System Vendor Checklist for Pharmacist Clinical Documentation Workflow

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Pharmacy Health Information Technology Collaborative

Table of Contents

1. PURPOSE

The purpose of this paper is to help pharmacists and system vendors work together on a plan to define the clinical documentation workflow of pharmacists in pharmacy practice settings. The intent of the document is to define external and internal data sources following pharmacist's process of care for clinical documentation steps.

GOAL:

- To provide a checklist for pharmacists to share with their system vendors to identify external and internal data sources.

2. OVERVIEW

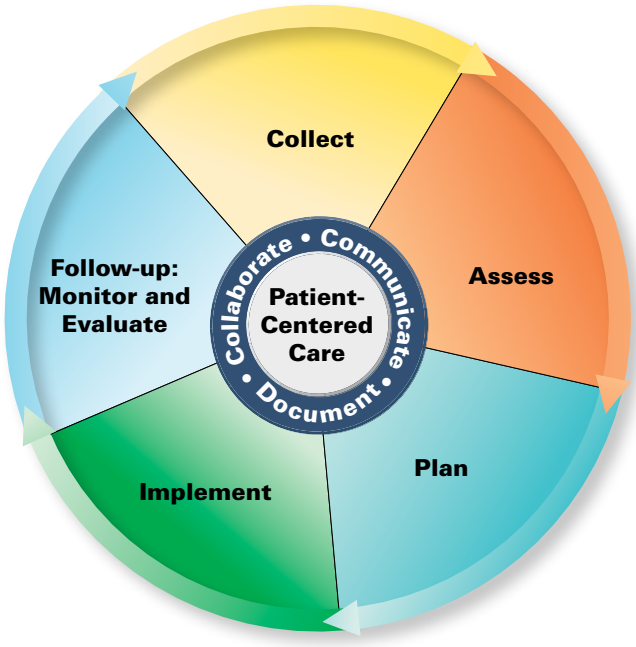
In May 2014, the Joint Commission of Pharmacy Practitioners defined five steps pharmacists use in the patient care process. These five steps are: collect, access, plan, implement, and follow-up (monitor and evaluate). Based on these fives steps, this guidance document identifies data from external sources, data to external sources, data from internal sources, and data to internal sources for the process of patient-centered care. The proposed system standards to be used are also listed.

3. DISCUSSION

3.1. PHARMACISTS' PATIENT CARE PROCESS FOR CLINICAL DOCUMENTATION SYSTEM AND DATA FLOW

The pharmacists' patient care process described in this illustration was developed by examining a number of key source documents on pharmaceutical care and medication therapy

Pharmacists' Patient Care Process



Pharmacists' Patient Care Process

Pharmacists use a patient-centered approach in collaboration with other providers on the health care team to optimize patient health and medication outcomes.

Using principles of evidence-based practice, pharmacists:

Collect
The pharmacist assures the collection of the necessary subjective and objective information about the patient in order to understand the relevant medical/medication history and clinical status of the patient.

Assess
The pharmacist assesses the information collected and analyzes the clinical effects of the patient's therapy in the context of the patient's overall health goals in order to identify and prioritize problems and achieve optimal care.

Plan
The pharmacist develops an individualized patient-centered care plan, in collaboration with other health care professionals and the patient or caregiver that is evidence-based and cost-effective.

Implement
The pharmacist implements the care plan in collaboration with other health care professionals and the patient or caregiver.

Follow-up: Monitor and Evaluate
The pharmacist monitors and evaluates the effectiveness of the care plan and modifies the plan in collaboration with other health care professionals and the patient or caregiver as needed.

management. Patient care process components in each of these resources were catalogued and compared to create the following process that encompasses a contemporary and comprehensive approach to patient-centered care that is delivered in collaboration with other members of the health care team. (Source: Pharmacists' Patient Care Process, Joint Commission of Pharmacy Practitioners, May 29, 2014).

http://www.pharmacist.com/sites/default/files/JCPP_Pharmacists_Patient_Care_Process.pdf)

3.2 SCENARIOS

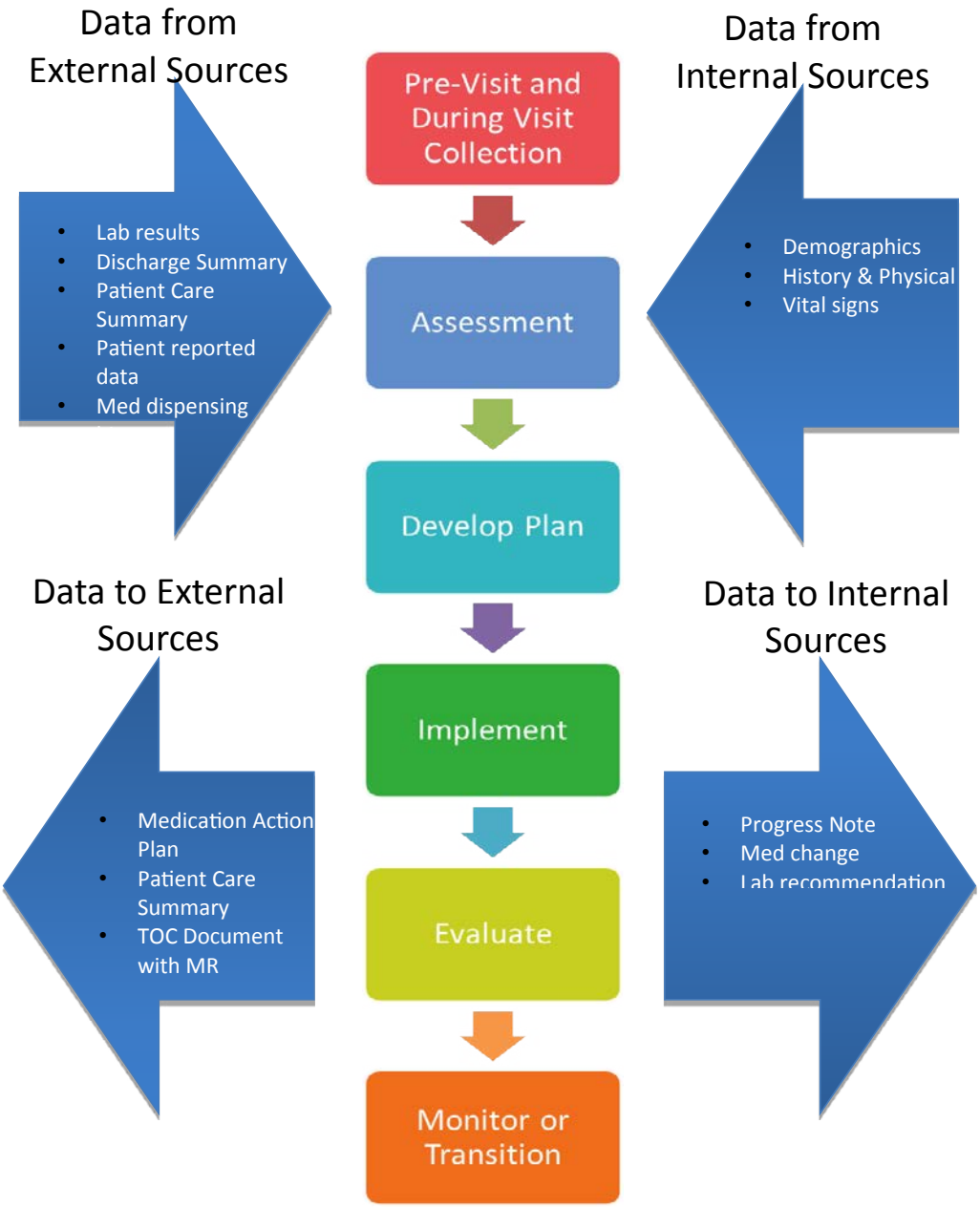
3.2.1 GETTING STARTED WITH SYSTEM VENDORS

- Pharmacists should evaluate their system to see if the system can accommodate clinical documentation workflow (identifying a patient's encounter, documenting the encounter with the patient, and electronically sending information to other healthcare providers and the patients themselves.)
- Pharmacists should make an appointment with their system vendor to discuss programming and functionality of clinical workflow by pharmacists.
- Pharmacists should use the checklist outlined in Section 3.3 to discuss how the system should be programmed to collect, document, and share the information as outlined in the checklist.
- Using the scenario in Section 3.2.2, walk through the steps of an actual patient encounter.

3.2.2 EXAMPLE OF A PATIENT ENCOUNTER

Dr. Smith electronically sends a request for service to Dr. Ford (pharmacist) to evaluate the medication use for Mrs. Jones (83-year-old female). Dr. Ford contacts Mrs. Jones to schedule an appointment. Dr. Ford contacts Mrs. Jones' insurer to determine eligibility of coverage. Mrs. Jones is covered by Health Insurer ABC for an annual comprehensive medication review (CMR). Dr. Ford queries State HIE for obtaining labs, Dr. Smith's patient care summary, and medication history from pharmacies prior to Mrs. Jones appointment. During the visit with Mrs. Jones, Dr. Ford documents subjective and objective information about Mrs. Jones (e.g., medication non-prescription and prescription not noted in medication history, blood pressure readings, smoking status, identification of drug-related problems, such as drug interactions, non-adherence, inappropriate indications, and medication needs). Dr. Ford documents patient assessment and Medication Action Plan, which is then electronically sent to Dr. Smith and the patient's electronic Personal Health Record (ePHR). Dr. Ford schedules a follow-up appointment with Mrs. Jones within three months.

3.3 PHARMACISTS CLINICAL DOCUMENTATION DATA FLOW



3.4 SYSTEM VENDOR CHECKLIST

Using the pharmacists patient care process and pharmacist clinical documentation data flow, a checklist for pharmacists to discuss with their system vendors how their software system collects, documents and exchanges clinical heath information. This checklist also is based on the assumption that health insurance information was already collected prior to implementing these steps.

Pre-Visit Collection Steps	Data from External Sources	Data to External Sources	Data from Internal Sources	Data to Internal Sources	Proposed Standard to be Used
PT-ID: Referral	ACO, MCO, Payer, Self (family)***, Other Provider*	None; N/A	Financial (Billing) System, Internal Other Provider, Front Office System	None; N/A	X12 270 271, HL7 ADT, or NCPDP.E1 or Following standards for medical cards**
Patient Contact Information	ACO, MCO, Payer, Self (family)***, Other Provider*, Pharmacy	None; N/A	Financial (Billing) System, Internal Other Provider, Front Office System	None; N/A	X12 270 271, HL7 ADT, or NCPDP.E1 or Following standards for medical cards**
Patient Demographic Information	ACO, MCO, Payer, Self (family)***, Other Provider*, Pharmacy	None; N/A	Financial (Billing) System, Internal Other Provider, Front Office System	None; N/A	HL7 ADT, Structured document, interface
Medical Condition(s) – Diagnosis, Indication, Problem (Past and Current)	ACO, MCO, Payer, Self (family)***, Other Provider*, Pharmacy	None; N/A	Financial (Billing) System, Internal Other Provider, Front Office System	None; N/A	HL7 ADT, Structured document, interface
Medication list	ACO, MCO, Payer, Self (family)***, Other Provider*, Pharmacy	None; N/A	Internal Other Provider, Front Office System	None; N/A	HL7 ADT, Structured document, interface
Allergy	ACO, MCO, Self (family)***, Other Provider*, Pharmacy	None; N/A	Internal Other Provider, Front Office System	None; N/A	HL7 ADT, Structured document, interface
Labs/Imaging/ Monitoring Device	ACO, MCO, Self (family)***, Other Provider*, Laboratory, Radiology, Pharmacy	None; N/A	Internal Other Provider, Front Office System, internal lab, internal x-ray	None; N/A	HL7 ADT, Structured document, interface
Social History	ACO, MCO, Payer, Self (family)***, Other Provider*, Pharmacy	None; N/A	Internal Other Provider, Front Office System	None; N/A	HL7 ADT, Structured document, interface
Family History	ACO, MCO, Payer, Self (family)***, Other Provider*, Pharmacy	None; N/A	Internal Other Provider, Front Office System	None; N/A	HL7 ADT, Structured document, interface
Physical Exam	ACO, Other Provider*, Self (family)***	None; N/A	Internal Other Provider	None; N/A	HL7 ADT, Structured document, interface
Functional Status/ Assessment	ACO, Other Provider*, Self (family)***	None; N/A	Internal Other Provider, Front Office System	None; N/A	HL7 ADT, Structured document, interface

Key

*Hospital, Outpatient Clinic, Physician office, NP, PA, LTC Facilities, Hospice/Home Care, Physician Specialties, Surgery, Dialysis, Infusion, Rehab, Optometrist, Chiropractor, Dentist, CAM Practice, Dietitian/Nutritionist, PT/OT, Pain Clinic, etc.

**Reminder to discuss how often patient info is updated. How often may be dependent on organization's policy or other states, government, accrediting organizations standards.

***Self (family) includes caregiver.

Collection During the Visit Steps	Data from External Sources	Data to External Sources	Data from Internal Sources	Data to Internal Sources	Proposed Standard to be Used
PT-ID: Referral	Self (family)***	None; N/A	Financial (Billing) System, Internal Other Provider, Front Office System	None; N/A	X12 270 271, HL7 ADT, or NCPDP. E1 or Following standards for medical cards**
Patient Contact Information	Self (family)***	None; N/A	Financial (Billing) System, Internal Other Provider, Front Office System	None; N/A	X12 270 271, HL7 ADT, or NCPDP. E1 or Following standards for medical cards**
Patient Demographic Information	Self (family)***	None; N/A	Financial (Billing) System, Internal Other Provider, Front Office System	None; N/A	HL7 ADT, Structured document, interface
Medical Condition(s) – Diagnosis, Indication, Problem (Past and Current)	Self (family)***	Other Provider*	Financial (Billing) System, Internal Other Provider, Front Office System	Internal EHR	HL7 ADT, Structured document, interface
Medication list	Self (family)***	Other Provider*	Financial (Billing) System, Internal Other Provider, Front Office System	Internal EHR	HL7 ADT, Structured document, interface
Allergy	Self (family)***	Other Provider*	Financial (Billing) System, Internal Other Provider, Front Office System	Internal EHR	HL7 ADT, Structured document, interface
Labs/Imaging/ Monitoring Device	Self (family)***	Other Provider*	Financial (Billing) System, Internal Other Provider, Front Office System	Internal EHR	HL7 ADT, Structured document, interface
Social History	Self (family)***	Other Provider*	Financial (Billing) System, Internal Other Provider, Front Office System	Internal EHR	HL7 ADT, Structured document, interface
Family History	Self (family)***	Other Provider*	Financial (Billing) System, Internal Other Provider, Front Office System	Internal EHR	HL7 ADT, Structured document, interface
Physical Exam	Self (family)***	Other Provider*	Internal Other Provider	Internal EHR	HL7 ADT, Structured document, interface
Functional Status/ Assessment	Self (family)***	Other Provider*	Internal Other Provider	Internal EHR	HL7 ADT, Structured document, interface

During Visit Assess Steps	Data from External Sources	Data to External Sources	Data from Internal Sources	Data to Internal Sources	Proposed Standard to be Used
PT-ID: Referral	Self (family)***	None; N/A	Financial (Billing) System, Internal Other Provider, Front Office System	None; N/A	X12 270 271, HL7 ADT, or NCPDP. E1 or Following standards for medical cards**
Patient Contact Information	Self (family)***	None; N/A	Financial (Billing) System, Internal Other Provider, Front Office System	None; N/A	X12 270 271, HL7 ADT, or NCPDP. E1 or Following standards for medical cards**
Patient Demographic Information	Self (family)***	None; N/A	Financial (Billing) System, Internal Other Provider, Front Office System	None; N/A	X12 270 271, HL7 ADT, or NCPDP. E1 or Following standards for medical cards**
Medical Condition(s) – Diagnosis, Indication, Problem (Past and Current)	Self (family)***	Other Provider*	Financial (Billing) System, Internal Other Provider, Front Office System	Internal EHR	HL7 ADT, Structured document, interface
Medication list	Self (family)***	Self (family)***, Other Provider*	Internal Other Provider, Front Office System	Internal EHR	HL7 ADT, Structured document, interface
Allergy	Self (family)***	Self (family)***, Other Provider*	Internal Other Provider, Front Office System	Internal EHR	HL7 ADT, Structured document, interface
Labs/Imaging/ Monitoring Device	Self (family)***	Self (family)***, Other Provider*	Internal Other Provider, internal lab, internal x-ray	Internal EHR	HL7 ADT, Structured document, interface
Social History	Self (family)***	Other Provider*	Internal Other Provider	Internal EHR	HL7 ADT, Structured document, interface
Family History	Self (family)***	Other Provider*	Internal Other Provider	Internal EHR	HL7 ADT, Structured document, interface
Physical Exam	Self (family)***	Other Provider*	Internal Other Provider	Internal EHR	HL7 ADT, Structured document, interface
Functional Status/					
Assessment	Self (family)***	Other Provider*	Internal Other Provider	Internal EHR	HL7 ADT, Structured document, interface

Plan	Data from External Sources	Data to External Sources	Data from Internal Sources	Data to Internal Sources	Proposed Standard to be Used
PT-ID: Referral	Other Provider*	Other Provider*	Financial (Billing) System, Internal Other Provider, Front Office System	None; N/A	X12 270 271, HL7 ADT, or NCPDP. E1 or Following standards for medical cards**
Patient Contact Information	Other Provider*	Other Provider*	Financial (Billing) System, Internal Other Provider, Front Office System	None; N/A	X12 270 271, HL7 ADT, or NCPDP. E1 or Following standards for medical cards**
Patient Demographic Information	Other Provider*	Other Provider*	Financial (Billing) System, Internal Other Provider, Front Office System	None; N/A	X12 270 271, HL7 ADT, or NCPDP. E1 or Following standards for medical cards**
Medical Condition(s) – Diagnosis, Indication, Problem (Past and Current)	Other Provider*	Other Provider*	Internal Other Provider	Internal EHR	HL7 ADT, Structured document, interface
Medication list	Other Provider*	Self (family)***, Other Provider*	Internal Other Provider, Front Office System	Internal EHR	HL7 ADT, Structured document, interface
Allergy	Other Provider*	Self (family)***, Other Provider*	Internal Other Provider, Front Office System	Internal EHR	HL7 ADT, Structured document, interface
Labs/Imaging/ Monitoring Device	Other Provider*	Self (family)***, Other Provider*	Internal Other Provider, internal lab, internal x-ray	Internal EHR	HL7 ADT, Structured document, interface
Social History	Other Provider*	Other Provider*	Internal Other Provider	Internal EHR	HL7 ADT, Structured document, interface
Family History	Other Provider*	Other Provider*	Internal Other Provider	Internal EHR	HL7 ADT, Structured document, interface
Physical Exam	Other Provider*	Other Provider*	Internal Other Provider	Internal EHR	HL7 ADT, Structured document, interface
Functional Status/ Assessment	Other Provider*	Other Provider*	Internal Other Provider	Internal EHR	HL7 ADT, Structured document, interface

Implement	Data from External Sources	Data to External Sources	Data from Internal Sources	Data to Internal Sources	Proposed Standard to be Used
PT-ID: Referral	Other Provider*	Other Provider*	Financial (Billing) System, Internal Other Provider, Front Office System	None; N/A	X12 270 271, HL7 ADT, or NCPDP. E1 or Following standards for medical cards**
Patient Contact Information	Other Provider*	Other Provider*	Financial (Billing) System, Internal Other Provider, Front Office System	None; N/A	X12 270 271, HL7 ADT, or NCPDP. E1 or Following standards for medical cards**
Patient Demographic Information	Other Provider*	Other Provider*	Financial (Billing) System, Internal Other Provider, Front Office System	None; N/A	X12 270 271, HL7 ADT, or NCPDP. E1 or Following standards for medical cards**
Medical Condition(s) – Diagnosis, Indication, Problem (Past and Current)	Other Provider*	Other Provider*	Internal Other Provider	Internal EHR	HL7 ADT, Structured document, interface
Medication list	Other Provider*	Self (family)***, Other Provider*	Internal Other Provider, Front Office System	Internal EHR	HL7 ADT, Structured document, interface
Allergy	Other Provider*	Self (family)***, Other Provider*	Internal Other Provider, Front Office System	Internal EHR	HL7 ADT, Structured document, interface
Labs/Imaging/ Monitoring Device	Other Provider*	Self (family)***, Other Provider*	Internal Other Provider, internal lab, internal x-ray	Internal EHR	HL7 ADT, Structured document, interface
Social History	Other Provider*	Other Provider*	Internal Other Provider	Internal EHR	HL7 ADT, Structured document, interface
Family History	Other Provider*	Other Provider*	Internal Other Provider	Internal EHR	HL7 ADT, Structured document, interface
Physical Exam	Other Provider*	Other Provider*	Internal Other Provider	Internal EHR	HL7 ADT, Structured document, interface
Functional Status/ Assessment	Other Provider*	Other Provider*	Internal Other Provider	Internal EHR	HL7 ADT, Structured document, interface

Follow up (monitor and evaluate)	Data from External Sources	Data to External Sources	Data from Internal Sources	Data to Internal Sources	Proposed Standard to be Used
PT-ID: Referral	Other Provider*	Other Provider*	Financial (Billing) System, Internal Other Provider, Front Office System	None; N/A	X12 270 271, HL7 ADT, or NCPDP. E1 or Following standards for medical cards**
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Patient Demographic Information	Self (family)***, Other Provider*	Other Provider*	Financial (Billing) System, Internal Other Provider, Front Office System	None; N/A	X12 270 271, HL7 ADT, or NCPDP. E1 or Following standards for medical cards**
Medical Condition(s) – Diagnosis, Indication, Problem (Past and Current)	Self (family)***, Other Provider*	Other Provider*	Internal Other Provider	Internal EHR	HL7 ADT, Structured document, interface
Medication list	Self (family)***, Other Provider*	Self (family)***, Other Provider*	Internal Other Provider, Front Office System	Internal EHR	HL7 ADT, Structured document, interface
Allergy	Self (family)***, Other Provider*	Self (family)***, Other Provider*	Internal Other Provider, Front Office System	Internal EHR	HL7 ADT, Structured document, interface
Labs/Imaging/ Monitoring Device	Self (family)***, Other Provider*	Self (family)***, Other Provider*	Internal Other Provider, internal lab, internal x-ray	Internal EHR	HL7 ADT, Structured document, interface
Social History	Self (family)***, Other Provider*	Other Provider*	Internal Other Provider	Internal EHR	HL7 ADT, Structured document, interface
Family History	Self (family)***, Other Provider*	Other Provider*	Internal Other Provider	Internal EHR	HL7 ADT, Structured document, interface
Physical Exam	Other Provider*	Other Provider*	Internal Other Provider	Internal EHR	HL7 ADT, Structured document, interface
Functional Status/ Assessment	Self (family)***, Other Provider*	Other Provider*	Internal Other Provider	Internal EHR	HL7 ADT, Structured document, interface

4. SUMMARY

The purpose of this paper is to help pharmacists and pharmacy system vendors work together on a plan to define the clinical documentation workflow of pharmacists in pharmacy practice settings. The intent of the document is to define the data external and internal sources following pharmacists' process of care for clinical documentation steps. The goal is to define a checklist for pharmacists to share with their pharmacy system vendors to identify workflow steps pharmacists use in the patient care process. These five steps are: collect, access, plan, implement, and follow-up (monitor and evaluate). Based on these five steps, this guidance document took the five steps and identified data from external sources, data to external sources, data from internal sources, and data to internal sources for the process of patient-centered care. The proposed system standards to be used are also listed.

Acknowledgements

The following representatives of the Pharmacy HIT Collaborative Work Group, which is devoted to Communication Standards, developed this document, "System Vendor Checklist for Pharmacist Clinical Documentation Workflow ":

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