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# Pharmacists Begin Prescribing Hormonal Contraception in Oregon: Implementation of House Bill 2879

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## Abstract

Prescription of hormonal contraception by pharmacists, without a doctor's visit or authorization, has been proposed as a strategy to improve access to contraception and reduce unintended pregnancy. Oregon is the first state to implement legislation expanding the scope of pharmacists to directly prescribe and dispense short-acting hormonal contraception (pill and patch) without a medical prescription. Several other states are considering similar legislation. Implementation of the policy is being researched to identify both barriers and facilitators to the successful dissemination of the practice, and to determine the safety, efficacy, and acceptability of pharmacist-prescribed contraception.

Oregon and California are the first two states to pass legislation allowing pharmacists to prescribe short-acting hormonal contraception to women without a doctor's visit. Beginning January 1, 2016, Oregon pharmacists are eligible to prescribe the oral contraceptive pill or patch for women. Prescription of hormonal contraception by pharmacists, without a clinic visit or authorization, has been proposed as a strategy to improve access to contraception and reduce unintended pregnancy (1, 2). HealthyPeople 2020 prioritizes prevention of unintended pregnancy and identifies access to contraceptive services as an area of strategic importance.

Over half of all pregnancies are unintended in the United States (US), with significant health and cost consequences, for the individual, her family and the community (3–5). Contraception is effective at preventing unintended pregnancy, but multiple barriers exist to correct and consistent use (2). Access to and cost of contraceptives are common reasons for nonuse or gaps in use (6, 7). A survey of women in the United States who are at risk for unintended pregnancy demonstrated that one out of four experienced challenges in obtaining either a prescription or a refill of their chosen method (8). Barriers to obtaining contraception from a doctor's office include: difficulty obtaining an appointment such as long waits, high co-pays, or inconvenient clinic hours, and not wanting to get a pelvic examination (8).

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Oregon has long been at the forefront of progressive health policies to improve access to contraception. Since 1999, Oregon has administered a Medicaid waiver that extends Medicaid eligibility for contraceptive service to individuals up to 250% of the federal poverty level through a program called Oregon ContraceptiveCare (CCare). These services are delivered through a statewide network of public and private clinics, many of which receive Title X funds and specialize in reproductive health care. Previous research has established the efficacy of these family planning waiver programs in preventing unintended births and reducing Medicaid costs (9, 10). Legislation requiring insurance companies to provide three months of a method on contraceptive initiation, and 12 months supply at time of refill was also passed in Oregon in 2015 (House Bill 3343)(11). House Bill 2879, allowing pharmacist prescription of hormonal contraception (the pill and the patch), is the latest contraceptive innovation out of Oregon. Similar legislation has passed in California, and is expected to be implemented in Spring 2016. In California, the legislation will also include pharmacist provision of the vaginal ring and injectable progestin (11).

This legislation was successfully passed in Oregon under the leadership of a physician who serves in the House of Representatives. Dr. Knute Buehler (R-Bend) was able to create agreement within the legislature by collaborating with Democratic physicians in the Senate. Members of the general legislature were initially concerned about safety of the practice, and medical evidence from the Direct Access study was instrumental in supporting the bill (12). To facilitate passage of the bill, a moderate approach was necessary, both in terms of the contraceptive method mix offered, and the age of individuals eligible for care.

The safety of hormonal contraception is well established, and there is data to support changing its status to over-the-counter (13–15). A national survey of women at risk of unintended pregnancy found that 68% of women were interested in using pharmacies to directly access hormonal contraception without a prescription (pill, patch, ring and emergency contraception)(8). Several studies have established that women can self-screen and non-physicians can safely evaluate for contraindications to HC use (12, 14). One cohort study suggests that continuation rates may even be improved with direct access in pharmacies (14–17). The American College of Obstetricians and Gynecologists (ACOG) supports over-the-counter access to hormonal contraception as a means to safely improve contraceptive use and decrease unintended pregnancy (13). This approach was considered in Oregon, but a significant faction argued that adopting over-the-counter status could jeopardize insurance coverage of contraceptives. Other legislators were concerned about the safety of adopting over-the-counter use, especially among adolescents. Within the Oregon program, the cost of the contraceptive and the pharmacist visit are billed to insurance. The importance of maintaining coverage of contraception as a key cost saving public health strategy was clearly recognized.

As a compromise, this legislation does not authorize over-the-counter access to hormonal contraception but instead expands the scope of pharmacists who choose to participate in the program to screen women and to prescribe short-acting hormonal contraception. Oregon's House Bill 2879 allows pharmacists to directly provide hormonal contraception including the patch and pill without a medical prescription. Women over 18 years of age can either initiate or continue contraceptive care with a pharmacist. For adolescents under age 18, the

law allows for them to only continue a hormonal contraception prescription received from a clinician. The legislation does not address insurance coverage, and with this prescribing authority, pharmacists will bill for the service. By doing this, the ability to bill insurances through a prescription was maintained, and the cost of the HC is still covered. Some carriers have already created a process for pharmacists to bill medical insurance for providing this service, and others are following. Additionally, pharmacies are working on billing platforms to be reimbursed, while others have chosen to charge a fee for the service.

The Oregon Board of Pharmacy has taken a proactive approach to facilitating the full implementation of the legislation in Oregon. The Oregon Board of Pharmacy convened a multidisciplinary task force consisting of pharmacists, obstetricians and gynecologists, pharmacy administrators and policymakers to guide implementation of the bill. Pharmacist participation in the program is voluntary, and prior to prescribing contraception, pharmacists must complete a five hour, online training module that covers general information on contraception, screening to rule out pregnancy, identifying medical contraindications, and a referral process. Checklists for both providing care and referral were developed based on the World Health Organization and Center for Disease Control's Medical Eligibility Criteria for Contraceptive Use (18, 19). The task force worked to create a clear referral process for women unable to access care in pharmacies due to cost or medical considerations. The Oregon Board of Pharmacy paid particular attention to training pharmacists to educate women on the most effective methods to prevent pregnancy (long acting reversible and permanent methods) and referral sources to access this care, even though pharmacists cannot provide this care directly.

The training was available online for pharmacists to enroll and complete in late fall 2015. In 2014 there were 3,041 pharmacists practicing in Oregon, with 1,579 working in retail pharmacies. Over 1,200 pharmacists have registered for the training, and as of April 2016, 350 pharmacists have completed the training. During the first two months the program was active, over 200 prescriptions were filled. Women complete a self-screening checklist that assesses for risk of pregnancy and contraindications to hormonal methods. A standard procedure algorithm is then used by the pharmacist to evaluate the responses and guide care.

At every step in the algorithm, there are clear markers for when a referral to a clinician is indicated. The algorithm steps are as follows: (1) review of the self-screening checklist and concomitant medications with the woman in a private area to ensure confidentiality, (2) screening for pregnancy using a validated checklist from the World Health Organization, (3) blood pressure screening, and (4) discussion of a woman's contraceptive history and preferred method of use. Counseling is provided on the Quick Start method of initiation, expectations of side effects (e.g bleeding irregularities) and the importance of adherence (e.g strategies to minimize forgotten pills). The Oregon Board of Pharmacy has published an online toolkit that includes information on the training modules, screening checklist, and standard procedures algorithm used to implement the Oregon bill (https://www.oregon.gov/pharmacy/Pages/ContraceptivePrescribing.aspx#Tool-Kit_Resources).

Pharmacist participation is expected to increase throughout summer 2016, as several major pharmacy chains adopt the practice and incorporate it into their services. Plans to expand the

bill to include the vaginal ring and progestin injectable were discussed in the last legislative session. While interest in program expansion is high among stakeholders, the decision was made to defer expansion until evidence of the current policy's success is available.

The authors formed a research collaborative between Oregon Health & Science University's department of Obstetrics and Gynecology Oregon State University's School of Pharmacy in which to study the implementation of the policy and evaluate its safety, efficacy, and acceptability.. We have set a research agenda to further study the effects of this policy in practice on women, pharmacists, and overall health of the population.

There are many reasons to expect legislation like Oregon's to spread to other states. Several states have expressed interest in expanding the roles of pharmacists in prescribing contraception. Oregon offers an important opportunity to understand the benefits and challenges to pharmacists prescribing contraception directly. A portfolio of implementation research is being integrated into the scale up of the program to facilitate effective and high quality care. Success of the policy will be contingent on support from physicians with proper pharmacy training programs and a strong referral network.

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