NM HFMA SPRING 2024

Breaking Barriers:

Healthcare Access, Financial Inclusion, and the New Mexico Paradigm

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Jerald Archibeque,
Director, Hospital Billing,
Presbyterian Healthcare Services

Career in healthcare began in 1999 (25 years). I have been with multiple organizations in my career that includes Presbyterian Healthcare Services (18 years), Lovelace Health System (6 years), Rehoboth McKinley Christian Health Care Services (1 year), and 2 DME companies (1 year). I have experience in Patient Access, Cash Management, both Commercial and Government Billing and Collections, as well as Revenue Recovery (contract underpayments & overpayments). I have also managed the Home Health and Hospice billing for Presbyterian.

On the personal side, I'm a Husband, Father, and Grandfather. Husband of 27 years to a great wife, Father of 2 (26 year old daughter and 25 year old son) and Grandfather of 3 (3 year old grandson, 1 ½ year old granddaughter, and 1 year old grandson).

Tamara Hidalgo, CCS-P, CPC, COC
Director, HIM, Informatics, Auditing and Physician Billing
Presbyterian Healthcare Services

Tamara has been at Presbyterian for over 25 years in a variety of roles within the Revenue Cycle. She completed her bachelor's degree in business administration from the University of New Mexico, Anderson School of Management in 2003. Since then, she has enjoyed working on projects within Presbyterian such as the implementation of the Electronic Health Record, computer assisted coding, Voice Recognition transcription, documentation management systems, along with numerous automation projects within the revenue cycle.

Tamara has 2 daughters, ages 18 and 15, who are both active in 4-H and FFA. They raise and show registered Brown Swiss dairy cattle all over the southwest. We also enjoy riding horses.

PRESBYTERIAN

Automation and Analytics in Healthcare

Jerald Archibeque, Director, Hospital Billing
Tamara Hidalgo, Director, HIM, Informatics,
Auditing & Physician Billing

MARCH 19, 2024

Presbyterian Healthcare Services

PRESBYTERIAN Healthcare Services

Integrated delivery and financing system with

$5.6B

in annual revenue.

New Mexico's most preferred healthcare system, serving

900k+

New Mexicans.

PRESBYTERIAN Health Plan, Inc.

30+

years of provider-led, managed care experience.

652,000+

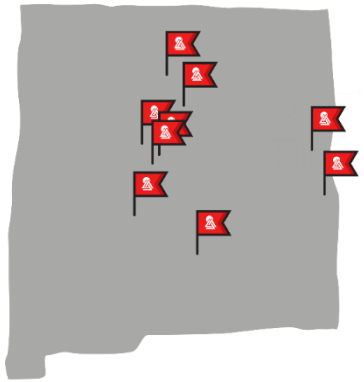
members statewide in commercial, Medicare Advantage and Medicaid.

PRESBYTERIAN Delivery System

1,200+

physicians and advanced practice clinicians in more than 100 clinic locations

9 hospitals across New Mexico



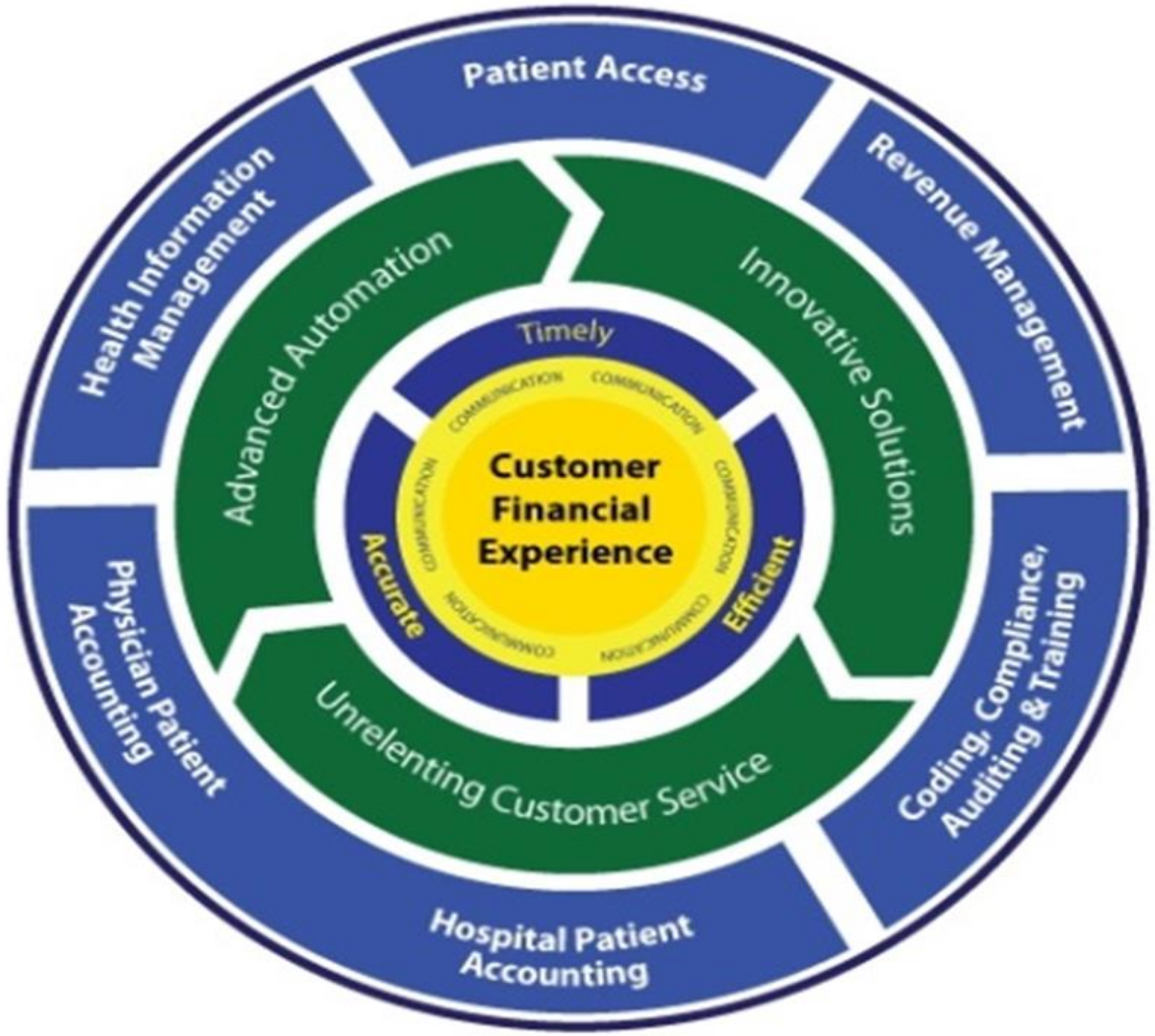
BEST HOSPITALS U.S.News 2023-2024

PHS named among best hospitals for 2023-2024 in New Mexico by US News & World Report

- Recognized as high performing hospital in 12 care areas

Presbyterian Healthcare Services

Revenue Cycle



Patient Access

Patient Access

Registration, Financial Counselors, Insurance Verification, & Financial Clearance Center

- **<u>Registration</u>**:
  1. QR code to download a copy of the inpatient or outpatient admission booklets.
  2. Online Register: patients can pre-register for any hospital service in MyChart up to 30 days in advance and can pay their copay or deductible.
  3. OB pre-registration: Labor and delivery patients can pre-register 7 months in advance of due date.
  4. Good Faith Estimates: templates have been built in EPIC to help with Self Pay estimates and preparing for insurance estimate automation in 2023.
  5. Automation (Bot) for insurance verification and benefits pulled into EPIC.
  6. Financial Assistance Module in EPIC: patients can now apply for financial assistance in MyChart and upload all documents.
  7. Automation (Bots) to request prior authorizations from payors
  8. Dashboard created for Registration regarding denials so areas can look and react in the moment (RPM-Registration, Prior Auth, & Medical Necessity).

Health Information Management (H.I.M.)

Health Information Management

Medical Records

1. Medical record document scanning uses AI to read and auto index documents
2. Utilizing EMR algorithms to match and auto-merge duplicate patient records

Coding

1. Use of Computer Assisted coding to aide in optimal coding workflows, both for improvements in accuracy and efficiency
2. Autonomous medical coding will allow specific types of services to be fully auto-coded and released to bill without needing coder review

Release of Information

1. Direct release of records to SSA for disability claims
2. Automatic release of all patient records to patient portal now allows for self service of medical record access

Health Information Management

Coding & Documentation Quality Assurance (CDQA)

What is CDQA?

CDQA is an integral part of our revenue cycle which helps prevent compliance risk to the organization. The OIG states in order to be compliant an organization needs to have strong internal audit standards, education, training, intervention and mitigation of compliance issues. This department aligns with our organizational compliance plan by: Defining, Preventing, Detecting and Evaluating risk.

CDQA uses analytics to proactively monitor and audit areas of risk across the organization.

- CMS Bell Curve Data
- Peer to peer outliers
- Predictive, data driven approach

Patient Accounting

Patient Accounting

Billing, Insurance & Patient Collections, Denials,
Cash Management, and Revenue Recovery

- **Billing**: currently we bill 15,800 claims per day for our Physician Group, and 3,400 claims per day for our hospitals.
  1. Claim Edits built in EPIC, including payor & contract specific edits, work queues built to hold accounts/claims prior to release.
  2. Claim Attachments- automated the process to pull medical records into work queue and submitted. Eliminated manual intervention and reduced process by more than a day.
  3. CLIA automation- was able to auto populate the CLIA numbers to the claim which previously was a manual process.
  4. Automation (Bot) was created to update insurance coverage information.
  5. Auto adjustment of non-billable charges at the time of billing (i.e. vaccine charges for rural health clinics).
  6. Automation (Bot) was created to calculate the milage for billing on ambulance claims.
  7. Automation (Bot) to enter hospice notice of elections (NOE's)
  8. Claim automation to combine outpatient & inpatient charges for Medicare patients within 72 hours of qualifying visits.

Patient Accounting

Billing, Insurance & Patient Collections, Denials,
Cash Management, and Revenue Recovery

- **Insurance Collections & Denials**: Analysis is key. Using CARC and RARC payor data to pinpoint areas of opportunity not only by volumes but also by overturn probability rate (RAEAA score-Risk Adjusted Expected Allowed Amount).
    1. Monthly denial meeting with regional facilities (specific focus on those denials that they can directly impact such as eligibility and authorization denials).
    2. Monthly denial meeting with specific departments (such as Infusion, Radiology, Cardiology, Oncology and Care Coordination)
    3. Monthly payor meetings
    4. Automation (EPIC) for adjustments if account paid according to contract
    5. Automation (EPIC) to send letter to patient for Registration denials
    6. Automation (Bot) to take the information from the payor portals and bring the claim information back into our system.
    7. Automation (EPIC) for claim resubmissions
    8. Automation (Bot) for medical record submission for information request denials
    9. Predictive Analytics on denials- started with Coding and have added Registration/Authorization denials.

Patient Accounting

Billing, Insurance & Patient Collections, Denials, Cash Management, and Revenue Recovery

- **Patient Collections**: Patient Debt Collection Act and No Surprise Billing Act requirements and compliance.
  1. Automation (Bot) Medicaid coverage discovery
  2. Charity/Financial Assistance module built in EPIC, used to track cases
  3. MyChart innovation
  4. Automation (Bot) to adjust ambulance balances for charity
  5. Adding the Visit Auto Pay function in EPIC to automatically take payment for outstanding patient balances based on patient permission.

- **Cash Management**: 96% of all payments received are electronic and auto posted (including the PLB segment).
  1. Automation (Bot) to post statement payments
  2. Credit Balance automation (Bot) to locate over contractualized accounts.
  3. Patient Refund automation (EPIC) to look for other open accounts & distribute if balances owed.
  4. Automation (Bot) to post payments that are in Undistributed due to error mismatch of identifiers between EHR system & the 835 electronic remittance advice.

Patient Accounting

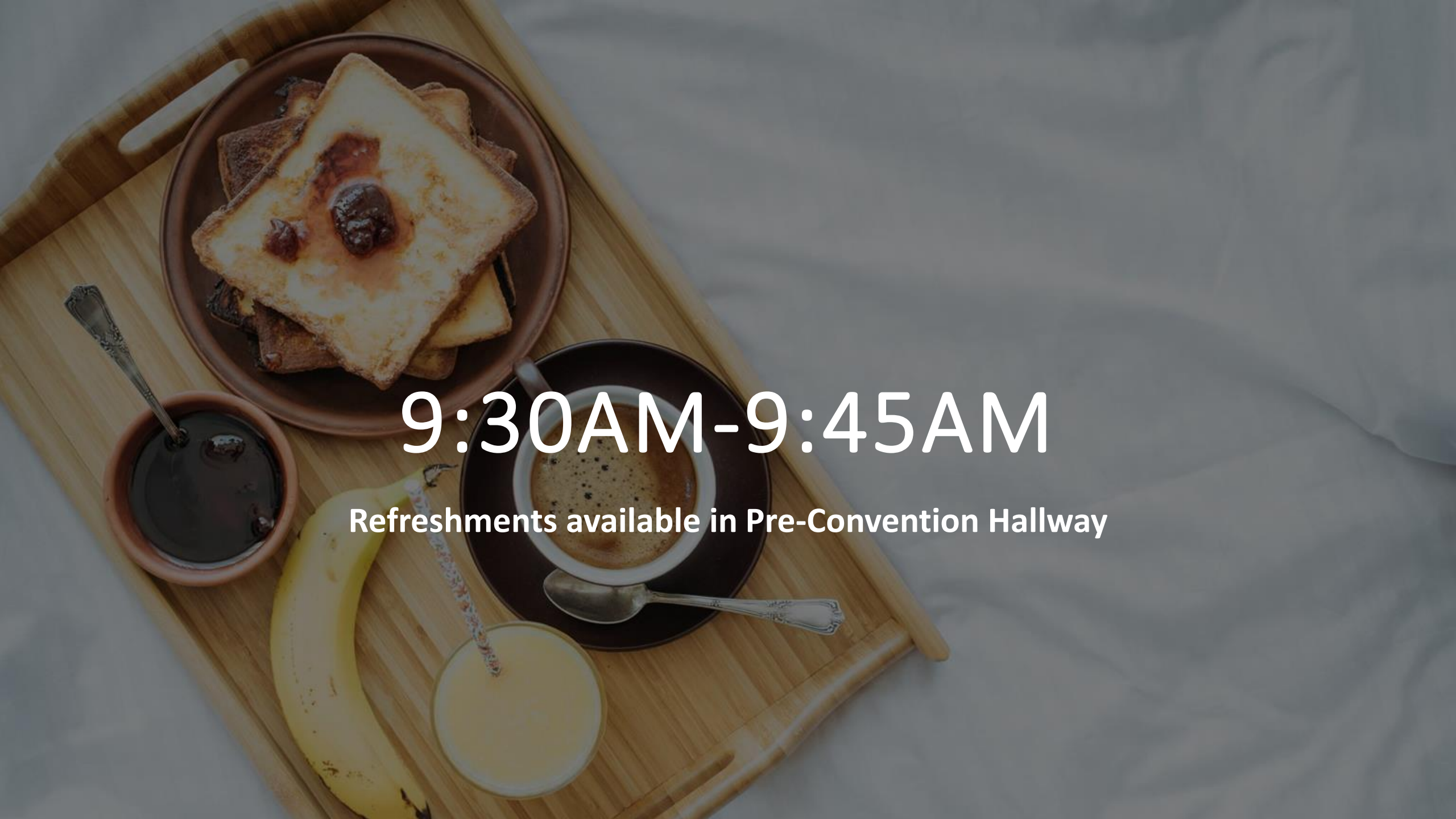
Billing, Insurance & Patient Collections, Denials, Cash Management, and Revenue Recovery

- **Revenue Recovery**: After adjudication, this team evaluates if the claim was paid according to contract (Underpayments and Overpayments). Contracts are loaded into EPIC and the system calculates if we were paid correctly. If not paid according to contract a record is recreated and the account flows to a work queue for the team to work.

- **Vendor Management**: We utilize partnerships for certain areas of the business to supplement our processes. We work with companies that specialize in…

1. Self Pay Collections
2. Workers Comp
3. Bad Debt Collections
4. Underpayment Recovery
5. Transfer DRG's
6. Strategic Pricing
7. Autonomous Coding
8. Auto Liability
9. Out of State Medicaid
10. Denials
11. Clinical Documentation Improvement
12. Eligibility & Enrollment
13. 340b
14. Utilization Review

Questions?



9:30AM-9:45AM

Refreshments available in Pre-Convention Hallway

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Georgia Green,
Senior Manager
Moss Adams | Healthcare Consulting Group

Georgia has worked in the health care industry since 2011.
She provides consulting services to health care providers and payers.

Georgia helps clients evaluate and integrate value-based care models, including the Medicare Shared Savings Program, ACO REACH, Making Care Primary, and other evolving programs.

Georgia's experience includes strategic analysis, program design, budgeting, contracting, waiver development, training, compliance, quality reporting, and performance improvement.

Throughout the pandemic, Georgia has supported clients with COVID-19 funding programs, including HRSA Provider Relief Funds and FEMA Public Assistance.

Prior to joining Moss Adams, Georgia cofounded a population health services organization, Caravan Health, now part of Signify Health/CVS Accountable Care, supporting community health systems in their value transformation.

Certifications
Certified Healthcare Financial Professional (CHFP), Healthcare Financial Management Association

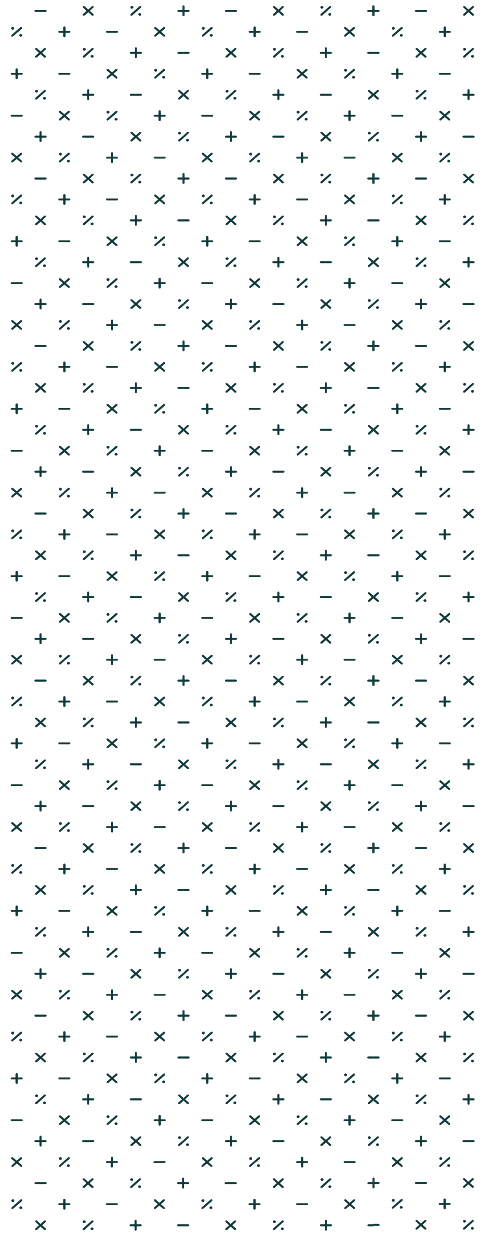
Education
MS, global health and environment, University of California, Berkeley
BS, conservation and resource studies, University of California, Berkeley

MOSSADAMS

Primary Care Payment Reform: New Medicare and Medicaid Programs Starting in 2024

Georgia Green, MS, Senior Manager

Health Care Consulting Practice



Agenda

01 CMS' VALUE-BASED CARE GOALS

02 MEDICARE PAYMENT REFORM: MAKING CARE PRIMARY

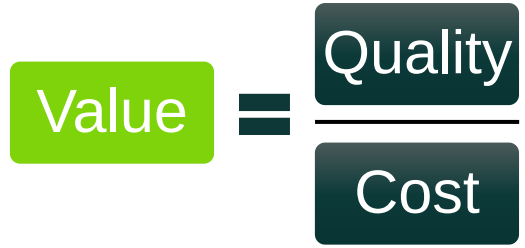
03 MEDICAID PAYMENT REFORM

04 APPENDIX: ABOUT MOSS ADAMS, SPEAKER BIO

CMS' Value-Based Care Goals

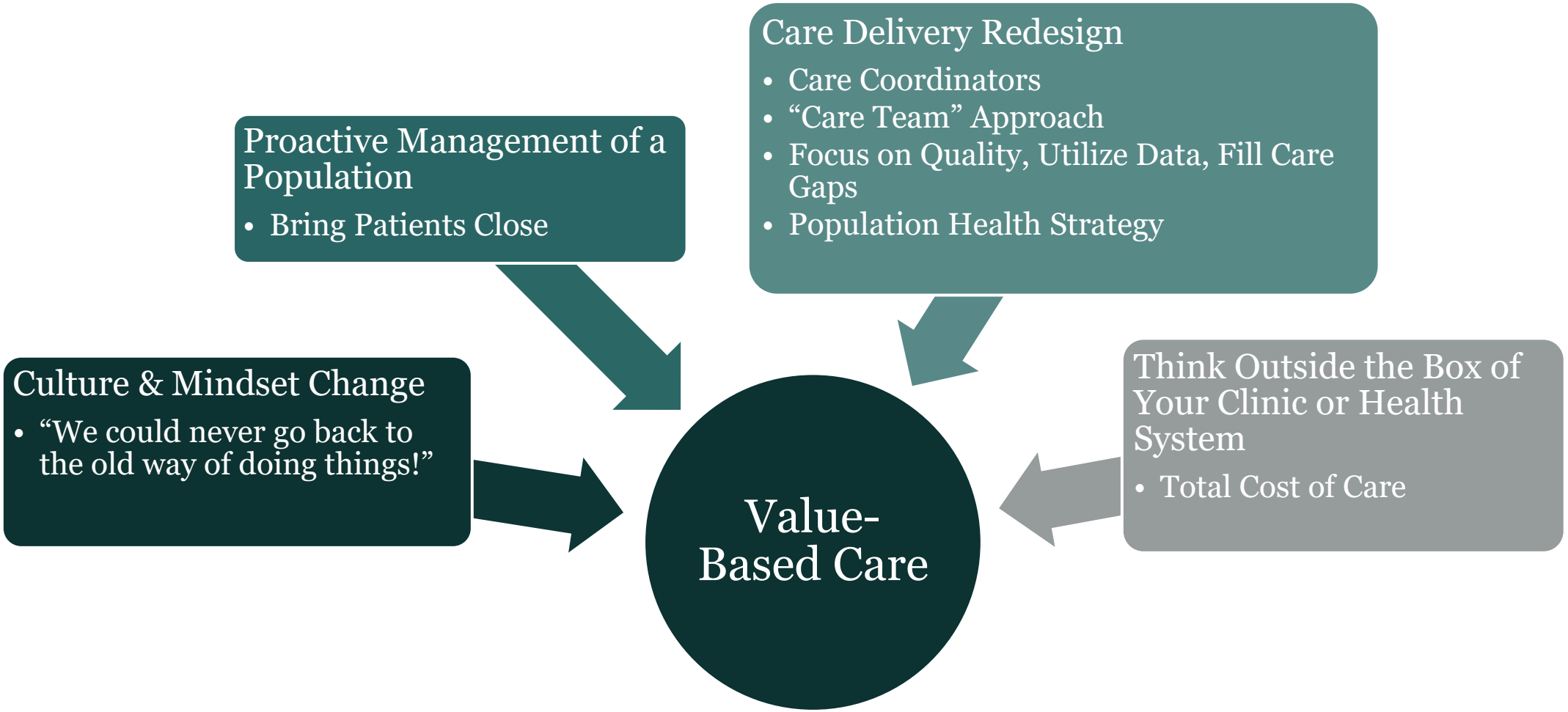
Value-Based Care Goals

In 2021, the Centers for Medicare & Medicaid Services (CMS) established a goal to have **100 percent of Original Medicare** beneficiaries and the **vast majority of Medicaid beneficiaries** in accountable care relationships by 2030.



- Improve clinical quality
- Reduce total cost of care
- Promote population health
- Improve equity & care access
- Improve provider experience

Shifting the Focus from *Volume* to *Value*



Challenges on the VBC Journey

Getting Started

- Not in VBC contracts – maybe getting left behind – will be unprepared for mandatory programs in the future
- Start-up activities pose a hurdle - analysis, application, legal, governance, contracts

Patient-Facing Processes

- Standard clinical workflows, evidence-based practices
- Emergency Dept transition management process
- Chronic Care Management, care navigation services
- Quality measure performance improvement, promoting Annual Wellness Visits
- Patient satisfaction improvement, increasing access to care

Internal Processes

- Clear processes, roles & responsibilities (VBC operations team)
- Data warehouse, providing meaningful dashboards to leadership
- Meaningful data/reports for frontline providers
- Provider education
- Compliance program

Success Strategies

- Post-Acute Care alignment
- Network management – high-value specialists, reducing leakage
- Contract alignment – overlapping measures, priorities

Medicare Payment Reform: Making Care Primary

Making Care Primary Fast Facts

Enhanced payments from Medicare & Medicaid

Open to primary care providers in 8 states, including NM

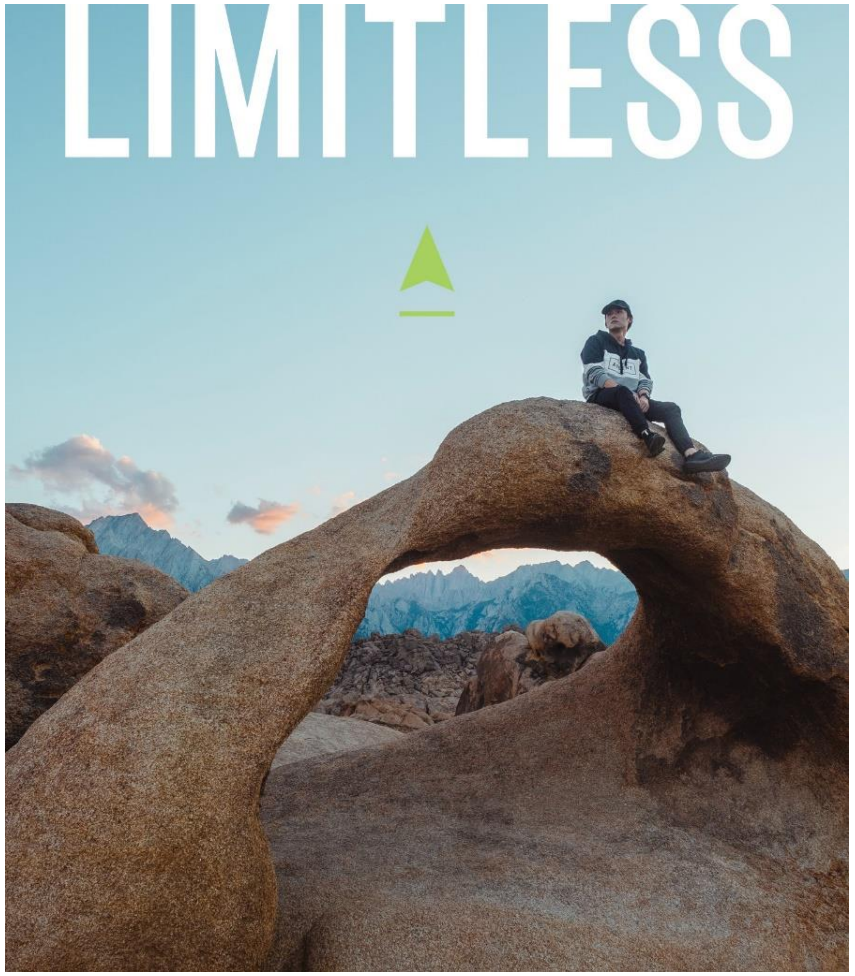
One opportunity to apply *(Aug-Nov 2023)*

10.5-year program, starting *July 2024*

Receive Advanced APM status for MIPS reporting in Track 2 & 3

Up-front infrastructure funding for Track 1

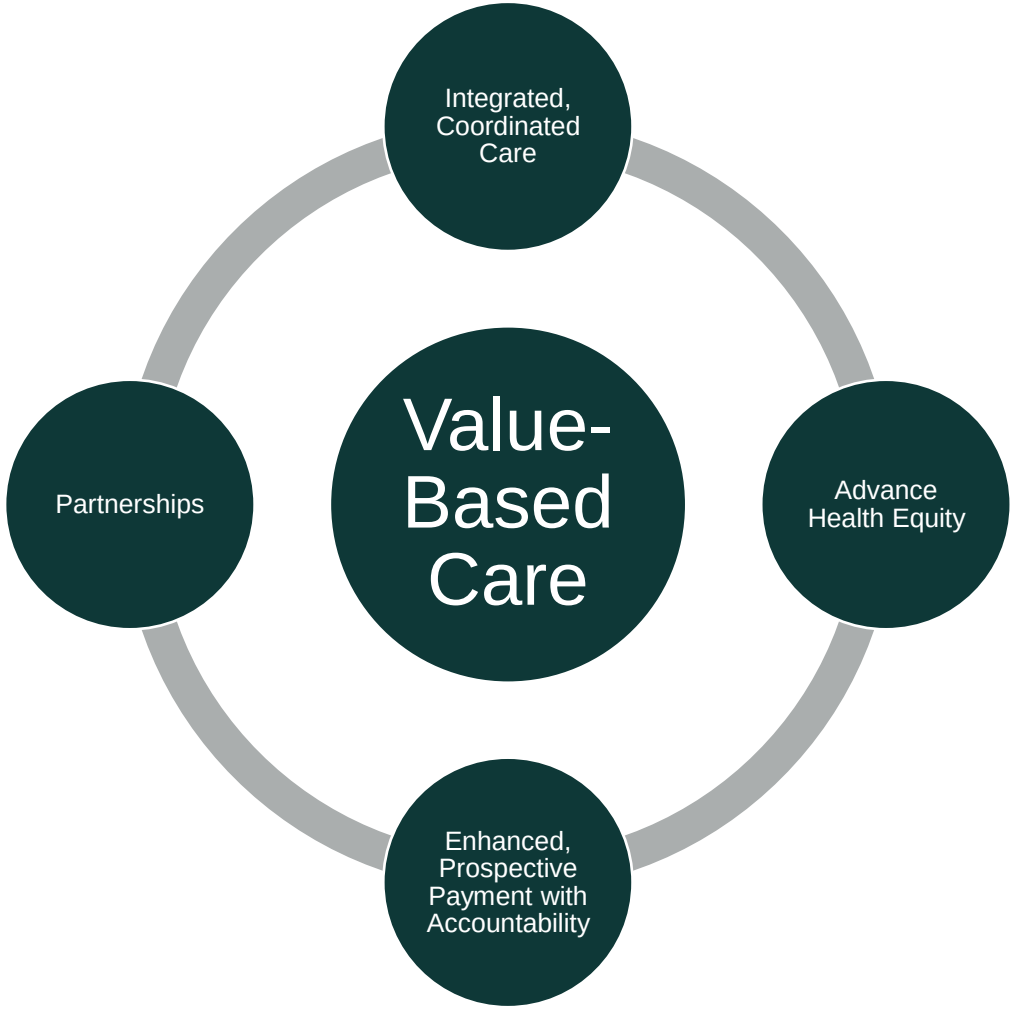
Payments for specialty care integration



Making Care Primary Introduction

Value-Based Care is the goal:

Equitable health outcomes through widely accessible, high-quality, affordable, person-centered care, with accountability for outcomes

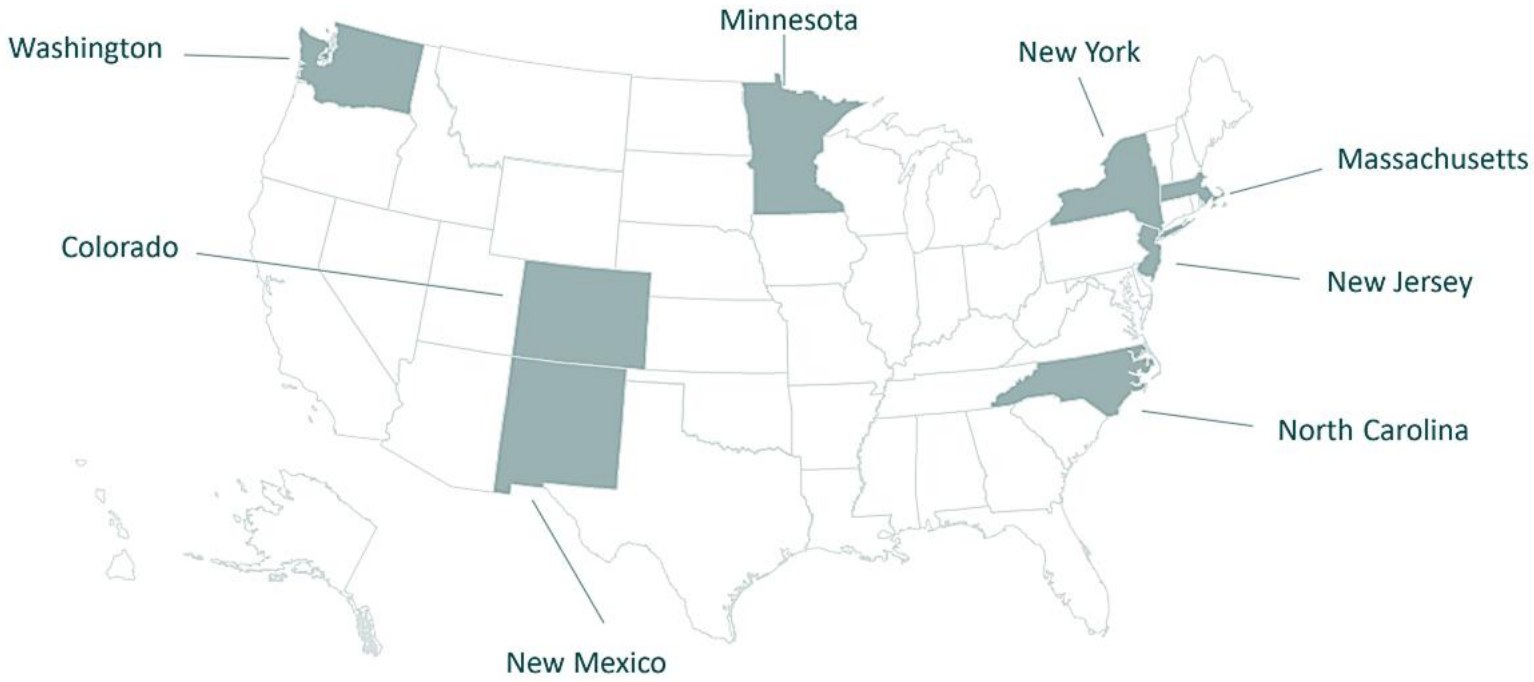


Participation Requirements

PARTICIPATING STATES

CMS selected eight (8) states using several factors, including geographic diversity, health equity opportunity, population, and in partnership with state Medicaid agencies to better align Medicare and Medicaid payers on quality measurement, data requirements, and learning priorities.

CMS received 406 applications – of these, 127 FQHCs & 279 non-FQHCs.



New York	Putnam; Rockland; Orange; Albany; Schenectady; Montgomery; Greene; Columbia; Rensselaer; Saratoga; Fulton; Schoharie; Washington; Otsego; Hamilton; Delaware; Ulster; Dutchess; Sullivan; Warren; Essex; Clinton; Franklin; Saint Lawrence; Onondaga; Cayuga; Oswego; Madison; Cortland; Tompkins; Oneida; Seneca; Chenango; Wayne; Lewis; Herkimer; Jefferson; Tioga; Broome; Erie; Genesee; Niagara; Wyoming; Allegany; Cattaraugus; Chautauqua; Orleans; Monroe; Livingston; Yates; Ontario; Steuben; Schuyler; Chemung;

Participation Requirements

ELIGIBILTY TO PARTICIPATE

Organizations that provide primary care services to patients may be eligible to apply to MCP.

Recommended minimum of 125 attributed Medicare beneficiaries.

Organizations Eligible for MCP

- Independent or solo primary care practices
- Group practices
- Federally Qualified Health Centers (FQHCs)
- Health Systems
- Indian Health Programs
- Certain CAHs

Organizations Not Eligible for MCP

- Rural Health Clinics
- Concierge practices
- Grandfathered Tribal FQHCs
- Primary Care First (PCF) practices and ACO REACH Participant Providers active as of 5/31/23

Organizations will not be able to concurrently participate in the Medicare Shared Savings Program (MSSP) and MCP.

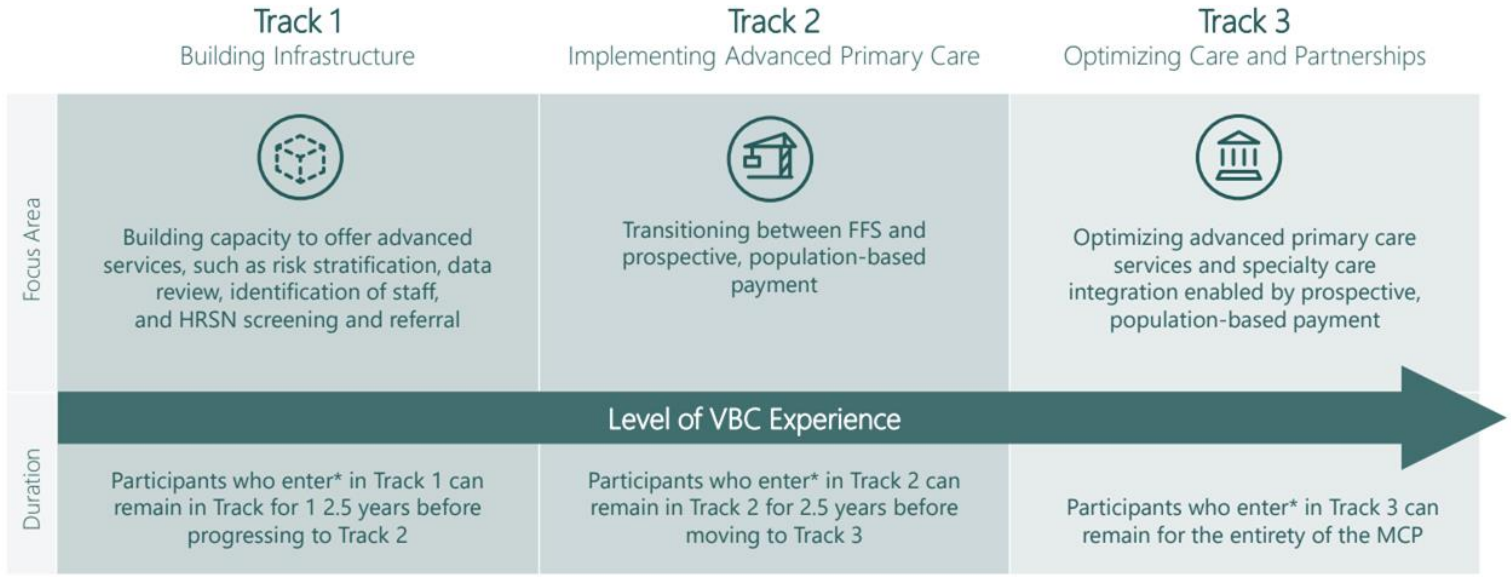
Only organizations operating in the listed MCP states will be eligible.

Your organization's prior experience with VBC will determine your eligibility for individual Tracks in MCP.

MCP Tracks and Timeline

PARTICIPATION TRACK OPTIONS OVERVIEW

MCP includes three tracks that health care organizations can select from when applying to the model. The three tracks provide opportunities for organizations with differing levels of care delivery and value-based payment experience to enter the model at a point that matches their capabilities.



**Organizations that start in Track 1, 2, or 3 will have an additional 6 months (or half of a year) in that track, given the mid-year start date for the model. A participant's length of time in a track depends on which track they started in.*

Payment Types, By Track

Prospective Primary Care Payment (PPCP)

Track 1	Track 2	Track 3

- Replaces fee-for-service revenue for primary care services for beneficiaries attributed to MCP
- Will reflect participants' historical primary care billing for the first three model years; CMS will introduce a methodology that bases a portion of the PPCP on regional spend trends[1] for Track 3 participants

Enhanced Services Payment (ESP)

Track 1	Track 2	Track 3

- Risk-adjusted per beneficiary[2] per month (PBPM) payment to participants in Tracks 1, 2, and 3 in addition to payment for typical primary care services; decreases by track as participants build capacity
- Supports ongoing care management activities, such as chronic disease management and health-related social needs (HRSN) screenings

Performance Incentive Payment (PIP)

Track 1	Track 2	Track 3

- Upside risk only bonus payment based on quality utilization, and cost; bonus potential increases by track
- Assessed every year

Upfront Infrastructure Payment (UIP)

Track 1	Track 2	Track 3

- Infrastructure payment that is only available to Track 1 participants new to VBC arrangements and meet a low revenue threshold, or do not have an e-consult platform[3]
- Eligible participants may receive $72,500 in a lump sum payment at the start of Year 1 and an additional $72,500 at the start of Year 2

UIP Use Categories:

- Increased Staffing
- Social Determinants of Health (SDOH) Strategies
- Health Care Clinician Infrastructure

The type of payment for primary care services will vary based on an organization's MCP Track.

Payment Type for Primary Care Services	Track 1	Track 2	Track 3
Prospective Primary Care Payment (PPCP)	0%	50%	100%
Fee-for-Service (FFS)	100%	50%	0%

Calculation Details

The decision tree below describes the steps CMS will use to determine ESP payment for each MCP patient:

Enrolled in Low-Income Subsidy?	
No	**Yes**
Amount varies based on patient's HCC and ADI-designated risk tier (see table below)	$25

CMS-HCC Clinical Risk Tier (Risk Score Percentile)	ADI Social Risk Tier (ADI Percentile)	Track 1	Track 2	Track 3
Tier 1 (< 25th)	NA‡	$9	$4	$2
Tier 2 (25th – 49th)	NA‡	$11	$5	$2.50
Tier 3 (50th – 74th)	NA‡	$14	$7	$3.50
Tier 4 (≥75th)	Tier 1, Tier 2, or Tier 3 (< 75th)	$18	$8	$4
	Tier 4 (≥75th)		$25	

Calculation Details

Track 1	Track 2	Track 3
Potential to receive upside-only PIP of up to 3% sum of fee-for-service (FFS)	Potential to receive upside-only PIP of **up to 45%** sum of FFS and prospective primary care payments (PPCP)	Potential to receive upside-only PIP of **up to 60%** sum of prospective primary care payments (PPCP)

New Payments for Specialty Care Integration

MCP e-Consult Code (MEC)

- **G9037:** Designed to capture the time MCP participants spend obtaining and implementing recommendations from specialist physicians using an e-consult platform.
- MCP participants in Tracks 2 and 3 may bill the MEC code on a fee-for-service. basis for all MCP-attributed beneficiaries
- In Track 3, the MEC code will be included in the PPCP, paid prospectively.
- $40 per service (+geographic adjustment, sequestration)

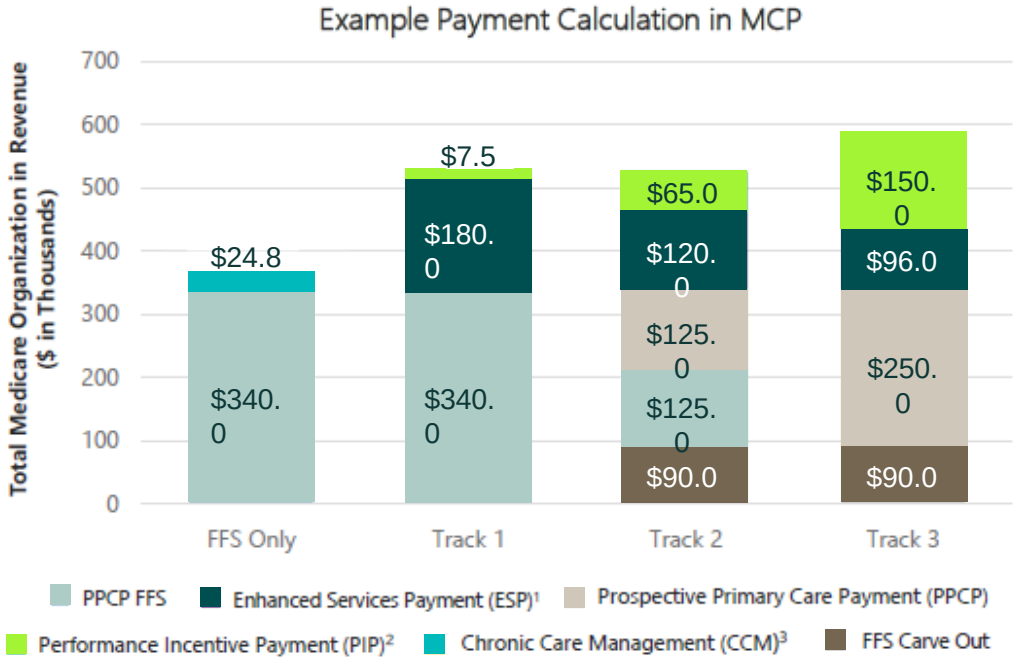
Ambulatory Co-Management (ACM)

- **G9038:** Specialty physicians who have the required agreements with Track 3 MCP participants can bill the ACM code for time spent co-managing MCP attributed beneficiaries.
- Supports coordination and communication between MCP clinicians and specialists that share management for a patient's condition.
- $50 per service (+geographic adjustment, sequestration)

Example Payment Enhancement

EXAMPLE CALCULATION

The graphic below illustrates the proportion of revenue each payment would make up for an average MCP Participant. The calculations below are based on a hypothetical organization with 1000 attributed MCP patients (and assuming equal representation in each HCC/ADI tier), and assuming they met the 50th percentile on 3 measures. 70th / 80th percentile on 3 measures, did not get credit for TPCC CI.



The hypothetical organization has the following characteristics:

- **1,000** attributed MCP patients with **200** in highest-risk category (e.g., LIS or HCC/ADI tier 4)
- **$21** PPCP PBPM based on own historical spending data
- Average ESP of $15 in Track 1, $10 in Track 2, and $8 in Track 3
- Prior to MCP, billed CCM for **90 beneficiaries** (average $23 PBPM)

Program Deadlines

After the *Participation Agreement* is signed & approved, participants will begin developing plans & prepare for reporting requirements:

- ✓ Update Clinician List (May 2024)
- ✓ Develop a UIP Spend Plan using CMS template (Summer 2024)
- ✓ Develop a Health Equity Plan using CMS template (October 2024)
- ✓ Submit baseline care delivery reporting (October 2024)
- ✓ Submit sociodemographic reporting (July 2025)
- ✓ Submit quality reporting (January 2026)

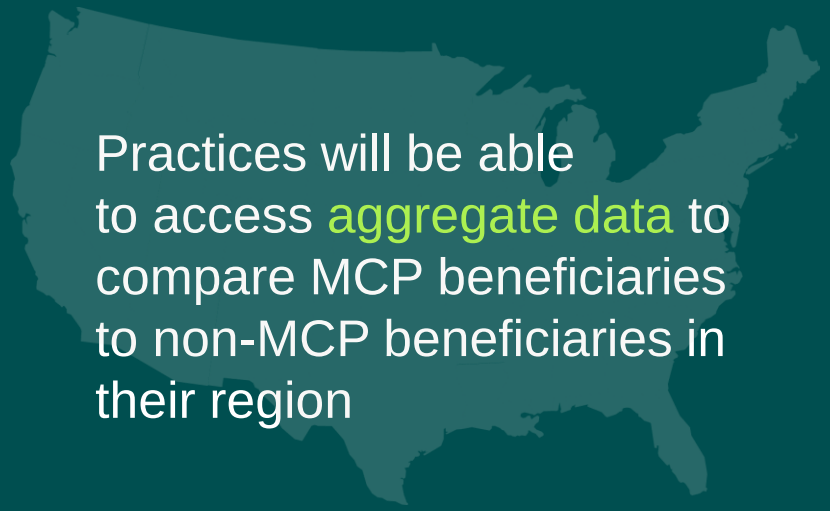
Annual Quality Measurement

Focus	Measure	Type	Track		
			1	2	3
Chronic Conditions	Controlling High Blood Pressure Diabetes Hba1C Poor Control (>9%)	eCQM eCQM	x x	x x	x x
Wellness and Prevention	Colorectal Cancer Screening	eCQM	x	x	x
Person-Centered Care	Person-Centered Primary Care Measure (PCPCM)	Survey	x	x	x
Behavioral Health	Screening for Depression with Follow Up Depression Remission at 12 months	eCQM eCQM		x x	x x
Equity	Screening for Social Drivers of Health	CQM		x	x
Cost/Utilization	Total Per Capita Cost (TPCC) Emergency Department Utilization (EDU) TPCC Continuous Improvement (CI) *(Non-FQHC's and Non-Indian Health Programs (IHP's))* EDU CI *(FQHC's and IHP'S)*	Claims Claims Claims Claims		x x x x	x x x x

Data-Informed Care Management

EXPANDED DATA FEEDBACK REPORTING (eDFR)

The MCP eDFR tool will provide participants with insights into their attributed beneficiary population



Practices will be able to access aggregate data to compare MCP beneficiaries to non-MCP beneficiaries in their region

CMS will provide participants with performance data on specialists in their region, prioritizing measures related to cardiology, pulmonology, and orthopedics

Application Timeline

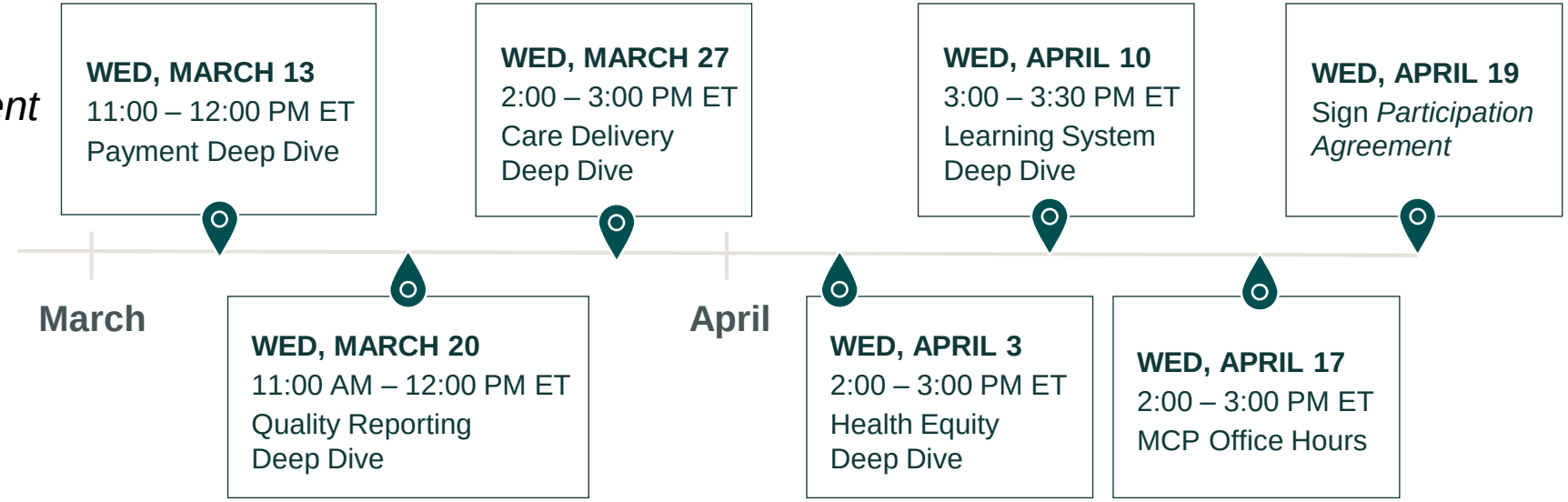
Listserv link

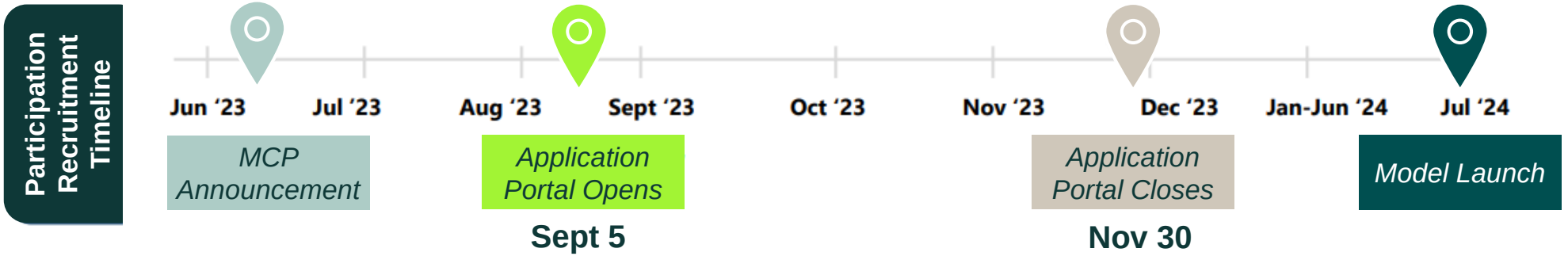
NEXT STEPS:

Signed *Participation Agreement* due April 19, 2024

Deadline to submit Track-change request

Attend webinar series





Medicaid Payment Reform

New Mexico Primary Care Payment Reform Goals

Reform aims to be:

- Data informed
- Fiscally sound
- Clinically relevant
- Grounded in equity principles
- Informed by community engagement

Support Primary Care Providers

Minimize Disparities

Promote Health of Patient Populations

Enhance Collaboration

Quality Measures Support Whole-Person Care

Patients are Partners in Care Delivery

Payers and Primary Care Teams Collaborate

New Mexico Primary Care Payment Reform Framework

Beginning **July 1, 2024**, all primary care providers participating in New Mexico's Medicaid program will be enrolled in the soft launch of the program (Tier 1), which will offer enhanced fee-for-service payments and incentive payments tied to quality performance.

The full three-tiered program will launch on **January 1, 2026**, offering the ability to participate in a full capitation arrangement with potential downside risk.

Each subsequent tier will be tied to increased quality reporting requirements and higher performance standards.

Payments detach from direct provision of services to increase providers' flexibility, as they move up the tiers.

New Mexico Primary Care Payment Reform Framework

TIER 1

Enhanced Reimbursement and Quality Rewards - begins on July 1, 2024

This program introduces two new funding sources, including **enhanced fee-for-service** tied to provision of services and **incentive payments** for quality performance and data submission. Engages all providers including rural, small practices, Indian Health Services, FQHCs.

TIER 2

Collaborative Partnerships – begins on January 1, 2026

This will serve as an entry point into capitation, with the provider and managed care organizations (MCOs) establishing **a primary care capitation arrangement**, for example, care management per member per month (PMPM) payments or direct service payments on a PMPM basis.

TIER 3

Capitation with Shared Savings – begins on January 1, 2026

Includes a **full capitation arrangement** reflecting primary care providers' influence on total cost of care, such as bundled payments or shared savings, where the provider may have both upside and downside risk.

New Mexico Primary Care Payment Reform Framework

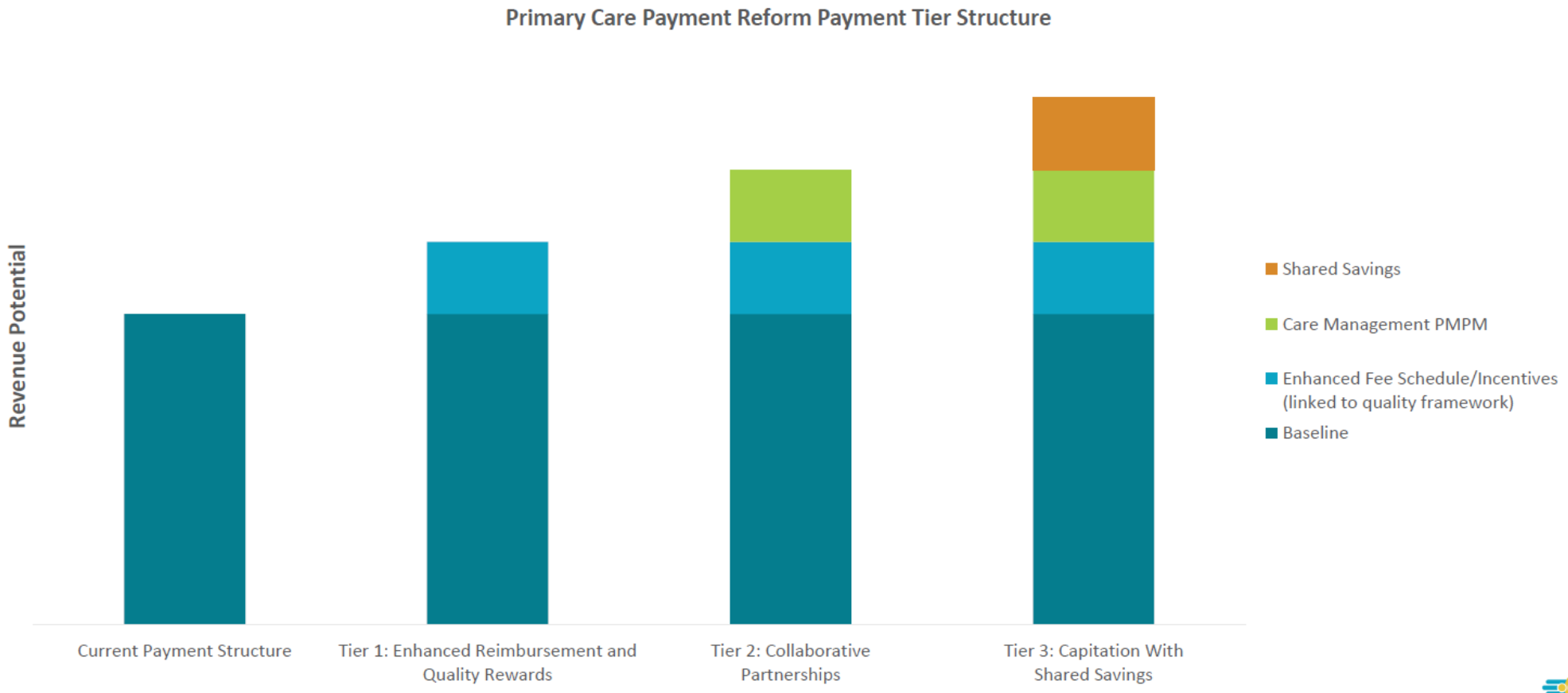


**Chart is for illustrative purposes only and does not indicate actual dollar amounts, percentages, or required/actual payment types.*

HEALTH CARE AUTHORITY

New Mexico Primary Care Payment Reform 2024 Quality Measures

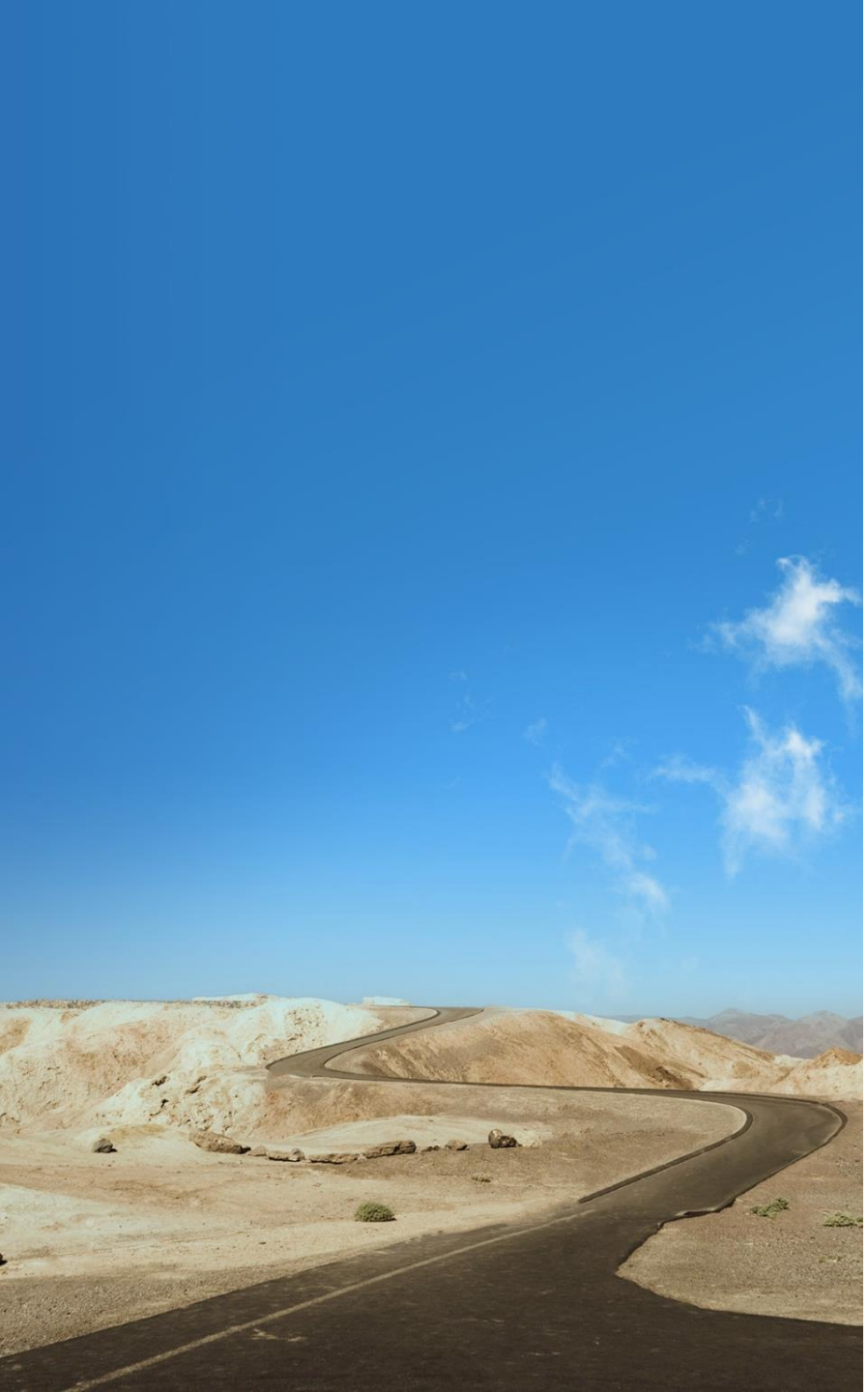
The following quality metrics will be introduced in 2024.

Access to Care: Third Next Available Appointment
This measures the average length of time in days between the day a patient requests an appointment and the third available appointment for a new patient physical, routine exam, or return visit exam. This metric will be self-reported quarterly.

Initiation and Engagement of Alcohol and Other Substance Use Treatment (IET)

- *Initiation phase:* This measure will evaluate the percent of members age 13+ who initiate treatment through an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication for addiction treatment (MAT) within 14 days of diagnosis.
- *Engagement phase:* The percent of members age 13+ who initiated treatment and had two or more additional services within 34 days of the initiation visit.

Consumer Assessment of Health Care Providers and Systems (CAHPS) Survey
Select items from this tool will be utilized to measure patients' experiences with their providers, focusing on *access to care* and *satisfaction with their provider*, for both adults and children.



New Mexico Primary Care Payment Reform 2026 Quality Measures

Beginning January 1, 2026, the following additional quality metrics will be introduced:

- Breast cancer screening
- Cervical cancer screening
- Prenatal and postpartum care
- Lead screening in children
- Follow-up after emergency room (ER) visit for substance abuse
- Follow-up after ER visit for mental illness

New Mexico Primary Care Payment Reform 2027 & 2028 Quality Measures

Additional measures starting in 2027 include:

- Statin therapy for cardiovascular disease
- Child and adolescent well-care visits

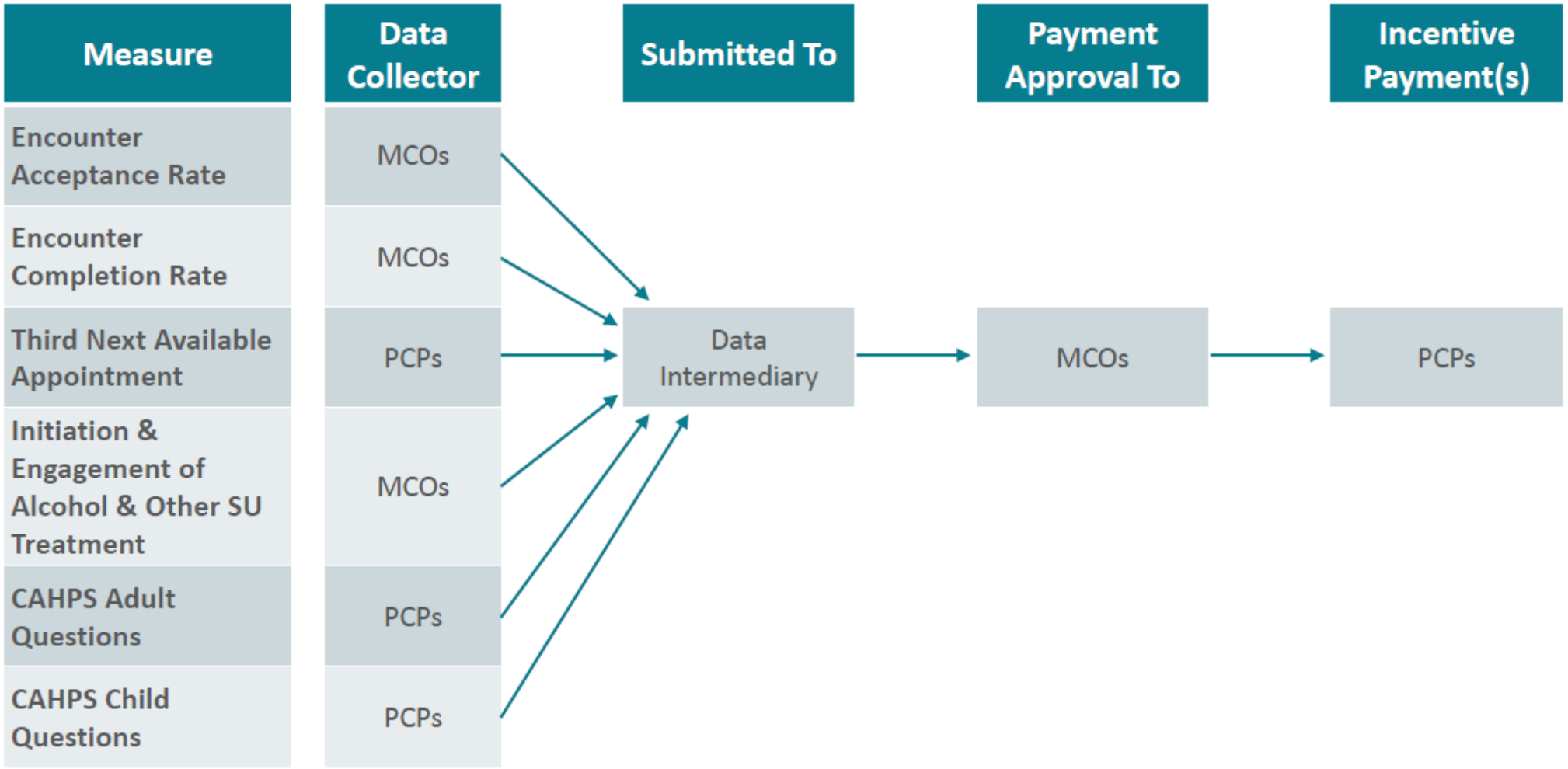
Measures beginning in 2028 include:

- Controlling high blood pressure
- Comprehensive diabetes care
- Immunizations for adolescents

Reimbursement will continue to be tied to the first set of metrics introduced in July 2024 until the introduction of new quality metrics in 2027. At this time, reimbursement will expand to include all metrics.

Providers will work directly with MCOs and data intermediaries to establish arrangements for data collection and reporting. All metrics will be standardized across MCOs, which will allow for identical reporting structures to alleviate provider burden.

Data Submission Flow



Prepare to Succeed

Financial modeling to evaluate the potential impact on your payments

Identify team member for data collection & submission oversight

Workflow planning, adjustments, & change management

Educate leadership & staff about quality and compliance requirements

Strategic planning, operations assessments, contracting support for success in all value-based care contracts

- Choose the appropriate Tier
- Track utilization & performance data
- Shift to capitation payments
- Sub-capitation arrangements
- Participate in HIE
- Provide care management services

Learn More from HCA

Webinar: Collecting and Reporting Quality Data Register HERE

Wed March 20 - 1:00-2:30 PM (tomorrow!!)

Learn how to collect and submit quality metric data to a data intermediary to achieve the quality reporting component of the primary care model.

In-Person Workshops (9am-2pm) in Southern New Mexico:

April 24 Silver City, April 25 Roswell, April 26 Las Cruces

In-Person Workshops (9am-2pm) in Northern New Mexico:

May 28 Farmington, May 29 Albuquerque, May 30 Las Vegas

Webinar: Redesigning Your Workflows for Value-Based Care

Tue June 18 - 12:00-1:30 PM

Appendix

About Moss Adams LLP

Firmwide Indicators

- 110 Year History
- 415 Partners
- 4400 Professionals
- $1B Revenue

Health Care Industry Group

D 3,700+ health care clients

E 285+ health care professionals firm-wide

E 30 health care partners

P Participation in 50+ national, regional, and state health care industry events

Relevant Experience

285+
healthcare professionals

1,200+
hospital clients nationwide

30+
trade organizations

participation in over 30 national, regional, and state health care and hospital industry organizations

Firm Services

We offer a full range of services and specializations that span accounting, consulting, and wealth management to suit your specific needs.

Accounting

ASSURANCE

- Financial Statement Audits
- Employee Benefit Plans
- Public Company & SEC
- Internal Audit
- SOC Audits
- Contract Compliance
- Sustainability Audits

TAX

- Accounting for Income Taxes (ASC 740)
- Accounting Methods
- Compensation & Benefits
- Controversy & Dispute Resolution
- Credits & Incentives
- International Tax
- Personal
- State & Local
- Tax Structuring

ADVISORY

- Disruption Services
- IPO Solutions
- Outsourced Finance & Accounting
- Technical Accounting

INTERNATIONAL

- China Practice 中国业务
- India Practice
- Latin America Practice

Consulting

IT

- Compliance
- Cybersecurity
- Assessment & Planning
- Development & Integration
- Enterprise Systems

STRATEGY & OPERATIONS

- Data Analytics
- Disaster Recovery & Continuity
- Organizational Planning
- Performance Audits
- Succession Planning

TRANSACTIONS

- Due Diligence
- M&A Tax
- Postmerger Integration
- Restructuring
- Valuations

SPECIALTY

- Financial Services
- Health Care
- Telecommunications

Wealth Management

INDIVIDUAL

- Tax
- Financial Planning
- Investments
- Family Office

INSTITUTIONAL

- Investments
- Insurance

Health Care Consulting

Audit and tax are vital. But you have complex needs that go beyond these core functions. Our dedicated health care consulting team provides a range of services to address all emerging needs—both now and in the future.

Health Care Consulting

COST REIMBURSEMENT

- Medicare & Medicaid
- Provider-Based Licensure & Certification
- Medical Education
- Uncompensated Care
- Wage Index Reviews
- Contract Compliance

STRATEGY & INTEGRATION

- Provider Risk Analysis, Contracting, & Operational Design
- M&A Support
- Feasibility Studies
- Market Intelligence & Benchmarking
- Strategic Planning & Implementation
- Managed Care Assessment & Negotiation
- Service Line Enhancement & Analyses

GOVERNMENT COMPLIANCE

- Regulatory Compliance
- Coding Validation
- Coding Department Redesign
- EHR Internal Controls
- Corporate Compliance

INFORMATION TECHNOLOGY

- HIPAA Security & Privacy
- Network Security & Penetration Testing
- Disaster Recovery Planning
- PCI DSS Audits
- SOC Pre-Audit Gap Analysis & Readiness
- SOC Audits

OPERATIONAL IMPROVEMENT

- Revenue Cycle Enhancement
- Claims Recovery
- Litigation Support
- Employer Health Benefits
- Lean Consulting
- Operational Assessments & Process Improvement
- Valuations
- Performance Improvement

2024 Executive Health Care Conference

SAVE THE DATE! Nov. 6-8, 2024

Join C-suite professionals from across the health care ecosystem to discuss the state of the industry and prepare leaders for 2025.

DATE: Nov. 6-8, 2024
LOCATION: Las Vegas, NV
Red Rock Casino, Resort & Spa

HIGHLIGHTS:

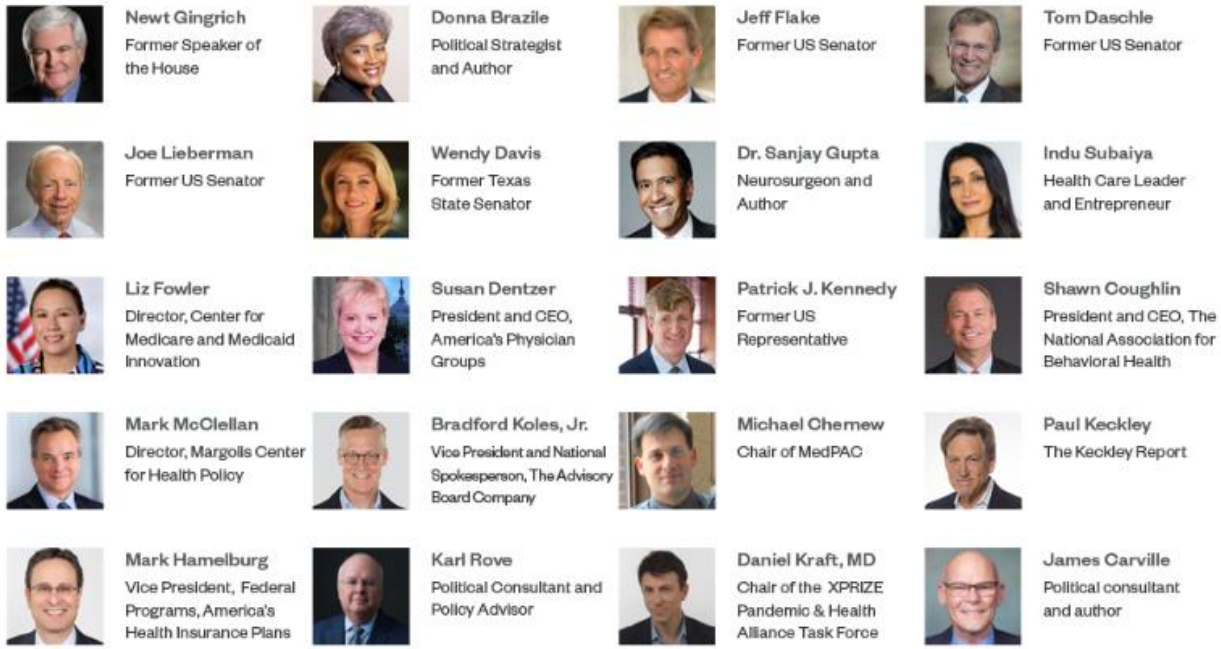
Nov. 6: Women's Executive Leadership Forum

Nov. 7: State of the Union
Political Point-Counterpoint
Reception with Keynotes

Nov. 8: Economic Forecast

2024 Keynotes will be announced soon.

Past keynotes have included:



Registration opens in April!

Presenter

Georgia Green, MS, CHFP | *Senior Manager, Moss Adams Health Care Consulting*
georgia.green@mossadams.com or (916) 503-8251

Georgia has worked in the health care industry since 2011. She provides strategic and operational consulting services to health care providers and payers. Georgia has extensive experience in helping clients integrate value-based care models, such as Accountable Care Organizations (ACOs) in the Medicare Shared Savings Program (MSSP) and Realizing Equity, Access, and Community Health (ACO-REACH). She supports health systems and primary care providers in evaluating and succeeding in new payment models.

Georgia's experience includes strategic analysis, program design, budgeting, contracting, waiver development, training, compliance, quality reporting, and performance improvement. She also has experience in developing population health revenue optimization programs.

Throughout the pandemic, Georgia has supported clients with COVID-19 funding applications and reporting compliance, including HRSA Provider Relief Funds, Dept. of Treasury Coronavirus Relief Funds, FEMA Public Assistance, FCC Telehealth Program, and others.

Prior to joining Moss Adams, Georgia co-founded a not-for-profit (National Rural Accountable Care Consortium) and a population health services organization (Caravan Health, acquired by Signify Health/CVS) serving community health systems in their transformation to value-based care delivery.

The material appearing in this presentation is for informational purposes only and should not be construed as advice of any kind, including, without limitation, legal, accounting, or investment advice. This information is not intended to create, and receipt does not constitute, a legal relationship, including, but not limited to, an accountant-client relationship. Although this information may have been prepared by professionals, it should not be used as a substitute for professional services. If legal, accounting, investment, or other professional advice is required, the services of a professional should be sought.

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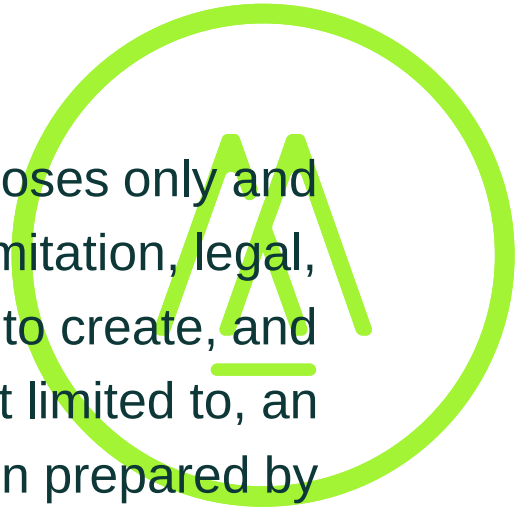

THANK YOU

PLATINUM

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GOLD

You've Got This Now®
KNOWTION HEALTH®

SIXTH SENSE INTELLIGENCE

medlytix

revenue enterprises

aspirion

MOSSADAMS

capta HEALTH PARTNERS

R1®

SILVER

Xtend Healthcare

TruBridge®

Kristina Tocce, Chief Medical Officer Planned Parenthood of the Rocky Mountains.

She has been at PPRM for 5 and a half years, overseeing and expanding clinical care, heading the Research Department, and supervising clinical training programs.

Prior to her move to Planned Parenthood, she was on faculty at the University of Colorado for 12 years in the Department of Ob/Gyn, where she remains on volunteer faculty roster.

She completed her Fellowship in Complex Family Planning at the University of Colorado, her residency at Mt Sinai SOM in New York City, and medical school at Albert Einstein College of Medicine.

Innovations in Telemedicine

Kristina Tocce MD, MPH
Chief Medical Officer
Planned Parenthood of the Rocky Mountains

Disclosures

- Consultant, Bayer Pharmaceuticals
- Merck, Speakers Bureau

Objectives

1

Develop awareness of innovative options for virtual delivery of reproductive health care

2

Confidently advocate that reproductive health care services via telemedicine are essential health care services

3

Prepare to troubleshoot the financial impact of these innovative models

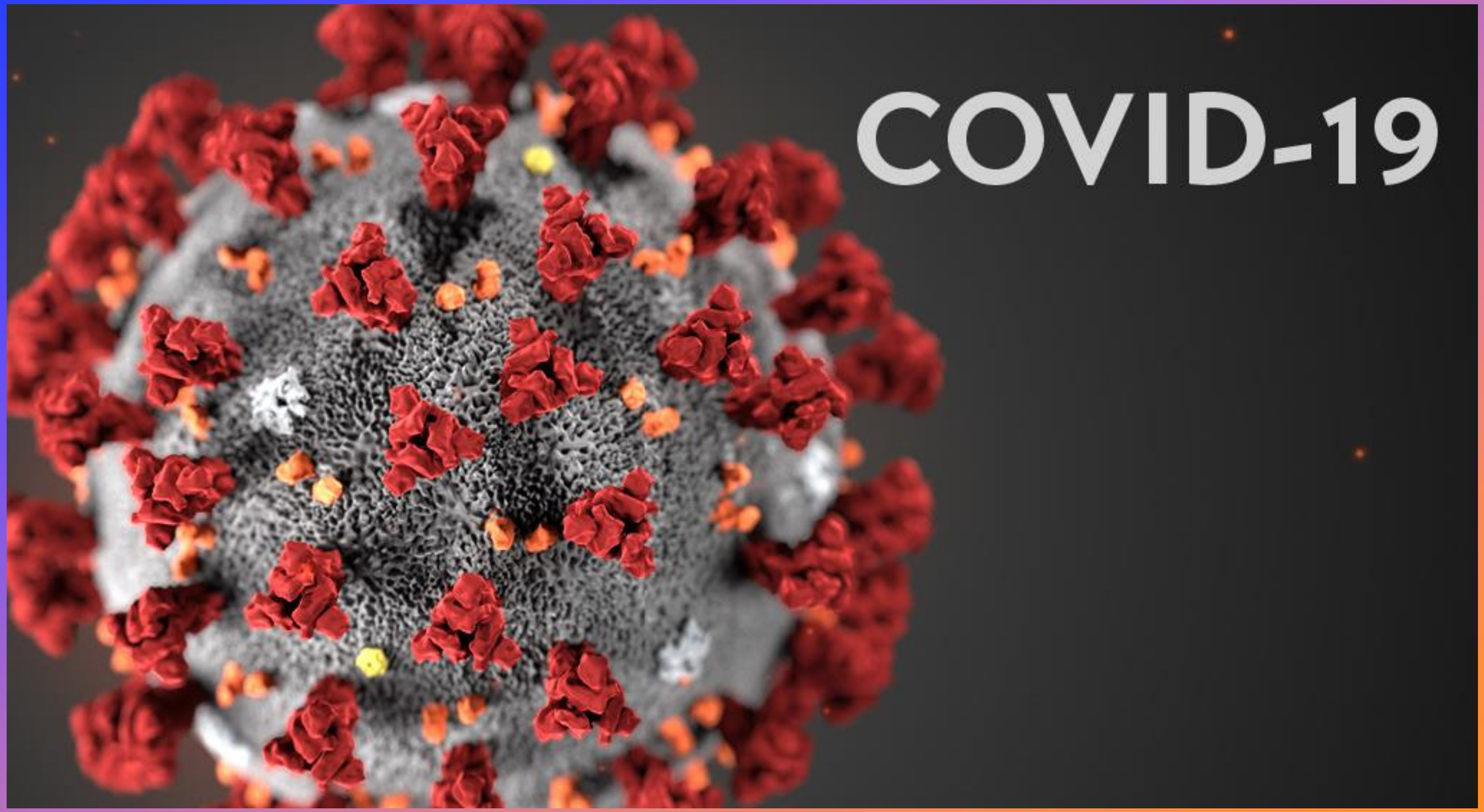
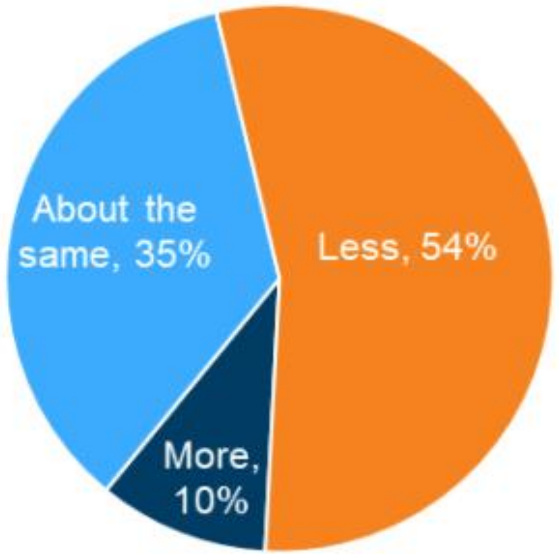

COVID-19

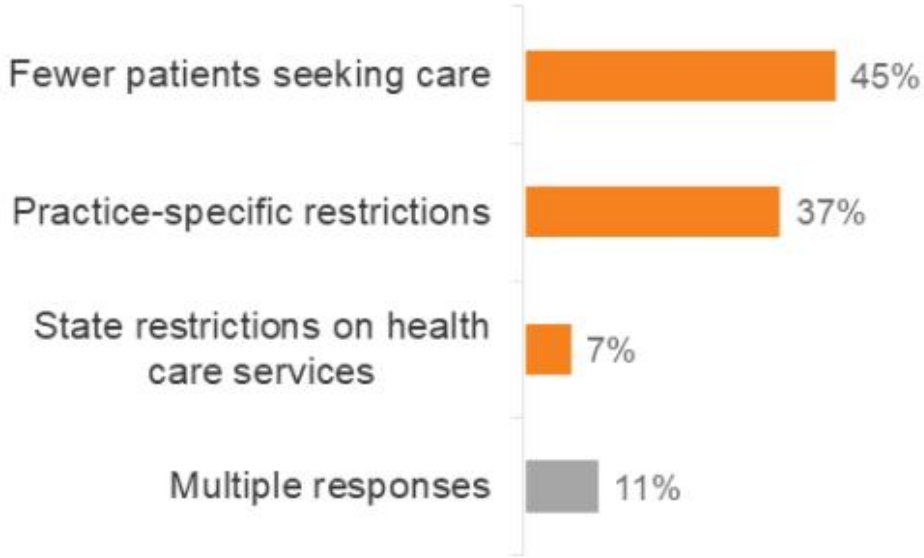
Figure 1

Most OBGYNs Saw Declines in Visits During the COVID-19 Pandemic, Attributed To Fewer Patients Seeking Care

How does the current number of patient visits at your practice compare to before the COVID-19 pandemic?
(June vs. before March 2020, n=855)



Which of the following do you think is the **primary** driver of the decline in patient volume?
(Among those with declines in patient volume, n=477)

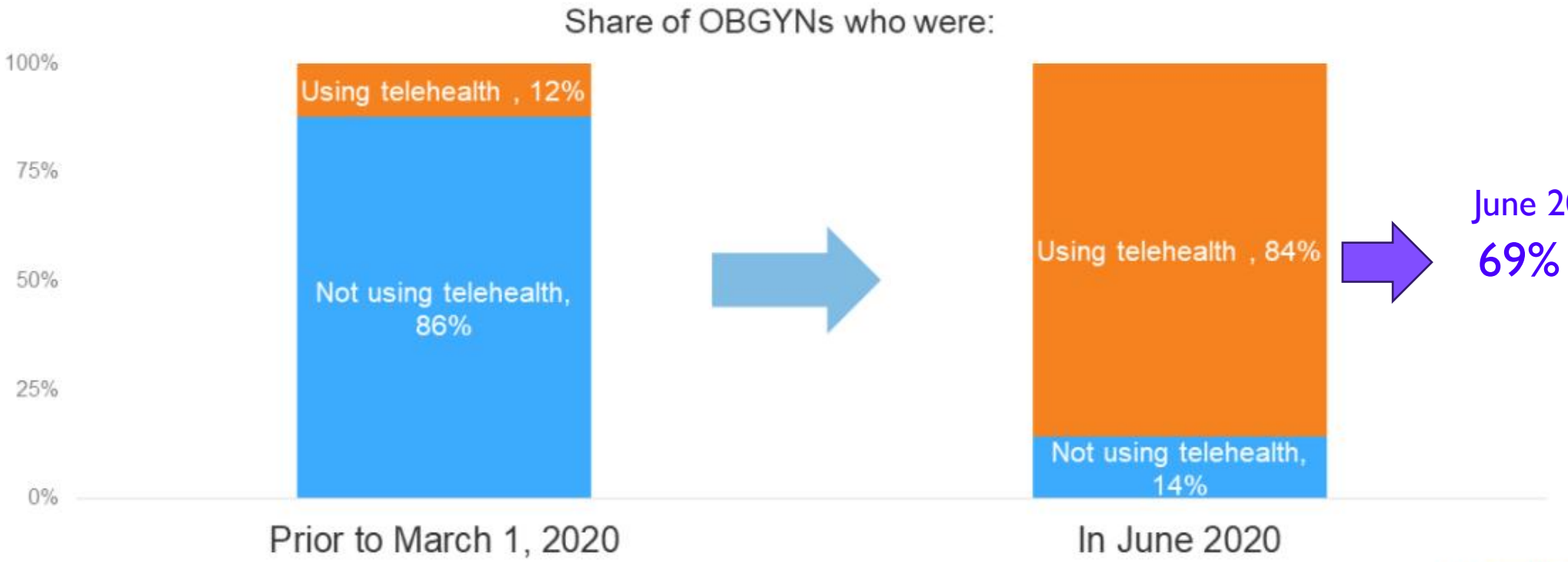


KFF

Source: KFF 2020 National Physician Survey on Reproductive Health. Fielding from July 8 to September 1, 2020.

Figure 2

Few OBGYNs Used Telehealth Prior To the COVID-19 Pandemic. Three Months Later the Vast Majority Were Doing So

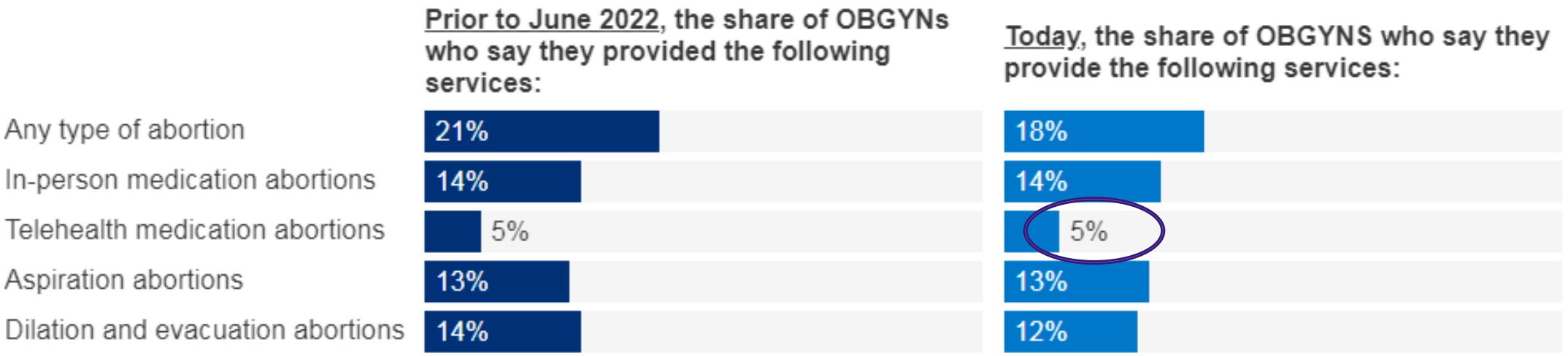


Notes: n=10 OBGYNs did not specify an answer. Total n= 855. Question wording: "Thinking about telehealth visits, what percentage of your practice visits were via telehealth before the start of the COVID-19 emergency in the U.S. (March 1, 2020) and in June 2020?" 0% telehealth classified as not using telehealth. >0% classified as using telehealth.

Source: KFF 2020 National Physician Survey on Reproductive Health. Fielding from July 8 to September 1, 2020.

KFF

Provision of Abortion Services by Office-Based OBGYNs, Pre- and Post-*Dobbs*



NOTE: Fielded March 17, 2023 - May 18, 2023. "Prior to June 2022, how did you typically handle provision of the following services?", "Today, how do you typically handle the provision of the following services?"

SOURCE: KFF 2023 National OBGYN Survey • PNG

KFF

TELEHEALTH MODELS:

DIRECT TO PATIENT
VIDEO
PHONE
SITE TO SITE

Billing & Reimbursement Considerations

- What does reimbursement for a telehealth visit cover?
- Which provider types can use telehealth for care?
- What if a patient and the provider are in different states?

Services available

- Hormonal contraceptives
- Emergency contraception
- UTI evaluation/treatment
- Mail-in STI testing
- PrEP
- Gender affirming hormone therapy
- Genital HSV management
- Vaginitis evaluation
- Medication abortion

Hybrid model when exams, labs, imaging, medication administration needed

- Video or phone interaction for history/counseling/consents
- Present to health center for portion that requires exam

Planned Parenthood Offering Mail-In, STI Test Kits

FEBRUARY 25, 2021

Services available

- Hormonal contraceptives
- Emergency contraception
- UTI evaluation/treatment
- Mail-in STI testing
- PrEP
- Gender affirming hormone therapy
- Genital HSV management
- Vaginitis evaluation
- Medication abortion

OPEN

2019 ASCCP Risk-Based Management Consensus Guidelines for Abnormal Cervical Cancer Screening Tests and Cancer Precursors

Rebecca B. Perkins, MD, MSc,[1] Richard S. Guido, MD,[2] Philip E. Castle, PhD,[3] David Chelmow, MD,[4] Mark H. Einstein, MD, MS,[5] Francisco Garcia, MD, MPH,[6] Warner K. Huh, MD,[7] Jane J. Kim, PhD, MSc,[8] Anna-Barbara Moscicki, MD,[9] Ritu Nayar, MD,[10] Mona Saraiya, MD, MPH,[11] George F. Sawaya, MD,[12] Nicolas Wentzensen, MD, PhD, MS,[13] and Mark Schiffman, MD, MPH[14] for the 2019 ASCCP Risk-Based Management Consensus Guidelines Committee

Table 1. USPSTF Recommendations for Routine Cervical Cancer Screening

Population*	Recommendation	USPSTF Recommendation Grade†
Aged less than 21 years	No screening	D
Aged 21–29 years	Cytology alone every 3 years‡	A
Aged 30–65 years	Any one of the following: • Cytology alone every 3 years • FDA-approved primary hrHPV testing alone every 5 years • Cotesting (hrHPV testing and cytology) every 5 years	A
Aged greater than 65 years	No screening after adequate negative prior screening results§	D
Hysterectomy with removal of the cervix	No screening in individuals who do not have a history of high-grade cervical precancerous lesions or cervical cancer	D

Abbreviations: FDA, U.S. Food and Drug Administration; hrHPV, high-risk human papillomavirus testing.

	2020 ACS	2012 ACS	2018 USPSTF
Age 21–24	No screening	Pap test every 3 years	Pap test every 3 years
Age 25–29	HPV test every 5 years (preferred) HPV/Pap cotest every 5 years (acceptable) Pap test every 3 years (acceptable)	Pap test every 3 years	Pap test every 3 years
Age 30–65	HPV test every 5 years (preferred) HPV/Pap cotest every 5 years (acceptable) Pap test every 3 years (acceptable)	HPV/Pap cotest every 3 years (preferred) Pap test every 3 years (acceptable)	Pap test every 3 years, HPV test every 5 years, or HPV/Pap cotest every 5 years
Age 65 and older	No screening if a series of prior tests were normal	No screening if a series of prior tests were normal	No screening if a series of prior tests were normal and not at high risk for cervical cancer

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

Updated Cervical Cancer Screening Guidelines

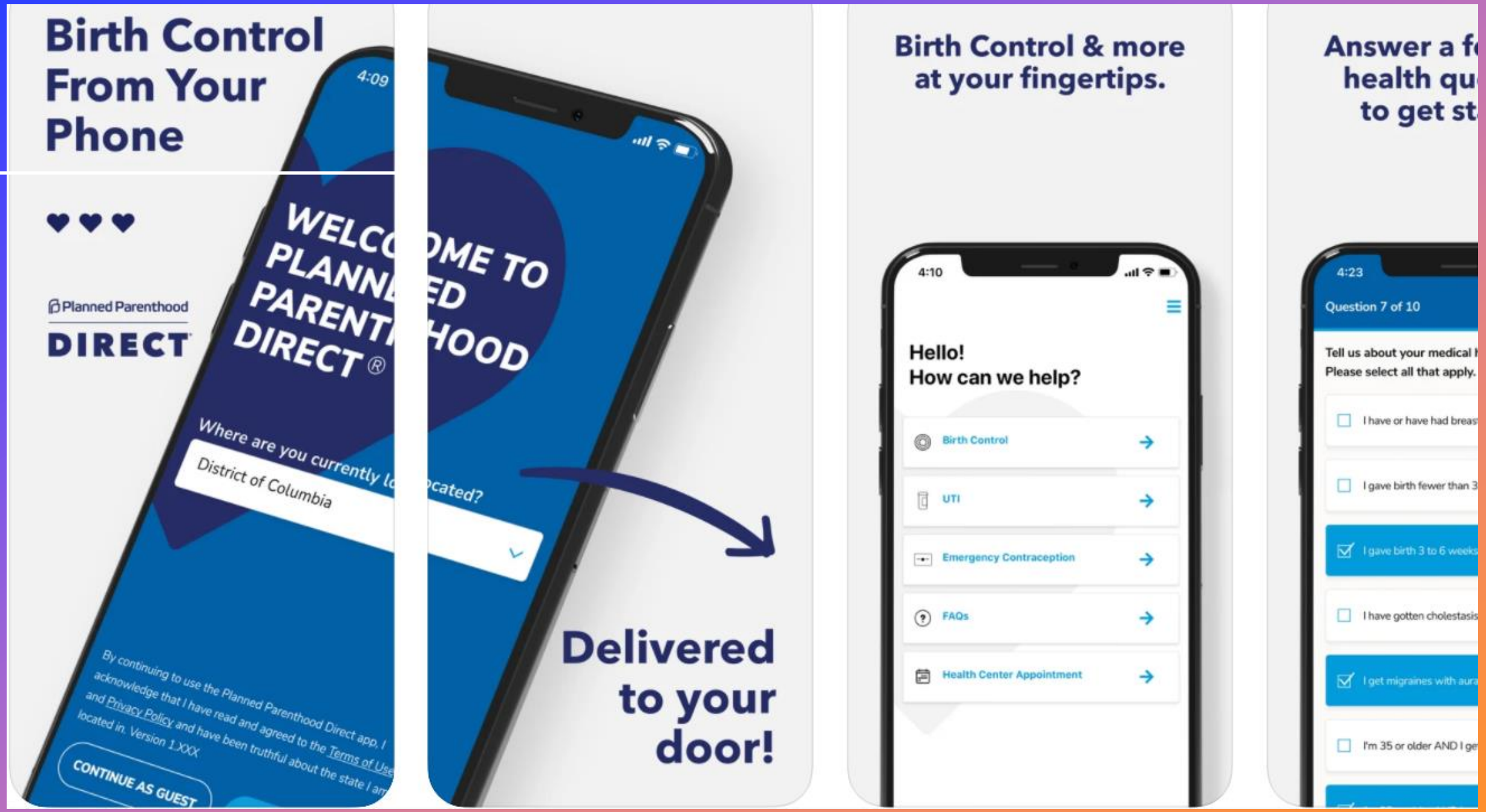
Practice Advisory | April 2021

- Nationwide HPV vaccination coverage remains below target levels
- Racial, ethnic, socioeconomic, geographical disparities in vaccination rates
- Cervical cancer screening rates below expectations; lowest among individuals under 30 yoa

- ***"Raising the screening start age to 25 years could increase the already high rate of underscreening among individuals aged 25–29 years and exacerbate existing health inequities in cervical cancer screening, incidence, morbidity, and mortality".....continue to recommend initiation at 21 yoa."***

Services available

- Hormonal contraceptives
- Emergency contraception
- UTI evaluation/treatment
- Mail-in STI testing
- PrEP
- Gender affirming hormone therapy
- Genital HSV management
- Vaginitis evaluation
- Medication abortion


Birth Control From Your Phone
Planned Parenthood DIRECT
4:09
Where are you currently
District of Columbia
By continuing to use the Planned Parenthood Direct app, I acknowledge that I have read and agreed to the Terms of Use and Privacy Policy and have been truthful about the state I am located in. Version 1.XXX
CONTINUE AS GUEST
Delivered to your door!
Birth Control & more at your fingertips.
4:10
Hello!
How can we help?
Birth Control
UTI
Emergency Contraception
FAQs
Health Center Appointment
4:23
Question 7 of 10
Please select all that apply.

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

Update to U.S. Selected Practice Recommendations for Contraceptive Use: Self-Administration of Subcutaneous Depot Medroxyprogesterone Acetate

Weekly / May 21, 2021 / 70(20);739–743

What is already known about this topic?

Subcutaneous depot medroxyprogesterone acetate (DMPA-SC) is an FDA-approved injectable contraceptive method available in the United States.

What is added by this report?

CDC updated recommendations in the U.S. Selected Practice Recommendations for Contraceptive Use to state that self-administered DMPA-SC should be made available as an additional approach to deliver injectable contraception.

What are the implications for public health practice?

Self-administration of DMPA-SC is safe and effective and might expand access to a user-controlled contraceptive method. This option should be offered in a noncoercive manner through shared decision-making, with a focus on patient preferences and equitable access to the full range of contraceptive methods, including provider-administered DMPA.

- U.S. Selected Practice Recommendations for Contraceptive Use
- Companion document to U.S. MEC 2016
- MEC=***who*** can use
- SPR=***how*** methods can be used

US SPR EXAMS AND TESTS PRIOR TO INITIATION

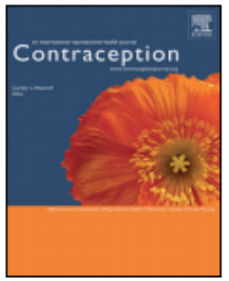
Examination	LNG and Cu-IUD	Implant	Injectable	CHC	POP	Condom	Diaphragm or cervical cap	Spermicide
Blood pressure	C	C	C	A*	C	C	C	C
Weight (BMI)	—†	—†	—†	—†	—†	C	C	C
Clinical breast examination	C	C	C	C	C	C	C	C
Bimanual examination and cervical inspection	A	C	C	C	C	C	A	C
Laboratory test								
Glucose	C	C	C	C	C	C	C	C
Lipids	C	C	C	C	C	C	C	C
Liver enzymes	C	C	C	C	C	C	C	C
Hemoglobin	C	C	C	C	C	C	C	C
Thrombogenic mutations	C	C	C	C	C	C	C	C
Cervical cytology (Papanicolaou smear)	C	C	C	C	C	C	C	C
STD screening with laboratory tests	—§	C	C	C	C	C	C	C

Contraception 98 (2018) 288–291

Contents lists available at ScienceDirect

Contraception

journal homepage: www.elsevier.com/locate/con



Original research article

Taking the provider “out of the loop:” patients' and physicians' perspectives about IUD self-removal☆,☆☆

Jennifer R. Amico [a,*], Ariana H. Bennett [b], Alison Karasz [b], Marji Gold [b]

[a] Department of Family Medicine and Community Health, Rutgers Robert Wood Johnson Medical School
[b] Department of Family and Social Medicine, Albert Einstein College of Medicine, Montefiore Medical Center

Results: The majority of patients and physicians cited both concerns about and potential benefits of IUD self-removal. Patients cited concerns about safety as the reason they did not wish to remove their own IUD, but physicians did not share these concerns; instead, physicians were apprehensive about not being involved in the discussion to remove the IUD. Both patients and physicians valued having the provider "in the loop" and reported fears about hasty or coerced removal.

Contraception 101 (2020) 393–398

Contents lists available at ScienceDirect

Contraception

journal homepage: www.elsevier.com/locate/con

Original Research Article

"$231 . . . to pull a string!!!" American IUD users' reasons for IUD self-removal: An analysis of internet forums ☆,☆☆,★

Jennifer R. Amico [a,*], Samantha Stimmel [a], Shawna Hudson [a], Marji Gold [b]

[a] Department of Family Medicine and Community Health, Rutgers Robert Wood Johnson Medical School, United States
[b] Department of Family and Social Medicine, Albert Einstein College of Medicine, Montefiore Medical Center, United States

Results: Search results initially identified 235 websites, of which 28 had online health or parenting forums with content related to IUD self-removal. Individual websites contained between 1 and 637 posts by between 1 and 454 individual users. IUD users described a variety of reasons for IUD discontinuation including undesired symptoms or side effects as well as planning for pregnancy. IUD users discussed difficulties accessing provider-removal because of cost or lack of appointment availability. IUD users also discussed how reading about others' successful self-removal experiences or approval by medical providers made self-removal a feasible or acceptable option.

ELSEVIER

CrossMark

Contraception

Contraception 90 (2014) 54–59

Original research article

Interest in and experience with IUD self-removal☆

Diana Greene Foster[a,*], Daniel Grossman[b], David K. Turok[c], Jeffrey F. Peipert[d], Linda Prine[e], Courtney A. Schreiber[f], Andrea V. Jackson[a], Rana E. Barar[a], Eleanor Bimla Schwarz[g]

Results: Three hundred twenty-six racially diverse women participated (mean age, 28 years; body mass index, 27; duration of IUD use, 3 years); more than half were willing to try self-removal [95% confidence interval (CI): 45-65%], and among those who tried, one in five was successful (95% CI: 14-25%). More than half of participants (54%) reported they were more likely to recommend IUD use to a friend now that they know that it might be possible to remove one's own IUD; 6% reported they were less likely to recommend the IUD to a friend. African American women were particularly interested in the option of IUD self-removal.

IUD self-removal by the patient is a safe alternative to the usual office removal. Clinicians should leave strings relatively long for patients who want the option of self-removal. The most effective position for self-removal is squatting or lying down. The patient uses their fingers to feel for the IUD strings. Exam gloves can help improve traction on the strings, but are not essential. The patient grasps the IUD strings and pulls firmly towards the opening of the vagina. As the IUD moves out of the uterus, the patient likely will feel cramping.

Once the IUD is removed, it should be checked to ensure that it has no parts missing. Patients can find pictures of the type of IUD they have on the RHAP IUD Facts patient hand-out or by using a search engine such as Google. Most patients have some spotting and cramping for up to a few days after removal, and they may get pregnant immediately after the IUD is removed if they have unprotected sex.

Contraceptive Pearls: IUD Self-Removal

January 21, 2020

reproductive health access project

Services available

- Hormonal contraceptives
- Emergency contraception
- UTI evaluation/treatment
- Mail-in STI testing
- PrEP
- Gender affirming hormone therapy
- Genital HSV management
- Vaginitis evaluation
- Medication abortion

Executive Order 3/22/2020

- Postpone surgeries and procedures that were not medically necessary
- Interpreted this to include most abortions
- Order expired April 21, 2020
- Contrary to medical associations recommendations

World Health Organization

When health systems are overwhelmed, countries need to make difficult decisions to balance the demands of responding directly to COVID-19, while simultaneously engaging in strategic planning and coordinated action to maintain essential health service delivery. The provision of many services will become more challenging. Women's choices and rights to sexual and reproductive health care, however, should be respected regardless of COVID-19 status.

ACOG | Clinical

The American College of Obstetricians and Gynecologists

The American College of Obstetricians and Gynecologists, in collaboration with other institutions, have recently released a statement on abortion access during the COVID-19 outbreak.

"Some health systems, at the guidance of the CDC [Centers for Disease Control and Prevention], are implementing plans to cancel elective and nonurgent procedures to expand hospitals' capacity to provide critical care," they say.

"To the extent that hospital systems or ambulatory surgical facilities are categorizing procedures that can be delayed during the COVID-19 pandemic, abortion should not be categorized as such a procedure."

“**The American College of Obstetricians and Gynecologists and the American Board of Obstetrics & Gynecology**, together with the **American Association of Gynecologic Laparoscopists, the American Gynecological & Obstetrical Society, the American Society for Reproductive Medicine, the Society for Academic Specialists in General Obstetrics and Gynecology, the Society of Family Planning, and the Society for Maternal-Fetal Medicine**, do not support COVID-19 responses that cancel or delay abortion procedures. Community-based and hospital-based clinicians should consider collaboration to ensure abortion access is not compromised during this time.”

RESEARCH LETTER

Changes in Abortion in Texas Following an Executive Order Ban During the Coronavirus Pandemic

Table 1. Number of Abortions Provided in Texas and to Texas Residents at Out-of-State Facilities and Percent Change in Abortions, February-May 2019 and February-May 2020[a]

	Abortions						
		Provided in Texas			Provided out of state[b]		
	Total No.	No.		Month-specific change 2019-2020, % (95% CI)[c]	No.		Month-specific change 2017-2020, % (95% CI)[c]
	2020	2019	2020		2017	2020	
February-May	17 923	18 268	16 349		532	1574	
February	4808	4287	4651	8.5 (4.1 to 13.1)	139	157	12.9 (−10.1 to 41.9)
March	4262	4922	3995	−18.8 (−22.2 to −15.4)	165	267	61.8 (33.3 to 96.5)
April	3803	4608	2856	−38.0 (−40.8 to −35.1)	107	947	785.0 (624.7 to 980.9)
May	5050	4451	4847	8.9 (4.6 to 13.4)	121	203	67.8 (34.0 to 110.1)

[a] Data from 2017 on Texas residents obtaining abortions out of state were used to compare changes in 2020 because data from 2019 were not available.

[b] Abortions provided to Texas residents at facilities in Arkansas, Colorado, Kansas, Louisiana, Oklahoma, and New Mexico.

[c] Percent change in February, March, April, and May 2020 vs 2019 (or 2017 for out-of-state abortions) estimated from negative binomial regression models.

RESEARCH LETTER

Changes in Abortion in Texas Following an Executive Order Ban During the Coronavirus Pandemic

Discussion | These data show that abortions declined in Texas during the executive order. Stay-at-home orders, facilities' coronavirus precautions, and patients' reluctance to seek in-person care may also have contributed to the decline. Other Texas patients traveled out of state or requested medications online.[5] Abortions at 12 weeks' GA or more increased after the order expired, which likely reflects delays in care among those who waited for an appointment and facilities' limited capacity to meet backlogged patient need. Although abortions later in pregnancy are very safe, they are associated with a higher risk of complications and may require additional visits compared with those provided earlier in pregnancy.[6]

Study limitations include lack of data from some Texas and out-of-state facilities, which may affect these estimates. Monthly facility data do not allow assessment of changes associated with the exact timing of the order.

Initial Shared System REMS approval: 04/2019

Mifepristone Tablets, 200 mg

Progestin Antagonist

RISK EVALUATION AND MITIGATION STRATEGY (REMS)
SINGLE SHARED SYSTEM FOR MIFEPRISTONE 200MG

The goal of the REMS for mifepristone is to mitigate the risk of serious complications associated with mifepristone by:

a) Requiring healthcare providers who prescribe mifepristone to be certified in the Mifepristone REMS Program.

b) Ensuring that mifepristone is only dispensed in certain healthcare settings by or under the supervision of a certified prescriber.

c) Informing patients about the risk of serious complications associated with mifepristone.

Legal abortion is *very safe*

- **Risk of overall complications:**[1]
  - **Major** (hospital admission, surgery, transfusion)
    - First-trimester aspiration: 0.16%
    - Medication abortion: 0.31%
  - **Minor** (infection, retained POC, excess bleeding without transfusion)
    - First-trimester aspiration: 1.1%
    - Medication abortion: 4.88%

Estimated pregnancy related maternal mortality

Type of pregnancy	Death rate
Legal pregnancy termination	0.567 per 100,000 terminations 0.7 per 100,000 (2000-2009)[2]
Miscarriage	1.19 per 100,000 miscarriages
Live birth	7.06 per 100,000 live births
Ectopic pregnancy	31.9 per 100,000 ectopic pregnancies

Estimates based on data from over 57 million pregnancies in the United States from 1991 to 1999.

Adapted from Grimes D. Am J Obstet Gynecol 2006; 194:92.

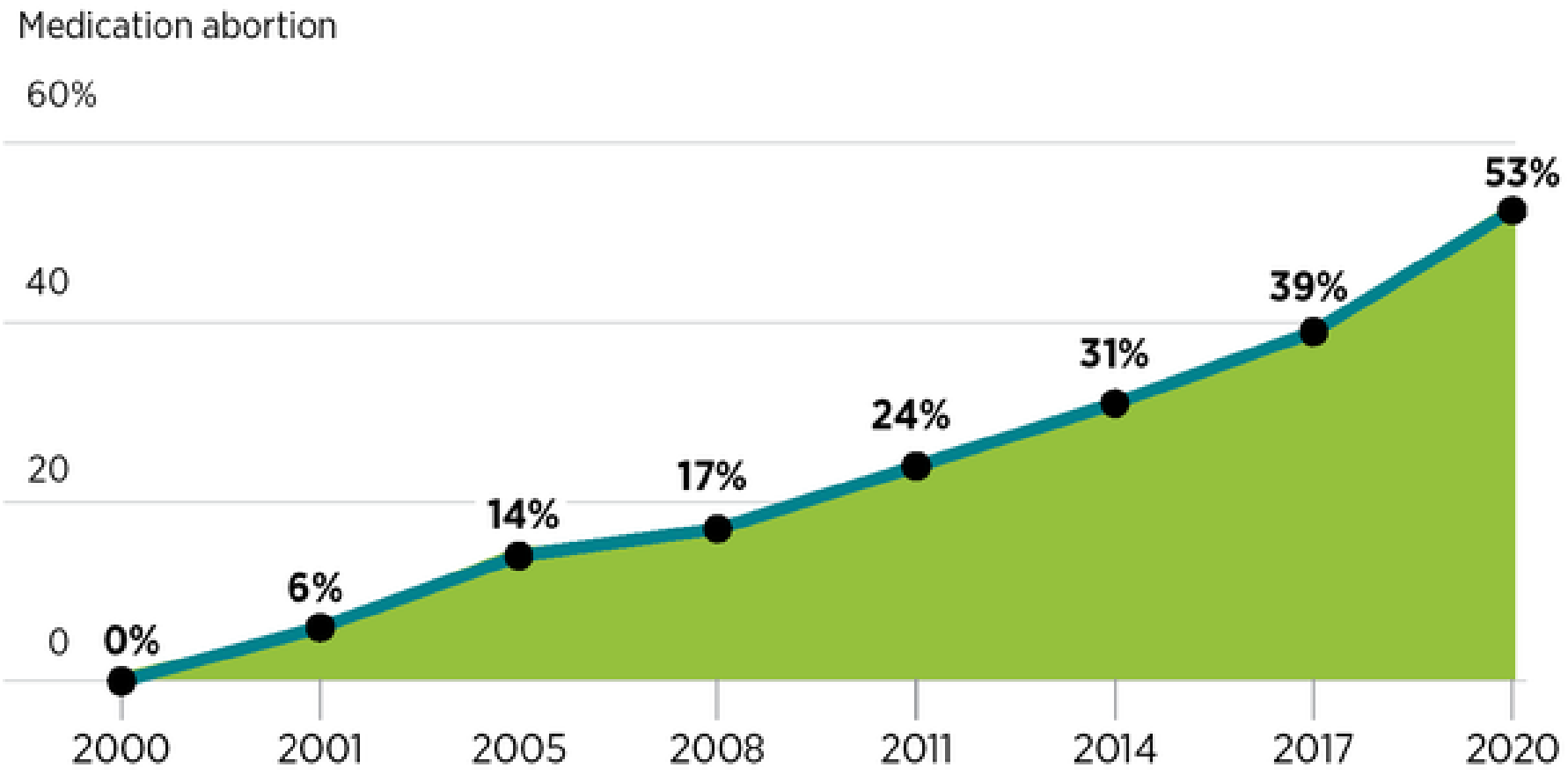
UpToDate®

1. Upadhyay UD, Desai S, Zlidar V, Weitz TA, Grossman D, Anderson P, Taylor D. Incidence of emergency department visits and complications after abortion. Obstet Gynecol. 2015 Jan;125(1):175-83

2. Raymond et al. Mortality of induced abortion, other outpatient surgical procedures and common activities in the United States. *Contraception.* Vol. 90Issue 5p476–479

GUTTMACHER INSTITUTE

As of 2020, medication abortions account for the majority of all US abortions



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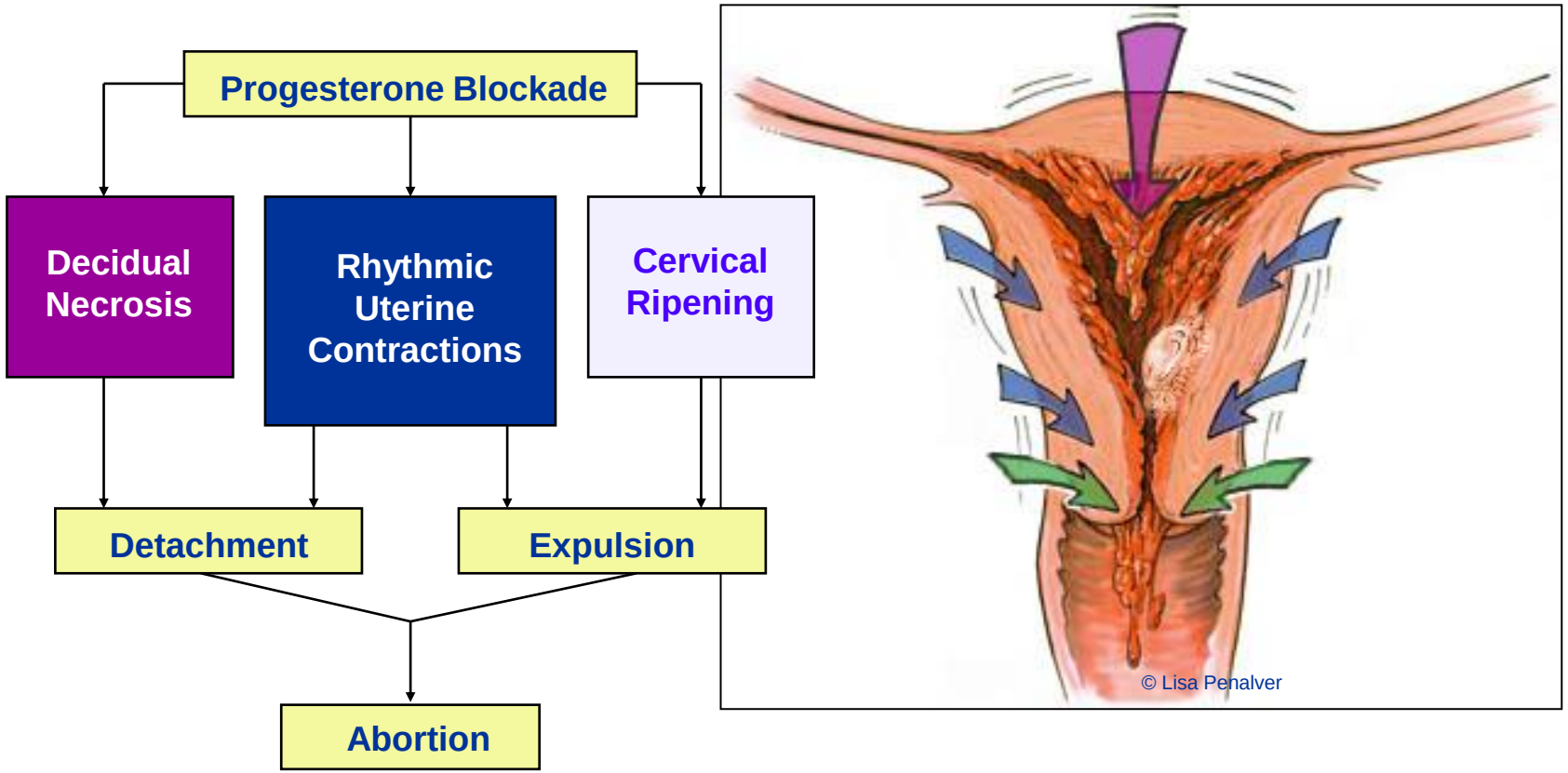
Medication Abortion

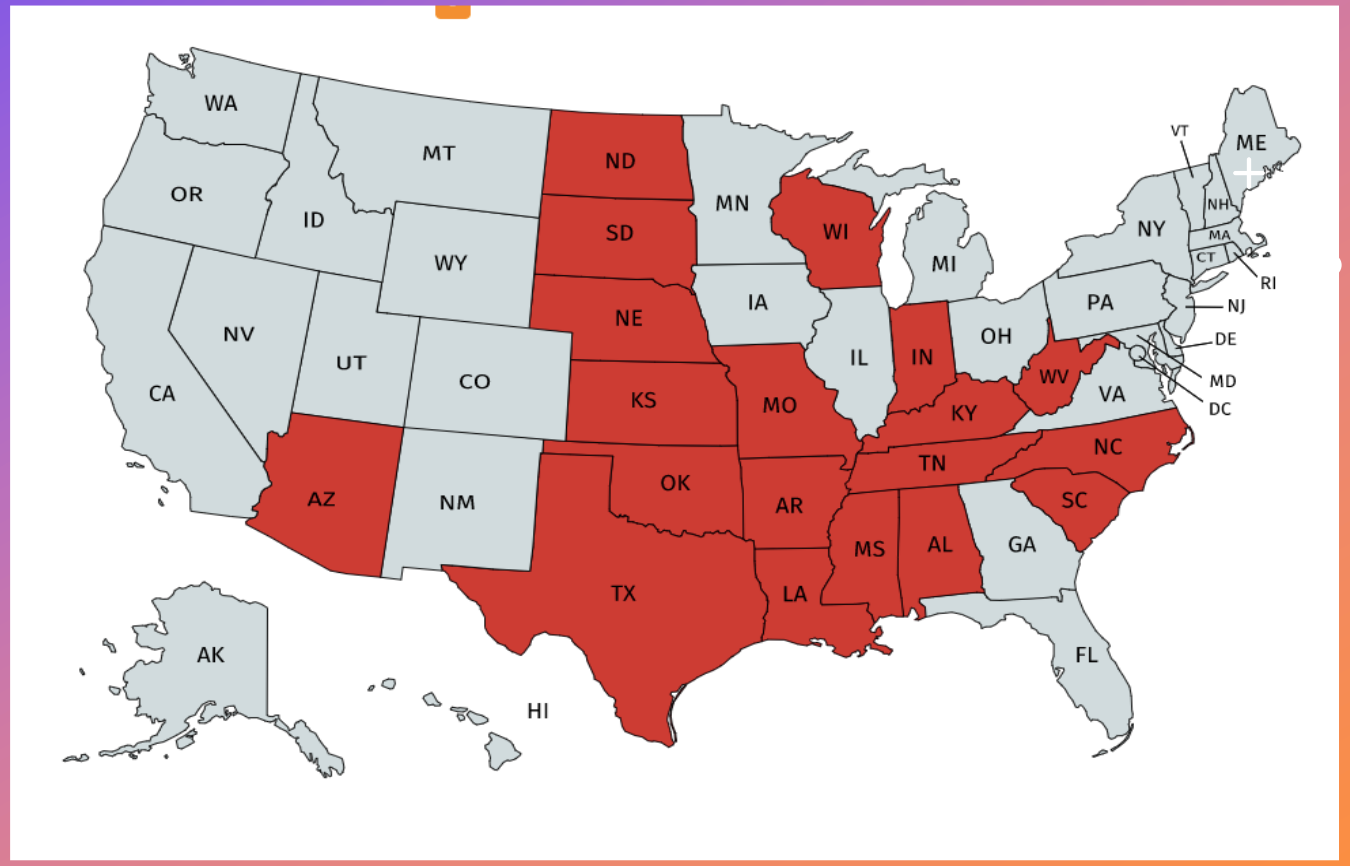
- **Mifepristone** (RU486)
  - Progesterone antagonist
  - Introduced in Europe in 1988
  - FDA approved for use in the U.S. in 2000
- **Misoprostol** (Cytotec)
  - PGE_1 analogue
  - Marketed for peptic ulcer prevention/treatment
  - Uterotonic agent
- **"MAB" medications:**
  - +/- Mifepristone (may be administered on site)
  - Misoprostol (1 or 2 doses)
  - Ibuprofen 10 tablets
  - Ondansetron 4 tablets

Mechanism of Action: Mifepristone + Misoprostol




Mifeprex
(Mifepristone)

TELEMAB BANS



REMS: Risk Evaluation & Mitigation Strategies

Product Name	Application Number	Application Holder
Mifeprex (mifepristone) (Info at Drugs@FDA)	NDA 020687	DANCO LABS LLC
mifepristone (Info at Drugs@FDA)	ANDA 091178	GENBIOPRO

Goal of the Mifeprex (mifepristone) Tablets REMS Program

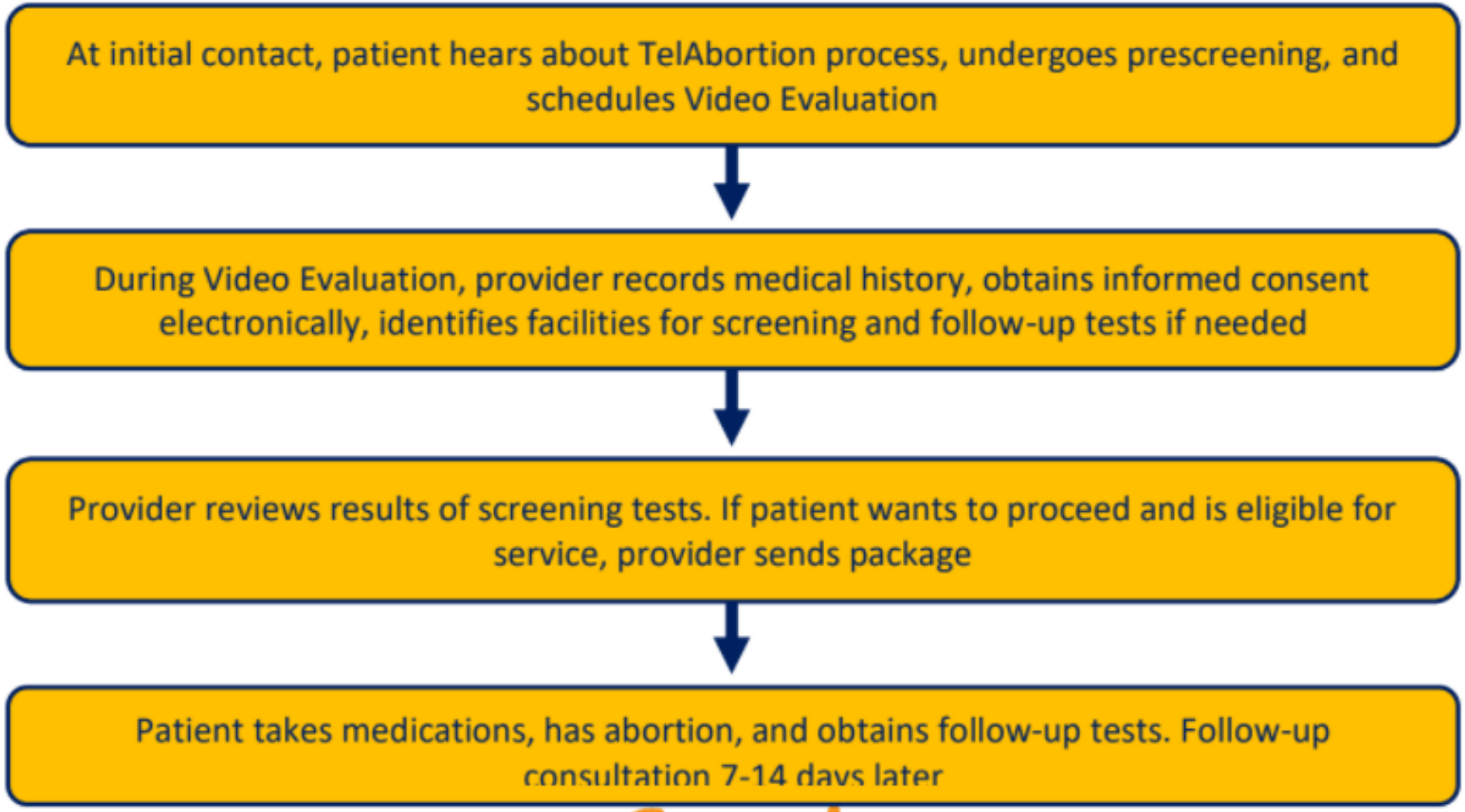
The goal of the Mifeprex REMS is to mitigate the risk of serious complications associated with Mifeprex by:

a) Requiring healthcare providers who prescribe Mifeprex to be certified in the Mifeprex REMS Program.

b) Ensuring that Mifeprex is only dispensed in certain healthcare settings by or under the supervision of a certified prescriber.

c) Informing patients about the risk of serious complications associated with Mifeprex.

- Launched in 2016
- Research study under a protocol filed with the U.S. Food and Drug Administration
- 17 states and DC: CO, GA, HI, IA, IL, MA, MD, ME, MN, MT, NJ, NM, NV, NY, OR, VA and WA
- 95% completed abortion without surgery
- Satisfaction high among both patients and providers



Gynuity HEALTH PROJECTS

To find out more information, visit www.telabortion.org or contact us at telabortion@gynuity.org.

Contraception 104 (2021) 43–48

Contents lists available at ScienceDirect

Contraception

journal homepage: www.elsevier.com/locate/contraception

Original Research Article

Expansion of a direct-to-patient telemedicine abortion service in the United States and experience during the COVID-19 pandemic

Erica Chong[a,1,*], Tara Shochet[a], Elizabeth Raymond[a], Ingrida Platais[a], Holly A. Anger[a], Shandhini Raidoo[b], Reni Soon[b], Melissa S. Grant[c], Susan Haskell[c], Kristina Tocce[d], Maureen K. Baldwin[e], Christy M. Boraas[f], Paula H. Bednarek[g], Joey Banks[h], Leah Coplon[i], Francine Thompson[j], Esther Priegue[k], Beverly Winikoff[a]

Conclusions: This direct-to-patient telemedicine service was safe, effective, and acceptable, and supports the claim that there is no medical reason for mifepristone to be dispensed in clinics as required by the Food and Drug Administration. In some cases, participants did not need to visit any facilities to obtain the service, which was critical to protecting patient safety during the COVID-19 pandemic.

Implications: Medical abortion using telemedicine and mail is effective and can be safely provided without a pretreatment ultrasound. This method of service delivery has the potential to greatly improve access to abortion care in the United States.

Contraception 104 (2021) 659–665

Contents lists available at ScienceDirect

Contraception

journal homepage: www.elsevier.com/locate/contraception

Original Research Article

Clinical and service delivery implications of omitting ultrasound before medication abortion provided via direct-to-patient telemedicine and mail in the U.S

Holly A. Anger[a,*], Elizabeth G. Raymond[a], Melissa Grant[b], Sue Haskell[b], Christy Boraas[c], Kristina Tocce[d], Joey Banks[e], Leah Coplon[f], Tara Shochet[a], Ingrida Platais[a], Beverly Winikoff[a]

Conclusions: Compared to patients who had pre-abortion ultrasound, patients who had no-test MA via telemedicine were more likely to have abortions that were not complete with pills alone and/or unplanned clinical encounters. However, both no-test and test-MA patients had similar and very low rates of ongoing pregnancy and hospitalization or blood transfusion.

Implications: Omitting pre-abortion ultrasound before provision of medication abortion via telemedicine does not appear to compromise safety or result in more ongoing pregnancies. However, compared to patients who have preabortion ultrasound, patients who do not have pre-abortion tests may be more likely to seek post-treatment care and have procedural interventions.

Contraception 107 (2022) 36–41

Contents lists available at ScienceDirect

Contraception

journal homepage: www.elsevier.com/locate/contraception

Original Research Article

Mail-order pharmacy dispensing of mifepristone for medication abortion after in-person clinical assessment ☆,☆☆

Daniel Grossman[a,*], Sarah Raifman[a], Natalie Morris[a], Andrea Arena[b], Lela Bachrach[c], Jessica Beaman[d], M. Antonia Biggs[a], Curtiss Hannum[e], Stephanie Ho[f], Eleanor B. Schwarz[g], Marji Gold[h]

Conclusions: Medication abortion with mail-order pharmacy dispensing of mifepristone appears effective, feasible, and acceptable to patients.

Implications: The in-person dispensing requirement for mifepristone, codified in the drug's Risk Evaluation and Mitigation Strategy, should be removed.

Contraception 101 (2020) 361–366

Contents lists available at ScienceDirect

Contraception

journal homepage: www.elsevier.com/locate/con

Commentary: No-test medication abortion: A sample protocol for increasing access during a pandemic and beyond ☆,☆☆

Elizabeth G. Raymond [a,*], Daniel Grossman [b], Alice Mark [c], Ushma D. Upadhyay [b], Gillian Dean [d], Mitchell D. Creinin [e], Leah Coplon [f], Jamila Perritt [g], Jessica M. Atrio [h], DeShawn Taylor [i], Marji Gold [j]

[a] *Gynuity Health Projects, New York, NY, United States*
[b] *Advancing New Standards in Reproductive Health (ANSIRH), Bixby Center for Global Reproductive Health, Department of Obstetrics, Gynecology, and Reproductive Sciences, University of California San Francisco, Oakland, CA, United States*
[c] *National Abortion Federation, Washington DC, United States*
[d] *Planned Parenthood Federation of America, New York, NY, United States*
[e] *Department of Obstetrics and Gynecology, University of California, Davis, Sacramento, CA, United States*
[f] *Maine Family Planning, Augusta, ME, United States*
[g] *Reproductive Health and Family Planning Specialist, Washington DC, United States*
[h] *Society of Family Planning, Clinical Affairs Subcommittee and Department of Obstetrics and Gynecology, Montefiore Hospital and Albert Einstein College of Medicine, Bronx, NY, United States*
[i] *Department of Obstetrics and Gynecology, University of Arizona College of Medicine Phoenix, AZ, United States*

Sample Protocol for No-Test Medication Abortion

PURPOSE

To enable safe and effective provision of medication abortion without a mandatory pre-treatment ultrasound, pelvic examination or laboratory tests when medically appropriate, given that these tests may be significant barriers to access and, in the setting of a pandemic, may increase transmission of infection to patients and health care workers.

CRITERIA

- Pregnancy confirmed by patient report of urine or serum test or prior ultrasound
- Last menstrual period started ≤77 days before anticipated date of mifepristone ingestion
- Certain of last menstrual period onset date ± 1 week
- None of the following symptoms or risk factors for ectopic pregnancy:
    - Vaginal bleeding or spotting within the past week
    - Unilateral pelvic pain or significant bilateral pelvic pain within the past week
    - Prior ectopic pregnancy
    - Prior permanent contraception or other tubal surgery
    - IUD in uterus at conception or currently
- None of the following contraindications to medication abortion, assessed by history:
    - Hemorrhagic disorder or concurrent anticoagulant therapy
    - Chronic adrenal failure
    - Concurrent long-term systemic corticosteroid therapy
    - Inherited porphyria
    - Allergy to mifepristone, misoprostol, or other prostaglandin
- No strong preference for pre-treatment ultrasound, pelvic examination or laboratory tests

Contraception 101 (2020) 361–366

RH TYPING AND ADMINISTRATION OF ANTI-D IMMUNOGLOBULIN

- Not needed if the gestational age on the anticipated mifepristone ingestion date will be <70 days or if the patient reports positive Rh type, wants no future children, or declines anti-D immunoglobulin.
- Should be considered for patients not meeting above criteria

TREATMENT

Provide the following:

- Mifepristone 200 mg orally
- Misoprostol 800 mcg x 2
- Analgesics, antiemetics per health facility protocol
- Patient instruction sheet and health facility emergency contact information
- Two high sensitivity pregnancy tests (HSPTs)

The patient should take mifepristone 200 mg orally followed by misoprostol 800 mcg buccally or vaginally 24-48 hours later. Patients with estimated GA >63 days should take a second dose of misoprostol 800 mcg 4 hours after the first. Patients with estimated GA ≤63 days should take the second dose if no bleeding occurs within the first 24 hours after the first misoprostol dose or if instructed to take it by a clinician. Review the instruction sheet with the patient.

Contraception 101 (2020) 361–366

FOLLOW-UP

1. Plan a follow-up contact with the patient one week after dispensing treatment.
2. If the patient reports indicators of continuing or ectopic pregnancy (e.g., any of the symptoms on the instruction sheet), evaluate with ultrasound or serum HCGs.
3. Otherwise, instruct the patient to perform the first HSPT 4 weeks after taking misoprostol (not earlier) and to contact the abortion provider if the result is positive.
4. If the patient has indicators of continuing or ectopic pregnancy, evaluate with ultrasound or serum HCGs
5. If the first HSPT result is positive but the patient has no such indicators, instruct the patient to perform the second HSPT in 1 week.
6. If second HSPT result is also positive, evaluate with ultrasound, serum HCGs, additional urine testing, or uterine aspiration.

Contraception 101 (2020) 361–366

3 key goals of clinical evaluation prior to Medication Abortion

- Establish that the patient has no contraindications to MAB
- Identification of ectopic pregnancy
- Confirm the gestational age within accepted limits for effective and safe outpatient treatment

Gestational Age Estimate

- Largest study, which was conducted in the United States in 2005–2007
- Only 31 (1%) of 3012 patients who were certain that their LMPs had started 77 days prior had GAs > 77 days by ultrasound examination.
- International studies that included more than 1600 patients treated with mifepristone and one or more misoprostol doses at 13–24 weeks of gestation reported efficacy and safety similar to that expected in earlier gestation:
  - >93% of patients aborted without further intervention
  - 0.7–4% required transfusion
  - No patient required hysterectomy or died

Ectopic Risk Assessment

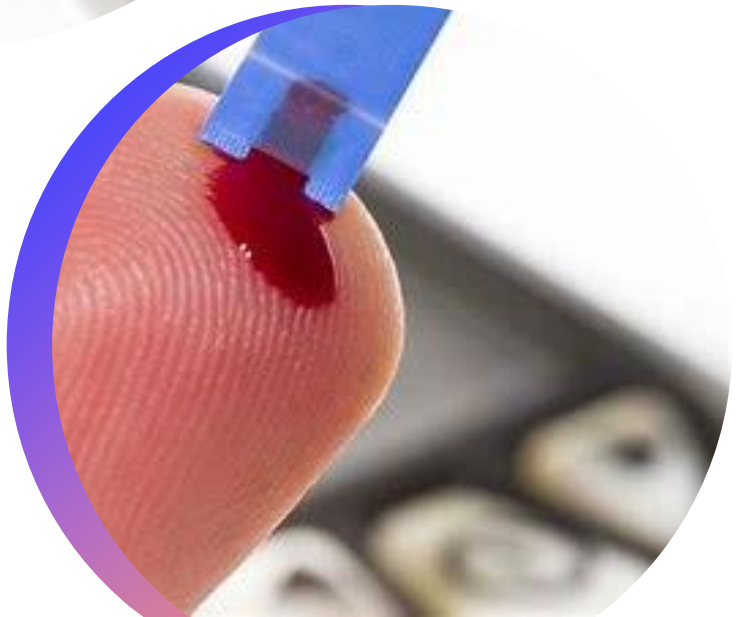
- Medications are not dangerous, but regimen not a proven treatment for ectopic
- No-test protocol excludes patients with significant symptoms or risk factors
- Incidence of ectopic pregnancy among patients seeking MAB is very low (<1%)
- Protocol will not identify every patient with an ectopic
  - Over half of patients with ectopic do not have risk factors
- Can detect and manage after MAB administration
- Does not exclude patients with history of prior pelvic inflammatory disease
  - Unconfirmed diagnosis are associated with only a mildly increased risk

Contraception 101 (2020) 361–366

77-day limit vs 70-day limit (date of mifepristone ingestion)

- Recent data indicates outpatient MAB is safe and effective through **77-days GA**
- Consistent with current guidelines of the *National Abortion Federation* and *Planned Parenthood Federation of America*
- Note of discrepancy with older guidelines
  - 2014 guidelines issued by ACOG & Society of Family Planning,
  - **2016** mifepristone label by the US FDA specifies a 70-day limit

Contraception 101 (2020) 361–366



Rh typing and other pre-treatment laboratory testing

- Hgb/Hct and other lab tests not routinely needed prior to first-trimester Ab; perform as indicated by PMHx and patient symptoms
- Recent research indicates Rh sensitization after early abortion is ***negligible***
- National Abortion federation concluded that ***forgoing*** is reasonable for:
  - ***First trimester MABs & PABs***

SCHEDULED FOLLOW-UP

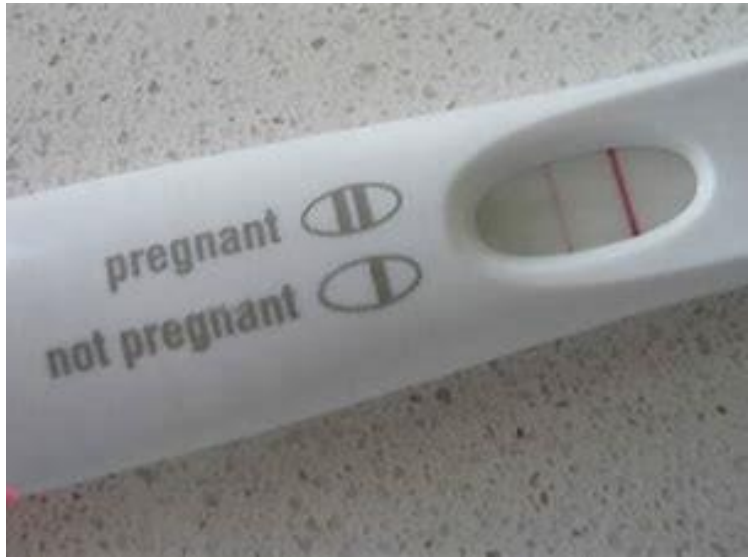
The primary goals of follow-up are to confirm absence of continuing pregnancy, to detect ectopic pregnancies not diagnosed before treatment, and to identify complications that need evaluation and treatment. To accomplish these goals, the sample protocol relies on patient symptoms and high sensitivity urine pregnancy tests (HSPTs) that the patient performs at home. This strategy has been validated in several studies [44,45], is consistent with current MA guidelines for follow-up of patients who have documented intrauterine pregnancies [16,17], and is increasingly used by MA providers.

Sample Instructions for Patients Receiving No-Test Medication Abortion

- ☐ <u>One week</u> after taking misoprostol, you have any of the following:
  - You have not had cramping and bleeding heavier than a period.
  - Your bleeding is not getting lighter.
  - You do not feel that you passed the pregnancy.
  - Your pregnancy symptoms (such as nausea and breast tenderness) are not resolving.
- ☐ <u>At any time</u>, you have any of the following:
  - An increase in pain/cramps or bleeding more than 24 hours after taking misoprostol.
  - Severe pain or cramps that don't get better with pain medicine, rest, or heating pads.
  - Enough bleeding to soak 2 maxi pads an hour for more than 2 hours.
  - Dizziness or vomiting lasting more than 2 hours.
  - Weakness, nausea, or diarrhea lasting more than 24 hours.

Sample Instructions for Patients Receiving No-Test Medication Abortion

Perform one urine pregnancy test 4 weeks after taking misoprostol (not earlier). **Call your abortion provider if the result is positive or invalid**. Use the second test if instructed to do so by your abortion provider.



Contraception 103 (2021) 400–403

Contents lists available at ScienceDirect

Contraception

journal homepage: www.elsevier.com/locate/contraception

Original Research Article

"False positive" urine pregnancy test results after successful medication abortion ☆,☆☆

Elizabeth G. Raymond [a,*], Holly A. Anger [a], Erica Chong [a,b], Sue Haskell [c], Melissa Grant [c], Christy Boraas [d], Kristina Tocce [e], Joey Banks [f], Bliss Kaneshiro [g], Maureen K. Baldwin [h], Leah Coplon [i], Paula Bednarek [h,j], Tara Shochet [a], Ingrida Platais [a]

[a] Gynuity Health Projects, New York, NY, USA
[b] Reproductive Health Education In Family Medicine, Bronx, NY, USA
[c] Carafem, Washington DC, USA
[d] Planned Parenthood of the North Central States, St. Paul, MN, USA
[e] Planned Parenthood of the Rocky Mountains, Denver, CO, USA
[f] Planned Parenthood of Montana, Billings, MT, USA
[g] Department of Obstetrics, Gynecology, and Women's Health, University of Hawaii John A. Burns School of Medicine, Honolulu, HI, USA
[h] Oregon Health & Science University, Portland, OR, USA

Conclusions: The proportion of participants with positive HSPTs declined with time after successful medication abortion. However, nearly one-fifth of participants with complete abortion had positive tests 4 weeks after treatment.

Implications: HSPTs provide an inexpensive, convenient option for confirming success of medication abortion at home. However, a substantial minority of patients without ongoing pregnancy have positive HSPT results. Development of a symptom-based strategy for medication abortion outcome assessment without any confirmatory tests should be a priority.

Rapid changes to standard MAB care

- Virtual patient evaluation
- Ultrasound not needed in select patients
- Labs not needed in select patients
- In person follow-up not needed for majority of patients

Can present reimbursement challenges

Medication Abortion Legal Timeline

US District Court of Maryland June 19, 2020

ACOG, NY State FM, Sistersong and other v.

FDA and US Department of Health and Human Services

Injunction in place July 13, 2020

Judge Theodore Chuang

In-person requirements "place a substantial obstacle in the path of women seeking MAB" and were ***likely to violate their constitutional rights***

US Supreme Court reinstates restrictions January 13, 2021

Request by Trump administration

Lifted federal judge's July 2020 order

In-person visits put back in place

Acting FDA Commissioner lifts restrictions April 12, 2021

FDA concluded that allowing MAB via telemedicine and mail will **NOT** increase risk and will keep people safe ***during the COVID pandemic***

Medication Abortion Legal Timeline

FDA permanently lifts in-person restrictions December 2021

Allows patients to received MAB medications by mail.

Signing Agreement Forms and receiving from specially certified health provider remain in place.

REMS updates went into effect January 3, 2023

Permanently removed in-person requirement and added a pharmacy certification process. All other components remain in place.

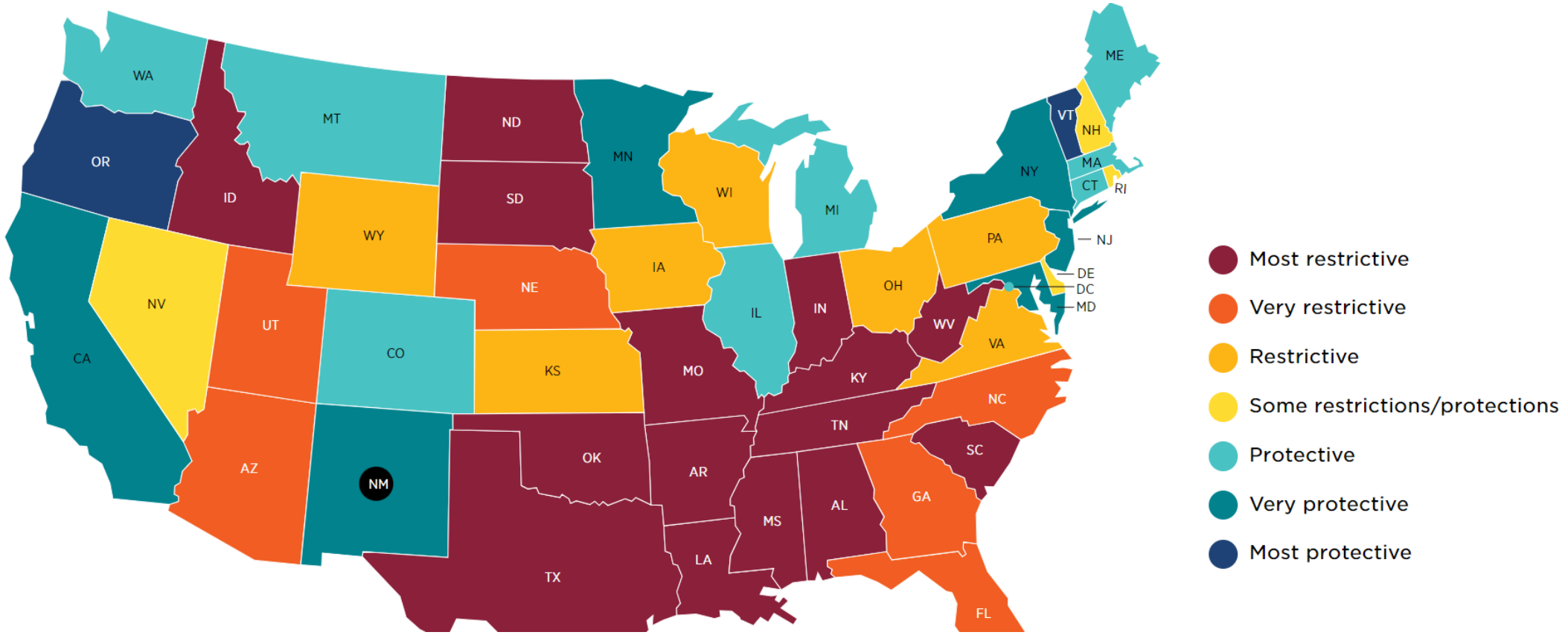
US Supreme Court decides *Dobbs v. Jackson Women's Health Organization* June 24, 2022

Court held that the Constitution of the United States does not confer a right to abortion.

SCOTUS hears oral arguments in *Alliance for Hippocratic Medicine v. U.S. Food and Drug Administration* March 26, 2023

Access to mifepristone in jeopardy.

Legal Landscape as of March 2023



Interactive Map: US Abortion Policies and Access After Roe | Guttmacher Institute

Abortion Policies in New Mexico

VERY PROTECTIVE

States have constructed a web of abortion laws and regulations that restrict or support whether, when and under what circumstances providers can offer abortion care and a pregnant individual can obtain an abortion. While a state's abortion policies affect all people seeking care, they are particularly significant for individuals who find it difficult or outright impossible to access care when forced to navigate around abortion bans and restrictions. This includes people already facing barriers due to factors like their race, income, age or gender identity.

Abortion policies currently in effect in New Mexico include the following:

- Abortion is not restricted based on gestational duration
- State Medicaid funds cover abortion
- Qualified health care professionals, not solely physicians, can provide abortions
- State has a shield law to protect abortion providers from investigations by other states; may cover patients and support organizations

Interactive Map: US Abortion Policies and Access After Roe | Guttmacher Institute

The Washington Post
Democracy Dies in Darkness

Justice Dept.: Despite bans, abortion pills may be mailed to any state

Legal opinion says existing federal law allows mail delivery because the sender cannot know if the recipient will use the medications illegally

January 4, 2023

The U.S. Postal Service had asked the Justice Department to say whether it would be legally allowed to deliver pills that could be used for abortion in a state where the procedure is outlawed. The response was a resounding yes.

The opinion notes that the two pills commonly used to perform abortions, mifepristone and misoprostol, also can be used in other ways, such as managing miscarriages or treating gastric ulcers. When ordered by mail, the intended recipient does not have to say how the pills will be used. Because of that, the Justice Department concluded, neither the sender nor postal workers are violating the Comstock Act by sending or delivering abortion pills in a state where the drugs cannot legally be used to terminate pregnancies in certain instances.

The opinion also noted that even states that have recently enacted strict abortion bans continue to allow people to terminate very early-stage pregnancies.

The New York Times

February 29, 2024

One in Six Abortions Is Done With Pills Prescribed Online, Data Shows

The first nationwide count of telehealth abortions includes pills mailed to states with abortion bans by clinicians in states with shield laws.

At least one in six abortions, around 14,000 a month, was conducted via telehealth from July through September, the most recent months with available data.

Some of the prescriptions included in the new count were given to patients in states where abortion is banned, a new development made possible by shield laws. These laws protect clinicians in states where abortion is legal when they prescribe and mail pills to patients in states where it is not.

Safe, private abortion care—no clinic visit needed

Hey Jane is the most-trusted virtual clinic offering safe and private abortion care from home. Get FDA-approved abortion pills discreetly delivered fast, plus ongoing medical and emotional support.

Consult with a provider in 1 business day

Am I eligible?

Trusted by more than 50,000 patients

Contraception 131 (2024) 110340

Contents lists available at ScienceDirect

Contraception

journal homepage: www.elsevier.com/locate/contraception

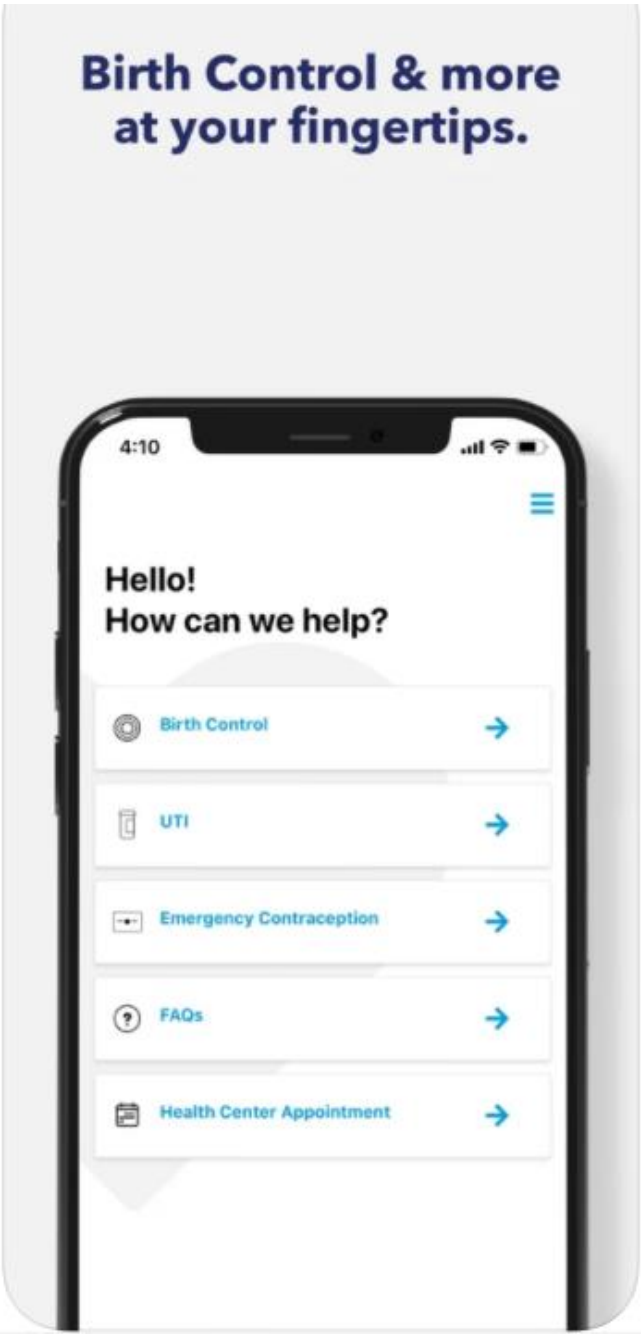
Evaluation of a "smart" screening tool for asynchronous assessment of medication abortion eligibility: A pilot study☆,☆☆

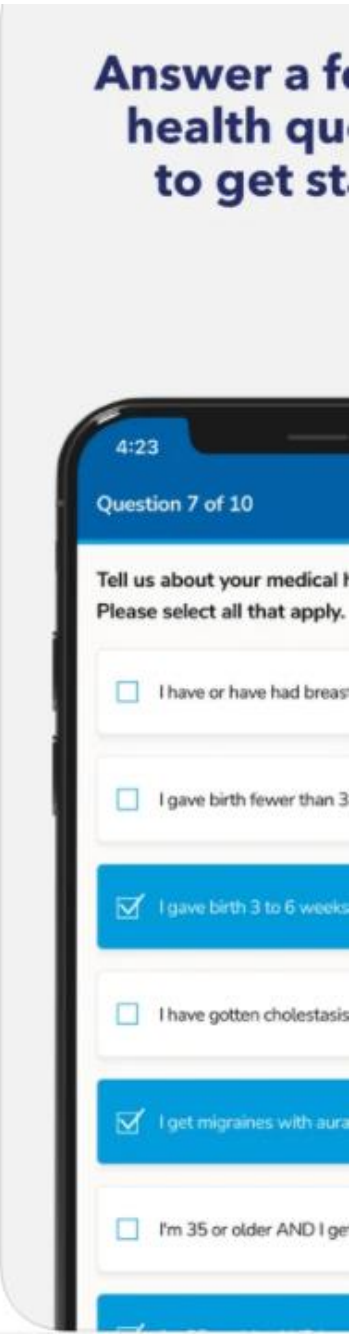
Elizabeth G. Raymond [a,*], Laura J. Frye [a], Kristina Tocce [b], Shay Gingras [c], Amy Almquist [c], Ann Firstenberg [b], Cynthia Ortega [b], Paul D. Blumenthal [d], Beverly Winikoff [a], Christy Boraas [c]

Conclusions: Data from this pilot project suggest that providing medication abortion based only on a self-administered, programmed questionnaire is likely to be effective, safe, efficient, and acceptable.
Implications: A programmed self-administered patient questionnaire to assess eligibility for medication abortion could reduce the cost of the service, augment clinic efficiency, improve quality of care, and enhance access to abortion.


Birth Control From Your Phone
Planned Parenthood
DIRECT
4:09
Where are you currently
District of Columbia
By continuing to use the Planned Parenthood Direct app, I acknowledge that I have read and agreed to the Terms of Use and Privacy Policy and have been truthful about the state I am located in. Version 1.XXX
CONTINUE AS GUEST


Delivered to your door!


Birth Control & more at your fingertips.
4:10
Hello!
How can we help?
Birth Control
UTI
Emergency Contraception
FAQs
Health Center Appointment


Answer a f
health qu
to get st
4:23
Question 7 of 10
Tell us about your medical
Please select all that apply.
I have or have had breas
I gave birth fewer than 3
I gave birth 3 to 6 weeks
I have gotten cholestasis
I get migraines with aura
I'm 35 or older AND I ge

Medication Abortion Legal Timeline

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Access to mifepristone in jeopardy.

Lack of mifepristone & impact to procedural abortion care

Contraception 101 (2020) 286–292

Contents lists available at ScienceDirect

Contraception

journal homepage: www.elsevier.com/locate/con

Review Article

Society of Family Planning clinical recommendations: Cervical preparation for dilation and evacuation at 20–24 weeks' gestation ☆,☆☆

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- Research on mifepristone has added significantly to the ability to provide safe, efficient cervical preparation before D&E.
- Adjunctive mifepristone may be comparable to a second day of dilators.
- Adjuvant mifepristone should be considered because it makes D&E subjectively easier and decreases procedure time without adding side effects.
- Patients were much more satisfied with overnight preparation with laminaria and mifepristone than with two days of osmotic dilators.

Lack of mifepristone & impact to management of miscarriage

INTERIM UPDATE

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

ACOG PRACTICE BULLETIN

Clinical Management Guidelines for Obstetrician–Gynecologists

NUMBER 200 *(Replaces Practice Bulletin Number 150, May 2015)*

Committee on Practice Bulletins—Gynecology. This Practice Bulletin was developed by the ACOG Committee on Practice Bulletins—Gynecology in collaboration with Sarah Prager, MD; Vanessa K. Dalton, MD, MPH; and Rebecca H. Allen, MD, MPH.

INTERIM UPDATE: This Practice Bulletin is updated as highlighted to reflect recent evidence regarding the use of mifepristone combined with misoprostol for medical management of early pregnancy loss. This Practice Bulletin also includes limited, focused updates to align with Practice Bulletin No. 181, *Prevention of Rh D Alloimmunization.*

Box 1. Protocol for the Medical Management of Early Pregnancy Loss

- Misoprostol 800 micrograms vaginally, with one repeat dose as needed, no earlier than 3 hours after the first dose and typically within 7 days if there is no response to the first dose*
- A dose of mifepristone (200 mg orally) 24 hours before misoprostol administration should be considered when mifepristone is available.†

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Contraception

journal homepage: www.elsevier.com/locate/contraception

Special Article

Medication abortion with misoprostol-only: A sample protocol☆,☆☆

Elizabeth G. Raymond [a,*], Alice Mark [b], Daniel Grossman [c], Anitra Beasley [d], Kristyn Brandi [e], Jen Castle [f], Mitchell D. Creinin [g], Caitlin Gerdts [h], Laura Gil [i], Melissa Grant [j], April Lockley [k], Jamila Perritt [e], Tara Shochet [a], Dominique Truan [l], Ushma D. Upadhyay [c]

TREATMENT

Provide the following:

- Misoprostol 800 mcg x 3-4 doses, per clinician judgment taking into account the patient's specific situation. An additional dose should be provided that the patient can use if needed.
- Analgesics, antipyretic, antiemetics and antidiarrheals as indicated.
- Patient instruction sheet and emergency contact information.
- At least one high sensitivity pregnancy test.

The patient should take misoprostol 800 mcg sublingually or vaginally every 3 hours for at least 3-4 doses. The patient may choose either route for each dose. If using vaginal administration, moistening each tablet with a few drops of water before insertion may improve effectiveness. The patient should take the extra dose if no more than scant bleeding occurs or the patient is not sure that the pregnancy has passed, or if instructed to do so by the clinician.

Raymond et al. Contraception 121 (2023).

Does it work?

Gest age	Failure of complete abortion		Continuing pregnancy	
	Mife/miso	Miso only	Mife/miso	Miso only
Overall (to 63 days)	2-6%	15%	0-2%	4%
< 49 days		15.6%		3.6%
< 56 days	2-6%	12.7%	0-1.4%	3.4%
57-63 days	4-6%	16.4%	0-1.9%	4.7%
63-70 days	1-2% (2 doses)		0-2.2%	
71-77 days	1-3% (2 doses)	17% (to 84d)	0-3%	6% (to 84d)

The continuing pregnancy rate with miso is ~4%, and increases with gestational age
Compared with 0-3% with mife/miso: ***difference to be aware of.***

The incomplete abortion rate with miso is ~15%, and increases with gestational age
Compared to 1-6% with mife/miso: ***difference we need to prepare for***

Is it safe? Is it acceptable?

Complication/Side effect	Mife + buccal miso (to 63d) [1,3]	Miso Alone (to 63d) [1,3]
Transfusion	0.03-0.6%	<1%
Admission to hospital	0.04-0.9%	0.2-1%
D&C for incomplete Ab	1.8-4.2%	11.6%
Infection	0.01-0.5%	<1%
Diarrhea	27% (buccal)	23-45% (vag, sublingual)
Fever	11-47% (buccal; no temp defined)	9-20% (>38C)
Mean bleeding duration	5-7 days	11.5 days
Satisfaction	88%	86%

1 – Medication Abortion Up to 70 Days of Gestation. Committee on Practice Bulletins-Gynecology, the Society of Family Planning. *Contraception* 2020; 102: 225-36

2 – Raymond EG, Harrison MS, Weaver MA. Efficacy of Misoprostol Alone for First-Trimester Medical Abortion: A Systematic Review. *Obstet Gynecol* 2019; 133: 137-47

3 - von Hertzen H, Piaggio G, Huong NTM, Arustamyan K, Cabezas E, Gomez M, Khomassuridze A, Shah R, Mittal S, Nair R, Erdenetungalag R, Huong TM, Vy ND, Phuong NTN, Tuyet HTD, Peregoudov A, on behalf of the WHO Research Group on Postovulatory Methods of Fertility Regulation. Efficacy of two intervals and two routes of administration of misoprostol for termination of early pregnancy: a randomised controlled equivalence trial. *Lancet* 2007; 369: 1938–46.

“Silver Lining” 2020-2024

The word "office" came to mean a bedroom, closet, outdoor coffee shop….. But we realized that we could be effective and productive making "work" fit into our circumstances rather than adapting our lives to fit a corporate mold.

Post Dobbs….increased financial and logistical assistance, a surge of publicity about ways to get abortions, and the expansion of telehealth.

Make health care fit into our patients lives/circumstances rather than requiring them to fit their care into our health care mold.
Telemedicine, hybrid models, and in-person visits are all essential in our path forward to offer truly accessible reproductive health care services.

In conclusion

1

Plan to incorporate new innovative options for delivery of reproductive health care

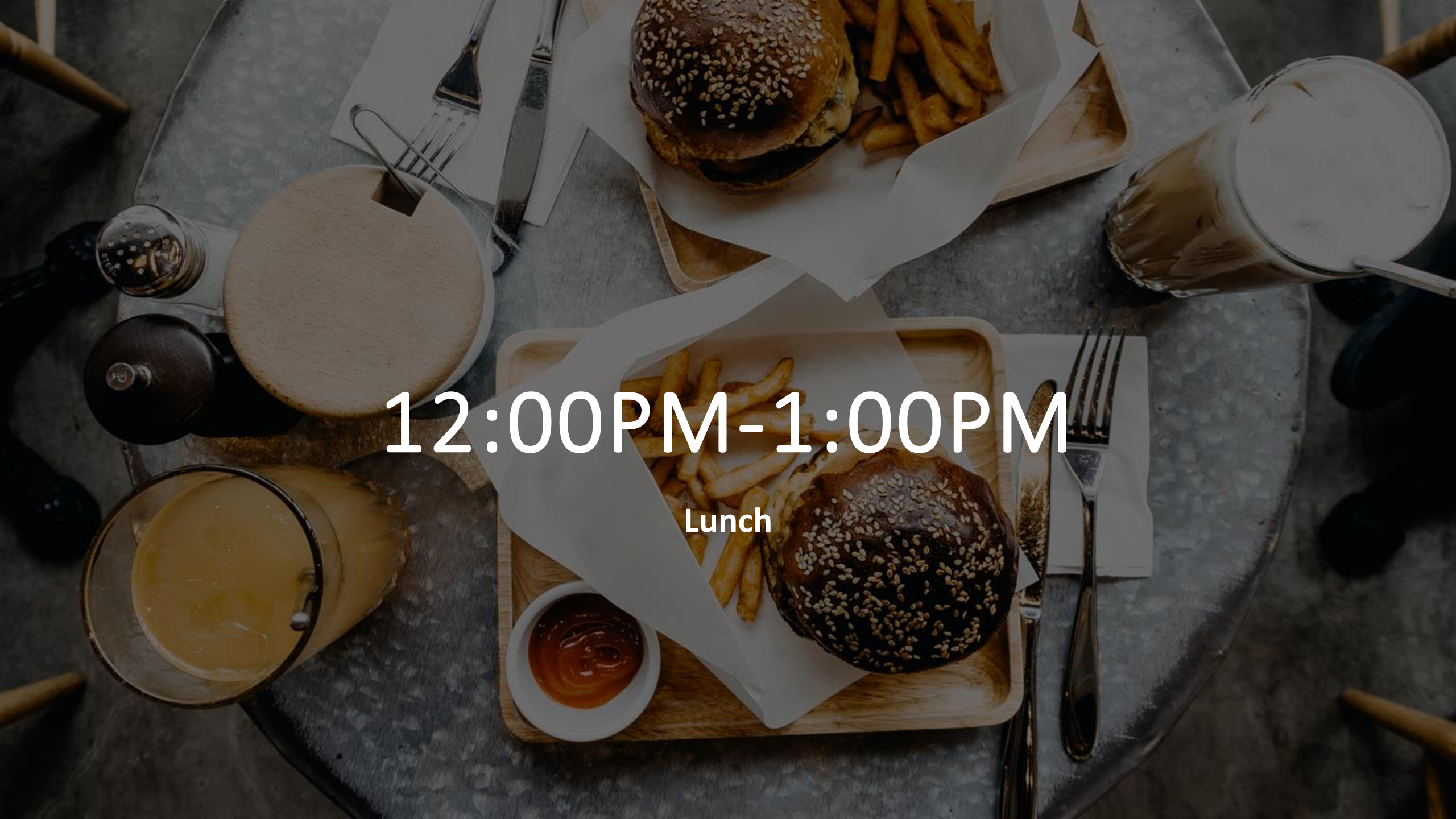
2

Confidently advocate that virtual reproductive health care services are essential health care services

3

Strategize to make these innovative care modalities sustainable

THANK YOU



12:00PM-1:00PM

Lunch

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Value: $250

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