The Big 3 of Adverse Drug Events: Best Practices for Safety and Care Coordination Webinar - Transcript

Thursday, February 23, 2017

Laurie Fink: Good afternoon and welcome to today's webinar, The Big 3 of Adverse Drug Events: Best Practices for Safety and Care Coordination. My name is Laurie Fink and I am the Quality Insights communication specialist for the Care Coordination and Medication Safety Initiative. We will get started with today's program in just a few moments, but first a few housekeeping items.

All participants enter today's webinar in a listen-only mode. Should you have a question during today's presentation, we ask that you please type it into either the chat or the Q&A box to the right of your screen. We will answer as many questions as we can at the end of today's program. A copy of the presentation slides were emailed to everyone who registered to attend today's session earlier this afternoon. We are also recording today's presentation, and the recording and slide deck will be posted on both the My Quality Insights Online Learning Platform and the Care Coordination and Medication Safety Community and also on the Quality Insights website. To access it on the Quality Insights website, simply go to www.qualityinsights-qin.org then click on the Events tab and select "Archived Events." These resources should be posted on the Quality Insights website within the next few days.

Here's a look at the agenda for today's presentation. We will begin with an introduction to Quality Insights Quality Innovation Network. Then we will discuss the problem of adverse drug events, focusing on the big three: anticoagulants, opioids, and diabetes drugs. Next we will talk about the solutions, including care coordination, medication reconciliation, and drug-specific best practices. Then, to wrap it up, we'll discuss project details and information about how to join our initiative.

Today's speakers will be Dr. Andrew Miller, who is the Care Coordination Network Task Lead for Quality Insights, and then we'll hear from Nicole Skyer-Brandwene, who is the Adverse Drug Events Network Task Lead.

Pictured here is our Quality Insights Adverse Drug Events Team. In today's world of e-mails and virtual meetings, we thought it would be nice for you to see the smiling faces of our coordinators from each state within our five-state network that are here to help you reduce adverse drug events in your facilities. As you'll see here, we have our coordinators from Delaware, Louisiana, New Jersey, Pennsylvania, and West Virginia. At this time, I'll hand over the presentation to

today's first speaker, Dr. Andrew Miller. Dr. Miller, I'll go ahead and hand you the presentation role.

Andrew Miller: Thank you, Laurie. Welcome, everybody. We're going to start out doing a quick poll. We just want to know who's represented on the call today. I'll just run through. If you are from a community pharmacy, a provider pharmacy, if you're a pharmacy consultant, if you're with an ambulatory pharmacy in a health system or a clinic, a specialty pharmacy, an inpatient pharmacy, or if you're a pharmacist, if you work for a hospital or a home health agency, a skilled nursing facility, and if you're from an inpatient rehab facility or a continuing care community or assisted living facility, if you're from a long-term acute care hospital, with a physician practice, or a hospice, or a dialysis facility, please let us know so we have an idea of who we're speaking with.

Next, we just want to talk about what are Quality Innovation Networks and Quality Improvement Organizations. The QIN-QIOs, as we pronounce them, are contracted by the centers for Medicare and Medicaid services to help providers, hospitals, nursing homes, home health agencies, the other types of providers that I listed, improve the quality of care they provide to Medicare beneficiaries and also while protecting the Medicare Trust Fund to know that there's enough money left to pay for the services that Medicare beneficiaries are eligible for. We also work to improve the quality of healthcare to meet both national and local priorities.

We convene healthcare providers and other community partners to increase communication and collaboration. On the slide, and you have the slides sent to you, as Laurie said, there's a link to a CMS page that provides a description of what the Quality Innovation Networks do.

We also, more specifically, provide support and facilitation. We bring together community partners. We provide support and education to use for with improvement tools, such as root cause analysis and other tools. We provide coaching and consultation services and we provide data services and reports to help measure the effectiveness of interventions and other community activities. Our services are provided at no cost.

Next, we just want to show a map of the 14 QIN-QIOs in the country. The Quality Insights Quality Innovation Network is our QIN. Our region includes the five states of Delaware, Louisiana, New Jersey, Pennsylvania, and West Virginia, in alphabetical order. You can see they're circled on the map.

A number of the initiatives, we just want to talk about initiates that we are undertaking as part of our contract with CMS. One is to improve cardiac health by aligning with the national Million Hearts initiative. The goal of that initiative is to prevent one million heart attacks and strokes. We also work with the Everyone with Diabetes Counts program. This is providing training for patients with diabetes or prediabetes in diabetes self-management through training classes. This training is also provided at no cost to the participant.

We have a Nursing Home Quality Improvement Program focused on decreasing morbidity among nursing home residents while increasing the satisfaction that they and their families have with the care they receive. We focus on reducing the use of unnecessary antipsychotic medications. More recently, we have started an initiative to reduce C. diff infections among nursing home patients.

Within the Quality Reporting and Payment Programs we help physicians and nurse practitioners meet the requirements of the Medicare Access and CHIP Reauthorization Act, or MACRA, and the Merit-Based Incentive Payment System, MIPS. This is how the changes in how physicians are going to be paid based on quality measures and to help them, help physician practices, transition smoothly into new alternative payment models that are being introduced in the Medicaid program. We also work on the inpatient side and also with outpatient facilities to help them improve the quality and efficiency of care that they provide. We also work with physician practices to increase the number of people on Medicare who receive recommended immunizations in the outpatient setting.

Our Outpatient Antibiotic Stewardship Program, this is also a new program. We're working to help providers in multiple outpatient settings, I won't list all them, to implement programs so that antibiotics are used appropriately. That's preventing misuse and overuse of antibiotics, but also when antibiotics are needed that they be prescribed as needed and prescribed at the right dose for the right amount of time and using the right antibiotic. This is focused on the four core elements of outpatient antibiotic stewardship, which were defined by the Centers for Disease Control and Prevention, CDC, and were released in November. Those are commitment to antibiotic stewardship, taking action to improve antibiotic stewardship, tracking and reporting what actions have been implemented, and educating and providing expertise, education for both staff of facilities and practices as well as for patients.

Our Care Coordination Program, in that we work with ... Many of you on the call are familiar with our Care Coordination work. We work with communities across our five states to develop coalitions to reduce avoidable hospital admissions and

readmissions and decrease the amount of time that patients spend in institutional settings. The idea is that patients are better off in the community when they're able to be there, in their own homes. The goal is to coordinate care for patients at high risk of being hospitalized, such as patients who have multiple chronic conditions.

I just wanted to give a quick update on what readmission numbers look like, both nationally and in each of our five states within our QIN. The orange dots are the national rates. You can see that, beginning in 2009, these are annual periods of each of the dots. They stayed relatively flat. When the Affordable Care Act was passed and penalties were announced for hospitals, there was an incentive to and an impact on reducing readmission rates across the country. You can see that's happened in each of our states. I just want to point out that during the past five quarters, if you look at Delaware, the purple line at the bottom, readmission rates have been dropping much faster than the rest of the nation. We'd like to see that happen across each of our five states, if possible.

We produce readmission reports. This is what the portal looks like for hospital readmission reports. But we also produce readmission reports based on hospital readmissions for long-term acute care hospitals, nursing facilities, inpatient rehab facilities, home health agencies, dialysis facilities, hospices, and inpatient psychiatric facilities. These can be accessed through our electronic data portal. If you don't have access to this now or don't know how to get to that, please reach out to your state contact. They'd be happy to get you registered for the portal. It's easy to get registered. Essentially all you have to do is pick a password and then you would have access to the reports that are available for your facility.

Now I'm going to turn the program over to Nicole Skyer-Brandwene, who will talk about our initiative to prevent adverse drug events.

Nicole: Thanks, Andy. We're just getting our slides and everything situated. The primary focus of today is to talk about the Adverse Drug Events Initiative and focus on a few groups of high-risk drugs. I just wanted to start with a couple of news articles, things in the news.

There was an investigative report that was done by the Chicago Tribune recently, back in December. As is so typical these days, there was somewhat of a, in my opinion as a pharmacist, inflammatory headline. "Pharmacies miss half of dangerous drug combinations." That's a little bit misleading. What they actually did was they looked at six drug pairs. They took six combinations of two drugs and went to, I believe, about 255 pharmacies in the Illinois area and

possibly surrounding states and filled the prescriptions and waited to see in what percentage of cases would the pharmacy counsel the person picking up the prescription on the potential drug interaction that they had pre-identified in these pairs of drugs that they had put together.

What they found was, overall, 52 percent of the time, there was no information or counseling offered to that individual. It doesn't necessarily mean that the pharmacist did nothing. There could have been investigation and discussion or outreach to a provider on the back end prior to the dispensing, but that was not communicated in the study necessarily. This slide shows, it's pulled directly from the online article, which we've put a link to in the chat if anybody's interested, which is showing the breakdown by pharmacy type. I'm not here to single any particular type of pharmacy out, or anything like that. I myself have a background in retail community pharmacy, independent pharmacy.

I thought it was interesting because they're really drilling down and holding pharmacy to the flame in these kinds of investigative reports. The drug pairs that were involved didn't even involve the three high-alert groups of drugs that we're here to talk about today. Some of the drug pairs did involve antibiotics, by the way, which as Dr. Miller pointed out is a very big initiative that we're working hand in hand with along with care coordination work and some of the other things that Andy mentioned.

I wanted to point that out because, if we go to the next slide, the reality is the public and our legislators are paying attention. They're really paying attention. They're looking for action. The eyes are already on community pharmacies in the forms of star ratings and surveys and things like that. In the home health arena, there's new requirements and regulations coming down requiring that, along with medication reconciliation, that clinically significant drug-related problems be identified by whosever doing the patient evaluation. Usually a nurse, but not always a nurse. Sometimes a physical or occupational therapist.

Not just identifying a clinically significant medication problem, but reaching out to the prescriber, getting that problem resolved within 24 hours and getting that all documented. In the long-term care arena, we're starting to see the impact of alternative payment models as well as Dr. Miller was talking about hospitals being penalized for readmissions within 30 days. The long-term care facilities are going to be looking towards the same thing. They're already looking at antipsychotic drug use and those sorts of things.

In my humble opinion, and I've certainly been wrong many times before, as my family and others will point out to me, these medication-specific issues are

somewhat like the final frontier or the next frontier of this kind of quality work that we've been doing for a long time. For everyone that's on the call, it's really good that you are, because there's no downside to getting involved. Be an early adopter of these safety best practices and some of the things that we work on and some of the things we're here to talk about today, because past experience dictates that some of these things that start off as voluntary initiatives, many of them end up being required or they end up being tied to penalties and payment down the line. We're all here in the right place right now on this call today.

I don't want to dwell too much, but just a couple of slightly less recent, 2015, 2016, reports which are pushed out into the public media, the public arena, looking at problems with medications. One in nursing homes. The other was a Q&A in response to the Institute for Safe Medication Practices, based outside of Philadelphia, Pennsylvania. They're a nonprofit organization that works hand in hand with the Patient Safety Authority in Pennsylvania. They take confidential, voluntary reporting of drug-related adverse events from the inpatient side and they analyze those reports and look for trends and make recommendations back to health system, FDA, and those sorts of things. This is inpatient. The focus of this discussion today is going to be more on the post-acute outpatient setting.

I point it out only because what they found as the most common problem in the inpatient setting, which had to do with omissions of anticoagulant admissions or omissions of warfarin orders where they should have been written. From my own personal experience doing quality work for almost eight years now and working in a multitude of different settings more on the post-acute side, unfortunately I can say with confidence that this problem is not limited to the inpatient arena. A health system or hospital is more of a controlled environment where reporting is encouraged. We just don't have that kind of information, that kind of data, as well with regards to what's going on in the post-acute arena. That's one of the things that Medicare and CMS is interested in taking a look at and is part of the reason that we're here talking today.

Moving on. What's an adverse drug event? There are many definitions out there. This is the one that I like, the one I always use. This comes out of that landmark report which goes all the way back to 2000 now, so 17 years, To err is human: Building a safer healthcare system. In that report, the definition that they use which comes out of the primary literature is adverse drug event is an injury resulting from a medical intervention related to a drug. Something that happens in the normal course of medical therapy, not only medication errors but other things that can go wrong which can be traced back to many possible root causes.

They're therapeutic duplication, polypharmacy, a less than optimal medication regimen where perhaps a combination of drugs are being used that augment common side effects, like when an opioid and a benzodiazepine are used together, which there's now an FDA warning against. Less than optimal situations where perhaps there's something preventable, something that could have been prevented. Not every situation, not every adverse drug event is preventable. There could be an allergy or a rash or something like that in somebody that has no prior history or no reason to think that that would happen. I just want to clarify that we're not only talking about medication errors where someone did something wrong or there was something wrong in the process. We're also talking more about the bigger picture of disease management, optimization of therapy, eliminating polypharmacy, and those kinds of things.

How common are ADEs? Just a couple more quick points out of the primary literature here is on the inpatient side one study showed that one third of all hospital-related adverse events were medication-related. The very, what I consider, because it's basically the foundation of all the work that I've been doing for the last eight years around quality is what is a landmark study for me is the Dr. Dan Budnitz, who released this national surveillance of emergency department visits for outpatient adverse drug events. That study from back in 2006 showed that an estimated one million ED visits per year and 125,000 hospital admissions per year could trace back to drug-related issues. One smaller study looked specifically at the time period around transitions of care post a hospital stay, in that incidents two thirds of complications within three weeks of hospital discharge were related to adverse drug events.

Now we move on to a little bit of our own data analysis. One of the benefits that we have in the work that we do is we have access to Medicare fee-for-service claims data. We're able to do claims analysis and even on Medicare Part D data and things like that to take a look at trends and track trends and track improvement in the various arenas that we're working in. Looking at fee-for-service claims data, we looked at high-risk individuals. These are people that are already on multiple medications plus one of the three high-risk drugs that we're here to talk about today, anticoagulant, a diabetes drug, or an opioid. This is done across our five states. Pretty consistently across our QIN about one in 10 people that fit this criteria experienced a possible adverse drug even to one of the three, one of the what we've dubbed "the big three."

How this was identified was looking at ICD-9 and then ICD-10 diagnosis codes. We looked only at where that code was involved in a primary diagnosis. I'm not talking about buried deep down in diagnosis code number 22 there was

something about a bruise or a bleeding in somebody on an anticoagulant. I'm talking about where it was the primary diagnosis, the primary reason why that person had an ED visit or a hospitalization. That's pretty significant.

Then, on the bottom, the 60 percent box, this is actually a study that just came out in December. This is an update to my friend, Dr. Dan Budnitz. He should be paying me, because I advertise his research so much that I'm like a walking billboard for the value of the work that he's done. This is a follow-up to his original research with 2013 and 2014 data. The interesting thing to be taken out of that is that in older adults, and that's the primary focus of our work in Medicare beneficiaries, anticoagulants, diabetes drugs, and opioids were implemented in 60 percent of ED visits for ADEs. Of all the times that people went to the ED for something related to medication, 60 percent of those medication-related events could be traced back to these three groups of drugs. This is 2013/2014 data.

What's notable about this update as opposed to his original research is that in this newer data set the new oral anticoagulant drugs were included. In the original data set those drugs were not out yet so they were not included. In this set they were included. The interesting thing is comparing that 60 percent figure to the 2006 original research, the number really hasn't changed that much. It was like 65-point-something percent back then, about 10, 11 years ago, about 10 years ago, and we're still at 60 percent. It's moved slightly, but not nearly enough. Again, it's the same three drugs that are the top three.

By the way, what's not shown on here, what's also usually number four or number five, is antibiotics. Again, that ties into the whole issue of antibiotic stewardship and how a lot of these initiatives that we're involved in really go hand in hand. They all tie together with care coordination and medication reconciliation. You can't really ... I guess you can, but my opinion is you can be more effective and you can really optimize the impact on the quality that you have by looking at these things more as a big picture, rather than isolated. "Now we're focusing on antibiotics. Now we're focusing on anticoagulants." Well, they're all medications and a lot of the same safety practices you can implement can help multiple areas. Moving on. Whoops. We went one too many. There we go.

Looking just specifically, I know we usually have a lot of home health people on our calls. We have a lot of long-term care and sub-acute people on our calls. I just wanted to point out another government report which looks specifically at skilled nursing stays of 35 days or less. Right in that 30-, 35-day care transitions window that everybody is so concerned about. They looked at serious adverse

events. Those adverse events were categorized. It's a little hard to read. It's in that little colored box in the bottom right is the NCC MERP Index for Medication Errors. This is an index which categorizes adverse events according to their severity by a letter system of letters A through I, A being the least amount or no harm and I being the most severe harm, which is death actually. This is something that's used a lot in the inpatient setting but is also now being applied to some other settings as well.

Using that system, looking at events, 22 percent of people had a serious adverse event. This is something that caused some type of significant or permanent effect to the person's health or quality or condition. Of those, 37 percent of those serious events were medication-related. I've highlighted a couple of those which relate to our discussion today. Falls could also possibly apply to that. Those are the serious things that caused potentially permanent harm.

Then, going one step further, next slide, going one step further into temporary harm, an additional 11 percent experienced a temporary harm. Of those, 43 percent were due to medications. When we run all those numbers together, I'm no statistician but I kind of did the math in my head. What that boils down to is about overall about 15 percent of all events were specifically tied to medication in some way. Again, these are significant things that caused some temporary to a more severe harm. That's definitely something, when you're talking about quality and patient satisfaction and all that, that's definitely something that you want to improve upon. That's what we're here to do. That's what we do.

All of these points that I brought out and some of these points I've tried to make through some of these news articles and studies and things like that, all really tie up very neatly together in this National Action Plan for Adverse Drug Event Prevention. This is a report that was put out about three years ago. It outlines recommendations regarding surveillance, reporting, interventions, future research relative to the three high-risk groups of drugs that we're here to talk about today, anticoagulants, diabetes drugs, and opioids. This report is essentially the reason why the initiative we're talking about right now exists. It's to try and move the needle. All the literature that I've been sharing with you is to try to move the needle on some of these things, particularly in the outpatient setting.

As I said, we've dubbed this project or initiative "The Big 3 of Adverse Drug Events" because it's these three groups of drugs that we always keep coming back to. We really want to engage with practitioners to implement best practices in interventions in the post-acute and outpatient setting to impact quality and safety around these three drugs. Why do I keep saying the post-

acute and the outpatient setting? We're already doing a lot on the inpatient side of things. We've been working in that arena for a while. What used to be called the Hospital Engagement Network is now called the HIINs, the HIINs. Andy, what does that stand for?

Andrew Miller: Hospital Improvement Innovation Network.

Nicole: There you go. He's the expert on the abbreviations. They're providing a lot of support on the inpatient side for some of the things that we've been talking about. We work collaboratively with them to share those learnings across settings. We want to learn from what's already been done on the inpatient side, what's already going on, and then apply those things more broadly. As I said, the outpatient setting and particularly the engagement of the ambulatory and community pharmacies or those that are involved in medication req and resolving medication problems are really the next frontier of that.

What are our goals? Incorporate medication safety surveillance and error prevention into care coordination activities. We talk a lot about care coordination and care transitions. "Care coordination" is the preferred newer term, but a lot of people still say "care transitions" and that's just fine. I would like to point out or propose sort of a new concept. Maybe it's not new. I don't know. Maybe someone else already thought of this and I haven't been paying attention. I would like to propose that every healthcare touch is a care coordination activity. It's not just, "Oh, well, talk to the nurse manager or talk to the care coordinator or talk to the care transitions pharmacist." Every healthcare touch is potentially a care coordination activity and should be treated as such and that opportunity should be taken advantage of.

What else? Develop and promote best practices to reduce adverse drug events associated with the big three, anticoagulants, diabetes agents, and opioids. You'll be saying it in your sleep like I do before you know it. We'll talk just in one minute a little bit more about exactly how we propose to do that and how we'd like to work with all of you to do that. Again, somewhat of a repeat, but engage the community in best practices, prevent problems before the person presents to the ED or the hospital. Again, every healthcare touch is a care coordination activity, because if you're preventing that problem from happening, if you're improving patient experience or quality of life, then you're doing care coordination.

One of the ways that we're going to do that is a toolbox or toolkit of different resources. There's no one fix. There's no one, "Well, if I hand this bit of communication about my patient to x, then that's all I have to do and all the

communications problems will be solved." Unfortunately it doesn't work that way, because healthcare is a continuum through many different settings and sites and through many different disciplines and practitioners. It really has to be a whole multidisciplinary, multifaceted team of or group of interventions or tools that we use together. Some of them can be very large and at the health system level, transitional care management, chronic care management, population health. Some are more down to the one-on-one, like a medication reconciliation or diabetes self-management education or using a particular tool, like a teach-back card or a dosing chart, to make sure that the patient understands what they're supposed to do or the dose of the medication is correct. There's many different facets that can be addressed.

What we're doing is, what I like to do is share a toolkit of resources with everyone that participates in this initiative. We've put together, it's not quite ready yet. We're still putting the finishing touches on it. Put together a toolkit of resources, over 50 pages, screening tools, patient education, and a directory of additional links and other information out there in the public domain that is free of charge. We're a nonprofit organization. Per our contract we cannot promote or advertise any particular pay product or service. But if things are free and in the public domain and readily available then we can. Where there's benefit and value we're happy to do that.

This toolkit, it's a combination of tools, screening tools, charts, things that we've developed here at Quality Insights in response to needs of our participants, but also things that are available through professional organizations and again, as I said, things that are free in the public domain. Even links to other toolkits. There are other organizations out there that have brought many valuable resources into the healthcare community. Medication reconciliation toolkits like the MATCH toolkit or the MARQUIS toolkit. In the home health arena, the Home Health Quality Initiative has a lot of ... They have two toolkits that address medication and things like that. Sometimes it's not a matter of reinventing the wheel, it's just a matter of finding all those wheels and putting them all in one place so that people can access them and utilize them. People that join will get access to that.

I want to just take a brief pause for a moment and do another polling question to ask for all the people that are on the call. The first polling question may be ... I know there were a lot of choices. I think I gave too many choices, because it looked like a lot of people didn't have time to answer, even though we did give 30 seconds. There's only three choices this time, so hopefully everybody will be able to answer. In your practice setting, whatever it is, where is your safety efforts being focused right now? I believe we set it up so that you can pick more

than one choice. Is it anticoagulants, diabetes drugs, or opioids? I probably should have also put "other," so if you were working on antibiotics or other things. Please, by all means. As I said, I think you can pick more than one. We do want to see where people's energy is being focused right now. I don't know. It may take a couple of moments for those answers to come up.

By the way, while we're waiting for those answers to come up, I just wanted to mention that I haven't really specifically mentioned opioid abuse and misuse, but we are working in that space as well. Opioid abuse prevention is a big focus area for us across our QIN as well. It all goes hand in hand. If you're working on general opioid safety to prevent drug interactions, to prevent respiratory depression, to prevent therapeutic duplications, things like that, the practice is you're going to be doing the tools you're going to be using. There's a lot of overlap into the abuse and misuse prevention space, as well. If that's more your focus, then I think you should definitely reach out to us as well, because we have an additional toolkit which has even more things that are in the big three toolkit that are focused specifically on that that you might be interested in.

I'm going to take a look at the poll answers. It looks like still a lot of people didn't answer. I guess people are shy. We'll have to work on that in future calls. Don't be shy. It looks like pretty close on opioids and diabetes. Anticoagulants does have the most answers and the most focus right now. That's good, because it looks like, at least amongst the people that answered, which looks like there's about half of our participants, people are focused in that area already, which is great. Why don't we move on just a bit.

Moving on to the next slide. Also, if you participate with us, I just wanted to share. Dr. Miller shared earlier a screenshot of some of the reports that are available. What's also available through our web portal when you set up that login that he mentioned is access to our educational online learning platform, which is called My Quality Insights or MyQI. There's lots of educational information. We also do post tools and resources on there as well, news, information. But also educational interactive what we call e-Learns, which are online educational programs.

Here's a screenshot of a program that just went live recently on opioid safety, Opioid Knowledge. Another new program that's on there as well, as I understand there's a program on shingles on there. Once you join an initiative, any initiative with us, you do get access to the full list of all the educational programs that are available. That's another thing to take advantage of. What was I going to say? I forgot what I was going to say. I can't remember. I hate

when that happens. I don't know. You got me. Oh yes. CE credits. I knew it was something. That's what happens when you don't write things down.

Those educational programs, by the way, there is CE credit available for nurses. There's CNE credit available. Unfortunately we don't have educational credit available for all disciplines. I know some disciplines can use some discretionary hours, so that might be beneficial to them. I wanted to point that out as well.

Who can participate? As I said, the big three, the three high-risk drug groups initiative is really intended to be pharmacy-driven, where pharmacies and pharmacists really act as the change agents and the drivers of this work, but does not need to be pharmacy-exclusive or specific at all. We really want all post-acute providers to be involved, and particularly because of some of those new evaluation measures and star ratings and other regulations that are coming down the pipe for some other settings like home health agencies, long-term care facilities. ACOs do a lot around optimization of medications and things like that. Physician practices. The work ties into their quality measures that physician practices are looking at around readmissions, things like that. Medication management.

Dialysis is not on this list. It was in one of our polling questions. But, again, that's another arena where they're looking a lot at medications, infection prevention, how they can assist with readmissions, because there's high readmission rate in the dialysis population. There's a lot of opportunity for work in multiple areas that all complement one another.

So, join the Big Three Initiative. You can download a flyer which summarizes what we've been talking about today. We've put a link to it in the chat box, as well. If you want to take a look and get more information. There's also some direct links in there or you can e-mail your state contacts, which we'll get to shortly. We also have a brief questionnaire which is very short. It's four questions. It can be done in less than three minutes. It basically addresses what you're already doing in the areas around these three drugs as far as quality and safety and what areas you're interested in. It helps give us a little bit of an idea of where to focus from here as we get these things off the ground and what gaps we need to fill and what resources we need to bring to the participants, people that are working on this.

Really, when you join, there's no legal forms to sign. An e-mail commitment to myself or one of our project coordinators is all you need to do to get involved. But to stay involved what we really like you to do is to commit to implementing a best practice or intervention targeted to one or more of the big three high-risk

drugs and share what you're currently doing in this arena, because this is a learning action network model of all teach, all learn, where those that are not as far along in the process can learn from those that have already adopted some practices. There can also be learnings both ways.

You don't have to share any patient-specific data or HIPAA-protected information. We just want to be able to, similar to the antibiotic stewardship work that Dr. Miller talked about in the beginning of the call, is just to get a sense of what areas have you made commitments to work on, what tools have you implemented, how many patients are impacted through this intervention or practice, and take it from there. We can, as the Quality Improvement Innovation Network, by virtue of our contract, we are a HIPAA-protected entity, as you could guess, because we have access to Medicare claims data already.

We can do, as part of more specific or more robust interventions with individual sites, claims analysis and other types of analysis where we can look at more identified information if that is something that a site is interested in doing. You don't have to, but it's an option that's available. In the past, over the years, the quality improvement work we've been doing is for about 30 years. I've been personally involved for about eight. I've seen a couple of journal articles, a couple of scientific posters developed as a result of some of the interventions and initiatives that I've been involved in, which is a very nice thing as well.

Moving on to ... Oh, it's not a polling question. It's just a slide. I thought it was a polling question. Join us. Oh, it is a polling question. Please answer the following question. Let us know where you're at. You've already joined the initiative, I want to join the initiative now, I need more info, I'm on the wrong call. You thought this was one of those things where you listen to them talk about condos for an hour and you get a free vacation, but unfortunately you ended up hearing about drug safety instead. Sorry about that. If you are interested, contact your state coordinator. We're going to get the contact information for those people up on the screen and up in the chat momentarily. I just want you to bear with me through one more slide before we get to that.

I'll be keeping one eye out for the results of the poll while I'm talking about the final phase or the final concept to drive this work forward is a multidisciplinary advisory team. These are experts, thought leaders in the field, people with expertise in areas related to the three high-risk drugs. It's pharmacists, physicians, nurses, other practitioners. I don't have on there but it could be administrators too, even beneficiaries. The purpose is to identify the best practices, identify effective interventions and education, and share that with participants to help drive progress in the area. Narrow the focus so it can be a

little bit more effective. It's an informal group. Again, no legal documents to sign. A periodic conference call amongst us and experts, thought leaders, to help identify what's worked, where should we be focusing our efforts, and then sharing that information across not only amongst our participants but also bringing that back to your own area practice and your own niche of practice within your profession.

Believe it or not, I'm done. Now we've got that contact information. Looking at the results of the poll while people are looking, while we're getting that contact information up in the chat, it looks like eight people on the call said they already joined, 15 said they want to join now. Awesome. 21 said they need more information. Great. E-mail us and we'll be happy to help you. Three people, I like these people, "I'm on the wrong call." I'm sorry I don't have that free vacation for you. I'm very sorry. Maybe next time. I'll talk to my contractor at CMS and see what I can do. Just kidding. A lot of people didn't answer. Again, there's always the shy people in the group. That's okay. We're glad to have you on, even if you don't answer the poll questions.

I think if we expose the chat, I just want to see what's going on in the chat so I can make sure. We've got three pages of contact people, three slides of contact people, so we can't show them all on one slide. Right now we have the Pennsylvania slide up, but we're getting all those contact e-mails in the chat. In your state, for example Pennsylvania, we've got four people out in the field. It's a very big state. Reach out to one of them. If necessary, they will put you in contact with the person that's covering the area that you're located in. Don't worry about which one, who I should contact. Just reach out to anyone and they'll be able to help you out.

I see a lot of some things going on in the chat there. At this point we're really just, in the time we have left, we don't open the phone lines because we don't want to worry about noise and all that stuff. We strongly encourage everybody to comment in the chat any questions you have or comments or ideas that you have. If anybody's interested in being involved, either in the advisory team or participant, you can comment that in now.

It looks like Caroline Smith has said, "UDS," I don't know what UDS is, so anybody that knows what that is, maybe a health system in one of our other states or something, "is implementing a ticket-to-home," I like that, "to decrease unnecessary readmissions because we are seeing same things in relation to adverse drug events during transitions in care." One pager. Red flags to look for. New medications. Follow up with a doctor's appointment. This is reviewed with patients. Make sure the follow-up visit is scheduled, lays out high

risk items and does not require a big health literacy from the patients. I really like that. We'd love to get Caroline. We'd love to hear a little bit more about that. United Disability Services. Okay. That was one thing maybe I didn't mention, is some of the social services. People that do so much.

Katie says, "Count me in." Oh, that was private. Sorry. That was supposed to be private. You didn't hear that. That's why I shouldn't be manning the chat. I'm going to leave that to our expert communications specialist to take care of that. At this point, Laurie, my expert communications specialist, do we have any other questions or things that I'm not seeing or things that I'm seeing that I shouldn't be saying?

Laurie Fink: We did get a question. It asks, "I'm a new director of nursing. How do I improve on my quality measures?"

Nicole: I'm not 100 percent sure what quality measures they're referring to. But if they're referring to those 13 measures that make up the composite score that facilities have to look at, as it was mentioned ... You did mention that in the beginning of the call, right, Andy? He's shaking his head yes. We are working with the majority of skilled nursing facilities and long-term care facilities throughout our five states on those 13 things that make up the composite score and quality improvement plans and things in that arena. I would say that just reach out to anyone in your home state and they will put you in contact with the right person that can help you address those matters.

Even if you don't know, sometimes, especially with some of these large organizations, it's very possible sometimes you may be already enrolled in an initiative that we're involved in, but you don't know about it because it's other staff that may have done that enrollment process.

Andrew Miller: Particularly if you're new.

Nicole: Particularly if you're new. By all means, if you reach out, we will help you. Help you as best that we can.

Laurie Fink: Another person is asking, "Doesn't an adverse drug event mean that an error was made by someone?"

Nicole: I think I did mention this in the beginning of the call. The term "adverse drug event" as we're using it in the context of improved quality and improved safety encompasses not only medication errors. On the inpatient side, historically with good reason there's been a tremendous focus on prevention of medication

errors, which is very important. Medications errors, as I said, are really only a subset of the larger constellation of adverse events that can happen. According to the definition that we looked at during the course of this discussion, an unwanted effect through medical use of a drug, things can happen even when no error has taken place. Meaning that a wrong dose was given, or something like that.

It could be a situation where medication therapy is not optimized or there's a disconnect between the dose of insulin and the amount of food intake that a person is having, which could lead to hypoglycemia or something like that. Nothing was necessarily done wrong. However, in looking at the big picture, we perhaps could have made adjustments or optimizations that could have prevented an event from happening. Polypharmacy, therapeutic duplication, use of drugs that have similar side effects, like multiple drugs that cause sedation and things like that, they're not necessarily errors and they're not necessarily wrong. Sometimes there's a therapeutic reason why that needs to be. But they can lead to adverse events.

It's more looking at the big picture of how these kinds of things can be more optimally managed and prevented. In the arena of opioid management, for example, the CDC guidelines for chronic opioid use strongly point out that the literature that's out there shows us that for people above a certain threshold of opioid dosage per day, 50 morphine milligram equivalents, there is a considerably higher risk of respiratory depression or other unwanted side effects from the medications. It doesn't mean the dose is wrong, it just means therapeutically they found the pharmacology of how the drug works that person's at higher risk.

There's screening that we can do to identify those people, give them the appropriate counseling, possibly identify people that are candidates for Naloxone antidotes and train them on how to use it or family members how to use it so that they can have it on hand in the event that respiratory depression does occur. Things like that.

Laurie Fink: We had another question come in. It says, "I'm a pharmacist and I'm involved with my county office's On Aging Advisory Council in New Jersey. How can I become involved with your organization using my appointment to this county organization as a springboard?"

Nicole: I think that that sounds like the kind of person that we definitely want to be involved in our advisory group and advisory team. Just e-mail me. Reach out. New Jersey is my home state, as well. Just e-mail me and we will take it from

there of how we can bring all the knowledge and expertise of everyone in their respective area to this focus.

Andrew Miller: And also involve this pharmacist in our initiatives that are being undertaken in his or her county.

Nicole: Yeah. Absolutely.

Laurie Fink: All right. Another question is, "Do you have an existing program for ambulatory clinics in New Jersey that has a specific toolkit to implement this initiative?"

Nicole: I think the answer to that question is the toolkit that we'll be putting out will have information and resources that can be applied in the ambulatory setting. That's a good place to start. That's a starting board. It may not be the answer to everybody's problem, but hopefully there will be some good information in there. It'll provide some useful tools and resources and possibly be a starting point for the next step or next ideas. Also that's part of the benefit of being part of a collaborative is the group weighs in and says, "Well, we really need a tool on x." Then that's something that the group can develop. I would say the toolkit that we'll be sharing is an excellent place to start. As I said, there are links to other toolkits in there as well. There's toolkits within toolkits. Then let's take it from there, as far as what's needed and where to go.

Laurie Fink: Do we create our own program within our community?

Nicole: Yeah. I think so. I think that the concept and the benefit of a collaborative like this is that you take the information and the resources and you adapt them and apply them as best appropriate to your particular practice setting.

Laurie Fink: Another question asks ... I'm sorry. Go ahead, Nicole.

Nicole: I just see one thing highlighted in the chat. It says, "Would a C. difficile infection after antibiotic treatment be considered an adverse drug event?" It actually is. It's an unwanted effect or an unwanted event from a medication. It is an adverse drug event. As I said, it's something that we're looking at as ties to the antibiotic stewardship angle in the outpatient setting, but the hospitals also look at that in the inpatient setting, and the long-term care arena. We're working with long-term care facilities on C. difficile event reporting.

As I said earlier in the call, that's currently a voluntary initiative. I've seen this happen many times before. We started 10 years ago with care coordination being a voluntary initiative. Lo and behold, it became something that hospitals

got penalized on not long after that. My guess, if I were a betting person, I would bet that at some point this is going to be something that all nursing homes are going to have to report on and look at and possibly even other settings as well. Good to get in on the ground floor. It's three o'clock on my clock. Laurie, did you want to ... Do we have any other questions? We need to wrap it up.

Laurie Fink: I'm noticing just one more question, so I'll read that one to you real quickly and then we'll wrap things up. This question, where is it? Oh, here it is. "Do you have any scorecards created to track the changes you make in your community? How do we project that we met our goal?"

Nicole: There's a couple of ways that that can be done. Possibly using claims data. Looking at adverse drug events or ED visits or readmissions and tracking that over time through Medicare claims data is one way that we can do that. Also, if you're involved in a practice or an intervention, your own data collection and your own tracking can also identify, possibly identify, some of that. Pharmacists, for those that are pharmacists, and that's one thing that we can bring to some of the other disciplines, is pharmacists are very good at capturing all the interventions, recommendations, and activities that they're doing. The hard part is always translating that into hard outcomes and hard dollars, but we're very good at that. Using those two things together I think is a starting point. That's also something that would be the purpose of the group is to identify how can we track and measure improvement.

Laurie Fink: We have run out of time. Thank you so much, everyone, for joining us today. If you're not already participating in Quality Insights Medication Safety Initiative, we hope you will consider joining us in this very important work. As I mentioned earlier, the recording of today's presentation will be posted on both the My Quality Insights Online Learning Platform, and that will be in the Care Coordination and Medication Safety Community, and we will also post it on the Quality Insights website. That will be under the Events tab in the Archived Events. Both of these resources should be posted on both of those sites within the next few days.

As you close out of today's session you will be directed to a very brief evaluation. Please take a minute to provide us with your feedback. With that, I'd like to thank you all again for joining us today. Have a great rest of your day. This now concludes the session. Thank you.