OHS CONNECTICUT Office of Health Strategy

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Project Charter

Medication Reconciliation & Polypharmacy Committee (MRPC) of the Health IT Advisory Council

October 11, 2019

Article 1: Name

Section 1: The name of this entity shall be the Medication Reconciliation & Polypharmacy Committee (MRPC), established by the Health Information Technology (IT) Advisory Council on September 19, 2019.

Article 2: Purpose

Section 1: The purpose of the MRPC is to provide strategic guidance, recommendations, and ongoing support to the Health IT Advisory Council and the Office of Health Strategy (OHS) for the development and implementation of patient-centered and evidence-based best practices in medication reconciliation and polypharmacy**.** The MRPC will build upon the approved recommendations and areas of focus identified by the Medication Reconciliation & Polypharmacy Work Group (found in Appendix A: MRP Work Group Recommendations). Through September 2021, the MRPC will focus on the following project goals:

- ***Goal 1:*** Develop a detailed strategic approach for the creation of a patient-centered Best Possible Medication History (BPMH), supported by active patient engagement, that results in near-term value for stakeholders while laying the foundation for a longer-term, more extensive and integrated solution.
- ***Goal 2:*** Create an online directory of medication management and medication reconciliation tools and solutions for communication of evidence-based, best practice medication tools; patient engagement strategies; technical advisories; subject matter experts; and policy and regulatory guidance documents.
- ***Goal 3:*** Serve as a resource to OHS and other state and national agencies and organizations to support development and implementation related to: technical solutions and use cases; workflow integration; medication reconciliation pilot activities; stakeholder engagement; and measurement and evaluation.
- ***Goal 4:*** Develop an implementation and evaluation plan for the Medication and Polypharmacy Work Group recommendations.
- ***Goal 5:*** Support Implementation Advance Planning Document (IAPD) and Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act funded initiatives and actively monitor funding opportunities related to the stated purpose and goals of MRPC.

Other goals may be considered to support the purpose and goals of the MRPC, as needed.

Section 2: The MRPC will not endorse or recommend any specific software solutions as part of its work; however, they may evaluate and review functionality for the purposes of achieving the above stated purpose and goals.

Article 3: Membership

Section 1: Membership in the MRPC shall be broadly representative of stakeholders involved in the matters of medication reconciliation and polypharmacy. Experience and expertise represented will include, at a minimum, the following:

- Patients, consumers, and caregivers
- Subject matter expertise in medication reconciliation
- Subject matter expertise in polypharmacy
- Community pharmacy
- Payers / pharmacy benefit managers
- Hospitals and health systems
- Providers / prescribers
- Long-term post-acute care, including skilled nursing and home health
- State agencies, including, but not limited to:
    - Department of Social Services
    - Department of Consumer Protection
    - Department of Mental Health and Addition Services
    - Department of Developmental Services
- Representation from the Health IT Advisory Council
- Health IT technology development and implementation

Section 2: Members of the MRPC shall initially be appointed by the Co-Chairs of the Health IT Advisory Council. Thereafter, the Chair, or Co-Chairs, in consultation with OHS, shall appoint members of the MRPC.

Section 3: Membership recruitment should take into consideration such factors as the geographic residence, race, ethnicity, and language of potential candidates to ensure that the group is as representative of as many perspectives and experiences as possible. This group will also include patient advocates to consult on patient engagement.

Section 4: As determined by the Chair, or Co-Chairs, of the MRPC, additional subject matter experts (SMEs) may be sought on a permanent or periodic basis for the areas identified in the MRP Work Group's recommendations (see Appendix A), including, but not limited to: software development; electronic health record (EHR) and pharmacy information systems; and policy and regulations.

Section 5: Although this is not a time-limited group, membership will be reviewed annually by the Health IT Advisory Council and OHS to determine if membership is adequate to support the above stated purpose and goals of the MRPC. Recognizing that consistent participation in MRPC meetings is critical for success, failure by any member to attend at least 66% of meetings (within a given calendar year), or members who are absent for three

consecutive meetings, shall result in consideration of termination from the MRPC. Members should notify the Chair, or Co-Chairs, if they will be absent for any meeting. Members serve on a voluntary basis and without compensation.

Article 4: Officers

Section 1: The Chairperson shall be chosen by the members of the MRPC during the first scheduled meeting. The MRPC may also choose to elect Co-Chairs if Co-Chairs (rather than a single Chair) are deemed a better structure to support the stated purpose and goals.

Section 2: As Chair, or Co-Chairs, the selected individual(s) will be responsible for setting meeting agendas, establishing regular meeting schedules, appointing subcommittees as needed, and acting as liaison between the MRPC, OHS, the Health IT Advisory Council, and the Health Information Alliance, Inc.

Article 5: Subcommittees

Section 1: Subcommittees of the MRPC may be formed as needed by the Chair, or Co-Chairs, in collaboration with OHS designated staff. Subcommittee leaders will be appointed by the Chair, or Co-Chairs, in collaboration with OHS designated staff. The subcommittee lead member is responsible for organizing subcommittee meetings, with assistance from OHS staff, as necessary. The subcommittee lead member will report subcommittee findings and recommendations to the full MRPC for their information or action.

Article 6: Operating Procedures

Section 1: The MRPC operates as a standing committee of the Health IT Advisory Council. All records of the MRPC will be transmitted as soon as practical to OHS for inclusion in Health IT Advisory Council matters as appropriate.

Section 2: The MRPC is initially chartered for the period November 2019 through September 2021. At the conclusion of this initial period, the MRPC may decide to continue its work if deemed valuable at that time. If so, the MRPC will make a request for continuation to the Health IT Advisory Council. Otherwise, the MRPC shall document the basis for the conclusion of its work.

Section 3: The Office of Health Strategy (OHS) may establish procedures to allow members to participate in meetings by videoconference or teleconference.

Section 4: Meetings will be governed by Robert's Rules of Order, Abbreviated. One half of the membership will constitute a quorum. Action on agenda items may be taken by no less than a majority of members present at the meeting.

Section 5: The Chair, or Co-Chairs, may solicit agenda items from members in advance of a meeting and establish agendas in collaboration with the OHS designated staff. Items may be added to the agenda on the day of the meeting if approved by the Chair, or Co-Chairs.

Section 6: All meeting information will be published on the Connecticut Public Notice web site and on the OHS web site. Meeting changes will be sent by email to members no later than 9 AM the day of the scheduled meeting.

Article 7: Duties of OHS

- OHS will provide the MRPC and the Chair, or Co-Chairs, with support in the areas of meeting facilitation, the development of agenda and meeting materials, logistical planning and scheduling, research and analysis and stakeholder engagement. This support will be provided by OHS personnel or through engagement of professionals with required expertise.
- OHS shall inform the MRPC about all known changes in federal and state policy as well as rules and regulations that impact its work and the stated purpose and goals.
- OHS will consult with ongoing committees and advisory bodies in the state, maintain familiarity of the subject and purpose of the MRPC, and communicate perceived areas of opportunity for collaboration.
- OHS will ensure ongoing communication between the MRPC and relevant OHS staff and leadership as well as communication with the Health IT Advisory Council.
- OHS staff assigned to the MRPC will attend all meetings and inform its members of timely developments relevant to its work.
- An OHS administrative support member(s) will assist the MRPC's Chair, or Co-Chairs, as needed, to maintain membership and interested parties with information, distribute meeting agendas and notices to the membership and interested parties, and record the meeting minutes of the MRPC's meetings, including attendance.

Article 8: Duties of Health IT Advisory Council

- The Health IT Advisory Council shall approve the MRPC Project Charter and any updates.
- The Health IT Advisory Council shall regularly review work products of the MRPC and provide feedback as requested and appropriate.
- The Health IT Advisory Council will take action on MRPC recommendations as necessary to support the work of the MRPC and the purpose of the Health IT Advisory Council, consistent with enhancing the health and healthcare of CT and its residents.
- The Health IT Advisory Council will consider requests from the MRPC for resources and support as needed to support the Purpose and Goals of the MRPC.
- The Health IT Advisory Council will consider requests from the MRPC for extension of its activities beyond the initial period that concludes September 2021.

Appendix A: Final Recommendations and Considerations of the Medication Reconciliation & Polypharmacy Work Group

Recommendations Overview

The following recommendations, goals, and objectives, organized into eleven domains, are the result of a nine-month planning process by the MRP Work Group and its four subcommittees, as described above in the Project Structure and Process section. A schematic was developed to support the visual display of these recommendations (Figure 1), as well as the central premise of the MRP Work Group that "The Patient is the North Star" in all deliberations and considerations.

The recommendations, goals, and objectives for the MRP Work Group are as follows:

Recommendation 1: Best Possible Medications History (BPMH)
Premise and Goal
It is well recognized by healthcare professionals, patient advocacy groups, and policymakers that an accurate list of active medications, medications history, and history of adverse reactions/side effects to medications are necessary to evaluate the efficacy, appropriateness, and safety of medications use. The importance of this information increases when the patient is on multiple medications (including over-the-counter medications, complementary alternative medications, and supplements), when the patient is seeing multiple prescribing providers, when providers do not share a common EHR platform, 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 basis 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 (for example, beginning with a best possible medications list of current medications rather than a full medications history), while working toward longer-term, more complete and integrated solutions that include decision support tools and a ledger of medication transactions (e.g., including current and prior-canceled prescriptions).
Objectives
1. Near-term efforts (1-2 years) should be focused on making tangible progress toward an enhanced and uniform best possible medication *list* 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) / CPMRS data, in coordination with the statewide health information exchange (HIE); ○ Dispensed prescription medications (i.e., initially *not* including non-prescription medications, OTCs, vitamins, herbals, and supplements); ○ Specification of characteristics of BPMH to support longer-term vision and planning; and ○ Evaluation of expanding CPMRS data and functionality for supporting BPMH requirements 2. A longer-term vision (3-4 years) for BPMH should be implemented and should include:

- Detailed business (legal, financial, operational), technical and functional requirements for best possible medication *history;*
- A ledger, or a cross-platform log, of medication transactions and considerations including those associated with medication reconciliation (e.g., canceling a prescription);
- Integrated clinical decision support tools; and
- Inclusion of OTC medications, dietary supplements, and other complementary alternative medicines.

Recommendation 2: Patient Engagement

Premise and Goal

Engaging patients and their family and caregivers throughout the medication reconciliation process leads to better results.

The MRP Work Group recommends the implementation of patient-centered and evidence-based best practices necessary to contribute to the development and maintenance of BPMH, supported by communication, education, and user-friendly digital tools.

Objectives

1. A process for patient and family/caregiver engagement should be designed, implemented, and adopted statewide. This process will likely vary depending on the setting in which medication reconciliation is being performed; however, key elements of patient or family/caregiver engagement should include the following:
    - Evidence-based and proven communication techniques, such as asking open-ended questions and teach-back method;
    - Initiating the engagement process before the patient comes to appointment;
    - Reminders for providing up-to-date medication information to their providers; and
    - Training on digital tools.
2. Tools for patients that support their ability to better manage their medications should be identified, developed if necessary and shared.
    - A communications plan should be developed for providers regarding how to most effectively engage patients and their families in the medication reconciliation process.
    - A systematic review should be undertaken to identify the most effective tools for supporting a patient's ability to keep medications up-to-date and communicated to their prescribers and care team.
3. A public awareness campaign to elevate the understanding of the importance of medication reconciliation and keeping one's provider up-to-date on active and discontinued medications.

Recommendation 3: Medication Reconciliation Process Improvements

Premise and Goal

As defined by the Joint Commission under its Ambulatory Health Care Accreditation Program, medication reconciliation is "a process of comparing the medications a patient is taking (and should be taking) with newly ordered medications. The comparison addresses duplications, omissions, and interactions, and the need to continue current medications. The types of information that clinicians use to reconcile medications include (among others) medication name, dose, frequency, route, and purpose."[1]

In addition, the Joint Commission recommends the following process for medication reconciliation:

1. Obtain and/or update information on the medications the patient is currently taking.
2. Define the types of medication information to be collected in different settings and patient circumstances.
3. Compare the medication information the patient brought to the organization with the medications ordered for the patient by the organization in order to identify and resolve discrepancies.
4. Provide the patient (or family as needed) with written information on the medications the patient should be taking at the end of the episode of care (for example, name, dose, route, frequency, purpose).
5. Explain the importance of managing medication information to the patient at the end of the episode of care.

The MRP Work Group endorses the Joint Commission definition and process for medication reconciliation, while emphasizing that this definition and process could be used in almost all care settings.

Objectives

- A repository of evidence-based, best practice medication tools, technical advisories, subject matter experts, and policy and regulatory guidance documents should be developed.
- A provider and prescriber communications plan for the dissemination of the above definitions, processes, and tools should be developed and implemented.
- A statewide public health campaign to raise awareness around medication and patient safety issues, including the importance of the CancelRx standards adoption and use, should be launched.

Recommendation 4: Team Approach

Premise and Goal

[1] https://www.jointcommission.org/ahc_2017_npsgs/

Team approaches to medication reconciliation are generally more accurate and provide more up-to-date medication lists than non-team approaches, where multiple data sources are needed to improve the quality of the medication reconciliation effort. When team approaches are supported by effective and integrated digital tools, results will be further enhanced. A team approach can only be effective when roles and accountability are clear, training is effective, and the team is properly resourced.

The MRP Work Group recommends the adoption of a team approach to medication reconciliation both within and across organizations, based on evidence-based best practices.

Objectives

1. Mission critical team members, whose participation in medication reconciliation is essential for success, should be identified.
2. All staff involved in medication reconciliation should receive proper training, including how to engage patients and families, employment of best practices, and the use of digital tools.
3. All organizations should clearly define team members' roles and responsibilities for medication reconciliation, within scope of practice and including accountability and decision-making.
4. Teams and staff involved in medication reconciliation should adopt evidence-based, best practice processes.
5. Teams should be properly resourced to support effective care management for the number and complexity of patients for which they are responsible.

Recommendation 5: Implementation and Adoption of CancelRx

Premise and Goal

While medications can be beneficial for the health of an individual, they also pose potential health risks through side effects, adverse drug-drug, drug-food, or drug-disease interactions, and excessive dosing. These risks are increased when a medication that is intended to be discontinued is taken inadvertently.

The ability to cancel a prescription medication electronically has existed from a technical perspective for several years through a technical messaging standard (SCRIPT Standard 10.6) developed by NCPDP and adopted by ONC.[2] However, there remains no requirement or incentive to incorporate this standard into EHRs and pharmacy information systems. As a result, adoption has been slow at both the pharmacy and provider side.

The MRP Work Group recommends the implementation of the findings and recommendations from the CancelRx Work Group. The executive summary of the CancelRx Work Group's Final Report can be found in Appendix B of this report.

Objectives

[2] https://www.ncpdp.org/NCPDP/media/pdf/NCPDPEprescribing101.pdf

1. A formal assessment of the return on investment (ROI) for the CancelRx standard and other medication reconciliation recommendations to support the widespread adoption by pharmacies should be conducted.
2. A formal assessment of the legislative/policy considerations associated with a mandate to require participation in the CancelRx standard by Connecticut pharmacies and practitioners.
3. The possibility of utilizing HIE funding to support onboarding, technical assistance, education, training, and implementation for pharmacies and practitioners should be explored and pursued.
4. Pharmacy CancelRx workflows through technical assistance support should be adopted.
5. A business case for the sustainability of CancelRx that is endorsed and supported by the state's HIE effort and associated stakeholders (e.g. payer-led cost containment analyses) should be developed.
6. An incentive program to support the adoption and use of the CancelRx standard and conduct pilot programs to determine ROI for each organization should be developed.
7. An analysis of funding opportunities available to help address polypharmacy and reduce opioid misuse should be conducted.
8. A partnership with the Department of Consumer Protection (who oversees and manages the CPMRS), the Substance Abuse and Mental Health Services Administration (SAMHSA), and other organizations/stakeholders should be developed to support CancelRx program objectives.

Recommendation 6: 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, scientific evidence supporting this decision-making process is limited. To date, providers are often caught between disease-specific guidelines recommendations, patient-specific needs, 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, as opposed to 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. Evidence-based best-practices for deprescribing should be identified and added to the repository of medication reconciliation tools in Recommendation 3: Objective 1 and included in provider and prescriber communications (Recommendation 3: Objective 2).

2. A shared decision-making model that engages patients and providers in discussing deprescribing should be created.
3. Risk algorithms to identify population health strategies for potential medications for deprescribing should be developed.
4. Prescribers should be surveyed regarding educational needs for deprescribing.
5. Have a mechanism for updating these educational materials and decision support tools as new evidence becomes available.

Recommendation 7: Technology
Premise and Goal
Technology continues to advance in ways that can help redress the challenges of medication reconciliation, polypharmacy management, deprescribing and CancelRx. Progress toward BPMH is of highest priority, and near-term, high-value steps should be undertaken as soon as practical in support of Recommendation 1. In addition, artificial intelligence, blockchain, and clinical decision support tools should be evaluated for integration into these solutions. Patient-facing digital tools will become increasingly important for supporting patient engagement. The MRP Work Group recommends an incremental approach to supporting Recommendation 1 (BPMH) be undertaken once requirements have been developed and funding is available. Future development should focus on integration of additional clinical data (e.g. OTC medications) and enhanced technical tools such as analytics and clinical decision support. In addition, ongoing surveillance of the industry should be conducted to identify promising solutions made possible through advancements in technology.
Objectives
1. Near-term (Years 1-2) focus should be placed on developing a best possible medication list, leveraging existing data resources that include community pharmacies, PBMs, and EHRs. 2. A longer-term (Years 3-4) vision for BPMH should be defined, including business, technical and functional requirements. 3. Advanced technologies, such as blockchain, analytics and clinical decision support tools should be monitored on an ongoing basis and integrated with BPMH based on value and funding. 4. The statewide HIE should be leveraged to support the incremental development of BPMH, and medications should be made available as a meaningful component of the clinical payload of the statewide HIE. 5. Patient-facing digital tools should be evaluated and an approach to integrating medications data should be defined. 6. An implementation plan and technology roadmap should be finalized, including business, functional, and technical requirements.

7. Ideas and lessons learned from the Med Rec Hackathon should be considered as technology options are reviewed and attempts to facilitate additional prototype development should be contemplated.
8. Adding the CancelRx transaction to the CPMRS should be formally assessed.

Recommendation 8: SUPPORT Act Funding and Planning/Design Process
Premise and Goal
Among its various funding opportunities, the SUPPORT for Patients and Communities Act[3] provides resources to better integrate and utilize state prescription drug monitoring programs (PDMPs), or PMP in Connecticut (CPMRS). The Department of Social Services (DSS), the Department of Consumer Protection (DCP), and OHS are submitting a request to the Centers for Medicare and Medicaid Services (CMS) to fund a planning and design process to identify specific, tangible, value-added initiatives related to CPMRS. The MRP Work Group recommends that the planning and design activities related to the SUPPORT Act be undertaken in close collaboration with the initiatives and future planning activities recommended by this Work Group.
Objectives
1. A process for communication and coordinated planning should be implemented between the SUPPORT Act activities and the initiatives and future planning activities recommended by the MRP Work Group. 2. An assessment should be made to identify mechanisms to include CPMRS data in the statewide HIE and the planned approach to build the BPMH. 3. The PMP database should be considered and evaluated for its potential to be used as a resource for establishing a single source of truth for all controlled and non-controlled medications.

Recommendation 9: Aligned Policy
Premise and Goal
Policies in the public and private sectors can support the achievement of the MRP Work Group's recommendations, as well as eliminate certain barriers to the achievement of those recommendations. The MRP Work Group recommends an ongoing policy review to identify opportunities in both the public and private sectors, with initial areas of focus indicated below.
Objectives

[3] https://www.congress.gov/bill/115th-congress/house-bill/6

1. Medication quality measures that align clinically meaningful outcomes with MRP Work Group initiatives should be identified and implemented.
2. Incentives for medication management, medication reconciliation, and the reduction of potentially inappropriate medications should be identified for inclusion in value-based care initiatives in Connecticut.
3. Privacy and confidentiality of medication-related information should be of high priority in all solutions.
4. An assessment of a policy mandate for CancelRx standard (as described in Recommendation 5) should be undertaken.
5. Healthcare provider scope of practice should be reviewed and revised as necessary to support team-based medication reconciliation efforts.

Recommendation 10: Planning/Design Process and Use of IAPD Funding
Premise and Goal
As a component of the overall IAPD funding request to establish HIE services in Connecticut, funding is also being requested to provide subject matter expertise to facilitate the planning and development of digital tools to support the goals and objectives identified in these recommendations. This request provides $100,000 in FFY 2019 and $150,000 in FFY 2020 for the facilitation of design groups, development of business, functional, and technical requirements to support priority use cases, workflow mapping, and additional stakeholder engagement and outreach. The MRP Work Group recommends that a work plan be developed for these subject matter expertise / planning and development funds for those areas prioritized by the MRP Work Group for further research, planning, and design, as indicated below. This work should be done in a manner that complements the planning and design activities pursuant to funding provided to Connecticut through the SUPPORT Act (Recommendation 8).
Objectives
1. Funds from the current IAPD should be utilized to finalize planning, design and requirements for the projects and services recommended in this report. a. A portion of funds should be allocated to conducting stakeholder interviews and focus groups to validate value created from services being proposed through this planning initiative. b. A dedicated team to conduct these interviews and begin the process of developing Med Rec Use Cases for consideration within the HIE should be empowered, funded and assigned and begin work as soon as possible. They should work with the HIE Entity, the OHS and the reconstituted MRP Work Group to lay out potential use case options for evaluation within 3 months 2. Future funding for implementation should be sought once planning, design and requirements have been developed.

Recommendation 11: Continuation of the MRP Work Group
Premise and Goal
The Medication Reconciliation and Polypharmacy (MRP) Work Group has demonstrated the ability to bring a diverse group of dedicated professionals together to tackle a daunting healthcare and public health challenge. The MRP Work Group recommends the continuation of the MRP Work Group as a standing committee of the Health IT Advisory Council.
Objectives
1. The MRP Work Group should be constituted as a Standing Committee of Health IT Advisory Council. 2. A new charter should be established for the MRP Work Group, reflecting the priorities and focus associated with ongoing strategy and policy development along with oversight of implementation of MRP recommendations. Specific milestones and timelines should be included in the charter. 3. Membership of the MRP Work Group should be evaluated to ensure representation of stakeholders and subject matter experts necessary to support the new MRP charter. 4. The MRP Work Group should meet not less than quarterly. 5. The MRP Work Group should provide an annual report to the Health IT Advisory Council on progress in implementing MRP recommendations and positively impacting medication reconciliation and polypharmacy management in the state.