Attachment A: **TEMPLATE FOR TRANSFORMATION PROJECT SUGGESTIONS**

Contact Information	*Heather Maisen, PHSKC 206-263-8295 heather.maisen@kingcounty.gov* *Contributing organizations: Public Health - Seattle & King County (Lead); Neighborcare Health, Planned Parenthood of the Great Northwest and the Hawaiian Islands and Coordinated Care MCO* Alignment with the North Sound ACH proposal "Increasing Awareness and Accessibility of Long-Acting Reversible Contraception". Jefferson County Public Health is interested in this project and DOH has endorsed this project.
Project Title	**Prevent Unintended and Adolescent Pregnancies**

Rationale for the Project

Problem Statement: Unintended pregnancy can have significant, negative consequences for individual women, their families and society as a whole. An extensive body of research links births resulting from unintended or closely spaced pregnancies to adverse maternal and child health outcomes and myriad social and economic challenges. Whereas, investing in contraceptive care reduces costs. Following national trends, Washington state births from unintended pregnancies are twice as high among women covered by Medicaid (51%) compared to women not covered by Medicaid (24%) with numbers much higher among women under age 20, low income women, and in communities of color.[i] In 2010, Washington State spent $220 million on Medicaid-financed prenatal care and deliveries for births from unintended pregnancies, while preventing those pregnancies with contraceptive care would have cost about $7 million annually.[ii] Meanwhile, new technologies (such as Long Acting Reversible Contraceptives – LARCs) and new approaches (pregnancy intention screening, such as One Key Question®®) have not been widely adopted by providers. These problems persist, in part, because of a lack of a coordinated system to reinforce evidence-based guidelines, to collect and monitor data, to train providers, and to promote strategies for unintended pregnancy prevention.

Support Research: Evidence supports the wider use of LARCs and the need for provider training. Combining system changes, provider training, and patient education led to an 88% increase in providers who provided LARCs and a 30% increase in LARC use in community clinics and school-based health centers.[iii] LARCs are now considered a "top tier" and first-line contraception method by the WHO and CDC. Extensive research has shown LARC can effectively reduce the rates of unintended pregnancy, both for nulliparous women and women avoiding repeat pregnancy.[iv, v] Multiple efforts have shown LARC provider training increases LARC use, and results in reducing unintended pregnancies by almost half among teens and young women.[vi] Neighborcare, a CHC in KC, has demonstrated success in implementing LARCs in new health care settings, such as school-based health centers as documented in the Journal of Adolescent Health publication, *Providing Long-Acting Reversible Contraception Services in Seattle School-Based Health Centers: Key Themes for Facilitation Implementation.*[vii] Additional review of this work evaluated the impact of health education and found a dramatic increase in young people accessing contraceptive services and an uptake in LARC use. Another key emerging evidence-based practice is routine screening for pregnancy intention. One Key Question® is an initiative of the Oregon Foundation for Reproductive Health that provides a tool for providers to routinely ask women about their pregnancy intentions, and then offer evidence-based pregnancy prevention or preconception services. This program has demonstrated favorable preliminary findings of provider and client acceptability, and increased provision of contraception and preconception care.[viii]

Relationship to federal Objectives: This proposal aligns with the Triple Aim within Medicaid by increasing the quality of contraceptive care for Medicaid members while reducing the high Medicaid maternal and infant care costs. It aligns with the following two federal objectives:

- **Per the *CMCS Maternal and Infant Health Initiative*,** the initiative seeks to increase the rate of pregnancies that are intended through increasing by 15 percentage points the use of effective methods of contraception in Medicaid and CHIP over a 3-year period.

- **Per CDC's *6/18 Initiative: Accelerating Evidence into Action***, unintended pregnancy is identified as one of the six common and costly health conditions that has evidence-based preventive practices with potential for emerging value-based payment and delivery models.

Project Description

Which Medicaid Transformation Goals are supported by this project/intervention? Check box(es)

√Reduce avoidable use of intensive services
√Improve population health, focused on prevention
☐ Accelerate transition to value-based payment
√Ensure Medicaid per-capita growth is below national trends

Which Transformation Project Domain(s) are involved? Check box(es)

√Health Systems Capacity Building
√Care Delivery Redesign
√Population Health Improvement – prevention activities

Target population: The target population includes Medicaid-covered women of reproductive age, especially women in need of publicly funded contraceptive services who are defined as women who are either younger than age 20, and women who are age 20-44 with incomes below 250% of the federal poverty level who are sexually active and able to become pregnant, but do not wish to become pregnant.

Goal: Prevent unintended pregnancies through improving health systems capacity to implement evidence-based family planning services. Ultimately, this would assure that any woman could see any health care provider at any point in their reproductive lifespan and receive the full array of client-centered evidence-based services that meet their contraceptive and sexual health needs.

Interventions:

1. Establish a cross-sector committee to oversee implementation of this project. PHSKC is already establishing a Family Planning Access and Quality Committee to coordinate efforts, leverage existing resources and elevate practices as embodied in the King County Health and Human Services Transformation Plan this is an effort to shift away from providers in silos and crisis-oriented responses and toward a coordinated focus on prevention.
2. Expand existing local provider LARC training programs, for example, PPGNHI program could be expanded with adding additional staff capacity to reach more providers. In addition, some training needs can be leveraged utilizing the UCSF Bixby Center evidence-based training resources.
3. Develop a health education and outreach campaign tailored to the target population to increase accurate reproductive health knowledge, positive norms and access to contraceptive services.

Potential partners, systems, and organizations: King County Family Planning Committee (PHSKC, all 6 FQHC Community Health Centers, Planned Parenthood and School-Based Health Centers); Dr. Sarah Prager (UW Dept. of OB/GYN and FP Div./Fellowship), Dr. Anne-Marie Amies Oelschlager (UW Dept. of OB/GYN); Dr. Leslie Walker (Seattle Children's Div. of Adolescent Medicine and UW Leadership of Education in Adolescent Health), Valerie Tarico, PhD, Katharine Harkins, CNM, MPH, North Sound ACH, Jefferson County Public Health, DOH and MCOs.

Health disparities: There are noted disparities for low-income women in obtaining access to more effective contraception, and disparities in contraceptive use are cited as a major cause of unintended pregnancies.[ix] The goal of this project is to directly address these disparities and reduce unintended pregnancies among those most disproportionately impacted. Family planning services, when equitably available, play a pivotal role in women's lives, not only preventing unintended pregnancies, but enabling significant health, economic and social benefits.

Links to complementary transformation initiatives*:* This project supports the Washington State Common Measure Set on Health Care Quality and Cost – Population Measure: Unintended Pregnancy and Results Washington's goal to Decrease Teen Pregnancy.

Core Investment Components

Proposed activities and cost estimates:

King County Family Planning Committee is comprised of members representing a cross-sector of healthcare providers with an initial focus on the FQHC Community Health Centers, Title X and School Based Health Centers, as they are the safety net system for vulnerable populations and provide the most contraceptive care to low-income women. The project will then expand to other providers. The committee will provide guidance and oversight on implementing the project and developing measures to monitor the project metrics. **($300,000 annually)**

Provider Training will extend current training infrastructures, such as PPGNHI, to expand LARC and training to cross-sector healthcare providers such as primary care providers, pediatricians, and obstetricians. **($1 million annually)**

Health education and outreach campaign encompassing a cross sector community-wide delivery approach to develop evidence-based materials, provide technical assistance to health educators, support dedicated health educator staffing, and develop online/computer-based delivery methods (i.e. an App). **($700,000 annually)**

Reach (# of people per monthly or annual basis): "With ACA implementation, the role of Medicaid in financing family planning services for low-income women will only grow."[x] In King County, there are approximately 110,000 women in need of publicly funded contraceptive services, and almost half of these women are under 138% of the federal poverty level. The full potential reach is 110,000; an initial goal would be to reach at least 50% of these women.

Cost per person served monthly or annually: If 110,000 women were reached it would cost $9-$18 per person annually. If 50% of these women were reached it would cost $18-$36 per person annually

How long to fully implement project: The King County Family Planning Committee will already be established and have started data development prior to the start of this project. This work will then be augmented with this proposal to expand the scope, which will take only a few months to realize. Additional activities that could be implemented within the first 3-6 months are health education materials development and an increase in One Key Question® implementation. The provider training and implementation of new services, and development of an online or computerized tool, may take up to a year to reach full implementation. Overall, all activities could be implemented within 9-12 months upon receipt of funding.

ROI and ROI timeline: With the current 7 times return on investment in publicly funded family planning services and a cost savings realized at two years with LARC use, this project will have a significant cost savings within five years of the project.[xi] The extent of cost savings needs further data to fully calculate, however impact could be tracked by monitoring birth rates in the Medicaid-covered population. The committee could develop strategies on how to sustain or expand this project with some of the cost savings reinvested in it.

Project Metrics

Process measures:

- Develop data set of pregnancy intention, services and outcomes
- Increased OKQ implementation
- Provision of provider trainings
- Development and dissemination of health education materials and activities
- Increased provision of contraceptive methods, including LARCs

Outcome measures:

- Increased use of moderate and most effective contraception
- Reduction in unintended pregnancy rates
- Decreased Medicaid spending

Efforts undertaken to establish benchmark measures: Through the committee, there is work already underway with King County's Public Health epidemiologists to develop benchmarks and potentially to utilize Medicaid claims data.

[i] Guttmacher Institute, *Fact Sheet: Contraceptive Use in the United States.* October 2015. http://www.guttmacher.org/pubs/fb_contr_use.html

[ii] Wasington State Department of Health, *Unintended Pregnancy.* Updated 1/17/2014. http://www.doh.wa.gov/Portals/1/Documents/5500/MCH-UP2013.pdf

[iii] Healthy People 2020, *Unity Health Care — Improving Family Planning to Low-Income and Uninsured Individuals.* 2014. http://www.healthypeople.gov/2020/healthy-people-in-action/story/unity-health-care-%E2%80%94-improving-family-planning-to-low-income-and

[iv] Association of Maternal and Child Health Programs, *Economic Analysis of LARC Program.* December 2014 http://www.amchp.org/programsandtopics/data-assessment/Documents/LARCInvestment12-22-14_Final.pdf

[v] Washington University Contraceptive CHOICE Project, UCSF Bixby Center Beyond the Pill Project and Colorado Department of Health state-wide implementation.

[vi] Harper et al*., Reduction in pregnancy rates in the USA with long-acting reversible contraception: a cluster randomised trial*. The Lancet 8–14 August 2015, Pages 562–568 http://www.sciencedirect.com/science/article/pii/S0140673614624600

[vii] Gilmore et al., *Providing Long-Acting Reversible Contraception Services in Seattle School-Based Health Centers: Key Themes for Facilitating Implementation.* Journal of Adolescent Health June 2015 Volume 56, Issue 6, Pages 658-665

[viii] Oregon Foundation for Reproductive Health, *One Key Questions®* http://www.onekeyquestion.org/about-ofrh/

[ix] Guttmacher Institute Policy Review, *What Women Already Know: Documenting the Social and Economic Benefits of Family Planning* Winter 2013 Volume 16, Number 1

[x] KFF, Medicaid and Family Planning: Background and Implications of the ACA July 2015. http://files.kff.org/attachment/issue-brief-medicaid-and-family-planning-background-and-implications-of-the-aca

[xi] Contraception, *Achieving cost-neutrality with long-acting reversible contraceptive methods*. 2015 January; 91(1): 49–56. http://www.contraceptionjournal.org/article/S0010-7824(14)00646-5/ppt