Administration on Aging
Affordable Care Act Training
Medication Management Tools and Resources
October 25, 2011
2:00 - 3:30 pm Eastern

Coordinator: Welcome and thank you for standing by.

For today's conference all parties will be on listen-only. During the question-and-answer session just press star 1 on your touchtone phone.

Today's conference is being recorded. If you have any objections you may disconnect at this time.

I will now turn today's conference over to your Marisa Scala-Foley. Thank you, you may begin.

Marisa Scala-Foley: Thank you so much, Denise. Good afternoon, everyone. Good morning to those of you on the West coast. My name is Marisa Scala-Foley; I work in the Office of Policy Analysis and Development at the Administration on Aging.

We thank you for joining us for this month's Webinar which is our latest in a series of Webinars focused on opportunities for the aging network -- both state and local agencies -- within the Patient Protection and Affordable Care Act, also known as the Affordable Care Act or the ACA.

We've designed this webinar series to provide the aging network with the tools that you need in order to develop care transitions work or participate in other Affordable Care Act related efforts such as accountable care organizations in your area.

If you've been with us on past webinars, because of its importance with the ACA, you'll know that most of our series is focused on the topic of care transitions. Patients or clients going from one care setting to another. From hospital to home, from hospital to skilled nursing facility, from skilled nursing facility to home and more.

Today we're going to really hone in and take a close look at one specific component of successful care transitions models. And that is medication reconciliation or medication management. As you'll hear from our presenters today medication errors are major driver of hospital readmission.

However, there are different tools and resources that you can use in order to prevent or address such errors before they harm your clients.

Today you'll hear about two such resources. First you will hear about the Health Resources and Services Administration's, or HRSA's, Patient Safety and Clinical Pharmacy Collaborative.

You'll hear about them at a national level and then you'll hear from one of the local collaboratives in Iowa.

And these - the PSPCs, the Patient Safety and Clinical Pharmacy Collaboratives, are quality improvement collaboratives that are aimed at improving health outcomes in patient safety.

And the second resource that you'll hear about is a program is called Home Meds which is an AoA-funded evidence-based model that promotes medication safety in the home.

So before I introduce our speakers, we have a couple of housekeeping announcements. First of all if you haven't done so yet, please do use the link that was included in your email confirmation to get onto WebEx so that you can not only follow along with us on the slides as we go through them but also ask your questions when you have them through chat.

If you don't have access to the link that we emailed you, you can also go to the main WebEx Web site, which is www.webex.com.

Again that's www.webex.com then click on the Attend A Meeting button at the top of the page and enter our Meeting Number, which is 664641344. Again that Meeting Number is 664641344.

And if you have any problems with getting into WebEx, please do call WebEx Technical Support at 1-866-569-3239. Again that's 1-866-569-3239.

As Denise mentioned, you are all in listen-only at this point, however, we do welcome your questions throughout the course of the Webinar and there are two ways that you can ask your questions.

First as I mentioned before, through the Web using the chat function in WebEx. You can enter your questions into the chat box, we'll sort through them and answer them as best we can when we take breaks for questions after each person presents.

In addition, after all of the presenters wrap up we'll offer you a chance to ask your questions through the audio line. When that time comes Denise will give you instructions as to how to queue up to ask your questions.

And if you think of any questions after the Webinar or if you have any questions you'd like us to follow up on that per chance did not get answered during the course of the Webinar, please do email them to us at Affordable Care Act at AoA.hhs.gov.

Again that's Affordable Care Act and that's all one word at AoA.hhs.gov.

And finally as Denise also mentioned we are recording this Webinar. We will post the recording slides and transcript of this Webinar on the AOA Website as soon as possible -- likely by early next week.

So enough with the housekeeping announcements we're thrilled to have with us today a terrific panel of speakers whom I'd like to introduce now.

First from the Health Resources and Services Administration is Linda Kwon. Linda and Kyle Peters, our next speaker I'm going to introduce them a little more fully now.

We have two additional speakers, June Simmons and Sandy Atkins from the Partners in Care Foundation who I'll give you a little more information about right before their presentation.

But first let me tell you a little bit about Linda. Linda Kwon is a Public Health Analyst in the Health Resources and Services Administration's Office of Pharmacy Affairs. She serves on the Leadership Team of the Patient Safety and Clinical Pharmacy Services Collaborative, which you'll hear about today.

She received her Masters in Public Health Degree at Drexel University in 2007.

And our second speaker will by Kyle Peters. Kyle is a Clinical Pharmacist Specializing in diabetes at Siouxland Community Health Center in Sioux City, Iowa. He is also a Clinical Assistant Professor at the University of Nebraska Medical Center College of Pharmacy. He graduated from Idaho State University in 2003 and he is currently serving as the faculty co-chair for the Patient Safety and Clinical Pharmacy Services Collaborative.

So let me turn things over to Linda.

Linda Kwon: Great. Thanks so much, Marisa, and thank you to AoA for allowing us this opportunity to share with your colleagues more about the Patient Safety and Clinical Pharmacy Services Collaborative.

So on slide number five we wanted to share with you the questions that we'll be running on for the next half an hour or so.

What you'll hear more about is a little bit about the Patient Safety and Clinical Pharmacy Services Collaborative or as Marisa mentioned before, PSPC in short.

We'll also share with you how to participate in this fourth year of the collaborative and you'll also hear from Dr. Kyle Peters.

He will be sharing Siouxland Community Health Center's progress and action plans in improving their health outcomes in patient safety.

So if we move on to slide number six, we kind of wanted to just paint the picture for everyone to kind of just let you know what the issue is and what this context is in mind it will help frame the collaborative and why we're doing it.

So on this slide we know that people with chronic conditions are the most frequent users of healthcare in the United States. They account for about 81% of hospital admissions and 76% of physician visits.

At least 91% of all prescriptions are filled for a chronic condition, and the Institute of Medicine found that safety and quality risks associated medications are severe.

At least 1.5 million people are injured each year as a result of medication errors. So when you couple these statistics and throw in the estimated cost of uncoordinated care, there's really a big opportunity to reconcile the care coordination on medication.

There's a sense of urgency to transform the delivery system to help deliver safer care and to save patient lives.

So on slide number seven, HRSA developed PSPC about four years ago. And this is a quality improvement collaborative aimed at improving health outcomes and patient safety for high risk patients.

We've adopted the Institute for Healthcare Improvement breakthrough series collaborative model, which will highlight in a few minutes. And what we've seen over the years is that community based teams are improving and transforming the delivery system where there used to be a gap.

Teams are able to enhance the care coordination among the providers and partners involved. They're fostering multidisciplinary team based care team approach.

The collaborative is helping teams strengthen the patient centered medical homes and help teams integrate medication management in other patient centered services to minimize harm related adverse drug events and to maximize (optimal) health outcome.

And again we're delighted to have Dr. Kyle Peters here with us who will share a little bit about Siouxland's experience in a little bit.

So we move on to slide number eight. We just wanted to tell you a little bit of who's involved in this collaborative.

This collaborative is truly driven by the communities across the country. We have community based teams and organizations that include safety net providers, hospitals, public health departments, and HIV clinics.

And some of these organizations have partnered with Schools of Pharmacy, primary care associations, and quality improvement organizations.

And all - and the composition of their team is really grounded in that multi disciplinary care team.

And together they're collectively delivering patient centered services to improve medication safety, to improve the care coordination, and to improve health outcomes.

On slide number nine this shows you a visual display of currently where our teams are in this fourth year of the collaborative. We just kicked -- jump started our fourth year and you can kind of see we have over 130 community based teams across the country.

If we move on to slide number ten, we just wanted to share with you kind of the value in the community partnerships and what we've seen over the years.

We realize that collectively we can learn more from each other and to help move this work forward. The partnerships add strength to the teams it helps to leverage resources to provide manpower and skill sets.

And also to provide synergy across entire communities. And we just wanted to share this quote with you that by Aristotle that the whole is greater than the sum of its parts.

Again, you know, the community partnerships really help drive this work and we'll talk a little about the composition of the teams that we've seen over the years and into this upcoming year.

On slide number 11 what we want to achieve in this collaborative is that bold goal that we have for all of our team.

And it's really to help integrate the health care delivery system across multiple health care partners to create a service delivery system for high risk patients that will produce breakthroughs in the following three areas - to improve patient health outcomes, to improve patient safety, and to increase the utilization of cost effective clinical pharmacy services and medication management services.

Slide number 12 kind of shows another visual display of our bold goal. We've started on this journey about four years ago and our teams are starting with the high risk patients -- so those patients who are taking multiple medications, seeing multiple providers, and have multiple chronic conditions.

And over time the community teams are working with these patients closely to identify opportunities to improve the care coordination on medications, to help them bring their health status under control, and to help improve patient safety.

And over time, changes are deliberately and rapidly refining their processes to build this more integrated delivery system so that they're able to spread the model that's currently in place at their organization so that all of their patients in their community are receiving the services that they've been able to put in place.

We're excited that we're partnering with the quality improvement organizations in this work. The QIOs will be able to help spread this work amongst the Medicare beneficiaries, Medicare Advantage, and the dual eligibles.

On slide number 13, we just wanted to describe a little bit of the composition of the teams that we've seen over the years and how they've been successful participating in this collaborative.

We have found that our most successful teams have an expanded care team so made up of multi-disciplinary care providers and they've fostered great relationships and partnerships at their local level all the way up to the national level.

And most importantly these organizations have been able to get leadership commitment at various levels so whether it's the CEO, the CFO or a very committed team leader to help drive this work we realize how important leadership commitment is in participating in this collaborative.

Some - also we've seen the value in partnering with the Schools of Pharmacy. A lot of our community-based teams have partnered with the School of Pharmacy and it's provided an enriching experience for students who've been able to spend some time at the clinic or at the health care setting where they can also provide their expertise around pharmaceuticals.

Again as I'd mentioned before the expanded care team has created some nice synergy within the organization and helped providers work more efficiently and more effectively.

Along the entire quality improvement journey PSPC continuously provides environments where we promote peer-to-peer learning and sharing.

We know that we learn - we have a lot to learn from each other and with each other and that we're always sharing best practices, insights and solutions to challenges that some teams may be experiencing.

PSPC also provides tools and resources to equip teams to help take their work to the next level and progress over the 12 month collaborative year.

In addition to the peer-to-peer learning that occurred, you know, community based teams are sharing resources that have worked in their studies as well so that way other teams can kind of adopt and apply the same insights or their same tools and see how they can utilize it in their setting.

We've also developed a powerful PSPC change package, which contains a menu of best practices that have been taken from high performing organizations and that includes team stories of how they've been in action on the change package.

We're excited that we'll be releasing an enhanced version of our PSPC change package this week and it will contain some additional supplements that will provide some additional insights for teams who are wishing to explore how they can get accreditation or certification or if they'd like to learn more about how to build that business case or their senior leaders that they can take back to their organization.

In addition to the tools and resources, we're delighted to have a very committed and diverse groups of faculty team members with us. And these faculty members are field experts from across the country who can provide expertise and technical assistance for all of our teams and again to help them with team development and support.

Along with the national leadership here at HRSA we've also established great relationships with external organizations and we're proud to have partnered with a few organizations that have made up the PSPC public and private alliance which is now a non-profit organization that's really going to help amplify this PSPC work and help teams sustain this work moving forward.

On slide number 14 we wanted to just describe to you kind of the PSPC model that we've used over the last few years. Again this was adapted from the Institute for Health Care Improvement Breakthrough Collaborative series model.

In the spirit of quality improvement, organizations are continuously testing small changes through the plan do study act cycles.

Nationally we convene the teams three times a year during the learning sessions. And again, this is an environment where we'd like to highlight what's working in organizations so that it can be spread to other communities across the country.

We'll be starting our first learning session for 4.0 with a three part series that starts in November. This learning session is also combined with our 3.0 team so we're excited that we'll have a good mix of teams with us.

What's not reflected here in this map, but we wanted to share with you is that we do periodically schedule webinars throughout the action period to help maintain the momentum and to accelerate momentum for team development and improvement.

So again this is just a quick schematic of the PSPC model that we use in this collaborative.

On the next slide, I'd just like to share with you before we conclude this part of the presentation is just some key attributes of the collaborative. This collaborative is really grounded in the health home with the interdisciplinary tier team focusing their efforts around the patient. So all the services that are being provided and enhanced, are really patient-centered services.

This collaborative systematically addresses medication management, safety and risk, which are huge issues for ambulatory care patients and for all of the patients that our teams are seeing.

This collaborative again promotes and fosters that all teach, all learn philosophy. We know we have a lot to learn from each other and we can do some really neat and exciting problem solving in real time by just sharing insights and solutions to common challenges or barriers that we hear from other communities across country.

We've heard a lot of national efforts around the patient safety work and we just wanted to just highlight that this collaborative does align with the Partnership for Patients campaign that some of you may have heard and along and it aligns with other quality improvement areas that focused in on medication management or care coordination.

On slide number 16 we wanted to share with you our enhanced aim that we share with all of our teams and with all of our partners.

The PSPC aim is patient-centered in integrated care teams are armed with cost deflective clinical pharmacy services to improve the health outcomes and safety for high medication risk, patient populations in alignment with national quality measures.

So this aim keeps us grounded in the work that we do day-to-day to help us achieve this bolder vision that we have that by 2015, 3000 communities have an integrated delivery system to assure optimal health outcomes in patient safety.

On slide number 17, we just wanted to share with you our - if you are interested in partnering with us in this collaborative some the process for enrolling into PSPC 4.0 we've developed an information package which kind of goes into more details about the guiding principals about putting together a successful team for PSPC.

Once you have reviewed the information package, we ask that you go online to submit a participation package. You can access both pieces of this information on our Website and there are actually two places where you can access it. On our patient safety Website which is www.hrsa.gov/patientsafety or you can access it at www.healthcarecommunities.org.

We are asking teams to submit their team information by October 30th. However, we do realize that we're here to help you, you know, if you are interested in joining we'll work with you in every way that we can to get you onboard and help catch you up with all the activities that we've lined up in November and moving forward.

And as I mentioned before we are excited to be partnering with the quality improvement organizations so if you are interested in partnering with the QIO there is a rolling deadline.

And again I just wanted to emphasize that HRSA is here to help. We definitely want to partner with the area agencies on aging and with other aging services providers.

We know that the work that you're doing is very important and I think there's some great opportunities for synergy moving forward.

So on the final slide we just wanted to again thank you for giving us this opportunity to share with you kind of the overview of the collaborative and if you do have more information or need information or have questions, if we don't get to them today here is our email address at patientsafety@hrsa.gov.

Marisa, I'll turn it back over to you and again thank you for letting us just share this overview about the collaborative.

Marisa Scala-Foley: Okay. Thank you so much, Linda, for a terrific presentation -- a great overview of the collaborative.

We did get a couple questions in through chat. The first one came from Jennifer who asks, are any of the collaboratives working with an area agency on aging or other aging network providers as a part of their PSPC team.

Linda Kwon: That is a great question. We currently - I think we do know if teams partnering with nursing homes. We would like to see more teams partnering with area agencies on aging or other aging services providers. So again, you know, I think there's some great opportunities here for synergy and alignment.

And again we'd like to see more and I think this partnership will only help us achieve great outcomes for the patients in our communities across the country.

Marisa Scala-Foley: And Lauren asks, how do they find out if there is a PSPC near them?

Linda Kwon: Great question. So on our Website at www.hrsa.gov/patientsafety there is a tab called Teams and we just updated it to reflect the teams that have enrolled in PSPC 4.0 to date.

There is also a link to the teams that were participating in the third year of the collaborative. And Marisa, I'd like to offer to share this information with you I can send you the Website address and maybe you could disseminate it to your colleagues or in this network?

Marisa Scala-Foley: Absolutely. We can post it along with the recording slides and transcript from this Webinar so that folks can have access to it through our Website.

Linda Kwon: Sounds good.

Marisa Scala-Foley: All right, we got one more question in from Jennifer who asks if you could share any key findings that are emerging from the PSPCs -- for example, common findings and terms of barriers or challenges for addressing medication management.

Linda Kwon: Well, that's definitely a great question. I know we have Kyle Peters with us who's going to talk a little bit about some of his experiences and what they're seeing in Iowa.

So hopefully Kyle's presentation will address that question from Jennifer.

Marisa Scala-Foley: Okay. And we have no more questions so that's a great segue into Kyle's presentation. So I'll turn things over to you, Kyle.

Kyle Peters: Great. Thank you so much. I'll actually go ahead and answer that question. We've seen a lot of good work in the first three years and when it was mentioned earlier on the call about care transitions we really felt that patients deserve to be treated the best way possible and know what's going on with their medications with their diseases.

And we see that the care transitions from clinic to hospital to long-term care back to clinic there's a lot of confusion on which medications they're on.

One of the main barriers to this is that the hospital will have a different formulary so they may stop the patient's home medication to one that they

have in their pharmacy. And then when they go home, they're put on the new hospital meds and continue the medication that they use at home so they may double up on therapy.

So really our ultimate goal is to improve the communication and decrease those barriers. And I think there is quite a bit that we could do with that.

So thank you so much for letting me be on the call.

On slide 20 discusses our integrated care team. Another lesson learned from the collaborative is that no team or person can do this by themselves.

You have to have a good care team that really helps to focus on patient centered care. The Siouxland Community Health Care Center that really helps to focus on patients centered care.

The Siouxland Community Health Center is an FQHC located in Sioux City, Iowa. We're about a hundred miles north of Omaha right on the western border of the state.

We have about 20,000 medical and dental patients. We see anybody from newborns to patients who are in their 90s.

We have eight MDs, one doctor of osteopathy. We're in one central location. We have six physician assistants, six advanced registered nurse practitioners, two clinical pharmacists, and then every month we have two to three pharmacy students from the University of Nebraska Medical Center College of Pharmacy.

And they're here on a four-week rotation every four weeks we get a new batch of students.

Next slide. So when we look at our integrated care team we really focused on patients on warfarin that are referred to the clinical pharmacist for management.

We mainly do diabetes or anticoag. There are main patient visits, but we're available for any other questions that arise from the providers.

So patients are seen regularly by Dr. Klinkcovil or myself to manage their INR. And we'll refer them back to their primary care provider for other diseases.

So if they have COPD, any pain management, we refer those back to their provider. And we really recommend that they see their provider every three months even though they may see us in between.

Next slide. So the benefits to the patients that our integrated team are there more people looking at their medications. We review their medication list each and every visit.

And it's not only the clinical pharmacists that do that, but the pharmacy students. And the benefit of having pharmacy students is they love to ask a lot of questions.

So they don't have the clinical experience we do so things that we may pass by or not notice, they usually notice and bring to our attention.

And so the benefit is having those questions asked, we could determine if the therapy they're receiving is safe and important enough to improve the health outcomes.

A lot of times we try to get rid of medications that may cause harm to improve the safety.

And so by having us look at the med list, the students, and then their nurse and primary care provider team, we really feel that we can improve the safety and the care for the patient.

And again it's really about patient-centered care where we put the patient in charge and allow them to make the decisions that are best for their healthcare.

Next slide. So we look at our outcomes what we've accomplished. In our anticoagulation clinic, which we've been doing for a year and it was a focus of our team for the PSPC in 3.0, is that we focus on people on warfarin therapy. One of the things we've noticed is there been people who only needed three months of therapy but they've been on it five, six, seven months. And no one has looked in the chart, made the decisions to stop it. So we've done that and a lot of people to be off of warfarin, which is a very high risk medication.

We've also noticed people with atrial fibrillation need to be on it long-term so we make sure they understand that they understand the benefits and what they can anticipate long-term. We also give them a closer follow up if patients are not within range.

So the chest guidelines which are the anticoagulation guidelines in America really recommend a maximum of four weeks between INRs.

We were seeing patients that hadn't been seen for two months. We actually had a patient that I saw in urgent care with a nose bleed who really requested "I want to be seen more frequently. My current provider only sees me every two months."

And so we enrolled her in our anticoagulation clinic. We're able to see her more often and get here INR to goal.

If a patient's INR is too high or too low, they're able to see us sooner than their primary care provider. Our schedules are a little more flexible, a little more wide open.

And so this really improves the access to care. And there's more timely follow up, we really feel benefits the patients.

It also benefits those that are in the hospital on anticoagulation. A lot of time for the first time maybe they developed a DVT or a pulmonary embolism or maybe they're diagnosed with atrial fibrillation. And so they can follow up with us in a few days instead of waiting weeks to be seen.

Next slide. So one of the biggest things that we really focus on is safety. And To Err Is Human -- a great book really -- mentioned that for every dollar spent on ambulatory care medications, a dollar is spent treating the harm associated with these medications.

And we keep that in mind in all of our teams have this how this in their training and so when they see patients and their charts, they do everything they can to improve safety.

What we have done is we've stopped a lot of aspirin. We see a lot of patients unnecessarily on aspirin and warfarin. And there really isn't a lot of good data of using it in combination except for if somebody has a heart valve.

And so if they don't have a heart valve and there's no other good reason, we'll stop it to really decrease the bleeding risk. The literature reports that there's about a two to three times increase risk of a bleed being on warfarin and aspirin.

Another thing that we're able to do is we're able to adjust the dose of warfarin when antibiotics are used. So antibiotics for most part will make the INR go up which thins the blood which increases the bleeding risk so we can modify the amount of warfarin to prevent that from occurring.

We've also noticed other medications more commonly that increased the INR such as amiodarone, fluconazole, and rifampin. We had one gentleman that was on rifampin for six weeks and he was up to a dose of 20 milligrams a day of warfarin which is a very, very high dose. And knowing that he was going off of it we were able to reduce the dose accordingly to prevent a clot or a bleed and now he's only on about eight milligrams a day. That's a huge reduction though luckily being clinical pharmacists and understanding the drugs, we were able to notice that and make appropriate changes before it was too late.

Next slide. Access to medications is something with a lot of our patients that they struggle. At a community health center we only have 50% of patients with insurance. And so we're trying to find the best way to give them their medication.

Adherence is a major barrier and one of those barriers to adherence is cost. And so we like to try to get patients on one tablet strength and five milligrams is pretty common. And so we may have them take one tablet on Monday, Wednesday, Fridays and two tablets on Thursday, Tuesday, Saturday, Sunday.

We may also give them a 90-day supply versus a 30 because the 90-day supply over time is cheaper per tablet. And so we really focus a lot on the patient and allowing them to afford their medication.

One of the newest things we've been done - been doing for our patients if they have atrial fibrillation is getting them on Pradaxa.

Pradaxa is a twice a day medication that's an anticoagulant that doesn't require monitoring. And if our patients qualify for the patient assistance program they can get this free of charge from the drug company which we charge a ten dollar processing fee every three months.

And they could be on this and not have to pay for monitoring and visits. And so really it's a good benefit to them, it's a little safer, a little more effective and it doesn't have the cost.

Next slide. Now we wouldn't be able to do all this great work without our partners. And the PSPC model is centered on partnerships. And many of you I would encourage you to seek out to see if you have teams in your area.

I was looking at the list of participants early on and I looked at Idaho because I am from there originally. Idaho currently doesn't have a team enrolled for this year the PSPC and so you may want to reach out to Linda or I and we may be able to team you up with people from the College of Pharmacy, other organizations with connections we have in Boise to try to get you a team.

But we're willing to do that for many of you out there that want to partner with teams in many states. And so we can do that really to spread this work.

And we've shown that partnerships allow us to provide better care to the patients and really reach more patients. If we can reach more patients we can improve the safety and improve the outcomes and really save lives what we want to do.

It also allows us to leverage resources. We make a request and offers to decrease the time to implement change. A lot of the change we do is very rapid acting and it gets things done which is quite nice to see in this day and age.

The partnership also allow us to spread to more and more communities to improve safety and outcomes. And if we can reach more and more people in the United States, we can hopefully decrease the burden of healthcare and improve the health of the citizens.

Next slide. So this is done with a partnership with the University of Nebraska Medical Center College of Pharmacy.

So I'm a Clinical Assistant Professor and Dr. Klinkcovil is a Clinical Assistant Professor as well and we see students every month and we train them and educate them and allow them to understand the work of the collaborative and also how it improves safety and outcomes.

If a lot of you remember your schooling you probably didn't get a lot on safety and that's a big disadvantage for our students. In the classroom they

may not get the safety piece but on rotations we really drive the point home that they need to look for safety and prevent any problems.

And so the students are able to gain this experience managing patients with diabetes on anticoagulation or other primary care conditions with the focus on safety.

Next slide. So in the first year of the collaborative our population of focus, which is the group of patients that we follow and manage, were patients who with diabetes who saw two of our physician assistants.

We teamed up and followed their patients to try to get their A1Cs less than seven and prevent any of the complications. In year two we focus on patients whose A1C was greater than nine which is a good quality marker for poor control.

The benefit was the students would interview the patients, discuss what diabetes was, the complications associated with it, why we wanted to treat it, and how to prevent complications. And so by meeting with the patients they were able to provide a lot of great education.

Next slide. When the students would get done talking to the patient we would ask them what their plan was, what their recommendation. They would present that to us and we would teach them the if we agreed with it or not and maybe what we could do better.

By having the student see the patients, this freed up our time and allowed us to see more and more patients, but also allowed the students to develop their clinical skills on safety and outcomes.

Next slide. So in the third year of the collaborative we started focusing on patients on warfarin. And the students would room the patient and ask them the anticoagulation questions. They would do this while we would poke their finger and obtain their INR.

Next slide. And the students would write out the SOAP note, which is documentation of the chart, discussing the visit, and they would do this and look for drug interactions and drug errors and also develop a good plan for the patient until their next visit.

And we would really love the students do everything but the INR because of liability we didn't want them poking a finger and have a chance of coming in contact with the patient's blood. But the students would do everything and then we would make the final decisions with them teaching them how to do this.

Next slide. So participating in the PSPC has really allowed students to apply their classroom knowledge to real patient situations. And we know that the rest of the career is not going to mean a classroom. It's going to be in a hospital, in a clinic providing this care.

And we focus on preventing errors and teaching patients how to achieve their goals and really the students love helping the patients and the patients love the students so this partnership has really been a win-win for all parties involved.

Next slide. And so without the student involvement we wouldn't be as efficient; we wouldn't be able to get as much work done. We probably wouldn't notice as many of the potential adverse drug events. By having their eyes on the chart, we notice more.

Students also decrease our workload. Even though we oversee them and help them learn, they really help us out quite a bit. And we find a lot of joy by having the students around. And it's really a benefit of this teamwork having partners get the work done that we find joy and are more efficient.

Next slide. So if we look at our results we started enrolling patients in our population of focus October of 2010 and so each month more and more patients were added.

The criteria of being added to the population of focus was if they were on warfarin and their INR was not in range at the end of this year we had about a hundred patients in our population of focus.

Next slide. If we look at those who receive clinical pharmacy service elements in the month this also increased. So we towards the end had about 74 patients every month receiving these services out of those hundred.

Next slide. And we saw that - we took people whose INR was not within range. So zero percent of people were at goal and over time we saw this increase.

In June we actually had 74% of patients whose INR were within range would this is quite good this is better than a lot of the studies that were out there.

And we ended with about 55%. So people who are not at range are now within range in their INR which will hopefully improve their outcomes and improve their safety.

Next slide. When we look at safety one of the things we noticed is a reduction in potential adverse drug events. And we saw a slight increase because we know these events are occurring but we're not tracking them.

Once we start tracking them we usually see them go up and then go down. And when we got to about one potential adverse drug event per patient, that's pretty good considering they're on warfarin, a very high risk medication.

Next slide. If we see the number of adverse drug events so this would be bleeds or major bleeds causing issues, we got to the point where in July and August we did not have any adverse drug events. This is pretty exciting. And this is the ultimate goal of the collaborative was to improve that safety.

Next slide. So in summary, partnerships allow the integrated care team to work more efficiently. The results obtained allow more patients to achieve their health outcome goals.

Safety is increased by having more eyes with different knowledge we're using patient information and success seen in the first three years of the PSPC would not have been accomplished without partners.

So thank you so much, Marisa. I'll go ahead and turn it over to you.

Marisa Scala-Foley: Okay, thank you so much, Kyle. We've gotten several questions in so why don't we go ahead and go through those and then we'll turn things over to June and Sandy?

The first one is just a really quick clarifying question and that comes from Russ, who asks, in your rates slides that you just finished going through, what was your N?

Kyle Peters: Those would be the amount of people in the population of focus per month. So the original slide of the chart would have our N. At the end our N was 100 and so each month the end would change quite a bit.

So for example if we look at February our N would have been about 60 patients. March would be about 80 and so on.

Marisa Scala-Foley: Okay, great. We got another actually we got this question from a couple of people, how is your partnership funded? Are you receiving outside funding or are, you know, for staff time or other costs or teams doing this on their won time?

Kyle Peters: That's a great question. So my partnership with the University of Nebraska College of Pharmacy is they pay half of my salary. And so the health center I have 100% employed by the community health center.

Half of my salary comes from the health center the other half comes from the College of Pharmacy. And the teams out there that are formed, a lot of them have these College of Pharmacy partnerships where they have co-funded faculty.

But the majority of the teams are really paying for this work as they pay for their normal staff. And what we want to remind people is this isn't extra work or different work, it's really the same work we're doing. It's just more enhanced, more streamlined, and more efficient.

And so a lot of times people are concerned when forming teams who's going to pay for it. But this really changes how we manage patients and it's actually saved quite a bit of money and staff time.

Marisa Scala-Foley: Okay, great. We've got another question in from Janice who asks, how do you document the care that you provide, not just the anticoagulants but also but all recommendations for changes in therapy?

And she also asks, if you have this information, what the pharmacy costs for patient is for the services in your clinic?

Kyle Peters: Okay. Great questions. The main reason or main way that we document all of our recommendations is through our EMR. We have an EMR where we're able to send notes to the physician or put notes in the chart letting them know what we've done.

We track a lot of our anticoagulation data on an Excel spreadsheet. So very easy, very simple where we have the patient's name, date of birth, medical record number, what their INR is, if they were within range, if they are in the population of focus, when we decide to see them back, and what the adverse drug events or potential adverse drug event is.

As far as looking at the cost per visit, we've looked at that in the past. I don't have that handy I don't have a great number of what that would be.

But one of the main benefits we have shown by having a clinical pharmacist on staff is that we're able to answer a lot of questions and free up a lot of time of our providers. And so we allow our providers to be more efficient and to see more patients than they could on their own. And so a lot of it's more of a cost sharing than a direct reimbursable expense.

Marisa Scala-Foley: Okay, great. And one last question in from Rus) who asks, and this is a more general PSPC question, is there a minimum patient population

requirement for establishing a PSPC? And Kyle, this can be for either you or Linda.

Kyle Peters: I'll go ahead and answer and Linda, if you have any input if you'd like to chime in that'd be great.

Linda Kwon: Absolutely.

Kyle Peters: If you're partnered with a QIO, the ultimate goal is to have a hundred patients and your population of focus.

If you do not have that QIO partnership you're not under a contract for those hundred patients and a lot of our teams have started off with five patients and increase it slowly over time to 20, 30, 40, or 50.

And we feel that if you start doing the work, you may only have 10, 20 people in your population of focus but you're going to benefit your whole organization.

And so even if you want to start low and spread the work over time, we highly encourage that.

Marisa Scala-Foley: Okay. I think we've caught up on all the questions in chat. Thank you so much Kyle and Linda for a terrific overview and a more specific look at how PSPCs work.

Now I think we'd like to turn things over to our next team of presenters. First let me introduce June Simmons who is the President and CEO of the Partners in Care Foundation in San Fernando, California.

As throughout her distinguished career, June has been instrumental in creating funding and operating forward-looking health and social services research and programs. She is currently a member of the National Advisory Council to the National Institute on Aging as well as the National Leadership Council of the National Council on Aging. And she is also a mentor and Advisory Board member of the Practice Change Fellows. And she was the founding chair of the National Chronic Care Consortium.

Teamed up with June is Sandy Atkins who is currently the Vice President of the Institute for Change Research Center at the Partners in Care Foundation. And she's in charge of consulting, evaluation, information technology and new initiative development. Prior to joining Partners in Care, she served as the Executive Director of the Hospice of Pasadena. So with that, I will turn things over to June and Sandy.

June Simmons: Well, thank you so much. We're appreciative of the opportunity to present this work. Let's go to the first slide. Slide 42.

Oh 41, I guess it is. Just to say briefly, the Partners in Care is a not-for-profit in California is focus on innovation. We're very interested in the new opportunity the Accountable Care Act brings to bring community and the person with health issues into a healthcare system that could begin promoting health rather than simply responding to people later on.

So moving to the next slide. So we develop and identify and adopt evidence based programs and try to then bring those into partnerships for adoption so that they get imbedded not just in our work because we do some safety network here quite a bit of it, but in the work of others both in our community and across the country.

And our signature and most beloved innovation is on the next slide -- slide 43 which is to address medication errors and we've been at this for quite a long time. This is kind of reflective of how we like to work -- find a big problem that's expensive and causes lots of suffering and it represents an opportunity for really changing the way care is delivered and improving quality of life.

And med sure meets that issue as you know from the excellent presentations you've been hearing, they're serious. They cause 7000 deaths a year in the country, but I think you have all seen the things short of death that they cause. They cause people to look like they're going downhill when they're really not. They cause falls, they cause confusion and dizziness and just can be very serious impacts on health and quality of life in really big ways.

And of course, they're extremely expensive. It's well documented that the cost of the meds plus the cost of the damage that comes when they're not taken properly and, most importantly, not combined properly is very costly.

And it's a widespread problem. Almost half of community dwelling elders have medication related problems, and fully 25% of all Medicare patients have medication issues especially in the health system we're trying to leave that's so fragmented, episodic, where people see multiple physicians for multiple issues and don't have a way to coordinate, and then meds become a problem.

And of course then we see that they're very preventable. At least 25% of the harmful adverse drug events are preventable and so this is big focus now I know in American medicine is to move to a system where we do avoid damage.

Next slide, 44. One of the big risk points is when people are leaving the hospital and going home to another care setting. We've all I think we've been tracking this important work that's emerging around transitions and post hospital care. Twenty percent of hospitalized Medicare patients are readmitted within 30 days after discharge.

And 72% of those issues then typically are driven by medications and so it's a huge opportunity to bring the HomeMeds program to bear and to really touch the lives of people most at risk.

Next slide, slide 45. So we've been fortunate over a long period of time, not quite 20 years, to look at medications through a home health lens and then through the aging services network care management originally was developed through funding with the John A. Harford Foundation.

And then the Administration on Aging, AoA, picked it up as one of their early evidence-based programs, and in that effort we brought it out of home health in more medical setting and into community and care management that can be done by social workers.

So we're presenting an intervention. You've just heard a very sophisticated, medically thoughtful presentation. This one says that social workers can do it, probably families can do it, that this dangerous medical problem can be identified and screened up to attention by others. So it's designed to enable community agencies to keep people at home and out of the hospital by addressing medication safety.

So this represents an important practice change with workforces in settings that already go to the home. So we've already paid someone to drive to the home, get into the home, and do a full assessment in the home, usually

including a full inventory of medications. And so this tries to take that investment that's already made and turn it to advantage by supporting it with very thoughtful and evidence based on software support.

So let's look on the next slide. So the core components then are in-home collection of the comprehensive meds list and noting how each drug is being taken because that can be an issue. And where feasible, vital signs -- if those aren't feasible it still works. Noting if there's a history of falls other symptoms like dizziness or confusion or other indicators of that likely would be coming from adverse medication effects.

So then the HomeMeds program uses the evidence-based protocols that were developed under grant funding with a national panel of experts, multidisciplinary to really look at the biggest risks and to screen for those risks and then deploy a consultant pharmacist appropriately as opposed to the pharmacy that usually fills your meds. There's a whole field of pharmacists whose job it is to really look at the appropriateness of medications and bring that tremendous expertise into the medical world.

So then it's placed into a computerized medication risk assessment tool, software that can be reached through the Cloud or inserted into somebody else's software. And very cost effective, I might add. And entering these meds which can be done right in the home on some cases we have people entering this right in the home on an iPad.

Then that sets up an alert process that says, better look at this -- this maybe an issue. And then the consultant pharmacist can look at that to see are these really issues or is this appropriate and then, if need be, they alert the physician.

So next slide. So these evidence-based protocols, as noted earlier, were identified by expert panel and they focus mainly on unnecessary therapeutic duplication which means several -- two or more drugs from the same class.

So you might have something for pain or something for sleep things that would have a similar kind of a class base of drugs, and they add up and create a big problem.

Psychotropic drugs while vitally crucial for many people also can have many side effects like falling or confusion. And some of the fancy sounding non-steroidal anti-inflammatory drugs can create bleeds in the stomach especially for older patients. And then some of the heart medications can really be an important issue.

So heading up this work to now to spread this program which is where we are, it's well developed, it's proven, it's published, it's endorsed, with important evidence under it.

Here's Sandy Atkins to kind of walk you through how it really works and really hopefully show you how it can be practically applied in community settings. Sandy.

Sandy Atkins: Hi. I was going to say good morning but at least two-thirds of you are good afternoon.

So just to jump right in, HomeMeds is an intervention with a technology course to it so the most important thing as June already mentioned is the quality of the information that we collect in the home which is we have a little discussion with people about each medication, and then document everything in the system which can be done in the home if people have laptops and

connections. But otherwise you would write it down on a piece of paper and take it back to the office and then enter it into the online, Web-based system.

And then if any of these medications and problems and issues that we've identified generate an alert that it could be caused by medications, we look at it and then depending on the scale of the people that collected the information we might then go and say, you know, are you sure you're taking both of these medications?

So if you have a generic and brand name of same medication prescribed by different people say, are you taking both of these? So that one of the reasons for the process is that we don't want to send to prescribers more alerts than are absolutely judged to be necessary because they get an overload of information.

And so we want to be very targeted. So once we've confirmed that the medications that produced an alert are actually being taken regularly then we communicate this to the consultant pharmacist for the site. And it says email or fax in the diagram, but they can also log directly into the software which is typically the way it's being done now.

And then the pharmacist will say, well, you know, this one is as needed and they're only taking it three times a week so I'm not going to consider that as duplication. I'm going to consider it to be an adjunct to therapy and we won't talk to the physician about it. It will show up on the medication list but we're not going to say, this a problem.

So then after eliminating whatever issues they think are not something that the physician prescriber needs to look at then they will communication usually by

fax with the physician providing recommendations and any documents that would substantiate the reasons for the recommendations.

And then there's a process of response and confirmation and hopefully the physician says, yes, this is a problem -- let's schedule the patient to come in. Or no, we've already done everything we can and tried to eliminate this, and it didn't work.

So there are a number of possible responses and very seldom does the doctor say, please don't bother me. Once in a while they do, but usually it's, oh my gosh, I had no idea. Thank you so much.

So then the pharmacist documents what they have done. They can do it on paper or within the software and then at the end we track to see if any changes have happened to the medication either by looking at the records or by in a care management program if they're making monthly phone calls or quarterly visits then we would check to make sure that everything has been dealt with. So the system also allows us to see if things have been resolved.

Next slide, number 49. So one of the reasons for doing this and, you know, people often say, well, doesn't the pharmacy know everything that the person's taking? And the truth is no, they don't.

First of all, they don't know what over the counter medications, and some of the most serious problems result from things like Advil PM, which combines something that can cause gastrointestinal bleeding or something that can cause falling. Just a delightful combination to take at bedtime on an empty stomach probably. So there are a lot of problems resulting from people thinking over-the-counters must be okay.

Then there are medications prescribed by other doctors and filled by other pharmacies so there isn't a full picture. And then very often I would say seldom do the physicians ask questions like, have you had any falls lately? Have you had any days where, you know, all of a sudden you felt confused or have you been more confused than usual?

So it's - it adds an assessment that's happening in the home. These people are going into the home to do an assessment so we structured some of the questions to make sure that they can create the best information in our online system including things like alcohol use, depression screening to give both the physician and the reviewing pharmacist as full a picture of what's actually happening with this client.

We've - sorry I just knocked my headset off my head. We also have a lot of - find a lot of incorrect self dosing where the instructions say, take three a day so they take three of them at lunch which is not the intent.

People here in California for sure are getting a lot of medications from Mexico. People order from Canada. And then they borrow things, you know, we don't - we say you shouldn't but, you know, this worked for me so why don't you try it?

Next slide, number 50. So we've been at this, as June said, for a long time and we have about 28 implementation sites now so we have a number of waiver programs for older adults in Florida, Illinois, and California.

We have about six agencies on aging in Texas doing this. In Minnesota we funded by the state unit on aging. We have the Carondelet Consortium which is been doing this in their block nurse programs and with assisted living. And

Wisconsin -- AoA funded them to try this with home-delivered meals programs very often associated with Aging and Disability Resource Centers. We have a Native American Tribal Community on the Arizona, California Border.

And in Connecticut, the Fairfield University Nursing School is trying this out with their students going into the home which is a wonderful eye-opener for nursing students to if they're going to wind up working in hospital or emergency room having seen what it's like in the home has been a wonderful eye-opener for them.

Next slide, 51. So just as an example, in Wisconsin over I'd say about six months they have screened 138 clients and found that 55% of them -- and these are people receiving home delivered meals, which means that they're tend to be homebound -- 55% with one or more alerts. An average of 11 medications per client, which includes 1.5 vitamins. 171 problems found and you can see the breakdown there. Typically the most common problem is therapeutic duplication, and others in fewer numbers.

And here's an example. Here we had a patient over age 80 who was taking three different medications that increased the risk of GI bleed. If you've ever seen someone my stepdad lost 60% of his blood so this is for real.

Patients -- there was a patient who fell and we found them taking five different medications that increased the risk of falls. And then another patient was taking four different narcotic pain killers.

Next slide, 52. And just so you know this isn't just about numbers. We had - we got a nice story from Texas where we had a client who was taking 20 medications and after reviewing the medication they wound up only having to

take eight of them which saved money both to themselves and I'm sure to their provider and he feels that we saved his life. So we get a lot of great thank yous that way.

Next slide. This is just an example to kind of tie this to the prior presentation about the PSPC. Also, AltaMed is one of our California partners and they worked on this from about 2007 to 2010. So they screened about 1000 of their waiver patients found that 430 of them had potential problems of which 138 our consultant pharmacists felt needed to be addressed by the doctor, and 122 of those were resolved which was a really nice high number.

And using HRSA's formula for medication therapy management we estimate that this could have saved up to $200,000 to the entire healthcare system not just the ultimate.

Next slide. I think this is where we're going to turn it back over to June.

June Simmons: So you can see that this what we think is a simple, very approachable change in practice that builds on the investment already made, and really impacts such dangerous areas as falls and other really important adverse affects.

And it's been proved through having the folks who go to the home use their detective skills to more effect, and especially by collaborating with the pharmacist and having a better link to the healthcare team.

So you can see we had many people in many sites who had problems sometimes several problems per client and from those really clear examples which you probably seen on your mother or grandmother's kitchen table. Everybody's kind of seen this struggle.

We know how powerful they are, and so we think it's very important to spread this program to have it adopted across the country.

Next slide 55, please. And given that AoA has blessed it as evidence-based and it's now undergoing at the National Registry review. It has strong support from AHRQ posted on their innovation site. We think it's got a lot to give it credence.

If you're in a community setting and trying to go to a medical partner, it's important to have that evidence. You might want that evidence for yourself to know that this is worth the effort, but I think very important to have it as a community people increasingly are joining hands with medical people.

Next slide, please. So we hope this becomes the standard of care for home-based services and in some of the health plans that do regular health risk assessments every year with more fragile people. That is part of the AoA vision for really seriously connecting the aging services network with healthcare delivery – much to the benefit of healthcare delivery and much to the growth of impact for the aging services system.

And so we're working on things like how pharmacist reimbursement works. So we have some ideas about that -- enhancing the technology.

Next slide. So we hope if you have interest that you'll either give us a call or an email or that you may send your friends, because Sandy has now got this in eight states and a number of sites but we are, we feel it's so cost effective, simple, and so important for the quality of the lives we all serve, that we encourage people to adopt it and we'd love to help.

I think that concludes our formal presentation. If you have time for questions, we'd welcome them.

Marisa Scala-Foley: Okay, thank you so much, June and Sandy. I think we've gotten numerous questions in through chat and we will try to get to them in a moment.

Just let me go through really quickly our resources sections of the slides as well as our next training, a little bit information about our next training. And then what we'll do is we'll open up the audio lines for questions, and we'll try to clear up the chat, what's come in through chat.

So really quickly, as we always do in all of our webinars we have included numerous resources having to do with, of course, for the purposes of this presentation, medication management, including the sites for both of the programs that you've just heard about both the pharmacy, the PSPCs, and HomeMeds as well as some other resources related to medication safety.

We've included -- because of our focus on care transitions, we've included lots of resources related to care transitions as well as some general resources on the Affordable Care Act.

Finally our next training. We will continue our webinar series -- we'll have one more webinar for 2011, and our next webinar will look at care transitions and long term care.

As I mentioned this will be our last webinar for 2011. We''ll look forward to doing more in 2012. Recognizing that everyone's schedule just gets a little more hectic around the holidays, this webinar will likely take place in early December. But we will send out registration information in mid-November. So please do watch your email for the announcement about this webinar.

So with that let me turn things over to Denise, who can tell you about how to queue up to ask questions through the audio line and then we'll take some more of the chat question.

So Denise, if you could give everybody instructions?

Coordinator: Thank you and at this time if you would like to ask a question please press star 1 on your touchtone phone.

Once again star 1, if you would like to ask a question. Please unmute your phone and record your name in order to be introduced into the conference.

Thank you.

Marisa Scala-Foley: Okay, let's take a few of the chat questions while we're waiting for people to queue up with Denise.

The first one came from Debbie who asks, do you - and this one's for June and Sandy, she asks, do you work with any home health agencies?

And her second question is have you adopted the ISMP or accrediting organization thought process on medication safety?

June Simmons: This work was originally done with home health agencies and after it was developed in the original research we had funding from the Hartford Foundation to spread it to home health agencies across the country and select areas the visiting nurse of New York is an example.

There are a variety of agencies across the country that use this and it certainly that could use this. And then right now we're also targeting very actively to reach out to area agencies on aging, senior centers, community care programs through Medicaid waivers and working with health plans and physician groups. So it can go a lot of places.

Sandy, I'm not familiar with the standard she referenced. Are you?

Sandy Atkins: No. Probably our pharmacist Denny Fry would be, but she's at a previous engagement, training a new site. So we can answer that at post if you like.

June Simmons: You're welcome to email us about it. Or let us know how to email you and we can get you the answer.

Marisa Scala-Foley: That's great. I'll make sure that she gets in touch with you. The next question came from Jennifer, who asks, have you - is HomeMeds specifically designed for older adults or have you used the protocols with younger adults or people with disabilities?

June Simmons: Sandy, you want to take that?

Sandy Atkins: Yes, they're specifically designed for older adults. We - a number of the programs - the problems are appropriate for younger disabled people.

For example, the psychotropic kinds of medications and falls and confusion can be an issue particularly - oh I'm sorry. They can be a particular problem for people with behavioral health problems. But we have not proven its effectiveness in that population.

So while logically we would say, yes, probably half of the protocols would apply. We don't make a claim for it just because it wasn't in the population that was studied.

Marisa Scala-Foley: Okay. Question from David who asks, can you comment on - oh wait, no, please -- he asks if you can talk a little bit about how an organization finds a consultant pharmacist who is ready to receive such alerts?

June Simmons: Go ahead.

Sandy Atkins: Sure. We have generally each site has just found their own. We have these models we have local pharmacy school professor and students, that's one model.

Small town with an active pharmacist who wants to be involved some of the sites particularly the area agencies on aging who have Title III(D) Medical Management Funds can pay for the pharmacist using those funds.

There are some sites that are using a volunteer pharmacist -- a community pharmacist, for example -- that, you know, is just doing this as part of their community service and so there are a number of models that have been followed.

The American Society of Consultant Pharmacists has a website. I think it's SeniorCarePharmacist.org -- something like that. If you look up American Society of Consultant Pharmacists, they have a national network of pharmacists.

So it depends on your community and your organization, but no one has had a problem finding a pharmacist.

We're also finding that it is -- most of the regulations governing pharmacy practice relates to dispensing and not consulting. So it is possible that you could for example contract with our pharmacist since most of this work is not done face-to-face. It is possible that you could contract with someone from another agency, share pharmacists and so there's a lot of possible models.

Marisa Scala-Foley: Okay. We'll take a couple more questions from chat and then we'll open up the audio lines and then we'll try to move back to chat for as long as we have time.

Question - actually we got this question from a couple of people, who asked, what are the most common problems that you encounter when it comes to medication safety using HomeMeds?

Sandy Atkins: Sure, the most common is therapeutic duplication. Either a generic and brand name of the same medication or two medications from the same therapeutic class. I think that one has around 25% of the problems found.

Then -- and let me take a sidebar here and say that if the percentage of problems found is not necessarily the percentage of problems that exist because a number of the agencies that implement this do not have access to vital signs.

So we feel that there would be many more cardiac problems with the home health agency for example, than with a social service agency where they don't take blood pressures.

So we instruct people to ask the client if they have a blood pressure cuff and then record it because we're missing a fair amount of orthostasis, low pulse,

low blood pressures from too much blood pressure medication or high blood pressure from not enough. So our recent implementation is a little bit skewed towards the duplication and the end set problem.

So a lot of people have are taking too many versions of ibuprofen, aspirin, Aleve, and prescribed arthritis medications that have non-steroidal anti-inflammatory drugs in them. And then too many in combination with the kinds of things that we were talking about before the aarfarin and blood thinners, steroids, things like that.

So those are the most common -- falls and confusion with anti - with - not antipsychotics but the psychotropics would be the next most common.

So in all about 50% of people have at least one of those problems. And typically about 30% of all patients screened wind up having alerts sent to the physician for review because the pharmacist has judged them to be important enough to bring to the physician's attention and try to fix.

Marisa Scala-Foley: Okay. Let's just take one more question -- and we got this question also from a couple of people -- and then we'll move to the audio line.

We got a couple inquiries with regard to the cost of HomeMeds.

Sandy Atkins: The cost?

Marisa Scala-Foley: Yes.

Sandy Atkins: Generally there's a software cost which at this point is approximately $200 a month for up to a certain number of patients entered into the system per month.

And then a modest kind of training/set up/support charge of $2000 if we do it through webinar and $4000 if we do it in person. And then it would be up to the site and their own arrangements how much the pharmacist cost.

We have a sheet that we can send out to people, but generally the pharmacists are approximately $60 to $75 an hour depending on geography and the arrangements that you make. Should be even more than that in some cases. But if you're using the university and in terms it's going to be less than that so.

June Simmons: Or the hospital might provide this, or a local pharmacy with some specification might provide this or there might be other groups that would view this as a community benefit or a chance to bond in the community.

Many sites are using the AoA, the Older Americans Act Title 3D, funding which is for meds and it has no specific deliverables on it unlike the other Older Americans Act funding.

And so a number of sites in Texas they pooled their funding across several area agencies on aging, and so there are ways to do this.

Some people have been able to obtain one time only funding at the end of the year for training or a grant sometimes these can get written into a grant, a health plan, a hospital, or physician group might have interest in supporting it for their patients because it has a tremendous return on investment for whoever is paying for the patients that person's care.

Sandy Atkins: And the finally the Part D Plan. I know that Humana, for example, delegates their medication therapy management to the last dispensing pharmacies.

So we're trying to work with some Part D Plans now to experiment a little bit with just sending the HomeMeds report or notifying the Part D provider and having them do the medication review.

We're hoping that the provisions in the Affordable Care Act will support a greater involvement of medication therapy management in HomeMeds and enable reimbursement for the pharmacist almost independent of the Part D providers that they can - if you find a problem you can get a consultant pharmacist to be paid.

Marisa Scala-Foley: Okay, Denise, why don't - is there anyone queued up on the audio line to ask questions?

Coordinator: There is one person from the audio line. I was not able to capture their name. I'll go ahead and open up their line.

If you had pressed star 1 and wanted to ask an audio question, your line is now open.

June Simmons: Must have answered this...

Sandy Atkins: That's an important question but hard to answer.

Marisa Scala-Foley: Okay, well, maybe we'll give that person a chance to try again. But we'll take another question in from chat.

And this question came from David who asks, can - actually two questions. First, can a patient or client print out a medication list from the HomeMed system?

And his second question is, can HomeMeds interface with other systems such as electronic medical records or other such systems?

Sandy Atkins: Sure, it is designed for access direct access by anyone that we create a login for. So it has not been done that way, but it is certainly -- I have created a patient access user name and password portal available so that yes they can.

But the reports are available in pdf and Word format so that the agency could print out the report and they could also provide a Word document so that the patients or families could update it themselves and then take it to all their doctor visits.

It comes in different formats so there's a sort of a training and background version that has all of the rationale behind the alert.

There's a version that is adjust the alert itself which we think is what you would send to the physician.

And then there's one without the alert so that there's just a plain medication list with all of the clinical indicators of potential problems but without interpreting them into a list of problems.

So there's a lot of different ways to do it. What was the second half of the question?

Marisa Scala-Foley: The second half of the question was, does HomeMeds interface with other systems such as electronic medical records or health information exchanges and so forth?

Sandy Atkins: Again it was designed to do that and we're working on our first implementation of that but it is imbedded in a system that has successfully exchanged information because our -- what we really want to do is prepopulate the records so that when somebody goes into the home they don't have to do anything except confirm the medications that are being taken, ask the questions about, are you taking this the way it's directed on the label? And then add in the things that are in the home -- the Costco, you know, thousand Ibuprofen pills that I'm taking ten of a day and that sort of thing.

So we wanted to prepopulate from EHRs and from the HIE, and we wanted to send information back, but we have not done that directly yet and are working on our first implementation.

But again it was designed in a data exchange format that would make that possible and desirable, and we're hoping to do it.

Marisa Scala-Foley: Okay, Denise, did our person who was queued up to ask a question come back or do we have any additional questions?

Coordinator: They did not. I have no audio questions at this time.

Marisa Scala-Foley: Okay so we've got a couple of minutes left so maybe we'll just close out with - we've gotten a number of questions from people who have asked, how can our states get involved in HomeMeds and if there are any programs existing in their state or agencies in their state using them?

Should they - can they go to your Website to find out that information, June and Sandy, or should they email you directly?

June Simmons: I would say email us directly. You know, certainly go to our Website, but I don't think we have the names of agencies on our Website.

Marisa Scala-Foley: Okay. Great.

June Simmons: www.picf.org is the easiest.

Marisa Scala-Foley: Can you repeat that I think I may have talked over you a little bit?

June Simmons: Okay homemeds@pics.org or www.picf.org.

Marisa Scala-Foley: Great. So with that we are just about at the end of our time. So I would like to first of all thank all of our speakers, Linda, Kyle, June, and Sandy for wonderful thought and question provoking presentations. We thank you for your time and for the wonderful information you presented and thank you to our audience for the terrific questions you've been asking.

For anyone who may not have gotten their questions answered because there were a couple in chat that we don't really have time to get to, please feel free to email us if you at AffordableCareAct@AoA.hhs.gov.

Also if you have suggestions for future webinar topics we would love to hear from you so please do email us again. That email address is AffordableCareact@AoA.hhs.gov.

We do want these webinars to be as relevant and as useful to you all as possible so we very much welcome your suggestions. And we thank you all for joining us today and we look forward to having you with us on future webinars.

Thank you very much.

Coordinator: Thank you and that does conclude today's conference call.

We appreciate your attendance. You may disconnect at this time.

END