March of Dimes Make Space Project, Stakeholder Informational Interviews Findings and Recommendations

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Introduction

In 2018, the Ohio chapter of the March of Dimes awarded a grant to the Ohio Collaborative to Prevent Infant Mortality (OCPIM). The purpose of the grant was to assemble information, resources and guidance for Ohio health care providers to better assess the pregnancy intent of their patients; provide accurate information about long-acting reversible contraception (LARC) and other contraceptive methods to all eligible women; and improve the utilization of LARC methods when the patient requests it. The goal of the project, was to improve birth spacing by better informing women about LARC, and improving provider confidence in counseling patients and placing LARC methods. This was to be accomplished through the creation of a web-based toolkit and related training. Due to a changing organizational structure, OCPIM was unable to complete the project, and March of Dimes engaged The Center for Community Solutions (Community Solutions) to see the project through to completion. MOD and Community Solutions determined in late 2019 that an important step to finalize a provider-facing tool was to better understand existing LARC and birth spacing training resources; and the barriers that interfere with a provider's ability to assess, counsel on and place LARC. To that end, Community Solutions conducted a series of interviews with a cross section of providers and leaders in the birth spacing community, and we detail results in this report.

Birth spacing and LARC

A pregnancy timed too close to a previous birth is linked to premature birth –which is the largest independent driver of infant mortality and health issues among infants. Closely spaced pregnancies can also pose a risk of complications for mothers. Adequate birth spacing is defined as 18 months or more, from a birth to the next pregnancy. The timing ensures maternal recovery to support the next pregnancy.

Birth spacing has become a central feature of maternal and infant health initiatives and social marketing campaigns across the state. The goal of those campaigns is to inform women and their caregivers of the importance of 'safe spacing' and interconception health care. Preconception and interconception health care focus on the health of the woman prior to the first, or between, pregnancies. It typically includes the following health and social screenings:

- Blood pressure
- Domestic violence
- Depression
- Family history of chronic disease and pregnancy
- Smoking, alcohol and other substance use
- Folic acid and prenatal vitamins
- Current health conditions and medications and the impact on pregnancy
- Contraception, and when to stop
- Housing
- Exposure at work to chemicals that could harm a pregnancy

Birth spacing is a strategy the Ohio March of Dimes uses to reduce premature births. March of Dimes recommends that women use effective birth control until they are ready to become pregnant, and talk to clinical providers about birth control options. Nationally, and in Ohio, birth control counseling currently emphasizes the use of LARC methods. This emphasis is due to their safety, very low fail rate, the lower cost of new methods and increased ability for women to cost-share as more insurers cover contraception than did before the Affordable Care Act went into effect.

Project goals

1. Identify health education and health care providers in Ohio to discuss birth spacing, intention and family planning.
2. Assess gaps in these capacity-building resources.
3. Create resource to fill these gaps.

Methodology

From February through April 2020, 16 individuals representing 14 organizations were interviewed about their professional experiences delivering information and care about birth spacing, reproductive life planning, and contraception to women of reproductive age in Ohio. The interviews conducted were based on a standard interview guide which was adapted based on the interviewee's role and scope of work.

Interviews represented all regions of Ohio with the exception of the northwest part of the state. We interviewed nurses, doctors and their state professional associations, reproductive health

trainers and administrators, and administrators of a home visiting program. Outreach was targeted to interviewees who would have training knowledge or experience.

One set of questions was for direct-service providers and focused on the interviewee's experience offering family planning education and/or methods, patient-provider conversations about birth spacing, the provider's training on the topic, and recommended training resources.

Another set of questions was for "community partners" – organizations like local and state government agencies, nonprofits, medical associations and academic institutions. One OB-GYN was interviewed for a community-partner perspective, given previous work on birth spacing. Community partner questions focused on perceptions of the strengths and limitations of birth spacing and family planning training resources in Ohio. The interviewers solicited recommendations to improve these tools, and for names of other potent interviewees. See Appendix A for the interview guide.

Interviewees included representatives from the following organizations:

- Buckeye Health Plan
- Cleveland Department of Public Health
- Ohio Association of Community Health Centers
- Ohio Better Birth Outcomes
- Ohio Chapter – American Academy of Pediatrics
- Ohio Chapter – American College of Nurse-Midwives
- Ohio Chapter – American College of Obstetricians and Gynecologists
- Ohio Chapter – Association of Women's Health, Obstetric and Neonatal Nurses
- Ohio Department of Health
- OhioHealth
- Ohio Perinatal Quality Collaborative
- Planned Parenthood of Greater Ohio
- Planned Parenthood of Southwest Ohio
- Preterm
- Summit County Public Health
- University Hospitals

Key findings

Terminology

Most interviewees used the terms "long-acting reversible contraception" or "LARC" and "birth spacing" interchangeably or spoke about LARC immediately when asked about birth spacing. When interviewers probed on the specific nomenclature, one respondent articulated that the terminology "birth spacing" does not resonate with patients or providers in part because they do not agree with it (even some clinical providers choose to have children close together). One former clinician shared that she never used the phrase "birth spacing," except with pregnant

patients, instead preferring to ask about plans to become pregnant. An interviewee from a local public health department noted women in her community do not respond well to "birth spacing" because they don't understand what it means. They also avoid "family planning" because it sounds like financial planning rather than related to one's body and healing. Her organization prefers "reproductive health and wellness." Title X programs use fairly broad framing about "most effective contraception method" and may focus on birth spacing there. Another interviewee noted she prefers "birth spacing" because it is better received by the Muslim community health workers with whom she works.

Example provider activities

Two clinicians were interviewed as a part of the project, one nurse and one OB-GYN. The clinicians were asked about current practices related to birth spacing and contraception and said their hospitals provide same-day LARC insertion. The nurse practices on a floor with high-risk pregnant women where the focus is not on contraception, though birth spacing and contraception information is included in discharge instructions. The OB-GYN's hospital-based practice discusses birth spacing explicitly with patients, framed around mom, baby and the health of future babies.

Provider training and capacity gaps related to birth spacing

When asked about the gaps to increase provider capacity to talk about and support patients with birth spacing, interviewees almost always responded by naming barriers to LARC utilization.

The barriers described fit into the following categories:

1. **Lack of public awareness/knowledge.** A few interviewees mentioned that women have little awareness and understanding of contraception, making it more difficult for providers to tackle these issues efficiently and effectively during appointments because they need to spend a good deal of time correcting myths or providing basic information.
2. **Insufficiently supportive culture**. If clinical leaders and payers (including state and federal governments) have not fully bought into the importance of family planning, birth spacing, and/or contraception, change is slower to occur because it is not a priority in the face of many other urgent clinical issues. There are also some physicians who have not yet bought in to how important and relevant this issue is, and thus are slow to follow updated guidelines and best practices. Family practice clinics were noted to be limited, as compared to hospitals, by the cost of stocking contraceptive methods. These clinics often have limited supplies on hand. One interviewee pointed out the need to make birth spacing as central to the conversation as safe sleep has become, where it is embedded in every prenatal and infant visit.
3. **Workflow challenges.** Respondents noted it is difficult to integrate reproductive health counseling and services into the clinical workflow. This can be due to the topic's low prioritization by the clinic/hospital and/or payer. This can provide funding challenges as well a lack of leadership on the topic, the lack of an internal champion to push for change, and/or knowledge gaps within a practice about how to schedule and bill for services (particularly for same-day LARC insertion, which requires top-to-bottom cooperation to

be successful). Even for enthusiastic and committed providers, incomplete workflow changes may stand in the way of full implementation.

4. **Skill and comfort challenges**. Some interviewees noted that providers may have insufficient skill and comfort with contraceptive method insertions or with counseling patients about reproductive health. One of the clinician interviewees noted that family practice physicians are insufficiently trained in IUD insertion. Another interviewee noted that the lack of tools/training to help providers deliver culturally competent reproductive health care as another specific barrier.

Special populations

The interviewers did not ask about specific populations of patients, but the interviewees noted certain patient populations that may need further consideration in terms of the strategies used to promote safe spacing:

1. **Adolescents.** Interviewees with experience treating adolescents recommended that birth spacing be integrated in pediatric practices and that those practices place LARC methods. Interviewees also suggested messaging to parents regarding contraception services early, and in advance of need. It was recognized by many interviewees that reproductive health education must come earlier – many young women do not know the basics about their bodies, reproductive health system, and basic biology.
2. **Patients covered by Medicare**. Medicare will not cover LARC methods, yet providers may have high-risk patients who are covered by Medicare due to other conditions.
3. **Women who do not use hormonal contraception.** Whether for cultural, religious, health or other reasons, for women who do not use hormonal contraception, birth-spacing messages can open the door to preconception health for them and organizations that serve them.

Existing capacity-building tools and trainings

Interviewees named a number of existing resources for providers related to birth spacing, LARC, and reproductive health. These resources varied in terms of the type and format, from in-person trainers to online modules and websites. It was noted that there are many experts in Ohio; one interviewee expressed disappointment when outside organizations are brought to Ohio (and then seek out Ohio experts to help translate their messages).

1. American Academy of Pediatrics national and state training resources
2. American College of Obstetricians and Gynecologists
3. Area Health Education Center at Ohio University
4. Bedsider.org
5. Cicatelli Associates, Inc. (CAI) training
6. Columbus Public Health Title X Clinical Training Center
7. Annual Contraceptive Technology conference
8. Family Planning National Training Center, the national technical assistance grantee for the Title X program
9. Healthy Start

10. IMPLICIT Toolkit
11. Infant mortality initiatives in Ohio, including Celebrate One, Cradle Cincinnati and First Year Cleveland
12. Merck's Nexplanon insertion training
13. OACHC Client-Centered Contraceptive Care Change Package
14. Ohio Department of Health Title X toolkit for CHWs and referrals
15. One Key Question®
16. Partners for a Healthy Baby curriculum from Florida State University
17. Patty Cason with Envision SRH
18. Planned Parenthood's contraceptive method quiz
19. SisterSong Birth Justice work
20. The University of Michigan's Adolescent Health Initiative Spark training on adolescent sexual health

Both of the clinician interviewees noted they became trained and familiar with these topics through professional career training (i.e., they did not seek out separate training on birth spacing or contraception).

One non-clinical interviewee noted that overall, positive changes have occurred in recent years. The interviewee noted organizations have prioritized discussions about reproductive life planning during, and immediately following, pregnancy such as offering LARC insertion at delivery and embedding questions about it into the prenatal electronic health record in some places.

One consistent finding related to how best to deliver training was that it is difficult for clinicians to take time away from patient care for long in-person training, so they prefer and are more likely to attend virtual training. In addition, one interviewee who works with numerous clinicians notes trainings must include concrete tools that can be used in their practices, alongside clear implementation guides for workflow and process changes. These should include roles and expectations for the many staff needed for institutional change to occur. This was echoed by another interviewee who developed a LARC provider change package previously.

The importance of follow up for trainees who take part in any training was emphasized.

Opportunities

Interviewees offered a number of suggestions and comments that point to training and capacity-building opportunities. In some cases, these were explicit suggestions and in others, these were based on the above-listed findings and other interviewee statements.

1. Fully train and engage non-physicians to counsel patients and deliver services. Four interviewees specifically named community health workers as a potential group to support this care, given their trusted position among diverse groups of women, interest, work in women's health and non-clinical work environment. Home visitors and lactation consultants were also identified as important resources for women. Finally, a few interviewees noted that nurse practitioners are already working with women (it is

assumed they are doing reproductive health work), are receptive to training and could benefit from targeted training opportunities.

2. Offer whole office training opportunities. While an individual provider may have been trained in LARC insertions, other clinic staff need to be trained in their own roles, specific to improving clinical workflow to make the service successful. This includes billing and scheduling patients correctly for LARC methods. The goal is to help clinical practices make this easy, and financially viable so they are more likely to do it.
3. Ensure that other physicians who see women of reproductive age are trained and supported to deliver this care, including pediatricians and family physicians.
4. Create and deliver culturally competent trainings on birth spacing and/or contraception, tailored to the audience.
5. Support and cultivate champions. While this isn't a training topic per se, a number of interviewees referenced the importance of internal champions for driving system and individual-level change.
6. Explore common features of existing champions around the state and bring them together to share best practices and support upcoming champions as a way to create sustainable change.
7. Create an online repository for existing resources on this topic. As demonstrated above, there are many local, state and national tools, some of which are free and open to the public. It may be helpful to categorize and link to them with information on how to access paid and proprietary products.

Four other ideas came out of the interviews that don't directly relate to training but do relate to awareness of, access to, and utilization of contraception:

1. **Public education campaigns**. Interviewees noted the need for public education on both contraception and birth spacing and said some are already conducting or planning local awareness and media campaigns on these issues.
2. **Advocacy** related to LARC costs specifically and reimbursement to maximize affordability for both providers and patients.
3. **Partnerships with public health** (local health districts, or LHDs). It was noted that consumers don't always associate health departments with reproductive health services– consumers have other ideas of what LHDs do. This presents an opportunity for outreach. It was also noted that if FQHCs worked with LHDs it could solve some same-day LARC barriers.
4. **Support from the state** Several interviewees suggested that the State of Ohio could raise awareness among provider groups (e.g., pediatricians) regarding their potential role in maternal health, and require birth spacing and reproductive health training for others (e.g., home visitors). It was also noted that Planned Parenthood has a contraceptive method quiz that is a useful tool and having a state version would be helpful. Consistent data collection across the state to inform gaps and strategies was also requested; one interviewee suggested adding LARC insertion to birth certificate data.

Conclusion

The results of the interview phase indicate a number of opportunities for innovation, knowledge sharing and resource development that could increase birth spacing awareness and LARC use in Ohio and ultimately, support the health of women and infants in the state. An immediate next step is for Community Solutions to update OCPIM's initial training tool in light of the interview findings and share the new tool broadly. The authors encourage all readers with an interest in improving women's health to review these findings and consider creative strategies for supporting this shared mission moving forward.

APPENDIX A: Interview Guide

SECTION 1: INTRODUCTION AND CONSENT

I want to thank you for taking the time to speak with me today. I would like to talk to you about provider training and capacity as it relates to birth spacing in Ohio. We understand you have experience training providers and your perspective is really valuable as the field determines additional capacity needs.

This interview is part of a series of in-depth interviews I am conducting on behalf of the March of Dimes to inform its work on birth spacing in Ohio.

The interview should take 30 minutes.

If you provide consent, I will be recording this call because I don't want to miss any of your comments. Is that OK?

Your interview responses will only be shared with research team members and we will ensure that any information we include in our report does not identify you as the respondent.

Are there any questions about what I have just explained? Are you willing to participate in this interview?

SECTION 2: ROLE

1. Are you a practicing clinician?
2. If NO, proceed to Section 3.
3. If YES, proceed to Section 4.

SECTION 3: COMMUNITY PARTNER

1. What is your role when it comes to training and capacity-building tools around birth spacing?
    a. What provider population(s) have you worked with?
2. What has been the nature of the training/tools you've seen?
    a. Has birth spacing been covered explicitly? (Probe further as needed)

3. Where do you believe the biggest gaps lies in terms of increasing capacity for providers to talk about and support patients with birth spacing?
    a. Examples, if needed: Is it a training issue? Awareness? Desire? Cost?
    b. At what levels? (patient, provider, community)
4. Where do you see strengths in existing capacity-building training and tools?
5. What recommendations do you have?
6. Who else should we talk to?
    a. If needed, can we follow up for contact information?

SECTION 4: DIRECT SERVICE PROVIDER

1. What is the nature of your interaction with women of reproductive age?
2. Is family planning education offered and/or methods?
    a. If LARC, are you able to accommodate same day placements for patients who request it?
3. Is birth spacing routinely discussed in your practice/program?
    a. Is the language 'birth spacing' used or something different.
        i. If different, what language is used?
4. How familiar are your patients/clients with birth spacing and family planning prior to receiving services? (very familiar, somewhat familiar, not familiar)
5. How did you/your facility/program become trained in family planning and birth spacing?
    a. If a LARC provider, how were you trained in placements? Billing? Clinic flow and scheduling?
6. If a colleague wanted to learn about birth spacing and/or family planning, what training resources would you recommend?
7. Have you heard of the family planning curriculum developed by the Government Resource Center at OSU in 2018 for clinical providers in the State of Ohio?
8. Do you or your program/practice face any challenges in delivering family planning education or services?

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