The JCAHO releases new 2004 medication management standards

Experts offer strategies and tips to help you comply

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However, administrators should pay attention to new wording and take special care when complying with the standards. The JCAHO posted the final, revised version of the standards on its Web site in mid-June.

“The intent was an evolution, not a revolution,” says Bud Pate, BA, REHS, director of accreditation and licensing for Kaiser Foundation Hospitals in southern California. He spoke during the recent audioconference, “JCAHO’s 2004 medication management standards: Prepare now to successfully comply with the new standards and survey process,” sponsored by the Marblehead, MA–based HCPro, Inc.

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Imagine this: health care professionals, some of whom are rivals, visit one another’s facilities to solve medication management problems.

The Northeast chapter of the VHA New England—a nationwide network of 2,200 community-owned health care organizations and affiliated physicians—calls the effort an on-site shared learning program. Based in Irving, TX, the shared learning program is a component of the organization’s medication error prevention initiative (MEPI)—a team effort to decrease medication errors in member hospitals in the Northeast.

The 22 MEPI members from health care facilities in Maine, New Hampshire, Vermont, and Massachusetts sit on a task force that meets monthly to discuss medication errors. (See the May HPRR for an indepth story on MEPI.) The program is a new endeavor that the group has piloted and will...
Medication management

These phases are selection, procurement and storage, prescribing and transcribing, preparing and dispensing, administering, and monitoring.

One major change to the standards is the revised definition of medication, says Bryant. The new definition will be much more extensive than in the past. Bryant and Pate also briefed listeners on the following JCAHO changes and offered tips to help facilities comply with the new standards.

Shared Visions—New Pathways™
The JCAHO’s new survey process, Shared Visions—New Pathways, will bring significant changes for January 2004, says Bryant. The purpose of the new process is to simplify standards and reduce duplications. One of the overall results of the program is the new medication management chapter.

As a part of the new process, the JCAHO will score facilities on standard elements of performance. While in the past, facilities only had access to intent statements, they will now be able to see the elements of performance prior to their review. “We view these changes as very positive,” says Pate.

Once in a while you might disagree with a surveyor as to whether your hospital complies with a certain standard.

In case you disagree with a surveyor, he or she can clarify by evaluating the level of compliance using the following rules:

- Full compliance—if you follow the standard 90% of the time
- Partial compliance—if you follow the standard 80% of the time
- Noncompliance—if you follow the standard less than 80% of the time

**TIP:** One medication standard might have up to 10 elements of performance. Keep in mind that if your facility is 75% compliant with one element of performance, you are noncompliant with the entire standard.

“One ‘no’ gets the entire standard noncompliance,” says Bryant.

IV solutions
Another area that hospitals should pay close attention to is the storage of IV solutions. A common practice for many hospitals is to keep basic IV solutions in regular storage rooms, says Pate.

As administrators develop policies to comply with the new standards, they must ask themselves whether their procedure for storing IV solutions is secure enough.

The standards address “authorized individuals,” but do not specifically say these solutions must be stored in the pharmacy. Pate says materials management could even be responsible for securing the solutions.

“But you do have to pay attention to the security of those areas. I think you have to use common sense. All of these things are a balance between clinical operations and security,” he says.

**TIP:** “As folks implement any of these standards, make sure what you’re asking people to do works operationally on the unit,” he adds.

Patient-specific information—standard MM.1.10
This first standard requires hospitals to have patient-specific information on hand for those involved in the medication system. Before administrators craft a policy on taking height and weight information for every patient, they should check what’s really happening on the units, Pate says.

**TIP:** Talk with your colleagues to determine whether there are times when you don’t need a patient’s height or weight.
Hospital administrators tuning into a recent audioconference on the Joint Commission on Accreditation of Healthcare Organizations’ (JCAHO) final version of its 2004 medication standards responded to questions about medication processes and procedures in their own facilities.

How does your hospital measure up? Check out your colleagues’ answers below from the HCPro, Inc. audioconference, “JCAHO’s 2004 medication management standards: Prepare now to successfully comply with the new standards and survey process” held in June, and see what comments our experts made on the poll results.

1. **How many of you have 24-hour-a-day, seven-day-a-week pharmacy coverage?**
   - Yes 58%
   - No 42%
   “Those who responded “no” should be extremely attentive to the systems and processes they have in place,” says Bud Pate, BA, REHS, director of accreditation and licensing for Kaiser Foundation Hospitals in southern California.

2. **How many of you have developed a policy on the implementation of range orders?**
   - Yes 47%
   - No 53%
   “I think that is something that people need to pay attention to,” says Pate. What the JCAHO is concerned about is how nursing will interpret a range order; he adds.
   “For those 47%, hopefully [the policy] just doesn’t say ‘range orders will not be taken.’ Hopefully, the policy talks about how to interpret a range order and limitations on what medications can be given as range orders.” Facilities should make sure their policies reflect current practice, he adds.

3. **How many of you have removed all concentrated electrolytes from patient care areas?**
   - Yes 74%
   - No 26%
   Steve Bryant, practice director of accreditation and regulatory compliance services at the Marblehead, MA–based consulting firm The Greeley Company, has visited several facilities that say they have eliminated all concentrated electrolytes from patient care areas. Bryant then visits the intensive care unit, where he tends to find concentrated electrolytes.

   The JCAHO doesn’t require facilities to remove all concentrated electrolytes. For those that are not removed though, hospitals must properly secure them and have a good clinical reason for the drugs to be on the unit.

   “Those 26% may be fine, as long as they’ve developed the proper safety procedures,” says Pate.

   **TIP:** At your next pharmacy and therapeutics committee meeting, discuss concentrated electrolytes and in which areas of your facility electrolytes are of clinical value.

   Talk about the procedures and policies your hospital will put in place to make sure these drugs are safe and secure.
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“Ensure that [your decision] makes good clinical sense, and that you can actually comply with your policy. Define when height and weight need to be captured and make sure you can live with it,” adds Bryant.

Properly and safely storing medications—standard MM.2.20
Standard MM.2.20 requires hospitals to make sure that they store medications safely. A secure area does not mean a separate medication room, says Bryant. Rooms such as the operating room are considered a secure place.

The standard specifies that facilities must store medications so that “unauthorized persons cannot obtain access.” Nothing in the standards says authorized personnel must be licensed, adds Bryant.

**TIP:** “If you authorize people, make sure it makes sense given their job duties, and that you train them on this during orientation,” he says.

Look-alike and sound-alike drugs—standard MM.2.20
Hospitals must segregate medications that are easy to confuse. “At Kaiser, we don’t see an end to this effort,” says Pate. Both he and Bryant say they’ve seen facilities that don’t isolate such drugs on the units.

**TIP:** “Don’t define the world; keep it down to what you think are the highest risk medications,” says Pate.

“Be comfortable that you’ve narrowed it down to the medications you truly think are high risk, or those areas that sentinel events have indicated a need for control. If you try to do all drugs, you’ll never get there.”

Unsafe abbreviations—standard MM.3.20
Hospitals must make sure that physicians clearly write all orders and that the rest of the medical team correctly interprets these orders. Facilities should have a policy that lists unsafe abbreviations, symbols, or acronyms.

**TIP:** “Start out with a controllable list,” says Bryant. Hospitals should keep their list simple so that employees are willing and able to comply.

Do not draft a four-page document of unsafe abbreviations and expect staff to immediately follow the policy.

Editor’s note: For more information on the HCPro, Inc. audioconference, “JCAHO’s 2004 medication management standards: Prepare now to successfully comply with the new standards and survey process,” go to www.hcmarketplace.com.
MM.8.10

formally institute soon.

“The shared learning program has us actually going into each other’s hospitals, reviewing the systems, and making recommendations for change,” says John Fields, vice president of quality services at Central Maine Healthcare in Lewiston and a MEPI participant. The program is unique since several of the hospitals are rivals, he says.

The endeavor also helps participants comply with the Joint Commission on Accreditation of Healthcare Organizations’ (JCAHO) medication standards.

The draft medication standard MM.8.10 requires organizations to evaluate their medication processes on a regular basis. (See evaluation below).

Note: The overhaul of the JCAHO’s hospital manual involves revising the medication standards and placing all TX medication standards in the new medication management chapter, thus changing the standard names from TX to MM. The accreditor approved the


Instituting a program similar to the on-site shared learning program can help you comply with the new medication standards. Any MEPI member can request help from the group with a medication problem in his or her facility.

“We then ask for [MEPI] volunteers to form a team and go to that organization, review the medication process [the member] is concerned about, and provide a collegial review,” says Arnold E. Mattis, RN, MSN, EdD, senior director of clinical and consulting services at the VHA New England.

During the on-site visit, the following takes place:

- Three or four task force members from

**Evaluation**

Standard MM.8.10
The hospital evaluates its medication management system.

Elements of performance
Hospitals evaluate their medication management system for risks and identify areas to improve safety.

- On a regular basis, hospitals review the literature for new technologies and successful practices that other facilities have used. Administrators evaluate this information to determine whether a similar practice could help improve their facility’s medication management system.

- Hospitals review internally generated reports for trends or problems in their medication management system.
different disciplines spend half a day at the organization that requests assistance

• The reviewers first meet with some of the organization’s administrators, nursing staff, and its representative to MEPI to explain why they’re there, what they’re going to examine, and what kind of cooperation they will need

• In the various departments task force members interview staff, observe procedures, and take notes

• At the end of their visit, the reviewers meet for 30 minutes to write up a report

• They then meet again with the same group of hospital representatives to explain their findings and make recommendations for change

“The goal is to identify weaknesses and to pinpoint what that organization could do to [improve] the safety of its processes. In addition, what [the reviewers] are hoping to collect are examples of some good things that they’re doing as well,” he continues.

During the monthly task force meeting, reviewers share all of these observations and conclusions so that everyone benefits from the visit, he adds.

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**JCAHO quick tip**

**Eliminate unsafe abbreviations from your medication administration record**

The use of unclear medication abbreviations can endanger patient safety by contributing to medical errors in your facility.

Eliminating this potential for error is a focus of the Joint Commission of Accreditation of Healthcare Organizations’ (JCAHO) National Patient Safety Goals.

As of January 1, JCAHO surveyors began to check compliance with these goals. Goal #2 requires organizations to improve communication among caregivers by standardizing the abbreviations, acronyms, and symbols that you and your colleagues use when caring for patients.

As a leader in your facility, it’s important for you to make sure that all caregivers follow approved abbreviations, not just physicians, says Brenda Summers, MBA, MHA, MSN, RN, CNA3, a senior consultant for The Greeley Company, a division of the Marblehead, MA–based HCPro, Inc., which publishes this newsletter. “It has to track throughout the whole organization,” she says.

One facility Summers visited had a simple policy on approved and unapproved abbreviations.

All administrators had done to guarantee compliance was to tell physicians not to use the unapproved abbreviations—the computer generated medication administration record (MAR) still included the unsafe abbreviations.

Although, Summers says the MAR is electronic and therefore not as unclear as written abbreviations, failing to eliminate unsafe abbreviations from the record went against the hospital’s policy of forbidding certain abbreviations. Administrators should not allow the practice to continue, she adds.

“If the hospital says [the abbreviations] are unapproved, they need to be inappropriate for anybody, in any situation.”

**TIP:** Because nurses use the MAR to give medications to patients, the record is an important form of communication. Eliminate all unsafe abbreviations from the MAR in your facility.
JCAHO medication management standards Q&A
Industry experts address your top concerns on the new standards

The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) posted its final version of the new medication management standards in June on its Web site www.jcaho.com. If you’re confused about the new standards, you’re not alone. During the American Society of Health Systems Pharmacists’ 2003 summer meeting in San Diego this June, Daryl Rich, PharmD, MBA, the JCAHO’s associate director for surveyor development and maintenance, answered participants’ questions in the session “New Medication Management Standards for 2004.” We adapted the questions and answers for publication in HPRR.

Q: The new standard for 2004 talks about IVs being prepared in the pharmacy. You gave an exception for emergent or stability IVs, but what is the JCAHO’s position on PRN (as-needed) medications?

A: We would still expect the pharmacy to make those up, if indeed it was not an emergency situation.

Q: Are the 2004 standards any more prescriptive in terms of pharmacy and nursing using a shared medication database or a shared medication administration record (MAR)?

A: No, they are not.

Q: You showed a list of do-not-use abbreviations. Are you required to have a to-use abbreviations list?

A: No, you are not required to have a list of acceptable abbreviations. That is was part of our old standards. We do talk about common abbreviations and acronyms in our current standards—which in the management of information chapter will change in 2004 to say, “a list of unacceptable abbreviations.” It will be very clear that it’s the unacceptable list that’s required.

Q: In the standard that said “Inform patient of any potential adverse drug reaction [ADR],” I assume that what you’re saying is to inform the patient of any ADR that, in our judgment, the patient is likely to detect?

A: Correct.

Q: It’s my sense that any drug can sound like or look like another drug. The U.S. Pharmacopeia (USP) has a list of about 700 or 800 different items. When dealing with look-alike and sound-alike drugs, is that also up to our judgment—up to what we believe is particularly problematic?

A: Yes. There are probably five or 10 big ones out there that have been reported by everyone that surveyors may want to see, but for the most part, it is your list. You determine what to include on it.

Q: As pharmacists, we know that the term “formulary” implies an appropriate use of drugs and a systematic methodology—which I would think the Joint Commission would be keen on. Why then do we almost seem to revert back to the term “drug list”?

A: Basically, when the standards went through the review process, it was the people in the field who said the term should not be “formulary.” It was mostly from people in the fields of home care, behavioral health, and long-term care who didn’t want that term in there. In the hospital manual, we do footnote the term formulary, but we needed the standard to be consistent among all the programs.

Within the next few years, because we’re surveying the same standard in all the programs, organizations are going to get one manual that’s customized to what they do. They’re not going to repeat the standard in different formats in different programs. That’s why we want “drug list” instead of “formulary” to be universal.

Q: With regard to providing the most ready-to-use form of a drug, if a tablet is 50 mg and is scored, we use the unit dose, but if the dose ordered is 25 mg, must we have the tablet and provide it?
**JCAHO Q&A**

**Q:** Can you clarify your statement about non-formulary drugs being used for the first time? I think you implied that if a nonformulary drug is ordered and has never been used before, that there’s some kind of approval process that’s needed?

**A:** Yes. If you’re going to use a non-formulary drug on patients, there has to be some sort of abbreviated approval process. You decide what that abbreviated approval process is. The JCAHO was afraid that there may be a dangerous drug that somebody orders, and gets into the hospital, and it never should have been there.

It was a compromise, rather than saying that non-formulary drugs cannot be stocked in the organization. This was added mostly through some of the physicians who sat on the committees. They felt that there should be a review process either by the chief of service, the chief of the pharmacy and therapeutics committee—someone who will say, “Yes, it’s okay.” Some organizations do this where they have to get infectious disease approval in order to use an antibiotic not on the formulary.

**Q:** A code cart has to be locked but the plastic seal on the cart can be considered a lock. Is that still true?

**A:** That is true. And this really deals with what the Centers for Medicare & Medicaid Services requires. They have told us that is acceptable, as well as even a plastic wrap seal around the medication trays. Now we’re saying that the supplies have to be locked, and that could be through another color locker or something similar.

**Q:** What is the policy or vision of the Joint Commission regarding enforcement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy rules? Are you going to be out there as an enforcer?

**A:** We specifically told our surveyors that they are not surveying HIPAA rules. We do have our own business agreements with hospitals so we’re in compliance with the organizations and can look at charts. But we’re not going to be surveying HIPAA.
Telepharmacy helps protect patient safety after hours

When faced with providing patients with medication 24 hours a day, seven days a week, hospitals have had two choices: staff the pharmacy around-the-clock, or close the pharmacy at night and provide an on-call pharmacist after hours.

Hospitals now have another option—telepharmacy. Proponents say telepharmacy is a great way to make sure patients receive medications in a timely and safe fashion. The system also helps detect medication errors.

“The need to fill servicing gaps in pharmacies can be done with the supplementation of these kinds of technologies and a centralized pharmacy model,” says Christopher Keeys, PharmD, BCPS, RPh, chief executive officer at MedNovations Inc., a health care solutions company in Greenbelt, MD.

Telepharmacy can also help you comply with the Joint Commission on Accreditation of Healthcare Organizations’ (JCAHO) medication standards MM.4.5, which requires you to craft specific processes and procedures to safely provide medications when the pharmacy is closed, and MM.4.10, which requires pharmacists to review all prescriptions and medication orders for appropriateness.

Off-site pharmacists review orders
For those hospitals without a 24-hour pharmacy, having a pharmacist on-call was once considered a best practice. That may no longer be the case, says Keeys. In 2003, this practice doesn’t meet standard MM.4.10 because it doesn’t allow for pharmacists’ review of orders.

Telepharmacy can help prevent errors involving patient allergies to drugs, drug interactions, or nurses’ incorrect interpretations of incomplete orders. Many of these errors occur at night, he adds.

MedNovations pharmacists dial in to client hospitals’ computers and review medication orders after hours. “It’s like they’re sitting in the pharmacy,” says Keeys. They control the Pyxis machines after the pharmacy is closed; nurses can’t enter the machines until Keeys and his staff have reviewed and approved the order. MedNovations is licensed in Maryland as a pharmacy and has reciprocal licenses in other states.

Improving technologies, stricter JCAHO standards, an increased focus on patient safety, the recent pharmacist shortage, and a societal trend to provide 24-hour service led Keeys and his team to develop this off-site system.

Here’s how it works:
• Keeys and his staff set up their system so that they can dial directly into a client’s hospital pharmacy
• They set up policies at the facility and work with pharmacy to train nurses on the new procedure for obtaining medication after hours
• After the pharmacy closes, instead of sending orders to the hospital’s pharmacy or leaving orders on the unit until the following morning, nurses fax medication orders to MedNovations, or scan them into Pyxis Connect
• MedNovations’ staff review the orders for the following:
  - Completeness
  - Legibility
  - Drug interactions
  - Patient allergies
  - Major drugs that need dosage adjustments
  - Drugs under protocol, such as Vancomycin

“If we have problems, we call the nurse or physician directly,” says Keeys.

Assuming the pharmacists encounter no problems, they then proceed in one of two ways:

1. Fax-back verification. If the hospital decides not to have the company enter the order into its pharmacy computer system, MedNovations instead faxes nurses a verification form. This form confirms MedNovation pharmacists’ review of the order and states whether the nurse can go...
Telepharmacy

Telepharmacy is a new way for hospitals to safely dispense medication to patients when the pharmacy is closed. At facilities that use telepharmacy, nurses fax medication orders to offsite pharmacists after hours, who then review and approve orders.

2. Electronic verification. If the hospital elects for MedNovations to input the order into its pharmacy computer system, nurses receive the verification electronically. This saves the hospital pharmacists the time it takes to enter orders into the pharmacy computer system themselves the next morning.

- Nurses then take medication from stock that’s outside the pharmacy, either in night cabinets or automated dispensing systems.
- Keeys and his staff have lists of where all drugs are stocked in each client hospital. Sometimes, a physician will order a medication available only inside the pharmacy. In this case, Keeys and his employees ask the on-call pharmacist to come into the hospital. At certain client hospitals, supervising nurses are not allowed into the pharmacy after hours, however this varies from state to state and is based on state law, says Keeys.

Staff report high satisfaction with the system

In April 2000, Keeys worked with administrators at the first hospital to use the system—Sibley Memorial Hospital in Washington, DC. “Prior to having MedNovations we had the on-call pharmacist position because we’re not open 24-hours,” says Jamie Belcastro, RPh, Sibley’s pharmacy operations manager. “Since implementing the telepharmacy system the number of times the on-call pharmacist gets paged has been greatly reduced.”

While Sibley administrators haven’t analyzed hospital data completely to determine the system’s effect on medication errors, Belcastro says it has been positive. Costs vary based on the number of hours the off-site pharmacists must cover. If a hospital spends $200,000 a year to staff a night shift, it should expect to spend approximately half that amount on a MedNovations system, Keeys says.

Other benefits include the following, according to Christopher Keeys, PharmD, BCPS, RPh, MedNovations chief executive officer:

- Nurses report high satisfaction with the fact that MedNovations pharmacists contact physicians directly if there is a problem with their order
- Nursing administration say they are pleased with the level of review that exceeds what their nurses could do (Keeys and his staff have the pharmacy profile to screen against for drug interactions, allergies, and dosing). Nurse administrators that in the past they were uncomfortable being the ones that had to do that review.
- Pharmacists enjoy the system because they don’t have to staff nights but are still in the loop professionally and economically (as part of the program, each facility must staff an on-call pharmacist).
President Bush’s proposed Medicare prescription drug benefit plan was set to become a reality at press time, as legislators geared up to enact the bill before the July 4 recess. The following is the latest update from Bill Sarraille, a partner at the Washington, DC–based law firm Sidley, Austin, Brown & Wood LLP:

- **Senator Charles Grassley, R-IA, and Senator Max Baucus, D-MT,** had announced a bipartisan agreement on a plan to provide prescription drug benefits under Medicare. The $400 billion legislation contains two main features:
  - A drug benefit for Medicare beneficiaries to begin in 2006
  - A new preferred provider organization option for Medicare beneficiaries

“A bill for a pharmaceutical benefit looks much more likely at this point,” said Sarraille last month. “Not simply because of the Grassley-Baucus deal, but perhaps even more importantly because President Bush has caved on the issue of whether the pharmaceutical benefit would be tied only to the Medicare+Choice program, or if it would run to the fee-for-services program as well, in equal measure.”

If Bush put the benefit in both the traditional Medicare and Medicare+Choices, beneficiaries don’t really have any incentive to move into the managed care program, added Sarraille. “[Bush has] given up on that, and that’s pretty significant.”

- One issue was whether **Senator Edward Kennedy, D-MA,** would stand in the way of the bill, said Sarraille. Kennedy indicated that he could support some revised version of the legislation. “If that happens, it does downplay and perhaps eliminate the possibility of a Democratic filibuster in the Senate. And if so, the sailing looks pretty smooth at that point for this bill,” said Sarraille.

- Once the bill passes, the Senate and the House work out differences in their legislation, and the President signs the bill, the Bush administration will begin to quickly institute the legislation. Saraille said that the administration may face some significant challenges during this phase, and even foresees the possibility of legal challenges.

- With the passage of the bill, the providers of other services and items in the Medicare program will face a shocking array of cuts to a broad group of providers. “The fallout from that will be years in the making,” said Sarraille.

The cuts for providers are going to immediately change the way they plan for services, and who enters into service lines. “You’re going to see a very fast, very significant reaction to the passage of this bill,” said Sarraille. “This is clearly going to be a sea change in the way that pharmaceuticals are used, purchased, and marketed. This is just a huge change that is going to affect every component of the pharmaceutical industry.”
HIPAA help: How to assist your business associates

Editor’s note: Last month in Hospital Pharmacy Regulation Report, our experts offered advice on complying with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) when interacting with patients. This month, we present the fourth in our five-part HIPAA series: HIPAA and business associates.

HIPAA’s privacy rule went into effect on April 14. As a hospital leader, you must confirm that all pharmacy staff and outside personnel with whom you work are compliant. An important part of HIPAA is making sure that all business associates understand and comply with it.

Pharmacy benefit managers
Those pharmacy benefit managers with whom you work, and who coordinate payment of services to your pharmacy, must also comply with HIPAA. “They have to know the rules and be in line with not providing any of that information [outside] their organization,” says Rick Demers, PharmD, assistant hospital director and director of pharmacy at the Hospital of the University of Pennsylvania in Philadelphia.

TIP: Check that the pharmacy benefit managers’ organizations have policies and procedures for HIPAA compliance.

Outside requests for patient information
When dealing with any type of request for patient information, you must evaluate whether the group that is receiving the information is involved in the treatment of the patient.

“If it’s not, then you need to have the patient know that the information may be going external,” says Demers. It’s your job to inform patients whether any of their information will go to an external source for research purposes. If you provide patient-specific information to a drug company that is marketing a new drug, the patient has to know.

TIP: Contact patients through phone, via e-mail, or send a letter asking permission to share patient-specific information. Drafting and sending a letter may be the best approach, Demers suggests.