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Implementation of hormonal contraceptive furnishing in San Francisco community pharmacies

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Abstract

Background: In 2013 California passed SB493, which allowed pharmacists to furnish hormonal contraceptives without a physician's prescription. Despite this expanded scope of practice, only 11% of pharmacies reported furnishing hormonal contraception over the following six years. Our study objectives were to determine the extent of hormonal contraceptive furnishing and identify factors that led to successful implementation in San Francisco community pharmacies.

Methods: We conducted a cross-sectional survey to identify community pharmacies furnishing hormonal contraception in San Francisco. Semi-structured interviews with pharmacists at locations that furnished contraception identified factors that had led to successful implementation in local community pharmacies, as well as assessing changes in practice during the Coronavirus Disease 2019 (COVID-19) pandemic. Interviews were coded inductively to identify consistent themes.

Results: San Francisco had 113 operational community pharmacies in April 2020. Of these, 21 locations reported that they furnished hormonal contraception (19%), and we interviewed pharmacists at 12 of those locations. We identified three key factors that drove implementation at the pharmacy level: administrative support, advertising, and pharmacist engagement. Additional drivers of implementation involved the nature of the community. Respondents also reported on

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barriers that continued to slow adoption, including consultation fees, time constraints, and patient privacy. Changes in demand for services due to COVID-19 risks were inconsistent.

Conclusions: Our findings suggest strategies that community pharmacies can use to expand their scope of practice and improve quality and continuity of care for patients.

Keywords

Pharmacists; Scope of Practice; Contraception; COVID-19; San Francisco

Introduction

Women and people with female reproductive organs in the United States face multiple barriers to accessing affordable, safe, and effective contraceptives. Over 19 million patients lack reasonable access to health centers that provide a variety of contraceptive methods.[1] Globally, at least 120 million couples are in need of contraception, 80 million women have unintended pregnancies, and 45 million of those pregnancies result in abortion.[2] Contraception provides people with choice regarding reproduction as well as enhancing sexual and emotional wellbeing. Having a range of contraceptive choices with respect to method improves rates of unintended pregnancy, user satisfaction, effectiveness, and continued use.[2,3]

Pharmacists are one of the most accessible healthcare providers in the community, and recognition of their potential role in reaching underserved populations has expanded their scope of practice. An increased number of pharmacists are now providing more services such as vaccination and furnishing—defined as initiating a prescription for a medication without a supervising physician[4]—medications such as nicotine replacement therapy, HIV (human immunodeficiency virus) pre-exposure prophylaxis, and naloxone.[5] In 2013 the state of California expanded furnishing rights further with the passage of SB (Senate Bill) 493, which ruled that pharmacists can furnish self-administered hormonal contraceptives. Under the California State Board of Pharmacy protocol, training to furnish contraception includes a continuing education program approved by the Board of at least one hour regarding self-administered hormonal contraception.[6] Pharmacists must also utilize USMEC (US medical eligibility criteria) for contraceptive use and other CDC (Centers for Disease Control and Prevention) guidance on contraception.[6] Alternatively, after 2014, training received through an accredited California school of pharmacy curriculum can suffice.[6]

Previous studies have shown that the implementation of SB493 in community pharmacies increased access to contraception. A community-based intervention study found that community pharmacists were able to efficiently and effectively provide safe contraceptive products for women, with high levels of satisfaction reported by both pharmacists and patients receiving the services.[7] Where furnishing is available, patients increasingly use community pharmacies as a resource to obtain hormonal contraception services and supplies.[8] Pharmacy-based contraceptive services prevent unintended pregnancies and reduce the costs of care.[9] However, several barriers remain and prevent full implementation and the success of this service.

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Existing studies have evaluated the number of pharmacies furnishing hormonal contraceptives in California under SB493. As of 2017, only 11% of California pharmacies were furnishing,[10] with barriers including limited reimbursement from health insurance plans. Legislation requiring Medi-Cal (California's Medicaid program) to reimburse pharmacists' fees by 2021 for furnishing contraception was enacted in 2017, 4 years after implementation.[11] Additional barriers reported include concerns about liability, time constraints, and lack of knowledge of this service.[12–14] As a result, although pharmacists have expressed interest in expanding their roles when surveyed, few have actually done so.[15] There is limited research identifying what differentiates pharmacies that effectively implement contraceptive furnishing, and the effects of existing policy on contraceptive continuation.[9,14]

In this study we sought to identify the extent of contraceptive furnishing in community pharmacies in San Francisco and to identify factors that had led to successful implementation. San Francisco served as a relevant study locale due to its past successful implementation of immunizations at community pharmacies and furnishing of tobacco cessation medications and naloxone,[16] a record of success that suggested it could provide guidance for expanding these services in other locations.

Methods

This cross-sectional study relied on contacting all community pharmacies operating in San Francisco, California and conducting a series of semi-structured interviews of those furnishing contraception. We focused on retail pharmacy settings, and excluded government, hospital, and clinic sites that focused on specific patient subpopulations.

To collect data, three authors (LC, AJ, JL) telephoned all retail and independent pharmacies listed as being located in San Francisco, which were identified using a combination of location searches on corporate websites and Google Maps. We first asked the pharmacy whether they furnished hormonal contraception. For those locations that furnished contraception, we asked if they were willing to participate in the study. For those that consented, we scheduled an interview and faxed the pharmacy a cover letter, the list of interview questions, and a written consent form for their records. A semi-structured interview guide consisting of open-ended questions with potential follow-up questions and prompts for elaboration were used for interviews (see Supplement). Each interview was conducted by phone and ranged from 15–30 minutes. Exploratory points of discussion were developed with reference to existing research on pharmacist furnishing of medications and included:

- Components of a successful contraceptive furnishing program
- Description of the furnishing process
- Pharmacists' perception of the program's effectiveness, advantages, disadvantages, and barriers
- Recommendations for replication or improvement, and

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- Changes in demand or site practices due to risks of COVID-19 (coronavirus disease of 2019) transmission.

Interviews were conducted over the phone, recorded and, transcribed; interviewers also took notes during and after interviews regarding responses. Pharmacists gave permission to record the interviews in advance. The recruitment and interview period began and concluded in April 2020. Interview recordings were transcribed and uploaded to a software program for qualitative analysis, Atlas.ti 7 (Berlin, Germany).

Using the notes generated during interviews, a preliminary codebook was created prior to coding the transcribed interviews. Specific quotes were marked in the transcribed interviews based on these preliminary codes. These notes consisted of: company protocol, extent and source of training, advertising, consultation fee, time constraints, patient privacy, access (later sub-coded into access to contraception and access to services), location/patient population, factors that facilitated furnishing, factors that hindered furnishing, and responses to questions regarding the effects of COVID-19. Codes were modified inductively based on findings in the interviews after consulting among all authors. After extracting quotations from the transcribed interviews, we categorized them into major themes. Initial coding and analysis was completed by two investigators (AJ and JL) and verification of the codes was completed by a third (LC).

The study was approved as exempt by the University of California, San Francisco (UCSF) Institutional Review Board (#19–29545) in January 2020. A modification to the interview guide to include questions about changes in demand and practice due to the risk of COVID-19 transmission was approved in April 2020.

Results

Our first objective was to identify the share of community pharmacies that furnished contraception in San Francisco; previous studies have reported low rates of furnishing (11%). After calling all 113 community pharmacies that we identified (CVS, Walgreens, Safeway, Costco, independent) as operating in San Francisco, 21 locations indicated that they furnished hormonal contraception (19%). Of those 21 pharmacies, 12 agreed to be interviewed (57%). Results are available in Table 1.

Chain community pharmacies were disproportionately likely to furnish hormonal contraception; 20 of the 21 pharmacies that furnished were chains (95%). Half or more of Costco, CVS, and Safeway locations furnished hormonal contraception, while less than 5% of Walgreens and independent pharmacies did. Only pharmacists were interviewed, and of the 12, 5 were male and 7 were female. We were able to interview at least one pharmacist from every type of location and chain pharmacy operating in San Francisco. The pharmacists' years of experience ranged from 2 to 30+ years, and none of the pharmacists interviewed had completed a postgraduate residency. The number of new contraceptive furnishings ranged from 0–1 per month to as many as 5 per month, and total prescription volume across the interviewed pharmacies ranged from 20 to 400 per day.

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Factors associated with successful implementation

Our coding identified two types of elements that pharmacists reported as being associated with successful implementation: factors within the control of the pharmacy, and factors that related to the setting or larger community.

Factors within the control of pharmacies—Factors within the control of the pharmacy included having a company protocol, advertising the service, and pharmacist engagement with access to service and to contraceptives; examples are provided in Table 2. Pharmacists were most likely to report that administrative support, and specifically a corporate protocol, was associated with successful implementation (11/12 respondents). The independent pharmacy relied on a protocol designed by the California State Board of Pharmacy. Respondents viewed this as critical because it established a precedent that should be followed by the pharmacist, and having one already set in place made it easier for the staff to follow it. Many large corporations also provided payment for the training that the pharmacists were required to complete. In the words of one pharmacist, “I took a 5 hour course that was mandated, but Safeway paid me to do it.”

The second most commonly reported element of successful implementation was advertising (9 /12 respondents), because there was limited awareness of the service in the community. The independent pharmacy did not advertise the service. As described by a Costco pharmacist, because SB493 is a statewide pharmacy law, Costco selectively advertises that their pharmacies can furnish hormonal contraceptive on their website. Generally, only customers already utilizing the service or who had been informed by their primary care providers were aware of this service. One Costco pharmacist stated, “We generally don’t advertise for these kinds of things. It’s in our in-house magazine, and because we’re inside a membership-only warehouse, certain services like that aren’t really as well known. So we kind of rely on providers that we have and word of mouth to get that done because you don’t have to be a Costco member to use the Costco pharmacy. But a lot of people don’t know that.”

The third factor associated with successful implementation was pharmacist engagement with increasing access to services (5/12 respondents) and to contraceptives (9/12 respondents). Respondents expressed the idea that the accessibility of pharmacists provides a convenience to the community that improves adherence and eliminates gaps in therapy. As one CVS pharmacist explained, “A lot of it is just that convenience for the customer instead of making the [physician’s] appointment, instead of waiting. We’re more readily accessible.”

Factors outside the control of pharmacies—Factors relating to the setting or larger community included the location of the pharmacy and its respective patient population, in addition to factors such as collaboration with local clinics. Half of respondents mentioned that proximity to students and other short-term residents increased the need for hormonal contraceptive furnishing services. A Safeway pharmacist shared, “I am pretty sure it’s because of our direct location to the students…we do the most. And it’s because of where we’re located.” Likewise, a Costco pharmacist near many technology companies stated, “I have a lot of people here who are contracted and they’re only here for like a year, six

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months, whatever, before they go back to wherever they're from. So they just want to continue their treatment because they can't go back and see their doctor for their annual because they're far away."

One pharmacy had a collaboration with a local clinic and its providers, highlighting another community-related factor that can contribute to implementation. Acting as a bridge-of-service provider, the pharmacist shared, "most primary care providers [are] just so overwhelmed that anything that supports them, that doesn't get in their way, it doesn't cause more problems, they're actually for it."

Results are summarized in Table 3.

Remaining barriers to implementation

Even though our sample included only those community pharmacies that furnished hormonal contraception, respondents nonetheless identified persistent barriers to successful implementation. These included the cost of consultation, lack of time, and patient privacy, as shown in Table 4.

The cost of consultation was identified as a barrier by nearly all respondents (11/12); the sole exception was reported at a location that reported that the fee was waived. Pharmacies that furnished hormonal contraception discussed this barrier in different ways, such as expressing concerns that patients cannot afford to pay out of pocket and lacked knowledge of the consultation fees. One Safeway pharmacist reported "Due to the cost of service, which is $30, not a lot of patients want to pay. So that's why we're kind of lacking…" However, even with the financial burden that consultation fees could place on patients, pharmacists shared that patients were willing to pay out of pocket for the services. As another Safeway pharmacist put it, "most of our patients are willing to pay out of pocket for the consult."

Lack of time was another barrier identified by many pharmacists. Eight of 12 pharmacists shared that furnishing hormonal contraception demanded additional time and would be improved by streamlining. One CVS pharmacist stated, "It is time-consuming… if there's a way to streamline it, that would be better. It's a great service to provide, but when it is added to the rest of that workload, it does seem like a hindrance." An additional solution, suggested by two pharmacists, was to schedule appointments ahead of time. Other pharmacists indicated that if there was more overlap of pharmacist shifts, there would be more flexibility and time for provision of hormonal contraceptive services.

The last identified barrier was patient privacy. Of the 12 respondents, 3 mentioned that they had private consultation rooms needed for confidential health screening information and consultation, including the independent pharmacy. Private rooms also provided an area for patients to sit for accurate blood pressure readings, part of the physical screening for hormonal contraceptives. As a Safeway pharmacist shared, an "advantage of the model is we have a private care room. It has a lock, a key pad on it, so it's private. It has a blood pressure automatic machine on the wall." Similarly, a Costco pharmacist stated, "I have a professional consultation room. So it's a private room where we can close the doors, I can have all those conversations with the patient without anybody else hearing or interfering.

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And that way the patient can sit and actually talk to me." The 9 pharmacies that did not have a private consultation room mentioned a need for one.

Results are summarized in Table 4.

Potential complications arising from the risks of COVID-19 transmission

Finally, we asked respondents whether their practices or demand for hormonal contraception had changed due to the risk of COVID-19 transmission. Under San Francisco's shelter-in-place order established on March 17, 2020, local residents could access only necessary goods and services during the period of data collection. Most pharmacies remained open, however guidelines led retail locations to establish 6-foot spacing for lines, add plexiglass barriers, and issue masks to staff. In addition, elective health care appointments were cancelled or transitioned to video teleconference. We anticipated that these changes might affect the furnishing of or demand for contraception in pharmacies. Overall reports of these effects were mixed. While some pharmacies reported an increase in demand for hormonal contraceptive furnishing, others experienced a decrease. One Walgreens pharmacist shared, "more kids started to try to get into the service and then went nuts during COVID because, you know, can't get to a doctor." In contrast, a Safeway pharmacist stated, "the number of requests for contraception furnishing has decreased." A CVS pharmacist noted an additional issue, "because of the social distancing measures in place, taking blood pressure is a challenge…it's pretty close interaction between the pharmacist and the patient."

Discussion

We contacted all community pharmacies in San Francisco to identify the extent of hormonal contraceptive furnishing and strategies that were used to effectively implement this service. We found that a larger share of pharmacies in San Francisco furnished contraception than the share reported in California in previous studies: 19% rather than 11%. This change could reflect either pharmacies adding this service gradually over time or a local phenomenon. CVS pharmacists reported that the company had initiated a new corporate protocol in 2020, suggesting that the higher rate we identified may be reflected statewide.

We identified strategies that community pharmacies could use to successfully implement hormonal contraceptive furnishing; these included administrative support in the form of a company protocol, advertising the service, and pharmacist engagement with the goal of increasing access. Our findings also identified community characteristics that affected the implementation of contraceptive furnishing, including serving a more transient population that had a higher need. These findings provide guidance for community pharmacies to assess whether their location is more likely to demand these services.

Finally, we identified barriers to implementation. These included limited time, the cost of consultation, and insufficient patient privacy. Respondents indicated that the flow of service could be improved and should be streamlined to be more time efficient. Also, while one independent pharmacist was flexible with costs to meet patients' budgets, others reported that there were patients who either could not afford the consultation fee or would prefer to see a primary care provider if they were required to pay for a consultation.

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Our study has several limitations. The small sample size and geographical area could limit generalizability. The results of this study were also based on self-reported interview data, raising the possibility that responses involved personal biases or perceptions that certain responses were socially desirable. Because this study was qualitative, we were unable to test for statistical significance. However, despite these limitations, our results provide new insight into elements associated with some pharmacies' success in implementing hormonal contraceptive furnishing services. The successes reported by these San Francisco pharmacies can serve as a model for expanding this service to other pharmacies.

Conclusions

Although providing access is important for reproductive choice and enhancing wellbeing, barriers still exist in accessing hormonal contraception. With the passing of SB493, California pharmacists have the capacity to meet this need by furnishing hormonal contraceptives; however, previous studies found that only 11% of pharmacies in California had implemented the service.[10] While these past studies have identified barriers, they did not seek to determine what factors led to successful implementation. We found that pharmacists at stores that furnish hormonal contraception were strongly committed to providing this service. Our findings suggest strategies that community pharmacies can use to expand their scope of practice and improve quality and continuity of care for patients. These include creating standardized protocols, advertising the service using strategies such as signage at the pharmacy, and increasing pharmacist engagement. Given the barriers identified even at pharmacies that did furnish contraception, effective administrative support could also include scheduling overlapping shifts for pharmacists and creating private consultation rooms. These changes have the potential to expand access to hormonal contraception and improve reproductive health.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Key points

What was already known

- Women in the US have limited access to contraception.
- Pharmacists can safely prescribe hormonal contraception and have expressed interest in providing this service
- California expanded the role of pharmacists by allowing them to furnish hormonal contraception, although as of 2017, only 11% of pharmacies actually did so.

What this study adds

- This study interviewed community pharmacists about contraceptive furnishing practices.
- We identified key elements that have led to pharmacists successfully furnishing hormonal contraception, persistent barriers, and changes in practice in 2020 due to the risk of COVID-19 transmission.
- We found three practices—administrative support, pharmacist engagement, and advertising—that could be used by other community pharmacies to implement contraceptive furnishing.

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Table 1:

San Francisco community pharmacies furnishing contraception

	All*	Furnished contraception (% of total)	Interviewed (% of furnishing)
Chain	90	20 (22%)	11 (55%)
—Costco	1	1 (100%)	1 (100%)
—CVS	24	13 (54%)	5 (38%)
—Safeway	10	5 (50%)	4 (80%)
—Walgreens	55	1 (2%)	1 (100%)
Independent	23	1 (4%)	1 (100%)
Total	113	21 (19%)	12 (57%)

*Excludes locations closed due to county shelter-in-place order

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Table 2:

Pharmacy-level associations with implementation

Key elements	
Company protocol and administrative support (11/12) • Mandated and subsidized training • Essential for widespread implementation	*"Probably about six months it was a voluntary thing while we were trying to get our protocol and things like that set up, and then towards the end, it became something that was mandatory for everyone to at least go through the training "*
Advertising the service (9/12) • Awareness that pharmacists can furnish birth control is limited	*'We have a banner up above the Costco pharmacy, where we list what services we provide and what we're currently featuring. So when we started rolling out with oral contraception, the banner went up on the wall. It's also on the Costco website, I believe, but not in every state because not every state does it yet. "* *'We have a couple of posters. And there's something at the pickup window. There's a little stand that says at the pharmacy offers birth control prescribing. "* *'There's a lot of customers who are not familiar with that or are unaware of it. "* *"Around the pharmacy, there are a couple signs, letting patients know that we do furnish birth control without a doctor prescription. I believe there's probably a marketing campaign as well online with our company. "*
Pharmacist engagement Increasing access to contraception (9/12) • Improves adherence and eliminates care gaps Increasing access to care (5/12) • Maintaining continuity of care • Pharmacies are more accessible	*"[When patients] are in-between insurance companies or in-between providers for whatever reason, there's a break in the continuity of care. And so I stepped in to fill that break and then try to get them into the women's clinic if they don't already have a provider. Or, let's say they're transitioning, they're a college student, then I make sure that they've got enough to get them to their new school or wherever they're headed to and be that point of contact with the provider when they get to the new site. So I'm more of a bridge of service type of person. "* *"The pharmacist is the most over-trained and underutilized healthcare professional we have and so being able to provide that extra, trying to try to track down doctors to get them to refill birth control is the most ridiculous thing because they're trying to get patients to get in to see a doctor for something that is so readily available. "* *"I still think it's a good service that we can provide, it's a lot quicker for the patient than to go to the doctor's office"*

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Table 3:

Community-level factors affecting implementation

	Key elements
Proximity to students and other short-term residents (6/12)	*'We're really close to [a university]. So we see a lot of students from there who are here going to school, and can't make it back home, but this is what they were taking. This kind of helps them stay on board without having to go try and find a new doctor and figure that out."*
Other factors • Collaborations with local clinics and providers • Strong desire to help	*"I think I'm very highly motivated as a person…and I think it's very, very important that we get help for those people who need it. And so the law is helping us be service to the community. That's the strongest motivation."* *"Since Walgreens didn't have it as a policy, I had to go out and do it myself."*

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Table 4.

Barriers to implementation

	Key elements
Consultation fee (11/12; the remaining respondent reported that the consultation fee was waived) • More cost-effective than seeing a physician • Some pharmacies will reduce the consultation fee or offer service at no charge	*"Most of the time people will pay that fee for the convenience of not having to go see their doctor and having to pay the copay anyway to see the doctor. So most people are actually really glad that we're here and that we're being able to provide that service for them. "* *'We just take the cost of the medication, bring it up to what is reasonable and what they can afford, and then we adjust it like that. So there's nothing set. There's no scale. It's not rigid. "* *"CVS waives the consultation fee. Previously, it was a $39 consultation fee, one time that's not covered by insurance. And then it was dropped to $29 and then I believe now they waive that fee for the patient. "*
Lack of time (8/12) • Need to streamline process • Scheduling appointments so pharmacies can plan ahead	*"I try to schedule it when we have pharmacists overlap so that I can provide the service to the patient while my other pharmacist is still running, like running the bench, kind of like what I'm doing with you now, right? Yeah, I have one, she's in there like running the show and I'm up here talking so that you know, we try to do it so that the patient doesn't necessarily feel rushed. "* *'We ask [patients] to make an appointment. So we're just trying to plan a date and time so we're prepared for the patient and I think that works really well. "*
Addressing patient privacy (3/12 had private consultation rooms; others mentioned the need for it) • Private consultation rooms allow patient to maintain privacy, which is needed for confidential health screening information and consultation • Provides area for patient to sit for accurate blood pressure readings	*'We unfortunately don't have a separate room or a separate area. It'd be nice to have that set area to do it where there would be more privacy and you can have a better one-to-one consult with the patient. "*