Medication Reconciliation and Polypharmacy Work Group

Policy Subcommittee

Meeting Minutes

Meeting Date	**Meeting Time**	**Location**
March 19, 2019	1:00PM – 2:00PM	https://zoom.us/j/153975347

Sub-Committee Members					
Peter Tolisano	x	Sean Jeffery	x	Marghie Giuliano	x
Valencia Bagby-Young	x	Jameson Reuter		Rod Marriott	x
Lesley Bennett		Barbara Bugella			
Supporting Leadership					
Allan Hackney (OHS)		Michael Matthews (CedarBridge)	x	Kate Hayden (UConn Health)	
Sarju Shah (OHS)		Chris Robinson (CedarBridge)	x	Tom Agresta (UConn Health)	

Minutes			
	Topic	**Responsible Party**	**Time**
1.	**Welcome and Call to Order**	**Michael Matthews**	**1:00 PM**
	Michael Matthews welcomed the Subcommittee members and called the meeting to order. As background, Peter Tolisano and Marghie Giuliano had discussed the need to meet and discuss next steps and to see what information was available online to support this subcommittee's work.		
2.	**Discussion**	**Attendees**	**1:05 PM**
	Marghie suggested that this group should start with a discussion of what has emerged from the other subcommittees and the overall Work Group. At this point, we can try to brainstorm what policies will be needed to support the recommendations and the policies that are barriers. Sean Jeffery said that all of the different subcommittees will be producing recommendations that will be condensed into the final report, and the Policy Subcommittee is responsible for reviewing all of the recommendations and identifying policy implications. Timing will be the biggest challenge, as we don't know when the recommendations will be completed. Michael Matthews hopes we have a good sense of the recommendations in early May. Marghie said that two there are two areas that are defined that we can begin to research – CancelRx and the PDMP. Marghie asked if this group will be going to be producing policy recommendations or recommending legislative changes. Sean Jeffery said that based on the people who are involved in the MRP Work Group, which includes a lot of different state agencies, he is wondering if there is something this group can be driving towards that can be directed towards specific agencies. Michael agrees with this and added that he thinks there is an opportunity to identify a wish list of policy changes or legislative changes that are obvious, low-hanging-fruit. Marghie said that the medication optimization concept is one potential area – she wishes pharmacists had the opportunity to participate in and get paid for medication reconciliation and assist providers. Is this something that could be included on the wish list? Are we looking at this from a scope of practice perspective? Michael said it could be, but he wants to re-frame this around a different example – Amy Justice had previously suggested that we should expand the PDMP to include all dispensed medications, and not just controlled substances. If this became a recommendation, then this subcommittee could determine the policy ramifications for this kind of change. Rod Marriott agreed that there needs to be thoughtful consideration around sustainability, in addition to the analysis of policy implications. Rod thinks		

we should consider the justification and sustainability of an all-drug PDMP, as well as document our concerns, such as patient matching, so that the legislature can make informed decisions. This group can look at other states that have gone this route, such as Nebraska, to review example legislation and policies and inform our recommendations.

Sean asked if there has been a survey of the licensure requirements for doing medication reconciliation in the state of Connecticut. Rod Marriott said there is no clear definition, from his experience. Rod believes the term "medication reconciliation" is only defined within Department of Social Services (DSS) for the purposes of Medicaid. Sean said that this is a point of confusion in his world – their care managers are told that they cannot reconcile medications; it has to be the provider. They have both social workers and nurses on the care management team that could easily conduct reconciliation effectively if they were permitted to complete this task. Sean thinks we have uncovered an area where we could clarify policy and this group can begin to work in parallel to the other subcommittees. This analysis could inform work that is conducted around training and will create a pathway to standardization. Marghie agrees that certain parts of the process can be handled by pharmacy techs, medical assistants, or community health workers. Peter agreed that this would be valuable. Sean said that we may already have access to internal policies and procedures for all of the different groups that are represented within the MRP Work Group – he is happy to pull together what is available from Hartford Healthcare around medication reconciliation. Peter can look for policies from DDS – he says that they typically rely on providers to conduct medication reconciliation. Valencia Bagby-Young said that she believes the provider is responsible for conducting medication reconciliation and is the only one who can sign off on this within the EHR.

Rod Marriott said that the term "medication reconciliation" is referenced in the statute that formed the MRP Work Group, but he will continue to look if there are any other places in the statute where this term exists. Rod thinks it may be housed in a sneaky location, such as within a statute pertaining to quality initiatives or provider licensure. Sean said that the people who configure EHRs are setting permissions for these tasks – and they are making these decisions based on some sort of policy. Marghie thinks this is a great starting place. Sean thinks we could spend a bit of time trying to collect where this is occurring in the state and any definitions or policies that have been created internally by various organizations. This group can then try to define the policy opportunity and clarify this point moving forward. Sean hopes we can pull this together relatively quickly.

Based on the discussion, the subcommittee developed the following initial list of organizations that should be included in the initial outreach/research effort for medication reconciliation related-policies and procedures:

- State agencies – DDS, DSS, DMHAS, etc. (Peter will reach out to Sarju for a list of agencies that provide healthcare services)
- Home health agencies – Marghie said that they have to do medication reconciliation under their conditions of practice, but this is not well-defined
- ACOs
- Physician practices
- Hospital systems
- Long-term and post-acute care – Sean said that we should look into the rules for participation in long-term care facilities and what CMS has defined within the state operation manuals. Sean Jeffery volunteered to research this area.
    - Sean said we need to know what the surveyors look for when they come in to complete an inspection. The inspection is conducted by the state.
    - Valencia said that intermediate care facilities are required to have a pharmacist review the medications quarterly. Sean thinks of these facilities as group home or skilled nursing facilities (SNFs).
    - Marghie said there is a tool used within the SNFs called "Interact" that has a med rec module, but it is unclear how this is being utilized, who is using the system, and what the challenges are.

- Professional societies:
    - Connecticut Pharmacists Association
    - Connecticut State Medical Society – Rod sent an email to the Medical Society
    - Connecticut Hospital Association - Sean said that Jennifer Osowiecki could probably get this information, as she works for CHA
    - Others?
- Joint Commission
- Schools / academic hospitals

Peter asked if we should query about how each group is completing medication reconciliation, in addition to who is allowed to conduct med rec. Marghie said that this would be great, if they are able to provide this information. Marghie said that if this is not reimbursable, then we will not make any progress. Payment is a huge barrier.

Sean said that the worst-case scenario would be when incorrect, incomplete, or non-existent medication reconciliation leads to patient harm. Sean asked the anybody is aware of any lawsuits that have been filed in this space that would allow us to draw policy recommendations from? Valencia said that most offices are using electronic prescriptions, which will create flags for interactions or risks for prescribed medications. Sean said that this is true for prescribers who have an EHR, however this is not always the case. Marghie said that med errors go through DCP, however DPH may be handling some of these protocols. Rod is not aware of any cases that go to DPH – he also thinks there is a degree of difficulty to prove that a practitioner did anything wrong when it comes to medication reconciliation. Sean said that as we put this together, we may see a series of new complaints once providers have increased access to medication data. Michael said that when HIEs were starting to be established, this was a major concern for a number of states (about health information more generally).

Sean asked, from a community pharmacy standpoint, if there is any policy around medication reconciliation. Marghie does not think this exists. However, there may be some policies specific to large pharmacies, such as CVS. Marghie thinks there are bits and pieces, at a high level, for how/when medication reconciliation should be done, but this is not sufficient and does not address reconciliation during transitions. Sean asked if the Pharmacist Association or the Medical Society has a position or stated policies on medication reconciliation. This could be another area that should be researched (and is included on the list above). Sean said one outcome of this work may be engaging the various professional societies to champion this cause. Michael thinks this is a great idea.

Action Item – Sean suggested that CedarBridge will develop a list of the organizations that were named during this call (listed above). Once validated, this list could be put into a spreadsheet so that the group can make assignments and track the outcomes. We are looking for specific policies or procedures that the organization promotes or follows around medication reconciliation. The subcommittee agreed with this suggestion.

Marghie said that any hospital we reach out to will say they follow the Joint Commission. Sean said that is fine, because we need to go back to the Joint Commission and document their stated policies.

Sean asked the group if there is anything else that needs to be tackled by the subcommittee in the immediate future. Marghie asked if it would be important to look at the uptake of collaborative practice agreements, once we start looking into polypharmacy and deprescribing in more detail. This gets back to the important topic of payment – somebody needs to be paid for this work. Marghie said there aren't that many providers or prescribers that understand the benefits of collaborative practice agreements. Sean said that he has seen big payers who are interested in polypharmacy – they wanted to find out if the health system could do something to address the overuse of medications. It is very difficult to make this actionable – Sean hopes this is something that becomes a recommendation from the subcommittee. At the company-level, they are

	recognizing the problem, but this has not translated to the people who actually write the prescription because they have different incentives. Sean said we can do some blue-sky work around the policy implications polypharmacy up-front, while we wait for the other subcommittees to form their recommendations. Deprescribing will naturally include polypharmacy. Michael said that this makes sense – "policy" can mean a lot of different things. Michael said that Marghie brought up reimbursement policy, which is hugely important in a value-based care world.		
3.	**Next Steps and Adjournment**	**Michael Matthews**	**1:55 PM**
	Michael thanked everyone for their participation. Chris will polish and distribute the meeting minutes from today's discussion. Michael said that CedarBridge has a resource that can be utilized to help support some of the research that was discussed today.		

Upcoming Meeting Schedule: Future meetings will be scheduled at a later date
Meeting information is located at: https://portal.ct.gov/OHS/HIT-Work-Groups/Medication-Reconciliation-and-Polypharmacy-Work-Group