CECA
Coalition to Expand Contraceptive Access

How Policymakers Can Help Expand the Capacity of the Contraceptive Care Workforce

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INTRODUCTION

Contraceptive methods, services, and counseling are provided by a wide range of US healthcare workers, including physicians, advanced practice clinicians, nurses, pharmacists, health educators, and community health workers. Some specialize in reproductive health, such as obstetrician-gynecologists and nurse-midwives; others provide broader care, such as family physicians. Their workplaces are similarly diverse: private practices, community health centers, specialized family planning clinics, state and local health departments, and many other settings.

Why is this work important for policymakers?

- **Health professionals providing contraceptive care face numerous barriers** to meeting the needs of US communities, and a more robust workforce is needed.
- **The Coalition to Expand Contraceptive Access has identified nine strategies** to examine and diversify the contraceptive care workforce, enhance contraceptive training and education, better incorporate the full range of health professionals, and address barriers such as inadequate reimbursement and provider burnout.
- **Federal and state lawmakers and executive branch officials are central to implementing these strategies**, through their powers to authorize funding, set priorities, adopt legislation and regulation, and provide oversight.

Despite the range of providers and settings, the capacity of this contraceptive care workforce cannot fully meet people's needs for comprehensive, high-quality, person- and community-centered care. For example, Power to Decide estimates that 19 million US women of reproductive age are in need of publicly funded contraception but live in a "contraceptive desert" that lacks reasonable access to the full range of contraceptive methods. Some of the barriers to a more robust workforce are long-standing and affect the entire healthcare system, such as staff shortages, lack of diversity, low reimbursement, and provider burnout. Other barriers are more specific to reproductive health, including inadequate training opportunities for contraceptive care and hostile policy environments, particularly in the wake of the *Dobbs v. Jackson Women's Health Organization* Supreme Court decision.

The Coalition to Expand Contraceptive Access (CECA) has developed nine evidence-based, actionable strategies to expand the capacity of the contraceptive care workforce in the United States. These strategies were developed as part of a collaborative process, informed by evidence from workforce efforts in related healthcare fields and drawing on the lived experience of contraceptive users and the expertise of a wide array of stakeholders. Federal and state policymakers have a role to play in advancing each of these strategies, and their engagement is crucial to improving contraceptive care for everyone who wants and needs it.

VISION AND STRATEGIES

CECA's recommended strategies are rooted in its vision of sexual and reproductive health equity (SRHE), a world where the systems ensure that all people—across age, gender, race, and other intersectional identities—have what they need to attain their self-determined goals for sexual and reproductive health. One necessity for achieving that vision is a diverse and robust workforce capable of providing comprehensive contraceptive care for everyone in a way that centers the needs of individuals and communities and that protects the health and wellbeing of patients and staff.

The strategies discussed below (see chart on the following page) fall into four major themes that policymakers can:

- **Address chronic staff shortages and staffing** that does not reflect local communities by examining, diversifying, and expanding the contraceptive care workforce.
- **Address incomplete and outdated knowledge about contraception** among segments of the workforce and the patient community by enhancing contraceptive training and education.
- **Expand workforce capacity** by better incorporating and supporting the full range of health professionals, including those with clinical training like advanced practice clinicians and nurses, as well as allied health professionals like health educators, doulas, and community health workers.
- **Address barriers** such as inadequate reimbursement rates and provider burnout, which affect the entire healthcare system and are compounded by specific actions to undermine access to sexual and reproductive healthcare.

Examine and Diversify the Composition of the CC Workforce

- Strategy 1. Identify models for optimal interprofessional contraceptive care teams, based on community needs
- Strategy 2. Recruit and retain diverse candidates into healthcare professions
- Strategy 3. Implement financial incentive programs with eligibility for the CC Workforce

Enhance Contraceptive Training and Education Within and Beyond the CC Workforce

- Strategy 4. Integrate SRHE training into health professions' curricula and continuing education
- Strategy 5. Expand access to contraceptive expertise for health professionals and community members

Expand the Role of Health Professionals in the CC Workforce

- Strategy 6. Expand scope of practice regulations for healthcare professionals to practice contraceptive care to full extent of training
- Strategy 7. Assess and implement strategies to integrate allied health professionals into CC Workforce

Address the Context in which the CC Workforce Provides Care

- Strategy 8. Address payment for sexual and reproductive health services
- Strategy 9. Address drivers of burnout for the CC Workforce

THE ROLE OF POLICYMAKERS

Although numerous stakeholders will need to be engaged in efforts to bolster the contraceptive care workforce, federal and state lawmakers and executive branch officials have unique and central roles to play. Policymakers can authorize and award the funding needed for research, evaluation, and programs, and set reimbursement rates for insurance programs like Medicaid. They can set priorities for how best to expand the capacity of the contraceptive care workforce and communicate the urgency of meeting those goals. They can adopt legislation and regulation to establish new workforce-support programs and to adjust existing ones to meet changing needs. Finally, they can provide oversight to assess whether funding is well spent, whether programs and providers are adhering to the law, and whether progress is being made toward the workforce needed to achieve SRHE.

1. Identify models for optimal interprofessional contraceptive care teams, based on community needs

The ideal mix of staff to provide contraceptive care will necessarily vary across settings and communities. For example, a small rural clinic may need to rely less on physicians and more on advanced practice clinicians than would an urban teaching hospital.

Assessing these needs, experimenting with different types and ratios of health professionals, and identifying best practices will need to happen locally, driven by providers and communities. Yet, federal and state policymakers can provide support for these efforts, such as through funding for research, implementation, and dissemination of best practices; requirements that providers consult with community members as they assess their staffing needs; and oversight to gauge the impact of local efforts.

2. Recruit and retain diverse candidates into healthcare professions

The US healthcare system has been reckoning for years with severe racial, ethnic, and gender disparities in its workforce. Efforts to improve diversity by creating pipelines to professional degrees and reforming admission processes have shown promise. However, recent studies demonstrate that more progress is needed to improve the recruitment, retention, and development of staff in the contraceptive care workforce and more broadly in the healthcare system.

Policymakers can help by explicitly championing diversity in healthcare professions as a priority, setting requirements for educational and healthcare institutions, providing dedicated funding and technical assistance, and conducting oversight to hold institutions accountable for making improvements. For example, a 2022 Urban Institute study offered recommendations for policymakers, including establishing and expanding funding for diversity initiatives such as pathway programs and mentorship initiatives; reducing financial barriers to higher education via tools like sliding-scale tuition; and requiring nursing and medical schools to adopt holistic admissions practices.

3. Implement financial incentive programs with eligibility for the contraceptive care workforce

Federal and state programs, such as the National Health Service Corps and the Nurse Corps, have long provided financial incentives such as loan repayment and scholarships to expand the capacity of the healthcare workforce. These programs have a history of encouraging providers to work in underserved communities and lower-paid specialties. However, these programs are not tailored to the needs and qualifications of reproductive health specialists and clinics, such as those funded by the Title X family planning program.

Federal and state legislators and regulators can help assess and address barriers to participation in these programs by reproductive health professionals and clinics. A first step would be to revisit which types of healthcare professionals and institutions are eligible and what actions they must take to establish their eligibility. Any barriers identified to full participation by reproductive health providers should be addressed by regulation, or by legislation if needed, to make it explicitly clear that these providers are eligible. Policymakers can also provide oversight and evaluation of efforts to expand financial incentive programs to a broader array of professionals, such as doulas and community health workers, and identify other professionals who have been left out. Notably, Congress in 2018 expanded eligibility and funding under the National Health Service Corps for the substance use disorder workforce as part of its efforts to address the opioid epidemic. Federal and state policymakers could consider a similar approach to addressing the post-*Dobbs* reproductive health crisis, with expanded eligibility and dedicated new funding for loan repayments and scholarships for reproductive health professionals.

4. Integrate SRHE training into health professions' curricula and continuing education

Many topics relevant for SRHE—such as reproductive coercion, reproductive justice, bias in healthcare, culturally sensitive care, and trauma-informed care—are often left out of the curricula for educating health professionals or in subsequent training and continuing education. Similarly, provider training has not traditionally centered or been led by the experiences and perspectives of patients and communities.

Federal and state policymakers can prioritize or require SRHE training for health professionals, as part of the standards they set for nursing and medical education programs and for publicly supported health programs such as Title X, the Section 330 Health Center program, and the Indian Health Service. They can also offer dedicated funding to program sites for SRHE training and assess whether this training results in better patient evaluations, such as on the Person-Centered Contraceptive Counseling Measure. Program officials might also build capacity for SRHE training through "train the trainer" sessions and by funding and testing new training models.

5. Expand access to contraceptive expertise for health professionals and community members

Many more healthcare professionals—including primary care providers, pediatricians, and many specialists—could be an effective part of the contraceptive care workforce if they had greater expertise and comfort with the subject. Members of the public also would benefit from accurate information about contraceptive rights and services.

Federal and state policymakers can start by eliminating existing barriers to accurate information, such as abstinence-only education requirements and restrictions on education about sexual and reproductive health, and instead putting in place requirements and funding for comprehensive sex education. They can also authorize, fund, and carry out public information campaigns about contraception and new types of training programs for healthcare professionals. Moreover, policymakers can set new or enhanced training requirements for providers that could be doing more to offer comprehensive contraceptive care. For example, policymakers could address the requirements for federally qualified health centers, which are required to offer access to family planning services, but often outsource much of that care via contracts and referral arrangements.

6. Expand scope of practice regulations for healthcare professionals to practice contraceptive care to the full extent of their training

State laws and regulations delineate the scope of practice for different types of health professionals, including physicians, nurse practitioners, physician assistants, nurse-midwives, nurses, and pharmacists. These policies prevent many healthcare professionals from providing contraceptive care to the full extent of their training and demonstrated ability.

State policymakers temporarily lifted many scope of practice limitations during the COVID-19 pandemic; they can evaluate the effectiveness of these temporary changes and permanently extend them, if deemed effective. Similarly, state policymakers can review the impact of other states' efforts to allow a greater array of professionals to prescribe and dispense contraception, and implement similar changes; for example, years of experience with pharmacist-prescribed contraception has demonstrated its effectiveness in expanding access. And state health officials could authorize and conduct studies to assess additional scope of practice expansions, such as around contraceptive implant placement and removal by registered nurses.

7. Assess and implement strategies to integrate allied health professionals into the contraceptive care workforce

Allied health professionals—including community health workers, doulas, and health educators—have long been an important part of many sexual and reproductive health, primary care, and maternal health programs. However, with more training and investment, they could play a greater role and expand the capacity of the workforce.

Federal and state health officials can provide funding and guidance to replicate proven strategies for expanding the role of allied health professionals in contraceptive care, as assessed by authorities like the World Health Organization. For example, sexual and reproductive health programs have a history of relying on community health workers to expand their reach and effectiveness, both in the United States and abroad. Policymakers can build on recent efforts to expand training opportunities for community health workers and other allied professionals, and provide the funding to make these efforts sustainable. State policymakers can also consider new requirements for training, certifying, and licensing allied health professionals, but should work closely with representatives of these professions to ensure that the benefits (such as strengthened professional identity and access to reimbursement) outweigh the potential risks (such as increased barriers to entry into the profession and decreased connection to the community as the profession becomes more clinical).

8. Address payment for sexual and reproductive health services

One long-acknowledged limitation on the contraceptive care workforce has been inadequate and unreliable funding, including grant funding like Title X that is consistently threatened, Medicaid reimbursement rates that cover only a fraction of providers' costs, and burdensome and confusing insurance red tape.

State legislators typically control Medicaid reimbursement rates and can adjust these rates so that they better reflect the cost of providing care and keep up with inflation. They can also ensure that allied health professionals, such as doulas and community health workers, are eligible for reimbursement without unnecessary credentialing requirements, and that all types of healthcare professionals are reimbursed equally for providing the same type of contraceptive care. As federal and state policymakers explore new models for insurance reimbursement, they can pay particular attention to contraceptive services and workforce needs. In addition, policymakers can take steps to provide more stable and predictable annual funding for grantees under programs like Title X and state-run sexual and reproductive health programs.

9. Address drivers of burnout for the contraceptive care workforce

The COVID-19 pandemic and the Supreme Court's *Dobbs* decision are just two recent examples of the stresses faced by healthcare professionals, particularly those providing reproductive health services. Yet, the evidence is thin on how best to promote resiliency and prevent burnout.

Federal and state policymakers can weigh in by flagging and funding burnout as a priority for further research. Health officials can direct grant money and technical assistance toward this type of research, and then identify and promote best practices, as the evidence base develops. Much of the necessary groundwork has been laid in recent reports by experts such as the US Surgeon General and the National Academy of Medicine. These reports include recommendations for policymakers that cover topics like reducing barriers to healthcare professionals' use of mental health and substance use care; reducing the administrative burdens that contribute to health worker burnout; and improving workplace policies, such as paid leave and protections against workplace violence.