Clinical Pharmacist Credentialing and Privileging: A Process for Ensuring High-Quality Patient Care

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The Red Lake Indian Health Service (IHS) health care facility is in north-central Minnesota within the Red Lake Nation. The facility supports primary care, emergency, urgent care, pharmacy, inpatient, optometry, dental, radiology, laboratory, physical therapy, and behavioral health services to about 10,000 Red Lake Band of Chippewa Indian patients. The Red Lake pharmacy provides inpatient and outpatient medication services and pharmacist-managed clinical patient care.

In 2013, the Red Lake IHS medical staff endorsed the implementation of comprehensive clinical pharmacy services to increase health care access and optimize clinical outcomes for patients. During the evolution of pharmacy-based patient-centric care, the clinical programs offered by Red Lake IHS pharmacy expanded from 1 anticoagulation clinic to multiple advanced-practice clinical pharmacy services. This included pharmacy primary care, medication-assisted therapy, naloxone, hepatitis C, and behavioral health medication management clinics.

The immense clinical growth of the pharmacy department demonstrated a need to assess and monitor pharmacist competency to ensure the delivery of quality patient care. Essential quality improvement processes were lacking. To fill these quality improvement gaps, a robust pharmacist credentialing and privileging program was implemented in 2015.

PATIENT CARE

As efforts within health care establishments across the US focus on the delivery of efficient, high-quality, affordable health care, pharmacists have become increasingly instrumental in providing patient care within expanded clinical roles.[1-8] Many clinical pharmacy models have evolved into interdisciplinary approaches to care.[9] Within these models, abiding by state and federal laws, pharmacists practice under the indirect supervision of licensed independent practitioners (LIPs), such as physicians, nurse practitioners, and physician assistants.[8] Under collaborative practice agreements (CPAs), patients are initially diagnosed by LIPs, then referred to clinical pharmacists for therapeutic management.[5,7]

Clinical pharmacist functions encompass comprehensive medication management (ie, prescribing, monitoring, and adjustment of medications), nonpharmacologic guidance, and coordination of care. Interdisciplinary collaboration allows pharmacists opportunities to provide direct patient care or consultations by telecommunication in many different clinical environments, including disease management, primary care, or specialty care. Pharmacists may manage chronic or acute illnesses associated with endocrine, cardiovascular, respiratory, gastrointestinal, or other systems.

Pharmacists may also provide comprehensive medication review services, such as medication therapy management (MTM), transitions of care, or chronic care management. Examples of specialized areas include psychiatric, opioid use disorder, palliative care, infectious disease, chronic pain, or oncology services. For hospitalized patients, pharmacists may monitor pharmacokinetics and adjust dosing, transition patients from IV to oral medications, or complete medication reconciliation.[10] Within these clinical roles, pharmacists assist in providing patient care during shortages of other health care providers (HCPs), improve patient outcomes, decrease health care-associated costs by preventing emergency department and hospital admissions or readmissions, increase access to patient care, and increase revenue through pharmacist-managed clinics and services.[11]

PHARMACIST CREDENTIALING

With the advancement of modern clinical pharmacy practice, many pharmacists have undertaken responsibilities to fulfill the complex duties of clinical care and diverse patient situations, but with few or no requirements to

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prove initial or ongoing clinical competency.[2] Traditionally, pharmacist credentialing is limited to a onetime or periodic review of education and licensure, with little to no involvement in privileging and ongoing monitoring of clinical proficiency.[10] These quality assurance disparities can be met and satisfied through credentialing and privileging processes. Credentialing and privileging are systematic, evidence-based processes that provide validation to HCPs, employers, and patients that pharmacists are qualified to practice clinically.[2,9] According to the Council on Credentialing in Pharmacy, clinical pharmacists should be held accountable for demonstrating competency and providing quality care through credentialing and privileging, as required for other HCPs.[2,12]

Credentialing and recredentialing is a primary source verification process. These processes ensure that there are no license restrictions or revocations; certifications are current; mandatory courses, certificates, and continuing education are complete; training and orientation are satisfactory; and any disciplinary action, malpractice claims, or history of impairment is reported. Privileging is the review of credentials and evaluation of clinical training and competence by the Clinical Director and Medical Executive Committee to determine whether a clinical pharmacist is competent to practice within requested privileges.[11]

Credentialing and privileging processes are designed not only to initially confirm that a pharmacist is competent to practice clinically, but also monitor ongoing performance.[2,13] Participation in professional practice evaluations, which includes peer reviews, ongoing professional practice evaluations, and focused professional practice evaluations, is required for all credentialed and privileged practitioners. These evaluations are used to identify, assess, and correct unsatisfactory trends. Individual practices, documentation, and processes are evaluated against existing department standards (eg, CPAs, policies, processes)[11,13] The results of individual professional practice evaluations are reviewed with practitioners on a regular basis and performance improvement plans implemented as needed.

Since 2015, 17 pharmacists at the Red Lake IHS health care facility have been granted membership to the medical staff as credentialed and privileged practitioners. In a retrospective review of professional practice evaluations by the Red Lake IHS pharmacy clinical coordinator, 971 outpatient clinical peer reviews, including the evaluation of 21,526 peer-review elements were completed by pharmacists from fiscal year 2015 through 2018. Peer-review elements assessed visit documentation, patient care, and other clinic processes defined by department standards. Beginning in 2016, peer-review feedback was implemented and completed on a quarterly basis with each pharmacist. In fiscal years 2015, 2016, 2017, and 2018, the percentage of peer-review elements found as noncompliant with department standards were 18.0%, 11.6%, 3.7%, and 3.4%, respectively. Compared with the 2015 year baseline, these data correlate with a decrease of peer-review concerns by 35.5% in 2016, 79.4% in 2017, and 81.1% in 2018.

CONCLUSION

Pharmacists have become increasingly instrumental in providing effective, cost-efficient, and accessible clinical services by continuing to move toward expanding and evolving roles within comprehensive, patient-centered clinical pharmacy practice settings.[5,6] Multifaceted clinical responsibilities associated with health care delivery necessitate assessment and monitoring of pharmacist performance. Credentialing and privileging is an established and trusted systematic process that assures HCPs, employers, and patients that pharmacists are qualified and competent to practice clinically.[2,4,12] Implementation of professional practice evaluations suggest improved staff compliance with visit documentation, patient care standards, and clinic processes required by CPAs, policies, and department standards to ensure the delivery of safe, high-quality patient care.

Author disclosures

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References

1. Giberson S, Yoder S, Lee MP. Improving patient and health system outcomes through advanced pharmacy practice. https://www.accp.com/docs/positions/misc/Improving_Patient_and_Health_System_Outcomes.pdf. Published December 2011. Accessed March 15, 2019.
2. Rouse MJ, Vlasses PH, Webb CE; Council on Credentialing in Pharmacy. Credentialing and privileging of pharmacists: a resource paper from the Council on Credentialing in Pharmacy. *Am J Health Syst Pharm.* 2014;71(21):e109-e118.
3. Berwick DM, Nolan TW, Whittington J. The triple aim: care, health, and cost. *Health Aff (Millwood).* 2008;27(3):759-769.
4. Blair MM, Carmichael J, Young E, Thrasher K; Qualified Provider Model Ad Hoc Committee. Pharmacist privileging in a health system: report of the Qualified Provider Model Ad Hoc Committee. *Am J Health Syst Pharm.* 2007;64(22):2373-2381.
5. Claxton KI, Wojtal P. Design and implementation of a credentialing and privileging model for ambulatory care pharmacists. *Am J Health Syst Pharm.* 2006;63(17):1627-1632.
6. Jordan TA, Hennenfent JA, Lewin JJ III, Nesbit TW, Weber R. Elevating pharmacists' scope of practice through a health-system clinical privileging process. *Am J Health Syst Pharm.* 2016;73(18):1395-1405.
7. Centers for Disease Control and Prevention. Collaborative practice agreements and pharmacists' patient care services: a resource for doctors, nurses, physician assistants, and other providers. https://www.cdc.gov/dhdsp/pubs/docs/Translational_Tools_Providers.pdf. Published October 2013. Accessed March 18, 2019.
8. Council on Credentialing in Pharmacy, Albanese NP, Rouse MJ. Scope of contemporary pharmacy practice: roles, responsibilities, and functions of practitioners and pharmacy technicians. *J Am Pharm Assoc* (2003). 2010;50(2):e35-e69.
9. Philip B, Weber R. Enhancing pharmacy practice models through pharmacists' privileging. *Hosp Pharm*. 2013;48(2):160-165.
10. Galt KA. Credentialing and privileging of pharmacists. *Am J Health Syst Pharm.* 2004;61(7):661-670.
11. Smith ML, Gemelas MF; US Public Health Service; Indian Health Service. Indian Health Service medical staff credentialing and privileging guide. https://www.ihs.gov/riskmanagement/includes/themes/newihstheme/display_objects/documents/IHS-Medical-Staff-Credentialing-and-Privileging-Guide.pdf. Published September 2005. Accessed March 15, 2019.
12. US Department of Health and Human Services, Indian Health Service. Indian health manual: medical credentials and privileges review process. https://www.ihs.gov/ihm/pc/part-3/p3c1. Accessed March 15, 2019.
13. Holley SL, Ketel C. Ongoing professional practice evaluation and focused professional practice evaluation: an overview for advanced practice clinicians. *J Midwifery Women Health.* 2014;59(4):452-459.