into further looking at our Med Rec process and how we manage anticoagulation.

We'd also like to send a special welcome to all of those who are joining us for the very first time. We hope that you're all joined by your teams, and you're not sitting in a room by yourself figuring out how you're going to manage this work. So thank you and welcome.

We are going to hold questions and discussions when Anne and I are finished, so if you could just hold onto that unless you have something that you really need to talk about, then, please, just alert our operator by indicating star 1. Also, this call is being recorded just for your future use.

So without further ado, let's go ahead and get started. Also, I'd like to just introduce that we have -- both -- we have two teams on the call with us here from IPRO. I'm being joined by my friend and colleague, Anne Myrka, who will be partnering with us to do this collaborative together, Anne and I. We're also joined by the Care Transition team here at IPRO. Of course, Sara Butterfield and her team, Chris Spegel, Fred Ratto, and their analyst, Joe O'Donnell and, certainly, our Drug Safety team led by Dr. Darren Triller, Anne Myrka is part of that team, I'm now part of that team, and our wonderful analyst, Susan Wymer is part of this team as well.

So without further ado, let's go on to disclosures here. As you all know and are very well aware, because many of you have already asked us for contact information from

participants, this project is designed to encourage our collaboration, and through that effort, we want to facilitate the sharing of facility names, team members, and your e-mail addresses with all that are involved in this project. We will not share your individual QI findings or QI data with any other organization without your consent.

So please contact Anne or I by next Friday, February 14, if you do not wish you have your contact information shared with those involved in this project only. We, of course, do not sell or anything like that of your information. So please let us know if not by -- probably by the 20th, we're going to be sharing with you the names and contact information of those involved in this project.

So as we're getting started here, our objectives are to reiterate our project focus and objectives. We're going to provide support in identifying -- finding your target patient population, and we're going to provide an overview of the measurement strategy for the MedRec and Med Management collaborative.

So, again, you know, this is a chart that we looked at through our recruitment WebEx a few weeks back. This gives a high-level overview of what we hope to accomplish in this project. So we're looking at medication reconciliation and the management of high-risk drugs, anticoagulants, across care setting, and we're going to do that in a two-pronged approach.

We're going to have you look at your individual medication reconciliation process, so you're going to examine and improve your current practices and improve the quality of the initial home medication list. Through a lot of the work that we've done nationally with 17 others states, what we've promoted was by improving the individual medication list at admission, hence, will help you improve the quality of that list at discharge. And we're going to go through some of those concepts in more detail in a few minutes.

What's late-breaking for this group, and you are certainly pioneers and cutting edge in diving deep into this work in improving medication management of the high-risk drugs; we're going to look at the adoption and implementation of evidence-based guidelines across care settings; and we're going to adopt improvement coordination between providers.

So you know that some of our goals are to improve the care coordination and care management and reduce our readmissions that are caused by ADEs.

So just a brief recap -- we know a lot of you are joining us for the very first time. We've met numerous times over the last few months, either through our coalition meetings here in Albany or down in the Hudson Valley or in other places. Actually, what we've done so far is having you identify your internal team, complete a memorandum of agreement. So if you have not already done so, please send us that MOA and, more importantly, we need a list of your team members. There are a few of you out there who we have been in communication with, but we need more than just your name and e-mail address. We want other members of your team so we can pull them into the process as you move forward.

And in our last webinar, which was on January 9th, we asked that you identify and gather your current auditing processes. So we want you to establish who is already auditing MedRec and anticoagulation so you are not duplicating efforts. We want information on your ongoing quality initiative, so maybe you were involved in other QI initiatives that

may not be related to IPRO's work. And we wanted you to gather your policies and procedures from MedRec and mid-management.

For those of you who did not hear this webinar, you can find it on our IPRO Care Transition website, and the link is provided for you there. And please contact us if you have any questions about that.

Let's dive deep into what we're really hoping to accomplish today. The goal of the Medication and Mid-Management process is to decrease medication errors and patient harm by obtaining, verifying and documenting patients' current prescriptions and over-the-counter medications. This is done, for some of you, through your admission process.

We also are comparing patients' pre-admission medication, the whole medication list, so ordered medication and treatment plans to identify unintended discrepancies, and we're going to be walking through this process with you as we move forward.

Discussing unintended discrepancies -- an example of those that are not explained by a patient's clinical condition or formulary status with the physician for resolution; and providing and communicating and updating medication lists to patients and to the next provider of service at discharge. For those of you who are Joint Commission accredited, this should be no surprise to you. We have been working on this since 2006, and we know that a few years back the Joint Commission did try to clarify this National Patient Safety goal and kind of loosened some of those requirements to allow you the facilities, especially in the hospitals, to determine where should this process begin and who should be involved in it.

For example, the ED in hospitals, hospitals were able to opt at the ED-only collect part of the medication list, and have that medication list once the patient is admitted, completing by the inpatient unit. So there were some significant changes made to that National Patient Safety goal, and that was well received by our hospitals.

And number five is added based on IPRO's unique process is going to be identifying patients on high-risk drugs and integrating evidence-based ADE -- adverse drug event prevention processes for identified patients across care settings.

Let's talk a little bit about MedRec and some of the elements of an improved MedRec process from the work that I've done in developing the MATCH toolkit and working on this problem nationally. These three areas in and of themselves can yield and improve the MedRec process. So the process design should center on the concept of a single list to documentation current medications. In the MATCH toolkit, we've called this a "one source of truth." Or maybe better said, it's a one-source list. Where is this medication list housed within your record, especially those of you who are hybrid on paper and computer. It's especially important that you really figure out how many places can you find a medication list in your medical record and how many times does that medication list not have any congruence amongst one another.

So this is part of the step we want you to take to determine the accuracy of these lists. To be safe, and some of the work that was done at Northwestern Medical Center in Chicago, there is one list within their electronic health record (inaudible), and each -- every one -- all disciplines including specialty services, contribute to this one list. And they're also encouraged to update this list as new and more current information becomes available.

Defining roles and responsibility -- determine which discipline should be involved in each step of MedRec including their roles and responsibilities. I share with Anne Myrka and part of the Drug Safety Team an ISMP survey that was done years back and, I assure you, if you think your staff knows exactly what their role is in MedRec, they don't. The survey indicated that almost 45 percent of the staff that were surveyed didn't understand what their role in MedRec was. And don't sit there and shoot the phone. We'll talk more about this as we move on, but we can no longer assume that our young clinical population knows exactly what we're talking about when we talk about MedRec.

And integrating MedRec into your existing workflow, we need prompts to complete required steps for MedRec, so when we start that list, does the person who has to complete that list understand that they have to do that?

If you work on these three steps in and of themselves, you will have an improved MedRec process.

Just another thought about the one source of truth. It's the single list of documents, the home medications, or any medications. It's standardized across the facility like I had just explained. It's maintained in a consistent location in the medical record, and all providers are empowered to update this list as I just said. And it's used at admission, transfer, and discharge. So when we talk about standardizing -- I can tell you my mother was hospitalized a year ago, and this was in a hospital that was electronic, they still had a printed MAR that was on the computer on wheels, or the COW, outside the patient's room that were literally two separate entities of medication lists. And we're really doing our patients a disservice, and our staff, thinking that we can keep a record straight when it's in more than one location.

Moving on now, and we're talking about slide number 9. We're looking at critical thinking skills. This is one of the tools in the MATCH toolkit, which all of you should have. This is on page 46 that you can look at afterwards. This is a great, great tool that really helps new clinician pharmacy techs, med techs, you know, techs that are doing MedRec in the ED that may not be clinical in nature, helping them think critically of when a physician needs to be contacted. And I think we can even use some refresher on when we really need to contact a physician.

So if we have a very black-and-white thinker who was looking for a medication and a one-to-one match, when we know that a formulary change was made, what we need to be focusing on those discrepancies that are unexplained or unintended, and that's the biggest part of the third part of this table, or the third row down, that explains an unintended discrepancy. Let's just take a brief minute to go through that.

So -- we're reviewing a record. We come across a discrepancy that exists and requires clarification of intent because there's no supporting documentation of explanation based on the patient's current clinical condition. So an example of this is the patient takes her blood pressure medicine twice a day, but it's only ordered once a day in the hospital. There is no indication for a frequency change, and the patient's current blood pressure is elevated.

Another example is the patient's statin was omitted. The discharge instructions without clear indication why. The physician needs to be contacted, the prescriber needs to be contacted for this level of discrepancy, and we're going to go through that and other examples as we look through the audit tool.

Now, along with this tool is the explanation of what an unintended discrepancy is. So there are several types of unintended discrepancies -- some that I just described in that example, but we need to be aware. And I think what -- not "I think," I know -- in discussing the process of MedRec with many facilities not only in this collaborative but nationally. We're talking hundreds of hospitals we've worked with that really think that the next provider of care is going to catch my error.

So folks are thinking, "Well, you know, okay, you know, this change may not have been done at discharge, but I know the next provider of care is going to catch it." I have to tell you we need to stop thinking this way. We need to have every part of our medical record as complete as possible, and I am going to depend, for me, Vicky Agramonte, if I'm discharging a patient, that my receiving provider, Anne Myrka, is going to follow-up and say, "Well, she missed something," and made a correction.

We can no longer have a system on which we rely that one physician was completely accurate in those discharge medications and that no error was made. The only way that we can help each other is by validating, at each time point, this list is as accurate as it can be. And that's what we'll be reinforcing through this project.

So those types of unintended medication discrepancies are omission, omission being very scary because, as we've discussed, a statin drug that may be omitted accidentally during a hospital stay and never restarted or not caught to be restarted, how do we know what harm that's caused? How do we know that six to eight to 12 months down the line that this patient doesn't have an acute MI? And at that point was it related to the statin drug being discontinued or omitted accidentally? Those are the type of discrepancies that are really scary, and we need to feel very comfortable in saying, "Well, hold it, Mr. Smith, you were on a statin drug way before this hospital stay. Why aren't you on one now?" and have that drug restarted at that next provider of care or that next setting as the patient moves down the road.

So in co-mission (ph), is the medication that's ordered at admission that the patient did not take before the hospitalization. The medication is listed on the discharge instruction, but it was not ordered during the hospital stay, and the patient did not take it during the hospitalization. These things happen. If you think that -- I'm sure you can all think of an example of when a medication was accidentally inverted for a close-named medication. An indication was put on -- I can't even think of an example, but we do know, Anne, that these errors happen all the time.

Anne Myrka: Yes.

Vicky Agramonte: Yes, and also the different dose route frequency. These things have to have clarity prior to discharge and duplication and/or a different medication order. This is why it's critical that at each timepoint we're validating this list again and again.

At this point, I'm going to turn it over to Anne Myrka to walk us through some of the tools.

Anne Myrka: Sounds good, thank you, Vicky. So -- slide -- I believe it's slide 12, you'll see an overview of our process. So this is basically a map of what you can expect during this project. So, first of all, we are going to look at process measures and outcome measures. Process measures demonstrate compliance with your established processes. And within

our process measure grouping, we will be looking at your internal medication reconciliation. We've created an audit tool for that. We've created an audit tool for anticoagulation management and a warfarin policy and procedure audit. So you'll have three audits and three tools that you'll be using to establish your process measures and establish your baseline.

All facilities will collect baseline process-measured data -- all the hospitals on the line will, all of the nursing homes, all of the home health care agencies on the line will measure their internal processes for baseline. And the measure completion date will be February 28, 2014. We'll be repeating that date, and we'll be going over each form with you during the rest of the slide set.

Regarding outcome measures -- oh -- I just wanted to go back to the process measures. What we're trying to do here is systematize and standardize a pattern of communication that would be the same across all care settings so that you're all speaking the same language, whether it's hospital, nursing home, home health care. So it's apples-to-apples communication. This is what we're hoping to achieve for medication reconciliation and for the management of high-risk drugs starting with anticoagulation management.

The outcome measure -- an outcome measure demonstrates overall impact of process improvements on patient care and safety. So that's your really high-level outcome. That's your readmissions, that's your hospital readmissions due to high-risk drug ADEs and anticoagulants are the primary focus. Only hospitals will collect the baseline outcome data. So the outcome measure is only for hospitals. We'll be looking at the readmissions due to ADEs for the hospitals.

Now, Sara and her Care Transitions team have been collecting readmissions data for all cause for the facilities. That has been ongoing, but within our project, we're going to dig a little deeper and look at those readmissions that are due to anticoagulants, and I'll be talking about that more later on in the slide set.

So -- once you gather your baseline process measures and the outcome measure, IPRO will analyze the data and provide confidential feedback to each of your facilities. So you'll be faxing your data to Vicky and I. We'll collect it, we'll analyze it for you, and we'll create a report, and we'll include some potential interventions that we think might be useful for you. And from that list and categorization of potential interventions, you'll select yourself and implement an intervention, and then you'll have a re-measure period.

So what we're thinking is that you will send us your baseline by February 28th. We'll quickly analyze it and create a report back to you, and then you will have an opportunity to implement an intervention. We can have conference calls, coaching calls, and (inaudible) business, if necessary. And at the end of March we would like to see another re-measurement period. We'd like to see something implemented and then a re-measurement by the end of March. But we can talk about that with you individually.

Vicky Agramonte: Anne, could I say something for a quick second? And this is a really big point that Anne had just mentioned. One of the specific interventions that we hope to have you implement is that you're sharing all the elements of the anticoagulation audit tool. All of those elements we need for you to establish internal communication with. We need to make sure that you have those elements that you're collecting to ready you to begin to coordinate with your partners that exact information.

We know that we're lacking in areas of anticoagulation coordination, and some big gaps are in our care processes. So we're also going to be coming up with a portfolio or a care plan on all those elements of anticoagulation that your next provider of care really requires and needs.

Anne Myrka: Thank you, Vicky.

Vicky Agramonte: Yes, no problem.

Anne Myrka: So, moving on -- we also are providing for you some ideas of how to identify your target patient population. If you're a hospital, you might want to look at your BTE or stroke core measures. You may be able to gather pharmacy reports to identify patients on anticoagulants. If you're a skilled nursing facility, you could look at your MDS 3.0 in certain sections. You could look at intake referral information or PRIs, and also gather pharmacy reports.

The same with home health care -- OASIS C responses to various questions can target the patient population that you'll focus on, and your intake referral information is also of importance there to identify the target patient population including MDT data and CTM-3 to target interventions using -- within the transition coach services.

But, most of all, what you could so is use the common diagnoses or conditions associated with anticoagulation use, such as treatment and prevention of blood clots, or VTE. Those patients who have a-fib or a-flutter, orthopedic patients, post-surgical orthopedics and stroke patients. And we did connect you with a link to find various ICD-9 codes for these diagnoses.

Okay, so now we're going to the process measures where we will do some audit tool demonstrations for you, and Vicky's first up in a few moments. First I'm going to go through some of the instructions at the beginning of each tool so that you're clear on how to use them. The Medication Reconciliation Audit Tool will evaluate the collection and accuracy of the home medication list, the accuracy and timeliness of the medication reconciliation of the homeless to admission orders, documentation of rationale for intended medication discrepancies, and the incidence of unintended medication discrepancies.

So you'll audit five to 10 medical records of patients discharged from you facility on any anticoagulant who has been re-hospitalized within the past 30 days. If you're having difficulty finding five to 10 records that occurred in the past 30 days, you can go out to 45 or 60 days, if needed. But the reason why you're choosing records of patients discharged on anticoagulants is to assist you with identification and the subsequent root cause analysis of anticoagulant medication discrepancies.

For the Anticoagulation Management Audit Tool -- that will evaluate your facility's internal discharge communication practices for patients who are discharged from your facility on an anticoagulant. And you'll use the same five to 10 records that were used for the MedRec tool. So that should make it pretty easy for you. And you will audit medical records of patients discharged from your facility on any anticoagulant in the past 30 days.

The warfarin management policy and procedure audit tool evaluates your facility's policies and procedures relating to the management of warfarin. And warfarin is the focus because it's still the most common anticoagulant -- oral anticoagulant -- and the

evidence base is very rich with high-quality medication management strategies, which are under-utilized in practice pretty much across all practice sites. And we can also -- Vicky and I can assist you with that comprehensive review of your policies.

An additional baseline that you can choose to do is an assessment of your patient population's INR time and therapeutic range for the entire population. The process that we use, it's a validated process. It was designed for skilled nursing facilities and outpatient clinics and other clinics that serve a population over a long term.

We would need at least four INRs -- four consecutive INRs -- in order to do this analysis. And, as you know, with warfarin, the INR should be within the range of two to three. What we provide you here is the median INR. In this example, you can see that the median INR was 2.55, the mean TTR, time and therapeutic range, was 67.4, I believe, in this example. And we can also provide you those extreme ranges of outliers. So INRs that are greater than or equal to 4.5 or less than or equal to 1.5. And also the median time between INRs.

So we did a study in 12 nursing homes, which showed an aggregate time and therapeutic range of warfarin to be 45.5 percent, yet we also found that the average time between testing was about six days. So although nursing homes frequently performed INRs on their patients, the response to those low INRs was not timely or adequate. So we did -- and the quality goal that CMS gave us for our 10th scope of work was to try to push facilities and partners that we worked with to a 70 percent time and therapeutic range, which we were able to achieve in the five collaborating partners that we worked with.

But anything over 60 is good, over 65 is even better. So we highly recommend that the nursing homes work with us to achieve this internal anticoagulation quality baseline. And what we do here is we actually work with the labs. We create an agreement with the laboratory that the nursing home uses to get the INRs from the lab, and then we analyze those INRs. Like I said, we need at least four consecutive INRs in order to do this process. So anybody who can do that for us, we could probably create a nice report for you, and we could talk about some quality interventions that we have already had established. So just let me or Vicky know if you would to do this also. It's kind of easy because we get the information from the lab, and it's not -- the baseline is not time-intensive for the facility, and I also provided the link there, as you see.

Now I'm going to turn it over to Vicky, and she's going to give you a demo of the audit tool.

Vicky Agramonte: Excellent. So as I'm bringing up my desktop, if you all would like to just grab your audit tools so we can -- you can follow along and jot down any questions that you might have so we can assist you as we're moving along here. Okay.

I have up here our Medication Reconciliation Audit Tool. Now, important, let's follow the directions. I know, as nurses, we tend to, you know, scan through them very quickly and jump right into our questions, but let's kind of take a deep breath here and look at what we're looking at. So, remember, we're evaluating your facility's internal MedRec process. One, the collection and accuracy of the list, as Anna said earlier, the accuracy and timeliness. The documentation of rationale and intended discrepancies, and the incidence of missed discrepancies.

Again, we're going to use the criteria below, audits five to 10 medical records, discharge from your facility on any anticoagulant. Again, you know, in our project, this is not a randomized controlled trial. We know that in quality improvement, if we don't have established process together, you're going to see that in your medical record by the second or third record, we need not keep auditing our record to try to get a better number of things that we did right. That's not our goal here. We are trying -- we now quickly where our gaps are. Let's get five to 10 records together quickly so we can drive improvement forward.

So for those of you on the line who are from very large facilities like our partners here in Albany, you might want to do 10 records, or do a larger sample size. But, for the most part, five to 10 will do.

You're going to answer "yes," "no," or "UTD," unable to determine, to the following audit criteria questions down on your patient's medical record. And, again, we'd like for you to use additional forms. If you need more, you could just Xerox your own forms or use them electronically.

So let's start from the beginning here. We're going to do a little example of kind of a mock patient record of what I know will probably exist in most everybody's medical record. So -- and we'd like to thank, too, Ferncliff -- Archcare at Ferncliff -- for helping us evaluate this tool and make corrections. Way to go, Ferncliff -- woo-hoo.

Was it original home medication list collected on admission? So think about this. For most of you, the answer for this is going to be yes. Did the list of the original home medications collected at admission include medication name, dose, route, and frequency for each medication?

For some of you that may not be the base, and please don't think that if you're on an electronic medical record that this is a given; that all those elements will be present. Trust me, I've worked with enough facilities who are either fully electronic or still on paper or a hybrid on both, and they all found problems with that question. So let the process roll itself out. Don't pre-judge until you've taken a look at a record.

Was that original home medication list reconciled with the admission orders in less than 24 hours?

And now for some of the skilled facilities, this may not even be feasible for you, but you need to think was MedRec conducted in a timely fashion? We know for home health, you're held to the one day, for one calendar day. So we know, for you, you need to get MedRec done quickly. We know in the hospitals, if medication reconciliation isn't done timely, you're impeding the patient's care. So you all know exactly what I'm talking about.

Nursing homes -- this is going to be really, really challenging for you. We're asking you to do something that you may not be doing right now, and that's -- so let's take, for example, Mrs. Smith, who was admitted to a skilled facility for short-term rehab for an orthopedic condition. That original home medication list, when, during that admission, do you re-validate that the original home medication list is accurate? I know this is a point where everyone is going to turn around and say, "Oy, jeez, you know, I'm not sure if we're doing that." We know you may not do it, and that's okay for now. We're going

to push forward for you to make sure that you have processes in place either through nursing or intake that's going to help you adopt a practice that can capture that.

Did the reconciled med list reside in the dedicated location in the medical record? We already talked about that one source of truth. Where is it? Where do you find your most accurate medication list? And was there a one-to-one match for every medication on the home med list to the admitting orders? There needs to be some. You have to have all these elements in place for you to say yes. And, in this case, we're saying no.

For meds without a one-to-one match, was there a rationale for the discrepancy documented?

And if "no," we're going to have you complete the med discrepancy tool. So in this case, we found that there were four no's, one unable to determine, and that's how we'd like you to score this. But now let's take, for example, the patient who Anne and I had talked about earlier. We had gotten a call from a provider, and here was the scenario -- the patient was discharged on warfarin. The patient had been diagnosed with a BTE event within the hospital. They were discharged with warfarin; overlap therapy with Lovenox and rivaroxaban, and nobody picked up the fact that rivaroxaban was being used in replacement of the overlap therapy. It said the patient was prescribed both treatments.

Now, you think this is an exaggeration? It's not. Had the admitting clinician had not picked this up, you can guarantee that patient would be right back in an emergency room with a bleeding event. They were on three anticoagulants, and nobody picked it up until the admitting clinician in the next setting did. So, again, this is a critical medication error and in this case this would be something that would be added to the medication discrepancy tool that at discharge it was incomplete, inaccurate, there was duplication, and probably this patient would have been harmed had this not been picked up.

All right, Anne, we're going to turn this over to Anne Myrka to walk us through the AC audit tool. Here we go, you're coming up right now. There you go.

Anne Myrka: Thank you.

Vicky Agramonte: You're very welcome.

Anne Myrka: So the AC management audit tool -- I just wanted to back up a minute and say the criteria questions were culled from various evidence-based literature sources that were published in 2013. One is optimizing the consensus statement from the Anticoagulation Forum for Optimization of Inpatient Anticoagulation Management, which had a listing of care transition issues that were important to communicate on discharge. So we used that information, and we also used information on the safe and appropriate transition of patients who were on the new oral anticoagulation agent.

So given that background, what we're asking you to do -- and our purpose here is to evaluate your internal discharge communication practices for patients who are discharged on an anticoagulant. So what kind of information are you, as a facility, providing to the next cross-setting provider when you discharge a patient who is on an anticoag agent.

So, again using the criteria below, you're going to audit five to 10 medical records. You can audit more if you want, as Vicky said, of patients who were discharged from your facility on any anticoagulant agent within the last 30 days, you can go out to 60, if

needed. You're going to answer "yes," "no," or "unable to determine," UTD, to the audit criteria questions using data found in the patient's discharge instruction, discharge summary, or other written communication that was intended to accompany the patient upon discharge. If a question does not apply, leave the answer section blank. Of course, you can always contact Vicky or myself if you have any questions.

Now, in Vicky's example, she had a patient who was taking -- or receiving three different anticoagulation agents, or three were ordered. So we are providing in this form the ability to have multiple anticoagulation agents be evaluated and the communication surrounding them. So for each record reviewed, assign a number in the patient column heading. So you see here, for patient column we have "Patient 1" has warfarin, and we add the name of the anticoagulation drug on the -- anticoagulant drug on the second row. Patient 1 has warfarin and Enoxaparin onboard. Patient 2 just might have warfarin. Patient 3 just might have rivaroxaban. So in that way, you will accomplish this task.

So for patients with more than one anticoagulant, complete an adjacent column for the additional drug. Use additional copies of the form, if needed, and you'll fax these forms to Vicky or I using the fax number above.

So -- was the primary indication for use of the anticoagulant clearly documented?

We want to know, when you look at your records, that you can clearly see why the anticoagulant was ordered, "yes" or "no" or "unable to determine." You'll answer one of those three questions. In these examples we say "yes," and "yes" for warfarin and Enoxaparin.

Was an assessment of fall risk clearly documented?

For the most part, I think most facilities won't have a problem finding a nursing record of a fall assessment. So we said "yes" for both of these examples.

Did documentation indicate whether the patient was new to anticoagulation therapy or a previous user?

So, hopefully, you will find that kind of information in the discharge information. If new -- and by "new" we mean within the last 30 days. The timeline that we're giving for a new order is within the last 30 days. If new, was the start date of anticoagulation therapy provided? In this instance there was not a start date provided for warfarin, but there was a start date determined for Enoxaparin.

Did documentation include whether treatment is intended to be acute or short-term or chronic or long-term? And so then you would enter your findings in the two columns.

If acute or short-term, was the total duration of therapy provided, i.e., was there a stopper end date indicated? There may or may not be in the record, so you'll have to do some searching there.

Was the date, time, and strength of the last dose given documented? And all of those three parameters must be documented and be present for "yes." You can't write "yes" in this column unless all three were given.

And was the date, time, and strength of the next dose due provided? And that all must be present for "yes" for both columns.

The next few questions are regarding warfarin only. So if the patient was on Coumadin or warfarin, was the target INR, or the INR range documented?

By the "target INR" I mean was there a certain INR, like, 2.5? That was indicated by the physician that that's where the patient -- the INR should be at? Or was a range indicated? Was it 2.0 to 3.0, was it 2.0 to 3.5, et cetera?

If on warfarin, were the last two INR lab results provided with dates and results?

And this is very important because a dosage change in warfarin cannot be determined on a single INR. You need at least two previous INR lab results to determine whether -- what the trending of the INR was, whether it's trending up or down. So making a dose change in one isolated INR can result in an adverse event.

If on warfarin, was the date provided for when the next INR was due?

And here -- this important -- we can't assume just because the patient appointment was made with a physician within seven days that the INR will be done. That's an assumption that cannot be made because it's not true. We're not sure what the physician will do when they get the patient unless they're directed that an INR must be tested.

And then what's the most recent serum creatinine, or creatine clearance evaluation provided with day end results? And "by recent," we mean within 30 days -- within the last 30 days was the serum creatinine or creatine clearance evaluation provided? And this is specific for the new oral agents? Several of them are adjusted based on kidney function, especially in the elderly.

The next few questions are regarding educational material that's provided, which, you know is a VTE core measure.

Was the patient provided with educational material regarding anticoagulation therapy?

And you could say yes. You know, most facilities will do some kind of patient education. However, was an assessment of patient or caregiver understanding of the education documented? This is more of a fuzzy area. We have tools an interventions and resources for you to answer this question appropriately.

And was documentation of caregiver and patient education and understanding communicated to the next provider setting?

So does the next provider setting know that you educated and documented the patient understanding? So in this instance, we said "no" for both.

Was contact information provided for the anticoagulation management prescriber or physician?

So who was the person that needs to follow up on anticoagulation management? Is it the cardiologist? Is it the primary care provider? But there needs to be somebody who is willing to take responsibility for management of this high-risk drug on hand-off? No

longer can we assume that it will be handled appropriately and that we know by default that it would be a certain provider without it being clearly documented.

Also, was a patient referred to an anticoagulation management service such as a Coumadin or warfarin clinic?

The guidelines indicate that systematic warfarin management, standardized warfarin management, was in a clinic or was in a management service is appropriate and is what would be ideal for a patient on transition.

So I understand that not every community has a warfarin clinic or a Coumadin clinic, but we can hopefully help you identify some clinics that you may not be aware of that do exist.

And then we'll be tallying -- we can tally the "no" and "unable to determine" responses for you.

I wanted to bring to your attention at the footer of the page, we have here the listing of the anticoagulants that you might encounter so that you're inclusive with what you need to be included of. And the novel oral agents are Pradaxa, Xarelto, and Eliquis that you'll see.

Then we have to go back in the slides, and I'll briefly go over the policy and procedure. I won't spend time going over the policy and procedure audit tool. It's pretty self-explanatory. You'll be pulling out your warfarin management policies and checking off and ranking them according to the rank that we give you here. I'm not going to belabor this point, but we can work with you individually with subsequent coaching calls. So I'm going to kind of quickly go through that.

And then the outcome measure, I introduced this in the January 9th webinar, and we spoke about the denominator and how we'll be extracting that data. Again, I'm not going to go into detail in the slide right now, but we will be contacting. We'll be looking at, hopefully, 2013 timeframe. We can look at six months or more of your abstracted data from your electronic health record, and we ask that hospitals should identify an IT lead to participate in discussions with IPRO for the electronic data retrieval process. And IPRO, Vicky and I will be contacting the key hospital leads in the next few weeks regarding the ADE data retrieval and transfer procedures. But you should be lining up your IT people right now, and we'll be calling the hospitals to schedule subsequent meetings.

And then I'm going to hand it back over to Vicky.

Vicky Agramonte: Great. We're just going to go through this very, very briefly. I'm sure, you know, we've been alluding to some of the interventions that we know can yield a safer warfarin or anticoagulation management of a patient that includes having a solid MedRec process within your institution. So these are some of the areas that I talked about earlier that we know what can give you an improved medication list within your facility, and that's just having a good process for how to obtain this list. And we'll talk about these more as we begin to meet with you all after your baseline has been established.

So some of the interventions that we're looking at for anticoagulation is some of the ARC (ph) educational material that many of our hospitals in New York state have been using to meet the requirements of their VCE-5 core measure, and it has a partner in DBD. So

we'll be working with you on a lot of these tools to adopt these tools to improve your internal discharge process and improve our care coordination.

So here we are at our next steps, and then we're going to have a few minutes for questions. So we need you to complete these three process audits by February 28th. We want you to fax them to Anne and I so we can help give you a nice, pretty document -- you know, reports on how to display or showcase these findings in a way that you can see some improvement, over time.

We want outcome baseline completion date will put the outcome measure with the hospitals. We'll be talking to you individually for when we can get that done. And, if nothing else, our next call together will be on February 20th. It will be by conference call only. We will not have a webinar. And by the 20th we're hoping you can have at least a few audits together so you can come back to the table and say, "Hold it. This isn't working for me. Look what I found," or "Gee, look what I found. It was a little better than I thought." Either way, we want to hear barriers, we want to hear what we can do to help you get past those barriers to yield improvement.

And, again, we're going to be providing individual support to all of you and contacting your leads to not only meet with you but to meet with your partnering facilities. So by the time we have meetings in March, we hope to be having those meetings regionally with the partners that are involved in this collaborative. So we'll be meeting with you individually and as a community.

For those of you who are just dying to know, some of the toolkits, maybe if you didn't seem them or didn't get a chance to look at them, here are the tools and resources -- the toolkits and resources for you and where they can be found online.

And, with that, Olivia, we're going to go ahead and instruct our audience on how to ask some questions.

Operator: Ladies and gentlemen,, if you have a question at this time please press the star then the 1 key on your touchtone telephone. You may remove yourself from the queue at any time by pressing the pound key. Again, to ask a question, please press the star then the 1 key on your touchtone telephone.

Vicky Agramonte: Excellent. And, thank you, Ashley, for bringing up our evaluation. Please, you know, as you know, we take your feedback very seriously. If you can just take a minute to do our online poll as you're coming up with your questions.

And also, just so you know, I've also included a more detailed IPRO team members list. Please feel free to contact any one of us, but Anne and I will be your top leads for this project, and we'll be pulling in our other team members to work with us, as needed.

Operator: We have a question come from the line of Mary McLaughlin, your line is open.

Vicky Agramonte: Excellent. Hey, Mary, thank you for joining us.

Mary McLaughlin: How are you doing?

Vicky Agramonte: Good.

Mary McLaughlin: A question about that AC audit tool.

Vicky Agramonte: Yes?

Mary McLaughlin: When you were talking, you were kind of going back and forth between what's in the medical record versus what is given in a hand-off -- what's given in a hand-off to a patient that goes home versus CNA versus facility are three different things. So which should we be doing? In the medical record or in what goes to -- ?

Anne Myrka: You know, I apologize for that. You know what? Go with the instructions -- Patient's Discharge Instructions, Discharge Summary or other written communication intended to accompany the patient upon discharge. That's really what it's intended for for the AC tool. But that should be found within the medical record.

Mary McLaughlin: Well, it should be found within the medical record, definitely; however, the only people that get the whole medical record is someone that goes to a facility, that goes to VNA (ph) or goes home doesn't even get a Discharge Summary. The patient gets instructions, but they don't -- a lot of this information to tell the patient their creatinine wouldn't really make sense. I mean, we could send it to their primary care provider, they'd get a --

Anne Myrka: What discharge communication do you send to the next provider?

Mary McLaughlin: Discharge Summary -- a Discharge Summary and sometimes a letter, depending.

Vicky Agramonte: Mary, I think what we're really trying to do -- we know some organizations already have an established mechanism for reporting this across settings; for taking these elements and communicating them well as the patient crosses settings. But I think what we're really trying to do now is to establish those internal communication mechanisms inside your internal medical record and prepare you for communication as that patient crosses setting as routine --

Anne Myrka: Yes, and it is intended to the next provider setting. So the next provider who is going to be providing care to that patient in any setting should have these criteria passed forward. Does that make sense?

Mary McLaughlin: All right, so if it's in the medical record, but it's not in the Discharge Summary that got back to the primary care physician, for example, on a home discharge, is the answer to the question yes or no?

Anne Myrka: So, yes. You would need to provide all of this information to a primary care provider, too. Even if we don't have any in the teams right now, but this is why I'm saying that we need the standardized communication across all care settings.

Mary McLaughlin: So it has nothing to do with what's in your medical record?

Vicky Agramonte: What we're thinking, too, Mary, it's -- Mary, we have to be able to have these included in our medical record in order to communicate them to the next provider setting. So it's what's ever in your medical record. It could be in 10 different locations. Our goal is to be able to collaborate, you know, to combine that into one type of summary to pass on to the next provider setting.

Anne Myrka: Correct.

Anne Myrka: But one of those documents, you may be able to get this information from is the discharge form. And that's okay to use that as part of this audit.

Mary McLaughlin: It's still -- I'm hearing two different things. So, I'm sorry, I'm being very specific but --

Vicky Agramonte: That's okay, this is good.

Mary McLaughlin: I have to understand -- so this information is always in our medical record, for the most part, let me say.

Vicky Agramonte: Right.

Mary McLaughlin: Creatinine is an example. However, it wouldn't necessarily be in the Discharge Summary. So do you want the answer to "Do I have the information?" Or do you want the answer to "Did I give the information away?"

Vicky Agramonte: Did you give it. Did you give it.

Anne Myrka: Okay, because -- no -- so here is the example. So you have -- if you have a recent serum creatinine, and did you -- did you give that serum creatinine level to the next provider, yes or no? You know, you have to determine whether you did it or not, and that's part of the audit tool. If you -- you know, the audit is the audit. So this is the baseline. So it's about what you give to the provider no matter where you found it in the medical record -- did you give it to the provider or not?

Mary McLaughlin: Okay, thank you.

Anne Myrka: Does that make sense?

Mary McLaughlin: It does. I just was hearing something different throughout the conversation. So I just wanted to be 100 percent clear that I understood exactly what you're saying.

Vicky Agramonte: No, we appreciate you bringing clarity to that, Mary.

Anne Myrka: Any other questions?

Operator: Again, ladies and gentlemen, to ask a question, please press the star then the 1 key on your touchtone telephone.

Vicky Agramonte: And, Olivia, while we're waiting for the next question to come up, I think Mary brings up a great point. You know, we are expecting that there are certain communities that are communicating this information back and forth routinely. But we know, first, we have to be able to say, "Okay, we're collecting this information in our medical record," and then "Are we developing a mechanism in which we can support -- we can provide this information to the next care provider."

So we have listed here 15-plus elements, all of which you need to -- you need to collect internally and develop a mechanism down the road for when times goes by for how you're going to communicate this to the next provider setting. We know if we've heard from facilities -- we may not be seeing the creatinine clearance being given, and some we're not even aware that we needed to be aware of the creatinine clearance if that patient

goes from -- that are on the new agents. So now that's a new element that we have to say, "Okay, we have to be aware of this because the next provider care, they need this information."

So I think if that helps to bring clarity to that -- the information. Olivia, were there any other questions in the queue?

Operator: Again, ladies and gentlemen, to ask a question, please press the star then the 1 key on your touchtone telephone. Our next question comes from Mary Clow, your line is open.

Vicky Agramonte: I'm sorry, Mary who?

Mary Clow: Hi, how are you?

Anne Myrka: Hi.

Mary Clow: I'm from Van Rensselaer Manor.

Vicky Agramonte: Hey, hi, how are you?

Mary Clow: Good, how are you?

Vicky Agramonte: Good.

Mary Clow: I just -- I need a little help here. I just want to clarify, because I want to capture these residents, but if we have data that's due in March, we may get admissions now where we can do the initial MedRec and follow through when they're discharged, but they may not be discharged. I just want to make sure we're able to capture enough residents by then.

Vicky Agramonte: So, Mary, you're saying that you, at this time point, if we're looking at the past 60 days, so we're looking, like, going back to the beginning of December, would you be able to find five patients discharged from your facility on an anticoagulant?

Mary Clow: I'm hoping I would. I'm going to say yes. Now when they're admitted, though, for, like, say, the next set of data on admission -- if we start looking at everybody right now, we're going to do the MedRec process that we discussed earlier right from the beginning, and then do everything as we filed to right up through discharge as far as analyzing the chart and everything -- collect the data for you?

Vicky Agramonte: That is awesome. But, you know, for your purposes, Mary, I want to even go back further than December. So if you're going to make a change in your process as of today --

Mary Clow: Yes.

Vicky Agramonte: We need for you to capture the timepoint in which you didn't collect this information (inaudible).

Mary Clow: That's good, okay, that's what I need.

Vicky Agramonte: Okay, so go back a little further if you have to. If you're not going to find it in 60 days, do it in 75 days.

Mary Clow: Okay.

Vicky Agramonte: But there's no way that you're going to demonstrate the improvement that we want you to unless we capture that timepoint before you make a change in your process.

Mary Clow: I got you. All right, I'm straight, I'm sorry.

Vicky Agramonte: Yes, it's perfect.

Mary Clow: Do we do this right? Okay. That makes a lot more sense to me.

Vicky Agramonte: Excellent, way to go.

Mary Clow: All right, thank you very much.

Anne Myrka: Thank you.

Operator: Again, to ask a question, please press the star then the 1 key on your touchtone telephone.

Vicky Agramonte: Is there anybody in the queue, Olivia?

Operator: I am showing no further questions at this time.

Vicky Agramonte: Excellent. So, please, as we said, the evaluation is up on your screen right now. Please take a moment to complete that as we come to a close on our meeting, and it's the top of the hour. Great. Anne, any last-minute thoughts?

Anne Myrka: No, thank you for joining us today, and we look forward to speaking with you on the 20th.

Vicky Agramonte: Excellent. Thanks, everyone, and have a great afternoon.

Anne Myrka: Call us in the meantime --

Vicky Agramonte: If you need anything. Thank you.

Anne Myrka: Bye.