On behalf of the Vermont Medical Society’s 2400 physician and physician assistant members, thank you for the invitation to participate in the stakeholder meetings regarding pharmacist prescribing authority in Vermont. We appreciate being part of the process and the opportunity to have a robust conversation with OPR, pharmacists, and the other prescribers who participated in the meetings.

I am submitting this letter to summarize and expand on some of the points of feedback the physicians attending the meetings shared with you. **VMS feedback focuses on two points: (1) the importance of mechanisms for clinical input as specific prescribing protocols are developed and (2) logistical concerns raised by pharmacy prescribing generally.**

1) **Mechanisms for Additional Clinical Input**

VMS does agree that there could be some instances in which expanded pharmacy prescribing could meet the multiple goals of increasing patient access to services, improving patient outcomes and reducing administrative burden to primary care practices. One example raised in the stakeholder meetings is the prescribing of devices that accompany other prescribed medications, such as inhaler spacers, pen needles or diabetes testing supplies.

On the other extreme, there are a number of areas of expanded pharmacy practice that have been pursued in Idaho that VMS believes put patient safety at serious risk, such as antibiotics for UTIs and Strep. Rather than repeat the range of concerns raised in Idaho, as OPR has stated that is not the model being recommended in Vermont at this time, please see the attached letters from the Idaho Board of Medical Practice and Idaho Medical Association outlining their extensive feedback regarding both the procedures for expanding prescribing and many of the expanded categories for pharmacist prescribing in Idaho. VMS particularly shares the concern expressed in Idaho that prescribing protocols developed in that state are merely voluntary and individual pharmacists can develop their own protocols.

**VMS believes that continued stakeholder participation and feedback is critical as any specific proposal for pharmacy prescribing is pursued.** OPR indicated that this evaluation and stakeholder process was not the appropriate time to begin developing specific categories of drugs/conditions that should be pursed in Vermont nor developing the clinical protocols or “guardrails” for their prescription at this time. Given that, it was difficult for physicians to provide feedback on a general concept and the clinical appropriateness of a proposal could vary widely. For example, prescribing to minors by pharmacists may generally be inappropriate, but perhaps appropriate in the context of certain medical devices, for example, insulin pen needles. VMS further appreciates that OPR indicated certain categories may be “off the table,” such as antibiotics, controlled substances and medications for mental health/behavioral health indications, however it was unclear from the meetings what the process will be for making such determinations or what statutory, rulemaking or other framework will be used for determining pharmacist prescribing authority.  **VMS believes that whether through rulemaking, protocol or other processes, public and transparent stakeholder input from prescribing clinicians is critical as the details of any proposal begins to be developed.** Further, given that the details of specific protocols were not discussed, VMS is not able to commit to supporting any of the specific categories of prescribing discussed at the stakeholder meetings.
(2) Logistical Concerns Raised by Pharmacy Prescribing

A. Loss of Integration with Primary Care Services

For over a decade, Vermont policy and statute have placed primary care practices, coordinated by the Blueprint for Health, at the center of creating “a system of health care for patients, improving the health of the overall population, and improving control over health care costs by promoting health maintenance, prevention, and care coordination and management.”1 Vermont policy has continued to emphasize primary care and care coordination through its All-Payer Model, implemented by the OneCare Vermont Accountable Care Organization.2

While making some services available at a pharmacy may improve patient care and outcomes, there is a real risk that making other services available at a pharmacy fragments primary care delivery to the detriment of patient health. For example, a patient coming in to the primary care practice to fill an annual prescription for a maintenance medication may be the only opportunity the practice has to remind a patient about other important screenings, vaccinations, medical and mental health services available. Data corroborate that patients are sensitive to skipping well care when they do not have other perceived incentives to see their provider. For example, even immunization receipt at a sick visit is associated with decreased subsequent well-child care.3

To reduce the risks of fragmenting primary care, VMS recommends:

1. That as OPR considers specific proposals for pharmacy prescribing, rather than the general concept, OPR seek and incorporate feedback from primary care clinicians, the Blueprint for Health and OneCare Vermont regarding the potential impact on primary care access and integration of services.

2. That at every instance of prescribing, a pharmacist must inquire whether the patient has a primary care clinician and provide a referral to a meaningful access point to primary care services within that community if the patient indicates he/she does not have a primary care clinician (this could include the Community Care Team, local hospital or Federally Qualified Health Center, depending on the community).

B. Communication with Primary Care Clinicians

Related to the potential to fragment care, any proposal for pharmacy prescribing must include specific requirements and timelines for communicating any medication prescribed back to primary care clinicians. Under current vaccine administration statutes, primary care physicians still do not universally receive reports of vaccines administered to patients. Primary care clinicians must have confidence that they will receive timely, accurate information from pharmacies. VMS strongly urges OPR to consider modes of electronic communication such as through Vermont’s Health Information Exchange, VITL. Participation in the Vermont Immunization Registry should be mandatory for any immunizations administered.


3 See https://pediatrics.aappublications.org/content/121/5/898.
C. Other Standards of Practice

A pharmacy is not a traditional medical office setting. As pharmacists expand into providing prescribing services, pharmacists must be held to the same standards of practice as other prescribing clinicians and such standards should be written into any rules or protocols for prescribing. These include, but are not limited to:

1. **Adequate consultation/history:** Depending on the protocols being considered, there are a range of serious contraindications to prescribing and it is critical that pharmacists have access to information regarding a patient’s medication and medical history. Ideally, pharmacists should have access to complete medical information via shared EHRs or the VITL system. Absent that, any protocol should specifically outline the information that must be gathered from a patient based on national guidelines appropriate to that condition/drug.

2. **Documentation:** Pharmacists must complete adequate documentation of any history taken, exam completed and medications prescribed.

3. **Private space/time for counseling patients:** While some pharmacies have begun to build private consultation space, it is still common practice to receive vaccines or medication counseling in a busy pharmacy sales location; private space must be available and used in prescribing situations.

4. **Follow-up care:** Pharmacists may not be able to provide patients or the health care professionals responding to an emergency or a subsequent event arising out of a prescribed medication with the information they need in a timely manner, as they are not required to be available to the patient after taking a prescription. Primary care practices have well-established protocols for remaining on-call 24 hours a day, 7 days a week, to address concerns that might arise well after a prescription is taken. Prescribing pharmacists must address how they, and the information in their medical record, will be available to patients or emergency personnel 24/7 for emergency situations.

5. **Financial incentives:** VMS shares the concern raised by the Vermont Board of Medical Practice regarding financial incentives in pharmacy practice, especially national pharmacy chains. It should be prohibited for prescribing pharmacists to receive salary or financial incentives linked to quantity or types of medications filled.

Thank you for considering this additional feedback. VMS, as well as our primary care partners at the American Academy of Pediatrics Vermont Chapter and Vermont Academy of Family Physicians look forward to continuing to work with OPR and the Board of Pharmacy as these proposals develop. Please contact me at any time if I can be helpful.