Author Manuscript
Author Manuscript
Author Manuscript
Author Manuscript

HHS Public Access
Author manuscript
J Womens Health (Larchmt). Author manuscript; available in PMC 2023 May 30.

Published in final edited form as:
J Womens Health (Larchmt). 2021 September ; 30(9): 1217–1224. doi:10.1089/jwh.2021.0414.

Increasing Access to Contraception in the United States: Assessing Achievement and Sustainability

Carla L. DeSisto, PhD, MPH[1], **Cameron G. Estrich, PhD, MPH**[2], **Charlan D. Kroelinger, PhD**[1], **Ellen Pliska, MHS**[3], **Sanaa Akbarali, MPH**[3], **Lisa Romero, DrPH, MPH**[1], **Shanna Cox, MSPH**[1], **Alisa Velonis, PhD, MPH**[2]

[1]Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, Chamblee, Georgia, USA.

[2]Division of Community Health Sciences, School of Public Health, University of Illinois at Chicago, Chicago, Illinois, USA.

[3]Family and Child Health, Association of State and Territorial Health Officials, Arlington, Virginia, USA.

Abstract

Background: During October 2016 through May 2018, a learning community was convened to focus on policies and programs to increase access to the full range of contraceptive options for women of reproductive age. The Increasing Access to Contraception (IAC) Learning Community included 27 jurisdictions, with teams from each jurisdiction consisting of state health department leaders, program staff, and provider champions. At the kick-off meeting, teams from each jurisdiction created action plans that outlined their goals.

Methods: We contacted jurisdictions during May–June 2019, 1 year after the learning community ended, and invited them to complete a post-assessment of goal achievement and sustainment through semi-structured interviews over the telephone or *via* email.

Results: Follow-up information was collected from 26 jurisdictions (96%) that participated in the learning community. The teams from these jurisdictions had created 79 total goals. At the time of the learning community closing meeting in May 2018, 35 goals (44%) had been achieved. Three jurisdictions achieved all their goals by the close of the learning community. At the time of the post-assessment 1 year later, jurisdictions were sustaining efforts for 69 (87%) of the total goals. In every jurisdiction, work on at least one goal that originated in the learning community was sustained.

Address correspondence to: Carla L. DeSisto, PhD, MPH, Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, 4770 Buford Highway NE, Mailstop S107-2, Chamblee, GA 30341-3717, USA, wup5@cdc.gov.

Disclaimer
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.

Author Disclosure Statement
No competing financial interests exist.

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Conclusions: The jurisdictions that participated in the IAC Learning Community continued the work of their action plan goals 1 year after the formal closure of the learning community, indicating sustainability of the learning community activities, beyond what jurisdictions accomplished during formal participation.

Keywords

contraception; long-acting reversible contraception; implementation science

Introduction

Nearly half of all pregnancies in the United States are unintended, defined as mistimed or unwanted pregnancies.[1] The proportion of pregnancies that are unintended increases as the interpregnancy interval length decreases.[2] Pregnancies that are spaced <18 months apart are associated with poor birth outcomes.[3] Increasing access to the most effective forms of contraception is a strategy to reduce unintended pregnancies and rapid repeat pregnancies.[4–7]

Long-acting reversible contraception (LARC), which includes intrauterine devices and contraceptive implants, is the most effective form of reversible contraception,[8] but there are numerous barriers to providing LARC, particularly in the immediate postpartum period.[9,10] In 2014, in collaboration with the Centers for Disease Control and Prevention (CDC), the Association of State and Territorial Health Officials (ASTHO) convened the Immediate Postpartum LARC Learning Community.[11] Six states participated in this learning community to share strategies and best practices in state-led immediate postpartum LARC protocol development and implementation. In 2015, an additional seven states joined the Immediate Postpartum LARC Learning Community, for a total of 13 participating states.[12–15] Implementation science theory and methods were used consistently throughout the learning community to frame the discussions on statewide scale-up of immediate postpartum LARC.

In response to the needs of participant states and interest from non-participating states, in 2016 an expanded Increasing Access to Contraception (IAC) Learning Community was created to focus on policies and programs that increase access to the full range of contraceptive options.[16] This learning community was convened in partnership with 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. In addition to the 13 states that participated in the Immediate Postpartum LARC Learning Community, 13 other states and 1 territory joined the IAC Learning Community, for a total of 27 participating jurisdictions (Fig. 1).

The IAC Learning Community centered on nine focus areas: provider awareness and training; reimbursement and financial sustainability; informed consent and ethical considerations; logistical, stocking, and administrative barriers; consumer awareness; stakeholder partnerships; service locations; data, monitoring, and evaluation; and specific populations[16] (Table 1). The jurisdictions each had a team of participants that included health department leaders and program staff, Medicaid leaders, provider champions and

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

clinicians, hospital administrators, and other partners. At the first meeting of the IAC Learning Community in October 2016, each team developed an action plan for their jurisdiction. These action plans outlined 2–6 goals for jurisdiction teams to accomplish during the learning community, with accompanying action steps. The team goals addressed one or more of the nine focus areas defined by the learning community.

The IAC Learning Community ended in May 2018. To better understand the sustainability of the learning community on jurisdictional work toward contraception access, we assessed whether participating jurisdictions accomplished team goals and sustained their work 1 year after the closure of the learning community. In this article, we describe the findings from this post-assessment, including the acceptability of the team goals and the barriers and facilitators related to goal achievement and sustainment.

Methods

We developed a short set of questions to assess goal achievement and sustainment, defined using Proctor's proposed implementation outcomes.[17] For each of the goals created for the IAC Learning Community, a jurisdictional team was asked to briefly describe: (1) the status of the goal at the end of the learning community (*i.e.*, in May 2018); (2) whether the team did anything to increase the acceptability of the goal to stakeholders; (3) barriers and facilitators for goal achievement; (4) how successful the team was in sustaining efforts for the goal in the year since the closing of the learning community; and (5) barriers and facilitators for sustainability efforts.

We contacted all 27 teams that participated in the IAC Learning Community during May–June 2019, approximately 1 year after the closing meeting and end date of the learning community. Four interviewers conducted 30-minute, semi-structured telephone interviews with 22 members of these teams. Four additional teams preferred to respond by email.

The telephone interviews were transcribed. Three reviewers coded the interview transcripts and email responses to the questions in Dedoose version 7.0.23 (Los Angeles, CA). All three reviewers coded 10 transcripts, and coding discrepancies were resolved *via* discussion to consensus. The remaining 12 interview transcripts and four emailed responses were then coded by one reviewer each. A preliminary coding dictionary was created based on the interview guide and the focus areas of the learning community. During the document review and coding process, additional *in vivo* codes were developed by using participants' own words and refined through the constant comparative method.[18] Coded text was reviewed, and emerging themes were identified.

Goals were categorized as achieved by the end of the IAC Learning Community if the jurisdiction's responding team members considered the goal achieved. If goal achievement was not explicitly stated during the interview or email response, the planned action steps for that goal were reviewed. If these action steps were completed, then we considered the goal achieved. Goals were categorized as sustained if the jurisdiction's responding team members reported the work related to the goal to be ongoing. Some goals were considered achieved in

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

May 2018 and also sustained at the time of data collection in May–June 2019, because there were ongoing actions associated with the completed goals.

The CDC determined that this project was non-research public health practice and did not require Institutional Review Board approval. This project was determined exempt by the University of Illinois at Chicago Institutional Review Board.

Results

Overall, post-assessment information was collected from 26 of the 27 jurisdictions (96%) that participated in the IAC Learning Community. In total, these 26 jurisdictions created 79 goals for participation in the learning community. The focus area with the largest number of associated goals was provider awareness and training; 77% of jurisdictions ($n = 20$) had goals within this focus area.

The teams reported that by the time the learning community ended in May 2018, 35 of the 79 total goals (44%) had been achieved (Table 2). Three jurisdictions (11.5%) fully achieved all goals by the close of the learning community (data not shown). At the time of the post-assessment 1 year later, teams were sustaining efforts made for 87% ($n = 69$) of goals, regardless of completion status. In every jurisdiction, work on at least one goal that originated in the learning community was sustained.

Goal acceptability

Teams made intentional efforts to increase the acceptability of 48% of goals ($n = 38$) to stakeholders or the target audience (*e.g.*, consumers). This was most common in goals related to specific populations (Table 2). Of the 38 goals that included acceptability efforts, 97% ($n = 37$) were achieved or sustained. Of the 41 goals without acceptability efforts, 78% ($n = 32$) were achieved or sustained.

In many instances, teams increased the acceptability of their goals by framing them within the broader context of maternal and child health outcomes or making a case for the goal to stakeholders. Several teams hosted round-table meetings to allow stakeholders to share perspectives. Some teams highlighted the role of provider champions in ensuring that the goals would be acceptable to clinicians in their jurisdictions. Other goals were created specifically in response to requests in that jurisdiction, so the team considered them acceptable. One team summarized what they did to increase acceptability of their goal to address health disparities as, "[We] hosted a provider meeting including adolescent health, family planning, maternal and infant health, and home visiting programs. Topics included healthy interpersonal relationships, healthy birth outcomes, and reproductive justice. Our planned provider trainings include implicit bias and community engagement and participation."

Barriers to goal achievement and sustainment

Teams identified several barriers to goal achievement and sustainment (Table 3). Lack of resources was the most consistently mentioned barrier. These resources included both funding and staff. Some teams noted a lack of necessary funding to complete the steps in

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

their action plans, such as purchasing of LARC or training of additional providers. Several teams also highlighted the lack of staff and staff turnover, especially within the context of many competing priorities within the team members' agencies. Some teams also found that when resources were limited, crucial partnering organizations chose to reprioritize their staff or funding elsewhere, hindering progress.

Another important barrier was difficulty framing access to contraception as a public health priority for leaders, often in a politically sensitive environment, requiring partnership to achieve goals. In some jurisdictions, complex relationships with religiously affiliated institutions presented challenges in goal attainment.

Further, sometimes organizations had disagreements about the priority activities and how success was defined. For example, in one jurisdiction, payment for inpatient LARC was unbundled (*i.e.*, billing outside, billing separate, or carving out from the diagnosis-related group or bundled payment) from the global obstetric reimbursement for fee-for-service Medicaid patients, but not for managed care plan patients. This was considered a success by one partner, but not by another. When the organization that saw this as a success stopped trying to make progress toward unbundling LARC for managed care plan patients, the overall team's progress was slowed.

Some teams also noted that goals were interdependent. This meant that if a barrier was encountered that made it challenging to achieve one goal, often the other action plan goals could not be achieved. For example, one team had set goals related to provider education and the creation of a system to monitor LARC uptake. As one team member explained, "I don't think that we fully understood the scope of the work that was ahead with this goal. Once further immersed in the project, we identified many foundational activities that needed to be done first, before provider education could take place." The team could not implement work related to monitoring changes in LARC uptake until foundational action steps and provider education were complete, increasing LARC availability and access in that jurisdiction.

Facilitators for goal achievement and sustainment

In general, the combination of multiple facilitators was important to state team success in goal achievement and sustainment, with a primary facilitator identified as the meetings and activities comprising learning community participation. Because the teams were composed of individuals from multiple agencies, team members were able to work together in new and unique ways. Team members often highlighted a collective commitment to the work and described how the regular meetings of the learning community supported completion of the action steps identified in the action plan. Similarly, many teams noted learning from other jurisdictions, especially through jurisdiction-created toolkits that were shared as part of the learning community, allowing teams to follow best practices in accomplishing goals. One team member summarized, "We used the models that were presented from other states, and we didn't have to reinvent the wheel. We saw what worked there, we looked at our political climate…to figure out what we had to do to make that a successful program here."

Author Manuscript

The work of key champions in the jurisdictions was also highlighted as facilitating goal achievement and sustainment. In several jurisdictions, individual team members were acknowledged by their colleagues as having the persistence and commitment necessary to achieve the team's goals and sustain the work. Many teams emphasized the crucial role of provider champions in their jurisdiction's work. Further, several jurisdictions identified champions in high levels of government as facilitators. This leadership engagement and support was integral to these teams' progress. Some of this engagement of provider champions and other jurisdictional leaders helped provide positive peer pressure, which teams identified as a facilitator. A team member summarized this by saying, "When large agencies like [the department of] public health…and the other hospitals buy into something like this…You don't want to be left behind."

Many teams indicated that institutionalizing the pursuit of the goals within their agencies helped sustain the work after the learning community ended. For example, some teams incorporated goals into jurisdictional Title V priorities. Some teams found that if goals were aligned with other priorities within their agencies, there was more momentum for the work. One example was a jurisdiction that had a goal of improving data measurement related to family planning. That jurisdiction had already been working to streamline electronic medical records systems, which helped the team access these data.

The teams identified funding as a key facilitator. With funds available, teams were able to implement action steps, such as hire consultants, pay costs associated with provider training and mentoring, and buy contraceptive supplies. Teams leveraged Title V funding, funding from private donors, state budget appropriations, and other funds to assist with completing action steps and then sustaining the work. Some teams also applied for specific grants to continue work beyond the closure of the learning community.

Another frequently referenced facilitator was the perceived strength and quality of the evidence in support of LARC as a safe and effective contraceptive option, and the potential for increased access to the full range of contraceptive options to improve health outcomes in the jurisdictions. As one team member explained, "Hearing about the experiences in other states and how effective LARC roll-outs had been in reducing unplanned and, particularly, teen pregnancies…every new director we get, because we've had so many, they maintain it as a priority." In at least one jurisdiction, the team credited their success in engaging and training providers in the provision of LARC to summarizing the literature to address provider misconceptions and concerns.

Many teams noted the additive nature of the facilitators for goal achievement and sustainment and identified stakeholder partnerships as central to success. Partnerships were used to secure funding, create and provide contraceptive training for providers, and create and disseminate materials to increase consumer education and awareness about contraception. As one team member explained, "[Funding] was a huge part of the success, but none of that would have mattered if we didn't have strong partnerships…We were able to take that investment of resources, technical assistance, funding, and make it successful through the partnerships. And those partnerships extended through the clinical and the hospitals, health centers, clinics, private practices and social service agencies we

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

worked with." Existing partnerships were particularly useful in speeding the implementation process, and strong stakeholder partnerships were noted as a way to continue the work despite limited resources.

Discussion

Overall, at the closure of the IAC Learning Community in May 2018, 44% of jurisdiction-created goals were achieved. At the time of our post-assessment 1 year later in May–June 2019, teams from every jurisdiction were sustaining their efforts toward achieving the goals from the learning community action plans. This suggests that for jurisdictions that participated in the learning community, the initiatives that emerged as part of the learning community are sustainable beyond formal participation in the learning community.

Although sustainability is acknowledged as an implementation outcome,[17] it has not received much attention in the literature because implementation science has primarily focused on the initial uptake and use of evidence-based interventions.[19] Sustainability has also been a central challenge for time-limited activities, such as those that are only temporarily funded.[20] We found that work begun in the learning community was being sustained by jurisdictions 1 year post-learning community. For half of the sustained goals, the continued effort was to achieve as-yet unachieved action items; for the remaining goals, sustaining, strengthening, and institutionalizing achieved goals was a priority.

Program or intervention sustainment is context-dependent and determined by the complex, dynamic interplay of multiple stakeholders, priorities, intervention or program-specific attributes, and resources.[21] The context varies by environment, organization, and intervention, but overarching commonalities are found in the existing literature and identified in this assessment: level of trust and/or evidence in the intervention, adequate resources, individuals who champion the intervention, leadership support of the intervention, and involvement and continued support by stakeholders.[21–24] Many of these contextual pieces that are integral to sustainment were supported by the structure of the learning community, as the participating jurisdictional teams included champions, leaders, and stakeholders for work on contraception access. Future programs and activities might consider how to incorporate such support for sustainability at project inception.

Responsiveness to community needs is theorized to be an important component of successful goal implementation and sustainment.[22,23] We found that a higher proportion of goals that included efforts focused on acceptability to stakeholders or consumers were achieved or sustained (97%) compared with those that did not (78%). The utility of goal acceptability for goal achievement and sustainment might have been more apparent if we had systematically captured whether goals were previously considered acceptable, in addition to asking whether teams did anything to improve acceptability. Acceptability can be considered at all stages of implementation as a way to promote adoption, penetration, and sustainability.[17]

Efforts to increase acceptability were most common for goals within the specific populations focus area (100%). Although the literature supports the acceptability of postpartum LARC

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

for eligible patients,[25] teams worked with the providers in their jurisdictions to address client-centered counseling, implicit bias, and reproductive justice. This work often crossed several of the learning community's focus areas.

Although none of the goals created for the learning community were primarily related to informed consent and ethical considerations, the teams strived to ensure that this focus area was still reflected in their work. Ensuring that clients receive comprehensive, patient-centered counseling is a key strategy for optimizing contraception use, improving reproductive autonomy, and reducing the potential for coercion.[26–30] After a client has chosen a contraceptive method, ensuring they can access their method of choice is key for providing quality family planning services.[31] There has been notable concern about biases associated with more frequent offering of LARC to Black or Latina women of low socioeconomic status[32] and the way that Medicaid is more likely to reimburse for immediate postpartum LARC than other payors.[33] Ongoing best practices to enhance health equity would benefit future work related to increasing contraception access in jurisdictions.

One of the challenges of measuring goal achievement was that the jurisdiction-created goals differed widely in scope. Some were very broad (*e.g.*, "Address health disparities"), whereas others were very focused (*e.g.*, "80% of birthing hospitals [*i.e.*, clinicians, billers and pharmacists] will receive training on the immediate postpartum LARC toolkit"). During the post-assessment, describing goal achievement was difficult for some teams, likely due to unclear goal definitions and measurement. Allowing jurisdictions to create goals and action plans that fit specific jurisdictional contexts, resources, and objectives was important; however, future activities that involve the use of team-created action plans might consider how to measure success more precisely. This may include developing robust, well-defined goals coupled with implementation strategies.

The findings in this article are subject to important limitations. First, there was substantial turnover in team members during and after the IAC Learning Community. In one jurisdiction, none of the people who participated in the interview were part of the learning community team that developed the goals. Further, many team members had limited availability to participate in the post-assessment. Therefore, our findings may not reflect the views of all the team members who participated in the learning community. Teams' assessments of goal progress may have also been affected by social desirability or recall biases. Finally, although we heard the perspective of 96% of jurisdictions that participated in the learning community, these findings may not be generalizable to the rest of the United States, freely associated states, or territories.

Conclusions

Goals identified by IAC Learning Community teams in their action plans were generally sustained by jurisdictions 1 year later. Although the learning community aided participating jurisdictions with technical assistance, networking opportunities, and dedicated time to focus on contraceptive access, the work continued in all 26 of the jurisdictions that participated in our post-assessment 1 year after the learning community ended. This sustainment of effort indicates ongoing implementation or sustainment of action items from the

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

learning community, beyond what jurisdictions accomplished during formal participation. In our post-assessment, we focused on the implementation outcomes of sustainability and acceptability. Including implementation outcomes and their measurement from the outset, along with implementation strategies, may help future teams creating time-bound action plans to identify those factors that will support not only the achievement of goals, but also the sustainability of efforts.

Acknowledgments

The authors would like to thank the members of all jurisdictional teams participating in the Increasing Access to Contraception Learning Community. They 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.

Funding Information

Partial funding of this activity was provided by CDC-RFA-OT18-1802.

References

1. Sawhill IV, Guyot K. Preventing unplanned pregnancy: Lessons from the states. Published 2019. Available at: https://www.brookings.edu/wp-content/uploads/2019/06/Preventing-Unplanned-Pregnancy-2.pdf Accessed March 31, 2021.
2. Ahrens KA, Thoma ME, Copen CE, Frederiksen BN, Decker EJ, Moskosky S. Unintended pregnancy and interpregnancy interval by maternal age, National Survey of Family Growth. Contraception 2018;98:52–55. [PubMed: 29501647]
3. Conde-Agudelo A, Rosas-Bermúdez A, Kafury-Goeta AC. Birth spacing and risk of adverse perinatal outcomes: A meta-analysis. J Am Med Assoc 2006;295:1809–1823.
4. Sackeim MG, Gurney EP, Koelper N, Sammel MD, Schreiber CA. Effect of contraceptive choice on rapid repeat pregnancy. Contraception 2019;99:184–186. [PubMed: 30471261]
5. Gemmill A, Lindberg LD. Short interpregnancy intervals in the United States. Obstet Gynecol 2013;122:64–71. [PubMed: 23743455]
6. Oduyebo T, Zapata LB, Boutot ME, et al. Factors associated with postpartum use of long-acting reversible contraception. Am J Obstet Gynecol 2019;221:43.e1–43.e11.
7. White K, Teal SB, Potter JE. Contraception after delivery and short interpregnancy intervals among women in the United States. Obstet Gynecol 2015;125:1471–1477. [PubMed: 26000519]
8. Trussell J. Contraceptive failure in the United States. Contraception 2011;83:397–404. [PubMed: 21477680]
9. Rodriguez MI, Evans M, Espey E. Advocating for immediate postpartum LARC: Increasing access, improving outcomes, and decreasing cost. Contraception 2014;90:468–471. [PubMed: 25107639]
10. Phillips J, Sandhu P. Barriers to implementation of long-acting reversible contraception: A systematic review. J Am Assoc Nurse Pract 2018;30:236–243. [PubMed: 29757790]
11. Kroelinger CD, Waddell LF, Goodman DA, et al. Working with state health departments on emerging issues in maternal and child health: Immediate postpartum long-acting reversible contraceptives. J Womens Health 2015;24:693–701.
12. Rankin KM, Kroelinger CD, DeSisto CL, et al. Application of implementation science methodology to immediate postpartum long-acting reversible contraception policy roll-out across states. Matern Child Health J 2016;20:173–179. [PubMed: 27085341]
13. DeSisto CL, Estrich C, Kroelinger CD, et al. Using a multistate learning community as an implementation strategy for immediate postpartum long-acting reversible contraception. Implement Sci 2017;12:138. [PubMed: 29162140]
14. DeSisto CL, Kroelinger CD, Estrich C, et al. Application of an implementation science framework to policies on immediate postpartum long-acting reversible contraception. Public Health Rep 2019;134:189–196. [PubMed: 30699303]

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

15. Kroelinger CD, Morgan IA, DeSisto CL, et al. Stateidentified implementation strategies to increase uptake of immediate postpartum long-acting reversible contraception policies. J Womens Health 2019;28:346–356.
16. Association of State and Territorial Health Officials. Increasing Access to Contraception Learning Community year three project summary. Published 2018. Available at: https://www.astho.org/Maternal-and-Child-Health/Increasing-Access-to-Contraception/Learning-Community-Year-Three-Project-Summary/ Accessed March 31, 2021.
17. Proctor E, Silmere H, Raghavan R, et al. Outcomes for implementation research: Conceptual distinctions, measurement challenges, and research agenda. Adm Policy Ment Health 2011;38:65–76. [PubMed: 20957426]
18. Glaser BG. The constant comparative method of qualitative analysis. Soc Probl 1965;12:436–445.
19. Birken SA, Haines ER, Hwang S, Chambers DA, Bunger AC, Nilsen P. Advancing understanding and identifying strategies for sustaining evidence-based practices: A review of reviews. Implement Sci 2020;15:88. [PubMed: 33036653]
20. LaPelle NR, Zapka J, Ockene JK. Sustainability of public health programs: The example of tobacco treatment services in Massachusetts. Am J Public Health 2006;96:1363–1369. [PubMed: 16809592]
21. Gruen RL, Elliott JH, Nolan ML, et al. Sustainability science: An integrated approach for health-programme planning. Lancet 2008;372:1579–1589. [PubMed: 18984192]
22. Damschroder LJ, Aron DC, Keith RE, Kirsh SR, Alexander JA, Lowery JC. Fostering implementation of health services research findings into practice: A consolidated framework for advancing implementation science. Implement Sci 2009;4:50. [PubMed: 19664226]
23. Palinkas LA, Chou CP, Spear SE, Mendon SJ, Villamar J, Brown CH. Measurement of sustainment of prevention programs and initiatives: The sustainment measurement system scale. Implement Sci 2020;15:71. [PubMed: 32883352]
24. Johnson K, Hays C, Center H, Daley C. Building capacity and sustainable prevention innovations: A sustainability planning model. Eval Program Plann 2004;27:135–149.
25. Thompson EL, Vamos CA, Logan RG, et al. Patients and providers' knowledge, attitudes, and beliefs regarding immediate postpartum long-acting reversible contraception: A systematic review. Women Health 2020;60:179–196. [PubMed: 31122167]
26. Dehlendorf C, Krajewski C, Borrero S. Contraceptive counseling: Best practices to ensure quality communication and enable effective contraceptive use. Clin Obstet Gynecol 2014;57:659–673. [PubMed: 25264697]
27. Dehlendorf C, Levy K, Kelley A, Grumbach K, Steinauer J. Women's preferences for contraceptive counseling and decision making. Contraception 2013;88:250–256. [PubMed: 23177265]
28. Coleman-Minahan K, Potter JE. Quality of postpartum contraceptive counseling and changes in contraceptive method preferences. Contraception 2019;100:492–497. [PubMed: 31491380]
29. Sznajder K, Carvajal DN, Sufrin C. Patient perceptions of immediate postpartum long-acting reversible contraception: A qualitative study. Contraception 2020;101:21–25. [PubMed: 31655067]
30. Mann ES, White AL, Rogers PL, Gomez AM. Patients' experiences with South Carolina's immediate postpartum long-acting reversible contraception Medicaid policy. Contraception 2019;100:165–171. [PubMed: 31028752]
31. Gavin L, Moskosky S, Carter M, et al. Providing quality family planning services: Recommendations of CDC and the U.S. Office of Population Affairs. MMWR Recomm Rep 2014;63(RR-04):1–54.
32. Dehlendorf C, Ruskin R, Grumbach K, et al. Recommendations for intrauterine contraception: A randomized trial of the effects of patients' race/ethnicity and socioeconomic status. Am J Obstet Gynecol 2010;203: 319.e1–319.e8.
33. Kroelinger CD, Okoroh EM, Uesugi K, et al. Immediate postpartum long-acting reversible contraception: Review of insertion and device reimbursement policies. Womens Health Issues 2021; (In Press).

FIG. 1.

Jurisdictions participating in the Increasing Access to Contraception Learning Community and year each joined the learning community.

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Table 1.

Definitions of the Nine Focus Areas for the Increasing Access to Contraception Learning Community and Examples of Jurisdiction-Created Goals

Focus area	Definition	Jurisdiction goal example
Provider awareness and training	Training, continuing education, and resources to enhance provider awareness and familiarity with various contraceptive methods. This includes training on insertion and removal of LARC and billing and coding procedures.	Increase the number of health care professionals providing and properly billing for LARC.
Reimbursement and financial sustainability	Strategies to secure adequate funding for contraception and reproductive health. This includes using Medicaid, private insurance, Title X, and other programs to ensure that health care providers and facilities are reimbursed for contraceptive devices and services.	Identify and achieve any Medicaid policy changes needed to facilitate access to contraception and support effective implementation of all relevant, existing Medicaid policies with a cohesive strategy utilizing quality initiatives.
Informed consent and ethical considerations	Approaches to improve client satisfaction with their chosen contraceptive methods and services. This includes addressing the timing and content of informed consent, client-centered counseling, reducing provider bias, and broader issues of reproductive justice and ethics.	None
Logistical, stocking, and administrative barriers	Supporting the successful implementation of policies and procedures to increase access to contraception by overcoming barriers. Strategies to address these barriers include stocking the full range of contraceptive methods, removing preauthorization requirements, and partnering with pharmaceutical companies to increase method availability.	Reduce the number of clinics that require two visits for intrauterine device placements.
Consumer awareness	Conducting consumer outreach to increase awareness of the full range of contraceptive options and services.	Increase public awareness of the full range of contraceptive methods, including the most effective and moderately effective methods.
Stakeholder partnerships	Establishing relationships across agencies to develop sustainable partnerships that can successfully increase access to contraception. These partnerships may include national and federal partners, payers, device manufacturers, and multiple jurisdictional agencies.	Develop and leverage partnerships and collaborative efforts to expand contraceptive access.
Service locations	Strategies for facilities and clinics in a variety of settings that deliver comprehensive contraceptive services. This includes unique strategies required for hospitals, federally qualified health centers, and clinics in urban, rural, and frontier settings.	Increase capacity of federally qualified health centers to provide the full range of most and moderately effective methods.
Data, monitoring, and evaluation	Conducting quality assurance and measuring improvements in access to contraception.	Develop and disseminate recommendations for aligning data collection and measurement at all levels (*e.g.*, provider/electronic health records, Medicaid claims data, surveys) as a strategy to facilitate clinical quality improvement, enable comparison across groups of providers, and support monitoring and evaluation of the initiative.
Specific populations	Engaging a specialized workforce, communication, outreach, policy, cultural competence, and clinical practice strategies to improve access to contraception for populations that are often difficult to engage through traditional outreach. These populations may include adolescents, clients with disabilities, the uninsured and underinsured, non-English speakers, undocumented populations, incarcerated individuals, and individuals with substance use disorders.	Integrate substance use disorders services and LARC access.

LARC, long-acting reversible contraception.

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Table 2.

Increasing Access to Contraception Learning Community Goal Achievement and Sustainment, 26 Jurisdictions

	No. of goals [a]	*Goals achieved, May 2018*	*Goals sustained, May–June 2019*	*Goals not achieved and not sustained, May–June 2019*	*Goals with efforts to increase acceptability*
Focus area	**N**	**% (n)**	**% (n)**	***% (n)***	**% (n)**
Overall	79	44 (35)	87 (69)	13 (10)	48 (38)
Provider awareness and training	20	45 (9)	75 (15)	25 (5)	40 (8)
Reimbursement and financial sustainability	13	46 (6)	85 (11)	8 (1)	54 (7)
Informed consent and ethical considerations	0	—	—	—	—
Logistical, stocking, and administrative barriers	8	50 (4)	88 (7)	13 (1)	50 (4)
Consumer awareness	13	54 (7)	77 (10)	8 (1)	46 (6)
Stakeholder partnerships	8	38 (3)	88 (7)	13 (1)	50 (4)
Service locations	8	25 (2)	88 (7)	13 (1)	50 (4)
Data, monitoring, and evaluation	8	25 (2)	88 (7)	13 (1)	38 (3)
Specific populations	3	67 (2)	100 (3)	0 (0)	100 (3)

[a] Goals can address more than one focus area; therefore, the sum of the rows does not equal the overall number.

Author Manuscript
Author Manuscript
Author Manuscript
Author Manuscript

Table 3.

Jurisdiction-Reported Barriers and Facilitators for Goal Achievement and Sustainment

Barriers	Facilitators
Lack of resources (*e.g.*, staff, funding)	Learning community meetings and activities
Staff turnover	Champions
Political concerns about contraception	Leadership engagement and support
Disagreement about priorities	Positive peer pressure
Inter-dependent goals	Institutionalizing work within agency
	Funding
	Evidence strength and quality Stakeholder partnerships