Increasing Access to Contraception Learning Community

Year Three | Project Summary

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INTRODUCTION: INCREASING ACCESS TO CONTRACEPTION LEARNING COMMUNITY

In October 2016, ASTHO, with support from CDC, HHS' Office of Population Affairs (OPA), and the Centers for Medicare and Medicaid Services (CMS), convened the third year of the Increasing Access to Contraception (IAC) Learning Community. In collaboration with federal and other national partners (listed in the box at right), ASTHO convened 27 states and territories to reduce unintended pregnancy among women of reproductive age and improve access to all methods of contraception. During this year, states enacted numerous strategies to address barriers to and improve access to contraceptive services. This report aims to:

- Summarize the project's history, goals, and year three timeline.
- Define the project's nine focus areas for success.
- Discuss ways that the learning community helped states move forward with their contraceptive access goals.
- Highlight select innovative practices emerging from the learning community's third year.
- Consider ASTHO's potential opportunities for supporting learning community efforts in the year ahead.

Increasing Access to Contraception Learning Community National and Federal Partners

American College of Obstetricians and Gynecologists

Association of Maternal & Child Health Programs

Association of Women's Health, Obstetrics, and Neonatal Nurses

CDC's Office of the Associate Director for Policy and Division of Reproductive Health

The Division of Quality and Health Outcomes in the Centers for Medicare and Medicaid Services' Children and Adults Health Programs Group

Center for Medicare and Medicaid Services' Center for Medicaid and CHIP Services

National Family Planning and Reproductive Health Association

NACCHO

HHS Office of Population Affairs

University of Illinois at Chicago

BACKGROUND: REDUCING UNINTENDED PREGNANCY THROUGH CONTRACEPTION ACCESS

Forty-five percent of pregnancies in the United States are unintended and almost one-third (30 percent) of U.S. births occur within 18 months of a previous birth.[1] Unintended pregnancies and short inter-pregnancy intervals are associated with higher rates of preterm birth, low birth weight, late access to prenatal care, and other negative maternal and infant health outcomes.[2] Increasing access to contraceptive services (defined in the box on the following page) helps to support planned and optimal birth spacing, which not only contributes to maternal well-being, but also reduces the risk of low-weight and premature births.[3]

Because Medicaid covers more than 70 percent of family planning services for low-income Americans and pays for nearly half of all U.S. births, efforts aimed at improving access to contraceptives for individuals enrolled in Medicaid offer significant opportunities for states to improve health outcomes and reduce health costs.[4,5] According to the American College of Obstetricians and Gynecologists (ACOG), "facilitating affordable access to contraceptives would not only improve health but also would reduce health care costs, as each dollar spent on publicly funded contraceptive services saves the U.S. health care system nearly $6."[6]

LEARNING COMMUNITY HISTORY AND OVERVIEW

Since its inception in 2014, the IAC Learning Community has expanded in scope and in size, growing from six to 27 participating states and territories that work within the community to remove barriers to and increase access to contraception.

Cohort 1: 2014-2015
In 2014, ASTHO and CDC convened a Long Acting Reversible Contraception (LARC) Learning Community with state and national partners to identify, develop, and discuss strategies and best practices to implement immediate postpartum LARC policy and programs. The goal of the LARC learning community was to identify, document, and address technical assistance needs, promising practices, and barriers to LARC use immediately postpartum. (For background on the LARC Learning Community and immediate postpartum LARC, see ASTHO's Increasing Access to Contraception web page) The first cohort of states included Colorado, Georgia, Iowa, Massachusetts, New Mexico, and South Carolina. These states had Medicaid policies in place that reimbursed providers for LARC insertion in an inpatient setting—a precursor to sustainable postpartum LARC initiatives.

Contraceptive Services Defined

According to CDC, providers should offer contraceptive services to individuals who want to delay or prevent pregnancy. "Contraceptive services should include consideration of a full range of FDA-approved contraceptive methods, a brief assessment to identify contraceptive methods that are safe for the client, contraceptive counseling to help a client choose a method of contraception and use it correctly and consistently, and provision of one or more selected contraceptive method(s), preferably on site, but by referral if necessary."

Cohort 2: 2015-2016
In the project's second year, ASTHO invited seven more states with Medicaid reimbursement payment policies in place to join the learning community: Delaware, Indiana, Louisiana, Maryland, Montana, Oklahoma, and Texas. Cohort 1 and 2 states participated in the second-year kickoff of the LARC Learning Community in October 2015.

Cohort 3: 2016-2017. In its third year, the learning community expanded by adding 14 additional states and territories (listed below) and broadening focus to increasing access to a full range of contraceptive services. This report focuses on detailing the third year's activities and achievements.

OVERVIEW OF YEAR THREE ACTIVITIES AND GOALS

With support from CDC, CMS, OPA, and national partners, ASTHO convened year three of the Increasing Access to Contraception Learning Community to help selected states reduce unintended pregnancy among women of reproductive age and improve access to all methods of contraception (see right for the learning community vision and goals). The learning community engaged state teams to:

Learning Community Goals and Purpose

Vision: Reduce unintended pregnancy among women of reproductive age in the U.S.
Purpose: Improve access to all methods of contraception.
Goals: Inform and guide public health and Medicaid programs and policies to increase access to contraceptives by promoting evidence-based guidance and developing collaborative partnerships among states and territories.

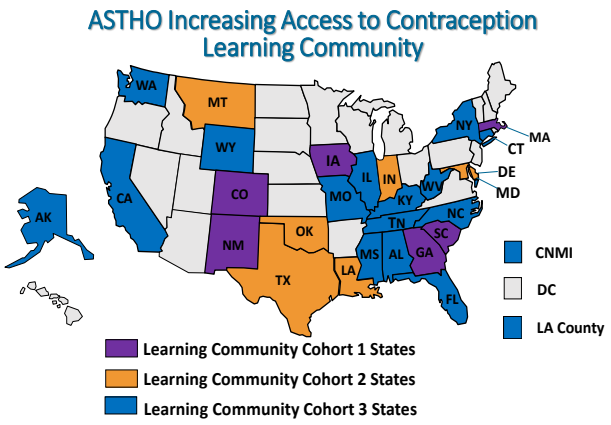
- Identify challenges and barriers to contraceptive access.
- Learn about promising practices, available resources and tools, and successful approaches that work in states facing similar challenges.
- Develop a shared vision for increasing access to contraceptive services and an action plan for realizing it.
- Implement the action plan, with support and assistance from the learning community.

ASTHO provides technical assistance and peer-to-peer learning and networking opportunities to help states and territories draw from the collective resources and expertise in the learning community, work through challenges, and learn from other state and territorial experiences and lessons learned.

Reflecting the learning community's expanded focus on increasing access to all contraceptives, the community expanded in 2016 to engage a diverse group of states and territories. Some were already engaged in related initiatives, such as the CDC Office of the Associate Director of Policy's 6|18 initiative and CMS's Center for Medicaid and CHIP Services (CMCS) Maternal and Infant Health Initiative, and others were selected based on a letter of interest that demonstrated readiness to implement contraceptive access strategies.

As was the case in the two prior cohorts, participation in the learning community's third cohort required a commitment from a core team of cross-sector stakeholders. ASTHO and CDC selected 13 states, one territory and one county to participate in year three of the learning community: Alabama, Alaska, California, Commonwealth of the Northern Mariana Islands, Connecticut, Florida, Illinois, Kentucky, Los Angeles County, Mississippi, New York, North Carolina, Washington, West Virginia, and Wyoming (see Figure 1).

Figure 1. ASTHO'S Learning Community Participants, Cohorts 1-3



The learning community included several key activities designed to achieve intended learning community and state-defined outcomes.

Planning Phase (October-December 2016)

On Oct. 13, 2016, ASTHO held a pre-meeting virtual learning session to provide an overview of the learning community history and goals and preview upcoming activities, outcomes, and next steps. Later in October 2016, ASTHO convened 27 state teams at an in-person meeting in Washington, D.C., with the goal of helping states learn from one another, identify technical assistance needs, and collaborate to develop a state action plan that improves access to contraceptive services. This meeting had the following goals:

- Launch the expanded IAC Learning Community.
- Facilitate a discussion with multi-disciplinary state and territorial teams to identify needs, determine priorities, outline strategies, and develop state and territorial action plans and next steps to expand access to effective methods of contraception.

- Improve the capacity of states and territories to successfully expand access to contraception by facilitating state-to state sharing of barriers; solutions; promising strategies, including new or amended policies and programs; and lessons learned.
- Identify and discuss technical assistance needs for the coming year.

Throughout the meeting, participants shared numerous strategies and successes related to the project's nine key focus areas (described in greater detail in the following section). In addition to learning community-wide planning activities, state and territorial teams developed action plans that would serve as a blueprint for subsequent implementation efforts. More information on the in-person meeting, including presentations and resources, are available on ASTHO's Increasing Access to Contraception web page.

Implementation Phase (December 2016-June 2017)
ASTHO and the learning community partners helped teams implement their action plans through technical assistance and support, which was provided through two rounds of conference calls, ongoing consultation, and a series of four virtual learning sessions (see box at right for additional information on and links to these sessions). These activities provided ongoing opportunities to disseminate information and best practices to the learning community.

As part of both planning and implementation activities, ASTHO conducted key informant interviews with the new Cohort 3 states and territories to listen to and learn from stakeholders' expectations and challenges and obtain a baseline interview with each state. In addition, ASTHO enhanced the Increasing Access to Contraception web page by developing a new searchable resource library of materials and tools arranged by focus area, resource type, and state or territory.

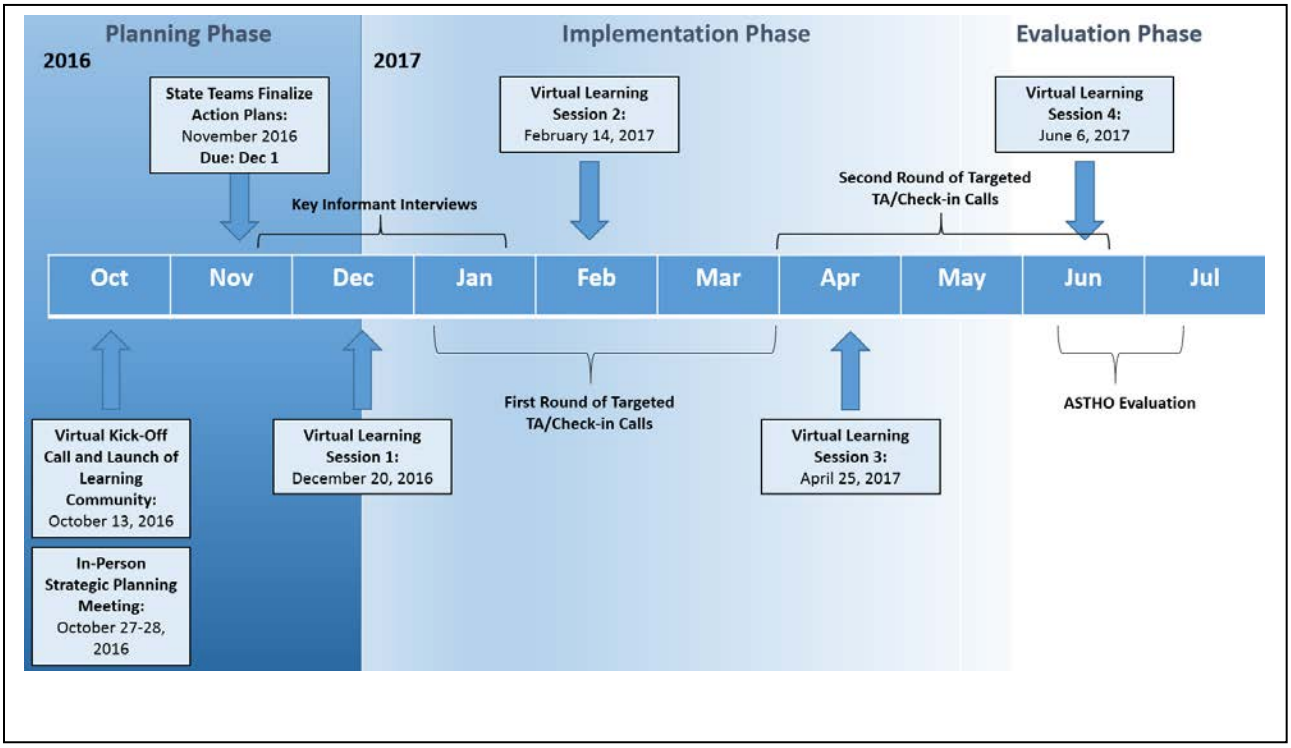
Year 3 Virtual Learning Sessions

ASTHO hosted four virtual learning sessions during the project's third year to share promising strategies for addressing many of the project's focus areas. Links to slides are provided below, and additional information on virtual learning sessions, including links to the webinars, is available on ASTHO's Increasing Access to Contraception web page.

- Increasing access for special populations, Dec. 20, 2016.
- Improving consumer awareness and data, monitoring and evaluation, Feb. 14, 2017.
- Provider awareness and training on coding procedures and for serving special populations, April 25, 2017.
- Reimbursement and financial sustainability, June 6, 2017.

Evaluation Phase (May-July 2017)
The evaluation phase involved developing a learning community-wide evaluation strategy, as well as tools and evaluation support, to help states monitor and assess their own impacts and outcomes. ASTHO selected the University of Illinois at Chicago (UIC), an experienced evaluator of access to LARC and implementation science, to help learning community states monitor and evaluate impact and outcomes related to implementing their contraception access action plans. UIC gathered information from learning community states through key informant interviews, online assessments, and other outreach methods. UIC also conducted a process evaluation to demonstrate the collective value of the project, and helped ASTHO develop an outcome evaluation framework for the IAC Learning Community for 2017-2018.

Figure 2. Timeline of the Learning Community's Third Year Activities



STATE ACTIVITIES IN THE NINE FOCUS AREAS FOR SUCCESS

As a result of key informant interviews and participant dialogue during the in-person meetings, the learning community established nine contraception access strategies. These included eight strategies developed through earlier cohort activities and a new strategy that emerged from the third year in-person meeting: "addressing access for specific populations." Learning community states and territories developed goals and action plans in each of the focus areas listed below, as Appendix A highlights, and conducted activities in each of these areas, as shown in Appendices B and C.

Strategy 1: Provider Awareness and Training
Most states cited provider and clinical staff training as an ongoing struggle, particularly for providers in rural and underserved areas, federally qualified health centers (FQHCs), and other locations that lack sufficient providers and resources. Participants identified several resources to address these needs.

Strategy 2: Reimbursement and Financial Sustainability
Many states reported difficulty in implementing contraception access policies due to lack of adequate reimbursement and provider frustration about claims denials. Participants identified federal and state resources to address these concerns, including billing toolkits and federal guidance on family planning funding regulations and options.

Strategy 3: Informed Consent and Ethical Considerations
States discussed the importance of fostering patient-centered decision making and addressing consent and confidentiality concerns. Participants cited standardized consent and counseling processes and

protocols, addressing the timing and content of informed consent, client-centered counseling, reducing provider bias, enhancing counseling and removal protocols, and broader issues of reproductive justice and ethics as important strategies for assuring access and promoting patient choice.

Strategy 4: Logistical, Stocking and Administrative Barriers
Participants discussed approaches for removing logistical and administrative barriers and helping hospitals and clinics stock and maintain adequate contraceptive supplies, allowing for same day services, and removing grandfathered clauses, preauthorization requirements, step-therapy requirements, and three-year moratoriums on LARC devices.

Strategy 5: Consumer Awareness
Participants cited state and local public campaigns and informational strategies as critical steps for improving awareness and addressing misconceptions about contraceptives among patients and the public.

Strategy 6: Stakeholder Partnerships
Facilitating and fostering partnerships are essential and facilitate data-sharing, policy development, workforce training, and other critical activities.

Strategy 7: Service Locations
Participants identified various strategies to address access disparities in specific locations, such as carving out FQHCs and improving provider capacity through telehealth, rural preceptorships, and mobile units to enhance education and service delivery.

Strategy 8: Data, Monitoring, and Evaluation
In response to concerns about current state data collection and analysis capacity, national partners and states shared available and emerging data and evaluation resources on contraception access and utilization, patient satisfaction, and performance measures for monitoring and evaluating pregnancy prevention initiatives.

Strategy 9: Specific Populations
A new strategy was added to reflect state discussion about persistent challenges and access barriers for specific groups, such as adolescents, individuals with disabilities, uninsured and under-insured individuals, non-English speakers, undocumented individuals, incarcerated individuals, and individuals with substance use disorders. This focus area includes specialized workforce, communication, outreach, policy, cultural competence, and clinical practice strategies for improving access for these populations.

IMPACT OF LEARNING COMMUNITY PROCESS

In a 2017 article published in *Implementation Science,* co-authors from ASTHO, CDC, and UIC found that implementation strategies, such as the learning community model, are "imperative for the successful adoption and sustainability of complex evidence-based public health practices." The IAC Learning Community integrates several research-based implementation strategies, including:

- Organized meetings, which included an in-person meeting and webinars with experts on the project's nine focus areas.
- Centralized technical assistance, delivered through targeted webinars and state calls.
- Ongoing consultation from topical experts (e.g., state team members or federal or national partners) through technical assistance calls, virtual meetings, and other formal and informal communications.
- Disseminated educational materials, including toolkits, procedures and evidence-based guidelines.
- Facilitated state team action planning meetings, an in-person meeting, virtual learning sessions, and technical assistance calls by ASTHO.
- Network weaving opportunities to promote information-sharing, collaborative problem-solving, and a shared vision among team members for the implementation strategy.

The study's authors concluded that the learning community model "can help states facilitate implementation of policies designed to improve access to the most effective contraceptive methods in the immediate postpartum period as well as address barriers." The model helps states and territories with their policy implementation work by providing structure and accountability, validating state and territorial approaches to expanding contraception access, and preparing for potential challenges and opportunities.

In its third year, the learning community model helped states move closer to their contraceptive access goals through the above approaches, three of which (dissemination and information-sharing, technical assistance, and networking opportunities) are discussed in detail below.

Dissemination and Information-Sharing

The learning community structure facilitates information-sharing and dissemination in various ways, including through the project website, virtual and in-person meetings, and technical assistance activities. The learning community members share with one another best practices, tools, and guidelines that members can use as part of their evidence-based approaches for improving contraceptive access. Below are several guidelines and resources that learning community members shared at the outset of the third year during the in-person meeting.

- *U.S. Medical Eligibility Criteria for Contraceptive Use:* A CDC report that provides evidence-based guidance for healthcare providers when counseling individuals about contraceptive method choice.
- *U.S. Selected Practice Recommendations for Contraceptive Use:* This companion document to the U.S. Medical Eligibility Criteria for Contraceptive Use provides evidence-based guidance to healthcare providers about initiation and use of contraceptive methods and ways to reduce barriers to access and use.

- *Quality Family Planning Recommendations:* CDC and OPA guidelines that recommend how to provide family planning services in a family planning visit.
- *Evidence Summary: Prevent Unintended Pregnancy:* Information from CDC's 6|18 Initiative that provides evidence-based strategies to address inadequate LARC reimbursement rates, expand coverage, and removing administrative and logistical barriers, (such as pre-approval requirements or step therapy restrictions) for LARCs.
- *Increasing Access to Contraception in the Context of Zika Preparedness: State and Jurisdictional-Level Strategies:* CDC guidance that provides seven strategies for reducing unintended pregnancy and preventing adverse pregnancy and birth outcomes.
- *Interactive Tool to Assess Impact of Increasing Use of Highly Effective Reversible Contraception Methods among Medicaid Beneficiaries (ROI Tool):* A new return on investment tool, available on the IAC Learning Community website, that was created to help Medicaid programs assess the economic impact of increased use of highly-effective LARCs among Medicaid beneficiaries. (A CDC senior economist is available to assist states with this tool.)

In addition, ASTHO, national partners, and states shared strategies and resources throughout the year, including clinical guidance, counseling protocols, and training resources for LARC insertion.

How Information-Sharing Helps Teams
State and territorial teams routinely incorporate best practices, project resources, and lessons learned from other states into their workplans and activities. They adopt and adapt strategies—e.g., coding and billing procedures or LARC toolkits—to fit their specific needs. States in this learning community frequently expressed that learning from other states is an important benefit of learning community membership:

- Following a virtual learning session presentation on the National Association of Community Health Center's newly-released report "Advancing Quality Family Planning Practices: A Guide for Health Centers," a team member from Massachusetts expressed an interest in disseminating the new guide and using it to launch partnerships with health centers with which they do not currently partner.
- During technical assistance calls, a Colorado team member noted that "just being able to know who else is working [on these issues] is good."
- A Delaware team member said that learning from South Carolina's experience at the in-person IAC learning community meeting helped the Delaware team immensely. She followed up by meeting one-on-one with a South Carolina team member, and said that Delaware is now borrowing from the South Carolina experience.

Technical Assistance
In collaboration with its learning community partners, ASTHO delivers technical assistance services to identify barriers and challenges to contraception access, answer questions, share best practices, and provide resources to help states move forward. Through the ongoing technical assistance process, the ASTHO team provides targeted research support and connects team members with resources and subject matter experts, depending on the team's specific needs. For example:

- In response to the **Commonwealth of the Northern Mariana Islands'** request for staff and provider immediate postpartum and outpatient LARC training, ASTHO linked the team to

relevant resources, including the Family Planning National Training Center's Quality Contraceptive Services Webinar and OPA's Quality Contraceptive Care summary.

- In response to **Florida's** request for information about working with specialty pharmacies to avoid out-of-pocket expense for LARCs, ASTHO shared a factsheet and webinar describing South Carolina's approach.
- In response to **Indiana's** request for training tools for coding and billing staff, ASTHO provided the team with a link to the Spring 2017 virtual learning session on coding procedures and resources.

ASTHO tracks these activities in a technical assistance document that is shared with each team. In addition to communicating the status of various requests, these documents help the ASTHO team identify common themes or challenges that could be addressed across the learning community. For example, in response to frequently-asked questions about state approaches for developing and marketing immediate postpartum LARC toolkits, ASTHO featured three state experiences in a facilitated technical assistance webinar in August 2017.

How Technical Assistance Helps State and Territorial Teams Move Forward
During ASTHO's technical assistance calls in 2017, several state team members said that their involvement with the learning community helped them stay focused on their contraceptive access goals, despite competing demands on their time and agency resources.

- A team member from Iowa thanked ASTHO for its guidance and for keeping the team on track despite multiple other demands on ASTHO's time. The team member added that ASTHO's technical assistance report helps focus conversations among team members and identify needs and next steps.
- An Indiana team member appreciated the team's access to resources and said that the calls are "needed nudges to remind us that we have work to do." Some state teams said that their participation helped them advance in ways not otherwise possible without it.
- An Alaska team member thanked ASTHO for involving Alaska in the community, noting that she "sometimes feels disconnected from the lower 48, so it's a fantastic way to feel part of a bigger movement."

Networking Opportunities
The learning community convenes state teams virtually and in person to foster strong stakeholder partnerships and facilitate information-sharing within and across state teams. In addition to ASTHO-led networking activities, each team develops its own strategy for engaging with stakeholders within its state or territory. Teams frequently meet by phone or in person as a core team, and members often participate in broader consortia, LARC working groups, or perinatal collaboratives. Members set the frequency and communications rates that work best for them.

How the Learning Community Helps Build Partnerships
By the October 2016 in-person meeting, most states reported that they had developed and continued to take steps to strengthen coalitions of diverse groups, including Medicaid agencies, hospital and provider associations, private payers, perinatal quality collaboratives, reproductive justice advocates, academic centers, and policymakers. Participants discussed the importance of federal agencies and national organizations in providing support for work in their states.

During the fall 2017 technical assistance calls, several states expressed that that participating in the learning community strengthened partnerships and built on what other states had done and on existing initiatives within their own states. According to a Maryland team member, one of the biggest benefits of the learning community is that it brings people to the table to look at what other states are doing and to talk about collaboration across agencies and other stakeholders. The member explained that the community provides an entrée to discuss contraceptive access with state health agency leadership, potential funders, and other stakeholder groups.

Team members described meeting with colleagues and stakeholders working on a wide range of issues, including resiliency and child maltreatment, substance use prevention and treatment, and Zika prevention. An **Alaska** team member met with the state health director to share team progress and plans for moving forward with the team's contraceptive access goals. The team member added that it "feels like there's a movement" afoot in Alaska. The **Illinois** state team pointed to a competitive advantage that the work gives them when they pursue foundation or other funding opportunities. One of **Maryland's** team members said that ASTHO's letter to **Maryland's** health secretary (sent at the team's request) helped to inform leadership about the learning community. The letter served as a briefing when leadership changed, and it is also included in the state's LARC toolkit.

SNAPSHOT OF INNOVATIVE PRACTICES EMERGING FROM THE LEARNING COMMUNITY'S THIRD YEAR

As shown in Appendix C, in year three of the IAC Learning Community, participating state and territory teams conducted nearly 100 state- and locally-initiated activities spanning the project's nine focus areas. Teams trained providers, created and disseminated provider toolkits, changed LARC Medicaid billing and reimbursement procedures, and adopted a wide range of other strategies to help them achieve their contraceptive access goals. This section features a sample of innovative approaches for addressing some of the learning community's most complex problems. These include coordinating or co-locating contraceptive services with substance use programs and detention settings, innovative social media campaigns, strategic partnerships with faith-based institutions and communities, partnerships with state medical schools, and outreach to foundation and private funders to support contraceptive access.

The list of innovative practices is not comprehensive and only represents a portion of all the innovations that emerged from the learning community in its third year. For more information on state approaches and innovations, see Appendices B and C and visit ASTHO's interactive database of state initiatives.

Adopt Innovative Partnerships to Train Providers and Expand Workforce Capacity

Learning community members frequently cited provider and clinical staff training as an ongoing challenge, particularly in rural and underserved areas, at FQHCs and in other locations that lack sufficient providers and resources. States and territories continued to implement and share workforce development and training practices that helped to bridge the gaps, especially in underserved or remote locations.

- In April 2017, members of the **Alaska** team shared the state's approach for training community health aides and practitioners to provide family planning services in the state's most remote locations. To reduce unintended pregnancies and disparities in contraceptive access and improve local access to contraceptive implants, the Community Health Aide program developed an implant insertion and removal curriculum and began pilot training in 2016.

- In the same learning session, **New Mexico** team members shared their state's approach for using telehealth to expand contraceptive access. In 2016, the New Mexico Department of Health partnered with the University of New Mexico Department of Obstetrics and Gynecology and Project ECHO to launch the Reproductive Health TeleECHO clinic, aimed at sharing best practices to promote equitable, high-quality reproductive healthcare throughout the state.
- During a technical assistance call, members from the **Oklahoma** team shared an innovative approach for training providers. The Oklahoma Health Care Authority partnered with the University of Oklahoma College of Medicine to deliver a LARC training pilot program to 124 family planning providers, advanced practice nurses, physician assistants, and other providers during July and August 2017. Faculty members developed a LARC manual, presented on patient-centered counseling, and performed mock counseling sessions.

Improve Contraceptive Access for the Criminal Justice-Involved Population and for Individuals with Substance Use Disorders

Voluntary contraceptive counseling and services for individuals who are incarcerated and for women with substance use disorders reduces unintended pregnancies and promotes positive birth outcomes. Learning community members shared several strategies aimed at linking and co-locating family planning with substance use treatment programs and detention facilities. Several state and local innovations are featured below.

State	Innovation Summary
AK	The team partnered with Mat-Su Valley Perinatal Opioid Treatment Program to address LARC and the prevention of neonatal abstinence syndrome (NAS).
TN	Eighty percent of neonatal abstinence syndrome cases in Tennessee resulted from prescribed substances. Other state challenges included high rates of infant mortality and unintended pregnancy and a lack of awareness about family planning services. The Tennessee Department of Health adopted various strategies to address these challenges, including partnering with jails, medication-assisted treatment clinics, and pharmacists. Currently, 30 counties have partnerships with jails to include LARC education and services.
NC	Modeled after Tennessee's approach for providing voluntary LARC for the incarcerated individuals, North Carolina took steps to provide reproductive life counseling for males and females in jail and detox settings. Their approach offers pre-screening, counseling in jails, and provision of contraceptives for individuals before they are discharged.
WV	West Virginia adopted a range of strategies to achieve the goal of decreasing unintended pregnancy and NAS through primary prevention. These include community needle exchange programs, group counseling for pregnant women at a behavioral health hospital, patient navigators who help women involved in the Adverse Childhood Experiences program attend their family planning appointments, and university family planning clinics. For example, the Cabell County drug court partners with the Marshall University School of Pharmacy and Marshall University Obstetrics and Gynecology Program to provide LARC methods to women with a history of substance abuse. During contraceptive counseling, physicians and staff are

	available to answer questions about LARC methods and register women for appointments.
MT	In a Montana community with a severe opioid problem, an FQHC is working with a hospital and county jail to offer voluntary family planning training to incarcerated women who opt to attend. The Montana team reported successful placement of one LARC as of mid-October 2017.
Baltimore	Baltimore communities with the highest incarceration rates are also the communities with the highest infant mortality and highest rates of women who are not already linked into Medicaid or other known sources of care. To reach these populations, "B'more for Healthy Babies" provide continuing health education and health navigation for women and men in detention facilities. The Baltimore City Health Department recently issued a request for proposal and will select a contractor to implement the policy recommendations and deliver enhanced resource materials (e.g., resource cards and comic strips) to improve detainee awareness about and access to contraceptive resources and services.

Incarcerated Populations

Develop Engaging Social Media Campaigns

States developed educational materials and tools to educate and inform consumers about the full range of contraceptive options and services. The learning community adopted several innovative practices aimed at improving consumer awareness and understanding of contraceptive options and services, and disseminated information through meetings, social media, and marketing campaigns. The approaches featured below varied in size, cost, and reach.

State	Innovation Summary
DE	The Delaware Contraceptive Access Now (Delaware CAN) program is a comprehensive, statewide plan for increasing access to the full range of contraceptive methods. Upstream USA supports Delaware CAN by providing training, assistance, and quality improvement support to all publicly-funded health centers with the goals of increasing provider awareness and consideration of contraceptive services and facilitating no-cost birth control. In addition to building provider capacity, Upstream USA implemented an evidence-informed public awareness campaign that reflects women's attitudes and best practices in social media marketing and engagement. The campaign, known as "Be Your Own Baby," translates what was learned through focus groups and interviews with women of reproductive age into targeted marketing messages and approaches. The marketing campaign is delivered through an interactive website that women can use to find nearby providers who provide free birth control, schedule appointments, secure free transportation (provided through a rebate arrangement between Upstream and

Uber), and get reimbursed for co-payments incurred at the point of service. Philanthropic groups provided the funding through a seven-year grant.

SC — In 2014, Choose Well, the South Carolina Contraceptive Access Campaign, partnered with the University of Charleston to design and pilot a LARC access campaign to raise awareness, increase knowledge, and improve access to LARC methods for young women in Charleston. The project's two goals included increasing positive perceptions of LARC methods among young women ages 18-24 years and prompting conversations about LARC between young women and their physicians. The "Keep Calm and LARC On" campaign disseminated messages through print and digital resources (e.g., infographics and YouTube video blogs), social media, traditional media, and in-person campus events. Despite the limited resources—the initial campaign budget totaled $770—the strategic use of resources enabled the pilot project to achieve outcomes that would inform a subsequent expansion.

New York City — A sexual and reproductive justice framework informed New York City's "Maybe the IUD" campaign. The five-year public awareness and community engagement initiative that began with a focus on increasing intrauterine device (IUD) use expanded to include all forms of birth control. Focus groups and stakeholder engagement informed the campaign, which launched in fall 2015. The campaign disseminated information through Spanish and English print ads, the campaign's website, social media, and mailings to clinical and community providers. A post-campaign online survey found that 70 percent of individuals who saw the ads were likely to report familiarity with the IUD as compared to 56 percent for all respondents. The New York City Department of Health and Mental Hygiene has adopted other education and awareness strategies, including an upcoming mobile app that presents sexual health for all populations, and a sexual and reproductive healthcare best practice guide and clinical assessment survey.

Partner with Religiously-Affiliated Health Systems and Faith Communities

Several teams noted the importance of engaging with religiously-affiliated health systems, which are significant care providers in many learning community states. According to an Illinois team member, the Illinois Perinatal Quality Collaborative is leading discussions with the state's Catholic institutions, allaying concerns that the state was prescribing or directing family planning policies. "We are at the table with them," the member said. Similarly, Montana team members noted that they were in early discussion with the state's Catholic hospitals about immediate postpartum LARC for certain high-risk populations.

In addition, the Illinois team members work closely with Chicago's First Ladies Group—a group of Episcopalian and Baptist churches on the city's south and west sides—to educate community members about vasectomies and other contraceptive options. The Chicago Department of Public Health produces educational flyers for distribution by the First Ladies Group.

Engage Foundations and Private Funders

Foundation and privately-funded projects played a critical role in supporting contraceptive access initiatives in several learning community states. Such funding partnerships are not new developments; for example, in 2008 Colorado's Department of Public Health and Environment received almost $28 million from a private foundation to create the Colorado Family Planning Initiative, in which 68 Title X

clinics provided free and low-cost LARCs to women across the state. Other examples of foundation and privately-funded state contraception access projects include:

- In February 2017, Upstream USA provided private funding of more than $10 million to the **Delaware** initiative Delaware CAN, which seeks to improve women's health and birth outcomes by ensuring same-day access to the full range of contraceptive methods.
- In late 2017, the J.B. and M.K. Pritzker Foundation funded a statewide collaborative in **Illinois** to increase contraceptive access with an emphasis on LARCs. The first year will engage multiple stakeholders, including the University of Chicago, Illinois Department of Public Health, Chicago Department of Public Health, and EverThrive (the initiative's convener). According to the Illinois team members, conversations are under way with Upstream about the team's potential role with the initiative.
- The **Oklahoma** Health Care Authority brought together partners from regional foundations, the Oklahoma State Department of Health, the state's major health insurance companies, and professional associations to undertake an innovative program: a two-year, statewide project that uses private funding (matched with federal funds) to increase LARC utilization. Additional information on Oklahoma's approach is available in ASTHO's 2016 state story.

CONCLUSION AND NEXT STEPS

In the project's third year, IAC Learning Community state and territorial teams achieved numerous accomplishments that moved them closer toward attaining their contraceptive access goals. In its fourth year, ASTHO will build on the collective achievements of the learning community and help the participating states and territories implement their action plans, making needed adjustments that respond to changes in population needs and in the political and public funding environment. ASTHO will develop the learning community's technical assistance activities to respond to emerging and common requests for assistance, including regarding reproductive justice and incorporating contraceptive access into opioid and other substance use disorder prevention strategies.

Working closely with CDC, CMS, OPA, and national partners, ASTHO will build state and territorial capacity through the following peer-to-peer sharing and networking and targeted technical assistance activities.

- *Virtual learning sessions*: As in prior years, the learning community will host four virtual learning sessions that incorporate emerging themes and challenges identified by the learning community. The first session, on October 26, 2017, featured federal and national partner presentations, previewed upcoming activities and evaluation expectations, and highlighted learning community successes.
- *Technical assistance webinars*: Learning community-wide technical assistance webinars are an efficient way to provide targeted assistance and respond to common requests for information and assistance. In August 2017, ASTHO hosted a technical assistance webinar on immediate postpartum LARC toolkits. ASTHO will continue to host targeted webinars in the learning community's fourth year, beginning with a December webinar on innovative stakeholder partnerships.
- *Learning community online library*: As in prior years, ASTHO will continue to expand the IAC online library to share best practices, state experiences, and key learning community resources. In response to learning community needs and requests for assistance, ASTHO

continues to develop and disseminate state stories, factsheets, and issue briefs through its Increasing Access to Contraception web page.

- *In-person close-out meeting*: ASTHO convened all learning community members and partners at a final, close-out meeting May 15-16, 2018 to share the work they have accomplished, the lessons they learned along the way, and their plans for sustaining momentum moving forward. ASTHO will develop and disseminate a meeting report to capture state accomplishments, evaluation findings, and share key resources identified by federal, national, state and other partners.
- *Technical assistance*: Several themes and challenges emerged from the second round of learning community technical assistance calls that took place in fall 2017. In addition to addressing these through the virtual learning sessions and targeted technical assistance webinars, ASTHO will continue to provide customized, one-on-one technical assistance to help each participating state or territory implement its workplan and achieve its access goals. In February 2018, ASTHO will communicate with every team to confirm that all technical assistance needs have been addressed and identify any remaining technical assistance needs.
- *Evaluation*: Beginning in June 2018, UIC evaluators will interview state and territorial teams to collect qualitative and quantitative data that will inform the process and outcome evaluations. Key informant interviews will focus on team activities, strategies, and barriers related to the learning community's nine focus areas. Closing interviews will seek to understand the role that the learning community played in each team's work.

Moving into its fourth year, the learning community has again expanded to include Tennessee and Los Angeles County. Now 29-strong, the learning community is at a critical point: it collectively offers a rich base of knowledge, practices, and tools that can inform other states as they take steps to address barriers and improve contraceptive access.

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APPENDIX A. University of Illinois at Chicago Matrix of Focus Areas Included in State Goals, 2016-2017

	Provider Awareness and Training	Reimbursement and Financial Sustainability	Informed Consent and Ethical Considerations	Logistical, Stocking, and Admin. Barriers	Consumer Awareness	Stakeholder Partnerships	Service Locations	Data, Monitoring, and Evaluation	Specific Populations	All Strategy Goal
Cohort 1										
Colorado	X	X						X		
Georgia	X				X			X		
Iowa	X			X			X	X		
Massachusetts		X		X						
New Mexico	X	X			X		X	X		
South Carolina	X				X		X		X	
Cohort 1 Total	5	3	0	2	3	0	3	4	1	0
Cohort 2										
Delaware				X		X				X
Indiana	X				X	X		X		
Louisiana	X	X	X		X	X		X		
Maryland	X						X	X		
Montana	X				X		X			
Oklahoma	X		X		X					
Texas	X		X		X					
Cohort 2 Total	6	1	3	1	5	3	2	3	0	1
Cohort 3										
Alabama	X				X	X				
Alaska	X	X				X				
California					X	X	X			
CNMI	X	X		X	X					
Connecticut	X				X		X			
Florida				X			X			
Illinois	X			X	X					
Kentucky	X					X				
Mississippi	X					X				
New York	X		X	X	X	X				
North Carolina	X	X			X					
Washington	X	X		X	X		X			
West Virginia	X			X	X				X	
Wyoming	X							X		
Cohort 3 Total	12	4	1	6	9	6	4	1	1	0
Total	**23**	**8**	**4**	**9**	**17**	**9**	**9**	**8**	**2**	**1**

APPENDIX B: Increasing Access to Contraception State Team Accomplishments in Years 1-3

Focus Area	Team Accomplishments
Provider awareness and training (#1)	• **The Commonwealth of the Northern Mariana Islands** contacted Merck for implant insertion/removal training. • **Colorado** completed a long-acting reversible contraception (LARC) Myths factsheet for providers to utilize. • **Florida** administered a LARC training questionnaire to Florida Department of Health family planning providers and programs to assess additional training implementation needs. • **Indiana's** Perinatal Quality Improvement Collaborative created a LARC toolkit that was distributed statewide. • **Illinois'** Chicago Department of Public Health developed a symposium to improve youth-friendly services for Chicago providers with a focus on offering LARCs. • **Louisiana** facilitated a daylong training on LARCs and motivational interviewing for 60 federally qualified health center (FQHC) partners • **Mississippi** executed contraceptive counseling and One Key Question training and was also able to conduct a survey of OB-GYNs and nurse practitioners on their attitudes, behaviors, and beliefs with regard to providing LARC. • **New Mexico** successfully integrated separate projects focused on immediate postpartum and interval LARC to deliver clinical and administrative training and support to three geographic regions, three hospitals, two federally qualified health center networks, and more than 50 clinicians and administrative staff. • **Washington** announced that Upstream USA is going to provide LARC training to providers in Washington state. The Washington State Department of Health and Upstream USA are now doing preliminary work on this project. Upstream USA will set up an office in Washington state, and training is anticipated to start in the summer of 2019. Federally qualified health centers are among the target providers. • **Wyoming** identified key opportunities from pilot hospital assessment with Cheyenne Regional Medical Center to guide development of LARC-related resources and training. • **Alaska** implemented a successful LARC provider survey.
Reimbursement and financial sustainability (#2)	• **Colorado** submitted a LARC carve-out for immediate postpartum LARC and FQHCs that is waiting on approval from the Centers for Medicare and Medicaid Services. • **Florida** separated LARC devices from the diagnosis-related group which allowed the state to implement a pilot program in Jacksonville.

Focus Area	Team Accomplishments
	• **Iowa** obtained agreements from two of three state managed care organizations (MCOs) to pay for immediate postpartum LARC. • **Massachusetts'** Division of Insurance surveyed private insurance plans and found that six of 11 plans cover immediate postpartum LARC unbundled. • **Maryland** held a billing and contracting webinar on Title X Family Planning Clinics on Sept. 25, 2017. • **Illinois** received funding from the J.B. and M.K. Pritzker Family Foundation to form a collaborative to increase contraceptive access with an emphasis on LARC. • **Montana** received approval from the Centers for Medicare and Medicaid Services (CMS) to unbundle LARC from an all-inclusive rate for FQHCs and rural health centers. • **North Carolina** successfully changed its rate methodology for all Physicians Drug Program contraceptives. • **New York's** Quality Improvement Network for Contraceptive Access held two virtual learning sessions on immediate postpartum intrauterine device (IUD) insertion and considerations and on same day provision of contraception. They also held a two-day in-person learning session on billing, coding, reimbursement, and revenue cycle management. • **Oklahoma's** State Plan Amendment was changed to remove restrictions on LARC devices for Medicaid members to support better access to LARC.
Informed consent and ethical concerns (#3)	• **Maryland** incorporated birth spacing and reproductive justice messaging into its immediate postpartum LARC toolkit. • **Texas** reported that HHS is continuing to work on implementing the One Key Question program and identifying LARC access challenges.
Logistical, stocking and administrative barriers (#4)	• **Louisiana** developed a reproductive health supply procurement guide for Title X sub-grantee FQHC partners. • **New Mexico** reported that it had established advocacy within the New Mexico Statewide LARC Working Group to achieve administrative funds for LARC stocking as a provision of the current Medicaid 1115 waiver application.

Focus Area	Team Accomplishments
Consumer awareness (#5)	• **California** collaborated with the California Department of Health Care Services' Medi-Cal Managed Care Quality Unit to study LARC utilization within managed care plans. • **New York** reported that through the Infant Mortality CoIIN, participating programs demonstrated an increase from 47.6 percent to 60.7 percent in effective contraceptive selection among their postpartum clients • **Delaware** developed the Be Your Own Baby Campaign.
Stakeholder partnerships (#6)	• **Arkansas** organized a LARC summit with key stakeholders, in conjunction with the Alaska State Hospital and Nursing Home Association conference, to discuss the need for postpartum LARC in Alaska with hospital administrators, educators, and clinicians. • **Kentucky** held a stakeholder meeting to meet LARC-related partners, review the status of the state LARC initiative, and identify reimbursement policies for LARC pilot sites. • **Los Angeles County** is developing a relationship with Health Net, with assistance from AltaMed independent practice association. • **South Carolina** is continuing its birth outcomes initiative stakeholder partnerships with Choose Well to expand its established efforts for immediate postpartum LARC. • **Texas** Health and Human Services hosts bi-monthly LARC stakeholder meetings to discuss challenges and successes with recently updated LARC policies in Texas.
Service locations (#7)	• **Commonwealth of the Northern Mariana Islands** continued its mobile clinic outreach at the high schools on all three islands. • **Los Angeles County** approached eight hospitals with a high volume of deliveries, representing diverse geography, systems, and percentages of MediCal births about providing access to immediate postpartum LARCs. • **South Carolina** is working with Palmetto Health Hospital to implement a five-site pilot of a contraceptive choice mobile unit. • **West Virginia** successfully implemented immediate postpartum LARC at three teaching Institutions, with plans to expand to two community hospitals. • **Wyoming** worked with a Cheyenne pilot hospital to assess immediate postpartum LARC readiness and training needs.

Focus Area	Team Accomplishments
Data, monitoring and evaluation (#8)	• **California** successfully completed and reported its 2014 and 2015 contraceptive care measures to HHS. • **Iowa** is developing a process to evaluate reproductive healthcare access under the new state-funded LARC program. This program began on July 1, 2017 and replaces the Iowa Family Planning Waiver. • **Kentucky** established a baseline rate of most and moderately effective contraception use in the Kentucky Medicaid population. • **Massachusetts** is working with the Massachusetts League of Community Health Centers to include contraceptive performance measures. • **Maryland** created a billing workgroup listserv and team drive for family planning resources and data sharing. • **North Carolina**'s unintended pregnancy rates among pregnancy medical home births dropped from 52.5 percent in 2012 to 45.7 percent in 2016. • **Oklahoma's** state health agency reported an increased in state LARC utilization: Nexplanon use increased by 13 percent and IUD use increased by 1.2 percent.
Specific populations (#9)	• **Arkansas** partnered with the Mat-Su Valley Perinatal Opioid Treatment Program to address LARC and prevention of neonatal abstinence syndrome. • **Montana** is working with a community drug task force to increase LARC access for women with substance use disorders who are incarcerated in county facilities. • **West Virginia** successfully partnered LARC services with harm reduction entities to promote better health of women of childbearing age with substance use disorders and reduce the incidence of neonatal abstinence syndrome.

APPENDIX C. The Increasing Accessing to Contraception Learning Community Logic Model

This document was created by the University of Illinois at Chicago (UIC) evaluation team under the direction of Principal Investigator Dr. Kristin Rankin for the ASTHO Increasing Access to Contraception Learning Community. It was developed using information collected from interviews with key staff members of the 27 state teams participating in the learning community. Interviews centered on the contraception-related activities states are conducting in order to achieve their goals for increasing access to contraception. (For reference, Appendix B contains a matrix of participating states and their goals that is organized under the learning community's nine focus areas.

The first page of this logic model represents the broad short-term, intermediate, and long-term goals and objectives of ASTHO's efforts to increase access to the full range of contraception and illustrates some of the contextual and resource-related factors that likely influence states' abilities to achieve those goals. The pages that follow contain some of the specific activities that the UIC evaluation team learned about during our interviews. These have been categorized under the nine focus areas of the learning community. Because our interviews were conducted at the state level, the state-level activities in this table are more complete than the local- and national-level activities.

This logic model is part of a framework that the UIC team is using as part of a larger process and outcome evaluation. None of the states participating in the learning community is conducting all of the activities listed in this document and, to date, none of the activities listed in this document has been tested or evaluated as an evidence-based intervention to increase access to contraception. Rather, this list represents a compilation of activities that states described, which we are sharing in this document in order to help states and other organizations plan their own activities, outputs, and outcomes for increasing access to contraception.

Context	Inputs	Activities	Outputs	Short-Term Outcomes	Intermediate Outcomes	Long-Term Outcomes
National: • Political climate **State:** • Political climate • Size/ demographics • Urbanicity • Climate for family planning • Medicaid MCO structure • Perinatal regionalization • Number of service locations	**National:** • Funding for family planning services • American College of Obstetricians and Gynecologists (ACOG), CDC, Office of Population Affairs (OPA) clinical guidance regarding contraceptive counseling and LARCs. • Federal initiatives on infant mortality, postpartum and inter-conception health, and contraceptive access (see arrow below). • Resources from organizations such as the Guttmacher Institute and the National Campaign to Prevent Teen and Unplanned Pregnancy **State:** • Funding for family planning services.	*See table below for activities, which are listed by learning community strategy and level (national, state, or local).*	*See table below for outputs listed by learning community strategy.*	• State policies established to: o Reimburse for the full range of contraceptive services. o Reimburse at cost for LARC and other methods. o Reimburse for LARC placement immediately postpartum. o Remove administrative barriers, such as pre-authorization. • Reduced logistical barriers for supply management of LARC devices. ↓ • Increased access to full range of most effective or moderately effective methods at outpatient clinics providing contraceptive services. • Increased access to immediate postpartum LARC in birthing facilities throughout the state.	• Increased uptake of most effective or moderately effective contraceptive methods by: o Women of reproductive age o Postpartum women • Improved client experience with contraceptive counseling services. • Improved client satisfaction with chosen contraceptive method.	• Increase in percentage of pregnancies that are planned. • Appropriate pregnancy spacing. ↓ Reductions* in: • Preterm birth • Infant mortality • Maternal morbidity Improved*: • Maternal educational and economic outcomes Reductions in: • Costs to the healthcare system

CMCS Maternal and Infant Health Initiative CMMI SIM Initiative CDC Teen Pregnancy Winnable Battle CDC 6|18
OPA Quality Family Planning Guidelines/Contraceptive Measures HRSA/MCHB CoIIN Preconception and Interconception Strategy

Overarching Goal: To support the Triple Aim: (1) Improve the individual experience of care, (2) improve the health of populations, and (3) reduce the per capita costs of care for populations.

*Increasing contraceptive access to reduce unintended pregnancy and improve birth spacing is one strategy for improving birth outcomes and maternal health and opportunity; complementary strategies to improve the social determinants of health are also needed to move the needle on these long-term outcomes.

Supplementary Table to Logic Model: Activities to Support Increased Contraceptive Access in States, by ASTHO Learning Community Focus Area and Level, with Associated Outputs

Focus Area	Activities by Level of Initiation			Outputs
	National Level	**State Level**	**Local Level**	
Cross-cutting	• Convene ASTHO Increasing Access to Contraception Learning Community.	• Share successful facility-level strategies through toolkits or protocol templates that can be adapted for local use. • Develop quality improvement initiatives to improve access to the full range of most and moderately effective methods.	• Develop a facility-level LARC protocol. • Involve administrators, pharmacists, and other non-clinical staff in LARC training/education to encourage buy-in.	• Number of state toolkits disseminated. • Proportion of birthing facilities with a protocol created. • Participation rate of state team members in national initiatives.
Reimbursement and financial sustainability	• CMS-OPA guidance (e.g., 90/10). • 340B pricing (outpatient only).	• Change LARC Medicaid billing and reimbursement process. • Implement IT systems and coding process after policy change. • Reach out to facilities to provide guidance on appropriate coding. • Create Medicaid State Plan Amendments, where needed. • Engage private insurers and Medicaid MCOs in creating enhanced reimbursement. • Engage private foundations to leverage state funds. • Develop a coverage and reimbursement factsheet that includes device costs and the 340B Drug Pricing Program. • Conduct a fiscal scan of federal, state, local, and private LARC resources.	• Amend or develop facility billing and coding procedures (e.g. coder training or technical system changes at facility level) • Test LARC inpatient reimbursement changes (hospital and Managed Medical Assistance Plan). • Provide one-to-one technical assistance services for hospitals to reduce LARC reimbursement barriers. • Provide ongoing support to billing staff.	• Proportion of outpatient and inpatient facilities in state with complete billing and coding procedures in place.

Focus Area	Activities by Level of Initiation			Outputs
	National Level	**State Level**	**Local Level**	
		• Identify training opportunities on the family planning budget program using coordinators from that program. • Explore ways to leverage federal dollars.		
Logistical, stocking, and administrative barriers	• Work with device manufacturers to incentivize providers (e.g. create LARC pods in the clinics). • Develop policies that reduce per capita costs (e.g., bundling/re-bundling services).	• Investigate options for bulk ordering or using coupons to stock LARC. • Identify barriers to implementing LARC policies to reduce costs. • Identify barriers to accessing contraceptive prescription drugs and devices. • Develop a tip sheet for administrative and infrastructure support that includes stocking and supply of LARC. • Include LARC in emergency preparedness plans.	• Change settings to remove logistical barriers to placing LARCs inpatient (e.g. store LARCs on floor in Pyxis; stock bedside supplies for implant insertions). • Solicit donated or loaned devices from manufacturers. • "Buy and bill" devices. • "White bag" devices. • Engage inpatient pharmacies to develop policies for stock and storage for immediately postpartum LARC supplies.	• Proportion of facilities (inpatient and outpatient) with LARC stocked. • Proportion of facilities with LARC supply-chains in place.
Stakeholder partnerships	• Identify, engage with, and align efforts with national partners, such as: o NFPHRA o ACOG o AAP o AMCHP o ASTHO o Federal agencies (CDC, CMS, OPA, etc.) o National Campaign to Prevent Teen and Unplanned Pregnancy	• Identify and engage stakeholders (see examples in Appendix A). • Organize stakeholders into a consortium or advisory group or leverage the existing maternal and child health consortium with shared goals and a common agenda. • Draft and distribute a white paper to partners and discuss current LARC policies, plans, and fiscal impact.	• Conduct regional meetings of stakeholders to discuss diversity, access within the coalition, and current contraception access. • Receive support from stakeholders regarding distribution of the immediately postpartum LARC toolkit.	• Number of active state partner organizations. • Quality of stakeholder partnerships.

Focus Area	Activities by Level of Initiation			Outputs
	National Level	**State Level**	**Local Level**	
		• Disseminate toolkit to partners. • Engage stakeholders in evaluation planning and implementation.		

Data, monitoring, and evaluation	• Define measures of success.
	• Coordinate monitoring and evaluation efforts across federal agencies.
	• Integrate:
	  • Contraceptive performance measures
	  • Developmental client-reported experience performance measures
	  • CoIIN performance measures
	• Evaluate policy uptake.
		• Create an evaluation subcommittee in the state working group.
		• Establish data sharing agreements between the Medicaid agency and state health agency.
		• Clearly define data needs for Medicaid analysts.
		• Review available baseline data.
		• Use PRAMS and Medicaid data to monitor uptake of most and moderately effective contraceptive methods.
		• Add immediate postpartum LARC field to birth certificate.
		• Monitor progress of adoption of LARC procedures in hospitals and clinics.
		• Measure impact and return on investment.
		• Develop and conduct qualitative/quantitative needs assessment of FQHCs (reimbursement status/ strategies).
			• Use hospital/clinic administrative and electronic medical record data to examine uptake of most and moderately effective contraceptive methods and denial rate.
			• Conduct follow-up studies with LARC users to understand satisfaction, experience, and efficacy.
			• Compare data geographically and by sub-population.
			• Develop and administer program evaluations.
				• Data sharing agreement established between Medicaid and health agency.
				• Set of performance measures defined at national level.
				• State teams have selected performance measures.
				• Number of state performance monitoring reports generated.

Service locations	• Engage with the Indian Health Service to discuss	• Engage with religiously-affiliated health systems, Title X clinics, FQHCs, school-	• Conduct service location needs assessments.	• Proportion of state outpatient service

Focus Area	Activities by Level of Initiation			Outputs
	National Level	**State Level**	**Local Level**	
	stocking, billing, and outreach strategies. • Engage with the National Health Service Corps to train providers that will work in underserved clinics.	based health centers, and other partners to identify barriers to accessing contraception across states. • Conduct an environmental scan of providers inserting and removing LARCs, including those providing vasectomies. • Develop a telemedicine pilot project for remote locations.	• Provide mobile clinics to reach schools.	locations with needs assessments completed • Proportion of needs assessments with associated strategies to address needs
Provider awareness and training	• Disseminate: o Federal recommendations: QFP, MEC, SPR o American Academy of Pediatrics clinical guidelines. o ACOG practice bulletins. • Maintain national evidence-based guidelines. • Provide in-person training by device manufacturers at national professional conferences.	• Conduct an environmental scan/needs assessment to identify gaps/need for further training. • Identify provider champions within American College of Obstetricians and Gynecologists and American Academy of Pediatrics chapters • Host a LARC symposium, an educational meeting for providers across the state. • Develop contraception counseling trainings for health educators at FQHCs. • Determine the appropriate mode for trainings (self-paced, single event, short-term, intensive long-term with a request for application component.) • Develop preconception care algorithm to ensure discussion of reproductive life	• Establish clinical champions within facilities to provide peer-to-peer training. • Develop a training schedule for providers and hospital staff. • Enhance the cultural competency of providers. • Create pre/post learning objectives. • Maximize the effectiveness of residency training programs. • Train clinicians and frontline staff for inpatient and outpatient settings • Identify steps for providers to receive continuing medical education credits for regional trainings. • Conduct lunch and learn webinars on contraception/LARC for	• Number of national-level trainings. • Number of state-run trainings. • Number of providers trained. • Number of medical residents trained. • Proportion of facilities (inpatient and outpatient) with at least one trained LARC provider. • Proportion of providers aware of current LARC guidelines. • Provider knowledge about LARC benefits and side effects.

Focus Area	Activities by Level of Initiation			Outputs
	National Level	**State Level**	**Local Level**	
		planning/contraception at all care visits. • Develop a webinar on the importance of preconception care for providers. • Develop training for clinic staff (pharmacy, labor and delivery, postpartum unit, obstetric/surgical). • Conduct trainings on LARC insertion/removal, client-centered counseling, education, same-day insertions, evidence-based guidelines, and social determinants of health. • Conduct outreach training visits to perinatal centers. • Implement reproductive health ECHO project. • Inform providers of training opportunities through statewide perinatal care program, the rural health association, and the American College of Obstetricians and Gynecologists. • Create an online provider community to share resources	Medicaid, MCOs and providers. • Conduct intra-agency trainings. • Use baseline data to assess provider knowledge, behavior, and skills about immediately postpartum LARC to inform trainings.	
Informed consent and ethical considerations	• Disseminate OPA guidance. • Develop an OPA measure of client experience.	• Create and disseminate protocols for how to discuss contraceptives, including LARC, in a patient-centered way.	• Engage with local community groups about how to best counsel for LARCs. • Have LARC educational materials available in	• Proportion of outpatient and inpatient facilities with counseling and consent protocols developed.

Focus Area	Activities by Level of Initiation			Outputs
	National Level	**State Level**	**Local Level**	
	• Initiate CMS billing activities to enhance counseling. • Disseminate research on best practices for counseling and consent.	• Draft consent language to bring to facilities' legal departments. • Conduct patient education on prenatal contraception decisionmaking. • Develop a shared decisionmaking model for contraceptive counseling.	medical facility waiting rooms. • Develop LARC educational materials on maintenance of side-effects. • Follow up with clients about education and consent process as quality improvement.	
Consumer awareness	• Partner with the National Campaign to Prevent Teen and Unplanned Pregnancy. • Disseminate MEC and SPR. • Engage with La Leche League about immediately postpartum LARC and breastfeeding data.	• Create a statewide LARC text message Q&A service. • Create a mobile app to help clients identify LARC service providers. • Create state-specific LARC webpages. • Include LARC education materials in Medicaid benefit card mailings. • Conduct public information campaigns (print, radio, and social media ads), including "myth busting," sexual and reproductive health, and family planning services. • Engage minority health groups, reproductive justice groups, youth, WIC, school nurses, universities, child advocacy centers, and home visitors to ensure clear messaging for consumers. • Ensure consistent messaging across agencies.	• Distribute educational materials from the National Campaign to Prevent Teen and Unplanned Pregnancy. • Distribute multilingual educational materials to schools and parents. • Develop and distribute a provider factsheet highlighting the benefit of LARC for commercial payers. • Explore a social media communication strategy to ensure that messaging reflects local community culture.	• Proportion of state covered by public information campaign. • Number/proportion of state providers (*to be defined*) that receive up-to-date MEC and SPR documents. • Proportion of people of reproductive age who have heard of LARC methods.

Focus Area	Activities by Level of Initiation			Outputs
	National Level	**State Level**	**Local Level**	
Specific populations	• Partner with the National Campaign to Prevent Teen and Unplanned Pregnancy.	• Partner with state prisons to include contraception as a pre-release option. • Allow emergency Medicaid immediate postpartum LARC reimbursement.	• Partner with drug rehabilitation facilities to include access to contraception. • Offer extended and weekend hours.	• Proportion of clients satisfied with contraceptive options available.

Examples of Stakeholders:

- Health department
- Medicaid agency
- Private insurers
- Medicaid managed care organizations
- Title V and X teams
- Academia
- Medical association
- Rural health association
- Minority health association
- American College of Obstetricians and Gynecologists chapter
- American Gynecological and Obstetrical Society chapter
- American Academy of Family Physicians chapter
- American College of Nurse-Midwives chapter
- American Academy of Pediatrics chapter
- Hospital association
- Perinatal quality collaborative
- March of Dimes
- Community health workers
- Governor's office
- Office of population affairs
- Family physicians
- Federally qualified health centers
- Department of mental health
- Teen pregnancy prevention advocates
- Faith-based organizations
- YWCA
- Perinatal opioid taskforce
- School and public health nurses
- Correctional institutions
- Planned Parenthood

List of Abbreviations

AAFP	American Academy of Family Physicians
AAP	American Academy of Pediatrics
ACOG	American Congress of Obstetricians and Gynecologists
ACNM	American College of Nurse-Midwives
AGOS	American Gynecological and Obstetrical Society
AMCHP	Association of Maternal and Child Health Programs
ASTHO	Association of State and Territorial Health Officials
CDC	Centers for Disease Control and Prevention
CHW	Community health worker
CME	Continuing medical education
CMS	Centers for Medicare and Medicaid Services
CoIIN	Collaborative improvement and innovation network
ECHO	Extension for Community Healthcare Outcomes
EMR	Electronic medical record
FPBP	Family planning benefit program
FQHC	Federally qualified health center
HCPCS	Healthcare Common Procedure Coding System
HHS	U.S. Department of Health and Human Services
IPP	Immediate postpartum
IT	Information technology
LARC	Long-acting reversible contraception
L&D	Labor and delivery
MCH	Maternal and child health
MCO	Managed care organization
MEC	Medical eligibility criteria
NFPHRA	National Family Planning and Reproductive Health Association
OPA	Office of Population Affairs
PRAMS	Pregnancy Risk Assessment Monitoring System
QFP	Quality family planning services
RFA	Request for applications
SPR	Selected practice recommendations
TA	Technical assistance
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children

Other Definitions

Brown bagging: When a contraceptive device is purchased through a specialty pharmacy and shipped directly to the patient. The patient is then responsible for transporting the device to the provider, who inserts it.

White bagging: When a contraceptive device is ordered from a pharmacy specifically for a particular patient using her Medicaid number.