QINCA Contraceptive Access Change Package

Developed for Cohort 2 QINCA Sites by the NYC Department of Health and Mental Hygiene in collaboration with John Snow Inc.

November 2016

Goal of the Change Package

Everyone has a right to have the information and resources needed to make personal decisions about their own life, including if or when to be pregnant and to choose if and when to have children.[1] Utilizing the current literature and national guidelines, this document provides recommendations for how to increase access, to 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 all 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.

> "Every woman should have the information and the resources she needs to make personal decisions about her own life, including when or if she wants to be pregnant. Our goal is to ensure that women, 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."
>
> - NYC Health Commissioner Dr.. Mary Bassett

This change package was developed by New York City Department of Health and Mental Hygiene (NYC DOHMH) in collaboration with John Snow, Inc. (JSI) to support the Quality Improvement Network for Contraceptive Access (QINCA), a learning collaborative focused on increasing access to contraception in participating New York City Hospitals' primary care, post-abortion, and postpartum services. The goal of the QINCA is to increase patient access to the most or moderately effective FDA-approved contraceptive methods.

Access will be assessed by: a) achievement of the *4 Steps,* and b) through utilization data as a proxy measure for access. Utilization will be assessed using the national performance measures developed by the Center for Disease Control and Office of Population Affairs, Office of Family Planning, and recently endorsed by the National Quality Forum:

- **An intermediate outcome measure:** Percentage of women aged 15-44 years at risk of unintended pregnancy that are provided the most effective (i.e., female sterilization, implants, intrauterine devices or systems [IUD/IUS]) or moderately effective (i.e., injectables, oral pills, patch, ring or diaphragm) method of contraception.

- **A contraceptive access measure:** Percentage of women aged 15-44 years at risk of unintended pregnancy that are provided a long-acting reversible method of contraception (LARC), i.e., implants, intrauterine devices or systems (IUD/IUS).

*Data will be used to reflect the access to and availability of the full range of FDA-approved contraceptive methods. Participating facilities should not set benchmarks or goals for the provision any particular method.

QINCA-participating sites that fulfill the Contraceptive Access Assessment Criteria, as described for each step below, will be eligible for a Certificate of Excellence in Contraceptive Access from the NYC DOHMH.

Sexual and Reproductive Justice Framework

The NYC DOHMH envisions a city where all New Yorkers can safely express their sexuality and gender identity with dignity, possessing the knowledge, skills and resources to support healthy and fulfilling lives.

Guiding all of the NYC DOHMH work is the Sexual and Reproductive Justice (SRJ) framework, which prioritizes individual choice and body autonomy within the context of historical events, lived experiences, sexualities, and social conditions. This term was created by African-American women in 1994 after the International Conference on Population and Development in Cairo.[2] The advocacy group SisterSong introduced the framework nationally at their first national conference in 2003 to illuminate the history of reproductive coercion experienced by women of color and to link sexuality, health, and human rights.[2] This framework asserts that all persons have the right to: Decide if and when to have a child and the conditions under which to give birth

- Decide if and when to not have a child and the options for preventing or ending a pregnancy
- Parent the children they have with the necessary social supports in safe environments and healthy communities, and without threat of violence from individuals, organizations or the government
- Bodily autonomy or self-expression and agency free from any form of sexual or reproductive oppression

It recognizes that unintended pregnancy is a consequence, and not a cause of poverty, and that underlying structural factors impact health and decision-making.[3] NYC DOHMH seeks to provide professional training programs focused on evidence-based clinical practice as well as on the historical and structural inequities that impact people's lives and health.

How to Use This Change Package

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.[1] This document draws from the QFP, the comprehensive guideline for the provision of family planning services, and the related guidance documents from the Centers for Disease Control and Prevention (CDC), including the *U.S. Selected Practice Recommendations*, *U.S. Medical Eligibility Criteria*, and *STD Treatment Guidelines*, and is in alignment with the NYC DOHMH *Sexual and Reproductive Health Care Best Practices for Adolescents and Adults*.[4-7] The change package is based on these guidance documents, and a literature review for evidence-informed approaches to making practice changes in sexual and reproductive health.

This change package is designed to support QINCA sites to develop a comprehensive strategy for increasing and ensuring ongoing contraceptive access. Specifically, this change package can help support QINCA sites' efforts to:

- Increase awareness of best practice strategies associated with increasing contraceptive access;
- Conduct a self-assessment by comparing best practices with existing practices; and
- Select high-impact system-level strategies to implement in your hospital.

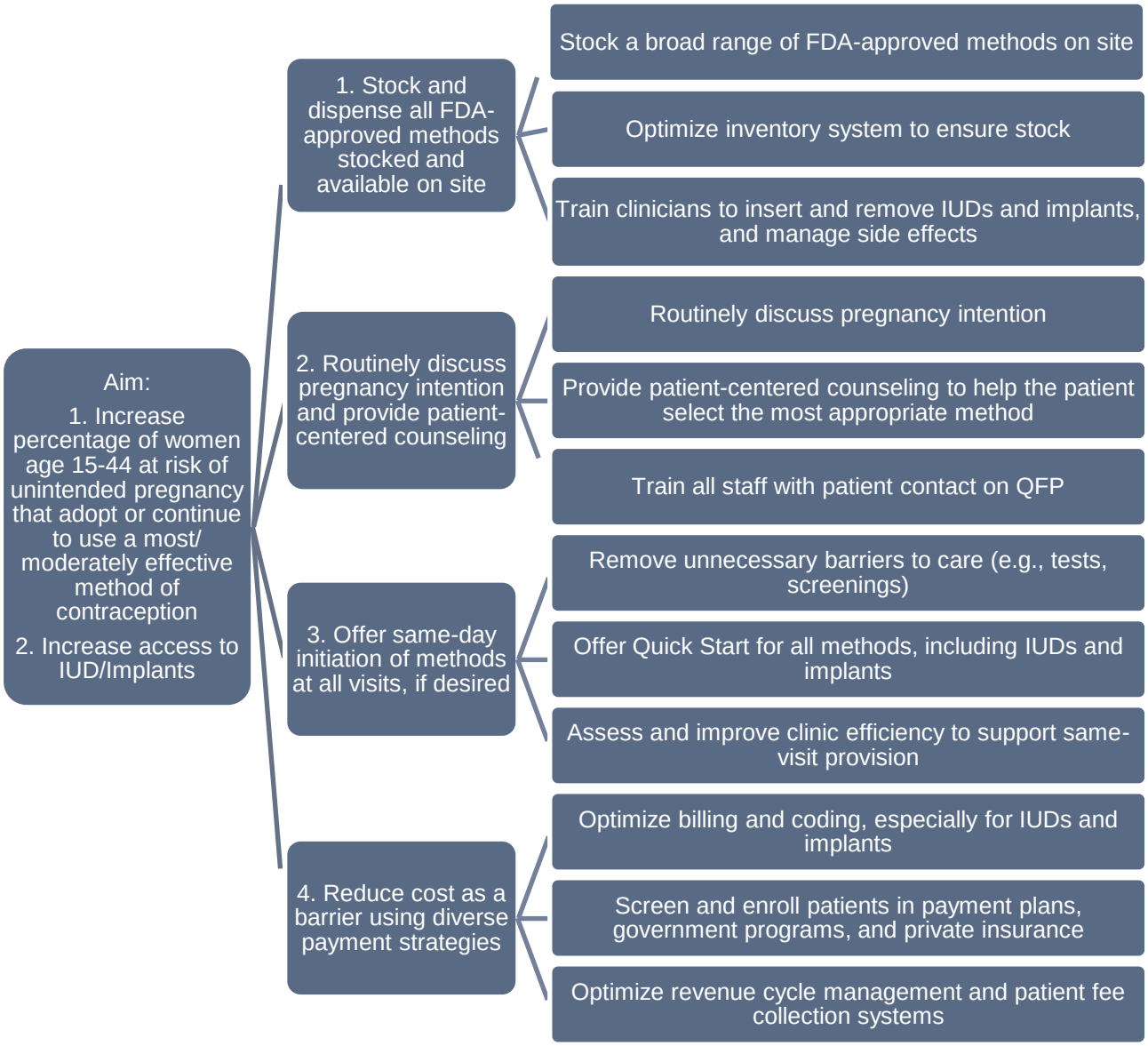
Excellence in Contraceptive Access

Based on a review of the literature, the following four steps have been identified by NYC DOHMH to increase access to the full range of FDA-approved contraceptive methods.

- **Step 1. Ensure access to all FDA-approved contraceptive methods.** Stock all provider-dependent contraceptive methods, including the injectable, intrauterine devices (IUDs), and implants.
- **Step 2. Routinely assess perceptions of pregnancy and pregnancy intention, and support patients through patient-centered counseling.** When applicable, provide evidence informed counseling so that patients can make informed choices from the full range of contraceptive methods if they do not desire a pregnancy presently.
- **Step 3. Develop systems for provision of all contraceptive methods during the same visit the method is requested.** Enable all patients, including those who chose an IUD or implant, to leave their healthcare visit or hospital admission with their chosen method, if desired (provided you can be reasonably certain the patient is not pregnant.)
- **Step 4. Utilize diverse payment options to reduce cost as a barrier for the facility and the patient.** Facilities should participate in diverse insurance and payment opportunities, and should inform patients about self-pay options, sliding fee schedules, and insurance enrollment options.

Drivers of Contraceptive Access

Below is a visual representation of these steps and associated drivers, which are explored further in the following pages of the change package.



Step 1. Ensure access to all FDA-approved contraceptive methods. Stock all provider-dependent FDA-approved contraceptive methods, including the injectable, IUDs, and implants.

A full range of contraceptive methods should be accessible and available to all patients on-site. Providing a method that best fits a patient's unique circumstances is patient-centered and a core characteristic of quality care.[1, 8] Services should be voluntary 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.[1] Stocking all methods requiring provider intervention (such as the injection, IUD, or implant) in advance of request, is essential to ensuring full access to care, since many patients do not return for follow up visits.

Strategies

- **Stock or otherwise ensure access to a full range of FDA-approved contraceptive method types**, which include:[9]
    - Services or referral for sterilization;
    - Hormonal implant;
    - Copper intrauterine device (Cu IUD);
    - Levonorgestrel intrauterine device (LNG IUD);
    - Depot medroxyprogesterone acetate (DMPA);
    - Combined hormonal pill (CHC);
    - Progestin-only pill (POP);
    - Patch;
    - Vaginal ring;
    - Diaphragm;
    - Condoms (male and female); and
    - Emergency contraception (EC).

- **Optimize an effective inventory system for sustainable management and stocking of provider-dependent contraceptives** (i.e., IUD, DMPA, hormonal implant) on-site, including:[10]
    - Utilize a "buy and bill" mechanism (for procurement of methods stocked on-site);
    - Forecast the range and number of each method needed;
    - Conduct a regular (e.g. weekly) inventory of stock.

- **Train core clinical staff** to:
    - Insert and remove IUDs and implants,
    - Evaluate and treat complications; and
    - Manage side effects (especially bleeding).[4]

- **Make condoms freely available and accessible** where patients can discreetly help themselves (e.g., exam rooms, front desk, and bathrooms).
    - Provide condoms free of charge;
    - Maintain ample supply and order regularly. Condoms can be ordered free of charge at: https://a816-healthpsi.nyc.gov/CondomOrder/

- **Inform clients about the availability of emergency contraception.**
    - Do not require appointment for emergency contraception visits;
    - Offer Copper IUD, the most effective EC available, as an option;
    - Make the process of obtaining emergency contraception as streamlined as possible;
    - Provide patients an advance supply of emergency contraceptive pills on-site or by prescription, if requested.

Step 1 Assessment Criteria

QINCA Team has submitted:

1. A written, approved, organizational policy and protocol for providing the full range of FDA- approved contraceptive methods (as listed above), including provision to provide condoms free of charge, without barriers.
2. Documentation that policy has been disseminated and shared with all relevant staff who have patient contact.† The organizational policy should be stored in a place accessible to all staff and include a plan for ongoing yearly review and updates as necessary.
3. Documentation of: a) training conducted for existing staff, including provision of continuing education (as needed); and b) a plan for training new staff.
4. At least six months of data demonstrating the provision of the full range of FDA-approved contraceptive methods.
5. Demonstration of all provider dependent methods stocked on site and available without barrier to the patient.

† Relevant staff with patient contact includes MD, NP, CNM, PA, RN, LPN, pharmacists, health educators, enrollment support, front desk, and support staff. Training should be appropriate to their level of licensure and contact with patients.

Step 2. Routinely assess perceptions of pregnancy and pregnancy intention and support patients through patient-centered counseling. When applicable, provide evidence informed counseling so that they can make an informed choice from the full range of contraceptive methods if they do not desire a pregnancy presently.

Engaging a patient in conversations around sexuality and pregnancy may help to identify unmet reproductive health care needs, especially for patients whose initial reason for a visit was not related to preventing or achieving pregnancy.[11, 12] CDC recommends that providers take every opportunity to engage patients in a conversation about perceptions of parenting and pregnancy intention and support patients through reproductive life planning (RLP). RLP encourages the patient to think about whether or when she or he wants to have children and how best to meet goals.[11] These conversations can support patients to make their own decisions about what, if any, method of contraception is most appropriate for them at that time.

According to QFP, there are five principles for quality contraceptive counseling.[1] Providers should: 1) establish a rapport with the patient; 2) assess and respond to individual patient needs; 3) assist in the development of a reproductive life plan; 4) provide patients information in an understandable way; and, 5) confirm patient understanding of the material. Using a patient-centered approach reduces the risk for reproductive coercion and provider bias.[1] Unfortunately, healthcare 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.[13-18] It is important to emphasize that counseling should help patients make a voluntary and informed choice, even if it is not what the provider would choose.[19]

Strategies

- **Provide evidence informed counseling and patient education tailored to their concerns**. When applicable, assess patients' pregnancy intentions:
    - Use an evidence-informed approach such as the One Key Question approach to start the counseling: "Would you like to become pregnant in the next year?"[12]
    - Consider alternative questions such as the following questions, which have been developed as patient-centered approaches to assess reproductive goals:
        1. Do you think you would like to have (more) children some day?
        2. When do you think that might be?
        3. 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 identified goals and preferences in line with QFP recommendations**.[1]
    - Use a "shared decision-making" approach to contraception counseling that is consistent with the five recommendations for contraceptive counseling outlined in the QFP:[1]
        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, as indicated; and
5. Provide the contraceptive method along with instructions about correct and consistent use, help the client develop a plan for using the selected method and for follow-up, confirm client understanding and allow time for addressing questions.

- Provide information to patients in a way that makes it more readily understood.[1] For example:
  - Develop materials for a 4th-6th grade reading level;
  - Deliver information in a culturally and linguistically appropriate manner, for example, use the client's primary language whenever possible;
  - Communicate numeric quantities in a way that is easily understood, for example, display quantities with graphs and visuals;
  - Present balanced information on risks and benefits, free from provider bias;
  - Use teaching aids when counseling, including visual aids showing contraceptive methods and using visual cues such as size of methods such as IUDs and implants;[20] and
  - Consider showing models of methods to patients, especially for methods that they may not be as familiar with, such as IUDs, implants, vaginal rings, and female condoms.
- When counseling patients about contraceptive methods, providers should ensure that patients understand:[1]
  - Method effectiveness;
  - Correct use of method;
  - Non-contraceptive benefits;
  - Side effects; and
  - Use of dual methods for protection from sexually transmitted infections (STI), including HIV.
- Depending on concerns, contraceptive counseling may also include:
  - Potential barriers to use, such as social-behavioral factors, mental health and substance use behaviors, intimate partner violence and sexual violence;[1]
  - Concerns about confidentiality;
  - Cost;
  - Contraception and breastfeeding intention; and
  - Access requirements (e.g., a visit to a provider for insertion).
- Providers should:
  - Engage in tailored counseling based on the patient's priorities, challenges, and preferences using open-ended questions;
  - Ask patients if all questions were answered;
  - Understand the history of contraceptive coercion and potential influence of provider bias;
  - Be aware that hurried or impersonal behavior may lead patients to feel uncomfortable or suspicious; and
  - Reassure patients that they can change their method or stop using a method.

- **Train all appropriate staff with patient contact** related to contraception on:
  - QFP recommendations;
  - Patient-centered contraceptive counseling protocol and skills;
  - Contraceptive method options and effectiveness, associated benefits, side effects, and warning signs for complications;
  - Contraceptive method myths/misinformation; and
  - Method-specific eligibility criteria including the most recent guidelines from CDC, ACOG, and AAP regarding eligibility for IUDs and implants.[5,21,22]

- **Provide unbiased pregnancy options counseling in the event of a positive pregnancy test**.
  - Ensure that all providers and staff giving pregnancy test results are trained in Pregnancy Options Counseling, which addresses the patient's options when learning she is pregnant (prenatal care and parenting, prenatal care and adoption, and surgical or medical abortion).
  - Options counseling should be provided in accordance with recommendations from professional medical associations, such as ACOG and AAP.
  - Provide counseling, as appropriate, on prenatal health (e.g., folic acid; nutrition; physical activity; avoidance of smoking, drugs, and alcohol; and management of chronic health conditions including follow-up with their primary care provider).

- **Provide STI prevention counseling according to the CDC *STD Treatment Guidelines*,**[7] including:
  - Educating and counseling persons at risk on ways to avoid STIs by changing sexual behaviors and using of recommended preventive services;
  - Providing high-intensity behavioral counseling for all sexually active adolescents and for adults at increased risk for STIs, including HIV; and,
  - Counseling on the use of a dual method: a most or moderately effective method of contraception in conjunction with condoms to reduce the chance of STI transmission and unintended pregnancy.

Step 2 Assessment Criteria

QINCA Team has submitted:

1. A written, approved, organizational policy that includes:
   a. A protocol for providing evidence informed , patient-centered contraceptive counseling using a shared-decision-making approach, if patients do not desire pregnancy presently
   b. STI prevention counseling and that promote dual method use for those at risk
   c. A statement that reproductive health services are voluntary and will be offered in an unbiased, non-coercive manner.
2. Documentation that the aforementioned policies have been disseminated and shared with all relevant staff with patient contact.†
3. Documentation of a) training conducted for existing staff, including provision of continuing education as needed, and b) a plan for training new staff.

† Relevant staff with patient contact includes MD, NP, CNM, PA, RN, LPN, pharmacists, health educators, and support staff. Training should be appropriate to their level of licensure and contact with patients.

Step 3. Develop systems for same-visit provision of all contraceptive methods. Enable all patients, including those who choose IUDs and implants, to leave their patient visit with their selected contraceptive method, if patient desires.

Patients should be offered the option to begin contraception at the time of the visit, or hospital admission, rather than waiting for her next menses or a follow-up appointment.[1] There is no medical reason to require multiple visits to initiate any contraceptive method if the provider can be reasonably sure that the patient is not pregnant and does not have medical contraindications to the method.[4,5] Although it has been common practice to require multiple appointments for methods such as the IUD or implant, CDC, ACOG, and other organizations encourage clinicians to initiate and provide the patient's method of choice in a single visit, unless additional testing is medically indicated.[4, 21] If a patient seeks pregnancy testing, a negative pregnancy test result provides an opportunity to discuss thoughts on pregnancy 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.[1, 23] The immediate postpartum and post-abortion period also has several potential benefits for addressing contraception and offering all contraceptive methods. For patients who choose an IUD or implant, this is an ideal time because women are known not to be pregnant and many women are motivated to avoid short-interval pregnancy.[24] Although contraception has been traditionally offered at the postpartum visit, offering it during hospital admission is important due to low postpartum visit follow-up rates. All services should be provided on a voluntary basis and the patient should not be coerced into using a method or any particular method.

Strategies

- **Remove unnecessary barriers to contraceptive access by following current QFP recommendations**:[1, 4]
    - The following examinations and tests are not needed routinely to provide contraception safely to a healthy client (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;
        - Routine STI screening results.
    - **Conduct STI screening, in accordance with CDC's *STD Treatment Guidelines.*** If a woman has not been screened according to guidelines, screening can be performed at the time of IUD insertion, and insertion should not be delayed. Women with purulent cervicitis or current chlamydial infection or gonorrhea should not undergo IUD insertion.[4,7]

- **Develop workflow and protocol for provision of a patient's chosen method during the same visit,** including IUDs and implants, if desired by the patient.* [1]
    - Offer to use the Quick Start Algorithm to start patients the same visit.[4,25]
    - Use CDC Selected Practice Recommendations to reasonably rule out pregnancy;[4]
    - If a patient chooses a method that is not immediately available, offer another effective method until she can start the chosen method.[1]

- **Develop and implement the necessary administrative and clinical support systems to increase efficiency and support immediate/same-day access** to all methods, for instance:
    - Offer flexible hours, such as during the evening or weekend;[26]
    - Provide or prescribe multiple cycles (ideally a one-year supply) of oral contraceptive pills, patch, or ring.[1]
    - Do not require provider appointments for routine method refills or DMPA injections;
    - Pre-verify contraceptive insurance benefits.

- **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, STI swab (if applicable).

Special Considerations for Primary Care

- Reasonably rule out pregnancy by:
    - Using CDC Selected Practice Recommendations;[4]
    - If a woman has had recent (i.e., within the last 5 days) unprotected sexual intercourse, consider offering emergency contraception (either a Cu IUD or pills).
    - Offer Cu IUD as an option for emergency contraception and as a long term method for those who choose it (99% effective within five days of unprotected intercourse).

Special Considerations for Post-abortion

- Address identified sexual and reproductive health needs at the same visit as the abortion, without delaying until a follow-up visit.
- Provide patient with birth control information and inform patient of options for contraception during pre-abortion counseling.
- When scheduling appointments for an abortion, inform patient that she will have the option to obtain contraception the same day as her abortion.
- Offer same-day provision of contraception, including IUD/implant, immediately post-abortion unless medically contraindicated.[4,5]

** Provided you can be reasonably sure the patient is not pregnant.*

Special Considerations for Postpartum

- Provide patient with contraceptive counseling by the third trimester prenatal care appointments.
- Discuss plans for breastfeeding and provide evidence-based guidance on contraception for breastfeeding moms.
- Offer post-placental IUD/implant insertion after delivery.
- Offer contraceptive counseling before discharge from the hospital.
- If no method is chosen before discharge, reassess patient preference for a contraceptive method at their postpartum visit.

Step 3 Assessment Criteria

QINCA Team has submitted:

1. A written, approved, organizational policy that supports same-visit/same-admission provision of contraceptive methods.
2. Documentation that the aforementioned policies are disseminated and shared with all relevant staff with patient contact.†
3. A training plan for training to support the aforementioned policies that includes: a) existing staff as needed, b) a plan for training new staff, and c) a plan for providing continuing education, as needed, for existing staff.

† Relevant staff with patient contact includes MD, NP, CNM, PA, RN, LPN, pharmacists, health educators, and support staff. Training should be appropriate to their level of licensure and contact with patients.

Step 4. Utilize diverse payment options to reduce cost as a barrier both for the facility and the patient. This includes informing patients about self-pay options, sliding fee schedules, and insurance enrollment options.

Cost has historically been a significant barrier to contraceptive use, especially for IUDs and implants which can have high up-front costs for patients (to pay) and providers (to stock on site).[27] The Affordable Care Act now requires most health insurance companies to cover FDA-approved contraceptive methods without cost-sharing.[28, 29] 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. 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.[27]

Strategies

- **Ensure referral or enrollment support services are available** for:
  - Self-pay options (sliding scale, payment plans, etc.);
  - Government programs; and,
  - Insurance enrollment options.

- **Provide insurance eligibility screening of all patients and application assistance** for all those identified as in need on site or by referral:[30]
  - Provide access to a Certified Application Counselor (CAC), Navigator, or other Marketplace Assister on site or develop a formal linkage with organizations that can provide enrollment assistance;
  - 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.[30]

- **Provide eligibility screening and enrollment assistance for the NY State Family Planning Benefit Program (FPBP).** [35]

- **Ensure third-party reimbursement for patients with, or eligible for third-party coverage** such as private insurance, Medicaid, or FPBP.
  - Regularly review, and if necessary, re-negotiate contracts with insurance companies, including Medicaid Managed Care Organizations, to ensure the best possible reimbursement rates;
  - Engage in conversations and/or initiatives with state Medicaid around new payment strategies.

- **Optimize billing and coding for contraceptive care, especially IUDs, implants and DMPA.**
  - Provide training to ensure staff members are current and up to date with correct billing codes and modifiers for sexual and reproductive health services.
  - Optimize revenue cycle management and patient fee collection protocols:[32]
  - Utilize standard revenue cycle management quality assurance and accounts receivable recommendations such as verify benefits prior to, and collect copays at each visit:[32]

- **Identify ways to obtain contraceptive methods at reduced cost.** Inform patients about device manufacturer payment plans and patient assistance programs.

- **Utilize the 340B Drug Pricing Program to purchase FDA-approved prescription drugs** at significantly reduced prices for outpatient services, if the health care organization is eligible.[33]

Special Considerations for Postpartum

- **IUDs and implants provided during an inpatient stay can be billed to Fee for Service Medicaid and Medicaid Managed Care** on an ordered ambulatory claim, separate from the inpatient claim.
  - In NY State, since 2014, hospitals can bill Medicaid fee-for-service (FFS) and as of September 2016 they can bill Medicaid Managed Care Organizations for the cost of IUDs and implants provided to women during their postpartum inpatient hospital stay.[34] IUDs and implants provided during an inpatient stay can be billed on an ordered ambulatory claim, separate from the inpatient claim. CMS issued guidance June 14, 2016 that, "States are encouraged to implement measures that facilitate immediate postpartum LARC insertion, when a woman chooses this option."[35]
  - Although private third-party payers are not under the same legal obligation to guarantee this same coverage, most have followed suit and are also covering IUDs and implants immediately postpartum outside of the global delivery fee.

Step 4 Assessment Criteria

QINCA Team has submitted:

1. A written, approved, organizational policy that includes: self-pay options (sliding scale, payment plans, etc.); government programs; and, insurance enrollment options.
2. A copy of facility's MOU with NY State for FPBP and documentation that patients are actively screened for enrollment.
3. Documentation that the aforementioned policies are disseminated and shared with all relevant staff with patient contact.†
4. A plan for training to support the aforementioned policies that includes: a) existing staff as needed, b) a plan for training new staff, and c) a plan for providing continuing education as needed for existing staff.

† Relevant staff with patient contact includes MD, NP, CNM, PA, RN, LPN, pharmacists, health educators, enrollment support, front desk, billing, finance, and support staff. Training should be appropriate to their level of licensure and contact with patients.

References

1. Gavin L, Moskosky S, Carter M et al. Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs. MMWR 2014;63(4)
2. Ross L, Understanding Reproductive Justice. SisterSong Women of Color Reproductive Justice Collective. November 2006 (updated March 2011). http://trustblackwomen.org/our-work/what-is-reproductive-justice/9-what-is-reproductive-justice, accessed November 2016.
3. Sisson G. Finding a way to offer something more: reframing teen pregnancy prevention. Sex Res Soc Policy. 2012;1(9):57-69.
4. Curtis KM, Jatlaoui TC, Tepper NK, et al. U.S. Selected Practice Recommendations for Contraceptive Use, 2016. MMWR Recomm Rep 2016;65(No. RR-4):1–66.
5. Curtis KM, Tepper NK, Jatlaoui TC, et al. U.S. Medical Eligibility Criteria for Contraceptive Use, 2016. MMWR Recomm Rep 2016;65(No. RR-3):1–104.
6. New York City Department of Health and Mental Hygiene. Sexual and Reproductive Health Care Best Practices for Adolescents and Adults. 2016
7. Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015. MMWR Recomm Rep 2015;64(No. RR-3): 1-137.
8. Institute of Medicine (IOM). Crossing the Quality Chasm. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, D.C: National Academy Press 2001.
9. Food and Drug Administration (FDA). Birth Control: Medicines to Help You http://www.fda.gov/ForConsumers/ByAudience/ForWomen/FreePublications/ucm313215.htm
10. Family Planning Logistics Management (FPLM). 2000. Contraceptive Forecasting Handbook for Family Planning and HIV/AIDS Prevention Programs. Arlington, Va.: FPLM/John Snow, Inc., for the U.S. Agency for International Development.
11. Preconception Health and Healthcare: Reproductive Life Plan for Professionals.http://www.cdc.gov/preconception/documents/rlphealthproviders.pdf
12. One Key Question http://www.onekeyquestion.org/
13. Yee L, Simon M. Urban minority women's perceptions of and preferences for postpartum contraceptive counseling. J Midwifery Womens Health. 2011 Jan-Feb;56(1):54-60.
14. Dehlendorf C et al. 2014. Counseling about IUDs: A mixed-methods analysis. Perspectives on Sexual and Reproductive Health, 46 (3)
15. Higgins JA. 2014. Celebration meets caution: LARC's boons, potential busts, and the benefits of a reproductive justice approach. Contraception, 89.
16. Gomez AM, L Fuentes L, A Allina A. 2014. Women or LARC first? Reproductive autonomy and the promotion of long-acting reversible contraceptive methods. Perspectives on Sexual and Reproductive Health, 46(3)
17. Gold RB. 2014. Guarding against coercion while ensuring access: A delicate balance. Guttmacher Policy Review, 17(3)
18. Gilliam ML, Neaustadt A, Gordon R. A call to incorporate a reproductive justice agenda into reproductive health clinical practice and policy. Section of Family Planning, Department of Obstetrics and Gynecology, The University of Chicago, Chicago, IL Association of Reproductive Health Professionals, Oakland, CA, USA. Published Online: February 02, 2009
19. Gold, Rachel. Guarding Against Coercion While Ensuring Access: A Delicate Balance. Vol. 17. Guttmacher Institute, Ser. 3.

20. Trussell J, Guthrie K. Lessons from the Contraceptive CHOICE Project: the Hull long-acting reversible contraception (LARC) initiative. J Fam Plann Reprod Health Care. 2014 Sep 18. [Epub ahead of print]
21. Long-acting reversible contraception: implants and intrauterine devices. Practice Bulletin No. 121. American College of Obstetricians and Gynecologists. Obstet Gynecol 2011;118:184-96.
22. American Academy of Pediatrics (AAP). Contraception for adolescents: Policy Statement. September 29, 2014.
23. Bergin A(1), Tristan S, Terplan M, Gilliam ML, Whitaker AK. A missed opportunity for care: two-visit IUD insertion protocols inhibit placement. Contraception. 2012 Dec;86(6):694-7.
24. Immediate postpartum long-acting reversible contraception. Committee Opinion No. 670. American College of Obstetricians and Gynecologists. Obstet Gynecol 2016;128:e32-7.
25. Reproductive Health Access Project. Quick Start Algorithm. http://www.reproductiveaccess.org/wp-content/uploads/2014/12/QuickstartAlgorithm.pdf
26. Kavanaugh ML, Jerman J, Ethier K, Moskosky S. Meeting the contraceptive needs of teens and young adults: youth-friendly and long-acting reversible contraceptive services in U.S. family planning facilities. J Adolesc Health. 2013 Mar;52(3):284-92. doi: 10.1016/j.jadohealth.2012.10.276. Epub 2012 Dec 12.
27. Secura GM, Allsworth JE, Madden T, Mullersman JL, Peipert JF. The Contraceptive CHOICE Project: reducing barriers to long-acting reversible contraception. Am J Obstet Gynecol. 2010 Aug;203(2):115.
28. Health Insurance Marketplace Home | Marketplace.CMS.Gov." Health Insurance Marketplace Home | Marketplace.CMS.Gov
29. Gandal-Powers, M. The Affordable Care Act and Birth Control Coverage: What Every Healthcare Provider Should Know. National Women's Law Center. Presentation. March 27, 2014
30. Enroll America. State of Enrollment: Lessons Learned From Connecting America to Coverage, 2013-2014. https://s3.amazonaws.com/assets.getcoveredamerica.org/20140613_SOEReportPDFlr.pdf
31. eMedNY. Clarification on Reimbursement for Long-Acting Reversible Contraception (LARC) Provided as an Inpatient Post-Partum Service. 04/09/2016 https://www.emedny.org/listserv/Inpatient/Inpatient_Clarification_on_Reimbursement_for_LARC_Provided_as_an_Inpatient_Post-Partum_Svc_4-9-15.pdf
32. United Health Foundation. Lessons for Financial Success: Accounts Receivable and Collections. 2009 http://www.mgma.com/Libraries/Assets/About/About%20MGMA/About%20Center%20for%20Research/Lessons-for-Financial-Success-Ch.-3-Accounts-Receivable.pdf Accessed 10/12/15
33. Health Resources and Services Administration: Office of Population Affairs. 340B Drug Pricing Program http://www.hrsa.gov/opa/
34. New York State Medicaid Comprehensive Coverage and Promotion of Long-Acting Reversible Contraception. 2016 http://www.health.ny.gov/health_care/medicaid/program/update/2016/2016-09.htm#larc_coverage
35. Centers for Medicare and Medicaid Services. Re: Medicaid Family Planning Services and Supplies. 2016 https://www.medicaid.gov/federal-policy-guidance/downloads/sho16008.pdf