



## ALASKA STATE LEGISLATURE

# Representative Genevieve Mina

Chair, House Health and Social Services Committee

*Serving House District 19: Airport Heights, Mountain View, & Russian Jack*

### House Bill 195 Version A Sponsor Statement

*"An Act relating to the prescription and administration of drugs and devices by pharmacists; relating to reciprocity for pharmacists; and providing for an effective date."*

House Bill 195 seeks to expand access to timely, high-quality health care by authorizing pharmacists in Alaska to provide direct patient care services in alignment with their education, training, and clinical expertise.

Across the state, many Alaskans face significant barriers to accessing health care. Primary care providers are in short supply, wait times for appointments are often lengthy, and in some areas, access is virtually nonexistent. Pharmacists—who are among the most accessible and trusted healthcare professionals—are uniquely positioned to bridge these care gaps, particularly in managing chronic conditions and treating common, uncomplicated ailments.

Pharmacists can provide evidence-based care for conditions such as COVID-19, influenza, strep throat, urinary tract infections (UTIs), and more. Enabling pharmacists to provide these services would reduce unnecessary emergency room visits, increase patient access to preventive care, and improve overall health outcomes. The public is ready for this model of care. According to 2022 data from the National Association of Chain Drug Stores (NACDS), Alaskans place a high degree of trust in community pharmacists. Pharmacists consistently rank among the most trusted healthcare providers nationwide.

Importantly, services authorized under HB 195 would follow nationally recognized standards of care, as already practiced in many other states. For nearly a century, federal healthcare systems have demonstrated the effectiveness of pharmacist-provided care. Under federal authority, pharmacists already deliver expanded services through the Public Readiness and Emergency Preparedness (PREP) Act and hold independent prescriptive authority within the Veterans Affairs system. Additionally, the Mainstreaming Addiction Treatment (MAT) Act permits pharmacist-led care for opioid use disorder when state law allows—something not currently permitted in Alaska.

HB 195 embraces a collaborative, team-based model of care. Pharmacists would refer patients to higher levels of care as needed, working in close coordination with physicians, nurse practitioners, and other providers.

Alaska has an opportunity to modernize its healthcare delivery system by recognizing the vital role of pharmacists. House Bill 195 is a critical step toward that future.

Session: State Capitol Room 416 • Juneau, AK 99801-1182 • (907) 465-3424

Interim: 1500 W. Benson Blvd. • Anchorage, AK 99503

*Rep. Genevieve.Mina@akleg.gov*

**HOUSE BILL NO. 195**

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTY-FOURTH LEGISLATURE - FIRST SESSION

BY REPRESENTATIVE MINA

Introduced: 4/15/25

Referred: Health and Social Services, Finance

**A BILL**

**FOR AN ACT ENTITLED**

1 "An Act relating to the prescription and administration of drugs and devices by  
2 pharmacists; relating to reciprocity for pharmacists; and providing for an effective  
3 date."

4 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

5 \* **Section 1.** AS 08.80.030(b) is amended to read:

6 (b) In order to fulfill its responsibilities, the board has the powers necessary  
7 for implementation and enforcement of this chapter, including the power to

8 (1) elect a president and secretary from its membership and adopt rules  
9 for the conduct of its business;

10 (2) license by examination or by license transfer the applicants who are  
11 qualified to engage in the practice of pharmacy;

12 (3) assist the department in inspections and investigations for  
13 violations of this chapter, or of any other state or federal statute relating to the practice  
14 of pharmacy;

- 1 (4) adopt regulations to carry out the purposes of this chapter;
- 2 (5) establish and enforce compliance with professional standards and
- 3 rules of conduct for pharmacists engaged in the practice of pharmacy;
- 4 (6) determine standards for recognition and approval of degree
- 5 programs of schools and colleges of pharmacy whose graduates shall be eligible for
- 6 licensure in this state, including the specification and enforcement of requirements for
- 7 practical training, including internships;
- 8 (7) establish for pharmacists and pharmacies minimum specifications
- 9 for the physical facilities, technical equipment, personnel, and procedures for the
- 10 storage, compounding, and dispensing of drugs or related devices, and for the
- 11 monitoring of drug therapy, including independent monitoring of drug therapy;
- 12 (8) enforce the provisions of this chapter relating to the conduct or
- 13 competence of pharmacists practicing in the state, and the suspension, revocation, or
- 14 restriction of licenses to engage in the practice of pharmacy;
- 15 (9) license and regulate the training, qualifications, and employment of
- 16 pharmacy interns and pharmacy technicians;
- 17 (10) license and regulate the qualifications of entities and individuals
- 18 engaged in the manufacture or distribution of drugs and related devices;
- 19 (11) establish and maintain a controlled substance prescription
- 20 database as provided in AS 17.30.200;
- 21 (12) establish standards for the independent prescribing and
- 22 administration of vaccines and related emergency medications under AS 08.80.168,
- 23 including the completion of an immunization training program approved by the board
- 24 and an epinephrine auto-injector training program under AS 17.22.020(b);
- 25 (13) establish standards for the independent prescribing and dispensing
- 26 by a pharmacist of an opioid overdose drug under AS 17.20.085, including the
- 27 completion of an opioid overdose training program approved by the board;
- 28 (14) require that a licensed pharmacist who **prescribes, administers,**
- 29 **or** dispenses a **schedule IA, IIA, IIIA, IVA, or VA controlled substance under**
- 30 **state law or** schedule II, III, [OR] IV, **or V** controlled substance under federal law to a
- 31 person in the state register with the controlled substance prescription database under

AS 17.30.200(n);

(15) establish the qualifications and duties of the executive administrator and delegate authority to the executive administrator that is necessary to conduct board business;

(16) license and inspect the facilities of pharmacies, manufacturers, wholesale drug distributors, third-party logistics providers, and outsourcing facilities located outside the state under AS 08.80.159;

(17) license Internet-based pharmacies providing services to residents in the state;

(18) adopt regulations pertaining to retired pharmacist status.

\* **Sec. 2.** AS 08.80.110 is amended to read:

**Sec. 08.80.110. Qualifications for licensure by examination.** An applicant for licensure as a pharmacist shall

(1) be fluent in the reading, writing, and speaking of the English language;

(2) be a graduate of a college in a degree program approved by the board;

(3) pass an examination or examinations given by the board or acceptable to the board under the score transfer process administered by the National Association of Boards of Pharmacy;

(4) have completed internship training or another program that has been approved by the board or demonstrated to the board's satisfaction that the applicant has experience in the practice of pharmacy that meets or exceeds the minimum internship requirements of the board; **and**

**(5) receive education in pain management and opioid use and addiction, unless the applicant has demonstrated to the satisfaction of the board that the applicant does not currently hold a valid federal Drug Enforcement Administration registration number; an applicant may include past professional experience or professional education as proof of professional competence.**

\* **Sec. 3.** AS 08.80.145 is amended to read:

**Sec. 08.80.145. Reciprocity; license transfer.** If another jurisdiction allows

1 licensure in that jurisdiction of a pharmacist licensed in this state under conditions  
 2 similar to those in this section, the board may license as a pharmacist in this state a  
 3 person licensed as a pharmacist in the other jurisdiction if the person

4 (1) submits a written application to the board on a form required by the  
 5 board;

6 (2) is at least 18 years of age;

7 (3) possesses at the time of the request for licensure as a pharmacist in  
 8 this state the qualifications necessary to be eligible for licensure in this state;

9 (4) has engaged in the practice of pharmacy for at least one year  
 10 immediately before applying for a license under this section;

11 (5) presents proof satisfactory to the board that the person is currently  
 12 licensed as a pharmacist in the other jurisdiction and does not currently have a  
 13 pharmacist license suspended, revoked, or otherwise restricted except for failure to  
 14 apply for renewal or failure to obtain the required continuing education credits;

15 (6) has passed an examination approved by the board that tests the  
 16 person's knowledge of Alaska laws relating to pharmacies and pharmacists and the  
 17 regulations adopted under those laws; [AND]

18 (7) meets the requirements of AS 08.80.110(5); and

19 (8) pays all required fees.

20 \* Sec. 4. AS 08.80.165 is amended to read:

21 **Sec. 08.80.165. Continuing education requirements.** The board shall  
 22 establish requirements for continuing education in pharmacy that must be satisfied  
 23 before a license issued under this chapter may be renewed. **The continuing education**  
 24 **requirements must include at least two hours of education in pain management**  
 25 **and opioid use and addiction in the two years preceding an application for**  
 26 **renewal of a license. The board may exempt a licensee from the requirement to**  
 27 **receive at least two hours of education in pain management and opioid use and**  
 28 **addiction if the licensee demonstrates to the satisfaction of the board that**

29 **(1) the licensee's practice does not include pain management and**  
 30 **opioid prescription or administration; or**

31 **(2) the licensee does not currently hold a valid federal Drug**

**Enforcement Administration registration number.**

\* **Sec. 5.** AS 08.80.337(a) is amended to read:

(a) A pharmacist may, under a collaborative practice agreement with a written protocol approved by a practitioner **who is not a pharmacist**, provide patient care services.

\* **Sec. 6.** AS 08.80.337(d) is amended to read:

(d) In this section, "patient care services" means medical care services, **including the prescription or administration of a drug or device to a patient, that are** given in exchange for compensation **and** intended to achieve outcomes related to the cure or prevention of a disease, elimination or reduction of a patient's symptoms, or arresting or slowing of a disease process.

\* **Sec. 7.** AS 08.80.337 is amended by adding a new subsection to read:

(e) A pharmacist prescribing or administering a drug or device under this section shall recognize the limits of the pharmacist's education, training, and experience and consult with and refer to other practitioners as appropriate.

\* **Sec. 8.** AS 08.80.480(30) is amended to read:

(30) "practice of pharmacy" means the interpretation, evaluation, and dispensing of prescription drug orders in the patient's best interest; participation in drug and device selection, drug administration, drug regimen reviews, and drug or drug-related research; provision of patient counseling and the provision of those acts or services necessary to provide pharmaceutical care; the independent prescribing, dispensing, and administration of drugs in accordance with AS 08.80.168; **providing patient care services in accordance with AS 08.80.337;** the responsibility for compounding and labeling of drugs and devices except labeling by a manufacturer, repackager, or distributor of nonprescription drugs and commercially packaged legend drugs and devices; proper and safe storage of drugs and devices; and maintenance of proper records for them;

\* **Sec. 9.** AS 08.80.480 is amended by adding a new paragraph to read:

(40) "opioid" includes the opium and opiate substances and opium and opiate derivatives listed in AS 11.71.140 and 11.71.160.

\* **Sec. 10.** AS 08.80.337(c) is repealed.

1      \* **Sec. 11.** This Act takes effect January 1, 2026.



## ALASKA STATE LEGISLATURE

# Representative Genevieve Mina

Chair, House Health and Social Services Committee

*Serving House District 19: Airport Heights, Mountain View, & Russian Jack*

### House Bill 195 Version A Sectional Analysis

*"An Act relating to the prescription and administration of drugs and devices by pharmacists; relating to reciprocity for pharmacists; and providing for an effective date."*

#### **Section 1.** Amends AS 08.80.030(b) **Powers and duties of the board.**

to require that a licensed pharmacist who prescribes, administers, or dispenses a controlled substance under state law or federal law to a person in the state register with the controlled substance prescription database (PDMP).

#### **Section 2.** Amends AS 08.80.110 **Qualifications for licensure by examination.**

to require that a pharmacist who holds a Drug Enforcement Agency (DEA) number applying for licensure (via examination) receive education in pain management and opioid use and addiction, in alignment with other practitioners in Alaska who hold DEA numbers.

#### **Section 3.** Amends AS 08.80.145 **Reciprocity; license transfer.**

to require that a pharmacist who holds a DEA number applying for licensure (via reciprocity) receive education in pain management and opioid use and addiction, in alignment with other practitioners in Alaska who hold DEA numbers and pay the associated fees.

#### **Section 4.** Amends AS 08.80.165 **Continuing education requirements.**

to require a pharmacist who holds a DEA number and renews licensure in Alaska meet continuing education requirements including at least two hours of education in pain management and opioid use and addiction in the two years preceding license renewal, in alignment with other practitioners in Alaska who hold DEA numbers. A pharmacist whose practice does not include pain management and opioid prescription, or administration is exempt from this requirement.

#### **Section 5.** Amends AS 08.80.337 **Other patient care services.**

(a)to clarify that a pharmacist may not provide patient care services under a collaborative agreement with another pharmacist.





## ALASKA STATE LEGISLATURE

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### **Section 6.** Amends AS 08.80.337 **Other patient care services.**

(d) to clarify that “patient care services” mean medical care services that include the prescription or administration of a drug or device to a patient for the purposes of curing or preventing a disease, reduction of patient symptoms or for slowing the disease progression.

### **Section 7.** Amends and adds a new subsection to AS 08.80.337 **Other patient care services.**

(e) requiring that a pharmacist prescribing or administering a drug or device under this section recognize the limits of the pharmacist's education, training, and experience and consult with and refer to other practitioners as appropriate. This aligns with standard of care and pharmacy regulation.

### **Section 8.** Amends AS 08.80.480 **Definitions.**

(30) to clarify that the “practice of pharmacy” includes providing patient care services in accordance with AS 08.80.337. This includes patient care services provided independently or under collaborative practice.

### **Section 9.** Amends and adds a new paragraph to AS 08.80.480 **Definitions.**

(40) adds to the definition of opioid to include opium and opiate substances and opium and opiate derivatives

### **Section 10.** Repeals AS 08.80.337 **Other patient care services (c)** to align with clarifications in Section 6.

### **Section 11.** Provides for an effective date of January 1, 2026.

# Fiscal Note

State of Alaska  
2025 Legislative Session

Bill Version: HB 195  
Fiscal Note Number: \_\_\_\_\_  
( ) Publish Date: \_\_\_\_\_

Identifier: HB195-DCCED-CBPL-04-25-25  
Title: PHARMACIST PRESCRIPTION AUTHORITY  
Sponsor: MINA  
Requester: (H) HEALTH & SOCIAL SERVICES

Department: Department of Commerce, Community and  
Economic Development  
Appropriation: Corporations, Business and Professional  
Licensing  
Allocation: Corporations, Business and Professional  
Licensing  
OMB Component Number: 2360

## Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below.

(Thousands of Dollars)

	FY2026 Appropriation Requested	Included in Governor's FY2026 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	FY 2026	FY 2026	FY 2027	FY 2028	FY 2029	FY 2030	FY 2031
Personal Services							
Travel							
Services	35.0		30.0	30.0	30.0	30.0	30.0
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
<b>Total Operating</b>	<b>35.0</b>	<b>0.0</b>	<b>30.0</b>	<b>30.0</b>	<b>30.0</b>	<b>30.0</b>	<b>30.0</b>

## Fund Source (Operating Only)

1156 Rcpt Svcs (DGF)	35.0		30.0	30.0	30.0	30.0	30.0
<b>Total</b>	<b>35.0</b>	<b>0.0</b>	<b>30.0</b>	<b>30.0</b>	<b>30.0</b>	<b>30.0</b>	<b>30.0</b>

## Positions

Full-time							
Part-time							
Temporary							

## Change in Revenues

1156 Rcpt Svcs (DGF)	35.0		30.0	30.0	30.0	30.0	30.0
<b>Total</b>	<b>35.0</b>	<b>0.0</b>	<b>30.0</b>	<b>30.0</b>	<b>30.0</b>	<b>30.0</b>	<b>30.0</b>

**Estimated SUPPLEMENTAL (FY2025) cost:** 0.0 (separate supplemental appropriation required)

**Estimated CAPITAL (FY2026) cost:** 0.0 (separate capital appropriation required)

**Does the bill create or modify a new fund or account?** No  
(Supplemental/Capital/New Fund - discuss reasons and fund source(s) in analysis section)

## ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? Yes  
If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/26

## Why this fiscal note differs from previous version/comments:

Not applicable, initial version.

Prepared By: Sylvan Robb, Division Director  
Division: Division of Corporations, Business and Professional Licensing  
Approved By: Hannah Lager, Administrative Services Director  
Agency: Department of Commerce, Community, and Economic Development  
Phone: (907)465-2524  
Date: 04/25/2025  
Date: 04/25/25

## FISCAL NOTE ANALYSIS

STATE OF ALASKA  
2025 LEGISLATIVE SESSION

BILL NO. HB195

### Analysis

HB 195 will allow pharmacists to expand their patient care services by prescribing and administering prescription drugs and devices, including controlled substances.

If the bill passes the following expenses will be incurred:

Services:	\$30.0 for legal costs related to investigations in FY2026 and beyond
	\$5.0 for legal costs to amend regulations FY2026 only

*Professional licensing programs within the Division of Corporations, Business and Professional Licensing are funded by Receipt Supported Services, fund source 1156 Rcpt Svcs (DGF). Per AS 08.01.065, licensing fees for each occupation are set so the total amount of revenue collected approximately equals the occupation's actual regulatory costs.*

# House Bill 195:

## Pharmacist Prescriptive Authority Patient Care Services/Standard of Care

Ashley Schaber, PharmD, MBA, BCPS  
Chair, Alaska Board of Pharmacy









# ALASKA BOARD OF PHARMACY

## 2024 STRATEGIC PLAN

The Alaska Board of Pharmacy endeavors to promote, preserve, and protect the public health, safety, and welfare by and through the effective control and regulation of the practice of pharmacy.

GUIDING PRINCIPLES	GOALS	STRATEGIES
 COMMUNICATION	1. Engage in effective communication and promote transparency of public information.	<p>1.1 Improve customer service by providing timely and informative updates to applicants and licensees.</p> <p>1.2 Maximize communication channels through the Board of Pharmacy website and List Service.</p> <p>1.3 Maintain accuracy of website content and ensure accessibility of up-to-date resources</p>
 ADMINISTRATION	2. Adhere to and strive for improved organizational efficiencies without compromising quality of record keeping.	<p>2.1 Avoid delays in application processing by maintaining adequate staffing and exploring flexible retention strategies.</p> <p>2.2 Maintain a proactive approach to licensing by consulting historical knowledge, researching national trends, and encouraging innovation in the planning process.</p> <p>2.3 Automate initial licensure through online applications.</p> <p>2.4 Exercise fiscal discipline through effective budget management.</p> <p>2.5 Embrace innovation by exploring integration and/or delegation opportunities to support core administration functions.</p>
 LICENSURE	3. Ensure competency and qualifications prior to licensure and renewal.	<p>3.1 Adhere to established licensing standards by reviewing education, experience, and examination requirements.</p> <p>3.2 Take a proactive approach to application and form revision subsequent to regulation changes.</p> <p>3.3 Ensure a 14 day or less processing time for licensee applications, and a 30 day or less licensing time for facility applications.</p>
 REGULATION & ENFORCEMENT	4. Grow the economy while promoting community health and safety.	<p>4.1 Routinely review effectiveness of regulations that reduce barriers to licensure without compromising patient health and safety.</p> <p>4.2 Combat the opioid crisis by effective administration of the state's Prescription Drug Monitoring Program (PDMP), including collaboration with providers and key stakeholders.</p> <p>4.3 Advocate for legislation addressing access to pharmacies as the pharmacy profession evolves and new opportunities for improved patient safety arise.</p> <p>4.4 Anticipate changes to the Drug Supply Chain Security Act and respond proactively. Address changes to compounding.</p>

**For more information, please visit the following resources:**

Board of Pharmacy Homepage: [pharmacy.alaska.gov](https://pharmacy.alaska.gov)  
Prescription Drug Monitoring Program (PDMP): [pdmp.alaska.gov](https://pdmp.alaska.gov)

Email: [boardofpharmacy@alaska.gov](mailto:boardofpharmacy@alaska.gov)  
Phone: 907-465-1073

# Background of HB 195

- Result of multi-year, multi-chair Board of Pharmacy review of statutes and regulations to align Alaska pharmacists' license authority with their education, training, and experience to increase access to care.
  - HB 145 (2021-2022)
    - New statute added for “other patient care services”
    - Clarifications needed
- HB 195 addresses changes by:
  - Increasing access to care
  - Incorporating established models of care
  - Encouraging interdisciplinary engagement
- Collaborative effort between the Alaska Board of Pharmacy and the Alaska Pharmacy Association



# Safe Access with Interdisciplinary Engagement



Pharmacists are readily accessible, including in rural communities



Allows healthcare practitioners to practice at the top of their education, training, and experience



"A pharmacist prescribing or administering a drug or device under this section shall recognize the limits of the pharmacist's education, training, and experience and consult with and refer to other practitioners as appropriate"



Pharmacists serve as part of the healthcare team to ensure access to safe care in Alaska

# Incorporates Established Models of Care

## Standard of Care Model

Care provided within scope of pharmacists' education, training, and experience.

Patient safety maintained by measuring practitioners within the same practice setting

## Federal Legislation

Public Readiness and  
Emergency Preparedness  
(PREP) act

Mainstreaming Addiction  
Treatment (MAT) Act

Aligns with Federal models  
including care provided in the  
Veterans Health Administration



# Support

**The Board of Pharmacy respectfully requests your support of HB 195, aligning with our Mission and Strategic Plan**

- To further promote, preserve, and protect the public health, safety, and welfare of Alaskans by and through the effective control and regulation of the practice of pharmacy.
- To promote community health and safety while growing Alaska's economy.





THE STATE  
of **ALASKA**  
GOVERNOR MIKE DUNLEAVY

## Department of Commerce, Community, & Economic Development

Corporations, Business, & Professional Licensing  
Board of Pharmacy

P.O. Box 110806  
Juneau, Alaska 99811-0806  
Main: 907.465.2550  
Fax: 907.465.2974

April 3, 2025

The Honorable Senator Giessel  
Alaska State Senate  
State Capitol Room 121  
Juneau, Alaska 99811

Re: SB- 147A – Letter of Support

Dear Senator Giessel,

The Alaska Board of Pharmacy (“board”) unanimously supports SB 147A, An Act relating to the prescription and administration of drugs and devices by pharmacists; relating to reciprocity for pharmacists; and providing for an effective date, because it:

- Increases access to pharmacist-provided patient care services, allowing healthcare practitioners in Alaska to practice at the top of their education, training, and experience.
- Aligns with the standard of care, including models established within multiple other states, the federal healthcare system, the Public Readiness and Emergency Preparedness (PREP) Act, and the Mainstreaming Addiction Treatment (MAT) Act.
- Encourages interdisciplinary collaboration for patient referral to other practitioners as needed, with pharmacists effectively working as part of the healthcare team to ensure access to safe care.
- Supports the board’s strategic plan, specifically goal #4 which is to grow Alaska’s economy while promoting community health and safety.

The board endeavors to promote, preserve, and protect the public health, safety, and welfare by and through the effective control and regulation of the practice of pharmacy. The board previously supported and provided testimony for HB 145 (2021-2022 Legislative Session), which added AS 08.80.337 Other Patient Care Services. Since the passing of that bill, the board received multiple inquiries about its applicability to independent prescribing. After feedback from the Alaska Department of Law, the Board recognized that clarifications were needed to allow pharmacists to practice at the top of their education, training, and experience. These changes, seen in SB 147A of the current legislative session, are important for overall access to patient care services in Alaska.

Pharmacists are highly qualified and educated healthcare professionals. We fully support the ability for pharmacists to exercise their education, training, and experience to promote community health and safety. As a regulatory body, we also support our ability to oversee these areas to the full capacity for the benefit to Alaskans and our communities.

Sincerely,

A handwritten signature in cursive script, reading "Ashley Schaber".

Ashley Schaber, PharmD, MBA, BCPS  
Chair, Alaska Board of Pharmacy



April 15, 2025

The Honorable Forrest Dunbar  
Chair, Health & Social Services Committee  
Butrovich 205  
120 4th St  
Juneau, AK 99801

### **SB 147 Pharmacist Prescription Authority – SUPPORT**

Dear Chair Dunbar, Vice Chair Giessel, and members of the Health & Social Services Committee:

The American Pharmacists Association (APhA) writes in support of [Senate Bill \(SB\) 147](#) (Sen. Giessel). SB 147 updates state law to align the pharmacist's role with their extensive education and training. It ensures that patients will continue to have accessible health care services and medications from their trusted local pharmacist.

SB 147 better aligns the pharmacists' role with their education and training by allowing pharmacists to order laboratory tests and furnish medications to facilitate care for their patients. Alaska pharmacists have been testing and treating patients since September 2021, when the U.S. Department of Health and Human Services (HHS) issued the ninth amendment under the PREP Act for Medical Countermeasures. This amendment authorized pharmacists to order and administer FDA-authorized, approved, or licensed subcutaneous, intramuscular, or certain oral therapeutics.<sup>1</sup> As beneficial as this temporary federal authority has been in expanding Alaskans' access to care, particularly in rural and underserved areas that lack access to low-cost health care services, it will expire on December 31, 2029.<sup>2</sup> SB 147 makes this temporary federal authority permanent under pharmacists' state scope of practice to minimize interruptions to patient access to these low-cost preventive care services provided by pharmacists and ensures Alaska can meet its citizens' public health needs, particularly in remote areas of Alaska where pharmacists may be the only health care providers for miles.

SB 147 also aligns pharmacists' scope of practice with many states where patients can receive accessible treatment for health conditions that do not need a new diagnosis, are minor, or after performing a point-of-care test under federal law, or for emergencies that threaten the health of the patient. Pharmacists can

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<sup>1</sup> Ninth Amendment to Declaration Under the Public Readiness and Emergency Preparedness Act for Medical Countermeasures. Available at <https://www.federalregister.gov/documents/2021/09/14/2021-19790/ninth-amendment-to-declaration-under-the-public-readiness-and-emergency-preparedness-act-for-medical>.

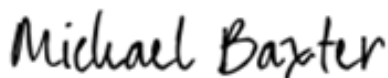
<sup>2</sup> 12th Amendment to Declaration Under the Public Readiness and Emergency Preparedness Act for Medical Countermeasures. Available at <https://www.federalregister.gov/documents/2024/12/11/2024-29108/12th-amendment-to-declaration-under-the-public-readiness-and-emergency-preparedness-act-for-medical>.

already test and treat for varying health conditions in 14 states<sup>3</sup> via a statewide protocol, standing order, or independent prescriptive authority.

Substantial published literature documents the proven and significant improvement in patient outcomes<sup>4</sup> and reduction in health care expenditures<sup>5</sup> when pharmacists are optimally leveraged as the medication experts on patient-care teams. SB 147 ensures that Alaskans maintain access to services they have already been receiving from pharmacists for years and better aligns the pharmacists' role with their extensive education and training.

For these reasons, APhA strongly supports SB 147 and respectfully requests your "AYE" vote. 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](mailto:mmurphy@aphanet.org).

Sincerely,



Michael Baxter  
Vice President, Government Affairs

cc: Senator Cathy Giessel, Vice Chair  
Senator Matt Claman  
Senator Löki Tobin  
Senator Shelley Hughes

**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 Alaska, with 510 licensed pharmacists and 870 pharmacy technicians, APhA represents pharmacists, students, and pharmacy technicians that practice in numerous 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.

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<sup>3</sup> Arkansas, California, Colorado, Delaware, Idaho, Illinois, Iowa, Kansas, Michigan, Montana, New Mexico, Oregon, Tennessee, Virginia

<sup>4</sup> 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](https://www.accp.com/docs/positions/misc/improving_patient_and_health_system_outcomes.pdf)

<sup>5</sup> 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>

Brandy Seignemartin, PharmD  
Alaska Pharmacy Association  
3211 Providence Dr., PSB 111  
Anchorage, AK 99508  
akpharmacistsassociation@gmail.com



April 18, 2025

Senator Cathy Giessel  
Alaska State Legislature  
State Capitol  
Juneau, AK 99801

**RE: Support for SB 147 – Pharmacist Provided Patient Care Services**

Dear Senator Giessel,

On behalf of the Alaska Pharmacy Association (AKPhA), I write to express our strong support for SB 147 – Pharmacist Provided Patient Care Services.

AKPhA proudly represents pharmacists, student pharmacists, pharmacy technicians, and pharmacies operating in all corners of our state—urban, rural, and remote. This legislation is an important step toward ensuring that Alaskans have timely, equitable access to healthcare services, especially in areas facing critical provider shortages.

SB 147 authorizes pharmacists to provide patient care services—including prescribing and administration of medications—within the scope of their education, training, and experience. This authority aligns with the current standard of pharmacist education and practice nationwide and ensures that Alaskans can fully benefit from the expertise of their most accessible healthcare providers.

Pharmacists today are highly trained clinicians. Every Doctor of Pharmacy (PharmD) graduate completes four years of intensive didactic coursework paired with a minimum of 1,740 hours of direct patient care before earning their degree. Many go on to pursue post-graduate residencies, clinical fellowships, certifications, and board specialties in fields ranging from ambulatory care and infectious disease to geriatrics and cardiology.

Yet despite this extensive training, pharmacists in Alaska remain underutilized due to outdated legal restrictions. SB 147 modernizes our statutes to reflect current clinical realities and removes unnecessary barriers that limit patient care. Similar legislation has been adopted in many other states and has demonstrably expanded healthcare access and improved outcomes, especially in underserved and rural areas.

Alaskans trust their pharmacists and regularly seek their advice and care. Authorizing pharmacists to provide care within their training improves system efficiency, supports team-based care, and reduces delays in treatment for patients who need it most. This bill helps maximize Alaska's existing healthcare workforce while reducing burdens on physicians and emergency departments.

For these reasons, the Alaska Pharmacy Association urges your full support of SB 147. We stand ready to serve as a resource and partner as this legislation advances.

Sincerely,

A handwritten signature in black ink that reads "Brandy Seignemartin". The signature is written in a cursive, flowing style.

Brandy Seignemartin, PharmD  
Executive Director  
Alaska Pharmacy Association





Walgreen Co.  
108 Wilmot Rd  
Deerfield, IL 60015  
Walgreens.com

April 14, 2025

Senator Cathy Giessel  
Alaska State Legislature  
State Capitol  
Juneau, AK 99801

**RE: Support for SB 147 – Pharmacist Provided Patient Care Services**

Dear Senator Giessel,

On behalf of Walgreens, I am writing to express our strong support for SB 147 - Pharmacist Provided Patient Care Services. As a leading community pharmacy provider with a long-standing presence in Alaska, Walgreens is committed to expanding access to high-quality and affordable care, especially in underserved and rural communities across the state.

SB 147 represents a meaningful step forward in meeting the healthcare needs of Alaskans by enabling pharmacists to practice to the full extent of their education and training. Pharmacists are among the most accessible healthcare professionals in the country. Community pharmacies like Walgreens are open evenings, weekends, and holidays without the need for an appointment and are uniquely positioned to help fill critical gaps in care.

Across the country, similar legislative efforts have empowered pharmacists to take on expanded clinical roles to improve health outcomes, reduce emergency department visits, and ease the burden on overextended primary care systems. SB 147 brings Alaska in line with these best practices, ensuring that communities facing provider shortages can fully benefit from the expertise and availability of their local pharmacists.

Alaskans rely on their neighborhood pharmacy for trusted guidance, timely care, and critical health services. By modernizing Alaska's laws to reflect today's healthcare environment, SB 147 helps ensure patients receive the care they need, when and where they need it most.

We deeply appreciate your leadership on this important legislation and welcome the opportunity to serve as a resource as it moves forward. Thank you for your continued commitment to improving healthcare access for all Alaskans.

Sincerely,

Lorri Walmsley, RPh, FAzPA  
Director, Pharmacy Affairs

Member of Walgreens Boots Alliance



# Alaska Native Health Board

THE VOICE OF ALASKA TRIBAL HEALTH SINCE 1968

☎ 907.729.7510 📠 907.729.7506 • 4000 Ambassador Drive (ANHB Office) • Anchorage, Alaska 99508 • [www.anhb.org](http://www.anhb.org)

ALASKA NATIVE TRIBAL  
HEALTH CONSORTIUM

ALEUTIAN PRIBILOF  
ISLANDS ASSOCIATION

ARCTIC SLOPE  
NATIVE ASSOCIATION

BRISTOL BAY AREA  
HEALTH CORPORATION

CHICKALOON VILLAGE  
TRADITIONAL COUNCIL

CHUGACHMIUT

COPPER RIVER  
NATIVE ASSOCIATION

COUNCIL OF ATHABASCAN  
TRIBAL GOVERNMENTS

EASTERN ALEUTIAN TRIBES

KARLUK IRA  
TRIBAL COUNCIL

KENAITZE INDIAN TRIBE

KETCHIKAN  
INDIAN COMMUNITY

KODIAK AREA  
NATIVE ASSOCIATION

MANIILAQ ASSOCIATION

METLAKATLA INDIAN  
COMMUNITY

MT. SANFORD  
TRIBAL CONSORTIUM

NATIVE VILLAGE  
OF EKLUTNA

NATIVE VILLAGE OF EYAK

NATIVE VILLAGE  
OF TYONEK

NINILCHIK  
TRADITIONAL COUNCIL

NORTON SOUND  
HEALTH CORPORATION

SELDOVIA VILLAGE TRIBE

SOUTHCENTRAL  
FOUNDATION

SOUTHEAST ALASKA REGIONAL  
HEALTH CONSORTIUM

TANANA CHIEFS CONFERENCE

YAKUTAT TLINGIT TRIBE

YUKON-KUSKOKWIM  
HEALTH CORPORATION

VALDEZ NATIVE TRIBE

April 15, 2025

The Honorable Cathy Giessel  
Senator, District N  
Alaska State Legislature  
State Capitol Room 121  
Juneau, AK 99811

RE: ANHB Support for SB 147 – Pharmacist

Dear Senator Giessel,

On behalf of the Alaska Native Health Board (ANHB)<sup>1</sup>, I write in support of Senate Bill (SB) 147, an Act relating to the prescription and administration of drugs and devices by pharmacists; relating to reciprocity for pharmacists; and providing for an effective date.

SB 147 authorizes pharmacists to provide patient care services—including prescribing and administration of medications—within the scope of their education, training, and experience. ANHB supports this legislation because it will increase access to pharmacist-provided patient care services, maximizing the professional capacity of Alaska's existing healthcare professionals. There are too few Alaskan providers to fill the current demand for healthcare services in Alaska, and job vacancies in the industry are significant. Pharmacists are already an integral part of the AHS and the need for their services is growing. The State of Alaska should take every commonsense step to maximize our existing healthcare workforce, including the more than 500 pharmacists, to ensure access to safe care and referrals to other practitioners as needed.

Pharmacists are highly qualified, trained healthcare professionals. We support legislation that enables pharmacists to utilize the full scope of their education, training, and experience to promote community health and safety for the benefit of Alaskans. Should you have any questions, please contact ANHB at [anhb@anhb.org](mailto:anhb@anhb.org) or (907) 729-7510.

Sincerely,

Chief William F. Smith, Chairman  
Alaska Native Health Board

<sup>1</sup> ANHB was established in 1968 to promote the spiritual, physical, mental, social, and cultural well-being and pride of Alaska Native people. ANHB is the statewide voice on Alaska Native health issues and the advocacy organization for the Alaska Tribal Health System (ATHS), which is comprised of Tribal health programs that serve the 229 Tribes and over 234,000 Alaska Native and American Indian people throughout the state. As the statewide Tribal health advocacy organization, ANHB supports Alaska's Tribes and Tribal programs to achieve effective consultation and communication with state and federal agencies on matters of concern.

April 15, 2025

Senator Cathy Giessel  
Alaska State Legislature  
State Capitol  
Juneau, AK 99801

**RE: SUPPORT FOR SENATE BILL 147 – PHARMACISTS PRESCRIPTION AUTHORITY**

Dear Senator Giessel,

I am writing today on behalf of the National Community Pharmacists Association (NCPA) in support **SB 147**, a bill that authorizes licensed pharmacist to provide patient care services including the prescribing and administration of medications within their education and scope of practice. We **support** this bill as it empowers pharmacists to practice at the top of their training, enhance patient outcomes and reduce administrative burdens among providers and patients.

The National Community Pharmacists Association (NCPA) represents the interest of America's community pharmacists, including owners of more than 19,400 independent community pharmacies across the United States and 83 independent community pharmacies in Alaska. These Alaska pharmacies filled over 900,000 prescriptions last year, impacting thousands of patients in your state. Our members are small business owners who are among the America's most accessible healthcare providers, and they provide an expanding set of health care services to millions of patients every day.

Within the next 10 years, the U.S. could see a shortage of over 55,000 primary care physicians. In Alaska there are 341 areas that are designated as health professional shortage areas. There are hundreds of pharmacists in Alaska who are ready to provide valuable healthcare services to these communities that have limited access to care.

With over 500 pharmacists practicing within Alaska, 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. This bill modernizes Alaska's statutes to reflect current clinical trends and realities as well as removing unnecessary barriers to care. Updating these laws 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,<sup>1</sup> 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 Alaska communities and are vital in the provision of immunizations, testing, and other services.

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<sup>1</sup> NCPDP Pharmacy File, ArcGIS Census Tract File, NACDS Economics Department.



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 Alaska Board of Pharmacy and the Alaska Pharmacy Association in their advocacy to align pharmacists' standard of care and improve efficiencies in healthcare delivery. We appreciate the time taken to address the important issue and urge the committee's approval so SB 147 can be passed and signed into law.

Sincerely,

A handwritten signature in black ink, reading "Belawoe Akwakoku". The signature is fluid and cursive, with the first name "Belawoe" and last name "Akwakoku" clearly distinguishable.

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

Sarah Spencer DO, FASAM  
Ninilchik Traditional Council Community Clinic  
Ninilchik, AK  
sarahspencerak@gmail.com  
907-299-7460  
4/18/2025

Senator Dunbar  
Chair, Senate Health and Social Services Committee  
Alaska State Legislature  
Juneau, AK 99801

Dear Senator Dunbar and Members of the Committee,

My name is Sarah Spencer, and I am a physician practicing in the Kenai Peninsula, specializing in addiction medicine. I am writing today in support of **Senate Bill 147 – Pharmacist Provided Patient Care Services**.

Pharmacists are valued members of the healthcare team, playing an essential role in medication management, patient education, chronic disease support, and preventive services. In my practice, I frequently collaborate with pharmacists and recognize their contributions to improving patient outcomes and ensuring continuity of care.

**Alaska has experienced the nations greatest increase in rates of overdose death in 2021 and 2023. The top evidence-based intervention to reduce mortality in opioid use disorder (OUD) is opioid agonist pharmacotherapy such as buprenorphine and methadone, which reduce death rates by more than 60%. Access to medication for opioid use disorder (MOUD) is severely limited in many parts of Alaska, and pharmacists can play a key role in increasing access by assisting with prescribing and administering MOUD, particularly oral and monthly injectable buprenorphine. Alaska should utilize every tool at its disposal to tackle this epidemic, and the federal MAT act allows of additional flexibility for expanding access to treatment by engaging pharmacist in diagnosing and treating OUD.**

Importantly, pharmacists are well-positioned to help triage patients appropriately and escalate care when higher levels of intervention are needed — working in true partnership with physicians and other providers. I urge you to support SB 147, and **although I am not available to testify on April 22<sup>nd</sup> due to patient care responsibilities, I am happy to be contacted with any questions.**

Thank you for your consideration.

Sincerely,  
Sarah Spencer DO, FASAM  
NTC Community Clinic

Karen Miller RPH  
Denali Pharmacy  
Fairbanks, AK  
Karen.miller@foundationhealth.org  
907-322-6314

4/18/2025

Representative Ivy Spohnholz  
Chair, House Health and Social Services Committee  
Alaska State Legislature  
Juneau, AK 99801

Dear Representative Spohnholz and Members of the Committee,

My name is Karen Miller, and I am a pharmacist practicing in Fairbanks, Alaska. I am writing to express my strong support for **House Bill 195**.

As a lifelong Alaskan, I've witnessed firsthand the many changes in our healthcare system. When I was growing up, it was common to be able to call your primary care provider at home after hours. Today, however, it's often difficult for patients to get a timely appointment with their provider. Pharmacists can help fill this gap in care.

Pharmacists today complete extensive clinical training and education, earning a Doctor of Pharmacy degree. We are the most accessible healthcare professionals — a fact that became especially clear during the COVID-19 pandemic, when pharmacists stepped up to advise patients, administer vaccines, and help maintain continuity of care during a time of crisis.

Every day in my practice, I see opportunities to help patients manage common conditions, chronic illnesses, and preventive care needs — but current laws limit how fully we can contribute. My current practice is working to embed pharmacists into primary care clinics, including those focused on behavioral health and substance use disorders. **HB 195** would help streamline this process and empower pharmacists to provide care more effectively.

This bill would allow pharmacists to practice at the top of their training and licensure, within a standard-of-care framework — just like other healthcare providers. By doing so, **HB 195** will reduce strain on overburdened physicians and emergency departments, while improving access and outcomes for patients.

I am confident in my ability to provide safe, effective care, and I am fully committed to working alongside other members of the healthcare team to ensure the best possible outcomes for our patients.

I respectfully urge you to support **HB 195** and help expand access to high-quality healthcare services for Alaskans.

Sincerely,



Karen Miller RPH

Carrie Urena  
Klawock AK Opioid Treatment Program  
Klawock, AK  
carrieurena22@gmail.com  
(907) 888-8234  
4/18/25

Senator Dunbar  
Chair, Senate Health and Social Services Committee  
Alaska State Legislature  
Juneau, AK 99801

Dear Senator Dunbar and Members of the Committee,

My name is Carrie Urena, and I am a pharmacist practicing in Klawock AK which is a small rural community in southeast AK on the Prince of Wales Island. I am writing to express my strong support for **Senate Bill 147**.

As a pharmacist, I have completed extensive education and clinical training, earning my Doctor of Pharmacy degree and completing over 1,900 hours of hands-on patient care training. I went on to complete a PGY1 residency with Alaska Native Tribal Health Consortium and then began work in 2023 in a newly opened opioid treatment program in Klawock AK. Every day in my practice I see opportunities where our underserved community members could benefit from additional pharmacist services — but existing statutory barriers prevent this from happening.

Those who know me know I'm extremely passionate about the work I do, working with our rural populations suffering from opioid use disorder. Throughout my education and into my residency I placed a high emphasis on experiences and learning opportunities that would enhance my knowledge and ability to serve this patient population. Our Alaskan statistics tell the story of the immense need we have for greater access to care, particularly when addressing medications for opioid use disorder (MOUD). At the end of 2023 when the majority of our nation saw a drop in opioid related deaths, here in AK our numbers continue to rise. Not only did we not see the decrease that so many other states saw, but we also actually had increased rates. It is clear that what we are currently doing is not enough. We simply don't have enough providers to cover the need for services. Our smaller, more rural communities continue to have little to no access to essential services such as MOUD. This is where pharmacists can begin to make a positive impact and really help bridge these gaps in care and services. The growing amount of evidence supporting pharmacists' involvement in MOUD continues to show improved patient outcomes. Our training and education make us uniquely qualified to help bridge the service gaps and improve access for MOUD. We are the medication experts with extensive knowledge about drugs, drug metabolism, drug interactions, and drug safety. We are taught how to assess and identify patients with sub- and supratherapeutic medication regimens. Our state continues to talk about increasing access for MOUD and the undeniable need for these services in our rural populations and we, as pharmacists, are here and more than capable of helping to make this happen. Our communities deserve to have access to these services. These increasing "rates" we continue to talk about and quote, were living breathing people that are no longer with us. Their

lives are lost forever. It's time to bring this immense pain and suffering our communities are feeling to stop. I know that I am eager to help bring healing to our communities, please let me use my education and training to bring some relief to the suffering our state is feeling right now.

SB 147 would allow me to practice at the top of my clinical ability, within a standard of care framework like other healthcare professionals. By streamlining patient access to pharmacist-provided services, this bill will improve health outcomes and reduce unnecessary burdens on physicians and emergency departments.

I am confident in my ability to provide safe, effective patient care, and I am committed to collaborating with other healthcare team members to ensure patients receive the best care possible.

I respectfully urge you to support SB 147 to expand access to high-quality healthcare services for Alaskans.

Thank you for your consideration.

Sincerely,  
Carrie Urena  
PharmD, BCPS  
Klawock Opioid Treatment Program

# ALASKA'S PHARMACISTS

## IMPROVING THE HEALTH OF COMMUNITIES



Pharmacists are essential members of the healthcare team and evidence clearly shows the growing need for pharmacist-provided patient care services. To guarantee equitable access to this vital care, both public and private health plans must cover pharmacists' patient care services.



### QUALIFIED

#### HIGHLY QUALIFIED HEALTHCARE PROVIDERS



##### EDUCATION

6-8 years of education including pharmacotherapy, disease management, and clinical decision-making



##### CLINICAL TRAINING

At least 1,740 hours of clinical practice experience focused on high-quality patient care in a variety of healthcare settings



##### ADDITIONAL TRAINING

Many complete post-graduate residencies, fellowships, and/or board certifications in various specialty areas

All current pharmacy school graduates earn the PharmD degree, a doctorate degree reflecting the advanced pharmacotherapy knowledge and comprehensive patient care training essential for providing high quality pharmacist services, a requirement that has been in place **since 2004**.

### ACCESSIBLE

#### MOST ACCESSIBLE HEALTHCARE PROFESSIONAL

**520**  
Pharmacists  
in Alaska <sup>1</sup>

**860**  
Pharmacy  
Technicians  
in Alaska <sup>1</sup>

**89%**  
Americans live within 5 miles  
of a community pharmacy. <sup>2</sup>

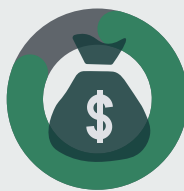
Number of pharmacies is  
**15% higher**  
than number of  
provider's offices  
in communities where more than  
30% of households live in poverty. <sup>3</sup>

### PUBLIC HEALTH IMPACT

#### VITAL TO IMPROVING PUBLIC HEALTH



Approximately 50% of  
all adults in the U.S.  
have one or more  
chronic disease  
conditions. <sup>4</sup>



Chronic conditions  
account for over 85%  
of total U.S. health  
care costs. <sup>4</sup>



Saved for every \$1  
spent on pharmacist  
service. <sup>5</sup>

## COVERAGE OF SERVICES

Pharmacists' clinical services are **rarely** covered under the medical benefit by **health plans**. This creates **barriers** to patients using their health insurance to receive care from pharmacists.

**\$9.64**

return on investment for every \$1 when pharmacists are paid for providing various patient care services.<sup>6</sup>

All health plans, public and private, **must** cover the services pharmacists provide to ensure patient access.

## TEST & TREAT

**Pharmacy-based point-of-care testing and treatment services provide prevention and early detection for minor health conditions.**

**30**

States now authorize pharmacists to directly order and administer CLIA-waived tests.

States now authorize pharmacists to directly prescribe treatment pursuant to a CLIA-waived test.

**13**

### Common Pharmacy-Based CLIA-Waived Tests\*

COVID-19	Flu	UTI	HIV
Strep	RSV	STI	& more

\*Abbreviation details available on references page.

## IMMUNIZATIONS

Alaska pharmacists are independently prescribing vaccines.

Pharmacies offer **TWICE** the operating hours for giving immunizations vs. provider's offices<sup>7</sup>

### 2023-24 Flu Season

Pharmacies gave **37.6 Million** flu shots

**vs**

**25.5 Million** given at provider's offices<sup>8</sup>

**27**

States now authorize pharmacists to **directly prescribe** and administer vaccines to patients.

## OPIOID USE DISORDER

**81,000 Americans** died from an opioid overdose in 2023.<sup>9</sup>

**222** average deaths per day<sup>9</sup>

**13**

States authorize pharmacists to prescribe medications for opioid use disorder.

**Naloxone access laws that grant pharmacists direct authority to prescribe are associated with significant reductions in fatal overdoses.**

## HIV PREVENTION

**Pharmacists have been identified by the White House as key professionals in achieving one of the CDC's goals of ending the HIV Epidemic in the U.S. by preventing HIV infection.**

States authorize pharmacists to directly prescribe HIV pre-exposure prophylaxis (PrEP) medications.

**16**

**19**

States authorize pharmacists to directly prescribe HIV post-exposure prophylaxis (PEP) medications.

This information was developed through a collaboration between NASPA and APhA, with generous support from the Community Pharmacy Foundation.



Access our references at  
[tinyurl.com/2024factsheet](https://tinyurl.com/2024factsheet)  
Or scan this QR code



# REIMBURSING U.S. PHARMACISTS TO TEST AND TREAT COMMON ILLNESSES

Prepared for:  
State of Alaska  
7/10/2024



Can speed up treatment, increase convenience, improve access to care and decrease costs for Alaska and its residents

## HEALTHCARE WORKERS ARE IN SHORT SUPPLY

The national shortage of U.S. healthcare workers (**more than 3.2 million by 2026**<sup>2</sup>) leaves many individuals without timely access to diagnosis and treatment services for low acuity respiratory symptoms.

Pharmacist test and treat services can help free up specialized medical technologists across the health system for priority testing and treatment of life-threatening illness.

## "HEALTHCARE DESERTS" COMPOUND THE PROBLEM

Nearly **75 million people**, or almost one-third of the population, reside in one of the **7,475** Primary Care Health Professional Shortage Areas (HPSAs) across the U.S.<sup>1</sup> HPSAs can be both rural and urban, and have limited access to basic medical services.

### IN ALASKA THERE ARE

**287.7 THOUSAND**

people living in

**333**

Healthcare Primary Care Professional Shortage Areas (HPSAs)<sup>1</sup>

**112.9 THOUSAND**

Medicare enrollees, or

**15.0%**

of the population<sup>3</sup>

**44 THOUSAND**

Estimated **Medicare enrollees** experiencing challenges to access care in HPSAs\*

## PHARMACISTS ARE FILLING THE VOID, ESPECIALLY IN RURAL AND UNDERSERVED COMMUNITIES



**89%**

of Americans live within **5 miles** of a pharmacy<sup>4</sup>



**62**

Alaska pharmacies with CLIA-waivers to perform diagnostic tests<sup>5</sup>

Since 2020, pharmacists have delivered over

**42 MILLION**

respiratory illness tests, establishing a **nationwide network for rapid testing**<sup>6</sup>

## PHARMACY TEST AND TREAT SERVICES CAN REDUCE HEALTHCARE COST

### UPPER RESPIRATORY TRACT INFECTIONS

### PATIENT OUT-OF-POCKET (COST SHARING)

### HEALTH SYSTEM PAYMENT

Average visit cost -  
Emergency Department

\$523<sup>7</sup>

\$1,535<sup>7</sup>

Pharmacy test and treat  
(assumes 20% co-pay)

\$28.70

\$143.50<sup>8,9</sup>

If 1% of Medicare enrollees in Alaska visited a pharmacy instead of an emergency department,

**\$1 MILLION**

in **health care system savings** could be achieved\*\*  
**reducing patient out-of-pocket costs**\*\*\*

**95%**

Estimates shown are for illustrative purposes only. There is no guarantee of the potential savings indicated.

\*(% of state population living in HPSA (287,657 people in HPSA<sup>1</sup> / 733,406 census population<sup>10</sup>) x 112,886 Medicare enrollees<sup>3</sup>).

Assumes distribution across HPSAs consistent with general population.

\*\*((ED Health System Payment (\$1,535-\$523<sup>7</sup>) - Pharmacy test and treat (\$143.50-\$28.70<sup>8</sup>)) x (112,886 Medicare enrollees<sup>3</sup> x .01)

\*\*\*\$523 out-of-pocket cost for ED visit<sup>7</sup> vs. \$28.70 out-of-pocket cost for pharmacy test and treat<sup>8</sup>

06/2024



## TEST AND TREAT AT THE LOCAL PHARMACY CAN REDUCE COST AND OFFER HIGH-QUALITY, CONVENIENT CARE



### REDUCED COST

Pharmacy test and treat services have the potential to reduce health system costs as well as out-of-pocket expenses for patients. These services, if reimbursed at current cash pay prices, would be **similar to costs for low acuity urgent care or primary care office visits**.

Patients who do not have access to a primary care doctor will have the opportunity to be quickly diagnosed and treated, so their respiratory **symptoms do not progress into a more serious and costly health care condition** such as bronchitis or pneumonia.<sup>11-13</sup>

Patients and insurers will receive the full clinical benefit of money spent on COVID-19 and influenza **treatments which are only effective if started within 2-5 days of symptom onset**.<sup>14-16</sup> Studies have shown that treatment within 48 hours for the Flu can shorten the duration, severity and cost of the illness.<sup>17</sup>

Individuals who live in medical provider shortage areas will have an **alternative to using the ER for respiratory infections** which are common and generally uncomplicated if diagnosed and treated early.<sup>18</sup>



### HIGH QUALITY CARE

Pharmacist education includes the **extensive study of diseases, their diagnosis, and corresponding treatments**.<sup>19</sup>

All states **mandate that pharmacists maintain their clinical expertise** through continuing education credits, and many states require pharmacists providing test and treat services to complete additional training.<sup>19, 20</sup>



### CONVENIENCE

Pharmacies are often located near homes, along bus lines or within locations people already frequent daily, like grocery and convenience stores. Reimbursing pharmacists to test and treat will **empower patients to seek care** at drug stores nearby, making convenience even greater.

Pharmacists can **speed up diagnosis and treatment** of common illnesses by offering both services in a single location. Immediate treatment can help patients get well sooner, allowing them to **return to work or school more quickly**.

Pharmacies have **flexible hours** beyond just the traditional workday, with many open on weekends or even 24/7. They can provide test and treat services during hours other care may not be available, **especially in parts of the country that lack other flexible options** (e.g. urgent care, after hours clinics).

## LEGISLATIVE ACTION IS NEEDED

| Respiratory testing access with pharmacists nationwide is at risk

Without action, pharmacies will lose their incentive to maintain their testing infrastructure, causing a **significant loss in availability of test and treat services needed during respiratory illness seasons** when preventing the spread of infection is most important for seniors. Ultimately, patient outcomes may suffer.<sup>21, 22</sup>

**Across the U.S., more than 7,000 pharmacies have closed since 2019.** Experts say they can leave behind communities that have come to depend on them as trusted sources of care and advice - both of which can be hard to find in many urban and rural areas.<sup>23</sup>

Reimbursement of pharmacy test and treat services can help offset losses from reduced dispensing reimbursement and DIR (direct and indirect remuneration) reform.<sup>24</sup>

### H.R. 1770 / S. 2477 EQUITABLE COMMUNITY ACCESS TO PHARMACIST SERVICES ACT

Authorizes pharmacists to **receive reimbursement for low-acuity respiratory illness** services for seniors and others receiving Medicare<sup>25</sup>

- Does not provide Medicare reimbursement for all services such as medication, chronic disease management, health and wellness screening, and education
- Does not recognize pharmacists as health care providers for all Medicare patients
- **Does not supersede state scope of practice laws**<sup>26</sup>

## REFERENCES

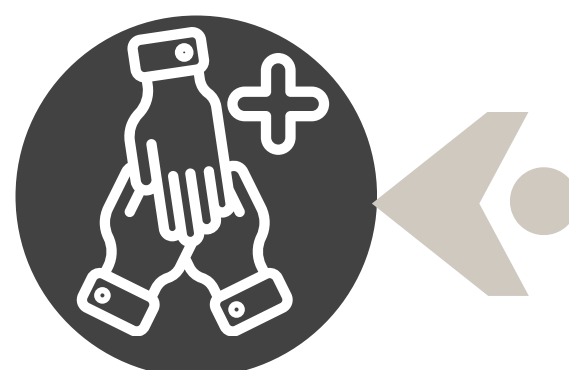
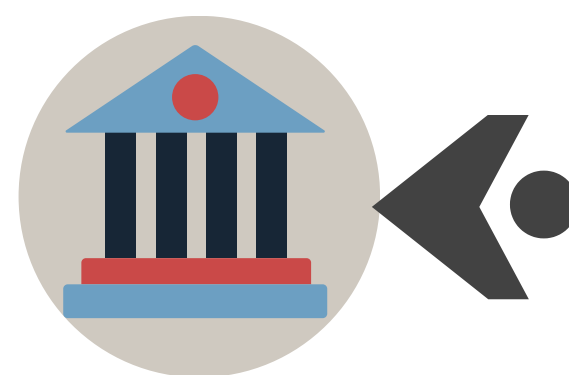
1. KFF's State Health Facts. Primary Care Health Professional Shortage Areas (HPSAs) 1-April-24. <https://www.kff.org/other/state-indicator/primary-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22all%22:%7B%7D%7D,%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>. Accessed 28-May-24.
2. Bateman T et al. Mercer, LLC. U.S. Healthcare labor market. 2021. <https://www.mercer.com/content/dam/mercer/assets/content-images/north-america/united-states/us-healthcare-news/us-2021-healthcare-labor-market-whitepaper.pdf>. Accessed 29-May-24.
3. Worstell C. Medicare Statistics 2024. <https://www.medicareadvantage.com/resources/medicare-statistics>. Accessed 16-May-24.
4. Berenbrok LA, et al. Access to community pharmacies: A nationwide geographic information systems cross-sectional analysis. *J Am Pharm Assoc* (2003) 2022;62(6):1816-1822 e2. DOI: 10.1016/j.japh.2022.07.003.
5. Centers for Medicare and Medicaid Services. Provider of services file - Clinical laboratories. ed.2023. <https://data.cms.gov/provider-characteristics/hospitals-and-other-facilities/provider-of-services-file-clinical-laboratories>.
6. Grabenstein JD. Essential services: Quantifying the contributions of America's pharmacists in COVID-19 clinical interventions. *J Am Pharm Assoc* (2003) 2022;62(6):1929-1945 e1. DOI: 10.1016/j.japh.2022.08.010.
7. Schwartz H et al. Emergency department visits exceed affordability threshold for many consumers with private insurance. KFF Health System Tracker. 16-Dec-22. <https://www.healthsystemtracker.org/brief/emergency-department-visits-exceed-affordability-thresholds-for-many-consumers-with-private-insurance/>. Accessed 3-June-24.
8. Walmart. Testing and treatment for strep throat, flu and COVID-19. [https://www.walmart.com/cp/test-treat/4097505?povid=OMNISRV\\_D\\_i\\_GLOBAL\\_Nav\\_ServicesNav\\_HW\\_4097505\\_SuperDepartment\\_Pharmacy\\_Testing&Treatment\\_1332399668](https://www.walmart.com/cp/test-treat/4097505?povid=OMNISRV_D_i_GLOBAL_Nav_ServicesNav_HW_4097505_SuperDepartment_Pharmacy_Testing&Treatment_1332399668). Accessed 3-June-24.
9. Walgreens. Walgreens Pharmacy tests & treatments. Walgreens. <https://www.walgreens.com/findcare/covid19/testing/services/>. Accessed 3-June-24.
10. U.S. Census Bureau. Annual estimate of the resident population for the United States, regions, states, District of Columbia and Puerto Rico: April 1, 2020 to July 1, 2023. In: Bureau USC, ed.2023. <https://www.census.gov/data/tables/time-series/demo/popest/2020s-state-total.html#v2023>. Accessed 30-May-24.
11. U.S. Centers for Disease Control and Prevention (CDC). Flu symptoms and complications. <https://www.cdc.gov/flu/symptoms/symptoms.htm#complications>. Accessed 3-June-24.
12. U.S. Centers for Disease Control and Prevention (CDC). Similarities and differences between flu and COVID-19. <https://www.cdc.gov/flu/symptoms/flu-vs-covid19.htm>. Accessed 3-June-24.
13. U.S. Centers for Disease Control and Prevention (CDC). About Strep throat. [https://www.cdc.gov/group-a-strep/about/strep-throat.html?CDC\\_AAref\\_Val=https://www.cdc.gov/groupastrep/diseases-public/strep-throat.html](https://www.cdc.gov/group-a-strep/about/strep-throat.html?CDC_AAref_Val=https://www.cdc.gov/groupastrep/diseases-public/strep-throat.html). Accessed 3-June-24.
14. U.S. Food and Drug Administration (FDA). Fact sheet for healthcare providers: Emergency use authorization for PAXLOVID(TM). <https://www.fda.gov/media/155050/download#:~:text=The%20dosage%20for%20PAXLOVID%20is,each%20active%20ingredient%20within%20PAXLOVID>. Accessed 4-June-24.
15. U.S. Food and Drug Administration (FDA).. TAMIFLU Highlights of prescribing information. ([https://www.accessdata.fda.gov/drugsatfda\\_docs/label/2011/021087s057lbl.pdf](https://www.accessdata.fda.gov/drugsatfda_docs/label/2011/021087s057lbl.pdf)). Accessed 4-June-24.
16. U.S. Centers for Disease Control and Prevention (CDC). What are flu antiviral drugs. <https://www.cdc.gov/flu/treatment/whatyoushould.htm>. Accessed 4-June-24.
17. MHPC Massachusetts Health Policy Commission. Urgent care centers and retail clinics: Growth in alternative care sites in Massachusetts over time <https://www.mass.gov/doc/datapoints-issue-8-printable-version/download>. Accessed 30-May-24.
18. HCUP Healthcare Cost and Utilization Project. Most frequent reasons for Emergency Department visits 2018. Statistical Brief. 2018. <https://hcup-us.ahrq.gov/reports/statbriefs/sb286-ED-Frequent-Conditions-2018.pdf>. Accessed 4-June-24.
19. ACPE Accreditation Council for Pharmacy Education. PharmD program accreditation. <https://www.acpe-accredit.org/pharmd-program-accreditation/>. Accessed 3-June-24.
20. NABP National Association of Boards of Pharmacy. Survey of pharmacy law. <https://nabp.pharmacy/news-resources/resources/publications/survey-of-pharmacy-law/>. Accessed 3-June-24.
21. NASPA. PREP Act Amendments 7, 8, 9 and 10 outline specific authority for pharmacists, pharmacy technicians and pharmacy interns. [www.naspa.us/resource/federal-prep-act-actions](http://www.naspa.us/resource/federal-prep-act-actions). Accessed 28-May-24.
22. Klepser NS et al. Impact of COVID-19 on prevalence of community pharmacies as CLIA-Waived facilities. *Res Social Adm Pharm* 2021;17(9):1574-1578. DOI: 10.1016/j.sapharm.2020.12.003.
23. Murphy T, Pananjady, K. As pharmacies shutter, some western states, black and latino communities are left behind. Associated Press News. <https://apnews.com/article/pharmacy-closure-drugstore-cvs-walgreens-rite-aid-91967f18coco59415b98fcf67adof84e>. Accessed 5-June-24.
24. Hamstra M. Industry in transition. *Drug Store News*. 23-April-24. <https://drugstorenews.com/industry-transition>. Accessed 5-June-24.
25. Congress.gov. H.R. 1770 / S. 2477 Equitable community access to pharmacist services act. 2024. <https://www.congress.gov/bill/118th-congress/house-bill/1770>. Accessed 29-May-24.
26. APHA American Pharmacists Association. Pharmacy's top priority: Medicare provider status recognition. <https://www.pharmacist.com/Advocacy/Issues/Provider-status/Equitable-Community-Access-to-Pharmacist-Services-Act-ECAPS>. Accessed 30-May-24.

# SB 147

## PHARMACIST PROVIDED PATIENT CARE SERVICES / STANDARD OF CARE



The goal of this bill is to increase access to pharmacist-provided patient care services, allowing healthcare practitioners in Alaska to practice at the top of their education, training, and experience.



### ALIGNMENT WITH THE STANDARD OF CARE

The Alaska Board of Pharmacy already regulates pharmacists under the standard of care, this bill aligns the statute with this model.

### ESTABLISHED FEDERALLY

Expanded pharmacist services have been established federally. MAT Act allows pharmacists to prescribe for opioid use disorder. Nearly 100 years of evidence based practice at federal healthcare settings show improved patient outcomes.

### INTERDISCIPLINARY COLLABORATION

The bill encourages interdisciplinary collaboration & patient referral to higher levels of care as needed.

### INCREASED ACCESS TO TIMELY CARE FOR ALASKANS

Pharmacists are uniquely positioned to help manage chronic diseases and minor ailments, decrease unnecessary emergency department visits, and deliver preventative health outcomes.

### DOCTOR OF PHARMACY EDUCATION

Pharmacists complete a standardized Doctor of Pharmacy (PharmD) degree nationwide, accredited by Accreditation Council Pharmacy Education, with 1,740 hours of clinical training.

State Boards of Pharmacy help ensure safe care through participation in accreditation reviews.



Communities trust their pharmacists. With pharmacists permitted to practice at the top of their education, training, and experience, a pharmacist can better triage a patient for referral to more acute care when needed.

Alaskans Strongly Support Expanded Pharmacist Care. A recent national poll, including Alaska-specific data, reveals that Alaskans overwhelmingly support expanded roles for pharmacists in testing, treatment, and prevention of common and chronic conditions at their local community pharmacies.

Alaska's healthcare system in general has limited hospital beds, emergency department space, and other services in general. Utilizing every provider at the top of their education, training, and experience can increase access to timely and appropriate care

**SUPPORTED BY THE ALASKA BOARD OF PHARMACY & THE ALASKA PHARMACY ASSOCIATION**



## Press Releases Published on Tuesday, December 10, 2024

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# HHS extends federal authority consistent with APhA request for pharmacy personnel to independently administer vaccines and test to treat services through 2029

WASHINGTON, DC — The American Pharmacists Association (APhA) released the following statement regarding the U.S. Department of Health and Human Services (HHS) response to APhA's request to issue a [twelfth amendment](#) to the declaration under the federal Public Readiness and Emergency Preparedness (PREP) Act for medical countermeasures.

"Today's necessary actions by HHS will continue to [save lives and lower health care costs](#), particularly in rural and underserved areas where the local pharmacy may be the only health care provider for miles," said Michael D. Hogue, PharmD, FAPhA, FNAP, FFIP, executive vice president and CEO of APhA. "As a vital part of our nation's health care infrastructure, pharmacy teams serve as the front line of defense against infectious disease. APhA applauds HHS for extending these federal authorities until [legislation](#) is passed by the U.S. Congress to make them permanent."

Key changes finalized in the amendment include:

- **Extends PREP Act coverage and authority for COVID-19 and seasonal influenza vaccines and COVID-19 tests.** PREP Act immunity from liability is extended through December 31, 2029, to pharmacists to order and administer and pharmacy interns and pharmacy technicians to administer COVID-19 and seasonal influenza vaccines (three and over), and COVID-19 tests.

Since 2020, licensed pharmacists in all 50 states have been able to utilize federal PREP Act authority to provide vaccination, and testing and treatment services, specifically to children ages 3 to 18 years, where they previously had not been permitted in certain states. Several states have taken action ([see map](#)) to make these federal PREP Act authorities permanent.



## The Community Pharmacy Technician's Role in the Changing Pharmacy Practice Space

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### Abstract

**Purpose:** The practice of pharmacy and role of pharmacists has evolved over the decades but markedly since the introduction of the Affordable Care Act (ACA) in 2010. The ACA allowed patients to have increased access to community pharmacy services, such as medication therapy management, leading to an increase in the clinical services provided by pharmacists. This expansion of pharmacist's roles has led to pharmacists to feel an increase in workload which negatively impacts the time spent with patients. One way for this shift to occur without continuing to increase the pharmacist's workload is by using technicians as pharmacist extenders to take on more technical tasks.

**Summary:** The role of pharmacy technicians has been slow to expand from fear of public safety due to the lack of required education and training. Today, state requirements to practice as a pharmacy technician have become stricter with state requiring licensing, registration or certification. This increase in requirements as led to the expansion of pharmacy technician duties. Studies show that pharmacy technicians are able to perform technician accuracy checking, provide immunization and perform Clinical Laboratory Improvement Amendments (CLIA)-waived screenings. In addition to these duties, pharmacy technicians are being utilized in more novel ways such as collecting medication information in primary care and telepharmacy settings.

**Conclusion:** In order for pharmacy to continue to grow as a profession, pharmacists need to use pharmacy technicians as extenders. As pharmacy technicians begin to take on more of the technical duties, pharmacists are able to increase the time spent with patients.

**Key Words:** Pharmacy technicians, expanding roles, community pharmacy

### Introduction

Community pharmacists are seeing an evolution in their role with the shift in healthcare focusing on quality of care, brought on by the Affordable Care Act. The act signed into law in 2010, helped to expand pharmacists' roles in coordinating care for patients and medication therapy management. While this was a great advancement for the profession of pharmacy, pharmacists feel an increased workload on a daily basis to provide their traditional dispensing services in addition to clinical services. According to the 2014 American Association of Colleges of Pharmacy's (AACP) National Pharmacists Workforce Survey, 66% of community pharmacists reported an increase or great increase in workload compared to a year ago.<sup>1</sup> In addition to the increase in workload, 54% of community pharmacists stated that their workload negatively impacted the time spent in contact with patients and 35.5% of community pharmacists felt that their workload negatively impacted the quality of care provided to patients.

On average community pharmacists spend 75% of their time on patient care services associated with dispensing which includes calling providers, counseling on medications and preparing medications.<sup>1</sup> The traditional role of a pharmacy technician is to aid the pharmacist in providing patient care services associated with dispensing that do not require professional judgement. The other 25% of the community pharmacist's day

is spent on patient care services not associated with dispensing and business management at 13% and 12%, respectively. Patient care services not associated with dispensing contain services billable by pharmacists such as completing comprehensive medication reviews, assessing medication needs, and adjusting medication dosages. Providing more patient care services not associated with dispensing can help close the gap between the actual dispensing cost and reimbursement received through the additional revenue. This shift in focus on clinical services to make revenue means that pharmacist's need to spend less time in the dispensing role and more time providing more clinical services. One way for this shift to occur without continuing to increase the pharmacist's workload is by using technicians as pharmacist extenders to take on more technical tasks. These technical tasks should include both traditional dispensing roles as well as novel non-traditional roles, such as vaccination administration and administration positions. To justify the expansion of pharmacy technician's role, pharmacists must recognize the history and development of pharmacy technician roles, understand pharmacy technician laws and regulation, and utilize technicians as pharmacist extenders.

### History of Pharmacy Technician Roles

Pharmacy technicians have a long history in the pharmacy profession. The first formal pharmacy technician role dates back to approximately 1939 during World War II.<sup>2</sup> Much like many pharmacy technicians today, technicians during this time were high school graduates without any formal training beyond employer-based training programs and their main duty was to assist the pharmacists in their daily tasks. For many years pharmacists were reluctant to increase the numbers of pharmacy technicians within pharmacies as they were hesitant

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to pay additional personnel and feared that they would take their careers.<sup>3</sup> In the 1960s and 1970s health-system pharmacists began to shift to more of a clinical role and automation became more common in pharmacies.<sup>2</sup> These innovations led to more formalized roles of pharmacy technicians, particularly in the hospital setting.

Community pharmacists, on the other hand, were reluctant to the idea of utilizing pharmacy technicians out of concern for public safety. Due to this fear and increased number of pharmacy technicians, the U.S. Department of Health, Education and Welfare in 1968 recommended that pharmacy technicians have formal training in junior colleges and other institutions. While the creation of training guidelines and programs for health-system pharmacy technicians began by the mid-1970s, it wasn't until 1990s when community pharmacy technician roles become better defined, which in turn brought the development of national certifications and implementation of training for community pharmacy.

### Pharmacy Technician Rules and Regulations

Today, the requirements and roles of community-based pharmacy technicians vary from state to state. Many states now require pharmacy technicians to become registered, certified or licensed but the requirements to obtain these designations is not uniform across the country. According to the Pharmacy Technician Certification Board (PTCB), registration is defined as "making a list of pharmacy technicians in the state or of being enrolled in an existing list" and licensure is defined as "the process by which an agency of government grants permission to an individual to engage in a given occupation upon recognizing that the applicant has attained the minimum competency necessary to ensure that the public health, safety, and welfare will be reasonably well protected".<sup>4</sup> While these definitions help distinguish between registration and licensure nationally, the specific requirements and terminology to hold these designations still vary by state. Variability among states include roles such as registered technician, certified technicians, licensed technicians, as well as entry-level and advanced technicians. Many states that require pharmacy technicians to become registered have education or training requirements making it similar to a license. For example, in Indiana and Ohio all pharmacy technicians must be 18 years of age or older, obtain a high school diploma or GED, submit a criminal background check and complete an approved education program, however Indiana pharmacy technicians are termed to be "licensed technicians" while Ohio pharmacy technicians are considered "registered technicians" even though the requirements are the same. Currently, 73% of the United States require training of pharmacy technicians, however 35% of states require board approved training programs and only North Dakota requires an ASHP accredited program.<sup>5</sup>

Certified pharmacy technicians are the only subset with a very defined set of requirements. In order for technicians to become

nationally certified as a technician they must pass an examination approved by the Pharmacy Technician Certification Board (PTCB) or National Pharmacy Technician Association (NPTA) which attests the status of their education. In addition, pharmacy technicians must possess a high school diploma, disclose criminal and State Board of Pharmacy actions, complete an accredited education program and receive a passing score on the PTCB or NPTA examination.<sup>6,7</sup>

**Table 1: Pharmacy Technician Requirements**

Required Status	Number of States*
Licensed	11
Registered	33
Certified	24
Training	38
*includes Washington D.C., Guam, and Puerto Rico	

In addition to the variation in requirements to become a pharmacy technician there are variations in pharmacy technicians' roles. The traditional role common in all states include entering prescriptions into a pharmacy computer, counting medications, and affixing labels.<sup>5</sup> As pharmacy expands the role of the pharmacy technician, they are given responsibilities in non-traditional roles such as accepting called-in prescriptions, checking the work of other technicians and administering immunizations. By allowing pharmacy technicians to take on these non-traditional roles, it will allow pharmacists to have more time to complete patient care services not associated with dispensing and allow for increased revenue.

**Table 2: Pharmacy Technician Roles**

Technician Role	Number of States*
Accept Called-in Prescriptions	14
Administer Immunizations	2
Call Physician for Refill Authorization	41
Check Work of Other Technicians	12
Compound Medication for Dispensing	52
Enter prescriptions into Pharmacy Computer	53
Transfer Prescriptions	12
*includes Washington D.C., Guam, and Puerto Rico	

### Pharmacy Technicians as Pharmacist Extenders

In order for the scope of pharmacists' practice to continue to grow, pharmacists should utilize their pharmacy technicians as extenders. As community-based pharmacists develop new roles, they are expected to do more with less time by providing an increase number of clinical services while performing traditional dispensing for more patients. By utilizing pharmacy technicians to their full potential, pharmacists can increase time spent with patients and conducting clinical services. The

term technicians as pharmacist extenders means that pharmacy technicians are used based on their full scope of practice to help pharmacists reach more patients, improve clinical outcomes and increase revenue. The full scope of pharmacy technicians includes the traditional roles of support for dispensing but also includes non-traditional roles of administering immunization, technician accuracy checking, and facilitation of Clinical Laboratory Improvement Amendments (CLIA)-waived screenings. Studies have shown that pharmacy technicians are capable of performing these non-traditional tasks by being just as safe and accurate as pharmacists and it allows pharmacist to spend more time in the clinical role.<sup>8-11</sup>

Pharmacy technician provided immunizations and technician accuracy checking are two areas that pharmacy technicians have recently been given more responsibility to complete. Currently only three states, Rhode Island, Idaho and Utah, allow pharmacy technicians to administer all United States Centers for Disease Control and Prevention (CDC) recommended vaccinations to patients. In these states, technicians must complete a 6-hour training program from the Accreditation Council for Pharmacy Education (ACPE) that contains 2 hours of home study material and a 4-hour live training or American Pharmacists Association (APhA) Pharmacy-based Immunization Delivery training. In addition to the training, technicians must be PCTB or NPTA and basic life support (BLS) certified. While there have been no randomized controlled trials conducted on technician administered vaccinations, Idaho collected anecdotal data from the 6-month pilot period before it became a law. During this 6-month period, 25 technicians administered 935 vaccines to patients that were 6 years or older and no adverse events were reported.<sup>8</sup> Currently there are no studies showing the direct benefit of pharmacy technicians administering vaccinations, however the profession of pharmacy can extrapolate anecdotal data from physician and other medical practice models. In these practice models, physicians often delegate vaccination administration to medical assistants and nurses whom have similar or less training as pharmacy technicians. While more studies need to be conducted to show the true economic and clinical benefit of pharmacy technicians administering vaccinations, with millions of immunizations provided to patients each year the pharmacists' time saved is the largest benefit.

Technician accuracy checking is another role that is becoming more common as part of pharmacy technician's full scope of practice. Technician accuracy checking (TAC) is defined as utilizing technology to check the work of someone else, an automated dispensing system or other technology assisted filling equipment. An example of accuracy checking includes having a technician ensure that the current product and quantity was dispensed by an automated dispensing machine. Currently, 20 states allow TAC either through a pilot program or is board approved but 10 states only allow it in the outpatient setting. In the inpatient setting, there have been 11 studies on TAC in which all show that technicians were just as accurate, if

not more accurate, than pharmacists at checking the accuracy of dispensed medication. In the community setting four studies have been conducted and found similar results to the inpatient studies; that technicians are just as accurate as pharmacists at accuracy checking.<sup>9-10</sup> In a study conducted by the University of Wisconsin researchers found that technicians are 99.95% accurate compared to pharmacist whom are 99.74% accurate.<sup>9</sup> In another study that looked at overall errors as well as administrative and patient safety errors found no statistically significant difference between pharmacists and pharmacy technicians.<sup>10</sup> In addition to technicians being equally accurate as pharmacists, two studies showed that by allowing technicians to check medications it allowed the pharmacists to have more time, equivalent to approximately 23 days a year, to complete other direct patient care tasks in the day. The increase in time in direct patient care allowed the pharmacist to spend significantly more time providing counseling to patients on medications and determining proper drug utilization.<sup>9</sup>

### Novel Technician Duties

In pharmacy, there has been an increase in the number of point of care testing (POCT) services provided to patients. CLIA-waived POCTs, which are defined as simple tests with a low risk for an incorrect result, are quick tests that may be performed by pharmacists and pharmacy technicians. Some common POCT performed by pharmacists and pharmacy technicians include cholesterol, blood glucose and International Normalized Ratio (INR) testing. Patients want quick and easy clinical services, and many pharmacies and ambulatory care clinics have shorter wait times than a traditional emergency room or acute care clinic leading to increased demand for POCTs and services. One practice model that would utilize pharmacy technicians would be having the technician set up appointments for patients, gather patient information when rooming patients for appointments and perform the CLIA-waived point of care test. This model would allow the pharmacist to see an increase number of patients since the pharmacy technician would be obtaining the laboratory value leaving the clinical decision making to the pharmacist. Some common CLIA-waived point of care tests performed by pharmacies include blood glucose, cholesterol, influenza, group B streptococcus, human immunodeficiency virus (HIV) and human papillomavirus (HPV) tests. As the scope of point of care testing completed in a community pharmacy and ambulatory care setting grows, the more pharmacists will need to rely on their pharmacy technicians.

Another novel role for pharmacy technicians would be when patients are admitted to an urgent care clinic or present to a community pharmacy either in person or virtually through telehealth to obtain patient information such as a medication history. The practice model would be similar to the point of care testing and would mirror that of a medical assistant or nurse and physician or physician assistant during a doctor's appointment. The pharmacy technician would collect all

background information then the pharmacist would see or talk to the patient. Again, this model would allow the pharmacist to focus on the medication related problems and clinical recommendations by having all needed information collected before seeing the patient. In rural areas, telepharmacy could be used to allow the pharmacist to access a larger patient population and allow patients to stay close to home for their care if done virtually. The practice model would work the same as in person appointments but would be done through a computer or phone.

Point of care testing and medication management services can provide additional revenue to ambulatory care clinics and community pharmacies when provided in person or virtually. At many community pharmacies, point of care testing is an out of pocket service for patients providing direct revenue to the pharmacy and the cost of these services vary by location. In ambulatory care clinics, pharmacists can bill incident-to a physician for services as a source of revenue. The reimbursement for pharmacy services billed incident-to a physician depends largely on the complexity of the appointment but could range from approximately \$20 to \$100 and depending on state regulations telepharmacy services may be billed similarly to in-person pharmacy services with similar reimbursement. The benefit of utilizing pharmacy technicians to help provide these services is the amount of time saved to pharmacists. In a study coordinated by the Pittsburgh Regional Health Initiative (PRHI), pharmacy technicians performed tasks such as obtaining patient medication, retrieving laboratory information from the patient's chart and gathering patient education materials which allowed for a 40.5% increase in the number of CMRs completed by pharmacists.<sup>11</sup>

Lastly, pharmacy technicians could be utilized in management roles needed to ensure the pharmacy runs efficiently such as inventory management, 340B coordination, informatics, and billing and finance integrity. These roles are very important to make sure that the pharmacy has sufficient inventory, reimbursed properly, and meeting compliance standards of the many regulatory bodies; and can take a lot of time to be done properly. While some health-systems utilize their pharmacy technicians in management roles, there is a great opportunity in the outpatient space. As frontline staff, pharmacy technicians are knowledgeable in possible workflow enhancements that need to be made, inventory management strategies and education and training of other technicians. Utilizing pharmacy technicians in these roles, once again allows pharmacist to spend more time performing clinical duties.

## Conclusion

As the world of healthcare continues to evolve so does the profession of pharmacy. While stagnant for many years, the role of the pharmacy technician has begun to evolve since 1939 when pharmacy technicians had minimal assistant duties. This movement is in large part due to more regulated training and registration or licensure requirements to be a pharmacy

technician. As pharmacy technician's roles begin to expand, registration or licensure requirements need to become more standardized. This standardization will not only help pharmacist feel more comfort allowing technician to take on more tasks but allow boards of pharmacy more oversight of technicians.

In order to be able to provide the services necessary to create a sustainable profession, pharmacy cannot get complacent and must utilize our pharmacy counterparts. By allowing pharmacy technicians to take on non-traditional roles such as administering immunizations, technician accuracy checking and point of care testing it allows pharmacists to provide more clinical services and increase the time spent with patients. While more studies need to be done to investigate the direct economic and clinical impact of these non-traditional roles of pharmacy technicians, the impact of pharmacists provided clinical services has shown a direct correlation to better health outcomes, increased patient satisfaction and positive economic impact.

**Conflicts of Interest:** None

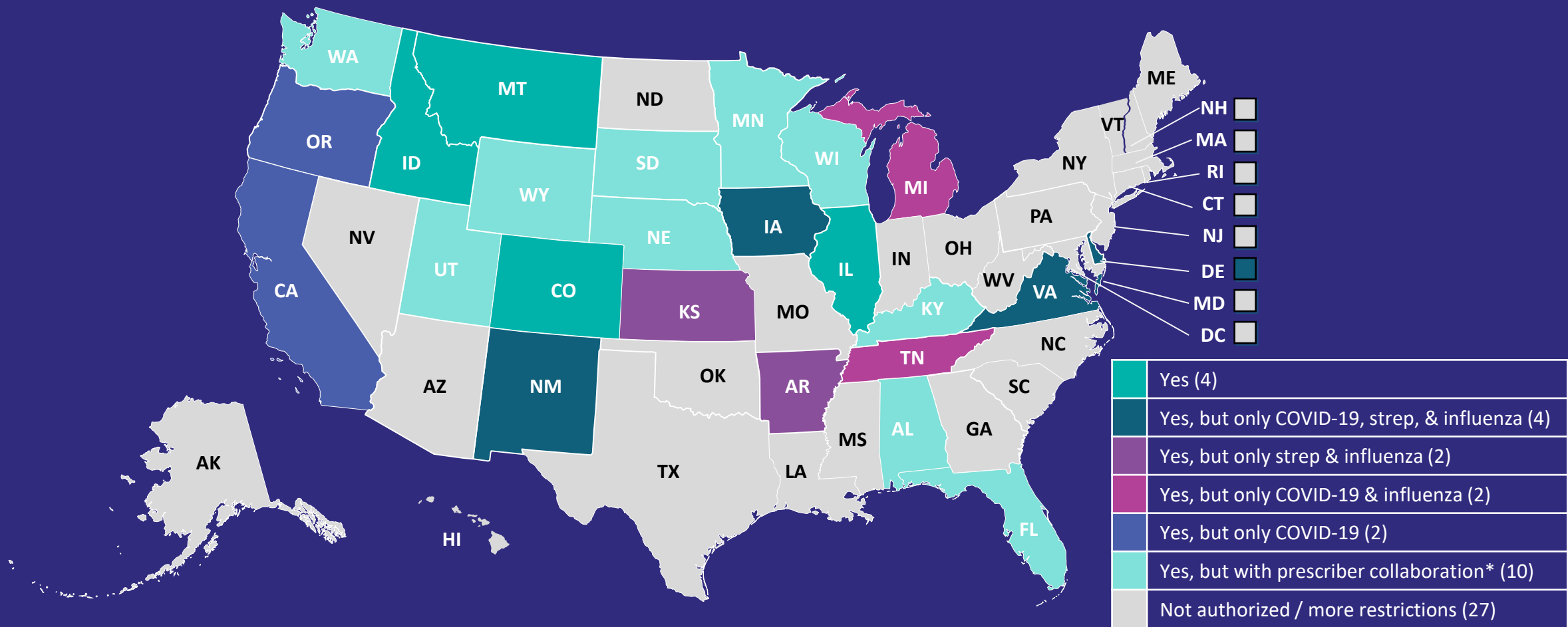
## References

1. Gaither CA, et al. Final report of the 2014 National Sample Survey of the Pharmacist Workforce to determine contemporary demographic, practice characteristics and quality of work-life. AACP. 2015 Apr 8.
2. McCarthy R. Pharmacy Technicians. American Institute of the History of Pharmacy. 2016. Available from: <https://aihp.org/wp-content/uploads/2018/08/4-Pharmacy-Technicians.pdf>
3. CCI Training Center [Internet]. Dallas (TX): CCI Training Center. Pharmacy Technicians: The Past, Present and Future; 2015 Dec 26 [cited 2019 May 10]. Available from: <https://www.ccitraining.edu/blog/pharmacy-technicians-the-past-present-and-future/>
4. Pharmacy Technician Certification Board [Internet]. Washington (DC):Pharmacy Technician Certification Board. How can I obtain a state license?; 2019 Nov 23[cited 2019 May 12]. Available from: <https://www.ptcb.org/resources/cpht-toolkit/state-regulations#.XUIpyS2ZNQI>
5. Survey of Pharmacy Law. Mount Prospect (IL): National Association of Boards of Pharmacy; 2017.
6. Pharmacy Technician Certification Board [Internet]. Washington (DC):Pharmacy Technician Certification Board. Credentialing Guidelines and Requirements; [updated 2020; cited 2019 May 13]. Available from: <https://www.ptcb.org/guidebook/ptcb-certified-pharmacy-technician-cpht-program>



7. National Pharmacy Technician Association [Internet]. Houston (TX): National Pharmacy Technician Association. The ExCPT Exam; 2010 [cited 12 May 2019]. Available from: <http://www.pharmacytechnician.org/excpt/>
8. McKeirnan KC, et al. Transforming pharmacy practice: Advancing the role of technicians. *Pharmacy Today*. 2018 Jun.
9. Miller RF, et al. Evaluation of Community Pharmacy Tech-Check-Tech as a Strategy for Practice Advancement. *J Am Pharm Assoc*. 2018 Nov.
10. Andreski M, et al. The Iowa new practice model: Advancing technician roles to increase pharmacists' time to provide patient care services. *J Am Pharm Assoc*. 2018 May.
11. Fera T, et al. Clinical support role for a pharmacy technician within a primary care resource center. *Am J Health Syst Pharm*. 2018 Feb 1;75(3):139-144.

# Can pharmacists test and treat for COVID–19, influenza, respiratory syncytial virus, or streptococcal pharyngitis via prescriptive authority, statewide protocol, or other means?\*



\*Limited to collaborative practice agreements or prescriber protocols that allow multiple patients and do not require past prescriber-patient relationship

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April 22, 2025

Alaska State Senate  
Alaska State House of Representatives  
Juneau, Alaska 99801

**Subject:** Support for SB147 / HB195 – Expanding Pharmacists’ Authority to Improve Access to Care & Response to Opposition Comments

**Dear Members of the Alaska State Legislature,**

I am writing to express strong support for **Senate Bill 147 and HB 195 (SB147 / HB195)**, which modernize Alaska’s pharmacy practice laws to allow pharmacists to provide **limited patient care services within their education, training, and experience**.

This legislation is essential to improving timely healthcare access for Alaskans, particularly in underserved and rural communities.

Unfortunately, some opponents — notably the **Alaska Board of Medicine** — have launched an aggressive misinformation campaign against SB147 / HB195. Their arguments closely mirror the outdated and protectionist tactics historically employed by the **American Medical Association (AMA)** in opposing the advancement of all non-physician healthcare professionals.

It is critical that policymakers see these objections for what they are: **a defense of professional turf, not a defense of public health**.

## **SB147 / HB195: What It Actually Does**

**These bills are carefully crafted, limited-scope reform.**

It authorizes licensed pharmacists to **independently prescribe medications and devices related to minor illnesses, chronic disease management, and preventive care**, within the limits of their clinical education, training, and experience.

**It does not:**

- Expand pharmacists’ authority beyond services they are well trained to perform.
- Allow pharmacists to prescribe abortion-inducing medications (current Alaska law under AS 18.16.010 prohibits this and remains unchanged).

**SB147 / HB195 empowers pharmacists to serve patients more fully in areas where they are already trained, while maintaining clear standards of competence and professional accountability.**

## **Pharmacists are Highly Trained, Patient-Centered Providers**

Pharmacists today are **doctoral-level healthcare providers**, completing at least six to eight years of higher education, over **1,700 hours of direct patient care training**, and frequently pursuing **postgraduate**

**residencies and board certifications.**<sup>1 2</sup>

Pharmacists specialize in medication therapy, minor acute care, chronic disease management, preventive care, and patient counseling — areas where their clinical expertise is not only sufficient but **essential to expanding access to care**.

Notably, pharmacists played a critical role during the COVID-19 pandemic, delivering over **350 million clinical interventions** to Americans, including point-of-care testing, treatment, chronic disease management, and vaccination services.<sup>3</sup>

## Physician-Centric Turf Protection is a Recurring Obstacle to Progress

The **Board of Medicine's opposition to SB147 / HB195** is not unique.

It follows a well-worn playbook historically used by the **American Medical Association (AMA)** to **protect physician monopolies**, not patient outcomes.

Over the past century, the AMA has **opposed expanded roles for nurse practitioners, physician assistants, pharmacists, psychologists, optometrists, and nurse anesthetists**, despite overwhelming evidence that these providers improve healthcare access and quality.<sup>4</sup>

In fact, the AMA boasts about using its **Scope of Practice Partnership** to **defeat hundreds of bills** across the country — legislation that would have expanded access to basic healthcare services for millions of Americans.<sup>5</sup> In 2022 alone, the AMA proudly reported it helped **stop more than 140 scope-of-practice expansion bills**.<sup>6</sup>

This obstructionist legacy is important because it shows that **today's opposition to SB147 / HB195 is not about patient safety — it is about protecting market share**.

The **Cato Institute** and other conservative voices have rightly called this behavior a “**guild monopoly**” harmful to public health and free-market healthcare innovation.<sup>7</sup>

Time and again, history shows that when physicians have fought against expanding the roles of other providers, **patients have suffered the consequences** through reduced access, longer wait times, higher costs, and worse outcomes.

## Protectionism Hurts Alaska's Patients

Alaska faces serious healthcare access challenges — vast geographic distances, rural community shortages, and a growing burden of chronic disease.

**Pharmacists are often the only healthcare providers accessible without delay**, particularly in remote areas.<sup>8</sup> Enabling pharmacists to test, treat, and manage minor conditions **will not replace physicians** — it will **complement them**, freeing doctors to focus on complex and emergent cases while pharmacists help close gaps in care.

Expanding pharmacists' authority under SB147 / HB195 will:

- **Increase access to basic care** across rural and underserved areas
- **Relieve strain** on primary care, urgent care, and emergency departments
- **Reduce delays** in treatment for common, manageable conditions
- **Lower healthcare costs** by minimizing unnecessary doctor visits for routine issues
- **Improve health outcomes** by catching and treating illnesses earlier

These improvements are **not theoretical** — they have been documented extensively in states that have expanded pharmacist practice, without compromising patient safety.<sup>9</sup>

## A Vision for Collaborative, Patient-Centered Healthcare

We must move beyond physician-centered turf battles and **embrace a patient-centered, team-based healthcare model.**

Pharmacists are not seeking to replace physicians or practice medicine; we are asking to **practice fully within our education and expertise** — to serve as the medication and minor illness specialists we are trained to be. As Rear Admiral Kelly J. Battese, Chief Pharmacist Officer of the U.S. Public Health Service, eloquently stated:

*“We advocate for pharmacists to provide the care they are trained to provide. We do not want your scope; we want your collaboration.”<sup>10</sup>*

SB147 / HB195 represents a necessary, thoughtful step forward. It prioritizes patients over protectionism, evidence over fear tactics, and healthcare access over entrenched monopolies.

**Alaska cannot afford to cling to outdated models that restrict care.**

**For the health of our communities, for the strength of our healthcare workforce, and for the future of patient-centered innovation — we urge you to vote YES on SB147 / HB195.**

Thank you for your leadership and your commitment to advancing healthcare access for all Alaskans.

**Sincerely,**



Brandy Seignemartin, PharmD  
Executive Director, Alaska Pharmacy Association

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#### References

1. American Association of Colleges of Pharmacy. *Pharmacy Education Overview*. 2024.
2. National Association of Boards of Pharmacy. *Pharmacist Licensure Requirements*. 2023.
3. Grabenstein JD. Quantifying the contributions of pharmacists in COVID-19 clinical interventions. *J Am Pharm Assoc*. 2022;62(6):1929-1945.
4. Singer JA. *Medical Cartels Are Hurting Patients*. Cato Institute; 2024.
5. American Medical Association. *Scope of Practice Partnership Annual Report*. 2022.
6. American Medical Association. *AMA Advocacy Accomplishments*. 2022.
7. Singer JA. *Medical Cartels Are Hurting Patients*. Cato Institute; 2024.
8. National Community Pharmacists Association. *Pharmacists Serving Rural America*. 2023.
9. Broughel J, Amez-Droz E. *Expanding Pharmacists' Prescriptive Authority: Options for Reform*. Mercatus Center; 2021.
10. Battese KJ. *USPHS Chief Pharmacist Officer Statement on Pharmacist Scope and Collaboration*. U.S. Public Health Service; 2024.

# Expanding Access to Patient Care in Community Pharmacies for Minor Illnesses in Washington State

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**Introduction:** As the shortage of primary care providers widens nationwide, access to care utilizing non-physician providers is one strategy to ensure equitable access to care. This study aimed to compare community pharmacist-provided care for minor ailments to care provided at three traditional sites of care: primary care, urgent care, and emergency department, to determine if care provided by pharmacists improved access with comparable quality and reduced financial strain on the healthcare system.

**Methods:** Pharmacy data was provided from 46 pharmacies and 175 pharmacists who participated across five pharmacy corporations over a 3-year period (2016–2019). Data for non-pharmacy sites of care was provided by a large health plan, matching episodes of care for conditions seen in the community pharmacy. Cost-of-care analysis was conducted using superiority study design and revisit data analysis was conducted using noninferiority study design.

**Results:** Median cost-of-care across traditional sites of care was \$277.78 higher than care provided at the pharmacies, showing superiority. Noninferiority was demonstrated for revisit care when the initial visit was conducted by a pharmacist compared to traditional sites.

**Discussion:** The authors conclude community pharmacist-provided care for minor ailments improved cost-effective access for patients with comparable quality and reduced financial strains on the healthcare system.

**Keywords:** patient access, community pharmacy, minor ailments, cost of care

## Introduction

As the need for healthcare in the United States grows beyond capacity, it is imperative we find new healthcare delivery models to ensure equitable access to efficient healthcare options. We are currently facing a scarcity of healthcare providers, and in 2012 it was projected that by the year 2025 we will face a shortage of primary care physicians (PCP), reaching up to 52,000.<sup>1</sup> Despite the roles of nurse practitioners and physician assistants expanding, it is estimated nearly 1 million office visits per year needed by patients will go unmet due to lack of provider availability.<sup>1</sup> Patients living in low-income neighborhoods with less access to retail clinics or urgent care centers, who are facing long wait times for primary care (PC) appointments, or who work during hours when PC office hours exist often end up in the emergency department (ED) for medical treatment.<sup>2</sup> For reference, in the United States a PCP visit is an outpatient visit with a provider for services, such as chronic medical conditions, annual wellness visits, and same-day appointments for urgent needs that are manageable by a general provider in an outpatient setting during normal daytime business hours. Urgent Care visits are open extended hours (evenings and weekends) and are the site of care for conditions that cannot wait until a PCP visit can be scheduled or that may need services more advanced than provided by a PCP, such as X-ray or casting broken bones but are not considered life threatening. An ED visit is for emergency care needs that may be life threatening, require emergency surgery, or require advanced imaging for conditions such as stroke or heart attack. According to the National Association of Community Health Centers, Inc., more than one-third of all ED visits



are avoidable and could be treated in an ambulatory setting with a savings of more than \$18 billion dollars annually.<sup>3</sup> ED treatment of urinary tract infections (UTIs) alone accounts for approximately \$4 billion per year in healthcare costs.<sup>4</sup>

It has been suggested that diversification of roles within the healthcare delivery system, along with workforce development efforts, can be capitalized upon to increase population health in a more efficient way.<sup>5,6</sup> Activities such as motivational interviewing and helping patients set goals for lifestyle modifications have been shown to greatly increase population health.<sup>5</sup> In addition, non-physician healthcare professionals can help fill the demand-capacity gap by utilizing technology and standing orders to provide patient care.<sup>6</sup>

Throughout the years, pharmacists' roles have evolved from solely medication dispensing functions to providing medication therapy management and other healthcare services designed to improve patient outcomes. Pharmacists have been integrated into health system care teams to help improve patient outcomes and forge innovative health delivery models through interprofessional collaborations in the community setting.<sup>7</sup> Key elements of pharmacy education prepare pharmacists to be medication experts, solve therapeutic problems, provide patient-centered care, advance population health, collaborate interprofessionally, and advocate for patients at the highest level.<sup>8</sup> The potential for pharmacists' clinical expertise to improve patient outcomes has been well studied in a range of scenarios, from examination of pharmacist-recommended clinical interventions implemented by a provider to direct pharmacist-provided care in managing acute and chronic disease states.<sup>7</sup>

In Rear Admiral Scott Giberson's Report to the US Surgeon General in 2011 titled "Improving Patient and Health System Outcomes through Advanced Pharmacy Practice", he outlines 55 peer-reviewed articles showing improved clinical outcomes for patients when pharmacists were involved in patient care delivery.<sup>7</sup> One systematic review of 12 randomized controlled trials including 2,060 patients showed pharmacist-directed or pharmacist-collaborative care was correlated with a significant decrease in all-cause hospitalizations (11 studies, 2026 patients) and heart failure hospitalizations (11 studies, 1977 patients).<sup>9</sup>

In the community pharmacy setting, both in the US and around the world, pharmacists have utilized Collaborative Practice Agreements (CPAs) and other prescriptive authority avenues to provide patients with access to affordable and expeditious screenings, treatment initiation, and medication management for many minor or acute ailments and chronic health conditions. Approximately 90% of all Americans live within 5 miles of a community pharmacy, with those residing in metropolitan areas living less than 2 miles from a pharmacy.<sup>10</sup> Proximity, walk-in patient access and extended hours make pharmacists the most accessible healthcare professionals in many geographic areas.

Point of Care (POC) testing and the ability for pharmacies to obtain a Clinical Laboratory Improvement Amendment (CLIA) Certificate of Waiver opened the door for pharmacists to enhance patient care access by providing screenings and prompt treatment initiation within the same pharmacy visit. Various CLIA-waived tests utilized in the outpatient and community pharmacy settings include those for Group A Streptococcus, influenza, Hepatitis C, HIV, hemoglobin A1c, cholesterol, and *Helicobacter Pylori*.<sup>11,12</sup> As of 2020, more than 15,600, or approximately 28% of US pharmacies, held CLIA-waiver certificates.<sup>13</sup>

Not all conditions appropriate for pharmacist-initiated treatment require testing. There are a number of minor ailments that can be effectively treated in a community pharmacy setting based on patient reported symptoms and examination. Uncomplicated UTIs are among these minor ailments. Since 2010, pharmacists around the world have provided patient care related to uncomplicated UTIs, with positive perceptions reported by patients and pharmacists.<sup>14</sup> Infectious disease guidelines do not require urine testing for uncomplicated UTI treatment, though pharmacists might consider criteria for referral prior to treatment initiation, such as patients who report flank pain, fever, chills, pregnancy, and others.<sup>15</sup> Treatment guidelines provide a framework for assessment and treatment with antimicrobial therapy or referral for complications when appropriate.<sup>12</sup> Many patients have reported seeking care at a pharmacy sooner than they would have with a general practitioner due to increased patient access to a community pharmacy.<sup>12</sup> Pharmacists have demonstrated improved antimicrobial stewardship for UTIs in ED and long-term care settings. Additionally, pharmacists are engaged in work to improve outpatient stewardship programs, which is promising for the future of antimicrobial stewardship of pharmacist-initiated interventions in the outpatient setting.<sup>16-19</sup>

Although some conditions appropriate in a community pharmacy setting do not require the use of CLIA-waived POC tests, like uncomplicated UTIs, others can utilize POC technology to assist in determining if and when medication therapy should be initiated. A literature review found positive evidence demonstrating pharmacist involvement in POC testing and, when

appropriate, initiation of therapy to be successful in improving patient access to safe and effective care for influenza, Group A *Streptococcus*, *Helicobacter pylori* (*H. pylori*), Hepatitis C, and human immunodeficiency viruses (HIV).<sup>20</sup>

As new patient-centered care delivery models are implemented in the community pharmacy setting, we should seek to ensure these care models meet patient needs and are sustainable. Correspondingly, the goals of this study were to conduct a cost-of-care and quality-of-care analysis by comparing pharmacist-provided care for selected conditions to care provided at three traditional sites of care: PCP, urgent care, and ED. The cost-of-care analysis includes median and mean costs from all sites of care for initial care and any revisit care needed for the same episode-of-care. The quality analysis compared patient revisit data as a measure to ascertain if the care provided by community pharmacists reduced the access burden on the traditional healthcare system. In addition, data was collected on the feasibility of offering services in a community pharmacy setting, which included training, supplies needed, space requirements, documentation, workflow, and compliance with prescriptive authority regulations. Data for traditional sites were collected from a large health plan in Washington state and compared to data collected from participating community pharmacies in Washington state over a 3-year period. Community pharmacies utilized in the study include drugstores, groceries, multidepartments, and big boxes. Washington state was selected for the study due to pharmacist delegated prescriptive authority through collaborative drug therapy agreements having been in place since 1979, with no limitation on patient eligibility, disease state, or medication prescribed. Many pharmacists included in the study were experienced in providing patient care services such as for immunizations and POC testing. In addition, pharmacists in Washington state are recognized as medical providers with billing authority, although at the time of this study the authority was new and not implemented in any of the study pharmacy locations.

## Materials and Methods

### Community Pharmacy Patient Visit Data

Data collected during monthly pharmacy site visits were used for pharmacy sites of care. Individuals under age 18 were excluded from the study. Cost per condition were set within each pharmacy company, of which it became the out-of-pocket cost for a patient to receive the service at that location. Participating study pharmacies did not bill patient insurance. The research team had no influence or decision-making authority as to the price each pharmacy organization set as their price for patient care services. Pharmacy mean and median cost per condition were both calculated; however, mean was utilized in the analysis due to cost data distribution having little variability.

Revisit data from pharmacy claims was collected through 30-day follow-up telephonic calls conducted by researchers. Data were reliant on patient-reported information, which could impact the accuracy of the data. Patient-reported data collected regarding revisits included when the revisit occurred, site of care for the revisit, and if symptoms resolved after the revisit. Utilizing the patient-reported site of care for a revisit, median cost from the traditional site of care data was utilized, in addition to the original pharmacy cost, to complete the total cost of care for those patient encounters. Difference in proportion of revisits between traditional sites of care and pharmacies was compared as a measure of quality with a noninferiority test using an equivalence margin of 20%.<sup>21</sup> Confidence intervals on the difference in the proportion of revisits were established with Wilson intervals.<sup>22</sup> Noninferiority testing was performed using a  $1-2\alpha$  confidence interval with an  $\alpha$  level of 0.05.<sup>23</sup>

### Traditional Sites of Care Patient Visit Data

Health plan episodes claim lines data were used to obtain cost and visit data for traditional sites of care. Primary diagnosis codes were categorized into the conditions considered in this study. Claims for individuals under age 18 were removed from consideration. For cost comparison, only the cost of anchor claims and computed total cost by episode, condition, and provider site of care were considered. An anchor claim was categorized as being the first claim for the condition for that patient in a previous 30-day window of time. Episode costs included that of the anchor claim and any revisit claims within 30-days post-anchor claim organized by the condition and traditional provider site of care. Cost distributions were right-skewed, and thus median costs were used in place of mean costs to reflect cost expectations for a typical episode. Bootstrapping was employed to construct 95% confidence intervals on the median cost. Differences between the median episode cost from each traditional site of care setting and the fixed pharmacy cost along with 95% bootstrap confidence intervals were computed by subtracting a fixed pharmacy cost.



Data for traditional sites of care claims were available only up to monthly resolution, limiting the accuracy to which revisits could be identified. We defined a member revisit as a subsequent episode, as determined through increasing episode number that met the condition of having a claim date either in the same month or 1 month later. We summarized the follow-up visits by constructing a table of episode counts as well as computing the proportion of episodes that were follow-ups by traditional site of care and condition.

The cost-of-care analysis was conducted using superiority study design, comparing community pharmacies to traditional sites of care. The revisit data analysis was conducted using noninferiority study design, comparing the pharmacy setting to traditional sites of care.

There were several steps undertaken in the design of the project, in addition to data analysis methods. These included training programs in partnership with the Washington State Pharmacy Association (WSPA), entering into agreements with community pharmacy organizations to participate in the research project, and to develop a Physician Advisory Committee (PAC) to ensure standards of care are met and to incorporate the PACs feedback into live training sessions.

The WSPA has an online refresher training certificate program titled “Clinical Community Pharmacist”, which was made accessible to pharmacists participating in this study. The certificate program focuses on ailments and conditions often seen in a community pharmacy setting. This includes both continuation of care for previously diagnosed conditions, as well as the assessment and initiation of treatment for certain ailments. Conditions included in the research project can be found in [Supplemental Box 1](#).

The research team approached several community pharmacy leaders to recruit sites for participation in the study. A mix of community pharmacies was desired as well as representation from varied regions in Washington state. Five large pharmacy organizations participated in the study with pharmacies located in southwest Washington, the Seattle/Puget Sound area, and the Spokane/Eastern Washington area. Pharmacies included two grocery chains, one drugstore chain, one multidepartment chain, and one warehouse club company. Overall, a total of 46 pharmacies participated and 175 pharmacists were trained.

Live training was created to facilitate participating pharmacists’ application of the online certificate modules through patient case discussions aimed at increasing confidence in the clinical decision-making process. The operational portion of the training included patient study consent and federally mandated health privacy forms, documentation requirements for data collection, and partner-specific operational components of implementing a new patient-care service. The clinical portion of the training was dedicated to patient case discussions related to each condition. Activities ranged in complexity and each activity emphasized the decision-making process to determine if a patient met criteria for pharmacist intervention or if referral to a different care provider was appropriate.

Pharmacists were required to complete the online training modules prior to attending the live session. Live training sessions conducted by the researchers were held either onsite at the pharmacy partner location in a large meeting room or on campus at the researcher’s university, depending on geographic location and space availability (grant funds supported training module costs, however, each pharmacy organization remained responsible for pharmacist wages). While there is no legal requirement in Washington state for pharmacists to receive additional training to provide these services, researchers required the training to participate in the study to minimize gaps in knowledge based on the length of time since completing pharmacy education and utilization of the knowledge and/or skill set in practice prior to the study.

Researchers shared best practices for documentation, record storage, and patient care workflow; however, implementation of patient care service was customized by each organization. Prescriptive authority Collaborative Drug Therapy Agreements (CDTAs) were the responsibility of each pharmacy organization, and the agreements were signed between each pharmacist and a delegating prescriber, as required in Washington state. Some variability in CDTAs exist, as the delegating prescriber customizes the agreement to meet their standard of care and referral criteria. Each pharmacy organization included policies and procedures to ensure a patient’s primary care provider, if they had one, was notified of the care provided by the pharmacist. Having CDTAs in place was a requirement for each organization to participate in the study as, without CDTAs, the pharmacists would not have the authority to prescribe treatment, when needed, based on their assessment of the patient and would have been required to refer all patients needing prescription treatment to a traditional site of care. Study recruitment began during the initial patient intake process at each pharmacy location. Consent into the study was not required for patients to receive care from the pharmacist, as determined by the IRB review.

Researchers visited pharmacies every 4 weeks over a period of 3 years to collect data, as documentation was in paper format. Data collected included patient demographics, insurance status, health history, and condition-specific information including treatments recommended and/or prescribed ([Supplemental Exhibit 1](#)). During each data collection visit, pharmacists were able to ask questions of the researchers to improve patient recruitment or patient care. For patients who consented to participate in the study, a 30-day follow-up phone call was conducted by researchers to assess the clinical outcome of the patient, either positively or negatively, and if additional care was sought (and where) for the condition ([Supplemental Exhibit 2](#)). Initial visit and 30-day follow-up data were stored utilizing REDCap electronic data tools hosted at the primary investigator's university.<sup>24,25</sup>

This human subject research project was reviewed and approved by the primary investigator's university Institutional Review Board (IRB) which complies with the Declaration of Helsinki.

## Results

Data provided by 4 of the 5 pharmacy companies show 977 patients utilized the service during the 3-year study period ending December 2018, while 506 patients across all 5 pharmacy companies consented to participate in the study (one company chose not to provide aggregate service use data for patients not consented to the study). Of the 506 patients consenting to the study, 10 met referral criteria and were not treated by a pharmacist, resulting in 496 patients being included in comparison data. Patient demographics of pharmacies and traditional sites of care were collected for comparison ([Supplemental Exhibit 3](#)).

The total number of patients included from health plan data for comparison for all conditions was 84,555: with hormonal contraception, asthma, UTI, allergies, and headache being the top five ([Table 1](#)). For each of the ten conditions

**Table 1** Initial and Revisit Care by Condition, Initial Site of Care, and Revisit Site of Care

Condition	Initial Site of Care	Number Receiving Initial Care	Cost of Initial Care per Patient	N (%) Revisit Care	Revisit Site of Care	N (%) Revisit Site of Care
<b>Hormonal Contraception</b>	Emergency Room	3	\$53.66	2 (66.67%)	Emergency Room	1 (50.0%)
					Primary Care	1 (50.0%)
	Primary Care	21,806	\$112.26	1485 (6.81%)	Primary Care	1485 (100%)
	Urgent Care	11	\$154.44	1 (9.09%)	Urgent Care	1 (100%)
	Pharmacy	179	\$24.00	0 (0%)		
<b>Asthma</b>	Emergency Room	1271	\$1472.95	626 (49.25%)	Emergency Room	173 (27.6%)
					Primary Care	432 (69.0%)
					Urgent Care	21 (3.4%)
	Primary Care	17,033	\$149.94	2890 (13.97%)	Emergency Room	290 (10.03%)
					Primary Care	2524 (87.34%)
					Urgent Care	76 (2.63%)
	Urgent Care	933	\$189.97	185 (19.83%)	Emergency Room	18 (9.73%)
					Primary Care	119 (64.32%)
					Urgent Care	48 (25.95%)
	Pharmacy	26	\$23.00	0 (0%)		

(Continued)

Table 1 (Continued).

Condition	Initial Site of Care	Number Receiving Initial Care	Cost of Initial Care per Patient	N (%) Revisit Care	Revisit Site of Care	N (%) Revisit Site of Care
Urinary Tract Infection	Emergency Room	1636	\$962.70	362 (22.13%)	Emergency Room	106 (29.28%)
					Primary Care	240 (66.30%)
					Urgent Care	16 (4.42%)
	Primary Care	14,971	\$121.21	1411 (9.42%)	Emergency Room	97 (6.87%)
					Primary Care	1270 (90.01%)
					Urgent Care	44 (3.12%)
	Urgent Care	1762	\$151.23	168 (9.53%)	Emergency Room	12 (7.14%)
					Primary Care	77 (45.83%)
					Urgent Care	79 (47.02%)
	Pharmacy	151	\$30.00	6* (3.97%)	Emergency Room	0 (0%)
					Primary Care	3 (50%)
					Urgent Care	3 (50%)
Allergic Rhinitis	Emergency Room	58	\$634.11	13 (22.41%)	Emergency Room	8 (61.5%)
					Primary Care	4 (30.8%)
					Urgent Care	1 (7.7%)
	Primary Care	17,683	\$95.77	6463 (36.55%)	Emergency Room	2 (0.03%)
					Primary Care	6454 (99.86%)
					Urgent Care	7 (0.11%)
	Urgent Care	401	\$150.61	23 (5.74%)	Primary Care	14 (60.9%)
					Urgent Care	9 (39.1%)
	Pharmacy	14	\$19.00	0 (0%)		
Headache	Emergency Room	5412	\$629.65	1338 (24.72%)	Emergency Room	517 (38.64%)
					Primary Care	737 (55.08%)
					Urgent Care	84 (6.28%)
	Primary Care	11,149	\$148.48	1812 (16.25%)	Emergency Room	371 (20.47%)
					Primary Care	1413 (77.98%)
					Urgent Care	28 (1.55%)
	Urgent Care	611	\$167.70	124 (20.29%)	Emergency Room	50 (40.32%)
					Primary Care	54 (43.55%)
					Urgent Care	20 (16.13%)
	Pharmacy	11	\$23.75	0 (0%)		

(Continued)

Table I (Continued).

Condition	Initial Site of Care	Number Receiving Initial Care	Cost of Initial Care per Patient	N (%) Revisit Care	Revisit Site of Care	N (%) Revisit Site of Care
Shingles	Emergency Room	209	\$548.04	86 (41.45%)	Emergency Room	25 (29.07%)
					Primary Care	57 (66.28%)
					Urgent Care	4 (4.65%)
	Primary Care	3586	\$140.52	281 (7.84%)	Emergency Room	17 (6.05%)
					Primary Care	261 (92.88%)
					Urgent Care	3 (10.7%)
	Urgent Care	463	\$154.44	56 (12.1%)	Emergency Room	2 (3.57%)
					Primary Care	45 (80.36%)
					Urgent Care	9 (16.07%)
Vaginal Yeast Infection	Pharmacy	7	\$30.00	1 (14.29%)	Urgent Care	1
	Emergency Room	41	\$922.59	13 (31.71%)	Emergency Room	8 (61.54%)
					Primary Care	4 (30.77%)
					Urgent Care	1 (7.69%)
	Primary Care	2534	\$119.44	193 (7.61%)	Emergency Room	1 (0.52%)
					Primary Care	192 (99.48%)
	Urgent Care	121	\$153.24	11 (9.09%)	Primary Care	1 (9.09%)
					Urgent Care	10 (90.91%)
	Pharmacy	22	\$30.00	1 (4.55%)	Urgent Care	1
Human, Canine, Feline Bite	Emergency Room	416	\$621.22	177 (42.55%)	Emergency Room	148 (83.62%)
					Primary Care	27 (15.25%)
					Urgent Care	2 (1.13%)
	Primary Care	444	\$162.80	60 (13.51%)	Emergency Room	19 (31.67%)
					Primary Care	39 (65.0%)
					Urgent Care	2 (3.33%)
	Urgent Care	99	\$190.00	11 (11.11%)	Emergency Room	4 (36.36%)
					Primary Care	1 (9.09%)
					Urgent Care	6 (54.55%)
	Pharmacy	7	\$28.00	1 (14.29%)	Emergency	1

(Continued)

Table 1 (Continued).

Condition	Initial Site of Care	Number Receiving Initial Care	Cost of Initial Care per Patient	N (%) Revisit Care	Revisit Site of Care	N (%) Revisit Site of Care
Burn	Emergency Room	15	\$133.86	2 (13.33%)	Emergency Room	1 (50.0%)
					Primary Care	1 (50.0%)
	Primary Care	200	\$140.52	17 (8.5%)	Primary Care	17 (100%)
	Urgent Care	25	\$154.44	1 (4%)	Primary Care	1 (100%)
	Pharmacy	15	\$29.00	0 (0%)		
Swimmer's Ear	Emergency Room	5	\$397.31	2 (40.0%)	Emergency Room	2 (100%)
	Primary Care	85	\$140.74	13 (15.29%)	Primary Care	12 (92.31%)
					Urgent Care	1 (7.69%)
	Urgent Care	14	\$150.84	1 (7.14%)	Urgent Care	1 (100%)
	Pharmacy	15	\$30.00	3 <sup>†</sup> (20%)	Emergency Room	1
Anaphylaxis					Primary Care	2
	Primary Care	13	\$109.75	2 (15.38%)	Primary Care	2 (100%)
	Pharmacy	2	\$23.00	0 (0%)		

listed, cost-of-care was significantly lower when provided by a community pharmacist than in the comparator traditional sites of care. The median overall cost of care for all conditions across all traditional sites of care combined was \$277.78 higher than care provided at the community pharmacies (Figure 1). The largest differences in cost of care between traditional sites and community pharmacy, in order of largest to smallest, are EDs, urgent care, and primary care

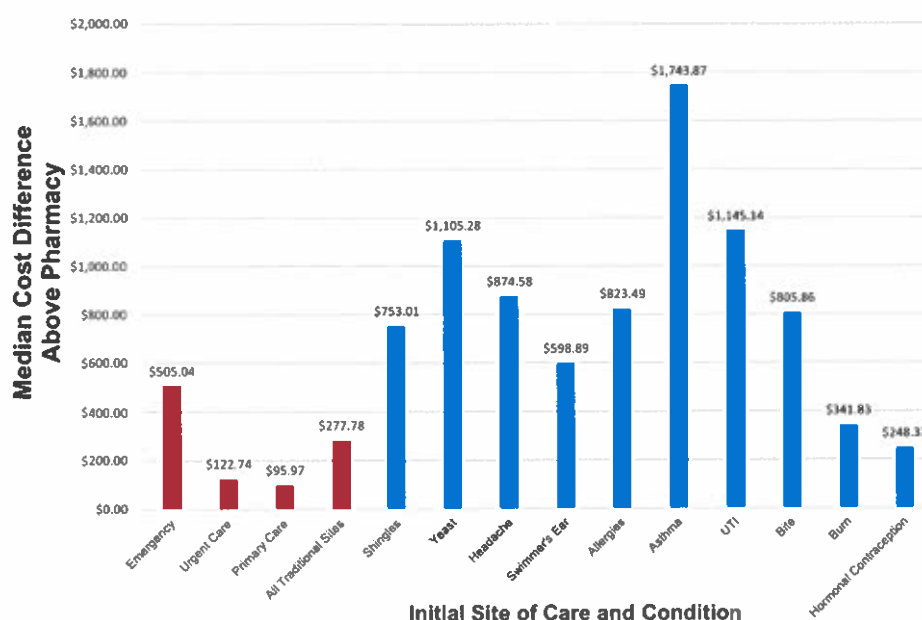
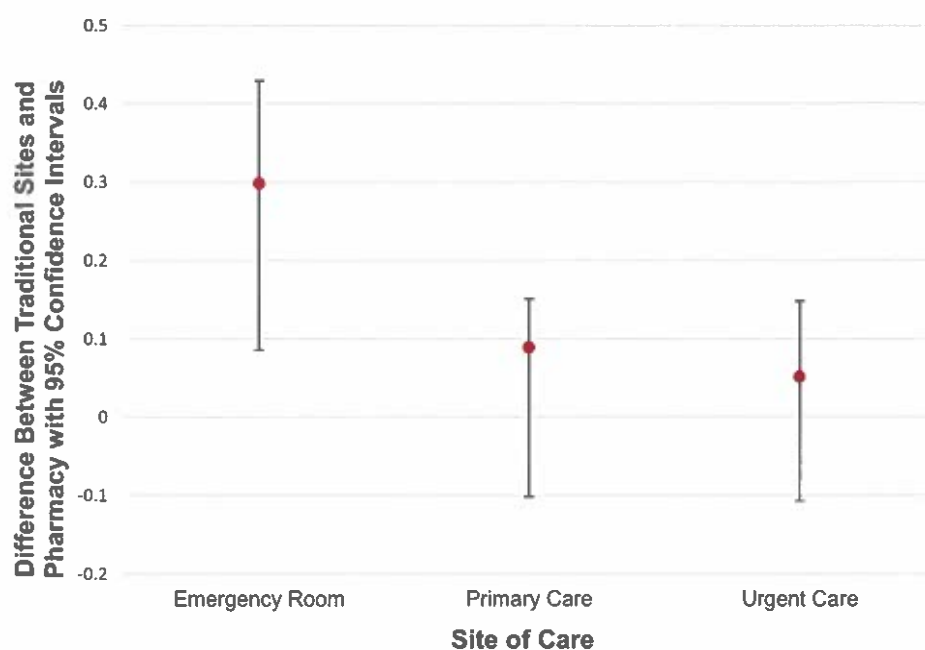


Figure 1 Traditional Site of Care Median Cost Difference Above Pharmacy by Initial Site of Care and Condition.



**Figure 2** Traditional Sites versus Pharmacy Revisit Noninferiority Analysis.

providers at \$505.04, \$122.74, and \$95.97 respectively (**Figure 1**). Further breakdown of the median cost of care difference by condition shows asthma, UTI, and yeast infection as the three conditions with the highest median difference of cost (**Figure 1**).

Patient revisit data was collected to compare the number of patients with an initial visit at a community pharmacy needing to seek additional care to those seen initially at a traditional site of care. The number of patients needing a revisit by condition and the site of care for the revisit can be found in **Table 1**. The traditional site of care difference in proportion of revisits with 95% CI by condition can be found in **Figure 2**, which shows noninferiority was found comparing community pharmacy to ED, primary care, and urgent care using a 20% margin (lower CI above -0.2). Further breakdown by conditions within the traditional sites of care show noninferiority in all 11 conditions comparing pharmacy to ED and in 8 of 11 conditions compared to urgent care and primary care (**Supplemental Exhibit 4**). The total cost of care, including revisits by condition and initial site of care, can be found in **Table 2**.

**Table 2** Total Cost of Care (Initial and Revisit) by Condition and Initial Site of Care

Condition	Initial Site of Care	Total Cost of Care
Hormonal Contraception	All Traditional Sites	\$2,616,827.84
	Emergency Room	\$326.90
	Primary Care	\$2,614,647.66
	Urgent Care	\$1,853.28
	Pharmacy	\$716

(Continued)

Table 2 (Continued).

Condition	Initial Site of Care	Total Cost of Care
<b>Asthma</b>	<b>All Traditional Sites</b>	<b>\$3,263,644.50</b>
	Emergency Room	\$2,195,703.25
	Primary Care	\$837,224.72
	Urgent Care	\$230,716.53
	Pharmacy	\$598
<b>Urinary Tract Infection</b>	<b>All Traditional Sites</b>	<b>\$4,076,441.11</b>
	Emergency Room	\$1,708,533.48
	Primary Care	\$2,068,607.63
	Urgent Care	\$299,300.00
	Pharmacy	\$5,347.32
<b>Allergic Rhinitis</b>	<b>All Traditional Sites</b>	<b>\$2,419,398.81</b>
	Emergency Room	\$42,384.95
	Primary Care	\$2,313,922.98
	Urgent Care	\$63,090.88
	Pharmacy	\$266
<b>Headache</b>	<b>All Traditional Sites</b>	<b>\$6,105,398.51</b>
	Emergency Room	\$3,856,704.04
	Primary Care	\$2,103,375.89
	Urgent Care	\$145,318.58
	Pharmacy	\$261.25
<b>Shingles</b>	<b>All Traditional Sites</b>	<b>\$767,544.36</b>
	Emergency Room	\$136,868.76
	Primary Care	\$550,360.44
	Urgent Care	\$80,315.16
	Pharmacy	\$364.44
<b>Vaginal Yeast Infection</b>	<b>All Traditional Sites</b>	<b>\$392,547.82</b>
	Emergency Room	\$45,837.91
	Primary Care	\$326,516.03
	Urgent Care	\$20,193.88
	Pharmacy	\$813.24

(Continued)

Table 2 (Continued).

Condition	Initial Site of Care	Total Cost of Care
<b>Human, Canine, Feline Bite</b>	<b>All Traditional Sites</b>	<b>\$468,556.94</b>
	Emergency Room	\$355,143.68
	Primary Care	\$90,815.58
	Urgent Care	\$22,597.68
	<b>Pharmacy</b>	<b>\$817.22</b>
<b>Burn</b>	<b>All Traditional Sites</b>	<b>\$36,776.64</b>
	Emergency Room	\$2,282.28
	Primary Care	\$30,492.84
	Urgent Care	\$4,001.52
	<b>Pharmacy</b>	<b>\$435.00</b>
<b>Swimmer's Ear</b>	<b>All Traditional Sites</b>	<b>\$18,846.39</b>
	Emergency Room	\$2,781.17
	Primary Care	\$13,802.62
	Urgent Care	\$2,262.60
	<b>Pharmacy</b>	<b>\$1128.79</b>
<b>Anaphylaxis</b>	<b>All Traditional Sites</b>	<b>\$1,646.25</b>
	Primary Care	\$1,646.25
	<b>Pharmacy</b>	<b>\$46</b>
<b>All Conditions</b>	<b>All Traditional Sites</b>	<b>\$20,167,629.17</b>
<b>All Conditions</b>	<b>Pharmacy</b>	<b>\$10,793.26</b>

## Discussion

This study quantitatively analyzed the cost-of-care difference between community pharmacies and traditional sites of care for several common conditions and assessed the impact on the healthcare system through revisit data. Data assessing the overall cost-of-care showed a statistically lower mean for patient care interventions provided by a pharmacist in a community pharmacy setting compared to the median cost from EDs, urgent care centers, and primary care. In addition, noninferiority was demonstrated related to the need to revisit care when the initial visit was conducted by a pharmacist compared to traditional sites of care. A sampling of patient comments documented during the 30-day follow up call were positive (Supplemental Exhibit 5). This, in addition to the number of patients who sought care at a community pharmacy, shows feasibility through patient demand as well as the ability to integrate the services into patient care workflows.

Patients in the study paid for services received at the community pharmacy out of pocket. If the 496 patients who received care at the pharmacy had sought care at traditional sites, using the aggregate median cost difference for all three traditional sites of care of \$277.78, the additional cost to the healthcare system would have been approximately \$138,000. In comparison, using the same aggregate median cost difference of \$277.78, if the 84,555 patients who had sought care initially at a traditional site of care had been seen at a community pharmacy, the cost savings would be approximately \$23,500,000. The potential cost savings to the healthcare system are staggering. As demonstrated, expanded opportunities for patients to receive clinical care in accessible, community-based settings may enhance sustainability of the healthcare system and, in turn, lower costs for patients and public health programs. As can be seen in the demographic



data (Supplemental Exhibit 3), more women utilized community pharmacies than men, with hormonal contraception and UTI being the two most common conditions. While the overall median cost difference for hormonal contraception was the lowest of the services evaluated, the median cost difference for UTIs was the second highest. The majority of patients seen for a UTI at a traditional site of care in the study utilized the primary care setting; however, a 2015 report by the Washington Health Alliance listed UTIs as the fourth top condition both commercially-insured and Medicaid patients had unnecessarily sought care for at an ED in the five-county Puget Sound region.<sup>26</sup> This study found costs of ED care for a UTI to be more than \$1000 higher than care provided by a community pharmacist. By anticipating these needs alone, UTI-associated interventions initiated by community pharmacists could reduce healthcare spending significantly.

The pharmacists included in the study all completed the WSPA Clinical Community Pharmacist Certificate Program, however the certificate is not a requirement for providing the services in Washington state. The confidence gained through the certificate program, as well as the 8-hr live training session, may have increased willingness to offer services to patients seeking care. The same certificate program and live training have been included in the required curriculum in the college of pharmacy where the primary investigator has been employed since 2015.<sup>27</sup> Recommendations made by the PAC (Supplemental Exhibit 6) were implemented in the live training, and recommendations related to the WSPA training were forwarded to them for consideration. As primary care physician shortage looms, and patient access to care is negatively impacted, pharmacy education programs around the country may have an opportunity to help address the gap in care by providing robust education for advanced patient care services and clinical decision making.

Community pharmacies offering patient care services might consider including methods to communicate with the PCP, allowing for a more complete patient health record and to decrease fragmentation of care. Ideally, community pharmacists would have access to electronic health records and input the care directly. For now, most community pharmacists fax or call a patient's PCP. This information may or may not be included in the patient's medical record at all, or in a way that is easily retrievable. One unexpected example of pharmacist and PCP collaboration was a patient informing the community pharmacist they were referred to the pharmacy to be seen for a UTI, as the PCP office stated the patient would be seen sooner than if making an appointment with them. While this is not currently commonplace, this level of trust and collaboration between the clinic and pharmacy is something to strive for in advancing collaborative, patient-centered care.

## Conclusion

Overall, this research showed both feasibility and significant patient and public health cost savings when care was provided by a community pharmacist as compared to providers at traditional sites of care. Research findings support nationwide replication of this model of pharmacist-provided patient care resulting in increased access to healthcare for patients, particularly in rural and underserved areas. Enhanced patient outcomes along a continuum of care that is professional and longitudinal, not transactional, are efficient and improved access to timely healthcare.

The findings support the benefit to patients and public health programs of removing barriers to clinical care opportunities for patients in effective community-based settings, such as pharmacies. Due to systematic restrictions, patients in some states would not be able to access the care delivered in this research model. One important barrier, outside the scope of this project, is the lack of patient access to coverage for health interventions in emerging, community-based clinical care settings. Out-of-pocket costs may exacerbate barriers to patient access, especially for vulnerable populations, who may stand to benefit the most from enhanced access to care options.

## Acknowledgments

We acknowledge the contributions of Chad Murphy, BS, PharmD, SVP/Chief Clinical Officer with Premier Blue Cross; Andrea Lazarus, PhD, Associate Dean for Research with the Washington State University College of Pharmacy and Pharmaceutical Sciences; Physician Advisory Committee members; Douglas Weeks, PhD; the Washington State Pharmacy Association; Bartell Drugs, Costco, Fred Meyer, Rosauers, and Yoke's Fresh Market pharmacy personnel.

Preliminary findings were presented in a short oral presentation at the 2023 NACDS TSE Conference.

## Disclosure

Dr Julie Akers and Dr Jennifer Miller report grants from the National Association of Chain Drug Stores Foundation, during the conduct of the study. The authors report no other conflicts of interest in this work.

## References

- Pettersson SM, Liaw WR, Phillips RL, Rabin DL, Meyers DS, Bazemore AW. Projecting US primary care physician workforce needs: 2010–2025. *Ann Fam Med*. 2012;10(6):503–509. doi:10.1370/afm.1431
- Weinick RM, Burns RM, Mehrotra A. Many emergency department visits could be managed at urgent care centers and retail clinics. *Health Aff*. 2010;29(9):1630–1636. doi:10.1377/hlthaff.2009.0748
- National Association of Community Health Centers. 2006 Data on Community Health Centers Summary of Findings. National Association of Community Health Centers; 2006
- ER visits for UTIs add almost \$4 billion a year in unnecessary healthcare costs. Infection Control Today; 2013. Available from: <https://www.infectioncontrolday.com/view/er-visits-utis-add-almost-4-billion-year-unnecessary-healthcare-costs>. Accessed August 24, 2020.
- Corso KA, Dorrance KA, LaRochelle J. The physician shortage: a red herring in American health care reform. *Mil Med*. 2018;183(3):220–224. doi:10.1093/milmed/usy211
- Bodenheimer TS, Smith MD. Primary care: proposed solutions to the physician shortage without training more physicians. *Health Aff*. 2013;32(11):1881–1886. doi:10.1377/hlthaff.2013.0234
- 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; 2011.
- Accreditation Council for Pharmacy Education. Accreditation standards and key elements for the professional program in pharmacy leading to the doctor of pharmacy degree; 2015. <https://www.acpe-accredit.org/pdf/Standards2016FINAL.pdf>. Accessed August 24, 2020.
- Koshman SL, Charrois TL, Simpson SH, McAlister FA, Tsuyuki RT. Pharmacist care of patients with heart failure: a systematic review of randomized trials. *Arch Intern Med*. 2008;168(7):687. doi:10.1001/archinte.168.7.687
- Open for business: pharmacies respond to emergency. Rx Impact: A Drug Store News Special Report; 2016:7–9. Available from: <https://s3.amazonaws.com/dig.drugstorenews.com/2016-02-rximpact/html5/index.html?page=1&noflash>. Accessed April 23, 2024.
- Erwin PB, Pitlick MK, Peters GL. Maintenance of goal blood pressure, cholesterol, and A1C levels in veterans with type 2 diabetes after discharge from a pharmacist-managed ambulatory care clinic. *Diabetes Spectr*. 2015;28(4):237–244. doi:10.2337/diaspect.28.4.237
- Gubbins PO, Klepser ME, Dering-Anderson AM, et al. Point-of-care testing for infectious diseases: opportunities, barriers, and considerations in community pharmacy. *J Am Pharm Assoc*. 2014;54(2):163–171. doi:10.1331/japha.2014.13167
- Klepser S, Klepser DG, Adams JL, Adams AJ, Klepser ME. Impact of COVID-19 on prevalence of community pharmacies as CLIA-Waived facilities. *Res Social Adm Pharm*. 2021;17(9):1574–1578. doi:10.1016/j.sapharm.2020.12.003
- Akers JM, Adams AJ, Klepser ME. Review of pharmacy-based management of uncomplicated urinary tract infections (UTIs) in community pharmacy settings. *Int J Pharm*. 2018;8:63–69.
- Gupta K, Hooton TM, Naber KG, et al. International clinical practice guidelines for the treatment of acute uncomplicated cystitis and pyelonephritis in women: a 2010 update by the infectious diseases society of America and the European Society for Microbiology and Infectious Diseases. *Clin Infect Dis*. 2011;52(5):e103–e120. doi:10.1093/cid/ciq257
- Lingenfelter E, Drapkin Z, Fritz K, et al. ED pharmacist monitoring of provider antibiotic selection aids appropriate treatment for outpatient UTI. *Am J Emerg Med*. 2016;34(8):1600–1603. doi:10.1016/j.ajem.2016.05.076
- Zhang X, Rowan N, Mangel Pflugeisen B, Alajbegovic S. Urine culture guided antibiotic interventions: a pharmacist driven antimicrobial stewardship effort. *Am J Emerg Med*. 2017;35(4):594–598. doi:10.1016/j.ajem.2016.12.036
- El Mansali S. Canadian Pharmacists Conference 2017 pharmacy practice research highlights. *Can Pharm J*. 2017;150(5):334–336. doi:10.1177/1715163517725517
- Dobson EL, Klepser ME, Pogue JM, et al. Outpatient antibiotic stewardship: interventions and opportunities. *J Am Pharm Assoc*. 2017;57(4):464–473. doi:10.1016/j.japh.2017.03.014
- Weber NC, Klepser ME, Akers JM, Klepser DG, Alex AJ. Use of CLIA-waived point-of-care tests for infectious diseases in community pharmacies in the United States. *Expert Rev Mol Diagn*. 2016;16(2):256–264. doi:10.1586/14737159.2015.1116388
- Kummervold PE, Johnsen JA, Skovseth SO, Wynn R. Using noninferiority tests to evaluate telemedicine and e-health services: systematic review. *J Med Internet Res*. 2012;14(5):e132. doi:10.2196/jmir.2169
- Altman D, Machin D, Bryant T, Gardner M. *Statistics with Confidence: Confidence Intervals and Statistical Guidelines*. 2nd ed. John Wiley and Sons; 2000.
- Walker E, Nowacki AS. Understanding equivalence and noninferiority testing. *J Gen Inter Med*. 2011;26(2):192–196. doi:10.1007/s11606-010-1513-8
- Harris PA, Taylor R, Thielke R, Payne J, Gonzalez N, Conde JG. Research electronic data capture (REDCap) – a metadata-driven methodology and workflow process for providing translational research informatics support. *J Biomed Inform*. 2009;42(2):377–381. doi:10.1016/j.jbi.2008.08.010
- Harris PA, Taylor R, Minor BL, et al. REDCap Consortium. The REDCap consortium: building an international community of software partners. *J Biomed Inform*. 2019;95:103208. doi:10.1016/j.jbi.2019.103208
- Washington Health Alliance. Right care, right setting: a report on potentially avoidable emergency room visits in Washington state; 2015. Available from: <https://wahealthalliance.org/alliance-reports-websites/alliance-reports/right-care-right-setting/>. Accessed January 20, 2022.
- McKeirnan KC, Akers JM, Czapinski JC, Robinson JD. Using collaborative drug therapy agreements to train student pharmacists to provide clinical patient care services. *Am J Pharm Educ*. 2017;81(2). doi:10.5688/ajpe81231

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THE STATE  
of **ALASKA**  
GOVERNOR MIKE DUNLEAVY

**Department of Commerce, Community,  
and Economic Development**

STATE MEDICAL BOARD

P.O. Box 110806  
Juneau, Alaska 99811-0806  
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April 17, 2025  
Alaska State Senate  
Alaska State House of Representatives  
Juneau, Alaska 99801

Re: Statement of Opposition – SB 147 & HB 195, Pharmacist Prescriptive Authority

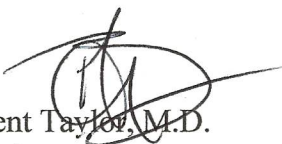
Dear Members of the Legislature,

Senate Bill 147 would effectively expand the prescriptive authority of pharmacists to prescribe and administer any medications, including controlled substances and abortion medications.

The authority to broadly prescribe any medication would mean pharmacists would have the ability to diagnose and therefore treat any medical condition. The diagnosis and treatment of medical conditions is the practice of medicine. The State Medical Board opposes pharmacists being granted the ability to practice medicine in Alaska.

The Alaska State Medical Board strongly urges you to vote against SB 147 and HB 195.

Sincerely,

  
Brent Taylor, M.D.  
Chair



Department of Commerce, Community,  
and Economic Development

STATE MEDICAL BOARD

P.O. Box 110806  
Juneau, Alaska 99811-0806  
Main: 907.465.2550  
Fax: 907.465.2974

THE STATE  
of ALASKA  
GOVERNOR MIKE DUNLEAVY



April 21, 2025

The Honorable Senator Scott Kawasaki, Senate State Affairs Chair  
The Honorable Representative Ted Eischeid, House Military & Veterans' Affairs Chair  
Alaska State Capitol, Rooms 119 and 412  
Juneau, Alaska 99801

Sent via email: [Senate.State.Affairs@akleg.gov](mailto:Senate.State.Affairs@akleg.gov), [House.Military.And.Veterans.Affairs@akleg.gov](mailto:House.Military.And.Veterans.Affairs@akleg.gov)

Re: Statement of Support – SB 145 & HB 158, Professional Licensing; Temp Permits

Dear Chairs Kawasaki and Eischeid, and Members of the Legislature,

At its meeting on April 17, 2025, the State Medical Board voted unanimously in support of Senate Bill 145 and House Bill 158. These bills would allow a pathway for applicants for professional licensure in Alaska to be issued a temporary license for applicants who hold a substantially equivalent license in good standing from another U.S. jurisdiction or meet the qualifications for Alaska licensure through military education, training and service and do not already hold a license in another jurisdiction. The bills would also conform State law with the Federal Servicemembers Civil Relief Act, which requires states to issue a servicemember of servicemember spouse a state license within 30 days of application, so long as they meet all criteria.

These bills will make it easier for qualified licensees in good standing to come to Alaska to fill vacancies and assist Alaskans in need of their services.

For many years, the Medical Board has successfully utilized the strategy of issuing temporary permits to its licensees as a tool to expedite getting physicians and physician assistants to work in Alaska and supports the expanded use of this approach to other professions.

The Alaska State Medical Board urges you to hear and vote in favor of SB 145 & HB 158.

Sincerely,

A handwritten signature in black ink, appearing to read "Brent Taylor".

Brent Taylor, M.D.  
Chair

**Department of Commerce, Community,  
and Economic Development**  
STATE MEDICAL BOARD

P.O. Box 110806  
Juneau, Alaska 99811-0806  
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April 21, 2025

The Honorable Senator Jesse Bjorkman, Senate Labor & Commerce Chair  
The Honorable Representative Zach Fields, House Labor & Commerce Co-Chair  
The Honorable Representative Carolyn Hall, House Labor & Commerce Co-Chair  
Alaska State Capitol, Rooms 427, 24, and 434  
Juneau, Alaska 99801

Sent via email: [Senate.Labor.And.Commerce@akleg.gov](mailto:Senate.Labor.And.Commerce@akleg.gov), [House.Labor.And.Commerce@akleg.gov](mailto:House.Labor.And.Commerce@akleg.gov)

Re: Statement of Support – SB 124 and HB 131, Nurse Licensure Compact

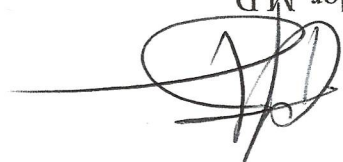
Dear Chairs Bjorkman, Fields, and Hall, and Members of the Legislature,

At its meeting on April 17, 2025, the State Medical Board voted unanimously in support of Senate Bill 124 and House Bill 131. These bills would allow the Alaska Board of Nursing to join the national Nurse Licensure Compact.

The State Medical Board recognizes nurses as being critical to the health care system in Alaska. Alaska has a significant nursing shortage which is projected to get worse. Joining the Nurse Licensure Compact would give Alaska more opportunities to recruit nurses to Alaska and get them to work quickly.

The Alaska State Medical Board urges you to hear and vote in favor of SB 124 & HB 131.

Sincerely,

  
Brent Taylor, M.D.  
Chair

GOVERNOR MIKE DUNLEAVY

THE STATE  
of ALASKA

