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Challenges and strategies for contraceptive care in independent abortion clinics in the United States, 2017

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ABSTRACT

Objective: Many patients may wish to receive contraceptive counseling and services during an abortion visit, but a 2009 study documented challenges faced by abortion clinics, especially independent ones, in providing contraceptive care. Since then, the Affordable Care Act (ACA) has made contraception more accessible by expanding coverage to millions of individuals and by eliminating out of pocket costs. This paper aims to update this previous work and describe recent challenges in providing contraceptive care in independent abortion settings following the ACA, as well as the strategies used to address these challenges.

Methods: We conducted two focus groups and 19 semi-structured interviews with clinic administrators and directors at independent abortion clinics.

Results: Challenges to providing contraceptive care in independent abortion clinics included navigating new guidelines under the Affordable Care Act for establishing coverage agreements with health insurance plans and receiving timely and sufficient reimbursement for services provided. Study respondents described strategies related to adjusting clinic flow and protocols to address patient needs regarding receiving contraception during abortion care.

Conclusion: Staff working in independent abortion clinics in the United States experience a tension between trying to provide holistic, patient-centered care – including contraceptive care – and navigating restrictive political and healthcare contexts for the delivery of abortion care.

Introduction

Abortion clinics can be an important point of entry into the healthcare system. One in four U.S. women will have an abortion by the age of 45 [1], rendering the abortion care facility a pertinent setting for reproductive health care access. Contraceptive service provision may be especially relevant for many abortion patients, half of whom report using contraception during the month they became pregnant [2], and who may wish to avoid pregnancy in the near future. Among abortion patients nationally in 2011, two-thirds wanted to leave their appointment with a contraceptive method, and over half indicated an abortion clinic as their preferred healthcare setting to receive information on contraception [3].

While virtually all abortion clinics offer some form of contraceptive services during an abortion visit, the scope and extent of these services differs across types of clinics. Specialized abortion clinics—those facilities where over 50% of patient visits are for abortion care and which provide the majority (59%) of all abortions in the United States [4]—may not have the same capacity or resources to provide comprehensive contraceptive care as non-specialized clinics. In 2009, administrators at abortion clinics across the United States identified several challenges to the provision of contraceptive counseling and services, including training and clinic flow, stocking supplies, costs, and interfacing with public and private insurance systems [5,6]. These challenges were most pronounced in specialized abortion clinics. Since that time, the Affordable Care Act (ACA) has made contraception more accessible by expanding health insurance coverage to millions of previously uninsured individuals [7], and by eliminating out of pocket costs, such as copayments and deductibles, for the full range of women's contraceptive methods. However, little is known about how the ACA has impacted specialized abortion clinics' practices for providing contraceptive services as a component of abortion care. In addition, given their reach, understanding how specialized abortion clinics' contraceptive care practices have changed in the context of an increasingly hostile abortion policy climate is key. For example, federal and state restrictions on insurance coverage of abortion create disincentives for

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insurers to contract with abortion providers and for providers to accept insurance contracts [8]; this impacts specialized abortion providers more acutely, as fewer report accepting public and private insurance for contraceptive services compared to family planning providers [9]. As a result, opportunities for integrating abortion care and post-abortion contraceptive care with other important reproductive and primary care services are limited [8].

This study aims to identify recent challenges in post-abortion contraceptive care following the ACA, as well as the strategies used to provide or improve contraceptive care in abortion care settings, among a sample of clinic directors at independent, specialized abortion clinics.

Methods

Sample and data collection

Between March and November 2017, we conducted two, in-person focus group discussions (FGD), and 19 semi-structured interviews (IDI) via telephone with clinic administrators and directors at independent abortion clinics. We defined independent abortion clinics as abortion providing facilities where greater than 50% of all patient visits were for abortion care, and which were not affiliates of Planned Parenthood. All participants received a description of the study, gave verbal informed consent, and were paid for their participation ($50 and a meal were provided for FGDs, $75 for the telephone interview). This study was reviewed and considered exempt by the federally registered Institutional Review Board of the authors' organization.

We recruited FGD participants and facilitated FGDs at a meeting of the Abortion Care Network, a national association for independent care providers in the United States. Focus groups ranged from 4 to 5 participants each and included clinic directors and/or administrators; one participant was a former clinic administrator. The nine FGD participants represented nine distinct clinics, though two participants worked at clinics in the same chain of affiliated abortion providers. A member of the research team facilitated each focus group while another team member took notes. The focus group discussion guide explored clinics' philosophies towards providing contraceptive care, methods which were available to patients, and challenges clinics face in providing contraceptive care. The FGDs focused primarily on changes in the past five years. Focus groups were audio-recorded and ranged from 60 to 90 min.

To recruit IDI participants, we sampled clinics from the universe of all known abortion-providing facilities as of 2014, according to information obtained from the Guttmacher Institute's 2014 Abortion Provider Census [4]. To be included in the sample, facilities had to have no affiliation with Planned Parenthood, were not classified as a hospital or physician's office, and must have provided at least 400 abortions in 2014; 243 facilities—or clinics—met these criteria. All eligible clinics were stratified by region (Northeast, South, Midwest, and West), and we randomly sampled nine clinics from each region (36 clinics total), with a goal of recruiting six clinics from each (n = 24). Each clinic was contacted initially via email or by phone to schedule an initial recruitment phone call. For those clinics that declined to participate, could not be reached, were determined to no longer provide abortion services, or were determined to be affiliated with the same larger entity as another clinic already in our sample, we selected a replacement clinic within the same geographic area, using the next consecutive clinic on our list. Twenty of the 58 clinics we attempted to contact consented to participate, and we successfully scheduled and conducted 19 telephone interviews. A member of our research team conducted each audio-recorded interview, lasting approximately 45 min. We adapted the interview guide used in 2009 to interview clinic administrators about contraceptive provision during abortion care [5] to focus on experiences of specialized abortion providing facilities and to focus on how the landscape of abortion and contraceptive care may have changed during the past decade.

Data management and analysis

We transcribed recordings from both the FGDs and IDIs verbatim and removed identifying information during transcript cleaning. We analyzed data from FGDs and IDIs sequentially. First, one member of the research team reviewed FGD data by organizing participant responses according to themes directly related to questions from the FGD guide; we used emergent themes from the FGD data to inform IDI guide development. Two members of the research team, one of whom had summarized the FGD data initially, identified emergent themes in the IDI data using the same process described above; the same two research team members reviewed FGD data again during IDI data analysis to gauge relative agreement between FGD and IDI themes. Next, as a full research team, we reviewed and further organized all responses by theme to discover salient challenges and strategies for providing contraceptive care in the context of abortion care. The research team members met regularly during this stage to come to consensus on themes and thematic groupings; we resolved initial thematic disagreements through discussion and further thematic refinement. We made no analytic distinction between FGD and IDI data, and gave equal import to responses from each group given how similarly themes resonated between IDI and FGD participants. We chose this method of content organization as an analytic approach to prioritize identifying and describing new challenges and strategies employed by independent abortion clinics to build on previous research, rather than providing an in-depth phenomenological analysis of the relationship between challenges and strategies and how they are experienced. Thus, this report focuses primarily on newly identified challenges and includes provider-identified strategies to address them. We pay particular attention to differences in state Medicaid coverage policy among all respondents, as well as other insurance-specific topics including navigating billing, reimbursement, client insurance coverage, and insurance landscape issues post-ACA, and document strategies presented by respondents to ameliorate or overcome clinic level barriers impacting their ability to provide contraceptive services within the context of abortion care. We summarize and illustrate key themes and topics below using direct quotes from participants. All coding and analysis was conducted manually in word processing software.

Results

Navigating complex challenges: insurance, billing, and centering patients in healthcare

While all clinics in our sample had a primary focus on providing abortion care, almost all articulated a commitment to providing a broader range of healthcare services whenever possible, including contraceptive care. However, participants' descriptions of best practices for contraceptive counseling and provision within the context of abortion care varied, and highlighted challenges, opportunities, and tensions that can arise when attempting to balance clinic-level priorities or needs with patient-centered care.

Many of the challenges to providing contraceptive care within the context of abortion care echoed challenges documented in previous research, including reimbursement and billing practices [6], offering and stocking a full range of methods [5,9], accepting insurance [9], variation in quality and length of contraceptive counseling [6,9], low rates of patients returning for follow-up care [6], differences in contraceptive uptake by type of abortion [10], the stigma associated with returning to an abortion provider for contraceptive care [6], and the isolation of abortion care from other types of medical care [6]. These previously identified challenges will not be explored in depth here. Instead, we present findings on newly emerging challenges encountered when navigating variations in insurance coverage and networks, and reimbursement and billing limitations post-ACA and/or Medicaid expansion, as well as navigating the tensions that can arise when a desire

to provide patient-centered care is limited by time, resources, training, and competing provider priorities.

Although all respondents described increases in patients with health insurance coverage and increased coverage for contraceptives as positive trends, the evolving health insurance landscape has simultaneously introduced new and evolving challenges. The proliferation of insurance plans in some state exchanges may have complicated the landscape, rather than simplified it. And, although more patients may now have health insurance coverage following the Affordable Care Act—and in turn, coverage for contraceptive methods—navigating coverage details is not always straightforward for either the patient or the clinic, and variations in how the coverage is administered can impact the contraceptive services or types of contraception that abortion patients receive. As one administrator described:

> It really comes down to having adequate, just general women's health coverage. Um, and we have come really far with, you know, the Affordable Care Act and now here we are, um and that's very frustrating. You know, it's like, with plans being able to choose whether or not they're going to be covering certain things, that makes it very difficult to try to figure out, do I have coverage for contraception? Do I have coverage for abortion? If I do, does it come after everything else? Um, you know,.. are you fully covered for annual exams or not? Those are things that influence whether you come in and influence whether you get your birth control on time. Umm, yeah, that's definitely part, high co-pays and high deductibles definitely have discouraged patients from coming in, which means they don't have access– even to birth control pills. It limits access and so I think finding a reasonable comprehensive coverage is key. (IDI participant 5, Northeast)

As this respondent suggests, insurance coverage limitations may be especially salient for independent abortion clinics, as their patients are typically presenting to them specifically for abortion care, and may not be fully covered for other services at that time. Additionally, several respondents reported being unable to receive reimbursement for contraceptive care to patients with insurance coverage; many attributed this to the fact that they were not designated as primary care providers for the majority of their patients. Because of how they perceived or experienced insurance coverage and reimbursement restrictions and variations, participants described a variety of consequences to contraceptive service provision, including patients being unlikely to seek ongoing or follow up contraceptive care with them. Clinic administrators also reported that changes in contraceptive insurance coverage resulted in decreased revenue from contraceptive sales (in instances where patients were no longer paying out of pocket for contraception), a drain on staff time and resources for clinics attempting to guide patients through the administrative process of confirming coverage and an inability to receive (adequate) reimbursement. One respondent described experiencing several of these consequences simultaneously:

> I do think that Obamacare has resulted in more women taking advantage of [birth control pills] being paid for. They don't need to pay cash to me when– if they just see their primary care doc, it's going to get covered by their insurance. Now when they walk into me and I'm not their primary care doc and I try to bill their insurance, [the insurance company] refuse[s] to pay me. They say, "No, no, you're not the primary care doc listed of record, so here's zero dollars for your IUD, here's zero dollars for your Depo shot." (IDI participant 11, West)

These challenges were also discussed at length within the context of focus groups. As one participant articulated, changes in how contraception can be covered has also shifted how independent abortion clinics fit in to the larger network of healthcare in their geographic areas:

> So, everyone has made this really grand assumption that birth-control services, whether it's pills, LARC, whatever are covered under ACA. What we've discovered is that, yes, it's covered under a woman's plan, but if she's gone through the exchange and how to choose an HMO with the primary care physician who doesn't necessarily believe in IUDs or Nexplanon, and won't give her referral to come to us, we've had to turn her away, [those] who have insurance coverage, who maybe have a Medicaid HMO, who can't jump through the hoops to get their authorization to come to us to get a long acting contraception. (FGD participant 3, Midwest)

Additionally, as focus group participants described, contraceptive counseling strategies and methods offered can be constrained by limitations of patients' insurance coverage, reimbursement levels, billable services, and billing policies. For example, pharmacies use special codes and software to bill insurers for contraception under a patient's pharmacy benefit, known as pharmacy billing. Providers who are not set up to bill for contraception under the pharmacy benefit can seek reimbursement through the medical plan instead, but they may be reimbursed at a lower rate by the insurer. Changes within state Medicaid structures have also complicated coverage, as one respondent, (IDI participant 19, Midwest) indicated that their state Medicaid plan, which used to function as one entity, had split among multiple carriers.

Finally, respondents also mentioned challenges that are unique to their position as independent abortion providers striving to provide patient-centered care. Many respondents noted that not all patients want contraceptive care, and that they do not want to coerce or shame patients through unwanted contraceptive counseling. As one participant stated,

> so what I'll say [to patients] is, "The best contraception is something that you choose and you're going to be happy with," and I usually tell them, "I could bully you into anything, but I do not want you picking something to make me happy or picking something because you think that I'm not going to do your procedure or I'm going to judge you. I just want you to know your options." (IDI participant 12, Northeast)

For these participants, it was often difficult to find ways to respect the full range of patients' preferences, such as by avoiding contraceptive counseling for those who don't want it while ensuring robust counseling and education for those who do. Some providers also expressed a goal of having every patient leave with a method, which could represent an additional conflict for providing patient-centered care. It was also difficult to find the right balance of information to provide, as some patients experience "information overload" during the course of the abortion appointment when coupled with the informed consent process. Additionally, because abortion is such an isolated component of reproductive health care, with limited insurance coverage as presented above, many patients pay for their procedure out of pocket. As one focus group participant related, those patients are often already struggling to cover the costs of their procedure, and not all patients anticipate or can afford the additional cost of contraception on the day of their abortion.

Strategies to improve care: shifting/rethinking approaches for patient communication, staffing, and service provision

To address the challenges identified above, respondents detailed a range of strategies to provide quality contraceptive care within the context of abortion care. Because most respondents articulated such a strong desire to provide the highest quality, patient centered care possible, many of the strategies they described were clinic-level approaches, or adjustments to clinic flow or procedure, to address patient-level needs. For example, several strategies for providing contraceptive care were operationalized within the context of clinic flow, and how contraceptive counseling could be optimized within this process. One frequently mentioned strategy was to allow for flexibility in the amount

of time spent on contraceptive counseling and education, responsive to individual patient needs, by not overscheduling patients on abortion-clinic days, so as to allow for longer patient visits. One respondent, (IDI participant 5, Northeast) described the benefit of this model to patients by saying, "I think that the fact that the doctors spend the time makes a big difference in terms of the health of the patient, and their feelings about having control over their reproductive health and, you know, their sexuality, I think that's really key." Respondents also discussed developing counseling techniques, language, and protocols that might promote patients' ownership over their own reproductive health in order to reduce stigma, and training all levels of staff in effective communication strategies. As one respondent said:

> The way it was years and years ago was we- we kind of would talk with patients in the counseling session about birth control, but it was more of like, "Are you interested in it? Uh, what are you interested in? Okay, we'll let the after care nurse know." So I think we've gotten really proactive in teaching our counselors and our nurses uh, all of the methods and teaching them accurately, uh, about the information and their effectiveness and, you know, "Should this person try this," or, you know, "you didn't like this, well how about this?" (IDI participant 2, West)

Another strategy for incorporating contraceptive care that did not interrupt clinic flow but still made an effort to ensure patients' contraceptive needs were met was to initiate contraceptive counseling in advance of a patient's abortion procedure appointment, sometimes by taking advantage of state-level restrictive abortion policies. Under this model, contraceptive conversations could take place during state-mandated counseling and waiting periods (where applicable), over the phone before the patient presented to the clinic in person, through written materials, or before the follow up appointment. By initiating contraceptive counseling conversations in advance of a patient's appointment, clinicians suggested that some patients may arrive better prepared to engage in those discussions, have questions ready, and make a decision regarding contraception on the day of their appointment. As one participant said,

> Get them to, um, start thinking about it before they even come in. Um, maybe when they make their appointment, um, letting them know that we offer contraception and we will have a discussion with them when they're here, and that maybe they want to think about some questions that they have or concerns that they have about payment or side effects or whatever. Um, [pause] you know maybe just plant that seed ahead of time, might help the conversation to flow a little bit better (IDI participant 1, Midwest)

Similar strategies introduced by both FGD and IDI participants included having multiple contraceptive conversations over the course of a visit to increase opportunities for questions and to mitigate "information overload" that might occur with intake forms, or to achieve these same goals by incorporating contraceptive counseling into follow up appointments, often scheduled four to eight weeks after the abortion according to standard protocol at some of the sites.

Other strategies respondents outlined as they described their efforts to provide patient-centered contraceptive care in abortion settings addressed financial barriers that patients may encounter in obtaining contraception. These included maintaining dedicated funds for helping patients cover contraceptive costs, applying for grants or other programs to cover the clinical costs of contraceptives, offering patients sliding scale or reduced rates for contraceptive care, partnering with pharmacies directly to negotiate for decreased co-pays and to make prescription pick-ups easier in instances where pharmacies were nearby, linking patients with a variety of external sources of funding or discounts, and offering pharmacy billing plans. One administrator described employing several of these strategies:

> periodically we will call pharmacies in the area and ask what their cash fee is for a few different brands of birth control pills and for the Depo shot, so that when we have the discussion with the patient who is going to have to pay for it herself, we can say well it only costs $10 if you go to [pharmacy A], but if you go to [pharmacy B] like everybody else, it costs $20. … Some of the brand name pill companies have their own coupons that they give to us to give to the patients when we give them samples. (IDI participant 1, Midwest)

Some participants identified partnering with pharmacies or investing in a pharmacy billing plan as a way to address pharmacy mark up costs that get shifted to the patient and as a strategy to avoid poor reimbursement rates billing under medical plans. One focus group participant pointed out that pharmacy billing can be challenging from a financial standpoint because of economies of scale: "Investing in a pharmacy billing plan, I need to have regular clients that are coming back in and getting methods, and it's too expensive to make it worth my investment in that as we are currently" (FGD participant 4, South).

In instances where a clinic might be unable to meet a patient's needs because of financial or insurance barriers, respondents talked about the need to maintain a robust network of providers in the community to which they could refer patients for more affordable options, such as health departments that could offer free contraceptives, or referrals for other types of health care beyond the abortion clinic's scope of practice. Participants discussed the necessity of making sure they were referring their patients to quality healthcare providers in these cases.

In terms of assisting both patients and clinic staff as they attempted to navigate the complexities of insurance coverage, one strategy clinic administrators described included employing dedicated financial counselors at the clinic to address insurance and financial issues with patients. Financial counselors' responsibilities included verifying insurance coverage in advance of a patient's appointment, providing on-site eligibility screening and same-day enrollment for Medicaid or state family planning programs, or acting as patient advocates in order to negotiate with insurance providers directly. One focus group participant also mentioned that their financial counselors provided patients with a standard list of questions to ask their insurance carrier regarding contraceptive coverage. Having a dedicated staff insurance liaison also enabled clinics to streamline clinic flow while empowering patients to make more informed contraceptive decisions.

At sites where no dedicated staff member took on the role of financial counselor for patients, alternative approaches for addressing insurance-related barriers included training individuals on staff to become "experts on the law" following changes resulting from the ACA, getting qualified with new insurance plans, and learning how to receive appropriate reimbursement from insurance plans for contraceptive services provided.

Participants also described strategies for addressing insurance coverage, billing, reimbursement, and other associated issues for covering the costs of providing medical care that included expanding clinical services to offer primary, comprehensive and/or well-woman care in order to round out their medical care and business models; training and/or utilizing advanced practice clinicians such as nurse practitioners to insert IUDs, increasing staff available for insertions to improve clinic flow and reduce costs of care; negotiating directly with pharmaceutical companies for reduced rates on contraceptive methods; and working to qualify for 340B drug pricing and other federal or public funding programs to help with the cost of care.

Finally, participants also identified some state or federal policy changes they think would be necessary to improve access to contraception within the context of abortion care, including changing insurance restrictions so that abortion providers are not prohibited from receiving reimbursement for medical care provided, and changing Medicaid policy to improve reimbursement rates and provide at least a one-year supply of contraceptives. One respondent, (IDI participant 16, West) summed up the importance of large-scale insurance policy changes by explaining, "on a national level we need to focus on

insurance coverage mandates and educating patients about their eligibility requirements. I think also, you know, if you want to encourage clinicians to provide the service, the reimbursement has to be enough to make it worth their while to navigate all of those challenges."

Discussion

This report documents challenges faced, and strategies used, to provide contraceptive services in the context of abortion care among independent abortion providers since the implementation of the Affordable Care Act. Almost all participants stressed that providing the highest quality abortion care was their top priority, and that they see themselves first and foremost as abortion providers. Still, most participants articulated a clear desire to meet the full range of women's reproductive health needs. The tension between wanting to offer a full array of clinical services, while giving primacy to holistic, patient-centered care and objectives within today's restrictive political and healthcare landscapes for independent abortion providers was a unifying thread throughout many of the respondents' answers in focus group discussions and semi-structured interview answers. For example, many respondents were quick to acknowledge that while they wanted to enable access to contraceptive care, they also did not want to coerce, shame, or stigmatize patients in providing that service, especially for the significant proportion of clients who may not want to discuss or receive contraceptive care [3,11].

In addition to many of the challenges documented in previous studies, respondents also identified several new challenges to providing contraceptive care in abortion clinics. These include some that may have been a direct consequence of the Affordable Care Act, such as navigating new guidelines for establishing coverage agreements with health insurance plans and a perception that they were precluded from insurance reimbursement for contraceptive services because they were not designated as their patients' primary care provider. This latter challenge warrants further attention, as current federal law does not limit contraceptive service reimbursement to primary care provider-designated entities; respondents' perceptions of this barrier may be either a misinterpretation of coverage guidelines on behalf of the abortion care providers or a misrepresentation of them on behalf of insurance companies. Either way, challenges such as these can be costly, time-consuming and confusing, resulting in difficulties for both patients and providers. Patients may find it difficult to obtain integrated, timely contraceptive care from reproductive health specialists they know and trust, and providers may have difficulty providing continuity of care to their patients, especially if their patients are disincentivized from returning to them for follow-up or ongoing contraceptive care. Moreover, these challenges underscore the complexities and difficulties for independent abortion clinics in providing healthcare services while effectively operating outside of most health insurance plans and networks, and being isolated from the majority of mainstream healthcare.

These findings suggest that more integrated abortion care would benefit providers and patients alike, as the inability to provide holistic patient care because of insurance reimbursement practices limits the quality and scope of care provided. One immediate approach to expanding independent abortion clinics' ability to provide more comprehensive care to their patients would be the repeal of the Hyde Amendment. The Hyde Amendment prohibits federal dollars from being used for abortion coverage for patients insured by Medicaid; only 15 states allow state funds to cover abortion services for Medicaid recipients [12]. Allowing full coverage of abortion services for all Medicaid patients has the potential to mitigate barriers to contraception at point of service by reducing bureaucratic hurdles of insurance coverage limitations, reducing financial burdens, decreasing stigma, and increasing the likelihood of patients returning for ongoing reproductive health care.

Clinic administrators also identified many of the strategies they employ to incorporate contraceptive counseling and care into their existing abortion practice. Most strategies offered were explicit attempts to best serve clients' needs, while often being constrained by the realities of clinic flow and insurance and payment barriers. Some strategies were oriented toward fitting more information and services into each patient visit, by allowing for enough time with each patient to conduct contraceptive counseling, and by initiating counseling in advance of the abortion appointment—or at the follow-up visit—in order to capitalize on the limited time patients have in clinic. Given increasing restrictions on abortion at the state-level in the United States during the post-ACA timeframe of this study [13], some clinics made the best of the policies that required clinics to have contact with patients ahead of their abortion appointments by repurposing this time to also cover contraceptive information. However, these strategies highlight the burden abortion care providers shoulder in trying to "do it all" in one visit, and risk compromising the quality of contraceptive care patients receive, especially if the visit is rushed, or if patients are not mentally or financially prepared to make a contraceptive decision on the day of their procedure. Furthermore, these strategies may not necessarily align with the preferences of patients; 42% of patients in one study preferred the contraceptive discussion to occur at the clinic during the abortion visit compared to 15% at a follow-up visit and 11% through a phone call before or after the appointment [3]. Another recent study found that 62% of first-trimester abortion patients did not want to discuss contraception during their visit, though 71% wanted to leave the clinic with a contraceptive method; the majority of those who did not want to talk about contraception already knew what method they wanted to use [11]. Paradoxically, for some independent abortion clinics, deprioritizing or not providing contraceptive care at all may enable them to focus and excel at providing high quality abortion care [6], free from competing demands from other types of services.

This study has several limitations. The goal of our analysis was to document new challenges and strategies to providing contraceptive care in the context of abortion care, and as a result, does not provide a comprehensive evaluation of providing such care. Additionally, because our study was conducted with health care providers, and not with patients, findings highlight provider-level priorities and their perspectives of patient needs, and do not address patient-level needs or desires as experienced by patients. However, we are confident in the trustworthiness of our qualitative findings through pursuit of: (1) credibility, by triangulating themes from the two different data source of FGDs and semi-structured interviews; (2) transferability, given relative theme saturation among the responding independent abortion-providing sites; and (3) confirmability and dependability, by our transparent description of our research process from development through analysis.

For abortion patients who want contraception during their abortion care, independent abortion clinics are working to meet these patients' needs in the challenging healthcare landscape within which they provide abortion services. Many of the challenges identified by clinic administrators to achieving this outcome, as well as the strategies they have developed to overcome the challenges, reflect broader, more systemic issues associated with the isolation and stigmatization of abortion care from broader healthcare delivery. Future research should consider this lens and work to elucidate how these systemic issues hinder the delivery of reproductive health care more broadly, as well as incorporate patient perspectives on preferred health care delivery models.

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Declaration of Competing Interest

None.

Appendix A. Supplementary material

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