June 1, 2024

Washington State Department of Health
Increase Scope of Practice Sunrise Review

Applicant Report for Expanded Prescribing by Pharmacists

On behalf of the licensed pharmacists of Washington State, we formally request a review of this proposal to expand the prescriptive authority of pharmacists. This proposal was initially outlined in House Bill 2116 and the companion Senate Bill 6019. Pharmacists in Washington State have been prescribers under collaborative drug therapy agreements (CDTAs) for 45 years. They receive a professional doctoral degree focused on medications, therapeutics, patient care, and outcomes. Pharmacists can do more to support the health of Washingtonians with the support of this scope expansion.

As of September 2023, there are 11,727 pharmacists licensed in Washington State, and the Bureau of Labor Statistics estimates there are 9,450 pharmacists working in Washington State. The Pharmacy Quality Assurance Commission regulates the practice of pharmacy under a standard of care model, and is well prepared to regulate pharmacist prescribing outside of CDTAs.

The Washington State Pharmacy Association (WSPA) is the requesting organization for this change in scope. Jenny Arnold, PharmD is the contact person for this request. Our offices are at 411 Williams Ave S, Renton, WA 98075. The office phone number is 425-228-7171, and Dr. Arnold's direct number is 425-207-3642. Her email is jenny@wsparx.org. The WSPA is the home and voice of pharmacy practice. We advocate on behalf of the profession to ensure pharmacy professionals are uniformly recognized as a vital members of the healthcare team. The members of the WSPA include pharmacists, pharmacy interns, technicians and pharmacies in Washington. There are 1,700 full members of WSPA.

The WSPA is affiliated with several national pharmacy associations including the American Pharmacists Association (APhA), National Community Pharmacy Association (NCPA), American Society of Health System Pharmacists (ASHP), American Society of Consultant Pharmacists (ASCP), and the National Alliance of State Pharmacy Associations (NASPA), to name a few.

Several states have advanced care under this independent prescribing model. Our neighboring state, Idaho, has enforced independent prescribing by pharmacists under a standard of care model since 2018. Since then, Colorado and Iowa have adopted this model. Many states support some level of independent prescribing by pharmacists for minor ailments and conditions (> 10 states), opioid reversal agents (nearly every state), contraception (>19 states), immunization (nearly every state), HIV pre- and

post-exposure prophylaxis (>10 states), travel medicine, tobacco cessation, and other medications and conditions could additionally be listed.

The WSPA welcomes the opportunity to provide any further information, data, and background beyond what is included in this application. Please do not hesitate to reach out.

Sincerely,

Jenny Arnold, PharmD, BCPS, FWSPA
Chief Executive Officer

Applicant Report
Proposal to Increase Scope of Practice

Washington pharmacists are uniquely trained to increase access to healthcare and safely help the patients of Washington State to better manage their acute and chronic illnesses and medications. To best support pharmacist provided care, an expansion of independent prescribing is requested. In considering this increase in scope of practice, the following should be considered.

1. Define the problem and why the change in regulation is necessary (refer to RCW 18.120.030(1)).

Washington State became the first state in the U.S. to permit pharmacists to prescribe medications in 1979. The Pharmacist Practice Act RCW 18.64.011(28)[1] defines the Practice of Pharmacy to include "the initiating or modifying of drug therapy in accordance with written guidelines or protocols previously established and approved for his or her practice by a practitioner authorized to prescribe drugs." Pharmacists have used this collaborative authority to prescribe a broad range of medications depending on their training, practice setting and patient needs. Pharmacists have safely prescribed medications to Washington patients for 45 years with an exceptionally low number of incidents reported to the Pharmacy Commission

Currently, pharmacists partner with providers who can independently prescribe, such as physicians, veterinarians, and nurse practitioners to sign collaborative drug therapy agreements (CDTAs) to prescribe medications under WAC 246-945-350.[2] A CDTA is a formal agreement that authorizes the pharmacist(s) to perform services and prescribe within their scope of clinical expertise and education.[3] These CDTAs must be filed with the Pharmacy Commission and list which medications, diseases or drug categories are included, which prescriptive authority is permitted, and any required training or procedures. These practice agreements have been a mainstay of pharmacy practice with pharmacists signing and assuming the liability for prescriptions written. In a 2023 Workforce Survey completed by the University of Washington School of Pharmacy, 59% of responding pharmacists indicated they prescribe medications under a CDTA in practice, and 47% use a CDTA to prescribe and administer vaccinations[4]. Further, pharmacists are prescribing medications in a variety of pharmacy practice settings, including community, primary care clinics, and hospitals. The following table outlines the number and percent of responding pharmacists who are using CDTAs to prescribe medications and immunizations overall and by practice setting:

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[1] *RCW 18.64.011: Definitions.* (n.d.). https://app.leg.wa.gov/RCW/default.aspx?cite=18.64.011
[2] WAC 246-945-350: (n.d.). https://app.leg.wa.gov/WAC/default.aspx?cite=246-945-350
[3] Pharmacists' Patient Care Process: A State "Scope of Practice" Perspective. (2019). Innovations in Pharmacy, 10(2), 1389. https://doi.org/10.24926/iip.v10i2.1389
[4] Bacci J, English C. Prescribing Change: Shaping Tomorrow's Pharmacy Workforce in Washington State. Lecture presented at: Washington State Pharmacy Association Annual Meeting; November 4, 2023; Cle Elum, WA.

Patient Care Service	Total (n=569)	Community (n=248)	Hospital (n=163)	Clinic (n=137)
Prescribing through CDTA or protocol	338 (59%)	137 (55%)	118 (72%)	99 (72%)
Administer immunizations	265 (47%)	217 (88%)	19 (12%)	32 (23%)

However, eligible CDTA prescriber partners have become extremely difficult for pharmacists to identify. In 2022, 74% of physicians are employed by hospitals, health systems or corporate entities.[5] These large corporate employers preclude physicians from participating in CDTAs with outside pharmacists. Washington pharmacists routinely cite difficulty with finding a CDTA partner as the main barrier to offering more care to patients.[6] Pharmacists are very willing to help with Washington's top preventative care needs, however they are limited by a lack of willing independent prescribers to sign their agreements as partners, especially in rural and underserved areas.

Anecdotally, each year the WSPA staff are contacted by pharmacists who need help identifying an independent prescriber to sign a CDTA. The most common request is for a prescriber to sign a CDTA for immunizations. Pharmacist prescribed and administered vaccines are the standard of care across all 50 states, with more routine vaccines administered by pharmacists than other providers.[7] After significant time spent connecting pharmacists to prescribers for the provision of immunizations, the WSPA is usually able to identify a physician prescribing partner – however, identifying a partner often takes months, and results in gaps in care and the related potential negative impact on public health in Washington communities.

As described further in the document, pharmacists are highly trained medication experts. Since 2004, the Doctor of Pharmacy degree is the minimum standard for U.S. pharmacist graduates. In Washington State, our schools began offering Doctor of Pharmacy degrees starting with the 2000 graduates. Pharmacists are medication experts and can better use their knowledge to close care gaps, increase control of chronic conditions, provide timely access to care for time-sensitive needs, and support preventative and primary care. Permitting the Pharmacy Commission to regulate pharmacist prescribing outside of CDTAs, a process currently resulting in gaps in care due to limitations of engaging prescriber partnership, will enhance patient care and access in all communities. At the same time, greater engagement of the expertise, training, and attention to medication safety and efficacy by pharmacists in all settings of care through enhanced prescribing should enhance the care process in support of disease prevention and management.

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[5] Report: Supermajority of U.S. physicians are employed by health systems or corporate entities. (2022b, April 25). Primary Care Collaborative. https://thepcc.org/2022/04/25/report-supermajority-us-physicians-are-employed-health-systems-or-corporate-entities

[6] Hensley, K, (2024, May 31). *Community Practice Network Session: Forum Discussion on Workplace Protocols* [Continuing Education]. Northwest Pharmacy Convention, Coeur d'Alene, ID, United States.

[7] Trends in vaccine administration in the United States. (Jan 13, 2023). IQVIA. https://www.iqvia.com/insights/the-iqvia-institute/reports-and-publications/reports/trends-in-vaccine-administration-in-the-united-states

2. Explain how the proposal addresses the problem and benefits the public (refer to RCW 18.120.030(4)).

According to the U.S. Health Resources and Services Administration (HRSA), as of March 31st, 2024, 2,606,632 Washington residents live in a primary care health professional shortage area.[8] To rectify this, HRSA estimates that 499 practitioners are needed in Washington State to adequately meet the need. An additional 156 mental health providers are also needed to meet Washington resident's needs. In 2022, the average wait time to see a family medicine physician in Seattle was 24 days.[9] Washington State lags significantly behind the national benchmarks in measures of health care quality and access for many chronic illnesses.[10]

Pharmacists are uniquely situated in primary and specialty clinics, community pharmacies, inpatient settings, and long-term care to provide care for chronic and acute conditions to provide optimal medication therapy care. "As medication experts, clinical pharmacists are the ideal health care providers to manage pharmacotherapy in patients with chronic diseases," according to Joseph and Hale in the American Journal of Managed Care.[11] Pharmacists with expanded prescriptive authority without the administrative limitations and barriers of CDTAs can help to fill the primary care shortages by treating minor ailments (e.g., strep throat, urinary tract infections, and dog bites) initiating and modifying treatments for chronic conditions, providing preventive care, and managing emergency situations that present in a pharmacy.[12] Pharmacists often care for patients by having individual office visits in primary and specialty clinics across Washington in partnership with physicians and other members of the healthcare team. Their CDTAs that they operate under are very broad, with expansive scope authorized. These practices effectively practice under a standard of care prescribing model and demonstrate the feasibility of our scope request.

In community pharmacies, pharmacists increasingly have access to primary care records through the health information exchange and electronic health records. This adoption of technology facilitates bi-directional data sharing and exchange of referrals, progress notes, and care plans. This evolution, while not a requirement for patient care, enhances continuity in a way that urgent care and emergency departments often do not provide. Washington community pharmacies routinely communicate with providers the need for medication adjustments and help to implement changes. With expanded

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[8] Designated Health Professional Shortage Areas Statistics. March 31, 2024. Bureau of Health Workforce, Health Resources and Services Administration, US Department of Health and Human Services.

[9] AMN Healthcare & Merritt Hawkins. (2022). Survey of physician appointment wait times and Medicare and Medicaid acceptance rates. In AMN Healthcare [Report]. https://www.wsha.org/wp-content/uploads/mha2022waittimesurveyfinal.pdf

[10] A-Z measure list | Community Checkup - Washington Health Alliance. (n.d.). https://wacommunitycheckup.org/a-z-measure-list/

[11] Joseph, T & Hale, G (2021, June 14). Provider perceptions of pharmacists in Primary Care–Based Accountable care organizations. AJMC. https://www.ajmc.com/view/provider-perceptions-of-pharmacists-in-primary-care-based-accountable-care-organizations.

[12] Adams, A. J., Weaver, K. K., & Adams, J. A. (2023). Revisiting the continuum of pharmacist prescriptive authority. *Journal of the American Pharmacists Association : JAPhA*, *63*(5), 1508–1514. https://doi-org.offcampus.lib.washington.edu/10.1016/j.japh.2023.06.025

prescriptive authority, delays resulting from the need for affirmative authorization from prescribers could be reduced with the pharmacist able to make simple adjustments to a patient's medication regimen based on a standard of care prescribing model.[13]

Pharmacist provided care saves healthcare dollars. A study completed in Washington State found that pharmacist-provided care is significantly less expensive than other care settings, and providing patients with expanded access to pharmacist care has the potential to save the healthcare system $23.5 million.[14] Pharmacists are highly-trained medication experts, and through expanded prescriptive authority, could help the healthcare system to better control chronic illnesses and save healthcare dollars by reducing emergency department and urgent care visits, and avoidable complications of under treated chronic illnesses. Further, pharmacists in Washington have been able to bill commercial and Medicaid health plans for clinical services since 2016 and are typically paid at 85% of a physician visit for the identical visit. This partnership and sharing of patients in the same primary care clinic setting also has the potential to reduce costs in primary care settings by reducing the cost for follow up care with pharmacists for management of chronic illnesses.

3. What is the minimum level of education and training necessary to perform the new skill or service based on objective criteria?

Completion of a Doctor of Pharmacy (PharmD) degree is the minimum level of education and training necessary to prescribe drug therapy. The PharmD degree has been required for pharmacist licensure since 2004 and is completed over a 4-year time frame (or the equivalent number of hours), For licensure, the PharmD degree must be obtained from a program accredited by the Accreditation Council for Pharmacy Education (ACPE), indicating the program provides the required didactic content, practical training, intensity, and duration.[15] The PharmD required curricula includes didactic instruction and skills training on the following:

- Pharmacology and Therapeutics: In-depth study of drug mechanisms, therapeutic uses, effects on the human body, and monitoring.
- The Pharmacists' Patient Care Process, a standardized model for pharmacy care that includes various steps to the process, specifically implementation of a care plan. Implementation of a care plan includes initiation of a prescription.[16]

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[13] Adams, A. J., Weaver, K. K., & Adams, J. A. (2023). Revisiting the continuum of pharmacist prescriptive authority. *Journal of the American Pharmacists Association : JAPhA*, *63*(5), 1508–1514. https://doi-org.offcampus.lib.washington.edu/10.1016/j.japh.2023.06.025

[14] Pharmacist-provided care is significantly less expensive than traditional care settings. The study found that emergency departments, urgent care, and primary care cost $505.04, $122.74, and $95.97 more, respectively, than care provided by pharmacists, potentially saving the healthcare system $23.5 million.

[15] Accreditation Council for Pharmacy Education. (2015). Accreditation Standards and Key Elements for the Professional Program in Pharmacy Leading to the Doctor of Pharmacy Degree. [Report]. Accreditation Council for Pharmacy Education. https://www.acpe-accredit.org/pdf/Standards2016FINAL2022.pdf

[16] Joint Commission of Pharmacy Practitioners. Pharmacists' Patient Care Process. May 29, 2014. Available at: https://jcpp.net/wp-content/uploads/2016/03/PatientCareProcess-with-supporting-organizations.pdf.

- Clinical Pharmacy Practice: Training in patient assessment, clinical decision-making, and the development of therapeutic plans, including initiation of drugs, dosage, frequency, route of administration, and duration of treatment.
- Pharmacokinetics and Pharmacodynamics: Understanding drug absorption, distribution, metabolism, excretion, and drug formulations.
- Pharmacy Law and Ethics: Knowledge of legal and ethical considerations in pharmacy practice, including prescribing.

In addition to their didactic coursework, pharmacists complete skills training with direct observation and feedback from faculty followed by extensive practical training with preceptors, licensed pharmacists. They are required to complete no less than 1,740 hours of practical training focused primarily on direct patient care, medication use, prescribing, and monitoring in various healthcare settings such as hospitals, community pharmacies, and clinics.

Pharmacists in many U.S. states have some level of independent prescriptive authority for immunizations, HIV PREP and PEP, opioid antagonists, and as a result of CLIA-waived tests.[17] The Pharmacists' Patient Care Process provides the standardized process for pharmacists to prescribe independently and is included in the PharmD accreditation standards taught across all U.S. colleges and schools of pharmacy.

4. Explain how the proposal ensures practitioners can safely perform the new skill or service (refer to RCW 18.120.030(1) and (4)).

This proposal seeks to authorize the Pharmacy Quality Assurance Commission (PQAC) to regulate independent prescribing by pharmacists outside of CDTAs. Currently, PQAC is charged with regulating the profession of pharmacy under a standard of care regulatory model, similar to the Medical Commission and other Commissions under the Uniform Disciplinary Act.[18] Therefore, Washington pharmacists could only be permitted under a standard of care regulatory model to prescribe based on the accepted standard of care that would be provided in a similar setting by a reasonable and prudent licensee with similar education, training and experience.[19] Pharmacists as highly qualified professionals, would therefore limit their prescribing to what their training, experience and education would reasonably allow. By comparison, there is not state law detailing that a family practice physician should not perform a craniotomy in their clinic. It would be expected that a community pharmacist would not prescribe oncology medications from the pharmacy counter under a standard of care model. Pharmacists must have training, experience and education sufficient to support their independent prescribing practices that may be authorized by the pharmacy commission. This request is not a blanket

[17] Scope of Practice Archives - NASPA. (2024, May 23). NASPA. https://naspa.us/blog/restopic/scope/
[18] Chapter 18.130 RCW: REGULATION OF HEALTH PROFESSIONS—UNIFORM DISCIPLINARY ACT. (n.d.). https://app.leg.wa.gov/rcw/default.aspx?cite=18.130
[19] Adams, A. J., Chopski, N. L., & Adams, J. A. (2024). How to implement a "standard of care" regulatory model for pharmacists. *Journal of the American Pharmacists Association : JAPhA*, *64*(3), 102034. https://doi.org/10.1016/j.japh.2024.02.007

request for every pharmacist to be able to prescribe every medication. It is a request to allow for the independent prescriptive authority for qualified professionals acting within their scope of practice and training, and according to the appropriate standard of care.

With regard to controlled substances, pharmacists who have a CDTA authorizing them to prescribe controlled substances already have a prescriber DEA registration . These pharmacist prescribers are subject to the pain management guidelines in Washington State, and professional practice standards, including use of the prescription monitoring program for referencing patient records.

Pharmacists, like other independent prescribers in Washington state, are held, and will continue to be held to a standard of care regulatory model by the Pharmacy Commission. They may be disciplined if they prescribe outside of their training, expertise and experience, or inconsistent with practice norms in Washington state.

5. **Explain how the current education and training for the health profession adequately prepares practitioners to perform the new skill of service (refer to RCW 18.120.030(4)). Address the nature and duration of the education, training, and continuing education, including Washington curricula and accredited/approved out-of-state programs. Be specific on course content and credits/length applicable to the proposal.**

In addition to the comprehensive 4-year professional doctoral training that pharmacists receive to qualify for licensure described in the response to question #3, pharmacists also have the opportunity to specialize in nearly every aspect of healthcare. Post graduation, approximately 30% of pharmacy graduates complete a post graduate residency of 1-2 years.[20] Further, pharmacists may become board certified or credentialed in dozens of areas and have access to hundreds of certification training programs.[21] With this diversity of training opportunities, a standard of care regulatory discipline approach to expanding pharmacist prescribing authority is preferred. Some states have authorized pharmacist prescribing based on advanced credentials or a limited list of medications which limits the positive impact on patient care a pharmacist may have, and is not inclusive of the individual education, training and experience of pharmacists.

6. **Is an increase in education and training necessary? If so, are the approved educational institutions prepared to incorporate the increase?**

Expanded prescribing by pharmacists does not required an increase in education because the request is to only permit a pharmacist to prescribe based on their individual education, experience, and training through a standard of care regulatory model. The two Doctor of Pharmacy training programs in Washington State have already been instructing pharmacists as prescribers under both the ACPE accreditation standards as outlined in question 3, as well as prescribers because of our ability to

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[20] Bederka, A. May 18, 2022. Jefferson College of Pharmacy Match Rate Among Highest in Nation. https://www.jefferson.edu/about/news-and-events/2022/05/jefferson-college-of-pharmacy-match-rate-among-highest-in-nation.html.

[21] Council on Credentialing in Pharmacy | CCP. (n.d.). Council on Credentialing in Pharmacy | CCP. https://www.pharmacycredentialing.org/ccp-resource-documents/

prescribe through CDTAs. Washington Pharmacists are required to complete 30 hours of CE accredited by the American Council on Pharmacy Education to remain current with evolving changes in healthcare. The WSPA will continue to support continuing education and advanced training of pharmacists to meet the evolving needs of Washington state residents.

Several states have implemented expanded prescribing by pharmacists, including Idaho in 2018, Montana in 2023, Colorado in 2023, and Iowa in 2024 without an increase in education and training beyond the required Doctor of Pharmacy degree for pharmacist licensure[22].

7. How does the proposal ensure that only qualified practitioners are authorized to perform the expanded scope of practice.

Pharmacists in Washington State are currently regulated under a standard of care regulatory model for discipline. The standard of care is "the degree of care a prudent and reasonable licensee or registration with similar education, training, and experience will exercise under similar circumstances[23]." Importantly, the standard of care model holds pharmacists accountable if they provide a service or level of care that deviates from what other prudent pharmacists would have done in the same or similar situation in alignment with the Uniform Disciplinary Act and similarly to other health professions in Washington State, including physicians.

8. If there are other factors in RCW 18.120.030 relevant to the proposal, please address them in detail.

Not applicable.

[22] Adams A. J. (2020). Pharmacist Prescriptive Authority: Lessons from Idaho. *Pharmacy (Basel, Switzerland)*, *8*(3), 112. https://doi.org/10.3390/pharmacy8030112

[23] National Association of Boards of Pharmacy. (2024, January 3). Model Pharmacy Act/Rules - National Association of Boards of Pharmacy. https://nabp.pharmacy/members/board-resources/model-pharmacy-act-rules/