ONC | HealthIT ADVISORY COMMITTEE

Transcript

PHARMACY INTEROPERABILITY AND EMERGING THERAPEUTICS TASK FORCE 2023 MEETING

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VIRTUAL

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

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, and welcome to the Pharmacy Interoperability and Emerging Therapeutics Task Force. This Task Force meeting is open to the public and your comments are welcome in Zoom chat throughout the meeting or during the public comment period that is scheduled around 11:50 Eastern Time this morning. I would like to begin rollcall of our Task Force members, so when I call your name, please let us know if you are here. Hans Buitendijk?

Hans Buitendijk
Good morning.

Michael Berry
Shelly Spiro, our other cochair, is not able to join us today. Pooja Babbrah?

Pooja Babbrah
Good morning.

Michael Berry
Chris Blackley? Shila Blend? David Butler?

David Butler
Present.

Michael Berry
Steve Eichner?

Steven Eichner
Good morning.

Michael Berry
Raj Godavarthi? Adi Gundlapalli?

Adi V. Gundlapalli
Present.

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, everyone.

Michael Berry
Good morning, Deven. Ketan Mehta?

Ketan Mehta
Good morning.

Michael Berry
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
Good morning.

Michael Berry
Sheryl Turney?

Sheryl Turney
Good morning.

Michael Berry
Afton Wagner?

Afton Wagner
Good morning.

Michael Berry
All right. Well, thank you so much, everyone. Now, please join me in welcoming Hans for his opening remarks. Hans?

Opening Remarks & Recommendation Drafting Example Review (00:02:12)

Hans Buitendijk
Good morning, everybody, and welcome to this session. We are about halfway, give or take, and when we look at the agenda, we see that we will spend a little bit of time on Tasks 1 and 2 in particular to review the recommendations that have been made or that still could be made. Next week, we will continue with the specialty medicines and topics there to round out Tasks 3 and 4. I will be off video today. I apologize, but I am in a setting that is not very conducive to using that. I am on my own today. Shelly unfortunately could not make it, as she has another session, so let me know if I go astray somewhere or need a quick nudge as we are trying to drive on through this and make sure we stay on point and target. Do not hesitate. So, with that, I think we can start to jump in and go to the next slide. Okeydoke.

So, if it is possible to display the spreadsheet, I am going to walk through a little bit of the work that Shelly, I, and others have started to progress on formulating more final recommendations, though they are not completely final. I am going to start with Topic 1, and we are going to concentrate on Columns D and E, a little bit further to the right. If you could display both, it would be great. Through our discussions, we have developed a number of topics in Column A, though you do not need to go back, and then we started to address a series of questions in that context. Column D resulted in a number of draft recommendations from across the Task Force, and what we started to do is copy them into Column E, look at where there are similarities across some of the recommendations, try to combine them, and try to look at where other comments later on that were already in the draft recommendations were actually already addressed or, with some adjustments, could cover multiple rows.

So, what you will end up looking at in Column E for Topic A reflects everything we believe we have reasonably addressed from the comments in Column D. We have indicated in a number of places where you see your name that might state that there is nothing behind it yet, that is not covered yet, that we still need to pick up, or that we might have a question asking you to double-check that we got it covered. We think we did, but we might not. So, you can use D to make sure we got everything complete. I know there are a couple things in Column D that have been added that we did not copy into E yet. For example, if you look in D2, a little bit below, at Anna's comment and recommendation, we have not yet had a chance to move that into E. There might be a couple other ones like that along the way where others added comments after we already jumped into Topic 2.

So, for today, what we wanted to do is focus on E, start to go from the top, and get agreement and consensus around the recommendation and the rationale. We are not going to try to get into the wordsmithing, but if somebody would like to volunteer to do a little bit of further wordsmithing in some of

these, that is more than welcome after the sessions, since we do not want to have too many people in Column E right now. I will go in there in a second and make notes.

Look at if it is providing the intent of the recommendation and if we are comfortable with that from a consensus perspective. We will not vote on that per se. We are primarily going to go by concerns that people bring up, and if we can address that, we might adjust it or we might be able to reflect different perspectives in it. Along the way, I will be calling on names wherever possible or reasonable, or if you are already ahead of me, maybe you can volunteer. There is a little bit more work to be done, so please do so so that we can work through this as rapidly as possible. Before jumping in, any questions at this point in time? Then we will start at the top. Is there anything we need to address?

Tricia Lee Rolle
Real quick, Hans, would you like me to do any real-time edits, or just capture notes separately for us to address later, or would you like to do real-time edits, just so we are not both writing over each other?

Hans Buitendijk
Let me do real-time edits, and you can make notes in Column F or wherever. Then, between the two of us, we can catch it all afterwards, and we will pick up whatever was still left in Column D as well.

Tricia Lee Rolle
Perfect.

Task Force Recommendation Drafting: Task 1 and Task 2 (00:08:11)

Steven Eichner
Hans, this is Steve Eichner. As part of transitioning and going into the detail, one of the things I noticed is that we are not consistent about differentiating or aligning our terminology between pharmacists, pharmacies, and other healthcare providers. Under the 21st Century CURES Act, pharmacists and pharmacies are considered providers. That is something that, again, I noticed it from an endemic piece that we want to have consistent language throughout.

Hans Buitendijk
Good point, and since we are tasked with working on pharmacies and pharmacists particularly, we need to make sure that we do that. Is it acceptable for us to say we use the term “provider” for non-pharmacists and non-pharmacies, and then we use “pharmacist” and “pharmacy” either together, both, or one or the other, where we are particularly calling out the pharmacy, the pharmacy and pharmacist, or the pharmacist, so that “provider” has the non-pharmacist and non-pharmacy. Is that a reasonable way?

Steven Eichner
I want to interject real quick. Because the law and the regulations used incorporate “pharmacist” into “provider” in the 21st Century CURES Act, I would suggest that if you want to refer to healthcare providers other than pharmacists, you probably want a term other than “providers.”

Hans Buitendijk

Are we okay to use "clinician," then, or is there another term that we are comfortable with? It also drifts into the same kind of thing as whether we are referring to an individual professional or an organization. Is there any preference from anybody? Because of our context, we have to separate the two for this purpose.

Steven Lane
"Provider" clearly has a definition in regulation. I do not know if "clinician" does.

David Butler
This is David Butler. Speaking as a pharmacist, I consider a pharmacist a healthcare provider who is also distinct and separate from the facility, which is the pharmacy, as a practitioner in a hospital would consider themselves separate from the hospital. Even though the names sound very similar, a pharmacist can practice independently of a pharmacy.

Deven McGraw
Why can't we just have an overarching thing at the top that says when we use the term "provider," we are talking about providers that are not pharmacists or pharmacies? We really have several recommendations in here that are intended to apply to the provider community that are not pharmacists and pharmacies in terms of exchanging data with pharmacists and pharmacies, so I worry about sub-picking within that group. Isn't it a much better idea to use the term "provider" and just make sure that, right up at the top of all our recommendations, we are clear that when we use that term, we do not mean pharmacists or pharmacies?

Hans Buitendijk
I would support that because in this context, we do need to somehow get a reasonable term for each of the three, and then we can point to one, the other, or all three in combination.

Pooja Babbrah
This is Pooja. You cannot have "pharmacy and pharmacists" in all of these because sometimes they are exchanging data and certification-related recommendations are going to apply to the pharmacy versus the actual pharmacist, so I want to make sure we are not combining "pharmacy" and "pharmacist" in everything.

Hans Buitendijk
Any objection to Deven's suggestion?

Steven Eichner
This is Ike. Just as an observation, because things like 21st Century CURES Act include pharmacists in their definition of "provider," that is a place where things might need an additional explanation because there is an internal conflict.

David Butler
I agree with Steven.

Hans Buitendijk
Maybe what we should do is then ponder this a little bit more because we are not quite immediately able to do it, we recognize we need to do it, and then we will come back to that and find the right word. Any suggestions are welcome. We have some hands up. Christian, go ahead.

Christian Tadrus
On the terminology, there is another piece to tease out. As an example, in the pharmacy regulatory world, we are often dealing with the situation where pharmacists are providing more traditional dispensing type of activities and not engaging in, say, clinical services, so we sometimes have to put modifiers on the word "pharmacist" to tease out authorities that may have to engage. It may be a word like "authorized provider," "authorized pharmacist," or "credentialed pharmacist" versus "pharmacist." It is another nuance where we might find a modifier that can differentiate pharmacists acting in different capacities, one that may be more facility-based authorized activity or default, and then, one that might be either disconnected activity, independent practice authorities, or what we would consider more clinical in nature and requiring scope-of-practice authorizations, but are not the dispensing activity. So, that is something to think about as we figure out how we are going to define that, but pharmacy regulatory speak might be helpful here.

Hans Buitendijk
David?

David Butler
Is it possible to just make it exclusionary in stating that the pharmacist is the provider within a pharmacy system, the pharmacy is the facility, and non-pharmacist providers would be all of those outside of those two sets?

Hans Buitendijk
It would make it a little bit longer in a couple places, but it would be precise. Jim?

Jim Jirjis
Sorry, I had to get off mute. It does not sound like that would meet it because to say "pharmacy" versus "pharmacist" versus "non-pharmacy provider," what I thought I heard was that there are pharmacy providers as well, so if we use those three, how would we distinguish between pharmacists who are not engaged in these clinical activities versus pharmacists who are doing the standard pharmacy work?

Hans Buitendijk
I suggest that we put this on the side, that we look at how we can do this, recognizing that there is language in the various laws, but that for this document, we need to somehow be able to address three different aspects. Where we can use definitions that are also used in law, that is great, but if it makes it harder to distinguish the non-pharmacies/non-pharmacists from them where we currently use "provider," we will have to come up with an approach to that. So, let's table that for now and come back to it. In the meantime, if anybody has suggestions, it would be great if you could put them in the chat. Okay, let's go back to E2 on the spreadsheet. Tricia, hopefully you are in there. There we go. So, we know we need to resolve that issue, but putting it aside, look at E2. For the first recommendation, I already picked up Ike's typo. Any general thoughts that we are not going in the right direction with that recommendation, that we are missing something? As you go through it on the rationale, Ike is making a suggestion to add medications to it, and I suspect, Ike, that you would be advancing the prescription and medication along those lines.

Tricia Lee Rolle

Hans, it might be helpful to read the recommendation in case there are members that are not online to view the screen or have some type of audio only.

Hans Buitendijk
So, the first recommendation reads, "Recommend that ONC engage both the NCPDP and HL7 standards development communities, including pharmacists and providers **[inaudible] [00:17:30]**, to advance the needs of pharmacies/pharmacists collaborating with providers to advance integrated care and delivery through enhanced funding, accelerating progress in the public health space." I am just going to change this. That is the recommendation. I am just making a couple of little adjustments there to make it better. Any other thoughts there, or are we okay for now and can just do a little wordsmithing later?

Scott Robertson
Hi, this is Scott. The second concept in that statement of enhanced funding just seems to be sort of tacked on. There is the work for enhancing integrated care delivery by engaging the standards organizations and the professionals, but then, HL7 and NCPDP really do not directly impact advancing funding. I do not know if that is an issue. I am just realizing that it is almost two different ideas, but if it works, that is fine.

Hans Buitendijk
The intent was for ONC to address the enhanced funding and work with both to advance and accelerate. So, perhaps splitting the sentence and making that part clearer that it is ONC being asked and suggested to consider funding and accelerating the progress working through these two organizations. That was one of the pointed parts of this, that there is some funding going on, but NCPDP is a critical party to help advance this space as well. Shall we split that up and wordsmith it a little bit more? Do you think the intent will then be there, or is there a fundamental problem otherwise?

Scott Robertson
No. I think if we split the sentence, it will be clearer. I see some things in the comments. Should public health be mentioned in the first half, along with the integrated healthcare delivery? I could take that as Task 2, just to provide a revision.

Hans Buitendijk
Thank you for volunteering that. That would be great. We will put your name next to it. Pooja, you have your hand up.

Pooja Babbrah
I think it is important to keep that in there. I think the intent of this was to make sure there is equal funding across SDOs. I agree that we just need to be clearer about it. We want to make sure this stays in from a funding standpoint, but I agree. I want to make sure we are not taking this out because it is an important aspect.

Hans Buitendijk
Okeydoke, thank you. Any other general comments there, or specifics? Scott will pick everything up, particularly related to rationale. Ike, can you clarify whether that is indeed only advancing the prescription and medications or if you had additional thoughts there?

Scott Robertson
Well, I will just make a suggestion on revising the recommendation. I will make sure the rationale actually supports both sides, but I am not seeing anything overtly missing.

Hans Buitendijk
Anybody else? I am going to adjust the statement by Ike and see whether this is what was meant. If not, Ike, if you could further clarify that, that would be great.

Steven Eichner
I think we are good.

Hans Buitendijk
Then let's move to the next. "Recommend that ONC work with the pharmacy, pharmacists, and public health to indicate organizations, including CDC and STLTs, to provide education, awareness, and, where needed, further policy guidance to pharmacies and pharmacists regarding submission of case reports, immunization data in particular," which is bidirectional, coming from Ike, who put that in, "laboratory results reporting, syndromic surveillance reporting, and other data required by PHAs and supporting standards available to report this information to comply with current reporting requirements." That is a pretty long statement, so I would suggest that we split this up, at least.

Steven Eichner
There is probably a little more wordsmithing to be done, just on tenses and the like, but that is not critical at the moment.

Hans Buitendijk
Okay. To clarify your note here, if we put "bidirectional immunization data sharing" in there, would that clarify better what you are looking at?

Steven Eichner
It may need a little additional restructuring, but the idea here is that not all information exchange with public health is unidirectional.

Hans Buitendijk
Correct. Do we want to make that statement generally, not just for immunization?

Steven Eichner
That would be fine. Again, my point was to call attention to… Yes, Jim?

Jim Jirjis
I would advocate that we make it broader than immunization because I think some of the potential strategies are to be more creative with bidirectional sharing, so I would be in favor of being less specific about immunization.

Hans Buitendijk

It is listed currently as part of it. So, case reports, immunization, laboratory results reporting, syndromic surveillance, and other data required for PHAs, so we are not limiting to immunization, but we can make the bidirectional aspect applicable to all.

Steven Eichner
Applicable where it is appropriate or where it is time. Again, the point is "bidirectional where supported" or something in that space. I am perfectly happy with that. My primary goal is to make sure that bidirectionality is recognized because there are benefits to pharmacists in being able to access IIS data as they are administering vaccines, even outside of a physician's order, per se. At least in Texas, I think pharmacists would have access to ImmTrac, our immunization registry, so they could help determine whether an individual needed an immunization or not.

Hans Buitendijk
Okay. Other comments here? Ike, would you be willing to do a little further wordsmithing based on this so we can clarify that?

Steven Eichner
Gladly.

Hans Buitendijk
Okay, we will put your name behind that. I stuck in a little note here to include it where applicable across the board. Any comments on the rationale? Is that sufficiently capturing the key points? I note the adjustments that Ike made. I will accept the first one. Any other thoughts? Let me check for hands raised. There is nobody at the moment. I am picking up on Ike's second comment as well. Any other suggestions, or do we feel that this one is reflecting our discussion? Okeydoke, we will be back if needed or make notes. Otherwise, we are going to go to the next one.

"Recommend that ONC initiates a collaborative initiative with the patient, pharmacy, provider, and public health communities, including CDC and STLTs, to prioritize use cases focusing on pharmacists' needs to access patient medical records, help patients and providers as part of the care team after emergency use interventions as well as during normal operation, access by providers to a patient's medical records held by pharmacists, and access by public health to records held by pharmacies." We need to take Ike's earlier comments around public health organizations and clean that up, and in the first statement, we are probably missing "pharmacists." Then, "Follow up by identifying appropriate relevant data sets, such as those kept using the Pharmacist eCare Plan in their communications with payers for these use cases to ensure the right amount of data is shared for the use cases at hand. Not too much, not too little." That last part might not be necessary. Thoughts?

Steven Eichner
Hans, we can probably simplify the language, again, looking here at "bidirectional exchange." Simplify that.

Hans Buitendijk
So, collapse the three excess dots by just doing it to the first "bidirectional access between"?

Steven Eichner

Yes, and then include all the relevant parties.

Hans Buitendijk
Right. We can do that.

Alexis Snyder
Hans, it is Alexis. I had my hand up, but I guess I will just jump in at this point.

Hans Buitendijk
Go ahead.

Alexis Snyder
I had made comments on the document yesterday in red that do not seem to be there now in regard to the piece that says "after emergency use intervention as well as during normal operation." We had spent a lot of time going back and forth in the past about having consent from patients outside of emergency use to have access by the pharmacist to medical records. I do not know where my comments went, but I did have one after the "as well as during normal operation," considering putting in something about "with patient consent." And then, again, on the line… Oh, it just jumped, so now I cannot see it. There we go. Again, where it says "access to the medical records by the pharmacist," we should also put in "with consent."

Hans Buitendijk
There might have been a comment if you go to Column D for a moment, next to Topic 1. I am looking for your comment there, because I have seen it, and I thought that we combined it with other consent statements. We can obviously include it in here as well, but there are a couple other places where consent is specifically called out more extensively.

Alexis Snyder
It looks like the comments were deleted, or I would be able to see them.

Hans Buitendijk
I am not sure what happened there.

Steven Eichner
This is Steve. To augment that, I would go so far as to say that the consent needs to be clear from the patient perspective as to what they are consenting to.

Alexis Snyder
I agree.

Steven Eichner
Oftentimes, consents are buried so deep in a 22-page agreement that you do not really know what you are agreeing to.

Hans Buitendijk

So, we will look at that, see what happened with that, and pull it back in. Alexis, I probably will follow up with you because I am pretty sure there is another place in Topic 2 where consent is coming back and some additional comments were made so that we make sure that both of them are aligned and not too duplicative. There we go. I will get to that. I will find that. Other comments on this one?

Christian Tadrus
Hans, this is Christian. I have a comment.

Hans Buitendijk
Go ahead.

Christian Tadrus
It does relate to the consent conversation. To pull it back up to a high level and explain a little bit about what we see in the clinical space in pharmacies today, the consent obviously is part of our process to engage with the patient, but the incentive and/or push for awareness to engage, usually from a contractual standpoint, is usually driven by a payer scenario, where a health plan may have performance goals and metrics for their business models. They contract with pharmacies or build it into their payment arrangements that they must do certain types of clinical interventions with the patients, and they will typically produce a panel and/or case work for them to pursue. The pharmacists are then compelled, in some cases, to ensure reimbursements are proper with their cash flow arrangements, or, from a performance payment model, then have to reach out to the patient and engage.

And so, the concept of permission linked to the patient's requests often may be somehow pushed around or implied by a contractual arrangement with the payer, and we have to somehow figure out how to ensure that we are capturing that in our ecosystem. Where that comes down into play is, as a pharmacy, I have a dispensing contract around a Medicare Part D plan with a business, for example, and by default, it comes with expectations of engaging the patient for these health and wellness outcomes somewhat independently of but as an extension of the health plan arrangement. Permission may be given or may have to be given through the health plan's arrangements for engagement this way, and so, it becomes somewhat repetitive, then, for the pharmacy to also have to ask that same permission at the pharmacy counter, for example, or if the patient gives permission at the pharmacy counter, that is not as portable.

Thinking through this at a higher level, we need to understand that it is not just a provider, meaning a pharmacist, and a patient exchanging information to do this. There is a somewhat different type of forced push-together scenario that comes through the payment arrangements that are disconnected. They are really tied to product distribution at this point. In the future, we hope they can be separated. We just have to recognize that when we are thinking about this with the big picture because the payers change the dynamic a little bit. I think it may be a little different than what we see on the medical side of the equation.

Hans Buitendijk
Any particular recommendations or updates that you see for this section, or do you believe that an additional one would be needed to clarify that to drill down a little further? Do we have some suggestions for that?

Christian Tadrus

I think it comes down to what I put in the chat, for example, "unless otherwise authorized through law or declared emergency," but we could probably generically talk whenever we have to bring this up about consent from wherever consent is provided and not revoked as a general concept. So, if a payer provides the evidence of the consent, the patient and pharmacist can engage, and the patient should not have to re-consent because they have already consented through somebody in their care process for that type of activity. That is the key thing that we have to dial in. And then, it will be less confusing for patients and even for our group here. The patient could have 17 different types of consents out there that do 17 different kinds of things. That is not going to solve any problems.

Hans Buitendijk
Okay, so we will take your comments and Alexis's comments that we pulled from the history collection that we can pull together into this and include that.

Christian Tadrus
Thank you.

Hans Buitendijk
Thank you. We are using raised hands, but I am jumping on a laptop between two screens or windows and can only see one at a time, so that makes it hard at times, so please keep me honest if somebody wants to **[inaudible] [00:37:12]**. Any other comments on the rationale? So, we have some updates to do on the recommendation, collapsing the bullets a little bit more, streamlining that, making it bidirectional, adding in the thoughts and notes on consent, that it needs to be done in a consent framework, as discussed with notes from Alexis and Christian, both from prior notes and in the chat. Any comments on the rationale? We probably then need to add some of the consent discussion into that rationale as well. Alexis, if you have any additional thoughts there, that would be great.

If there are no other comments there, then let's go to the next one. "Recommend that ONC establish a learning collaborative to explore the uses of privacy-protecting record linkage, PPRL, by different federal agencies, programs, and others on how standards for PPRL use can be implemented and leveraged across surveillance, research, and other national priorities." This was based on a comment made by Eliel. I am not sure whether Eliel is on the call. I do not think I saw him.

Alexis Snyder
Hans, this is Alexis. I would suggest that we also put "patient/caregiver," not just "patient."

Hans Buitendijk
Okay. Is that for this particular one, or are you looking back at the prior one?

Alexis Snyder
No, the one that you just read.

Jim Jirjis
Can I ask about that one real quick? We are talking about notification, if I am understanding this correctly. The notion here is that data may be transmitted to federal authorities, and if by "linkage" we mean the ability

to identify that we are talking about the same patient but still have it be deidentified, how does the caregiver fit into that?

Alexis Snyder
I do not know if we are in the same place. I am talking about the one that Hans just read, about the recommendation for a collaborative initiative.

Hans Buitendijk
I am trying to find the word "patient."

Jim Jirjis
Yes, we are talking about the same thing.

Alexis Snyder
"…is initiated with patient, pharmacy, pharmacist, provider, and public health organizations."

Jim Jirjis
Maybe we need to clarify what we mean by "linkage" because with my understanding of linkage, for deidentified, how do we make sure data coming from different sources is still linked to the same patient, while maintaining deidentification?

Alexis Snyder
I think we are talking about two different things. Maybe I am not reading the recommendation clearly enough, then, so maybe we need to fix and wordsmith it. To me, it is talking about setting up a collaborative initiative that includes patients, pharmacies, and pharmacists. So, in the initiative, that also should include caregivers, especially when we are talking about pediatrics.

Hans Buitendijk
I think we are talking about two different recommendations.

Alexis Snyder
That is what I just said before. You read that one, that was the one I commented on, and then Jim referenced a different one, so we are talking about two different ones.

Hans Buitendijk
We already read the last one on there, and that is why we got confused. The one I just read was "Recommend that ONC establish a learning collaborative to explore the uses of privacy-protecting record linkage, PPRL," etc. That is after the one that I think you are talking about that starts with "Recommend that ONC initiate a collaborative initiative with the patient, pharmacy, pharmacist, provider, including CDC," etc., and that is where you suggest putting in "caregiver."

Alexis Snyder
I think "caregiver" needs to go in both. Any learning collaborative would need to include caregivers as well as patients.

Hans Buitendijk
So, in the last one, "Recommend that ONC establish a learning collaborative," we are not indicating yet who should be part of that, so the question is if we should list the same list.

Alexis Snyder
Yes, and make sure that we include caregivers.

Tricia Lee Rolle
Sorry, Hans, I am lost. Where are we?

Hans Buitendijk
There are two recommendations that start very similarly.

Tricia Lee Rolle
Are we still in Cell 2? It looks like you moved it to 3.

Hans Buitendijk
No, we are still in E2, and if you go to E2 and scroll down to the bottom…

Tricia Lee Rolle
Okay, very good.

Steven Eichner
Hans, just for kicks and giggles, can you really quickly give each of the recommendations in there a letter in front, just so we are all making sure we are talking about the same thing?

Tricia Lee Rolle
I tried to put some in, but Hans, you were going over each other. I was just adding these.

Steven Eichner
Yes, just so that we are clear on where we are talking about, so it is easy.

Tricia Lee Rolle
We are on R4 now.

Hans Buitendijk
Yes, we are on R4, and then Alexis went back to R3, and there is a comment that she made on R3 that we should consider for R4 as well.

Tricia Lee Rolle
Okay, I captured it for R3, and I will capture it for R4.

Hans Buitendijk

Yes, because what that means is those two recommendations start out very much the same. R3 has a collaborative initiative, where R4 does not state "patient," "caregiver," or any of those, and I am hearing Alexis saying we should include that in there as well.

Steven Eichner
R4 should not necessarily be national priorities because there may be state priorities or other jurisdictional priorities as well.

Hans Buitendijk
Okay, "national and state priorities." Jim, any **[inaudible] [00:44:02]** based in this clarification as well of concern in R4 that by putting in the full list," patient, caregiver, pharmacy, pharmacist, provider, and public health organizations," we repeat that, and it is the same in R4.

Jim Jirjis
Okay.

Hans Buitendijk
Okay, we will copy that across. Alexis, does that address your concern?

Alexis Snyder
Yes.

Steven Eichner
Hans, in addition, it should not be constrained to federal agencies.

Hans Buitendijk
Yes, "federal and state agencies."

Steven Eichner
Potentially, it is broader than that if you are looking at research components outside of government activity. There may be governmental regulation, but for example, if you are trying to build a deidentified research repository for clinical research outside of a government-managed registry, that would be an instance where you may have the same challenge, but again, not a governmental entity creating the data resource.

Hans Buitendijk
Okay, we will smith that a little bit more. Alexis, would you be willing to do a little bit more wordsmithing on R3 with the comments that were made? I will certainly look for your other comments, but would you like to do that?

Alexis Snyder
Sure.

Steven Eichner
Alexis, you might look and see if you made your comments on a spreadsheet version that might have been sent out or something.

Alexis Snyder
No, I sent them on the document that went out.

Tricia Lee Rolle
With the history feature, we should be able to look back on edits that were made. Google Sheets should have that history feature.

Hans Buitendijk
All right. One reminder: If you can, use the raised hands. That would be great. I need to do a better job of flipping between screens to see the latest hands raised as frequently as possible, but if you could use that, that would be great, and then we can jump to that person in sequence. Any additional comments on R4 or R3? Then let's go to the next cell, E3. This is part of the fun with spreadsheets. Soon, we are going to move to the Word document, and I think you need to go through that. If you page down, you can get that. This states, "Recommend that ONC coordinate advancements in the integration of pharmacies/pharmacists into the public health fabric, including CDC and STLTs, to share critical data more widely from and with all involved in the test-to-treat process," and Ike suggested removing the rest. Then, there is the rationale after that with an additional word suggested by Ike. Any comments on that recommendation?

Steven Lane
Is it actionable?

Hans Buitendijk
What would you want to add to make it actionable?

Steven Lane
It is not clear to me what they are going to do with that.

Hans Buitendijk
Fair point. Let's see. If you go to the left, this has been brought up by Ike and Christian. Christian, maybe you have some additional thoughts on which ones to call out further.

Christian Tadrus
Well, a lot of my recommendation here is from experience in what we do regulatorily to empower pharmacists at the state level where they do not have provider status or are not recognized, and part of our pathway to do that, especially with regard to public health, is to partner with our board of pharmacy. We partner with our local state agencies, either the Medicaid program or with the department of health, to issue statewide protocols and standing orders. That became a pseudo-authoritative way to broadly and quickly address public health emergencies and needs by de facto creating authorities pulling back or eliminating restrictions. So, I think it is actionable, I think those types of approaches are possible, and the COVID pandemic kind of illustrated that that can be done. Hopefully, the data over the years will show that it was done safely and to the benefit of the public.

I think that is a way to broadly approach the issue of adoption and facilitation in driving IT development and interoperability interest by recommending that that be a pathway to avoid some of the state legislative and

board of pharmacy regulatory implementations that pharmacists do face. So, that also includes this idea of how you engage public health, whether it is a public health entity, state or federal. These are ways that I know from our position here in Missouri, where I sit on the board of pharmacy. We have federal authorities that were issued under the PREP Act that made us have to go back and modify or waive state law to make sure they were aligned. These are the things I am trying to solve for when emergencies come up. If we can have a broad ONC approach to that, I think some of that stuff will help other states broadly. We were pretty reactive, but other states took some time. That is where I was going with these recommendations here.

Hans Buitendijk
Deven, do you have a comment in that context?

Deven McGraw
No, I put it in the chat and you or Tricia Lee added it in the comments. This is great stuff, but it will be much more impactful if we can think about how we could frame this recommendation in terms of the frankly limited authorities that ONC actually has. So, for example, the setting of standards, the development of information-blocking rules… Every now and then, you can pull on their bully pulpit…not authority, but I guess "gravitas" is a word that some might use to describe it, as a convener of entities to help resolve this, but I am not sure that they have any way to deal with this directly, and we admitted so in the rationale. Such adoption is beyond the scope of ONC. It does not mean that there is not value to the recommendation, but I am just not sure that the space in which we are recommending has any power to do anything about it.

Christian Tadrus
Would it help if the recommendation had a preamble of recognition that these are some of the hurdles, and that the recommendation can go more around ensuring that IT, at least, is supportive of pharmacists operating in this manner?

Deven McGraw
Yes, it absolutely would help. In terms of ONC working with other organizations, I see Pooja's comment in the chat, and that is okay too, but as long as ONC is acting from a space of its authority as opposed to asking ONC to pass a recommendation onto another entity, which does not mean we could not do it, but it sort of strays a little bit because we only advise one office, and that is ONC.

Hans Buitendijk
On that note, I just started to type "not complete yet." Christian might be able to look at that further and address Steven's question. If we add something along the lines of "through the adoption and advancement of critical standards," etc., that is the area where ONC can work and focus a little bit more on that. Would that help?

Christian Tadrus
Yes, and it may be an overly broad ask, but in my mind, it almost comes down to building it anyway, and then we will work on the stuff that allows it, because what we are trying to do is conceptually facilitate the IT needs to support pharmacists as providers and pharmacist services, everything we are talking about in these scenarios of public health and emergency use scenarios, so we have to have a framework there that can then be supported by regulatory and/or legislative changes. So, it is a chicken-and-egg argument, but I think we have an opportunity to limit or reduce some barriers, or allow them to fall, if we can say, "But it

can be done, we have it in place, it is a legislative regulatory scenario." I think if we can frame our recommendation to support that, then we can move in that direction in anticipation or support of allowing for some of the regulatory and/or legislative laws that are prohibiting this interoperability and this coordination of care from happening. I think IT can lead that conversation.

Hans Buitendijk
In that context, maybe if we go to the next cell in a moment, which has one of the recommendations around a certification approach that we have been talking about, perhaps, depending on how we arrive at that, we can come back to this one and see if there is anything else we want to add that is beyond or separate from certification that ONC can do to add to advancements in there. And then, Christian, perhaps you have an opportunity to further wordsmith E3 in that context.

Steven Eichner
This is Ike. Looking at examples of what a metric or a standard might be is kind of relevant. I think that is getting into the next recommendation, though. We are jumping around.

Hans Buitendijk
All right. So, do we want to hold this one for a moment, go to E4, and look at the recommendation, particularly the second one there, and then we will circle back, Christian, and see what else we can do to clarify, offset, or recognize that it might be part of that as the primary thing that ONC can do? Is that reasonable?

Christian Tadrus
Yes, thank you.

Hans Buitendijk
Anybody else before we move on? So, we are going to circle back and then look at E4. I do not want to jump around too much, so let's first look at the recommendation in E4. "Recommend that ONC work with the public health community, including CDC and STLTs, to create a set of metrics and outcome measures specifically addressing key measures that identify the advances and gaps in exchange of clinical data between pharmacies/pharmacists capturing clinical data related to immunizations, medications, treatments, etc. during the pharmacists' encounters." I think we can clean that up a little bit and make it shorter and more to the point. There is a little bit of repetition. Any comments generally around that? Ike, you initially had a question in an earlier iteration of that about what was intended. We were wondering whether this made it clearer, or not yet. I do not see any hands up.

Christian Tadrus
Hans, this Christian. Sorry, I will raise my hand. I do not know if this is part of my recommendations, but when I think about what this seems to be leading towards, it is this idea of the reporting of coverage, of types of interventions, using pharmacist data that is surrogate data that indicates something did or did not happen or may not have happened. We see from health department data reporting and state-level data reporting that the population health metrics are showing percentages of counties that have had X, Y, or Z done. That is what I am thinking this might be, unless other people are seeing it in other ways, but it really comes down to how there is a lot of data that can be discerned from pharmacies and pharmacists' work

that is not being captured out there that contributes, implies, or can corroborate engagement, and public health is missing that.

They really are these markers of pharmacists' professional awareness, engagement, dedication, or whatever, but there is so much information in our computer systems out there in these pharmacies that public health is just missing and making assumptions about something happening or not. So, I think having information about that, if it is relevant for public health outcomes, then getting reports back, maybe even at a more granular level, can really help advance and target engagement, funding dollars where they need to go in different areas of the country and things like that.

With regard to the case reporting, that is very relevant to point-of-care testing. We see that, obviously, in our regulatory standpoint. We are writing the regs around what pharmacists need to do in this space, but when we started in these clinical worlds of test-to-treat and maybe even issuing and authorizing labs to validate things, our pharmacists came across different public health scenarios that are mandatory reporting types of things in the medical world. Pharmacies generally are not engaged in that, so we will have to have some ways to do that, both at a regulatory, "This is your scope of practice, you must do this" level, but also, how do you do it efficiently in an IT environment where the system is designed to auto-route information around that? That is what I see here. I do not know that I have a specific recommendation, but if I interpreted this right, I think there is some value here, and we may have to dial in.

Hans Buitendijk
If you have any additional thoughts or recommendations beyond the measures identified here, that would be great. Then we can put your name behind things.

Christian Tadrus
The recommendation on measures would have to be identifying the appropriate pharmacy-specific measure group, whether it is by consensus or otherwise, that can identify this for the purposes of use by public health, and I think that may be the recommendation in terms of if there is meat on this bone for the rationale, then the recommendation comes down to a simple phrase like "ONC work with the lead-in here and relevant subject matter expertise entities, consensus, and/or other to identify meaningful metrics and outcome measures, specifically around public health use gaps." Does that make sense?

Hans Buitendijk
Can you make that update to this recommendation?

Christian Tadrus
Yes, I will log in and do it. I have dug my grave.

Steven Eichner
Can you give an example of what you are considering a metric or outcome measure?

Christian Tadrus
So, for example, if we are talking about a respiratory emergency like we had with COVID, which obviously goes beyond respiratory, what are the factors that indicate whether or not a patient has all the necessary or recommended countermeasures in their hands or has been engaged? So, typically, we are going to do

that through a screening process, but there are some significant indicators. If they are at high risk in a particular disease state, it may make sense for them to have nebulizers and certain types of rescue medications on hand. If there is a recommended countermeasure provided, has that been made available? For example, when we think about COVID-19 testing kits, it could be as simple as if they have been dispensed, or it could be something more. Have they had their COVID shots? Have they had these things? So, I guess it goes beyond the vaccination piece. Is there some sort of validation to say they have masks in hand and those types of things?

Steven Eichner
That sounds more like an evaluation of medical delivery than an assessment of data.

Christian Tadrus
Well, you could also throw in things that are specific to the proper use of medications. So, in this recommendation as is, it has immunizations, medication/treatments prescribed, dispensed, and administered, such as antivirals, and case reporting, so those are test-to-treat types of things, but you could put things like serum creatinine and liver function tests. Are those available to the pharmacy, which would imply that they are being considered in validation of the dosing amount? As we know with the COVID process with Paxlovid, that was a critical thing in terms of what pharmacists had to deal with. It is an indicator of overall health status.

Hans Buitendijk
Christian and Ike, would you be able to have a follow-up conversation to see how this can be further advanced to capture some of those thoughts?

Steven Eichner
Sure.

Christian Tadrus
Yes, I am happy to.

Steven Eichner
I think some of this ties into some of the work ONC has done in the last little bit in terms of the evaluation criterion around EHR performance, and I think that is probably a place to leverage what this builds on.

Hans Buitendijk
If you guys could follow up together and come up with an advancement to that recommendation, it would be great. Anna?

Anna McCollister
Hey there. I just wanted to voice a concern that is going through my head as I hear this. Christian's suggestion makes a lot of sense in many respects. My concern, however, is the instance he just mentioned about serum creatinine as it relates to Paxlovid dosing. There is so much lower hanging fruit as it relates to getting access to information for access to Paxlovid than getting serum creatinine levels to my pharmacist. I have kidney disease. It is difficult to identify a pharmacy that actually has the renal dosing for Paxlovid. The amount of time and effort it took for me to just identify the inventory or have the pharmacy call around

to different pharmacies when I was sick with COVID to identify where I could get this stuff with as few Ubers needed as possible…it took a lot of time. I knew I had kidney disease, the doctor knew I had kidney disease, they called in the Rx…

I am prone to making recommendations that are not within ONC's jurisdiction as well, and maybe this is not ONC jurisdiction, but I really think there are lower hanging fruit that would have significant impact on the life and capability of patients, providers, and pharmacists to be able to act in a public health emergency. So, if we are grouping it as "These things should happen now, these things should happen five years from now," three years from now, whatever cadence makes sense…

Christian Tadrus
It is probably long-term.

Hans Buitendijk
If you could look at that and see if there is anything specific that ONC could follow up with, that would be great. That is going to be the challenge throughout here. What can ONC do?

Steven Eichner
This is Steve again. It sounds kind of close, perhaps, to a modification or an extension of CMS's requirements under Promoting Interoperability, looking at the exchange of patient data, and those regulations are in CMS's world, not really in ONC's.

Hans Buitendijk
Right. Can you have a look at that and then, maybe together with Christian and Ike, see whether anything can be blended in that ONC can do, or whether they have to work with somebody else if they have an opportunity to do that? Why don't we look at R7? It is a bigger one, with a little bit more text. That is about certification, where there has been a discussion. It states, "Recommend that ONC initiates the development of a certification approach in collaboration with critical industry organizations such as NCPDP, HL7, and NAPB," and others could be listed as well, if need be, "for key functionality for pharmacy-based interoperability across practice settings," for example, community clinics, clinical specialty pharmacies, and LTPAC, etc. should be clinics, "to encourage adoption of necessary standards and technology by pharmacists to interact with providers throughout the test-to-treatment process during emergency **[inaudible] [01:08:22]** operations. Such a program should focus on the following use cases," and that is the list of use cases that we had developed, and we are going to describe them a little bit further in general before we get to the recommendations to have context.

It follows with, "and utilize the SAFE standards used in ONC's current certification program, particularly HL7 Version 2, C-CDA, 'FHIR-based,' SMART, NCPDP Script Direct Messaging, IG document exchange. Consideration should be given to specialty certification and considered bidirectional certification of pharmacy prescription and standards encouraging the use of additional transactions to support clinical data exchange, including consideration for the use of Pharmacist eCare Plan." So, it is fairly broad, and not that that could all be done at once, but that is generally the idea to advance and have that standards-focused program that takes the use cases that we identified and then work with the community to understand what needs to be there, what can already be certified from both sides, what is already on one side, what needs to be on the other side, etc. That is the intent behind this. Let's see whether there are comments. Christian?

Christian Tadrus
So, I just have a high-level comment that certification is challenging for the pharmacy space, especially with so many disparate solutions providers, and the cost will be significantly passed onto the individual pharmacies and providers. I will just put my small business owner hat on and say certification translates to me as "That is going to cost a lot." However, that being said, on the list of use cases here, I would just like to make a couple recommendations. I do think that we have concepts, such as digital therapeutics and pharmacogenomics, that are not on this list that are very relevant too because it is moving so fast, there is so much non-standardization in that space, there is a lot of innovation in that space, and not a regulation in that space, so we might want to think about those two use cases being incredibly…

We are going to see a lot of pressure over the next couple years and a few years on in those two spaces, and we might want to think about what ONC's role is in terms of ensuring that quality data and quality standardization of that data is captured in recommendations, whether they are short- or long-term. The FDA has already put out statements on the fact of their concern around AI-based clinical decision-making in some of these technological solutions, including in devices, so I think that is probably our cue. We need to be thinking about standardization in the type of data that we are going to be exchanging amongst ourselves in these decision-making processes. I hope that is helpful.

Hans Buitendijk
Thank you. You are coming around to the additional use cases point while **[inaudible] [01:12:41]** until we got to Task 3, and that is particularly where the other ones come up, so, yes, I agree they should be added. We will go to Ike, but also thinking about how it is a balancing act between how we advance adoption of common standards to make this work. When you start to already pre-read into the next recommendation, it is trying to address that funding challenge and see what can be done there. So, while we continue the discussion of the certification part, have a look at the next one as well. Ike?

Steven Eichner
I noticed that my comment about taking out information about full transparency and the like was removed from the patient engagement item. I think that is really, really important, based on past discussions. If we are building something from relative scratch, we need to not make the same set of choices we made earlier, where we did not have as much technology available around transparency. We really need to highlight that so we are building right this time around.

Hans Buitendijk
I completely agree. Actually, what we were thinking of is rather than having these further explanations in each one of these, which could be done for the other ones as well, if you look at Topic 2, we defined a series of use cases, including this one. We included your statements there so we could explain what is encompassed within patient engagement so that this recommendation need not repeat the content of those topics. That was the intent, to organize that comment in a different place, but not drop it.

Steven Eichner
Wonderful. Not necessarily looking at patient engagement, but from an overarching recommendation, that might be looking back at the things that we have learned thus far in interoperability and exchange as a

foundation for new work so that we can make improvements, implementing things that are relatively new, greenfield development.

Hans Buitendijk
Would that be something along the lines of initiating the development of a streamlined certification approach, based on current experiences, and then ongoing, something in that condition that you are trying to…?

Steven Eichner
It just occurred to me that that might be a more holistic recommendation overall that says we have quite a bit of experience with interoperability. Holistically, some things work well, some things not so much, and there is room for improvement. As we are exploring and implementing things in this new space, let's make things the best we can while still maintaining compatibility with what has come before.

Hans Buitendijk
That sounds like a good point, and we actually should pull that out and add it as a separate recommendation so that it is based on experienced to date and streamlined where it can be.

Steven Eichner
Yes, because that would really apply to every single recommendation that we are making in this document. We are not in a vacuum. We do have a bunch of years of experience now, so let's build upon it.

Hans Buitendijk
All right, thank you. We will make that note and expand it. Pooja, I saw you had your hand up earlier, and then you made a comment in the chat that you wanted to highlight that not only the specialty, but the current certification program, which is voluntary, should be voluntary as well.

Pooja Babbrah
I just remember in the discussion that someone had pointed to pediatric certification, which we technically consider a specialty, but is also voluntary. So, given the concerns about the cost and whether or not we can actually get funding. I just want to make sure this next recommendation we are going to go through is clear that maybe what we should consider recommending is a voluntary certification or, like everyone mentioned before, just around certain things. I just was not sure if "specialty" also equated to "voluntary," because I have heard that tossed around several times in the context of certification.

Hans Buitendijk
Is that comment made in R7 or R8?

Pooja Babbrah
Actually, I think I am looking at the rationale for R7. I am on my laptop too… I think that is where it calls for voluntary, right? Sorry, now I missed it. I will put it in the chat. Let me find where it says "voluntary."

Hans Buitendijk
Yes, and if you have a particular suggestion on where to put in the word, that would be great.

Pooja Babbrah
I will add that in.

Hans Buitendijk
Okeydoke. We only have two minutes left, so before going to R8, which is where we will pick up next and keep ongoing, we would like to go back for just a moment to the recommendation in E3, and Christian, whether you believe, in light of what we just discussed with certification, recognizing that it only can work if it is put as voluntary more clearly. With funding in R8 with the recommendation in E3, which is R5, how would we further advance that? That is where you might be able to provide some suggestions on if it is part of it or something separate that we need to dig into a little bit deeper.

Christian Tadrus
From my perspective, for certification, voluntary seems more workable, and probably provides a better run-in period for people to adopt, rather than a hard line. Again, independent community pharmacists, and even those that are just operating clinically on their own, really rely on their system vendors to do this, so it becomes a burden both to them and us, so I would say I would lean more toward voluntary in the certification conversation, but from the coordination and engagement in R5 recommendations, I think we need to talk about it and understand that we are all trying to get to a certain point that works for everybody, including public health and individual patients, so certification is going to be a significant burden and slow it down.

Hans Buitendijk
Can you make a further suggestion, then, offline on how to advance R5 a little bit further to make that clearer? Would that work? Christian, is that okay?

Christian Tadrus
Yes, it is. I will look it over.

Hans Buitendijk
That would be great. All right, then we are at time for public comment, so I am going to pass it back to Mike, and then we will keep going where we left off during any time left.

Public Comment (01:19:49)

Michael Berry
Thanks, Hans. We are going to now 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 in the toolbar on the bottom of your screen. If you happen to be on the phone only, press *9, and once called upon, press *6 to mute or unmute your line. Let's pause for a moment to see if anyone raises their hand. I am not seeing any hands raised, Hans, so I will turn it back to you.

Hans Buitendijk
All right, thank you. So, let's go back to the spreadsheet, and we will use the remaining nine minutes to make a little bit more progress. Tricia is going to have a look at R5. We talked about R7. We have not talked about R8 yet, other than generally. R8 indicates, "Recommend that ONC work with HHS to enable receipt of incentives to develop and adopt certified HIT under ONC's HIT certification program, for example, through…" That word dropped for a moment. It was too far to the right. This thing is jumping around on my

screen. "…through full recognition of pharmacists as providers." Then there is the rationale. Any thoughts around that? I do not see any hands raised. Does that mean that everybody is in agreement with R8 and it rationale? Did we get it? Maybe there is some fine tuning, but other than that, are we good? I do not hear anybody, so we must have gotten that one complete.

Let's look at the last one for today, which is R9. R9 states, "Recommend that ONC work with pharmacies, pharmacists, networks, and the public health community to identify methods, such as tokenization and privacy-preserving record linkage, PPRL, capabilities, in combination with relevant standards, as well as record locator services, patient-linking knowledge for further advancing linking the patient data across multiple sources to the same deidentified person record to establish a more complete person record for analytics that can fully and accurately incorporate pharmacy/pharmacist-sourced data." It ties a little bit into the prior one that we had on PPRL. I am not sure where we can combine them, but they sound very much in the same space. They are about two topics. Does this work, or should we combine it with the other PPRL comment that we made?

Steven Lane
I think combining them makes sense, Hans, though I am not volunteering to do the wordsmithing. Also, Hans, since nobody mentioned anything, I wanted to slip in something about R8. That is such an important recommendation. It passed without comment, but it is so central to all the discussions we have been having. I just wanted to highlight it.

Hans Buitendijk
It is. I think this is what we come back to. What has been working so far is voluntary certification with voluntary participation and programs that have incentives to encourage everybody to participate, but if you only have one certification and not the other, it is not working, and that is what we see there. That is a fair point in the chat. The sequence right now is the sequence of how to talk through it, but in a number of these, the sequence in which we are actually going to organize it is putting like recommendations together so we can touch on the same them and so critical ones like these are going to be on top. We still need to work out exactly what the sequence is, but we will work through it shortly as well. I see a number of different comments in the chat. While nobody else spoke up per se, in the chat, there is definitely support for that recommendation as it came up. Thank you, Steven.

Okeydoke, with that, we still actually have a little bit of time left to find our way into the next section. What you start to see right now is that there are some blank spaces as well, and when you go to the left for a moment to D5, we think we covered it in other topics, like E4 or E2, for example. Summer and Christian, do you want to look at that and make sure that it is accurate, and if not, can you suggest what additional recommendations we should make to highlight the key points you were trying to hone in on? That is the reason why E5 is blank, because we thought that other topics addressed that already.

And then, let's go to what might then be the last one. I think this going to be R10, Tricia, if I counted correctly, in E6. "Recommend that ONC recognize provider-pharmacist interactions as critical components of trusted exchange frameworks, treatment exchange purpose, and address the barriers and encourage education for pharmacies and pharmacists to join the TEF as it is operationalized. This should address both the ability for pharmacists to query providers as well as providers querying pharmacies for patient data." So, this is a

way to further advance as well to make sure that under TEFCA, there are no further barriers that would enable participation by everybody. Any thoughts on that? Okeydoke.

There is a question from Christian. "The PPRL solution may need to be necessary for cueing interoperability." That is an interesting one. There are record location services that are being used that would be there, and that would be an interesting topic as to how they actually tie together, so let's hold that thought. I see Anna has a question, and that is probably the last comment for today. We are going to wrap up afterward, but Anna, go ahead. You have the last word.

Anna McCollister
I went in yesterday and put in a number of recommendations, though not in the final recommendation columns. They are all based off the use cases that I submitted previously, and I apologize for just getting them in yesterday. I have had some personal and family health stuff recently that has diverted my attention. I would like for them to at least be considered, and we did not discuss them today, so I just wanted to highlight that. There are several.

Hans Buitendijk
Yes, and we started to notice you had just added them. We are going to go back through that and see if they have already been addressed or are new, and then we are going to move them to Column E accordingly. We did not have a chance to do this quite yet.

Anna McCollister
Awesome, and again, this is all stuff I had mentioned before, and I have elaborated on the use cases, but I just have not converted them into specific recommendations or suggestions.

Task Force Work Planning (01:28:20)

Hans Buitendijk
I appreciate that. That will make it a lot easier to put them wherever in Column E they fit. Thank you. Unless there are any other final comments, I think we have arrived at the end of the meeting. Next week, we are going to continue on some of the specialty medication topics, the three that we have from Task 3, and anything left. So, we hope to wrap that up in the next one or two weeks, and then we really have to dive back deep into these recommendations and make sure that we are fine-tuning and completing them during October so that we have a final recommendation by November 9th. So, by October 19th, we will have a Task Force update at that point in time on all the progress made and a glimpse into the recommendations that we have so far. Thank you very much for all the discussion and contributions and all the notes in the chat that we have, so we will take those and move forward, and please, if you have any suggestions or thoughts, as you have I seen, I drop it in in red mark. If you have any suggestions on the text, please do so as well. Thank you very much, and have a great day.

Adjourn (01:29:49)