Overview:

On Thursday, July 14, 2016, the Centers for Medicare & Medicaid Services (CMS) held a webinar on care transitions, which focused on challenges and best practices for medication reconciliation and review as well as data integration across multiple providers. This is the second webinar in the care transitions series. The webinar featured presentations from Dr. Jamie Dwyer and Dr. Brigid Bryne of Premier, Inc. The recording, transcript, slides, and webinar summary have been uploaded into a Content Pack on the Connect site here.

Highlights from the presentations:

Dr. Dwyer first defined medication reconciliation and review, then described the importance of these two processes in the dialysis center, and finally identified the challenges of and best practices for conducting them. Next, Dr. Byrne presented on how the integration of data from labs and pharmacies across multiple providers can improve patient care and safety during transitions of care. Polling questions and discussion questions were integrated throughout the presentations.

I. Speaker information

**Jamie Dwyer, M.D.** currently serves as the medical director of both inpatient and outpatient dialysis services at Vanderbilt Medical Center in Nashville, Tennessee. He is a practicing nephrologist who cares for dialysis patients across the care continuum and led efforts to shift the dialysis practice at Vanderbilt to a more streamlined, integrated system. His clinical expertise focuses on kidney disease, specifically diabetic kidney disease and glomerular lesions, including glomerulonephritis. He also has expertise in the evaluation, management, and prevention of kidney stones.

**Brigid Byrne, Ed.D., ARNP-BC** has 35 years of experience in various facets of health care operations as a chief operations officer, practitioner, health advisor, medical economist, and strategist. In 2013, she joined Premier’s Population Health with expertise in clinical integration, care management, and patient-centered medical home service lines. She is a gerontologist with a background in nursing and post-acute/community medical management and has experience as a practitioner in neurology, sleep medicine, pain management, occupational, and internal medicine.

II. Webinar topics

**Jamie Dwyer**

- Discussed why dialysis patients are at an increased risk for medication-related problems (MRPs), leading to negative patient outcomes and high costs.
  - Medication errors are common and preventable.
Incidence rates of adverse drug events range from 2 to 7 per 100 admissions.

46 percent of medication errors occur during transitions, admissions, transfer, or discharge from a clinical unit or hospital.

- Dialysis patients are at increased risk for medication errors.
  - On average, dialysis patients in the United States are prescribed 11 to 12 medications per day and take 17 to 25 doses per day.
  - Sixty-five percent of MRPs identified in hospitalized dialysis patients were associated with gaps in transferring medication information among the patients, caregivers, and various health care settings and caregivers.

- Common MRPs in dialysis patients include improper drug selection, overdose, adverse drug reaction, failure to receive a drug, and inappropriate laboratory monitoring.

- **Defined medication reconciliation and medication review** (see slides for definitions), emphasizing the difference between the two processes as well as how and when they overlap.
  - To illustrate this difference, Dr. Dwyer explained that during medication reconciliation, clinicians enter a medication on a list; during medication review, they ask themselves whether the patient should still be taking the medication.

- **Described the importance of medication reconciliation and review** and reasons why the dialysis center is an ideal site.
  - MRPs are costly, as they often require additional physician office visits or hospitalizations and can result in deterioration of health status and even death.
  - Medication reconciliation can reduce the costs associated with emergency department visits and hospitalizations and readmissions.
  - In patients with stage 5 chronic kidney disease, MRPs were implicated in nearly 50 percent of hospitalizations and were the sole reason for 18 percent of hospitalizations.
  - The dialysis center is the optimal location for medication reconciliation and review because of the frequent contact with patients and the providers’ knowledge of medical history, comorbidities, and dialysis-related medications.
  - Given the exceptionally high number of medications that many end-stage renal disease (ESRD) patients take, conducting these processes in the dialysis unit helps ensure patients can keep track of them.

- **Discussed challenges and best practices for medication reconciliation and review** in the dialysis center.
  - Some common challenges include a lack of accurate initial medication lists, low patient health literacy, and inadequate language preference resources.
    - Patients often do not understand why they are taking each medication and might not tell their provider about over-the-counter drugs or dietary supplements.
The National Center for Cultural Competence offers additional resources for language preference identification and how to avoid miscommunication.

- **Best practices include:**
  - Assigning staff to each step in the medication reconciliation and review process so that it is clear who is responsible for each task.
  - Using information technology to obtain a complete and accurate list of each patient’s current medications and comparing it to the admission, transfer, and discharge medication orders.
  - Asking patients who have phones with cameras to take photos of their prescriptions when they have them filled helps staff in the dialysis unit track their medications.

**Brigid Byrne**

- **Described how data integration from labs and pharmacies across multiple providers can improve patient care and safety during transitions of care.**
  - Dialysis patients frequently receive care at multiple delivery sites.
  - It is difficult to track and integrate this information from different sites to ensure that the patient’s care plan is communicated to the providers across the continuum.
  - Obtaining the most recent metrics from labs and pharmacies can enhance care transitions and management by providing seamless care for ESRD patients.

- **Outlined common challenges and best practices for data integration.**
  - Access to electronic medical records (EMRs) among providers at different care delivery sites, multiple data sources and EMR systems, timeliness of the data, and inaccurate or incomplete data all pose challenges for data integration.
  - Collaboration with other health systems and providers is an important strategy to data integration.
    - Decreasing barriers to access is one solution to achieve this goal. This can be accomplished by attaining permissions to EMR or admitting rights at multiple hospitals, either by contacting the provider credentialing or transitions management office or by locating the person who is responsible for transitions.
    - Offering a provider portal is a helpful way of exchanging information with other providers, especially regarding the emergency department and the hospital.
    - Developing common metrics and data fields is another actionable step facilities can take to facilitate collaboration with other health systems and providers.
    - Finally, ESRD seamless care organizations (ESCOs) can establish a process for sharing real-time information to decrease or eliminate the time lag and increase communication. This is possible through admission notifications and real-time medication lists or discharge summaries.
Q&A

There were no questions asked during the Q&A section. Below is a summary of select discussion questions the presenters asked.

**Discussion Question #1**: What are the barriers to obtaining an accurate medication list at your ESCO? How have you addressed these barriers?

**Participant**: Timely access to medications, ensuring our initial list is accurate, and determining whether the hospital uses our list or the list it had from the patient’s last visit are our biggest challenges. We also need to determine whether the care coordinator has access to the records or if he or she needs to request access. Some strategies we’ve used to overcome these challenges are to ask our patients to bring in their medications monthly, visit their homes if possible to obtain more accurate medication lists, be persistent with our procedures during each visit, and remind the patients to let us know each time they change their medications. We also try to credential our staff when possible so that we can access patients’ records in a more timely fashion.

**Discussion Question #6**: For those ESCOs that have integrated lab and pharmacy data, what barriers did you face? How did you overcome them?

**Participant**: Our medication therapy management (MTM) software is integrated with the dialysis EMR. Unfortunately, it is not real-time, so there is a 5- to 6-day delay. We work around this time lag by ensuring that our pharmacist also has access to the dialysis organization’s EMR. That way, when the pharmacists are doing the medication review, they have another information repository. We’ve also created a reporting mechanism for this challenge. If an episode of care has closed, we receive a report and an audit to see whether this actually happened, determine whether medication reconciliation has started, and put the timelines in order. With EMRs, user log-in information and time stamps are available, so creating reports and queries helps us identify gaps in our process.