# Transcript

## PHARMACY INTEROPERABILITY AND EMERGING THERAPEUTICS TASK FORCE 2023 MEETING

August 16, 2023 10:30 AM – 12 PM ET

VIRTUAL

# Speakers

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

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

**Michael Berry**
Good morning, everyone. Welcome to the Pharmacy Interoperability and Emerging Therapeutics Task Force. I am Mike Berry with ONC and we are always glad when you can join us. This task force is open to the public and your comments are welcome in the chat of the meeting or during the public comment period that will be held around 11:50 Eastern Time this morning. I would like to begin rollcall of our task force members. When I call your name, please let us know if you are here. I will begin with our cochairs. Hans Buitendijk.

**Hans Buitendijk**
Good morning.

**Michael Berry**
Shelly Spiro.

**Shelly Spiro**
Good morning.

**Michael Berry**
Pooja Babbrah.

**Pooja Babbrah**
Good morning.

**Michael Berry**
Chris Blackley.

**Chris Blackley**
Good morning.

**Michael Berry**
Shila Blend. David Butler. Steve Eichner.

**Steven Eichner**
Good morning.

**Michael Berry**
Raj Godavarthi.

**Rajesh Godavarthi**
Morning.

**Michael Berry**
Sanjeev Tandon.

**Sanjeev Tandon**
Good morning.

**Michael Berry**
Jim Jirjis.

**Jim Jirjis**
Present.

**Michael Berry**
Summer Kahlon. Steven Lane.

**Steven Lane**
Good morning.

**Michael Berry**
Meg Marshall. Anna McCollister. Deven McGraw.

**Deven McGraw**
Good morning.

**Michael Berry**
Ketan Mehta. Justin Neal.

**Justin Neal**
Good morning.

**Michael Berry**
Eliel Oliveira. Naresh Sundar Rajan. Scott Robertson.

**Scott Robertson**
Good morning.

**Michael Berry**
Alexis Snyder.

**Alexis Snyder**
Good morning.

**Michael Berry**
Fil Southerland. Christian Tadrus.

**Christian Tadrus**
Present.

**Michael Berry**
Sheryl Turney.

**Sheryl Turney**
Good morning.

**Michael Berry**
Afton Wagner is not able to join us today. Thank you, everybody. Now, please join me in welcoming Hans and Shelly for their opening remarks.

## Opening Remarks (00:02:06)

**Shelly Spiro**
Good morning, everyone! Welcome again to another week of Pharmacy Interoperability and Emerging Therapeutics Task Force. We are so glad you are able to join us and I will let Hans make his comment.

**Hans Buitendijk**
Good morning, everybody. Appreciate that we keep on moving forward today building on discussions we had last week. Looking forward to that, to see if we can get a few more recommendations teased out from our conversations. Also, welcome to the public today. General reminder, we use the chat a lot. If you go to the meeting notes, it is always good to go back to actually the chat that is listed as well. Anybody can participate in that. Also, anybody from the public. Take advantage of that. You will not be able to speak until public comments. As you have seen in the past we can have some very rich discussions in the chart as well. Take advantage of that and then we are going to look today at a number of different topics. We do not have a speaker today as you noticed on the agenda. We are going to work our way through the different aspects, starting with Task 2C, pass it to Shelly in a moment, and then we are going to go back to Task 2B and 2C to see whether we have more recommendations and continue the conversation aiming for recommendations. That is our goal for today. With that, I am going to pass it to Shelly to go back to our overall charger what we are trying to do today specifically for 2C.

## Task 2c Introduction: What technology gaps exist for pharmacists to participate in value-based care? Task 2b and 2c Recommendation Discussion, & Task 2 Discussion (00:03:55)

**Shelly Spiro**
Thank you, Hans. What we are going to be doing today is focusing on 2C, which is what technology gaps exist for pharmacists to participate in value-based care. As Hans said, we do not have any presenters today so we will be working off of the spreadsheet first. Hans will go through 2B and 2C discussions and try to capture as much as we can into the spreadsheet. Just a reminder to the task force members, it is your responsibility to enter recommendations into the spreadsheet. If you have not looked at it, please do so. If you have a problem in accessing it, please send an email to Mike Berry and/or the Excel team, Maggie or others, or Tricia Lee.

We are on Task 2, which is identifying opportunities and recommendations to improve interoperability from pharmacy constituents. Many of them for pharmacy-based clinical services and care coordination. Just a

reminder, 2B is which priority pharmacy-based clinical use cases should ONC focus on in the short-term and long-term, but really, what we are focusing on is 2C which is what technology gaps exist for pharmacists to participate in value-based care.

Go to the next slide. We need to start our discussion with the spreadsheet. If you could, pull up the spreadsheet. Just to remind us, and keep in mind that we are discussing value-based care and what is important for a pharmacy to participate in value-based care. What are some of the gaps that are existing? As we have heard from CMS, there is a plan for the Medicare patients to move to Medicare Advantage and value-based care by 2030. That is a target, not set in stone, but we can see where things are going. Pharmacy plays a very important role in value-based care. There are many aspects. Every patient that is a high-risk patient is on at least one medication and usually more, and therefore what pharmacists do in clinical services related to value-based care has the ability to capture that information.

Working towards sharing that information in an interoperable way with the care team. For those of you who have been involved in value-based care, care team approach is an extremely important concept under value-based care. At this time, we can open up the discussion. Hans, is there anything you want to add?

**Hans Buitendijk**
No, not at this point. I am curious what some of the thoughts and suggestions are around that. We probably are going to go back and forth between 2C and 2B, and likely 2A as well, as we go. I am curious what some of the reactions are. I already see Pooja has her hand raised. Then, Steven and Deven right after that.

**Pooja Babbrah**
Yes. I am happy to kick off the discussion. I think a lot of the things we have been talking about already play into value-based care. If I think about what the pharmacist would need, they would obviously, from a contracting standpoint, physicians would be contacting with the pharmacists. I think it goes back to our discussion of what is the clinical information that they need to be able to access to participate in value-based contracts and then also how do they capture the information to be sent back to a provider. I think there is a couple of different settings, at least from what I have seen, where in some cases the pharmacist is able to access the exact same clinical record as the provider. I think that is an ideal situation, if the pharmacist has the same information.

If not, I think it goes back to how is the pharmacist able to access the patient record and then, as they are capturing information, I know we have the eCare plan that we mentioned a couple of times that can do this. I think the other thing that I would just throw out there in terms of technology, and I think I brought this up on the last call, is ADT notification. I think, as I am starting to learn more, I know in the last call we mentioned NCPDP has a new task group that is going to be looking at this. If the pharmacist could get alerted that something is happening to this patient, that they are contracted as part of the care team, I think that is another important thing from a technology aspect. I think those two things are top of mind when I think about this topic.

**Hans Buitendijk**
Thank you. Steven, you want to go next?

**Steven Lane**

Yes. Thank you. I sort of pursue the same line of reasoning but from the PCP perspective. It is interesting because we have not really had this discussion in the ONC context more broadly. As we have been working through USCDI we have talked about care plans and care teams and Mark Savage has been a great advocate there. We have not made a lot of progress in USCDI. Here, we are talking about how we can incorporate pharmacists as providers into this process that we are still trying to figure out for physicians and other sorts of providers. I think part of it is clearly to exchange data and maintain and utilize data about the care team. Who is on the care team, both professional care team and the perhaps the lay family support care, that part of the care team. We have ADT alerts but there are obviously other kinds of alerts that can be really relevant.

I think one in particular, if a pharmacist is providing care to a patient that is involved in a value-based care arrangement, the other appropriate members of the care team should be alerted to that. That is not an admission discharge or a transfer but it is a care event that, especially until everyone is more accustomed to the idea of pharmacists as active members of the care team, that alerting is going to be particularly important. I know the care plan is the other thing, which again, some discussion, not a lot of dramatic movement forward on that. I know the pharmacy group, under Shelly's leadership and others, has done a tremendous amount of work on a pharmacists' care plan. I do not think most physicians are even aware of that. Physicians have done a little bit of work on their care planning, more in certain settings, especially in emergency medicine, supported by specific technology and vendors. I think if we are going to do value-based care as a team in a coordinated matter, sharing and maintaining data on the care team and the care plan is going to be important. It seems like pharmacists, if anything, are more ready to do that than a lot of physicians are. Thank you.

**Hans Buitendijk**
Steven, just as a follow-up question there, do you see that this is more a standards issue, a technology issue, an adoption issue? What would be the part to help move us forward in that space to make this happen?

**Steven Lane**
I think you hit on three key e-issues and I think they all exist simultaneously. We need to have standards that are adopted. We need to have policies that say that this data is included in a version of USCDI and must be exchanged if collected. We certainly need to have pilots or support for implementations of this so that we can really see it functioning in real life. Of course, when we are talking about value-based care we are also talking about payers being part of the dialogue. Payers, providers of all different stripes, including pharmacists and physicians, being aware, and of course patients. We always leave them until the end but they should also have access to their care team and their care plan information.

**Hans Buitendijk**
Thank you. Deven.

**Deven McGraw**
Yes. I think my comment follows on from some that have just been made. It seems to me that some of the technical and standards recommendations that we have made in other contexts would be equally as applicable here. I am not sure that there are additional technical recommendations we need to make for this particular use case. It did occur to me, I was trying to crack into the homework with some thoughts that

most of these questions that either we have been asked or we have come up with, I cannot remember who generated them, are focused more on the technical and standards components of this and a lot less on policy and business barriers which have been coming up from some of our folks who have given us commentary and folks who have weighed in on the chat.

Things like contractual barriers, perceptions of pharmacists as not being providers and therefore eligible under HIPAA, for example, as being part of treatment sharing. Lots of these obstacles that, if we do not tackle them, frankly, no matter what we do on the standards and technical side, we still will not get the pharmacy data interoperability that we need. It is an overarching plea to see where can we slot in some of these recommendations around data hurdles that are not technical but are more policy, contract, business obstacles? I guess, I am wondering whether we have any PBM expertise on the group that I am not aware of or whether we could bring in some PBMs who would be willing to tell us exactly what is going on because we have repeatedly heard from some of our commenters, and some members of our workgroup, that that is where some of the contractual obstacles to getting data to move are.

**Hans Buitendijk**
Thank you. I think that is a good point, to see where we are reaching out. **[Audio garbles] [00:15:20]** did not have somebody yet but if anybody has particular suggestions it would be great. Then, we can reach out and get somebody into the meetings as well. As far as you bringing up where can we find a slot, wherever you feel it best connects, like in 2B we were talking about some of the foundational topics. We were talking about is it short-term? Is it long-term? Where we should be able to, and we have done, identify this as a clear barrier and ONC can do X, Y, Z to help with that. Do not hesitate to put it in any of the existing places at this point in time, especially where it makes sense.

**Deven McGraw**
Okay. I tried to shoehorn it in a Topic 2 recommendation, where I could.

**Hans Buitendijk**
Okay. Try to put it wherever. If it is maybe not the right slot, just add it as well. **[Inaudible – crosstalk] [00:16:12]**

**[Crosstalk]**

**Deven McGraw**
You can move it. Okay. Thank you. Appreciate that.

**Hans Buitendijk**
Shelly.

**Shelly Spiro**
Yes. I think if we are talking about value-based care from a technology standpoint, we need to link it into quality measures. Most of the quality measures for value-based care are on the health plan side, which is really not necessarily the PBM side. The PBMs have been focused primarily on the reduction of cost, not necessarily the improvement of care. The pharmacy profession has focused on working directly with health plans and trying to integrate the quality measures that others of the care team are focused on. This requires

technology to do that. As you are capturing, there needs to be knowledge of the technology that is needed for electronic clinical quality measures and digital quality measures. We need to be able to work closely on the coding that the care team is, and the ACOs or MCOs that are building value. That becomes one of the bigger technology issues, is not only sharing what pharmacists can capture in exports like the pharmacist electronic care plan, but also codifying that information in a way that brings value back to those payers of the health plans.

Although I understand the interest in bringing the PBMs into place, but we have handled most of the technology aspects with the PBMs on the claims. I would be more interested in hearing from the health systems and health plans of how we can integrate pharmacists that might not be embedded in the health plan but are providing services to rural areas or underserved areas where pharmacists are able to have an impact for those patients within health systems.

**Hans Buitendijk**
Great points, Shelly. I am curious, and others might have some thoughts on that as well as we go through, one of the challenges that we are seeing with the quality measures around ACOs and how they need to be reported, where they need to come across multiple providers that are participating together, different systems, different legal entities, etcetera. It is very hard to do that. That sounds like some similarities of either lessons learned or working at the problems together on how to solve that cross organizational quality measurement reporting or analysis. It seems to be a hard nut to crack still at this point in time. I am curious from you or others along the discussion, what are some of the things we can do there? It is an issue we are already in not even talking about pharmacists. Not to diminish it in that way but it is a challenge of cross organizational reporting.

**Shelly Spiro**
That is why as pharmacists we focused on some of the disease states and some of the social issues, like social determinants of health, such as diabetes management, hypertension management, looking at the focuses where health plans have really been interested in sharing the type of information, what pharmacists can intervene on and showing value back to these value-based models that are being built within MCOs, ACOs, and others.

**Hans Buitendijk**
Thank you. Ike.

**Steven Eichner**
Thank you. I guess, three or four different points. One, I think from a language perspective, if we talk about data or content standards as one bucket as to what data needs to exist and be exchanged with whom, or what data needs to be exchanged, looking at exchange requirements as a bucket that addresses what needs to be exchanged with whom. Not talking about the formatting but what data is of value to whom for what purpose or to the vital components. From a technology gap perspective, one of the things that I think would be very useful is technology support to help address minimum necessary requirements to help pharmacists get access to the data that they need without getting overwhelmed in a haystack of data that makes it difficult to find what they need. We have heard numerous stories over long years of physicians being able to have access to a bunch of data but challenges in finding the data that they actually need to accomplish the task at hand.

I am curious about whether we could make some technology recommendations to help filter that so that pharmacists have an easier time accessing the data that they need to do the activity in front of them. I do not have the expertise on this one but I am curious about the relationship between PBMs and medical insurance in terms of the coordination of services not just between physicians and pharmacists, but on the payer side of the equation as to how that actually gets coordinated and then transferred into value-based care decisions between the physician and the pharmacy. I am not looking for an answer here now but I think that is part of the puzzle as well, that technology may help resolve or at least address.

**Hans Buitendijk**
Thank you. In regards to some of the comment you made, if you already want to put a placeholder of a suggestion that maybe, with some others, we can work out, by all means put that in even though it might not be in some areas as detailed out as we need to get to. At least we can keep track of it that way.

**Steven Eichner**
Thank you.

**Hans Buitendijk**
Let us see. Anna, your turn.

**Anna McCollister**
Hello there. I am really struggling to get my head around exactly what we need in this context in terms of pharmacies participating in value-based care. I say this as somebody who takes 15 different medications and has been on NQS and now whatever the **[inaudible] [00:23:40]** is called, quality measure committees for 13 years at this point. I do not understand how, I am also familiar with some of the case studies where pharmacists play a critical role in managing patients with Type II diabetes. That is not my reality. From my perspective, pharmacies are barriers to any quality of care because the dysfunction that I live with and that I see my parents live with in trying to get their medications. I am really struggling to understand exactly what it is we are trying to solve with this in a realistic way. I can list specific examples of different bits of technology or data that could have prevented a series of barriers but I do not understand what we mean by pharmacists being involved in value-based care other than one of the things that most contributes to my hypertension is trying to get my hypertension medications for my pharmacy on time.

I mean, maybe from a quality measure perspective, we should be evaluating pharmacies and or PBMs on the amount of effort it takes for patients to be able to get access to their medications or supply chain issues, which seems to be euphemism for lots of things these days, even for drugs for which there is no supply chain issue. I just do not understand how, and I am not trying to diss on pharmacists because they can and do have a very significant role. It is just, from an experiential perspective, that has rarely, if ever, been the case from my perspective. I want to provide meaningful and constructive comments about both technology as well as the role that pharmacists can play in improving care quality but I am really struggling with the fact that they just do not do the basic stuff, dispensing drugs.

**Hans Buitendijk**
A question that might come up there, and I am curious whether you might have a chance to identify some of those barriers, either throughout the conversation or as a follow-up, is that, which ones of these barriers

as you see them and experience them can we chase back to if a pharmacist and provider had more access to the same data about the patient. If the pharmacist and the quality measures of the care approaches overall that the care team collectively is working on, that they are represented in there more and that we understand the overall quality of the process where, as a result the performances, as well as some of the other ones that are paying from a pharmacy to, be it, a health plan, what is covered or and what is not, PBMs, etcetera? Having some idea of where those barriers are, we might be able to translate them back into patient specific awareness of data as well as overall process that happens. **[inaudible] [00:27:06]** some thoughts around it as well. Maybe they can help to get a sense of where might the gaps be that we can fill.

**Anna McCollister**
I have some some specific datapoints. I do not know if you want me to get into some of those things in this discussion or put it in the spreadsheet? For instance, I could name a couple of different things if you are interested. Recently, I take Concerta, which is long-acting Ritalin for ADD. I have been on it for years. It also helps with anemia, energy issues from my chronic kidney disease. To make a long story short, I had issues accessing a drug. Suddenly, out of nowhere, it required prior approval. There are all sorts of dysfunctions in terms of getting paperwork to my doctor and the doctor getting it to a PBM, or health plan, or whatever, the pharmacy. The amount of coordination it takes is absurd. It turns out, I accidentally was traveling when I got this covered and it did not, for some reason, need to be prior approved. When I backed that out, what I realized finally, with the help of somebody from CareFirst, is that the health plan had decided to only cover one specific NDC code for this medication, which is a generic.

Nobody knew that. My provider did not know that. I did not know that. The pharmacy did not know that. The PBM did not know it until they actually went into the health plan after, an hour and a half on the phone with the person, they went into the health plan and had seen  where I gotten this medication covered, accidentally when I was out of state, that they only covered that one NDC plan. That information was not stated anywhere for anyone to find. It was just an accidental discovery. NDC information would be a very valuable bit of technology or data that could be communicated to everybody involved that would have facilitated a lot of care disruption on my part and hours, I mean hours, of time and effort and stress and frustration. **[Inaudible – crosstalk] [00:29:29]**

**[Crosstalk]**

**Shelly Spiro**
Hans, this is Shelly. I would like to address what Deven talking about. I think it is important to realize that the dispensing for pharmacy is put in the middle of this. The dispensing functions is a very technical function and pharmacists do not have control over what the health plans or a PBM is doing in terms of how they want the benefit run. We have, through NCPDP, built a lot of safeguards in place to try to automate that process is much as possible. Pharmacists are looked at as the gatekeepers of this information and we are not. We are dependent upon the information that we receive from the health plans and the health plans change their formulary, sometimes on a moment's notice, based on when they have a pharmacy and therapeutics meeting, and decide what their formulary is, depending on the different health plan, whether it is an employer plan or a government plan. We are put in the middle on this aspect.

The technical portion of dispensing is not what we should be focusing on within this task force because we have put as much in place to help with the dispensing, including shortages, and prior authorization, in many cases real-time information instead of waiting months for a return because we know access to medications are very important to our patients. What we need to be focusing on, and what, Deven, you might not understand, as pharmacists are highly trained as doctors of pharmacy, to be clinicians in understanding the overall relationship to medications and the patient's body, their environment, and the other medications they are taking. That is the clinical aspect that we are trying to document and share with our counterparts of the care team. It is unfortunate that you are receiving these problems but, in my mind, this is not necessarily a pharmacy problem but a payer problem that the pharmacist has no control over in terms of access to certain medications to patients. We can help with those, and we do in many cases, but we are not in control of those issues.

**Anna McCollister**

I have great empathy for my pharmacist because they are on the receiving end from a lot of frustrated patients and they are in the middle. I am trying to think of what data and technology could do to make this work better. Rarely do I think it is the individual pharmacy with a few exceptions, like a general pharmacist. I think it is the pharmacy system. In my case, I get my stuff from Walgreens. That does not make any sense. Their distribution system seems to be somewhat mysterious and I just hope for some sort of serendipitous appearance of medication that was ordered that was supposed to arrive several days ago. Maybe the quality measures need to be placed on the PBMs or the pharmacy change in distribution centers or something like that because they are the ones that I see as one of the biggest barriers to quality care because they are making it so difficult for patients to access medications that adherence is almost impossible.

**Hans Buitendijk**

As we go through the conversation, these are examples where the experience, in this case of the patient, there is experience of the pharmacist, the provider, that things do not work from their end, as expressed by Anna and others in other contexts. I think what we need to try to distill from this conversation is that, where in the chain of information exchange and awareness do we find that there might be a gap that could help with that? At times we have talked about is it education? Is it awareness? Is it technology? Is it standards? Is it governance? I think they all can help to identify some potential recommendations. I appreciate the input there. Let us move on and we will keep that in mind as we go through what might jump out as specific things that we can ask ONC about. Going to Christian.

**Christian Tadrus**

Thank you, Hans. Very **[inaudible] [00:34:13]** to the conversation. Shelly covered a lot of comments that I was interested in making so I will leave it at that. From the pharmacist perspective, and this is just me sitting in my store in a small independent operator scenario, it is all of this stuff that we are dealing with. We are in the middle. The connectivity piece is interesting. What can we address? Let us put aside the concept of this siloed look at quality through a payer specific perspective and look at the situation around the quality of the pharmacy operation, which gets at how does the pharmacy handle all of their patients in their database, or all of the patients that choose to utilize that pharmacy, assuming they are not being steered around for other interests, payer interests. In that case, we should not really even, I do not want to be absolute about this but I think the better approach is to look at how do we recommend standards around

evaluating how a pharmacy looks at all of their patients and handles all of their patients by disease state, by patient care interests, by care team goal, risk stratification, things like that.

Standards that both data as well as policy approaches to value-based care make much more sense because in the end, while we do not live in this world now, it would be a better world if we treated all diabetics in every pharmacy the same way. The pharmacy had an approach to how they handle their diabetics. They had an approach to how they handle their hypertension approaches, just like clinical care is done in hospitals and in clinics, physicians' offices. That does not exist in pharmacy because of its very technical history of dispensing a medication, which is part of it, just like adherence measure is a part of value. It is unfortunately becoming a significant part of it but it is a surrogate marker right now and in its current implementation. The PBMs are designed to do the true quality look at the operations of how pharmacists operate clinically in addition to integration in a care team. To Shelly's earlier comments, the data pathways, the data standards, should look not so much at pushing us back and forth through a PBM but how you do it through more coordination care management.

What that looks like is pharmacies probably providing maybe even a different value proposition. What we see in our world as as healthcare professionals, we recommend a better approach and we take a unique approach to achieving the goal that is not as standardized perhaps, and is not maybe even defined by the health plan in a lot of cases, but gets the patient efficiently to that outcome. That to me looks more like how do we look at a pharmacy's process operations? What does the minimum dataset there look like, that would be indicative of the pharmacy having access to in some way, electronic or otherwise, but also then utilizing that data. I think we might want to think about value-based arrangements, not only from a payer perspective, but maybe from the provider perspective to help the patient get where they need to go. What does that build look like?

Because we would probably build it differently from the pharmacy side of the equation than we would from the payer side although both worlds have to exist. I think we can get farther faster if we figured out how to, it is a version of grassroots that is based on a more standardized approach to how the pharmacy would approach it, and see if that recommendation actually changes the old **[inaudible] [00:38:19]** over time where we have seen a lot of money over a lifetime trying to get a lot of quality to justify payment. We probably have not moved the needle that much. I am more of an advocate of let us ask the pharmacies how this might work and see what they could recommend that way.

**Hans Buitendijk**
I am curious in that regard, Christian, looking at the chat today, the comments made, looking at some of the chat Steven had, some of the comments that Shelly made when we started last week **[inaudible] [00:38:53]** about some of the measures. There is that overall theme of establishing a set of quality measures that looks at the performance and perhaps, in this context, pharmacist specific, pharmacy specific, pharmacists as part of the care team overall, value-based care as part of the larger team. I am wondering whether you might be able to with a couple of others offline to put an initial recommendation together on what should we suggest to focus on, which areas in particular, and what would ONC's role, in working with other parties to help advance that so that can fill in one of those foundational elements of the picture? You cannot manage what you cannot measure. Along those lines, that we need to have some insights that can then help further spur improvements all along the stack and as part of the care team as well. Would you be able to do that and start to pull that together and maybe others to join in with that?

**Christian Tadrus**
Yes. I am happy to assist with that. I do not know that I would be able to lead the thing but **[inaudible] [00:40:03]**. Thank you very much for the opportunity. Just leave it with this idea of the inefficiencies and what we see **[inaudible] [00:40:11]** is the policy, payer design, and lack of patient choice or ability to put the care team together in a way that allows the care team to work best for that patient. It is an artifact of our design of payment which is creating most of the inefficiencies that we see at the pharmacy level, and burdens. We will work to get access to data through standards design, of course, but that is really going to be this look back at, we are self-inflicting a wound here to be able to pull back from the approach a bit or at least ease it up so we can rewire so it will work. A lot of these things, to the earlier point that was made, in my world, I will reiterate over and over again, it is the payer directional movement of patients, primarily around a product distribution function rather than an expression of the pharmacists' ability to impact the overall cost spend. Policy wise, that has to be in place, that paradigm shift, for most of this stuff to work.

**Hans Buitendijk**
Thank you. Jim.

**Jim Jirjis**
Yes, thank you. I was just observing the conversation. It seems like recommendations we end up landing on ought to be grounded in well-articulated use cases for either how pharmacists participate today in value-based care or how we think they should. Because, at least in my experience, it could range anywhere from being an active part of the care team that sees patients directly, frequently, and adjusts medicines, and coordinates communication back with the physician care team, all the way to reviewing population data and identifying high-cost patients, etcetera, etcetera. It seems like conversations could get all over the place unless we identify use cases. That will help us determine where the policy, legal, technical, communication barriers are that could lead to more cogent recommendations.

**Hans Buitendijk**
Do you have any particular ones in mind that we should, based on the conversation that we have had, that might sound like higher priority ones we should focus on?

**Jim Jirjis**
Mine are probably going to be biased from a provider standpoint where we hunger for pharmacists who may be more conveniently located with patients to be part of the care team and seeing patients in encounters. What is missing from that, do pharmacists have access to the medical record, to HIE, for example. Do pharmacists have an ability to communicate asynchronously with the care team? I am not sure if, that is just one use case. I would love to hear from a pharmacist what other use cases are for participation in value-based care. My only point is that having a framework like that will help it be less abstract.

**Hans Buitendijk**
Good point. David, any comments that you would like to raise?

**David Butler**

Yes. Just to add to the conversation, this is such a huge beast, the elephant. We all see so many different sides and it is hard to touch all of it because there are so many issues. I had just four points to make that I think apply to that. Number one, we are dealing with an industry, a pharmacy, that basically, and this is an opinionated statement from me as a pharmacist, that we spent 75 years where the pharmacy is the final packaging step for pharmaceutical manufacturers. It is get into the bag to give to the patient. Get it into the bottle to get to the patient. For many of those decades, we were not doing anything to achieve a true counseling patient care aspect. Now, all pharmacists are trained at a doctoral level and the focus that I see as a use case is, and these next three points I am seeing as possible use cases. One is the pharmacist needs to be recognized as a revenue generator rather than the bottle being the revenue generator, the product.

This, as much as Anna was saying, that pharmacist sits behind that wall and is not accessible because the whole focus has been to get the packages out the door. It has not been fully successful at that. A rethought of how to show, find ways, and I do this. I made this in my comments on the side, of the need for some entrepreneurial aspects. The pharmacy is willing to do that redesigns and some of them have created these little counseling booths but they still have not put the pharmacists in them. They still have to go to those counseling areas. We need to rethink that and come up with a way to drive revenue into those counseling areas so the pharmacist is spending all of their time in there seeing patients rather than staying behind the counter and watching a team or viewing a screen. That's a significant area that needs a business focus to it.

The next point is removing the wall and that facility redesign, is that we have got to be able to use factors that the pharmacist can bring to the patient care and become personalized in the patient care. That is my final point. We have even had throughout many of these discussions, we say it goes to the pharmacy. We use the word pharmacy rather than the practitioner who is the pharmacist. There has to be a rethinking of a lot of the technical aspects to realize, and even to make it truly HIPAA compliant. I use that as the example. The pharmacist is the one who has to be HIPAA compliant, which means the pharmacist should be the one who is responsible for a specific patient, not another pharmacist unless there are procedures, pretty much as nursing, hands off from work shifts in the hospitals. There have to be procedures for other pharmacists to also be able to see the patient's data and other patients, or other pharmacy technicians to see that patient's data.

We need to think about that from the HIPAA viewpoint. We need to think about that from the interoperability viewpoint. Do we send information to the pharmacy or do we send it to a practitioner, pharmacist, in each of these roles? We need to start using those terms correctly and recognizing that it is, we are trying to talk about the pharmacist. It is never really the pharmacy that it goes to. Now, the final point in all of that is we are getting a further clouding of all of this in that, if you look at the industry, there is becoming a cloud in the sense that these practitioner groups are now becoming more and more merged. We have got companies out there, and you can look at any one of the big chains that are out there that are pharmacies, that are PBMs, that are health practitioners. They own medical clinics and they are our own health insurers. They have to health insurance side, the PBM side, the physician's side, and the pharmacist's side, and the PBMs side, all within one corporate structure.

So far, they have left in place most of the legal aspects that the states require for state boards but there is going to be a point where they begin seeing opportunities to merge and create new revenue streams for

themselves by overcoming the boundaries and they will begin to create more of that interactivity. We need to think about the interoperability from the viewpoint that we have still the independent practitioner as well as the chain that is no longer, or the corporation that is a longer just one practice. It is no one sub industry within healthcare.

**Hans Buitendijk**
Thank you. You raised a couple of interesting points there that are bouncing between business cases that may need to change, and then, in order to make that happen that there is technology standards, governance, otherwise to help enable that. I am curious as part of theme conversation how to we translate that from, some of those things into the use cases that we can build some recommendations around. David, if you have a chance to drop some of those in perhaps 2B already, in the progression that we can build on. It looks like value-based care is one of the use cases that evolved. I also see that, before going to Pooja, there was a comment that pointed to Shelly's statement about a use case. After Ike, I am curious whether, Shelly, you can provide more insight into that part of the chat. Pooja.

**Pooja Babbrah**
Yes. This has all been wonderful conversation but I guess my concern is we are getting outside, I think, the scope of ONC and the technology gap. We have talked a lot about business models, contracts, all of that, which is all definitely important but I think we need to be thinking in terms of what do we have in place today and what can we do from a technology standpoint. Two things I wanted to mention. NCPDP has a strategic initiative. They have been running around value-based care for the past couple of years. We talked about standards. We do know there was an analysis done that talked about what specific data elements are in the standards today that could be captured within the existing standards and shared back to a provider.

I can put some of these recommendations into the spreadsheet but I want to make sure that everyone knows there is some analysis that has been done and there are data fields including capturing blood pressure, other things, that could be a basis of what we start with in terms of recommendations. From a recommendation standpoint, though, I think it comes down to, potentially, certification. Who is being certified in order to share that information? That is one thing. I think the other thing that has come out, and I see Katie Russel and Kim Voigt commenting. There is the other piece, and I think Kim just put this in, credentialing. Pharmacist credentialing is another big piece of value-based care. I just want to make sure, and I think everyone has been making really good points. However, I think our, as a task force and what we are focused on, let us be thinking about things that we can immediately recommend because I am concerned that we are trying to boil the ocean here. Which, of course, is not a bad thing but we definitely want to get a little more focused, I think, especially in the recommendations.

**Hans Buitendijk**
Thank you, Pooja, for that point. Actually, we need to home in on what is it that we think that ONC can do to advance there. As you were talking, and some of the comments made, I put something in the chat that I am trying to figure out, are those some of the use cases that we seem to be talking about that we can organize some of the thoughts that we have. I see another one from Jim just popping up as well. That would be great, that we can anchor our comments, a lot of the conversations around standards and technology, how can each of those things advance in that space. Have a look at that. It probably is incomplete or incorrect here and there, but just to have something to look at. Ike, go ahead.

**Steven Eichner**
Thank you. I think a couple of points. One, we need to remember that patients are at the center of this equation, and from a value-based perspective it really needs to be the value of care to the patient and evaluating the impact of care on patients, not necessarily at the provider level, whether the provider be a pharmacy or otherwise. Really concerned about the idea of treating every condition the same in every pharmacy and the burden that would place on pharmacists in trying to keep up to date. I have got a really rare condition and about 300 people in the country have the condition. Trying to have every pharmacist educated on my condition is a large challenge. It is a lot easier and more efficient to have some specialty services and pharmacists with specialty knowledge going on in the same space to try to change a patient's relationship from having a relationship with a pharmacy to a pharmacist. It then puts a huge burden on patients in trying to potentially get things done in terms of looking at getting things dispensed and filled. Looking at counseling, obviously, that is a little bit of a different story. I work well with the pharmacist in my local grocery store when I have a complex question or a set of needs that goes beyond filling a particular prescription.

As far as coming back to the idea of what recommendations can we make to ONC to fill in technology gaps, if there is an existing gap in pharmacists having access to patient data, because they had a recurrent lack of technology in their facilities to access and process the data, which does have costs, one potential solution is to use technology like the patient unified lookup system for emergencies, PULSE, which ONC helped develop, which provides read-only access to patients' medical data via the World Wide Web for authorized users. This type of technology would help provide access to critical data for pharmacists without creating a significant, immediate additional technology burden for them to have access to the data. A computer, internet connectivity, and a secure browser, and an authenticated account is all that is really necessary to access that data.

That may be a concrete first step rather than trying to get all the way to the next planet. You may want to start with some incremental steps to get us to the moon first and providing some of that base level key services or access to key data might be a good first step and a good initial recommendation.

**Hans Buitendijk**
Thank you. Would you be willing to put that into one of the short-term?

**Shelly Spiro**
Before Ike does that, I want to address what I just said. The issue, what we are asking with that, and in many cases we do have areas where pharmacists can go out of their current workflow, go access some information, manually put it back into their system, which is what we call provider burden. In order to reduce that burden, we need to have the information electronically available to our vendors so they can work it into the workflow. What we proved with the work that we did with the pharmacist electronic care plan, of what Jake had talked about with the CPSN model, the Community Pharmacy Enhanced Service model, was that those pharmacists, no matter who they saw, no matter which patient they saw, they were able to document their information and their encounters with those patients in a very consistent way without leaving their own computer system and going to look for additional information.

This caused an increase in productivity which made those services more valuable. That is the type of model we want to have. What I tried to explain in the comments, of what you asked me to comment on, Hans,

which is dealing with the workflow. The workflow in an EHR current system that physicians use or hospitals use, which is encounter-based or problem-based, and we are looking to document the same way that a physician does is counter to how we are trained as pharmacists to look at the entirety of all the medications that the patient is on, coming up with assessments, interventions, and outcomes that will be useful for value-based models that we do not see in the current EHR systems. Unless the pharmacist is embedded in and using their own system that integrates with an EHR, like in a health system that we see, example, the VA, or we see in other types of health systems like Kaiser, or Intermountain, or Cleveland Clinic, we are not going to be able to get that taken care of.

When you look at pharmacists who are community pharmacists in the independent community pharmacy setting in rural and underserved areas, these pharmacists need to have access to multiple different systems to document within their own system. What you are asking for, what Ike is saying is, yes, the information. Go out and get it, whether it is with the patient. Then we have to enter it into our own system. This causes a lot of provider burden increased across the productivity of these pharmacists. We have a different workflow. We have a pharmacist patient care process workflow that is very different from other EHRs. It is very similar to, in a hospital system, if you expect the surgeon to document into the internal medicine EHR portion or module. If you ask the pharmacy in a hospital system to document in the electronic medical record that has an entirely different workflow. They end up doing double documentation. This is what we are trying to prevent by having electronic access to that data.

**Jim Jirjis**
Can I comment on that?

**Steven Eichner**
I would like to reply first very quickly. I was not suggesting that tools like PULSE would be the end state. It is, as I said, I thought, pretty clearly, an initial concept or initial tool that creates a first step that improves access to data for pharmacists that may otherwise not have a technology platform or immediate access while additional technology tools can be developed and implemented. The PULSE tool does not require any additional work to be developed for that purpose. It is ready. It is actually deployed in the real world today and could be readily utilized for that purpose. Again, not as an end state, but as one tool among several to provide an incremental step approach to get to the end state that you laid out. Thanks.

**Hans Buitendijk**
Before going to Jim, generally, there is this challenge where there is no connectivity, what is a good first step? At times it leads to this so-called swivel chair integration where you have to go from one portal to the next where indeed the intent is to move to less and less **[inaudible] [01:01:32]** comes together. Where that has an opportunity to at least get a starting point, it might not be for all, but it might be something for a number of, that could work. Jim.

**Jim Jirjis**
Thank you. I was just going to comment because I agree with Shelly that that is in fact in part what ONC over the last 10 years has been trying to do for providers. One EMR to another, goodness sake, the workflow that she described the pharmacists are doing with double entry is exactly what happens across the country with providers. Somebody in a clinic down the hall using a different EMR, we have to retype all of the meds and allergies, etcetera, in. What the ONC has done is created not only content but format

standards, transport standards, to allow machine understandable data to enter from EMR 1 to EMR 2. The EMR 2 can then use that information for decision support and reduce double entry. What I am suggesting is a lot of those tools have been created. The HITAC task force could take use cases and say, "Okay, what data do you need? What are they entering it in?" Then, we can utilize USCDI and a lot of these other tools to create regulatory standards to help facilitate that for the pharmacy side. It seems like that is the job of the HITAC task force recommendation in this space.

**Hans Buitendijk**
Maybe, to add to that based on some of the conversations, we have identified a number of existing technologies, networks, otherwise, PULSE is added to the list as another alternative to that with a different set of adoption characteristics and opportunities. Part of the conversation then comes back to yes, the technical standards are there, the technology is there, but there are other barriers, whether it is contractual, incentives, funding, governance, whatever they might be, that stand in the way of that actually happening. I think, as part of our looking at the use cases, having that multiple dimensional, are technical standards there? Yes or no? They might be. If they are, what are the other areas that could be addressed to help advance us given that we have already done it up to a point. We can do better but up to a point in other areas and take advantage of that. Going back to the comment that Deven also made, and we made over the last week as well with Mary Kay, that there are other barriers out there that we would like to understand that need to be addressed to advance that. Shelly.

**Shelly Spiro**
Yes. It is Mary Kay Owens, by the way.

**Hans Buitendijk**
Okay. Thank you.

**Shelly Spiro**
To address what Jim is saying, through the work that we did with the pharmacists electronic **[inaudible] [01:04:29]**, years. We have a good thousands of pharmacies who are utilizing the care plan to capture data in a very standard way, following how they are trained as pharmacists using the pharmacist patient care process. We have codified that data and made sure that the care plan is following USCDI. We have done a lot of work on a pilot level, very large pilot level, a national level, not just one state or in location, but nationally where we are driving the system vendors where pharmacists are capturing. Not every pharmacy have adopted it. Some of the large retail pharmacies have not adopted it. We do have use cases out there where it is working, were pharmacists can document in a very standard way, a highly codified way, where we can export the clinical documentation following USCDI data classes. I think **[inaudible - crosstalk] [01:05:39]** –

**[Crosstalk]**

**Jim Jirjis**
Shelly, is that something, that sounds wonderful because my understanding of how it rulemaking often works is it is a gift that is gold when there are pilots that are working out there and consensus is built, and the next step is the federal government helps take it to the next level through regulatory standards. Maybe that is one of the use cases that we select.

**Shelly Spiro**
Jim, you are right. This use case actually started out of an innovation grant out of North Carolina, Community Care North Carolina. It was extremely successful because they originally were documenting into a web-based portal that caused more problems. That is one of the reasons why we went to the care plan, to export data out that was very consistent no matter which patient the pharmacist was seeing and was able to document in a very consistent way.

**Jim Jirjis**
I will be quiet after this. I am just responding to her, Hans. To me, it seems like our suggestions earlier about grounding this in use cases because that lets us develop standards, implementation guides, etcetera, lets ONC develop them, that is a great example. What she just described could be a use case and the gift of there having been a pilot where people have worked on standards could be a wonderful starting place.

**Hans Buitendijk**
Perhaps on how to organize that, we currently have 2A, 2B, 2C that we went through. We have not gotten to 2D yet, but I will do that next week. It sounds like a sequence in which we are trying to put the recommendations together actually starts with a combination of 2B and 2C. Particularly, use cases on what we are trying to address in the direct communication between pharmacists and provider, or payer, or otherwise in the context of a care team, in the context of value-based care, measures around that. Within that, how can ONC facilitate that? Each of these use cases has a standards and technology, a governance, an incentive, other types of components to that to make it work. Some are already in place. Other ones need to be adjusted to make it fully work.

It sounds like we might want to switch it that direction and organize accordingly so that if we look at the spreadsheet we start with the use cases, we identify within those what can be done short-term, long-term, what aspects can be addressed with network-based exchange, queries, or otherwise. We organize it a little bit more that way to where we can, or that we say, "No, regardless of the use case, this is a foundational topic. This needs to happen across the board no matter what we do." With that type of organization of how we are starting to talk about health and as we progress further to put more specific recommendations in play.

**Jim Jirjis**
I think so, Hans. One question is, ONC had the authority with CMS to actually compel providers and incentivize them to adopt certified technology. How do we answer that same question on the pharmacy side? Are there levers? Would it just be developing standards that we hope people adhere to, consensus-based, or is there an opportunity to actually incentivize use of those standards?

**Hans Buitendijk**
Good question as to what are the parties that, beyond ONC, we need to include or reference that needs to be collaborated with to make those advances. Various ideas might exist. I will go to Shelly. Maybe she has, or others have, ideas around that.

**Shelly Spiro**

Yes. Jim, to answer your question in relationship to the pilot we did with the care plan that is still ongoing and very successful, as you heard Jake talk about, a million care plans a quarter just out of the CPSN network, which is just one network out of 3,500 pharmacies across the United States. It is a very viable model. We have approached ONC in the past and maybe one of the reasons why they formed this task force was we were having problems in getting our care plan counterpart, care team counterparts, to accept our care plan and to utilize the data. It is difficult you're your counterparts who already have certified EHRs are not willing to accept a FHIR-based care plan because they do not know what to do with it other than printing it off or creating a PDF and throwing it in a file somewhere that does not fit into the care team's **[inaudible - crosstalk] [01:10:20]** –

**[Crosstalk]**

**Jim Jirjis**
It is interesting because **[inaudible - crosstalk] [01:10:24]** –

**Shelly Spiro**
– with the problems that we are facing as barriers to some of these models.

**Jim Jirjis**
That is why I say we take the use cases but then we divide up into atomic capabilities. One, is access to information. Another might be communication back to EMRs. Another might be, we could begin to separate it out so we do not get bogged down. For example, FHIR may help us, it may be that many of the EMRs do not want a big care plan, like some urgent care EMR, but they might in any given encounter want to know that there is a care plan and hit it. FHIR, facilitated or brokered, would allow that EMR to access the care plan without necessarily having to stuff the whole care plan in every urgent care EMR the patient's seen. You see what I am saying?

**Shelly Spiro**
This is exactly why we are starting a new FHIR-based implementation guide for what we call a standardized medication profile, which is used for transitions of care, that has a smaller subset of data that would fit into what NCPDP is trying to do with the ADT. Once we know that a patient has a mission discharge and transfer information, that the actual documentation of information, including multiple medication lists, so that medication reconciliation can occur but other information that is medication related. We already have a project underway within NHL7 and NCPDP. We are in the process of creating the implantation guide that would go through a connection, we are hoping in January of 2024, and then also continue with a ballot in May of 2024 so we can begin to exchange medication related information during transitions of care that hopefully will drive this process.

**Hans Buitendijk**
Maybe just a comment there and then I will go to Pooja. There is an analogy that at times I am using is that it takes two to tango. That means, when we talk interoperability in particular we have at least two sides of the coin that we need to work with. The question I think that Jim raised, that is still relevant, there are things that currently in the scope of what HIT has done, what could be put into certification, what could be put in USCDI, etcetera, where ONC has direct opportunity. The interesting part of the relationship with CMS is the adoption of certified technology is where CMS, through payment programs, has the opportunity to incent

and encourage the adoption of what was billed. There is still friction between what is needed, what is not, can everybody do it, should USCDI be supported by everybody, etcetera, but there is that mechanism.

That question is also relevant if you look at the pharmacy aspect. What is that other party that can provide the appropriate levers, incentives, funding, whatever it might be, to enable everybody to advance so that both sides of the equation, if we just look at provider and pharmacy, pharmacy and pharmacist, that we have the opportunity to advance it? If we are only looking at what ONC currently is focusing on and able to move forward, we would not quite as easily get to the community and commercial pharmacists. What is that? What are those organizations? Where are those that can enable us to advance the ball because we only can go so far at times with industry momentum. Sometimes there is indeed a need for some regulations to help move that along. What would that be? I do not know what the answer is to that but if we only focus on one side of the equation, we typically end up building something and nobody will come, or not enough. Pooja.

**Pooja Babbrah**
Yes. This is more a procedural question, to be honest with you. It is sounding like we are landing on use cases. I am assuming that we still want to go and fill in the spreadsheet on recommendations. Are we thinking the use cases will come up as another tab? Maybe you do not even know this yet. I am assuming we can still keep moving forward with the spreadsheet as is and **[inaudible - crosstalk] [01:15:08] –**

**[Crosstalk]**

**Hans Buitendijk**
Absolutely. Fill in the spreadsheet. What I suspect may happen, but we need to talk through that, is that based on the conversation we may want to organize. As we did in Topic 1, we may organize the tab a little bit differently that we can identify what these main use cases are and within each one of those, the different aspects and then foundational topics above. That might be a way to organize but we need to play with that a little bit to see how the conversation went or whether we just stick with this organization. In which case, we can still enter the recommendations as, are they use cases to add or are they technology or standards or something else to add as a recommendation. The questions remain the same. The way we organize it might just flow a little different. Does that work, Pooja?

**Pooja Babbrah**
Sorry. I went back on mute. Yes. Absolutely. Thank you.

**Hans Buitendijk**
Okay. Yes. Until we have figured it out to stay with it as is or adjust the format a little bit, please add any recommendations in 2B, whether they are general use cases, clinical use cases in 2C when they are specific to the value-based care aspects that are above and beyond that, if you will. In a sense, that is another use case with multiple aspects to it. Question 2A so far is that where can ONC facilitate adoption of standards and support data for pharmacy-based clinical services that, really, for some of those use cases, if not all, are going to be underpinnings to make them happen. We are with about three minutes up to the public comment period of time and we have been able to have this discussion and conversation without having to look at time, agenda, topics to change, or whatnot, which has been great.

Now, we suddenly ended up in a little bit of a lull of two minutes spare before we go to public comment. Are there any other thoughts right now or would be good that we go to public comment? There might be, based on the chat, some on the line who would like to make some further suggestions or comments as part of that. We can go there and then we will wrap up after that with any remaining thoughts and next steps. Any final thoughts before we pass it back to Mike for public comment? Not final, final but, okay. Mike, then I think we are passing to you for public comment and we will go back after that with any additional thoughts that might have come up from that as well.

## Public Comment (01:17:56)

**Michael Berry**
Yes. Sounds great. Thanks, Hans. As Hans said, we are going to open up our meeting for public comment. If you are on Zoom and would like to make a comment please use the hand raise function located on the Zoom toolbar at the bottom of your screen. If you happen to be just on the phone only, press star-nine to raise your hand, and once called upon, press star-six to mute and unmute your line. Let us pause just for a moment to see if any members of the public want to raise their hand. Not seeing hands raised so I will turn it back to you, Hans.

**Hans Buitendijk**
All right. Thank you. In that case, we have another nine or 10 minutes to continue the conversation. Are there any other thoughts that we have related to today's 2C topic, where we particularly focused on the value-based care? Any additional thoughts to add to the discussion? Anything related to 2B, as well? Any use cases? From the chat, we have quite a few that we can blend together, whether it is a list about three or four, or eight or nine. We need to work through that. Any additional wants that have not been raised that you wanted to clarify? Anything around 2A? Okay. I will take quiet as not at the moment. Maybe, Shelly, before we start to close out the meeting, maybe one more comment on Topic 1, on progress made and that we are still looking for suggestions there as well?

**Shelly Spiro**
Let us go back to the spreadsheet, if we can, for the last 10 minutes.

**Hans Buitendijk**
Do want to go to Topic 2 or Topic 1?

**Shelly Spiro**
I will leave that up to you, Hans, where you have been following this closer than I have. I will leave it up to you, where you think we need some efforts.

**Hans Buitendijk**
On Topic 2, from the chat, we noted Deven has some thoughts. David was going to add some. We have a couple. Ike was going to add some. We have some notes there on starting points for recommendations. I think we also have for you, Tricia Lee, and myself, that we want to, based on the conversation, look at is there a better way to organize it to further put everything in context and then pull it together. I think that is where we sit on Topic 2. On Topic 1, we know we have a number of subgroups that are in progress. If you have not met yet, please do so and provide your suggestions as updates. If you have, then they should be there on the Tab 1. Next week, we would go to 2D, if I am not mistaken. At which point in time, we want to

make sure that we have any of the suggestions you have made and you would like to forward as a recommendation, even as a draft. Please put that in the tab, Topic 2 recommendations that can help us further organize and focus the discussion next week. Shelly, do you have any other comments, or anybody on the line?

**Shelly Spiro**
I just want to make it clear, in terms of what D says, which is addressing drug inventory transparency for prescribers and consumers, which is a lot what Anna had talked about earlier. Again, please realize that pharmacies' hands are tied in many cases to this issue. I think some of these recommendations might have to go to the health plans, the MCOs, the ACOs, who are creating the situation where a prior authorization is needed. In terms of technology, we have already put in place electronic prior authorization for pharmacy that is different from a medical prior authorization. The electronic prior authorization, in terms of the NCPDP standard, is real-time, which makes the access to the medications a lot faster. There is no inclination that the government has to address that because, again, most of the models that have built around medications are in relationship to reducing overall costs not necessarily improving the care and quality of the patients' care using those medications.

This is where we see a lot of the problems that occur. There might be a prior authorization that the pharmacy might be noticing of but it still requires that physician or prescriber to complete the prior authorization. We are not, in some cases, aware of what that prescriber has done or where it is in process or the cycle of that electronic prior authorization. We see different models in the long-term and post-acute care setting where the facility is separate from the physician or prescriber, separate from the pharmacy, that causes another issue of this communication for electronic prior authorization and the transparency that prescribers and consumers need. That is one of the reasons why NCPDP has put out formulary and benefit, and also through HL7 consolidating with real-time pharmacy and benefit information to the prescriber so they are more aware of what that patient's benefit does cover where prior authorization is needed.

I think we have addressed a lot of these issues. I do not know if it is necessarily entirely in pharmacies' court. We are a participant in these issues but we are not that responsible problem. We are not responsible for the problems that are occurring but we are looked at as responsible for the problems that are occurring.

**Hans Buitendijk**
We have two hands raised. We will go to Anna and then to Ike. Then, I think we are at the time, at the end of the meeting. Anna.

**Anna McCollister**
Yes. I just wanted to emphasize to Shelly, and everybody, I do not need to be dissing on pharmacists. I realize, my local Walgreen's has had such turnover because people are so frustrated. They were forced to then do immunizations but they were not given additional staff. I complained to Walgreen's corporate, not to the pharmacist themselves. I empathize for the issues. I do think the problems lie in health plans and PBMs and would love to see the government give more oversight there. I put in the chat a couple of different things that I think could be basic data elements that would be helpful in at least illuminating where things are for both the pharmacists and patient. One of my big issues has been on supply chain and access. I order different medications, or the pharmacist orders them on my behalf, and maybe they come, maybe

they do not. They say when they order them that they should be in by the next day, by 4:00 p.m., and sometimes that happens. More often, it does not and it goes on for days, if not weeks.

With some medications, with absolutely no insight into what the issue is. Is the distributor having an issue? Is it stuck in a UPS truck somewhere on I-95? Nobody has any insight and that seems to me to be something that could be solved with data and technology, given the fact that lots of companies use very detailed tracking of shipping and inventory. Another suggestion is that one of the great mysteries that I seem to confront every time I require prior authorization, is the doctor says they have not received the form from the pharmacist. The pharmacist swears they sent it a number times. The doctor says they sent it in and the pharmacist says they have not received it.

Likewise, with the PBMs. All of that process has to be mediated by me. Everybody is saying they have done their thing but they have no idea whether or not, whether it is the PBM or the pharmacy or whomever happens to be on whatever end of the PA process has seen the data or received it, etcetera. The person stuck in the middle of coordinating all of that is the patient. That just is, it is difficult to articulate how burdensome and frustrating that process is because everybody claims to have no insight into what is wrong and they claim to have done what they need to do. It is maddening. That feels like something that could be handled with data and technology.

**Hans Buitendijk**
We are running short of time. Thank you, Anna. We have two more comments within a minute and half. If you can keep it short, that would be great and then we will pick it up further because 2D is also next week. Ike.

**Steven Eichner**
This may be of basic question, or basic problem, but I wonder if a recommendation you might make is to produce a systems model, not on the technology side first, but from a systems model, how do pharmacies and PBMs fit into value-based care from a systems thinking perspective? Then, look at that to drive where technology needs to support connectivity within the system. Just to help us make sure we have got all of the players that need to be included, included.

**Hans Buitendijk**
Thank you, Ike. That might be a good consideration for one of the foundational topics. I see that Jim also joined the queue.

**Jim Jirjis**
Yeah, I **[inaudible - crosstalk] [01:28:47]** –

**[Crosstalk]**

**Hans Buitendijk**
Hold on, Jim. Pooja first, and then Jim if we still have time because we are just about to run out.

**Jim Jirjis**
I will type it in the comments.

**Hans Buitendijk**
Oh, great.

**Pooja Babbrah**
Yes. Just 30 seconds on this, the big problem with PAs, the specialty meds. I think we have the topic coming. I also think it is important to bring to this group probably an understanding of price transparency as well on the pharmacy side because I saw some questions on that. Just throwing that out to the group, that we should probably do a quick what is happening with price transparency, at least on the pharmacy side, not the medical side.

**Hans Buitendijk**
Right. Thank you. Next week, we will have D on what can ONC do to address inventory transparency for prescribers and consumers, where some of these topics can come right back. We have not completed that and if you have in the meantime any particular recommendations, thoughts, suggestions on anybody to invite to get more clarity and insight, please forward, either into the spreadsheet or directly to Shelly, Tricia Lee, or myself, or combined, to put that in the hopper. Thank you very much for today's discussion. Very lively. Lots of thoughts and ideas around opportunities there. Looking forward to the continuation of that conversation next week. Shelly, you may close the meeting.

**Shelly Spiro**
Thank you very much for attending. We will see you next week.

**Hans Buitendijk**
Thank you.

**Shelly Spiro**
For those who are interested, we will be presenting at the HITAC meeting tomorrow.

**Hans Buitendijk**
That will be a summary of progress to date. No final recommendations being discussed there, just progress.

**Shelly Spiro**
Thank you, everyone.

**Hans Buitendijk**
Thank you.

## Adjourn (01:30:39)