Pharmacist Prescriptive Authority Sunrise
Written Comments Received as of April 2, 2025

My name is Lee Foley. I am a practicing board certified emergency medicine physician in the state of Washington. I just learned about the proposal to allow pharmacists to prescribe medications and I am writing to tell you why I wholeheartedly think that is an insidious idea and should be opposed.

The proposal states "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.1" In effect, this would grant pharmacists the ability to *practice medicine* without having gone to medical school (or one of the advanced practice provider schools) and the years of training and education that entails. Indeed, pharmacists are highly skilled and knowledgeable, but their education is quite distinct from medicine and while they may be experts on pharmacodynamics and pharmacokinetics, they do not have the requisite knowledge of medicine to be prescribers. If a pharmacist wants to prescribe, they should change professions! For instance, does a pharmacist learn how to diagnose strep throat?

Do they learn about strep throat mimics? Do they learn about potential complications of both treating and not treating a strep throat infection? Or what about the dog bite example: does a pharmacist learn what dog bite lacerations should be sutured and which should not and what the potential complications are of suturing a dog bite or what the alternatives are to primary closure? Are pharmacists going to request that they should be allowed to perform medical procedures such as suturing next?

I understand that there is an overwhelming lack of primary care availability in the state of Washington. As an emergency medicine doctor, I am acutely aware of this problem. I commend the legislature for thinking outside of the box in trying to come up with solutions, but the solution proposed in this Sunrise Review is one of expediency and overreach and it is at once dangerous and egregious. I urge you to deny expanding pharmacy scope of practice.

Please, if you have any questions or if I can be of any service in preventing this proposal from becoming law, please reach out.

E. Lee Foley IV, M.S. D.O.
Emergency Medicine Physician

It is so incredibly difficult to get into urgent care from time to time and some of the symptoms are so basic even to public.

I had some muscle tenderness and cramps and next Dr appt was in two months. All I wanted was some muscle relaxants.

In Korea where I visit sometimes pharmacist saves so many patients time by directly prescribing meds themselves.

I am for pharmacists having more autonomy.

Sue Choi DDS
Owner, Board Certified Pediatric Dentist

I support allowing pharmacist prescribing outside of a collaborative drug therapy agreement. Pharmacists are accessible and trusted health care professionals. Their training allows them to provide quality patient care. It makes sense to expand their scope of practice in view of the current shortage of health care workers.

Rebecca Flagg, PharmD, RPh

Why did I go to medical school?

Every time I turn around, the state of WA wants to give more prescribing power to unqualified professionals.

Narcotics prescribing for optoms, narcotics prescribing for naturopaths, now prescribing for pharmacists?

Pharmacists are not clinicians! They have no background, no training, and no experience deciding whats is an infection vs inflammation vs a zebra that needs more workup.

You already have enough low level providers delivering horrible care due to “physician shortages” - ie NPs and PAs… Please DO NOT add pharmacists to this list

Do you want to help the physician shortage? Stop having me do useless regulatory paperwork and MIPS and woke training… I could see thousands of more patients a year without this burden that is outside of my expertise - patient care!

Chad Bouterse DO

What a horrible idea. Sure the pharmacy board wants broader power but pharmacists are NOT physicians.

They do not have the same education or responsibilities.

Pharmacists are supposed to fill scripts, look for drug interactions and work collaboratively WITH physicians.

NO, NO, NO to pharmacists prescribing outside previously determined regimen of treatment.

Sandra H Woodfield

I would like to voice my support for increasing pharmacist scope of practice. Recently there has been an increase in availability of reliable home testing for significant respiratory illnesses. This allows the public to do a pretty good job of identifying these illnesses at home with the help of the over the counter testing. Critically, these illnesses cause significant burden to an already taxed healthcare system each year and can be treated by straightforward antiviral prescriptions if they are started in time. If

pharmacists had the freedom to streamline the process of home test to rx, there could be a significant positive impact on emergency rooms, urgent cares, primary cares, and inpatient hospital beds each respiratory season.

I will use myself as an example. On a Friday my son came down hard with a febrile illness. I had purchased a set of combo tests for covid 19+influenza a+b at the beginning of the respiratory season. He was vaccinated, but sure enough tested positive for influenza A. We were able to call his pediatrician after hours, as they do have an after hours service, and it was a straightforward prescription for Tamiflu, saving us the worry of the inevitable asthma exacerbation this time of year brings. Not all offices have this service, we are lucky. However, I am immune compromised and needed prophylaxis. My primary care does not have after hours service to call and they were closed. I raced to the urgent care before they closed, where I was exposed to additional illnesses, and went through a visit to get my prophylaxis prescription. The prescription from urgent care turned out to be written incorrectly and the pharmacy was unable to fill it because the urgent care had closed by the time we got to the pharmacy. The pharmacist knew how it should be written and what needed to be done, but their hands were tied until the urgent care could fix their mistake the next day, which only happened at the very end of that next day. All in all it was a 24h delay, an urgent care visit, 3 trips to the pharmacy (2 for attempts to get my rx and 1 for my son's), multiple calls to urgent care and pharmacy by me, and multiple calls to the urgent care by the pharmacy. All of this resembled a circus for what was extremely straightforward and intentionally proactive on our part.

For patients early in diagnosis, at high risk of flu and covid complications where reliable home testing and effective medications are available but must be started in a tight window, being able to go directly through a pharmacist could be a great opportunity. The more patients that can access treatment in the intended treatment window, before they are having complications, the better for reduced ER visits and hospital stays. Fewer patients would be in primary care and urgent care waiting rooms with fevers just trying to get their antiviral prescription, potentially sitting next to infants, pregnant women, cancer patients, elderly community members, and immune compromised people. Giving pharmacists increasing autonomy to provide a service like this could be a significant public health win. It could very well be that a system like this could help our community members with more limited access the healthcare as well. There could be a reduced cost to a pathway that included just a home test and a prescription for antivirals, than a pathway that included an office visit. This could all promote compliance with early testing as well as get more of our neighbors treated and diverted from complications. When more people have access to treatment, the whole community is healthier.

Shannon Hirst

I have recently become aware of a possible program to allow pharmacist to prescribe medication and antibiotics for sore throat and other ailments. After rigorous training for over 13 years, I find this to be dangerous and unacceptable. We have been trained for many years to understand in-depth what these ailments are and what complications may arise. If we have practitioners treating patients without appropriate follow up and appropriate understanding of what these complications can be this can be dangerous for both the public And for doctors.

Dr Shah

My name is Alexandra Zirkle, and I am a student in the PharmD (Doctor of Pharmacy) professional degree program at the University of Washington. I am set to graduate this year and wanted to share my perspectives on the pharmacist sunrise review and what I have learned as someone about to become a new practitioner.

Firstly, I want to make sure that the education pharmacists receive is understood. Pharmacists' role in healthcare has grown, and the requirement to practice evolved from a BSPharm to a PharmD in 2000. After undergraduate schooling with the large majority of students having a bachelor's degree, pharmacist students then spend another 3 to 4 years to obtain their PharmD. There can be variances in curriculum, but overall schools are held to the same standards set by the ACPE (Accreditation Council for Pharmacy Education).

As a student at the University of Washington, our first two years were spent learning medications, therapeutics, pharmacokinetics, and pharmacology. We learned how to interpret labs, how to differentially diagnose, guidelines on treatments of many different disease states, medication choices, when to refer a patient to seek additional care, and how to chart patient care, amongst many other practical skills utilized by many other prescribers. This didactic education then prepares us for our final year of school through Advanced Pharmacy Practice Experiences (APPEs). This is where we get hands on experience at a variety of sites and the clinical portion of our education where under a preceptor. Each rotation is a minimum of 160 hours, and in total, we finish our final year with 1440 hours of APPE experience. Our rotations are also required to include a community setting, a general health system setting, a specialty health system setting, and an ambulatory setting. After graduating it is not uncommon for new pharmacists to also have residency training, which is one to two years of additional clinical education. Overall, pharmacist education prepares upcoming practitioners for many different aspects of pharmacy practice under the same, intensive standards.

From a personal perspective, as a student who is in the midst of APPE clinical rotations, it is clear how well the school prepared me to succeed. The University of Washington gave us the tools to become strong practitioners who are capable of practicing at the top of the pharmacy license. I was well prepared to work in an interprofessional team and how to communicate effectively with other healthcare providers, as well as with patients. To become a pharmacist takes a lot of dedication and hard work. My peers are all highly motivated and highly intelligent people who take patient care and a lifetime of learning very seriously.

With this in mind, this sunrise review approval is not a step I am advocating for lightly. Pharmacists truly see not only the gaps in available care but also the barriers to current care that exist. They have been prescribers under collaborative drug therapy agreements (CDTAs) for approximately 45 years with a low incidence of prescribing-related issues. With all these considerations plus many others outlined in the sunrise review proposal, it is time to expand the scope of pharmacists to match what pharmacists are capable of.

Alex Zirkle (she/her)
PharmD Candidate, Class of 2025

I am writing on behalf of Ostroms Drug, Bob Johnson's Pharmacy and Madison Park Pharmacy to provide support and comments for the Sunrise Review of the Pharmacists Scope of Practice.

As a three store pharmacy owner and one of very few people who has opened a new pharmacy in the past three years, I can tell you the CDTA system is antiquated.

Pharmacists spend 8 years receiving a doctorate level education in the exact same schools that our MDs graduate from. We consistently score as one of the most trusted professions. We are by far the most accessible healthcare providers in the country – many rural Washington areas do not have any providers at all – but they do have a pharmacy.

The CDTA process is one that requires a pharmacist to find an existing prescriber and get a sign-off on a protocol. Most providers in Washington State work for a health system that contractually bars them from signing such a document. Some providers have declined due to concerns with their insurance. Others have asked for five figure payments.

Every vaccine that you have ever received in a pharmacy was because of a CDTA. What happens when no providers are willing to sign one?

The CDTA process was groundbreaking when it first passed some decades ago. Since then pharmacists have significantly increased their education, many independent providers have disappeared, and doctor malpractice insurance concerns have overridden patient care.

It is time to let pharmacists do what we are trained to do.

Dr. Matt Binder, PharmD
Ostroms Drug & Gift, Bob Johnson's Pharmacy, Madison Park Pharmacy & Wellness Center

---

I am writing on behalf of pharmacy students and the pharmacy profession. I am a pharmacy intern at Providence Regional Medical Center and a student at Ostroms Drug and Bob Johnson's Pharmacy. I am writing to provide support and comments for the Sunrise Review of the Pharmacists Scope of Practice.

While I am still learning to become a practicing pharmacist, I am very near to receiving my degree in June 2025. I have learned the importance of our roles in the community, and especially the importance of advocating for our profession. I have recognized that the CDTA system is antiqued and prevents pharmacists from practicing to the fullest potential.

Pharmacists spend 8 years receiving a doctorate level education in the exact same schools that our MDs graduate from. We consistently score as one of the most trusted professions. We are by far the most accessible healthcare providers in the country – many rural Washington areas do not have any providers at all – but they do have a pharmacy.

In school, we learn how to diagnose, recognize signs and symptoms of various disease states, and both pharmacological and nonpharmacological treatments. We know how to manage medications based on a patient's response to it and know the next steps if the first option is no longer the best one.

The CDTA process is one that requires a pharmacist to find an existing prescriber and get a sign-off on a protocol. Most providers in Washington State work for a health system that contractually bars them from

signing such a document. Some providers have declined due to concerns with their insurance. Others have asked for five figure payments.

Every vaccine that you have ever received in a pharmacy was because of a CDTA. What happens when no providers are willing to sign one? Access to care will become even more limited to our patients.

The CDTA process was groundbreaking when it first passed some decades ago. Since then pharmacists have significantly increased their education, many independent providers have disappeared, and doctor malpractice insurance concerns have overridden patient care.

It is time to let pharmacists do what we are trained to do.

Sincerely,

Alexis Jasmine Quisao, PharmD Candidate, Class of 2025
University of Washington, School of Pharmacy

I am writing on behalf of myself and Cascadia Pharmacy Group to provide support and comments for the Sunrise Review of the Pharmacists Scope of Practice.

I have worked in community practice since graduating from WSU with my PharmD in 2012. I completed a PGY1 Residency with Fred Meyer in 2013 and went on to be Clinical Coordinator for Fred Meyer in 4 states. I have also worked in transitions of care, in healthcare technology and am now working as Chief Clinical Officer with a forward thinking and passionate group of independent pharmacists. Throughout my career I have written and implemented many different collaborative drug therapy agreements that have helped expand access to care. These are sometimes very basic services such as vaccine administration or continuation of therapy to improve public health and mitigate issues with adherence. We were once even asked by to write up a protocol for OTC prescribing to help reduce burden and unnecessary expense of patients waiting in the urgent care or ER for Tylenol or Ibuprofen so that it could be covered at no cost with their health insurance. Creative solutions like this can have a big impact when it comes to savings for the healthcare system, better allocation of resources to higher levels of care and even saving the patient and their family valuable time.

Slightly more complex CDTA's include tobacco cessation, hormonal contraception, or minor ailments including burns, bites, stings, shingles and yeast infections. We even have flu/COVID and strep Test to Treat services which are particularly important to be seen right away as early initiation of treatment can have a big impact on outcomes. While I say more complex, there are still very clear referral criteria and guidelines/decision trees to follow. Pharmacists are very well educated and capable of taking care of these patient needs which is especially important as we face a provider shortage and escalating healthcare expenditure. Where I'd truly like to see pharmacists expand CDTA's is to move from more acute services into chronic disease management. Pharmacists are the most accessible healthcare providers and we see our patients at least 12 times/year. As such, we are the perfect professional to collaborate with patient PCP's or specialists to help drive them toward their care goals. Whether lipids, diabetes or hypertension, our profession is not only ready to help, we are already helping. We just typically have to coordinate all changes through their physician.

While I am thankful our state allows CDTA's and this has been critical in how far we have been able to come, it is becoming increasingly difficult to find a collaborating provider that can sign off on protocols. As private practices have reduced significantly, many providers are limited by the corporations that own them and are instructed not to sign due to fears about liability. Independent prescribing similar to Idaho would help overcome this obstacle while still facilitating the great collaboration, referral streams, and communication we have developed in the community pharmacy setting.

Thank you for your consideration.

Sincerely,

Crystal Bryan Chief Clinical Officer

I am the Lead Pharmacist at the Multicare Medication Management Clinic in Gig Harbor. In this role, I manage diabetes medication therapy and anticoagulation therapy for my patients. I am honored to have the opportunity to use my doctorate-level degree, with its focus on medications and the diseases they treat, to help these people improve outcomes and their quality of life. However, due to the limitations of Collaborative Drug Therapy Agreements (CDTA), I am unable to provide full care to these patients. For example, many of my diabetes patients also need help with hypertension management. Without a specific CDTA, I am unable to address this issue. I must remain focused on diabetes management.

The extensive medication training that pharmacists receive, and our track record of consistently providing safe, high-quality care, puts us in a unique position to work collaboratively with other members of the medical team to optimize patient care. House Bill 1520 will provide an eased in approach to allow pharmacist prescribing and diagnosis within standard of care expectations. I am hopeful that you will support this bill and express your support to the House Health Care and Wellness Committee. I also hope you will support a hearing on this bill.

Please let me know if I can provide any additional information.

Jeannette B Quimby, PharmD

I am writing on behalf of Goldendale Pharmacy to provide support and comments for the Sunrise Review of the Pharmacists Scope of Practice.

I own and operate an independent pharmacy in rural central Washington. This area has limited medical services, with a small family practice clinic and a critical access hospital as the only other healthcare for more than 35 miles. At our pharmacy we provide a number of medical services for our community, including testing and treatment for acute conditions such as flu, covid, strep throat and urinary tract infections and more. We are also able to help provide continuity of care for patients recently discharged from a facility by writing prescriptions for emergency refills until they are able to get an appointment with a regular provider. We also help to protect the community through a robust vaccination program.

Our pharmacists provide this care through additional certifications and training to stay current on guidelines. This is a responsibility that we do not take lightly but based on our doctorate level education, combined with regular continuing education we are fully qualified to prescribe in these situations. The

practitioners we collaborate with trust our clinical decision making and allow us to practice with limited oversight.

While CDTA's currently do provide the ability to provide these services, it is increasingly difficult to obtain CDTA's. Finding an independent provider is very difficult. Providers that are part of a health system are often contractually unable to sign agreements, which then drastically limits the number of providers that can sign. Often the providers that are able to sign are at or close to retirement which doesn't allow for any longevity to the pharmacist provider relationship, and requires the pharmacist to find new partners regularly. Then, when one is found, the fees are often prohibitive. For a new service that may take some time to get up and running at scale, it may not make financial sense for a pharmacy to offer it just because of the initial cost of the CDTA. Without the challenges and costs associated with obtaining a CDTA we would be better positioned in the future as public health needs change over time to be able to pivot and assist our communities in a timely manner.

Over the years that I have been providing this service, I have had the opportunity to help a child that was having an asthma attack receive an inhaler helping to prevent the need for an emergency room visit, after hours when the primary care clinic was closed and unable to provide a refill. I have helped countless women be able to get urinary tract infection treatment over a weekend, being able to prevent escalation of the infection by treating at the onset. Mental health patients that are discharged from facilities without sufficient medication were able to remain stable until their next appointment which are notoriously difficult to get in a timely manner. All of these interventions were communicated back to the primary care providers office, ensuring that all providers are informed. While these are wonderful stories of patients that have received safe and effective care at the pharmacy, I am also trained to know when a patient is beyond my scope, and have been able to successfully triage a patient into their providers office as needed. Often with the addition of a referral from the pharmacist who is trained to treat they are able to get an appointment faster with the referral further improving the outcomes of the patient even if the pharmacist is unable to treat. It is this collaboration and working together to care for a community that provides the best care for all patients.

Thank you for your consideration.

Jacqueline Eide, PharmD Pharmacy Owner

In response to regulating pharmacist prescribing outside of a collaborative drug therapy agreement (CDTA):

I collaboratively wrote 100s of prescriptions with an MD in direct consultation- clinically- concerning best medication therapy- for about 9 years. After consulting with the MD and convincing him of the best medication for the etiology and symptomology and labs for the patient, and patient statistics, along with literature referencing, I wrote the prescription only for reference. I then had the MD send by Surescripts a prescription "covering" my "reference prescription" for the Prescription File. This may be a better system so that the pharmacy is covered, the patient will know it was an Rx by the Doctor, and the Pharmacist will know he has done the best for medication therapy management along WITH the doctor.

Paul Naber, Pharm, Consultant Pharmacist

I am writing on behalf of Acts Pharmacy and Healthcare Services to provide support and comments for the Sunrise Review of the Pharmacists Scope of Practice.

At Acts Pharmacy, our pharmacists play a critical role in patient care by providing medication therapy management (MTM), travel health consultations, immunizations, and HIV PrEP services. Under a Collaborative Drug Therapy Agreement (COTA), we assist in prescribing and managing medications, but the need for a prescribing provider presents ongoing challenges.

Challenges with CDTAs & Need for Independent Prescribing

Key barriers to expanding pharmacist prescribing include the difficulty finding willing prescribers, administrative upkeep, and the cost of compensating collaborating prescribers. These factors increase operational costs, limit patient access, and restrict the reach of pharmacist-drivencare, particularly in underserved areas.

- Immunizations: Despite pharmacists administering vaccines for decades, we still depend on CDTAs to provide them. This adds unnecessary administrative burdens and limits access to immunization services.
- HIV PrEP: While pharmacists at ACTS Pharmacy are fully equipped to manage HIV pre-exposure prophylaxis (PrEP), we rely on a COTA with a prescriber to authorize the prescribing. Finding and maintaining a prescriber collaborator presents ongoing challenges, leading to delays in patient access and additional administrative work.
- Travel Health: We administer travel vaccines but cannot prescribe essential travel medications (e.g., malaria prophylaxis, traveler's diarrhea treatment) without a prescriber, delaying patient care.
- Chronic Disease Management: We have partnered with the washington State Pharmacy Association (WSPA) for a Self-Blood Pressure Monitoring Program, but the shortage of available prescribers has delayed full implementation. Pharmacist-led chronic care services could fill this critical gap, especially in hypertension, diabetes, and lipid management.

Safe & Effective Care Model

Our pharmacists are highly trained, follow evidence-based guidelines, and have a proven track record of safe patient care. We recognize the need for physician referrals when necessary, ensuring a structured and secure approach.

Lessons from Other States

In Idaho and Oregon, pharmacists have independent prescribing authority, leading to improved patient outcomes, reduced treatment delays, and increased healthcare accessibility. These states have successfully implemented policies ensuring safe pharmacist prescribing while maintaining regulatory oversight.

Conclusion

Expanding pharmacist prescribing authority in washington would help address healthcare provider shortages, streamline patient care, and improve access to essential treatments, aligning with public health priorities

Thank you for your consideration.

Jazel Jane M. Bautista, RPh
Pharmacist-Owner

This email is response to pharmacist scope of practice from a Washington State psychiatrist point of view.

1. A brief screen of psychiatrist currently practicing in Washington state, only one had been approached about a CDTA, most didn't know much about it, and almost none had seen anything about it while searching for employment or during current employment. Psychiatrist likely are not getting asked about them. If pharmacist are looking for psychiatrist assistance please contact the Washinton Psychiatric association, Washington State Medical Association, or one of our regulator boards and they can assist.

2. While access to care is commonly cited as the most urgent mental health need, Washington state has a profound problem with psychotropic polypharmacy, psychotropics being used for non-FDA approved / evidenced based indications, and rampant overuse of controlled substances when they are not clinically indicated. More research is needed to fully understand the scope of the problem but the imminent dangers are obvious to anyone in clinical practice. Knowing pharmacist education, I empathize with them being forced to fill some of these medication combinations. Pharmacist are in a good position to help with this problem. My suggestion is as follows FIRST, empower and encourage pharmacist to not fill inappropriate medications through legislation, and change in physician, nurse, physician assistant, and pharmacy education with a main clinical focus of reduction of polypharmacy. After this safeguard is in place, grant increased independent prescriptive authority for a few psychotropics for areas w/ greatest clinical need (prescribing and continuation of Long acting injectables for schizophrenia, vivitrol for alcohol use d/o and opiate use d/o, refills of psychotropics for schizophrenia and bipolar, and suboxone for opiate use d/o).

3. 90% of mental illness can be effectively treated without medication and 1st line evidenced based treatment is therapy. While patients often want medications first we need to be better about saying no. Physicians, nurses, and physicians assistants are frequently prescribing before trying evidence based therapies. Adding another independent prescriber to the state with decreased education in diagnosis and therapy is likely to compound the problem we are already facing.

4. The following is the group that is most at risk of being inappropriately treated without carefully weighing risks/benefits of expansion of scope: those under 18, those over 65, those with serious mental illness (schizophrenia, bipolar, eating d/o), those with treatment resistant mental illness (OCD, comorbid personality disorder, tx-resistant depression/anxiety/psychosis), those with severe comorbid medical conditions, and females during menarche, peripartum, postpartum, breastfeeding, and menopause.

Thank you for your time.

Kevin McLean D.O.
Adult Psychiatrist

I am in strong opposition to House Bill 2116, which would expand prescriptive authority for pharmacists. This bill exceeds their scope of practice and education. Furthermore, I am also in opposition of the precedent this would set in our state for this level of legislative delegation of authority for setting scope of practice to a board or commission.

Bryce Robinson, MD, MS, FACS, FCCM
Professor of Surgery, University of Washington
Associate Medical Director, Critical Care, Harborview Medical Center

---

I oppose House Bill 2116, Expanding prescriptive authority for pharmacists.

I work closely with pharmacists across Washington state in their pharmacy practices, teaching pharmacy students and trainees, and conducting clinical and health services research with outstanding pharmacy professional leaders.

PharmD pharmacists do not have the foundational education, practical training, or clinical experience necessary to carry out the expanded practice suggested by Bill 2116. They do not have the knowledge, experience, or facilities to take on these extra patient care responsibilities. There is nothing in the bill that remedies these deficiencies or proposes required training or programs to meet the minimal standards of care in Washington state.

There's nothing in House Bill 2116 that advances team-based healthcare.

William R . Phillips, MD, MPH
Clinical Professor Emeritus of Family Medicine, UW School of Medicine
Past Clinical Professor of Epidemiology, UW School Public Health
Past Clinical Professor of Health Systems and Population Health, UW School Public Health
Past editor, Annals of Family Medicine
Past member, US PREVENTIVE SERVICES TASK FORCE
University of Washington

As a physician in the state of WA I am writing you in opposition of House Bill 2116, which would expand prescriptive authority for pharmacists. The bill, brought forward during the 2024 legislative session by the Washington State Pharmacy Association, would move our state away from the collaborative drug therapy agreement currently being utilized and would instead grant the Pharmacy Quality Assurance Commission the ability to determine a pharmacist's prescriptive authority. We are not aware of any precedent in our state for this level of legislative delegation of authority for setting scope of practice to a board or commission.

Thank you for considering this problematic expansion of prescriptive authority.

Jeffrey L. Evans, MD
SMG Urology

It has come to my attention that the pharmacists in this state want to start prescribing medication.

That is absolutely insane.

If a pharmacist wants to prescribe medications he/she can attend/graduate from medical school, and then he/she can prescribe medications.

I implore you to stop this insanity. It is criminal enough that naturopaths can already prescribe medications in WA state. That is truly mind-boggling as well, as they too haven't actually attended a real medical school.

Please stop the insanity.

Joshua Cooper, MD, FACS
Plastic & Reconstructive Surgery
Sound Plastic Surgery

I wanted to reach out about House Bill 2116 regarding prescriptive authority for pharmacists. While I understand what the original intent was with this bill, I do not think that as currently written it would provide a safe and comprehensive health management plan for patients. Our system is disjointed as is, and allowing prescriptive authority likewise could lead to patients receiving partial treatments, wrong treatments, or unintended treatment side effects.

Andrew Liechty, MD

I am writing to voice my concerns and opposition to House Bill 2116. The act of prescribing medications is inherently part of the practice of medicine. Pharmacists are not physicians or healthcare providers. While they have extensive knowledge of drugs and pharmacology, they are not trained in diagnosing or managing diseases or health problems. This would put patients at unnecessary risk. Pharmacists are already overworked in their current role, and do not have the bandwidth for this additional role that they are not trained or licensed to provide.

There are no specifically stipulated additional education or training requirements for pharmacists providing these services.

I have concerns not limited to patient safety and care coordination, as this proposal doesn't include any meaningful safeguards. Furthermore, the Legislature—not a regulatory board—is responsible for setting a profession's scope of practice, and this bill would set a precedent for both the practice of pharmacy and other professions.

Please stop this travesty before Washingtonians are harmed by this I'll advised proposal.

Brett M Schmitz MD MPH, Clinical Instructor
Department of Family Medicine | UW Medicine Urgent Care Ravenna Clinic

---

I write to strongly oppose the proposal to sunrise House Bill 2116 brought forward by the 2024 legislature to expand the prescriptive authority of pharmacists in Washington state for the following reasons.

1) There are no specifically stipulated additional education or training requirements for pharmacists providing these services. Pharmacists generally lack the education and experience to diagnose or evaluate health conditions, yet this bill would allow them to modify treatment for chronic conditions and manage emergency situations.
2) Allowing this authority for pharmacists would disrupt care coordination between the physician and patient, and also risk patient safety.
3) There are no meaningful safeguards in the bill
4) The legislature, not a regulatory board, is responsible for setting a profession's scope of practice.

Paul Williams MD

As a physician, I am opposed to granting pharmacists expanded prescription authority. Per WA HB 2116: "The list of providers who may prescribe legend drugs and controlled substances is amended to reflect the expansion of pharmacist prescribing as authorized by rule."

Passage of this bill would set a negative precedent and likely endanger patients and the public in general. This would also discourage growth of the MD and DO numbers that are in need of positive support.

V/R,
Howard L. Wong, MD

I am writing in response to House Bill 2116. I am a pediatrician in Washington State.

Pharmacists play an incredibly important role in healthcare. They are they experts in understanding how drugs function as well as dosages and interactions. However, pharmacists are not trained in diagnosing or treating health conditions. While this bill proposes pharmacists treat "minor ailments" how do they classify what is minor? Is this a small medical problem that is really part of a more serious diagnosis? Does this patient have a chronic medical problem that makes this "minor ailment" more serious? A pharmacist is not trained to answer these questions. In addition they should not be "initiating and modifying treatment for chronic conditions." Pharmacists are not trained in complex and chronic medical conditions and do not fully understand how different medical problems may interfere with our treatments or conditions a patient may have. Understanding these questions and the management of medical conditions are far outside of a pharmacists scope of practice. Allowing pharmacists to practice outside of their scope of practice will put Washington patient's health at risk.

Allison Maidman, MD

As we look for ways to increase access we must keep patient safety, scope of practice, and the complementary roles those of us in healthcare can provide one another. As a physician and physician educator I immensely value the team role a pharmacist plays. In fact, in 1994 I wrote a HRSA grant to

embed a pharmacist into my former residency program and 30 years later that role is still there – and still invaluable.

Yet I do not support HB 2116 as it would move our state away from the collaborative drug therapy agreement currently being utilized – and which is not broken. Further, granting the Pharmacy Quality Assurance Commission the ability to determine a pharmacist's prescriptive authority would set precedent for a board or commission to have the authority to set scope of practice to a board or commission. Although messy, removing legislative oversite would have unintended consequences.

I know how much more I had to learn after 7 years of medical school and residency. I don't see where in 4 years of pharmacy school the educational content for pharmacists to treat "minor ailments, initiating and modifying treatment for chronic conditions, providing preventative care, and managing emergency situations that present in a pharmacy" occurs. There are no additional education or training requirements for pharmacists to provide these services.

In the precepting room there is a conversation between the pharmacist, attending physician, resident, and patient to make those interventions.

Russell Maier, MD FAAFP, Associate Dean for Graduate Medical Education
Pacific Northwest University of Health Sciences

They do not have the appropriate training to do this obviously. I would never allow any pharmacist to treat anyone I cared about. I know as I was in the pharmacy D training before I became a doctor. Don't let this happen.

Patricia Coyman

I am writing to comment on House Bill 2116. I am in opposition of this bill. I am a boarded and licensed Washington state physician anesthesiologist who works daily on a first-hand basis with medications, including dosing, titrating, and managing the consequences on patient health and care.

I have significant concerns over the prescriptive power of pharmacists, since they are not medically trained, experienced, boarded or licensed. Pharmacists do not undergo the same medical training and licensure requirements as physicians. Pharmacists do not have the same scope of practice as physicians. This would result in unsafe patient care due to inability of pharmacists to balance patients' comorbidities and safety profiles, to perform appropriate medication selection, as well as medication titration and monitoring. Finally, pharmacists are not legally required to follow up in clinic with patients, and would not be able to appropriately manage the downstream effects of medications on patients' health. Medication error and inappropriate prescriptions and dosing without proper follow up can cause significant harm to patient's lives, organs, and limbs. In turn, this bill would cost more health care dollars due to preventable patient hospitalizations.

Opposition to House Bill 2116.

Priscilla Huang

I agree with extremely limited prescribing by pharmacists—ie, only in the case of a limited supply of refills when the clinician isn't reachable. Otherwise, pharmacists don't have the years of training and experience and judgment that come with advanced training as a physician/ARNP, and should not have the right to prescribe medication.

I think many ARNPs miss the mark when it comes to prescribing, and they have much more training than pharmacists!

Sara Lerner, MD
Psychiatrist
Olympia Mental Health & Wellness
Kaiser Permanente of Washington

I am a neurologist in Sonohomish county. I think expanding pharmacist prescriptive authority will bring about chaos in the care.

Even without pharmacist changing medication, when there is multiple care providers, prescription disagreement and error arise and lead to unwanted hospital admissions which cost the health care.

I had an incident where nursing home facility tried to change medication which made no sense. It was in conjunction with pharmacist , and this one nurse practitioner decided to change medications for this demented patient who is having hallucination. And the direction they were going was actually making hallucination and agitation worse leading to hospitalization.

Pharmacist having more prescription right will lead to "belief" based medicine as opposed to "evidence" based as they lack training.

I think this is very dangerous.

Duk Soo Kim, DO | OptumCare Washington
Movement Disorders Neurologist

I have concerns about the current bill giving pharmacists the authority to diagnose and treat patients, both with acute and chronic conditions.

The proposal allows pharmacists to diagnose and treat "ailments, initiating and modifying treatment for chronic conditions... and managing emergency situations that present in a pharmacy."

There are no additional training requirements to provide diagnoses through history and physical exams, diagnostic tests, nor longitudinal care.

As an emergency physician and physician leader for more than 20 years in Washington State, I've seen ailments that are considered minor result in life-threatening events.

Washington residents deserve to be diagnosed and treated by a physician or a physician-led team. There is no safer alternative.

Additionally, this proposal doesn't include any meaningful safeguards. Furthermore, the Legislature—not a regulatory board—is responsible for setting a profession's scope of practice, and this bill would set a precedent for both the practice of pharmacy and other professions.

Pete Mikkelsen MD
Chief Medical Officer
Medical Director of Emergency Services
Pullman Regional Hospital

House bill 2116 contemplates pharmacists treating "minor ailments, initiating and modifying treatment for chronic conditions, providing preventative care, and managing emergency situations that present in a pharmacy." There are no specifically stipulated additional education or training requirements for pharmacists providing these services and thus is concerning for patient care. I would like to voice my opposition to this bill.

Abigail Laudi MD

I am writing in opposition to the proposal in HB 2116, which would expand prescriptive authority for pharmacists. The bill would move our state away from the collaborative drug therapy agreement currently being utilized and would instead grant the Pharmacy Quality Assurance Commission the ability to determine a pharmacist's prescriptive authority.

The proposal contemplates pharmacists treating "minor ailments, initiating and modifying treatment for chronic conditions, providing preventative care, and managing emergency situations that present in a pharmacy." There are no specifically stipulated additional education or training requirements for pharmacists providing these services.

I have concerns not limited to patient safety and care coordination, as this proposal doesn't include any meaningful safeguards. Furthermore, the Legislature—not a regulatory board—is responsible for setting a profession's scope of practice, and this bill would set a precedent for both the practice of pharmacy and other professions.

Please reconsider the ramifications of moving forward on this bill and I strongly urge you to vote no on HB2116.

Alexis David, MD
Diplomate, American Board of Obesity Medicine
Diplomate, American Board of Family Medicine
Premier Medical Weight Management, www.premiermwm.com
Past President, Washington Obesity Society
Seattle Met Top Doc 2024, Obesity Medicine

I am opposed to passage of House Bill 2116 regarding expanding independent prescriptive authority for pharmacists.

1) There is already a shortage of qualified pharmacists at retail pharmacies in our state and adding to their potential burden of increased contact time for consumers and patients does not promote improved health care and slows down an already overburdened pharmacy team which I have experienced as a patient seeking prescription renewals or insurance approval resolution.

2) I am a physician licensed in Washington State and I do not believe the training required to validate a patient's symptoms, current medication, and prior health conditions is within the presumptive training of pharmacists.

3) This is a legislative / regulatory proposal which will further deteriorate and overburden an already insufficient health care delivery resource (pharmacists) while unjustifiably expanding their prescriptive authority beyond their competence. Please oppose this legislation

Thank You
Richard McGee, MD

Dear DOH, I am writing to register my opposition to broadening the prescriptive authority of pharmacists as sought in House Bill 2116. Only the Legislature should be able to modify this authority. Thank you.

John T. Collier,MD

Please oppose Bill 2116. Pharmacists do not have the training to diagnose or alter treatment plans.

Dr Christina Lyons | Dermatologist | Dermatology
PeaceHealth

I am writing to express my strong opposition to House Bill 2116, which proposes to grant the Pharmacy Quality Assurance Commission (PQAC) broad authority to define and expand the prescriptive scope of pharmacists in Washington State.

While I appreciate the intent to improve access to care, this bill raises significant concerns regarding **patient safety, accountability, and legislative oversight**.

Most notably:

Legislative Overreach: HB 2116 delegates an unprecedented level of authority to a regulatory board to determine the scope of practice for an entire profession. This is a responsibility that has historically—and appropriately—been reserved for the Legislature, with direct public input and deliberation.

Lack of Safeguards: The bill allows pharmacists to prescribe medications for minor ailments, chronic conditions, preventive care, and emergencies without specifying any baseline standards for **additional education, clinical training, or credentialing**. Without these safeguards, there is a real risk to patient safety and fragmentation of care.

Care Coordination Risks: Expanding prescriptive authority without clear integration into a broader care team may compromise **continuity of care** and increase the potential for misdiagnosis, medication errors, or duplicated therapies—particularly for patients with complex or chronic conditions.

Precedent for Other Professions: Allowing a regulatory board to unilaterally define and expand scope of practice sets a concerning precedent that could lead to similar changes across other professions, bypassing the legislative process and reducing public accountability.

For these reasons, I urge the Department of Health to **recommend against this proposal** and instead support collaborative, evidence-based approaches to expanding access while maintaining high standards for patient care and safety.

Thank you for considering this input.

Sincerely,

Andrew Elizaga MD
Pacific Anesthesia

My name is Dr. Roberta Trandev. I am a physician, hospitalist at St. Micheal's Medical Center in Silverdale, WA. I am writing to express my concerns regarding the proposal to expand independent prescribing/treatment authority for pharmacists, as outlined in House Bill 2116 and the associated Washington State Pharmacy Association (WSPA) applicant report.

While I value the essential role pharmacists play in our healthcare system—particularly in dispensing medications, providing medication counseling, and supporting treatment adherence—I do not support expanding their role to include diagnosing and independently prescribing medications outside of collaborative agreements with licensed medical providers.

The core of my concern lies in the **scope and depth of pharmacists' clinical training**. Pharmacists are highly trained in pharmacology and therapeutics, but their education and practical experience, particularly in outpatient and community settings, do not generally include comprehensive training in **whole-patient evaluation**, **extensive medical history-taking**, **physical examinations**, or **interpretation of labs and diagnostics**—skills fundamental to making safe and effective prescribing decisions. These are areas in which physicians and physician assistants undergo rigorous, hands-on training designed for direct patient care.

While pharmacists in hospitals may work in multidisciplinary teams and have access to detailed patient records, that is often **not the case in most community pharmacies**, where limited access to diagnostic data, labs, and patient history can increase the risk of fragmented or inappropriate care. Pharmacists should instead be empowered to continue playing a collaborative role by offering recommendations and referring patients to appropriate medical providers when medication needs arise.

In addition to patient safety concerns, I urge policymakers to carefully consider the **cost and infrastructure implications** of this proposal:

- What are the **training requirements** and associated costs for pharmacists to safely assume this expanded role?
- Will pharmacists be required to obtain **malpractice insurance** equivalent to that of other independent prescribers?

- How will pharmacies accommodate the **physical and logistical needs** for private consultations, examinations, and documentation?
- Will this create a system dominated by **large private pharmacy groups**, potentially excluding smaller or rural practices?
- **What is the administrative burden** of running and regulating this initiative—and is that factored into the projected cost savings?
- **What is the expected timeline** to have all systems in place to operationalize this expansion safely and effectively?
- How will services be **reimbursed**? What portion of these costs will be passed on to **insurance companies, Medicare, Medicaid**, or directly to **patients**?

I also urge you to consider whether this proposal is necessary **at this moment in time**, given the **rapid technological advances** reshaping how we deliver care—especially in rural communities. If access to care is a key driver of this proposal, then we should be investing in **telemedicine infrastructure**, **mobile clinics**, and **digital tools** that extend the reach of licensed medical providers without compromising clinical standards or continuity of care.

We are already grappling with an overburdened and inefficient healthcare system. Adding **another layer of complexity**, regulation, and responsibility—especially one that may blur lines for patients—risks creating more confusion, not less. The lower cost of pharmacy services alone should not be the main driver of a systemic shift, especially when we **do not yet have a full accounting of the real implementation costs** or long-term implications.

Let's not rush to expand human-powered infrastructure when **technology-enabled models** could achieve similar goals more sustainably. I respectfully urge you to consider **stopping or delaying this proposal for several years** to allow time for a more comprehensive, forward-thinking approach to emerge.

Sincerely,
Roberta Trandev, DO

My name is Dr. Rudo Ambayi, a hospitalist with significant concerns regarding the proposed expansion of pharmacist prescribing authority. While I deeply respect the expertise and valuable contributions of pharmacists, I have reservations about the potential implications of this legislation on patient care and provider-patient relationships.

My primary concern centers around the maintenance of comprehensive and coherent medical records. Will the proposed framework ensure that pharmacists' interventions are thoroughly documented in a manner accessible to the treating physician? The lack of clear documentation could compromise continuity of care and potentially lead to adverse events due to conflicting treatment plans or missed information.

Furthermore, I question the mechanisms for effective communication and collaboration between pharmacists and physicians. Will there be a mandated system for pharmacists to proactively discuss medication changes with the prescribing physician, ensuring alignment with the patient's overall

treatment strategy? The absence of such a system could lead to unintended medication interactions or deviations from established care plans, potentially resulting in patient harm.

My most serious concern revolves around the potential for pharmacists to override existing treatment plans. This raises questions of clinical authority and patient safety. Disagreements between the pharmacist and the physician regarding the appropriate course of treatment could lead to confusion and distrust amongst patients, ultimately undermining their confidence in their healthcare team. While pharmacists' expertise is invaluable, overriding a physician's prescribed treatment without direct consultation could result in negative outcomes and jeopardizes the physician's ability to provide holistic care.

I urge you to carefully consider these concerns and reconsider the passage of this bill in its current form. A more robust framework addressing documentation, communication, and oversight is crucial to ensuring the safety and well-being of our patients. I am available to discuss these issues further at your convenience.

Sincerely,

Rudo Ambayi, MD

I am writing in opposition of HB 2116, which would expand prescriptive authority for pharmacists. The bill, brought forward during the 2024 legislative session by the **Washington State Pharmacy Association**, would move our state away from the collaborative drug therapy agreement currently being utilized and would instead grant the Pharmacy Quality Assurance Commission the ability to determine a pharmacist's prescriptive authority.

Clinical pharmacist training is almost entirely medication focused, and mental health diagnosis and treatment is far more complex that medications. In WA state we already struggle with symptom-based prescribing of medications that comes from advanced practice providers, which leads to side effect burden and polypharmacy for patients, and also increases the cost to both them individually, and as a system, for those on state and federal aid. Allowing clinical pharmacists to operate without appropriate clinical oversight from a physician is a safety risk. This puts patents at risk because their treatment is primarily focused on medications, which is not the answer for many of our patients with complex mental health conditions.

This is also a quality and parity issue that those who are vulnerable are going to get the least qualified persons to treat them. Instead, there are other solutions to the problem of access including integrated behavioral health expansion, expansion and permanent implementation of telehealth that allows patents to attend visits from their home rather than from the physician's office. I encourage you to consider the negative impact on patients in our state from this proposal and urge you to oppose it.

Tanya Keeble MD
Division Lead, Behavioral Health
Providence INWA
Sacred Heart Medical Center

As a physician who helps train clinical pharmacists, I am made aware nearly daily of their lack of education on anatomy, physiology, and the many clinical intricacies of physician practice. Allowing them the ability to prescribe without the basic groundwork will result in exceptional patient morbidities and even mortality, especially vulnerable populations such as transplant, where my main practice is. As such, I would oppose any expansion in their prescribing scope, both on behalf of my patients, and for myself and my family.

Many thanks,

Jared Brandenberger

Proposed legislation in Washington House Bill 2116 would confer prescriptive authority to pharmacists licensed in Washington. I am writing to firmly oppose this proposal as a serious threat to patient's health and safety as well as a dangerous precedent which will further erode our already endangered health care system.

My professional background is that of a Pulmonary and Critical Care physician who has practiced in Washington now for 30 years. I have served as the chair of both Credentials and Peer Review committees at major hospitals in Washington and was the director of Critical Care Services for PeaceHealth in Vancouver for many years. I have been on the faculty of both Oregon Health Sciences University and the University of Washington School of Medicine. As an Intensivist in the ICU, I was part of a multidisciplinary team which included residency trained PharmD pharmacists. I personally championed the creation of this team and its collaborative model beginning more than 20 years ago. The level of collaboration between physicians and pharmacists in the ICU was unmatched compared to all other areas of the health system. Pharmacists served as important experts in designing efficient and evidence-based order sets which facilitated high quality and safe care of our most seriously ill patients. I could not imagine practicing Critical Care medicine or managing any complex patients without the availability of an experienced and residency-trained pharmacist any more than I could imagine doing so without nurses or respiratory therapists.

During my career I have encountered a broad spectrum of expertise and knowledge on the part of the pharmacists I've worked with. As with physicians, not all pharmacists are equipped by experience, training, or their fund of knowledge to contribute to caring for complex patients. The proposed legislation, HB 2116, would grant the Pharmacy Quality Assurance Commission the authority to confer prescriptive authority to any Washington licensed pharmacist for any and all medications and devices as deemed appropriate by the PQAC independent of any other regulatory bodies. Without any formal training or experience in Medicine such as that which physicians acquire during 4 years of medical school followed by internship, residence and, in some cases, fellowship, pharmacists could independently initiate and modify the treatment of acute and chronically ill patients without guidance or input from physicians. This is a dangerously ill-conceived and shortsighted plan which will end very badly for many patients.

The extreme shortage of primary care physicians in Washington and across the nation is a result of several similarly shortsighted decisions over the last few decades. One such decision was to create a role for independent practice nurses on par with that of a residency trained physician in Internal Medicine or Family Medicine. This has created a health care system that views residency trained primary care

physicians and advanced practice nurses as interchangeable commodities with financial incentives favoring the use of nurses in this role. Only in the United States has such a model been adopted. It should interest the Department of Health to look outside the US and consider why no other developed country is turning to nurses, and now pharmacists, to replace primary care physicians. The proposed legislation, HB 2116, would further blur and diminish what should be the central role of the primary care physician within the healthcare system. Why would anyone consider becoming a primary care physician and spend years accruing debts in medical school and postgraduate training only to step into a career which the Department of Health has opened to nurses and pharmacists with their abbreviated and less rigorous training.

In the case of House Bill 2116, the expanded role of pharmacists to treat patients without physician involvement would not be limited to that of a primary care physician. Entirely at the discretion of the PQAC, pharmacists could be allowed to prescribe any and all medications and devices, and thus treat all diseases. It is shocking that nowhere in the proposed legislation does the DOH explicitly acknowledge that prescribing a drug is more than just writing words and numbers on a piece of paper or entering an order into an electronic system. Perhaps it should be emphasized that treating a patient necessarily requires the prior establishment of an accurate diagnosis. This requisite first step of diagnosis is often the most challenging part of practicing Medicine but without it, prescriptive authority becomes a license to harm. Prescribing any treatment creates a responsibility to the patient for the appropriateness, effectiveness, and safety of the treatment. HB 2116 allows the PQAC to independently determine which pharmacists can prescribe which treatments without any involvement on the part of physicians who have been trusted with this exclusive responsibility ever since Washington became a state.

I strongly urge the Department of Health and the Washington House to withdraw this bill and begin anew on the important work of improving, and not further degrading, the healthcare of Washington residents.

William S McBride MD FCCP
Pulmonary and Critical Care Medicine

I am writing to express my concern and opposition to House Bill 2116, which proposes to expand prescriptive authority for pharmacists in Washington State.

This bill would remove the existing collaborative drug therapy agreement model and instead allow the Pharmacy Quality Assurance Commission to determine pharmacist prescribing authority. I am deeply concerned about the precedent this would set by delegating such a significant scope of practice decision to a regulatory board rather than the Legislature, which has historically held that responsibility.

Additionally, the bill allows pharmacists to treat minor ailments, initiate and modify treatment for chronic conditions, and manage emergency situations without any clearly defined additional education or training requirements. This raises serious questions about patient safety, care coordination, and accountability.

I urge the Department to consider the potential long-term implications of this proposal on both patient care and professional regulatory frameworks in Washington State.

Asa Tapley, MD, MSc

Pronouns: he/him/his
Acting Instructor
Division of Allergy & Infectious Diseases, Department of Medicine
University of Washington School of Medicine
Research Associate
Vaccine and Infectious Diseases Division, Fred Hutchinson Cancer Center

---

Hello, I am a primary care provider (NPI 1325492182) in Auburn, WA and oppose expanding pharmacist scope for prescribing ability. Given that prescriptions are written with the patient's medical background including lab results, chronic conditions, not to mention diagnosis in mind, I do not believe that pharmacists have access to the relevant information needed to safely prescribe independently.

IF pharmacist training were to be expanded first to include diagnostic ability and ability to interpret lab and imaging results, as well as pharmacists having access to patient medical records prior to prescribing, then something like this could be considered.

With their current level of training, I don't see how this can be considered safe.

Mark Garcia DO
Virginia Mason Franciscan Health

I am a community Pediatrician and correct diagnosis and prescribing in children is complex especially in our youngest patients. We are careful before jumping to a diagnosis as an MD and cautious about medication in children, advice and follow up care. It is not appropriate for the pharmacist to make diagnosis and especially continue medication that may have been purposely not refilled or continued as the child likely has new concerns or needs follow up care. I am sure this could happen in adult medicine as well.

Thank you ,

Erin Harnish MD FAAP
Community Pediatrician

As a primary care physician I have strong concerns and opposition to the expansion of pharmacy prescribing (outside of the current standard of collaboration with the pharmacist and the clinicians in practice).

This could give prescribing ability to a wide variety of people who may not have the training, knowledge or expertise to engage. This would be having a pharmacist practice medicine but without the same training as physicians and other health care clinicians.

Pharmacists are not trained in making diagnoses, initiating appropriate treatment for any conditions or long term management of chronic diseases.

Nor do they have similar practical training to physicians and allied health professionals to be able to recognize disease patterns and unique needs of each patient.

I have worked very closely with our pharmacists and feel the current collaborative standards are appropriate for doing good evidence based team-work and allowing everyone to work together for the benefit of our patients.

Giving prescribing capability to those not in collaboration with a physician (or APP) or expanding scope of practice can certainly cause harm to patients. Giving prescribing capability to those without the training or experience can harm patients.

Also there is very little evidence that expanding the scope of practice helps people access appropriate care or appropriate disease management and follow up .

Please OPPOSE HB 2116 for the health and well being and safety of our patients Thank you

Carrie Horwitch MD, MPH

I strongly urge you to oppose the WA House Bill 2116 that would expand prescriptive services to pharmacists. The current and long-standing patient / physician relationship is critical to make appropriate medication management decisions. Allowing pharmacists to prescribe medications without a clear clinical history, exam, and context in one's past medical history would certainly make medication prescriptions dispensed based on minimal information, perhaps solely a positive screening test. Please join me and many other physicians in opposition this ill sighted bill.

Regards, Jeff Ernst, MD

This bill would expand pharmacist's prescriptive authority and I OPPOSE it.

I am an ABIM certified MD who holds an associate professorship with the UW School of Medicine. I consult with 3 clinics, one of which is FM residency program where I precept residents and students. I have over 30 years of clinical experience. Although pharmacists are well trained in the science of medications, they are not clinicians. Over the years, well intending pharmacists have made medicine recommendations that in theory can be correct, but were not appropriate for the particular patient and their medical issue. There is an "art" to clinical medicine obtained by being trained and pacticing clinical medicine. Pharmacists are not trained in this manner and not practicing with patients. They are not the best to make clinical medical decisions.

I recommend the current policy to assess each pharmacist and their relationship with a medical provider and use a collaborative drug therapy agreement be continued.

I oppose HB 2116 giving pharmacists independent presciptive authority by other pharmacists.

Tavis Taylor MD, ABIM

This should not occur without at least a year of additional training and then their liability insurance should be required to equal that of MD/DOs. Too many chances to assume a simple problem when it is

the beginning of a very serious problem. Followup cannot be deflected to physicians and middle levels once treatment has been initiated.

Margaret MacLeod

Im a physician assistant and just like the Naturopath expansion bill Im against the expansion of scope of a pharmacist with this house bill above . Though Rph are such a valuable and educated person of the care team I do depend on heavily . Pharmacists are NOT clinicians . They don't usually lay hands on the patient have access to the lab data like LFT's (Liver function) and serum creatinine (kidney test)

Please consider a vote no on expansion of RpH in prescribing medications. I understand this is done often in Europe but that too is a totally different system.

Kristine Wessels PA-C

I disagree with the proposal to allow pharmacists to prescribe. Collaborative prescription agreements are working well, and I believe giving pharmacists independence in prescribing is a big mistake. Pharmacists are good at pharmacology but don't have the training to integrate patient clinical presentation/assessment with the best options. They will be good with guidelines but guidelines do not always have the best interest of the particular clinical scenario.

Guidelines must be interpreted very carefully by a trained clinician.

Jaime Novais, MD,MPH
Primary care and Geriatric Medicine

I am one of the licensed and practicing physician in WA state and also serve on WSMA board of trustees. I am writing to you today expressing my concerns about some specific points regarding limitations with pharmacists' training in practice of diagnosis and medical decision making needed to classify ailments as minor or major.

I am a primary care internal medicine physician. I have trained in the medical ICU and ER settings. I have treated several patients with critical manifestations of common illnesses. Urosepsis aka UTI turning into a severe blood stream infection, influenza ARDS, diabetic ketoacidoses, status asthmaticus, respiratory failure from COPD exacerbation are common ICU diagnoses. My training gives me the breadth of knowledge to identify from a patient with UTI that can go home with antibiotics from one who will need ICU. It also helps me assess an asthma patient with exacerbation with confidence and accountability that I know how to recognize when things progress, when to escalate care, and accountability in relationship to monitor care as a PCP. I also know which of my UTI patients are more likely to go into delirium, rapid afib, and heart failure, and DKA. I also know of that senior female patient who has atrophic vaginitis which feels like UTI but is not, got C diff from multiple antibiotics written by urgent cares.

Episodic care and administering treatment without a comprehensive evaluation for common conditions that present uncommonly are latent factors which compromise patient safety. A physician is trained in to classify UTI as complicated vs uncomplicated. This is the key first step which affects subsequent care plans. A wrong first step can set up a cascade of poor medical care, delays in diagnoses, and errors.

I value my pharmacist colleagues for their skills and knowledge, I trust and lean on them for advice if I need advice on vancomycin dosing, medication formulary exchange, warfarin anticoagulation. I account for my knowledge gaps and collaborate for patient safety.

Independent treatment by a pharmacist without a physician making the initial diagnosis in this care model compromises patient safety. Please utilize pharmacists for what they are trained for and physicians for what they are trained for. Technical workforce with a mismatched skill set in this critical industry is what is driving the worse outcomes despite mega expansion of workforce.

Thank you for considering my humble opinion.

Anukrati Shukla MBBS FACP

I practiced rural Family Medicine in Othello and Moses Lake, WA for over 30 years. There needs to be a requirement for additional training regarding diagnosis and treatment of conditions pharmacists are allowed to treat. Also, there needs to be a requirement for pharmacists to communicate with a potential patients' Primary Care Physician/PA-C/ARNP about any care rendered or changes in care made. Pharmacists should also be responsible for entering immunizations given into the State data base. This was particularly frustrating as they would send a fax to my office and expect me or my staff to enter the information into the data base; there was no revenue sharing to cover the cost of this labor/effort. There are current discrepancies in the data as my wife recently discovered pertaining to immunizations administered by a pharmacist. If pharmacists want an increased scope of practice, they must assume the responsibilities that come with that and any changes in policy or law need to reflect that.

Best regards,

Randel S. Bunch, MD

I have concerns about this BIll.

I are not aware of any precedent for this level of legislative delegation of authority for setting scope of practice to a board or commission.

There are no specifically stipulated additional education or training requirements for pharmacists providing these services.

I have concerns not limited to patient safety and care coordination, as this proposal doesn't include any meaningful safeguards. Furthermore, the Legislature—not a regulatory board—is responsible for setting a profession's scope of practice, and this bill would set a precedent for both the practice of pharmacy and other professions.

Thank you.

Rahul Khurana MD
Psychiatrist

As a physician who has had numerous interactions with pharmacists They have changed.

They don't understand simple prescriptions Call about everything Make no decisions They simply do not have the knowledge to treat patients. Many times the pharmacist have hindered care and Given faulty advice.

Where is the medical training ?

Where are the safety checks?

Where does the liability fall?

Physicians should practice medicine

Not untrained pharmacists, this is dangerous for all of us.

Teresa Girolami MD
Bel-Red Internal Medicine, PLLC, Founder and CEO

I am writing in opposition to House Bill 2116. Allowing the Pharmacy Quality Assurance Commission the right to determine the extent of a pharmacist's prescriptive authority would lose the present safeguards on scope of practice and open the door to a pharmacist making inappropriate decisions, in the absence of the range of information (including lab work and physical findings as well as history) that help to inform the decisions by licensed physicians, osteopaths, and advanced practice clinicians.

I think our population would be less safe if this bill passes.

Thank you for your attention,

Elizabeth Wise, MD

I am writing, as a physician, to oppose expended pharmacist prescribing as proposed in House bill 2116.

It does not provide measures for patient safeguarding or coordinating care, among other concerns.

Thank you,

Susan Hakeman, MD

I am writing in support of SB1690 to add pharmacist prescribing privileges according to rules promulgated by the Washington Pharmacy Quality Assurance Commission (PQAC). There has been a long history of delegated prescribing by pharmacists through Collaborative Drug Therapy Agreements (CDTA) in Washington State with Physicians, Physician Assistants, and Nurse Practitioners. In fact Washington was the first state in the USA to allow pharmacists to prescribe.

Since then multiple states have adopted this framework, and now all states permit this practice in various forms. All branches of the military under the Department of Defense, the Department of Veterans Affairs, the US Public Health Service, Indian Health Service, and US Department of Corrections all permit this type of pharmacist prescribing.

In addition to dependent prescribing there is also the practice of autonomous or independent pharmacist prescribing. Where permitted by state, provincial, or national government regulatory agencies are also becoming more common. This is not a new practice, be it in England, Scotland, Wales, New Zealand, Queensland Australia, or Alberta Canada. Many other states in Australia are considering similar moves as are most of the provinces in Canada. Several other regions in Europe are exploring this well.

Autonomous prescribing by Advanced Practice Pharmacists (APP) in California is already permitted under regulations of the Board of Pharmacy. Idaho also permits pharmacist autonomous prescribing when adhering to the laws and regulations overseen by the Board of Pharmacy.

Even as pharmacist practice evolves to permit autonomous prescribing, that does not mean there will no longer be collaboration between pharmacists and other healthcare professionals. In fact there is likely to be substantially more communication between other providers and pharmacists. Pharmacists are usually conservative by nature, and will want to be actively involved in a collaborative effort with other providers.

Some prescribing providers will be wary or openly hostile to the idea, fearing the unknown. Those providers who have personal experience with pharmacists in teams managing pharmacotherapy understand the benefits to patients.

Pharmacists are very likely to be involved in minor ailments prescribing with referral in more serious cases. Pharmacotherapy management of chronic conditions like diabetes, will typically occupy the focus of prescribing pharmacists. However, pharmacists will only prescribe in circumstances that they are trained and confident in their skills. Thank you for the opportunity to comment on this proposal.

Jason McCauley, PharmD

I am writing to voice my opposition to Bill 2116. As a physician it is important to understand the vast differences in training, education and experience between a physician and pharmacist and our roles in healthcare. If a pharmacist is going to treat and prescribe medications, they would need comprehensive training to diagnose as well. This is precisely what 4yrs of medical school followed by years of residency training are for…Bill 2116 is not the solution to increasing access. It just increases suboptimal care.

Dr. Michael Elliott, MD

I'm writing to express my opposition to the proposed legislation that would expand pharmacists' scope to prescribing medication and independently diagnosing or managing conditions. While the doctor shortage means that access to healthcare is impaired and it's frustrating to have such long wait times to see providers for appointments, relying on an individual who does not have the appropriate clinical training and hours to meet this need is not the way. Pharmacists are a valued part of the healthcare team and crucial to me being able to do my job safely, but asking them to provide healthcare in a way they're not trained for is unsafe and reckless.

Andrea Carnie, MD
Family Medicine Physician with Obstetrics

I oppose HB 2116.

It's not precedented or reasonable to delegate authority for setting scope of practice to a board or commission such as the pharmacy quality assurance commission.

Seth Scott MD
Family Medicine Physician
Med Safety Lead (Olympia, Tacoma)
Kaiser Permanente – Olympia

I oppose this bill that would allow pharmaceutical companies to

Acosta the ability to prescribe medications without first seeing a physician or APP. Pharmacists know drug interactions well but they do not care for patients clinically and do not have the appropriate training to prescribe medications to patients.

Sincerely,

Dr. Jennelle Marcereau D.O..

I have been a Washington State and national leader regarding pharmacist prescribing activities and I have spent a significant amount my career working in tribal health clinics working with complex drug therapy teams. For 30 years I have been a pharmacy professor at the University of Washington.

Medical team members repeatedly question why I, as the drug therapy expert on the team, was the only team member who didn't have my own prescriptive authority.

I strongly feel, however, that the two related bills introduced in this year's legislature, would have diminished, rather than expanded our State's pharmacy practice. They listed drugs/conditions that pharmacists could prescribe for, rather than allowing pharmacists to prescribe for all the medications they are trained to provide.

The reason that pharmacists in WA State are known nationally for rapidly and professionally responding to emerging medical needs, is that they don't have go back and ask the legislature to add permitted diseases and drugs...in the same way that physicians don't have to ask legislators to approve the conditions that they treat.

I urge the legislature to approve standard of practice pharmacist prescriptive authority in WA State without Legislative approval of specific and limited lists of drugs/conditions. Our patients deserve to have access to expert care without needing Legislative approval when the need arises.

Don Downing
Clinical Professor Emeritus
University of Washington School of Pharmacy

On behalf of Providence, thank you for the opportunity to submit feedback on the proposal to increase the pharmacist scope of practice.

Providence is a not-for-profit Catholic health care ministry committed to providing for the needs of the communities it serves – especially for those who are poor and vulnerable. In Washington state, Providence and our secular affiliated partners – Swedish Health Services, Pacific Medical Centers and Kadlec – comprise 15 hospitals, physician clinics, senior services, supportive housing, hospice and home health programs, care centers and diverse community services. In 2023, Providence and our partners provided $885 million in community benefit, including $632 million in unfunded costs of Medicaid and other government programs and $93 million in free and discounted care for Washingtonians who could not afford to pay. Together, we are working to improve quality, increase access and reduce the cost of care in all the communities we serve.

As the healthcare ecosystem struggles with workforce shortages across all roles, Providence strives to find creative solutions. Providence is supportive of this proposal as it would allow the Pharmacy Quality Assurance Commission (PQAC) to examine pharmacist scope of practice and expand it to let pharmacists utilize their license and education to their full extent and in a way that would improve access to primary care. Sites of care that incorporate pharmacists into their care teams, such as long-term care, would be able to tap into the pharmacist skillset to treat minor ailments instead of delaying care until that patient can be seen by a different provider.

After reviewing the proposal, we have the following considerations that, should the proposal ultimately move forward, we would like PQAC to take into account:

1. There needs to be close examination of the education, training, and expertise requirements to ensure patient safety.
2. Whether these practices will only be allowed at a subset of certain facilities where pharmacists are present or limited to specific services like primary care and behavioral health. Retail pharmacies could be good options for patients to seek this type of care, but are already stretched thin and adding increased walk-ins could demand resources they do not already have.
3. Reimbursement and billing for these services.
4. Unintended consequences with expanded scope – when one specialty is pulled over to cover gaps for a second specialty, sometimes a gap is created in the first specialty when there is not enough workforce to fill in. We do not want to accidentally create a shortage.

Additionally, given the expected breadth of work this rulemaking will cover and the importance of stakeholder input and deliberation, we request PQAC hold separate rulemaking workshops that allow for open discussion on concepts and draft language. PQAC typically holds rulemaking workshops within their regular commission meetings which does not usually allow for back-and-forth engagement with interested parties, and requests for comments on draft languages consistently do not allow for enough time for stakeholders to discuss and submit meaningful feedback.

Thank you again for the opportunity to comment on the proposal and the continued partnership to improve access for our communities. Please let us know if you have any questions.

Sincerely,
Lauren Platt McDonald

Chief State Government Affairs and Community Health Investment Officer - North Division
Providence

I am writing this letter from a perspective of public safety and concern for the future of healthcare as a dual board certified physician licensed in Washington State.

The initiative to expand the scope of prescriptive practice for pharmacists is not warranted based on their lack of medical education and applied clinical experience in the patient care setting.

Pharmacists are well-trained as medication experts. However, this knowledge does not make a pharmacist an expert in patient diagnosis or the formulation of a treatment plan. Therefore, it follows that a regulatory board comprised of members from the profession of pharmacy does not have the education and training to safely regulate how a pharmacist diagnoses and treats a patient.

Individuals without extensive training in patient assessment, differential diagnosis, and disease management cannot adequately regulate those who do. A pharmacist's education and training does not prepare a pharmacist to diagnose or treat medical conditions.

Prescribing a medication necessitates a preceding diagnosis to ensure appropriate care and effective treatment.

The ability to provide a diagnosis requires years of specialized medical training to assess complex and co-occurring symptoms, rule out serious conditions, and develop comprehensive treatment plans. A pharmacist has not undergone this medical training.

I sincerely hope that for the longevity of patient care and patient safety that this initiative does not move forward.

It takes a village to support patient care and pharmacists are an important part of the community infrastructure.

However, to maintain patient safety and appropriate use of medications that often require a depth of clinical understanding, nuance, years of training, education and coordination of care, pharmacists should not be given the same scope of practice as healthcare professionals who do.

Thank you for your time and consideration of this crucial matter.

Keira Barr, MD (she/her)
Center for Mind-Skin Medicine

As a medical doctor and surgeon, I am adamantly opposed to House Bill 2116. Allowing pharmacists to diagnose and treat medical conditions jeopardizes the health and well-being of Washingtonians.

Pharmacists have not gone to medical school. They do not have the training or experience to distinguish symptoms that can be very similar, as in heartburn vs. **heart attack**, stomach flu vs. **ruptured appendix**,

headache vs. **ruptured brain aneurysm**, itchy skin rash vs. **Stevens Johnson Syndrome**. The entities in bold are all life-threatening emergencies and pharmacists cannot be relied upon to diagnose these!!!

Furthermore, the Legislature—not a regulatory board—is responsible for setting a profession's scope of practice, and this bill would set a precedent for both the practice of pharmacy and other professions.

Shu-Hong (Holly) Chang, MD, FACS
Private office: Pacific Oculofacial Plastic Surgery PLLC
Academic office: Clinical Associate Professor, University of Washington Eye Institute

---

I am in support of House Bill 2116 which would expand the prescriptive authority of Pharmacist in Washington state.

This bill will allow greater access for patients needing Mental Health Treatment by allowing Pharmacist to actively provide care.

Thank you
Ajay Sinha
Health System Director of Pharmacy
UHS Fairfax Hospital

I am writing to express my opposition to House Bill 2116. This bill would give pharmacists' prescriptive authority to the Pharmacy Quality Assurance Commission. It contemplates pharmacists treating "minor ailments, initiating and modifying treatment for chronic conditions, providing preventative care, and managing emergency situations that present in a pharmacy". As a physician working in hospital medicine with 30 years of experience, I rely on pharmacists for assistance with medication dosing and recommendations. However, this proposed bill would give pharmacists prescriptive authority without stipulating the need for expanded clinical training. This is potentially harmful to patient care. Please contact me to discuss my concerns further.

Joseph F Minore, MD
Washington Permanente Medical Group (Kaiser Permanente)
Hospitalist Service Line Medical Director

I am a WA State physician and I absolutely oppose prescriptive authority for pharmacists and House Bill 2116. We already have enough charlatans in our state "practicing" medicine and hurting patients. This is not the answer to the physician shortage and more patients will be injured, maimed or killed with this policy in addition to others that have given "doctoring" to non-physicians in our state.

Sherry L. Cavanagh, MD, FACS, FSVS, RPVI
Hospice and Palliative Medicine

The American Pharmacists Association (APhA) appreciates the opportunity to comment on the proposal to better align pharmacists' scope of practice with their education and training through the sunrise criteria in RCW 18.120.010.

For over 45 years, Washington pharmacists have played an essential role in patient care by providing care with prescriptive authority under collaborative drug therapy agreements (CDTAs). However, the current requirement for CDTAs creates unnecessary barriers, limiting patient access to pharmacist-provided care, particularly in rural and underserved communities. The sunrise review process provides a critical opportunity to modernize pharmacist practice by allowing pharmacists to prescribe independently, similar to what has been successfully implemented in states like Idaho, Colorado, and Montana.

Addressing Health Care Shortages in Washington

Washington faces significant health care workforce shortages, with over 2.6 million residents living in designated primary care health professional shortage areas.[1] The Health Resources and Services Administration (HRSA) estimates that 499 additional primary care practitioners are needed to meet patient demand. With 9,450 licensed pharmacists in the state and over 900 pharmacies in underserved areas, pharmacists stand to play an essential and efficient role in addressing the health care workforce shortage.[2,3]

1 Bureau of Health Workforce Health Resources and Services Administration (HRSA) U.S. Department of Health & Human Services. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2025

Designated HPSA Quarterly Summary. Published December 31, 2024. https://data.hrsa.gov/default/generatehpsaquarterlyreport. Accessed March 18, 2024.

2 U.S. Bureau of Labor Statistics. Occupational Employment and Wage Statistics. https://data.bls.gov/oes/#/geoOcc/Multiple%20occupations%20for%20one%20geographical%20area.

3 Murphy EM, West L, Jindal N. Pharmacist provider status: Geoprocessing analysis of pharmacy locations, medically underserved areas, populations, and health professional shortage areas. J Am Pharm Assoc (2003). 2021 Nov-Dec;61(6):651-660.e1. doi: 10.1016/j.japh.2021.08.021. Epub 2021 Aug 27.

By aligning pharmacists' prescriptive authority with their education and training, Washington can address these gaps by allowing pharmacists to treat minor ailments, manage chronic diseases, and provide preventive care, improving access to cost-effective health services.

Eliminating Administrative Barriers

While CDTAs have allowed pharmacists to prescribe within defined agreements, locating willing prescriber partners has become increasingly difficult due to corporate employer policies restricting prescriber participation. The Washington State Pharmacy Association (WSPA) has documented that pharmacists often wait months to secure a prescriber partner, leading to gaps in patient care. The administrative burden of CDTAs also creates inefficiencies, requiring constant renewals and re-filing with the Pharmacy Quality Assurance Commission (PQAC). Allowing pharmacists to prescribe based on their training and experience rather than relying on external agreements eliminates these administrative barriers and increases the efficiency of care delivery.

Ensuring Safe and Effective Patient Care

Pharmacists play a critical role as medication experts within the health care team, ensuring that patients receive safe and effective medication therapy. Their expertise extends beyond dispensing to include comprehensive patient assessment, therapeutic decision-making, and ongoing medication management. Pharmacists rely on their extensive education, clinical experience, and evaluation of high-quality, evidence-based literature to optimize medication use for individual patients. Pharmacists' education and training include completing a Doctor of Pharmacy (PharmD) degree, which requires six to eight years of study and over 1,700 hours of hands-on patient care experience. This education and training prepare them to provide a range of direct patient care services. Under CDTAs, pharmacists in Washington already initiate, modify, and manage medications for numerous conditions, including, but not limited to, diabetes, hypertension, smoking cessation, contraception, and infectious diseases across hospital, ambulatory care, and community settings. Given their established role in patient care and demonstrated ability to ensure the safe and effective use of medications, pharmacists are well-equipped to prescribe medications independently. Recognizing pharmacists' ability to prescribe independently will increase patient access to timely, high-quality care while maintaining the rigorous safety standards already inherent in pharmacy practice.

Economic and Public Health Benefits

Substantial published literature documents the proven and significant improvement to patient outcomes4 and reduction in health care expenditures5 when pharmacists are optimally leveraged as the medication experts on patient-care teams. A recent scoping review evaluating the return on investment (ROI) of pharmacists' services among non-hospitalized patients found an ROI ranging "from $1.29 to $18.50 per dollar spent on the pharmacy service among the 19 studies that reported ROI as a ratio."[6] By modernizing

> 4 Giberson S, Yoder S, Lee MP. Improving Patient and Health System Outcomes through Advanced Pharmacy Practice. A Report to the U.S. Surgeon General. Office of the Chief Pharmacist. U.S. Public Health Service. Dec 2011. Available at: https://www.accp.com/docs/positions/misc/improving_patient_and_health_system_outcomes.pdf
>
> 5 Murphy EM, Rodis, JR, Mann HJ. Three ways to advocate for the economic value of the pharmacist in health care. Journal of the American Pharmacists Association. August 2020. Available at: https://www.sciencedirect.com/science/article/abs/pii/S1544319120303927
>
> 6 Almodovar AS, Blankenship B, Murphy EM, et al. Return on investment of pharmacists' services among non-hospitalized patients: A scoping review. Research in Social and Administrative Pharmacy. 2025. Article in Press. DOI: 10.1016/j.sapharm.2025.01.012

pharmacy practice, the Department of Health can ensure that Washingtonians receive timely, high-quality care while reducing the burden on an already strained health care system. For these reasons, APhA urges the Washington State Department of Health to support the proposal to better align pharmacists' scope of practice with their education and training through the sunrise criteria in RCW 18.120.010. If you have any questions or require additional information, please do not hesitate to contact E. Michael Murphy, PharmD, MBA, APhA Senior Advisor for State Government Affairs, by email at mmurphy@aphanet.org.

Sincerely,
Michael Baxter
Vice President, Government Affairs
cc: Jenny Arnold, Chief Executive Officer, Washington State Pharmacy Association

> **About APhA:** APhA is the largest association of pharmacists in the United States advancing the entire pharmacy profession. APhA represents pharmacists in all practice settings, including community pharmacies, hospitals, long-term care facilities, specialty pharmacies, community health centers, physician offices, ambulatory clinics, managed care organizations, hospice settings, and government facilities. Our members strive to improve medication use, advance patient care and enhance public health. **In Washington, with 9,450 licensed pharmacists and 8,890 pharmacy technicians, APhA represents the pharmacists and student pharmacists that practice in all settings and provide care to many of your constituents.** As the voice of pharmacy, APhA leads the profession and equips members for their role as the medication expert in team-based, patient-centered care. APhA inspires, innovates, and creates opportunities for members and pharmacists worldwide to optimize medication use and health for all.

I urge you to recommend legislative approval for pharmacist prescribing to become regulated by the PQAC outside of Collaborative Drug Therapy Agreements (CDTA), while also adopting a "standards of care' regulatory model. We are in an era where long waits and high costs related to shortages in healthcare personnel are a norm, and this is vital way we can begin addressing Washingtonians access to care.

WSPA and others have already spoken to issues surrounding difficulties in finding willing signers of CDTAs, and the challenges to smaller pharmacies to afford the financial arrangements demanded by some signers just to enable pharmacies to provide immunization services.

I will focus my comments to the unique barriers CDTAs present in high need specialty areas, particularly mental health.

As a board-certified psychiatric pharmacist, I am saddened by the lack of utilization of this specialty area in a state that is so deeply in need of psychiatric and substance use disorder providers. While CDTAs were a vital tool for me to gain experience in the mental health prescribing space, they also became a barrier to further innovations.

A main reason for this is that CDTA content is unregulated by the PQAC, which makes each one unique and specific, describing varying scopes of practice, and not necessarily tying these to experience level or board certification.

This creates administrative barriers to innovate the pharmacist's roll to what is most needed in a health system and complicates reimbursement as it is not clear simply from licensure or credentials what activities are legally permitted by a given pharmacist.

Also, the lack of consistency in CDTAs creates challenges in training development, such as in specialty pharmacy residencies as we are left to guess what rolls the residents may have in the future.

Moving towards a 'standards of care' model would allow the PQAC to thoughtfully consider prescribing rules based on a pharmacist's knowledge and experience, rather than this decision being made by other professionals who are unfamiliar with our board certifications. I foresee this would open doors for psychiatric pharmacists and others to increasingly work alongside other providers in direct patient care rolls, helping to alleviate the overburdened primary care workforce and adding to the understaffed mental health provider workforce.

Multiple policy development centers have suggested similar changes as ways to improve access to healthcare and increase innovation in the pharmacy space. See the following:

"Toward Pharmacy Full Practice Authority," Nov. 2024, Cicero Institute, Austin Texas.

"Reforming the Practice of Pharmacy: Observations from Idaho," Apr. 2020, Mercatus Center, George Mason University, Arlington, Virginia.

I once again urge your consideration of this Sunrise Review, so that pharmacists may continue to innovate and contribute to the healthcare of our great State.

Respectfully,

Glen Chase, Pharm. D., BCPP

The Pharmacy Quality Assurance Commission (PQAC) thanks the Department of Health (Department) for the opportunity to provide remarks on the Sunrise Review: Pharmacist Scope of Practice. PQAC appreciates the Washington State Pharmacy Association for their initiative to further advance the profession's scope of practice through the sunrise review process. We understand that SB 6019 (2024) seeks to increase pharmacists' scope of practice by allowing pharmacists to prescribe medications without the need for a collaborative drug therapy agreement (CDTA).

After review of SB 6019, PQAC would like to express support to increase the scope of practice for pharmacists and allow pharmacists to prescribe medications without the need for a CDTA. Pharmacists can assist in providing primary care services that are instrumental to personal and population health in Washington. PQAC would like to highlight the successful history of CDTAs, extensive training that pharmacists complete, and increasing access to patient care as evidence for the Department to consider when applying the requirements in RCW 18.120.010.

Pharmacists complete comprehensive education and extensive training to ensure they are prepared for the field of pharmacy. Since 2000, all pharmacists graduate with a Doctor of Pharmacy degree, and many pursue postgraduate training and residencies. Through their required minimum training, pharmacists become medication experts that have the knowledge to recognize disease states and necessary medication therapies, and through additional post-graduate or residency training, pharmacists have the knowledge and skill to effectively manage, adjust, and modify medication regimens to improve health outcomes.

Pharmacists in Washington have been able to initiate and modify drug therapy pursuant to a CDTA since 1979. In the 46-year history of PQAC regulating pharmacists diagnosing, initiating, and modifying drug therapies pursuant to CDTAs, the Commission has not observed any significant errors. All pharmacists in Washington practice under the standard of care model ensuring that patient care is their priority, and

that each pharmacist is working within their professional expertise. If the scope of practice for pharmacists is expanded, pharmacists prescribing without the need of a CDTA will still be expected to practice within the standard of care. In other words, pharmacists would still only legally be allowed to prescribe medications appropriate for their training, education, and skill. The Uniform Disciplinary Act (UDA), set forth in Chapter 18.130 RCW, provides PQAC with a well-established process by which it can investigate complaints and, if necessary, take enforcement action against personnel it regulates. The UDA framework enables PQAC to protect the public, an obligation PQAC takes incredibly seriously.

Pharmacists have been able to use CDTAs to increase access to vital healthcare services for patients throughout Washington, specifically in rural and underserved areas. Pharmacists are at the frontlines of healthcare service and have provided crucial care through CDTAs. This flexibility was highlighted during the COVID-19 pandemic when the U.S. Department of Health and Human Services (HHS) extended the PREP Act to allow pharmacists to independently order and administer vaccines and test to treat services through 2029, further solidifying an expanded role for pharmacists in patient care.

PQAC broadly agrees with the efforts to increase the scope of practice for pharmacists, but offers the following recommendation to further clarify the "practice of pharmacy" in the expansion:

SB 6019 amends the definition of "Practice of pharmacy" in RCW 18.64.011(28) to include "the prescribing and ordering of drugs and devices as authorized by the commission in rule." PQAC recommends that the definition of "Practice of pharmacy" also include "the diagnosing of conditions and diseases as authorized by this chapter and commission rules" to ensure that a vital step in the prescribing process is not overlooked.

PQAC supports expanding the scope of practice for pharmacists to prescribe without the need for a CDTA and is well-equipped to continue regulating the profession if the scope of practice is expanded. PQAC appreciates the opportunity to provide comments on the Sunrise Review: Pharmacist Scope of Practice.

Marlee B. O'Neill, Executive Director, Pharmacy Quality Assurance Commission

---

Thank you for the opportunity to submit comments on the Sunrise Review: Pharmacist Scope of Practice. The National Association of Boards of Pharmacy (NABP) is a 501(c)(3) nonprofit association that, for over 120 years, has protected public health by assisting its member boards of pharmacy, including the Washington Pharmacy Quality Assurance Commission, and offering programs that promote safe pharmacy practices for the benefit of consumers.

The practice of pharmacy has evolved exponentially within the last decade. Today, pharmacists do much more than verify providers' orders, screen for medication interactions, counsel patients on the appropriate use of drug therapy, and dispense medications. For years, pharmacists in many states have initiated, evaluated, and modified drug therapy through collaborative drug therapy agreements (CDTA). In Washington, pharmacists have been initiating and modifying drug therapy pursuant to a CDTA since 1979. During the COVID-19 pandemic, pharmacists stepped in and assisted with responding to the public health emergency. Between September 1, 2022, and September 30, 2023, 40.5 million of the 59.8 million COVID-19 bivalent vaccine doses administered in the United States were administered by pharmacists.[1] Furthermore, pharmacists were provided authority under the Public Readiness and

Emergency Preparedness (PREP) Act to perform COVID-19 diagnostic testing and provide prescription treatment[2].

Drug distribution, medication compounding, and dispensing are highly regulated with bright-line regulations, and for good reasons. It is critical for patients and consumers to have access to high-quality, legitimate, and safe pharmaceutical products. Bright-line regulations regarding drug distribution and controlled substance accountability ensure regulatory standards are consistent between licensed pharmacies and distributors.

In 2018, NABP convened a task force to develop regulations based on standards of care[3] within the practice of pharmacy. The task force consisted of state board of pharmacy directors, pharmacy board members, and practicing pharmacists. The task force was charged with exploring the feasibility of transitioning pharmacy regulation from prescriptive rule-based regulations to a model that defines regulation through a standard of care process. The task force further considered and discussed the necessary tools that boards of pharmacy

[1] Federal Retail Pharmacy Program Contributions to Bivalent mRNA COVID-19 Vaccinations Across Sociodemographic Characteristics-United States, September 1, 2022-September 30, 2023

Kalach, Roua E. et al.

Morbidity and Mortality Weekly Report (MMWR), April 4, 2024, 73(13;286-290

[2] Ninth Amendment to Declaration Under the Public Readiness and Emergency Preparedness Act for Medical Countermeasures against COVID-19 A Notice by the Health and Human Services Department

[3] NABP Report of the Task Force to Develop Regulations Based on Standards of Care

would need to develop and utilize to achieve this transition. Most notably, the task force recommended that state boards of pharmacy should consider regulatory alternatives for clinical care services that require pharmacy professionals to meet the standard of care. Since 2018, several states have moved in this direction for professional pharmacy practice[4], which mirrors how other health professions boards regulate their respective professional's practice.

Pharmacy boards, including the Washington Pharmacy Quality Assurance Commission, are well-suited to regulate the professional practice of a pharmacist based on a standard of care to maintain the protection of the public's health. Pharmacy boards consist of licensed pharmacists who are actively engaged in the practice of pharmacy and board membership is typically diversified among the various pharmacy practice settings. When the board is determining whether a pharmacist has met the appropriate standard of care in a given situation, the members will call upon their individual experiences and practices to determine if the pharmacist in question "exhibited a level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers"[5].

Pharmacists are the most accessible health care provider, with over 96% of the United States population living with ten miles of a pharmacy.[6] State legislatures are actively seeking ways to capitalize on pharmacists' accessibility and expertise to provide high quality care to their constituents. During the

current 2024-2025 legislative session, at least twelve states have considered bills that expand the scope of practice of pharmacists.

In closing, as Washington State considers transitioning from a prescriptive bright-line regulatory framework to a framework based on the standard of care to allow for expanded clinical practices of the pharmacists it regulates, NABP is committed to continuing to provide support to the Commission to the extent it's needed.

Sincerely,

Lemrey "Al" Carter Executive Director/CEO
National Association of Boards of Pharmacy (NABP)

As a physician in this state since 1990, I would oppose the expansion of prescriptive authority by pharmacists. Such a move, no matter how well intentioned will likely increase public risk as the proposal is made by individuals who do not completely understand the details of providing medical care and doesn't include any meaningful safeguards.

Eric Thorson

I am writing on behalf of myself to provide support and comments for the Sunrise Review of the Pharmacist's Scope of Practice. My comments below support independent prescribing by pharmacists:

- I am a practicing pharmacist in the state of Washington and have worked in ambulatory, acute and long-term care pharmacy services for 40 years. I have also served as Affiliate Associate Professor at UW School of Pharmacy and have precepted hundreds of students over the years and participated in didactic training for pharmacists.
- Pharmacists are uniquely prepared academically and professionally to operate as independent prescribers in a variety of practice settings. WSPA additionally provides skills training for additional certifications for pharmacists such as immunization certification. On top of training at accredited pharmacy schools, many pharmacists seek additional residency training and board certification in their practice area. CDTA's are an administrative process for pharmacists to prescribe and adjust drug therapy. CDTA's represent a regulatory burden that will benefit from modernization.
- The standard of care model modernizes the current practice of pharmacist prescribing and scope by using established protocols, national best practice guidelines or organizational privileges to ensure that best practices are followed.
- Independent prescribing by pharmacists ensures access to medications across Washington state, including rural areas, often for critical medications. Pharmacists in our communities are equipped with tests that provide results to guide independent prescribing, such as a rapid test for strept throat.
- Many immunizations are now given at community pharmacies. National guidelines are followed and the access is now much more expansive than in previous years. Using standard of care-based models will continue to meet the diverse medication needs of Washington state citizens.

- Health care organizations rely on pharmacist prescribing and monitoring of high-risk medications and this results in increased patient safety and reduces the risk of adverse medication outcomes.

Thank you for your consideration.

Sincerely,
Nancy Driesner
Doctor of Pharmacy

We are writing to offer our support and provide comments regarding the Sunrise Review of the Pharmacists' Scope of Practice. As the owners and operators of Lakeside Pharmacy and Whitestone Pharmacy in rural Okanogan County, we believe it is important to share our experiences and insights on this matter.

Our pharmacies serve rural North Central Washington, and we are often the most accessible healthcare provider in our area. We currently offer services to patients through Collaborative Drug Therapy Agreements (CDTAs) for vaccines and minor ailments. Given the lack of nearby urgent care options, we often hear from patients who would otherwise face days of waiting to be seen by a healthcare provider. For instance, one woman sought care for a simple urinary tract infection (UTI). Unable to schedule an appointment with her primary care provider for several days, she visited our pharmacy, where our pharmacist was able to assess her condition and prescribe the necessary antibiotics, preventing further discomfort and reducing the risk of a worsening infection.

Pharmacists are recognized as experts in medications. Healthcare providers regularly consult our pharmacists for guidance on the most appropriate medications for their patients.

Pharmacists receive specialized training and are committed to continuing education to stay current with best practices and emerging treatments.

While CDTAs provide a valuable mechanism for pharmacists to offer these services, they also introduce unnecessary administrative and financial burdens on pharmacies. The physicians who sign these agreements do not directly supervise the pharmacists' work. They are primarily paid to endorse basic prescribing principles for vaccines and minor ailments—areas where our pharmacists are already well-trained and competent. Over the years that we have been utilizing CDTAs, we have not experienced a single adverse event. Pharmacists are trained to monitor for drug interactions and are often the first to reach out to providers to prevent potential complications.

Eliminating the administrative and financial obstacles associated with CDTAs would empower pharmacists to practice to the fullest extent of their licenses and would significantly increase access to healthcare, particularly in rural areas such as ours, where primary care providers are in short supply. By removing these barriers, pharmacists can play an even greater role in improving the health and well-being of our community members.

We strongly believe that expanding the scope of practice for pharmacists would be an important step toward addressing healthcare challenges in rural areas and improving patient care.

Thank you for considering our input.

Michael H Steinman PharmD Stephanie A Steinman RN, CPhT
Owners/Operators
Lakeside Pharmacy & Whitestone Pharmacy

On behalf of the Washington State Medical Association (WSMA), the Washington Osteopathic Medical Association (WOMA), and the undersigned physician specialty organizations, thank you for the opportunity to provide comment on the Department of Health's (Department) current sunrise review of pharmacist prescriptive authority. Physicians deeply respect the expertise and essential role that pharmacists play in patient care – particularly in medication management, patient education, and ensuring the safe and effective use of prescriptions, such as preventing adverse drug interactions.

However, the proposal offered by the Washington State Pharmacy Association (WSPA/applicant) raises significant concerns. It represents wholesale delegation of authority on the part of the legislature to establish scope of practice for health care professionals to the Washington State Pharmacy Quality Assurance Commission (PQAC). The delegated authority includes the drugs a pharmacist could prescribe, the types of patients they could treat and the circumstances in which care could be provided. The proposal also leaves to the PQAC's jurisdiction what, if any, additional education and training would be required for pharmacists to be eligible for scope expansion.

Physicians value the partnership we have with pharmacists – working together in clinical settings, alongside one another in communities, and in formal arrangements such as collaborative drug therapy agreements (CDTAs). This proposal inappropriately and unnecessarily severs that partnership – siloing pharmacists and jeopardizing patient safety. This proposal raises several other concerns that we will elaborate on throughout this comment, but fundamentally this proposal is flawed in the delegation of authority it delivers to members of a profession. The Department should reject this proposal on its merits, as well as precedent this would set for other professions.

The legislature sets a profession's scope of practice – not a regulatory board

According to WSPA's application, "the proposal seeks to authorize the PQAC to regulate independent prescribing by pharmacists outside of CDTAs". The bill would grant PQAC broad authority to expand the profession's scope of practice – placing PQAC pharmacists in the position of having to regulate the level of clinical autonomy of members of their own profession. While it is common for legislation to direct rulemaking to fine tune elements of policy, we are aware of no precedent for this level of legislative delegation of authority for setting scope of practice to a board or commission.

During a 2021 sunrise review of the optometric scope of practice, the Optometric Physicians of Washington (OPW) proposed a similar regulatory structure promulgated in the WSPA application – allowing the Board of Optometry to set the profession's scope of practice on a procedure-by-procedure process. In its report to the legislature, the Department stated, "no health care licensing or regulatory entity sets their own scope of practice in Washington. Per Article 20, Section 2 of the Washington State Constitution, all health care scopes of practice are determined by the Washington state legislature." For this reason, we urge the Department to also reject the current application under consideration.

The proposal seeks to regulate independent prescribing via a standard of care regulatory model, which charges individual pharmacists with determining whether their personal education and training allow them to safely and competently treat each patient. Pharmacists are well-trained as medication experts. However, this knowledge does not make a pharmacist an expert in patient diagnosis or the formulation of a treatment plan.

In the absence of any meaningful legislative or regulatory safeguards, the application relies on the assumption that "pharmacists as highly qualified professionals, would therefore limit their prescribing to what their training, experience, and education would reasonably allow". The applicant offers in its report that "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." It is important to note that there are existing safeguards that protect against physicians from performing procedures they are not trained. For example, physicians must be credentialed and privileged by a hospital or medical group before performing certain procedures. A primary care physician would not receive privileges to perform craniotomies. Physicians must also be credentialed by insurance carriers, which will not reimburse for procedures done by unqualified practitioners. These credentialing processes are focused in large part on the experience and expertise a physician has attained through board certification, where physicians are evaluated on their knowledge and skills to practice safely and effectively in a specialty. These safeguards do not exist in the pharmacy setting.

It follows that a regulatory board comprised of members from the profession of pharmacy do not have the education and training to safely regulate how a pharmacist diagnoses and treats a patient. Individuals without extensive training in patient assessment, differential diagnosis, and disease management cannot adequately regulate those who do.

A pharmacist's education and training does not prepare them to diagnose or treat medical conditions

Prescribing a medication necessitates a preceding diagnosis to ensure appropriate care and effective treatment. The ability to provide a diagnosis requires years of specialized medical training to assess complex and co-occurring symptoms, rule out serious conditions, and develop comprehensive treatment plans. It is concerning that the applicant states that "expanded prescribing by pharmacists does not required [sic] 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 education and training of a pharmacist is significantly different than a primary care or family physician. Primary care physicians diagnose, treat, and provide preventative care to individuals and families across the lifespan. It is a specialty that integrates biological, clinical and behavioral sciences. Primary care encompasses all ages, life stages, backgrounds and conditions. Moreover, the examples cited by the applicant regarding current functions of CDTAs solely include medication management functions – that is an important role with the health care team, but it is not analogous with the ability to see any patient and make a diagnosis.

A primary care physician's education and training begins before they enter medical school with pre-requisites included in their bachelor's degree program. Once accepted into medical school, physicians spend four years learning the human body and its systems, as well as the fundamental principles of

medicine. The coursework trains students to identify and understand the root cause and impact of disease. Students not only complete didactic courses in pharmacology but also learn the clinical application of pharmacology. This period of intense study is supplemented by two years of patient care rotations through different specialties during which medical students assist licensed physicians in the care of patients – allowing medical students to develop clinical judgment and medical decision-making through the direct experience of managing patients. All of this takes place before a physician even applies to and is accepted into a residency.

By contrast, pharmacists are required to complete a Doctor of Pharmacy (PharmD) degree. PharmD programs do not require a bachelor's degree for entry, however most applicants have at least three years of undergraduate coursework and may hold a bachelor's degree. The majority of the PharmD curriculum consists of instruction and labs in applied sciences and therapeutics. While pharmacy students do engage in 1,740 hours of "skills training" during their education, it is not focused on providing medical care to patients. Notably, the practice experiences in the PharmD curriculum do not include performing a physical or mental examination, making a diagnosis, developing differential diagnoses, or delivering primary care services. The application references the Pharmacist Patient Care Process as a relevant component of the PharmD curricula. It's important to note that while that program does include an "assess" prong, it does not cover diagnosis or differential diagnosis.

Following graduation from medical school and passage of relevant exams, primary care physicians enter an Accreditation Council on Graduate Medical Education (ACGME) accredited primary care/family medicine residency – a three-year to five-year period (12,000-16,000 patient care hours) during which they provide care under the supervision of experienced physician faculty. Primary care physicians receive training in pediatrics, obstetrics and gynecology, internal medicine, psychiatry and neurology, and surgery. The ACGME requires that residents dedicate a minimum of 200 hours or 250 patient encounters to the care of acutely ill or injured adults in an emergency department setting. At the end of their residency, primary care physicians must demonstrate competence to independently provide patient care in a broad range of areas of medicine. The concept of graded and progressive responsibility is one of the core tenets of graduate medical education.

Pharmacists are not required to complete a residency. According to the applicant, only 30% of pharmacy graduates complete a post-graduate residency of one to two years. Moreover, pharmacists are generally not required to spend any time with patients of any age or with any specific medical condition over the course of their training—this means that a pharmacist could graduate without ever providing care to a child, an elderly person, or without ever having seen a person with an illness that this proposal would potentially authorize them to diagnose and treat. Our understanding is pharmacy residencies that give pharmacists experience in patient care are not common in the community setting.

The differences between the education and training of a physician and pharmacist continue throughout their respective careers. The Washington Medical Commission (WMC) requires that physicians complete 200 hours of CE every four years. The WMC heavily regulates what type of CME qualifies as acceptable – limiting CME hours spent publishing books and papers, as well as teaching. By contrast, Washington pharmacists are required to complete 30 hours of continuing education every two years.

We believe that pharmacists play an integral role in the delivery of health care in our state, but the health and safety of patients are put at risk when healthcare professionals are permitted to perform services that are not commensurate with their education and training. To reiterate, pharmacists are not

trained to examine a patient, they are not trained to make a diagnosis, and they are not trained to take on the role of primary care provider in the boundless parameters contemplated in the proposal.

	Physicians	Pharmacists
Clinical training	12,000 – 16,000 hours of clinical education in medical school and residency.	1,740 hours of "patient care activities" in pharmacy school. There is no residency requirement.
Diagnosis	A broad-based clinical education trains physicians to provide differential diagnoses, develop a treatment plan that addresses multiple organ systems, and order and interpret tests within the context of a patient's overall health condition.	"Patient care activities" in the pharmacy curriculum do not include making a diagnosis, developing differential diagnoses, prioritizing diagnoses, or performing a physical examination.
Pathology	Medical students and residents study and treat patients representing a broad range of commonly occurring disease.	No amount of time in pharmacy school must be spent with patients with any specific medical conditions. While pharmacists learn about disease states in pharmacotherapy courses, the content of these courses is not standardized and actual time spent on each topic is minimal.
Care across the lifespan	Physicians' training includes preventative, acute, chronic, continuing, rehabilitative, and end-of-life care. Medical students study each phase of the human life cycle.	No amount of time in pharmacy school must be spent with patients of any specific age.

Proposal may jeopardize patient health and safety

The legislation that is the basis of the proposal does not include specific parameters on the prescriptive authority for drugs and devices that may be conferred to pharmacists, but the applicant report cites some specific examples of care that would be provided. According to the applicant report, the proposal would allow the Pharmacy Quality Assurance Commission (PQAC) to define a pharmacist's scope of practice utilizing a pharmaceutical standard of care model that, at a minimum, contemplates treating "minor ailments (e.g. strep throat, urinary tract infections, and dog bites), initiating and modifying treatment for chronic conditions, providing preventative care, and managing emergency situations that present in a pharmacy". However, the legislation does not limit the number and types of services pharmacists could provide.

Treating minor ailments

Without a physical exam by a trained healthcare professional done in the full context of the patient's overall health, the severity of an illness and the underlying causes of symptoms may go overlooked. Consider respiratory illness as an example. A cold may be "minor and generally self-limiting," but one must ask how a pharmacist might know whether the lungs are clear without any training and without listening to a patient's lungs? Neither the didactic nor practice experience component of a pharmacist education prepare pharmacists to clinically assess patients or perform differential diagnoses to discern the root cause of a symptom. As such, pharmacists may be ill-equipped to appropriately treat seemingly minor conditions. If not treated appropriately, patient conditions worsen and often become required to seek a higher level of care. Physicians are trained in residency to identify patients across the care spectrum and to perform differential diagnoses; pharmacists are not.

Initiating and modifying treatment for multiple or chronic conditions

For patients with multiple or chronic conditions, the pharmacist may be interfering with or altering an already established, effective management plan. Any change in treatment could diminish effectiveness, create adverse side effects, drug to drug interactions, or require further evaluation for efficacy by a physician. For example, a patient with a diagnosis of hypertension, a very common condition, could present to the pharmacy with high blood pressure, and the pharmacist may prescribe a beta blocker, diuretic, or other agent to control the blood pressure. If the patient has undisclosed asthma, however, a beta blocker will make the asthma worse. High blood pressure may also indicate heart failure, requiring immediate medical attention. It is critical to understand that without the training or infrastructure in the pharmacy retail setting to perform a full medical examination this life-threatening situation will go undetected.

Providing Preventative Care

The WSMA supports the important role that pharmacists play in preventative medicine by administering vaccines and immunizations in communities across our state under current CDTAs. However, preventative medicine is not limited to vaccines and immunizations. Providing preventative care could be defined to allow pharmacists—who are not trained to perform a physical examination and have no education in making a medical diagnosis—to diagnose and treat any child, adult, senior, pregnant patient, or chronically ill patient who arrives at the pharmacy, over the counter, from the pharmacy line. The pharmacist could do so without performing a physical examination, without a review of the patient's medical record, without knowledge or understanding of the patients' other medical conditions or potential co-morbidities, and regardless of whether the pharmacist has any experience treating the patient's population. It is not possible to provide comprehensive preventive and primary care over the retail pharmacy counter.

Managing Emergency Situations

If people are experiencing a medical emergency, they should be treated in an emergency department – not a retail pharmacy. Outside of calling 911 if someone experiences a medical emergency *inside* the pharmacy, it isn't clear what the applicant is envisioning by referencing the treatment of "emergency situations" in their application.

A pharmacist's current authority to directly dispense medication to a patient is governed by a CDTA entered by a physician or other practitioner in a collaborative and safe fashion. The proposal under

review would circumvent this proven regulatory structure that safely and effectively bridges community health care needs and instead places decision making into the hands of the pharmacy commission – largely comprised of pharmacists that as noted, do not have the training and education necessary to safely diagnose and prescribe medication. Any number of prescription medications could fall under the categories of "…treating minor ailments, initiating and modifying treatments for chronic conditions, providing preventative care, and managing emergency situations that present in a pharmacy".

CLIA tests are not a substitute for differential diagnosis

In the follow-up document included in the report, WSPA notes that "…pharmacists routinely use CLIA-waived tests and lab results to address patient's needs, as demonstrated by their role in administering COVID-19 tests during the pandemic. While this may not constitute a full differential diagnosis, it represents pharmacist's abilities exist along a spectrum of diagnostic capabilities." We agree that a Clinical Laboratory Improvement Amendments (CLIA) test is not a substitute for a differential diagnosis. There are more than 1,500 CLIA-waived tests, many of which require special laboratory equipment and/or specially trained personnel to perform or read. It is unclear how CLIA-waived tests would be administered in a community pharmacy setting.

More importantly, the results of a test alone are not enough to make a conclusive diagnosis or to rule out other complications. Consider a UTI, as one example. A UTI may be contemplated as a "minor condition," diagnosable with a CLIA-waived test; however, it cannot be safely managed over the pharmacy counter. A CLIA-waived test alone is not enough to diagnose and treat a UTI. In addition to urinalysis, cultures are often necessary to confirm infection, guide treatment, and to identify serious complications including severity of the infection, kidney stones, and even cancer. Life-threatening kidney infections can mask as a UTI and are undetectable without palpating the abdomen, which can only be done through a competent physical exam. The very presence of a UTI in a man or a child warrants further inquiry, and women with bladder cancer may be misdiagnosed with UTIs. Changes over time or recurrent UTIs call for further workup; however, the clinician must have a clear longitudinal understanding of the patient's history to recognize this. In the siloed pharmacy setting, the pharmacist will only have access to an isolated test result and will not have the findings of a competent physical exam or the patient's medical history.

In the absence of a collaborative agreement with physician oversight, it is not appropriate to rely on a CLIA-waived test to make a diagnosis or determine the appropriate course of treatment and doing so puts patients at risk.

Independent prescribing by pharmacists siloes patient care

If a pharmacist prescribes a medication without understanding a patient's medical history, or ensuring proper follow-up with the patient's primary care physician, underlying conditions may go undiagnosed for longer, leading to worsened outcomes that require a higher and more costly level of care.

The application notes that community "…pharmacists increasingly have access to primary care records through the health information exchange and electronic health records". We challenge this assertion. It is our understanding that retail pharmacies generally do not have access to a patient's comprehensive electronic health record (EHR). Pharmacies can access certain patient health records via health information exchanges, but this varies by system, region and privacy regulations. In Washington state,

only a handful of EHR vendors have made a connection to OneHealthPort – the state's designated Health Information Exchange (HIE). These EHRs generally do not offer products for the retail pharmacy setting. Given the challenges posed by healthcare interoperability, pharmacists that desire more information must contact the prescribing physician.

It is unclear how the pharmacist will confirm a patient has been diagnosed with a medical condition without medical records or incomplete medical records. Relying on patient reporting to confirm a diagnosis raises concerns. For example, if a patient presented to a pharmacist with a current diagnosis of depression but failed to disclose that they also suffered from multiple mental illnesses, the pharmacist may alter the patient's prescription without this information. Treatment for multiple mental illnesses is an extremely complex field within medicine; any changes in medications could result in dangerous consequences for the patient.

Also, the diagnosis and need for re-evaluation by a physician varies considerably based on the age and overall health of the patient, as well as the severity and type of diagnosis. For example, if a patient presents to the pharmacy with a red eye and previous diagnosis of bacterial conjunctivitis, the pharmacists may treat the patient with a topical antibiotic. In this instance, however, the red eye may be a manifestation of a completely different disease such as herpes simplex infection, anterior uveitis, narrow angle glaucoma, or a myriad of other conditions. Given insufficient access to interoperable medical records, we would be concerned that decisions made by a pharmacist to initiate or alter a care plan in a retail setting would not be coordinated or communicated back to the primary care physician – to the detriment of patient care.

Community pharmacists prescribing without having access to a patient's complete and updated medical record which could lead to unnecessary, or worse, unsafe prescribing. At best, this increases inefficiencies and costs to our health care system as patients must ultimately seek a higher, more costly level of care.

This comes at a time when we know that pharmacists – especially those in the community setting – are already overburdened. Data suggests that pharmacists in community settings are already at capacity, without the added burden of treating illness and providing primary health care. A reputable workforce study of more than 3,000 pharmacists found that a full 75 percent of pharmacists in chain settings said they already have so much work to do that everything cannot be done well. The problem appears systemic: 71 percent of all pharmacists and 91 percent of pharmacists working in pharmacy chains rated their workload as high or excessively high. This proposal would only add burden to an overburdened pharmacist workforce.

Self-referral is restricted by state and federal law

Since the 1980s, state and federal laws have restricted physicians from engaging in kickbacks and self-referrals. These laws are in place to control for overutilization, increased healthcare costs, corruption of medical decision making, patient steering, and unfair competition. We are concerned that the application does not contemplate updating state law by adding pharmacists in addition to physicians, to prevent financial interests from influencing patient care.

Our state already has a system that allows pharmacists to safely prescribe

Our state was the first in the nation to enact legislation allowing for the formation of CDTAs or Collaborative Practice Agreements (CPA) which allow a physician or other prescriber to partner with a pharmacist to directly provide drugs to patients in pharmacy settings. The applicant asserts that eligible CDTA partners are hard to find and that WSPA spends significant time connecting pharmacists to prescribers. However, an interview with WSPA CEO Jenny Arnold contradicts this assertion noting that nearly every pharmacist is signed onto a CPA.

The article also notes that "…all states now allow pharmacists to enter into a collaborative practice agreement, most limit pharmacists' prescriptive authority to certain patients, circumstances or types of drugs. The changes proposed in the WSPA application would represent among the broadest latitude across states regarding pharmacist prescriptive authority. Only a few states grant pharmacists prescriptive authority for drugs to treat specified conditions such as influenza or streptococcus, or drugs and medical devices listed on a state-authorized formulary.

Rather than move away from a partnership that has allowed for safe prescribing and administering of prescriptions for nearly 50 years, the WSMA recommends bringing relevant stakeholders – including the Washington Medical Commission and PQAC – to address concerns and improve the CDTA regulations to meet our shared patient safety and access to care goals.

Members of the physician community have a deep respect for the profession of pharmacy. When each member of the health care team plays their optimal role clearly defined by one's education and training, patients benefit. **We continue to work towards our shared goals of high-quality, efficient care for all Washingtonians. The proposal under sunrise review is not an appropriate means to achieve this end**. We urge the Department to reject the changes contemplated in the WSPA's application.

Washington State Medical Association
Washington Osteopathic Medical Association
Washington Academy of Family Physicians
Washington Chapter of the American Academy of Pediatrics
Washington State Psychiatric Association
Washington State Medical Oncology Society
Washington State Society of Anesthesiologists
Washington Chapter of the American College of Emergency Physicians
Washington Academy of Eye Physicians and Surgeons
Washington State Dermatology Association
Washington State Radiological Society

On behalf of the Washington Chapter of the American College of Emergency Physicians, thank you for the opportunity to provide comment on the Sunrise Review proposal to increase the scope of practice of pharmacists pursuant to 2024 Senate Bill 6019.

WA-ACEP endorses the comment of the Washington State Medical Association and would particularly echo the significant concerns related to delegation of legislative authority for setting scope of practice to the Pharmacy Quality Assurance Commission. We have deep respect for our pharmacist colleagues, but we feel it is inappropriate for the Commission to be granted the authority – and the responsibility – of setting scope of practice for their colleagues in their profession.

In addition to the elements in WSMA's comment, we offer the below considerations.

Emergency care We have questions and significant concerns with the applicant's assertion that pharmacists with expanded prescriptive authority could be "managing emergency situations that present in a pharmacy." The only place where emergency care can be appropriately provided is the emergency department. Emergency physicians receive unique, extensive training to prepare for responding to patients who present with a broad spectrum of acute, undifferentiated illness and injury.

Even facilities like urgent care clinics – which employ physicians and other health care practitioners with training in differential diagnosis – recognize that they are unequipped to treat emergency medical conditions and refer to EDs in circumstances where patients present with emergent medical conditions. It would be patently inappropriate for patients with "emergency situations" to be treated in a pharmacy.

Self-referral At the state and federal level, physicians are bound by laws restricting their engagement in behaviors related to kickbacks and self-referrals. Washington state's law is located at RCW 74.09.240 (3). The purpose of the laws is to control for the potential influence of money in the delivery of patient care, ensuring that physicians are considering only what is best for the patient in making diagnoses and referrals, and writing prescriptions.

RCW 74.09.240 (3)(a)(ix) expressly prohibits physicians from self-referring patients for services to an entity that provides outpatient prescription drugs with which the physician has a financial relationship, to include circumstances where a physician would have a compensation agreement in place with the entity that provides outpatient drugs.

At the state level, RCW 74.09.240 (3) was established in 1985 and arguably should be revised to refer to all practitioner types who are able to diagnose, prescribe to, and refer patients for health care services. But consideration is particularly important in the pharmacy setting, where a pharmacy would directly benefit from prescriptions written for a patient that are filled at the pharmacy.

According to the Office of the Inspector General, the federal antikickback law is necessary to control for overutilization, increased program costs, corruption of medical decision making, patient steering, and unfair competition.

We oppose the independent authority proposed for pharmacists to be able to independently diagnose and treat patients under the sunrise application. But to the extent this is considered by the Department, and in the future by the Legislature, there must also be consideration of adding pharmacists to RCW 74.09.240 (3) to ensure that financial incentives do not influence patient care.

Thank you for your consideration. WA-ACEP welcomes the opportunity to provide further information as appropriate and will continue to participate in this process as it moves forward.

Sincerely,

Joshua Frank, MD, FACEP *President* Washington Chapter of the American College of Emergency Physicians (WA_ACEP) Joshua.Frank@confluencehealth.org wa.chapter@ace.org

---

The National Association of Chain Drug Stores (NACDS) appreciates the opportunity to submit comments to the Washington State Department of Health (Department) to inform the sunrise review of

Washington's pharmacy practice regulations. Washington state remains a pioneer and champion in promoting healthcare access for its residents through community pharmacies. Building on this legacy, the upcoming sunrise review offers a timely opportunity to deploy the clinical expertise of pharmacists through a "standard of care" model to meet the dynamic healthcare needs across communities, building on existing Collaborative Drug Therapy Agreement (CDTA) regulations enacted in Washington. As such, NACDS urges the Department to adopt a "standard of care" approach through the upcoming sunrise review.

Value of a "Standard of Care" Model

As the U.S. population ages and the demand for accessible clinical care continues to rise, it is important to enable pharmacists to build on the clinical services they can offer in alignment with the health needs of the communities they serve. To make this a reality, pharmacist practice authority should better reflect the advanced clinical skills and expertise of pharmacists. A "standard of care" model for pharmacists will enable them to optimize their provision of clinical services to achieve broader health goals like improved health outcomes and access to care.

The "standard of care" model is permissive in nature, evolving with new evidence, education, and technology and requires fewer legislative and regulatory updates given the less prescriptive law.[1] This model empowers pharmacists to use their professional judgment and robust clinical training, in alignment with what is considered the standard of care, to provide effective healthcare for their patients and communities. Given pharmacy is among the most regulated professions,[1] implementing a standard of care model offers tremendous opportunity to better apply the expertise of pharmacists toward better health and improved access to safe and high-quality healthcare.

Expand Access & Improve Health through a "Standard of Care" Model in Washington

In Washington State, 3 million people reside in a health provider shortage area,[2] which can result in delayed access to care. Conversely, nearly 90% of Americans live within 5 miles of a community pharmacy[3] and 85% of adults in Washington report that pharmacies are easy to access.[4] Pharmacies are open extended hours – including nights and weekends – when other healthcare providers are unavailable. There are also 15% more pharmacies compared to physician practices in low-income communities.[5] Across populations, it is observed that people visit pharmacies more often than other healthcare settings, and pharmacists have proven their ability to improve health.

A "standard of care" model could help better deploy this unique reach and value to improve care in Washington. For example:

- A study observed that high-risk Medicaid patients visit their pharmacy 35 times per year compared to 4 visits per year with primary care physicians.[6] In such instances, pharmacy visits offer critical touchpoints to improve healthcare access and outcomes.
- During the recent public health emergency, pharmacy interventions such as testing, treatment, and vaccinations averted over 1 million deaths, prevented more than 8 million hospitalizations, and saved $450 billion in healthcare costs.[7]
- A study found that a 50% uptake of a pharmacist-prescribing intervention to improve blood pressure control was associated with $1.137 trillion in cost savings and could save an estimated 30.2 million life years over 30 years.[8]

People in Washington want more care opportunities with their pharmacist [9]:

- 73% support pharmacists helping patients prevent chronic diseases such as heart disease and diabetes.
- 76% support pharmacists helping patients to understand their nutritional choices.
- 80% believe it's important for the state to update its policies to ensure maintained access to pharmacy vaccination, testing, and treatment services that were available during the public health emergency.

Conclusion

As the Department aims to protect and improve the health of all people in Washington state, leveraging the clinical expertise of pharmacists through a "standard of care" model would be invaluable. Pharmacists are highly qualified and stand ready to enhance access and improve health outcomes. They are also well-positioned to adapt and respond to the ever-changing healthcare landscape. However, to fully deploy pharmacists' value, restrictive practice limitations must be removed, and a broader "standard of care" approaches must be embraced. NACDS urges the state to take this opportunity to further modernize pharmacy practice for the betterment of Washington residents. We greatly appreciate your consideration of our comments and welcome any further discussion. Feel free to contact NACDS' Mary Staples at mstaples@nacds.org, if you have questions.

NACDS represents traditional drug stores, supermarkets and mass merchants with pharmacies. Chains operate over 40,000 pharmacies, and NACDS' member companies include regional chains, with a minimum of four stores, and national companies. Chains employ nearly 3 million individuals, including 155,000 pharmacists. They fill over 3 billion prescriptions yearly, and help patients use medicines correctly and safely, while offering innovative services that improve patient health and healthcare affordability. NACDS members also include more than 900 supplier partners and over 70 international members representing 21 countries. Please visit NACDS.org.

1 Alex J. Adams, Nicole L. Chopski. Rethinking pharmacy regulation: Core elements of Idaho's transition to a "Standard of Care" approach. Journal of the American Pharmacists Association. https://www.sciencedirect.com/science/article/pii/S1544319120303332?via%3Dihub#bib5
2 https://www.fightchronicdisease.org/sites/default/files/download/PFCD%20-%20Health%20Equity%20Fact%20Sheet%20%28WA%29.pdf
3 https://www.japha.org/article/S1544-3191(22)00233-3/fulltext
4 https://www.nacds.org/pdfs/Opinion-Research/NACDS-OpinionResearch-Washington.pdf
5 https://www.japha.org/article/S1544-3191(22)00094-2/fulltext
6 https://www.pharmacytimes.com/view/pharmacists-as-influencers-of-patient-adherence-
7 https://pubmed.ncbi.nlm.nih.gov/36202712/
8 Dixon DL, Johnston K, Patterson J, Marra CA, Tsuyuki RT. Cost-Effectiveness of Pharmacist Prescribing for Managing Hypertension in the United States. JAMA Netw Open. 2023;6(11).
9 https://www.nacds.org/pdfs/Opinion-Research/NACDS-OpinionResearch-Washington.pdf

Sincerely,

Steven C. Anderson, FASAE, CAE, IOM President and Chief Executive Officer
National Association of Chain Drug Stores (NACDS)

On behalf of the Washington State Hospital Association (WSHA), we thank you for the opportunity to comment on the Department of Health's (Department) review of the proposal to expand pharmacy scope of practice. WSHA represents more than 100 member hospitals and health systems that employ pharmacists across Washington State.

We deeply respect the pharmacy profession and appreciate the essential role that pharmacists play in the delivery of health care for Washingtonians. We support increasing access to care but want to ensure that proposals are appropriately defined and implemented to protect patient safety.

WSHA respectfully requests that the Department recommend not enacting this proposal due to process concerns. The proposal would authorize the Pharmacy Quality Assurance Commission (PQAC) to regulate independent prescribing by pharmacists outside collaborative drug therapy agreements. More specifically, it would allow PQAC to determine, in rule, the drugs and devices a pharmacist could prescribe, types of patients or circumstances in which a pharmacist may or may not prescribe, and any required education, training, or continuing education that must be completed prior to prescribing or ordering drugs or devices.

It is unclear how the Department can sufficiently evaluate whether the proposal meets the requisite criteria to support scope expansion. The proposal, as written, is too broad and does not adequately describe what would be allowed. Without specification, it is difficult to determine how the proposal protects the public from harm, provides assurance of sufficient education, training, and professional ability to perform the scope of practice, and how it is the most cost-beneficial option to protect the public.

Scope of practice should not be established in rule; it should be set in statute by the state legislature. Setting scope of practice in statute ensures transparency, defined parameters, a consistent legal framework, and the most collaborative public process. This is critical for oversight, public trust, and public safety. Moreover, the Department previously found that per the Washington State Constitution, all health care scopes of practice are determined by the Washington state legislature.[1]

Thank you for your consideration. Please contact me if you have any questions.

1 *Sunrise Review Optometry Scope of Practice*. (2021). Washington State Department of Health. Retrieved March 28, 2025, from https://doh.wa.gov/sites/default/files/2022-04/OptometrySunrise2022.pdf

Sincerely,

Katerina LaMarche, JD Policy Director, Government Affairs Washington State Hospital Association

---

My name is Zoe McDu, a student pharmacist and PharmD candidate at the University of Washington School of Pharmacy. I strongly support expanding pharmacists' scope of practice to improve healthcare access and chronic disease management in Washington. Through my clinical experiences in hospitals, community pharmacies, and public health settings, I have seen firsthand the vital role pharmacists play, especially in underserved communities.

My four years of doctorate-level education have equipped me with strong critical thinking and problem-solving skills in patient-centered care. In addition to extensive coursework in pharmacology, disease states, diagnosis, and treatment selection, I have applied this knowledge in real-world clinical settings. We are highly trained healthcare professionals who have been safely prescribing and diagnosing under Collaborative Agreements since 1979 and will continue to be reliable practitioners in the healthcare field.

As an immigrant to the United States, I witnessed my parents struggle to access medical care due to language barriers and limited understanding of the healthcare system, leaving them without the support they needed. As I pursued my pharmacy education, I recognized that these challenges extend beyond immigrant communities and affect both urban and rural populations. Urban patients often face long wait times for follow-ups, difficulty accessing immediate care, and limited opportunities for routine vaccinations. In rural areas, the barriers are even greater, with fewer urgent care facilities and limited healthcare resources. As the most accessible healthcare professionals, pharmacists are uniquely positioned to bridge these gaps. Expanding pharmacists' prescribing authority would improve continuity of care, reduce unnecessary emergency visits, and enhance patient outcomes across all communities.

Many states already recognize pharmacists' ability to diagnose and manage conditions such as diabetes, hypertension, and respiratory infections. The COVID-19 pandemic further demonstrated our ability to assess, prescribe, and administer critical treatments, reinforcing our essential role in public health. Expanding pharmacists' prescribing authority would allow us to practice at the top of our training, easing the burden on the healthcare system while ensuring better patient care.

As a soon-to-be graduate, I urge the Sunrise Review committee to support this independent practice, enabling future pharmacists to fully utilize their expertise and expand access to essential healthcare services.

Sincerely,
Zoe McDu
PharmD Candidate Class of 2025
University of Washington School of Pharmacy

My name is Chase King, I'm a fourth year Doctor of Pharmacy student at Washington State University, set to graduate in May. I'm looking forward to becoming a practicing pharmacist, as this last year of my education has been filled with different experiences and rotation practices. These range from holding patient appointments to managing complex diabetes cases, to conducting research on the logistics and barriers of Covid testing and treatment in rural Washington, to educating providers on current pharmacotherapy practice and medication regimens. Experiences like these, as well as the intensive doctorate curriculum, have made me excited to enter the healthcare workforce and do what I can to treat the public and be a lifelong learner of current medical practice.

By expanding pharmacists' practice to allow for prescribing and diagnosing independently, I would be able to treat patients in rural Washington who otherwise wouldn't have the time or resources to access further care. One patient visit comes to mind, where I was treating their diabetes, yet they mentioned a complaint that their lack of appetite was negatively affecting their life. After reviewing their chart to rule out differential causes or medication side effects, I was able to make a recommendation of exactly which medication could help them. However, my current scope would not allow me to prescribe that drug, since it wasn't specifically outlined in the CDTA, although I had extensive training on its use. Had I been able to prescribe and schedule a follow-up message, the patient could have received treatment that day, rather than having to schedule a new appointment and ultimately falling through the cracks due to time restraints. I want to make a change for patients in the future, doing what I can by continuing to serve in the rural areas of our state. Additionally, I also plan on becoming board certified in diabetes care and education to ensure the population receives appropriate lifestyle guidance and medication management.

The ability for pharmacists to independently prescribe and diagnose based on the regulations set by the state board of pharmacy is a necessary step in expanding access to healthcare for Washington residents. Whether you see patients being treated for minor ailments in community pharmacies, or a larger pool of providers to staff clinics who are able to provide specialized care, or not needing to navigate the complex landscape of finding a CDTA co-signer, pharmacists being able to practice with the full scope of their training should be looked on favorably by the Department of Health in this Sunrise Review.

Chase King
Doctor of Pharmacy Candidate 2025 | WSU CPPS
Rural Health Initiative Student | WSU CPPS
WSU Chapter Immediate Past-President | American Association of Psychiatric Pharmacists

---

My name is Boris Zhang, and I am emailing in support of the sunrise review for the independent prescribing by pharmacists. My background includes 3 years in long term care pharmacy, 7 years in academia and 7 of years precepting student pharmacists . I am writing this email to show support for the sunrise review for the expanded scope of practice for pharmacy based on my years of personally teaching student pharmacists and knowing the rigorous training they receive to become practitioners.

I want to start by first reading a handful of accreditation standards and skills from the Accreditation Council for Pharmacy Education that student pharmacist graduates fulfill by graduation to obtain a Doctor of Pharmacy (PharmD) degree:

- Application of clinical laboratory data to disease state management, including screening, diagnosis, progression, and treatment evaluation.
- Evaluation of patient function and dysfunction through the performance of tests and assessments…to data important to the diagnosis and provision of care.
- Therapeutic needs assessment, including the need for triage to other health professionals, drug product recommendation/selection, diagnosis, prescribing, and counseling of patients on non-prescription drug products, non-pharmacologic treatments and health/wellness strategies.

These may sound like standards that you would expect from other prescribers like physicians and nurse practitioners, but these are standards that are upheld by every single pharmacy school in the nation for PharmD's. Alongside these standards are 25 strictly written standards instilled into graduates. All of these standards highlight the depth of the education to enable new student graduates to analyze patient data to make sound judgements, to diagnose, prescribe, and maintain therapy, and provide the highest quality of patient care. Additionally, after graduation, pharmacists can also seek board certification in specialties where they undergo years of additional training in residencies or specialty practice intensively studying disease states like cardiology, oncology, pharmacotherapy, and infectious diseases within interprofessional teams. There are also certifications that train pharmacists to diagnose and prescribe for minor ailments, prescribe tobacco cessation, or become a certified diabetes educator. A lot of these trainings are precedented by other pharmacists in many other states. Pharmacists are highly trained individuals who can diagnose and prescribe if they have the right credentials or training.

Pharmacists have already been prescribing for over 45 years under collaborative drug therapy agreements in WA state, and the ability to allow the Pharmacy Quality Assurance Commission to remove this barrier for highly trained pharmacists will allow them to do more for the community. Pharmacists who undergo additional training and certifications can utilize those skills to practice at the top of their clinical ability to continue providing necessary care for WA communities. In rural communities especially, a pharmacy can alleviate the shortage of healthcare providers and decrease the patient care gap caused by the current shortage of available providers.

To finish, I want to state that this ask for expanded scope of practice is not asking for the moon or full prescriptive authority. We're asking for understanding and compromise to improve patient safety, to fill in the gaps of care that have risen over the last several years in WA State that can be remedied by pharmacists. Pharmacists are highly trained, extremely dedicated, and highly accessible healthcare professionals who are always ready to help patients and that is why I speak in favor of expanding the scope of practice for pharmacists in Washington State.
Best Regards,
Boris Zhang, Pharm.D. (he/him)
Director of Professional Affairs
Washington State Pharmacy Association

I am writing on behalf of myself to provide support and comments for the Sunrise Review of Pharmacists' Scope of Practice. I would like to share my experience obtaining and working under Collaborative Drug Therapy Agreements (CDTAs) to shed light on the reality of practicing under CDTAs.

From 2015 to 2023, I worked as a staff pharmacist at a small, independent pharmacy in Seattle that has been serving the community since 1965. Known as the "vaccination destination," it was one of the first pharmacies in the state to offer vaccines, including for children as young as six months old. Though I no longer work there, my colleagues still frequently administer 150+ vaccines daily, all prescribed by pharmacists under our CDTA.

At one point, we were in danger of not being able to renew our CDTA. The doctor who had previously authorized our CDTA closed his practice and retired, leaving us in search of a new provider. Despite strong community ties, many providers were ineligible due to their affiliation with large healthcare organizations. We struggled to find a new authorizing provider. Eventually, a provider with whom we have a long standing relationship was willing to work with us. This allowed us to continue providing care to our patients, particularly vaccines and travel health consultations.

In another experience in 2022, I embarked on a journey to create my own travel health practice which would require a CDTA for me to prescribe travel medicine. I knew obtaining a CDTA would be an obstacle, but I was confident I could manage it based on my knowledge and experience. After everything was prepared, including the protocol for the CDTA, I began my search for an authorizing prescriber. I started with some providers I knew, both personally and professionally. Unfortunately, this was not successful. After months of failed attempts, I finally connected a provider familiar with CDTAs. With his support, I've been able to help hundreds of travelers stay healthy abroad.

In summary, **getting a CDTA signed is challenging.** Based on feedback from colleagues, my experiences are far from unique. And it does not matter if you are a new or well-established provider. It's important to note that I was working in an urban area with strong professional connections to support me through this process. I can only imagine the added difficulty of securing a CDTA in a rural setting with fewer providers or as someone new to the industry, without established connections to rely on.

Another important thing I would like to share is that during all the years that I have been prescribing under CDTAs, **the supervision has been very minimal at best**. At most, there would be a retrospective review every six months. That is all. As the pharmacist, we recognize that even with an authorizing prescriber, in practice, we are the prescriber and it is our name on that prescription. That means it is up to us to deliver safe and effective care. To be clear, I do not believe the authorizing prescribers we worked with were negligent. I believe they trusted our knowledge, expertise and skills to safely prescribe.

This brings up another thing you should know about CDTAs. Some are written very strictly and spell out exactly what you can prescribe, to who, in which situations and when you cannot. However, **some CDTAs contain nearly no restrictions** and will simply say something to the effect of the following:

"Manage care for patients with diabetes according to current guidelines and best practices"

Please note this is paraphrasing and not a direct quote from a CDTA. This is especially beneficial for pharmacists in ambulatory care clinics, offering them greater flexibility to care for their patients. It also eliminates the need to re-sign CDTAs when new drugs are introduced or guidelines are updated. In these cases, it is clear that the pharmacist is expected to use their professional judgment, skills and expertise to prescribe and manage the patient's care.

In conclusion, my years of experience have made the following clear:

1) Obtaining CDTAs is a challenging process.

2) The supervision of prescribing under CDTAs is minimal.
3) Many CDTAs impose few, if any, restrictions.

When considered alongside the years of safe and effective prescribing by pharmacists in Washington state, it becomes evident that CDTAs do not safeguard patients—pharmacists do.

Thank you for your time and consideration of this matter. Please feel free to contact me for any additional information.
Lisa Garza, PharmD

I am writing on behalf of the University of Washington School of Pharmacy to provide support and comments for the Washington State Sunrise Review of the Pharmacists' Scope of Practice. University of Washington is one of two educational institutions offered the Doctor of Pharmacy (PharmD) degree within the state of Washington, and we graduate approximately 100 graduates a year who are ready to apply their four years of doctoral-level training to provide healthcare for Washingtonians, those visiting Washington, and patients they encounter in their practice sites elsewhere across the country.

Like other Doctor of Pharmacy educational programs across the United States, the University of Washington School of Pharmacy is accredited through the Accreditation Council for Pharmacy Education (ACPE). Per ACPE, the Doctor of Pharmacy degree is the minimum degree that is required for pharmacy graduates in the United States. ACPE also issues Standards that accredited pharmacy schools must adhere to across the country.

Regarding the Pharmacy Scope Sunrise Review in Washington, I would like to highlight key elements of the University of Washington School of Pharmacy Curriculum that ensure that students address the requirements of the ACPE Standards 2025 to prepare students to be able to diagnose and prescribe.

- **Pharmacists' Patient Care Process (PPCP) serves** as the foundation for pharmacists as care providers. It is introduced in the first quarter of the program and intentionally integrated throughout the didactic and experiential curriculum.
  During the first two quarters, students engage in all steps of the PPCP through the Foundations of Being a Pharmacist (FBP) courses and the Pharmacist Provider Series (PPS). In FBP, students apply the PPCP—focusing on the Collect and Assess steps in the first quarter; Plan and Monitor in the second quarter—through a longitudinal exercise on medication therapy management with a real patient. This learning is reinforced through exercises and patient cases in PPS, helping students apply and internalize the PPCP framework. Students also engage in exercises related to learning about the medical billing process as an added component of training around diagnosing and prescribing in the pharmacy context.

- **Pharmacist Provider Series (PPS)** is a longitudinal course series spanning the first seven quarters of the program. It combines didactic skills instruction, assessments, and experiential coursework to develop key competencies in diagnosing and prescribing.
  - First Year: Students begin verifying working diagnoses for new medication orders, identifying and diagnosing medication therapy problems (MTPs), developing intervention plans, and completing related medication orders. They also receive a basic

introduction to differential diagnosis by considering alternative diagnoses in patient cases.
    - Second Year: Students gain training in basic physical assessment and the interpretation of vitals, labs, and test results. MTP cases become more complex, further enhancing differential diagnosis skills. Students also provide drug therapy recommendations and specify monitoring parameters for each patient case.
    - Third Year: These skills are applied to more complex patient cases, with regular assessments on students' ability to conduct basic differential diagnosis and develop appropriate drug therapy and treatment recommendations.

- **Clinical & Population Therapeutics (CPT) series,** which spans seven quarters starting in the second quarter of the program, builds students' knowledge in patient-centered clinical case management.
    - The series begins with introductory topics, including over-the-counter (OTC) medications and self-care, before progressing to infectious diseases and common conditions encountered by pharmacists, organized by organ system or population.
    - The final course in the series focuses on complex patient cases, integrating concepts from earlier courses.
    - Students learn not only about the common drugs used to treat various medical conditions but also how to recognize symptoms, diagnose conditions, and recommend appropriate drug therapies.
    - In self-care, students are trained and assessed on diagnosing common conditions in an OTC setting and determining when patients need to be referred for further medical evaluation.
    - Assessments throughout CPT evaluate students' ability to:
        - Analyze subjective and objective patient data (e.g., vitals, lab values, current medications).
        - Apply clinical guidelines to patient cases.
        - Develop appropriate treatment plans, including drug selection, dosage, route, frequency, and duration.

- **Team-Based Diagnosis:** The program's Interprofessional Education curriculum includes opportunities for students to work with trainees in other health professions to assess and respond to patient cases and explore the ways in which each profession contributes to the diagnostic and patient care process. The didactic IPE curriculum culminates in a series of acute care simulations with pharmacy and medical students. These simulations involve standardized patients with students engaging in the steps of the Pharmacists Patient Care Process and working with medical students on a differential diagnosis. Students then receive feedback from peer observers, faculty facilitators, and standardized patient actors.

- **APPE Evaluation:** The preceptor evaluation of students completing their APPEs has been updated to include examples of diagnosing and prescribing in appropriate places in the Pharmacists Patient Care Process.

I would also like to highlight a *few* key ACPE accreditation Standards required for all Doctor of Pharmacy programs. Each Doctor of Pharmacy educational program ***must teach each student***:

- **Patient Assessment** Evaluation and interpretation of health screenings, patient lab tests, physical findings, and other assessments, as well as subjective (patient interview) data important to the diagnosis and provision of care.
- **Clinical Laboratory Data** application involved in screening, diagnosis, progression, and treatment evaluation, relative to disease state management.
- **Pharmacotherapy** Evidence-based clinical decision making, therapeutic treatment planning (including diagnosing and prescribing), and medication therapy management strategy development for patients with specific diseases and conditions that complicate care and/or put patients at high risk for adverse events.
- **Pharmacology** Pharmacodynamics, mechanisms of therapeutic and adverse drug actions and interactions, lifespan-dependent variations in physiology or biochemistry that impact drug action and effectiveness, and application of these principles to therapeutic decision making.
- **Ethics** Exploration of approaches for resolving ethical dilemmas in patient care and its delivery, with an emphasis on moral responsibility and the ability to critically evaluate viable options against the needs of patients and other key stakeholders.

During recent accreditation reviews, ACPE found that both the University of Washington School of Pharmacy and the Washington State College of Pharmacy and Pharmaceutical Sciences exceeded the accreditation standards set by ACPE.

Pharmacists should be able to practice at the highest level of their individual education, training and experience. The University of Washington supports the Washington State Pharmacy Quality Assurance Commission regulating the prescribing and diagnosis by pharmacists to enable a practical, evidence-based expansion that enhances patient safety and addresses critical gaps in care. Pharmacists are among the most accessible, highly trained, and dedicated healthcare professionals, and empowering them to practice at the top of their training will benefit patients across Washington State.

Thank you for your time and consideration.

Sincerely,

Jeremy Hughes, PharmD, EdD
Associate Dean for Professional Pharmacy Education
University of Washington

I am writing today on behalf of the National Community Pharmacists Association (NCPA) in support of the proposal made by the Washington State Pharmacy Association to expand pharmacists' scope of practice and removing barriers to care. Their proposal would grant the Pharmacy Quality and Assurance Commission the authority to regulate pharmacist prescribing outside a collaborative agreement. We **support** this proposal empowers pharmacists to practice at the top of their training, enhance patient outcomes and reduces administrative burdens among providers and patients.

NCPA represents the interest of America's community pharmacists, including owners of more than 19,400 independent community pharmacies across the United States and 199 independent pharmacies in Washington. These Washington pharmacies filled over 11 million prescriptions last year, impacting the lives of thousands of patients in your state.

Within the next 10 years, the U.S. could see a shortage of over 55,000 primary care physicians. In Washington there are 148 areas that are designated as health professional shortage areas. There are hundreds of pharmacists in Washington who are ready to provide valuable healthcare services to these communities that have limited access to care.

With over 9,450 pharmacists practicing within Washington, approval of this legislation will allow pharmacists, pharmacy personnel, and pharmacies to meet the demand for health care services and continue to be a gateway for patients to access quality care. Washington pharmacists have been prescribing and diagnosing patients under collaborative agreements since 1979, which have permitted pharmacists to use their training and experience to treat patients and administer medications. The permission to practice outside of a collaborate agreement will not only allow pharmacies to expand immunization and testing capacity but will allow pharmacists to dispense opioid antagonists, epinephrine auto injectors, post exposure prophylaxis (PEP) for exposure to HIV infection and hormonal contraception.

More than 90% of Americans live within five miles of a community pharmacy,1 and more than any other segment of the pharmacy industry, independent community pharmacies are often located in underserved rural and urban areas. These pharmacies are frequently the most accessible healthcare providers in many Washington communities and are vital in the provision of immunizations, testing, and other services.

Over the years, the pharmacy profession has evolved from a dispensing and product reimbursement industry to a profession with training and patient relationships to provide outcomes-based services and participate in care coordination efforts. Pharmacists' care has increasingly involved patient counseling, and we have learned how their presence in underserved communities has seen improved health outcomes and reduced healthcare costs.

NCPA supports the Washington State Pharmacy Association in their advocacy to expand pharmacists' scope of practice and improve efficiencies in healthcare delivery. We appreciate the time taken to address the important issue and urge the committee's approval so the legislative process can begin, and SB 6019 can be passed and signed into law.

Sincerely,
Belawoe Akwakoku
Associate Director, State Government Affairs
National Community Pharmacists Association

Good morning, I write you today to share my thoughts on expanding the scope of pharmacists to diagnose and treat minor illnesses, engage in the treatment of chronic illnesses, managing emergencies at pharmacies and engaging in preventive care.

From the start of my career as a physician, and a resident trainer, I have embraced the collaboration with pharmacists, behaviorists and other non-physician clinicians. I believe that these services are a great complement to our practices. That said, I believe that the expansion of the pharmacist's scope of practice is one that will cause more harm than good and is likely dangerous.

When a family physician, for example, graduates from residency, they've had at least 7 years dedicated to the diagnosis and treatment and management of disease. They have spent countless hours in hospitals on the labor deck and in the ICU. They have been exposed to a variety of presentations of illness, and are trained to think critically about how a "small" problem can turn critical rapidly. When we see a "minor" complaint like a URI or a UTI, we are trained to consider the risk factors for the patient, past medical history, our diagnostic acumen to decide whether this has the potential or is already heading to pneumonia, asthma exacerbation, COPD exacerbation or in the case of the UTI, pyelonephritis, among many others. A pharmacist has no experience or training in diagnostic procedures nor are they experienced in telling the acuity of a problem as most of them have never spent much time in the hospital, let alone the ICU, emergency room, etc.

Even when deciding whether or not to screen someone for colon or breast or prostate cancer, physicians are trained to look at the whole patient and the whole picture and know full well that over screening can cause harm.

I ask you to please consider not expanding the scope of pharmacists. It is hard enough to practice in a world where we have to constantly fix and remediate problems created by "clinicians" such as chiropractors and naturopaths causing serious harm to our patients to also allow for more people to participate in the diagnosis and treatment as well as health maintenance of our patients without proper training. Collaborative care agreements are great because they are collaborative; allowing independence of inexperienced individuals to treat our patients however "minor" their complaint, would have bad and potentially devastating consequences.

Thank you for your time, sincerely,
J. Miguel Lee, MD
Program Director
St. Peter Family Medicine Chehalis Rural Training Program

Please accept the following written comments regarding the Department of Health (DOH) Sunrise Review process that will examine expanding prescribing by pharmacists.

The Commission regularly works with the Pharmacy Quality Assurance Commission (PQAC). As its colleagues, we value our working partnership. The Commission regularly consults with the PQAC investigators on cases involving medication therapy. The Commission has taken part in a roundtable

group within the Department of Health (Department) regarding intravenous hydration therapy with PQAC and their participation is invaluable. There are many other examples of this valued partnership. So, as I voice concerns, please accept the following comments with that background in mind.

In general, pharmacists make immense contributions to public healthcare, but as detailed below, they lack sufficient education and clinical experience in diagnostic reasoning. Also, PQAC lacks the requisite regulatory knowledge and experience to protect the public with the requested expanded prescribing rules.

Authority over scope of practice The applicant seeks to vest authority over when, how, and under what circumstances a pharmacist could prescribe, which raises significant concerns. In the recent past, the Department has weighed in against sunrise proposals, such as the 2021 Optometry Scope of Practice and the 2024 Naturopathic Physician Scope of Practice where the scope of practice is delegated wholesale by the Legislature to the regulatory body.

Education

Without the multi-modal education from other professions, a far reduced residency and no universal requirements between schools offering pharmacological degrees, their training cannot be considered equivalent to medical doctors. It is not at all clear there are universal standards taught in pharmacy schools with regard to direct patient contact or training in clinical settings. This is in direct contrast with the clear and published accreditation standards for medical schools and residency training programs accredited by the Accreditation Council on Graduate Medical Education. A few examples from the Family Medicine training program, which is the shortest route to full scope licensed practice:

- No fewer than 1,600 unique patient encounters over three years, none of whom may be fellow students or trainees,
- Must be on call seven days per week/24 hours per day for 50 weeks of the year for the three-year duration of the training,
- Demonstration of observed and documented competence on a standardized entrustment scale in solo practice, group practice, and system settings.

A Doctor of Medicine degree (M.D.) includes several aspects that a Doctor of Pharmacy (Pharm.D.) does not. Including but not limited to:

- 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,
- Demonstration of competence at the end of the residency, and
- Continued professional oversight that ensures physicians stay current with professional standards and safely incorporate new treatments and medications into their practice.

While the applicant provides examples of courses available at the two Washington schools of pharmacy, there are no examples of standardized curricula. In other words, the state of the modern healthcare

workforce draws clinicians from all fifty states and around the globe. There is no information indicating whether the UW and WSU courses are at all universal in nature.

Clinical Experience

Being recognized as a prescriber does not equate to being qualified to provide the full scope of diagnostic services, nor justify scope expansion. Despite the attainment of professional degrees, pharmacists are not front-line providers of direct clinical care, primary or specialized. While overlaps may exist, there are necessary limitations to ensure patient safety. For example, pharmacists do not perform a comprehensive evaluation of a patient's medical history and a physical examination to assess their current health status which can lead to dangerous outcomes if more medication is given without this insight. We already see the dangers of this with lifestyle drug platforms and the patient harm that occurs when fully trained physicians neglect their duty to perform an adequate examination. We do not have any confidence that practitioners with less training, most likely in retail settings not designed for patient care, are used as a supplement for whole person care.

Doctors are responsible for the diagnosis of serious health conditions that may require use of controlled substances while pharmacists cannot diagnose patients. Notably, there is still a prevalence of overdose deaths from prescription opioids. Recent data from the Drug Enforcement Administration (DEA) have indicated a substantial increase in the prescription of amphetamines for adult ADHD, as well as notable misuse of ketamine. Having more non-physicians prescribe medications that have substantial harms including addiction and diversion is a significant public safety concern that goes against the clear intent of the elected leadership of Washington State. While pharmacists have made the argument that more primary care is needed, this expansion will not address that gap. In this era of addiction epidemics, the issue lies not in access to medications, but in the lack of access to knowledgeable care regarding their safe use.

The underlying conditions have evolved in recent years, but the fundamental issues remain regarding training and the significant public health challenges with mitigating addiction and abuse of opioids. Therefore, this request to expand the pharmacist scope of practice does not meet the first criteria for expansion: protecting the public from harm.

Regulatory Knowledge

The applicant was asked to “explain how the proposal ensures practitioners can safely perform the new skill or service.” Their answer was PQAC can regulate independent prescribing by pharmacists outside of collaborative drug therapy agreements (CDTAs). This creates a regulatory issue. PQAC will have to regulate new complaints in areas which they have not practiced, do not have experience reviewing such cases, and have no directly relevant case law upon which to base even their most basic decisions. They further compare the “lack of state law detailing that a family practice physician should not perform a craniotomy in their clinic” as grounds to have pharmacists self-regulate. This completely ignores the entire medical practice framework in which a surgeon must be given hospital credentialing privileges, board certification, proof of residency and continuing medical education. Additionally, it ignores the clear regulatory history of the WMC taking regulatory action against practitioners performing functions outside of their scope and training. The applicants’ lack of awareness regarding the basic function of the health care delivery system itself should raise concerns.

The applicant report implies that the complete removal CDTAs can help to fill the primary care shortages, and that legislation aimed at restrictions on participation in CDTAs would not work. However, this isn't accurate. A more balanced approach would involve refining these agreements, leveraging technological advancements, and ensuring that pharmacists continue to work within a framework that prioritizes patient safety while enhancing their ability to contribute to healthcare delivery. Additionally, the applicant report does not include any data on how many CDTAs exist present or compared to prior years. Absent data, it's difficult to ascertain whether the trend cited in the applicant report exists.

Furthermore, the applicant states that, "pharmacists have pursued a diverse range of physicians to address the shortage of providers willing to sign collaborative agreements. This has led to situations where out-of-state physicians, licensed in Washington, have signed agreements with numerous pharmacies, often turning this practice into a business. In many of these situations, the physicians provide little to no oversight or guidance." The applicant is correct that many CDTAs, especially those used by large chain stores, have turned signing the documents into a business and one that is not in keeping with the intent of the statute. The applicant statement ignores the clear history of CDTAs and the absolute lack of oversight of that tool both by the regulator, employer, and the signatories. Further, past attempts by the WMC to engage with the members of the pharmacy profession to explore avenues of making the CDTA process more meaningful have been met with, at best, skepticism. CDTAs are not simply bureaucratic tools but are essential in defining the scope of pharmacist practice in a way that ensures patient safety and promotes accountability. They should be used as the statute describes: clear scope guidance, appropriate scope expansion, and a quality assurance tool for both the signatories and the public that relies on those expanded services.

Expanding the role of pharmacists in prescribing medications must be done with great caution, ensuring that any changes prioritize patient safety, comprehensive care, and regulatory accountability. The current proposal does not adequately address the gaps in
education, training, and oversight necessary to ensure that pharmacists can safely expand their scope of practice without compromising public health.

Sincerely,
Kyle Karinen, Executive Director
Washington Medical Commission