COMMUNITY-BASED PHARMACY PATIENT CLINICAL RECORD RUBRIC

Overview: This rubric tool was developed utilizing the expert opinion of several key stakeholders including community pharmacists, technology vendors, and health information technology specialists through a Delphi method. The 46 items are organized into three types: 1) essential elements for a pharmacy patient record, 2) essential elements for an episode of care, and 3) functionalities for a pharmacy patient records system. The purpose of this rubric is for pharmacists, vendors, and other stakeholders to assess a platform to ascertain if it contains the elements and functionalities needed for an ideal patient record based on expert opinion.

Instructions for use: During the assessment of an electronic patient clinical record platform, check the "Yes" or "No" columns if it contains an essential element or functionality. The more elements and functionalities the record contains, the more robust and functional the platform. Pharmacists can use the rubric as a way to assess multiple platforms before making costly financial decisions. Vendors can use the rubric to evaluate their own platform to determine how their platform compares to an expert panel's opinions on an ideal robust clinical patient record system. Payers can use this rubric to assess different platforms to determine which ones may meet their needs in terms of data transmission. Other stakeholders may have an interest in community-based pharmacists' abilities to document their patient care activities and safely and securely share that information with prescribers and other providers.

Regardless of the end user of this rubric, it is the hope of the developers that this rubric will be used to improve platforms, reduce pharmacists' burden in documenting patient care, improve documentation within workflow, and improve the pharmacists' abilities to truly transform their practice. Clinical documentation and care planning are essential components of a transformed community-based pharmacy practice, let this rubric be used to help improve that process.

Community Pharmacy Foundation

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COMMUNITY-BASED PHARMACY
PATIENT CLINICAL RECORD RUBRIC

ESSENTIAL ELEMENTS FOR A LONGITUDINAL PATIENT RECORD	YES	NO
Patient demographics *(names, ethnicity, sex, date of birth)*		
Patient contact information *(current address, email address, phone number)*		
Health insurance *(coverage type, identifiers & numbers)*		
Allergies and intolerances *(substance and reaction)*		
Immunizations		
Vital signs *(blood pressure, body height & weight)*		
Laboratory *(tests, values/results)*		
Goals of therapy		
Assessments *(screenings and questionnaires)*		
Plan of treatment		
Outcomes of therapy *(reported, assessed)*		
Past medical history		
Prescription/OTC/supplement/alternative medication history *(complete medication record)*		
Social history *(substance use, social determinants of health)*		
Special needs of patient *(patient note, e.g., delivery, caregiver, language)*		
Pharmacist intervention history		

ESSENTIAL ELEMENTS FOR A PATIENT ENCOUNTER	YES	NO
Encounter information *(encounter time, type & reason)*		
Pharmacist identifier *(author)*		
Patient identifier *(first name, middle name/initial, last name, date of birth)*		
History of present illness *(problems, social determinants of health problems/health concerns)*		
Relevant prescription/OTC/supplement/alternative medication history/adherence *(medications relevant to the acute patient care episode)*		
Assessment *(identification of medication-related problems)*		
Plan of action to address problems *(interventions, procedures)*		

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ESSENTIAL FUNCTIONALITIES FOR A PHARMACY PATIENT RECORD SYSTEM	YES	NO
Formatted for intuitive navigation of patient record		
Searchable patient clinical notes shown chronologically by date of encounter		
Multiple filters for sorting content *(e.g. date of encounter, type of medication-related problems, medications, health conditions/indications, interventions made, results of interventions)*		
Dashboard for viewing and analyzing patient information		
Calendar/scheduling		
Date & time stamp for care plans		
Author and location of patient information including care plans		
Quick and efficient documentation *(e.g., templates to guide actions)*		
Patient identification by selected criteria, affiliations, or payer programs *(tag, flag, color code, sort/filter)*		
Running reports based on selected criteria, affiliations, or payer programs		
Work queue for navigating care plan progress		
Longitudinal observations and notes *(e.g., labs/vitals or notes over time)*		
Dashboard for viewing and analyzing pharmacy performance metrics *(e.g., adherence rate, appropriate statin use, vitals/labs at goal)*		
Capture of information from ePrescriptions *(e.g., labs, vitals)*		
User initiated import and export of selected patient files or documents		
Transmission of secure information to other providers *(i.e. interoperability)*		
Bidirectional sharing of selected patient information with providers		
Seamless transition across various platforms *(e.g., from clinical documentation to pharmacy management system; using a single sign-on)*		
Integration with pharmacy management system *(i.e., no dual entry)*		
Risk stratification of patients		
Automated medical billing		
Automated background mapping of terminology to codes *(e.g., SNOMED, CPT)*		
Standardization of care plan for use by other providers & settings of care		

Abbreviations: CPT, Current Procedural Terminology; OTC, over-the-counter.