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BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
GOVERNOR EDMUND G. BROWN JR.

ENFORCEMENT AND COMPOUNDING COMMITTEE REPORT

Amy Gutierrez, PharmD, Chair, Board President
Greg Lippe, Public Member, Vice Chair
Stan Weisser, Professional Member
Allan Schaad, Professional Member
Rosalyn Hackworth, Public Member
Greg Murphy, Public Member

Report of the Enforcement and Compounding Committee meeting held on September 9, 2015.

I. ENFORCEMENT MATTERS

a. Update on the CURES 2.0 Prescription Monitoring Program

The California Department of Justice (DOJ) is continues to work on upgrades to the CURES system. On June 30, the DOJ had a "soft launch" of CURES 2.0 as the new system is called. Since then the DOJ has been working to pilot test the new system and install upgrades that will permit conversion to the new, enhanced system.

Below is the update prepared in late June on the soft launch from the DOJ's press release:

CURES 2.0 Soft Launch and Phased Rollout

Update from July 1, 2015:

The Department of Justice (DOJ) and the Department of Consumer Affairs (DCA) are pleased to announce that the state's new Controlled Substance Utilization Review and Evaluation System – commonly referred to as "**CURES 2.0**" – went live on July 1, 2015. This upgraded prescription drug monitoring program features a variety of performance improvements and added functionality.
In order to ensure a smooth transition from the current system, CURES 2.0 will be rolled out to users in phases over the next several months, beginning with early adoption by a select group of users who currently use CURES and meet the CURES 2.0 security standards, including minimum browser specifications. DOJ is currently identifying prescribers and dispensers who meet these criteria and will contact and coordinate their enrollment into CURES 2.0. For all other current users, access to CURES 1.0 will not change and no action is needed at this time. For users and entities not currently enrolled in CURES, further notification will be provided in August as to the enrollment/registration process.

Practitioners and health systems should begin to prepare for universal adoption of the system by January 2016, at which point all users will be required to meet CURES 2.0's security standards. If you have any questions please contact cures@doj.ca.gov.

Thank you for your continued support of the CURES program.
Note: CURES 2.0 users will be required to use Microsoft Internet Explorer Version 11.0 or greater, Mozilla FireFox, Google Chrome, or Safari when accessing the system.

At the Committee Meeting

Robert Sumner and Mike Small of the DOJ provided an update on the transition to the new CURES 2.0 system. They advised the committee that CURES 2.0 should be available to all users by January 2016 and explained some of the barriers in transitioning to CURES 2.0. Mr. Sumner explained that there are 18,487 pharmacists registered with CURES, which is less than 50% of all licensed California pharmacists.

There were no further comments from the committee or public.

Following the meeting, on October 11, 2015, Governor Brown signed a bill (AB 679, Allen) that will delay implementation of the CURES registration requirements for pharmacists and prescribers that was to take effect January 1, 2016. The new deadline is July 1, 2016.

b. Update on the University of California, San Diego on its Pilot Program to Permit Patients to Access Medications from an Automated Storage Device not Immediately Adjacent to a Pharmacy

At the Board of Pharmacy's April 2015 board meeting, the board approved an 18-month pilot study under the auspices of the UCSD School of Pharmacy. This study would permit UCSD and San Diego's Hospital staff and their families, who opt in, to retrieve their outpatient medications from an automated storage device located in a hospital, rather than going to a community pharmacy. Consultation would be provided via telephone before dispensing medication to the patient. This study, which was originally scheduled to begin in June or July, 2015, has been delayed.

At the Committee Meeting

Via telephone, Dr. Hirsch delivered a presentation on the implementation of the program, which she anticipates will start in December 2015. A copy of Dr. Hirsch's presentation is provided in the meeting minutes **(Attachment 6).**

There were no questions or comments.

c. Enforcement Options for Patient Consultation Violations

Nearly 25 years ago, the Board of Pharmacy promulgated regulations to require pharmacists to consult with patients when receiving a medication for the first time. The board included in the regulation additional occasions where a pharmacist must consult a patient, such as when the patient has questions or the pharmacist believes a medication warrants consultation. A copy of the requirement is provided in **Attachment 1**.

California's requirements are sometimes confused with national requirements enacted about the same time by CMS for Medicare patients in what was known as "OBRA 90." However, California's requirements were actually adopted before OBRA 90's requirements. The OBRA 90 requirements require that Medicare patients be offered consultation when they receive medication for the first time. California's requirements, requiring the pharmacist to initiate consultation, were stronger and broader than the OBRA 90 requirements in that they pertained to all patients, not just those whose medications were paid for by Medicare, establishing one standard of care for all patients in California.

After approval of California's patient consultation requirements, the board delayed implementation of patient consultation at the request of the profession because pharmacists stated they could not provide consultation without the aid of pharmacy technicians. The approved patient-consultation regulation was delayed so that the board could secure statutory authority and then promulgate regulations to establish the licensure of pharmacy technicians to "free" the pharmacist to provide consultation.

California's requirement is for the pharmacist to consult the patient – not to offer to consult. When preparing the consultation rulemaking, the board emphasized that consultation was to be initiated by the pharmacist, and that any denial of the consultation must be made directly to the pharmacist, other staff (e.g., pharmacy technicians or ancillary staff) are not to screen for consultation by asking if the patient wanted to speak to the pharmacist or have questions about the medication. Consultation is required when the patient or the patient's agent is present in the pharmacy to receive consultation.

Over the years, the board has added other enhancements to help ensure patients receive meaningful consultation, including a Notice to Consumers poster that must be posted in the pharmacy. This poster states the pharmacist must consult with each patient about his or her new medication, and lists the five questions a patient should understand before taking a prescription medication.

More recently in promulgating the requirements for patient-centered labels, the board required that oral consultation services be available in 12 languages to aid limited-English speaking patients in better understanding how to take their prescription medication.

Over the years, the board has enforced the patient consultation requirement in various ways. Initially, it was one of the first violations for which the board used its citation and fine authority. In recent years, the board typically assesses fines of approximately $1,000 when it observes failure to consult during an inspection. If a medication error has occurred and consultation was not provided, the board generally issues a higher fine.

In 2011, board staff began working on a project with three California District Attorney's (DA's) offices to aid in the board's enforcement of patient consultation. Using the state's unfair Business Practices statute in Business and Professions Code section 17200, the DA was able to

assess higher fines for failure to consult. Additionally, the DA's used undercover investigators to pass prescriptions, which is an action the board has not done.

The DA's investigations resulted in substantial fines to three pharmacy chains: CVS (2013, $658,500); Rite Aid (2014, $498,250); and recently Walgreens (2015, $502,000). Copies of the press releases are provided in **Attachment 1**.

At the July board meeting, the board heard a report summarizing the results of a short Survey Monkey questionnaire conducted by the board involving patient consultation. The survey results are provided in **Attachment 1**.

<u>At the Committee Meeting</u>
The committee heard many comments and questions from the public. Following this discussion, the committee directed the Communication and Public Education Committee to focus on consumer education and why patient consultation is important.

d. Proposed Regulation for Pharmacies and Clinics Aimed at Reducing Losses of Controlled Substances

At the July board meeting, the board approved initiation of a rulemaking to establish inventory requirements for controlled drugs for pharmacies and clinics.
The regulation requires perpetual inventories of all federal Schedule II drugs, with a physical count every 90 days. Additionally, the board will establish a list of one or several additional controlled drugs from Schedules III – V that are reported as frequently stolen to the board and/or DEA.

Provided below is a list of the top non-Schedule III-V drugs reported lost or stolen to the board in the last year. For ease of comparison, all drugs listed have been converted into administration dosage units (i.e., liquids have been converted into 5 mL teaspoons to identify a dose). Based on list, the board would require the inventory monitoring of Alprazolam and Promethazine with Codeine.

Top Ten: FY 2014 – 2015 CS Schedules III-V Losses by Quantity

Drug	Quantity In Actual Dosage Equivalents *mLs converted into 5mL dosage units
Alprazolam	160,169
Promethazine/Codeine	77,862*
Carisoprodol	38,579
Tramadol Hydrochloride	34,801
Acetaminophen/Codeine	27,903
Lorazepam	26,864
Zolpidem Tartrate	18,657
Diazepam	17,139
Clonazepam	14,628
Phentermine	10,820

The board's staff also developed the following list of Schedule II controlled drugs reported lost or stolen within the last year.

Top Ten: FY 2014 – 2015 CS Schedule II Losses by Quantity

Drugs	Quantity In Actual Dosage Equivalents
Hydrocodone and Combos	402,377*
Oxycodone and Combos	73,756*
Amphetamine/Salts/Methamphetamine	26,368
Hydromorphone/Oxymorphone	20,885
Dex/Methylphenidate	19,212
Methadone	9,817
Fentanyl Citrate	6,822
Diphenoxylate/Atropine	4,130
Tapentadol Hydrochloride	2,062
Meperidine HCl	831

*total dosages (mLs converted into 5mL dosage units and added to solids)

At the Committee Meeting

Dr. Gutierrez provided an overview of the above charts.

There were no questions or comments.

An update on the proposed regulation will be discussed during the Regulation Report scheduled for Thursday, October 29, 2015.

e. Tracking of Automated Drug Delivery Devices in Use in California

Pharmacies are able to operate automated dispensing machines or devices in various settings away from the licensed pharmacy. This includes:

- Skilled nursing homes and other health care facilities licensed under Health and Safety Code section 1250 (c), (d) or (k) (the devices are authorized under section 1261.6 of the Health and Safety Code, authority for pharmacies to do this in specific locations is specified in Business and Professions Code section 4119.1)
- Clinics licensed under section 4180 of the Business and Professions Code (the devices are authorized under section 4186) – these include licensed, nonprofit community or free clinics defined under Health and Safety Code 1204(a)(1), a clinic operated by a federally recognized Indian tribe or tribal organization referred to in Health and Safety Code section 1206(b), a clinic operated by a primary care community or free clinic operated on a separate premises from a licensed clinic and that is open no more than 20 hours per week as referred to in Health and Safety Code section 1206(h), a student health center clinic operated by a public institution of higher education such as college health center as referred to in Health and Safety Code section 1206(j).

- Hospitals may use Pyxis or Pyxis-type machines throughout a hospital to store medication under application of provisions in Title 22 that allow drugs to be stored in nursing stations. The Pyxis and like devices are considered secured storage units for drugs.

The board does not know how many of these devices are in use, where they are in use, or which pharmacies are responsible for the machines.

The demand for additional use of these devices is growing. As reported earlier at this meeting, a pilot study is underway that if proven valuable, would allow patients to pick up medication from devices not located in a pharmacy.

Board staff suggests that a simple registration be established for pharmacies that operate these devices to identify their locations and consider this action to be a beneficial step in board oversight and enforcement. Pharmacies that add, move, or remove a device could report changes to the board via the submission of a form. This registration could operate much like the off-site storage waivers for records waivers. At annual renewal of the pharmacy license, the pharmacy would update or confirm the list of devices it operates and where each one is located.

It was noted that a regulation or statutory amendment may be needed to establish this requirement.

At the Committee Meeting
The committee heard comments from the public in support of having device locations in outpatient and retail settings and to differentiate between the two. Chair Gutierrez suggested that the board consider a separate proposal to require licensure of drug delivery devices.

f. Enforcement Statistics

Attachment 2 includes the first quarterly report of the Enforcement Statistics and SB 1441 Program Statistics.

II. COMPOUNDING MATTERS

a. Medicare's Pharmacy Practice Expectations for Critical Access Hospitals

At the Committee Meeting
Time was set aside for a discussion of these practice guidelines for hospital pharmacies. This item was for discussion and information purposes.

There are two related documents provided in **Attachment 3.** Various excerpts from the ASHP article are provided below:

The "CMS document officially establishes United States Pharmacopeia (USP) Chapter 795 as the minimum standard for practices related to nonsterile compounding and USP chapter 797 for compounded sterile products."

"USP chapter 795 has been an enforceable standard since 2001, meaning that state boards of pharmacy and other organizations can use it as the basis for fines and other adverse actions against noncompliant regulated entities. Chapter 797 has been enforceable since 2004."

The article later goes on to quote ASHP as stating: "'only by a pharmacist or other personnel authorized in accordance with State and Federal law' may pose compliance problems for sparsely staffed critical access hospitals."

"According to the CMS document, critical access hospitals that contract for compounding activities must have access to the vendor's quality assurance data to verify compliance with USP chapters 795 and 797. Each hospital must document that it obtains and reviews the data. CMS also expects vendors to demonstrably follow state laws and meet the requirements of 503A of the Food, Drug and Cosmetic Act that relate to the compounding of human drug products."

The article then goes on to discuss outsourcing facilities and their potential future role in providing compounded drugs for hospitals. It notes that CMS's policy acknowledges the Food and Drug Administration's (FDA) preference for hospitals to use official outsourcing facilities to obtain compounded sterile products. But then the article notes that outsourcing facilities are not meeting FDA's expectations when information from the FDA's Web site is reviewed. The FDA Web site lists all licensed outsourcing facilities and the number of FDA inspection report findings (on form 483) and 12 warning letters issued by the FDA to outsourcers. As of late January, only 1 of the 42-registered outsourcing facilities that had been inspected by the FDA had "no significant objectionable conditions" identified by the FDA.

There were no comments from the committee or the public.

b. Warnings about Becton-Dickinson Syringes and Loss of Medication Potency from the Food and Drug Administration and Institute for Safe Medication Practices

Several weeks ago, the FDA and Institute for Safe Medication Practices released warnings about the loss in potency detected for certain medications stored in 3mL, 5mL or perhaps additional larger Becton–Dickinson syringes. **Attachment 4** contains these two warnings, which were distributed by the board as subscriber alerts. A copy of the Becton-Dickinson public notice is also provided in this attachment.

This item was added to the agenda so that the committee could discuss the situation, and make a determination as to whether the board needs to initiate additional actions or

warnings to clinicians. The board is aware of one recall that was initiated following release of these warnings. The executive officer has also learned that several outsourcers may have identified this loss in potency prior to these releases and took steps to notify their customers.

Following this meeting, the board issued an updated subscriber alert with the following information:

> The board had received several questions about information contained in prior e-mail alerts about the loss of potency noted when medication is stored in B-D Syringes.
> We are therefore re-issuing a subscriber alert that contains the FDA's most recent update on this issue:
> http://www.fda.gov/drugs/drugsafety/ucm458952.htm.
> We also call to the reader's attention the FDA's statements in this update that provide:
> Hospital pharmacies and staff should:
>
> - Contact any outsourcers to determine if affected lots of BD syringes were used for compounded or repackaged products
> - Not administer compounded or repackaged drugs that have been stored in any of these syringes unless there is no suitable alternative available

The committee heard public comments and questions.

c. Compounding for Prescriber Office Use

Section 4052(a)(1) of the California Business and Professions Code provides that: Notwithstanding any other law, a pharmacist may furnish a reasonable quantity of compounded drug product to a prescriber for office use by the prescriber.

This "reasonable quantity" of compounded drug product has been defined in 16 California Code of Regulations section 1735.2(c) as:

> (c) A "reasonable quantity" as used in Business and Professions Code section 4052(a)(1) means that amount of a compounded drug product that:
> (1) Is sufficient for administration or application to patients in the prescriber's office, or for distribution of not more than a 72-hour supply to the prescriber's patients, as estimated by the prescriber; and
> (2) Is reasonable considering the intended use of the compounded medication and the nature of the prescriber's practice; and
> (3) For any individual prescriber and for all prescribers taken as a whole, is an amount which the pharmacy is capable of compounding in compliance with pharmaceutical standards for integrity, potency, quality and strength of the compounded drug product.

The recent proposed modifications to the compounding regulation take out the 72-hour supply that could be distributed to patient. Other changes have also been made to this section which as currently proposed reads:

> (c) A "reasonable quantity" that may be furnished to a prescriber for office use by the prescriber as authorized by Business and Professions Code section 4052, subdivision (a)(1), means that amount of compounded drug preparation that:
> (1) Is ordered by the prescriber or the prescriber's agent and paid for by the prescriber or the prescriber's agent using a purchase order or other documentation received by the pharmacy prior to furnishing that lists the number of patients seen or to be seen in the prescriber's office for whom the drug is needed or anticipated, and the quantity for each patient that is sufficient for office administration; and
> (2) Is delivered to the prescriber's office and signed for by the prescriber or the prescriber's agent; and
> (3) Is sufficient for administration or application to patients solely in the prescriber's office, or for furnishing of not more than a 120-hour supply for veterinary medical practices, solely to the prescriber's own veterinary patients seen as part of regular treatment in the prescriber's office, as fairly estimated by the prescriber and documented on the purchase order or other documentation submitted to the pharmacy prior to furnishing; and
> (4) That the pharmacist has a credible basis for concluding the quantity provided for office use is reasonable considering the intended use of the compounded medication and the nature of the prescriber's practice; and
> (5) With regard to any individual prescriber to whom the pharmacy furnishes, and with regard to all prescribers to whom the pharmacy furnishes, is an amount which the pharmacy is capable of compounding in compliance with pharmaceutical standards for integrity, potency, quality and strength of the compounded drug preparation; and
> (6) Does not exceed an amount the pharmacy can reasonably and safely compound.

If the proposed compounding regulation changes take effect, pharmacies will be able to compound for prescriber office use, but not in quantities for prescribers to dispense to a patient.

d. Comments on the Food and Drug Administration's Guidance Document on Compounding Animal Drugs from Bulk Drug Substances

The Board of Pharmacy has previously expressed interest in submitting comments on the FDA's Guidance Document 230, *"Compounding Animal Drugs from Bulk Substances."*

The committee discussed this guidance document and the comments it wishes to submit to the FDA. **Attachment 5** contains this guidance document and the additional questions posed in the Federal Register. The comments are due November 16. A draft response to these questions is also included in **Attachment 5.**

The following provides an overview and summary of the guidance provided in the FDA's document. The guidance supports and reinforces the regulatory framework developed by FDA for pharmacies and outsourcers who compound human drugs with several exceptions.

- For pharmacies that compound medications for animal use, the FDA guidance states that a veterinarian's prescription is required for the specific animal. The prescription must contain the standard information required on all prescriptions but also must include:
    1. The name and species of the animal
    2. A statement that the animal is not a food-producing animal
    3. If a manufactured drug exists, a statement that the compounded product would make a clinical difference from the manufactured product

  The guidance provides that pharmacies that compound such drugs must do so pursuant to USP 795 and 797 standards, by or under the supervision of a pharmacist, and such compounded products may not be distributed by wholesalers.

  Finally, the guidance allows a pharmacy to compound for future furnishing but is limited to the maximum quantity of that drug dispensed in a 14-day period within the last six months.

- For outsourcing facilities that compound animal drugs from bulk substances, the FDA is developing a list (which is not yet completed) of approved drug substances that an outsourcing facility must use when compounding for animals, linked to the species and the condition.

  The compounding must be done in accordance with cGMP standards by or under the supervision of a pharmacist. Outsourcing facility-compounded drugs may not be used on or in food producing animals, and must be expressly labeled to state this prohibition.

  The veterinarian must note on the order or prescription that the veterinary drug is intended to treat a specific condition and specific species, and this must match the listing on the FDA's bulk drug substances list. The guidance specifies labeling requirements and a statement on the label that the product is not for resale. The guidance also requires that any drugs compounded by an outsourcing facility must

be reported on the biannual lists of products compounded that must be sent to the FDA, with a notation of the products intended for animals.

The guidance also permits compounding by a veterinarian.

Ms. Herold recommended that the board support the FDA's direction with respect to the guidance document.

The committee recommended that anyone with comments on the guidance document submit them to the FDA.

Note: Since the committee meeting the board has received comments from the public on the guidance document. These comments are provided in **Attachment 5**.

Committee Recommendation:
Recommend that Ms. Herold draft comments that the board supports the direction of the guidance document and bring to the next board meeting.

Attachment 5 contains the board's draft response.

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e. Compounding Services Provided by Sterile Compounding Pharmacies and Outsourcing Facilities

The November 2013 enactment of the Drug Quality and Security Act (DQSA) created a new type of entity authorized to compound medications – the outsourcing facility. These generally large-scale production facilities are authorized to compound large quantities of medications for use by other entities. The medications must be prepared under current good manufacturing practices (or cGPMs), which are more stringent than compounding requirements for pharmacies, since many patients in multiple locations can receive these medications that are not usually linked to a patient-specific prescription.

The legislation essentially creates a new entity, with the results that there are three types of drug producers.

1. Manufacturers who are regulated by the FDA, and for facilities located in a specific state, often by a unit of the state's Department of Health (this occurs in CA). Manufacturers are required to perform extensive drug testing trials before receiving authorization to market a drug. Their physical plants are inspected by the FDA and must comply with rigorous cGMPs.

2. Outsourcers are regulated more like drug manufacturers and are regulated under cGMPs, but outsourcing facilities are exempted from performing drug approval

testing like manufacturers must do for their products. In the future, the FDA has stated they plan on developing specific cGMP requirements for outsourcing facilities, but these specialized requirements are not yet available.

3. Pharmacies, which are authorized to compound pursuant to a patient-specific prescription, are regulated by state boards of pharmacy. Because pharmacies generally do not compound drugs in quantities the size of those produced by outsourcing facilities or manufacturers, pharmacies are regulated under lesser standards. Sterile compounding pharmacies, however, are generally regulated at a level closer to that of manufacturers and outsourcers because of heightened concerns about sterility, integrity, potency and quality of the compounded medication.

For a number of years, the board and other agencies have grappled with the issue of at what point does a pharmacy compounding medications in large quantities in anticipation of receiving a prescription, actually become a manufacturer because the pharmacy is compounding so much medication, or compounding not specific to received prescriptions. The board, the CA Department of Public Health and the FDA have all studied and discussed this issue in CA over the years, and similar discussions have gone on in other states and federally.

With the advent of outsourcing facilities, the issue is simplified;

- An outsourcing facility (aka a 503B facility) licensed by the FDA (and in the future by the CA Board of Pharmacy if located or shipping into the state), shall function under the supervision of a pharmacist and operate according to cGMPs, to produce compounded drug products for multiple entities without a prescription.
- A pharmacy (aka a 503A facility) may compound a medication pursuant to patient-specific prescription order or in very limited quantities based on normal dispensing patterns in anticipation of a prescription, and dispense pursuant to a patient-specific prescription.
- A specially licensed sterile compounding pharmacy may compound a sterile medication pursuant to a patient-specific prescription or in limited quantities based on normal dispensing patterns in anticipation of a patient-specific prescription, but dispense pursuant to a patient-specific prescription.
- A pharmacy may compound medication or sterile medication for administration in a physician's office (but after implementation of California's new compounding requirements, not for dispensing to patient in 72-hour quantities).

This item was information only. There were no comments or questions.

f. Review of Sterile Compounding Statistics Identified by the Board

Supervising Inspector Dr. Acosta provided an overview of the statistics compiled by the board from inspections and investigations of California-licensed compounding pharmacies from

March 2015 to September 2015. A copy of Dr. Acosta's presentation is provided in the meeting minutes **(Attachment 6)**.

g. Future Committee Meeting Dates

- December 14, 2015
- March 2, 2016
- June 1, 2016
- August 31, 2016

The full minutes of the September 9, 2015 Enforcement and Compounding Committee meeting, including copies of all presentations, are provided in **Attachment 6**.

Attachment 1

1707.2 Duty to Consult.

(a) A pharmacist shall provide oral consultation to his or her patient or the patient's agent in all care settings:
  (1) upon request; or
  (2) whenever the pharmacist deems it warranted in the exercise of his or her professional judgment.

(b) (1) In addition to the obligation to consult set forth in subsection (a), a pharmacist shall provide oral consultation to his or her patient or the patient's agent in any care setting in which the patient or agent is present:
    (A) whenever the prescription drug has not previously been dispensed to a patient; or
    (B) whenever a prescription drug not previously dispensed to a patient in the same dosage form, strength or with the same written directions, is dispensed by the pharmacy.
  (2) When the patient or agent is not present (including but not limited to a prescription drug that was shipped by mail) a pharmacy shall ensure that the patient receives written notice: of his or her right to request consultation; and a telephone number from which the patient may obtain oral consultation from a pharmacist who has ready access to the patient's record.
  (3) A pharmacist is not required by this subsection to provide oral consultation to an inpatient of a health care facility licensed pursuant to section 1250 of the Health and Safety Code, or to an inmate of an adult correctional facility or a juvenile detention facility, except upon the patient's discharge. A pharmacist is not obligated to consult about discharge medications if a health facility licensed pursuant to subdivision (a) or (b) of Health and Safety Code Section 1250 has implemented a written policy about discharge medications which meets the requirements of Business and Professions Code Section 4074.

(c) When oral consultation is provided, it shall include at least the following:
  (1) directions for use and storage and the importance of compliance with directions; and
  (2) precautions and relevant warnings, including common severe side or adverse effects or interactions that may be encountered.

(d) Whenever a pharmacist deems it warranted in the exercise of his or her professional judgment, oral consultation shall also include:
  (1) the name and description of the medication;
  (2) the route of administration, dosage form, dosage, and duration of drug therapy
  (3) any special directions for use and storage;
  (4) precautions for preparation and administration by the patient, including techniques for self-monitoring drug therapy;
  (5) prescription refill information;
  (6) therapeutic contraindications, avoidance of common severe side or adverse effects or known interactions, including serious potential interactions with known nonprescription medications and therapeutic contraindications and the action required if such side or adverse effects or interactions or therapeutic contraindications are present or occur;
  (7) action to be taken in the event of a missed dose.

(e) Notwithstanding the requirements set forth in subsection (a) and (b), a pharmacist is not required to provide oral consultation when a patient or the patient's agent refuses such consultation.

Pleasanton Weekly.com

http://pleasantonweekly.com/news/print/2014/06/30/rite-aid-pays-nearly-500000-in-pharmacy-consultation-lawsuit

Updated: Tue, Jul 1, 2014, 6:54 am
Uploaded: Mon, Jun 30, 2014, 3:08 pm

Rite Aid pays nearly $500,000 in pharmacy consultation lawsuit

Pleasanton drug store one of 582 in California suit

by Jeb Bing

Alameda County District Attorney Nancy E. O'Malley announced this week that the Office's Consumer and Environmental Protection Division, along with Riverside and San Diego District Attorneys' Offices and the California State Board of Pharmacy, has settled a $498,250 lawsuit against the owners of the Rite Aid pharmacy chain in California.

Rite Aid operates a pharmacy at Hopyard Road and Valley Avenue in Pleasanton.

The civil complaint, filed in San Diego Superior Court, alleges that California Rite Aid pharmacists frequently failed to comply fully with the board's rules requiring personal pharmacist consultations when prescription drug customers receive new prescriptions or new dosages of existing prescriptions.

In 2011 the California State Board of Pharmacy contacted the three District Attorneys' offices concerning health risks that may arise when pharmacists fail properly to provide needed personal consultation to prescription drug customers. Working with the Board of Pharmacy, the three DA offices conducted an undercover investigation of the consultation practices of a number of the major pharmacy chains in California.

Under the terms of the judgment, which was entered without admission of liability, Rite Aid is permanently enjoined to comply properly with California's standards for patient consultations, and must fully implement an internal compliance program. The Rite Aid entities also agreed to pay agency investigative costs of $78,250 and civil penalties totaling $420,000.

Alameda County will receive one-third, or $140,000, of those civil penalties and $18,500 of the costs.

Rite Aid and its counsel worked cooperatively with the prosecutors to promptly resolve the matter and to implement the new compliance procedures.

"The collaboration of the three D.A. Offices and the State Board of Pharmacy resulted in today's settlement," O'Malley said.

"Pharmacist consultations are imperative to safeguard that prescriptions have been filled according to a doctor's order, as well as to advise the patient of proper and safe usage of the medication. My Office remains dedicated to ensuring that the public has access to knowledge and education regarding the use of all prescription drugs."

Thrifty Payless, Inc., a California corporation, is the wholly-owned subsidiary of Pennsylvania-based Rite Aid Corporation, a Delaware corporation. Payless owns and operates the 582 Rite Aid-branded pharmacies in California, including the one in Pleasanton, on behalf of the Rite Aid Corporation.

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August 17, 2015
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Walgreens Pharmacy to Pay $502,200 to Resolve Consumer Protection Case

Pharmacists failed to Provide Patient Consultations

San Diego County District Attorney Bonnie M. Dumanis announced today that Consumer Protection Unit, working with the Riverside and Alameda District Attorneys' Office and the State Board of Pharmacy, has obtained a $502,200 settlement in a consumer protection lawsuit brought against the owners of the Walgreens pharmacy chain in California.

The civil complaint, filed in San Diego Superior Court under California's unfair competition laws, alleges that Walgreens pharmacists throughout the state frequently failed to comply fully with the state Board of Pharmacy's rules requiring personal pharmacist consultations when prescription drug customers receive new prescriptions or new dosages of existing prescriptions.

"Pharmacist consultations prevent drug errors and ensure that patients have the right prescription for their condition," DA Dumanis said. "Without these checks and balances, dire consequences could result."

Defendant Walgreen Co. (known as "Walgreens") is an Illinois corporation headquartered in Deerfield, Illinois, that owns and operates the 620 Walgreens-branded pharmacies in California.

In 2011, the California State Board of Pharmacy brought to the three District Attorneys' Offices the problem of health risks to California pharmacy customers when pharmacists fail to properly provide needed personal consultation to prescription drug customers. Uninformed or improper use of prescription drugs harms an estimated 150,000 Californians each year and contributes to an estimated $1.7 billion in economic losses throughout the state.

Regulations enforced by the California State Board of Pharmacy require that a pharmacist must provide personal consultation to a patient receiving a prescription drug not previously dispensed to that patient, or a prescription drug in a different dosage, form, or strength, or on the patient's request.

Working with the Board of Pharmacy, the three District Attorneys' Offices conducted an undercover investigation of the consultation practices of a number of the major pharmacy chains in California. Today's enforcement action is the third of several such actions anticipated in this statewide project, and follows our December 2013 judgment against CVS pharmacies (injunction and $658,500 in monetary relief) and our June 2014 judgment against Rite Aid (injunction and $498,250 in monetary relief).

With regard to the Walgreens chain, the Board provided the District Attorneys with copies of 21 administrative citations issued to Walgreens by the Board of Pharmacy between 2010 and 2014 showing ongoing violations of the pharmacists' consultation requirement. Subsequently, in 28 undercover purchases at Walgreens stores conducted by the District Attorneys in late 2013 in San Diego, Riverside, and Alameda counties, district attorney investigators found a significant pattern of failures to provide the required consultations and/or failures to offer patient consultations by proper personnel.

Under the terms of the judgment, which will be entered without admission of liability, Walgreen Co. will be subject to an injunction requiring full compliance with California's standards for proper patient consultations, and must fully implement an internal compliance program. In the stipulated final judgment, the Walgreens entities have also agreed to pay $502,200, including agency investigative costs of $79,200 and civil penalties of $423,000. (San Diego DA will receive one-third, or $141,000, of those civil penalties and $18,600 of the costs.) Walgreens and its counsel worked cooperatively with the prosecutors to resolve this case and to implement new consultation compliance procedures.

The stipulated final judgment in this case was signed by Judge Lisa Schall and finalized by the court last Friday.

The case was handled for the San Diego District Attorney's Office by Deputy District Attorney Tom Papageorge, head of the Consumer Protection Unit (619-531-3971), and Deputy District Attorney Steve Spinella (619-515-8160).

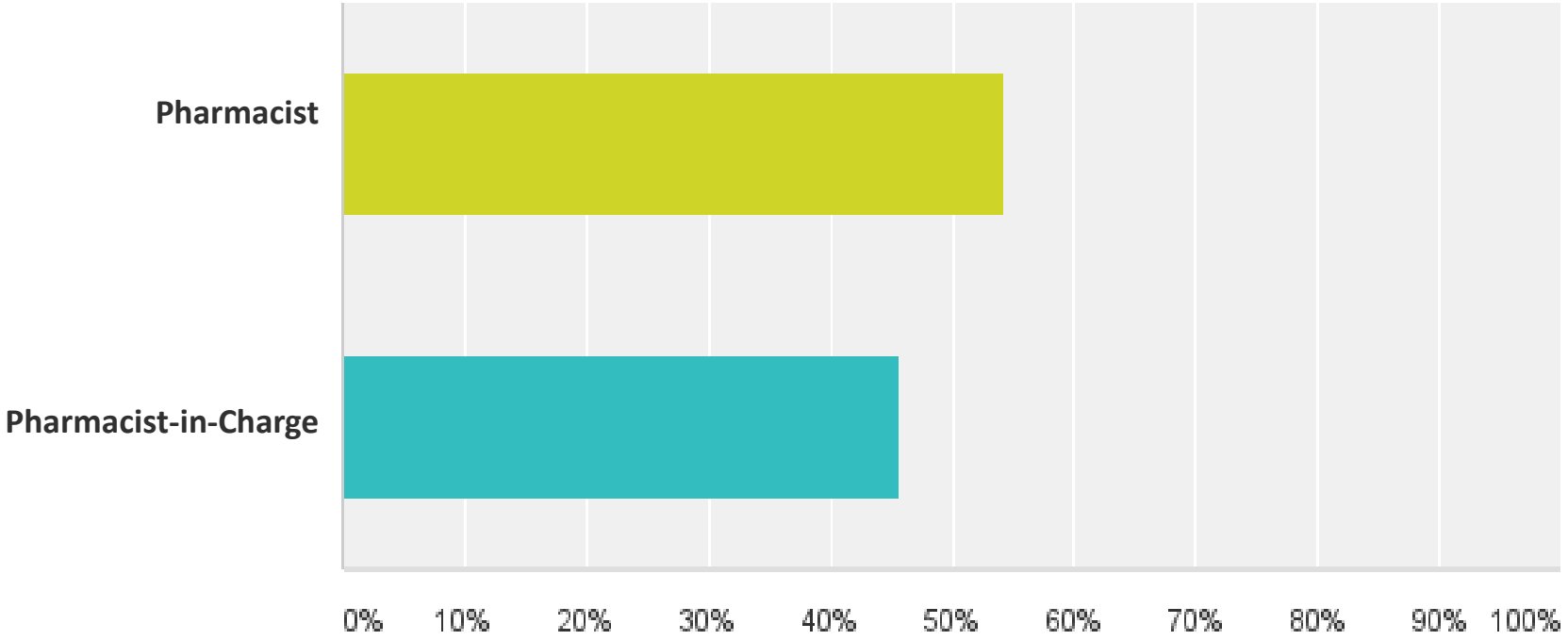
Survey for Pharmacists

1,006 total responses

Survey Date: July 20-24, 2015

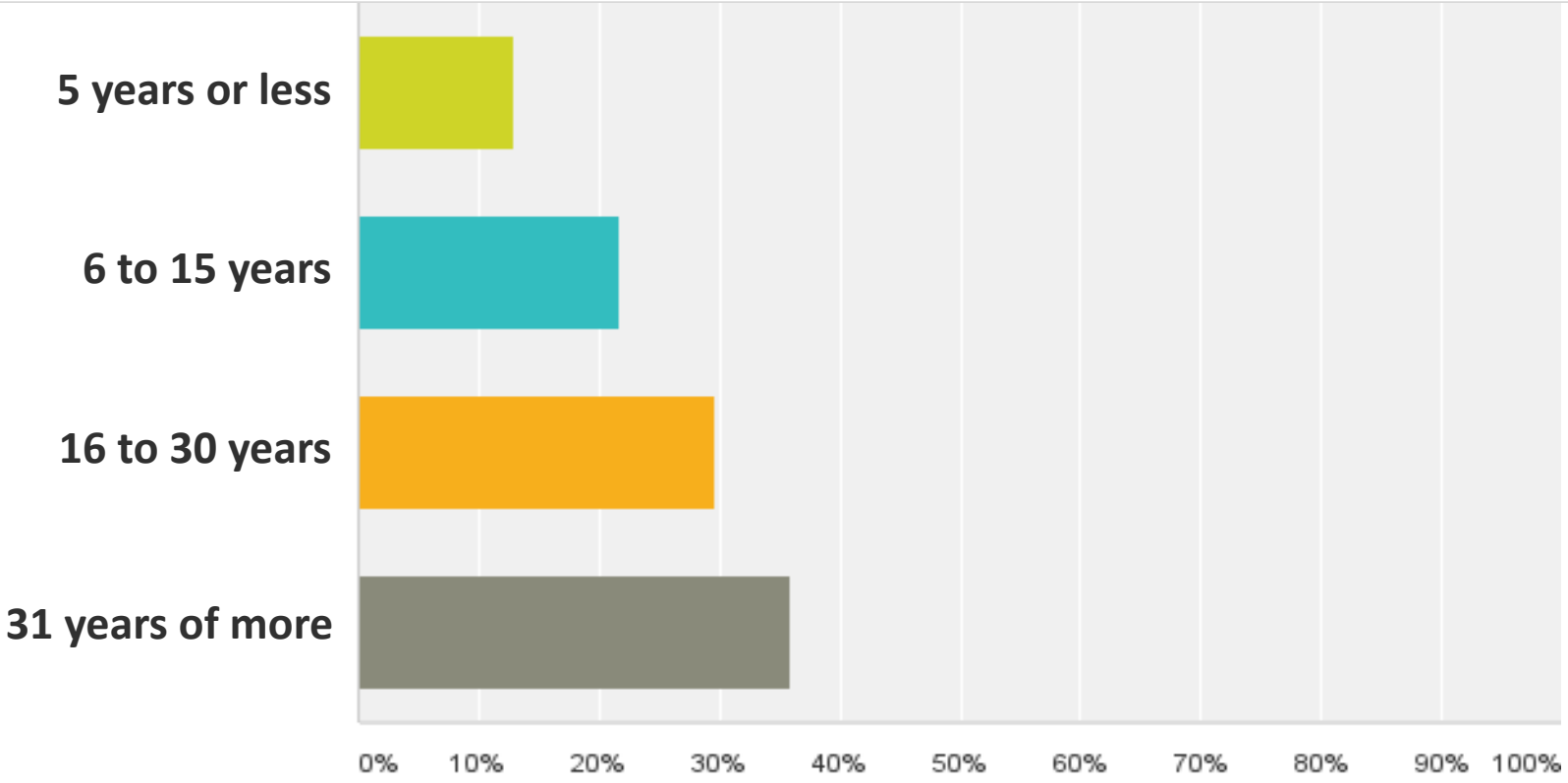
Question 1: I am a licensed California_____.

Answered: 998 Skipped: 8



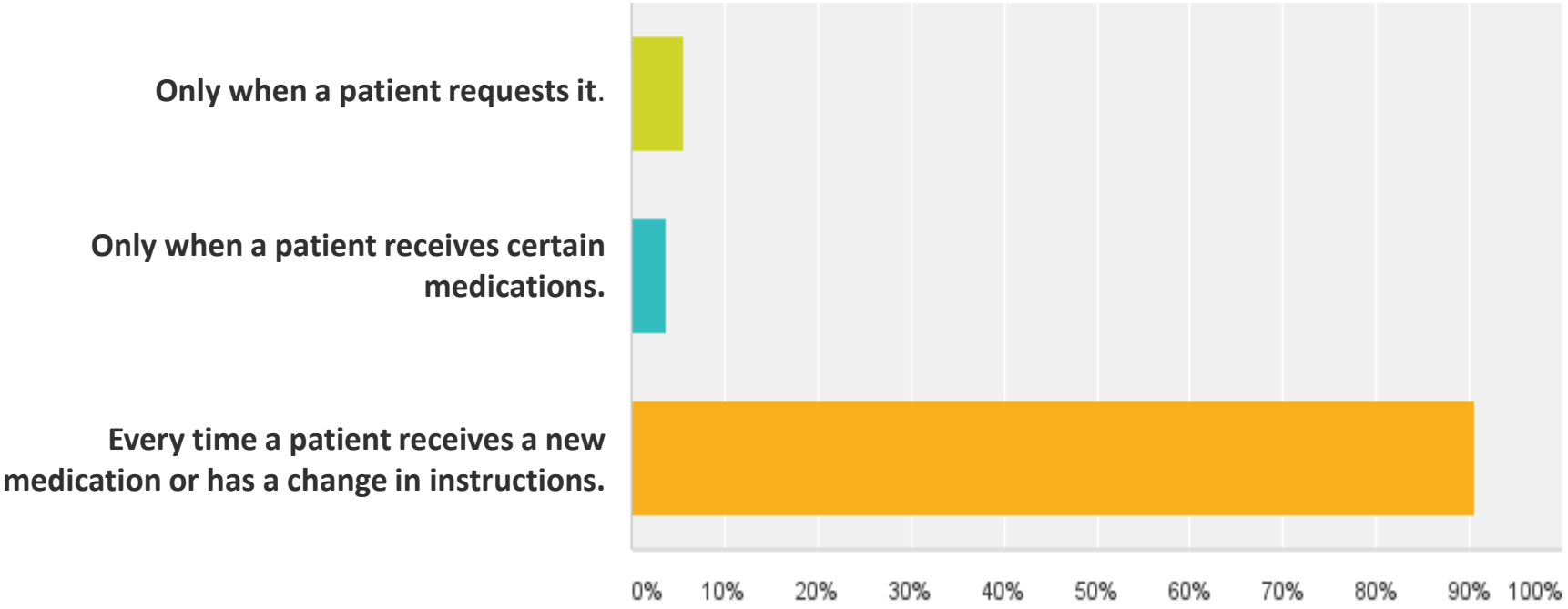
Question 2: How long have you been a pharmacist?

Answered: 1,004
Skipped: 2



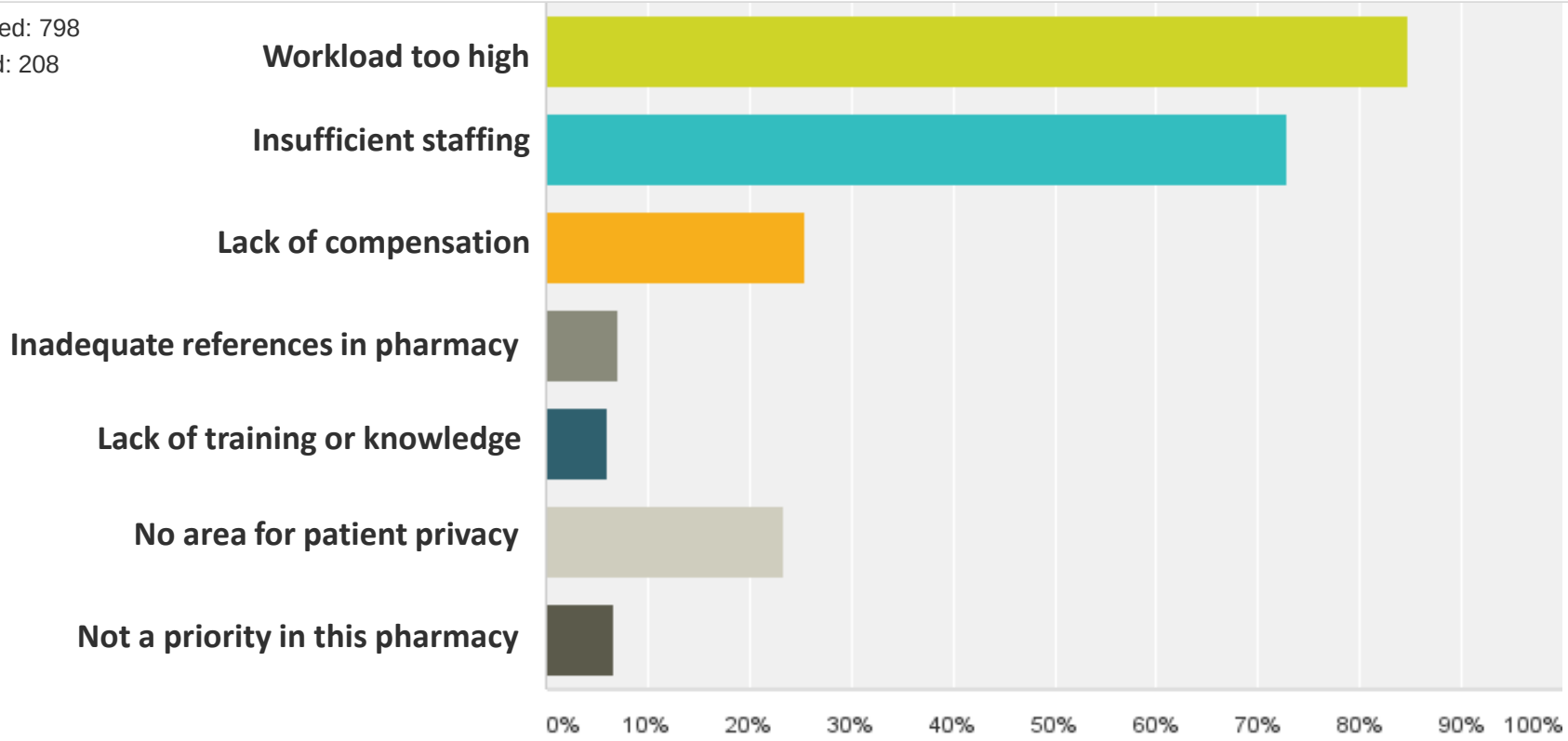
Question 3: I consult….

Answered: 897 Skipped: 109



Question 4: What barriers exist to a pharmacist initiating consultation (mark all that apply):

Answered: 798
Skipped: 208



Answers to the question: What barriers exist to a pharmacist initiating a consultation?	
None, I make it a priority to consult.	53
Patients in are in hurry and will not wait for consultation.	37
Doesn’t apply to my practice setting.	30
The pharmacist is too busy / pressure from employer to fill prescriptions quickly even if that means not consulting.	24
No reimbursement for consultation.	12
Language or other communication barriers.	12
Lack of privacy to provide consultation.	9
The clerk or technician is the one working with the patient initially and they do not tell the patient they need to wait to talk to the pharmacist.	8
Ratio of technicians to pharmacists is too low.	6
Lack of training or experienced staff.	2

Attachment 2

Board of Pharmacy Enforcement Statistics
Fiscal Year 2015/2016

Workload Statistics	July-Sept	Oct-Dec	Jan-Mar	Apr-June	Total 15/16
Complaints/Investigations					
Received	730				730
Closed	751				751
4301 letters	12				12
Pending (at the end of quarter)	2105				2105
Cases Assigned & Pending (by Team) at end of quarter*					
Compliance / Routine Team	787				787
Drug Diversion/Fraud	361				361
RX Abuse	95				95
Compounding	85				85
Probation/PRP	51				51
Mediation/Enforcement **	325				325
Criminal Conviction	401				401
Application Investigations					
Received	165				165
Closed					
Approved	118				118
Denied	32				32
Total ***	218				218
Pending (at the end of quarter)	138				138
Letter of Admonishment (LOA) / Citation & Fine					
LOAs Issued	56				56
Citations Issued	550				550
Total Fines Collected ****	$451,827.69				$451,827.69

* This figure includes reports submitted to the supervisor and cases with SI awaiting assignment.

** This figure include reports submitted to the citation and fine unit, AG referral, as well as cases assigned to enf. Staff

*** This figure includes withdrawn applications.

****Fines collected (through 9/30/2015 and reports in previous fiscal year.)

Board of Pharmacy Enforcement Statistics
Fiscal Year 2015/2016

Workload Statistics	July-Sept	Oct-Dec	Jan-Mar	Apr-June	Total 15/16
Administrative Cases (by effective date of decision)					
Referred to AG's Office*	126				126
Accusations Filed	73				73
Statement of Issues Filed	17				17
Petitions to Revoke Filed	2				2
Pending					
Pre-accusation	271				271
Post Accusation	260				260
Total*	600				600
Closed					
Revocation					
Pharmacist	3				3
Intern Pharmacist	1				1
Pharmacy Technician	24				24
Designated Representative	1				1
Wholesaler	0				0
Sterile Compounding	0				0
Pharmacy	1				1
Revocation,stayed; suspension/probation					
Pharmacist	4				4
Intern Pharmacist	0				0
Pharmacy Technician	1				1
Designated Representative	0				0
Wholesaler	0				0
Sterile Compounding	0				0
Pharmacy	0				0
Revocation,stayed; probation					
Pharmacist	11				11
Intern Pharmacist	0				0
Pharmacy Technician	3				3
Designated Representative	0				0
Wholesaler	0				0
Sterile Compounding	0				0
Pharmacy	5				5
Surrender/Voluntary Surrender					
Pharmacist	3				3
Intern Pharmacist	0				0
Pharmacy Technician	4				4
Designated Representative	0				0
Wholesaler	0				0
Sterile Compounding	0				0
Pharmacy	5				5

Board of Pharmacy Enforcement Statistics
Fiscal Year 2015/2016

Workload Statistics	July-Sept	Oct-Dec	Jan-Mar	Apr-June	Total 15/16
Public Reproval/Reprimand					
Pharmacist	3				3
Intern Pharmacist	0				0
Pharmacy Technician	0				0
Designated Representative	0				0
Wholesaler	0				0
Sterile Compounding	1				1
Pharmacy	1				1
Licenses Granted					
Pharmacist	0				0
Intern Pharmacist	0				0
Pharmacy Technician	3				3
Designated Representative	0				0
Wholesaler	0				0
Sterile Compounding	0				0
Pharmacy	0				0
Licenses Denied					
Pharmacist	0				0
Intern Pharmacist	0				0
Pharmacy Technician	2				2
Designated Representative	0				0
Wholesaler	0				0
Sterile Compounding	0				0
Pharmacy	0				0
Cost Recovery Requested**	$355,106.58				$355,106.58
Cost Recovery Collected**	$314,805.00				$314,805.00

* This figure includes Citation Appeals

** This figure includes administrative penalties

Immediate Public Protection Sanctions					
Interim Suspension Order	3				3
Automatic Suspension / Based on Conviction	1				1
Penal Code 23 Restriction	8				8
Cease & Desist - Sterile Compounding	1				1

Board of Pharmacy Enforcement Statistics
Fiscal Year 2015/2016

Workload Statistics	July-Sept	Oct-Dec	Jan-Mar	Apr-June	Total 15/16
Probation Statistics					
Licenses on Probation					
Pharmacist	149				149
Intern Pharmacist	3				3
Pharmacy Technician	37				37
Designated Representative	3				3
Pharmacy	42				42
Sterile Compounding	6				6
Wholesaler	2				2
Probation Office Conferences	35				35
Probation Site Inspections	106				106
Successful Completion	5				5
Probationers Referred to AG for non-compliance	0				0

As part of probation monitoring, the board requires licensees to appear before the supervising inspector at probation office conferences. These conferences are used as 1) an orientation to probation and the specific requirements of probation at the onset, 2) to address areas of non-compliance when other efforts such as letters have failed, and 3) when a licensee is scheduled to end probation.

As of September 30, 2015.

SB 1441 – Program Statistics

Licensees with substance abuse problems who are either on board probation and/or participating in the Pharmacist Recovery Program (PRP)

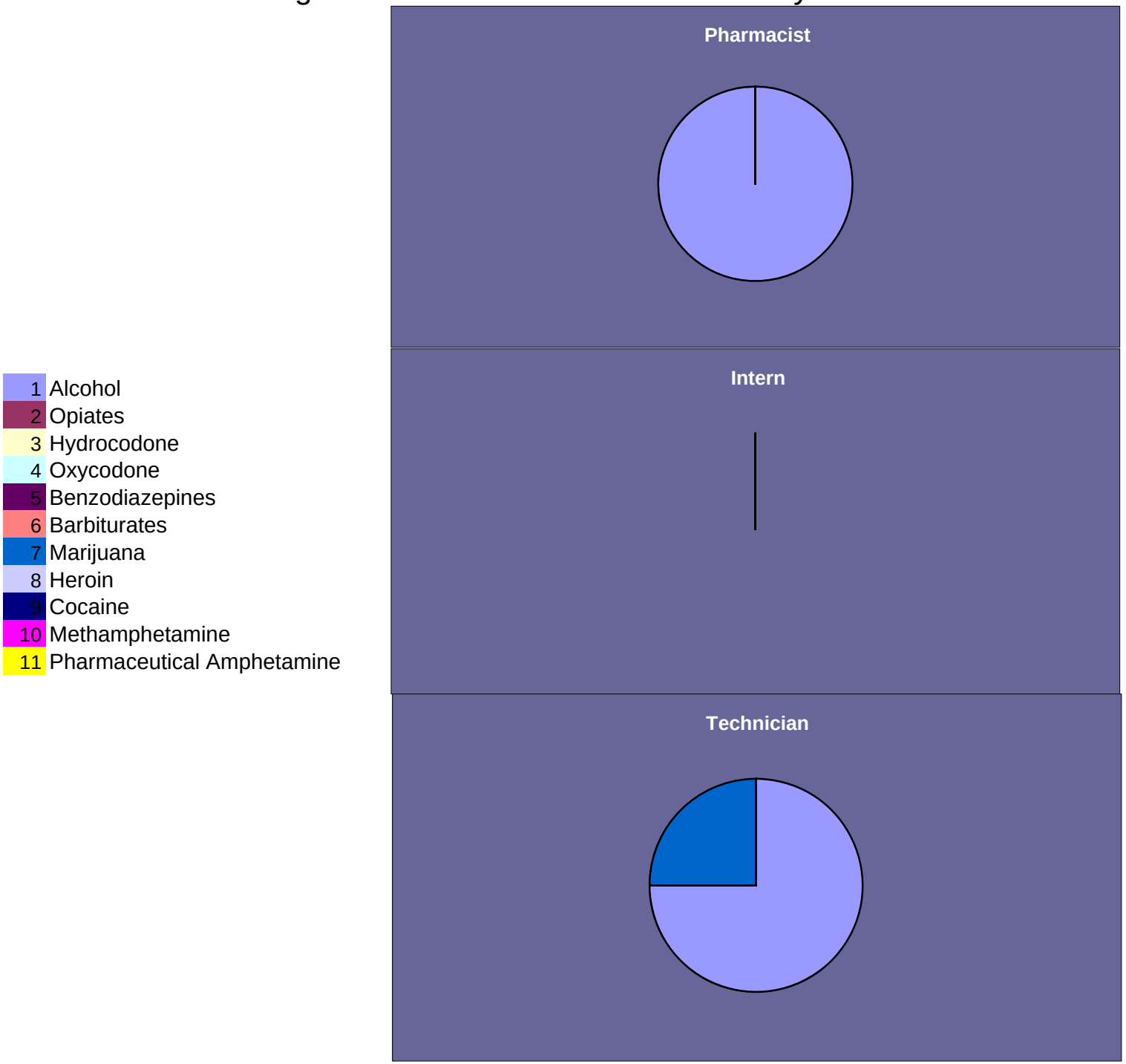
Board of Pharmacy	July -Sep	Oct – Dec	Jan-Mar	Apr-Jun	Total 15/16
PRP Intakes					
PRP Self-Referrals	1				1
PRP Board Referrals	1				1
PRP Under Investigation	3				3
PRP In Lieu Of					
Total Number of PRP Intakes	5				5
New Probationers					
Pharmacists	3				3
Interns					
Technicians	3				3
Total New Probationers	6				6
PRP Participants and Contracts					
Total PRP Participants	66				N/A
Contracts Reviewed	61				61
Probationers and Inspections					
Total Probationers	82				N/A
Inspections Completed	106				106
PRP Referrals to Treatment					
Referrals to Treatment	6				6
Drug Tests					
Drug Test Ordered	1006				1006
Drug Tests Conducted	974				974
Relapse					
Relapsed	3				3
Major Violation Actions					
Cease Practice/Suspension	8				8
Termination - PRP	1				1
Referral for Discipline					
Exit from PRP or Probation					
Successful Completion	5				5
Termination - Probation					
Voluntary Surrender	4				4
Surrender as a result of PTR					
Public Risk	1				1
Non-compliance	8				8
Other	4				4
Patients Harmed					
Number of Patients Harmed	None	None	None	None	None

SB 1441 – Program Statistics

Licensees with substance abuse problems who are either on board probation and/or participating in the Pharmacist Recovery Program (PRP)

Board of Pharmacy	July -Sep	Oct – Dec	Jan-Mar	Apr-Jun	Total 15/16
Drug of Choice at PRP Intake or Probation					
Pharmacists	**July-Sep**	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**	**Total 15/16**
Alcohol	2				2
Ambien					
Opiates					
Hydrocodone					
Oxycodone					
Morphine					
Benzodiazepines					
Barbiturates					
Marijuana					
Heroin					
Cocaine					
Methamphetamine					
Pharmaceutical Amphetamine					
Phentermine					
Methadone					
Zolpidem Tartrate					
Hydromorphone					
Clonazepam					
Tramadol					
Carisprodol					
Phendimetrazine					
Promethazine w/Codeine					
Intern Pharmacists	**July-Sep**	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**	**Total 15/16**
Alcohol					
Opiates					
Hydrocodone					
Oxycodone					
Benzodiazepines					
Barbiturates					
Marijuana					
Heroin					
Cocaine					
Methamphetamine					
Pharmaceutical Amphetamine					
Phentermine					
Methadone					
Zolpidem Tartrate					
Hydromorphone					
Clonazepam					
Tramadol					
Carisprodol					
Phendimetrazine					
Promethazine w/Codeine					
Pharmacy Technicians	**July-Sep**	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**	**Total 15/16**
Alcohol	3				3
Opiates					
Hydrocodone					
Oxycodone					
Benzodiazepines					
Barbiturates					
Marijuana	1				1
Heroin					
Cocaine					
Methamphetamine					
Pharmaceutical Amphetamine					
Phentermine					
Methadone					
Zolpidem Tartrate					
Hydromorphone					
Clonazepam					
Tramadol					
Carisprodol					
Phendimetrazine					
Promethazine w/Codeine					

Drug Of Choice - Data entered from July 2014 to June 2015



Printed on 10/12/2015

Attachment 3

Pharmacy News

Medicare Updates Pharmacy Practice Expectations for Critical Access Hospitals

[March 15, 2015, AJHP News]

Kate Traynor

BETHESDA, MD 02 Mar 2015—A January 16 directive to state survey agencies gives new details about Medicare's expectations for compounding practices and other pharmacy activities at critical access hospitals.

But the Centers for Medicare and Medicaid Services (CMS) communication—an update to interpretive guidelines for state surveyors—has wider ramifications, said Patricia C. Kienle, director of accreditation and medication safety for Cardinal Health Innovative Delivery Solutions.

That's because CMS is mandating well-established pharmacy practices that ASHP, the Institute for Safe Medication Practices, the United States Pharmacopeial Convention, and other professional groups have endorsed for years, Kienle said. And she expects CMS to ultimately require the same practices at all hospitals.

Kienle said the directive is good news.

"I think it's a very positive thing for patients, because it's incorporating minimum standards, for everybody, that we know are the safe ways of practicing," she said. "And they need to remember, it's a minimum standard."

A substantial portion of the 93-page CMS communication addresses pharmacy practice, including sterile and nonsterile compounding; infection prevention and control; medication safety, handling, administration, and storage; and contracted operations.

"It's not really necessarily any different from what we had been doing already," said clinical pharmacist Todd Lemke of CentraCare Health, a critical access hospital in Paynesville, Minnesota. "I kind of see a lot of this as just regulation catching up with practice, at least for us."

Lemke said that although meeting the Medicare-required practice standards isn't really difficult for critical access hospitals, finding time to document compliance with those practices can be a concern.

CONTACT US

For questions, comments, or more information on this article, please contact the ASHP News Center at newscenter@ashp.org.

"The part that I struggle with the most is just making sure that our policies are up to date," Lemke said. "That just doesn't always seem to be something that's actually doable, as a critical access pharmacist, because we have to also do the day-to-day stuff."

David T. Caron, Jr., director of pharmacy at Martha's Vineyard Hospital in Oak Bluffs, Massachusetts, likewise said that finding time to document compliance with changing standards and regulations is difficult for critical access hospitals, in general.

Nevertheless, he said, "I think we all know, as pharmacists, it's the right thing to do. And we all want to do the right thing . . . It's just that getting there is the monumental task."

Surveys. State survey agencies—the CMS document's official audience—are responsible for certifying that hospitals not accredited by a so-called deeming organization, such as the Joint Commission, meet the Medicare program's conditions of participation (CoPs).

CoPs, Keinle noted, "drive everything in the hospital."

According to CMS, 83% of hospitals overall but just 33% of critical access hospitals in fiscal year 2013 were Medicare-certified through a deeming agency, suggesting that state survey agencies play a large role in ensuring that critical access hospitals meet Medicare's CoPs.

But federal regulations require accrediting organizations with deeming authority to employ survey procedures that are comparable to those used by state survey agencies, including new requirements imposed by CMS.

ASHP Engages on Compounding

ASHP's Bona Benjamin said ASHP has been providing technical expertise on safe compounding practices for many years and has long supported the principles contained in *United States Pharmacopeia* (*USP*) chapter 797. She said ASHP "will continue to engage with the Centers for Medicare and Medicaid Services, as we always have, to support their efforts to improve oversight of sterile compounding and better their understanding [of] *USP* 797 requirements as they develop surveyor training materials."

ASHP recently issued a regulatory alert that summarizes CMS's compounding requirements for critical access hospitals. ASHP's "Guidelines for Outsourcing Sterile Compounding Services" and the ASHP Research and Education Foundation's "Outsourcing Sterile Products Preparation: Contractor Assessment Tool" are being revised to reflect current regulatory requirements.

A Joint Commission spokesperson stated that the accrediting agency revised its standards for critical access hospitals last year to reflect regulatory changes in CMS's state operations manual for critical access hospitals.

She said the Joint Commission is currently "reviewing the details" of the new CMS directive to examine how the compounding provisions compare against the accrediting agency's medication management standards for critical access hospitals.

Lemke's Minnesota hospital is certified by Medicare through his state survey agency, and Caron's Massachusetts hospital is accredited by the Joint Commission.

Compounding. The CMS document officially establishes *United States Pharmacopeia (USP)* chapter 795 as the minimum standard for practices related to nonsterile compounding and USP chapter 797 for compounded sterile products.

USP chapter 795 has been an enforceable standard since 2000, meaning that state boards of pharmacy and other organizations can use it as the basis for

fines and other adverse actions against noncompliant regulated entities. Chapter 797 has been enforceable since 2004.
Bona Benjamin, ASHP's director for medication-use quality improvement, said the CMS communication means that critical access hospitals, regardless of whether they are accredited by a deeming organization or surveyed by a state agency, should expect "additional scrutiny of sterile and nonsterile compounding services."

Lemke said the CMS requirement that compounding be performed "only by a pharmacist or other personnel authorized in accordance with State and Federal law" may pose compliance problems for sparsely staffed critical access hospitals.

"Sometimes we only have seven people in the hospital, so it's not economically feasible to always have a pharmacist onsite," Lemke explained. He noted that some critical access hospitals have no staff pharmacists and rely on a local community pharmacist or other contract arrangement for compounding services.

Kienle said the CMS provisions that relate to contracted operations, including offsite compounding, "may be something that needs some attention" from pharmacy departments at critical access hospitals.

"For any contracted service, the hospital needs to have a written agreement—it can't just be a handshake—and they need to have written expectations and a way of monitoring what these places are doing," Kienle said.

According to the CMS document, critical access hospitals that contract for compounding activities must have access to the vendor's quality assurance data to verify compliance with USP chapters 795 and 797. Each hospital must document that it obtains and reviews this data. CMS also expects vendors to demonstrably follow state laws and meet the requirements of Section 503A of the Food, Drug, and Cosmetic Act that relate to the compounding of human drug products.

Hospitals also have the option to contract with FDA-registered outsourcing facilities to obtain compounded sterile products. Also known as 503B entities, outsourcing facilities are FDA regulated and must use current good manufacturing practices—the same standard to which drug manufacturers are held, with some exceptions.

Lemke said his hospital purchases manufacturers' premixed sterile i.v. solutions and, when those products aren't available, ready-to-mix products that require minimal manipulation by a nurse. Otherwise, he said, one of the three staff pharmacists prepares compounded sterile products onsite.

"We don't have any things that are made by compounding pharmacies here," Lemke said.

Lemke noted that his experiences with product recalls, including Hospira's January recall of ketorolac tromethamine injection, make him hesitant to outsource compounding activities.

"If the big drug companies are having problems with sterility and having foreign material in the vial, I'm really concerned with the compounding pharmacies," Lemke said.

Caron said his hospital purchases some high-use compounded sterile products, such as premixed i.v. pitocin for infusion, from an FDA-registered outsourcing facility.

Caron said he checks information on FDA's website to ensure that the outsourcing facility has "no obvious violations." And the hospital's parent organization, Boston-based Partners HealthCare, evaluates and makes recommendations about vendors.

"Before you use a company like that you have to be sure that all of their quality standards meet yours, . . . that they're 797 compliant, that they have quality indicators that they report to you," Caron said. "In light of all the tragedies that have happened in this state, it's my number-one job to ensure the safety of those products, whether I'm making them or somebody else is making them."

Massachusetts was home to the New England Compounding Center, a compounding pharmacy whose tainted products were blamed for 64 deaths and hundreds of fungal infections during an outbreak that began in 2012.

A 2014 Massachusetts law codified USP chapters 795 and 797 as the standards for pharmacy compounding in the state. In addition, after June 30 of this year, all pharmacies in the state that perform sterile or nonsterile compounding must be licensed by the state to do so.

Caron said his hospital has been preparing for this change in addition to maintaining compliance with federal law and accreditation requirements.

FDA's commissioner in January 2014 urged hospitals and other healthcare facilities to purchase compounded sterile products only from FDA-registered outsourcing facilities. The agency also asked state boards of pharmacy to request that out-of-state pharmacies that ship compounded sterile products into the state register with FDA as outsourcing facilities.

The CMS document acknowledges FDA's preference for hospitals to use official outsourcing facilities to obtain compounded sterile products. But the facilities do not yet appear to be fully meeting federal regulators' expectations.

As of late January, just 1 of the 42 FDA-registered outsourcing facilities that had been inspected by the agency had passed the review with no "significant objectionable conditions," according to FDA. The agency issued warning letters or requested product recalls for 12 of the inspected facilities.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality /Survey & Certification Group

Ref: S&C: 15-19-CAH

DATE: **January 16, 2015**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Revised State Operations Manual (SOM) Appendix W, Critical Access Hospitals (CAHs)

Memorandum Summary

The Centers for Medicare & Medicaid Services (CMS) CAH Conditions of Participation (CoPs) Changed in Two Final Rules:

- CMS-3267-F was published on May 12, 2014 and portions related to CAHs became effective July 11, 2014. Among other provisions, this final rule revised the CAH Conditions of Participation (CoP) requirements related to the responsibilities of doctors of medicine (MDs) and doctors of osteopathy (DOs).

- CMS-1599-F was published August 19, 2013 and became effective October 1, 2013. This final rule revised the CAH CoP requirements related to provision of inpatient acute care services.

SOM Appendix W Updated:

- We are updating the pertinent portions of the CAH interpretive guidelines, found in SOM Appendix W, to reflect these rule changes.

- In addition, we are taking this opportunity to update the guidance for the portions of 42 CFR 485.635 addressing the following topics, in order to bring them into alignment with current accepted standards of practice: pharmacy services; infection prevention and control; dietary services; services under arrangement; nursing services; and rehabilitation services.

Two final rules published by the CMS include changes to the CAH CoPs:

- "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of

Participation; Payment Policies Related to Patient Status," published August 19, 2013 and effective October 1, 2013 (78 Fed. Reg. 50495).

- "Medicare and Medicaid Programs; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction; Part II," published May 12, 2014 and effective July 11, 2014 (79 Fed. Reg. 27105).

Briefly, the new and revised CAH regulations from these two final rules are:

- Designation and Certification of CAHs, §485.606:

  The cross-reference to hospital swing bed services found in this CAH regulation was revised to reflect the renumbering of the hospital regulation. This CAH regulation prohibits a State from denying CAH designation to an otherwise eligible hospital solely because the hospital provides swing bed services. The revision has no substantive effect on the current CAH requirement. *This change was effective July 11, 2014.*

- Number of Beds and Length of Stay, §485.620:

  The provision at §485.620(a) was revised to remove an outdated reference to a January 1, 2004 effective date, after which a CAH may not maintain more than 25 inpatient beds that may be used to provide either inpatient or swing-bed services. *This change was effective October 1, 2013.* The revision has no substantive effect on the current CAH requirement.

- Staffing and Staff Responsibilities, §485.631:

  o §485.631(b)(1)(v) & (vi) were revised, *effective July 11, 2014,* to:

    - Addresses the confusion about the prior rule's requirements concerning physician review of outpatient records by deleting §485.631(b)(1)(vi) and incorporating its provisions into §485.631(b)(1)(v). The revised requirement calls for a CAH MD or DO to periodically review and sign a sample of outpatient records of those patients cared for by non-physician practitioners (nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician assistants), but only to the extent required under State law where State law requires such record reviews and/or co-signatures by a collaborating physician.

      The amended requirement is not substantively different from the previous CAH requirement, but is stated more clearly.

    - Removes the requirement for those reviews which are required under State law to take place at least every two weeks.

  - §485.631(b)(2) was revised, *effective July 11, 2014,* to remove the requirement that an MD or DO must be present in the CAH at least once every two weeks. CAH MDs/DOs are now required to be present for sufficient periods of time to provide medical direction,

consultation, and supervision for the services provided in the CAH. This revision recognizes that many of the MD/DO required functions may be performed remotely via electronic means, and that the time required to be on-site will vary from CAH to CAH, depending on the volume and type of services they offer.

- Provision of Services, §485.635:

  - §485.635(a)(2) was revised to remove the requirement for the CAH's patient care policies to be developed with the advice of at least one individual who is not a member of the CAH's professional healthcare staff. *This change was effective July 11, 2014.*

  - §485.635(a)(3)(vii) was revised to remove the conditional language that could have been misunderstood as making it appear optional for a CAH to provide acute inpatient services. *This change was effective October 1, 2013.*

  - §485.635(b)(1) was revised to add a new, explicit requirement at §485.635(b)(1)(ii) for CAHs to furnish acute care inpatient services. After regulation changes adopted in 2012 removed language referring to "direct" services a CAH must provide, as opposed to services a CAH may provide under arrangement, the language remaining could have been misinterpreted to suggest that a CAH must only provide outpatient services. *This change was effective October 1, 2013.*

  - §485.635(c) was revised to remove inpatient hospital care as a service that may be provided under arrangement, to avoid creating the misperception that CAHs are not required to furnish inpatient services. *This change was effective October 1, 2013.*

We have revised our interpretive guidelines in Appendix W of the SOM, to reflect these rule changes.

In addition to the changes based on the revised regulations, we are taking this opportunity to update the guidance in Appendix W for the portions of 42 CFR 485.635 addressing the following topics, in order to bring them into alignment with current accepted standards of practice: pharmacy services; infection prevention and control; dietary services; services under arrangement; nursing services; and, rehabilitation services.

An advance copy of the revised portions of SOM Appendix W is attached. The online SOM will be updated at a later date and may differ slightly from this advance copy.

Revisions have also been made to Tags in the Automated Survey Processing Environment (ASPEN) to correspond to the revised guidance. Note that some tags have been consolidated or address different regulations than previously.

Questions concerning this memorandum should be addressed to CAHSCG@cms.hhs.gov.

Effective Date: Immediately. Please ensure that all appropriate staff are fully informed within 30 days of the date of this memorandum.

Training: The information contained in this letter should be shared with all survey and certification staff, their managers, and the State/RO training coordinators.

/s/
Thomas E. Hamilton

Attachment: 1- Revisions to State Operations Manual Appendix W, related to critical access hospitals.

cc: Survey and Certification Regional Office Management

CMS Manual System

Department of Health & Human Services (DHHS)

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Provider Certification

Transmittal	**(Advance Copy)**	**Date:**

SUBJECT: Revisions to State Operations Manual Appendix W, related to critical access hospitals.

I. SUMMARY OF CHANGES: We are revising: Appendix W, Survey Protocol, Regulations and Interpretive Guidance for Critical Access Hospitals (CAHs) and Swing Beds in CAHs, to reflect recent regulation changes. We are also taking this opportunity to make clarifications and updates to existing guidance.

NEW/REVISED MATERIAL - EFFECTIVE DATE: Upon Issuance
IMPLEMENTATION DATE: Upon Issuance

The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS:

(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	Appendix W/Table of Contents
R	Appendix W/C-0211/§485.620(a)
R	Appendix W/C-0260/§485.631(b)(1)(iv) &/§485.631(b)(1)(v)
R	Appendix W/C-0261/§485.631(b)(2)

R	**Appendix W/C-0270/§485.635**
R	**Appendix W/C-0271/§485.635(a)(1)**
R	**Appendix W/C-0272/§485.631(a)(2) &/§485.631(a)(4)**
R	**Appendix W/C-0273/§485.631(a)(3)(i)**
R	**Appendix W/C-0274/§485.635(a)(3)(ii)**
R	**Appendix W/C-0275/§485.635(a)(3)(iii)**
R	**Appendix W/C-0276/§485.635(a)(3)(iv)**
R	**Appendix W/C-0277/§485.635(a)(3)(v)**
R	**Appendix W/C-0278/§485.635(a)(3)(vi)**
R	**Appendix W/C-0279/§485.635(a)(3)(vii)**
R	**Appendix W/C-0280/§485.635(b)(1)(i)**
R	**Appendix W/C-0281/§485.635(b)(1)(ii)**
R	**Appendix W/C-0282/§485.635(b)(2)**
R	**Appendix W/C-0283/§485.635(b)(3)**
R	**Appendix W/C-0284/§485.635(b)(4)**
D	**Appendix W/C-0286**
R	**Appendix W/C-0287/§485.635(c)(1)(i) & /§485.635(c)(2)**
R	**Appendix W/C-0288/§485.635(c)(1)(ii) & /§485.635(c)(2)**
R	**Appendix W/C-0289/§485.635(c)(1)(iii)**
D	**Appendix W/C-0290**
R	**Appendix W/C-0291/§485.635(c)(3)**
R	**Appendix W/C-0292/§485.635(c)(4)**
D	**Appendix W/C-0293**
R	**Appendix W/C-0294/§485.635(d) & /§485.635(d)(1)**
D	**Appendix W/C-0295**

R	**Appendix W/C-0296/§485.635(d)(2)**
R	**Appendix W/C-0297/§485.635(d)(3)**
R	**Appendix W/C-0298/§485.635(d)(4)**
R	**Appendix W/C-0299/§485.635(e)**

III. FUNDING: No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2015 operating budgets.

IV. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

State Operations Manual

Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs

(Rev.)

Transmittals for Appendix W

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Survey Protocol

Regulations and Interpretive Guidelines for CAHs

§485.620 Condition of Participation: Number of Beds and Length of Stay
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§485.631 Condition of Participation: Staffing and Staff Responsibilities
§485.635 Condition of Participation: Provision of Services
§485.638 Condition of Participation: Clinical Records
§485.639 Condition of Participation: Surgical Services.
§485.641 Condition of Participation: Periodic Evaluation and Quality Assurance Review
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§485.645 Special Requirements for CAH Providers of Long-Term Care Services ("Swing-Beds")

C-0211

(Rev.)

§485.620(a) Standard: Number of Beds

Except as permitted for CAHs having distinct part units under §485.647, the CAH maintains no more than 25 inpatient beds. *Inpatient beds may* be used for either inpatient or swing-bed services.

Interpretive Guidelines §485.620(a)

Section 1820(c)(2)(B)(iii) of the Social Security Act limits a CAH to a maximum of 25 inpatient beds that can be used for inpatient acute care or swing bed services. The statute also requires CAHs to provide inpatient acute care limited, on an annual average basis, to 96 hours per patient (see interpretive guidelines for §485.620(b)).

Section 1820(c)(2)(E) of the Act also permits a CAH to operate a 10-bed psychiatric distinct part unit (DPU) and a 10-bed rehabilitation DPU, without counting these beds toward the 25-bed inpatient limit.

The limit applies to the number of inpatient beds; not to the number of inpatients on any given day. CAHs that were larger hospitals prior to converting to CAH status may not maintain more than 25 inpatient beds, plus a maximum of 10 psychiatric DPU inpatient beds, and 10 rehabilitation DPU inpatient beds. *Any bed used for inpatient services at any time must be counted when assessing compliance with the 25 inpatient bed limit. Beds used for outpatient services, such as observation services, sleep studies, emergency services, etc. do not count towards the CAH's 25-bed limit only if they are never used for inpatient services.*

***Beds Used for* Observation Services**

*Beds used solely for patients receiving o*bservation *services* are not included in the 25-bed maximum, nor in the calculation of the average annual acute care patient length of stay. This makes it essential for surveyors to determine that CAHs with observation beds are using them appropriately, and not as a means to circumvent the CAH size and length-of-stay limits. Inappropriate use of observation services also subjects Medicare beneficiaries to an increased beneficiary coinsurance liability that could have been avoided, had the beneficiary been properly admitted as an inpatient. This is the case because, as CAHs are not paid under the hospital Outpatient Prospective Payment System (OPPS), the beneficiary in an observation status will be liable for a coinsurance charge equal to 20 percent of the CAH's customary charges for the services. Further, as CAHs are also not subject to the preadmission payment window, a Medicare beneficiary would be liable for the coinsurance charges for the observation status services even when subsequently admitted. Depending on the terms of their health insurance coverage, other CAH patients may also face similar increased and avoidable costs when inappropriately placed in an observation status.

Observation care is a well-defined set of specific, clinically appropriate services that include ongoing short-term treatment, assessment, and reassessment, that are provided before a decision can be made regarding whether a patient will require further treatment as an inpatient, or may be safely discharged. Observation status is commonly assigned to patients with unexpectedly prolonged recovery after outpatient surgery, and to patients who present to the emergency department and who then require a significant period of treatment or monitoring before a clinical decision is made concerning their next placement. The CAH should ensure that once there is sufficient information to render this clinical decision, the patient should be expeditiously admitted, appropriately transferred, or discharged.

A patient may be in an observation status even though the CAH furnishes the patient overnight accommodation, food, and nursing care.

Observation services are **NOT** appropriate:

- As a substitute for an inpatient admission;
- For continuous monitoring;
- For medically stable patients who need diagnostic testing or outpatient procedures (e.g., blood transfusion, chemotherapy, dialysis) that are routinely provided in an outpatient setting;
- For patients awaiting nursing home placement;
- To be used as a convenience to the patient, his or her family, the CAH, or the CAH's staff;
- For routine prep or recovery prior to or following diagnostic or surgical services; or

- As a routine "stop" between the emergency department and an inpatient admission.

Observation services **BEGIN** and **END** with an order by a physician or other qualified licensed practitioner of the CAH.

- The order for observation services must be written prior to initiation of the service, as documented by a dated and timed order in the patient's medical record. The order may not be backdated. Orders should be clear for the level of care intended, such as "admit to inpatient" or "place *in* observation." *(Note: It is not uncommon for hospitals and practitioners to refer to "admitting" a patient for observation. Technically, only inpatients are "admitted," while patients receiving observation services are in an outpatient status. However, usage of the term "admit" in an order placing a patient in observation status does not violate any CAH CoP and is not cited.)*

- Observation services end when the physician or other qualified licensed practitioner orders an inpatient admission, a transfer to another health care facility, or discharge. The inpatient stay begins on the date and time of the new order.

- Standing orders for observation services are not acceptable, since it is not necessary to employ observation services for every patient in a given category, e.g., every emergency department patient, in order to reach a clinical decision about the appropriate next step in the patient's care.

Medicare generally will not pay for observation services lasting more than 48 hours. However, *s*ome States may have more stringent limits in their licensure or other regulatory requirements *on the length of observation services*, e.g., 24 hours. In such cases the *State's* more stringent limit on the length of an observation stay applies to Medicare beneficiaries as well*, but is not enforced through the Federal survey process, unless the State has taken a final enforcement action.*

The CAHs must provide appropriate documentation upon surveyor request to show that an observation bed is not an inpatient bed. The CAH must be able to document that it has specific clinical criteria for *placing a patient in* and discharg*ing* from, the observation service, and that these criteria are clearly distinguishable from those used for inpatient admission and discharge. CMS expects a CAH to employ the same type of clinical criteria for observation versus inpatient status for all patients, regardless of their payer status. For example, if a CAH were routinely placing only Medicare beneficiaries in its dedicated observation unit, then this *could* suggest that non-clinical criteria were being used in the decision to admit versus place in observation status. This would not only call the observation bed status into question, but *c*ould *also* violate the CAH's provider agreement *requirement that prohibits differential treatment of Medicare beneficiaries*. (See 42 CFR 489.53(a)(2).)

If a CAH maintains beds that are dedicated to observation services, the CAH must be able to provide evidence, such as the clinical criteria for admission to that unit and how patients in the unit meet those criteria, to demonstrate that its observation beds are not being used for inpatient services. CMS expects there to be a reasonable relationship between the size of the CAH's inpatient and observation operations. For example, a 10-bed observation unit in a 25-bed CAH

might be disproportionately large, and the surveyor must determine whether the observation unit is actually functioning as an inpatient overflow unit. A CAH observation unit that routinely operates at a high occupancy rate could also be an indicator of the need to probe further.

Other Types of Beds

Other bed types that do not count toward the 25 inpatient bed limit include*, but are not limited to*:

- Examination or procedure tables;
- Stretchers;
- Operating room tables;
- Beds in a surgical recovery room used exclusively for surgical patients during recovery from anesthesia;
- Beds in an obstetric delivery room used exclusively for OB patients in labor *or recovery after* delivery of newborn infants;
- Newborn bassinets and isolettes used for well-baby boarders *(Note: If the baby is being held for treatment at the CAH, his or her bassinet or isolette* ***does*** *count towards the CAHs 25-bed limit);*
- Stretchers in emergency departments; and
- Inpatient beds in Medicare-certified distinct part rehabilitation or psychiatric units.

Beds Used for **Hospice Services**

A CAH can dedicate beds to a hospice under arrangement, but the beds must count as part of the maximum bed count. The computation contributing to the 96 hour annual average length of stay does not apply to hospice patients. The hospice patient can be admitted to the CAH for any care involved in their hospice treatment plan or for respite care.

Medicare does not reimburse the CAH for the hospice CAH benefit. Medicare reimburses the hospice. The CAH must negotiate payment for services from the hospice through an agreement.

Survey Procedures §485.620(a)

- Count the number of inpatient beds the CAH maintains, excluding any DPU beds.
- Ask the CAH how frequently it uses observation services, and for its policies and procedures governing use of observation services.

- Verify that patients are never pre-registered for observation services; there should be no scheduled observation stays.

- Check to see if the CAH has specific clinical criteria for *placement in* and discharge from observation *status*, and that these clinical criteria are clearly distinguishable from those used for inpatient admission and discharge.

- If there is a separate unit of observation beds, ask the CAH for evidence of how its criteria for *placement in* the observation unit differ from admission criteria for an inpatient bed. Count the number of beds in the observation unit and compare them to the number of inpatient beds. The higher the proportion of observation beds, the greater is the CAH's burden to prove these are not being used as inpatient beds. Ask for the occupancy rates for the observation unit; the higher the occupancy rate, particularly if there are more than a couple of beds, the greater is the CAH's burden to prove these are not being used as inpatient beds.

- Review the medical records for patients who are in observation status at the time of survey. Verify that the medical record includes an order to place the patient in observation status, including the clinical reason for observation, *e.g.*, as "Place patient in observation to rule out possible myocardial infarction (MI)."

- Select a sample of closed medical records for patients who were in an observation status. Verify that the medical record includes an order to place the patient in observation status, as well as a later order to admit, discharge, or transfer the patient.

    - Verify through medical record review that observation services are not ordered as a standing order following outpatient surgery or prior to admission from the emergency department.

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(Rev.)

§485.631(b)(1)

(iv) Periodically reviews and signs the records of *all in*patients cared for by nurse practitioners, clinical nurse specialists, or physician assistants.

(v) Periodically reviews and signs a sample of outpatient records of patients cared for by nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician assistants only to the extent required under State law where State law requires record reviews or co-signatures, or both, by a collaborating physician.

Interpretive Guidelines §485.631(b)(1)(iv) ***& (v)***

All inpatient records for patients whose treatment is/was managed by a nonphysician practitioner in the CAH, i.e., nurse practitioners, clinical nurse specialists, or physician assistants, must be reviewed periodically by a CAH MD/DO who must sign the records after the review has been completed. The MD/DO review is expected to cover all applicable inpatient records open at the time of the review, as well as all applicable inpatient records closed since the last review.

In the case of inpatients whose care is/was managed by an MD/DO, as evidenced by an admission order, progress notes, and/or medical orders, etc., but who also receive services from a non-physician practitioner, a subsequent MD/DO review of the inpatient record is not required.

In States where State law requires a collaborating physician to review medical records, co-sign medical records, or both for outpatients whose care is managed by a non-physician practitioner, i.e., a nurse practitioner, a clinical nurse specialist, a certified nurse midwife, or a physician assistant, a CAH MD/DO must review and sign a sample of outpatient records. The outpatient medical record sample reviewed must be representative of all non-physician practitioners providing care to patients of the CAH. The CAH determines by policy the size of the sample reviewed and signed; however, CMS recommends, but does not require, a sample size of 25% of the records of all outpatient encounters managed by a non-physician practitioner since the prior MD/DO review. If State law requires MD/DO review or signature of a larger percentage of the outpatient records, the CAH must comply with State law.

In States where no physician record review or physician co-signature is required for patients managed by a non-physician practitioner, an MD/DO is not required to review or sign outpatient records of such patients.

Neither the regulation nor the preamble to the final rule adopting this regulation (79 Fed. Reg. 27105, May 12, 2014) specify a particular timeframe to satisfy the requirement for "periodic" review, but the CAH must specify a maximum interval between inpatient record reviews in its policies and procedures. The CAH is expected to take into account the volume and types of services it offers in developing its policy. For example, a CAH that has only four certified beds and one MD/DO on staff and which does not always have an inpatient in house would likely establish a different requirement for inpatient record review than a CAH with 25 certified beds, multiple MDs/DOs on staff and a high inpatient occupancy rate. Further, there is no regulatory requirement for the review of records to be performed on site and in person. Thus, if the CAH has electronic medical records that can be accessed and digitally signed remotely by the MD or DO, this method of review is acceptable. Therefore, CAHs with and without the capability for electronic record review and signature might also develop different policies for the maximum interval between reviews.

Survey Procedures §485.631(b)(1)(iv) ***& (v)***

Select a sample of inpatient and outpatient records, including both open and closed records.

- *For inpatient records of patients whose care is/was managed by a non-physician practitioner,* verify that:

  - A*n* MD/DO has reviewed and signed all records *that were open at the time of the review, and all inpatient records that were closed since the MD/DO's last review; and*

  - *That reviews take place within the timeframe specified by the CAH's policy*.

  - *If State law requires a physician to review or co-sign (or both) any outpatient records of patients whose care is/was managed by non-physician practitioner, determine whether an MD or DO has reviewed and/or co-signed a representative sample of these records within the timeframe specified in the CAH's policies.*

    - *Ask the CAH how many outpatient encounters are managed by non-physician practitioners, what sample size its policy requires to have an MD/DO review, and what timeframe its policy specifies for reviews.*

    - *Ask the CAH to explain how it ensures the sample is representative of the various non-physician practitioners as well as of the various types of outpatient services they provide.*

    - *Ask the CAH to describe the method it uses to make sure that reviews are performed in a timely manner on a sample that complies with the CAH's policy.*

    - *Review selected records from the CAH's outpatient sample to verify that there is evidence of and MD or DO review and/or signature.*

C-0261

(Rev.)

§485.631(b)(2) A doctor of medicine or osteopathy is present for sufficient periods of time to provide medical direction, consultation, and supervision *for the services provided in the CAH*, and is available through direct radio or telephone communication *or electronic communication* for consultation, assistance with medical emergencies, or patient referral.

Interpretive Guidelines §485.631(b)(2)

An MD/DO must be present in the CAH for sufficient periods of time to provide overall medical direction, consultation and supervision of the healthcare services the CAH furnishes. Being "present" in the CAH means being physically on-site in the CAH. The regulation does not specify a minimum amount of time an MD/DO must spend on-site that applies to all CAHs. Instead, CAHs have the flexibility to develop policies appropriate for their circumstances. With the development of technology such as telemedicine, a CAH may use a variety of ways and timeframes for MDs/DOs to provide the necessary medical direction and oversight. For CAHs that offer a range of more complex services, have more than one MD/DO on staff, and have busy

emergency departments and/or extensive outpatient services, an on-site visit by an MD/DO only once every week or every two weeks, for example, would be grossly inadequate. On the other hand, a bi-weekly on-site visit could be unduly burdensome as well as unnecessary for a small CAH in a remote rural area that offers very limited services and has a low patient volume.

CAHs are expected to have adequate staffing to provide the services they have chosen to furnish, including staffing or supervision by MDs/DOs as applicable. CMS expects each CAH to evaluate its services and adjust its MD/DO on-site schedule accordingly, as an appropriate MD/DO schedule must reflect the volume and nature of services offered.

Note that §485.618(d) also establishes a maximum timeframe for an MD, DO, PA, NP, or clinical nurse specialist to be on-call and available to be on-site to provide emergency care, and that §489.20(r)(2) requires the CAH to maintain an on-call list of MDs/DOs who are available to be on-site as part of the CAH's Emergency Medical Treatment and Labor Act obligations. The CAH must consider all pertinent requirements when developing its policies for MD/DO presence on site.

In addition to requiring an MD or DO to be on-site for sufficient periods of time, consistent with the requirement at §485.618(e), the CAH must also ensure an MD/DO is available through direct radio, telephone or other form of electronic communication, such as video conferencing, for consultation, assistance in handling patient medical emergencies and referral of patients to other healthcare facilities. An MD/DO providing telemedicine services to the CAH may be used to fulfill the requirement for availability via telecommunications. Further, consistent with the requirements for CAH provision of emergency services at §485.618(d), unless a, PA, NP, or clinical nurse specialist with training in emergency care is immediately available via one of these telecommunication methods and available on site within the timeframe specified at §485.618(d)(1), an MD or DO must fulfill these requirements.

Survey Procedures §485.631(b)(2)

- *Does the CAH have policies and procedures that address the minimum amount of time and frequency of MD or DO presence on-site at the CAH? Can the CAH demonstrate how its policy reflects the volume and type of services the CAH provides such that there is sufficient MD/DO presence on-site to support the services provided?*

- *Is there* documentation *showing* that an MD *or* DO *is on-site for the frequency and duration specified in the CAH's policies?*

- *Can the CAH demonstrate* that an MD *or* DO is *always* available by *telecommunications* contact for consultation, assistance and/or patient referral?

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§485.635 Condition of Participation: Provision of Services

Interpretive Guidelines §485.635

This condition establishes requirements related to patient care policies, required CAH services, and CAH services provided through agreements or arrangements. Assessment of the manner and degree of noncompliance with any one of the following standards in this condition is required in order to determine whether there is noncompliance with this condition.

C-0271
(Rev.)

§485.635(a) Standard: Patient Care Policies

(1) The CAH's health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law.

Interpretive Guidelines §485.635(a)(1)

The CAH must have written policies governing the health care services the CAH furnishes and these policies must be consistent with applicable State law. As discussed in relation to the requirements at §485.608, CMS does not interpret or enforce local law; that is the responsibility of State or local government. If surveyors identify practices related to delivery of health care services that they believe are not consistent with State law, they should refer the matter to the appropriate State authorities.

The regulation requires the CAH to furnish its health care services in accordance with its written policies. In other words, the CAH must not only have written policies, but must actually adhere to them in delivering services.

Survey Procedures §485.635(a)(1)

- *Verify that the CAH has written policies covering the health care services that are furnished in the CAH.*

- Observe staff delivering health care services to patients. *Is the actual provision of services consistent with the CAH's written policies?*

C-0272
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§485.635(a)(2) The policies are developed with the advice of *members of the CAH's professional healthcare staff, including* one or more doctors of medicine or osteopathy and one or more physician assistants, nurse practitioners, or clinical nurse specialists, if they are on staff under the provisions of §485.631(a)(1).

§485.635(a)(4) These policies are reviewed at least annually by the group of professional personnel required under paragraph (a)(2) of this section, and reviewed as necessary by the CAH.

Interpretive Guidelines §485.635(a)(2) *& (4)*

The CAH's written policies governing patient care services must be developed with the advice of members of the CAHs professional healthcare staff. This advisory group must include:

- *At least one MD or DO; and*

- *One or more physician assistants, nurse practitioners, or clinical nurse specialists, at least one of these non-physician practitioners if these professionals are included in the CAH's healthcare staff, as permitted at §485.631(a)(1). A CAH with no non-physician practitioners on staff is not required to obtain the services of an outside non-physician practitioner to serve on the advisory group.*

The advisory group not only makes recommendations for new CAH patient care policies, but is also expected to review the existing patient care policies at least annually and, if it concludes that changes are needed, recommend those changes. Policies must be reviewed and, as applicable, revised more frequently when required, for example, in response to a change in Federal or State regulations to which the CAH is subject.

The CAH must maintain documentation that provides evidence that the advisory group has conducted its reviews and made recommendations concerning patient care policies.
Although a CAH's patient care policies are developed and periodically reviewed with the advice of members of the CAH's professional healthcare staff, the final decision on the content of the written policies is made by the CAH's governing body or individual responsible for the CAH, consistent with the requirement at §485.627(a). If recommendations of the advisory group are rejected, the governing body must include in the record of its adoption of the final written policies its rationale for adopting a different policy than that recommended.

Survey Procedures §485.635(a)(2)

- Review any meeting minutes *for the group of healthcare professionals that advises the CAH's governing body or responsible individual on patient care policies* to determine *if the group's* composition *meets the regulatory requirements*.

- Interview *all staff listed as part of the policy development advisory group* to determine *if they had the opportunity to express opinions and make recommendations to the group, for the group's consideration as a group recommendation*.

- *Can the CAH provide documentation that the advisory group developed written recommendations on the CAH's patient care policies for consideration by the CAH's governing body/responsible individual?*

- *Is there evidence that the group reviewed the CAH's existing policies at least annually and indicated whether or not it recommended any changes?*

C-0273
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§485.635(a)(3) The policies include the following:

(i) A description of the services the CAH furnishes, including those furnished through agreement or arrangement.

Interpretive Guidelines §485.635(a)(3)(i)

The CAH's written patient care policies must describe the types of health care services that are available at the CAH, including whether those services are furnished by CAH staff or through agreements or arrangements. The types of health services described must include services provided both on-site and off-site.

Healthcare services provided through agreement or under arrangement include those provided through formal contracts, informal agreements, or lease arrangements. Services furnished under arrangement or by agreement may include both healthcare services provided on-site at the CAH by a contractor, as well as healthcare services provided to the CAH's patients outside the CAH. For example, the CAH may contract with a laboratory to provide certain laboratory services on-site, and others at an off-site laboratory; or it may contract with an imaging center for provision of certain advanced radiologic diagnostic services, such as MRI, to CAH inpatients who are temporarily moved to the center for the test and then returned to the CAH.

The descriptions of the services provided may be brief but informative, for example, statements like "taking complete medical histories, providing complete physical examinations, laboratory tests including" (with a list of tests provided), radiologic tests and their interpretation, surgery (with a list of the types of surgery available) would satisfy this requirement.

Survey Procedures §485.635(a)(3)(i)

Verify that the CAH's healthcare policies identify and describe all healthcare services offered by the CAH, including services provided under arrangement or by agreement.

C-0274
(Rev.)

§485.635(a)(3) [The policies include the following:]

(ii) Policies and procedures for emergency medical services.

Interpretive Guidelines §485.635(a)(3)(ii)

The CAH's written patient care policies must include its policies and procedures for providing emergency services*, addressing all of the* requirements *at 42 CFR 485.618. See the interpretive guidelines for §485.618.*

Survey Procedures §485.635(a)(3)(ii)

Verify that written policies and procedures detail how the CAH plans to comply with the requirements of 42 CFR 485.618. Do the written policies and procedures address the following:

- *How the CAH provides 24 hour emergency care to its patients?*
- *What equipment, supplies, medications, blood and blood products are maintained onsite and which are readily available for treating emergency cases by agreement at other facilities?*
- *What types of personnel are available to provide emergency services and what are their required onsite response times?*
- *Do they address how the CAH coordinates with local emergency response systems?*

C-0275
(Rev.)

§485.635(a)(3) [The policies include the following:]

(iii) Guidelines for the medical management of health problems that include the conditions requiring medical consultation and/or patient referral, the maintenance of health care records, and procedures for the periodic review and evaluation of the services furnished by the CAH.

Interpretive Guidelines §485.635(a)(3)(iii)

The written policies for the CAH's healthcare services must include guidelines*, such as general instructions and protocols,* for the medical management of *patients'* health problems. *The guidelines may include directly or reference protocols that are documented elsewhere for the treatment of medical conditions that are commonly presented in the CAH.*

Because nurse practitioners, clinical nurse specialists, and physician assistants may play a large role in patient care at a CAH, the CAH's policies must address the circumstances under which consultation with an MD or DO should occur and which situations require them to consult with or refer to an MD/DO for advice on how to treat a patient. The CAH's policies must also address the circumstances under which patient referral outside the CAH should occur.

The policies must also address maintenance of medical records, consistent with the requirements at §485.638. See interpretive guidelines for §485.638.

The policies must also address the CAH's procedures for periodical review and evaluation of its services, consistent with the requirements of §485.641. See interpretive guidelines for §485.641.

Survey Procedures §485.635(a)(3)(iii)

Verify that the CAH's written patient care policies:

- *Address the circumstances under which consultation with other CAH professional healthcare staff, or referral outside the CAH should occur;*
- *Address maintenance of medical records, in a manner consistent with the requirements at §485.638; and*
- *Address periodic evaluation of the CAH's healthcare services, in a manner consistent with the requirements at §485.641.*

C-0276

(Rev.)

[§485.635(a)(3) The policies include the following:]

(iv) Rules for the storage, handling, dispensation, and administration of drugs and biologicals. These rules must provide that there is a drug storage area that is administered in accordance with accepted professional principles, that current and accurate records are kept of the receipt and disposition of all scheduled drugs, and that outdated, mislabeled, or otherwise unusable drugs are not available for patient use.

Interpretive Guidelines §485.635(a)(3)(iv)

The CAH must ensure that drugs and biologicals are managed in a manner that is safe and appropriate, and that its pharmacy system provides all drugs and biologicals prescribed by the CAH's practitioners in a timely manner for administration to its patients.
The CAH's written patient care policies must include rules governing pharmacy services within the CAH. The CAH's rules may be in the form of pharmacy services policies and procedures. These CAH rules must address storage, handling, dispensing, and administration of drugs and biologicals within the CAH. The rules must be in accordance with accepted professional principles of pharmacy and medication administration practices. Accepted professional

principles include compliance with applicable Federal and State law and adherence to standards or guidelines for pharmaceutical services and medication administration issued by nationally recognized professional organizations, including, but not limited to: U.S. Pharmacopeia (www.usp.org), the American Society of Health-System Pharmacists (http://www.ashp.org/), the Institute for Safe Medication Practices (http://www.ismp.org/default.asp), the National Coordinating Council for Medication Error Reporting and Prevention (www.nccmerp.org); the Institute for Healthcare Improvement (http://www.ihi.org/ihi); or the Infusion Nurses Society (http://www.ins1.org).

Note re: US Pharmacopeia/National Formulary (USP/NF)

According to the Federal Food, Drug and Cosmetic Act (FCDA), the official compendia of the United States for excipients, drug substances, and drug products is the USP/NF. It is published every year in November by the United States Pharmacopeial Convention (http://www.usp.org/) and includes two supplements published in February and June.

The USP is a not-for-profit, non-governmental organization that since 1820 has established quality standards for, among other things, drug substances, drug products and compounded preparations. Congress established a role for USP standards in the adulteration provision of the 1906 Food and Drug Act. That role was expanded in the modern Food, Drug and Cosmetic Act (FDCA) beginning in 1938, with a role for USP compendial standards for naming and identity; strength, quality, and purity; and packaging and labeling, in both the adulteration and misbranding provisions of FDCA. (See, for example, §501(b) of the FDCA regarding compendial standards for strength, quality and purity, §502(g) for compendial standards for packaging and labeling). Under the FDCA, a drug with a name recognized in the USP/NF must comply with compendial identity standards, or be deemed adulterated, or misbranded, or both. To avoid being deemed adulterated, such drugs must also comply with compendial standards for strength, quality, and purity, unless labelled to show all respects in which the drug differs.

The CAH's rules must address the following:

- ***Responsibility for pharmacy services.***

  The CAH must identify the qualifications for and designate an individual who has overall responsibility for the CAH's pharmacy services, including development of the rules governing pharmacy services. The CAH and the responsible individual must ensure adherence to State law requirements governing who may perform pharmacy services as well as requirements for supervision of pharmacy staff. The CAH and responsible individual are also responsible for assuring that pharmacy practices adhere to accepted professional principles. The CAH is expected to be able to identify the sources of accepted professional pharmacy practices that it relies upon in developing the CAH's pharmacy rules, policies and procedures.

- ***Storage of drugs and biologicals, including the location of storage areas, medication carts, and dispensing machines.***

  Consistent with accepted professional principles, CAHs must demonstrate appropriate storage and preparation of medications under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security.

- ***Proper environmental conditions***

  Where the manufacturer's FDA-approved package insert specifies environmental conditions, such as temperature, humidity, exposure to light, etc., for storage of drugs, the CAH is expected to follow the labelled conditions. Absent the manufacturer's labelled conditions, USP indicates that storage of drugs and biologicals be done according to USP/NF, or the food chemicals codex (FCC) monograph requirements. CAHs must exercise caution in dispensing or using any drug or biological that is not labelled to indicate proper storage conditions or that may have been stored under inadequate conditions.

- ***Security***

  The CAH must have policies and procedures that are consistent with State and Federal law to address who is authorized access to the pharmacy or drug storage area. Drugs and biologicals must be stored in a secure manner to prevent unmonitored access by unauthorized individuals. Drugs and biologicals must not be stored in areas that are readily accessible to unauthorized persons. For example, if medications are kept in a private office, or other area where patients and visitors are not allowed without the supervision or presence of a health care professional (for example, ambulatory infusion), they are generally considered secure. Areas restricted to authorized personnel only would generally be considered "secure areas."

  CAHs are permitted flexibility in the storage of non-controlled drugs and biologicals when delivering care to patients, and in the safeguarding of drugs and biologicals to prevent tampering or diversion. An area in which staff are actively providing care to patients or preparing to receive patients, i.e., setting up for procedures before the arrival of a patient, would generally be considered a secure area. When a patient care area is not staffed, both controlled and non-controlled substances are expected to be locked.

  Medication carts, anesthesia carts, epidural carts and other non-automated medication carts containing drugs or biologicals (hereafter, all referred to as "carts") must be secured when not in use. A CAH's policies and procedures are expected to address the security and monitoring of carts, locked or unlocked, containing drugs and biologicals in all patient care areas to ensure their safe storage and to ensure patient safety.

  If a cart containing drugs or biologicals is in use and unlocked, someone with authorized access to the drugs and biologicals in the cart must be close by and directly monitoring the cart. That person could be a nurse, a physician, or other individual who in accordance with State and Federal law and CAH policy is authorized access to the drugs and biologicals in

the cart. That individual must monitor the cart and be aware of other people's activities near the cart. He/she is responsible for the security of the drugs and biologicals in the cart.

- ***Handling drugs and biologicals.***

  "Handling" includes reconstituting or mixing medications in accordance with directions contained in approved labeling provided by the drug's manufacturer. "Handling" also includes compounding or admixing of sterile intravenous preparations or of other drugs, either on- or off-site, using either CAH staff or a contracted pharmacy service. CAHs use many medications that need to be reconstituted, mixed or compounded. Whether furnishing the services via CAH staff or a contractor, the CAH is responsible for proper handling of drugs and biologicals.

  Except in emergencies or when not feasible (for example, when the product's stability is short), only the pharmacy performs reconstituting, mixing, admixing or compounding.

  Compounding

  All compounding of medications used or dispensed by the CAH must be performed consistent with accepted professional principles which are equivalent to or more stringent than those described in the compounding-related chapters in the USP/NF, which are recognized as authoritative standards regarding minimum standards of safe practice applicable to both sterile and non-sterile compounding.

  The definition of compounding as that term is used in the USP is found in USP Chapter <795> (USP <795>):

  "The preparation, mixing, assembling, altering, packaging and labeling of a drug, drug-delivery device, or device in accordance with a licensed practitioner's prescription, medication order or initiative based on the practitioner/patient/pharmacist/compounder relationship in the course of professional practice. Compounding includes the following:

  - *Preparation of drug dosage forms for both human and animal patients*
  - *Preparation of drugs or devices in anticipation of prescription drug orders based on routine, regularly observed prescribing patterns*
  - *Reconstitution or manipulation of commercial products that may require the addition of one or more ingredients*
  - *Preparation of drugs or devices for the purposes of, or as incident to, research (clinical or academic), teaching or chemical analysis*
  - *Preparation of drugs and devices for prescriber's office use where permitted by federal and state law"*

  Compounded medications, whether non-sterile or sterile, may be subject to physical and chemical contamination and unintended variations in strength. Microbial contamination and bacterial endotoxins are particularly hazardous with respect to compounded medications that are intended to be sterile.

A CAH pharmacy must be administered in accordance with accepted professional principles, and therefore must be able to demonstrate how it assures that all sterile and non-sterile compounded preparations dispensed and/or administered to the CAH's patients are being compounded consistent with accepted professional standards to ensure safety. The applicable standards for safe compounding are, at a minimum, the standards published in USP Chapters <795> ("Pharmaceutical Compounding – Nonsterile Preparations"), <797> ("Pharmaceutical Compounding – Sterile Preparations") and other relevant USP-NF Chapters. The CAH must be able to provide evidence that the CAH's standard operating procedures for compounding, if performed in-house, and for quality oversight of compounding, regardless of source, are consistent with accepted professional principles.

USP <797> outlines minimum standards of practice to be followed by all health care personnel in any setting when preparing, storing and transporting "compounded sterile preparations" (CSPs). Its stated objective is "to describe conditions and practices to prevent harm, including death, to patients that could result from…microbial contamination…excessive bacterial endotoxins…variability of intended strength of correct ingredients…unintended chemical and physical contaminants…and ingredients of inappropriate quality…." Contaminated CSPs are especially hazardous if administered into body cavities, the central nervous system, vascular system, eyes, joints, and/or used as baths for live organs and tissues. "All compounded dosage forms that must be sterile when they are administered to patients" are considered by USP <797> to be CSPs, including but not limited to:

- *"Aqueous bronchial and nasal inhalations;*
- *Baths and soaks for live organs and tissues;*
- *Injections [and infusions];*
- *Irrigations for wounds and body cavities;*
- *Ophthalmic drops and ointments;*
- *Tissue implants."*

USP <797> specifies differing standards for the physical layout and structure of the locations in which compounding takes place as well as processes, precautions and quality assurance practices to be implemented during the preparation, transport and storage of CSPs. The standards differ in part based on the level of risk of microbial contamination of the CSP, and the risk level has implications for whether a CSP must be terminally sterilized before being dispensed and for how long a CSP may be stored before use. The risk categories and accompanying standards are based on specific criteria, including but not limited to factors such as:

- *The structural design, environmental controls, air quality levels (based on International Organization for Standardization (ISO) standards for particulate matter in air) and air flow patterns in and surrounding the environment to which the contents of the CSP as well as the surfaces of devices and containers for the preparation, transfer, sterilization and packaging of CSPs are exposed.*

- *The sterility of the original ingredients and/or device(s) used in compounding, the number of containers that need to be entered, how many times they need to be entered, the nature and complexity of the manipulations and length of time required to prepare the CSP.*

- *Whether compounding personnel are appropriately garbed and gloved.*

- *Whether multiple doses of sterile products are pooled to produce a CSP that will be administered on more than one occasion or to more than one patient.*

The goal of the USP <797> standards is to prevent and/or minimize the risk of microbial contamination of CSPs, whether by direct contact, exposure to particles in air generated by personnel or objects, or other mechanisms. A major concern is preventing contamination of "critical sites," which include "any component or fluid pathway surfaces (e.g., vial septa, injection ports, beakers) or openings (e.g., opened ampules, needle hubs) exposed or at risk of direct contact with air…moisture…or touch contamination."

USP <797> describes two basic structural designs for the physical layout and environmental controls intended to minimize airborne contamination of critical sites during preparation of CSPs. The risk level of the CSPs a facility can produce depends, in part, on which USP <797> environmental quality and control/facility design standards the CAH (or its vendor) is able to meet (low-risk level, medium-risk level and high-risk level are discussed here; see §485.635(d)(3) for a discussion of "immediate-use" CSPs):

- *Some facilities may only prepare low-risk level nonhazardous and radiopharmaceutical CSPs pursuant to a physician order for a specific patient, and administration must commence within the lesser of 12 hours of preparation or as recommended in the manufacturer's package insert. Such a facility would have a designated, demarcated room or space that is the "segregated compounding area (SCA)," which contains a device that provides unidirectional airflow of International Standards Organization (ISO) Class 5 air quality (quality class ranges from class 0, the most stringent, to class 9, the most relaxed). The SCA may not be in an area with unsealed openings/potential openings to high traffic locations, the outdoors and other proscribed environmental conditions, and the SCA area may not contain any materials or be the site of any activities unrelated to preparing low-risk CSPs.*

- *If a facility is preparing high- or medium-level risk CSPs or low-risk CSPs with a beyond-use date of greater than 12 hours, it must meet additional environmental design and monitoring/testing standards in the buffer and ante-areas.*

- *USP<797> contains separate standards for the safe compounding of hazardous medications (defined as "...if studies in animals or humans indicate that exposures to them have a potential for causing cancer, development or reproductive toxicity, or harm to organs…"), radiopharmaceuticals and allergen extracts.*

In addition, USP <797> includes standards for various processes, precautions and quality assurance practices required and recommended for the safe preparation of all risk levels of CSPs. These address issues such as:

- *The responsibilities of compounding personnel and their supervisors to implement and maintain proper procedures and quality assurance checks.*

- *Issues specific to "immediate use" CSPs; single- and multiple-dose containers; CSPs containing hazardous drugs; radiopharmaceuticals; allergen extracts; and automated compounding devices used for parenteral nutrition compounding.*

- *Methods for sterilization, depyrogenation and for verifying compounding accuracy and sterility.*

- *Specifications for environmental quality and control, including but not limited to:*

    - *Specifications and related personnel training, including competency assessment and evaluation of skill in aseptically preparing CSPs using visual observation as well as bacterial sampling of glove fingertips and "media-fill testing" at specified intervals.*

    - *Evaluation and monitoring/testing of the environment in which compounding takes place and, if applicable, the adjacent "ante-" and "buffer" areas, including facility layout, design, environmental controls, restricted access, air quality standards and testing, surface characteristics, furnishings, cleaning and disinfection procedures, and standards for personnel health, attire/cosmetics, cleansing/garbing/gloving, aseptic work practices, etc.*

- *Suggested standard operating procedures to protect the quality of the environment in which CSPs are prepared.*

- *Quality control related to ingredients, devices and equipment used in relation to CSPs.*

- *Quality checks to be performed before CSPs are dispensed or administered.*

- *Issues related to beyond-use dating and packaging, storage and transportation conditions for CSPs.*

- *Protecting dispensed and distributed CSPs.*

- *Patient education issues.*
- *Monitoring for and reporting adverse patient events related to CSPs.*
- *Requirements for a formal quality assurance program to be maintained by providers of CSPs.*

For Information – Not Required/Not to be Cited

USP <797> Appendices I and III-V contain summaries and assessment tools that CAHs may find helpful. However, there is no requirement to use specific forms or materials as long as the CAH and/or its external sources of CSPs are implementing plans, procedures, testing and documentation consistent with applicable standards for safe compounding. These USP <797> suggested materials are referenced here only as examples:

- *"Appendix I: Principal Competencies, Conditions, Practices, and Quality Assurances That Are Required…and Recommended in USP Chapter <797>"*
- *"Appendix III: Sample Form for Assessing Hand Hygiene and Garbing Related Practices of Compounding Personnel"*
- *"Appendix IV: "Sample Form for Assessing Aseptic Technique and Related Practices of Compounding Personnel"*
- *"Appendix V: "Sample Form for Assessing Cleaning and Disinfection Procedures"*

Compounding may take place in the CAH's pharmacy on-site and/or the CAH may obtain some or all of its compounded medications from external sources. Regardless of the source, if accepted standards for safe compounding are not met, compounded medications may contain less or more than the intended dose and/or may be chemically or microbiologically contaminated, with potentially serious adverse consequences for the patients who receive them.

Use of Outside Compounders (also known as Outsourcing Facilities)

The Drug Quality and Security Act (DQSA), signed into law on November 27, 2013, contains provisions relating to the oversight of compounding of human drugs. The DQSA created a new section 503B in the FDCA under which a compouder may elect to become an "outsourcing facility." The law defines an "outsourcing facility" as a facility at one geographic location or address that is engaged in the compounding of sterile drugs; has elected to register as an outsourcing facility; and complies with all of the requirements of section 503B of the FDCA. Facilities that elect to register as outsourcing facilities:

- *Must comply with the FDA's Current Good Manufacturing Practice (CGMP) requirements, which contain minimum requirements for the methods, facilities, and controls used in manufacturing, processing, and packing of a drug product. The CGMP requirements make sure that a product is safe for use, and that it has the ingredients and strength it claims to have. The FDA's publishes the most current versions of its draft and final regulations and guidance related to compounding on its website: http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/PharmacyCompounding/default.htm ;*

- *Will be inspected by FDA according to a risk-based schedule; and*

- *Must meet certain other conditions, such as reporting adverse events and providing FDA with certain information about the products they compound.*

In a January 2014 letter to purchasers of compounded medications (available at http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/PharmacyCompounding/ucm380596.htm), the Commissioner of the FDA encouraged the use of registered outsourcing facilities and noted that,"[a]s a purchaser of compounded drugs, you can play an important role in improving the quality of compounded drugs by requiring compounding pharmacies that supply drugs to your facility to register as outsourcing facilities. Once they register, you and the patients you serve can be assured that FDA will inspect these facilities on a risk-based schedule, hold them to CGMP requirements, monitor the adverse event reports they are required to submit to the agency, and require appropriate labeling."

FDA has posted a list of Registered Human Drug Compounding Outsourcing Facilities, including the end date of the last FDA inspection related to compounding, whether investigators observed any significant objectionable conditions, and whether other FDA actions were taken based on the last inspection, at: http://www.fda.gov/drugs/guidancecomplianceregulatoryinformation/pharmacycompounding/ucm378645.htm

Note that these registered outsourcing facilities are also popularly referred to as "503B pharmacies."

Use of Compounding Pharmacies

If a CAH obtains compounded medications from a compounding pharmacy rather than a manufacturer or a registered outsourcing facility, then the CAH must demonstrate how it assures that the compounded medications it receives under this arrangement have been prepared in accordance with accepted professional principles for compounded drugs as well as applicable State or Federal laws or regulations. For example, does the contract with the vendor include provisions:

- *Ensuring that the CAH has access to quality assurance data verifying that the vendor is adhering to current USP <795> and <797> requirements, and can the CAH document that it obtains and reviews such data?*

- *Requiring the vendor to meet the requirements of Section 503A of the FDCA concerning pharmacy compounding of human drug products?*

Note that these types of compounding pharmacies are also popularly referred to as "503A pharmacies" and generally are subject to oversight only by their State pharmacy board.

For Information – Not Required/Not to be Cited

ASHP Research and Education Foundation™ "Outsourcing Sterile Products Preparation: Contractor Assessment Tool"

The ASHP Research and Education Foundation™ offers a tool that CAHs may find useful for assessing vendors that provide compounded sterile preparations. http://www.ashpfoundation.org/MainMenuCategories/PracticeTools/SterileProductsTool.aspx and click on "Start using Sterile Products Outsourcing Tool now."

- ***Dispensing drugs and biologicals.***

CAHs must comply with applicable State law that governs the qualifications, certification, or licensure of staff who dispense drugs and biologicals. There must be sufficient numbers and types of personnel to provide accurate and timely medication delivery.

Medications must be dispensed in a timely manner. The CAH must have a system that ensures medication orders get to the pharmacy promptly and medications are available for administration to patients when needed, including when the pharmacy is not open. Methods to accomplish this when the pharmacy is not open could include, but are not limited to, one or more of the following: automated dispensing units outside the pharmacy, night cabinets, contracted services after hours via telepharmacy contracting, on-call pharmacists, etc.

Concerns, issues or questions pharmacy staff have about any medication order must be clarified with the prescribing practitioner or another practitioner responsible for the care of the patient before dispensing.

A CAH may utilize a unit dose system, individual prescription, floor stock system or a combination of these systems, properly stored.

- *Automated Dispensing Cabinets (ADCs) for medications are a secure option for medication storage since they ensure locked storage of medications and allow for electronic tracking of controlled substances and other drugs. These cabinets often have embedded security features, such as login and password or biometric identification so that they can only by accessed by authorized personnel.*

- *Policies and procedures must address who can access medications during after-hours.*

For Information Only – Not Required/Not to be Cited

In addition to the required pharmacy policies and procedures above, a well-designed pharmacy service would have policies and procedures addressing medication safety practices such as:

- *Implementation of a do-not-use abbreviation list. CAHs may wish to refer to lists offered by the Institute for Safe Medication Practices (http://www.ismp.org/tools/errorproneabbreviations.pdf) or The Joint Commission (http://www.jointcommission.org/assets/1/18/Do_Not_Use_List.pdf) ;*

- *A high alert drug list. CAHs may wish to refer to a high alert drug list offered by the Institute for Safe Medication Practices (https://www.ismp.org/tools/institutionalhighAlert.asp);*

- *For specific high alert medications designated by the CAH, having two health professionals independently check doses CAHs may wish to refer to guidance from the Institute for Safe Medication Practices concerning appropriate use of double-checks (http://www.ismp.org/Newsletters/acutecare/showarticle.aspx?id=51);*

- *Quantities of medications are dispensed which minimize diversion and potential adverse events while meeting the needs of the patient;*

- *Whenever possible, medications are dispensed in the most ready to administer form available from the manufacturer or, if feasible, in unit doses that have been repackaged by the pharmacy;*

- *The CAH consistently uses the same dose packaging system, or, if a different system is used, provides education about the use of the dose packaging system; and*

- *The American Society of Health-System Pharmacists (ASHP) recommends that floor stocks of medications should be limited to medications for emergency use and routinely used safe items (e.g. mouthwash, antiseptic solutions).*

When utilizing automated dispensing cabinets (ADCs), the Institute for Safe Medication Practices recommendations include the following: (See: http://www.ismp.org/Newsletters/acutecare/articles/20090212.asp *and* http://www.ismp.org/Tools/guidelines/ADC_Guidelines_Final.pdf *) Security processes are established to ensure adequate control of medications outside of the pharmacy and to reduce the potential for medication diversion from ADCs.*

- *Utilize biometric user identification or, at a minimum, change user passwords quarterly.*

- *Link the ADC to the pharmacy computer to allow for patient "profiling," so that a pharmacist can review each medication order and screen it for safety before the drug is dispensed or accessed by the nurse or other healthcare professional.*

- *Limiting the availability of overrides to the ADC system.*

- *Limiting access to drugs based on the patients profile so to decrease medication selection errors.*

- *Store each medication and strength in an individual lidded ADC compartment that opens only when the specific medication is selected.*

- *Document the destruction of medication waste at the time of removal of the medication whenever possible. Record this waste via the ADC, and match the administered dose with ordered dose. Have a process to routinely review/reconcile the documented medication waste*

- *Return all medications to a common secure one-way return bin that is maintained by pharmacy, not to an individual pocket or bin within the ADC.*

- ***Administration of drugs and biologicals to patients.***

  CAHs must comply with applicable State law that governs the qualifications, certification, or licensure of staff who administer drugs and biologicals and must adhere to accepted standards of practice for medication administration. See the guidance for §485.635(d)(3) concerning medication administration by CAH nursing staff.

- ***Record keeping for the receipt and disposition of all scheduled drugs.***

  The U.S. Department of Justice Drug Enforcement Administration (DEA) classifies drugs that are controlled in accordance with the Controlled Substances Act into five "schedules", ranging from Schedule I substances, which have a high potential for abuse and no currently accepted medical use in treatment, to Schedule V substances, which have a low potential for abuse relative to substances listed in Schedule IV and consist primarily of preparations containing limited quantities of certain narcotics. The CAH is required to accurately track the receipt and disposition of all scheduled drugs used in the CAH. Components of a record system for scheduled drugs would include:

  - *Locked storage of scheduled drugs when not in use.*

  - *Accountability procedures to ensure control of the distribution, use, and disposition of all scheduled drugs.*

  - *The record system tracks movement of all scheduled drugs from the point of entry into the hospital to the point of departure either through administration to the patient,*

destruction or return to the manufacturer. This system provides documentation on scheduled drugs in a readily retrievable manner to facilitate reconciliation of the receipt and disposition of all scheduled drugs.

- *Any discrepancies in count are reconciled promptly. The CAH is capable of readily identifying loss or diversion of all controlled substances in such a manner as to minimize the time frame between the actual loss or diversion to the time of detection and determination of the extent of loss or diversion.*

- ***Ensuring that outdated, mislabeled, or otherwise unusable drugs are not used for patient care.***

  The CAH must have a pharmacy labeling, inspection, and inventory management system that ensures that outdated, mislabeled, or otherwise unusable drugs and biologicals are not available for patient use. This would include drugs that are the subject of a manufacturer's recall.

  A drug or biological is outdated after its expiration date, which is set by the manufacturer based on stability testing under specified conditions as part of the FDA approval process. It should be noted that a drug or biological may become unusable prior to its expiration date if it has been subjected to conditions that are inconsistent with the manufacturer's approved labeling.

  A drug or biological is also outdated after its "beyond-use date" (BUD), which may be reached before the expiration date, but never later. The BUD takes into account the specific conditions and potential for deterioration and microbial growth that may occur during or after the original container is opened, while preparing the medication for dispensing and administration, and/or during the compounding process if it is a compounded medication.

  The BUD is to be based on information provided by the manufacturer, whenever such information is available. The CAH must maintain and implement policies and procedures that provide clear and consistent direction to pharmacy staff regarding how to determine a BUD when complete BUD information is not available from the manufacturer. The policies and procedures must be based on accepted professional principles which are equivalent to, or more stringent than, those described in the United States Pharmacopeia-National Formulary (USP).[1]

  According to Chapters <795> and <797> of the USP, the BUD must be safe for patients, and determined conservatively. The section in USP <797> entitled "Determining Beyond-Use Dates", which addresses sterile compounding, notes that "the truly valid evidence for predicting beyond-use dating can be obtained only through product-specific experimental studies." It provides an example of testing considered more appropriate for certain types of

[1] All references to "USP" herein are from: United States Pharmacopeial Convention. *USP on Compounding: A Guide for the Compounding Practitioner. Current with USP 37-NF32 through First Supplement.* Rockville, MD: United States Pharmacopeial Convention, 2014.

compounded sterile preparations (CSPs) such as "CSPs with a narrow therapeutic index, where close monitoring or dose titration is required to ensure therapeutic effectiveness and to avoid toxicity…." It also provides examples of important issues that a pharmacist must be able to critically interpret and evaluate when consulting literature sources in the process of determining a BUD; and distinguishes between reviewing literature specific to a particular drug, composition, concentration of ingredients, fill volume, container, storage conditions and duration of use, etc., versus merely reviewing available publications or tables. The former is the preferred approach, while the latter results in a "theoretical BUD," which has an inherent likelihood of inaccuracy or error.

For individual drug containers: each floor stock drug container is expected to be labelled with the name and strength of the drug, lot and control number equivalent, and expiration date. Appropriate accessory and cautionary statements are included as well as the expiration date and/or, if applicable, a BUD. It should be noted that, for multi-dose medication vials with antimicrobial preservatives which have been opened or entered (e.g., need-punctured), the USP standard is that the BUD is 28 days, unless otherwise specified by the manufacturer. In addition, where applicable, each patient's individual drug container is expected to be labelled with the patient's full name and quantity of the drug dispensed.

If the unit dose system is utilized, each single unit dose package is expected to be labelled with the name and strength of the drug, lot and control number equivalent, expiration date and/or, if applicable, a BUD.

For Information Only

Certain provisions of the FDCA address the labeling of prescription drugs generally (e.g., section 503(b)(2) of the FDCA). Section 503B of the FDCA includes labeling requirements for drugs compounded by registered outsourcing facilities (see section 503B(a)(10)). Although CAHs are expected to comply with these requirements, surveyors conducting a Medicare survey do not assess compliance with other Federal law.

Assessing Adverse Drug Reactions & Medication Administration Errors

In accordance with §485.635(a)(3)(v) the CAH must have a system for staff to report adverse drug reactions and medication administration errors. The pharmacy services is expected to assess all such reports to determine if problems or errors in pharmacy services caused or contributed to the adverse reaction or medication administration error. Where such problems or errors are identified, the CAH is expected to take effective action to address the identified issues.

Survey Procedures §485.635(a)(3)(iv)

- *Has the CAH adopted pharmacy rules that were developed with the advice of the CAH's professional healthcare staff?*

- *Has the CAH identified the qualifications of and designated an individual who is responsible for developing and implementing the rules for the CAH's pharmacy services, consistent as applicable with State and Federal law?*

    - *Review the qualifications of the responsible individual to verify that they satisfy the CAH's written criteria.*

- *Ask CAH practitioners, nursing and pharmacy staff whether the CAH's pharmacy service dispenses prescribed drugs and biologicals in a timely manner. If there is evidence in medical records reviewed of late administration of prescribed medications, probe to determine whether delays are due to pharmacy dispensing delays.*.

- *Ask the individual responsible for CAH pharmacy services what sources of accepted professional principles of pharmacy practice the CAH relies upon in developing and implementing its CAH pharmacy rules, policies and procedures. Is the source(s) a nationally recognized source?*

- *Are drugs and biologicals stored in a secure manner?*

    - *Are drugs stored in areas not accessible to unauthorized personnel?*

    - *When drugs or biologicals are kept in a patient care area during hours when patient care is not provided, are they locked up?*

- *Conduct a spot check of drug use and other inventory records to ensure that drugs are properly accounted for.*

- *Determine if the CAH has a system that tracks movement of all scheduled drugs from the point of entry into the CAH to the point of departure either through administration to the patient, destruction of the drug, or return to the manufacturer.*

    - *Does this system provide documentation on scheduled drugs in a readily retrievable manner to facilitate reconciliation of the receipt and disposition of all scheduled drugs?*

    - *Review records of scheduled drugs over a recent time period. Is there evidence of discrepancies, and if so, of efforts by the CAH to reconcile and address the discrepancies?*

    - *Interview the person responsible for pharmacy services as well as other CAH staff to determine their understanding of the CAH's controlled drug policies.*

- *Verify that only a pharmacist or other personnel authorized in accordance with State and Federal law compound, label and dispense drugs or biologicals, regardless of whether the services are provided by CAH staff or under arrangement.*

- *Interview pharmacy and CAH staff to determine how drugs and biologicals are dispensed;*

- *Observe on-site dispensing operations;*

- *Review records to see if drugs and biologicals are removed from the pharmacy by unauthorized personnel;*

- *Do the CAH's pharmacy rules address ADCs, if used within the CAH? Are the ADCs being used in the manner prescribed by the CAH's rules?*

- *Can the CAH demonstrate that compounded medications used and/or dispensed by the hospital are being compounded consistent with standard operating procedures and quality assurance practices equivalent to or more stringent than the standards described in USP <795> and <797>?*

  - *Does the individual responsible for the pharmacy service, including compounding policies, practices and quality assurance within the CAH, and selecting and overseeing any external sources of compounded medications, have the expertise to conduct effective quality oversight consistent with USP <795> and <797> (or equivalent/more stringent) standards?*

  - *Can the individual responsible for the pharmacy services explain the risk level(s) of the CSPs being produced in-house and/or obtained from external sources? Can he or she demonstrate that the assigned risk levels are consistent with USP <797> or equivalent/more stringent standards?*

  - *If any CSPs are produced in the CAH:*

  - *Ask for one or more examples of situations in which a BUD had to be determined for a compounded sterile medication (CSP) based on the policy. Interview pharmacy personnel assigned to carry out this function within the CAH and/or to assess how this is done by external source(s) of CSPs. Is there evidence that the BUDs are determined consistent with the CAH's rules, policies and procedures?*

    - *Interview staff who engage in sterile and non-sterile compounding. Are they knowledgeable about applicable levels of aseptic practices?*

    - *Ask the individual responsible for pharmacy services to demonstrate how the following are accomplished to ensure that sterile compounding practices are consistent with USP <797> or equivalent/more stringent standards for the risk level(s) of CSPs being produced for/dispensed to CAH patients:*

      - *Verification of compounding accuracy and sterility.*

- *Environmental quality and controls, including environmental sampling; testing and monitoring; and cleaning and disinfection;*

- *Personnel training and competency assessment, including but not limited to accuracy/precision in identifying and measuring ingredients; cleansing and garbing; aseptic manipulation skills; environmental quality and disinfection; appropriate work practices within and adjacent to the direct compounding area; verification/calibration of equipment; sterilization; and post-production quality checks.*

- *Review the CAH's procedures for maintaining the quality of CSPs during storage, transport and dispensing. Are CSPs packaged in a manner to protect package integrity and sterility? How are CSP-specific requirements with respect to motion, light exposure, temperature and potentially hazardous contents addressed? How does the CAH ensure that such information is effectively conveyed to non-pharmacy health care personnel and/or to patients/caregivers, if applicable?*

- *Review the pharmacy rules, policies and procedures for determining BUDs (for medications compounded in-house as well as from external sources).*

    - *Can the CAH demonstrate that the policies and procedures are consistent with or more stringent than the applicable USP standards?*

    - *Can it demonstrate that the pharmacy personnel assigned to determining BUDs when a manufacturer's instructions are not available have the expertise and technical support needed to properly conduct the assessments needed to make such determinations in a manner consistent with standards and hospital policies?*

- *Ask for one or more examples of situations in which a BUD had to be determined for a compounded sterile medication (CSP) based on the policy. Interview pharmacy personnel assigned to carry out this function within the CAH and/or to assess how this is done by external source(s) of CSPs. Is there evidence that the BUDs are determined consistent with the CAH's rules, policies and procedures?*

- *If the CAH obtains compounded products from an external source that is not an FDA registered outsourcing facility, can it demonstrate that it systematically evaluates and monitors whether these sources adhere to accepted professional principles for safe compounding?*

- *Does the CAH have a process for following up on adverse drug reactions and errors in medication administration reported by CAH staff in accordance with §485.635(a)(3)(v)? If any have been reported, did the CAH thoroughly assess and analyze them? Has the CAH taken effective preventive action to address identified issues?*

- Spot-check the labels of individual drug containers to verify that they contain the following minimal information:

- Each patient's individual drug container bears his/her full name and strength and quantity of the drug dispensed. Appropriate accessory and cautionary statements are included as well as the expiration date*, and, when applicable, a BUD.*.

- Each floor stock container bears the name and strength of the drug, lot and control number of equivalent, expiration date*, and, when applicable, a BUD*.

- If the unit dose system is utilized, verify that each single unit dose package bears name and strength of the drug, lot and control number equivalent, expiration date*, and, when applicable, a BUD*.

- *Spot-check* patient-specific and floor stock medications to identify expired, mislabeled or unusable medications*, including medications that are past their BUD*.

C-0277
(Rev.)

[The policies include the following:]

§485.635(a)(3)(v) Procedures for reporting adverse drug reactions and errors in the administration of drugs.

Interpretive Guidelines §485.635(a)(3)(v)

CAH staff must report all drug (medication) administration errors and all adverse drug reactions. This required reporting includes two distinct steps in the reporting of drug (medication) administration errors and adverse drug reactions. The first and highest priority reporting relates to the care of the patient, at time of occurrence. The second reporting step is related to the CAH-wide Quality Assurance review as addressed in §485.641(b).

- *Medication administration error:*

  The National Coordinating Council Medication Error Reporting and Prevention definition of a medication error is "Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use." A medication administration error is one that occurs in the phase of the medication process where the drug actually enters the patient by one of various possible routes, e.g., orally, intravenously, etc.

- *Adverse drug reaction:*

  The American Society of Health-System Pharmacists (ASHP) defines an adverse drug reaction (ADR) as "Any unexpected, unintended, undesired, or excessive response to a drug that:

  1. *Requires discontinuing the drug (therapeutic or diagnostic)*
  2. *Requires changing the drug therapy*
  3. *Requires modifying the dose (except for minor dosage adjustments)*
  4. *Necessitates admission to a hospital*
  5. *Prolongs stay in a health care facility*
  6. *Necessitates supportive treatment*
  7. *Significantly complicates diagnosis*
  8. *Negatively affects prognosis, or*
  9. *Results in temporary or permanent harm, disability, or death.*

  Consistent with the definition, an allergic reaction (an immunologic hypersensitivity occurring as the result of unusual sensitivity to a drug) and an idiosyncratic reaction (an abnormal susceptibility to a drug that is peculiar to the individual) are also considered ADRs."

Patient Care

In the case of ADRs or medication administration errors that are not caught before they reach the patient, a "report" must be made to a practitioner responsible for the care of the patient.

For example, if a medication actually is administered to a patient when it should not be, or the wrong dose is administered, or the wrong route of administration is used, etc., or a medication that should have been administered to the patient has not been administered in a timely manner, then the medication administration error has reached the patient and must be reported to the responsible practitioner.

- *If, on the other hand the wrong dose of a drug is prepared for a patient, but a nurse catches this and does not give that dose to the patient, then a medication administration error has occurred, but the error has not reached the patient, and thus does not need to be reported to the responsible practitioner.*

  .

Not every medication administration error that reaches the patient causes harm or has the potential to cause harm; it depends both on the drug and on the patient's condition.

In the case of all ADRs and any medication administration error that has harmed or has reached the patient and could potentially cause harm, the report to a practitioner must be made immediately after the staff identify the adverse reaction or (potentially) harmful error, to enable a timely assessment and intervention. The report must be made directly in a manner that confirms a practitioner received the report, for example, via a phone call. If the impact of the medication error that reached a patient is unknown, the error must be reported to a practitioner

immediately. Documentation of the error or reaction, including notification to the practitioner, must be in the patient's medical record.

Medication administration errors that have reached the patient but result in no harm and do not have the potential to cause harm can be reported to a practitioner during usual working hours. For example, if an over-the counter analgesic dose is missed during the night shift, it can be reported first thing in the morning as no further intervention would be required by the practitioner. CAHs should provide clinical staff with expected guidance on how to respond to these situations.

Quality Assurance/Improvement Reporting:

Reduction of medication administration errors and ADRs may be facilitated by effective internal CAH reporting that can be used to assess vulnerabilities in the medication process and implement corrective actions to reduce or prevent reoccurrences. To facilitate reporting, the CAH must educate staff on medication administration errors and ADRs including the criteria for those errors and ADRs that are to be reported for quality assurance/improvement purposes, and how, to whom and when they should be reported.

Reporting for quality assurance/improvement purposes covers all identified medication errors, regardless of whether or not they reach the patient, and those ADRs meeting the criteria specified in the CAH's policies.

For Information Only - Not Required/Not to be Cited

To improve staff willingness to report medication errors and ADR incidents, CAHs are encouraged to adopt a non-punitive approach that focuses on system issues rather than individual health care professionals. A non-punitive approach is likely to encourage reporting by those who otherwise may fear retribution or CAH disciplinary action.

In addition to internal staff reporting, the CAH is expected to take other steps to identify medication administration errors and ADRs. Reliance solely on staff-generated incident reporting fails to identify the majority of adverse drug events. Proactive identification includes observation of medication passes, concurrent and retrospective review of patient's clinical records, implementation of medication usage evaluations for high-alert drugs, and identification of indicator drugs that, when ordered, automatically generate a drug regimen review for a potential adverse drug event.

The CAH must assess the effectiveness of its internal reporting system to determine whether or not it is identifying as many medication errors and ADRs that would be expected for the size and scope of services provided by the CAH. In making such assessments the CAH could refer to established benchmarks or studies on error or ADR rates published in peer-reviewed journals.

For Information Only – Not Required/Not to be Cited

CAHs are encouraged to participate in state-wide and national patient safety organizations for reporting of drug administration errors, ADRs, and drug incompatibilities. National organizations include, but are not limited to, the FDA MedWatch Reporting Program and the Institute for Safe Medication Practices (ISMP) Medication Errors Reporting Program. These organizations, along with other patient safety organizations, collect and analyze data, identify trends, and provide feedback and recommendations to health care organizations to reduce the risk of medication related errors and events.

Survey Procedures §485.635(a)(3)(v)

- *Assess whether the CAH ensures that medication administration errors and ADRs are reported to practitioners in a timely manner.*
    - *Are nursing staff familiar with the concepts of medication errors that do and do not reach the patient, as well as ADRs?*
    - *Ask nursing staff what they would do in the case of a medication administration error that reaches the patient or an adverse drug event.*
    - *Ask nursing staff if they can provide examples of cases where they needed to report an ADR. Is the report to the practitioner documented in the medical record?*
    - *Review records of medication errors and ADRs to determine that they are reported immediately in accordance with written procedures, and that medications administered and/or drug reactions are promptly recorded in the patient's medical record.*
- *Can the CAH demonstrate that it has a system for reporting/identifying ADRs and medication administration errors for quality assurance/improvement purposes?*
    - *Interview CAH staff (nursing, pharmacy and medicine) to ascertain awareness of the CAH's policy on reporting medication administration errors and ADRs for quality improvement purposes*
    - *Does the CAH have evidence of training staff on reporting expectations?*
    - *Does the CAH rely only upon internal staff incident reporting or does it use other methods to identify potential/actual medication errors and ADRs, as well?*

Ask the individual responsible for the QA program to demonstrate how the CAH determines if the number of medication administration errors and ADRs reported is consistent with the size and scope of services provided by the CAH.

- *Review QA activities for medication administration errors and ADRs to determine if, upon analyses of the reports, potential corrective actions are identified and implemented, if appropriate.*

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(Rev.)

[The policies include the following:]

§485.635(a)(3)(vi) A system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel.

Interpretive Guidelines §485.635(a)(3)(vi)

This regulation requires the CAH to have a facility-wide system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel. The National Institute of Allergy and Infectious Diseases (NIAID) defines infectious disease as a disease caused by microbes that can be passed to or among humans by several methods. (http://www.niaid.nih.gov/topics/microbes/pages/glossary.aspx)

The Centers for Disease Control and Prevention (CDC) refers on its website to the following definition (from the state of New York) of a communicable disease: "an illness caused by an infectious agent or its toxins that occurs through the direct or indirect transmission of the infectious agent or its products from an infected individual or via an animal, vector or the inanimate environment to a susceptible animal or human host" (http://www.cdc.gov/tb/programs/laws/menu/definitions.htm)

*A Healthcare-associated infection (HAI) is one that develops in a patient who is cared for in any setting where healthcare is delivered (e.g., acute care hospital, chronic care facility, ambulatory clinic, dialysis center, surgical center, home) and is related to receiving health care (i.e., was not incubating or present at the time healthcare was provided). According to the CDC, healthcare-associated infections, i.e., infections that patients acquire during the course of receiving treatment for other conditions within a healthcare setting, are one of the top ten leading causes of death in the United States. Based on a large sample of U.S. acute care hospitals, a CDC survey found that on any given day, about **1 in 25** hospital patients has at least one healthcare-associated infection. There were an estimated **722,000** HAIs in U.S acute care hospitals in 2011. About **75,000** hospital patients with HAIs died during their hospitalizations. More than half of all HAIs occurred outside of the intensive care unit.*

The CAH must provide and maintain a sanitary environment to avoid sources and transmission of infections and communicable diseases. All areas of the CAH must be visibly clean and sanitary. This includes all CAH departments and off-site locations.

The CAH is expected to have a designated individual who is qualified by education and/or experience and who is responsible for the infection control program. This person must have education or experience in the principles and methods for infection prevention and control.

The CAH's program for prevention, control and investigation of infections and communicable diseases must be conducted in accordance with nationally recognized infection control practices or guidelines, as well as applicable regulations of other federal or state agencies. Examples of organizations that promulgate nationally recognized infection and communicable disease control guidelines, and/or recommendations include: the Centers for Disease Control and Prevention (CDC), the Association for Professionals in Infection Control and Epidemiology (APIC), the Society for Healthcare Epidemiology of America (SHEA), and the Association of periOperative Registered Nurses (AORN). The U.S. Occupational Health and Safety Administration (OSHA) also issues federal regulations applicable to infection control practices.

Special Challenges in Infection Control

- ***Multi-Drug Resistant Organisms (MDROs)***

  The prevention and control of MDROs is a national priority - one that requires that all healthcare facilities and agencies assume responsibility and participate in community-wide control programs. MDROs are defined as microorganisms – predominantly bacteria – that are resistant to one or more classes of antimicrobial agents. A notable example is methicillin-resistant Staphylococcus aureus (MRSA), an MDRO pathogen which is transmitted within and between healthcare facilities, as well as in the community setting. Options for treating patients with MDRO infections are very limited, resulting in increased mortality, as well as increased length of stay and costs. During the last several decades the prevalence of MDROs in hospitals has increased steadily. CAHs are encouraged to have mechanisms in place for the early identification of patients with targeted MDROs prevalent in their CAH and community, and for the prevention of transmission of such MDROs. When ongoing transmission of targeted MDROs in the CAH is identified, the infection prevention and control program should use this event to identify potential breaches in infection control practice.

- ***Ambulatory Care***

  The ambulatory care setting, including emergency departments and outpatient clinics, accounts for a growing number of patient health encounters. Ambulatory care settings present unique challenges for infection control, because patients remain in common areas for prolonged periods waiting to be seen by a healthcare professional or awaiting admission to the CAH, examination or treatment rooms are turned around quickly with limited cleaning, and infectious patients may not be recognized immediately. Furthermore, immuno-compromised patients may receive treatments in rooms among other patients who may be infectious.

  The CAH's infection prevention and control program must be designed with these ambulatory care setting challenges in mind. After assessing the likely level of risk in its

various ambulatory care settings, including off-site settings, a CAH might identify particular settings, such as the emergency department, where it would be appropriate to employ measures for screening individuals with potentially communicable diseases during their initial patient encounter, and taking appropriate control measures for those individuals who may present risk for the transmission of infectious agents by the airborne or droplet route. For example, when potentially infectious individuals are identified, prevention measures should include prompt physical separation wherever possible, implementation of respiratory hygiene/cough etiquette protocols, and/or appropriate isolation precautions based on the routes of transmission of the suspected infection.

- ***Communicable Disease Outbreaks***

Community-wide outbreaks of communicable diseases (such as measles, SARS, or influenza) present many of the same issues and require many of the same considerations and strategies as other CAH infectious disease threats. If a communicable disease outbreak occurs, an understanding of the epidemiology, modes of transmission, and clinical course of the disease is essential for responding to and managing the event. Among the infection control issues that may need to be addressed are:

- *Preventing transmission among patients, healthcare personnel, and visitors;*
- *Identifying persons who may be infected and exposed;*
- *Providing treatment or prophylaxis to large numbers of people; and*
- *Logistics issues (staff, medical supplies, resupply, continued operations, and capacity).*

Widespread pandemics present special challenges for CAH staffing, supplies, resupply, etc. CAHs should work with local, State, and Federal public health agencies to identify likely communicable disease threats and develop appropriate preparedness and response strategies.

- ***Bioterrorism***

CAH facilities would confront a set of issues similar to naturally occurring communicable disease threats when dealing with a suspected bioterrorism event. The required response is likely to differ based on whether exposure is a result of a biological release or person-to-person transmission. A variety of sources offer guidance for the management of persons exposed to likely agents of bioterrorism, including Federal agency websites (e.g., http://www.ahrq.gov/prep; http://www.usamriid.army.mil/ ; http://www.bt.cdc.gov). Because of the many similarities between man-made and naturally occurring threats, an all-hazards approach to developing emergency response plans is preferred, and CAHs are encouraged to work with their State and local emergency response agencies to develop their plans.

Surveillance & Corrective Action

In order to prevent, control and investigate infections and communicable diseases, the CAH's program must include an active surveillance component that covers both CAH patients and personnel working in the hospital. Surveillance includes infection detection, data collection and analysis, monitoring, and evaluation of preventive interventions.

The CAH must conduct surveillance on a facility-wide basis in order to identify infectious risks or communicable disease problems at any particular location. This does not imply "total hospital surveillance," but it does mean that CAHs must have reliable sampling or other mechanisms in place to permit identifying and monitoring infections and communicable diseases occurring throughout the CAH. The CAH must document its surveillance activities, including the measures selected for monitoring, and collection and analysis methods. Surveillance activities must be conducted in accordance with recognized infection control surveillance practices, such as, for example, those utilized by the CDC's National Healthcare Safety Net (NHSN).

The CAH must develop and implement appropriate infection control interventions to address issues identified through its detection activities, and then monitor the effectiveness of interventions through further data collection and analysis.

Sanitary environment

Prevention of infections includes the proper maintenance of a sanitary environment.

The CAH must provide and maintain a sanitary environment to avoid sources and transmission of infections and communicable diseases. All areas of the CAH must be visibly clean and sanitary. This includes all CAH units and off-site locations. The infection prevention and control program must include appropriate monitoring of housekeeping, maintenance (including repair, renovation and construction activities), and other activities to ensure that the CAH maintains a sanitary environment. Examples of areas to monitor would include: food storage, preparation, serving and dish rooms, refrigerators, ice machines, air handlers, autoclave rooms, venting systems, inpatient rooms, treatment areas, labs, waste handling, surgical areas, supply storage, equipment cleaning, etc. Failure to maintain a clean environment would also be a deficiency related to §485.623(b)(4), which requires the CAH to maintain clean and orderly premises.

Mitigation of Risks

The CAH must have policies and procedures in place to mitigate the risks that contribute to healthcare-associated infections. They must incorporate infection control techniques and standard precautions including, but not limited to:

- *Hand Hygiene*
- *Respiratory Hygiene/Cough Etiquette*
- *Use of Transmission-Based Precautions such as: contact precautions, droplet precautions, and airborne precautions.*

- *Use of personal protective equipment (PPE) for healthcare personnel such as gloves, gowns, masks, and respirators.*
- *Safe work practices to prevent healthcare worker exposure to bloodborne pathogens, such as safety needles and safety engineered sharps devices.*
- *Safe medication preparation and administration practices including, but not limited to:*

    - *Routine preparation of injectable medications takes place in a designated clean medication area that is not adjacent to areas where potentially contaminated items are placed;*

    - *Proper hand hygiene before handling medications;*

    - *Always disinfecting a rubber septum with alcohol prior to piercing it;*

    - *Always using aseptic technique when preparing and administering injections;*

    - *Never entering a vial with a used syringe or needle;*

    - *Never administering medications from the same syringe to more than one patient, even if the needle is changed;*

    - *Recognizing that. after a syringe or needle has been used to enter or connect to a patient's IV it is contaminated and must not be used on another patient or to enter a medication vial;*

    - *Never using medications labelled as single-dose or single-use for more than one patient. This includes ampoules, bags, and bottles of intravenous solutions. Exception: It is permissible to use medications that have been* ***repackaged*** *from a previously unopened single-dose container if the repackaging has been done by a pharmacy in a manner consistent with USP/NP Chapter <797> standards, and if the repackaged medications have subsequently been stored consistent with USP <797> and the manufacturer's package insert, provided that each repackaged dose is used for a single patient.*

    - *If multi-dose vials are used for more than one patient, they must not be kept or accessed in the immediate patient treatment area. This is to prevent inadvertent contamination of the vial through direct or indirect contact with potentially contaminated surfaces or equipment that could then lead to infections in subsequent patients. If a multi-dose vial enters the immediate patient treatment area, it must be dedicated to that patient only and discarded after use.*

    - *Never using bags or bottles of intravenous solution as a common source of supply for more than one patient.*

    - *Wearing a surgical mask when placing a catheter or injecting material into the spinal canal or subdural space.*

- *Never using insulin pens and other medication cartridges and syringes intended for single-patient-use only for more than one person.*

- *Other safe care practices, including, but not limited to:*

  - *Never using the same fingerstick device for more than one person.*

  - *Avoiding sharing blood glucose meters if possible. If they must be shared, the device must be cleaned and disinfected after every use, per manufacturer's instructions. If the manufacturer does not specify how the device should be cleaned and disinfected, it must not be shared.*

  - *Policies to ensure that reusable patient care equipment is cleaned and reprocessed appropriately before use on another patient.*

The CAH must train staff on infection control policies and practices pertinent to the staff's responsibilities and activities. For example, the CAH is expected to provide role-specific education on proper hand hygiene, standard and transmission-based precautions, asepsis, sterilization, disinfection, food sanitation, housekeeping, linen care, medical and infectious waste disposal, injection safety, separation of clean from dirty, as well as other means for limiting the spread of infections.

The CAH is also expected to provide education to patients and their visiting family members/caregivers, when applicable, about precautions to take to prevent infections.

The CAH is expected to monitor compliance with all policies, procedures, protocols, and other infection control program requirements and to conduct program evaluation and revision of the program, when indicated.

Survey Procedures §485.635(a)(3)(vi)

- *Verify that the CAH has designated a qualified individual to be responsible for the infection control program.*

- *Can the responsible individual demonstrate that the CAH's program adheres to nationally recognized practices or guidelines?*

- *Is the environment sanitary throughout the CAH?*

- *Do CAH staff employ standard precautions appropriately?*

- *Do CAH staff employ safe infection control practices for preparing and administering medications?*

- *Does the CAH perform active surveillance to identify infections?*

- *Can the responsible individual demonstrate how staff compliance with infection control program requirements is assessed and what corrective actions are taken?*

- *Can the responsible individual demonstrate that infection control incidents, problems, and trends are analyzed and that corrective actions are taken and further assessed?*

- *Is there evidence of training of staff in infection control practices pertinent to their roles?*

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C-0279
(Rev.)

[The policies include the following:]

§485.635(a)(3)(vii) *P*rocedures that ensure that the nutritional needs of inpatients are met in accordance with recognized dietary practices and the orders of the practitioner responsible for the care of the patients, and that the requirement of §483.25(i) *of this chapter* is met with respect to inpatients receiving post*hospital* SNF care.

Interpretive Guidelines §485.635(a)(3)(vii)

The dietary services must be organized, directed and staffed in such a manner to ensure that the nutritional needs of inpatients are met in accordance with practitioners' orders and recognized dietary practices. The CAH must designate a qualified individual who is responsible for dietary services. The designated individual must be qualified based on education, experience, specialized training, and, if required by State law, licensed, certified, or registered by the State.

If the CAH provides swing-bed services, then it must also comply with the following requirement for resident nutrition:

> *483.25(i): Nutrition. Based on a resident's comprehensive assessment, the facility must ensure that a resident—*
>
> *(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and*
>
> *(2) Receives a therapeutic diet when there is a nutritional problem.*

Each CAH inpatient (including residents) must have their nutritional needs met in a manner that is consistent with recognized dietary practices.

For Information Only – Not Required/Not to be Cited

Although not required by the explicit language of the regulation, CMS recommends that the CAH also ensure it meets the nutritional needs of those patients in observation status whose stay is sufficiently long that they must be fed.

According to the U.S. Department of Agriculture's (USDA) Food and Nutrition Center, the nationally recognized source for recommended dietary intakes allowances is the Institute of Medicine Food and Nutrition Board's Dietary Reference Intakes (DRIs), which are designed to provide recommended nutrient intakes for use in a variety of settings. The DRIs are a set of four reference values:

- *Recommended Dietary Allowance (RDA) is the average daily dietary intake of a nutrient that is sufficient to meet the requirement of nearly all (97-98%) healthy persons.*

- *Adequate Intake (AI) for a nutrient is similar to the Estimated Safe and Adequate Daily Dietary Intake (ESADDI) and is only established when an RDA cannot be determined. Therefore a nutrient either has an RDA or an AI. The AI is based on observed intakes of the nutrient by a group of healthy persons.*

- *Tolerable Upper Intake Level (UL) is the highest daily intake of a nutrient that is likely to pose no risks of toxicity for almost all individuals. As intake above the UL increases, risk increases.*

- *Estimated Average Requirement (EAR) is the amount of a nutrient that is estimated to meet the requirement of half of all healthy individuals in the population.*

USDA provides access to an interactive DRI tool and DRI tables at
http://fnic.nal.usda.gov/dietary-guidance/dietary-reference-intakes

Meeting individual patient nutritional needs may include the use of therapeutic diets. Therapeutic diets refer to a diet ordered as part of the patient's treatment for a disease or clinical condition, to eliminate, decrease, or increase certain substances in the diet(e.g., sodium or potassium), or to provide mechanically altered food when indicated.

Patients must be assessed for their risk for nutritional deficiencies or need for therapeutic diets and/or other nutritional supplementation. The care plan for patients identified as having specialized nutritional needs must address those needs as well as monitoring of their dietary intake and nutritional status. The methods and frequency of monitoring intake and nutritional status to be used must also be identified in the patient's care plan and could include one or more of the following, as well as other methods:

- *Patient weight (BMI, unintended weight loss or gain)*
- *Intake and output*
- *Lab values*

Examples of patients who may require a comprehensive nutritional assessment include:

- *Patients whose medical condition, surgical intervention, or physical status interferes with their ability to ingest, digest or absorb nutrients;*

- *Patients whose diagnosis or presenting signs/symptoms indicates a risk for malnutrition, (e.g., anorexia nervosa, bulimia, electrolyte imbalances, dysphagia, malabsorption, end stage organ diseases, etc.):*

- *Patients whose medical condition can be adversely affected by their nutritional intake and thus require a special diet (e.g., diabetes, congestive heart failure, patients taking certain medications, renal diseases, etc.).*

- *All patients requiring artificial nutrition by any means (e.g., enteral nutrition (tube feeding), total parenteral nutrition, or peripheral parenteral nutrition);*

All inpatients' diets, including therapeutic diets, must be provided in accordance with orders from a practitioner responsible for the care of the patient.

CAHs may choose, when permitted under State law, to designate qualified dietitians or qualified nutrition professionals as practitioners with diet-ordering privileges. In many cases State law determines what criteria an individual must satisfy in order to be a "qualified dietician;" State law may define the term to mean a "registered dietician" registered with a private organization, the Commission on Dietetic Registration, or State law may impose different or additional requirements. Terms such as "nutritionists," "nutrition professionals," "certified clinical nutritionists," and "certified nutrition specialists" are also used to refer to individuals who are not dieticians, but who may also be qualified under State law to order patient diets. It is the responsibility of the hospital to ensure that individuals are qualified under State law before appointing them to the medical staff or granting them privileges to order diets.

A CAH may provide dietary services under arrangement with a food vendor, but the CAH retains responsibility for ensuring that all dietary services meet the regulatory requirements.

Survey Procedures §485.635(a)(3)(vii)

- *Verify that the individual responsible for dietary services* is qualified based on education, experience, specialized training, and, if required by State law, is licensed, certified, or registered by the State.

- Ask the *responsible individual* to *demonstrate how the CAH uses DRIs* in its menus to meet the nutritional needs of patients.

- *From the sample of inpatient and swing-bed patient records, identify if patients were assessed using a screening mechanism for the risk of malnutrition and nutritional complications.*

- *Among patients who were assessed as having special nutritional needs , were dietary orders reflecting the assessment written and implemented?*

- *Is/was their dietary intake and nutritional status being monitored, as appropriate? If the CAH has swing bed patients, verify that it has documentation of maintaining acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible;*

- Verify that *all inpatient diets are* prescribed by *a* practitioner(s) responsible for the care of the patient. *If the State and the CAH permit dieticians or other nutrition professionals to order diets, has the CAH verified that they meet any requirements for licensure or certification under State law?*

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§485.635(b) Standard: Patient Services

(1) General

(i) **The CAH provides those diagnostic and therapeutic services and supplies that are commonly furnished in a physician's office or at another entry point into the health care delivery system, such as a low intensity hospital outpatient department or emergency department. These CAH services include medical history, physical examination, specimen collection, assessment of health status, and treatment for a variety of medical conditions.**

Interpretive Guidelines §485.635(b)(1)*(i)*

This regulation addresses the minimum level of outpatient services (with the exception of emergency services – see §485.635(b)(4)) which a CAH must provide. Such services must be provided on-site at the CAH, but may be provided either by CAH staff or under an arrangement or contract. At a minimum, the CAH must provide those diagnostic and therapeutic services and supplies which are typically found in an ambulatory healthcare setting where patients first come into contact with the healthcare delivery system. The services required to be provided must, at a minimum, reflect the scope and complexity of services provided in a physician's office or in a hospital outpatient or emergency department that furnishes low intensity (i.e., less complex) services. Such services include, but are not limited to: taking a patient's medical history; conducting a physical examination of the patient; specimen collection, assessment of health status, and treatment for a variety of medical conditions. The extent of the CAH's outpatient services is expected to be sufficient to meet the needs of the patients it services for basic

ambulatory care services. Further, the CAH's outpatient services must be integrated with its inpatient services.

For those outpatient services that fall only within the scope of practice of a physician or non-physician practitioner, in order to demonstrate compliance, a CAH physician or non-physician practitioner must be available to treat patients at the CAH when such outpatient services are provided. This requirement does not mean the CAH must have a practitioner physically present in the CAH 24 hours per day, seven days per week. See the discussion of required emergency services at §485.618(d) concerning required response times for a physician or non-physician practitioner to come to the CAH to provide medical care.

Survey Procedures §485.635(b)(1)*(i)*

- Does the CAH provide on-site outpatient services that are typical of those provided in a physician office or low intensity hospital outpatient or emergency department, including medical history, physical examination, specimen collection, assessment of health status, and treatment for a variety of medical conditions?

- Determine that the outpatient services are integrated with the appropriate CAH inpatient services in accordance with the needs of the patient care provided.

- Verify that the types and number of qualified personnel are appropriate for the scope and complexity of the outpatient services offered. Review personnel files or contracts to verify current licensure, certifications and training of staff consistent with applicable State laws.

- Verify that equipment, staff and facilities are adequate to provide the outpatient services and are in accordance with acceptable standards of practice.

C-0281

(Rev.)

[§485.635(b) Standard: Patient Services

(1) General]

(ii) The CAH furnishes acute care inpatient services.

Interpretive Guidelines §485.635(b)(1)(ii)

In accordance with §485.620(b), CAHs are required to have an average annual per acute inpatient length of stay that does not exceed 96 hours. Accordingly, CAHs are expected to provide less complex inpatient services in order to comply with the length of stay requirement. Furthermore, for each Medicare beneficiary, the CAH is required in accordance with Medicare payment law and regulations to have the practitioner who admits the beneficiary as an inpatient

certify that the beneficiary may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH. However, while it may be true that CAHs generally are not expected to handle patients requiring complex, specialized inpatient services, such as those services provided by trauma centers, or cardiac surgery centers, CAHs should be able to handle a range of patient needs requiring inpatient admission. CMS does not believe it is in the best interest of patients for them to routinely be transferred to a more distant hospital if instead their care can be provided locally without compromising quality or the length of stay requirements (78 FR 50749). Accordingly, acute inpatient services must be furnished to patients who present to the CAH for treatment so long as the CAH has an available inpatient bed and the treatment required to appropriately care for the patient is within the scope of services offered by the CAH.

Given the resources of the CAH, the needs of the community it serves, and the variable nature of a CAH's inpatient census, a CAH may not be actively treating inpatients at all times. CAHs may experience significant seasonal variations in the inpatient occupancy rates as well as variations that are a function of the size of the community in which the CAH is located.

A CAH is not required to maintain a minimum average daily census of patients receiving inpatient acute care services or maintain a minimum number of beds that are to be used for inpatient services. However, in determining compliance with this requirement factors to be considered include, but are not limited to, the following:

- *What is the volume of emergency services the CAH provides on average quarterly and annually?*
- *What is the number of certified inpatient beds in the CAH?*
- *Are there dedicated observation beds in the CAH? If so, how many compared to the number of inpatient beds?*
- *What is the average acute care occupancy rate for the CAH's inpatient beds quarterly and annually?*
- *What is the volume of acute inpatient admissions in the CAH quarterly and annually?*
- *What is the volume of patients placed in observation status in the CAH quarterly and annually?*
- *What is the percentage of emergency department patients admitted to the CAH as an inpatient versus transferred to a hospital quarterly and annually?*
- *What is the range, volume and complexity of outpatient services the CAH provides?*

While there is no specific formula for determining the number of patients a CAH is expected to admit, surveyors must be alert to disproportionate relationships among the CAH's various services. For example, if a CAH has only 4 certified beds and an average of 3 acute care inpatients per month, but has 18 observation beds that have an annual occupancy rate of 85%, has an ED staffed by physicians 24/7 and sees 9,000 ED patients/year, offers extensive and complex outpatient services, such as chemotherapy, advanced diagnostic imaging, sleep lab services, and same day surgery, but transfers to another hospital from the ED almost all patients who need inpatient admission, then these inpatient services would not be reasonably proportional to the overall mix and volume of services offered by the CAH. Based on data published by the Agency for Healthcare Research and Quality (AHRQ), in 2008 approximately

8.3 percent of emergency department (ED) visits in a rural "hospital" resulted in an inpatient admission, compared to 16 percent for non-rural hospital ED visits. Also, a higher percentage of rural ED patients were likely to be discharged – 91.7% compared to 84% for non-rural hospitals. The AHRQ rural hospital data included both hospitals and CAHs, with CAHs accounting for 51 percent of rural EDs. [2] *Other published AHRQ data indicates that, in 2009, 3 percent of patients who lived in a rural area were transferred from the ED where they presented to a hospital, compared to 1.5 percent of all patients nationally who presented to an ED.*[3]

Given that a CAH may offer fewer services than even the average rural hospital and is expected to achieve a 96-hour average length of stay or less, there is no expectation that every CAH is expected to admit 8 percent of its ED patients. This benchmark can, however, provide a useful starting point for assessing compliance.

- *Generally, if a CAH admits at least 8 percent of its ED patients annually, it would be considered compliant with the requirement to provide inpatient services and surveyors do not have to investigate further.*

- *If a CAH admits less than 8 percent of its ED patients annually, this is **not** in and of itself evidence of noncompliance. More investigation is needed to assess compliance by determining whether the volume of activity and number of staff the CAH has for its ED, other outpatient, and inpatient services are reasonably related to each other. There can be great variation among CAHs in their volume and types of activities, despite their relative similarity in size, making a "one size fits all" formula inappropriate. Researchers in one State with 79 CAHs found that they averaged 3,851 ED visits annually, but that visits for individual CAHs ranged from a low of 389, or a little more than one patient per day, to a high of 14,425, or about 40 patients per day. CAHs in this State averaged 19,705 other types of outpatient visits annually, but again the range was very large, from a low of 89 to a high of 86,367 per year. For inpatient admissions the annual average was 836, ranging from a low of 100 to a high of 3,838*[4]*. Presentation of the data found in this State is not intended to provide benchmarks for CAHs in other States, but rather to emphasize the tremendous range in the volume of activity among CAHs, even within one State.*

- *A couple of extreme but illustrative examples are presented below to indicate the types of factors to be considered when assessing whether the CAH satisfies the requirement to provide inpatient services:*

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[2] Hines, A.L., Fraze, T., and Stocks, C. *Emergency Department Visits in Rural and Non-Rural Community Hospitals, 2008*. HCUP Statistical Brief #116. June 2011. Agency for Healthcare Research and Quality, Rockville, MD. http://www.hcup-us.ahrq.gov/reports/statbriefs/sb116.pdf

[3] Kindermann, D, Mutter, R. and Pines, J.M. *Emergency Department Transfers to Acute Care Facilities, 2009.* HCUP Statistical Brief #155. May 2013. Agency for Healthcare Research and Quality, Rockville, MD. http://www.hcup-us.ahrq.gov/reports/statbriefs/sb155.pdf

[4] Moscovice, I. and Casey, M. *Rural-relevant Quality Measures for Critical Access Hospitals.* June 27, 20211 PowerPoint presentation to the Minnesota Rural Health Conference. http://www.health.state.mn.us/divs/orhpc/conf/2011/presentations/2b.pdf

- *Example #1: A CAH has a very low volume of ED visits, such as 2 or fewer patients per day on average, discharges over 90% of its annual ED patients, has a total professional health care staff that consists of one physician who spends a limited amount of time on-site, and one nurse practitioner who works days five days per week. In this case it would not be unreasonable for the CAH to admit a patient for acute inpatient services only occasionally and transfer a majority of those ED patients who require inpatient services to a hospital.*

- *Example #2: A CAH has 50 ED visits per day on average, 4 certified inpatient beds, 2 inpatient admissions per month on average (all elective surgery patients who started as outpatient cases), 10 dedicated observation beds and places about 2 ED patients per day in observation; transfers out to a neighboring hospital an average of 15 ED patients per week who require admission, has twenty physicians on staff, is performing an average of three thousand outpatient surgeries per year, provides outpatient chemotherapy, cardiology and advanced diagnostic imaging, and has a total of about 40,000 outpatient visits per year, not counting ED visits. This CAH's services are very skewed toward outpatient services, and the needs of its patient population for inpatient services do not appear to be met by the CAH. The CAH might arguably have the staff to provide a larger volume of inpatient services to many of the ED patients who require admission. The CAH would be expected to demonstrate to the surveyor why it could be reasonable for its inpatient capacity and admissions to be so disproportionately small compared to its outpatient services volume and capabilities, and in view of the needs of its ED patients for inpatient services. The surveyor would also review the medical records of a sample of ED patients transferred out to see if they required services the CAH's professional healthcare staff is not able to provide. (This case might also raise EMTALA issues related to on-call lists and appropriate transfers. See Appendix V)*

- *Example #3: A CAH has 25 ED visits per day, 25 certified beds, 23 of which, on average, are used for swing-bed services and are occupied by nursing home or skilled nursing facility residents. The CAH transfers out to a neighboring hospital an average of eight ED patients per week who require admission, and admits an average of one patient per month for acute inpatient services. The CAH has fifteen physicians on staff, is performing an average of 800 outpatient surgeries per year, provides outpatient chemotherapy, cardiology and advanced diagnostic imaging, and has a total of about 20,000 outpatient visits per year, not counting ED visits. In this situation the CAH's services are skewed towards outpatient and long-term care services and the needs of its patient population for inpatient services do not appear to be met by the CAH. The CAH would be expected to demonstrate to the surveyor why it could be reasonable for its inpatient acute care capacity and admissions to be so disproportionately small compared to its outpatient and long term care services and to the needs of its ED patients for inpatient services. The surveyor would also review the medical records of a sample of ED patients transferred out to see if they required services the CAH's professional healthcare staff is not able to provide. (This case might also raise EMTALA issues related to on-call lists and appropriate transfers. See Appendix V)*

Survey Procedures §485.635(b)(1)*(ii)*

- *Verify that the CAH is furnishing acute care inpatient services by reviewing data on the number of patients admitted over the prior year.*

- *Determine the percentage of ED visits that result in an admission to the CAH. If fewer than eight percent of ED visits lead to an inpatient admission, review data on transfers of ED patients, overall staffing, the volume and type of outpatient services offered, including observation services, and swing bed services to determine whether there is a reasonably proportionate relationship among the various services the CAH provides.*

- *Review a sample of records of the patients the CAH transferred and determine if the transfers were appropriate based on the services available at the CAH.*

C-0282
(Rev.)

§485.635(b)(2) Laboratory Services

The CAH provides basic laboratory services essential to the immediate diagnosis and treatment of the patient that meet the standards imposed under section 353 of the Public Health Service Act (42 U.S.C. 236a). (See the laboratory requirements specified in part 493 of this chapter.) The services provided include the following:

(i) Chemical examination of urine by stick or tablet method or both (including urine ketones).

(ii) Hemoglobin or hematocrit.

(iii) Blood glucose.

(iv) Examination of stool specimens for occult blood.

(v) Pregnancy tests.

(vi) Primary culturing for transmittal to a certified laboratory**.**

Interpretive Guidelines §485.635(b)(2)

Laboratory services that must be provided on-site at the CAH's main campus are the tests specified in the regulation, which would be considered the minimum necessary for diagnosis and treatment of a patient:

- Chemical examination of urine by stick or tablet method or both (including urine ketones);

- Hemoglobin or hematocrit;
- Blood glucose;
- Examination of stool specimens for occult blood;
- Pregnancy tests; and
- Primary culturing for transmittal to a certified laboratory.

These services may be provided by CAH staff or under arrangement or agreement *with a laboratory*, or through a combination of CAH staff and a laboratory under arrangement. Laboratory services, whether provided directly by the CAH or under an arrangement with a laboratory contractor, must have a current Clinical Laboratory Improvement Act (CLIA) certificate or waiver for all tests performed and meet the laboratory requirements specified in Part 493 of this chapter. Compliance with Part 493 is not assessed by CAH surveyors evaluating compliance with the CAH conditions of participation, but surveyors are expected to refer potential issues they may identify to the program responsible for CLIA certification.

Given that the CAH must provide emergency services 24 hours a day, 7 days a week, the CAH must determine which laboratory services are to be immediately available to meet the emergency needs of patients and how the services are to be provided. The emergency laboratory services available should reflect the scope and complexity of the CAH's emergency services operations.

The provision of laboratory services that exceed the minimum tests specified is optional. The scope and complexity of the CAH's laboratory service must be adequate to support the clinical services the CAH offers to patients. Additional laboratory services may be offered directly or through arrangement. The CAH should have a written description of all the laboratory services that it provides, including those delivered on routine and stat basis.

The laboratory must have written policies and procedures for the collection, preservation, transportation, receipt, and reporting of tissue specimen results.

Patient laboratory results and all other laboratory clinical patient records are considered patient medical records and the CAH must comply with the requirements of the clinical records CoP at §485.638(a)(4)(ii).

Survey Procedures §485.635(b)(2)

- Ask the CAH to identify which laboratory services it offers. Are the required lab services provided at the CAH's main campus?
- Does the CAH have a CLIA certificate or waiver, as applicable, for all laboratory tests performed in CAH facilities?

- Verify that the CAH has a procedure in place for obtaining tests that are needed but unavailable at the CAH laboratory.

- If the CAH refers specimens to another laboratory for testing, does the CAH have documentation that the referral laboratory is CLIA certified for the appropriate tests?

- Has the CAH identified laboratory services that must be available to support the emergency services the CAH provides? Ask the staff who furnish emergency services whether these laboratory services are available whenever they provide emergency services.

C-0283

(Rev.)

§485.635(b)(3) Radiology services. Radiology services furnished by the CAH are provided by personnel qualified under State law, and do not expose CAH patients or personnel to radiation hazards.

Interpretive Guidelines §485.635(b)(3)

Radiologic services encompass many different modalities used for the purpose of medical imaging. Each type of technology gives different information about the area of the body being studied or treated, related to possible disease, injury, or the effectiveness of medical treatment. All the modalities use some form of radiation, such as ionizing radiation (radiography, computed tomography, fluoroscopy), which has enough energy to potentially cause damage to DNA, and other forms of radiation (ultrasound, magnetic resonance imaging) to view the human body in order to diagnose, monitor, or treat medical conditions.

Radiological services furnished by the CAH may be provided by CAH staff or under arrangement. The CAH must maintain and have available diagnostic radiological services to support the services the CAH provides to meet the needs of its patients. These services must be available at all times the CAH provides services, including emergency services. The CAH has the flexibility to choose the types and complexity of radiologic services offered. They may offer only a minimal set of services or a more complex range of services (including nuclear medicine).

All radiological services provided by the CAH, including diagnostic, therapeutic, and nuclear medicine, must be provided in accordance with acceptable standards of practice and must meet professionally approved standards for safety. The scope and complexity of radiological services offered should be specified in writing and approved by the governing body (or responsible individual).

Acceptable standards of practice include maintaining compliance with appropriate Federal and State laws, regulations and guidelines governing radiological services, including facility licensure and/or certification requirements, as well as any standards and recommendations

promoted by nationally recognized professions such as the American Medical Association, Radiological Society of North America, Alliance for Radiation Safety in Pediatric Imaging, American Society of Radiologic Technologists, American College of Cardiology, American College of Neurology, American College of Physicians, American College of Radiology, etc.

Qualified Radiologic Personnel

There *must* be written policies that are developed and approved by the governing body or responsible individual and are consistent with State law, that designate which personnel are qualified to use the radiological equipment *and* administer procedures.

When telemedicine is used to provide teleradiology services, radiologists who interpret radiological tests must satisfy the telemedicine privileging requirements §485.616(c)(3).

In addition to radiologists, there are other types of healthcare personnel who, depending on State law and the scope and complexity of the CAH's radiologic services, may be involved in the delivery of radiologic services in the CAH, including radiologic technologists and medical physicists. Radiologic technologists perform diagnostic imaging examinations and administer radiation therapy treatments. They are educated in anatomy, patient positioning, examination techniques, equipment protocols, radiation safety, radiation protection and basic patient care.

For Information Only – Not Required/Not to be Cited

Well-designed radiologic services include a medical physicist, who, in conjunction with the person responsible for radiologic services, performs or supervises the pertinent procedures necessary to assure the safe and effective delivery of radiation to achieve a diagnostic or therapeutic result. The responsibilities of the medical physicist include: protection of the patient and others from potentially harmful or excessive radiation; establishment of adequate protocols to ensure accurate patient dosimetry; the measurement and characterization of radiation; the determination of delivered dose; advancement of procedures necessary to ensure image quality; development and direction of quality assurance programs; and assistance to other health care professionals in optimizing the balance between the beneficial and deleterious effects of radiation (www.aapm.org). CAHs are encouraged to involve a medical physicist in the calibration of the imaging equipment and monitoring of radiation dosage exposures.

Safety from Radiation Hazards

The CAH must adopt and implement policies and procedures that ensure safety from radiation hazards for patients and personnel. The CAH must implement and ensure compliance with its established safety standards. The policies *must address* at least the following:

- Adequate radiation shielding for patients, personnel and facilities, which includes:
    - Shielding built into the CAH's physical plant, as appropriate;

- Types of personal protective shielding to be used, under what circumstances, for patients, including high risk patients as identified in radiologic services policies and procedures, and CAH personnel;

- Types of containers to be used for various radioactive materials, if applicable, when stored, in transport, in use, and when disposed;

- Clear signage identifying hazardous radiation areas;

- Labeling of all radioactive materials, including waste, with clear identification of all material(s);

- Transportation of radioactive materials between locations within the CAH;

- Security of radioactive materials, including determining who may have access to radioactive materials and controlling access to radioactive materials;

- Periodic testing of equipment for radiation hazards;

- Periodic checking of staff regularly exposed to radiation for the level of radiation exposure, via exposure meters or badge tests;

- Storage of radio nuclides and radio pharmaceuticals as well as radioactive waste; and

- Disposal of radio nuclides, unused radio pharmaceuticals, and radioactive waste.

Radiologic Equipment Maintenance

The CAH must have policies and procedures in place to ensure that periodic inspections of radiology equipment are conducted, and that problems identified are corrected in a timely manner. The CAH must ensure that equipment is inspected *and maintained* in accordance with Federal and State laws and regulations, as applicable, and *the manufacturer's recommendations*. The CAH must have a system in place to correct identified problems. The CAH must have evidence of its inspections and corrective actions.

Radiology Records

The CAH radiology records are to be treated in the same manner as any other part of a medical record. The medical records CoP at §485.638(a)(4)(ii) requires that the CAH maintain reports of physical examinations, diagnostic and laboratory test results, and consultative findings.

Survey Procedures §485.635(b)(3)

- Interview the person responsible for radiologic services.

- Ask what radiologic services the CAH offers at its main campus. At off-site locations ask how the CAH ensures patient needs for radiologic services are met, if applicable.

- Ask how the CAH ensures that radiologic services are provided consistent with acceptable standards of practice.

- Safety:

  - Determine if the radiologic services staff is familiar with the policies and procedures related to safety.

  - Verify that patient shielding (aprons, etc.) are properly maintained and routinely inspected by the CAH.

  - Observe areas where radiologic testing is done and check for safety problems.

  - Verify that hazardous materials are clearly labelled. Review records to verify that they are tracked, handled and stored properly in a safe manner with the requisite containers.

    - Review records to verify that periodic tests of radiology personnel by exposure meters or test badges are performed.

- Equipment maintenance:

  - Review the inspection records to verify that periodic inspections *and maintenance* are conducted *in accordance with the manufacturer's recommendations* .

  - Determine whether any problems identified are properly corrected in a timely manner and the correction is maintained over time.

- Qualified Personnel:

  - Are studies interpreted only by qualified staff approved to do so by the CAH's governing body or responsible individual?

  - Determine which staff are using various pieces of radiological equipment and/or administering patient procedures. Review their personnel folders to determine if they meet the qualifications for tasks they perform, as established in the CAH's policies and consistent with state law.

  - Ask staff to explain the protocol for the procedures/studies they administer. Ask to see the CAH's written protocols and verify that the staff is adhering to them.

C-0284
(Rev.)

§485.635(b)(4) Emergency procedures. In accordance with the requirements of §485.618, the CAH provides medical services as a first response to common life-threatening injuries and acute illness.

Interpretive Guidelines §485.635(b)(4)

Emergency services must be provided by the CAH at the CAH campus either by CAH staff or *by individuals providing services* under arrangement or agreement. The individuals providing the services must have the ability to recognize a patient's need for emergency care at all times. The CAH must provide *medically appropriate* initial interventions, treatment and stabilization of any patient who requires emergency services.

Survey Procedures §485.635(b)(4)

The survey procedures for §485.618 *apply*.

C-0287
(Rev.)

[§485.635(c)(1) The CAH has agreements or arrangements (as appropriate) with one or more providers or suppliers participating under Medicare to furnish other services to its patients, including—]

(i) **Services of doctors of medicine or osteopathy;**

§485.635(c)(2) If the agreements or arrangements are not in writing, the CAH is able to present evidence that patients referred by the CAH are being accepted and treated.

Interpretive Guidelines §485.635(c)(1)(i) & §485.635(c)(2)

In accordance with §485.631(a)(1), the CAH is required to have at least one doctor of medicine or osteopathy (MD or DO) on its staff who is responsible for the functions described in §485.631(b). CAHs are free to have additional MDs or DOs on staff, part- or full-time. MDs and DOs who have been credentialed and privileged to provide services on-site at the CAH are part of the CAH's professional healthcare staff, even if they are not at the CAH full-time; they would not be considered to be providing services under an arrangement and would not be covered by these regulatory provisions. These regulations also do not apply to MDs and DOs who provide telemedicine services to the CAH's patients, even when they are provided under arrangement. (See §485.616(c) and §485.635(c)(5) concerning telemedicine requirements.)

Under §485.635(c)(1)(i) & §485.635(c)(2), the CAH must have policies and procedures for referring patients it discharges who need additional specialized MD or DO services not available at the CAH. The policies and procedures must at a minimum identify the services for which the CAH has referral arrangements or agreements, as well as the information to be provided to referred patients. MDs and DOs to whom the CAH refers its patients must participate in Medicare.

The CAH is not required to have referral arrangements in writing, but if it does not, then it must be able to document that patients it has referred to an outside MD or DO have been offered appointments and treatment.

Survey Procedures §485.635(c)(1)(*i*) *& §485.635(c)(2)*

- *Verify that the CAH has arrangements with one or more MDs or DOs for referral of discharged CAH patients who need medical services not available at the CAH.*

- *Are the referral arrangements in writing? If not, can the CAH document that patients referred to an outside MD or DO have been offered appointments and treatment?*

- *Does the CAH have policies and procedures addressing referral of discharged patients? Are the CAH's practitioners and staff who handle the discharge of patients familiar with these policies and procedures?*

C-0288
(Rev.)

[§485.635(c)(1) The CAH has agreements or arrangements (as appropriate) with one or more providers or suppliers participating under Medicare to furnish other services to its patients, including—]

(*ii*) Additional or specialized diagnostic and clinical laboratory services that are not available at the CAH; and

§485.635(c)(2) If the agreements or arrangements are not in writing, the CAH is able to present evidence that patients referred by the CAH are being accepted and treated.

Interpretive Guidelines §485.635(c)(1)(*ii*) *& §485.635(c)(2)*

In accordance with §485.635(b)(2), the CAH is required to furnish, either directly by the CAH staff, under arrangement or agreement, or through a combination of CAH staff and a laboratory under arrangement basic laboratory services essential to the immediate diagnosis and treatment of the patient that meet the standards imposed under section 353 of the Public Health Service Act (42 U.S.C. 236a). These services must be provided on-site at the CAH and may be provided either by CAH staff or under an arrangement with a laboratory. The CAH is also free to provide

additional laboratory services on-site, beyond the minimum required services. The provision at §485.635(c)(1)(ii) does not apply to laboratory services provided on-site.

Instead, this provision addresses the requirement for the CAH to have an arrangement or agreement, as appropriate, with with a laboratory that can provide additional or specialized clinical laboratory services that are not available at the CAH. The arrangement or agreement may provide either for the CAH to draw the specimens to be examined and send them to the outside laboratory. The CAH is not required to have a written agreement or arrangement, but if it does not, it is expected to be able to document that an outside laboratory to which it sends specimens provides the CAH with test results.

Laboratories that provide additional diagnostic and clinical laboratory services to a CAH *under* agreement or arrangement must *have a current Clinical Laboratory Improvement Act (CLIA) certificate or waiver for all tests performed and meet the laboratory requirements specified in Part 493 of this chapter. The CAH is expected to have evidence of the outside laboratory to which it refers patients holding a current CLIA certificate or waiver.*

The CAH must have policies and procedures for additional or specialized laboratory services provided under arrangement or agreement which address at least the following: the specific laboratory services provided under arrangement; and the collection, preservation, transportation, receipt, and reporting of tissue specimen results.

Likewise, although the CAH is expected to provide radiology services in accordance with §485.635(b)(3), it is also expected to have an arrangement or agreement, as appropriate, with other providers or suppliers of diagnostic imaging services, including advanced diagnostic imaging services, such as magnetic resonance imaging, computed tomography, etc. The CAH is not required to have a written agreement or arrangement, but if it does not, it is expected to be able to document that an outside diagnostic imaging facility to which it sends patients provides the CAH with the resulting studies and reports.

Patient diagnostic imaging studies and reports, laboratory results and all other laboratory clinical patient records must be included in the patient's medical record and meet all requirements at §485.638(a)(4)(ii).

Survey Procedures §485.635(c)(1)(*ii*) *& §485.635(c)(2)*

- *Verify that the CAH has an agreement or arrangement with an outside laboratory and an outside diagnostic imaging facility for services not provided in the CAH.*

- *Ask the CAH how it ensures that the laboratory with which it has an agreement or arrangement holds the necessary CLIA certification.*

- *If the agreement or arrangement is not in writing, can the CAH document that it is sending specimens to an outside laboratory and patients to an outside diagnostic imaging facility when needed, and that it is receiving test results?*

- *Do policies and procedures address which imaging and lab services are provided under arrangement, as well as, for lab services, collection, preservation, transportation, receipt, and reporting of tissue specimen results?*

C-0289
(Rev.)

[§485.635(c)(1) The CAH has agreements or arrangements (as appropriate) with one or more providers or suppliers participating under Medicare to furnish other services to its patients, including—]

(i*ii*) Food and other services to meet inpatients' nutritional needs to the extent these services are not provided directly by the CAH.

Interpretive Guidelines §485.635(c)(1)(iii)

If the CAH does not provide all food and other services required to meet the nutritional needs of the CAH's inpatients using CAH staff, then the CAH must provide these services under an agreement or arrangement..

The CAH must assure that dietary services provided under an agreement or arrangement are provided in accordance with the CAH's policies adopted as required by §485.635(a)(3)(vii). Unless the CAH is a grandfathered co-located CAH (see §485.610(e)(1)) that has an arrangement with the co-located facility to provide food services to the CAH's inpatients, it is expected that the CAH's vendor provides dietary services on-site at the CAH in order to meet the needs of the CAH's inpatients. Surveyors assess compliance with the requirements of §485.635(a)(3)(vii) in the same manner, regardless of whether the services are provided by CAH staff or a vendor. In the case of a grandfathered co-located CAH that obtains food services from the co-located facility, surveyors must assess the food service operations in the co-located facility as part of the CAH survey.

Survey Procedures §485.635(c)(1)(i*ii*)

- *Verify that the CAH has an agreement or arrangement with a vendor to provide dietary services to inpatients if the CAH does not use its own staff to provide these services.*

C-0291
(Rev.)

§485.635(c)(3) The CAH maintains a list of all services furnished under arrangements or agreements. The list describes the nature and scope of the services provided.

Interpretive Guidelines §485.635(c)(3)

The CAH must maintain a list of all patient care services furnished by the CAH through arrangements or agreements. The list must be updated each time a contracted service is added or removed. For each service the list must include, at a minimum, the following information:

- *The service(s) being offered;*
- *The individual(s) or entity providing the service(s);*
- *Whether the services are offered on- or off-site;*
- *Whether there is any limit on the volume or frequency of the services provided; and*
- *When the service(s) are available.*

Survey Procedures §485.635(c)(3)

- Review the list of contracted services and verify that *it contains all required information*.
- *Ask the CAH for evidence that the list is updated whenever there are changes.*
- *Ask various CAH staff during the course of the survey whether they work directly for the CAH or some other entity; check that services provided by staff employed by outside entities are on the list of contracted services.*

C-0292
(Rev.)

§485.635(c)(4) The person principally responsible for the operation of the CAH under §485.627(b)(2) of this chapter is also responsible for the following:

(i) Services furnished in the CAH whether or not they are furnished under arrangements or agreements.

(ii) Ensuring that a contractor of services (including one for shared services and joint ventures) furnishes services that enable the CAH to comply with all applicable conditions of participation and standards for the contracted services.

Interpretive Guidelines §485.635(c)(4)

The person principally responsible for the operation of the CAH, in accordance with §485.627(b)(2), i.e., the CAH's Chief Executive Officer (CEO), is responsible for the operation of all patient care services furnished at the CAH. This includes services provided directly by CAH staff and services provided by the CAH under arrangement or agreement. It includes not only care provided directly to patients, but also services related to patient care, such as environmental cleaning, instrument cleaning and sterilization, laundry, pharmacy services, laboratory services, etc. (This requirement for the CEO to be responsible does not relieve the CAH's governing body of its ultimate responsibility for the CAH's total operation in those CAHs where there are both a governing body and a CEO.)

The CEO must take actions to assure that all services furnished by the CAH through a contractor comply with the applicable requirements of the CAH's CoPs. When assessing compliance of a service provided by a contractor with the CoPs, deficiencies cited under other CoPs warrant a citation of this requirement, because the CEO has failed to assure that the contractor provides services in a manner that allows the CAH to comply with the CoPs.

Survey Procedures §485.635(c)(4)(i)

- *Ask the CAH's CEO to demonstrate how he or she provides oversight of all contracted services related to patient care.*

- *Ask for specific examples of how the CEO assures that services furnished in the CAH comply with the CoPs (*e.g. policies and procedures, by-laws, etc.) that the individual responsible for its operations is responsible for all services provided through arrangements or agreements.

C-0294
(Rev.)

§485.635(d) Standard: Nursing Services

Nursing services must meet the needs of patients.

(1) A registered nurse must provide (or assign to other personnel) the nursing care of each patient, including patients at a SNF level of care in a swing-bed CAH. The care must be provided in accordance with the patient's needs and the specialized qualifications and competence of the staff available.

Interpretive Guidelines §485.635(d) & (d)(1)

In order to meet the needs of patients, nursing services must be a well-organized service of the CAH. The CAH designates an individual who is responsible for nursing services, including development of policies and procedures for nursing services. The designated individual is generally expected to be a registered nurse. Various titles may be used for the responsible nurse leader may have (e.g., director of nursing services, nurse executive, chief nursing officer, or nurse manager). The nurse leader is responsible for the overall management and evaluation of nursing care in the CAH, including, but not limited to:

- *Development and maintenance of nursing policies and procedures;*
- *Supervision of nursing staff, either directly, or, depending on the size of the CAH, indirectly through other nursing managers; and*
- *Ongoing review and analysis of the quality of nursing care.*

As required at §485.631(a)(5), the CAH must have a registered nurse, clinical nurse specialist, or licensed practical nurse on duty whenever the CAH has one or more inpatients (including patients in a swing bed receiving long term care services).

The CAH must also ensure that, for outpatient nursing services, appropriate nursing staff are available in accordance with State law and CAH policy.

For both inpatient and outpatient services there must be sufficient numbers of supervisory and non-supervisory nursing personnel with the appropriate education, experience, licensure *(as applicable),* competence and specialized qualifications to *respond to the nursing needs of the patient population of each CAH department or nursing unit. Staffing schedules must be reviewed and revised as necessary to meet patient care needs and to make adjustments for nursing staff absenteeism.*

The CAH must have a procedure for assigning and coordinating the nursing care for every CAH patient. A registered nurse must either provide directly, or assign to other staff, the required nursing care for each CAH patient, including patients receiving swing bed services. The RN making the assignment must consider the specialized qualifications and competence of the CAH's available nursing staff in order to meet patients' nursing care needs. Nursing care duties may be assigned to appropriate personnel, such as a licensed practical nurse, nursing assistant or nurse's aide, so long as such assignment is consistent with state law and the individual has the qualifications and competence to perform the assigned tasks.

The CAH *must* ensure that all CAH *nursing* staff are adequately trained and oriented*, aware of CAH nursing policies* and procedures, supervised, and that their clinical activities are evaluated. *If temporary outside agency nurses are employed to address temporary nurse staffing needs, determine how are these nurses oriented and supervised. (Note that regular nursing services may be provided under arrangement instead of using CAH employees, but in this case the CAH is responsible for the ongoing training and supervision of these regular nursing staff.)*

Survey Procedures §485.635 ***(d)(1)***

- *Determine whether an RN has been designated responsible for nursing services at the CAH.*

- Observe the nursing care in progress to determine the adequacy of staffing and to assess the delivery of care. Sources of information to use in the evaluation of the nursing services are: staffing schedules, nursing care plans *for inpatients* credentialing and training files (including contracted staff), and QA activities and reports.

- *Interview the registered nurse responsible for nursing services and ask the following--*

  - *How are the nursing needs of patients determined? Who makes this determination?*

  - *How are staff assigned to provide nursing care to patients?*

  - *How does the CAH ensure that care provided meets the needs of each patient?*

  - *How are staff trained and oriented? If temporary outside agency nurses are used, how are they oriented and supervised?*

- *Review nursing assignments in one or more inpatient units, the emergency department, and one other outpatient department. Did an RN make the assignments? Was the complexity of patient care needs and the competence and specialized qualifications of the nursing staff taken into consideration?*

- *Review written staffing schedules; do they adhere to the CAH's policies and procedures for staffing levels and types of nursing personnel?*

- *Verify that there is supervision of personnel performance and nursing care for each nursing unit.*

- *If there are temporary agency nurses providing services, interview one or more to determine if they are familiar with the nursing policies and procedures of the unit or department where they are working.*

- *Review personnel files to determine that nursing staff have required licenses and competencies.*

C-0296
(Rev.)

485.635(d)(2) A registered nurse or, where permitted by State law, a physician assistant, must supervise and evaluate the nursing care for each patient, including patients at a SNF level of care in a swing-bed CAH.

Interpretive Guidelines §485.635(d)(2)

The nursing care of each patient of the CAH must be supervised by a registered nurse or *a physician assistant where permitted by State law. Even where permitted under State law, a CAH is not required to have nursing care supervised by a physician assistant. This is simply an option for the CAH.*

For inpatients, including patients receiving long term care services in swing beds, evaluation of their nursing care includes evaluating the care for each patient upon admission and, when appropriate, on an ongoing basis in accordance with accepted standards of nursing practice and CAH policy. Evaluation would include assessing the patient's care needs, patient's health status/conditioning, as well as the patient's response to interventions.

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Nursing care plans are not developed for outpatients, so the focus of the evaluation would be on adherence to generally acceptable standards of nursing care practice, including requirements at §485.635(d)(3) for medication administration.

Survey Procedures §485.635(d)(2)

- Determine that a registered nurse (or *physician assistant* where *permitted by* State law *and CAH policy*) supervises and evaluates the nursing care for each patient.

- Interview *one or more registered nurses* (or *physician assistants, if applicable)* who supervis*e* and evaluat*e* the nursing care for CAH patients.

C-0297
(Rev.)

485.635(d)(3) All drugs, biologicals, and intravenous medications must be administered by or under the supervision of a registered nurse, a doctor of medicine or osteopathy, or, where permitted by State law, a physician assistant, in accordance with written and signed orders, accepted standards of practice, and Federal and State laws.

Interpretive Guidelines §485.635(d)(3)

As required at §485.635(a)(3)(iv), the CAH must have written policies and procedures for the administration of all drugs and biologicals that adhere to accepted standards of practice and Federal and State laws. In accordance with §485.635(d)(3), all medication administration must be consistent with accepted standards of practice, as well as Federal and State laws. Examples of nationally recognized organizations with expertise in medication administration include, but are not limited to:

- *National Coordinating Council for Medication Error Reporting and Prevention (www.nccmerp.org);*
- *Institute for Healthcare Improvement (http://www.ihi.org/ihi) ;*
- *U.S Pharmacopeia (www.usp.org) ;*
- *Institute for Safe Medication Practices, which offers guidelines specifically on timely medication administration, which can be found at: www.ismp.org/Newsletters/acutecare/articles/20110113.asp;*
- *Infusion Nurses Society (http://www.ins1.org).*

In addition, the Centers for Disease Control and Prevention (CDC) publishes evidenced-based practice guidelines and recommendations on medication preparation and administration practices, designed to reduce the risk of infection associated with these activities.

Who May Administer Medications?

Drugs and biologicals, including intravenous (IV) medications, must be administered by, or under the supervision of, an MD or DO; an RN, or, where permitted by State law, a PA. Other personnel, such as LPN's, may administer medications when permitted by State law and CAH policy, so long as they are supervised by an MD, DO, RN or, where permitted by State law, a PA. The CAH's written policies must delineate the categories of clinical staff authorized to administer medication at the CAH.

Medication Orders

Drugs and biologicals, including intravenous (IV) medications, may only be administered in accordance with orders written and signed by a practitioner who is authorized by CAH policy, and in accordance with State law, to write orders and who is responsible for the care of the patient as specified under §485.631(b)(1)(iii).

Accepted standards of practice

Based on accepted standards of practice for medication administration, the CAH must assure compliance with the following requirements concerning:

- *Minimum content of medication orders;*
- *Policies and procedures for verbal and standing orders;*

- *Self-administration of medications, if the CAH permits this;*
- *Training;*
- *Basic Safe Practices;*
- *Timing of Medication Administration;*
- *Assessment/Monitoring of Patients Receiving Medications;*
- *Intravenous (IV) medications; and*
- *Documentation*

Content of the medication order

In accordance with accepted standards of practice, the minimum elements that must be present in orders for all drugs and biologicals to ensure safe preparation and administration include:

- *Name of patient;*

- *Age and weight of patient, to facilitate dose calculation when applicable. Policies and procedures must address weight-based dosing for pediatric patients as well as in other circumstances identified in the CAH's policies. (Note that dose calculations are based on metric weight (kg, or g for newborns). If a CAH permits practitioners to record weight in either pounds or using metric weight, the opportunity for error increases, since some orders would require conversion while others would not. Accordingly, CAHs must specify a uniform approach to be used by prescribing practitioners. For example, a CAH could require all prescribers to use pounds or ounces and have the electronic ordering system or the pharmacy convert to metric);*

- *Date and time of the order;*

- *Drug name;*

- *Exact strength or concentration, when applicable;*

- *Dose, frequency, and route;*

- *Dose calculation requirements, when applicable;*

- *Quantity and/or duration, when applicable;*

- *Specific instructions for use, when applicable; and*

- *Name of the prescriber*

Verbal and Standing Orders

Although the regulation requires medication administration be based on a written, signed order, this does not preclude the CAH from using:

- *Verbal orders; or*

- *Standing orders.*

In the case of both verbal and standing orders, a practitioner responsible for the care of the patient must authenticate the order in writing as soon as possible after the fact. The CAH must adopt policies and procedures regarding verbal and standing orders. (Note that CAHs that have a distinct part psychiatric and/or rehabilitation unit must follow the hospital CoPs for all services provided in those units, including the hospital requirements for verbal and standing orders.)

For verbal orders, *CAH policies must, at a minimum, address the following:*

- *Describe situations in which verbal orders may be used, as well as limitations or prohibitions on their use;*

- *Provide a mechanism to establish the identity and authority of the practitioner issuing a verbal order;*

- *List the elements required for inclusion in the verbal order process;*

  Establish protocols for clear and effective communication and verification of verbal orders. CMS expects nationally accepted read-back verification practice to be implemented for every verbal order..

- *Identify the categories of clinical staff who are authorized to receive and act upon a verbal order.*

- *Provide for prompt documentation in the medical record of the receipt of a verbal order.*

For standing orders, *CAH policies must, at a minimum, address the following:*

- *The process by which a standing order is developed; approved; monitored; evaluated and updated when needed;*

- *For each standing order, which staff may initiate it and under what circumstances; (under no circumstances may a CAH use standing orders in a manner that requires any staff not authorized to write patient orders to make clinical decisions outside of their scope of practice in order to initiate such orders); and*
- *The requirements for subsequent authentication by a practitioner responsible for the care of the patient.*

For Information Only – Not Required/Not to Be Cited

Verbal Orders

CAHs are encouraged to minimize the use of verbal orders as much as possible and not permit their use merely as a convenience to practitioners. Verbal orders carry a higher risk of miscommunication and error and thus should only be used when necessary. With the increasing use of Electronic Health Records and Computerized Physician Order Entry systems, the need for verbal orders is expected to decline.

Standing Orders

There is no standard definition of a "standing order" in the healthcare community, but the terms "pre-printed standing orders," "electronic standing orders," "order sets," and "protocols for patient orders" are various ways in which the term "standing orders" has been applied. The lack of a standard definition for these terms and their interchangeable and indistinct use by health care facilities professionals may result in confusion

CAHs are encouraged to focus on those situations where their use of "standing orders" permits treatment that is outside the scope of practice of a non-practitioner, such as a nurse, to be initiated by the non-practitioner without a prior specific order from a practitioner responsible for the care of the patient. Such treatment is typically initiated when a patient's condition meets certain pre-defined clinical criteria. For example, standing orders may be initiated as part of an emergency response or as part of an evidence-based treatment regimen where it is not practical for a nurse to obtain either a written, authenticated order or a verbal order from a practitioner prior to the provision of care.

Appropriate use of standing orders can contribute to patient safety and quality of care by promoting consistency of care, based on objective evidence. Much of the evidence on the effectiveness of standing orders has been narrowly focused on aspects of their use by Rapid Response Teams addressing inpatient emergencies. However, standing orders may also be appropriate in other clinical circumstances, including, but not limited to:

- *Protocols for triaging and initiating required screening examinations and stabilizing treatment for emergency department patients presenting with symptoms suggestive of acute asthma, myocardial infarction, stroke, etc. (This does not relieve a CAH of its obligations under the Emergency Medical Treatment and Labor Act (EMTALA) to have qualified medical personnel complete required screening and, when applicable, provide stabilizing treatment in a timely manner.)*

- *Post-operative recovery areas.*

- *Timely provision of immunizations, such as certain immunizations for newborns, for which there are clearly established and nationally recognized guidelines.*

CAHs are encouraged to address at least the following in their standing orders policies and

procedures:

- *Review and approval of each standing order by a multi-disciplinary team that includes the following individuals or their designees: the MD/DO providing medical direction and the individuals designated responsible for nursing and pharmacy services.*

    - *The CAH should be able to document that the standing order is consistent with nationally recognized and evidence-based guidelines. This does not mean that there must be a template standing order available in national guidelines which the CAH copies, but rather that the content of each standing order the CAH uses is consistent with nationally recognized, evidence-based guidelines for providing care.*

- *Clear, specific criteria in the protocol for the order for authorized non-practitioners to initiate the execution of the order, for example, the specific clinical situations, patient conditions, or diagnoses by which initiation of the order would be justified.*

- *Instructions that the clinical staff receive on the conditions and criteria for using standing orders as well as any individual staff responsibilities associated with the initiation and execution of standing orders.*

- *At least annual review of each standing order as well as a process for the identification and timely completion of any requisite updates, corrections, modifications, or revisions based on changes in nationally recognized, evidence-based guidelines. Among other things, reviews should consider:*

    - *Whether there have been any preventable adverse patient events resulting from the use of the standing order, and if so, whether changes in the order would reduce the likelihood of future similar adverse events. The review would not be expected to address adverse events that are a likely outcome of the course of patient's disease or injury, even if the order was applied to that patient, unless there is concern that use of the standing order exacerbated the patient's condition; and*

    - *Whether a standing order has been initiated and executed in a manner consistent with the order's protocol, and if not, whether the protocol needs revision and/or staff need more training in the correct procedures.*

Self-Administration of Medications

The CAH may choose to allow practitioners to write orders allowing patients to self-administer CAH-issued drugs and biologicals or drugs the patient has brought from home into the CAH for use during their stay, e.g., an insulin pen for a diabetic patient. If the CAH does permit this, it must develop policies and procedures for self-administration of drugs by patients or their informal caregivers.

Training

Medication administration education and training is typically included in the CAH's orientation or other continuing education programs for nursing staff and other authorized healthcare personnel. Training or continuing education topics regarding medication administration may include but are not limited to the following:

- *Safe handling and preparation of drugs, biologicals, and IV medications;*
- *Knowledge of the indications, side effects, drug interactions, compatibility, and dose limits of administered medications;*
- *Equipment, devices, special procedures, and/or techniques required for medication administration;*

Policies and procedures must address the required components of the training and if the training provided during CAH orientation imparts sufficient education or whether ongoing in-services or continuing education will be required to demonstrate competence.

Basic safe practices for medication administration

The CAH's policies and procedures must reflect accepted standards of practice that require the following be confirmed prior to each administration of medication (often referred to as the "five rights" of medication administration practice):

- *Right patient: the patient's identity— acceptable patient identifiers include, but are not limited to: the patient's full name; an identification number assigned by the CAH; or date of birth. Identifiers must be confirmed by patient wrist band, patient identification card, patient statement (when possible) or other means outlined in the CAH's policy. The patient's identification must be confirmed to be in agreement with the medication administration record and medication labeling prior to medication administration to ensure that the medication is being given to the correct patient.*
- *Right medication: the correct medication, to ensure that the medication being given to the patient matches that prescribed for the patient and that the patient does not have a documented allergy to it;*
- *Right dose: the correct dose, to ensure that the dosage of the medication matches the prescribed dose, and that the prescription itself does not reflect an unsafe dosage level (i.e., a dose that is too high or too low);*
- *Right route: the correct route, to ensure that the method of administration – orally, intramuscular, intravenous, etc., is the appropriate one for that particular medication and patient; and*

- *Right time: the appropriate time, to ensure adherence to the prescribed frequency and time of administration.*

Note: the "5 rights" focus specifically on the process of administering medications. The medication process is generally recognized as consisting of five stages: ordering/prescribing; transcribing and verifying; dispensing and delivering; administering; and monitoring/reporting. Errors may occur in other components of the process, even when there is strict adherence to the "5 rights" of medication administration, for example when there has been a prescribing or a dispensing error. CAHs are also expected to comply with requirements for pharmacy services at §485.635(a)(3)(iv), using a systems approach to all components of the medication process.

For Information – Not Required/Not to be Cited

Recent literature identifies up to nine "rights" of medication administration including:*

Right patient
Right drug
Right route
Right time
Right dose
Right documentation
Right action (appropriate reason)
Right form
Rght response

However, other sources refer to 8 or 10 "rights, and some of these topics, such as right action, appear to involve prescribing and/or dispensing. Accordingly, there does not (yet) appear to be consensus about expanding beyond the 5 "rights."

**Reference: Elliott, M. and Lis, Y. (2010). The Nine Rights of Medication Administration: An Overview. British Journal of Nursing, Vol. 19, 5, 300-305.*

CAHs are encouraged to promote a culture in which it is not only acceptable, but also strongly encouraged, for staff to bring to the attention of the prescribing practitioner questions or concerns they have regarding medication orders. Any questions about orders for drugs or biologicals are expected to be resolved promptly.

Timing of Medication Administration

Appropriate timing of medication administration must take into account the complex nature and variability among medications; the indications for which they are prescribed; the clinical situations in which they are administered; and the needs of the patients receiving them. The chemical properties, mechanism of action, or therapeutic goals of some medications require administration at the exact time prescribed, or within a narrow window of its prescribed

scheduled time, to avoid compromising patient safety or achievement of the intended therapeutic effect. However, the therapeutic effect of many other medications is uncompromised by a much broader window of time for administration. Consequently, the application of a uniform required window of time before or after the scheduled time for the administration of all medications, without regard to their differences, could undermine the ability of nursing staff to prioritize nursing care activities appropriately. This could also result in staff work-arounds that jeopardize patient safety due to the imposition of unrealistic or unnecessary time constraints for medication administration. Instead, CAH policies and procedures must specifically address the timing of medication administration, based on the nature of the medication and its clinical application, to ensure safe and timely administration. The policies and procedures must address at least the following:

- *Medications **not eligible** for scheduled dosing times;*
- *Medications **eligible for** scheduled dosing times;*
- *Administration of eligible medications outside of their scheduled dosing times and windows; and*
- *Evaluation of medication administration timing policies, including adherence to them.*

Medications or categories of medication not eligible for scheduled dosing times

The policies and procedures must identify medications or categories of medication which are not eligible for scheduled dosing times, either in general or in specific clinical applications. These are medications that require exact or precise timing of administration, based on diagnosis type, treatment requirements, or therapeutic goals. The policies and procedures must reflect consideration of factors including, but not limited to, the pharmacokinetics of the prescribed medication; specific clinical applications; and patient risk factors. Examples of medications that CAHs may choose to identify as not eligible for scheduled dosing times may include, but are not limited to:

- *Stat doses (immediate);*
- *First time or loading doses (initial large dose of a drug given to bring blood, tissue or fluid levels to an effective concentration quickly);*
- *One-time doses; doses specifically timed for procedures;*
- *Time-sequenced doses; doses timed for serum drug levels;*
- *Investigational drugs; or*
- *Drugs prescribed on an as needed basis (PRN doses).*

The policies and procedures must ensure timely administration of such medications. In addition they must specify if the policy for the administration of these medications will be applied throughout the CAH or only for specific CAH units or specific clinical situations or types of diagnoses.

Medications eligible for scheduled dosing times

Medications eligible for scheduled dosing times are those prescribed on a repeated cycle of frequency, such as once a day, BID (twice a day), TID (three times a day), hourly intervals

(every 1, 2, 3 or more hours), etc. The goal of this scheduling is to achieve and maintain therapeutic blood levels of the prescribed medication over a period of time. Medication administration policies and procedures typically establish standardized dosing times for the administration of all 'scheduled' medications. For example, medications prescribed for BID (twice a day) administration might, under a given CAH's policies and procedures, be scheduled to be administered at 8am and 8pm. Another CAH might choose to schedule BID medications at 7:30 am and 7:30 pm. Use of these standardized times facilitates the medication administration process, e.g., by providing to the CAH's pharmacy that morning doses of all BID drugs must be dispensed and delivered to patient units in time for the scheduled administration. For the nursing staff, the scheduled administration time might prompt prioritization of additional activities that may be required, in the case of particular drugs, such as vital sign assessment or the collection and review of blood work, to ensure safe and timely medication administration.

Policies and procedures for medications eligible for scheduled dosing times must also address: first dose medications, including parameters within which nursing staff are allowed to use their own judgment regarding the timing of the first and subsequent doses, which may fall between scheduled dosing times; retiming of missed or omitted doses; medications that will not follow scheduled dosing times; and patient units that are not subject to following the scheduled dosing times.

Time-critical scheduled medications

Time-critical scheduled medications are those for which an early or late administration of greater than thirty minutes might cause harm or have significant, negative impact on the intended therapeutic or pharmacological effect. Accordingly, scheduled medications identified under the CAH's policies and procedures as time-critical must be administered within thirty minutes before or after their scheduled dosing time, for a total window of one hour.

It is possible for a given medication to be time- critical for some patients, due to diagnosis, clinical situation, various risk factors, or therapeutic intent, but not time-critical for other patients. Therefore, CAH policies and procedures must address the process for determining whether specific scheduled medications are always time-critical, or only under certain circumstances, and how staff involved in medication administration will know when a scheduled medication is time-critical. Examples of time-critical scheduled medications/medication types may include, but are not limited to:

- *Antibiotics;*
- *Anticoagulants;*
- *Insulin;*
- *Anticonvulsants;*
- *Immunosuppressive agents;*
- *Pain medication (non-IV);*
- *Medications prescribed for administration within a specified period of time of the medication order;*

- *Medications that must be administered apart from other medications for optimal therapeutic effect; or*
- *Medications prescribed more frequently than every 4 hours.*

Non-time-critical scheduled medications

Non-time critical scheduled medications are those for which a longer or shorter interval of time since the prior dose does not significantly change the medication's therapeutic effect or otherwise cause harm. For such medications greater flexibility in the timing of their administration is permissible. Specifically:

- *Medications prescribed for daily, weekly or monthly administration may be within two hours before or after the scheduled dosing time, for a total window that does not exceed four hours.*

- *Medications prescribed more frequently than daily but no more frequently than every four hours may be administered within one hour before or after the scheduled dosing time, for a total window that does not exceed two hours.*

Missed or late administration of medications

The CAH's policies and procedures must address the actions to be taken when medications eligible for scheduled dosing times are not administered within their permitted window of time. This includes doses which may have been missed due to the patient being temporarily away from the nursing unit, for example, for tests or procedures; patient refusal; patient inability to take the medication; problems related to medication availability; or other reasons that result in missed or late dose administration. Likewise, policies and procedures must also outline guidelines for the administration and timing of new medications which are initiated between standardized dosing times.

These policies and procedures must identify parameters within which nursing staff are allowed to use their own judgment regarding the rescheduling of missed or late doses and when notification of the practitioner responsible for the care of the patient is required prior doing so. In either case, errors in the administration of medication must be reported internally as required at §485.635(a)(1)(v).

Evaluation of medication administration timing policies

CAHs must periodically evaluate their medication administration timing policies, including staff adherence to the policies, to determine whether they assure safe and effective medication administration. Medication errors related to the timing of medication administration must be tracked and analyzed to determine their causes. Based on the results of the evaluations of the policies and the medication administration errors, the CAH must consider whether there is a need to revise the policies and procedures governing medication administration timing.

Assessment/Monitoring of Patients Receiving Medications

Observing the effects medications have on the patient is part of the multi-faceted medication administration process. Patients must be carefully monitored to determine whether the medication results in the therapeutically intended benefit, and to allow for early identification of adverse effects and timely initiation of appropriate corrective action. Depending on the medication and route/delivery mode, monitoring may need to include assessment of:

- *Clinical and laboratory data to evaluate the efficacy of medication therapy, to anticipate or evaluate toxicity and adverse effects. For some medications, including opioids, this may include clinical data such as respiratory status, blood pressure, and oxygenation and carbon dioxide levels;*

- *Physical signs and clinical symptoms relevant to the patient's medication therapy, including but not limited to, somnolence, confusion, agitation, unsteady gait, pruritus, etc.*

Certain types of medications – "high alert medications" - are considered inherently high risk for adverse drug events. Although mistakes may or may not be more common with these drugs, the consequences of errors are often harmful, sometimes fatal, to patients

For Information – Not Required/Not to be Cited

The Institute for Safe Medication Practices (ISMP) makes available a list of high alert medications, which it defines as those medications that bear a heightened risk of causing significant patient harm when they are used in error. The current list may be found at: http://www.ismp.org/Tools/highAlertMedicationLists.asp

In addition, certain factors place some patients at greater risk for adverse effects of medication. Factors including, but not limited to, age, altered liver and kidney function, a history of sleep apnea, patient weight (obesity may increase apnea or smaller patients may be more sensitive to dose levels of medications), asthma, history of smoking, drug-drug interactions, and first-time medication use may contribute to increased risk.

Consideration of patient risk factors as well as the risks inherent in a medication must be taken into account when determining the type and frequency of monitoring. Further, to enhance continuity of care/safe medication administration, it is essential to communicate all relevant information regarding patients' medication risk factors and monitoring requirements during hand-offs of the patient to other clinical staff, such as when patients are moved from a nursing for tests, during shift report at change of shift, etc. This would apply to hand-offs involving not only to nursing staff, but also to any other types of staff who administer medications, e.g., respiratory therapists.

Adverse patient reactions, such as anaphylaxis or opioid-induced respiratory depression, require timely and appropriate intervention, per established CAH protocols.

An example of vigilant post-medication administration monitoring in the case of a high-alert medication where patient factors may increase risk would be regularly checking vital signs, oxygen level via pulse oximetry, and sedation levels of a post-surgical patient who is receiving pain medication via a patient controlled analgesia (PCA) pump. Narcotic medications, such as opioids, are often used to control pain but also have a sedating effect. Patients can become overly sedated and suffer respiratory depression or arrest, which can be fatal. Timely assessment and appropriate monitoring is essential in all parts of the CAH in which opioids are administered, to permit intervention to counteract respiratory depression should it occur. (See also the discussion below for intravenous medications.)

As part of the monitoring process, staff are expected to include the patient's reports of his/her experience of the medication's effects. Further, when monitoring requires awakening the patient in order to assess effects of the medications, the patient and/or the patient's representative must be educated about this aspect of the monitoring process. In addition, CAHs are encouraged to educate the patient and his/her representative and/or family members about notifying nursing staff promptly when there is difficulty breathing or other changes that might be a reaction to medication.

CAH policies and procedures are expected to address how the manner and frequency of monitoring, considering patient and drug risk factors, are determined, as well as the information to be communicated at shift changes, including the CAH's requirements for the method(s) of communication.

IV Medications & Blood Transfusions

Many of the medications included in the high-alert categories are administered intravenously. CAH policies and procedures for IV medications must address at least the following:

> ***Vascular Access Route***
>
> *Patients may require a form of vascular access to deliver blood or medications, either venous or arterial, based on the desired treatment plan. Safe administration of blood transfusions and IV medications includes the correct choice of vascular access. IV medications, such as fluids, antibiotics, and chemotherapy, may require specific types of access, such as peripheral or central catheters versus implanted port devices, based on the medication's chemical properties or safety concerns. Hospital policies and procedures must address which medications can be given intravenously via what type of access.*

Other Patient Safety Practices

In addition to the basic safe practices that apply to all medication administration, there are additional safe practices specific to IV medication administration that require consideration, including but not limited to, the following:

- *Tracing invasive lines and tubes prior to administration to ensure the medication is to be administered via the proper route (for example, peripheral catheter versus epidural catheter connections);*

    - *Avoiding forcing connections when the equipment offers clear resistance;*

- *Verifying proper programming of infusion devices (concentrations, flow rate, dose rate).*

Monitoring patients receiving IV medications

To the extent that IV medications have a more rapid effect on the body, it is important that staff administering medications via IV understand each medication and its monitoring requirements. Policies and procedures for IV medication administration must address appropriate IV medication monitoring requirements, including assessment of patients for risk factors that would influence the type and frequency of monitoring.

> *For example: a 50 year old patient with a history of renal failure is receiving IV vancomycin to treat a wound infection. The CAH policy for IV antibiotics, including vancomycin, requires the patient's kidney function to be monitored daily with blood draws. Based on review of the lab results, a practitioner responsible for the care of the patient would be expected to determine on a timely basis whether or not the antibiotic dose needs to be adjusted to protect kidney function or prevent drug toxicity while achieving the desired therapeutic effects. Staff administering the medication would be expected to review the lab results as well, and to raise with a practitioner responsible for the care of the patient any concerns they might have about whether an adjustment in the medication is needed.*

CAH policies and procedures related to monitoring patients receiving IV medications are expected to address, but are not limited to, the following:

- ***Monitoring for Fluid & Electrolyte Balance***

    Whenever IV medications and blood transfusions are administered, the patient may become at risk for fluid and electrolyte imbalance. Policies and procedures must address monitoring and treatment for fluid and electrolyte imbalances that may occur with blood transfusions and IV medications.

- ***Monitoring Patients Receiving High-alert Medications, Including IV Opioids***

  Policies and procedures related to IV medication administration must address those medications the CAH has identified as high-alert medications and the monitoring requirements for patients receiving such drugs intravenously.

  At a minimum, if the CAH provides surgical services, it is expected to address monitoring for over-sedation and respiratory depression related to IV opioids for post-operative patients

  Opioids are a class of medication used frequently to treat pain. The sedating effects of opioids make it difficult at times to properly assess the patient's level of sedation. It can be erroneously assumed that patients are asleep when they are actually exhibiting progressive symptoms of respiratory compromise - somnolence, decreased respiratory rate, and decrease in oxygen levels. These symptoms, if unrecognized, can progress to respiratory depression and even death.

  In addition to those patient characteristics that affect risk of adverse effects from medication discussed above, other factors placing patients receiving IV opioids at higher risk for oversedation and respiratory depression include, but are not limited to[5]:

  - *Snoring or history of sleep apnea*
  - *No recent opioid use or first-time use of IV opioids*
  - *Increased opioid dose requirement or opioid habituation*
  - *Longer length of time receiving general anesthesia during surgery*
  - *Receiving other sedating drugs, such as benzodiazepines, antihistamines, sedatives, or other central nervous system depressants*
  - *Preexisting pulmonary or cardiac disease*
  - *Thoracic or other surgical incisions that may impair breathing*

  Of particular concern are patients receiving IV opioids post-operatively. *The effects of IV opioids in post-operative patients must be monitored vigilantly via serial assessments of pain, respiratory status, and sedation levels.*

  CAHs that provide surgical services must have policies and procedures related to the use of high-alert medications, including IV opioids for post-operative patients. Policies and procedures must address, at a minimum, the process for patient risk assessment, including who conducts the assessments, and, based on the results of the assessment, monitoring frequency and duration, what is to be monitored, and monitoring methods. The policies and procedures must also address whether and

[5] *Jarzyna D., Junquist C., Pasero C., et al. American Society for Pain Management Nursing - Guidelines on Monitoring for Opioid-Induced Sedation and Respiratory Depression. Pain Management Nursing, Vol 12, No. 3 (September), 2011: pp 118-145*

under what circumstances practitioners prescribing IV opioids are allowed to establish protocols for IV opioid administration and monitoring that differ from the CAH's policies and procedures.

The frequency of the serial assessments and duration of the monitoring timeframe for post-operative patients receiving IV opioids must be determined based on at least the following considerations:

- *Patient risk for adverse events;*
- *Opioid dosing frequency and IV delivery method. (push or patient-controlled analgesia (PCA));*
- *Duration of IV opioid therapy.*

Regardless of the above factors, at a minimum monitoring must include the following:

- *Vital signs (blood pressure, temperature, pulse, respiratory rate)*
- *Pain level;*
- *Respiratory status;*
- *Sedation level; sedation levels are important indicators for the clinical effects of opioids. Sedation is a useful assessment parameter to observe the effects of opioids since sedation typically precedes respiratory depression6. See the blue box below for information on sedation assessment methods.*

For Information – Not Required/Not to be Cited

In addition to assessing risk for respiratory depression, the Institute for Safe Medication Practices recommends hospitals use a standard sedation scale when assessing patients receiving PCA. Scales such as the Richmond Agitation Sedation Scale, Pasero, Ramsey, or Glasgow Coma Scale are useful in assessing sedation.

Institute for Safe Medication Practices (ISMP), Medication Safety Alert – Fatal PCA Adverse Events Continue to Happen…Better Patient Monitoring is Essential to Prevent Harm. May 30, 2013

In addition to vigilant nursing assessment at appropriate intervals, CAHs may choose to use technology to support effective monitoring of patients' respiratory rate and oxygen levels.

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[6] *Institute for Safe Medication Practices (ISMP), Medication Safety Alert – Fatal PCA Adverse Events Continue to Happen…Better Patient Monitoring is Essential to Prevent Harm. May 30, 2013*

For additional information regarding recommendations of expert organizations on post-operative opioid monitoring, including technology-supported monitoring, see blue boxes below. The practices described in the blue boxes below are not required under the regulations.

The assessment and monitoring process must be explained to the patient and/or the patient's representative, to communicate the rationale for vigilant monitoring, including that it might be necessary to awaken the patient in order to assess effects of the medications. In addition, CAHs are encouraged to educate the patient and his/her representative and/or family members about notifying nursing staff promptly when there is difficulty breathing or other changes that might be a reaction to medication.

For Information – Not Required/Not to be Cited ***Institute for Safe Medication Practices Guidelines for PCA Monitoring***						
Assessment of Opioid Tolerance	***Vital Signs***	***Pain***	***Sedation***	***Respiratory***		
				Rate	***Quality***	***SPO_2* &/or $ETCO_2$*****
Baseline Assessment before PCA	*X*	*X*	*X*	*X*	*X*	*X*
PCA Initiation or Change in Drug/Syringe *Q 15 minutes x 1 hour* *Q 1 hour x 4 hours* *Then Q 2 hours*	*X*	*X*	*X*	*X*	*X*	*X*
PCA Dose Change or Bolus *Q 1 hour x 4 hours* *Then Q 2 hours*	*X*	*X*	*X*	*X*	*X*	*X*
Adverse Event or Patient Deterioration (e.g., adverse change in sedation score) *Q 15 minutes x 1 hour* *Q 1 hour x 4 hours* *Then Q 2 hours*	*X*	*X*	*X*	*X*	*X*	*X*
Hand-offs/Shift Change	*X*	*X*	*X*	*X*	*X*	*X*
Institute for Safe Medication Practices (ISMP), Medication Safety Alert – Fatal PCA Adverse Events Continue to happen…Better Patient Monitoring is Essential to Prevent Harm. May 30, 2013 ISMP adapted these recommendations from the San Diego Patient Safety Council ** SPO_2: Saturation of peripheral oxygen via pulse oximetry* *** $ETCO_2$: End-tidal carbon dioxide via capnography*						

For Information – Not Required/Not to be Cited

Anesthesia Patient Safety Foundation

- *APSF calls for every patient receiving postoperative opioid analgesics to be managed based on the following clinical considerations*:*
  - *Individualize the dose and infusion rate of opioid while considering the unique aspects of each patient's history and physical status.*
  - *Make continuous monitoring of oxygenation (pulse oximetry) the routine rather than the exception.*
  - *Assess the need for supplemental oxygen, especially if pulse oximetry or intermittent nurse assessment are the only methods of identifying progressive hypoventilation.*
  - *When supplemental oxygen is indicated, monitoring of ventilation may warrant the use of technology designed to assess breathing or estimate arterial carbon dioxide concentrations. Continuous monitoring is most important for the highest risk patients, but depending on clinical judgment, should be applied to other patients.*

APSF also has issued a video on opioid induced ventilatory impairment: http://apsf.org/resources_video4.php

**Stoelting, RK.,Weinger MB. Dangers of postoperative opioids: Is there a Cure?* APSF Newsletter *2009;24:2.*

For Information – Not Required/Not to be Cited
The Patient Safety Movement Foundation

PSMF recommends all patients receiving IV opioids have continuous measure-through motion and low perfusion pulse oximetry, and that patients on supplemental oxygen also have continuous respiration rate monitoring. It also calls for the monitoring system to be linked with a notification system to clinical staff who can respond immediately. It calls for an escalation protocol so that if a staff person does not acknowledge the alert in 60 seconds a second person will be notified.

The Patient Safety Movement Foundation - Actionable Patient Safety Solution (APSS) #1: Failure to Rescue: Post-Operative Respiratory Depression. January 13, 2013

Adverse patient reactions to IV medications require timely and appropriate intervention, per established protocols.

IV Blood Administration Procedures

According to the U.S. Department of Health and Human Services, 13,785,000 units of whole blood and red blood cells were transfused in the United States in 2011[7]. The collection, testing, preparation, and storage of blood and blood components are regulated by the Food and Drug Administration. Blood transfusions can be life-saving. However, they are not without risk of harm to patients. Transfusion reactions and/or errors can be fatal.

In addition to the safe practices and other safety considerations that apply to all IV medication administration, policies and procedures must address blood administration procedures that are consistent with accepted standards of transfusion practice, including but not limited to:

- *Confirming the following prior to each blood transfusion:*

  - *the patient's identity*
  - *verification of the right blood product for the right patient*

  The standard of practice calls for two qualified individuals, one of whom will be administering the transfusion, to perform the confirmation.

- *Requirements for patient monitoring, including frequency and documentation of monitoring*

- *How to identify, treat, and report any adverse reactions the patient may experience during or related to transfusion.*

Documentation

Note that documentation of medication administration is addressed in the Medical Records CoP at §485.638(a)(4)(iii). This regulation requires that the record contain: "All orders of doctors of medicine or osteopathy or other practitioners, reports of treatments and medications, nursing notes and documentation of complications and other pertinent information necessary to monitor the patient's progress, such as temperature graphics, progress notes describing the patient's response to treatment…." Documentation is expected to occur after actual administration of the drugs or biologicals to the patient; advance documentation is not only inappropriate, but may result in medication errors. Proper documentation of medication administration actions taken and their outcomes is essential for planning and delivering future care of the patient. See

[7] *The 2011 National Blood Collection and Utilization Survey Report. Retrieved September 27,2013 from http://www.hhs.gov/ash/bloodsafety/2011-nbcus.pdf*

the guidance for the various parts of §485.638 concerning documentation in the medical record. Deficiencies in documentation would be cited under the Clinical Records regulation.

Survey Procedures §485.635(d)(3)

- *Ask the person responsible for nursing services what type of personnel administer drugs and biologicals, including IVs. Are they practicing within their permitted scope?*
    - *If anyone other than an MD/DO, RN or PA administers drugs or biologicals, are they supervised by an RN or, if permitted under State law and CAH policy, a PA?.*
- *Verify that nursing staff administering drugs have completed training consistent with CAH training policy.*
- *Review a sample of medication orders and determine if they contain the required elements:*
    - *Determine if orders are legible, timed, dated and authenticated with a signature by the practitioner or practitioners responsible for the care of the patient.*
    - *Was the administration of the medication consistent with the order, i.e., the correct medication was administered to the right patient at the right dose via the correct route, and that timing of administration complied with the hospital's policies and procedures? Check that the practitioner's order was still in force at the time the drug was administered.*
- *Ask nursing staff if the CAH permits verbal orders and, if so, what the policy is for a verbal order. If staff are unaware of any policy, or if their description of a policy suggests it is incomplete or inconsistent with accepted standards of practice, ask to see the written policy.*
- *Ask nursing staff whether they initiate medications in accordance with standing orders. Are they familiar with the hospital's policies and procedures for using standing orders? Are they following the policies and procedures? Ask to see the protocol for a standing order used by nursing staff, and ask nursing staff to explain how their practice conforms to the protocol.*
    - *Determine whether all standing orders which were initiated by a nurse were authenticated by an authorized practitioner.*
- *Ask nursing staff if the CAH permits patient self-administration of medications.*
    - *If yes, does the CAH have policies and procedures addressing this?*

- *Is there an order from a practitioner responsible for the care of the patient permitting self-administration of medications, either issued by the CAH or brought from home?*

- *Observe the preparation of drugs and their administration to patients [medication pass] in order to verify that procedures are being followed.*

  - *Is the patient's identity confirmed prior to medication administration?*

  - *Are procedures to assure the correct medication, dose, and route followed?*

  - *Are drugs administered in accordance with the hospital's established policies and procedures for timely medication administration?*

  - *Does the nurse remain with the patient until medication is taken, unless they are permitted to self-administer?*

- *Are patients assessed by nursing and/or other staff, per hospital policy, for their risk to their prescribed medications?*

- *Are patients who are at higher risk and/or receiving high-alert medications monitored for adverse effects?*

  - *Are staff knowledgeable about intervention protocols when patients experience adverse medication-related events?*

- *Interview personnel who administer medication to verify their understanding of the policies regarding timeliness of medication administration.*

  - *Are they able to identify time-critical and non-time-critical scheduled medications? Medications not eligible for scheduled dosing times?*

  - *Are they able to describe requirements for the timing of administration of time critical and non-time critical medications in accordance with the hospital's policies?*

- *Interview nursing staff who administer IV medications and blood transfusions. Are staff knowledgeable with respect to:*

  - *Venipuncture techniques;*

  - *Safe medication administration practices, including general practices applying to all types of medications and practices concerning IV tubing and infusion pumps;*

  - *Maintaining fluid and electrolyte balance;*

- *Patient assessment for risk related to IV medications and appropriate monitoring;*
- *Early detection and intervention for IV opioid-induced respiratory depression in post-operative patients;*
- *With respect to blood transfusions:*
  - *Blood components;*
  - *Process for verification of the right blood product for the right patient; and*
  - *Transfusion reactions: identification, treatment, and reporting requirements.*

- *If able, observe blood transfusion and IV medication administration to assess staff adherence to accepted standards of practice.*
  - *Were safe medication administration practices used?*
  - *Was the transfused patient correctly identified and matched to the correct blood product prior to administration?*
  - *Was the appropriate access used for IV medications?*
  - *Were appropriate steps taken with regard to IV tubing and infusion pumps?*
  - *Are patients being monitored post-infusion for adverse reactions?*

- *If staff appear to not be following accepted standards of practice for patient risk assessment related to IV medications, particularly opioids, and appropriate monitoring of patients receiving IV medications and/or blood transfusions, review policies and procedures for IV medication administration and blood transfusion to determine if they address safe practices considerations.*

C-0298

(Rev.)

485.635(d)(4) A nursing care plan must be developed and kept current for each inpatient.

Interpretive Guidelines §485.635(d)(4)

There must be a nursing care plan for every CAH inpatient. Nursing care planning starts upon admission. It includes planning the patient's care while in the CAH as well as planning for transfer to a hospital, to a post-acute care facility or for discharge. A nursing care plan is based on assessing the patient's nursing care needs (not solely those needs related to the admitting diagnosis). The assessment considers the patient's treatment goals and, as appropriate, physiological and psychosocial factors and patient discharge planning. The plan develops appropriate nursing interventions in response to the identified nursing care needs. One resource for information about nursing care plans is The American Nurses Association http://www.nursingworld.org/EspeciallyforYou/StudentNurses/Thenursingprocess.aspx .

The nursing care plan is kept current by ongoing assessments of the patient's needs and of the patient's response to interventions, and updating or revising the patient's nursing care plan in response to assessments. The nursing care plan is part of the patient's clinical record and must comply with the clinical records requirements at §485.638.

CAHs have the flexibility of developing the nursing care plan as part of a larger, coordinated interdisciplinary plan of care. This method may serve to promote communication among disciplines and reinforce an integrated, multi-faceted approach to a patient's care, resulting in better patient outcomes. The interdisciplinary plan of care does not minimize or eliminate the need for a nursing care plan. It does, however, serve to promote the collaboration between members of the patient's health care team.

Survey Procedures §485.635(d)(4)

Select a *representative* sample of nursing care plans *based on the number of inpatient records reviewed*.

- Are the *care* plans created as soon as possible after admission for each patient?
- Are the care plans based on the nurse's assessment of the individual patient?
- *Is there evidence that the care plans are reviewed on an ongoing basis?*
- Is the*re evidence that the nursing care* plan *is* revised as *needed and is there documentation of nursing reassessment*?
- Verify that there is evidence that the nursing care plans *have been* implemented.

C-0299

(Rev.)

§485.635(e) Standard: Rehabilitation Therapy Services

Physical therapy, occupational therapy, and speech-language therapy pathology services furnished at the CAH, if provided, are provided by staff qualified under State law, and consistent with the requirements for therapy services in §409.17 of this subpart.

Interpretive Guidelines §485.635(e)

Rehabilitation services are optional CAH services. If a CAH provides any rehabilitative services to its patients, either directly or under arrangement or agreement, either inpatient or outpatient, the services must be provided by staff qualified under State law, and consistent with the requirements for therapy services in §409.17. Rehabilitation services services can be initiated only upon the order of a practitioner responsible for the care of the patient. Physical therapy, occupational therapy, or speech-language pathology must be furnished in accordance with the

regulation at 42 CFR 409.17, which specifies the following rehabilitation services plan of care requirements:

- *Establishment of the plan: "The plan must be established before treatment begins by one of the following: (1) A physician. (2) A nurse practitioner, a clinical nurse specialist or a physician assistant. (3) The physical therapist furnishing the physical therapy services. (4) A speech-language pathologist furnishing the speech-language pathology services. (5) An occupational therapist furnishing the occupational therapy services."*

- *Content of the plan: "The plan: (1) Prescribes the type, amount, frequency, and duration of the physical therapy, occupational therapy, or speech-language pathology services to be furnished to the individual; and (2) Indicates the diagnosis and anticipated goals."*

- *Changes in the plan: "Any changes in the plan are implemented in accordance with the provider's policies and procedures."*

Also in accordance with 42 CFR 409.17, rehabilitation services must be provided by qualified physical therapists, physical therapy assistants, occupational therapists, occupational therapy assistants, and/or speech-language pathologists who meet the personnel qualifications defined in 42 CFR 484.4. CAHs must have policies and procedures consistent with State law.

Rehabilitation services must be provided according to national standards of practice as established by professional organizations such as, but not limited to, the American Physical Therapy Association, the American Occupational Therapy Association, and the American Speech-Language-Hearing Association.

Survey Procedures §485.635(e)

If the CAH provides rehabilitation services:

- *Review clinical records of patients who received rehabilitation services. Determine whether the required care plan was developed and implemented.*

- *Review employee personnel files to verify the rehabilitation service providers (i.e., physical therapists, physical therapy assistants, occupational therapists, occupational therapy assistants, and/or speech-language pathologists) have the necessary education, experience, training, and documented competencies to provide rehabilitation services.*

- *Ask the CAH what national standards of rehabilitation practice provide the basis for its rehabilitation services. Is there supporting documentation?*

Attachment 4

U.S. Food and Drug Administration
Protecting and Promoting *Your* Health

FDA expands warning on Becton-Dickinson (BD) syringes being used to store compounded or repackaged drugs

[9-8-15] FDA is expanding its alert regarding compounded or repackaged drugs stored in Becton-Dickinson (BD) general use syringes to include certain additional syringe sizes including 1mL, 10mL, 20mL and 30mL BD syringes, and BD oral syringes. The FDA's original alert applied to compounded or repackaged drugs that have been stored in 3 mL and 5mL BD syringes. This expansion of the alert to additional sizes of syringes is based on BD reports that an interaction with the rubber stopper in certain lots of these syringes can cause some drugs stored in these syringes to lose potency if filled and not used immediately.

BD reports that the following drugs in particular can be affected by the stoppers, but we do not know whether other drugs can be affected: fentanyl, rocuronium, neostigmine, morphine, midazolam, methadone, atropine, hydromorphone, cisatracurium, and remifentanyl. BD has created a **webpage (http://www1.bd.com/alerts-notices/)** to assist customers in determining if their lots are affected.

Hospital pharmacies and staff should:

- Contact any outsourcers to determine if affected lots of BD syringes were used for compounded or repackaged products
- Not administer compounded or repackaged drugs that have been stored in any of these syringes unless there is no suitable alternative available.

FDA continues to investigate this issue and will provide more information when it is available. FDA asks health care professionals and patients to report any adverse reactions to FDA's **MedWatch (/Safety/MedWatch/default.htm)** program:

- Complete and submit the report online at **www.fda.gov/medwatch/report.htm (https://www.accessdata.fda.gov/scripts/medwatch/index.cfm?action=reporting.home)**
- Download and complete the **form (http://www.fda.gov/downloads/AboutFDA/ReportsManualsForms/Forms/UCM349464.pdf)**, then submit it via fax at 1-800-FDA-0178

BD issued letters to their customers on **July 31, 2015 (http://www1.bd.com/hypodermic/pdf/07-31-15-letter.pdf) (http://www.fda.gov/AboutFDA/AboutThisWebsite/WebsitePolicies/Disclaimers/default.htm)** and **September 1, 2015 (http://www1.bd.com/hypodermic/pdf/09-01-15-letter.pdf) (http://www.fda.gov/AboutFDA/AboutThisWebsite/WebsitePolicies/Disclaimers/default.htm)**,

and provides an **Alternate Stopper Quick Reference Guide (http://www1.bd.com/hypodermic/pdf/US-Quick-Reference-Guide.pdf)** **(http://www.fda.gov/AboutFDA/AboutThisWebsite/WebsitePolicies/Disclaimers/default.htm)** on their **webpage (http://www1.bd.com/alerts-notices/)** **(http://www.fda.gov/AboutFDA/AboutThisWebsite/WebsitePolicies/Disclaimers/default.htm)**. The Institute for Safe Medication Practices (ISMP) issued statements regarding this issue in **July (http://www.ismp.org/newsletters/acutecare/articles/loss-of-drug-potency.aspx)** **(http://www.fda.gov/AboutFDA/AboutThisWebsite/WebsitePolicies/Disclaimers/default.htm)** and **August (http://www.ismp.org/newsletters/acutecare/showarticle.aspx?id=117)** **(http://www.fda.gov/AboutFDA/AboutThisWebsite/WebsitePolicies/Disclaimers/default.htm)** 2015.

FDA warns health care professionals not to use compounded or repackaged drugs stored in Becton-Dickinson (BD) 3 milliliter (ml) and 5 ml syringes unless there is no suitable alternative available

[8-19-2015] FDA is alerting health care professionals not to administer to patients compounded or repackaged drugs that have been stored in 3 milliliter (ml) and 5ml syringes manufactured by Becton-Dickinson (BD) unless there is no suitable alternative available. Preliminary information indicates that drugs stored in these syringes may lose potency over a period of time due to a possible interaction with the rubber stopper in the syringe.

If you have been using products packaged in these syringes, be aware that using a substitute product may require a dosage adjustment in case the patient has been receiving a subpotent product, or adverse consequences could occur.

BD's 10ml, 20ml and 30ml syringes may also contain the same rubber stopper. The company is alerting their customers not to use these syringes as a closed container system for compounded and repackaged drugs.

FDA has cleared these syringes as medical devices for general purpose fluid aspiration and injection only. These syringes were not cleared for use as a closed container storage system for drug products, and the suitability of these syringes for that purpose has not been established. This issue may extend to other general use syringes made by other manufacturers that were not cleared for the purpose of closed-container storage usage.

FDA has received several reports of compounded and repackaged drugs, such as fentanyl, morphine, methadone and atropine, losing potency when stored in BD 3ml and 5ml general purpose syringes. It is possible that this chemical reaction may affect other compounded and repackaged drugs stored in syringes not FDA cleared for closed-container storage.

Hospital and pharmacy staff should check supply stocks and remove drug products that were filled by pharmacies or outsourcing facilities and stored in general purpose BD 3ml and 5ml syringes. These syringes are marked with the BD logo at the base of the syringe.

At this time, FDA does not have information on how long drugs can be stored in these syringes before degrading. There is no information to suggest that there is a problem with potency or drug degradation when medication is administered promptly after the syringes are filled.

This warning does not extend to products approved by FDA for marketing as pre-filled syringes, because as part of the approval process, FDA has determined that these products have been shown to maintain stability in the syringe container through the expiration date on the product.

On July 30, 2015, the Institute for Safe Medication Practices (ISMP) issued a Special Alert regarding this problem. See **http://www.ismp.org/newsletters/acutecare/articles/loss-of-drug-potency.aspx (http://www.ismp.org/newsletters/acutecare/articles/loss-of-drug-potency.aspx)**

The FDA is continuing to investigate this issue and will provide more information when it is available.

FDA asks health care professionals and patients to report any adverse reactions to the FDA's **MedWatch (http://www.fda.gov/medwatch)** program:

- Complete and submit the report online at **www.fda.gov/medwatch/report.htm (http://www.fda.gov/medwatch/report.htm)**
- Download and complete the **form (http://www.fda.gov/downloads/AboutFDA/ReportsManualsForms/Forms/UCM349464.pdf)**, then submit it via fax at 1-800-FDA-0178

The BD logo is marked on the base on the syringe, and may be covered by a label on the product.

More in Drug Safety and Availability (/Drugs/DrugSafety/default.htm)

Drug Alerts and Statements (/Drugs/DrugSafety/ucm215175.htm)

Medication Guides (/Drugs/DrugSafety/ucm085729.htm)

Drug Safety Communications (/Drugs/DrugSafety/ucm199082.htm)

Drug Shortages (/Drugs/DrugSafety/DrugShortages/default.htm)

Postmarket Drug Safety Information for Patients and Providers (/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/default.htm)

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Drug Safety Podcasts (/Drugs/DrugSafety/DrugSafetyPodcasts/default.htm)

Safe Use Initiative (/Drugs/DrugSafety/SafeUseInitiative/default.htm)

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Drug Supply Chain Integrity (/Drugs/DrugSafety/DrugIntegrityandSupplyChainSecurity/default.htm)

Acute Care ISMP Medication Safety Alert!®
Educating the Healthcare Community About Safe Medication Practices

Special ALERT

Loss of drug potency

Some hospital pharmacists have been in touch with us recently to report potency issues with certain medications prepared in advance in 3 mL or 5 mL BD syringes. One of the medications is fenta**NYL** citrate injection diluted to 10 mcg per mL for pediatric use, which was prepared in a hospital pharmacy. One hospital sent 3 syringes of diluted fenta**NYL** 10 mcg/mL to an outside laboratory for testing. At 48 hours, the potency had declined to 67% on average, and by day 6, the potency was at 55%. Another hospital tested syringes of fenta**NYL** 5 mcg/mL in 3 mL syringes and found a range of potencies between 10% and 70%. Retesting at two other laboratories showed similar results. A third hospital reported inadequate patient analgesia, also with diluted fenta**NYL**

We spoke with a BD representative, who confirmed that an issue exists. The issue may be related to black plunger rod stoppers from a secondary supplier that affect "pH sensitive" medications such as fenta**NYL** citrate, methadone hydrochloride, and possibly a few others. BD continues to investigate the matter and is planning to send a letter shortly to pharmacy directors to provide more details. Potency problems have **not** been identified with BD 1 mL, 10 mL, and larger syringe sizes, and no problems have been reported with other manufacturers' syringes.

According to BD, the loss of potency is also time dependent. At 24 hours, fenta**NYL** remains between 90 to100% potent, but by 48 hours, some deterioration may already be underway, as noted above. Patient safety could be compromised if subpotent opioid doses cause a dose elevation that is followed by administration of a fully potent opioid at the higher dose via a syringe that does not have this issue.

Until further information is available from BD and the problem is resolved, hospitals using BD 3 mL and 5 mL syringes should prepare medication syringes as close to the time of administration as possible. One of the hospitals that identified the problem is providing a 1 mL dose of fenta**NYL** 10 mcg per mL in a 2 mL vial for now.

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Safe Medicine

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CANTRELL DRUG COMPANY

Pharmaceutical Outsourcing Specialists

August 21, 2015

Re: BD 3 mL and BD 5 mL Syringes For Compounded Sterile Products

Dear Valued Client,

Voluntary Recall:

Cantrell Drug Company is initiating a voluntarily recall of fentaNYL citrate injections packaged in certain lots of BD 3 mL and 5 mL plastic syringes. This recall only affects a small number of clients and Cantrell will notify each affected client directly. The reason for the recall is potential adsorption of fentaNYL citrate to a reported modified component in specific lots of BD syringes. Cantrell Drug Company was notified of specific modified lot numbers on August 20th, 2015. BD Medical Affairs has assured us that the 10 mL, 30 mL and 50 mL syringes are not affected by this issue. Details of this recall will be sent to any client hospital today that has received affected fentaNYL citrate product.

Cantrell lots of fentaNYL citrate identified using the modified BD component are: 5425, 5977, 6234, 6977, 5784, 6208, 6851, 6943, 5737, 5960, 6324, 5695, 144735, 147647, 147858, 143734, 150125, 145906, 148525, 151142, 146567, 150370, 140306, 144607, 148292, and 150610.

Quarantine Action:

Except for fentaNYL citrate, Cantrell is not recalling other medications packaged in the modified BD syringe lot numbers. However, in the abundance of caution, we ask client hospitals to quarantine all medications in the affected BD 3 mL and 5 mL syringes until further notice. Specific product names and lot numbers are found in the attachment to this letter. Cantrell has begun testing retention samples with a FDA registered third party analytical laboratory working through the weekend to test and analyze stability data of other products packaged in the BD modified syringe lot numbers. Upon data receipt from testing identified above, results will be reviewed and clients will be notified of the status of the quarantine. We expect results of testing early next week.

Background:

On August 4th Cantrell Drug Company (Cantrell) became aware of an Institute for Safe Medication Practices (ISMP) Safety Alert stating that some hospital pharmacists have recently reported potency issues with certain compounded medications prepared in advance in 3 mL or 5 mL BD syringes and one other hospital reported inadequate analgesia. Analytical results reported to those hospitals ranged from 10% to 70%.

CANTRELL DRUG COMPANY

Pharmaceutical Outsourcing Specialists

This ISMP Safety Alert prompted Cantrell to immediately launch a stability review of all our products, especially for fentaNYL citrate, compounded using BD 3 mL and 5 mL syringes. As you are probably aware, fentaNYL citrate has the potential for adsorption to certain containers and tubing (adsorption is the adhesion of atoms, ions, or molecules to a surface). Furthermore, fentaNYL citrate concentrations are manufactured in extremely low concentrations (i.e. microgram concentrations), so small amounts of adsorption to a container's materials may cause significant reductions in the amount of available fentaNYL citrate. Our stability studies did not see precipitous drops in concentration experienced by those in the ISMP Safety Alert, nor have we received any reports from our clients of a lack of therapeutic effect. Testing of fentaNYL citrate retained samples in 3 mL and 5 mL BD syringes that had reached their beyond-use-date (BUD) were tested and found to be well within specifications.

On August 18th the FDA issued a MedWatch Safety Alert for Human Medical Products alerting healthcare professionals that compounded drugs stored in Becton-Dickinson (BD) 3 mL and 5 mL syringes should not be used. We became aware that only certain lot numbers of these syringes were the potential cause of the noted instability. On August 19th we spoke directly with BD Medical Affairs personnel asking for those specific lot numbers. On August 20th we received the requested lot numbers from BD and immediately compiled a list of Cantrell products that were compounded using those lot numbers. In the interim, we proactively compounded and packaged new lots of fentaNYL citrate in multiple BD syringes. The results, when analyzed against BD lot numbers in question, revealed out-of-specification results for fentaNYL citrate packaged in the BD syringe lot numbers with modifications. Importantly, non-modified lot numbers of BD syringes resulted in expected concentrations of fentaNYL citrate.

Cantrell shares your concern over the potential impact on the supply of necessary medications to your patients and is taking aggressive actions to ensure that product you receive from Cantrell meets the highest of quality standards.

Please refer to our website for immediate publishing of information regarding the matter.

Sincerely,

R. C. Anderson

Raymond C Anderson, PhD
Vice-President of Quality Assurance and Regulatory Affairs

CANTRELL DRUG COMPANY

Pharmaceutical Outsourcing Specialists

Quarantine List of Cantrell Drug Company Products and Lot Numbers Packaged in BD 3 mL & 5 mL Modified Syringes

ATROPINE SULFATE 0.4 MG/ML INJECTION SOLUTION 1 ML SYRINGE
144757
145585
148324
148574
149690
151665
ATROPINE SULFATE 0.4 MG/ML INJECTION SOLUTION 2 ML SYRINGE
144873
145900
147037
148163
149198
151454
151962
BETAMETHASONE SODIUM PHOSPHATE 6_MG/ML INJECTION SOLUTION (PH 8.5) 1 ML SYRINGE
146504
147968
149181
149980
151497
151861
DEXAMETHASONE SODIUM PHOSPHATE 24 MG/ML INJECTION SOLUTION 1ML_SYRINGE
147497
149668
EPHEDRINE SULFATE 10 MG/ML IN 0.9%_SODIUM CHLORIDE 5 ML SYRINGE
144129
144891
EPHEDRINE SULFATE 50 MG/ML IN 0.9%_SODIUM CHLORIDE 1 ML SYRINGE
149266
150655
150740
151508
GLYCOPYRROLATE 0.2 MG/ML INJECTION SOLUTION 1 ML SYRINGE
5794
6100
6336
6461
6698
6861

CANTRELL DRUG COMPANY

Pharmaceutical Outsourcing Specialists

Quarantine List of Cantrell Drug Company Products and Lot Numbers Packaged in BD 3 mL & 5 mL Modified Syringes

GLYCOPYRROLATE 0.2 MG/ML INJECTION SOLUTION 2 ML SYRINGE
5882
6172
6401
6660
HEPARIN SODIUM 0.5 USP UNITS/ML IN 0.45% SODIUM CHLORIDE 2 ML IN A 3 ML BD SYRINGE
5804
6146
HYDROMORPHONE HCL 0.5 MG/ML IN 0.9% SODIUM CHLORIDE 1 ML SYRINGE
6192
6558
KETAMINE HCL 50 MG/ML INJECTION SOLUTION 1 ML SYRINGE
144537
145910
146487
147062
149162
149495
149881
150840
LIDOCAINE HCL 1% BUFFERED WITH SODIUM_BICARBONATE INJECTION
145259
146142
147251
148248
149643
150033
150947
151087
MIDAZOLAM HCL 0.1 MG/ML IN 5%_DEXTROSE 2.5_ML_SYRINGE
147016
149167
MIDAZOLAM HCL 0.5 MG/ML IN 0.9% SODIUM CHLORIDE 1 ML SYRINGE
5940
6090
6218
6877
MIDAZOLAM HCL 1 MG/ML IN 0.9% SODIUM CHLORIDE 2 ML SYRINGE
6178
6529

CANTRELL DRUG COMPANY

Pharmaceutical Outsourcing Specialists

Quarantine List of Cantrell Drug Company Products and Lot Numbers
Packaged in BD 3 mL & 5 mL Modified Syringes

MORPHINE SULFATE 0.5 MG/ML IN 0.9%_SODIUM_CHLORIDE 1 ML SYRINGE
143692
147713
151504
MORPHINE SULFATE 1 MG/ML IN 0.9% SODIUM CHLORIDE 1 ML SYRINGE
6184
ONDANSETRON HCL 2 MG/ML INJECTION SOLUTION 2 ML SYRINGE
147926
PHENYLEPHRINE HCL 1.5% IN BALANCED SALT SOLUTION
148802
PHENYLEPHRINE HCL 1.5% WITH LIDOCAINE HCL 1% IN BALANCED SALT SOLUTION 1 ML SYRINGE
147654
149175
150845
PHENYLEPHRINE HCL 1_MG/ML IN 0.9%_SODIUM_CHLORIDE 1 ML SYRINGE
145377
147125
150471
PHENYLEPHRINE HCL 100_MCG/ML IN 0.9%_SODIUM_CHLORIDE 1 ML SYRINGE
144230
148580
PHENYLEPHRINE HCL 2.5% IN BALANCED_SALT_SOLUTION
148211
150506
SUCCINYLCHOLINE CHLORIDE_20_MG/ML INJECTION SOLUTION 5 ML
144693

Attachment 5

California State Board of Pharmacy
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Phone: (916) 574-7900
Fax: (916) 574-8618
www.pharmacy.ca.gov

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
GOVERNOR EDMUND G. BROWN JR.

October 15, 2015

Submitted electronically to: http://www.regulations.gov
Docket No. FDA-2015-D-1176

RE: Comments on the Food and Drug Administration's Guidance Document #230 on Compounding Animal Drugs from Bulk Drug Substances

Dear FDA Staff:

The California State Board of Pharmacy thanks the FDA for this opportunity to provide comments on FDA's Guidance Document 230, "Compounding Animal Drugs from Bulk Substances."

The board supports the elements of this guidance document.

The board believes that this guidance both supports and reinforces the regulatory framework developed by FDA for pharmacies and outsourcers who compound human drugs with several exceptions. The board will summarize some of these provisions below:

- For pharmacies that compound medications for animal use, the FDA guidance states that a veterinarian's prescription is required for the specific animal. The prescription must contain the standard information required on all prescriptions but also must include:
    1. The name and species of the animal
    2. A statement that the animal is not a food-producing animal
    3. If a manufactured drug exists, a statement that the compounded product would make a clinical difference from the manufactured product

  The guidance provides that pharmacies that compound such drugs must do so pursuant to USP 795 and 797 standards, by or under the supervision of a pharmacist, and such compounded products may not be distributed by wholesalers.

  Finally, the guidance allows a pharmacy to compound for future furnishing but is limited to the maximum quantity of that drug dispensed in any 14-day period within the last six months.

- For outsourcing facilities that compound animal drugs from bulk substances, the FDA is developing a list (which is not yet completed) of approved drug substances that an outsourcing facility must use when compounding for animals, linked to the species and the condition.

The compounding must be done in accordance with cGMP standards by or under the supervision of a pharmacist. Outsourcing facility-compounded drugs may not be used on or in food producing animals, and must be expressly labeled to state this prohibition.

The veterinarian must note on the order or prescription that the veterinary drug is intended to treat a specific condition and specific species, and this must match the listing on the FDA's bulk drug substances list. The guidance specifies labeling requirements and a statement on the label that the product is not for resale. The guidance also requires that any drugs compounded by an outsourcing facility must be reported on the biannual lists of products compounded that must be sent to the FDA, with a notation of the products intended for animals.

While the guidance also permits compounding by a veterinarian; however, since this board does not regulate veterinarians, we will not comment on these provisions in the guidance. The board supports the elements in this guidance as they pertain to pharmacies and outsourcing facilities.

In closing, the board thanks the FDA for releasing this guidance document and providing an opportunity to provide comments.

In addition to the guidance document itself, the Federal Notice listed eight additional questions for comment on bulk compounding of veterinary drugs. The board wishes to provide comments on the following questions:

1. Should the final guidance address the issue of FDA-approved animal and human drugs that are in shortage or are otherwise unavailable (*e.g.,* disruptions in the manufacture or supply chain; business decisions to stop marketing the drug; drug is subject to Agency action based on safety, effectiveness, or manufacturing concerns)? If so:
   a) How should these situations be addressed in the final guidance?
      A: To remove ambiguity about whether a drug is in shortage, the FDA could develop a list that names the drugs, geographical areas and dates of shortage.
   b) How should the final guidance define the terms ''shortage'' and ''unavailable''?
      A: A shortage is something one or more primary wholesalers cannot provide to their pharmacy customers. Unavailable means the drug is unavailable and no wholesaler can cannot provide the medication.
   c) What criteria should FDA use to determine if an approved animal or human drug is in shortage or otherwise unavailable?
      A: Information from manufacturers on delays or their ability to manufacture a product, inability of one of the primary wholesalers to ship a product

2. Do United States Pharmacopeia and National Formulary (USP–NF) 1 Chapters 795 and 797 provide suitable standards for animal drugs compounded by veterinarians, and if not, what standards of safety, purity, and quality should apply to animal drugs compounded by veterinarians?
   A: We believe there should be one set of standards under which pharmacies and when authorized, physicians and veterinarians, may compound medications. This would generally mean use of United States Pharmacopeia and National Formulary (USP–NF) 1 Chapters 795 and 797, unless specific compounding standards are created at the state level.

3. Should licensed veterinarians be able to sell or transfer an animal drug compounded from bulk drug substances by a State-licensed pharmacy or an outsourcing facility to owners or caretakers of animals under the veterinarian's care?
   A: Only a licensed outsourcer should be able to do this.

4. Should the final guidance include a condition on the amount or percentage of compounded animal drugs that a pharmacy or outsourcing facility can ship in interstate commerce? If so, what would a reasonable amount be?
   A: The board is unable to determine an appropriate limit of compounded products for pharmacies to ship in interstate commerce; specifically, we are uncertain about whether 30 percent is appropriate. There should not be a limit on an outsourcing facility's ability to ship its products across state lines.

5. Is additional guidance needed to address the repackaging of drugs for animal use?
   A: We have no specific comments on this except that there should be one set of medication standards for all pharmacies, whether for human or animal use.

6. – 8. We have no comments on the remaining questions, other than guidance is a generally a good thing for securing the compliance of pharmacies and outsourcers.

In closing, the California State Board of Pharmacy thanks the FDA for this opportunity to provide comments on their development of standards for compounding. Please do not hesitate to contact me if clarity is needed in our responses.

Sincerely,

VIRGINIA HEROLD
Executive Officer

#230

Guidance for Industry
Compounding Animal Drugs from Bulk Drug Substances

DRAFT GUIDANCE

This guidance document is being distributed for comment purposes only.

Comments and suggestions regarding this draft document should be submitted within 90 days of publication in the *Federal Register* of the notice announcing the availability of the draft guidance. Submit electronic comments to http://www.regulations.gov. Submit written comments to the Division of Dockets Management (HFA-305), Food and Drug Administration, 5630 Fishers Lane, rm. 1061, Rockville, MD 20852. All comments should be identified with the docket number listed in the notice of availability that publishes in the *Federal Register*.

For questions regarding this draft document, contact Eric Nelson (CVM) at 240-402-5642, or by e-mail at eric.nelson@fda.hhs.gov.

U.S. Department of Health and Human Services
Food and Drug Administration
Center for Veterinary Medicine (CVM)

May 2015

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Contains Nonbinding Recommendations

Draft — Not for Implementation

Guidance for Industry[1]

Compounding Animal Drugs from Bulk Drug Substances

This draft guidance, when finalized, represents the Food and Drug Administration's (FDA or Agency) current thinking on this topic. It does not create or confer any rights for or on any person and does not operate to bind FDA or the public. You can use an alternative approach if the approach satisfies the requirements of the applicable statutes and regulations. If you want to discuss an alternative approach, contact the FDA staff responsible for implementing this draft guidance using the contact information on the title page of this guidance.

I. INTRODUCTION AND SCOPE

This draft guidance sets forth the Food and Drug Administration's ("FDA") policy regarding compounding animal drugs from bulk drug substances[2] by state-licensed pharmacies, licensed veterinarians, and facilities that register with FDA as outsourcing facilities under section 503B of the Federal Food, Drug, and Cosmetic Act (FD&C Act) (21 U.S.C. 353b). This guidance reflects FDA's current thinking regarding compounding animal drugs from bulk drug substances and describes the conditions under which FDA generally does not intend to take action for violations of the following sections of the FD&C Act: section 512 (21 U.S.C. 360b), section 501(a)(5) (21 U.S.C. 351(a)(5)), section 502(f)(1) (21 U.S.C. 352 (f)(1)), and, where specified, section 501(a)(2)(B) (21 U.S.C 351(a)(2)(B)), when a state-licensed pharmacy, licensed veterinarian, or an outsourcing facility[3] compounds animal drugs from bulk drug substances.

This draft guidance only addresses the compounding of animal drugs from bulk drug substances. It does not apply to the compounding of animal drugs from approved new animal or new human drugs. Such compounding can be conducted in accordance with the provisions of section 512(a)(4) and (5) of the FD&C Act (21 U.S.C. 360b(a)(4) and (5)) and 21 CFR part 530. In addition, this draft guidance does not address the compounding of drugs intended for use in

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[1] This draft guidance has been prepared by the Center for Veterinary Medicine (CVM) in consultation with the Center for Drug Evaluation and Research (CDER) and the Office of Regulatory Affairs (ORA) at the Food and Drug Administration.

[2] FDA regulations define "bulk drug substance" as "any substance that is represented for use in a drug and that, when used in the manufacturing, processing, or packaging of a drug, becomes an active ingredient or a finished dosage form of the drug, but the term does not include intermediates used in the synthesis of such substances." 21 CFR 207.3(a)(4). "Active ingredient" is defined as "any component that is intended to furnish pharmacological activity or other direct effect in the diagnosis, cure, mitigation, treatment, or prevention of disease, or to affect the structure or any function of the body of man or other animals. The term includes those components that may undergo chemical change in the manufacture of the drug product and be present in the drug product in a modified form intended to furnish the specified activity or effect." 21 CFR 210.3(b)(7). Any component other than an active ingredient is an "inactive ingredient." See 21 CFR 210.3(b)(8). Inactive ingredients used in compounded drug products commonly include flavorings, dyes, diluents, or other excipients.

[3] "Outsourcing facility" refers to a facility that meets the definition of an outsourcing facility under section 503B(d)(4) of the FD&C Act. See draft guidance for industry *For Entities Considering Whether to Register As Outsourcing Facilities Under Section 503B of the Federal Food, Drug, and Cosmetic Act*. http://www.fda.gov/ucm/groups/fdagov-public/@fdagov-drugs-gen/documents/document/ucm434171.pdf.

humans, which is addressed in other guidances.[4] Further, the draft guidance does not address new animal drugs for investigational use. See 21 CFR part 511.

FDA's guidance documents, including this draft guidance, do not establish legally enforceable responsibilities. Instead, guidances describe FDA's current thinking on a topic and should be viewed only as recommendations, unless specific regulatory or statutory requirements are cited. The use of the word *should* in FDA guidances means that something is suggested or recommended, but not required.

II. BACKGROUND

A. Regulatory Framework

To be legally marketed, new animal drugs must be approved under section 512 of the FD&C Act, conditionally approved under section 571 of the FD&C Act (21 U.S.C. 360ccc), or included on the Index of Legally Marketed Unapproved New Animal Drugs for Minor Species under section 572 of the FD&C Act (21 U.S.C. 360ccc-1). The FD&C Act does not generally distinguish between compounding and other methods of animal drug manufacturing. Animal drugs that are not approved or indexed are considered "unsafe" under section 512(a)(1) of the FD&C and adulterated under section 501(a)(5) of the FD&C Act.

Although sections 503A (21 U.S.C. 353a) and 503B of the FD&C Act provide certain statutory exemptions for compounded human drugs, these sections do not provide exemptions for drugs compounded for animal use. The compounding of an animal drug from bulk drug substances results in a new animal drug that must comply with the FD&C Act's approval/indexing requirements.[5] Further, all animal drugs are required to, among other things, be made in accordance with current good manufacturing practice (cGMP) requirements (section 501(a)(2)(B)) of the FD&C Act and 21 CFR parts 210 and 211) and have adequate directions for use (section 502(f)(1) of the FD&C Act).

Sections 512(a)(4) and (5) of the FD&C Act provide a limited exemption from certain requirements for compounded animal drugs made from already approved animal or human drugs. Such use is considered an extralabel use and the FD&C Act provides an exemption from the approval requirements and requirements of section 502(f) of the FD&C Act for extralabel uses that meet the conditions set out in the statute and FDA regulations at 21 CFR part 530. Among other things, these regulations specify that nothing in the regulations should be construed as permitting compounding animal drugs from bulk drug substances.

In 1996, FDA announced the availability of a CPG (section 608.400) entitled, "Compounding of Drugs for Use in Animals" (61 FR 34849, July 3, 1996), to provide guidance to FDA's field and headquarters staff with regard to the compounding of animal drugs by veterinarians and pharmacists. An updated CPG was made available on July 14, 2003 (68 FR 41591). This draft guidance supersedes that CPG, which has now been withdrawn.

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[4] http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/PharmacyCompounding/ucm166743.htm.

[5] See *Medical Center Pharmacy v. Mukasey*, 536 F.3d 383, 394 (5th Cir. 2008).

B. Compounding Animal Drugs

Numerous drugs are approved or indexed for use in animals. However, there are many different species of animals with different diseases and conditions for which there are no approved or indexed animal drugs. In some cases, approved human drugs can be used to treat an animal under the extralabel use provisions of the FD&C Act and FDA regulations (sections 512(a)(4) and (a)(5) of FD&C Act and 21 CFR part 530). For example, various chemotherapeutic drugs approved for humans are used to treat cancer in dogs and cats. FDA recognizes that there are circumstances where there is no drug available to treat a particular animal with a particular condition, because either no drug is approved for a specific animal species or no drug is available under the extralabel drug use provisions. In those limited circumstances, an animal drug compounded from bulk drug substances may be an appropriate treatment option.

However, FDA is concerned about the use of animal drugs compounded from bulk drug substances, especially when approved alternatives exist that can be used as labeled or in an extralabel manner consistent with the requirements of FDA's extralabel provisions. Compounded drugs have not undergone premarket FDA review of safety, effectiveness, or manufacturing quality. The unrestricted compounding of animal drugs from bulk drug substances has the potential to compromise food safety, place animals or humans at undue risk from unsafe or ineffective treatment, and undermine the incentives to develop and submit new animal drug applications to FDA containing data and information to demonstrate that the product is safe, effective, properly manufactured, and accurately labeled.

III. POLICY

As discussed above, animal drugs are generally subject to the adulteration, misbranding, and approval provisions of the FD&C Act. Generally, FDA does not intend to take action under sections 512(a), 501(a)(5), 502(f)(1) and 501(a)(2)(B) of the FD&C Act if a state-licensed pharmacy or a licensed veterinarian compounds animal drugs from bulk drug substances in accordance with the conditions described below, and the drug is not otherwise adulterated or misbranded. In addition, FDA generally does not intend to take action under sections 512(a), 501(a)(5), and 502(f)(1) of the FD&C Act if an outsourcing facility compounds animal drugs in accordance with all of the applicable conditions described below, and the drug is not otherwise adulterated or misbranded.

FDA's decision not to take enforcement action depends on its ability to evaluate whether the compounding of animal drugs is in accordance with the conditions below. Therefore, entities compounding animal drugs should keep adequate records to demonstrate that they are compounding such drugs in accordance with all of the applicable conditions described below.

The conditions referred to above are as follows:

A. If the animal drug is compounded in a state-licensed pharmacy:

1. The drug is compounded by or under the direct supervision of a licensed pharmacist.

2. The drug is dispensed after the receipt of a valid prescription from a veterinarian for an individually identified animal patient that comes directly from the prescribing veterinarian or from the patient's owner or caretaker to the compounding pharmacy. A drug may be compounded in advance of receipt of a prescription in a quantity that does not exceed the amount of drug product that the state-licensed pharmacy compounded pursuant to patient-specific prescriptions based on a history of receipt of such patient-specific prescriptions for that drug product over any consecutive 14-day period within the previous 6 months.

3. The drug is not intended for use in food-producing animals, and the prescription or documentation accompanying the prescription for the drug contains the statement "This patient is not a food-producing animal." For purposes of this draft guidance, all cattle, swine, chicken, turkey, sheep, goats, and non-ornamental fish are always considered to be food-producing animals regardless of whether the specific animal or food from the specific animal is intended to be introduced into the human or animal food chain (e.g., pet pot-bellied pigs and pet chicks are always considered to be food-producing animals). In addition, for purposes of this draft guidance, any other animal designated on the prescription or in documentation accompanying the prescription by the veterinarian as a food-producing animal, regardless of species, is considered to be a food-producing animal (e.g., rabbits, captive elk, captive deer).

4. If the drug contains a bulk drug substance that is a component of any marketed FDA-approved animal or human drug:

    a. there is a change between the compounded drug and the comparable FDA-approved animal or human drug made for an individually identified animal patient that produces a clinical difference for that individually identified animal patient, as determined by the veterinarian prescribing the compounded drug for his/her patient under his/her care, and
    b. the prescription or documentation accompanying the prescription contains a statement that the change between the compounded drug and the FDA-approved drug would produce a clinical difference for the individually identified animal patient. For example, the veterinarian could state that, "Compounded drug X would produce a clinical difference for the individually identified animal patient because the approved drug is too large a dose for the animal and cannot be divided or diluted into the small dose required."

5. If there is an FDA-approved animal or human drug with the same active ingredient(s), the pharmacy determines that the compounded drug cannot be made from the FDA-approved drug(s), and documents that determination.

6. The pharmacy receives from the veterinarian (either directly or through the patient's owner or caretaker), in addition to any other information required by state law, the following information, which can be documented on the prescription or documentation accompanying the prescription:

    a. Identification of the species of animal for which the drug is prescribed; and,
    b. The statement "There are no FDA-approved animal or human drugs that can be used as labeled or in an extralabel manner under section 512(a)(4) or (5) and 21 CFR part 530 to appropriately treat the disease, symptom, or condition for which this drug is being prescribed."

7. Any bulk drug substance used to compound the drug is manufactured by an establishment that is registered under section 510 of the FD&C Act (21 U.S.C. 360) (including a foreign establishment that is registered under section 510) and is accompanied by a valid certificate of analysis.

8. The drug is compounded in accordance with Chapters <795> and <797> of the United States Pharmacopeia and National Formulary (USP—NF)[6] (e.g., a sterile drug is compounded in an area with air quality that meets or exceeds ISO Class 5 standards (see USP—NF Chapter <797>, Table 1)).

9. The drug is not sold or transferred by an entity other than the entity that compounded such drug. For purposes of this condition, a sale or transfer does not include administration of a compounded drug by a veterinarian to a patient under his or her care.

10. Within 15 days of becoming aware of any product defect or serious adverse event associated with animal drugs it compounded from bulk drug substances, the pharmacy reports it to FDA on Form FDA 1932a. Form FDA 1932a can be downloaded at http://www.fda.gov/downloads/aboutfda/reportsmanualsforms/forms/animaldrugforms/ucm048817.pdf.

11. The label of any compounded drug indicates the species of the intended animal patient, the name of the animal patient and the name of the owner or caretaker of the animal patient.

B. If the animal drug is compounded by a licensed veterinarian:

1. The drug is compounded and dispensed by the veterinarian to treat an individually identified animal patient under his or her care.

[6] Chapters <795> *Pharmaceutical Compounding—Nonsterile Preparations* and <797> *Pharmaceutical Compounding—Sterile Preparations* can be found in the combined *United States Pharmacopeia and National Formulary (USP-NF)*, available at http://www.usp.org.

2. The drug is not intended for use in food-producing animals as defined in section III.A.3 of this guidance.

3. If the drug contains a bulk drug substance that is a component of any marketed FDA-approved animal or human drug, there is a change between the compounded drug and the comparable FDA-approved animal or human drug made for an individually identified animal patient that produces a clinical difference for that individually identified animal patient, as determined by the veterinarian prescribing the compounded drug for his/her patient under his/her care.

4. There are no FDA-approved animal or human drugs that can be used as labeled or in an extralabel manner under sections 512(a)(4) and (5) of the FD&C Act and 21 CFR part 530 to appropriately treat the disease, symptom, or condition for which the drug is being prescribed.

5. The drug is compounded in accordance with USP—NF Chapters <795> and <797> (e.g., a sterile drug is compounded in an area with air quality that meets or exceeds ISO Class 5 standards (see USP—NF Chapter <797>, Table 1)).

6. Any bulk drug substance used is manufactured by an establishment that is registered under section 510 of the FD&C Act (21 U.S.C. 360) (including a foreign establishment that is registered under section 360(i)) and is accompanied by a valid certificate of analysis.

7. The drug is not sold or transferred by the veterinarian compounding the drug. For purposes of this condition, a sale or transfer does not include administration of a compounded drug by the veterinarian to a patient under his or her care, or the dispensing of an animal drug compounded by the veterinarian to the owner or caretaker of an animal under his or her care.

8. Within 15 days of becoming aware of any product defect or serious adverse event associated with animal drugs the veterinarian compounded from bulk drug substances, he or she reports it to FDA on Form FDA 1932a. Form FDA 1932a can be downloaded at http://www.fda.gov/downloads/aboutfda/reportsmanualsforms/forms/animaldrugforms/ucm048817.pdf.

9. The label of any compounded drug indicates the species of the intended animal patient, the name of the animal patient and the name of the owner or caretaker of the animal patient.

C. If the animal drug is compounded by an outsourcing facility:

1. The drugs are compounded only from bulk drug substances appearing on Appendix A of this draft guidance.

2. The drug is compounded by or under the direct supervision of a licensed pharmacist.

3. The drug is not intended for use in food-producing animals, as defined in Section III.A.3 of this guidance, and the prescription or order, or documentation accompanying the prescription or order, for the drug contains the statement, "This drug will not be dispensed for or administered to food-producing animals."

4. The drug is compounded in accordance with cGMP requirements.[7]

5. Any bulk drug substance used is manufactured by an establishment that is registered under section 510 of the FD&C Act (21 U.S.C. 360) (including a foreign establishment that is registered under section 360(i)) and is accompanied by a valid certificate of analysis.

6. The drug is not sold or transferred by an entity other than the outsourcing facility that compounded such drug. For purposes of this condition, a sale or transfer does not include administration of a compounded drug by a veterinarian to a patient under his or her care.

7. Within 15 days of becoming aware of any product defect or serious adverse event associated with animal drugs it compounded from bulk drug substances, the outsourcing facility reports it to FDA, on Form FDA1932a. Form FDA 1932a can be downloaded at http://www.fda.gov/downloads/aboutfda/reportsmanualsforms/forms/animaldrugforms/ucm048817.pdf.

8. All drugs compounded for animals by an outsourcing facility are included on the report required by section 503B of the FD&C Act to be submitted to the Food and Drug Administration each June and December identifying the drugs made by the outsourcing facility during the previous 6-month period, and providing the active ingredient(s); source of the active ingredient(s); NDC number of the source ingredient(s), if available; strength of the active ingredient(s) per unit; the dosage form and route of administration; the package description; the number of individual units produced; and the NDC number of the final product, if assigned.[8] The outsourcing facility should identify which reported drugs were intended for animal use.

9. The veterinarian's prescription or order states that the drug is intended to treat the species and condition(s) for which the substance is listed in Appendix A.

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[7] FDA intends to determine whether this condition is met by evaluating whether the facility complies with FDA regulations applicable to cGMPs for compounding of human drugs by outsourcing facilities. *See, e.g.*, draft guidance for industry, *Current Good Manufacturing Practice—Interim Guidance for Human Drug Compounding Outsourcing Facilities Under Section 503B of the FD&C Act* (July 2014), at http://www.fda.gov/downloads/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/UCM403496.pdf

[8] FDA has issued a draft guidance for industry, *Electronic Drug Product Reporting for Human Drug Compounding Outsourcing Facilities Under Section 503B of the Federal Food, Drug, and Cosmetic Act* (November 2014), which prescribes how human drug compounding facilities are to submit drug product reports to FDA. Available at http://www.fda.gov/downloads/Drugs/NewsEvents/UCM424303.pdf. Although this guidance addresses reporting of compounded human drug products, outsourcing facilities should follow the same procedure to electronically report the animal drug products they compounded.

10. The label of the drug includes the following:

    a. Active ingredient(s).
    b. Dosage form, strength, and flavoring, if any.
    c. Directions for use, as provided by the veterinarian prescribing or ordering the drug.
    d. Quantity or volume, whichever is appropriate.
    e. The statement "Not for resale."
    f. The statement "For use only in [fill in species and any associated condition or limitation listed in Appendix A]."
    g. The statement "Compounded by [name of outsourcing facility]."
    h. Lot or batch number of drug.
    i. Special storage and handling instructions.
    j. Date the drug was compounded.
    k. Beyond use date (BUD) of the drug.
    l. Name of veterinarian prescribing or ordering the drug.
    m. The address and phone number of the outsourcing facility that compounded the drug.
    n. Inactive ingredients.
    o. The statement "Adverse events associated with this compounded drug should be reported to FDA on a Form FDA 1932a."
    p. If the drug is compounded pursuant to a patient specific prescription, the species of the animal patient, name of the animal patient, and name of the owner or caretaker of the animal patient.

APPENDIX A[9]

LIST OF BULK DRUG SUBSTANCES THAT MAY BE USED BY AN OUTSOURCING FACILITY TO COMPOUND DRUGS FOR USE IN ANIMALS

This Appendix, when finalized, will contain a list of bulk drug substances that may be used by facilities registered under section 503B as outsourcing facilities to compound animal drugs pursuant to a prescription from a veterinarian for an individually identified animal patient or pursuant to an order from a licensed veterinarian for veterinarian office use, and in accordance with any specified limitations or conditions.

This list will be developed with public input; the process for nominating bulk drug substances for this list is described in the Federal Register notice soliciting nominations for such bulk drug substances. FDA intends to limit the bulk drug substances in this Appendix to address situations where all of the following criteria are met:

- there is no marketed approved, conditionally approved, or index listed animal drug that can be used as labeled to treat the condition;
- there is no marketed approved animal or human drug that could be used under section 512(a)(4) or (a)(5) and 21 CFR Part 530 (addressing extralabel use of approved animal and human drugs) to treat the condition;
- the drug cannot be compounded from an approved animal or human drug;
- immediate treatment with the compounded drug is necessary to avoid animal suffering or death; and
- FDA has not identified a significant safety concern specific to the use of the bulk drug substance to compound animal drugs (under the listed conditions and limitations).

FDA intends to review the nominated bulk drug substances on a rolling basis and to periodically update this Appendix.

LIST:

[9] To submit nominations for this list, refer to the Federal Register notice entitled, "List of Bulk Drug Substances That May be Used by an Outsourcing Facility to Compound Drugs for Use in Animals," published May 19, 2015**.** After the period for nominations closes, you may petition FDA under 21 CFR 10.30 to add or remove specific listings.

The Federal Register

The Daily Journal of the United States Government

Notice

Compounding Animal Drugs From Bulk Drug Substances; Draft Guidance for Industry; Extension of Comment Period

A Notice by the **Food and Drug Administration** on **08/17/2015**

This document has a comment period that ends in 28 days (11/16/2015) **How To Comment**

Read the **84 submitted public comments**

Action

Notice; Extension Of Comment Period.

Summary

The Food and Drug Administration (FDA) is extending the comment period for the document that appeared in the Federal Register of May 19, 2015. In the document, FDA requested comments on draft guidance for industry (GFI) #230 entitled "Compounding Animal Drugs from Bulk Drug

Substances." FDA is taking this action in response to a request for an extension to allow interested persons additional time to submit comments.

Table of Contents

DATES:

FDA is extending the comment period on the document published May 19, 2015 (**80 FR 28624**). Submit either electronic or written comments on the draft guidance by November 16, 2015.

ADDRESSES:

You may submit comments by any of the following methods.

Electronic Submissions

Submit electronic comments in the following way:

- *Federal eRulemaking Portal: http://www.regulations.gov*. Follow the instructions for submitting comments.

Written Submissions

Submit written comments in the following ways:

- *Mail/Hand delivery/Courier (for paper submissions):* Division of Dockets Management (HFA-305), Food and Drug Administration, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852.

Instructions: All submissions received must include the Docket No. FDA-2015-D-1176. All comments received may be posted without change to ***http://www.regulations.gov***, including any personal information provided. For additional information on submitting comments, see the "Request for Comments" heading of the SUPPLEMENTARY INFORMATION section of this document.

Docket: For access to the docket to read background documents or comments received, go to ***http://www.regulations.gov*** and insert the docket number, found in brackets in the heading of this document, into the "Search" box and follow the prompts and/or go to the Division of Dockets Management, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852.

FOR FURTHER INFORMATION CONTACT:

Division of Compliance, Center for Veterinary Medicine, Food and Drug Administration (HFV-230), 7519 Standish Pl., Rockville, MD 20855, 240-402-7001, *CVMCompliance@fda.hhs.gov*.

SUPPLEMENTARY INFORMATION:

I. Background

In the Federal Register of May 19, 2015, FDA published a document with a 90-day comment period for draft GFI #230 entitled "Compounding Animal Drugs from Bulk Drug Substances." The draft guidance describes FDA's policies with regard to compounding animal drugs from bulk drug substances. When final, the guidance will reflect FDA's current thinking on the issues addressed by the guidance.

FDA has received a request for a 90-day extension of the comment period. The request conveyed concern that the current 90-day comment period does not allow sufficient time to respond. FDA has considered the request and is extending the comment period for 90 days, until November 16, 2015. FDA believes that a 90-day extension allows adequate time for interested persons to submit comments without significantly delaying further FDA action on this guidance document.

II. Specific Topics for Comment

In addition to comments on the draft guidance as written, we are specifically requesting comments on the following issues:

- Should the final guidance address the issue of FDA-approved animal and human drugs that are in shortage or are otherwise unavailable (*e.g.,* disruptions in the manufacture or supply chain; business decisions to stop marketing the drug; drug is subject to Agency action based on safety, effectiveness, or manufacturing concerns)? If so:

○ How should these situations be addressed in the final guidance?

○ How should the final guidance define the terms "shortage" and "unavailable"?

○ What criteria should FDA use to determine if an approved animal or human drug is in shortage or otherwise unavailable?

- Do United States Pharmacopeia and National Formulary (USP-NF)[1] chapters 795 and 797 provide suitable standards for animal drugs compounded by veterinarians, and if not, what standards of safety, purity, and quality should apply to animal drugs compounded by veterinarians?

- Should licensed veterinarians be able to sell or transfer an animal drug compounded from bulk drug substances by a State-licensed pharmacy or an outsourcing facility to owners or caretakers of animals under the veterinarian's care?
- Should the final guidance include a condition on the amount or percentage of compounded animal drugs that a pharmacy or outsourcing facility can ship in interstate commerce? If so, what would a reasonable amount be?
- Is additional guidance needed to address the repackaging of drugs for animal use?

○ How widespread is the practice of repackaging drugs for animal use?

○ What types of drugs are repackaged for animal use, and why are they repackaged?

○ Have problems been identified with repackaged drugs for animal use?

- Is additional guidance needed to address the compounding of animal drugs from approved animal or human drugs under section 512(a)(4) or (a)(5) of the Federal Food, Drug, and Cosmetic Act (the FD&C Act) (**21 U.S.C. 360**b(a)(4) and (a)(5)) and **21 CFR part 530**?
- Is additional guidance needed to address the compounding of animal drugs from bulk drug substances for food-producing animals?
  Show citation box
- As one condition under which FDA does not generally intend to take action for certain violations of the FD&C Act if this and the other conditions are followed, FDA is proposing that State-licensed pharmacies and veterinarians report any product defect or serious adverse event associated with animal drugs they compound from bulk drug substances to FDA within 15 days of becoming aware of the product defect or serious adverse event. Outsourcing facilities are required to report adverse events associated with the drugs they compound. FDA believes it is important to receive this information from State-licensed pharmacies and veterinarians because there are no other State Departments of Health or Federal Agencies (*e.g.,* the Centers for Disease Control and Prevention) charged with identifying and tracing animal injuries or disease associated with an animal drug compounded by these entities. FDA has the following specific questions with respect to this proposed condition:

○ How many State-licensed pharmacies and veterinarians compound animal drugs from bulk drug substances and would potentially be reporting product defects and serious adverse events to FDA?

○ Are State-licensed pharmacies and veterinarians reporting the same or similar information to any State regulatory agency (*e.g.,* State boards of pharmacy, State boards of veterinary medicine)? If so, how many reports on average does each State-licensed pharmacy and veterinarian submit to these State agencies each year?

○ For purposes of the guidance, how should FDA define the terms "product defect" and "serious adverse event?"

○ Can FDA achieve the same objective of identifying and tracing the source of injuries or disease associated with an animal drug compounded from a bulk drug substance through means other than product defect and serious adverse event reporting, and if so, what other means? For example, would reports of product defects alone achieve the same objective?

III. Request for Comments

Interested persons may submit either electronic comments regarding this document to *http://www.regulations.gov* or written comments to the Division of Dockets Management (see ADDRESSES). It is only necessary to send one set of comments. Identify comments with the docket number found in brackets in the heading of this document. Received comments may be seen in the Division of Dockets Management between 9 a.m. and 4 p.m., Monday through Friday, and will be posted to the docket at *http://www.regulations.gov*.

IV. Electronic Access

Persons with access to the Internet may obtain the draft guidance at either *http://www.fda.gov/AnimalVeterinary/GuidanceComplianceEnforcement/GuidanceforIndustry/ucm042450.htm* or *http://www.regulations.gov*.

Dated: August 11, 2015.

Leslie Kux,

Associate Commissioner for Policy.

[FR Doc. **2015-20174** Filed 8-14-15; 8:45 am]

BILLING CODE 4164-01-P

Footnotes

1. Chapters <795> "Pharmaceutical Compounding—Nonsterile Preparations" and <797> "Pharmaceutical Compounding—Sterile Preparations" can be found in both the *USP Compounding Compendium* and the combined *United States Pharmacopeia and National Formulary (USP-NF).* These compendia are available at ***http://www.usp.org/***.

Back to Context

Dear Pharmacy Board Member,

As you may know, the FDA is proposing "Guidance for Industry-Compounding Animal Drugs from Bulks Drug Substances." This guidance is remarkable in its restrictions and impact to the veterinary community such as:
-documenting clinical need on each prescription for compounded drugs
-no office stock of compounded medicinals, sterile or otherwise
-scripts to be pet-specific--no flocks, fish or groups of shelter animals
-no allowance for dispensing of acute amounts from office stock

Not only do we find these guidelines contrary to the practice of contemporary veterinary medicine, they are also detrimental to pharmacies, many of whom are no longer making sterile products.

Enclosed is the AVMA response to this proposal which addresses serious deficiencies, intensified record keeping and discusses the need and urgency for compounded sterile items for office use as well as the need to dispense compounds for acute conditions. Additionally, I am enclosing a copy of a letter to the FDA from several congressmen who oppose the FDA's process. They feel the FDA has exceeded its authority and ask that the FDA proposal be withdrawn.

Veterinary medicine is vastly different than human medicine. Vets must deal with numerous species and even more numerous body weights and unusual diseases; human pharmaceuticals rarely meet their needs. Further, industry has abandoned many veterinary products that were unprofitable, notably injectables. Lastly, dispensing small amounts of specialized medication is often essential to a pet's health in the absence of readily available customized strengths and dosage forms.

In spite of recognized shortcomings, some state boards of pharmacy are seriously considering this FDA proposal for incorporation into their own regulations through a Memorandum of Understanding. Roadrunner Pharmacy has been a partner in the veterinary community for more than 16 years; we know how important these issues are to animal health practitioners. As your board addresses veterinary compounding issues, I urge you and your board to oppose these contested FDA guidelines in the presence of an 18 page letter from an organization that represents more than 85,000 veterinarians AND given the serious misgivings from members of Congress. A number of states have granted exclusions, affording unique and often life-saving compounds to veterinarians, both sterile and non-sterile.

Thank you for your time and consideration.

ROBERT L. EATON, JR.
President/CEO
Roadrunner Pharmacy, Inc

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www.RoadrunnerPharmacy.com

AVMA
Our Passion. Our Profession.

August 14, 2015

Mr. Eric Nelson
Center for Veterinary Medicine
Division of Compliance
FDA Center for Veterinary Medicine
7519 Standish Pl
Rockville, MD 20852

RE: [Docket Nos. FDA-2015-D-1176 and FDA-2003-D-0202] Compounding Animal Drugs From Bulk Drug Substances; Draft Guidance for Industry; Availability; Withdrawal of Compliance Policy Guide; Section 608.400 Compounding of Drugs for Use in Animals

Dear Mr. Nelson:

I am writing on behalf of the American Veterinary Medical Association (AVMA), established in 1863 and the largest veterinary medical organization in the world with over 86,500 members. The AVMA's mission is to lead the profession by advocating for its members and advancing the science and practice of veterinary medicine to improve animal and human health.

The AVMA recognizes that the FDA Draft Guidance for Industry #230 sets forth the Food and Drug Administration's (FDA) policy regarding compounding animal drugs from bulk drug substances by state-licensed pharmacies, licensed veterinarians, and facilities that register with FDA as outsourcing facilities under section 503B of the Federal Food, Drug, and Cosmetic Act (FD&C Act) (21 U.S.C. 353b). We understand this guidance describes the conditions under which FDA generally does not intend to take action for violations of the following sections of the FD&C Act: section 512 (21 U.S.C. 360b), section 501(a)(5) (21 U.S.C. 351(a)(5)), section 502(f)(1) (21 U.S.C. 352 (f)(1)), and, where specified, section 501(a)(2)(B) (21 U.S.C 351(a)(2)(B)), when a state-licensed pharmacy, licensed veterinarian, or an outsourcing facility compounds animal drugs from bulk drug substances.

Additionally, we recognize that this draft guidance only addresses the compounding of animal drugs from bulk drug substances, and that it does not apply to the compounding of animal drugs from approved new animal or new human drugs. The AVMA was a leader in the development of, and advocacy for, the enactment of the Animal Medicinal Drug Use Clarification Act on behalf of our members and the patients they serve. Extralabel drug use, including the compounding of preparations from FDA-approved drugs, continues to provide access to critical medications and our members continue to rely on this FDA-regulated activity in the practice of veterinary medicine within the confines of the 21 CFR 530.

The AVMA appreciates the FDA's recognition that there is a need for preparations compounded from bulk drug substances. We also share the agency's concern about the use of these preparations when approved alternatives exist that can be used as labeled or in an extralabel manner consistent

with the requirements of FDA's extralabel provisions. The AVMA continues to believe that three circumstances exist wherein compounds prepared from bulk drug substances might be necessary:

- the approved product is not commercially available, or
- the needed compounded preparation cannot be made from the approved product, or
- there is no approved product from which to compound the needed preparation.

While we are formally submitting these comments today, we will continue to assess whether the draft guidance can realistically address the needs of veterinary patients and ask that the FDA continue its dialog with us.

Overarching comments

Drug Availability

Veterinary medicine is unique in that we treat a multitude of species with an even greater number of unique diseases and conditions. Approval of new animal drugs is critical to veterinary medicine and engaging with the Agency in facilitating that process remains a high priority for our Association. However, compounding from bulk drug substances is still a necessary practice for veterinarians because there are, and always will be, a limited number of FDA-approved drug products for the many species and conditions that we treat. Intermittent drug shortages and commercial unavailability of FDA-approved drug products drive the need for compounded preparations within veterinary practice. While FDA has not identified cost as appropriate reason for compounding from bulk drug substances, the AVMA acknowledges that cost can be a reason veterinarians utilize compounded preparations because that is the only way a client can afford to treat their pet.

Our members have clearly conveyed that they need access to safe and efficacious drug products that can be practicably used in their patients. While recognizing FDA's jurisdiction is limited to issues related to safety and efficacy, not cost or commercial availability of drug products, we underscore the increasingly critical need for effective pathways for drug products to achieve legal marketing status. A robust, competitive animal health industry can benefit animal patients by way of increased numbers of legally marketed products that can be prescribed, dispensed or used in the preparation of compounds.

Existing pathways to legal marketing

- We continue to support the concept of user fees, so long as those fees go toward expedited reviews. Increased numbers of both pioneer and nonproprietary approved drug products can help to minimize the impacts of drug shortages.
- FDA's indexing process can be a valuable way to increase the number of legally marketed drug products for use in minor species or in major species with rare conditions. We recognize that indexing provides a process to obtain legal marketing status for eligible products. The indexing process should be utilized to a fuller extent, or revised accordingly, so that well-vetted drugs that have undergone expert panel scrutiny can be used legally for wildlife, aquaria, zoo, aquacultural, and laboratory animal species, and for major species with rare conditions.

Innovative pathways to legal marketing

- In 2010, the FDA published a Federal Register notice FDA-2010-N-0528 seeking comments related to identification of emerging paths toward legal status of drugs that are medically necessary and manufactured using good manufacturing processes. At the time, FDA conveyed that it is open to using both the agency's existing authority and new approaches to

make more drugs legally available to veterinarians, producers, and pet owners. We commended the FDA on its pursuit at the time and urge the FDA to implement innovative strategies to legal marketing. The AVMA stands ready to discuss possible approaches further with FDA.

Non-food minor species

In species including but not limited to zoo animals, laboratory animals, exotic pets, wildlife, aquaria animals, and non-food aquacultural animals, the use of compounded preparations is unquestionably necessary. We urge FDA to carefully consider the critical need for access to compounded preparations within these species, as FDA further refines its guidance. There are few choices of FDA-approved or indexed products available for use in these species; therefore, availability of properly compounded preparations to be maintained for office use in appropriate strengths and formulations, and the ability to mix and dilute medications are necessary to provide adequate veterinary care. Several provisions within this draft guidance should not apply to non-food minor species in their respective environments, such as limiting preparations to be maintained in office for urgent or emergent needs, patient-specific prescriptions, and detailed labeling requirements for compounded preparations maintained for office use.

Federal vs. State Jurisdiction

The licensure of veterinarians is regulated by state governmental authorities. Given this is a federal guidance, not a regulation, coupled with the existence of a wide range of state compounding rules, we would appreciate clarification on how GFI #230 will be enforced by the FDA. State rules regulating compounding in veterinary practice vary greatly. Some even provide substantial permissiveness for veterinarians to obtain preparations compounded for office use, and administer and dispense from the compounded preparations maintained in their office.

- How will the FDA evaluate whether the compounding of animal drugs is done in accordance with the conditions outlined in the guidance?
- Will the FDA rely on state boards of pharmacy and boards of veterinary medicine to enforce provisions within GFI #230, and how will the FDA reconcile discrepancies between state rules and GFI #230?

Enforcement

For many years the AVMA has advocated for, and applauded, the FDA's enforcement of illegal manufacturing activities. The AVMA asserts that large-scale manufacturing of animal drugs under the guise of compounding does not serve to benefit animal health; rather, circumvention of the drug approval process yields substances with unknown safety, efficacy, and potency, potentially allowing disease to progress. Animal drug manufacturers also contend that these compounded preparations result in a supply/demand disincentive for new FDA-approved drug products.

- As FDA is concerned about the use of animal drugs compounded from bulk drug substances, especially when approved alternatives exist that can be used as labeled or in an extralabel manner consistent with the requirements of FDA's extralabel provisions, how does this guidance change the FDA's ability to take action to address these concerns?
- Does the FDA currently have the needed resources and enforcement capabilities to fully enforce all egregious compounding activities, or are new authorities and appropriations necessary for the agency?
- Will the FDA develop and provide a user's guide on implementing the GFI #230 for state boards of pharmacy, state boards of veterinary medicine, individual veterinarians, and pharmacists to follow? We anticipate that time for a transition to the new paradigm will be

needed across stakeholder groups, especially given the wide array of state rules that exist related to veterinary compounding. Some veterinary state boards might not be prepared to inspect veterinary facilities for compliance with standards delineated within GFI #230.

- How will FDA's enforcement of compounded preparations be reconciled with the Drug Enforcement Administration's expectations that preparations containing controlled substances must only be prepared pursuant to patient-specific prescriptions?
- We also encourage FDA to coordinate with all relevant governmental agencies related to use of bulk drug substances in depopulation efforts, which might be needed during large-scale national emergencies. The AVMA stands ready to serve as a resource to FDA related to this topic.

Adverse Event Reporting System

The AVMA contends that there is a need for the continued development and strengthening of adverse event reporting systems for all adverse events, including lack of efficacy. We believe that there must be a strong, science-based, transparent and systematic surveillance system, especially considering the wide scope of species and disease conditions that veterinarians treat. The AVMA supports development of a user-friendly, easy to access form for all adverse events related to compounding. A user-friendly electronic system would be anticipated to promote both reporting by those compounding, and ease of review by FDA. For example, FDA could maintain a database of recently reported adverse events for veterinarians and pharmacists to use as a resource. Sufficient and meaningful data inputs, or adverse event reports, are imperative for a strong reporting system foundation.

- Does the FDA's current 1932a form, as a means of capturing adverse events, provide the robustness FDA needs to detect and act on trends? The AVMA contends that all adverse events associated with compound preparations should be reported, not just serious adverse events. Adverse events related to lack of efficacy should also be collected and analyzed.

Comments on Specific Provisions within Draft GFI #230

Scope of AVMA Comments

The AVMA has chosen to comment on the sections and questions that impact veterinary medicine. We will defer to the pharmacy community for feedback related to the practice of pharmacy and functioning of outsourcing facilities: pharmacist supervision (Section III.A.1. and Section III.C.2); compounding in advance of receipt of a prescription (Section III.A.2); determining and documenting that the compounded drug cannot be made from the FDA-approved drug(s) (Section III.A.5); current Good Manufacturing Practices (cGMP) (Section III.C.4); certain labeling requirements (Section III.C.10); and reporting requirements from 503B of the FD&C Act (Section III.C.8).

Definitions

We request the FDA provide clarification on the following terms:

- "Outsourcing facility"—Draft GFI #230 defines an "outsourcing facility" as a facility that meets the definition of an outsourcing facility under section 503B(d)(4) of the FD&C Act. Section 503B(d)(4) defines an outsourcing facility as a facility at one geographic location or address that (i) is engaged in the compounding of sterile drugs; (ii) has elected to register as an outsourcing facility; and (iii) complies with all of the requirements of that section of the law.

  As the use of outsourcing facilities in veterinary medicine is an entirely new concept, we are still assessing how the requirements for registration as an outsourcing facility would impact

the ability to meet veterinary needs. We wish to underscore that there is a substantial need for both non-sterile and sterile compounded preparations to be maintained for office use in veterinary medicine. We appreciate that the use of outsourcing facilities in the preparation of office stock is intended to increase safety of compounded preparations, yet we caution that use of outsourcing facilities might have the unintended consequence that some preparations of critical importance to animal health may no longer be available due to economic or other business considerations.

We ask the FDA to clarify how it will reconcile the clear discrepancies between statutory language and provisions in various agency documents:

- Specifically, it is our understanding that outsourcing facilities in compliance with Section 503B are only exempt from the *human drug approval requirements* in section 505 of the FD&C Act (21 U.S.C. 355), the requirement to be labeled with adequate directions for use in section 502(f)(1) of the FD&C Act (21 U.S.C. 352(f)(1)), and the track and trace requirements in section 582 of the FD&C Act (21 U.S.C. 360eee-1). How does this guidance impact the facility's exemption from animal drug approval requirements?
- Per the FDA's draft guidance for industry *For Entities Considering Whether to Register As Outsourcing Facilities Under Section 503B of the Federal Food, Drug, and Cosmetic Act,* referenced in draft GFI #230, outsourcing facilities are required to meet certain conditions to qualify. Of particular concern is the requirement that the outsourcing facilities must not compound drugs that appear on a list published by the FDA of drugs that have been withdrawn or removed from the market because the drugs or components of such drugs have been found to be unsafe or not effective *for humans.* We are aware of a number of such compounded preparations needed in veterinary medicine, including but not limited to cisapride, asparaginase, and chloramphenicol. In these cases, the FDA-approved product was withdrawn from the market due to human safety concerns, leaving us with no alternative to treat animal patients.
- An additional concern is that a facility, in order to meet the definition of an outsourcing facility, must be engaged in the compounding of sterile human drugs. The draft guidance clearly states that "you should not register a facility as an outsourcing facility if the only activities conducted at the facility are…animal drugs,…because none of the products produced at the facility would qualify for the exemptions provided in section 503B." A number of pharmacies currently exist that serve the needs of veterinarians and would need to register as an outsourcing facility per GFI #230, but they are explicitly prevented from registering per Section 503B because they do not meet certain requirements and were told not to register by the agency in another Guidance for Industry.

- "Compounding" as defined within 503A does not include mixing, reconstituting, or other such acts that are performed in accordance with directions contained in approved labeling provided by the product's manufacturer and other manufacturer directions consistent with that labeling. Defined within 503B, compounding is the combining, admixing, mixing, diluting, pooling, reconstituting, or otherwise altering a drug or bulk drug substance to create a drug. Is the administration of a bulk drug substance directly to an animal (for example, dissolution of metronidazole powder in aquaria for medical treatment of pet fish) considered compounding, or would administration be considered compounding only if the bulk drug

substance is mixed with another active or inactive ingredient? We ask the FDA to fully clarify its definition of animal drug compounding within this guidance.

- "Bulk drug substance" is defined within 21 CFR 207.3(a)(4) as "any substance that is represented for use in a drug and that, when used in the manufacturing, processing, or packaging of a drug, becomes an active ingredient or a finished dosage form of the drug, but the term does not include intermediates used in the synthesis of such substances." We understand that compressed gases, household items, herbals and homeopathics, and manufactured unapproved drugs such as glucosamine, would be outside the scope of this guidance. We ask the FDA to fully clarify what it considers a bulk drug substance for purposes of this guidance.
    - In its Table 1—Estimated Annual Recordkeeping Burden, please clarify details surrounding FDA's estimate that 75,000 pharmacies will receive approximately 6,350,000 prescriptions for compounded animal drugs annually. From where were these numbers obtained, and are these numbers specific to preparations compounded from bulk drug substances or prescriptions for all compounded preparations?

- "Patient" is defined by the AVMA (https://www.avma.org/KB/Policies/Pages/Model-Veterinary-Practice-Act.aspx) as an animal or group of animals examined or treated by a veterinarian, which would include herds, flocks, groups of shelter animals, laboratory animal colonies or groups, and zoo animal and aquaria collections. We respectfully request the use of this definition for the term "patient."

- "Non-ornamental fish" needs further clarification. Which definition is the FDA using for this term? The FDA-CVM's Program Policy and Procedures Manual *Enforcement Priorities ForDrug Use In Non-Food Fish* includes a definition of "ornamental fish." For purposes of GFI #230, are all fish not included in that definition to be considered "non-ornamental fish" and therefore food-producing animals?

- "Clinical difference" is not expressly defined within Section 503B or in the draft GFI #230. How will "clinical difference" be evaluated by the FDA, or does the FDA intend to seek state enforcement of this component?

- The terms "sale" and "transferred" need to be more clearly defined. For example, does this include the sharing of a compounded preparation between one clinic and a co-owned satellite clinic, between multiple zoological institutions or government agencies, or from one university laboratory to another within the same university system?

Section III.A.

(2) We have serious concerns with the verbiage "The drug is dispensed…for an individually identified animal patient..." AVMA fully supports the requirement that a veterinarian-client-patient relationship must exist for the use of a compounded preparation in an animal patient. However, the requirement that a patient must be 'individually identified' would eliminate the ability for veterinarians to obtain a preparation for a collection of animals, such as in a zoo, laboratory animal research facility or aquarium. In some of these situations, the patient cannot be individually identified or the entire group needs to be treated; it would not be feasible or reasonable to write an individual prescription for each animal.

- We request the FDA delete the words "individually identified" and use the AVMA's definition of "patient": https://www.avma.org/KB/Policies/Pages/Model-Veterinary-Practice-Act.aspx.

(3) "Food-producing animal" defined to include all cattle, swine, chickens, turkeys, sheep, and goats is consistent with our understanding and definition of a "food-producing animal."

The AVMA contends that compounding from bulk drug substances in food-producing animals is medically necessary for certain poison antidotes, euthanasia, and depopulation medications. There must be some allowance for compounding from bulk ingredients for these explicit situations, when there is no FDA-approved product or the approved product cannot feasibly be used per label or in an extralabel fashion. Veterinarians must also be able to legally maintain sufficient quantities of these compounded preparations in their office for urgent administration needs or emergency situations in food animals. Without access, animals would die before the medication could be delivered; for example, methylene blue is needed to treat nitrate toxicosis in cattle in the southeastern part of the USA. We recognize veterinarians' need to ensure food safety, maintain required records, and label drugs appropriately, as required under FDA's extralabel drug use rules. We ask that FDA draft a separate guidance to address these needs.

We are not opposed to the requirement that the prescription or documentation accompanying the prescription for a non-food animal must contain the statement "This patient is not a food-producing animal." The statement also helps to distinguish those patients that could be a food-producing animal in some situations, independent of species (e.g., rabbits, captive elk, captive deer).

We also would appreciate clarification on the wording in the latter half of this provision: "...any other animal designated on the prescription or in documentation accompanying the prescription by the veterinarian as a food-producing animal, regardless of species, is considered to be a food-producing animal."

- Would this mean that a veterinarian would state "This patient is a food-producing animal" to identify for the pharmacist that a bulk drug substance is not to be used?

(4)(a) The AVMA disagrees with the requirement that a pharmacy may compound a preparation using a bulk drug substance that is a component of any marketed FDA-approved animal or human drug only if the change between the compounded drug and the FDA-approved drug would produce a clinical difference. We assert that compounding should be allowable if the approved product is not commercially available for other reasons (i.e., unavailable) and no therapeutic alternatives exist, or if the needed compounded preparation cannot be made from the approved product (such as preparation of metronidazole benzoate for use in a cat) as allowed per Section III.A.5. We ask the agency to amend the provision accordingly. Given the frequency of FDA-approved drug product shortages and backorders, including all marketed FDA-approved drugs is too restrictive for the needs of veterinary patients.

(4)(b) The AVMA has concerns with, and is opposed to, the requirement for a statement from the veterinarian that the compounded preparation "produces a clinical difference for the individually identified animal patient" with an explanation of that difference. We contend that a medical rationale is necessary for use of compounds, and is a more applicable term than "clinical difference." However, we believe documentation of why the compounded preparation was chosen is more appropriate for the medical record.

- Should FDA still choose to require inclusion of a statement in documentation, will the statements be evaluated by the FDA, or does the FDA intend to seek state enforcement of this component?

Additionally, we believe that the term "clinical difference" does not capture other medical needs for compounded preparations, such as certain worker and client safety needs, client compliance, and animal stress situations (e.g., fractious cats). These safety/animal handling needs are not related to clinical differences but rather, the ability to adequately medicate patients.

(5) Related to pharmacists documenting that a compounded preparation cannot be made from an FDA-approved drug, what does the FDA consider to be "acceptable documentation," and to whom will the documentation be provided?

(6)(b) In concept, the AVMA does not oppose the requirement that the statement "There are no FDA-approved animal or human drugs that can be used as labeled or in an extralabel manner under section 512(a)(4) or (5) and 21 CFR part 530 to appropriately treat the disease, symptom, or condition for which this drug is being prescribed" be documented on the prescription or documentation accompanying the prescription, because we believe veterinarians need to carefully consider their therapeutic options. However, the statement could inadvertently discourage use of FDA-approved drugs in preparing compounded medications. For example, we understand that sometimes the best starting ingredient for a pharmacist's preparation of a compounded medication is the FDA-approved drug. If the veterinarian includes the above statement, that essentially would direct the pharmacist to utilize a bulk drug substance. Moreover, the veterinarian writing the prescription would not necessarily know whether the FDA-approved drug or the bulk drug substance is best for the preparation. We wholeheartedly agree with the need for veterinarians to utilize FDA-approved products whenever feasible. We ask that FDA discuss this topic further with the AVMA.

(9) We would like clarification on the statement that "a sale or transfer does not include administration of a compounded drug by a veterinarian to a patient under his or her care." It is our understanding that under the guidance, the compounded preparation may only be dispensed by the pharmacy to the patient's owner or caretaker, a concept with which the AVMA disagrees. Does this provision in some way allow for the veterinarian to receive the compounded preparation from the pharmacy, and then administer and dispense the preparation to the patient's owner or caretaker? The AVMA asserts that the prescribing veterinarian should be able to dispense these preparations to help ensure that the medications are being used and administered appropriately by the client. Such dispensing also keeps the prescribing veterinarian more closely attuned to the current status of the patient should client questions or concerns (such as adverse events) arise.

We request that the FDA amend the provision to allow dispensing: "...a sale or transfer does not include administration of a compounded drug by a veterinarian to a patient under his or her care, <u>or the dispensing of a compounded drug by the veterinarian to the owner or caretaker of an animal under his or her care</u>."

Section III.B.

(1) Again, the AVMA contends that compounding should be done within the confines of a veterinarian-client-patient relationship. However, veterinarians must be able to legally maintain sufficient quantities of compounded preparations in their office for urgent administration needs or emergency situations, including compounds prepared by veterinarians and pharmacies. In fact, the

maintenance of preparations for office use is lawful for veterinarians under some states' rules. We request that the FDA include an allowance for the preparation of compounds by veterinarians in advance of a specific patient's need.

(2) For food animals, the AVMA, again, asserts that a publically available list of bulk drug substances for veterinarians to prepare poison antidotes, euthanasia, and depopulation preparations should be made available.

As previously stated in Section III (A) 3, veterinarians must also be able to legally maintain sufficient quantities of these compounded preparations in their office for urgent administration needs or emergency situations in food animals. Without access, animals would die before the medication could be delivered; for example, methylene blue is needed to treat nitrate toxicosis in cattle in the southeastern part of the USA. We recognize veterinarians' need to ensure food safety, maintain required records, and label drugs appropriately, as required under FDA's extralabel drug use rules. We ask that FDA draft a separate guidance to address these needs.

(3) If the veterinarian is prescribing a medication to be compounded in lieu of an FDA-approved drug, then there is a clinical need that has already been determined by the prescribing veterinarian. Thus the AVMA agrees with the purpose of the provision. We do not support any additional reporting or recordkeeping requirements related to this provision.

We request that the FDA amend the provision to allow for compounding from bulk ingredients if the approved product is not commercially available (either due to a backorder, shortage, or no longer marketed) or if the needed compounded preparation cannot be made from the approved product. As stated with respect to Sec. III.A.4.a., the frequency of FDA-approved drug product shortages and backorders makes inclusion of all marketed FDA-approved drugs too restrictive for the needs of veterinary patients.

(4) The AVMA supports the intentions of this provision as the AVMA believes that an FDA-approved drug product should always be used first and foremost.

(5) The AVMA supports the requirement that veterinarians compounding from bulk drug substances do so in accordance with USP—NF Chapters <795> and <797> (e.g., a sterile drug is compounded in an area with air quality that meets or exceeds ISO Class 5 standards (see USP—NF Chapter <797>, Table 1)).

(6) The AVMA agrees with the requirements for use of bulk drug substances that are accompanied by a valid certificate of analysis and that come from FDA-registered manufacturers.

(7) The AVMA agrees with the provision's allowance for veterinarians to administer the preparation to the patient or dispense to the owner or caretaker. The AVMA also agrees that this should all be done within the confines of a veterinarian-client-patient relationship.

The AVMA contends that dispensing practices by veterinarians should be regulated by individual state boards of veterinary medicine. We would like the FDA to clarify what the agency would consider to be the "transfer" of compounded preparations to another veterinarian or a satellite facility.

Section III.C.
(1) Please see our comments in the section below related to Appendix A. We have reservations about the outline drafted for the creation of such a list and whether patient needs can be met through the use of such a list.

(3) We do not oppose the requirement for a statement on the prescription or supporting documentation that "This drug will not be dispensed for or administered to food-producing animals." Including such a statement is important to help minimize the risk of the medication being used in a food animal.

As stated previously, the AVMA contends that compounding from bulk drug substances in food-producing animals is medically necessary for certain poison antidotes, euthanasia, and depopulation medications. There must be some allowance for compounding from bulk ingredients for these explicit situations, when there is no FDA-approved product or the approved product cannot feasibly be used per label or in an extralabel fashion. Veterinarians must also be able to legally maintain sufficient quantities of these compounded preparations in their office for urgent administration needs or emergency situations in food animals. Without access, animals would die before the medication could be delivered; one example also stated previously is methylene blue, which is needed to treat nitrate toxicosis in cattle in the southeastern part of the USA. We recognize veterinarians' needs to ensure food safety, maintain required records, and label drugs appropriately, as required under FDA's extralabel drug use rules. We ask that FDA draft a separate guidance to address these needs.

(6) As the draft guidance is currently written, outsourcing facilities would be the only way by which a veterinarian could obtain office stock of certain compounded preparations. Many of these preparations are not only needed for immediate in-house administration by the veterinarian but also for dispensing to the patient's owner or caretaker for treatment at home, up to a 14-day timeframe. This allows for dispensing for emerging needs, and to help ensure the drug is going to be effective in a particular patient. It would also help to avoid a client needing two prescriptions for one drug in a short timeframe (which could decrease compliance), and would allow time to detect any immediate adverse events (e.g., intolerance to the drug, such as seen when amlodipine results in inappetence in cats).

We request that the FDA amend the provision to allow dispensing: "...a sale or transfer does not include administration of a compounded drug by a veterinarian to a patient under his or her care, or the dispensing of a compounded drug by the veterinarian to the owner or caretaker of an animal under his or her care." This would bring the provision in line with what is allowed for physicians under Sec. 503B of the FD&C Act.

(9) At this time, the AVMA has reservations related to the requirement that a veterinarian's order state that the product will be used in a manner and in a species that complies with the list of permitted bulk ingredient uses under Appendix A. If any such list is created, it needs to be maintained properly and reflect veterinarians' needs. These concerns will be further addressed in the feedback below on Appendix A.

(10) The AVMA contends that certain information should be incorporated into labels/packaging and generally agrees with inclusion of:

a. Active ingredient(s)
b. Dosage form, strength, and flavoring, if any
c. Directions for use, as provided by the veterinarian prescribing or ordering the drug

d. Quantity or volume, whichever is appropriate
e. The statement "Not for resale."
f. The statement "For use only in [fill in species and any associated condition or limitation listed in Appendix A]."
g. The statement "Compounded by [name of outsourcing facility]."
h. Lot or batch number of drug
i. Special storage and handling instructions
j. Date the drug was compounded, and date of dispensing, if dispensed
k. Beyond use date (BUD) of the drug
l. Name of veterinarian prescribing or ordering the drug
m. The address and phone number of the outsourcing facility that compounded the drug
n. Inactive ingredients
o. The statement "Adverse events associated with this compounded drug should be reported to FDA on a Form FDA 1932a."
p. If the drug is compounded pursuant to a patient specific prescription, the species of the animal patient, name of the animal patient, number of refills if applicable, and name of the owner or caretaker of the animal patient. We wish to underscore that "patient" can also mean a herd, collection or group of shelter animals. We assert that the AVMA's definition of "patient" should be used.

We also request that FDA require all compounded preparations be labeled that they are not FDA-approved products. We believe it is important for consumers to recognize that safety, efficacy, potency and sterility, where applicable, of compounded preparations have not been assessed or verified by the FDA.

Labeling requirements for preparations to be maintained for office use can be difficult for minor species, including but not limited to zoo, aquaria, laboratory-animal, and wildlife collections and/or facilities. For example, some compounds maintained for office use will be used to treat lameness in a number of species in a zoo collection. The labeling requirement as posed in (f) would be particularly difficult in these collections.

Pertaining to Provisions Which Appear in Multiple Sections
Related to Labeling by Pharmacies and Veterinarians (Section III.A.11 and Section III.B.9)
AVMA requests that the labeling requirements for pharmacists and veterinarians include name of client; veterinarian's name and address; identification of animal(s) treated, species and numbers of animals treated, when possible; date of dispensing; name, active ingredient, and quantity of the drug preparation to be dispensed; drug strength (if more than one strength available); dosage and duration; route of administration; number of refills; cautionary statements as needed; beyond use date; and the statement "Compounded by [name, address, and contact number of the pharmacy or veterinarian]." We also assert that compounded preparations should be labeled that they have not been approved by FDA. Patient owners or caretakers should have information available to contact the compounding entity, be it a pharmacy, veterinarian or outsourcing facility.

The AVMA agrees with inclusion of the name of the owner or caretaker and species of animal. AVMA contends that a patient may be an animal or group of animals so the "name" of the animal patient should only be required for prescriptions where applicable and appropriate.

Related to Patient-Specific Prescriptions (Section III.A.2 and Section III.B.1)
Veterinarians must be able to legally maintain sufficient quantities of compounded preparations in their office for urgent administration needs or emergency situations. These cannot be obtained through patient-specific prescriptions. Examples are many, and include: methylene blue to treat nitrate toxicosis; apomorphine to induce emesis in dogs; antibiotics, such as metronidazole, formulated into an appropriate dose for small dogs and cats and a palatable flavor for non-human primates to treat acute diarrhea; and nonsteroidal anti-inflammatory drugs, such as meloxicam, for pain control in small mammals.

This guidance's allowance that preparations that appear in a list will only be available from an outsourcing facility will greatly restrict veterinarians' access to critical medications and hamstring their ability to provide appropriate care in a timely manner. We must ask the FDA to reconsider provisions related to preparations compounded for office use and engage in discussion with the AVMA and the veterinary profession to better ascertain how to best meet the needs of both the FDA and veterinary patients.

Related to Sourcing of, and Information on, Bulk Drug Substances (Section III.A.7, Section III.B.6, and Section III.C.5)
Section III.A.7 states that "Any bulk drug substance used to compound the drug is manufactured by an establishment that is registered under section 510 of the FD&C Act (21 U.S.C. 360) (including a foreign establishment that is registered under section 510) and is accompanied by a valid certificate of analysis." How does the intent related to this statement differ from the intents for Section III.B.6 and Section III.C.5, which both state "Any bulk drug substance used is manufactured by an establishment that is registered under section 510 of the FD&C Act (21 U.S.C. 360) (including a foreign establishment that is registered under section 360(i)) and is accompanied by a valid certificate of analysis"?

The AVMA agrees with the requirement that any bulk drug substance used by either a pharmacy, veterinarian, or outsourcing facility be manufactured by an establishment that is registered under section 510 of the FD&C Act (21 U.S.C. 360) (including a foreign establishment that is registered under section 360(i)) and is accompanied by a valid certificate of analysis.

Related to USP-Related Requirements (Section III.A.8 and Section III.B.5)
The AVMA asserts that compliance with USP guidelines continues to be an element that can be utilized when a veterinarian considers the quality of a compounding pharmacy's preparations. The AVMA supports the requirement that veterinarians, outsourcing facilities, and pharmacists compounding from bulk drug substances do so in accordance with USP—NF Chapters <795> and <797> (e.g., a sterile drug is compounded in an area with air quality that meets or exceeds ISO Class 5 standards (see USP—NF Chapter <797>, Table 1)).

Related to the Sale or Transfer of Compounded Preparations (Section III.A.9 and Section III.B.7)
The AVMA advocates that compounded preparations should not be wholesaled. However, we seek clarification from FDA related to the definition of "sale" and "transfer" as indicated previously in our comments.

Related to Adverse Event Reporting Requirements (Section III.A.10, Section III.B.8, and Section III.C.7)
The AVMA advocates for robust, strong adverse event reporting systems. However, we ask whether the FDA's current 1932a form, as a means of capturing adverse events, provides the robustness FDA

needs to detect and act on trends? The AVMA underscores that all adverse events associated with compounded preparations should be reported by those compounding the preparations, rather than just serious adverse events. Adverse events related to lack of efficacy should also be collected and analyzed.

The AVMA contends there is a need for the continued development and strengthening of adverse event reporting systems for all adverse events, including lack of efficacy. We believe there must be a strong, science-based, transparent and systematic surveillance system, especially considering the wide scope of species and disease conditions that veterinarians treat. The AVMA supports development of a user-friendly, easy to access form for all adverse events related to compounding. A user-friendly electronic system would be anticipated to promote both reporting by those compounding and ease of review by the FDA. For example, the FDA could maintain a database of recently reported adverse events for veterinarians and pharmacists to use as a resource. Sufficient and meaningful data inputs, or adverse event reports, are imperative for a strong reporting system.

Related to the proposed requirement for submission of all adverse events within 15 days, the AVMA asserts that this timeframe is acceptable for veterinarians. We hope that such a timeframe is amenable to pharmacies and outsourcing facilities.

Appendix A, List of Bulk Drug Substances That May Be Used By An Outsourcing Facility to Compound Drugs for Use in Animals

In GFI #230, the FDA conveys its general intent to enforce all adulteration and misbranding provisions of the FD&C Act against entities compounding animal drugs from bulk drug substances if they are not in accordance with provisions delineated within the guidance. The AVMA understands this to mean that while all compounding from bulk drug substances continues to be illegal, those activities not provided for within the confines of GFI #230 are subject to *greater* likelihood of enforcement.

Although we want compounded preparations that veterinarians maintain for office use to be safe, we have concerns that the explicit use of outsourcing facilities might have the unintended consequence of making some preparations unavailable.

The AVMA asserts that use of a compounded preparation should be limited to those individual patients for which no other method or route of drug delivery is practical; those drugs for which safety, efficacy, and stability have been demonstrated in the specific compounded form in the target species; or disease conditions for which a quantifiable response to therapy or drug concentration can be monitored. Needs vary greatly across species treated by veterinarians.

- Zoo animals, laboratory animals, wildlife, exotic pets, camelids, aquaria species, and non-food aquacultural species: These minor species have few FDA-approved animal or human drug products or indexed drugs that can be used as labeled or in an extralabel manner to treat conditions. For example, diminutive dosages and volumes are required for some exotic pets, so office use is critical. Zoo veterinarians have advised they need to have office stock to be able to readily treat lameness or other conditions that can arise at any time among the large collections of animals they treat. For that reason, the importance of having preparations compounded from bulk drug substances in anticipation of the patient's need and available in the hospital or clinic for administration, and dispensing when appropriate, is undeniable.
- Food-producing animals: The AVMA suggests that the FDA draft a separate guidance to address compounding from bulk drug substances for food producing animals. The draft GFI

#230 provides no allowance for the preparation of compounds from bulk drug substances for food-producing animals. The AVMA has advocated for a publically available, current list of bulk drug substances that can be legally compounded within a veterinarian-client-patient relationship specific and limited to euthanasia, depopulation, and poison antidote compounds for food-producing animals. There currently exist no FDA-approved animal or human drug products or indexed drugs that can be used for these specific needs. Therefore, it is imperative that veterinarians have these preparations available and in their clinic when the need arises. Not only is compounding from bulk drug substances necessary for food-producing animals, the FDA must allow for the preparations to be obtained in anticipation of a specific patient's need (i.e. via a nonpatient-specific prescription or prescription order) for treating certain toxicoses and for euthanasia or depopulation.

- Dogs, cats, and horses: While there are a number of FDA-approved drug products for dogs, cats and horses, there remain circumstances where there is no FDA-approved drug product available to treat a particular animal with a particular condition, because either no drug product is approved for a specific animal species or no approved drug product is available or feasible for use under the extralabel drug use provisions. For example, some shelters receive 20,000 to 30,000 animals per year and have immediate needs that require compounded preparations for adequate treatment. Another example is the need for compounded buprenorphine when an owner is unable to adequately medicate their painful cat with the injectable or oral treatment at home. In instances such as these, having access to these compounded preparations for administration and dispensing by the veterinarian is critical to preventing animal suffering and death.

The criteria that all substances must meet to be included on the list are challenging.

- As asked previously, will the identified "significant safety concern specific to the use of the bulk drug substance to compound animal drugs" be related to safety concerns for humans or for animal patients? For example, cisapride was removed from the market due to human safety concerns, but is critical in feline medicine. We contend that safety concerns related to the use of compounded medications in human medicine should have no bearing on their use in animal patients in most circumstances.
- Additionally, evidence clearly indicating the ineffectiveness of a substance to be used should be a criterion by which the substance is not included on the list.

We have concerns related to the feasibility of creating an all-encompassing list of bulk drug substances within the paradigm framed by FDA, with supporting documentation as outlined in the Docket No. FDA-2015-N-1196. In lieu of the list, we contend that compounding from bulk drug substances should be allowed in three general sets of circumstances: the approved product is not commercially available, the needed compounded preparation cannot be made from the approved product, or there is no approved product from which to compound the needed preparation.

AVMA will be providing a separate set of comments pursuant to the Federal Register notice titled, "List of Bulk Drug Substances That May be Used by an Outsourcing Facility to Compound Drugs for Use in Animals."

Specific Topics for Comment

Should the final guidance address the issue of FDA-approved animal and human drugs that are in shortage or are otherwise unavailable (e.g., disruptions in the manufacture or supply chain; business

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decisions to stop marketing the drug; drug is subject to Agency action based on safety, effectiveness, or manufacturing concerns)?
The AVMA is committed to the continued availability of medicinal products that are pure, safe, potent and efficacious for animals. While we recognize that many factors can impact a manufacturer's decision or ability to produce and make FDA-approved drug products available, the short and long-term breaks in availability or complete withdrawal of a product from the market make access to compounded preparations even more important. Lack of information regarding why the products have been removed from the market and when they might return causes frustration and uncertainty for veterinarians and pet owners as they plan for treatment of patients.

Accordingly, the AVMA contends that the lack of commercially available FDA-approved drug products is a valid reason for veterinarians to prescribe compounds prepared from bulk drug substances for patients. For example, ticarcillin-clavulanic acid is critical for treatment of certain types of bacterial otitis externa in dogs and must be compounded when commercially unavailable. We ask that the final guidance address the issue of compounding preparations from bulk drug substances when the FDA-approved drug products are unavailable for any reason. As requested earlier in our comments, does the FDA have the needed resources to address and minimize impacts of drug unavailability on patient care? Additionally, what protocols and procedures will FDA follow to assure that timely notification is made regarding emerging drug shortages that impact veterinary medicine and notification when the drug is once again commercially available? And how does FDA know when a shortage of a human FDA-approved drug will impact veterinary medicine?

How should these situations be addressed in the final guidance?
The AVMA contends that a robust, nimble, current drug shortage list should be made publically available. While we do not yet have a recommendation on whether this action should be incorporated into the provisions delineated within GFI #230, implemented elsewhere for the agency to manage, or maintained by an external stakeholder(s), appropriate resources must be dedicated toward its continual upkeep. In the interim, any role that the FDA plays with regard to identification of drug shortages needs to be well-informed and more broadly encompassing than the current list housed at
http://www.fda.gov/AnimalVeterinary/SafetyHealth/ProductSafetyInformation/ucm267669.htm.

How should the final guidance define the terms "shortage" and "unavailable"?
A "shortage" refers to insufficient quantities of a needed FDA-approved product. "Unavailable" means that the FDA-approved product is entirely inaccessible to practitioners. Shortages and unavailability of products may be due to a back order, temporary discontinuation, or other supply interruption, resulting in limited or no accessibility through regular distribution channels.

What criteria should FDA use to determine if an approved animal or human drug is in shortage or otherwise unavailable?
FDA should consider products that are backordered, temporarily discontinued, no longer marketed, or provided intermittently in limited quantities when determining whether a product is in shortage or unavailable.

Do United States Pharmacopeia and National Formulary (USP-NF) [2] chapters <795> and <797> provide suitable standards for animal drugs compounded by veterinarians, and if not, what standards of safety, purity, and quality should apply to animal drugs compounded by veterinarians?
The USP chapters 795 and 797 are suitable standards for compounding from bulk drug substances by veterinarians.

Should licensed veterinarians be able to sell or transfer an animal drug compounded from bulk drug substances by a State-licensed pharmacy or an outsourcing facility to owners or caretakers of animals under the veterinarian's care?
We seek FDA's clarification related to the definitions of "sell," "transfer," and "dispense" before we can provide feedback related to this concept. In general, we assert that the prescribing veterinarian should be able to dispense preparations compounded by pharmacies or outsourcing facilities to his or her clients.

How should FDA apply the condition to identify an individual patient when it is not possible to identify an individual animal (e.g., koi in a koi pond)?
The AVMA contends that a "patient" is an animal or group of animals examined or treated by a veterinarian and does not need to always be individually identified. So long as the licensed veterinarian is meeting the requirements of his/her state veterinary practice act with respect to prescribing, then being able to identify an individual patient when it is not possible is unnecessary.

Should facilities registered as outsourcing facilities under section 503B of the FD&C Act be able to compound animal drugs from bulk drug substances that do not appear on Appendix A for an individually identified animal patient under conditions similar to those applicable to state-licensed pharmacies (i.e., the conditions contained in section III.A. of the draft guidance)?
Yes, so long as the outsourcing facility is a state-licensed pharmacy.

Is additional guidance needed to address the repackaging of drugs for animal use?
- *How widespread is the practice of repackaging drugs for animal use?*
- *What types of drugs are repackaged for animal use, and why are they repackaged?*
- *Have problems been identified with repackaged drugs for animal use?*

We understand repackaging to mean "The act of taking a finished drug product from the container in which it was distributed by the original manufacturer and placing it into a different container without further manipulation of the drug. Repackaging also includes the act of placing the contents of multiple containers (e.g., vials) of the same finished drug product into one container, as long as the container does not include other ingredients." If this is FDA's definition, the AVMA agrees and understands that veterinarians sometimes need to repackage drugs, including compounded preparations, into smaller aliquots for administration by the owner or agent, as long as the repackaging does not affect the stability, efficacy, purity, safety, and potency of the product (e.g., light-sensitive drugs).

Is additional guidance needed to address the compounding of animal drugs from approved animal or human drugs under section 512(a)(4) or (a)(5) of the FD&C Act and part 530?
No. The AVMA was a key leader in the development and advocacy for the Animal Medicinal Drug Use Clarification Act on behalf of our members and the patients they serve. Extralabel drug use, including the preparation of compounds from FDA-approved drugs, continues to be a needed activity in veterinary medicine, and our members continue to utilize this FDA-regulated activity in the practice of veterinary medicine, within the confines of the 21 CFR 530.

Is additional guidance needed to address the compounding of animal drugs from bulk drug substances for food-producing animals?
Yes. The AVMA suggests that the FDA draft a separate guidance to address compounding from bulk drug substance for food producing animals.

The AVMA continues to recommend that there be a publically available, current list of bulk drug substances that can be legally compounded within a veterinarian-client-patient relationship specific and limited to euthanasia, depopulation, and poison antidote compounds for food animal species. If adequate scientific information is not available to determine a withdrawal time, the AVMA contends that the compounded preparation cannot be used in a food animal or the treated animal cannot enter the food supply.

As one condition under which FDA does not generally intend to take action for certain violations of the FD&C Act if this and the other conditions are followed, FDA is proposing that State-licensed pharmacies and veterinarians report any product defect or serious adverse event associated with animal drugs they compound from bulk drug substances to FDA within 15 days of becoming aware of the product defect or serious adverse event. Outsourcing facilities are required to report adverse events associated with the drugs they compound. FDA believes it is important to receive this information from State-licensed pharmacies and veterinarians because there are no other State Departments of Health or Federal Agencies (e.g., the CDC) charged with identifying and tracing animal injuries or disease associated with an animal drug compounded by these entities. FDA has the following specific questions with respect to this proposed condition:

- *How many State-licensed pharmacies and veterinarians compound animal drugs from bulk drug substances and would potentially be reporting product defects and serious adverse events to FDA?*
  We are unaware of any data that could assist in answering this question. Anecdotally, we understand that few veterinarians personally compound from bulk drug substances.

- *Are State-licensed pharmacies and veterinarians reporting the same or similar information to any State regulatory agency (e.g., State boards of pharmacy, State boards of veterinary medicine)? If so, how many reports on average does each State-licensed pharmacy and veterinarian submit to these State agencies each year?*
  It is our understanding that adverse events are grossly underreported to FDA; however, members have conveyed that when they do report an adverse event, they generally report the adverse event to the respective compounding pharmacy. We do not know the actual number of these reports, nor are we aware of the number of events reported by veterinarians to their state boards.

- *For purposes of the guidance, how should FDA define the terms "product defect" and "serious adverse event"?*
  AVMA contends that "serious adverse events" are ones that are fatal, life-threatening, require professional intervention, cause an abortion, stillbirth, infertility, congenital anomaly, prolonged or permanent disability, or disfigurement as referenced in 21 CFR 514.3.

  A "product defect" would include any obvious physical abnormalities, such as consistency, color and precipitant materials or contents, or problems with the amount, type or effectiveness of an ingredient triggered by production errors, poor quality bulk drug substances, or problems with transportation and/or storage. Any obvious physical defects of the container, seal or stopper and of the label of the product container would also constitute a product defect.

AVMA believes lack of efficacy is an adverse event and should be included in any reporting system.

- *Can FDA achieve the same objective of identifying and tracing the source of injuries or disease associated with an animal drug compounded from a bulk drug substance through means other than product defect and serious adverse event reporting, and if so, what other means? For example, would reports of product defects alone achieve the same objective?* We are unable to provide a clear answer without additional definitions for the terms "product defect" and "serious adverse event," which would help inform our understanding and opinion.

We appreciate the opportunity to comment on the draft Guidance for Industry and provide needed feedback on behalf of the AVMA's membership. For questions or concerns regarding the AVMA's comments, please contact Drs. Ashley Morgan (amorgan@avma.org; 202-289-3210) and Lynne White-Shim (lwhite@avma.org; (800) 248-2862 ext. 6784).

Sincerely,

W. Ron DeHaven, DVM, MBA
CEO and Executive Vice President

October ##, 2015

Commissioner Stephen Ostroff, M.D.
Food & Drug Administration
10903 New Hampshire Ave
Silver Spring, MD 20993

Dear Commissioner Ostroff:

We are writing to express our serious concern with FDA's proposed "Guidance for Industry - Compounding Animal Drugs from Bulk Drug Substances", which the agency issued on May 19, 2015. Through a draft guidance, FDA is proposing a new regulatory scheme for compounded animal drugs that prohibits veterinarians from properly treating their animal patients. These fundamental changes are proposed despite the fact that Congress has not passed any statute giving FDA the broad authority it would need to make such a substantial change in animal health.

Under the proposed guidance, veterinarians would be singled out as the only health care professionals required to document in writing a clinical need before they can prescribe a medication. The draft guidance mandates very specific language that veterinarians must include on each and every prescription for a compounded preparation. This represents an unprecedented and dangerous intrusion into the state-regulated practice of veterinary medicine

The draft guidance also eliminates the ability of veterinarians to maintain an office stock of medications from compounding pharmacies that are necessary for animal health. This access to important compounded medications, commonly referred to as "office use," is permitted under most state laws. Office use of compounded medications is critical in the practice of animal health because veterinary clinics often serve as emergency rooms and hospitals for animals, and certain compounded medications must be immediately available in order to insure proper patient outcomes.

Through the draft guidance, the agency establishes and authorizes §503B outsourcing facilities to compound and distribute medications for veterinary use. When Congress established that category of FDA-registered and regulated facilities within the Drug Quality and Security Act of 2013, it was specific to the provision of sterile drug products for human use. The agency has far exceeded its authority by presuming to extend these entities into veterinary medicine.

This proposed guidance takes portions of the statute related to compounding contained in the Drug Quality and Security Act and attempts, without authorization and through a guidance document, to apply these provisions to animal drug compounding despite the fact that the Act is expressly limited to human compounding. If FDA believes that fundamental changes are needed in the regulation of animal drug compounding, the agency should instead submit a specific legislative proposal for Congress to consider. As a result, we ask that you withdraw this proposed guidance.

Thank you for your attention in this matter. We look forward to the withdrawal of this proposed guidance and please do not hesitate to contact our offices if you require any further information.

Sincerely,

Matt Salmon
Member of Congress

Kurt Schrader
Member of Congress

Contact Greg Soften (greg.safsten@mail.house.gov) in Rep. Salmon's office, or Chris Huckleberry (huck@mail.house.gov) in Rep. Schrader's with questions and to sign onto the letter.

Attachment 6

California State Board of Pharmacy
1625 N. Market Blvd, N219, Sacramento, CA 95834
Phone: (916) 574-7900
Fax: (916) 574-8618
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BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
GOVERNOR EDMUND G. BROWN JR.

STATE BOARD OF PHARMACY
DEPARTMENT OF CONSUMER AFFAIRS
ENFORCEMENT AND COMPOUNDING COMMITTEE
MEETING MINUTES

DATE: September 9, 2015

LOCATION: DCA Headquarters, First Floor Hearing Room
1625 North Market Blvd.
Sacramento, CA 95834

COMMITTEE MEMBERS PRESENT:
Amy Gutierrez, PharmD, Chair, Professional Member
Greg Lippe, Public Member, Vice Chair
Stan Weisser, Professional Member
Allan Schaad, Professional Member
Rosalyn Hackworth, Public Member

COMMITTEE MEMBERS NOT PRESENT:
Greg Murphy, Public Member

STAFF PRESENT:
Virginia Herold, Executive Officer
Anne Sodergren, Assistant Executive Officer
Janice Dang, PharmD, Supervising Inspector
Christine Acosta, PharmD, Supervising Inspector
Laura Freedman, DCA Staff Counsel
Susan Cappello, Enforcement Manager

Call to Order

Dr. Gutierrez, chair of the committee, called the meeting to order at 10:01 a.m.

Dr. Gutierrez welcomed those in attendance. Roll call of the board members present was taken and a quorum of the committee was established.

I. PUBLIC COMMENT FOR ITEMS NOT ON THE AGENDA/AGENDA ITEMS FOR FUTURE MEETINGS

No public comments were received.

II. ENFORCEMENT MATTERS

a. Update on the CURES 2.0 Prescription Monitoring Program

Background

The California Department of Justice (DOJ) is continuing to work on upgrading the CURES system. On June 30, the DOJ had a "soft launch" of CURES 2.0 as the new system is called. Since then the DOJ has been working to pilot test the new system and install upgrades that will permit conversion to the new, enhanced system.

Below is the update prepared in late June on the soft launch from the DOJ's press release:

CURES 2.0 Soft Launch and Phased Rollout

Update from July 1, 2015:

The Department of Justice (DOJ) and the Department of Consumer Affairs (DCA) are pleased to announce that the state's new Controlled Substance Utilization Review and Evaluation System – commonly referred to as "**CURES 2.0**" – went live on July 1, 2015. This upgraded prescription drug monitoring program features a variety of performance improvements and added functionality.
In order to ensure a smooth transition from the current system, CURES 2.0 will be rolled out to users in phases over the next several months, beginning with early adoption by a select group of users who currently use CURES and meet the CURES 2.0 security standards, including minimum browser specifications. DOJ is currently identifying prescribers and dispensers who meet these criteria and will contact and coordinate their enrollment into CURES 2.0. For all other current users, access to CURES 1.0 will not change and no action is needed at this time. For users and entities not currently enrolled in CURES, further notification will be provided in August as to the enrollment/registration process.

Practitioners and health systems should begin to prepare for universal adoption of the system by January 2016, at which point all users will be required to meet CURES 2.0's security standards. If you have any questions please contact cures@doj.ca.gov.

Thank you for your continued support of the CURES program.
Note: CURES 2.0 users will be required to use Microsoft Internet Explorer Version 11.0 or greater, Mozilla FireFox, Google Chrome, or Safari when accessing the system.

Discussion and Comment

At this meeting, Robert Sumner and Mike Small of the DOJ provided an update on the transition to the new CURES 2.0 system. They advised the committee that CURES 2.0 should be available to all users by January 2016 and explained some of the barriers in transitioning to CURES 2.0. Mr. Sumner explained that there are 18,487 pharmacists registered with CURES, which is less than 50% of all licensed California pharmacists.

Steven Gray representing Kaiser requested that the DOJ attend the California Society Hospital Pharmacists (CSHP) seminar to conduct CURES enrollment. Mr. Gray was asked to submit details of the meeting for consideration. Ms. Herold offered to help with CURES enrollment at this meeting.

There were no additional comments from the committee or public.

b. Update by the University of California, San Diego on Its Pilot Program to Permit Patients to Access Medication from an Automated Storage Device not Immediately Adjacent to a Pharmacy

Background

At the Board of Pharmacy's April 2015 Board Meeting, the board approved an 18-month pilot study under the auspices of the UCSD School of Pharmacy involving use of an automated storage device for prescription medication for which staff and their families of a Sharp Hospital in San Diego, who opt in, may pick up their outpatient medications from this device located in a hospital, instead of having to go to the community pharmacy. Consultation will be provided via telephone before medication can be dispensed to a patient.

This study was planned to start in June or July, 2015. However, in scheduling items for this committee meeting, we learned that the project is running a bit behind.

Discussion and Comment

At this meeting, via telephone, Dr. Hirsch delivered a presentation on the implementation of this program, which she anticipates will start in December 2015.

There were no comments from the public or committee.

A copy of this presentation can be found at the end of this document.

c. Discussion Regarding the Board's Proposed Regulations for the Take Back of Prescription Medication

Background

Since the July board meeting, work has continued to refine the board's proposed requirements for drug take back programs.

Meanwhile, additional counties have established requirements to permit or require take back of unwanted pharmaceuticals from the public. This often involves pharmacies.

On September 26, the Drug Enforcement Administration (DEA) will conduct another national Drug Take Back day. The board has released a subscriber alert and posted information about this collection day on the board's web site.

Board staff agreed to incorporate comments from this meeting into a draft and bring it to the October Board Meeting.

Board staff respectfully suggested a motion from this meeting for a recommendation that staff complete work on the proposed regulation, including incorporating comments made at this meeting, and bring the draft to the board meeting with a recommendation for the board to initiate a rulemaking by releasing the requirements for the 45-days of public comment.

Discussion and Comment

Ms. Freedman, board counsel, suggested that the committee focus on policy of the regulation and allow the board to tweak the language.

Heidi Sandborn, representing the California Product Stewardship Council, thanked the committee and stated the number one concern with this regulation is funding. She requested that the mandate be modified to include both a sharps container and a drug bin. She states that will provide more flexibility to local governments.

The San Mateo Department of Public Health expressed concerns with the sharps requirement and stated that this requirement may hinder pharmacies participation.

Mr. Weisser inquired into the cost of sharps disposal.

Jenn Jackson from San Francisco County voiced concern about the cost of sharps disposal. While she agreed it is necessary, she asked for clarification as to how existing pharmacies that do not take back controlled drugs would register.

The proposed regulations require pharmacies to register with the DEA. Ms. Jackson offered to provide the committee with information about the Health and Safety Code that allows for the co-mingling of sharps and drugs.

Mr. Weisser asked that a future agenda item include the manufacturer responsibility of drug take back.

A representative of the City of Santa Rosa agreed with comments made by previous speakers and requested clarification on several items including why inhalers are excluded. He requested that the committee remain cognizant of the impact the regulations may have on existing programs. Ms. Herold responded that pharmacies are DEA registrants and must comply with the DEA requirements irrespective of what the board does. The representative of Santa Rosa requested that the committee consider maximum flexibility and questioned about how the use of a common or contract carrier can ensure the chain of custody. He also asked if the language can reference “bags” instead of “liners”.

It was noted that the committee should consider is if there is value in the board creating a standardized sign for all drug take back.

Dr. Gutierrez discussed the need to educate pharmacies about the DEA requirements to register as a collector.

Brian Ward of CSHP thanked the committee for moving forward with these regulations. He informed the committee that the Environmental Protection Agency (EPA) just released information about their requirements for drug take back. He encouraged the committee to ensure that the board's regulations are consistent with EPA requirements.

Dr. Gutierrez sought clarification from counsel on whether the board's regulation indicated that drug take back is not required in our regulation but is required by a local ordinance, which one supersedes the other. Counsel indicated she would research the issue.

Dr. Gutierrez recessed for a break at 11:17 a.m.

The meeting reconvened at 11:27 a.m.

Dr. Gray representing Kaiser made several suggestions:

- He stated that the term "tampering" is ambiguous and suggested that the committee provide a definition of this term.
- He suggested that the regulation require that the liner material be made of antineoplastic material.
- He suggested that the board clarify the definition of controlled substances to include the state and federal schedules.
- He asked for the purpose of the signage requirement and whether this posting provides safe harbor if a consumer places a prohibited item in the bin.
- He requested that the board pursue legislation to create the safe harbor.
- He asked for clarification on the placement of the bin and stated that it is ambiguous.
- He suggested that the board clarify the documentation requirement when the mail back option is provided to the consumer.

<u>Committee Policy Discussion</u>
Question: Should we assume that all medications being brought in are controlled substance?
Answer: Yes.

Question: Do we want to differentiate between sharps vs. other mail bins?
Answer: The committee recommended removing the sharps requirement.

The committee stated that pharmacies shall not be required to participate in drug take back programs and that pharmacies on probation is prohibited from participating in this program.

The committee stated that pharmacies participating in drug take back programs should not be prohibited from receiving reimbursement.

It was noted that the committee should focus on where the bins can be located and find other ways to prevent a consumer from dropping off medications when a pharmacy is closed. It was also noted that bins should be lockable when the pharmacy is closed.

The committee questioned whether there should be common signage and agreed that the board should develop a sign for posting.

Public Comment on Committee Policy

Heidi Sandborn expressed concern that some capacity will be lost if the board follows the DEA regulations because some pharmacies do not want to handle controlled substances.

Brian Warren sought clarification as to whether counsel will be researching drug take back, sharps take back or vs. both. Counsel advised that the current draft calls for both.

The Marin County Pharmacist Association recommended that the committee keep the focus on getting drugs out of the home to prevent drug abuse and overdose.

The City of Santa Rosa concurred with comments by Heidi Sandborn and expressed concern about the cost.

Tim James from the California Grocers Association is trying to determine how all of the different pieces will work together, including the technical aspects of the regulations. They are concerned that this program could compromise food safety. His association will provide written comments in the next few days.

Committee Recommendation:

Motion: Recommend that staff complete work on the proposed regulation, including the policy comments, and bring the proposed regulation to the board for possible initiation of a rulemaking.

M/S: Weisser/Lippe
Support: 5 Oppose: 0 Abstain: 0

There were no additional comments or questions.

Dr. Gutierrez recessed for a 30-minute lunch break at 12:24 p.m.

The meeting reconvened at 1:02 p.m.

d. Discussion on Enforcement Options for Patient Consultation Violations

Background:

Nearly 25 years ago, the Board of Pharmacy promulgated regulations to require pharmacists to consult with patients when receiving a medication for the first time. The board included in the regulation additional occasions where a pharmacist must consult a patient, such as when the patient has questions or the pharmacist believes the medication warrants consultation.

California's requirements are sometimes confused with national requirements enacted about the same time by CMS for Medicare patients in what was known as "OBRA 90." However, California's requirements were actually adopted before OBRA 90's requirements. The OBRA 90 requirements require that Medicare patients be offered consultation when they receive medication for the first time. California's requirement that the pharmacist initiate consultation is stronger and broader than the OBRA 90 requirement in that it pertains to all patients, not just those whose medications were paid for by Medicare. This established one standard of care for all patients in California.

After approval of California's patient consultation requirements, the board also delayed implementation of patient consultation at the request of the profession because pharmacists stated they could not provide consultation without the aid of pharmacy technicians. So the approved patient-consultation regulation was delayed so that the board could secure statutory authority and then promulgate regulations to establish the licensure of pharmacy technicians to "free" the pharmacist to provide consultation.

California's requirement is that the pharmacist consult the patient – not to offer to consult. When creating the consultation rulemaking, the board emphasized that consultation was to be initiated by the pharmacist and that denial of the consultation must be made directly to the pharmacist. Other staff (e.g., pharmacy technicians or ancillary staff) are not to screen for consultation by asking if the patient wanted to speak to the pharmacist or have questions about the medication. Consultation is required when the patient or the patient's agent is present in the pharmacy to receive consultation.

Over the years, the board has added other enhancements to help ensure patients receive meaningful consultation, including a Notice to Consumers poster that must be posted in the pharmacy. This poster states the pharmacist must consult with each patient about his or her new medication, and lists the five questions a patient should understand before taking a prescription medication.

More recently, in promulgating the requirements for patient-centered labels, the board required that oral consultation services be available in 12 languages to aid limited-English speaking patients in better understanding how to take their prescription medication.

Over the years, the board has enforced the patient consultation requirement in various ways. Initially, it was one of the first violations for which the board used its citation and fine

authority. In recent years, the board typically assesses fines of approximately $1,000 when it observes failure to consult during an inspection. If a medication error has occurred and a consultation was not provided, the board generally issues a higher fine.

In 2011, board staff began working on a project with three California District Attorney's (DA's) offices to aid in the board's enforcement of patient consultation. Using the state's Unfair Business Practices statute in Business and Professions Code section 17200, the DA was able to assess higher fines for failure to consult. Additionally, the DA's used undercover investigators to pass prescriptions, which is an action the board has not done.

The DA's investigations resulted in substantial fines to three pharmacy chains: CVS (2013, $658,500); Rite Aid (2014, $498,250); and recently Walgreens (2015, $502,000).

At the July board meeting, the board heard a report summarizing the results of a short Survey Monkey questionnaire conducted by the board involving patient consultation.

Discussion and Comment

The committee heard testimony from Anna Guerrero, representing Fred Meyer, as well as the president of the Marin County Pharmacists Association, Natalia Mazina, and the Alameda County Pharmacists Association.

Members of the Marin County Pharmacists Association asked the board to slow down the workflow of pharmacists. As this issue was not previously included in the agenda, they requested a future agenda item to discuss workflow issues.

The board received a comment that while the pharmacists want to consult, they are not given the opportunity to consult.

Dr. Gutierrez noted that providing patient consultation provides an opportunity to catch errors.

Dr. Gutierrez requested that the Communication and Public Education committee focus on consumer education and why patient consultation is important.

Some comments and/or questions received from the public included if the board can prohibit the use of a system that requires a patient to accept or decline patient consultation in advance of payment or dispensing of a prescription and if putting a cap on the number of prescriptions filled in a day could be enforced by the board. In addition citations should be issued to the business and as part of the order of abatement, require a pharmacy to take certain steps to ensure patient consultation is provided.

Dr. Gutierrez noted that mail order pharmacies should be addressed as well and requested that an agenda item be added to revise title 16 California Code of Regulations section 1707.6 and point of sale devices.

Public Comment

Robert Stein from the KGI School of Pharmacy stated that by checking the box it was clear that no patient consultation occurred. He stated that the pharmacist should document that patient consultation was provided or refused.

There were no additional comments.

e. Discussion of the Proposed Regulation for Pharmacies and Clinics Aimed at Reducing Losses of Controlled Substances

Background

At the July board meeting, the board approved initiation of a rulemaking to establish inventory requirements of controlled drugs for pharmacies and clinics. This regulation will be noticed before the October board meeting.

The regulation requires perpetual inventories of all federal Schedule II drugs, with a physical count every 90 days. Additionally, the board will establish a list of one or several additional controlled drugs from Schedules III – V that are reported as frequently stolen to the board and/or DEA.

Provided below is a list of the top non-Schedule III-V drugs reported lost or stolen to the board in the last year. For ease of comparison, all drugs listed have been converted into administration dosage units (i.e., liquids have been converted into 5 mL teaspoons to identify a dose). On the basis of this list, the board would require the inventory monitoring of alprazolam and promethazine with codeine.

Top Ten: FY 2014 – 2015 CS Schedules III-V Losses by Quantity

Drug	Quantity In Actual Dosage Equivalents
Alprazolam	160,169
Promethazine/Codeine	77,862*
Carisoprodol	38,579
Tramadol Hydrochloride	34,801
Acetaminophen/Codeine	27,903
Lorazepam	26,864
Zolpidem Tartrate	18,657
Diazepam	17,139
Clonazepam	14,628
Phentermine	10,820

*mLs converted into 5mL dosage units

The board's staff also developed the following list of Schedule II controlled drugs reported lost or stolen within the last year.

Top Ten: FY 2014 – 2015 CS Schedule II Losses by Quantity

Drugs	Quantity In Actual Dosage Equivalents
Hydrocodone and Combos	402,377*
Oxycodone and Combos	73,756*
Amphetamine/Salts/Methamphetamine	26,368
Hydromorphone/Oxymorphone	20,885
Dex/Methylphenidate	19,212
Methadone	9,817
Fentanyl Citrate	6,822
Diphenoxylate/Atropine	4,130
Tapentadol Hydrochloride	2,062
Meperidine HCl	831

*total dosages (mLs converted into 5mL dosage units and added to solids)

Dr. Gutierrez provided an overview of the above charts.

There were no comments from the committee or the public.

f. Tracking of Automated Drug Delivery Devices in Use in California

Background

Pharmacies are able to operate automated dispensing machines or devices in various settings away from the licensed pharmacy. This includes:

- Skilled nursing homes and other health care facilities licensed under Health and Safety Code section 1250 (c), (d) or (k) (the devices are authorized under section 1261.6 of the Health and Safety Code, authority for pharmacies to do this in specific locations is specified in Business and Professions Code section 4119.1)
- Clinics licensed under section 4180 of the Business and Professions Code (the devices are authorized under section 4186) – these include licensed, nonprofit community or free clinics defined under Health and Safety Code 1204(a)(1), a clinic operated by a federally recognized Indian tribe or tribal organization referred to in Health and Safety Code section 1206(b), a clinic operated by a primary care community or free clinic operated on a separate premises from a licensed clinic and that is open no more than 20 hours per week as referred to in Health and Safety Code section 1206(h), a student health center clinic operated by a public institution of higher education such as college health center as referred to in Health and Safety Code section 1206(j).
- Hospitals may use Pyxis or Pyxis-type machines throughout a hospital to store medication under application of provisions in Title 22 that allow drugs to be stored in

nursing stations. The Pyxis and like devices are considered secured storage units for drugs.

The board does not know how many of these devices are in use, where they are in use, or which pharmacies are responsible for the machines.

The demand for additional use of these devices is growing. As reported earlier at this meeting a pilot study is underway that, if proven valuable, would allow patients to pick up medication from devices not located in a pharmacy.

Board staff suggests that a simple registration be established for pharmacies that operate these devices to identify their locations and consider this action to be a beneficial step in board oversight and enforcement. Pharmacies that add, move, or remove a device could report changes to the board via the submission of a form. This registration could operate much like the off-site storage waivers for records waivers. At annual renewal of the pharmacy license, the pharmacy would update or confirm the list of devices it operates and where each one is located.

A regulation or statutory amendment may be needed to establish this requirement.

Discussion and Comment
Dr. Gray spoke in support of having device locations in outpatient and retail settings, but not require it in hospitals. He suggested that the board should differentiate between the two.

Dr. Gutierrez commented that board should consider a separate proposal to require licensure of drug delivery devices.

There were no additional comments.

III. COMPOUNDING MATTERS

a. Discussion on Medicare's Pharmacy Practice Expectations for Critical Access Hospitals

Background
Time was set aside for a discussion of these practice guidelines for hospital pharmacies. This item is for discussion and information purposes.

Various excerpts from the ASHP article are provided below:

> The "CMS document officially establishes United States Pharmacopeia (USP) Chapter 795 as the minimum standard for practices related to nonsterile compounding and USP chapter 797 for compounded sterile products."

"USP chapter 795 has been an enforceable standard since 2001, meaning that state boards of pharmacy and other organizations can use it as the basis for fines and other adverse actions against noncompliant regulated entities. Chapter 797 has been enforceable since 2004."

The article later goes on to quote ASHP as stating: "'only by a pharmacist or other personnel authorized in accordance with State and Federal law' may pose compliance problems for sparsely staffed critical access hospitals."

"According to the CMS document, critical access hospitals that contract for compounding activities must have access to the vendor's quality assurance data to verify compliance with USP chapters 795 and 797. Each hospital must document that it obtains and reviews the data. CMS also expects vendors to demonstrably follow state laws and meet the requirements of 503A of the Food, Drug and Cosmetic Act that relate to the compounding of human drug products."

The article then goes on to discuss outsourcing facilities and their potential future role in providing compounded drugs for hospitals. It notes that CMS' policy acknowledges the Food and Drug Administration's preference for hospitals to use official outsourcing facilities to obtain compounded sterile products. But then the article notes that outsourcing facilities are not meeting FDA's expectations when information from the FDA's Web site is reviewed. The FDA Web site lists all licensed outsourcing facilities and the number of FDA inspection report findings (on form 483) and 12 warning letters issued by the FDA to outsourcers. As of late January, only 1 of the 42-registered outsourcing facilities that had been inspected by the FDA had "no significant objectionable conditions" identified by the FDA.

There were no comments from the committee or the public.

b. Warnings about Becton-Dickinson Syringes and Loss of Medication Potency from the Federal Food and Drug Administration and Institute for Safe Medication Practices

Background

Several weeks ago, the FDA and Institute for Safe Medication Practices released warnings about the loss of potency detected for certain medications stored in 3mL, 5mL, and larger Becton–Dickinson syringes.

This item was added to the agenda so that the committee can discuss the situation and make a determination as to whether the board needs to initiate additional actions or warnings to clinicians. The board is aware of one recall initiated following release of these warnings. The executive officer has also learned that several outsourcers may have identified this loss in potency prior to these releases and took steps to notify their customers.

A proposed additional warning is:

> The California State Board of Pharmacy is resending the following subscriber alert that was recently sent involving IV medications stored in BD syringes in the interests of ensuring that all pharmacy practitioners are aware of this potential public safety issue. Please review this cautionary information carefully. The issue seems to be isolated to 3 and 5 mL BD syringes at this time, although the FDA has concerns with larger syringes. Pharmacists need to make certain all of their clinicians are aware of this situation so they can report any therapy failures/nonresponses to drug therapy when administering drugs that have been stored in syringes to the pharmacy and to FDA's MedWatch.

William Stewart recommends that the board be cautious in its actions because he believes there has not been sufficient research.

There were no additional comments or questions.

c. Discussion on Compounding for Prescriber Office Use

Background

Section 4052(a)(1) of the California Business and Professions Code provides that: Notwithstanding any other law, a pharmacist may furnish a reasonable quantity of compounded drug product to a prescriber for office use by the prescriber.

This "reasonable quantity" of compounded drug product has been defined in 16 California Code of Regulations section 1735.2(c) as:

> (c) A "reasonable quantity" as used in Business and Professions Code section 4052(a)(1) means that amount of a compounded drug product that:
> (1) Is sufficient for administration or application to patients in the prescriber's office, or for distribution of not more than a 72-hour supply to the prescriber's patients, as estimated by the prescriber; and
> (2) Is reasonable considering the intended use of the compounded medication and the nature of the prescriber's practice; and
> (3) For any individual prescriber and for all prescribers taken as a whole, is an amount which the pharmacy is capable of compounding in compliance with pharmaceutical standards for integrity, potency, quality and strength of the compounded drug product.

The recent proposed modifications to the compounding regulation take out the 72-hour supply for that could be distributed to patient. Other changes have also been made to this section which as currently proposed reads:

> (c) A "reasonable quantity" that may be furnished to a prescriber for office use by the prescriber as authorized by Business and Professions Code section

4052, subdivision (a)(1), means that amount of compounded drug preparation that:

(1) Is ordered by the prescriber or the prescriber's agent and paid for by the prescriber or the prescriber's agent using a purchase order or other documentation received by the pharmacy prior to furnishing that lists the number of patients seen or to be seen in the prescriber's office for whom the drug is needed or anticipated, and the quantity for each patient that is sufficient for office administration; and

(2) Is delivered to the prescriber's office and signed for by the prescriber or the prescriber's agent; and

(3) Is sufficient for administration or application to patients solely in the prescriber's office, or for furnishing of not more than a 120-hour supply for veterinary medical practices, solely to the prescriber's own veterinary patients seen as part of regular treatment in the prescriber's office, as fairly estimated by the prescriber and documented on the purchase order or other documentation submitted to the pharmacy prior to furnishing; and

(4) That the pharmacist has a credible basis for concluding the quantity provided for office use is reasonable considering the intended use of the compounded medication and the nature of the prescriber's practice; and

(5) With regard to any individual prescriber to whom the pharmacy furnishes, and with regard to all prescribers to whom the pharmacy furnishes, is an amount which the pharmacy is capable of compounding in compliance with pharmaceutical standards for integrity, potency, quality and strength of the compounded drug preparation; and

(6) Does not exceed an amount the pharmacy can reasonably and safely compound.

If the proposed compounding regulation changes take effect, pharmacies will be able to compound for prescriber office use, but not in quantities for prescribers to dispense to a patient.

There were no comments from the committee.

Public Comment

Marie Cottman remarked that this is in direct conflict with the federal 503A. She was advised that the board is moving towards making its requirements consistent with the FDA.

There were no additional comments or questions.

d. Comments on the Food and Drug Administration's Guidance Document #230 on Compounding Animal Drugs from Bulk Drug Substances

Background

The Board of Pharmacy has previously expressed interest in submitting comments on the FDA's Guidance Document 230, *"Compounding Animal Drugs from Bulk Substances."*

The committee discussed this document and the comments it wishs to submit to the FDA.

The following provides an overview and summary of the guidance provided in the FDA's document. The guidance supports and reinforces the regulatory framework developed by FDA for pharmacies and outsourcers who compound human drugs with several exceptions.

- For pharmacies that compound medications for animal use, the FDA guidance states that a veterinarian's prescription is required for the specific animal. The prescription must contain the standard information required on all prescriptions but also must include:
  1. The name and species of the animal
  2. A statement that the animal is not a food-producing animal
  3. If a manufactured drug exists, a statement that the compounded product would make a clinical difference from the manufactured product

  The guidance provides that pharmacies that compound such drugs must do so pursuant to USP 795 and 797 standards, by or under the supervision of a pharmacist, and such compounded products may not be distributed by wholesalers.
  Finally, the guidance allows a pharmacy to compound for future furnishing but is limited to the maximum quantity of that drug dispensed in a 14-day period within the last six months.

- For outsourcing facilities that compound animal drugs from bulk substances, the FDA is developing a list (which is not yet completed) of approved drug substances that an outsourcing facility must use when compounding for animals, linked to the species and the condition.

  The compounding must be done in accordance with cGMP standards by or under the supervision of a pharmacist. Outsourcing facility-compounded drugs may not be used on or in food producing animals, and must be expressly labeled to state this prohibition.

  The veterinarian must note on the order or prescription that the veterinary drug is intended to treat a specific condition and specific species, and this must match the listing on the FDA's bulk drug substances list. The guidance specifies labeling requirements and a

statement on the label that the product is not for resale. The guidance also requires that any drugs compounded by an outsourcing facility must be reported on the biannual lists of products compounded that must be sent to the FDA, with a notation of the products intended for animals.

The guidance also permits compounding by a veterinarian.

Public Comment
Jeremy Schmidt stated that the list for bulk powders changes on daily basis. Ms. Herold suggested that he provide his comments to the FDA.

Ms. Herold recommended that the board support the FDA's direction with respect to the guidance document.

Committee Recommendation:
Motion: Recommend that Ms. Herold draft comments that the board supports the direction of the guidance document and bring to the September 30, 2015 board meeting.

M/S: Lippe/Weisser
Support: 5 Oppose: 0 Abstain: 0

There were no additional comments or questions.

e. Discussion on the Compounding Services provided by Sterile Compounding Pharmacies and Outsourcing Facilities

Background
The November 2013 enactment of the DQSA created a new type of entity authorized to compound medications – the outsourcing facility. These generally large-scale production facilities are authorized to compound large quantities of medications for use by other entities. The medications must be prepared under current good manufacturing practices (or cGPMs), which are more stringent than compounding requirements for pharmacies, since many patients in multiple locations can receive these medication that are not usually linked to a patient-specific prescription.

The legislation essentially creates a new entity, with the results that there are three types of drug producers.

1. Manufacturers who are regulated by the FDA, and for facilities located in a specific state, often by a unit of the state's Department of Health (this occurs in CA). Manufacturers are required to perform extensive drug testing trials before receiving authorization to market a drug. Their physical plants are inspected by the FDA and must comply with rigorous cGMPs.

2. Outsourcers are regulated more like drug manufacturers and are regulated under cGMPs, but outsourcing facilities are exempted from performing drug approval testing like manufacturers must do for their products. In the future, the FDA has stated they plan on developing specific cGMP requirements for outsourcing facilities, but these specialized requirements are not yet available.

3. Pharmacies, which are authorized to compound pursuant to a patient-specific prescription, are regulated by state boards of pharmacy. Because pharmacies generally do not compound drugs in quantities the size of those produced by outsourcing facilities or manufacturers, pharmacies are regulated under lesser standards. Sterile compounding pharmacies, however, are generally regulated at a level closer to that of manufacturers and outsourcers because of heightened concerns about sterility, integrity, potency and quality of the compounded medication.

For a number of years, the board and other agencies have grappled with the issue of at what point does a pharmacy compounding medications in large quantities in anticipation of receiving a prescription, actually become a manufacturer because the pharmacy is compounding so much medication, or compounding not specific to received prescriptions. The board, the CA Department of Public Health and the FDA have all studied and discussed this issue in CA over the years, and similar discussions have gone on in other states and federally.

With the advent of outsourcing facilities, the issue is simplified;

- An outsourcing facility (aka a 503B facility) licensed by the FDA (and in the future by the CA Board of Pharmacy if located or shipping into the state), shall function under the supervision of a pharmacist and operate according to cGMPs, to produce compounded drug products for multiple entities without a prescription.
- A pharmacy (aka a 503A facility) may compound a medication pursuant to patient-specific prescription order or in very limited quantities based on normal dispensing patterns in anticipation of a prescription, and dispense pursuant to a patient-specific prescription.
- A specially licensed sterile compounding pharmacy may compound a sterile medication pursuant to a patient-specific prescription or in limited quantities based on normal dispensing patterns in anticipation of a patient-specific prescription, but dispense pursuant to a patient-specific prescription.
- A pharmacy may compound medication or sterile medication for administration in a physician's office (but after implementation of California's new compounding requirements, not for dispensing to patient in 72-hour quantities).

<u>Discussion and Comment</u>

It was asked if compounding hospital pharmacies should be required to be licensed as a 503B to comply with federal law.

Dr. Gray asked what will happen in the next few months.

Dr. Gutierrez requested that discussion of 503B's be added to the next agenda.

There were no further comments from the public.

f. Review of Sterile Compounding Statistics Identified by the Board

Supervising Inspector Dr. Acosta provided an overview of statistics compiled by the board from inspections and investigations of California-licensed compounding pharmacies from March 2015 to September 2015.

Discussion and Comment
Dr. Gutierrez requested that compounding statistics be posted on the boards website. Dr. Gutierrez also requested that board staff create FAQ's regarding compounding.

It was recommended by staff counsel that the board create a link to view the statistics rather than attach the presentation to the minutes since it's a snapshot in time.

Dr. Gray representing Kaiser, inquired about possible problems with completing sterile compounding inspections timely for those pharmacies with a November 1, renewal date.

There were no further comments from the public.

Dr. Acosta's presentation can be found at the end of this document.

IV. FUTURE MEETING DATES

- December 14, 2015
- March 2, 2016
- June 1, 2016
- August 31, 2016

Dr. Gutierrez adjourned the meeting at 3:11 p.m.

Study of Expanded Use of an Automated Delivery Device

UPDATE 9-09-15

Jan D. Hirsch, BPharm, PhD
UCSD Skaggs School of Pharmacy & Pharmaceutical Sciences

UC San Diego
HEALTH SCIENCES

Update

- ScriptCenter Kiosk Installation
  - Location
  - Progress and timeline
- Update on Study
  - Reminder of Research Questions
  - Updated Timeline

ScriptCenter Kiosk Location
Sharp Memorial Hospital

Sharp Memorial Hospital employee entrance located on ground floor. Secure access only.

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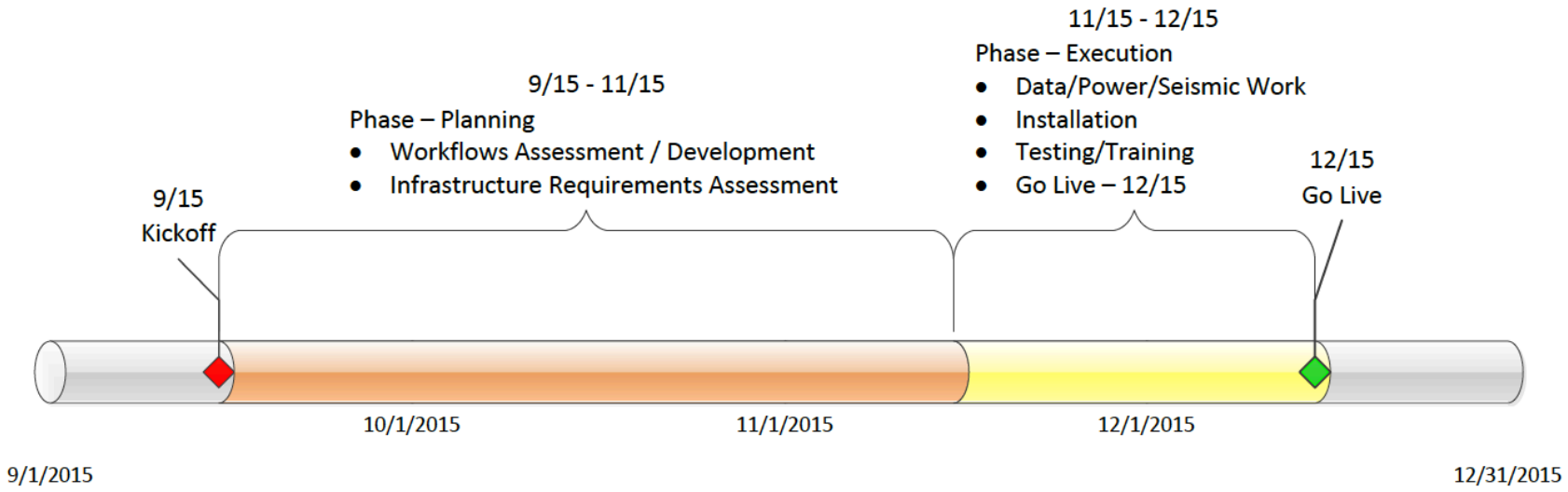
ScriptCenter Kiosk Installation

Asteres ScriptCenter Implementation, Sharp Memorial Hospital



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Study Research Questions

Primary: Is patient *primary adherence* (prescription retrieval rate; all prescriptions) greater for kiosk vs.

- Historical and concurrent regular counter rate?
- Rx retrieval rate based on Return to Stock (RTS) rate per month

  RTS rate = # Rxs RTS after 14 days/# Rxs filled

Secondary: Kiosk vs. Regular Counter Patients

- Is number or nature of questions for pharmacists during consultation for new prescriptions different? *(consultation log)*
- What is mean time from fill (RPh verified) to pick up?

Kiosk patients:

- Satisfaction with access to pharmacist for questions & convenience

Sharp Memorial Hospital employees:

- Would kiosk be beneficial and increase primary adherence?

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Study Design

Quasi-experimental with non-randomized control group

- *Pre-Kiosk Implementation Survey (Sharp Employees)*

Kiosk Start

6 months pre-kiosk | Month 1 | Month 6

Regular Counter

- RTS rate*

Kiosk

- RTS rate
- Consultation Log
- Time to Pick-up
- Kiosk Patient Satisfaction

Regular Counter

- RTS rate*
- Consultation Log (1 week sample pts w/ new Rxs)
- Time to Pick-up*

RTS = Return to Stock

* For employees and dependents

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Updated Projected Study Timetable

- Q4 2015 — Pre-kiosk 6-month data collection phase begins
- Q1 2016 — Implement Kiosk device (12/15/15)
  Refine data collection tools & process
  Deployment of program/enroll patients
- Q2 & Q3 2016 — Post-kiosk implementation
  Data collection and analysis
- Q4 2016 — Report Results to Board

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Questions?

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Sterile Compounding Inspections

3-19-15 to 8-28-15

Presented on 9-9-15

Enforcement & Compounding Committee

By Christine Acosta PharmD.

Total Inspections

- Hospital: 169
- Pharmacy: 107
- Non-resident pharmacy: 25
- 503b: 10

- **Grand Total** **311**

Total inspections by inspection type

- Renewal: 283
- New: 28

- **Grand Total** **311**

Compounding Inspections:
3-19-15 to 8-28-15

Violations by type of license

- **375 violations issued**
  - 62 hospitals had 138 violations
  - 107 pharmacies had 207 violations
  - 11 non-resident pharmacies had 26 violations
  - 2 503b's had 4 violations

Violations by type of inspection

- Renewal: 254
- Routine: 24
- Compliance visit: 76
- New: 12
- Change of Ownership: 4
- Remodel: 2
- Other (PRP, DEA 106): 3

Violations issued to Hospitals
138 total violations

- 23 violations for facility and equipment not with regulations
  - 8 violations for equipment not made of material that was easily cleaned and disinfected
  - 7 violations for cleaning not being done the on correct schedule

Violations issued to Hospitals
138 total violations

- 12 violations for not having all the required compounding records
  - CCR 1735.3
- 11 violations for a lack or inadequate training
  - CCR 1751.6
- 11 violations for not completing the self- assessment
  - CCR 1735.2(j)

Violations issued to Hospitals
138 total violations

- 11 violations for not having a master formula before compounding
  - CCR 1735.2(d)
- 11 violations for incorrect labels
  - CCR 1735.4
- 8 violations for having an inadequate quality assurance plan
  - CCR 1735.8

Violations issued to Non-resident Pharmacies: 26 total violation

- 3 violations for lack of staff process validation
  - CCR 1751.7(b)
- 3 violations for cleaning not being done on correct schedule
  - CCR 1751.4(d)
- 3 violations for not completing the self- assessment
  - CCR 1735.2(j)

Violations issued to Non-resident Pharmacies: 26 total violation

- 2 violations for inadequate training for non-sterile to sterile compounding.
  - CCR 1751.6(e)
- 2 violations for having an inadequate quality assurance plan
  - CCR 1735.8

Violations issued to Pharmacies: 207 total violations

- 23 violations for not having all the required policies and procedures
  - CCR 1735.5
- 21 violations for a lack or inadequate training
  - CCR 1735.7
- 21 violations having an inadequate quality assurance plan
  - CCR 1735.8

Violations issued to Pharmacies: 207 total violations

- 17 violations for not having all the required compounding records
  - CCR 1735.3
- 16 violations for not completing the self-assessment
  - CCR 1735.2(j)
- 13 violations for not having a master formula before compounding
  - CCR 1735.2(d)
- 11 violations for a lack or inadequate training
  - CCR 1751.6

Violations issued to 503B facilities: 4 total violations

- 1 violation for lack of staff process validation
  - CCR 1751.7(b)
- 1 violation for cleaning not being done on the correct schedule
  - CCR 1751.4(d)
- 1 violation for incorrect labels
  - CCR 1735.4(b)
- 1 violation for the PIC's failure to review policies and procedures annually
  - CCR 1735.5(b)

Sterile Compounding Inspections: 3-19-15 to 8-28-15

THE END