CECA
Coalition to Expand Contraceptive Access

Statewide Contraceptive Access Initiatives: Updated Environmental Scan Report

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TABLE OF CONTENTS

ABSTRACT 1
INTRODUCTION 1
METHODS 2
SUMMARY OF FINDINGS 3
Description of Search Results 3
Overview of Statewide Contraceptive Access Initiatives 4
Implementation of Statewide Contraceptive Access Initiatives 5
Evaluation of Statewide Contraceptive Access Initiatives 6
Sustainability 13
Applying Equity-and Justice-Focused Frameworks in Statewide Contraceptive Access Initiatives 15
RESEARCH GAPS AND IMPLICATIONS 16
CONCLUSION 18
APPENDIX A: SEARCH TERMS AND INCLUSION/EXCLUSION CRITERIA 19
APPENDIX B: OVERVIEW OF STATEWIDE CONTRACEPTIVE ACCESS INITIATIVES 20
APPENDIX C: REFERENCES 23

ABSTRACT: UPDATED ENVIRONMENTAL SCAN REPORT

Statewide Contraceptive Access Initiatives (SCAI) expand access to contraception by bringing together key stakeholders and partner organizations committed to mobilizing interest in expanding access to contraceptive services, increasing health center capacity to provide services, and removing structural barriers to contraceptive access, such as cost. This report presents an overview of the existing evidence in the published and grey literature related to the implementation and evaluation of SCAI—as well as the initiatives' effects on expanding contraceptive access; identifies gaps in the available evidence; and makes recommendations for future research. Sixty-one relevant resources were identified in the scan, describing implementation approaches and evaluation findings across 30 states and/or territories that have implemented, or are currently implementing, contraceptive access initiatives. The environmental scan findings demonstrate that SCAI consist of similar implementation approaches, including clinician and support staff training and technical assistance; funding for the provision of low/no-cost contraceptive services and supplies; public awareness campaigns; and public policy analysis and championing. The available evidence describes effects on contraceptive use, service utilization, and pregnancy-related outcomes. Research gaps remain in understanding the impact of SCAI in reducing inequities in contraceptive access and fostering sustainability.

INTRODUCTION

Statewide Contraceptive Access Initiatives (SCAI) expand access to contraception by bringing together key partners committed to advancing access, increasing health center capacity to provide services, and removing structural barriers to contraceptive access, such as cost. Since the early 2000s, more than SCAI have been implemented in the U.S.,[a] creating a key opportunity for ongoing and future efforts to be shaped by previous project activities, challenges, and successes.

> ***SCAI Definition***
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> *SCAI are projects implemented across all or multiple regions of a state that involve a coalition of key stakeholders from public, private, and non-profit sectors who undertake coordinated efforts to increase access to contraception. Efforts focus on:*
>
> - *Mobilizing interest in expanding access to contraception*
> - *Providing contraceptive products at no or low cost*
> - *Providing training and capacity building*
> - *Removing other structural barriers to enhanced contraceptive access*

SCAI share the intent of expanding access to contraceptive services and supplies with a variety of expressed goals, including reducing unintended, unplanned, and/or teen pregnancy and increasing equitable access to services to support contraceptive choice and decision-making.[1] There is growing evidence that SCAI can advance the provision of person-centered care, expand contraceptive access, and improve health outcomes.[2–4]

As some of the legacy SCAI end and a new generation of SCAI emerge, there is a critical need to expand the potential of these initiatives with an eye toward advancing Sexual and Reproductive Health Equity (SRHE) across all phases of project implementation and evaluation. In 2023, the Coalition to Expand Contraceptive Access (CECA), in partnership with the Center for Reproductive Health Research in the Southeast (RISE) at

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[a] This includes the 27 states and/or territories that participated in a multi-state contraceptive access learning community coordinated by the Association of State and Territorial Health Officials (ASTHO), as well as additional SCAI that are documented in the literature that did not participate in the ASTHO project.

Emory University, launched a collaborative effort to document and share lessons learned across SCAI, and identify opportunities to advance implementation. To inform this effort, the team conducted an environmental scan to synthesize existing evidence describing SCAI implementation and evaluation approaches, outcomes, and lessons learned, and update the findings of a previous environmental scan on SCAI that CECA conducted in 2021. The team sought to identify evidence to address the following key research questions:

Key Research Questions

1. ***What SCAI have been initiated since 2005, and why were these initiatives undertaken?***
   a. *What is the current status of these SCAI (e.g., completed, in-progress)?*
   b. *How have the SCAI evolved since their inception?*
2. ***What are the implementation approaches for SCAI, and what lessons have been learned?***
3. ***What are the evaluation approaches for SCAI, and what lessons have been learned?***
   a. *At what phase of data collection/analysis are the various SCAI?*
   b. *What outcomes are being assessed among SCAI, and how are various outcomes measured?*
4. ***What findings have been published on the impact of SCAI related to:***
   a. *Outcomes for health centers and healthcare providers?*
   b. *Outcomes for clients and potential clients (e.g., contraception use, client satisfaction)?*
   c. *Health and social outcomes?*
   d. *Public policy outcomes?*
5. ***When the current SCAI conclude, what will we be positioned to understand about their impact? What questions will remain?***

METHODS

This report combines the findings of two distinct environmental scan efforts with similar methodologies – an original environmental scan of published materials related to SCAI conducted by CECA in 2021, and an updated environmental scan conducted by RISE in 2024. Both scans consisted of a review of descriptive and experimental peer-reviewed publications and grey literature (e.g., commentaries, white papers, conference abstracts, blog posts, webpages) that addressed implementation, evaluation, and outcomes of SCAI implemented in the U.S. Evidence on completed SCAI projects and projects in progress were eligible for inclusion in the scans—including projects specifically focused on contraceptive access, such as long-acting reversible contraception (LARC) access projects—and all method approaches.

The teams searched PubMed, Google Scholar, and Google Search to identify relevant articles published from January 2005 through January 2024. Search terms included statewide initiative-related terms (e.g., "contraceptive access"; "LARC Access"; "statewide") and terms to identify implementation and evaluation (e.g., "implementation"; "evaluation"; "assessment"; "outcomes"). A complete list of search terms can be found in **Appendix A**. The scans also considered unpublished information available through a collaborative project undertaken by CECA and the Association of State and Territorial Health Officials (ASTHO) in 2020 to explore the feasibility of seeking a Centers for Disease Control and Prevention (CDC) Community Guide recommendation on SCAI, which resulted in the publication of a special issue in the American Journal of Public Health entitled "Reshaping Contraceptive Access Efforts by Centering Equity, Justice, and Autonomy."

The environmental scans excluded projects that focused solely on increasing access to immediate postpartum (IPP) LARC, with an exception made for states that participated in an ASTHO Learning Community that initially focused on increasing access to IPP LARC, and later expanded to focus on access to all contraceptive methods more broadly. The rationale for non-inclusion was that implementation of the IPP LARC initiatives relied almost exclusively on modifying hospital practices and state Medicaid reimbursement policies, rather than the broader set of activities typically undertaken by SCAI. Teen pregnancy prevention projects conducted collaboratively by the CDC, Office of Adolescent Health, and Office of Population Affairs (OPA) were also not included, as these projects were multi-component, community-wide initiatives that were heavily focused on implementation of evidence-based curriculum and youth development approaches, and contraceptive access was not a primary focus.[5]

Local contraceptive access projects, such as those undertaken in Rochester, NY[6] and Tulsa, OK[7], were not included in this scan, as their focus was on a local area rather than statewide, and in the case of the Rochester project, focused only on teens. Some information from the HER Salt Lake Initiative is included, as this work was formative for the Utah statewide initiative, Family Planning Elevated (FPE) Program.[4]

SUMMARY OF FINDINGS

Description of Search Results

The team identified 61 resources (e.g., journal articles, reports, websites, whitepapers) describing the implementation, evaluation, outcomes, and the impact of SCAI that have been implemented in the U.S., along with evidence from a related multi-state learning community, coordinated by ASTHO. SCAI included in this scan are listed in **Table 1**. Additional details for each SCAI are provided in **Appendix B**.

Table 1. Overview of SCAI Included in the Environmental Scan

State	Initiative Name	Lead Organization	Status
Colorado	Colorado Family Planning Initiative (CFPI)	Colorado Department of Public Health and Environment	Complete; 2008-2014
Delaware	Delaware Contraceptive Access Now (DelCAN)	State of Delaware and Upstream USA	Complete; 2015-2020
Illinois	Illinois Contraceptive Access Now (ICAN!)	AllianceChicago	Ongoing; 2021-2025
Indiana	PATH4YOU	Indiana University School of Medicine	Ongoing; 2020-
Iowa	Iowa Initiative to Reduce Unintended Pregnancies	The Iowa Initiative	Complete; 2007-2013
Massachusetts	Massachusetts Initiative to Improve Contraception Services	Massachusetts Executive Office of Health and Human Services	Complete; 2018-2023
Missouri	The Right Time (TRT)	Missouri Family Health Council	Ongoing; 2019-2028
Nebraska	Nebraska Sexual and Reproductive Health Initiative	Nebraska Family Planning	Ongoing; 2023-
South Carolina	Choose Well Initiative	New Morning	Ongoing; 2017-
Utah	Family Planning Elevated (FPE)	University of Utah Department of Obstetrics & Gynecology	Complete; 2019-2022

For the purposes of the CECA/RISE effort, states that participated in the ASTHO Learning Communities were considered to fit the definition of "statewide contraceptive access initiatives" and also included in this scan.[8] Those states/territories included: 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.

Overview of Statewide Contraceptive Access Initiatives

Origination and Evolution of SCAI

Many of the early contraceptive access projects were modeled after the Contraceptive CHOICE study (CHOICE), a regional contraceptive access initiative implemented in 2006. CHOICE enrolled over 9,000 women in the St. Louis, Missouri area in a research project to promote and provide the most effective reversible methods of contraception, including intrauterine devices (IUD) and contraceptive implants. While all contraceptive methods were available at no cost, information about contraceptive methods was presented in a "tiered" approach, from most to least effective, meaning that LARC methods were presented first. The study found that when both knowledge and cost barriers were eliminated, 75% of participants chose LARC methods, and LARC continuation rates at 12 and 24 months were 86% and 77%, respectively.[9] Beyond method choice and continuation rates, the study also found substantial reductions in teen pregnancy, birth, and abortion.[10]

Based on the success of the 2006 CHOICE Project in St. Louis, statewide projects that heavily focused on uptake of LARC were privately funded in Iowa and Colorado.

The Iowa Initiative to Reduce Unintended Pregnancies was a five-year project that began in 2007 and employed a multi-component approach that included family planning providers, an advocacy organization, and a university research center. The aims of the project were to reduce unintended pregnancies and the number of abortions among adult women ages 18-30 years by increasing access to family planning services, the use of LARC methods, the number of low-income individuals who accessed family planning services, and public funding for family planning. In addition, the project sought to improve the political climate regarding family planning through a statewide marketing campaign and outreach to a number of professional, governmental, and business representatives.[11,12]

The Colorado Department of Public Health and Environment began receiving private funding in 2008 to launch the Colorado Family Planning Initiative (CFPI), which supported an expansion of the state's Title X Family Planning Program, including training, operational support, and low/no-cost LARC to low-income women statewide. Enhanced training and technical assistance were provided to staff to enable them to increase utilization of these methods. The expressed goal of the CFPI was to "reduce unintended pregnancy by increasing access to family planning services for low-income women and men, improving the capacity of healthcare settings to provide family planning services, and increasing coverage of all contraceptive methods by removing cost barriers for the most effective methods: long-acting reversible contraception."[13]

In response to the documented impact of these initiatives, state and funder interest prompted the implementation of several contraceptive access initiatives focused on addressing barriers specific to LARC access, including cost and logistical barriers (e.g., need for provider training on insertion and removal, lack of availability of devices in clinics and hospitals, high costs of LARC devices that made them unattainable for many people). Many of these early initiatives were generally categorized as 1) LARC "first", referring to projects that "promoted" the uptake of LARC above other contraceptive methods, particularly among "high-risk" populations, framing LARC as a "first-line" contraceptive that should be offered to all women[14], or 2) LARC "access", referring to projects focused on reducing or eliminating barriers to LARC access, but that do not necessarily employ counseling techniques that promote uptake of LARC above other methods.

> ***Concern grew within the reproductive health, rights, and justice community*** *that LARC promotion efforts were actually or potentially coercive, undermined reproductive autonomy, were not patient-centered, and were in conflict with Reproductive Justice principles.* [14,15]

Likely based on these concerns within the reproductive health, rights, and justice community, initiatives shifted, over time, to approaches that included offering the full range of contraceptive options, most using a shared decision-making approach that centers individual preferences and priorities.[16] The majority of SCAI implemented in the past ten years focus on access to all contraceptive methods and employ strategies to ensure that all methods are available for individuals to choose the method that will work best for them.

Implementation of Statewide Contraceptive Access Initiatives

Common Intervention Components

In 2020, CECA and ASTHO, along with seven SCAI partners identified eight multilevel core intervention components commonly implemented across SCAI.[1] These core intervention components were confirmed in a series of listening sessions CECA convened in 2023 with SCAI leaders and are listed in **Table 2**. The following sections describe the implementation of these components across various SCAI, based on evidence identified in the scan.

Table 2. Core Intervention Components Implemented Across SCAI
As published in the American Journal of Public Health

Level	Intervention Component	Description
Healthcare Provider	**Training/Continuing education**	Training for clinicians, support staff, and administrative staff through various modalities (e.g., small-group in-person training, one-on-one proctoring, virtual webinar series) on topics including family planning 101; medical management of contraception; hands-on clinical skills (e.g., LARC insertion and removal); billing, coding, and reimbursement; and preventing coercion and bias.
	Ongoing technical assistance	Providing ongoing, targeted technical assistance to clinicians, support staff, and administrative staff delivered via various modalities (e.g., coaching calls, training specialists in-clinic) on topics including hands-on clinical skills; purchasing, stocking, and billing for contraceptives; patient education materials; contraceptive access policies/procedures; contraceptive workflow; data collection and reporting.
Healthcare Organization	**Provision of low- or no-cost contraception**	Direct funding and/or stocking for participating health centers across delivery settings (e.g., Title X clinics, Federally Qualified Health Centers (FQHCs), school-based health centers (SBHCs), hospitals for immediate post-partum contraception, abortion providers for immediate post-abortion contraception[b]) to offer FDA-approved contraceptive methods and services to eligible individuals at low/no-cost without per-client caps on use of contraceptive services and devices.
	Grants for equipment/supplies	Direct funding to participating health centers to purchase contraceptive supplies and equipment, other clinic supplies (e.g., exam tables, technology for patient education), and personnel costs.
	Quality improvement, data, monitoring, and evaluation	Conducting continuous quality improvement and providing feedback to quickly identify implementation barriers and potential strategies to address barriers. Measuring aggregate, deidentified utilization of various contraceptives, provision of contraception services or person-centered counseling, and knowledge, skills, attitudes, or beliefs about contraception among providers.

[b] Two of the seven contraceptive access initiatives that participated in CECA and ASTHO's virtual meeting series in 2020 included post-abortion contraception access in their projects.

Level	Intervention Component	Description
Community	**Public awareness campaign**	Digital media and marketing campaigns to increase awareness about the availability of reproductive health services and provide information and resources on reproductive health topics.
Community	**Stakeholder engagement**	Engaging multi-stakeholder partnerships with public and private entities for effective implementation.
Public Policy	**Legislation or other public policy change**	Championing enactment and implementation of legislation and public policy to support contraceptive access, including overall public and private insurance coverage for contraception, such as LARC coverage and reimbursement and multiple months of dispensing; expanded ability of providers (e.g., pharmacists, advanced practice clinicians) to prescribe and dispense contraception; ensured payment parity for providers; and over-the-counter contraception without a prescription.

Training/Continuing Education

Most SCAI include training and continuing education for healthcare providers and staff, including clinic administrative and community organization staff (e.g., medical assistants, front desk staff, social workers, community health workers, Title V home visitors), at clinical and community partner sites as a part of project implementation.

Training occurs across several levels of health center staff on a range of topics. For example, in Delaware, training was provided to clinicians and support staff, including medical assistants, front desk staff, accounting and billing staff, and other administrative staff, to increase clinical, counseling, and administrative capacity for providing the full range of contraceptive methods.[2] In South Carolina, for example, support was also provided to nursing schools to incorporate hands-on reproductive health and contraceptive education and training to family nurse practitioner students.[17,18]

Clinician and staff trainings use various modalities (e.g., small-group in-person training, one-on-one proctoring, virtual webinar series, conference training sessions, train-the-trainer approaches) and encompass a range of topics, including LARC insertion and removal; medical management of contraception aimed at increasing awareness of CDC's evidence-based contraceptive guidance (US MEC and US SPR), billing, coding, and reimbursement; person-centered contraceptive counseling and education; and the role of bias and coercion in reproductive healthcare.[19] For example, in Utah, the full patient care team at partnering clinics, from administrators to providers, receive tailored education and training on a variety of topics, including person-centered contraceptive counseling, LARC placement and removal, fertility awareness-based methods, clinic workflow, billing and coding, and other areas of need jointly identified by clinics and the research team. Clinic staff at all levels, including front desk staff and medical assistants, were involved in education and training to support capacity for contraceptive provision throughout the entire clinic.[20]

Utah's Family Planning Elevated: Training Sustainability Strategies

Family Planning Elevated Contraceptive Access Program (FPE CAP) members are asked to identify clinic champions at the provider, medical assistant, and administrative levels to support the project and to increase the likelihood of sustainability after the program ends. Clinic providers who receive IUD and implant training also receive onsite proctoring and mentorship, clinical assistance with complex cases, and additional specific training, such as IPP insertions. Providers also have access to an on-call nurse practitioner who specializes in family planning care to support and troubleshoot any issues. [20]

Ongoing Technical Assistance

Technical assistance involves targeted, one-on-one site-specific or person-specific assistance provided to assist clinicians, support staff, administrative staff, and other clinical and community partner staff on a range of person or site-specific topics. SCAI often provide technical assistance to partnering health centers around billing and coding, updating or creating clinical protocols, stocking of contraceptive products, making electronic health record modifications, and collecting and analyzing data. For example, for The Right Time initiative in Missouri, family planning clinical consultants supported health centers by modifying clinic workflows to allow more time during patient visits to deliver same-day services, which contributed to an overall increase in same-day access to contraception.[21] ICAN! in Illinois' technical assistance focused on supporting FQHC staff to build financial sustainability through developing clinic workflows that makes it easier to stock same-day contraceptive supplies, determining coverage eligibility, and maximizing reimbursement through accurate billing and coding practices.[22]

Provision of Low- or No-Cost Contraception

Most SCAI included in this scan provide(d) low/no-cost contraceptive products, through a combination of public and private funding. The ability to provide contraceptive methods at no cost to all patients is dependent on private funding, while leveraging public programs, such as Title X, enables SCAI to offer low-cost contraception. For example, the private funder of the CFPI in Colorado provided funding to support the provision of LARC, and DelCAN in Delaware received funding for the purchase of LARC devices from the Delaware Division of Public Health.[2,23] In general, SCAI leverage multiple reimbursement and financing sources, including Medicaid, private insurance, Title X, the 340B Drug Pricing Program, Temporary Assistance for Needy Families (TANF), and donor funding, to facilitate access to low/no-cost contraceptives.[19]

Grants for Equipment and Supplies

Direct funding to support the funding of contraceptive supplies, clinical infrastructure, personnel costs, and administrative overhead is often a core intervention component of SCAI. Both the Colorado and South Carolina initiatives provided direct funding for purchasing equipment and hiring staff.[24,25] Additionally, the Colorado initiative used funding to support purchasing equipment and electronic health records for clinical partners.[24]

Quality Improvement (QI) and Data Monitoring

QI, data monitoring, and evaluation help support evidence-based practices and demonstrate SCAI's effectiveness. Some SCAI—such as projects in Iowa, Delaware, and South Carolina—engage an independent evaluation partner, usually a research institution or consulting firm, to lead evaluation activities. Other projects often collect data for quality improvement and monitoring in-house.

ASTHO's SCAI Learning Community Focus Areas of Success:
Quality Assurance/Improvement Strategies

Quality assurance and measuring improvements in access to contraception is critical for modifying clinical practice, and for monitoring and reporting long-term success and growth. Strategies may include developing a QI program that integrates clinical performance measures related to contraceptive care, improving surveillance systems, conducting process and outcome evaluations, establishing agreements to access existing data (e.g., Medicaid or hospital records), and developing innovative data collection methods that provide information to guide implementation of these strategies.

States can perform ongoing data analyses to discover opportunities to strengthen contraceptive programs, such as identifying providers who need training, service locations that do not provide a full range of contraceptive methods, sub-populations or geographic areas experiencing highest need, and ways to ensure method satisfaction among clients. [19]

Public Awareness Campaigns

Public awareness campaigns serve as an opportunity for SCAI to increase visibility of their initiatives, discuss reproductive health topics, and guide potential patients to the initiatives' reproductive services. Most SCAI included digital outreach strategies as a part of their public awareness campaigns, such as internet and media advertising, social media channels, and innovative digital platforms. South Carolina launched the "No Drama" marketing campaign to direct potential patients to a website or phone line where they can learn more about reproductive health topics and schedule appointments at Choose Well-participating clinics. The marketing campaign used a combination of billboards, radio spots, and social media advertising to increase awareness of the Choose Well initiative in the state.[25]

In Illinois, the ICAN! website used interactive features to provide evidence-based and unbiased birth control information and connect users to services. The website included a quiz in which users could assess and identify which birth control methods fit their needs and includes a "phone-a-friend" feature for users to speak with a trusted expert.[22] Colorado initiated the Beforeplay campaign, a public awareness campaign for young people to encourage them to make healthy sexual decisions.[13] The purpose of the campaign was to offer reliable and easy-to-understand information, normalize the statewide conversation about reproductive health, and increase the visibility of Title X clinics and other health centers offering affordable reproductive health services. The campaign was conducted through social media, posters and billboards, and a website.

SCAI also use non-digital methods to reach potential patients. In Missouri's The Right Time initiative, the public awareness campaign included distribution of promotional materials, such as brochures, postcards, posters, and palm cards. Additionally, outreach and education coordinators and community mobilizers engaged in both virtual and in-person community outreach activities to effectively amplify awareness of the initiative.[21]

Stakeholder Engagement

The implementation of all the SCAI involve strategic collaborations and partnerships among diverse stakeholders, including healthcare institutions (e.g., FQHCs, Title X clinics, and hospitals), private and public insurers, contraceptive device manufacturers, state agencies, local organizations, and community members.[19] Examples of stakeholder engagement and partnership are described below.

SCAI Stakeholder Engagement and Partnership Examples

- ***ICAN! in Illinois*** *was guided by a 15-member community advisory board, representing the communities served by the health centers. ICAN also collaborated with the Chicago public school system and Department of Public Health, Illinois Department of Human Services, and local youth organizations to disseminate education and resources on contraception, along with community-based maternal and child health providers and community-based organization staff members to offer training to screen clients for contraceptive needs.* [22]
- ***South Carolina's Choose Well Initiative*** *involved systematic coordination across sectors, including FQHCs, hospital inpatient and outpatient providers, rural health clinics, free clinics, college and university health centers, and the Title X-funded public health departments, community organizations, and higher education institutions.* [25]
- ***Utah's Family Planning Elevated*** *incorporated a diverse network of clinics, including FQHCs, private clinics, and city and county clinics (Simmons et al., 2020). The project also formed a Reproductive Justice Advisory Board to "ensure that FPE understands the needs of historically underserved populations and is addressing access barriers specific to those populations."* [26]

Legislative or Other Public Policy Change

Supporting the passing and implementation of public policy change is essential to systemically supporting and expanding contraceptive access within states. Many SCAI whose efforts are described within this scan focused their policy initiatives on improvements to Medicaid reimbursement, state family planning funding, and policies to expand the ability of providers to prescribe and dispense contraception. For example, the Colorado initiative formed two coalitions that engaged Title X clinics in advocacy efforts, which led to improvements in Medicaid reimbursement, confidentiality protections, and state funding for family planning.[24] In the Illinois initiative, implementers focused on implementation and enforcement of existing legislation, such as supporting the implementation of Illinois' pharmacy prescribing law and working to improve components of the state Medicaid program.[22]

Restrictive state policies can cause barriers to sustainability of an initiative's activities. In an evaluation of site leaders in South Carolina, respondents expressed their concerns about limited insurance coverage for contraception. Implementers of South Carolina's Choose Well are exploring various solutions to address this challenge, including 340B drug pricing, expansion of insurance coverage and reimbursement policies, and facilitation of patient Medicaid enrollment.[27]

Challenges and Lessons Learned from Implementation Approaches

Implementation of SCAI can be challenging, as many SCAI are operating within polarized political landscapes and under limited capacity among clinical and community partners. This section summarizes a range of challenges faced by SCAI during implementation, as well as lessons learned that may inform future efforts.

Implementation Challenges and Lessons Learned			
Costs and Reimbursement	Clinical Implementation	Political Landscape	COVID-19 Pandemic

Costs and Reimbursement

Although many SCAI provide funding to clinical partners for contraceptive methods, it is important for initiatives to leverage state and federal funding sources to ensure supply of all contraceptive methods are maintained after the initiative ends. Reimbursement was a consistent challenge across SCAI, due to both the inadequacy of reimbursement and the resources needed to train clinic staff to adequately perform coding and billing. Research evaluating a longitudinal cohort of clinics engaging in Family Planning Elevated in Utah found that "successful reimbursement requires a tailored approach to education, training, and follow-up of clinic administrative staff as well as programmatic flexibility to accept and correctly interpret program billing inputs provided variably."[20]

In interviews with clinical partner site leaders for Delaware's DelCAN initiative, the most common challenge reported was a lack of clarity on processing payments and billing for services and devices.[28] Many site leaders expressed concerns about double billing, either the insurance companies or patients. Additionally, site leaders in smaller clinical practices worried about the loss of money in scenarios where the patient changes their mind or does not come in for their appointment.[28] Similar billing and coding were documented in South Carolina's Choose Well initiative in which staff from the partnering clinics discussed on-going issues with billing and coding due to complicated coverage and reimbursement policies across insurance policies.[27] Both site leaders from the DelCAN initiative and staff from the Choose Well initiative recommend that ongoing technical assistance for coding and billing is needed to ensure a stock of devices and supplies are maintained within clinics.

Clinical Implementation

Oftentimes, SCAI are implemented across diverse networks of clinics with varying administrative policies, clinical capacity and priorities, and reporting systems.[20] These differences among clinics require SCAI implementers to understand the unique needs of clinics and tailor the initiative to meet those needs. When discussing the challenges faced in Utah's initiative, the implementers emphasized the importance of intervention designs being cognizant of "initiative fatigue" to ensure participation, completion, and compliance.[20] In the evaluation of site leaders for DelCAN's initiative, many leaders discussed how they were initially enthusiastic about the implementation of the initiative, however their enthusiasm waned as they tried to address multiple logistical challenges.[28] Site leaders discussed facing multiple difficulties in implementing the initiative's activities, including challenges with preceptorship for providers and changes to the practice workflow to accommodate same-day insertions of methods of LARC.[28]

Clinical partner site leaders in Delaware emphasized the need for more inclusive communication at multiple levels and cultural humility in communication with patients. They recommended an initial assessment of clinics, a pre-implementation phase prior to the training, and more conversations about the initiative with providers and staff across roles.[28] The site leaders believed this would allow for more tailoring of the initiative to the wide range of clinics and establish a smoother transition from training to implementation, which ultimately can lead to more buy-in across the clinics.[28]

Research on an initiative to implement IPP LARC in rural New Mexico found that clinical champions were a major facilitator and drove efforts at every hospital that made progress in implementation. They also found that multidisciplinary teams are critical to complete implementation steps, including active participation of administration, pharmacy, nursing, and clinical staff.[29]

Political Landscape

SCAI operate in varying political contexts which can impact the implementation of project activities. The Right Time initiative in Missouri described how the political climate in Missouri and the overturning of *Roe v. Wade* limited the ability for implementers to pursue proactive contraceptive legislation due to the polarized environment around reproductive healthcare.[21] Implementers also described needing to combat the spread of mis- and disinformation among legislators. The Right Time initiative has increased outlets for broader dissemination of high-quality contraceptive information to help counteract distrust and myths about birth control services. Additionally, staff have created messaging for legislative decision-makers showing the benefits of contraceptive-friendly policies and regulations.[21]

COVID-19 Pandemic

Initiatives in Illinois and Missouri described the effects of COVID-19 pandemic on implementation in materials identified in the environmental scan. In Illinois, the ICAN! Team found that the COVID-19 pandemic further exacerbated barriers for people of color and people with few resources when accessing contraceptive care at physical health centers.[30] To address this challenge, the initiative focused on increasing access points beyond the health center and planned to include more in-person community outreach and train community-based social service providers on screening for clients' contraceptive needs and desires.[30]

In Missouri, the availability of services declined at more than half of the initiative's health centers due to the centers shifting to COVID-19 testing, vaccination, or contact tracing.[21] Additionally, the concerns about COVID-19 exposure led to fewer people seeking reproductive health services. Lack of access to reliable internet in Missouri also meant about one-third of the population in Missouri had limited access to telehealth services, which worsened existing health disparities. The challenges led the implementers to reimagine elements of the initiative and create new opportunities to support the community. For example, many health centers served as food distribution sites and social support centers. The integration of social

service delivery in a healthcare setting created a venue for implementers to increase outreach and uptake of contraception and an environment promoting family health and well-being. Additionally, health centers provided alternate care delivery, including "curbside contraception pick-up and mailing, drive-through Depo-Provera clinics, and technologies for mail-order contraception."[21]

Evaluation of Statewide Contraceptive Access Initiatives

Evidence identified in the environmental scan indicated that SCAI use a range of shared measures to evaluate various components and levels of the initiatives. SCAI projects included in the scan were at varying phases of data collection and analysis, and available resources ranged from published findings on completed projects, to evaluation methodologies and early findings from ongoing initiatives.

Summary of Evaluation Outcomes

Outcomes of interest focused on healthcare providers and health centers, clients and potential clients, health and social outcomes, and public policy outcomes, are described below and outlined in **Table 3**.

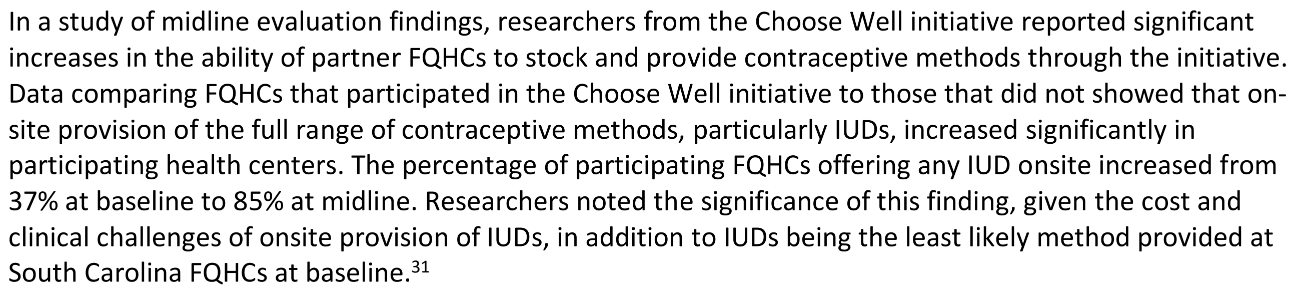
Table 3. Overview of SCAI Measures/Outcomes of Interest

Level	Measure/Outcome
Health Centers and Healthcare Providers	• Service expansion • Provider changes in knowledge, skills, attitude, and beliefs • Perceived barriers and opportunities
Clients and Potential Clients	• Service utilization • Patient-reported experience of care • Contraceptive use
Health and Social Outcomes	• Reproductive autonomy and other person-centered measures • Unintended pregnancy • Birth and fertility rates • Abortion rates • Maternal health and infant health
Public Policy Outcomes	• Medicaid enrollment and policy change • Cost savings

Health Centers and Healthcare Providers

The environmental scan identified publications describing measures of interest related to SCAI partnering health centers and healthcare providers, including increased service offerings, clinical capacity, and the effect of training and technical assistance on provider knowledge, skill, perceptions, and care delivery. The available evidence demonstrated how SCAI contribute to changes in care delivery practice for contraception as well as perceptions of expanded contraceptive access among clinical staff. These studies reported that organizational factors, sustainability of funding, and training are key to realizing the full potential of these initiatives.

Service Expansion in Health Centers. One study and two midline evaluation reports described service expansion in health centers as a result of SCAI implementation, including offering the full range of contraceptive methods. The Iowa Initiative found that the 17 participating Title X clinics used funding to implement changes to expand services and reach, including: 82% (14) added a new marketing strategy; 76% (13) added practitioners; 59% (10) added the contraceptive implant; 59% (10) added the ParaGard IUD; 59% (10) expanded clinic hours; 53% (9) added the Mirena® Intrauterine system; 53% (9) added clinic locations; 47% (8) hired interpreters; 35% (6) increased their walk-in hours; and 29% (5) added educators or counselors.[12]



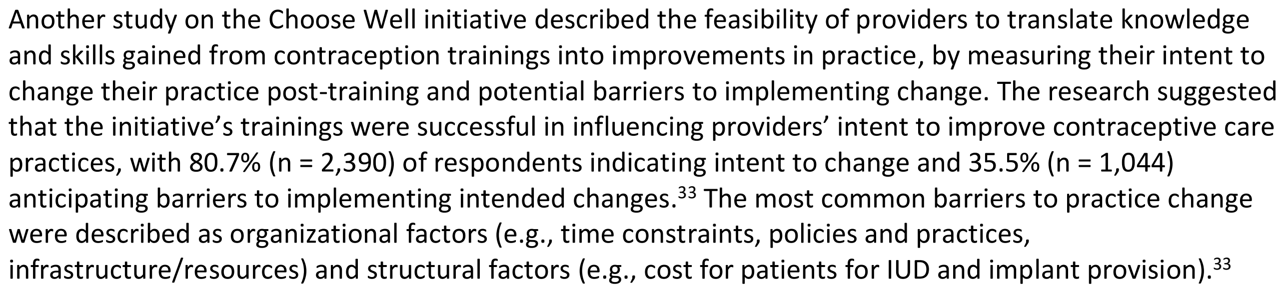
In a study of midline evaluation findings, researchers from the Choose Well initiative reported significant increases in the ability of partner FQHCs to stock and provide contraceptive methods through the initiative. Data comparing FQHCs that participated in the Choose Well initiative to those that did not showed that on-site provision of the full range of contraceptive methods, particularly IUDs, increased significantly in participating health centers. The percentage of participating FQHCs offering any IUD onsite increased from 37% at baseline to 85% at midline. Researchers noted the significance of this finding, given the cost and clinical challenges of onsite provision of IUDs, in addition to IUDs being the least likely method provided at South Carolina FQHCs at baseline.[31]

A midline evaluation of the Right Time initiative in Missouri found that financial support from the SCAI enabled more health centers to have contraceptive methods in stock. On average, stocked methods increased from five of fourteen contraceptive methods at baseline to right of fourteen methods at 18 months into implementation. More health centers stocked more costly short-term methods, such as the ring, as well as IUDs and implants at midline. Qualitative data also suggested that increased affordability and coverage of contraceptive services through the initiative's financial support expanded the options providers offered to patients due to less concern about cost.[21] Additionally, the number of health centers that offered same-day access to IUDs increased from one of twelve surveyed health centers at baseline to five of twelve health center at midline. Similar trends were observed for the patch, Depo-Provera shot, and NuvaRing. Same-day LARC placement increased from 72% at 6 months to 84% at 18 months, among people requesting LARC.

Outcomes Related Healthcare Providers. The scan identified eight resources describing outcomes related to healthcare providers and staff. One study described changes in the number of contraceptive care providers during the New Mexico initiative. The initiative found that the number of providers rendering contraceptive care to adolescents and young women, reimbursable by Medicaid, increased 20-fold and four-fold, respectively, during the initiative.[32] Researchers conclude that an increase in Medicaid-rendering providers helped expand access to contraceptive services, especially in rural areas.[32]

Other studies described surveys and qualitative interviews with clinical leaders and staff, healthcare providers, and nursing students to understand changes in perceptions, knowledge, skills, and beliefs about contraception and contraception access, associated with implementation of a SCAI. In Delaware, researchers conducted semi-structured interviews with 32 leaders from 26 practice settings participating in the initiative to identify common themes in implementation experiences. Results showed that most practices found an increase in patients requesting LARC methods during the initiative.[28] These practices also reported needing significant flexibility to respond to and adapt their contraceptive access interventions to fit the needs and constraints of their settings and patient populations. Practice settings with greater pre-existing capacity found it easier to offer the full range of contraceptive care than practice settings with less pre-existing capacity; those that faced more barriers included primary care practices, smaller practices, and practices that served large numbers of adolescents. The study noted that addressing logistical challenges, particularly around billing, is key to expanding contraceptive access in clinical settings.[28]

In South Carolina, one study examined perceived clinical and administrative facilitators and barriers related to contraceptive access among staff at Choose Well-participating FQHCs. Data from 34 interviewed staff found that the most notable clinical facilitators for contraceptive access were increased capacity for contraceptive counseling and provision through training, external funding for IUDs and implants, and streamlining workflow processes.[27] Buy-in and engagement among clinic staff and leadership were noted as facilitators for some clinics and a barrier for others. Policy and structural factors related to costs of devices and insurance coverage were also among the noted barriers, and threatened sustainability of the initiative.[27] An endline survey was planned for 2023.[25]



Another study on the Choose Well initiative described the feasibility of providers to translate knowledge and skills gained from contraception trainings into improvements in practice, by measuring their intent to change their practice post-training and potential barriers to implementing change. The research suggested that the initiative's trainings were successful in influencing providers' intent to improve contraceptive care practices, with 80.7% (n = 2,390) of respondents indicating intent to change and 35.5% (n = 1,044) anticipating barriers to implementing intended changes.[33] The most common barriers to practice change were described as organizational factors (e.g., time constraints, policies and practices, infrastructure/resources) and structural factors (e.g., cost for patients for IUD and implant provision).[33]

Two additional studies related to the Choose Well initiative assessed the effect of hands-on LARC and reproductive health trainings among family nurse practitioner students at four public colleges of nursing. With funding from Choose Well, the colleges incorporated reproductive health content in the core curriculums of their master's and doctoral nursing programs. Anecdotal information gathered from students in 2019 and 2020 indicated the trainings better equipped the students to discuss reproductive health options and insert and remove IUDs and implants.[17] Students also reported improved perceptions about LARC, intra- and interprofessional opportunities, employment opportunities, and improved salary negotiation.[17] In a post-graduation cross-sectional survey conducted in 2021, nursing school graduates reported that opportunities to reinforce learning through simulation and clinical placement contributed to increased comfort, confidence, and competency in LARC insertion and removal, as well as a strong level of satisfaction with the training curriculum.[18]

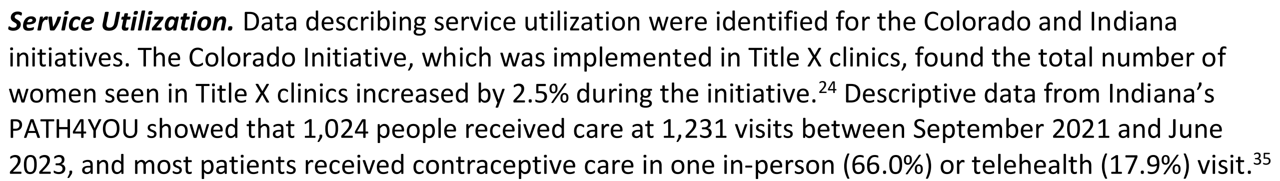
A midline evaluation of the Right Time initiative in Missouri described qualitative and quantitative findings related to provider awareness of contraceptive methods and confidence with person-centered counseling. At 18-months into implementation, many interviewed health center staff reported the initiative helped increase their knowledge and skills across different methods, as well as multiple dimensions of culturally competent care. Qualitative data suggested that increased awareness and specialized training enabled providers to confidently address LARC myths, counsel patients on their options, and place and remove LARCs. Quantitative data, however, showed decreases in the percentage of surveyed providers who reported being "very comfortable" with varying contraceptive methods. The researchers described staff turnover as the likely cause for the reduction and suggested the need for additional training on contraceptive methods and person-centered care based on the data.[21]

A study of both the Colorado and Iowa initiatives surveyed 159 clinicians, including physicians, physicians' assistants, nurse practitioners, certified nurse midwives, and registered nurses, in 47 family planning agencies across both states in 2010. Researchers found that clinicians' beliefs around immediate post-partum contraceptive or post-abortion use and use with menorrhagia or dysmenorrhea differed from clinical guidelines. Clinicians were also hesitant to recommend IUDs and implants to some groups of patients.[34] Findings from Colorado and Iowa suggest that provider perceptions, attitudes, and bias may be barriers to contraceptive use, that professional and in-service training may help address.[34]

Clients and Potential Clients

Evidence identified in the scan on outcomes related to clients and potential clients focused on:

- **Service utilization** by describing clinic visit data.
- **Patient-reported experience of care** by exploring experiences receiving person-centered care from healthcare providers.
- **Contraceptive use** by exploring LARC use, postpartum LARC uptake, contraceptive method mix, and discontinuation rates.



Service Utilization. Data describing service utilization were identified for the Colorado and Indiana initiatives. The Colorado Initiative, which was implemented in Title X clinics, found the total number of women seen in Title X clinics increased by 2.5% during the initiative.[24] Descriptive data from Indiana's PATH4YOU showed that 1,024 people received care at 1,231 visits between September 2021 and June 2023, and most patients received contraceptive care in one in-person (66.0%) or telehealth (17.9%) visit.[35]

Patient-Reported Experience of Care. The scan identified one report with tentative patient survey data from South Carolina's Choose Well initiative and one study of patient experience from South Carolina's IPP LARC effort. The Choose Well patient study is underway with peer-review and publication expected in the future. A midline evaluation summary described that, between 2018 and 2021, 2,027 patients from participating and non-participating clinics were surveyed before their contraceptive care visit about their goals and expectations, and after their visit about their experiences. Surveys were designed to assess whether patients received high-quality, person-centered contraception care by asking whether they discussed key reproductive health topics with their providers and whether their provider showed them respect and counseled them in a patient-centered manner. Questions related to provider respect and patient-centered contraceptive counseling included whether individuals perceived that their provider: is looking out for the patient's best interest, clearly respects the patient as a person, took the patient's preferences about contraception seriously, gave the patient the information they needed to choose the best method for them, and let the patient say what mattered to them about their contraceptive method.[36]

Results found that most patients from both participating and non-participating clinics reported that their provider discussed these key topics with them. Greater percentages of patients from participating clinics, compared to patients at non-participating clinics, reported that (1) their provider discussed possible side effects and the safety and efficacy of IUDs and implants; and (2) they completely agreed that their provider was very knowledgeable about birth control. Similarly, greater percentages of patients from participating clinics completely agreed that their provider clearly respected them as a person, took their preferences about contraception seriously, and let them say what mattered to them about their contraceptive method.[36]

A study of patients' experiences with IPP LARC counseling and use during South Carolina's Medicaid policy change was conducted in 2016 to 2018. Findings indicated that some patients were dissatisfied with providers' approaches to counseling because they either did not receive enough information or felt pressured to use a LARC method. Some objected to the timing of the counseling, and three of ten patients who elected to receive IPP LARC later desired removal and encountered barriers. This study suggests that the IPP LARC counseling may not have been sufficiently person-centered and lack of access to barrier-free LARC removal limits patients' reproductive autonomy, indicating the need for additional counseling training and increased care coordination.[37]

Contraceptive Use. Studies identified in this scan assessed contraceptive use across nine initiatives: seven contraceptive access projects and two postpartum LARC initiatives. All studies described changes in use of LARC, and most described overall contraceptive use, including method switching. Some studies examined the association between the initiative and contraceptive use changes, and described use across different patient characteristics, including age and coverage (e.g., Medicaid enrollees). Findings from these studies are summarized in **Table 4** and suggest that SCAI are an effective strategy for increasing initiation of LARC methods.

Table 4. Summary of Evidence on Contraceptive Use

State	Summary of Evidence on Contraceptive Use
Colorado	• Increase in LARC use among 14-24 year-olds in Title X clinics from 5-19% [23] • Increase in LARC use among women under 30 – from less than 3% for under 18 year-olds and 7% for 20-29 year-olds, to nearly 30% for the under 30 age group [38] • Increase in proportion of female contraceptive clients using LARC from 6% to 32% from 2008-2019; decrease in proportion of clients using combined hormonal methods (48% to 25%); no change in Depo Provera use [24]
Delaware	• Increase in overall LARC use from 4.1% in 2008 to 25.0% in 2017; increased LARC use associated with DelCAN initiative [2] • Increase in LARC adoption among adolescents, from 33% in early project phase to 68% in later period; no significant change in adult LARC adoption [39]; increase in LARC among adolescent Medicaid enrollees [40] • Increase in number of same-day LARC encounters, particularly for contraceptive implants[41] • Decrease in use of hormonal methods (e.g., pill, patch, ring) from 2008-2014 [42]; decline in any method initiation among Medicaid enrollees from early project phase to later period [39]
Indiana	• Most common primary methods of contraception used were implants (25.8%), contraceptive pills (20.5%), and intrauterine devices (16.0%) [35]
Iowa	• Increase in IUD use among women in Title X clinics by 218% from 2007-2010; increase in implant use by 829% [12]
Missouri	• Higher rates of contraceptive use among patients in the initiative (96%) compared to state-level estimates of contraceptive use in Missouri (69%) for women ages 18-49 [21] • Increase in uptake of birth control pill (10% increase), Depo-Provera (5%) and LARC (3%); decrease in male condom use and abstinence as primary contraceptive methods [21] • Increase in contraceptive switching (3% increase in switching from other method to LARC method), following efforts to eliminate cost barriers6/11/2024 7:25:00 PM
New Mexico	• Increase in LARC use among Medicaid-enrolled women 24 years and younger; overall greater increase in moderately effective method (e.g., pill, patch, ring) users than increase in LARC users [32]
South Carolina	• Increase in LARC use (8.5% to 10.9%) and decrease in short-acting hormonal contraception (45.7% to 40.6%) from baseline to midline intervention; IUD initiation primarily among women 20-25 years-old; increased IUD use attributed to Choose Well initiative [43]
Utah	• Most (70%) women reported continued LARC use at six-month assessment; high rates of discontinuation among women using short-acting methods, 36.9% of which switched to LARC [44] • No difference in LARC use among securely housed and insecurely housed women during no-cost contraception intervention period, compared to higher LARC use among insecurely house women during control period [45] • Lower use of barrier methods, emergency contraception, and no documented contraception and higher use of more effective methods among women visiting participating HER Salt Lake clinics, compared to women visiting non-participating clinics [4]
IPP LARC Initiatives	• Increase in postpartum LARC insertions (259% increase) among women in South Carolina after implementation of Medicaid policy change[46]; increase in IPP LARC use among adults and adolescents for all hospital inpatient births, relative to that expected without the policy change [47] • Uptake of LARC post-delivery among women who wanted to delay childbearing at a hospital offering IPP LARC in Texas; limited LARC access among women in hospitals that did not offer IPP LARC [48]

Health and Social Outcomes

Health and social outcomes assessed among SCAI and identified in the environmental scan include reproductive autonomy, unintended pregnancies, fertility rates, abortion rates, and maternal and infant health outcomes.

Limited Evaluation of Equity-Focused Outcomes

While there continues to be limited evaluation of reproductive autonomy, person-centered counseling, and sexual and reproductive health equity outcomes in SCAI, this scan found one study from Utah's FPE initiative related to reproductive autonomy. Similarly, initiatives in Missouri and Illinois reported shifting to more person-centered evaluation and focusing on outcomes outside of unintended pregnancies.

Reproductive Autonomy and Other Person-Centered Measures. The FPE initiative in Utah examined feelings of control over pregnancy as one indicator of reproductive autonomy.[49] They used survey data from young women 18-24 years old eligible for the FPE initiative to assess their level of agreement with the following statement: "I feel that I have control over whether or not I get pregnant" and its relationship with sociodemographic characteristics. The study found that 86% of women agreed with the statement, with the remainder of participants responding with neutral or disagree. Neutral responses were more likely among participants who reported poverty-level incomes and previous unwanted pregnancies.[49]

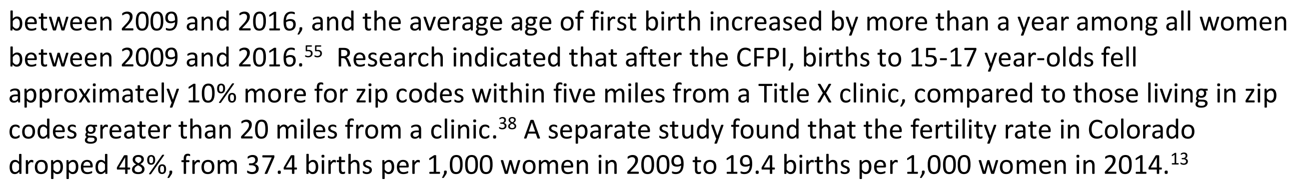
The ICAN! initiative in Illinois has reported plans to focus on person-reported outcome performance measures, including the Person-Centered Contraceptive Counseling (PCCC) measure, in the evaluation to meaningfully assess reproductive autonomy and wellbeing.[22] The evaluation plan also included use of PRAMS data to assess changes in mistimed or unwanted pregnancies where the patient had a preconception healthcare visit.[50] No data had been reported at the time of this scan. The Right Time initiative in Missouri has also reported plans to assess reductions in mistimed or undesired pregnancy. [21]

Unintended Pregnancy. Data on reducing unintended pregnancy was identified for three statewide initiatives – Delaware, Iowa, and South Carolina. According to modeling performed by ChildTrends related to the DelCAN initiative in Delaware, researchers estimated a substantial reduction in unplanned pregnancy among the population studied.[42] PRAMS data indicated a 25% reduction in births from pregnancies wanted later or not wanted in Delaware from 2014 (baseline period) to 2017.[51] An article identified in the scan noted that an independent evaluation assessing the effect of DelCAN on unintended pregnancy rates statewide is underway.[28]

In Iowa, data from the Iowa Department of Health and vital records indicated the percentage of unintended pregnancies declined 14% between 2006 to 2011. Additionally, the decline in unintended pregnancies in Iowa was greater than other Midwest states between 2005 to 2008.[52]

The Choose Well initiative in South Carolina aimed to have a 25% reduction in statewide unintended pregnancies by 2022. Unpublished data from the South Carolina PRAMS in 2020 suggested a 44% decrease in unwanted births across the state.[53,54]

Birth and Fertility Rates. The scan identified one initiative that reported data on birth and fertility rates, particularly among adolescents and young women - the Colorado Initiative. From the start of the initiative in 2009 to 2016, Colorado's teen birth rate dropped 54% from 37.5 births per 1,000 teens in 2009 to 17.1 in 2016.[55] The number of repeat teen births (i.e., teens giving birth for the second or third time) dropped 63%



between 2009 and 2016, and the average age of first birth increased by more than a year among all women between 2009 and 2016.[55] Research indicated that after the CFPI, births to 15-17 year-olds fell approximately 10% more for zip codes within five miles from a Title X clinic, compared to those living in zip codes greater than 20 miles from a clinic.[38] A separate study found that the fertility rate in Colorado dropped 48%, from 37.4 births per 1,000 women in 2009 to 19.4 births per 1,000 women in 2014.[13]

In a study on Colorado's outcomes at the five-year follow-up period, the initiative reported on the decline of adolescent birth rate in the state, from 11.2 per 1,000 in 2008 to 3.9 per 1,000 in 2019[24]. However, it should be noted that the project faced criticism for justifying increased funding for promoting LARC-first strategies and justifying the project based on costs avoided by governmental programs after a decrease in adolescent birth rates was seen in the state.[13,24]

Although data has not been reported to date, Illinois and South Carolina's evaluation plans described assessing public health surveillance indicators related to birth rates from state and local vital records data in their evaluations.[25,50]

Abortion Rates. Evidence on abortion rates were identified from three initiatives (CO, DE, and IA). Research from the Colorado initiative reported the abortion rate fell 63% among women ages 15-19 years, and 41% among women ages 20-24 years between 2009 and 2016.[55] In a five-year follow-up evaluation, the initiative reported a decline from 39.6 per 1000 in 2008 to 13.5 per 1000 in 2019.[24] In Delaware, a 2017 report from the Guttmacher Institute found that from 2014 to 2017 during the period that the DelCAN initiative was in place, Delaware experienced a 37% reduction in abortion rates.[56] Finally, in Iowa, the number of abortions decreased by 19% between 2007 and 2010 when the initiative ended. [12] A later report indicated the percentage of pregnancies in Iowa terminated by abortion declined by 21% between 2006 and 2011.[52]

South Carolina has included abortion rates as a part of their planned health and social outcomes, leveraging state level vital records data, but no data has been reported to date.[25]

Maternal and Infant Health. This scan identified studies that examined maternal and infant health, including birth spacing, in Colorado and South Carolina. Findings from Colorado's initiative indicated that the project contributed to an increase in average maternal age at first birth, reduced the proportion of all births to mothers without a high school education, reduced the number of births to unmarried women under age 25 without a high school education, reduced the number of repeat births to young women, and increased the length of time between births.[13]

Research from South Carolina's IPP LARC effort, prior to the Choose Well initiative, studied the association between Medicaid payment change for IPP LARC and a change in birth intervals. Findings indicated that adolescent short-interval births were increasing before the policy change and flattened afterward. There was no statistically significant change in trend in short-interval births for adults following the policy change. Researchers concluded the need for further study.[47]

Regarding adverse pregnancy outcomes, researchers in Colorado indicated that a statistically significant decrease in preterm birth (PTB) between 2008 (pre-initiative) and 2012 (during initiative) for the state of Colorado. Researchers compared Low Birth Weight (LBW) and PTB in 2008 and 2012, in counties with and without Title X clinics, and then compared the relationship between LARC use and the incidence of LBW or PTB in 2012 for women living in counties with Title X clinics. They found that living in a county with a Title X clinic with the highest degree of LARC use at the peak of the Colorado Initiative was associated with decreased odds of PTB. There were no statistically significant results for LBW babies.[3]

Public Policy Outcomes

Medicaid Enrollment and Policy Change. One study in Utah assessed changes in Medicaid enrollment. Despite the initiative's goal to support clinics to enroll newly eligible Medicaid clients, researchers found that the proportion of Medicaid eligible patients at the clinics remained largely unchanged after the initiative's implementation.[57] Researchers identified "application burden, enrollment requirements, and lack of presumptive eligibility" as challenges for Medicaid utilization.[57]

Other studies related to Medicaid policy change studied Medicaid agencies' experiences with implementing payment for postpartum LARC[58] and outlined implementation approaches for successful implementation of postpartum LARC access projects.[59,60]

Cost Savings. Regarding savings to public programs, an analysis by health economists at the University of Colorado contracted by the Colorado Department of Health found that between 2010 and 2014, between $66,063,664 and $69,625,751 were saved in costs to entitlement programs, such as Medicaid, Temporary Assistance to Needy Families, Supplemental Nutrition Assistance Program, and Special Supplemental Nutrition Program for WIC due to reductions in teen and unintended pregnancy.[13] In Colorado, the outcomes of the initiative are believed to have led to a significant increase in the state's family planning budget [13]ost. Although these cost-savings data are cited as the primary reason for the Colorado state legislature approving a significant increase to the state family planning budget, from an equity perspective these types of rationale for contraceptive access initiatives may be harmful.[61]

Sustainability

An important goal for SCAI is to build sustainable capacity for contraceptive care after project activities and funding ends. Sustaining an initiative after private funding ends can be challenging for initiatives that have depended on the scale of funding, as implementation and evaluation can be resource intense. Information in the current literature about approaches to SCAI sustainment is limited, as some of the initiatives are still in progress.

However, some initiatives included in this scan reported that sustainability was considered throughout the planning and implementation of project activities, such as leveraging payers and coverage to fund access activities, building and engaging a coalition of committed organizations, building workforce knowledge and capacity through provider trainings, and advocating for legislation that supports increased access to high-quality, affordable family planning services. The literature highlighted various SCAI approaches to maximizing funding, extending timelines, and advocating for legislative and policy change, and the potential positive impact of receiving tailored technical assistance on sustainability as part of a learning community. Further research is needed to understand how, and to what extent SCAI, have (or have the potential to) sustain change after the initiatives have ended.

Funding Approaches

Both the SCAI in Massachusetts[62] and New Mexico[32] described the importance of receiving buy-in and funding support from government agencies, such as the state health department and the state Medicaid program, for the purposes of sustaining the delivery of contraceptive services.

One initiative, ICAN! In Illinois, described its approach to funding health centers, different than other initiatives, aimed at achieving long-term sustainability. Instead of providing funding to clinical partners to support the provision of low- or no-cost contraceptive methods, the initiative focuses on "shifting payer practices to reward contraceptive care provision, expanding coverage for individuals with few resources, and supporting health centers in maximizing revenue from contraceptive care services through accurate billing and coding practices."[22]

Extended Timelines

In a midline evaluation report, representatives of The Right Time Initiative in Missouri described how SCAI are often functioning in an evolving and dynamic environment that can create challenges for sustaining the initiative's efforts, including the COVID-19 pandemic, a polarized political climate, and misinformation of contraception.[21] The implementers of the Missouri initiative have approached this by extending both health center participation and community mobilization activities to provide more time to improve and sustain the initiative's project activities.[21]

Building Capacity

SCAI have incorporated training and technical assistance in their core intervention components to support building the knowledge and capacity of the contraceptive care workforce. Choose Well in South Carolina has made training recordings available online that cover a range of topics, such as patient-centered care and sustainability.[63] The initiative also developed a toolkit to support community health centers broadly to increase access to contraception. The toolkit details changes health centers can make to operational and administrative systems, clinical services, financial systems, and sustainability to improve access, including tips and resources. It also describes how a coordinating organization can support multiple health centers to attain their goals.[54]

Legislative Advocacy and Policy Change

SCAI also focused efforts on improving existing legislation or advocating for new legislation to sustain contraceptive services within the health system. For example, in Illinois, implementers sought to increase access points for contraceptive care by introducing an amendment to a new pharmacy prescribing law seeking to establish high-quality care and referral protocols and influence pharmacist training standards.[22] In Utah, implementers discussed how policies can provide improvements for access to care, however, they stressed the importance of policies including an adequate budget and plan to ensure successful implementation and, ultimately, sustain change in the healthcare system.[57] The Utah initiative experienced challenges with policy implementation through the state Medicaid expansion, following low utilization of Medicaid reimbursement for family planning services at the initiative's clinical partner sites.[57]

Participation in ASTHO's Learning Community

ASTHO's multi-state Increasing Access to Contraception Learning Community was convened during October 2016 through May 2018, and was evaluated by the University of Illinois at Chicago, with a focus on the implementation outcomes of sustainability and acceptability.[8] The learning community focused on nine key areas of SCAI implementation and evaluation: 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. A year after the Learning Community ended, data collected from 26 of the 27 participating jurisdictions indicate that teams were sustaining efforts made for 87% (n = 69) of goals identified in their action plans and work on at least one goal was sustained in every jurisdiction.[8] These findings suggest that participation in learning communities and technical assistance opportunities for SCAI implementers and evaluators can help sustain progress on goals, even when the collaborative has ended.

Applying Equity-and Justice-Focused Frameworks in Statewide Contraceptive Access Initiatives

In the evolving landscape of sexual and reproductive health (SRH) care delivery in the US, interrelated barriers (e.g., political, geographical, and economic challenges) continue to threaten equitable contraceptive access. A number of articles emerged in the scan calling for a deeper examination of harmful assumptions, ideologies, and provider-patient relationships in the implementation and evaluation of SCAI.

For example, experts described how policy and practice approaches that problematize (by prioritizing the reduction of) unintended and adolescent pregnancies perpetuate the narrative that the reproduction of some people (particularly Black, Indigenous, and people of color and individuals living in poverty) is less valuable than the reproduction of others.[61] Discourse that promotes the prevention of unintended pregnancies and increased contraceptive access as a strategy to reduce poverty continue to perpetuate stigma, particularly against young people and individuals with low-incomes, and neglect to address the true structural causes of poverty, such as systematic racism and economic inequity.[61,64] Additionally, the persisting emphasis of LARC as "first-line" contraceptive methods across various programs and policy initiatives continue to undermine reproductive autonomy and result in women reporting feeling pressured by medical professionals to get or keep a LARC.[14,65]

In response to these challenges, several articles identified in the environmental scan outlined opportunities for SCAI to draw from equity-centered perspectives and proposed innovative approaches aimed to address systemic barriers and supporting all people in reaching their self-determined sexual and reproductive goals. These proposed approaches are described in **Table 5**.

Table 5. Proposed Frameworks for Sexual and Reproductive Health with Application to SCAI

Framework/ Approach	Description	Example Application in SCAI
Sexual and Reproductive Health and Wellbeing[66]	• Described as "a self-defined state that includes reaching one's individual sexual and reproductive goals" • Recognizes the need to de-silo clinical care, public health programming, and policy and advocates for the integration of a wide spectrum of health services and social supports • Seeks to incorporate services beyond SRH services, including maternal and child health, fertility, childcare, paid leave and housing	• Redesigning clinical practice and training to support increase in access to equitable SRH care, empower individuals who have faced harm and barriers in the healthcare system, and prepare clinicians to deliver patient-centered and trauma-informed SRH care and services in a way that reflect a holistic approach to health and wellbeing
Sexual and Reproductive Equity[66]	• Requires systemic changes to ensure that all individuals, regardless of age, gender, race, or other intersectional identities, have equitable access to the resources necessary for achieving their reproductive goals • Policies, programs, and services must center the needs of those most harmed by inequities and eliminate the influence of historical and current forces that limit an individual's ability to attain SRHW	• Examining and changing existing structures, prioritizing the inclusion of diverse voices, building accountability into systems and processes, and aligning language and definition with values • For example, the unintended pregnancy framework, which SCAI often incorporate into their overall approach and evaluation plans, could be replaced with patient-centered outcomes that prioritize bodily and reproductive autonomy

Framework/ Approach	Description	Example Application in SCAI
Reproductive Wellbeing[67]	• Described as "all people having equitable access to information, services, systems, and support they need to have control over their bodies, and to make their own decisions related to sexuality and reproduction throughout their lives" • Achieved through four key systems-level domains: policy, education and communication, healthcare and social services delivery, and health equity	• Implementing community-driven initiatives with strategies based on the four key systems-level domains: policy, education and communication, healthcare and social services delivery, and health equity • Recognizing that communities are best positioned to determine the specific interventions needed to increase awareness and access to contraceptive methods
Adopting Reproductive Justice Principles[68]	• Recognizes how historically prevalent contraceptive frameworks continue to perpetuate coercive policy and clinical practices • Involves understanding a community's history and challenges, developing trusting and power-sharing relationships with communities, and recognizing communities as decision makers in the design and implementation of policies, programs, and care	• Meaningfully collaborating with community-based leaders in Reproductive Justice organizations who are already reimagining and transforming how contraceptive care, policy change, provider training, and contraceptive methods counseling are conceptualized, implemented, and measured

RESEARCH GAPS AND IMPLICATIONS

This environmental scan summarized available evidence on the implementation and evaluation of SCAI that are completed and in progress. The available evidence demonstrated that most initiatives have common implementation strategies, including training, provision of low/no-cost contraceptives, patient education and awareness campaigns, partnerships, equity focus, and policy change. Evidence from this scan suggests that the evaluation methodologies, data, and analyses of initiatives are more wide-ranging. The body of evidence is growing, but additional research is needed on areas outlined below, and in **Table 6.**

Table 6. Overview of Gaps and Needed Research

Gap	Needed Research
Full Range of Methods	Explore ability of SCAI to increase access to and uptake of a broad range of contraceptive methods, beyond LARC
Equity-focused Approaches	Document and assess how strategies to integrate person-centeredness, reproductive autonomy, and equity into the design, implementation, and evaluation of SCAI better meet patient needs and affect outcomes and impact
Project Comparisons	Investigate how these projects compare and whether the variances between projects might result in differences in outcomes
Policy Change	Explore the impact of changes related to policies governing Medicaid reimbursement and state family planning funding on SCAI and potentially support sustainability.

Delivery of the Full Range of Contraceptive Methods

The most common evaluation measure among SCAI was contraceptive use, with a focus on LARC uptake. Evidence on outcomes from these projects demonstrate that SCAI have been effective at increasing uptake

of LARC methods. Some evidence exists demonstrating that SCAI are successful at increasing uptake of other contraceptive methods and access to contraceptive services. While an increasing number of initiatives have reported findings related to initiation and use of varied contraceptive methods, there is a paucity of research examining overall contraceptive use and whether people are receiving the contraceptive method of their choice as a result of these projects. The available research demonstrates the prioritization of LARC uptake in SCAI, despite the evolution of more recent initiatives prioritizing access to the full range of contraceptive methods and expressed commitment to contraceptive choice and meeting people's individual contraceptive needs.

Equity-Focused Approaches

Research gaps remain around documenting the design, implementation, and impact of SCAI, particularly in relation to SRHE. The published evidence on the outcomes of the SCAI is just beginning to reflect the evolution of the SCAI to broader focuses on person-centeredness, reproductive autonomy, and equity. Measures of contraceptive choice, access to all contraceptive methods (including access to removal of contraceptive methods as desired), quality of contraceptive care, and person-reported measures of experience are lacking in the current evidence. While many initiatives assess their effects on contraceptive use, there is still a need for future research to examine whether increased contraceptive uptake or method changes resulted from improvements in access or changes in person-centered quality of care (e.g., counseling styles and provider proficiency). There is also a need to look at a broader and more nuanced range of health outcomes, beyond unplanned pregnancy, birth rates, and abortion rates, that can explore domains like unmet need, pregnancy acceptability, sexual and reproductive wellbeing.

Lack of Research on Equity-Focused Approaches

This scan did not identify research that explicitly examined racial inequities in contraceptive access, the influence of coercion on contraceptive choice, improvements to racial and ethnic gaps in contraceptive access, improvements in contraceptive access for communities of color and other communities facing barriers to care, or pregnancy or maternal health outcomes of diverse communities.

Given that SCAI evolution was partly attributed to an increase in awareness of racial inequities and reproductive justice, it would be useful to evaluate whether these changes led to increased access and reproductive autonomy. Future research should evaluate if contraceptive use related to SCAI are aligned with individual preferences and reproductive goals and assess patient experiences as well as the quality of contraceptive counseling to ensure patients' preferences and choices are respected.

Project Comparisons

Peer-reviewed publications comparing outcomes between states that have implemented SCAI, or whether variations in project implementation, funding, or other key aspects might result in differences in outcomes, were not identified in this scan.

Policy Change

Given the critical importance of policy to SCAI success, research on the effects policy changes related to SCAI is limited in the evidence. Additional research on policy changes related to Medicaid reimbursement, state family planning funding, and other issues may expand the body of evidence and foster support for the sustainability of these projects.

CONCLUSION

Findings from this environmental scan demonstrate that SCAI across the U.S. implement strategic, multilevel interventions that can help increase access to and utilization of contraception. As these initiatives continue, additional analysis might be beneficial to support their utility. Reframing measurement and analysis from a reproductive justice lens, expanding research on policy implications, and examining the sustained effects of these projects may be important perspectives to foster continued support of SCAI.

Table 7. Summary of Key Takeaways from the Environmental Scan

Domain	Key Takeaways
Origin and Evolution	• Thirty states and/or territories have implemented, or are currently implementing, contraceptive access initiatives that are documented in the published literature, including the 27 states and/or territories that participated in ASTHO's multi-state contraceptive access learning community. • SCAI are an important intervention to increase access to contraceptives, given their focus on increasing access to contraception through coordinated efforts across clinical and community partners by reducing cost and other barriers that inhibit contraceptive choice. Although many of the early SCAI focused primarily on expanding access to LARC, they have evolved to implement approaches that expand access to the full range of contraceptive options using a shared decision-making approach.
Implementation	• SCAI consist of similar implementation approaches, including clinician and staff training and technical assistance; funding for the provision of low/no-cost contraceptive services, equipment and supplies; public awareness campaigns; public policy analysis and championing; strategic partnerships; and data management and quality assurance. • Evidence suggests that continued attention to organizational and structural factors (e.g., time, policies and practices, staffing, infrastructure/resources, billing/coding, costs/reimbursements), training, engagement of site leaders, and sustainability of funding are key to realizing the full potential of SCAI.
Evaluation	• SCAI evaluations consist of varied methodologies, data, and analyses. However, one common evaluation measure was contraceptive use, with a focus on LARC uptake. • Limited data on the impact of SCAI on expanding access to contraceptive care exists in the published literature. Available evidence demonstrates that SCAI might have positive impacts on increasing capacity and quality of contraceptive care provision, service utilization, patient experiences of high-quality care, contraceptive use, and pregnancy-related outcomes.
Sustainability	• An important goal for SCAI is to build sustainable capacity for contraceptive care after project funding has ended, yet current literature about approaches to SCAI sustainment is limited. • The literature that does exist highlights strategies to secure funding support from government agencies in addition to philanthropy, extend health center participation and community mobilization activities, and create legislative and policy change.
Research Gaps	• Research is needed to explore the ability of SCAI to influence access to the full range of contraceptive methods, effects on broader health and social outcomes, and how this may differ across states. • Additional research is needed to document and assess how equity-focused approaches meet the contraceptive needs and preferences of patients and affect project outcomes.

APPENDIX A: ENVIRONMENTAL SCAN SEARCH TERMS AND INCLUSION/EXCLUSION CRITERIA

Search Terms		
• Program • Initiative • State • Statewide • Regional • Evaluation • Implementation • Outcomes • Assessment	• Pregnancy • Unintended pregnancy • Pregnancy prevention • Teen pregnancy • Teen pregnancy prevention • Postpartum • Immediate postpartum	• Contraceptive • Contraceptive access • Long-acting reversible contraceptives • LARC access

Inclusion Criteria	Exclusion Criteria
Journal Article	**Studies outside the U.S.**
Project/Initiative Reports	Studies not evaluating a statewide effort
State or Federal agency reports	Studies published prior to 2005
Reports, presentations, commentary, websites, meeting notes, discussions regarding SCAI	
Studies examining implementation of coordinated statewide contraceptive access efforts	
Studies examining outcomes of contraceptive access, utilization, inequities, cost-benefits, impact on unintended pregnancy	
Studies examining evaluation of contraceptive access, utilization, inequities, cost-benefits, impact on unintended pregnancy	
Studies within the United States	
Studies after 2005	

APPENDIX B: OVERVIEW OF STATEWIDE CONTRACEPTIVE ACCESS INITIATIVES

State	Initiative Name, Lead Organization and Status	Project Aims	Recent Publications
Colorado	**Colorado Family Planning Initiative (CFPI)** Lead: Colorado Department of Public Health and Environment Status: Complete; 2008-2014	Increase access to contraception, via: 1. Increased access to quality family-planning services via Title X network 2. Providing LARCs at no cost 3. Improving community outreach and health education through public awareness campaign 4. Supporting state policy changes to family planning	• Romer, S. E., & Kennedy, K. I. (2022). The Colorado Initiative to Reduce Unintended Pregnancy: contraceptive access and impact on reproductive health. *American Journal of Public Health, 112*(S5), S532-S536. • Yeatman, S., et al. (2022). Expanded Contraceptive Access Linked To Increase In College Completion Among Women In Colorado: Study examines the link between expanded contraceptive access and increased college completion among women in Colorado. *Health Affairs, 41*(12), 1754-1762.
Delaware	**Delaware Contraceptive Access Now (DelCAN)** Lead: State of Delaware and Upstream USA Status: Complete; 2015-2020	Reduce unintended pregnancies rate and improve access to and delivery of family planning services and contraceptives (including LARCs) for all women of reproductive age, via: 1. Implementing state-level policy change 2. Providing trainings and technical assistance to clinical sites 3. Developing statewide public awareness campaign	• McColl, R. et al. (2023). (2023). Same-day long-acting reversible contraceptive utilization after a statewide contraceptive access initiative. *American Journal of Obstetrics and Gynecology, 228*(4), 451-e1. • Yoder, M., & Boudreaux, M. (2023). The effect of contraceptive access reform on privately insured patients: Evidence from Delaware Contraceptive Access Now. *PLoS One, 18*(1), e0280588.
Illinois	**Illinois Contraceptive Access Now (ICAN!)** Lead: AllianceChicago Status: Ongoing; 2021-2025	Create an Illinois where every person can decide whether, when, and under what circumstances to become pregnant and parent, using a three-pronged, systems-change approach to achieving their goals of: 1. Establishing screening for contraceptive needs and desires as a routine and essential component of preventive and primary care 2. Decreasing the number of people without health coverage for contraceptive care 3. Expanding points of access to contraceptive care and education	• Lassar, M., Tao, K., & Thiede, K. (2022). Advancing Reproductive Health Equity Through a New Contraceptive Access Initiative. *American Journal of Public Health*, *112*(S5), S500-S503. • Wolff, H., et al. (2024). Reproductive care in community health centers: Multi-method evaluation of the Illinois Contraceptive Access Now (ICAN!) demonstration program. *Contraception*, *129*, 110305.
Indiana	**PATH4YOU** Lead: Indiana University School of Medicine Status: Ongoing; 2020-	Provide high-quality, non-coercive, patient-centered, comprehensive contraceptive access to people throughout the state of Indiana.	• Ruggles, M., Wendholt, K., & Bernard, C. (2023). Indiana Contraceptive Use Metrics through PATH4YOU Program: Initial Review. *Proceedings of IMPRS*, *6*(1).

State	Initiative Name, Lead Organization and Status	Project Aims	Recent Publications
Iowa	**Iowa Initiative to Reduce Unintended Pregnancies** Lead: The Iowa Initiative Status: Complete; 2007-2013	Increase access to family planning services, improve the political climate towards family planning, and reduce unintended pregnancy in the state by 1. Increasing the number of women accessing family planning services 2. Increasing adoption of more effective LARCs 3. Increase public funding for family planning 4. Increasing support for family planning services among general public and elected officials	• Quinlan, T. (2018). *Assessing the Impact of Two Statewide Family Planning Initiatives on Birth Rates: Outcomes from the Colorado Family Planning Initiative and the Iowa Initiative to Reduce Unintended Pregnancies* (Doctoral dissertation, University of Colorado).
Massachusetts	**Massachusetts Initiative to Improve Contraception Services** Lead: Massachusetts Executive Office of Health and Human Services Status: Complete; 2018-2023	Promote the availability of effective contraception to decrease the number of unintended pregnancies and improve maternal and infant health outcomes across Massachusetts, in partnership with Partners in Contraceptive Choice and Knowledge (PICCK) and Upstream USA, by: 1. Addressing training, technical assistance, stakeholder engagement, and quality improvement 2. Creating a public information campaign similar to a previous national contraceptive training initiative	• White, K. O., et al. (2022). Massachusetts Initiative to Improve Contraception Services: A Tale of Two Programs. *American Journal of Public Health*, *112*(S5), S478-S483.
Missouri	**The Right Time** Lead: Missouri Family Health Council Status: Ongoing; 2019-2028	Improve reproductive health and rights in Missouri by expanding the availability of contraceptive services, improving access to quality information about contraception, and removing structural barriers to contraception.	• O'Neil, S., & Hoe, E. (2022). Lessons learned from The Right Time show how to advance reproductive health during COVID-19 and beyond. Mathematica. • O'Neil, S., Hoe, E., & Magee, M. (2022). Progress toward comprehensive contraceptive access through the right time in Missouri. Mathematica.
Nebraska	**Nebraska Sexual and Reproductive Health Initiative** Lead: Nebraska Family Planning Status: Ongoing; 2023-	Provide access to SRH care services and education and serves as a resource and ally for programs and services across Nebraska.	N/A
South Carolina	**Choose Well Initiative** Lead: New Morning Status: Ongoing; 2017-	Promote equitable access to contraception without judgment or coercion, with an aim of a 25% reduction in statewide unintended pregnancy by 2023.	• Beatty, K., et al. (2023). Impact of the Choose Well Initiative on Contraceptive Access at Federally Qualified Health Centers in South Carolina: A Midline Evaluation. *American Journal of Public Health, 113*(11), 1167-1172.

State	Initiative Name, Lead Organization and Status	Project Aims	Recent Publications
			• Hale, N., et al. (2023). Impact of the Choose Well Contraceptive Access Initiative on Method Use Among Women Enrolled in South Carolina's Medicaid Program: A Mid-line Assessment. *Women's Health Issues*, *33*(6), 626-635.
Utah	**Family Planning Elevated (FPE)** Lead: University of Utah Department of Obstetrics & Gynecology Status: Complete; 2019-2022	The mission of FPE is equitable access to all methods, for all communities, at all times, with two main objectives: 1. Improve clinic capacity to provide comprehensive, person-centered contraceptive care across the state 2. Make no-cost contraceptive care available to individuals falling in Utah's contraceptive "coverage gap," which exists for individuals who fall between the newly expanded Medicaid eligibility parameters and 250% of the federal poverty level	• Dalessandro, C., Kaiser, J. E., & Sanders, J. N. (2022). Reproductive autonomy and feelings of control over pregnancy among emerging adult clients in a Utah (USA) contraceptive initiative study. *Sexual & Reproductive Healthcare*, *31*, 100688. • Simmons, R. G., et al. (2022). Implementation and Monitoring of the Family Planning Elevated Contraceptive Access Program, Utah, 2018–2019. *American Journal of Public Health*, *112*(S5), S528–S531.

Association of State and Territorial Health Officials (ASTHO) Statewide Contraceptive Access Initiative Learning Communities

In 2014, ASTHO, with support from and participation of multiple federal agencies—including the CDC Division of Reproductive Health, CMS Centers for Medicaid and CHIP Services, and OPA—convened a multi-state Learning Community focused on facilitating access to IPP LARC. The **ASTHO IPP LARC Learning Community** initially included 13 states and focused on facilitating cross-state collaboration in implementation of policies and practices to improve access to IPP LARC. The 13 state teams were comprised of state health officials, payers, clinicians, and health department staff that participated in peer-to-peer learning and state-to-state strategy-sharing activities to facilitate systems change within hospitals and state Medicaid policies to enable provision of IPP LARC.

In 2016, ASTHO's Learning Community expanded its focus from IPP LARC to "Increasing Access to Contraception," including all contraceptive methods, and the number of participating states increased to 27. The expressed objective of the re-purposed **Increasing Access to Contraception Learning Community** was to disseminate best practices to implement policies and programs that increase access to the full range of contraception options.[19] The Learning Community ended in 2018.

For the purposes of the CECA/RISE effort, states that participated in the ASTHO Learning Communities were considered to fit the definition of "statewide contraceptive access initiatives." Those states/territories included: 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.

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