Medication Reconciliation and Polypharmacy Work Group

Medication Reconciliation and Deprescribing Subcommittee

Meeting Minutes

Meeting Date	Meeting Time	Location
April 15, 2019	1:00PM – 1:50PM	https://zoom.us/j/153975347

Sub-Committee Members					
Marghie Giuliano	x	Rod Marriott	x	Anne VanHaaren	x
Sean Jeffery	x	Jennifer Osowiecki	x	Marie Renauer	
Amy Justice	x	Jameson Reuter		Ken Whittemore	
Nitu Kashyap		Nathaniel Rickles		Stacy Ward-Charlerie	x
Diana Mager		Ece Tek			
Supporting Staff / Leadership					
Allan Hackney (OHS)		Michael Matthews (CedarBridge)	x	Kate Hayden (UConn Health)	x
John Schnyder (HIE Entity)	x	Chris Robinson (CedarBridge)	x	Tom Agresta (UConn Health)	x
				Jennifer Boehne (CVS Health)	x

Minutes			
	Topic	**Responsible Party**	**Time**
1.	**Welcome and Call to Order**	**Michael Matthews**	**1:00 PM**
	Michael Matthews welcomed the subcommittee members to the meeting and called the meeting to order. Michael provided an overview of the agenda.		
2.	**Public Comment**	**Attendees**	**1:05 PM**
	There was no public comment.		
3.	**Discussion**		**1:10 PM**
	Amy Justice explained that the main goal of the meeting is to review the documents that were circulated before the meeting. The group decided there was not a need to review or revise the CancelRx Executive Summary. The document for review during today's call include the following components: (1) Accurate Medications List, and (2) Deprescribing. Sean said that the document is getting close to being finalized, however there is some nomenclature that is being used, particularly around the use of "community pharmacy," inconsistently. In some places we say, "retail community pharmacies" or "chain pharmacies" or "independent pharmacies." In the pharmacy world we think of "community pharmacy" as any chain or corporate pharmacy separate from an independent pharmacy. There are also long-term care pharmacies and those that are associated with health systems or hospitals. Sean would like for us to determine a definition of "community pharmacies." Sean agreed that he will edit the document and provide this update. Stacy Ward-Charlerie said that she sent in some comments a few weeks ago, but she is not sure they have been incorporated. Michael Matthews said that we did receive the documents and took great care to incorporate her edits and comments into the document. If there is anything else that needs to be added, Michael asked Stacy to please flag the areas of concern and let him know.		

Amy Justice said that we decided at prior meetings that we would focus on prescription medications for this exercise, and we would not focus on over-the-counter (OTC) medications. OTC medications can be discussed from an aspirational perspective. Amy said that another issue that has been brought up in the document pertains to people who have enrolled in clinical trials. Amy said she believes that a research note needs to be added to the EHR when someone is enrolled in a clinical trial, but it does not need to be added to the pharmacy package. Amy said in the VA there is a note to indicate someone is enrolled in a trial, but the specifications are not listed, although she is not positive of this. Sean said he thinks there needs to be a way to track the active and inactive ingredients in case there is an issue. Amy agreed and said this is visible by the pharmacy that dispensed the medications, but the provider, patient, and clinic are blinded. Amy said we need to be careful not to "let the perfect be the enemy of the good" and suggested that we put this item in the same bucket as OTC medications as future work that could be addressed.

Jennifer Boehne of CVS said she agreed with the overarching concept of relegating OTC as future work; however, she has seen some negative consequences associated with OTC medications. She would encourage the group to make a statement that if a patient is on a trial medication, there should be a generic flag for "trial medication" on the medication list with a phone number that can be used in case of an emergency. Amy agrees that this suggestion should be included as part of the recommendations. Michael asked if a clinical trial medication comes along with decision support. Tom said that no this is not included, and this is one thing that can emerge from a trial. Tom said that to a large extent, unknown meds on a trial exclude patients that are taking a lot of other medications to try and reduce the risk of bad outcomes and reduce the risk of not being able to interpret the results. Jennifer said that she has not seen any EHR that is able to provide decision support for clinical trial medications. Amy said that there could be a generic alert. Tom said that we could leverage the fact that the current clinical decision support does not provide for this possibility. Amy said that we should include a recommendation for a general alert that indicates the person is taking a clinical trial medication and include a phone number for someone involved in the trial. Sean said that we could reach out to the pharmacies to find out the nomenclature that they are using to document these medications and see if they have suggestions for how to improve this process.

Amy Justice said that in an earlier draft of the document, there was a suggestion for best practices, and she wanted to discuss this item. There are a wide range of best practices on medication reconciliation, including from CMS and the Joint Commission. She does not think we should get into the best practices for medication reconciliation, but we could recognize where best practices have been developed and published. She does not think we are the body to recommend which best practices should be followed. Tom agreed. Sean said that we should keep in mind that there are also state operation manuals within long-term care settings, and other documentation and accreditation considerations outside of the health system setting that need to be considered. Home health care is an important setting in terms of medication reconciliation.

Amy said that her conceptualization of the database, is that it would be a go-to source to start a conversation about medications. It would not be the final source or the only source of information. Tom said that this representation of how to use aggregated and curated data is in line with the discussions that occurred at the Hackathon. Tom said that Amy's approach of starting with a better source of information to enable collaborative conversations is the right way to think about this. Sean said that what has been surfacing in the literature is the terminology of "best possible medication list" and this really captures the fact that this will never be perfect, and this document will not be static.

Jennifer Osowiecki asked if the group is going to make any recommendation in terms of how far of a look-back will be considered for medication reconciliation, and what retention period will be used for the data if there will be a single database. Jennifer asked if there is any thought in terms of consent and patients not being comfortable with the retention of their medication history. Stacy Ward-Charlerie said that Surescripts allows for requests to be made for up to 12 months of data, from the time of the request. Tom said that he thinks you are able to see further back within EHR systems. Tom said that the EHR may store Surescripts data for a longer period of time, but he is not positive. Stacy said that is correct and the EHR can store the 12 months of data that is returned from Surescripts. Amy asked for Rod Marriott's perspective in terms of what

is done within the Prescription Monitoring Program (PMP). Rod said that the PMP holds 3 years' worth of data and defaults the search to 12 months automatically. Rod said that they are working with their vendor in terms of what is done in terms of data archival. Jennifer Boehne said that in terms of archiving, there is a great use case for PA and having to show that a patient is on a failed medication. This would be helpful. Amy agreed and said that this would very valuable information for the provider.

Sean Jeffery said that we need to be mindful of patients that transfer between health systems and EHRs. If we only have 12 months of data from Surescripts, when a patient moves to a new health system, this may be all that is available. Amy agreed and said that there are issues about privacy that clearly need to be tackled. Tom said that the issues around privacy are really more consent-related issues. Stacy said that from the Surescripts side, they do archive the data; however, usually the 12-months' worth of data is hard enough for people to reconcile, but there are use cases to go back further than 12 months. Tom said that he agrees from a PCP perspective and that the current mechanisms by which data is provided is less-than ideal for the clinicians. Michael asked Stacy if discontinued drugs are included in the Surescripts data request. Stacy said that this includes all dispensed medications and added that if a medication is subsequently discontinued, it will still be included in the dispensed history. They are working on something to help carry forward the CancelRx into the medication history.

Amy said that we agree in principle that the data should not be discarded after some period of time, and that the data should be maintained as part of the medication history. Amy added that the explicit details of how the data will be displayed, or whether or not we consider something as an active medication, will be tackled later or will be (or have been) addressed by other groups, such as EHR vendors. Sean and Tom agreed.

Tom said that as part of the summary, we can list the items that should be considered as the use case and model are developed. Tom said we are essentially developing a collaborative research project.

Sean asked if we can pivot to the deprescribing document. Amy said that her only comment is that there was no discussion about the problem people get into in terms of guidelines. People often run up against specific disease guidelines as a barrier. This deserves some discussion. Sean said that we can highlight the work that has been done by Mary [audio was not decipherable]. Amy said that many deprescribing trials run into this issue. "Right prescribing" is often dictated by specific disease guidelines, and this can be a big problem. Sean said we talked a lot of polypharmacy, and we can all recognize the issue when we see it but getting to an action-oriented step of deprescribing is a challenge when you bump up against a guideline or a provider who is very confident in the medications that they prescribed. It can be difficult to communicate the patient's goals effectively. Sean said that Holly Holmes works in Texas and has developed a conceptual framework for deprescribing that takes into account the person's expected outcomes, risks, and expected longevity that allows you to have this conversation, but it ultimately leads us to the question of who will drive the process of deprescribing and be responsible. Amy said that Sean's summary of this was very good. Amy said that we need to include a recognition that the disease-specific guidelines are problematic as a way to start the conversation. Amy said that this should be included in the document as a recommendation, with a few steps for how to address the issue.

Tom Agresta asked if there are any clinical decision supports tools that are available or could be developed to assist someone in deprescribing. Sean said that we should look to what is happening in Canada to see what they are doing in the Canadian Deprescribing Network. They really have taken the approach of using the high-risk stratification with a communication plan that is overlapped with the patient information. They also have some nice visuals. Sean thinks this could be incorporated into decision support. Amy said that MedStopper is one example that is described in the summary.

Jennifer Boehne asked Tom to clarify if he is looking to score or identify high-risk patients based on age and conditions, or if he is looking at dosing support for the medications that they are currently prescribed. Tom said that in this particular context, we are looking at what kind of support can clinicians be provided through an interactive service of the HIE in terms of deprescribing medications. He thinks dosing support may be appropriate to occur within the EHR in the longer term, however for us we should focus on deprescribing.

	Jennifer said that Partners had clinical decision support that she re-built within Epic when she worked there. These support tools were aimed at deprescribing or decreasing doses of medications that could have negative outcomes. She thinks there are a number of hospitals in the Mid-West with scoring algorithms to help identify patients that are taking ten or more meds, or have significant co-morbidity, to identify people who should be receiving medication therapy management services and pharmaceutical care. She has seen both types of decision support that we are talking about. Tom said that the ability to identify patients that could benefit from deprescribing could be valuable function. Amy said that the VA has an alert that is distributed whenever a patient is taking a certain number of medications and there is a recommendation that the patient is sent to geriatric, however this has process concerns. Amy said it would be more helpful to have a tool inspect the list of active medications and provide guidance on which medications should be deprescribed. Then the pharmacy and providers are able to have a meaningful dialogue and develop a viable plan for deprescribing. Sean said that we could as a group think of nuances for what high-risk individuals look like and we could develop consensus around what type of person we are building tools to support. Michael Matthews said that to Tom's point, this issue is being wrestled with HIEs around the country, and there is a question about whether or not the Connecticut HIE should have a decision support service that goes along with the presentation of clinical data. Michael doesn't think we have the time to debate this issue today, but it may be worth discussing further in the future. Amy said that this is a fair point, but the key issue is that you can only apply decision support appropriately once you have an accurate list of medications, and if the accurate list only sits in a central location, then you will need to echo back the accurate list to each relevant facility or have decision support provided at the central location. Amy said that she would argue that some decision support could be provided centrally, but most of it should be occurring within the facilities. Tom agreed that this tension will be important to address for the HIE.		
5.	**Next Steps and Adjournment**	**Michael Matthews**	**1:55 PM**
	Amy Justice adjourned the meeting.		

Upcoming Meeting Schedule: Future meetings will be scheduled at a later date
Meeting information is located at: https://portal.ct.gov/OHS/HIT-Work-Groups/Medication-Reconciliation-and-Polypharmacy-Work-Group