New York: Medication Management Strategies for the High-Risk Patient

Presenter: Maria Strohmeyer, Taconic (NY faculty)

Moderator: Suzie Daly, TMF Health Quality Institute

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Hello everyone. This is Suzie Daly from TMF Health Quality Institute. Welcome to our CPC regional webinar entitled Medication Management Strategies for the High-Risk Patient. Today we're going to start with just a few announcements. Today's program is being recorded and will be posted along with all slides and materials to the Collaboration site. You can additionally download the slides directly from the WebEx environment during the event. Just go to the top toolbar and select file, save as, and then choose documents. We appreciate the presenter's time and effort in preparing for and sharing their valuable knowledge. Any statements regarding their technology, products or vendors are expressions and opinions of the person speaking, and not an opinion of nor endorsement by the Center for Medicare and Medicaid Innovations nor TMF Health Quality Institute nor the host of the program. So just a few attendee instructions. As a reminder, all lines will remain muted throughout the session. To submit questions, click on the Q and A tab on the right-hand side of your screen. Because there is no registration for these events, in order to be tracked as a participant, you must complete the survey at the end of the event. If your Chat box is not visible, you can go to the top right and click on the Chat icon which looks like a bubble. This will open the Chat box on your screen. Additionally, today, our presenter will ask you to respond to a poll. And this will also display on the right-hand side of your screen. Additionally, the presenter may ask you to raise your hand if you would like to verbally ask a question. You can do this by selecting the hand icon in the participant panel. And with that I'd like to now introduce Maria Strohmeyer our facilitator for today's presentation. Maria? Oops Maria, you may be on mute. I can't hear you talking.

Hello, this is Maria Strohmeyer. Can everybody hear me now?

Hey Maria we can hear you.

Yeah sorry about that. Thank you Suzie for the introduction. With me in the New York office today we have Dr. Holly Miller, Kim Barnett, and Sheila Conciatori, part of your New York regional faculty. One more time, your attendance at this webinar is only recorded by completing the survey once you exit. So please be sure to do that. So before we get started, in the past we used to show this driver diagram. And we thought it might be an important thing to bring it back to focus. The main revision with the driver diagram this year as opposed to last year is the very outer pale pink ring that indicates Environment to Support Comprehensive Primary Care. That's the new layer for this particular year. For this particular session, we are focusing again where the red arrow is pointed on planned care for chronic conditions and preventative care.

Maria, this is Jeff. Let me interrupt just a minute. I'm not sure the computer you're controlling is the right one that has the ball in front of it. We're only seeing the first slide. So do I need to pass the ball to another one of your teammates, Kim or Sheila?

Okay we will pass the ball to Sheila. Hang on. Sorry about that. Okay.

Alright now we're in slide four.

Can everybody see the primary driver change package document now?

Yes we can see slide four now.

Okay. Okay back to, let me back up a slide so you can see what we're speaking about. We originally started out with the driver diagram, and I was orientating you to that. The newest change is the outer like pink ring where in 2015 the focus in on the Environment to Support CPC. Today we're looking at the Planned Care for Chronic Conditions and Preventative Care. And the next document, which all of you should have seen at this point, it's also located on the collaborative drive. And the point is is that all of you should be taking a look, besides your implementation guide, to look at this primary driver, the change tactics and concepts for 2015. So today we're looking at managing medications to maximize efficiency, effectiveness and safety. And in the red bracket on the right you're seeing that we're going to be covering all of those change tactics. One thing to think about is while we're moving through this presentation, if there are any other key change tactics that would drive improvement in this area that you can think of, please go ahead and add them to the Chat and we can review them at the end during the Q and A. So, although this slide is a reflection of Milestone 2, and it's a reiteration around the deliverables for Milestone 2 this year, we want to take a minute here to really emphasize that implementing advanced care management strategies such as medication management is really an opportunity for you to improve not only the quality of care for all your patients, but to really make an impact on your practice utilization. So the purpose of this webinar is to move beyond just thinking about medication management as a population-based strategy that you may have implemented in the past or you may be considering adding to your implementation this year around behavior, or around population-based care. But to learn about some of the techniques and tools developed by our guest speaker, Dara Becker, our pharmacist today that will support you doing during your transitions of care activities. And this will also hopefully impact your utilization. So you've heard on many occasions that 30-day readmits occur primarily around medication errors or adverse events. And you really want to think about every time a patient transitions from one care entity to another or to home, you want to perform medication verification or medication reconciliation during their follow-up visit and focus not only on the high-risk patients, but also on the fairly stable patients that may be taking complex medications such as blood thinners or those patients who are taking medications with a complex adverse event profile, or those medications that the patient may have took regularly at home, such as like Colace or Zantac that were then stopped when they were hospitalized. Or sometimes during their hospitalization we find that the route has changed. They're put on IV administration, and then when they're discharged home, they're not necessarily placed back on the PO regimen. So just to reiterate, remember that medication management can also impact the quality of care, transitions of care, and

ultimately utilization. So at this time, we have a poll question that should be appearing to the right of your screen. And we're asking for yes/no here. The question is, has a patient or patients in your practice experienced some medication-related adverse events in the last three years? So take a minute to go ahead and answer that. And while you're answering that, I have some statistics some of you probably have heard from the National Transition of Care Coalition. Their article in September 2010 indicated that on discharge from the hospital, approximately 30 percent of patients have at least one medication discrepancy. And one in five patients discharged to their home from hospitals experience an adverse event within three weeks of their discharge. Approximately 60 percent were medication-related errors or adverse events that could have been avoided. We'll give you a few more seconds here to answer. I think that's it. Has everybody had a chance to answer? We'll then move on. There we go. So it looks like more of you almost, more of you have had a medication-related adverse event in the past three years with one or more of your patients. And that's in line with the information we see in reports. The reason we asked this question in this manner was we felt that this might be a [inaudible], so I'm glad that you took the time to answer this, you know, anonymously. That we do see that this is an area that should be covered more than once within this project. Here we go. So for today, the shared learnings are reviewing medication management change concepts, which we did by looking at the secondary driver and primary drivers. Understand how to implement optimal medication management to hopefully reduce occurrence of adverse events and decrease your utilization. And then hear from a New York regional pharmacist on how to manage medications to maximize efficiency and effectiveness with your high-risk patients. And then look at some of the tools she's developed that should help you even if you can't implement a pharmacist around Milestone 2 and Milestone 6 transitions of care. So without further ado, let me introduce our two panelists from Phelps Memorial Hospital Center located in Sleepy Hollow. We have Judy Sapione, who is the RN QI Manager, and Dara Becker, who is the pharmacist. They're comprised of four practice sites with approximately 13 providers, and their EHR is eClinicalWorks. At this time we're going to speak to Judy to get us started on our panel discussion. Judy's going to give us kind of a foundation on why the practice chose medication management and how they implemented their pharmacist. So Judy.

[Overlapped Speaking]

Why medication management as opposed to the self-management or behavior health?

Well as you had just said, studies have identified increased rates and adverse drug events and medication errors due to lack of understanding and duplication of medications. And because medication reconciliation is one of the nation's national patient safety goals and that medications need to be reconciled at each level of care as a patient transitions through the system. And medication management, it'll increase patient safety and adherence to medications will decrease the hospital readmissions and ER utilization. And then of course also we assessed our patient population, and we, you know, looked at what would, what they really needed and looking at the high-risk patients and their medication regimens and the discharges from the hospital, we felt that this was an area we needed to focus on.

So can you tell me a little bit about how you went about hiring your pharmacists?

Sure when we were looking for a pharmacist, we, you know, were looking for a clinical pharmacist that had both inpatient and community pharmacy experience. And experience with patient counseling and education regarding medication management. So we were really looking for someone that was really truly a clinical pharmacist and really enjoyed working one-on-one with patients and working that could really work with the health care team and the care management team.

And then can you talk a little bit about the development of your role-based workflow process for medication management? How did you integrate your pharmacist into the practice?

Well really we had, we worked on the process a bit so that we could smooth it out. First, we worked with her and identified our high-risk and our very high-risk patients. We reviewed their medication lists, identifying potential drug interactions, duplication, medication, effectiveness and overall safety. And we reviewed the disease processes and their multiple comorbidities and looking at their lab values and their vital signs and the effects that the medications had or didn't have with regard, you know, to their lab values, if it was helping the patient overall. And also interaction with the healthcare team, the providers and the MAs, because you know, sometimes patients will tell more to the MA when they go right into the provider's office. You know, everything is perfect when they see the doctor, but the true story comes out with the person they feel most comfortable with. So it's a truly an integration of the whole health care team and the care management team, and referrals from the team and availability at the sites. We found it important that Dara physically be in each site. She does spend a day in each site. And she was recently, we had her hours increased from part-time from three days a week to full-time. This way she has more flexibility and has more time to schedule one-on-one appointments as opposed to telephone appointments so that there's more patient face-to-face interactions.

That's great. And do you find that the patients are more amenable to meeting with the pharmacist independently?

Yes they are. In fact they kind of enjoy meeting with her. So now she knows to make her appointments even longer. I mean it's nothing for a patient to spend an hour with her. Sometimes even longer. And then of course there's the follow-ups. And they really do enjoy sitting down with her.

That's great.

You know and over, you know and patient — physician buy-in didn't happen overnight. I mean it was something that once they saw the benefit of having the pharmacist there, the buy-in was there. The referrals have increased from the provider.

Very good. At this point I think we're going to include Dara Becker now into the conversation. And she's going to give us her perspective on how she became part of the care team and how she serves not only the high-risk but all of the patients. So welcome Dara. Thank you for taking this opportunity to share some of your knowledge with us and some of the tools which we'll see a little bit later. So tell me, how are the high-risk patients being referred to you? And how do you communicate with the care team about the patients? Do the doctors primarily send you the referrals or the care manager?

Hi Maria. Thank you. This is really a pleasure to be a part of this. Looking at the high-risk patients and how they're referred to me, it's a little bit of both. I do round with our care management team each week at two of our sites. And at that point we do have the provider's involvement. We print out a list of the patients that are coming in for the week. And we discuss with the providers about the patients and if there's any medication involvement. And that's of course where I come in, and I'll contact the patient, schedule a time over the phone or if the patient can come in and see me physically. And of course I remind them to bring in their medications for review. I also communicate with our clinical inpatient hospital pharmacist. She actually provides counseling to discharge patients about medications. And I have access to her list of those patients. And I will then look to see if they're coming into the office or through one of our PMA clinics. And I'll follow up with them. And also I'll identify the patients in our EMR eCW, because they're list as high risk, medium risk, very high risk or low risk. And a little bit more involvement each week with just our team, the care management team so we can discuss who we've talked to. And also communication with the providers. It can be through email or through our eCW system. We have a communication tool called the jelly bean where they can send us messages about patients they think that could be needing my needs or any one of our care management team, our patient care navigator and our nurse case manager as well. And we do have a shared spreadsheet with our care management team of who we've talked to, our goals for that patient, follow-up period, et cetera. And patients may also self-refer. We do have medication management brochures at each practice site for community involvement. And I also have, you know, my own communication, you know, number so the patients can get in contact with me. And there may be, actually a majority of the time I do see who's coming into the practice sites that day and ask the patients to visit with me. I of course talk to the provider about my recommendations, and it's been very well received.

Great. How are your patients' periodic medication reconciliation being performed? And does this happen for all of the patients in the practice or just the high-risk ones?

So it would be all patients that medication reconciliation is being performed for. Medications are being reviewed by the providers at the appointments. And when I do see them for a pharmacy visit, I will update the medication list as well. I'll also provide them with a list, a printed list of their updated medication lists. And if I schedule ahead of time for the patient, I'll of course ask them to bring in their medications. And if it's a new patient and it's very, we're working on this, but it's stressed that patients do bring in their medications to each visit with the provider. Especially like I said, if it's a new patient. And more often than not I have seen patients come in with their own medication list that they carry in their purse or their wallet, and that makes it easier. And it's great. It's good.

Very good. So is medication reconciliation being performed by the provider after each patient transition of care? Or by the care manager? And how do you get involved in that?

Great. I think it's a little bit of both through our care management team. They review.

[Overlapped Speaking]

As the patient's discharged from the hospital, our care manager follows up with them within the 48 hours. And she reviews their medications with them. She sees if there is any new medication that

they're on. If there was a change in dosage. If they understand what they're taking, why they're taking it. If they have any side effects from it or any other complaints, anything that's out of the ordinary that they didn't have before taking this medication. And then again, you know, we meet, you know, they speak to each other every day, the care management team. And they're referred back and forth. And then Dara will pick the patient up from there if there's any, you know, further teaching, updating the medication list. We'll see the patient when the patient follows up with their post-discharge appointment with the physician. And we're also, like she said, like Dara said, she's working with the inpatient pharmacist so that we can bridge the gaps and get in touch with the patients, you know, a lot sooner. And we're also working, you know, with the inpatient side and care management team. Like we're working on a AVE [phonetic] project, sponsored through IPRO. So this way we kind of are closing the gaps.

Yep.

So I wanted to ask you, for those, so say you're in a practice that maybe doesn't have a pharmacist, and they're working on a transition of care. And would, how do pharmacists feel about say a provider or even a care manager at a primary care physician's office calling the pharmacist from the hospital? Would they be open to calls like that if there were questions around medication?

Maria, I definitely think that would be open. Patient care and anything that we can do to benefit the patient's health is our utmost priority. And you know, everybody I've worked with is very open to that, and I haven't come into any negative experiences. It's been very good.

Well that's good to know. So that was kind of one of the barriers I was thinking of. But I don't know if you can elaborate on any other barriers to integrating the pharmacist as part of the care team.

Okay, great. We might, Judy briefly said earlier, really building that provider relationship and the provider buy-in, I think what I have physically done at each practice site, reviewing the medications with the patient there, with the provider, and offering recommendations, that new workflow they see the outcome of that. And it's been very positive. Oh sure. And there's, you know, I've found that there's been a lot of success with that. I've changed some medication regimens for COPD. There has been a patient that I modified one of their diabetes medications, and they have not gone to the ER at all when they have been I think for the past six months. So that decrease in ER utilization there. And just adjusting different medications maybe from one class to another to reduce an adverse side effect or an adverse drug event. A lot of that has been very positive from the provider. And yes, it is a change in the practice workflow. It was a little challenging at first. But I think just putting myself forward and offering what I had to present, of course it's always for the patient that really became successful.

Right, it really sounds like you're providing a lot of value. And I think that a lot of practices would probably really like to have an individual as part of their care team like this. Can you also talk about, you conduct periodic structured medication reviews and maybe for some of the audience you might want to define what a structured medication review is versus medication verification or reconciliation.

Okay. Yes. I do each time I perform a telephone encounter with a patient or a visit with a patient I have a structure of how I perform this medication review. And I've done a lot of research, mainly through American Pharmacists Association on their learning website they have a tab for MTM, or medication therapy management. So I developed my tools simply from there. I looked to see what would be, you know, a golden rule. Just so I had a structure and an appropriate work flow. I also used a lot of resources from Pharmacist Letter. And there is one that looks at medication. I think it's medication-related events, you know, so I'm not missing is the drug dose too low? Is it too high, for example. Or is this an appropriate dose. Are there any side effects? Is this an indication for this certain disease state? Is the medication not there? So there's a lot that I work with with the patient. I review their non-prescription medication, herbal dietary supplements, looking for drug interactions. I ask them how they're taking their medications during the day. So that involves do they use a weekly medication box? Are they taking the medications directly out of the pill vials? Do they have help at home? Are they okay with managing their medications independently? So I try to incorporate a lot of questions so I develop my own story as if I was there with the patient helping them with their medications at home. And then I also look for, there's what I call a medication action plan. So I, at that point I update the medication lists. If there's any changes that I see may be appropriate or discontinuing a medication, I always run that past as a recommendation to the provider just as kind of a verification if I was to do that as a pharmacist. And I always have a follow-up period with the patient where I reassess their goals, anything that I provided counseling, education on, maybe even as simply as are you taking this medication before breakfast. Because it's more effective at that time. So there's a lot of really nitty-gritty things that I look for. But I'm always am following back with that patient. They're okay.

And I think this question you asked about the action plan you mentioned. But the medication, structured medication, is that documented within the EHR? Or right now is all that captured by paper tools and then shared with the care team?

Okay, yeah. I actually what I do is it's all entered as in template into our EMR. And I look under, I think I label it as one, two, three, four as bullet points. And my third is the medication action plan or that medication goal. So from whatever is there I usually put that into our shared Excel file with our care management team. So maybe they have, they, you know, they need assistance at home or help with a new insurance application. Or they need further education about wound care at home. Or if they need home health aids. So that maybe I would gauge that from my, you know appointment with the patient. But then that of course would go to one of our care management, either the patient care navigator or our nurse case manager. But that's always going to be documented in that medication action planning and going on to our shared Excel file.

Well that's good. It's good to hear that you're utilizing your EHR to capture that data and then sharing it too with the care management. Do you provide collaborative drug therapy management for selected conditions or medications?

At this time, no. But I've been doing a lot of research into that. And you know, hopefully in the future we can develop something like that with a provider. Of course they have their own laws designated for that. I've been researching that as well, and so I'm just being very hopeful about it. It would be great.

Yeah. How about when you think about support for self-management strategies that involve medications or for developing shared decision aids that highlight medication choices. Do the providers pull you into that or even the care managers if they're the ones sharing the tool?

I mean we don't have many developed at this time. I know we're working.

We're working on developing two more in the very near future. In fact that's at our steering committee meeting, that'll be one of the topics. And smoking cessation happens to be one of them. And hypertension we're also looking at. And so we are looking to develop them. One for diabetes. But you know, of course with our multidisciplinary team bringing the physicians into that.

I see, so then at that point, if say patients, you know, have a shared decision aid, and they're not quite sure, you know, the pros and cons for certain medications, then you would pull Dara in to discuss the Chantix or whatever it is.

Yeah definitely.

Exactly.

That’s neat. And can you share with us now some of the tools you've created that may be useful for other practices participating today, because in looking at your tools, I think they are generalizable enough for practices to implement even if they don't have a pharmacist on board. So I know you have these four to look at. So I will bring them up one-by-one if you want to cover those one at a time.

Great. Thank you Maria.

So the first one we have is, oh let's see. I think we want to see letter, cover letter to the patients.

Great. This was developed for our care management team. And you know, it's structured this way. We can change it according to the patient that we're sending it to. But for my purposes as a pharmacist, this may go out if I'm not able to get their medication lists during our appointment. And you know, I stress here too you know, please bring any of your medication lists back to your next provider. All of your provider appointments. Or even keep it with you. Also, I may sometimes send education materials, maybe about Coumadin for example and diet. And I'll of course document that in our EMR. But this is just a way to pleasantly present, you know, the following information that is in the letter.

So is this letter given to patients that are referred to you after you have had a discussion with them? Or patients you haven't yet reached out to?

This would just be right now just referrals or patients that I see for the day. Yeah.

I see. Okay. The other tool we have is the, I guess we can look at this worksheet for medication review.

Yep. I took this from Pharmacists Letter and really, this is just a guideline for me to make sure I'm, you know, mindful enough looking at everything clinically. So you see all the way to the left this looks at medication-related problems. So for example, is a medication ineffective? Meaning, is the dose too low.

Is the frequency of dosing inadequate? Is there a drug interaction that's reducing the drug's effect, et cetera? So it really acts as just an extra bolt for me to look at the patient's drug regimen.

Very good. Okay. The next tool is I guess medication management process steps.

Yeah. Like I said earlier, this is related to that question about structured medication review. So this is what I use to document in eCW with, you know, you have the one, two, three, four. I assess the patient's medication-related needs. So that includes their understanding of the medication, maybe there's some lab work that I look at. So I'll include here vital signs. Anything else that's relevant. And then the second bullet point identifying the patient's medicated-related problems. So looking then each medication individually for appropriateness, effectiveness, safety and also adherence of medication. Is the patient taking the medication every day? Are there reasons why they're not? So that's where I would evaluate that. And then three, bullet point number three, if you scroll down is where that medication action plan comes into place. So looking at that goal for the patient, any interventions that maybe have come by working with the provider, updating that medication list and if there's a scheduled follow-up appointment, maybe they're getting their I&R checked in a couple weeks, so I want to make sure I write that down. And I'll put that into my, our shared Excel file for the care management team. So I'll go back to that patient and follow up with them. And then the follow-up I usually just, as a note, just remember there that I'm going to be continuing to follow that patient and that, you know, their case isn't closed yet with me. And all of this from the American Pharmacist Association looking at their medication therapy management tools. They have a wide, you know, range, they have great, great tools there. It's very, very, very, very helpful.

So maybe at the end of the webinar we can post these to the collaborative site along with the link to that particular website if it's helpful.

I could send that link out. Absolutely.

Okay. And then finally I think we're, we have this, the medication list table.

Right. So this sometimes, you know, in our EMR we do have a current medication list that does print. But other times I'd like to write this out for patients maybe so they further understand what the medication is used for. In that comments field all the way to the right, maybe I'll add, remember to take a half an hour before breakfast or don't take this medication with calcium or iron because it reduces the drug's effectiveness. So this is, what I do here is I fill this out. I handwrite it, and then I'll scan this into the patient's chart. And in the note, in the EMR that I write I just reference, okay, this is in medication lists under the Rx file from this day visit. So then we have it documented and we can go back to it if anything else comes up in the future regarding this.

So this is primarily a tool to be given to the patients so they have all the information, one nice little table for themselves.

Right.

Okay. Very good. Now we're going to go back to the slide deck to answer a few more questions. Let's see.

Maria, it should be labeled New York regional.

Oh sorry. Let's see. There we go. I'm sorry about that. Okay. So, the next question we have is, besides your tools, if a practice can't engage a pharmacist, what would you say is the most important action a practice could take to prevent medication-related adverse events?

Well sure, absolutely. Medication reconciliation, if there's a nurse case manager on the team or involving more thoroughly medical assistance that is important, very, very important. And like I said with the care management education, if there's a nurse case manager available, they can provide education, counseling, looking at doses, et cetera as well.

Collaborating with the care manager.

Right, right.

Is kind of almost doing a double take for all those patients. And then even on one of the tools I noticed that you could actually, a care manager could actually pull out some of those headings to implement into her own care plan as well if say there wasn't a pharmacist on board.

Right.

Okay. Okay, so we have one more poll. This is an interactive poll question. So you want to use your annotation tool to the left top. And just simply click yes or no. Are any of you planning to implement medication management as a secondary advanced care management strategy for Milestone 2, or simply just to beef it up for managing all your patients in to impact utilization? Jeff, do we have the annotation tool available?

I think I turned it on. Let me just double-check. Yes it is turned on.

Okay.

They may need to click on the highlight or symbol to open up the annotation tools to find the arrow.

There we go. We're starting to see it now. So those of you who are answering yes, does anybody want to share if your plan is really to implement it as a second population-based strategy? Or just from what you've learned today or in other action groups if you feel that you need to really beef up your medication management oversights to prevent adverse events or re-hospitalizations? If you just want to raise your hand, and we can unmute your line. Or you can also type your question in the Chat, and we can read it out loud if you don't want to speak. Looks like somebody entered a Q and A. So we have a question that we can open up. It's directed to Dara. Do you chart medication management through your CCMR since you have eCW or through structured data in the process note? And how do you track this?

Sure, right now we're not using CCMR.

[Overlapped Speaking]

We're developing, and we're working towards that. Right now in eCW I'm on a virtual, if it's a telephone encounter, I use a virtual visit under telephone encounter. Or if it's an actual visit, I'm documenting under the plan and under treatment. And I have a tool where I've, it's just a, I think it's under the notes tool where I just indicate that I perform medication reconciliation. And then that's where I perform that structured medication review template.

And we have another question from the same individual. How do the providers feel when you suggest a change in the medication? How do they react to you? Are they open to it, or?

The majority of the time they're open to it. And of course, I always present the reasons for why I'm making that medication change. And you know, they'll discuss with the patient. And it could be that day when the recommendation is made, or, you know, within a couple of days. So yes, it's very well received.

Okay. So at this time, we're going to open up the lines to any and all questions. Again, feel free to raise your hand or type in the Q and A or the Chat. And we can, this would be either for Dara with regard to medications or processes or her role as a pharmacist. Or even to Judy with regard to the workflows or how the care manager interfaces with the pharmacist. I'll give you a few minutes to type that. We've got about 15 minutes left in the webinar. We will make those tools available, and we thank Dara for sharing those tools with us and the website. So I think it might behoove many of you out there that really don't have the resources or the funds to have an embedded pharmacist within your practice, especially if you're solo to go on that website and see if there are any tools that might be helpful to you that you could implement or integrate into any of your workflows, be that the provider or maybe the care manager or the nurse [inaudible]. You know, just general questions around medication management that may ultimately, you know, impact a future adverse event or, you know, unneeded hospitalization. I'm not sure, those of you who have clicked on the questions and comments, if you either Orlando or Kathy, if you wanted to go ahead and raise your hand, and we can unmute you.

I think I raised my hand. Am I connected?

We can hear you Kathy. Go ahead.

Okay. I just wanted to comment on, thank you for this medication management because to tell you the truth, I was, we were a little, kind of, you know we didn't really know how to handle. We do medication reconciliation and, you know, and we actually do medication management. But we didn't, this actually made it clear to us how to do it. Like those tools are great. And you know, and if we do need to report it on Milestone, second, the second thing on Milestone 2, this would really, this opens up the possibility of going and choosing medication management. And you know, her presentation was wonderful. I just wanted to comment on that.

Thank you Kathy. Yes Sarah it was. And I know that when I had seen the tools you used when we were at a site visit, it was easy to see how those tools could be accessible to practices that don't have access to a

pharmacist or even how to implement the pharmacist or contact a pharmacist at a hospital. So this was very helpful.

[Overlapped Speaking]

I don't know if Orlando has a question or. Okay, if that is all the questions and answers, we want to just take a minute again to thank both our presenters today, Dara and Judy. If you have any other questions after this webinar that you wish to contact them, please contact your New York regional faculty, and we can relay that information to them. We will post those tools as well as the link that Dara spoke to on the collaborative site for your reference later on. And at this time we have a couple of important announcements, so I'm glad we're finishing a tad early. Just to give you an update, there's going to be a CPC audit. Approximately 21 practices within this region as well as nationally and the other regions will undergo an audit between March and July of this year. If you are chosen to participate in the audit, you will receive a letter from Bland and Associates, which is a firm that they contracted with, CMS. And that letter will give you additional information on the audit process including how to complete an online training module, and the online training module is how you will communicate the audit requirements. So if you are chosen and you receive a letter, you must comply with all aspects of this request. But CMS has respectfully requested that the regional faculty not really interfere with the audit process. Therefore, if you have communications or queries, you have to direct them to the auditors, not necessarily to the New York region. If you receive a letter, technically we can't step in and help you prepare you. We can just direct you to who you should be communicating with. So again, it will be 21 practices within this region. Not everybody, if you don't get a letter, that means most likely you haven't been chosen. So this is just a heads up for you to be aware that this is a, something that may be coming down the pike. In addition, AHRQ is offering a shared decision management training to faculty and anybody in the practices using a SHARE approach. It's a one day train the trainer course with five modules, and the cost is free. Right now it is being held in Denver in June. However, and there's limitations around attendance there. However we were informed from CMS at a recent meeting that there may be the same training program offered within this region. It may be in New Jersey or the New York area. So, but it might not be until later summer or this fall. So if you're interested, this is something to look out for. Regional learning faculty will be sending out a survey in the next week or so to identify how many practices would be interested in attending this, not only if it was in Denver but also here in the New York region. And we're fairly confident it might, there will be a training in this region. Because I think there'll be enough folks interested in this. So look out for that survey. And then for the general announcements, again the next regional webinar is March 23 from noon until one, and it's going to be addressing barriers to the implementation of effective care management. We're going to have three or four care managers as our panelists from various sites practices. Tomorrow night from 6 to 7:30 is the medical leadership. In addition we have the national webinars, continuity of care, tracking for quality, that's March 25, noon, Eastern Standard Time. And then action groups again, all of you should be participating in at least one of these. They will be kicking off in April and June for Milestone 2. And in May will be for Milestones 3, 4, 6 and 7. And there's just a little note about the requirements. And then Affinity Groups March 12, those of you who have GE Centricity, that will be held from 2 to 3. Then also you want to, as mentioned in the beginning of this webinar, continue to read the 2015 Curriculum guide,

Implementation of Reporting Summary. Also review the annual report. We want to encourage you to use the forum to share any of your tools or questions, suggestions, get feedback and CPC sharing with the other practices for both the action groups and the Affinity Groups. Again, if you have any questions and you need to contact us directly, I know you've seen this. So at this point I am going to turn it over back to Suzie for some final announcements before we exit today.

Great, thanks so much Maria. And thank you all for attending. Just as a note, we began using a new evaluation tool on December 1 of last year. As you complete the evaluation of this session, please indicate the practice you are representing. If you happen to have multiple attendees gathered together today, and are from more than one CPC practice ID, please contact your regional learning faculty and let them know the names of the attendees and which practice ID they are from. CPC is a practice-based initiative, and we would like to capture practice-level participation and feedback. And with that, we'll go ahead and close. I hope you have a great afternoon. Take care.

Thank you. Bye, bye everyone.