2019 House of Delegates
Report of the Policy Committee

- ❖ Consolidation within Health Care
- ❖ Pharmacists' Role in Mental Health and Emotional Well-Being
- ❖ Referral System for the Pharmacy Profession

Committee Members

Steve C. Firman, Chair
M. Lynn Crismon
Nicholas Dorich
Betsy Elswick
Alison Knutson
Michaela Newell
Cynthia Pigg
Adrienne Simmons
Dennis Williams

Ex Officio
Michael D. Hogue, Speaker of the House
Joey Mattingly, Speaker-elect of the House

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2018–19 APhA Policy Committee Report

Consolidation within Health Care

The Committee recommends that the Association adopt the following statements:

1. APhA advocates that health care mergers and acquisitions must preserve the pharmacist–patient relationship.
   [Refer to Summary of Discussion Items 8,9,10,11,12.]

2. APhA supports optimizing the role of pharmacists in the provision of team-based care following health care mergers and acquisitions in order to:
   - enhance patient experience and safety,
   - improve population health,
   - reduce health care costs, and
   - improve the work life of health care providers.

   [Refer to Summary of Discussion Items 12 and 13.]

3. APhA asserts that the scope of review by federal agencies regarding the impact of health care mergers and acquisitions on patients and the provision of care is inadequate. Therefore, APhA calls for:
   - Reform of the review process for health care mergers and acquisitions;
   - Creation of an ongoing post-health care mergers and acquisitions evaluation process; and
   - Open and continuing dialogue among stakeholders regarding strategies to assure patient access to care.

   [Refer to Summary of Discussion Items 14,15,16,17,18.]

Summary of Discussion

1. The Committee discussed the original focus of this policy topic around vertical integration and broadened the issue to address integration in any health care setting, be it considered a vertical or horizontal type of integration. (all statements)

2. The Committee considered the original title language and modified it to "consolidation within health care" to be inclusive of vertical integration while also applying to other types of integration. Additionally, the language of "mergers and acquisitions" are used throughout these policy statements as it is the terminology familiar to a business environment and federal agencies who review these types of business deals. (all statements)

3. The Committee discussed the topic of payment and reimbursement for pharmacists within integrated health care models and determined that existing policy from APhA **2017 Pharmacy Performance Networks** (statement 2) and **2017 Pharmacists' Role within Value-based Payment Models** (statement 3) sufficiently covers the issues of payment and reimbursement. (all statements)

4. The Committee reviewed APhA **2013 Ensuring Access to Pharmacists' Services** as it relates to recognition by payers and the integration of outcomes and claims data between providers and determined no additional statements were needed on technology or payment. (all statements)

5. The Committee reviewed APhA **2004,1990 Freedom to Choose** and believed that this existing policy covers the topic of patient choice and did not feel an additional policy statement was needed. (all statements)

6. The Committee considered the use of the phrase "health care integration" instead of the phrase "mergers and acquisitions" to be broader; however, it was noted that health care integration typically refers to the integration of health care information technology (HIT) so this term was not used. The Committee believed the terminology of "mergers and acquisitions" is more accurate when calling for reform of the process as this is what the FTC and other federal agencies review. (all statements)

7. The Committee decided to keep the policy statements focused on the pharmacist–patient relationship versus specific mergers and acquisitions so that the statement would have broader application. (all statements)

8. The Committee considered potentially focusing on business practices as a whole and not only looking at vertical integration as there may be other controversial business practices that may occur in the future that would not be covered by a policy specifically focused on vertical integration. They also discussed the existing APhA policy that applies to business practices and felt no additional statements were needed at this time. (Statement 1)

9. The Committee decided that these policy statements are meant to include both a patient's access to medications and pharmacist patient care services. (statement 1)

10. The Committee specifically chose the term "preserve," in statement 1, to ensure that when a pharmacist–patient relationship exists, any merger or acquisition would maintain this relationship. The Committee noted that there may be some health care mergers and acquisitions that don't involve pharmacists and chose not to use the term "ensure" in place of "preserve." (statement 1)

11. The Committee developed statement 1 with the intent for consumer protection and preserving the patient's relationship with the pharmacist. (statement 1)

12. The Committee discussed the potential positive and negative aspects of vertical and horizontal integration and emphasized the importance of addressing issues and opportunities that might impact patient's access to care post-mergers and acquisitions. (Statement 1,2)

13. The Committee reviewed the Institute for Healthcare Improvement (IHI) Triple and Quadruple Aim and believed it was important to incorporate these concepts into the policy statement to emphasize. (statement 2)

14. The Committee noted that the current oversight of the Federal Trade Commission (FTC) includes the "quality of goods or services," but the review of this subject as it relates to a health care setting may not be comprehensive or transparent and could be limiting a patient's access to care. The Committee referenced the following charges of the FTC regarding merger review: https://www.ftc.gov/enforcement/merger-review. (statement 3)

15. The Committee referenced a statement from the American Medical Association (AMA) that discussed how the FTC is not considering the effect of mergers and acquisitions on patient care. While this may not currently be within the FTCs purview, the Committee felt that it should be. The Committee crafted the proposed statement to be similar with the AMA statement, aiming to raise awareness by policy makers of the impact of these mergers and acquisitions on patient care. (statement 3)

16. The Committee recognized the current involvement of the FTC and DOJ in the review and approval process of mergers and acquisitions and decided to broaden the statement scope to include engagement of other federal agencies, such as the Department of Health and Human Services (HHS) or others. (statement 3)

17. The Committee reviewed the American Medical Association's analysis and response to the CVS–Aetna merger that urged the DOJ and state antitrust enforcers to monitor the post-merger effects of this merger. (statement 3)

18. The Committee discussed the importance of an ongoing post-merger review process by federal agencies to evaluate the impact a merger or acquisition has on quality of care over time, similar to how FDA conducts post-market surveillance for a newly approved medication. (statement 3)

Pharmacists' Role in Mental Health and Emotional Well-Being

The Committee recommends that the Association adopt the following statements:

1. APhA encourages all health care personnel to receive training and provide services to identify, assist, and refer people at risk for or currently experiencing a mental health crisis.
   [Refer to Summary of Discussion Items 8,9,10,11,12,13.]

2. APhA encourages employers and policy makers to provide the support, resources, culture, and authority necessary for pharmacists and student pharmacists to engage and assist individuals regarding mental health and emotional well-being.
   [Refer to Summary of Discussion Items 14,15,16,17,18,19.]

3. APhA supports integration of a mental health assessment as a vital component of pharmacist-provided patient care services.
   [Refer to Summary of Discussion Item 20.]

Summary of Discussion

1. The Committee discussed existing APhA **1979 Dispensing and/or Administration of Legend Drugs in Emergency Situations** and referenced the applicability of the existing statement on Good Samaritan Acts and new policy was not needed in this area. (all statement)

2. The Committee determined payment should not be specifically included as it may be misinterpreted that pharmacists are asking for payment for helping an individual in a mental health crisis. However, this idea may be covered with the reference to "resources" and previous APhA policy calls for compensation for pharmacists provided patient care services. (all statements)

3. The Committee discussed the importance of knowing where to refer patients for mental health care and how pharmacists have the opportunity to fill a recognized gap in primary care coverage for mental health services. (all statements)

4. The Committee referenced NAMI's *Navigating a Mental Health Crisis* when discussing activities to respond to a mental health crisis: https://www.nami.org/About-NAMI/Publications-Reports/Guides/Navigating-a-Mental-Health-Crisis/Navigating-A-Mental-Health-Crisis.pdf?utm_source=website&utm_medium=cta&utm_campaign=crisisguide. (all statements)

5. The Committee decided to consider the terms of "emergency" and "crisis" as meaning the same thing and used "crisis" throughout this policy item. NAMI references both terms interchangeably as do other organizations. (all statements)

6. The Committee referenced a statement from the Surgeon General that uses the phrase "mental and emotional well-being," https://www.surgeongeneral.gov/priorities/prevention/strategy/mental-and-emotional-well-being.html. The Committee decided that "mental health" should be used in these policy statements as we are trying to fight the stigma associated with mental health disorders and should not be afraid to use this term to encompass a wide variety of symptoms that may not necessarily qualify someone for a diagnosed mental illness. In addition, it was felt emotional well-being encompasses a wider range of symptoms that may not be included in mental health. (all statements)

7. The Committee agreed that the term mental health crisis could be defined as a situation where a patient has suicidal/homicidal ideation or extreme emotional disturbances as described by Mental Health First Aid USA and the National Alliance of Mental Illness (NAMI). The Committee also emphasized that substance use or addiction can be a part of a crisis but was not the focus of these policy statements. (all statements)

8. The Committee defined "health care personnel" by using the following definition from the Centers for Disease Control and Prevention (CDC): all paid and unpaid persons working in health care settings who have the potential for exposure to patients and/or to infectious materials, including body substances, contaminated medical supplies and equipment, contaminated environmental surfaces, or contaminated air. (statement 1)

9. The Committee recognized the importance of training that includes what to do when patient needs are identified and the importance of resources for patient referral being available. The Committee reviewed APhA **2018 Efforts to Reduce the Stigma Associated with Mental Health Disorders or Diseases** and believed that the proposed policy statement expands on the 2018 policy by including information on referral of identified people needing assistance. (statement 1)

10. The Committee discussed focusing these policy statements on only the pharmacy profession, but felt it was important to include all health care personnel to address the issue of mental health crisis management across the patient care continuum. Health care personnel includes pharmacy staff members, medical and nursing providers, and other individuals serving patients across the health care spectrum. (statement 1)

11. The Committee utilized the analogy of individuals being CPR certified in preparation for potential need to administer the service to a patient in cardiac arrest. The likelihood of a health care personnel interacting with individuals at risk for or currently experiencing a mental health crisis is greater and therefore makes the case for training and engagement of individuals throughout the health care system. (statement 1)

12. The Committee discussed whether the training of health care personnel should be mandatory or voluntary and decided to encourage everyone to receive training but felt a mandate for this training was not necessary. (statement 1)

13. The Committee emphasized the importance of identifying people who are at risk as opposed to only focusing on those who are currently experiencing a mental health crisis. It is important to recognize pre-event signs and intervene where appropriate. (statement 1)

14. The Committee discussed the application of current Good Samaritans laws and the implementation of mental health screening into pharmacist workflow. The Committee felt that employers/company policies and policy makers needed to ensure that pharmacists had the support and resources necessary to appropriately implement the identified interventions. (statement 2)

15. When the Committee referred to "policy makers," this is meant to include federal and state legislators, regulatory agencies, and staff members at hospitals, health systems, or employers who develop internal company policies. (statement 2)

16. The Committee referenced APhA **2004,1965 Mental Health Programs** and determined existing policy is focused on pharmacist involvement and does not advocate for support or resources from employers to advance the pharmacist's role in this area. (statement 2)

17. The Committee discussed that individuals may not have a diagnosis of a mental health condition prior to being identified as being at risk or experiencing a mental health crisis. Therefore, the Committee utilized the term individual to describe the targeted population of these services as being potentially beyond current patients. (statement 2)

18. In reviewing the scope of this topic, the Committee acknowledged the numerous approaches it could take, in addition to existing APhA policy. The Committee decided to keep the proposed policies focused on the patient/individual versus issues related to the individual practitioner, as they would be encompassed under the "individual" descriptor. (statement 2)

19. The Committee discussed that states have Qualified Mental Health Professionals lists that do not include pharmacists and additional work is needed to expand this throughout the states. (statement 2)

20. The Committee emphasizes the importance of inclusion of mental health and emotional well-being assessment as part of the JCPP Pharmacist's Patient Care Process (PPCP) and the value of identifying individuals at risk before a mental health crisis occurs. PPCP incorporates assessment of "health and functional status" or "other aspects of care" within its process and therefore could encompass assessment of mental health status as part of the process. The Committee also considered how mental health status is not disease specific and crosses many conditions and should be included as part of PPCP. The Committee acknowledged numerous places within PPCP for pharmacists to assess, identify, and act upon a patient's mental health needs. (statement 3)

Referral System for the Pharmacy Profession

The Committee recommends that the Association adopt the following statements:

1. APhA supports referrals of patients to pharmacists, among pharmacists, or between pharmacists and other health care providers, to promote optimal patient outcomes.
   [Refer to Summary of Discussion Item 6.]

2. APhA supports referrals to and by pharmacists that ensure timely patient access to quality services and promote patient freedom of choice.
   [Refer to Summary of Discussion Items 6,7,8,9.]

3. APhA advocates for pharmacists' engagement in referral systems that are aligned with those of other health care providers and facilitate collaboration and information sharing to assure continuity of care.
   [Refer to Summary of Discussion Items 10 and 11.]

4. APhA supports attribution and equitable payment to pharmacists providing patient care services as a result of a referral.
   [Refer to Summary of Discussion Items 12,13,14.]

5. APhA promotes the pharmacist's professional responsibility to uphold ethical and legal standards of care in referral practices.
   [Refer to Summary of Discussion Item 15.]

6. APhA reaffirms its support of development, adoption, and use of policies and procedures by pharmacists to manage potential conflicts of interest in practice, including in referral systems.
   [Refer to Summary of Discussion Item 16.]

Summary of Discussion

1. The Committee reviewed APhA **2018 Pharmacists Electronic Referral Tracking** and noted this existing policy was focused on the process and procedures of a referral and intended for the new policy statements to be focused on the principles of a referral. (all statements)

2. The Committee avoided words such as "bidirectional" and wanted to avoid a focus on technology because these topics already exist in **2018 Pharmacists Electronic Referral Tracking** and **2015 Interoperability of Communications Among Health Care Providers to Improve Quality of Patient Care** policy statements. (all statements)

3. The Committee discussed varying types of referral processes and intends for these policy statements to apply to any type of referral process and intends for these policy statements to be broad to apply to any existing process or a process yet to be developed. (all statements)

4. The Committee reviewed multiple APhA policies that reference team-based care such as **2013 Ensuring Access to Pharmacists' Services**, **2011 Pharmacist's Role in health Care Reform**, and **2017 Pharmacists' Role within Value-based Payment Models**, which cover a broader context of what services pharmacist should be able to provide. (all statements)

5. The Committee discussed the important role pharmacists are having in providing primary care services and referenced APhA **2013 Pharmacists Providing Primary Care Services** in addition to the following article from Forbes: https://www.forbes.com/sites/sachinjain/2018/10/10/can-pharmacists-help-reinvent-primary-care-in-the-united-states/#1d45b1d2590b. (all statements)

6. The Committee emphasized that the original intent of (statement 1) is to get referrals and be a part of the system and the intent of (statement 2) is to get the right patients to the right providers. (statements 1 and 2)

7. The Committee believes that any pharmacist could be included in a referral system described in these policy statements as a referrer of patients and recipient of referrals if able to meet quality service expectations. (statement 2)

8. The Committee considered the phrases "needed," "medically necessary," or "essential pharmacist services" in place of "quality" but believed "quality" more accurately described a measurable outcome. The Committee discussed that "medically necessary" was more of a subjective term and "essential" implied that pharmacists may provide non-essential services and decided not to use these terms. (statement 2)

9. The Committee reviewed APhA **2004,1990 Freedom to Choose** and still felt it was necessary to call out the importance of a patient's freedom of choice regarding a referral system within statement 2. (statement 2)

10. The Committee considered including the "team-based care" in statement 3, but felt that the statement needed to be broader. The Committee believes that a referral system aligned with those of other health care providers encompasses "team-based care." (statement 3)

11. The Committee discussed using the phrase "referral systems for pharmacists" and changed it to "advocates for pharmacists' engagement in referral systems" to add clarity for the role of a pharmacist within an existing or new system versus something being created solely for pharmacists. (statement 3)

12. The Committee discussed using the phrase "patient care services" and determined that it encompasses the breadth of services that pharmacists provide and is the appropriate terminology for the policy statements. (statement 4)

13. The Committee discussed the pharmacist's liability when referring a patient or having a patient referred to her/him and believed these topics are covered in statement 4 through upholding ethical and legal standards of care in referral practices. (statement 4)

14. The Committee felt that the term "equitable" was necessary to ensure pharmacists received sufficient payment to cover patient care services provided by pharmacists similar to other health care providers. Additionally, the word "attribution" was included in order to ensure recognition of the pharmacist's role in the delivery and management of patient care services. (statement 4)

15. The Committee reviewed the Oath of a Pharmacist, APhA's Pharmacist Code of Ethics, and the AMA Referral Code of Ethics when developing these statements and decided that "ethical and legal standards of care" was all encompassing. (statement 5)

16. The Committee reviewed APhA **2011 Potential Conflict of Interest in Pharmacy Practice** and reaffirmed their support of a component of this existing policy while attributing the reaffirmed statement to referral practices. (statement 6)