Medication Reconciliation and Polypharmacy Work Group

Meeting Minutes

Meeting Date	Meeting Time	Location
March 18, 2019	2:00PM – 4:00PM	195 Farmington Ave Farmington, CT 06032

Work Group Members					
Thomas Agresta	x	Nitu Kashyap	T	Jameson Reuter	
Lesley Bennett	x	Janet Knecht		Nathaniel Rickles	x
R. Douglas Bruce		Diane Mager	x	Kate Sacro	T
Jeremy Campbell		Rodrick Marriott	x	Ece Tek	
Marghie Giuliano	x	MJ McMullen		Peter Tolisano	x
Sean Jeffery	x	Bruce Metz	x	Anne Van Haaren	T
Amy Justice		Jennifer Osowiecki			
Marie Renauer	T	Barbara Bugella	x		
Supporting Leadership					
Allan Hackney, HITO		Sarju Shah, OHS	x	Brenda Shipley	x
Kate Hayden, UConn Health	x	Michael Matthews, CedarBridge	x		
Sabina Sitaru, HIE Entity		Chris Robinson, CedarBridge	x		
x = in-person participation; T = remote participation					

Minutes			
	Topic	**Responsible Party**	**Time**
1.	**Welcome and Call to Order**	**Michael Matthews**	**2:00 PM**
	Michael Matthews welcomed the Medication Reconciliation & Polypharmacy (MRP) Work Group members to the meeting and called the meeting to order. Michael provided an overview of the agenda.		
2.	**Public Comment**	**Attendees**	**2:05 PM**
	There was no public comment.		
3.	**Review and Approval of 2/20/19 Meeting Minutes**	**Michael Matthews**	**2:10 PM**
	Michael Matthews asked for a motion to approve the minutes from the February 20, 2019 meeting. Sean Jeffery created the motion to approve the meeting minutes, and Marghie Giuliano seconded the motion. The February 20, 2018 meeting minutes were approved without opposition or abstentions.		
4.	**Update on Funding Opportunities**	**Sarju Shah / Michael Matthews**	**2:15 PM**
	Sarju Shah provided an overview of the federal funds that are available for MRP planning activities. This funding is made available through the IAPD process and is provided by CMS at a 90% match rate. It is anticipated that this funding will total $100,000 for 2019 and $150,000 for 2020. The Office of Health Strategy (OHS) will be looking at how to support the MRP Work Group with these funds. The MRP Work Group should think about how this funding can complement and support the MRP Workgroup recommendations. Michael provided an overview of funding available through the SUPPORT Act (H.R. 6 – Section 5042). This funding will be available at a 100% funding rate from the federal government to support increased access to data from prescription drug monitoring programs (PDMPs). On March 15, 2019, several different state agencies convened in a productive meeting to discuss potential opportunities that could be supported by this funding. Michael provided an overview of the planning process that will be utilized to develop this funding request, which is led by OHS and the Department of Consumer Protection (DCP). Rod Marriott believes there are a number of opportunities that can be pursued and wants to ensure that as many agencies as possible are involved. The funding is only available for another 18 months; the state will need to		

	be strategic about which projects are pursued. Tom Agresta said that the scope for this funding is narrower than the MRP planning funds. Tom said that as we are thinking about this funding, proposed solutions should be based on modern architecture with open APIs. Sean Jeffery asked if Rod has any sense how many EHRs are currently integrated with the PDMP. Rod said that he is unsure of the exact numbers off the top of his head. Tom asked Rod to describe the different ways in which doctors connect to the PDMP. Rod explained that the most basic level is a clickable link that sends the user to the PDMP's website. The next level allows the user to use their EHR log-in credentials to access the PDMP through single sign-on, which launches a query with patient context. The third level continually pulls down a metric based on prescribing history and displays a score. This is called NarxCare. The NarxCare platform provides a three-digit score, which adds a level of clinical decision support. DCP's grant proposal includes funding to provide NarxCare for every PDMP user for at least 2 years. Rod's understanding is that if you are already integrated, you will begin to receive the NarxCare score. Rod said there is a little bit of a learning curve, but he thinks it will be valuable. Tom asked if organizations need to pay onboarding and licensing costs currently. Rod said yes, but they want to pay for these integration costs through the SUPPORT Act funding in the future. Rod believes that the price for NarxCare, or for integration with the vendor, is negotiable. He has been hearing encouraging stories recently about the pricing. Rod is not responsible for contracting or costs between the health system and the vendor. Rod believes that it makes sense to leverage the state's buying power, but there are some challenges, such as if the vendor goes out of business. We need to be thoughtful as we move forward. Rod is hoping that SUPPORT Act funding can help to demonstrate the value of NarxCare. Marghie Giuliano asked if the statewide health information exchange (HIE) could handle the vendor negotiation. Rod said this is possible and is something that is actively being considered. There are a number of decisions that need to be answered, such as who would manage the help desk, or manage access controls and user credentials.		
5.	**Caregiver Perspective: Defining Value**	**Brenda Shipley**	**2:35 PM**
	Michael Matthews introduced Brenda Shipley, who will be presenting her perspective on medication reconciliation and polypharmacy as the primary caregiver for her mom. Sarju previously distributed her brief biography with the group. Brenda worked with the University of North Carolina's School of Pharmacy, in their Medication Optimization Center, to produce the video that was shared with the MRP Work Group (https://vimeo.com/liftfilms/review/311306072/24e58b1eb7). Brenda is interested in the concept of having an embedded pharmacist within an integrated primary care office. Brenda believes that amateur caregivers, such as family members, or the patients themselves, should not be responsible for medication management. In addition, Brenda was part of a consumer advocacy panel and developed a list of value statements related to her experience and perspective as a caregiver. Brenda shared this list of value statements with the group. Brenda said that this one patient experience resulted in a 19-day hospital stay and thousands of dollars of unnecessary services. This could have been prevented if there was effective medication reconciliation and management at the point of care transition. Lesley Bennett asked if Brenda knows how many medications her mom is taking currently and if the doctor or pharmacist provides a schedule for when each medication needs to be taken. Brenda said that she has personally developed a spreadsheet that lists all relevant information and is used to inform the doctors. Marghie thanked Brenda for sharing her story. Marghie said she believes there is definitely room for another PCP - a "primary care pharmacist." Marghie said that Sean is in a unique position where he can help with medication issues in the primary care setting, but this is not common. Marghie added that the big barrier with this type of integration is the cost and reimbursement. Pharmacists are the most qualified to handle these medication problems, but payers have not re-evaluated and do not pay pharmacists for what they should be doing. This type of practice transformation goes hand-in-hand with the quality-driven move that is currently seen in healthcare. These issues require concerted effort to make sure pharmacists are prescribing and practicing at the top of their license. Diane Mager said that she agrees with Marghie. Diane said that we		

can't forget about the home healthcare setting – they are the front line for the transition of care in many instances. Diane wants to make sure the group does not forget about this high-risk setting.

Tom Agresta also thanked Brenda for her presentation and said her story strikes home. Tom thinks it is very hard for the primary care setting to balance all of the different challenges and problems, and there needs to be better tools and processes. Tom has worked with pharmacists as collaborative care partners before, and it can be very beneficial for complex patients. He also thinks there is an opportunity to establish a standard format for reporting from home health agencies. The pharmacists are also spending a huge amount of time reviewing medication lists and interpreting them.

Sean Jeffery also thanked Brenda for her presentation. Sean works within one of the health systems in Connecticut. There are 3 pharmacists in his group that are responsible for more than 200,000 patients and they have to figure out how to identify who will receive the greatest value from the services they provide. For Sean, the thing that resonated most with him was if Brenda did not step up and take ownership, who would have? The deliberate advocacy is valuable. Sean said that there are currently bills in the legislature that would enable pharmacists to be part of the healthcare team. These bills have not moved forward because of the potential cost they may create. Sean wants to make sure that Brenda's story is heard by the new governor. We don't have to wait for the federal government. Sean believes there are real savings that can be realized here. Brenda thanked Sean and said she would be happy to testify at any upcoming hearings. She would also like to have a list of current bills so that she can reference them in future presentations. Marghie said that legislation is great, but it still does not necessarily solve the reimbursement issue. Marghie thinks the group should also be engaging they payers and pleading with them to re-evaluate.

Nate Rickles thanked Brenda. Nate said he is going to use this story as a case study for what we are trying to accomplish. Nate asked how long it took Brenda to develop the spreadsheet of her mom's medications. Brenda said it is constantly changing and she updates it on a weekly basis. Nate asked if Brenda knows of any other lists that exist that are discrepant from her spreadsheet. Brenda said she begins every appointment with at least 10-15 minutes of medication reconciliation using her spreadsheet. Tom said this is paid time that is not spent focusing on delivering care to her mom. Tom said in the primary care side, the MAs are trying to queue up these issues for the doctor, so the work can be more targeted. Marghie said that if this reconciliation work was shared with everyone, including the home health agency, then we can reduce the burden – but this would require interoperable information systems.

Sean Jeffery said there is a lot of communication that needs to happen, but what usually breaks down is the trust in the communication. As we get further from the source of truth, which is not known to everyone, then we lose trust in the accuracy of the information. Solving for trust is very difficult. Brenda agrees and says that another challenge is the wide variety of terminology and nomenclature that is used to reference the medications, as well as the patient's ability to pronounce the names of the medications. Diane said she wants to build on Sean's comments related to trust and being able to see something in real-time. Diane is excited to hear that the home health nurses are taking the time to look at Brenda's medication list, because this doesn't always happen.

Tom asked Brenda if her mom has access to a patient portal. Brenda said that her mom struggles with technology, so she does not access a patient portal. Brenda wants her mom to be enabled and empowered to manage this information herself and to take command of her own health and healthcare. If this involved using technology, there would be less of a chance that she would be engaged. Tom said there may be solutions out there that could help her, and it would be interesting to hear her perspectives on these.

Nate said that it sounds like Brenda owns the list – the caregiver is the one who owns the list, but the caregiver does not usually want this burden. The caregiver owns the list because this is the only viable option, but they are under-prepared and don't have the experience to deal with the issues that arise. Brenda said that the caregivers don't have enough knowledge to prevent adverse events. With all of the healthcare services received, it feels like she bought her mom a first-class ticket, but once she boarded, she was asked

	to sit in the pilot's chair and fly the plane without any training. Marghie said that this is a great analogy – but she thinks there will always be the need for dedicated advocacy from patients and their families. Sean asked Brenda if there would be any value in early warning sign triggers, or flags to alert providers that certain patients need extra help managing their medications. From a public awareness perspective, this group can highlight what might be indicators that people need deliberate and dedicated medication management. Brenda said this is a great idea. Brenda did not think there would be medication errors or that those errors could be near-fatal. She did not know enough to know what to look for. Phil Smith said that this conversation is a good example of how complicated this topic is. Phil thinks we need a partnership between pharmacies and doctors that allows them to work together more effectively. Phil thinks the idea of an annual medication review to target issues with polypharmacy would be very beneficial. It takes time and effort to execute effective medication management. Michael Matthews thanked Brenda for sharing her story with the group. Michael said that as we think about what will happen with the recommendations from this Work Group, the ongoing engagement of the broader community needs to be considered. This is a powerful story – as we are crafting recommendations around patient safety and engagement, we should remember today's discussion.		
6.	**Update on Student Research Assignments**	**Nate Rickles**	**3:10 PM**
	Nate Rickles provided an update on his student research assignments and an overview of the topics that are included in this literature review and research effort. Nate distributed this list to the group, and asked people for comments or additions. Nate said that the items are focused on factors that will impact the accuracy of the accurate medication list. This will be a gradual process – we will not reach the ideal state tomorrow, or on the first try. We need to come up with an initial model that can be scaled and iterated upon. Michael asked Nate for his projection on timing. Nate said that the Drobox is being populated as we speak. The students will begin to work on distilling the literature and will look to have some synthesis ready for the April meeting. Nate said this is an aggressive goal, but it should be possible. Michael asked the group if there are particular items from the list that can be prioritized. Diane said that many of these topics will not have any peer-reviewed research documents available because they are so new. Nate said he will report back in April if they are blown away by the amount of research that is, or is not, available. Bruce Metz said it would be important to know the areas where there is not any existing research, or where more research is needed. Sean said we think about how far back we should look because any literature that pre-dates EHRs may not make sense for this group's purposes. Nate said he told his students to focus on the past five years, and not to go beyond 10 years. Nate said he thinks we will find a lot of one-off information that is specific to individual organizations. The information may not be generalizable – it may be specific to one health system or hospital's experiences and conclusions. Rod Marriott said that they may be able to remove over-the-counter medications from the list, as we have previously discussed the possibility of limiting the scope this way. However, this is a hugely important topic, and if the students can collect this information, they should do it, but it may not be worth the time to synthesize this information right now. Rod said there is currently a bill out about the cost of medication adherence – they want DCP and DPH to study how cost is affecting utilization. This is Senate Bill 4. Nate asked about the idea of looking at return on investment. Nate was a little caught off guard about this, but it is the right thing to do. Michael said ROI does not necessarily mean financial return. Tom said you could imagine an ROI study being done within an organization on this topic, or a related topic. Barbara Bugella said she remembers reading something related to EHRs and the expectation that they will reduce errors, however EHRs have actually been shown to increase errors in certain areas. She is wondering if this can be a consideration, because we have to rely on the technology. Tom said that this is a tradeoff – you move from one type of error to another. Tom said there are some studies that try to estimate this.		

	Nate asked if we should be focusing on the accuracy of the "golden list" or should we be focused on the processes and mechanisms for developing and validating the list. Phil Smith said the biggest problem today is getting to the list. Phil thinks the list of research items is good and we will be amazed by how little literature exists in this area. We will have challenges getting a good amount of evidence-based knowledge to support these items. Phil thinks the Hackathon will help to inform what people see as the best opportunities to pursue. Nate said we are on the right path and will incorporate today's comments into the process.		
7.	**Overview of Final Report Outline and Components**	**Michael Matthews**	**3:25 PM**
	Michael Matthews reminded the group that we will need to deliver a recommendations report by July 1, 2019. Michael presented an overview of how the final report could be structured, and what components could be included in the report. Michael also provided an overview of a process diagram that was developed by Phil Smith. This diagram will be presented at the Hackathon from the perspective of potential solutions. Marghie said that the Policy Subcommittee's work is dependent on the efforts of the other subcommittees. She asked if we are looking for strictly policy recommendations based on the work of the other groups, or are we looking for recommendations around legislative changes. Michael said he thinks we will have recommendations coming out of all of the subcommittees, as well as CancelRx. If we compile all of those recommendations, the Policy Subcommittee should identify what policies are necessary to support the recommendations and what policies are barriers that would prevent the implementation. Michael thinks there can be an aspirational aspect as well, but we will need tangible, concrete recommendations as well. If we have specific goals that can immediately be moved to funding through an IAPD request, that is great, but if we have higher-level, long-term aspirational items that need additional validation, that is okay as well. Tom said we should not underestimate the reach that this MRP Work Group has. There may be people that are inspired by the recommendations we produce, or the conversations we are having. Michael said that we just need to start throwing clay on the potter's wheel and start to get the ideas on paper.		
8.	**Overview of Current Action Items**	**Attendees**	**3:40 PM**
	Michael presented an overview of the current action items and assignments. Nate asked if it would be useful to document the workflows for how we would gather all of the relevant medication information. Marghie reviewed one of the documents from the Medication Reconciliation and Deprescribing Subcommittee and asked about the term "Statewide Medication Management Service." Marghie said that this term may create unrealistic, or unintended expectations. She does not think this is the right terminology. Michael explained the provenance of that term, which was created for the IAPD funding request. Michael agreed that we should be cautious and said that Marghie's point is well taken.		
9.	**Medication Reconciliation Hackathon**	**Tom Agresta**	**3:45 PM**
	Tom Agresta provided an overview of the upcoming Medication Reconciliation Hackathon which will occur on April 5 and 6, 2019. The Hackathon will focus on the potential problems and solutions in this area. At the end of the event, there will be a demonstration of some of the solutions that have been developed. There is a wide range of healthcare professionals who will be attending. Tom thinks it would be great to have Brenda attend to share some of her perspectives and experiences. Tom said they are going to try and record some of the main presentations. Anybody is welcome to attend if they sign-up in advance.		
10.	**Update on Subcommittee Scheduling**	**Sarju Shah**	**3:50 PM**
	Sarju Shah provided an overview of the upcoming subcommittee meetings.		
11.	**Next Steps and Adjournment**	**Michael Matthews**	**3:55 PM**
	The next meeting is scheduled for April 15, 2019 from 2pm-4pm ET in the same location (195 Farmington Avenue, Farmington, CT).		

Upcoming Meeting Schedule: April 15, 2019; May 15, 2019; June 17. 2019
Meeting information is located at: https://portal.ct.gov/OHS/HIT-Work-Groups/Medication-Reconciliation-and-Polypharmacy-Work-Group