POLICY PROFILE

Population-Based Collaborative Practice Agreement for Naloxone

RAND-USC SCHAEFFER OPIOID POLICY TOOLS AND INFORMATION CENTER

Pharmacists are given permission to voluntarily enter into collaborative agreements (or standing orders) with physicians and other providers to dispense naloxone to eligible patients without a patient-specific prescription according to patient criteria and instructions defined by the authorizing prescriber.

A panel of experts rated how they expect this type of policy to affect four outcomes: *naloxone distribution* through pharmacies, *opioid use disorder (OUD) prevalence*, rates of *nonfatal opioid overdose*, and *opioid overdose mortality*. Another panel of experts rated the policy on four implementation criteria: *acceptability* to the public, *feasibility* of implementation, *affordability* from a societal perspective, and *equitability* in health effects.

POLICY RECOMMENDATION ACCORDING TO EXPERT RATINGS

OPPOSE	UNCERTAIN	SUPPORT

SUMMARY OF EXPERT RATINGS

OUTCOMES	EFFECT RATING		
Naloxone Pharmacy Distribution	HARMFUL	LITTLE-TO-NO	BENEFICIAL
OUD Prevalence	HARMFUL	LITTLE-TO-NO	BENEFICIAL
Nonfatal Opioid Overdose	HARMFUL	LITTLE-TO-NO	BENEFICIAL
Opioid Overdose Mortality	HARMFUL	LITTLE-TO-NO	BENEFICIAL
CRITERIA	**IMPLEMENTATION RATING**		
Acceptability	LOW	MODERATE	HIGH
Feasibility	LOW	MODERATE	HIGH
Affordability	LOW	MODERATE	HIGH
Equitability	LOW	MODERATE	HIGH

SUMMARY OF EXPERT COMMENTS

- Experts expect the policy to increase naloxone pharmacy distribution by removing patient barriers to acquiring naloxone (prescriptions and physician involvement) and enable pharmacist autonomy. They expect minimal effects on other outcomes due to the complex implementation chain from policy to provision of naloxone.
- Experts think the policy is acceptable to the public because of its successful adoption without much public pushback.
- Experts believe the policy could be feasible, conditional on pharmacist willingness and lack of opposition from prescribers concerned about professional scope creep.
- Experts rated the policy as affordable due to eliminating the costs of prescriber office visits.
- Experts believe the policy to be only moderately equitable because of the possibilities of pharmacist bias and limited access to pharmacies.

THE PANELS AND RESULTS INFORMING THIS POLICY PROFILE ARE FULLY DOCUMENTED IN

Smart, Rosanna, and Sean Grant. (2021). "Effectiveness and implementability of state-level naloxone access policies: Expert consensus from an online modified-Delphi process." *International Journal of Drug Policy,* 98, 103383. As of July 31, 2023: https://www.rand.org/t/EP68824.html

Grant, Sean, and Rosanna Smart. (2022). "Expert views on state-level naloxone access laws: A qualitative analysis of an online modified-Delphi process." *Harm Reduction Journal*, 19(1), 64. As of July 31, 2023: https://www.rand.org/t/EP69032.html

For a complete list of OPTIC Policy Profiles, visit www.rand.org/policy-profiles.

To view this Policy Profile online, visit www.rand.org/t/RBA3054-10.

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Outcomes Summaries

NALOXONE PHARMACY DISTRIBUTION

Amount of naloxone dispensed through retail pharmacies (e.g., chain pharmacy stores, independent community pharmacies).

EFFECT RATING	SUMMARY OF EXPERT OPINION	REPRESENTATIVE QUOTATIONS
BENEFICIAL	This pharmacist-driven approach could increase access particularly among large chain pharmacies and with patients motivated to acquire naloxone.	"More effective for large chains and independents as barriers reduced (finding provider for [a prescription]/sign an agreement)"
LITTLE-TO-NO	Depends on the size of the population (patient criteria), nature of the agreement, pharmacist interest in entering an agreement, and pharmacist availability (in underserved areas).	"Unclear how much initiative pharmacists will take or how broad of a population this would end up covering"
HARMFUL	N/A	N/A

OPIOID USE DISORDER PREVALENCE

Percentage of the general population with a pattern of opioid use leading to clinically and functionally significant impairment, health problems, or failure to meet major responsibilities.

EFFECT RATING	SUMMARY OF EXPERT OPINION	REPRESENTATIVE QUOTATIONS
BENEFICIAL	N/A	N/A
LITTLE-TO-NO	No credible mechanism linking collaborative practice agreements and OUD prevalence.	"Narcan [naloxone] distribution would not change disorder prevalence"
HARMFUL	Potential for revival from overdose could (1) have a small, indirect, and mechanistic impact on OUD prevalence due to increased survivorship (rather than new cases of OUD) and (2) lead to continued opioid misuse.	"I expect greater availability of naloxone would lead to continued or slightly increased opioid misuse"

Outcomes Summaries

NONFATAL OPIOID OVERDOSE

Per capita rates of nonfatal overdose related to opioids, including opioid analgesics (e.g., oxycodone), illegal opioids (e.g., heroin), and synthetic opioids (e.g., fentanyl).

EFFECT RATING	SUMMARY OF EXPERT OPINION	REPRESENTATIVE QUOTATIONS
BENEFICIAL	Could facilitate pharmacist identification of patients at risk for an overdose.	"Would allow for pharmacists to assist prescribers in identifying high risk patients"
LITTLE-TO-NO	No credible mechanism linking collaborative practice agreements and nonfatal overdoses.	"Doesn't impact non-fatal OD [overdose]—only the lethality of the individual OD"
HARMFUL	Potential for revival from overdose could (1) have a small, indirect, and mechanistic impact on nonfatal overdoses due to increased survivorship and (2) lead to continued opioid misuse.	"As pharmacy distribution increases, more and more people who are likely to use it will get it, thereby increasing the number of nonfatal overdoses via a reduction in fatal overdoses (assuming increased distribution will not significantly impact OUD prevalence, which I do not believe it will). However, I expect the increase in naloxone distribution associated with this policy to be relatively small, thereby limiting the effectiveness of this policy on overdoses"

OPIOID OVERDOSE MORTALITY

Per capita rates of fatal overdose related to opioids, including opioid analgesics (e.g., oxycodone), illegal opioids (e.g., heroin), and synthetic opioids (e.g., fentanyl).

EFFECT RATING	SUMMARY OF EXPERT OPINION	REPRESENTATIVE QUOTATIONS
BENEFICIAL	Significant increase in naloxone pharmacy distribution (by removing barrier of needing to obtain individual prescriptions) would yield meaningful decreases in fatal overdoses.	"Making Naloxone more accessible to anyone who wants it and removing the barriers to get it (such as seeking out a prescription from a doctor) would lead to more nonfatal opioid overdoses and less fatal opioid overdoses"
LITTLE-TO-NO	Marginal overall impact due to the complex implementation chain from policy to provision of naloxone.	"Many limitations and stigma among pharmacists, lack of confidence, knowledge, mandate means little effect"
HARMFUL	N/A	N/A

Implementation Criteria Summaries

ACCEPTABILITY

The extent to which the policy is acceptable to the general public in the state or community where the policy has been enacted.

IMPLEMENTATION RATING	SUMMARY OF EXPERT OPINION	REPRESENTATIVE QUOTATIONS
HIGH	Successful adoption without much public pushback (likely due to its commensurability with obtaining other types of medication from pharmacists).	"Communities have become more familiar with retail pharmacies providing vaccines, this would likely be generally accepted in the same way"
MODERATE	N/A	N/A
LOW	N/A	N/A

FEASIBILITY

The extent to which it is feasible for a state or community to implement the policy as intended.

IMPLEMENTATION RATING	SUMMARY OF EXPERT OPINION	REPRESENTATIVE QUOTATIONS
HIGH	Feasible so long as pharmacists are willing to dispense naloxone without physician involvement and there is no opposition from prescribers concerned about professional scope creep.	"Main factor impacting implementation is availability of pharmacists and prescribers who are interested and willing to engage in these partnerships. Also need to provide education and information to the public that this is available"
MODERATE	Concerns about getting physicians and pharmacists to form collaborative practice agreements and about pharmacies stocking naloxone sufficiently.	"Setting up these collaboratives are challenging and puts a lot of onus on individual pharmacies and physicians"
LOW	Creates more work and burden for already overtaxed pharmacists and physicians.	"This seems like a policy that will put much of the effort back on the prescriber and pharmacists which will make statewide coverage difficult"

Implementation Criteria Summaries

AFFORDABILITY

The extent to which the resources (costs) required to implement the policy are affordable from a societal perspective.

IMPLEMENTATION RATING	SUMMARY OF EXPERT OPINION	REPRESENTATIVE QUOTATIONS
HIGH	Eliminates the costs associated with prescriber office visits.	"This is cheaper than having a physician involved in every prescription"
MODERATE	Depends on the costs of naloxone, administratively setting up agreements, and regulatory monitoring of agreements.	"Some costs associated with physician, pharmacist, and pharmacy time setting up [collaborative practice agreements]. Increased access to naloxone will incur additional costs to patients and payers"
LOW	Creates costs for pharmacists and physicians.	"Much of the effort in establishing and maintaining the collaborative practice [agreement] is borne by the prescriber and pharmacist. These variances in practice will increase costs generally"

EQUITABILITY

The extent to which the policy is equitable in its impact on health outcomes across populations of people who use opioids.

IMPLEMENTATION RATING	SUMMARY OF EXPERT OPINION	REPRESENTATIVE QUOTATIONS
HIGH	Removes the need to access prescribers.	"Great way to increase equitable access to naloxone without requiring barrier of healthcare provider access"
MODERATE	Concerns about potential pharmacist bias and limited access to pharmacies.	"The policy itself should be equitable because it doesn't require people to go to a physician. However, individual biases of a pharmacist and lack of access to pharmacies could reduce equity"
LOW	Voluntary nature of agreement allows for pharmacist bias and pharmacy availability to influence equitability of implementation.	"Voluntary nature may lead to inequitable access and pharmacist attitudes/biases may lead to inequitable implementation"

This Policy Brief was developed by the RAND-USC Schaeffer Opioid Policy Tools and Information Center (OPTIC), a multidisciplinary research center dedicated to improving the effectiveness of opioid policies by enhancing opioid policy science. OPTIC is a collaboration between the RAND Corporation and the USC Leonard D. Schaeffer Center for Health Policy and is funded by the National Institute on Drug Abuse (P50DA046351). RAND is a research organization that develops solutions to public policy challenges to help make communities throughout the world safer and more secure, healthier and more prosperous. RAND is nonprofit, nonpartisan, and committed to the public interest. RAND's publications do not necessarily reflect the opinions of its research clients and sponsors. RAND® is a registered trademark.