STATE LAW FACT SHEET

Select Features of State Pharmacist Collaborative Practice Laws

Background

Hypertension and hyperlipidemia, two leading risk factors of cardiovascular disease, each affect 1 in 3 US adults.[1,2] Hypertension, also known as high blood pressure, is a leading cause of employee absence and lower on-the-job productivity, costing the U.S. economy $51 billion annually, including $3.5 billion in lost productivity costs and $47.5 billion in direct medical expenses.[3] Fewer than half (46.5%) of people with hypertension and a third (33.2%) of people with hyperlipidemia have their condition under control.[1,2]

Studies have revealed that drug therapy monitoring, counseling, and educational services provided by community pharmacists contribute to improved health outcomes related to chronic conditions, such as hypertension, diabetes, and hyperlipidemia.[4,5] The Centers for Disease Control and Prevention (CDC) Community Preventive Services Task Force found strong evidence of effectiveness in blood pressure control when a pharmacist was included in team-based care.[6] A 2010 systematic review and meta-analysis found pharmacist engagement in interdisciplinary health management with physicians and other providers significantly improved patients' blood pressure, hemoglobin A1c, and low-density lipoprotein (LDL) cholesterol levels, along with fewer adverse drug events.[7] Pharmacists' patient care services also reduce fragmentation of care, decrease health expenditures, and optimize health outcomes.[8]

Federal agencies, such as the Indian Health Service and the Veterans Health Administration, began authorizing pharmacists and other health care providers to collaborate on disease management and other pharmacist care services starting in the 1960s.[8] In 1997, the American College of Clinical Pharmacy (ACCP) released a position statement endorsing pharmacist collaborative drug therapy management (CDTM) as a method of improving the quality of patient care.[9] At that time, 16 states already had enacted legislation to allow pharmacists to participate in patient drug therapy management through collaborative arrangements with physicians and other health care providers.[10]

ACCP defines CDTM as a *"collaborative practice agreement (CPA) between one or more physicians and pharmacists wherein qualified pharmacists working within the context of a defined protocol are permitted to assume professional responsibility for performing patient assessments; ordering drug therapy-related laboratory tests; administering drugs; and selecting, initiating, monitoring, continuing, and adjusting drug regimens."*[11] This multidisciplinary approach allows pharmacists to coordinate a patient's therapeutic care, as prescribed by a physician or other health provider, by initiating or monitoring medication therapy and even adjusting a medication dosage or type of medication while communicating with the provider and patient about the patient's health status, medication management, adverse reactions, and other pertinent information.

States regulate pharmacists' patient care services through scope of practice acts, Boards of Pharmacy and Medicine regulations, and other laws. Pursuant to state law, pharmacists may collaborate with other health care providers to perform an array of patient care services, such as CDTM for hypertension and hyperlipidemia, in any pharmacy setting.

This fact sheet summarizes the extent to which states authorize collaborative pharmacist practice for drug therapy management and other patient care services and describes some of the more common elements of state law.

Data Collection

The research team collected and reviewed laws (statutes, legislation, and regulations) in the 50 states and District of Columbia (collectively referred to as "states") in effect as of December 31, 2012. The team used two search engines: Westlaw (Thomson Reuters, Eagan, Minnesota) and State Net (LexisNexis, Sacramento, California). Findings were cross-referenced with Internet legislative and administrative code sites for each state. Search terms included "collaborative practice agreement," "collaborative drug therapy management," "physician delegation," and other variations of these terms.

State Laws

As of December 31, 2012, at least 36 states authorize physician-pharmacist CDTM, in any setting (i.e., hospital, clinic, retail pharmacy), to provide for an array of health conditions, including

chronic diseases, as specified in a written provider protocol (see Figure and Table). Some of these states expand the list of health conditions authorized for CDTM through the rule-making process. For example, Louisiana allows CDTM for hyperlipidemia but not hypertension, whereas most states allow the practitioner and the pharmacist to determine the health conditions covered within the agreement. Another 6 states allow pharmacist CDTM only in specified health facility settings (i.e., hospitals, ambulatory care clinics), whereas 5 states only authorize pharmacists to provide immunizations or emergency contraception under protocol. In Alabama, South Carolina, and Tennessee, state law does not explicitly allow pharmacists to enter into CPAs, but pharmacists are authorized to perform some drug therapy management services in Alabama and Tennessee. With respect to Michigan and Wisconsin, physician delegation is considered permissive and allows pharmacists to perform delegated medical services similar to other mid-level practitioners.[12]

Other CDTM elements incorporated in state law include the extent of pharmacist-dependent prescriptive authority, whether the pharmacist may order and interpret laboratory tests, whether the Board of Pharmacy must approve the CPA or protocol, whether the pharmacist must meet any specialized training or continuing education requirements, and other provisions.

Along with performing other drug-related services (e.g., implement, add, monitor, administer), pharmacists are authorized to initiate drug therapy in at least 21 states, modify drug therapy in at least 38 states, and discontinue therapy in 6 states. A pharmacist may order or interpret laboratory tests related to drug therapy management in 31 states. Twenty-one states require the pharmacist, and in some cases the physician, to submit the CPA or protocol to the Board of Pharmacy or Medicine for approval or for notification purposes, and 9 of those states also require board approval of any amendments or modifications to the CPA or protocol. At least 24 states require the pharmacist to attain a specified level of advanced education, credentialing, or training to participate in CDTM; 3 of these states require credentialing at the level of a pharmacist clinician. New Mexico allows all pharmacists to conduct CDTM for emergency contraception, vaccinations, and tobacco cessation, but only certified pharmacist clinicians may perform CDTM for other health conditions.

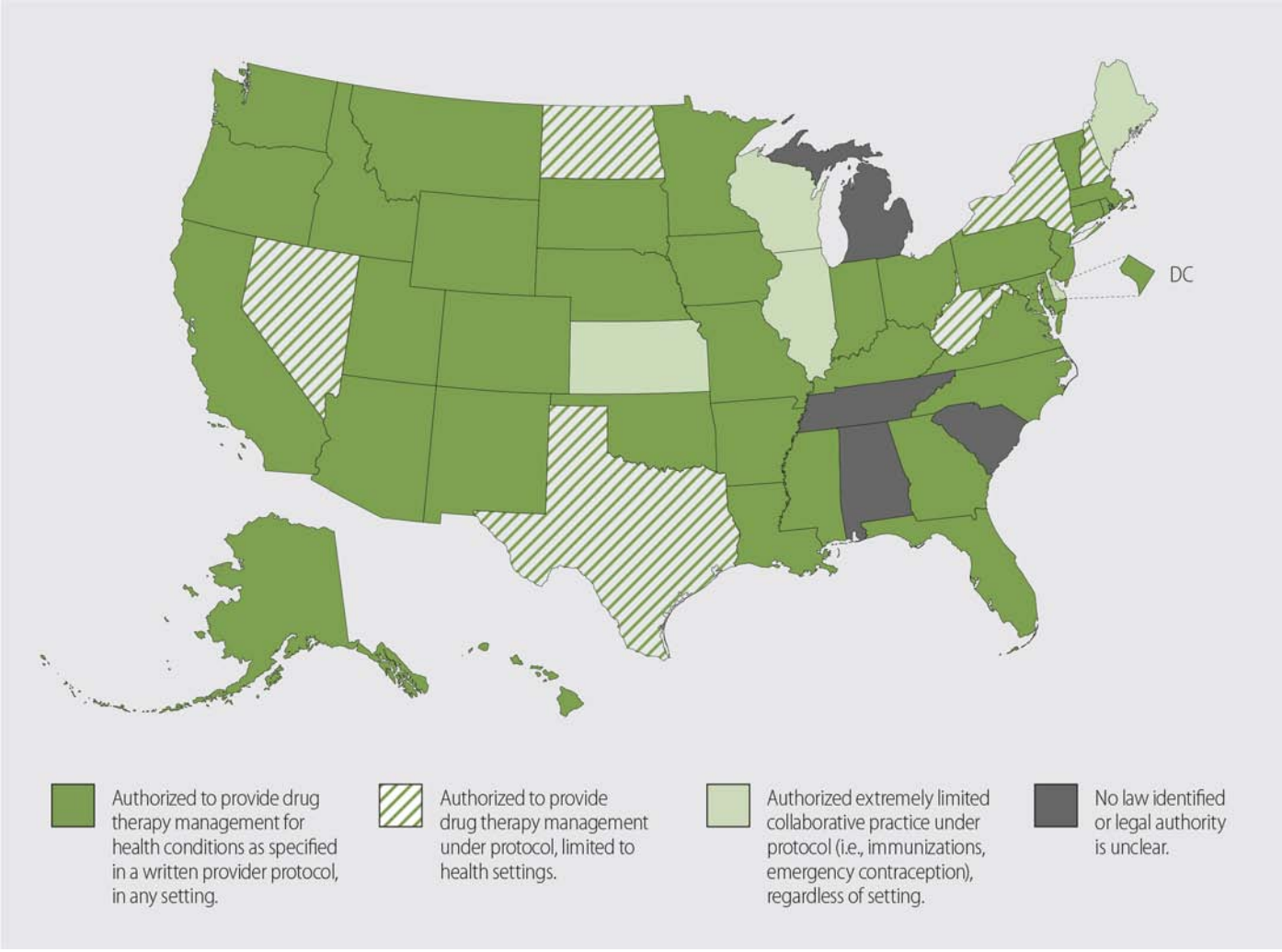

Figure: Map of States with Laws Authorizing Pharmacist Collaborative Practice Agreements, 2012

Implications

The extent to which pharmacists are engaged in collaborative practices is not known because few states provide a public listing of collaborating providers (e.g., see the Texas State Board of Pharmacy Web site[13]), even though at least 21 state Boards of Pharmacy collect such information. With more than 60,000 community-based pharmacies employing more than 170,000 pharmacists in retail settings (e.g., supermarkets, chains, and independent practices) across the United States, a significant portion of the adult population could have access to CDTM services, which may result in improved management and control of hypertension and hyperlipidemia, potentially improving the return on investment in states where CDTM is authorized.[14]

Pharmacists, clinicians, and others interested in working collaboratively should understand what is permissible within state law, contact their state professional licensing board, and consult other resources to learn how collaborative practice can be incorporated into health care delivery systems.[15]

Table: Select Features of State Pharmacist Collaborative Practice and Related Laws, 2012

State	Statutory and regulatory citation(s)	CPA or CDTM explicitly authorized	Other legal provision for drug therapy management or other services under protocol	Restrictions on practice settings and limitations or specifications on diseases or conditions covered
AL	Ala. Admin. Code r. 680-X-2-.14 (2013)	No	Authorized to participate in drug selection, drug utilization reviews, and drug therapy management	—
AK	Alaska Stat. §08.80.480.(27) (2013); Alaska Admin. Code tit. 12 §52.240 (2013)	Yes	—	—
AZ	Ariz. Rev. Stat. §32-1970 (2013) *(Ariz. Admin. Code §R4-23-421 to R4-23-429 repealed by final rulemaking at 17 A.A.R. 2600, effective February 4, 2012 [Supp. 11-4])*	Yes	—	Before July 2011, limited to inpatient health care institutions
AR	Ark. Code Ann. §17-92-101 (16) (2013); 070.00 Ark. Code R. §§9-09-00-0001 & 9-09-00-0002 (2013); 070.00 Ark. Code R. §§9-09-01-0001 to 9-09-01-0006 (2012)	Yes	—	As of January 2013, the board of pharmacy must recognize the following areas of practice in disease state management: asthma, anticoagulation therapy, diabetes, and dyslipidemia (list may be expanded)
CA	Cal. Bus. and Prof. Code §§4052.1 & 4052.2 (West 2013)	Yes	—	—
CO	Colo. Rev. Stat. Ann. §12-42.5-102 (West 2013); 3 Colo. Code Regs. 719-1 §§6.00.10 to 6.01.20; 3 Colo. Code Regs. 719-1 §6.01.40; 3 Colo. Code Regs. 713-32 (2013)	Yes	—	—
CT	Conn. Gen. Stat. Ann. §20-631, 631a & 631b (West 2013); State of Connecticut, Department of Consumer Protection issued notice of intent to amend regulations May 01, 2012 for CDTM (see Conn. Agencies Regs. §§20-631-1, 2 & 3 [2013])	Yes	—	Effective October 1, 2010, no longer limited to outpatient care for diabetes, asthma, hypertension, hyperlipidemia, osteoporosis, congestive heart failure, or smoking cessation and no longer limited to hospital or nursing home facilities and piloting in community pharmacies
DC	D.C. Code §§3–1201.02 & 3-1202.08 & 3-1204.12 (2001)	Yes	—	—
DE	Del. Code Ann. tit. 24, §2502(19) (2013)	No	Administer injectable medications, biological, and adult immunizations pursuant to a valid prescription or physician-approved protocol	—
FL	Fla. Stat. Ann. §465.003(13) & §465.0125 (West 2013); Fla. Admin. Code Ann. r. 64B16-27.1001 & 64B16-27.830 (2013)	Yes	—	—
GA	Ga. Code Ann. §§ 26-4-4, 43-34-24 & 26-4-50 & §§ 26-4-210 to 214 (2013); Ga. Comp. R. & Regs. §§ 480.35.01 to 35.08 (2013)	Yes	—	—

State	Statutory and regulatory citation(s)	CPA or CDTM explicitly authorized	Other legal provision for drug therapy management or other services under protocol	Restrictions on practice settings and limitations or specifications on diseases or conditions covered
HI	Haw. Rev. Stat. §461-1 et seq. (2013); Haw. Code R. §16-95-130 (2013)	Yes	Physician order or prescription required for health conditions other than emergency contraception	CPA required for emergency contraception
ID	Idaho Code §54-1704 to 1705 (2013); Idaho Admin. Code r. 27.01.01 §§010, 011, 310, 320 & 330 (as approved 3-21-2012)	Yes	—	—
IL	225 Ill. Comp. Stat. Ann. 85/3 (West 2013)	Undetermined	Vaccination pursuant to physician prescription or standing order; patient care MTM functions authorized in a physician standing order; MTM services in a licensed hospital include "following protocols of a hospital pharmacy and therapeutics committee with respect to the fulfillment of medication orders"	—
IN	Ind. Code Ann. §§25-26-13-2 & 25-26-13-31 & 25-26-16.5.1 to 25-26-16.5-18 & 27-8-10-3.5 (West 2013); 856 Ind. Admin. Code §1-28.1-7 (2013)	Yes	Required for insurance coverage of chronic disease management	—
IA	Iowa Code Ann. §§155A.3(34) & 135.159 (West 2013); Iowa Admin. Code r. 657 §8.2 & §8.34 & 653 §13.4 (2012)	Yes	Department of Public Health required to develop a plan for implementation of a statewide medical home system that provides access to pharmacist-delivered medication reconciliation and MTM services, where appropriate	—
KS	Kan. Stat. Ann. §§65-1626a & 65-1635a (2012)	No	Vaccinations	—
KY	Ky. Rev. Stat. Ann. §§315.010 & 315.040 (West 2012); 201 Ky. Admin. Regs. 2:220 (2013)	Yes	—	—
LA	La. Rev. Stat. Ann. §37:1164 (2012); La. Admin. Code tit. 46 §523 (2013)	Yes	—	Arterial and venous clot propagation and disease; diabetes; asthma; dyslipidemia; smoking cessation; disease-specific vaccines to patients aged 16 years or older; and other board-approved, disease-specific drug therapies
ME	Me. Rev. Stat. Ann. tit. 32 §§13702-A(28) &13831-13834 & 13821-13823 (2012); 02-392-4A Me. Code R. §1 (Weil 2013)	Yes	—	Emergency contraception, specific vaccines, epinephrine, and diphenhydramine (board may approve other drugs)
MD	Md. Code Ann., Health Occupations §§12-101(n) & (t) & 12-6A-01 to12-6A-10 (West 2013); Md. Code Regs. 10.34.32.01 to .09 (2013)	Yes	—	—
MA	Mass. Gen. Laws Ann. ch. 112 §24B1/2 & §24B3/4 (West 2013); 247 Mass. Code Regs. 16.00-16.04 & 243 Mass. Code Regs. 2.12 (2013)	Yes	—	In a community pharmacy setting: asthma, chronic obstructive pulmonary disease, diabetes, hypertension, hyperlipidemia, congestive heart failure, HIV/AIDS, or osteoporosis (and diagnosed comorbidities)
MI	Mich. Comp. Laws Ann. §§333.16104 & 16215 (West 2013); see State of Michigan Attorney General Opinion, OAG, 1979-1980, No 5630 (January 22, 1980)	No	—	—
MN	Minn. Stat. Ann. §§151.01(27) & 151.21 & 62q.676 (West 2013)	Yes	—	—

State	Statutory and regulatory citation(s)	CPA or CDTM explicitly authorized	Other legal provision for drug therapy management or other services under protocol	Restrictions on practice settings and limitations or specifications on diseases or conditions covered
MS	Miss. Code Ann. §73-21-73 et seq. (2013); 30-20-3001 Miss. Code R. §XXXVI & 30-20-3001 Miss. Code R. §XXIX & 23-1-15 Miss. Code R. §31.19 & 30-17-2630 Miss. Code R. §2.1 et seq. (2013)	Yes	—	—
MO	Mo. Ann. Stat. §338.010 (West 2013); Mo. Code Regs. Ann. tit. 20, §§2220-6.050 - 2220-6.080 (2013)	Yes	—	—
MT	Mont. Code Ann. §37-7-101 (2013); Mont. Admin. R. §§24.174.524 to 24.174.527(2013)	Yes	—	—
NE	Neb. Rev. Stat. §§38-2831, 38-2837, 38-2866 & 38-2870 (2012); 172 Neb. Admin. Code §§128.002 & 128.013 (2013)	Yes	—	—
NV	Nev. Rev. Stat. §§639.0124 & 639.2809 (2012); Nev. Admin. Code §639.297	Yes	—	CPA required for immunizations; licensed medical facility or a setting affiliated with a medical facility where the patient is receiving care (other than immunizations)
NH	N.H. Rev. Stat. Ann. §§318:1 & 318:16-a (2013); N.H. Code R. Ph. §§1101 to 1104.03 (2013)	Yes	—	Hospitals, long-term care facilities, licensed inpatient or outpatient hospice settings, and ambulatory care clinics with onsite supervision by attending practitioner and collaborating pharmacist who has no connection to any onsite retail pharmacy
NJ	N.J. Stat. Ann. §§45:14-41, 45:14-61 & 45:14-62 (West 2013)	Yes	—	—
NM	N.M. Stat. Ann. §§61-11B-1 to 61-11B-3 (West 2013); N.M. Code R. §§16.19.26.1 to 16.19.26.11 & 16.19.4.7 & 16.19.4.17	Yes	Any pharmacist may prescribe, administer, or modify drug therapy, limited to vaccines, tobacco cessation drug therapy, and emergency contraception, as per board-approved written protocols	Pharmacist clinicians may enter into CPA for health conditions as specified under protocol in any setting
NY	N.Y. Education Law §§6801 & 6801-a & N.Y. Social Services Law §367-A(9)(h) (McKinney 2013)	Yes	Licensed pharmacist may execute a nonpatient-specific regimen prescribed or ordered by a licensed physician or certified nurse practitioner, pursuant to rules and regulations promulgated by the commissioner of health; commissioner authorized to establish an MTM pilot program in one or more counties or regions to improve drug therapy outcomes	Immunizations (nonpatient-specific); CDTM in teaching hospital, as specified in CPA or written protocol
NC	N.C. Gen. Stat. Ann. §§90-18 (3a) & 90-18.4 & 90-85.1 et seq. (West 2013); 21 N.C. Admin. Code §46.3101 (2013); 2011 N.C. Sess. Laws 145	Yes	As of July 1, 2011, Department of Health and Human Services authorized to develop a 2-year MTM pilot program to, in part, "determine the most effective and efficient role for community-based pharmacists" in team-based care	
ND	N.D. Cent. Code §§43-15-01(24) & 43-15-31.4 (2011); 61 N.D. Admin. Code §§04-08-01 to 04-08-07 (2013)	Yes	—	Institutional setting: hospital, physician clinic, skilled nursing facility, or swing-bed facility
OH	Ohio Rev. Code Ann. §§4729.01 & 4729.39 (West 2013); Ohio Admin. Code §§4729-29-01 to 4729-29-07 (2013)	Yes	—	—
OK	Okla. Stat. tit. 59 §353.30 (2013); Okla. Admin. Code §535:10-9-5 (2013)	Yes	—	Immunizations; other conditions pending rulemaking

State	Statutory and regulatory citation(s)	CPA or CDTM explicitly authorized	Other legal provision for drug therapy management or other services under protocol	Restrictions on practice settings and limitations or specifications on diseases or conditions covered
OR	Or. Rev. Stat. Ann. §689.655 (West 2013); Or. Admin. R. §§855-006-0005, 855-019-0260 & 855-019-0250 (2013)	Yes	—	—
PA	63 Pa. Stat. Ann. §390-2(14), §390-9.1 & §390-9.3 (West 2013)	Yes	—	—
RI	R.I. Gen. Laws 1956, §§5-19.2-1 to 5-19.2-5 (2013); 31-2-8 R.I. Code R. §§1.0 & 25.0 & 31-5-36 R.I. Code R. §25.0 & 31-5-41 R.I. Code R. §§1.0 & 13.0 (2013)	Yes	—	—
SC	S.C. Code Ann. §§40-43-30(18),(38)&(44) & 40-43-190 (2012)	No	—	—
SD	S.D. Codified Laws §36-11-19.1(6) (2013); S.D. Admin. R. §20:51:16:04 (2013)	Yes	—	—
TN	Tenn. Code Ann. §63-10-204 (LexisNexis 2010)	No	—	—
TX	Tex. Occ. Code Ann. §§157.101(b-1), 157.001 & 551.003(33) (West 2013); 22 Tex. Admin. Code §§295.13 & 193.7 (2013)	Yes	—	Hospital, hospital-based clinic, or an academic health care institution
UT	Utah Code Ann. §58-17b-102(16), (17), (45) & (56) (2013); Utah Admin. Code r. §156-17b-611 (2013)	Yes	—	—
VT	2011 Vt. Acts & Resolves 63; Vt. Stat. Ann. tit. 26, §§2078-2079 (2013); 04 Vt. Code R. §20-4-1400:1.10 (2013)	Yes	Department of Health to establish a population-based MTM pilot project in collaboration with the Department of Vermont Health Access and the University of Vermont Office of Primary Care, to include CPAs	Emergency contraception; administer vaccine pursuant to written protocol, including emergency measures based on a CPA or a patient-specific prescription from a licensed prescriber; provision of pharmaceutical care: chronic disease management, smoking cessation, maternal and child health, immunizations, family planning, self-care consulting, drug selection under protocol, etc.
VA	Va. Code Ann. §§54.1-3300, 3300.1, 3303 & 38.2-340 & 38.2-4221 (2013); 18 Va. Admin. Code §§110-40-10 to 110-40-70 (2013)	Yes	—	CPAs only used for conditions that have protocols that are clinically accepted as the standard of care or for board-approved protocols
WA	Wash. Rev. Code Ann. §18.64.011(23) (West 2013); Wash. Admin. Code §§246-863-100, 246-863-110 & 246-863-095 (2013) (see also Wash. Admin. Code § 388-530-1050 definition for practice of pharmacy within Medicaid context)	Yes	—	—
WV	W. Va. Code Ann. §§30-5-1b(4),(5),(25)& (28), 30-5-26 & 30-5-27 (West 2012); W. Va. Code R. §11-8-1 to §11-8-9 (2013)	Yes	—	Facility-based (hospitals, nursing homes, medical schools, hospital community and ambulatory care clinics) and 5 pilot community pharmacies
WI	Wis. Stat. Ann. §§450.01(16) & 450.035 (West 2013)	No	Vaccine protocols; inpatient therapeutic alternate drug selection pursuant to pharmacy or hospital protocols	—
WY	Wyo. Stat. Ann. §§33-24-124 & 33-24-101(b)(iii); Pharm. Act, Rules & Regs. ch. 2, Wyo. Code R. §4 & 28 (LexisNexis 2013)	Yes	—	—

— Indicates no relevant provision identified.

CPA: collaborative practice agreement; CDTM: collaborative drug therapy management; MTM: medication therapy management.

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