

Prescribing privileges among pharmacists in Veterans Affairs medical centers

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Am J Health-Syst Pharm. 2001; 58:1143-5

Since implementation of Veterans Health Administration (VHA) directive 10-95-019, clinical pharmacy specialists (CPSs) have worked within the Veterans Affairs (VA) health care system as independent providers, similar to nurse practitioners and physician assistants.¹⁻³ Under Veterans Affairs Medical Center (VAMC) protocol, a CPS may prescribe medications; this includes initiation, continuation, discontinuation, and alteration of therapies.^{1,4} CPSs can review and order appropriate laboratory tests, perform venipuncture for the purpose of withdrawing blood for laboratory testing, analyze laboratory and diagnostic test data, and perform physical examinations. They can assist in the management of medical emergencies, adverse drug reactions, and patients with acute and chronic diseases, and they can administer medications, in addition to performing the activities of a state-licensed and registered pharmacist. A survey was conducted to ascertain the use of CPSs as independent prescribers and to determine the types and numbers of specialty clinics at VAMCs and the extent of CPS use within the specialty clinics.

Background. The Food, Drug, and Cosmetic Act (FDCA) limits nonphysician prescribing authority

to practitioners who are granted prescribing authority by their state of current licensure. However, on April 4, 1994, FDA officials informally advised the VA that the language in the FDCA does not apply to federal employees acting within the scope of their government employment.⁵ On March 3, 1995, VHA issued directive 10-95-019, giving authority to VAMCs for an expanded scope of practice, including independent prescribing privileges within VAMC protocols, for CPSs.¹ This was followed on May 7, 1996, by VHA directive 96-034, which further defined the activities of the CPS and provided methods for establishing and maintaining written policies at each VAMC to address all aspects of the scope of practice (SOP) for each CPS.⁴ Each VA facility may identify a SOP specific to an individual or a

group of CPSs. These SOPs identify elements such as the responsible physician or medical service, physical limits such as clinic versus facility-wide privileging, limits on prescribing authority (e.g., no controlled substances), and effective time frame of authority. A document requesting privileging is then presented to the medical executive committee, approved, and signed by designated administrative and clinical personnel within each VAMC.

Methods. Out of 164 VAMCs, as listed in the *U.S. Medicine Directory 2001*,⁶ telephone contact was attempted with 162 by four Albany College of Pharmacy Pharm.D. students on clinical rotation at the Stratton (Albany) VAMC and by two Pharm.D.s over a four-month period from May through August 2000. Two VAMCs, in Hawaii and the Philippines, were not contacted, because of the time difference from the calling site. Each caller sequentially asked to speak with a clinical pharmacy coordinator, director or assistant director of pharmacy, clinical pharmacist, or staff pharmacist. If one of these individuals was available, the seven-question survey was conducted. If none were available, the facility was contacted at a later time. If three calls to any site did not result in a completed survey, that site was listed as a

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nonresponder. The survey was kept simple and concise (only seven questions), with intention of minimizing surveyor variances and maximizing respondent participation. Four survey questions could be answered yes, no, or unknown, and three questions required the respondent to say how many pharmacists had the specified prescribing privileges. If asked by the respondents, the surveyors were allowed to define prescribing privileges as "not requiring cosignature." The 20 most common types of VAMC clinics were listed in one of the questions (which asked about the presence of the clinics and whether they had a pharmacist with prescribing privileges), but each respondent was allowed to name clinics not included in that list.

Twenty-two VAMCs were randomly selected for follow-up contact by different surveyors three months apart. The duplicate data were analyzed for agreement—responses to the initial contact were used in compiling aggregate results—and all surveys were reviewed for accuracy of responses.

Results. One hundred four VAMCs answered the survey by telephone and one VAMC submitted written responses after requesting that option. Fifty-seven VAMCs were nonresponders. Nonresponses included failed contact (operator nonanswer, disconnect, or incorrect transfer), unanswered voice mail, and refusal to participate.

Of the 105 responding VAMCs, 81% (85) stated that they had CPSs with an expanded SOP that included independent prescribing privileges for inpatients or outpatients, and 498 pharmacists were identified as privileged to prescribe. A majority of these VAMCs (66, or 62.9%) are located in states that (according to the National Association of Boards of Pharmacy⁷) do not have board of pharmacy rules and regulations that support pharmacist prescribing. Six VAMCs (5.7%) identified 14 CPSs as

privileged to independently prescribe controlled substances. Five of these are located in states that do not support pharmacist prescribing; none are in states that allow pharmacists to obtain an independent Drug Enforcement Administration (DEA) number,⁷ which means that institutional VAMC DEA numbers had to be assigned. At the time of the survey, four additional pharmacists in New York State were identified as prescribing controlled substances. Most of the VAMCs surveyed (98, or 93.3%) had outpatient clinics in which pharmacists had prescribing privileges. The 105 respondents identified 41 different types of clinics; the average number of clinics per VAMC was 3.45. The most commonly identified clinics and CPS presence in these clinics are shown in Table 1. Anticoagulation clinics were the most common, but renewal maintenance clinics had the most CPSs per clinic.

In the duplicate surveys of 22 sites, the person responding to the survey was different in 20 of 22 cases. Question 1 (whether any pharmacists had prescribing privileges) was answered identically 90.9% (20/22) of the time. Question 4 (whether any pharmacists could prescribe controlled substances) was answered identically 100% of the time. For questions 6 and 7, if either respondent answered "unknown," that pairing was discarded. Question 6 (whether the state allowed pharmacist prescribing in collaboration with a physician) was answered identically

94.7% (18/19) of the time. For question 7 (whether the state allowed collaborative agreements outside the institutional setting), which was asked only if an affirmative answer was given to question 6, the answers were identical 94.1% (16/17) of the time. Question 2 (number of pharmacists with prescribing privilege in the institution) was answered identically 59.1% (13/22) of the time; the nonidentical responses (from nine pairs) had an average disparity of 5.1 CPSs with prescribing authority per VAMC.

Discussion. Surveys inherently incorporate surveyor and respondent error into the collected information, and a 100% response is rare. This survey, because of failed contacts, underrepresents Veterans Integrated Service Networks (VISNs) 13, 17, and 20. Included in these VISNs are Oregon, Texas, and Washington State. Each of these states allows pharmacist prescribing authority with physician collaborative agreements, and Washington State allows independent DEA number assignment for pharmacists.⁷ Thus, failure to contact the three VAMCs located in Washington State contributed to the very small number of CPSs reported as prescribing controlled substances. No attempt was made to differentiate between VAMCs that provide extensive clinical pharmacy services and those that do not; therefore, either type might be over or under represented in the results without

Table 1.
Most Common Types of Clinics and Presence of Clinical Pharmacy Specialists (CPSs) in Veterans Affairs Medical Centers (VAMCs)

Clinic Type	% VAMCs with Clinic	CPSs per Clinic
Anticoagulation	75.0	2.0
Primary care	40.9	2.8
Renewal maintenance	26.7	5.4
Lipid	24.8	1.2
Mental hygiene	20.9	1.1
Diabetes	20.0	1.9
Infectious diseases/HIV	17.0	0.9
Geriatric	14.3	1.3
Smoking cessation	12.4	1.9
Oncology/hematology	10.5	0.8

corrective analysis. Real employment information for pharmacists, correlated with the individual SOP statements for each CPS at every VAMC, would be necessary for a complete and accurate assessment of the SOP of pharmacists within the VA health care system. To accurately predict the impact that this expanded SOP has on patient care and costs within the VHA, billing data, patient outcomes, and patient satisfaction surveys would need to be associated with CPS activities within the VAMCs.

Pharmacists and CPSs in the VA health care system provide patient care services as part of multidisciplinary teams, as consultants, and as clinic-based independent practitioners. CPS patient assessment and medication monitoring, which includes the authority to initiate, discontinue, renew, and alter drug therapies, has been shown to reduce adverse drug events and drug-related illnesses.^{2,3} CPSs were providing independent patient care services in 41 different clinic types in 81% of the VAMCs responding to the survey. This expanding role of pharmacists within the VA health care system is consistent with a vision of its transformation from a medical-center-based system to a clinic-based "virtual integrated health system" with opportunities for CPSs in multidisciplinary care teams, primary care, individual care, and new practice models.²

Recent data suggest that medication errors are an important and growing source of adverse patient outcomes, increased use of services,

and increased costs. Many of these errors occur in the prescribing phase of the medication-use process.⁸⁻¹²

There has been a presumption that these errors may be attributable in part to nonphysician practitioners, but there is no published evidence to support that view. (In fact, currently available data with respect to pharmacists suggest just the opposite; that pharmacists have had a positive impact on patient outcomes.^{3,11,13-15})

As more state boards of pharmacy seek to expand pharmacists' SOP to include collaborative prescribing agreements, VA hospitals and clinics should be looked upon as a model. The activities of CPSs in the VA system can provide outcome data for states to use in defining an expanded SOP.

Conclusion. Most VAMCs have pharmacists with prescribing privileges. Although anticoagulation clinics are the most common type of clinic in VAMCs, renewal maintenance clinics have the most pharmacists with prescribing privileges.

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