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Moderator: Sara Butterfield
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Operator: Good day, ladies and gentlemen. And welcome to the IPRO Medication Reconciliation Collaborative Kick Off conference call. At this time, all participants are in a listen-only mode. Later, we will conduct a question and answer session, and instructions will follow at that time. If anyone should require assistance during the conference call, please press star, then 0 on your touch tone telephone. I'd like to now introduce your host for today's conference, Ms. Sarah Butterfield. Ms. Butterfield, you may begin.

Sara Butterfield: Thanks so much, Andrew. And good afternoon, everybody. Welcome to the IPRO Medication Management and Reconciliation Collaborative Launch webinar. My name is Sara Butterfield and I'm the project lead for the Care Transitions Team. And we're very excited about this collaborative because our Care Transitions Team is partnering with IPRO's Drug Safety Team, who you will meet shortly. So we're very excited about this.

And today we're going to provide an overview of the collaborative. Some of the measurements that we'll be looking at during the collaborative. And our goal for our team is really to be invested in your success for this program. We know that medication management is a huge issue related to care transitions for all different provider settings. So we're very hopeful that you'll all be successful and we'll do whatever we can to support that.

You will be receiving in the mail in about a week a welcome packet that will have some of the tool kits and the information that you'll see referenced here today. You should have received the slides for today's presentation via email sent to those folks who actually did the registration, so that person that was designated. And we're also going to record the webinar today so that if you have a bunch of folks within your organization that weren't able to join today, they will be able to access this webinar, as well as the handouts in about three to four business days. And I will send an email out to everyone to let you know that is posted and how to get to those. It's going to be on the IPRO Care Transitions micro site.

So I'm going to do some introductions of our speakers and the folks that are going to be working directly with you on the collaborative. We're very excited, as I mentioned before, to be working with the Drug Safety Team.

Our first introduction is going to be Ann Myrka, and Ann is a graduate of the Albany College of Pharmacy, has a Bachelors of Science in pharmacy provided in 1992. Ann is a

practicing licensed pharmacist in the states of New York and Vermont and she's currently employed by IPRO. And prior to joining IPRO, she taught at the Albany College of Pharmacy and Health Sciences in Albany, New York and Southern Vermont College in Bennington, Vermont. And she also attained her Masters of Arts and Teaching Science and Biology degree from the State University of New York at New Palz in 2003. And the wonderful thing, as well as many other wonderful things about her, her professional experience really includes long-term care consulting, hospital and home care and community pharmacy practice. And Ann has also received certification as a geriatric pharmacist in 2005. So we're very, very, very happy to have her working with us on this project.

Along with Ann, you're going to hear from Vicky Agramonte and Vicky is a Project Manager with IPRO. She was the project manager of the Arc funded QIO learning network program. So she brings a wealth of expertise to the collaborative. Through the project, Vicky has become a national expert in large scale dissemination of evidence based practices in preventing hospital acquired venous thromboembolism and improvement in medication reconciliation and management. So she really brings the national perspective to this collaborative. She also has expertise in hospital quality reporting, care transitions and other clinical topics.

So I think you will enjoy today's presentation. What we're going to do is just provide an overview and then we're going to open the lines up for your feedback, recommendations and any questions you might have.

And with that, I'm going to turn it over to Ann.

Ann Myrka: Thank you, Sara. So today again we're going to be presenting on the medication reconciliation and medication management across care settings project. This will be a rapid cycle project and we will be going over the timeline during this presentation. And we -- the beginning of the program we'll describe the med rec and medication management program, we'll provide an overview of the curriculum's goals, measures, interventions and outcomes, establish the timeline and gain your cross setting community commitment. And then we'll talk about next steps and have a Q&A session.

So why med reconciliation? Why focus on cross setting management of high risk medications? And why now?

First of all, we are working to avoid readmissions. And we want to prevent adverse events after hospital discharge. A study was done of 400 consecutive hospitalized general medicine patients that were discharged home. 19% of these patients had an adverse event within three weeks of discharge and 66 of these adverse events were adverse drug events. And most ADEs were preventable or ameliorable. ADE is adverse drug event.

So system modifications recommended by the study authors were to evaluate patients prior to discharge to identify unresolved problems, educate patients about drug therapy, side effects and what to do if new or worsening signs and symptoms of problems occur. Improve monitoring therapies and improve monitoring of patients' overall condition.

And part of understanding what ADEs are, are to measure medication discrepancies and understand what that is. And a medication discrepancy is an unintended or unexplained difference among documented medication lists across different sites of care. Examples are omissions, duplications, dose frequency or route of administration errors, a drug name that's discrepant or incorrect, among other issues that occur across care settings.

Greater than 50% of patients have at least one discrepancy on admission and up to 60% of admission medication histories contain errors. So this is a definite problem that can contribute to adverse drug events.

And an adverse drug event is defined as many definitions for ADEs, but a short definition for the purposes of this presentation, it's an injury resulting from medical intervention related to a drug. And medication discrepancies, as I said earlier, are an important contributor to ADEs among hospitalized patients.

Classen in 1997 documented that about 3% to 28% of admissions to the hospital were due to ADEs. In fact, we believe that that number is in fact higher. This is a low estimate. And ADEs are costly. It increases the length of stay or LOS by about 4.6 days and in fact that value of $4,700 has doubled by this time. The studies that were done in 1997 based in Classen evaluated this number and it's approximately doubled for 2013 values.

Preventable ADEs in a 700 bed teaching hospital were shown to cost about $2.8 million a year in another study. So this is a huge problem, it's costly and it causes patient harm. And additionally, what you should all know is that admission to ICU increases the risk of unintentional discontinuance of medications for chronic diseases. And that was a study by Bell where they found that many patients were discontinued inadvertently from their anticoagulants, from their lipid lowering drugs and other (inaudible) to other drugs that were required for chronic disease states. So this is an issue.

So in other words, medication discrepancies and adverse events occur across setting boundaries between care settings and also intra facility boundaries, so we have to be cognizant of that also.

Additionally, med discrepancies and adverse events, an estimated 70% of patients experience an actual or potential unintended discrepancy at hospital discharge, which can then precipitate an ADE. And preventable ADEs identified within hospitals, nursing homes and ambulatory care range between 27% and 50%. So the idea is we need to get at those preventable ADEs. And that's what we're hoping to do in this project. ADEs and issues with med reconciliation across care settings are major drivers for hospital readmission.

So what can med rec do for your system? What is the impact that medication reconciliation can have if done appropriately? Med rec at admission resulted in 43% reduction in actual ADEs caused by errors in admission orders in one study by Boockvar in 2011. And medication reconciliation as a part of a package of interventions decreased the rate of medication errors by 70% and reduced adverse drug events by over 15% in a study done by Whittington in 2004.

And also, medication reconciliation reduced discharge medication errors from 90% to 47% on a surgical unit and from 57% to 33% on a medical unit of a large academic medical center. And that was a study done by Murphy in 2009. So medication reconciliation when done right can impact patient care and reduce ADEs. And it's also important to note that medication reconciliation as part of a bundled effort is highly effective.

So why are we talking about this now? Why is it important now to focus on medication reconciliation and reducing ADEs? Well, in 2011 in November, Dr. Daniel Budnitz and colleagues of the CDC published a very important paper regarding emergency

hospitalization for adverse drug events in older Americans. And within that -- and this was published in the New England Journal of Medicine. And within this article, and in this research, they found that the majority of medication categories that cause admissions were anticoagulants, anti platelets, hypoglycemics and opioids. So these are considered the high risk drugs that were directly causing admissions to the hospital in elderly patients.

Then just this last September, the National Action Plan for Adverse Drug Event Prevention was released by Department of Health and Human Services. Based on the groundwork done by the CDC and other academic centers and collaboratives, which have identified anticoags, opiates and hypoglycemics as problematic, the federal government chose to align forces together to look at ways we can as a nation impact and reduce adverse drug events in these high risk drug areas.

And if you haven't seen the National Action Plan for Adverse Drug Event Prevention, you can contact me and I can give you a link to it and it's in draft form right now and undergoing the commentary period has closed. And HHS is reviewing those comments and will be finalizing the plan by springtime apparently.

And so based on this national alignment of work here, they have released the new QIO and Quality Innovation Network and Quality Improvement Organization scope of work request for proposals, which includes an increased focus across care transitions and through care coordination and reducing adverse drug events in those three drug categories.

And for our purposes, what we're going to be looking at are maintenance management of these three care areas, primarily anticoagulants, and we want to close the gaps that cause communication failures, that cause suboptimal management of systems that manage these drugs and we also want to improve access to medication lists and lab results. We want to help you do that. These are the three areas that the National Action Plan identified as problematic for all these drug groups.

So what is IPRO's med rec and management of high risk drugs across care settings project? First of all, we want this to be a patient centric process. And it's a cross setting medication management process. We want all of you to work together, hospitals, nursing homes, adult facilities, visiting nurses associations, to work together to improve medication management across the care settings. We will be using cross setting evidence based medication management of these high risk drugs, we want to have high quality cross setting medication reconciliation processes and we will coach you with that. And we want to acknowledge your existing care coordination quality improvement initiatives and merge with that so that it can be a user friendly process that has the maximum impact for patients because our major goal is to reduce patient harm and readmissions. But the reduction of patient harm is primary.

So this slide kind of gives the project in a nutshell. So as you know, it's med rec and management of the high risk drugs across care settings. We want to help you improve your current medication reconciliation process, so we'll be asking you to examine and really look at that current practice closely. And improve the quality of the initial home medication list so that it's carried forward through every care setting site, so nothing is missed. And we also want to improve the management of the high risk drugs. We'll help you adopt and implement evidence based guidelines within and across care settings, and adopt improvement coordination between providers.

Our primary focus will be on anticoagulants, primarily because the evidence base is rich. There are many tools and resources that we can use to help you improve these processes and so -- and so secondly we have been working on anticoagulation management improvement through our drug safety initiative for the past three years and we have standardized processes already in place to help hospitals and nursing homes and clinics improve their anticoagulation management and care.

Now hypoglycemics, opioids, those issues there really is not a lot of an evidence base of addressing care transitions. There is some evidence, but we will be working on that and I am collecting literature as we speak. And we are going to contact subject matter experts in those areas to help us. So that focus will be more ad hoc per facility request. It may be that you want to focus on some issues regarding low blood glucose mitigation cross settings so that patients are not readmitted due to hypoglycemic episodes, et cetera. So we can work with you on that also. But primarily we'd like you to definitely look at anticoagulants.

And another area that per community request was to look at antibiotics, specifically on discharge, that the discharge instructions contain the right drug with the right stop date, start date and that the duration for use is clear. So we'll be talking about that.

However, we're not limited to just talking about med rec and just talking about management of high risk drugs. We're interested in cross setting communication improvement. And some of the issues that occur with medication and drug management that have arisen in our existing communities are issues affecting drug acquisition. So the barriers that patients encounter when they leave the hospital and their drug requires a prior authorization. Or the drug, the pharmacy doesn't have the current drug and where can they get it. So these kind of nitty-gritty issues we want to help you with.

We will also help with establishing multi dose dispensing from the hospital and establishing policies and procedures for that. That is allowed in New York State, hospitals can allow patients to leave the hospital with their inhalers, for example, and so that they have access to needed medications on discharge. According to the New York State Board of Pharmacy, that's allowable as long as there's appropriate policies and procedures in place. So we'll be talking about things like this and helping you with it.

Again, and then also we want to improve quality improvement of the care management that you're already providing to your patients. For example, in nursing homes we have a program that we worked on through another granted program where we have tools in place already to help manage warfarin therapy within the nursing home. Policy and procedure review check lists, and also we have analytic capabilities where if the nursing homes that are in collaborative wish to have their residents' time and therapeutic range be assessed for the quality of management, we can do that for you. So we're really excited about spreading some of the best practices that we've learned in the last three years.

Having said all that, not to fear. These are issues that we've dealt with for the last three years. We can hold your hand through everything and data collection is not -- should not be as onerous as it would be in some other projects because we've been doing it already. So we're hoping to have this be a very user friendly process.

You will have time to ask more questions at the end of the conference, but for now I'm going to pass it to Vicky and she will be giving you details on project requirements.

Vicky Agramonte: Great. Thank you so much, Ann. We're just going to go over together some of the requirements of participation. And again, many of you have heard us discuss this through your care transition meetings and again, as Ann said, we -- certainly there needs to be structure to a project because as we've talked about in many of your meetings, to be able at the end of your care transition work on an annual basis you should be able to catalog the amount of effort that you put forth in improving certain elements of care transition.

So what we're doing here, again as Ann said, we are going to provide you with -- flood you with support. There are four to six of us here on this team that will be able to go onsite and talk with you personally, help you motivate other members of your team to get involved and take action on some of these best practices. So we -- like Ann said, we don't want you to fear, but we do need the structure in place in order for you to have a real structure in place that you can walk away from and have some measureable differences at the end of the year. Because we know with your advanced states of care transition and how well you do that those improvements will be visible by the end of 2014.

So what are we asking of you? Certainly you need a team to work on this project. Many of you have this team in place and we strongly discourage you trying to work on this by yourself knowing how much is involved in this type of work. So we do need some degree of a root cause analysis of your current internal med rec process and how that manages across settings especially when we look at the high risk classifications of drugs that Ann has mentioned.

We want you to develop a QI plan to address these gaps. We're going to help you collaborate with other providers in your community to improve the quality of med information shared with your hospitals and post acute care providers.

We'd like you to attend and actively participate in our half-day meetings that'll be held in your community and our IPRO coaching staff support calls. We want you to self monitor this project through the collection of your performance improvement data and Ann and I are going to be discussing later on how we can help streamline that process to make it as easy for you as possible, even to the extent in which we will come onsite and help you conduct some audits.

At the conclusion of the project, we really want you to commit to a sustained enhanced med rec and cross setting med management system in your community. None of us, and especially you caring for patients on the front line, have time for these meetings where nothing comes out of them. So we're really going to push this forward and help you achieve some great benefits for your patients. And as we've talked about, our commitment to you is ongoing and we're going to provide you with the assistance as listed in this slide.

We have sent you documents that we'd like for you to return to us to Sara Butterfield by January 24, 2014 that detail some of the elements of commitment I just described. And with that we'd also like for you to tell us who's going to be part of your team. And certainly as you know, some of the best people to work on this project beyond our care coordinators and discharge planners, we need care management folks involved. We need pharmacists, we need physicians, we need frontline nurses who are carrying out this care. So again, this is jumping a lot of -- trying to pair together a lot of the work you've done on care coordination and now infusing care management into that. So with that said, we'd like to invite other team members to come to the table as well. And even if that means having to accommodate your busy schedule, as we said we'd be happy to do that.

These documents were provided to you along with the handouts for this call and Sara has put very clear directions on how to get these back to us by January 24th.

Just going to briefly go through the timeline, especially in the first few months of the project. We're of course going to be front loading a lot of effort in the first months of this project. So again, we have a good solid baseline of your performance and between now, from January 9th today to our next webinar, which will be February 6th, we really need to just start thinking about your team, and I know some of you have already done it, I guarantee some of you already have your team, have already looked at all of this. But we want everyone to kind of be, at least in the beginning, on the same page in gathering up this information.

So we want you to identify your internal team, complete your MOA and send it back to us. We want you to take a look at your current auditing process. Again, we don't have time to keep reinventing the wheel every time you run another collaborative. I know in your facilities that there are folks who are already auditing the med rec process. Or already auditing or evaluating for adverse drug events.

We really want you to get out there and do some seeking and what these folks are auditing. And how we can use that information to enhance this information and bring it into this project.

Last thing we want you to do is start from the beginning. Med rec is a process that's been in place since 2006, although of course everyone knows we've had horrific issues with our med rec processes in every setting. So now's the time to take a look at what you're currently doing to monitor that and we'll help you weave that into this project.

Also of course comes hand in hand with your auditing process are your policies and procedures. We'd like you to start taking a look at some of the policies and procedures you have in place, not only for medication reconciliation, but how you manage your internal high risk drugs -- your high risk internally for your patients. We want you to start taking a look at them now. We don't want these things to kind of linger on as time goes on.

So our pre-work webinars, when we're going to go through with you the actual elements and how we'd like you to collect your baseline. So we're going to go through that in a few minutes.

And our first coaching call with you are going to be on February 20th. You'll see from that point forward, the live meetings in March, the coaching calls in March that there are dates and times to be determined. And this was done purposely. So each of these timelines could be specific to the needs of your community and we're going to modify this for each one of your communities so that these dates and times are convenient and at your convenience, not ours.

So what are the measurement strategies that we've been talking about for both med rec and cross setting management of high risk drugs? As I began to say earlier between now and February 6th, and that's going to be our pre-work webinar, we're going to have you identify your team, identify your current auditing process, gather your policies and procedures, and in particular, as we said, looking at the med management policy and procedures focus on anticoagulation.

Following that between the February 6th and February 20th we are going to have the measurement of the baseline practice. It's going to be a collection of the baseline data on the facilities current med rec process. So we're going to ask for you to conduct a retrospective review of 5 or 10 medical records, and of course depending on your size or your scope we'd like for you to conduct no more than that because we've known from doing this work nationally the problems that you're going to find with either your med rec process or how we handle med management across settings are going to become quite evident after the fifth record. And again this is quality improvement, we're not looking at large sample sizes for quality improvement, but we do need a standardized baseline from each one of you as we move forward.

Ann and I and the Drug Safety Team are modifying the current match audit tool. We're looking at integrating components of anticoagulant management based on the evidence into this audit tool. So you'll be looking at both issues concurrently, med rec and med management.

Were going to be looking at patients discharge to the last 30 days or greater if needed to achieve the minimum of five records. Those on anticoagulants specifically or as we said ad hoc for opioids, hypoglycemics, antibiotics if this is your focus. And if you're using your own audit tool. This is perfectly acceptable, but please run a bias. Let's make sure that were all looking at the same thing. I know many of you have talked about some of the work you're doing with the joint commission and we're just thrilled with that. Again, we want to mold this into what you're currently doing and add elements that are just going to strengthen that process for you. So please, if you're using an existing audit tool, once you determine that send it on over to us so we can give you some feedback.

And again looking at the collection of baseline med discrepancy data across settings are pivotal to this project. And we're going to ask that of post acute care, at the point of long-term care or home healthcare admission or readmission, the point of return to primary care using Coleman's med discrepancy tool of the same records as we've stated above.

Just so you know we're talking about with anticoagulants, because I know most of us are thinking warfarin, Coumadin. Warfarin certainly from conversations that we've had not only in this project, but through the work that we've done with BPE prevention and anti-coagulation safety. We know that the novel oral anticoagulants are creating quite the hubbub out there and I know many of you have developed anticoagulant taskforces to deal with some of these problems and what the unknown is. So we're not only going to look at Coumadin we are going to look at all anticoagulants both oral and parenteral.

And just to kind of show you, I know many of you are familiar with the meds tool kit that we developed under the Arc contract that we had at IPRO. We will be modifying this to meet the needs of the management of the oral agents that we'll be looking at.

And as I said, we're going to be measuring the med rec process using a modified med discrepancy tool that we of course know is a product of the care transition program developed by Dr. Coleman. The New York Care Transition Project has been using this since 2008. It measures discrepancies across care settings and it guides cost analyses. And I know, and you guys have done a tremendous amount of work with Sara's team on the use of the med discrepancy tool.

Sara Butterfield: Thank you.

Ann Myrka: And I just wanted to say there, we'll get in our little conversations, but what will happen with these tools that we're asking you to fill out is we're just asking you to fill it out and fax it to us. And we'll give you details on that in our February 6th webinar. But we're planning on taking your raw data and we will analyze it for you and help you determine your root cause. So that's a step that you're not going to have to do on your own. Then we can provide you the tools with the Excel spreadsheets that we've used to analyze the data when the projects over so that you can make it a sustainable project.

Vicky Agramonte: And we also have a lot of talent on this team where we can help you develop run charts that can help you display this data in such a way that you can be very proud of the work you've done. So again, we're trying to handle as much of the busywork as possible. And of course then helping you create revisions of your policies and procedures, putting interventions in place that we know have worked in other areas that we've worked on. So Ann, with that, I'll turn it back over to you.

Ann Myrka: Thank you. So medication reconciliation and medication management have been -- these terms have been bandied about for a very long time and yet overall it's very difficult to draw a direct line in studies that have been done thus far to reductions to readmissions. Nobody's really looked at that in any studies that's in the literature.

So what we've decided to do was actually look at the actual drug product in a similar fashion that the CDC did in the Budnitz paper that I introduced to you earlier in the program and we wanted to look at want to work with the hospitals that are working on this collaborative project directly to look at readmissions due the high risk drugs and get down to the nitty-gritty of whether an ADE actually occurred or not, and was the patient admitted due to that ADE.

So we've developed this little schematic here and I want to acknowledge Dr. Darren Triller, my Senior Director, whose vision came up with this plan and we think it will be very effective in ferreting out this important information.

So this would be an extra step or a different step that the hospitals will take who are in this collaborative. So we'll be working closely with the hospitals using their electronic medical record data and which we can then analyze. And we can look at all patients who possess and if we're looking at the -- number one, if you just look at the top and it says denominator, and associated with that will be all patients possessing the following elements at the time of hospital discharge. And this is in alignment with the CMS request for proposal for QIO work. They want to focus on Medicare beneficiaries who have greater than three medications ordered in total and who are receiving anticoagulants, opioids or hypoglycemics. And so we will be looking at all of those patients who were discharged who have greater than three medications ordered in total, which will not be hard to identify those patients. Most of them will. And our primary focus, like we said, will be on anticoagulants and then we can also look at opioids or hypoglycemics on discharge at an ad hoc basis.

So how will we get this data? Well, via electronic health record query. Using a patient identifier, such as the Social Security number or a medical record number, we can identify patients and we can identify the drugs using NDC drug class tables provided by IPRO. We have the ability to determine the drug class tables for all the anticoagulants -- we already have them done basically for ICD9 codes. And we can run that data against the hospital discharge records, the patients discharged, and we can run that -- if the hospital provides the raw data to us, we can run it against our NDC files and also against Medicare beneficiary files that we receive from CMS and do an analysis.

The raw numerator would be all of those patients identified in the denominator with emergency department visit or hospital readmission within 30 days. And we identify that -- IPRO analysis will identify that via Medicaid Part A data.

The final adjudicated numerator has to be determined also, so that would be the determination of a presence of an ADE by root cause analysis. How we would do that is we will be using a modified CDC abstraction tool, which was validated for anticoagulants, opioids and hypoglycemics for ADEs. This particular tool doesn't require professional judgment. It's a tool that was validated for anybody to pick up and abstract through a medical record. And preventable ADEs are targeted through coalition wide evidence based intervention. So during that final adjudicated numerator, we can look at those patients that actually we can identify those patients that were actually admitted due to ADEs, not just because they had the anticoagulation onboard at readmission. We'll make sure that it was due to an ADE, look at the preventable ones and use the evidence to base to mitigate them.

Now we worked pretty closely with the CDC, Dr. Budnitz's team is involved with our drug safety coalition --- the anticoagulation coalition that we already have established. So we have them at the ready as subject matter experts also.

So regarding this, we hope to have a remeasurement period post intervention. So what's the time frame for this? Now the time frame for this hospital based measurement will be a little different. So we'll be looking at the first baseline readmission and the EHR query for that would be any timeframe in 2013. Six months or more of data would be best. So we can gather data for the whole year and analyze it or just six months or I think six months or more would be best. If you only had three months, that's fine if you were transitioning in your EHR. But some kind of baseline data could be determined.

And we have time to determine that. I think that perhaps according -- for each hospital you'll have a different time frame to achieve that goal. But we can work with you pretty closely and with your IT staff to get that baseline data. We have experience in doing that.

And then we're hoping that we can do a remeasure perhaps quarterly or at least prior to the end of our six month collaboration so that we can draw some -- perhaps draw some conclusions between any of the interventions we've done and impacting readmissions in each of your facilities.

And then process measures that we might want to look at would be determined by the methods of interventions and the community needs. And that would be done at least quarterly.

Vicky Agramonte: Ann?

Ann Myrka: Yes.

Vicky Agramonte: This is Vicky. Before you go on, so this is voluntary. For some of the hospitals we're looking for volunteers and this is a one-time data submission for baseline.

Ann Myrka: One-time data submission for baseline, right, Darren? Darren's in the room.

Darren: Yes.

Vicky Agramonte: Yes, excellent. So we're looking for some guinea pigs to help us out with this.

Ann Myrka: Yes. And this is quite a unique way of looking at readmissions to directly relate them to drug therapy in a wider scale.

Vicky Agramonte: Excellent.

Ann Myrka: So just to give you -- back up a little bit regarding the CDC tool, here's the evidence that we have evaluation and overview of the adverse drug events surveillance project. This is the original article that the abstraction tool for ADEs is based on.

So now I'm going to hand it over to Vicky to talk about our med rec tool kit.

Vicky Agramonte: Excellent. Thanks, Ann. And you know what? You were describing that additional voluntary data submission, I want you to begin to think about not all the things that I discussed with the commitments to the project, start to think about how are you going to identify these patients? Many of you may already be sitting there saying well we have been anticoagulation monitoring process in place. Let me go ahead and think about how we're doing that. And maybe discuss this with the IPRO team so we can all kind of really focus on the same thing.

Again, ways to identify patients who are on anticoagulants can easily be done by reviewing the med list, by going by diseases. Of course, as Ann had mentioned, looking at our blood clots or ETEs, looking at our orthopedic patients, looking at our afib patients. These are all those that we know may be on some type of anticoagulation. Just a thought as we move forward.

Just a quick introduction to the toolkits. We're not going to go too much into this because were going to be spending a lot of time together talking about this. But we do want to just take a minute to of course promote the toolkit that IPRO developed and I developed with a large team of folks from Northwestern as well as here from IPRO. We promoted in this toolkit what's known as a one source of truth. And I've talked to many of you about this concept.

Is there one part of your medical record that documents the patient's medical list -- medication list rather? And do all members of the team contribute to that list? We're going to talk a lot more about this as time goes on. There's a strong emphasis on staff development and promoting critical thinking skills which as you know our young clinicians, especially our young nurses coming up into the profession, really need help in the critical thinking area. So a lot of the elements of this toolkit you're going to find very helpful as we move forward.

We can't leave out the marquee toolkit. I'm not sure many of you have seen this. It takes a lot of the concepts we developed in the master toolkit, it's promoting a physician driven med rec process, focuses on the collection of the best possible medication history, abbreviated BPMH and what they're doing is brilliant. Something that Dr. Triller had thought of years ago is providing certification in med rec. And what's even more wonderful about this toolkit is they have a usable Excel sheet that provides a return on investment calculator for the use of pharmacists conducting med rec. And I provided all these links for you.

The IHI Star initiative was another care transition initiative that was conducted in three states as a pilot program. And what came out of this was a wonderful toolkit for home

health and skilled nursing facilities. So we're going to be providing these to you with your welcome packet next week and we know that there are going to be many elements of those toolkits that we're going to be working together to implement in your hospital -- in your facility.

I and finally the health literacy universal precautions toolkit is a physician office toolkit. I know I've worked with many critical access hospitals across the nation who have physician practices within their hospital who use this toolkit. It's very fast, it's very easy to use, promotes med rec during every patient encounter and has actually six easy steps to implement. So something more that we can talk about. If this is needed in your facility we can surely work with you to get this started.

And the introduction to care transition and that evidence base that we had talked about. Ann, you want to walk us through this?

Ann Myrka: Sure. Just very briefly, this is just a screenshot of some of the evidence-based guidelines and evidence-based literature that we've been collecting and that we'll be using in this project to pinpoint the intervention that you need and make sure that what you measure and whatever intervention that you use will have the greatest impact on a patient's safety in your facility.

And we're creating an annotated bibliography of all of our evidence base. And it's a living document, we keep adding to it and streamlining it. So that will be available also to you as we move forward and will be a compendium of the evidence we have used thus far.

And the next steps. The next steps will be our webinar for pre-work, so our pre-work session. It will be another WebX webinar and it will be February 6, 2014 from 3:00 to 4:00 PM. The objectives will be a medication reconciliation overview, we'll develop the projects scope together, identifying the team members, conducting a high-level process map and development of the project plan. We'll develop a measurement plan for -- and including how to obtain the baseline. And will explore potential interventions and process measures for quality improvement in the management of anticoagulants and other high risk drug categories. So you'll have kind of an a la carte list of things that you may be interested in to focus on for this project.

Vicky Agramonte: Thank you, Ann. Thank you so much. And we did probably take a few more minutes than we had planned to. And we apologize for that, but we'd love to get some of your questions and feedback. And knowing how diligent this group is, I'm sure you're all sitting there saying I'm not sure what you want me to do. So don't worry about that. I want you take this all in, start thinking and taking those first steps that I outlined on the timeline and we'd love to hear some feedback and any questions anyone has.

Sara Butterfield: Andrew?

Vicky Agramonte: Oh, yes, Andrew. Open the lines for questions.

Operator: Thank you. Ladies and gentlemen, if you have a question for the speakers at this time, please press star then one on your touchtone telephone. That's star, one. If your question has been answered or if you wish to remove yourself from the queue, please press the pound key. One moment please, while we wait for participants to queue up.

Sara Butterfield: So while we're waiting for our first question, this is Sara, I know that some folks have emailed me and asked about that memorandum of agreement form about who should sign that. We would love to have someone within your senior leadership sign this. And the reason for that is we want them to be aware of what you're doing obviously. But we'd like also to be able to have you establish within your organization a report back to them as far as what you've done, what you found and the progress that you're making on this project. So if you could have someone within your senior leadership sign that, that would be wonderful. Any questions, Andrew?

Operator: Yes, we have one question in the queue. I have a question from the line of Colleen Page. Your line is open.

Colleen Page: Hi, thank you. I just have a question about the baseline because when I was first listening to it I felt like I needed the baseline data for the next meeting. But then at the end it says that were going to discuss about that, but I think I might understand the project more if I tried to start to put together.

Vicky Agramonte: Yes. Hi, Colleen. It's Vicky. Good to hear your voice. I had a feeling somebody would say that. Yes.

Colleen Page: Oh, okay.

Vicky Agramonte: We actually want you to start, and I know you are one of the folks I was referring to that's advanced -- that has been doing this for a long time.

Colleen Page: Okay.

Vicky Agramonte: I want you to really start thinking about those elements that we had discussed prior to the collection of baseline. And Colleen in your case we know there are a few of you who are ready to collect baseline now. We'd be happy to talk to you off-line about that.

Colleen Page: Oh great. Okay, thank you.

Vicky Agramonte: Great.

Operator: Thank you. The next caller is Mary McLaughlin. The line of Mary McLaughlin, your line is open.

Mary McLaughlin: Hi. I'm just asking a question about the data that you're looking from an organization. I mean we might -- we think we can get you the initial data, but my concern would be the adjudicated numerator. It looks like we would have to manually review every 30 day readmit. Is that correct or is it a subset we would have to review? What --?

Ann Myrka: No. So what would happen is that we would get the raw adjudicated numerator and then based on that we would be able to use the abstraction tool. Now it's possible that we can come and help you do that in the facility. So that's not a problem. This is -- so we can work with you on an individual basis for that.

So say for example, you have a six month data pull and you have maybe -- I'm just going to guess -- you have out of the six month data pull you might have 200 patients, 300 patients discharged on anticoagulant. I'm just putting a number out there as the raw numerator. And then the tool would help you determine who you should really go look at and pull the chart.

So we're working with actually with the CDC to modify that tool to make it better for this facility to use. This is Darren Triller, so we were -- yes.

Darren Triller: This is a great question. I don't think the numbers will be quite that large. (Inaudible)

Ann Myrka: Right. I'm just -- I think -- yes.

Darren Triller: Of all admits, you're narrowing it down to just the ones who were discharged on three or more meds and who are on one of the three drugs.

Ann Myrka: Right.

Darren Triller: So if you focused in on anticoagulants (inaudible).

Mary McLaughlin: It's a very large number.

Ann Myrka: It is.

Darren Triller: It's a large number, but still then it would be the number that are readmitted within 30 days that are also on a drug. The number will get small.

Vicky Agramonte: The number of readmissions will get smaller quickly. So you have 200 who are discharged on it and then the number that are readmissions might be 20%. So if you think about readmissions are about 20%.

Mary McLaughlin: So our readmissions are about 15%, our average daily census is 590, 600.

Vicky Agramonte: Right.

Mary McLaughlin: On anticoagulants. We already know that number. Would you say in a day -- what percent?

Speaker: On average we have 20 to 60 patients on an anticoagulant a day.

Vicky Agramonte: That are discharged on anticoagulants, but how many get readmitted? That number that gets readmitted is probably smaller.

Mary McLaughlin: Right. So your tool will help us narrow this so it's something manageable.

Vicky Agramonte: Exactly.

Darren Triller: Right. It'll also in the ER -- when you initiate the abstraction, it will identify whether it's likely that it was an adverse drug event or is it just they came in and happened to be on it. You're not going to go any further if they came to the ER but they came in because of a gall bladder or something like that. So the number should get small for the next --

Vicky Agramonte: It'll rule out the ones that were not -- if the admission -- if they were on an anticoagulant, but the admission was not due to an ADE, that would be thrown out.

Mary McLaughlin: All right. Sounds like it would be manageable. I just got nervous.

Darren Triller: Yes. And the CDC when they did the work, they've got a number of, I think somewhere between 50 and 150 hospitals around the country that are already doing this as part of a surveillance program. So this process of abstraction has already been very well developed by them. And we'll narrow it down even further to just these drugs of interest. So the more we can use the data to narrow the numbers and use the tool that they've already developed, I think it'll make it go very easily.

Ann Myrka: And Mary, with a facility your size, this is ideal to really have this support.

Vicky Agramonte: And then hopefully once this process is streamlined and understood, you can then apply it -- it's replicable to other drug classes.

Mary McLaughlin: Right. Okay, thank you.

Vicky Agramonte: Thank you.

Operator: Thank you. Ladies and gentlemen, as a brief reminder, you may queue up for a question with star, one. If your question has been answered or if you wish to remove yourself from the queue, please press the pound key. The next question comes from the line of Maureen Pace. Maureen Pace, your line is open.

Maureen Pace: Hi, Vicky. How are you?

Vicky Agramonte: Good, Maureen. How are you?

Maureen Pace: I'm good, thanks. I just want to clarify that the primary focus of the collaborative is the mediation reconciliation. So everyone who's moving forward with an MOU is going to do this and then the voluntary part is the readmission project with the ADE focus. Correct?

Vicky Agramonte: Well, we want the ADE focus. If the hospitals -- we really want the hospitals to give us the readmission data. So this -- what we just spoke about, the hospital part, we would really -- we're saying it's voluntary, but we really want that. We really want you to work on ADE reduction and work at those high risk drugs. So it's really a two-part program.

Maureen Pace: I see, okay. So I mean we collect ADEs, but we don't identify them as coming through the door. The reason why they came through the door was that an ADE occurred.

Vicky Agramonte: Right.

Maureen Pace: That's very difficult --

Vicky Agramonte: At least that's what we're looking for.

Ann Myrka: Maureen, we can really help you begin to have a solid program of self identification of these and we know how hard ADEs are to track within your hospital.

Maureen Pace: Right. So for now, between now and the next call, our charge really is to identify the team that's going to work on the project. And then this piece of the readmission ADEs, we're going to work separately with you on an IT on how to gather the data.

Vicky Agramonte: You got it.

Ann Myrka: However, gather your policies and procedures, any policies and procedures that you have regarding anticoagulation or if you want to look at opioids or hypoglycemics, gather them too. Your medication rec processes, any medication management process policy that you have, we'd like you to gather that so that we can help you assess it. Assess it for completeness and usability.

Maureen Pace: Okay. We already have an anticoagulation task force going forward. That's our SMEA for this year. So we have a lot of activity going on around that. Do you recommend that we actually do the root cause analysis for med rec before the next call?

Vicky Agramonte: If you can, Maureen. It certainly is what we're recommending that you begin to look at this process. And just for the folks around the table, this is Maureen Pace from Putnam Hospital. Maureen, and I've used your folks as the example on having the AC task force. And I know we had someone from your ambulatory surgery center who also voiced interest in some of the peri-procedural interruptions that we go through with some of our Coumadin patients. So even include that for your group and be able to help move you forward with that.

Maureen Pace: Okay, great. Thank you.

Darren Triller: This is Darren again. If I can put in a shameless plug, we've already established the last couple of years what we call the New York State Anticoagulation Coalition. So we've got a group of over 150 people from around the state and actually around the country who are now collaborating, sharing ideas. We've got workgroups on peri-procedural interruptions. We'll have tools coming out on that. Point of care testing, things along those lines, EHRs. But that's available to anybody that's involved. Anybody that wants to join the coalition is more than welcome. Some of the expert physicians we have on this coalition, about a half dozen of them are the author guidelines and some of the top coag folks in the world that are --

Maureen Pace: I need their email addresses.

Vicky Agramonte: You will have them.

Darren Triller: You'll have (inaudible).

Vicky Agramonte: You'll have access them through us. Yes.

Maureen Pace: Okay, perfect.

Darren Triller: So we've got directly right now, to keep the names right, Alex Spyropoulos, Dr. Spyropoulos, who's now down in North Shore Health System down in New York, he authored the guideline chapter on peri-procedural management in several of the papers sent and we're sitting down across a table working on this tool to put out that you'll have your hands on. You'll be some of the first people to get their hands on.

Maureen Pace: Great.

Darren Triller: So if you want to be in on the coalition separate from this collaborative, we can get you on the coalition. Just send Ann an email, say get me on the coalition.

Vicky Agramonte: I'll go ahead and, Maureen at Putnam, do you want me to just add you all anyway from (inaudible)?

Maureen Pace: That would be great. Thank you.

Vicky Agramonte: Okay, great. And I just wanted to say this. We'll meet you where you're at. So wherever you're at in your current quality improvement initiatives, we can meet you there and help you improve what you're already doing, help troubleshoot the problems that you've seen, et cetera. So --

Maureen Pace: Vicky, as I said before, I see you as the free consultant.

Vicky Agramonte: Yes.

Darren Triller: Can I throw in another little is (inaudible)? We've been talking through the coalition, just an example of how we've gotten things going, is it's not just coag people, we've got two different gastroenterology groups that are represented on the coalition. We've identified gastroenterology as being the most common reason for interrupting anticoagulants in the outpatient basis. We've got a large group here in Albany that's starting to get involved with and also one down in the Poughkeepsie area. So one of the things we hope to do through the collaborative is start having these conversations between the caregivers, the prescribers of the anticoagulants and these interventionalists so we can figure out how these policies and procedures are all going to work together, plus the tools and the guidance that we've developed through the coalition. So it should be very, very cool and we're very excited about working with you guys.

Ann Myrka: Excellent.

Maureen Pace: Great. Sounds good.

Vicky Agramonte: Andrew, any other questions? I know we're reaching the top of the hour.

Operator: I am seeing no further questions in the queue at this time.

Vicky Agramonte: Let's just do a quick review. We want to make sure that everybody's clear on what we're asking you to do. I know some of you may be feeling that you're in a more advanced state than others. If you're completely overwhelmed, please don't be. This is the way most projects begin. We're thinking we've got a lot of energy going around the room. You're thinking of how you can make this happen. We want you to first get that thought process moving, think about who the right people are to bring to the table.

For those of you who are ready, give me a call and we will be happy and actually let me move forward because Ann and I have our contact information here. We would be happy to begin to talk to you about collecting this baseline data in lieu of our next meeting. But we really want you to begin to think about how you're going to do this and come prepared to have that discussion with us on February 6th, where we'll walk you through the collection of the baseline data.

And with that, Sara, we're going to come to a close. Would you like to give your words of wisdom to our group?

Sara Butterfield: Well, I think you've already provided them the words of wisdom. I will be sending you information on that call for the webinar for February 6th. If you could complete your program evaluations for today, we'd be most appreciative. Feel free to write on there any concerns or questions you may have. And truly, use our team. Feel free to call, email if

you have questions. There are no stupid questions. Everybody's at a different level, so please feel free to use us as a resource. And we'll be glad to help. As I mentioned before, we're investing in your success for the program.

And with that, we'll -- Andrew, you can end the webinar.

Operator: Ladies and gentlemen, thank you for participating in today's conference. This now concludes the program and you may all disconnect. Everyone have a great day.