

Expanding Access to Emergency Contraception Through State Systems: The Washington State Experience

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Access to family planning and reduction of unintended pregnancy are long-standing priorities for Washington State's Department of Health (DOH) and Department of Social and Health Services (DSHS). Working together to ensure that all pregnancies are intended (consciously and clearly desired at the time of conception), the two agencies provide family planning counseling and a broad choice of contraceptive methods through a range of health and social service programs. When a dedicated product for emergency contraception became available in 1998, widespread integration of relevant information and services became one more strategy the agencies used to realize the goal of reducing unintended pregnancy in the state.

Since 1997, the Program for Appropriate Technology in Health (PATH) has collaborated with state colleagues to increase access to emergency contraception. In a series of interviews conducted in December 2003, PATH asked administrators, managers and others who were involved in the initial process to describe the experience. The story that emerged, described here, is one of strong, high-level support for family planning services that created an ideal platform for expanding emergency contraception services, establishing collaborations between relevant agencies, and increasing the number of state programs and the range of service providers offering emergency contraception services. The result was an innovative approach to service delivery that made it possible to reach underserved and low-income populations, including those not served by Title X-funded clinics. Our objective in sharing Washington State's experience is to stimulate further state-level innovation for expanding access to emergency contraception.

LAYING THE GROUNDWORK

Efforts to integrate emergency contraception into the state's health care and social service systems benefited immensely from strong, high-level support for reducing unintended pregnancy. DOH and DSHS cultivated this support over a period of more than 15 years, using clinical and programmatic evidence to convince state policymakers of the benefits of improving access to family planning services. Providing emergency contraception was one step in a progression of activities designed to increase access to family planning and decrease unintended pregnancy rates.

Emphasizing Healthy Birth Outcomes

Washington's maternity care access program, known as First Steps, was established by the state legislature in 1989. To ensure healthy birth outcomes for low-income families, this

program expanded Medicaid eligibility to pregnant women with incomes of up to 185% of the federal poverty level (the federal mandate was 133%). In seeking to achieve its goal, the program highlighted the important roles of birthspacing and pregnancy intention. This led to a change in the maternity care access statutes in 1993 to include provision of family planning services and, for women whose Medicaid eligibility was related to pregnancy, expansion of the period of postpartum eligibility for family planning services from two to 12 months.

Also in the early 1990s, through collaboration between the Medical Assistance and Economic Services Administrations of DSHS, Washington started a pilot program to bring family planning services into DSHS welfare offices. By 1994, family planning services had been introduced into all of the state's welfare offices. In 1997, when welfare reform was implemented, decreasing the number of unintended pregnancies among welfare clients received strong emphasis.

With support from the First Steps program, DSHS developed the First Steps database, which links Medicaid claims and eligibility to birth certificates. Additionally, in 1993, DOH and DSHS enrolled Washington State in the Pregnancy Risk Assessment Monitoring System (PRAMS), a population-based survey sponsored by the Centers for Disease Control and Prevention, which is designed to supplement vital records with information on selected prenatal and perinatal maternal behaviors. PRAMS contains information about pregnancy intention for women who had a live birth, but not for women whose pregnancy ended in an abortion, miscarriage or fetal death. Unintended pregnancies identified through PRAMS are defined as those that were either unwanted (i.e., they occurred when no children or no more children were desired) or mistimed (i.e., they occurred earlier than desired). The First Steps database, together with the PRAMS data, allowed the DOH and DSHS to identify for the first time the number of births resulting from unintended pregnancy that were covered by Medicaid.

Raising Awareness of Unintended Pregnancy

In 1995, the Institute of Medicine report *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families*¹ focused national attention on unintended pregnancy and provided additional support to Washington State's efforts to expand access to family planning. Using evidence from numerous studies, the report firmly linked unintended pregnancy with negative health and social consequences for women, children and families. The report provided a

framework that laid out the prevention of unintended pregnancies as a human value as well as a cost issue. While using the report to brief state government and legislative leaders, DOH and DSHS staff received highly visible support from the governor.

In the same year, the first Washington State PRAMS data (for 1993) became available. These data, together with information on expenditures related to pregnancy and family planning from the First Steps database, provided striking evidence of the economic impact of unintended pregnancy. The proportion of unintended pregnancies resulting in live births among women receiving Medicaid assistance (61%) was nearly twice that among women not receiving Medicaid (32%), and births resulting from unintended pregnancies among women covered by Medicaid cost the state approximately \$90 million a year.² In the years that followed, as more pregnant women became eligible for services through First Steps, program expenses increased. By 2001, annual costs for maternity care, delivery and medical expenses for infants' first year had risen to an estimated \$220 million,³ nearly 50% of these births had resulted from unintended pregnancies.

In 1998, the secretary of health and the secretary of social and health services made prevention of unintended pregnancy a part of their performance agreements with the governor. State leaders, including a member of Washington's house of representatives who became a "legislative champion" for family planning, realized that the current approach—providing large numbers of women with Medicaid coverage that included family planning only after they were pregnant—was insufficient. The leaders also understood that women served by Medicaid face a number of barriers in trying to access the family planning information and effective contraception that would help them prevent unintended pregnancy. DOH and DSHS saw in emergency contraception a unique contraceptive option that could benefit all women at risk of unintended pregnancy. Realizing that it would be necessary to raise awareness among women and their communities, as well as health providers, they developed a strategy to build support for emergency contraception and its provision through a range of programs.

BUILDING SUPPORT FOR EMERGENCY CONTRACEPTION

DOH and DSHS reached out to state- and local-level groups and to communities through three initiatives. In 1998, the DOH assistant secretary of community and family health and the DSHS assistant secretary of medical assistance canvassed the state to bring information about unintended pregnancy and its prevention to state- and local-level groups, including hospital associations, boards of health, medical associations, legislators, the bipartisan Washington State Women's Political Caucus, county councils, school administrators and community groups. The presenters sought common ground with their audiences by stressing their agencies' goal of supporting healthy families. Their presentations emphasized evidence-based information, such as data from the Institute of Medicine report on the out-

comes of unintended pregnancy, and data from PRAMS and the First Steps database. Key messages included that unintended pregnancy affects all segments of society, not only teenagers or low-income, minority or unmarried women; that unintended pregnancy can have a negative impact on the health and safety of children; that unintended pregnancy has a significant economic impact; and that greater access to family planning, including emergency contraception, is critical to preventing unintended pregnancy.

DOH and DSHS also invited community organizations from the private and nongovernmental sectors, as well as program managers from public sector-supported programs, to join a steering committee to look at the ways that existing services could be used to educate the public about unintended pregnancy and available resources, including emergency contraception.

At the same time, DOH and DSHS began informing their programs and providing technical assistance to staff who would be offering emergency contraception services. State health personnel implemented a range of activities to facilitate the introduction of emergency contraception information and services into programs. For example, the DOH assistant secretary of community and family health sent a memo to all local public health officers, asking for their support for activities to reduce rates of unintended pregnancy. DOH and DSHS then scheduled training sessions for providers at Title X-funded clinics, First Steps agencies and clinician groups. Training sessions used a PATH curriculum that covered emergency contraception screening, counseling and prescribing, and clarified the definition of emergency contraception and how it differs from the "abortion pill," mifepristone. Because DOH and DSHS incorporated emergency contraception information into regularly scheduled trainings and meetings, they were able to reach providers without incurring additional costs. Both agencies have continued to conduct emergency contraception training (as needed) at update sessions for programs that include family planning services.

Concurrent with this statewide recognition of the need to expand family planning services were three developments that would have a significant impact on emergency contraception service delivery in the state. First, in 1997, the U.S. Food and Drug Administration approved the off-label use of oral contraceptives for emergency contraception. Then, in 1998, the first dedicated emergency contraception product—which was packaged and specifically marketed for that use—became available. Finally, recognizing the potential impact of this method and the need for timely access, PATH led a partnership that implemented a pilot project enabling Washington State pharmacists to provide emergency contraception directly to women. (Partners in this effort were the Washington State Pharmacists Association, the University of Washington Department of Pharmacy and DDB, a public relations firm.) Launched in 1998, the project promoted collaborative drug therapy agreements, under which licensed prescribers (such as physicians or nurse practitioners) delegate authority to phar-

Examples of Washington State programs providing emergency contraception information and services

Large statewide or regional programs that provide emergency contraception services

- The First Steps program for pregnant women and new mothers provides emergency contraception information and supplies as part of its family planning services. In 2000, it instituted a performance measure requiring its providers to discuss goals and desired family size with all clients, to ensure that clients have information about family planning methods (including emergency contraception) and to link them with family planning services as needed.
- The Take Charge family planning waiver program, which reaches Washington State residents lacking full family planning insurance coverage, provides pre-pregnancy family planning benefits for those with an income at or below 200% of the federal poverty level. Clients can obtain emergency contraception free of charge from participating clinics and pharmacies, which are reimbursed by the state.
- Many local health jurisdictions, such as Public Health Seattle and King County, routinely provide emergency contraception not only in response to need, but also in advance of need, although the state has no policy promoting advance provision. These jurisdictions also have integrated emergency contraception information into their community health education programs, hotlines, family planning brochures and provider guidelines.
- The Southwest Washington Health District's HIV Education and Prevention program provides emergency contraception for people who use injection drugs.
- The Washington State Division of Alcohol and Substance Abuse, which promotes prevention of and supports recovery from chemical dependency, includes emergency contraception among the family planning methods discussed in its program for pregnant women and mothers.
- In 2002, the state legislature required hospital emergency departments to provide female victims of sexual assault with written materials on emergency contraception and with the method itself. The Department of Health's Family Planning and Reproductive Health Office convened a task force to develop written materials specifically oriented toward emergency departments. The group, which included a diverse assortment of religious leaders and family planning experts, approved the contents for an emergency contraception fact sheet and a wallet card, which the Department of Health supplies to all hospital emergency departments in the state.

Community organizations that participated in some of the local networks

- The Emergency Support Shelter in Cowlitz County routinely refers survivors of domestic violence and sexual assault to the family planning services at the neighboring welfare office for emergency contraception.
- The Healthy Mothers, Healthy Babies Coalition provides emergency contraception and includes information about it on its hotline.
- The Special Supplemental Nutrition Program for Women, Infants and Children (WIC), a federal grant program, collaborates with local health jurisdictions in many parts of the state, referring clients for family planning services, including emergency contraception.

macists trained in emergency contraception service provision, allowing the pharmacists to prescribe a particular therapy according to a specific protocol. When the pilot project ended in 1999, collaborative agreements for emergency contraception had been established as a standard of pharmacy practice, increasing access to the method for women in the state.* For DOH and DSHS, pharmacy access became an important element in state-level emergency contraception strategies.⁴

ENCOURAGING INNOVATION

DOH and DSHS leaders sought innovative ways to increase access to emergency contraception. Collaboration with the pharmacy pilot project is one example. State leaders supported the pharmacy access effort by participating in the project advisory committee and encouraging obstetricians and other physicians to enter into emergency contraception collaborative agreements with pharmacists. Further, in 2000 and 2001, DSHS requested funds through Temporary Assistance for Needy Families (the post-welfare reform successor to Aid to Families with Dependent Children) to support efforts by PATH and the state pharmacists as-

sociation to expand the pharmacy access approach, targeting rural areas that had high rates of unintended pregnancy. Finally, to make emergency contraception easily available to low-income women, DSHS arranged to reimburse pharmacies for providing the pills and related services (screening, counseling and referral) to Medicaid clients. Pharmacies ultimately became key providers of emergency contraception services through clients of Take Charge (a program developed under a Medicaid waiver that expanded access to family planning services).

Decentralized, flexible programming was another innovation. Because many diverse programs, services and communities had the potential to be involved in emergency contraception service delivery, DOH and DSHS determined that the approach for integrating information and services into state programs should be flexible and allow for local control on the part of institutions and health jurisdictions. Taking advantage of the local momentum and ideas that had been generated during the statewide canvass, the agencies encouraged state programs—health jurisdictions, welfare offices and contracted family planning agencies—to develop community networks of organizations receiving state funding for social and health services, such as migrant worker clinics and teenage outreach programs, as well as independently funded groups. The arrangements for collaboration between these groups varied: Some were temporary, others were long-term.[†] They represented locally driven, bottom-up innovations that could help reach women at risk of unintended pregnancy (see box), not policy directives issued by state-level management.

DOH distributed emergency contraception to family planning providers, which distributed the supplies to their network partners with prescribing authority. All of these providers made emergency contraception available to clients free of charge. Network partners without prescribing authority helped expand access to the method by providing referrals to DOH-funded agencies.

DOH and DSHS also built on external partnerships. For example, to develop emergency contraception training and client materials, they collaborated with PATH, which had experience in developing culturally appropriate materials and, as a nongovernmental organization, was able to obtain funding from private foundations to support these activities. Working with both agencies, PATH prepared two training curricula for health and social service providers working among diverse populations and developed emergency contraception client materials in three languages.[‡] In addition, while DOH and DSHS focused on emergency

*Information about emergency contraception pharmacy access in Washington State is available on the Pharmacy Access Partnership Web site, <www.go2ec.org/ProfileWashington.htm>.

†Because of this approach, there was no tracking of overall numbers of providers trained, and each program kept its own data on the number of clients served. The data have not been compiled across programs.

‡The curricula for clinical and nonclinical providers and client brochures, in English, Russian and Spanish, are available at <http://www.path.org/projects/ec_featured_publications.php>.

contraception program implementation, PATH provided technical expertise, helped inform key audiences in the state about the method, responded to inquiries from the press and spoke out to correct misinformation. One important outcome of this collaboration was that the expansion of emergency contraception services through state programs happened gradually and was accepted without significant controversy.

INSTITUTIONALIZING SERVICES

DOH and DSHS institutionalized emergency contraception information and services by ensuring product availability, developing mechanisms for ongoing access and disseminating information.

As part of their joint strategy to increase awareness of emergency contraception and introduce and integrate services, DSHS decided to include emergency contraception in the covered services for all Medicaid clients, and DOH decided to purchase emergency contraception centrally and make the method available to clients free of charge. To ensure that all DOH programs had the product on hand and could provide it to clients, the agency gained approval from its family planning providers to use some allocations for family planning services and supplies to purchase the product. This centralized purchasing approach also ensured volume discount. Washington State agencies became leading purchasers and providers of the currently marketed dedicated emergency contraception product; from September 2000 to October 2003, DOH and Planned Parenthood of Western Washington (PPWW), the two largest emergency contraception purchasers in the state, purchased a total of 227,239 single-use packets of emergency contraception.⁵ Later, as demand increased, some groups responded by organizing local coalitions for emergency contraception procurement and volume discounts. DOH continues to provide emergency contraception to some programs, although its role in central purchasing has decreased.

Data collected by PPWW indicate that women who have received emergency contraception at clinics tend to come back and receive ongoing contraceptive methods. At the agency's clinics, which serve the largest population area in Washington, 76% of the 12,162 clients who came to the clinic over a 12-month period for emergency contraception only, and who were not using a regular contraceptive method, subsequently initiated use of some contraceptive.⁶ For an estimated 75% of the women who received emergency contraception, PPWW was able to provide the pills at no charge through the Take Charge program. For women not eligible for that program and not able to pay, the agency provided emergency contraception supplied by DOH for distribution at no cost. During the period 2001–2003, for example, DOH allocated 10,764 emergency contraception doses to PPWW.

For years, public health nurses with the First Steps Maternity Support Services advocated the delivery of contraceptives through state maternity services as a way to increase access to family planning. In 2000, DOH developed a pro-

ocol⁷ for delivery of emergency contraception in advance of need during home visits to women at risk of unintended pregnancy. This protocol, under which the nurses receive verbal, individualized orders, was piloted in one local health jurisdiction. As of 2005, nine local health jurisdictions and one tribal program allowed this approach.

DOH also revised a risk management tool that the largest malpractice insurer in the state provides to covered physicians. The updated version of the form includes a check-off for “emergency contraception dispensed” in the postpartum care section.

DOH and DSHS have thoroughly integrated emergency contraception into their family planning information and education materials and services. For example, information about the method is a menu option on state family planning hotlines and crisis hotlines, which provide information about it, and the national emergency contraception hotline (1-888-NOT-2-LATE). Emergency contraception fact sheets and brochures are now a regular part of the DSHS publication inventory, and providers can order them as needed free of charge. DOH and DSHS Web sites provide information about emergency contraception, including locations where the method can be obtained and how it is covered by multiple state programs. The Head Start newsletter, which is sent to women soon after they have given birth, includes information about spacing pregnancies and emergency contraception.

LOOKING BACK

The interviews PATH conducted in 2003 with key individuals in the process of expanding access to and awareness of emergency contraception in Washington State focused on programmatic considerations regarding service provision, perspectives of frontline providers and lessons learned that could benefit similar efforts elsewhere. A review of the interview transcripts highlighted several common themes at the state and community levels. Those interviewed agreed that making emergency contraception widely available takes time and persistence, and that it is essential to keep emergency contraception on the agenda at all levels while building on small successes.

Administrators and program managers emphasized the importance of common values and an understanding of the social norms in a community in building support for emergency contraception. A common desire for healthy women, children and families, for example, can be the basis for starting a discussion about unintended pregnancy. State-specific data can bring home the health, social and economic benefits of preventing unintended pregnancy, and this in turn can provide a context for prioritizing the provision of emergency contraception. It also is important to communicate these messages to various state health care and social service systems. In Washington, DOH and DSHS leaders knew and understood a wide range of state programs, and they worked to establish relationships and collaborate on strategies for building emergency contraception services into existing programs and networks.

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Frontline providers of health and social services expressed confidence that communities know what will work in their own setting. By decentralizing emergency contraception provision and allowing communities to decide the best approach for expanding access, a state initiative can take advantage of local partners' experience, insights and creativity. Some providers emphasized advance provision of emergency contraception as the best way to promote use, when needed. Flexibility allowed by decentralization enables providers to seek collaborations to expand emergency contraception access. As residents of the communities they served, providers also had insight into local perceptions, and believed that a locally centered approach that creates dialogue among people of diverse persuasions can help avoid active opposition to emergency contraception.

LOOKING AHEAD

The experience in Washington State illustrates that state agencies and local partners can work together effectively to expand women's options for preventing unintended pregnancy. While laws and practices vary from state to state, determination and commitment to the well-being of women, children and families, along with an openness to innovative ways of using existing resources and programs, can increase access to emergency contraception. The approach centers on maximizing opportunities for reaching women who need help to ensure that their next pregnancy is an intended one.

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