Advancing Pharmacy Practice via Privileging and Credentialing

Ohio Society of Health-System Pharmacists
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OBJECTIVES:

• Pharmacist:
  – Define privileging and credentialing
  – Describe the barriers to implementation
  – Define what duties and programs can be incorporated
  – Perform an analysis of the carrot versus the stick approach
OBJECTIVES:

• Pharmacist:
  – Discuss the advantages associated with privileging and credentialing
  – Explain the process to privilege and credential pharmacists
  – Identify methods to overcome barriers to privileging and credentialing pharmacists
OBJECTIVES:

• Technician:
  – Define privileging and credentialing
  – Define how technician roles can be elevated in the new practice model
  – Discuss the advantages associated with privileging and credentialing
  – Describe the impact of privileging and credentialing pharmacist on pharmacy department workflow
Privileging and Credentialing

- Distinct, but related processes
- Above and beyond licensure
  - Licensure provides the foundation of entry-level knowledge and skills for the provision of services
- Intended to build upon the foundation licensure provides
Credential

- Documentation/Evidence of Qualifications
  - Degree
  - Licensure
  - Certification
  - Clinical Experience
Credentialing

• Process by which an organization obtains, assesses, and validates an individual’s credentials
  – Assures minimum qualifications are met

• Formally introduced into Joint Commission accreditation standards in 1989
Privileging

- Process used by organizations to grant a specific practitioner the authorization to provide a specific scope of patient care services
  - Granted only after credential and performance review
The Joint Commission

• Requires privileging for “licensed independent health care practitioners”
• 2003 created a single set of standards that apply to all long-term and subacute care programs
• Require privileges fall within defined limits based upon qualifications and current competence
Caregiver Credentialing/Privileging

• Effective January 1, 2012, Joint Commission revision
  – All patient caregivers now credentialed under medical staff

• Change prior credentialing/privileging process where “allied health” providers were under separate category
The Joint Commission
CREDENTIALING STANDARD (HR 02.01.03)

• Before:
  – Document licensure and disciplinary actions
  – Verifies individual (view photo ID)
  – Obtains and documents information from the NPDB*
  – Monitor until determined that the individual is able to provide the care, treatment, and services that he/she is being permitted to provide
Specific Information

• Primary practice
• Supervising physician*
• Personal Information
• Education
• Licenses/Certifications
• Experience
Specific Information

• Professional references
• Personal health status*
• Disciplinary actions
• Professional liability insurance
• Statement of understanding and agreement
The Joint Commission
CREDENTIALING STANDARD (HR 02.01.03)

• At least every two years:
  – Document licensure & disciplinary actions
  – Document NPDB data*
  – Clinical performance review that is outside acceptable standards
  – Review information from the organization’s improvement activities pertaining to performance, judgment, and clinical/technical skills
  – Confirms practitioner’s adherence to policies, procedures, rules, and regulations
An institutional policy for consult agreements developed pursuant to division (C) of section 4729.39 of the Revised Code must include at least the following criteria:

– The appropriate institutional credentialing or privileging procedures for each individual pharmacist prior to the pharmacist acting under any consult agreement;
– The credentialing or privileging procedures that delineate an individual pharmacist's scope of privileges when acting under a consult agreement;
– An appropriate quality assurance mechanism to ensure that pharmacists who act under a consult agreement do so only within the scope of privileges granted;
– A written description for each of the following:
  • The mechanism to be used for coverage when the consult agreement pharmacist or physician is not physically present;
  • How the consult agreement will be made in writing;
  • How the consult agreement shall be communicated to the patient or legal guardian;
  • How the pharmacist shall document each action taken under the consult agreement;
  • The methods to be used for the required communication between a pharmacist and physician;
  • The appropriate methods for terminating a consult agreement.
Four General Steps

1. Gather background information
2. Define Services
3. Develop policies and procedures
4. Approval
Pharmacist Credentialing and Privileging

University of Toledo Medical Center
Russell Smith BS, Pharm D, MBA, BCPS
Pharmacy Overview

- 4 pharmacies: hospital inpatient, UTMC outpatient, student medical center outpatient, UTCare
- $22 million pharmaceutical expense
- 1.2 million dispensed doses annually inpatient and 100,000 outpatient prescriptions
- 112 employees
- 9 Residents: 8 PGY1, 1 PGY2 Critical Care
- 15 Advanced Pharmacy Practice Experience (APPE) Students per month
- 15 Intermediate Pharmacy Practice Experience (IPPE) Students per year
History

• 1979: MCH Opened:
  – centralized order processing
• 1985: first on site faculty rounding service
• 1998 first kinetics, IV to PO, and renal adjustment programs implemented
• 2006 merger with University of Toledo
• 2007: decentralized pilot
• 2008: decentralized hospital wide
• 2012: integrated care:
  – residency expansion
  – layered learner model
Pharmacy Practice Model

Academic Specialists -> Integrated care pharmacist -> Resident -> Student -> Clinical Specialists
Integrated Care Pharmacy Team

Profile review

Integrated Care Pharmacist

Drugs level monitoring

Order processing

Drug level ordering

Drug info

BOP room high $

Medication security

Medication Education HCAPHS

Transition of care Discharge Rx

Dispensing

Automatic IV to PO

Precepting

Disease state education

Follow up visits for high risk

Automatic renal adjustments

Code blue

Transition of care Discharge Rx

Dispensing

Integrated Care Pharmacist
Getting started

• ASHP and other articles
• Do not reinvent the wheel
• Go to your medical staff office, they have done this numerous times and for professions you would not have guessed
• Physician champions
  – Medical director and Chair of P&T
Concept Literature review
Action plan: Use templates to match vision Set time lines!!!
Meet with key stakeholders Staff Chief of Staff Medical director P&T Chair Medical Staff office Human Resources Union Senior Administration Board of Pharmacy Finance Legal
Generate required documents: applications define privileges policies consult agreements job descriptions budget impact monitoring tools competencies patient consent
Obtain approval P&T MEC Medical Staff Office Forms Policy Review Board of Trustees
Pharmacists complete credentialing application
Yes: Pharmacist II
BCPS
Review Begin FPPE process
Review by HR and leadership team hired as Pharmacist I
OPPE q6months
If not acceptable: Remedial education and action plan
No Remain at Pharmacist I
Created a career ladder

**Pharmacist I**
- BS or Pharm D
- Residency Preferred
- Centralized or limited duties
- integrated care
- FPPE optional: max time limit of 2 OPPE cycles
- ACLS optional

**Pharmacist II**
- BS or Pharm D
- Residency Preferred
- FPPE Completion Required
- OPPE q6 months
- Board Certification Required
- 5% pay increase
- ACLS required
Credentialing Application

• Application
  – BS or Pharm D
  – Residency not required

• Focused Professional Practice Evaluation (FPPE):
  – Clinical panel review of 100 interventions
  – Competency test
Ongoing assessment

• Ongoing Professional Practice Evaluation (OPPE)
• Every 6 months review 50 interventions covering all privileges
• Pass annual credentialed pharmacist competency
• Board Certification through Board of Pharmacy Specialties required within 24 months of practice as a credentialed pharmacist
Board Certification

- Pharmacotherapy or applicable specialty
  - Ambulatory care
  - Nuclear
  - Nutrition
  - Oncology
  - Psychiatric
- 100% of management and clinical specialists
- 66% of integrated care pharmacists
- 50% of faculty
- 100% pass rate to date
- 2014: 2\textsuperscript{nd} and 3\textsuperscript{rd} shift and 1 more integrated care
Establish Privileges

• Core Privileges
  – Profile review
  – Patient education
  – Remove duplicates
  – Kinetics consults
  – Precept students and residents
  – Dose rounding
  – Warfarin consults
  – ACLS
Privileges requiring additional training

• Phase I
  – Automatic IV to PO
  – Automatic disease state adjustments
  – Therapeutic laboratory ordering
  – Stress ulcer prophylaxis cessation

• Phase II
  – TPN ordering
  – Antibiotic de-escalation
Where do my privileges fall?

<table>
<thead>
<tr>
<th><strong>Protocol</strong></th>
<th><strong>Consult</strong></th>
</tr>
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<tbody>
<tr>
<td>Prescriptive</td>
<td>Liberal</td>
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<tr>
<td>Definitive can not be</td>
<td>Clinical judgment</td>
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<tr>
<td>changed based on</td>
<td>No cosignatory</td>
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<tr>
<td>clinical judgment</td>
<td>Ordering lab data for</td>
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<tr>
<td>Emergent</td>
<td>outpatients</td>
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<tr>
<td>Need physician to</td>
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<tr>
<td>review and cosign in</td>
<td></td>
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<tr>
<td>a reasonable time</td>
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<tr>
<td>Ok for formulary</td>
<td></td>
</tr>
<tr>
<td>conversions</td>
<td></td>
</tr>
<tr>
<td>Ordering lab data</td>
<td></td>
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<tr>
<td>for inpatients</td>
<td></td>
</tr>
</tbody>
</table>
Carrot vs Stick

Develop a proven quality employee who fits our culture but has a couple of known flaws or gaps in experience

Or

Hire an unproven employee who interviews well
Engaging the 30 year employee

• Pay: 5% increase
• Include them in the process:
• Resources:
  – Training manuals
  – Study groups
  – Procedures, protocols, and checklists
• Set hard deadlines
  – Certification exam now twice a year
Current Staff

Current Pharmacist Completes FPPE

BCPS

Yes Pharmacist II

No Pharmacist I
Staff Development

- BCPS or appropriate equivalent
  - Gave existing pharmacist 2 years to complete BCPS
  - Initial exam covered
  - 5% Pay increase upon completion
- Part-time and Contingents encouraged but not required
Recruiting new pharmacists

• Recruit from within PGY1 and PGY2 class
  – Complete FPPE during residency
  – Hire July 2014 as Pharmacist I
  – During 4 month probationary training period obtain board certification
  – Move to Pharmacist II after Probation
Elevation of technician roles

Layered Learning Model

– Increased number of APPE and IPPE students
– Technicians require preceptor development to assist in training of dispensing functions to students and residents
– Residency program coordination
Elevation of technician roles

Medication safety technician

– Collects data
  • Interventions
  • ADRs
  • Med Errors

– Publishes newsletter
Keys to Success

- Keep it simple
- Build over time
- Staff buy in
- Medical Staff Support
- Partner with State Board of Pharmacy
- Union support
- Human resources and medical staff office:
  - They have done this before
Items not to forget

• Patient needs to be notified for consults: place in admission packet that a pharmacist will be involved in the care “medication management may be supplied by a pharmacist”

• Same criteria for positive ID as medical staff

• Refer to general counsel for interpretation
Akron General Medical Center

Located in Akron, Ohio

511 adult-bed, community, teaching hospital
How to Begin

• Does not mean you have to redo your entire structure
• Helpful to have a clear idea of your practice model goal
• Most of us only have the resources to do this incrementally
• Just start!
Challenge #1

• Get the paperwork right

• Medical Staff Office Personnel/Person

• Get examples of existing forms
Challenge #2

- Education of those involved with the process
- Internal champions
Challenge #3

- Defining the privileges requested
## Pharmacist Privilege Request

<table>
<thead>
<tr>
<th>Request Privileges Listed Below</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Request</strong></td>
</tr>
<tr>
<td>Assess, diagnose, monitor, promote health and protection from disease, and manage illnesses and injuries of complex acute, critical, and chronically ill patients within age group of consulting physician. Pharmacists may not admit patients to the hospital. They may provide care to patients in the intensive care setting in conformance with unit policies and assess, stabilize, and determine disposition of patients with emergent conditions consistent with Medical Staff policy regarding emergency and consultative call services.</td>
</tr>
<tr>
<td>Core Procedures (This list is not intended to be an all encompassing procedure list. It defines the types of activities/procedures/privileges that the majority of practitioners in this specialty perform at this organization and inherent activities/procedures/privileges requiring similar skill sets and techniques.)</td>
</tr>
<tr>
<td>Participate as a member of a treatment team in planning, evaluating, and implementing individualized treatment plans</td>
</tr>
<tr>
<td>Conduct comprehensive medication histories</td>
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<tr>
<td>Consult with physicians in areas such as drug therapy selection, pharmacokinetics, nutritional support, and determination of therapeutic endpoints</td>
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<tr>
<td>Initiate, continue, renew, modify, or discontinue medications</td>
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<tr>
<td>Order lab tests to monitor medication therapy</td>
</tr>
<tr>
<td>Analyze lab and diagnostic tests to modify drug therapy</td>
</tr>
<tr>
<td>Consult ancillary services</td>
</tr>
</tbody>
</table>
Challenge #4

- Who are you credentialing vs. privileging
Other Challenges

• Culture
• Pushback by other LIP’s
• Cost
• Existing staff- How do you make it work?
• Re-credentialing requirements
Advantages

• Aside from the obvious thrill of finally being recognized as a Licensed Independent Practitioner instead of an ancillary provider?
Advantage #1

- Formalizes consults
- Increases awareness of pharmacist capabilities
- Increases medical staff exposure
Advantage #2

• Patient Care Impact
  – Can significantly decrease the amount of time necessary to modify therapy
  – Allows for personalization of therapy
  – Improves transitions of care
Advantage #3

- Privileging through medical staff procedures provides an almost instant policy and procedure manual
- Also provides a Code of Conduct
- Policies on consults, medical records requirements
Advantage #4

• Eliminates the need for countersignatures
Advantage #5

• Peer evaluation
  – Can also be a challenge
  – A very effective way to raise the bar
  – Be careful with definition
AGMC Practice Model

• Status at the beginning - a complete mix

• Where to start?
Step One

• Determine appropriate activities and credentials for all existing levels
Level I

- Order assessment- appropriateness and ADR’s
- Patient Education
- Medical staff approved standard interventions
  - IV to PO; therapeutic substitution, renal dosing
Level II

• Decentralized services
• Medication Reconciliation
• Proactive assessment and intervention
Level III

- Additional training- specialty area

- May participate in collaborative practice agreements in specialty area
  - IP and OP
Level IV

- BCPS and/or other credential
- Residency or equivalent experience
- Full range of activities
- Teaching rounds - medicine and pharmacy
Transitioning I - II

- Decision to eliminate Level I
- Assigned to existing Level II to observe and be observed performing duties
Transitioning II - III

- Expressed interest
- Requires a mentor
- Advanced training
  - Rotations
  - Certificates
  - CE concentration
Transition III - IV

- BCPS or other credential
The Million Dollar Question

• How long do you have at each level?
• The Practice Model will no doubt look different in each organization

• The standard of practice is changing
JUST START!