Medication Reconciliation and Polypharmacy Committee

Meeting Minutes

Meeting Date	Meeting Time	Location
January 13, 2020	3:30pm – 5:30pm Web Conference:	Integrated Care Partners, 1290 Silas Deane Highway Fourth Floor Success Conference room Wethersfield, CT 06109 Join Zoom Meeting https://zoom.us/j/421087233 Meeting ID: 421 087 233 Dial by your location +1 646 876 9923 US (New York) +1 669 900 6833 US (San Jose)

Committee Members					
Sean Jeffery	X	Jennifer Osowiecki	X	Christopher Diblasi	
Anne VanHaaren	X	Marie Renauer	X	Rachel Peterson	
Margherita Giuliano		Lesley Bennett	X	Pat Carroll	X
Nate Rickles	X	Jameson Reuter		Stacy Ward-Charlerie	
Rod Marriott	X	MJ McMullen	x		
Amy Justice		Diane Mager	X	**Guests:**	
Nitu Kashyap		Ece Tek		Dr. Naomi Nomizu	
Kate Sacro	X	Jeremy Campbell			
Peter Tolisano		Tom Agresta	X		
Elizabeth Taylor		Alejandro Gonzalez Restrepo	X		
Supporting Leadership					
Allan Hackney, OHS		Ryan Tran, UConn	X		
Adrian Texidor, OHS	X	Michael Matthews, CedarBridge	X		
Tina Kumar, OHS	X	Sheetal Shah, CedarBridge	X		

Agenda

	Topic	Responsible Party	Time
1.	**Welcome and Call to Order**	**Adrian Texidor**	**3:30 pm**
	Adrian Texidor thanked everyone for joining the meeting. Adrian announced that Michael Matthews of the CedarBridge Group will be retiring at the end of the month. He continued to acknowledge that Michael has been a tremendous asset for OHS, with leading this group from the CancelRx group to the MRP Workgroup, and now the MRPC. The committee joined Adrian in thanking Michael for his assistance and guidance. Michael thanked the committee and acknowledged that group has been a delight to work with and will continue to follow the efforts of the group.		
2.	**Review and Approval of December 16, 2019 Minutes**	**All**	**3:35 pm**
	Sean Jeffery asked for a motion to approve the December 16, 2019 meeting minutes. Jennifer Osowiecki created the motion. All in favor.		
3.	**Public Comments**	**Public**	**3:40 pm**
	No public comment.		
4.	**Recap of Previous Meeting**	**Nitu Kashyap + Sean Jeffery**	**3:45 pm**
	Sean Jeffery provided a brief recap from the MRPC meeting on 12/16. During this meeting a fair amount of time was spent going through the Impact + Effort survey, which everyone was going to see and respond to. Based on		

	the work the MRP Work Group completed last year, the survey is intended to come up with a way to prioritize both the impact and efforts of what the committee will be moving forward with this year. This will be a bulk discussion of today's discussion. The CancelRx Survey was also discussed at the previous meeting. What would be the needs, and how we'll get ahead of the educational/training requirements as systems go live with CancelRx. Tom Agresta and Ryan Tran were going to do additional work on the survey and will be discussing this today.		
5.	**Update on Health Information Alliance, Inc.**	**Adrian Texidor**	**3:50 pm**
	Adrian Texidor updated the committee that the HIA has been going through its foundational business requirements: developing HR policies, hiring practices, etc. The HIA Board of Directors met last week to finalize the business documents and requirements. During the next MRPC meeting (Feb. 27), Allan Hackney will discuss how the HIA relates to the MRPC, and how the MRPC relates to the OHS/DSS Governance Process, which is the overall process governing the HIA effort; and ultimately the MRPC and its relationship to the Health IT Advisory Council. There are use cases currently under development by the HIA, which includes secure messaging, and other foundational use cases. Additionally, there will be a review of the HIA milestones document and how the MRPC relates to that work. Tom Agresta indicated that the deliverables that are for med rec/MRPC relate to funding that is tied to being released from the HITECH funding. Sean Jeffery asked if some of the of the (HITECH) funding could be used for CancelRx outcomes and education. Adrian answered yes. **SUPPORT Act Update** Michael Matthews shared an update on the Support ACT. Michael recalled that there was a funding opportunity to support local state opioid initiatives. CT did submit the IAPD funding request in, which is now in a 60-day review period. The funding horizon goes through Sept. 30, 2020. It was important to pick up projects that could be done in the timeframe, like creating a qualified PDMP (meet qualified status), connecting providers to the PDMP, and connecting providers to the HIE, there's an outreach/education component and not just technology. Also, PULSE (Patient Unified Lookup System for Emergencies) nationally developed approach which started in CA as a disaster preparedness. There's a lot of interest in building PULSE capabilities out in every state. This was also considered a synergy with SUPPORT Act for the opioid approach as well. Rod Marriott added that the idea is with a short timeline is to get people connected to the PDMP. The PDMP should be easy to use for the provider at the point of care. Middlesex Health just joined and had a lot of steady growth, but some places don't have funding to get that up ongoing. PULSE is an interesting use case for the PDMP, but the major limitation is they only cover 14% of the drugs prescribed. As we see these disasters and different situations that occur, how do we ensure care providers have the best information possible at the point of care? Sean Jeffery asked for further explanation of PULSE in the setting of an emergency where records have been destroyed, is there an ability to connect to a repository of information? Michael Matthews answered that PULSE is more policy than technology. eHealth Exchange already has connections to 270 health care systems. Care Equality and eHealth Exchange are already connecting, all the agreements, DURSA, and what provider can access. With PULSE, when you are in a disaster situation, can you get credentialed in a 1-time scenario for those patients to go into an e-health exchange to get back to where their data resides. The records aren't being destroyed, but the providers access may be compromised.		

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	Rod Marriott added that we are only capturing the A lot of the functionality already exists, CT and Ohio already have a connection, so not every EMT has access, they could in theory access it as a delegate and how do you make sure information that you are storing is available at the time of the emergency.		
6.	**Review Impact + Effort Assessment Results**	**All**	**3:55 pm**

Tom Agresta reviewed the Impact + Effort Assessment Results. This exercise is done so the committee can decide how to approach the work over the next few months. About 14-15 members responded and included comments to the survey. The key comments and groupings of impact and effort were reviewed. The comments were taken to create themes since most of the comments were clustered around one or two areas. A few comments indicated that a particular goal or objective was problematic because it was combined.

Please refer to pages 6-11 to review results:
https://portal.ct.gov/-/media/OHS/Health-IT-Advisory-Council/MRP/MRPC/2020-MRPC-Meetings/OHS_MRPC_Presentation_011320.pdf.

Tom shared that the lowest rating for impact was around 4.2, so nothing really scored below 3 or 4 for impact or effort. Tom noted in the objectives there will be a range, a standard deviation associated with them. Some have a pretty high range in standard deviation, and some were clustered in terms of how people thought about it.

High Impact/High Effort:
1.Define vision for best possible medication history (BPMH) and develop methods of achieving a best possible medication list. This rated highest impact (avg. impact 6.1).
Comments: The vision is easy to create in terms of effort, but determining the methods need to be long term and planned.
Sean Jeffery commented that defining the vision is going to be really important in crystallizing how we think about the other ones. Without that vision of what we're driving towards, the other categories can get muddled.

5. *Conduct an analysis of potential funding sources and then seek funding to assist in the continued additional planning, design, development and implementation of opportunities to help improve attainment of the BPMH and to appropriately and safely reduce polypharmacy and reduce potentially inappropriate prescriptions.*
The comments who said identifying funding opportunities may not be complicated, but most people thought funding to be grants or federal opportunities. Working with payers may also be an option.
Comments did not suggest things like working with payers-this may be an option. This requires time, effort and people to carry on task. Additional comments were around what if we don't achieve the funding.
7. Create a medication reconciliation plan implementation plan and technology roadmap which includes business, functional and technical requirements. This rated the highest effort. Comments: Members thought it was high impact activity and there could be tools available; and putting tools along a roadmap could be valuable. This depends on how detailed roadmap would be.
8. *Utilize HIE funding as made available to partnering organizations to develop medication tools as part of the onboarding and technical assistance provided, including education, training and implementation assistance relating to medication reconciliation.* Comments: If you can identify specific tools and practices, then getting technical assistance (mechanisms to help organizations) will require some dedicated resources. The effort is related to finding and making sure the resources are dedicated to that.
9*. Identify, design and implement appropriate tools and methods to engage patients and providers in collaborative medication reconciliation and deprescribing*. Comments: Members said this overlapped with objectives 1 & 7. Also, providing incentives for tools is important, and identifying tools already made is easier than building new ones.

Tom paused for comments and questions from the group.

Michael Matthews said that as we heard consistently in the planning process about BPMH, and when thinking about the high impact/high effort of the BPMH and tools to support MedRec, shouldn't the BPMH be first before tools to reconcile the meds? How do you sort out tools if thinking about prioritize and strategy?
Tom answered that in an earlier meeting at Children's Hospital today, their challenge was their tools in play, are now are inadequate to keep the best possible medication list relevant in the EHR. If the patient has the best list, the ability to distribute it or keep it up to date is not feasible at the moment.
Lesley Bennett asked if they are looking at any mobile apps? Tom said this meeting today was mainly about EPIC and their use of their tool and how they may use patients as a part of that process. Lesley mentioned that some patient engagement groups are talking about using mobile apps through Apple and integrate with Epic.
Sean Jeffery asked if this is so the patient can curate their list? Lesley said yes, with pediatric patients, with exception of autism, obesity, and asthma, they are rare diseases. They can't go to one place because their patients need to go to different specialists, and they get put on different medications. They are now asking parents to use a mobile app; and then go to PCP to be central hub.
Nate Rickles added that one of the challenges we see here is there is a lot to unpack in this list. Nate suggested doing If a few items really well initially and then adding some of the other objectives.
Tom commented that it's vision and methods; let's try to accomplish a vision.
Naomi (guest) commented she likes "vision". It's not entirely the list, it's the patient and safety. Ideally, the patient knows what they are taking, and they show it to the provider, and goes across every site of care. The vision is the source of truth. If you focus on mechanisms to reconcile various different list from various different sources-this still doesn't tell you what the patient is taking every day-but hopefully they know it.
The vision is how close can you get the medical record to the source of truth. And what's the vision for it in terms of what the best med rec? The other problem is the discontinuities in all of the sites of care, there's no advocate for the patient so patients have no knowledge. What are the goals for the med list? It should be safe, affordable, simplest schedule and then source of truth is what are the best list?

Tom agreed that it does make sense, but also had the experience with a patient last week who came in with three different medication bottles and wasn't sure which one he was taking. Sometimes patients may be the best source, but not always.
Lesley asked if there was a way to get more information to the patients and caregivers to educate them about medications, for example if something has changed and ways to teach them to notify pharmacists.

Dr. Naomi Nomizu suggested in this example, you need to document somewhere that's accessible to every other provider that the patient came in with three bottles, but then its recorded somewhere.

Rod Marriott added that when we talk about CancelRx being mandated, should it be full drug PDMP to ensure continuity is there. That continuity is incredibly important.
Sean Jeffery said that this is pieces of conversation we have been talking about over the last year and a half.
Nitu Kashyap commented that in listening to this, it seems like some things may be high impact but critical to mission. Who is source of truth – what we can't say, it's what they should be taking vs what they are taking and that may be hard to gather? Should we say what we aspire to do is best possible medication list is what the patient should be on at an individual level. Is that the general sentiment?
Margie added in doing med rec, the first step in gathering the information is looking at two different sources, we are restating the steps to do a med rec.
Sean Jeffery Echo what Nitu and Margie says; number 1 in defining vision is really important.

Sean Jeffery in looking at the identifying funding opportunities. He read that question differently can-do analysis and have some degree of confidence of what you'll score. Secondly, if you get funding you have to do

work. The analysis piece isn't that hard, but what do you do once you get it. Sean think it's worth doing the analysis. It's not just federal dollars but should be broader.
Michael said this goes back to refine and define vision, when people try to find funding, they will turn themselves into a pretzel to fit the funding requirements.
Nate Rickles added that once we have our vision, then we go and find funders relative to that.
Jennifer commented that may also be dependent on patient population. We get off track when say we're going to do it for everyone. Maybe filter it to patients 65+ with 3+ medications, or different disease states, different folks have different ways of looking at it. The funding would become readily apparent when you define the parameters, because people have different disease states.
Tom agreed we always design with ostensible format.
Anne VanHaaren asked if the purpose of the survey was to create a vision for the group.
Nitu answered that internally this information emerges as workstreams or efforts coming out of this group. We could choose to say that this one particular part is out of scope and looking at the data that's merging. There may be technical components, education or patient experience component coming out. Then we would have a sense to put them on a timeline and have deliverables by next fiscal year.
Nate Rickles asked what do the citizens of CT most want?
Tom suggested that the group later on talk about focus groups. We don't know the answers to it, but in many ways the agency committee went around and did the initial use cases did how many interviews. This came up as a high activity. What it means wasn't discussed in detail, it was just that this is a problem.

Tom continued to review the results from the High impact and low effort.
3. *Develop a medication reconciliation repository and a communication plan to dispense evidence based, best practice tools, technical and safety advisories, Subject Matter Experts (SMEs) and policy and regulatory guidance to patients, providers, pharmacies, governmental agencies and other stakeholders.* This was rated high impact. Comments: will require ongoing maintenance to keep it up to date, also how useful is education going to change behavior.
6. *Identify possible incentives, in addition to current value-based care initiatives, for medication management, medication reconciliation, and the reduction of potentially inappropriate medications.* This rated relatively low effort and high impact. Comments: Identify incentives to implement are challenging.

Low impact and Low effort
11. *Review and make recommendations about healthcare provider scope of practice, as necessary, to support team-based medication reconciliation efforts.* Comments: There were recommendations on scope of practice on who can do what, the thought was that there are unintended consequences in posing legislation. Suggestions included doing a workshop or seminar to go through pros and cons, could be a low effort way of bringing multiple stakeholders together to make recommendations. Sean agrees that this is really important about what the implications would be if we did make recommendations.
12. *Assess Return on Investment (ROI) and legislative/policy considerations associated with CancelRx and include state level agencies for support.* Comments: This was highly supported because it was technical feasible to do this through multiple organizations in our state who are moving forward with pilots. Also, potential legislation to facilitate an appropriate use of standard was recommended.
MJ McMullen shared with the group that the State of Illinois passed legislation mandating that pharmacies have technical capability and activated to receive Cancel transaction. This was the first state that has mandated the adoption, there are lots of other things about having technical capabilities to do so, from the prescriber side. Michael asked what the catalyst was in Illinois? MJ said the med rec capabilities, and it was more around patient safety concerns.
Jennifer added that *Chicago Tribune* did an expose about pharmacists not warning about medication interactions. This received a lot of press ultimately changed a lot of pharmacy laws in Illinois. This included laws for mandatory counseling and notice to patients about potential interactions, including indefinite factors

around that. This created a liability concerns for providers practicing in the area, because the mandate is the pharmacy has to override the physician/patient relationship until the patient shouldn't be taking something. There's nothing in this legislation to say how to resolve a conflict. Legislation seems to indicate that pharmacy makes a decision, so there are concerns and haven't played out yet.
Tom commented there may be an opportunity to learn from this on how Illinois framed it, if we pursue this in CT.
Scott (guest) asked that, with the implementation of a new NC PDP script standard, how big of a problem is the technical adoption at this point? On the pharmacy side there's probably very few left, that don't have the technical capability.
MJ commented that in his responsibility of monitoring efforts at both Surescripts the migration to the new standard-looking at cancel adoption. Surescripts had requirement that all network participants-both EHRs and pharmacies needed to technically be able to receive cancellations or send it. So that gets us over very large hurdle, what our requirement does not mandate is use of it. That's where they are pounding the pavement – that the transaction is important.
Anne VanHaaren asked if Surescripts is monitoring actual transactions?
MJ said that we look at it a couple of different ways – how many physical locations are turned on the network. also look at market share of entities who can receive the transactions.
Looked in November/December; had 70% of market share activated to receive cancel. How many transactions are being sent? That could be wildly different depending on HER functionality; some EHRs have automatic cancel features or if it's done from the prescriber. We see 40% of EHRs new Rx's resulting in Cancels. There are so many different variables – there's also workflow issues.
Tom added that from pharmacy perspective, there may not need to be legislative or policy. From provider side, people are dipping their toes in the water. This is where we should focus on the collaboration between pharmacies and providers are dealt with.

13. *Provide guidance on the addition of CancelRx transactions to the Connecticut Prescription Monitoring and Reporting System (CPMRS).* Comments: Discussed how to help in a ledger way, but several members who said they had a general lack of knowledge of how data flow exists. This may be educational opportunity for the group for the future.
Rod Marriott suggested in a future meeting, he could provide a high-level synopsis, and how the PMP generally functions. He doesn't think anyone is doing CancelRx in PMP at all, and it would be helpful to bring the vendor in at some point.
14. *Conduct stakeholder interviews and focus groups to validate value created from proposed services.*
Comments: Members said that it would be good to get more buy in and focus groups are easier to do.
The other supporting competing idea was that there is a lot of information already and if focus groups were necessary. If we do a focus group, to figure out who you will do it with, and what purpose.

15. *Identify possible medication quality measures that align with clinically meaningful outcomes which can be implemented.* This was rated the lowed impact. Comments: Members questioned what was meant by quality measure with regards to MedRec. When we combine this, the thought was that if I have a system that records change before or after, a possible way of doing that may actually be a quality measure.
Sean Jeffery added that he would like to us move from checking a box and how we capture that into an area where it's been done, it's been done well and resulting from something clinically meaningful.
Michael asked to think about this relative to the best practice repository as well. How do you know you are achieving best practices?
Sean said they have had a challenge on how to figure out how-to do-good medication reconciliation and to close a gap in care. Where do all those technical pieces fit, so they can move the goal post down.
Margie commented that we can see what the Pharmacy Quality Alliance (PQA) has done with med rec for quality measures, suggested we can work with them, so we don't have two sets of quality measures.

Nate added they are just starting to work on something on medication therapy management.
Tom suggested maybe there is an opportunity to take advantage of their working process.
SJ: It would also be good to touch base with collaborative???

Low Impact/High Effort

2. *Evaluate how to best incorporate the Connecticut Prescription Monitoring and Reporting System (CPMRS) in Health Information Exchange (HIE) planning for the development of BPMH, including the possible use of Prescription Monitoring Program (PMP) database as a single source of truth for all prescribed medications.*
Comments: Members thought it was good for scheduled drugs and integration into the HIE. Suggestions to use Surescripts or other formats. Additionally, this could get complex and political because it would require legislative work which would take a long time, concerns over data presiding and state privacy concerns.

Michael suggested it may be worth it to get in contact with the one state that has pulled this off-Nebraska. To learn how they overcame access issues; PMP schedule – law enforcement and how to access points.
Adrian added that there will be a regular update of the SUPPORT Act in the MRPC meetings.

4. *Identify, review and revise risk tools to determine population health strategies for potential medication de-prescribing and conduct a survey of educational needs and best methods of delivery for providers.* Comments: Some members indicated they did not know what was meant by "risk tools," and wanted a better understanding of what the targeted risk tools are.
Nate Rickles commented that there is a deprescribing network and some money for junior investigators ($25-30K), but if there are folks you know of, they could support some of our work.
Sean Jeffery clarified that the junior investigator was from Center at UCSF and identified US Deprescribing; one of their goals is to create a junior investigator category for people who haven't had a major grant. They didn't specify age or years of service, they'll also help mentor you. It is required to have to have an academic appointment to be a junior investigator or could be for any of their dollars. Also, there is an opportunity for seniors.

10. *Review and advance prototypes from Medication Reconciliation Hackathon and monitor advanced technologies and clinical decision support tools that should be integrated with BPMH.*
Comments: Members who were in hackathon thought it was good to advance, folks who weren't didn't. There were folks that thought that pushing some prototypes would be valuable.

Sean Jeffery said as we've reviewed this, the group should start thinking what this is going to lead up to. The vision was identified as important to create. As a next step, the committee should form working groups to work on the objectives.

Nitu added that the general sense there are some things that are critical to the mission. We can agree to collate around themes. She hopes that in a subsequent meeting to take this information and put it on a timeline. The mandate from the group was to be action oriented and being a finite timeline-so anything is possible with time and resources-neither of which we have. We can take a crack at digesting this and putting it out there for the group if they think this is helpful.

Anne VanHaaren commented that the theme is vision throughout all of these, and it would help us to refine which one in each of the boxes would need to have a focus.

Nate Rickles added that as we get the vision down and work on some priorities, we also have to do some technical specification for what needs to be done for each of these tasks. Some tasks are are achievable, but there are a lot of details and require other stakeholders and support.

	Tom added that as we lay out what tasks are required, it will become clearer of what we may try to accomplish- but that can't happen without some of the work occurring. He agrees with Nitu's suggestion to have a small group lay out a timeline is a good strategy. Another suggestion is to have another small group to layout the vision. Also, to have a repository available of materials that we've been using i.e. research that Nate's student did, put all the articles by our student, Ryan, begin to put it in a location and organize it to share it and what a repository may look like. Adrian commented on what tools are available in our landscape. Interview skill of a doctor or provider at a given point of time. We can figure out where those interview skills would lie. where would it land? What tools exist in our landscape? Are there any medical schools that focus on this? Or pharmaceutical schools? What are the best practices for interview skills? Tom said that you have a variety of different practitioners that engage in this and varying levels of education. Around med rec the pharmacy schools would be the best job where they spend a lot of time. Dr. Naomi Nomizu thinks EHRs are problematic; it was better to not have the list than having it. Nate Rickles thinks the feasibility of standardizing interview skills is really difficult to put in place. He is looking at this group for practicable and feasible implementable. Sean Jeffery asked if there is any pushback to the suggestions? We'll be reaching out to people to be apart of these groups and asked if the group had any desire to participate to let us know. He suggests having a timeline and articulating what a vision would look like would be good next steps. Tom said that we will seek member interests for participating in small groups by email.		
	CancelRx Survey and Update	**Tom Agresta**	**5:10 pm**
	Tom updated the group on the CancelRx survey. This is an impactful small working group who met once virtually and continued to email back and forth. They were able to make some modifications to the CancelRx s survey based on feedback from the larger group and developed a better explanation of what the group was trying to accomplish. They also rearranged it for different format. Tom thanked Diane, Pat and Stacey for providing a lot of feedback to the survey. There is additional feedback to incorporate in the survey, but it's pretty close to completion. The suggestion to the group is to determine what to do with the survey, who to share it with, and when. Diane Mager added that the survey is pretty user friendly, and the small group was able to get it down to barebones and gather enough data that can help us. Feedback from everyone is welcome. Nate Rickles asked to clarify who will be taking the survey? Tom answered initially we would send this to folks who would do technology implementation but based on feedback from this group they ended up thinking about clinicians. Tom suggested leveraging this group and access the organizations that members belong to share to share the survey. Sean Jeffery suggested to consider that it may benefit to do regional, or potentially nationally. Tom suggested put this in CT first and then expand it. Diane Mager asked if the goal is to survey as many people as possible; or is it do a sampling of each category? Michael answered there is no need to survey 36K people to get a good analysis, but if you are raising awareness – then yes. If you want to learn more, you have educational material.		

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	Tom said by the next time we meet, we will have educational material available and will share before that meeting.		
	Next Steps and Planning for Future Meetings	**All**	**5:20 pm**
	Tina Kumar announced that if members have a location preference or if they are able to host for meeting to please email her with suggestions.		
	Wrap up and Meeting Adjournment	**All**	**5:25 pm**
	Rod Marriott thanked Michael Matthews for his work and that he enjoyed and learned a lot from working with him. Sean asked if anyone had any comments or questions. There was no further discussion. The meeting adjourned at 5:30 pm.		

Upcoming Meeting Schedule: February 27, 2020 11:00 am-1:00 pm

Meeting Information is located at: https://portal.ct.gov/OHS/HIT-Work-Groups/Medication-Reconciliation-and-Polypharmacy-Committee