Director's Forum

Enhancing Pharmacy Practice Models Through Pharmacists' Privileging

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Director's Forum is designed to guide pharmacy leaders in establishing patient-centered services in hospitals and health systems. This article focuses on the concept of granting clinical privileges to pharmacists (acute and ambulatory care) to improve the efficiency and effectiveness of medication use. As the practice models change in hospital pharmacy practice to require the pharmacist to enter into pharmacy board-approved consult agreements, institutional privileging of pharmacists will be necessary. The pharmacy director must understand the steps of the credentialing and privileging process and should apply the process where appropriate in the department. Through hospital medical staff actively supporting pharmacists' privileging, the national Pharmacy Practice Model Initiative (PPMI) can meet its goals of integrating pharmacists as effective members of the patient care team with tangible accountability for achieving optimal drug therapy outcomes.

The American Society of Health-System Pharmacists (ASHP) Pharmacy Practice Model Summit in 2010 continues to serve as a call to action for acute care pharmacy leaders to design patient-centered pharmacy services. To achieve this goal, pharmacists have relied on various strategies such as expanding the roles of technicians, implementing medication-dispensing technology, and expanding the capability of health information systems. Professional organizations have adopted the philosophy of medical associations by developing systems for certification of clinical knowledge; the America Pharmacy Association's Board of Pharmaceutical Specialists certifies pharmacists in a variety of therapeutic areas. The growing recognition of the pharmacists' role in medication therapy management has resulted in the approval of collaborative drug therapy management practice rulings in nearly all states. It is now common practice to have pharmacists actively rounding on medical teams, collaboratively managing the medication of patients with chronic diseases, and providing antibiotic stewardship and specialty consultative services.

There are barriers to fully implementing the changing role of the pharmacist. Physicians, nurses, and other health care professionals still struggle with the changing role of pharmacists and their value in participating in drug therapy management activities.¹

Pharmacy directors also face a continued bias by administrators who view the pharmacy as an ancillary service, or a cost center, rather than a clinical care department. Other barriers may include some restrictive state laws (eg, limiting immunization practices, restricting practice agreements) and the inability to bill as a provider, which impacts pharmacy reimbursement.¹ The pharmacists' inability to bill for services as a provider significantly reduces the revenue stream of the pharmacy not related to medication dispensing. Health system pharmacists are caught in a circuitous paradigm – pharmacists are unable to generate revenue for cognitive services and hospitals do not have the revenue to support pharmacists in these activities.

A new model of medication prescribing has been recently recommended that further emphasizes the pharmacists' role in patient care. Interdependent prescribing involves the physician making the initial diagnosis and, in specific patients where the health care team decides it is appropriate, the pharmacist taking the lead on choosing the medication regimen, writing the prescriptions, and providing ongoing monitoring of drug therapy – all in cooperation with the physician and other members of the team.² This model of prescribing is not independent as it requires a collaboration of team members and use of their expertise.

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This new model, along with any other model that provides pharmacists with responsibilities for prescribing medications, requires that criteria be established for pharmacists to qualify for prescribing activities through a process of credentialing and privileging. These processes ensure that the pharmacists' role in prescribing is associated with the proper quality and safety controls so that prescribing is done in a competent manner. Organizations such as the Veteran's Administration have developed a system for pharmacist privileging that can be used as a model.³

In May 2012, the Centers for Medicare & Medicaid Services (CMS) modified their definition of medical staff to include non-physician practitioners.⁴ Pharmacists are an example of non-physicians who can now be classified as part of the medical staff, which creates an opportunity to privilege pharmacists provided that state and federal regulations are observed. Institutional clinical pharmacists are still unable to bill for their patient care services, but this change in CMS policy provides additional strategies for pharmacists to generate revenue for clinical services.

Privileging of pharmacists is a relatively new concept, and directors of pharmacy should know the basics of this process to prepare their departments for changing roles. This article provides a brief primer on the credentialing and privileging process. The specific aims of the article are to (1) describe what is meant by privileging and credentialing, (2) list the steps in pharmacist privileging, and (3) discuss the benefits of privileging of health system pharmacists. Through active support of hospital medical staffs in pharmacists' privileging, the national Pharmacy Practice Model Initiative (PPMI) can meet its goals of integrating pharmacists as effective members of the patient care team with tangible accountability for achieving optimal drug therapy outcomes.

INTRODUCTION TO PRIVILEGING AND CREDENTIALING

Privileging is the process by which a health care organization authorizes an individual to perform a particular clinical service within a defined scope of practice.⁵ Privileging is integral to the ability of physicians and mid-level practitioners (eg, nurse practitioners, physician assistants) to provide independent clinical activities in a hospital or clinic. Privileging should not be confused with credentialing. Credentialing is the process by which an organization reviews and verifies an individual's credentials to ensure that they meet established standards.³ A brief case illustrates the differences between credentialing and privileging. A hospital's

interventional cardiology department may require that physicians have the credentials of a medical degree, a state license, and specific residency training in interventional cardiology. That same hospital may only privilege specific physicians in a cardiovascular interventional study based on the credentialed physician's specific case experience and outcomes.

For pharmacists, credentialing has been limited to verification by the health system human resources department that the pharmacist is a graduate of an accredited school or college of pharmacy and that their license is in good standing. In a pharmacy department that credentials and privileges pharmacists for more clinical activities, the hospital interested in providing immunizations by the pharmacy may credential all pharmacists to work in the hospital based on completing the PharmD degree and residency training but may only privilege certain pharmacists based on the number of patients immunized and their outcomes.

STEPS IN THE PRIVILEGING PROCESS

Privileging can be a complicated process, and the pharmacy director must understand the basic steps of privileging and be able to apply them to privileging of the pharmacy staff. Because privileging is conducted by a hospital's medical staff, gaining the support of physicians to privilege pharmacists is a key initial step in the process. The director of pharmacy must develop a strategy that demonstrates the benefits and values of privileging pharmacists for medication-related clinical activities. Previous articles of the *Director's Forum* discuss the role the pharmacy director plays on important committees to demonstrate the value of pharmacy services – the pharmacy and therapeutics committee, the medical executive committee, and certain board subcommittees.

Once the pharmacy gains support for pharmacist privileging, the following steps include: (1) determining necessary credentials for practicing pharmacists, (2) determining the specific scope of the patient care service, (3) designing an application process for clinical privileging, and (4) determining initial and ongoing monitoring of quality performance in the patient care service.

Although there are no official standards that specify the credentials necessary for a pharmacist to become privileged, minimum requirements may include a pharmacy degree and a license to practice pharmacy. Expanded requirements can include residency training, board certification, number of years of practice, and level of specialization and competency examinations. As part of the privileging process,

individuals will also need to undergo initial and ongoing quality monitoring. The institution will typically establish policies regarding what specific elements related to competency will need to be reviewed for ongoing evaluation and how often this will need to occur.

Once the determination has been made that the pharmacist is both competent and qualified to become privileged, they can be granted the authority to practice within a defined scope. The scope of practice delineates the boundaries within which the pharmacist is able to provide clinical services and may differ depending on state pharmacy and medical laws and bylaws of an organization's medical staff. Independent activities where pharmacists can be privileged include the following: anticoagulation management; lipid management; diabetes management; medication reconciliation (adjusting medication based on home medications); modification of drug regimens based on a patient's renal, hepatic, and hematological parameters; management of total parenteral nutrition therapy; conversion of intravenous medication to equivalent oral dosages; initiation of culture-directed antimicrobial therapy. Within each of these clinical activities, specific procedures or tasks that fall into the scope of practice must be specified. For example, for pharmacists who are privileged to manage anticoagulation, specific procedures include selecting the medication and the proper dosage and frequency, ordering appropriate laboratories, and selecting the appropriate consultative help (eg, dietitian consult to prevent food and drug interactions).

Medical staff members of a hospital, managed care organization, large group practice, or ambulatory health clinic grant privileges to pharmacists. Most medical departments have a process for an internal review of privileges that uses criteria to determine which individuals are permitted to apply for privileging. The pharmacy department must also develop an internal process to approve pharmacists to be privileged for a specific patient care service. This involves defining appropriate performance measures for specific clinical privileges.

After privileges have been granted, a process must be in place to conduct initial assessment of a clinical practice service and an ongoing regular assessment of a clinical activity. Samples of pharmacists' clinical work are routinely subject to peer review to ensure that these activities are conducted within the reasonable scope of practice. **Appendix 1** is a sample credentialing and privileging document that can be used as a template. In addition, the references in this article also contain samples of documents containing

information and formatting necessary to gain medical staff approval.

BENEFITS OF PHARMACISTS' PRIVILEGING

Privileging of pharmacists has a variety of benefits. It improves the efficiency of pharmacists and physicians by avoiding the need for direct physician oversight of pharmacist activities. For example, pharmacists may modify a drug dosage for a patient and enter a verbal order change in the electronic medical record with a physician co-signature. Given the time to identify and sign verbal orders in an electronic system, eliminating this activity by privileging pharmacists to independently perform the activity allows the physician to care for more patients, increasing the organization's clinical revenue. Pharmacists also can more effectively utilize their time optimizing drug therapy and addressing medication-related problems without being limited by the availability of a physician.^{2,3}

Pharmacists' privileging will ensure the competence of pharmacists performing these activities and guarantee that only those with the appropriate credentials are able to perform these functions.³ This will create greater uniformity between the various disciplines, because pharmacists will be evaluated in the same structured process as physicians and midlevel practitioners.³ From an accountability standpoint, privileging of pharmacists conveys on a system-wide level the idea that pharmacists are integral to the care of patients and that they are directly responsible for the outcomes of these patients.³

As stated earlier, the PPMI provides a vision for the future of the profession and makes recommendations for developing the most optimal pharmacy practice model for hospitals and health systems.⁴ There is a strong imperative for practice model change, particularly in light of a tumultuous health care and economic climate.⁵ The PPMI outlines the practice changes and advancements that will be necessary to ensure the profession is well poised to succeed in the evolving health care landscape. A key focus of the PPMI is the involvement of pharmacists in drug therapy management and their accountability for patients' medication-related outcomes.¹ To accomplish these goals, the PPMI recommends that "pharmacists must have privileges to write medication orders in the healthcare setting."¹ The PPMI further states that "through the credentialing and privileging processes, pharmacists should include in their scope of practice prescribing as part of the collaborative practice team."¹

Pharmacists are uniquely qualified to manage drug therapy, but in most institutions, due to legislative

obstacles and a limited scope of practice, they are unable to efficiently or effectively perform this function.¹ Pharmacists perform many of their clinical functions with regard to drug and disease state management under the prescriptive license of a physician.² Although some institutions have policies in place that allow pharmacists to perform certain functions related to medication orders, each medication order management action conducted by a pharmacist requires a physician's oversight and co-signature. This requirement is cumbersome for both the parties and can significantly impede the efficiency of the pharmacist.² Fortunately, in the past few years, there have been significant changes in legislation that have begun to recognize pharmacists as providers of direct patient care and to impart greater autonomy.

The Medication Modernization Act of 2003 incorporated a prescription drug benefit program known as Medicare Part D.⁶ Beginning in 2006, Medicare Part D required that prescription drug programs offer medication therapy management services to select patients with comorbid chronic conditions.⁶ It was recognized that pharmacists were uniquely positioned to help optimize drug therapy and significantly improve patient outcomes in this patient population. Pharmacists in the ambulatory care setting have been able to utilize Medicare Part D to receive reimbursement for medication therapy management services. Many institutions have successfully implemented medication therapy management services by having pharmacists enter into collaborative practice agreements with physicians to provide disease state and drug therapy management. Although this is a step in the right direction, collaborative practice agreements have their own challenges and can pose significant administrative burdens to pharmacists, physicians, and patients.

Historically the medication use process has been a relatively rigid structure with individual health care professionals confined to their own respective areas (ie, physicians in ordering, pharmacists in reviewing/dispensing, nurses in administration/monitoring). With changes in legislation and reimbursement, midlevel

practitioners have gained the ability to become providers and receive prescriptive authority. This precedent serves as a model for the profession of pharmacy as efforts are made to advance practice along a similar path.

CONCLUSIONS

As the practice models change in hospital pharmacy to require pharmacists to enter into pharmacy board-approved consult agreements, institutional privileging of pharmacists will be required. The pharmacy director must understand the steps of the credentialing and privileging process and should apply the process where appropriate in the department. Through hospital medical staff members actively supporting pharmacists' privileging, the national PPMI can meet its goals of integrating pharmacists as effective members of the patient care team with tangible accountability for achieving optimal drug therapy outcomes.

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7. Electronic Code of Federal Regulations. Title 42: Part 482.

APPENDIX 1

Sample Registered Pharmacist Application for Privileges

MINIMUM CRITERIA FOR CORE PRIVILEGES FOR PHARMACISTS:

1. Basic Education:
 - a) B.S. in Pharmacy or PharmD
2. Licensure:
 - a) A full, unrestricted licensed to practice as a Registered Pharmacist in the State of XXX.
3. Quality Monitoring:
 - a) Initial appointment: Submission of a quality plan that defines clinical indicators to be monitored on an ongoing basis.
 - b) Semi-annual: Submission of data reflecting evaluation of clinical indicators monitored over the previous six months.
4. Minimum Criteria for Core Inpatient Pharmacist Privileges:
 - a) Computer system written exam;
 - b) Parenteral nutrition written exam;
 - c) Renal, hepatic, antithrombotic, and hematologic monitoring written exam; and
 - d) Emergency response practical exam (eg, Code Blue).
5. Minimum Criteria for Optional Privileges:
 - a) Anticoagulation therapy management privileges:
 - a. Successful completion of written exam and
 - b. Objective competency checklist.
 - b) Cardiovascular risk reduction and lipid management privileges: Successful completion of cardiovascular risk reduction and lipid management written exam.
 - c) Antiarrhythmic medication management privileges: Successful completion of antiarrhythmic medication management written exam.
 - d) Diabetes education and diabetes therapy management privileges: Successful completion of diabetes education and diabetes therapy management written exam.
 - e) Chemotherapy management privileges: Successful completion of the Beacon chemotherapy written exam.

REGISTERED PHARMACIST PRIVILEGE FORM

Applicant Name: _____

Title: _____

Department/Division of Collaborating

Physician(s) _____

Privileges Requested for (check all that apply): ☐ University Hospital ☐ Cancer Hospital

AMBULATORY PHARMACIST CORE PRIVILEGES: (cross out if not requesting)	General Hospital	Cancer Hospital
Evaluate subjective and objective patient information; Coordinate appropriate referrals; Following physician initiation, evaluate and adjust laboratory and other diagnostic tests as necessary; Provide patient counseling and education; Perform vital signs, physical inspection, and review of systems as necessary; Provide consultation in decision making/planning for clinical services including the provision of drug information.		
OPTIONAL AMBULATORY PHARMACIST PRIVILEGES:	General Hospital	Cancer Hospital
Anticoagulation therapy management: Modify or discontinue anticoagulation therapy as appropriate. Perform point-of-care testing.		
Cardiovascular risk reduction and lipid management: Modify or discontinue antihyperlipidemia therapy as appropriate.		
Antiarrhythmic medication management: Modify or discontinue antiarrhythmia therapy as appropriate.		
Diabetes education and diabetes therapy management: Provide disease self-management and behavior change education. Monitor progress of current therapy. Recommend medication changes as needed. Perform point-of-care testing.		
Chemotherapy management: Adjust and modify physician initiated chemotherapy regimens based on patient-specific parameters.	N/A	
INPATIENT PHARMACIST CORE PRIVILEGES: (cross out if not requesting)	General Hospital	Cancer Hospital
Evaluate subjective and objective patient information; Coordinate appropriate referrals; Provide consultation in decision making/planning for clinical services; Transition patients from intravenous to oral therapy per P&T IV to PO Policy; Following physician initiation, monitor and adjust medications based on renal, hepatic, antithrombotic indications, and hematologic parameters; Following physician initiation, modify and adjust total parenteral nutrition (TPN) therapy and associated fluids and electrolytes in conjunction with a licensed dietitian; Evaluate and adjust laboratory tests related to medication therapy as necessary; Delete duplicative medication therapy within the same therapeutic class when necessary; Following physician diagnosis of <i>C. difficile</i> and physician initiation, modify and adjust therapeutic management; Following physician initiation, monitor and adjust culture-directed antimicrobial therapy with de-escalation of antimicrobials.		
OPTIONAL INPATIENT PHARMACIST PRIVILEGE:	General Hospital	Cancer Hospital
Chemotherapy management: Adjust and modify physician initiated chemotherapy regimens based on patient-specific parameters.	N/A	

Applicant signature

Date

Collaborating physician

Date

I attest that I am credentialed to perform the above procedures at the hospital(s) requested.

Division Director signature (if applicable)

Date

Department Chair signature

Date

Credentials Subcommittee Chair signature

Date

Medical Director signature

Date