Medication Reconciliation & Polypharmacy Work Group

Medication Reconciliation & Deprescribing Subcommittee

MAY 15, 2019

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Agenda

Agenda		
Welcome and Call to Order	Amy Justice	1:00 PM
Public Comment	Attendees	1:05 PM
Last Call on Med Rec and Deprescribing Report	Amy Justice	1:10 PM
Recommendations Review: BPMH	Attendees	1:15 PM
Recommendations Review: Med Rec Process Improvement	Attendees	1:30 PM
Recommendations Review: Deprescribing	Attendees	1:40 PM
Other Issues to Discuss and Adjournment	Amy Justice	1:45 PM

Public Comment

Last Call on Med Rec and Deprescribing Document

Recommendations Review

Recommendations Review: BPMH

Premise and Goal

The vital importance of an accurate list of active medications and history of adverse reactions to medications for the safety and appropriateness of medications is well recognized by healthcare professionals, patient advocacy groups, and policymakers. The importance of this list increases when the patient is on multiple medications, when the patient is seeing multiple prescribing providers, when providers do not share a common EMR, or when the patient needs the assistance of a caregiver for the patient's healthcare needs.

Statewide databases like the Connecticut Prescription Monitoring and Reporting System (CPMRS) and networks like Surescripts have established feasible methods of maintaining and accessing prescription medication fill data and have largely addressed issues of privacy, data security, data storage, and data access. With appropriate resources and legal empowerment, these databases might form the nidus of a centralized master list of active prescription medications and medication history.

The MRP Work Group recommends an incremental approach to support BPMH that enables near-term, value-added solutions while working toward longer-term, more complete and integrated solutions.

Objectives

1. Near-term efforts should be focused on making tangible progress toward an enhanced and uniform BPMH, and should include:
   - Integration of data derived from groups such as pharmacy benefit manager (PBMs) and community pharmacies, EHR-based medication data, and prescription monitoring program (PMP) data, in coordination with the statewide HIE
   - Exploration of the expansion of CPMRS to include all prescribed medications
   - Dispensed prescription medications, i.e., not including over-the-counter (OTC) and supplements initially
2. A longer-term vision for designing and implementing a "single source of truth" should be established and should include:
   - Integrated artificial intelligence (AI) and clinical decision support (CDS) tools
   - Evaluation of business (legal financial, operational), technical and functional requirements
   - Inclusion of over-the-counter medications (OTC) and supplements

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Full medication history is probably a bridge too far. The main concern is past adverse reactions to medications.

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Recommendations Review: Med Rec Process Improvements

Premise and Goal

As defined by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), medication reconciliation is "the process of comparing a patient's medication orders to all of the medications that the patient has been taking. This reconciliation is done to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions. It should be done at every transition of care in which new medications are ordered or existing orders are rewritten. Transitions in care include changes in setting, service, practitioner or level of care."[1]

The MRP Work Group recommends standardizing definitions, processes, and tools to enhance the effectiveness, efficiency, and consistency of medication reconciliation across the State of Connecticut.

Objectives

1. Adopt JCAHO definition (above) and process to standardize terminology and approach for prescribers, caregivers and other stakeholders in Connecticut. This includes:
   - Defining "current medications";
   - Developing a list of current medications;
   - Comparing the medications on the two lists;
   - Making clinical decisions based on the comparison; and
   - Communicating the new list to appropriate caregivers and to the patient.
2. Develop a standardized toolkit of best practices, including tools of the Multi-Center Medication Reconciliation Quality Improvement Study (MARQUIS).[2]
3. Develop and implement a provider and prescriber communications plan for the dissemination of the above definitions, processes, and toolkits.

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Recommendations Review: Deprescribing

Premise and Goal

Once medication reconciliation is accomplished, medications identified as potentially inappropriate, no longer needed, or where the risk outweighs the benefit should be considered for discontinuation. However, the scientific evidence supporting this decision making process is limited. To date, providers are often caught between what specific disease guidelines recommend and concerns regarding polypharmacy and potential drug interactions. Because the evidence is limited and new evidence is likely to become available with time, the joint patient-provider decision to stop (deprescribe) specific medications requires clear and thoughtful communication between the patient and prescriber(s). Many medications may require slow tapers rather than abrupt cancellation.

The MRP Work Group recommends the identification and adoption of best practices in deprescribing, along with support from tools such as risk algorithms and training materials that are regularly re-evaluated and updated as new evidence becomes available. The group also encourages active research to develop and validate best practices.

Objectives

1. Identify best-practices for deprescribing
2. Create a shared-decision making model that engages patients and providers in discussing deprescribing
3. Develop medication risk algorithms to identify population health strategies for potential medications for deprescribing
4. Survey prescribers regarding educational needs for deprescribing
5. Create/disseminate training materials to support deprescribing
6. Have a mechanism for updating these educational materials and decision support tools as new evidence becomes available.

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Other Issues to Discuss?

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