Brian Willis: Hello everyone. Thank you for attending the second webinar in the Care Transitions and Reducing Avoidable Readmission series. Before we begin, we like to cover a few housekeeping items. At the bottom of your audience console are multiple application widgets that you can use. You expand each widget by clicking on the maximize icon at the top-right of the widget or by dragging the bottom-right corner of the widget panel.

If you have any questions for presenters during Q&A portion of this webcast, you may dial 4*. You can dial 4* anytime during the webcast and unmute yourself and join the conversation. You can also join the conversation by clicking on the Q&A widget at the bottom at submitting your question. We’ll try to address as many questions as possible during the webcast.

A copy of today’s slide deck is available in the resource list widget. That looks like a green folder at the bottom of your screen. If you have any technical difficulties, please click on the help widget. It has a question mark icon and covers common technical issues.

An on-demand version of this webcast will be available approximately one day after the webcast and can be accessed the same audience links sent to you earlier. Now I like to pass it over to Elyse Pegler from Premier. Elyse, you now have the floor.

Elyse Pegler: Thank you so much. Welcome everybody to today’s webinar on Care Transitions and Reducing Avoidable Readmissions 201. Today, I’m going to read the disclaimer and then I’ll talk about the agenda and I’ll introduce our speakers.

1 To the extent possible, this document includes a verbatim transcription of the webinar. Webinars with low audio quality may contain minor gaps in content.
**Learning Systems**

for Accountable Care Organizations

The disclaimer states that the comments made on this call are offered only for general informational and educational purposes. As always, the agency’s positions on matters may be subject to change. CMS’s comments are not offered as and do not constitute legal advice or legal opinions, and no statement made on this call will preclude the agency and/or its law enforcement partners from enforcing any and all applicable laws, rules and regulations. ACOs are responsible for ensuring that their actions fully comply with applicable laws, rules and regulations, and we encourage you to consult with your own legal counsel to ensure such compliance.

Furthermore, to the extent that we may seek to gather facts and information from you during this call, we intend to gather your individual input. CMS is not seeking group advice.

So for today’s call, we will do the welcome and introduction, and then we will provide some information about care transition. As we’ve been doing in the past couple of calls, we have places in the deck where we’re really interested in generating discussion as well among you all. So we hope to get your feedback through polls and discussion questions, and we hope that you’ll speak up during that time as well as in the Q&A section that follows the content. Then at the end of the webinar we’ll wrap-up and talk about some next steps.

So the objectives for today’s webinar are to identify the challenges and best practices for conducting medication reconciliation and review in the dialysis center as an integral part of the care transitions process.

We will also describe how data integration from labs and pharmacies across multiple providers can improve patient care and safety during transitions of care.

So this is the second webinar of this series. We held our first webinar on care transition about a month ago and we talked about lots of different topics there including handovers and the relationship to build and in your processes to ensure that care transitions can go smoothly for your patients.

And today we’ll really focus on medication reconciliation and review and data integration as a follow-up to that conversation. We also have one more webinar in this series where we’ll be focusing more specifically on reducing readmissions, and that will be coming up in August.
So today for our speakers, we are pleased to be joined again by Dr. Jamie Dwyer who is a consultant for Population Health with Premier and an associate professor for Vanderbilt Medical University – University Medical Center.

He is also the medical director both the inpatient and outpatient dialysis facility at Vanderbilt Medical Center in Nashville. And so he brings tremendous experience on the ground in a real-life situation where he is dealing with ESRD pop-up patients all the time.

We’re also pleased to be joined by Dr. Brigid Byrne, who is a director for Clinical Transformation at Premier. And she has great experience in care transition in numerous different care settings. And she’s had the operational experience as a chief operations officer, a practitioner, a health advisor and a medical economist and strategist.

So we’re really pleased to have both of their perspectives to facilitate the discussion today. So now I’d like to turn it over to Dr. Dwyer.

Jamie Dwyer: Thank you, Elyse. So I wanted to start with this image that we showed in our prior webinar, and which we talked about the chasm of potential safety issues that a dialysis patient has to cross in order to move from the hospital to the community.

I want to remind everybody that the concept of care management takes place across this entire continuum. And if there are potential opportunities for dialysis unit care managers to partner with the hospitals and other parts of the continuum.

Likewise, I want to just reiterate the value of informatics exchange of clinical information, which can be used to facilitate effective handovers from one location to another.

One piece of the solution to crossing this so called safety chasm is medication reconciliation and medication review. We are being purposeful in separating these concepts not just for precision of terminology, but really to think about the differences between the two.

So let’s start with a question to set the stage. Who in your dialysis unit is conducting medication reconciliation? Feel free to select more than one option. The people we’re thinking of here include nephrologists, pharmacists and pharmacy technicians, nurses or specific care managers or coordinators or other people. If there is
someone else who might be doing it, feel free to raise your hand
during one of the discussion questions and let us know.

So go ahead and pick from among these options about who is
conducting medication reconciliation dialysis units.

Right, so let’s see the results. So I think we’re seeing that almost
there are no pharmacists really in our dialysis units and I think
that’s something that’s important for us to recognize. 9% of people
said other, so I’d be interested to hear who that might be later. And
I think many of these tasks are being done by the dialysis nurses or
the care manager or the care coordinators.

So the prior question talks about the act of reconciliation, how
often are you doing it. Here, you could select more than one as
well. Are you never doing it? Are you doing it for new patients
only? Various timeframes? And then after certain critical medical
advance? So how often are you conducting medication
reconciliation?

Right, so let’s see the results here. So about 8% saying new
patients only. 25% saying every treatment, and 25% saying every
month. Every treatment can be very hard to accomplish, so perhaps
we can talk about those of you who are doing that. And then after
hospitalization or an ER visit, and no one suggested after non-
nephrology provider visits.

So the reason that we’re asking these questions about who does
medication reconciliation and how often it occurs is because
medication errors are as you know common and preventable. So
we’ve talked a lot about the term medication reconciliation, but
how does it really differ for medication review?

Reconciliation involves generating the most accurate list of
medications that a patient is taking. It should include the name and
the dose and the frequency and the route of all of the medications,
and it should compare it to all other lists. And these lists should be
trued up to get the correct list for the patient at all transition points.
It also includes knowing what medications get filled, and that I
think is a commonly overlooked point.

Medication review however is a thoughtful structured critical
examination of why the patient has these medications on their list.
So that you and the patient can agree about the goals of therapy,
attempt to minimize medication-related problems and reduce
waste.
This is where the example of Warfarin comes in our dialysis units. We’ve all seen patients whose cardiologist or perhaps the hospital starts the patient on Coumadin, but a few months later the patient experiences post-procedure bleeding or falls and bleeds. Medication reconciliation puts the Coumadin on the list. Medication review asks should Mrs. Smith still take Coumadin.

So as you know, medication errors are common and preventable. Let’s just discuss some numbers to quantify the magnitude of the problem. Adverse drug events are estimated to occur in up to 7% of hospital admissions. Well over 50% of medication errors are thought to happen during the prescribing process.

We all know that dosing a medication in dialysis patients is one of the hardest things to tackle, and that the determination of dose occurs when the provider writes the prescription. Almost 50% of medication errors occur at the transition points of care. 20% of adverse events occurring with medication are thought to relate to poor communication at the transition points.

And we all know about the low – the rates of low health literacy in our dialysis populations. And the result of that many of our patients are more likely to misunderstand instructions or have hard time demonstrating their regimen. A low health literacy contributes to cost and worse outcomes, including the risk of death. And everyone who’s been in dialysis for more than a few years laments how we haven’t really done much to reduce the risk of death in dialysis patients in decades.

For many reasons dialysis patients are at increased risk for medication errors. The burden of medications is obvious to anyone who has seen a dialysis patient’s medicine list, which has on average 12 medications per day comprising up to 25 doses.

This high pill burden, to borrow a phrase from phosphate binder lingo, results in frequent medication-related problems, which are all of those undesirable events that interfere with the goals of therapy. The vast majority of these medication-related problems are associated with gaps in transfers of medication information across this chasm, between patients and providers and family or caregivers in different care settings.

Perhaps, most importantly though medication reconciliation has been shown to reduce readmissions and length of stay in dialysis patients. So there is a clear impetus for doing it.
There are a lot of common medication-related problems in dialysis patients. This table describes some of the problems that face our patients. Spanning the full spectrum from getting drugs that they don’t need to not getting drugs that they do. We’ve already touched a little bit on dosing issues perhaps too high, but remember that it’s hypothesized that some patients on dialysis may not do well with infections, because of potential under-dosage of antibiotics on dialysis.

True adverse drug reaction, as well as failure to give medications also complicate the picture. We’ve all seen this patient whose needs in antibiotic, but it’s not in the dialysis unit stock on the day they return from the hospital. And what exactly do you do in that circumstance?

Finally, I want to remind everybody about the lack of data on much of what we use to treat dialysis patients. Since these patients are almost uniformly kept out of research study for new medications, for all the reasons listed here on this table. In some ways we’ve got to catch 22 of no good data and no good way to get data.

Again, thinking about Warfarin. The use of Warfarin in dialysis patients may actually increase the risk of stroke, or is it used – it is used to reduce the risk of stroke in everyone else with atrial fibrillation.

So we’ve hinted at just how costly these medication-related problems are, but here are some of the hard dollars. Medication-related problems can lead to more visits or hospitalizations, worsening of overall health status and even death. The numbers are staggering and it’s estimated that 200,000 patients die and another 2.2 million are injured per year because of medication-related problems.

For every dollar spent on drugs in nursing facilities another $1.33 is spent to treat medication-related problems resulting in a cost of almost $8 billion for the country.

Just an example, think about the potential cost savings from not giving an unnecessary medication and then not having to treat a side effect that doesn’t occur?

So these processes of medication reconciliation and review are complimentary. Because failure to do it can account for many preventable adverse events. Likewise, medication reconciliation can reduce costs associated with visits to the ED and other
providers, as well as reduced admissions and baseline admissions. And just this one example cited here, medication-related problems were implicated in 50% of all hospitalizations for patients with advanced renal failure, and were the sole contributor in 18% of hospitalizations.

Little old ladies who get described to medications to treat diabetic neuropathy, but who are made delirious by the drugs is the example that comes to mind most easily. They get admitted and ruled out for infection, or drug induced delirium clears with time dialysis.

Given the importance of these complimentary processes, the dialysis unit is the ideal site for medication reconciliation and review. There is very frequent contact with the patients such that the unit becomes the care hub for them. Of course, the ideal model is such that the dialysis unit and then nephrologist are exceptionally in-tune with the medical history, comorbidities and the medications used at dialysis for all of their patients.

Remember the number of medications is just simply astonishing. If you’ve never done this, taken informal poll among the people who work in the dialysis unit, not the patients, the health ones, and ask them if they’ve ever forgotten their medicines. It’s no wonder that our patients need as much support as they do.

There are of course many challenges to these processes. The multiple sources of potentially incomplete data contribute to the lack of an accurate initial medication list. Language needs and low health literacy irrespective of language can result in outdated lists. And patients may not understand why take a medication.

As a result, patients may not talk about over the counter or herbal remedies. Think about the number of patients who routinely forget what their binder is for, phosphorous or potassium. Language of course plays an important role here. If you spell out once, O-N-C-E in English, it’s obviously one-time per day. But in Spanish, it’s once, eleven.

There are resources available to help with language preference identification, just an example at the national center for cultural competence. Another series of challenges centers around the fact that many facilities do not have an individual assigned to do medication reconciliation and review.

Nurses may feel like it’s not their responsibility and there may not be pharmacists on staff at dialysis units. I think our poll supports
that. Patients can use multiple pharmacies and moving towards getting all of a patient’s medicines filled at a single pharmacy may have obvious benefit. Then of course is the need to continually tweak the logistics of the processes of medication reconciliation and review if the patients change in the unit, and all of these challenges can lead to issues during care transitions.

So remember how I said that the process of medication reconciliation includes confirming that medications are filled? Are you confirming that all medications are actively filled when performing medication reconciliation? Now here, everyone can only vote once.

See the results. So about 40% of people are not routinely confirming that medications are filled. So there may be some opportunity to discuss how people who are doing it could share with us some of their best practices. And we can get to that during some discussion sections.

So this is maybe a harder question. Do you see anyone doing medication review that is that highly individualized? Should Mrs. Smith still be taking Coumadin? What types of critical appraisal of medications are occurring in the dialysis centers? And here it can be anybody. For example, the pharmacist, the nurse, the nurse practitioner or PA. Anybody who’s qualified, are you seeing medication review for appropriateness being performed?

See the results. A perfectly even split. So I would certainly like to hear from both sides about who’s doing it and how that process is occurring if it’s on dialysis rounds or if it’s afterwards, to sort of understand different ways to improve that.

And finally, do you ask patients to bring their medications to dialysis to review? And if so, how often? I guess another way to ask this, you know question for sort of the millennials among us and of our patients is if a patient is using an app to track medications, like say the Walgreens app that also tells you if it got filled, how often do you have them open up their app and review their list to yours? And here you can pick from multiple sources.

So as we suspected, doing this every treatment is very, very difficult and it’s exceptionally time consuming. And then I think we’re mostly split across monthly and quarterly with a few not knowing. But that’s okay. That maybe reflection of your role in the dialysis program.
So we’ve covered a lot of ground so far, but we certainly need to leave room for discussion. So it’s at this point that I want to thank Lisa Hobson and Harold Manley from DCI who have agreed to give us some perspective during this section. But I really want everyone to be able to contribute. So first, we want to ask what are the barriers to obtaining an accurate medication list at your ESCO? And how have you addressed those barriers?

Lisa Hobson: Hi, this is Lisa. Can you hear me?

Jamie Dwyer: Hi, Lisa. Yeah, go ahead.

Lisa Hobson: Hi, so this is Lisa Hobson and I work for DCI and we have our three ESCOs. And I would have to say within our ESCOs, the whole medication reconciliation and review process has been one of the biggest challenges we’ve encountered. We do have the luxury of having a pharmacist, a group of pharmacist that helps us in all of our ESCO market.

But your question up here, what are the barriers to obtaining an accurate medication list? I mean, you nailed all of them on all of your slides. The biggest thing is timely access to medications. But really it goes back to the processes in the clinic to begin with whether or not our initial list was accurate. And then if a patient does have an episode of care where they go to the hospital, and the hospital start with the list we had or is it a list that they had in the hospital from the last time the patient was in.

And then upon discharge, whether or not the care coordinators have access to the records or if they have to request them, sometime there is a time lapse in there from when they can get those records. We do often ask the patients to bring in their discharge paperwork because there’s often a med list associated with that. However, we’ve also found once we finally do get the records from the hospital, they don’t always match the med list application left with. So there’s definitely some barriers there.

As far as the medications coming into the clinic, in our attempt to have the most accurate med list, we do have our patients to bring in their medications monthly. Of course, what they bring in is sometimes what they could find that they or what they just happen to have in their purse that day.

We have found some successes with some of our other partners in the ESCOs that go to the patient’s home. So we have some partners that are home health, we have some talented care partners, we have an ACO partner. They have the ability of going to the
patient’s home and can provide us with a more accurate description of what’s in the house. But then you have the list of patients or the list of drugs that they have versus what are they taking versus when was it last filled.

So the list is long of the barriers that we come across when trying to have an accurate med list. The biggest thing though is persistence and education in the clinic. So teaching all of the staff in the clinic to emphasize how important that med list is, asking the patients every treatment whether or not they’ve had care since their last treatment, and if the answer to that is yes, our care coordinators are reaching out to wherever that was to find out if there were any medication changes so that we can keep our medication list as accurate as possible.

We’re also, as we mentioned before our care coordinators try to get credentials to hospitals so that we can have at least read-only access to medical records, so that we can have more timely access to their medications post discharge. And then just reeducating the patients on how important it is to let us know anytime that there is a change in their medication.

Harold Manley: It’s Harold Manley. I’m actually sitting physically next to Lisa. You know from the pharmacist’s perspective, one of the things we have also done was working with patients conducting their medication reviews. We’ll ask, we’ll perform med reconciliation at that time to when we’re doing a comprehensive med review with the patient to video conferencing or teleconferencing or perhaps even face-to-face.

And we’ve also reached out to the patient’s pharmacy, and to see what they are billing. We’ll ask the patients what pharmacies that they use. Sometimes, all the pharmacy means multiple pharmacies that the patient uses level one and multiple medications. So we’ve had to call the local pharmacy, the male order pharmacy, and to try to really ascertain what medications the patients are taking the refill history around it.

And right now we’re getting – we’re preparing for use of the claims that CMS is providing for us. So a pharmacy claims data from – to the 2CLF files as another source of information to see what medications the patients are taking.

So it’s through these various pieces of information, be it from the patients, from the patient’s pharmacy, from the claims data. We’ll have a better picture of what is being taken, as well as how often it’s being taken and then make recommendation during our review
of the information to the nephrologist to change a dose, start a med, or whatever, whatever the intervention happens to be.

Jamie Dwyer: Thank you guys so much. I really appreciate it. I think I completely agree with you that you’ve got to ask the patient every time you see them not have your medicines changed, but maybe have you been anywhere? Have you been to the ER? Have you been to a doctor? And then go out and ask those questions. Did your medicines changed? But asking them to the physician’s office or finding them in the ER.

So we had some comments from April Parham [00:29:06] about that not confirming medications are filled, because you may not have all access to all the places where the patient gets their medications. And that reminding us that sometimes medications can actually be samples from physician’s offices, so it can be very difficult to see what the patient is filling or actually taking.

April, if you have something you wanted to say, I don’t want to put you on the spot so don’t feel like you have to do. But if you wanted to share your perspective, we’d be happy to hear it. I think you raised some great points in your comments to us. And remember, if you want to raise your hand you have to press 4* to unmute to join the conversation.

All right. So let’s move on and we’ll sort of suggest some best practices for medication reconciliation and review, and there will be opportunities for other discussion. There are many opportunities for further discussion in a few minutes. So to start, one must actually define the steps involved and decide who is responsible for each step.

This should result in an assignment of a team member to do the actual medication reconciliation. I’m a medical director and I always say shared responsibilities sometimes results in no responsibility. So among the people listed here who can do it, assign someone.

Maybe you have a team-based nursing approach which works very well. But that situation is one where you might really need to name the nurse or name the person who is responsible. Develop an approach that works for you and your patients across the care continuum. Try to utilize information technology to facilitate these medication processes. Obtain lists from other providers to start kind of like Lisa was mentioning, and use those lists generated by discharge summaries if you can get them in a timely enough
fashion in other transition points to resolve discrepancies as much as possible.

In our units, the care coordinator reviews hospital notes for medicines that might need to be given at dialysis before the patient leaves the hospital. So we try to know what’s going to happen before the patient shows back up. And of course it’s easy for some people and not for others. And remember resolve any discrepancies before an adverse drug event can occur.

So our next discussion question, it asks how you retrieve information from hospitals and other systems of particular importance to dialysis patients? What about their access surgeon, their pharmacies? There may be multiple pharmacies or poly-pharmacy, and a radiologist who might be doing their access procedures.

These are just the places and providers that our patients go the most so that’s why I was specifically asking about them. But there may be others. If you’d like to contribute something, either put some commentary into the Q&A box or press 4* to unmute.

Harold Manley: Can you hear me? It’s Harold again.

Jamie Dwyer: Yeah.

Harold Manley: So like I said we’re going to start using the claims data. So integrating that information that CMS is providing to us in the near future, we’re looking forward to that. We are also developing a provider portal from our universe of information to share in a lot of access for the emergency or the hospital the patients may go to, so they can see what we have in our medication list. So we not only receive information, but share information the best that we can as well.

And as far as like retrieving information from hospitals, we do not have any formal mechanism right now as far as like data coming across. We just have our care coordinators for clinic staff having I guess read access to individual hospital EHRs to full or extracts data PDF ourselves as more of a manual process, nothing [inaudible 00:33:46] right now.

Lisa Hobson: And I’ll just add to that, how critical having a care coordinator is in that process because anytime you talk to the staff in the clinic they want accurate medication list. But if you’ve sat down and actually try to create one, it is very time consuming. And most of the time the staff on the floor do not have the time to really get the
information they need. So having a care coordinator who does not perform patient care on a day-to-day basis is critical to having the time and the resources and the access.

I mean, just getting access to different hospital systems sometimes takes months just because of the way they’re setup to do their credentialing and things. So it is very important. And then we do have a pathway that we initiate. As soon as we know a patient is in the hospital, there are certain steps that are triggered by a timeline and as different steps evolve the next step pops up. And so the medication reconciliation is one of the very first steps that they work on so that they can be proactive with that.

Jamie Dwyer: Thank you guys so much. Melissa Echols from Fresenius Seamless Care says that they have access to pull discharge records and medications from local hospitals via secured portals. I think we’re going to see more and more of that. I know that we’re working on that here in Nashville.

And Karen Nugent from Metropolitan Kidney says that she usually uses fax requests to physician’s offices and surgical center, and is credentialed at one hospital and therefore can visit the patient there while they’re in the hospital. My analogy that I gave where our coordinators are looking in the chart is because they’ve all got access to our unified hospital system. So that helps in that circumstance. But getting credentialing as all of you know can be extremely time consuming.

So finally, let’s ask how do you address patient self-medication and self-prescribing? Which would include everything from over-the-counter medications to herbal medicines or complementary and alternative therapies. Would even could be God forbid an old antibiotic lying around that they take for a cough.

I remember you can put your reply in the Q&A box, or you can press 4* to unmute and join the conversation.

Harold Manley: From our perspective, well first really digging in and during the med reconciliation process to really determine how much of medicating and self-prescribing that they are doing. And once you have a better picture of it over-the-counter medications, herbals, whatever, educating the patients, physically spending the time to educate the patients on the risks and the potential harms associated with them, and counseling them to stop therapies if appropriate, but minimally raise any of these concerns to the nephrologist or their PCP or the prescriber so they are aware of the use and are
basing other clinical interventions that they may want to perform in their patients with this information.

So the first step is documenting how much they are using, what they're using. Second step is counseling on it, and always letting – communicating what you’re finding to prescribing, because this is important information that they need to know.

Jamie Dwyer: Thank you guys so much. One of the things that – Go ahead.

Lisa Hobson: I was just going to say that having the whole team, having the same message. So when the dietician is talking to the patient, the social worker, the nurse, the doctor, everybody is giving the patient the same message about being honest with what they’re doing and how that can affect not just their medication regimen, but their entire health.

Harold Manley: And just one more thing to add to this. I’m thinking another self-medication, self-prescribing especially in some states where now a medical marijuana is approved for us. Patients is in the news, patients are using it more or they’re being – I mean, using it more, but at least telling us that they’re using it more.

That even having your own systems capable of documenting what these patients are taking. Our informatics system, we had to add that medication to the list so we can document it in our system so it will appear on our medication list that we want to share with the prescriber and others.

So you’re going to have to take it to your own informatics systems to see whether or not if you could document the medications, the over counters that you are finding your patients that you actually can document in your system.

Jamie Dwyer: Thank you guys so much. Now I think several of the points raised, particularly getting the IT system to quickly put medicines into the system, you know a medicine could get prescribed before it makes its way into the thing, before it makes its way into the database. Medical marijuana, which now we are calling a medicine, but five years ago we didn’t, we called it a drug.

And I agree completely. It’s no different than using Dronabinol. One of the things that we’re doing is just asking the patient to call the dialysis unit to ask those medicine type questions, what medicine can I take for a cold that’s not going to raise my blood pressure, and then using the dialysis unit as the point of first contact to move out for that.
Karen Nugent from Metropolitan Kidney commented that during medication reconciliation she asks about herbals and over the counters, and then provide education then, and then can consult with the physician or the pharmacist regarding interactions, which we haven’t entirely discussed. That’s sort of one of the keys to why we need to know about these things is interactions whether or not they interfere with their blood pressure medicines or anything else. But she ends with, “The key is education.” I couldn’t agree more.

So at this point, I’d like to turn it over to Dr. Brigid Byrne, who will discuss the integration of data from labs and pharmacies. Brigid?

Brigid Byrne: Thank you, Jamie. And at this point one of the pros that I wanted to share with some of my patients in helping them to track their medication, especially the new ones is those patients that have the photo on their phone. Many times we’ll ask them to just go ahead and take a picture when they fill a prescription and hold it on their phone and when the envelopes or the folders are able to put in their photos, so that when they do come see us, they can share that with us.

And that really does help survive some of the most accurate information we get. So in segwaying into the data integration that we want to be able to utilize in transitioning our patients, we know that our patients are receiving multiple sites, whether it’s with their cardiologist, their primary care, as well as the needy in the hospital.

And it’s very difficult to funnel and track that, but to integrate that information into the patient’s care plan so it is one care plan that is being communicated to the providers across the continuum. And when we’re able to have a EMR where we’re integrating the lab or if some of you has had, you’re able to reach out to the pharmacies and integrate that, the information that you have the most current metrics that can enhance the care transition and provide the management so a lot of seamless transitions for these patients.

So in looking at your organization, do you own your own lab and pharmacy in order to help integrate that? And do you have access to that information? So if you would share with me what’s current in your world?

Jamie Dwyer: And DCI said, “Yes, we have our own lab. We own some number of labs, and we have access to the medication orders or EMR etc. So when we conduct a medication review, we do take in context
the available labs data that we have.” If there are missing lab
values or labs that we wouldn’t like to have during the medication
review, we would make that recommendation to the nephrologist
or the PCP to provide that information, because that is one of the
medication-related problems being inappropriately laboratory
monitoring. So we use lab data as a means to identify central issues
and resolve potential medication-related problems.”

Brigid Byrne: Great. So it allows you to be very proactive [inaudible 00:44:29] in
working with these folks. Okay. So some of the challenges that
we’re working at with state integration is as you know each
provider may have their own EMR, and there’s not that continuity.
And even within the same system there may be multiple systems
that are not used or they may not always talk to each other. So that
you don’t have that concise integration.

The timeliness of the data isn’t always what we would like. It’s not
real-time. There is the ways. And it maybe unstructured or not able
to fall into the data fields of your EMR, which can create issues.

And so when we’re looking at these processes one of the most
important things get back into the communication and being able
to collaborate with other systems and providers to decrease the
barriers they access. And one of you in our discussion had
mentioned being able to offer that provider portal, so that not only
are you looking for their information, but you’re willing to share
your information with them, especially when it comes to the
emergency room in the hospital who is seeking information.

The other is having that opportunity to have the admitting rights at
multiple hospitalizations, even if it’s a look only – that goes into
the EMR. To be able to have that ability to access that information
and establish the process, so sharing the information with one
another so that we’re trying to operate in a real-time venue in
coordinating the care for these patients.

Setting up notifications when your patients are admitted in the area
hospitals as well as getting as close as possible to real-time data
and the medication list and the discharge summon.

And so in looking at your world, where and how did the surgeons
that you worked with receive the last another information about
your patients? Are they all in the same EMRs? Are they expecting
back and forth, or are they just not having access?

Lisa Hobson: Hi. This is Lisa and I would have to say it definitely varies from
location to location. Some of our markets only use one hospital.
Other markets use multiple hospitals, so we may not know all of the surgeons. However, I will say that with the care coordination programs and in the areas that we have acute programs we’ve definitely increased communication by first finding out that our patients are even in the hospital, because that has definitely been a barrier in the past.

But as part of our pathway for a hospitalized patient, it’s the care coordinator’s job to find out what information the hospital needs and making sure they have access to it, if they don’t have access to it electronically. So whether it be over the phone report or fax or an e-mail or whatever they need until we do get the portal where they can look it up themselves.

Brigid Byrne: Okay. Great. Okay. And then another question for you all; which of your ESCOs help information systems speak to each other?

Harold Manley: Our system already had an integrated – is a problem-based system, so it had medications, labs, progress notes. So I guess initially we’re quite lucky to have a system as really integrated to begin with. But as of late, we’ve added on top of that a case management like our program. We use Browning-Well [00:49:06], so a third party vendor.

And we are now having that system integrated with our system as well. So I think we’re in a good standing initially and we’re even better now with the nurse, the care coordination, care management platform integrated.

And there’s actually one other system that we have. It’s a one-way system from our dialysis clinic EMR stem data integrated with medication therapy, management software system through a third party vendor. Data that’s being sent across from our dialysis EMR to the MTM software, includes the various patient demographics, their [inaudible 00:49:59] conditions, their lab data, their medication data, but a very integrated system as well.

So each discipline; nursing, pharmacy, medicine is really looking at all the same information which is key for best communication practices.

Brigid Byrne: Right. Absolutely. Now next question, for those ESCOs who have integrated lab and pharmacy data, what is the barriers that you face? And how are you overcoming them?

Harold Manley: Like I mentioned on that, our MTM software is integrated with the dialysis EMR which has all the lab data. The barrier that we have
is one that is uni-directional. And unfortunately, it’s not real-time. There’s up to – the interface goes once a week. So we may be up to five or six days behind. But aside from that it’s very well integrated I believe.

Brigid Byrne: Okay. So you’re just having to work around that time delay?

Harold Manley: Yeah, we’re working around the time delay by having the pharmacist also have access to the dialysis organization EMR. So they may have two systems open up concurrently when they’re doing the evaluation, the medication review. So we can’t integrate seamlessly at least grant access to the other information repository.

Lisa Hobson: We have also created a reporting mechanism. So if there are episodes of care that are close, that generates a report so we kind of have an audit to go in to see if it actually happened and then has the medication reconciliation started and can put those timeframes in place.

Harold Manley: And speaking of audits, the good thing about EMRs is that there is user log-in, timestamps associated with almost every data element in it. So having reports and queries created to audit your processes, identify the gaps, so you can have like a copy or CQI process to address any deficiencies that you note in the process.

Because I really like one of the sites they showed earlier was everybody has a assigned task in the process and med review. And those are different users in the organization with – and they have user timestamps etc., when they log-in information. So one of the key things that we’ve done in our process was just to look at our own data and try to drive change through a CQI or copy process as it relates specific there and med rec and med review.

Brigid Byrne: Okay. Great. All right. I’m going to move on to the Q&A portion and turn this back to Jamie as well, and open it up to any questions that folks out there might have that we haven’t touched on.

Okay. If no one has any questions, then I’m going to transfer this back over to Elyse Pegler to wrap-up and talk about next steps.

Elyse Pegler: All right. Well, thank you so much everybody. That was a great discussion. So we really appreciate everyone that spoke up and that chatted in.

So today’s materials will be posted on the Connect Site. And as we mentioned this is the second in a series of three webinars. And so our third webinar will be on Best Practices for Reducing
Readmissions. And that webinar will take place on August 11th from 4 to 5 PM Eastern time.

One thing to note about the materials on the Connect Site is that we have included in the slide deck several pages of references in case that would be of interest to you all to see some of the places that we had some end notes in the slides, as well as some additional resources around both medication reconciliation and review and data and sharing and information. So we hope that you’ll find that information useful and use the Connect Site as a great resource.

So we’ll go ahead and wrap-up. If you have any questions for us or any comments we always welcome your feedback. Please share it with the ESCOLearningActivities@mathematica-mpr.com. And I think we’ll go ahead and adjourn for today. Again, we really appreciate everyone joining us.

Brian Willis:  This concludes today’s webcast. But first, I like to make a couple of announcements. First, please submit feedback about this webinar using the survey in the browser window when the broadcast concludes. If you’re unable to provide your feedback now this time, you can use the on-demand recording and access the survey there.

The on-demand webcast would be available approximately one day after the webcast and can be accessed using the same audience link you had sent following registration. Also, I want to let you know that the post webinar materials including the side deck transcript, recording and summary reposted on the CAC Connect Site when it becomes available.

Lastly, any future topics or discussion points can be shared with a team using the ESCO Learning Activities mailbox. Thank you for attending.