Medication Reconciliation and Polypharmacy Work Group

Meeting Minutes

MEETING DATE	MEETING TIME	Location
November 16, 2018	12:00PM – 2:00PM	195 Farmington Ave Farmington, CT 06032

WORK GROUP MEMBERS					
Thomas Agresta	X	Nitu Kashyap		Jameson Reuter	X
Lesley Bennett	X	Janet Knecht		Nathaniel Rickles	X
R. Douglas Bruce	X	Diane Mager	X	Kate Steckowych	X
Jeremy Campbell		Rodrick Marriott		Ece Tek	X
Marghie Giuliano	X	MJ McMullen	X	Peter Tolisano	X
Sean Jeffery	X	Bruce Metz	X	Anne Van Haaren	T
Amy Justice		Jennifer Osowiecki	X		
SUPPORTING LEADERSHIP					
Allan Hackney, HITO	X	Sarju Shah, OHS	T	Carol Robinson, CedarBridge	X
Kate Hayden, UConn Health	X	Michael Matthews, CedarBridge	X	Chris Robinson, CedarBridge	X
x = in-person participation; T = remote participation					

Minutes

	Topic	Responsible Party	Time
1.	**Welcome and Call to Order**	**Michael Matthews**	**12:00 PM**
	Michael Matthews welcomed Work Group members to the meeting and called the meeting to order. Michael provided an overview of the agenda.		
2.	**Public Comment**	**Attendees**	**12:05 PM**
	Dr. Richard Shuman, President of Medical Groups and Provider Services at Trinity Health of New England, is working with the state Prescription Drug Monitoring Program (PDMP) vendor (Appriss) to provide clinicians access to patient-controlled substance prescriptions to help battle the Opioid Epidemic. Appriss has worked with other state governments to fund Single Sign On (SSO) and patient context connectivity to the clinicians in many states (e.g. Massachusetts) to simplify the process of accessing the PDMP for clinicians. This functionality removes clicks from a busy clinical workflow by passing login, password, and patient information over a secure connection to the PDMP. Without this connection, clinicians must manually login to the PDMP and manually search for a patient which can be time intensive repeating the process multiple times a day. The state of Connecticut has not adopted the same state sponsored funding methodology leading to a situation where each health organization will need to contract separately with Appriss for the SSO and patient context connection. Each organization will need to foot the bill for their clinicians which could lead to duplicate/triplicate charges for the same clinician using the system at multiple organizations as clinicians often provide services to multiple hospitals in our state. The current proposal by Appriss with Trinity Health of New England is $50 per provider annually to use these enhanced tools mentioned above. We are requesting that this committee work with Appriss to create a contract for all clinicians in the state of CT (as other states) to keep the costs down and prevent the vendor from profiting from each organization acting independently. Jake Star, Chief Information Officer at VNA Community Healthcare and Hospice in Guilford, has been a member of the Health IT Advisory Council for more than 2 years representing home healthcare and LTPAC. During that time, Jake has served on a number of workgroups similar to the MRP group. He thanked those who are volunteering on this important work group on behalf of the Health IT Advisory Council. Jake's comments, which were delivered in-person and provided as a written statement, are as follows: "With major changes in the homecare industry, I have been giving thought to new roles which our agency could play in helping to address the opioid crisis and our daily nightmare which is med rec. That led me to a number of ideas, including some of which might generate revenue for me and my agency. For that reason,		

	while I very much wanted to be an official member of this group, I felt there was a potential conflict of interest. I have published the basics of some of these ideas as articles on my LinkedIn account, making them part of the public domain. Special Act 18-6 instructed the Health IT Officer, Allan Hackney, to form this group. It was given a requirement of delivering a report by July 1, 2019. The teams at OHS and CedarBridge will work diligently to ensure that the group delivers. I have great confidence in that process. However, if this group only works toward that objective, I fear that we will all miss out on significant opportunities which are much more time sensitive. You will hear about funding opportunities today. This funding is time sensitive – it takes a couple of months from the point of request to get approval, and the funds run out in approximately two years. If you wait until after the report is issued to the legislature, and for action to be taken after that, you will lose valuable time. Therefore, I encourage you to quickly move past the definition phase of the group to address real issues as soon as possible. For a start, I hope that you will consider recommending that the HITO seek funding to further the adoption and rollout of CancelRx, which I hope is part of Tom Agresta's agenda item today. Even though I came to it late in the game, I am proud to have played a tiny part in the CancelRx workgroup. A great group of people came together to pilot something which is a no-brainer. Your timely recommendation could help providers across a wide spectrum gain the ability to make this a standard practice. Your timely recommendation can enable action from the HITO and OHS. I also wanted to briefly comment on med rec. Most efforts I have seen focus on prescribers and pharmacies and making sure that we have an accurate list of what is prescribers. In home care, we are required to look at not only what is prescribed, but what the patient is actually taking. It would be very disappointing to me if Connecticut's solutions fail to address this challenge or push discussion so far into the future that funding is no longer available. As I am not a member of this group, it is not appropriate for me to comment during your meetings. However, I remain unavailable to answer questions you may have regarding home care or ideas for med rec, and I will do all that I can to support the success of this group."		
3.	**Review and Approval of 9/24/18 Meeting Minutes**	**Michael Matthews**	**12:10 PM**
	Michael Matthews asked for a motion to approve the minutes from the October 15, 2018 meeting. Jennifer Osowiecki moved to approve the October 15, 2018 meeting minutes, Lesley Bennett seconded the motion; all Work Group members voted to approve the minutes, with no oppositions or abstentions.		
4.	**Discussion: Med Rec Definitions**	**Definitions Small Group**	**12:15 PM**
	Michael Matthews introduced the next section, regarding the definitions of medication reconciliation. At the last meeting, a small group was formed and tasked with discussing available definitions and bringing a recommendation forward to this group. The group included Marghie Giuliano, Diane Mager, Janet Knecht, and Sean Jeffery. Michael asked Marghie to frame the discussion and recommendation. Marghie Giuliano said the group met and reviewed various definitions that were presented at the earlier meeting. The whole group agreed that the medication reconciliation definition should include the processes and steps that occur during the reconciliation. The group also concurred that the hospitals and other groups that need to be accredited follow the Joint Commission definition, therefore they are recommending that the Work Group adopt the Joint Commission definition of medication reconciliation. The biggest concern is to ensure that each of the steps within the definition are appropriate at different levels of care. Diane Mager agreed with Marghie's overview. The group wanted to ensure that there is accountability in the process but did not want to specifically define or dictate who would be accountable for completing medication reconciliation at the different organizations. Sean Jeffery added that the conversation tried to ensure that the perfect is not the enemy of the good; and that we need something actionable. Sean thinks there needs to be a quarterback for the medication list that is able to deal with the issues that surface and the PCP is the most apt provider for this role. Tom Agresta asked if there were any areas that the small group felt were missing in the definition and added that this is a hospital-centric approach. Sean Jeffery responded that it is important to capture what the		

patient is taking, which implies a direct conversation with the patient. Marghie added that when you look at the processes, there are standards of practice in some areas. If you can engage the patient, it is ideal but not always possible. We are not trying to re-invent the wheel; Diane feels this recommendation is not missing much, if anything, if we follow best practices to the best of our ability.

Lesley Bennett, a patient advocate, asked if the definition includes supplements. This is not explicitly stated in the presented definition. Marghie responded that she agrees that this should be included, but this is sometimes difficult to include from certain data sources, such as claims.

Doug Bruce said that the first item in the Joint Commission definition may imply that the provider needs to ask the patient what they are taking, but he could see a lot of people thinking this only means you should reconcile what is received from the hospital, as opposed to actually talking with the patient. We need to make sure that there is the explicit understanding that one should talk with the patient. Marghie responded that this is considered a best practice, but the conversation is not always possible. Doug Bruce responded that if the PCP is the principle owner, then most people should be able to have this conversation at their PCP appointment, directly or through a care giver. Talking with the patient adds time to a visit that we don't have, so unless it is explicitly stated in the definition, then it may be overlooked.

Ece Tek said that her concern is that some insurance companies do not let you see your PCP every year. Doug Bruce added that some patients see their specialists, or a different provider, more often than their PCP.

Tom Agresta asked if there is a difference between desiring for each provider that encounters a patient to have a reconciled list, as opposed to having a reconciled list that makes it to the PCP. There is a difference in ownership. Tom thinks there is a difference between a curated, accurate list and the process one goes through to get to the accurate list. A curated, accurate list should be available from any point that a patient has contact. This is the ideal situation. Sean Jeffery asked where the accountability would reside in this ideal situation. Tom Agresta responded that if we overly prescribe accountability, then we are getting beyond our scope. Tom said if you require the PCP to have the updated list and keep track of it, but the patient is not seeing the PCP, then the only way this would be possible is if the list was curated externally from the PCP, and available immediately without creating additional work. Marghie responded that until we have the perfect world, then somebody needs to be accountable to make sure the PCP receives the updated information. Diane said home care may be the easiest environment to meet this requirement, but in other settings it may be more difficult. Doug Bruce responded that the lists they receive can be a disaster. His concern is that when you become an owner of something, you feel responsible for the accuracy, however there is no penalty for a specialist not to communicate or to be accurate. If we say the PCP is the owner, we are putting the burden on the PCP because people will go to them and blame them for inaccuracies, even when they receive incomplete data or don't receive data at all. Jameson Reuter said he agrees with the PCP portion but said that the physician who is responsible for the patient at the point of care and who is in charge of coordinating the care for each episode should be responsible.

Jennifer Osowiecki asked why the ownership would not lie with the patient, as they are the ones who are present at each setting. Tom Agresta responded that the average patient does not have the information or knowledge necessary to handle this responsibility. The providers should be providing them with updated, accurate information and collaborating with them. Having the patient responsible for this does not seem realistic, as they do not have the information and knowledge. Our goal is to get to the point where all of the meds are available all the time in the right format and we aren't playing catch up.

Ece Tek said she agrees that the information received is inconsistent. She said it would be beneficial to receive an alert or warning when a patient is prescribed a certain medication; an electronic system or bank that stores and distributes the information. Jennifer Osowiecki said that what is prescribed is not always what is picked up by the patient. The ability to take meds off the list is also important. Having the patient provided a form before every patient, or having the patient bring a list or pictures on their phone could be beneficial. If

	the patient does not know what they are taking, then the process breaks down. Jameson Reuter thinks there is an opportunity for patient education. Michael Matthews thanked everyone for the discussion. Michael said he is not hearing any opposition to the recommended definition; the discussion thus far is focused on details related to the process and how this will work in the real world. Michael suggested that the group should move forward with the vote to approve this recommended definition, and then separately develop a package of operating principles and guidelines. That way, we move beyond the discussion of the definition, and recognize that there is more work to be done. Diane Mager said she agrees with the suggestion and this is the approach that the small group was discussing. We did not want to define who is responsible for medication reconciliation. Tom Agresta asked if we want to be more explicit about the other items that have been discussed, such as supplements. Sean Jeffery said that this could be part of the operating principles and guidelines. Kate Steckowych said that this is a hospital-centric definition, and we don't want to lose the outpatient perspective in this definition. The "transitions of care" phrase is at issue in the definition. When we say transitions of care, we should make sure we include specialists-to-PCP and specialist-to-specialist, among others. We can discuss this in more detail in the future, but I wanted to make sure this is flagged. Tom Agresta thinks this could be added to the operating principles. Ece Tek said she would like to include methadone in the definition of medications. She wants to make sure this is included, as it is an important issue. Marghie agrees but said that this is hard to find out unless the patient tells the provider directly. Tom Agresta said it is not impossible to suggest this and look for solutions, even if it requires patient consent. Michael asked if the group is ready to move forward with the recommended definition. Marghie Giuliano created the motion to approve the recommended definition and Diane Mager seconded the definition. The motion passed with no opposition or abstentions.		
5.	**Funding Opportunity: Discussion and Approval**	**Tom Agresta**	**12:30 PM**
	Tom Agresta introduced the next discussion regarding a potential funding opportunity for a statewide medication management service. To begin, Tom provided background on the funding opportunity. The funding is available through the HITECH Act and can be used for a wide range of HIE activities. This funding is a 90/10 match, in which the federal government provides 90% funding for a 10% state match. This has been the vehicle that many states have used to fund HIE activities in recent years, including Connecticut. This funding is available until September 2021 and must be submitted through the state's Medicaid agency. The Connecticut Department of Social Services (DSS) is planning to submit an implementation advanced planning document (IAPD) to CMS before the end of the year for Federal Fiscal Years 2019 and 2020. The review process takes a couple of months and funding could be available by the middle of next year. Tom said that what will be proposed today is funding for planning activities, as well as design, development, testing, piloting, and implementation. These funds do have a shelf life, so we need to start now. The state is working to develop a statewide HIE that is built as a network-of-networks model. Allan Hackney, the state Health IT Officer, has previously said that this group can directly request funding to do some planning and development of medication reconciliation services. The planning activities can define how the funding will be used, as long as if follows some operating principles, such as the use of modern architecture and standards. Tom added that a subgroup could be established to look at medication reconciliation from an HIE perspective. We can also provide technical assistance and onboarding support to providers and organizations. Tom outlined some example activities that could be conducted with the funding in 2019 and 2020, including scoping, developing an initial focus, developing a plan, designing solutions, creating an onboarding plan, exploring integration of the PDMP, and leveraging the CancelRx work to implement the standard via technical assistance funding. In 2020, we could continue technical assistance and onboarding, expand to additional providers, add additional use cases, and developing deployable tools at the point of care, as well as emerging technology, such as SMART on FHIR. Tom presented an example of how open source data is currently being		

leveraged and an example of medication adherence SMART on FHIR. Tom also provide an example of InfoSage to demonstrate how opportunities are created by standardizing information. Tom is not recommending or selling any of these tools but wants to make the group aware of the possibilities.

Tom Agresta stated that this funding proposal, at a high level, is to deploy the CancelRx standard via technical assistance support and to design, develop, test, pilot, and deploy and support onboarding for medication reconciliation services through the statewide HIE.

Diane Mager said that this is a well-developed, robust proposal. She thinks it would be more robust proposal if we include home health in the terminology from the start and include these providers everywhere that we say, "other providers." Tom Agresta said that he agrees completely.

Marghie Giuliano said that there are concerns with how EHRs look at meds from a pharmacist perspective, and that there is a lot lacking in this area. She asked if this has improved recently. Sean Jeffery said that this has improved tremendously and that we are seeing enhancements on a regular basis. Marghie asked if some of the information that has been worked on at the national level by the health IT pharmacy groups is being included. Sean said that this has been included, but it is still clunky when information is received back from community pharmacists into the EHR. The information can be hard to decipher. Sean said that as we start to reconcile and test technology, and if there is an opportunity, then we should consider including deprescribing. He thinks this is a natural evolution of our work. Tom Agresta agrees.

MJ McMullen commented that Surescripts is solving a lot of these issues. They are asking and requiring pharmacies to certify to the cancel transaction in response to the movement to the new SCRIPT standard, but they are not mandating usage. Tom Agresta does not think this would change the proposal, as technical assistance and onboarding funding will still be needed.

Sean Jeffery said the National Institute of Health (NIH) has a new grant that is coming out to establish a deprescribing consortium. Jennifer Osowiecki asked what settings are included when we talk about deprescribing. Sean responded that this issue is across all settings. Jennifer asked if there is more of an impact in any given setting. She can see obstacles in the ambulatory care setting. Tom Agresta said that the people with the most meds have the most to gain, which usually ends up being the geriatrics.

Michael Matthews paused the discussion and commented that the proposal's language is not overly prescriptive, by design. It will give the latitude to see where the planning efforts are headed and allow strategies to evolve over time. Michael said we can make sure deprescribing and home care are included, but if other things come up, then we will have the flexibility to add them. Michael asked the group if they are ready to move forward and endorse this proposed funding approach.

Bruce Metz said that the proposal was great, but he would encourage us to move the innovative work to the first year and begin this as soon as possible. Bruce asked when we will need to define what we are doing. Tom Agresta said that if we request the funding, shortly afterwards we will create sub-groups and prepare for this. We could leverage existing funding to do some planning as well. Tom does not think we will wait very long to get started. To get off the ground. Tom asked if Allan Hackney could speak to this topic.

Allan Hackney said that implicit to this type of funding request is the difference between planning funding and implementation funding. CMS thinks about this in these two buckets. When Tom uses the word "deploy" he is suggesting that there would be enough body of work to suggest what we want to implement. What Tom is suggesting when he says design, build, and test, he is talking about planning funding. The point Michael was making that this group can decide what is brought forward for implementation. It could be deprescribing or a med rec tool – you can decide through the planning process. At this point, we will go back for more implementation funding. Allan said he would also echo Jake's point that time is not our friend on this. The HITECH funding runs out in September 2021. We have 32 months, after the review period, and the clock is ticking. Allan said he would encourage this group to approve this proposal if they are interested in doing something more than submitting a legislative report on July 1, 2019.

	Sean Jeffery created a motion to approve the funding proposal, and Doug Bruce seconded the motion. The motion was approved unanimously without objections or abstentions. Tom Agresta added that UConn Health is going to try to hold a medication reconciliation workshop or hack-a-thon in the Spring. The event is being planned and more information will be distributed in the near future. Tom asked anybody who is interested to reach out to him and Kate Hayden. This will be a public invitation.		
6.	**Surescripts Presentation**	**Stacy Ward-Charlerie**	**1:05 PM**
	The next presentation was provided by Stacy Ward-Charlerie, who is a product manager at pharmacist at Surescripts. Stacy is happy to be here and is passionate about this topic. The purpose of Stacy's presentation is to make the Work Group aware of what Surescripts is currently doing in this space. The first slide presented by Stacy outlined the purpose of Surescripts – to serve the nation with the single most trusted and capable health information network, built to increase patient safety, lower costs, and ensure quality care. The next slide provided details on the Surescripts Network Alliance and the Surescripts footprint nation-wide. Surescripts sends 4.8 million e-prescriptions daily, and 13.7 billion transaction annually. They are connected to virtually all EHRs, pharmacy benefit managers (PBMs), pharmacies, and clinicians, and they are expanding to health plans, long-term care, and specialty pharmacy organizations. The next slide presented by Stacy described actionable intelligence at critical points in care by enhancing prescribing and informing care decisions. These are two areas that they are focused on. The next slide stated that real-time, electronic medication history is critical for acute care. There is real value here. The next few slides discussed Medication History for Reconciliation, which provides 12 months of dispensed medication data from PBMs and pharmacies, delivered to the EHR workflow. This enables healthcare providers in hospitals or long-term care settings to reduce adverse drug events (ADEs) and ultimately improve care. The data includes things like the name of the drug, the dosage, the quantity dispensed, the supply, the dispensing pharmacy information, and more. The first step is that there is an (1) "initiate history request," followed by a (2) "unique patient match," followed by a (3) "multi-source data gathering," followed by (4) "aggregated data." This process was outlined in a flow chart on Slide 7 of Stacy's presentation. Data quality is checked throughout the entire process. Next, Stacy discussed the Medication History for Reconciliation data details. The slide lists what is included in PBM claims data and pharmacy fill data. One question they receive all the time is if they have cash prescriptions, and the answer is yes. They collect cash and claims. They do allow EHRs and end users to request either fill, claim, or both data sets. They are working to streamline this process and they are looking to do data de-duplication between the two data sets and reduce the amount of time a user has to spend sifting through the data. Sean Jeffery asked if Stacy can describe how this is different than what he sees in Epic in the Dispense Rx History. Stacy said this is the same thing. In the flow chart, Epic is in the #1 stage, as well as the other EHRs. Sean asked a follow-up question regarding Stacy's comment that they are able to include information on cash prescriptions. Sean asked if this is only when it is purchased at the counter and the pharmacist enters the information into the profile. Stacy said that this is correct. The pharmacy sends a batch file of what is dispensed every day and this information must be entered into the system. This may not include over-the-counter medications. It must be part of the pharmacy record in order for them to receive this. Sean stated that he does not believe this is a standard of practice to enter over-the-counter medications into the patient profile. Marghie said that for cash scripts, if you are not going to a third-party payer, you would not be sharing this information with Surescripts. Tom Agresta said it sounds like there is a question of the breadth of coverage and where there may be gaps. He said this is great, but it is a good idea for them to understand where the gaps are as a first step. Stacy said that over-the-counter drugs that are not captured in the system would be one gap, as this is not a standard of		

	practice. The other gap would be that they are not in 100% of pharmacies today. The remaining 10-15% of pharmacies that they are not connected to is another gap. They are working hard to get to 100%. Jennifer Osowiecki asked if there is patient matching across settings. Stacy said that Surescripts has a sophisticated patient matching system, so they are able to accommodate different situations. One of the challenges states are having is related to the PDMP and sharing information across state lines through Appriss. This can be challenging, but Surescripts has a sophisticated patient matching capability. Michael Matthews asked if there is a prescription that is listed both in the PBM file and the pharmacy feed, is Surescripts currently conducting de-duplication. Stacy said they are not doing this today, but a lot of the EHRs are doing de-duplication. They know this is an opportunity for them and they are currently working to develop a de-duplication process that will be releases in the near future. Stacy said that getting the patient list is a key part of the process. The first step is getting the current patient list and this process supports that. When you review the data, you may not ingest the entire history and every EHR has a different process. Tom Agresta said that most EHRs and organizations make decisions about the ingestion that is contingent upon clinician review and validation. Just because the information is available in the EHR, does not mean they are ingested into the medication list. Tom thinks that we may want to have a demonstration of how this is done in various EHR systems. Stacy said that she pulled some numbers for the State of Connecticut – there were 5.25 million medication history requests in the ambulatory care setting in October and 314,000 requests in the hospital setting in October. There are 519 pharmacy stores provide their data to Surescripts and about 18,000 providers out of 23,000 in Connecticut use the service. Michael Matthews thanked Stacy for her presentation. Michael added that it would be valuable to see these statistics from Stacy on an ongoing basis. Stacy agreed she could provide these reports on an ongoing basis.		
7.	**Work Group Framework**	**Michael Matthews**	**1:30 PM**
	Michael Matthews introduced the next topic, related to sub-groups and Work Group leadership. Sarju distributed a survey to start to identify interest in different groups and to get volunteers for leadership and to develop the project charter. We will dedicate some time up-front at the next meeting to try to get leadership in place and decide which groups we want to launch, without spreading ourselves too thin. We need your brain power to keep people headed in the right direction. Diane Mager volunteered to help with the project charter. Sean Jeffery volunteered, but said there are other areas he would be better suited. Ece Tek volunteered for the opioid reduction sub-group.		
8.	**Next Steps and Adjournment**	**Michael Matthews**	**1:50 PM**
	The next meeting will occur on December 21 from 2-4pm. This is the Friday before Christmas, so Sarju may follow-up to determine how many people will be able to attend this meeting. Michael asked the group which days and times work best to schedule meetings in 2019. The group provided some responses and OHS will follow-up with a proposed 2019 schedule. The motion to adjourn the meeting was created, seconded, and passed without objection.		

Upcoming Meeting Schedule: 2018 dates – December 21
Meeting information is located at: https://portal.ct.gov/OHS/HIT-Work-Groups/Medication-Reconciliation-and-Polypharmacy-Work-Group