EXPLAINER

Expanding Access to Health Care Services: Three Models of Pharmacy Access

January 2024

Scope of the Problem

In the past year,
35.2 percent
of U.S. adults have not had a wellness visit.

By 2034, there could be a shortage of up to **40,920** primary care physicians.

As of December 2023,
100,985,760 people are in designated primary health care professional shortage areas.

Background

Accessing health care can be a complicated and time-consuming process. For some individuals, coordinating transportation, child care, time away from work, and other logistical challenges can make it difficult to attend a medical appointment. Societal factors, such as shortages of health care providers and lack of insurance coverage, compound logistical challenges. Taken together, these issues are so pervasive that the focus of the U.S. Department of Health and Human Services' Healthy People 2030 is "helping people get timely, high-quality health care services."

Implementing policies that allow pharmacists to provide an expanded range of services—such as vaccination, point-of-care diagnostics and screenings, and the prescription of some medications—is one solution to address some of the challenges Americans face when seeking health care services. Policymakers often use one of three models to expand pharmacists' ability to provide additional services: statewide standing orders and protocols; collaborative practice agreements (CPAs); and direct/independent prescribing.

Statewide Standing Orders and Protocols

Standing orders and protocols authorize pharmacists to dispense or administer medications without consulting a prescriber. Policies may permit individual physicians to establish standing orders and protocols allowing a pharmacist or pharmacy to dispense specific medications without a prescription (often used in hospitals), but this requires pharmacies to find prescribers to issue these documents. This process is inefficient and can result in incomplete coverage of pharmacies. Instead, a state health official and/or licensing board(s) can issue a statewide standing order or protocol that applies to all pharmacists or relevant health care providers in that state.

The terms "standing order" and "protocol" have slightly different meanings but are used interchangeably in some policy contexts. A state board or agency issues statewide protocols, whereas one physician at a state agency—often the director of the state public health agency, the state epidemiologist, or the state chief medical officer—generally signs statewide standing orders. The latter can present a challenge if the physician vacates their position, as a new standing order must then be issued. For this and other reasons, a joint workgroup of the American Association of Colleges of Pharmacy (AACP) and the National Association of Boards of Pharmacy (NABP) expressed a preference for statewide protocols over standing orders.

Statewide standing orders and protocols are beneficial because they apply to all pharmacists in a state who meet designated criteria; however, they must be issued for individual drugs or classes of drug. Also, education is necessary to ensure that pharmacists know that they have been granted the ability to dispense medications without an individual prescription.

Collaborative Practice Agreements

CPAs are similar to standing orders and protocols in that a prescriber must authorize a pharmacist to dispense prescription medications to a specific patient or population. They differ from standing orders in that they are negotiated agreements whereby a prescriber delegates certain elements of care to a pharmacist. CPAs are also usually not statewide.

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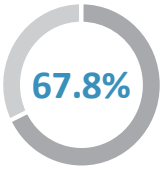
Fast Facts About Pharmacies

of the U.S. population lives within 5 miles of a pharmacy

Pharmacists have doctoral-level training in medication and medication management



of adults use prescription medication

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State legislation can authorize pharmacists to enter into CPAs at the individual patient or population level. Individual-level CPAs are mostly used in hospitals for chronic disease management, as it makes little sense for a retail pharmacy to have a CPA for only one patient. Population-level CPAs allow a pharmacist or pharmacy to dispense medications to a doctor's entire patient population or other category of people. Population-level CPAs are more useful for achieving public health goals.

Policymakers should familiarize themselves with existing legislative language surrounding CPAs so they know whether their state allows CPAs at the individual patient or population level and can consider amending ineffective legislation.

Direct/Independent Prescribing

Policies that allow direct prescribing let pharmacists issue prescriptions to an individual patient the same way a doctor or advanced-practice provider would. This method of facilitating pharmacist prescribing provides pharmacists with the most autonomy of the three models.

When creating direct prescribing policies, there are two primary methods of specifying which medications pharmacists can or cannot prescribe. The first is specifying an individual drug or class of drugs in the bill. Using N.J. Stat. § 45:14-67.9 as an example, a bill authorizing direct prescribing of a class of drugs might state:

> Notwithstanding any other law to the contrary, a pharmacist shall be authorized to furnish self-administered hormonal contraceptives to a patient, in accordance with standardized procedures and protocols to be jointly developed and approved by the Board of Pharmacy and the State Board of Medical Examiners…

The second method for implementing direct prescribing is codifying a framework describing what is permissible as opposed to authorizing the prescription of individual drugs or classes of drugs. The framework model makes the state board of pharmacy the ultimate authority in developing rules for pharmacist prescribing and gives them more latitude to adapt quickly to the rapidly changing medical environment. Idaho was the first state to adopt a framework model of independent prescribing; however, Colorado and Montana have implemented similar laws. The growing interest in this model is evident, as the American Legislative Exchange Council has released model legislative language for states interested in expanding pharmacists' independent prescriptive authority.

Conclusion

When crafting legislation authorizing a pharmacy access model, policymakers should consider their current goals and potential future needs to determine which model is most appropriate for their state and situation. More specifically, as the AACP and NABP workgroup suggested, "[i]nitial authorizing legislation … should be general and allow for the specific medications and/or categories of medications to be determined in the regulatory process." Regardless, best practice is to make the legislative language clean, direct, and free from unnecessary stipulations and regulations, leaving specific rules and processes for the state board of pharmacy to establish.