HHS Public Access

Author manuscript

Am J Public Health. Author manuscript; available in PMC 2023 January 09.

Published in final edited form as:

Am J Public Health. 2022 June ; 112(Suppl 5): S523–S527. doi:10.2105/AJPH.2022.306823.

Use of a Learning Community to Expand Access to Contraception

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Sanaa Akbarali and Ellen S. Pliska are also guest editors for this supplement issue.

CONTRIBUTORS

C. Estrich, C. L. DeSisto, K. Uesugi, and A. Velonis designed the study, conducted interviews, and analyzed the data. C. Estrich and C. L. DeSisto drafted the manuscript. S. Akbarali and E. S. Pliska led implementation of the Increasing Access to Contraception Learning Community and data collection. L. Romero, S. Cox, and C. D. Kroelinger conceptualized the Increasing Access to Contraception Learning Community and provided scientific guidance throughout the project. C. L. DeSisto and C. D. Kroelinger led the revisions of the manuscript. All authors provided substantive feedback and edits to the manuscript.

CONFLICTS OF INTEREST

The authors do not have any potential or actual conflicts of interest to disclose.

Note. The findings and conclusions in this article are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention, the Association of State and Territorial Health Officials, or the University of Illinois at Chicago.

HUMAN PARTICIPANT PROTECTION

This project was determined to be exempt by the University of Illinois at Chicago institutional review board. At the Centers for Disease Control and Prevention, the project was determined to be public health practice and did not require human participant approval.

Abstract

The Increasing Access to Contraception Learning Community was established to disseminate strategies and best practices to support 27 jurisdictions in the development of policies and programs to increase access to the full range of reversible contraceptives. We describe Learning Community activities and identify those that were most useful to participants. Although participation in Learning Community provided jurisdictional teams with structured activities such as virtual learning and peer networking opportunities, some teams struggled with full participation because of staffing turnover and shifts in priorities.

Learning collaboratives are a strategy to improve knowledge dissemination and practice, but evidence of their effectiveness remains mixed.[1,2] Some learning communities have shown substantial impact on policies, practices, and clinical outcomes, including use of most and moderately effective contraception methods,[3] whereas others have demonstrated no significant effect. Evidence is limited about which learning community components are useful to participants.

INTERVENTION AND IMPLEMENTATION

From 2014 to 2016, in partnership with the Centers for Disease Control and Prevention, other federal agencies, and maternal and child health organizations, the Association of State and Territorial Health Officials (ASTHO) convened the Immediate Postpartum Long-Acting Reversible Contraception (LARC) Learning Community.[4] In 2016, ASTHO called for letters of interest from more jurisdictions, and this collaborative expanded to become the Increasing Access to Contraception Learning Community (henceforth, the "Learning Community").[5]

PLACE, TIME, AND PERSONS

The Learning Community included 27 US jurisdictions and centered on nine focus areas (Table A, available as a supplement to the online version of this article at http://www.ajph.org).[6] The jurisdictional teams included representatives from public health, Medicaid, and clinical care leadership. In October 2016, the Learning Community began with an in-person meeting, which included the creation of jurisdictional action plans that outlined team goals. Throughout the Learning Community, ASTHO provided technical assistance, hosted virtual learning sessions, and sent additional communications to teams, including updates to available resources, which could be accessed on the ASTHO Web site. The Learning Community concluded in person in May 2018. Funding was not provided to Learning Community jurisdictions; the in-person meetings were funded by ASTHO.

PURPOSE

Evaluations of other learning communities have demonstrated their feasibility, but participation has been primarily oriented toward clinical care.[1,7,8] By contrast, the Learning Community focused on public health and included representatives from a wide array of backgrounds. Participants in the earlier years of the Learning Community reported that its framework provided structure, accountability, and perceived validity, and prepared participants for potential challenges and opportunities.[9] This article builds on those findings

by describing participant experiences with the activities of the Learning Community and evaluating which specific components (e.g., action planning, technical assistance, virtual learning sessions) were considered most useful.

EVALUATION AND ADVERSE EFFECTS

Evaluation data were collected at multiple time points by tracking technical assistance requests, administering Web-based polling to measure participant knowledge and usefulness of content immediately after virtual learning sessions, and semistructured telephone interviews with members of all 27 jurisdictional teams. Interviews were conducted during June through August 2018 and included an average of three participants per team. Interviews were audio-recorded, transcribed, and coded based on the nine focus areas and key activities.

The most common uses of the action plan were to coordinate teamwork, prioritize next steps, structure work and responsibilities, provide accountability, and guide the team when facing barriers or momentum challenges. Teams used the action plan to inform new team members, document activities for reports, and remind others in the jurisdiction that increasing contraception access was a formal priority. The majority of teams (70.4%) identified the process of developing an action plan as helpful (Table 1). Teams reported that having dedicated time at the in-person meeting to discuss the plan as a group, with a facilitator to guide the process, was also helpful. However, some teams did not think the action plan was helpful; two teams (7.4%) had existing action plans, and three (11.1%) were frustrated by ambitious action plans with achievements expected in a relatively short timeframe, or issues outside of team control such as administrative transitions and accompanying shifts in jurisdictional priorities.

Technical assistance requests were primarily related to the focus areas of reimbursement and financial sustainability, and provider awareness and training. Eleven teams (40.7%) reported that technical assistance helped further goals. Having scheduled calls for technical assistance helped keep teams accountable for action plans. Technical assistance resources were developed to be broadly applicable to all Learning Community teams. However, eight teams (29.6%) reported a need for more detailed resources customized to individual jurisdictions. Multiple teams suggested pairing with teams at similar stages of development, in similar regions, or working within similar payment systems to enable focused discussion and problem-solving.

Twenty-three teams (85.2%) participated in the virtual learning sessions, which enabled progress in their work. Based on polls after each session, 86% to 100% of participants reported increased knowledge of session subject matter (data not shown). Teams reported appreciating the sharing of resources such as LARC toolkits and how to train and support health system billing staff. Sessions were used as forums to contact experts, and teams reported peer-to-peer learning as the most beneficial component. Teams referenced using strategies from other jurisdictions to reduce barriers or facilitate progress to address challenges. Difficulty in finding time to attend the virtual learning sessions was mentioned by 11 teams; they suggested shortening sessions to one hour. Archiving sessions made it possible for teams to access the material and review sessions as needed.

The Learning Community encouraged both structured and unstructured peer-to-peer and expert-to-peer communication. The diversity in team structure enabled regular, informal connection with others of disparate areas of expertise (e.g., public health, Medicaid, and clinical care) and facilitated problem-solving. Seventeen teams (63.0%) reported increasing connections to other teams, individuals, and potential collaborating organizations in other jurisdictions. The most frequently shared resources addressed two barriers: (1) reimbursement and (2) logistical, contraceptive stocking, and administrative barriers. Teams reported that such resources increased progress, confirmed activity direction, supported success, and maintained motivation. The remaining 10 teams did not report any specific barriers to communication.

No adverse events occurred during the Learning Community, although more than half the teams (14 teams, 51.9%) reported less than full participation. Seven of these teams identified personnel changes as the main barrier. The other seven teams identified competing priorities and projects or too few resources to fully participate. Individual team members felt "stretched a little thin," compounded by the need to coordinate with multiple team members and conflicting schedules. Thirteen teams reported being able to fully participate, and one team member reflected on facilitating factors:

> I appreciate that there were actual resources . . . . We were flown to meetings. We were provided technical assistance . . . . We were provided some evaluation tools . . . . That's all very important, so I would love to see that model continue.

SUSTAINABILITY

By the end of the Learning Community, 44% of goals had been achieved by jurisdictions.[6] One year following the Learning Community, jurisdictions were continuing efforts for 87% of goals, with all jurisdictions still working on at least one goal, indicating sustainability of the activities.[6] Additionally, the Learning Community was an important precursor for the Coalition to Expand Contraceptive Access and ASTHO collaboration, as described in "Scaling Up Evidence-Based Practices in Contraceptive Access Initiatives" in this issue (Malcolm et al., p. S473). Six of the seven states involved in that collaborative were also part of the Learning Community.

PUBLIC HEALTH SIGNIFICANCE

Nearly every team found participation in the Learning Community to be helpful in developing programs and policies. Teams identified the opportunity to engage in a structured planning process as useful and reported that peer learning, both within and across teams, generated new ideas and effective strategies to overcome barriers, particularly those related to reimbursement. Other learning communities have also found that coordinated, structured planning by multidisciplinary teams,[1] and learning from both experts and peers,[8] are useful.

The interviews identified several challenges inherent to multiyear learning communities, including the need for organizations to continue momentum despite participant turnover. For some teams, maintaining momentum was challenged by unachievable action plan goals.

Organizations planning learning communities may consider proposing activities to prioritize goals while establishing specific, measurable, actionable, and time-limited objectives.

Experiences of jurisdictional early adopters of Medicaid contraceptive reimbursement policies demonstrate that policy change alone is insufficient to increase access to the full range of effective contraceptive methods.[10,11] Implementation strategies are needed to bridge the gap between policy and access to contraception. Interviews suggested that participation in a multisectorial learning community composed of jurisdictional officials and providers can serve as a useful strategy to overcome implementation barriers and increase the effectiveness of health care systems change. Participating in a learning community can add to perceived credibility and prioritization of efforts to improve contraceptive access. When actual policy use has stalled, policymakers may find value in encouraging participation in a learning community to discover and share policy-development best practices.[9,12]

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

ACKNOWLEDGMENTS

This work was partially supported by the Centers for Disease Control and Prevention (CDC-RFA-OT18-1802.NU38, award no. 6NU38OT000290-01-02).

We acknowledge and thank the participating teams in the ASTHO Increasing Access to Contraception Learning Community for their contributions. We also thank the Office of Population Affairs and the Center for Medicaid and Children's Health Insurance Program Services from the Centers for Medicare and Medicaid Services for their leadership and participation in this learning community.

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TABLE 1—

Jurisdictional Team Experiences With Increasing Access to Contraception Learning Community (IAC LC) Activities: 2016–2018

Team #	Technical Assistance (TA)	Virtual Learning	Action Plan	Communications Within IAC LC Increased?	Fully Able to Participate?
1	Had barriers no TA could help	Rarely participated, did not use them	Helpful	No	No
2	Don’t remember	Participated, helpful	Helpful	No	No
3	TA they wanted was not available	Participated, not helpful	Unclear	No	No
4	Not asked	Not asked	Not asked	Increased	No
5	TA helpful	Participated, helpful	Helpful	Unclear	No
6	Not asked	Couldn’t remember participating	Helpful	No	No
7	TA helpful	Participated, helpful	Helpful	Increased	Yes
8	“Somewhat” helpful, TA they wanted was not available	Participated, helpful	Helpful	Increased	Yes
9	TA helpful	Participated, helpful	Helpful	Increased	Yes
10	TA they wanted was not available	Participated, did not use	Helpful	Increased	Yes
11	Had barriers no TA could help	Participated, helpful	Not helpful	Increased	No
12	TA helpful	Participated, helpful	Helpful	No	Yes
13	TA helpful	Participated, helpful	Not helpful	Increased	No
14	TA helpful	Participated, helpful	Helpful	Increased	No
15	TA helpful	Participated, helpful	Helpful	No	No
16	TA helpful	Participated, helpful	Unclear	Increased	No
17	TA helpful	Participated, helpful	Helpful	No	Yes
18	TA not helpful	Participated, helpful	Helpful	Increased	Yes
19	TA helpful	Participated, helpful	Helpful	Increased	Yes
20	TA not helpful	Participated, helpful	Helpful	No	Yes
21	Don’t remember	Participated, helpful	Helpful	No	Yes
22	TA not helpful	Participated, helpful	Helpful	No	No
23	Had barriers no TA could help	Did not participate	Not helpful	No	No
24	TA helpful	Participated, helpful	Helpful	Increased	Yes
25	Did not get wanted TA, not helpful	Participated, helpful	Not helpful	Increased	Yes
26	TA helpful	Participated, helpful	Helpful	Increased	Yes

Team #	Technical Assistance (TA)	Virtual Learning	Action Plan	Communications Within IAC LC Increased?	Fully Able to Participate?
27	Got all requested TA, no mention of helpful versus not helpful	Participated, helpful	Unclear	Increased	No

Note. Participating jurisdictional teams include the following: Alabama, Alaska, California, Colorado, Commonwealth of the Northern Mariana Islands, Connecticut, Delaware, Florida, Georgia, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maryland, Massachusetts, Mississippi, Montana, New Mexico, New York, North Carolina, Oklahoma, South Carolina, Texas, Washington, West Virginia, and Wyoming.