FPNTC
FAMILY PLANNING
NATIONAL TRAINING CENTER

CONTRACEPTIVE ACCESS CHANGE PACKAGE

UPDATED MARCH 2020

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FPNTC is supported by the Office of Population Affairs of the U.S. Department of Health and Human Services (FPTPA006028-01-00). The information presented does not necessarily represent the views of OPA, HHS, or FPNTC member organizations.

INTRODUCTION

Every woman has a right to have the information and resources she needs to make personal decisions about her own life, including when or if she wants to be pregnant, and to choose if and when she wants a family. Yet nearly half (45%) of all pregnancies in the U.S. are unintended.[1] According to *Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs (QFP)*, family planning services can help reduce unintended pregnancy and other public health challenges by providing education, counseling, and medical services.[2] Utilizing the current literature and guidelines, this *Contraceptive Access Change Package* provides recommendations for how to increase access, uptake, and continuation of the most effective and moderately effective methods of contraception among patients who could become pregnant, but wish to avoid pregnancy at this time. The ultimate goal of the recommendations is to ensure that patients, regardless of life circumstances or ability to pay, can make informed choices about their reproductive health based on accurate information and have access to the full range of contraceptive methods.

GOAL OF THE CHANGE PACKAGE

The goal of this change package is to support Title X grantees' performance improvement on the following two measures.

- **An intermediate outcome measure:** The percentage of women aged 15-44 years at risk of unintended pregnancy that is provided a most effective (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately effective (i.e., injectables, oral pills, patch, ring, or diaphragm) FDA-approved methods of contraception
- **A contraceptive access measure:** Percentage of women aged 15-44 years at risk of unintended pregnancy that is provided a long-acting reversible method of contraception (i.e., implants, intrauterine devices or systems [IUD/IUS], also referred to as LARC)

A specific benchmark has not been set for the intermediate outcome measure, and it is not expected to reach 100%, as some women will make informed decisions to choose methods beside the most and moderately effective methods, even when offered the full range without barrier. The goal of providing contraception should never be to promote any one method or class of methods over women's individuals choices.

The LARC access measure is intended to be used to identify service sites reporting rates well below the mean which may signal the presence of barriers to LARC provision. The LARC access measure should not be used to encourage high rates of use, as this could lead to coercive practices related to contraception and sterilization, especially practices targeting racial/ethnic minorities and low-income individuals. All services should be provided solely on a voluntary basis. Patients should never be coerced to use or not use any particular method of family planning.

Based on a review of scientific literature and established guidelines, four best practices have been identified. A visual representation of these best practices and associated drivers is on the following page (Figure 1).

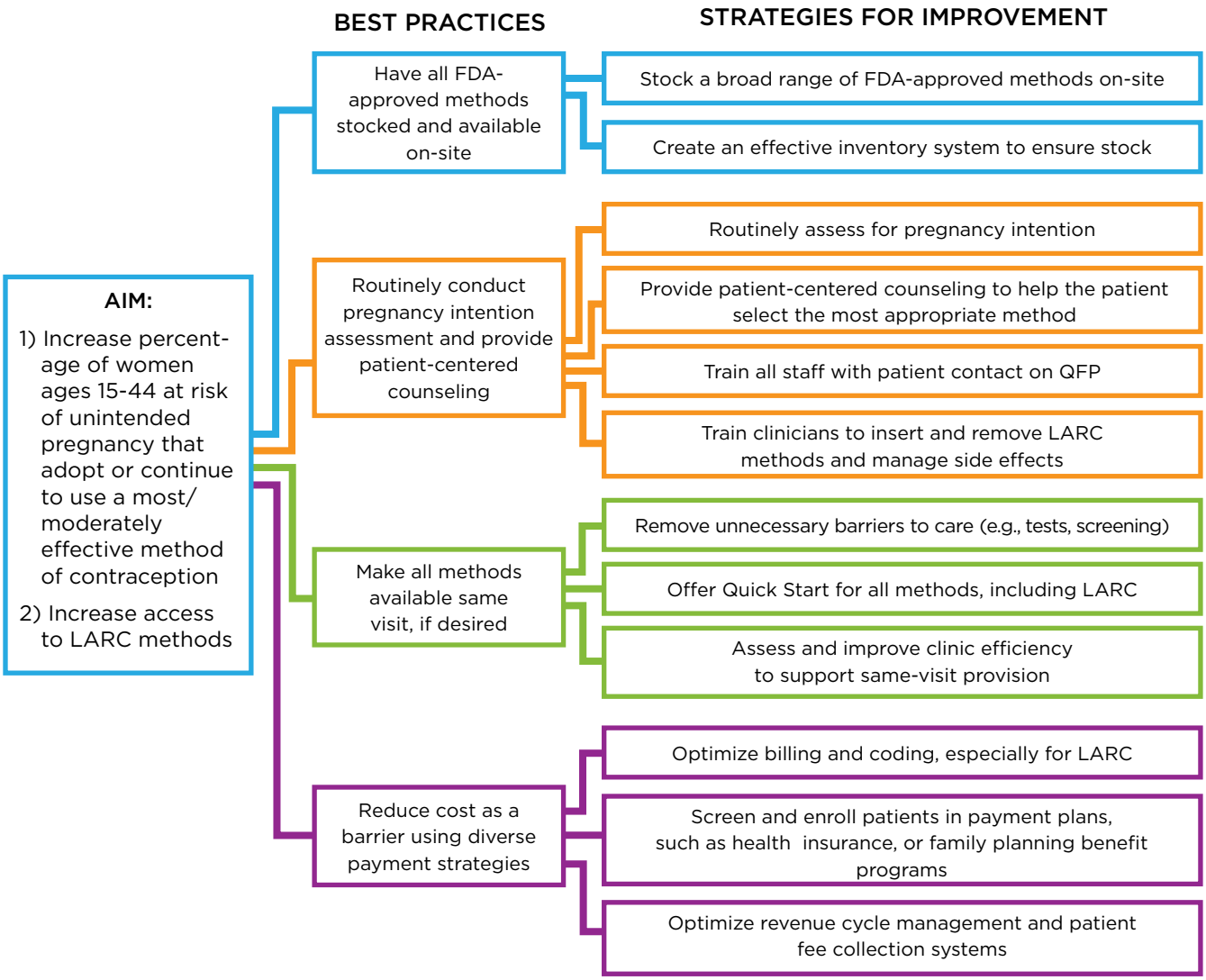
» **Best Practice 1.** Stock a broad range of contraceptive methods including all provider-dependent FDA-approved contraceptive methods.

» **Best Practice 2.** Discuss pregnancy intention and support patients through evidence-informed, patient-centered counseling that enables them to choose from the full range of contraceptive methods if they do not desire pregnancy presently.

» **Best Practice 3.** Develop systems for same-visit provision of all contraceptive methods, at all visit types. Make it possible for patients, including women who choose LARCs, to leave their visit with their selected contraceptive method.

» **Best Practice 4.** Utilize diverse payment options to reduce cost as a barrier for the facility and the patient. Inform patients about self-pay, sliding fee schedules, and insurance enrollment options. Ensure access to services regardless of ability to pay.

FIGURE 1. Driver Diagram



HOW TO USE THIS CHANGE PACKAGE

This change package is designed to support sites when developing a comprehensive strategy for increasing contraceptive access. Specifically, this change package can help support efforts to:

- Increase awareness of best practice strategies associated with increasing contraceptive access
- Conduct a readiness assessment by comparing best practices with existing practices in a clinic
- Select high-impact strategies to implement in a clinic
- Select evaluation measures to test impact of changes

A supplementary set of tools that can support implementation of these strategies can be found on the FPNTC.org website. The five-part series of eLearning modules on Quality Improvement in Family Planning can help you:

- Conduct a quality improvement (QI) readiness assessment;
- Establish a QI foundational infrastructure (e.g., development of a QI team, coordinator, data monitoring system);
- Use a methodical QI approach;
- Conduct small tests of change (Plan-Do-Study-Act cycles); and
- Use data to drive processes.

Sites are encouraged to engage with other family planning sites to discuss implementation of these strategies and QI processes.

BEST PRACTICES

BEST PRACTICE 1.

Stock a broad range of contraceptive methods including all provider-dependent FDA approved contraceptive methods.

RATIONALE

A full range of contraceptive methods should be accessible and available onsite. Providing a method that best fits a patient's unique circumstances is patient-centered and a core characteristic of quality care.[2, 3] Services should be provided on a purely voluntary basis and patients should not be coerced to use, or not use, any particular contraceptive methods. Patients who obtain their method of choice are more likely to use it consistently and correctly and have higher satisfaction and continuation rates.[2] Stocking all methods requiring provider intervention (such as LARC) and hormonal injections in advance of request, is crucial to ensuring full access to care, since a large percentage of patients do not return for follow-up visits. Since there is no medical reason to routinely require multiple visits to initiate any contraceptive method (provided that the health care provider can be reasonably certain that the patient is not pregnant),[4] having a broad range of methods available onsite for same-visit delivery can reduce a substantial burden for patients in obtaining their preferred method. Title X clinics are required to stock a "broad range" of acceptable and effective contraceptive methods.[5]

STRATEGIES

» Stock a broad range of contraceptive methods on-site. At a minimum, all provider-dependent methods should be stocked on-site. Approved methods include:[6]

- Services or referral for sterilization (vasectomy, abdominal, laparoscopic, hysteroscopic);
- Hormonal implant;
- Levonorgestrel intrauterine device (LNG IUD)
- Copper intrauterine device (Cu IUD);
- Hormonal injection;
- Oral contraceptive;
- Contraceptive patch;
- Vaginal ring;
- Diaphragm and cervical cap;
- Sponge;
- Condoms (male and female); and
- Spermicide.

» Ensure same-visit access to fertility awareness-based methods (FABM).

» Inform patients about the availability of emergency contraception. Make the process of obtaining emergency contraception as streamlined as possible. Provide patients an advance supply or prescription of emergency contraceptive pills on-site or by prescription, if requested.[2]

» Optimize the inventory system for sustainable management and stocking of contraceptives, including:[7]

- Forecast the range and number of each method needed;
- Conduct a regular (e.g., monthly) inventory of stock;
- Monitor internal prior monthly utilization reports and PAR system;
- Monitor dispensing amounts and adjust ordering accordingly; and
- Utilize a "buy and bill" approach (for procurement of methods stocked on-site).

» Seek opportunities to obtain low-cost supplies including:

- Volume discounts, wholesale ordering, 90-day net terms and other payment options;
- Patient assistance programs;
- Centralized ordering; and
- 340B pharmacy pricing.

TOOLS AND RESOURCES

- CDC Pocket Guide to Managing Contraceptive Supplies (Source: CDC)
- LARC Modeling Tool (Source: CAI Global)
- UCSF's IUD/Implant Guide to Reimbursement (Source: UCSF, NFPRHA, ACOG et al)

SUGGESTED EVALUATION MEASURES

- # of contraceptive methods available onsite on the 15th of the month
- # of each contraceptive method stocked on the 15th of the month

SUCCESS STORIES

Prior to March 2016, **Cameron County Department of Health and Human Services (CCDHHS)**, a sub-recipient of Women's Health and Family Planning Association of Texas, did not stock IUDs on site. A challenge for them has been that a majority of their patients are below the federal poverty level (FPL), and a large number do not have coverage for high-cost contraceptives. Liletta offers a low-cost option for the site using 340B pricing. CCDHHS reached out to another site in their network that had already planned a Liletta insertion training and was able to train their one clinician on Liletta insertion. They established an account with Liletta and ordered 20 IUDs; they also ordered 40 Nexplanon. Over 20 Nexplanon and three Liletta were inserted between March and May 2016. Now with a stock of LARC methods on-site, they have the ability to provide same-visit LARC when patients request it. CCDHHS continues to monitor their inventory to ensure that current stock adequately meets client demand.

Southern Nevada knew that some of their patients wanted Nexplanon, but prior to May 2016 they were not able to provide this method to their patients consistently. To increase access and meet the needs of their patients, they focused on making this available in their clinic. They developed a policy for Nexplanon, arranged for an insertion training for the provider, and ordered the devices. They also prepared Nexplanon insertion kits with everything the provider might need, to facilitate the insertion process for their provider. Within a two-month window, they inserted 27 Nexplanon at their **East Las Vegas Clinic** and 14 at their **West Las Vegas Clinic**. The proportion of women using a LARC method increased from 13% in March to 16% in May, and these patients were grateful for access to their chosen method.

BEST PRACTICE 2.

Discuss pregnancy intention and support patients through evidence-informed, patient-centered counseling that enables them to choose from the full range of contraceptive methods if they do not desire pregnancy presently.

RATIONALE

Evidence-informed counseling helps patients identify the most appropriate contraceptive method for them. According to QFP, there are five principles for quality contraceptive counseling.[2] Providers should: 1) establish a rapport with the patient; 2) assess and respond to individual patient needs; 3) assist in the development of a pregnancy intention and/or reproductive life plan; 4) provide patients information in an understandable way; and 5) confirm patient understanding of the material. Adhering to this patient-centered counseling approach can contribute to increased knowledge and use of contraception, particularly the most effective methods, as well as satisfaction with services.[2] Using a patient-centered approach reduces the risk for reproductive coercion and provider bias. Unfortunately, health care professionals have not always been unbiased in providing reproductive health services and some patients continue to report feeling coerced, or having received racially-biased counseling.[8-13]

One approach to contraceptive counseling is to begin by discussing reproductive intentions with all patients. Asking the question, "Do you think you would like to have (more) children someday?" is an introduction to the conversation that opens the door for further discussion of reproductive health needs—including contraception.[22] The CDC recommends that providers take every opportunity to engage patients—both men and women—in a conversation about reproductive life planning. Reproductive life planning encourages the patient to think about whether or when she or he wants to have children and how best to meet goals.[14]

Although the concept of "planning" for pregnancy may not work for everyone, for some patients whose initial reason for visit was not related to preventing or achieving pregnancy, discussing pregnancy intention and/or reproductive life planning may help identify unmet reproductive health care needs.[14, 15] Use a patient-centered, responsive approach to the conversation. CDC's *Reproductive Life Planning Guidelines* support women to make their own decisions about what, if any, method is most appropriate for them at that time. Men can be engaged in a conversation about reproductive intention by using the same guidelines.[15] Not only does this approach encourage men to also consider their future and desires, but may help ensure the information is accurately reinforced among female patients. Women are influenced by sexual partners, but there has been a documented lack of awareness of methods, particularly lesser known LARC methods.[16] Evidence suggests that incorporating goal setting and developing action plans have been associated with increased contraceptive use, increased correct use of contraceptives, increased use of more effective methods, and increased knowledge.[17-21] It is important to emphasize that counseling should help patients make an informed choice, even if it is not what the provider would choose.[12]

STRATEGIES

- Follow QFP recommendations for discussing pregnancy intention and reproductive life plans. Discuss pregnancy intention routinely with all patients of reproductive age. The discussion should enable flexibility based on prior provider-patient conversations and on the patient's needs and characteristics.[2]
- Support patients in developing a pregnancy intention and/or reproductive life plan. Use one of the evidence-informed approaches to pregnancy intention assessment and/or reproductive life plan:

- Use the evidence-informed One Key Question® approach to start counseling: Would you like to become pregnant in the next year?[15]
- Consider alternative questions such as the four reproductive life planning questions or the following questions, which have been developed as patient-centered questions for reproductive goals assessment:[14,22]
  - Do you think you would like to have (more) children some day?
  - When do you think that might be?
  - How important is it to you to prevent pregnancy (until then)?

» If pregnancy is not desired in the next year, provide contraceptive services in response to the patient's identified goals and preferences in line with QFP recommendations:[2,24]

- According to QFP recommendations, quality contraceptive services have five steps:[2]
  1. Establish and maintain rapport with the client;
  2. Obtain clinical and social information from the client;
  3. Work with the client interactively to select the most effective and appropriate contraceptive method;
  4. Conduct a physical assessment related to contraceptive use, when warranted; and
  5. Provide the contraceptive method along with instructions among correct and consistent use, help the client develop a plan for using the selected method and for follow-up, and confirm client understanding.
- When counseling a patient about contraceptive methods that the patients can use safely, providers should ensure that patients understand:[2]
  - Method effectiveness;
  - Correct use of method;
  - Non-contraceptive benefits;
  - Side effects; and
  - Protection from STDs, including HIV.

» Start by asking, "What is important to you in a birth control method?"[22]

- Starting this open-ended question lets the patient identify what considerations are most important to them, and can direct the conversation to the methods that best fit with the patients preferences and priorities.

» Depending on concerns, contraceptive counseling may also include:

- Potential barriers to use, such as mental health and substance; use behaviors, intimate partner violence and sexual violence;[2]
- Patient concerns about confidentiality;
- Cost; and
- Access requirements (e.g., a visit to a provider for insertion).

» Provide information to patients in a way that makes it readily understood by clients:[2]

- For most patients, communication and materials should be written at a 4th-6th grade reading level;
- Deliver information in a culturally and linguistically appropriate manner (e.g., use the patient's primary language whenever possible);
- Communicate numeric quantities in a way that is easily understood (e.g., to explain the risk of pregnancy use 'less than one out of 100,' 'to 2 out of 3,000,' or '18 out of 100');
- Present balanced information on risks and benefits and frame messages positively;

- Use teaching aids when counseling, including visual aids; and[23]
- Consider showing models of methods to patients, especially for methods (e.g., IUDs, implants, and vaginal rings) that they may not be as familiar with

» Train staff with patient contact on:

- QFP recommendations;
- Patient-centered contraceptive counseling protocol and skills;
- Contraceptive method options, how to use the method accurately and consistently, effectiveness, associated benefits, side effects, and warning signs for complications;

SUCCESS STORIES

Arizona Family Health Partnership set the goal that by May 2016, 60% of their female patients seen in the **Theresa Lee Public Health Center** would have documented reproductive life plans, a 20% increase from their baseline. They scheduled a training (providers were required to attend) that included an overview of reproductive life planning, how to document the reproductive life plan in the patient's record, and standardized messaging for providers to use. Over 20 providers attended. Using a pre/post-test, they were able to measure an increase in staff knowledge of reproductive life planning questions, when and how often to ask these questions, and how to document the results. A chart audit conducted two months after the training revealed that 79% of women had reproductive life plans documented, exceeding their initial goal of 60%.

Unity Health Care is a federally-qualified health center located in Washington, DC. It, too, identified an unmet need for discussion of pregnancy intention and/or reproductive life planning among primary care patients. To get buy-in from primary care physicians in the center, they educated providers on the potential impact of assessing pregnancy intention on the clinical performance measure related to trimester of entry into prenatal care that all health centers report through the Uniform Data System. By assessing women's pregnancy intention, staff at Unity hypothesized that they could link women who desired pregnancy to prenatal care earlier, while also linking women who sought to delay pregnancy to contraceptive methods. Pregnancy intention screening is now practice-wide, and they saw an increase in the proportion of women using most and moderately effective methods from 62% to 68% between October 2015 and May 2016 at the **Upper Cardoza Health Center** pilot site.

New Jersey Family Planning League's Paterson site tested a strategy to increase the frequency of assessing pregnancy intention. They provided training on reproductive life planning for all staff, including front desk staff. The training consisted of an overview of reproductive life planning questions and role plays for staff to practice new skills. Clinic staff say that this comprehensive training dramatically improved counseling flow and comfort related to assessing pregnancy intention. New Jersey Family Planning League then collected data on the rates of documented reproductive life plans. A chart audit in March 2016, after the staff training, revealed that 90% of patients had a documented reproductive life plan at the Paterson site.

- Contraceptive method myths and misinformation; and
- Method-specific eligibility criteria, including the most recent guidelines from CDC, ACOG, and AAP regarding eligibility for LARC.[24-26]

» Train core clinical staff to:

- Insert and remove IUDs and implants;
- Manage complications; and
- Manage side effects (especially bleeding).[4]

» Have a written and widely circulated policy stating that services must be provided solely on a voluntary basis, and that individuals must not be subjected to coercion to receive services or to use or not to use any particular method of family planning.[5]

TOOLS AND RESOURCES

» Providing Quality Contraceptive Counseling and Education: A Toolkit For Training Staff (Source: FPNTC)

» Birth Control Method Options: A Job Aid for Patient-Centered Counseling (Source: FPNTC)

» Explaining Contraception: A Job Aid for Patient-Centered Counseling (Source: FPNTC)

» Bedsider.org

» One Key Question (Source: Oregon Foundation for Reproductive Health)

» Adolescent Health Care 101: The Basics (Source: Adolescent Health Working Group)

SUGGESTED EVALUATION

MEASURES

» # of and % of staff with patient contact trained on QFP recommendations

» # of and % of staff with patient contact trained on patient-centered counseling protocol

» # of and % of staff with patient contact trained on reproductive life planning

» # of and % of patients with a documented reproductive life plan in their record

» # of and % of clinicians trained to insert and remove IUDs

» # of and % of clinicians trained to insert and remove implants

BEST PRACTICE 3.

Develop systems for same-visit provision of all contraceptive methods, at all visit types. Make it possible for patients, including women who choose LARCs, to leave their visit with their selected contraceptive method.[†]

RATIONALE

Patients should be offered the option to begin contraception at the time of visit rather than waiting for her next menses, or returning for another appointment (also known as Quick Start).[2] There is no medical reason to routinely require multiple visits to initiate any contraceptive method if the provider can be reasonably sure that the patient is not pregnant.[4] Although it has been common practice to require multiple appointments for methods such as the IUD or implant, there is now agreement among CDC, ACOG, and other organizations that clinicians can initiate and provide the patient's method of choice in a single visit, unless additional testing is medically indicated.[4, 25, 27] If a patient seeks pregnancy testing, a negative pregnancy test result provides an opportunity to discuss pregnancy intention and/or reproductive life plan and ongoing reproductive health needs. Ideally, these services are offered during the same visit because patients might not return at a later time for services.[2, 28] All services should be provided on a voluntary basis, and the patient should not be coerced into using a method, or selecting any particular method.

STRATEGIES

» Remove unnecessary barriers to contraceptive access:[2, 4]

- The following examinations and tests are not needed routinely to provide contraception safely to a healthy patient (although they might be needed to address other non-contraceptive health needs):[4]
  - Pelvic exams, unless inserting an IUD or fitting a diaphragm;
  - HIV screenings;
  - Cervical cytology or other cancer screening, including clinical breast exam; and
  - Laboratory tests for lipid, glucose, liver enzyme and hemoglobin levels or thrombogenic mutations.
- Conduct STD screening, in accordance with CDC's *STD Treatment Guidelines*.[29] If a patient has not been screened according to these guidelines, screening can be performed at the time of IUD insertion, and insertion should not be delayed. Patients with purulent cervicitis or current chlamydial or gonorrhea infection should not undergo IUD insertion until appropriate testing and treatment occurs.[4, 29]

» Offer emergency contraception (Cu-IUD or pills) when appropriate.

- The Cu-IUD is highly effective as emergency contraception; it can be inserted within 5 days of the first act of unprotected sexual intercourse as an emergency contraceptive and continued as regular contraception.
- Emergency contraceptive pills should be taken as soon as possible within 5 days of unprotected sexual intercourse. UPA and levonorgestrel ECPs have similar effectiveness when taken within 3 days after unprotected sexual intercourse; however, UPA has been shown to be more effective than the levonorgestrel formulation 3–5 days after unprotected sexual intercourse. The combined estrogen and progestin regimen is less effective than UPA or levonorgestrel and also is associated with more frequent occurrence of side effects (nausea and vomiting). The levonorgestrel formulation

[†]Provided that the health care provider can be reasonably certain that the patient is not pregnant.

might be less effective than UPA among obese women.[4]

» Offer emergency contraception (Copper IUD or pills), when appropriate.[4] According to *ACOG Emergency Contraception Practice Bulletin*, there are three Level A recommendations:[30]

- Compared with the levonorgestrel-only regimen, ulipristal acetate is more effective and maintains its efficacy for up to 5 days.
- Compared with the combined hormonal regimen, the levonorgestrel-only regimen for emergency contraception is more effective and is associated with less nausea and vomiting.
- The most effective method of emergency contraception is copper IUD insertion.

» Develop and implement the necessary administrative and clinical support systems to increase efficiency and support immediate/same-visit access to all methods, for instance:

- Offer flexible hours, such as during the evening or weekend;[31]
- Provide or prescribe multiple cycles (ideally a one-year supply) of oral contraceptive pills, patch, or ring at one time;[2]
- Do not require appointments for routine method refills;
- Pre-verify contraceptive insurance benefits for contraception;
- Assess and improve clinic flow to maximize operational efficiency;
- If staffing allows, schedule time with a trained non-clinician family planning counselor before time with clinician during visit;
- Allocate time in clinician schedule to provide contraception during a single visit (including IUD/implant insertions);
- Develop standard protocols and paperwork for all methods available; and
- Create pre-made contraceptive method packets that include items such as consent forms, instruments, cervical prep, STD swab (if applicable).

TOOLS AND RESOURCES

NATIONAL GUIDELINES

» How to Be Reasonably Certain That a Woman is Not Pregnant; When to Start Using Specific Contraceptive Methods (Source: CDC)

» U.S Selected Practice Recommendations 2016 (Source: CDC)

» U.S Medical Eligibility Criteria (MEC) for Contraceptive Use, 2016 (Source: CDC)

» U.S MEC and SPR App (Source: CDC)

» 2015 STD Treatment Guidelines Print Version (Source: CDC)

» 2015 STD Treatment Guidelines App for Android and Apple Devices (Source: CDC)

CLINIC FLOW RESOURCES

» Clinic Efficiency Dashboard (Source: FPNTC)

» Using Data to Increase Clinic Efficiency: A Quality Improvement Guide (Source: FPNTC)

» Reducing Patient Wait Time Video (Source: FPNTC)

- LARC Insertions and Removal Material Checklists (Source: UCSF)
- Bedsider article on Copper IUD as emergency contraception (Source: Bedsider)
- Support Staff Toolkit: Information About Contraceptive Methods for Support Staff (Source: Upstream)

SUGGESTED EVALUATION MEASURES

- # of and % of women who received contraceptive method on day of initial visit, among women who received any most or moderately effective method of contraception
- # of and % of women who received contraceptive method on day of initial visit, among women who received a LARC

SUCCESS STORIES

When **Johnston County Public Health Department**, a sub-recipient of the **North Carolina Department of Health and Human Services,** explored barriers to same-visit provision of LARC, they discovered that they did not have enough stocked methods on-site to offer it to women who desired it. They worked with their finance department to purchase and maintain an inventory of LARCs on site. Managers provided finance staff with the number of inserts from previous months, as well as cost and reimbursement rates, which helped justify the need to order and maintain an adequate number of LARCs on-site. The proportion of LARC insertions provided on the same day as the patient's initial consult increased from 36% in November 2015 to 50% in May 2016.

When **Nebraska Reproductive Health** analyzed barriers to LARC access, they found that their systems did not support same-visit provision of LARC. They subsequently changed their policy to allow for same-visit insertions, and adjusted their scheduling system to have one appointment type with a standard length to maximize flexibility and efficiency of the clinic schedule. To support these changes, they now educate providers and administrators about the benefits of same-visit insertion and the importance of making this service available. They are continuing to evaluate the impact of these changes, asking clinic staff, "Do things seem to be running more smoothly now?" They are also considering additional ways to change systems and provider behaviors to support same-visit insertion for patients who desire it, including scheduling trainings on reproductive life planning and patient-centered counseling.

With support from the **Louisiana Department of Health and Hospitals' Office of Public Health, the Rapides Parish Health Unit** was able to offer same-visit provision of LARC relatively early compared to peer sites. A number of strategies contributed to this success.

First, all clinicians were trained on all methods. Second, they put together LARC insertion kits and stored them in exam rooms. Third, they staggered clinicians' lunch schedules to ensure that someone was always available for an insertion. An experienced clinician's buy-in greatly contributed to the success of their efforts. The clinician shared guidelines to support same-visit provision as well as his own experiences with these process changes. Having a clinician champion led credibility to the effort and ultimately normalized same-visit provision of LARC in the clinic.

BEST PRACTICE 4.

Utilize diverse payment options to reduce cost as a barrier for the facility and the patient. Inform patients about self-pay, sliding fee schedules, and insurance enrollment options. Ensure access to services regardless of ability to pay.

RATIONALE

Cost has historically been a significant barrier to contraceptive use, especially for IUDs/implants which have high upfront costs for patients (to pay) and providers (to stock on-site).[31] The Affordable Care Act has increased access to contraception for those with health insurance, as it requires most health insurance companies to cover FDA-approved contraceptive methods without cost-sharing.[32, 33] Enrolling eligible patients in insurance and ensuring they remain enrolled is a priority for increasing access to contraception. For providers, increasing insurance coverage means that quality services can be appropriately reimbursed, which makes offering contraception more financially sustainable. However, gaps in coverage remain and cost may still pose a substantial barrier for the uninsured or underinsured.[34] The Title X Family Planning Program is the only Federal program dedicated solely to the provision of family planning and related preventive health services. The program is designed to provide contraceptive supplies and information to all who want and need them, with priority given to persons from low-income families.[5] Research shows that removing cost barriers increases the adoption of contraception, empowers individuals to choose the most appropriate and desired method for them, and results in increased continuation rates and satisfaction over time.[31]

STRATEGIES

» Ensure organizational policy includes the following:[5]

- Patients must not be denied services or be subjected to any variation in quality of services because of inability to pay;
- Projects should not have a general policy of no fee or flat fees for the provision of services to minors, or a schedule of fees for minors that is different from other populations receiving family planning services;
- Patients whose documented income is at or below 100% of the federal poverty level (FPL) must not be charged, although projects must bill all third parties authorized or legally obligated to pay for services;
- A schedule of discounts is required for individuals between 101% and 250% FPL;
- For families over 250% FPL, charges must be made in accordance with a fee schedule to recover the reasonable cost of providing services;
- Eligibility for discounts for unemancipated minors must be based on the income of the minor;
- Where there is legal obligation or authorization for third-party reimbursement, including public or private sources, all reasonable efforts must be made to obtain third-party payment without the application of any discounts; and
- Reasonable efforts to collect charges without jeopardizing client confidentiality must be made.

» Obtain third-party reimbursement for patients with, who are eligible for, third-party coverage such as private insurance, Medicaid, or family planning benefit programs;

- Regularly review and, if necessary, re-negotiate contracts with insurance companies, including Medicaid managed care organizations, to ensure up-to-

date reimbursement rates; and

- Work with state Medicaid to establish new payment strategies and ensure all related services are covered.

» Optimize billing and coding for contraceptive care, especially LARC:

- Conduct quality assurance procedures to ensure coding for contraception is accurate to ensure reimbursement; and
- Conduct training, as needed, for providers, administrative, and billing staff to ensure full reimbursement for services rendered.

» Provide insurance eligibility screening and application assistance for all patients identified as in need on-site or by referral:[35]

- Provide access to a certified application counselor (CAC), Navigator, or other Marketplace Assister on-site or develop a formal linkage with federally qualified health centers or other organizations that can provide enrollment assistance;
- Train financial staff to refer patients without insurance or in difficult financial situations to enrollment assistance services;
- Educate all staff including front desk/ receptionist staff to answer basic questions about eligibility/enrollment and where patients can go to apply or renew; and
- Post "apply and renew" signage in public waiting spaces with information on how to connect with an enrollment assistance worker. Include information about financial assistance available in brochures, signage, and other promotional materials.[35]

» Optimize revenue cycle management and patient fee collection protocols:[36]

- Consider asking for donations. Voluntary donations from clients are permissible; however, clients must not be pressured to make donations, and donations must not be a prerequisite to the provision of services or supplies.[5]
- Bill third-party payers when possible.
- Charge all patients as appropriate. Projects should not have a general policy of no fees for minors, or a schedule of fees for minors that is different from other populations. Eligibility for discounts must be based on the income of the minor."[5]
- Inform patients about device manufacturer payment plans and patient assistance programs.
- Collect copays at the time of visit.
- With regard to insured patients, family income should be assessed before determining whether copays are charged. Patients whose family income is at or below 250% FPL should not pay more (in copays or additional fees) than what they would otherwise pay when the schedule of discounts is applied.

» Identify and access all available sources of revenue including private and grant funding.

TOOLS AND RESOURCES

» Getting the Coverage You Deserve Toolkit (Source: NWLC)

» Clinic Confidential Billing Algorithm (Source: STD TAC)

» Confidential and Covered Staff Workflow (Source: NFPRHA)

» Sample Financial Policy (Source: NFPRHA)

» Sample Patient Policy and Form (Source: NFPRHA)

» Billing and Coding e-Learning Series (Source: FPNTC)

» Coding Guidelines for Contraceptives (Source: Upstream)

» Credentialing Job Aid (Source: FPNTC)

» IUD/Implant Guide to Reimbursement (Source: UCSF, NFPRHA, ACOG et al)

» Financial Sustainability Dashboard

(Source: FPNTC)

- Revenue Cycle Metrics (Source: STD TAC)
- Common ICD 10 Codes for Family Planning (Source: FPNTC)

SUGGESTED EVALUATION MEASURES

- # of new on-site insurance enrollments conducted in prior month
- # of referrals to insurance enrollment assistance offsite in the prior month
- % of patients who are uninsured
- % of total program revenue from patient fees
- % of total program revenue from third-party payers (private or public)

SUCCESS STORIES

In October 2015, **Charles County Health Department**, a sub-recipient of **Maryland Department of Health and Mental Hygiene** did not have any contracts with third-party payers. They set a goal of one contract by the end of May 2016. They began by reaching out to other recipients of Title X funding in Maryland. They identified two insurance companies with which to contract. Working with Charles County Health Department's fiscal officer, they credentialed the providers in their organization and contracted with two insurers. By May 2016, they were billing both insurers, exceeding their initial goal of one. Strong and regular communication with their fiscal office has been critical to success.

When a new clinician arrived at **East Georgia Healthcare Center**, a federally-qualified health center and sub-recipient of **The Family Health Centers of Georgia's Title X Program**, she was surprised to learn that they were not actively enrolling patients in Planning for Healthy Babies (P4HB), a Georgia state insurance program that covers contraceptive services for uninsured and underinsured patients. Patient representatives were trained to identify potential applicants, help applicants to complete the application upon arrival at the clinic, and provide a warm handoff to navigators who could then submit the application and follow up on approvals. Simultaneously, the grantee organization worked on becoming a verification site, which made applications easier to process. Since October 2015, East Georgia Healthcare Center submitted 112 applications, of which 36 were approved.

Family Health Council of Central Pennsylvania wanted to focus on ensuring reimbursement from third-party payers and began by investigating what codes should be used and creating a protocol for how to bill LARCs inserted during the same visit to third-party payers. After analyzing the data, they discovered some quality issues in coding practices at the **Lebanon Family Health Services** site. They identified problems with incorrect coding for some services and realized they were not always getting paid. These problems motivated the site to institute a formal training for all staff including clinicians, supervisors, clinician assistants, front desk and billing staff on coding and billing procedures. They stressed the importance of accurate coding for the health of the organization and to ensure third-party reimbursement for services provided to patients with private and public health insurance. All staff contributed to the success of the initiative.

Montana Department of Public Health and Human Services Women's and Men's Health Section took a multifaceted approach to reducing cost as a barrier, beginning with their sub-recipient, **Bridgercare**. This included pre-verifying patient benefits prior to visits, utilizing a sliding fee scale, increasing their application assistance on-site for Montana's Medicaid program, and purchasing and stocking the low-cost IUD, Liletta. Between October 2015 and May 2016, the percent of women 15-44-years-old with pre-verified insurance information increased from 70% to 100%. Also over that time, the percentage of women using most or moderately effective methods increased from 80% to 86% and the percentage of women choosing LARC increased from 11% to 16%.

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