

Documenting Patient Care Services



Module 5

MEDICATION THERAPY MANAGEMENT SERVICES

Documenting Pharmacy-Based Patient Care Services



Professional education monograph series for pharmacists from APhA



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Learning Objectives

After reading this monograph, the pharmacist will be able to:

1. Describe examples of standardized formats for documenting patient care services in patient charts.
2. List the components of SOAP documentation and explain information elements within each component.
3. Identify key elements of data to document in a given patient case and structure the documentation in a medically appropriate format.
4. Explain the legal requirements for proper documentation of patient care services, requirements for the maintenance and protection of records, and legal ramifications for failure to comply.
5. Describe quality measures that can be used to evaluate the outcomes of MTM service delivery.

Introduction

“If you didn’t document it, you didn’t do it,” is a common mantra in many fields of health care. Pharmacists have experience maintaining prescription records, but many lack experience documenting patient care activities. More comprehensive documentation practices are essential when pharmacists implement patient care services, including medication therapy management (MTM).

Documentation helps to ensure the delivery of high-quality patient care. Cipolle, Strand, and Morley, pioneers of pharmaceutical care, have written, “If you are not documenting the care you provide in a comprehensive manner, then you do not have a practice.”¹

Pharmacists who provide patient care services must create and maintain ongoing patient-specific records that contain, in chronological order, a record of all care provided to each patient. Documentation for a service should be standardized—consistent in process and nature among all pharmacists at a practice site.

Patient care services may require many different types of documentation, including those for the pharmacy’s internal records, billing, patient information, outcomes evaluation, and communication with other health care providers and other external entities. Several types of documentation may be associated with an MTM service, including documentation for the pharmacy’s internal records, for the patient’s records, and for communicating with other members of the health care team. Many of these documentation elements are relevant to a variety of pharmacist-provided patient care services. When implementing a service, pharmacists should consider the various roles that documentation plays, as well as determine and establish an infrastructure and process for creating and maintaining documentation.

Purposes of Documentation

Documentation can fulfill several purposes, including²:

- Improving patient care and outcomes.
- Providing patients with information about their care.
- Enhancing continuity of care.
- Ensuring compliance with laws and regulations for the maintenance of patient records.
- Protecting against professional liability.
- Creating a record of services provided for billing and reimbursement purposes.
- Allowing analysis of patient outcome data to assess the value of the service delivered and communicate this information to others.

Documentation also serves several less concrete, but important purposes, such as establishing the pharmacist’s credibility as a health care provider and conveying the professionalism of the care that is provided. Whether the documentation is clear, thorough, and concise, or sloppy, incomplete, and inconsistent, it will be a reflection on the pharmacist and the practice.

Patient Care

Continuity of care—coordinating health care measures among all of the patient’s providers—is supported by documentation. The quality of documentation can affect the quality of care provided to a patient. It is the primary source of communication with others about the care provided to the patient.

Documentation that is created for the pharmacy records, communicating with other providers, and patient use all contribute to patient care. For example, a personal medication record may be a useful tool for pharmacists and patients to communicate with other health care providers and may serve as an educational tool and resource for the patient.

Legal and Regulatory Considerations

Patient care records become legal documents describing the care provided. As such, they may be viewed some day by patients, their lawyers, defense attorneys, malpractice insurance companies, judges, jurors, and others. Individuals from other organizations also may utilize the documentation when performing peer review, conducting research, or looking for evidence of fraud or other illegal conduct. Although the likelihood is small that any single record will come under legal scrutiny, pharmacists should keep this possibility in mind when documenting.

Because documentation eventually could be subject to inquiry, pharmacists should remember that if a patient's record does not include documentation of the care provided, then it will be assumed that the action never occurred.³ Examples of inadequate documentation that could result in liability include failing to: create a record of a consultation with a physician, take an adequate patient history, or receive authorization to change a prescription. A pharmacist could completely assess a patient, consult with the prescribing physician, and make modifications to the regimen based on the physician's orders; however, if that sequence of events is not thoroughly documented to acknowledge the collaborative efforts, it could be concluded that the pharmacist acted independently.

All documentation must be maintained in a manner that complies with certain legal and regulatory requirements, including those established by the Health Insurance Portability and Accountability Act (HIPAA). Statutes of limitations (the maximum time period for an individual to file a claim for an injury) vary from state to state, which may impact the length of time that records must be maintained. States may have additional laws and rules for documentation by pharmacists as established by the legislature, the board of pharmacy, or both. Pharmacists should verify requirements for patient records with their state boards of pharmacy and/or their insurance carrier.

Billing and Reimbursement

Third-party payers typically require documentation as proof of services performed. Various payers have different requirements, and pharmacists should determine what information payers want. To ensure consistency, these data elements should be included in documentation of all patients, not only those with a specific payer.

Documentation should support the use of billing codes designed for use by pharmacists, and should specify the amount of time spent caring for the patient. In October 2007, the American Medical Association released its plans to change the MTM *Current Procedural Terminology* (CPT) code status from the temporary Category III to the permanent Category I

classification. Effective January 1, 2008, the temporary CPT codes (0115T, 0116T, 0117T) are replaced by these permanent CPT codes:

- 99605—MTM service(s) provided by a pharmacist to an individual patient, face-to-face encounter, with assessment and intervention if provided; initial 15 minutes with a new patient.
- 99606—Initial 15 minutes with an established patient.
- 99607—Each additional 15 minutes of initial or subsequent MTM encounter (list separately in addition to code for primary service).

For more information about billing codes, see www.pstac.org.

Documentation Formats

The particular form of documentation to select for a patient care service requires careful consideration. When choosing, the pharmacist will want to ensure that the documentation format serves all necessary purposes and meet the needs and requirements of the pharmacists delivering the services, including communication with external entities. Several different forms may be appropriate for recording pharmacist interventions. Because of the volume of information that may be considered during patient care services, a structured format may be preferred to free-form text. Structured formats simplify the process of thoroughly completing records, and may make it easier to retrieve desired pieces of information in the future.

In health care, the most commonly used structured format is the SOAP (subjective, objective, assessment, plan) note. Other formats include TITRS (title, introduction, text, recommendation, signature) and FARM (finding, assessment, recommendations/resolutions, management).³

When selecting a format, pharmacists must consider which method will best support the creation of documentation that is accurate and complete. Documentation of patient encounters should include the patient's medical and medication history; a list of existing and potential patient care problems, including drug-related problems; interventions and referrals that were made; goals of therapy; and plans for follow-up.

Because the use of SOAP notes is widespread, adoption of this format may assist pharmacists in communicating with other health care providers, third-party payers, and other entities. The pharmacist should assess the documentation requirements of third-party payers for the service. Standard documentation should include information that satisfies the requirements of payers for billing, record keeping, and outcomes tracking.

Several other aspects of the patient visit should also be documented. Pharmacists generally request that patients fill out a medical history form and a complete medication list at the initial visit for patient care

services, although comprehensive forms may not be necessary for some services such as immunizations. Depending on the service, pharmacists may want to incorporate various condition-specific assessment tools (e.g., Brief-Pain Inventory form, Medication Nonadherence Risk Assessment form).

Writing SOAP Notes

SOAP notes are widely used in the health care field to document patient care. These records summarize the patient encounter according to subjective findings (e.g., patient concerns, reports of adverse events), objective findings (e.g., vital signs, medication lists, laboratory data), assessment (e.g., a list of identified drug-related problems, goals of therapy), and the plan (e.g., monitoring, referrals, follow-up care).

Occasionally this format has been criticized because the distinction between subjective and objective findings is not always clear-cut. For example, a patient's weight could be recorded in the subjective section when it is reported by the patient, or in the objective section when it is measured by the pharmacist. However, it will be easier to monitor and review the patient's weight over time if it is always recorded in the same location. While reasonable arguments can be made for positioning certain information under either of these headings, pharmacies should aim to have all documenting pharmacists organize information in the same way.

Case Study

The following case study illustrates information that might be gathered at and/or prior to an initial patient care visit, the ensuing SOAP note, and a SOAP note for a follow-up visit.

INITIAL VISIT

RC is a 63-year-old man who has enrolled in a pharmacy's MTM service. He presents at the initial visit for a comprehensive medication therapy review. Table 1 lists data gathered during the initial patient visit.

Based on this information, the pharmacist determines the following about RC:

- Significant family history for heart disease.
- Significant past medical history of interrelated diagnoses—diabetes, heart disease, and hyperlipidemia for at least 6 years of disease progression including the occurrence of a myocardial infarction.
- No known drug allergies.
- Moderate response to prior therapies for each of his primary diagnoses but has not achieved therapeutic goals.
- Therapeutic goals include:

- Weight reduction (obesity): 1–2 lb/week with an initial goal of 10% weight loss (23 lb) in 4 months.
- Pain and inflammation management (arthritis): decrease pain, increase range of motion, and return to activities of daily living.
- Blood glucose and hemoglobin A1c management (diabetes): A1c <7% and check fasting blood glucose in the morning and 2 hours after largest meal.
- Blood pressure management (hypertension): <130/80 mm Hg.

This is not a simple case and requires a concerted effort.

A primary focus for the initial MTM visit is to improve therapeutic outcomes and adherence to treatment and lifestyle measures. To address these goals, the pharmacist takes the following actions (Any recommendations outside the pharmacists' scope of practice that require the approval of other members of the healthcare team should not be initiated until approved):

- Reviews dietary guidelines and recommendations on beverage and snack selections with RC, and provides him with a blood glucose tracking log and a personal health tracking tool to assist in monitoring his diabetes control.
 - These tools should help reinforce the importance of daily blood glucose and blood pressure tracking and the related impact on meal planning.
- Recommends adding low-dose aspirin for its cardiovascular protective effect.
 - This represents a simple over-the-counter option that could improve the patient's global treatment outcomes.
- Recommends doubling the dose of atorvastatin to 40 mg once daily as an attempt to reach RC's LDL reduction goal before changing to a different agent or adding a second agent.
 - There was significant opportunity for increased effect with the existing agent before considering a medication change.
- Recommends modifying lisinopril 20 mg twice daily to a combination tablet of lisinopril 20 mg/hydrochlorothiazide 12.5 mg twice daily, to improve blood pressure control.
 - The combination product is recommended to enhance adherence.
- Recommends extended-release diclofenac for arthritis pain.
 - RC had not previously tried this medication. Pain relief was an important target both for arthritis management and its impact on the patient's ability to maintain the physical activity level needed to help control his cardiovascular and metabolic conditions.
- Reinforces tobacco cessation success.

Table 1. Initial Visit Data Information

Topic	Patient Data
Demographics	63-year-old man, self-referred
Past Medical History	<p>10 years ago:</p> <ul style="list-style-type: none"> ■ Rheumatoid arthritis (inflammation in hands/wrists, knees, and neck) <p>6 years ago:</p> <ul style="list-style-type: none"> ■ Diabetes mellitus type 2 ■ Hypertension ■ Hyperlipidemia ■ Acute MI ■ Angioplasty (3 vessels) ■ Obesity
Family History	<ul style="list-style-type: none"> ■ Mother—Deceased at age 47 years from MI ■ Father—Deceased at age 46 years from MI ■ Sister—49 years old with hypertension ■ Brother—61 years old with multiple MI, coronary artery bypass graft, angioplasty
Social History	<ul style="list-style-type: none"> ■ Married ■ Business executive ■ Smoker, previously (1–2 packs per day from teens until approximately age 55 years) ■ Drinks 1 martini in the evening; occasional glass of wine with dinner ■ Walks for exercise about 20 minutes daily when pain related to arthritis symptoms is minimal; very little exercise in the last few months ■ Drinks approximately 2 cups of coffee per day
Allergies	<ul style="list-style-type: none"> ■ No known drug allergies
Physical Assessment	<p>Vital signs:</p> <ul style="list-style-type: none"> ■ BP = 145/85 mm Hg ■ Heart Rate = 82 bpm ■ Respiration = 22 bpm <p>Weight = 230 lb (represents 25 lb gain over last 6 months) Height = 5'11" Body Mass Index = 32.1</p>
Background	<ul style="list-style-type: none"> ■ Arthritis Has tried numerous over-the-counter and prescription NSAIDs and rofecoxib 25 mg daily for treating symptoms of rheumatoid arthritis with minimal success. Patient used rofecoxib 25 mg daily, with success, until it was removed from the market in 2004. ■ Diabetes Original hemoglobin A1c was 10.5% and reduced to 9.5% within 3 months following diagnosis and treatment. Previously used metformin 500 mg twice a day, discontinued because of elevated serum creatinine. Admits that he does not always maintain a proper diet, particularly during the day when he often consumes fast food for lunch. Early morning BG is 100–130 mg/dL or sometimes higher. Sporadically tests BG levels ("once daily a couple of days a week"). ■ Hyperlipidemia At diagnosis, 6 years ago, original TC levels were approximately 300 mg/dL and LDL levels were consistently 180+ mg/dL, TRG was 315 mg/dL, and BG was significantly elevated (patient cannot remember the exact numbers). Uses atorvastatin 20 mg daily. Fasting lipid panel 8 months ago: TC = 185 mg/dL, LDL = 130 mg/dL. ■ Hypertension BP had become significantly elevated prior to MI. States that he has had only marginal success controlling with exercise and diet. States that he does not routinely monitor BP at home. Uses lisinopril 10 mg daily and metoprolol XL 100 mg daily.
Medication Therapy	<ul style="list-style-type: none"> ■ Laboratory Results Based on labs from 3 months ago: A1c = 8.1%, TC = 195 mg/dL, LDL = 130 mg/dL, TRG = 190 mg/dL, serum creatinine = 1.8 mg/dL. ■ Prior medications: <ul style="list-style-type: none"> —NSAIDs (multiple) for arthritis pain —Rofecoxib 25 mg daily for arthritis pain —Ibuprofen 400–600 mg, orally, four times daily for arthritis pain —Metformin 1,000 mg, orally, twice daily for diabetes (discontinued 3 months ago)

continued on next page 4

Table 1. Initial Visit Data Information (continued)

Topic	Patient Data
Medication Therapy	<ul style="list-style-type: none"> ■ Current medications: <ul style="list-style-type: none"> —Metoprolol XL 100 mg daily for high BP —Lisinopril 20 mg twice daily for high BP and diabetes —Atorvastatin 20 mg daily for hyperlipidemia —Insulin glargine 40 units inject subcutaneously daily for diabetes —Acetaminophen 1,000 mg as needed, for arthritis pain
Current Issues	<ul style="list-style-type: none"> ■ Arthritis pain and obesity ■ BP control ■ LDL cholesterol level reduction ■ Diabetes control

BG = blood glucose; BP = blood pressure; LDL = low-density lipoprotein; MI = myocardial infarction; NSAIDs = nonsteroidal anti-inflammatory drugs; TC = total cholesterol; TRG = triglycerides; XL = extended-release.

- Schedules the patient for a follow-up visit in 90 days and recommends the following lab tests prior to next MTM visit to assess the impact of the treatment interventions:
 - Serum creatinine—to assess renal function because of the history of diabetes and the addition of the hydrochlorothiazide; and to evaluate if the addition of a diuretic agent has a negative impact.
 - Hemoglobin A1c—to assess adherence and impact of treatment on improving diabetes control.
 - Fasting lipid profile—to assess whether the increased atorvastatin dose is moving the patient to cholesterol level goals.

The pharmacist documents this information in a SOAP note (Figure 1) and communicates with the physician or other health care professional to determine the appropriate course of action.

FOLLOW-UP VISIT

When RC returns for a follow-up visit 90 days later, he reports improvement in exercise and nutrition. This information is supported by data from the lab tests. However, he still complains of knee and hip pain (Table 2).

The pharmacist commends RC for these successes and refers him to a rheumatologist for further evaluation of the arthritis and records any other follow-up for the next visit. This information is documented in a SOAP note (Figure 2).

Rules and Etiquette for Documentation

When documenting patient care, it is essential to take into account the many audiences that may eventually view the records.⁴ Pharmacists should follow certain rules for the manner in which the records are

created, and respect guidelines for professional etiquette. Following these standards will help facilitate communications with other health care providers, and furnish appropriate documentation in the event that the records ever come under legal scrutiny.

Rules for Appropriate Documentation

Electronic documentation systems have been designed to create and maintain data in an appropriate manner. However, pharmacists who use a paper system to maintain patient care notes (e.g., SOAP notes), should follow these rules^{5,6}:

- All entries should be legible and written in permanent ink. Spelling and grammar should be correct.
- The date, time, and patient’s name should be listed on each page of the record.
- Entries should be sequential and conclude with the provider’s signature.
- Documentation should be completed as soon as possible.
- The record should never be altered by using correction fluid or similar implements. If an error is made, the erroneous portion of the entry should be bracketed and a single line drawn through it. It should be labeled “error,” and signed and dated by the pharmacist. The original entry should remain legible. If there is adequate space, the correction can be made within the note. If not, an addendum should be made to the original note.
- No blank lines should appear between entries. If there are blank lines at the bottom of a page and the provider wants to start the next entry on a fresh page, draw straight lines across the blank spaces.

Pharmacists should always perform their own documentation of patient interactions. Although technicians can perform some types of data entry, records of the interaction should always be written by the pharmacist who provides the care. The documentation

Figure 1. Initial SOAP Note

Patient Name: _____

Date: _____

S: 63-year-old male Pt, with Hx of arthritis, obesity, hyperlipidemia, hypertension. Several questions about medications and improving health status.

O: Type 2 DM: Early morning BG 100–130+, does not test routinely, A1c 8.1% (3 mo ago)
HTN: 145/85 on lisinopril 20 mg twice daily
Hyperlipidemia: TC 195, LDL 130, TRG 190 (3 mo ago) on atorvastatin 20 mg once daily
Obesity: 5'11" / 230 lb, BMI 32.1
RA: Knee and hip pain with exercise, APAP PRN only
SCr: 1.8 (3 mo ago)
Vitals: P 82, R 22
Not taking ASA for CVD prevention

A: Diabetes: Poor compliance diet/meal planning; minimal understanding of BG testing; above goal of A1c <7%
HTN: Above goal of BP 125/80 with Tx
Hyperlipidemia: Above goal of LDL ≤100 with Tx
Obesity: Above goal, 25 lb gain over last 6 mo, min exercise frequency
Initial goal 10% weight loss at 1–2 lb/wk (23 lb in 4 mo)
RA: Still not well controlled

P: Improve medication adherence and health outcomes

1. Recommended changing lisinopril 20 mg twice daily to lisinopril 20 mg/HCTZ 12.5 mg twice daily
2. Recommended increasing atorvastatin from 20 mg to 40 mg once daily
3. Recommended diclofenac XR 100 mg once daily for RA
4. Recommended adding low-dose ASA daily
5. Provided and instructed Pt with Daily BG Monitoring log
6. Provided and instructed Pt with personal health tracking tool
7. Reviewed "ADA Dietary Guidelines" and shopping/meal planner guide
8. Requested Pt walk for 30–60 min daily
9. Schedule for 90-day F/U appt
10. Schedule for repeat of the following labs 2 weeks prior to 90-day F/U appt:
SCr, fasting lipid profile, A1c, BG

Duration of appointment: 45 minutes

Pharmacist's signature: _____

A1c = hemoglobin A1c; ADA = American Diabetes Association; APAP = acetaminophen; ASA = aspirin; BG = blood glucose; BMI = body mass index; BP = blood pressure; CVD = cardiovascular disease; DM = diabetes mellitus; F/U = follow-up; HCTZ = hydrochlorothiazide; HTN = hypertension; Hx = history; LDL = low-density lipoprotein; P = pulse; po = orally, PRN = as needed; Pt = patient; R = respiration; RA = rheumatoid arthritis; SCr = serum creatinine; TC = total cholesterol; TRG = triglycerides; Tx = therapy; XR = extended release.

should indicate that the pharmacist actually assessed the patient. For example, stating that the "patient does not use herbals" does not necessarily indicate that the pharmacist asked the patient about the use of herbals. "Patient denies use of herbals" does indicate that the pharmacists questioned the patient on this topic.

Assessments that reveal negative findings should be recorded. This step will help ensure that assessments are not repeated unnecessarily (which may save time and money), can help monitor conditions over time, and will protect against future lawsuits for failing to thoroughly assess the patient. Attempts to contact other health care providers also should be included in the documentation.

It is important to record data that support the pharmacist's judgments. For example, instead of saying

that a patient's blood pressure is better controlled with a new medication, state what the blood pressure was before and after the introduction of the medication. Information should be quantified whenever possible.

In addition to spelling and grammar, word choice is important for creating appropriate documentation. Pharmacists should aim to³:

- Use objective rather than subjective language (e.g., "patient was crying" rather than "patient seemed sad").
- Avoid using judgmental words to describe either a patient (e.g., unreasonable, stubborn, lazy) or a medication (inappropriate, wrong, senseless).
- Refrain from expressing opinions about other health care providers or their treatment preferences.

Table 2. Follow-Up Visit Data Information

Topic	Patient Data
Demographics	63-year-old man, self-referred
Past Medical History	No changes
Family History	No changes
Social History	Walks 30 minutes a day, 5 days a week, over the past 3 months. Pain in knees and hip limit his exercise. Food diary indicates portion control has improved and he has changed more consistently to low-fat, low-carbohydrate snacks and drinks.
Allergies	No known drug allergies
Physical Assessment	<ul style="list-style-type: none"> ■ Vital signs: <ul style="list-style-type: none"> —BP = 125/76 mm Hg —Heart Rate = 78 bpm —Respiration = 18 bpm ■ BG = Self-monitoring before breakfast and after dinner every day. Morning fastings averaging 100–125 mg/dL, 2-hr postprandials after dinner 160–180 mg/dL ■ Weight = 215 lb (represents 15 lb weight loss over last 3 months) ■ Height = 5'11" ■ Body Mass Index = 30.0
Background	<ul style="list-style-type: none"> ■ Arthritis Still complains of knee and hip pain on diclofenac especially when he walks. Diclofenac not helping much. ■ Diabetes A1c has dropped from 8.1% to 7.5% over the last 3 months. Currently taking insulin glargine 40 units subcutaneously every evening. He is packing his lunch more and eating fast foods less often. He checks his BG before breakfast and 2 hours after dinner. Early morning BG averaging 100–125 mg/dL and 2-hr postprandial BG after dinner are 160–180 mg/dL. ■ Hyperlipidemia TC = 175 mg/dL, LDL = 100 mg/dL, HDL = 45 mg/dL, TRG 150 mg/dL on atorvastatin 40 mg orally once daily. Food diary indicates portion control has improved and he has changes more consistently to low-fat, low-carbohydrate snacks and drinks. He is packing his lunch more often and eating less fast food. ■ Hypertension BP today is 125/76 on lisinopril 20 mg/HCTZ 12.5 mg, orally, twice daily. He is not monitoring his BP at home on a routine basis. ■ Laboratory Results Based on labs from 2 days ago: A1c = 7.5%, TC = 175 mg/dL, LDL = 100 mg/dL, HDL = 45 mg/dL, TRG = 150 mg/dL, serum creatinine = 1.8 mg/dL.
Medication Therapy	<ul style="list-style-type: none"> ■ Current medications: <ul style="list-style-type: none"> —Metoprolol XL 100 mg daily for high BP —Lisinopril 20 mg/HCTZ 12.5 mg twice daily for high BP and diabetes —Atorvastatin 40 mg daily for hyperlipidemia —Insulin glargine 40 units inject subcutaneously daily for diabetes —Diclofenac XR 100 mg daily for arthritis pain —Low-dose aspirin once daily
Current Issues	<ul style="list-style-type: none"> ■ Arthritis pain ■ BG control

BG = blood glucose; BP = blood pressure; HCTZ = hydrochlorothiazide; HDL = high-density lipoprotein; LDL = low-density lipoprotein; TC = total cholesterol; TRG = triglycerides; XL/XR = extended release.

- Avoid making a diagnosis in the documentation. If signs and symptoms of an undiagnosed condition are apparent during the patient assessment, the pharmacist should record the signs and symptoms and refer the patient for evaluation.

Etiquette for Communicating With Prescribers

It is important to carefully word recommendations that are sent to prescribers. Many prescribers recog-

Figure 2. Follow-Up SOAP Note

Patient Name: _____ Date: _____

- S:** Nutrition: Food diary indicates portion control with low-fat, low-carb snacks and drinks
 Exercise: Increased walking and exercise, feels better, but still has leg pain when walking
 HTN: Not routinely monitoring BP at home
- O:** Type 2 DM: Checking BG before breakfast and 2 hours after dinner. BG logs show morning BG in range. BG frequently runs high after dinner. A1c improved at 7.5% on insulin glargine 40 units every evening
 HTN: BP reduced to 125/76 S/P change (lisinopril 20 mg/HCTZ 12.5 mg) twice daily
 Hyperlipidemia: TC 175, LDL 100, HDL 45, TRG 150 on diet, exercise, and atorvastatin 40 mg once daily
 Obesity: 15 lb weight loss
 RA: Still complains of knee and hip pain on diclofenac
 SCr 1.8 Pt already on ACE, no change S/P addition of diclofenac
- A:** Diabetes: Improving toward goal; postprandial BG is high
 HTN: At goal
 Hyperlipidemia: At LDL goal of 100 mg/dL
 Obesity: Exceeded weight loss goal of 1 lb/week
 RA: Still not well controlled
- P:**
1. Patient notes improvement in exercise and nutrition, reinforced with lab results, but still complains of knee and hip pain. Referred to rheumatologist.
 2. Reinforced success of weight loss and increase emphasis on nutrition and exercise.
 3. Recommended learning to carb count and add insulin lispro prior to meals.
 4. Recommended decrease LDL goal to less than 70 mg/dL and to add ezetimibe 10 mg po daily.
 5. Recommended continued weight loss at 1 lb/week.
 6. F/U in 90 days.

Duration of appointment: 20 minutes

Pharmacist's signature: _____

A1c = hemoglobin A1c; ACE = angiotensin-converting enzyme; BG = blood glucose; BP = blood pressure; DM = diabetes mellitus; F/U = follow-up; HCTZ = hydrochlorothiazide; HDL = high-density lipoprotein; HTN = hypertension; LDL = low-density lipoprotein; po = orally, Pt = patient; RA = rheumatoid arthritis; SCr = serum creatinine; S/P = status post; TC = total cholesterol; TRG = triglycerides.

nize the value that pharmacists bring to the patient care team. These providers tend to welcome and respond to communications from pharmacists in a timely manner. Others may have little experience interacting with pharmacists who provide MTM and related patient care services and might be unaccustomed to recommendations sent from a pharmacist.

Ideally, pharmacists will have an opportunity to contact local prescribers as part of their process for implementing the service and explain their qualifications as well as the goals and functions of the service. This step may make the prescriber more receptive to recommendations that are generated from the patient encounter. In addition, some pharmacists recommend communicating with patients' primary care providers prior to the service visit to inform the providers that their patients will be participating in the pharmacy's service. However, pharmacists may encounter resistance from prescribers and should strive to carefully word all recommendations so that prescribers do not feel that their judgments are coming under attack or

that the pharmacist's documentation leaves them exposed legally.

When pharmacists request a specific change to the patient's prescription medication regimen, it is important to be precise in the written communication. For example, do not write "Would you consider changing the patient to metformin?" If the provider writes back "yes," it is not clear whether the prescriber actually wants to change the medication or if the change is merely being considered. The use of statements that describe specific actions with check boxes for the prescriber can help eliminate confusion. For example:

- Yes, switch the patient's medication to metformin 500 mg twice a day.
- No, do not switch the patient's medication to metformin 500 mg twice a day. Instead, please make the following change:

-
- No, do not make any changes to the patient's medication regimen.

Abbreviations in Documentation

Pharmacists should limit the use of abbreviations to those that are standard for use by various health care providers.

The use of electronic documentation may help to reduce confusion that surrounds certain abbreviations, particularly those that result from poor handwriting. However, other abbreviations may cause confusion if they trigger multiple possible interpretations. Many health systems have approved lists of abbreviations as well as “do not use” lists. Pharmacists should aim to minimize the use of abbreviations in documentation. Although several abbreviations have a widely understood meaning, such as HIV for human immunodeficiency virus, others could be misinterpreted. For example, AZT for zidovudine could be mistaken for azathioprine or aztreonam.

The Institute for Safe Medication Practices publishes a list of error-prone abbreviations, symbols, and dose designations (www.ismp.org/Tools/errorprone-abbreviations.pdf). This list includes those on the Joint Commission’s official “do not use” list required for accredited health care organizations. Pharmacists should avoid the use of these abbreviations. In addition, pharmacists should never invent their own abbreviations as a form of shorthand and assume that someone else would be able to infer the meaning. For example, Yocum describes an instance in which a nursing assistant used the abbreviation “PWISOTF” to indicate “plus what I spilled on the floor.”⁷ It is unlikely that any future reader would be able to make sense of this abbreviation.

Outcomes and Quality Improvement

Documentation is essential for measuring and tracking clinical, financial, and humanistic outcomes to evaluate the patient care service, and it can be used to guide quality improvement efforts.

In addition to allowing for quality improvement activities, tracking outcomes can enhance the marketability of the service. While published reports demonstrating pharmacists’ beneficial impact on outcomes can be useful during initial marketing efforts, potential referral sources and third-party payers will be most interested in the specific outcomes achieved through the pharmacy service for their own patient population. Pharmacists who track and monitor their outcomes should be able to generate these data for their marketing presentations. (These functions are often streamlined by electronic documentation systems.)

Outcomes that can be measured for current status and change from baseline include:

- Percentage of patients using medications correctly.
- Percentage of patients achieving clinical goals.
- Patient satisfaction regarding patient care received.

Pharmacists also may choose to track workload statistics and measures of service performance, such as time required for each appointment, time spent documenting services, number of no-shows/cancellations, number of therapy recommendations made and accepted, types of interventions provided, etc. When possible, pharmacists should assess the impact of the service on other outcomes, such as total cost of health care, emergency department visits, hospital stays, and employee absenteeism and productivity.

Outcomes can be measured in aggregate and analyzed by various subpopulations, including number of chronic conditions, specific chronic conditions, demographic characteristics, prescribers and/or number of prescribers, insurance type, pharmacist providing the service, and other variables.

Conclusion

Documentation is a vital component of any pharmacy-based patient care service. Appropriate documentation is essential for high-quality patient care, and serves many other important functions, ranging from communications with other health care providers to serving as a legal record of care provided. Several structured documentation formats are in use today. The use of SOAP notes to track patient progress is widespread in the health care field, and many pharmacists are adopting this tool for their patient care services. However, SOAP notes are only one component of a comprehensive documentation system. Pharmacists should assess all of their documentation needs when selecting and/or developing a system for their practice.

In addition to tracking the care provided to individual patients, documentation is essential for evaluating the overall impact of a service. Documentation allows ongoing monitoring of outcomes, which generates data essential for continuous quality improvement and marketing efforts.

MTM Resources

MTM Resources can be found at www.pharmacist.com/mtm.

References

1. Cipolle RJ, Strand IM, Morley PC. *Pharmaceutical Care Practice. The Clinician’s Guide*. New York, NY: McGraw-Hill Co.; 2004.
2. Ferrell KG. Documentation part 2: the best evidence of care. *Am J Nurs*. 2007;107:61–4.
3. Zierler-Brown S, Brown T, Chen D, Blackburn RW. Clinical documentation for patient care: models, concepts, and liability considerations for pharmacists. *Am J Health Syst Pharm*. 2007;64:1851–8.
4. Lacy CF, Saya FG, Shane RR. Quality of pharmacists’ documentations in patients’ medical records. *Am J Health Syst Pharm*. 1996;53:2171–5.
5. Sullivan DD, Mattingly IJ. *Documentation for Physician Assistants*. Philadelphia, PA: FA Davis Co.; 2004.
6. Monarch K. Documentation part 1: principles for self-protection. *Am J Nurs*. 2007;107:58–60.
7. Yocum RF. Documenting for quality patient care. *Nursing*. 2002;32:59–64.

CE Assessment Questions

Instructions: For each question, circle the letter corresponding to the correct answer on the CE Examination Form. **Please review all of your answers to be sure you have marked the proper letter.** There is only one correct answer to each question.

1. Starting on January 1, 2008, the CPT code to bill for the initial 15 minutes of MTM with a new patient is:
 - a. 0115T.
 - b. 0116T.
 - c. 99605.
 - d. 99606.

2. In health care documentation, SOAP stands for:
 - a. Subjective, Objective, Assessment, Plan.
 - b. Subjective, Objective, Action, Prognosis.
 - c. Subjective, Objective, Agreement, Problems.
 - d. Superior Organization And Prognosis.

3. What action should a pharmacist take if an error is recorded in the patient documentation?
 - a. Use correction fluid to conceal the error and then write the correct information in its place.
 - b. Copy the page by hand without the erroneous information and throw away the original.
 - c. Bracket the erroneous information, draw a single line through it, write "error," and sign and date it.
 - d. The original documentation should never be altered; instead the pharmacist should staple a corrected addendum to the original.

4. Which of the following statements regarding documentation of patient care is true?
 - a. Pharmacists may delegate responsibility for patient care documentation to pharmacy technicians.
 - b. Pharmacists are encouraged to develop their own shorthand system to make their documentation more efficient.
 - c. To streamline workflow, pharmacists should jot down notes when meeting with patients, and then complete all documentation before the patient's next visit.
 - d. Pharmacists should be objective in their documentation and avoid use of subjective or judgmental terminology.

5. Which of the following statements about abbreviations in patient care documentation is true?
 - a. Pharmacists should avoid the use of abbreviations that have multiple possible interpretations.
 - b. Abbreviations should be used whenever possible to streamline the documentation process.
 - c. An abbreviation key should be placed in each patient chart, and updated as new abbreviations are added.
 - d. Pharmacists may develop their own set of abbreviations as long as they share the key with other members of the pharmacy staff.

6. Which of the following statements about documentation of MTM services is true?
 - a. The patient's complete medical history should be incorporated in the SOAP note.
 - b. There should be no mention of billing in the patient care record.
 - c. All documentation must be maintained in compliance with HIPAA standards.
 - d. Patient records are exempt from statutes of limitations.

7. Which of the following would be the best language to use to communicate a recommendation to increase the dosage of a prescription?
 - a. Do you think we might be able to increase the dosage?
 - b. Can we increase the dosage as to 20 mg as suggested?
 - c. We need to increase the dosage to bring it into an appropriate therapeutic range.
 - d. Patient is receiving the wrong dosage. Please fax a new prescription.

8. Which of the following outcomes of a pharmacy-based patient care service might most interest an employer who purchases the service?
 - a. Employees' sick time.
 - b. Employees' income.
 - c. Time spent documenting the service.
 - d. Cost of pharmacy software maintenance.

9. Which of the following types of information should be located in the objective portion of a SOAP note?
 - a. The patient's stated therapeutic goals.
 - b. The patient's report of medication adherence.
 - c. Measurement of the patient's blood pressure.
 - d. Plans for follow-up appointments.

10. How should a pharmacist document a blood pressure of 160/95 mm Hg for a patient who does not have a diagnosis of hypertension?
 - a. BP 160/95, referred to primary care physician for further evaluation.
 - b. Patient has hypertension.
 - c. Pharmacists should not record this information in the absence of an existing diagnosis.
 - d. This patient's blood pressure is really high! I can't believe his physician has overlooked this!

CE Credit

To obtain 1.0 hour of continuing education credit (0.1 CEU) for "Medication Therapy Management Services: Documenting Pharmacy-Based Patient Care Services," complete the assessment exercise, fill out the CE Examination Form at the end of this publication, and return that page to APhA. A Statement of Credit will be awarded for a passing grade of 70% or better. Pharmacists who complete this exercise successfully before December 1, 2010, can receive credit.



The American Pharmacists Association is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education. The ACPE Universal Program Number assigned to the program by the accredited provider is 202-000-07-268-H04-P.

"Medication Therapy Management Services: Documenting Pharmacy-Based Patient Care Services" is a home-study continuing education program for pharmacists developed by the American Pharmacists Association.



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CE EXAMINATION FORM

Medication Therapy Management Services: Documenting Pharmacy-Based Patient Care Services

To receive **1.0** contact hour of continuing education credit (**0.1 CEU**), please provide the following information:

- Type or print your name and address in the spaces provided.
- Mail this completed form for scoring to:
American Pharmacists Association—CE Exam
P.O. Box 791082
Baltimore, MD 21279-1082
- The CE processing for grading the assessment instrument and issuing the Statement of Credit is free of charge for all users.

A Statement of Credit will be awarded for a passing grade of 70% or better. If you fail the exam, you may retake the exam once. If you do not pass the second time, you may no longer participate in this continuing pharmacy education program. Please allow 6 weeks for processing. Pharmacists who complete this exercise successfully before **December 1, 2010**, can receive credit.



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How long did it take you to read the continuing education program and complete this test? _____ Hours _____ Minutes

My signature certifies that I have independently taken this CE Examination:

CE ASSESSMENT QUESTIONS—ANSWERS

Please circle your answers (one answer per question).

- | | | | |
|------------|------------|------------|-------------|
| 1. a b c d | 4. a b c d | 7. a b c d | 10. a b c d |
| 2. a b c d | 5. a b c d | 8. a b c d | |
| 3. a b c d | 6. a b c d | 9. a b c d | |

PROGRAM EVALUATION

PLEASE ANSWER EACH QUESTION.

	EXCELLENT			POOR	
1. Overall quality of the program	5	4	3	2	1
2. The program was relevant to pharmacy practice	5	4	3	2	1
3. Value of the content	5	4	3	2	1

PLEASE ANSWER EACH QUESTION MARKING WHETHER YOU AGREE OR DISAGREE.

	Agree	Disagree
4. The program met the stated learning objectives:		
• Describe examples of standardized formats for documenting patient care services in patient charts.	<input type="checkbox"/>	<input type="checkbox"/>
• List the components of SOAP documentation and explain information elements within each component.	<input type="checkbox"/>	<input type="checkbox"/>
• Identify key elements of data to document in a given patient case and structure the documentation in a medically appropriate format.	<input type="checkbox"/>	<input type="checkbox"/>
• Explain the legal requirements for proper documentation of patient care services, requirements for the maintenance and protection of records, and legal ramifications for failure to comply.	<input type="checkbox"/>	<input type="checkbox"/>
• Describe quality measures that can be used to evaluate the outcomes of MTM service delivery.	<input type="checkbox"/>	<input type="checkbox"/>
5. The program increased my knowledge in the subject area.	<input type="checkbox"/>	<input type="checkbox"/>
6. The program did not promote a particular product or company.	<input type="checkbox"/>	<input type="checkbox"/>

Impact of the Activity

The information presented (check all that apply):

7. Reinforced my current practice/treatment habits Will improve my practice/patient outcomes Provided new ideas or information I expect to use
 Enhances my current knowledge base
8. Will the information presented cause you to make any changes in your practice? Yes No
9. How committed are you to making these changes? (Very committed) 5 4 3 2 1 (Not at all committed)
10. Do you feel future activities on this subject matter are necessary and/or important to your practice? Yes No

Follow Up

As part of our ongoing quality-improvement effort, we would like to be able to contact you in the event we conduct a follow-up survey to assess the impact of our educational interventions on professional practice. Please indicate your willingness to participate in such a survey.

- Yes, I am interested in participating in a follow-up survey. No, I am not interested in participating in a follow-up survey.

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