Supplemental Box 1

WSPA Clinical Community Pharmacist Certificate Program Disease States

Initiation of Therapy
Allergic Rhinitis
Burns
Human, Canine, Feline Bite (infection prophylaxis)
Oral Fluoride
Herpes Zoster (shingles)
Hormonal Contraception
Insect Sting
Swimmer's Ear
Urinary Tract Infection
Vaginal Yeast Infection
Continuation of Therapy
Anaphylaxis (epinephrine autoinjector refill)
Bronchospasm (fast acting beta agonist refill)
Headache (triptan refill)
Insulin refill

Supplemental Exhibit 1

STUDY PARTICIPANT INTAKE FORM

Only fill out this form for patients who have signed the informed consent form to be in the study, "Increase Access to Quality Patient Care in Community Pharmacies for Minor Illnesses in Washington State" sponsored by the WSU College of Pharmacy and the NACDS Foundation

PATIENT HAS SIGNED INFORMED CONSENT FORM: ☐ Yes ☐ No **(If no, do not complete this form)**

PHARMACY NAME/STORE NUMBER_____

DATE: _____ **BEGINNING/END OF PATIENT ENCOUNTER TIME:** _____/_____

PATIENT NAME: _____ **SEX:** ☐ Male ☐ Female **DATE OF BIRTH:** _____

PATIENT ZIP CODE: _____ **HOME PHONE:** _____ **WORK/CELL PHONE:** _____

PRIMARY INSURANCE COVERAGE: ☐ Private ☐ Medicaid ☐ Medicare ☐ None ☐ Unknown

If Private, name of insurer: _____

TOBACCO USE IN LAST 30 DAYS: ☐ Yes ☐ No **PATIENT IS PREGNANT:** ☐ Yes ☐ No

CONDITION SEEN FOR:

	Allergic Rhinitis		Hormonal Contraception		Stinging Insect
	Anaphylaxis		Human, Canine, Feline Bite (Circle one: Human, Dog, Cat)		Swimmer's Ear
	Bronchospasm		Insulin Refill		Urinary Tract Infection
	Burn wound		Oral Fluoride Supplement		Vaginal Yeast Infection
	Headache (Circle One: Migraine, Cluster, Tension)		Shingles		Other: _____

Treatment already received for condition in the previous 60 days:

☐ **Saw Care Provider (Date: ___/___/___ Location: _____)**

☐ **Taking Prescribed Medicines (Type: _____)**

☐ **Self-Treated with OTC (Type: _____)**

PATIENT TREATED UTILIZING CDTA: ☐ Yes ☐ No

If Yes, please list: Medication name: _____

Sig: _____

Qty: _____

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PLEASE CHECK TO INDICATE IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

Please Note: It is very important that you tell the pharmacist about all previous and existing conditions to make sure you receive the best care possible

General
□ Allergies
□ Cancer
□ Diabetes
□ Overweight

Nervous System/Psychological
□ Alcoholism
□ Anorexia
□ Anxiety
□ Brain Aneurysm
□ Brain Tumor
□ Depression
□ Dizziness/Vertigo
□ Drug abuse
□ Epilepsy
□ Insomnia
□ Migraine headaches
□ Multiple Sclerosis
□ Neuropathy
□ Parkinson's Disease
□ Stroke
□ Suicide attempt

Muscle / Joint
□ Fibromyalgia
□ Gout
□ Herniated disk
□ Low back pain
□ Osteoarthritis
□ Osteoporosis
□ Pinched nerve
□ Psoriatic arthritis
□ Polio
□ Rheumatoid arthritis

Skin
□ Eczema
□ Psoriasis
□ Seborrhea
□ Varicose veins

Eye, Ear, Nose & Throat
□ Cataracts
□ Glaucoma
□ Goiter
□ Sinus infection
□ Thyroid problem
□ Tonsillitis

Gastrointestinal
□ Appendicitis
□ Colitis/Crohn's
□ Colon polyps
□ Diverticulosis
□ Gallbladder problems
□ Gastroesophageal reflux disease
□ Hernia
□ Hemorrhoids
□ Liver disease
□ Ulcer

Genitourinary
□ Bladder infection
□ Kidney disease
□ Kidney infection
□ Kidney stones
□ Prostate problem
□ Urinary incontinence

Cardiovascular/Blood
□ Anemia
□ Angina
□ Bleeding disorder
□ Blocked heart vessels
□ Blocked leg vessels
□ Blocked neck vessels
□ Congestive Heart Failure
□ Edema
□ Heart attack
□ Heart murmur
□ Heart valve disease
□ High blood pressure
□ High cholesterol
□ Low blood pressure
□ Irregular heart beat
□ Pulmonary embolism
□ Sickle cell anemia

Respiratory
□ Asthma
□ Bronchitis
□ COPD
□ Emphysema
□ Pneumonia

Infectious Conditions
□ Chicken pox
□ Cold sores
□ Hepatitis
□ Herpes
□ HIV/AIDS
□ Malaria
□ Measles
□ Meningitis
□ Mononucleosis
□ Mumps
□ Rheumatic fever
□ Scarlet fever
□ Tuberculosis
□ Typhoid fever
□ Venereal disease
□ Whooping cough

Other Conditions
□ _____
□ _____
□ _____
□ _____
□ _____
□ _____
□ _____

Other medications, if recommended: _____

_____

_____

_____

_____

_____

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Supplemental Exhibit 2

WASHINGTON STATE UNIVERSITY
HEALTH SCIENCES SPOKANE

INCREASE ACCESS TO QUALITY PATIENT CARE IN COMMUNITY PHARMACIES FOR MNOR ILLNESSES IN WASHINGTON STATE

WSU COLLEGE OF PHARMACY

TELEPHONIC 30 DAYS POST PATIENT CARE FOLLOW UP

PT #_____

Call attempts made: 1 2 3 4 5 **Date of Follow-up phone conversation: _____**

Hello, my name is "name" and I am calling from the WSU College of Pharmacy as part of a research study that "patient's name" agreed to participate in when seen at "enter name" pharmacy. May I speak with "patient's name"? It is now 30 days since you signed up to be in the study and we want to check in with you one final time. Is now an okay time to ask you a few questions regarding your care? It should only take 10 minutes at most. (If not a good time ask when is convenient for the patient and offer to call another time).
Alternate day to call: _____ Alternate time to call: _____

Questions

1. **I can see from the paperwork from your visit that you were seen for "enter condition name". Is that correct?**
   ☐ **Yes** ☐ **No** ☐ **Do Not Recall**

2. **Were you seen for the same condition in the previous 60 days?**
   ☐ **Yes** ☐ **No** ☐ **Do Not Recall**

***If condition is a minor illness and condition, complete #3 &4 and skip #5. If a refill protocol, skip #3 &4 and continue to #5.**

3. **After being seen at "x" pharmacy, did the condition improve or clear up completely?**
   ☐ **Yes** ☐ **No** ☐ **Do Not Recall**

4. **Were you seen again for the same condition in the last 30 days?**
   ☐ **Yes** ☐ **No** ☐ **Do Not Recall**

IF YES: "I'm going to ask you some extra questions about this."

i. **How long after the initial care at "x" pharmacy were you seen?**
☐ **Days**

ii. **If you needed additional care more than once in the last 30 days for this condition, how many times were you seen not including the initial care at "x" pharmacy?**
☐ **Times**

iii. **Where did you go for care? (Check all that apply)**
☐ **"X" Pharmacy** ☐ **Dr. Office** ☐ **Urgent Care** ☐ **Emergency Room** ☐ **Other**

Name (and address?) of the care provider if not "x" pharmacy: _____

iv. **Did you need medication?**
☐ **Yes** ☐ **No** ☐ **Do Not Recall**

If yes, can you name the medicine(s) and the dosage of each medicine?

v. **Were labs done? (Blood draw, urinalysis, etc. depending on condition)**
☐ **Yes** ☐ **No** ☐ **Do Not Recall**

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If yes, can you name the labs and how many times each lab was done?

vi. Did you need imaging? (X-ray, CT scan, MRI, etc.)
☐ Yes ☐ No ☐ Do Not Recall

If yes, can you name the tests and how many times each test was done?

vii. Were you admitted to a hospital? (Inpatient care)Can you name the hospital?
☐ Yes ☐ No ☐ Do Not Recall

If yes, can you name the hospital and the length of stay?

5. Have you been seen in the past 30 days to receive a new prescription for this medication?
☐ Yes ☐ No

IF YES: Where did you seek care and when? Date _____
☐ "X" Pharmacy ☐ Dr. Office ☐ Urgent Care ☐ Emergency Room ☐ Other

IF NO: What is the reason for not having sought out care to renew your prescription?
☐ Have appt. for future date ☐ Plan to make appt. in future ☐ No plan for care

6. If you had not received care at the pharmacy, where would you have gone for care?
☐ Dr. Office ☐ Urgent Care ☐ Emergency Room ☐ Would have sought no care

Thank you for your time answering questions for this research study. Your participation in this study is now complete. Do you have any questions for me at this time? If you have any questions in the future feel free to call the primary investigator, Dr. Julie Akers at 509-358-7561.

TELEPHONIC PROVIDER FOLLOW UP: patients who answer yes to 4. above and seen elsewhere

Provider's Name _____

Site of Care/Phone Number _____

1. What condition was the patient seen for? ICD-9 or ICD-10? _____

2. Did the patient need medication?
☐ Yes ☐ No

If yes, can you name the medicine(s) and the dosage of each medication prescribed?

3. Were labs ordered? (Blood draw, urinalysis, etc. depending on condition)
☐ Yes ☐ No

If yes, can you name the labs and how many times each lab was ordered?

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4. Was imaging ordered? (X-ray, CT scan, MRI, etc.)

☐ **Yes** ☐ **No**

If yes, can you name the tests and how many times each test was ordered?

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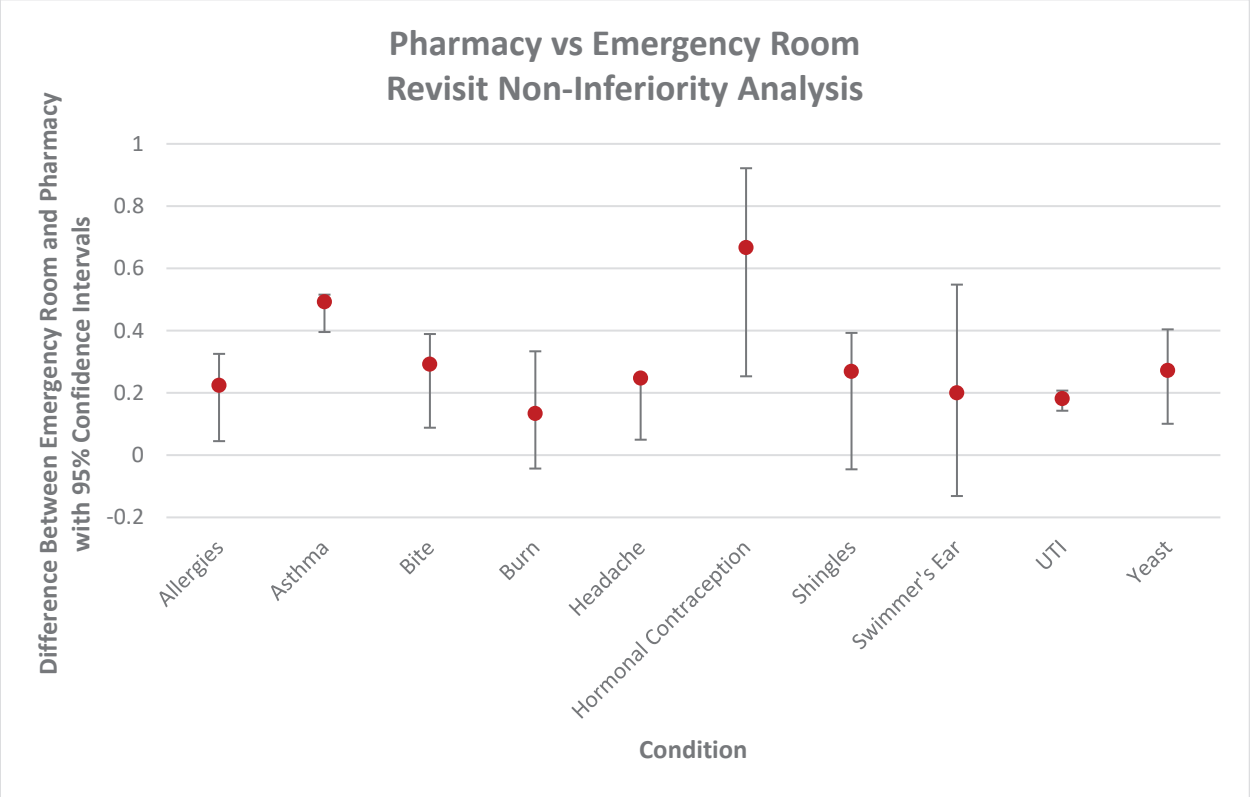
Supplemental Exhibit 3

Demographics		
	Traditional Sites of Care	**Pharmacy**
Total Patients		
n	84 555	506
Sex		
Male	18 770 (22.20%)	72 (14.23%)
Female	65 785 (77.80%)	434 (85.77%)
Median Age (Min, Max)	40 (17, 97)	38 (20, 90)
Insurance		
Yes	84 555	420
No	0	24
Unknown	0	62
Private	84 555	319
Medicaid	0	56
Medicare	0	31
Tricare	0	14
None	0	24

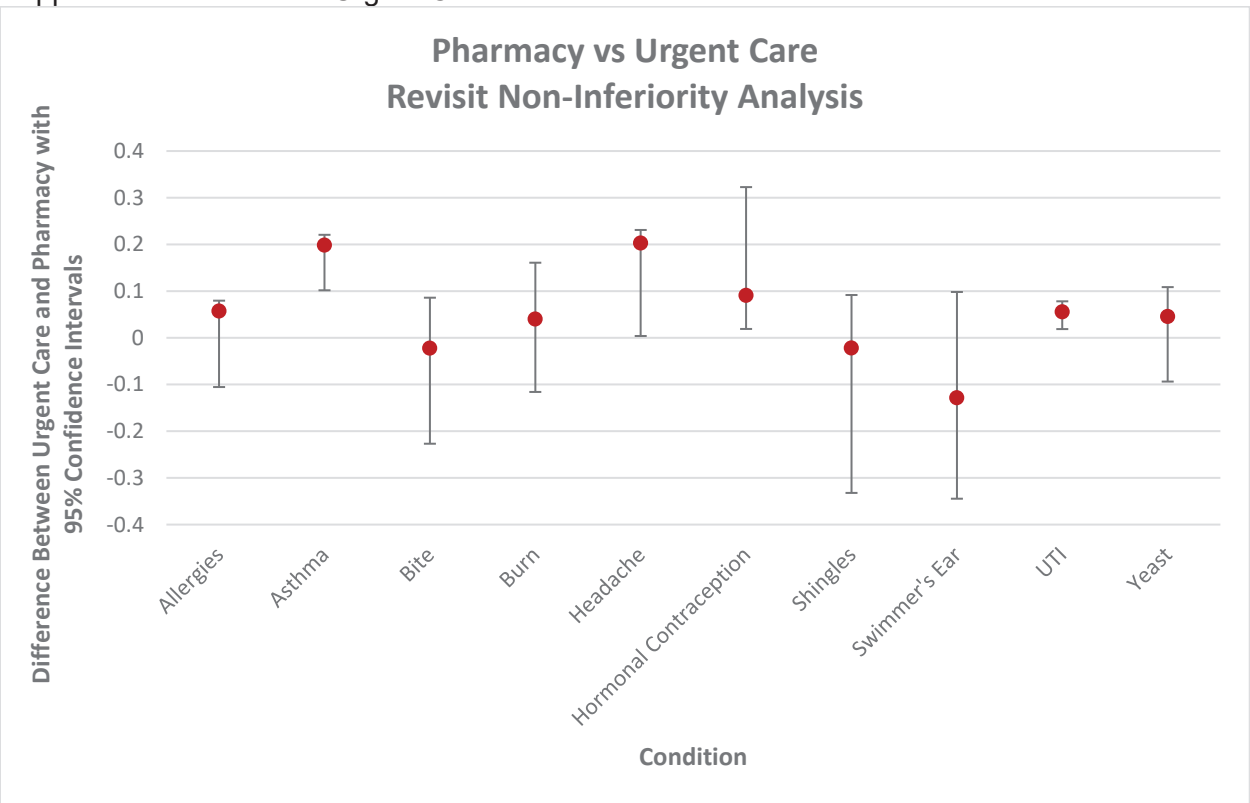
Supplemental Exhibit 4

Revisit Noninferiority Analysis Comparing Pharmacy to Traditional Sites of Care by Condition with 95% CI

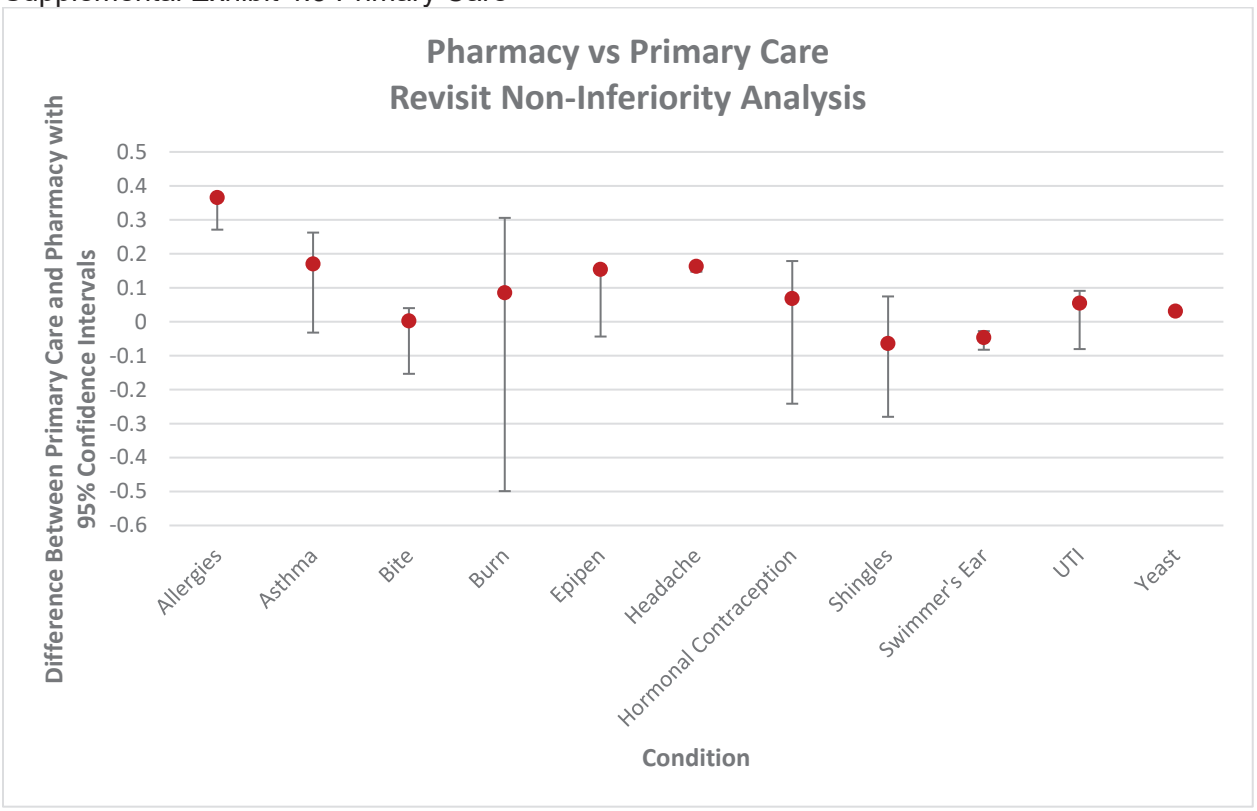
Supplemental Exhibit 4.1 Emergency Room



Supplemental Exhibit 4.2 Urgent Care



Supplemental Exhibit 4.3 Primary Care



Supplemental Exhibit 5

Sample of Patient Comments during 30-day Follow-Up Call

1. Patient stated if it were not for this service, she would have presented to the ER because she was out of medication and in the middle of a migraine.

2. Super convenient, would use it again

3. The two pharmacists she dealt with were amazingly helpful. They went above and beyond what was expected.

4. It is much more convenient to go to a pharmacist/pharmacy when your doctor is only open the same hours you work. Thanks so much for helping me.

5. Patient talked to pharmacist about symptoms she was having, and he offered her the service, which she really appreciated. At the time she could not really afford to go to the urgent care so this was very helpful for her.

6. Patient states this was very convenient because her usual clinic is 60 miles away and there are no urgent care centers nearby. She states that the pharmacist was great to work with.

7. Wonderful Program! Really helped me out since it was a weekend, and I didn't have very many options. The Pharmacist was so nice and friendly!

8. Awesome! Great service if it wasn't there, she would of gone to emergency room and paid a lot of money!

9. Thinks it is really helpful and saves so much time for patient, convenient service with high quality care

10. This service was great because I am a full-time student and work full-time and just do not have the time to sit at urgent care. The pharmacists were quick and helpful.

Supplemental Exhibit 6

Physician Advisory Committee

1. Design
    a. Six physicians
    b. Varied practice backgrounds represented.
        i. Emergency Department
        ii. Primary Care
        iii. Specialty Care
        iv. Academia
2. Charge
    a. Review established WSPA Clinical Community Pharmacist training modules.
        i. Feedback submitted to state association for consideration.
    b. Review Collaborative Drug Therapy Agreements, which delegate prescriptive authority to participating pharmacists.
        i. Critical feedback and professional insight related to the standard of care for each condition gathered and shared with delegating prescriber for consideration.
            1. Final approval of agreement language is between the delegating prescriber and the participating pharmacist(s).
    c. Review live skills seminar material related to the standard of care for each condition.
        i. Feedback integrated into live skills seminar by research team members charged with development and delivery of the seminar.
3. Content Recommendations
    a. Swimmer's Ear
        i. Add odor, occlusion, and discharge as common symptoms in otitis externa.
        ii. Assess for jaw pain or neurologic issues, refer if present.
    b. Stinging Insects
        i. Add sting to the genital area as a referral criterion.
        ii. Consider sting to the fingertip(s) as a referral criterion.
        iii. Ensure patient education includes watching for signs of infection, including red streaking from the wound.
    c. Shingles
        i. Update reference article included in module resources from a 2002 article to a 2013 NEJM article: http://www.nejm.org/doi/full/10.1056/NEJMcp1302674#t=article
        ii. Recommend referral if more than 3 dermatomes are involved.
    d. Migraines
        i. Consider converting a portion of the pharmacist clinical decision-making process described into a flow chart.
    e. Anaphylaxis
        i. In the "Overview of Anaphylaxis" portion of the WSPA training module, clarify that histamine is not a cytokine.

f. Human, Canine, Feline Bites
    i. Emphasize in training that cat bites are potentially life threatening if not treated appropriately. Stress importance of follow up and immediate referral if not improving or getting worse. Consider adding this language to the patient handout as well.
    ii. Emphasize in training the importance of monitoring for sepsis.
    iii. Approach rabies risk in the same manner as local Emergency Departments
    iv. Ensure modules and live seminar emphasize difference between prophylaxis and full treatment, as the number of days for therapy are different.
    v. Stress the discharge messaging regarding follow up, what to look for, and when to seek additional care.
    vi. Recommend follow up be in person vs telephonic to allow for wound inspection.
g. Burns
    i. Emphasize that SSD cream is only indicated for superficial partial thickness burns and not for superficial burns, as the skin is intact.
    ii. Recommend adding topical analgesic options for when the skin is intact, such as lidocaine/benzocaine.
    iii. Emphasize renal impairment and dosing considerations for aspirin, acetaminophen, and naproxen treatment.
    iv. Recommend not only referring if burn is on a major joint, but for any joint, as they can be more problematic and should be considered for referral.
    v. Emphasize mandatory report requirements if child abuse is suspected.
    vi. Recommend referral for immunocompromised patients.
h. Urinary Tract Infection
    i. Consider referral criterion of 2 or more UTIs in the last 6 months or 3 in the last 12 months.
    ii. Add hematuria as a referral in all documents.
    iii. Include evidence related to use of cranberry for daily prophylaxis.