Medication Reconciliation:
why it matters to you, why it matters to your patients

Opening Remarks
Medication Reconciliation

Processes and Technology Interfaces
Overview

- Med Rec as Patient Safety Best Practice
- A Primer on Medication Reconciliation
- Local Solutions
- Technology Opportunities
- Challenges in Implementing Technology Solutions
Transition Points & Patient Safety

Errors of Omission

Dosing Errors

Duplication
Types of Medication Errors

- Failure to prescribe clinically important home medications in hospital
- Incorrect doses or dosage forms
- Missed or duplicated doses resulting from inaccurate medical records
- Failure to clearly specify which home medications should be resumed or discontinues at home after hospital discharge
- Duplicate therapy at discharge (due to hospital formulary substitutions)
MedRec as Patient Safety Best Practice

} **Safer Healthcare Now!** identifies medication reconciliation as a safety priority.

} The WHO **High 5s** Projects has identified it as one of their five Standard Operating Protocol initiatives.

} Institute for Safe Medication Practices (ISMP) Canada has lead both the **Safer Healthcare Now!** and the **High 5s SOP initiatives**
Accreditation Canada defined and grouped Required Organizational Practices that address high priority areas identified as central to quality and safety.

Communication Category Goal
- Improve the effectiveness and coordination of communication among care and service providers and with the recipients of care and service across the continuum

An ROP must be in place for an organization to meet accreditation requirements.

ROPs are measured against tests for compliance
Medication Reconciliation as a ROP

A Leadership Priority

At Admission
- Ambulatory Care Services
- For Emergency Department Standards
- For Acute Care Services
- For Community-Based Services

At Transfer or Discharge
- Ambulatory Care Services
- For Acute Care Services.
- For Community-Based Services
- For teams using Long Term Care Services and Residential Homes for Seniors.
A Primer on MedRec Processes

Fun
with Dick and Jane

CATHEDRAL BASIC READERS
Definition: Reconcile

1: to restore to friendship or harmony; settle, resolve

2: to make consistent or congruous

3: to cause to submit to or accept something unpleasant

4: to check (a financial account) against another for accuracy; to account for
### Balancing the Medication Cheque Book

<table>
<thead>
<tr>
<th></th>
<th>Credit</th>
<th>Debit</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance Forward</td>
<td></td>
<td></td>
<td>$350.00</td>
</tr>
<tr>
<td>Allowance</td>
<td></td>
<td>200.00</td>
<td>550.00</td>
</tr>
<tr>
<td>School Supplies</td>
<td></td>
<td>-150.00</td>
<td>400.00</td>
</tr>
<tr>
<td>Interest</td>
<td>0.03</td>
<td></td>
<td>400.03</td>
</tr>
<tr>
<td>Closing Balance</td>
<td></td>
<td></td>
<td>$400.03</td>
</tr>
</tbody>
</table>

### Medication Reconciliation

<table>
<thead>
<tr>
<th></th>
<th>Add Rx</th>
<th>D/C Rx</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medications at Discharge last visit</td>
<td></td>
<td>amoxicillin 500 mg tid</td>
</tr>
<tr>
<td>CHF</td>
<td>furosemide 40 mg daily</td>
<td>amoxicillin 500 mg tid furosemide 40 mg daily</td>
</tr>
<tr>
<td>Rash – allergy</td>
<td></td>
<td>amoxicillin furosemide 40 mg daily</td>
</tr>
<tr>
<td>Non-prescribed</td>
<td>ibuprofen 300 mg prn</td>
<td>furosemide 40 mg daily ibuprofen 300 mg prn</td>
</tr>
<tr>
<td>Adjust dose at Discharge</td>
<td>Change furosemide to bid</td>
<td></td>
</tr>
</tbody>
</table>
Who Should be Involved?

- Interdisciplinary healthcare professionals
  - Prescribers
  - Nurses
  - Pharmacists
  - Pharmacy technicians

- Patients and family/caregivers

- Roles and responsibilities depend on model

- Practice Models may differ
  - Hospital to hospital
  - Team to team
Definition: Medication Reconciliation

Structured process in which healthcare professionals partner with clients, families and caregivers for accurate and complete transfer of medication information at transitions of care (Accreditation Canada)

To prevent adverse medication events and in doing so, eliminate harm to patients.
MedRec at Transition Points

Admission: Collated, Verified, Data Information, Actioned
Transfer: Collated, Verified, Data Information, Actioned
Discharge: Collated, Verified, Data Information, Actioned
Proactive MedRec: Admission

Best Possible Medication History
- Patient’s List
- DPIN
- Medication Containers
- Interview

Care Plan
- Current Problems
- Chronic Problems

Reconciliation
- Continue
- Modify
- Add
- Discontinue
- HOLD
Retroactive MedRec: Admission

- Care Plan
  - Current Problems
  - Chronic Problems

- Admission Medication Orders
  - Best Possible Medication History
    - Patient’s List
    - DPIN
    - Medication Containers
    - Interview

- Reconciliation
  - Continue
  - Modify
  - Add
  - Discontinue
  - HOLD

Adjusted Admission Medication Orders
Best Possible Medication History (BPMH)

} Essential foundation of the process

} Inputs

  ◦ Insurance database view / printout
  ◦ Medication summary/ counseling cards
  ◦ Medication containers
  ◦ Patient / family interview
  ◦ Discharge summary (Med Rec) from previous visit
# It's Safe to Ask About Your Medications

**Vous pouvez poser des questions au sujet de vos médicaments**

Share your medication list with your doctor, nurse and pharmacist. Carry this card with you at all times!

Communiquez votre liste de médicaments à votre médecin, votre infirmière et votre pharmacien. Ayez cette carte avec vous en tout temps!

---

**Name/Nom:**

---

**Manitoba Health Registration #: N° d'immatriculation Santé Manitoba:**

---

**Personal Health ID #: N° d'identification personnelle**

(9 numbers/chiffres):

---

**Medical Plan #: Autre nom et N° d'assurance santé**

(e.g. Blue Cross):

---

**Family Doctor's Name/Nom du médecin de famille:**

---

**Phone/N° de téléphone:**

---

**Emergency Contact/Nom contact en cas d'urgence:**

---

**Phone/N° de téléphone:**

---

**Pharmacy Name/Nom de pharmacie:**

---

**Medical History/Antécédents médicaux:**

- [ ] diabetes/diabète
- [ ] high blood pressure/haute pression
- [ ] heart disease/maladie de cœur
- [ ] breathing problems/problèmes respiratoires
- [ ] other medical problems (list below)/autres problèmes médicaux (veuillez préciser)

---

**My allergies or bad reactions to medications:**

Allergies ou réactions indésirables aux médicaments:

---

---

**LIST ALL MEDICATIONS THAT YOU TAKE. INCLUDE HERBAL MEDICINE AND VITAMINS.**

**INDIQUEZ TOUS LES MÉDICAMENTS QUE VOUS PRENEZ, Y COMPRIS LES PLANTES MÉDICINALES ET LES VITAMINES.**

Update your list by crossing out old medications and adding new ones! Mettez votre liste à jour en rayant les vieux médicaments et en ajoutant les nouveaux!

<table>
<thead>
<tr>
<th>Medication name</th>
<th>Strength</th>
<th>How much</th>
<th>How often</th>
<th>Date/Date</th>
<th>Reason for taking</th>
<th>Who prescribed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex: My drug</td>
<td>20 mg</td>
<td>1 tablet</td>
<td>2 times a day</td>
<td>May 1, 2008</td>
<td>blood pressure</td>
<td>Dr. Doe</td>
</tr>
<tr>
<td>Ex: mon médicament</td>
<td>20 mg</td>
<td>1 comprimé</td>
<td>2 fois par jour</td>
<td>1er mai 2008</td>
<td>haute pression</td>
<td>Dr. Tremblay</td>
</tr>
</tbody>
</table>

If you have questions call your pharmacist, or, The Manitoba Information Line for Everyone (474-6493). Si vous avez des questions, téléphonez votre pharmacien ou la ligne d’information publique en composant le 474-6493.
Factors contributing to successful BPMH
- Experienced history taker
- Subject matter expert
- Timeliness in process
- Available Resource
- Purposeful “independent redundancies”
MedRec: Admission

 Outputs

  ◦ BPMH
  ◦ Reconciliation documentation
  ◦ Active medication list = prescriptions
MedRec at Transfer

Transfers documented in Policy
- Between Services
- Between Physicians
- Between levels of care
- Between Facilities

Not just incremental linkage between Admission and Discharge
- Significant vulnerability for “errors of omission”
MedRec: Transfer

Best Possible Medication List
- BPMH
- Home Med List
- Active Orders/MAR

Treatment Plan
- Current Problems
- Chronic Problems

Reconciliation
- Continue
- Modify
- Add
- Discontinue
- Resume

Transfer Medication Orders
MedRec: Discharge

- Preparation for Discharge from Facility
  - To Community
  - To LTC

- Utilize BPMH and Reconciliation documentation

- Evaluate Discharge prescription requirements in the context of the “home medication” list

- Communication Patient / family
  - Primary Care Provider
  - Community Pharmacist
  - Retained on chart
MedRec: Discharge

- Best Possible Medication List
  - BPMH
  - Home Med List
  - Active Orders/MAR

- Treatment Plan
  - Current Problems
  - Chronic Problems

- Reconciliation
  - Continue
  - Modify
  - Add
  - Discontinue
  - Resume

- Discharge Medication Orders
Benefits to Patients

- Reduced adverse drug events
- Enhanced communication at Discharge
  - Patient / family
  - Primary care provider / community pharmacy
- Reinforcement to actively maintain their own up-to-date medication list
Benefits to the Health Care System

- Improved patient medication safety
- Enhanced communication at transitions of care
- Reduced costs associated with discrepancies and adverse drug events
- Reduced workload and rework in medication management
Local Processes include:

- Paper-based medication reconciliation and order form for admission

- Web-based application for Transfer and Discharge
  - Discharge prescription report

- Electronic patient record (EPR) / Report for Discharge reconciliation and prescription
Admission Reconciliation and Order Form

Paper based medication reconciliation at Admission

Forms used as Admission prescription at most acute care sites

Similar forms used in Community Care, LTC, PCH.
Web-based Application for Transfer & Discharge

Sources from the WRHA pharmacy databases

Online reconciliation of current orders prior to report generation for discharge prescription
Web-based MedRec application provides an electronic MedRec DISCHARGE order form

Demographics print on the form including:
- Address
- PHIN#
- Allergies

Scheduled and PRN medications at time of discharge are printed off
EPR Report for Discharge Reconciliation & Rx

SBGH

Sources from electronic patient record.

Exact orders that are in the current inpatient record.

Manual reconciliation once printed.
Risk Assessment Tools

Patient Risk Assessment Tool
For Best Possible Medication History (BPMH)
This form is designed to facilitate reconciliation of home medications upon admission to the hospice. It is to be completed on all patients admitted to the program.

Patient Risk Assessment Tool (check all applicable boxes)

<table>
<thead>
<tr>
<th>Age</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 44</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>45 - 79</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Greater than or equal to 80</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Number of Medications Prior to Admission

<table>
<thead>
<tr>
<th>0 - 4</th>
<th>4</th>
<th>5 - 10</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Was there a barrier to obtaining a history (e.g., language, confusion, deceased LoS)?

Yes | 2 | No | 0 |

High Risk Medications Prior to Admission

<table>
<thead>
<tr>
<th>Anticoagulant</th>
<th>3</th>
<th>Warfarin, low molecular weight heparin (e.g., enoxaparin, dalteparin), not N/A</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If the reason for admission is clearly drug-related (e.g., drug toxicity, non-compliance, polypharmacy)?

Yes | 1 | No | 0 |

Total Score

Referral to Pharmacist recommended/required?

Yes | 2 | No | 0 |

Reason for referral:

Name of physician (responsible completing form):

Time completed: _______ | Time completed: _______

Printed Name: ___________________________ | Signature and Classification: ___________________________
**Winnipeg Regional Health Authority**  
**Medication Reconciliation - Current Status and Spreadplan 2011-2012**

<table>
<thead>
<tr>
<th>ACUTE CARE</th>
<th>CURRENT STATUS</th>
<th>Summer 2011</th>
<th>Fall 2011</th>
<th>Winter 2011</th>
<th>Spring 2012</th>
<th>Summer 2012</th>
<th>Fall 2012</th>
<th>Winter 2012</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental Health</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admission</td>
<td>HSC, SEH, VGH, GGH</td>
<td></td>
<td></td>
<td>SOGH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfer/Discharge</td>
<td>HSC, SEH, VGH, GGH</td>
<td></td>
<td></td>
<td>SOGH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Note: Includes both adult and pediatric patients.  
Note: Manual discharge form for GGH. |

| **Oncology**        |                |             |           |             |             |             |           |             |       |
| Admission           | HSC            |             |           |             |             |             |           |             |       |
| Transfer/Discharge  | HSC            |             |           |             |             |             |           |             |       |
| Note: Includes inpatient D&BMT. |

| **Palliative Care** |                |             |           |             |             |             |           |             |       |
| Admission           | SBH, RHC       |             |           |             |             |             |           |             |       |
| Transfer/Discharge  | SBH, RHC       |             |           |             |             |             |           |             |       |

| **Rehabilitation / Geriatrics** |                |             |           |             |             |             |           |             |       |
| Admission           | DLC, RHC, SBH |             |           | HSC         | SOGH        |             |           |             |       |
| Transfer/Discharge  | DLC, RHC, SBH |             |           | RHC         | SBH, HSC    | DLC         | SOGH      |             |       |
| Includes Acquired Brain Injury. |

| **Surgery**         |                |             |           |             |             |             |           |             |       |
| Admission           | MHC, VGH, HSC, GGH |             |           | SBH, SOGH, CH |             |             |           |             |       |
| Transfer/Discharge  | HSC, VGH       |             |           | MHC, GGH    | SBH, SOGH   | VGH, GGH    | MHC, CH   |             | VGH trial of post-op transfer form.  
HSC trial of discharge form for rad oncology & ortho surgery patients. |

| **Women's Health**  |                |             |           |             |             |             |           |             |       |
| Admission           | HSC, SBH       |             |           |             |             |             |           |             |       |
| Transfer/Discharge  | HSC, SBH       |             |           |             |             |             |           |             |       |

---

This document was compiled by Patient Safety and is based on current knowledge and data extracted from Quality and Accreditation documents.
Is it time to rest?

Sorry. Not yet.
Existing Shortfalls

- **DPIN as an Input Source**
  - Insurance adjudication
  - **Eligible** prescriptions that have been dispensed
  - Not updated for discontinued

- **Admission Reconciliation and Order Form: EPR**
  - used as a worksheet
  - Efficiencies as an order form lost with CPOE
  - Proactive -> Retrospective
Existing Shortfalls

Web-based Transfer/ Discharge application
- Source: Cerner or Centricity pharmacy database
  - Degree of separation from orders “source of truth”
- Customized reporting to provide desired output
  - Specialized application functionality must be understood
  - Susceptible to changes in the pharmacy database

EPR
- No online reconciliation prior to discharge prescription *
- Manual updating of discharge prescription required
- Co-ordinated updates required with inventory and formulary changes
Future Technology Opportunities

} Jurisdictional (MB) Drug Information System (DIS)
• Improve the input source for BPMH/ Admission

} EPR with CPOE
• Improve order source for Transfer and Discharge
• Foundation for electronic reconciliation
• Enhance availability of medication list from previous visit

} Electronic reconciliation within EPR
• Admission, Transfer, Discharge
• Include Home Medications in electronic documentation

} Data Mining
• Selection of High Risk Patients for Med Rec
Jurisdictional (MB) Drug Information System (DIS)

- (Provincial) prescription repository
- Prescriptions added by all prescribers. Discontinuations and Holds recorded.
- Rx retrieved by retail pharmacies; dispensing and pickup information recorded against the prescription
- Foundation for ePrescribing from electronic medical records (EMR) [electronic charts in primary care provider’s office]

- Improved currency of information
Jurisdictional DIS

Drug Information System

EMR

New Discontinue Hold Allergies

Patient

Dispensing Pickup Allergies

Retail Pharmacy

Drug database
Electronic reconciliation within EPR

- Integrated Orders Reconciliation module
  - Documentation of “home” meds
  - Online reconciliation
    - Continue, New, Change,
  - Define flags to remind clinicians as per policy
  - Integrate reconciliation with Discharge Summary documentation
Reconciliation Documentation in EPR

<table>
<thead>
<tr>
<th>Medication Class</th>
<th>Medication</th>
<th>Status</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>macrolide derivatives</strong></td>
<td>erythromycin</td>
<td>Active Historical Order</td>
<td>Replaced with erythromycin</td>
</tr>
<tr>
<td></td>
<td>Tablet</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>250 mg By Mouth Every 6 hours (Q6H)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>penicillins (1/1 reconciled)</td>
<td>penicillin V</td>
<td>Active Historical Order</td>
<td>Held and Reconciled</td>
</tr>
<tr>
<td></td>
<td>Tablet</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>300 mg By Mouth Four times a day (QID)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>cardiovascular agents</td>
<td>captopril</td>
<td>Active Historical Order</td>
<td>Replaced with captopril</td>
</tr>
<tr>
<td></td>
<td>Tablet</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6.25 mg By Mouth Every 8 hours (Q8H)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>angiotensin converting enzyme inhibitors (2/2 reconciled)</td>
<td>captopril</td>
<td>Active Historical Order</td>
<td>Held and Reconciled</td>
</tr>
<tr>
<td></td>
<td>Tablet</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>12.5 mg By Mouth Every 8 hours (Q8H)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>central nervous system agents</td>
<td>naproxen Rectal</td>
<td>Active Historical Order</td>
<td>Therapeutic Substitute</td>
</tr>
<tr>
<td></td>
<td>Suppository</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>500 mg Rectally Two times a day (BID) PRN Pain</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Admission
Reconciliation Documentation in EPR

Discharge
Other Solutions: eDocuments
Other Solutions: Pharmacy Applications

- Reporting from Pharmacy system
  - Access to reporting outside pharmacy hours

- Reconciliation within the Pharmacy system
  - Consider impact of segregating to a specific discipline
  - Resource implications
  - Opening up access to pharmacy system
Considerations with Technology Implementations

} PATIENT SAFETY FIRST

- Don’t be fooled that technology reduces all errors
- Technology can create new errors / error types
- HIT errors have a high potential to harm

} Clinical Solutions require Clinician involvement

- Understanding the needs
- Defining solution/ content
- Testing
Considerations with Technology Implementations

Integration with Clinician Workflow
- Integration with existing processes
- Maintain or improve efficiency
- Evaluate application maturity against workflow requirements

Sharing information between electronic sources
- “Can’t we just have it appear?”
- Equivalent data elements
- Compatibility between systems
- Testing
- Just because you can – is it the right thing to do?
Considerations with Technology Implementations

Keeping Parallel Systems in Sync
- Use common standards or guidelines
- Define principles about the relationship between parallel systems

- Example: medication databases
- Provincial drug formulary
- Regional Formulary
- Pharmacy Database
- EPR medication database

Use data as close to the "the truth" as possible
## Medications

<table>
<thead>
<tr>
<th>Medication</th>
<th>Start Date</th>
<th>Quantity</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>amoxicillin - Capsule</td>
<td>13-Sep-2012</td>
<td>500 mg</td>
<td>By Mouth Every 8 hours (Q8H)</td>
</tr>
<tr>
<td>amoxicillin / clavulanic acid 500F - Tablet (CLAVULIN)</td>
<td>1 tablet(s) By Mouth Every 12 hours (Q12H)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>captoril - Tablet</td>
<td>21-Sep-2012</td>
<td>12.5 mg</td>
<td>By Mouth Every 8 hours (Q8H)</td>
</tr>
<tr>
<td>esomeprazole - Tablet</td>
<td>20 mg</td>
<td>40 mg</td>
<td>By Mouth Daily (OD)</td>
</tr>
<tr>
<td>tamsulosin CR - Capsule</td>
<td>0.4 mg</td>
<td>12 mg</td>
<td>By Mouth Every OTHER day with Supper</td>
</tr>
<tr>
<td>warfarin - Tablet</td>
<td>12 mg</td>
<td></td>
<td>By Mouth Every OTHER day with Supper</td>
</tr>
</tbody>
</table>

### Allergy Alert

- amoxicillin
- clavulanic acid

### Active Medications

<table>
<thead>
<tr>
<th>Drug</th>
<th>Allergy</th>
<th>Reaction</th>
<th>Description</th>
<th>Entered Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>amoxicillin Capsule</td>
<td></td>
<td></td>
<td></td>
<td>13-Sep-2012</td>
</tr>
<tr>
<td>tamsulosin CR Capsule</td>
<td></td>
<td></td>
<td></td>
<td>15-Sep-2012</td>
</tr>
<tr>
<td>warfarin</td>
<td></td>
<td></td>
<td></td>
<td>04-Oct-2012</td>
</tr>
</tbody>
</table>

### Actions

- Start Date: 13-Sep-2012 10:19
- Start Date: 10-Sep-2012 22:09

### Notes

- AMOXICILLIN/CLAVULANIC ACID — 500 mg/125 mg — Tablets
- AMOXICILLINE/ACIDE CLAVULANIQUE — 500 mg/125 mg — comprimés
- Clavulinate
- Apo-Amoxi Clav
Considerations with Technology Implementations

} Data Quality
  ◦ Entry quality
  ◦ Accuracy in transmission
  ◦ Accuracy of display and context

} Downtime Procedures
Considerations with Technology Implementations

Preparing for the Ideal but Understanding the Gaps

◦ “Rolling front” of clinical technologies puts everyone on a slightly different playing field
◦ “Vision” for the future, but identify the increments
◦ Be prepared for “long term temporary” solutions
Reduce

- The number of input sources by strengthening the accuracy of those available

Reuse

- Minimize the amount of “throw away” work
- Efficient documentation / retrieval of previous cycles through the process

Recycle

- Leverage previous medication histories/ updating to keep current
MedRec is recognized internationally as a key strategy in promoting Patient Safety. MedRec focuses on transitions in patient care to minimize medication discrepancies that potentiate Adverse Drug Events. Technologies have the capability of improving source information and providing efficiencies in process but must go in “eyes wide open.” “Rolling front” of technology implementations within MB requires patience in realizing results.
Agenda:

Nutrition Break-15 min
Panel Discussion
Closing Remarks