Medication Reconciliation and Polypharmacy Work Group

Meeting Minutes

MEETING DATE	MEETING TIME	Location
May 15, 2019	2:00PM – 4:00PM	195 Farmington Ave Farmington, CT 06032

WORK GROUP MEMBERS					
Thomas Agresta	x	Nitu Kashyap		Jameson Reuter	T
Lesley Bennett	T	Janet Knecht		Nathaniel Rickles	x
R. Douglas Bruce		Diane Mager		Kate Sacro	x
Jeremy Campbell		Rodrick Marriott		Ece Tek	
Marghie Giuliano	x	MJ McMullen	T	Peter Tolisano	x
Sean Jeffery	x	Bruce Metz	x	Anne Van Haaren	
Amy Justice	x	Jennifer Osowiecki	T	Stacy Ward-Charlerie	
Marie Renauer	T	Barbara Bugella			
SUPPORTING LEADERSHIP					
Allan Hackney, HITO	T	Sabina Sitaru, HIE Entity		Chris Robinson, CedarBridge	x
Kate Hayden, UConn Health	x	John Schnyder, HIE Entity		Michael Matthews, CedarBridge	x
				Sheetal Shah, 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 4/15/19 Meeting Minutes**	**Michael Matthews**	**2:10 PM**
	Michael Matthews asked for a motion to approve the minutes from the April 15, 2019 meeting. Sean Jeffery created the motion to approve the meeting minutes and Amy Justice seconded the motion. The April 15, 2018 meeting minutes were approved without opposition or abstentions.		
4.	**Update on Literature Review Process**	**Nate Rickles**	**2:15 PM**
	Nate said that his April students have finished up the process as much as possible before finishing their term. Anne and Nate will figure out if there are any articles that have not been summarized and complete the process and develop a table summary. Michael said that this would be great for the final report. Nate said there are 20 – 25 articles that have been summarized. Michael said that it would be great even if they presented the article summaries in the report or included them as an annotated bibliography. Tom said the process won't stop, but if people can repeat the process, or expand on it, then that will have value. Nate said that the students developed a table of contents. Within the table of contents, there is a category for the accuracy of lists, the second category is CancelRx, and there are also articles related to discontinuation after deprescribing, electronic prescribing assistance, initial medication adherence, and more. There are also articles relating to potential solutions, which include 14 articles. In total, there are 17 categories. Michael said he thinks the bibliography itself is valuable. Marghie asked if the presentation from the students is available. Chris Robinson clarified that the presentation is available on the OHS website and		

	in the previous meeting's presentation. Nate said that the presentation has been updated slightly since the last meeting.		
5.	**Engagement & Safety Subcommittee**	**Nate Rickles**	**2:30 PM**
	Nate Rickles explained that this subcommittee has been focused on the literature review and the development of recommendations.		
6.	**Med Rec & Deprescribing**	**Amy Justice**	**2:40 PM**
	Amy Justice explained that this subcommittee has been focused on the development and review of recommendations.		
7.	**Policy Subcommittee**	**Peter Tolisano & Marghie Giuliano**	**2:50 PM**
	Peter Tolisano explained that this subcommittee met on May 10 and has been focused on the development of recommendations and the review of results from the flash survey of state agencies.		
8.	**Technology & Innovation Subcommittee**	**Bruce Metz and Tom Agresta**	**3:00 PM**
	Tom Agresta explained that they will have the final draft of the Medication Reconciliation Hack-a-thon White Paper distributed in the very near future. The White Paper will include an executive summary and a glossary. Tom said that this document will be something that will be utilized for the MRP final report. Michael said that we should be thinking about whether or not we want to include the entire White Paper as an appendix to the MRP recommendation, or just the executive summary. Tom said that he thinks we should include the executive summary, the final summary at the end, and the glossary. Tom thinks we could submit the Hack-a-thon White Paper separately to the Health IT Advisory Council. Bruce Metz said that we want to think about how this type of event can be replicated in the future, as an outcome of this process. Tom said this could be an annual event, but exactly how we proceed needs to be figured out. Amy said that all of the recommendations have an IT component, and we could think about these as future topics. Sean said that he just got back from the American Geriatric Society meeting and there was a lot of interest in what we are doing here and the Hack-a-thon. They may be interested in doing something similar and he will be knocking on people's doors for volunteers to participate. Tom said the there is a meeting at Surescripts that will include some of these materials. Tom said that the more we engage other groups and share what is being done in Connecticut, the more we can avoid having to recreate the wheel in other states. Sean said it would be helpful to know where there are appropriate venues to share this work. Amy has had this same thought and suggested a few ideas. Sean said there are other non-professional society meetings that pull together leaders and we would want to showcase some of the information we are developing. Tom suggested a number of conferences, including HIMSS. Amy suggested a Health Innovations Conference that is sponsored by Yale.		
9.	**DRAFT Recommendations: Review and Discussion**	**Michael Matthews**	**3:10 PM**
	Michael introduced the process that has been utilized to develop the initial recommendations. Michael provided an overview of the decisions and discussions that occurred during the Medication Reconciliation & Deprescribing Subcommittee meeting from May 15. Michael explained that today the group will walk through each recommendation and discuss verbiage changes or edits, possible timing, and any other considerations that need to be included as the recommendations are finalized. Recommendation #1: Best Possible Medication History (BPMH) • Michael provided an overview of the BPMH recommendation and the changes that were discussed at the Medication Reconciliation & Deprescribing Subcommittee. • Kate Sacro asked for an elaboration on the concept of a ledger and the discussion related to med history vs. med list that occurred at the previous subcommittee. Kate asked what we are referring to when we say, "medication history." She said that part of building the accurate list is understanding the history. Tom explained that the history may include the past month or two, whereas a ledger would allow for a prescriber to look back further. Sean said the ledger will have		

time-stamped changes so that a prescriber can see a record of where changes occur. The home health care industry needs to know when changes were made and by who. Sean said it could be enhanced to include other data elements, but the first step is to get the accurate list. Kate asked if we are thinking across settings. Tom said yes and that eventually you will have to make decisions about what is relevant and what is not. Sean said that this is when we will get into the advanced tools, such as artificial intelligence (AI) and clinical decision support (CDS).

    - Phil Smith thinks we should add a footnote that the ledger is a cross-platform audit trail of changes and considerations concerning the medication history. This verbiage may be clearer and more understandable. Kate liked this idea. Phil said the considerations of why changes occur is important to include, because currently this is only documented in the native system, if at all.

- Bruce said that the ledger is hard to include in a single location, technologically speaking. The ledger is distributed, and this is challenging, but this is what can be achieved by using BlockChain. It is a virtual ledger that does not need to be centralized. Bruce thinks it will be hard to manage the ledger if it is not centralized, using the current technology. Michael is not aware of any standards for such a ledger at this point. Bruce said that this is part of the problem because it is an emerging technology. MJ McMullen said he is not aware of this type of technology or standards, but he will ask his colleagues. MJ says it may be beneficial to have a presentation on the Record Locator & Exchange product. We don't have all of the answers, but we have some of them. He does not think we have a standardized language for a ledger at this point. Marghie asked if Shelly Spiro would know the answer and Sean said he thinks she would either know or know someone who knows.
- Michael said that for this recommendation, we have proposed time-boxing of recommendations and objectives. Michael asked if there were any thoughts on the proposed times. Bruce said that 5 years is a long time, and that his recommendation would be to reduce the long-term goals to 3 years. Bruce suggested that we could say "next generation tools" for the years 4 and 5. Michael said that this is a reasonable point and that technology will continue to evolve. Tom said that we may develop and pilot something in years 2 and 3 that it would not be implemented until years 4 and 5.

Recommendation #2: Medication Reconciliation Process Improvement

- Michael explained the discussion from the Medication Reconciliation & Deprescribing Subcommittee meeting. They recommended that we move up the JCHO process into the premise section of the recommendation, alongside the definition. The first objectives will focus on the creation of a repository for best practices. The second objective will focus on the communication plan, with the verbiage staying the same.
- Amy Justice said there is a big difference between guidelines and recommendations. She asked what we are talking about here. Michael said that there is no enforcement authority on any of this at the moment. Amy said she would say recommendations at this point and does not want to contradict what has already been done. She would vote for the recommendations for all of these reasons.
    - Marghie said she is a little bit on the other side. If the best practice has been determined, she thinks it should be included. Amy said she agrees when you are talking an oral history, but when you are looking at actual fill prescriptions, you have a little more clarity and there is less research on this side. This is an evolving area. Marghie said that this is a problem; the way the processes are implemented is varied and we are trying to move this towards standardization. Tom said there are tools that allow patients to self-report using advanced user interfaces and that this is an evolving world where different settings will have different tools available. Tom said we have to account for that and acknowledge it. Sean said that some of this could be how the information is represented in the recommendations. Sean said that we could list best practices for each setting and there could be expert opinions

and tools that may be developed or available. Sean said we need to decide how we want to present the information and what is most useful to include.
    - Tom said when we talk about tool kit development and maintenance, we need to discuss ownership and funding. Michael said we are stopping short of recommendations or guidelines; we are saying we are creating an annotated repository of best practices and communicating this to stakeholders. Tom said we could recommend a methodology and resource for maintaining this type of resource.
    - Michael asked for a time horizon on this recommendation and the communication. Amy said this would likely occur in years 2 and 3. Tom said this is something that we have already started.
- Tom said that after all of these recommendations are made, somebody will need to fund them. Tom asked if we are suggesting a prioritization of the recommendations. Bruce is thinking about the outline for the full report, and the business case and ROI of the recommendations. Bruce also asked who the audience will be for these recommendations.
    - Michael said that we have developed and shared an outline and table of contents for the full report. Amy said that some of the materials are sparse on the ROI perspective and we are a long way from being able to demonstrate ROI. Michael said that this is not for budgeting purposes or for an action plan and presumably, if we approve recommendation 11, the group can pick back up to identify which areas we want to continue to develop using planning dollars. Michael said that this is outlining the priority and vision for what we want to tackle in Connecticut. Bruce said that this makes sense, but the prioritization and funding needs to be a separate conversation.
    - Michael said if we have a "year 1" category, we can outline the items that immediately need to be addressed. Michael said we could indicate which items are highest priority with an asterisk or bold font. Nate said that getting back to the ROI topic, he wonders if there are there any recommendations that are the greatest concern in terms of cost, or that would potentially save the state money. Nate said that this is where he would spend some attention, because the Governor's Office would be very interested in these items. Tom asked if it would make sense to have some kind of impact statement for each recommendation and draw from the literature to outline where we think there will be positive impacts. Amy thinks our greatest benefit is improvements to patient safety. Nate said there is cost associated with patient safety. Sean said this is nebulous cost.
    - Michael said for right now, we will move forward with the idea of indicating the items that are highest priority.

Recommendation 3: Team Approach

- Michael said there were several comments received related to this recommendation. Some people were looking to have the team members be defined or explained. Michael was not sure if we wanted to change the verbiage in the premise and goals section, or if this question would be answered in the objectives section.
    - Kate said that her questions would be answered through the objectives. The definition of the team will vary based on the setting and where medication reconciliation is performed. Marghie said that this is where Rod was focused on his comments as well. Rod has been looking at this from a legislative and scope of practice perspective. Michael said we should add "scope of practice" to the recommendation.
- Amy said there should be some language about how extensive the team needs to be dependent on the setting. In a prior meeting, we determined 80% of medication decision occur between the provider and the patient, but the other 20% are really important and are often the more complex situations. Amy said she is concerned that this language implies that we need to assemble a team every time a decision needs to be made. She does not think this is the intent, but thinks it reads this

way. Marghie said that she does not think the MA should be doing the reconciliation, even if they are collecting the data. Sean said this involves scope of practice, because this will lead to the training. Tom said he would encourage us not to get down to this level of policy discussion.
    - Tom said he agrees with Amy's point and suggested adding language about complex patients. Sean said that the team may be most important during care coordination and transitions. Amy thinks complex patients is a better description. Kate said the collection of medications is a different part of the process and would always involve multiple people when conducted correctly. Kate does not think we should specify for the complex patients because we are recommending a best practice and not dictating a guideline.
- Michael said that based on a previous discussion, we agreed we would not use the word "standardized" for this recommendation.
- Nate asked if objective number 5 is too broad. Marghie said that there should be some type of monetary support to ensure that this actually occurs. Tom said he does not have an issue with the recommendation. Marghie said this statement will be included in the policy recommendation.
- Kate asked if the order of recommendations indicates priority or timing. Tom and Michael said that it is not currently organized in any particular order. Michael said he listed BPMH as number one because it is highest priority, and patient engagement will be listed as second by request of Lesley Bennett, who made an important point via email.

Recommendation 4: Patient Engagement

- Michael said that Lesley made a good point about the patient engagement recommendation. Lesley said that patients feel left out of the process and they don't understand some of terminology and processes. They need to be the center of this whole process. According to some groups, more than 60 % of the whole population are very tech savvy and want to be engaged, but do not understand why there is not a system where they can track their current medications, and have it integrated with their health record. If we don't involve the patients front and center, then the recommendations are less meaningful. Lesley said we have to find a way to engage patients and their caregivers from the very beginning if we want to have the most accurate list possible. Lesley said it is also a huge cost issue to not engage the patient effectively.
    - Tom said he wants to expand this recommendation to include patient safety and engagement. Patients need to be provided with the right tools and the actual work for them needs to be minimized.
    - Amy said that every time you see an inaccuracy in your medication list, it undermines your confidence in the health care system and the provider. Sean said that patient satisfaction is another important component.
    - Lesley said that one of the things they are finding is that phone applications could be an effective tool for engaging patients. Amy said that until we have a way to reconcile conflict lists, then this won't be helpful. Tom disagreed and said it could help on the front end of the process. Michael said that the sub-bullet under objective 2 speaks to this point and addresses this concept.
- Bruce suggested using the term "common and available" instead of "standardized." Bruce said we should have some narrative about the business case and value proposition narrative and describe the execution plan. Michael suggested that he could develop an MRP road map, building off of the road map that was developed for the Technology Subcommittee. Bruce said this is a good idea. Bruce said the communication is going to be critical.

Recommendation 5: CancelRx

- Nate asked if CancelRx is proprietary. Tom said no, CancelRx is a standard, deprescribing protocol. Tom said that Surescripts has the majority market share, but there are other vendors that can send this message. Sean said that by 2020, providers will need to be doing this if they want to receive

reimbursement from CMS. Tom said this needs to be implemented on the pharmacy side. MJ said they are requiring all partners, both EHRs and pharmacies, are certified of the transaction. They are not mandating the adoption. Tom said that this is helpful to understand. Tom said that that because this will be implemented by all pharmacies on the Surescripts network, it will be available, and the recommendation could be to push providers to achieve certification and start utilizing CancelRx.

- Michael asked if all objectives in this recommendation would be years 1 and 2. Tom agreed that this would be correct. Bruce said this assumes a certain level of resources and we need to make sure this is clear.
- Nate said that he was unsure if we wanted to embed CancelRx in the statewide public health campaign, or if this should be broadened to patient safety. Tom thinks the campaign should be focused on medication and patient safety. Tom said this is a good point.

Recommendation 6: Deprescribing

- Michael said there was new language that was circulated for the premise and goal on this recommendation. Michael asked if there were any other suggestions, or if everyone is ready to accept the new language.
    - Nate said that we should keep in mind the reader's perspective, and we may want to do a teaching point on the differences between CancelRx and deprescribing. Michael agreed.
    - Nate asked if we need to include the current level of detail. Amy said her rationale is that patients don't always understand, and this needed to be spelled out.

Recommendation 7: Technology

- Bruce said that he is not ready to opine until he is able to do a deeper dive. He needs more detail and will come back with a more thorough review. Michael said we can go asynchronous with this recommendation. Bruce said that there are the technologies themselves, and there are also the pieces that are enabled by technologies from the other subcommittees.

Recommendation 8: SUPPORT Act Funding

- Rod Marriott was not in attendance to speak to this recommendation. Michael said we need to make sure this effort is complementary with the MRP Work Group's recommendations and make sure Rod is comfortable with the language in this section.

Recommendation 9: Policy Alignment

- Michael said that this section did not get updated based on the May 10 Subcommittee meeting, but he did note the areas that will be updated. Michael provided an overview of what language will be updated.
- Tom said there was another conversation about providing technical assistance for each activity, and we just use deprescribing as an example. Amy agreed that this makes sense. Michael said this will be updated to support policy mandates around all of these recommendations.
- Michael asked if years 1 and 2 are agreeable for this recommendation in terms of timing. Tom said we need to determine what is foundational, the sequencing, and if we can start to work on something without any financial resources.

Recommendation 10: SMMS / IAPD

- Michael provided an overview of this recommendation, as well as Marghie's suggestion to utilize a name other than "SMMS" to describe the concept detailed in this recommendation. Michael said we may also want to tweak this objective based on any discussion or determination the group makes in terms of sequencing.

	Recommendation 11: MRP Work Group Continuation
	• Michael provided an overview of this recommendation. Michael suggested that a reconvened group would need to create a new charter and an evaluation of membership to determine who wants to continue to meet, and who wants to retire. Everyone has their actual day jobs and some people may want to take a break or focus on other things. Michael said we could recommend quarterly meetings or specify annual reports to the Health IT Advisory Council.
	• Amy said it would be nice to agree on milestones in the charter. Amy said that people who have been involved in this process feel like we have done a lot of talking, which has been valuable, but are ready to move into an action-oriented phase.
	  ○ Amy said that we need some concrete steps at this point. Amy said these conversations need to happen, but we are ready to move into the next phase.
	  ○ Nate agreed and said he knows there are some partners who are willing to raise their hand and start working, or piloting and testing. Tom agreed.
	• Sean said we will need resources for administrative support if we are going to reconvene this group. Sean said that CedarBridge has done a great job with this group and said he would be happy to have them continue to provide support. Tom said he thinks we can recommend that we need to support but we can't nominate a specific organization. Sean agreed but recognized that the support from CedarBridge has been vital to the progress the group has been able to make.
	• Marghie recommends that we add payers to the next group. Sean said that we do have Jameson Reuter on the current group. Marghie said it would be good to add someone from an ACO.
	Nate said as a general comment, we should keep in mind that the framing of recommendations and objectives changes from verbs to statements and we need to make sure we polish and align the recommendations during a final review.		

10.	**Remaining Schedule and Next Steps**	**Michael Matthews**	**3:55 PM**
	Michael said that the recommendations will be wordsmith and re-published. Michael said he is nervous about the technology piece and said we need to be in a position to approve the recommendations in June. The recommendations will be republished a week before the next MRP meeting (June 17), if possible.		
11.	**Next Steps and Adjournment**	**Michael Matthews**	**4:00 PM**
	The next meeting is scheduled for June 17, 2019 from 2pm-4pm ET in the usual location (195 Farmington Avenue, Farmington, CT). The meeting was adjourned.		

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