February 5, 2024

Dr. Micky Tripathi
National Coordinator for Health Information Technology
Department of Health and Human Services
330 C Street, S.W.
Washington, DC 20201

Submitted via email

Re: Pharmacy Interoperability and Emerging Therapeutics Task Force 2023 Recommendations

Dear Dr. Tripathi:

The National Association of Chain Drug Stores (NACDS) thanks you and your office, ONC, for prioritizing pharmacy interoperability in 2023. We greatly appreciate ONC's request to create the HITAC Pharmacy Interoperability and Emerging Therapeutics Task Force (Task Force) and its charge to provide a series of recommendations to support interoperability between pharmacy constituents, and the exchange of information necessary for medication management, patient safety, and consumer engagement. We are aligned with ONC in our recognition of the great need to appropriately connect health care providers, patients, caregivers, and other stakeholders toward improving health information interoperability.

As you are aware, the Task Force met regularly throughout the second half of 2023 and recently, in November 2023, it issued important recommendations to help advance pharmacy interoperability. The establishment of the Task Force and its development of recommendations are important early steps that we hope will lead to even greater collaboration between ONC and the pharmacy community to drive toward our mutual goals, ultimately to improve health care across communities.

As we are reviewing the Task Force's robust set of recommendations, we wish to provide ONC with our initial thoughts and impressions that could help ONC prioritize implementation of those recommendations with the greatest potential impact to improve health care for the nation. **In particular, we strongly recommend ONC first focus on the Task Force's use cases of (1) bi-directional data sharing and/or exchange among pharmacies and other relevant providers and (2) integrating pharmacists into the care team, as well as (3) the Task Force's recommendation that ONC work with HHS enabling receipt of incentives to develop and adopt certified Health IT under ONC's Certification Program, e.g., through full recognition of pharmacists as providers.** Focusing on these three priorities initially, in concert, would provide the greatest impact toward achieving pharmacy interoperability. NACDS looks forward to opportunities to work together with ONC and other leaders in interoperability to implement these critical recommendations.

We agree with HITAC that the increase in the availability of pharmacy-based and pharmacist delivered clinical services necessitates improved coordination between pharmacies and other health care providers.

More and more, community pharmacies are providing patients increased options for safe, affordable and convenient clinical care. In recent years, community pharmacies have been granted expanded authority to provide a broad range of clinical care services, which has enhanced access to routine healthcare services like testing, immunizations, treatment for minor ailments, preventive therapies, and other low-acuity clinical care. The following charts outline some of the expanded clinical care services that pharmacists can now provide at local pharmacies in certain states:

Allowances to Test & Initiate Treatment for COVID, Flu, Strep and/or Other Conditions
18 States: Alaska, Arkansas, Colorado, Connecticut, Delaware, Florida, Idaho, Illinois, Iowa, Kansas, Kentucky, Michigan, Missouri, Montana, Nevada, New Mexico, Oregon, Virginia

Allowances to Prescribe or Furnish Specific Drug Therapies	
Naloxone	All 50 states + District of Columbia
Contraceptive drugs	25 States: Arizona, Arkansas, California, Colorado, District of Columbia, Delaware, Hawaii, Idaho, Illinois, Indiana, Maryland, Michigan, Minnesota, North Carolina, Nevada, New Hampshire, New Jersey, New Mexico, New York, Oregon, South Carolina, Utah, Vermont, Virginia, West Virginia
"Uncomplicated minor ailments"	7 States: Alaska, Delaware, Florida, Idaho, Kentucky, Montana, Washington
HIV PEP/PrEP	15 States: Arkansas, California, Colorado, Connecticut, Idaho, Illinois, Maine, Missouri, Nevada, New Mexico, New York, North Carolina, Oregon, Utah, Virginia
Tobacco cessation	20 States: Arizona, Arkansas, California, Colorado, Iowa, Idaho, Indiana, Kentucky, Maryland, Maine, Missouri, New Hampshire, New Mexico, North Carolina, North Dakota, Oregon, Utah, Vermont, Virginia, West Virginia
Other specified therapies	14 States: California, Colorado, Delaware, Idaho, Kentucky, Maryland, New Mexico, New York, North Carolina, Oregon, Utah, Vermont, Virginia, Wyoming

Moreover, in the aftermath of the COVID pandemic, pharmacies achieved unimaginable access for the nation to receive needed pandemic services. Consider that the nation's pharmacies administered more than 300 million COVID-19 vaccines, more than 42 million tests, dispensed 8 million antiviral courses, and were the top provider of OTC COVID-19 tests in a CMS' demonstration program. Using conservative estimates, pandemic interventions by pharmacists and pharmacy personnel averted >1 million deaths, >8 million hospitalizations, and $450 billion in healthcare costs.[1] State Medicaid and commercial insurers are recognizing the expansion of pharmacists' scope, while at the federal level, there are ongoing efforts to secure payment for pharmacist care services under Medicare Part B. The chart below provides examples of

[1] https://pubmed.ncbi.nlm.nih.gov/36202712/

where state Medicaid and commercial payers have recognized the expansion of pharmacists' scope of practice:

Examples of states with policies for coverage of certain pharmacist-provided clinical care services	
Medicaid coverage	19 States: California, Colorado, District of Columbia, Indiana, Iowa, Maryland, Missouri, Montana, Nevada, New Hampshire, New Mexico, North Dakota, Ohio, Oregon, South Carolina, Tennessee, Virginia, Wisconsin, Wyoming
Commercial coverage	13 States: Alaska, California, Illinois, Kentucky, Maryland, Nevada, New Mexico, Ohio, Oklahoma, Oregon, Texas, Washington, West Virginia

Considering the above evidence of the ongoing expansion of pharmacists' scope of practice, it is imperative that ONC prioritize the Task Force recommendations that would help ensure and advance patient care and safety through interoperability. As stated above, we believe ONC should first focus on the Task Force's use cases of (1) bi-directional data sharing and/or exchange among pharmacies and other relevant providers and (2) integrating pharmacists into the care team, as well as (3) the Task Force's recommendation that ONC work with HHS enabling receipt of incentives to develop and adopt certified Health IT under ONC's Certification Program, e.g., through full recognition of pharmacists as providers. Focusing on these three priorities initially, in concert, would provide the greatest impact toward achieving pharmacy interoperability.

As the Task Force recognizes, a single practitioner's electronic health record (EHR) would not necessarily contain all of a patient's relevant clinical data. Similarly, a single pharmacy's practice management system would not necessarily contain all of a patient's relevant medication and clinical data. Such is the state of our fragmented health care system. Overcoming the current state of fragmentation will, at a minimum, require bi-directional sharing and/or exchanging information among all relevant health care providers, especially and including pharmacies, as well as the recognition of the pharmacist as a member of the patient's care team. There must be a focus on coordinated collaboration to manage and implement a patient's care plan across and among all relevant health care providers. Especially critical is the sharing of appropriate information relevant to care planning, care gaps, care coordination, event notifications such as medication fill notices and immunizations, and transitions of care including medication reconciliation and medication-related data.

Moreover, the Task Force recognizes that pharmacies and pharmacists are not eligible for the receipt of incentives to develop and adopt certified Health IT under ONC's HIT Certification Program. Until pharmacies and pharmacists are provided incentives similar to those of other health care providers, we cannot expect pharmacies and pharmacists to embrace HIT to the same degree as the others. ONC should address this incentive gap and develop an incentive program for pharmacies and pharmacists to help ensure full access to necessary, relevant data for all care team members. Absent an incentive program, we

would encourage ONC to at minimum implement a voluntary certification program for pharmacies and pharmacists.

Fostering interoperability helps support care coordination and better and safer health care. Fostering pharmacy interoperability helps close critical gaps in provider access to all of patients' relevant clinical data among the entire health care delivery team. NACDS thanks ONC for considering our perspectives on the recommendations of the HITAC Pharmacy Interoperability and Emerging Therapeutics Task Force. If we can provide further information to assist ONC, please do not hesitate to contact Sara Roszak, Senior Vice President, Health and Wellness Strategy and Policy at sroszak@nacds.org.

Sincerely,

Steven C. Anderson, FASAE, IOM, CAE
President and Chief Executive Officer

cc: Tricia Lee Rolle

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NACDS represents traditional drug stores, supermarkets and mass merchants with pharmacies. Chains operate nearly 40,000 pharmacies, and NACDS' chain member companies include regional chains, with a minimum of four stores, and national companies. Chains employ nearly 3 million individuals, including 155,000 pharmacists. They fill over 3 billion prescriptions yearly, and help patients use medicines correctly and safely, while offering innovative services that improve patient health and healthcare affordability. NACDS members also include more than 900 supplier partners and over 70 international members representing 21 countries. Please visit NACDS.org.