ONC | HealthIT ADVISORY COMMITTEE

Transcript

PHARMACY INTEROPERABILITY AND EMERGING THERAPEUTICS TASK FORCE 2023 MEETING

August 9, 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
Wendy Noboa	Office of the National Coordinator for Health Information Technology	Acting Designated Federal Officer
Tricia Lee Rolle	Office of the National Coordinator for Health Information Technology	ONC Program Lead

Name	Organization	Role
Jake Galdo	Seguridad	Presenter

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

Wendy Noboa
Hello, everyone, and welcome to the Pharmacy Interoperability and Emerging Therapeutics Task Force. I am Wendy Noboa with ONC, filling in for Mike Berry. I would like to thank our Task Force members for their participation, as well as our public attendees. We are so glad you could join us today. The Task Force meeting is open to the public, and your comments are welcome in the Zoom chat throughout the meeting and during the public comment period, which will commence at about 11:50 Eastern Time this morning. I would like to begin with roll call of our Task Force members. When I call your name, please indicate that you are present. I will begin with our cochairs. Hans Buitendijk?

Hans Buitendijk
Good morning.

Wendy Noboa
Shelly Spiro?

Shelly Spiro
Good morning.

Wendy Noboa
Pooja Babbrah?

Pooja Babbrah
Good morning.

Wendy Noboa
Chris Blackley? Shila Blend? David Butler? Steve Eichner? Raj Godavarthi?

Rajesh Godavarthi
Good morning.

Wendy Noboa
Adi Gundlapalli? Jim Jirjis?

Jim Jirjis
Present.

Wendy Noboa
Summer Kahlon?

Summerpal Kahlon
Good morning.

Wendy Noboa
Steven Lane?

Steven Lane
Good morning.

Wendy Noboa
Meg Marshall? Anna McCollister? Deven McGraw?

Deven McGraw
Present.

Wendy Noboa
Ketan Mehta?

Ketan Mehta
Good morning.

Wendy Noboa
Justin Neal? Eliel Oliveira?

Eliel Oliveira
Good morning, I am here.

Wendy Noboa
Naresh Sundar Rajan?

Naresh Sundar Rajan
Good morning.

Wendy Noboa
Scott Robertson?

Scott Robertson
Good morning.

Wendy Noboa
Alexis Snyder is absent today. Fil Southerland?

Fillipe Southerland
Good morning.

Wendy Noboa
Chris Tadrus?

Christian Tadrus
Present.

Wendy Noboa
Excuse me, Christian. Sheryl Turney?

Sheryl Turney
Good morning.

Wendy Noboa
Afton Wagner?

Afton Wagner
Good morning.

Wendy Noboa
Good morning, everyone, and thank you. Now, please join me in welcoming Hans and Shelly for their opening remarks.

Hans Buitendijk
Go ahead, Shelly.

Opening Remarks (00:02:07)

Shelly Spiro
Good morning, everyone. I hope everyone enjoyed their time off for a week, and we are going to get back and move everything forward. I am so glad everyone could join us. We have a couple of speakers today, and they are on and ready to go. We will also be looking at our spreadsheet for our recommendations. The recommendations for public health need to be done as soon as possible. If you have not put them in, they need to be created. Hans, I will let you say a few words if you would like.

Hans Buitendijk
All right. Good morning, everybody. Welcome also to those on the call from the public. I am looking forward to picking up where we left off after a small hiatus. As Shelly indicated, we are going to have a presentation today. We will start that in a moment after briefly looking at Task 2a, refreshing from where we left off two weeks ago, and then we will jump into the presentation. Shelly will introduce that and go from there. Then, we will continue our discussion around Task No. 2. That is what we have on tap for today. As always, if you chat, please do. It is a great place to exchange thoughts, ideas, and otherwise. Everybody from the public is welcome to put a note in the chat as well, but you will not have the opportunity to join in the conversation, other than at the end when the public comments are there. So, we are looking forward, again, to a lively discussion and the generation of some ideas and recommendations that we can pull together. Unless there is anything else, Shelly, shall we?

Shelly Spiro
Let's go on. Let's just quickly review Task 2, which I believe is the next slide. So, we finished Task 1, which is public health emergency use authorization. We are now on Task 2, identifying opportunities and recommendations to improve interoperability between pharmacy constituents, prescribers, pharmacists, pharmacy benefit managers, dispensers, payers, intermediaries, PDMPs, public health agencies, HIEs, third-party service providers, consumers, etc., the pharmacy-based clinical services, and care coordination. So, this is our second topic. For those of you on the Task Force, please start putting your recommendations into the spreadsheet. After our presentations, we will be looking at what we have done so far and get some additional recommendations. We added a final page, which we will go over, a new sheet within our Google spreadsheet that is going to tell us to do some follow-up on subgroups that have met. So, let's go on to the next slide, Wendy.

Just in addition, we have other subtopics, and one of the ones that we will be talking about is which priority pharmacy-based clinical use cases ONC should focus on in the short term and long term, so that is what our presenters are going to be looking at today, along with some of the other subcategories that are in here. Let's go to the next slide.

Task 2a Recommendation Discussion & Task 2b Introduction: Which Priority Pharmacy-Based Clinical Use Cases Should ONC Focus on in the Short-Term and Long-Term? (00:05:46)

Hans Buitendijk
I think that is where we will stop, just looking back at the Task 2a discussion so far. I am not sure who is controlling the screen, but can you pick up on the spreadsheet?

Shelly Spiro
Maggie is.

Hans Buitendijk
And then we can go to the Topic 2 recommendations first to have a quick glance at that. Can you make it a little bit smaller and scroll through it? We are not going to necessarily read through it just yet. So, based on the conversation, on the left-hand side, we have the four subtask topics for Tasks 2a, B, C, and D, so we will work away as we go through the meetings. You can already start to put specific comments, thoughts, and suggestions in there as well as you go along. In Column B, based on the conversation two weeks ago, are some potential thoughts. So, you will primarily see my name there. It was fairly blank. We put together a couple of different areas that jumped out from the conversation and looked like we could have some recommendations around.

So, there was a good amount of discussion around RESTful APIs and Direct, how we can use network-based exchange to advance some of the challenges that we are facing, and opportunities we have for patient matching and what could be done there in the absence of a unique patient identifier, alignment with USCDI, what, if anything, would be helpful to do in that space, focusing on communications with pharmacists, discrete data feeds, labs, and ADT. A number of the other things we look at are frequently queries generally, but now, when a result is there, a lab or an ADT notification would be helpful. Can we

expand on that a little bit more? And then, lastly, any kind of first steps or near-term things that can start to be done now, maybe not completed, but at least get started to move forward.

So, there is a combination of those. I took the liberty to look back at some of the transcript, some of the discussion, so that is where a number of these thoughts come from, and to provide something to build on, replace, or put it in the proverbial trash can if it does not work, and then go from there. So, we would like everybody to look at that, expand, contract, etc. We will jump just for a second back to Topic 1, if you could just jump to that to clarify what was meant on that tab. You will see there the red text starting to pop up nicely all over the place. That is the way that works very well to insert your thoughts where somebody already started or to replace it with something totally new, so, look at that for some of the ways it is being done. It also happens to include some of the placeholders that Shelly just mentioned.

So, back to Topic 2, we have until 10:55, when we are going to jump to Topic 2b, but we would like to take advantage of the time to get started with some additional thoughts by looking at these and seeing whether additional other kinds of main thoughts come to mind. So, we will look at starting at the top, in no particular order other than the sequence they are in, and see RESTful APIs and Direct, which were some topics that came up with interest on how we can advance them. There are standards and capabilities that are out there that could be used, but what could we recommend to advance the use of those? Is there some education, development, or work we could do together? Some of that may come back in the first steps as well, but what were some of the things that jumped out from that conversation that we should include?

I just put two in there: Availability and promotion of it. Is everybody aware that we have these opportunities for general RESTful API queries using FHIR or Direct messaging to do that? Is there promotion of gaps that we need to fill? There was some discussion around that, that Direct may not be as consistently done. Do we need more guidance? Are there any thoughts around that at this point that already jump out from our conversation two weeks ago?

Shelly Spiro
It looks like we have two people. Steven Lane?

Steven Lane
Hans, I think those are both really important tools for us to consider. I think lumping them together into the same bucket for discussion is a little confusing. I would definitely separate those. I think RESTful FHIR queries and Direct messaging to push and manage care coordination are very important, very different challenges. I would just put them on two different lines. I support consideration of both. I think that giving pharmacists access to those particular toolsets could be very helpful in terms of both informing the care that they can provide safely, as well as integrating that care back into the care provided by other members of the care team.

Hans Buitendijk
Thank you.

Shelly Spiro
Pooja?

Pooja Babbrah
I agree with that as well, and I just want to make a comment. We just got back from the NCPDP workgroup meeting. I think education is an important piece, and it looks like there are some NCPDP folks on in the chat. Maybe they can comment as well. A lot of the NCPDP standards could be available through APIs, so I think it would be good to have some insights into that, first of all, and I would love to hear from a couple of the pharmacists on, which may be part of their presentation. In talking to some folks, I think pharmacists are, in some cases, using Direct messaging, so I would love to hear from a couple of the pharmacists. We can dig into a little bit more how NCPDP standards can be used using APIs. That would be an important thing as well, as would some education around that.

Shelly Spiro
Afton?

Afton Wagner
Hi. Pooja, great segue into my comments. As a pharmacist, just thinking about pharmacists on the bench and what information they receive, we get quite a bit of information, and we do receive it right now in text fields, but it is not uniform. We get a lot of information from many different providers in many different ways, and so, something that I think we need to look at a little bit is that bidirectional exchange, and once we get the information, are we getting it unified from many multiple different sources, can we send messages back in a succinct way, and is there a way to unify different messaging to just make sure we can understand it and respond quickly? I think it was Steven who mentioned that separation, and I agree with that. I think those are two very distinct issues, and it is helpful to do so.

Hans Buitendijk
Great. I think it was Tricia Lee who already went ahead and split them up, so we can work from there. I believe the use of Direct, some of the consistencies, inconsistencies, challenges, and connections were in Steven Mullenix's discussion. Is this an area where we believe that it is mostly awareness guidance education, or do we think that there is further work to be done, given the environment that Direct would need to support pharmacies, pharmacists, and providers, that there is something additional to be done to make sure that it can be better deployed or better taken advantage of, and that we need to provide ONC some guidance on how to work with Direct and trust others to advance that?

Shelly Spiro
Pooja?

Pooja Babbrah
I think part of it is education. I think there is definitely a piece where, especially through this group, we are just starting to look across the different standards organizations, and I think part of it is us understanding, first of all, what is available and what people are doing today, but I do think there is an education aspect, at least from what I have seen.

Hans Buitendijk
Thank you.

Shelly Spiro

Steven?

Steven Lane
I put a comment in the chat, but just to put voice to it, we have been struggling to make full use of Direct messaging for many, many years, and I do not think there has been a fundamental shift in the consistency in use of that. We are also at the beginning of TEFCA, and TEFCA includes push messaging across the QHIN framework, and I think that as we are considering the role of push messaging to support communication, data sharing, and care coordination, we should probably simultaneously think about what we can do today with Direct and what we might be able to do in the future with TEFCA push messaging, especially since we are providing feedback to ONC, which is going to have strong input into the QHIN technical framework. Considering whether we might be able to solve some of these issues using TEFCA push is worthwhile.

Hans Buitendijk
Great point, Steven, and I am wondering whether, as a result, we should not have the two topics be RESTful APIs and Direct, but maybe querying and push messaging in general. Under querying, I can query for data using RESTful APIs, but I can also do it with IG document exchange and a couple different variations of push messaging, Direct, TEFCA, or XCDR. There are a number of different ways to achieve that.

Steven Lane
I completely agree, Hans. Just to follow up, I think we should be starting at that high-level query and push, looking at the various functionalities that are available to us and figuring out a glide path for the most appropriate.

Hans Buitendijk
Thank you.

Shelly Spiro
Summer?

Summerpal Kahlon
Thanks, Shelly. I just want to broaden the discussion to some degree here. As it relates to Direct, TEFCA, or whatever process we use, I think what is less important, honestly, is the standard itself which is chosen. To me, what is more important are two things. One is what is easiest to make ubiquitous, because that is really the key here: Scale. If we are talking about being able to connect, it is not about just connecting a handful of players in a few different regions, it is about scale. Especially if we go back to the original use case of public health emergency, these are the kinds of things where we need to have the connections at a scale that allows it to really be effective. It cannot be piecemeal.

So, I think that has to be taken into account as far as what is preexisting, but also what is easy for the various technology vendors that sit in between to be able to connect: EMR vendors, pharmacy system managers, and that sort of thing connecting into the public health environment as well. I think the other thing we probably ought to spend a little bit of time on is focusing in on use cases. So, I think there is the broader idea of TEFCA, the broader idea of Direct, but in terms of a recommendation here, we ought to be thinking specifically about how we are handling these use cases.

So, again, going back to the public health emergency type of use case, is it something that breaks the glass, that is built into the systems, but is only activated when a public health agency at the local, state, or federal level activates it, and then it goes dormant when the public health emergency is over? I think the more tightly defined the use cases can be around the standards, the greater likelihood there is for the vendors who are implementing these standards and networking together to be more focused. It is a simple, straightforward, well-defined use case to implement the standard effectively for the kind of things we need to get done. My fear is that if we leave it too open-ended, it will not really create the level of connectivity and scale that we need for the public health agencies to be effective in collaborating with pharmacists and providers in that particular use case, for example.

Hans Buitendijk
Summer, great points on both scaling on use cases. On scaling and the topic that we pulled out as well, network-based exchange, which is a form of scaling to make things more widely accessible, are there any particular recommendations that we need to address to make where ONC can jump in to help advance the ability to scale it better? TEFCA is certainly an effort to do that. Is that where we need to voice support to rally more around? Is there some alternative or addition? How do you look at that?

Summerpal Kahlon
I will think out loud here, and I definitely welcome any other thoughts. One thing would be to query the technology vendors that would be implementing these standards to get a sense of what they have either already implemented or will be implementing in the next, say, six months to see what is preexisting that we could go after and get a feel for where they are developing anyway, that we could piggyback on as far as rails. I think the other thing is when we talk about the standards, in my mind, it is really about being as specific as possible so that when the systems vendors go out and actually implement these standards, it is as well-defined and cookie-cutter as it can be.

Let's take Direct messaging, for example. It is a reasonably well-defined standard, but it gets implemented in different ways and with different systems. The workflow is not exactly the same all the time. I think about something like the Script standard with NCPDP, where the standard is very well defined, but also, the implementation of the standard is fairly well defined, so e-prescribing has a very consistent feel on both sides of the network for any user. So, thinking about it in that context here as well, I think if ONC can be a little more specific about what needs to be implemented using these standards to support the use case, it will likely be more effective and easy for the system vendors, who are trying to scope it, plan it, develop it, and that sort of thing, but I am just thinking out loud. I am open to other ideas on the subject.

Shelly Spiro
Pooja?

Pooja Babbrah
Summerpal, I like your idea. My concern is that I do not want to limit it to public health. We need to think more broadly, and I put this in the chat. I would love to think about how pharmacists can support value-based care. How can they become part of the clinician team? I mentioned this to the small group before we started, but we just approved the ADT notifications taskgroup at NCPDP, so we are going to start doing some research on how we can start to make sure that pharmacists are getting these ADT notifications so

they can support when a patient is getting discharged from the hospital, but as we started to have some conversations around this, a couple of the pharmacists were saying, "Hey, we get this information, but what we cannot do is then get the clinical information we need to do interventions or support that patient." So, I think an important use case for us as we are starting to talk about TEFCA and clinical exchange would be more around value-based care so we can look a little more broadly.

Shelly Spiro
Christian?

Christian Tadrus
Thank you, Shelly. This may be my naivety, and not to discount the use case scenarios from the public health use conversation and example setting, but we presumably have quite a bit of infrastructure out there already that supports healthcare practitioners exchanging information and being connected. The gap is that pharmacists are not typically seen as part of that healthcare team. Wouldn't it be more cost-effective and easier to implement to just include them in the connectivity roadmap than to define special use cases and limited applications around where the pharmacists might fit in? I get the feeling that the infrastructure is there; it is just an issue of having the authority to access it and whether the endpoint interface seems fairly similar or we are trying to build specific use cases for pharmacists, which I think can be somewhat limiting. That is more of a question back to this informed group. It seems more logical to include pharmacists and connect them to existing infrastructure.

Shelly Spiro
Thanks, Christian. Summer?

Summerpal Kahlon
I just wanted to comment there. If I take a step back from pharmacy for a minute, I think a lot of what we are talking about is applicable to a lot of different stakeholders in the healthcare ecosystem. I think home health agencies, skilled nursing facilities, and mental health facilities would all say very similar things. They do not feel as integrated as they would like to. Honestly, even just hospitals and doctor's offices are not very well connected either at this point, not nearly at the level we would like them to be. So, those points of bigger goals, value-based care, and broader connectivity of the pharmacist into that ecosystem are where I come back to these use cases. I referenced public health emergency because that was the first use case we dug into here as a group, but I think there are certainly others. The more focused it is, it provides the reason to make that connection, and then it gives the opportunity to build further connections on top of that.

When we talk about value-based care, for example, it is such a broad concept. Value-based care really is healthcare, and so, there is a whole variety of use cases that sit underneath value-based care as a topic, and it can be a struggle for two different stakeholders or multiple stakeholders to get together and say what exactly we need to do to fulfill the use case that we see as important. So, out of, say, MTN, vaccines, or gaps in care, that sort of thing, which one do we focus on and how do we build the rails for that? So, that is what I mentioned, just the idea of taking some of these use cases that were outlined in our agendas over the course of this committee and saying can we take some of those specific use cases, give people a reason to build these rails with an eye to a bigger picture of building these connections so they enable more down the line, and really hone in on those things that start to build those connections, and provide the focused use cases that add value?

Again, I come back to public health emergency just as an example, not the only one, but one that we have talked about already in this group. It is one of those things where, especially coming off of COVID, we have a much clearer sense of the role of the pharmacist and pharmacy and the various activities that help us react and respond, identify the rise of the public health emergency, and respond to it effectively. We talked about vaccines, medications, inventory, and those kinds of things. I come back to that only because that is one we talked about here. I think there are other use cases, but at scale, those sorts of things help build the broader networks that give us the reason to then start to do a lot of the other things that I think we would like to see as an industry.

Shelly Spiro
Thank you, Summer. I am going to take the last minute, and then we will go into the presentations and continue this conversation. One of the things that we have in pharmacy over the years that has created problems, especially with health information exchanges, is that pharmacists were not recognized as providers in the Social Security Act, and the governance on some of the health information exchanges and those who want to exchange with physicians and hospitals would not recognize pharmacists. They wanted the prescription dispensing data, but they did not want to share the clinical data, and I think we have gone through some of those problems and worked with the Office of the National Coordinator to help recognize pharmacists, especially in the information-blocking rules that they started to write, and I think that this is a problem.

We need to make sure there is a clear understanding that pharmacists need clinical data in order to be part of the care team for value-based care for public health, and I think that once we get through those issues, work with HHS, and make sure there will be an understanding that pharmacists are part of the clinical team and need to exchange clinical information. So, we are at the top of the hour. We are now going to go into our presentations, if that is okay with you, Hans, and then we will come back to this discussion with the spreadsheet. So, we have two presenters today. First is Christian Tadrus, who is one of our Task Force members, and then we will go to Jake Galdo, who is the managing network facilitator for CPSN Health Equity and CEO of… I cannot say that, Jake.

Jake Galdo
Seguridad.

Shelly Spiro
Seguridad, thank you. Just to remind our presenters, please keep your time down to five minutes so that we can have some discussion. We want to end the discussion at the bottom of the hour, so I am going to turn it over to Christian first.

Task 2b Guest Presentation (00:30:17)

Christian Tadrus
Thank you, Shelly. I appreciate the opportunity to provide a community pharmacist/small business operator viewpoint on what is going on in the space. My background is as a primary care pharmacist and operator of independent, community-owned pharmacies. We have embedded primary care clinics, and we are located in rural areas of Missouri. Our pharmacies are pretty typical in that we work with our communities to improve the health outcomes of our patients and improve health disparities through partner programs,

clinical medication synchronization, adherence packaging, and entering into advanced practice protocols. In addition, we do routine things like provide immunizations, point-of-care testing, comprehensive, targeted medication **[inaudible] [00:30:59]**.

Monitoring care consulting is something we do initially in our operation, and increasingly, we are doing more screenings for health conditions and for social determinants of health. There are a lot of areas that impact small community operators, but really, anybody operating in a community space, that need to be addressed regarding interoperability to ensure that pharmacists have access to the information they need to perform their duties and contribute as part of a patient's healthcare team. I have a couple I would just like to pull out here and highlight for the group, if that is possible. In our world, pharmacists are generally hobbled by lack of efficient access to information, basic information that is necessary to perform the primary function of a pharmacist, which is really to ensure that drugs are safe and appropriately dosed for patients so as to assess risk and optimize outcomes from therapy.

Simplifying and reducing these barriers to access to access the patient's health history, their condition list, medication history, and plan of care really would help our pharmacists better understand what is happening with a patient and be able to minimize risk related to inappropriately dosed drugs and drug-disease interactions. For example, pharmacists are medication experts. They are trained in pharmacodynamic and pharmacokinetic principles. Biomarkers, pharmacogenomic factors, organ function, disease states, race, gender, height, and body weight are all data that is really required for pharmacists to be able to understand how a patient will metabolize or excrete a medication, and it is necessary to do calculations and validate or recommend appropriate, safe dosing for a patient.

While this information can be accessed through health information exchanges, clinical charts, discharge notes, and perhaps even care plans, our pharmacists are largely disconnected from that or prohibited from accessing those data sources due to policies, as Shelly mentioned, or technical reasons, or the failure of decision makers to recognize them as part of the healthcare safety net for the patient. Our pharmacists end up resorting to phone calls, fax requests, and patient inquiries, typically navigating phone systems and human gatekeepers to get this information, and they sometimes find themselves just bewildered having to make the case to a distrusting healthcare provider as to why a pharmacist might need this information. System designs need to evolve as well. For most of us, the primary tools we use on a daily basis in community pharmacies are platforms designed for dispensing and packaging the medications. While they are evolving to support patient care in some areas, there is wide disparity in them in terms of their ability to consume and present data in a manner that facilitates workflow and clinical decision making.

The systems do not always have or make available fields to store critical health data or functionality designed to support the clinical decision-making thought processes that pharmacists are trained to follow. Complicating matters and stop-gapping these issues, our teams routinely have to access multiple systems: Electronic medical records, if they are granted access, multiple scheduling tools to take care of the patients, back-office management tools, immunization registries and prescription drug monitoring registries across multiple states, multiple MTM platforms, multiple long-term care electronic medication administration records, and multiple wholesaler sites, multiple revenue and cycle management platforms, multiple medical billing tools, and the federal COVID-19 scheduling reporting platform.

As community pharmacists, that disparate and repetitive workflow is really burdensome, not only from a cost standpoint, but really from an efficiency standpoint, and it just consumes the time to do anything. Lastly, I will just call out here transitions of care, which continue to be an area of risk for our patients, one where our pharmacists struggle to get access to information to minimize that risk. We see this both in our community deployments, as well as our consultant pharmacists in the long-term care space, who struggle with getting information from labs, recent hospitalizations, and clinic visits to send electronic care notes to facility staff, prescribers, or servicing pharmacies. We are still doing this by paper and fax, and facility staff still routinely ask us to provide copies of orders that we receive electronically, but the facility does not. That is all I have for you to consider. I hope that is something unique that gives us more to talk about. Thanks for the opportunity.

Jake Galdo
Shelly, you are muted.

Shelly Spiro
Thank you. Thank you, Christian. We are going to hold our discussion until after Jake's presentation. Go ahead, Jake. You have five minutes.

Jake Galdo
Yes, ma'am, and thank you very much, everyone, for having me. I have very busy slides, mostly as a reference for you, because I am going to talk fast. So, we are going to talk about health equity and community pharmacy equality. May I have the next slide? So, here is a patient case. We have a patient that is enrolled in a care coordination service within a pharmacy. This can be like a chronic care management service. It can be medication synchronization. It is care coordination. They come to the pharmacy or the pharmacy reaches out to the patient on a monthly basis. This is a real case, by the way.

During this intervention, the patient expresses concern to the community health worker or pharmacy technician that is caring for them about affording electricity and heat. The patient says that they have been receiving assistance from PA EOC, which you can see is defined at the bottom as a nonprofit community action agency, but they have not heard anything that year. The community health worker or pharmacy technician, which is the same person in two roles, is able to verify patient eligibility and get forms to the patient to keep their assistance active. So, this is an intervention at the pharmacy that ensures that the patient has electricity and heat. This is a big deal because this is something that happens in pharmacies across the nation right now, and these are pharmacies that are addressing health inequities. May we have the next slide?

So, the prompt for these five slides that I have for you asked for some short-term and long-term goals for looking at engagement within ONC and the role of interoperability in the activities that pharmacies do. I would argue that our short-term win, the first thing we do, is look at health equity and health equity standards. As Kristol Meit, my cochair within Workgroup 20, put in our chat today and to many of our NCPDP colleagues, we had an approved taskgroup for health equity within Workgroup 20 that happened one week ago. There are current NCPDP data elements that touch upon health inequities: Age, race, gender, ethnicity, and so forth. This new taskgroup is digging deeper into some of the other data elements around health inequities like Z codes, language preference, disability status, and educational status to look at how that could possibly get packaged together to transit to other members of the healthcare team.

Ultimately, this gets us into HL7 and FHIR interoperability. It is a data package around health equity that can be aligned with other stakeholders because we see currently that the joint commission has a health equity standard so health systems are currently tracking this data, but we need to align it with other players, like pharmacy, and then there is also a CMS Health Equity Index that is coming into play starting next year around how managed care payers are addressing beneficiary needs. So, some of the details are at the bottom there. You can just highlight and see a picture of a pharmacy management system right now, where under the race field, they have white, Black, Asian, American Indian/Native American, other, and animal. So, they are mixing animal in race. When I argue about having this type of health equity standard or priority, it is to do two things, 1). Standardize data elements for FHIR interoperability, and 2). Optimize standard implementation so that we do not have systems that intermingle animal and race. May I have the next slide, please?

This really gets us into the longer-term goal that we could have, which is to identify pharmacy quality. As you can see here, my pharmacy, Ross Bridge Pharmacy, smack dab in the middle, has a variety of patients, interns, companies, PSAOs, and boards of pharmacy, but we also have a lot of vendors that work with us. Computer systems, technology partners, wholesalers, and other providers are looking at pharmacies and asking what their quality is. So, when we go to the next slide, we will see that the longer-term goal that we should really think about here is how to standardize pharmacy quality, and there are the National Quality Forum criterion for what makes a good quality to the left, and I highlight Criterion No. 3, feasibility. NQF defines feasibility as the extent to which required data are readily available, retrievable without undue burden, and can be implemented for performance measurement.

So, if we look at a pharmacy through the lens of feasibility, then that really boils down to pharmacy dispensing data and e-care plan data because when we ask how the quality of a pharmacy is described right now, we tend to go to health plan-adjacent quality measures like adherence. These are calculated off of PDE. These are plan-level measures using a data source not at the pharmacy, and so, they do not really align with how NQF defines quality, so I want to start to think about how we standardize this idea of pharmacy quality. If we go to the slide and the last minute that I have for these two big topics that are both weekends worth of conversations in five minutes, NQF is the National Quality Forum. They were the governmental organization fort he last two decades that endorsed quality measures, so you can have NQF endorsement on a quality measure. Ultimately, you can have good quality measures, but you have to have a measurement system or star rating for these to work.

We do have a measurement system for community pharmacy called Choose My Pharmacy. It is designed to look like a food safety score because if you can go into any restaurant and know the quality of a restaurant, you should be able to go into any pharmacy and know the quality of a pharmacy. To think about these value-based conversations that we are having, you can see some of the measures that we have listed there. My personal favorite is assessment of weight in pediatrics, the percent of patients 17 years and younger with a weight at the pharmacy. We did empirical validity research, and we found that 60% of pediatric antibiotics are dosed incorrectly at the prescriber, so they are coming from the prescriber to the pharmacy dosed incorrectly, and the only way that the pharmacy can make an intervention is if we know the weight of a child.

So, there is a way to change this by looking at pharmacy differently. In the chat earlier today, we saw folks talk about Paxlovid for COVID prescribing. There is a quality measure for assessment of renal function in older adults so the percent of patients 65 and older with **[inaudible] [00:42:00]** on file at the pharmacy so that we can make sure drugs are dosed appropriately for renal-disadvantaged patients. We have measures around medication indication, and we have measures around safety, like improving naloxone access to the household level for households at risk for opioid overdose. I am going to pause here because this is the end of all my slides. Since I had five minutes to cover five slides, I know I have thrown a lot at you, but I am happy to address questions and support the conversation. Thank you again for letting me be here.

Shelly Spiro
Thank you, Jake. So, let's open it up for discussion over the next 15 minutes. Any discussion questions? Continue the chat, please. Steven?

Task 2 Discussion (00:42:45)

Steven Lane
I will just say how eye-opening it is to hear from our speakers and how much I appreciate your taking the time to put this together. As a primary care physician and informaticist, I have to say I have not thought about a lot of these issues. I work in an urban area where we do not leverage pharmacists as a safety net provider or continuity care provider, so it is great to hear that this kind of care is being provided and these things are being considered, and I also just want to echo what so many people put into the chat, which is that we should not be developing bespoke workflows to support this or any new set of participants in nationwide interoperability. Rather, we should rely upon the floor that we are building that supports providers generally and embrace the fact that there are these additional providers that are contributing to and improving care across the spectrum. Again, thank you so much.

Shelly Spiro
Thank you, Steven. Pooja?

Pooja Babbrah
Thanks, Steven, for that comment. I think it is really important for us to think about. I think it was Surescripts that released a report that talked about the rural areas where the only provider within 100 miles is a pharmacist. So, as we are thinking through our recommendations, I think that is an important data point for us to keep in mind, so I just think as we are thinking through that, we have to think about all the different areas where pharmacists can play that role.

Shelly Spiro
Thank you, Pooja. For those of you who do not know, Christian's pharmacies are in what we call dual shop. That means that they take care of the ambulatory patients or the community pharmacy patients and also skilled nursing facility patients or assisted living, and Christian, I know you had talked about the many different systems you are asked to access, which really decreases the productivity of the pharmacists who are trying to provide these clinical services. I just wanted to ask you to explain a little bit further all of the connectivity issues that you face and the staffing issues you face because I know that many of your pharmacies are in rural areas.

Christian Tadrus

I will address the staffing issue first. It is obviously widespread. Everybody has challenges these days post-COVID, but in pharmacy, where our workload was going up, we were seeing staff members bugging out, and then you add these higher-level-complexity tasks where the data is not in your primary workflow or easily retrievable electronically, and you have fewer people doing more work, accessing more systems, remembering and resetting more passwords, and having limitations on that data anyway because it may be an access issue or credentialing issue, possibly, so it is a burden. I think part of our morale degradation in healthcare is the clunkiness, the time consumption, and the frustration of fighting these systematic issues when we are just trying to get information that we need to make a decision.

With regard to the long-term care space, it is a bit of a Wild West out there. Larger facilities may have practice management systems that do quite a bit, everything in the back-end management of the facility, with clinical documentation complete with access to e-prescribing and some other types of data feeds. From a community pharmacy setting, we are usually not seeing to be qualified to have access, even for our own patients that we service in these facilities, and most of those facilities are using separate systems, so we end up having to connect in with various intermediary vendor systems that are translating data, such as **[inaudible] [00:47:14]** order request, fulfillment, and status of prescriptions, through interfaces that can convert the data from pharmacy systems to whatever system they are using, which is usually an HL7-based system.

The consultancy pieces are interesting, too, because there are very few systems out there designed to be electronic consulting systems, but the need for being able to electronically exchange a consultant note with the outside world if you are operating from within the facilities or from a pharmacy or remote scenario where, increasingly, we are doing more work to review charts and prepare for visits, or just come from a visit and then write up our notes, are issues that we are trying to solve for as well. Is that the type of thing you are looking for?

Shelly Spiro
That is perfect, thank you. Hans?

Hans Buitendijk
Thank you. Thank you for the presentations. One of the topics that jumps out there and is in the chat as well is focus on quality measures, and in many ways, measures can help identify progress, particularly when we look at interoperability. Is there a pickup of it, do we see changes, etc.? The question I have there is if you take that and we look at quality measures, which is a very broad area to cover, from an interoperability perspective, what are some of the areas that you would say if we were to start to measure this, which then really translates into which use cases we are going to want to focus on first, in that area of interactions, like Jake's slide which had pharmacy in the middle and different parties around that, which I liked, which ones are we going to look at? Which ones would have the greatest effect, and therefore are most worthy of both measuring it and putting the effort behind to adopt the interoperability that we are looking for?

Jake Galdo
I think that is an amazing question, and thank you for it. I am going to address it in two perspectives. One is to take us back, because I am a recovering academician, and I apologize, to Measurement Science 101 from the 1966 article from Atlas Donabedian, which talks about quality measures being constructed in a

structure-process-outcome formality. Now, everybody in healthcare is looking at the outcome quality measures, like readmission rate for health systems. Pharmacy quality is in a brand-new area because there really is not anything out there, so we have to look at it from a structural level. Do we have access to the weight? Do we have access to the same creatinine? So, if that is our first quality measure, that is where we start. Are we interoperable? Can the pharmacy collect that information? I practice in Alabama, and I can get ICD-10 on the prescription when it comes in to me, but when I adjudicate the claim to my primary payer in my state, they tell me it is a denied claim until I delete syndication.

So, there is this issue with interoperability of who accepts data because anytime you transfer it from one stakeholder to the next, you have natural attrition because you did the least common denominator of data to send it over, so I think we put a lens on the pharmacy, and what can we say is a structure-type quality measure? Access to weight, which is an NCPDP standard, or access to serum creatinine. Is that something that the pharmacy can capture, yes or no, and then, how do we push it forward? I would say that is Option 1, which is the structure and using quality to define the structure of the pharmacy.

No. 2 is to really hone in on safety. Heck, "Seguridad" means "safety" in Spanish. A lot of our quality measures are focused on how to optimize safety. I actually do not care if the pharmacy has the weight, I care if the dose is correct for the child. By 12 months, my daughter had three antibiotics, and two were dosed wrong from her pediatrician because they were underdosed based on her weight, and our pharmacy caught that because they used this measurement system and evaluated it. And so, I think we have to start on some of these safety-type use cases. Again, Paxlovid needed serum creatinine. What percentage of pharmacies had serum creatinine readily available so they were making sure it was the right dose, particularly in a test-to-treat environment, where they tested for COVID and then were treating with Paxlovid, so they probably did not have the clinical information.

Hans Buitendijk
Thank you.

Shelly Spiro
Afton?

Afton Wagner
Thanks, Shelly. I agree, safety is obviously key to a lot of what we do as pharmacists, and we get a lot of that information all the time, and being able to share that information is really important to us, but something that I think might be helpful is taking a look at the capabilities that were expanded for us during COVID, like Paxlovid, which Jake just mentioned, and taking a look at some of the pain points that pharmacies experienced during that time, and race and ethnicity was something that we specifically struggled with trying to get, and using existing standards that are already in place, as was mentioned earlier, to be able to share that information and populate it into our systems would be really helpful. Maybe a good exercise would be to take a look at what is required under what we can do right now with immunizations, COVID vaccines, and Paxlovid and take it from there. Let's see what fields we can accept in pharmacies and what would be really beneficial to have, what is easy to get, and what is not easy to get, and start from there.

Shelly Spiro
Thank you, Afton. Ike?

Steven Eichner
Thank you. I have two or three points. First, I need to make sure that patients are included at the table as part of the discussion as a focus point. I think looking at safety information and communicating to patients why information is necessary to be shared with pharmacists is really important. I have a complex medical history. I do not really want copies of my full medical records sitting in 32 different places, but if you could explain to me why a necessary subset of that information needs to be available, that is great. If you say, "We need to know your other message and your core diagnoses to help ensure that there is not an adverse interaction," that is fantastic.

I think a second component is how we look at pharmacy exchange or pharmacy participation as an example of specialty data exchange as a model for other environments where there is still specialty data needed, whether you are looking at mental health/behavioral health services, where the existing exchange standards work generally, but not necessarily specifically enough to do things like mental health assessment data. There is not really a good way of exchanging that in today's society. Again, that is not meant to detract from pharmacy, but how do we look at using pharmacy exchange as a model to support other things like long-term care, substance abuse care, and similar spaces? That is just a thought.

Shelly Spiro
Thank you, Ike. Any response? Okay, then we will go to Steven.

Steven Lane
What an amazing discussion. I wanted to circle back on the issue that Fil, I, and others have been putting into the chat, which is really a question to ONC. What is the role for USCDI Plus in this discussion? USCDI Plus has really been focused so far on the marginal data needs of federal agencies, but is there an opportunity for USCDI Plus to also expand to look at the marginal and unique data needs related to other specialties? Fil has long championed the needs of LTPAC, where perhaps the data needs are narrower than USCDI, and certainly, when we talk about veterinary, dental, or complementary care, there are all sorts of participant groups that we want to invite into and embrace in our interoperability framework, but that will have unique data needs, either more or less than what we have in USCDI. We have talked about this with the ONC team for years now, but I think this is another great opportunity to ask what the role is of USCDI.

For pharmacists, if you are diagnosing and treating, it seems like you probably need all of USCDI. I do not think there is a narrow piece or a chunk of USCDI which is irrelevant to the pharmacist's treating workflow, but certainly, for veterinary, dental, complementary, or LTPAC, it may be somewhat different, and I think we should really ask ONC, and the USCDI Plus team in particular, to address this question directly. As a separate comment, I was really struck by this notion of the potential tension between equity and safety. We want to leverage pharmacists in the community, especially remote and rural communities, to provide part of the care net that is available, but we do not necessarily want to trade off safety in supporting that care. Having done lots of disaster and third world medicine myself, I know that we often trade off equity and safety or access and safety, but I think that as we set standards for the direct primary care that will be provided by pharmacists, we should try to hold onto safety as much as possible. Thank you.

Shelly Spiro

Thank you, Steven. Hans?

Hans Buitendijk
Building a little bit more on Steven's and Fil's comments, tying back to the use cases that are starting to be mentioned, general ones like patient safety, public health, or other ones being a driver, part of the question taps a little bit into Question 2b. Which priority do we go to? How do you get a community together to identify which priorities to focus on first? There are some models out there that have started to work and that happen to be particularly around FHIR, like accelerators, where a community of interested parties, providers, payers, and community providers with Gravity come together. Between NCPDP, HL7, and other environments, where is a place that such a community can be created and focused to move that forward? Otherwise, we are dealing with a large ocean to be boiled, and we need to start somewhere.

Where do we start first? That really means how do we collectively agree on where to start first? In this environment of USCDI, USCDI Plus, certification, and other things, it may help to understand what the relevant subset is that we should focus on. I like the comment that Fil made, "I was hoping that I could add more than one Plus set to it." For interoperability, exchange, and data sharing purposes, there is a set within USCDI, USCDI Plus, or otherwise that is relevant in order to do that. As Jake identified, how do I get the weight across correctly from one to the other where it is relevant, or where do I get the lab results that are relevant for that thing? They could be addressed in parallel. They are not addressing all of USCDI. They are focusing on a particular set. How do we rally around that? How do we govern that? Because this Task Force would not be the one, but we might be able to recommend where ONC should help put that together. Where do we look to make that happen?

Shelly Spiro
Thank you. Christian, then Pooja, and then we will close the discussion on the presentations and go back to the spreadsheet. Go ahead, Christian.

Christian Tadrus
Shelly, I apologize. My hand was raised before Hans asked his question, so I was going to respond with something, but I did just type a response to Hans's question in the chat.

Shelly Spiro
Thank you. So, exchanging PGX, lab, SDOH, diagnosis, and care plans would be areas of great impact. I will add to that list in the chat, but we are working on a project on exchanging pertinent information during transitions of care, including the medication lists, and I think these are important components that we will be discussing through this process. Pooja?

Pooja Babbrah
Just to also address Hans's comment, I think the point of bringing folks together, similar to an accelerator, is really important, and I know in Rick's and Steve's presentations, there was that infographic created that shows how NCPDP work as a strategic initiative is aligning with some of the accelerator work, but I think where we need to be thinking about is how we now bring folks together to do some… There is so much great work happening. Jake, I love to see the work that you are doing, and Christian, I love to see the work that you are talking about, but I think there is the question of how we bring more folks together to do some of this pilot work, this use case work, and all of that. From an ONC perspective, one of our recommendations

is to think about how we do that, and I think it is important to make sure that if there is some funding that is available, if there is work that could be done, some of those recommendations get made as well of coalescing around some of these use cases and getting some of these folks involved, and Christian, I think the areas that you put in there are the ones where we could be thinking about how we do that.

Shelly Spiro
Thank you, Pooja. Maggie or Wendy, if we can go now to the spreadsheet, I will turn it over to Hans to help us with that.

Hans Buitendijk
All right. So, we effectively started with the conversation already in the direction, and we wanted to get this a little bit further discussed, and I think it is just a continuation of the conversation. So, we are looking at Rows 9 and 10, long-term and short-term opportunities around use cases, and a number of those were already raised, but where do we think we should focus as a Task Force with ONC on advancing these capabilities? Are there any of these that clearly jump out? Christian provided a number in the chat, and we talked about a couple other ones in combination as well. Are there any particular ones that jump out from a Task Force perspective as places where we can provide the best opportunity in the short term, which can be listed there, or in the long term, and start to identify them there as they require more work before we are there?

I would also suggest that for both of them, the question becomes how and in what kind of environment you advance that. Is there opportunity or need for an accelerated approach for that? Is it something that ONC can put out there? How do we go about advancing that? I do not think we can just say, “Hey, ONC, do this,” and off we go. Who do we really need to get involved and engaged to make that happen? So, patient safety has been mentioned, public health has been mentioned, Christian provided the list of exchange of PGX, lab, SDOH, diagnosis, and care, and Jake mentioned patient safety, and more specifically, weight. How do we tackle this to suggest where to focus?

Shelly Spiro
Pooja?

Pooja Babbrah
I like all the short-term ones, but this should probably fit under the long-term, right? I think the goal out of this, being able to exchange clinical data and all of that, is really to support value-based care and bring the pharmacist into the care team, so I think a longer-term priority is that overall look at how we support value-based care and bring the pharmacist into the loop.

Hans Buitendijk
Thank you. Afton?

Afton Wagner
I agree, Pooja. I was just thinking about immunization status as well. I think that is going to be very important moving forward.

Christian Tadrus

Fil, I am curious whether you can speak to some of the thoughts you have had and that have been raised. Where do you see that fitting into it and helping advance some of these use cases? They might not be specifically the use case, but how to organize and focus might fall within that. Maybe we can put something in the third bar, Row 11, to put that in there. How do we manage and organize that?

Fillipe Southerland
Sure, Hans. I think you and Steven spoke quite eloquently on this. Before I jump into some thoughts there, I did have a question about… So, I notice that HL7 FHIR and ONC seem to coordinate quite well when it comes to advancing USCDI versions and mapping the FHIR resourcing to that. I am curious: Is there that same level of coordination between NCPDP and ONC?

Hans Buitendijk
Anybody? We are looking for insight here.

Shelly Spiro
Pooja, I do not know if you want me to go ahead and answer that, but I think there is. I think we have had a general push on the NCPDP side. I think that Steve Mullenix and Rick Sage talked in our previous calls about some of the initiatives of harmonizing between NCPDP and HL7. That is something that we do quite a bit. We did it with the Pharmacist Electronic Care Plan, we are doing it with the Standardized Medication Profile Project for transitions of care, and what we did find with our system vendors, especially in the community pharmacy setting and the independent community pharmacy setting, was the use of FHIR and FHIR-ready for exchanging the Pharmacist Electronic Care Plan.

So, the care plan was developed mainly to handle the majority of information that is in USCDI and would follow USCDI, and it is highly codified. We built several value sets. I think there are about 80 value sets that are bound to the Pharmacist Electronic Care Plan to begin to standardize the clinical documentation, all within SNOMED, but still have the capability of handling some of the social determinants of health assessments, like Repair, so pharmacogenomic information and all of that can actually be captured within the care plan. I do not know if that answered your question.

Pooja Babbrah
Shelly, this is Pooja. Maybe I can add to that. I definitely think there has been coordination between ONC and NCPDP, but I think part of the effort here is to bring more of that coordination and education and to figure out where there could be additional coordination around that. The way I look at this Task Force is really to start doing more of that because I think it has been a little bit… Shelly mentioned a couple things that we have moved forward, but I think part of this group is to clearly get a little bit more on that coordination. That would be the way I look at it.

Shelly Spiro
Most of the focus between ONC and NCPDP has been around the Script standard, but also, the Pharmacist Electronic Care Plan is recognized in the ISA. Ike?

Steven Eichner
Thank you. I do think something that is important as we are laying out potential priorities is, in addition to looking at standards and what data is being exchanged, that we also have an opportunity to ensure that

there is functionality of systems to track when information is being disclosed and make that information available to patients whose data is being disclosed. That is one of the things that is a current limitation in many existing EHR systems and EHR platforms, but if we can look here and capture that as a function early on as technologies begin to be developed, we then do not have to come back around on the back end and reengineer after the fact. The subject was brought up in previous HITAC Task Force meetings, so it is not a new idea. This just becomes an opportunity to begin to advance that. A second component, which may be a little more on the C side of it, is what the relationship is, if any, between different payment systems, whether you are looking at pharmacy or drug insurance versus looking at medical insurance and where that fits into value-based care and data exchange. Thanks.

Shelly Spiro
Thanks, Ike. Hans?

Hans Buitendijk
I was wondering, Steve, with those comments, where would we want to do that? So, in support of the use cases, we need that insight, that transparency, etc. Where would we want to advance that? Is that a use case, or is that more just a fundamental capability that, along the lines of integrating pharmacists within the process more to enable access… I saw the point that Summer made in the chat around privacy firewall rules that need to be in place more at the organizational level. We have had prior discussions around consent and otherwise. How do we attack that? That seems to be a fundamental topic across whatever use cases we are going to advance.

Steven Eichner
Thanks for the great question. Looking at the way you have laid things out with short-term priority use cases and longer-term cases, I think there is a third category that is kind of up above, which is foundational components that would probably apply regardless of whether it was the first focus of a use case or later on, not so much as a separate use case, but things that would apply to any of the use cases that might get put forward.

Hans Buitendijk
Thank you.

Steven Eichner
I am thinking about it from a Lego base plate kind of approach. Regardless of what you are building on creating on top, you still want a strong foundation on which to build.

Hans Buitendijk
Correct, agreed. Other thoughts and comments? I think we have about six minutes left before we go to public comments.

Shelly Spiro
Pooja?

Pooja Babbrah

Sorry, I did not unmute. I think Kathy Graf put this in the comment, and there has been some chatter on this. I think we talked about this earlier, but I just do not know enough about TEFCA and what is going on there. For pharmacists to access data through HIEs, is there anything around TEFCA that will assist with that? I just do not know, and I look to Task Force members that know more about TEFCA to help us understand that a little bit more. That seems to come up a lot. How do you get access? Are they going to have to pay? I just do not know if TEFCA is going to address any of that.

Hans Buitendijk
There are a couple others that can jump in as well from different perspectives, but the use case for TEFCA is initially focusing on treatment and subsequently on individual right-of-access patients from a sequence perspective, but on the treatment side, it goes back to our larger question. To what extent is there a recognition of authority, etc., that the pharmacist is part of the treatment process? In that sense, where there is agreement that there is, one could argue that TEFCA already effectively addressed that, that where there is that understanding, it can slide right in and go back to our prior comments about tapping into existing structures and otherwise. So, from a TEFCA perspective, that would seem to be a place where, if there is good clarity, what role and access can be had that will roll right in. Steven Lane might have seen this in other topics and pharmacy-specific discussions, but I have not seen it yet.

Shelly Spiro
Christian?

Christian Tadrus
We are struggling with things because of the way pharmacists and pharmacies are perceived in their siloed models of delivery of healthcare, which is disparate and fairly unique from other healthcare models and professions. From a regulatory standpoint, the comment around pharmacists as members of the healthcare team… By definition of their professional license, in fulfilling and receiving a prescription, they are a member of the healthcare team because they are a healthcare professional involved in providing healthcare service, as well as products. I think there is commentary there, I think it is an educational component, but it should provide every state the legal support to defend the pharmacist having access to this data because it is relevant to what they do and expected to provide what they do.

I would say that while it may not be a data standards issue, I think the data standards issues are hobbled and controlled by these misunderstandings of that pharmacist role in the overall model increasingly as we get into clinical services and frontline public health responses because that is where that recognition is coming through, and I know we have to build around federal mindsets on this stuff, but I think we can call these things out. Maybe there is a recommendation to say that there needs to be a more cohesive look at this concept around the definition, understanding, or acceptance of a pharmacist being a member of the healthcare team. To me, that seems like a foundational recommendation for a lot of what we are trying to get done.

Shelly Spiro
Deven?

Deven McGraw

Thanks, Shelly. I was just going to add that a pharmacist is considered to be a medical provider under information-blocking rules, but I can speak from the perspective of a laboratory. Even though we are providers under information blocking, we are also covered by HIPAA, as with pharmacy data. There is definitely a bit of a hostility toward those types of providers that are not physicians or hospitals in terms of whether they are part of the treatment team, and I see in the chat that Mary Kay is going to opine on this in public comments, and we should ask Shila, who I do not think was able to make our call today, but who runs an HIE, to speak more to the issue of why pharmacy connections to existing networks are not as robust as they should be. Thanks.

Shelly Spiro
Thank you, Deven. We are almost at the point of public comment, so let's give the Wendy and the ONC team a chance to get us set up with the Accel team.

Public Comment (01:17:50)

Wendy Noboa
Accel, can you bring up the public comment slide? Okay. So, we are going to open our meeting now for public comment. If you would like to make a comment, please raise your hand on the Zoom platform using the toolbar on the bottom of your screen. If you are on the phone only, you can press *9 to raise your hand, and once called upon, press *6 to mute or unmute your line. Let's pause for a moment to see if any members raise their hand. Great. It looks like Mary Kay has a comment. You have three minutes. Go ahead.

Mary Kay
Yes, thank you. I appreciate the opportunity to speak to the Task Force and the other members in regard to the numerous questions regarding pharmacists needing access to medication history. The problem lies in the actual terms of use and contractual obligations between whether you are an HIE or a dispensing pharmacist and the fact that it is not an approved use case for you to access the 12-month medication history and initiate it on behalf of a dispensing pharmacy, and that is the various PBNs, including Surescripts network and other networks.

And so, this is a real problem. We have been running into this in the last several months in terms of trying to bring this information in for pharmacists that need it for test-to-treat, to calculate adherence measures, or for all different reasons, and the USCDI is certainly not going to fix this. TEFCA is not necessarily going to fix it unless people really understand the terms of these and the contractual provisions that are preventing and prohibiting this from happening, and it is quite perplexing to us. Obviously, all of us believe pharmacists are truly providers of care involved in treatment of patients and need to have access to this information for various purposes, so this really is going to have to get addressed at some point by ONC. I am happy to talk to any of the other groups like NCPDP, etc., about this because I think there is just a real gap in knowledge of everyone understanding that this is based specifically on the contractual terms and obligations for that med history product and for accessing that information.

Wendy Noboa
Great. Thank you for your comment, Mary Kay. At this time, there are no additional public comments, so we will yield the time back to the committee. Shelly, Hans, go ahead.

Hans Buitendijk

All right, Shelly. You are on mute.

Shelly Spiro
Thank you. I think Mary Kay is right on, and we have seen this quite a bit over the years, and a lot of it is in the contractual agreement and based on the fact that pharmacists are not recognized as providers in the Social Security Act even though ONC does recognize pharmacists in the information-blocking portion. But, I think the problem still comes into the governance, and we are hoping that the governance around TEFCA will take care of this particular issue and allow access. We know that our care team counterparts, especially physicians and hospitals, are very interested in our prescription dispensing information, but are reluctant to share that information with pharmacists. I am not quite sure why, but there are some problems that we have seen in the past, and we have encouraged our pharmacists to let the Office of the National Coordinator and OCR know that they are being blocked from information that is pertinent for them to continue their practice under the State Boards of Pharmacy Practice Acts that require pharmacists to have certain clinical information in providing clinical services. I will stop and turn it over to Pooja.

Pooja Babbrah
Thanks, Shelly. I have been seeing a lot of chatter in the chat about specialty, and Steve, I believe you just added a comment. In my mind, with a pharmacy hat on, I think of specialty pharmacy. Fillipe, maybe we can hear from you, but I just want clarification on the comment you made in the chat. That would be helpful for me, and maybe others as well.

Deven McGraw
Sure, Pooja. This is Fil. For want of a better term, when I speak to specialty, I do realize there is that subset of pharmacy providers out there, but my term is more general in that in a specialty EHR framework, for ONC to evaluate not only pharmacy HIT, but we also look at other sectors like behavioral, long-term care, etc. under that umbrella, and maybe we need to find a better term for that. That is where my term is coming from there.

Shelly Spiro
Pooja, this is Shelly. A lot of people who are on this call who are not pharmacists do not understand that there is a sector of pharmacy called specialty pharmacy, and when ONC uses the term “specialty” for different types of EHRs that are not recognized, such as physicians under the MIPS program or hospitals under the Meaningful Use Value-Based Purchasing program, that term “specialty” sort of confuses pharmacists and pharmacies. Pooja, I hope you understand where that term came from, and thank you, Fil, for the clarification. Hans, is there anything else that we need to discuss?

Hans Buitendijk
No, I do not think so. I think we had a great discussion today. There were lots of thoughts on potential use cases, priorities, and perspectives, and the last part had the realities of contractual challenges and limitations vis-à-vis what various laws and regulations would allow, how that then fits in, and how we can then take advantage of existing capabilities or not. I think those are all great points that have been raised, and now we need to start to think about how we turn them into recommendations. Great discussion today.

Task Force Work Planning (01:24:44)

Shelly Spiro

I agree. So, for homework for the Task Force, if we can bring up the spreadsheet one more time, I just want to go through that last page. Maggie or Wendy, can you bring up the spreadsheet again and go to the last page? Keep on going over to the side.

Hans Buitendijk
Subgroup tracking?

Shelly Spiro
Yes, the subgroup tracking. For those of you who have talked about doing a subgroup, please go ahead and make sure that you put the primary person designating the calls, which is in Column C, and then the other members, so if you want to be added to the list, please enter your name on here, but we need to get these done, especially for those that are part of the public health discussion, Topic 1. Does anybody have any questions about this? Please start filling in your recommendations. If you have any questions, you can certainly reach out to Hans, me, or Tricia Lee. We will be glad to help you.

Unless there are any other comments, I want to personally thank Christian and Jake for their presentations today. They were very insightful and informative as we move into this very important part for the pharmacy profession, which is clinical documentation and sharing that information, not only with our patients, but with the care team. I think these are really important pieces that, at the basis of the pharmacy profession, are an integral part of what we do as pharmacists and how we need to make sure that, for the benefit of our patients, we are actually sharing information that is pertinent to the care. Every patient who is high risk is on at least one medication. We know this, and that is why it is so important that we get this right. I want to thank ONC for bringing this Task Force forward so that we can flesh out some of these issues. Hans, I will leave the last words to you.

Hans Buitendijk
Again, thank you very much. We had a great discussion today, so we will have a busy week ahead of us to get our notes into the spreadsheet, review what we have, and then move on to Task 2C next week. Thank you to everybody from the public, particularly Mary Kay, for your feedback and input, and for everybody's chat contributions. I am looking forward to preparing for next week with the ONC team.

Shelly Spiro
Thank you, everyone, and thank you, Wendy, for stepping in on behalf of Mike, and Maggie and Tricia Lee for all your help, and the Excel team. Thank you.

Adjourn (01:28:06)