Increasing Access to Contraception
Learning Community
Year 3 In-Person Kick-Off Meeting

Renaissance Washington DC
October 27-28, 2016
Welcome

Michael Fraser, PhD, CAE
Executive Director
Association of State and Territorial Health Officials
ASTHO, with support from the CDC’s Division of Reproductive Health (DRH), formed the learning community to focus on improving state capacity to increase access to contraception.
Agenda Review

Lisa Waddell, MD, MPH
Chief, Community Health and Prevention
Association of State and Territorial Health Officials
Agenda – Day 1

10:00  Welcome
10:10  Agenda Review
10:15  Leveraging Federal Initiatives – An Integrated Vision for Contraceptive Access
11:15  State and Territory Team Introductions (Round 1)
11:30  ASTHO Learning Community: Past, Present and Future
12:00  State and Territory Team Introductions (Round 2)
12:15  Remarks from Dr. Wanda Barfield
12:30  State and Territory Team Action Planning Session #1
2:00   State and Territory Team Introductions (Round 3)
Agenda – Day 1 Cont.

2:15  Qualitative and Evaluative Data Collection
3:15  Wellness Break
2:45  Leveraging and Learning Session – Topical Group Discussion
3:15  Group Reports and Facilitated Discussion
5:30  Wrap Up and Plans for Day 2
5:45  Day 1 Adjourn
Agenda – Day 2

7:30  Breakfast Served
8:15  Welcome
8:45  State and Territory Team Action Planning #2
10:15 Accessing Expertise, Tools and Resources: A National Partner Panel Discussion
11:15 Wellness Break
12:45 State and Territory Team Report Out – Working Lunch
2:15  Making Connections Discussion
3:00  Wrap Up
3:15  Adjourn
Meeting Objectives

- Launch the expanded Increasing Access to Contraception Learning Community Year 3
- Facilitate a discussion with multi-disciplinary state and territory teams to identify needs, determine priorities, outline strategies and develop state and territory action plans and next steps to expand access to effective methods of contraception broadly (inpatient and outpatient)
- Improve the capacity of states and territories to successfully expand access to contraception through facilitating state-to-state sharing of barriers, solutions, promising strategies including new or amended policies and programs, and lessons learned
- Discuss technical assistance needs for the coming year
ASTHO Staff Introductions

Kathy Vincent
Facilitator
ASTHO Staff Introductions

Lisa Waddell
Chief

Christi Mackie
Senior Director

Ellen Pliska
Director
ASTHO Staff Introductions

Claire Rudolph
Senior Analyst

Sanaa Akbarali
Analyst

Eighmey Zeeck
Analyst
ASTHO Staff Introductions

Ify Mordi
Program Manager

Chelsea Moultrie
Program Coordinator
ASTHO Staff Introductions

Kristen Rego
Director

Emily Moore
Senior Analyst
Partner Organization Introductions

- American College of Obstetricians and Gynecologists (ACOG)
- Association of Maternal and Child Health Programs (AMCHP)
- Association of Women’s Health, Obstetrics, and Neonatal Nurses (AWHONN)
- National Family Planning and Reproductive Health Association (NFPRHA)
Leveraging Federal Initiatives: An Integrated Vision for Contraceptive Access

Panel Discussion
Leveraging Federal Initiatives: An Integrated Vision for Contraceptive Access

Shanna Cox
Associate Director for Science
Division of Reproductive Health
Centers for Disease Control and Prevention
CDC’s Strategies to Prevent Unintended Pregnancy
Unintended Pregnancy
Women of Reproductive Age (15 – 44 years), U.S.

- Annually, ~45% of 6.1 million pregnancies
- Highest among:
  - Teens and young adults (≤25 years)
  - Racial/ethnic minorities
  - Lower education and income
- Increased risk for poor maternal and infant outcomes
- Increased morbidity in women with chronic medical conditions

Champaloux, Steven W. PhD, MPH; Tepper, Naomi K. MD, MPH; Curtis, Kathryn M. PhD; Zapata, Lauren B. PhD; Whiteman, Maura K. PhD; Marchbanks, Polly A. PhD; Jamieson, Denise J. MD, MPH. Contraceptive Use Among Women With Medical Conditions in a Nationwide Privately Insured Population. Obstet Gynecol. 2015 Dec;126(6):1151-9. doi: 10.1097/AOG.0000000000001134
Preventing Unintended Pregnancy is a CDC Priority

- Winnable Battle—Teen Pregnancy Prevention
- Contraceptive Guidelines
- 6/18 Initiative
  - Removing administrative and logistical barriers to provider billing and reimbursement
  - LARC Calculator – a tool under development for state use
- Increasing Access to Contraception (LARC) Learning Community
- Minimizing the Health Outcome Impact of Zika
- Data for Action
Progress in Teen Pregnancy Prevention

Between 2007-2014, teen pregnancies dropped 42%.

CDC/NCHS, National Vital Statistics System
Teen Pregnancy Prevention

- Supporting multi-component approaches to teen pregnancy prevention and evaluating impact of improvement in clinical services for adolescents
- Strengthening effective clinical interventions and promoting the use of highly effective contraceptive methods
- Exploring the impact of the consequences and costs of teen pregnancy
- Supporting systems change approaches
- Expanding the analytic agenda
Contraceptive Guidelines

The U.S. Medical Eligibility Criteria for Contraceptive Use (U.S. MEC):

- Provides evidence-based guidance for the safe use of contraceptive methods for women and men with specific medical conditions (i.e., hypertension and diabetes) and characteristics (i.e., age and smoking status). These guidelines are used by health care providers when counseling women, men, and couples about contraceptive method choice.

U.S. Selected Practice Recommendations (SPR):

- Companion document to the U.S. MEC, the U.S. SPR provides evidence-based guidance to health care providers that addresses a common group of issues regarding initiation and use of specific contraceptive methods, as well as ways to reduce medical barriers to contraception access and use.

Quality Family Planning (QFP)

- Developed by CDC and OPA, these national guidelines recommend how to provide family planning services so that individuals can achieve their desired number and spacing of children, increase the chances that a baby will be born healthy, and improve their health even if they choose to not have children.
6/18 Initiative

Focus on 6 health conditions (including unintended pregnancy) and 18 evidence-based interventions that can improve health and control costs.

- For Prevention of Unintended Pregnancy:
  - Strategy 1: Reimburse for actual cost of providing contraceptive services
  - Strategy 2: Reimburse providers for the actual cost of LARC or other contraceptive devises in order to provide the full range of contraceptive methods
  - Strategy 3: Reimburse for immediate postpartum insertion of LARC by unbundling payment for LARC from other postpartum services
  - Strategy 4: Remove administrative and logistical barriers to LARC

- 4 participating states selected unintended pregnancy as a topic of focus (CO, LA, MI, NY)
Zika Response

“Never before in history has there been a situation where a bite from a mosquito could result in a devastating malformation.”
– Dr. Tom Frieden, CDC Director
*Fortune*, April 13, 2016

“...the last time an infectious pathogen (rubella virus) caused an epidemic of congenital defects was more than 50 years ago...”
Increasing Access to Contraception in the Context of Zika Preparedness

- Increasing access to contraceptive services and the full range methods, including long-acting reversible contraception (LARC), to reduce unintended pregnancy, is an important strategy for preventing the number of pregnancies affected by Zika
- CDC published an MMWR outlining 7 strategies for states and localities to increase access to contraception, including LARC
- Each of the 7 strategies was based on input from professional organizations, federal agencies, healthcare providers, and state and local health departments
Supporting Efforts in Puerto Rico through Zika Contraception Access Network (Z-CAN)

- Network of trained OB/Gyn and other physicians, family planning clinics, and community health centers in Puerto Rico
  - Will provide women access to the full range of contraceptive methods, including the most effective methods, such as long acting reversible contraception (LARC)
  - Services to be provided from May 2016 to May 2017

Increase Awareness
Increase Supply
Increase Provider Education
Increase Those Trained
State and Local Voices

- CDC and AMCHP convened a leadership meeting September 28, 2016
  - Purpose: To collect information from jurisdictions currently implementing strategies to increase access to highly effective contraception and support state and local health initiatives to reduce unintended pregnancies

- Meeting attendees represented:
  - 14 jurisdictions
  - 3 federal partners
  - 6 maternal and child health membership organizations
**Strategies**

- **Facilitate partnerships among private and Public insurers, device manufacturers, and state agencies**
  - Improve acquisition management
  - Streamline service provision
  - Increase efficiency in product purchase
  - Reduce per capita costs

- **Reimburse healthcare providers for the full range of contraceptive services, including**
  - Screening for pregnancy intention
  - Client-centered contraceptive counseling
  - Full cost of LARC device insertion, removal, and replacement
  - Device reinsertion and follow up

- **Remove logistical and administrative barriers for contraceptive services and supplies**
  - Eliminate policies requiring pre-approval
  - Decrease step therapy restriction or required use of generic drugs before brand-name medication
  - Stock LARC in all hospitals and clinics
Strategies

Train healthcare providers on current insertion and removal techniques for LARC
• Support use of CDC’s evidence-based contraceptive guidance, and provide quality family planning services
• Increase healthcare provider awareness on appropriateness of LARC for most clients of all ages

Support youth-friendly reproductive health services
• Educate healthcare providers on confidentiality concerns of adolescents/minors
• Withhold automated distribution of explanation of benefits (EOB) to the primary payer
• Offer extended and weekend hours
• Provide teen-focused, culturally appropriate materials during healthcare visits

Engage smaller or rural facilities including community healthcare centers
• Ensure adequate healthcare provider training and supply of LARC
• Partner with larger facilities to implement contraceptive services

Increase consumer awareness of contraception options and assess client satisfaction with service delivery
• Implement public/private campaigns
• Provide comprehensive sexual health education in secondary schools
Immediate Postpartum LARC Learning Community

- Bring leadership from a group of states with developed policies on immediate postpartum LARC to identify success, barriers, and challenges to full policy implementation
- Provide state peer-to-peer exchange and federal guidance
- 13 state teams established to provide qualitative information on barriers
Learning Community

Domains of Focus → Strategies

- Provider Training
- Outreach – Provider and Consumer Awareness
- Surveillance and Evaluation – Quality Improvement
- Reach Frontier, Rural and Smaller Clinics and Service Centers
- Provider Reimbursement
- Client-centered Counseling
- Stocking and Supply
- Stakeholder Partnerships
- Client-centered Counseling
- Provider Reimbursement
- Reach Frontier, Rural and Smaller Clinics and Service Centers
- Provider Training
- Outreach – Provider and Consumer Awareness
- Surveillance and Evaluation – Quality Improvement
- Stakeholder Partnerships
- Stocking and Supply
- Client-centered Counseling
Immediate Postpartum LARC Learning Community Lessons Learned

- Involving state leadership
  - State Health Officials, Health Commissioners, and Medicaid Medical Directors must be at the table to decision-make, facilitate data-sharing, amend policies, and partner on statewide bulletins
- Identifying a champion
  - A provider champion garners support from Hospital Administrators, local clinical membership chapters (e.g., ACOG), and acts as an advocate for change
- Removing duplicative efforts
  - Acknowledging competing federal initiatives and including discussion on how all activities align increases state involvement
- Uptake measurement
  - Partnering with states to develop process and outcome indicators that are clear and easy reduce the burden of work for participants
CDC Efforts to Strengthen Measurement

- Pregnancy Risk Assessment Monitoring System (PRAMS) awarded FY 16 funds to 51 applicants, including 11 new sites; PRAMS now covers 83% of live births in the US. PRAMS will also capture pregnancy intendedness and post-partum contraception, including LARC, utilization. [www.cdc.gov/prams/](http://www.cdc.gov/prams/)

- The Behavioral Risk Factor Surveillance System (BRFSS) family planning module- 41 states and territories in 2017. CDC is using the BRFSS platform to do a contraceptive needs assessment in Puerto Rico to inform the Zika response. [www.cdc.gov/brfss/](http://www.cdc.gov/brfss/)

- CDC worked with OPA on the development of NQF contraceptive use performance measures for monitor and evaluate initiatives to reduce unintended pregnancy
Next Steps

- Expand ASTHO Learning Community beyond immediate post-partum period to prevention of all unintended pregnancies
- Connect state-developed contraceptive policies to resources within Medicaid, commercial insurance, and clinical organizations
- Continue to disseminate and updated guidelines on contraception (e.g., MEC, SPR)
- Evaluate policies and program to demonstrate what works
- Disseminate effective tools (e.g., CDC LARC Calculator) to assess cost and return on investment
Improving Access to Contraception in Continental US: CDC’s Role Within the Larger HHS Context

- **CDC’s 6/18 Initiative**
  - 4 states funded to implement evidence-based payment strategies to improve health outcomes and reduce costs

- **CDC’s ASTHO Learning Community**
  - 27* states and 1 territory to identify the opportunities, challenges, and TA needs using a multi-pronged approach to policy implementation of increasing contraceptive access, including LARC.

- **CMCS’ Maternal and Infant Health Initiative**
  - 14 states funded to facilitate data collection/report on contraceptive measure

- **CMMI’s Payer-Provider Summit**
  - 4 states brought together to identify promising alternative payment strategies

- **MCHB’s COIIN focused on reducing infant mortality**
  - 29 states are addressing increased access to contraception

- **OPA’s Quality Improvement Initiative**
  - 15-20 Title X grantees aligned with the state Medicaid programs funded by CMCS

- **HRSA’s Bureau of Primary Health Care**
  - Strengthening the quality of contraceptive services provided by community health centers

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*Final number of participating states to be determined

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*Centers for Medicaid/CHIP Services (CMCS); Maternal and Infant Health Initiative (MIH); Maternal and Child Health Bureau (MCHB); Collaborative Improvement & Innovation Network (COIIN) to Reduce Infant Mortality (COIIN); Office of Population Affairs (OPA); Health Resources and Service Administration (HRSA)
Thank you!

If you have any questions please contact Shanna Cox
cio8@cdc.gov

For more information, contact CDC
1-800-CDC-INFO (232-4636)

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.
Leveraging Federal Initiatives: An Integrated Vision for Contraceptive Access

Lekisha Daniel-Robinson
Division of Quality, Evaluation and Health Outcomes
Children and Adults Health Programs Group
Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
Improving Contraceptive Care In Medicaid and CHIP

Increasing Access to Contraception Learning Community
October 27, 2016

Lekisha Daniel-Robinson, MSPH
Technical Director and Coordinator, CMCS Maternal Infant Health Initiative
In July 2014, CMCS launched a Maternal and Infant Health Initiative in collaboration with states to:

1) Increase the rate and content of postpartum visits; and
2) Increase access to effective methods of contraception in Medicaid and CHIP.

This initiative builds on the work of an Expert Panel that identified strategies CMS and states could undertake to improve maternal and infant outcomes in Medicaid and CHIP.
Exploring Payment Strategies

• Informational Bulletin released on 4/8/16 identified emerging promising payment approaches to increase access to long-acting reversible contraceptives (LARC)

• Key strategies:
  • Timely, patient-centered comprehensive coverage
  • Increasing payment rates for contraceptive devices to ensure access to the range of methods available
  • Reimbursement for Immediate Postpartum LARC by “unbundling” payments for LARC from payment for labor and delivery services
  • Removing logistical barriers for supply management (e.g., addressing supply chain, stocking cost and disposal cost issues).
  • Removing administrative barriers to access for LARC (e.g. minimize preauthorization and “step therapy” requirements)
The Medicaid Managed Care Final Rule (81 FR 27498) promotes access to family planning services and effective contraception methods, including LARC. Specifically, the rule promotes:

- **Choice** – reiterates enrollees right to directly access family planning providers without need for referral (42 CFR 438.10(g)(2)(vii))
- **Non-discrimination of providers** – MCOs cannot discriminate in the participation, reimbursement or indemnification of any providers acting within the scope of their licensure or certification (42 CFR 438.12 and 438.214)
- **Utilization management** – clarifies that “step therapy” utilization methods cannot be applied to contraceptive methods (42 CFR 438.210(a)(4)(ii)(C))
- **Cost-sharing for family planning services and/or items** – stipulates that any cost-sharing imposed on Medicaid enrollees must be in accordance with Medicaid’s cost-sharing regulations (42 CFR 438.108 and 447.50 et seq.)
Policy Guidance

- State Health Official Letter, 6/14/16, clarified family planning regulations and offered additional options for increasing accessibility of LARC
  - Application of Family Planning Policy to Fee-for-Service and Managed Care
  - Clarification of the Purpose of the Family Planning Visit
  - Access to Services and Supplies
  - Additional Strategies to improve access to LARC, including an 1115 demonstration project
Measuring Contraception Access

- There are two Contraceptive Care MIHI measures – global and postpartum – that are stratified by age and have multiple rate categories
- The global measure includes a total of 4 rates:
  - Provision of most effective or moderately effective FDA-approved methods of contraception for ages 15–20 and ages 21–44.
  - Provision of long-acting reversible method of contraception (LARC) for ages 15–20 and ages 21–44.
- The postpartum measure includes a total of 8 rates:
  - Provision of most effective or moderately effective FDA-approved methods within 3 days postpartum for ages 15–20 and ages 21–44.
  - Provision of most effective or moderately effective FDA-approved methods within 60 days postpartum for ages 15–20 and ages 21–44.
  - Provision of LARC within 3 days postpartum for ages 15–20 and ages 21–44.
  - Provision of LARC within 60 days postpartum for ages 15–20 and ages 21–44.
Measuring Contraception Access: MIHI Grantees
Next Steps

- Work with states to explore payment that supports high quality prenatal, postpartum, and inter-conception care.
- Continue to explore policy options to address effective contraceptive counseling and removal.
- Identify innovative care delivery models that have demonstrated promising results in improving outcomes, but do not have a sustainable source of funding.
- Consider how contracting, alternative payment bundles and other models may be applied to contraceptive care services.
For more information visit Medicaid.gov:

Maternal and Infant Health Care Quality –


or contact
CMCS_MIH_Initiative@cms.hhs.gov
Leveraging Federal Initiatives: An Integrated Vision for Contraceptive Access

Brittni Frederiksen
Health Scientist
Office of Population Affairs
Leveraging Federal Initiatives: An Integrated Vision for Contraceptive Access

A Perspective from the Office of Population Affairs

Launch of ASTHO Learning Community
October 27-28, 2016
Objectives

During this presentation, I will describe:

• The Office of Population Affairs (OPA) and the Title X Family Planning Program

• Recent OPA initiatives & resources that may be helpful to Learning Community participants
OPA’s Mission:

To assist individuals and couples in planning and spacing births, contributing to positive birth outcomes and improved health for women and infants.
The Title X Program

Title X Service Grantee Network:

- **89 Service Grantees**, including State, territorial, tribal, county or local health agencies, universities, faith-based and community-based nor for profit agencies

- **4,100 Family Planning Clinics**, in the 50 States, the District of Columbia, and the eight U.S. Territories and Jurisdictions

- **4.13 Million Clients Served**, with family planning and related preventive health care services
Recent OPA initiatives

- Training & Technical Assistance
- Performance Measurement
- Electronic Health Records
Family Planning
National Training Center

- Wide range of training resources (webinars, e-learning courses, job aids, patient education) available at:

  www.fpntc.org
Zika response

OPA has developed several relevant resources as part of its response to Zika:

• Webinars focused on caring for non-pregnant clients
• Zika “toolkit”
• Meeting in a box
• Description of 8 state initiatives (AZ, CA, FL, GA, LA, MS, SC, TX)
• M&E protocol
• Core training curriculum for how to deliver client-centered contraceptive care

For more information:  [http://www.hhs.gov/opa/index.html](http://www.hhs.gov/opa/index.html)
Performance Measurement

• OPA validated the first national performance measures for contraceptive care:
  • % using a most or moderately effective method of contraception
  • % using a long-acting reversible method of contraception
  • Consider all women at risk and postpartum women

Contraceptive use among women at risk of unintended pregnancy, by age, National Survey of Family Growth, 2011-2013
Performance Measurement

- Submitted to National Quality Forum (NQF) for endorsement, ratification decision on October 25, 2016

- Technical assistance resources are available:
  - Details for how to calculate the measures (http://www.hhs.gov/opa/index.html)
  - Learning collaboratives & resources for how to improve performance (www.fpntc.org)
Patient-Reported Outcome Performance Measure

Please rate the health care provider you saw today with respect to the following qualities:

- Respecting me as a person
- Showing care and compassion
- Letting me say what mattered to me about my birth control method
- Giving me an opportunity to ask questions
- Taking my preferences about my birth control seriously
- Considering my personal situation when advising me about birth control
- Working out a plan for my birth control with me
- Giving me enough information to make the best decision about my birth control method
- Telling me how to take or use my birth control method most effectively
- Telling me the risks and benefits of the birth control method I chose
- Answering all my questions

Source: Dehlendorf (2016). Interpersonal quality of family planning care
Electronic Health Records

• OPA helping to develop standardized ways to measure family planning care in electronic health records, in partnership with ACOG. This will lead to:

  • Consistent measurement of pregnancy intention, contraceptive use & key preconception health services
  • Ability to access the data elements (included in base EHR package or FHIR system)

• Will allow us to develop an electronic version of the contraceptive care measure, which is being developed in partnership with NACHC.
Thank you to our partners!
For More Information

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Getting to Know Your Learning Community Colleagues: State Team Introductions (Round 1)

Kathy Vincent
Facilitator
Delaware

Leah Woodall
Amanda Wardwell
Khaleel Hussaini
Kathy Kolb
Oklahoma

Tina Johnson
Mike Herndon
Tara Jackson
Joyce Marshall
New York

Lauren Tobias
Lacey Clarke
Lusine Ghazaryan
Kimberly Potter
Alabama

Chris Haag
Leigh Ann Hixon
Drew Nelson
Rosemary Blackmon
Colorado

Karen Trierweiler
Jody Camp
Melanie Reece
Rebecca Cohen
Iowa

Debbie Kane
Stephanie Trusty
Julie Baker
Mississippi

Mary Currier
Tracy DeVries
Christy Lyle
Sonja Fuqua
North Carolina

Kelly Kimple
Kate Berrien
Velma Taormina
Belinda Pettiford
ASTHO Learning Community:
Past, Present, and Future
“Setting the Stage” for the In Person Meeting and the Year Ahead

Ellen Pliska, Director, Family and Child Health, ASTHO
Christi Mackie, Senior Director, Family and Child Health, ASTHO
Kate Curtis, Health Scientist, CDC
History of the ASTHO LARC Immediately Postpartum Learning Community

Ellen Pliska
Director, Family and Child Health
Association of State and Territorial Health Officials
ASTHO LARC Immediate Postpartum Learning Community History

- Goal: Improve state capacity to improve access to LARC immediately postpartum
- Facilitate state-to-state sharing
- Provide technical assistance
- Develop resources and tools on state solutions and materials

- Funder: CDC Division of Reproductive Health
- Federal Partners: CDC, CMS, OPA
- Organizational Partners: ACOG, AMCHP, NFPRHA
LARC Learning Community Cohorts 1 & 2 State Teams

- LARC Learning Community Cohort 1 States
  - CO
  - NM
  - OK
  - TX
  - LA

- LARC Learning Community Cohort 2 States
  - MT
  - IA
  - IN
  - GA
  - SC
  - MD

- MA
  - DE
LARC Immediate Postpartum Learning Community Strategies

- Training*
- Reimbursement and Sustainability*
- Consent*
- Stocking and Supply*
- Outreach^* 
- Stakeholders and Partnerships^* 
- Service Location^* 
- Data, Measurement, and Evaluation^*
- Cross cutting: Policy, Leadership *^*

*Cohort 1  ^Cohort 2
Strategy 1: Training

Strategy 2: Reimbursement and Sustainability

- Training: Several states provide training to state providers:
  - Colorado, Delaware, Georgia, Iowa, Louisiana, South Carolina, Texas provide training
  - Include insertion and educational training to OBGyn, nurse practitioners, and lactation consultants

- Sustainability: Oklahoma worked with three foundations to hire full time employees, provide trainings and revise policies.
Strategy 4 Stocking and Supply  
Strategy 6: Stakeholders and Partnerships

- Stocking and Supply: Delaware allocated one-time repurposed funding covering providers’ initial LARC stock to set up a system to replenish that stock through third-party insurance.

- Partnerships: South Carolina partnered with Choose Well Initiative to create their LARC Toolkit, providing “A-Z” guidance on immediate postpartum LARC in hospitals.
Strategy 7: Service Location

Strategy 8: Data, Monitoring, Evaluation

- Colorado is developing a carve out reimbursement for rural health centers

- Maryland blends 5 hospital claims data and key informant interviews
  - Quantitative data: How hospitals are billing for the immediate postpartum LARCs
  - Qualitative data: Issues and successes that hospitals have faced
Setting the Stage for the In-Person Meeting and the Year Ahead

Christi Mackie
Senior Director, Family and Child Health
Association of State and Territorial Health Officials
Learning Community Timeline of Activities

**Planning Phase**
- **2016**
  - State Teams Finalize Action Plans: November 2016
  - Due: Dec 1
  - Key Informant Interviews

**Implementation Phase**
- **2017**
  - Virtual Learning Session 1: December 20, 2016
  - Virtual Learning Session 2: February 14, 2017
  - First Round of Targeted TA/Check-in Calls

**Evaluation Phase**
- **2017**
  - Second Round of Targeted TA/Check-in Calls
  - Virtual Learning Session 3: April 25, 2017
  - Virtual Learning Session 4: June 6, 2017
  - ASTHO Evaluation

**In-Person Strategic Planning Meeting:**
- October 27-28, 2016

**Virtual Kick-Off Call and Launch of Learning Community:**
- October 13, 2016
State and Territory Team Action Planning

- Three facilitated state action planning sessions
  - Session 1:
    - Landscape on existing state initiatives
    - Vision and Goals
  - Session 2
    - Identify Strategies & Action Steps
  - Session 3
    - Finalize action steps
    - Determine first action steps to take before Dec. 20th
Desired Outcomes

Increasing Access to Contraception:

Strategic Action Plan

Reducing unintended pregnancy among women of reproductive age in the U.S.
Contraception Resources from the CDC: 2016 U.S. MEC and U.S. SPR Updates

Kathryn Curtis
Health Scientist
Division of Reproductive Health
Centers for Disease Control and Prevention
Contraception Resources from the CDC: 2016 U.S. MEC and U.S. SPR Updates

Kathryn Curtis, PhD
Division of Reproductive Health
Centers for Disease Control and Prevention
Disclaimer

- The findings and conclusions in this report are those of the author and do not necessarily represent the official position of the Centers for Disease Control and Prevention.
Why is evidence-based guidance for contraceptive use needed?

- To base family planning practices on the best available evidence
- To address misconceptions regarding who can safely use contraception
- To remove unnecessary medical barriers
- To improve access and quality of care in family planning
U.S. Medical Eligibility Criteria for Contraceptive Use, 2016

- Safe use of contraceptive methods by women and men with certain characteristics or medical conditions

- Target audience: health care providers

- Purpose: to assist health care providers when they counsel patients about contraceptive use and to serve as a source of clinical guidance

- Content: more than 1800 recommendations for over 60 conditions
Contraceptive Methods in US MEC

- Intrauterine devices
- Progestin-only contraceptives
- Combined hormonal contraceptives
- Emergency contraceptive pills
- Barrier contraceptive methods
- Fertility Awareness-Based Methods
- Lactational Amenorrhea Method
- Coitus Interruptus
- Female and Male Sterilization
<table>
<thead>
<tr>
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<th>U.S. MEC: Categories</th>
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<tbody>
<tr>
<td>1</td>
<td>No restriction for the use of the contraceptive method for a woman with that condition</td>
</tr>
<tr>
<td>2</td>
<td>Advantages of using the method generally outweigh the theoretical or proven risks</td>
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<tr>
<td>3</td>
<td>Theoretical or proven risks of the method usually outweigh the advantages – not usually recommended unless more appropriate methods are not available or acceptable</td>
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<tr>
<td>4</td>
<td>Unacceptable health risk if the contraceptive method is used by a woman with that condition</td>
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**Example: Smoking and Contraceptive Use**

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<tr>
<th>Condition</th>
<th>Cu-IUD</th>
<th>LNG-IUD</th>
<th>Implants</th>
<th>DMPA</th>
<th>POPs</th>
<th>CHCs</th>
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<td>a. Age &lt;35</td>
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<td>b. Age≥35</td>
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<td>i. &lt;15 cigarettes/day</td>
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<td>II.≥15 cigarettes/day</td>
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Cu IUD: Copper IUD;  
LNG-IUD: Levonorgestrel IUD;  
DMPA: Depo-Medroxyprogesterone Acetate;  
POPs: Progestin-only pills;  
CHCs: Combined hormonal contraceptives including pills, patch, and ring
2016 Updates to U.S. MEC: New Recommendations

- **4 new conditions**
  - Cystic fibrosis
  - Multiple sclerosis
  - Women using selective serotonin reuptake inhibitors (SSRIs)
  - Women using St. John’s wort

- **1 new emergency contraception method**
  - Ulipristal acetate (UPA)

- **Revised emergency contraception section**
2016 Updates to U.S. MEC: Changes to Existing Recommendations

- **Hormonal methods (Implants, DMPA, POP, CHCs)**
  - Migraine headaches
  - Superficial venous disease
  - Women using antiretroviral therapy
  - Women with known dyslipidemia

- **Intrauterine devices (Cu-IUD, LNG-IUD)**
  - Gestational trophoblastic disease
  - Postpartum and breastfeeding women
  - Human immunodeficiency virus
  - Factors related to sexually transmitted diseases
Take Home Messages, U.S. MEC

- U.S. MEC can help providers decrease barriers to choosing contraceptive methods
- Most women can safely use most contraceptive methods
- Certain conditions are associated with increased risk for adverse health events as a result of pregnancy
  - Affected women may especially benefit from highly effective contraception for family planning
- Women, men, and couples should be informed of the full range of methods to decide what will be best for them
U.S. Selected Practice Recommendations for Contraceptive Use, 2016

- Recommendations for contraceptive management questions
- Target audience: health care providers
- Purpose: to assist health care providers when they counsel patients on contraceptive use and to serve as a source of clinical guidance
- Content: Guidance for common contraceptive management topics such as:
  - How to be reasonably certain that a woman is not pregnant
  - When to start contraception
  - Medically indicated exams and tests
  - Follow-up and management of problems
Major Updates to 2016 U.S. SPR

- **New recommendation**
  - Using medications to ease IUD insertion

- **Update of existing recommendation**
  - When to start regular contraception after ulipristal acetate

- Updates consistent with changes in U.S. MEC 2016
U.S. SPR can help providers decrease medical barriers to initiating and using contraception

Most women can start most methods anytime

Few, if any, exams or tests are needed

Routine follow-up generally not required

Regular contraception should be started after emergency contraception

Recommendations for anticipatory counseling for potential bleeding problems and proper management are provided
Dissemination and Implementation Plan

- Work with partners
  - Federal agencies
  - State and local agencies
  - Professional organizations
  - Continuing education and credentialing organizations

- Presentations and publications

- Updating and disseminating provider tools
2016 U.S. MEC and U.S. SPR App

MEC by Condition

MEC by Method

SPR

About this App

Full Guidelines

Provider Tools

Select Method (MEC)

Intrauterine Contraception

Progestin-only Contraceptives

Combined Hormonal Contraceptives

Barrier Methods

Fertility Awareness-based Methods

Lactational Amenorrhea Method

Coitus Interruptus

SPR

How To Be Reasonably Certain That A Woman Is Not Pregnant

Cu-IUD

LNG-IUD

Implants

Injectables

Combined Hormonal Contraceptives

Progestin Only Pills
 CDC Contraceptive Guidance for Health Care Providers

U.S. Medical Eligibility Criteria for Contraceptive Use, 2016 (US MEC)

The 2016 U.S. Medical Eligibility Criteria for Contraceptive Use (U.S. MEC) comprises recommendations for the use of specific contraceptive methods by women and men who have certain characteristics or medical conditions. The recommendations in this report are intended to assist health care providers when they counsel women, men, and couples about contraceptive method choice.

U.S. Selected Practice Recommendations for Contraceptive Use, 2016 (US SPR)

The 2016 U.S. Selected Practice Recommendations for Contraceptive Use (U.S. SPR) addresses a select group of common, yet sometimes controversial or complex, issues regarding initiation and use of specific contraceptive methods. The recommendations in this report are intended to serve as a source of clinical guidance for health care providers and provide evidence-based guidance to reduce medical barriers to contraception access and use.

Quality Family Planning

Providing Quality Family Planning Services (QFP) recommends how to provide family planning services so that individuals can achieve their desired number and spacing of children, increase the chances that a baby will be born healthy, and improve their health even if they choose to not have children.

http://wwwdev.cdc.gov/reproductivehealth/contraception/contraception_guidance.htm
Other Tools and Aids

- MEC Wheel
- Summary charts
- Continuing Education Activities
- Speaker-ready slides
- Contraceptive Effectiveness Charts
- Online alerts to receive updates
- eBook for SPR
The Quality Family Planning Recommendations (QFP) Integrate & Fill Gaps in Other Guidelines for the Family Planning Setting
• Key purposes are to:
  
  o Define *what* services should be offered in a family planning visit, and describe *how* to do so
  
  o Support consistent application of quality care across settings and provider types
  
  o Translate research into practice, so the most evidence-based approaches are used
  
• The intended audience is all providers of family planning services, including Title X grantees
Flow Diagram of Family Planning & Related Services

Determine the need for services

Reason for visit is related to preventing or achieving pregnancy

Initial reason for visit is not related to preventing or achieving pregnancy

Acute care
Chronic care management
Preventive services

If needed, provide services

Assess need for services related to preventing or achieving pregnancy

If services are not needed at this visit, re-assess at subsequent visits

Clients should also be offered these services, per recommendations

Contraceptive Services
Pregnancy testing and counseling
Achieving Pregnancy
Basic infertility services

STD services
Preconception health services

Related preventive health services

Preconception health services

STD services

Clients should also be offered or referred for these services, per recommendations
Resources


- Sign up to receive alerts!
Getting to Know Your Learning Community Colleagues: State and Territory Team Introductions (Round 2)

Kathy Vincent
Facilitator
Jane Gatimu
Tonia Calder
Paula Brown
South Carolina

Monty Robertson
Deborah Billings
Jane Key
Louisiana

Carolyn Wise
Lyn Kieltyka
Piia Hanson
Maryland

Stacey Little
Prema Ray
Charlotte Hagar
Molly Legrand
Texas

Lesley French
Evelyn Delgado
Tamela Griffin
Jan Realini
Commonwealth of the Northern Mariana Islands

Heather Santos Pangelinan
Irene Barrineau
Maria Hy
Helen Sablan
Washington

Cynthia Harris
Anaya Balter
Florida

Susan Speake
Michelle Spano
Janicka Harris
Jacqueline Murphy
Illinois

Shannon Lightner
Teresa Hursey
Sadia Haider
Kai Tao
Montana

Jennifer Rieden
Remarks from Dr. Wanda Barfield

Dr. Wanda Barfield
Director
Division of Reproductive Health
Centers for Disease Control and Prevention
State and Territory Team Action Planning: Session 1

Kathy Vincent
Facilitator
State and Territory Team Action Planning Session #1

- The following state teams will convene in Meeting Room 10/11, one level up.

- Lunch for these teams and their facilitators is available in Meeting Room 10/11

  Alabama
  Louisiana
  Wyoming

  Connecticut
  New Mexico
Getting to Know Your Learning Community

Colleagues: State and Territory Team

Introductions (Round 3)

Kathy Vincent
Facilitator
New Mexico

Janis Gonzales
Erica Archuleta
Abigail Reese
April Neri
Massachusetts

Jill Clark
Monica Le
Katherine White
Indiana

Art Logsdon
Martha Allen
Velvet Miller
California

Flojaune G. Cofer
Nomsa Khalfani
Karen Roque
Connecticut

Monica Jensen
Amy Gagliardi
Mark DeFrancesco
Robert Zavosky
Kentucky

Carrie Cotton
Samantha McKinley
Vaughn Payne
Joy Hoskins
West Virginia

Cathy Capps-Amburgey
Jennie Yoost
Sarah Young
Tracy Dlott
Wyoming

Danielle Marks
James Bush
Michael Nelson
Ashley Busacker
Qualitative and Evaluative Data Collection

Kristin Rankin, Assistant Professor, Division of Epidemiology and Biostatistics
Carla DeSisto, Maternal and Child Health PhD Candidate
Cameron Estrich, Community Health Sciences PhD Candidate
University of Illinois at Chicago School of Public Health
Evaluation Products:
2015 - 2016 ASTHO IPP LARC Learning Community

Kristin Rankin, PhD, Assistant Professor
Division of Epidemiology and Center for Excellence in Maternal and Child Health
University of Illinois at Chicago School of Public Health

ASTHO LARC Learning Community In-Person Meeting
October 27, 2016
2015-2016 Learning Community Evaluation Activities

• Participation in and facilitation of 2015 In-Person Learning Community Meeting

• Key Informant Interviews
  • Cohort 2 States: DE, IN, LA, MD, MT, OK, TX
  • Cohort 1 States: CO, GA, IA, MA, NM, SC

• Data Monitoring Tool Development
2015-2016 Learning Community
Key Informant Interviews

• One-hour semi-structured telephone interviews with teams
  ➢ Audio-recorded, externally transcribed, internally reviewed

• Organized by Domains:
  ➢ Eight ASTHO LARC Learning Community Domains
  ➢ Consolidated Framework for Implementation Research (CFIR)

• Coded for:
  ➢ Barriers
  ➢ Facilitators
  ➢ Implementation Strategies
2015-2016 Learning Community Evaluation Products

**Past products**

- Key Informant Interview Reports
  - Cohort 1 States
  - Cohort 2 States

- Published article in *MCHJ* documenting 2015 In-Person Meeting

- IPP LARC State Monitoring Tool

**Future products**

- Four peer reviewed articles reporting Key Informant Interview results (*in preparation*)
Long-Acting Reversible Contraception (LARC)

Long-acting reversible contraception (LARC) is safe and highly effective in preventing unintended pregnancies. Unlike other forms of birth control, LARC requires no user intervention, works over long periods of time, and can be reversed. LARC includes intrauterine devices (IUDs) and contraceptive implants that prevent ovulation.

ASTHO is working to identify the opportunities, challenges, and technical assistance needs of states through a multi-state learning community to improve the capacity of states to successfully implement LARC, particularly immediately postpartum.

Immediately Postpartum Learning Community

ASTHO launched the LARC Learning Community, a collaborative of six states, in August 2014 to assist state health agencies in implementing LARC, specifically via initiatives focusing on postpartum insertion following delivery. The following materials document the launch of years 1 and 2 of the learning community and the results of “key informant interviews” to assess challenges and barriers to increase LARC access.

Year 1 (2014)

- LARC Immediately Postpartum Learning Community Launch: full report | summary report | slide decks
- Findings from Key Informant Interviews: Cohort 1 Report

Year 2 (2015)

- LARC Immediately Postpartum Learning Community Launch: full report | summary report | slide decks
- Findings from Key Informant Interviews: Cohort 1 Report | Cohort 2 Report

Learning community call recordings and presentations

http://www.astho.org/Programs/Maternal-and-Child-Health/Long-Acting-Reversible-Contraception-LARC/
Application of Implementation Science Methodology to Immediate Postpartum Long-Acting Reversible Contraception Policy Roll-Out Across States

Kristin M. Rankin¹ · Charlan D. Kroelinger² · Carla L. DeSisto¹ · Ellen Pliska³ · Sanaa Akbarali³ · Christine N. Mackie³ · David A. Goodman²


Abstract  Purpose Providing long-acting reversible contraception (LARC) in the immediate postpartum period is an evidence-based strategy for expanding women’s access to highly effective contraception and for reducing unintended and rapid repeat pregnancy. The purpose of this article is to demonstrate the application of implementation science methodology to study the complexities of rolling-out policies that promote immediate postpartum LARC use across states. Description The Immediate Postpartum LARC Learning Community, sponsored by the Association of State and Territorial Health Officials (ASTHO), is made up of five state, territorial, and local partners and is guided by two experts in implementation science. These experts guided a 6-month project that involved consulting with community stakeholders, conducting an in-person meeting, and developing recommendations for policy implementation. Assessment To demonstrate the utility of this approach, we present a systematic assessment of the implementation science strategies used in the Learning Community. Conclusion Our findings suggest that these implementation science strategies can be applied to improve the roll-out of postpartum LARC policies across states.
Implementation Science Defined

Research focused on identifying, developing and refining effective and efficient…

- Methods
- Systems
- Infrastructures; and/or
- Strategies

…to disseminate and implement evidence-based public health interventions, policies, and clinical guidelines
Implementation Science Defined

Focused on identifying:

- **facilitators** of implementation;
- **barriers** to successful implementation; and
- **strategies** for overcoming barriers and improving implementation

Emphasis placed on importance of context
Consolidated Framework for Implementation Research (CFIR)

39 constructs within 5 domains

Damschroder, et al, 2009

http://cfirguide.org/index.html
CFIR: Intervention Characteristics

- Complexity
- Cost
- Design Quality/Packaging
Intervention Characteristics: Complexity

• **Complexity**: Perceived difficulty of implementation
  - Length: Number of sequential steps
  - Breadth: Number of choices presented at decision points
  - Number of target organizational units / types of people
  - Alteration of central work processes

• IPP LARC: Reimbursement policy structure and associated billing and coding
  - Unbundling of IPP LARC from delivery reimbursement (DRG)
  - Billing/coding system work-arounds at Medicaid and hospitals
  - MCOs and Fee-for-service; private insurers
CFIR: Process of Implementation

- Planning
- Engaging: Champions
- Reflecting/Evaluating
Process: Engaging Champions

- **Engaging (Champions):** Attracting and involving individuals through social marketing, education, role modeling, training, etc. who will “drive through” an implementation and overcome indifference/resistance in the organization.

- **IPP LARC:** Provider champions in birthing facilities
  - Inform and coordinate administration, pharmacy, nursing, and billing staff
  - Local, on the ground, steady force
  - Develop with education and trainings
CFIR: Inner Setting

- Networks and Communication
- Climate
- Structural Characteristics
- Readiness: Available resources
Inner Setting: Readiness (Resources)

- **Readiness for Implementation (Available Resources):** Tangible and immediate indicators of organizational commitment, including money, training, physical space, time

- **IPP LARC: Funding and Time**
  - **Barrier:** Lack of time for implementation team members to dedicate to efforts
  - **Facilitator/Strategy:** Leveraging resources from multiple sources to support staff members dedicated to IPP LARC initiative
    - Title V
    - Title X
    - Foundations
    - Perinatal quality collaboratives or other existing coalitions
CFIR: Outer Setting

- Patient Needs and Resources
- Cosmopolitanism
Outer Setting: Patient Needs/Resources

- **Patient Needs/Resources:** Patient-centeredness; extent to which patient needs are known and prioritized by addressing barriers

- **IPP LARC:** Diversity of patient needs for the following across different contexts within states
  - Education
  - Outreach
  - Informed consent
The Role of Social Networks in the Expansion of Immediate Postpartum Long-Acting Reversible Contraception Access

Cameron Estrich, MPH
PhD candidate, Community Health Sciences
University of Illinois at Chicago School of Public Health
Theme that emerged from qualitative data analysis of interviews with state teams.

Web of social relationships

Links to people may or may not provide

- Emotional support
- Tangible aid or services
- Information
- Constructive feedback and evaluation
Social Networks as Emergent Theme

- Within the state team
  - Bonding, cohesion and communication
  - Diverse make-up
  - Interlocking group memberships
- External working relationships
  - Existing partnerships
  - Bridging social ties
  - Learning Community as source of connections, bonding, support
Bonding Within Teams

- Formal communication:
  - Timelines
  - Responsibilities
  - Leadership

- Informal communication:
  - Physical proximity during working hours
  - In-person meetings
  - Previous or concurrent collaborations

“I definitely feel a little left out of the loop by those guys.”

“I appreciate the support from everyone. It’s nice to be part of the team, not just chugging away on our own and feeling a little bit helpless.”
Diverse State Teams

Diverse team makeup increases the likelihood of diverse, novel, non-redundant social networking ties

"[Dr.X] is our main clinical champion and sits as both a practicing OBGYN, a professor at [University] and then also the Medicaid medical director. She has a great reach through those three different professional streams."

"I was past president for the [Professional Organization]. That’s why I was asked to join in. Because of the rural nature, a lot of the providers throughout the state are family physicians. Not all are OB-GYN. They thought if they could bring in someone from [Professional Organization], then that would help."
Interlocking Networks

Individuals with multiple positions held concurrently

“I sit on another committee around [infant health in the state], and they’re doing some pilot work...could be at least a useful or interesting model to consider”

Resources

“[Person] was working at [health system]...She’s taken on a new role as the lead of the [State] plan for [non-profit].”

Shared vision

"We've been able to keep engaged a very broad mix of stakeholders, and we've been able to see improvements across broad areas that very much impact maternal child health outcomes."
Leverage Existing Relationships

Existing external ties can serve new purposes

“We built relationships between myself and the obstetrics department at our major hospital...to have somebody or entity that was willing to work with us and develop processes and work through the bugs, it was critical for getting this off the ground.”

“We actually have the [State] Perinatal Quality Improvement Collaborative...We can bring it to that group and they also get it out. They can also take it to their administrators...That’s an avenue that we do have.”

“I think it was fortuitous that the founder and CEO of [the NPO] also knows our governor...This partnership is really critical to our success.”

“We've tried to partner with [private insurers] for some stuff, and it's just not been real successful. A lot of the administration has changed at those insurance companies.”
Seek New Social Ties

- New connections can be sources of novel information or resources.

- “Actually [Person] is the one who—she told me about [the Learning Community].”
- “I just conducted some research on what other states were doing. I reached out to [Person] and got some feedback.”
- “I followed up with [Person] and she looped some folks in.”
- “I have dropped the ball. I will say that…”
Learning Community: Promote Network Weaving

Participating in the ASTHO Learning Community provided opportunities and encouragement to create new working relationships.

"There was a connection made there. It didn't go as far as we had hoped, but we wouldn't have known about that person if we hadn't been at that meeting...She helped us expand our network of clinicians that were interested and wanted to collaborate with us..."

"[The LC] encourages you to get the word out more to key people, try to find physician champions who think about LARCs in the same way you do, and wanna make them more available to the women that they care for. Without this [LC], I probably wouldn’t be out there having those conversations."
Learning Community: Source of Social Support

Team Bonding

“At our first meeting, our physician champion, [Dr. X] was there...She was probably about two and a half hours away from the rest of our team. [We] can interact on almost a daily basis. We’re in the same space on the same floor of the same building... It gave us time to really think through some things and talk. I think it was great to have her get to know us personally a little bit better, the whole team, and what our mission and vision was. “

Social Support

“I also appreciate kind of the commiseration. Not everything’s perfect. I think that it is really nice to be a part of the community where you actually hear other people’s struggles as well...I think that there’s value in that and hopefully it will help speed up the corrective actions that we can take because we can learn from others.”
Team bonding is essential to individual engagement, and resource and information coordination.

The make up of a team influences the variety of social networks it can draw on.

A single relationship can connect a team to novel information and resources.

Create or strengthen social networks to enhance implementation efforts.
Thank you!
Using a Multi-State Learning Community as an Implementation Strategy for Immediate Postpartum Long-Acting Reversible Contraception

Carla DeSisto, MPH
PhD student, MCH Epidemiology
University of Illinois at Chicago School of Public Health
Introduction: Implementation Strategies

- Byron Powell and colleagues have compiled and defined 73 evidence-based implementation strategies.
- Strategies can be used in isolation or combination.
Learning Community as a Strategy

- Theme that emerged from qualitative data analysis: Learning Community is a strategy for implementation.
- Create a multi-state learning collaborative (Powell et al 2015) = Learning Community
  - Facilitate the formation of groups of providers or provider organizations and foster a collaborative learning environment to improve implementation of the clinical innovation.
Learning Community as a “Meta” Strategy

- The structure of the ASTHO Immediate Postpartum LARC Learning Community helps integrate several other implementation strategies proposed by Powell et al:
  - Organize clinician implementation team meetings
  - Conduct educational meetings
  - Centralize technical assistance
  - Provide ongoing consultation
  - Distribute educational materials
  - Facilitation
  - Promote network weaving
Develop and support teams of clinicians who are implementing the innovation and give them protected time to reflect on the implementation effort, share lessons learned, and support one another’s learning.

In-person meetings provide a unique opportunity for the teams to work on their immediate postpartum LARC efforts, including creating action plans to prioritize their activities.
State Feedback on In-Person Meetings

“We spent quality time set aside to address this issue. You probably think we’re nuts but we’re also busy doing our other jobs. [The in-person Learning Community meeting] was the first time that we really got together and kind of strategized about what we thought we should do.”
Strategy: Conduct educational meetings

- **Hold meetings** targeted toward different stakeholder groups to teach them about the clinical innovation.
- Regular Learning Community webinars provide a forum for ongoing education.
- Webinars feature guest experts on topics related to Learning Community domains.
Strategy: Centralize technical assistance

- Develop and use a centralized system to deliver *technical assistance* focused on implementation issues.
- Use webinar technology that includes:
  - Chat box for participants to communicate with each other.
  - Poll questions for participants to give instant feedback to presenters.
  - Recording and archiving of the live presentation.
“One of the things I find helpful is the fact that [the webinars] are archived. I find in some of the presentations they’re a little further along than my thinking is. It’s nice to be able to go back when I get to that point to refer back and review that information.”

“I think the chat box in the presentations is always very helpful. A lot of things get asked or typed in or comments made that aren’t necessarily for the presentation but really adds to the value of the message.”
Strategy: Distribute educational materials

- Distribute *educational materials* in person, by mail, and/or electronically.
- States have developed toolkits, protocols, etc. and then shared them with ASTHO.
- ASTHO, in turn, shares these materials with the other states in the Learning Community.
“I have information [to share with hospitals] in an organized folder that has a very brief PowerPoint on why immediate postpartum LARCs are encouraged, information on billing Medicaid, information on a sample hospital policy, sample consents, information for pharmacy, the videos for the physicians…A lot of stuff that I got from the ASTHO learning collaborative are the pieces that I use. That is the other [benefit of the Learning Community], is really references and resources.”
A process of *interactive problem solving and support* that occurs in a context of a recognized need for improvement and a supportive interpersonal relationship.

The webinars and in-person meetings that are hosted by ASTHO foster the sense of a supportive team across the country.
“I think the connections to folks outside of the actual calls or meetings has been very helpful...I also appreciate the commiseration. Not everything’s perfect. I think that it is really nice to be a part of the community where you actually hear other people’s struggles as well...Right now we’re even dealing with some issues with reimbursement that are very reminiscent of the things that we heard [another state] say. Even having had that relationship and having seen that presentation we find ourselves having a similar problem...It’s nice to know that you’re not alone even if it feels a little bit different and there are nuances in each case that make them sort of unique. At the same time it is nice to be able to commiserate with others. I think that there’s value in that and hopefully it will help speed up the corrective actions that we can take because we can learn from others.”
Identify and build on existing high-quality working relationships and networks within and outside the organization to promote information sharing, collaborative problem-solving, and a shared vision/goal related to implementing the innovation.

Most Learning Community state teams include representatives from the state Medicaid agency and the state health department, and many of these agencies do not traditionally work together.

The in-person Learning Community meetings and the webinars often include representatives from national partner agencies, such as AMCHP, CMS, and ACOG.

State teams have many opportunities, including through the in-person meetings and webinars, to network with each other.
“Not only the states represented, but some of the other organizations, from ACOG and CMS and AMCHP and all the other organizations, that were there...was really valuable so that they can hear some of what’s going on in states, and states can pick their brains a little bit, too. It’s also helpful to get on the same page so that different organizations aren’t going down different paths. I think in addition to the states, having those national organizations present really makes a big difference.”
Strategy:
Provide ongoing consultation

- Provide *ongoing consultation* with one or more experts in the strategies used to support implementing the innovation.

- Experts who participate in the in-person meetings and webinars include state team members and individuals from national agencies.
“[State A] and [our state] have had lots of offline conversations about the various LARC programs and LARC training programs. That’s an important piece to document is some of those connections made and offline conversations.”
Other Ways Learning Community Supports Implementation

- The **structure and accountability** of being part of a national learning collaborative helps state teams get support from their leadership and prioritize their work around immediate postpartum LARC.

- Working with other states and national organizations helps give **validity** to the work that teams are doing around immediate postpartum LARC.

- Including states at varying stages of implementation helps states **prepare** for potential challenges and opportunities of the future.
The ASTHO Immediate Postpartum LARC Learning Community serves as a package of implementation strategies.

ASTHO serves as a convener; its staff fosters the activities that take place.
Setting the Stage for Evaluation - What to Expect Over the Next Year

Christi Mackie
Senior Director, Family and Child Health
Association of State and Territorial Health Officials
At a Glance – Evaluating the Learning Community

1. Pre-and post survey for participants
2. Conduct key informant interviews for the new Cohort 3 states entering the *Increasing Access to Contraception Learning Community*
3. 2 TA calls to capture qualitative data to support the evaluation of the project
4. Utilize the logic model to conduct a complete process evaluation of this year’s learning community
5. Develop assessment and evaluation tools for participating states and territory to monitor policy uptake and lessons learned/barriers
Snapshot: Process Evaluation

Outputs
- Key Informant Interviews
- Tool Kits for States to Assess Progress
- TA Check-ins
- State Success Stories

Short-Term Outcomes
- Est./Improved Policies
- Increased Access to Contraception Across States
- Improved Knowledge, Approaches, and Practices
- Increased National, State, and Local Partners Informed and Mobilized

Intermediate Outcomes
- Increased Positive Client Experiences with Healthcare System
- Improved Satisfaction with Chosen Contraception
- Increase Voluntary Uptake of Effective Contraceptive Methods
- Decreased Administrative and Logistical Barriers Associated with LARC
Increasing Access to Contraception Learning Community

What assessment/evaluation tools would be most useful for your teams?
Wellness Break

Kathy Vincent
Facilitator
Leveraging and Learning Session
Communicating Barriers and Challenges, Sharing Strategies and Solutions: A Topical Group Discussion

Kathy Vincent
Facilitator
Topical Group Discussions

- Provider Topic Groups (Red Dot and Red Star) will convene in Meeting Room 10/11, one level up.

- Remaining topic groups will meet here
  - Adolescent: Neon Orange Dot
  - Coding and Billing: Gold Star
  - Data, Monitoring, and Evaluation: Silver Star
  - FQHC: Neon Yellow Dot
  - Hospital: Clear Yellow Dot
  - Medicaid: Green Dot, Green Star
  - Rural: Neon Red Dot
  - Patient Outreach & Education: Blue Dot, Blue Star
Group Reports and Facilitated Discussion

Kathy Vincent
Facilitator
Wrap Up and Plans for Day 2

Kathy Vincent
Facilitator
Agenda – Day 2

7:30 Breakfast Served
8:15 Welcome
8:45 State and Territory Team Action Planning #2
10:15 Accessing Expertise, Tools and Resources: A National Partner Panel Discussion
11:15 Wellness Break
12:45 State and Territory Team Report Out – Working Lunch
2:15 Making Connections Discussion
3:00 Wrap Up
3:15 Adjourn