Continuing Education

Continuing education will be offered for this program for compliance, health care executives and nursing.

Full attendance and completion of the online evaluation and attestation of attendance are required to receive CEs for this webinar. CEs are complimentary and available for the registrant only.

Faculty

BJ Bartleson, RN, MS, NEA-BC, is the vice president of nursing and clinical services, providing leadership in developing, communicating and implementing CHA policy related to nursing, emergency services, trauma and medication safety. She is recognized statewide and nationally as a nurse leader with more than 30 years of experience as an administrator, educator, researcher, clinician, manager and expert in multiple areas of acute patient care management and nursing practice.
Faculty

Rita Shane, PharmD, FASHP, FCSHP is the Chief Pharmacy Officer and Professor of Medicine at Cedars-Sinai Medical Center, an 886-bed acute, tertiary care, teaching institution in Los Angeles and Assistant Dean, Clinical Pharmacy Services, at the University of California, San Francisco, School of Pharmacy. She is responsible for over 350 staff members. Dr. Shane’s research and legislative efforts led to tech check tech in California and Senate Bill 1254 requiring high-risk patients to have medication lists obtained by pharmacy staff. She has published 100 papers and given over 200 presentations nationally and internationally.

Faculty

Sarah Stephens, PharmD, BCPS, CPPS is the Medication Safety Coordinator for Kaweah Delta Health Care District in Visalia, California. The majority of Dr. Stephens’ career has focused in acute care adult internal medicine. Current initiatives and research interests include reducing medication errors in the areas of anticoagulation and pain management, improving transitions of care with an emphasis on discharge medication reconciliation, and evaluating safety culture. Dr. Stephens is a member of the California Hospital Association Medication Safety Committee and is a Director-at-Large for ASHP’s Section of Inpatient Care Practitioners.
**Faculty**

Sarah A. Bajorek, PharmD, BCACP, is the Pharmacy Supervisor for Transitions of Care and Medication Reconciliation at UC Davis Health and an Assistant Clinical Professor with UC San Francisco’s School of Pharmacy. At UC Davis, she leads the Transitions of Care and Medication Reconciliation team, which consists of pharmacy technicians and pharmacists completing best possible medication histories (BPMH) and medication reconciliation for high risk patients.

**Faculty**

Mithu Molla is a Health Sciences Clinical Professor of Medicine at UC Davis School of Medicine and currently serves as Section Chief for Hospital Medicine at UC Davis Medical Center. He is involved in numerous hospital quality initiatives, hospital operations, and practice management, including medication management and medication reconciliation.
Special Thank You

~ Rita Shane, Chief Pharmacy Officer and Professor of Medicine, Cedars-Sinai Medical Center
~ Senator Jeff Stone, PharmD and his office, special thanks to Brittny Garcin
~ CHA Medication Safety Committee
~ Daniel Kudo, PharmD, FCSHP, APh, Associate Professor, Keck Graduate Institute
~ Joseph Sky, MD, FACC Lt Col, Chief of Cardiology, David Grant Medical Center, United States Air Force, Travis Air Force Base
~ Hattie Hanley, MPP, Right Care Project Director
~ Sarah Bajorek, PharmD, Pharmacy Supervisor for Transitions of Care and Medication Reconciliation, UC Davis Health
~ Mithu Molla, MD, MBA, Section Chief for Hospital Medicine at UC Davis Health
~ Cedars-Sinai Medical Center
~ CSHP

Agenda

• SB 1254 History and Legislation
• Regulatory Requirements
• Hospital Case Studies
• FAQs
Objectives

1. Cite evidence related to errors on medication lists for high-risk patients
2. Review SB 1254 requirements
3. Describe processes for training pharmacy staff to obtain an accurate medication list
4. Describe quality assurance processes to ensure staff competency

Supportive Evidence

- Up to 70% of patients have errors on their medication lists when they are admitted to hospitals\(^1\)
- Only 5.3% of patients 65 years and older on 5+ medications have accurate lists\(^2\)
- If not corrected, discrepancies/errors continue during an inpatient admission and at discharge
  - Study of high-risk patients identified eight errors per admission med list\(^3\)
  - These errors resulted in an average of three errors per patient when they were hospitalized\(^3\)
- One-third of inpatient orders have errors and 85% of medication errors originate from the medication history\(^4\)
- If the medication lists are not accurate, the inpatient orders will be inaccurate

\(^1\) Up to 70% of patients have errors on their medication lists when they are admitted to hospitals
\(^2\) Only 5.3% of patients 65 years and older on 5+ medications have accurate lists
\(^3\) Study of high-risk patients identified eight errors per admission med list
\(^4\) One-third of inpatient orders have errors and 85% of medication errors originate from the medication history
Supportive Evidence (cont.)

Pharmacists have the highest level of knowledge about medications

- Recent study demonstrated increased accuracy of medication lists obtained by pharmacy staff vs. usual care\(^5\)
- Pharmacists and technicians reduced medication history-related errors by over 80%\(^5\)

Shouldn’t responsibility for ensuring the accuracy of the medication list be owned by the pharmacy team?

Up to 70% of Medication Lists Contain Errors

Leveraging pharmacy staff prevents harm and increases clinician time for patient care functions.

⚠️ Problem

- 20% of admissions are medication-related\(^1\)
- High risk patients have 8 errors on admission medication lists\(^2\)
- Only 5.3% of patients 65 year or older on ≥5 medications have accurate lists\(^3\)
- One third of inpatient orders have errors and 85% originate from the medication history\(^4\)
- Up to 59% of errors can cause harm\(^5\)
- Up to 80% of patients have at least 1 medication error at discharge\(^6\)

✅ Solution

On admission, studies demonstrate increased accuracy of medication lists obtained by pharmacy staff vs. usual care
- Accuracy rates: Nurses, 20%; Hospitalists, 50%; Technicians, 100%\(^7\)
- Nurses 14% vs. pharmacy technicians 94% (p<0.0001)\(^8\)

At discharge, pharmacists identified errors in medication lists in 49% of patients and problems in an additional 16% vs usual care\(^9\)
Up to 70% of Medication Lists Contain Errors (cont.)

Business Case

$ Cost of Harm
- Cost of adverse drug event (ADE): $2,262 - $5,7907,10-13
- Increased length of stay due to ADE: 3.1 days13
- Cost/readmission ~ $12,300 - 13,80014

Benefits
- 75% reduction in ADEs7
- 41 minutes of nursing time saved/patient16
- Cost-effective to utilize technicians for medication histories; $830,0007
- Patients have an accurate medication list upon discharge
- Reduced readmissions
- Enables clinicians to practice at the highest level of their license and training

Recommendation: For high-risk patients, pharmacy will ensure the accuracy of the medication list at admission

References in Appendix 2

New Legislation

New section added to California Business and Professions Code, 107.1 establishes pharmacist’s responsibility in acute care hospitals for obtaining an accurate list of the patient’s current medications on admission, or promptly thereafter.

In hospitals, the pharmacist is responsible for obtaining an accurate medication profile for high risk patients upon admission.
- This function can be completed by technicians and interns who have successfully completed training and proctoring by pharmacists and where a quality assurance program is used to monitor competency
- Passed into law September 22, 2018
- Enforced January 1, 2019

Case Studies

- Kaweah Delta
- UC Davis
- Cedars-Sinai Medical Center

Doing the Right Thing
Medication Histories and SB 1254

Sarah Stephens, PharmD, BCPS, CPPS
Medication Safety Coordinator
Kaweah Delta Health Care District
Objectives

- Describe key considerations before implementing a transitions of care program in an underserved area
- Identify at least one strategy that can be utilized to gain funding, support, and ensure success with meeting SB 1254 requirements

Kaweah Delta Demographics

- 581-bed academic regional medical center (400 acute care beds)
- Level 3 trauma center
- Serving over 454,000 in Tulare County
Support for The Cause

- Use data and focus on patient safety
- Tell a story; use your own examples
- Utilize published materials
- Public Hospital Redesign and Incentives in Medi-Cal Program (PRIME)
- And now we have – regulatory umph!
  - Staff “buy-in” vs. Executive “buy-in” and support for FTE

Clinical Model Considerations

**Discharge Advocates**
- Determine which patients are high-risk for readmission using approved tool
- Assist with discharge planning
- Perform follow-up phone calls after discharge

**Patient Care Pharmacy Technician**
- Collects and enters highly accurate home medication lists on high-risk patients identified by the Discharge Advocates
- Enrolls patients in KD Outpatient Pharmacy Meds to Bed service

**Transitions of Care (TOC) Clinical Pharmacist**
- Reviews medication lists on admission and discharge for patients identified as high risk by discharge advocates
- Daily chart review for optimal inpatient treatment to shorten hospitalizations
- Direct patient education on high-risk* discharge medications

*High risk medications = anticoagulants, insulin, digoxin, narcotics, antiplatelet agents, transplant medication, home chemotherapy agents
Defining the Patient Population

• Evaluate published, validated tools (e.g., LACE)
• Consider EHR capability to automate process
• Track outcomes such as:
  • Total numbers of patients
  • Time to complete medication histories
  • Number of discrepancies identified (consider impact, high alert medications, harm or its potential)
• Phased unit rollout

The Ultimate Goal is a Best Possible Medication History for ALL Patients

Training and Competency (Pharmacy Technicians and Interns)

• Utilize available literature to design approach
  - MARQUIS manual
  - AJHP. 2014;71:1567-74
• Didactic and simulation strategies
• Direct and indirect observations
Pharmacist-Specific Duties

- Inpatient Clinician
- Outpatient Clinician
- Transitions of Care Clinician

Medication History and Reconciliation Optimization

Sarah A. Bajorek, PharmD, BCACP
Pharmacy Supervisor, UC Davis Health
Assistant Clinical Professor, UCSF School of Pharmacy

Mithu Molla, MD, MBA, FACP
Health Science Clinical Professor of Medicine, UCD School of Medicine
Section Chief, Hospital Medicine, UCD Medical Center
UC Davis Medical Center

• 627-bed academic medical center
• Level 1 trauma center
• Magnet recognized

Outline

• Background
  - Timeline
  - Medical reconciliation (med rec) policy updates
• Results
• ROI and Resources
• Workflow
  - High risk criteria definition
  - Timeframe to complete med history
  - Screening whole hospital
  - Interviewing patients
  - Documentation
Timeline

- TOC Med Management Workgroup established
- Grant funded TOC Med Hx techs start
- MARQUIS* intervention begins
- TOC Med Hx workflow expands to 6 hospital units
- MED Rec Policy approved
- TOC Med Hx techs permanently funded
- MARQUIS intervention ends
- Hospital-wide TOC Med Hx workflow expansion

*MARQUIS – Multi-site Medication Reconciliation Quality Improvement Study

Medication Reconciliation Policy

- Previous policy restricted updating medication list to providers and pharmacists
- A clear need to:
  - Allow more disciplines the ability to update the EMR medication list
  - Clearly define roles and responsibilities
- Challenges:
  - Initially met resistance when requesting to expand non-provider roles
  - Overcame resistance through one-on-one meetings to address concerns without the risk of “group-think”
- Responsibilities expanded to five disciplines
### Expanded Roles and Responsibilities

|expanded role | medication reconciliation | assist with medication administration | obtain and document dose | update list based on patient's medication history | provide medication list to patient’s caregivers in person or via EMR |
|---------------|---------------------------|---------------------------------------|--------------------------|-----------------------------------------------|-----------------------------------------------------------------
| Pharmacist    | ✓                         | ✓                                     | ✓                        | ✓                                             | ✓                                                                |
| Pharmacy Technicians | ✓                   | ✓                                     | ✓                        | ✓                                             | ✓                                                                |
| Nurses with Specialized Training | ✓ | ✓                                     | ✓                        | ✓                                             | ✓                                                                |
| Nursing       | ✓                         | ✓                                     | ✓                        | ✓                                             | ✓                                                                |
| Respiratory Therapy | ✓ | ✓                                     | ✓                        | ✓                                             | ✓                                                                |
| Medical Assistants – PCP | ✓ | ✓                                     | ✓                        | ✓                                             | ✓                                                                |
| Medical Assistants – Nurse | ✓ | ✓                                     | ✓                        | ✓                                             | ✓                                                                |
| Hospital Administrators | ✓ | ✓                                     | ✓                        | ✓                                             | ✓                                                                |

### Results – Discrepancies

- **Baseline** – average five clinically significant discrepancies per patient
- **Intervention patients**
  - Less than one discrepancy per patient
  - **64% relative reduction** in discrepancies compared to control
  - **89% accuracy in medication list** compared to 52% for control
Results - Length of Stay and Costs

<table>
<thead>
<tr>
<th></th>
<th>FY 2018 Current State</th>
<th>FY 2019 Sustainment (without sustainment)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Med Rec Pharmacy</td>
<td>2 Techs (Career FTE)</td>
<td>2 Techs</td>
</tr>
<tr>
<td></td>
<td>4 Techs (Grant Funded)</td>
<td></td>
</tr>
<tr>
<td>Tech FTEs Requested</td>
<td>-</td>
<td>4 Techs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Errors avoided</td>
<td>350</td>
<td>400</td>
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<tr>
<td></td>
<td></td>
<td>136</td>
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<tr>
<td>Annual savings as a result of avoided harmful medication errors</td>
<td>$1,500,000</td>
<td>$1,800,000</td>
</tr>
<tr>
<td>Total cost of staff + RX Refill software</td>
<td>$600,000</td>
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<tr>
<td>Net Savings</td>
<td>$900,000</td>
<td>$1,200,000</td>
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<tr>
<td></td>
<td></td>
<td>$250,000</td>
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</table>

Financial Justification

**Request**
- 4 Pharmacy Techs
- RX Refill Software

**Expense**
$600,000

**Net Savings**
$1,200,000
Resources

- Decentralized Transitions of Care Medical History Team
  - Seven (7) pharmacy technicians
  - Three (3) pharmacists
- Available seven (7) days a week from 0800-1630
- Pharmacy residents and students on clinical rotations on weekdays

Training

- Medication history and reconciliation online competency
- New TOC Med Hx Technician Training
  - New tech shadows current techs for 2-3 days
  - Current tech shadows new tech for 2-3 days
  - Medication history checklist signed off prior to seeing patients independently
  - Pharmacist reviews medication histories for accuracy
- Pharmacy Residents and Interns
  - 10-hour orientation and training with current tech
  - Clinical pharmacist preceptor reviews medication histories for accuracy
**High-Risk Criteria**

Age > 65, at least two of the following:
- Unable to provide medication list or medication bottles
- ≥ 10 prior to admission meds
- ≥ 2 high-risk medications*
- High health care utilization**

*Anticoagulants, antiplatelets, opioids, insulin, oral hypoglycemic, anti-psychotic or anti-epileptic, antiretrovirals, drugs requiring therapeutic drug monitoring
** > 2 ED visits or hospitalizations within the past 6 months

---

**Multidisciplinary Approach**

High-Risk Patients
- Pharmacy Technicians
- Pharmacy Interns
- Pharmacy Residents
- Pharmacists

Low-Risk Patients
- Nurses
- Mid-levels
- Physicians
- Pharmacy as needed
Communication Between Pharmacy Staff and Providers

- Goals
  - Prevent duplication of work
  - Make it easier for provider to understand issues pertaining to PTA meds
- Patient list column where pharmacy staff add name, contact info, follow-up items
- Standardized smart phrases to communicate information regarding admission medication histories

Med Rec Acuity Score

- Quick way to identify if a patient meets high-risk criteria
- Legend
  - One point assigned to all categories
  - Exception – inpatient orders = 0.1 point
- Code

<table>
<thead>
<tr>
<th>Color</th>
<th>Score</th>
<th>“Risk”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Green</td>
<td>0-1.9</td>
<td>Low</td>
</tr>
<tr>
<td>Yellow</td>
<td>2-3.9</td>
<td>Moderate</td>
</tr>
<tr>
<td>Red</td>
<td>≥4</td>
<td>High</td>
</tr>
</tbody>
</table>
Best Possible Medication History (BPMH) Workflow

- MARQUIS best practice
- Hospital-wide initiative
- Improved patient interviewing technique
  - Obtain complete information regarding prescriptions (i.e. name, strength, dose, route, frequency) using open-ended and probing questions
  - Distinguish between what patients are actually taking vs. what they are prescribed
- Complete within 48 hours of admission of admission for high-risk patients

High-risk Documentation – BPMH Note

- Document contact information for sources
- Document patient/caregiver’s understanding of medications
- Document issues regarding access, adherence, etc.

Medication List:

- **Cephalaxin (C-DOSO) 12.5 mg Tablet**
  - Sig: Take 12.5 mg 2 times daily with meals
  - Note: 12/28/2019 DISCONTINUED; 12/28 mg by mouth BD; REPORTED: 12.5 mg by mouth BD (patient reported 12/28 mg BD)

- **Celecoxib 150 mg tablet**
  - Sig: Take 150 mg twice daily

- **Prexige 100 mg ER Capsule**
  - Sig: Take 100 mg once daily at bedtime

- **Facility Administered Medications: None**
High-Risk Documentation – BPMH Note

Current Encounter
BPMH note files to H&P

Previous Encounters
BPMH note filter in Chart Review

Low-Risk Documentation – Pharmacy Navigator

1. Document Informants
2. Select “Pharmacy Complete” in Med List Status
3. Select “Mark as Reviewed”
Med List Status

Available options

Example

Pharmacy Fill History Software

- Ability to see prescription information without need to contact pharmacy
- Great resource for overnight admissions, obtunded patients
- Limitations: Veteran’s Affairs, Kaiser Permanente
From Legislation to Implementation

Rita Shane, PharmD, FASHP, FCSHP
Chief Pharmacy Officer and Professor of Medicine, Cedars-Sinai Medical Center
Assistant Dean, Clinical Pharmacy Services, UCSF School of Pharmacy

Cedars-Sinai Medical Center
Non-profit, acute, level 1 trauma, tertiary academic teaching community hospital

- 886 licensed beds
- Decentralized clinical pharmacy services
- Drug utilization policy services
- Transitions of care
- Emergency department
- Operating room services
- Outpatient services
- Outpatient cancer centers (2)
- Solid organ transplant services
- Residency program (six PGY-1, four PGY-2)
- Over 150 pharmacists
- 200+ pharmacy technicians
**Priority 1 medication histories to be done within 24 hours**

- 10 or more non PRN PTA medications (chronic meds)
- Acute transplant episode (hospitalization where the organ transplant occurs)
- BPA fires for patients who meet the high risk criteria. If you have urgent patient care issues then you can “Dismiss” the alert for 4 hours.

**Acknowledge reason to satisfy BPA:**
- Patient does not meet criteria due to valid reasons (e.g. errors on the PTA med list, hospice)
- Unable to assess - Staff deem that the medication history cannot be obtained during the patient’s entire encounter
  - Document reason (e.g. cognitive impairment/no family)

**Timeline**

- Goal is to obtain a complete medication list **within the first 24 hours** upon admission
- In some circumstances, **up to 72 hours** may be needed to obtain a medication list:
  - Medically unstable
  - Cognitive impairment
  - Family and/or caregivers are unavailable or otherwise unable to obtain additional details
- If a medication list cannot be obtained, the list will be documented as “unable to assess”
- Inpatient hospice patients and observation patients are excluded
Technology

- Clinical Decision Support
- Best Practice Alerts
  - Flag ‘high-risk’ patients in need of medication histories
- List of High-Risk patients
  - Populates based on BPA
  - Facilitates prioritization of medication histories in the ED and throughout the hospital

Satisfying the BPA Alert: My List View of the “Med Hx”

Upon completion of the medication history, check “Mark patient as reviewed” to satisfy the BPA
• Prescription Fill History
  - Previous 3 months of dispenses

**Medication Dispense History (from 10/10/2018 to 3/12/2017)**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dispensed</th>
<th>Days Supply</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allopurinol 100 mg tabs</td>
<td>12/03/2018</td>
<td>90</td>
<td>90 bottle</td>
</tr>
<tr>
<td>Amiodarone HCl</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alloprim 2.5 mg tabs</td>
<td>12/02/2018</td>
<td>30</td>
<td>60 bottle</td>
</tr>
<tr>
<td>Eliquis 2.5 mg tabs</td>
<td>11/12/2018</td>
<td>30</td>
<td>60 bottle</td>
</tr>
<tr>
<td>Eliquis 2.5 mg tabs</td>
<td>10/13/2018</td>
<td>30</td>
<td>60 bottle</td>
</tr>
</tbody>
</table>

**Technology (cont.)**

Optimize use of Pharmacy Technicians
- Positioned in the ED to capture medication histories before admission orders are written
- Performed time and motions studies to determine opportunities to improve efficiency
- Expanding technician workforce through reallocation of a vacant pharmacist FTE to three technicians to support inpatient medication histories

Leverage Residents
- Pharmacy residents transitions of care longitudinal year long experience
  - Three hours per week dedicated to transitions of care activities, including medication histories in the Emergency Department, high-volume inpatient units, and post-discharge follow up calls
Implement layer learning model (LLM) - Pharmacy Interns
• Emphasis on value of patient interactions as part of the learning experience on rotation
• Increased rotation offerings for next academic year

Pharmacist’s role and benefits
• Accurate medication histories reduce number of calls to physicians to clarify/charge orders during admission
• Established minimum requirements for medication histories

Training materials for technicians and student interns:
• Training manual
• Competency test
• Technician: Initial training includes proctoring (~Two weeks)
• Student interns: students observe 2 histories being taken and are proctored for at least 2 histories
• Training checklist signoff
• TOC clinical handouts and periodic in-services by student interns (LLM)
Training Checklist - New Technicians

- Managing the PTA med list in the EHR - Adding, modifying, deleting and discontinuing medications
- Customer service - Interviewing patients
- Calling retail pharmacies
- Calling caregivers and family
- Adding notes to the list
- Sending faxes and cover forms
- Interpreter Services
- HIPAA compliance

Training Technicians and Interns

Competency Exam
- Written exam
- Requires 90% to pass
- Contents
  - Top 200 medications including brand/generic names
  - Common indications
  - Basics of medication histories
All Pharmacy Staff Get Proctored

Evaluation of the following:

- Patient interaction
  - Establishing rapport
  - Active listening
  - Addressing patient needs
  - Communication

- Medication History
  - Gathering complete information
  - Medication literacy and adherence stratification
  - Documentation
  - Note and handoff

New pharmacists are trained on EHR basics, customer service skills, and proctored medication histories

Quality Assurance of Technicians/Interns

- Quality assurance is performed at least semi-annually for pharmacy technicians and interns involved in obtaining medication lists
- Observation of a complete medication history performed by the transitions of care pharmacists for minimum of two cases
- SharePoint to document proctoring and areas of improvement for next TOC pharmacist to focus on
Panel Discussion

- How did the CHA Med Safety Committee initially react to your recommendations for pharmacy to “own” medication histories?
- How did you shift your approach to get buy-in from this committee?
- Accrediting bodies, such as TJC, have attempted to hold hospitals accountable for quality around med rec without much success; how is this approach different?
- Do you think SB 1254 will result in meaningful, long-term change? How?
- What are the next steps?

Next Steps: Demonstrating Impact of SB 1254

Proposal: Multicenter California Quality Improvement Project
What: Collect institutional data on drug-related problems and potential harm prevented identified as a result of SB 1254
Who: Pharmacy residents, Class of 2019-20
Methodology:
- Document DRPs and severity (low capacity for harm, serious, life-threatening)
- Physician independent evaluation of severity at each site
- Duration: 6 weeks during Jan-March 2020 timeframe
- Resources: IRB Quality Improvement Template, Project Toolkit
- Planning conference calls
Deliverables:
- Impact of SB 1254 on preventing harm at each site
- Statewide impact on preventing harm and estimated cost savings based on aggregate project results
Questions

Online questions:
Type your question in the Q & A box, press enter

Phone questions:
To ask a question, press *1

Thank You

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Upcoming Programs

Hospital Compliance Seminar
February 7, Sacramento
February 20, Costa Mesa

Penalties for compliance violations are escalating, legal definitions continue to shift, scrutiny around substance abuse-related issues has increased, and many gray areas in the law expose hospitals to risk. Stay ahead of the curve and learn where trends are leading this complicated area of the law.

Register at calhospital.org/hospital-compliance

Upcoming Programs (cont.)

Transforming to Value-Based Care: Strategies for Hospital Success
February 25-26, Pasadena

Moving from traditional fee-for-service payment to value-based reimbursement means a change in status quo – and a need to redesign care delivery. Hosted by the CHA's Center for Post-Acute Care, this conference provides expert advice and strategies to develop and thrive with acute and post-acute partnerships.

Register at calhospital.org/value-based-care
Thank You and Evaluation

Thank you for participating in today’s webinar. An online evaluation will be sent to you shortly.

For education questions, contact Jaime Welcher at (916) 552-7527 or jwelcher@calhospital.org.