National Institute for Reproductive Health

PROVIDING CONTRACEPTIVE IMPLANTS AT TIME OF MEDICATION ABORTION

A CASE STUDY FROM PLANNED PARENTHOOD LEAGUE OF MASSACHUSETTS

Using a framework that centers patient autonomy and choice, the National Institute for Reproductive Health (NIRH)'s LARC Access Project supports organizations across the country who are working to address barriers to LARC, with the ultimate goal of increasing access to the full range of contraception. In 2016, NIRH partnered with organizations in Massachusetts, New Mexico, New York, Tennessee, and Utah to implement innovative strategies that addressed challenges impacting LARC access in their states. This case study, led by Planned Parenthood League of Massachusetts (PPLM) in Boston, was conducted as part of the 2016 NIRH LARC Access Project.

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INTRODUCTION

While providing long-acting reversible contraception (LARC) at the time of aspiration abortion is an established practice, it has not been routine to offer LARC, specifically etonogestrel implants, at the time of medication abortion until recently.[1] Reducing the number of visits a patient is required to make to obtain post-abortion LARC decreases barriers to access to highly effective contraception.[2] Initiating LARC at the time of abortion has also been shown to increase contraceptive utilization at six months.[3, 4, 5]

Providing Contraceptive Implants at Time of Medication Abortion: A Case Study from Planned Parenthood League of Massachusetts presents a model that may be useful for health centers interested in expanding patient access to LARC — specifically by offering the option of peri-abortion contraceptive implants, or implants during the same visit as a medication abortion.

This case study describes the steps taken by one reproductive health center to integrate provision of etonogestrel implants at the time of medication abortion into routine clinic operations. To support replication of this practice, it outlines staff workflow and patient visit flow, details billing and reimbursement processes, and highlights keys to success in the implementation process.

PROJECT BACKGROUND

Planned Parenthood League of Massachusetts ("PPLM" or "the health center") participated in a 2016 study sponsored by Gynuity Health Projects ("the study"), which found that initiating etonogestrel implants ("contraceptive implants") at the time of mifepristone administration was associated with increased use of highly effective contraceptive methods at six months and did not decrease the efficacy of the medication abortion regimen. This practice was also associated with increased patient satisfaction.[6]

The research team at Planned Parenthood League of Massachusetts saw these findings as an opportunity to improve patient access to highly effective contraception. The health center typically provides approximately 200 medication abortions and 300 aspiration abortions each month. Patients are routinely offered LARC for immediate insertion after an aspiration abortion, and approximately 30 percent of patients choose to receive one of these contraceptive methods at the time of abortion. However, **prior to this initiative, patients who chose medication abortion were required to return to the health center for a follow-up visit to confirm completion of abortion before they could receive LARC. Fewer than 50 percent of medication abortion patients returned for this follow-up visit.**

Fueled by support from NIRH and compelling results from the study, the health center's research team designed a pilot project to offer peri-abortion contraceptive implant insertion during a medication abortion visit at the time of mifepristone administration.

PREPARING FOR IMPLEMENTATION OF THE SERVICE

WHO WAS INVOLVED

The Vice President of Research and Clinical Training at PPLM first shared findings of the study with the health center's Executive Team and had discussions with the Medical Director and health center leadership about the importance of implementing this clinical change and to prepare for possible challenges associated with implementation. Once leadership agreed to proceed, the health center's Director of Research Operations served as the point person driving implementation of the pilot. Understanding that launching this new process would involve multiple departments within the health center, it was important to elicit input from each level of operations to ensure the development of a viable implementation plan. The Director of Research Operations engaged staff from finance and billing, health center management, clinical and health care assistant teams, reception, information technology, research, and the education department. From the earliest days of planning, the Director of Research Operations met with staff members individually and during regularly scheduled meetings to explain the results of the Gynuity Health Projects study and discuss plans to implement the project.

TIMELINE TO LAUNCH

Planning for and designing the pilot project began in spring 2016. During that time, inserting contraceptive implants at the time of mifepristone administration for medication abortion was not yet included in Planned Parenthood Federation of America's (PPFA) 2016 Medical Standards and Guidelines (MS&Gs). In order to implement the practice prior to official inclusion in PPFA's MS&Gs, the medical leadership of PPLM applied for and received a waiver to launch this pilot initiative. Then, after taking time to prepare the operations staff, including health care assistants (HCAs), clinicians, and billing and finance staff, the Director of Research Operations informed the teams of a September launch date.

PREPARATIONS WITH BILLING TEAM

With the implementation of any new process or service comes concern that insurers will reject claims. Although the health center was reimbursed routinely for contraceptive implants provided at the time of aspiration abortion, there was concern that insurers would reject these new claims on the basis that patients are still pregnant after mifepristone administration but before taking misoprostol, and therefore would not be eligible for LARC until complete abortion was confirmed.

To prepare for this scenario, the Vice President of Research and Clinical Training and the Director of Research Operations met with leadership from the finance team in the

spring of 2016 to discuss the potential financial risk. As part of the 2016 LARC Access Project, NIRH provided funding to prevent financial loss to the health center if claims were denied; this enabled the health center to use a "try and see" approach. Billing staff were committed to conducting pre-verification of insurance coverage of LARC and to tracking claims to monitor reimbursement.

PREPARATIONS WITH STAFF TEAMS

During the 2016 Gynuity Health Projects study, staff found that there was not as much patient demand for implants at the time of medication abortion as there was at the time of aspiration abortion. Because of this experience, staff did not anticipate that many patients would choose a peri-abortion contraceptive implant, making initiation of this new protocol seem manageable.

Health center staff were accustomed to providing medication abortions and inserting contraceptive implants, albeit at different visits. This pilot project required adjustments to counseling protocols and the development of new workflows and new billing processes, but it did not require the initiation of any new clinical services. Patient care staff were involved in devising an implementation strategy that included "retraining" to accommodate new workflow and patient flow processes (described below), but not new training.

During daily huddles, HCAs and advanced practice clinicians (APCs) were given the new medical protocols, including information on the evidence supporting the safety and benefits of offering peri-abortion contraceptive implants and how to offer contraceptive implants in the context of a medication abortion visit.

CHANGES TO COUNSELING AND CLINIC FLOW

It was necessary to make several changes to the clinic flow for a medication abortion visit at the health center, which involved retraining for staff. Contraception had always been routinely discussed at the "Pre-abortion Information Session," during which patients were given information about the abortion procedure as well as contraceptive counseling. Staff also began discussing the option for same-day contraceptive implant insertion in their contraceptive counseling.

At the health center, most medication abortion visits do not require a physical examination and are completed in a counseling room. However, patients who chose a contraceptive implant needed to be moved to a procedure room. After the medication abortion administration was complete, any patient desiring an implant was moved to a procedure room where the same clinician provided the insertion. The insertion procedure added about 15 minutes to the entire visit. When and how to move a patient to a procedure room for LARC insertion is now included in the onboarding training for new clinical staff.

CHANGES TO THE ELECTRONIC HEALTH RECORD

At the time of this pilot project, there was no place in the health center's Electronic Health Record (EHR) system, NextGen, to document peri-abortion contraceptive implant insertions with medication abortions. The health center's information technology (IT) group added a field to document this service to the NextGen medication abortion template. At the time of implementation, the health center had a full-time staff member in the IT department who was able to change templates and manage other EHR adjustments, so the only cost associated with these system changes was staff time.

In the first week of launching the new model, two patients received a contraceptive implant during their medication abortion visit. After two months, 11 patients had chosen this option, and after six months, 20 patients had. Given the volume at the health center, approximately 1.7 percent of medication abortion patients chose this option.

IMPLEMENTATION: HOW IT WORKS

PRE-VERIFICATION OF LARC COVERAGE

Because of the concerns regarding reimbursement for this service, the billing team implemented a workflow to verify insurance coverage the day prior to the abortion visit that was similar to that used for LARC initiation with aspiration abortions. The process was as follows:

1. **Staff ran a daily report** from the EHR practice management system, NextGen Enterprise Practice Management, which showed the week's upcoming appointment types and the insurance carriers on file for those patients.
2. **Staff called each of the insurance carriers** for those patients with upcoming appointments to determine the following:*
   - If the patient had elective abortion/GYN procedure coverage
   - If the patient had a deductible that had not been met and if that deductible applied to the patient's visit type
   - If the patient was responsible for a copayment on the date of service or should expect a bill for coinsurance
3. **A financial intake form was generated** within NextGen that detailed the patient's coverage and the amount owed on the upcoming date of service.
4. **Staff contacted patients** to discuss coverage, deductible information, and payment options when more than $50 would be owed on the date of service, a routine practice at this health center before for other procedures. Benefit information was explained to patients using the following language:

*While under the Patient Protection and Affordable Care Act (ACA) should be no patient cost-sharing for contraceptives, there are instances where reimbursement for the device is denied globally to the abortion procedure. This clinic also pre-verified LARC services for non-participating or out-of-state plans that tended to have more exclusions for services (e.g., grandfathered plans or plans with coverage for in-state providers only).

"Your insurance company has advised us that your procedure is covered at _____ percent, and you are responsible for $_____ at the time of your appointment. It is important that you know that benefit information given to us is not a guarantee of payment, and you may receive a bill for any services not covered in full by your insurance company."

This same language was used to address questions that came up in information sessions about insurance coverage for contraceptive implants at a medication abortion visit.

5. **Staff updated the appointment payment notes** indicating the benefits had been verified and a financial intake form has been completed.

VISIT FLOW PLAN

Staff designed and refined this patient visit flow plan:

1. Patient checks in and provides payment for abortion visit as needed depending on insurance coverage.
2. Patient goes to a room where an ultrasound is performed.
3. Patient goes to the lab for a hematocrit, Rh status, chlamydia and gonorrhea testing, and baseline hCG (if the patient prefers follow-up by hCG instead of ultrasound).
4. Patient goes to a counseling room for a "Pre-abortion Information Session," during which the patient is given information about the abortion and contraceptive counseling is provided. The patient signs an informed consent form for abortion and for an implant if patient desires a contraceptive implant that day.
5. Medical screening and evaluation is done by a physician or an APC, which includes a chart review to assess for implant eligibility.
6. APC or medical doctor (MD) gives patient mifepristone and dispenses misoprostol with instructions. The APC or MD also gives prophylactic antibiotics (and Rhogam if needed) and follows up about the patient's desired contraception.
7. If the patient wants a contraceptive implant:
   a. A HCA and/or registered nurse (RN) prepares a mobile cart with all the necessary implant insertion supplies (implant cart).
   b. The patient is moved to a room with an examination table.
   c. A HCA or RN brings the implant cart into the procedure room.
   d. The APC or MD does insertion.
8. APC or MD completes charting.
9. Patient checks out and provides required payment for implant.

BILLING

After the visit, the following codes were submitted to the insurance carrier, and reimbursements were tracked to ensure full payment:*

Medication Abortion	• S0190: Mifepristone, Oral, 200 mg • S0191: Misoprostol, Oral, 200 mcg • S0199: Medically induced abortion by oral ingestion of medication, including all associated services and supplies
Contraceptive Implant Insertion	• J7307: Etonogestrel implant (contraceptive implant device) • 11981: Insertion of a non-biodegradable drug delivery implant • 51 modifier: Added to the insertion code above to indicate that the insertion was a separate procedure performed at the time of the medication abortion

MONITORING AND STREAMLINING AFTER IMPLEMENTATION

DAILY HUDDLES

Every morning, clinical and operations staff gathered for a briefing on any changes taking place at the clinic and to discuss the flow for the day. Similarly, at the end of the day, the staff gathered for a debriefing. At the beginning of the project, the Director of Research Operations was often present at these huddles to support integration of peri-abortion contraceptive implants with medication abortion visits by answering questions and discussing any troubleshooting that needed to take place to smooth out the process. She attended these huddles sporadically over the following months to keep the project on the forefront of the staff's minds. As with any change to workflow, it is important to keep momentum going until new processes become routine.

*Though most of the coding for these procedures is uniform across the country, there are always exceptions. Please reach out to your payer or Medicaid agency to ensure that you are using the correct modifier for your state or agency. For additional help with billing and coding, please visit larcprogram.ucsf.edu.

REIMBURSEMENT

Research and billing staff worked together to track the status of insurance claims using Confluence, a shared work tool that allows multiple parties to see and provide input on the progress of various projects. All claims from the state Medicaid program and private insurers paid for the medication abortion, the cost of the contraceptive implant device, and half of the insertion cost, which is consistent with payments for implants and IUDs provided with aspiration abortions in Massachusetts. Only one private insurer denied the contraceptive implant insertion fee because it considered this procedure to be under the global bundled payment for abortion (S0199). The health center has not been able to get clarification as to why this insurer bundles these procedures when other insurers do not, and all efforts to appeal have failed.

CLINICIAN AND PATIENT FEEDBACK

Within two months of launch, staff reported that the new processes for providing peri-medication abortion contraceptive implants were completely integrated in an efficient, streamlined fashion. Initially, staff reported that the new processes felt "clunky" due to the additional counseling and the new flow, which required the patient to move from a counseling space to a procedure room. The staff were committed to smoothing out the workflow with time and practice, and one year after launching this integration, staff felt positive about the processes used and about providing this option for patients overall. Here are some of their comments:

"I think this was a great service for patients. Feedback I received from patients is that they were happy to leave with a LARC instead of having to wait for their follow-up, or coming back (after lab work follow-up)."

"Providing [contraceptive implant] at the time of medication abortion is a great service of convenience to our patients who want this method. It allows them to do their follow up visits by hCG and not need to travel back to the clinic for contraception."

Overall patient satisfaction with this option was high. Patients who chose to get an implant at their medication abortion visit were grateful to be offered this service so they did not have to come back for another procedure. Patients who declined to get a peri-abortion contraceptive implant provided a range of reasons: they did not want to make a decision about birth control at that time, they were not enthusiastic about what they considered an invasive procedure when they just wanted to go home and complete their abortion, and/or they simply did not want an implant as their contraceptive method. The Director of Research Operations noted that patients may have felt some residual fear that the implant would affect the efficacy of the medication abortion, despite evidence to the contrary.

THE KEYS TO SUCCESS

Several elements were crucial to successful implementation of peri-abortion contraceptive implants with medication abortion: buy-in, ongoing communication, and sustainable reimbursement for the services.

1. PRIORITIZING BUY-IN AT MULTIPLE LEVELS

As described above, this project first began to take shape when the Vice President of Research and Clinical Training discussed findings of the study with the health center's Executive Team and leadership, including the Medical Director. Once teams at the leadership level were on board with integrating this new clinical practice, the Director of Research Operations became involved to spearhead implementation efforts. She prepared for the launch of this new process by formulating plans with the finance and billing teams and discussing operational strategies with key administrative, operations, and clinical staff.

Frontline patient care staff were involved early on in planning patient flows and workflows. When the Director of Research Operations presented the Gynuity Health Projects study to introduce this pilot project and explain why the health center chose to implement peri-abortion contraceptive implant insertion with medication abortion, staff at all levels were enthusiastic about the potential for improved patient care.

The Director of Patient Services and the Health Services Director played critical roles in onboarding staff and operationalizing changes. These leaders identified which team members needed what information and when, and they ensured timely and thorough communication. They were instrumental in providing guidance to the research team, monitoring the project, and supporting patient care staff.

2. TALKING IT OUT

Ongoing communication among PPLM staff was critical to the success of this project after launch. As described above, the health center used a daily huddle process, which provided a forum for staff to discuss operations and patient flow regularly. The Director of Research Operations was often present during morning huddles to be available for questions about the project, understand how implementation was going, and maintain momentum until the new processes became routine. In addition, the project was discussed at weekly meetings and through frequent email communication.

3. SUSTAINABILITY THROUGH REIMBURSEMENT

The financial burden of providing same-day LARC to abortion patients can be prohibitive. Integrating peri-abortion contraceptive implants with medication abortion was successful at the patient and operations level with funding from NIRH, but could only be sustained after the pilot phase if the health center could ensure reimbursement from major payers for the medication abortion as well as the device and insertion.

Designing and funding this new process as a pilot project enabled the health center to use a "try and see" approach without losing money or compromising patient care. One year after the pilot launched, all but one major payer reimbursed at rates that could sustain this service without additional funding.

IMPLEMENTING AT YOUR HEALTH CENTER

It is important to acknowledge context that benefited this pilot project: status as a Planned Parenthood affiliate and location in Massachusetts, a state with laws and insurance regulations that generally support reproductive services, including abortion. The team implementing this project had advantages that not all health centers will have. The keys to success noted above will make a powerful difference in all contexts.

RECOMMENDATION: STEPS FOR ORGANIZATIONS SEEKING TO IMPLEMENT PERI-ABORTION CONTRACEPTIVE IMPLANT INSERTION

1. **Conduct a cost-benefit analysis to determine the feasibility of launching and sustaining this service. Considerations include:**
   - How many medication abortion patients are likely to choose a contraceptive implant? Look at the number of medication abortions at the site and potential number of those who will get a contraceptive implant based on proportion at the pilot clinic.
   - What are reimbursement practices for abortion services and contraceptive implants when provided separately?
   - What costs will the site likely be reimbursed for? Look at the payer mix at the site and reimbursement from each.
2. **Identify a champion, or several, to lead integration and implementation. It is critical for people who take the lead on implementing this service to have the time to manage and monitor progress of the project.**
3. **Involve staff at multiple levels. The expertise from finance and billing teams and administrative, operations, and clinical staff is vital to planning and executing an effective implementation strategy.**
4. **Use a pre-verification process to streamline insurance billing and collecting patient fees on the day of the visit.**
5. **Establish a plan to monitor insurance claims and reimbursement levels prior to launch. Members of the billing team need to be committed to conducting ongoing monitoring of reimbursement for these services and to following up with discrepancies in payments from all insurers.**

SUMMARY

Providing peri-abortion contraceptive implants with medication abortion reduced the number of visits required for patients by providing LARC during the medication abortion visit, a time when a patient was already at the health center and motivated to prevent pregnancy. Critical elements to the success of this pilot project included effective planning that drew upon the expertise from staff at multiple levels of the organization and reliable reimbursement for services from third-party payers. In addition, the health center was located in a state that is not hostile to reproductive care, including abortion, and insurers reimbursed for abortion and contraception provided on the same day. Once systems were streamlined, providing this service required little additional time for health center staff and had important benefits for patients.

ADDITIONAL RESOURCES TO ADDRESS BARRIERS TO LARC

Many LARC providers are working to offer same-day LARC insertion to improve access to highly effective contraception and reduce the likelihood of attrition associated with a two-visit process.[7] However, LARC providers often face reimbursement challenges when LARC is offered as part of other visits, such as labor and delivery or aspiration abortion. Often LARC care is not reimbursed because insurers consider it part of the bundled cost of providing other services like postpartum care. Unfortunately, bundled rates do not cover the actual costs associated with LARC care, including the devices, stocking, insertion, and removal. Several states have acted to unbundle reimbursement rates for LARC care when provided alongside other services.

If these issues are a concern in your state, consider the following for resources or solutions:

1. Association of State and Territorial Health Officials (ASTHO): Increasing Access to Contraception Learning Community
2. American College of Obstetricians & Gynecologists (ACOG): LARC Program
3. National Institute for Reproductive Health (NIRH): Resources for Advocates
4. National Family Planning and Reproductive Health Association (NFPRHA): Contraceptive Coverage/Preventive Services
5. National Women's Law Center: Health Care and Reproductive Rights
6. American Civil Liberties Union (ACLU): Reproductive Freedom

This resource was created by JLYS Consulting, with support from the National Institute for Reproductive Health and Planned Parenthood League of Massachusetts. It is based on PPLM's successful experience launching and implementing the provision of contraceptive implants to patients during the time of medication abortion at their health center. Their experience, including the issues and questions they faced, the solutions they adopted, and lessons learned, forms the foundation of this toolkit. Special thanks to Linda Prine, MD, of the Reproductive Health Access Project for her thoughtful contributions to the content of this resource, and to Saba Golmohammadi.

ENDNOTES

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National Institute for
Reproductive Health

National Institute for Reproductive Health
14 Wall Street
Suite 3B
New York, NY 10005

Tel. 212-343-0114

info@nirhealth.org
www.nirhealth.org