D*EPARTMENT OF HEALTH AND HUMAN SERVICES*

INDIAN HEALTH SERVICE
CROW SERVICE UNIT
CROW/NORTHERN CHEYENNE SERVICE UNIT
LODGE GRASS CLINIC
PRYOR CLINIC

TITLE: 14.02.210 Pharmacy Collaborative Practice Agreement	**STANDARD(S) TAG:**
DEPARTMENT: *Pharmacy*	**EFFECTIVE DATE: 06/2021**
	REVISION DATE:

Indian Health Service – Crow Service Unit
Collaborative Practice Agreement
Pharmacist Providers

Original Approval Date: 11/17/2016; Revised 03/2021, Supersedes 12/2018 version

I. Introduction

A. This Collaborative Practice Agreement (CPA) establishes guidelines for Pharmacist Providers, as set by the Clinical Director and approved by the Medical Executive Committee (MEC). This agreement serves as a method by which a Pharmacist Provider may perform a broad range of services (defined below) for eligible patients. It also serves as the standing order by the Clinical Director for the Pharmacist Provider to perform all necessary activities related to disease state management according to recognized pharmacy and medical regulations at the state and federal levels, in addition to the Indian Health Service Manual.
B. This CPA will be in effect for two years unless rescinded or modified earlier, in writing, to the Clinical Director by either the MEC or Pharmacy Staff.
C. Any modification of this CPA shall be forwarded for MEC approval.
D. This CPA will be reviewed, updated, and approved at least annually to reflect revisions of national and IHS guidelines.

II. Rationale

Multidisciplinary clinics have shown to improve patients' quality of life. Pharmacists are one of the most accessible health care professionals and fulfill a fundamental role in public health as key providers of multiple services. The CSU Pharmacy Department is requesting renewal of privileges from the MEC to expand clinical pharmacy services and patient access to healthcare through an integrated patient care team model. Integration of pharmacists into primary care

clinics supports the Patient Centered Medical Home model and increases patient access to primary care.

III. Purpose

A. To increase access to collaborative primary care for patients with disease states in which medications are the primary means of treatment to further serve the mission of the IHS.
B. To promote safe medication use through pharmacist-managed clinical services in order to provide cost-effective, specialized patient care, and drug therapy management.
C. To expand access to care for preventative measures and medication related issues, which will increase the quality of health and quality of life of the community.
D. To provide an educational platform for patients, CSU staff, and healthcare (i.e., pharmacy, medical, nursing) students.

IV. Medical Executive Committee Responsibilities

The MEC will vote to approve, modify or revoke this CPA. The MEC will vote to approve, modify or revoke privileges for each pharmacist based on recommendation from the Pharmacy Director and Clinical Director. Pharmacist providers will only be considered for privileging once all collaborative practice requirements have been met. Separate agreements for each Pharmacist Provider recommended by the Pharmacy Director and accepted by the Clinical Director will be advanced to the MEC.

V. Clinical Director Responsibilities

The Clinical Director or delegate will maintain responsibility for the oversight of care provided by Pharmacist Providers in coordination with the Pharmacy Director. The Clinical Director will forward this CPA to the MEC for approval of any modifications. The Clinical Director is the point of contact for any concerns of the MEC, and should collaborate with the Pharmacy Director.

VI. Pharmacy Director Responsibilities

The Pharmacy Director or delegate will maintain responsibility for the oversight of this CPA, as well as the operational procedures for management of the clinical services provided. The Pharmacy Director or delegate will coordinate peer reviews and competency exams, determine which trainings/certifications are appropriate for credentialing, and compile annual reports. The Pharmacy Director or delegate is the point of contact for any concerns of the Pharmacy Staff, and should collaborate with the Clinical Director or delegate.

VII. Pharmacist Provider Responsibilities

A. Adhering to the specified referral process (see example below)
B. Maintaining clinical currency of evidence-based medicine for each disease state being treated. This includes the most updated national clinical guidelines, expert consensus guidelines, published reviews, obtaining sufficient hours of Accreditation Council for Pharmacy Education (ACPE), or equivalent approved CE annually on applicable topics, etc.
C. Obtaining pertinent subjective and objective information during each clinic visit.
D. Adherence to CSU formulary and/or non-formulary process.
E. Complete, timely, and appropriate EHR documentation of all clinic visit events as per service unit and IHS standards including visit creation, IPL(s), EHR note, CPT code(s), etc.
F. Enter all orders (for medications, labs, consults, etc.) through EHR in the same manner as other CSU providers.
G. Document adverse drug events or patient outcomes through EHR and/or ISTAR as appropriate.
H. Address and/or follow up on all orders (for medications, labs, consults, etc.) in the same manner as other CSU providers.
I. If patient referral to a CSU service is indicated, consult with PCP to issue a referral.
J. The Pharmacist Provider will practice within the scope of his/her credentials and expertise and will consult with the primary care provider (PCP) for concerns outside of their credentials and expertise.
K. Provide case presentations of rare/complicated cases for peer review/learning opportunities to be presented at Pharmacy and Medical Staff meetings or as requested by the Pharmacy Director.

VIII. Goals of this CPA

A. Endorse a team-based, patient-centered, health care model incorporating Pharmacist Providers augmenting medical providers in the endeavor to accomplish the IHS mission and goal of providing the most effective and accessible healthcare possible for our patients.
B. Increase patient access to the healthcare system while improving facility achievement of GPRA targets.
C. Promote cost-savings by reducing the number of school/work sick days and unscheduled clinic visits/hospitalizations due to patient decompensation and/or disease state progression.
D. Reduce patient morbidity and mortality while enhancing performance of thorough medication reconciliation, review, and de-prescribing strategies in an effort to limit polypharmacy, complicated medication regimens, and medication errors.

E. Improve the quality of life for Medical Staff, Pharmacy Staff, and patients while also increasing patient satisfaction.
F. Set the groundwork to develop additional clinic revenue through the provision of team-based disease state management by Pharmacist Providers.

IX. Pharmacist Provider Scope of Practice

The scope of practice of the Pharmacist Provider will be primarily post-diagnostic, drug therapy related chronic disease state management. Pharmacist Providers will also actively engage in preventive health measures to include, but not limited to, immunizations, tobacco cessation, assessment and completion of GPRA measures.

Chronic Disease States (All Pharmacist Providers)	
Diabetes	Hypertension
Hyperlipidemia	Anticoagulation
Hepatitis C	Tobacco Cessation
Asthma/COPD	
With Additional Training and Experience	
Heart Failure	Autoimmune disorders
Pain Management	Mood Disorder
Acne	Substance Use Disorder

X. Types of Authorization Granted to Pharmacist Providers

A. Prescriptive: the Pharmacist Provider may start, stop, or change any medication within the scope of practice of the disease state being treated.
B. Laboratory: the Pharmacist Provider may order and interpret any pertinent labs to aid in the management of the disease state being treated. Diagnostic tests (labs, x-ray, etc.) are to be ordered after consultation with the PCP, Clinical Director or delegate when unavailable, and under the PCP's name, Clinical Director or delegate when unavailable. The PCP, Clinical Director or delegate when unavailable, will assume ultimate responsibility for any indicated interventions based on the results of the testing.
C. Physical exam: the Pharmacist Provider may perform a physical exam to the extent of his/her training as related to the disease state being treated.
D. Referrals to dental, behavioral health and optometry services may be generated by the pharmacy provider. If a referral is indicated for other services, the pharmacy provider will consult with the patients PCP who will generate the referral.

XI. Pharmacist Provider Training, Credentialing, and Privileging

A. Applicants will have completed one or more of the following experiences to be considered for pharmacist provider training:
   1. Successful completion of a PGY1 residency
   2. Board of Pharmacy Specialties certification or equivalent
   3. Three (3) or more years of previous practice-related experience where greater than 50% of practice time was spent managing chronic diseases (confirmed by attestation by the Director of Pharmacy)

   NOTE: All applicants will be expected to apply for Clinical Pharmacy Practitioner (CPP) designation with the state of Montana within 1 year of completing training.

B. Prior to receiving pharmacist provider privileges, the pharmacist provider will complete an intensive 4 week practice experience with a credentialed pharmacist provider trainer.
   1. Applicants possessing existing licensure as a CPP or equivalent in any State and with significant clinical practice experience, may be granted pharmacist provider privileges with successful performance of 10 proctored, direct observation visits with a credentialed pharmacist provider trainer.

C. The credentialed staff member(s) providing pharmacist provider training shall be assigned by the Pharmacy Director and will possess the designation of CPP or equivalent from any State.

D. A staged approach to developing and demonstrating competency will be utilized.
   1. The initial stage will consist of observing encounters led by a credentialed staff member.
   2. The next stage will consist of a supervised patient encounter.
      a. With modeling and coaching from the credentialed pharmacist provider, pharmacist providers completing the practice experience will work directly with patients, caregivers, and other health care professionals to become independently proficient in providing clinical pharmacy services for the management of diabetes.
      b. The number of supervised encounters will depend on the pharmacist's background, experience, and demonstration of competency.
   3. When a credentialed Pharmacist Provider and/or the Pharmacy Director determine the Pharmacist to be competent in the defined disease state(s), they will enter the final stage in which the pharmacist is an independent clinic provider, and can teach and train other providers.

E. Newly credentialed Pharmacist Providers will have their initial ten encounters subject to FPPE

F. All credentialed Pharmacist Providers will have four encounters subject to OPPE each quarter.
G. The Pharmacist Provider must demonstrate a working proficiency with current national guidelines and recommendations for each managed disease state.
H. Pharmacist Providers may be subject to supervised evaluation/training prior to, and/or while, practicing in any clinic at the discretion of the Pharmacy Director or Clinical Director.
I. Pharmacists Providers will have 1 year after the completion of their training to complete the requirements, and submit the application for, Montana's Clinical Pharmacist Practitioner (CPP). After 1 year, Pharmacist Providers will not be scheduled in the Pharmacy Clinic if they fail to complete or maintain this requirement. Removal from the schedule will remain in effect until the CPP designation is obtained or renewed.
J. Pharmacist Providers should be credentialed as members of the Medical Staff.
K. Credentialing certificate and associated documents will be kept in Pharmacist Provider's personal non-official file.
L. Individual, signed CPA's will be kept in the Pharmacist Provider's official file.

XII. Procedural Components for Practicing Pharmacist Providers

A. Inclusion criteria include (but are not limited to): each patient must have an EHR chart and, ideally, a designated PCP, and each patient must be seen by their PCP at least once annually. If patient does not have a PCP, a referral will be placed for patient to be assigned a PCP, then additional management will be arranged with PCP at their request.
B. Exclusion criteria include (but are not limited to): inability/unwillingness to adhere to Pharmacist Provider appointments with a demonstrated history of 3 or more consecutive missed appointments, and inability/unwillingness to meet inclusion criteria.
    1. Patient will be referred out of the Pharmacy clinic when presenting any emergency symptoms including but not limited to: signs and symptoms consistent with CVA, TIA, ACS, etc. such as acute angina, diaphoresis, acute vision changes, recent onset unilateral facial paralysis, severe headache, hypertensive crisis (BP >180/120), altered mental status, blood glucose >450mg/dL with evidence of end organ damage and or evidence of metabolic acidosis, etc. The PCP will be consulted and the patient escorted to the Emergency Department if necessary.
C. Clinic scheduling is subject to staffing of the Pharmacy Department, among other things, and varies by disease state.

D. Referrals to clinic is required for all services except for immunizations, OTC, and tobacco cessation.
    1. Each referral will be assessed by Pharmacist Providers for appropriateness and either accepted (with attempt made to contact the patient to schedule a clinic visit) or denied with reasoning documented.
    2. Referrals should be placed via the consults tab in EHR, as appropriate.
    4. The PCP referral will include
        a. The specific reason for referral (which may include):
            (1) Disease State Management
            (2) Optimizing medical therapeutics
            (3) Polypharmacy concerns
            (4) Medication interaction concerns
            (5) Preventive medical services (Health promotion, primary prevention, secondary prevention)
        b. The scope of Pharmacist Provider service requested
            (1) Evaluate and recommend: Pharmacist Provider will evaluate the patient in accordance with the specific reason for referral and make recommendations regarding optimizing pharmaceutical treatments.
            (2) Evaluate and treat: Pharmacist Provider may initiate, modify or discontinue medications in a manner consistent with the specific reason for referral.
        c. Designation of a request for continuity
            (1) Isolated consultation
            (2) Establish and continue care in a manner consistent with the specific reason for referral and the scope of services recommended.

E. Baseline patient data and labs will be collected and documented in EHR as necessary. This will enable accurate tracking of outcomes.

F. Clinic visits may be performed in a variety of ways depending on resources currently available and patient availability. These options may include scheduled appointments, walk-ins, tele-visits, and/or phone visits, etc. Each visit will be documented in EHR. A Pharmacist Provider will assess each patient during each visit. Follow up visits will vary based upon the disease state, clinical condition of each patient, and Pharmacist Provider discretion.

G. If the patient has co-morbid conditions with treatment modalities within the scope of the Pharmacist Provider, those will be addressed by the pharmacist and will be based on current disease-state related guidelines.

H. Patient education will be provided and documented by the Pharmacist Provider on any medication changes and/or therapeutic lifestyle change (TLC) recommendations and/or non-pharmacologic interventions at each clinic visit, as applicable.
I. Referral back to PCP is at the discretion of the Pharmacy Provider, and may be issued in the following situations: if/when a patient meets his/her goal(s) and/or treatment is completed, upon patient request, if/when a patient meets any exclusion criterion, and/or if a minimum of three attempts at contacting the patient were unsuccessful (deeming the patient lost to follow up).
J. Situations requiring definitive care treatment or assessment will be referred to PCP/ER/Specialist, etc..

XIII. Quality Assurance/Performance Improvement

A. Required, ongoing, continuing education (CE) of 30 hours per year is required.
    1. Each Pharmacist Provider will have their education file and documentation of training maintained in their non-official personnel file
    2. Contents may be submitted to the Quality Assurance director and/or Clinical Director upon request
B. OPPE and FPPE processes will be conducted consistent with Medical staff bylaws.
    1. Minimum of four OPPE's quarterly.
    2. Using the Peer Review Checklist for that specified disease state
    3. Upon request for any hospitalizations, sentinel events, death, etc.
C. Clinic outcome evaluation should be done at least annually. This shall be reported to the local Pharmacy & Therapeutics Committee and the National Clinical Pharmacy Specialists Committee (NCPSC). Data may be collected from RPMS, iCARE, and ISTAR to evaluate: patient satisfaction, DUE data, reported incidents, patient outcomes, and other data points as needed. General outcomes reported should include, but not limited to:
    1. GPRA data
    2. Clinical outcome results to include, but not limited to, those required by NCPSC
    3. De-prescribing results
D. If a Pharmacist Provider is unable to meet or exceed the national or IHS standard goals of a disease state, additional training and/or review may be required until performance is deemed acceptable or privileges revoked by the Pharmacy Director and/or MEC.

E. Peer reviews and clinical outcomes will be reported annually to the Pharmacy Primary care clinic manager and the Pharmacy Director to review for performance improvement.

XIV. Pharmacy Intradepartmental Details

The Pharmacy Department will establish operational procedures for management of the clinical services provided. Each Pharmacist Provider will follow these procedures to promote continuity of care for our patients. Operational procedures shall be reviewed at least annually and updated as needed.

XV. IHS National Clinical Pharmacy Specialist (NCPS) Certification

In an effort to promote competency, consistency, increased patient safety and standardization of care within IHS clinical pharmacy practice, Pharmacist Providers that are strongly encouraged to seek NCPS certification once they have fulfilled credentialing obligations. NCPS certification is intended to recognize an advanced scope of practice in the management of chronic disease states and optimization of drug therapies by clinical pharmacists.

References:

Advancing Team-Based Care Through Collaborative Practice Agreements: A Resource and Implementation Guide for Adding Pharmacists to the Care Team. Centers for Disease Control.

License Requirements and Procedures for Clinical Pharmacist Practitioner Montana Board of Pharmacy.

Collaborative Practice Agreement Requirements Montana Board of Pharmacy.

Clinical Pharmacy Services IHS Manual Chapter 7.

Additional Authorized Disease States	
☐ Congestive Heart Failure	☐ Autoimmune disorders
☐ Pain Management	☐ Mood Disorder
☐ Acne	☐ Substance Use Disorder

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Signatures

_____

Pharmacist Provider

_____

Pharmacy Director

_____

Clinical Director

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Example: Referral for Clinical Pharmacy Services

Reason for Referral:

- ☐ Chronic Disease State Evaluation:
  - ☐ Hypertension
  - ☐ Anticoagulation
  - ☐ Diabetes (Consider Referral to the Diabetes Center of Excellence)
  - ☐ COPD
  - ☐ Asthma
  - ☐ Dyslipidemia
  - ☐ Congestive Heart Failure
  - ☐ Hepatitis C
  - ☐ Other_____
- ☐ Polypharmacy concerns
- ☐ Medication interaction/side effect concerns
- ☐ Preventive medical services (health promotion, disease prevention, etc.)

Scope of Referral:

- ☐ Evaluate and recommend in accordance with the reason for referral
- ☐ Evaluate & initiate, modify or discontinue medications in a manner consistent with the reason for referral, including appropriate laboratory monitoring parameters.

Continuity:

- ☐ Single consultation
- ☐ Establish and continue care in a manner consistent with the specific reason for referral and the scope of services recommended.