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Some challenges that we have taste by doing this call is that patients can't always be reached. We do have a max of calling the patient three times, and at least one time per day for three days. And then the physicians may not respond to some of the recommendations we give. That could be a challenge. Also in general it's [Indiscernible] mode. We are trying to with any issues we might find and fix these problems as opposed to some of these could have been resolved in the hospital if we found out before hand. Hospital pre-discharge medication reconciliation I am doing currently. We are trying to move more of our team members back into the larger hospitals. I started doing this pre-discharge. Same concept when it comments to [Indiscernible]. We want to have the length of stay but if they are anticipated to have a six or greater score, then I would talk to the patient, conduct am medical reconciliation and then reconciling them with their impatient or their anticipated mats. I can make any recommendations to the physician or hospital right away and make sure we can resolve any discrepancies. The biggest thing about this is we are preventing some of the issues instead of laying catch-up. Being here I would also pick up any pedis measures also.

The prevention mode is the goal that we are trying to do here with being on-site at the hospital. Other things we could do is we are able to build more professional relationships with physicians and providers. We meet with them face-to-face as opposed to over the phone and through our notes going back-and-forth with them. I am able to be more involved with these measures real-time [Indiscernible] and they may not have come up on our list but I know they are here for [Indiscernible] so I can go ahead and make sure that we meet those measures. Other challenges with doing a pre-discharge medication reconciliation is being new to this hospital and patient specifically at holy cross I've had to gain the trust of the physicians which is, that's going to happen with any new role and also turf wars with other disciplines such as the hospital pharmacy. Luckily we have had some great collaboration with holy cross hospital and I knew Jennifer had asked some questions about this, but we are working collaboratively instead of competitively. This is very important. We make sure we have a specific role and I make sure we are established at the transition. We are not going to make any changes to the inpatient orders if there are any recommendations, I would talk to the physician or the inpatient pharmacist to make changes and not to it myself. That's a clear role for me. Other things are just logistical things such as workspace. Reaching the patient before discharge is another thing. I've had to run up there and the patient had left already. That happens with any kind of medication reconciliation program before discharge. Our future goal is to have more involvement in the skilled nursing facility. We do have our own Kaiser core Smith, and we've had some issues with there is a lot of readmissions coming from patients who have been discharged from the hospital. Hopefully we can conduct, we are hoping to do a two-part. We will do medication reconciliation for patients who are getting discharge from the hospital, and the second part would be medication

reconciliation at discharge. We are only able to do a quick med reviews, so we still look at those patients and their discharge summary and medication list to see if there any issues. It is a little bit more difficult to resolve issues if there are any, that we do our best and hopefully with the future coming into our future goal of getting more involved, we can do a complete medication review by talking to the patient and reconciling their medications from their home meds. I wanted to show some of our outcomes. We do Kaiser and take data by making sure everything has an impact. From TCC Ps copyist of medication review and that's when we talk to the patient. We have made some great reductions. If you see the lace are equal to 10 we have an actual reduction of 3 to 14% and a relative reduction of 15 to 43%. We have some hard numbers instead of a range. We have a reduction of 27% and 6 to 9 of reduction of 43% which is a tremendous impact. Since we have done a lot with the patients going home, our project is to help more with Smith. There was a pilot program that was sent by one of our members, and she found that with doing a med rec for these patients, there is a 1% reduction in readmission for these patients. Another thing that we have worked on is to do some bedside delivery for medications. This is a great program and we are still in our pilot program. We have worked with Washington hospital and also Children's Hospital and the pharmacy department to get this program, it still in the pilot stages, but it's looking very good. Our future goals for the TCC P team is to progress pre-discharge medication reconciliation at a larger or hospital. As I spoke of about the Smith involvement is the phase 1 and the phase 2. Hopefully we can roll that out also. Expand the bedside delivery program. We are pretty much established at Children's Hospital Washington Hospital Center, but we are having some plans to expand that to Virginia Hospital Center and there may be a pilot coming up at the holy cross Germantown. That is to come and hopefully we can expand with also expanding membership. Thank you everyone.

This is Bonnie. Can everyone hear me?

Yes. We can hear you.

Great. I am Bonnie live in and that was a great reason Tatian from Kaiser. I'm very excited to add on to what was presented. Washington Hospital Center is one of the Kaiser hospitals. What I would like to cover in the next few minutes are some discussions about programs from med management across care and pharmacy intervention meant and resource requirements. I just want is say that med start is the 10 hospital system in DC and Baltimore including Washington Hospital Center, DC and Baltimore including Washington Hospital Ctr., Georgetown and Washington DC. We have more than 200,000 inpatient admissions per year, we have about 3000 hospital beds. Have 10 hospitals, but we also have retail pharmacies that most of our locations and what we will talk about is how we work together across the levels of care to provide transitions. We've had at MedSTAR a very active free admission steering committee at the system level for about four years. Each of the hospitals has their own working group. On these groups is a very interdisciplinary number of people including case management, social work, physicians, plus quality and safety and of course pharmacy. We've worked to define both the initiative and the metrics as we've looked at our readmission rates. You've all seen something like this. These are all of the places that we, as patients receive our care. I just put it here because if you think about the hospital portion, which is primarily what we are discussing, we have a profound opportunity to harm patients with medications at that level of care. Our need to really focus on providing safe transition of care is very critical. And met*we concentrated on the

transitions at the beginning and middle end of the hospital stay. We are starting at the bottom from the emergency room and preop obtaining that history doing a med red inpatient med management discharge med rec and then discharge prescription. This just list the various activities. It's a little bit redundant what we are doing at MedSTAR. Have to say our initiatives have been like a research laboratory. We have tried a number of initiatives and each of our 10 sites has slightly approaches. We will talk about all of the activities starting from the home med history all the way down to assessment and optimization and discharge delivery. We will try to get most of these and talk about the operational aspects and the challenges. This is a survey that was done by ASHP which is the national pharmacy Association. We started this in January and they asked who is primarily responsible for getting the home med list? With 100 responses it was a little more than a third were pharmacy related. Either pharmacy techs are students. I think we've made great strides in getting pharmacy into the ER to do this important function of collecting this list. I want to differentiate home med collection is different than reconciliation. MedSTAR into of our hospitals we have two of our technicians collecting the med list. Typically on the second shift wonder to full-time equivalents, the technician is able to access external prescription databases. You can go in and see what prescriptions have been filled outside of the hospital. The technicians also will contact the primary care provider, the community pharmacy, the nursing home, whomever is necessary to get their drug history. It is then entered into our electronic record. At one of the sites they saw one more than a third of the patients. We definitely have some work to do on collecting metrics. It's very hard to get a before and after assessment of a home med list, but we have a hospitalist reviewing the list afterwards and we are also doing some evaluation of changes made to the med list after the patient is admitted. Operationally this kind of program needs to start with the emergency department. Either a nurse or physician or both. It's changing the workflow in the ER. The resource that provides this service, usually a pharmacy tech, has to be well-trained and meet a number of competencies, but the use of the EMR and a lot of different competencies. You want to get the right person and typically it's the pharmacy technician with retail pharmacy experience because of their ability to meet face-to-face with patients and do interviewing. They are also familiar with the different dosage forms. There are some restrictions on the dosis it doses and they might not know the 40 kinds of exiles with a product. That is critical when collecting the history. The resource needs to get that electronic record and asked Colonel databases. We need to have a far missed backup to deal with the complex cases. This is a really cost-effective model that the pharmacy technician is less expensive than a nurse or pharmacist and able to perform a great service. That is on the ER side. Once the patient is admitted, the pharmacy staff are involved in a number of different interventions. First is med reconciliation which is everyone knows is primarily a physician responsibility. We all know that pharmacist play a great role in that reconciliation. We use a couple of different scoring criteria for readmission list. One was mentioned by Kaiser. We just want to identify who is best target of resources of identifying these patients. At one of our sites and Baltimore I published a study that's referenced here where they focused on the moderate risk Tatian's because they felt that they have the most impact on readmission reduction. They did about four interventions per patient. This just looks that all of the interventions done at our hospital in a given month. Starting from the left to the right, we did all kinds of dosing reviews and changes, duplication, there are couple here that specifically target readmission reduction and transition of care. So medication reconciliation and incomplete and remission assessment. But really all of the interventions the pharmacy makes are identified to improve the medication management process and therefore to improve the transitions. To get patients ready to go home

the pharmacists are involved in a number back tivity's including lifestyle modification. Smoking cessation, weight management, education and making referrals to and from other providers and working closely with social work case management, physical therapy, dietitian and all of that interdisciplinary work happens before the patient goes home. We want to make sure that before the discharge prescriptions are written, that there is a reconciliation and an effort to look at making sure those prescriptions are on the patients benefit so that the co-pay is minimized. If there is a four dollar prescription plan available, but they are used appropriately. This is the point where the pharmacist work so closely with the provider in optimizing the medications. Many of the interventions we saw in the previous slide were working here to optimize therapy. Counseling the patient prior to leaving is an important function. Sometimes challenging because once the patient is ready to go home, they are work walking out the door. This is an opportunity to catch the patient days before the discharge to make sure they really understand how to take their medication. We have programs that focus on anticoagulants, insulins, other hypoglycemia and and heart failure meds to make sure the patient understands the side effects and they address all of the issues with the patient. The pharmacist can also have an impact on the patient experience because side effects are so critical for patients to understand and feel empowered about their medications. For the inpatient intervention there obviously a number of issues to consider. It's a really resource intensive program. We tried to have about one full-time pharmacist per 15 to 30 beds depending on the acuity. We are able to do that in many of the hospitals and are nursing units, but not all. To do it requires a lot of IT support. The pharmacist need to get into records and have some kind of device that makes it portable and easy to access. Certainly want to make sure that your clinical decision support, your alerts and reminders support appropriate medication use and enable the pharmacist to quickly make changes in the system. We do interdisciplinary rounds when possible working with physicians and case managers and physical therapists. We have a varying kind of governance model. Daring degrees of how much autonomy the pharmacist has to make changes and do consult it is a little different, but to be able to do dosing and other dosing changes without contacting a physician and waiting for callbacks makes the program really effective. Once the discharge prescriptions are written, we then have programs that seven of our hospitals for bedside prescription delivery. It was referenced in the Kaiser conversation that at Washington Hospital we do have delivery and selective nursing units. It's a 900 bed hospital. I'm sure many of you have seen something like this when prescriptions are written about half are picked up. Than the have to be taken correctly and refilled. By having a bedside delivery program, we are nailing the first half of this problem because we are getting the prescriptions and filling them and putting them in the hands of the patient. It's a terrific program to improve adherence of this transition care. To get there it takes a village. This is a program that is challenging to bring life and to maintain. We've been pretty successful because we've had leadership support at our sites. The chief medical officer, the chief nurse officer to provide support to this program. We run it out of our retail pharmacy which is on-site at seven of our hospitals. We recruit pharmacy technicians that have rollerskates because it's a lot of running around, and we figure about one full-time equivalent for every 152 200 beds. We are keeping track of prescriptions we rate and we haven't looked at impact in adherence but there is some literature that suggests a bedside delivery program does improve adherence and does. Use readmission. We depend on ongoing readmission by public affairs by word-of-mouth and all of our associates because it's really a concierge program. It's a convenience to patient and it improves adherence and readmissions. At some of our sites they also deliver prescriptions to their employees because it's a convenience. There number of operational issues to pull off a

bedside delivery. One is ideally you need to access to the patient's prescription insurance card. Not just their medical insurance, and if it's available it helps to identify the right medications for patients. All of that can happen before discharge if you have the insurance information. Prescriptions need to be written at least a couple of hours before it discharge. Getting the prescriptions to the pharmacy and getting them filled and getting them back to the patient takes time. Has to be during business hours of the pharmacy so late discharges unfortunately are hard to capture and weekend hours make it difficult. Assessing the co-pay and the patient's ability to pay require some interviewing and then in many cases you still have to get in touch with case management to see if there can be some co-pay assistance in the form of about sure. Fundamentally patients always have to be given a choice of which pharmacy they want to fill their prescription. They have to approve an in-house pharmacy. And electronic prescription versus a hard copy the workflows are little different for the bedside delivery program. We had a few bumps along the way with the prescribed because those prescriptions just showed up in the queue of the pharmacy and they didn't know that this was for patient with bedside delivery. We were able to work out most of those issues. Once the patient leaves, we have some programs in place where there are some cost to the patient to assess adherence and understand the medication. We have rehab, transitional care units and warfarin clinics, with heart failure clinics and joint X which is in ortho discharge program. We also have an ongoing pilot project using electronic pillbox that sends adherence messages to the patient's primary care provider. We hope to be able to expand our met history program in the ER to our other sites. We hope to improve our ability to do analytics and reporting because I think that being able to document the efficacy and the outcomes is critical. The one art that site delivery program and add more discharge education. Right now they are separate functions. We want to spend a lot more time and energy to adherence tools. We want to work with our retail pharmacy to send text reminders about refills, providing Tatian specific adherence tools for helmets are package, and the electronic pillboxes. With that, next slide please. I think we opened it up to questions. I know there are at least wanted to MedSTAR folks on the phone. If they have anything to add or if I misrepresented the program, I'm sure they will correct me. Thank you for your participation.

Thank you. Ladies and gentlemen if you would like to register for a question, please press the one followed by the for on your telephone. You will hear a prong to acknowledge your request. If you would like to read draw your registration please press the one followed by the star. If you are using a speakerphone please mute your phone. Please limit it to one question. Once again as a reminder, few would like to register for a question, please press the one followed by the for on your telephone. There no questions at this time. I turn the call back to you.

[Indiscernible]

Go for it.

How is your medication transition program different from [Indiscernible] program?

The medication there be program in the retail setting?

Yes.

They are not as connected as they should be. We are doing a limited amount of [Indiscernible] in our retail site and it really is more directed to outpatient therapy than it is transitioning from the inpatient side.

Okay. One more from the chat. [Indiscernible] resources [Indiscernible] for that many beds?

It's always a challenge to get resources, but we have been able to demonstrate that in the emergency room department, it is better utilization of resources with the tech nation than the resources. It is a less expensive resource. On the meds to bedside delivery, it's easy to justify the bedside delivery tech because it increases the volume of prescriptions in the pharmacy. That's a direct one to one correlation.

Thank you. Any questions from online?

Ladies and gentlemen is a reminder to register for a question please press the one followed by the for.

We are showing here that we have from the line of Jennifer Thomas and I will open the line. Please Madame go ahead.

Hot hello thank you for your presentations. I have a couple of questions for each of you. First of all, regarding the risks for the score others Bonnie that you've mentioned. Is that information that's readily available from a standpoint of either electronically obtaining that? Is that something that is generated through EMR? Is that something that you have to determine on your own from whoever the it is an obtaining or reviewing the record? How do you obtain that score?

Based on our [Indiscernible] score, it is not like we had that option within our EMR epic system. That's actually the filled out by the case manager. They are called PTCs which are case managers and registered nurses. A fill it out but it's not automatic, and I think there could be some room for errors because sometimes that can happen. Sometimes have to finish it in order to make these patients eligible instead of so the numbers aren't skewed. It's actually from a study. It's a Canadian study, can pull it up. It's from the Canadian medical journal in April 6 the Canadian medical journal in April 6, 2010. They actually go through the index and they did a whole study on how it represents the readmissions for patient. That could be readily available. I think you can find it on [Indiscernible] and that can be used by other institutions as well.

We use a score that is literature-based but I don't have the reference of offhand. It looks at it's done manually and it looks that the number of variables including the patient's PRG, whether they are Medicare or Medicaid, and their number of secondary qualifiers that look at age and number of medications. There are about 10 different variables they are. Then they are given a score that ends up being low, moderate or high risk. I probably could get that reference if you like.

Yes that would be great I can share that. Another question for each of you. Skilled nursing facilities [Indiscernible]. Again can you expand upon how you would move forward with that.

For Kaiser would that be [Indiscernible] within the facility or some other options? How does that work?

The Kaiser patients would, when patients get discharge from the core hospitals, we deftly try to place them in our core skilled nursing facilities. That doesn't always happen, but hopefully our involvement will come from our core skilled nursing facilities and helping. I am being placed and other members are being placed in the hospital, we can place also in the [Indiscernible]. Don is on the line and he can add to that if you'd like.

Don are you on their? Right now for patients who are going to Smith, we don't talk to them in person and less the physician specifically asks us to. We don't do a full medication reconciliation. We do a quick med review as opposed to a med rec. Hopefully if we were to get more resources and rollout the Smith project, then we could actually have enough people to look at all of the patients going to Smith and also hopefully do another med rec when they get discharged.

From the MedSTAR side we have relationships with the nursing homes, but not the kind of closed network the Kaiser does. I do know that some of our hospitals have very close relationships with some of the nursing homes to that they meet regularly to discuss issues of transition of care. The pharmacist and tax will work back and forth with assuring that the medalists are correct that

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Wish we could.

This might the a shout out to those consultant pharmacists and maybe that could be helpful. Again thank you all. Great presentations. I appreciate your taking your time for this afternoon. I will turn it back over to marry and see if there any more questions.

We [Indiscernible] I will open his line now.

In my line yet?

Your line is open now.

Thank you. Getting back to your question on Smith this still is a very challenging environment. They are not associated with the hospital, they don't have a computer system. We actually have to do things manually. Our Kaiser team actually has been running for the past 13 years and we actually have two pharmacists who had to go to collect data and to perform any reconciliation or interventions. It's a very challenging situation. Moving forward, that is on our plate. We are looking into getting into the transition part of the Smith. We have to deal with many components of the Smith. That to deal with their pharmacy provider and Omnicare. We have to deal with their formulary. It's a whole new ballgame with the Smith which requires a lot more effort in making the connections and communicating back and forth within the Kaiser system. It can be done but it's just a lot more effort.

Thank you.

[Indiscernible]

Yes.

Bonnie I want to thank you again for presenting for us. I wish everybody a wonderful afternoon. Thank you again so much for your presentations. Spec thank you for having us.

Thank you.

Ladies and gentlemen that concludes the conference call for today. Thank you for your participation and I ask that you please disconnect your lines.

[event concluded]