Same-Visit Contraception

AN IMPLEMENTATION GUIDE FOR FAMILY PLANNING PROVIDERS

FPNTC
FAMILY PLANNING
NATIONAL TRAINING CENTER

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Introduction

According to the Centers for Disease Control and Prevention (CDC) and the Office of Population Affairs (OPA), clients should have access to their contraceptive method of choice—regardless of whether that method is an intrauterine device (IUD), implant, pill, patch, ring, condoms, natural family planning, or any other method—without unnecessary delays.[1, 2]

"Same-visit" provision of contraception means providing immediate access to contraceptive methods using Quick Start, and not requiring clients to return for a separate appointment on another day or even later the same day to initiate contraception.[3]

As long as a clinician can be reasonably certain a client is not pregnant, there is no medical reason to require clients to return for a follow-up visit or to initiate methods during menses.[1] This includes provider-dependent methods like the IUD, implant, and injectable. For the purposes of this toolkit, clinician refers to physicians, nurse practitioners (NPs), advanced practice registered nurses (APRNs), physician assistants (PAs), and certified nurse midwives (CNMs).

This implementation guide offers action steps, tools, and other resources inspired by family planning providers offering the full range of methods same-visit. Title X grantees and service site staff may find this guide and associated tools useful as they begin—or streamline—offering same-visit contraception.

The tools and resources in this guide can be used in any order according to needs and priorities.

The guide is organized into four sections:

STRATEGY 1. Stock Devices and Make Supplies Readily Available

STRATEGY 2. Adjust Systems to Ensure Efficient and Sustainable Service Delivery

STRATEGY 3. Engage, Train, and Support All Staff

STRATEGY 4. Use a Quality Improvement Approach to Implementation

To start, listen to these providers share why they think it is important to provide contraception same-visit, and how they have been able to do so in their clinics.

A CASE STUDY:
Same-Visit Provision of Contraception at the **Southern Nevada Health District, East Las Vegas Health Clinic**

A CASE STUDY:
Same-Visit Provision of Contraception at the **Lousiana Office of Public Health, Rapides Parish Health Unit**

A CASE STUDY:
Same-Visit Provision of Contraception at **NYC Health + Hospitals, Morrisania Health Center and Lincoln Hospital**

ACCESS THESE VIDEOS ONLINE AT

https://www.fpntc.org/resources/case-study-same-visit-provision-contraception-southern-nevada-health-district-east-las

https://www.fpntc.org/resources/case-study-same-visit-provision-contraception-louisiana-office-public-health-rapides

https://www.fpntc.org/resources/case-study-same-visit-provision-contraception-nyc-healthhospitals-morrisania-and-lincoln

When can providers initiate contraceptive methods same-visit?

Although it has been common practice to require multiple appointments for methods such as the IUD or implant, there is agreement by CDC and the American College of Obstetricians and Gynecologists (ACOG) that clinicians can provide contraceptive counseling and initiate the client's method of choice in a single visit, if they can be reasonably certain that the client is not pregnant, and unless additional complex medical management is indicated.[1,4] Receiving a method same-visit should be by client preference; if the preference is to wait, this should be respected. Clients should never be pressured to accept a particular method, or any method of contraception at all.

According to CDC,[1] a health care provider can be reasonably certain that a woman is not pregnant if she has no symptoms or signs of pregnancy and meets any one of the following criteria:

- ❑ Is ≤7 days after the start of normal menses
- ❑ Has not had sexual intercourse since the start of last normal menses
- ❑ Has been correctly and consistently using a reliable method of contraception
- ❑ Is ≤7 days after spontaneous or induced abortion
- ❑ Is within 4 weeks postpartum
- ❑ Is fully or nearly fully breastfeeding (exclusively breastfeeding or the vast majority [≥85%] of feeds are breastfeeds), amenorrheic, and <6 months postpartum

Providers should follow the U.S. Medical Eligibility Criteria (MEC) and the U.S. Selected Practice Recommendations (SPR) to ensure clients are candidates for same-visit provision.[1,5] If screening for sexually transmitted diseases (STD) is indicated, it can be performed at the time of the IUD insertion and insertion should not be delayed unless there are medical contraindications (e.g., clients with current purulent cervicitis, chlamydial infection, or gonococcal infection).[6]

Why should providers offer methods same-visit?

Many providers already prescribe short-acting methods—like the pill, patch, and ring—when requested by the client. Provider-dependent methods have not always been stocked in the clinic, thus requiring clients to return for a second visit. However, when clients are required to return for a second visit for the insertion of a long-acting reversible contraception (LARC) method, the likelihood they receive their method of choice decreases. Up to 50% of clients will not return for a LARC insertion visit.[7] Moreover, a two-visit insertion protocol disproportionately impacts low-income clients.[8]

Clients face many barriers when trying to get to a medical appointment. For some clients, it can be challenging to take time off of work, obtain child care, or secure transportation to and from the clinic. Some clients are only in the area for a limited period of time—for example, students who are home on college break.

Given their challenges, clients are satisfied when they can obtain a contraceptive method same-visit. When major barriers to contraception are eliminated and clients can receive the method they want, they are satisfied and have high method continuation rates.[9,10] High client satisfaction drives continued demand for services, and contributes to increased staff satisfaction for being able to meet client needs.

If the patient wants a LARC method and we provide it the same day, it prevents the risk of an unplanned pregnancy because they're going to forget a pill, or forget to come back for their next Depo, or not be able to take another day off work to come back and get that LARC method.

ERIN COOKE, APRN
Nurse Practitioner
Southern Nevada Health District

Where should providers start in order to offer contraception same-visit?

As with any improvement initiative, starting with an assessment of the current status ensures that improvements build on existing efforts.

Title X clinics must provide a "broad range" of Food and Drug Administration (FDA)-approved contraceptive methods and services.[11,12] Although some methods can be obtained by prescription, the provider-dependent methods and their associated supplies need to be stocked on site in order to offer them same-visit. Strategies and related tools for stocking devices and making supplies readily available are described below.

FIRST STEPS	RESOURCES
Assess what methods clients can currently obtain same-visit and reflect on barriers that prevent all methods from being available same-visit.	Contraceptive Access Assessment
Discuss with staff what strategies that support same-visit provision are already being implemented in the clinic.	Same-Visit Contraception Implementation Checklist
Brainstorm ideas for improvement and develop an action plan for implementing same-visit contraception.	Same-Visit Contraception: Implementation Strategies for Clinic Staff Discussion Guide & Slides

What I'm hearing from patients about how they feel about being able to get all of their needs met in one visit is that they are sometimes surprised and always very excited. All of us have challenges in going to appointments and our patients are no different.

CARMEN SULTANA, MD, FACOG
Chief of Obstetrics and Gynecology
NYC Health + Hospitals/Lincoln

Contraceptive Access Assessment

How often are patients able to receive the following methods during the SAME VISIT in which they request them (when you can be reasonably certain the patient is not pregnant)?	NEVER/ ALMOST NEVER	RARELY	SOMETIMES	OFTEN	ALWAYS/ ALMOST ALWAYS
Copper Intrauterine Device (IUD)	☐	☐	☐	☐	☐
LNG Intrauterine System (IUS)	☐	☐	☐	☐	☐
Hormonal Implant	☐	☐	☐	☐	☐
Hormonal Injection	☐	☐	☐	☐	☐
Oral Contraceptive Pills	☐	☐	☐	☐	☐
Contraceptive Patch	☐	☐	☐	☐	☐
Vaginal Ring	☐	☐	☐	☐	☐

How often do providers adhere to the following **EVIDENCE-BASED CLINICAL PRACTICES?** *Not sure? Consider observing a few patient visits using the Patient Visit Tracking Sheet or conduct chart reviews to find out.*	NEVER/ ALMOST NEVER	RARELY	SOMETIMES	OFTEN	ALWAYS/ ALMOST ALWAYS
Patients are provided their contraceptive method of choice (inlcuding IUD/IUS and impant) at their visits rather than waiting for next menses (also known as "quick start") if the provider can be reasonably certain that the patient is not pregnant. (QFP)	☐	☐	☐	☐	☐
Evidence-based medical criteria for contraceptive use are used to assess safety and eligibility for contraceptive methods. (MEC)	☐	☐	☐	☐	☐
Patients are provided their methods of choice (including IUD/IUS) without requiring a negative STD test result (unless medically indicated). (SPR)	☐	☐	☐	☐	☐
Patients are provided or prescribed multiple cycles of oral contraceptive pills, the contraceptive patch, or the vaginal ring. (QFP)	☐	☐	☐	☐	☐
Patients are provided or prescribed their methods of choice, without requiring a pelvic exam (with the exceptions of IUD, IUS, or diaphragm). (SPR)	☐	☐	☐	☐	☐

Same-Visit Contraception Implementation Checklist

Use this checklist to implement (or streamline) provision of the full range of contraceptive methods during the same visit your client first requests contraception.

STOCK: Stock devices and make supplies readily available.

- ❑ Stock the full range of methods, including at least one of each provider-dependent method *(i.e., hormonal intrauterine device [IUD], copper IUD, implant, and injectable)*.
- ❑ Keep supplies for IUD and implant insertions and removals in exam rooms.
- ❑ Utilize 340B pricing and other discounts to obtain lower-cost supplies.
- ❑ Develop a system to maintain sufficient stock of contraceptive methods.

SYSTEMS: Adjust systems to ensure efficient and sustainable service delivery.

- ❑ Adopt a policy that supports same-visit provision of all methods.
- ❑ Eliminate designated appointment slots for IUD and implant insertions.
- ❑ Make adjustments to the schedule if necessary *(e.g., block appointments, eliminate double booking, use one appointment length)* to enable flexibility for same-visit provision.
- ❑ Make changes as necessary to clinic workflow *(e.g., reduce number of client stops, eliminate duplication of effort, increase efficiency of client flow)* to ensure same-visit integration does not increase client cycle time.
- ❑ Track claims data and conduct quality assurance of coding and billing to ensure adequate reimbursement of same-visit services.

STAFF: Engage, train, and support all staff.

- ❑ Cultivate staff buy-in for same-visit provision *(e.g., by sharing how same-visit provision impacts client access, engaging staff in improvement strategies, sharing success stories)*.
- ❑ Train staff on current standards of care related to the provision of contraceptive services *(e.g., Quality Family Planning, Selected Practice Recommendations, Medical Eligibility Criteria, Sexually Transmitted Diseases Treatment Guidelines)*.
- ❑ Train clinicians to insert and remove the full range of LARC methods.
- ❑ Train front-desk, nursing, and other staff with client contact on the agency's policy and procedures for same-visit services.
- ❑ Give front desk staff suggested language to use when responding to clients' frequently asked questions regarding same-visit services.
- ❑ Post Quick Start job aids in exam rooms.
- ❑ Train staff who are responsible for billing and coding on how to code accurately, including the use of coding modifiers, for reimbursement of same-visit services.

Same-Visit Contraception: Implementation Strategies for Clinic Staff Discussion Guide

HOW TO USE THIS GUIDE	This guide is designed to support facilitation of an interactive discussion about **Same-Visit Contraception: Implementation Strategies for Clinic Staff**. This discussion guide is part of Same-Visit Contraception: An Implementation Guide for Family Planning Providers. Facilitators should feel free to adapt and revise this guide.
LEARNING OBJECTIVES	By the end of the discussion, participants should be able to: » Describe why it is important to offer methods during the same visit initially requested by the client (i.e., same-visit) » Discuss the clinic's policy regarding clients being able to obtain their method of choice same-visit, and when they may not » Identify strategies to increase client access to methods same-visit
LENGTH	At least **90 minutes**, with more time for discussion as schedules allow.
MATERIALS	» **Same-Visit Contraception: An Implementation Guide for Family Planning Providers:** A guide to support provision of contraception during the same visit the client first requests contraception. » **PowerPoint Slides with Notes:** Slides with speaker notes and discussion questions » **Speakers:** To play videos during the session.
FORMAT	This discussion is designed to be conducted **in person.**
SUGGESTED PARTICIPANTS	**Family planning clinic staff.** These slides are meant to be presented by a Title X grantee, Title X clinic manager, or other clinic staff motivated to provide same-visit contraception at a clinic.
BEFORE YOU START...	Facilitators should review and be familiar with the tools and resources outlined in **Same-Visit Contraception: An Implementation Guide for Family Planning Providers.**

Same-Visit Contraception: Implementation Strategies for Clinic Staff Discussion Guide

Introduction to Same-Visit Contraception

10 minutes | Slides 1-5

	Present Slide	Facilitate
1	Same-Visit Contraception: Implementation Strategies for Clinic Staff	Activity: » Conduct participant and facilitator introductions.
2	Meeting objectives	
3	Contraceptive Access Change Package	
4	Defining same-visit access	
5	Initiating Long-Acting Contraceptive Methods Same-Visit: The Provider Perspective Video	Activity: » Watch this four-minute video to hear from several clinicians who provide methods same-visit.

Importance of Providing Same-Visit Contraception

10 minutes | Slides 6-13

	Present Slide	Facilitate
6	Rationale for same-visit access	
7	Quick Start Algorithm	
8	How to be reasonably certain a client is not pregnant *(CDC)*	
9	When to start using specific contraceptive methods *(CDC)*	
10	Examinations or tests needed before initiation *(CDC)*	
11	Additional visits are a barrier for clients	

Same-Visit Contraception: Implementation Strategies for Clinic Staff Discussion Guide

12	Clients are busy
13	Client satisfaction

Clinic Policy for Providing Methods Same-Visit

5 minutes | Slides 14-15

Present Slide	Facilitate
14 Our policy	
15 Our policy (cont.)	

Discussion of Challenges and Implementation Strategies

25 minutes | Slides 16-21

Present Slide	Facilitate
16 What methods are available same-visit?	Discussion: » What methods are we currently able to provide same-visit?
17 Why is it challenging to offer some methods same-visit?	Discussion: » What makes it challenging to offer some methods same-visit?
18 Domains of same-visit contraception implementation	
19 Stock devices and make supplies readily available	Discussion: » Which of these strategies do we already do? » Which strategies are we not already doing? How can we go about implementation?
20 Adjust systems for efficient and sustainable service delivery	Discussion: » Which of these strategies do we already do? » Which strategies are we not already doing? How can we go about implementation?
21 Engage, train, and support all staff	Discussion: » Which of these strategies do we already do? » Which strategies are we not already doing? How can we go about implementation?

Same-Visit Contraception: Implementation Strategies for Clinic Staff Discussion Guide

Same-Visit Contraception Implementation Plan

20 minutes | Slides 22-23

Present Slide	Facilitate
22 Brainstorm improvement ideas	Discussion: » What are we trying to accomplish? What is our goal? » How will we know (i.e., measure) that a change is an improvement? » What changes will lead to improvement?
23 Implementation plan	Discussion: » Select 3–4 implementation strategies from the brainstorm and begin to fill out the implementation plan, including who will do what, by when, and how.

Success Stories & Lessons Learned From the Field

15 minutes | Slide 24

Present Slide	Facilitate
24 Case study videos	Activity: » Watch one or more of three case study videos (each about five minutes). In the videos, staff at family planning clinics talk about some of the challenges they encountered when they began providing methods same-visit, and how they overcame those challenges. Discussion: » How are we feeling about offering methods same-visit? » How has hearing from other sites in the case study videos impacted any fears or reservations we have?

Conclusion

5 minutes | Slides 25-26

Present Slide	Facilitate
25 We're not alone!	
26 Thank you!	

Same-Visit Contraception: Implementation Strategies for Clinic Staff Slides

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Same-Visit Contraception: Implementation Strategies for Clinic Staff

Last Reviewed July 2018

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Meeting Objectives

- Describe why it is important to offer methods during the same visit initially requested by the client (i.e., same-visit)
  - Including provider-dependent methods like the intrauterine device (IUD), implant, and injectable
- Discuss our policy regarding when clients can obtain their method of choice same-visit, and when they may not
- Identify strategies to increase client access to methods same-visit

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Contraceptive Access Change Package

Best Practice Recommendations

1. Stock all methods
2. Utilize client-centered counseling
3. Offer same-visit access
4. Reduce cost as a barrier

Link: https://www.fpntc.org/resources/contraceptive-access-change-package

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Defining Same-Visit Access

- "Same-visit" access to all methods means that during a single visit, clients can **request a method and leave their visit** with that selected method*
  - Not requiring clients to come back for new appointment on a different day, or later the same day
- Option should be **available** to clients
  - Regardless of reason for initial visit
  - Not expected that this will work for all clients

*When the provider can be reasonably certain that the client is not pregnant

FPNTC 4

Initiating Long-Acting Contraceptive Methods Same-Visit: The Provider Perspective

Link: https://www.fpntc.org/resources/initiating-long-acting-contraceptive-methods-same-visit-provider-perspective

FPNTC 5

Rationale for Same-Visit Access

- There is **no medical reason to routinely require multiple visits** to initiate any contraceptive method, if the provider can be reasonably certain that the client is not pregnant
- CDC and ACOG agree that **clinicians can provide the client's method of choice in a single visit**, unless additional testing is medically indicated
- Use the Quick Start method to initiate contraceptive methods same-visit

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Same-Visit Contraception: Implementation Strategies for Clinic Staff Slides

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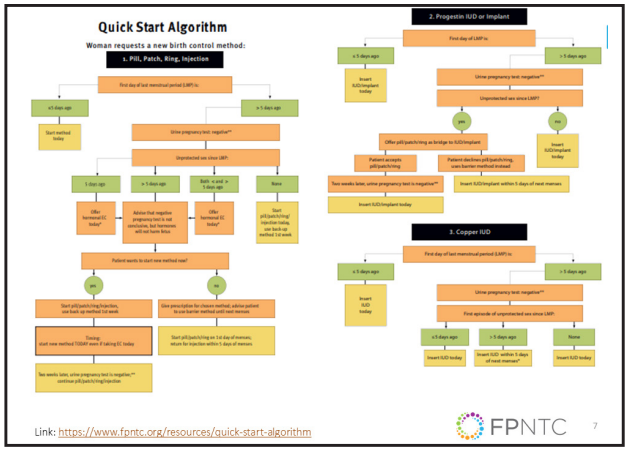

Link: https://www.fpntc.org/resources/quick-start-algorithm

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How to Be Reasonably Certain a Client is Not Pregnant (CDC)

The client has no symptoms or signs of pregnancy and meets any one of the following criteria:

- ❑ is ≤7 days after the start of normal menses
- ❑ has not had sexual intercourse since the start of last normal menses
- ❑ has been correctly and consistently using a reliable method of contraception
- ❑ is ≤7 days after spontaneous or induced abortion
- ❑ is within 4 weeks postpartum
- ❑ is fully or nearly fully breastfeeding (exclusively breastfeeding or the vast majority [≥85%] of feeds are breastfeeds), amenorrheic, and <6 months postpartum

US Selected Practice Recommendations for Contraceptive Use, 2016
Link: https://www.fpntc.org/resources/how-be-reasonably-certain-patient-not-pregnant-and-when-start-contraceptive-methods-palm

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How to Be Reasonably Certain That a Woman is Not Pregnant

A health-care provider can be reasonably certain that a woman is not pregnant if she has no symptoms or signs of pregnancy and meets any one of the following criteria:

- is ≤7 days after the start of normal menses
- has not had sexual intercourse since the start of last normal menses
- has been correctly and consistently using a reliable method of contraception
- is ≤7 days after spontaneous or induced abortion
- is within 4 weeks postpartum
- is fully or nearly fully breastfeeding (exclusively breastfeeding or the vast majority [≥85%] of feeds are breastfeeds), amenorrheic, and <6 months postpartum

In situations in which the health-care provider is uncertain whether the woman might be pregnant, the benefits of starting the implant, depot medroxyprogesterone acetate (DMPA), combined hormonal contraceptives and progestin-only pills likely exceed any risk; therefore, starting the method should be considered at any time, with a follow-up pregnancy test in 2–4 weeks. For IUD insertion, in situations in which the health-care provider is not reasonably certain that the woman is not pregnant, the woman should be provided with another contraceptive method to use until the health-care provider can be reasonably certain that she is not pregnant and can insert the IUD.

When to Start Using Specific Contraceptive Methods

Contraceptive method	When to start (if the provider is reasonably certain that the woman is not pregnant)	Additional contraception (i.e., back up) needed	Examinations or tests needed before initiation[1]
Copper-containing IUD	Anytime	Not needed	Bimanual examination and cervical inspection[2]
Levonorgestrel-releasing IUD	Anytime	If >7 days after menses started, use back-up method or abstain for 7 days.	Bimanual examination and cervical inspection[2]
Implant	Anytime	If >5 days after menses started, use back-up method or abstain for 7 days.	None
Injectable	Anytime	If >7 days after menses started, use back-up method or abstain for 7 days.	None
Combined hormonal contraceptive	Anytime	If >5 days after menses started, use back-up method or abstain for 7 days.	Blood pressure measurement
Progestin-only pill	Anytime	If >5 days after menses started, use back-up method or abstain for 2 days.	None

Abbreviations: BMI = body mass index; IUD = intrauterine device; STD = sexually transmitted disease; U.S. MEC = U.S. Medical Eligibility Criteria for Contraceptive Use

[1] Weight (BMI) measurement is not needed to determine medical eligibility for any methods of contraception because all methods can be used (U.S. MEC 1) or generally can be used (U.S. MEC 2) among obese women. However, measuring weight and calculating BMI (weight [kg]/height [m²]) at baseline might be helpful for monitoring any changes and counseling women who might be concerned about weight change perceived to be associated with their contraceptive method.

[2] Most women do not require additional STD screening at the time of IUD insertion. If a woman with risk factors for STDs has not been screened for gonorrhea and chlamydia according to CDC's STD Treatment Guidelines (http://www.cdc.gov/std/treatment), screening can be performed at the time of IUD insertion, and insertion should not be delayed. Women with current purulent cervicitis or chlamydial infection or gonococcal infection should not undergo IUD insertion (U.S. MEC 4).

Source: For full recommendations and updates, see the U.S. Selected Practice Recommendations for Contraceptive Use webpage at http://www.cdc.gov/reproductivehealth/unintendedpregnancy/uspr.htm.

CDC

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How to Be Reasonably Certain That a Woman is Not Pregnant

A health-care provider can be reasonably certain that a woman is not pregnant if she has no symptoms or signs of pregnancy and meets any one of the following criteria:

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- is ≤7 days after spontaneous or induced abortion
- is within 4 weeks postpartum
- is fully or nearly fully breastfeeding (exclusively breastfeeding or the vast majority [≥85%] of feeds are breastfeeds), amenorrheic, and <6 months postpartum

In situations in which the health-care provider is uncertain whether the woman might be pregnant, the benefits of starting the implant, depot medroxyprogesterone acetate (DMPA), combined hormonal contraceptives and progestin-only pills likely exceed any risk; therefore, starting the method should be considered at any time, with a follow-up pregnancy test in 2–4 weeks. For IUD insertion, in situations in which the health-care provider is not reasonably certain that the woman is not pregnant, the woman should be provided with another contraceptive method to use until the health-care provider can be reasonably certain that she is not pregnant and can insert the IUD.

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Source: For full recommendations and updates, see the U.S. Selected Practice Recommendations for Contraceptive Use webpage at http://www.cdc.gov/reproductivehealth/unintendedpregnancy/uspr.htm.

CDC

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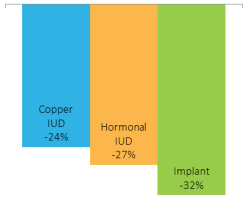
Additional Visits are a Barrier for Clients

- Clinical Training Center for Family Planning online survey of APRNs (n=390)
  - 35% of respondents had policies that permitted same-visit provision
  - Over half (56%) required ≥2 visits to provide method
  - Every one visit increase required for LARC provision resulted in fewer insertions

Every one visit increase required for LARC provision resulted in the placement of fewer LARCs.



National Clinical Training Center for Family Planning, 2016.

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Clients are Busy

- Client barriers to accessing care
  - Child care
  - Transportation
  - Leave from work

"If the patient wants a LARC method and we provide it the same day, that prevents an issue with the patient having to come back to the clinic. It prevents the risk of an unplanned pregnancy because they're going to forget a pill or forget to come back for their next Depo or not be able to take another day off work to come back and get that LARC method."

- Nurse Practitioner, Southern Nevada Health District

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Same-Visit Contraception: Implementation Strategies for Clinic Staff Slides

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Client Satisfaction

- Offering methods same-visit increases client satisfaction
- And when clients are satisfied, we're satisfied!

"What I'm hearing from patients about how they feel about being able to get all of their needs met, including their contraceptive needs in one visit, is that they are sometimes surprised and always very excited to be able to do this."

- Physician, NYC Health + Hospitals

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Our Policy

Based on nationally recognized standards of care (QFP, SPR, MEC), it is our policy to:

- Provide clients access to the contraceptive method that they want without delay, unless medically contraindicated and as long as the provider can be reasonably certain the client is not pregnant.

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Our Policy (cont.)

- Methods should be available exclusively on a voluntary basis.
  - No client should be coerced to use a particular method or any method of birth control.
- It is a client's right to delay receiving the method, or have any method removed on request, at any time.

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What Methods are Available Same-Visit?

- What methods are we currently able to provide during the same visit initially requested by the client?
  - Hormonal IUD
  - Copper IUD
  - Contraceptive implant
  - Depo
  - Pill, patch, ring

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Why is It Challenging to Offer Some Methods Same-Visit?

- What makes it challenging to offer these methods during the same visit initially requested by the client?
  - Hormonal IUD
  - Copper IUD
  - Contraceptive implant
  - Depo
  - Pill, patch, ring

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Domains of Same-Visit Contraception Implementation

1. STOCK
Stock devices and make supplies readily available.

2. SYSTEMS
Adjust systems for efficient and sustainable service delivery.

3. STAFF
Engage, train, and support all staff.

Link: https://www.fpntc.org/resources/same-visit-contraception-implementation-guide-family-planning-providers

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Same-Visit Contraception: Implementation Strategies for Clinic Staff Slides

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Stock Devices and Make Supplies Readily Available

- ❑ Stock the full range of methods, including at least one of each provider-dependent method.
  - i.e., hormonal IUD, copper IUD, implant, and injectable
- ❑ Keep supplies for IUD and implant insertions and removals in exam rooms (e.g., in kits or a caddy).
- ❑ Develop a system to maintain sufficient stock of contraceptive methods.

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Adjust Systems for Efficient and Sustainable Service Delivery

- ❑ Adopt a policy that supports same-visit provision.
- ❑ Make adjustments to the schedule, if necessary, to enable flexibility in service provision.
  - e.g., eliminate designated appointment slots for IUD and implant insertions, use one appointment length
- ❑ Make changes, if necessary, to clinic workflow to ensure same-visit integration does not increase client cycle time.
  - e.g., reduce number of client stops, eliminate duplication of effort

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Engage, Train, and Support All Staff

- ❑ Clinicians
  - Current standards of care
  - Insertion and removal of LARC methods
  - Quick Start (including posting of reference guides)
- ❑ Administrative and support
  - How to respond to clients' questions about obtaining methods
- ❑ Billing and coding
  - Use of coding modifiers
  - Tracking claims data and quality assurance of coding and billing to ensure adequate reimbursement

FPNTC 21

Brainstorm Improvement Ideas

- What are we trying to accomplish?
  - Where are we starting from? What is our goal?
- How will we know that a change is an improvement?
  - How will we measure it?
- What changes will lead to improvement?
  - What are our improvement ideas?
  - What will have the most impact?
  - What is the "low-hanging fruit"?

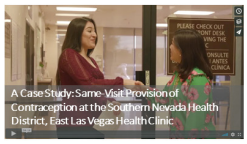
FPNTC 22

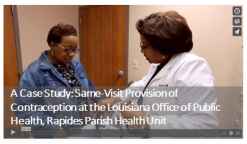
Implementation Plan

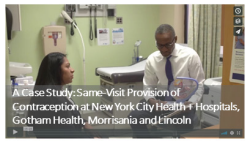
What (Strategy)	Who	By When	Communication Plan	Sustainability Plan
Example: Stock exam rooms with supplies	*Rosa*	*End of the month*	*Rosa will let Dr. May know when rooms are ready*	*Rosa will check rooms once a week to monitor supplies*

FPNTC 23

Case Study Videos





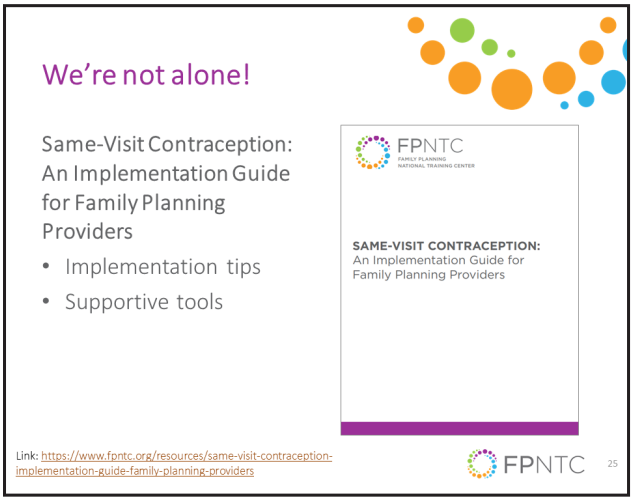


Links:
https://www.fpntc.org/resources/case-study-same-visit-provision-contraception-southern-nevada-health-district-east-las
https://www.fpntc.org/resources/case-study-same-visit-provision-contraception-louisiana-office-public-health-rapides
https://www.fpntc.org/resources/case-study-same-visit-provision-contraception-nyc-healthhospitals-morrisania-and-lincoln

FPNTC 24

Same-Visit Contraception: Implementation Strategies for Clinic Staff Slides

PAGE 5 OF 5



ACCESS AN ELECTRONIC VERSION OF THIS TOOL ONLINE AT
https://www.fpntc.org/resources/same-visit-contraception-implementation-strategies-clinic-staff-discussion-guide-slides

STRATEGY 1

Stock Devices and Make Supplies Readily Available

Title X clinics must provide a "broad range" of Food and Drug Administration (FDA)-approved contraceptive methods and services.[11,12] Although some methods can be obtained by prescription, the provider-dependent methods and their associated supplies need to be stocked on site in order to offer them same-visit.

Strategies and related tools for stocking devices and making supplies readily available are described on the following pages.

STRATEGY 1.1

Stock the full range of methods, including at least one of each provider-dependent method.

At a minimum, at least one type of each FDA-approved provider-dependent method (i.e., hormonal IUD, copper IUD, implant, and injectable) should be stocked on site. Other methods (e.g., pill, patch, ring, condoms, and information about natural family planning) should also be readily available, either stocked on site or through a pharmacy.

ACTION STEPS	RESOURCES
Identify what methods are currently stocked on site and, if necessary, what methods need to be added.	What Methods Should Family Planning Providers Stock?
Forecast demand for new methods based on prior client interest, experience of other sites, or national data.	Contraceptive Method Forecasting and Inventory Monitoring Calculator
Utilize the buy-and-bill approach to obtain methods prior to the client's arrival.	Intrauterine Devices and Implants: A Guide to Reimbursement *Find this tool on fpntc.org*
Use distributor programs that make devices more affordable, including volume discounts, 90-day net terms, pay by credit, and patient assistance programs.	How to Purchase Intrauterine Devices (IUDs) and Implants
Utilize the 340B drug pricing program to obtain contraceptive methods at reduced cost.	340B Drug Pricing Program Frequently Asked Questions

One of the things we had to do to make sure we were able to provide same day LARCs for our patients was to do some forecasting, to look up some data to see what methods patients really wanted, so that we can order the appropriate amount for our clinic.

YORDANOS BROWN, RN
Senior Community Health Nurse
Southern Nevada Health District

What Contraceptive Methods Should Family Planning Providers Stock?

All clients should have access to the "full range" of contraceptive methods. According to the U.S. Department of Health and Human Services, and in line with Institute of Medicine recommendations, this means that clients should be able to obtain any of the 18 types of contraceptive methods approved by the Food and Drug Administration (FDA). When multiple products are available within a category (e.g., the hormonal intrauterine device or IUD), at least one should be accessible. To ensure client access, the full range of methods should be stocked on site or be easily available through a pharmacy. Providers should also offer services or referrals for FDA-approved sterilization procedures.

Provider-Dependent Contraceptive Methods

*Given the additional barriers that clients face to obtain **provider-dependent methods(*)**, sites should have at least one of each provider-dependent method in stock.*

- ❑ Copper IUD*
- ❑ IUD with progestin*
- ❑ Implantable rod*
- ❑ Progestin shot/injection (Depo-Provera)*

Contraceptive Methods Available by Prescription or Over the Counter

Methods that do not require provider intervention may be dispensed on site or at a nearby pharmacy.

- ❑ Combination oral contraceptives
- ❑ Oral contraceptives (Progestin-only)
- ❑ Patch
- ❑ Vaginal contraceptive ring
- ❑ Diaphragm
- ❑ Sponge
- ❑ Cervical cap
- ❑ Male condom
- ❑ Female condom
- ❑ Spermicide
- ❑ Emergency contraception (EC) pills
    - ❑ Levonorgestrel 1.5 mg (1 pill) or Levonorgestrel .75 mg (2 pills)
    - ❑ Ulipristal Acetate

SOURCES

» Food and Drug Administration (FDA). "Birth Control." Last Updated: March 6, 2018.
» Institute of Medicine. "Clinical preventive services for women: closing the gaps." Washington, DC: National Academies Press; 2011.
» HealthCare.gov "Birth Control Benefits." https://www.healthcare.gov/coverage/birth-control-benefits/
» Kaiser Family Foundation. "Minimum Contraceptive Coverage Requirements Clarified by HHS Guidance." May 11, 2015.

Contraceptive Method Forecasting and Inventory Monitoring Calculator

PAGE 1 OF 2

The purpose of this calculator is to forecast monthly client demand for each contraceptive method.

Instructions: In order to use this calculator to estimate monthly client demand for contraceptive methods:
1. Enter known (if possible) or estimated data from your site(s) in the gray boxes below.
2. Blue boxes will calcuate automatically.

Step 1. Calculate approximate total demand for contraceptive services.
Instructions: Enter known or estimated data about your site(s) in the gray boxes below. Data in the blue boxes will update automatically.

	Enter Your Site(s) Data Here	*Example Site's Data*
Average # of Clients Seen Per Day		*100*
% of Clients that are Female and of Reproductive Age (15-44 Years)		*50%*
# of Days Per Month Clinic is Open		*20*
Approximate # of Female Clients 15-44 Seen Per Month (calculates automatically)	0	*1000*
Approximate # of Female Clients 15-44 Seen Per Month Who Are Possible Candidates for Contraceptive Services^ (calculates automatically)	0	*904*

Enter data about your site's female clients of reproductive age.

^Nationally, among all female clients 15-44, about 9.5% are pregnant or seeking pregnancy (Source: FPAR 2016). These are excluded for the estimated number of female clients that are possible candidates for contraceptive services.

Step 2. Calculate known or estimated proportion of clients interested in each contraceptive method.
Instructions: Enter known or estimated proportn of your clients inton of your clients interested in each method in the gray boxes below.
If unknown, use national data as reference. Use only the rows that are applicable for the site. Ignore rows that do not apply based on your site's needs.
Data in the blue boxes (see Step 3) will update automatically.

Contraceptive Methods	Enter Known or Estimated % of Your Site(s) Female Clients 15-44 Interested in Using Method	National Data	Reference for National Data
Copper IUD		1.7%	*Birgisson 2015**
Hormonal IUD		6.7%	*Birgisson 2015**
Hormonal implant		6.1%	*FPAR 2016^*
Hormonal injection		14.9%	*FPAR 2016*
Oral contraceptive		27.5%	*FPAR 2016*
Contraceptive patch		1.4%	*FPAR 2016*
Vaginal ring		2.5%	*FPAR 2016*
Male condom		23.8%	*NSFG 2011-2015*
Female condom		0.1%	*FPAR 2016*
Cervical cap or diaphragm		0.1%	*FPAR 2016*
Contraceptive sponge		0.0%	*FPAR 2016*
Spermicide		0.1%	*FPAR 2016*

Enter data about your site's clients interested in each contraceptive method.

**If you have a large adolescent (14-17) population, demand for the implant may be higher (Birgisson 2015). Nationally, 8.7% of Title X clients are <17 years of age (FPAR 2016).*
**Overall, 8.3% of Title X female clients 15-44 used the IUD in 2016. (FPAR 2016) * Among all women, hormonal IUDs are preferred at a rate of 4:1.*
Sources:
Family Planning Annual Report (FPAR) 2016
Birgisson NE, Zhao Q, Secura GM, Madden T, Peipert JF. Preventing Unintended Pregnancy: The Contraceptive CHOICE Project in Review. Journal of Women's Health. 2015;24(5):349-353.
National Survey of Family Growth 2011-2015. National Health Statistics Report Number 108 August 2017. https://www.cdc.gov/nchs/data/nhsr/nhsr108.pdf

Step 3. Analyze estimated monthly, forecasted demand for quantity of each method. Data in the blue boxes will update automatically.

Contraceptive Methods	Estimated Monthly Demand of Each Method (calculates automatically)
Copper IUD	0
Hormonal IUD	0
Hormonal implant	0
Hormonal injection	0
Oral contraceptive	0
Contraceptive patch	0
Vaginal ring	0
Male condom	0
Female condom	0.0
Cervical cap or diaphragm	0.0
Contraceptive sponge	0.0
Spermicide	0.0

The monthly demand for each contraceptive method will be automatically calculated.

Contraceptive Method Forecasting and Inventory Monitoring Calculator

PAGE 2 OF 2

The second tab of the calculator will allow you to determine if adequate stock is on hand and how much stock should be ordered.

Instructions: In order to use this calculator to monitor inventory:
1. Enter known (if possible) or estimated data from your site(s) in the gray boxes below.
2. Use only the columns that are applicable for your site. Ignore columns that do not apply based on your site's needs.
3. Blue boxes will calcuate automatically.

Step 1. Calculate average monthly consumption (AMC).
Instructions: Enter the amount dispensed of each method for at least the prior three months in the gray boxes below. The blue boxes will calculate the AMC for each method automatically

	Copper IUD	Hormonal IUD	Hormonal implant	Hormonal injection	Oral contraceptive	Contraceptive patch	Vaginal ring	Male condom	Female condom	Cervical cap or diaphragm	Contraceptive sponge	Spermicide
Quantity Dispensed Month 1												
Quantity Dispensed Month 2												
Quantity Dispensed Month 3												
Quantity Dispensed Month 4 (optional)												
Quantity Dispensed Month 5 (optional)												
Quantity Dispensed Month 6 (optional)												
Average Monthly Consumption (# of Supplies) (calculates automatically)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Enter the amount of each method dispensed.

Step 2. Calculate maximum and minimum stock quantities.
Intructions: Enter the order interval (time between regular orders) and average lead time in months in the gray boxes below.
The blue boxes will calculate automatically with the minimum and maximum quantity of devices that should be stocked.

	Copper IUD	Hormonal IUD	Hormonal implant	Hormonal injection	Oral contraceptive	Contraceptive patch	Vaginal ring	Male condom	Female condom	Cervical cap or diaphragm	Contraceptive sponge	Spermicide
Order Interval (Months)												
Lead Time (Months)												
Minimum Quantity of Devices (#) (calculates automatically)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Maximum Quantity of Devices (#) (calculates automatically)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Calculate the maximum and minimum stock quantities.

Step 3. Determine how many months of supply are on hand.
Instructions: Enter the amount of stock on hand in the gray boxes. The blue boxes will calculate automatically with the number of months of supply currently on hand

	Copper IUD	Hormonal IUD	Hormonal implant	Hormonal injection	Oral contraceptive	Contraceptive patch	Vaginal ring	Male condom	Female condom	Cervical cap or diaphragm	Contraceptive sponge	Spermicide
Amount Stocked on Hand (#)												
Supply on Hand (Months) (calculates automatically)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Step 4. Determine how much stock needs to be ordered.
Instructions: Enter the amount of stock is on order. The blue boxes will calculate automatically with the amount of stock to order.

	Copper IUD	Hormonal IUD	Hormonal implant	Hormonal injection	Oral contraceptive	Contraceptive patch	Vaginal ring	Male condom	Female condom	Cervical cap or diaphragm	Contraceptive sponge	Spermicide
Amount of Stock on Order (#)												
Order Quantity (#) (calculates automatically)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

After entering your data in Steps 1-4, the amount of stock that needs to be ordered for your site will be automatically calculated.

ACCESS AN ELECTRONIC VERSION OF THIS TOOL ONLINE AT
https://www.fpntc.org/resources/contraceptive-method-forecasting-and-inventory-monitoring-calculator

How to Purchase Intrauterine Devices (IUDs) and Implants

This summary outlines steps to order IUDs and implants. It also includes information on discounts available through distributors and patient assistance programs.

Method (Manufacturer)	Distributor(s)	How to Place a Wholesale Order	Discounts Available	Patient Assistance Programs
Kyleena, Mirena, and Skyla (Bayer)	Women's Health Care Support Center	» Create an account for online ordering: https://www.whcsupport.com/ » Call 1-866-647-3646	» 90-day net terms » Pay by credit card » Volume discounts (see VDP Flashcards)	ARCH Patient Assistance Program is available for clients that are U.S. residents, uninsured, and low-income.
Liletta (Medicines360)	ANDA	» Create an account for online ordering: http://lilettaaccessconnect.com/ » For help call 1-855-LILETTA (1-855-545-3882)	» $50 340B pricing » 90-day net terms » Pay by credit card » Volume discounts	Patient Savings Program covers out of pocket expenses over $75 for insured clients. Offices can enroll by calling 855-706-4508.
Nexplanon (Merck)	CuraScript and CVS Caremark	CuraScript SD » Create an account for online ordering: https://www.merckconnect.com/nexplanon/curascript.html » Call 1-866-844-0148 CVS Caremark » Create an account for online ordering: https://www.merckconnect.com/nexplanon/cvs-caremark-theracom.html » Call 1-866-318-3492	» 90-day net terms » Pay by credit card or line of credit » 2% discount for orders paid with credit card or within 90 days of invoice	Clients can pay for devices in 3- or 6-month installments. Contact distributors to enroll clients.
ParaGard (Teva)	ParaGard Direct	» Create an account for online ordering: https://www.paragarddirect.com/ » Call 1-877-PARAGARD (727-2427) » Existing customers can complete an order form to order by email or fax	» 90-day net terms » Pay by credit card, check, or line of credit » Volume discounts (contact distributor)	Clients can pay for devices in 4- or 12-month installments. To enroll, clients complete a Patient Direct Request form.

Source: UCSF Intrauterine Devices & Implants: A Guide to Reimbursement. http://larcprogram.ucsf.edu

340B Drug Pricing Program Frequently Asked Questions for Title X Family Planning Agencies

WHAT IS 340B?

The 340B Drug Pricing Program allows safety-net providers to obtain and provide outpatient drugs at a discounted or "340B" rate. The program's purpose is to help safety-net providers take advantage of limited federal resources in order to reach more eligible patients and provide more comprehensive services. The program is administered by the Office of Pharmacy Affairs, within the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS). This office is sometimes abbreviated to OPA (but should not be confused with HHS's Office of Population Affairs, also known as OPA).

ACCESSING THE PROGRAM

What kind of organizations can use 340B supplies?

Safety-net providers, including "disproportionate share" hospitals and recipients of specific federal grants from HRSA, the Centers for Disease Control and Prevention (CDC), the Office of Population Affairs, and the Indian Health Service are eligible to participate in the 340B program. Once approved and registered in the 340B database, safety-net providers are understood to be "covered entities."

How do we access this program?

All Title X-funded health centers are eligible to participate in the 340B program.

If you believe your agency is eligible, you can go to the 340B Office of Pharmacy Affairs Information System to register during one of the four annual open enrollment periods. New registrations are accepted January 1-15, April 1-15, July 1-15, and October 1-15 annually.

After you set up your account, you may make changes, such as update addresses, change contact information, and withdraw service sites from the program at any time. New sites or contract pharmacy arrangements may only be added during one of the four open enrollment periods.

When you register for the 340B program, each site must select an authorizing official (AO) and a primary contact (PC). AOs must be able to sign for and represent your organization legally. AOs and PCs must create individual user accounts and will not be able to share access. It is required that you select different individuals to serve in the AO and PC roles to ensure access to your 340B database entry, links and information for annual recertification, and to provide continuity if one of the two is away or leaves the organization.

Does the service site, the sub-recipient, or the grantee apply for certification?

In the past, the Title X grantee was responsible for the application. Now the sub-recipient or service site is usually the entity responsible for applying, with the grantee identified as part of the application. The grant number must be provided as part of the application, which is obtained from the grantee.

340B Drug Pricing Program Frequently Asked Questions for Title X Family Planning Agencies

Do we have to recertify every single year?

Yes, 340B-covered entities must recertify annually. Covered entities must prove their continued eligibility to participate in the 340B Drug Pricing Program as part of applying for recertification. Recertification also serves as an annual attestation of compliance with the requirements of the 340B program.

How do we access discounted medications?

The primary way to access discounted medications is through the Prime Vendor Program, run by Apexus. This program operates as a large group purchasing organization. Any 340B-covered entity can become a member of the Prime Vendor Program. It is free of cost to join and drugs and devices can be purchased through the program. Most pricing is set at what is referred to as a "sub-ceiling" price and may be more cost effective than other purchasing options. The Prime Vendor Program also offers other non-340B eligible items, including male and female condoms, test kits, and vaccines, at a reduced price to its members.

Alternatively, you can purchase medications through the manufacturer, a wholesaler, or a group purchasing organization (GPO) at a 340B price. Some manufacturers of long-acting reversible contraceptives (LARC) require their devices to be purchased from specified specialty distributors, which make 340B pricing available to eligible entities. There are some GPOs that cater to family planning providers, such as Afaxys.

We receive both Title X funding and 318 STD funding. Do we need to be certified as a 340B-covered entity twice?

You are not required to register for each eligible grant you receive. Some entities choose to maintain two registrations in order to maximize the number of patients able to receive 340B-priced drugs.

We are a federally-qualified health center (FQHC) that also receives Title X funding. Do we need to be certified as a 340B-covered entity twice?

No. Because FQHCs have an expanded scope of services that includes family planning services, many choose to register only once under their FQHC designation.

How can we find out if we are already a covered entity?

Search the 340B Office of Pharmacy Affairs Information System (OPAIS).

340B Drug Pricing Program Frequently Asked Questions for Title X Family Planning Agencies

ELIGIBLE PATIENTS

Now that we know we are a covered entity, which patients can get these drugs, and which cannot?

There are three criteria that a patient at a Title X-funded health center must meet in order to receive 340B-priced drugs:

1. The patient must have an established relationship with you (i.e., medical record). *(This individual must be your patient already and not coming to you solely for the purpose of obtaining discounted medications.)*
2. The patient must have received some clinical services from a provider that is employed by or contracted with your organization. *(This patient must not be coming to you solely for the purpose of obtaining discounted medications.)*
3. The patient has to receive a health care service that is consistent with the grant that makes you eligible for 340B pricing. In an entity certified for 340B under Title X, a patient has to receive some kind of family planning or family planning-related service, in order to be eligible to receive 340B-priced drugs. *(If you are also a 318 STD site or a FQHC, a patient can receive health care services that are consistent with those grants, if you are certified as a covered entity for those grant programs.)*

As long as the patient is an outpatient and meets these three criteria, any drug that you give at that visit can be a 340B-priced drug. If a patient receives a service consistent with the grant, but then you prescribe an additional drug that has nothing to do with family planning but is needed by the patient, both medications can be 340B-priced.

Note that there are no requirements about insurance status or income level when considering if a patient is eligible to receive 340B-priced drugs.

Can patients get 340B-priced drugs on their first visit?

Yes. Patients can receive 340B-priced drugs during their first visit, as long as a clinical service was provided and a medical record was initiated by the covered entity. Contraceptive counseling may be considered a service consistent with the grant in this context.

Do patients have to see a provider and have an encounter in order to get 340B-priced drugs?

Yes. Patients have to see a provider and receive a health care service for the patient to receive a 340B-priced drug. Note: They can receive 340B medications—such as regular Depo Provera, or pills, patch, and the ring—as refills without seeing a provider every visit.

STRATEGY 1.2
Keep supplies for IUD and implant insertions and removals in exam rooms.

Having the supplies and devices stocked in (or at a minimum, accessible to) the exam rooms expedites the insertion process when a client requests a method same-visit.

ACTION STEPS	RESOURCES
Listen to a family planning provider talk about how a portable caddy with supplies expedites clinic flow when a client requests same-visit contraception.	A Case Study: Same-Visit Provision of Contraception at the Southern Nevada Health District, East Las Vegas Health Clinic Video
Maintain a checklist of materials needed for IUD and implant insertions and removals.	Supplies for Insertion and Removal of Intrauterine Devices (IUD) and Implants
Pre-assemble the materials in kits (e.g., sealable bags), on trays, or in a portable caddy. Try different approaches to determine what works best.	
Designate a staff person to routinely (e.g., weekly) monitor and ensure that an adequate supply of materials has been pre-assembled.	

LARCs are actually stocked in the room itself and then in a separate cabinet we have a kit. And so for the APRN, it's just a question of taking the product and then taking the kit, putting it on a tray, spreading it out and doing the procedure. It's all readily available.

DR. DAVID HOLCOMBE, MD, MSA
Regional Administrator and Medical Director
Louisiana Office of Public Health Region VI

Supplies for Insertion and Removal of Intrauterine Devices (IUD) and Implants

To expedite same-visit provision, these supplies for IUD and implant insertions and removals should be readily available (e.g., in the exam room, in a pre-assembled kit). You can adapt this list based on your clinical practices.

IUD INSERTION

- ❑ Informed consent form for IUD insertion
- ❑ IUD insertion instructions (see prescribing information for ParaGard, Liletta, Mirena, Kyleena, or Skyla)
- ❑ Urine pregnancy test
- ❑ IUD client education sheet
- ❑ Device (ParaGard, Liletta, Mirena, Kyleena, or Skyla. Do not open until after sounding uterus.)
- ❑ Drape
- ❑ Chux for underneath buttocks
- ❑ Speculum
- ❑ Light source for speculum
- ❑ Sterile gloves (non-sterile exam gloves sufficient if "no touch" technique is used)
- ❑ Water-based lubricant
- ❑ Sterile 4x4 gauze or cotton balls (or equivalent)
- ❑ Povidone iodine or chlorhexidine (if iodine allergy)
- ❑ Silver nitrate sticks (not mandatory)
- ❑ Uterine sound; metal or plastic (sterile)
- ❑ Tenaculum forceps (sterile)
- ❑ Os finders
- ❑ Long scissors (non-sterile is okay)
- ❑ Sanitary pad

IMPLANT INSERTION

- ❑ Informed consent form for implant insertion
- ❑ Implant insertion instructions (see prescribing information for Nexplanon)
- ❑ Urine pregnancy test
- ❑ Implant client education sheet
- ❑ Implant device (Nexplanon)
- ❑ Sterile gloves
- ❑ Chux for under arm
- ❑ Povidone iodine or chlorhexidine (if iodine allergy)
- ❑ Alcohol wipes
- ❑ Cotton swabs
- ❑ Local anesthetic 1-2% (5cc)
- ❑ Long (1.5") needle (22-27g)
- ❑ Marker
- ❑ Sterile 4x4 gauze
- ❑ Scissors
- ❑ Small adhesive bandage or Steri-strip
- ❑ Bandage to wrap arm

Supplies for Insertion and Removal of Intrauterine Devices (IUD) and Implants

IUD REMOVAL	IMPLANT REMOVAL

Standard Removal

- ❑ Informed consent form for IUD removal
- ❑ IUD removal instructions (see prescribing information for ParaGard, Liletta, Mirena, Kyleena, or Skyla)
- ❑ Speculum
- ❑ Light source for speculum
- ❑ Non-sterile gloves
- ❑ Ring forceps
- ❑ Sanitary pad

Additional Supplies for Removals With No Visible Strings

- ❑ Single tooth tenaculum forceps (sterile)
- ❑ Alligator forceps (sterile)
- ❑ Thread retriever (sterile)
- ❑ Ultrasound (not required)

- ❑ Informed consent form for implant removal
- ❑ Implant removal instructions (see prescribing information for Nexplanon)
- ❑ Sterile gloves
- ❑ Povidone iodine or chlorhexidine (if iodine allergy)
- ❑ Alcohol wipes
- ❑ Cotton swabs
- ❑ Sterile 4x4 or 2x2 gauze
- ❑ Local anesthetic 1-2% (5cc)
- ❑ Long (1.5") needle (22-27g)
- ❑ Small bore needle (to inject) (e.g., 25 gauge)
- ❑ Straight scalpel (#11-#15 blade)
- ❑ 1 straight and 1 curved mosquito forceps/ hemostats (sterile)
- ❑ Small adhesive bandage or Steri-strip
- ❑ Bandage to wrap arm

Adapted from Unity Healthcare, Inc., Washington, DC.

STRATEGY 1.3
Develop a system to maintain sufficient stock of contraceptive methods.

To consistently offer methods same-visit, an adequate supply of each method must be maintained. Strict inventory control prevents both over-stocking (which may lead to expired contraceptives) and shortages or stock-outs of contraceptive supplies.

ACTION STEPS	RESOURCES
Use an inventory control system to ensure that the amount of stock on hand is always between desired maximum and minimum levels.	 Contraceptive Method Forecasting and Inventory Monitoring Calculator *See page 20*
Monitor utilization trends and adjust ordering as needed. Consider low-technology strategies, such as a logbook, to track devices.	
Designate a staff person to monitor stock levels and order supplies, and include this task in the job description.	

STRATEGY 2

Adjust Systems to Ensure Efficient and Sustainable Service Delivery

If staff already feel they have hectic and full clinic schedules, asking them to add another service to the visit without making adjustments may frustrate them. That said, many clinics are not working to their full productivity potential.

This section describes efficiency-increasing strategies to ensure that integration of same-visit contraception is successful.

STRATEGY 2.1

Adopt a policy that supports same-visit provision of all methods.

A clear, written policy stating that methods should be available same-visit can be critical for obtaining buy-in from key staff and will serve as the foundation upon which clinic processes are established.

ACTION STEPS	RESOURCES
Listen to a family planning provider talk about how they adopted a policy for same-visit contraception.	A Case Study: Same-Visit Provision of Contraception at NYC Health + Hospitals, Morrisania Health Center and Lincoln Hospital Video
Adopt a policy that: • Establishes that clients can obtain methods same-visit, unless medically contraindicated and as long as the clinician can be reasonably certain that a client is not pregnant. • Cites nationally recognized standards of care including QFP, SPR, MEC, and STD Treatment Guidelines. • Reiterates that methods should be available on a voluntary basis, and that no client should be coerced to use a particular method or any contraceptive method. • Includes that it is a client's right to delay receiving the method, or have any method removed by request, at any time.	Sample Policy for Same-Visit Contraceptive Services

Sample Policy for Same-Visit Contraceptive Services

PAGE 1 OF 2

This sample policy establishes that same-visit initiation of contraception should be available, in accordance with current standards of care. You can adapt the language to fit your program's needs.

SUBJECT: SAME-VISIT CONTRACEPTIVE SERVICES

POLICY: IT IS THE POLICY OF <CLINIC NAME> TO PROVIDE CLIENTS WITH THEIR CONTRACEPTIVE METHOD OF CHOICE WITHOUT DELAY.

ISSUE DATE: JULY 2018

1. All clients with reproductive potential will have their contraceptive and future pregnancy plans discussed at every visit. Contraceptive counseling and methods are provided on a voluntary basis, with respect to a client's choice, and in a non-coercive manner.

2. All clients desiring a new contraceptive method will have a documented negative urine pregnancy test when pregnancy cannot be reasonably excluded (see below).

   A provider can be reasonably certain that a woman is not pregnant if she has no symptoms or signs of pregnancy and meets any one of the following criteria:

   - ❑ Is ≤7 days after the start of normal menses
   - ❑ Has not had sexual intercourse since the start of last normal menses
   - ❑ Has been correctly and consistently using a reliable method of contraception
   - ❑ Is ≤7 days after spontaneous or induced abortion
   - ❑ Is within 4 weeks postpartum
   - ❑ Is fully or nearly fully breastfeeding (exclusively breastfeeding or the vast majority [≥85%] of feeds are breastfeeds),amenorrheic, and <6 months postpartum

3. All sexually active clients will be counseled on the use of condoms for the prevention of sexually transmitted diseases (STD). Male and female condoms will be made available in the clinic at no charge to clients.

4. All non-pregnant clients with reproductive potential will be screened for their need for emergency contraception and counseled regarding its use. A prescription will be provided to all clients desiring emergency contraception.

5. If a client chooses a contraceptive injection (Depo-Provera) after counseling, she will receive it that day. Injections will be scheduled 11–13 weeks apart. A follow-up pregnancy test should be considered in 2–3 weeks for those who had unprotected sex in the two weeks prior to their injection.

Sample Policy for Same-Visit Contraceptive Services

PAGE 2 OF 2

6. If a client chooses an intrauterine device (IUD)—either a copper IUD (ParaGard) or hormonal IUD (Mirena/Liletta/Skyla/Kyleena)—or contraceptive implant (Nexplanon) after counseling, she will be able to receive it that day if the clinician can be reasonably certain she is not pregnant (see bullets above). Clients for whom pregnancy cannot be reasonably ruled out should be counseled about using condoms/abstinence, and return in 2–3 weeks for a repeat urine pregnancy test and insertion of their chosen method. The copper IUD can be placed within 5 days of unprotected intercourse as a form of emergency contraception.

7. If a client desires an IUD or implant, every effort should be made to facilitate same-visit initiation. If the client has no contraindications to her method of choice, she will be counseled on the risks, benefits, and alternatives. The client will also be asked to give consent for insertion.

8. A gonorrhea/chlamydia (GC/CT) screening and a pap smear/human papillomavirus (HPV) test can be performed at the time of IUD insertion, if indicated. Any abnormal results will be treated with the IUD in situ. If a provider notes mucopurulent discharge or other concerning signs of cervicitis, the IUD insertion will be delayed until after treatment.

9. If a client receives a hormonal IUD or implant more than 7 days from the beginning of her last menstrual period, she will be counseled on the need for one week of back-up contraceptive coverage (condoms/abstinence). Copper IUDs do not require this back-up, as they are immediately effective when inserted.

10. A client should be scheduled for follow-up 6-8 weeks after IUD insertion and annually thereafter, or as needed, for all other methods initiated.

11. A client will have her IUD or implant removed at any time upon her request.

12. If the specified time for use of an IUD (3, 5, or 10 years) or implant (3 years) has passed, a client may have the old device removed and a new one inserted during the same visit.

13. If a client desires female sterilization surgery, she should be consented on the <INSERT STATE> required consent form. She should be counseled on the two different methods (hysteroscopic versus laparoscopic). She should also be told that the efficacy of permanent sterilization procedures is equivalent to that of long-acting reversible methods (IUD and implant). If surgery is desired, every effort will be made to schedule it as soon as possible. Once the consent form is signed, surgery must happen more than 30, but less than 180 days, later. If 180 days have lapsed, another signature of consent must be obtained, and the 30-day waiting period applied again.

STRATEGY 2.2

Adjust the schedule, if necessary, to enable flexibility for same-visit provision of contraception.

Many providers are concerned that they will not have enough time for same-visit provision within their existing schedules. However, many providers find that the amount of time for LARC insertions is just a few minutes when supplies can be assembled quickly. Use data to determine if changes to the appointment system are necessary.

ACTION STEPS	RESOURCES
Conduct a time study to learn how long IUD and implant insertions actually take when the materials are already gathered.	Same-Visit Contraception Schedule Impact Calculator
Eliminate designated appointment slots for LARC insertions. Listen to a family planning provider talk about how eliminating designated appointments for LARC insertions increased their ability to provide methods same-visit.	A Case Study: Same-Visit Provision of Contraception at the Louisiana Office of Public Health, Rapides Parish Health Unit Video
Use a standard length for all appointment types, including LARC insertions. Some appointments will take more (or less) time but will balance out over the course of the day and should not cause delays for clients.	
Consider adjusting the length of the standard appointment or blocking appointments during the day to catch up for same-visit insertions if the clinic is already at maximum capacity and its no-show rate does not allow same-visit procedures to be absorbed in the existing schedule.	

A LARC insertion only adds a little bit of extra time to the visit. I would say a Nexplanon adds maybe three minutes to the visit. The IUD insertion takes a little bit longer because we have to set up the field and get the patient undressed. I would say that maybe adds five minutes to the visit.

ERIN COOKE, APRN
Nurse Practioner
Southern Nevada Health District

Same-Visit Contraception Schedule Impact Calculator

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This calculator can be used to identify adjustments to the schedule (if necessary) to accommodate same-visit insertions for intrauterine devices (IUDs) and implants; calculate the amount of time needed for insertions; and determine the average length of a visit.

Instructions: In order to use this calculator to identify adjustments to the schdule to accomodate same-visit insertions:
1. Enter known (if possible) or estimated data from your site(s) in the gray boxes below.
2. Blue boxes will calcuate automatically.

Step 1. Quantify demand for same-visit insertions.
Instructions: Collect (if necessary) and enter data about your site(s) in the gray boxes. Enter the total number of IUD and implant requests for five consecutive days that the site is open (for example, Monday through Friday of one week).
Blue boxes will calculate automatically.

	# of IUD Requests	# of IUDs That Could Have Been Same-Visit (i.e. Clinician Reasonably Certain Client Not Pregnant, Patient Desired Method Immediately)	# of Implant Requests	# of Implants That Could Have Been Same-Visit (i.e. Clinician Reasonably Certain Client Not Pregnant, Patient Desired Method Immediately)
Observation Day 1				
Observation Day 2				
Observation Day 3				
Observation Day 4				
Observation Day 5				

Enter data about your site's total number of IUD and implant requests in the past 5 days.

Average # of Same-Visit IUDs Per Day (calculates automatically)	#DIV/0!
Average # of Same-Visit Implants Per Day (calculates automatically)	#DIV/0!

Step 2. Quantify length of time needed for long-acting reversible contraception (LARC) insertions.
Instructions: Collect information through observation, about how many minutes it takes, on average, for IUD and implant Insertions.
Observations of time for IUD and implant insertions can be tracked on Tab 2 of this calculator: "Insertion Time Study"
Enter data about your site(s) in the gray boxes.The blue box will calculate automatically.

Average Length of Time (Minutes) a Clinician Needs for an IUD Insertion	10
Average Length of Time (Minutes) a Clinician Needs for an Implant Insertion	5

Enter the average minutes per IUD and implant insertions.

Anticipated Total Time (Minutes) Needed to Allow for Same-Visit Insertions Per Day (calculates automatically)	#DIV/0!

Step 3. Specify your current schedule requirements.
Instructions: Enter data about your site(s) in the gray boxes. If you use Tab 3 to determine your average appointment length, the data will automatically populate in the gray boxes below. If you don't use a standard appointment lengh, use Tab 3 "Average Appointment Length" to calculate your average appointment length.
Blue boxes will calculate automatically.

Standard Appointment Length (Minutes)	#DIV/0!
Total # of Appointment Slots Per Day	24
Average # of Clients Seen Per Day (Include Scheduled and Walk In)	20

Enter the current schedule requirements for your site.

Average Rate of Appointments that are Unfilled *Number of clients seen (scheduled or walk in) divided by the number of appointment slots per day.* (calculates automatically)	17%
Average # of Appointments Unfilled (calculates automatically)	4
Average # of Minutes of Appointments Unfilled (calculates automatically)	#DIV/0!

Same-Visit Contraception Schedule Impact Calculator

PAGE 2 OF 4

This calculator can be used to identify adjustments to the schedule (if necessary) to accommodate same-visit insertions for intrauterine devices (IUDs) and implants; calculate the amount of time needed for insertions; and determine the average length of a visit.

Step 4. Review possible schedule adjustment options below.
In many cases, same-visit LARC can be integrated into the schedule without major changes, when factoring in unfilled appointments due to no-shows.
Instructions: Blue boxes will calculate automatically.

Schedule adjustment option 1: Change standard appointment length, to account for additional time for LARC insertions.

Minutes of Catch-Up, After Accounting for Same-Visit LARC Insertions (Minutes) *Subtracts the minutes expected for same-visit insertions from the average minutes of unfilled appointments, including no-shows.* (calculates automatically)	#DIV/0!	If more than zero, the minutes of unfilled appointments (including no-shows) exceeds the expected number of minutes for same-visit LARC, and so should provide the "catch up" time to accomodate same-visit LARC.
Adjust Length of Standard Appointment Length to this # of Minutes Per Visit to Allow for Same-Visit Insertions *Takes the minutes of same-visit insertions and spreads them out over the existing number of appointments.* (calculates automatically)	#DIV/0!	If you were already reaching productivity goals, consider adjusting your standard appointment length to this number of visits to avoid getting backed up while providing same-visit LARC

Schedule adjustment option 3: Block off empty appointments periodically to allow for catch up time required for insertions

# of Standard Length Appointments Needed to Accomodate Same-Visit Insertions (calculates automatically)	#DIV/0!	
# of Standard Length Appointments You Should Block Each Day to Allow for Same-Visit Insertions, Given Unfilled Appointments (Including No-Shows) (calculates automatically)	#DIV/0!	If less than zero, your unfilled appointments (including no-shows) exceeds same-day insertions and so should provide the "catch-up" time to accomodate same-visit LARC.

Possible schedule adjustment options will be automatically calculated in the blue boxes.

Same-Visit Contraception Schedule Impact Calculator

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Tab 2 of the tool will calculate the amount of time needed for IUD and implant insertions.

Instructions: In order to use this calculator to determine average time of IUD and implant insertions:
1. Observe 10 IUD and implant insertions.
2. Record procedure start and end time in the gray boxes.
3. Blue boxes will calcuate automatically. Note: In order for calculation to work correctly, 10 observations must be recorded

Step 1. Quantify length of time needed for IUD insertions.
Instructions: Collect information through observation, about how many minutes it takes for an IUD insertion.
For increased accuracy, observe a range of providers inserting different IUD types (i.e. copper IUD, hormonal IUD[s])
Enter data about your site(s) in the gray boxes.

IUD Type	Provider Name	Procedure Start Time (When clinician has supplies in hand and is bedside with client.)	Procedure End Time (When the clinician completes the procedure and is ready to leave client.)	Insertion Time (calculates automatically)
ex. Liletta IUD	*M. James, MD*	*9:04:00 AM*	*9:12:00 AM*	0:08:00
				0:00:00
				0:00:00
				0:00:00
				0:00:00
				0:00:00
				0:00:00
				0:00:00
				0:00:00
				0:00:00
				0:00:00

Enter data about the length of time for IUD and implant insertions. Insertion time will be automatically calculated in the blue boxes.

Step 2. Quantify length of time needed for implant insertions.
Instructions: Collect information through observation, about how many minutes it takes for an implant insertion.
Enter data about your site(s) in the gray boxes.

Implant	Provider Name	Procedure Start Time (When clinician has supplies in hand and is bedside with client.)	Procedure End Time (When the clinician completes the procedure and is ready to leave client.)	Insertion Time (calculates automatically)
ex. Nexplanon	*T. Larson, NP*	*2:44:00 AM*	*2:49:00 AM*	0:05:00
Nexplanon				0:00:00
Nexplanon				0:00:00
Nexplanon				0:00:00
Nexplanon				0:00:00
Nexplanon				0:00:00
Nexplanon				0:00:00
Nexplanon				0:00:00
Nexplanon				0:00:00
Nexplanon				0:00:00
Nexplanon				0:00:00

Step 3. Review possible schedule adjustment options to accomodate same-visit insertions.
Instructions: Blue boxes will calculate automatically. Note: In order for calculation to work correctly, 10 observations must be recorded.

Average IUD Insertion Time (Minutes) (calculates automatically)	0:00:00
Average Implant Insertion Time (Minutes) (calculates automatically)	0:00:00

Same-Visit Contraception Schedule Impact Calculator

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Tab 3 of the tool will calculate a standard appointment length based on your site's current average appointment length.

Instructions: 1. Enter your site(s) data in the gray boxes below.
2. Blue boxes will calcuate automatically.

Step 1. Enter your current appointment schedule specifications.
Instructions: Enter the various visit lengths you have in your schedule in Column A in minutes.
In Column B, enter the number of appointments in the daily schedule with the visit length in Column A.
Enter data about your site(s) in the gray boxes.

Enter the Visit Length (Minutes)	Enter the # of Appointments Per Day You Have for Each Appt Length	# of Appointment Minutes (calculates automatically)
		0
		0
		0
		0
		0
		0

Enter data about the various visit lengths and number of appointments in your site's daily schedule. The number of appointment minutes will be automatically calculated in the blue boxes.

Step 2. Review average visit length below.
Instructions: The blue box will calculate automatically.

Average Visit Length (calculates automatically)	#DIV/0!

The average appointment length will be automatically calculated in the blue box.

ACCESS AN ELECTRONIC VERSION OF THIS TOOL ONLINE AT
https://www.fpntc.org/resources/same-visit-contraception-schedule-impact-calculator

STRATEGY 2.3

Make changes as necessary to clinic workflow to ensure same-visit integration does not increase client cycle time.

If the process by which clients move through the visit is not efficient to start with, it may be hard to add another service to the existing workflow. Eliminating waste, reducing client stops, and increasing flow through the visit can allow for the integration of same-visit provision of contraception and increase overall efficiency of services.

ACTION STEPS	RESOURCES
Assess clinic flow to identify opportunities for freeing up clinician availability for same-visit insertions.	Clinic Flow Assessment
Eliminate waste and duplication of effort in order to ensure sufficient time during the visit to provide contraceptive methods.	Using Data to Increase Clinic Efficiency: A Quality Improvement Guide
Collect data and track improvements on selected clinic flow measures, such as client cycle time, wait time, and number of client stops.	Clinic Efficiency Dashboard

Find these and other clinic efficiency resources in the ***Clinic Efficiency Training Package*** on fpntc.org: https://www.fpntc.org/training-packages/clinic-efficiency

Clinic Flow Assessment

Use this assessment to determine how well clinic flow is working at your site(s). After completing Step 1, consider implementing the actions for improving clinic flow under Step 2 in order to provide comprehensive services in the most efficient way.

Step 1. Assess Clinic Flow

Which of the following would you say is consistently true about your site?
(Check all that apply.)

- ❑ Clients spend less than 5 minutes filling out paperwork.
- ❑ Clients do not fill out the same information more than once.
- ❑ Clients rarely wait to check in for a visit.
- ❑ Clients wait, on average, less than 15 minutes total during a visit. (Waiting is defined as any time the client is not in contact with staff.)
- ❑ Staff take clients' vital signs in the exam room.
- ❑ Staff roles are clearly defined. Multiple staff ask the same questions only if medically indicated (e.g., a clinician following up on a finding of nurse or medical assistant.)
- ❑ Clients are taken to one room and all services are brought to them, rather than moving them to multiple places throughout a visit.
- ❑ Exam rooms are stocked with all materials commonly used (including the provider-dependent contraceptive methods and all associated supplies).
- ❑ Staff do not have to leave the exam room to get equipment, supplies, or paperwork.
- ❑ Staff complete documentation in the exam room and before the client leaves.
- ❑ Clients do not wait to check out.
- ❑ Clients spend, on average, less than 60 minutes in the clinic for a visit, for any reason.

Step 2. Improve Clinic Flow

Get started with improving clinic flow using the actions and related resources below.

1. Develop staff buy-in for improving clinic flow:
   - » Review the assessment tool above. Which items are not checked, and why? Which would you like to be able to check off, and what would you need to get there?
   - » Discuss clinic flow with staff. Discuss what's working, and what's not.
   - » Watch this video on patient wait time together as a staff to get the conversation going.
   - » Watch this clinic efficiency quality improvement case study video for inspiration.

Clinic Flow Assessment

2. Collect data on clinic flow:
   - » Track, observe, and record client visits.
   - » Evaluate clinic flow. For example, map current clinic flow to identify parts of the visit that are redundant or do not add value.
   - » Identify bottlenecks and opportunities for improvement, based on observation data.

3. Identify a clinic flow improvement goal. Measures you may consider:
   - » Cycle time (client departure minus arrival time, in minutes): target <45-60 minutes
   - » Wait time (total time clients spend waiting): target <15 minutes
   - » Client stops (number of transitions from one location to another): target <5-6 transitions

4. Develop and implement a clinic flow quality improvement plan:
   - » Identify and test improvement ideas. For change ideas, see Using Data to Increase Clinic Efficiency: A Quality Improvement Guide.
   - » Use the Clinic Efficiency Dashboard to assess and track improvements on selected measures.

STRATEGY 3

Engage, Train, and Support All Staff

Although having clinic systems set up to support same-visit provision is important, it is the staff who will actually implement same-visit services. All staff have a role to play in making methods available same-visit, and thus it is essential that they receive appropriate training and support.

Strategies and related tools for involving all staff in a collaborative way are described on the following pages.

STRATEGY 3.1
Cultivate staff buy-in for same-visit provision.

For many staff, same-visit provision may represent a significant change in practice, and it will be helpful for them to see how other providers have done it. Involving staff in discussions about implementation can not only increase buy-in, but also identify opportunities for streamlining processes.

ACTION STEPS	RESOURCES
Involve staff in a discussion about the importance of same-visit contraception, the agency's protocols and policies, and how staff can work together to provide same-visit contraception.	Same-Visit Contraception: Implementation Strategies for Clinic Staff Discussion Guide & Slides *See page 8*
Share standards of care including QFP, SPR, MEC, and STD Treatment Guidelines.	How to Be Reasonably Certain a Woman is Not Pregnant and When to Start Contraceptive Methods Palm Card
Share success stories with staff to show that same-visit services can be successfully implemented.	Initiating Long-Acting Contraceptive Methods Same-Visit: The Provider Perspective Video

The nursing staff has been tremendous as far as educating the patients and helping us to prepare for the procedure. So by streamlining the process, we're able to do procedures same day, unplanned, unscheduled and still complete our clinic in a timely way.

NORMA PORTER, DNP
Nurse Practitioner
Rapides Parish Health Unit, Louisiana Office of Public Health Region VI

How to Be Reasonably Certain a Woman is Not Pregnant and When to Start Contraceptive Methods

A provider can be reasonably certain that a woman is not pregnant if she has no symptoms or signs of pregnancy and meets **any one** of the following criteria:

- ❑ Is ≤7 days after the start of normal menses
- ❑ Has not had sexual intercourse since the start of last normal menses
- ❑ Has been correctly and consistently using a reliable method of contraception
- ❑ Is ≤7 days after spontaneous or induced abortion
- ❑ Is within 4 weeks postpartum
- ❑ Is fully or nearly fully breastfeeding (exclusively breastfeeding or the vast majority [≥85%] of feeds are breastfeeds), amenorrheic, and <6 months postpartum

When to start using specific contraceptive methods

Contraceptive method	When to start*	Additional contraception (i.e., back-up) needed	Examinations or tests needed before initiation
Copper-containing IUD	Anytime	Not needed	Bimanual examination and cervical inspection**
Levonorgestrel-releasing IUD	Anytime	If >7 days after menses started, use back-up method or abstain for 7 days	Bimanual examination and cervical inspection**
Implant	Anytime	If >7 days after menses started, use back-up method or abstain for 7 days	None
Injectable	Anytime	If >7 days after menses started, use back-up method or abstain for 7 days	None
Combined hormonal contraceptive	Anytime	If >7 days after menses started, use back-up method or abstain for 7 days	Blood pressure measurement
Progestin-only pill	Anytime	If >7 days after menses started, use back-up method or abstain for 7 days	None

*If the provider is reasonably certain that the woman is not pregnant.

**Most women do not require additional STD screening at the time of IUD insertion. If a woman with risk factors for STDs has not been screened for gonorrhea and chlamydia according to CDC's STD Treatment Guidelines (http://www.cdc.gov/std/treatment), screening can be performed at the time of IUD insertion, and insertion should not be delayed. Women with current purulent cervicitis or chlamydial infection or gonococcal infection should not undergo IUD insertion (U.S. MEC 4).

In situations in which the provider is uncertain whether the woman might be pregnant:

- » The benefits of starting the implant, injectable, combined hormonal contraceptives, and progestin-only pills likely exceed any risk; therefore, starting the method should be considered at any time, with a follow-up pregnancy test in 2-4 weeks.
- » For IUD insertion, the woman should be provided with another contraceptive method to use until the provider can be reasonably certain that she is not pregnant and can insert the IUD.

STRATEGY 3.2

Train and support clinicians to insert and remove LARC methods, and on current standards for providing contraceptive services.

In order for same-visit to be an option, trained clinicians must be available all hours during which the clinic is open. Training should address both the technical skills for insertion and removal of the full range of methods, along with the current standards of care related to provision of contraceptive services. upon which clinic processes are established.

ACTION STEPS	RESOURCES
Train clinicians on current standards of care related to the provision of contraceptive services including QFP, SPR, MEC, and STD Treatment Guidelines. Available training resources include training slides with speaker notes, quick reference guides, and mobile and desktop applications.	
Train clinicians to insert and remove LARC methods. Obtain training at conferences, through pharmaceutical representatives, or at other venues.	LARC Link *Find this tool on fpntc.org*
Provide job aids for clinicians—such as CDC recommendations for *How to Be Reasonably Certain a Woman is not Pregnant and When to Start Contraceptive Methods*—in exam rooms.	How to Be Reasonably Certain a Woman is Not Pregnant and When to Start Contraceptive Methods Palm Card *See page 44*
Offer copper IUD as emergency contraception (EC). According to CDC, the copper IUD can be placed within seven days of unprotected intercourse as a form of EC. Use videos and handouts to motivate and train staff.	Quick Start Algorithm *Find this tool on fpntc.org*

STRATEGY 3.3

Train and support clinic assistants and front desk staff to answer basic questions about obtaining contraception same-visit.

Clients often ask clinic assistants and front desk staff about obtaining contraception during an appointment. All staff should be able to answer basic questions from clients about obtaining methods, and be able to direct questions to appropriate staff as needed.

ACTION STEPS	RESOURCES
Provide sample language for responding to questions about obtaining contraception to clinic assistants and front desk staff.	Sample Responses to Frequently Asked Questions about Obtaining Contraception for Front Desk Staff
Use role-playing exercises to help staff practice responding to client questions.	

Sample Responses to Frequently Asked Questions about Obtaining Contraception for Front Desk Staff

Clients often ask front desk staff questions about obtaining contraception during an appointment. Providing front desk staff with sample scripts can help them to respond to clients' concerns or questions in alignment with your agency's policies. As always, make sure the responses are approved by your medical director and aligned with Title X guidelines and nationally recognized standards of care.

Q: I want to come in to talk about birth control, but I have no idea what kind I want.

Response: We're so glad you've decided to come in to see us! That's what we're here for. Your doctor or nurse will talk to you about all your options. Most clients leave with whatever method they chose—even if it's an IUD or implant—unless the doctor or nurse can't reasonably rule out pregnancy. It is recommended that you use a reliable method of birth control, or not have sex between your last period and your visit, to increase the chance you can leave with the method you want.

Q: I'm interested in getting a new method of birth control while I'm here for my visit today. Is that something I'll be able to do?

Response: We make it a priority to provide clients the method of birth control that they want without delay. In many cases, we are able to provide methods immediately—but not always. During your visit, your doctor or nurse will ask you some questions to make sure it is safe for you to receive the method today.

Q: I'm really interested in getting an IUD today. I recently had unprotected sex. Can I still get an IUD?

Response: It *may* be possible for you to obtain an IUD today. Your doctor or nurse will ask you some questions during your visit to find out if you can safely receive an IUD. If not, she/he will talk to you about options like the copper IUD as emergency contraception, the emergency contraceptive pill, or schedule you for a follow-up visit. She/he will be able to answer your questions about next steps.

Q: I think I want to get an implant or IUD today, but what if I change my mind later?

Response: You can have your IUD or implant removed at any time. You should share all your concerns with your doctor or nurse today. If you decide you don't want to receive the method today, we can schedule you for a follow-up appointment for the insertion. If you do get the method today and decide you don't like it, you can always call us, and we will schedule you for an appointment to remove it.

Q: I want to get my IUD/implant removed.

Response: Okay. We can take care of that for you. Your doctor or nurse may want to talk to you about your options, but it is always your choice to continue a method or to have it removed.

Sample Responses to Frequently Asked Questions about Obtaining Contraception for Front Desk Staff

Q: I have an upcoming visit scheduled. I'm interested in starting a new birth control method at that visit. Is there anything I should do to prepare in advance?

Response: Yes. In order for your doctor or nurse to provide you with the method that you want, she/he needs to be reasonably sure that you're not pregnant. If you have not had sex since your last period, or used a reliable method of birth control, or if your visit occurs within seven days of your last period, it's likely we will be able to provide you with your selected method. However, you'll have to talk to your doctor or nurse to make sure that it's okay.

Q: Do I need to have my period to get an IUD or implant?

Response: No. You do not need to have your period to get an IUD or implant. If you do have your period, you do not have to cancel your appointment, and you can still get your method. However, if you do not have your period, your doctor or nurse will just want to make sure you are not pregnant. So, we recommend that you try not to have sex between your last period and your appointment, or use a reliable method of birth control, or try to come in within seven days of your last period.

Q: Do I need to have sexually transmitted disease (STD) test results before I get an IUD (or implant)?

Response: No. If you need STD screening, it can be performed at the time of IUD (or implant) insertion. However, if your doctor or nurse sees signs of an infection, she/he may need to wait until the infection is treated before inserting an IUD. You should come back and get STD screening regularly (annually for women 25 and younger) even after you get your device.

Q: Do I need to have a pap smear before I start a method of birth control?

Response: No. You should get pap smears (for cervical cancer screening) at regular intervals, as recommended by your doctor or nurse, to protect your own health. But a pap smear isn't required for you to get your birth control method of choice.

Q: I have an IUD (or implant) already, and I am due for an annual exam. Can I get my exam, and my IUD (or implant) removed, and a new one put in during the same visit?

Response: Yes. We should be able to do all that for you during one visit.

Reference: 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. DOI: http://dx.doi.org/10.15585/mmwr.rr6504a1

STRATEGY 3.4

Train and support staff responsible for billing and coding on accurate coding to obtain appropriate reimbursement for same-visit services.

All Title X clients should have access to services regardless of ability to pay. That said, obtaining reimbursement for services will always be important for a clinic's sustainability. According to the Title X Program Requirements, where there is legal obligation or authorization for third-party reimbursement, all reasonable efforts must be made to obtain third-party payment.[12] Using the proper codes, sites can get reimbursed for an evaluation and management code, the insertion procedure, and device in one visit.

ACTION STEPS	RESOURCES
Train staff on how to bill accurately for same-visit contraception.	Same-Visit Contraceptive Services Coding Examples
Train staff on the use of coding modifiers, and provide quick reference guides to support implementation.	Coding Modifiers for Contraceptive Services
Track billing and reimbursement for IUDs, implants, and injectables to ensure adequate reimbursement is being obtained.	Long Acting Reversible Contraception (LARC) Device and Injectable Tracking Tool

Same-Visit Contraceptive Services Coding Examples

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CPT = Current Procedural Terminology
E/M = Evaluation & Management CPT Code
ICD-10 = Diagnostic code
HCPCS = Healthcare Common Procedure Coding System
LARC = Long-acting reversible contraception (implant and IUD)
Modifier = 2-digit code billed with CPT codes to describe special circumstances
UPT = Urine pregnancy test

LARC Device Codes

Kyleena IUD	HCPCS code J7296
Liletta IUD	HCPCS code J7297
Mirena IUD	HCPCS code J7298
ParaGard IUD	HCPCS code J7300
Skyla IUD	HCPCS code J7301
Nexplanon implant	HCPCS code J7307

How to use: Common same-visit coding scenarios are described below, with associated sample CPT and ICD-10 diagnosis codes, for providers, billers, and coders to use as examples of appropriate coding scenarios. These are only examples. Always follow the guidance and ensure you are in line with individual payers, state laws and regulations, and organizational policy.

1A) Same-visit: preventive check-up and IUD insertion

Example: A 22-year-old new client presents, seeking a new method of birth control and for her well-visit exam. After receiving patient-centered counseling, she decides on a Liletta IUD and asks to have it inserted during this same appointment. A UPT is done and the result is negative. Since she is 22 and has a new partner, the clinician gets her consent to do chlamydia and gonorrhea screening while she is inserting the IUD. The IUD is taken from stock and billable on the claim. Clinician inserts the IUD successfully.

How should this be coded?

Service	CPT and Modifier Code	ICD-10 Diagnosis
E/M	**99385–25** (22-year-old new patient)	**Z01.419** Encounter for GYN exam (general) (routine) without abnormal findings
Procedures and other services	**58300** IUD insertion	**Z30.430** Encounter for IUD insertion
Labs	**81025** UPT	**Z32.02** Encounter for pregnancy test, result negative **Z11.3** Encounter for screening for infections with a predominantly sexual mode of transmission (STD screening) *Chlamydia and gonorrhea cultures are often billed by the laboratory provider—check with payer for guidance.*
Supply	**J7297** Liletta IUD	**Z30.430**
Modifier use	Add a **modifier 25** to the E/M CPT code to indicate the visit is separate and distinct from the LARC insertion procedure in order for both services to be paid correctly.	

Same-Visit Contraceptive Services Coding Examples

1B) Same-visit: preventive check-up and implant insertion

Example: The same client decides to have the implant inserted during the same appointment.

How should this be coded?

Service	CPT and Modifier Code	ICD-10 Diagnosis
E/M	**99385–25** (22-year-old new patient)	**Z01.419** Encounter for GYN exam (general) (routine) without abnormal findings
Procedures and other services	**11981** Implant insertion	**Z30.017** Encounter for implant insertion
Labs	**81025** UPT	**Z32.02** Encounter for pregnancy test, result negative **Z11.3** Encounter for screening for infections with a predominantly sexual mode of transmission (STD screening) *Chlamydia and gonorrhea cultures are often billed by the laboratory provider—check with payer for guidance.*
Supply	**J7307** Nexplanon implant	**Z30.017**
Modifier use	Add a **modifier 25** to the E/M CPT code to indicate the visit is separate and distinct from the LARC insertion procedure in order for both services to be paid correctly.	

2A) Same-visit: IUD removal and re-insertion (only)

Example: At a client's prior well-visit, the clinician noted that her ParaGard IUD would be expiring in the next few months and scheduled an appointment for her to return for the reinsertion procedure. The client presents today for this appointment. Clinician reviews her record in the EHR and answers any additional questions before successfully removing the old IUD and reinserting the new device. The IUD is taken from stock and billable to the claim.

How should this be coded?

Service	CPT and Modifier Code	ICD-10 Diagnosis
E/M	None. Client is here for removal and reinsertion procedures only that were scheduled at a prior visit; no separate and significant E/M services have been provided. *(See coding tip below.)*	
Procedures and other services	**58301** IUD removal **58300-51** IUD insertion	**Z30.433** Encounter for IUD reinsertion
Labs	None	
Supply	**J7300** ParaGard IUD	**Z30.433**
Modifier use	Add a **modifier 51** to the IUD insertion because it is separate and distinct from the IUD removal. Note: Some payers require modifier 59 (distinct procedural service), rather than modifier 51. Check with payers to ensure accurate payment.	

Same-Visit Contraceptive Services Coding Examples

IUD Removal and Reinsertion

There is NOT one singular code that describes an IUD removal and reinsertion. It is essential that you code and bill BOTH the CPT code 58301 for the IUD removal and 58300 for the IUD reinsertion with a modifier 51 on the second procedure in order to be paid appropriately for the services. Some payers require modifier 59, instead of 51, so ensure your billers track these requirements and use the correct modifier. Use the unique ICD-10 diagnosis code Z30.433 (encounter for IUD reinsertion) to support both CPT codes.

Coding Tip—E/M

The American College of Obstetricians and Gynecologists (ACOG) provides the following guidance when coding and billing for medical visits and same-day procedures such as LARC insertions, removals, or reinsertions:

- If clinician and client discuss a number of contraceptive options, decide on a method, and then an implant or IUD is inserted during the visit, an E/M service may be reported, depending on the documentation.
- If the client comes into the office and states, "I want an IUD," followed by a brief discussion of the benefits, risks, and the insertion, an E/M service is not reported since the E/M services are minimal.
- If the client comes in for another reason and, during the same visit, a procedure is performed, then both the E/M services code and procedure may be reported.

2B) Same-visit: implant removal and re-insertion (only)

Example: The same client presents to have her implant removed and replaced with a new one.

How should this be coded?

Service	CPT and Modifier Code	ICD-10 Diagnosis
E/M	None	
Procedures and other services	**11983** Implant reinsertion	**Z30.46** Encounter for surveillance of implant (includes the removal and reinsertion)
Labs	None	
Supply	**J7307** Nexplanon implant	**Z30.46**
Modifier use	None	

Same-Visit Contraceptive Services Coding Examples

IUD Removal and Reinsertion

Unlike the CPT codes for IUD procedures, there is a unique CPT code 11983 that is used to describe the removal and reinsertion of the contraceptive implant. Include the ICD-10 code Z30.46 (encounter for surveillance of implantable subdermal contraceptive) which supports the routine checking, removal, or reinsertion of the implant.

3) Same-visit: implant removal and IUD insertion

Example: A returning client is experiencing issues with heavy periods and break-through bleeding six months after she had an implant inserted. After patient-centered counseling, the client decides to switch to the Mirena IUD and agrees to have her implant removed and the IUD inserted during this appointment. Clinician removes the implant and inserts the IUD successfully. The IUD is taken from stock and billable on the claim.

How should this be coded?

Service	CPT and Modifier Code	ICD-10 Diagnosis
E/M	**99213–25** E/M code is based on the 3 key components of history, exam, and medical decision making as documented in the medical chart.	**N92.1** Excessive and frequent menstruation with irregular cycle **Z30.09** Family planning advice
Procedures and other services	**11982** Implant removal **58300-51** IUD insertion	**Z30.46** Encounter for surveillance of implant (includes the removal and reinsertion) **Z30.430** Encounter for IUD insertion
Labs	None	
Supply	**J7298** Mirena IUD	**Z30.430**
Modifier use	Add a **modifier 25** to indicate the service is separate and distinct from the insertion. Add a **modifier 51** to the IUD insertion because it is separate and distinct from the implant removal. Note: Some payers require modifier 59 (distinct procedural service), rather than modifier 51. Check with payers to ensure accurate payment.	

Same-Visit Contraceptive Services Coding Examples

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4A) Same-visit: contraceptive counseling and Depo-Provera injection

Example: A 26-year-old new client presents, seeking birth control. She receives patient-centered counseling and decides on a Depo-Provera injection as her method; she is quick started on the method during this same appointment. Clinician documents > 50% of the 20-minute face-to-face encounter is spent on counseling and codes a problem-focused E/M code for the visit based on time. She administers a urine pregnancy test (UPT) and the result is negative. Client will return for a preventive visit at a later date. Clinician injects 150 mg of Depo-Provera successfully. Depo-Provera is taken from stock and billable on the claim.

How should this be coded?

Service	CPT and Modifier Code	ICD-10 Diagnosis
E/M	**99202–25** for new patient	**Z30.013** Encounter for initial prescription of injectable contraceptive (Note: It is also acceptable to code Z30.09 for family planning advice, as significant time is spent on counseling about contraceptive method options to support a higher level of the E/M code being billed.)
Procedures and other services	**96372** Injection	**Z30.013**
Labs	**81025** UPT	**Z32.02** Encounter for pregnancy test, result negative
Supply	**J1050** Depo-Provera 1 mg (report 150 units—or as applicable—on the claim)	**Z30.013**
Modifier use	Add a **modifier 25** to indicate the service is separate and distinct from the injection.	

Depo-Provera Billing: per unit

J1050 Injection, medroxyprogesterone acetate, 1 mg is used to bill for the Depo-Provera drug administered. Since the description is for 1 mg, it is essential that you include 150 units on the claim to ensure appropriate reimbursement. Adjust units as needed to match dosage administered (e.g., 104 for SQ). Claims with low payments for the drug should be reviewed and corrected as necessary.

Same-Visit Contraceptive Services Coding Examples

4B) Scheduled Depo-Provera follow-up injection (refill every 3 months)

Example: The client returns three months later for a second injection of Depo-Provera (refill). A nurse checks in with the client about satisfaction with her method and if she is having any problems; the nurse also checks her vitals. The nurse injects 150 (or 104) mg of Depo-Provera, as appropriate. Depo-Provera is taken from stock and billable on the claim.

How should this be coded?

Service	CPT and Modifier Code	ICD-10 Diagnosis
E/M	None	
Procedures and other services	**96372** Injection – Therapeutic, prophylactic, or diagnostic injection	**Z30.42** Encounter for surveillance of injectable contraceptive (includes refills)
Labs	**81025** UPT	**Z32.02** Encounter for pregnancy test, result negative
Supply	**J1050** Depo-Provera 1 mg (report 150 units—or as applicable—on the claim)	**Z30.42**
Modifier use	None	

Modifier 25

In order to bill for an office visit in addition to a procedure, including an injection on the same day, the medical necessity of the visit must be documented as separate and distinct from the scheduled procedure. Include a modifier 25 with the E/M code on the claim to indicate that the E/M is being billed as a separate service.

RN Injections: CPT 99211 vs. 96372

- Do NOT code BOTH a 99211 and a 96372 on the same visit for a Depo-Provera injection. The services will typically not pay even with a modifier 25 attached.
- CPT 96372 is typically billed when a RN provides an injection service only and there is a supervising provider onsite.
- According to the CPT manual, a 99211 is an office or other outpatient visit "that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, five minutes are spent performing or supervising these services."
- Clarify billing guidelines with your individual payers.

Same-Visit Contraceptive Services Coding Examples

4C) Same-visit: problem with Depo-Provera follow-up injection

Example: A returning client presents, complaining of a discharge that is evaluated and treated. It is also noted that the client is ready for another injection of Depo-Provera. At the end of the visit, the clinician injects 150 mg of Depo-Provera. The E/M CPT code is based on the documented three key components of a detailed history, detailed examination, and medical decision making of moderate complexity.

How should this be coded?

Service	CPT and Modifier Code	ICD-10 Diagnosis
E/M	**99214–25** for established patient	**N76.0** Acute vaginitis
Procedures and other services	**96372** Injection – Therapeutic, prophylactic, or diagnostic injection	**Z30.42** Encounter for surveillance of injectable contraceptive (includes refills)
Labs	**81025** UPT	**Z32.02** Encounter for pregnancy test, result negative
Supply	**J1050** Depo-Provera 1 mg (report 150 units—or as applicable—on the claim)	**Z30.42**
Modifier use	Add a **modifier 25** to indicate the service is separate and distinct from the injection.	

Depo-Provera Injection with E/M

Ensure the documentation supports the E/M service and that the appropriate ICD-10 diagnosis codes are billed. Describe the reason for the billable visit, in addition to the injection.

This tool was developed in consultation with Ann Finn Consulting, LLC (www.annfinnconsulting.com).

Coding Modifiers for Contraceptive Services

	Modifier 25	Modifier 51	Modifier 59	Modifier 52
Label	Significant, separately identifiable E/M service	Multiple procedures	Distinct procedures	Reduced services
Definition	Significant, separately identifiable E/M service provided by the same clinician to the same client on the same day as another service.	Multiple separate procedures (non E/M) performed on same day, during same session, by the same clinician.	Distinct procedural service (non E/M) indicates a: 1) different encounter or session; 2) different procedure; 3) different site; or 4) separate incision, excision, injury, lesion, or body part.	Procedure is started but can't be finished for anatomical factors.
Example	Birth control visit to decide on a method followed by LARC insertion at the same appointment.	IUD/implant removal and reinsertion at same appointment.	Lesion removal and IUD insertion at same appointment.	Failed IUD insertion due to stenosis.

	Modifier 53	Modifier 76	Modifier 77	Modifier 22
Label	Discontinued service	Repeat procedure (same clinician)	Repeat procedure (different clinician)	Increased procedural services
Definition	Procedure is started but can't be finished due to concerns regarding client safety.	Procedure or service was repeated subsequent to the original procedure or service by the same clinician.	Procedure or service was repeated subsequent to the original procedure or service by a different clinician.	Used to describe unusually difficult procedures that took additional resources outside the norm of the procedure provided.
Example	Failed insertion due to vaso-vagal episode, pain, perforation during insertion; client changed mind during procedure.	Successful insertion but the IUD is expelled, followed by repeat insertion by the same clinician.	Successful insertion but the IUD is expelled; client returns for a new device but sees another clinician for the repeated procedure.	Difficult LARC insertion or removal due to body habitus or other complications.

Key: E/M - evaluation and management; IUD - intrauterine device; LARC - long-acting reversible contraception
This tool was developed in collaboration with Ann Finn Consulting, LLC (www.annfinnconsulting.com).

ACCESS AN ELECTRONIC VERSION OF THIS TOOL (A PALM CARD OR WALL CHART) ONLINE AT
https://www.fpntc.org/resources/coding-modifiers-contraceptive-services

Long-Acting Reversible Contraception (LARC) Device and Injectable Tracking Tool

This tool can be used to track billing and reimbursement of individual LARC devices, and to ensure that adequate reimbursement is received.

Instructions:
1. Each time a LARC device is used for a client, enter details about the device in a row below.
2. Complete the columns about coding and reimbursement as the information becomes available.
3. Periodically review for trends in issues or lessons learned around reimbursement.

Tracking for Individual LARC Devices

#	Account #	Date of Service	Device Number	Cost of Device	Device Type (use dropdown)	Insurance Plan	Service Provided	CPT Codes with Modifiers Billed to Claim	Was an Evaluation and Management (E/M) Documented as Separate and Distinct from the LARC Procedure? (Yes or No; if yes, bill with a modifier 25)	Charge Reported on Claim	Expected Reimbursement for Device
Ex.	*AAA123*	*3/25/2018*	*12567*	*$300.00*	*IUD ParaGard*	*BCBS*	*contraceptive counseling, ParaGard insertion, UPT*	*99212-25, 58300, 81025, J7300*	*Yes*	*$500.00*	*$500.00*
1											
2											
3											
4											
5											
6											
7											

Tabs 1 and 2: Enter data each time a LARC device or Depo-Provera insertion is used for a client, including coding and reimbursement information.

Instructions:
1. Complete each row with information about reimbursement as it becomes available.
2. Enter insurance plan names and expected reimbursement.
3. Periodically review for trends in issues or lessons learned around reimbursement.

				Expected Reimbursement by Payer						
Codes	Counseling Visit Separately Payable with LARC Procedure (Yes or No)	Contraceptive Separately Payable from Visit (Yes or No)	Contraceptive Cost	Medicaid Fee-For-Service (FFS)	Plan 2	Plan 3	Plan 4	Plan 5	Plan 6	Plan 7
58300 IUD Insertion										
58301 IUD removal										
58301 IUD removal, 58300-51 IUD Reinsertion										
J7296 Kyleena IUD										
J7297 Liletta IUD										
J7298 Mirena IUD										
J7300 ParaGard IUD										
J7301 Skyla IUD										
J1050 Depo-Provera (150 units)										
J1050 Depo-Provera (104 units SubQ)										
96372 Injection										
11981 Implant Insertion										
11982 Implant removal										
11983 Implant Reinsertion										
J7307 Nexplanon										

Tab 3: Track individual device reimbursement and update this spreadsheet with findings and lessons learned.

ACCESS AN ELECTRONIC VERSION OF THIS TOOL ONLINE AT
https://www.fpntc.org/resources/long-acting-reversible-contraception-larc-device-and-injectable-tracking-tool

STRATEGY 4

Use a Quality Improvement Approach to Implementation

Use a quality improvement approach to monitor what implementation strategies are working, and where continued improvement is needed.

STRATEGY 4.1

Apply quality improvement principles when implementing same-visit contraception.

A clear, written policy stating that methods should be available same-visit can be critical for obtaining buy-in from key staff and will serve as the foundation upon which clinic processes are established.

ACTION STEPS	SUPPORTIVE RESOURCES
Become familiar with quality improvement approaches.	Introduction to Quality Improvement for Family Planning eLearning
Develop an action plan to track implementation of improvement strategies.	Quality Improvement Plan
Use Plan-Do-Study-Act (PDSA) cycles to test small changes and see what works. For example, try a same-visit insertion with one clinician, one time, or for one day.	Plan Do Study Act Worksheet
Regularly meet as a clinic staff to discuss ongoing challenges and to identify next steps until same-visit contraception is implemented routinely.	

Find these and other quality improvement resources in the ***Conducting Quality Improvement Training Package*** on fpntc.org: https://www.fpntc.org/training-packages/conducting-quality-improvement

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