Health Information Technology Advisory Committee

Pharmacy Interoperability and Emerging Therapeutics Task Force 2023 Virtual Meeting

Meeting Notes | August 16, 2023, 10:30 AM – 12 PM ET

Executive Summary

The goal of the Pharmacy Interoperability and Emerging Therapeutics (PhIET) Task Force meeting on August 16 was to continue the discussion surrounding Task 2 and give recommendations on existing technology gaps for pharmacists to participate in value-based care. A robust discussion followed.

Agenda

10:30 AM	Call to Order/Roll Call
10:35 AM	Opening Remarks
10:40 AM	Task 2c Introduction: What technology gaps exist for pharmacists to participate in value-based care?
10:45 AM	Task 2b and 2c Recommendation Discussion
11:10 AM	Task 2 Discussion
11:50 AM	Public Comment
11:55 AM	Task Force Work Planning
12:00 PM	Adjourn

Call to Order

Mike Berry, Designated Federal Officer, Office of the National Coordinator for Health IT (ONC), called the meeting to order at 10:30 AM.

Roll Call

Members in Attendance

Hans Buitendijk, Oracle Health, Co-Chair
Shelly Spiro, Pharmacy Health Information Technology Collaborative, Co-Chair
Pooja Babbrah, Point-of-Care Partners
Chris Blackley, Prescryptive
Shila Blend, North Dakota Health Information Network
David Butler, Curatro, LLC
Steven Eichner, Texas Department of State Health Services
Rajesh Godavarthi, MCG Health, part of the Hearst Health Network
Jim Jirjis, HCA Healthcare

Steven Lane, Health Gorilla
Meg Marshall, Department of Veterans Health Affairs
Anna McCollister, Individual

Deven McGraw, Invitae Corporation
Ketan Mehta, Micro Merchant Systems
Justin Neal, Noble Health Services
Eliel Oliveira, Dell Medical School, University of Texas at Austin
Alexis Synder, Individual
Naresh Sundar Rajan, CyncHealth
Scott Robertson, Bear Health Tech Consulting
Fillipe (Fil) Southerland, Yardi Systems, Inc.
Christian Tadrus, Community Pharmacy Owner
Afton Wagner, Walgreens

Members Not in Attendance

Adi Gundlapalli, Centers for Disease Control and Prevention (CDC)
Summerpal (Summer) Kahlon, Rocket Health Care
Sheryl Turney, Elevance Health

ONC Staff

Mike Berry, Designated Federal Officer, ONC
Tricia Lee Rolle, ONC

Key Points of Discussion

Opening Remarks

PhIET Task Force Co-Chairs, Hans Buitendijk and Shelly Spiro, welcomed the Task Force, reviewed the Meeting Agenda, and recapped the Charge. PhIET Task Force continued discussions on Task 2, focusing on Task 2c Introduction: What technology gaps exist for pharmacists to participate in value-based care?

Task 2c Introduction: What technology gaps exist for pharmacists to participate in value-based care? Task 2b and 2c Recommendation Discussion, & Task 2 Discussion

- Hans Buitendijk reminded the task force to review the chat transcript in meeting notes as there is much information there to consider. He reviewed the agenda and noted there would be no presenters for this meeting.
- Shelly Spiro reviewed the spreadsheet, reminded the task force to enter their recommendations, and informed them that if they have a problem accessing the spreadsheet, they should email Mike Berry or the Accel team. She reviewed the topic and opened the floor to discussion. She mentioned the Centers for Medicare & Medicaid Services (CMS) goal for Medicare patients to move to Medicare Advantage and value-based care by 2030.

Pooja Babbrah started by noting that many topics already raised by the task force play into value-based care. She said that pharmacists should have the same access to information as clinicians, especially regarding Admission, Discharge and Transfer (ADT) notifications. She added that pharmacists should receive notifications whenever something is happening with a patient.

- Steven Lane agreed and added that ADT alerts are important for all care providers as well as sharing and maintaining patient information.
- Hans asked Steven if this would be an issue of standards, technology, or adoption.
    - Steven answered that it is an issue of all three. He continued that standards need to be adopted, policies need to be implemented, and implementation support to see real life function. He added that payers also need to be a part of the dialogue.
- Deven McGraw agreed that previous recommendations made are applicable to the topic at hand. She added that most questions raised have been regarding technology, not policy or business, and those obstacles need to be addressed first. She also asked any potential PBM experts present to clarify any contractual obstacles to data sharing.
- Hans asked if this was a short-term or long-term topic. He noted that she could place it wherever it makes sense on the worksheet right now.
- Deven said she would put it with another recommendation within topic 2.
- Shelly noted that the task force is looking at this issue through the lens of technology, and it needs to be linked to quality measures. She also mentioned the need to work closely on codifying the data in a way that brings value to the payers. She noted that Pharmacy Benefit Managers (PBM) have been focused on cost reduction, not improvement of care. She said that that the focus should be on integrating pharmacists not embedded in the health plan but providing services to underserved and rural populations.
- Hans mentioned one of the biggest challenges concerning quality measures around Accountable Care Organization (ACO) reporting as quality measures need to cross multiple systems, legal entities, providers, etc. He asked to hear suggestions on what to do regarding cross-organizational reporting.
- Shelly said that is why pharmacists focused on social determinants of health (SDOH) and other aspects of care where health plans have been interested in sharing information.
- Steven Eichner mentioned the importance of looking at what data needs to be shared, with whom, and identifying what data is of value and to what purpose. HE provided three areas for recommendations: 1. data and content standards; 2. exchange requirements 3. Technology support to address the minimum technology requirements needed to give pharmacists the information they need without overwhelming them with excess. He recommended a filter to help sort relevant information. He also mentioned PBMs and medical insurance and inquired on how coordination of services regarding PBMs, payers and providers translates into value-based care decisions.
- Hans said he should put a placeholder for his suggestions to keep track of them until they get further discussed.
- Anna McCollister said she is struggling to understand what is needed in the context of pharmacists being participants in value-based care. She went into detail on her personal experiences with pharmacies being a barrier to quality of care. She noted the principal issue was receiving needed medications on time. She suggested evaluating how long it takes for a patient to get needed medications or looking at supply chain issues.
    - Hans asked if she could identify some of the barriers she has faced to see if they can be solved by improving access to information between clinicians and pharmacists. He added that knowing barriers can translate into tangible solutions.
    - Anna continued to detail challenges she has faced from a patient's perspective and gave specific data points, i.e., paperwork, prior authorization, and access to medications.

- Shelly noted that medication dispensing is a technical function dependent on the health plan formulary and payer, not the pharmacists. She added that ONC has worked with the National Council for Prescription Drug Programs (NCPDP) to streamline the process, but the pharmacists are dependent on the payer. She said the task force should focus on the clinical aspect of the pharmacist, instead of issues of benefit design or payer dispensing requirements.
- Anna suggested placing quality measures on the PBMs or distributors since they are the cause of these barriers to access to medications.
- Hans said that Anna's experience is an example of what does not work between the patient and pharmacist and can help identify potential gaps and recommendations.
- Christian Tadrus agreed with Shelly and added that pharmacy operation quality needs to be addressed. He said recommending standards around evaluating how a pharmacy handles all their patients so that those with the same ailments are treated uniformly would make more sense.
- Hans referred to the overarching theme of establishing performance quality measures discussed in the chat. He asked for suggestions on what to focus on to drive improvement on that front. He asked if an initial recommendation can be made in the worksheet.
- Christian said he can assist with that. He added that the inefficiencies lie within policy, payer design, and lack of patient choice in the care team.
- Jim Jirjis said recommendations should consider how pharmacists should participate in the care plan since the role of pharmacists varies widely. He added that identifying use cases would address access and participation in HIE as an area to address gaps.
- Hans asked if he had any specific use cases in mind that should be prioritized.
- Jim said access to the medical record and the ability to communicate asynchronously with the care team can be one use case. He added that he would like to hear from a pharmacist about other use cases relevant to participation in value-based care.
- David Butler said the pharmacist has spent 75 years being the final step in distribution for pharmaceutical manufacturers; now pharmacists are trained at a doctoral level though nothing is being done to achieve true counseling patient care. He gave three points that can be seen as potential use cases. Firstly, pharmacists need to be recognized as revenue generators and not medications. Secondly, rethinking the facility design to drive pharmacist-patient interactions. Thirdly, rethinking the technical aspect of using the term pharmacy vs. pharmacist.
- Hans asked how those points can be translated into use cases to build recommendations. He also asked Shelly to expand upon her comments in the chat.
- Pooja said that the conversation was getting outside of the scope of ONC and the technology gap. She suggested the task force look at what is in place today in terms of technology and look at data elements available in current standards and use those as a basis for recommendations. She added that considering who is being certified to share information and pharmacist credentialing are two big components of value-based care. She shared that NCPDP has a strategic initiative on value-based care.
- Hans agreed and added that the task force needs to focus on what ONC can do to advance the objective. He also referred to his comment in the chat regarding use cases.
- Steven Eichner said the impact of care for patients needs to be considered. He is concerned that treating conditions uniformly across pharmacies would increase provider burden on the pharmacists. He opined that changing focus from pharmacy to pharmacist would increase patient burden. He suggested the Patient Unified Lookup Systems for Emergencies (PULSE) as a potential solution to the gap in patient data access.
    - Shelly said this does not decrease provider burden as is the goal. She added that information needs to be electronically available in the same system within the pharmacist's workflow to increase productivity.

    - Steven said PULSE would not be an end game but a first step toward information access while the technology is developed.
- Hans said the intent is to move away from jumping from one portal to the next. He added that PULSE might not work for everyone but may be a good starting point for some.
- Jim agreed with Shelly and added that ONC has worked on this for the past ten years. He suggested using tools already created by ONC, United States Core Data for Interoperability (USCDI), and others to create standards to reduce pharmacist burden.
- Hans said many technologies have been identified and asked what other areas can be advanced and what other barriers exist.
- Shelly said much work has been done on a pilot level, nationally, and data has been codified to follow USCDI. She noted that not all pharmacies have adopted it; however, it has been very successful.
- Jim said maybe the next step is getting the government to set federal standards.
- Shelly said the pilot started from an innovation grant out of North Carolina.
- Jim said what Shelly described could be a use case.
- Hans commented on possible reorganization in the spreadsheet based on the current discussion.
- Jim asked how pharmacies can be incentivized to adopt and use standards.

- Hans said asking what collaborators can be brought in to make those advances is important.
- Shelly said the pilot is still ongoing and still very successful. She also mentioned that physician counterparts did not accept pharmacists' care plans or utilize the data.
- Jim suggested dividing use cases into smaller, more manageable categories, i.e., access to information, communication back to EMRs, bulk FHIR etc. Separating them could help prevent stalling.
- Shelly said that is why a new Fast Healthcare Interoperability Resources (FHIR) based implementation guide is being developed with a smaller subset of data for easier medication data reconciliation.
- Hans said there are areas where ONC has a direct opportunity to encourage adoption. He asked what other parties can provide what is needed to incentivize adoption and implementation.
- Pooja asked if use cases must be reorganized on the spreadsheet.

QUESTIONS AND COMMENTS RECEIVED DURING PUBLIC COMMENT

None received.

QUESTIONS AND COMMENTS RECEIVED VIA ZOOM WEBINAR CHAT

Shila Blend: Good morning. Couldn't get mute off fast enough

David Butler: David Butler, Present

Mike Berry (ONC): Welcome everyone to the Pharmacy Interoperability and Emerging Therapeutics Task Force! Please remember to tag "Everyone" when using Zoom chat.

Pooja Babbrah: Good point - are pharmacists part of the directory mandates?

Pooja Babbrah: that may be a CMS question, not ONC

Pooja Babbrah: +1 on steven re: education on availability of Pharmacist eCarePlan

Katie Russell: Can we discuss the technology/business policy gap that is that health plans are the ones that make the value based agreements and often view anything pharmacy as a PBM function?

Jim Jirjis: Maybe it would be helpful to start with use cases where pharmacists are currently participating in VBC and then determine what the technical barriers are for them to participate in those use cases

Katie Russell: +1 Jim , agree

Ketan Mehta: @Jim... agree

Jim Jirjis: For example, is the challenge access to information about the. Patient, challenges to documenting what they did back to the care team, or challenges in communication with the care team

Pooja Babbrah: Jim - there are several examples where pharmacists are participating in VBC agreements. One in particular that comes in mind is a group in Minnesota - they are actually part of the PCP care team

Ketan Mehta: use cases allow tech vendors to apply standards within the workflow to make it easier for users

Pooja Babbrah: In that case, they have access to clinical data and the EHR

Shila Blend: I think also policies in place to encourage health plans sharing information across providers and pharmacists

Pooja Babbrah: +1 Shila

David Butler: I agree with many of Deven's comments regarding recognizing the business aspects of pharmacy operations that are still not clearly defined for allowing patient care, care team, provider, and privacy. For example, many comments have stated "pharmacy" rather than "pharmacist" for what should be hipaa-compliant interactions for patient-pharmacist relationships and subsequent sharing of patient-specific information across a pharmacist care team within a pharmacy, hospital, ltc, or home care setting.

Katie Russell: I think it makes sense to talk in use cases like Pharmacists could help with this set of quality measures instead of only pilots that are very granular and maybe not replicable

Pooja Babbrah: +1 Katie

Chris Blackley: +1 Devon - you nailed it with regard to the criticality of addressing policy, data and financial conflicts of interest that are barriers that must be addressed before technology standards will have any impact. To your question re PBM expertise - I've built a PBM from scratch (in market for the last 5 years) and expect I can contribute to this aspect of the discussion and the barriers they present to progress, their impact on the practice of pharmacy, and the financial implications on the same. We have built value-based models and one of the biggest barriers to execution is the access to data necessary to measure outcomes in order to manage contract performance.

Shelly Spiro: @Katie the Pharmacy Quality Alliance (PQA) on value based quality measures around clinical pharmacists' services.

David Butler: I have experience working at and consulting with PBMs for many years, as well, if input is needed.

Katie Russell: I think Pharmacist have a much larger role to play than solely access, dispense, and medication issues themselves

Shelly Spiro: @Katie +1

Shila Blend: Agree Katie, Pharmacists can do so much with monitoring utilization, outcomes, and effectiveness of treatment as well as cost savings on prescriptions

Pooja Babbrah: +1 Kate and Shelly

Jim Jirjis: The intervention we recommend depends on the mental model each of us has as to what the role of pharmacy is or should be in VBC. Widely different interventions ranging from frequent patient encounters with med adjustments, to eduction to medication list review etc. all with different needs

Steven Lane: Love the idea of a quality measure related to the average time it takes for a pharmacy to fill a prescription and make it available for dispensing to the patient, perhaps split by those products that do or do not require PriorAuth.

David Butler: Anna has many good points that have to be addressed. The key factor to address many of those issues will require entrepreneurial actions by pharmacists, physicians, pbm's, health insurer's, and state boards to create business drivers (i.e., cash flows) within pharmacies that pay the pharmacists to apply their doctoral degrees toward seeing and counseling patients rather then overseeing the final packaging steps of pharmaceuticals.

Donna Doneski: Agree with @Deven & @Anna points. Shouldn't business/legal/contractual obstacles be considered "standards" issues?\

Katie Russell: I too have experienced many medication coordination issues with my son who has ADHD & is on a controlled medication that has had supply issues etc. However, when I look at the data overall, my experience doesn't show gaps in care. I think we need to focus on the overall data

Richard Sage: I agree with Hans that many issues tie back to a lack of communication between the pharmacist and the physician, especially when a PBM adds requirements, such prior auth, limited formulary, changes in therapy, drug to drug interactions, etc.

Pooja Babbrah: +1 Rick

Hans Buitendijk: @Steven - Great topic that perhaps we can indicate as part of developing quality measures that include process efficiencies for 2c?

Alexis Snyder: The patient and caregiver is the one stuck in the middle-I have raised the issue in the past over real time information about coverage, PA's, shortages etc

Shila Blend: +1 Richard Hans

Pooja Babbrah: Steven and Hans - specialty pharmacies have requirements put on them by Manufacturers if they have direct contracts for turn around time, etc. I agree worth a discussion on this as a quality measure, but we would have to really think through how PAs, shortages, etc. would impact this

Katie Russell: But PBMs aren't the ones that set up value based agreeements

Shelly Spiro: @Katie agree PBMs aren't the ones that set up VBA

Shelly Spiro: @Pooja +1

Katie Russell: Turnaround time is often hard to measure because of delayed claims etc. For example I think that an example of a quality measure that a pharmacist could assist with as a use case is Pharmacotherapy Management of COPD Exacerbation: The percentage of COPD exacerbations for members 40 years of age

and older who had an acute inpatient discharge or ED visit on or between January 1–November 30 of the measurement year and who were dispensed appropriate medications. Two rates are reported:

1. Dispensed a Systemic Corticosteroid (or there was evidence of an active prescription) within 14 days of the event.

2. Dispensed a Bronchodilator (or there was evidence of an active prescription) within 30 days of the event These pieces are measured as dispense rates from the Health Plan/PBM but if a Pharmacy was provided an ADT notification, they could close that gap and completely fulfill that quality measure

Justin Neal: Per turn around time, there are also reporting requirements as part of some accrediting bodies (such as URAC) to try and capture for Specialty Pharmacies in addition to the pharma relationships Pooja referred to. Also PQA is working on a Turn-around-time pilot to create a standard turn around time measure. Currently about half way thru the pilot.

Pooja Babbrah: Thanks for that info Justin - I didn't realize PQA has a pilot going around this

Chris Blackley: PBMs are well-positioned to facilitate VBAs (we've actually done it). They should be able to access the data necessary to manage performance, as well as establish the payment structure to properly compensate pharmacists for their role. The barrier to PBMs furthering these arrangements more broadly is the negative impact it has on the PBMs' financial performance relative to their current business model.

Kim Boyd: Use case driven efforts, based on plan willingness to pay for pharmacist engagement/consultative, etc.

Kim Boyd: @pooja previously mentioned ADTs as a use case

Jim Jirjis: @Steven, when we did this we did not focus on rare cases

Jim Jirjis: Rare cases were handled by MD or even specialist. The pharmacist was instrumental, for example, in frequently encounters with patient to measure BP and adjust meds/adherence, etc

Alexis Snyder: Quality measures: how many times did patient need to call pharmacy, how may people did they need to speak with, how much time did patient spend communicating with pharmacy and/or payor and/or provider to coordinate care

Scott Robertson: +1 Kim: I'm all for the pharmacist being more directly and fully engaged. A huge barrier is economic - a business model the supports these services

Jim Jirjis: Other value based care examples were reviewing large lists pf patients and identifying patients who were are a large number of meds to determine if some could be stopped, review for interactions, etc

Katie Russell: I think there are many ways to use the term use case: one could be use cases for pharmacist as the care team, roles etc but then also the use cases for the actual clinical work that the pharmacy would collaborate on for value based arrangements

Kim Boyd: +Scott - Pharmacist as Provider – ubiquitous Recognition is needed

Jim Jirjis: The business model for us, in a past life, was the provider who was on the hook for quality and financial outcomes, they paid for pharmacists to be part of the care team to avoid medication costs, medication issues (interactions, side effects, etc) and adherence, monitoring.

Kim Boyd: No clinician (pharmacist or other) performs services without a means/way to obtain reimbursement for those services, at risk (VBA) or otherwise

Kim Boyd: +Jim

Shelly Spiro: @Jim we have a few models where pharmacists are embedded in physician practices, MCOs and ACOs and are part of the care team. In many cases we lack access to the care teams EHR that is interoperable with the Pharmacist's own clinical documentation system and are asked to document with an encounter based EHR system. This encounter based EHR does not fit with the pharmacist clinical documentation workflow. Pharmacists' clinical documentation (EHR) is based on a person centric model and overview of all the medications the patient is taking and becomes difficult to manage and engage the patient with their overall care and not just the encounter based on the dispensing of one prescription.

Kim Boyd: +1 shelly

Jim Jirjis: @Shelly, maybe we start with the use cases you just typed

Katie Russell: Yes if we are talking about true technology gaps, even with access to all these tools, the ability for them to integrate within workflow is difficult for what Shelly has referenced

Christian Tadrus: Use cases… Lab and objective data access for general dosing validation and risk reduction. HIE access to access and exchange clinical car documents. Access to both Medical and Pharmacy coverage information for both PBMs and Health plans to understand cost of care options. Ability to not have to use the patients primary payer if other payer or payment options are available and cheaper or otherwise in the best interest of the patient with sharing and acceptance of the health plan /PBM of that i formation and accepting of this approach without penalty (accountability in contracts must change). PGx testing information to support proper and most efficient dosing and drug selection which reduces cost and improves outcomes.

Suzanne Gonzales-Webb, CPhT: Pharmacists 'now as PharmDs' are less in dispensing functions, that relies more on pharmacy technicians... allowing the pharmacists more clinical functions as part of care teams.

Jim Jirjis: @Katie, and that is exactly what ONC is focused on—technical standards and recommendations. They can also influence policy through CMS etc

Kim Boyd: eCarePlan

Kim Boyd: Certification, credentialing

Deven McGraw: Agree with staying in ONC's parameters — but we should also consider their information blocking authorities in terms of data sharing snags (at least to the extent some of those snags are attributable to actors covered by those rules). Otherwise, we fix the tech and still no one uses it…. But don't disagree there is lots to do on the technical side.

Hans Buitendijk: Would the following start to summarize some of the high-level use cases we seem to be honing in on that recommendations can focus on?

Hans Buitendijk: As pharmacists goes from dispenser to test to treatment, member of care team, and part of VBC, there seem to be the following use cases:

- Enabling pharmacist to perform tests and provide appropriate treatment
- Incorporating pharmacist into the care team

- Providing insight in and advancement of pharmacist and pharmacy through quality measures as pharmacy/pharmacists and as part of the care team for the VBC arrangements.

Kim Boyd: NCPDP VBA Subcommittee preparing a white paper with call to action on pharmacist credentialing

Jim Jirjis: Suggestions for use cases: 1) data-driven medication-related population level interventions (identifying patients whose med list is not optimized) 2) patient encounter disease management. 3) medication optimization 4) Patient education and adherence

Pooja Babbrah: I agree with those items Hans

Jim Jirjis: With these use cases, we could then identify obstacles in information access, communication, documentation, care management tools

Pooja Babbrah: +1 Jim

Alexis Snyder: +1 to Ike

Kim Boyd: NCPDP SPC VBA Committee NCPDP standards available to capture specific data points related to VBA efforts

Kim Boyd: Completed initial analysis and data crosswalk of NCPDP standards that could be used to support VBA and the exchange of clinical data:

62% of data elements in SCRIPT Standard

45% within TELECOM

67% within eCare Plan

Hans Buitendijk: Which ones of these, plus Jim's would we put into short vs. long term use cases? Or are they in both and have foundational/short-term/long-term recommendations to advance each?

Pooja Babbrah: I think we put both in to start to flesh out the recommendations

Jim Jirjis: @Hans it seems like they are in both and there is a continuum or maturity that would decide what is short versus long term

Katie Russell: Use cases - integrating pharmacist as a care team specifically in exchanging information to have actionable clinical information related to quality measures that Providers and Health Plans contract.

Jim Jirjis: For example, short term could be access to patient data, long term could be standards for Pharmacy systems to interact with Provider systems

Hans Buitendijk: +1 Jim, Pooja

Katie Russell: +1 Jim

Jim Jirjis: One could do short and long term for 1) access to patient data 2)documentation with information available to entire care team, 3) access to population level data, etc. short term and long term recommendations could be made for each

Deven McGraw: Apologies, but I need to drop early - strong support for coming up with use cases and look forward to catching up with all next meeting.

Katie Russell: I agree what Deven is addressing that staying in ONC's parameters but also recommendations that information blocking and who is a covered actor to increase adoption of technology should be a long term recommendation

Kim Boyd: The 2019 findings showed that 34% of U.S. pharmacists devoted their time primarily to medication providing (compared to 40% in 2009 and 2014), 52% contributed a significant portion of their time to patient care service provision (compared to 40% in 2009 and 2014), and the remaining 14% contributed most of their time to other health-system improvement activities.

Kim Boyd: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7355503/

Jim Jirjis: Shelly, you are correct that we need integration of machine understandable information to integrate the workflow and reduce manual data entry. That is exactly what ONC has been solving for the provider side for years (now allergies, meds, problems are more machine understandable and some EMR's allow that information to be recruited to the EMR to support decisions support.) those same tools could be used for provider-pharmacy interoperability, and ONCE, CMS, etc should be able to create regulation to assist with that

Scott Robertson: Ike mentioned PULSE: Patient Unified Lookup System for Emergencies (PULSE) https://www.healthit.gov/topic/health-it-health-care-settings/public-health/patient-unified-lookup-system-for-emergencies-pulse

Suzanne Gonzales-Webb, CPhT: @Shelly scalability of access is spot on

Kim Boyd: NCPDP (SDO) continues to focus on data integration into their standards related to SDoH, PGx, Digital Therapeutics and other expanding focus areas of health plans what they may be willing to cover in the near or distant future - this will also tie to potential opportunities in VBA's.

Hans Buitendijk: PULSE is network based, thus able to access multiple sources.

Scott Robertson: PULSE as an additional *existing* technology to consider and leverage

Katie Russell: Agree with Jim & also stating the barriers outside of what this committee can recommend is helpful

Jim Jirjis: Maybe some of our recommendations are to suggest that ONC work with other agencies to remove some of the non-technical barriers

Pooja Babbrah: +1 Jim

Hans Buitendijk: We can do that (and have done that on other groups/task-forces) where ONC's role would at least be informational, if not working together with other parties. We have to be within understanding of ONC's authority to make those recommendations.

Jim Jirjis: @Shelly are the pilots mature enough that the results and design could be used to form recommendations for standards regulation

David Butler: Recommendations: 1) a specified pharmacist must be the identified authority over receipt and transmission of all data for each specific patient - not the pharmacy; 2) this specified pharmacist must be identified on all communications between patients and other providers and viewable on the user interface; 3) all pharmacist actions must be identified in reimbursement structures for value-based care, so that those actions can be correlated with patient outcomes data; and 4) the pharmacist must not be restricted in necessary data access, nor for actions taken and documented, in order to benefit patient care.

Pooja Babbrah: agree with Shelly and Jim

Christian Tadrus: Need more endpoints (HIEs, clinics, etc.) to accept and send pharmacist eCareplans

Christian Tadrus: Ability for pharmacies that have eCareplan ability to send patient status and history to an er or LTc upon admission could pair with an ADT transaction and reduce repetitive workload. Sending an ecareplan to a pharmacy upon acceptance of an ADT message could facilitate bidirectional exchange of the most up-to-date status and plan of care for a patient both inbound and outbound. This could also help establish the pharmacist/pharmacist part of the care team definition even if short term, multiple or long term.

Shelly Spiro: @Jim Yes we heard about this during Jake Galdo's presentation

Pooja Babbrah: +1 Christian

Shelly Spiro: NCPDP/HL7 Project Scope Statement Standardized Medication Profile (SMP) FHIR IG https://jira.hl7.org/browse/PSS-2264

Anna McCollister: would it be possible to use ONC's ability to require more accurate data on distribution chain and supply chain? The pharmacist seems to have no insight into whether or not their distributor has information about medications, where a medication that has been ordered but hasn't arrived might be in the process, whether or not local pharmacies would have that medication in stock in the specific strength/dose needed, etc.

Anna McCollister: could we require notifications for providers and for insurers when PA requests have been received and viewed by the other? This seems like an issue that could be handled through automated data/notifications?

Pooja Babbrah: Anna - PA is automated on the pharmacy side and they should be able to see status updates

Katie Russell: Pharmacies do not have access to whether pharmacies not in their chain (if a chain) have other stocks. And Pharmacies are deincentivized with how the payment structure is set up even if they did have that access to send them to a different pharmacy because they wouldn't get paid on that transaction. True value based care isn't a transaction based model but Im not sure even with technology improvements, anything shorter or longterm outside of changing the drug dispensing payment model would have a solve for that

Pooja Babbrah: We have an NCPDP standard that is used for this and has also been mandated by CMS for MA plans

Hans Buitendijk: What are the patient portal/App opportunities today to have insight into PMS? Any opportunities there to address these questions?

Pooja Babbrah: The one big exception is on specialty medications that are covered under the health plan

Shila Blend: I will agree nobody has insight. I have seen patients surprised multiple times the cost of a medication after insurance applied. It can greatly affect compliance

Katie Russell: PA process has real issues in the speciality drug space because of the Payer/PBM interaction

Katie Russell: Payers are not mandated to utilize a standard for PA for speciality medications

Christian Tadrus: Our whole mandate is to provide an electronic work around to problems created by industry focus primarily on the cost of a medication. Value based care can't happen efficiently under those conditions. Fixing the root cause of these barriers would simplify the task.

Fil Southerland: Agree with the systems model approach for VBC Ike. Does ONC have a VBC support framework in place to coordinate with CMS?

Jim Jirjis: @Ike. Agree completely with defining how Pharmacy fits in the VBC system. That will spawn then the use cases I was talking about and that will in turn drive our recommendations

Christian Tadrus: Recommend ONC help,describe the cross currents in policy that create misalignment in the system.

Pooja Babbrah: GREAT discussion - thank you all!

QUESTIONS AND COMMENTS RECEIVED VIA EMAIL

No comments were received via email.

Task Force Work Planning

- Hans said the worksheet will be rearranged to capture use cases more accurately. He asked everyone to continue inputting recommendations into 2b and 2c and then reviewed the spreadsheet sections. He asked if anyone had any comments on Task 2c, 2b or 2a.
- No comments were made.
- Hans reviewed topic 2 recommendations organization and asked for suggestions and updates on Topic 1. He reminded the task force that all recommendations need to be noted in the spreadsheet before next week's meeting.
- Shelly clarified Topic 2d and noted the importance of realizing that pharmacists and pharmacies are limited by health plans, MCO's, and ACO's. She asked for recommendations on handling those challenges on the payer side.
- Anna reiterated that problems lay in the care plans and referred to her chat comments. She noted that supply chain issues suggest a need for a solution within the distribution system. She added that prior authorizations are cumbersome and can also be remedied with data-sharing technology.
- Steven Eichner suggested a systems model of how pharmacies and PBM fit in value-based care from a systems perspective.
- Pooja suggested looking into the current standings on price transparency on the pharmacy side regarding challenges with prior authorizations.
- Hans said next week, there will be a discussion surrounding transparency. He reiterated noting recommendations on the spreadsheet.

Resources

Pharmacy Interoperability and Emerging Therapeutics 2023 Webpage
Pharmacy Interoperability and Emerging Therapeutics 2023 – August 16, 2023 Meeting Webpage
HITAC Calendar Webpage

Adjournment

The meeting adjourned at 12:00 PM.