NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: **LT William Christopher Charles**
                                               (Name)

2/14/2018   **United States Public Health Service**
(Date)   **(Organization)**

Subject: Pharmacists Electronic Referral Tracking

Motion: Move to adopt the following policy statements:

1. APhA supports the development of electronic systems that enhance and simplify the ability of pharmacists in all practice settings to receive, send, and track referrals between all members of the health care team irrespective of the health care system, model, or network the patient participates in.
2. APhA supports the interoperability and integration of referral tracking systems with electronic health records so patients can receive the benefit of optimally coordinated care from all members of the health care team.

Background:

In recent years, APhA has adopted several policies acknowledging the positive impact of pharmacist-provided services. Currently, outside of pharmacy academia, the majority of these services are provided to patients within closed systems such as Veterans Affairs and Kaiser Permanente. Common threads within these systems' electronic health records (EHR) are universal access of information, and ease of patient referrals to pharmacist services. APhA policy advocates for national EHR integration and pharmacists' access to the same. A piece that is missing in current policy is a statement focused specifically on the enhancement of referrals within such a system.

Several initiatives have been launched in recent years to expand the successes seen in these systems to more patients. Medical Home Models, Value-Based Payment structures, and Performance Networks are examples of these initiatives. APhA policy also addresses pharmacists' activities within these structures. The purpose of this proposal is to address the aforementioned missing piece, so pharmacists across practice settings have an avenue to effectively and efficiently coordinate with providers. This will allow many more pharmacists to use their training to the fullest for all patients, whether or not the patients receive their care within a closed health system or innovative health care model.

The National Committee on Quality Assurance (NCQA), which certifies Patient Centered Medical Homes (PCMH), publishes standards and guidelines for practices wishing to provide care in this innovative fashion. PCMHs provide many services inhouse, but often need to refer patients out for specialty care. Complete referrals require the transmission of many pieces of information including the reason for referral, the patient's PMH, HPI, labs, test results, accurate

medication list, current care plan, therapies previously tried, etc[1,2]. Inaccurate, incomplete, or delayed transfer of information might result in delayed access to care, duplicate testing, polypharmacy, inappropriate medication use, erosion of trust in the medical system, and increased costs[1]. To avoid these pitfalls and to ensure good coordination of care between PCMHs and outside specialists, NCQA has highlighted efficient referral tracking and follow-up as a must-pass element to gain recognition as a PCMH in each update of its standards since 2011[3-5].

The University of California San Francisco (UCSF) in conjunction with San Francisco General Hospital (SFGH), San Francisco's main safety net provider of specialty care, developed a web-based referral system that allows for interactive communication between referring and specialty providers[2]. A survey of users after the first two years of implementation revealed a host of positive results. Highlights include decreased duplication of diagnostic tests, improved instructions and education back to the primary provider, reduced time to specialist appointment from 5-12 months to 1-2 months, prioritization of referrals based on patients' needs, time saved for most users, and the reduction of unnecessary referrals. While this referral system did not include pharmacists, some organizations have shown success integrating pharmacists' services into theirs.

Mountain Area Health Education Family Health Center (MAHEC) is one such NCQA certified PCMH that utilizes pharmacists in an embedded Pharmacotherapy Clinic to provide several services. All clinic activities, which include MTM, osteoporosis management, anticoagulation, diabetes, and medication assistance, are initiated by referral[6]. MAHEC patients also benefit from referrals to unaffiliated community pharmacies for immunization services[6]. The Indian Health Service's (IHS) National Clinical Pharmacy Specialist Committee has applied this concept directly to pharmacists as well. Their recently updated Comprehensive Pharmacy Services Handbook makes documented, trackable, multidirectional referrals part of their standard operating procedure[7]. The IHS referral-consultation process provides a seamless, electronic transfer of complete, relevant information between providers, allowing pharmacists to coordinate and manage disease states such as Hypertension, Hyperlipidemia, Diabetes, Nicotine Dependence, Asthma, Immunizations, COPD, Hypothyroidism, Spirometry, and more[7].

The APhA Foundation's Project IMPACT has devoted many resources to developing collaborative practice agreement (CPA) structures that expand the high level of success seen in the previously described systems to patients in communities across the nation. The Diabetes Ten-City Challenge connected pharmacists with 573 patients who achieved statistically significant improvements in their average A1C, LDL, systolic blood pressure, influenza vaccination rate, eye exam rate, and foot exam rate over an average 14.8-month period[8]. Project IMPACT: Diabetes produced similar results for 1,836 patients in 25 communities in 17 states over an average 11-month period[9]. Notably at the end of the project in 2014, 92% of the communities intended to sustain pharmacists' services beyond the conclusion of the grant[9].

Personal interviews with one of the participating pharmacists based in an independent community pharmacy revealed challenges that ultimately ended the CPA for that community. CPAs were entered into with two physicians to see 60 patients. The pharmacist was embedded in one office so had easy access to the EHR and the physician partner. Patients from the other practice were seen in the pharmacy. Referrals were hand written on prescription pads, and all information was transmitted by fax, phone, or hand-delivered by the pharmacist to be scanned into the physician's EHR later. With the slow flow of information, many patients became confused as to which provider to see for their diabetes care – the physician or the pharmacist. The CPA for the embedded practice was able to sustain for nearly an additional 3 years. The CPA with the remote, paper-based referral system ended shortly after the end of the study period. Based on the successes seen in various previous examples, enhanced & simplified referrals and free-flow of electronic health information likely would have enabled the remote CPA to continue and perhaps expand to more patients and practices.

APhA's 2015 policy on Interoperability of Communications shows APhA's support for enhancing electronic communication between healthcare providers and pharmacists, and to that end the Pharmacy Health Information Technology Collaborative (PHITC) has been working with stakeholders to include pharmacists in those standards. Unfortunately, according to the PHITC, the digitization of multidirectional referrals between pharmacists and providers not integrated into a closed health system or innovative health care model is not currently being targeted by any entities.

Due to the work of APhA over the past several years, more states and Congress are moving ever closer toward granting provider status to pharmacists. Now is the time for APhA to pointedly advocate for the development of electronic systems that improve all aspects of the referral interface between providers and pharmacists. Easing this critical transaction of information will do much to enhance pharmacists' ability to implement CPAs for the care of our patients.

References:

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9. Bluml BM, Watson LL, Skelton JB, Gasdek Manolakis P, Brock KA. Improving Outcomes for Diverse Populations Disproportionately Affected by Diabetes: Final Results of Project IMPACT: Diabetes. JAPhA. 2014;54:477–485.

Current APhA Policy & Bylaws:

2017 Patient Access to Pharmacist-Prescribed Medications

4. APhA urges prescribing pharmacists to coordinate care with patients' other health care providers through appropriate documentation, communication, and referral.

2015 Interoperability of Communications Among Health Care Providers to Improve Quality of Patient Care

1. APhA supports the establishment of secure, portable, and interoperable electronic patient health care records.
2. APhA supports the engagement of pharmacists with other stakeholders in the development and implementation of multidirectional electronic communication systems to improve patient safety, enhance quality care, facilitate care transitions, increase efficiency, and reduce waste.
3. APhA advocates for the inclusion of pharmacists in the establishment and enhancement of electronic health care information technologies and systems that must be interoperable, HIPAA compliant, integrated with claims processing, updated in a timely fashion, allow for data analysis, and do not place disproportionate financial burden on any one health care provider or stakeholder.
4. APhA advocates for pharmacists and other health care providers to have access to view, download and transmit electronic health records. Information shared among providers using a health information exchange should utilize a standardized secure interface based on recognized international health record standards for the transmission of health information.
5. APhA supports the integration of federal, state, and territory health information exchanges into an accessible, standardized, nationwide system.
6. APhA opposes business practices and policies that obstruct the electronic access and exchange of patient health information because these practices compromise patient safety and the provision of optimal patient care.
7. APhA advocates for the development of systems that facilitate and support electronic communication between pharmacists and prescribers concerning patient adherence, medication discontinuation, and other clinical factors that support quality care transitions.
8. APhA supports the development of education and training programs for pharmacists, student pharmacists, and other health care professionals on the appropriate use of electronic health records to reduce errors and improve the quality and safety of patient care.
9. APhA supports the creation and non-punitive application of a standardized, interoperable system for voluntary reporting of errors associated with the use of electronic health care information technologies and systems to enable aggregation of protected data and develop recommendations for improved quality.

2014 Care Transitions

4. APhA supports the development and utilization of standardized processes that facilitate real-time, bidirectional communication of protected health information during care transitions.

2009 Health Information Technology

1. APhA supports the delivery of informatics education within pharmacy schools and continuing education programs to improve patient care, understand interoperability among systems, understand where to find information, increase productivity, and improve the ability to measure and report the value of pharmacists in the health care system.
2. APhA urges that pharmacists have read/write access to electronic health record data for the purposes of improving patient care and medication use outcomes.
3. APhA encourages inclusion of pharmacists in the definition, development, and implementation of health information technologies for the purpose of improving the quality of patient-centric health care.
4. APhA urges public and private entities to include pharmacist representatives in the creation of standards, the certification of systems, and the integration of medication use systems with health information technology.

(JAPhA NS49(4):492 July/August 2009) (Reviewed 2010)(Reviewed 2013)(Reviewed 2014) (Reviewed 2015)

2006 Continuity of Care

3. APhA supports patient access to pharmacists with specialized skills and expertise. The patient's pharmacist should make patient referrals where appropriate.