

Credentialing and privileging for pharmacists

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The privileging and credentialing processes used by health systems have evolved over the past 30 years, and the pace of that change is increasing. This evolution is driven by society's interest in protecting the public's health, liability law, and the emergence of regulation in response to these issues. This article answers basic questions that pharmacists may have about the privileging and credentialing processes and explains the purposes, terminology, rationale, and processes of clinical privileging. The differences between privileging and credentialing are explained, and background information about the privileging of other health professions is also provided. A glossary of terms can be found in the appendix, and several case studies are included in this article.

What is credentialing? Credentialing is the process used by health care organizations to validate professional licensure, clinical experience, and preparation for specialty practice. Health care professionals must have some form of credentialing before they are hired by a health care system and before they are granted specific patient care privileges. For pharmacists, this process has generally been limited to verification by the health system's human resources

or personnel department that the pharmacist is a graduate of an accredited pharmacy curriculum and is licensed to practice pharmacy in that state.

The Council on Credentialing in Pharmacy defines three fundamental types of credentials: college or university degrees; licensure and relicensure; and certificates, awards, or postgraduate work.¹ In other health care professions, credentials include proof that the practitioner has completed either an accredited training program for a specific patient care activity or a defined number of specific patient care activities under the supervision of an expert. Other quantifiable means of determining competency for a specific patient care service are also sometimes used, such as log books' recording date, type of procedure or service performed, and signature of supervising health professional, or documentation of special education or training (e.g., board certification, competency-based continuing education, fellowship or residency training).

Credentialing was formally introduced into accreditation procedures in 1989, when the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) established standards that required health care

organizations to perform credentialing functions.² As organizations gained experience with credentialing, they recognized the need for more specific competency assessment of individual practitioners. Credentialing a health care practitioner can provide the health care organization with a broad assessment of a practitioner's qualifications in a subject area, but the process often lacks the specificity required to ensure competence for specific patient care functions. For example, the credentials needed to ensure competence depend on local standards of practice and the procedures determined by the health care organization for self review and peer review. Credentials that ensure competence in one health care organization or region may not be adequate to ensure competence in a different health care organization or region. Organizations have increasingly come to rely on privileging as a method of assessing the competency of independent practitioners.

What is privileging? Privileging is the process used by health care organizations to grant to a specific practitioner the authorization to provide specific patient care services. Privileging ensures that the individual requesting clinical privileges is capable of providing those patient care ser-

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vices in accordance with the standard of care of the facility granting the privilege.

Pharmacists have not generally participated in privileging. After a preemployment review of a pharmacist's credentials, health systems have generally allowed pharmacists to perform all the activities permitted by the state's pharmacy practice act. Pharmacists are facing mounting pressure to ensure competency as their patient care role expands and as pharmacy specialization increases. Privileging of pharmacists has been generally limited to ensuring competency in the provision of clinical services that are not specifically identified in state licensure to practice pharmacy. For example, a health system may require that pharmacists be privileged to provide pharmacokinetic monitoring and make dosage adjustments for patients receiving gentamicin. Dosing and monitoring are within the legal scope of practice for the pharmacist, but a health system may decide that the dosing and monitoring of gentamicin is a specific clinical privilege that will require the pharmacist to establish his or her competency.

How do credentialing and privileging work? Privileging and credentialing are distinct but related processes. When a health care practitioner applies for privileges from a health system, the organization grants the privileges only after thoroughly reviewing a defined set of credentials. Credentialing and privileging processes may overlap and can occur simultaneously.

The processes for credentialing and privileging must be clearly defined in the medical staff bylaws and in the policies and procedures of each health care organization.³ JCAHO standards require that the clinical privileges granted by an organization "fall within defined limits based upon the licensed independent practitioner's qualifications and current competence" and that consideration

of initial, renewal, or revision of clinical privileges be based on peer evaluation of professional performance, judgment, and clinical and technical skills.¹ JCAHO standards also stipulate that nonphysician providers may be appointed to the medical staff of the organization and granted clinical privileges if those privileges fall within the practitioner's scope of practice as defined by state law or regulations. However, once practitioners seek clinical privileges, they are bound by the requirements of the organization's bylaws.⁴

The first step in the privileging process is usually application for clinical privileges by a practitioner. Organizations typically have application packets that list the information required for consideration. The applicant submits a comprehensive list of the requested privileges and provides evidence of his or her credentials. The initial task of credentialing is to verify the applicant's qualifications. While the applicant's credentials are being evaluated, temporary approval of privileges may be awarded.⁵

Credentialing is usually governed by a health-system committee, often called the credentialing committee, which also grants patient care privileges. The credentialing committee includes representatives of providers who hold clinical privileges in that organization, and they make recommendations regarding the granting of privileges to the organization's governing body (e.g., the medical staff executive committee). The credentialing committee varies in composition. It may be composed primarily of medical staff with some administrative representation, although some organizations prefer a more interprofessional group.

In some organizations, the administrative aspects of the credentialing process are conducted by staff (such as a quality assurance department) who forward information to the appropriate administrative body (e.g., the credentialing committee)

for a decision. Increased demand for credentialing has spawned the emergence of private credentialing services. These services process application packages, verify applicants' credentials, and present their findings to the organization. It is critical that, whatever the organizational approach, applicants are protected from potential bias from economic competitors and receive due process.⁵⁻⁷

As a result of the Health Care Quality Improvement Act of 1986, the Health Resources and Services Administration (HRSA) developed a national registry of providers who lose malpractice claims or are subject to adverse actions of greater than 30 days on licensure, privileges, or society memberships. This registry, the National Practitioner Data Bank (NPDB), is operated jointly by HRSA and JCAHO.⁸ All health care organizations are required to query the NPDB each time an independent practitioner applies for medical staff appointment or clinical privileges and every two years thereafter.^{2,9} All health professionals should be aware of the NPDB and how it is used to contribute to the assessment of a health professional's competence.^{10,11}

JCAHO and the National Committee for Quality Assurance (NCQA) expect health systems to critically reappraise the qualifications and competence of their providers at least biennially for reappointment and renewal of clinical privileges. Emphasis is placed on the process of reappraisal to ensure that the professional continues to be competent and maintains the necessary clinical skills.^{12,13}

Who participates in privileging? JCAHO currently requires privileging for "licensed independent health care practitioners," defined as those who are permitted by law and regulation and by the health care organization to provide patient care without supervision or direction, within the scope of the individual's license and individually granted clinical privi-

leges.¹⁴ JCAHO does not currently consider pharmacists to be independent health care practitioners, but this classification may change, as JCAHO recognizes nurse practitioners and physician assistants as licensed independent practitioners where state law permits them to provide unsupervised patient care. As pharmacist involvement in collaborative practice agreements grows, health systems and regulators will face increasing pressure to ensure the competence of these practitioners. Hospitals and health systems may also choose to credential and privilege health care practitioners, including pharmacists, who are not independent practitioners but whose complex roles in patient care require an assurance of competence.¹⁵

Credentialing and privileging are no longer limited to inpatient settings, as the Accreditation Association for Ambulatory Health Care and NCQA require their use.⁵ Managed care organizations, large group practices, ambulatory care organizations, and others are developing mechanisms to ensure standard qualifications and competence of all autonomous care providers.⁶ In 2003, JCAHO created a single set of credentialing and privileging standards that apply to all long-term-care and subacute care programs within the organizations it accredits.¹⁶

Why health care organizations participate in privileging. Privileging minimizes a health care organization's legal liability, helps fulfill an organization's mission of providing quality patient care, and can reduce staff conflicts by establishing criteria required to provide specific patient care services.

Health systems are liable for services provided by health care providers on their premises. The duty of selecting medical staff and supervising or monitoring their actions cannot be delegated, meaning that the hospital or health system cannot shift this responsibility to another

entity, such as state licensure boards or other bodies that offer specialty credentials or other measures of competency. Health systems and their medical staffs may be held liable for damages if they permit an unqualified practitioner to practice in the organization or if they allow even a qualified practitioner to provide specific clinical services that he or she has not been deemed competent to perform within that health system.

Why individuals participate in privileging. Individuals participate in the privileging process to gain authorization to perform specific patient care services within a health care system. Examples include the privileging of surgeons to perform surgical procedures not included in the core surgical training program (e.g., laparoscopic general surgery, comprehensive gynecological endoscopic surgery, colonoscopy)¹⁷⁻¹⁹ and the privileging of advanced practice nurses (nurse midwives, nurse anesthetists, and nurse practitioners) to admit patients to hospitals.^{20,21} Pharmacists may choose to participate in privileging to establish their competency in providing specialized patient care services (e.g., pharmacokinetic dosing; individualization of anticoagulation dosing and monitoring; design, ordering, and monitoring of parenteral nutrition services; preparation of specialized medications).

Importance of privileging and credentialing to pharmacists. As pharmacists gain recognition through health care regulation as health care providers (e.g., Medicare-recognized providers), they may find it necessary to ensure their competence to gain authorization from their health system to provide certain patient care services. Some pharmacists may need to seek authorization for the clinical privilege to provide a patient care service for which they have developed a protocol or agreement with a medical staff member. Health care organizations are obligated to assess the competency of professional staff,

regardless of collaborative practice agreements or departmental policy.

Some pharmacists are concerned that the recognition of pharmacists as health care providers under Medicare will encourage state boards of pharmacy or other government agencies to establish procedures beyond licensing to determine a pharmacist's competence to provide specific patient care services. Such an approach would deviate from the standard practice for other medical professions, in which competence to provide certain services is determined at the level of the health care organization, rather than by state boards or other government agencies. JCAHO states that "privileges awarded must be component specific and consistent with the organization's plan for service and its ability to support the care provided."³ In other words, competence to provide specific patient care services needs to be established locally by the health care organization, as only that organization can determine what it can support. Such an assessment cannot be made by a state board or other government agency. Although specific measures of competency can and will be debated, an examination of the processes used to privilege other health care professionals demonstrates that competency should be measured against a local, rather than a statutory, standard of practice.

As the use of privileging has expanded, health care organizations have increasingly sought the guidance of the health care professions for competency assessment. Dermatologists, rehabilitation medicine physicians, psychiatric nurses, and other professional groups have established task forces to provide such guidance.²²⁻²⁴

Additional sources of information about privileging. The department responsible for the privileging process (typically the medical staff credentialing or quality assurance department) should be able to pro-

vide you with information about your institution's privileging process. The following Web sites, along with the references cited in this paper, provide additional information about privileging:

- American Society of Addiction Medicine. A guideline for credentialing and privileging of clinical professionals for care of substance-related disorders: a joint statement of the American Society of Addiction Medicine and the American Managed Behavioral Healthcare Association. www.asam.org/ppc/Credentialing.htm.
- The Credentials and Clinical Privileges Consortium. Introductory report of the Credentials and Clinical Privileges Project of the Australian Council for Safety and Quality in Health Care. October 2002. www.ccpproject.com.au/AboutTheProject.htm.
- Jones DC. Reimbursement, privileging, and credentialing for pediatric nurse practitioners. www.medscape.com/viewarticle/433372.
- Joint Commission Resources. The expert connection: credentialing and privileging: five steps for meeting JCAHO standards. January 2003. www.jcrinc.com/subscribers/source.asp?durki=3853.
- Credentialing, privileging, competency, and peer review: examples of compliance for the medical staff. Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations; 2003 Jan.
- The LIP's guide to credentials review and privileging: a handbook for licensed independent practitioners. Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations; 1999 Jun.
- Joint Commission guide to allied health professionals. Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations; 2002.
- U.S. Army Medical Department Activity. Credentialing, privileging, and competency of healthcare practitioners. January 24, 2003. www.narmc.amedd.army.mil/kacc/employees/epubs/regulations/regulation_40-20.pdf.

www.narmc.amedd.army.mil/kacc/employees/epubs/regulations/regulation_40-20.pdf.

- American Association of Nurse Anesthetists. Guidelines for clinical privileges. www.aana.com/practice/clinical_priv.asp.
- Credentialinfo.com. Homepage. www.credentialinfo.com/.

Below are illustrative case studies of privileging for pharmacists. A brief summary of their key points appears in Table 1.

Case study: Veterans Affairs Medical Centers. *Description of the privileging health system.* The Veterans Health Administration (VHA) operates the nation's largest integrated health care system, employing approximately 180,000 health care professionals at 163 hospitals, more than 800 community and facility-based clinics, 135 nursing homes, 206 readjustment counseling centers, and other facilities. VHA is also the nation's largest provider of graduate medical education and a major contributor to medical and scientific research.

Pharmacists granted privileges. Clinical pharmacy specialists (CPSs) working within Veterans Affairs medical centers (VAMCs) are defined as "Masters or Doctor of Pharmacy (Pharm.D.) graduates, pharmacists who have completed an accredited residency, specialty board certified pharmacists, or pharmacists with equivalent experience."²⁵

What privileges mean for pharmacists. In addition to performing the activities of a state-licensed and registered pharmacist, a CPS practicing under a VAMC protocol may initiate, continue, discontinue, or alter therapies; review and order appropriate laboratory tests; perform venipuncture to withdraw blood for laboratory testing; analyze laboratory and diagnostic test data; perform physical examinations; assist in the management of medical emergencies, adverse drug reactions, and

acute and chronic diseases; and administer medications.²⁶ In VAMC terminology, this is a "scope of practice determination": Only physicians receive full clinical privileging.

Privileging process. Health care practitioners, including CPSs, in a typical VA health system undergo an initial credentialing process and a separate privileging process.²⁷ The initial credentialing process of one VA network consists of primary source verification of professional education, training, licensure, and specialty certifications, as well as a review of the applicant's health status, experience, previous clinical privileges, professional references, and history of adverse actions (e.g., malpractice reports). Candidates seeking employment complete application forms, provide additional information in an electronic credentialing file created through VetPro (an Internet site for credentialing VA health care providers), and fill out a supplemental information form that addresses questions that JCAHO, NCQA, and VHA require. All applicants are screened through NPDB and the Healthcare Integrity and Protection Data Bank (HIPDB). The clinical specialty lead reviews the hard-copy credentialing file and VetPro database and makes a recommendation to the credentialing committee, a subcommittee of the facility's multidisciplinary executive committee of the medical staff (ECMS). After its review, the credentialing committee submits a recommendation to the facility's ECMS, which reviews the files and makes a recommendation to the facility's chief of staff and facility director. The facility director has the ultimate decision-making authority. A practitioner's credentials are reappraised every two years, and the reappraisal examines continued licensure (e.g., fulfillment of continuing-education requirements, NPDB results, Medicare and Medicaid sanctions); professional performance, judgment,

Table 1.
Case Studies of Privileging Processes^a

Health System	Pharmacists Obtaining Privileges	What Obtaining Privileges Means for Pharmacists	Privileging Process					
			Time Required	Granting Body	Credentials Required	Other Credentials Reviewed	Privileges Granted for	Renewal Requirements
140-bed hospital with medical, surgical, ICU, CCU, NICU, nursery, and maternity wards; owned by a large HMO	1 consultant clinical pharmacist	Provide anticoagulation monitoring, review of drug regimens, and TPN consultation; helped develop an inpatient protocol for heparin therapy and an outpatient DVT treatment protocol	60 days	Hospital credentialing committee, consisting of physician administrators and practicing physicians	Valid state licensure and Pharm.D. degree	Curriculum vitae	NA	NA
Community-based health system treating persons with disabilities related to mental illness, mental retardation, and substance abuse; 15 facilities serving over 12,000 indigent adults and children annually, including 4,500 adults at 4 outpatient clinics	All clinical pharmacy specialists	Clinical pharmacy specialists are authorized within the scope of practice to function as independent providers of services to patients with mental illness	30 days	Professional staff organization (medical director, staff development coordinator, director of nursing, and chief psychiatrist)	Valid state licensure, Pharm.D. degree, minimum of 1 yr of postdoctoral training in psychiatric pharmacy residency, 1 additional year of clinical specialist experience, eligibility to become BCPP	NA	Indefinitely	None, but CDTM agreement and scope of practice are reviewed and updated annually
368-bed patient care, teaching, and research facility; level 1 regional trauma center also serves as a low-income and indigent care facility for a large metropolitan community	23 clinical pharmacists providing direct patient care in primary and specialty care clinics under a state board-approved CDTM protocol	Provide direct patient care under the state board-approved CDTM protocol and bill third-party payers for services	60 days	Allied health privileging committee	State licensure	Residencies (or comparable experience), certification (e.g., BPS or NCBDE), other credentials (NISC disease state management exams, advanced cardiac life support certification, ASHP traineeships in asthma, anticoagulation, and HIV/AIDS)	3 yr	Renewal application and verification from manager that physician and peer reviews of the pharmacist's clinical work demonstrate continued competency

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Table 1 (continued)

Health System	Pharmacists Obtaining Privileges	What Obtaining Privileges Means for Pharmacists	Privileging Process					
			Time Required	Granting Body	Credentials Required	Other Credentials Reviewed	Privileges Granted for	Renewal Requirements
Veterans Affairs Medical Centers (VAMCs)	Clinical pharmacy specialists	In addition to performing the activities of a state-licensed and registered pharmacist, a clinical pharmacy specialist practicing under a VAMC protocol may initiate, continue, discontinue, or alter therapies; review and order appropriate laboratory tests; perform venipuncture to withdraw blood for laboratory testing; analyze laboratory and diagnostic test data; perform physical examinations; assist in the management of medical emergencies; adverse drug reactions; and acute and chronic diseases; and administer medications	90 days	Facility director, upon recommendation from multidisciplinary executive committee of the medical staff and others	Current state license and Pharm.D. or M.S. degree (or equivalent qualifications, which may include but are not limited to completion of an ASHP-accredited residency program, specialty board certification, or 2 yr of clinical experience)	Health status	Determined by each VAMC, typically 2 yr	Same as initial requirements, plus 2 peer performance reviews

^aICU = intensive care unit; CCU = critical care unit; NICU = neonatal intensive care unit; HMO = health maintenance organization; TPN = total parenteral nutrition; DVT = deep vein thrombosis; NA = not available; BCPP = board-certified psychiatric pharmacist; CDTM = collaborative drug therapy management; BPS = Board of Pharmaceutical Specialties; NCBDE = National Certification Board for Diabetes Educators; NISPC = National Institute for Standards in Pharmacist Credentialing.

and clinical and technical competence and skills demonstrated through provider-specific performance-improvement activities (e.g., information from infection control or pharmacy and therapeutics review and drug-use evaluations); and factors such as the number of procedures performed or trends in adverse results.²⁷

Applications for “scope of practice” determinations follow a similar procedure. The clinical specialty lead establishes the criteria for granting an expanded scope of practice. To request an expanded scope of practice that lists the clinical functions the pharmacist can provide, the pharmacist submits an application to the clinical specialty lead of the specialty area to which the services will pertain, along with the credentials required to support the request. The clinical specialty lead reviews the application and supporting materials and recommends approval, disapproval, or modification of the request. The clinical specialty lead’s recommendation, along with the appointment recommendation of the credentialing committee, is submitted to the ECMS. The ECMS evaluates the applicant’s credentials and submits a final recommendation to the facility director, who makes the final decision. The process usually takes no more than 90 days, and the scope of practice determination must be renewed every two years.

Prescribing privileges for CPSs can serve as specific examples of these processes. In 1995, VHA issued directive 10-95-019, which gave VAMCs the authority to create an expanded scope of practice for non-physician practitioners, including CPSs.²⁶ In 2003, VHA directive 2003-004 further defined the activities of CPSs, requiring each VAMC to establish and maintain a written policy that addresses the scope of practice for each CPS. A scope of practice may be specific to an individual or a group of CPSs and describes such elements of practice as the responsible

physician or medical service, limits on prescribing authority (e.g., clinic versus facilitywide privileging, whether prescribing authority includes controlled substances), and the time frame of the privilege.²⁵

Case study: Utah Health Maintenance Organization. *Description of the privileging health system.* The health system is a health maintenance organization (HMO) that insures approximately 250,000 lives and operates eight outpatient clinics that provide family practice, obstetrics and gynecology, geriatrics, internal medicine, pediatrics, oncology, gastroenterology, cardiology, and infectious diseases medical services. Ancillary medical services include dentistry, optometry, podiatry, physical therapy, laboratory, and x-ray services. The HMO's clinical pharmacy department has specialists in geriatrics, oncology, family medicine, and internal medicine, and it manages an anticoagulation clinic that treats approximately 800 patients annually.

The HMO had also owned a separately licensed, 140-bed hospital that offered medical, surgical, intensive care unit, critical care unit, neonatal intensive care unit, nursery, and maternity services. The hospital's pharmacists had developed a pharmacokinetic monitoring service for the inpatient facility but did not undergo a clinical privileging process to offer this service.

Pharmacist granted privileges. After the hospital hired a consultant clinical pharmacist to provide anticoagulation monitoring, review of drug regimens, and total parenteral nutrition (TPN) consultation, hospital administrators determined that, since the practitioner was not employed directly by the hospital, she was not covered by its liability insurance. Hospital administrators recommended that the consultant clinical pharmacist seek privileges to define her scope of practice and limit the liability of the organization. No

other pharmacists sought privileges in the hospital before it went out of business.

What obtaining privileges meant for the pharmacist. Having privileges at the hospital enhanced recognition of the services a clinical pharmacist could offer; in this case, the services most often included anticoagulation monitoring and TPN consultation. These services were unique in the hospital and helped relieve physicians of some of their workload. Other pharmacists in the hospital were motivated to explore an expanded role in direct patient care. Privileging also helped with other pharmacy departmental responsibilities, such as when the consultant clinical pharmacist helped develop an inpatient protocol for heparin therapy and an outpatient deep vein thrombosis treatment protocol.

Privileging process. The first step in the privileging process was to ask someone from the hospital medical staff to bring the consultant clinical pharmacist's name before the hospital's credentialing committee, which was composed of physician administrators and practicing physicians. The pharmacist wrote a letter to the committee asking it to review the request for privileges. She described the responsibilities she would have in the hospital and the privileges she would need to perform them, such as documenting data in the patient's chart, ordering laboratory tests and TPN, changing warfarin doses, and counseling patients on anticoagulation therapy. The committee members based their decision on a review of the consultant clinical pharmacist's responsibilities, qualifications, and training. The HMO had verified her licensure and training in the course of her initial hiring, so the credentialing committee did not request any additional proof of training or competency. The process took about two months, primarily because privileging a pharmacist was a novel endeavor.

Case study: Center for Health Care Services (Texas). *Description of the privileging health system.* The Center for Health Care Services (CHCS) is a community-based health care organization that provides comprehensive services to persons with disabilities related to mental illness, mental retardation, and substance abuse. Fifteen facilities, including a screening and evaluation unit, a crisis stabilization unit, and a case management program, serve over 12,000 indigent adults and children annually. CHCS's four adult outpatient clinics serve approximately 4500 patients, and CHCS is the single portal authority for the San Antonio State Hospital.

Pharmacists granted privileges. All CPSs are required, as a condition of employment, to receive clinical privileges, as are physicians, physician assistants, and nurse practitioners. At CHCS, CPSs are advanced-level clinicians authorized within the scope of practice to function as independent providers of services to psychiatric patients.

To receive patient care privileges at CHCS, CPSs must meet the following qualifications: valid licensure to practice pharmacy in the state of Texas by the Texas State Board of Pharmacy, a Pharm.D. degree from an accredited school of pharmacy, a minimum of one year of postdoctoral training in a psychiatric pharmacy residency, one additional year of clinical specialist experience, and eligibility to become a board-certified psychiatric pharmacist through the Board of Pharmaceutical Specialties.

What obtaining privileges means for pharmacists. Privileging allows the CPS, as outlined in the scope of practice document, to perform the following clinical services: managing medication regimens; generating medication orders; measuring vital signs; performing limited physical, mental, and neurologic examinations for the purposes of monitoring drug therapy; monitoring and evalu-

ating the effect of pharmacotherapy; ordering laboratory tests; requesting referrals for appropriate consultation services (e.g., psychology, social work, dietetics), providing disease and drug education; documenting all patient encounters in the patient's permanent medical record; scheduling patients for follow-up appointments; and conducting clinical research protocols.

CHCS did not employ CPSs until 1999. Until that time, all practitioners received privileges, so pharmacists were routinely granted privileges when hired without a formal privileging process. The pay grade of CPSs was increased when implementing their privileging.

Privileging process. The privileging process at CHCS takes approximately four weeks. Applicants complete the official CHCS employment application for providers and provide copies of state licensure, Pharm.D. diploma, and residency certificate. Administrative staff verifies additional experience by contacting employers. A collaborative therapy agreement and scope of practice are signed by the pharmacist, collaborating physician, and medical director. The professional staff organization is the credentialing body for CHCS. This committee consists of the medical director, staff development coordinator, director of nursing, and chief psychiatrists. Privileges do not expire, but the collaborative drug therapy management (CDTM) agreement and scope of practice are reviewed and updated annually.

Case study: Harborview Medical Center (Washington). *Description of the privileging health system.* Harborview Medical Center (HMC) is a 368-bed patient care, teaching, and research facility located in Seattle, Washington. Owned by King County and managed by the University of Washington, HMC is the only level-1 regional trauma center in the Pacific Northwest, and it also serves as the low-income and indigent care facility

for Seattle and surrounding communities. Clinical pharmacists practice in all of the primary care and most of the specialty care clinics operated by HMC.

Pharmacists granted privileges. All of the clinical pharmacists who provide direct patient care services in ambulatory care clinics at HMC are required to obtain clinical privileges as a condition of employment. There are 23 clinical pharmacists in both primary and specialty care clinics throughout the organization. They practice under a CDTM protocol approved every two years by the Washington State Board of Pharmacy. This CDTM protocol includes standards of practice and cites nationally recognized treatment guidelines that the pharmacists use to initiate, adjust, and discontinue medications; order laboratory tests; and refer patients to other health care providers. The protocol is signed by the organization's ambulatory care medical director, making it effective in all of HMC's clinics.

In general, these pharmacy practitioners have completed rigorous academic preparation that includes pharmacy practice and specialty residency training in addition to a Pharm.D. degree. Several pharmacists have demonstrated other competencies, such as certification by the Board of Pharmaceutical Specialties as a pharmacotherapy specialist or by the National Certification Board for Diabetes Educators as a Certified Diabetes Educator. All of the clinical pharmacists have been in practice for at least five years and have clinical faculty appointments with the University of Washington School of Pharmacy.

What obtaining privileges means for pharmacists. The privileging process allows the ambulatory care clinical pharmacists to provide direct patient care under the CDTM protocol approved by the Washington State Board of Pharmacy. Protocols used include treatment guidelines for 22

chronic and acute care conditions, including cardiovascular care, diabetes, HIV/AIDS, pain management, travel medicine, emergency contraception, thromboembolic disorders, women's health issues, and more. Refill authorization is provided by the clinical staff but is also provided by nonprivileged pharmacists who staff the refill authorization center and provide pharmacy distribution services. In addition, staff pharmacists participate in therapeutic interchange programs, enhanced patient education programs (e.g., asthma, diabetes, smoking cessation), and physician consultations.

The privileging process was established for allied health providers, including clinical pharmacists, to comply with the requirements of third-party payers. Most of the insurance company contracts with HMC stipulate that health care professionals who provide and bill for services must obtain privileges before billing. Privileging allows HMC to bill insurance companies the facility fee portion of the clinic visit charge. Only privileged pharmacists are able to bill for patient care services as allied health professionals.

Privileging process. The HMC privileging process takes approximately two months. The initial application is lengthy, and each credential undergoes primary source verification by an assistant to the allied health privileging committee (AHPC). The AHPC is an administrative committee within HMC that meets monthly. It is composed of a representative from each of the nonphysician disciplines with patient care responsibilities at HMC, including clinical pharmacists, master-level social workers, state-certified registered dietitians, occupational therapists, physical therapists, nurse practitioners, nurse anesthetists, certified physician assistants, speech and language pathologists, psychologists, mental health counselors, audiologists, prosthetists, and orthotists.

The only credential required for a pharmacist to become privileged is state licensure. However, most HMC pharmacist clinicians have completed at least one residency, and many have completed an additional specialty residency. These residencies are listed on the application and verified in the privileging process. Comparable experience can substitute for residency training, but this experience must be described in the application and verified. Optional credentials include any certification or other credentials (e.g., National Institute for Standards in Pharmacist Credentialing disease state management exams, advanced cardiac life support certification, ASHP traineeships in asthma, anticoagulation, and HIV/AIDS) the pharmacist has obtained. All credentials listed in the application are verified with the primary source.

Privileges are granted for three years. To renew privileges, the clinical pharmacist submits a shorter renewal application with verification from a manager that physician and peer reviews of the pharmacist's clinical work demonstrate continued competency.

Clinical pharmacists were the first group of allied health providers to become privileged at HMC. The application process was lengthy, but the pharmacists understood its importance and were willing to cooperate. The application process has been improved and streamlined, as the AHPC gained experience with review and assessment of applications.

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Appendix—Glossary of privileging and credentialing terms

Certificate: The granting of a certificate is the result of a structured and systematic post-graduate educational and training experience for pharmacists that is generally smaller in magnitude and shorter in time than a degree program and imparts knowledge, skills, attitudes, and performance behaviors designed to meet specific pharmacy practice objectives.²⁸

Certification: Normally a voluntary process instituted by a nongovernmental agency through which individuals are recognized for advanced knowledge or skill. Certification normally requires assessment, including testing, and an evaluation of education and experience.¹

Competence: The ability to perform one's duties accurately, make correct judgments, and interact appropriately with patients and colleagues. Professional competence is characterized by good problem-solving and decision-making abilities, a strong knowledge base, and the ability to apply knowledge and experience to diverse patient care situations.¹

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Competence assessment: The determination of whether an individual has the ability to do the job that is expected.

Continuing education: Planned, organized learning experiences and activities beyond the basic educational or preparatory program. These learning experiences and activities are designed to promote the continuous development of skills, attitudes, and knowledge necessary to maintain proficiency, provide quality service or products, be responsive to needs, and keep abreast of significant change.²⁸

Credential: Documented evidence of a pharmacist's qualifications. Pharmacist credentials include diplomas, licenses, certificates, and certifications. These credentials are reflected in a variety of abbreviations that pharmacists place after their names (e.g., Pharm.D., an earned academic degree; R.Ph., which indicates state licensure; and acronyms, such as BCNSP for board-certified nutrition support pharmacist, which indicate that an individual has demonstrated advanced knowledge or skill in a specialized area of pharmacy).²⁹ Credentials may also be more broadly interpreted to include an individual's background,

experiences, work history, references, and health status.

Credentialing: The process of obtaining, verifying, and assessing the qualifications of a health care practitioner to provide patient care services in or for a health care organization.³⁰ It may also represent the granting of a credential (i.e., a designation that indicates competence in a subject or area).¹⁴

Fellowship: A directed, highly individualized, postgraduate training program designed to prepare the participant to become an independent researcher.³¹

Licensure: Generally refers to the minimum mandatory governmental requirement necessary to practice in a particular profession or occupation.¹⁴

Pharmacy residency: An organized, directed, postgraduate training program in a defined area of pharmacy practice.³² A pharmacy residency provides the knowledge and experience that pharmacy practitioners need to face challenges in today's complex health care systems while also providing essential skills to meet the practice demands of the future. Increasingly, many employment opportunities indicate a

strong preference for individuals who have completed an ASHP-accredited residency.³²

Privileging: The process whereby a specific scope and content of patient care services (i.e., clinical privileges) are authorized for a health care practitioner by a health care organization, on the basis of its evaluation of the individual's credentials and performance.²² Privileges granted are dependent on the background and experience of the individual in relationship to the needs and capabilities of the practice site.

Privileging system: Sometimes referred to as *credentialing*. A process that includes the collection, assessment, and verification of provider data in accordance with specified standards and criteria that have been determined by the individual health care system. A privileging system is usually used to define the provider's scope of practice within that organization.

Scope of practice: The boundaries in which a health care provider may practice. For pharmacists, the scope of practice has traditionally been established by the board or agency that regulates the profession within a given state or organization.²⁹