ASTHO Increasing Access to Contraception Learning Community Virtual Learning Session

December 20, 2016
2:00-4:00p ET
For Audio: 866-740-1260, ext. 7428625#
Welcome and Introductions

Welcome from ASTHO

- Lisa Waddell, MD, MPH
  Community Health and Prevention Chief
Webinar Objectives

- Demonstrate the utility of contraceptive desert maps and other tools for states to enhance access to all forms of contraception.

- Describe how Tennessee’s work to link methadone and reproductive health clinics enhances access for substance users of reproductive age.

- Identify steps and strategies for increasing access to contraception for incarcerated populations, with an eye towards reproductive justice.

- Introduce the UIC Team and steps that will be taken to evaluate the learning community.

- Discuss state plans and progress to improve increasing access to contraception for specific populations.
Agenda

2:00   Welcome and Introductions
2:15   National Campaign Birth Control Access Map
2:35   Linking Methadone and Contraception Clinics in Tennessee
2:55   Incarcerated Populations and Access to Contraception
3:15   Evaluating the Increasing Access to Contraception Learning Community
3:30   State Updates: California and West Virginia
3:45   Next Steps
3:50   Closing
4:00   Adjourn
The National Campaign
Mapping Birth Control Access

Liany Arroya, MPH, CPH
Senior Director of Health Equity

Lawrence Swiader, MA
Vice President of Digital Media

The National Campaign to Prevent Teen and Unplanned Pregnancy
2026 GOALS

- Reduce the teen pregnancy rate by 50% by 2026.
- Reduce the rate of unplanned pregnancies among 18-29 year olds by 25% by 2026.
- Reduce the racial/ethnic disparities in teen and unplanned pregnancy rates by 50% by 2026.
- Reduce the socioeconomic disparities in teen and unplanned pregnancy rates by 50% by 2026.
BIG BETS

• Make it the norm among young people to act consistently with their decisions about when, if and under what circumstances to get pregnant.

• Ensure that all young people have a trusted adult or social network with which they can discuss sex, relationships, and their futures.

• Ensure that everybody has reliable, resonant, and accurate information about sexual health, including all contraceptive methods.

• Ensure that everybody has full access to the full range of contraceptive methods within 60 minutes of where they live.

• Make pregnancy planning standard practice in settings influential in the lives of young people, such as education.
Mapping Birth Control Access
ANY BIRTH CONTROL ACCESS BY COUNTY

More than 5000 in need with no access.
ANY BIRTH CONTROL ACCESS BY COUNTY

Fewer than 1000 women served per clinic, “reasonable access.”
ANY BIRTH CONTROL ACCESS BY COUNTY

Total Number of Counties in the U.S: 3,142
Counties that lack “reasonable access”: 1,533
ACCESS TO THE FULL RANGE OF BIRTH CONTROL
ACCESS TO THE FULL RANGE OF BIRTH CONTROL

Total number of women in need of publicly funded contraceptive services in the U.S: 20,017,990
ACCESS TO THE FULL RANGE OF BIRTH CONTROL

Women in need who lack reasonable access: **19,765,530**
ACCESS TO THE FULL RANGE OF BIRTH CONTROL

1 in 50 women in need in the U.S. have the access they need.
Total number of counties in U.S. that lack access to a single clinic with the full range of methods: 1,679
A SCALABLE SOLUTION = BETTER BIRTH CONTROL
BETTER BIRTH CONTROL INITIATIVE

GOALS

• Dissemination and adoption of a best practice framework that addresses the policy, systems, and practice levers to ensure quality contraceptive access across a state or a region.

• Training and technical assistance to support state and regional initiatives to increase access to the full range of contraceptive methods.

• An online, one stop assessment and resource hub to support states and regions working to ensure access to the full range of contraceptive methods.

• National learning collaborative and strategic communications support to catalyze quality replication and resource sharing.
BETTER BIRTH CONTROL BEST PRACTICE DOMAINS

• Fundamental Supports
• Policy
• Communications & Education (Demand)
• Clinical Policy & Practice
• Health Equity & Cultural Competency
QUALITY IMPROVEMENT PROCESS

- Convene a representative state/regional coalition
- Assess current status of policies, systems and practices
- Establish state/regional priorities
- Develop a Blueprint for Action
- Implement
- Measure and celebrate success
DEVELOPMENT PROCESS

• Input and guidance from more than 50 leading experts in reproductive health and family planning.

• Worked with communities currently undertaking this work:
  • Baltimore, MD
  • Washington, DC
  • South Carolina

• Dynamic and inclusive process.
SUSTAINABLE AND SCALABLE

- Community led
- Early identification and inclusion of existing assets and resources
- Flexible to fit community context
- National infrastructure allows for refinement and continued improvement across sites in a coordinated way
QUESTIONS AND DISCUSSION
Linking Methadone and Contraception Clinics in Tennessee

Morgan F. McDonald, MD, FAAP, FACP
Assistant Commissioner and Director
Division of Family Health and Wellness
Tennessee Department of Health
Language and Location: Family Planning Strategies to Meet Emerging Public Health Priorities

Morgan McDonald, MD - Assistant Commissioner, Family Health and Wellness | December 20, 2016
Discuss ways in which the Tennessee Department of Health has conceptualized and communicated family planning opportunities to meet the changing needs of its residents.
Challenges and Opportunities

• Neonatal Abstinence Syndrome
• Zika and neurologic birth defects
• Infant mortality
• Unintended pregnancy
• Awareness of family planning services
• Support for family planning services
Neonatal Abstinence Syndrome Surveillance
November Update (Data through 12/03/2016)

Cumulative Cases NAS Reported

Maternal Source of Exposure

- **Unknown**: 1.0%
- **Prescribed only**: 53.7%
- **Only illicit or diverted**: 19.6%
- **Mix of prescribed and non-prescribed**: 25.7%

Week
TDH NAS Strategy

• Decrease Opiate Supply
  • Controlled Substance Monitoring Database (CSMD)
  • Regulation/Oversight of Pain Clinics and Prescribers
  • Count It! Lock It! Drop It!
  • Enforcement
• Neonatal Abstinence Syndrome (NAS) surveillance
  • Mandatory provider reporting
  • Monthly reports shared publicly and with partners
• NAS subcabinet
  • Innovative Family Planning Partnerships
Family Planning Partnerships

- Extending education and family planning services to non-traditional sites through partnerships
  - Jails
  - MAT clinics
  - Pharmacists
- Focus on highest risk population
- Minimize barriers to effective contraception when desired, recognizing particular cultural and system barriers to long acting contraception
Statewide replication of jail partnerships

*image courtesy of Jana Chambers
43 counties had no change or a decrease in rate between 2013 and 2015.

Infant Mortality, Tennessee

Drivers:
- 56% < 37 weeks
- 78% < 2500 grams
- 25% sleep related
Infant Mortality Reduction Initiatives

• Community based collaborations
• Provider based initiatives
  – 17P
  – Birth spacing
  – Group prenatal care
• Hospital partnerships
  – Early elective delivery
  – Quality collaborative
• Safe sleep campaign
• Breastfeeding
Zika and Neurologic Birth Defects

- Messaging effective methods of contraception for those wishing to delay pregnancy
- Messaging barrier protection following any potential exposure
- Community round tables
- Direct Services
Pregnancy Intention, Tennessee 2011-14

Data source: Tennessee Department of Health; Division of Policy, Planning and Assessment; Pregnancy Risk Assessment Monitoring System (PRAMS).
Family planning funding utilization

- Sources: Title X, service reimbursement, Medicaid infant mortality funding, MCH
- Organization
  - Direct reporting and funding structure with rural health departments
  - Contracts with 5 metro health departments
  - Partnerships with professional associations, CHCs
- Provider training in device placement and client counseling (health dept and external)
- Public messaging
- Provider outreach (state associations, directly to MAT)
Key Messages

- **Voluntary Reversible Long-Acting Contraception**
  - Language to communicate to clients, funders, stakeholders
  - Importance of including spectrum of options with personalized, tiered-effectiveness approach to contraception

- Flexible approach (jails, hospitals, MAT providers)

- Essential nature of services

- Facilitated conversations
  - Recognizing key priorities, partners, drivers, and barriers
  - Emerging priorities: same day and immediate post-partum VRLAC access, development of pharmacy partnership opportunities
Questions?

Morgan McDonald, MD, FACP, FAAP
Assistant Commissioner
Director, Division of Family Health and Wellness
Morgan.mcdonald@tn.gov
Incarcerated Populations and Access to Contraception

Rebecca Dineen, MSc
Assistant Commissioner
The Bureau of Maternal and Child Health
Baltimore City Health Department
Meeting the Needs of Baltimore’s Most Vulnerable Women

Rebecca Dineen  
Assistant Commissioner, Maternal and Child Health  
Baltimore City Health Department
Acknowledgements

- Wexford Health
- Baltimore City Detention Center
- HealthCare for the Homeless
- Herman Kelly, RN
- Carolyn Sufrin, MD, PhD
- Stephanie Regenold, MD, MPH
- Shelly Choo, MD, MPH
- Jen Kirschner, MSPH
- Isaac Howley, MD, MPH
- Xaviour Walker, MD, MPH
Baltimore in 2009

- 127 babies died
- 102 mothers had stillbirths
- Black babies died 5 times the rate of white babies

Now we have 10 empty second grade classrooms this year
All of Baltimore’s babies are born at a healthy weight, full term, and ready to thrive in healthy families.
B’more for Healthy Babies Goals

More babies surviving to their first birthdays:
- Babies born full term and healthy weight
- Deaths from unsafe sleep

Help women and families:
- Advocate for themselves
- Feel able to become healthy
- Improve education and literacy
- Be healthy and strong, even when bad things happen

“ALONE WE CAN DO SO LITTLE; TOGETHER WE CAN DO SO MUCH.”
- Helen Keller
How Well Are We Doing?

2009: 127
2015: 88
How Well Are We Doing?

27 died from unsafe sleep

2009

13 died from unsafe sleep

2014

7 died from unsafe sleep

2015
25% of Women in our System are Unable to be Located

Composite Indicator Analysis
Quantifying Risk for Poor Birth Outcomes, 2010-11

Women Discharged as Unable to Locate: Clients who Tiered to Vulnerability Index HCAM, CY2013

Legend
Risk Score
-33.00 - -11.00
-10.99 - -1.00
-0.99 - 5.00
5.01 - 13.00
13.01 - 22.00
Categorized by Quintile

Legend
Rate of UTL (tiered) by CSA per 100 live births (2012)
0.00 - 4.00
4.01 - 7.00
7.01 - 9.00
9.01 - 11.00
11.01 - 16.00
Categorized Manually Comparable to UTL NoTier Map CY2013
Rate Not Calculated

Prepared by Baltimore City Health Department Bureau of Maternal & Child Health

Source: Health Care Access Maryland, Insight Database 2013
Prepared by Baltimore City Health Department, Bureau of MCH
These are the SAME communities with our highest unable to locate population and our highest infant mortality rates.
MARYLAND INCARCERATION RATES BY RACE/ETHNICITY, 2010

(Number of people incarcerated per 100,000 people in that group)

- **White**: 310
- **Hispanic**: 311
- **Black**: 1,437

Source: Calculated by the Prison Policy Initiative from U.S. Census 2010 Summary File 1. Incarcerated populations are all types of correctional facilities in a state, including federal and state prisons, local jails, halfway houses, etc. Statistics for Whites are for Non-Hispanic Whites.
Opportunity

- **72%** of women surveyed had no consistent birth control\(^1\)
- **60%** of women wanted to initiate contraception in custody\(^2\)
- **85%** of women surveyed plan to be sexually active when released\(^1\)
- **70%** of detention centers with no policy on family planning and reproductive health
- **38%** of providers offered any contraception and counseling
- **11%** of centers provide counseling prior to release

---

1. Clarke 2006 AJPH 2. LaRochelle 2012 J Corr Health Care
88% of Female Detainees are of Reproductive Age

Age Distribution of Female Detainees in Detention

Over 40% of Women with a Fetal or an Infant Loss Have Been Incarcerated
Female Detainees in BCDC (Windows study 2005)

- 200-300 at intake and discharge every month
- **Race:** 70% African American, 16% White
- **Education:** 47% No education, 31% HS diploma, 15% GED
- **No. close family members:** 0: 8%, 1-2: 30%
- **Sexual orientation:** 11% Lesbian, 20% bisexual
- **Recent sex work:** 34%
- **Ever overdosed:** 30%
Feasibility assessment

- Develop partnership and detailed detainee clinic flow
- Review existing policies, administrative records, and formularies
- Conduct staff surveys
- Detainee surveys
  - Demographics
  - Substance use
  - Reproductive history
  - Contraception
- Detainee focus groups
  - Access to healthcare
  - Attitudes on contraceptives
  - Personal health priorities
WDC detainee flow - intake

Arrest

BCBIC ~700/mo

Nurse screening

At risk for pregnancy

Pregnancy test

Injured/sick

H

Hospital

Not pregnant

Pregnant

avg. 7.5 intakes/mo

≤12 weeks, no issues

≥13 weeks, or medical risk

Infirmary

~2 deliveries/yr

Released on bail/own recognizance

General Population

~225/mo committed

“Not at risk for pregnancy”

"Not at risk for pregnancy"

~225/mo committed

committed
WDC detainee flow – release planning

Detainees (in Gen Pop or infirmary) → Medical exam

Within 7 days

Court → Sentenced to XX days at BCDC*

List of sentenced detainees & release dates given to release planner (Herman Kelley, RN)
200-300, men + women, 2-3x/wk

Detainees

Released

Released

Medical exam

Identified medical issues

No identified medical issues

Release planning:
- Medicaid enrollment
- Clinic appointments
- Health information transfer
- Rx drugs and devices
Feasibility Assessment

- Conducted three focus groups with a total of 22 WDC detainees
- Surveyed 116 women
- Average participant was age 29.5 (range: 19-44).
- Over 60% will be caring for at least one child after release
- Medical staff members were also convened
Findings

- **Detainees have unmet family planning needs**, upon both entry and release.
  - Although more than half of women surveyed planned to be sexually active with a male upon release, **62% did not want to be pregnant in the next year**
  - 24% reported they used a reliable form of birth control prior to arrest
  - 20 of the women surveyed would have qualified for emergency contraception (EC) upon arrival to the WDC, based on when they last had unprotected intercourse.
  - Approximately 44% of women said they would take EC at intake if it were available and indicated.
## Findings

<table>
<thead>
<tr>
<th>Indicator</th>
<th># (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>LARC should be available/offered in jail</td>
<td>92 (79.3%)</td>
</tr>
<tr>
<td>Women can easily get LARC removed in community</td>
<td>98 (84.5%)</td>
</tr>
<tr>
<td>Personally interested in starting or continuing any birth control method while in jail</td>
<td>30 (25.9%)</td>
</tr>
<tr>
<td>Personally interested in starting LARC method in jail</td>
<td>30 (25.9%)</td>
</tr>
<tr>
<td><strong>Reason:</strong> Want to avoid pregnancy at least a year after release</td>
<td>17 (56.7%)</td>
</tr>
<tr>
<td>Not personally interested in getting LARC in jail</td>
<td>64 (55.2%)</td>
</tr>
<tr>
<td><strong>Reason:</strong> Side effect concerns</td>
<td>26 (40.6%)</td>
</tr>
<tr>
<td><strong>Reason:</strong> Do not trust jail staff</td>
<td>21 (32.8%)</td>
</tr>
<tr>
<td><strong>Reason:</strong> Want to be pregnant in the next year</td>
<td>19 (29.7%)</td>
</tr>
<tr>
<td><strong>Reason:</strong> Know someone who had bad experience</td>
<td>14 (21.9%)</td>
</tr>
<tr>
<td>Participant would take EC at intake if it were available and indicated</td>
<td>51 (44%)</td>
</tr>
</tbody>
</table>
Preconception counseling and education on how to have a healthy pregnancy is particularly needed.
  - During the focus groups, many women expressed interest in learning how to have a healthy pregnancy.
  - Close to 30% of those surveyed wanted to be pregnant within a year upon release.

Medical staff was overall supportive of increasing on-site reproductive health education and services.
Priority Strategies

#1 Continue Health Education for Women and Men in Detention – Build Trusting Network

#2 Increase Health Navigation Services Community Health Detention Center Liaisons + Resource Materials
Trauma-Informed Care

#3 Increase Equity in Access to Reproductive Health Services
Next Steps

• RFP for health services now includes these recommendations
• Ensure policy changes are integrated and implemented
• Work with incoming contractor (trauma/racism training, reproductive health, etc.)
• Offer Continuing Health Education and Materials
• Ensure every Detainee Receives Resource Card
References

Thank you!

Every Baby Counts on You!

Every baby counts on you.
Questions?
Evaluating the Increasing Access to Contraception Learning Community

Kristin Rankin, PhD
Assistant Professor
Division of Epidemiology and Biostatistics and Center of Excellence in Maternal and Child Health
University of Illinois at Chicago - School of Public Health
Increasing Access to Contraception
Learning Community
Evaluation Plan

Kristin Rankin, PhD
Assistant Professor

Division of Epidemiology and Biostatistics and
Center of Excellence in Maternal and Child Health

University of Illinois at Chicago
School of Public Health
Evaluation Team

Kristin Rankin, PhD, Principal Investigator
Keriann Uesugi, PhD, Co-Investigator

Carla DeSisto, MPH Doctoral Res. Asst.

Cameron Estrich, MPH Doctoral Res. Asst.

Paula Satariano Masters Research Assistant
Evaluation Questions

- What are the major barriers preventing access to the full range of contraceptive methods across Learning Community states and territories?

- What strategies (within the nine ASTHO focus areas) are being employed by Learning Community teams to increase access to the full range of methods across their states/territory?

- By the end of Year 1, to what extent have learning community teams made progress on or met the goals established in their state action plans?

- By the end of Year 1, has progress been made on process indicators within the nine focus areas, such as policy development, partnership engagement, and data availability/use, since before the launch of the expanded Learning Community?
Evaluation Activities

- Participation and Observation at Learning Community Meetings and Virtual Learning Sessions

- Pre/Post Online Survey
  - January 2017 / Summer 2017

- Key Informant Interviews – Cohort 3 State Teams
  - January – March 2017

- Observation during Technical Assistance Calls
  - Tracking progress on Action Plan goals

- Framework and plan for future Outcome Evaluation
Evaluation Products

- **State Contraception Data Monitoring Tool**
  - Contraceptive measures from claims data
  - Measure bank for state-initiated data collection efforts

- Report of key informant interview themes

- Final report of all process evaluation activities

- Learning Community and scientific meeting presentations; peer-reviewed manuscripts
Questions/Suggestions?

Kristin Rankin, PhD
krankin@uic.edu
Increasing Access to Contraception
Webpage Updates

Ellen Pliska
Director, Family and Child Health
Association of State and Territorial Health Officials
Website Redesign

MATERNAL AND CHILD HEALTH

Increasing Access to Contraception
ASTHO is identifying state opportunities, challenges, and technical assistance needs through a multi-state learning community to improve their capacity to increase access to contraception.

State Initiatives to Increase Access to Contraception
This clickable map contains resources for U.S. state and territorial health agencies for increasing access to contraception to promote better health outcomes. See map »

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)
State Initiatives to Increase Access Map

COLORADO

Colorado joined the Increasing Access to Contraception Learning Community in August of 2014 as part of Cohort 1.

ASTHO Learning Community Resources
Webinar Presentation: Colorado Provider Training, July 25, 2016; 19:03
Webinar Presentation: Colorado Service Locations, March 31, 2016

State Work
Colorado Women and Health Statistics and Services Fact Sheet (CDC)
Hospital Providers Immediate Post-Partum LARC October 2013
Hospital Providers Immediate Post-Partum LARC November 2013
Post Placental IUD Patient Education
Protocol for Post Placental IUD Insertion
Website Redesign

Please send your state’s materials to
ContraceptiveAccess@astho.org

Future changes:
- State map pop-ups will include a summary of your state’s work
- Reorganization of the landing page
- Searchable database of materials
State Reports:

CA

WV
Vision Statement

- Enabling the environment and systems so that any woman, man or youth can walk through any door and have their sexual and reproductive health needs met

**Goal #1:** Build upon the existing Preconception Health Council of California network to improve collaboration of partners working to increase access to contraception in the state of California

- Important to solidify a coalition that is proactive not reactive
- Vision for this coalition is to work coordinated manner
- Ongoing, roles shift

**Strategy #1:** Identify synergies, existing resources, redundancies, and priorities over the next year
Goal #2: Create a comprehensive plan to address the needs of reproductive and sexual health deserts

- Identify geographic areas with high need for reproductive health services
- Cross reference high need areas with population density and unmet needs (UIP rates, STI rates, teen pregnancy rates, high school non-completion, incarceration)

Strategy #1: Identify the root causes and strategies to address needs of health care deserts over the next year
Goal #3: Increase consumer awareness of the contraceptive benefit and ancillary services

- One of the challenges of contraception access is perceived cost and burden
- Consumers are unaware of the existence of the birth control benefit (no cost sharing), the well women visit (no cost sharing), the 12 month supply benefit, Freedom of Choice Act
- Communication strategies focused on ages 15 -24

- Strategy #1: Develop a statewide communications campaign that is fresh, simple, and youth focused (ages 15-24)
WEST VIRGINIA
ACTION PLAN TO “MARRY” LARC WITH SUBSTANCE USE DISORDER

- Cabell County Drug Court partnering with Marshall University School of Pharmacy and the Marshall Department of OBGYN
  - Provide LARC methods to women with history of substance abuse.
- Women in the drug court complete a program with multiple education initiatives (e.g. contraceptive counseling).
- Marshall OBGYN physicians and staff available during contraception counseling session
  - Answer questions about LARC methods and register women for appointments.
- Goal: Decrease unintended pregnancy and NAS through primary prevention.
WEST VIRGINIA

- Health Right in Morgantown has a needle exchange program
  - Monongalia Health Department may start similar program.

- West Virginia University now offering a family planning clinic 2 Thursdays per month
  - Same day Chestnut Ridge (Behavioral Health Hospital) has group counseling sessions for pregnant women.

- During group counseling a women's health nurse provides education on contraception and schedules appointments.

- Patient navigator for the ACES Program helps women attend their family planning appointments.
FPP reached out to Cabell-Huntington Health Department about providing family planning education during the needle exchange time period.
- Clinician at that clinic has been trained in LARC insertions and could provide those on site.

Kanawha County Health Department’s Needle Exchange Program provides contraception counseling and access to LARC.

Contraception counseling has been incorporated into the roundtable discussion at the Maternal Addiction Recovery Center at Marshall.
- Reaching out to the OB/GYN provider champions identified at other teaching institutions to see if this is happening elsewhere.
Jefferson County Drug Court - staff there are interested in partnering with us to provide contraception counseling and access.

- Drug Court has a robust program which also incorporates telepsychiatry and MAT (Medication Assisted Treatment).

Drug Court is working on a program to have Vivitrol available upon release from the Eastern Regional Jail

- Potentially available for pre-trial inmates or those that are incarcerated for a probation and/or parole violation.

Project ECHO is a program which started in New Mexico and is similar to Grand Rounds and is currently focusing on MAT.

- In cases where women of childbearing age, pregnant members or new mothers with substance use disorder are discussed there is an opportunity to discuss LARC.
Increasing Access to Contraception Learning Community

Next Steps

Ellen Pliska
Director, Family and Child Health
Association of State and Territorial Health Officials
Next Steps

- **January:**
  - Scheduling TA & Key Informant Interview calls
  - Pre-Survey – Online

- **Late January – March**
  - Cohort 1 & 2 TA and Action Plan Status Calls: 30 minutes
  - Cohort 3: TA, Action Plan Status, and Key Informant Interview Calls: 90 minutes

- **February 14, 2:00-4:00p ET**
  - 2nd Virtual Learning Session
Closing

Charlan D. Kroelingor
Division of Reproductive Health, CDC

Lekisha Daniel-Robinson
CMCS Maternal and Infant Health, CMS

Lorrie Gavin
Office of Population Affairs

asthoh"
Evaluation

Please take our evaluation survey so we can improve for future calls:

http://astho.az1.qualtrics.com/SE/?SID=SV_bsh0QInsShnqNYV
Thank you!!

Additional tools, materials and recordings available on the ASTHO Increasing Access to Contraception page:

http://www.astho.org/Programs/Maternal-and-Child-Health/Long-Acting-Reversible-Contraception-LARC/

State map: