HIT Policy Committee's Certification and Adoption Workgroup
Regarding Certification for Long Term and Post and Acute Care (LTPAC) Settings
Panel 1: Clinical Perspective
Thursday, December 12, 2013 9:00-1:30 PM/ET

My name is Shelly Spiro; I'm the Executive Director of Pharmacy HIT Collaborative representing over 250,000 members of the majority national pharmacy associations and key pharmacy organizations involved in Health Information Technology (IT). Long Term and Post Acute Care (LTPAC) and Behavioral Health (BH) pharmacy settings need ONC certification criteria support to voluntarily adopt electronic health records (EHRs). From a clinical perspective, this support will assist LTPAC and BH providers with improved medication management abilities. According to the 2013 Assistant Secretary for Planning and Evaluation (ASPE) Report *EHR Payment Incentives for Providers Ineligible for Payment Incentives and Other Funding Study*, Pharmacists and Pharmacies are ineligible for Meaningful Use (MU) incentives.[1] Pharmacists play an important role in the inter-professional healthcare team in providing medication related services outside and in conjunction with the prescription dispensing functions.[2] Pharmacists in the LTPAC and BH settings are an integral part of the care team including physicians in these settings receiving incentives for adopting technology as part of the MU program.

Consultant Pharmacists are federally mandated to perform monthly medication regimen review (MRR). According to the nursing facility regulations and interpretive guidelines found in Appendix PP of the Centers for Medicare & Medicaid Services (CMS) State Operations Manual (SOM), "*the facility must employ or obtain the services of a licensed pharmacist (consultant pharmacist) who provides consultation on all aspects of the provision of pharmacy services in the facility. This includes a review of each nursing facility resident's medication regimen at least once a month to identify irregularities and clinically significant risks and/or adverse consequences resulting from, or associated with, medications. It may be necessary for the pharmacist to conduct the MRR more frequently depending on the resident's condition and the risks for adverse consequences related to current medications. This MRR process is defined as: A thorough evaluation of the medication regimen of a resident by a pharmacist, with the goal of promoting positive outcomes and minimizing adverse consequences associated with medication. The review includes preventing, identifying, reporting, and resolving medication-related problems, medication errors, or other irregularities, and collaborating with other members of the interdisciplinary team*."[3] In some cases these services are adopted by BH facilities.

Pharmacists electronically accessing and exchanging clinical information in these settings are vital to meeting institutional quality and safety medication management processes. Pharmacists are highly trained as medication management experts. Over several years, the Pharmacy HIT Collaborative and its members have been working with National Council for Prescription Drug Programs (NCPDP) and Health Level Seven (HL7) on standards that will assist pharmacists in standard structured documentation of these patient care services such as MRR and Medication Therapy Management (MTM) as required by the Medicare Part D program, some Medicaids and private insurers. One such standard is a joint project between NCPDP and HL7 for a Consolidated Clinical Document Architecture (cCDA) structured document to meet CMS required Part D patient "take away" document after an annual Comprehensive Medication Review (CMR).[4] This structured document contains a pharmacist-provided reconciled active medication list, allergy list, indication for each active medication, and special instructions for the patient in easily understandable language. The electronic structured document supports RxNORM and SMOMED CT.

This CMS regulatory requirement went into effect January 1, 2013 and includes residents in the LTPAC and BH settings. For 2014, CMS recognized the electronic version of the structured document in their 2014 Call Letter by encouraging Part D plans to adopt the use of the electronic version of the "take away" structured document and the use of MTM defined SNOMED CT codes. In addition, CMS asked for comments related to the coordination of the CMR and the physician's Annual Wellness Visit.[5] Pilot testing of the use of the CMR electronic structured document should begin next year. NCPDP Work Group activity is taking place to provide pharmacy industry guidance for electronic structured document templates using cCDA for pharmacy care notes and transition of care documents. These standard CDA structured document templates can be used by pharmacists and other health care providers in the LTPAC and BH settings.

In addition, the Pharmacy HIT Collaborative worked with NCPDP and HL7 in the development of an American National Standards Institute (ANSI) accredited Pharmacist/Pharmacy Provider Electronic Health Record (EHR) functional profile designed to facilitate capturing of clinical medication-related data at the point of care in a single logical health record.[6] The functional profile specifies the requirements needed to support messaging among prescribers, pharmacists or pharmacy providers, and other health care entities benefiting from medication-related information. Through the Pharmacy HIT Collaborative's work group activity, industry leaders are in the process of preparing guidance adoption of this standard in the community, hospital and long-term care settings.

According to a 2011 survey report by the American Society of Consultant Pharmacists (ASCP) and QS1 for Long Term Care (LTC) Pharmacies & Consultant Pharmacists, "*Pharmacies are continuing to move more into automation, especially the larger operations. Pharmacies surveyed have been quickest to embrace e-prescribing, automated packaging and electronic Medication Administration Records (eMARs) in Skilled Nursing Facilities (SNFs), but at least half of those responding have yet to invest in those technologies. However, many more are investigating ways to enhance their use of technology. The greatest interest is in e-prescribing and eMARs. Most pharmacy management system vendors (80%) are supporting e-prescribing even though most are not utilizing it yet. LTC pharmacies appear to be getting more access to electronic records, but there is still a long way to go. One-third of LTC pharmacies and over half (53.3%) of the consultants surveyed still can't send or receive data electronically to facilities although the facilities have Electronic Medical Records (EMRs).* "[7]

In terms of electronic prescribing, in August 2011 National Institute of Standards and Technology (NIST) provided a high level overview and NCPDP Analysis of the use of SCRIPT in the LTPAC setting. The document noted inconsistencies in LTPAC e-prescribing adoption "*because the largest institutional pharmacies have added support for SCRIPT messaging in recent years, the majority pharmacies used by LTPAC facilities today have some level of support for electronic prescribing using SCRIPT version 10.1 or higher. However, the particular SCRIPT message types and versions supported vary by pharmacy, as well as implementation details, due to the fact that most facility-to-pharmacy messaging in the setting is accomplished using point-to-point connections negotiated separately between facility and pharmacy vendors rather than through networks such as Surescripts or Emdeon. The lack of direction on LTPAC e-prescribing standards in the CMS e-prescribing standards for Medicare Part D has contributed to this inconsistency, by leaving a vacuum of guidance to vendors implementing e-prescribing in this setting.*"[8] Since the exemption is scheduled to be removed November 1, 2014, the industry is unsure how lifting the exemption will affect e-prescribing adoption in the LTPAC setting.

In addition, the August 2011 NIST report noted unique issues related e-prescribing of controlled substances in the LTPAC setting. The report stated "*a higher proportion of medications used in the LTPAC setting are controlled substances, as compared to the ambulatory setting. These medications present a further obstacle to LTPAC e-prescribing adoption due to the additional requirements established by the DEA in its interim final rule. Especially problematic are rules that would effectively require prescribers in this setting to have an uncommonly formal employment relationship with their patient's LTPAC facilities in order to use the facilities' prescribing systems to create electronic controlled substance prescriptions. However, as a result of NCPDP comments to the initial DEA controlled substance rule, the interim final rule contains directional language supporting an electronic workflow by which a prescriber creates an electronic controlled substance prescription and routes it to an LTPAC facility for review and annotation, after which it is forwarded to the pharmacy. As noted above, the NCPDP LTPAC E-Prescribing Task Group is currently working on a messaging process that would enable that workflow—protecting the prescriber's medication order while enabling the facility to review, annotate, and forward the order to the patient's pharmacy.*"[9]

During the ASCP November 2013 Annual Meeting, Rob Baird, MS, President of Geriatric Practice Management and myself presented a session on "*LTC e-Prescribing Model - Physician and Pharmacy Perspective*".[10] The presentation outlined working models for the LTPAC physicians, pharmacists and pharmacies could use to meet the e-prescribing regulatory and standard requirements including those for controlled substance electronic prescribing while using messaging standards to meet the facility staff and consultant pharmacists workflow and communication processes.

LTPAC and BH voluntary EHR certification program can assist with improving medication management and ONC support for pharmacist and pharmacy EHR adoption in these settings is needed. We applaud ONC's efforts in providing industry guidance to pharmacists in all practice settings to voluntarily adopt EHR certification.

Respectfully submitted,

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[1] EHR Payment Incentives for Providers Ineligible for Payment Incentives and Other Funding Study, accessed December 9, 2013: http://aspe.hhs.gov/daltcp/reports/2013/ehrpi.shtml.

[2] The Roadmap for Pharmacy Health Information Technology Integration in U.S. Health Care, accessed December 9, 2013: http://www.pharmacyhit.org/pdfs/11-392_RoadMapFinal_singlepages.pdf.

[3] ASCP Guidelines for Medication Therapy Management Services in Long-Term Care Facilities, accessed December 9, 2013: http://www.ascp.com/resources/policy/upload/ASCP-MTMGuidelines-3-3-07-3.pdf.

[4] Project Summary for Medication Therapy Management (MTM) Templated CDA, accessed December 9, 2013: http://www.hl7.org/special/Committees/projman/searchableProjectIndex.cfm?action=edit&ProjectNumber=842.

[5] CY 2014 Medication Therapy Management Program Guidance and Submission Instructions, page 12, accessed April 5, 2013: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MemoCY2014MTMP040513.pdf

[6] HL7 EHR Pharmacist/Pharmacy Provider Functional Profile, accessed December 9, 2013: http://www.hl7.org/implement/standards/product_brief.cfm?product_id=262.

[7] ASCP and QS1 Report for Long-Term Care Pharmacies & Consultant Pharmacists 2011, non-public access December 9, 2013: https://www.ascp.com/sites/default/files/2011-ASCP-BenchmarkingSurveyReport.pdf (ASCP approved use available to HITPC Certification/Adoption WG members)

[8] NIST NCPDP Analysis – SCRIPT in Long-Term and Post-Acute Care August 31, 2011, accessed December 9, 2013: http://healthcare.nist.gov/resources/docs/FirstAmerican/NIST_NCPDPSCRIPTSupportLTPAC.pdf.

[9] NIST NCPDP Analysis – SCRIPT in Long-Term and Post-Acute Care August 31, 2011, accessed December 9, 2013: http://healthcare.nist.gov/resources/docs/FirstAmerican/NIST_NCPDPSCRIPTSupportLTPAC.pdf

[10] Long-Term Care e-Prescribing Model - Physician and Pharmacy Perspective November 22, 2013, accessed December 9, 2013: http://www.ascp.com/annual2013/sites/default/files/files/LTCePrescribing.pdf.