

BHS Policies and Procedures



City and County of San Francisco
Department of Public Health
San Francisco Health Network
BEHAVIORAL HEALTH SERVICES

1380 Howard Street, 5th Floor
San Francisco, CA 94103
415.255-3400
FAX 415.255-3567

POLICY/PROCEDURE REGARDING: BHS Electronic Prescribing

Issued By: Marcellina Ogbu, DrPH
Deputy Director
San Francisco Health Network

Date: May 17, 2016

Manual Number: 6.00-02
References: 42 CFR Part 2, 2.1-2.31

Substantive revision. Replaces Policy 6.00-02 March 22, 2011

Purpose:

To ensure the proper use and application of the Behavioral Health Services (BHS) electronic prescribing system.

Policy Statements:

1. BHS complies with all State and Federal laws and regulations governing prescribing, electronic prescribing activities and client health records.
2. As a component of the BHS health record, the BHS electronic prescribing system will be utilized by all BHS and BHS affiliated medical providers to transmit and document BHS outpatient medication prescriptions, and to document client allergy and medication information.
3. In substance abuse treatment programs, a signed client Authorization to Release Protected Health Information for Electronic Prescribing must be obtained prior to entries into the electronic prescribing program. (See Procedures Section 6, and Attachment B Authorization to Release Form)

Scope:

This policy and procedure applies to all BHS and BHS affiliated medical providers, with the exception of the Private Providers Network (PPN). Medical providers includes licensed Physicians, Doctors of Osteopathy, Nurse Practitioners, Pharmacists, Registered Nurses, Licensed Vocational Nurses, Psychiatric Technicians and Pharmacy Technicians.

Procedure:

1. All BHS prescription activities shall be entered into the electronic prescribing system.
2. Prescribing activities entered into the electronic prescribing system shall include:
 - a. All prescriptions (new or renewals) transmitted or sent to a pharmacy, including verbally transmitted prescriptions
 - b. Medications ordered but not transmitted to a pharmacy, such as medications administered from clinic floor stock (e.g. haloperidol decanoate) or medications supplied by a patient assistance program (e.g. paliperidone injectable)
 - c. Prescription order changes
 - d. Discontinuation of medications
3. Medication allergy information
 - a. Medication allergy information shall be entered into the electronic prescribing system by the prescriber or his/her designee at the start of care with the prescriber
 - b. Clients with no reported medication allergies shall have the entry “No Known Allergy”
 - c. Medication allergy information shall be updated as needed
4. Non-BHS Prescriptions
 - a. It is recommended that clinicians enter other current medications (those not directly prescribed via BHS), including
 - i. Primary care medications
 - ii. Over-the-counter and/or herbal remedies
5. Non-Controlled and Controlled Substances Prescriptions Transmission
 - a. Non-controlled prescriptions
 - i. Shall be entered into the electronic prescribing system to document the medication order
 - ii. Shall be transmitted as electronic prescriptions whenever possible
 - b. Controlled Schedule III-V prescriptions
 - i. Shall be entered into the electronic prescribing system to document the medication order
 - ii. Shall be transmitted as electronic prescriptions whenever possible
 - iii. If electronically faxed, a verbal verification will be needed by the accepting pharmacy
 - c. Controlled Schedule II prescriptions
 - i. Shall be entered into the electronic prescribing system to document the medication order
 - ii. Shall be transmitted as electronic prescriptions whenever possible
 - iii. Cannot be electronically faxed
 - iv. If not transmitted electronically shall be written on a tamper resistant security prescription form which meets state and federal regulations
6. “No Current Medications Noted” shall be indicated by checking the box in the electronic prescribing “Current Medication Profile” page for clients who have no active medications and receiving care from a prescriber

7. Providers in substance abuse treatment programs must obtain a signed client Authorization to Release Protected Health Information for Electronic Prescribing prior to any entries into the electronic prescribing program. The authorization is limited to disclosing of allergy and prescription information. Substance abuse treatment providers shall not enter diagnoses information into the electronic prescribing record.
 - e. The provider shall not enter any diagnosis information into the electronic prescribing system. If a diagnosis is required to enter a prescription, use “799.9 Axis 1 Diagnosis Deferred”.
 - f. See Attachment B for the Authorization to Release Protected Health Information for Electronic Prescribing Form.
 - g. The specific client authorization shall include:
 - i. The substance abuse program name and address or person permitted to make the disclosure,
 - ii. Disclosure released to: “DPH-authorized clinicians involved in my care”,
 - iii. Contents of disclosure: “my allergy and prescription information into my electronic behavioral health record”,
 - iv. Purpose of the disclosure: “to improved coordination of my care”,
 - v. Terminates: “Unless revoked, this authorization will expire one year from receiving last known prescription service at the substance abuse treatment program”
 - vi. Client rights:
 1. I understand that authorizing the disclosure of this health information is voluntary.
 2. I understand that I may not be denied treatment, payment, enrollment in a health plan or eligibility for benefits if I refuse to sign.
 3. I understand that I have a right to receive a copy of this authorization.
 4. I understand that all my allergy and medication information entered into the prescribing system during this authorization period by this substance abuse treatment program will become part of my general behavioral health permanent record and cannot be deleted.
 5. I understand that I may cancel my authorization at any time by writing a note of cancellation and giving it to _____. I understand that when I give or cancel my authorization, it is effective from that date forward and not retroactively. I understand that if and when I revoke my authorization, from that time forward my allergy and prescription information will no longer be entered into my general electronic behavioral health record by this substance abuse treatment program.
 - vii. Client’s name, signature, date authorization is given. If parental/guardian consent is necessary for providing the service to a minor client, the signature of parent or guardian.
 - h. The client authorization for electronic prescribing is a specific authorization and does not replace any other client authorizations for release of protected health information.
 - i. If the client does not authorize the release of protected health information for electronic prescribing, the provider shall document medication orders and allergy information on the hardcopy Prescriber’s Order Form (MRD 16)

8. Electronic Prescribing System users shall have access at one of three levels: Prescribers, Prescriber Agents or Non-prescribing Users.
 - a. "Prescribers" are authorized to write prescriptions under their own name. Prescribers must be currently licensed to prescribe medications by the State of California and credentialed by the BHS Department of Compliance
 - b. "Prescriber Agents"
 - i. Prescriber Agents are authorized to enter and transmit prescriptions and laboratory orders into the electronic prescribing system under the direction and on behalf of a licensed Prescriber who has Prescriber level access to the electronic prescribing system.
 - ii. The Prescriber must submit a completed Prescriber Agent Authorization Form to authorize a Prescriber Agent to transmit prescriptions and laboratory orders in his/her behalf. (See Attachment A- Prescriber Agent Authorization Form).
 - iii. Prescriber Agents may not transmit orders for Schedule II controlled substances, however they may enter orders for prescriber review and the prescriber may transmit the order upon review.
 - iv. Only medical providers, including licensed vocational nurses, registered nurses, psychiatric technicians, and pharmacy technicians may act as Prescriber Agents.
 - v. Prescriber Agents may be authorized to transmit prescriptions and laboratory orders for more than one prescriber. Each prescriber must complete the Prescriber Agent Authorization Form to authorize the Agent to transmit prescriptions in his/her behalf.
 - c. "Non-Prescribing Users" are authorized to enter into and update non-prescribing information in the system, including entering medication allergies, entering non-BHS prescriptions, and viewing medication related information.



Mayor Edwin Lee

**BHS Electronic Prescribing
 Prescriber Agent Authorization**

1. I am an authorized BHS electronic Prescriber.
2. I authorize the following individual(s), who is an authorized BHS electronic prescription system user, to enter and transmit prescriptions and laboratory orders via the BHS electronic prescribing system on my behalf:

Name of Prescriber’s Agent(s): _____

Title of Prescriber’s Agent(s): _____

Email and Telephone of Prescriber’s Agent(s): _____

3. I understand I may withdraw this authorization at any time.

Prescriber’s Name and Title (print):		
Prescriber’s Signature:		Date:
Name of Agency & Program:		
Prescriber’s Ph# and email:		

Submit Completed form to:
 Electronic Prescribing Registration
 CBHS Pharmacy
 1380 Howard Street Room 130
 San Francisco, CA 94103

or FAX to 415-252-3036

ATTACHMENT A



City and County of San Francisco

**AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION
Electronic Prescribing by Substance Abuse Treatment Providers**

Name*		Date of Birth*
Aliases		SSN
I authorize*: _____ (Name & address of Substance Abuse Treatment Program authorized to disclose this information.) to disclose and enter my allergy and prescription information into my electronic behavioral health record.		
Purpose of disclosure is to improve coordination of my care.		
Disclosure will be made to DPH-authorized clinicians involved in my care.		
Expiration:	Unless revoked, this authorization will expire one year from receiving last known prescription service at this substance abuse treatment program.	

My rights:

1. I understand that authorizing the disclosure of this health information is voluntary.
2. I understand that I may not be denied treatment, payment, enrollment in a health plan or eligibility for benefits if I refuse to sign.
3. I understand that I have a right to receive a copy of this authorization.
4. I understand that all my allergy and medication information entered into the prescribing system during this authorization period by this substance abuse treatment program will become part of my general behavioral health permanent record and cannot be deleted.
5. I understand that I may cancel my authorization at any time by writing a note of cancellation and giving it to _____.
 - a. I understand that when I give or cancel my authorization, it is effective from that date forward and not retroactively.
 - b. I understand that if and when I revoke my authorization, from that time forward my allergy and prescription information will no longer be entered into my general electronic behavioral health record by this substance abuse treatment program.

* Client/Patient Signature * Date

Parent/Guardian/Conservator Signature (if Client/Patient is unable to sign) Date

If Client/Patient is unable to sign, Witness Signature Also Required Date

Failure to provide ALL information marked * will invalidate this authorization. Rev 031511 ATTACHMENT B

ATTACHMENTS: 2

Contact Person: Director of Pharmacy, BHS, 415-255-3703

Distribution:

BHS Policies and Procedures are distributed by the Office of Quality Management for Community Programs

Administrative Manual Holders

BHS Programs

SOC Managers

BOCC Program Managers

CDTA Program Managers