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Feasibility and acceptability of a process change for patients with Medicaid to receive LARC in a private OBGYN office

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Feasibility and Acceptability of a Process Change for Patients with Medicaid to Receive
LARC in a Private OBGYN Office

by

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Scholarly Project

Submitted to the College of Health and Human Services

Eastern Michigan University

in partial fulfillment of the requirements for the degree of

DOCTOR OF NURSING PRACTICE

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November 1, 2021

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Abstract

Background and Review of Literature: Long-acting reversible contraception (LARC) is an effective form of contraception that has been shown to have high rates of satisfaction and few contraindications for patients. However, patients with Medicaid coverage may face barriers and challenges in obtaining LARC. Often, providers in small obstetrics and gynecology (OBGYN) private practices are unable or unwilling to provide LARC placement due to financial burdens as a result of limited Medicaid reimbursement. Regardless of insurance carrier or size of practice, patients should have access to the contraception method of their choice.

Purpose: This project aims to determine the feasibility and acceptability of a quality improvement (QI) process in a privately owned OBGYN office where patients received initial LARC placement from a partnering clinic, returning to their private OBGYN for follow-up and continuation of care.

Methods: A mixed methods study was completed to measure the success of the process change. Two neighboring clinics were approached to develop and implement a straightforward and seamless QI process for patients to receive a LARC that includes education, referral, and follow-up. Utilizing Quality From the Patient's Perspective (QPP) questionnaire and open-ended questions, interviews were performed, and data were analyzed to determine feasibility and acceptability.

Results: Three patients out of seven patients from the QI group obtained a LARC and returned for the follow-up. While these patients had positive feedback about the process, they disliked having to leave their established practice for LARC placement.

Implications/Conclusions: The results showed an increase in satisfaction among the three women surveyed in the referral process for LARC and is therefore acceptable. Feasibility in the allotted 4-month timeframe was not determined. However, it was deemed that this QI process has implications for future use.

Keywords: Medicaid, long-acting reversible contraception, patient satisfaction

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Introduction

Long-acting reversible contraception (LARC) are popular devices used for contraception as well as other medical reasons, such as metrorrhagia and menorrhagia. Barriers exist for patients and providers alike regarding reimbursement for LARC for those individuals with Medicaid insurance. Some providers do not participate in programs that require significant costs upfront for LARC. As a result, practices may refer patients to other clinics for LARC placement. If this referral process is required, it should be as straightforward and seamless as possible.

Oral contraceptives and condoms are the most used patient-controlled contraceptives in the United States (U.S.) due to the ease of use and availability (Kaunitz, 2020). However, the effectiveness of patient-controlled contraceptive methods, such as oral contraceptives, condoms, contraceptive rings, and patches, are limited by their high failure and low continuation rates (Kaunitz, 2020). The most effective, reversible method of contraception is LARC, including intrauterine devices (IUDs) and hormonal implants (Curtis & Peipert, 2017). LARC are a type of contraceptive that may remain in place for 3-10 years dependent on the device and can be easily removed to restore fertility if a pregnancy is desired. There are two types of IUDs: those that contain hormones and one type that does not. Mirena, Kyleena, Liletta, and Skyla contain the hormone Levonorgestrel. A copper IUD, Paragard, does not contain hormones (Paragard, 2020). A hormonal implant, Nexplanon, is a small rod containing the hormonal etonogestrel, which is inserted under the skin in the upper arm.

Using effective and reversible methods of contraception can help to lower the rate of unplanned pregnancies (Curtis & Peipert, 2017), thus making ease of access to LARC an important component in preventing unintended pregnancy. A study by Daw et al. (2017) found that many women that are eligible for Medicaid insurance coverage have a higher rate of

unintended pregnancy than women with other types of insurance. Insurance coverage, especially those with Medicaid, remains a barrier for patients who desire a LARC.

Medicaid in the U.S. is a federal and state program that helps with medical costs for qualified people with limited income and resources. As the largest source of health coverage in the U.S., it is often a program of last resort for those without access to other resources, and eligibility is determined by the Modified Adjusted Gross Income (MAGI; Medicaid.gov, 2020). The Patient Protections and Affordable Care Act (ACA) facilitated the ease with which people apply and enroll in the program, regardless of their income or the state of their health (Medicaid.gov, 2020). Federal law requires states to provide certain benefits to patients with Medicaid including inpatient and outpatient hospital services, physician services, laboratory and x-ray services, and home health services (Medicaid.gov, 2020). Other optional benefits that states may choose to cover include prescription drugs, case management, physical therapy, and occupational therapy. Medicaid programs offer free birth control, but they are not required to cover all Food and Drug Administration (FDA)-approved birth control methods (Medicaid.gov, 2020).

While not required to cover all birth control methods at all clinics, Medicaid does fully reimburse for multiple types of contraception, including LARC provided at federally funded clinics. LARC have the highest rate of patient satisfaction and several other advantages over traditional contraception methods. Some of these advantages include having high rates of continuation and efficacy, requiring minimal maintenance, and being cost-effective (Centers for Medicaid & Medicare Services [CMS], 2016). However, individuals in the U.S. with Medicaid are not as likely to utilize LARC when compared to other countries (CMS, 2016). Under the ACA, all commercial insurance plans are required to cover all FDA-approved methods of

contraception, sterilization, and related education and counseling (Evans et al., 2019). However, states have some flexibility when defining the specific family planning services and supplies covered by Medicaid (Evans et al., 2019). In Michigan, LARC are only fully covered when they are placed at a federally funded clinic (CMS, 2016). As a result, private offices who choose to offer LARC placement often do so at a financial loss. Additionally, the supplementary costs to practices including supplies and personnel involved in placing LARC are not feasible for the sustainability of the practice (Fuerst & George, 2020).

With almost 200,000 Wayne County residents covered by Medicaid, patients often turn to privately owned clinics for their contraception (Mack, 2019). While larger clinical practices that have a high volume of patients can obtain LARC devices at a much lower cost, in Wayne County, Michigan, there are fewer than a dozen federally funded clinics that provide LARC (Health Resources & Services Administration, 2020; Planned Parenthood, 2020). Smaller, private outpatient practices, due to the limited reimbursement for LARC by Medicaid, are often unable to offer LARC to patients who have Medicaid insurance secondary to the cost that must be absorbed by the practice. As a result, patients must choose between settling on another form of contraception or receiving a LARC at a federally funded clinic or another practice.

Providing contraceptive choices to patients demonstrates a way that health care providers treat patients with dignity and respect, as adults capable and willing to be involved in decisions made about their medical care (Zolkefli, 2017). However, a small, privately owned OBGYN practice in Wayne County, Michigan, has providers that are unable to offer LARC to patients with Medicaid coverage due to poor reimbursement and the significant out-of-pocket expense incurred by the practice. As a result, the providers often recommend other types of contraception. If a patient desires a LARC, they are referred to nearby clinics which are able to place them. It is

unclear whether these patients follow through with the referred LARC placement or return to the private office for follow-up. Conversely, some patients may forego their desired form of contraception for a more accessible option with their provider.

Health care providers respect the autonomy of their patients by involving them in their own care (Zolkefli, 2017). However, if patients are limited in their options and are not able to obtain the contraception they desire with their established provider, secondary to their insurance, a change must be made. This feasibility and acceptability study focuses on a small, privately owned OBGYN practice in Wayne County, Michigan, which accepts both commercial insurance and Medicaid. For those individuals with commercial insurance, all birth control methods including LARC are provided. However, if patients with Medicaid were to receive LARC, reimbursement by Medicaid would be less than 50% of the cost to the small practice. As a result, the practice either refers patients with Medicaid to another office to obtain a LARC or initiates a discussion about other types of contraception.

At this small, privately owned OBGYN practice, patients with Medicaid insurance coverage make up roughly 53% of the patient population and these patients make approximately 25-30 requests for LARC a year. The providers in this practice aim to provide their patients with every available contraception option, however providing LARC to patients covered by Medicaid results in a heavy financial burden to the practice. For this reason, the practice currently chooses not to offer LARC to the population with Medicaid coverage.

Additionally, there is little evidence to guide physicians that accept Medicaid on how to provide LARC for patients in the absence of adequate reimbursement. Currently, patients covered by Medicaid in this practice who desire a LARC receive a name and phone number for an alternative practice in the area which provides LARC services. There is no established process

in place to determine if patients ever receive a LARC. The current process includes a referral to another practice for LARC placement, with instructions to return to the referring provider for follow up after insertion of the device. Furthermore, there is no information on the patients' satisfaction regarding seeing an unknown provider for LARC placement. Therefore, this QI process is the result of a provider-requested feasibility and acceptability study of a process change to improve access for patients covered by Medicaid by providing a straightforward and seamless option for these private-practice patients to receive a LARC.

Problem Statement

Individuals with Medicaid insurance in the state of Michigan are unable to obtain LARC at a privately owned OBGYN practice due to the cost incurred by the individual and/or practice. Due to inadequate reimbursement, patients often choose another, less desired or effective method of contraception, or leave their current provider for one which provides LARC placement. This loss of patients jeopardizes the viability of the practice. To improve contraceptive access and decrease health disparities, patients should have access to the contraception method of their choice, with their established OBGYN provider, no matter their insurance carrier or size of practice.

Purpose, Objectives and Aims

The purpose of this project was to determine the feasibility and acceptability of a quality improvement project to allow patients with Medicaid access to LARC by collecting data on the following specific objectives:

- Assess the current process at the practice and the population of focus and their desires for LARC from May 2020 to May 2021.

- Expected outcome: Determine a need for a QI process change for patients with Medicaid that desire LARC.
- Develop a QI process that educates, refers, and discusses follow-up, allowing patients with Medicaid to receive LARC at a referred office from May 2021 to August 2021.
 - Expected outcome: Implement a QI process for patients to receive their desired LARC.
 - Follow up with their referring provider after receiving the LARC.
 - Patient will be satisfied with the QI process.
- Assess the feasibility of the QI process from May 2021 to August 2021.
 - Expected outcome: The process will be determined feasible as evidence by completion of the QI process by all participants that are enrolled.
- Assess the acceptability of the QI process over a 4-month period.
 - Expected outcome: The process will be determined acceptable as evidence by satisfaction of those completing the QI process.

Review of the Literature

Long-Acting Reversible Contraception

Contraception is the deliberate use of artificial methods to prevent pregnancy and is mainly used for patients to have control over their reproduction. LARC are a type of contraception that are inserted either into the uterus or under the skin by a provider, preventing pregnancy for 3 to 10 years, depending on the device. LARC include an injectable progesterone implant, progestin IUDs, and an IUD that does not contain hormones. The progestin IUDs include Liletta, Mirena, Skyla, and Kyleena. These IUDs have different doses of progestin and

are FDA approved for different lengths of time to prevent pregnancy. The hormonal implant, called Nexplanon, is an implantable device that releases progestin (Nexplanon, 2021).

While the longevity of LARC varies, all provide stable and continuous contraception for patients. For example, Mirena is approved for 7 years and Kyleena works for up to 5 years (FDA, 2020), while Liletta is effective up to 6 years and Skyla for up to 3 years (Bayer, 2020; Liletta, 2021). Paragard is a copper IUD that prevents contraception for up to 10 years (FDA, 2020). Nexplanon is effective for up to 3 years (Nexplanon, 2021). Alternative uses for contraception such as LARC exist. Patients may utilize LARC to regulate their menstrual cycle, treat metrorrhagia, reduce risk of uterine cancer and ovarian cysts, relieve symptoms of premenstrual syndrome (PMS) and premenstrual dysphoric disorder (PMDD), help manage endometriosis and menstrual migraines, and reduce menorrhagia (American College of Obstetrics and Gynecology [ACOG], 2017).

Medicaid and Cost of LARC

Despite the effectiveness of LARC, placement services for LARC devices generally require significant up-front costs to providers. The cost of LARC range from \$500-\$1300 each, which is initially covered by providers at as out-of-pocket expense. If a LARC is purchased by a provider up front, a financial loss to the provider may result if the LARC is not used (CMS, 2016). As a result, it may be prohibitive for some Medicaid providers, especially small, private practices to purchase and offer LARC placement. The extent of coverage by Medicaid can affect the use of LARC and how often they are prescribed, and patients are at the mercy of how much the state has determined they can receive (Vela et al., 2018). In a study by Cleland et al. (2011), where women were given the choice of contraception method without regard to insurance coverage or financial liability, most women chose LARC. For patients that do desire LARC, if

the method is not covered by their insurance, as in the case of LARC in this private practice, patients must be prepared to cover the cost, depending on the type of LARC they choose (Planned Parenthood, 2020).

Other disparities exist regarding Medicaid and commercial insurance. A study by Higgins et al. (2018) determined that fewer women with Medicaid compared to those with private insurance received LARC and more became pregnant. This study found that women with Medicaid insurance coverage are less likely than women with private insurance to request a LARC device when two visits are required for insertion: one visit for education and counseling and a second visit for insertion. Another study found that the recent Medicaid expansion was associated with an increase in use of LARC by 1.2% among women at risk of pregnancy in states that expanded Medicaid, compared with non-expansion states (Darney et al., 2020). Currently, 12 states have reported expanding Medicaid to allow for all practices to provide LARC. Michigan is not one of those states.

Equitable Access to Contraception

More than half of the women in the U.S. who needed contraceptive services in 2010 used publicly funded services (ACOG, 2015). Racial and ethnic disparities in access to health care exist across the US. This disparity has a negative effect on women's ability to prioritize, afford, and receive contraceptive services (Ranji et al., 2019). Those with Medicaid tend to face more barriers to accessing LARC services than those with commercial insurance coverage. Logistical problems accessing LARC can occur in outpatient and ambulatory settings where it can be difficult to stock LARC devices (ACOG, 2015). Best practice for LARC is same-day insertion, as it reduces the risk of having to take time off work or travel long distances to another clinic

(ACOG Contraceptive Working Group, 2015). Improved access to LARC is essential to make sure all individuals have control over their reproductive choices (Wilkinson et al., 2019).

In a study by Vela et al. (2018), a disparity in Medicaid coverage regarding LARC insertion, removal, and follow-up was found. Availability to contraceptive services depends on the type of services offered by providers as well as what the insurance coverage allows for reimbursement (Chen et al., 2021). There are some states that have programs to increase LARC access and availability for those patients with Medicaid, including coverage expansion and reduced product costs, but significant differences in coverage still occurs. Brandi and Fuentes (2020) found that a history of discriminatory coverage for reproductive health care exists. Due to this discriminatory coverage, some providers find that additional counseling and referral services may be required to assist in their patient's contraceptive decision-making (Brandi & Fuentes, 2020). Appropriate counseling is essential to promote patients' choice with respect to what type of contraception to use, as well as policies that remove barriers to reimbursement for providers (Dehlendorf, 2019). When providers cannot afford to make LARC available to patients, counseling on best methods and types of contraception may be limited.

Theoretical Model

Loretta Ross developed reproductive justice as a framework for activist women of color to address how race, gender, class, ability, nationality, and sexuality intersect (Ross et al., 2017; Figure 1). Ross was a co-founder and National Coordinator of the SisterSong Women of Color Reproductive Justice Collective from 2005–2012 (SisterSong, n.d.). The reproductive justice framework addressed women of color not being able to exercise reproductive choices as easily as their more privileged counterparts (Ross et al., 2017). According to Ross et al. (2017), “Reproductive justice theory is needed because many earlier theories about reproduction pay

inadequate attention to the physical, socioeconomic, and emotional realities of Indigenous women, poor women, trans women, and women of color” (p. 3456). The reproductive justice theory is used to focus on issues related to abortion, contraception, immigration, welfare, HIV/AIDS, environmental justice, racism, education, LGBTQ+ rights, and disability, and many other issues impacting people's reproductive lives (Ross et al., 2017).

Reproductive justice is a critical, theoretical framework that was also invented as a response to United States reproductive policies (Unitarian Universalist Association, n.d.). The framework “moves women's reproductive rights past a legal and political debate to incorporate the economic, social, and health factors that impact women's reproductive choices and decision-making ability” (Ross et al., 2017, p. 3461). Reproductive justice explains how people may find it more difficult to access health care because of factors such as education, income, geographic location, immigration status, and potential language barriers, among others (Ross et al., 2017).

One concept behind reproductive justice is having the ability to choose whether to use birth control, what method to use, and the access to all types of birth control no matter the type of insurance coverage. The theory of reproductive justice includes community safety, violence, and the government's role in reproduction. For example, women with low incomes are more likely to rely on state supports such as Medicaid, which often further limits their access to birth control and reproductive health services such as LARC (Ross et al., 2017).

Reproductive justice theory is used as a foundation for this study because it promotes an individual's right to be informed about and have access to all birth control options. In many cases, vulnerable women seeking contraceptive care do not always get the most appropriate contraceptive counseling. Persistent racial and socioeconomic inequality obstructs both providers and patients and is inherent in clinical encounters (Higgins, 2014). To help reduce the incidence

of discrimination, the family planning community must make efforts to ensure that women are able to freely choose LARC methods.

The fact that many poor communities of color have experienced historical reproductive mistreatment is the basis for the development of reproductive justice. The socioeconomic and cultural inequalities facing poor women of color are evident in the fact that some people have easier access to autonomy and freedom of choice than others (Higgins, 2014). For this study, concepts of reproductive justice will be used to enable women to obtain a LARC if they desire, independent of their insurance coverage. Based upon the theory of reproductive justice, it is the responsibility of health professionals to not only provide the most effective contraception possible in accordance with their patient's request, but to ensure the well-being and self-determination of the patient's own body (Higgins, 2014).

Methods

Project Site and Population

This study was completed at a privately owned OBGYN practice located in Wayne County, Michigan that sees 600-700 patients a month, of which approximately 45-50% have Medicaid or part Medicaid insurance coverage. The providers in the office include two physicians and a certified nurse midwife (CNM). Inclusion criteria included all patients 18 years or older who desired a LARC and were covered by Medicaid insurance. Key stakeholders included the health care providers and office staff at the referring office, the health care providers and support staff at the referral offices, and the patients who have Medicaid insurance and desired a LARC.

Process

Retrospective Review/Comparison Group

A descriptive comparison design was used to examine the feasibility and acceptability of a QI process. A retrospective chart review of patients with Medicaid who were referred for LARC was completed. To perform the retrospective review, a flow chart was completed to determine how many total patients were referred to another office for LARC administration, and of those, how many patients received a LARC (Figure 2). Of the patients that received LARC, phone calls were made to find out how many appointments the patient had to attend at the receiving office and how many came back for follow up to original practice. The Quality from the Patient's Perspective (QPP; Appendix A) developed by Larsson and Larsson (2002) was the survey tool used to evaluate satisfaction of LARC placement.

Partnership

Providers in two referred OBGYN offices agreed to insert LARC during a single visit. Patient information was shared with the referred office, if they had not been a patient there before, to reduce patient redundancy of forms and increase satisfaction. If any information was required to be sent to the referred office, the patient completed a consent form for release of records prior to faxing medical information in compliance with the Health Insurance Portability and Accountability Act (HIPAA). A discussion evolved with the referred offices, and it was agreed that all referred providers would insert LARC while the patient was on her menstrual cycle or within 24 hours of obtaining a negative serum beta human chorionic gonadotropin (hCG). To meet cultural and ethnic diverse patient needs, health care providers and interpreters were identified and secured. Additionally, the burden of transportation was considered, and partnering offices were specifically chosen based on their proximity to public transit.

Clinical Encounter During LARC Visit

After the chart review was completed, the QI process began by identifying patients with Medicaid coverage that desired LARC and were greater than 18 years of age. Patients were counseled about LARC if they were interested in a long-term option, had no contraindications for LARC, and had declined all other contraceptive options. In addition to the counseling and education provided by a health care provider at the private office, a pre-process demographic questionnaire (Appendix B) was completed with desk staff at checkout.

The next step in the process was choosing from one of the referred offices to provide a LARC for Medicaid-covered patients. The staff then assisted the patients in making an appointment for the LARC insertion as well as making a follow-up appointment at the referring office 4-6 weeks after LARC insertion. An information sheet on the chosen office and provider was given to provide directions, address, phone number, and how to change an appointment if necessary. The process included the patient arriving at the chosen referred office at the appointment time, receiving the desired LARC, and following up with the referral office at a previously made appointment day and time.

Survey

Two weeks following their LARC placement appointment, the patient received an email to complete a survey using Survey Monkey© (Appendix A). Post-survey questions that were posed consisted of how the process went, if they would recommend the process to others, and if they would go through the process again. The post-procedure survey consisted of 15 Likert-scale questions and two open-ended questions. If the initial survey was not completed, a second email with the Survey Monkey© link was sent a week later with the request for it to be completed. After an additional week, if the survey was not completed via Survey Monkey©, a phone call

was made using the QPP (Appendix A) to complete by phone. During the phone call, a provider at the referring office used a scripted dialog to implement the QPP over the phone (Appendix C).

Follow-up

During the follow-up appointment with the referring clinic, the placement of the LARC was examined and checked by a provider by either an IUD string check with a speculum or determine proper placement of the implant and viewing incision site as clean, dry, and intact. Additionally, time was allotted for the patient to ask questions and the QPP (Appendix A) was administered. If the patient missed their LARC follow-up appointment, the patient was contacted by phone to ask if the LARC had been inserted, and if not, why. If the patient did not respond to both emails and phone calls and did not have a record of receiving a LARC from referred office, the patient was considered lost to follow-up.

Measures

The survey tool was adapted from the short version of the QPP (Appendix A) that was originally a 24-question tool to measure patient satisfaction in a hospital medical department. The short version of the QPP survey has 15 Likert-scale questions and two open-ended questions. The revised tool was approved by all stakeholders. The short form was derived from the long form, which has been determined as valid and reliable (Larsson & Larsson, 2002). Satisfaction and perceptions of the quality of the patient's care are the variables the tool was used to measure. The short form bases items in theory to interpret more significant results and was selected for its ease of use due to its consideration of patient's health literacy (Larsson & Larsson, 2002). The survey addressed dimensions such as competence, waiting time, information, participation, commitment, responsible persons, environment, respect, and referral.

A pre-process questionnaire (Appendix B) obtained demographic information such as zip code, age, reason for desired LARC, reproductive history, length of time on Medicaid, the referred clinic of the patient's choice, and the date that LARC insertion was scheduled. The questionnaire also consisted of other questions targeted to determine how the patient came to their decision to obtain a LARC, as opposed to other types of contraception.

Feasibility and acceptability was determined by the patients completing the process and the overall patient's view of the need for and satisfaction with the process. If patients decided to leave the office, it was essential to determine the reason. A patient may decide to leave the office due to having fewer choices for contraception, having an unpleasant experience during the process, or changing OBGYN providers to the referring practice. Any problems or issues discovered by patient responses on the QI survey were addressed by the OBGYN practice and once identified, many of the suggested changes were incorporated into the process.

Feasibility (Appendix D) was measured by the patient's ability to complete the process. The criteria for feasibility were (a) the number of patients that obtain LARC and (b) attendance of the scheduled follow-up appointment. Patients completed the process by answering QPP survey questions via Survey Monkey© or by telephone survey.

Acceptability (Appendix D) was measured by determining how well the process was received and the extent to which the new process met the needs of the patients. The criteria for acceptability were (a) quantitative evaluation from the fifteen 5-point Likert scale questions and (b) qualitative feedback from the two open-ended questions which explored how patients felt about and would improve the process.

Ethical Considerations

Institutional Review Board (IRB) application and consent forms were submitted to IRB at Eastern Michigan University. The QI process was deemed exempt from formal review (Appendix E). HIPAA guidelines were strictly followed throughout the process. Printed demographic forms were completed together with patient and desk staff then placed in the patient's chart. These charts were set aside in an area monitored by office staff and inaccessible to patients. QPP was used for the post-procedure survey, and the information was transferred from Survey Monkey© to a password protected computer. All patients' names were assigned a number, data remained anonymous, names remained anonymous, and no names were associated with any data resulting from this study. Paper data was stored in a locked container in the referring office to be kept confidential and destroyed three months after it was analyzed.

A potential conflict of interest prior to implementation was the concurrent employment of this researcher by the privately owned OBGYN office. Patients may have had difficulty discussing negative opinions to their own provider, which is why all attempts were made to have questions answered anonymously via Survey Monkey©. Some questions arose with respect to the providers encouraging LARC placement to increase the number of participants in study; however, all participants' health records were reviewed by one of the private practice physicians to ensure best practices were being followed.

Results

Results From Retrospective Review-Comparison Group

The comparison group was selected through a review of patient visits between May 2020 and May 2021. Documentation of contraceptive counseling was used to identify patients for the comparison group. Based on chart reviews, 16 patients met eligibility and were found to have

been referred for a LARC at an outside clinic. Eleven of the 16 patients completed the QPP survey and five were unable to be contacted (Figure 2).

Demographics: Comparison Group vs. QI Group

The comparison group included patients who were identified during the retrospective chart review that were referred for and obtained a LARC with usual care (standard clinic procedure). Among 16 patients who were between 19 and 39 years ($M = 27.8$ years), 11 completed the QPP survey (age range: 21 and 36 years old; $M = 28.4$ years). The QI group consisted of seven patients between 20 and 37 years old ($M = 24.4$ years) that were initially referred for LARC. Among seven patients referred, three patients completed QPP surveys in the QI group with ages range from 20 and 29 ($M = 23.3$ years). The demographic characteristics for both comparison and QI group can be found in Table 1.

Patients in the QI group traveled an average distance of 10 miles to see their OBGYN. All three of the patients (100 %) referred for a LARC desired the device for contraception. Two (67%) of patients desired IUDs, and one (33%) desired an implant. In terms of duration of Medicaid coverage, 67% ($n = 2$) were covered less than four years and 33% ($n = 1$) were covered for 5-10 years. Qualitative results for demographic data can be found in Table 2.

Feasibility of QI Process

Seven patients were referred for a LARC over a 4-month period. Three out the seven patients completed the QPP survey (Figure 3). Two patients, who were contacted by phone, declined to complete the survey and confirmed that they did not receive a LARC. Two patients were unable to be reached by phone or email and were considered lost to follow up. The results of feasibility were as follows (a) three out of seven patients (42.9%) obtained a LARC, and (b) three out of seven patients (42.9%) attended the scheduled follow-up appointment.

Acceptability: Comparison vs. QI Group

Eleven patients in the comparison group completed QPP surveys. Prior to QI process implementation, approximately 82% of the comparison group would refer friends or family for a LARC at the referred office and they would repeat the process. The comparison group also had neutral responses in the QPP surveys as well as negative responses to the process. See Table 3 for QPP survey results for the comparison group.

Three patients completed the QPP surveys in the QI group. Unlike the comparison group, 100% of the patients in the QI group would refer friends and family for the referral process as well as repeat the process in the future. Results of the QPP survey for the QI group can be seen in Table 4. The results of acceptability are as follows (a) all three participants that completed the survey reported either strongly agree or agree to all 15 Likert questions, and (b) one person provided feedback on open ended questions and suggested that staying at referring clinic was a way to improve the process, but no other suggestions were given. The differences between the comparison group and QI group survey results can be found in Table 5.

Qualitative Results: Feedback from Comparison vs. QI Group

Qualitative feedback was obtained from the comparison and QI group through the QPP surveys. The open-ended questions solicited feedback from participants regarding ways to improve the process. When asked how the process could be improved, out of 11 participants in the comparison group, nine quotes were found. Specifically, three indicated positive responses, “I wouldn’t,” “There’s not really anything to improve,” and “very good process.” Four negative responses were found. Two indicated experiencing issues with pain management. Two requested to have the procedure at their established practice for continuity of care. And one did not feel she

should have to leave the clinic to receive a LARC. Finally, two responses were answered not applicable (N/A).

Qualitative comments from three participants in QI group were obtained. The feedback also included frustration in having to leave the practice for a LARC. Two patients from the QI group that were contacted by phone did not complete the process; their comments included, “I don’t want to fill out a survey,” and “I did not want to see another doctor.” Another patient stated, “I would have gotten my IUD that day if they would have let me.”

Discussion

A straightforward and seamless referral process was developed and implemented for patients that desire LARC but are unable to receive them at their established practice. The purpose was to determine the feasibility and acceptability of such a process. The foundation of this process was grounded in the concepts of the reproductive justice theory (Appendix A). Review of the literature showed that there is a lack of information to instruct providers how to refer patients for LARC services.

Results of the QI initiative determined acceptability of the process. Patients that completed the process were satisfied with the education, referral, and follow-up provided. Even with the low number of participants, the process was still well received. Although all participants reported satisfaction with the process, patients in both comparison and QI groups were dissatisfied with having to leave their established provider for an alternative provider to receive their desired LARC. Due to the small number of participants completing the QI process, it was found not to be feasible.

This project is an example of the implementation of a process change in real time context in a small, privately owned OBGYN practice. It was delivered by a provider with office staff and

medical assistants. It is important to point out that other practices with a similar setting can incorporate a similar QI process change.

Implications for Quality Improvement Practice Implementation

While this QI process could be implemented and replicated into other practices, there are conditions to consider. While patients could be happy with this process, the consensus was patients preferred to receive a LARC from their established provider. Other solutions may need to be considered, such as a Medicaid policy change to fully cover LARC. Another consideration is the possibility that referred patients may want to continue their gynecological care with the referred office. This can be deterred by the referring office making follow up appointments prior to the LARC insertion appointment. If the patient misses the follow-up appointment, the patient would be contacted. Of course, if the patient expresses desire to change providers, transfer of all records should be made upon request.

For practices that adopt this QI process and conclude that the change is not feasible or acceptable, further action may need to be taken at a policy level to ensure all patients can receive a LARC by any provider. In the state of Michigan, a change in Medicaid policy for LARC reimbursement may be required as a sustaining solution for patients to receive the contraception of their choice. To remove barriers for LARC for patients with Medicaid and/or their provider, Michigan needs to pursue initiatives to supplement reimbursement.

Implications for Future Research

A limited number of studies were found to include LARC referrals, of those, none were found to involve referral due to Medicaid insurance coverage. A study by Murphy et al. (2016) found there was an association with referral for LARC and a provider's confidence, education, and training about LARC. Another analysis by Broecker et al. (2016) evaluated LARC barriers

for patients having to pay out-of-pocket for the devices. In these studies, barriers to equitable access to contraception was also noted. Further research is needed with a larger sample size and a longer time frame to determine if a process change for LARC referral is feasible. An alternative approach for a study may focus on patient views about being referred to other providers for LARC or other ways that providers may be able to provide LARC for their patients. Another potential study would be to assess Medicaid LARC reimbursement policy and evaluate ways to impact policy change. This additional research is important in providing evidence to aid in policy change at a legislative level.

Limitations

Several limitations were noted with this process change. The time frame required for this project led to a small sample size. In the 4-month time span allotted for the project, seven patients were referred for LARC, which is less than the number of patients usually referred in this time frame. The reason for this may be attributed to a decline in patients seeking health care, likely due to the Covid-19 pandemic. Another limitation was the ability to collect surveys from those that received a LARC post-intervention as well as with the retrospective review. Reimbursement was offered to patients to complete surveys after initial communication resulted in no surveys being completed. Due to being reimbursed, biased responses may have been obtained from patients.

Conclusions

The feasibility and acceptability of a QI process to obtain a LARC has a multitude of implications for a small OBGYN practice. When a process to simplify receiving a LARC is implemented, patients not only report increased satisfaction with the health care received, but it provides patients with control over their contraceptive choices. Results from this QI process

provides insight to small OBGYN practices on how to refer patients with Medicaid that desire LARC. Removing such barriers to receive LARC is necessary to provide the universal human right to voluntary, informed, affordable access to the full range of contraceptive methods.

References

- American College of Obstetrics and Gynecology. (2015). Committee opinion 615: Access to contraception. *Obstetrics & Gynecology*, 250, 250-255. <https://acoglarc.freshdesk.com/support/solutions/articles/31000126972-acog-committee-opinion-615-access-to-contraception>
- ACOG Committee on Practice Bulletins-Gynecology. (2017). Practice Bulletin No. 186: Long-acting reversible contraception: Implants and intrauterine devices. *Obstetrics & Gynecology*, 130(5), e251-e269. <https://doi.org/10.1097/AOG.0000000000002400>
- ACOG Contraceptive Working Group. (2015). *Increasing access to contraceptive implants and intrauterine devices to reduce unintended pregnancy*. American College of Obstetrics & Gynecology. <https://www.acog.org/-/media/Committee-Opinions/Committee-on-Gynecologic-Practice/co642.pdf?dmc=1&ts=20200208T0032118744>
- Bayer. (2020). *Bayer women's healthcare (WHC) support center*. <https://www.whcsupport.com/>
- Brandi, K. & Fuentes, L. (2020). The history of tiered-effectiveness contraceptive counseling and the importance of patient-centered family planning care. *American Journal of Obstetrics and Gynecology*, 222(4), S873-S877. <https://doi.org/10.1016/j.ajog.2019.11.1271>.
- Broecker, J., Jurich, J., & Fuchs, R. (2016). The relationship between long-acting reversible contraception and insurance coverage: A retrospective analysis. *Contraception*, 93(3), 266-272. <https://doi.org/10.1016/j.contraception.2015.11.006>.
- Darney, B., Jacob, R., Hoopes M, Rodriguez, M., Hatch, B., Marino, M., Templeton, A., Oakley, J., & Cottrell, E. (2020). Evaluation of Medicaid expansion under the Affordable Care Act and contraceptive care in US community health centers. *JAMA Network*

Open, 3(6), 1-15. <https://doi.org/10.1001/jamanetworkopen.2020.6874>

Centers for Medicaid & Medicare Services. (2016). *State Medicaid payment approaches to improve access to long-acting reversible contraception*. [Informational bulletin] Maryland Department of Health and Human Services.

<https://www.medicaid.gov/federal-policy-guidance/downloads/CIB040816.pdf>

Chen, C., Strasser, J., Banawa, R., Luo, Q., Bodas, M., Castruccio-Prince, C., Das, K., & Pittman, P. (2021, August 18). Who is providing contraception care in the United States? An observational study of the contraception workforce. *American Journal of Obstetrics and Gynecology*, e1-e11. <https://doi.org/10.1016/j.ajog.2021.08.015>.

Cleland, K., Peipert, J., Westhoff, C., Spear, S., & Trussel, J. (2011). Family planning as a cost-saving preventive health service. *New England Journal of Medicine*, 364(18). e37(1-3). <https://doi.org/10.1056/NEJMp1104373>

Curtis, K., & Peipert, J. (2017). Long-acting reversible contraception. *New England Journal of Medicine*, 376, 461-468. <https://doi.org/10.1056/NEJMcpl608736>

Daw, J., Hatfield, L., Swartz., K., & Sommers, B. (April 2017). Women in the United States experience high rates of coverage ‘churn’ in months before and after childbirth. *Health Affairs*, 36(4), 598-606. <https://doi.org/10.1377/hlthaff.2016.1241>

Dehlendof, C. (2019). *Contraceptive counseling and selection for women*. Uptodate.com.

Evans, M., Broyles, S., Frederiksen, B., Gee, R., Phillippi, S., Sothern, M., Theall, K., & Wightkin, J. (2019). Long-acting reversible contraceptive utilization after policy change increasing device reimbursement to wholesale acquisition cost in Louisiana. *American Journal of Obstetrics and Gynecology*, 221(2), 128-138. <https://doi.org/10.1016/j.ajog.2019.04.024>

Food and Drug Administration. (2020). *Resources for information/approved drugs*.

<https://www.fda.gov/drugs/drug-approvals-and-databases/resources-information-approved-drugs>.

Fuerst, M., & George, K. (2020). Advancing person-centered LARC access among the Medicaid population. *Institute for Medicaid Innovation*. www.medicaidinnovation.org.

Heath Resources & Services Administration, (2020). *Find a health center*.

<https://findahealthcenter.hrsa.gov/>

Higgins, J. (2014). Celebration meets caution: LARC's boons, potential busts, and the benefits of a reproductive justice approach. *Contraception*, 89(4), 237-241.

<https://doi.org/10.1016/j.contraception.2014.01.027>

Higgins, T., Daugherty, A., Badger, G. & Heil, S. (2018). Comparing long-acting reversible contraception insertion rates in women with Medicaid vs. private insurance in a clinic with a two-visit protocol. *Contraception*, 97(1), 76-78.

<https://doi.org/10.1016/j.contraception.2017.08.016>

Incite! (2010). *SISTERSONG, SPARK, and SisterLove Defeat SB 529*. <https://incite-national.org/2010/07/11/sistersong-spark-and-sisterlove-defeat-sb-529/>

Kaunitz, M. (2020, February 11). *Patient education: Birth control, which method is right for me? (Beyond the Basics)*. Up to Date. <https://www.uptodate.com/contents/birth-control-which-method-is-right-for-me-beyond-the-basics>.

Larsson, B. & Larsson, G. (2002). Development of a short form of the Quality from the Patient's Perspective (QPP) questionnaire. *Journal of Clinical Nursing*, 11(5) 681-

687. <https://doi/10.1046/j.1365-2702.2002.00640.x>

Liletta. (2021). *Liletta*. <https://www.lilettahcp.com/#>

Mack, J. (2019). *See number of Medicaid recipients in your Michigan county*. Mlive.

https://www.mlive.com/news/erry-2018/04/08f422a3824447/see_number_of_medicaid_recipie.html?appSession=75S0SMW2EG8MULA3FI2BWMFB5B2I067J5ZWS12OM68W469P80DEDF35I4L02J564F91D4G0Q6R6975G25Q8GNOLK K2T9VL2516BQYEO32192RS4368HWFN567AR362H3

Medicaid.gov. (2020). *Contraception in Medicaid: Improving maternal and infant health*.

<https://www.medicaid.gov/medicaid/quality-of-care/downloads/mih-expert-workgroup-recommendations.pdf>

Murphy, M., Stoffel, C., Nolan, M., & Haider, S. (2016). Interdependent barriers to providing adolescents with long-acting reversible contraception: Qualitative insights from providers. *Journal of Pediatric and Adolescent Gynecology*, 29(5), 436-442,

<https://doi.org/10.1016/j.jpag.2016.01.125>.

Nexplanon. (2021). *Nexplanon*.

https://www.nexplanon.com/?utm_source=google&utm_medium=cpc&utm_campaign=Nexplanon_+NexplanonEXCT_BRND_NA_ENGM_EXCT_TEXT_FEMALE&utm_term=nexplanon&utm_content=Nexplanon+-+Exact&utm_kxconfid=sgaizzyx0&gclid=Cj0KCQjwqp-LBhDQARIsAO0a6aIRPFCv5IHLAiiw2sG64gNSfIKobF6kPEPmEjIH5qAG02Qr36dA8vQaAmhhEALw_wcB&gclsrc=aw.ds

Paragard. (2020). *Paragard, intrauterine copper contraceptive*. <https://www.paragard.com/>

Planned Parenthood. (2020). *What are the different type of IUDs?*

<https://www.plannedparenthood.org/learn/birth-control/iud#:~:text=The%20Mirena%2C%20Kyleena%2C%20Liletta%2C,that%20our%20bodies%20make%20naturally.>

Sister Song. (n.d.). *Reproductive justice*. <https://www.sistersong.net/reproductive-justice>

Ranji, U., Long, M., Salganicoff, A., Silow-Carroll, S., Rosenzweig, C., Rodin, D., & Kellenberg, R. (2019). *Beyond the numbers: Access to reproductive health care for low-income women in five communities*. Kaiser Family Foundation.

<https://www.kff.org/report-section/beyond-the-numbers-access-to-reproductive-health-care-for-low-income-women-in-five-communities-executive-summary/>

Ross, L., Roberts, L., Derkas, E., Peoples, W., & Bridgewater Toure, P. (2017). *Radical reproductive justice: Foundation, theory, practice, critique*. [Kindle Edition]. The Feminist Press at CUNY.

Unitarian Universalist Association (UUA). (n.d.). *Comparing frameworks: What is reproductive health, rights, and justice?*

<https://www.uua.org/reproductive/action/199536.shtml>

Vela, V., Patton, E., Phil, M., Sanghavi, D., Wood, S., Shin, P., & Rosenbaum, S. (2018).

Rethinking Medicaid coverage and payment policy to promote high value care: The case of long-acting reversible contraception. *Women's Health Issues*, 28(2), 137-143.

<https://doi.org/10.1016/j.whi.2017.10.013>

Wilkinson, T. A., Downs, S. M., & Tucker Edmonds, B. (2019). Cost minimization analysis of same-day long-acting reversible contraception for adolescents. *JAMA Network*

Open, 2(9), e1911063. <https://doi.org/10.1001/jamanetworkopen.2019.11063>

Zolkefli, Y. (2017). Evaluating the concept of choice in healthcare. *The Malaysian Journal of*

Medical Sciences. 24(6), 92–96. <https://doi.org/10.21315/mjms2017.24.6.11>

Table 1*Intervention Demographic Characteristics*

Characteristic	Number
Age (mean)	25 years
Miles to office from home (mean)	10 miles
Number of prior pregnancies	2.4
Number of children	1.7
Number of months since last period	
<6 months at time of referral	29%
>6 months at time of referral	29%
Unknown	42%
Number of years with Medicaid	
0-4 years	42%
5-10 years	29%
>10 years	29%
Type of LARC desired	
IUD	71%
Implant	29%
Purpose of LARC	
Contraception	100%
Other	0%
Referred Office	
Dearborn OBGYN	43%
Dearborn Obstetrics and Gynecology Associates	43%
Unknown	14%

Table 2*LARC Questions From Intervention Group*

LARC specific questions	Quotations
How did you decide on a LARC?	“Have had one before” “My doctor recommended it” “Reliable” “I want to be safe and I am not ready for another baby” “Want something long term” “No more babies” “I do not want an IUD”
Why do you want an IUD/implant as opposed to other forms of contraception?	“Have had one before” “I don’t need to worry about it every day” “I don’t want depo anymore” “Want something more effective” “I don’t want to take a pill everyday” “Effective” “I want this to work for a while”

Table 3*Acceptability QPP Results: Comparison Group*

Dimensions and factors	Question	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree
Competence	1. I received the best possible physical care	72.7% (n=8)	9.1% (n=1)	9.1% (n=1)	0	9.1% (n=1)
	2. I received the best possible medical care	72.7% (n=8)	9.1% (n=1)	9.1% (n=1)	0	9.1% (n=1)
	3. I received appropriate education and instructions	63.6% (n=7)	27.3% (n=3)	9.1% (n=1)	0	0
Waiting time	4. My appointment was scheduled in an appropriate amount of time	63.6% (n=7)	27.3% (n=3)	9.1% (n=1)	0	0
Information	5. I received useful information on my procedure	54.5% (n=6)	36.4% (n=4)	9.1% (n=1)	0	0
	6. I received useful information about follow-up care	54.5% (n=6)	36.4% (n=4)	9.1% (n=1)	0	0
Participation	7. I had good opportunity to participate in the decisions that applied to my care	63.6% (n=7)	27.3% (n=3)	9.1% (n=1)	0	0
Commitment	8. The providers showed commitment; 'cared about me'	63.6% (n=7)	18.2% (n=2)	9.1% (n=1)	9.1% (n=1)	0
	9. The staff at the receiving office showed commitment; 'cared about me'	81.8% (n=9)	9.1% (n=1)	9.1% (n=1)	0	0
Responsible persons	10. I received useful information on the providers responsible for my care	54.5% (n=6)	36.4% (n=4)	9.1% (n=1)	0	0
Respect	11. The providers were respectful towards me	90.9% (n=10)	0	9.1% (n=1)	0	0
	12. The staff were respectful towards me	81.8% (n=9)	9.1% (n=1)	9.1% (n=1)	0	0
Environment	13. There was a pleasant atmosphere in the receiving office	54.5% (n=6)	36.4% (n=4)	9.1% (n=1)	0	0
Referral	14. I would refer my friends and family for this process	54.5% (n=6)	27.3% (n=3)	9.1% (n=1)	9.1% (n=1)	0
	15. I will do this again if I want to replace/new LARC	45.5% (n=5)	36.4% (n=4)	9.1% (n=1)	0	9.1% (n=1)
Open-ended Questions:	Quotes					
	"Not sending patients somewhere else"					
	"I wouldn't"					
16. How would you improve this process?	"There's not really anything to improve"					
	"I would have Dr. Grahovac's office schedule IUD with the clinic and schedule the 4-week check up with Dr. Grahovac's office to maintain continuity of care"					
	"I had a very bad experience where I went!! I was very uncomfortable getting the IUD inserted and I was in pain for 2 weeks after that with a very bad infection"					
	"Very good process"					
	"Take a pain pill before the procedure"					
	"N/A"					
	"N/A"					
17. How did You hear About LARC?	"Friend has one"		"Facebook!"		"My doctor"	
	"My doctor"		"Family"		"N/A"	
	"My OB doctor"		"My doctor told me about it"		"My gynecologist"	
	"From my doctor"		"My gynecologist"			

Table 4*Acceptability QPP Results: QI Group*

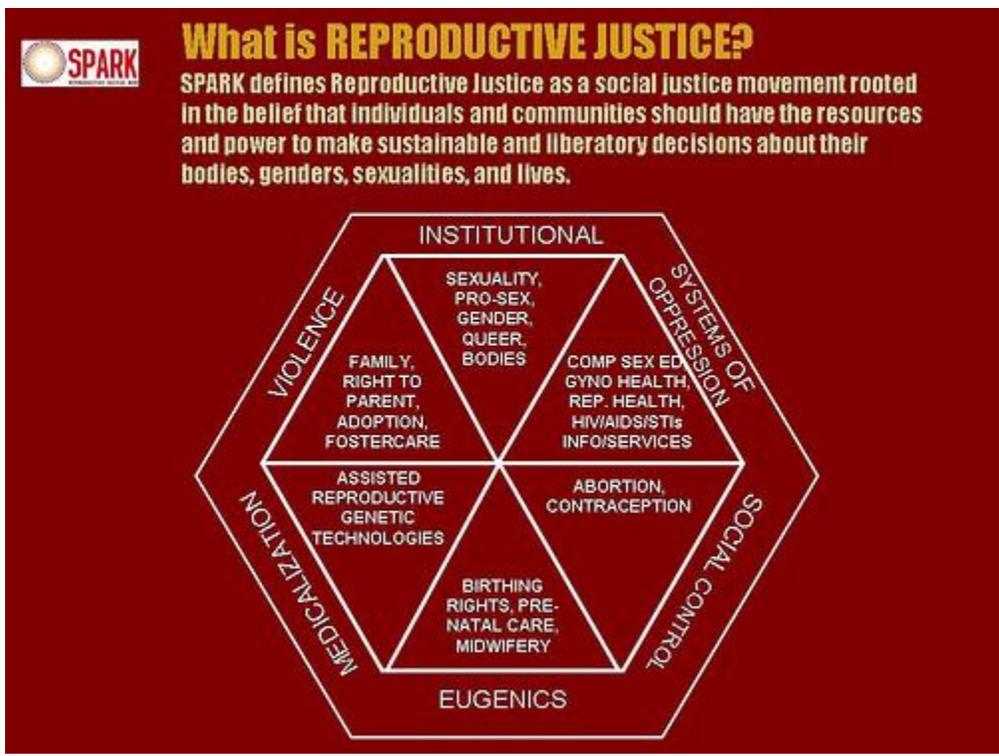
Dimensions and factors	Question	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree
Competence	1. I received the best possible physical care	33.3% (n=1)	66.7% (n=2)	0	0	0
	2. I received the best possible medical care	66.7% (n=2)	33.3% (n=1)	0	0	0
	3. I received appropriate education and instructions	66.7% (n=2)	33.3% (n=1)	0	0	0
Waiting time	4. My appointment was scheduled in an appropriate amount of time	66.7% (n=2)	33.3% (n=1)	0	0	0
Information	5. I received useful information on my procedure	66.7% (n=2)	33.3% (n=1)	0	0	0
	6. I received useful information about follow-up care	100% (n=3)	0	0	0	0
Participation	7. I had good opportunity to participate in the decisions that applied to my care	66.7% (n=2)	33.3% (n=1)	0	0	0
Commitment	8. The providers showed commitment; 'cared about me'	66.7% (n=2)	33.3% (n=1)	0	0	0
	9. The staff at the receiving office showed commitment; 'cared about me'	66.7% (n=2)	33.3% (n=1)	0	0	0
Responsible persons	10. I received useful information on the providers responsible for my care	66.7% (n=2)	33.3% (n=1)	0	0	0
Respect	11. The providers were respectful towards me	100% (n=3)	0	0	0	0
	12. The staff were respectful towards me	100% (n=3)	0	0	0	0
Environment	13. There was a pleasant atmosphere in the receiving office	100% (n=3)	0	0	0	0
Referral	14. I would refer my friends and family for this process	100% (n=3)	0	0	0	0
	15. I will do this again if I want to replace/new LARC	33.3% (n=1)	66.7% (n=2)	0	0	0
Open-ended	Question	Quotes				
	16. How would you improve this process?	"Not to have to go somewhere else" "Not to have to go to another clinic and waited til I was on my period"				
	17. How did you hear about LARC?	"Friend" "Just exploring my options after I had my son" "Online"				

Table 5*Comparison of Comparison Groups*

QPP Dimension	QI Group (Strongly Agree + Agree) (%)	Comparison Group (Strongly Agree + Agree) (%)
Competence – Physical Care	100	81.8
Competence – Medical Care	100	81.8
Competence – Education and Instructions	100	90.9
Waiting Time	100	90.9
Information – Procedure	100	90.9
Information – Follow Up Care	100	90.9
Commitment – Providers	100	90.9
Commitment – Staff	100	90.9
Responsible Persons	100	90.9
Respect – Providers	100	90.9
Respect – Staff	100	90.9
Environment	100	90.9
Referral – Friends and Family	100	81.8
Referral - Self	100	81.8

Figure 1

Reproductive Justice, 2010



Note. Adapted from SISTERSONG, SPARK, and SisterLove Defeat SB 529, by Incite! 2010

<https://incite-national.org/2010/07/11/sistersong-spark-and-sisterlove-defeat-sb-529/>

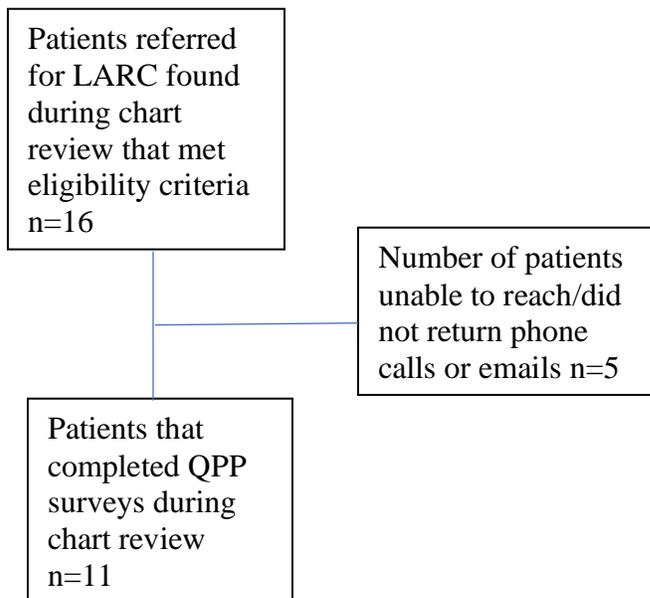
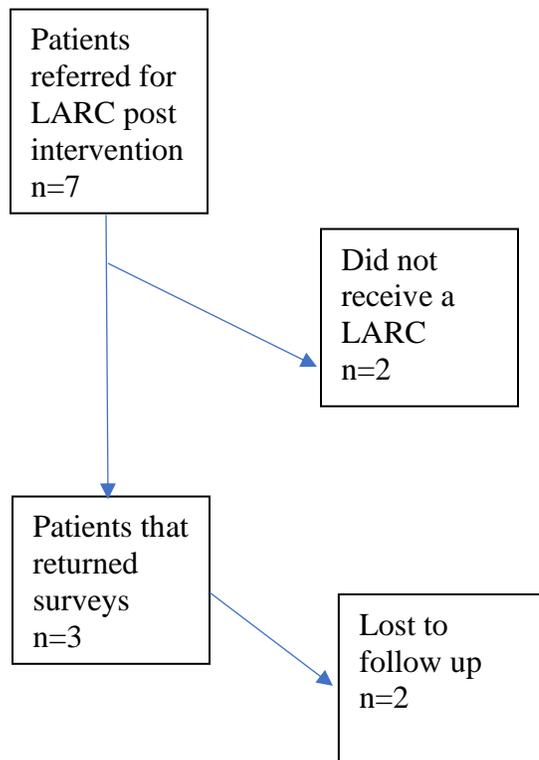
Figure 2*Comparison Group Flowchart*

Figure 3

Participant Enrollment and Follow-Up Flow Chart



Appendix A

Quality From the Patient's Perspective (QPP)

Dimensions and factors	Short version
Competence	1. I received the best possible physical care Strongly agree Agree Neither Disagree Strongly Disagree
	2. I received the best possible medical care Strongly agree Agree Neither Disagree Strongly Disagree
	3. I received appropriate education and instructions Strongly agree Agree Neither Disagree Strongly Disagree
Waiting time	4. My appointment was scheduled in an appropriate amount of time Strongly agree Agree Neither Disagree Strongly Disagree
Information	5. I received useful information on my procedure Strongly agree Agree Neither Disagree Strongly Disagree
	6. I received useful information about follow-up care Strongly agree Agree Neither Disagree Strongly Disagree
Participation	7. I had good opportunity to participate in the decisions that applied to my care Strongly agree Agree Neither Disagree Strongly Disagree
Commitment	8. The providers showed commitment; 'cared about me' Strongly agree Agree Neither Disagree Strongly Disagree
	9. The staff at the receiving office showed commitment; 'cared about me' Strongly agree Agree Neither Disagree Strongly Disagree
Responsible persons	10. I received useful information on the providers responsible for my care Strongly agree Agree Neither Disagree Strongly Disagree
Respect	11. The providers were respectful towards me Strongly agree Agree Neither Disagree Strongly Disagree
	12. The staff were respectful towards me Strongly agree Agree Neither Disagree Strongly Disagree
Environment	13. There was a pleasant atmosphere in the receiving office Strongly agree Agree Neither Disagree Strongly Disagree
Referral	14. I would refer my friends and family for this process Strongly agree Agree Neither Disagree Strongly Disagree
	15. I will do this again if I want to replace/new LARC Strongly agree Agree Neither Disagree Strongly Disagree
Open-ended	16. How would you improve this process?
	17. How did you hear about LARC?

Adapted from (Larsson & Larsson, 2002)

Appendix B**Pre-procedure demographic questionnaire**

Last Name _____ First Name _____ Patient Number _____

Age _____ Zip Code _____ Referred Office/Provider _____

How many pregnancies have you had? _____ How many children do you have? _____

First day of last period _____ Type of IUD/implant you are getting _____

Are you getting the device for contraception? Yes No If not, why? _____

How long have you had Medicaid insurance coverage? _____

How did you decide on an IUD/implant? _____

Why do you want an IUD/implant as opposed to other forms of contraception? _____

Appendix C

Script for Telephone Interview to Obtain QPP

My name is (insert name), I am a provider at Dr. Jure Grahovac MD, P.C.. I am calling because I see you were consulted about or may have received an IUD or implant from an office that we referred you to. I am working with the other providers to ask you questions about how you felt the process went being referred to another office for this procedure. The survey should take less than 2 minutes to complete and could really help us become better at caring for patients in the future. I will ask you 15 questions that you will respond with strongly agree, agree, neither, disagree, or strongly disagree. Then I will ask 2 open-ended questions and document your answers.

Appendix D

Feasibility and Acceptability

Feasibility	If findings can be shaped to be relevant and sustainable, the following questions will be asked:
	How many patients were referred for the process?
	How many patients followed through with receiving LARC?
	How many patients completed post-procedure survey?
	How many patients attended follow-up appointments after receiving LARC?
Acceptability	Determining how well the process will be received by the Medicaid population and the extent to which the new process meets the needs of the patients with Medicaid that desire LARC.
15 Likert-scale questions	Evaluated with quantitative analysis
2 open-ended questions	Analyzed with narrative analysis

Appendix E

Institutional Review Board Decision

IRB #: UHSRC-FY20-21-214

Title: Feasibility and Acceptability of a Process Change for Patients with Medicaid to Receive LARCs in a Private OBGYN Office

Creation Date: 4-30-2021

End Date:

Status: **Approved**

Principal Investigator: Laura Mills

Review Board: University Human Subjects Review Committee

Sponsor:

Study History

Submission Type	Initial	Review Type	Exempt	Decision	No Human Subjects Research

Key Study Contacts

Member	Lydia McBurrows	Role	Co-Principal Investigator	Contact	lmcburro@emich.edu
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