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ACCP COMMENTARY

Key state-level policy elements governing pharmacist collaborative practice

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Abstract

The American College of Clinical Pharmacy previously published a white paper in 2015, "Collaborative Drug Therapy Management and Comprehensive Medication Management," as well as position statements on collaborative drug therapy management (CDTM) in 1997 and 2003. Although significant federal and state legislation addressing collaborative practice has evolved and expanded throughout the United States since then, variability in state-level policy remains a barrier for effective collaborative practice. Collaborative practice facilitates the delivery of comprehensive medication management by clinical pharmacists and enhances team-based care. State governments are the primary entities that determine the scope of practice for health professionals. As such, state-level policy plays a crucial role in enabling or impeding the implementation of advanced pharmacist services and effective CDTM. Almost all states currently enable pharmacist prescriptive authority in some form. In 2017, the National Alliance of State Pharmacy Associations and the National Association of Boards of Pharmacy issued joint recommendations outlining model elements of state policies for statewide protocol authority and pharmacist prescribing.

KEYWORDS
advocacy, clinical pharmacist, collaborative practice, policy

1 | INTRODUCTION

The American College of Clinical Pharmacy (ACCP) previously published a white paper in 2015, "Collaborative Drug Therapy Management and Comprehensive Medication Management," and position statements on collaborative drug therapy management (CDTM) in 1997 and 2003.[1-3] Although significant federal and state legislation addressing collaborative practice has evolved and expanded throughout the United States since then, variability in state-level policy remains a barrier for effective collaborative practice. Collaborative practice facilitates the delivery of comprehensive medication management (CMM) by clinical pharmacists and enhances team-based care.

Clinical pharmacists are well positioned to provide high-quality, cost-efficient care as integrated members of team-based practice models. Because of their knowledge and skills in managing drug therapy and ability to identify and resolve complex drug-related problems, clinical pharmacists can improve patient outcomes, promote patient involvement, increase cost-efficiency, and ease workload burden on other health care providers.

State governments are the primary entities that determine the scope of practice for health professionals. As such, state-level policy plays a crucial role in enabling or impeding the implementation of advanced pharmacist services and effective CDTM. Almost all states currently enable pharmacist prescriptive authority in some form.[4] However, the variety of state approaches may complicate pharmacists' ability to accurately weigh the relative pros and cons of different models. An incremental change that is touted as progress in one state may be considered a step backward if implemented in a different state.

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In 2017, the National Alliance of State Pharmacy Associations (NASPA) and the National Association of Boards of Pharmacy (NABP) issued joint recommendations outlining model elements of state policies for statewide protocol authority and pharmacist prescribing.[5] In addition to providing clarity on commonly used terms, this commentary explores the practical application of the recommendations set forth by NASPA/NABP specifically within the context of CDTM and CMM.

2 | DEFINITIONS

Collaborative drug therapy management (CDTM)[1]—Clinical pharmacist application of drug therapy knowledge, skills, and experience to complement the care provided by collaborating professionals and enhance the care provided to patients.

Comprehensive medication management (CMM)[1]—Standard of care that ensures each patient's medications are individually assessed to determine that each is appropriate for the patient, effective for the medical condition, safe given the patient's comorbidities and concomitant medications, and able to be taken by the patient as intended.

Prescribing—Selecting, initiating, monitoring, continuing, discontinuing, modifying, and/or administering drug therapy.

Collaborative prescribing—Clinical pharmacist prescribing authority that is derived from voluntary agreements between pharmacists and other prescribers:

- Collaborative practice agreement (CPA)—A formal voluntary agreement between one or more prescribers and one or more pharmacists who work within the context of a defined protocol that is site and practice specific.
- Patient-specific CPA—An agreement that establishes a relationship between the participating patient, the patient's provider, and the clinical pharmacist, and services are limited to such patients.
- Population-specific CPA—An agreement that establishes a relationship between the participating provider and the clinical pharmacist, and services may be provided for broad patient populations regardless of whether they were previously a patient of the collaborating provider(s).
- Statewide CPA—A formal defined protocol issued by a specific prescriber for use by all pharmacists in the state.

Autonomous prescribing—Pharmacist prescribing authority that does not require a CPA between a prescriber and a pharmacist:

- Statewide protocol—A framework that specifies conditions under which pharmacists are authorized to prescribe a specified medication or category of medications when providing a clinical service.
- Statewide standing order—An authorization issued by a single prescriber allowing all pharmacists in a state to dispense medication(s) directly to a patient in certain scenarios. Typically, the person who issued the agreement is indicated on the prescriptions as the prescriber.
- Unrestricted prescribing—Pharmacists have independent prescriptive authority without any state-derived protocol. Parameters around such authority may be tied to prevailing practice guidelines.

Non-prescription dispensing—Allows pharmacists to dispense certain medications, which are not available for purchase as over-the-counter products, directly to patients without requiring a valid prescription.

3 | POLICY IMPLICATIONS

Currently, states have a wide range of policies that use clinical pharmacists' expertise to optimize medications. Some policy components can be restrictive to effective collaborative practice, whereas other policy components can enable collaborative practice.

Components that limit collaborative practice include restricting clinical pharmacists from initiating treatment and imposing patient/prescriber limitations. Some states only allow the modification of medication regimens and place restrictions on initiating new therapies. Pharmacists' ability to initiate new medication therapy is a necessary component of high-fidelity CMM.

Certain state policies place restrictions on the number of collaborating prescribers and CDTM-eligible patients. Common examples include:

- Requiring a CPA to apply to a single patient or group of patients listed in the agreement.
- Limiting eligible patients to the current patient panel of the collaborating prescriber(s).
- Allowing only one prescriber per CPA or limiting the overall number of participating prescribers.
- Allowing only one pharmacist per CPA or limiting the overall number of participating pharmacists.
- Requiring formal patient referral to the pharmacist from a collaborating prescriber or limiting allowable services to post-diagnostic care.

Components that enable effective collaborative practice include population-specific collaborative practice and statewide protocols in collaborative practice. Certain states allow pharmacists and collaborating prescribers to define population-based criteria to establish patient eligibility for advanced pharmacist services. The population-specific approach has many advantages:

- Enables pharmacists to provide services to newly presenting patients in advance of the patient's first scheduled clinic encounter with the collaborating prescriber(s).
- Creates an opportunity for pharmacists to serve patients who do not have a regular primary care physician.
- Broadens pharmacists' ability to address the public health needs of the community.

- Promotes consistency of service for the entire patient population articulated in the agreement.

Statewide protocols can be used to establish pharmacist eligibility to provide expanded patient care services and formalize basic elements of pharmacist scope of practice in CDTM. Statewide protocols in collaborative practice have many benefits.

1. Promote the consistency of service provided across a state, making service delivery a market expectation and allowing patients to rely on the availability of such services.
2. Allow clinical pharmacists to implement covered services faster and in broader settings without having to negotiate the terms of a CPA with collaborating providers.
3. May carry fewer liability concerns than individually negotiated CPA parameters.

Pharmacists and collaborating prescribers can still use CPAs to provide advanced services that are beyond the scope of statewide protocols.

4 | NASPA/NABP RECOMMENDATIONS

In 2017, NASPA and NABP convened the Statewide Protocol Workgroup, which developed policy recommendations for pharmacist statewide protocols. These recommendations included the key elements that should be included in state laws and regulations authorizing the development of statewide protocols—including the components that should be included in the protocol itself.

The workgroup considered the existing landscape of state laws and regulations, patient access, and pharmacist education and training in compiling these recommendations.[5]

1. Statewide protocols are preferable to statewide standing orders and other approaches to ensure products or categories of products are available from pharmacists.
2. The initial authorizing legislation for pharmacist statewide protocols should be general and allow the specific medications and/or categories of medications to be determined during the regulatory process.
3. The state board of pharmacy should be the state body primarily responsible for issuing pharmacist statewide protocols. In addition, the state department of health should be authorized to issue pharmacist statewide protocols for public health needs.
4. State laws and regulations governing pharmacist statewide protocols should be silent with respect to delegation to non-pharmacist staff.
5. State laws and regulations should be silent with respect to the practice settings where pharmacist statewide protocols can be implemented.
6. The following core components should be included in the design of pharmacist statewide protocols:
    a. The medications or categories of medications included in the protocol.
    b. The training or qualifications required for licensed pharmacists to implement the statewide protocol. (Training/qualifications vary depending on the clinical application of the protocol and may include further training, such as continuing education, in addition to educational experiences obtained through pharmacy school curricula.)
    c. Procedures:
        i. Patient inclusion criteria.
        ii. Requirements for documentation and maintenance of records.
        iii. Communication requirements (eg, notification to the primary care provider).
7. Product selection decisions within protocols that apply to categories of medications should be left to the pharmacist, who then applies clinical judgment and/or available evidence-based guidelines.

5 | DISCUSSION

Collaborative team-based care must be effective and efficient in order to provide high-fidelity CMM. As part of the CMM process of care,[6] implementing the care plan, as well as making changes to it, is important to achieving medication optimization.

Lawmakers and pharmacists should assess their current state laws as a starting point. Determining the precise characterization of a specific state law is not as important as having a general idea of how different approaches compare. Of importance, statewide protocols and CPAs are not mutually exclusive approaches to establishing pharmacist scope of practice in CDTM. Each approach can be uniquely valuable in enabling CMM. Conversely, if applied incorrectly, each approach can create barriers to patient access to CMM and hinder pharmacist collaborative practice.

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CONFLICT OF INTEREST

The author declares no conflicts of interest.

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