Medication Reconciliation and Polypharmacy Work Group

Meeting Minutes

Meeting Date	Meeting Time	Location
Sept. 24, 2018	3:00 pm – 5:00 pm	Rm U3071AB, 3rd Floor 195 Farmington Avenue Farmington, CT

Committee Members					
Thomas Agresta	X	Nitu Kashyap	T	Jameson Reuter	
Lesley Bennett	T	Janet Knecht		Nathaniel Rickles	X
R. Douglas Bruce		Diane Mager	X	Kate Steckowych	X
Jeremy Campbell		Rodrick Marriott*	T	Ece Tek	
Margie Giuliano	X	MJ McMullen	T	Peter Tolisano	X
Sean Jeffrey	X	Bruce Metz	X	Anne Van Haaren	
Amy Justice	T	Jennifer Osowiecki	X		
*Rodrick Marriott, DCP Director was represented by Debora Jones at this meeting					
Supporting Leadership					
Allan Hackney, HITO	T	Sarju Shah, OHS	X	Kelsey Lawlor, OHS	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 & Call to Order**	**Allan Hackney**	**3:00 PM**
	Allan Hackney welcomed the Work Group members and called the meeting to order. Allan thanked everyone for their demonstrated interest in this work, and stated that it is evidence of how important Medication Reconciliation and Polypharmacy reduction is in the state of Connecticut. He also stipulated that he will be listening in on these meetings, but he is not an official member. This is to be a structured work group that is managed by the appointed members. He also noted that the statute that gave rise to this work group also speaks to a final report to be presented by the group, and he hopes that that report will be a summary of all the operational and policy recommendations that develop from this group over the course of the next year. Allan then stated that Sarju Shah of OHS is the primary point of contact for this group. Michael Matthews of CedarBridge Consulting Group, a well-known management consulting firm in this health IT space, will also assist with the facilitation of this group. Allan closed by recognizing the extensive CancelRx efforts led by Dr. Tom Agresta of UConn Health. He then turned the presentation over to Sarju Shah. Sarju stated that the meeting would be structured as an open planning discussion to go over direction, focus areas, logistics, and next steps for the group.		
2.	**Public Comment**	**Attendees**	**3:15 PM**
	There was no public comment.		
3.	**Work Group Overview**	**Sarju Shah**	**3:17 PM**
	Sarju explained that this group was created by Special Act 18-6, which was put forward by the Public Health Committee. The Public Health Committee held a hearing and received presentations from Dr. Amy Justice, Dr. Tom Agresta, Dr. Sean Jeffrey, Rod Marriott, and Allan Hackney. The objective of this group is to recommend practical approaches and investment to improving the ability to reconcile medication lists and demonstrably reduce the incidence of undesirable drug interactions. These recommendations will be made in real time to the Health IT Advisory Council, and there will also be a formal final report of recommendations to be submitted to the Council and the General Assembly no later than July 1, 2019.		

4.	Background on the Issues	Michael Matthews and Tom Agresta	3:30 PM

Michael Matthews, a consultant from CedarBridge Group who is assisting with the facilitation of this group, explained some of the background that gave rise to this group through Special Act 18-6. This information can be found in slides 6-8 of the presentation.

Dr. Tom Agresta then described the work of the CancelRx group. He noted that one of the top-priority use cases that came out of the HIE Use Case Design Group was medication reconciliation. Through his involvement with OHS and his work in CT and nationally, it became clear that addressing electronic prescription cancellations would set the stage to address the larger medication reconciliation issues. From this, the CancelRx group evolved. In the past 8 months, CancelRx has had a total of 11 meetings. The group started with a core group of people, but grew to more than 50 individuals and 15 different organizations, including Surescripts, EHR vendors, hospital systems, and more. This group grew very organically as an action-oriented group; there were 3 sub-groups which all had additional leadership. One sub-group was focused on workflow, Sean Jeffrey helped on a technical requirements sub-group, there was a return on investment sub-group, and a workflow sub-group which had their own leaders. There is currently a pilot at Yale with the surrounding pharmacies, and other groups are interested in their own pilots, including Hartford Health and Trinity New England. The group produced a white paper that was published in the Journal of the American Medical Informatics Association (JAMIA). CancelRx is almost ready to produce a final report. From their work, there are some recommendations that can be handed off to this work group immediately:

- Make recommendations to the state legislature to increase electronic prescription cancellation adoption.
- Going from a pilot to implementation at multiple organizations requires a few well-trained individuals. Perhaps some of the HIE funding could be used to provide training, implementation support, and the development of an implementation manuals, as well as enhanced pilots.
- A good target would be to design an innovative solution as a common medication profile across the state and provide a tool for accessing the profile.
- Provide funding for peer-to-peer mentoring and technical assistance. We need to find a way to support this as a group and to figure out how this can be sustained.

Other members of the CancelRx group present at the meeting added their comments, including Sean Jeffrey, Nitu Kashyap, and MJ McMullen.

Jennifer Osowiecki asked if there is a particular demographic or system the group will be looking at – stated that the process seems very EHR-centric, and not patient-centric. Tom Agresta answered that, if a patient receives prescriptions from a variety of settings, such as mail-order, chain, and small community pharmacists, how does this come together? We were very cognizant of this in CancelRx. One thing that can happen is, if a prescription is sent to CVS, and the patient moves it to Walgreens, that data does not automatically flow to the new pharmacy. As part of our group here, we can take what we learned from CancelRx. We did not solve for everything, but we identified gaps, and he feels they did a pretty good job of identifying most of the challenges and opportunities. Sean Jeffrey added that this would allow for multiple prescribers who are not on the same EHR to cancel prescriptions, if clinically appropriate. Not only does this impact where someone could be getting a prescription, but also all of the settings that a prescription could have originated from.

Jennifer Osowiecki asked if they would be targeting a specific population, and if the insurers would be involved. Tom answered that this is up for discussion as this body develops.

Marghie Giuliano stated that as we look at transitions of care, med rec plays a big role. Med rec from this perspective is very important, but you cannot forget about polypharmacy. If we are focusing on med rec to begin with, care transitions could be an area where we could have an impact.

Jennifer Osowiecki stated that we don't want to create problems because we think we have a solution for something else. We need to be very careful thinking through what can get cancelled, what does not get cancelled, and how this is communicated. We need to be careful about what we do and how we do it. Tom Agresta added that, in terms of the patients having a printed list of medications for a family member, or themselves, there is nothing to stop us from making a recommendation for a patient-facing web-based app or solution to help solve for this. He hopes the group makes these recommendations because these technologies are starting to become available.

5.	Areas of Interest and Organizing Our Work	All	3:55 PM

Michael Matthews stated that, as we think about the CancelRx discussion, this Work Group will have several phases; there will be a definition and scope phase, a discovery and analysis phase, a strategy and recommendations phase, and we will end with a point of execution. Where do we want to focus our time and resources to attack these issues? He then asked the members to participate in an open discussion around their areas of interest. The members' comments are outlined below:

- Diane Mager (Connecticut Association for Healthcare at Home) – the number one that we could accomplish is related to simple terminology for Polypharmacy – there is a wide range of terms currently in use. What are we considering as polypharmacy? We should get everyone on the same page.
  - Tom Agresta – there is probably the same need on the medication reconciliation.
- Amy Justice (Yale / Connecticut Veterans Affairs Healthcare System) – it has become very clear that it is very time consuming to make an accurate list of medications. No one health system can do this on their own. Getting a few steps closer to an accurate, time-updated, total list of prescriptions that is one-stop-shopping for the patient, pharmacists, and medical providers would be my goal.
  - Tom Agresta asked if she would want to see a "single source of truth"? Amy Justice answered that she wants something as close as possible to what the patient is actually taking. We also need to think about over the counter medications at some point, but she recognizes that this is more challenging.
- Anne VanHaaren (CVS Health) – from her pharmacist perspective, to help with this issue and engaging patients, she would like to see a single source of truth and that everyone has access to the same information; particularly around ePrescribing, she thinks this could be a good focus for the group.
- MJ McMullen (Surescripts) – he would echo the thoughts shared by others, and added that there is also an opportunity to introduce products that are already in the market that could meet the needs that people are describing, including products from Surescripts. They have a medication history product that may be worth talking through. Somebody from his team could provide a demonstration and describe who is using these products in the marketplace.
- Debora Jones (Department of Consumer Protection) – she is joining today's meeting for Rod Marriott. DCP manages the prescription drug monitoring program (PDMP) in Connecticut, which collects information on controlled substances.
  - Tom Agresta stated that in other states, the PDMPs are being incorporated into the HIE functions and is exchanging data with the HIE to make information more accessible. We want to explore how to make the PDMP most useful to help solve the opioid crisis. I don't know what this looks like, but this is a real opportunity. There is a lot of federal funding available to solve the opioid crisis, and it would be foolish to not investigate this. Michael Matthews agreed that Tom made some good points, and shared that in Maryland the HIE runs the PDMP, which allows for some effective use cases. In some cases, we are just lacking effective systems integration. Debora Jones agreed that it would be beneficial to have information available to more people for effective use cases. Nathaniel Rickles (UConn School of Pharmacy) believed that Rod Marriot would be open to this type of conversation.
- Nitu Kashyap (Yale New Haven) agreed with the comments already made, and stipulated that defining the issue at hand and determining what can be measured is usually the starting point of these discussions and is valuable in determining what can be influenced.
  - Michael Matthews asked Nitu if she wanted to define the success factors and what could be measured. Nitu Kashyap stated that that is correct, and thinks defining the issue statement and working backwards from there will be helpful. There are a lot of good ideas that have already been brought to the table.
- Lesley Bennett (consumer advocate) stated that she would like to see a single consumer medication list with all medications, including supplements. She wants to avoid serious adverse reactions in elderly patients and patients with chronic conditions.
- Sean Jeffrey (Integrated Care Partners / Hartford Health Care) stated that, for many years, he chaired the polypharmacy interest group for American Geriatric Society. The industry is moving towards de-prescribing – getting rid of inappropriate medications. What drives the decision about what should be removed? There are a huge number of reasons for removing prescriptions and he thinks this will naturally lead us to a path of de-

prescribing. There is an increasing amount of literature around de-prescribing. What would a quality measure for polypharmacy look like? It may include some elements from CMS' assessment of high-risk medications. To some of the other comments, we cannot solve this without a real-time, best possible medication list that is available to everyone who needs this list at the point of care. Creating this list will be paramount. As we start thinking about when the industry moved to ePrescribing, which is almost universally adopted at this point, this is a structured, standard process that has been widely adopted. We need to look at de-prescribing through this lens.

    - Amy Justice stated that she doesn't think we really know how these drugs interact with one another in the context of 5 or more medications, as an arbitrary number. We also need to be thinking about how we direct research to help inform polypharmacy and definitions. It is not just known drug-to-drug interactions; nobody is studying or researching this. Michael Matthews stated that there is writing now about bringing in claims, labs, clinical information, etc. that will allow for a broader perspective. To the extent that we can look at large populations, we may have this capability in the future.

- Bruce Metz (UConn Health and Health IT Advisory Council) stated that it is hard for him to take off his CIO hat. If we are looking at personal preferences... fill and accurate medication lists, transitions of care, patient discharge - This is closely tied to patient engagement and adherence. If there is some way to do an environmental scan to determine what the literature is saying, we can determine the trends and the problems that need solving. Are we looking to solve at the state-level, as opposed to the organizational level? In addition to organizing the literature and trends, this could stimulate our thinking by researching what is working and has not worked in other states. What do we need to do from an architecture and operations stand point? We want to do things that are scalable and replicable. When we solve problem number one, we do not want to have to solve the architecture issues again for future priorities. Having some criteria to assess what we come up with as a group, including the level of effort, the sequencing, and the potential return on investment would be valuable. Without making something too arduous, he thinks adding some way to create priorities would be beneficial. An environmental scan to enlarge our thinking would be very beneficial.
- Peter Tolisano (Department of Developmental Services) stated that, in terms of psychiatric polypharmacy, the average is 2.87 medications per person. Guardians and family members often do not understand what is being taken. He has spearheaded efforts to reduce the number of these medications, and agrees that we need to work on defining polypharmacy. Also, issues around inherited prescribing are important.
- Nathaniel Rickles noted that something that Sean said is critical; we need to identify outcomes that we really care about. The outcome that patients care about is whether or not their medications are appropriate. We could look at appropriateness as an outcome. One of the first things we could do as a group could be to create a framework to begin our process. Thinking about structure, outcomes, process; this could be a useful way to guide our work. How do we document medication-related problems? When you look at de-prescribing, this is related to the documentation of problems and outcomes.
    - Michael Matthews asked if he thinks this works at the overall med rec / polypharmacy level, or if he thinks the work needs to be more narrowly defined. Nathaniel answered that he thinks it could apply to both the macro and micro level.
- Jennifer Osowiecki (Connecticut Hospital Association) stated that her interest is to represent CHA, but also in navigating specific issues, such as operating without an HIE, or dealing with our limited financial resources. In defining what the group will do, she thinks we should develop a framework. What kinds of recommendations are appropriate for the legislature? She doesn't want us to have unintended consequences when we try to do something positive. There are a lot of moving pieces. The interplay between state and federal law is a challenging concept.
- Kate Steckowych (Value Care Alliance) stated that her role is focused on the ACO-level and she is here for her background as a clinical pharmacist in a primary care setting. She wants to try to piece together some of the conversation so far – in trying to create a gold standard medication list, she is curious what is done with it at the end of the day. How this is used defines the efficacy of what we are doing. There still needs to be patient engagement to verify accuracy. The clinical piece should not be removed. Creating a structure and framework would be beneficial.

        - Tom Agresta added that one of the goals he would have is to make the medication reconciliation process occur with the patient and to make the right thing to do the easiest thing to do. The process is not currently easy. There may be low-hanging fruit that can be addressed. Jennifer Osowiecki stated that the transparency for the patient is not there, either.
    - Marghie Giuliano (CT Pharmacists Association) said that she has been involved in quality work as well. There has been good discussion. We need to come together with common definitions. Med rec is not just a med list, it is a process. Med rec has not been standardized across settings. This should be one of our focus areas. Being able to understand the processes will be important. It would be great to have diagnoses codes, lab values, etc. to make sure you are working in a comprehensive manner. Let's give clinicians the tools they need to do the work and let's pay for the work.

Michael Matthews asked what everyone's reactions were to the discussion so far.

- Jennifer Osowiecki stated that she thinks there is one thing that we are not discussing: prescriber habits and proclivities. The question is, are we creating a system that is good for 80% of the people but making the other 20% have a more complex, burdensome process? Are we really helping patients in terms of these discussions around de-prescribing? Who are we to second guess a specialist and does this lead to more problems?
- Sean Jeffrey asked what are the data elements and the information that a prescriber needs at the point of prescribing? Is it enough to have a complete list of the meds? Probably not. Does there needs to be some additional input around the profile that leads to a next step and what is that next step?
- Tom Agresta stated that if he goes to prescribe a medication, he will get an alert if there is a potential interaction. Often times, the human brain is the one that finds the pattern. For the long-term solutions we are looking for, having these types of issues solved would be ideal, but may be beyond what we are working on at this time.
- Amy Justice stated that we cannot do the research until we have the information and an accurate list of what people are taking. This is the first step for research and improving patient care.
- Nitu Kashyap stated that it sounds like one of the things the group agrees on is that having a single source of truth for medications as an objective would allow us to create a few workstreams under this.
- Jennifer Osowiecki asked who the keeper of the single list would be.
    - Amy Justice said that she believes there should be a list available to all of these people that is stored independently. Navigating privacy and security may be one of the challenges. Jennifer Osowiecki responded that the PDMP is required by law to only have access for specific reasons. It is required to report to this. Is this going to be helpful? Amy Justice stated that the different databases do share data across state lines to some level. Tom Agresta stated that it is parallel queries that run, but he doesn't think data is shared across databases. We are surfacing some of the major challenges and questions that we will have to answer to solve any problem. The reality is that patients will cross state lines and we will never solve for this perfectly. Nitu Kashyap added that she thinks it would be valuable to look at what Surescripts offers today.
- Tom Agresta stated that it sounds like the group is raising the question of having a formal set of literature search around these topics. One thing we did in CancelRx is we went to the medical librarian with a series of questions to curate and prepare the literature list. Somebody will need to read and digest this literature. We would have to have a process for analyzing this information.
    - Nathaniel Rickles asked if the group agrees on the characteristics of any end goal or solution. Marghie Giuliano responded that she thinks, from a health IT perspective, it is important that we make sure to align efforts with what is going on nationally. There is a pharmacy health IT collaborative that has done work in this area. Maybe we need to get someone engaged from the national perspective. Tom Agresta agreed that they should absolutely leverage work that has already been done. Marghie Giuliano added that there have also been a lot of groups that have created interoperable solutions that document processes. There is a lot out there currently. Bruce Metz agreed that this is important. In some ways, the technology is advancing so quickly that it doesn't necessarily need to dictate what we want to do. Capitalizing on future trends could be another thing we should think about.

6.	**Meetings and Logistics**	**Michael Matthews**	**4:45 PM**
	Michael Matthews provided a recap of what was discussed during the discussion: ○ Need to find a common definition for medication reconciliation and polypharmacy ○ Environmental scan - what is working and what has been done elsewhere? What are the future trends? ▪ Surescripts presentation / demonstration – MJ wants to give his colleagues some expectation to know how much time they are working with for a demonstration. The Work Group will circle back once there is a framework developed. ○ Success measures ○ Framework – structure/process/outcome/decision criteria ○ Low-hanging fruit ▪ If there is something that is achievable quickly, we should discuss this and start working in parallel to defining the group's structure, framework, and operations. ▪ Sean Jeffrey added that if it is categorized as low-hanging fruit, we could bring the CancelRx work to this MRP group in more detail. ○ Organizing our work ▪ The group should think about what roles should exist in the group. Should there be chairs, co-chairs, workgroups, sub-committees, etc.? ○ Allan Hackney added that an early use case could be connecting the PDMP to the new HIE services. This is something that Rod Marriott has talked a lot about. This could be defined fairly quickly as the group works out more complex issues.		
7.	**Wrap up and Meeting Adjournment**		**4:55 PM**
	Allan closed the meeting and reminded everyone that the next meeting will be held on October 15th at St. Francis in Hartford. The Work Group will need to consider future locations for the meetings in 2019.		

Upcoming Meeting Schedule: 2018 Dates – October 15, November 16, December 21
Meeting information is located at: https://portal.ct.gov/OHS/HIT-Work-Groups/Medication-Reconciliation-and-Polypharmacy-Work-Group