American Pharmacists Association

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Report of the Policy Committee

Interoperability of Communications among Health Care Providers to Improve Quality of Patient Care
Integrated Nationwide Prescription Drug Monitoring Program
Role of the Pharmacist in the Care of Patients Using Cannabis

Committee Members
Michael Moné, Chair
Laura Carpenter
Susan Dickey
Betsy Elswick
Terry Gubbins
Kayla Hansen
Brenna Neumann
Eric Roath
Thomas Worrall

Ex Officio
William Riffe, Speaker of the House
Theresa Tolle, Speaker-elect of the House

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Interoperability of Communications among Health Care Providers to Improve Quality of Patient Care

The Committee recommends that the Association adopt the following statements:

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 multi-directional electronic communication systems to improve patient safety, enhance quality care and facilitate care transitions.

3. APhA advocates for the inclusion of pharmacists in the development 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 and with minimal cost to providers.

4. APhA advocates for pharmacists and other health care providers to have comprehensive read and write access to electronic health records. Information shared between providers utilizing a health information exchange (HIE) should utilize a standardized secure interface based upon 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, as 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 and other health care professionals in the appropriate use of electronic health records to reduce errors and improve the quality and safety of patient care.

9. APhA supports the creation of a voluntary, non-punitive, standardized, interoperable system for reporting 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.
Summary of Discussion

1. The committee reviewed current APhA policy related to electronic health records, electronic prescribing, and health information technology and recognized continuing challenges in these areas.
2. The committee discussed challenges related to current electronic prescribing systems and recognized that e-prescribing is one piece of a larger interoperability issue.
3. The committee discussed the need for an overall vision for interoperability and felt that statement 1 accurately reflects that vision.
4. The committee recognized inconsistencies in the engagement of pharmacists in the development and implementation of electronic communication systems.
5. The committee agreed that electronic health information must be bi-directional, HIPAA compliant, billing accessible and timely. The term “bidirectional” was discussed in detail, and the committee reached consensus around the idea that “bidirectional” means read and write access to electronic health records. The term “timely” refers to the idea that the information being received is current and useable by the practitioner when they are working with the patient. The term “billing accessible” refers to the fact that electronic health information should be integrated with claims processing systems.
6. The committee discussed the costs that could by incurred by pharmacists and other health care providers related to interoperability of systems, and agreed that cost to the providers should be minimized to the extent possible.
7. The committee discussed current technologies versus new technologies and agreed that some current systems could be enhanced to meet the goal of interoperable systems that improve the quality of patient care.
8. The committee recognized the importance of pharmacists having access to information that would assist them in making both collaborative and clinical decisions. In addition, pharmacists and other health care team members should have read and write access.
9. The committee discussed the effect of meaningful use incentive programs on the use of electronic health records and health information exchanges. These payment systems are driving some clinicians to use these systems, but not all members of the health care team have access. The committee agreed that health care professionals who are not incentivized through meaningful use programs must still be included in the use of these electronic systems.
10. The committee considered patient access to and control of their own electronic health records. The committee agreed that HIPAA regulations adequately address this issue as patients may request access to their health information at any time.
11. The committee discussed the need for health information exchanges to move beyond just state- and regional-based exchanges. The committee considered the difference between a nationwide systems and standards that connect state and regional exchanges, and agreed that there should be an infrastructure that facilitates the exchange of information among existing systems. The committee also recognized the need for standardization of a secure interface based upon recognized international standards.
12. The committee recognized that federal entities, such as Veterans Affairs, currently utilize nationwide electronic health records, but noted that these systems do not necessarily integrate and exchange information with state and territory exchanges.

13. The committee discussed business entities that may withhold patient health information for their own financial benefit. These practices and proprietary systems hinder or prevent the sharing of patient health information, negatively impact patient care, and should be avoided.

14. The committee discussed how systems could facilitate communication between pharmacies and prescribers during care transitions. Communications related to patient adherence and medication discontinuation would be especially helpful to support the quality of patient care and patient safety during care transitions.

15. The committee considered how the reporting of issues with electronic prescriptions could be utilized for the quality improvement and research, and agreed that continuous quality improvement is key to effective utilization of health information technology. The committee recognized that, currently, there is no system in place to accomplish this.

16. The committee agreed that education of all stakeholders is a key aspect of appropriate and effective utilization of health information technology. Effective utilization will support improved quality of patient care and patient safety.
The Committee recommends that the Association adopt the following statements:

1. APhA supports the establishment of a standardized and integrated nationwide prescription drug monitoring program that includes all federal, state and territory databases for the purpose of providing health care professionals with accurate and real-time information to assist in clinical decision making when prescribing and dispensing controlled substances.

2. APhA supports pharmacist involvement in the development of uniform standards for an integrated nationwide prescription drug monitoring program such as the definition of authorized registered users, documentation, reporting requirements, system response time, security of information, minimum reporting data sets, and standard transaction format.

3. APhA supports mandatory PDMP enrollment by all health care providers who prescribe or dispense controlled substances, system query before prescribing controlled substances, and reporting by all those who dispense controlled substances.

4. APhA advocates for the development of seamless workflow integration systems that would enable consistent use of a nationwide prescription drug monitoring program (PDMP) by prescribers and pharmacists to facilitate prospective drug review as a standard of practice prior to the prescribing and dispensing of controlled substances.

5. APhA advocates for the continuous, sustainable federal funding sources for practitioners and system operators to utilize and maintain a standardized integrated and real-time nationwide prescription drug monitoring program.

6. APhA supports the use of interprofessional advisory boards to coordinate collaborative efforts for compiling, analyzing and using prescription drug monitoring program (PDMP) data trends related to controlled substance misuse, abuse, and/or fraud, in addition to providing focused provider education and patient referral to treatment programs, and to support research activities on the impact of PDMP programs.

7. APhA supports the education and training for authorized users about a nationwide prescription drug monitoring program (PDMP) to ensure proper data integrity, use and confidentiality.
Summary of Discussion

1. The committee reviewed the 1989 APhA policy related to multiple copy, prescription order programs and agreed that there was a need to revisit APhA’s position on this issue.

2. The committee recognized the current lack of nationwide connectivity among state-based drug monitoring programs. The term “nationwide” was used intentionally to describe a system that connects data rather than one system at the national level.

3. The committee agreed that these systems should be used for clinical decision-making and that part of the clinical decision-making process includes the consideration of misuse, abuse, diversion and fraud regarding controlled substances.

4. The committee discussed platforms, such as NABP PMP InterConnect, that connect state-based information, but that the lack of nationwide connectivity interferes with the prescribers’ and pharmacists’ ability to make sound clinical judgments related to the prescribing and dispensing of controlled substances.

5. The committee agreed on the need to support a system that allows for interconnectivity of the data currently being collected in each state.

6. The committee discussed the need to have uniform standards for an integrated nationwide prescription drug monitoring and agreed that pharmacists must be involved in the development of such standards. Recognizing that each state currently has its own requirements related to these programs, the development of standards will be key to successful implementation of a nationwide program. The committee agreed that funding will be a key driver in the development of nationwide standards.

7. The committee discussed the issue of access to the information housed in prescription drug monitoring programs. The definition of an authorized, registered user and the level of user access may vary among states and should be addressed in the creation of nationwide standards. The committee also agreed that the pharmacists’ ability to delegate access should be addressed in nationwide standards.

8. The committee discussed the need for pharmacists to document when they refuse to fill a prescription and return it to the patient based on information found in the prescription drug monitoring program. Lack of documentation may pose a risk to the pharmacist if he or she is unable to explain why the database was accessed for a particular patient. The committee felt that this concept is addressed by “documentation” in statement 2.

9. The committee agreed that the use of these systems should not interfere with the delivery of legitimate patient care. The seamless integration of these systems into both prescriber and pharmacist workflow is essential for the successful implementation of an integrated, nationwide program.

10. The committee agreed that enrollment in prescription drug monitoring programs must be mandatory to ensure that both prescribers and pharmacists participate in the program. Optional enrollment could result in a lack of participation. There was discussion around the need to develop systems that enable the programs to be used consistently and within the standard of practice.

11. The committee discussed the fact that pharmacists have a duty to protect the public and using prescription drug monitoring programs in the course of patient care assists pharmacists in performing this duty.
12. The committee recognized the costs associated with the creation and implementation of any nationwide system and agreed that sustainable funding is necessary to facilitate the development of such a program. The committee believes that federal funding drives implementation of nationwide standards.

13. The committee agreed on the need to have an interprofessional advisory board to guide collaborative efforts related to prescription drug monitoring programs. Compiling, analyzing, and using program data will assist in providing focused provider education. In addition, analyzing data trends may help providers identify and refer patients who need addiction treatment.

14. The committee recognized the need for ongoing education and training related to the use of a nationwide prescription drug monitoring program to ensure that users of the systems understand how data should be maintained and utilized to ensure patient confidentiality.
Role of the Pharmacist in the Care of Patients Using Cannabis

The Committee recommends that the Association adopt the following statements:

1. APhA advocates for resolution of the federal and state conflicts surrounding the legal status of cannabis and its various components.

2. APhA supports the establishment of a USP monograph for the standardization of cannabis and its various components.

3. APhA supports regulatory changes to facilitate clinical research related to the clinical efficacy and safety associated with the use of cannabis and its various components.

4. APhA encourages health care provider education related to the clinical efficacy, safety and management of patients utilizing cannabis and its various components.

5. APhA advocates that the pharmacist collect and document information in the pharmacy patient profile about patient use of cannabis and its various components and provide appropriate patient counseling.

6. APhA supports pharmacist participation in dispensing cannabis and its various components when the products and delivery mechanisms have scientific data supporting legitimate medical use, and federal and state/territory law or regulation permits their dispensing.

7. APhA opposes the furnishing of cannabis and its various components for medical purposes unless performed by licensed health care professionals whose scope of practice includes the dispensing of prescription medications and who comply with state and federal regulations.

8. APhA supports the clinical judgment of pharmacists to decide whether or not to furnish cannabis and its various components for medical use where allowed by law.

9. APhA opposes pharmacist involvement in furnishing cannabis and its various components for recreational use.
Summary of Discussion

1. The committee reviewed 1980 APhA policy related to the medicinal use of marijuana and agreed that further policy in this area is warranted.
2. The committee agreed that pharmacists should have a role in dispensing only when cannabis has an approved medical use defined by FDA and has been rescheduled outside of a schedule 1 substance by the DEA.
3. The committee reviewed the usage of the term “cannabis” versus “marijuana” and chose cannabis as it comprehensively covers the various forms of the plant. Merriam-Webster dictionary defines cannabis as any of the preparations (as marijuana or hashish) or chemicals (as THC) that are derived from the hemp and are psychoactive.
4. The committee discussed the need for pharmacists to include cannabis within their patient medication records to assess for clinical interactions. Screening for cannabis is only in terms of questioning the patient and pharmacists should not be required to actually obtain test results for the presence of illicit substances. This is similar to how health care professionals currently assess patient use of tobacco, alcohol, and other substances. Patient/pharmacist confidentiality will be maintained.
5. The committee agreed that education is key so that pharmacists can appropriately counsel patients regardless of whether the product is being used for medical or recreational use.
6. The committee reviewed the terms “dispensing”, “distribution”, and “furnish” related to how pharmacies will interact with cannabis products. Furnish was chosen and is used similarly to the term furnish in prior APhA policies.
7. The committee discussed the issues related to quality and purity of the product. In doing so, the USP was identified as a reliable reference for the creation of a cannabis drug monograph. The role of the FDA to determine proper medical indication and usage was also identified.
8. The committee discussed how the current conflict between state and federal laws puts pharmacists and pharmacies at risk for potential litigation related to pharmacist licensure and pharmacy DEA licensure.
9. The committee discussed the usage of pharmacist conscious clause information related to cannabis and the issue of pharmacists being held liable to dispense cannabis products. Pharmacists should be able to use their own independent professional judgment on whether or not to dispense cannabis in a pharmacy. The committee felt that the conscience clause adequately covered this issue and chose “clinical judgment” rather than “professional judgment.”
10. The committee reviewed policies passed by the American Medical Association related to the rescheduling of cannabis for the purposes of research.