Referral System for the Pharmacy Profession

Background Paper Prepared for the 2018-2019 APhA Policy Committee *(not yet copyedited)*

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Issue

The American Pharmacists Association (APhA) Board of Trustees has directed the 2018-2019 Policy Committee to recommend policy to the APhA House of Delegates related to a referral system for the pharmacy profession. The Board's guidance on this topic included -but was not limited to- two-way referral mechanisms, ability to refer patients to other pharmacists, health information technology needs to accommodate new referral methods, and ethical considerations when considering referrals.

BACKGROUND

As the Centers for Medicare and Medicaid Services (CMS) and health insurance companies move in the direction of value-based models, the concept of team-based care becomes much more vital in delivery and optimization of health care. One direct influencer often discussed by health care providers is patient referrals. Patient referrals traditionally consist of a health care provider with potential limited resources (i.e., training, equipment, time, or scope of practice) seeking the assistance of a differently resourced or capable health care provider. An important mechanism physician practices can employ to greatly increase their capacity to meet patient demand is to use a coordinated, team-based, patient-centered approach to care and delegate appropriate clinical responsibilities to non-physician practitioners.[1] Due to the increased demand for primary care providers, pharmacists can help address health care needs in the management of specific disease states in which they have the training and authority to oversee. There are over 300,000 pharmacists in the U.S., many of whom are underutilized in their capacity to contribute to addressing these unmet health care needs.[2] In addition, CMS continues to encourage the collaborative treatment and management of patients within the health care team.

PHARMACISTS' TRAINING AND CERTIFICATION

Pharmacist education, training, credentialing, and professional practice models closely mirror those of physicians in the U.S. In parallel to the physicians' Doctor of Medicine (M.D.) degree, pharmacists complete a degree program at the Doctor of Pharmacy (Pharm.D.) level, both focused on the delivery of meaningful clinical services.[3] Beyond the entry level degree to practice as a pharmacist, most will continue further training. Post-graduate training includes continuing education, certificate training programs, Advanced Practice and on-the-job Training, Fellowships and specialty certification. Some state laws require additional training and/or recognition for the provision of patient care services and expanded scope of practice.

A Post-Graduate Year One (PGY-1) residency program is the baseline of residency training. It is a 12 month organized, directed, accredited program that builds upon knowledge, skills, attitudes and abilities gained from pharmacy school.[4] Further training is available through Post-Graduate Year Two (PGY-2)

residency program and is often referred to as a specialty residency as its focus is within a specific area of pharmacy practice, such as oncology, pediatrics, ambulatory care, or management. A PGY-2 residency increases the depth of knowledge related to medication therapy and clinical leadership in the specific area of focus.[5] Board certification through pharmacy-specific certifications, such as the Board of Pharmacy Specialties (BPS) is a credential sometimes required or preferred in advanced practice settings. Certification for pharmacists is in alignment with physician certification through the American Board of Medical Specialties.[6] Pharmacists are also able to attain additional certifications through multi-disciplinary certifications such as the Certified Diabetes Educator (CDE).

CURRENT REFERRAL PRACTICE WITHIN HEALTH CARE

Pharmacists to Other Health Care Providers

Rather than create a referral system that is independent of current practice in other health care settings, it is important to understand the current state of referrals within the field. Two segments of the health care community that have established referral practice models are physicians and dentists. Understanding the current referral systems, communication, provider databases, payment or other compensations, and ethical considerations for referrals helps build a platform for the discussion of pharmacist referral.

Generally, in the physician setting, primary care physicians typically provide the referral to a specialist based on the need for specific expertise, complexity of patient needs, or guideline recommendations of certain disease states. Variability in referral practice does exist based on the health insurance and compensation models for the health care provider. As patients are referred to specialists, issues/ obstacles are present with the continuity of care and proper communication of clinical decisions. Many referrals do not include a transfer of information, either to or from the specialist; and when they do, it often contains insufficient data for medical decision making.[7] Furthermore, the list of available providers is heavily based on practice-setting and relationship with the primary care provider. Concern also exists regarding the return of the referred patient to the referring practitioner.

Payment and compensation for referrals, whether through direct or self-referral, are heavily regulated and in many cases against the law. Under current law, if a health care provider sends a referral to another health care provider, the primary provider may not be compensated for the referral.[8] Furthermore, physicians are prohibited from referring patients to specific entities in which they have a vested interest.[9]

The ethical considerations and views of the referral system in the various health care settings are well defined by the corresponding code of ethics. The American Medical Association (AMA) Code of Medical Ethics states "[p]hysicians' fiduciary obligation to promote patients' best interests and welfare can include consulting other physicians for advice in the care of the patient or referring patients to other professionals to provide care."[10] AMA's code of ethics further outlines the specific consideration for the physician, when a physician seeks or provides consultation about a patient's care or refers a patient for health care services, including diagnostic laboratory services. Specifically, a physician should:

a) *"Base the decision or recommendation on the patient's medical needs, as they would for any treatment recommendation, and consult or refer the patient to only health care*

professionals who have appropriate knowledge and skills and are licensed to provide the services needed.

b) *Share patients' health information in keeping with ethics guidance on confidentiality.*

c) *Assure the patient that he or she may seek a second opinion or choose someone else to provide a recommended consultation or service. Physicians should urge patients to familiarize themselves with any restrictions associated with their individual health plan that may bear on their decision, such as additional out-of-pocket costs to the patient for referrals or care outside a designated panel of providers.*

d) *Explain the rationale for the consultation, opinion, or findings and recommendations clearly to the patient.*

e) *Respect the terms of any contractual relationships they may have with health care organizations or payers that affect referrals and consultation."* [10]

Another topic that the AMA Code of Ethics considers is self-referrals. When physicians enter into arrangements that provide opportunities for self-referral they must:

a) *"Ensure that referrals are based on objective, medically relevant criteria.*

b) *Ensure that the arrangement:*
   1. *Is structured to enhance access to appropriate, high quality health care services or products.*
   2. *Is within the constraints of applicable law.*
   3. *Does not require physician-owners/investors to make referrals to the entity or otherwise generate revenues as a condition of participation.*
   4. *Does not prohibit physician-owners/investors from participating in or referring patients to competing facilities or services.*
   5. *Adheres to fair business practices vis-à-vis the medical professional community—for example, by ensuring that the arrangement does not prohibit investment by nonreferring physicians.*

c) *Take steps to mitigate conflicts of interest, including:*
   1. *Ensuring that financial benefit is not dependent on the physician-owner/investor's volume of referrals for services or sales of products*
   2. *Establishing mechanisms for utilization review to monitor referral practices*
   3. *Identifying or if possible making alternate arrangements for care of the patient when conflicts cannot be appropriately managed/mitigated*

d) *Disclose their financial interest in the facility, product, or equipment to patients; inform them of available alternatives for referral; and assure them that their ongoing care is not conditioned on accepting the recommended referral."*[11]

The American Dental Association (ADA) published its own "General Guidelines For Referring Dental Patients," which states:

"[D]entists shall be obliged to seek consultation, if possible, whenever the welfare of patients will be safeguarded or advanced by utilizing those who have special skills, knowledge, and experience. When patients visit or are referred to specialists or consulting dentists for consultation:

1. *The specialists or consulting dentists upon completion of their care shall return the patient, unless the patient expressly reveals a different preference, to the referring dentist, or, if none, to the dentist of record for future care.*

2. *The specialists shall be obligated when there is no referring dentist and upon completion of their treatment to inform patients when there is a need for further dental care."*[12]

Currently there does not exist a formal process or mechanism for pharmacist referral to and by other health care professionals, nor a system for referrals between pharmacists.

DEVELOPING PHARMACISTS REFERRAL SYSTEMS

The development of a referral system for pharmacists consists of a multitude of factors to consider. A framework for pharmacist referral needs to be developed that guides the process across and within the healthcare system. Whether it be support for transitions of care or comprehensive medication management, access to pharmacists with advanced or specialized knowledge and skills can only improve care delivery and outcomes. Supporting the framework are access by pharmacists to necessary information within patient medical records utilizing technology and other communication vehicles. Under the *Health Insurance Portability and Accountability Act of 1996* (HIPAA), the Department of Health and Human Services (HHS) adopted standards for electronic transactions, including referral certification and authorization.[13] These standards outline that specific requests or responses between a health plan and health care provider follow HIPAA requirements.

Besides an interdisciplinary referral system, a referral system within the profession of pharmacy may increase access to pharmacists with specialized skillsets and enhance collaboration within the profession of pharmacy. A challenge for many pharmacists is isolation in practice and the ability to consult with or refer patients for further work-up by a specialist might be a solution to this pharmacist well-being challenge. Currently, pharmacists with specialized skillsets may not be readily accessible to other pharmacists because of system processes, payment policies or other barriers.

As seen in other health care professions, referral systems need a searchable database of providers that the referring provider may access and directly communicate the request. Physicians, other providers, and even pharmacists need a reliable resource to identify board certified or credentialed pharmacists to refer patients with specific needs. Referring providers will also need the ability to verify each of the specialists listed in the database maintain their professional licenses and other credentials. In addition, a referral database must also possess the capacity to collect the necessary information on providers for payers, employers, and referring health care providers.

Individual practice settings may have specific needs based on their resource availability and pharmacist-provided patient care services offered. Traditionally, in the inpatient setting, physicians and other health care providers partner with pharmacists under collaborative practice agreements (CPAs) and standing orders to optimize medication management needs. The inpatient settings afford a pharmacist with access to patient protected health information (PHI), clinical lab data, and ability to document within the patient's electronic health record (EHR). Similarly, outpatient clinics have comparable PHI and access to primary care providers to coordinate patient care.

One example study shows the opportunity for community pharmacies to be an ideal point of contact for specific health care needs. Cognitive memory screening can be easily incorporated into clinical service offerings in community pharmacy practice and provides a valuable opportunity to identify patients at-risk and refer them to a physician for appropriate testing and diagnosis.[14] Consultant pharmacists have limited access to PHI and often need to request specific information from the referring provider. The study identified maintaining recommended minimum expected resource requirements for overall

pharmacist referrals practice are necessary; however, understanding specific pharmacy practice settings abilities and limitations helps address the issues currently being faced by the pharmacists in these settings.

As patient referrals are received by the pharmacist there is need for the interoperability of the EHR to ensure the proper documentation, recommendations, and implementation of clinical decisions. The decisions and notes made by both the primary care provider and each specialist need to be readily accessible throughout the continuum of care. In addition, as pharmacists receive referrals from the health care providers, the need for access to patient history and clinical data becomes important to provide team-based care. Pharmacists need this information to make well informed clinical-decisions based on the complete clinical state of the patient.

Access to the referring health care provider and other team members to coordinate care and provide important evaluation and treatment decisions is considered the norm within health care settings. A practice model [See, Figure 1] from Canada looks at how pharmacists may be integrated into the outpatient referral-consultation process.[15]

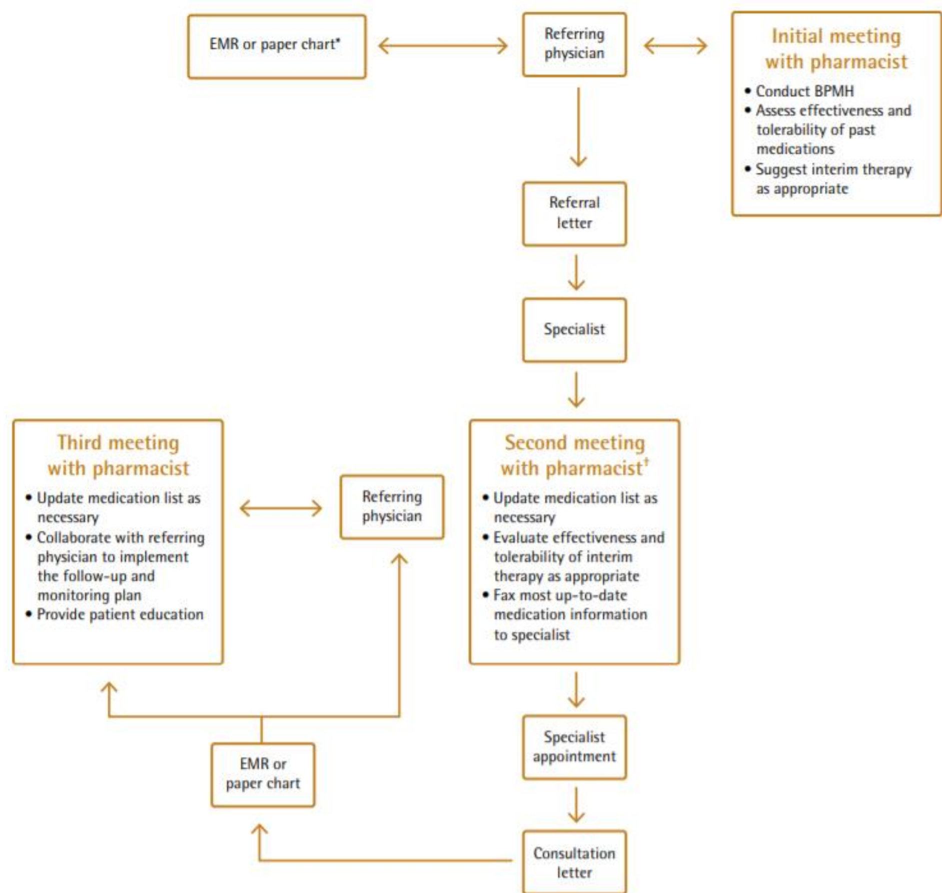

Figure 1. Proposed model for involving pharmacists in the referral-consultation process[16]

Legal, financial and ethical considerations must also be taken into account when building a pharmacist referral system. For a pharmacist to be eligible to receive referrals from other health care providers and payment for the referrals, most health care plans require formal referrals be sent to other health care providers, or at minimum a CPA to exist. Notifying a referring provider of decisions made by the pharmacist and the patient is needed to ensure proper documentation and communication. Depending on the payer and state specific regulations, pharmacists may be viewed as health care providers under Medicaid[16], or by commercial payers[17]; however, pharmacists would need federal recognition to receive referrals as health care providers within Medicare.

In practice, the clinical decisions shall be independent of the business decisions for the pharmacist. However, compensation to the pharmacist for the medical referral also needs to be carefully addressed under any functioning patient referral system. Although physicians and pharmacists are not directly compensated under Medicare for referring to a particular specialist, pharmacists often provide services incident to physician services arrangements that are billed by physicians using evaluation and management (E/M) codes. It is important to note that if CMS finalizes a recently proposed rule that would collapse E/M codes for new and established office visits (Levels 2 through 5 (99202-99205)) into a single blended payment rate, the Agency projects decreased payments for certain specialties (geriatrics (-4%), rheumatology (-7%), neurology (-7%), hematology/oncology (-7%), and endocrinology (-10%)) that require additional time under more complex E/M codes, which would also impact potential compensation for participating pharmacists.[18]

A last point of ethical consideration comes with the patient's choice of where the prescription should be filled. The Pharmacist Code of Ethics addresses this through III. A pharmacist respects the autonomy and dignity of each patient.[19] As a health care provider, pharmacists must be cautious to direct patients towards the personalized care specific to the best clinical, financial, and outcomes focused decision. This includes the ability for patients to fill a prescription at their preferred location.

AUDIENCE

The concept of pharmacist referral is not a novel one. Pharmacists have been referring patients daily to other healthcare professional, as well as receiving referrals, without formal documentation and communication processes or compensation for those activities. As the landscape of patient-centered care further develops the accessibility and opportunities for pharmacist-delivered care becomes critical to the optimized delivery of quality healthcare. Payers, health care providers, health care agencies, pharmacists, and patients must all understand the challenges and benefits of incorporating pharmacists into existing referral systems, as well as the benefit of creating referral systems within and outside of the pharmacy profession. A collaborative approach is needed to develop and implement the process that might include the legislative, regulatory, and practice policy spheres to ensure the key role of pharmacist referrals in providing integrated care.

Related APhA Policy

2018 **Pharmacists Electronic Referral Tracking**

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, including other pharmacists, irrespective of the health care system, model, or network in which the patient participates.
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.

2004 **Freedom to Choose**

1. APhA supports the patient's freedom to choose a provider of health care services and a provider's right to be offered participation in governmental or other third-party programs under equal terms and conditions.
2. APhA opposes government or other third-party programs that impose financial disincentives or penalties that inhibit the patient's freedom to choose a provider or health care services.
3. APhA supports that patients who must rely upon governmentally-financed or administered programs are entitled to the same high quality of pharmaceutical services as are provided to the population as a whole.

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