

## Determining user implementation needs for pharmacist-prescribed contraception using concept mapping: A participatory, multiple stakeholder approach

Jenny L. Newlon<sup>a</sup>, Jennifer A. Campi<sup>a</sup>, Sally Rafie<sup>a</sup>, Ashley H. Meredith<sup>b,\*</sup>

<sup>a</sup> Birth Control Pharmacist, 1155 Camino Del Mar, Del Mar, CA 92014, USA

<sup>b</sup> Purdue University, 640 Eskenazi Ave, Fifth Third Bank FOB, 3<sup>rd</sup> Floor, Indianapolis, IN 46202, USA

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### ABSTRACT

**Background:** As of October 2024, 29 states and the District of Columbia allow community pharmacists to prescribe hormonal contraceptives. Pharmacists have reported many challenges and barriers to service implementation.

**Methods:** Concept mapping was used to gather insights from diverse stakeholders to identify resources to facilitate implementation of pharmacist-prescribed contraceptive services. Stakeholders included end-users (pharmacy managers, staff pharmacists) and decision-makers (pharmacy owners/executives). Participants' ideas for resources were collected via multi-stakeholder focus groups. Participants then rated each idea (i.e. statement) in terms of importance and feasibility (1 = not at all important/feasible, 4 = extremely important/feasible) and sorted ideas into groups based on similarity via an online survey. Sorting data were analyzed using multidimensional scaling and hierarchical cluster analysis to develop a cluster map. Descriptive statistics were used to analyze rating data to develop a go-zone map, where statements rated above average in terms of both importance and feasibility are plotted in the "go-zone" and are considered the most actionable ideas.

**Results:** Participants (focus groups  $n = 19$ , survey  $n = 48$ ) generated 46 unique statements which created four clusters via multidimensional scaling: 1) implementation guidance for practice setup, 2) marketing resources, 3) billing and payment resources, and 4) appointment management. The majority of the statements (13 of 15) considered the most actionable were from the implementation guidance and appointment management clusters. **Conclusions:** Stakeholders seek guidance on implementation, marketing, billing and payment, and appointment management. To increase the ability of community pharmacies to meet the contraceptive needs of patients, resources should be dedicated to creating tools and solutions to address these identified needs.

### 1. Background

Over 19 million women live in contraceptive deserts and lack reasonable access to a health center with the full range of contraceptive methods.<sup>1</sup> Reported barriers to contraceptive access include cost, lack of insurance, challenges getting a clinic appointment, clinicians requiring a physical exam, and difficulty traveling to a clinic.<sup>2,3</sup> Since 2013, states have been attempting to increase access to contraception by passing legislation allowing pharmacists to prescribe hormonal contraceptives. As of October 2024, 29 states and the District of Columbia allow pharmacists to prescribe hormonal contraceptives.<sup>4,5</sup>

Despite this enabling legislation, implementation of pharmacist-prescribed contraceptive services remains low. The first two states authorizing pharmacists to prescribe contraceptives were California and

Oregon. Only 5 % of pharmacies in California offered contraceptive services within the first year of legislation enactment.<sup>6</sup> Three years after legislation passed in Oregon, 42 % of pharmacies provided contraceptive services.<sup>7</sup> Other states that followed suit have also struggled with implementation following passage of legislative authority, with fewer than one-third of pharmacies providing contraceptive services in New Mexico, Hawai'i and Utah.<sup>7-9</sup> These low uptake rates, in addition to pharmacist-reported barriers identified across multiple states,<sup>10</sup> indicate that pharmacies across the nation need additional resources and support to successfully uptake this service.

Although the overwhelming majority of community pharmacists support contraceptive services at the individual-level,<sup>11,12</sup> past research has shown that community pharmacists cite many barriers to implementation of contraceptive services that are addressable at the system

\* Corresponding author.

E-mail address: [ahmeredith@purdue.edu](mailto:ahmeredith@purdue.edu) (A.H. Meredith).

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level, including time constraints, liability concerns, lack of training, lack of payment for pharmacists' services, and physician resistance.<sup>3,13-15</sup> However, little research has been done to determine how best to address these barriers. One study in Utah found that the development of a technology-based patient/pharmacist screener tool and a healthcare provider/pharmacist referral network are potential solutions to improve implementation,<sup>16</sup> while another study identified the use of an electronic workflow as a method to increase pharmacist performance and acceptance of contraceptive visits.<sup>17</sup> Specific solutions to pharmacist acknowledged barriers must be identified in order to improve implementation rates and effectively expand access to contraceptives.

In order to address barriers to implementation, it is necessary to find solutions that everyone can agree upon; however, frontline pharmacists and pharmacy owners or executives may have differing opinions on what resources and tools are needed to make implementation of contraceptive services more feasible. Additionally, solutions may not be one-size-fits all since adaptability, or the ability to tailor an intervention or service to meet the unique needs of the local pharmacy, is a key element of implementation science.<sup>18</sup> For example, when starting new clinical services such as pharmacist-prescribed contraceptives, chain pharmacies and independent pharmacies may have access to different resources and therefore require different support. Furthermore, pharmacies in different states or settings (rural, suburban, or urban) may have different needs in regards to implementation support. Any tools or resources addressing barriers to implementation must include all stakeholder groups involved in implementation to be effective on a national scale.

The objective of this study was to bring diverse pharmacy stakeholders together to collaboratively identify resources that are important and feasible for facilitating implementation of pharmacist-prescribed contraceptive services in community pharmacies. The results of this study can inform development of tools and resources to improve implementation that will integrate the needs of various stakeholders from diverse community pharmacy settings, ultimately improving access to contraception.

## 2. Methods

Concept mapping, a collaborative, participatory methodology involving both quantitative and qualitative data, was used to gather insights from diverse stakeholders involved in the process of implementing pharmacist-prescribed contraceptive services.<sup>19</sup> Different stakeholders (e.g. staff pharmacists and pharmacy executives) may have conflicting opinions of what makes a pharmacy service feasible or safe to provide<sup>20,21</sup>; therefore, concept mapping was the chosen methodology because it is a modified, simplified Delphi method that can facilitate consensus among multiple stakeholders.<sup>16</sup> Concept mapping has the advantage of not only assessing participants' opinions of each idea's importance, but also its feasibility. This allows for more actionable insights to be drawn from the results by focusing on solutions that are considered the most important and the most feasible. The project was approved by Purdue University's Institutional Review Board.

### 2.1. Sample

Invited stakeholders included pharmacy end-users (staff pharmacists and pharmacy managers) and decision-makers (pharmacy owners and pharmacy executives). End-users are individuals who participate directly in the provision of patient care, whereas decision-makers are individuals who have the authority and power to decide whether or not to implement a new service in their pharmacy. The focus of this study was to identify facilitators for implementation of contraceptive services; therefore, patients were not considered end-users because although patients utilize the service, they do not implement the service. To be eligible for inclusion in the study, participants had to currently work for a community pharmacy (chain or independent), work in a state where at

least one chain has implemented pharmacist-prescribed contraception services at the time of the study (California, Colorado, Hawaii, Idaho, Maryland, Minnesota, New Mexico, Oregon, Tennessee, and Utah), and be interested in either starting or improving pharmacist-prescribed contraception services in their pharmacy. Purposeful sampling was used to ensure that participants in each focus group would provide a unique perspective due to their location (state), setting (rural, suburban, or urban), position (end-user or decision-maker), and/or pharmacy type (chain or independent).

### 2.2. Recruitment

Participants were recruited via the Birth Control Pharmacist email list, existing professional partnerships between Birth Control Pharmacist and several chain and independent pharmacies, the National Alliance of State Pharmacy Associations (NASPA), and the American College of Clinical Pharmacy's (ACCP) Women's Health Practice and Research Network (PRN). An initial and two follow-up emails were sent to prospective participants. Anyone interested in participating followed a link in the recruitment email to an online form. In the online form, participants were consented prior to providing demographic characteristics and selecting which portions of the study in which they wished to participate (focus group, survey, or both).

### 2.3. Data collection

All data were collected between December 2022 and April 2023. Participants were split between six one-hour virtual focus groups facilitated by a study team member. Enrollment was kept to fewer than seven participants per focus group to ensure that everyone had time to share. Participants in the focus groups co-created ideas (or statements) in response to the prompt "What do you need to provide contraceptive services in your pharmacy?". A focus group guide was developed for this study to introduce participants to the process of participating in concept mapping. Statements generated by participants in the focus group were summarized and written by a second study team member and shared with participants in real time via screen sharing to allow participants to verify that their ideas were accurately captured.

After all focus groups were complete, the study team combined and reconciled statements generated across all focus groups to remove duplicative statements. An online survey, which included the finalized statements, was then distributed via email to the survey participants. The survey was completed in Qualtrics and allowed participants to sort statements into groups based upon similarity and rate each statement individually based on how a) important and b) feasible they felt each idea was to support implementation of pharmacist-prescribed contraceptive services in their pharmacy. Statements were rated using a four-point Likert-type response format (1 = not important/feasible at all, 2 = slightly important/feasible, 3 = fairly important/feasible, 4 = extremely important/feasible). Demographic characteristics were also collected to assist with identifying trends in the data.

### 2.4. Data analysis

Multidimensional scaling using a similarity matrix and hierarchical cluster analysis were used to analyze sorting data.<sup>19</sup> Sorting data from participants who failed to sort all items or created one or more groups containing only a single statement were excluded for violating the sorting rules. To create the cluster maps, researchers reviewed the quantitative results from the multidimensional scaling and hierarchical cluster analysis to qualitatively determine which clusters made sense and aligned with previous knowledge of pharmacists' barriers to implementing pharmacist-prescribed contraception services.

Descriptive statistics were used to evaluate the rating data and create "go-zone" maps, which are scatterplots generated using the average ratings of each statement with importance ratings on the x-axis and

feasibility ratings on the y-axis. Any statements falling above both the average importance score and the average feasibility score for all statements are in the “go-zone” and are considered to be of the highest priority and the most actionable.<sup>16</sup> Average ratings of importance and feasibility were also calculated for two sub-groups: 1) decision-makers (pharmacy owners and executives), and 2) end-users (pharmacy managers and staff pharmacists).

### 3. Results

A total of 48 unique individuals participated in the study ( $n = 48$  total,  $n = 19$  in the focus groups, and  $n = 48$  in the survey). The demographic characteristics of the participants may be found in [Table 1](#).

#### 3.1. Focus groups

After removing duplicative statements, 50 unique statements remained. Four of these statements were determined to be outside the scope of this study due to not being relevant to the focus group prompt, leaving 46 statements that were sorted and rated by participants.

#### 3.2. Survey

For the sorting data, 12 of the participants were excluded from the analysis for violating the sorting rules, leaving responses from 36 participants for analysis. The stress value for the cluster point map was 0.235, which indicates a good model fit.<sup>18</sup> Based upon the output from the multidimensional scaling and hierarchical cluster analysis and the study team’s analysis, four clusters were identified: 1) implementation guidance for practice setup, 2) marketing resources, 3) billing and payment resources, and 4) appointment management ([Fig. 1](#)). These clusters represent the common themes among resources that were identified by participants.

The go-zone map ([Fig. 2](#)) showed that 15 statements fell in the upper right quadrant, and therefore should be prioritized when supporting implementation of pharmacist-prescribed contraception services. Seven of the statements belonged to the implementation guidance for practice setup cluster, six statements were a part of the appointment management cluster, and one statement each came from the billing and payment and marketing resources clusters.

The average importance rating for all statements was 3.19 out of 4, and the average feasibility rating for all statements was 2.88 out of 4. Average importance and feasibility ratings for the four clusters are listed in [Table 2](#). Statements in the appointment management cluster were the most highly rated in importance overall (3.29/4), however all statement clusters scored above 3 in importance. Billing and payment resources were rated the lowest in feasibility by both end-users (2.63) and decision-makers (2.70).

### 4. Discussion

The process of concept mapping identified four defined clusters on which to focus development of tools and resources to improve implementation of pharmacist prescribed contraception.

#### 4.1. Implementation guidance for practice setup

The implementation guidance cluster included statements such as creating example workflows for various staffing levels and models for the service and providing training for support staff and their role in providing this service. Concerns related to the appropriate staffing level are frequently highlighted, and pharmacists are unsure how best to incorporate this service into an existing workflow.<sup>14,22,23</sup> Additionally, while pharmacists have been allowed to prescribe contraception for up to eight years in some states, a desire by pharmacists for training and certification prior to implementation is often expressed.<sup>22</sup> In contrast to

**Table 1**  
Participant demographics.

	Focus Groups <i>n</i> = 19		Survey <i>n</i> = 48	
Age				
Mean (SD) (years)	45 (10.2)		40 (10.9)	
Range (years)	33–65		24–65	
Sex				
Female	14	73.7 %	39	81.3 %
Male	5	26.3 %	9	18.8 %
Race				
White	15	78.9 %	33	68.8 %
Black or African American	–	–	1	2.1 %
American Indian or Alaskan Native	1	5.3 %	1	2.1 %
Asian	3	15.8 %	13	27.1 %
Native Hawaiian or Pacific Islander	–	–	–	–
More than one race	–	–	–	–
Ethnicity				
Not Hispanic or Latinx	16	84.2 %	41	85.4 %
Hispanic or Latinx	2	10.5 %	6	12.5 %
Prefer not to answer	1	5.3 %	1	2.1 %
State <sup>a</sup>				
California	12	63.2 %	24	50.0 %
Colorado	5	26.3 %	17	35.4 %
Hawaii	3	15.8 %	8	16.7 %
Idaho	3	15.8 %	9	18.8 %
Maryland	3	15.8 %	14	29.2 %
Minnesota	2	10.5 %	2	4.2 %
New Mexico	8	42.1 %	14	29.2 %
Oregon	6	31.6 %	13	27.1 %
Tennessee	2	10.5 %	2	4.2 %
Utah	3	15.8 %	7	14.6 %
Urbanicity				
Urban	7	36.8 %	17	35.4 %
Suburban	11	57.9 %	28	58.3 %
Rural	1	5.3 %	3	6.3 %
Pharmacy Type				
Chain (5 locations or more)	11	57.9 %	33	68.8 %
Independent (4 locations or fewer)	7	36.8 %	10	20.8 %
Other Community/Retail	1	5.3 %	5	10.4 %
Position				
Pharmacy Owner	3	15.8 %	5	10.4 %

(continued on next page)

**Table 1** (continued)

	Focus Groups n = 19		Survey n = 48	
Pharmacy Executive (district manager or higher)	5	26.3 %	10	20.8 %
Pharmacy Manager	4	21.1 %	13	27.1 %
Staff Pharmacist (full-time, part-time, or per diem)	7	36.8 %	20	41.7 %

<sup>a</sup> Sum does not total to n = 19, 100 % (focus group) or n = 48, 100 % (survey) because n = 4, 21.1 % of focus group participants and n = 9, 18.8 % of survey participants represented more than one state.

this, studies have found that after one year of implementing pharmacist prescribing, nearly all pharmacists feel comfortable prescribing and counseling on contraception.<sup>24,25</sup> This suggests that if tools are available to assist and support with the initial implementation of pharmacist prescribing, pharmacists will quickly gain the confidence in their skills to successfully prescribe contraception.

**4.2. Marketing resources**

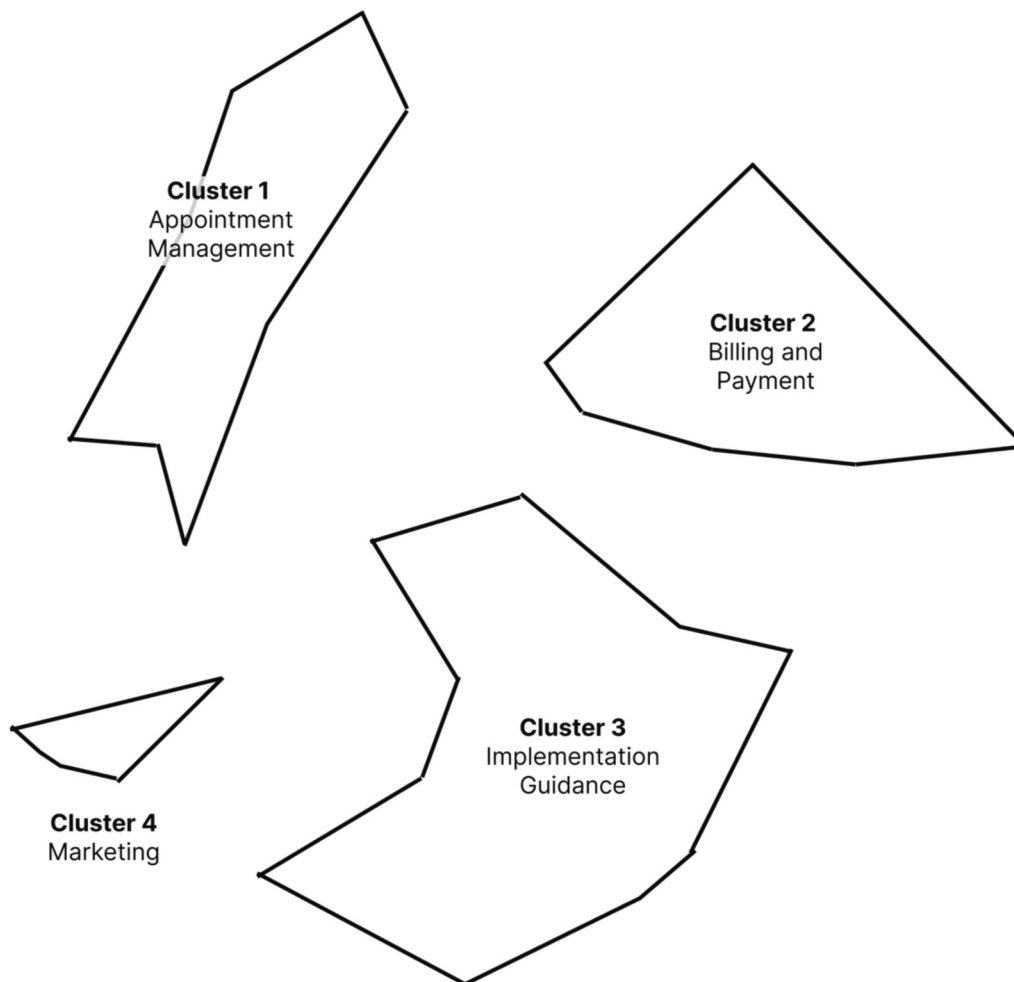
The marketing cluster included statements about providing community pharmacists with example marketing materials and media kits to raise awareness of the service. A major reported barrier to providing pharmacist contraception prescribing is a lack of patient awareness of the service.<sup>14,22</sup> While the State of Washington requires pharmacies to display a sign that contraceptives are able to be prescribed at that

location,<sup>26</sup> it is unclear how it has impacted service utilization. This struggle is not unique to contraception prescribing alone, and is a challenge that presents with any new service offered at the pharmacy. Lessons may be able to be gleaned from other pharmacist-provided services such as immunizations and smoking cessation.

**4.3. Billing and payment resources**

The billing cluster included statements such as providing training on credentialing with health plans and resources explaining billing codes and procedures. At the federal level, pharmacists are not recognized as healthcare providers who can bill for their services.<sup>27</sup> This presents a challenge as it is left to each state to determine what services are eligible to be covered and the process pharmacists must follow. Some states have addressed this through requiring state Medicaid payment for the time spent by pharmacists in a contraception prescribing encounter.<sup>27</sup> However, as pharmacists have historically not been able to bill for the cognitive services they provide, it is an unfamiliar process for which pharmacists will require additional support to be effective and efficient.

A few states, including Ohio<sup>28</sup> and Idaho,<sup>29</sup> allow pharmacists to bill Medicaid as a provider. In these states, resources regarding new billing procedures and enrollment in Medicaid programs as a provider may be necessary to educate and support pharmacists. Billing for contraceptive services would ideally be done digitally, in real-time, like prescription drug billing. Otherwise, pharmacies would likely need to dedicate staff to billing, sending invoices to patients, and tracking payments received. The costs associated with this additional administrative effort would



**Fig. 1.** Cluster Map.

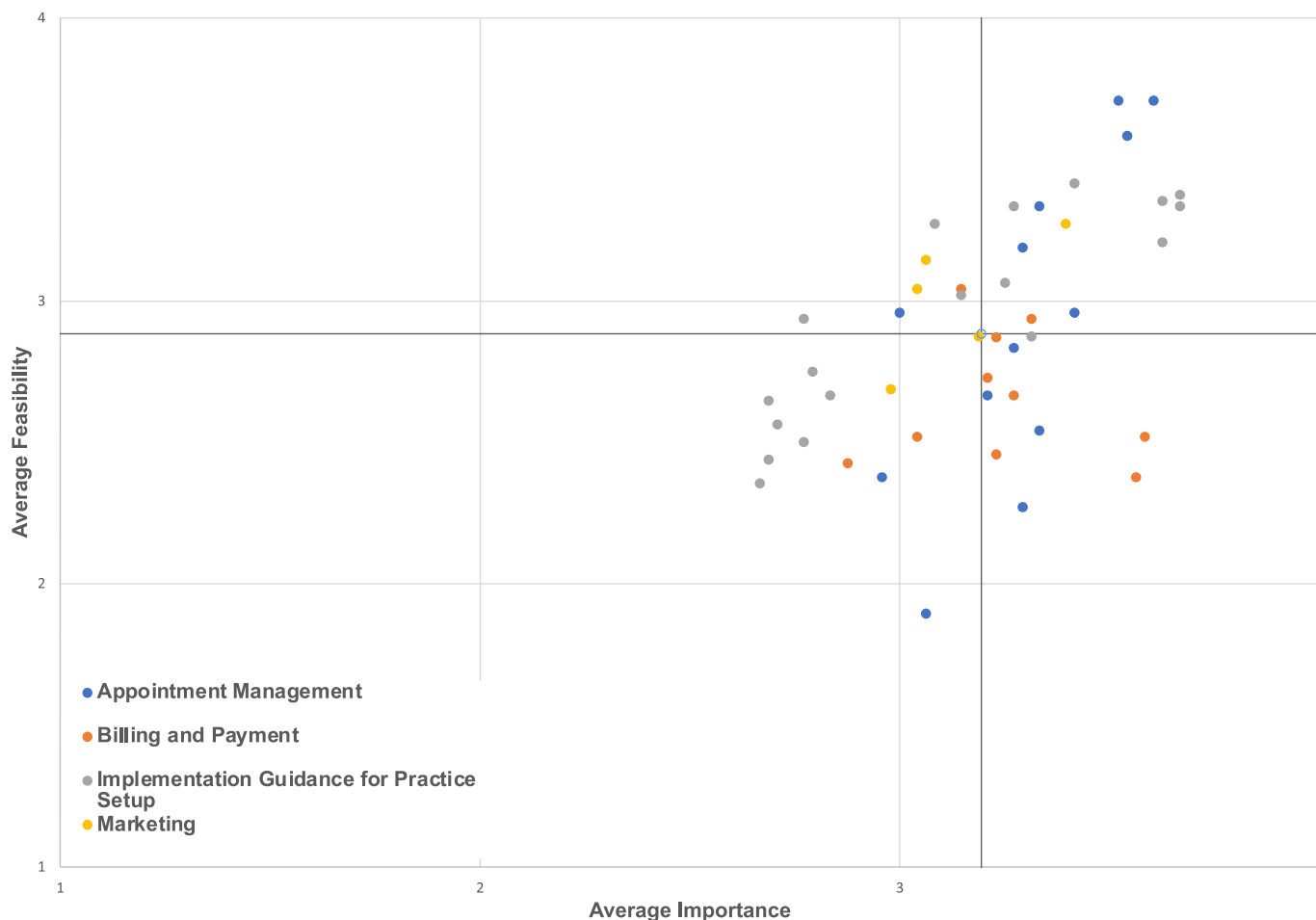


Fig. 2. Go-Zone Map.

Table 2 Importance and feasibility ratings.

	All Participants n = 47	End-Users <sup>a</sup> n = 33	Decision-Makers <sup>b</sup> n = 15
	Mean (SD)	Mean (SD)	Mean (SD)
Cluster 1: Implementation Guidance for Practice Setup			
Importance	3.11 (0.91)	3.15 (0.88)	3.02 (0.96)
Feasibility	2.95 (0.91)	2.87 (0.92)	3.13 (0.86)
Cluster 2: Marketing Resources			
Importance	3.13 (0.81)	3.08 (0.86)	3.24 (0.67)
Feasibility	3.00 (0.85)	2.92 (0.88)	3.19 (0.77)
Cluster 3: Billing and Payment Resources			
Importance	3.25 (0.88)	3.24 (0.86)	3.25 (0.93)
Feasibility	2.65 (0.92)	2.63 (0.92)	2.70 (0.90)
Cluster 4: Appointment Management			
Importance	3.29 (0.79)	3.32 (0.80)	3.23 (0.78)
Feasibility	2.92 (0.95)	2.94 (0.96)	2.89 (0.94)

<sup>a</sup> Staff pharmacists and pharmacy managers

<sup>b</sup> Pharmacy owners and pharmacy executives

likely outweigh the revenue from providing the service.

#### 4.4. Appointment management

The appointment management cluster included statements focusing

on tools to manage scheduling and documenting clinical encounters for this service. While appointment scheduling and documentation have not been directly mentioned in any identified literature examining barriers to pharmacist contraception prescribing, it is an extension of cited workflow barriers.<sup>14,22,23</sup> Documenting a contraception encounter is estimated to take five to ten minutes of pharmacist time.<sup>30</sup> Tools to improve the scheduling of appointments and efficiency of documentation can guide staffing levels and pharmacy workflow, while minimizing the time required by the pharmacist to complete each encounter.

#### 4.5. Go-Zone map

Although approximately half of statements in both the appointment management and implementation guidance clusters fell below the average ratings for importance and feasibility for all statements, these two clusters made up almost all of the statements in the go-zone. This suggests that efforts to support implementation of pharmacist-prescribed contraceptive services should prioritize resources addressing these two themes. That may include resources that help pharmacists to streamline and organize the process of scheduling and taking care of the paperwork associated with providing this service. In addition, resources are needed to help pharmacists shift from a service model that solely relies on prescription dispensing to a model that includes patient assessment and prescribing.

Most of the billing and payment statements were above average in terms of importance, but fell below average in terms of feasibility. While lack of payment for services has been a consistently cited barrier to providing this service,<sup>13,14</sup> participants did not see it as an easily addressable barrier. The majority of statements having to do with



marketing fell below the average in terms of importance. Despite the need to raise awareness of the service among patients,<sup>14,22</sup> pharmacists and pharmacy decision-makers did not report a strong need for marketing materials. This may be because marketing the pharmacy and the services it offers may not be a novel concept.

Due to the small sample size, direct comparisons cannot be made between decision-makers and end-users. However, it may be noted whether decision-makers or end-users ended up above or below the average of all importance and feasibility statement ratings, which create the quadrants of the go-zone map. Both decision-makers and end-users rated billing and payment feasibility and implementation guidance importance as below the average for all statements. Additionally, both decision-makers and end-users rated marketing feasibility, billing and payment importance, and appointment management importance and feasibility above the average for all statements. It was only with respect to implementation guidance feasibility and marketing importance that end-users and decision-makers found each other on opposite sides of the average for all statements.

For implementation guidance feasibility, decision-makers felt it was above average in terms of feasibility, while end-users felt it was below average. Pharmacy owners and executives may have more experience initiating new services, giving them pre-existing resources and more confidence in the steps necessary to implement pharmacist-prescribed contraception. For example, pharmacy decision-makers may have more familiarity with legislation, protocols, and standing orders that may dictate the parameters within which a service may be implemented, as well as have access to legal counsel to assist with implementation guidance. Conversely, pharmacy managers and staff pharmacists may feel ill equipped to start a service from scratch and be more acquainted with the more minute details of day-to-day operations that may present challenges to implementing a new service. Therefore, creating implementation resources targeted towards pharmacy end-users, such as consultant services, documentation templates, and workflow examples, may be especially beneficial.

For marketing importance, end-users rated it as below average importance, while decision-makers rated it as above average importance. While most marketing resources were rated below average in terms of importance, decision-makers rated marketing resources as more important and more feasible than end-users. This may be because pharmacy owners and executives are more likely to create and disseminate marketing strategies for various pharmacy services compared to pharmacy managers and staff pharmacists. Having access to pre-existing marketing templates specific to pharmacist-prescribed contraceptive services would likely benefit the decision-makers to a greater degree than end-users, since they are the ones responsible for executing marketing for pharmacy services.

One limitation of this study is that the relatively small sample size does not allow for statistical comparisons between decision-makers and end-users. However, the sample size is appropriate for concept mapping methods.<sup>19,23</sup> In addition, the sample includes participants from all states allowing pharmacist-prescribed contraception services at the time of the study, as well as from a variety of settings (i.e. urbanicity) and community pharmacy types (e.g. chain, independent, etc). This suggests that the findings of this study have accounted for the unique legislative environments of all states that allow pharmacist-prescribed contraception services at the time of this study. Despite the variation in legislative restrictions on this service, the findings suggest that most pharmacists could benefit from the same general types of resources.

Further research should focus on creating and evaluating the resources described by stakeholders that were rated highly in both importance and feasibility. The findings of this study can be used to inform the development of resources that address the needs of end-users while also acknowledging the needs of decision-makers. Stakeholders demonstrated that guidance on practice setup and appointment management should be prioritized when developing resources. Guidance on practice setup will help pharmacies initiate contraceptive services, while

tools that optimize appointment management will help to reduce time burden. This study highlights that while participants did not feel that addressing lack of payment for pharmacists' services was feasible, it is still an important barrier to overcome. More efforts should be put into working with policymakers and payors to overcome financial barriers and ensure pharmacist payment for contraceptive services.

## 5. Conclusions

The use of concept-mapping provided specific insight into what is needed by community pharmacies to implement contraception prescribing. End-users and decision-makers are seeking guidance on implementation, marketing, billing and payment, and appointment management. To increase the ability of pharmacists to meet the contraceptive needs of patients seeking care at a pharmacy, resources should be dedicated to creating tools and solutions to address these identified needs. A multi-pronged approach that provides resources aimed at barriers at the individual-level (e.g. clinical training), pharmacy-level (e.g. implementation guidance), and system-level (e.g. advocacy guides for changing billing policies or legislation) is likely to be the most successful in getting more pharmacists to implement contraceptive services.

## Glossary

NASPA—National Alliance of State Pharmacy Associations.

ACCP—The American College of Clinical Pharmacy.

PRN—Women's Health Practice and Research Network.

## Ethics approval and consent to participate

In accordance with the Declaration of Helsinki, this study was approved by Purdue University's Institutional Review Board (IRB# 2022-1418). Anyone interested in participating followed a link in the recruitment email to an online form. In the online form, participants were consented prior to providing demographic characteristics and selecting which portions of the study in which they wished to participate (focus group, survey, or both). This approach to consent to participate was approved by Purdue University's Institutional Review Board.

## Consent for publication

Not applicable.

## Consent for participation

All human subjects provided informed consent prior to participation in research activities.

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## Availability of data and materials

The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

## CRediT authorship contribution statement

**Jenny L. Newlon:** Conceptualization, Data curation, Formal analysis, Funding acquisition, Investigation, Methodology, Project administration, Supervision, Validation, Writing – original draft, Writing – review & editing. **Jennifer A. Campi:** Data curation, Formal analysis, Writing – original draft, Writing – review & editing. **Sally Rafie:**

Conceptualization, Funding acquisition, Supervision, Writing – original draft, Writing – review & editing. **Ashley H. Meredith:** Conceptualization, Formal analysis, Funding acquisition, Supervision, Writing – original draft, Writing – review & editing.

#### Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Sally Rafie reports a relationship with Afaxys Inc. that includes: board membership and consulting or advisory. If there are other authors, they declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Ashley Meredith reports financial support was provided by Centers for Disease Control and Prevention. Ashley Meredith reports a relationship with American College of Clinical Pharmacy that includes: consulting or advisory and speaking and lecture fees. Ashley Meredith reports a relationship with Indiana Department of Health that includes: funding grants. Ashley Meredith reports a relationship with Pharmacy Times Office of Continuing Professional Education LLC that includes: speaking and lecture fees. Ashley Meredith reports a relationship with Hamad Medical Corporation that includes: travel reimbursement. Birth Control Pharmacist - advisory board member (Ashley Meredith) If there are other authors, they declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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