CHAPTER 32

CONTRACTS IN THE NURSING HOME
1. Current Florida laws require contracts between both
   (1) the vendor Pharmacy and the facility - required (October 1, 1990) (483)
   (2) the Consultant Pharmacist and the facility - required (483)

2. The Centers for Medicare & Medicaid Services issued the following statement to facilities in July 2004 requiring written agreements that also includes Vendor Pharmacies

   **CMS Submits Reminder to SNFs on Payment Agreements**

   The Centers for Medicare and Medicaid (CMS) recently submitted a transmittal to skilled nursing facilities (SNF) reminding them that they need to have written agreements specifying payment procedures in place when they utilize outside suppliers that provide services to nursing home residents. Of particular concern are services that fall under “consolidated billing,” where a SNF bundles virtually all the services received by a resident and submits it to Medicare for reimbursement. According to CMS, there are occasions where the reimbursement goes directly to the SNF and the supplier of services risks not being paid for the services they provide. The transmittal reminds SNFs that they must have these agreements in place or face civil penalties. This document can be accessed directly at:

3. Vendor and consultant agreements may be separate contracts or may be combined in one contract.

4. The contract must be in writing, signed by both parties, and cover a term of at least one year.

5. The contract must state that the facility assumes the responsibility for obtaining services that meet all the standards and for the timeliness of those services.

6. The regulations define the responsibilities of the consultant and the vendor; therefore a blanket statement will comply with all federal and state regulations.

7. Where the contract is silent on service points the terms will be negotiated by facility administration and the vendor Pharmacy.
   Examples would include the drug distribution system, private pay charges, daily deliveries

8. Must reflect fair market value for services and indicate how much time expected to work.

9. May not establish payment based on volume of business. This violates Medicare’s “Safe Harbors” requirements.
COMPONENTS OF A NURSING HOME CONTRACT

• Identify the Pharmacy Services the vendor Pharmacy has agreed to provide

• Identify how ordering and delivery will take place

• List Equipment placed in the Facility
  - establish the ownership by vendor Pharmacy
  - identify facility obligation if equipment lost or damaged
  - identify how the equipment will be returned at the end of the agreement

• Identify Facility obligations
  - Providing access to information
  - Allowing for delivery of medications
  - Timely access to billing information

• Define length of agreement
  - Suggest a minimum of 1 year but should attempt to get 2 or 3 year contract
  - Add “auto-renew” language to ensure the contract does not expire
  - Can the contract be terminated early, if so what is the process? Will the facility need to buy the equipment?
  - Define the process for notification for extension or termination of agreement
  - Define the length of notice for a termination of service (typically 30 to 60 days)

• Notice – identify the official contacts along with addresses for both facility and Pharmacy. These are the people who will be contacted in the event of a contract issue or dispute

• Early Termination
  - Define how contract or service disputes get addressed
  - Define the “period of cure” which establishes how many days the Pharmacy will have to correct service issues to the facility’s satisfaction.
  - Define the process if the facility (or Pharmacy) wants to terminate the contract early

• Insurance
  - Identify the liability coverage the vendor Pharmacy maintains
  - Holds the facility harmless in the event of a dispensing error

• Invoicing
  - Where will Pharmacy invoices be sent?
  - What is the obligation of facility to pay bills (30 days, 60 days etc)
  - Pricing – usually defined for floor stock, supplies and Medicare pricing
  - Will the Pharmacy charge interest on outstanding balances

• Credit Terms and Limits

• Disputed Charges
  - Define how these disputed charges will be handled
  - All charges not being disputed should continue to be paid by the terms of the contract

• Payment Default
  - Define the obligations of the facility in case of a default?
  - How can the vendor Pharmacy alter the agreement (ex higher pricing) in the case of a default
• Change of Ownership
  • Define what happens to the contract in the event that either the Pharmacy of Facility ownership changes
  • Successors and Assigns – requires that the new owners agree to the terms of the contract
• Compliance with Laws
  • allows for the facility to purchase elsewhere when needed
  • allows patient their rights to use another vendor pharmacy

• Restrictions to Hiring
  • This prohibits both the facility and the Pharmacy from hiring each others employees
  • May also prohibit either party from discriminating in their hiring practices

• Confidentiality of Agreement
  • This language prohibits either party from sharing the terms of the contract with another facility or vendor

• Books and Records
  • This language will define how long each party will maintain their records for possible audits to ensure that contract language has been met.

• Severability
  • If a portion of the contract is determined to violate current law that this portion of the contract will no longer be enforceable but the remainder of the contract will remain enforceable

• Addendums for each service provided
  • Contracting
  • IV Services
  • Medicare Part B services
  • Medical Records

• HIPAA ADDENDUM
  • Must address use and security of patient information
64B16-27.104 Conduct Governing Pharmacists and Pharmacy Permittees.
(1) A pharmacist or pharmacy shall be permitted to advertise medicinal drugs other than those controlled substances specified in Chapter 893, F.S., and patent and proprietary preparations so long as such advertising is not false, misleading or deceptive.

(2) No pharmacist, employer or employee of a pharmacy shall maintain a location, other than a pharmacy for which a permit has been issued by the Florida Board of Pharmacy, from which to solicit, accept or dispense prescriptions.

(3) No pharmacist or pharmacy, or employee or agent thereof, shall enter into or engage in any agreement or arrangement with any physician or other practitioner or nursing home or extended care facility for the payment or acceptance of compensation in any form or type for the recommending of the professional services of either; or enter into a rebate or percentage rental agreement of any kind, whereby in any way a patient’s free choice of a pharmacist or pharmacy is or may be limited.

(4) No pharmacist, employer or employee of a pharmacy may knowingly place in stock of any pharmacy any part of any prescription compounded for, or dispensed to, any customer of any pharmacy and returned by said customer, unless otherwise permitted by Rule 64B16-28.118, F.A.C.

(5) Pursuant to Section 465.018, F.S., that requires that a permit for a community pharmacy may not be issued unless a licensed pharmacist is designated as the prescription department manager responsible for maintaining all drug records, providing for the security of the prescription department and following such other rules as relate to the practice of the profession of pharmacy. The Board shall not register a prescription department manager as the manager of more than one pharmacy. The Board may grant an exception to this requirement upon application by the permittee and the prescription department manager showing circumstances such as proximity of permits and limited pharmacist workload that would allow the manager to carry out all duties and responsibilities required of a prescription department manager.

FACT SHEET

November 1999

FEDERAL ANTI-KICKBACK LAW AND REGULATORY SAFE HARBORS

Overview: On the books since 1972, the federal anti-kickback law's main purpose is to protect patients and the federal health care programs from fraud and abuse by curtailing the corrupting influence of money on health care decisions. Straightforward but broad, the law states that anyone who knowingly and willfully receives or pays anything of value to influence the referral of federal health care program business, including Medicare and Medicaid, can be held accountable for a felony. Violations of the law are punishable by up to five years in prison, criminal fines up to $25,000, administrative civil money penalties up to $50,000, and exclusion from participation in federal health care programs.

Because the law is broad on its face, concerns arose among health care providers that some relatively innocuous -- and in some cases even beneficial -- commercial arrangements are prohibited by the anti-kickback law. Responding to these concerns, Congress in 1987 authorized the Department to issue regulations designating specific "safe harbors" for various payment and business practices that, while potentially prohibited by the law, would not be prosecuted.

The Office of Inspector General has previously published 13 regulatory safe harbors, 11 in 1991 and two in 1992. A new final rule scheduled for publication in the Nov. 19, 1999, Federal Register will establish eight new safe-harbor provisions and clarify six of the original 11 safe harbors published in 1991. These proposals were published in the Federal Register in 1993 and 1994 and have been significantly modified in response to voluminous public comments. Additionally, an interim final rule establishing a safe harbor for shared-risk arrangements is scheduled for publication in the Nov. 19, 1999, Federal Register. After publication of the two new rules, there will be a total of 23 anti-kickback safe harbors consolidated in the Code of Federal Regulations in 21 subparagraphs.

SAFE HARBORS GENERALLY

Safe harbors immunize certain payment and business practices that are implicated by the anti-kickback statute from criminal and civil prosecution under the statute. To be protected by a safe harbor, an arrangement must fit squarely in the safe harbor. Failure to comply with a safe harbor provision does not mean that an arrangement is per se illegal. Compliance with safe harbors is voluntary, and arrangements that do not comply with a safe harbor must be analyzed on a case-by-case basis for compliance with the anti-kickback statute. Parties who are uncertain whether their arrangements qualify for safe harbor protection may request an advisory opinion. Instructions on how to request an advisory opinion are available on the Internet at http://oig.hhs.gov.
THE 13 EXISTING SAFE HARBORS

The 1991 safe harbors addressed the following types of business or payment practices: investments in large publicly held health care companies; investments in small health care joint ventures; space rental; equipment rental; personal services and management contracts; sales of retiring physicians’ practices to other physicians; referral services; warranties; discounts; employee compensation; group purchasing organizations; and waivers of Medicare Part A inpatient cost-sharing amounts. The 1992 interim final safe harbors, which were finalized in 1996, addressed the following practices in managed care settings: increased coverage, reduced cost-sharing amounts, or reduced premium amounts offered by health plans to beneficiaries; and price reductions offered to health plans by providers.

THE NEW SAFE HARBORS

The preamble to the new final rule includes a summary of each proposal from 1993 and 1994, a summary of each new safe harbor, and the Office of Inspector General’s response to public comments on each topic area. The new safe harbors address the following areas: investments in underserved areas; practitioner recruitment in underserved areas; obstetrical malpractice insurance subsidies for underserved areas; sales of practices to hospitals in underserved areas; investments in ambulatory surgical centers; investments in group practices; referral arrangements for specialty services; and cooperative hospital service organizations.

Investments in Ambulatory Surgical Centers (ASCs)

The original proposal protected only Medicare-certified ASCs wholly owned by surgeons. Many in the industry urged that the original proposal be broadened. The expanded final rule protects certain investment interests in four categories of freestanding Medicare-certified ASCs: surgeon-owned ASCs; single-specialty ASCs (e.g., all gastroenterologists); multi-specialty ASCs (e.g., a mix of surgeons and gastroenterologists); and hospital/physician-owned ASCs. In general, to be protected, physician investors must be physicians for whom the ASC is an extension of their office practice pursuant to conditions set forth in the safe harbor. Hospital investors must not be in a position to make or influence referrals. Certain investors who are not existing or potential referral sources are permitted. The ASC safe harbor does not apply to other physician-owned clinical joint ventures, such as cardiac catheterization labs, end-stage renal dialysis facilities or radiation oncology facilities.

Joint Ventures in Underserved Areas

Often health care ventures in medically underserved areas have difficulty attracting needed capital, and, often, the best available sources of capital are local physicians. Many underserved area ventures cannot fit in the existing safe harbor for small entity joint ventures because that safe harbor limits physician ownership and the revenues that can be derived from referrals from physician investors. The underserved area joint venture safe harbor relaxes several of the conditions of the existing joint venture safe harbor. The new safe harbor permits a higher percentage of physician investors -- up to 50 percent -- and unlimited revenues from referral source investors. The new safe harbor expands on the 1993 proposal by including joint ventures in underserved urban, as well as rural, areas. To qualify, a venture must be located in a medically underserved area, as defined by Department regulation, and serve 75 percent medically underserved patients.
Practitioner Recruitment in Underserved Areas

This safe harbor protects recruitment payments made by entities to attract needed physicians and other health care professionals to rural and urban health professional shortage areas (HPSAs), as designated by the Health Resources and Services Administration. The safe harbor requires that at least 75 percent of the recruited practitioner's revenue be from patients who reside in HSPAs or medically underserved areas or are members of medically underserved populations, such as the homeless or migrant workers. The safe harbor limits the duration of payments to three years. The safe harbor does not prescribe the types of protected payments, such as income guarantees or moving expenses, leaving that determination to negotiation by the parties.

Because of the risk of disguised payments for referrals, the safe harbor does not protect payments made by hospitals to existing group practices to recruit physicians to join the group, nor does it protect payments to retain existing practitioners. Such arrangements remain subject to case-by-case review under the anti-kickback statute.

Sales of Physician Practices to Hospitals in Underserved Areas

This safe harbor protects hospitals in HPSAs that buy and "hold" the practice of a retiring physician until a new physician can be recruited to replace the retiring one. To qualify for safe harbor protection, the sale must be completed within three years, and the hospital must engage in good faith efforts to recruit a new practitioner.

Subsidies for Obstetrical Malpractice Insurance in Underserved Areas

This safe harbor protects a hospital or other entity that pays all or part of the malpractice insurance premiums for practitioners engaging in obstetrical practice in HPSAs. To qualify for protection, at least 75 percent of the subsidized practitioners' patients must be medically underserved patients.

Investments in Group Practices

This safe harbor protects investments by physicians in their own group practices, if the group practice meets the physician self-referral (Stark) law definition of a group practice. The safe harbor also protects investments in solo practices where the practice is conducted through the solo practitioner's professional corporation or other separate legal entity. The safe harbor does not protect investments by group practices or members of group practices in ancillary services' joint ventures, although such joint ventures may qualify for protection under other safe harbors.

Specialty Referral Arrangements Between Providers

The safe harbor protects certain arrangements when an individual or entity agrees to refer a patient to another individual or entity for specialty services in return for the party receiving the referral to refer the patient back at a certain time or under certain circumstances. For example, a primary care physician and a specialist to whom the primary care physician has made a referral may agree that, when the referred patient reaches a particular stage of recovery, the primary care physician should resume treatment of the patient. The safe harbor does not protect arrangements involving parties that split a global fee from a federal program. The safe harbor requires that referrals be clinically appropriate, rather than based on arbitrary dates or time frames.
Cooperative Hospital Services Organizations

This safe harbor protects cooperative hospital service organizations (CHSOs) that qualify under section 501(e) of the Internal Revenue Code. CHSOs are organizations formed by two or more tax-exempt hospitals, known as "patron hospitals," to provide specifically enumerated services, such as purchasing, billing, and clinical services solely for the benefit of patron hospitals. The safe harbor will protect payments from a patron hospital to a CHSO to support the CHSO's operational costs and payments from a CHSO to a patron hospital that are required by IRS rules.

CLARIFICATION OF EXISTING SAFE HARBORS

The new final rule clarifies aspects of the original safe harbors for large and small entity investments; space rental; equipment rental; personal services and management contracts; referral services; and discounts. Many of the changes are technical in nature. The intent of the clarifications is to make the regulations easier for the industry to understand and apply to particular factual circumstances.

Withdrawal of Proposed "Sham" Transactions Rule

The Office of Inspector General elected not to adopt the "sham" transactions rule proposed in the 1994 proposed regulation. However, the preamble to the new rule makes clear that safe harbors only protect arrangements if the form and substance of the transaction conform to the safe harbor in which shelter is sought.

SHARED-RISK SAFE HARBORS

In 1996, Congress enacted a new exception to the anti-kickback statute for certain shared-risk arrangements and directed the Department to issue regulations through a negotiated rulemaking process. The negotiating committee, composed of industry and government representatives, issued a joint committee statement in January 1998 that describes the agreement reached by the committee and served as a guideline for the government's rulemaking. The interim final rule with comment period for the shared-risk exception is also scheduled for publication in the Nov. 19, 1999, Federal Register.
NURSING HOME

SAMPLE OF SIMPLE VENDOR PHARMACY AGREEMENT

I. PURPOSE

The purpose of this agreement is to ensure that pharmaceutical services will be provided in accordance with all the governing laws by ___________________ (the “Pharmacy”) to _______________________ (the “Facility”).

II. QUALIFICATIONS

_______________ Pharmacy is a duly licensed and registered pharmacy in the State of Florida.

III. FUNCTIONS, RESPONSIBILITIES AND OBJECTIVES

PHARMACY:

A. The Pharmacy and the Facility agree to comply with all the applicable laws and regulations and by any facility policy and procedures as may be amended from time to time and as incorporated herein by reference.

B. It is agreed that the Facility and the residents therein reserve the express right to purchase and obtain prescriptions from other sources, at any time provided that the “other source” uses a similar drug distribution system that is compatible with the facility’s current distribution system. In accordance therewith, the Pharmacy shall not necessarily have the exclusive right to supply and furnish said items, provided, however, that the Facility shall whenever possible use __________ Pharmacy as the preferred vendor Pharmacy.

C. The Pharmacy agrees to promptly deliver to the Facility any prescriptions and supplies without unreasonable delay, except for such circumstances and conditions beyond its control, which shall include but not be limited to out of stock situations.

D. The Pharmacy agrees to provide continuous service, and in accordance therewith shall be available for delivery during every day of the week, except Sunday, and shall provide medications on an emergency basis whenever needed.

E. The Pharmacy agrees to bill each resident in conformity with the usual and proper method of billing required or accepted under the respective reimbursement of payment plans. In the event that items are not covered under a resident’s insurance plan the items will only be supplied if the resident or responsible party agrees to pay for said items.

F. The Pharmacy reserves the right to discontinue Pharmacy services to any resident who has not kept their account current. Pharmacy agrees to notify Facility prior to discontinuing service to any resident. Pharmacy may ask Facility to assist in the collection of past due balances.

G. In case of an emergency, requiring the Facility to evacuate all residents the Pharmacy agrees to deliver all medications and narcotics to the evacuation site if safely possible.
FACILITY:

A. The Facility agrees to notify the Pharmacy as to the status of each resident regarding source of reimbursement for prescription drugs and supplies and shall promptly notify the Pharmacy as to change of status or source of reimbursement. The Facility shall give the Pharmacy reasonable access to all the resident records necessary for the performance of its duties herein as long as access complies with all State and Federal privacy requirements.

B. The Facility shall promptly pay for any drugs, supplies or ancillary equipment purchased on its own account and shall remit payment on same promptly upon receipt of bill from the Pharmacy.

C. The Facility shall establish procedures for communications between the Pharmacy and the Facility staff including the Administrator, bookkeeper and Director of Nursing Services.

D. The Facility shall identify the person designated as Director of Nursing Services or the person responsible for coordinating the ordering and distribution of medication in the Facility.

E. The Facility shall provide general orientation for the Pharmacy to the facility, including its staff, policies, etc.

IV. TERMS OF AGREEMENT

The Facility retains professional and administrative responsibility for the services rendered.

V. TERMINATION OF AGREEMENT

This agreement shall be for the term of one year, and year to year, thereafter, beginning on ________ and will continue in force thereafter until terminated by either party upon giving the other party sixty (60) days written notice.

Termination shall be for cause by the vendor pharmacy not performing its duties herewith or the nursing home not fulfilling any of its obligations as described herein.

This agreement has been entered into on this the ________ day of ________________, 2005.

_______________________   ___________________________________
WITNESS      PHARMACY

_______________________   ___________________________________
WITNESS     FACILITY ADMINISTRATOR
SAMPLE CONSULTANT PHARMACISTS AGREEMENT

This agreement between ___________________________ inc., (hereinafter referred to as "Consultant pharmacist") and the ______________________ nursing home (hereinafter referred to as the "facility") wherein it is agreed that the consultant pharmacist is duly licensed and registered as a pharmacist in good standing by the fsbp and agrees to act as consultant pharmacist to the facility according to the provisions set forth below is entered into for good and valuable consideration.

I. The consultant pharmacist shall be responsible for the general and overall supervision of the facility's drug distribution system and pharmaceutical services. These services shall include but are not limited to the following:

a) General supervision of the procedures for the control and accountability of all drugs and biologicals throughout the facility and the establishment of procedures that will ensure that all such drugs and biologicals are approved, prescribed and dispensed in compliance with all federal and state laws and regulations applicable thereto and in compliance with the facility's own policies and procedures.

b) Establishment and supervision of records of receipt and disposition of all controlled substances and the maintenance of such records in sufficient detail so as to allow an accurate reconciliation at any point in time.

c) Supervision of the labeling of all drugs and biologicals to ensure that such labeling is based on currently accepted professional standards and is in compliance with all federal and state laws and regulations applicable thereto. This labeling shall include the appropriate accessory and cautionary instructions as well as the expiration date when applicable.

d) The preparation of recommendations, plans for implementation and continuing assessment of the drug distribution system through dated, signed reports, which are given to and retained by the administrator for follow-up action and evaluation of performance.

e) Provision when requested by the administrator of the facility, of programs for in-service education for professional staff of the facility when such programs would enhance the effectiveness of the pharmaceutical service; said in-service education to be conducted by the consultant pharmacist or his designee and records of program content and attendance kept.

f) Monthly reviews of the drug regimen of each skilled care patient with written, dated, and signed reports of any irregularities noted being delivered to the nurse in charge and/or the attending physician, and if no appropriate action is taken the consultant pharmacist shall report it to the facility administrator.

g) In the case of skilled care facility, quarterly written reports to the pharmaceutical service committee on the status of the facility's pharmaceutical service and staff performance.

h) In the case of skilled care facility, active membership and participation in the pharmaceutical services and infection control committees of the facility.

i) All other responsibilities required of a consultant pharmacist as set forth in any federal or state laws or regulations as enacted or as may be enacted or amended.

II. The consultant pharmacist, for his part, agrees that it shall be his responsibility to provide continuous services to the facility during the term of this agreement and, in accordance therewith, the consultant pharmacist shall arrange for the provision of services by another pharmacist, duly licensed to practice pharmacy in the state of Florida who shall act as his agent during any absence, vacation, period of illness, or other limited period when the consultant pharmacist is not available.

III. The consultant pharmacist agrees that during the term of this agreement he shall be covered by adequate professional liability and malpractice insurance.

IV. It is hereby agreed and stipulated that the consultant pharmacist is, in all matters, to be considered an independent contractor and nothing in this agreement is to be construed to establish an agent/principal relationship between the consultant pharmacist and the facility. Further, the facility acknowledges that it has full control over the acts of all its employees and agents supplying or administering drugs within the facility, and in accordance therewith, the consultant pharmacist shall not be responsible for any losses or liabilities sustained as a result of their independent, nonfeasance, malfeasance or negligence.
V. The facility shall take all necessary steps to assure complete access by the consultant pharmacist to all records and supplies within the facility necessary for the performance of the duties enumerated herein.

VI. The consultant pharmacist agrees not to divulge the content of any records, policies or procedures of the facility to anyone without the prior written consent of the facility or as he is required by law to divulge.

VII. The consultant pharmacist reserves the express right to act as a consultant to any other nursing home or related institution during the term of his agreement or subsequent thereto.

VIII. In that the consultant pharmacist may from time to time provide and make available to the facility on loan certain equipment and reference material to aid in the provision of proper pharmaceutical services, the facility agrees to promptly return same in good condition upon the termination of this agreement.

IX. The consultant pharmacist agrees to devote a sufficient number of hours, based upon the size and needs of the facility, to satisfactorily carry out the above responsibilities.

X. The facility shall retain professional and administrative responsibility for the provision of all required services.

XI. This agreement shall not be assignable by either party except as provided in provision ii herein.

XII. In consideration of the consulting services to be performed, the facility agrees that the current method of payment shall remain at $____ patient/month for each skilled bed.

XIII. This agreement shall be valid for a term of twelve (12) months, and year to year, thereafter, beginning on ______ and will continue in force thereafter until terminated by either party upon giving the other party thirty (30) days written notice.

____________________________ NURSING HOME                      DATE:_____________________

_____________________________      ___________________________
ADMINISTRATOR        CONSULTANT PHARMACIST
# SAMPLE CAFETERIA STYLE CONTRACT

## SAMPLE CONSULTING SERVICES MENU

<table>
<thead>
<tr>
<th>Core Services</th>
<th>Frequency</th>
<th>Additional Services Offered</th>
<th>Additional Service Fees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Regimen Review</td>
<td>Monthly</td>
<td>1. Fall assessment services</td>
<td>$xx.xx/hr</td>
</tr>
<tr>
<td>1. Compliance with Federal Indicators</td>
<td></td>
<td>2. Review of current drug therapy as it relates to triggered RAPS - with written reports</td>
<td>$xx.xx/hr</td>
</tr>
<tr>
<td>2. Unnecessary Drug Requirements</td>
<td></td>
<td>3. Review care plans as related to drug therapy with written report.</td>
<td>$xx.xx/hr</td>
</tr>
<tr>
<td>3. Psychoactive Drug Use &amp; Compliance</td>
<td></td>
<td>4. Specialized reviews as requested by facility.</td>
<td>$xx.xx/hr</td>
</tr>
<tr>
<td>5. Clinical issues such as adverse drug reactions, drug interactions, food-drug</td>
<td></td>
<td>6. Specialized disease management programs (as requested by facility)</td>
<td>$xx.xx/hr</td>
</tr>
<tr>
<td>interactions and drug allergies</td>
<td></td>
<td></td>
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<tr>
<td>6. Provide all necessary documentation to facility administration, nursing</td>
<td>Quarterly</td>
<td>1. Comprehensive comparison of facility medications to existing Physician orders</td>
<td>$xx.xx/hr</td>
</tr>
<tr>
<td>staff and Prescribers</td>
<td></td>
<td></td>
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<tr>
<td>7. Monitor for appropriate responses to all consultant comments</td>
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<tr>
<td>Medication Storage Audits</td>
<td>Quarterly</td>
<td>2. Perform controlled substances audits and review drug disposition records</td>
<td>$xx.xx/hr</td>
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<tr>
<td>1. Check all medication storage areas for appropriate temperature control,</td>
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<tr>
<td>drug security, expired medication, proper labeling and condition of</td>
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<tr>
<td>emergency med kits</td>
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<tr>
<td>2. Perform controlled substances audits and review drug disposition records</td>
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</tr>
<tr>
<td>Observe Medication Administration</td>
<td>Once quarterly</td>
<td>1. Monthly Medication Administration Observations (instead of quarterly)</td>
<td>$xx.xx/bed/month (add on)</td>
</tr>
<tr>
<td>Observe nursing administration technique to ensure proper preparation and</td>
<td>(during day shift)</td>
<td>2. Additional Medication Administration Observations including 2nd &amp; 3rd shift</td>
<td>$xx.xx/hr</td>
</tr>
<tr>
<td>administration of medication in facility. Observation will cover at least</td>
<td></td>
<td>(1 hour minimum)</td>
<td></td>
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<tr>
<td>25 opportunities for administration errors</td>
<td></td>
<td></td>
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<tr>
<td>Med Pass observation will be documented in writing</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Education Programs</td>
<td>annually</td>
<td>1. Education programs offering CE hours</td>
<td>$xx.xx/CE Hour plus $xx.xx/participant</td>
</tr>
<tr>
<td>1. Includes drug related programs, regulatory considerations, and policy &amp;</td>
<td>annually</td>
<td>2. Specialized training programs offering certification (ex. IV programs for nursing)</td>
<td>$xx.xx/hr</td>
</tr>
<tr>
<td>procedure changes. (5 person minimum)</td>
<td>On request</td>
<td>3. In-services during 2nd or 3rd shift</td>
<td>$xx.xx/hr</td>
</tr>
<tr>
<td>2. Medication Administration techniques (5 person minimum)</td>
<td></td>
<td></td>
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<tr>
<td>3. New Staff orientation programs (written and/or VHS format)</td>
<td></td>
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<tr>
<td>Quality Assurance Committee</td>
<td>Quarterly</td>
<td>1. Participation in monthly QAA meetings</td>
<td>$xx.xx/bed/month (add on)</td>
</tr>
<tr>
<td>Preparation of quarterly written report and attendance at the Quality</td>
<td></td>
<td>2. Participation in additional committee meetings (ex. Care plan, restraint, psych)</td>
<td>$xx.xx/hr</td>
</tr>
<tr>
<td>Assessment and Assurance Committee meetings</td>
<td></td>
<td>3. Attendance at family night meetings</td>
<td>$xx.xx/hr</td>
</tr>
<tr>
<td>Formulary Management</td>
<td>monthly</td>
<td>1. Consultant review or monthly drug bills</td>
<td>$xx.xx/hr</td>
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<tr>
<td>Consultant will work with NCS site and Prescribers to offer Therapeutic</td>
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<tr>
<td>Initiatives and lower cost alternatives to help control drug costs in the</td>
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<tr>
<td>facility</td>
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<tr>
<td>Policy &amp; Procedure Development</td>
<td>as needed plus</td>
<td></td>
<td></td>
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<tr>
<td>Consultant will ensure that P&amp;P manuals reflect current Pharmacy services</td>
<td>annual review</td>
<td></td>
<td></td>
</tr>
<tr>
<td>in the facility. Regulatory changes will also be addressed whenever needed.</td>
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