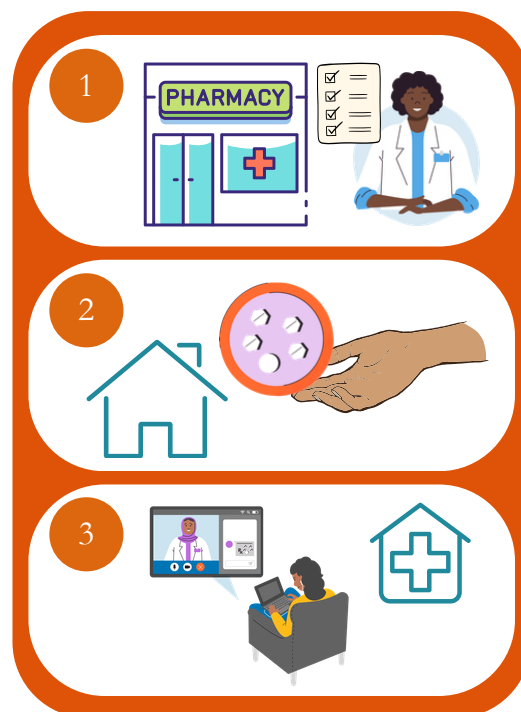


INTRODUCTION

Abortion care is difficult to access in the United States and availability of clinic-based care largely depends on geographic location. Since the *Dobbs v Jackson's Women's Health Organization* decision in 2022, many states have banned abortion completely or at early gestations with few exceptions. In response, states like Massachusetts have worked to protect access to abortion rights and care for state residents and those traveling from out of state. Massachusetts enacted a “shield law” to protect patients, providers, and anyone aiding abortion care from legal consequences imposed by other states, enabling providers in the state to offer virtual abortion care to people across the country. Despite these efforts, barriers to accessing abortion care persist in Massachusetts, especially among people living in rural areas and young people. As threats to abortion access increase, there is a need for a broader range of access points and cadres of providers offering abortion.

Pharmacies are playing an increasingly important role in abortion care. Some pharmacies dispense medication abortion, and pharmacists have also expanded their role in sexual and reproductive health care provision. In many states, pharmacists prescribe emergency contraception and hormonal birth control and have demonstrated interest in extending their provision to medication abortion. In other countries, pharmacists play an integral role in medication abortion care by dispensing medications and directly providing medication abortion. A model of care where pharmacists not only dispense but prescribe medication abortion would further reduce barriers by expanding where abortion care is delivered and who can provide this care.



WHAT IS A PHARMACIST-PRESCRIBED MODEL OF MEDICATION ABORTION?

This model of care would enable patients to 1) walk into a pharmacy (or virtual pharmacy), consult with a pharmacist, and obtain a medication abortion prescription directly from the pharmacist. The pharmacist consultation would include eligibility screening for potential contraindications as well as counseling. This model of care follows a safe and effective “no-test” model in which medication abortion care is provided to eligible participants without requiring an ultrasound, pelvic exam, or laboratory tests. 2) Patients would then take the pharmacist-prescribed medication in a location of their choice. 3) Patients would have access to clinical follow-up as needed.

KEY TAKEAWAYS

- Pharmacist-prescribed medication abortion may offer an accessible, discreet, and timely care option for people facing barriers to clinic-based care.
- This type of model has been successfully piloted in other states. Implementation in Massachusetts will require legislative/regulatory updates, accessible trainings for pharmacists and pharmacy staff, billing infrastructure to reimburse for services provided by pharmacists, and patient-facing materials.

A pharmacist-prescribed medication abortion model offers a promising solution to expand access to abortion care. A study in California found a large proportion of pharmacists were willing to prescribe medication abortion. California and Washington are piloting pharmacy-based models with success; patients in California expressed high levels of satisfaction.

In 2024, Ibis Reproductive Health conducted a study to assess the feasibility of a pharmacist-prescribed medication abortion model in Massachusetts. We interviewed 31 experts from Massachusetts including pharmacists, policy makers, medication abortion patients, advocates, and abortion providers, to explore their perspective on this model and characterize key considerations for implementation. Findings from the interviews are summarized below.

WHO WOULD BENEFIT FROM THIS MODEL OF ABORTION CARE?

Pharmacist-prescribed medication abortion could expand access to medication abortion for anyone, but specifically for communities who face compounded barriers to accessing abortion care, such as individuals who are unhoused, have limited transportation, live far from clinics, experience domestic violence, and are young (16 and older given parental consent requirements for younger teens).

Pharmacies tend to be more geographically accessible than abortion clinics; this proximity is especially beneficial for people living in rural areas and anyone with limited transportation. For some, the pharmacy setting also offered a sense of anonymity and confidentiality given the wide variety of healthcare services offered at pharmacies beyond reproductive health care, helped avoid clinic protestors, and required interacting with just one healthcare provider. Implementing this model could provide patients greater agency over their abortion experience.

The flexibility of taking the medication at home, without the need for an appointment, would allow individuals to cater their care to their own preferences and circumstances—particularly those who may distrust or feel hesitant about clinics, have restrictive schedules, or are worried about the lack of privacy when shipping the medication to their home or accessing abortion care at a reproductive health clinic.

CONSIDERATIONS FOR IMPLEMENTING THIS MODEL IN MASSACHUSETTS

Training pharmacists

To ensure this model effectively supports both pharmacists and patients, pharmacists need adequate training including easily accessible guides containing information on ‘no-test’ medication abortion regimens, effective follow-up protocols, and values-clarification training.

Cost and reimbursement

Similar to other pharmacist-prescribed services, cost and reimbursement of services may act as a barrier to the implementation of pharmacist-prescribed medication abortion. Experts we interviewed highlighted the need for efficient administrative systems to alleviate the paperwork burden for pharmacists and reimbursement by insurance for pharmacist services and the medications.

Advocacy may be needed for pharmacists to be viewed as health care providers who should be reimbursed for their time and services. Collaborating with existing abortion funds (organizations that help people pay for and access abortion) and obtaining block grants could potentially help mitigate financial barriers to providing and obtaining abortion care.

“I think pharmacists deserve to get reimbursed for the work that they do. Also, I am assuming that someone coming for this service is probably under a lot of stress. And, you know, they have a lot going on that they're thinking about, so telling them that they'll also need to pay a whole lot of money doesn't sit right with me either. If their insurance were to reimburse the services, that would be awesome because nobody wants to work for free, but we do a lot of things that aren't reimbursed already. But at the same time these services need to be there. There are people that need them.” —*Pharmacist*

Patient-pharmacist interactions at the pharmacy

A consultation with the pharmacist would be similar to abortion care in other settings. It would include a series of questions to confirm the pregnancy and gestational duration, the opportunity to discuss pregnancy options and answer questions, patient consent, a description of each step of the medication abortion process, information to differentiate

expected symptoms from indications to seek additional care, and information about where to safely access care in the event of an emergency. Participants highlighted the need for clear patient-facing materials. Some participants we interviewed wanted information about the pharmacy visit and required steps prior to their visit.

“[It would be useful to have] illustrated checklists and guides around, 'Okay, I took my pills at this time, here's how I'm feeling,' and so, it's something for the patient to have that tracks how it's going. They also [need] instructions...[and information on] here's who you call if you are experiencing anything outside of this common set of symptoms.” –*Abortion Care Advocate*

Protecting patient privacy

Participants also provided implementation ideas for protecting patients' privacy in the pharmacy setting:

- Hold consultations in private spaces within the pharmacy to maximize privacy and confidentiality.
- Create a system that allows patients to approach the pharmacy window and non-verbally disclose that they are seeking a medication abortion. Ideas to operationalize this included giving the pharmacist a form, registering interest online or via phone prior to arriving at the pharmacy, and indicating interest via a QR code upon arrival.

“Collaboration with different partners is necessary. Whether it's community leaders, community-based organizations that have a finger on the pulse of how different communities and constituencies receive information. How they talk about reproductive healthcare issues. I think partnering with those entities, whether it's trusted leaders, maybe municipal officials or faith leaders in some cases. I think those collaborators could be helpful as well” – *Reproductive Health Policy Advocate*

Follow-up care

Participants posed questions and highlighted the need for follow-up care and support throughout the duration of their abortion experience.

To address potential limited capacity of pharmacists and any partnering clinicians for providing adequate follow-up care, participants suggested:

- Providing a 24/7 phone line (or nurse triage line) with a rotating call schedule. This system could potentially screen patient questions and redirect more urgent questions to pharmacists and/or other clinicians.
- Establishing partnerships with abortion providers, local hospitals, and abortion doulas that provide additional follow up support. Patients would receive information on where to seek trustworthy care in the event of an emergency.

Community Outreach

Interviewees provided suggestions for how to disseminate information on pharmacy provision of medication abortion: word of mouth, pamphlets, posters and flyers, social media posts, targeted internet advertisements, and television or radio commercials. Participants also emphasized the importance of building community and rapport with local organizations, community leaders, physicians, abortion providers, and hospitals to build trust in this model and tailor services for specific communities.

Legal and policy considerations

There are multiple ways to implement this model of care including using collaborative practice agreements between abortion-providing clinicians and pharmacists, a state-wide standing order, a statewide protocol, or via legislation granting pharmacists prescriptive authority. The current Massachusetts law related to collaborative drug therapy management limits practice and would need amending to implement the model in community pharmacies. Participants preferred a standing order to implement this model of care over a collaborative practice agreement.

CONCLUSION

Massachusetts is at the forefront of supporting abortion rights and has the opportunity to build collaborative efforts between pharmacists, policymakers, abortion providers, and advocates to make pharmacist-prescribed medication abortion a reality. To do so will require pharmacies to become certified mifepristone dispensers, amending state policies, and increasing the recognition of pharmacists as trusted and important health care providers in the state. As attacks continue on abortion services across the country, pharmacist-prescribed medication abortion could expand availability and access to care.