Health IT Advisory Council

July 18, 2019

Agenda

Agenda Item	Time
Welcome and Call to Order	1:00 pm
Public Comment	1:05 pm
Review and Approval of May 16, 2019 Minutes	1:10 pm
Review of Final Recommendations of *Medication Reconciliation & Polypharmacy Work Group*	1:15 pm
Announcements	2:50 pm
Wrap-up and Meeting Adjournment	3:00 pm

Welcome and Call to Order

Public Comment

(2 minutes per commenter)

Review and Approval of:

May 16, 2019 Meeting Minutes

Review of *Final Recommendations of the Medication Reconciliation & Polypharmacy Work Group*

Medication Reconciliation & Polypharmacy Work Group

Overview of Final Recommendations

Medication Reconciliation & Polypharmacy Workgroup

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University of Connecticut School of Pharmacy

Director of Clinical Pharmacy Services
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Thomas Agresta, MD, MBI

Professor and Director of Medical Informatics Family Medicine &

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Associate Professor of Pharmacy Practice
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University of Connecticut School of Pharmacy

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What are barriers (policy/professional/patient) that prevent us from being better stewards of patient medications?

FAX
DON'T EAT YOUR HEART OUT COOKBOOK

Membership

- Sean Jeffery *(Integrated Care Partners - Hartford Healthcare)*
- Nityu Kashyap *(Yale New Haven)*
- Kate Sacro *(Value Care Alliance)*
- Amy Justice *(VA CT Healthcare System)*
- Janet Knecht *(University of Saint Joseph)*
- Nathaniel Rickles *(UConn School of Pharmacy)*
- Marghie Giuliano *(CT Pharmacists Association)*
- Anne VanHaaren *(CVS Health)*
- Thomas Agresta *(UConn Health)*
- R. Douglas Bruce *(Cornell Scott-Hill Health Center)*
- Marie Renauer *(Yale New Haven Health)*
- Ece Tek *(Cornell Scott-Hill Health Center)*
- Lesley Bennett *(Consumer Advocate)*
- MJ McMullen *(Surescripts)*
- Jennifer Osowiecki *(CT Hospital Association)*
- Diane Mager *(CT Association of Healthcare at Home)*
- Jameson Reuter *(ConnectiCare)*
- Jeremy Campbell *(Boehringer-Ingelheim)*
- Peter Tolisano *(CT Dept. of Developmental Services)*
- Rodrick Marriott *(CT Dept. of Consumer Protection)*
- Bruce Metz (UConn Health)
- Barbara Bugella *(CT Dept. of Mental Health and Addiction Services)*

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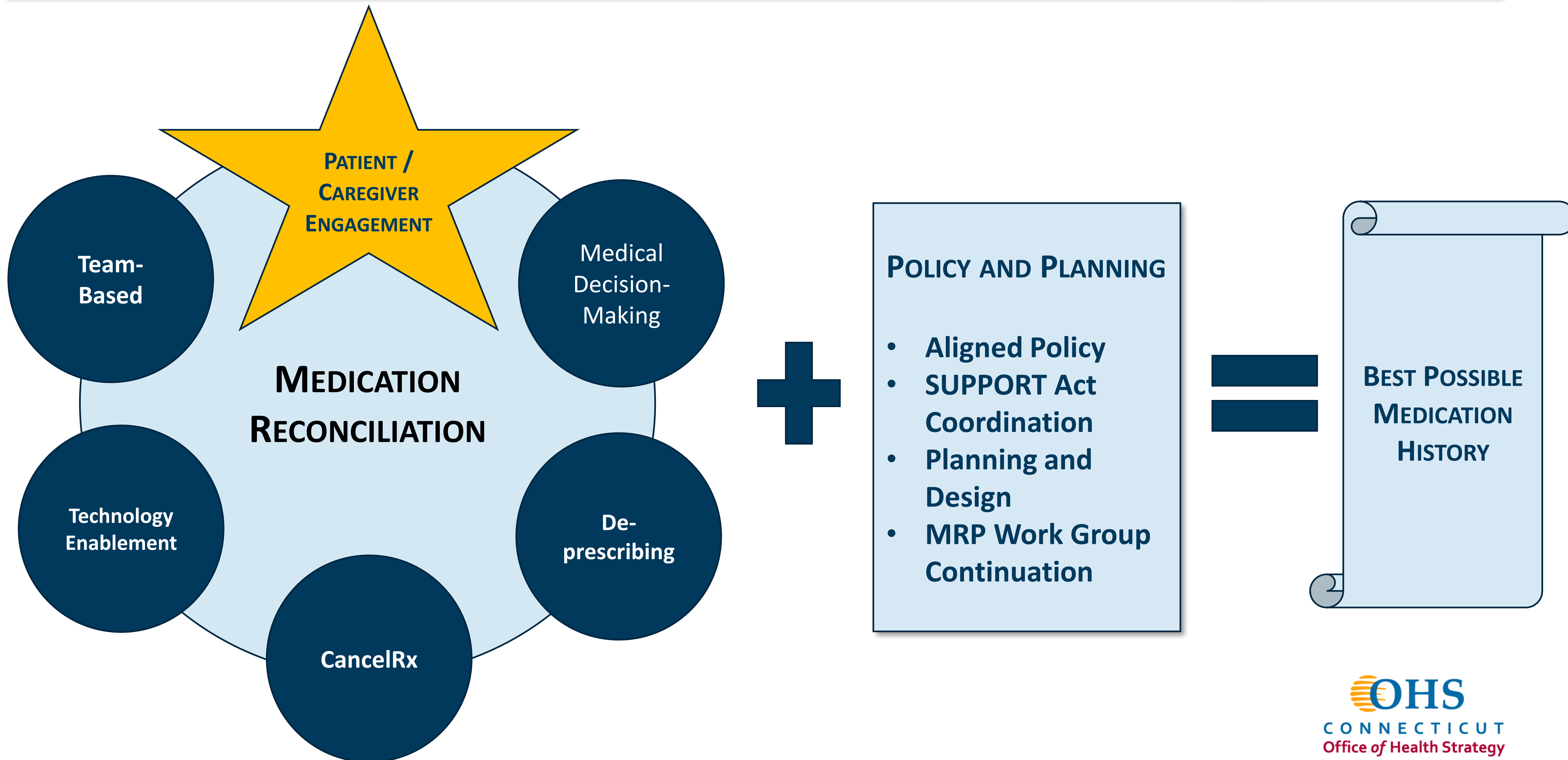
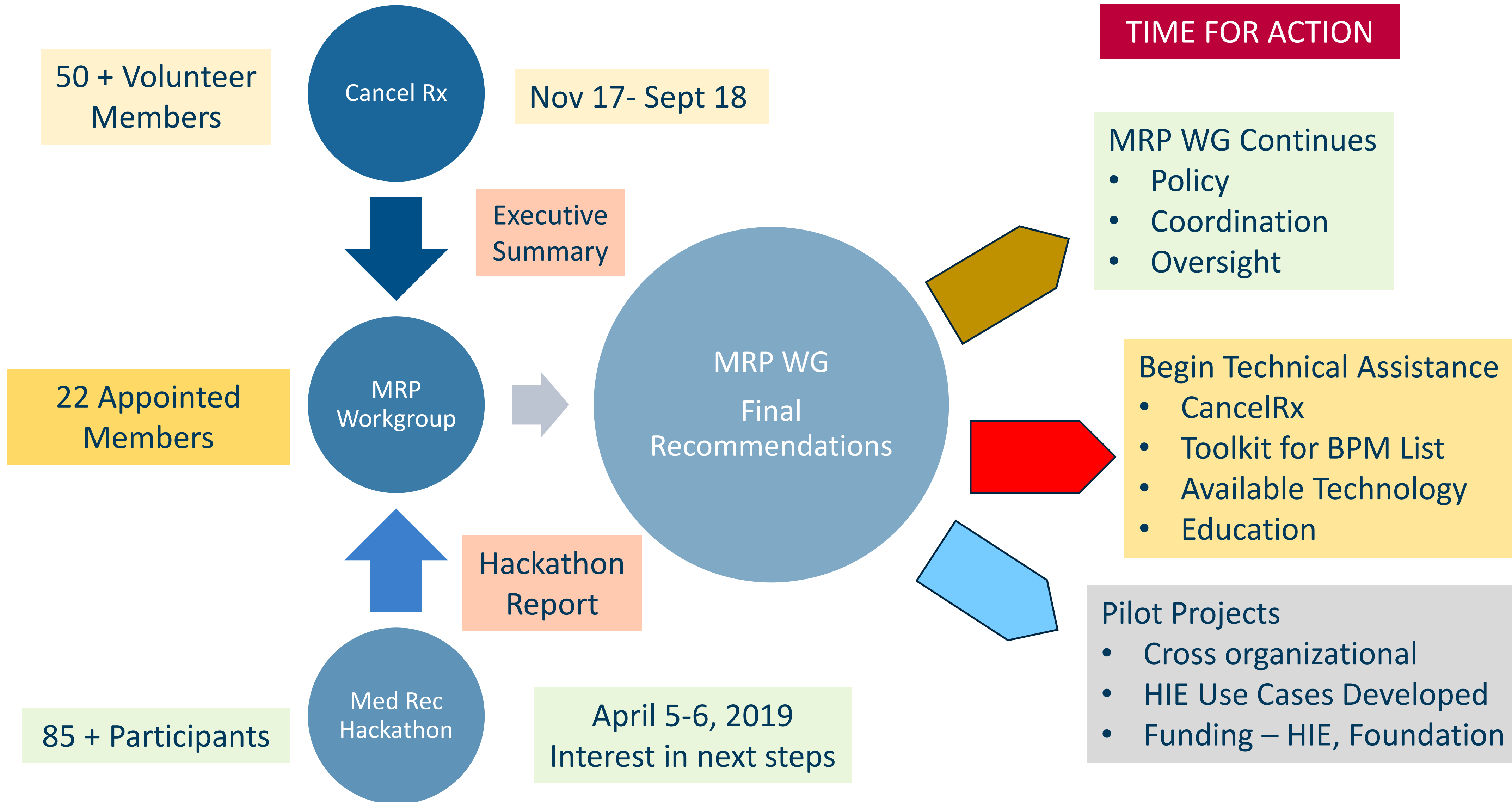
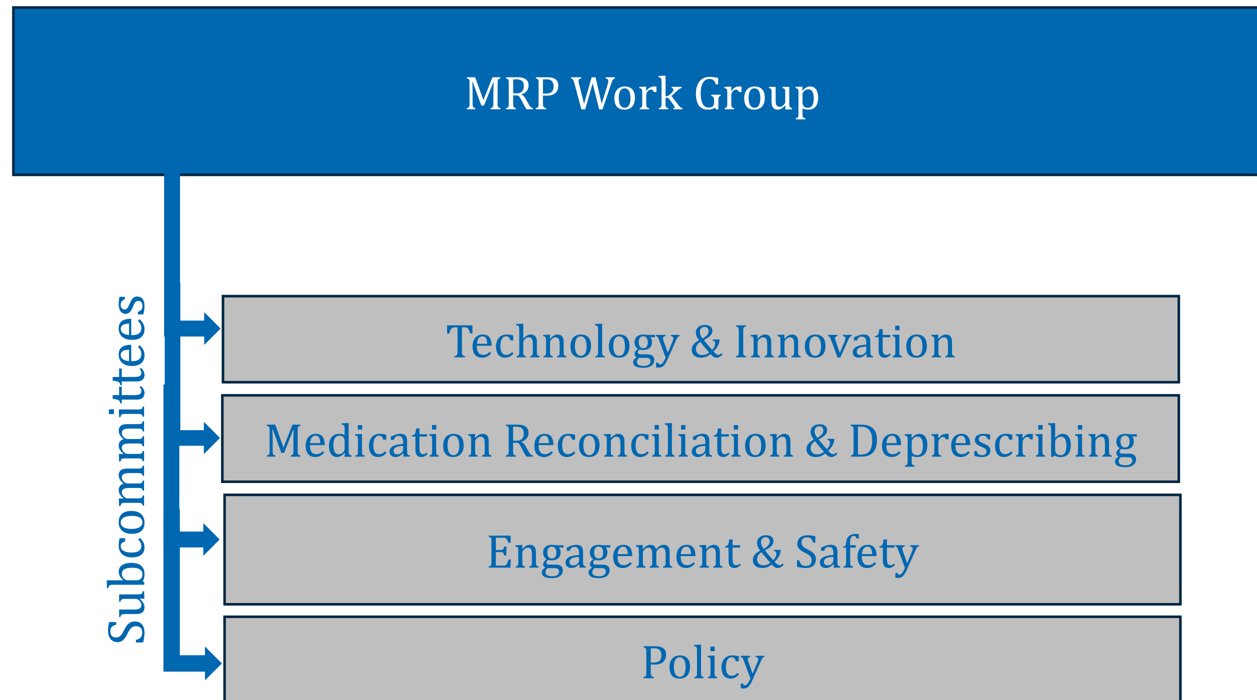
Patient-Centered Best Possible Medication History Process of Care




50 + Volunteer Members
Cancel Rx
Nov 17- Sept 18
Executive Summary
22 Appointed Members
MRP Workgroup
MRP WG Final Recommendations
Hackathon Report
85 + Participants
Med Rec Hackathon
April 5-6, 2019 Interest in next steps
TIME FOR ACTION
MRP WG Continues
• Policy
• Coordination
• Oversight
Begin Technical Assistance
• CancelRx
• Toolkit for BPM List
• Available Technology
• Education
Pilot Projects
• Cross organizational
• HIE Use Cases Developed
• Funding – HIE, Foundation

MRP Work Group Structure



The Problem

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Literature Review

- **Goal:** Identify studies that provided evidence on the extent to which different factors affected the construction of a “true or most accurate” medication list.

- **Searched key databases:** PubMed, International Pharmaceutical Abstracts, Science Direct, and that of the American Medical Informatics Association (AMIA). Focused on publications within the past 15 years.

- **Key search terms:** included “medication reconciliation”, “accuracy of medications”, “errors in medications”, “patient verification“, “methods of medication reconciliation”, and “pharmacist involvement.”

Literature Review

- 23 manuscripts were identified that involved a variety of settings, methods, and outcome measures.
- A majority of the papers identified were projects done in the primary care settings and several outside of the US.
- 5 randomized, controlled intervention trials (RCTs).
- Common: retrospective analyses of existing data sources such as electronic medical records, insurance claims data, and patient charts or data sampled at one point in time such as cross-sectional surveys.
- Several papers explored the impact of pharmacists and other health professionals on the medication reconciliation process.
- Outcome measures were diverse and defined in different ways given the populations, settings, and methods used. Common: number of discrepancies between different sources of medication reconciliation.

Literature Review

- There are **considerable discrepancies in accuracy** across medication lists obtained by practitioners in different settings and especially at times when transitions of care occur
  - Walsh et al. (2018) noted a wide range of agreement from 50-90% across between lists obtained by interview and in the charts.
  - Sources of inaccuracy: medications erroneously prescribed and not discontinued, lack of awareness regarding patient initial and continued use of prescribed medications, and over-the-counter medications used
- Using a **single data source** such as EHRs, patient portals, insurance claims data, and patient history **is insufficient** to ensure medication list accuracy and the use of multiple data sources improves medication list accuracy;
- **Greater patient engagement** in the medication reconciliation process resulted in fewer discrepancies;

Literature Review

- **Pharmacist and pharmacist technician roles** have a positive impact in the medication reconciliation process that can be seen across the hospital setting at admission, treatment, discharge, and among pharmacists in community settings

and

- **Use of technology** can be of value in bringing data sources together and creating functions to help automatically reduce medication list inaccuracies.

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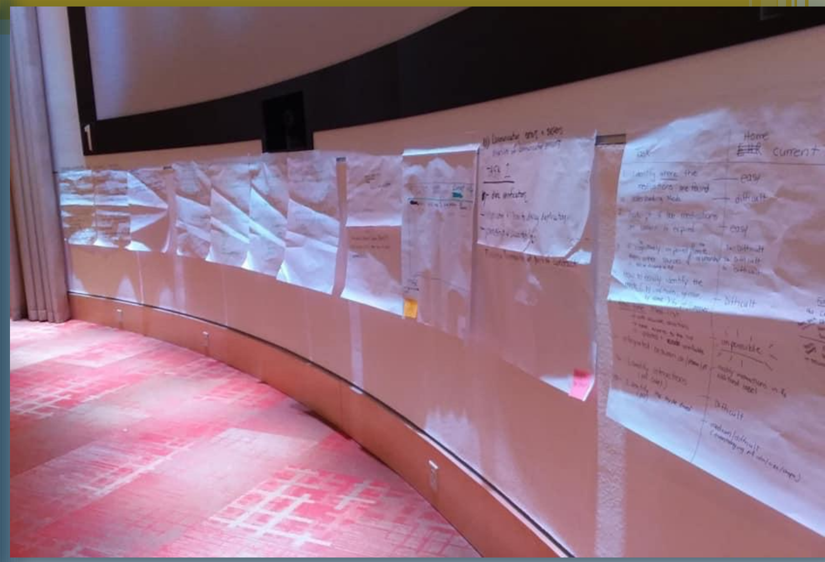

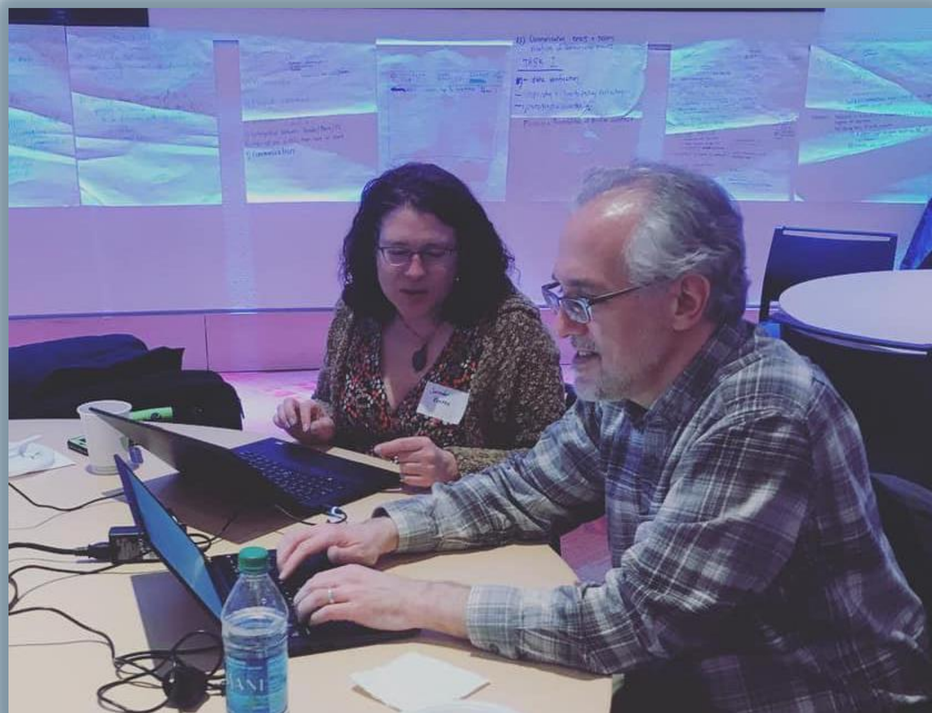

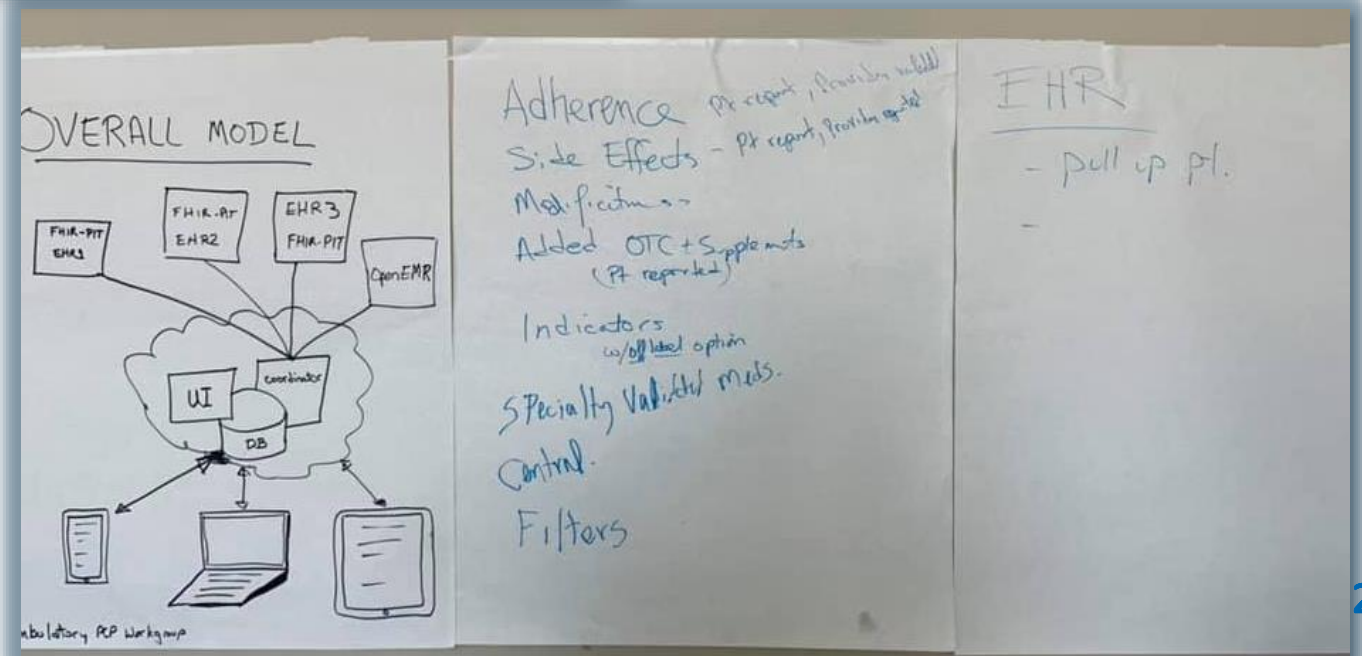
OVERALL MODEL
OpenEMR
UI
DB
Adherence
Side Effects
Indicators
Filters
EHR
- pull up pt.

MRP Work Group Recommendations

1. Best Possible Medications History (BPMH)

The MRP Work Group recommends an incremental approach to support BPMH that enables near-term, value-added solutions while working toward longer-term, more complete and integrated solutions that include decision support tools and a ledger of medication transactions (e.g., including current and prior-canceled prescriptions).

2. Patient Engagement

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.

3. Medication Reconciliation Process Improvements

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

4. Team Approach

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.

5. Implementation & Adoption of CancelRx

The MRP Work Group recommends the implementation of the findings and recommendations from the CancelRx Work Group regarding the widespread adoption and use of the CancelRx standard.

MRP Work Group Recommendations

6. Deprescribing
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.

7. Technology
The MRP Work Group recommends an incremental approach in deploying technology to support 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., non-prescription medications including, over-the-counter medications, vitamins, herbals and supplements) and enhanced technical tools such as analytics, clinical decision support (CDS) and artificial intelligence (AI). In addition, ongoing surveillance of the industry should be conducted to identify promising solutions enabled by technological advancements.

8. SUPPORT Act Funding and Planning / Design Process
The MRP Work Group recommends that the planning and design activities related to the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act be undertaken in close collaboration with the initiatives and future planning activities recommended by this Work Group.

9. Aligned Policy
The MRP Work Group recommends an ongoing policy review to identify opportunities in both the public and private sectors, with the following initial areas of focus: medication quality measures; payments, resources and incentives for medication reconciliation; privacy and confidentiality; and an assessment of mandating CancelRx standards adoption and use.

MRP Work Group Recommendations

10. Planning / Design Process and Use of IAPD Funding

The MRP Work Group recommends that Implementation Advance Planning Document (IAPD) planning funds for federal fiscal year (FFY) 2019 and FFY 2020 be utilized to finalize planning, design, and requirements development for the projects and services recommended in this report, with future funding for implementation once these activities have been completed.

11. Continuation of the MRP Work Group

The MRP Work Group recommends that the MRP Work Group be re-chartered as a standing committee of the Health IT Advisory Council and that an evaluation of membership occur to ensure continuity and appropriate stakeholder representation are maintained.

Take Action Now
Operationalize Recommendations

- Reconfigure MRP Workgroup
  - Focus on recommending actions, priorities, policy, evaluation and oversight

- Create an action-oriented Technical Assistance group
  - Knowledgeable, dedicated resources for tasks
  - Multidisciplinary and multi-organizational membership

- Facilitate, Incent and Fund Pilot Projects
  - Consider starting with Med Rec Hackathon ideas
  - Foster Innovation – how to use the HIE infrastructure, what can be cross organizational, how to best engage patients and caregivers

Announcements

Articles Signed!

Health Information Alliance, Inc.

FILING #0006598639 PG 03 OF 08 VOL B-02611
FILED 07/17/2019 08:30 AM PAGE 01738
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

CERTIFICATE OF INCORPORATION

OF

HEALTH INFORMATION ALLIANCE, INC.

The undersigned Incorporators hereby form a corporation under the Connecticut Revised Nonstock Corporation Act (the "Nonstock Act"):

1. The name of the corporation is "Health Information Alliance, Inc." (the "Corporation").

2. The Corporation is organized and shall be operated exclusively for charitable, literary and educational purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code"). Subject to the foregoing, the Corporation is organized pursuant to § 128 of Connecticut June Special Session Public Act No. 17-2, as amended by § 12 of Connecticut Public Act 18-91 (as so amended, the "Enabling Act") which has been codified as § 17b-59g of the Connecticut General Statutes. Subject to, and without limiting the foregoing, the purposes of the Corporation, shall be:

(a) to assist the State-wide Health Information Exchange in establishing and maintaining itself as a neutral and trusted entity that serves the public good for the benefit of all Connecticut residents, including, but not limited to, Connecticut health care consumers and Connecticut health care providers and insurance carriers, (2) to perform, on behalf of the state, the role of intermediary between public and private stakeholders and customers of the State-wide Health Information Exchange, and (3) to fulfill the responsibilities of the Office of Health Strategy ("OHS"), as described in section 19a-754a of the Connecticut General Statutes;

(b) to lessen the burdens of the government by enhancing, but not supplanting, the role of the State of Connecticut in its duties and powers with regard to implementing comprehensive, data-driven strategies that promote equal access to high quality health care, control costs, enhance data sharing and interoperability of health records, and ensure better health for the people of Connecticut; and

(c) to perform those acts set forth in the Enabling Act, under which the Corporation may:

(i) employ a staff and fix their duties, qualifications and compensation;

(ii) solicit, receive and accept aid or contributions, including money, property, labor and other things of value from any source;

(iii) receive, and manage on behalf of the state, funding from the federal government, other public sources or private sources to cover costs associated with the planning, implementation and administration of the State-wide Health Information Exchange;

- ***HIE Articles of Incorporation registered July 17!***
- ***Creates a non-profit, non-governmental entity to house the HIE services***
- ***Corporate name reflects input from a variety of stakeholders***
  - "Alliance" evokes a alignment of interests among participating organizations
  - Recommended not to reference CT in name to acknowledge the many citizens who receive care outside the state, and the Federal trend toward regionalization
- ***Brand name also selected based on stakeholder input:***
  - Brand is subject to Board approval

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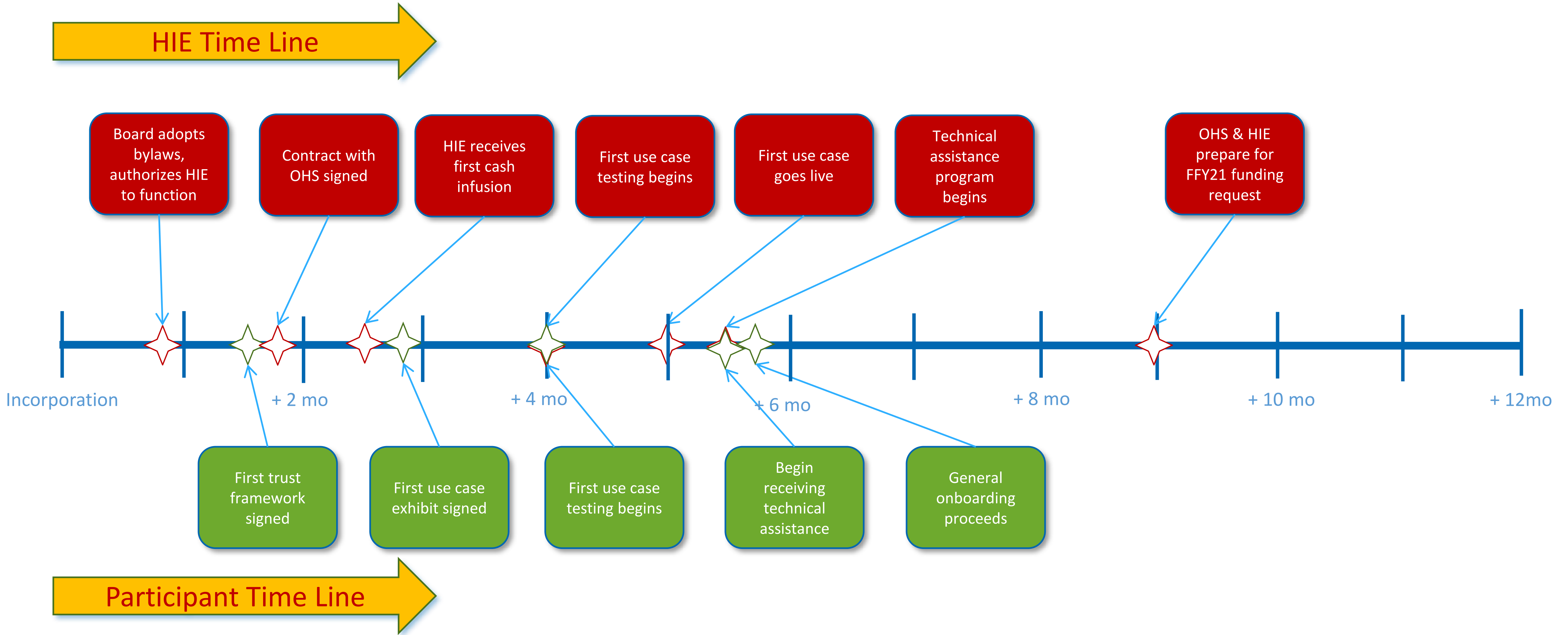
Status of HIE Board Appointments

Designated Qualification	Appointer	Board Member
Advocate for consumers of health care	Governor	Awaiting appointment. Nominee is a consumer advocate with health care start-up expertise
Clinical medical doctor	Sen. President Pro Tempore	Finalizing– likely candidate from a major CT ACO
Expert in the area of hospital administration	House Speaker	Lisa Stump, CIO - YNHHS
Expert in the area of corporate law or finance	Sen. Minority Leader	Finalizing – likely candidate from a health care venture capital firm
Expert in group health insurance coverage	House Minority Leader	Awaiting appointment. Nominee is president of a major CT health insurer
CT CIO	Ex-officio	Mark Raymond
CT Sec. OPM	Ex-officio	Awaiting designation
CT HITO	Ex-officio (Chair)	Allan Hackney

HIE Year 1 Timeline



Note: All dates relative to incorporation data

IAPD Status

IAPD Status

- ***IAPD FFY19-20 "Request for Additional Information" (RAI) letter received Jun 18***
  - Typically signals CMS has completed its review and is preparing to issue final decisions
- ***CMS RAI generally seeks clarification in three broad categories:***
  - Clarifications for Medicaid-specific activities
  - Clarifications for "Appendix D" HIE activities
  - Mechanical and procedural adjustments
- ***CMS RAI approved FFY19 portions of key contracts for OHS:***
  - Enables continued acceleration of HIE activities
- ***DSS and OHS collaborating to submit unified response***

RAI Response Timeline

1. **DSS and OHS first draft responses due (Jul 22)**
2. **Combined draft response due (Jul 25)**
3. **DSS Comm/OHS ED review (Jul 26)**
4. **Final draft due (Jul 29)**
5. **Submission to CMS (Jul 30)**

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Health IT Advisory Council Website:

https://portal.ct.gov/OHS/HIT-Work-Groups/Health-IT-Advisory-Council