Report to the Legislature

Sunrise Review

Naturopathic Physician Scope of Practice

December 2024

Prepared by
Health Systems Quality Assurance

Washington State Department of HEALTH

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Executive Summary

The Senate Health and Long Term Care committee requested the Department of Health (department) review a proposal under chapter 18.120 RCW to expand the scope of practice for licensed naturopathic physicians (ND)[1] in Washington to include Schedule II-V controlled substances, broaden the definition of "minor office procedures," and add the authority to sign forms that other primary care physicians are authorized to sign. The Washington Naturopathic Physicians Association (WANP) is the applicant for this proposal.

Recommendation:

Didactic training in naturopathic schools has evolved to include a strong foundation in basic sciences and pharmacology. In addition, the applicant has identified a need to expand ND's prescriptive authority to increase access to opioid use disorder (OUD) treatment, help patients taper off controlled substances, and treat acute or post-surgical pain.

However, the department recommends this proposal not be enacted because it does not meet the criteria in RCW 18.120.010. The proposal:

- Does not demonstrate sufficient minimum education and training to safely prescribe Schedule II-V controlled substances. Though naturopathic programs include foundational didactic training in pharmacology, the clinical training occurs mainly in naturopathic clinics under supervision of naturopathic physicians. Naturopathic programs do not require clinical training in diverse health care settings or exposure to specific patient populations or conditions, such as pediatric patients, patients with specific behavioral health conditions, and/or patients on pain management medication.
- The other states that grant authority to prescribe controlled substances limit NDs to Schedules III-V or specific formularies and include safeguards such as collaboration or supervision by MDs, additional or continuing education, an additional pharmacology examination, and oversight by the state medical board.
- The proposed definition of "minor office procedures" is vague and subject to a wide range of interpretations. The department cannot evaluate adequate training without knowing what specific procedures would be included in this definition.
- The Board of Naturopathy does not include providers with sufficient expertise to evaluate what additional education and training is needed to safely expand the ND scope of practice.
- Providing primary care includes coordination of care and referrals when needed. Referrals for controlled substances are often necessary because of their significant risks to public health due to overdose, abuse, and misuse. This is especially true in long-term opioid therapy or behavioral health treatment, to ensure only the most qualified health care professionals are prescribing these substances.

[1] Also referred to as "naturopath" and "doctor of naturopathic medicine." RCW 18.36A.030(2).

Summary of Information

Legislative Request

The proposed bill under review, Senate Bill 5411 (2023) makes the following changes to the naturopathic scope of practice:

- Broadens the definition of minor office procedures to include "primary care services."
- Adds the prescriptive authority for controlled substances contained in Schedules II through V of the uniform controlled substances act, chapter 69.50 RCW, as necessary in the practice of naturopathy.
- Adds the authority for naturopathic physicians (ND) to sign forms and any documents physicians are authorized to sign (e.g., disability determinations) if they are within the ND scope of practice.
- Adds "or naturopathic physician" to the definition of naturopath in RCW 18.36A.020 and changes "naturopath" to "naturopathic physician" in RCW 18.36A.040 (Scope of practice).

Section 1 of the bill consists of findings which include:

- Washington has a primary care shortage and the pandemic "further expos[ed] the need to empower primary care providers to practice to the full scope of their training."
- Naturopathic medical training emphasizes behavioral health, counseling, and lifestyle medicine in addition to conventional medicine to include pharmaceutical prescriptions.
- Many patients seek care from naturopathic physicians to stop taking or lower their doses of prescription medications.

Background

Naturopaths have been licensed and regulated with autonomous practice in Washington since 1987.[2] Their original scope of practice included:[3]

> The prescription, administration, dispensing, and use, except for the treatment of malignancies or neoplastic disease, of nutrition and food science, physical modalities, homeopathy, certain medicines of mineral, animal, and botanical origin, hygiene and immunization, common diagnostic procedures, and suggestion.

[2] Laws of 1987, ch. 447.
[3] Id. at § 3.

Prescriptive authority excluded legend drugs except vitamins, minerals, whole gland thyroid, and substances as exemplified in traditional botanical and herbal pharmacopoeia, and nondrug contraceptive devices excluding interuterine devices.[4] The law also limited the use of intramuscular injections to vitamin B-12 preparations and combinations when clinical and/or laboratory evaluation has indicated vitamin B-12 deficiency and prohibited the use of controlled substances.[5] It also prohibited ND's use of controlled substances.[6]

Minor office procedures meant "care incident thereto of superficial lacerations and abrasions, and the removal of foreign bodies located in superficial structures, not to include the eye; and the use of antiseptics and topical local anesthetics in connection therewith."[7]

Physical modalities were defined as "the use of physical, chemical, electrical, and other noninvasive modalities including, but not limited to heat, cold, air, light, water in any of its forms, sound, massage, and therapeutic exercise."[8]

ND's scope of practice was amended in 2005 to add controlled substances limited to codeine and Schedule III-V testosterone products, increase the scope of minor office procedures, add nondrug contraceptive devices, and change the term "naturopathy" to "naturopathic medicine" throughout the chapter. The bill required consultation with the Board of Pharmacy (now the Pharmacy Quality Assurance Commission) on education and training requirements.[9]

In 2011, the scope of practice was further amended to change the definition of "physical modalities" to remove the term "noninvasive" and add that the modalities cannot exceed those used as of the effective date of the bill (7/22/2011) in minor office procedures or common diagnostic procedures.[10] The bill also removed "nondrug" from the contraceptive devices included in the practice of naturopathic medicine.[11]

The current prescriptive authority for naturopaths encompasses "vitamins; minerals; botanical medicines; homeopathic medicines; hormones; and those legend drugs and controlled substances consistent with naturopathic medical practice in accordance with rules established by the board. Controlled substances are limited to codeine and testosterone products that are

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[4] Laws of 1987, ch. 447 § 4.
[5] Id.
[6] Id.
[7] Id.
[8] Id.
[9] Laws of 2005, ch.158 § 1,2.
[10] Laws of 2011, ch. 40 § 1.
[11] Id. at § 2.

contained in Schedules III, IV, and V in chapter 69.50 RCW (Uniform Controlled Substances Act).[12]

Between 2021-23, there were 1,620 licensed NDs in the State of Washington.[13] Since 2005, the department has taken disciplinary action in 26 cases involving controlled substance violations outside the ND scope.[14] The department has imposed sanctions such as fines, probation, registering with the prescription monitoring program, and prohibitions from applying for DEA registrations for a period of time.[15] In addition, at least 11 NDs voluntarily surrendered or gave up their DEA licenses as an act of good faith or due to disciplinary action imposed by the DEA.[16]

Summary of Applicant Report

The laws on sunrise reviews require the applicant group to explain several factors about the proposed legislation, including the problem it is attempting to fix, how it ensures competence of practitioners, and how it is in the public interest.[17] The department refers to this as the "applicant report." The applicant report is intended to supplement the proposed legislation to help the department determine if the proposed change in scope of practice meets the criteria in RCW 18.120.010(2)(Purpose – Criteria).

Once the department receives the proposed bill and applicant report, the department posts the materials online and solicits public comments. The department reviews all the data and comments received, drafts a report with initial recommendations, then solicits additional public comments on the draft recommendations. At the end of the public comment period, the department reviews comments received and adjusts the report and recommendations as necessary before submitting the final report to the legislature.

The applicant asserts Naturopathic Doctors (NDs) are recognized as primary care physicians and need the proposed scope of practice increase to adequately serve in this role, which is limited by: [18]

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[12] RCW 18.36A.020(12).
[13] Washington State Department of Health, Health Systems Quality Assurance, *Report to the Legislature: 2021-23 Uniform Disciplinary Act (UDA) Report*, December 2023, https://doh.wa.gov/sites/default/files/2024-03/631093-UDAReport2021-2023.pdf.
[14] Washington State Department of Health, *UDA Cases Received and Closed*, retrieved from Washington State Department of Health Integrated Licensing and Regulatory System (ILRS), current as of June 30, 2023.
[15] "*UDA Cases Received and Closed*."
[16] "*UDA Cases Received and Closed*."
[17] RCW 18.120.030.
[18] "Proposal to Increase Scope of Practice," Washington Association of Naturopathic Physicians, Appendix B – Applicant Report. (Hereinafter referred to as "Applicant Report").

1. Lack of full prescriptive authority:
    a. Many ND patients are already taking or require prescriptions for controlled substances and expect their ND to be authorized to prescribe them. The ND must refer their patients to other providers for these medications, which the applicant asserts creates duplication of services and is a financial burden on the patients, NDs, and the health care system.

    b. Primary care physicians are expected to provide treatment for anxiety, insomnia, panic, ADHD, and addictions; provide temporary pain management; and provide medication assisted treatment (MAT) for opioid use disorder (OUD). NDs are not currently allowed to provide all forms of treatment for these issues. The applicant also provided examples of medications NDs would need authority to prescribe, including benzodiazepines, stimulant medications (e.g., methylphenidate to treat ADHD), and buprenorphine.

    c. Applicants state NDs should be included in the definition of an "other health care provider" who can terminate or assist in terminating a pregnancy, but "the current limitations in naturopathic prescriptive authority and outdated language in the minor office procedures section of naturopathic scope preclude their participation."

2. Inability to sign all documents and certificates that primary care providers are routinely expected to sign:
    a. NDs have the authority to sign death certificates, but not Physician Orders for Life Sustaining Treatment (POLST), disability determinations, hospice orders, etc. This creates delays in obtaining this paperwork and a burden on patients to find another provider to sign these documents.

3. Exclusion from the Death with Dignity Act
    a. The applicant asserts the limited prescriptive authority of naturopathic physicians resulted in an automatic exclusion of naturopathic physicians from the definition of "attending qualified medical provider," who is expected to be the patient's primary care provider. They state the list of qualified medical providers includes all statute-recognized primary care providers except for naturopathic physicians, who routinely provide primary care and support through end of life and occasionally receive requests for Death with Dignity from terminally ill patients.

What is Primary Care

There is not a consistent definition of primary care in Washington and the applicant report did not include a definition. However, the department found several sources that define or

describe primary care that include serving as a patient's primary point of contact, providing continuous, integrated care to meet most health care needs, and care coordination. Here are some examples the department identified.

- **RCW 74.09.010 – Medical Care**

  According to the applicant report, the legislature recognized NDs as primary care providers in 2011. They reference RCW 74.09.010 (Definitions) on public assistance, which was amended in in 2011 to add a definition of primary care provider as "a general practice physician, family practitioner, internist, pediatrician, osteopath, naturopath, physician assistant, osteopathic physician assistant, and advanced registered nurse practitioner licensed under Title 18 RCW (Businesses and professions)." [19]

- **Office of Financial Management (OFM)**

  In its 2019 legislative report on annual primary care expenditures, the Office of Financial Management (OFM) defined primary care using the National Academy of Medicine's (formerly the Institute of Medicine) definition:[20]

  > The provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs including physical, mental, emotional, and social concerns, developing a sustained partnership with patients, and practicing in the context of family and community.

  This report describes the four main features of primary care services as:[21]

  - First-contact access (into the health care system) for each new need.
  - Long-term person- (not disease-) focused care (also referred to as continuous care).
  - Comprehensive care for most health needs.
  - Coordinated care when it must be sought elsewhere.

- **U.S. Department of Health and Human Services (HHS)**

  In 2023, HHS released an issue brief on primary care that describes it as providing health promotion, disease prevention, and disease treatment and management services for individuals across the lifespan. The brief states "[p]rimary care is founded on a longitudinal, trusted relationship between patients and their primary care clinicians and

[19] Laws of 2011, ch.316 § 2.
[20] Office of Financial Management (OFM), *Primary Care Expenditures: Summary of Current Primary Care Expenditures and Investment in Washington*, December 2019, https://ofm.wa.gov/sites/default/files/public/publications/PrimaryCareExpendituresReport.pdf.
[21] OFM, 3.

associated care teams."[22] HHS recognizes "[o]ther essential elements of primary care include: serving as a patient's initial point of contact to the healthcare system, providing person- or family-centered, comprehensive, continuous, and coordinated care, and having a community orientation and engagement."[23]

The applicant asserts that because naturopathic physicians serve as primary care providers, limitations in their scope of practice create challenges in providing care, burdens on the health care system, and duplication of services. However, there are necessary statutory limitations in scopes of practice for different types of health care providers based on education and training.

Death with Dignity Act

According to Washington's Death with Dignity Act, prescribing and dispensing medications requires a diagnosis of a terminal illness by an attending qualified medical provider and confirmed by a consulting qualified medical provider.[24,25] If either medical provider believes a patient may be suffering from a psychiatric or psychological disorder causing impaired judgment, they must refer the patient for counseling and cannot prescribe end-of-life medications until the person performing the counseling determines their judgment is no longer impaired.[26]

Qualified medical provider:

Washington's Death with Dignity Act defines a consulting qualified medical provider as "a qualified medical provider who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease."[27] These providers' responsibilities include examining the patient and relevant medical records, confirming in writing the attending qualified medical provider's diagnosis that the patient has a terminal disease, and verifying the patient is competent, acting voluntarily, and has made an informed decision.[28]

The definition also includes allopathic and osteopathic physicians, physician assistants, and advanced registered nurse practitioners.[29]

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[22] Department of Health and Human Services (HHS), *HHS is Taking Action to Strengthen Primary Care*, 2023, https://www.hhs.gov/sites/default/files/primary-care-issue-brief.pdf.
[23] HHS.
[24] RCW 70.245.010
[25] RCW 70.245.020.
[26] RCW 70.245.060.
[27] RCW 70.245.010(4).
[28] RCW 70.245.050.
[29] RCW 70.245.010(10).

Washington's Death with Dignity Act defines an attending qualified medical provider as "the qualified medical provider who has primary responsibility for the care of the patient and treatment of the patient's terminal disease."[30] Responsibilities include:[31]

- Making the determination of whether a patient has a terminal disease;
- Ensuring an informed decision by notifying the patient of their diagnosis;
- Informing the patient of their prognosis, risks of the medications, probable result of the medication, and feasible alternatives;
- Prescribing and dispensing medication to the patient (including ancillary medications to ease discomfort);
- Referring the patient to a consulting qualified medical provider for confirmation of the diagnosis; and
- Sign a patient's death certificate listing the underlying terminal disease as cause of death.

Selection of qualified medical provider:

If a qualified patient selects an attending qualified medical provider who is a licensed professional other than a physician, the qualified patient must select a physician to serve as the qualified patient's consulting qualified medical provider.

A qualified patient may select a consulting qualified medical provider who is a licensed professional other than a physician, only if the qualified patient's attending qualified medical provider is a physician.[32]

Abortion

In Washington, the only health care providers allowed to perform abortions are physicians (allopathic or osteopathic),[33] physician assistants, advanced registered nurse practitioners, or other health care provider acting within the provider's scope of practice.[34] A health care provider may assist a physician, physician assistant, advanced registered nurse practitioner, or other health care provider acting within the provider's scope of practice in an abortion.[35] This includes surgical abortions, which require anesthesia, may require pain medications, and have small risks of cervical injury or uterine perforation or infection.

[30] RCW 70.245.010(2).
[31] RCW 70.245.040(1).
[32] RCW 70.245.230
[33] RCW 9.02.170(4).
[34] RCW 9.02.100.
[35] Id.

It also includes medical abortions, which require prescriptive authority for Mifepristone to block progesterone needed for a pregnancy to continue and Misoprostol (used through 10 weeks gestation).[36]

Controlled Substances

Controlled substances are drugs, substances, or immediate precursors included in Schedules I through V of the state and federal Uniform Controlled Substances Acts (chapter 69.50 RCW and Title 21 USC). Drugs are scheduled based on acceptable medical use and potential for abuse or dependence, with the lowest number classifications indicating the most dangerous substances. Schedule I drugs have no accepted medical use and the highest abuse potential. Schedule II drugs have a high potential for abuse which may lead to severe psychological or physical dependence. Schedules III through V drugs have lesser potential for abuse and dependence than Schedule I and II drugs.

Opioid pain medications fall under Schedule II and III. Also included in Schedule II are methamphetamines, pentobarbital, and hallucinogenic substances. Drug overdose and opioid misuse is a serious public health crisis in the United States. This includes the use of prescription opioids.[37]

Medication Assisted Treatment

Medication-assisted Treatment (MAT) is the use of medications in combination with counseling and behavioral therapies to treat substance use disorders, including opioid use disorders (OUD).[38,39] MAT is used to treat both OUD and Alcohol Use Disorder (AUD), however the drugs used to treat OUD are different than the drugs used to treat AUD.

There are three drugs approved by the FDA for the treatment of OUD: buprenorphine, methadone, and naltrexone. They are safe to use for long periods of time and some people may

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[36] "Questions and Answers on Mifepristone for Medical Termination of Pregnancy through Ten Weeks Gestation." U.S. Food and Drug Administration (FDA), last modified September 1, 2023, https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/questions-and-answers-mifepristone-medical-termination-pregnancy-through-ten-weeks-gestation#:~:text=Mifepristone%20is%20a%20drug%20that,of%20the%20last%20menstrual%20period.

[37] "Opioid Data." Washington State Department of Health. Accessed May 13, 2024. https://doh.wa.gov/data-and-statistical-reports/washington-tracking-network-wtn/opioids.

[38] "Information about Medication-Assisted Treatment (MAT)." U.S. Food & Drug Administration, last modified May 23, 2023. https://www.fda.gov/drugs/information-drug-class/information-about-medication-assisted-treatment-mat.

[39] "Medications for Substance Use Disorders." Substance Abuse and Mental Health Services Administration SAMHSA, last modified April 11, 2024. https://www.samhsa.gov/medications-substance-use-disorders.

be on them safely for their lifetime. All three of these medications operate to normalize brain chemistry, block the euphoric effects of opioids, relieve cravings, and relieve negative withdrawal symptoms. [40]

Buprenorphine is the first medication to treat OUD that can be prescribed or dispensed in a primary care physician's office.[41] Methadone used to treat OUD can only be dispensed through a certified Opioid Treatment Program (OTP).[42] Naltrexone can be prescribed and administered by any practitioner licensed to prescribe medications, as it is not considered a controlled substance.[43] However, for OUD, it is only available in an intramuscular injectable formula.[44] A critical note is that for patients who discontinue naltrexone or relapse after a period of abstinence, they "may have a reduced tolerance to opioids. Therefore, taking the same, or even lower doses of opioids used in the past can cause life-threating consequences."[45]

Program Comparisons

Because the skills and knowledge to prescribe controlled substances are intertwined across courses and clinical experience for each educational program, the department is unable to compare courses across professions. Instead, the department chose to compare major components of the programs. All of the programs require similar prerequisite courses, such as chemistry and biology. Note that an in-depth description of education and practice requirements by program is included in Appendix D.

[40] "Medications for Substance Use Disorders."
[41] "Buprenorphine." Substance Abuse and Mental Health Services Administration (SAMHSA), last updated March 28, 2024. https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions/buprenorphine.
[42] "Methadone." Substance Abuse and Mental Health Services Administration (SAMHSA), last updated March 29, 2024. https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions/methadone.
[43] "Naltrexone." Substance Abuse and Mental Health Services Administration (SAMHSA), last updated March 29, 2024. https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions/naltrexone.
[44] "Naltrexone."
[45] "Naltrexone."

Requirements for entering training programs

MDs (Doctorate)	ARNPs (Doctorate)	PAs (Master's)	NDs (Doctorate)
UW Medical School	*UW DNP Program*	*UW MEDEX NW PA Program*	*Bastyr University*
• Undergraduate degree • Passage of the Medical College Admission Test® (MCAT®)	• Undergraduate degree • Active RN license • Passage of national exam	• Undergraduate degree • 2,000 hours clinical patient care experience	• Undergraduate degree

All four professions require undergraduate degrees. MDs have an additional requirement of passing a pre-admission examination and PAs are required to complete 2,000 hours of clinical patient care experience to enter their program.

Didactic Training

MDs	ARNPs	PAs	NDs
UW Medical School	*UW DNP program*	*UW MEDEX NW PA program*	*Bastyr University*
• Focuses on anatomy, embryology, pathology, histology, and pharmacology integrated into interdisciplinary blocks that cover all body systems, the lifecycle, behavioral health, infections & immunity, and the fundamentals of medical science and research. • Pharmacology is integrated across courses.	• BSN focuses on the fundamentals in professional nursing practice, pharmacotherapeutics, and pathophysiology, as well as psychosocial nursing, and nursing practicums. • DNP focuses on advanced physical assessment, diagnosis, pathophysiology, and pharmacology.	• Focuses on basic scientific concepts, intensive history and physical exam instruction. Body systems are studied in blocks across courses, so the content of each course is reinforced in the other courses. Includes behavioral medicine, emergency medicine, adult medicine, and maternal and child health. • Pharmacology is	• Includes core principles in anatomy, histology, embryology, biochemistry, physiology, pathology, immunology, and infectious diseases in the context of body systems. • Pharmacology content integrated into psychopathology, naturopathic approaches to addiction, and

		integrated across courses.	medical procedures courses. • Program also includes naturopathic therapeutics of body systems and conditions, minor medical/surgical procedures and multiple courses in hydrotherapy, homeopathy, electrotherapy, manipulation, and botanical medicine.

It is difficult to compare naturopathic educational programs to medical and nursing programs because the focus of the training is so different. Naturopathic programs are doctorate level and include biomedical sciences, body systems/interactions, and specific courses dedicated to pharmacology like other professions. These programs have evolved to include more pharmacology courses. However, the four-year naturopath training program also includes courses and treatment options in botanical medicine, exercise therapy, hydrotherapy, nature cure, acupuncture/traditional Chinese medicine, and homeopathy. This leaves less time and focus on pharmacology-related training and sciences.

Specific pharmacology training

MDs	ARNPs	PAs	NDs
UW Medical School	*UW DNP program*	*UW MEDEX NW PA program*	*Bastyr University*
• Integrated into interdisciplinary blocks covering all body systems	• 3 courses (9 credits total) in pharmacotherapeutics and pathophysiology and 1 course in advanced pharmacotherapeutics in complex case management	• 2 courses (6 credits total) in principles of patient management (drug and non-pharmacological therapy)	• 1 course (3 credits) in medical pharmacology • 5 courses (2.5 credits total) in clinical pharmacology

	• Prerequisite course, introductory pharmacy practice experience in community pharmacy (1 credit)		

ARNPs, PAs, and NDs have pharmacology-specific training, while MDs appear to integrate it into interdisciplinary blocks.

Clinical training

MDs	ARNPs	PAs	NDs
UW Medical School	*UW DNP program*	*UW MEDEX NW PA program*	*Bastyr University*
• Required clerkships in family medicine, internal medicine, obstetrics and gynecology, pediatrics, psychiatry, and surgery, across urban and rural settings, hospital wards and outpatient clinics. • Requires specific patient encounters and procedures.	• 1,000 clinically relevant practice hours required.	• Approximately 1,600 hours. • Core family medicine placement and required rotations in behavioral medicine, emergency medicine, surgery, inpatient, and underserved populations.	• 1,204 clinical training hours in a supervised setting. • The Dean stated students may manage patients on controlled substances in their required rotations.

Allopathic and osteopathic physicians have the most extensive training, which includes required clerkships/rotations and specified patient encounters that must be experienced as part of their program. PAs train under allopathic or osteopathic physicians, are required to take clerkships and rotations in specific medical settings and populations.

ARNPs are required to be licensed as RNs before entering an advanced practice program, which means they train under the supervision of MDs and other practitioners.

There are limited minimum requirements for clinical training in naturopathic programs. The Council on Naturopathic Medicine Education (CNME) requires clinical training to provide opportunities to treat patients of all ages, with a variety of conditions and diseases and include

a minimum number of patient encounters to ensure competency. However, CNME accreditation requires 900 of the 1,200 clock hours involving patient contact to be supervised by NDs in naturopathic clinics.[46] In addition, clinical training in naturopathic programs can occur mainly in naturopathic clinics and does not include requirements ensuring sufficient exposure to controlled substance prescribing. For example:

- Through Bastyr's and the National University of Natural Medicine's (NUNM) clinical experiences, students *may* manage patients on controlled substances during their required clinical rotations.[47]
- NUNM states students must demonstrate competency in pharmacological prescription through a total of only 12 prescriptions in at least eight different condition categories.[48]
- Sonoran states it has two community clinics offering six clerkship opportunities per week where substance abuse disorders are common among the participants and that most student rotations are family practice, meaning many of the patients seen are taking medications the supervising physician has prescribed.[49]

Sonoran University has elective site locations that are staffed by physicians in private practice, hospitals, ambulatory care facilities, long-term acute care facilities, etc., at the college's nine community clinics and more than 100 off-site clinics, including hospitals, medical centers, and medical mobile units.[50]

Examination

MDs	ARNPs	PAs	NDs
• Passage of all steps of the United States Medical License Examination (USMLE) or the Licentiate of the Medical Council of Canada (LMCC).	• Passage of the National Council Licensure Examination (NCLEX) for RN license. • National specialty certification which	• Passage of the National Commission on Certification of Physician Assistants (NCCPA) examination.	• Passage of the Naturopathic Physicians Licensing Examination (NPLEX).

[46] Council on Naturopathic Medical Education (CNME), *Handbook of Accreditation for Naturopathic Medicine Programs*, January 2024, CNME-Handbook-of-Accreditation-January-2024-edition.pdf.
[47] "Applicant Report."
[48] "Applicant Report."
[49] "Applicant Report."
[50] "Clinical Training," Sonoran University of Health Sciences, accessed May 14, 2024, https://www.sonoran.edu/programs/college-of-naturopathic-medicine/clinical-training/.

	includes passage of an examination.		

All professions require passage of an examination prior to licensure. In addition, ARNPs must obtain and maintain national specialty certification, which requires passage of an examination.[51]

Post-graduate requirements

MDs	ARNPs	PAs	NDs
• 2-year residency in general medicine or surgery, or a specialty or subspecialty in the field of medicine or surgery.	• National specialty certification requires a minimum number of clinical hours, specific pharmacology courses, an exam, and renewal requirements.	• None.	• None.

Note: There are voluntary certification options available for NDs.

MDs cannot be licensed to practice independently before completing a one- or two-year residency and ARNPs must maintain their specialty certification and meet ongoing requirements for that certification.

Prescriptive Authority

MDs	ARNPs	PAs	NDs
• No restrictions.	• No restrictions.	• Delegation agreement allows PAs to prescribe, order, administer and dispense legend drugs and Schedule II-V controlled substances. If a supervising or	• No restrictions, except controlled substance prescriptions are limited to testosterone and codeine-containing substances in Schedules III-V. • For intravenous therapy, must

[51] WAC 246-840-302.

		alternate physician's prescribing privileges are restricted, the physician assistant will be deemed similarly restricted.	submit 16-hour training attestation.

PAs must have a practice agreement with a physician or physicians, which includes a supervising MD or DO.[52]

NDs are limited in their prescriptive authority and for intravenous therapy, they must submit an attestation of training for at least sixteen hours of instruction.[53] At least eight hours must be part of a graduate level course.[54]

Continuing education

MDs	ARNPs	PAs	NDs
• 200 hours every 4 years.	• 30 hours every two years plus 15 hours in pharmacotherapeutics to retain prescriptive authority. • National certification requires 100 contact hours of advanced CE, including 25 credits of advanced practice pharmacology every 5 years.	• 100 hours every 2 years	• 60 hours every 2 years plus 15 hours in pharmacotherapeutics for those with limited prescriptive authority.

[52] WAC 246-918-035.
[53] WAC 246-836-220.
[54] WAC 246-836-220.

Continuing education requirements vary substantially by profession. Only ARNPs and NDs have specific requirements for pharmacology continuing education.

In this review, the department must assess the minimum qualifications for NDs to practice or plan to practice in Washington. However, the department must note that it received public comments from several NDs who appear to exceed minimum qualifications such as by receiving clinical training from a variety of settings like hospitals, surgery centers, and federally qualified health clinics where broad patient populations and conditions were represented, and oversight was provided by a diversity of provider types. Some of these NDs held specialty certifications and/or completed residencies. The department also heard from several NDs who work in collaborative practices with MDs, DOs, ARNPs, and PAs.

Other States

The applicant report provided information on states with broad prescriptive authority. The department conducted additional research into each state's scope of practice and educational and practice requirements to gain prescriptive authority. Please note we use ND throughout this section for consistency.

Arizona

The Arizona Physicians Medical Board regulates NDs, who have limited authority to prescribe controlled substances if they are granted a certificate to dispense. This requires either graduation from an approved naturopathic school after January 1, 2005 or completion of a 60-hour pharmacological course on natural substances, drugs, or devices.[55]

ND prescriptive authority for Schedule II controlled substances is unclear. According to the applicant report, prescriptive authority includes Schedule III-V plus morphine in Schedule II, which aligns with A.R.S. § 32-1501(15) (definitions).[56] Intravenous administration of legend drugs is excluded from ND's prescriptive authority except vitamins, chelation therapy, drugs used in emergency resuscitation and stabilization, minerals, and nutrients. In addition, NDs cannot prescribe cancer chemotherapeutics classified as legend drugs, or antipsychotics.[57]

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[55] A.A.C. R4-18-902.

[56] There is a potential conflict between two Arizona statutes on which types of drugs, including Schedule II drugs, may be dispensed by an ND. A.R.S. § 32-1501(15), and accompanying rules, define a drug under the naturopath chapter as not including most legend drugs and controlled substances, except for any drug that is reclassified from schedule III to II after January 1, 2024, and any homeopathic preparation that are also controlled substances. However, A.R.S. § 32-1581(A), which is under the same chapter, allows NDs to dispense any drug except a schedule II controlled substance that is an opioid. The department reached out to the Arizona licensing board in April to inquire about the apparent conflict in their regulations but never received a response.

[57] A.R.S. § 32-1501(15).

NDs must provide evidence of 30 credit hours of continuing medical education activities annually, which include ten credit hours in pharmacology relating to the diagnosis, treatment, or prevention of disease.[58]

The department reached out to the Arizona board to request information on disciplinary actions but were unable to obtain this information.

California

The California Board of Naturopathic Medicine (board) regulates NDs, who are authorized to prescribe Schedule III-V controlled substances, limited to drugs agreed upon by the naturopathic doctor and a supervising physician and surgeon.[59] The ND must function under a standardized procedure or protocol developed and approved by the supervising physician and surgeon and the ND.[60] The protocol must include which drugs may be furnished or ordered under what circumstances, the extent of supervision, the method of periodic review of the naturopathic doctor's competence, and review of the standardized procedure.[61] When the NDs furnish or order Schedule III substances, there must be a patient-specific protocol approved by the supervising physician.[62]

NDs must include the following in their licensure application: (1) whether they intend to furnish or order controlled substances, and (2) provide written evidence to the licensing authority that they have completed at least forty-eight hours of instruction in pharmacology that included the pharmacokinetic and pharmacodynamic principles and properties of the drugs they are furnishing or ordering.[63]

NDs are specifically prohibited from performing an abortion or surgical procedure.[64]

The board also requires satisfactory completion of 60 hours of approved continuing education biennially, including at least 20 hours in pharmacotherapeutics.[65]

The department reached out to the board to obtain information on disciplinary actions but were unable to obtain this information.

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[58] A.A.C. R4-18-205(A).
[59] CAL. BUS. & PROF. CODE § 3640.5.
[60] Id.
[61] Id.
[62] Id.
[63] CAL. CODE REGS. § 4212.
[64] CAL. BUS. & PROF. CODE § 3642.
[65] CAL. BUS. & PROF. CODE § 3635.

Vermont

The Office of Professional Regulation (OPR) regulates NDs in Vermont. NDs must obtain a special endorsement for prescription medications. The endorsement requires passage of the National Board of Medical Examiners (NBME) pharmacology examination or a substantially equivalent examination.[66] The first 100 drug prescriptions issued by an ND must be reviewed by an independent supervising physician or a naturopath with the endorsement through a formal written agreement.[67]

NDs are allowed to administer and provide for preventative and therapeutic purposes such things as: nonprescription medicines, topical medicines, homeopathic medicines, naturopathic physical medicine, therapeutic devices, barriers for contraception and certain prescription medicines.[68] Those prescription medicines are any human drug required by federal law or regulation to be dispensed only by prescription.[69] NDs are authorized to possess and control all controlled substances (referred to as "regulated drugs" in Vermont law) to the extent doing so is within their education, training, experience, and scope of practice.[70] There are currently no rules clarifying this scope of practice.[71]

For licensees possessing the special endorsement for prescription medications, Vermont requires 30 hours of continuing medical education every two years upon renewal, including ten hours in pharmacology of legend drugs.[72]

There are 122 NDs holding a prescriptive authority endorsement out of 416 active, licensed NDs.[73] The department could not identify any disciplinary actions specifically related to ND's prescriptive authority.

New Mexico

NDs are regulated by the New Mexico Medical Board. [74] A Naturopathic Doctors' Advisory Council advises the board. All licensees are required to pass the NPLEX biomedical science

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[66] CVR 04-030-380 § 3.5.
[67] Id.
[68] 26 V.S.A. § 4121.
[69] Id.
[70] Confirmed by the Vermont Office of Professional Regulation (OPR). (Lauren K. Layman, email to Department of Health, March 29,2024) (See Appendix C, p. A-44).
[71] Lauren K. Layman, email to Department of Health, March 29,2024. (See Appendix C, p. A-44).
[72] CVR 04-030-380 §3.2.
[73]"Find a Professional," Vermont Office of Professional Regulation, accessed May 14, 2024, https://secure.professionals.vermont.gov/prweb/PRServletCustom/app/NGLPGuestUser/V9csDxL3sXkkjMC_FR2HrA*/!STANDARD?UserIdentifier=LicenseLookupGuestUser. (Search "Profession" = Naturopathic Physicians" and "Profession Type" = "Naturopathic Physician" and "Status" = "Active").
[74] "Apply for Licensure in the State of New Mexico," Licensing, New Mexico Medical Board, accessed May 20, 2024, https://www.nmmb.state.nm.us/licensing.html. (The board regulates physicians, physician assistants,

examination (Part I) and the core clinical science examination (Part II), as well as the clinical elective examination in minor surgery and pharmacology.[75]

Under New Mexico's rules on naturopathic doctors, "primary care" is defined as: [76]

> Health care provided by a healthcare provider who typically acts as the first contact and principal point of continuing care for patients and coordinates other specialist care or services that the patient may require. Primary care providers are trained in non-specialty internal medicine and pediatrics, family medicine, general internal medicine, geriatrics (gerontology), general obstetrics and gynecology and general pediatrics, and refer to specialists when those services are warranted.

NDs must practice in collaboration with a medical or osteopathic physician and in alignment with naturopathic education.[77] "Collaboration" is defined under New Mexico rules as:[78]

> The process by which a licensed physician and a naturopathic doctor jointly contribute to the health care and treatment of patients; provided that: (a) each collaborator performs actions that the collaborator is licensed or otherwise authorized to perform; and (b) collaboration shall not be construed to require the physical presence of the licensed physician at the time and place services are rendered by the collaborating naturopathic doctor.

After passing a pharmacy examination authorized by board rules, NDs are authorized to prescribe all legend drugs, and testosterone products and all schedule III-V controlled substances, except all benzodiazepines, opioids, and opioid derivatives.[79] They are prohibited from performing surgical abortions.[80] They are also required to take 75 hours of continuing medical education every three years, including five hours in pain management and ten hours in pharmacology.[81]

The department reached out to the New Mexico board to obtain information on disciplinary actions but were unable to obtain this information.

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anesthesiologist assistants, genetic counselors, doctors or naprapathy, physician supervisors of pharmacist clinicians, polysomnographic technologists, naturopathic doctors, and podiatric physicians).

[75] N.M. Code R. § 16.10.22.9.
[76] N.M. Code R. § 16.10.22.7.
[77] N.M. Code R. § 16.10.22.11.
[78] N.M. Code R. § 16.10.22.7.
[79] Id.
[80] N.M. Code R. § 16.10.22.12.
[81] N.M. Code R. § 16.10.22.15.

Oregon

Oregon NDs are regulated by the Oregon Board of Naturopathic Medicine, which also determines which drugs an ND can prescribe.[82] Licensees are required to pass the Oregon Jurisprudence Examination and the NLPEX [sic] exams part I & II, as well as the NLPEX exams on clinical elective surgery and clinical elective pharmacology.[83] NDs are authorized to prescribe a large formulary of Schedules II-V controlled substances with no additional training.[84] Two exceptions are ketamine therapy and injection and IV therapy, which have additional educating and reporting requirements.[85] NDS are also prohibited from prescribing:[86]

- General anesthetics;
- Injectable ketamine for the purpose of general anesthesia;
- Mifepristone and misoprostol as an abortifacient;
- Barbiturates, except phenobarbital, butalbital, primidone; and
- Systemic oncology agents except for certain antineoplastic agents, in oral and topical form only.

The formulary council has adopted the current American Hospital Formulary Service Pharmacologic-Therapeutic Classification, which has been in use in hospitals and health systems for many years and is a logical way to group drugs for easy comparison and aggregate reporting on drugs for utilization and billing.[87,88,89]

Licensees are required to obtain 32 hours of continuing education annually, including one hour in pain management and ten hours of pharmacology.[90]

There are 1,213 naturopathic physicians licensed in Oregon.[91] There have been 23 disciplinary actions that appear to be related to prescribing since 2017.[92]

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[82] ORS § 685.145.
[83] OAR 850-030-0020.
[84] OAR 850-060-0226.
[85] OAR 850-060-0212.
[86] OAR 850-060-0223.
[87] OAR 850-060-0226.
[88] "AHFS Pharmacologic-Therapeutic Classification System," American Society of Health-System Pharmacists, Inc., 2019, accessed May 20, 2024, https://www.oregon.gov/obnm/Documents/Formulary%20Information/AHFSClassificationwithDrugs2019.pdf.
[89] "AHFS Pharmacologic-Therapeutic Classification System," American Society of Health-System Pharmacists (ASHP), accessed May 20, 2024, https://www.ashp.org/products-and-services/ashp-licensing/ahfs-therapeutic-classification?loginreturnUrl=SSOCheckOnly.
[90] ORS § 850-040-0210.
[91] Robin Crumpler, email to the Department of Health, April 17, 2024. (See Appendix C, p. A-47).
[92] "Discipline," Oregon Board of Naturopathic Medicine, accessed April 19, 2024, https://www.oregon.gov/obnm/Documents/Discipline/N16-01-01%20N16-05-05%20McVeigh%20Amended%20Consent%20Order%20and%20Settlement%20Agreement%203.29.24.pdf.

2014 Sunrise Review

In a 2014 sunrise review of a similar proposal to include prescriptive authority for all Schedule II-V controlled substances for NDs, the department determined the proposal did not meet the sunrise criteria.[93]

However, the Health Care Authority (HCA) argued in support of a limited expansion of prescriptive authority because expanded Medicaid coverage was expected to include an expanded demographic of patients with medical conditions requiring controlled substances in the naturopathic primary care setting. HCA also argued that: (1) deaths related to prescription opioids occurred almost without exception in patients on chronic therapy, (2) short-term treatment of acute conditions with controlled substances is considered safer, and (3) limited prescriptive authority may reduce the number of unnecessary emergency department visits.

The department suggested a less expansive scope increase option for the legislature to consider that included:

- Limiting ND prescriptive authority to controlled substances in Schedule III-V (and hydrocodone products in Schedule II),
- Limiting prescriptions to no more than seven days;
- Setting a maximum dosage;
- Instructing the Board of Naturopathy consult with the Pharmacy Quality Assurance Commission on rules to determine appropriate training and education;
- Requiring adoption of pain management rules; and
- Requiring registration in the Prescription Monitoring Program (PMP)[94] to access patient prescription history.

The legislature did not enact a scope expansion in response to these suggested options.

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[93] Washington State Department of Health (DOH*), Naturopathic Scop of Practice Sunrise Review: Information Summary and Recommendations*, December 2014, https://doh.wa.gov/sites/default/files/legacy/Documents/2000/NaturopathFinal.pdf.

[94] The PMP allows the department to monitor the prescribing and dispensing of all Schedule II-V controlled substances. Itis a secure online database that collects data on Schedules II-V controlled substances. RCW 70.225.020(1). Prescribers are authorized to access PMP data before prescribing or dispensing drugs to look for duplicate prescribing, possible misuse, drug interactions, and other potential concerns.

Public Engagement

The department posted the applicant's proposal and all materials to the department's sunrise webpage and notified interested parties of the written comment period in the fall of 2023. The department received over 1,100 written comments. The department held a public comment meeting and accepted oral comments on April 24, 2024.

Here is a summary of the written and oral comments the department received.

Support (over 660 comments):

Commentors in support of the proposal stated that NDs are educated and trained in accredited naturopathic medical colleges to provide primary care. They argued this proposal would give Washington residents access to a broader range of healthcare options, particularly in rural and underserved areas, where access to conventional medical care can be limited or have long wait times. They also stated the proposal would decrease patient costs and make care timelier, as patients would not have to schedule a second office visit with another provider to fill or change a prescription. Requiring double visits delays care and increases costs due to insurance co-pays, time off work, and other cost shares, especially in rural communities.

NDs commented that natural medicine and conventional medicine are not mutually exclusive and there are circumstances that require both. NDs follow the least invasive approach first before introducing pharmaceuticals but are trained to identify when and whether a patient is overmedicated and when medications can be tapered off or discontinued.

Commentors also stated that inconsistencies in naturopathic regulation between Washington and Oregon places a burden on patients and doctors that travel across state lines for work or to seek care. Commentators claimed it is irrational for NDs who practice medicine in Oregon to be restricted or prohibited from providing the same level of care in Washington.

The dean of Bastyr University wrote that the level of training by their graduates meets similar requirements as other healthcare practitioners who hold full prescriptive authority. The Bastyr program includes 300 credits, which equates to over 4,200 hours. The dean made some corrections to the education provided in the applicant report, which we note in the section on Bastyr training on page 23. The dean attached updated information about Bastyr's current pharmacology and patient management courses on controlled substances, which include pharmacology, pharmaceutical management, and substance use disorders. According to these materials, Bastyr's ND program allocates 12.65 of curricular credits, which is equivalent to 141.75 hours of classroom time, specifically for didactic training and medication management. The latter is provided in a supervised setting throughout students' 1,204 hours of clinical training and is where students learn how to assess, manage, and refer substance use disorders. Bastyr emphasizes safe practice standards at every level of the student's education.

An instructor at Bastyr University who has also taught at Sonoran University stated their Bastyr graduates are well trained in the use of controlled substances, including having around 150 hours of classroom training and clinical training hours in pharmacology. They state NDs can simultaneously provide treatment on and support for managing controlled substances while ultimately reducing or eliminating the need for these medications. They attested that almost every patient encounter by their ND students involved pharmacological therapies.

The executive director of the Council on Naturopathic Medical Education (CNME) wrote to affirm that CNME-accredited naturopathic medical programs train naturopathic primary care physicians, and that training covers basic medical sciences, advanced clinical sciences, and pharmacology. The program includes training on controlled substances and drug-herb-nutrient interactions, as well as public health, diagnostics, and non-pharmacologic therapeutics.

The executive director of the North American Board of Naturopathic Examiners (NABNE) wrote to confirm that the competencies tested in the NPLEX Part II – Core Clinical Sciences Examination are designed to test to the highest scope of practice available in any state, including medications used in primary care.

The Association of Accredited Naturopathic Medical Colleges (AANMC) wrote to confirm that ND training is similar to the biomedical and clinical requirements for other medical degrees such as MDs, ARNPs, and DOs. The AANMC's recommended core competencies outline stringent guidelines and expectations for clinical and professional practice among licensed NDs who have graduated from accredited naturopathic programs. Accredited naturopathic medical schools train their students to meet the AANMC's recommended clinical competencies and prepare them for the NPLEX exam. All accredited naturopathic medical schools in the US provide high-level pharmacology training, including coverage of controlled substances, pharmacology, pharmacognosy, drug-herb, and drug-nutrient interactions. They add that comparisons between naturopathic and conventional primary care programs (MD/DO, ARNP) demonstrate similarities in foundational medical training.

Other commentors noted that federal law requires that NDs who have DEA licenses, including those practicing in Washington, are required to obtain the same eight hours of training on Opioid Use Disorder (OUD) as all other practitioners who prescribe controlled substances. Washington NDs are also required by state law to take 15 hours of continuing education in pharmacology every two years.

One commenter who is both an ND and a family nurse practitioner (FNP)[95] stated that their FNP training did not include education on opioid prescriptions except to limit them, or on morphine equivalents. They also stated a third-party, rather than the program instructors, taught the

[95] FNPs are a category of ARNP in Washington and are authorized to prescribe controlled substances.

buprenorphine section and that FNPs do not have mandatory residency requirements. They added that oftentimes FNPs never work as an RN or have clinical experience to support their success as an FNP.

The department also heard from an ND working in a primary care clinic that their ability to provide comprehensive primary care to their patients is impeded by their "limited prescriptive scope." This ND completed a residency in interventional pain management and serves as the medical director for an outpatient drug and alcohol treatment center. They stated they are constantly looking for providers to refer patients to for medication management and see regular lapses in care due to three-to-six-month waitlists. They state this proposal is critical for their patients using medications commonly used to treat conditions like ADHD, insomnia, addiction, and acute pain.

The department heard from an ND working for a rural FQHC who discussed provider (especially mental health provider) shortages and burnout in their health center. They often see acute walk-in patients they would like to keep out of the emergency department for unnecessary visits. The closest urgent care is more than an hour away and local provider schedules are often booked out for weeks. The ND often must send patients to the emergency department or try to find another busy provider to help with prescriptions.

Other commentors stated NDs can help decrease opioid dependence, which is supported by the 2022 AANP Naturopathic Profession Benchmarking Survey that ranked NDs treatment modalities. The study showed opioid prescribing ranked last of all modalities used in the five states that allow NDs to prescribe controlled substances. Without access to Suboxone and other formulations of buprenorphine, NDs are left trying to help patients with OUD "with one arm tied behind their back."

Commentors further stated many patients seek out naturopathic care to decrease dependence on addictive medications, and hospitals increasingly provide limited pain management. NDs often must refer patients to their primary care providers for follow- up and ongoing management of post-procedural pain. A primary care physician must have the authority to prescribe a medication both to manage patients in these situations and to safely taper them off.

The department also heard that patients turn to their primary care provider to sign hospice orders, POLST forms, various disability determinations, and other vital records. Restricting NDs from signing these documents creates an undue burden on patients forcing them to locate and establish care with additional providers to sign these documents.

An ND who worked with patients experiencing homelessness and behavioral health issues wrote in support of the proposal. They stated they frequently have patients request MAT treatment for OUD and, under current regulations, are forced to refer them out. They also argued the department should consider using NDs more since we are currently experiencing a

fentanyl epidemic and individuals experiencing homelessness are some of the most affected, stigmatized, and vulnerable.

The department also heard from an MD who is the chief medical officer (CMO) at a medical center that hires NDs for their primary care team. The CMO stated they use an integrated model where these NDs work alongside MDs, ARNPs, and PAs. He researched the ND training, specifically in pharmacology, and stated NDs have substantially comparable training to nurse practitioners and PAs, and very similar training to MD's. The CMO stated they have a program where they select charts randomly from all their providers every quarter and send them out for outside review. The NDs consistently scored high for appropriate diagnosis and treatment. He added there is no scientific evidence that ND prescribing would increase the risk of narcotics in our state. The CMO argued there is an adequate system of measuring controlled substance use, as well as prescribing rules and reporting tools to track their use.

The department further heard from NDs with patients who wanted to reduce or get off their medications. Without the authority to prescribe these medications, NDs are unable to help de-prescribe their patients by giving them smaller and smaller dosages to wean off a medication.

Others stated the limitation in ND prescribing is more obvious in rural communities where the requirement to see a separate provider for a controlled substance is unreasonable, unfair, and inequitable for the patient. They argued NDs in other states have been safely prescribing controlled substances for years, with no reported increase in adverse events. In addition, they stated the concerns around the need for ND residencies are unfounded because nurse practitioners can prescribe these medications without a residency.

The department heard from one ND who stated their patients are all over the socioeconomic spectrum and those with the most precarious financial situations often had more complex medical needs that were greatly influenced by socioeconomic determinants of health. They argued these patients could save valuable time and money if they did not have to take additional unpaid time-off for health-related medical visits. They also stated NDs are not anti-conventional medicine but believe there is a time and a place for both approaches.

A pharmacist wrote they collaborated with nearly half of all licensed NDs this year and their interactions have consistently revealed ND's competence, compassion, and accessibility. They also worked at Bastyr University as affiliate faculty, contributing to the pharmacology series, specifically in dermatology. They stated it is routine that ND pharmacology training addresses specific medications, with a focus on mechanism of action, dosing and indications, contraindications and cautions, adverse reactions, and drug interaction.

The department heard from several NDs who practiced under Oregon's expanded scope of practice but now cannot prescribe and deprescribe pain medications like Tramadol, ADD meds like Adderall and anxiolytics like Xanax. They described situations where patients in Washington had a severe fear of air travel where they would benefit from the authority to prescribe a small

number of Xanax pills for a trip, patients who are stable on their ADD medication would like the ND to take over their prescription, patients who are taking a benzodiazepine such as alprazolam for sleep or anxiety and are ready to taper off. Some of these NDs describe their education at the National University of Natural Medicine in Portland as including countless hours of training in pharmaceutical prescribing.

The department heard comments from an ND who completed a residency at Bastyr and is the Power of Providers ND representative, which is an advisory committee to the department. This group meets monthly with health care providers of all disciplines on topics like COVID vaccines and access to underserved populations. They are also adjunct faculty at Bastyr, where they train on the full scope of practice, including pharmaceuticals. They noted that when they were beginning their residency, they advocated for the Medicaid scope expansion and stated expertise and education in primary care has advanced since 2014. NDs are pivotal to addressing the concerns facing our state, including their holistic approach, which can include safe and practiced ways to use pharmaceuticals.

An ND who has practiced and held licenses in Oregon and has taught NDs and MDs for 30 years commented in support of the proposal. This ND is also a professor of pharmacology and clinical medicine and has taught physicians CME as well as naturopathic medical students, specifically in the pharmacology and management and safe prescribing and deprescribing of controlled substances at Vaster University and at other universities.

An ND and chief quality and compliance officer at a federally qualified Health Center serving the communities of Okanogan and Douglas County wrote in support of the proposal. They were also chief resident of Bastyr in 2012, a trainer at McMaster University Evidence Based Clinical Practice program and served as a professor in evidence-based clinical practice at Bastyr prior to their current position. This experience makes them uniquely qualified to speak to the quality and compliance concerns related to safety and risk in primary care. They said that states with expanded scope have NDs working in FQHCs, community clinics, rural clinics, and underserved areas. This scope expansion supports continuity of care for primary care relationships with NDs. They requested this proposal be evaluated against precedent set by the scope and training of other health professions in this state.

The department heard from MDs and others that they had misconceptions about naturopathic training and practice. They stated they had learned through working with NDs that they are supportive of vaccines and science-based decision making. They had also watched many traditionally biased MDs begin referring their patients to NDs. They added that the patients of the NDs they work with reported high patient satisfaction, high positive outcomes, and low incident reports.

The department heard from over 300 ND patients who wrote in support of the proposal. Many patients questioned why their ND could not write prescriptions for them since they are their primary care physician. They expressed concerns with the need to see multiple physicians for

titrating medications and paying more than one co-pay, especially considering the long wait times to find another provider. Some patients wrote that they wished Medicare covered their naturopathic care, but they are willing to pay out of pocket because it is the care they trust. Many of the patients wrote specifically in support of having their ND prescribe ADHD and anti-anxiety medications.

Oppose (over 420 comments):

Those opposed to the proposal argued that naturopathic education and training is not equivalent to the education and training received by allopathic and osteopathic physicians. They cited how the CNME provides no standards around ND program course content and the incorporation of naturopathic principles with pharmacological sciences. They noted NDs take a two-part exam (NPLEX) covering basic sciences, diagnostic and therapeutic subjects, and clinical sciences that is written entirely by naturopaths and not subject to rigorous oversight or external review by experts in medical education. Furthermore, NDs are not required to complete a residency and only need to complete 850 hours of patient care with no requirement on treating specific conditions or patient populations.

Other commentors stated that naturopathic training does not prepare NDs to practice under the proposed increase in their scope of practice, including full prescriptive authority, minor office procedures that could potentially include surgery such as vasectomies and abortions, and signing forms like disability determinations and hospice orders.

One person commented that the current ND scope of practice was achieved by misrepresentation of their education and training to lawmakers. They also stated naturopathic clinical training takes place in naturopathic teaching clinics that use patients with fake conditions and treatments like homeopathy, hydrotherapy, and botanical medicines. This commentor also stated NPs have no clinical training in hospital settings and their training hours are exaggerated and closer to 561 hours in direct patient care.

A surgeon and ophthalmologist spoke on behalf of the Washington Academy of Eye Physicians and Surgeons to oppose the proposal. They stated they have a unique insight from training various health professions – MDs, medical students, NDs, nurse practitioners, and physical therapists – and understand the distinct educational differences among these specialties. While there is importance to all health medical subspecialities, the commentator believed there is not appropriate expertise and training given in naturopathic schools.

Other commentors in opposition to the proposal state that MD and DO education includes:

- A highly regulated curriculum on the human body and its systems;
- Didactic courses and clinical training in pharmacology;
- Two years of patient care rotations through different specialties;
- Passage of a standardized, three-part licensing exam;

- Three to five years of accredited residency treating the acutely ill or injured in an emergency room setting; and
- Demonstration of competence at the end of the residency.

They argue the proposed scope of practice change is beyond NDs' knowledge and training, disregarding that care coordination is a critical part of patient care. They also state that comprehensiveness of training, including residency, experience working as a team member with other physicians, and continued professional oversight allow board-certified physicians to stay current with professional standards and safely incorporate new treatments and medications into their practice.

Other commentors stated hospitals are already treating conditions that occurred due to naturopathic mismanagement. They argue NDs that practice independently cannot be compared to hospital-employed NDs who work in an integrated team-based care model with allopathic and osteopathic providers.

The department also heard that in-clinic abortions are safe when performed by practitioners with adequate clinical training in obstetrics and gynecology, including preprocedural preparation, performance of the procedure, and post-procedural patient care. Vasectomies are delicate surgical procedures that involve injecting local anesthetics, incision into the scrotum, and tying, cauterizing, using surgical clips, or a combination of these.

Comments from pharmacists included they already see improper prescribing practices under the current naturopathic prescriptive authority. They do not believe naturopaths understand their current scope of practice and laws.

Others argued talented physicians in non-psychiatric specialties struggle with the treatment of serious mental illness and addiction and they have the benefit of much more extensive medical training and experience compared to NDs.

The department also heard that NDs do not have the training, guidance, and oversight to responsibly provide the level of care outlined in this bill. A 2018 study evaluating opiate prescribing patterns in Oregon found a greater percentage of high-risk opiate prescribing patterns by naturopaths. These commentors concluded that expanding opiate prescribing authority to naturopaths could undermine the progress Washington has made in reducing prescription opiate deaths.

Some opposing the proposal stated that while the idea of NDs playing a pivotal role in pain management is appealing, it lacks historical perspective. They argue there have been many regulations imposed on opioid prescribers who are attempting to find a balance between over- and under-prescribing of these substances. Treating opioid use disorder is a daunting prospect even for experienced prescribers.

Others stated that in this era of addiction epidemics, the issue lies not in access to these medications, but in the lack of access to knowledgeable care regarding their safe use. They argue that decreasing prescribing standards will just worsen this issue and allowing NDs to prescribe these substances would only worsen the current opioid crisis.

Emergency medicine physicians stated they have seen harm caused by NDs, including patients who have died of strokes and had end-state cancer that could have been prevented with appropriate care. They stated there has also been a growing number of adverse events in office-based settings associated with sedation and/or anesthesia care. This care should be based on nationally accepted standards, guidelines, and levels of care established by states that are consistent throughout dental offices, hospitals, ambulatory surgery centers, and clinics. When NDs are already failing to appropriately care for patients, these physicians argue expanding the ND scope of practice seems at best ill-advised and at worst dangerous.

The department also heard that NDs do not have standards of care based on medical science. They argued naturopathic medicine is philosophically and foundationally different than allopathic and osteopathic medical practice, not science-based and, does not follow medically accepted standards of care. Commentors stated that botanical and homeopathic medications lack compelling evidence of their therapeutic efficacy and national standards for primary care physicians consider these interventions medically unnecessary and substandard care. These medications are also not approved for medical use by the FDA.

Some commentors were concerned about assertions that referrals to specialists or other practitioners for medications are administrative red tape and that NDs must explain limitations to their prescriptive authority. They argued these referrals are intentional to protect patient safety and ensure care is provided only by those with adequate education and training. NDs cannot be considered comprehensive primary care providers due to the naturopathic community's lack of consensus around vaccines. The Naturopathic Medicine Institute opposed mandatory COVID-19 vaccines.

The department also heard there was no evidence to support the applicant's assertion that NDs may be the only health care providers in some rural communities. NDs generally practice in the same areas as allopathic and osteopathic physicians. In addition, there are safer options to address workforce challenges, including increased funding for student loan repayment programs, the workforce, retention initiatives, residencies, and continued use of telemedicine.

Others stated that while the applicant report highlights the ongoing mental health crisis as the rationale for expansion of ND prescribing authority, psychiatric care is much more than just prescribing medications. NDs have limited medical education, and this proposal disregards the training needed to understand the complex interactions between mental and physical health.

Other commentors argued that being recognized as a primary care provider does not equate to being qualified to provide the full scope of primary care services, nor justify scope expansion.

The scope of practice for primary care MDs, DOs, PAs, ARNPs, NDs, and others is differentiated based on education and training. While overlaps may exist, there are necessary limitations to ensure patient safety.

The department also heard the proposed vague definition of minor office procedures could lead to troubling interpretations. The definition could be interpreted to include surgery, which may involve using lasers, scalpels, and needles; cutting and burning tissue; and making injections into body cavities, internal organs, and the central nervous system. It could also be interpreted to include injections in eye structures, which require specialized anatomical and procedural knowledge learned through surgical training.

Commentors stated the Board of Naturopathy already interprets minor office procedures to include the use of in-office nitrous oxide without guardrails, as well as procedures using Botox. There has been a growing number of adverse events in office-based settings associated with sedation or anesthesia care. This care should be based on nationally accepted standards and the proposal does not adhere to these standards.

Others reported that some Arizona naturopaths interpret the practice of naturopathy to include liposuction and gluteoplasty (Brazilian butt lifts) and the Arizona board has failed to clarify the definition or discipline naturopaths who have performed "botched surgeries." This may also happen in Washington.

In addition, the department heard concerns that the Board of Naturopathy does not have the expertise to determine adequate education and training for this size of scope of practice increase, including full prescriptive authority.

The department also received comments from two NDs who opposed the proposal because of issues with existing continuing education rules. These included how NDs are not able to provide continuing education on pharmaceutical drugs they are not currently allowed to prescribe in Washington. In addition, they assert that graduates of naturopathic doctoral programs have some of the worst debt to earnings ratios in the entire country, which makes them vulnerable and desperate to make more money. They state the proposal is intended to increase the earnings of naturopathic physicians.

Concerns/Other (about 15 comments):

The department also heard from people with concerns about the proposal, stating:

- It is unclear what percentage of NDs embrace the use of legend (prescribed) drugs and believe it is essential to obtain controlled substance prescriptive authority.
- The proposed bill makes changes to the definitions of minor office procedures and physical modalities. However, the applicant report does not address these changes and what education NDs obtain on these procedures.

- The applicant report referenced the passage of House Bill 1851 in 2022, which added PAs, ARNPs, and other clinicians as providers who perform or assist in the termination of pregnancy. However, it does not address what training naturopathic physicians receive on pregnancy termination.
- No disciplinary data was provided to support the applicant's claim that NDs have been safely prescribing since 2005.
- It's time for open, transparent communication between naturopathy and the greater healthcare community. They stated concerns that the foundational support for increased authority is not in place and included meeting notes from the Board of Naturopathy's CE rules update process over the last 3 years as evidence.

Some commentors noted only one NP program's pharmacology content is included in the curricula comparison, omitting the pharmacology content of pre-licensure nursing programs and neglecting the integration of pharmacology content into other clinical courses.

An anesthesiologist stated they've heard success with NDs in multidisciplinary practices where there's teamwork and cultural norms and the practices hold practitioners accountable for the care they provide. However, the anesthesiologist does not believe most NDs are practicing in these types of teams, but rather independently.

An ND provider in Tacoma with 20 years of experience as a professor in the training program stated that as more and more ND providers are moving into the FQHC and urgent care setting, it is not acceptable they cannot prescribe this important medication. In addition, the lack of clear parameters on what can be administered as an intravenous medication allows for providers to inject patients with any item obtained through a compounding pharmacy, even if this item lacks basic safety or efficacy research. This is an easy risk to address by adding a caveat to the ND scope of practice that stipulates that only FDA-approved medications can be administered. In addition, adding a restriction on off-label medication prescribed to patients with a current cancer diagnosis would be helpful.

The department also heard comments from NDs who would support a residency or additional exam requirement for NPs to qualify for full prescriptive authority.

The HCA provided comments that Medicaid managed care plans have concerns about the varying amounts of training and education NDs receive in pharmacology, specifically on stimulants and controlled substances. Regardless of the potential for addressing health care provider shortages, the HCA wants to ensure NDs caring for their clients have the level of training needed to provide quality care. HCA recognizes the potential of this proposal to impact access to care for Washington residents. However, they expressed concerns about the quality of care that might result from increasing the scope of practice without additional training requirements for the expanded prescriptive authority.

Comments from boards and commissions:

The **Washington State Board of Naturopathy** wrote in support of the proposal because it would increase public safety and health by granting a wider range of options, as well as reducing costs associated with unnecessary duplicative care. They stated that an ND's approach starts with the least invasive method possible and includes a wide variety of treatment modalities on a case-by-case basis. Their position is that treatment options available to NDs should be the same as those available to and routinely used by all other recognized primary care providers. This should include controlled substances.

The Board added that the applicant report makes it clear ND's foundational training already meets or exceeds that of other providers with an advanced and autonomous scope of practice. In addition, the bill requires registration with the prescription monitoring program (PMP), which adds an additional safeguard and visibility into ND prescribing trends. They conclude that the board has a demonstrated history of careful and cautious rulemaking and will continue those efforts with a focus on keeping the public safe. In addition, there has been little evidence of safety concerns regarding ND's current prescribing practices and the board is confident that this will continue once expanded prescriptive authority is granted.

The **Washington Medical Commission (WMC)** wrote with concerns about the adequacy of naturopathic training in the diagnosis of serious health conditions that may require use of controlled substances and the prevalence of overdose deaths from prescription opioids. They stated underlying conditions have evolved over the nine years since the last sunrise review, but the fundamental issues remain regarding training and the significant public health challenges with mitigating addiction and abuse of opioids.

They also expressed concerns that the proposed change to the definition of minor office procedures is meant to authorize vasectomies and dilation and curettage, adding that it is notable that the 2023 bills regarding who can perform abortions and participate in the death with dignity act excluded naturopathic physicians.

The **Washington State Board of Nursing (WABON)** stated they believe the proposal meets the sunrise criteria and may increase overall access to primary care. They stated a few areas of the applicant report needed correction. For example, the comparison of ARNP preparation to other providers in pharmacology credits on page 10 did not include the pharmacology background completed in all nurses' baccalaureate education. WABON requested this be corrected to represent the full ARNP education. In addition, they stated the continuing education hours required for all providers who prescribe opioids is a one-time four-hour course. New opioid prescribers may require more continuing education depending on the individual provider. They added that there needs to be more clarity around the definition of office procedures.

Review of Proposal Using Sunrise Criteria

The Sunrise Act, in RCW 18.120.010, states that a health care profession should be regulated, or the scope of practice expanded only when:

- Unregulated practice can clearly harm or endanger the health, safety, or welfare of the public and the potential for the harm is easily recognizable and not remote or dependent upon tenuous argument;
- The public needs and can reasonably be expected to benefit from an assurance of initial and continuing professional ability; and
- The public cannot be effectively protected by other means in a more cost-beneficial manner.

Because the above criteria focus on new professions, the department directs applicant groups to demonstrate the following for proposals to increase a profession's scope of practice. The proposal benefits the public by:

- Protecting the public from harm;
- Providing assurance of sufficient education, training, and professional ability to perform the scope of practice; and
- Demonstrating the proposal is the most cost-beneficial option to protect the public.

First Criterion: Protecting the public from harm.

The proposal does not meet this criterion.

Naturopaths are currently a thoroughly regulated profession. The proposal, as written, does not offer adequate protections to meet this criterion. Controlled substances are drugs that have potential benefits but also carry substantial risks, which is why they are scheduled based on their potential for misuse, abuse, and dependence. The proposal's vague definition of minor office procedures also leaves the door open for broad interpretation. Without knowing what specific procedures are intended, the department cannot evaluate whether NDs have adequate training for those procedures.

The department acknowledges that pharmacology training in naturopathic schools has clearly evolved, adding a stronger didactic foundation in basic sciences and pharmacology. However, compared to other prescribers with full prescriptive authority, the minimum clinical requirements on pharmacology training and surgical procedures for NDs do not provide sufficient education and experience for NDs to warrant full prescriptive authority. In addition, ND programs share time with courses and treatment options in botanical medicine, exercise therapy, hydrotherapy, nature cure, acupuncture/traditional Chinese medicine, and homeopathy. This leaves less focus on pharmacology-related training and sciences.

Allowing NDs to sign or attest to hospice orders, POLST (portable medical orders) forms, etc., for conditions or decisions that are within their scope of practice to diagnose or advise on would save patients from needing to see additional providers. However, based on their limited training and education, NDs run a greater risk of making incorrect diagnoses, evaluations, or recommendations on treatment options, which could result in serious life or death impacts for patients.

Second Criterion: Providing assurance of sufficient education, training, and professional ability to perform the scope of practice.

The proposal does not meet this criterion.

There are adequate laws and rules in place to assure the public of initial and continued professional ability for the current naturopath scope of practice. The proposal, as written, does not offer adequate protections to meet this criterion. The applicant has not shown adequate minimum core training requirements, especially clinical requirements, to ensure the public of their ability to safely prescribe Schedule II-V controlled substances. The proposed expanded definition of minor office procedures is too broad for the department to evaluate naturopathic school training since the department cannot determine what procedures need to be included in that training.

Third Criterion: The public cannot be effectively protected by other means in a more cost-beneficial manner.

This criterion was not fully evaluated because the applicant did not provide data or information that could be analyzed with a cost-benefit approach. In addition, the department did not fully evaluate these claims because the applicant did not demonstrate the proposal met the first two criteria to protect the public.

Detailed Recommendations

The applicant report identifies a need to expand ND's prescriptive authority to increase access to OUD treatment like Buprenorphine, help patients taper off controlled substances, treat acute or post-surgical pain, and sign documents like hospice orders or POLST (portable medical orders) forms.

However, the department recommends this proposal not be enacted because it does not meet the criteria in RCW 18.120.010, demonstrating it provides assurance of initial and continuing ability to protect patients from harm.

Rationale:

The department must be able to confirm sufficient education to perform increases to scope of practice. This proposal:

- Does not demonstrate sufficient minimum education and training to safely prescribe Schedule II-V controlled substances:
    - Naturopathic programs have evolved to include more pharmacology focus. However, these programs also share time with courses and treatment options that include botanical medicine, exercise therapy, hydrotherapy, nature cure, acupuncture/traditional Chinese medicine, and homeopathy over the four-year program. This leaves less time to focus on pharmacology-related training and sciences.
    - NDs' clinical training can occur almost entirely in naturopathic clinics without exposure to a variety of providers, settings, and situations like would be experienced in hospitals or emergency medicine. Naturopathic programs do not require:
        - Clinical training in settings such as hospitals or involving behavioral health medicine, emergency medicine, surgery, inpatient procedures, etc., or
        - Exposure to specific patient populations or conditions, such as pediatric patients, patients with specific behavioral health conditions, and patients on pain management.
- The other states that grant authority to prescribe controlled substances limit NDs to Schedules III-V or specific formularies and include safeguards such as collaboration or supervision by MDs, additional or continuing education, an additional pharmacology examination, and oversight by the state medical board.
- The proposed definition of "minor office procedures" is vague and subject to a wide range of interpretations. The department cannot evaluate adequate training without knowing what specific procedures would be included in this definition.

- The Board of Naturopathy does not include providers with sufficient expertise to evaluate what additional education and training is needed to safely expand the ND scope of practice.
- Many primary care providers refer patients requiring long term use of controlled substances to specialists because the significant risks of overdose, abuse, and misuse require additional training to prevent and mitigate.