Family Planning Access: An Elusive Resource for Interconceptional Women

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Enterprise Community Healthy Start

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Improving Pregnancy Outcomes Program
ICCLC Family Planning 1 Collaborative

- Focus on linkages and partnerships to improve interconception care among each Healthy Start project’s target population
ICCLC Family Planning 1 Collaborative

• Cycle 1 Members
  – Brooklyn Healthy Start
  – Enterprise Community Healthy Start*
  – Improving Pregnancy Outcomes Program (IPOP)*
  – Low Country Healthy Start*
  – Missouri Bootheel Healthy Start
  – Metro Nashville Health Department
  – MomsFirst
  – St. Petersburg Healthy Start
Introductions: Ice Breaker

Find a partner:

– Name
– Job Title
– Organization
– Ideal number of children for you personally
– Ideal age to initiate childbearing for you personally
What is family planning?

“...allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility.”


NATIONAL HEALTHY START ASSOCIATION
12TH ANNUAL SPRING CONFERENCE
Significance of Family Planning

• Existing research supports the strategy of addressing family planning to improve pregnancy outcomes (*J of Maternal & Child Health*, 2006).

• Many low-income women get their basic health care for the year during an annual visit to a family planning center (*AGI Report*, 2009).

• Three out of 4 low-income women consider a family planning center to be their usual source of health care (*AGI Report*, 2009).
Significance of Family Planning

• 3/4 low-income women use FP clinics
• Title X addresses:
  – “inability to pay” population
  – Service gaps not covered by Medicaid
• 24 states (2007) – no FP waiver*
  – CA and SC = broad eligibility >5 yrs
  – GA, effective 1/1/11

Significance of Family Planning

• Lower birth rates
• Reduced unintended pregnancy and abortion rates
• Increased spacing $\Rightarrow$ lower VLBW rates
• Cervical and breast cancer screening
• STI screening and treatment
Low Country Healthy Start

Virginia Berry White, LMSW
Program Director
About Low Country Healthy Start (LCHS)

- Part of the SC Office of Rural Health
- Service area is four rural counties in the Low Country region of the state — Allendale, Bamberg, Hampton, Orangeburg
- LCHS is staffed by masters prepared social workers and lay home visitors, called Client Navigators
About Low Country Healthy Start (LCHS)

- Very poor, under-resourced counties
- Target population is African American women
- In 2008, there were 1,385 African American live births in the service area, 592 white births and 23 other
- LCHS provided services in 2010 to 380 pregnant women, 409 postpartum women and 660 infants
### Service Area IMR Data

**Infant Mortality: 2005-2008**

<table>
<thead>
<tr>
<th>County, Service Area, State</th>
<th>White</th>
<th>Black &amp; Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Rate</td>
<td>Number</td>
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<tr>
<td>Allendale</td>
<td>2</td>
<td>19.8</td>
<td>10</td>
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<tr>
<td>Bamberg</td>
<td>1</td>
<td>4.5</td>
<td>3</td>
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<tr>
<td>Hampton</td>
<td>1</td>
<td>2.2</td>
<td>9</td>
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<tr>
<td>Orangeburg</td>
<td>20</td>
<td>12.1</td>
<td>71</td>
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<tr>
<td>Service Area</td>
<td>24</td>
<td>9.9</td>
<td>93</td>
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<tr>
<td>South Carolina</td>
<td>983</td>
<td>6.2</td>
<td>1,101</td>
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Description of the Change Project

- Subtopic/Change Project: Develop relationships with family planning providers and organizations who serve low income women
- Assure that at least 50% of LCHS participant women have a family planning method prescribed at discharge from the hospital after delivery
Description of the Change Project

- Assure that at least 75% of LCHS participant women are using a family planning method effectively at 60 days after delivery and at 9 months, 12, 18 and 24 months after delivery.
Aim: What LCHS is trying to accomplish?

- Assure that at least 50% of LCHS participant women have a family planning method prescribed at discharge from the hospital after delivery.
- Assure that at least 75% of LCHS participant women are using a family planning method effectively at 60 days after delivery and at 9 months, 12, 18 and 24 months after delivery.
Why LCHS Chose This Change Project

• Because too many women become pregnant too soon after delivery and did not intend to be pregnant.
• Because planning for pregnancy is important to women and impacts their lives and the life of the family and community
• Because understanding, managing and controlling reproductive health and pregnancy intent is essential to quality of life for women.
Why LCHS Chose This Change Project

• Because women need assistance in finding, selecting, securing and using a long acting, effective birth control method

• Because the most effective, long lasting birth control methods require a physician or advanced practice nurse to prescribe the long lasting method and insert it.
  – Women (clients) cannot secure long-lasting birth control methods without direct access to a health provider that can secure, order and insert the method
  – The most effective, long lasting methods are expensive
Who Is Involved in the Change Project?

- LCHS staff including the Perinatal Social Workers, Client Navigators, contract staff, Data Manager, Perinatal managers, Program Director are involved in the change.
  - Traveling Team members are also involved in the change are the local evaluator and a member of the Title V MCH team.
Who Is Involved in the Change Project?

- Members of the Perinatal Provider Advisory Group (PPAG) and members of the ICC Home Team, which include obstetricians, pediatrician, family practitioner, certified nurse midwives, nurse practitioners, nurses, hospital L&D nurses and Regional System Obstetric outreach staff
Implementing the Change Project

Background: Improvement in family planning use and helping women secure effective birth control methods has been a central part of the Local Health System Action Plan (LHSAP) over five years.
Implementing the Change Project

• LCHS reviewed program data, listened to women, listened to the staff, reviewed progress and LHSAP action.

• LCHS met with obstetric providers participating in the PPAG and Multi-disciplinary Team Meetings and sought their input.
Implementing the Change Project

- Based on the discussion from that group, a PPAG member arranged a meeting for LCHS and the Home Team to meet with labor and delivery staff in the one birthing hospital in the service area.
Implementing the Change Project

• Nurse midwives, nurse practitioners, obstetricians and others discussed access to long acting methods, reimbursement & other logistical issues, opportunities for improvement and determined a standing order for Depo Provera (DP) was an essential, important, doable step.

  A pre-hospital discharge DP injection would allow women time to secure a post-partum appointment, select a method before becoming pregnant again, get to the practice for the appointment and secure the method of choice.
Implementing the Change Project

• OB staff, nurse midwives and others discussed the protocol. The Regional Perinatal Center perinatologist came to the service area and discussed strategy.

• LCHS staff discussed with clients the strategy of having a DP injection before leaving the hospital, answered questions, strongly encouraged women to ask for it if before discharge.
Implementing the Change Project

• Staff were trained on the importance of women understanding birth control methods, on the effectiveness and risks of each and to discuss methods with women, helping them choose.

• LCHS staff were trained on program expectations of when in the prenatal period BC methods will be discussed, how documented and the expectations for close follow-up and documentation in the two years after delivery.
Implementing the Change Project

• Data collection tools and logs were discussed, along with responsibility for completion
• Data are collected, results analyzed and shared with the PPAG and Home Team.
Success to Date

• LCHS developed a tracking log used by LCHS staff to collect and report data on each woman after she delivers.

• Improvements have been documented in the number of women leaving the birthing hospital in the service area with DP or a permanent method such as tubal or hysterectomy.
Success to Date

- Periodic results have been presented to the Home Team, PPAG and LCHS Staff
- The PPAG and Home Team members have been consulted about the strategy, implementation success and asked for additional input
Success to Date

• Providers are now openly discussing what has to be done to help women gain access to effective long-lasting contraceptives, particularly the Mirena IUD.

• LCHS has a project with the SC Primary Care Association, comprised of a study group to determine how FQHCs can overcome barriers to providing long acting, effective birth control methods for clients.
Success to Date

• LCHS has met with physicians and NP representing all FQHCs in the service area to identify problems and find solutions.

• LCHS met with the Title X director to implore her to help find solutions to pressing issues with lack of nurse practitioners in the county HD system.
What we have gained from our peers

- Information and perspective from the Expert Advisory group reinforcing the need for focus on family planning
- Ideas about documentation of which providers, provide what services, when, under what circumstances and through what hopes women have to jump to receive long lasting, effective methods
What we have gained from our peers

• Reinforcement from MCHB, Division of Healthy Start about focusing on family planning as a vitally important way to serve high risk women, families and communities
Measuring the Change

• # of partners (delivering providers) using the protocol to assure women are discharged from the hospital, after delivery, with a method. Planned number is 4.

• # of primary care partners accepting our referrals and assisting clients to select and use an effective contraceptive method. Planned number is 8; 2 per county.
Measuring the Change

• Assisting with a selecting and using an effective contraceptive method is defined as LCHS or the client securing an appointment within 2 weeks of appointment request. Payment for care is not a barrier which means the client has Medicaid, other insurance and/or the provider has agreed to accept LCHS referrals for free, or low cost or uses a sliding fee scale
Measuring the Change

- # of LCHS post-partum clients using a birth control method effectively at 3, 6, 9, 12, 18, 24 months ÷ # of LCHS post-partum clients at 3, 6, 9, 12, 18, 24 months after index delivery. Target is 75%.
Where we plan to go from here

- Improve our data collection, making it more seamless and fitting with staff already report better

- Continue to work with the FQHCs and assure they work with women, prescribe the method women want and then provide the method

- Find even more effective ways to help women advocate for their own reproductive desires
Where we plan to go from here

- Work with Title V to determine what can be done to improve access to Title X required services given the staffing issues, i.e. propose Title X sub-contract when they can’t serve.
- Continue to work with the birthing hospital and obstetric providers to keep the focus on interconceptional care
- Work with other hospitals, outside the service area, to use the protocol
Objective is at least 50% of LCHS participants will leave the hospital with a method. Data is from LCHS client records.
Results to Date

Low Country Healthy Start

<table>
<thead>
<tr>
<th>Reporting Interval - After Delivery</th>
<th>Clients Using Family Planning Method</th>
<th>Clients with No Family Planning Method</th>
<th>Clients with Reported Family Planning Method Status</th>
<th>% Effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 months</td>
<td>161</td>
<td>43</td>
<td>204</td>
<td>79%</td>
</tr>
<tr>
<td>6 months</td>
<td>80</td>
<td>24</td>
<td>104</td>
<td>77%</td>
</tr>
<tr>
<td>9 months</td>
<td>45</td>
<td>12</td>
<td>57</td>
<td>79%</td>
</tr>
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</table>

Notes: Objective is at least 75% of LCHS participants will be using a birth control method effectively at specific intervals after delivery. This report represents 234 participants of which 4 became pregnant, 6 were using condoms and 73 reported they were not using a method. Source: LCHS client records.
Enterprise Community Healthy Start

Sandra Mobley, PhD, RN
Project Director
# ECHS IMR and LBW Rates

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<tr>
<th></th>
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<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Black</td>
<td>White</td>
<td>Total</td>
</tr>
<tr>
<td><strong>Burke</strong></td>
<td>12.6</td>
<td>9.3</td>
<td>11.3</td>
</tr>
<tr>
<td><strong>McDuffie</strong></td>
<td>16.5</td>
<td>4.1</td>
<td>10.2</td>
</tr>
<tr>
<td><strong>ECHS</strong></td>
<td>14.1</td>
<td>6.5</td>
<td>10.8</td>
</tr>
<tr>
<td><strong>Georgia</strong></td>
<td>12.7</td>
<td>5.8</td>
<td>8.0</td>
</tr>
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</table>

*2008 IMR Rates have not yet been released
Enterprise Community

• Average caseload=200 women
  — 25 pregnant
  — 175 women with infants
  — CY2010 clients =317 women + 282 children

• Enrollment criteria
  — prenatally through 1 year postpartum
  — Women at risk for subsequent poor outcome
  — Fragile infants
Enterprise Community

• Challenges
  – % of clients completing FP visit in 1\textsuperscript{st} year postpartum
    • 2008 Deliveries – 45.4\% (59/130)
    • 2009 Deliveries – 53.2\% (66/124)
  – % of clients completing FP visit in 2\textsuperscript{nd} year postpartum
    • 2007 Deliveries – 19.2\% (20/104)
    • 2008 Deliveries – 23.1\% (30/130)
Cycle I-II Actions

• Introduced the reproductive health plan

• Changed documentation system to include:
  – Reproductive health plan
  – Added date to family planning method
  – Changed teaching page to force documentation of method when any teaching is done → prompting FP focus
Methods

• Survey of public and private providers
• Client self report of methods used
• Client satisfaction survey with family planning services
• Reproductive health manual
ECHS Providers

• Burke (n= 13)
  – 1 health dept w/1 NP and 3 expanded role RNs
  – 1 board certified OB-GYN - 5 days / week
  – 5 family medicine physicians (2 provide PNC)
  – 3 physician assistants

• McDuffie (n=14)
  – 1 health dept w/1 NP and 1 expanded role RN
  – 2 board certified OB-GYNs – each 1 day / week
  – 8 family medicine physicians
  – 1 nurse practitioner
  – 1 physician assistant
Contraceptive Methods Provided or Prescribed by Local Providers

- Depo
- OCPs
- Ring
- IUD
- Patch
- Spermacide
- Condom
- Emergency
- Implant
- Sterilization

Bar chart showing the percentage of contraceptive methods provided or prescribed by local providers in Burke County and McDuffie County.
Contraceptive Methods of ECHS Clients, Cycle I vs. Cycle II

- IUD
- Depo
- Sterilization

Burke County, I
Burke County, II
McDuffie County, I
McDuffie County, II
## Satisfaction Survey Results

<table>
<thead>
<tr>
<th></th>
<th>Burke (n=31)</th>
<th>McDuffie (n=29)</th>
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<tbody>
<tr>
<td><strong>Location</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Office</td>
<td>64.5</td>
<td>37.0</td>
</tr>
<tr>
<td>Health Department</td>
<td>22.6</td>
<td>51.9</td>
</tr>
<tr>
<td>Other</td>
<td>12.9</td>
<td>11.1</td>
</tr>
<tr>
<td><strong>Wait Time to Get Appointment</strong></td>
<td></td>
<td></td>
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<tr>
<td>&lt;3 Days – &lt;2 Weeks</td>
<td>42.9</td>
<td>72.7</td>
</tr>
<tr>
<td>2-4 Weeks</td>
<td>10.7</td>
<td>4.5</td>
</tr>
<tr>
<td>&gt;1 Month</td>
<td>46.4</td>
<td>22.7</td>
</tr>
<tr>
<td><strong>Need to Take Off from Work</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>25.8</td>
<td>30.4</td>
</tr>
<tr>
<td>No</td>
<td>74.2</td>
<td>69.6</td>
</tr>
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</table>
Enterprise Community

• Cycle III Action steps
  – Monitor use of contraception by IC PPs
  – Monitor intro of reproductive health plan
  – Disseminate reproductive health resource manuals to PPs and CPs
  – Educate providers by meeting with each provider to explain waiver
  – Educate, facilitate, and monitor PP enrollment in FP Medicaid
Key take-away messages

• Partnering with providers is key
• Ongoing relationships important
• More expensive methods may not be available due to reimbursement rates
• Shortage of providers skilled in IUD insertion
• Ongoing assistance to PPs related to Medicaid enrollment process
• Key systems change = hospital discharge with method
Improving Pregnancy Outcomes Program

Dana Cruz Santana, MSW, MPH, CHES
Interim Sr. Program Specialist
Improving Pregnancy Outcomes Program (IPOP)

• Change Project
  – In partnership with referring providers, community members, and volunteers, initiated “secret shopping” calls to assess the accessibility of forty-seven (47) local family planning providers from a consumer perspective in Alameda County (located in San Francisco Bay Area)
Current Landscape: Family Planning in Alameda County

• About 50 FamilyPACT providers in the county

• Clinics participating in FamilyPACT have direct relationship with State of California; local public health department does not have primary care clinics

• No county-level coordination & dedicated family planning Alameda County Public Health Department staff
Current Landscape: Family Planning in Alameda County

• Existence of Family Planning Sub-Committee under auspices of IPOP/Community Forum for Perinatal Health

• Only about half (51.8%) of the women in need actually access publicly-funded family planning services in Alameda County. The other half in need go without receiving family planning services (FamilyPact Report, May 2009).

• “It’s a family planning wilderness.”
Methods

• In 2009, assembled and convened Family Planning Sub-Committee to:
  – Validate available referral information
  – Assess accessibility & consumer-friendliness

• Using information available to consumer, identified 47 family planning providers funded through FamilyPACT

• Developed “Telephone Contact Log”
Methods

• Solicited 10-12 volunteers to make secret shopping calls & document observations
• Secret shopper asked to “recommend” or “not recommend” provider
• Determined provider selection criteria for inclusion in family planning resource guide
  1) Working telephone number
  2) Free/low-cost
  3) No clinic membership required
  4) Appointment within 2 weeks
Results

• Placed 1-5 secret shopping calls per provider
  – 7 had non-working telephone numbers
  – 5 stated “no longer FamilyPact provider”
  – 7 required membership (increases delay in getting care)
  – 1 charged illegal fees (against FamilyPact policies)
  – 17 deemed not consumer-friendly
Results

• 37 providers not recommended

• Total providers recommended
  – English version = 10
  – Spanish version = 9

• One “recommended” clinic closed down before printing

• Final family planning resource guide
  – English version = 9
  – Spanish version = 8
Analysis

• Consumers attempting to access family planning services experience significant “runaround”

• Validating referral information available to consumers is critical for increasing likelihood of accessing family planning services
Action Steps & Follow-Up

• Revision of family planning resource guide every two years (will repeat process in 2011 in FP1 Cycle 2)
• Offer staff training in making effective referrals to local family planning providers based on findings
• Share findings with key stakeholders willing to listen
Key Lessons Learned Across the Three Change Projects

• Partnering with providers is key to increase their buy-in
• Ongoing assistance to participants with getting/maintaining coverage
• Adequate number of providers with necessary skill-level is lacking (long waiting time for appointments)
Key Lessons Learned Across the Three Change Projects

• Use consumers to assess access to family planning services
• Do not *overestimate* the complexity of the barriers (most were simple barriers)
• Need for standing order for family planning method at discharge from hospital after delivery
Questions & Answers