Inviting the pharmacist: a model for improved reproductive care access

On a Saturday afternoon in 1998, in a small town in Washington State, a 15-year-old young woman accompanied by her friend enters a local pharmacy and walks up to the counter. The tearful 15-year-old needs help and tells the pharmacist of being raped the night before. She expressed being too afraid to tell her parents, the police or her doctor. She decided to come to the pharmacy because it was “less scary” and she was aware that pharmacists in the state could prescribe emergency contraception. The pharmacist took the patient to a private counseling room, prescribed and provided her with emergency contraception, and gave her a glass of water to take the medication. After talking with the pharmacist, the patient agreed to have the pharmacist call a local Title X clinic where the pharmacist had a preexisting collaborative agreement; she was seen by clinicians there shortly thereafter [1].

1. Inviting the pharmacist

With myriad barriers preventing easy and timely access to effective contraception, especially for youth, it is critical that providers utilize all available resources. Rarely, however, do nonpharmacist health professionals and their respective organizations consider the potential role pharmacists can play in supporting access to care.

Much of this underutilization stems from an outdated view by other members of the health care team regarding what pharmacists do and what clinical roles they can play. Images of crowded retail pharmacy counters, with no privacy and little if any time or place to speak with patients, combined with unfortunate examples of pharmacists who have refused to fill prescriptions for their patients only exacerbate this negative perception. Dismiss pharmacists and you miss out on opportunities to provide better and more accessible reproductive health care. Many newly sexually active youths have not yet been seen by a medical provider but can and do walk into pharmacies. Private counseling rooms can and have been built. Youth- and adult-friendly, evidence-based reproductive health information and consumer education portals and care can comprehensively be provided. All of these can lead to important medical–pharmacy safety nets.

2. Collaborative models of pharmacy practice

Beginning in 1979, Washington State pharmacists, physicians and nurse practitioners were legislatively empowered to enter into legally binding, collaborative agreements in order to extend the arm of health care [2]. These agreements establish mutually crafted care protocols to provide a strong therapeutic bridge between patients, medical providers and pharmacists. In essence, they are the forerunners of the patient-centered medical home model. In 1994, the Washington State Pharmacists Association and the University of Washington School of Pharmacy, looking at statewide low immunization rates, initiated a project to train pharmacists to provide immunizations and other injectable medications using the collaborative agreement mechanism [3]. This group then began to take this model “on the road” to educate policy makers, medical providers, pharmacists and patients on the value and mechanisms of these collaborations. The results of this innovative project are now seen in the 50-state scope of pharmacist-provided delivery of influenza, pneumococcal, shingles, HPV and many other vaccines. This new medical–pharmacy delivery model of preventative care has allowed women and men to access care without taking time off from work or school, as they can now go to a neighborhood pharmacy on evenings, weekends and holidays for their vaccinations.

This same public health model — including a new partner, PATH (formerly known as Project for Appropriate Technologies in Health) — was expanded and utilized from 1998 until the availability of emergency contraception (EC) over-the-counter (OTC), in order to train pharmacists in nine states to provide EC to women under protocol. Access to prescription EC places an undue burden on women by requiring them to obtain a prescription from a health care provider — a system that is not accessible and not well suited for large-scale “urgent prevention” services. The 15-year-old rape victim described above and the innumerable women who followed her benefit from this collaboration. This model played a part in moving EC OTC in the US and in the international movement to adopt direct access to pharmacists to initiate contraceptive care [4,5].

These services are only small examples of beneficial medical–pharmacy collaborations. At least 45 states have
legislation that enables pharmacists and medical providers to enter into collaborative agreements [6]. These collaborations, when fully utilized, are a terrific example of how to establish a patient-centered medical home that is inclusive of pharmacists. Patients in traditional allopathic medical practices, not open on weekends or after hours, now have immediate access to contraceptive care and vaccinations. Think of patients who need access to their 3-month Depo-Provera™ injection or their second and third HPV vaccination, yet cannot get to a clinic during traditional business hours. Think also of a 20-year-old patient who needs EC on a weekend but the OTC product is out of reach financially. A pharmacist prescribing this EC rather than selling it OTC can bill the patient’s insurance without the patient deductible or co-pay [7].

3. Barriers and solutions to access

Access to reproductive and sexual health care is determined by many factors. Among the influences affecting both consumers and providers are age, geographic location, personal reproductive health literacy, family, money, insurance, culture, religion, country, public policy, health system fragmentation, provider time constraints, product availability, local and national standards of care, peer pressure, the time of day, the day of the week and urgency of need. Each of us has the ability to positively impact one or more of these access issues — pharmacists are no exception. Uniquely placed in small towns and in inner cities, their walk-in access, their extended hours and their clinical education put pharmacists in a position to impact access to reproductive health in ways that may be inherently difficult for other providers to attain on their own.

Successful pharmacy partnership solutions may involve, but are not at all limited to, the following examples:

- Pharmacists engaged as consultant partners or as professional staff members/employees in reproductive health clinics and school-based health centers. These primarily nondispensing pharmacy partnerships support key health messages to patients, assist in eliminating medication issues (i.e., refills, insurance, drug interactions, adherence, etc.) and help clinics to meet or exceed their ever-increasing quality assurance requirements [8].
- Pharmacists, using collaborative agreements with local physicians or Advanced Registered Nurse Practitioners, initiating hormonal contraception as a brief bridge for women without ready access to a medical provider [5]. Long-acting reversible contraception may be the ultimate objective for many women, but contraception initiated at the pharmacy may be a vital temporary solution. Pharmacists using collaborative agreement protocols with local medical providers can establish formal referral pipelines for cancer, rape and sexually transmitted infection screenings, not to mention improving access to EC and hormonal contraception pills, patches, rings and injectables.
- Development of youth-friendly pharmacies to help youth access objective reproductive health information and to help facilitate medical referrals. The Pharmacy Access Partnership program, supported by reproductive health visionaries such as Dr. Felicia Stewart, Dr. Jane Boggess, Belle Taylor-McGhee, Dr. Philip Darney and Sharon Landau, among others, has helped us to better understand the reproductive health access needs of youth and the role that enlightened pharmacists can play in removing access barriers. Advocates for Youth in Washington, DC, continues this work by embracing pharmacists as key reproductive health partners.
- Pharmacists providing Depo-Provera™ injections, as stated previously, after initial evaluation by a medical clinician. HPV injections can similarly be provided, and there may be additional opportunities for collaboration with other important adherence medications.
- Pharmacists stocking free or low-cost contraceptives acquired from local clinics or by 340B purchasing agreements, a national medication discount program designed for patients of Federally Qualified Health Centers. This model utilizes medical–pharmacy collaborative protocols to provide low- or no-cost contraceptive access to patients who are uninsured or underinsured. Nonemancipated youth without access to their parent’s insurance can also benefit by these pharmacy partnerships. Low-income patients needing an urgent refill of their hormonal contraception or perhaps EC can access these services under a specific protocol even when their medical provider is temporarily unavailable.
- Pharmacists prescribing EC, under a collaborative agreement protocol, to undocumented immigrants and women under 17 years of age needing a prescription for EC. Currently, this can only happen in the nine states with pharmacist authority to initiate EC care services, but many other states could be added to the list. Pharmacists prescribing EC under a collaborative agreement protocol to women 17 years of age and older who technically have access to OTC EC but require EC to be prescribed for insurance coverage. With no co-pay for prescription contraceptives, this would eliminate cost barriers for many women.

4. Conundrums, compensation and considerations

Pharmacists, like other medical providers, have an inherent conflict of interest when they simultaneously provide clinical interventions, yet profit from the sale of their own medications. Unfortunately, the compensation model for pharmacists is historically dependent on product
sales. Similar to the necessary change in medical provider payment from procedure-based to patient outcomes-based compensation, pharmacists must move away from product-based compensation in order to free themselves of this conflict of interest and to use their clinical education and expertise to better effect.

The collaboration opportunities outlined in this editorial are not limited to reproductive health care. Outcomes from medical–pharmacy collaborations in diabetes, asthma, hypertension, heart disease, anticoagulation and other chronic problems are extremely encouraging for their effect on patient outcomes and health costs and for their positive effect on medicine’s ability to meet quality assurance standards [9–11].

Pharmacy schools graduate pharmacists not only with extensive knowledge of medications but also with excellent knowledge of prevention-based interventions, chronic disease medication management, management of patient health behaviors and patient counseling/education, all of which are currently subjugated to filling one more prescription in order to survive. Pharmacists engaged in best reproductive care practices must find ways to balance traditional dispensing obligations and embrace outcomes-based incentives as part of a patient-centered health care team. Many new pharmacy graduates are considering forgoing any connection with prescription sales and preparing to be the medication use provider on their diverse health care team.

It is not that pharmacists can be and do everything; it is that patients deserve better than what each of us can provide on our own. When pharmacists are engaged as important partners, rather than dismissed as inconsequential (or worse as competitors or care obstructionists), history has shown that women have greatly benefitted. When awareness, policy and leadership come together, we can all participate in creating radically new care delivery opportunities.

References