Medication Reconciliation and Polypharmacy Work Group

Meeting Minutes

Meeting Date	Meeting Time	Location
Oct. 15, 2018	3:00 pm – 5:00 pm	Connecticut Institute for Primary Care Innovation (CIPCI) 260 Ashley Street, Hartford CT

Committee Members					
Thomas Agresta	x	Nitu Kashyap	x	Jameson Reuter	T
Lesley Bennett		Janet Knecht	x	Nathaniel Rickles	x
R. Douglas Bruce	x	Diana Mager	T	Kate Steckowych	x
Jeremy Campbell		Rodrick Marriott	T	Ece Tek	x
Marghie Giuliano	T	MJ McMullen	T	Peter Tolisano	x
Sean Jeffrey	T	Bruce Metz		Anne Van Haaren	T
Amy Justice	x	Jennifer Osowiecki	x		
Supporting Leadership					
Allan Hackney, HITO	X	Sarju Shah, OHS	X	Kelsey Lawlor, OHS	X
Kate Hayden, UConn Health	X	Michael Matthews, CedarBridge	X	Chris Robinson, CedarBridge	X
Jake Star, Council Member	X				

X= in-person participation; T = remote participation

Minutes			
	Topic	**Responsible Party**	**Time**
1.	**Welcome & Call to Order**	**Sarju Shah**	**3:00 PM**
	Sarju Shah welcomed Work Group members to the second meeting and called the meeting to order.		
2.	**Public Comment**	**Attendees**	**3:05 PM**
	There was no public comment.		
3.	**Review and Approval of the 9/24/18 Meeting Minutes**	**Members**	**3:10 PM**
	The 9/24/18 meeting minutes were approved.		
4.	**Review Outcomes of Previous Meeting**	**Sarju Shah**	**3:15 PM**
	Sarju Shah provided an overview of the outcomes that emerged from the previous meeting. She noted that there will be homework assignments for members and that it is important that this is a collaborative group. Michael Matthews, of CedarBridge Group, noted that the group is actively going through the four phases of group formation: storming, forming, norming, and performing. As sub-groups are created, this process will be replicated to ensure smaller work cycles are executed and completed.		
5.	**CancelRx Recommendations**	**Tom Agresta**	**3:25 PM**
	Tom Agresta provided an overview of the draft CancelRx recommendations. He explained that the recommendations are not listed in order of importance. The recommendations are still in their draft form but have been developed and validated enough to be shared with this Work Group. The following recommendations were presented and discussed: 1. Conduct a formal assessment of the return on investment (ROI) for the CancelRx standard and other medication reconciliation recommendations to support the widespread adoption by pharmacies. 2. Conduct a formal assessment of the legislative / policy considerations associated with a mandate to require participation in the CancelRx standard by Connecticut pharmacies and practitioners. 3. Explore the possibility of utilizing health information exchange (HIE) funding to support onboarding, technical assistance, education, training, and implementation for pharmacies and practitioners. 4. Standardize pharmacy CancelRx workflows through technical assistance support.		

5. Launch a statewide public health campaign to raise awareness for medication safety, CancelRx, medication reconciliation, polypharmacy, election prescriptions for controlled substance, etc.
6. Develop a business case for the sustainability of CancelRx that is endorsed and supported by the state's HIE effort and associated stakeholders (e.g. payers conducting a cost containment analysis).
7. Develop an incentive program to support the adoption and use of the CancelRx standard and conduct pilot programs to determine the ROI for each organization.
8. Conduct an analysis of available funding opportunities to help address polypharmacy and reduce opioid misuse.
9. Partner with the Connecticut Prescription Monitoring Program (PMP), the Substance Abuse and Mental Health Services Administration (SAMHSA), and other organizations/stakeholders to determine how CancelRx can be supported by, or provide support to, relevant program efforts.

Regarding recommendation #4, Tom Agresta explained that there is no understanding of standardized workflows for the cancellation of an electronic medication. Tom thinks this group should come up with a method to understand the workflow for cancelling medications and that standardization will be beneficial. Regarding recommendation #1, Tom explained that the CancelRx group analyzed the ROI for cancelling a medication electronically and recognized the need to conduct an ROI assessment in order to develop a more granular understanding. Regarding recommendation #2, Tom explained that an assessment is needed to determine the need for legislative or policy changes or mandates to require the use of the CancelRx standard.

Amy Justice asked for clarification around the mandate in recommendation #2. Tom explained that the requirement would be for certain systems and software to use this tool. Nitu Kashyap added her perspective that pharmacies require a license to accept cancellations and that prescribers need to be able to send a message and pharmacies need to be able to accept the message. Nitu explained that the CancelRx group is suggesting a legislative process to require pharmacists to adopt these standards. Nitu added that some issues are being addressed by Surescripts removing the cost per transaction for pharmacies to receive messages.

Rod Marriott commented that this type of mandate will have an impact on the Department of Consumer Protection and the PMP. Rod believes that industry should drive this process. Tom Agresta agreed and clarified that the recommendation seeks to understand the implications of this policy lever and legislative changes. Marghie Giuliano echoed Rod's comments and cautioned against putting any specific vendor into the legislation. Tom Agresta commented that certified EHRs should be able to handle this type of message.

Regarding recommendation #3, Tom Agresta said there is great potential. Nathaniel Rickles asked if it is possible to roll this out in small pilots to see how it will work. Tom Agresta agreed that small pilots would be ideal. Nathaniel added that there should be some evaluation of the pilots as they occur. Tom agreed.

Regarding recommendation #8, Tom stated that the MRP Work Group should analyze current funding opportunities, and that this work should be a priority. Regarding recommendation #9, Tom explained the importance of synergistic efforts. Tom concluded his overview of the CancelRx recommendations by explaining that additional lessons learned, and recommendations may emerge over the next month as the recommendations are finalized. Tom Agresta asked if there were any questions or comments from the group.

- Amy Justice asked a question regarding funding, collaboration with other agencies, and which specific areas were being considered. Tom Agresta explained that the funding and collaboration needs to be based on synergies. Tom said that it could be a missed opportunity to only pursue HIE support, and not think about how funding to address the opioid epidemic could be leveraged as well. Marghie Giuliano agreed that there are opportunities to look at synergistic projects in support of sustainability.
- Sarju Shah explained that the governor has issued a press release about opioid funding and that it may be beneficial to consider if this group can develop a strategy for analyzing the funding opportunities. Amy Justice asked if anyone knows which medications were included in this funding effort. Tom Agresta stated that he thinks more details will emerge in the rule making process and that there could be opportunities for collaboration. Rod Marriott explained that these grants are usually restrictive, which could prevent near-term collaboration with this funding. Rod said it comes down to timing and having the right people understand the different efforts and connections.

- Amy Justice asked if CMS has released quality metrics around medication reconciliation, as this could be a driver. Tom Agresta said that this is a good question. Janet Knecht said that transitions of care should include medication reconciliation but are not verified.
- Sarju Shah explained that the Office of Health Strategy is rolling out a pilot for electronic clinical quality measures (eCQM), which will involve the collection of C-CDAs from 8 pilot organizations. OHS is looking at measures from CMS and NQF to identify areas of success and gaps.
- Nitu Kashyap explained that there are commercial care metrics related to medication adherence, and that commercial payers may have other relevant measures in effect. Marghie Giuliano said that home health agencies may have a medication reconciliation requirement as part of their condition of practice. Nitu Kashyap said that she thinks CMS has a medication reconciliation component.
- Ece Tek stated that managed Medicare will not pay for certain medication for elderly patients.

Tom Agresta asked the Work Group members to provide their perspectives on next steps for CancelRx.

- Michael Matthews recognized the great thought and effort of CancelRx and asked Tom Agresta if the CancelRx work will continue. Tom Agresta stated that it would be difficult for CancelRx to continue their work for a number of reasons, including overlap of membership.
- Amy Justice stated that she would like the opportunity for the MRP Work Group to comment on the CancelRx recommendations, now that they have been presented. Tom Agresta agreed.
- Tom Agresta asked Allan Hackney what he thinks about next steps. Allan Hackney stated that his preference would for the MRP Work Group to adopt or adapt the work from CancelRx and make sure that the recommendations align with the priorities of this group. Allan explained that the statutory authority of this group is important, and that funding can be pursued on behalf of the MRP Work Group's recommendations and work efforts.
- Marghie Giuliano observed that some recommendations are specific to CancelRx, whereas some are much broader. Marghie asked if the recommendations specific to CancelRx should be separated or if the recommendations should be expanded to encompass MRP. Amy Justice wondered if it would be beneficial to identify the recommendations that are highest priority.
- Nitu Kashyap asked if the group agrees that the CancelRx recommendations connects to the MRP Work Group's larger mission. Everyone agreed. Kate Steckowych agreed, but stated that there should be more discussion around the overall goal of the MRP Work Group. Michael Matthews suggested that we revisit the CancelRx recommendations for clarifications, comments, and questions at a future meeting to allow for the MRP Work Group to organize and standardize their processes.
- Nitu Kashyap stated that there needs to be a discussion of medication reconciliation and polypharmacy definitions in order to understand how this all fits together. Tom Agresta agreed and observed that the group has already begun to discuss issues and obstacles. Tom suggested that the group should consider a sub-set of recommendations to move forward with, such as exploring the opportunity of HIE funding. Allan Hackney agreed that the sooner this is started, the better.
- Tom Agresta asked the group what would need to be done around legislation and policy analysis and if there is background work that can be done by CedarBridge Group or OHS. Nathaniel Rickles asked if there is any background information available on the CancelRx group. Tom Agresta explained this information is being developed and will be shared as soon as possible. Jennifer Osowiecki stated that she wants to review the background information before voting on the Cancel Rx recommendations.
- Jennifer Osowiecki observed that there are semantic issues with some of the terminology, such as cancellation and discontinuation. Tom Agresta and Amy Justice agreed. Tom explained that definitions will be outlined in the CancelRx final report.

Michael Matthews summarized the group's discussion. Michael observed that there is a consensus that the CancelRx recommendations fit well into the larger framework of the MRP Work Group, but some additional review and thought is needed to determine exactly how they fit. The MRP Work Group members agreed. Michael observed that there were no stated concerns with prioritizing the analysis of funding opportunities. The MRP Work Group members agreed.

Michael Matthews also provided insights into two process techniques that are utilized by the Health IT Advisory Council. One technique is the concept of "two bites of the apple" in which no concept goes to the Council for acceptance or approval in the same meeting that it is introduced to allow for the Council to give though and consideration to any concept or recommendation. The other technique is to define the terms of approval and acceptance. Accepting a report or

recommendation would mean the Council is adopting it as part of a body of knowledge. Approving something is a much higher bar. Michael observed that the Work Group is not ready to approve the CancelRx recommendations and that the group should be discussing the idea of accepting the recommendations as part of their body of knowledge.

- Amy Justice agreed and asked for Tom Agresta to provide a recommendation of the highest priority items necessary to keep the CancelRx work moving forward. Amy stated that it would be easier to approve the recommendations if they were more specific to CancelRx. Tom Agresta agreed and stated that the recommendation for an analysis of the funding opportunities is a high priority.
- Tom Agresta asked about recommendation #5 and if a public health campaign would be beneficial to build awareness. Amy Justice stated that she believes this is important, but that it will need to be aligned with the larger goals of the MRP Work Group.
- Michael Matthews added that the MRP Work Group wants to identify "low hanging fruit." Michael observed that the group is interested in which CancelRx recommendations could be prioritized while the MRP Work Group formalizes and standardizes its own work. Tom Agresta agreed and stated that an analysis of the funding opportunities and the assessment of pilot efforts would be high priority recommendations. Tom also believes technical assistance will be important.

Dr. Ece Tek and Dr. R. Douglas Bruce introduced themselves to the group.

6.	**Discussion: Definitions**	**Michael Matthews**	**3:45 PM**

Michael Matthews introduced three activities that have been prepared for the Work Group. The Work Group will be discussing the definitions of "medication reconciliation" and "polypharmacy." The Work Group also needs to discuss how their work is organized and how the group is structured. The definition of "medication reconciliation was discussed first. Two definitions were provided for the group's review and to start the discussion. One definition was from CMS, and the other from the Institute for Health Improvement (IHI). The Work Group's discussion is summarized below:

- Amy Justice observed that neither of the listed definitions mention over the counter medications. Amy believes over the counter medications should be included at some point. Amy commented that she does not think the gold standard should be somebody else's medication list.
- Ece Tek commented that the definitions exclude methadone patients. She explained the importance of identifying methadone patients and believes this should be included in the definition.
    - Michael Matthews agreed with the importance of this issue and suggested that methadone should be included in the definition of "medications" but that it is not necessary for the definition of "medication reconciliation" as the verbiage does not list specific medications. Rod Marriott stated that there are some barriers to acquiring methadone information and we should not limit ourselves by specifically listing this in the definition.
- Marghie Giuliano stated that the group should review the Joint Commission definition of "medication reconciliation" as it includes more details on the process of acquiring and validating the best possible list and is referenced by pharmacists.
    - Jenifer Osowiecki stated that the Joint Commission information referenced by Diana is a standard, not a definition.
    - Tom Agresta stated that there is a difference between the definition and the process and that the Work Group should differentiate. Tom explained that the process will have many challenges and obstacles that will need to be discussed.
    - Diana Mager stated that the Joint Commission provides important information that is not listed in the IHI definition. Diana explained that medication reconciliation is a three-phase process and involves the determination of appropriateness and next steps.
    - Kate Steckowych commented that she does not want to confuse the two different concepts of medication reconciliation and comprehensive medication management. Kate explained that the determination of appropriateness is a different process from reconciliation. Kate believes that herbal supplements and over the counter medications should be included in the definition from the beginning because these can have major safety implications.
- Jennifer Osowiecki stated that the CMS definition is the most commonly used across state lines. Jennifer added that from a legal perspective, she agrees with the inclusion of herbal supplements and over the counter medications. Jennifer agrees that the group should talk about process separate from the definition. Jennifer added that the group should discuss who conducts the reconciliation.

- Amy Justice stated that the first step is to have the most accurate list of all medications possible, encompassing any active ingredient. Amy expressed concerns that both listed definitions try to define the process and thinks the process should be separate.
- Diana Mager stated that she appreciates everyone's input and cautions against excluding any groups, such as nursing and home health care.
- Tom Agresta stated that medication reconciliation is an "all-hands-on deck" process. Tom stated that the process of how you get to an accurate medication list is messy and dynamic.
    - Marghie Giuliano stated that she disagrees, and that the group should avoid recreating an approach that has already been standardized. Marghie is concerned about defining medication reconciliation as just a medication list and excluding details of the process.
    - Tom Agresta commented that the end goal of having an accurate list will require complicated processes and the collaboration of many people having access to accurate information. Tom believes that the use of the word "accurate" in the definition implies that there is a process involved, and that we are talking about more than just a list.
    - Amy Justice stated that CMS and IHI both use the term "most accurate list possible" and that this may be a good middle ground. Amy said that you need to separate the process, as this will be something that is discussed separately.
- Nitu Kashyap said that you can break this conversation down into the who, what, where, when, and how. The group has been talking about the "what" or the definition and agree that this involves obtaining a list, and that the other elements (who, where, when, and how) also need to be discussed.
- Tom Agresta stated that when patients leave his office, he wants to provide the most accurate list possible from his EHR. Nitu Kashyap said that Tom's example illustrates that the goal is to have a list that is reconciled against what the patient is actually taking and updated.
    - Jennifer Osowiecki commented that there is a benefit to understanding adherence. Tom Agresta commented that this is a separate step. Jennifer mentioned the idea of a patient passport to track medications and Tom said this may be a solution that is discussed later.

Michael Matthews asked the group if they wanted to continue the medication reconciliation discussion, or if they let want to table the discussion until next time.

- Marghie Giuliano asked everyone to review the Joint Commission definition, as she is concerned we are trying to re-invent the wheel. Diane Mager agreed.
- Michael Matthews commended the group on the rich conversation.
- Tom Agresta wants to avoid having the same conversation next meeting. Tom suggested forming a small sub-group that would wrestle with this topic and bring a couple of options to the group.
    - Marghie Giuliano and Diane Mager volunteered to develop a few options.

Michael Matthews explained that the next discussion is around the definition of "polypharmacy." An example definition from the World Health Organization was provided for review. Michael asked Anne Van Haaren to frame the conversation based on an article that she provided to the group in advance of the meeting.

- Anne Van Haaren explained that there are many different definitions for polypharmacy that include other considerations, including duration, threshold, appropriateness, etc.
- Michael Matthews said he was I was particular struck by appropriate vs. inappropriate, as my understanding is that it is a neutral term.
    - Amy Justice said that we have no idea what happens when people are on many different medications and would be very hesitant to use the word "appropriate."
    - R. Douglas Bruce stated that drug-to-drug interactions are often limited to a one-to-one relationship and are tested on the healthiest of individuals.
- Jennifer Osowiecki provided an example from Scotland where a rubric was developed that included appropriate vs. inappropriate polypharmacy. Jennifer offered to send this to the group.
    - Amy Justice said that start/stop is not evidence based and that the research has not shown any beneficial effect. Jennifer said she is not referring to start/stop.
- Tom Agresta said that it can be acknowledged that nobody knows what happens when people use multiple medications at the same time. Tom said our high-level goal could be to create an opportunity to limit polypharmacy that causes harm and build a better understanding of the risks and harms. Tom said in the short term the group can define the issue, how it can be monitored, and educate the community. Tom suggested a

	literature review. R. Douglas Bruce said we should develop an understanding the issue, as there is a morbidity associated with it. Amy Justice said that the science is in its infancy, but that we should review articles that adjust for how sick the patient is when the medications are prescribed. Michael Matthews asked the group if a review of the harms/risks is a good next step for this topic. • Amy Justice said we won't be able to address this issue unless there is an accurate medication list. R. Douglas Bruce commented that the dosage is also important. Jennifer Osowiecki suggested that the group may also think about a medication history and allergies. • Amy Justice asked about the Work Group's scope. Tom Agresta agreed that this needs to be defined. • Michael Matthews asked if there are volunteers for a sub-group to start researching the harms and risks and bring something to the group at the next meeting. Kate Steckowych asked if we are looking to create a definition or a standard of care. Tom Agresta said that the development of a standard of care would be beyond the group's scope and authority.		
7.	**Discussion: Organizing our Work**	**Michael Matthews / Sarju Shah**	**4:15 PM**
	For the next meeting, Michael said that we will be discussing how to organize the Work Group and its work, including determining internal leaders to help manage and facilitate the conversation and the creation of sub-groups. Michael explained that this group needs to own the overall structure and process. • Sarju Shah asked everyone to send their thoughts via email regarding the organization of the Work Group and if anyone is interested in being nominated as Chair or Co-chair. • Sarju Shah asked everyone to send definitions or articles to be reviewed by Diane and Marghie. Next meeting there will also be a discussion around sub-groups / committees and we will create strawman to be reviewed by the group. Nathaniel Rickles asked Sarju to send an email asking people to sign up for sub-groups. Nathaniel also suggested the use of a discussion board to help promote work and collaboration between meetings. Sarju then stated that there are two more meetings scheduled in November and December, and that she will begin working to identify dates and times for the 2019 meetings. Nitu Kashyap suggested the idea of developing a project charter for the Work Group. Tom Agresta thinks this is a good idea and asked people to volunteer if they want to help scoping out a charter.		
8.	**Wrap up and Meeting Adjournment**	**Sarju Shah**	**4:55 PM**
	Sarju Shah closed the meeting.		

Upcoming Meeting Schedule: 2018 Dates – November 16, December 21
Meeting information is located at: https://portal.ct.gov/OHS/HIT-Work-Groups/Medication-Reconciliation-and-Polypharmacy-Work-Group