Priority Roadmap for Policy-Ready Contraceptive Research
Draft Environmental Scan Report
Statewide Contraceptive Access Initiatives

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ABSTRACT
Statewide Contraceptive Access Initiatives (SCAIs) 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 SCAIs—as well as the initiatives' impacts on expanding contraceptive access; identifies gaps in the available evidence; and makes recommendations for future research. Forty-four relevant articles were identified in the scan, describing implementation approaches and evaluation findings across 29 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. Limited data on the impact of SCAIs on expanding access to contraceptive care exists in the published literature. The available evidence, which documents findings across a limited number of initiatives, describes impacts on contraceptive use, service utilization, and pregnancy-related outcomes. Research gaps remain in understanding the impact of SCAIs in expanding access to contraception, reducing inequities in contraceptive access, and fostering sustainability.

INTRODUCTION
The Coalition to Expand Contraceptive Access (CECA) is leading a collaborative process to create **a Priority Roadmap for Policy-Ready Contraceptive Research.** Building on the existing foundation of the coalition and leveraging its unique positioning and diverse collaborative relationships, CECA will:

- Craft a long-term, national-level research and policy agenda.
- Identify the rigorous evidence needed to influence policy, leverage federal processes, and set the stage for state-level implementation.
- Position funders, researchers, and clinical organizations to strategically invest in and carry out ongoing research to inform policies.

To begin the process of identifying existing needs and innovations in the field, CECA performed a series of six targeted and strategic environmental scans[1] to survey existing evidence on key priority topics related to contraceptive access and identify where gaps remain to build a solid foundation of research. The environmental scan findings and supplementary evidence sources will serve as the basis for CECA's Research Roadmap Workgroup's efforts to understand the current body of evidence around contraceptive access, identify research needs and innovation, prioritize research gaps and promising practices, and translate evidence into national research and policy priorities and actions.

[1] The environmental scan topics were: (1) Definitions and measures of reproductive and sexual health-related constructs; (2) Measuring health, economic and social outcomes related to contraception; (3) Impact of major policy changes related to contraceptive access; (4) Implementation and evaluation of pharmacist-prescribed contraception; (5) Implementation and evaluation of statewide contraceptive access initiatives; and (6) Contraceptive care workforce.

This report describes the findings of the environmental scan on Statewide Contraceptive Access Initiatives (SCAIs). For the purposes of this scan, SCAIs are defined as 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, such as mobilizing interest in expanding access to contraception; providing contraceptive products at no or low cost; providing training and capacity building; and removing other structural barriers to enhanced contraceptive access. These initiatives 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 around if and when people want to become pregnant.

Since 2007, 29 states and/or territories have implemented contraceptive access initiatives that are documented in the literature. These 29 states and/or territories include 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 two SCAIs that are documented in the literature that did not participate in the ASTHO project. A number of other local or statewide projects have also been initiated, and later discontinued. This environmental scan describes the approaches, evaluations, known outcomes, and impact of documented SCAIs, as well as research gaps and outstanding questions. There is growing evidence that these types of initiatives can have a substantial impact on access to and utilization of contraceptive services and supplies. An understanding of the full body of evidence generated by these initiatives to date and what evidence is currently being generated is needed to replicate any best practices and plan future research. CECA undertook this environmental scan to inform these discussions and future research efforts.

For this environmental scan, the team sought to identify evidence to address the following key research questions:

1. What SCAIs have been initiated in the past 15 years and why were these initiatives undertaken?
    a. How have the SCAIs evolved since their inception?

2. What are the implementation approaches for SCAIs, and what lessons have been learned?

3. At what phase of data collection/analysis are the various SCAIs?

4. What outcomes are being assessed among SCAIs?
    a. How are the various outcomes measured and what is the impact of SCAIs on these outcomes?
        i. Effectiveness of initiatives for promoting contraception access and use?
        ii. Effectiveness of initiatives for promoting reproductive health services access and use?
        iii. Changes to public policy?

5. When the current SCAIs conclude, what will we be positioned to understand about their impact? What questions will remain?

METHODS

The scope of the environmental scan focused on identifying peer-reviewed and grey literature that addressed implementation, evaluation, and outcomes of statewide contraceptive initiatives. Evidence on completed SCAI projects and projects in progress were eligible for inclusion in the scan—including projects specifically focused on contraceptive access, such as Long-Acting Reversible Contraception (LARC) access projects—and all method approaches. Many of the projects that are still in progress have not yet published evidence in the peer-reviewed literature. To supplement this publication gap, the team also spoke with organizational representatives of current or past projects to gather project implementation and evaluation information. Additional projects may exist that have not published—or were started and later discontinued; these were not included in this scan.

Projects that focused solely on increasing access to immediate postpartum (IPP) LARC were not included in this scan (with an exception made for states that participated in the ASTHO Learning Community that initially focused on increasing access to IPP LARC, and later expanded to focus on access to all methods). The rationale for non-inclusion was that their implementation relies almost exclusively on modifying hospital practices and state Medicaid reimbursement policies. Teen pregnancy prevention projects conducted collaboratively by the Centers for Disease Control and Prevention (CDC), Office of Adolescent Health), (OAH), and Office of Population Affairs (OPA) during the past 10 years were not included, as these programs 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 (Centers for Disease Control and Prevention, 2020).

Local projects, such as the LARC Access programs undertaken in Rochester, NY (Aligne et al., 2020) and Tulsa, OK (Putnam, 2017), 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 (Sanders et al., 2018).

The team included both descriptive and experimental peer-reviewed publications in the environmental scan, as well as grey literature (e.g., commentaries, white papers, conference abstracts, blog posts, webpages) relevant to the topic. Databases searched to identify relevant articles included PubMed, Google Scholar, and Google Search. Search terms included statewide initiative-related terms (e.g., “contraceptive access”; “LARC Access”) and terms to identify implementation and evaluation (e.g., “implementation”; “evaluation”; “assessment”; “outcomes”). A complete list of search terms can be found in **Error! Reference source not found.**. The search was limited to research conducted in the United States (U.S.) and literature published since 2005. The scan also considered unpublished information available through an ongoing, collaborative project undertaken by CECA and ASTHO to explore the feasibility of seeking a CDC Community Guide recommendation on SCAIs.

SUMMARY OF FINDINGS

Description of Search Results

The team identified 44 resources (e.g., journal articles, reports, websites, whitepapers) relevant to the environmental scan.

This report describes the implementation, evaluation, outcomes, and the impact of eight SCAIs that have published descriptions regarding the implementation or evaluation approaches and/or evidence on the impact of the initiatives. SCAIs included in this scan are Colorado (CO), Delaware (DE), Iowa (IA), Massachusetts (MA), Missouri (MO), New Mexico (NM), South Carolina (SC), and Utah (UT). Initiatives in Colorado, Iowa, and New Mexico are complete, and the other five are in progress. The available published evidence primarily described findings from completed projects in Colorado and Iowa, and in-progress projects in Utah and Delaware.

This environmental scan also considers evidence describing the implementation and evaluation of a multi-state learning community, coordinated by ASTHO, which included 27 states/territories implementing contraceptive access initiatives. States/territories that participated in ASTHO's Increasing Access to Contraception Learning Community are listed in Appendix B. Of the eight states listed above, six states (i.e., Colorado, Delaware, Iowa, Massachusetts, New Mexico, and South Carolina) also participated in the ASTHO Learning Community until it ended in 2018. Missouri and Utah did not participate.

Additionally, CECA partnered with ASTHO in 2020, along with state-based partners representing seven active or completed statewide contraceptive access initiatives, to explore the impact these SCAI potentially had, or may have, on a range of contextual, behavioral, and health outcomes. This project explored strategies to mobilize interest among other states to undertake similar initiatives to expand contraceptive access and the feasibility of a CDC Community Guide recommendation for SCAIs to disseminate best practices. States participating in the CECA-ASTHO project include Colorado, Delaware, Louisiana, Massachusetts, New Mexico, South Carolina, and Utah. Projects in Delaware, South Carolina, Massachusetts, and Utah are currently active; Colorado, Louisiana and New Mexico have completed their projects.

Overview of Statewide Contraceptive Access Initiatives

Overview and Implementation

SCAIs focus on increasing access to contraception through coordinated efforts across clinical facilities (e.g., hospital out-patient facilities, Title X clinics, Federally Qualified Health Centers (FQHCs), college/university health centers, etc.) and other community partners throughout a geography. These partnerships are established to expand access to contraception by reducing cost and other barriers that inhibit contraceptive choice.

Many of the early contraceptive access programs 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. 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 (McNicholas et al., 2014). Beyond method choice and continuation rates, the study also found substantial reductions in teen pregnancy, birth, and abortion (Birgisson et al., 2015). 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, the number of low-income individuals who access 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 (Philliber Research Associates & UCSF Bixby Center for Global Reproductive Health, 2010, 2012).

The Colorado Department of Public Health and Environment (CDPHE) 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 health care 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" (Colorado Department of Public Health and Environment, 2017).

In addition, 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. Both Iowa and Colorado also participated in this Learning Community (DeSisto et al., 2017). 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. Implementation strategies were identified by the state teams in eight domains: 1) provider training; 2) pay streams and reimbursement; 3) informed consent; 4) stocking and supply of devices; 5) outreach; 6) service locations; 7) data, monitoring, and evaluation; and 8) stakeholder partnerships. All 13 states identified stakeholder partnerships and provider training, and 12 of 13 identified outreach as essential implementation strategies (Kroelinger et al., 2019). 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.

SCAIs can generally be categorized by three approaches: 1) LARC "First"; 2) LARC access initiatives; and 3) initiatives that focus on access to all methods. LARC "First" refers to programs and contraceptive counseling that "promote" 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 (Gomez et al., 2014). LARC "access" programs are focused on reducing or eliminating barriers to LARC access, but do not necessarily employ counseling techniques that promote uptake of LARC above other methods. Initiatives that focus on access to all methods employ strategies to ensure that all methods are available for individuals to choose the method that will work best for them. Many initiatives that focus on access to all contraceptive methods utilize a shared decision-making approach, generally based on research conducted at the University of California, San Francisco (Dehlendorf et al., 2017).

Evolution of Statewide Contraceptive Access Initiatives

As previously noted, most initial contraceptive access initiatives focused on increasing access to LARC as the most effective reversible form of contraception. The unique challenges presented by LARC provision—including relatively high, up-front cost and the need for specific training of clinical providers for insertion and removal—complicate making these methods readily available. As previously described, many of the LARC first initiatives used a tiered-effectiveness counseling approach, providing information on the most effective methods (LARC) first before presenting information on less effective 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 (Gomez et al., 2014; Gubrium et al., 2016). Likely based on these concerns, programs—over time—shifted to approaches that included offering the full range of contraceptive options, most using a shared decision-making approach that centers individual preferences and priorities (Dehlendorf et al., 2017).

In 2016, the expressed objective of the re-purposed "ASTHO 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. Similar to the initial IPP LARC Learning Community, the Increasing Access to Contraception Learning Community collaboratively identified nine focus areas with expanded implementation strategies that could increase access to contraception: 1) provider awareness and training; 2) reimbursement and financial sustainability; 3) informed consent and ethical considerations; 4) logistical, stocking, and administrative barriers; 5) consumer awareness; 6) stakeholder partnerships; 7) service locations; 8) data monitoring, and evaluation; and 9) specific populations (ASTHO, 2017b). Technical assistance needs for states in each of the focus areas were identified, and federal staff facilitated one-on-one technical assistance calls. Specific information regarding program components for each of the 27 states participating in the Learning Community has not been published. The Learning Community ended in 2018, and an evaluation of the initiative by the University of Illinois at Chicago is currently underway, with completion anticipated later in 2021.

Implementation of Statewide Contraceptive Access Initiatives

Common Intervention Components

In 2020, CECA and ASTHO undertook a collaborative project, along with seven state-based partners implementing contraceptive access initiatives, to explore the feasibility of seeking a CDC Community Guide recommendation on SCAIs. As a part of that project, the seven state-based partners identified six core program components that include or included: 1) training/continuing education, 2) ongoing technical assistance, 3) provision of low/no-cost products, 4) financial assistance for equipment/supplies (e.g., grant funding), 5) public awareness campaigns, and 6) a focus on legislation or public policy change. Additional "focus areas" identified within the ASTHO Learning Community as integral to ensuring access included: partnerships and community engagement; informed consent and ethical considerations; service locations; data, monitoring, and evaluation; and specific populations (ASTHO, 2017b). Information is not readily available regarding how many states implemented the focus areas nor how they were implemented.

Table 1 describes the core program components identified during the CECA-ASTHO SCAI Project and the nine focus areas for success identified by the ASTHO Increasing Access to Contraception Learning Community.

TABLE 1. Common Intervention Components for Statewide Contraceptive Access Initiatives

CECA-ASTHO SCAI Project ***Core Program Components***	***ASTHO Increasing Access to Contraception Learning Community*** ***Nine Focus Areas for Success***
1. Training/Continuing Education Training to clinicians, support staff, and administrative staff delivered via various modalities (e.g., small-group in-person training, one-on-one proctoring, virtual webinar series) on a range of topics, including: family planning 101; medical management of contraception; billing, coding, and reimbursement; and person-centered counseling and education.	**1. Provider Awareness and Training** Ongoing guidance, resources, and training to enhance providers' awareness and familiarity with recommending various contraceptive methods. Examples include: identifying provider champions, promoting CDCs evidence-based contraceptive guidance (US MEC and US SPR), QFP, client-centered counseling, training clinicians on insertion and removal of LARC, training ancillary providers, and training on billing and coding.
2. Technical Assistance Provision of ongoing, targeted technical assistance to clinicians, support staff, and administrative staff delivered via various modalities (e.g., coaching calls, training specialist in-clinic) on a range of topics, including: purchasing, stocking, and billing for contraceptives; patient education materials; contraceptive access policies/procedures; contraceptive workflow; and data collection and reporting.	**2. Reimbursement and Financial Sustainability** Securing adequate funding to support the provision of contraception and reproductive health services, development of policies and programs, and sustainability of ensuring programs. Examples include: identifying strategies to improve reimbursement and financial sustainability—including direct billing for LARC devices—and reimbursing health care providers and facilities for the full range of contraceptive services.
3. Provision of Low/No-Cost Contraception Direct funding to participating health centers across delivery settings (e.g., Title X clinics, FQHCs, SBHCs, hospitals for immediate post-partum contraception, abortion providers for immediate post-abortion care) to offer FDA-approved contraceptive methods (via direct funding and/or stocking) and services to eligible clients at low/no-cost without per-client caps on use of services and devices.	**3. Informed Consent and Ethical Considerations** Approaches to improve satisfaction with clients' chosen contraceptive services and methods and trust in providers by assuring clients that a chosen method can be changed or removed if desired and ensuring that clients do not feel pressured to select a particular method. Strategies address timing and content of informed consent, client-centered counseling, reducing provider bias, enhancing counseling and removal protocols, and issues of reproductive justice and ethics.
4. Grants for Equipment And Supplies Direct funding to participating health centers to purchase contraceptive equipment, other clinic supplies (e.g., exam tables, technology for patient education), and personnel costs.	**4. Logistical, Stocking, and Administrative Barriers** Addressing administrative and logistical barriers to support successful implementation of policies and procedures to increase contraceptive access. Examples of strategies include: • Stocking the full range of contraceptive methods. • Partnering with manufacturers and pharmaceutical companies to increase method availability across jurisdictions. • Decreasing costs through cost-sharing programs, specialty pharmacies, and pharmaceutical pricing incentives. • Ensuring availability of a sufficient supply of methods for same-day services, particularly with LARC.

CECA-ASTHO SCAI Project *Core Program Components*	*ASTHO Increasing Access to Contraception Learning Community* *Nine Focus Areas for Success*
5. Public Awareness Campaigns Online media and digital marketing campaigns to increase awareness about the available reproductive health services and provide information and resources on reproductive health topics.	**5. Consumer Awareness** Strategies for conducting consumer outreach, assessing client satisfaction with methods and services, client experience, and implementation of public and private campaigns to increase awareness of contraceptive options and services.
6. Legislation or Other Public Policy Change Championing and supporting implementation of public policy to support contraceptive access, such as changes to Medicaid reimbursement policies to cover the cost of LARC services; policies to expand ability of providers (e.g., pharmacists, APRNs) to prescribe and dispense contraception and ensure payment parity; and policies to improve comprehensive sex education and youth sexual health.	**6. Stakeholder Partnerships** Engaging state, national, and federal partners to increase contraceptive access. Strategies include establishing partnerships across agencies to develop sustainable consortiums and task forces, facilitating partnerships among private and public insurers, device manufacturers, and state agencies.
	7. Service Locations Facilities and clinics with adequate staff support to deliver comprehensive services to enhance access to the full range of contraceptive methods in various settings and locations; might also include using telemedicine for remote, rural, or frontier areas and partnerships with larger facilities to implement some contraceptive services.
	8. Data, Monitoring, and Evaluation Quality assurance and measuring improvements in access to contraception in order to modify clinical practice and monitor and report long-terms success and growth. Strategies might include developing a quality improvement (QI) program that integrates clinical performance measures, improving surveillance systems, conducting process and outcome evaluations, and conducting ongoing data analyses to discover opportunities to strengthen program.
	9. Specific Populations Addressing access challenges and barriers for groups that are difficult to engage through traditional outreach, such as adolescents, clients with disabilities, non-English speakers, incarcerated individuals, undocumented persons, and individuals with substance use disorders. This includes having specialized workforce, communication, outreach, policy, cultural competence, and clinical practice strategies for improving access for specific populations.

Training/Continuing Education

Clinician and clinic staff training is critical to the success of SCAIs. The ASTHO Learning Community identified provider awareness and training as one of the nine focus areas for success in increasing access to contraception and suggested that providers need ongoing guidance, resources, and training to enhance their awareness and familiarity with recommending various contraceptive methods (ASTHO, 2017b). All seven CECA-ASTHO project state-based partners include training and continuing education for health care center 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) —as a part of their contraceptive access projects.

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 (Boudreaux et al., 2020).

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 counseling and education; and the role of bias and coercion in reproductive health care (ASTHO, 2017b). For example, In Utah, the full patient care team—from administrators to providers—at clinics 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 (Simmons et al., 2020).

A sample training description from Utah's Family Planning Elevated program is below:

> The full patient care team from administrators to providers at member clinics receives tailored education and training on a variety of topics, including person-centered contraceptive counseling, Intrauterine Device (IUD) and implant placement and removal, barriers, fertility awareness-based methods, clinic workflow, billing, coding, and other areas of need jointly identified by each clinic and the program team. Clinic staff at all levels, including front desk staff and medical assistants, will be involved in education and training to support the systems' capacity for contraceptive provision throughout the entire clinic. 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 will 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 (Simmons et al., 2020).

Ongoing Technical Assistance

Technical assistance involves targeted, one-on-one site-specific or person-specific assistance that is provided to assist clinicians, support staff, administrative staff, and other community partner staff on a range of person or site-specific topics. Examples of specific technical assistance that SCAI implementers provide to partner health centers include assistance with billing and coding, updating or creating clinical protocols, stocking of contraceptive products, making electronic health record modifications, and data collection and analysis.

Low/No-Cost Contraception

All seven SCAIs that participated in the CECA-ASTHO project provide(d) low/no-cost contraceptive products. Availability of low/no-cost contraceptives is essential to enhance access. Many initiatives use a combination of public and private funding to enable provision of low/no-cost contraceptives to patients. 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 programs to offer low-cost contraception. For example, the private funder for the CFPI provided funding to support the provision of LARC (Ricketts et al., 2014), and Delaware received funding for the purchase of LARC devices from the Delaware Division of Public Health (Boudreaux et al., 2020). In general, states use 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 (ASTHO, 2017b).

Equipment and Supplies

Direct funding to support the purchase of contraceptive supplies, clinical infrastructure, personnel costs, and administrative overhead is essential to SCAIs. All seven of the SCAIs that participated in the CECA-ASTHO project had some source of direct funding for equipment and supplies, coming from a variety of public and private sources. Funding to support purchasing equipment and supplies is a major issue for continued sustainability of initiatives.

Public Awareness Campaigns

Six of the seven SCAIs that participated in the CECA-ASTHO project included patient or public engagement campaigns to increase awareness of contraception options and services. Colorado initiated the Beforeplay campaign, a public awareness campaign for young people to encourage them to make healthy sexual decisions (Colorado Department of Public Health and Environment, 2017). The purpose of the campaign (www.beforeplay.org) was to offer reliable and easy-to-understand information in order to 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. The Delaware Initiative's public awareness campaign, "Be Your Own Baby," from May 2017 through October 2018 included social media, online music videos, and paid advertising that targeted women in Delaware, ages 18-29 years. The call to action was to visit the Be Your Own Baby Web page (https://beyourownbaby.org), which steered visitors to a nearby participating clinic that could provide free same-day contraceptive services (Boudreaux et al., 2020).

Public Policy or Legislative Changes

Seeking public policy changes are essential to SCAIs, particularly to postpartum and other LARC access initiatives. Policy initiatives might include expanding Medicaid coverage, increasing reimbursement rates, adopting State Plan Amendments (SPA), or Family Planning Waivers. For example, Family Planning Elevated in Utah states that they "will support existing and emerging legislative policy that expands family planning service to individuals in Utah. A primary goal of FPE is to demonstrate the unmet need for contraceptive coverage among those who fall in the 'contraceptive coverage gap' (un or underinsured, including individuals between 100% and 250% federal poverty level)" (Baayd & Simmons, 2020).

All states that participated in the initial ASTHO IPP LARC Learning Community had to address state Medicaid policy changes to permit "unbundling" the reimbursement for IPP LARC (device and insertion) from the overall prenatal care and delivery "bundled" fee. Another important example of the importance of policy is reflected in the FQHCs system. Depending on a specific state's LARC coverage and reimbursement policies under Medicaid, FQHCs might face specific disincentives to providing LARC. Pursuant to federal law, under Medicaid, FQHCs receive an all-inclusive fee via a pre-negotiated, state-specific "Prospective Payment System" (PPS) for all

services provided during a visit. How the PPS rate is structured, what costs might be carved out, and whether the rate is sufficient to cover the cost of LARC impacts the ability and willingness of the FQHC to offer LARC. Some states, such as Mississippi, have applied to CMS for an SPA to enable them to bill separately from the PPS under the pharmacy benefit for certain physician-administered drugs, including LARC. In 2018, CMS approved two SPAs for Mississippi enabling FQHCs and Rural Health Clinics to bill separately under the pharmacy benefit, and these SPAs were made retroactively effective July 1, 2018 (Converge, 2019).

Partnerships

Partnerships in SCAIs are often described as lasting and sustainable consortiums and task forces and facilitate collaboration among diverse health care institutions (e.g., FQHCs, Title X clinics, and hospitals), private and public insurers, contraceptive device manufacturers, state agencies, and local organizations (ASTHO, 2017b). All seven SCAIs that participated in the CECA-ASTHO project leveraged strategic partners for project implementation. Examples include:

- Utah's program incorporates a diverse network of clinics, including FQHCs, private clinics, and city and county clinics (Simmons et al., 2020).
- The New Mexico (NM) program involved collaboration across multiple NM institutions, including the NM Department of Health Title X Program, Bold Futures NM, and the NM Perinatal Collaborative (CECA-ASTHO, 2020).

Data Management and Quality Assurance

Data management and quality assurance contribute to supporting evidence-based practices and demonstrating programs' effectiveness. Some SCAIs—such as projects in Iowa, Delaware, and South Carolina—engage an independent evaluation partner, usually a research institution, such as a university or consulting firm who leads program reporting and research.

Programs might approach quality assurance in many ways, and according to ASTHO's Learning Community:

> 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 quality improvement 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 the 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. (ASTHO, 2017b)

Informed Consent and Ethical Considerations

The ASTHO Learning Community identified informed consent and ethical considerations as important focus areas; this included timing and content of informed consent, client-centered counseling, reducing provider bias, enhancing counseling and removal protocols, and broader issues of reproductive justice and ethics. More recently, commitment to health equity has emerged as an area that should be a primary focus. For example, New Mexico states that a program goal is to "Confront coercion in the provision of LARC and contraception within clinical care, advocacy, and every opportunity." As part of their program, they provide training to health care providers in preventing coercion and define three specific principles for preventing coercion, including:

1. "The decision to use a LARC device should be made by each person after quality contraceptive counseling that helps identify what will work best for their unique reproductive health needs."

2. “The decision to cease using a long-acting method should be made by each person with support from a health professional without judgment or obstacles.”
3. “Enthusiasm for LARCs should not distract from the ongoing need to support policies and programs that address the full scope of healthy sexuality and other critical health care needs.” (New Mexico Legislature, 2019)

However, with the exception of New Mexico, other SCAI projects do not expressly define health equity for their projects; yet, state that they have a commitment to ensuring equitable access.

The Utah FPE Initiative uses the tenets of the Human Rights-based Approach to Family Planning and targets activities at the individual, community, clinic, and policy levels (Hardee et al., 2014). At the community level, FPE 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” (Baayd & Simmons, 2020).

Challenges and Lessons Learned from Implementation Approaches

The evidence reviewed in this scan found key lessons from Colorado, Utah, Delaware, and New Mexico, and a multi-state analysis of postpartum LARC programs that were part of the initial ASTHO IPP LARC Learning Community. The lessons learned from these programs are in the areas of **cost/reimbursement, administrative practices/policies, and clinical implementation**. While the findings summarized in this section focus primarily on the experiences of Colorado and Utah, these lessons learned might be representative of those experienced by other statewide projects.

Cost/Reimbursement

A core component of any SCAI is the availability of contraceptive supplies. To build programs with sustainability, SCAIs must leverage existing payment mechanisms, such as Title X and Medicaid, to guarantee funding for the delivery of services. For both Colorado and Utah, reimbursement was a consistent challenge, not only because of the inadequacy of reimbursement but because of the resources needed to train clinic staff to adequately perform coding and billing. Research evaluating a longitudinal cohort of clinics engaging in Utah’s FPE 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” (Simmons et al., 2020). In Colorado, a key finding was that reimbursements were inadequate for the services provided (ASTHO, 2017a).

LARC cost/reimbursement emerged as an insurmountable barrier to LARC implementation for IPP LARC programs. Key informant interviews with each of the 13 IPP LARC teams that were part of the initial ASTHO LARC Learning Community found similar intractable cost/reimbursement barriers preventing widespread IPP LARC implementation; states and hospitals described using training grants at teaching hospitals and Title X funds to provide IPP LARC (Kroelinger et al., 2019).

Administrative Practices/Policies

Understanding policy and implications of policy changes is critical to the execution of SCAIs. Among the barriers to contraceptive access, the Utah FPE team identified challenges associated with the continually changing policy environment. Significant policy changes in the state involved the subsumption of the Medicaid family planning waiver into the larger Medicaid expansion; this was both a positive development for health care in Utah as well as a challenge to the initiative. A significant issue around these changes involved eligibility, as individuals that were initially eligible lost coverage for contraception under the expansion creating additional challenges to the FPE operations (Simmons et al., 2020).

Clinical Implementation

Implementation challenges in Utah highlight the challenges of implementing an SCAI in a diverse network of clinics, including FQHCs; private clinics; and city and county clinics with varied policies, protocols, and norms. Operating in busy clinical environments that provide a wide range of services and the need to strike a balance between the intervention requirements and reducing burden on clinics is challenging. Additionally, in Utah, data collection proved to be a challenge, including working across multiple electronic medical record systems (Simmons et al., 2020).

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 (Palm et al., 2020).

Evaluation and Outcomes of Statewide Contraceptive Access Initiatives

Phase of Data Collection/Analysis

The included statewide contraceptive access projects are at varying phases of data collection and analysis. The Iowa Initiative to Reduce Unintended Pregnancies was privately funded from 2007 to 2010, and annual data were collected and analyzed between 2004-2011 on family planning clinic data and number of unintended pregnancies in Iowa. In addition, surveys were conducted with providers and patients in family planning clinics, and key personnel in each participating agency were interviewed (Philliber Research Associates & UCSF Bixby Center for Global Reproductive Health, 2010). Data regarding the effects of increased access to family planning services on abortion rates in Iowa after a Medicaid expansion and the privately funded initiative were analyzed and published in 2015 (Biggs et al., 2015).

Data collection and analysis are also complete for the Colorado initiative, which ended in 2011, and pre-initiative and post-initiative data have been published on Title X patient characteristics, fertility rates, high-risk births, abortion rates, and Women, Infants, and Children (WIC) infant caseload (Ricketts et al., 2014). As previously noted, the ASTHO multi-state Learning Community ended in 2018, and the evaluation by the University of Illinois at Chicago is in process with completion anticipated later in 2021. Data collection, including key informant interviews, has been completed. Data collection and analysis for Iowa and Colorado are complete. Of the SCAIs participating in the CECA-ASTHO initiative, Colorado, Louisiana, and New Mexico are complete. Published evidence from Colorado was identified in the scan; no published evidence from Louisiana or New Mexico was identified in the scan.

Statewide initiatives in Delaware, Massachusetts, Missouri, South Carolina, and Utah are still in process and are collecting data, although Delaware has published trend data regarding changes to contraceptive method use at Title X clinics—the project began in 2015, and the publication reflects the trend in method use between 2008 and 2017 (Boudreaux et al., 2020).

The Utah Family Planning Elevated (FPE) Contraceptive Access Program has published two study protocols, one of which describes the study protocol for evaluating the success of the program (Simmons et al., 2020). The other publication describes the protocol for the planned process evaluation of the program to document: 1) the community, state and national contexts in which the program is implemented; 2) how FPE is implemented; and 3) the mechanism by which FPE creates impact (Baayd & Simmons, 2020).

No publications documenting data collection methodology or analysis were identified for the other three SCAIs in South Carolina, Massachusetts, and Missouri.

Summary of Outcomes Related to Promoting Contraception Use, Access, and Related Health Outcomes

SCAI outcomes research identified in the scan focused on **contraceptive use** (e.g., LARC use, contraceptive method mix, postpartum LARC uptake, and discontinuation rates), **service utilization** (e.g., utilization of contraceptive services in hospitals, geographic reach, and service expansion at SCAI participating sites), and **pregnancy outcomes** (e.g., fertility rates, abortion rates, and unintended and teen pregnancy rates).

Contraceptive Use

While many SCAIs are focused on increasing access to contraceptive methods generally, current evidence is focused mainly on LARC uptake. This scan identified 18 studies examining contraceptive use as a result of an SCAI. These studies covered six SCAIs: four contraceptive access projects (CO, DE, IA, and UT) and two postpartum LARC initiatives (SC and TX). All studies focused on the increase in use of LARC, and only three studies also examined overall contraceptive use.

Findings from these studies suggest that SCAIs are an effective tool for increasing initiation of LARC methods. Three studies described LARC use after implementation of contraceptive access projects. In Delaware, LARC utilization increased from 4.1% in 2008 to 13.2%, reaching 25.0% by 2017 (Boudreaux et al., 2020). In Colorado, LARC users in Title X clinics increased from 5% to 19% among 14-24 year-olds between 2008 and 2011 (Ricketts et al., 2014). Another analysis of the Colorado initiative found that in 2008, LARCs had a primary usage rate for teenagers of less than 3% and for 20-29 year-olds of 7%. By 2015, the rate among women under age 30 was nearly 30% (Kelly et al., 2020). Two studies described LARC use after implementation of a postpartum LARC initiative. South Carolina experienced a 259% increase in postpartum LARC insertions (756 pre-Medicaid policy change to 1,961 post-Medicaid policy change), during their 2012-2014 IPP LARC program (Mattison-Faye, 2019). In Texas, a prospective cohort study of women ages 18-44 years who wanted to delay childbearing for at least two years was conducted. At six months post-delivery, at a hospital that offered IPP LARC, one-third of women chose this option. In comparison, more than one-third of the women who delivered in hospitals that did not offer IPP LARC but wanted a long-acting or permanent method, were more likely to be using less effective methods, such as condoms or withdrawal (Potter et al., 2017).

The three studies that explored contraceptive utilization beyond LARC examined method switching. Those studies showed that LARC remained a preference even when other methods were available in contraceptive access projects. These studies evaluated programs from Delaware, Iowa, and Utah. Research on method switching in Utah found that 70% of women with a LARC method reported continuation at the six-month assessment, women using short-acting methods had higher rates of discontinuation, and 36.9% of those women switched to a LARC method (Simmons et al., 2019). Similarly, between 2008 and 2014, Delaware's increase in LARC use correlated with a decrease in use of hormonal methods, such as the Pill, patch, and ring (Welti & Manlove, 2018). During the Iowa Initiative between 2007 and 2010, the number of women in Title X clinics using an IUD increased by 218%, and the number using an implant increased by 829% (Philliber Research Associates & UCSF Bixby Center for Global Reproductive Health, 2012).

Service Utilization

Service utilization refers to the service offering, health center changes to increase access, and studies that evaluate utilization of available services. Studies included in this section of the scan examined the ability of IPP LARC initiatives to increase access to inpatient LARC; clinic changes to accommodate a contraceptive access initiative; and service utilization by housing insecure women in areas with an SCAI. This scan found eight studies evaluating utilization of contraceptive access initiative services, including postpartum LARC (SC and TX), and contraceptive access (CO, IA, and UT).

IPP LARC programs are challenging because of clinical and administrative requirements. However, when implemented successfully, programs can be effective at increasing access to LARC. This portion of the scan focuses on utilization of IPP LARC access through programs in South Carolina and Texas. In 2012, South Carolina's Medicaid program began reimbursing hospitals for IPP LARC separately from the global payment (Steenland et al., 2019). In research determining the uptake of IPP LARC provision in South Carolina hospitals, Medicaid claims data were examined for all live births pre (2010-2011) and post (2012-2014) IPP LARC Medicaid coverage policy implementation for up to 60 days following delivery. The analyses identified that IPP LARC users were more likely to be White/Caucasian, Black/African American, and 15-29 years old.

Researchers also found a significant increase in the number of postpartum device claims (756 pre-policy to 1,961 post-policy). Of LARC device claims 20.8% linked to an inpatient placement claim (Mattison-Faye, 2019). More recent research assessing South Carolina found that for all hospital inpatient births between 2010 and 2017, IPP LARC use increased 5.00 percentage points in adults and 8.32 percentage points in adolescents relative to that expected without the policy change (Steenland et al., 2019). Programs in Texas assessed hospital adoption of IPP LARC policies and found that only one of the eight hospitals in the study provided IPP LARC. In the hospital that provided IPP LARC, 36% of women who did not want to get pregnant again in the next two years took advantage of this option; a much smaller percentage of women that delivered at the other seven hospitals were using LARC at three and six months and a higher percentage were using hormonal and less effective methods (Potter et al., 2017).

Regarding service utilization, research examined geographical reach, access by women with housing insecurity, and clinic changes to accommodate SCAIs. The research on geographical reach indicates that SCAIs are effective at increasing access to highly effective contraceptive methods—such as LARC to women—in close proximity to clinics participating in SCAIs. This finding was documented in research of programs in Colorado and Utah. In Colorado's Family Planning initiative (CFPI), research indicated that after the CFPI, births to 15-17 year-olds fell approximately 10% more for zip codes within five miles from a clinic than they fell for zip codes greater than 20 miles from a clinic (Kelly et al., 2020).

In Utah, research examining the effect of a no-cost contraceptive initiative on method selection by women with housing insecurity found that 22% of women seeking contraceptive care at participating clinics during the HER Salt Lake Contraceptive Initiative reported housing insecurity. Compared to secure housing participants, the proportion of women who selected a LARC was higher among housing insecure women during the control period (22.2% vs. 29.9%), but there was no difference across housing status during the "no cost" for contraception intervention period (61.8% vs. 61.5%). Women with housing insecurity trended toward increased uptake of IUDs and implants in the control period when standard clinic sliding fee scale and Title X assistance were available (Gawron et al., 2020).

Research on method choice, also from the HER Salt Lake contraception initiative, compared method choice among women seeking contraception in participating clinics, compared to those seeking services in clinics that were not. Participating clinics removed barriers of cost and ensured adequate staffing and pharmacy stocking. This research indicated that women visiting clinics not participating in HER Salt Lake had higher use of barrier methods (condoms, diaphragms) and emergency contraception and a higher proportion of clients walking away from the clinic with no documented contraception, compared to participating facilities (Sanders et al., 2018).

There is also evidence that statewide contraceptive initiatives might affect service offerings at participating clinics. Research from 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 (Philliber Research Associates & UCSF Bixby Center for Global Reproductive Health, 2012).

Pregnancy Outcomes

One of the most commonly assessed factors of SCAIs are pregnancy outcomes. Research was identified that examined the effects of SCAIs on unintended pregnancies, teen pregnancy, fertility rates, abortion rates, maternal health, short-interval births, and adverse birth outcomes. Seven studies examined pregnancy outcomes from SCAIs. These studies examined outcomes from three contraceptive access initiatives (CO, DE, and IA), and one study on postpartum LARC programs (SC).

Unintended Pregnancy. Data on SCAI outcomes related to reducing unintended pregnancy was identified for Colorado and Delaware. Between 2009 and 2016, the birth rate in Colorado fell 54% for young women ages 15-19 years, and 30% among women ages 20-24 years (ASTHO, 2017a). It was unclear how/whether Colorado calculated how many of these pregnancies were "unintended," as the terms "unplanned" and "unintended" are both used within the publication, seemingly to mean the same thing. Researchers in Colorado found substantial effects on birth rates, concentrated among women in zip codes within 7 miles of a clinic. The initiative reduced births by approximately 20% for 15-17 year-olds and 18-19 year-olds living in such zip codes (Kelly et al., 2020).

In Delaware, Upstream, the organization that is partnering with the Delaware Division of Public Health to implement the DelCAN program, contracted with ChildTrends to analyze some preliminary data from the program. According to their analysis and based on modeling that took into consideration a substantial increase in LARC use and decrease in "no method," they indicate that this would suggest a substantial reduction in unplanned pregnancy among the population studied (Welti & Manlove, 2018). The CDC's Pregnancy Risk Assessment Monitoring System (PRAMS) data for the DelCAN (Contraceptive Access Now) Initiative indicates that from 2014 (the baseline year in Delaware) to 2017, the state saw a 25% reduction in births from pregnancies wanted later or not wanted (Upstream USA, 2020).

Missouri began a five-year contraceptive access initiative in 2019, "The Right Time" with the expressed goal of reducing unintended pregnancy in the state by 10% by 2024 (Missouri Foundation for Health, 2019). No other evaluation information is available on that initiative.

Teen Pregnancy. The scan identified one report on SCAIs and reductions to teen pregnancy. In Colorado, the number of repeat teen births (i.e., teens giving birth for the second or third time, etc.) dropped 63% between 2009 and 2016. The average age of first birth increased by more than a year among all women between 2009 and 2016. From the start of the initiative in 2009 to 2016, Colorado's teen birth rate dropped 54% and teen abortion rate fell by 63%. The birth rate dropped from 37.5 births per 1,000 teens in 2009 to 17.1 in 2016 (ASTHO, 2017a).

Fertility Rates. While not as frequently reported, research from Colorado assessed the program's impact on fertility rates. In 2007, two years before the implementation of the CFPI, the fertility rate for women ages 15-19 year was 40.2 births per 1,000 women; in 2009 when the CFPI began, the rate was 37.4%. In the next five years, the rate dropped 48% from the 2009 rate, to 19.4 births per 1,000 women in 2014. For young women ages 20-24 years, rates also fell after the CFPI began, although not as dramatically as among teens. The rate fell 20%, from 91.9 births per 1,000 in 2009 to 73.8 in 2014. National rates for this group fell 19%, from 96.2 to 79.0, during the same time period, with Colorado's rate about five points lower than the nation's in 2014 (Colorado Department of Public Health and Environment, 2017).

Abortion Rates. Like other pregnancy outcomes, in some states, abortion rates also saw significant reductions after implementation of an SCAI. Research was identified from Colorado, Delaware and Iowa to support this. In Colorado, the abortion rate fell 63% among women ages 15-19 years, and 41% among women ages 20-24 years between 2009 and 2016 (ASTHO, 2017a). A 2017 report from the Guttmacher Institute on Abortion Incidence and Service Availability in the U.S., found that from 2014 to 2017 during the period that the DelCAN initiative was in place, Delaware experienced a 37% reduction in abortion rates (Jones et al., 2019). Finally, in Iowa, the number of abortions decreased by 19% between 2007 and 2010 when the initiative ended (Philliber Research Associates & UCSF Bixby Center for Global Reproductive Health, 2012).

Maternal Health and Adverse Birth Outcomes. This scan identified four studies that examined maternal health (including birth spacing) and adverse birth outcomes (high-risk and preterm births). Findings from the CFPI 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 (Colorado Department of Public Health and Environment, 2017).

Research findings from South Carolina regarding an association between Medicaid payment change for IPP LARC and a change in birth intervals indicate the need for further study. Findings indicate 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 (Steenland et al., 2019).

Regarding adverse pregnancy outcomes and high-risk pregnancies, SCAIs might have positive impacts, although additional research is needed. Research was identified for only one state (CO) in this area, and the authors noted that the link between unintended pregnancy and poor birth outcomes is multi-faceted and little has been published on the impact of access to family planning services and use of highly effective contraception on birth outcomes. The Colorado paper indicated that there was 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 (Goldthwaite et al., 2015).

Additional Outcomes of Interest

Public policy changes can be very influential on the success of SCAIs, particularly for postpartum LARC initiatives, as these initiatives rely significantly on Medicaid policy changes at both federal and state levels. Eight studies identified in this scan focused on implementation strategies for postpartum LARC access policies. This research included postpartum LARC programs in South Carolina and Texas and a multi-state analysis of postpartum LARC programs. The multi-state analysis identified the necessary program components needed to successfully implement postpartum LARC programs. These studies do not address the policies themselves, rather the implementation approaches needed to successfully implement these programs (Kroelinger et al., 2019; Rankin et al., 2016).

Regarding savings to entitlement 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 (TANF), Supplemental Nutrition Assistance Program (SNAP), and Special Supplemental Nutrition

Program for WIC due to reductions in teen and unintended pregnancy. In Colorado, the outcomes of the initiative are believed to have led to a significant increase in the state's family planning budget (Colorado Department of Public Health and Environment, 2017). 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 are problematic.

RESEARCH GAPS AND IMPLICATIONS

This environmental scan summarized available evidence on the implementation and evaluation of SCAIs that are active and in progress. It primarily focused on eight states with published evidence and SCAIs that participated in the 2014-2018 ASTHO Increasing Access to Contraception Learning Community and the 2020 CECA-ASTHO project exploring the feasibility of a Community Guide recommendation on SCAIs. The available evidence demonstrates that most initiatives have common implementation strategies, including training, provision of low/no-cost contraceptives, patient education and awareness campaigns, partnerships, equity focus, policy change, and data and evaluation. Evidence on outcomes from these projects demonstrate that SCAI are effective at increasing uptake of LARC methods. Some evidence exists demonstrating that SCAIs are successful at increasing access to contraceptives, including LARC; and one state has shown an impact to costs associated with federal/state entitlement programs. However, there is a paucity of research examining overall contraceptive use as a result of these programs. The available research demonstrates the priority of LARC in SCAIs, despite the evolution of more recent initiatives to offering all methods and expressed commitment to contraceptive choice.

The available evidence also suggests that SCAIs might contribute to pregnancy outcomes. Some evidence exists to support the ability of SCAIs to impact/reduce unplanned pregnancy, teen pregnancy rates, fertility rates, and abortion rates. While some research exists surrounding the ability of SCAIs to impact maternal health and adverse birth outcomes, additional research is needed to validate these effects. SCAIs might also contribute to the expansion of service offerings in participating clinics.

Research gaps remain around documenting the implementation and impact of SCAIs. There is a paucity of published research on the outcomes of any of the SCAIs. The existing evidence on outcomes of the SCAIs represent very few of the projects that have been undertaken. Published evidence on the outcomes of the SCAI also represent early projects and often do not reflect the evolution of the SCAI to broader focuses on contraceptive choice and access to all contraceptive methods. Noticeably absent from the research is the lack of published findings of comparisons between states. There is no research evaluating how these programs compare or whether the variances between programs might result in differences in outcomes. Finally, there was no research identified in the scan on the sustained impacts of the SCAIs after program conclusion.

This scan also did not identify research that explicitly examined racial inequities in contraceptive access, the influence of coercion on contraceptive choice, the impact of shared decision-making on contraceptive use in communities of color, improvements to racial and ethnic gaps in contraceptive access, improvements to the use of contraceptives in marginalized communities or communities of color, or pregnancy or maternal health outcomes of diverse communities. Given that program 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, utilization, improvements to reproductive autonomy, or impacts on the effects of shared decision making within SCAIs. The scan also found no research on the impact of SCAIs in rural communities.

CONCLUSION

Given the critical importance of policy to program success (specifically for contraceptive access and postpartum LARC programs) research on the policy changes needed was lacking in this review. Additional research on Medicaid policy changes might be necessary for the sustainability of these programs.

SCAIs might be an effective tool for increasing access to contraceptive service and supplies. The programs that have published results have shown that they are able to increase access to and utilization of contraception. As these programs continue, additional analysis might be beneficial to support their utility. Reframing analysis from reproductive justice lens, including research on access in rural communities, expanding research on policy implications, evaluation among programs, and expanding research to examine the sustained effects of these programs might be important perspectives that engender continued support of SCAI.

Key Takeaways from the Environmental Scan
• Twenty-nine 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. • SCAIs focus on increasing access to contraception through coordinated efforts across clinical facilities and other community partners by reducing cost and other barriers that inhibit contraceptive choice. Although many of the early SCAIs 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. • SCAIs 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. • Limited data on the impact of SCAIs on expanding access to contraceptive care exists in the published literature. The available evidence demonstrates that SCAIs might have positive impacts on contraceptive use, service utilization, and pregnancy-related outcomes. • Research gaps remain in understanding the impact of SCAIs in expanding access to contraception (including evidence that compare findings across states), reducing inequities in contraceptive access, and leveraging policy to foster sustainability.

APPENDIX A: SEARCH TERMS AND INCLUSION/EXCLUSION CRITERIA

TABLE 1 Search Terms

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

TABLE 2 Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
Journal Article	**Studies outside the U.S.**
Program/Initiative Reports	Studies not evaluating a statewide effort
State or Federal agency reports	Studies 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: ASTHO CONTRACEPTIVE ACCESS LEARNING COMMUNITY STATES

Alabama	Illinois	New York
Alaska	Indiana	North Carolina
California	Iowa	Oklahoma
Colorado	Kentucky	South Carolina
Commonwealth of the Northern	Louisiana	Texas
Mariana Islands	Maryland	Washington
Connecticut	Massachusetts	West Virginia
Delaware	Mississippi	Wyoming
Florida	Montana	
Georgia	New Mexico	

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