Transcript

PHARMACY INTEROPERABILITY AND EMERGING THERAPEUTIC TASK FORCE 2023 MEETING

June 28, 2023 10:30 AM – 12 PM ET

VIRTUAL

Speakers

Name	Organization	Role
Hans Buitendijk	**Oracle Health**	**Co-Chair**
Shelly Spiro	**Pharmacy Health Information Technology Collaborative**	**Co-Chair**
Pooja Babbrah	Point-of-Care Partners	Member
Chris Blackley	Prescryptive	Member
Shila Blend	North Dakota Health Information Network	Member
David Butler	Curatro, LLC	Member
Steven Eichner	Texas Department of State Health Services	Member
Rajesh Godavarthi	MCG Health, part of the Hearst Health network	Member
Adi V. Gundlapalli	Centers for Disease Control and Prevention	Member
Jim Jirjis	HCA Healthcare	Member
Summerpal Kahlon	Rocket Health Care	Member
Steven Lane	Health Gorilla	Member
Meg Marshall	Department of Veterans Health Affairs	Member
Anna McCollister	Individual	Member
Deven McGraw	Invitae Corporation	Member
Ketan Mehta	Micro Merchant Systems	Member
Justin Neal	Noble Health Services	Member
Eliel Oliveira	Dell Medical School, University of Texas at Austin	Member
Naresh Sundar Rajan	CyncHealth	Member
Scott Robertson	Bear Health Tech Consulting	Member
Alexis Snyder	Individual	Member
Fillipe Southerland	Yardi Systems, Inc.	Member
Christian Tadrus	Community Pharmacy Owner	Member
Sheryl Turney	Elevance Health	Member
Afton Wagner	Walgreens	Member
Michael Berry	Office of the National Coordinator for Health Information Technology	Designated Federal Officer
Tricia Lee Rolle	Office of the National Coordinator for Health Information Technology	ONC Program Lead

Name	Organization	Role
Pamela Schweitzer	USPHS	Presenter
Lisa Schwartz	National Community Pharmacists Association (NCPA)	Presenter
Darren Townzen	Walmart	Presenter
Chad Worz	American Society of Consultant Pharmacists (ASCP)	Presenter
Michael Popovich	STC Health	Presenter
Jason Briscoe	STC Health	Presenter

Call to Order/Roll Call (00:00:00)

Michael Berry
Hello, everyone, and welcome to the Pharmacy Interoperability and Emergency Therapeutics. I am Mike Berry with ONC, and we are glad that you could join us. We have several guest presenters with us today, and I would like to welcome them to the meeting. This task force meeting is open to the public, and your comments are welcomed in Zoom chat throughout the meeting or during the public comment period that will be held around 11:50 Eastern Time this morning. I would like to begin rollcall of our task force members, so when I call your name, please indicate if you are here. I will begin with our cochairs. Hans Buitendijk?

Hans Buitendijk
Good morning.

Michael Berry
Shelly Spiro?

Shelly Spiro
Good morning, everyone.

Michael Berry
Pooja Babbrah is not able to join us today. Chris Blackley?

Chris Blackley
Good morning.

Michael Berry
Shila Blend?

Shila Blend
Good morning.

Michael Berry
David Butler? Steve Eichner?

Steven Eichner
Present. Good morning.

Michael Berry
Raj Godavarthi?

Rajesh Godavarthi
Good morning.

Michael Berry
Adi Gundlapalli?

Adi V. Gundlapalli
Good morning.

Michael Berry
Jim Jirjis?

Jim Jirjis
Good morning.

Michael Berry
Sumer Kahlon? Steven Lane?

Steven Lane
Good morning.

Michael Berry
Meg Marshall? Anna McCollister? Deven McGraw?

Deven McGraw
Good morning.

Michael Berry
Ketan Mehta?

Ketan Mehta
Good morning.

Michael Berry
Justin Neal? Eliel Oliveira? Naresh Sundar Rajan?

Naresh Sundar Rajan
Good morning.

Michael Berry
Scott Robertson?

Scott Robertson
Good morning.

Michael Berry
Alexis Snyder?

Alexis Snyder
Good morning.

Michael Berry
Fil Southerland? Christian Tadrus?

Christian Tadrus
Good morning.

Michael Berry
Sheryl Turney?

Sheryl Turney
Good morning.

Michael Berry
Afton Wagner?

Afton Wagner
Hi, good morning.

Michael Berry
Good morning, everyone, and thank you, and now, please join me in welcoming Hans and Shelly for their opening remarks.

Opening Remarks (00:02:06)

Shelly Spiro
Good morning, everyone, and welcome to our task force. I am not going to say many remarks at this time because I want everyone to have enough time, since we got a little bit of a late start. Also, Hans, when you are done with your remarks, we will go ahead and introduce the people who are on the call today who were not on the introductory call.

Hans Buitendijk
Good morning, everybody. This is Meeting No. 2, and today, we are going to start to dive in with some great topics. We have guests and subject matter experts in various areas that I am looking forward to for forming

our recommendations, so we have a great agenda, a great slate of presenters, and I am looking forward to the discussion. I also want to welcome any of the public today. We have a good number already there, and thank you again for joining. With that, Shelly, back to you, and let's dive in.

Shelly Spiro
Okay, we have a few people who were not on our last call, so I would like you to introduce yourselves. You have no more than 20 seconds. Adi?

Adi V. Gundlapalli
Thank you, good morning. This is Adi Gundlapalli from Centers for Disease Control. I'm an infectious disease physician and pharmatician, and I have had the honor and privilege of working on the COVID-19 response for many years, and also, after that, Mpox response, so this topic of trying to capture for public health surveillance emergency use authorizations and prescriptions is very important to us, so thank you.

Shelly Spiro
Thank you. Christian?

Christian Tadrus
Hi, thank you, Shelly. My name is Christian Tadrus, PharmD. I am an independent community pharmacy owner involved in dispensing prescriptions, long-term care services, clinical pharmacy services, lab services, and we also have a direct primary care operation. A few other things that I am involved in: NCPDP Data Standards Organization, State Board of Pharmacy regulator, as well as National Council on Prescription Drug Program activities that involve strategic planning.

Shelly Spiro
Great. Jim Jirjis?

Jim Jirjis
Hello. Sorry I could not be on the first call. I am Jim Jirjis, an internist and also in infectious diseases, and am the CHIO at HCIA. I was at the heart of doing a lot of the COVID reporting during the pandemic, so I am glad we are focusing on pharmacy informatics here in our recommendations to ONC.

Shelly Spiro
Great. Lastly, Meg Marshall.

Meg Marshall
Good morning. This is Meg Marshall, Director of Regulatory Affairs. I am with the Office of Health Information Clinical Informatics with the Department of Veteran Affairs.

Shelly Spiro
Thank you. In front of us is our agenda, and I want to move things along because we have five presenters today, and we want to make sure that we give them enough time. The presenters are listed here. We have Rear Admiral (Ret.) Pamela Schweitzer, who previously was the Assistant Surgeon General and the 10th Chief Pharmacist of the United States Public Health Service, we have Lisa Schwartz with us, who is the Senior Director of Professional Affairs at the National Community Pharmacy Association, we have Darren

Townzen, who is the Senior Director of Health and Wellness Billing and Reconciliation at Walmart, we have Chad Worz, who is our Executive Director and CEO of the American Society of Consultant Pharmacists, representing the long-term, post-acute care setting, and we have Michael Popovich, who I think goes by "Mike," and I hope I said his last name right, CEO, and also Jason Briscoe, who is Director of Pharmacy Operations, at STC Health, so let's move forward, and we will try to get through everything as quickly as possible.

I just wanted to reiterate that our recommendations are due on November 9th, and these are our specific charges. We have four topics areas. I am not going to read them, to save some time. We have put them out several times, so let's go on to the next slide. For this first topic, which will be June 21st and today, June 28th, is the public health emergency use authorization and prescribing authorities. These will be discussed during this particular time, and then we will have two other sessions that will follow. Go to the next slide. So, this is our first topic. These are our panelists on the short-term public health emergency use authorization and prescribing authorities. Let's go to the next slide, and hopefully, Admiral Schweitzer is there.

Pamela Schweitzer
Yes, can you see me or hear me?

Shelly Spiro
We can definitely hear you. I do not know if we see you.

SHORT-TERM Public Health, Emergency Use Authorizations, and Prescribing Authorities (00:08:00)

Pamela Schweitzer
I see people. I see Christian, Chad, and you. Thank you, Shelly. I am Pam Schweitzer, and I just want to thank the HITAC Task force on Pharmacy Interoperability and Emergency Therapeutics Task force for just inviting us here today and letting us provide input to identify these critical standards and data needs for pharmacists and others participating in emergency use. So, I am going to focus on covering just the general public health experience for pharmacists, really around COVID. As we know, COVID just overwhelmingly highlighted many of the gaps we had in interoperability, meaning there was basically no interoperability, with and between pharmacy constituents in the healthcare ecosystem, and pharmacies played a critical role in this disaster, but actually in other disasters too, because they stay open. They stay open, and early on, at least, they were some of the only accessible healthcare providers. Physicians' offices were closed. There was not anybody to give the injections to patients that were getting routine injections. They were the ones that were open.

So, what we do know is we need to prioritize getting pharmacists prepared because there are only going to be more disasters and emergencies coming down the pipeline. I saw the rest of the speakers, so what I am going to do is focus on things that I think they may not have but that we saw early on as really critical. Just for my background, I was trained in emergency response through all the FEMA incident command training, and these are some of the things early on that let us all know we were going to be in trouble. One thing is maintaining a list of key points of contact for all pharmacies, not just the insider pharmacies, because we can do this now because COVID forced us to get organized, and there are probably a dozen people

that we can start out with this incident command and cover the whole nation. These are pharmacies that are chains, in box stores, in grocery stores, and independents that now have a consortium that they are putting together. It has the nursing homes and pharmacies that service assisted living facilities.

Basically, we want to cover FQHCs, federal pharmacies. We want to make sure we have representation for all the 88,000 pharmacies that there are because they all service different people. If it is just a few, we are going to find lots of holes, which is what we did. We found lots of holes. One of the first questions is in order to prepare a response, we need to know where the holes are, what geographic areas are not covered, and where we need more resources. You can only do that when you have data. So, early on, part of this was finding out if the pharmacy was even open, what services they were providing, if they are doing testing, if they are stocking a particular drug. This is real-time data that would be invaluable to emergency rooms, to the community health workers, public health departments, EMTs, and, of course, pharmacies and hospitals. Everybody needs this data.

The other thing is we need to know whether the systems… Early on, we were trying to find out "Can your system do this? Can your system do that?" so we need to know which systems pharmacies are using and what their capabilities are. Are they able to report? Are they able to do something with the data? So, being able to have a few people come down from the top, be able to get all that information, and have it current to help make decisions, to know where we need to put resources, is absolutely critical, and we were fumbling the whole time. As we know, we did not have it, so, early on, lots of the inputted data was manual. We cannot do this. We are smarter than that. It is not sustainable to do that.

We need to avoid losing institutional knowledge with the changing administrations. I know this does not have to do with interoperability, but it is so critical that we have some kind of infrastructure in place that is going to live through the passing of the change of an administration. This is déjà vu all over. We had processes and implemented things back with H1N1, and everything went out the door, so we need to make sure that it is just not a few people that know. We need to have a way to continue this on, and later, in my recommendations, the only way you get good at this is by training, by practice, and doing this over and over again, and so, we need to build that into practice using these systems that we are hopefully going to be building and practice using them so that people know how to use them and 10 years do not go by until we use them again. So, we need to know whether the data can be shared, if you can share it with a provider.

Shelly Spiro
You have one minute left, Pam.

Pamela Schweitzer
Oh, holy cow. Okay, I am going to go into some data. We need demographics, we need to know who is homebound, social determinants of health, and if their primary care provider is needed. I heard the VA there. We need to know if they get their care at the VA so we can better coordinate. Inventory management is another one. We used the vaccine finder, but that was very cumbersome. We need to be able to find a way to have that inventory so people have access to it and know where there are drugs, where there are vaccines, instead of having to log on, create an app, and look it up and make a phone call anyway. Someone is talking about reporting…

Shelly Spiro

Pam, I am going to have to stop you. We only have a five-minute limit. Thank you for your time. We appreciate it. If you go to the next slide, Lisa is next.

Lisa Schwartz
Good morning. I am going to say hello on camera. We are working on getting some more bandwidth here, and I am going to save what I have. Next slide. One of the things I do in my role with the association is to help make sure that independent pharmacy owners have the health IT information needs that they have to participate in what is going on with healthcare. You see here the pharmacist patient care process from the Joint Commission of Pharmacy Practitioners. There is a link to that at the bottom if you would like. This care plan graphic, or at least that cycle of collect, assess, plan, implement, monitor, and evaluate should seem pretty familiar and pretty logical to you task force members, so I am going to move on from that before your eyes glaze over.

I am going to call out how each step, as applied to a case study for a SARS-COV-2 test-to-treat can be improved with data standards and exchange. One of the real interesting things here on the plan bullet that I will call out, which Pam referred to, is the thousands of pharmacies in the CPSN USA network, the clinically integrated network of pharmacies that use the Pharmacist eCare Plan standard today. They are able to share and exchange that today, there are just not many opportunities to be able to send that anywhere. Next slide.

Pharmacists have provider status in certain states for certain services in their scope of practice, but the COVID-19 response really relied on language in the Paxlovid emergency use authorization letter to authorize pharmacists to initiate treatment under specified circumstances. This case study is pretty typical of a patient who went to a pharmacy, usually one that they already filled all their meds at, to get Paxlovid. This patient had a few days of symptoms, and they understood that the antiviral could help prevent severe symptoms and hospitalization or death. The particular pharmacist that helped me with this case study had access to some HIE and was able to get renal function and liver function lab data.

A significant barrier to the success of COVID-19 test-to-treat really came from reimbursement. Pharmacies reported anything from negative $0.01 to $12.00, which does not even cover the cost of the work to dispense something. We might have made more progress on the HIE, the information exchange, in the roughly 18 months since the EUA was issued if there had not been this disincentive to our private-sector partners. The people who most needed antiviral access at a pharmacy to overcome a social determinant of health or other barrier could not find a pharmacy that stocked it, let alone one that was doing the whole test-to-treat program. Our society really needs to have pharmacist provider status recognized and have health plans credential pharmacists before the next time we need to rely on them for something like this. Next slide.

So, the reimbursement issue aside, data standards in health information exchange would make it fast and easy for a pharmacist to collect an active medication list if they did not already have it in their dispensing system and obtain lab results, as in the case study, or even a current problems list that might shed light on hepatic or renal function. Data standards and actual exchange of an active medication list, lab results, and even allergy or tolerance information should be prioritized for use cases like this in the next test-to-treat scenario. Patients accessing their own patient portals with some of this information was a halfway workaround solution that we saw independent pharmacies using during the COVID-19 test-to-treat

program. The Pharmacist Care Plan is a great tool for sharing a treatment plan with the patients and their care team, but we need better models for exchange of the care plan. I have pharmacy owner members who are eager to send care plans, even if it is just a reconciled medication list, to their patient's care team. We want everybody to know what the patient is on and what they are supposed to be taking.

Shelly Spiro
Lisa, you have 30 seconds left.

Lisa Schwartz
Yes. The last significant need to highlight here is the bidirectional communication with immunization information systems. Then we get the care process starting all over to address things like vaccine status and maybe post-acute COVID-19 system. Next slide. So, this one just bullets out what the pharmacy needs to have a successful test-to-treat program for routine practice or the next pandemic.

Shelly Spiro
Sorry, Lisa, your time is up. I know you have your contact information on the next slide, so let's go to Darren. You are up next.

Darren Townzen
Hello. Good morning, and thank you, everyone, for this opportunity to speak. I am going to approach this by presenting and answering a series of questions that will hopefully give a historical point of view as well as what the pharmacy units could need to do to succeed in the future. Next slide. So, what is pharmacy today? It is a real-time adjudication system. So, pharmacists receive real-time feedback from payers as to whether medication is covered, patient's copay, as well as other messaging the payer wants to communicate, but the main thing is this: It is a real-time communication. So, I guess by definition, by lead pharmacy and pharmacy units of managers in the processors, the pharmacy industry is already interoperable within those two pillars.

So, what was experienced with the last PHE? Well, there was a lot of billing complexity, for sure. It is not typical for us to administer a vaccine that is not owned by the pharmacy. In this case, the pharmacy administered vaccines that were provided by the federal government, and the pharmacy just billed for the administration fee. It was just a little complex as well with it being a two-dose regimen. So, what were some of the other things we had? Well, we had reduced or no visibility around the other vaccine administrations. So, state vaccine registries provide great information, but this could be complicated if the patient leaves the state, so that is one thing we really ran into, especially with this multidose administration. You had somebody get one in one state and one in the other, and we lost that visibility.

So, what was done? Well, it was an adaptation from the NCPDP Emergency Preparedness Task Group. I am sure many present on this call today can remember many, many two-hour NCPDP calls to try to work within the existing NCPDP telecommunication standards to try to build a vaccine. As an industry, we came together to not only succeed and provide guidance in bills for the COVID vaccine, but also outline how to bill for services in a real-time environment. Next slide.

So, what did we learn from this? Well, first of all, it is not all about pharmacies. As stated early, as a pharmacy industry, we do a pretty good job of exchanging information within our world of prescriptions. The

downside is we are not used to being in this healthcare data continuum. It would be great to have interoperability with the industry with lab values that could be communicated in a standard format, similar to our other standards, but this is just something we were not that familiar with. Also, there is a need to consume and utilize these data elements, such as lab values or test-to-treat, and make sure that they are present in our practice management system.

So, what needs to be done? Well, I think it is rethinking pharmacy systems to incorporate interoperability with other systems and providers. From a policy perspective, our focus has historically been on processing prescriptions safely and efficiently. Immunizations have focused on that safety process, but it is a little less efficient than dispensing prescriptions. Next slide, please.

So, what can ONC do? Well, I love this forum that is put together, so I think continuing pharmacy and industry engagement like this keeps everybody abreast, and also, I will call out that pharmacists are just one of many in the care of a patients. There are a lot of pieces involved, and the pharmacist does have value here. What I mean by normalization of sharing of information is that the concept of sharing information should be as common as sharing billing information during the adjudication process in real time, so I think creating that environment where that is the expectation is something that really needs to happen. Also, I think there should be more of a demonstration process to really understand what is possible for the future to strengthen our healthcare system. Shelly, I think that is all I have.

Shelly Spiro
Thank you for getting through that so quickly. Chad, you are up next.

Chad Worz
Great, thanks, Shelly. I am Chad Worz, the Chief Executive for ASCP. We are the American Society of Consultant Pharmacists, and represent pharmacies and pharmacists that work in the long-term care space. Just to give you some perspective, at the beginning of the pandemic, this was a sector of healthcare that was commonly overlooked. There are about 4.2 million people that touch or put their head down in a skilled nursing facility every year. That is roughly a little less than one percent of the over-65 population. In terms of long-term care, it is about a 10, or 11 million-person group, and that includes assisted living facilities as well as skilled nursing facilities. One of the things that was unique to COVID-19 was that prior to COVID, nursing home pharmacies and long-term care pharmacies were a supplier relationship, so vaccines for flu or pneumococcal disease would be supplied by the pharmacy, but administered by the nurses at the nursing facilities. Next slide. This is just who ASCP is. I will skip that. Next slide.

This really gives you a sense of what was operationalized during COVID, and essentially, the supplier relationship between pharmacies and skilled nursing facilities became a responsibility of the long-term care pharmacy, so nursing homes admittedly could not handle the vaccination process for COVID-19 and turned that process over to the long-term care pharmacies. Fortunately, in that emergency period, the government was good to get pharmacies signed up for Medicare Part B roster billing and helped force the state IIS systems to link long-term care pharmacies to the IIS systems, which is something, again, prior to this, that was not common from a long-term care pharmacy perspective.

Since that, we have now enjoyed a pretty robust process, which is depicted here on the slide, where the SNF requests from the pharmacy either a mass vaccination clinic for flu or COVID, and the pharmacy will

either contract with those nurses at that nursing facility or provide their own personnel to go into those nursing facilities and administer vaccines. The important piece of this is that the pharmacy is ultimately still responsible for the process, so the pharmacy is acquiring the vaccine, storing, handling, and delivering the vaccine, in some cases, administering the vaccine, and then, most importantly, reporting that data back to the pharmacy for input into the state IIS systems. This is probably one of the only areas where we have a closed loop on the vaccination process, and that would be in the 15,439 nursing facilities.

That exists, really, until Friday, at which point pharmacies can still do the vaccines for the patients that are in their custodial stay of the nursing home, their Part D stay, but there is an inability right now with CMS for pharmacists to continue to bill for vaccines for the Part A group, which are those transitional patients that are moving through the nursing home, having been post-hospital stay, rehabbing in the nursing facility, and then going home. That reverts back to the nursing facility.

So, I think one area that is critical for ONC to help is to help us and help CMS understand the importance of allowing pharmacies to continue to be able to vaccinate individuals regardless of their care setting. Whether they are transitional/Part A or custodial, the ability to keep them locked into the system allows us to ensure that the data that we are submitting to state IIS, at least on a state-by-state basis, is as accurate as possible, so every time someone is admitted to a nursing facility, the pharmacy can look up their vaccine status, get a picture of where they are at, make the right recommendations, execute the vaccines that they need to execute, and then report that information back into that state IIS system.

Shelly Spiro
Chad, you have 50 seconds left.

Chad Worz
Okay. Beyond that, I think the biggest thing that ONC can help with, maybe agnostic to this process, is helping the state IIS systems to be interoperable with each other. We do have residents and patients that move from state to state periodically during the year, and the inability for a pharmacy in a particular area to access the particular state IIS system where that patient's information may be located is a continuing challenge. Thank you, Shelly.

Shelly Spiro
Thank you, Chad. Mike and Jason, you are up next.

Michael Popovich
You bet, thank you, Shelly. Great presentations so far. Next slide, please. The first thing I want to do is give folks a feel for some of the numbers. Pam mentioned that a lot of the processes that were established in the H1N1 pandemic fell through the hoops between then and now, and so, during the 2009 pandemic, about 6 million shots were given in the pharmacy, but in the 2020 COVID pandemic, the number was 50 times that. So, I think we all understand these numbers, but I also wanted to point out that about 60,000 of the pharmacies across the country have been connected to the state immunization systems during this pandemic, and at STC, we were fortunate enough to have a network to process about 85% of those, so we have a pretty good feel on interoperability and how this works in the pharmacies. Next slide, please.

One of the things I want to do before we make recommendations for what ONC needs to do is to validate that some of the things ONC has done in the past have really worked well in this pandemic, and there are half a dozen here that are listed real quickly, but it is all the way from the early setting of standards to Meaningful Use driving interoperability and electronic data exchange. There were a lot of success stories here, all the way up to the end, where, in the early days, ONC recognized the power and the value of a consumer, and we all know that during this pandemic, when consumers needed access to their immunization records across these networks and through pharmacies and public health, they drove a lot of interoperability to occur very rapidly. Next slide, please.

I think Pam also touched on some of this in terms of what we learned from COVID and where the major gaps that were out there were, and clearly, they were largely driven by the volume of data and rapid changing of environments that occurred, so you actually had to have interoperable systems that could quickly scale and change as vaccines changed, as decision support and recommendations changed, as pharmacists needed to be educated on processes and delivery. So, as this environment evolved rapidly with the large amount of data, it really illustrated the importance of change and agility across these interoperable networks. You just could not build information systems that would run the same way for months and months. In fact, these things were turning over in weeks. There is a lot of good information pulled out of this. Next slide.

I am going to skip this slide, but this slide is really all about what a pharmacist needs to do to make sure that their interoperability with public health and, most notably, the state immunization systems, and if a pharmacy does this, there is huge upside and value, not only in their store, but also in establishing a framework that will support more rigorous kinds of activities as we go forward, all the way from surveillance reporting to point-of-care testing and those sorts of things, so there are lots of things pharmacists can do, and there is a rigorous process that makes that happen with the public health environment. We do not need to go through that. Next slide, please. Jason, I am going to turn this over to you because you are an operational pharmacist, and you see the future.

Jason Briscoe
Thank you, Mike. I will take it from here. I think this slide speaks to how, when opportunity presents itself, it is often too late to prepare. I think success of pharmacies within the pandemic response is well documented. I do not know how much attention has been given to early success by those that really hit the ground running, and typically, you could point to the fact that those were pharmacies, whether they were independents, regionals, or national chains that had previously established connectivity to state and jurisdictional IIS. Why is that important? Ease of reporting, to efficiently and effectively check that box.

Shelly Spiro
Jason, you have one more minute.

Jason Briscoe
Thank you. By the way, that was the precursor for continued access to vaccine, which, by the way, was a precursor to the installation of the bandwidth and capacity at store level to allow pharmacists and pharmacy technicians to take care of the next generation. Bidirectional access to IIS for those with previously established connections was able to inform the registration and scheduling process, inform clinical decision

making, whether somebody was eligible for the vaccine or not, whether they were due for their next dose or not. What we are talking about here is patient safety, quality of care, and health outcomes.

So, when we look at the what ifs on this slide, if they are not already, they are soon to become "now thats," so it is important to lean in interoperability to fully capitalize on the healthcare providers and professionals that pharmacies are in an accessible, flexible, and scalable way.

Shelly Spiro
Sorry, Jason, we are out of time for your presentation, but to all of our presenters, thank you very much, and you will be able to stay on and answer questions as we continue with our discussion. Thank you, everyone. We appreciate all of you getting on and presenting to us. At this time, we are going to open up for discussion in relationship to what our presenters say. The public can ask questions to a presenter within the chat, and also, panelists, please start the discussion and ask your questions. Hans, is there anything you want to add?

Hans Buitendijk
No, just a reminder that if you use the chat, use it freely and widely, and use "everyone." Anybody in the public can also provide questions or comments in the chat, but from a speaking perspective, you cannot be called upon until the public comment period, but feel free to contribute to the chat as well to raise questions that might be addressed.

Shelly Spiro
Yes. For the panelists, please raise your hand, and we will go from there. Steven, you are up first.

Discussion (00:35:17)

Steven Lane
Thank you so much, and thank you for those excellent presentations. I come at this as a primary care physician, having been in the trenches for decades. I am very focused on trying to help my patients to keep up on their immunization schedules. It is a huge challenge in primary care to have access to all historical immunization data, to be able to have good decision support to help know just what an individual is due for, to be able to administer all of those necessary vaccines in the right combinations with the right timing, to be able to have the vaccine products in the refrigerator onsite…

It is really a pain, and it is a very important part of the job of primary care, and it would be wonderful, frankly, if I could just hand that all off to the pharmacy, if the pharmacy had the responsibility to maintain the supply, to have access to all of the historical immunization data that a patient has received, regardless of their age or their disease conditions, to have access to all of the clinical data to know about contraindications and reasons for selecting different products, and then to administer that and make that data available back to all the other members of the care team. In my mind, that would be ideal, so that any individual could walk into a pharmacy at any time and get their immunizations updated appropriately and with all appropriate decision support and clinical context. Is that a future that we could imagine? Because that is what I think we would love.

I think individuals would love that and society would benefit from it if we could bring pharmacists into that loop in a way where people could really get what they need with all appropriate decision support informed

by their clinical data. I do not know if that is what we are envisioning. I would be interested in commentary from the discussants.

Jason Briscoe
I would start. In my previous life, a few months ago, I came from a community pharmacy, a regional chain in Ohio, and that is exactly who we were working to be and continue to try to be as an immunization destination. Everything that you outlined certainly is within pharmacies' reach. I think we are very front of mind with Joe Q. Public currently. With flu shots, I think it was evidenced based on the number of COVID vaccinations that we provided that pharmacy was a destination to get vaccinations, but there is more work to do with awareness, and whether that is with the general public, whether that is with fellow pharmacists, pharmacies, or other healthcare professionals like yourself, and I appreciate your commentary. Absolutely, pharmacy can continue to be an immunization destination.

Shelly Spiro
I do not see any other hands raised. Do any of the panelists want to address Steven's question? Hans?

Hans Buitendijk
No, if there is somebody else from that panel that wants to further address Steven's question, that is great. I will wait for that.

Michael Popovich
Steven, this is Mike. I think Jason is right. One of the things that we saw during COVID is that a significant number of the pharmacies had access to the data that were in the public health immunization information systems that providers and pharmacists have been reporting immunizations to over the decades, and because they had that access, those pharmacies that had the capability to have a two-way data exchange with their immunization registry, which included decision support tools that the registry and public helped people maintain, gave that pharmacists at the point of care, essentially, the power to understand what a particular individual was due for at any particular point in time.

What we are seeing happening now is more and more that traditional vaccines are starting to be given in the pharmacies, and this data is flowing through this national network that we certainly connect to, but other folks also do around the country, that has access to these immunization registries, so what is rapidly evolving here is that the pharmacies are playing a larger and larger role, if they so choose and want to, in providing a more universal class of care for all the immunization. Now, there are a lot of policies of state that impact this, and there are various rules and regulations that create some confusion out there, but this is probably where it is having a nice partnership between the pharmacy, the providers like yourself, and public health in terms of sharing the immunization capabilities across the country. So, I think the answer to your question is that this is going to happen.

Shelly Spiro
Hans?

Hans Buitendijk
Thank you. I would like to build a little bit on the question that Heidi Poliquin also put in the chat, and it is around some of the comments made that pharmacists having better access to more data about the patient,

a fuller patient record for the context is which they are working as they particularly are in the test-to-treat cycle. There are two areas in particular that I am curious about some of your reactions. One is in the direction of the IIS registries to get medication lists. We heard a little bit about some of the challenges when a patient changes jurisdictions and how to still get that information, but just generally, what would be the current obstacles and challenges to get either more pharmacists connected or to improve on the connections? I would be interested in feedback on either one of those.

In the other direction, towards the providers, potentially the personal record that a patient may have, how to get access to that information, where lab tests and other information may be. What are some of the key barriers and obstacles there to get connected, be it to HIEs directly or national networks? What are some of the key challenges there that you see that we should address to expand on the connections or to improve on the data? So, basically, how to expand and improve for IIS and for providers.

Shelly Spiro
Well, first, I am going to go to Christian. Thanks, Hans. And then, other panelists can respond to Hans's comments. Go ahead, Christian.

Christian Tadrus
Thank you, Shelly. I wanted to reiterate the issue from the perspective of a state regulator. As regulators, we have patient safety at the forefront of all regulations that we write and enforce, and the expectations on pharmacists are that certain types of things, such as checking registries, PDMPs, and so forth are a core expectation before providing types of services. Interoperability is important here in order to provide a mechanism that pharmacists can stay with in the highest professional safety allowances and be compliant with regulations in our state. We do not have to do this now, but I would ask the panelists to think about what type of regulatory and/or legislative band-aids might be imposed on the profession of a pharmacist from a professional standards-of-care process that we also need to be considering here in the interoperability task force because I think that is a key driver of why we need to solve for some of these issues. So, that was my comment, Shelly, if that is helpful.

Shelly Spiro
Great. Do we have any other hands raised? Mike, go ahead.

Michael Popovich
Just real quick, one of the mechanisms for pharmacies and EHR folks connecting to state registries is to make sure that the interoperability is built into the workflow, so those pharmacies that partner with their pharmacy management systems vendors and their EHR vendors so that those vendors essentially put an easy button in their system to connect to the registries to not only report, but to pull data down, which is when you find huge successes for the pharmacy, really making life easy in terms of connecting and having access to the immunization records themselves.

Medication data will never be in these data immunization registries, but the more interoperable a network gets, the more likely that pharmacist will eventually be able to not only pull immunization records of a state public health system, but also connect with an EHR system within a clinical care environment and that patient's medical history out of the EHR, along with their immunization history out of the public health registry. When you begin combining that and then linking decision support with that, you have the real

power of the interoperability in these networks, and those are the kinds of demonstration projects in ONC, like Darren put forth in his recommendations, which would be very helpful to see make happen and then scale.

Hans Buitendijk
On that note, Michael, I am kind of curious. Currently, there is data being shared through HIEs, through national networks, and otherwise, and perhaps you or other panelists can comment on what some of the challenges are for pharmacists and pharmacy systems who are not part of the provider organizations, but particularly out in the community. What are some of the key barriers to connect to that that you see that ONC could help address? What do we need to focus on?

Michael Popovich
Right. One good thing is that ONC has established standards, so any of the IT folks working in this industry, whether you are on the pharmacy management side, the EHR side, the HIE side, or the public health side, all understand what that HL standard needs to look like for an immunization record and a patient record to both send and retrieve data. ONC created that framework, and that is universally utilized by the IT world out there to make these systems more interoperable. I think the next key is that you have to continually invest in modernizing your systems, both on the public health side but also in the private sector side, to encourage this interoperability, and then, essentially, using these frameworks and these standards that ONC creates out there is really critical.

There is not enough money to go around to do all the kind of investment you would like to do, but if it is possible through the federal government, ONC, CDC, and whatnot to continue to provide modernization funds to build these links, then they will be sustained and grow by themselves because there is a huge revenue and patient care upside once you have these links established, so we are really in a fortunate place now after this recent pandemic that we did not have after the H1N1 pandemic, and then, a lot of infrastructure and systems are in play, and they just need to continue to evolve and reach out to the long-term care pharmacies and this whole world that is rapidly evolving.

Shelly Spiro
Thank you, Mike. Afton, before you go, I just want to ask you all to raise your hands so that we get the comments in appropriately from the people who want to make them, so please watch the chat and raise your hand. Afton?

Afton Wagner
Thanks, Shelly. I just wanted to mention a data element that was particularly hard for pharmacies and all the clinicians, really, to capture during the early COVID era and that is continuing now, which is race and ethnicity data, and we know that this provides really critical information to all of us and also helps provide equitable care and allocation of resources as needed. During at least the first month and continuing with the rollout of the vaccines, we had a really hard time collecting that information. A lot of the times, it was not available, and obviously, we cannot share that, either, if we do not have it. I think there was a letter actually written that AMA and the American Pharmacists Association joined onto addressing this, but just ensuring that data elements need to be available, how we make it available, and how we make it easier for people to report this, and the education that is needed for patients to explain why we need the data so we can get it and allocate resources effectively.

Shelly Spiro
There were a couple comments that came in from the public. Specifically, Kim Boyd had asked if TEFCA would potentially help resolve the challenges of cost for pharmacies in connecting with HIEs and the cost of obtaining information from this source. Does anybody from ONC or those who might be a QHIN want to tackle that question?

Hans Buitendijk
Noting that we do not have QHINs, so, aspiring.

Shelly Spiro
I know that. Pre-QHINs, if you will. Okay, I guess not, so we will ask ONC to address that. Does anyone else have any other comments?

Hans Buitendijk
I would like to follow up on one other question, perhaps. In the chat, there has been some question, and a couple, including Ham, raised the need for reporting from pharmacies on what services are available, when things are open, stock, etc. I am curious about what the capabilities are today to actually report to the various jurisdictions or parties that have an interest and a need for that data. What is there today, and what are some of the big gaps that are missing there or in place that we need to address or fill to get to better reporting from pharmacies and pharmacists on their state of availability, etc.? Would anybody like to jump in? I see Lisa's hand.

Shelly Spiro
Lisa?

Lisa Schwartz
Inventory levels have been viewed by pharmacies as potentially proprietary or information held closely to the vest, and I know folks have been reluctant to report data like this. There is not a good way that that would be reported, even if they could be convinced to do that, but in the situation that we saw during COVID-19, a lot of the inventory was managed very tightly so that there was not a lot of elasticity in what pharmacies could get ahold of. They might just be getting supply that was going to last them for a day or two, which is one of the things with next-day ordering that most wholesalers offer. Pharmacies manage inventory very tightly, but we also saw plenty of shortages that were either a true, widespread shortage or something that was a spot shortage where a distribution center, because of local demand, ran out of something very quickly and they needed replenishment from another distribution center, or the pharmacy tried to source inventory. It is something where, if the information was available, it might not be terribly useful because it might go stale very quickly.

Hans Buitendijk
Thank you.

Shelly Spiro
Scott?

Scott Robertson
Sorry, the mute button moved. I just wanted to point out that there is a precedent or existing standard in the emergency management space for both service and inventory request and response, not that that is a solution here, but the concept does exist and is in use. In emergency management processes, such as FEMA and others, it is widely employed and very successfully used, so we would not necessarily be starting with a totally green field. We would be able to look at things that exist that have worked, or ONC would have that kind of background to lean upon, however it moves forward, if we recommended.

Shelly Spiro
Great. It looks like we have some comments in here about immunization reconciliation. Does anybody want to comment on that? Steven, I know you put some in there, and I do not know who else did.

Jim Jirjis
This is Jim Jirjis. I put a comment in there echoing Steven's comments about immunization and med rec, but with both immunization and med rec, it is no surprise that society today is very time pressured, there are not enough primary care docs, etc., and the average amount of time docs have to see a patient is limited, so they are always making tradeoffs and figuring out what they are going to cover in the 10 or 15 minutes they have with a patient. Usually, it is complaints the patients have that take precedence. Not having ready access to medications that the patients are on or have been prescribed and their immunization statuses makes it really burdensome for the provider, and therefore it often does not get done.

So, just to echo Steven Lane's comments, I think with improved interoperability, whether it is a pharmacist administering a vaccine or a primary care doctor, it is more likely to get done, and that has tremendous personal benefit to the patient, but also has a broader societal public health benefit, but it has to be in the workflow, readily available in real time, and presented so it just takes seconds to decide what to do, instead of 20 minutes of trying to have the staff get data to figure out what to administer by the time the patient leaves.

Hans Buitendijk
On that note, Jim, and building on that, I have a fairly reasonable idea as to what activities are going on among providers to get connected and share patient data, get access to patient lists, etc., and data beyond that, and the challenges in that as well, but from a pharmacist perspective, particularly out in the community, how far are we with connecting pharmacies to those same networks where the data is becoming more and more available on med lists, on lab tests, etc.? How far have we gone, and how far do we still have to go, and therefore, what do we need to focus on to advance that further?

Shelly Spiro
Okay. We have another comment from Christian.

Hans Buitendijk
Before we go to that, Shelly, I would be real curious about anybody reacting to that, if we have that information or where to go for that, so I would like to see whether there is any insight or we just need to take it as still having a long way to go, and therefore we should focus on that with incentives and other programs to essentially expand on that, or if we say pharmacists are generally connected and that there are other things we need to do.

Pamela Schweitzer
This is Pam. Can I talk to that real quick?

Shelly Spiro
Yes, go ahead.

Pamela Schweitzer
I think it should be a priority. I know within a system where everybody is connected, we all know, but it needs to be shared on the outside. The capability would not be hard, it just needs to be a priority and get over some of the other little bumps, but it is actually something I think is very much worth working on, especially in emergency situations. Public health people and providers need to know that information or they will spend a lot of time on the phone.

Shelly Spiro
Christian?

Christian Tadrus
I have a couple comments on the last two. I will speak to Hans's question. There is reporting access that is twofold in some of these scenarios. You have the point-of-care testing access to lab information, whether that is done in the physician or the pharmacy realm, or from an external source in getting access, and then the med history being an issue as well, whether that is vaccination history or medications. One is probably more technical and possibly related to scope-of-practice allowances in various states, and that is primarily the lab activity and the testing activity. Then, you have access to the med list, which presumably should be available to most pharmacies, but is not because of possible competitive reasons in the industry, as well as not having direct functionality, like an EHR might, to existing transactions out there.

On the reporting topic that was asked about earlier, one of the challenges we found in independent pharmacy land was that we needed to report to different sources of authority, depending on where the vaccine was sourced from, for example. Initially, we started with a state vaccine registry, we had state inventory that we had to manage, and reported to a state reporting entity, then the federal programs came online and we transitioned to a federal program, but we had remaining inventory from the state, so we had to manage that transition, and then, broadly, we added the vaccines we were managing, such as flu, and tried to get those reports out, so disparate sources of accountability are a challenge in the industry, as is managing reporting aspects on multiple systems. So, I would think we need to speak about and investigate a little bit into how interoperability can solve for that.

Shelly Spiro
I know that Deven had a question in earlier and would love to understand more about blocking by intermediaries. Do we have any comments for Deven on that?

Deven McGraw
I was reacting to a comment in the chat about how there can be blocking by claims processing entities, intermediaries, and PBMs that seems to be an important piece of this puzzle. I would love to hear more about that.

Shelly Spiro

Does anybody have any comments on that? Well then, I will take a cochair's question at this time. So, since I am a past president of the American Society of Consultant Pharmacists and am also on the LTPAC HIT collaborative, we know there is a different process, and Chad, you have done a great job of really outlining the different processes that we have to do, especially with our skilled nursing facilities or where multiple people are collected, as opposed to what we see in the community pharmacy setting. What can we do to improve that process? Because I know we have Christian's operation and some of the other community pharmacies that might have what we call dual shops, where they are doing both patients and assisted living or long-term care facilities, but also servicing community pharmacies. Christian or Chad, do you want to address that on some of those anomalies that take place, and not just what we see in the majority of some of the community pharmacy settings?

Chad Worz

I will try, Shelly. No. 1, long-term care and pharmacies that service long-term care facilities, particularly those that serve as skilled nursing facilities, are a smaller population. I used the number 15,439 nursing homes. They service, again, about 4 million people over the course of a year. There are a limited number of EHR systems that skilled nursing facilities utilize, and there are a limited number of pharmacy operation systems that long-term care pharmacies utilize, and because of that, creating interoperability has been easier. I think it is more challenging on the community side, and I can let Christian speak to that, because you have so many more EHR systems and so many more relationships to create links with to get information. So, I think that is part of it.

I have put looking at risk in a lot of my comments. I just feel like in long-term care, particularly in SNFs, the SNF-pharmacy relationship is unique right now because it is sort of closed. Again, in two days, it may open a little bit in terms of the Part A residents of nursing facilities, but for the majority of the patients in skilled nursing facilities, it is still relatively closed. We have a good, responsible system where pharmacy is central to not only acquiring, but administering and reporting the information around vaccines, and I think we need to somehow use that as a platform to push this out into the community. I am not smart enough to figure out how that works because of the complexity of the community setting, but from a long-term care perspective, we just have some advantages because of our size.

Christian Tadrus

I will add on that we may be more common in some ways and less common in others, but intermediaries that run EMAR systems on behalf of some of these entities do provide some access to pharmacies for access and/or at least exchange of prescription-specific data, orders, med orders, and so forth, and so, a pharmacy that might be connected may have more access than others that are not, that are simply servicing into the facility. There are also variations based on levels of care. For example, we are going to be talking about traditional, but in a skilled facility, possibly with Med A beds, versus something that is assisted living or residential care, whatever the state allows or defines as long-term care, which could be group homes or jails, the sophistication level varies with those entities. As you get less sophisticated, generally, you are going to have fewer capabilities. There are costs to pharmacies to connect to these entities, and they may have to connect to multiple intermediaries in order to make that happen.

So, those costs and those endpoint connections can be significantly prohibitive, so interoperability does have a role to play there to get access to history and even contribute to accurate records in the long-term care space. That also goes for orders that are being sent to pharmacies that are for delivery into facilities. We often find a lot of situations where the pharmacy has the order, but the facility never received the order because it emanated directly from a physician's office that was required to take care of the patient, so ensuring there is communication there so orders do not get out of sync is an important aspect as well. There are many other areas that I think we could go into, Shelly, and there are disparities there, but those are just some, and hopefully that helps answer the question.

Shelly Spiro
Thanks. I know that Donna Denesci from Aveon just asked a question. "Would adoption of the next NCPDP Script help in thinking of three-way sharing with pharmacies, prescribers, and SNFs, some way to leverage the functionality once CMS makes it a Part D standard?" Does anybody want to comment on that?

Hans Buitendijk
I am curious in that area. Would that enable expansion to the additional data? To some extent, it might help, perhaps. I am curious, but in part of the discussion, I am hearing it is data beyond medications that is of interest, so are we then talking more about the other sets of standards and interactions that are needed to create the interoperability? But then, it goes to a policy question. How easy is it for pharmacists to actually get access to the data if they are connected? Are they authorized to get access to the data or not, or do they need consent? How can we ease that process?

Shelly Spiro
Yes, and there have been a lot of questions about consent in the chat. Again, we have not talked much about test-to-treat at all and what type of data is needed for a test-to-treat type of program that I know is part of this discussion also. Does anybody want to comment on that, about the lack of access by some pharmacy systems?

Jim Jirjis
I think Lisa did a nice job in her case study outlining the value that community pharmacy can provide in providing timely care, with COVID therapeutics as an example. There were other barriers potentially in play related to payment, but from living up to what the standards were to be able to have access to hepatic and renal function to determine if you then can prescribe and ultimately dispense on a Tuesday at 7:00 p.m. or a Sunday at 1:00 p.m., some of the value that the accessibility of community provides, that is a barrier that needs to be unblocked so you can fully tap into the power of community pharmacy, and again, it is patient safety, quality of care, and timeliness of care, not to mention operational efficiencies, so you have timely access to that information to then help that patient and the next one.

Shelly Spiro
Sorry, I was on mute. Christian?

Christian Tadrus
I was just going to add the communication piece there. A pharmacy that is servicing long-term care, or medical at home, for that matter, which is the same services, but not in a facility, might be located in a home where there may not be IT infrastructure. The core piece here is to communicate with a broader care team.

For community pharmacies, working with a facility or where patients are residing in a long-term care space, communication with providers is important, and I think that is where standards such as the Pharmacist eCare Plan could be valuable in ensuring that at least information is being exchanged about the services provided. It would also help pharmacies be more engaged and be able to provide additional services that are more aligned with the overall plan of care.

Most pharmacies in community settings are not in the loop, I would say, of what the overall plan of care for a patient is, whether that is on discharge or in a long-term care plan setting, so improving communication with the pharmacist of record or pharmacy that is involved in that patient care would facilitate more engagement and probably more collaborative care as well. You are on mute again, I think.

Hans Buitendijk
Shelly, you are on mute.

Shelly Spiro
Sorry, my dogs are barking. There are many patients who see the pharmacist as a retail supplier who does not need to know everything about them. Does anybody want to comment on that? Lisa?

Alexis Snyder
This is Alexis. That was my comment in reference to a comment a couple of lines back, where someone was saying that the pharmacist should be seen as a provider of care and have access to information to make informed decisions about my care, from Kim, and I was just saying on the other end, knowing from many patients and caregivers that that is not necessarily the case for all patients and caregivers, that they may not want the community pharmacist or the techs in the pharmacy, who may live in their area, to know every single detail about them and be able to pick and choose and share what portions of their medical history they want shared with whom and when, so it really cannot be a be-all or end-all standardized process, as someone had stated earlier, as simple as sharing building. We are talking about private confidential information, and that should be in the hands of the patient at all times.

Shelly Spiro
Steven, did you want to comment?

Jim Jirjis
Yes, I want to jump in on that discussion because, Alexis, I think you have it on a really important point, and again, as a primary care physician, I have been there so many times with patients who say, “No, send that prescription to the mail order or to a pharmacy in another community because I do not want the pharmacist, whose kids go to school with mine, to know I have a given condition.” We have to figure out what the right answer is because if pharmacists are going to be treating, testing, and administering, they really do need to be treated like the providers that they are. They are defined as providers in federal rules, and if they are providers, they should have access and should have the responsibility to access comprehensive health data insofar as it is required to make their decisions. Minimum necessary still applies.

You do not need to access information that is irrelevant to the service you are providing, but we cannot have it both ways. We cannot both say they only need a little information most of the time, but they need more information other parts of the time, and also say we need to treat professionals as professionals, hold

to the same standards of HIPAA privacy, hold them to the same standards of professional liability, as I mentioned in the chat earlier, and then move on. We want to take advantage of this army of resources that is on the ground, in our communities, and available to provide care, but we have to connect them to the data in order to do that safely.

Shelly Spiro
Steven, that is such a great point, and I just want to give a reminder that in 1996, when we passed HIPAA, pharmacists had to follow the rules of HIPAA, and if there are complaints to sharing information that a patient does not want shared, I can assure you that the pharmacists fall under the same rule that any other healthcare provider does in assuring that information stays secure and should not be shared outside of their practice. I think that is something that the pharmacy profession has to continue to talk about, and thank you, Steven, for sticking up for the pharmacy profession, in terms of what we bring to the professional needs of our patients in terms of medication management and understanding all the medications that are there. Our pharmacists are trained as doctors of pharmacy, they go through extensive training, as any other healthcare provider does, and they are in a unique situation to look at all patients' medications and be able to assure that it is appropriately used. Alexis, you wanted to respond.

Alexis Snyder
I had put this way back in the comments earlier, and I think Anna just brought it up again as well, that we are not talking just about the pharmacist. Seeing the pharmacist as a professional provider and part of the care team is one thing, but there are a whole bunch of people behind the pharmacy that have the same access, so I think that burden is also going to be on the pharmacies, then, about how they keep that information safe and private, and who has access to it, because again, especially in a community setting, does a patient, a caregiver, or whoever we are talking about want that 18-year-old possible pharmacy tech that is behind the counter that goes to school with your child having access to your medical record and the medications you are taking? So, I think we are talking about a slippery slope of how much is shared without consent.

So, again, just as a patient or caregiver would decide who gets to see what and when, regardless of what any folks think in terms of care, it is up to them. If they feel that they do not want the pharmacist to have every single thing about them in a be-all and end-all system, then that should be their prerogative. If that interrupts care for them, they should be educated on that and understand that that is a risk, but still, at the end of the day, we cannot make choices and decisions for patients and caregivers. They just need to be educated on what will be the consequence, perhaps, if the information is not completely shared. Again, at the end of the day, it is really in the hands of the patient and the caregiver.

Shelly Spiro
Okay, we have three hands up, and we only have three minutes left. Scott, Christian, and David, you have one minute each, and then we will have to cut off the conversation to go to public comment.

Scott Robertson
Okay, very quickly, then. This is Scott. Yes, the patient needs to be central to make the decision about who gets what information, of course, with the exception of emergency cases, and the ancillary personnel must be educated and be held responsible for keeping things private that are private, and if they cannot, they

should not be in that environment. We all have responsibilities that we have to adhere to. I will cut it off there. Thank you.

Shelly Spiro
Thank you. Christian?

Christian Tadrus
I will echo Scott's comment and augment it with the fact that that is what the boards of pharmacies in those states, who regulate the practice of the profession, and those individuals that work in pharmacies will set standards on and enforce. So, in alliance with the expectations of payer and federal guidelines, there are mechanisms that do that. So, the fear that it will be accessed and misused, perhaps, should be a minor conversation because there are already mechanisms in place to address that. The permission base, of course, is relevant, and I think that might get into a discussion around how we create an environment in which patients can choose their pharmacist as the person who is part of their care team, rather than just a pharmacy, or have it be wide open. Patients know their primary care doctor, they know their specialist, they may know other practitioners involved in their care, but typically, they do not think about a pharmacist being part of that team and say things like "My pharmacist, as part of my care team," whether that is a primary care pharmacist or a specialty care pharmacist.

Shelly Spiro
David, quickly, you have about 30 seconds. David Butler?

David Butler
Sorry about that. I have the same comment as what Alexis was saying. That also applies to all personnel in any physician office or any hospital with any situation, and what we are dealing with is a structure that was created a century ago that was originally designed to separate the pharmacist who was managing and selling the product that the physician was prescribing. We have reached a different time now, and we have a lot of legal aspects, as well as infrastructure from a facilities basis, where we need to bring the physician and the pharmacist together as a team and a partnership that is caring for patients in that method. As much as that design is going to be difficult to do, ONC needs to work with other organizations, and we all need to work together to create a better care process, and by doing that, if we can get greater general practitioner expertise for both diagnosis and therapy into the community level, which that type of structure would allow, we could probably reduce healthcare costs because it there would be less need for specialist referral.

Shelly Spiro
Sorry, David, I do not mean to cut you off, but we are going to have to go to public comment. Mike?

Public Comment (01:18:37)

Michael Berry
Thank you, Shelly. We are going to open up our meeting for verbal public comments. If you are on Zoom and would like to make a comment, please use the hand raise function located on the Zoom toolbar at the bottom of your screen. If you happen to be on the phone only, press *9 to raise your hand, and once called upon, press *6 to mute and unmute your line. Mary Kay Owens, I know you have been patiently waiting with your hand raised, so you have three minutes.

Mary Kay Owens
Hello. Can you hear me?

Michael Berry
Yes.

Mary Kay Owens
Okay. I just wanted to make a comment regarding the intermediaries and the PBMs blocking access to medication histories. Obviously, in the chat, there was quite a bit back and forth about this. This is an issue. We are standing up a very large initiative here called the Paid Florida Partnership throughout the state of Florida for all providers, including pharmacists, to be able to log into a secure portal and access all the information, clinical documents, prescription histories, etc. on a patient, but we ran into this issue with being told that the intermediaries that would be able to offer up the medication histories are not going to allow community pharmacists to be able to request that query, but other providers and other care team members would be able to request that information.

And so, this is a very big issue that I think ONC needs to look into, this information blocking, because pharmacists cannot expand their scope of practice, test-to-treat, and do many things that need to be done, even under their liability under their practice app. They cannot address and do many of the functions that they need to do from a clinical management perspective and a coordination of care perspective if this information blocking stays in place, and so, I think this is an issue that I would really like to see ONC and the task force take up in terms of recommendations going forward. In terms of patient consent, we are advising that one of the problems that we see in pharmacy is that they do not have what we would consider to be a standardized patient consent similar to a primary care physician or any other person that is treating a patient.

If you recall, when you go to a physician, you have the ability to say whether you want to opt out of mental health information being shared with other providers, or HIV information and those kinds of things. We are helping pharmacies prepare what is more of a standard consent form that actually would address these issues, but then, pharmacy has to have a way internally to keep track of that because when they ask to access our portal, we are requiring them to say, “Yes, we have patient consent” in order to access this information. And so, one of the problems that we see is that pharmacy systems do not have the ability, perhaps, to maintain that broad-based consent or, if there are specific opt-out provisions that the patient chooses to do, as they would with a primary care doctor, any other physician, or any other provider treating them, there needs to be a way for that information to be maintained in their system. So, those would be my comments. Thank you.

Michael Berry
We will pause there, Shelly and Hans, if you have a comment. Shelly, I think you are muted.

Shelly Spiro
Oh, sorry. Thank you for your comments, Mary Kay. Are there any other comments?

Michael Berry
We have one from Kim Boyd. Ken, you have three minutes. Go ahead.

Kim Boyd
Good morning, everyone. Can you hear me okay?

Michael Berry
Yes, we can.

Kim Boyd
Perfect, thank you so much. This is Kim Boyd with Boyd Consulting Group, chair of the NCPDP Strategic Planning Committee. As a member of the board of trustees, I want to thank the task force for continuing to convene this group of experts and helping to prove out the forward movement for pharmacy interoperability. I think it is extremely important. My only comment here was part of the earlier question about certification is that it will be very important to continue to evaluate the opportunities to provide certification for pharmacy management systems and pharmacy services systems and to continue to move the needle on interoperability. Not only the sharing of information and gathering of information, but the real-time, bidirectional sharing of information is going to be critical to continue to move the needle on expanding the role of the pharmacist and being part of the care team, expanding opportunities under value-based care where pharmacists can be a convener within that realm, but I also think that we should consider some of the incentives that could be applied to creating a more streamlined and bidirectional ecosystem. That is my comment. Thank you.

Shelly Spiro
Thank you, Kim.

Michael Berry
Thank you, Kim. I do not see any more comments, so I will turn it back to our cochairs.

Shelly Spiro
We have four minutes left to comment on any of our comments. Does anyone want to raise their hand?

Hans Buitendijk
Shelly, I would like to jump in for a moment. Based on the conversation that has occurred around the challenges around sharing in both the chat and verbally, I want to point out one area that we may want to consider looking at as a task force as well. Consent has come up a couple of times as part of the HTI-1 in the prior HITAC workgroup and task force discussions around what steps would be needed, and I think it would be worthwhile to review that in the context of this and see what are some additional considerations to enable this environment where data can be shared in a trusted and transparent way, where you see where you can and where you cannot. It would be worthwhile to consider how that extends into this space as well, where it goes across provider organizations into pharmacies and otherwise. So, that is just a suggestion for consideration.

Shelly Spiro
Thank you, Hans. Alexis? Did you have your hand raised?

Alexis Snyder

Shoot, sorry. I forgot to unmute. I was talking away. I just wanted to make a quick comment about some of the chat regarding HIPAA training and compliance within the pharmacy and remind folks that just because you can be held to HIPAA, it does not really stop the damage before that, so having nonclinical pharmacy staff having access to information that the patient or caregiver may not want them to see, again, really does not help that they have to be held to HIPAA because yes, they have to not share it with others outside of the pharmacy, but that does not stop the person, who you may not want to know everything about you and your medical history, from knowing it at that point of care.

Shelly Spiro
I agree, and I think that what we see is just like with any other healthcare provider, such as a dentist or a hospital. You are going to have situations, and from a pharmacy and pharmacist standpoint, we do not want to be treated any differently than any other healthcare provider is, so we put things in place, just like any other healthcare or health setting does, to assure that patient privacy is kept in. We do know that the concerns about consent and segregation of data are an important aspect. People also have to realize that when people see a medication being dispensed within a pharmacy or they are reviewing for medication reconciliation, that medication information leads you to a clear understanding of what is happening with the patient, and on behalf of the pharmacy profession, I think we take this very seriously. I am going to give one more minute to anyone else. Mike, I think we are done, unless I see any hands. Hans, do you have any other comments before we close up?

Hans Buitendijk
I think it was a great discussion. I really appreciate the insights of the panelists and the discussion that followed that we can dig into for thoughts and recommendations on where we identify gaps and how we might suggest to ONC how they can address that, so I really appreciate that. Thank you.

Shelly Spiro
Thank you, and I am going to turn it over to Mike. Is there anything else for us?

Michael Berry
Sure. I just wanted to remind our task force members that we have lots of comments, but only a few crafted recommendations so far, so if you could take the time and take a crack at crafting some recommendations to some items that we have covered over the last two weeks, I think it would help keep us moving. We are not meeting next week, but we will be meeting the week after, so, thanks to everyone for joining us, especially our guest presenters, and we will see you all in a couple weeks. We are adjourned.

Shelly Spiro
Thank you.

Hans Buitendijk
Thank you.

Adjourn (01:27:56)