



# Client-Centered Contraceptive Care Change Package

developed by the Ohio FQHC Infant Vitality Initiative



# Table of Contents

Executive Summary . . . . .	3
Key Driver Diagram . . . . .	6
How to Use This Change Package and Tools. . . . .	7
Understanding Your System. . . . .	8
Setting your SMART Aim and Understanding your Process. . . . .	11
LARC Stocking and Financing. . . . .	12
LARC Stocking. . . . .	12
LARC Financing. . . . .	12
LARC Services in Ohio . . . . .	13
Evidence-Based Clinical Practices. . . . .	14
Trained and Competent Staff . . . . .	16
Planning . . . . .	16
Training . . . . .	16
Implementation Support . . . . .	17
Workflow: Identify, Counsel, Prescribe/Provide. . . . .	18
LARC Exam Room Readiness. . . . .	19
Implementation and Sustainability . . . . .	20
Acknowledgements . . . . .	21
About OPQC. . . . .	21
About CAI . . . . .	21
Appendix. . . . .	22
Data Collection Resources . . . . .	22
Evidence-Based Clinical Practices Resources. . . . .	22
LARC Stocking and Financing Resources . . . . .	22
Workflow: Identify, Counsel, Prescribe/Provide Resources . . . . .	22
Trained and Competent Staff. . . . .	22
Organizing for Change Resources. . . . .	22
Sustainability Resources . . . . .	22
Model for Improvement . . . . .	23
Process Map Examples. . . . .	23



## Executive Summary

Most individuals and couples want to plan the timing and spacing of their childbearing. Yet every year, 49% of pregnancies in the US are due to unintended pregnancies according to the American College of Obstetricians and Gynecologists (ACOG)<sup>1</sup>. Unintended pregnancy can have an adverse impact on the lives of families such as delayed prenatal care, premature birth and negative physical and mental health effects for children.

Contraception – or more importantly, lack of contraception – plays a crucial role in observed unintended pregnancy rates. Despite the wide variety of FDA-approved birth control methods available, significant gaps exist in women's access to these methods, especially to the most effective reversible contraception methods like long-acting reversible contraceptives<sup>2</sup>, or LARC. Not surprisingly, when availability of these methods is increased at the front-lines of care we observe both great demand for these methods coupled with measurable improvements in patient outcomes.<sup>3</sup>

Nationwide studies have shown that when women have the knowledge about and opportunity to access the full range of contraceptive methods, a large portion choose IUDs and Implants, which are over 99% effective at preventing pregnancies, regardless of age, race, or ethnicity. Women choosing these methods also have higher satisfaction and continuation rates than women using less effective methods. Use of these effective methods has led to a reduction in unintended pregnancies and abortions. Improved access to family planning services and increased use of LARC are associated with a lower risk of preterm birth.<sup>4</sup>

**"Infant mortality continues to be a leading public health issue with Ohio's rate of infant deaths at levels that are simply unconscionable.**

The Infant Vitality Initiative serves as a springboard of interventions and education that will inform and shape effective, evidence-based birth spacing practices. The culmination of leadership from participating health centers, shared learning, and actionable experiences is so important in achieving the ultimate end goal: healthier mothers and babies, and the celebration of more 1st birthdays."

– Ted Wymyslo, MD  
OACHC Chief Medical Officer



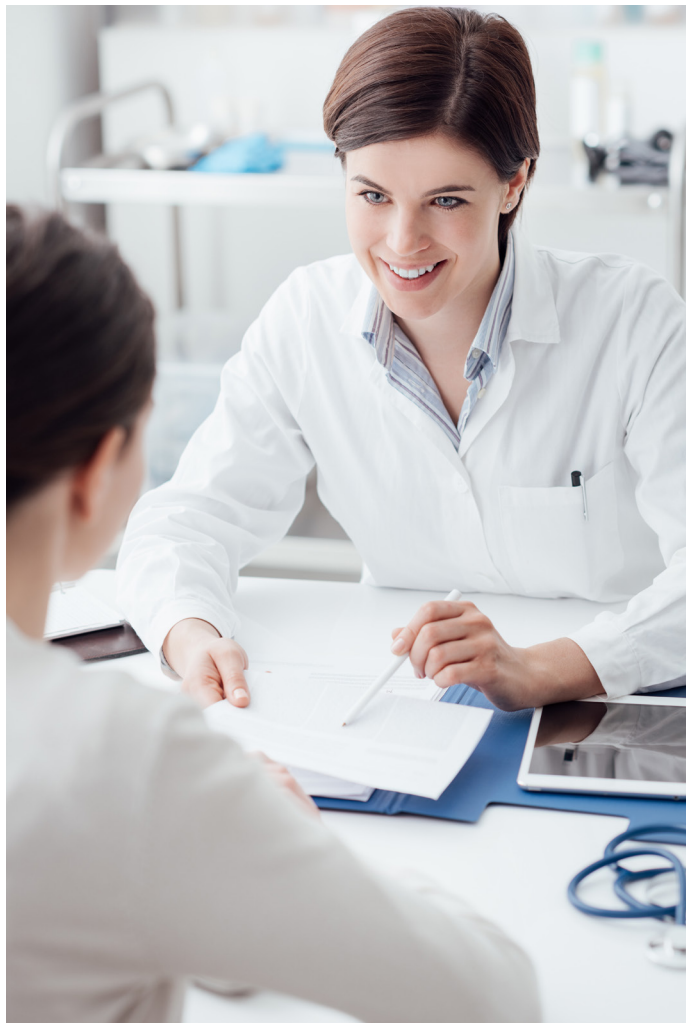
**"Efforts around safe spacing are part of a comprehensive strategy driving evidence-based care for women in order to improve maternal and infant outcomes.** The Ohio Department of Medicaid has focused on systems changes that first improve access through presumptive eligibility and extension of the Medicaid benefit, but also through targeted quality improvement initiatives. Notable efforts have included the identification of women at risk for poor birth outcomes, the provision of Progesterone to prevent preterm birth and streamlined processes to support tobacco cessation."

– Mary Applegate, MD, FAAP, FACP  
ODM Medical Director

### Executive Summary

In April 2016, the Ohio General Assembly passed House Bill 294 which made state funds available to the Ohio Association of Community Health Centers (OACHC) “to assist Federally Qualified Health Centers (FQHCs) and FQHC Look-Alikes with best practices in safe sleep, birth spacing, and smoking cessation initiatives that are focused on process and system improvements”. In January 2017, the OACHC partnered with the Ohio Department of Medicaid (ODM) to launch the *Ohio FQHC Infant Vitality Initiative*, a quality improvement collaborative in partnership with Cicatelli Associates Inc (CAI), the Ohio Perinatal Quality Collaborative (OPQC), the Ohio Colleges of Medicine Government Resource Center (GRC), and the Ohio Department of Health (ODH). The collaborative aim was to increase the percent of women who desire and receive effective contraception in a timely manner from 55% to 75% by December 2017.

CAI and OPQC worked closely with nine FQHC sites from five FQHC networks in Ohio to test and implement changes designed to meet their goals. These changes were organized around a **Client-Centered Contraceptive Care Model**, which prioritizes all women having accurate and unbiased information about all contraceptive methods and the opportunity to get the contraceptive method of their choice by a trained provider.



<sup>1</sup> Access to contraception. Committee Opinion No. 615. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2015;125:250–5.

<sup>2</sup> Long-acting reversible contraception: implants and intrauterine devices. Practice Bulletin No. 186. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2017;130:e251–69.

<sup>3</sup> O’Neil-Callahan M, Peipert JF, Zhao Q, Madden T, Secura G. *Twenty-Four-Month Continuation of Reversible Contraception*. *Obstetrics and Gynecology*. 2013;122:1083-91.

<sup>4</sup> Goldthwaite LM, Duca L, Johnson RK, Ostendorf D, Sheeder J. *Adverse Birth Outcomes in Colorado: Assessing the Impact of a Statewide Initiative to Prevent Unintended Pregnancy*. *Am J Public Health*. 2015;105(9):e60-6.

## Executive Summary

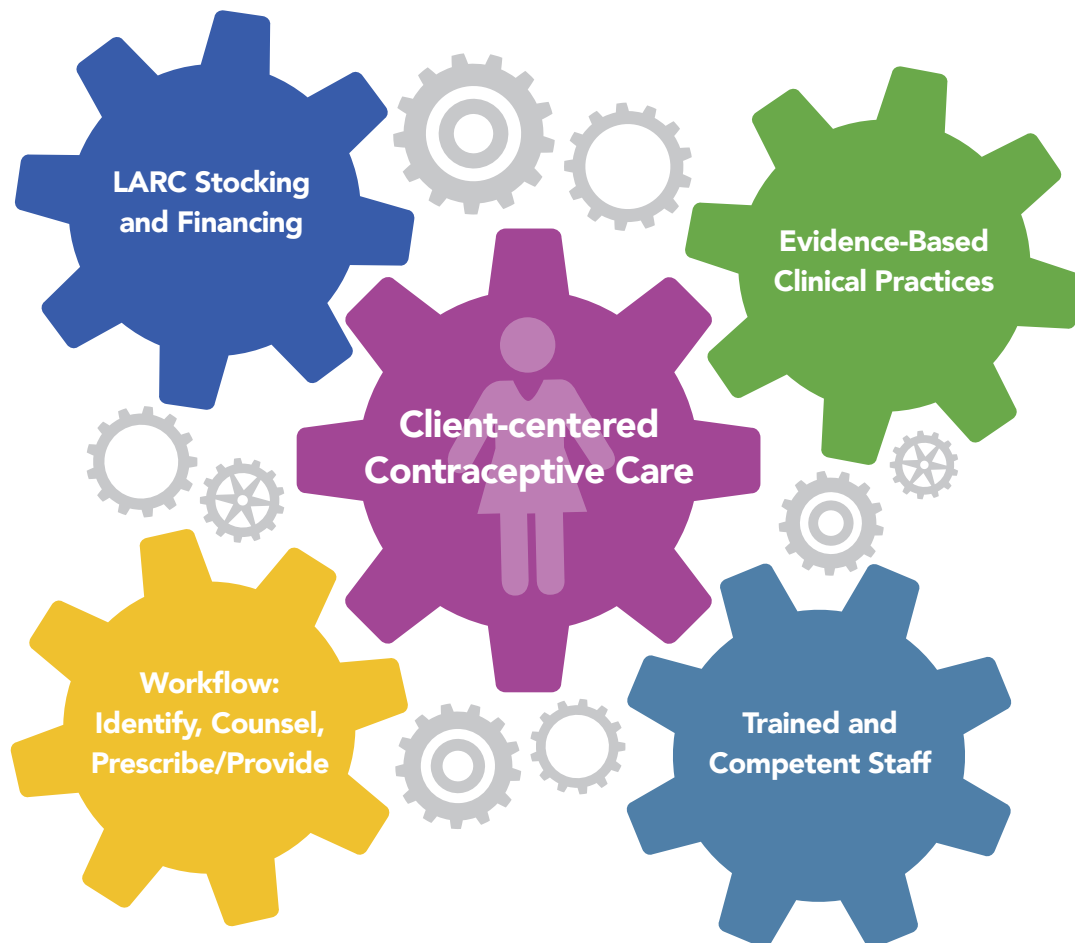
In the **Client-Centered Contraceptive Care Model**, healthcare providers have systems and processes in place to:

- 1) Identify women in need of contraceptive services at every visit
- 2) Ensure that they have accurate and unbiased information about all FDA-approved contraceptive methods
- 3) Employ a shared decision-making approach to contraceptive counseling and, if clinically appropriate
- 4) Provide or prescribe a woman's contraceptive method of choice on the same day of the visit

To reach the goal of client-centered contraceptive care, four components must be in place. These are:

- 1) **LARC Stocking and Financing**
- 2) **Evidence-Based Clinical Practices**
- 3) **Trained and Competent Staff**
- 4) **Workflow**

Each component is explored in greater detail throughout this change package.

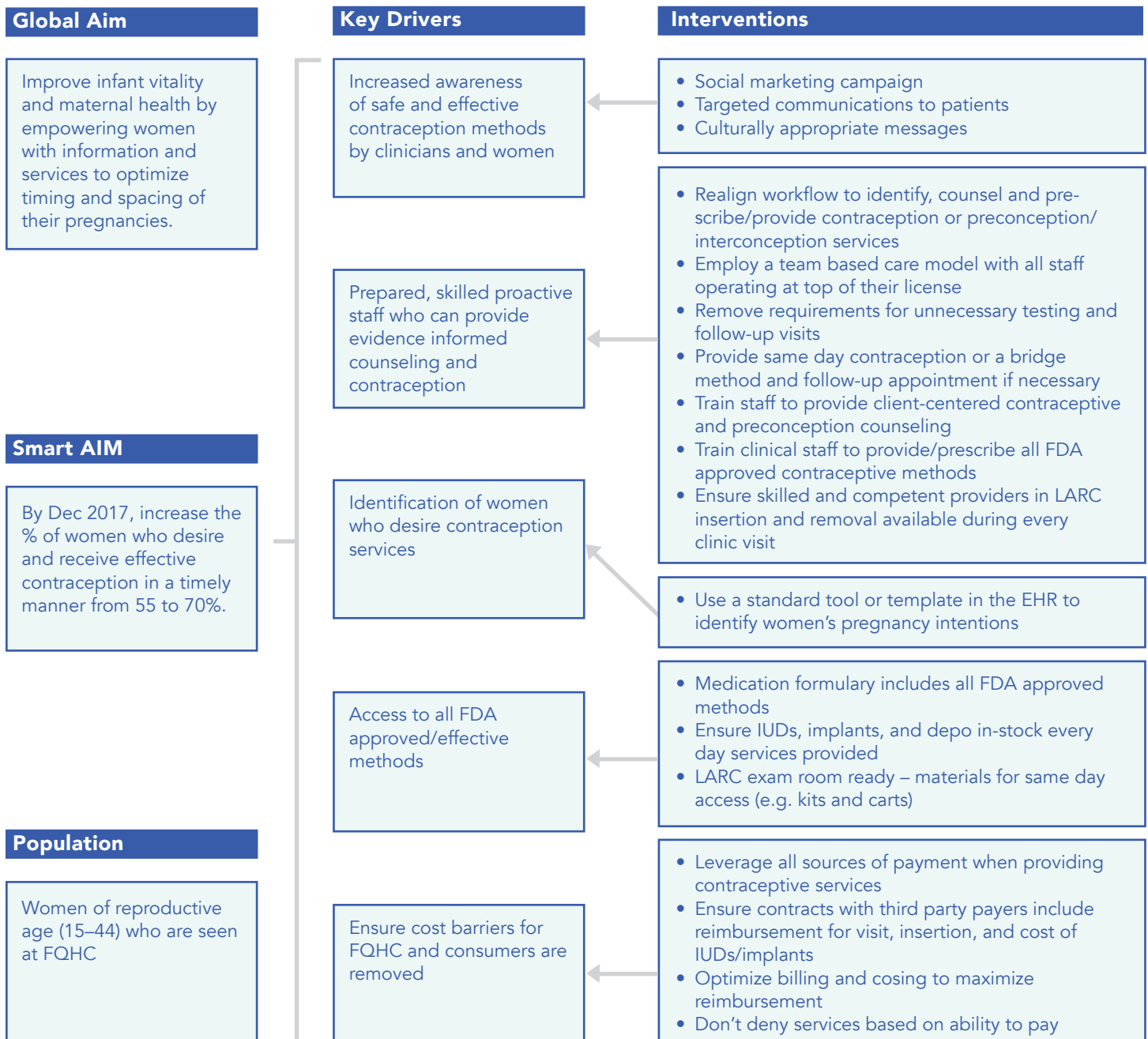


This change package offers tools, resources and quality improvement strategies designed to assist health centers to improve screening for pregnancy intentions and access to preconception health information and/or effective contraception methods for all women at each health center visit.

## Key Driver Diagram

The Key Driver Diagram (KDD) used in the Infant Vitality Initiative is the project team's theory for how to achieve the aim of improving the percentage of women who receive effective contraception in a timely manner. The KDD includes the key components of

the Client-Centered Contraceptive Care Model as the key drivers or factors that will contribute to achieving the aim. Using a KDD can help focus and communicate the strategies a team is testing.





## How to Use This Change Package and Tools

### A STEP BY STEP PLAN TO IMPLEMENT CHANGES AND TRACK IMPROVEMENT

#### UNDERSTANDING YOUR SYSTEM

It is useful to begin this work by reviewing your agency's current policies, structures, and systems that support the delivery of contraceptive services. This will help your team to better understand your agency's strengths and weaknesses and identify the areas you will need to focus on to improve care.

The following Organizational Capacity Self-Assessment tool has been designed to assist health care agencies with examining their organizational capacity to provide contraceptive services. The assessment is organized by the domains described within the change package (i.e., LARC Stocking and Financing, Evidence-Based Clinical Practices, Trained and Competent Staff, and Workflow). In addition, it supports an examination of processes your practice has in place to facilitate continuous quality improvement and ensure awareness of contraceptive services among the clients you serve.

Completing this assessment will require the engagement of a multidisciplinary team, which should include a Medical Director, practice manager, a data analyst/QI staff, and/or a fiscal/billing staff person.

**Instructions:** For each of the following statements, indicate the response (1-3) that most accurately reflects your agency's current capacity. Use the scale below:

- 1. Not in place**
- 2. Somewhat in place**
- 3. In Place**

Once you have completed a section, add up the responses to see your score. *Lower scores indicate potential areas of focus.*



## Understanding Your System

EVIDENCE-BASED CLINICAL PRACTICES	CURRENT CAPACITY
	1. NOT IN PLACE 2. SOMEWHAT IN PLACE 3. IN PLACE
Contraceptive services, policies, and protocols are provided in accordance with evidence-based clinical recommendations (respond to each practice listed below)	
IUDs and Implants are available to nulliparous women	
IUDs and Implants are available to adolescents	
IUDs are inserted without the requirement of STD results	
IUDs and Implants are inserted without requirement that women be on menses	
Implants are inserted without requirement of a pelvic exam	
No requirement of removal of IUD with positive Chlamydia or Gonorrhea test	
Same-day insertion of IUD or Implant are offered if pregnancy can reasonably be ruled out	
Quick Start of any non-LARC method is offered	
Quick Start is offered to women following a negative pregnancy test	
"Bridge method" is offered for women who are rescheduled for a LARC method insertion procedure	
Copper IUDs offered as emergency contraception	
IUD or implant insertion are offered at post-partum visit	
Medication formulary includes all FDA-approved contraceptive methods	
<b>Total Score for "Evidence-Based Clinical Practices"</b> (Scores below 28 indicate possible area of focus for implementation)	

LARC STOCKING AND FINANCING	CURRENT CAPACITY
	1. NOT IN PLACE 2. SOMEWHAT IN PLACE 3. IN PLACE
IUDs (e.g, Mirena/Liletta, Paragard), Implants and Depo-Provera are in stock every day of clinical services	
Contracts with all 3rd party payers include reimbursement for visit, insertion, and cost of LARC device	
Contraceptive service billing codes have been identified (e.g., ICD10, CPT, HCPC, J, and modifier codes)	
Billing and Coding are optimized to maximize reimbursement for provision of contraceptive services	
No client is denied contraceptive services, including a LARC method, based on their ability to pay	
<b>Total Score for "LARC Stocking and Financing"</b> (Scores below 10 indicate possible area of focus for implementation)	



## Understanding Your System

WORKFLOW: IDENTIFY, COUNSEL, AND PRESCRIBE/PROVIDE	CURRENT CAPACITY
	1. NOT IN PLACE 2. SOMEWHAT IN PLACE 3. IN PLACE
Clinical team employs a team-based model of care with all staff operating at the top of their licenses	
EHR includes prompts reminding staff to ask client about contraceptive used at the beginning of the visit	
EHR includes checkbox fields allowing staff to document contraceptive method at the beginning and end of visit	
Steps in the delivery of care consistently and reliably identify clients in need of contraceptive services, provide for an opportunity for contraceptive counseling, and prescribe/provide contraception the same day by a trained provider at every visit	
LARC insertion and removal supplies are in stock ( <a href="#">Exam Room Readiness Checklist</a> )	
Exam rooms are "LARC Ready" (reference <a href="#">Exam Room Readiness Checklist</a> ) to facilitate same-day access to LARC methods	
Systems are in place to refer clients for contraceptive services not available at the health center	
<b>Total Score for "Workflow to Identify, Counsel and Prescribe/Provide"</b> <i>(Scores below 14 indicate possible area of focus for implementation)</i>	

TRAINED AND COMPETENT STAFF	CURRENT CAPACITY
	1. NOT IN PLACE 2. SOMEWHAT IN PLACE 3. IN PLACE
Frontline staff is trained to provide key messages about available contraceptive and pre-conceptive services	
Staff identified to provide contraceptive counseling is trained to provide client-centered contraceptive counseling	
Clinical staff is trained to prescribe/provide all FDA-approved contraceptive methods, including LARC methods	
<b>Total Score for "Trained and Competent Staff"</b> <i>(Scores below 6 indicate possible area of focus for implementation)</i>	

## Understanding Your System

CONTINUOUS QUALITY IMPROVEMENT STRATEGIES	CURRENT CAPACITY
	1. NOT IN PLACE 2. SOMEWHAT IN PLACE 3. IN PLACE
Change team structure is in place ( <a href="#">Change Leadership Structure Worksheet</a> )	
Systems are in place to collect, report, and use data and information describing the rate at which clients are identified who need contraception and are provided contraceptive services	
Process is in place to regularly share data about contraceptive services with staff to promote continuous improvement	
<b>Total Score for "Continuous Quality Improvement Strategies"</b> (Scores below 6 indicate possible area of focus for implementation)	

COMMUNICATION	CURRENT CAPACITY
	1. NOT IN PLACE 2. SOMEWHAT IN PLACE 3. IN PLACE
Patient communication (including use of social media) strategy is in place	
Staff and written material use culturally-appropriate messaging	
<b>Total Score for "Communication"</b> (Scores below 4 indicate possible area of focus for implementation)	

Once the assessment has been completed it is important to review and discuss the results with a multidisciplinary change and improvement team, comprised of agency leaders who have the power and authority to make necessary changes and provide guidance through the implementation process. Based on this review, your team will be able to develop an implementation plan.

## Setting your SMART Aim and Understanding your Process

One of the most important initial steps to improving care is to develop a written statement of the expected accomplishment(s).

**A SMART AIM is a written statement of the accomplishment expected from a team's improvement effort.**

Your SMART AIM should be **S**pecific, **M**easurable, **A**ctionable, **R**ealistic and **T**imely. For example, your AIM might be: By July 2018 we will increase the percent of women who are asked about pregnancy intentions at every visit from 10% to 95%. By collecting a small amount of data each month you can monitor your progress to reaching your goal. A sample data collection form is provided in the appendix or you may be able to review information in the Electronic Medical Record, if applicable.

Based upon the woman's response to the pregnancy intention question, determine the next steps regarding contraceptive counseling, preconception counseling, or both. Since this population on a monthly basis can be a large number, the recommendation is to collect data monthly on a sample of patients (20-30 patients per month) to be able to understand the entire population.



A helpful data monitoring strategy would be to evaluate your practice data on a monthly basis to be sure that all women are screened for pregnancy intentions [in the target population], and that those not wanting to get pregnant in the next three months or have a baby in the next year are receiving contraceptive counseling and leaving with a moderate/most effective form of contraception. Sharing this data with the team has been shown to also be an effective in achieving the results of the improvement effort.

The beginning of an improvement project should always include an observation of the current state of the process. A quality improvement tool used for this is a process map. With your team, walk through the process from the patient's perspective. Seeing and observing the process firsthand creates team learning and agreement on the steps of the process. This tool can also show unexpected complexity and unnecessary steps of the process.

### Some key questions to consider when creating your process are:

- What does the current state of your process look like?
- What should staff roles and responsibilities be related to providing contraceptive care?
- To what extent do you have the equipment needed to insert IUDs/Implants in the clinic settings?

**Review the current process for women in the target population of 15-44 years of age who are seen in the clinic to better understand the process for pregnancy intention screening at each visit through creation of a process map with a cross functional group of team members.**



## LARC Stocking and Financing

Start with the first key component of Client-Centered Contraceptive Care which is LARC stocking and financing. The first element of this practice involves ensuring that LARC methods are in stock every day

of clinic operations and necessary supplies for LARC insertions and removals are in-stock and readily available. Also, ensure that women can choose the best method for them regardless of their ability to pay.



### LARC Stocking and Financing

#### Key Driver and Interventions

**Driver:** Access to all FDA approved methods

**Interventions:**

- IUDs, Implants and Depo in-stock every day of services

**Driver:** Ensure no cost barriers for FQHC and Consumer

**Interventions:**

- Leverage all sources of payment when providing contraceptive services
- Ensure contracts with third party payers include reimbursements for visit, insertion, and cost of IUD/Implants
- Optimize billing and coding to maximize reimbursement
- Do not deny services based on ability to pay



#### LARC STOCKING

Streamlining the time associated with providing LARC methods to women, and avoiding unnecessary patient waiting time, includes ensuring that LARC methods are stocked and located in the practice setting. With an updated medication formulary and no pre-authorization requirements, health centers can maintain a stock of LARC methods (Implants, hormonal IUDs and non-hormonal IUDs) in the practice setting to facilitate the provision of same-day LARC insertion services to those women who are interested in and eligible for a LARC method.

#### LARC FINANCING

There are widely held perceptions that ensuring access to LARC methods is cost prohibitive. However, provisions associated with the Affordable Care Act (ACA) cover, as preventive care, access to all FDA approved birth control methods without requirements of cost sharing to the patient. In addition, the recent availability of a new generation of LARC methods will help to significantly reduce the cost of these devices now and in the future. Measurable improvements in patient outcomes, including reductions in unintended pregnancy and abortion rates, and improved birth outcomes are observed when cost barriers are removed to stocking and providing LARC to women.

## LARC Stocking and Financing



Finance officers can support agencies in achieving positive health outcomes for the clients and community they serve by building a business case for LARC services and ultimately allocating budget resources to the purchase of LARC methods.

### LARC SERVICES IN OHIO

Currently in Ohio, health centers can bill for and expect reimbursement for LARC services, although the amount of reimbursement varies by payer source. Below is a summary of the reimbursement structure for third party payers in Ohio:

- 1. Medicaid Fee-for-Service:** LARC services (including the cost of the device) are included in the standard Prospective Payment System (PPS) rate (approximately \$125/visit).
- 2. Medicaid Managed Care Plans:** All Ohio Medicaid Managed Care Plans (MCPs) should provide reimbursement for the visit/evaluation, the insertion, and the cost of the device.
- 3. Private Insurers:** private insurers reimburse for the visit/evaluation, insertion and cost of the device (all methods are included and reimbursement varies by plan).

In order to make sure women and adolescents have access to the most effective methods of contraception, including LARC methods, fiscal officers must partner with the medical leaders and program administrators to make sure cost is never a barrier to a patient's receipt of a LARC method. The following systems and processes may be put into place:

- **Fiscal Triage** - Ensure fiscal triage process includes asking every client about insurance status and collect necessary insurance information to facilitate billing.
- **Coding** – Make sure staff are coding correctly and consistently for the provision of LARC services to maximize reimbursement for insured clients.
- **Sliding Fee Scale** - Use a sliding fee scale to enable clients without insurance to access contraceptive services.
- **Carry a Balance** - Allow clients to carry a balance for providing contraceptive services.
- **Never Deny Care** - Never deny clients contraceptive services, including LARC methods, based on ability to pay.

## Evidence-Based Clinical Practices

Focus on the second key component of Client-Centered Contraceptive Care **Evidence-Based Clinical Practices**. Ensure providers are following evidence-based clinical practices and recommendations when providing

contraceptive services, such as not requiring STD test results or that a woman be on her period for LARC insertion.



### Evidence-Based Clinical Practices

#### Key Driver and Interventions

**Driver:** Prepared, skilled, proactive staff who can provide evidence-informed counseling and contraception

**Interventions:**

- Remove requirements for unnecessary testing and follow-up visits
- Medication formulary includes all FDA-approved methods
- Provide same day contraception or a bridge method, and follow-up appointment if necessary



Changes associated with nationally recognized clinical recommendations make it easier than ever to ensure women have access to their birth control method of choice. This includes broader access to the most effective and reliable methods of birth control – LARC. At the same time, significant gaps in clinician knowledge about these recommendations exist. Putting into place evidence-based contraceptive policies will serve to set the stage for quality care and increase awareness of these recommendations among staff.

Nationally recognized **clinical policies** for the delivery of LARC services include:

- LARC available to nulliparous women
- LARC available to adolescents
- Same-day insertion of LARC methods when appropriate
- No requirement for STI results prior to IUD insertion
- No requirement for removal of LARC method with positive STI test
- LARC insertion available immediately post-partum or post-abortion
- Use of a Copper IUD as a method of emergency contraception



## Evidence-Based Clinical Practices



Access to effective contraception depends on the health center's ability to provide or prescribe all FDA-approved methods. As such, clinical leadership should work to maintain a **medication formulary** that ensures access to all moderately effective and most effective birth control methods.


This includes:

- Hormonal IUD(s) (Mirena, Skyla, Liletta, Kyleena)
- Non hormonal IUD (Paragard)
- Hormonal Implant (Nexplanon)
- Hormonal Injection (Depo-Provera)
- Hormonal contraceptive pill
- Contraceptive Patch
- Vaginal Ring
- Condoms

## Trained and Competent Staff

Focus on the third key component of Client-Centered Contraceptive Care which is **Trained and Competent Staff**. This includes training staff to assess a client's pregnancy intentions, provide client-centered contraceptive counseling, provide all methods of

contraception, and provide insertion and removal of LARC devices. Front line staff may also be trained to provide consistent messaging about the availability of contraceptive services.



### Trained and Competent Staff

#### Key Driver and Interventions

**Driver:** Prepared, skilled proactive staff who can provide evidence-informed counseling and contraception

**Interventions:**

- Train staff to provide client-centered contraceptive and preconception counseling
- Train clinical staff to provide/prescribe all FDA approved contraceptive measures
- Ensure skilled and competent providers in LARC insertion and removal available during every clinic session

**Driver:** Increase awareness of safe and effective contraceptive methods by clinicians and staff

**Interventions:**

- Targeted communication to patients
- Culturally appropriate messaging
- Social marketing campaign



#### PLANNING

The first step in building knowledge and skills among staff is selecting who will receive this training. By updating the health center workflow, leadership will have decided which staff members will prescribe contraception (including inserting and removing LARC methods), conduct contraceptive counseling, assess pregnancy intentions, and reinforce key messages about the availability of LARC methods.

#### TRAINING

After selecting which staff will participate in the training, mentors will work with select staff to lay out a training schedule. If possible, sites should attempt to find a time during the work day for this training. The recommended courses are available on-line and broken down as follows:

- **Clinical Staff** (staff designated to provide contraception/LARC insertion): one introductory module (15 minutes) and four clinical modules (each approximately 30 minutes)

## Trained and Competent Staff



- **Staff providing contraceptive counseling:** one introductory module (15 minutes) and four contraceptive counseling modules (each approximately 30 minutes)
- **Front line staff and other staff reinforcing key messages:** one introductory module (15 minutes) and one module on key messages and questions (approximately 30 minutes)

After completion of each module, staff will be required to complete a knowledge assessment. They must receive a satisfactory score over 80% in order to proceed to the next module. Staff will be able to complete the assessment multiple times until they attain a satisfactory score.

Additionally, staff interested in receiving CME/CNE for the clinical modules will be required to complete a short evaluation at the conclusion of the course.

### IMPLEMENTATION SUPPORT

After staff have completed the trainings, it is critical that they immediately implement what they learned in their daily work. Through this follow-up implementation, staff will demonstrate that they are able to translate their newly acquired knowledge into practice. Leadership staff and mentors will reinforce implementation of knowledge through periodic reports of progress during all staff meetings.

**Client-centered contraceptive care should always empower clients to make the decision that is best for them, based on their unique needs and preferences.** When providing quality contraceptive care, it is important to be aware of the history of coercive contraceptive practices in the United States, especially those targeting women of color and socioeconomically disadvantaged groups. Coercive practices have ranged from extreme and intentional restriction of women's choices, to more subtle attempts to influence their decisions by encouraging the use of specific methods over others without medical justification.

We know that when women are provided with meaningful options and accurate, unbiased information, they will choose the method that is best for them. This results in greater rates of contraceptive use and client satisfaction. It is critical, therefore, in our eagerness to provide access to the most highly effective contraceptive methods, to ensure at all times that our own personal opinions do not overshadow women's freedom to select the method that is best for them.



## Workflow: Identify, Counsel, Prescribe/Provide

Focus on the fourth key component of Client-Centered Contraceptive Care which is **Workflow: Identify, Counsel, and Prescribe/Provide**. Establishing a workflow that standardizes the identification of pregnancy

intentions of women in the target population ensures that all women have the opportunity to discuss their reproductive healthcare needs.



### Workflow: Identify, Counsel, Prescribe/Provide

#### Key Driver and Interventions

**Driver:** Prepared, skilled, proactive staff who can provide evidence informed counseling and contraception

**Interventions:**

- Employ a team-based model of care with all staff operating at the top of their license
- Realign workflow to identify, counsel and prescribe/provide contraception or precontraception/intercontraception care
- Use a standard tool or template in EHR to identify women's pregnancy intentions
- Ensure skilled and competent providers in LARC insertion and removal during every clinic session
- LARC exam room-ready materials on hand for same day access

#### In a client-centered contraceptive care workflow, every woman is:

- Asked about her pregnancy intentions



**Do you want to be pregnant in the next few months, or have a baby in the next year?**

- Provided follow-up counseling based on her response
- Provided with the contraceptive method of choice that same day

Successfully integrating contraceptive services into the FQHC environment hinges on the ability of health center leadership to develop clinical processes that integrate contraceptive care into existing clinical practice. Using a team-based model of care, each team member operates at the top of their license and is assigned a unique task or responsibility associated with providing contraceptive services.

For the team-based model to work, team members must have a **shared goal** for the client encounter. The team's shared goal is to make sure that every sexually active woman and adolescent who does not want to be pregnant has an opportunity to know about and receive the birth control method of their choice by a trained clinical provider. The health care team can achieve this goal by reliably and consistently:

- Identifying a woman's or adolescent's need for contraceptive services by asking about her pregnancy intentions;
- Providing women with an opportunity to receive accurate and unbiased information about all FDA-approved birth control options and;
- Providing an opportunity for women or adolescents who want contraception to receive the contraceptive method of their choice by a trained clinical provider, without requirement of a subsequent visit.

## Workflow: Identify, Counsel, Prescribe/Provide



A member of the team must be assigned responsibility, and be provided training and support, to complete any one or more of the tasks listed below. These tasks should be completed during every visit where contraceptive services could be provided:

- Use of a pregnancy intentions screening question to identify women in need of contraceptive services.
- If client desires pregnancy, provide pre-conception counseling to help ensure healthy pregnancies.
- If client does not desire pregnancy, assess interest in learning more about contraceptive options and/or initiating contraception.
- If contraception is desired, provide client-centered contraceptive counseling using the CAP Contraception Options Grid and assist in method selection. (available in [English](#) and [Spanish](#))
- Provide the client with their contraceptive method of choice that same day or bridge with another method.
- If client does not want contraception on the same day and is at-risk for an unintended pregnancy, offer emergency contraception (EC).
- Provide condoms as needed to protect against sexually transmitted infections.

### LARC EXAM ROOM READINESS

To avoid wasted time attempting to identify necessary tools and information to provide LARC methods, and to promote efficiency in the steps necessary to facilitate same-day delivery of contraceptive care, health center teams can create processes to ensure that all necessary insertion and removal supplies are readily available. They can do this by:

- **Creating LARC kits** that are bags/boxes/caboodles that include all necessary insertion and removal supplies. These kits can be kept in a centralized location and brought to the exam rooms as needed.
- **Creating LARC carts** with all insertion and removal devices that can be wheeled to exam rooms as needed.
- **Ensuring that all procedure/exam rooms are LARC ready** with all insertion and removal supplies.

Regardless of the strategy selected to ensure LARC insertion and removal supplies are readily available, health center teams will also create processes for sterilizing, replenishing, and staffing these responsibilities.

## Implementation and Sustainability

Before a change is able to be fully implemented into your system, it is helpful to do small tests of change, which are called PDSA (Plan-Do-Study-Act) cycles in Quality Improvement Methodology. Testing small will allow the team to explore and adapt existing ideas to the population that is the focus of the SMART Aim Statement. A test involves putting a change into effect on a temporary basis, measuring its effect, and learning about its impact.

Continue to use PDSAs to test and implement methods to increase the percent of visits where women age 15-44 are screened for pregnancy intentions, increase the appropriate type of counseling that is taking place based on the woman's response to her pregnancy intention, and increase the percent of visits where a woman is leaving with the most or moderately effective form of contraception.



Once testing is completed, the time has come to make these changes permanent. In order to ensure successful implementation is sustained, you will want to ensure that the processes are standardized and everyone understands their role and responsibilities. The following activities will be helpful as you sustain your changes:

- review your initial process map and make changes to reflect your new process,
- rewrite job descriptions that may have changed to incorporate new activities,
- train all personnel in the new process,
- monitor the data to ensure you are maintaining your gains, and
- assign a champion who will ensure the new process is maintained.

A helpful tool is the Implement/Sustain Performance Checklist which provides questions for specific key deliverables of success.

In summary, to effectively implement changes:

- Use multiple PDSA cycles to implement change
- Standardize the changes in the system
- Redesign support processes for new process
- Collect data over time when conditions are expected to change
- Think about and plan for maintenance of change



## Acknowledgements

### **Ohio Association of Community Health Centers (OACHC)**

Ted Wymyslo, MD  
Julie DiRossi-King  
Ashley Ballard, RN, BSN  
Teresa Rios-Bishop

### **OACHC Participating Sites**

Crossroad Community Health Center  
(Cincinnati, OH)

- Crossroad OTR
  - Crossroad West
- Erie County Community Health Center  
(Sandusky, OH)

Lower Lights Christian Health Center  
(Columbus, OH)

- Lower Lights 5th Street
- Lower Lights Broad Street

Neighborhood Family Practice  
(Cleveland, OH)

- Ridge Road Site
- West 117th Street Site

Third Street Family Health Center  
(Mansfield, OH)

- Mansfield
- Shelby

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### **ABOUT OPQC**

The Ohio Perinatal Quality Collaborative (OPQC) is a statewide consortium of perinatal clinicians, hospitals, policy makers and governmental entities that aims, through the use of improvement science, to reduce preterm births and improve birth outcomes across Ohio. OPQC involves subject matter experts, uses successful evidence-informed strategies, and employs data-driven quality improvement methods and well-accepted project management processes. Success comes from a collaborative approach that builds upon an established network of OPQC-member hospitals with a history of executing successful statewide quality improvement initiatives. OPQC's role in this project was to lead the quality improvement, data collection, and data analytics.

### **ABOUT CAI**

For over 35 years, CAI has worked with local and state health departments, FQHCs, community health centers, and Title X clinics across the country to strengthen the quality and use of sexual and reproductive health services, and improve the health outcomes of the communities they serve. CAI is

a nationally-recognized provider of training and technical assistance (T/TA) with expertise in working with leaders, health systems, social service, and community-based organizations to build effective, sustainable systems that integrate evidence-based practices and guidelines into clinical practice. CAI's role in this project was as content expert, leading the training and technical assistance components. Primary care settings, particularly FQHCs, can be important providers of contraceptive services for the women they serve. CAI has worked with many FQHC networks over the past several years, providing training and technical assistance to their health center teams to successfully integrate the full range of contraceptive services into their primary care model. When representatives from participating FQHCs were asked whether they felt it was the role of FQHCs to provide this care, they emphatically and unanimously answered that FQHCs should be providing contraceptive services, as these services represent a critical component of preventive care. For more information on resources and trainings, please visit us at [caiglobal.org](http://caiglobal.org) or contact [info@caiglobal.org](mailto:info@caiglobal.org).

## Appendix

### Data Collection Resources

- [Sample data collection form template](#)

### Evidence-Based Clinical Practices Resources

- [Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs](#)
- [US Medical Eligibility Criteria \(US MEC\) for Contraceptive Use, 2016 \(Summary table\)](#)
- [US Selected Practice Recommendations \(US SPR\) for Contraceptive Use, When to Start Contraception and Follow-up Summary Table, 2016](#)
- [Reproductive Access Quick Start Algorithm](#)
- [Contraceptive Point-of-Care App \(iTunes app\)](#)
- [American Academy of Family Physicians Practice Guidelines for Use of Long-Acting Reversible Contraceptives \(2012\)](#)
- [American Academy of Family Physicians Intrauterine Devices: An Update \(2014\)](#)
- [American Academy of Pediatrics Policy Statement, Contraception for Adolescents \(2014\)](#)
- [American College of Obstetrics and Gynecology Committee Opinion, Increasing Access to Contraceptive Implants and Intrauterine Devices to Reduce Unintended Pregnancy \(2015\)](#)

### LARC Stocking & Financing Resources

- [Financing LARC Services Fact Sheet](#)
- [CAP LARC Cost Modeling Tool](#)
- [CAP Contraceptive Care Billing Codes](#)
- [Guide to Billing and Coding for LARC Services in Ohio](#)
- [CMS Informational Bulletin: State Medicaid Payment Approaches to Improve Access to LARC \(2016\)](#)

### Workflow: Identify, Counsel, Prescribe/Provide Resources

- [CAP LARC Exam Room Readiness Checklist](#)

### Trained & Competent Staff

- [CAP Staff Structure and Skills Table](#)
- [CAP Training Menu](#)
- [CAP Clinical Mentor Toolkit](#)
- [CAP Contraceptive Counseling Observation Tool](#)

- [CAP Contraceptive Counseling Model: A 5-Step Client-Centered Approach](#)
- [CAP Birth Control Options Grid \(English\)](#)
- [CAP Birth Control Options Grid \(Spanish\)](#)
- [Reproductive Autonomy and the Provision of LARC Services](#)

### Organizing for Change Resources

- [Organizing for Change Checklist](#)

### Sustainability Resources

- [Stakeholder Analysis](#)
- [Implement/Sustain Performance Checklist](#)

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### Smart Aim

A **S**pecific, **M**easurable, **A**ction oriented, **R**ealistic, **T**imely (**SMART**) statement of expected results of an improvement process (a statement of a specific, intended goal). Include:

- A general description of what you hope to accomplish
- Specific patient population who will be the focus
- Some guidance for carrying out the activities to achieve aim

### Quality Improvement Method

The work of quality improvement teams participating in the OPQC project is guided by the Model for Improvement. The Model asks three key questions as teams test changes in care processes: *What are we trying to accomplish? How will we know that a change is an improvement? What changes can we make that will result in improvement?*

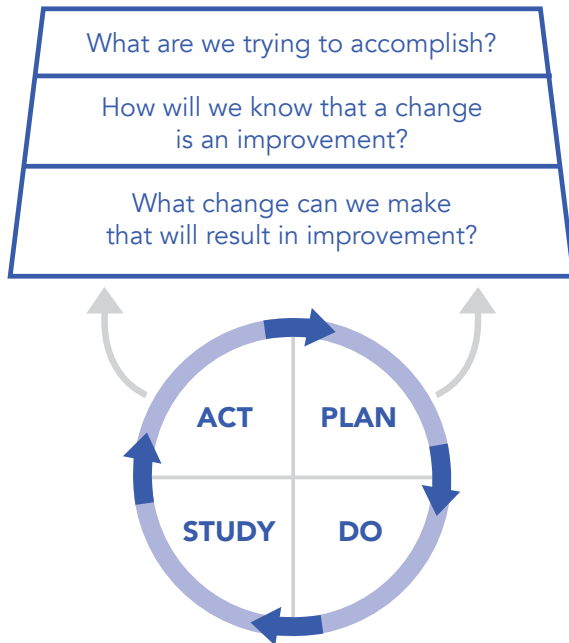
The final element is the Plan-Do-Study-Act (**PDSA**) cycle in which a change to be tested or implemented is planned and carried out, outcomes are monitored and analyzed, and then, based on the lessons learned, the change is fully implemented or the next change cycle is planned.

The PDSA Cycle Video; Speaker: Robert Lloyd, PhD, Institute for Healthcare Improvement; can be found at: [www.youtube.com/watch?v=xzAp6ZV5ml4](http://www.youtube.com/watch?v=xzAp6ZV5ml4).

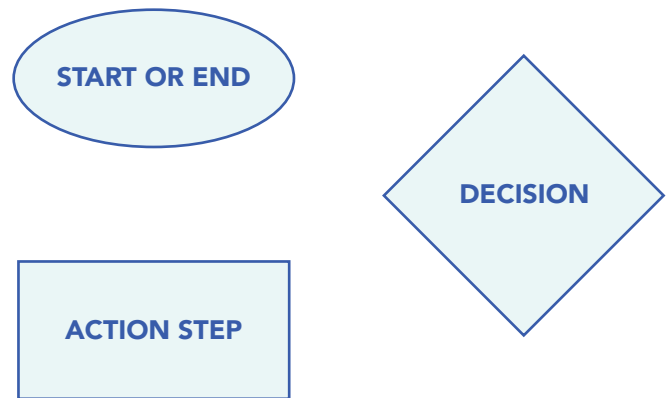
Langley, Nolan, Norman, and Lloyd P. Provost. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*. New York: Jossey-Bass Inc., 1996

## Appendix

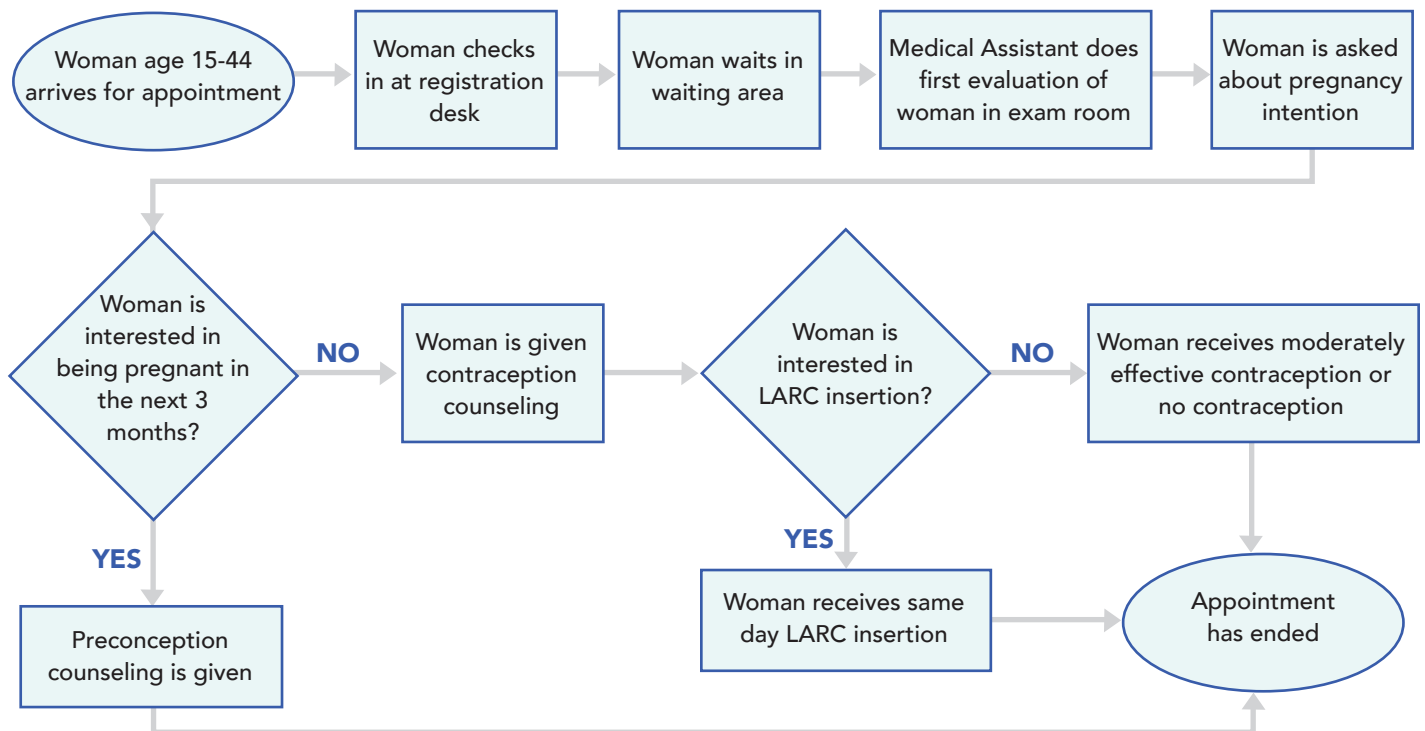
### Model for Improvement



### Standard Shapes in a Process Map



### Process Map Example







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