DRX 2-1A – Receipt of description of services

DRX 2-2A – Receipt of Patient Rights and Responsiblities

DRX 2-2C – Evidence of Medicare supplier standards delivered for patients receiving equipment and supplies under Medicare Part B – likely N/A. Interpreted as oral chemo does not qualify as equipment and supplies

DRX 2-4C – Receipt of who to contact with complaint

DRX 2-5B – Documentation that the patient receives and understands confidentiality prior to care

* Can use either:
	+ Documentation from EMR from admission of patient to clinic when they get new patient packet that includes HIPAA privacy act.
		- If signature page in new patient packet does not include this language, have proof printed in preparation of survey and explain clinic will have that added at next printing of patient packet
	+ Signature log from dispensing software at first time of pick up if POS system prompts patient to sign that they received HIPPA privacy act.
		- If POS software does not do this, contact dispensing software support and see if this step can be added for new patients to pharmacy.

DRX 2-5B – Patient signed release of information statement/form before the organization bills a third party payor as required by HIPAA – can be from EMR

DRX 3-4B – Documentation that patient was informed of charges prior to filling

* Sig logs
* Receipt of payment

DRX 3-5A – Financial hardship forms completed if client/patient is unable to pay

DRX 5-1A – Accurate record for each patient is maintained and shall include:

* Demographics/Identification data
* Names of emergency contact/family/authorized persons to release PHI to
* Name of primary caregiver
* Source of referral (remember, this is referral for pharmacy services, so prescribing physician is the source)
* Name of physician responsible for care
* Diagnosis
* Physician’s orders
* Admission and informed consent documents
* Initial assessments/plan of care – visit notes from physician, pharmacy adherence program
* Ongoing assessments/plan of care – visit notes from physician, pharmacy adherence program

Note: Can use multiple platforms to form one patient record: EMR, pharmacy dispensing service, adherence program, etc. Will need to know where to readily find each piece of information if using multiple platforms.

DRX 5-1B – Patient record includes:

* Physician orders which include:
	+ Current medications – can use med rec summary from EMR. Must be sure that clinic has med rec policy where each patient’s medications are verified upon each visit.
	+ Dietary orders (if applicable)
	+ Treatment orders
* Advance directives, if applicable
* Admission and discharge dates from hospital (if applicable)
	+ Can find in EMR
* Name of power of attorney (if applicable)
* Evidence of coordination of care – if services provided by other physicians, there is evidence
* Signed and dated progress notes from pharmacy with assessments taking place at least every 30 days.
* Copies of reports sent to physicians (if applicable)
* Discharge summary, if applicable

DRX 5-2B – Initial assessments must include:

* Demographics
* Physical health evaluation:
	+ Appropriateness of in home therapy (if applicable) – if no challenges noted, then it is not applicable
	+ Identification of health problems
	+ Review of medications
		- Dosing
		- Frequency
		- Method
	+ Dietary requirements
	+ Principle diagnosis and other pertinent diagnoses
	+ Allergies
* Social
	+ Identification
	+ Emergency contact
* Environmental
	+ Identification of safety or health hazards
	+ Presence of adequate living arrangments
* Economic
	+ Review of financial resources
	+ Documentation of any POI, financial hardship if applicable
* Mental component
	+ Evaluation of ability to understand and remember treatment schedule, dosing, administration, etc.

Note: May use EMR, dispensing software, and adherence platform

DRX 5-2B – Pharmacist, Nurse, Physician, or other professional as per state licensure regulations conducts and initial evaluation to determine eligibility, care, and support needs of the patient

DRX 5-2B – Documentation included on whether services will continue or not

* If prescription transferred to another in network pharmacy, it is noted in a log as well as on the patient record

DRX 5-2C – Initial Plan of Care

* Start date
* Demographics
* Diagnosis
* Problems/needs
* Current medications
* Allergies
* Orders for specific services or treatment
* Expected outcomes/goals
* Monitoring – EMR – labs, vitals, etc.

Note: Can use same means of displaying initial plan of care as used for initial assessment as there is some overlap

DRX 5-2G – Documentation shows effective communication and coordination between all personnel involved in patient’s care

DRX 5-2H – Documentation showing patient record reflects the plan of care is reviewed for:

* Appropriateness – care provided is still needed. Not shipping refills without authorization from patient and/or physician
* Effectiveness – what is the patient’s response to care
* Any change in patient’s condition that would make services unnecessary

DRX 5-2H – Organization follows policies and procedures and any applicable laws for review of plan of care. Plan of care must be reviewed:

* At a minimum of every 60 days
* When there are changes in patient’s response to therapy
* When physician orders change
* At the request of the patient
* As defined by organization’s P&P’s

DRX 5-4A – Patient record shows evidence of patient’s participation in plan of care. Evidence includes, but is not limited to:

* Plan of care may be signed by patient
	+ Evidence they received plan of care
	+ This could be in the form of payment
	+ Sig logs at time of prescription pick up/delivery
* A notation may be made in the patient record that the patient participated in the development of the plan of care
	+ Notation of receipt of new start counseling which included:
		- Administration
		- Goals of therapy
		- Adverse effects
		- Potential drug-drug interactions
		- Dosing schedule
		- Safe handling/storage
* There may be documentation in the patient record that the plan of care was reviewed and accepted by the patient
	+ Payment for presription
	+ Sig logs

DRX 5-4B – Evidence of changes in the plan of care based on reassessment data. Changes made based on:

* Patient request
* Change in patients condition
* Patient’s response to therapy
* When physician orders indicate changes

Evidence of communication to the physician regarding the patient’s condition

* If any correspondence occurs between pharmacy and physician, note in patient’s care plan that the correspondence took place.

If new or revised patient treatment goals are indicated, they must be reflected in a revised plan of care. Revised plans of care shall be approved by the patient’s physician.

* Visit notes in EMR meet this standard

DRX 5-5E – Patient education focuses on goal and outcome achievement as established in plan of care. Elements of patient education include, but is not limited to:

* Ongoing assessment of patient/caregiver’s learning needs
* Communication of needs to other health care team members
* Incorporating needs into the plan of care

Patient record includes documentation of all teaching, patient’s response to teaching, and the patient’s level of progress in goals. Written instructions are provided to the patient.

* P&P’s written that describe each teaching point provided when a patient started on new medication. Can write a P&P so that when a pharmacist notes, “new start counseling provided and accepted by patient,” it encompasses all teaching points needed

DRX 5-7A – Evidence that a Registered Pharmacist reviews all medications and consults with other health care professionals, including the physician. All OBRA counseling is completed as specified by law. A licensed pharmacist is specifically responsible for recognizing the following:

* Side effects
* Allergic reactions
* Desired outcomes
* Potential drug-drug interactions
* Appropriateness of the drug for the diagnosis
* Appropriateness of the dose
* Changes in the patient’s condition that contraindicate continuation of drug

Evidence that a medication profile is established at the start of therapy

* This can be done by medical assistants/triage nurses at each office visit
* Can use documentation from EMR that the above positions provide to meet this standard

There is documentation that the medication profile is reviewed at least every 30 days, updated whenever there are changes in the patient’s medication therapy, or as designed by the pharmacy policies and procedures

* Can write policies and procedures that detail the review of patient’s profile every 30 days.
* Documentation of refill assessments will suffice to meet this standard.
	+ i.e. as long as the patient is being reviewed every 30 days and an assessment is done, that is all the documentation needed

Evidence that if the patient is transferred to another healthcare entity, a copy of the medication profile is offered to the agency

DRX 5-9A: Referrals – Do not over-think this. “Referrals” are new prescriptions. This is only referring to pharmacy services, so don’t get to detailed here thinking that it is whole clinic P&P’s.

* Documentation exists that the organization follows their policies and procedures when accepting referrals (new prescriptions from the office)
* Documentation exists that referrals containing verbal orders are given to the designated professional for verification and documentation of verbal orders
	+ Interpretation: If state law requires a pharmacist to be the one to take verbal orders, that is who takes verbal orders.

DRX 5-9B – Evidence that patients receiving care meet eligibility requirements as outlined in the organization’s policies and procedures

* Examples:
	+ If closed door pharmacy, only accepting patients of physicians inside the facility
	+ Pharmacy is inside patient’s insurance network and contracted to fill prescriptions

DRX 5-15C – Patient record must reflect all discharge planning which includes:

* Summary of services provided
* Patient’s response to therapy, progress toward clinical goals – may use EMR
* Date and reason for transfer:
	+ Not in network
	+ Keep a log of these transfers
* Brief description of ongoing needs that could not be met
	+ Not in PBM network to fill prescriptions, etc.
* Any instructions/information given to patient
	+ In network pharmacy name/phone number

DRX 7-4C – Documentation that patient received emergency preparedness education

* Recommend to place this in new patient packet
* When patient signs for receipt of new patient packet and that page is scanned in the EMR, it will cover this standard

DRX 7-7A – Patient records are maintained to identify each patient who has received recalled medication (if applicable). Documentation includes but is not limited to:

* Manufacturer
* Lot numbers
* Expiration dates

DRX 7-7B – Patient record documents notification of recalled medication (if applicable)

DRX 7-9C – Documentation that the organization ensures that pharmaceuticals are stored under appropriate conditions, light, and temperature in the patient’s home by:

* Educating the patient
* Clearly labeling the product as to the appropriate storage condition requirements
	+ If dispense in stock bottles, that meets this requirement
	+ For products not dispensed in stock bottles, need to place auxiliary label describing storage conditions for each drug dispensed (including those stored at room temperature)

DRX 7-17A – only applicable if you service investigational drugs out of the dispensing pharmacy. If investigational drugs are studied in the clinic, but not coordinated through the dispensing pharmacy, this standard is N/A.

DRX 7-18A – REMS drugs

* If pharmacy dispenses drugs that have REMS requirements, policies and procedures are in place that describe the process by which these drugs are managed and dispensed.

DRX 7-21A – documentation in the record that the organization has verified the identity of the patient and the treatment the patient is to receive

* Policies and procedures describing identification of patient at pickup/delivery
	+ Name
	+ Address
	+ DOB
* Sig logs at pickup/delivery
* Picture – if patients have pictures in EMR, can show this as well