Welcome and Introductions

Welcome from ASTHO

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

- Describe how to support provider training on coding procedures. (Focus Area 1: Provider Awareness and Training)

- Recognize training needs for providers and staff that provide care to migrant and immigrant populations (Focus Area 1: Provider Awareness and Training; Focus Area 9: Special Populations)

- Identify telehealth training methods for rural and frontier providers. (Focus Area 1: Provider Awareness and Training)

- Discuss how to train community health aides that provide contraceptive access in rural, frontier, and tribal areas. (Focus Area 1: Provider Awareness and Training; Focus Area 9: Special Populations)

- Review technical assistance requests and next steps.
2:00  Welcome and Introductions
2:15  Fundamental Objective of Coding
2:35  Access to Contraceptive Care for Migrant and Immigrant Women
2:55  TeleECHO Training Program – New Mexico
3:15  Community Health Aide Program - Alaska
3:30  Report on Technical Calls
3:45  Next Steps
4:00  Adjourn
ASTHO Increasing Access to Contraception Learning Community

Learning Community Cohort 1 States
Learning Community Cohort 2 States
Learning Community Cohort 3 States
Partners: ACOG, AMCHP, AWHONN, NACCHO, NFPRHA
Agencies: CDC, CMS, OPA
The Fundamental Objective of Coding

Mike Policar, MD, MPH
Clinical Professor
University of California, San Francisco
ASTHO Contraception Learning Community
April 25, 2017

Coding of Family Planning Visits

Michael S. Policar, MD, MPH
Clinical Professor of Ob, Gyn, RS
UCSF School of Medicine
policarm@obgyn.ucsf.edu
What Is the *Fundamental Objective* of Coding?

- **Provider**
  - To prepare a standardized “bill” for services given to a patient

- **Payer**
  - To determine the amount to be paid to the provider (based on contracted rates)....
  - For medically necessary services....
  - That are a benefit of the payer’s health plan....
  - And supported by documentation
Codes Numbers Tell A Story

<table>
<thead>
<tr>
<th>Encounter content</th>
<th>Code book</th>
</tr>
</thead>
</table>
| What              | • Services performed  
                   | • Drugs, supplies provided  
                   | • CPT  
                   | • HCPCS II |
| Why               | • Diagnoses  
                   | • ICD-10-CM |
| Additional Explanation | • Modifier  
                   | • CPT |

• To establish medical necessity, for every *what* there must be a *why*
• Unusual circumstances explained with *modifier*
Uses of ICD-CM Claims Data

- Establish medical necessity
- Performance metrics
- Case finding
- Severity risk adjustment (burden of illness score)
- Public health statistics (cancer registry)
- Inaccurate ICD coding can result in
  - Denied claims
  - Patient erroneously thought to have disease; could result on loss of insurance, discrimination
Case Study 1: Family Planning Health Screening Visit

- Ms. B, a 17-year-old established patient seen for initiation of contraception and “annual visit”
- Menses are regular; no complaints
- Sexual debut 6 months ago; 2 lifetime partners
- BP checked; vaginal self-swab for GC/Ct NAAT
- FTF time: 29 minutes. Counseling time: 18 minutes
- Dispensed 9 norelgestromin/ethinyl estradiol transdermal patches
Outpatient Coding: Basic Questions

1. Is the patient new, established, or a consult?

2. Which procedures were done?
   - Office surgical procedures
   - Office laboratory tests or imaging studies done
   - Drugs administered or devices inserted
   - Billable supplies
Outpatient Coding: Basic Questions

3. Which visit type and level of E/M?
   – Problem-oriented office visit
   – Office consultation
   – Preventive service

4. What is the (ICD-10) diagnosis for each CPT (+E/M)?

5. Which modifiers are necessary, if any?
Two Methods to Calculate E/M Level

- Composite of 3 key components

Or

- Time

1 method doesn’t fit all visits
E/M: Time Based Method

- Time can be used when
  - > 50% of clinician’s total Face-to-Face (FTF) time with patient is spent on counseling and coordination of care
- MUST document in the medical record
  - Total duration of encounter
  - > 50% of time is spent counseling
### Problem Oriented E/M: Face-to-Face Time “Midpoints”

<table>
<thead>
<tr>
<th>New</th>
<th>Time (typical)</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>≤ 15 (10)</td>
</tr>
<tr>
<td>99202</td>
<td>16-25 (20)</td>
</tr>
<tr>
<td>99203</td>
<td>26-37 (30)</td>
</tr>
<tr>
<td>99204</td>
<td>38-53 (45)</td>
</tr>
<tr>
<td>99205</td>
<td>&gt; 53 (60)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Established</th>
<th>Time (typical)</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>≤ 7 (5)</td>
</tr>
<tr>
<td>99212</td>
<td>8-12 (10)</td>
</tr>
<tr>
<td>99213</td>
<td>13-20 (15)</td>
</tr>
<tr>
<td>99214</td>
<td>21-33 (25)</td>
</tr>
<tr>
<td>99215</td>
<td>&gt;33 (40)</td>
</tr>
</tbody>
</table>
E/M: Preventive Medicine Services

• Components
  – Comprehensive history and exam (as indicated)
  – Counseling, anticipatory guidance, risk reduction
  – Order lab, diagnostic procedures
  – Address insignificant or trivial problem(s)

• F-to-F time, physical exam components *are not used*

• Indicate immunizations with separate codes

• If additional work-up for pre-existing or new problem, may add problem-oriented E/M (-25)
### E/M: Preventive Medicine Services

- **Preventive medicine:** "check-up" visit

<table>
<thead>
<tr>
<th>Age</th>
<th>New patient</th>
<th>Established</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-17 yrs old</td>
<td>99384</td>
<td><strong>99394</strong></td>
</tr>
<tr>
<td>18-39 yrs old</td>
<td>99385</td>
<td>99395</td>
</tr>
<tr>
<td>40-64 yrs old</td>
<td>99386</td>
<td>99396</td>
</tr>
<tr>
<td>65 yo or older</td>
<td>99387</td>
<td>99397</td>
</tr>
</tbody>
</table>
Which Tests to Check on the Encounter Form?

- **Taking cervical or vaginal samples for STI tests?**
  - No...included in the E/M code

- **Cervical cytology sampling?**
  - No...included in E/M code (except Medicare)

- **Gonorrhea/ Chlamydia NAAT tests?**
  - Usually not...the lab bills for these
  - *BUT...the practice may bill the payer (then pays the lab) or the lab test code may be required by the payer*

- **Point of care tests** (pregnancy test, wet mount, etc.)
  - Yes...modifier -25 on the E/M code is not necessary
## Case Study 1: Answer

<table>
<thead>
<tr>
<th>Procedure</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supplies</td>
<td>None</td>
</tr>
<tr>
<td>Drug</td>
<td>J7304 (patch x9 units)</td>
</tr>
<tr>
<td>Lab</td>
<td>None; lab will bill for CT NAAT</td>
</tr>
<tr>
<td>Lab slip</td>
<td>Z11.8 (Ct screening)</td>
</tr>
<tr>
<td>E/M</td>
<td>99394 (preventive svc, 12-17) or 99214 (problem visit, 25 min)</td>
</tr>
<tr>
<td></td>
<td>1° Z01.419 (routine GYN exam, no abnl findings)</td>
</tr>
<tr>
<td></td>
<td>2°: Z30.016 (Initial encounter for prescription of contraceptive patch)</td>
</tr>
</tbody>
</table>
Which E/M Code to Use?

• Does the payer for this patient cover?
  – Preventive services [check-up visit] (99394)
  – Problem oriented visit, established (99214)

• What are comparative reimbursement rates for the covered codes? Code for the highest supported code

• If *only* problem oriented visit codes are covered, code for the higher E/M level of
  – By the 3 key components, or
  – Time
Case Study 2: STI Check and IUS Insertion

- Ms. L is 19 year-old established client who presents with concerns about STI and wants to be tested
- She also received contraceptive counseling (10 minutes); asked to have a 3 year LN-IUS inserted
- Samples sent for GC/CT NAAT, HIV serology
- Office urine pregnancy test negative
- Bimanual exam performed; then IUS inserted easily
- Pelvic ultrasound with vaginal probe to check placement
ACOG on CPT + E/M Visit

- If the patient comes in for another reason and, during the same visit, a procedure is performed, then both the E/M services code and procedure may be reported
  - Documentation must indicate
    - A significant, separately identifiable service
    - Either the key components or time spent counseling
  - Modifier 25 is added to the E/M code (not the CPT code)
    - This indicates that two distinct services were provided: an E/M service and a CPT procedure

ACOG; LARC Quick Coding Guide
### Case Study 2: Answer

<table>
<thead>
<tr>
<th>Procedure</th>
<th>CPT/ HCPCS II Code</th>
<th>ICD-10-CM Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supply</td>
<td>none</td>
<td></td>
</tr>
<tr>
<td>Drug</td>
<td>J7301 LNG-IUS, 13.5 mg</td>
<td>Z30.430 Insertion of IUC</td>
</tr>
<tr>
<td>Lab</td>
<td>81025 UPT</td>
<td>Z32.02 Preg exam or test, negative</td>
</tr>
<tr>
<td>E/M</td>
<td>99212-25</td>
<td>Z 30.09 Other FP advice</td>
</tr>
</tbody>
</table>

-25 indicates that a significant and separately identifiable E/M was provided on the same date of service as a procedure.
Changing Trends

- Fewer screening pelvic and breast exams
- But more counseling...
- Are you still scoring E/M codes based on Hx/PE/MDM?
- Using time to score the E/M almost always results in higher reimbursement...
Questions?
Access to Contraceptive Care for Migrant and Immigrant Women

Deliana Garcia, MA
Director, International Projects and Research on Emerging Issues
Migrant Clinicians Network
Migrant Considerations

• The health care service environment in which migrant and immigrant women seek contraceptive care consists of a patchwork of geographically static health delivery sites, with varying payment structures and eligibility guidelines.

• Human migration involves increasingly diverse populations moving rapidly between the sending and receiving locations, often with unequal social and physical environments that affect the health and well-being of those moving between locales.
Migration causes discontinuity of care and loss of familiarity with health care systems, as well as special needs related to traveling long distances.
Migration presents both...

Vulnerabilities

Opportunities
Migration...

- Migration is changing the demographics of the US
- Unprecedented growth with many arriving in non-traditional receiving areas
- Isolation from social networks as well as from social service and healthcare providers
Health affected by:

- Employment
  - Poverty
- Racism
- Education
  - Access
  - Quality
- Health care
  - Access
  - Quality
- Public safety
- Food access
The risk behavior most frequently reported by migrants in all labor groups is multiple sexual partners
More than Contraception

- A bad economic situation may induce a person to offer paid sexual services.

- Selling sexual services as a strategy to survive is not uncommon amongst migrants the world over.
The complexity of cultural proficiency
Contraceptive Care

• While in the host country, migrants find themselves in a socio-cultural context which in one or more ways is substantially different from their own frame of reference.

• The feeling of being an “alien” may continuously be present.

• This feeling may be strengthened by ever present linguistic distinctions between the domestic population and the migrants.
Birth planning and spacing

An 18-year-old pregnant woman working as a farmworker in Arizona. Moves to Idaho for work. Has limited transportation, no English and very little money.
Missed appts led to discovery of recent trauma.

Every time center called the patient was sad, numb, and confused.

Saw therapist for a bit. Slowly improving.

Regular communication from center.

Deliver in late February, 2016.
A staff person who can recall that when she first came to the community she could not get services at site.
Eligibility staff
Views use of benefits as a weakness
Lab staff
In a hurry and not focused on role of blood and removal of blood in some cultures
Medical Assistant
Speaks the language but from another region and does not know some of the nuances
Clinician

Feels that the patient “knows” that she is working in her best interests.
Effective engagement of migrant women in contraceptive care

• With “emotionally charged or uncomfortable topics” it is often the health care professional that is the most uncomfortable!!

• If you are “professional and open” with your questioning—the patient will be much more forthcoming with sensitive information.
Any questions?

Deliana Garcia
dgarcia@migrantclinician.org
www.migrantclinician.org
Questions?
Reproductive Health TeleECHO™ Clinic

This presentation was adapted with permission from Project ECHO.
What is Project ECHO?

- **Extension for Community Healthcare Outcomes**
- Collaborative model of medical education and care management
- Increases access to specialty treatment in rural and underserved areas.
Our 4 key principles

• **Use technology** to leverage scarce resources
• **Share “best practices”** to reduce disparities
• **Use case-based learning** to master complexity
• **Use web-based database** to **monitor outcomes**

ECHO will:

• Provide collaborative feedback and recommendations for cases presented.
• Present evidence-based educational resources through didactic presentations and case-based learning.
• Give access to additional clinical provider support.
<table>
<thead>
<tr>
<th>Clinic Date</th>
<th>Clinic Didactic</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/23/17</td>
<td>Intrauterine Devices - Types, candidates and timing of insertion</td>
</tr>
<tr>
<td>1/30/17</td>
<td>IUDs and Cervical and Vaginal Infections</td>
</tr>
<tr>
<td>2/6/17</td>
<td>IUDs - Bleeding profiles and what you can do</td>
</tr>
<tr>
<td>2/13/17</td>
<td>IUDs and Pain of Insertion - What you can offer your patient</td>
</tr>
<tr>
<td>2/20/17</td>
<td>Malpositioned IUDs - What should you do?</td>
</tr>
<tr>
<td>2/27/17</td>
<td>IUDs - Missing strings and difficult removals</td>
</tr>
<tr>
<td>3/6/17</td>
<td>Pregnant with an IUD in place</td>
</tr>
</tbody>
</table>

**Subdermal Implants**

<table>
<thead>
<tr>
<th>Clinic Date</th>
<th>Clinic Didactic</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/13/17</td>
<td>Introduction to the Implant - Candidates for insertion and timing</td>
</tr>
<tr>
<td>3/20/17</td>
<td>Implants - Bleeding profiles and management</td>
</tr>
<tr>
<td>3/27/17</td>
<td>Implants - Bone health, weight gain and other side effects</td>
</tr>
<tr>
<td>4/3/17</td>
<td>Malpositioned Implants - Evaluation and management</td>
</tr>
</tbody>
</table>

**Hormonal Contraceptive Methods**

<table>
<thead>
<tr>
<th>Clinic Date</th>
<th>Clinic Didactic</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/10/17</td>
<td>Oral Contraceptive Pills - How to pick a pill, initiation, and counseling</td>
</tr>
<tr>
<td>4/17/17</td>
<td>Combined Hormonal Methods - Indications and contraindications</td>
</tr>
<tr>
<td>4/24/17</td>
<td>Managing side effects of Pills/Patch/Ring</td>
</tr>
<tr>
<td>5/1/17</td>
<td>DMPA as a Contraception</td>
</tr>
</tbody>
</table>

**Adolescents and Contraception**

<table>
<thead>
<tr>
<th>Clinic Date</th>
<th>Clinic Didactic</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/8/17</td>
<td>Cancelled for ACOG</td>
</tr>
<tr>
<td>5/15/17</td>
<td>Adolescents and Contraception</td>
</tr>
<tr>
<td>5/22/17</td>
<td>Emergency Contraception - Everything you need to know about EC</td>
</tr>
<tr>
<td>5/29/17</td>
<td>Holiday - No meeting</td>
</tr>
</tbody>
</table>

**Other Contraception Methods including Permanent Contraception and Barrier Methods**

<table>
<thead>
<tr>
<th>Clinic Date</th>
<th>Clinic Didactic</th>
</tr>
</thead>
<tbody>
<tr>
<td>6/5/17</td>
<td>Contraception and Coercion</td>
</tr>
<tr>
<td>6/12/17</td>
<td>Female Permanent Contraception</td>
</tr>
<tr>
<td>6/19/17</td>
<td>Male Contraception - What we know and what the future holds</td>
</tr>
<tr>
<td>6/26/17</td>
<td>Barrier Methods, Fertility Awareness based Methods, and the Rest</td>
</tr>
</tbody>
</table>
Inside the Reproductive Health TeleECHO clinic:
Photo taken during Dr. Eve Espey’s presentation on March 27, 2017
Join us!

• Launched Monday **January 23, 2017**.

• Clinics occur weekly on **Mondays from 12-1 pm** MDT.

• For more information, please contact us through: [reproductivehealthecho@salud.unm.edu](mailto:reproductivehealthecho@salud.unm.edu)
Questions?
Role of the Community Health Aide and Contraception in Rural Alaska

Bethany Berry, CNM, MSN
Senior Nurse Midwife, Southcentral Foundation

Quana Ticket, PA-C
Instructor & Mid-Level Provider, Tribal Health and Southcentral Foundation
Overview of CHAP

- ~550 Community Health Aides
- 178 villages
- 20-1700 people in a village
- 60% of Alaskan Natives live in a village
- 50,000 customer owners seen
- Over 250,000 clinic visits/year
- Most villages inaccessible by roads
  - Boat and planes in summer
  - Snow machine and planes in winter
Overview

- Role of the Community Health Aide began with village-based oral antibiotic therapy during the tuberculosis epidemic in rural Alaska 1940s-1950s

- Later program adopted by the Indian Health Service
The Community Health Aide Program has 5 different levels (I-IV) of Community Health Aides (CHAs) depending on training.

- The highest level is the certified CHA Practitioner (CHAP).
- Over 90% have HS degree
- Today CHA/Ps are employed and supervised by Tribal Health Organizations
CHA/Ps Practice

- Based on the Community Health Aide/Practitioner Manual (now eCHAM)
  - Scripted questions
  - Directed Exams

- Work closely via telephone with MDs located in their regional health care centers
  - Standing orders
  - Initiation of family planning methods requires a consult with physician (usually same day).
Job Description

- Frontline medical responder
  - Trauma
  - Medical Emergencies
  - Chronic Disease management
  - Preventative Care
  - Acute Illnesses
  - Behavioral Health issues
Challenges

- Burnout
- Stress
- Confidentiality
- Taking care of family members (community)
- Travel for continuing education often for several weeks at a time
- WEATHER/GEOGRAPHY affects everything
Only 1% of visits to the CHA/P in 2006 were labeled as Family Planning visits (2216/175,992)

Unintended pregnancy rate of Native Alaskans over 50%, Non-Native Alaskans 36.3% (2008)
Currently most women in rural Alaska have to travel long distances (up to 1200 miles) to have a LARC inserted.
Goals

- Decrease disparity between urban and rural women and their contraception options.
- Improve local access to implants, a highly effective LARC method
- Decrease unintended pregnancy rates for rural women
Figure 1

Unintended Pregnancy
Alaska, 2000-2008

Percent of Women Delivering a Live-Born Infant

- AK Native
- Overall

Data Source: Alaska
Implementation Steps

- Approached Merck to find out feasibility of CHA/Ps being approved to place and remove implants.
  
  ▪ Precedent: Submarine medical personnel able to place implants without a license.

  ▪ Minimal requirement needed was an NPI number, which CHA/Ps have.
Implementation Steps

- Approached CHA/P Program Administration and Instructors
  - Implants seen as less invasive than many procedures that CHA/Ps perform
- Presented to the CHAP directors from different Tribal Health Organizations
- Developed the eCHAM procedure for implant insertion and removal module
Implementation Steps

- Began pilot training of 5 CHA/Ps in 2016

- Now designing an implant preceptorship in Anchorage for CHA/Ps

- Meet with Clinical Directors of Tribal Health Organizations for final approval to make implant training a part of the general CHA/P curriculum. (May 2017)
Main Motivators for Administrators

- Cost Savings $$$
- Birth Spacing
- Preterm Birth Prevention
- NAS Prevention (rising opioid crisis in AK)
- FASD Prevention

For CHA/P Program Administration and AK LARC Initiative Team: 1) Increasing access to most effective method of reversible contraception and 2) Decreasing the disparity of family planning options available between rural and urban Native women.
Who pays for it?

- Treaties ensure that all Native American/Alaskan Native peoples receive quality health care
- It is not “free” but pre-paid
- Federal funds channeled to Tribal Health Organizations who manage the health care costs.
  - Indian Self Determination and Education Assistance Act, Public Law 93-638 (aka 638)
- Medicaid reimbursement for device available in the outpatient setting
Resources

- https://archive.org/stream/pubmed-PMC3417638/PMC3417638-ijch.v71i0.18543#page/n1/mode/2up

Accomplishments and Technical Assistance Calls

Ellen Pliska
Director, Family and Child Health
ASTHO
Learning Community Team Accomplishments

- **CT**: Secured support of Community Health Association of CT to convene web-based provider shared decision making training - tentative June 2017 date

- **DE**: 66 provider sites trained and 1130 staff trained by Upstream USA in comprehensive practice transformation training on evidence based counseling on all methods of contraception

- **IN**: The LARC toolkit was completed by the IN Perinatal Quality Improvement Collaborative and approved by the IN Department of Health
Learning Community Team Accomplishments

**MT**

LARC Provider Training planned for May 17th and 18th for Title X and other community providers. Training: Nexplanon incudes and IUD insertion training.

**NY**

Quality Improvement Network for Contraceptive Access completed three learning sessions on insertions and billing/reimbursement topics.

**SC**

Developed standard Learning Plans for all new RNs and APRNs. Plans are pre-set and assigned to new employees.
Learning Community Team Accomplishments

Texas Health and Human Services launched a Texas Health Steps LARC Quick Course at the beginning of the year and continues to share the course with providers and stakeholders.

The Community Health Worker Family Planning Module was added to the general course offerings the end of March, and presented about the module at United for Better Health CHW Conference in April with great feedback.

WVU has scheduled Grand Rounds on Immediate Postpartum LARC insertions. One smaller rural hospital has requested training.
Share your documents with us!

Please share your toolkits, fact sheets, stakeholder meeting agendas, policies, training manuals with us!

ContraceptiveAccess@astho.org
Technical Assistance

All 27 States and Territories participated from February – April

All Nine Themes Represented

1. Provider Awareness & Training
2. Reimbursement & Financial Sustainability
3. Informed Consent/Ethical Considerations
4. Logistical, Stocking, & Administrative Barriers
5. Consumer Awareness
6. Stakeholder Partnerships
7. Service Locations
8. Data, Monitoring, & Evaluation
9. Specific Populations
Technical Assistance Timeline

**Short Term** (Less than 2 months)
- What are ACOG’s policies around LARC: immediate postpartum, teens
- Send Letters to State Health Official to remind about IAC (Sent 4/4/17)
- What are states doing to engage providers in a virtual space? (4/25/17 VLS)

**Intermediate** (Less than 6 months)
- FQHC reimbursement; 340B pricing, State Plan Amendments/SPAs (6/6/17 VLS)
- Create a “recipe” for success within each focus area
- Build a repository of measures for contraceptive access (See next slide)

**Long Term** (Longer than 6 months)
- Outpatient version of the LARC Tool on ASTHO Website
Developing a repository of measurable process, short, medium, and long term indicators for state self-monitoring/evaluation of contraceptive initiatives

- Indicators that can be calculated from existing data (e.g., claims, PRAMS)
- Indicators that can be assessed with prospective data collection (e.g., surveys)

**Asks**

1) Comments in the chat box:
   a. Surveys or indicators you would like to see included
   b. Surveys or indicators your state has used and can contribute to repository

2) Volunteers to participate in a brief advisory call within the next month *(chat box now or krankin@uic.edu later)*
Increasing Access to Contraception Learning Community

Next Steps

Ellen Pliska
Director, Family and Child Health
Association of State and Territorial Health Officials
Focus Area 2: Reimbursement and Financial Sustainability

TA Requested From States: Themes
- FQHC Reimbursement
  - Depending on the device and billing type, alternative payment methods
  - Carve-out for various services
  - White Bagging
- 340B Pricing
- Ensuring payment/no duplicate payment
- Return on Investment, Cost Savings
- Immediate Postpartum
- MOU and contract issues
- State Plan Amendments (SPAs)
- Commercial Insurance

Next Virtual Learning Session:
June 6, 2017, 2:00-4:00p ET
AMCHP/ASTHO Webinar: Opioids and MCH Populations

- The webinar will highlight prevention efforts and cross-collaborations in maternal and child health populations.

- Title: Public Health Approaches to Address the Opioid Epidemic: Cross-sector Collaboration in Maternal and Child Health
  - Date: May 9, 2017
  - Time: 1-2:30pm ET

- Register here!
  - Registration details will also be emailed to the Learning Community after the session.
Closing

Shanna Cox
Division of Reproductive Health, CDC

Lekisha Daniel-Robinson
CMCS Maternal and Infant Health, CMS

Brittni Fredericksen
Office of Population Affairs
Save the Date!

Quality Contraceptive Services Webinar

May 15, 2017
11:00am-12:00pm CT

Email invitation coming soon...
Evaluation

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

http://astho.az1.qualtrics.com/jfe/form/SV_035Rcdc4rEAUwQJ
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: