Primary Intended Outcome
To expand from protocol-driven, narrowly focused pharmacist-run clinics to advanced scopes of practice where pharmacists may prescribe medications without specificity for drugs or conditions.

Relevant PPMI Recommendation
B13. As an essential member of the healthcare team, pharmacists must have privileges to write medication orders in the health care setting.

Situation Analysis
The Central Alabama Veterans Health Care System (CAVHCS) was established January 1, 1997, from the merger of the Montgomery and Tuskegee VA Medical Centers, which are approximately 40 miles apart. Along with two community-based outpatient clinics, these four sites serve more than 134,000 veterans living in a 43-county area of Georgia and Alabama. Patients receive care in a variety of practice settings, including outpatient primary and specialty care, inpatient acute care, inpatient psychiatric care, and nursing homes.

In 2000, clinical pharmacists at CAVHCS had prescribing privileges only in the system’s anticoagulation clinics, under a protocol. In 2002 and 2003, pharmacist prescribing privileges were extended to lipid management and dyslipidemia in diabetes, respectively, again under protocols.

As the CAVHCS serves a predominantly rural population, patients often travel considerable distances to receive care, and many patients meet criteria laid out by the Veterans Administration (VA) for reimbursement for their travel expenses. Upon arrival patients often then had to wait to see their physicians. Patients would also have to wait while pharmacists recommended and obtained approval for medication adjustments. In addition, follow-up visits for medication monitoring and titrations after initial medication changes by the primary care provider were limited due to clinic capacity. This significantly increased the time it took for patients to reach therapeutic goals.

There was also a significant delay in implementing both the initial and follow-up dosing recommendations for anticoagulants, antibiotics, and nutritional therapy for CAVHCS acute and long-term care units. Hospitalists did not have time to investigate the details of administration (i.e., whether the dose was actually given, and what the temporal relationship between dose and level was), leading to medication errors on the inpatient units.
**Service Description**
Sensing the need to improve the provision of care and make the best use of both physicians’ time and pharmacists’ training, we sought a broad scope of practice for pharmacists that is centered on national treatment guidelines such as those published by the VA, American College of Chest Physicians, American Diabetes Association, American Association of Clinical Endocrinologists, etc. We developed competency checklists and professional practice evaluations to determine and demonstrate pharmacists’ knowledge and ability, and we implemented a mentoring process to improve pharmacist performance as necessary.

Pharmacist care has evolved from protocol-driven and drug-driven clinics to encompass not only medication management, but prescribing privileges across a wide spectrum of diseases and conditions, including anticoagulation, diabetes, dyslipidemia, hypertension, pain, hypothyroidism, osteoporosis, and gout. Patients can consult directly with pharmacists about changes in medication via telephone, as well as in person.

**Key Elements for Success**
1. Having an accountability system and professional practice reviews already in place when we submitted our request for a broader scope of practice,
2. Gradual evolution to accustom physicians to expanded pharmacist responsibility and care provision, and
3. Collaboration with a well-respected endocrinologist who vouched for our competency.

**Resource Utilization**
**Personnel:** There are 7.1 full-time equivalents (FTEs) with expanded outpatient scopes of practice and 3 FTEs with expanded inpatient scopes of practice.

**IT and other infrastructure:** Progress note templates for the electronic medical record that have guidelines and point-and-click recommendations.

**Supply Expense:** Pharmacist and informatics staff salaries.

**Return on Investment:** Patients are not charged for pharmacist care provided via telephone. Likewise, the CAVHCS saves the cost of reimbursing patients for travel to and from the care facilities. If the veteran has private insurance, medication therapy management services are billed and the VA is reimbursed for pharmacist face-to-face appointments.

**Recognized Intangible Benefits**
1. Better use of pharmacists’ education, training, and skills;
2. More efficient use of physician time, resulting in improved patient access to physicians; and
3. Improved continuity of care and more comprehensive medication management.

**Outcome Measures**
1. Expansion of privileges.
2. Expansion of staff and residency-trained pharmacists from 5.35 FTEs for outpatient scopes of practice in FY09 to 7.1 in FY11, and from 1 FTE for inpatient scopes of practice in FY09 to 3 in FY11.
3. Clinical encounters (telephone visits, face-to-face visits, or chart consults) generated by clinical pharmacy staff increased 25 percent between FY10 and FY11 and 35 percent between FY11 and FY12. Clinical pharmacy visits delivered by telephone increased from 4 percent of total encounters in FY10 to 20 percent in FY11 and have remained at 20 percent for FY12. Note: The increases are not all due to expansion in scope of practice but rather a national decision to allow workload capture (encounters) to be generated for chart reviews that involved clinical decision making such as approval of non-formulary consults, nursing home monthly pharmacist reviews, etc. Also, inpatient clinical services were now captured via encounters using medication therapy management codes per a national VA decision.

Lessons Learned

1. Professional practice reviews should be as specific as possible. We found it helpful to use a letter system instead of yes/no checklists. For example, if a pharmacist receives Cs in certain competencies or a certain number of competencies, it triggers action to improve that pharmacist's performance.

2. Embracing a stepwise approach from protocol-driven to drug-driven to broad scope of care makes upper administration more comfortable with the thought of pharmacists prescribing medications.


Other Considerations

1. Each health system in the VA has its own culture. Residency trained pharmacists from other VA systems brought their knowledge to our system when we hired them, which enhanced our department.

Suggestions for Other Hospitals/Health Systems

1. Ensure clear, thorough documentation in progress notes. This way if a provider questions your decision-making, pharmacy leadership can defend you.

2. Develop training to ensure pharmacist competence, such as didactic education and side-by-side mentoring while seeing patients. Pharmacists must demonstrate their ability to do what you intend to have them do or it will destroy your credibility.

Helpful References


3. Academy of Managed Care Pharmacy. Sound medication therapy management programs, version 2.0 with validation study. J Manag Care Pharm. 2008; 14:(1 Suppl B):S2-S44.