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Department of Social and Health Services – Alice Huber
Health Care Authority – Anaya Balter
Office of Superintendent of Public Instruction – Laurie Dils

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Valerie Tarico and Katherine Harkins – Families2030
Heather Maisen – Public Health - Seattle and King County Family Planning Program
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List of Acronyms

ACA – Affordable Care Act
ACH – Accountable Community of Health
ACOG – American College of Obstetricians and Gynecologists
ASTHO - The Association of State and Territorial Health Officials
CDC – Centers for Disease Control and Prevention
CME/CNE – Continuing Medical or Nursing Education
CMS – Center for Medicare and Medicaid Services
DOC – Department of Corrections
DOH – Department of Health
DSHS – Department of Social and Health Services
EOB – Explanation of Benefits
F2030 – Families 2030
FQHC – Federally Qualified Health Center
HCA – Health Care Authority
HIV – Human Immunodeficiency Virus
HPV – Human Papillomavirus
IUD – Intrauterine Device
LBW – Low Birth Weight
OSPI – Office of Superintendent of Public Instruction
PREP – Personal Responsibility Education Program
RCW – Revised Code of Washington
STI/STD – Sexually Transmitted Infection/Disease
Title X – Federal family planning grant through Office of Population Affairs
Executive Summary

Approximately 36% of pregnancies in Washington State are unintended. Such births are cases where the mother of the child reported conception when there was no desire for (more) children or that her pregnancy had occurred earlier than anticipated. Because resources and services such as affordable health insurance, quality reproductive care, and contraceptives are not equally accessible to everyone statewide, pregnancy intention and planning can be a complicated issue. For example, unintended pregnancies disproportionately affect women of color as well as those who have lower education levels or a lesser income. Research shows that unintended pregnancies result in children that are more likely to experience health concerns over the course of their lives.

In an effort to discuss what it would take to better address unplanned births in Washington, the Department of Health (DOH) led a multi-agency effort during the spring and summer of 2016 to review current programs that work to address obstacles preventing families from having the necessary information to make informed family planning decisions. Collectively, DOH, Health Care Authority (HCA), Department of Social and Health Services (DSHS), Office of Superintendent of Public Instruction (OSPI), and Department of Corrections (DOC) attended and actively participated in a workgroup to analyze their approach and develop new strategies for future efforts to improve their overall impact on unintended pregnancy. The following report examines how those strategies will help to reduce unplanned births, ensure that more children have a healthy start, and arrange for all families to have the best chance possible for success. As a result of implementing new efforts, the hope is that the unintended pregnancy rate will decrease by 10% over the next five years.

The following account includes an overview of programs such as the federal Title X family planning grant administered by DOH and the Medicaid 1115 family planning only demonstration waiver, known as Take Charge, administered by the Health Care Authority.

Members of the workgroup propose a comprehensive set of potential strategies that offer the best chance of long-term success. Some strategies include:

- Increase availability of LARC (long acting reversible contraceptives)
- Provider training on LARC
- Increase access to LARC for incarcerated women transitioning back to the community
- Family planning screening
- Family Planning Only program for undocumented
- Implementation of the Safe Deliveries Road Map
- Registered Nurse family visit reimbursement
- Personal Responsibility Education Program
- Public awareness campaign for young adults

Each proposed future strategy outlines the cost and terms necessary for implementation, and highlights which agency would take responsibility if that process is not already underway. The aspirational strategies listed in Appendix 5 are less likely to be accomplished within our timeframe.

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There is no way to determine whether an unintended pregnancy will result in a wanted birth. This is a sensitive, deeply personal subject. The impact of an unintended pregnancy extends beyond whether pregnancy and the birth is wanted or not. An unintended pregnancy can exacerbate circumstances that may already be causing stress for an individual or family. Part of unintended pregnancy prevention is making sure that men and women, regardless of their desire to be parents, actively attend to their sexual and reproductive health. Reducing the unintended pregnancy rate could assist in improving graduation rates, earning potential, and family stability⁴ among Washington residents.

Purpose

The following collaborative research analyzes current strategies within and outside of Washington State, offering a cross examination of efforts to reduce unintended pregnancy. The outline will list national best practices and compare them with strategies currently implemented across state agencies in Washington to better locate gaps where we could improve upon and expand our reach with regard to family planning.

Goal: Reduce the percent of pregnancies that are unintended from a projected rate of 36% in 2013 to 32.4% by 2022.

For more information on unintended pregnancy, research methods, and project limitations, see Appendix 1.

For a more detailed background of the project see Appendix 2.

Issue

Washington State has an unintended pregnancy rate of approximately 36%. Research shows that children born from unintended pregnancies are more likely to experience health issues over the course of their lives. Consequently, the potential for impact on the child, family, and community is increased. The subject of unintended pregnancy complicates further as studies show that access to family planning information is not equal for all Washington State residents. Access to affordable health insurance, quality reproductive care, and contraceptives are some of the problem areas identified. For example, it is not known if all primary care providers practicing in the state have up to date information on all contraceptive methods and the latest counseling techniques to properly support their clients in finding a birth control method that works best for them and their family planning needs. Preventing unintended pregnancies can mean a healthier mom and child and contribute to more opportunity for the family as a whole.

- Studies show that unintended, mistimed and unwanted pregnancies are associated with low birth weight (LBW) and pre-term births. LBW and premature babies are at risk for a host of life threatening and chronic health conditions.
- Thirty percent of young women who drop out of school cite parenthood and pregnancy as a contributing factor. All of these pregnancies may not be unintended which makes this a complicated topic. Children of teen moms are also more likely to drop out of school.
- Less than 2% of teen mothers finish college by the time they reach 30 years of age.
- Unintended pregnancy may contribute to household stress.

For more information on unintended pregnancy and case-specific considerations see Appendix 3.

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7 http://www.marchofdimes.org/baby/low-birthweight.aspx
9 http://www.marchofdimes.org/baby/low-birthweight.aspx
11 Ibid
Preventing Unintended Pregnancy - Success in Other States

Other states have successful programs that decrease unintended pregnancy. These states use strategies such as:

- Train providers to counsel clients about effective contraception
- Train providers to insert/remove contraceptive IUDs and implants
- Offer clients access to free or very low cost IUDs and implants

Educate policy makers and work to move policy that increases women’s access to contraception and reproductive health care.

**Colorado:** The Colorado Family Planning Initiative received $23 million from a private donor in 2009 to support a four-year initiative. The initiative used the funds to address barriers to LARC by 1) training providers and 2) financing LARC at their Title X clinics. By 2011, Colorado increased LARC use among 15-24 year olds from 5% to 19% and saved an estimated $42.5 million in public funds in 2010 as a result of this program.\(^{13}\) This effort is attributed to a 40 percent decrease in teen birth rates.\(^{14}\)

**Iowa:** Iowa increased access to LARC through Title X clinics to reduce unintended pregnancies and repeat abortions among women ages 18 to 30.\(^{15}\) Between 2007 and 2010, this privately funded initiative decreased unintended pregnancies by 5% and abortions by 19%.\(^{16}\)

**Delaware:** Effective April 2016, inspired by Colorado’s results, Delaware formed a public/private partnership with a non-profit, contraceptive training partner, Upstream, and others to provide low or no cost LARC to 200,000 women.\(^{17}\) Upstream will train providers how to insert and IUDs and implants. Private and public monies will fund this effort to increase women’s access to a full range of contraceptive methods.

The American College of Obstetricians and Gynecologists (ACOG) in their 2015 committee opinion\(^{18}\) supports the approaches discussed above. They recommend obstetricians and gynecologists counsel patients on all birth control methods, specifically LARC to increase access and use of implants and intrauterine devices (IUD). The opinion encourages that LARC be considered by all appropriate patients, including teens. Another suggestion made includes the implementation of best practices for LARC insertion. Additionally, the ACOG committee opinion advocates for payment and reimbursement for all birth control methods, and proposes that providers become familiar with local, state, and federal programs that improve affordability of such methods. The Association of State and Territorial Health Officials (ASTHO) supports increased access to quality, comprehensive reproductive services as a means

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\(^{16}\) Ibid.

\(^{17}\) [http://www.upstream.org/delaware/](http://www.upstream.org/delaware/)

\(^{18}\) Increasing access to contraceptive implants and intrauterine devices to reduce unintended pregnancy. Committee Opinion No. 642. American College of Obstetricians and Gynecologists 2015; 126 e 44-8
of improving birth outcomes.\textsuperscript{19} The Centers for Disease Control and Prevention supports payer interventions to increase access to LARC.\textsuperscript{20} It is important that Washington State consider the above information when making decisions on how best to address unintended pregnancy going forward.

**Current Activities to Address Unintended Pregnancy**

Most of the state agencies involved in writing this document have activities, programs, or policies currently in place that contribute toward decreasing unintended pregnancy. We are including brief descriptions of specific program work with the most influence at some of the participating agencies. The following information is organized alphabetically by agency. (For activities implemented by other programs see Appendix 4.)

**Department of Health**

**Title X Family Planning**

**Need Addressed**

The U.S. Department of Health and Human Services’ Office of Population Affairs (OPA) oversees the Title X program. For more than 40 years, Title X family planning centers have provided high quality and cost-effective family planning and related preventive health services for low-income women and men. Title X assists individuals and couples in planning and spacing births, contributing to positive birth outcomes and improved health for women and infants. Family planning centers play a critical role in ensuring access to family planning information and services for their clients regardless of their ability to pay.\textsuperscript{21}

Title X staff is trained to meet the contraceptive needs of individuals with limited English proficiency, teenagers, and those confronting complex medical and personal issues such as substance use disorder, disability, homelessness or interpersonal and domestic violence.\textsuperscript{22}

Publicly funded family planning services are usually not limited to only providing contraceptives. Publicly funded family planning, which includes contraceptive care, testing for sexually transmitted diseases/infections (STI/STD), pap tests and human papilloma virus vaccines, results in a return of $7.09 for every $1 invested.\textsuperscript{23}

**Population Focus**

The program prioritizes serving low income women and men, including teens, per federal requirements.

**Description of Strategy**

The Department of Health is the Washington State Title X Family Planning Grantee. We provide access to disease screening, preventive exams, contraceptive services and supplies, information on family planning and sexual health, and much more. We serve everyone in Washington who wants and needs family planning services, with priority for low-income individuals and families.

\textsuperscript{19}http://astho.org/Policy-and-Position-Statements/Position-Statement-on-Reproductive-Health/

\textsuperscript{20} http://www.cdc.gov/sixeighteen/pregnancy/index.htm

\textsuperscript{21} http://www.hhs.gov/opa/title-x-family-planning/index.html

\textsuperscript{22} Ibid

The Family Planning Program funds 13 family planning agencies with 71 clinic sites throughout Washington. Our family planning services include access to affordable contraception, including LARC, which are among the most effective means of preventing unintended pregnancies.

Whether a woman is pregnant or not, complete preventive health care for women includes regular breast exams and pap tests. Women and men may also need and receive testing, treatment or counseling for sexually transmitted diseases.

Our family planning services include pregnancy testing, counseling before and after conception and postpartum contraception to ensure healthy spacing between children. Women who receive our services are better able to decide when the time is right to start, or expand, a family. The agencies that contract with our program averted an estimated 13,409 unintended pregnancies in 2015. Of these unintended pregnancies, 3,495 would have occurred among women or girls age 19 or younger. All these unintended pregnancies would have led to an estimated 5,788 births and 1,749 miscarriages. Roughly 40% percent of unintended pregnancies end in abortion. Averting these unintended pregnancies also prevented an estimated 5,872 abortions.

**Measures of Success**
In 2016-2017 we will require all of our funded sites to track the measures:

- Pregnancy intention (want to become a parent, don’t want to become a parent, unsure, OK either way).
- Clients primary birth control method before and after the visit to identify if she moved to a more effective method (Example: on oral contraceptives at beginning and had an IUD/implant at end of visit).

Each site also tracks measures related to the unique needs/characteristics of the populations they serve, geographic region they are located in and program specialties.

**Adolescent Health Program**

**Need Addressed**
Fifteen counties in Washington State have been identified with significantly higher than average rates of adolescent pregnancy. The school districts in those counties are less likely to offer comprehensive sexual health education, a proven intervention that reduces the rates of teen pregnancy. Teens who are already pregnant or parenting are at particularly high risk for rapid repeat pregnancy.

**Population Focus**
The State Adolescent Health program is focusing efforts in 15 counties with highest rates of teen pregnancy, STDs and poverty. The 15 counties are (with first being the highest): Yakima, Franklin, Adams, Okanogan, Grant, Asotin, Ferry, Lewis, Mason, Grays Harbor, Walla Walla, Cowlitz, Skagit, Clallam and Pierce.

**Description of Strategy/Program Elements**
The following three programs are the focus of this work in these counties.

**Personal Responsibility Education Program (PREP)** is an evidence based sexual health education program. Its curricula are implemented in schools, juvenile detention centers and community based organizations such as Boys and Girls Clubs. Selected curricula must have evidence showing efficacy.
The *Enlace Project* supports pregnant and parenting teens with a focus on Latina/o communities with high teen pregnancy and poverty rates. Adolescent parents are offered parenting support as well as evidence based interventions shown to decrease rapid repeat pregnancy. Additionally, programming is implemented to reduce domestic violence, sexual assault and reproductive coercion.

**Sexual Health Curriculum Reviews** have adolescent health staff participating in sexual health curriculum reviews coordinated by the State Office of Superintendent of Public Instruction to ensure sexual health education curricula meet the criteria for comprehensive sexual health education included in the Healthy Youth Act of 2007. Comprehensive sexual health education is shown to delay the initiation of sexual intercourse and decrease both adolescent pregnancy and STD rates.

**Measures of Success**

**PREP**
Performance measures established at the federal level by Health and Human Services include:
- The number of youth served and hours of service delivery.
- Fidelity to the program model or adaptation of the program model for the target population.
- Community partnerships and competence in working with the target population.
- Reported gains in knowledge, changes in behavioral intentions and changes in self-reported behaviors of participants.
- Community data, including birth rates and the incidence of STI.

**Enlace** - portion of federal measures included below
- Total number of expectant teens (19 and younger) who are enrolled in school to track high school graduation rates among pregnant teens.
- Number of expectant and parenting teens that have graduated high school or passed the GED during the program year.
- Number of expectant and parenting teens that dropped out of high school during the program year.
- Number of parenting participants 19 years and younger who reported a new pregnancy during program year.
- Number of public awareness or education strategies that were implemented by the program during the reporting period.
- Number of expectant and parenting teens that received parenting skills training/information.

**Health Care Authority**

**Family Planning**
The Health Care Authority administers Medicaid, which fully covers family planning services through Apple Health, and two family planning only programs. HCA’s family planning coverage contributes to reducing unintended pregnancies in Washington and lowering overall expenditures for Medicaid paid births.

Goals of current strategies used by HCA:
- Access to health care coverage for those who do not have access to insurance coverage, especially those who are low income and cannot afford to purchase health insurance.
- Ensure access to reproductive health services including family planning services to those who have Apple Health as their health coverage.
• Reduce barriers to obtaining family planning services by increasing access points where contraception can be obtained.
• Reduce barriers to obtaining family planning services by incentivizing providers to offer LARC.

Population Focus
1. Those enrolled in Apple Health.
2. Specific populations that are at risk for lack of access to needed family planning services
   • Low income uninsured women and men
   • Minors and domestic violence victims who require confidentiality to obtain contraception and STI/STD services.
   • Undocumented persons

Description of Strategies
• Full Coverage of Family Planning, Family Planning Related and other Reproductive Health Services
  o All Apple Health enrollees (fee for service and managed care) are covered for the following services:
    ▪ All FDA-approved forms of contraception, including natural family planning and sterilization
    ▪ Screening, diagnosis and treatment for cancers in reproductive organs (e.g. cervical, uterine, ovarian cancers)
    ▪ Screening, diagnosis and treatment of STI/STD
    ▪ Over the counter (OTC) access (written prescription not needed) for condoms, spermicides, and emergency contraception (EC)
• Two special programs to extend family planning services to three populations not covered by Apple Health. These programs have a limited benefit package covering all FDA-approved contraception and natural family planning, sterilization, limited STI testing and treatment and cervical cancer screening.
  o Take Charge (started 2001) – Women and men who are uninsured up to 260% Federal Poverty Level (FPL) and not eligible for Apple Health. Minors and domestic violence victims who are insured may enroll if due to “good cause” they require confidentiality. Undocumented persons are not eligible.
  o Family Planning Only (started 1993) – Women who are enrolled in Pregnancy Medical continue on Family Planning only until 12 months after the delivery. There are two eligibility groups:
    ▪ Citizens and lawful residents – federal/state funding
    ▪ Women who are undocumented – state funded only
• Pharmacists receive a counseling fee when they prescribe and dispense emergency contraception.
• Enhanced reimbursement for specific family planning services and programs:
  o Family planning clinics who participate in the 340B program receive a dispensing fee for each pack of pills, patches, and rings that are dispensed from their clinic, regardless of the number of packs dispensed at one time (implemented January 2007). Pharmacies are paid a smaller dispensing fee for each dispense, not for each pack.

24 https://www.hrsa.gov/opa/ The 340 b program allows manufacturers participating in Medicaid to provide outpatient drugs at reduced priced to eligible, covered health care organizations.
• Take Charge providers receive preventive visit reimbursement for a family planning preventive visit. Other providers are paid at the regular Evaluation and Management (clinic visit) rates for the same service (implemented November 2006).
• All providers receive an additional $299 for the insertion of a LARC - either IUD or implant (implemented September 2015).

- Family planning clinics and pharmacists are required to dispense a one year supply for oral, transdermal and intravaginal hormonal contraceptives unless the client does not want that much, there is a clinical reason for the prescription to be less than a year or there is not enough in stock for one year. All providers are encouraged to write pill, patch and ring prescriptions for a one year supply (implemented January 2014).
- Immediate postpartum LARC insertion is covered. Billing and system changes were instituted so that this service is reimbursed in addition to other reimbursable services (implemented September 2015).
• For categorically needy women who are eligible for both Medicare and Medicaid, Apple Health covers services not covered by Medicare including LARCs and sterilization. Some women do not qualify for dual eligibility and they must meet a spenddown before getting these services. Medicare Part D may cover prescription contraception – oral, transdermal or intravaginal hormonal contraception depending on the plan the client is enrolled in.

Measures of Success
HCA received a grant from Center for Medicare and Medicaid Services (CMS) through the Center for Medicaid Children’s Health Insurance Program (CHIP) Services Maternal and Infant Health Initiative to participate in the development of a Contraceptive Quality Measure. This grant runs from September 2015- June 2017. The performance measure has two parts - all women and postpartum women. There is also a measure to look at access to LARC. These measures could be used in the future to evaluate statewide efforts at providing reliable contraception. Information on the specifications of the measures and how they are to be used is available here: https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/maternal-and-infant-health/index.html

DSHS’s Research and Data Analysis (RDA) division assists HCA with evaluations of the Take Charge program which has proven to be very successful25. RDA is also assisting HCA in developing utilization reports to track contraceptive utilization by Apple Health/Medicaid clients.

Office of Superintendent of Public Instruction

Exemplary Sexual Health Education (ESHE) Need Addressed
According to the 2016 Healthy Youth Survey26, half of all Washington 12th graders have had sexual intercourse. Almost a quarter reported not using a condom during last sexual intercourse and 13% had had 4 or more partners during their lifetime. Students who reported having had sex also reported higher rates of depression and alcohol use, both of which may decrease teens’ ability to use effective pregnancy prevention strategies. The unintended pregnancy rate among teens who are sexually active is

more than twice the rate among all women. While about 72% of 10th graders reported receiving instruction on abstinence and “other ways” to prevent pregnancy, fewer than half of 12th graders received such instruction during the year they reported the highest level of sexual activity.

Washington State schools are required to provide HIV prevention education, but more comprehensive sexuality education is voluntary and varies considerably between districts. It is most commonly provided only during a required 9th or 10th grade health class. Schools that completed the School Health Profiles Survey in 2014 reported using a wide array of curricula, including a handful that are inconsistent with requirements of the 2007 Healthy Youth Act. This legislation requires that information be medically and scientifically accurate, appropriate for all students and include information about both abstinence and other methods of preventing pregnancy and sexually transmitted diseases.

Population Focus
ESHE focuses on all Washington public schools including students in grades K-12, teachers, school nurses and administrators.

Description of Strategy
This strategy recommends the promotion of Exemplary Sexual Health Education in Washington schools, for students grade K-12. ESHE, as defined by the Centers for Disease Control and Prevention, is a system-wide, evidence-based approach to sexual health education that spans multiple grades. It ensures that youth receive information and skills to avoid HIV, STDs and unintended pregnancy and trains and supports teachers to ensure that education is accurate and appropriate for students. New student learning standards approved by the Office of Superintendent of Public Instruction in March, 2016 include a comprehensive set of K-12 outcomes related to sexual health. Increasing the number of schools that provide exemplary sexual health education would help prevent unintended pregnancy among teens. There is much evidence showing a reduction in sexual risk-taking behavior among young people exposed to comprehensive sexual health education including young people delaying the first time they have sex, decreasing the number of sexual partners, decreasing the number of times they have unprotected sex and increasing condom use.

Measures of Success
• Increase the number of schools reporting the use of a medically and scientifically accurate, comprehensive sexual health education curriculum.
• Increase the number of students receiving comprehensive sexual health education.

Proposed Future Strategies to Decrease Unintended Pregnancy

Implementing a comprehensive set of strategies creates the best chance of long-term success.

- Increase availability of LARC, page 12
- Provider training on LARC, page 14
- Increase access to LARC for incarcerated women transitioning back to the community, page 16
- Family planning screening, page 18
- Safe Deliveries Road Map, page 20
- Personal Responsibility Education Program, page 21
- Public awareness campaign for young adults, page 23

Increase access to free and low cost long-acting reversible contraception (LARC)

Need Addressed
LARC methods are recommended as first-line contraception for women of all ages, including adolescents.32 National data show that LARC methods, like intrauterine devices and implants, are currently the most effective forms of birth control. Less than 1 percent of women become pregnant using these methods.

LARC methods are far more effective than shorter-acting methods like pills.33 Reported failure rates were 4.55% for pills, patch, and ring and 0.27 percent for LARC users.34 LARC methods typically last three to five years: however, some can last up to ten years. Thus, these methods can also improve the health of newborns and mothers by aiding healthy spacing between pregnancies.

The upfront cost of LARC methods ($500 to $1000 for the device and insertion) often prevent uninsured, low-income and undocumented women from accessing it. Women who can’t afford healthcare insurance or don’t have a job that includes healthcare insurance coverage are less able to pay for a LARC procedure. These women may choose a less effective method that works for their budget or may not use contraception at all.

Population Focus
It is important to increase access to LARC among women who want it and cannot afford it. This can improve parity between low-income women and their higher income, insured peers. This includes women of reproductive age who are ineligible for Apple Health/Medicaid because they have incomes just above the threshold of eligibility or are undocumented.

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Description of Strategy
This strategy will provide funding to Title X family planning providers to cover the higher cost of providing LARC services for clients who want this form of birth control, but can’t afford to pay for it out of pocket. Family planning providers will either be reimbursed or allocated funds for LARC procedures.

DOH will implement should funding become available, costs include:

<table>
<thead>
<tr>
<th>Program Elements</th>
<th>Cost Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>IUD insertion (Skyla, Mirena, Paragard or Liletta) at 3, 5, 10 years respectively or Nexplanon Implant at 3 years</td>
<td>$600 – $775 (Liletta is $50 at 340B* pricing, $500 w/o 340B)35</td>
</tr>
<tr>
<td>Insertion fee or removal fee</td>
<td>$350 (aligned with Medicaid)</td>
</tr>
<tr>
<td>Visit fee</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Total per client cost (3 – 10 years contraceptive coverage)</strong></td>
<td><strong>$500 – $1,225</strong></td>
</tr>
<tr>
<td><strong>Total cost for additional 6,250 clients</strong></td>
<td><strong>$3,125,000</strong></td>
</tr>
</tbody>
</table>

Return on Investment
The public investment in family planning programs helps women and couples avoid unintended pregnancy and abortion and helps many avoid preterm and low birth weight births. Nationally, for every $1 invested in publicly funded contraception and family planning services, just over $4 are saved in Medicaid costs the following year for birth related costs women whose unintended pregnancies were prevented.36 LARC is the most effective contraception to help women plan and space their pregnancies. Providing 6,250 eligible women per year with LARC would decrease unintended pregnancies by 10 percent by 2020.

Measures of Success
- Provide 6,250 women in Department of Health funded family planning agencies with a LARC by June 2017.
- An increase in LARC use will reduce unintended pregnancies, unintended births and abortions among women accessing the Title X Project.37

Summary Points
- LARC can better ensure planned pregnancies and healthy spacing between pregnancies.
- Many women don’t want more than two children; which means they will need birth control for most of their reproductive life.38 The upfront cost of LARC compared to the long-term cost of a less effective method every month (pill, patch or ring) is more cost-effective over time.39

35 The 340B Drug Pricing Program requires drug manufacturers to provide outpatient drugs to eligible healthcare organizations/covered entities at significantly reduced prices.
37 DOH Family Planning Program, LARC compared to use of contraceptive pill, patch or ring estimates for 6,250 women, Developed July 2015.
39 The cost of the pill varies greatly without insurance ($10-$50 per month), patch and ring are about $50 a month without insurance or Medicaid, or $600 per year x 3-5 years to compare with intrauterine device and implant is $1800-$3000. http://bedsider.org/en/methods. Accessed September 2015
The American College of Gynecologists (ACOG) and American Academy of Pediatrics (AAP) recommend LARC as first line birth control and safe for women of all ages including teens.\textsuperscript{40, 41}

LARC methods don’t prevent sexually transmitted infections (STIs) including the human papilloma virus (HPV), which can cause cervical cancer. Young women who haven’t started or finished the HPV vaccine series should talk with their doctor about completing the series to prevent cervical cancer.\textsuperscript{42}

The Centers for Disease Control and Prevention (CDC) and the ACOG recommend that healthcare providers continue to screen teen clients for STIs and counsel clients on the use of condoms.\textsuperscript{43}

**Provider training on LARC**

**Need Addressed**

It is unclear how many women are aware of the options, effectiveness and benefits of long-acting reversible contraceptive (LARC) methods. Improving provider knowledge about LARC, and increasing providers’ self-efficacy in the insertion and removal of devices, may help increase the number of women receiving information about LARC during methods counseling. A recent *Lancet* study showed that training providers how to insert IUDs and counsel patients about the effectiveness and side effects of the device can lead to an increase in those providers discussing LARC with patients over providers in a control group. As a result, more patients chose this more effective method than patients in the control group.\textsuperscript{44}

There are two goals (1) increase provider knowledge about this method in order to properly introduce it while counseling a client about birth control options and (2) instruct provider technique to insert and remove the device(s) properly. Ultimately, women must have access to information about all methods of birth control to choose a method based on her needs to plan and space pregnancies. Improving provider information and efficacy with regard to LARC ensures women access to their preferred method among all birth control methods.

Washington currently provides similar training for post-partum insertion of LARC. This training builds on an existing post-partum LARC insertion training that providers can register for on the clinical training provider, Cardea Services, site directly. Clinical providers, registered nurses, counselors, and administrative staff who work in either prenatal care or labor and delivery settings learn best practices for insertion and managing complications for post-partum LARC insertion. This strategy also expands access to training that is currently available through the North Sound Accountable Community of Health, noted on page 16. We want to ensure access to as many providers as possible throughout Washington.

**Population Focus**

The focus for this strategy includes all primary care providers interested in providing LARC. The target population for this on-line training includes healthcare providers that serve uninsured and underinsured

\begin{itemize}
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women of childbearing age. Staff responsible for scheduling appointments, stocking supply and billing will also be trained for all aspects of LARC related services.

**Description of Strategy**

**Option 1:** Cardea Services is used as an example for this strategy. Cardea Services will develop two eLearning courses:

1. Introduction to LARC for physicians and mid-level providers that includes an overview of LARC, comparison to other methods, benefits, possible side effects/risk of use and counseling scenarios; and
2. Building systems and supports for LARC for providers and staff, including stocking, scheduling, obtaining reimbursement (third-party payers, manufacturer assistance programs, coding), etc.

**Option 2:** In-person training can be provided by a number of training vendors with similar curriculum described above in the video training option. All trainers and materials (including biologic models) are included in the training.

The Department of Health will promote the courses 1 and 2 through provider listservs and state medical associations. The training videos will be hosted on the Cardea site and providers will be able to earn continuing medical/nursing education (CME/CNE) credit for completing the training.

**DOH will implement should funding become available, costs include:**

<table>
<thead>
<tr>
<th>Program Elements</th>
<th>Cost Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Video training</strong></td>
<td></td>
</tr>
<tr>
<td>• 60 minute provider training video</td>
<td>$15,000 - $20,000</td>
</tr>
<tr>
<td>• 30 minute systems and supports video</td>
<td>$10,000</td>
</tr>
<tr>
<td><strong>Total Video training</strong></td>
<td>$25,000 - $30,000</td>
</tr>
<tr>
<td><strong>In-person training</strong></td>
<td></td>
</tr>
<tr>
<td>• In-person training provided to clinical and office staff of 12 FQHCs at approximately $80,000 per providers office</td>
<td>$956,675</td>
</tr>
<tr>
<td>• .5 FTE to schedule trainings and provide follow up</td>
<td>$43,325</td>
</tr>
<tr>
<td><strong>Total In-Person training</strong></td>
<td>$1,000,000</td>
</tr>
</tbody>
</table>

**Return on Investment**

The public investment in family planning through Medicaid and Title X programs helps women and couples avoid unintended pregnancy and abortion, but may also help many avoid low birth weight and preterm births. Health Care Authority, Department of Social and Health Services and Department of Health are working to determine a calculation that accurately reflects costs and savings associated with unintended pregnancy and birth.
Measures of Success

- Number of providers trained.
- Among providers that attend training, report an increase use of contraception counseling that includes LARC among birth control methods as a result of training (using clinic billing data, may require data sharing agreement with health insurance exchange). Among providers that attend training, report an increase use of a more effective contraceptive method among clients receiving contraception counseling (using clinic billing data, may require data sharing agreement with health insurance exchange).

Summary Points

- The American College of Obstetrics and Gynecology (ACOG) and American Academy of Pediatrics recommend LARC as first-line birth control and safe for women of all ages including teens.45 46
- Providing women with the most effective contraceptive method such as LARC gives them the ability to plan and prepare for a family at the time that works best for them and when they are healthiest for a baby.
- Many women don’t want more than two children; which means they will need birth control for most of their reproductive life.47 When you compare the upfront cost of LARC to the long-term cost of a less effective method every month (pill, patch or ring) the LARC is more cost-effective over time.48
- LARC methods don’t prevent sexually transmitted infections (STIs). The Centers for Disease Control and Prevention and the ACOG recommend that healthcare providers continue to screen teen clients for STIs and counsel clients on the use of condoms to prevent sexually transmitted disease.49
- Young women who haven’t started or finished the HPV vaccine series should talk with their doctor about completing the series to prevent cervical cancer.50

Increase LARC access to incarcerated women transitioning back into the community

Need Addressed

The Department of Corrections desires to increase the level of health education and clinical services available to incarcerated women for the purpose of improving support for family planning prior to reentering the community.

Population Focus

The adult women offender population is one in which many of the women have not traditionally accessed comprehensive healthcare and counseling services in the community prior to their incarceration. For many of the women, the health care services and counseling they receive in prison are the first comprehensive care they’ve had in quite some time. When the women enter the prison setting

48 http://bedsider.org/en/methods pill cost varies greatly without insurance ($10-$50 per month), patch and ring are about $50 a month without insurance or Medicaid, or $600 per year x 3-5 years to compare with IUD and implant is $1800-$3000.
49 Boonstra H, Guttmacher Policy Review, Fall 2013, Vol 16, Number 4
they undergo complete medical, dental and mental health examinations and appropriate treatment plans are then established to treat illness and manage chronic disease. There are approximately 1,100 incarcerated women within the DOC system at any given time, and roughly 40% of them have a sentence of less than five years. The average age of the women is in the mid-thirties and many of the women entering the prison system are of child-bearing age and self-report engaging in high risk behaviors in the community prior to their incarceration. Some of the women arriving at prison are pregnant and will deliver a child during their period of incarceration.

**Description of Strategy**
DOC currently provides healthcare and counseling services during the period of incarceration, with some focus on family planning prior to release. Current efforts include:

- Offering an appointment through a kite (written request to see a doctor or receive treatment) with a medical provider to discuss family planning to approximately 60-72 women (annually)
- Making birth control oral contraceptives or injection based contraceptives available 30 days prior to expected release date

**DOC will implement should funding become available, costs include:**

<table>
<thead>
<tr>
<th>Program Elements</th>
<th>Cost Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Train providers at WA Corrections Center for Women and Mission Creek Corrections Center for Women on IUD insertion.</td>
<td>$10,000</td>
</tr>
<tr>
<td>• 60-72 women receive discharge planning appointment with a licensed nurse or a primary care physician to plan with patient for post release contraception. Contraceptive options will include oral contraceptives, an injection based contraceptive or a LARC.</td>
<td>$50,000</td>
</tr>
<tr>
<td>• Securing funding to provide LARC to all releasing offenders who want them. (future work)</td>
<td>$35,000</td>
</tr>
</tbody>
</table>

**Total Annual Cost** $80,000-$100,000

**Return on Investment**
National data show that LARC methods, like intrauterine devices and implants, are currently the most effective forms of birth control. Less than one percent of women become pregnant using these methods. The public investment contraception for female offenders transitioning to the community could help those women and their partners avoid unintended pregnancy and abortion and avoid preterm and low birth weight births. *Health Care Authority, Department of Social and Health Services and Department of Health are working to determine a calculation that accurately reflects costs and savings associated with unintended pregnancy and birth.*

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Measures of Success

- Number or percent of child-bearing aged women that receive a discharge planning appointment prior to release.
- Number or percent of eligible medical staff that are trained to provide LARC insertions and removals.

Note: LARC uptake will not be used as a measure of success to ensure that women have a personal choice of contraception during the discharge planning appointment. DOC will track the following birth control method data:

- Number of women that have a LARC insertion procedure (most effective method)
- Number of women who take available oral birth control

Summary Points

- Incarcerated women are some of the most vulnerable individuals in our population because they are more likely to have high risk and unintended pregnancies without prenatal care and complicated by domestic violence, mental health issues and drug use and abuse.\(^{52}\)
- DOC reports that their adult women offender population is one in which many of the women have not traditionally accessed comprehensive healthcare and counseling services in the community prior to their incarceration.
- Many of the women are of child-bearing age and report engaging in high risk behaviors in the community prior to their incarceration.\(^{53}\)

Family Planning Screening

Need Addressed

Healthcare providers can support family planning by routinely talking with women and men of reproductive age about their reproductive health needs and goals for having - or not having - children. Generally this is known as family planning screening or reproductive life plan counseling. In 2006, the Centers for Disease Control and Prevention developed recommendations to improve preconception health and care. The recommendations include the use of a reproductive life plan with men, women and couples to improve a personal knowledge and help an individual modify behavior based on a desired outcome around pregnancy intention.\(^{54}\)

Population Focus

The focus of this strategy is healthcare providers, especially those serving populations at greater risk of having an unintended pregnancy.

\(^{52}\) American College of Obstetricians and Gynecologists, Health Care for Incarcerated Pregnant and Post-partum Women and Adolescent Females; Committee Opinion Number 511, November 2011,
\(^{53}\) Washington State Department of Corrections
\(^{54}\) Centers for Disease Control and Prevention. Recommendations to improve preconception health and health care — United States: a report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care. MMWR 2006;55
Description of Strategy
Provide electronic access to the online course “Quality Contraceptive Counseling and Education: A Client Centered Conversation”. This course includes demonstration videotaped counseling scenarios and will provide CNE/CME for each individual participant. This course dovetails with a 5-part train the trainer Toolkit titled, Providing Quality Contraceptive Counseling: Toolkit for Training Staff. This toolkit helps providers understand and practice effective contraceptive counseling with their clients. This complete training kit is recommended by Title X Family Planning Office of Population Affairs. The video series will be posted on state Learning Management site for electronic access by providers. A link to access the five-part toolkit will be available if providers/clinics want further information or want to spend more time with the curriculum. Providers will register for the training and use the product on their own timeline. The video series provides counseling examples to help providers use this important healthcare screening with clients, understand their desire to become pregnant or avoid pregnancy and help a client find a birth control method that best fit their needs.

Reproductive life plan counseling is a Federal Title X Family Planning requirement of funded providers and also part of the quality improvement initiative of the Washington State Hospital Association Partnership’s Safe Deliveries Roadmap. This helps illustrate the importance of this intervention among reproductive health providers for improving the overall health of men, women and couples as they consider their intention to become pregnant or not.

A Note
Title X Family Planning priorities include ensuring that all clients receive contraceptive services in a “voluntary, client-centered and non-coercive manner in accordance with Quality Family Planning55 and Title X requirements". While LARC are the demonstrated most effective birth control methods on the market for preventing pregnancy56, it is essential that a woman and her provider find the method that works best for her and that a provider receives proper contraceptive counseling training to ensure this occurs in a non-coercive environment.

DOH is in the process of implementing the following strategy:

<table>
<thead>
<tr>
<th>Program Elements</th>
<th>Cost Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post training on LMS</td>
<td>$0</td>
</tr>
<tr>
<td>Family Planning staff respond to follow up call</td>
<td>$0 In kind</td>
</tr>
<tr>
<td>Total</td>
<td>$0</td>
</tr>
</tbody>
</table>

- CME/CNE can be available to providers that register for the course.

Return on Investment
Family planning screening is another tool to help men and women decide if they want to become pregnant or prevent a pregnancy. Family planning screening may help women plan and space pregnancies that can decrease low-birth weight babies. Studies show the unintended, mistimed and unwanted pregnancies are associated with low birth weight (LBW) and pre-term births.57 LBW and

55 http://www.hhs.gov/opa/program-guidelines/family-planning-services/index.html#qpf-updates
56 The American College of Obstetricians and Gynecologists, FAQ 184, May 2016; http://www.acog.org/Patients/FAQs/Long-Acting-Reversible-Contraception-LARC-IUD-and-Implant#LARC
premature babies are at risk for a host of life threatening and chronic health conditions.\textsuperscript{58} Family planning screening may help teen women delay pregnancy and stay in school longer. Only 40% of teen mothers finish high school and less than of 2% complete college by 30 years of age.\textsuperscript{59}

**Measures of Success**

- Number of unique users that register for the training.
- Information from a post-tool-kit follow-up survey.
  - Providers that indicate they are using the training to implement contraceptive counseling in their clinical environment with clients
- Information from follow up calls that come into the Family Planning Program.

**Summary Points**

- Federal Title X guidelines require funded entities to discuss a reproductive life plan with all patients
- Healthcare providers can support family planning by routinely talking with women and men of reproductive age about their goals for having - or not having - children.
- Preconception health includes men. Men can take actions to become physically and emotionally healthy as an individual, partner and future parent.
- Integration of the reproductive life plan into primary care and public health settings is supported by the Association of State and Territorial Health Officials.\textsuperscript{60}

**Safe Deliveries Road Map**

**Need Addressed**
Preventable maternal and infant mortality and morbidity persists in Washington State. The Safe Deliveries Roadmap aims to improve maternal and infant outcomes by applying the best evidence to care before, during and after pregnancy.

**Population Focus**
The focus of this strategy is healthcare systems in Washington including hospitals, clinics and individual providers.

**Description of Strategy**
The Safe Deliveries Roadmap is a collaborative, evidence-based, actionable effort sponsored by the Washington State Hospital Association to ensure healthy pregnancies, mothers and newborns. Within the roadmap are groups of best practice care recommendations called “bundles.” There are four bundles that serve different stages of pregnancy: pre-pregnancy care (primary care), pregnancy care, labor management care and postpartum care. There is a need to promote the bundles with clinical, pediatric and family planning providers and assist with implementation. Our focus will be in implementing the communication plan to disseminate and promote adoption of the optimal care recommendations in public and private practice settings statewide. Integrate the bundles into the Accountable Communities of Health as part of Healthier Washington.

\textsuperscript{58} http://www.marchofdimes.org/baby/low-birthweight.aspx
\textsuperscript{60} http://astho.org/Policy-and-Position-Statements/Position-Statement-on-Reproductive-Health/
This strategy is underway at DOH and funded through existing resources. Costs include:

<table>
<thead>
<tr>
<th>Program Elements</th>
<th>Cost Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two .07 FTE Public Health Nursing Consultants (In Kind)</td>
<td>$17,410 (salary and benefits) - $93,503 annual x .14 FTE $ 1,742 (communications, rent/utilities, IT, training) $ 4,424 (indirects)</td>
</tr>
<tr>
<td>Total</td>
<td>$23,576</td>
</tr>
</tbody>
</table>

Return on Investment
Poor maternal and infant health impacts population health. Improving maternal and infant health has the potential to reduce future healthcare costs and workforce absenteeism.

Measures of Success
- Short-term measures are still to be determined.
- Long-term measures include: reduction in infant mortality, preterm birth and low birth weight.

Summary Points
- Unintended pregnancy and healthy birth spacing are part of the pre-pregnancy care and postpartum care bundles. The identified best practices include counseling on a woman’s reproductive life plan, screening for pregnancy intention in the next year, contraception counseling and planning during pregnancy and postpartum including the option of immediate LARC insertion after delivery.

Personal Responsibility Education Program (PREP)

Need Addressed
Washington State has a teen birth rate of 25.4 for every 1,000 young women under 20. While six points lower than the national average, many counties across the state have disproportionally higher rates. The top seven have rates greater than 50 per 1,000 females. The Washington State Personal Responsibility Education Program (WA PREP) targets the 15 counties in the state with the highest teen birth rates. Most youth in the state do not receive evidence-based reproductive health education that is inclusive of all sexual and gender orientations, culturally and age appropriate, and medically/scientifically accurate. This is particularly true in the counties with the highest number of teen pregnancies and births. High quality comprehensive sex education is a critical component of preventing teen pregnancy.

Population Focus
The program targets rural and urban youth ages 10-21 with disproportionately high rates of teen pregnancy. Recruitment efforts are focused on youth who:

- Have been in foster care
- Are pregnant and parenting
- Are incarcerated youth
- Are racial/ethnic groups with higher rates of teen pregnancy - African and Native American, Hispanic/Latino
Description of Strategy
WA PREP is a federally funded teen pregnancy and sexually transmitted disease prevention program. The program aims to increase abstinence and decrease teen parenthood in young men and women. The strategy employed is implementation and sustainability of comprehensive, research-based adolescent sexual health education in schools, community organizations, and juvenile detention facilities.

Additionally, all programs teach three adult preparation topics: parent/child communication, healthy relationships and healthy life skills. These programs have been proven to: delay the initiation of sexual involvement, reduce the number of sexual partners and sexual encounters, increase the use of contraception and increase condom use for prevention of both pregnancy and sexually transmitted disease transmission. Improvements in these behaviors are linked to reductions in teen pregnancies and births.

Cost of Strategy
To increase the reach of PREP among at-risk youth across the state, WA PREP needs to implement and sustain evidence-based teen pregnancy prevention curricula in all juvenile detention facilities and in the largest school districts in all of the 15 counties with the highest teen rates of pregnancy.

This strategy is underway at DOH and funded through existing resources. Costs include:

<table>
<thead>
<tr>
<th>Program Elements</th>
<th>Cost Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardea Services:</td>
<td></td>
</tr>
<tr>
<td>• Technical Assistance and Training</td>
<td>$750,000</td>
</tr>
<tr>
<td>• Evaluation Services</td>
<td></td>
</tr>
<tr>
<td>• Curricula</td>
<td></td>
</tr>
<tr>
<td>• Meeting rental</td>
<td></td>
</tr>
<tr>
<td>• Travel</td>
<td></td>
</tr>
<tr>
<td>JRA Liaison</td>
<td>$30,000</td>
</tr>
<tr>
<td>Total</td>
<td>$780,000</td>
</tr>
</tbody>
</table>

Return on Investment
A study of a comprehensive teen pregnancy prevention programs showed the intervention reduced the teen childbearing rate from 94.10 to 40.00 per 1,000 teenage females. In an extrapolation analysis, benefits to society exceed costs by $10,474.77 per adolescent per year by age 30 on average, with social benefits outweighing total social costs by age 20.1 years.61

Measures of Success
Performance measures established at the federal level by Health and Human Services include:
- The number of youth served and hours of service delivery.
- Fidelity to the program model or adaptation of the program model for the target population.
- Community partnerships and competence in working with the target population.
- Reported gains in knowledge, changes in behavioral intentions and changes in self-reported behaviors of participants.

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Community data like birth rates and the incidence of sexually transmitted infections.

**Summary Points**
- PREP is most effective when the curricula are implemented in their entirety by trained, experienced facilitators.

**Public Awareness Campaign for Young Adults**

**Need Addressed**
Media is an important source of health information for teens and young adults and there is evidence that media campaigns can influence prevention behavior. Media includes television, print (magazines), radio and internet and provides another resource to influence the health behavior of young adults who may not have learned the information elsewhere. Successful media campaigns where data show the target audience health behavior was influenced by exposure to the campaign include condom use, anti-smoking, HIV awareness, HIV testing and physical activity.

**Population Focus**
The focus of this strategy is young adults, 19-24 years of age, who are sexually active.

**Description of Strategy**
Implement a statewide media campaign to address unintended pregnancy that includes development, testing and cost of campaign. The example below depicts a range of campaign options depending on size of the desired targeted population for the campaign. A larger, statewide approach requires at least two to three times the funding of a smaller, targeted campaign. This strategy involves working with a media consultant and an epidemiologist to determine target audience and location of state.

**DOH will implement should funding become available, costs include:**

<table>
<thead>
<tr>
<th>Program Elements</th>
<th>Cost Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0 FTE HSC 4 media campaign manager</td>
<td>$93,176 (salary and benefits)</td>
</tr>
<tr>
<td></td>
<td>$9,749 (communications, rent/utilities, IT, training)</td>
</tr>
<tr>
<td></td>
<td>$23,775 (indirects)</td>
</tr>
<tr>
<td>0.2 Epidemiologist 2</td>
<td>$22,163 (salary and benefits)</td>
</tr>
<tr>
<td></td>
<td>$4,950 (communications, rent/utilities, IT, training)</td>
</tr>
<tr>
<td></td>
<td>$5,570 (indirects)</td>
</tr>
<tr>
<td><strong>Advertising Consultant Contract – creative development and multi-media purchase only</strong></td>
<td>$1,000,000 – 3,000,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$1,156,383 – 3,156,383</strong></td>
</tr>
</tbody>
</table>

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64 Estimate provided by GMMB Inc. [http://www.gmmb.com/](http://www.gmmb.com/)
Return on Investment
A media campaign could have a short- to medium-term impact on the target population depending on duration of the campaign and how often the target audience is exposed. The average proportion of the target audience that changes their behavior is 4-5 percent.\textsuperscript{65}

Example: A media campaign targeted toward women of reproductive age between ages 19 and 24 in Washington could reach a potential audience of 214,000 women.\textsuperscript{66} Approximately 8,500 to 10,700 women (4-5 percent) could engage in behavior that delays or spaces their pregnancies as a result of exposure to the media campaign. Health Care Authority, Department of Social and Health Services and Department of Health are working to determine a calculation that accurately reflects costs and savings associated with unintended pregnancy and birth. Other possible outcomes include a more informed target population that engages in other healthy behaviors such as prevention screenings for chronic disease. This could improve the overall health of women in this target group and their babies if they choose to become pregnant. The campaign could help young men and women understand the importance of planning and spacing a pregnancy.

Measures of Success
We would work with an epidemiologist and the media consultant to determine how to measure the success of the campaign.

Summary Points
- Media is an important source of health information for teens and young adults.
- We would work with a media consultant with public health experience and test potential campaign messages with a focus group before developing a campaign to ensure proper messaging for the target population.

For aspirational strategies proposed by stakeholders, see Appendix 5.

\textsuperscript{65} Ibid., Brown J.
Appendices
Appendix 1
Proposed Overall Measures of Success

- Reduce the percent of pregnancies that are unintended from a projected rate of 36% in 2013 to 32.4% by 2022.

Data Sources and Notes for Proposed Measure

Unintended births are measured through questions in the Pregnancy Risk Assessment Monitoring System (PRAMS), an annual survey of mothers conducted two to six months after delivery. Births classified as unintended are those that the mother said were conceived when she wanted no (more) children ever or the pregnancy occurred earlier than she wanted.67

PRAMS data for unintended births, combined with abortion data, develops the unintended pregnancy measure. While there is some concern that a woman’s feelings about birth intention may change over time, these data are used nationally and allows us to compare data across states.

Unintended Pregnancy Rates

Between 2002 and 2011, there was a significant drop in the unintended pregnancy rate from 54% in 2002 to 48% in 2011 (about a 10% decline). With the implementation of the new PRAMS question in 2012, the unintended pregnancy rate dropped between 2012 and 2013 was from 41% to 36%.

Notes on Limitations.

A new response option was added to the survey beginning with the 2012 data year. This new response changes the definition of unintended pregnancy and does not allow us to compare data to previous years. The response allows women the option of, “I wasn’t sure what I wanted” as a response category.68 An affirmative response on the survey to this new category is not classified as an unintended pregnancy. Given that the PRAMS question has changed, there is concern about being able to compare data before 2012 with data 2012 and later. The significant drop between 2012 and 2013 suggests that we will need more years of data to understand the impact of the new question and whether this is an indication of any type of trend. The percent of unintended births dropped about 18% between the two years (28% in 2012 vs. 23% in 2013). However, the unintended pregnancy rate is also influenced significantly by the abortion rate which dropped by 5% between 2012 and 2013, but remained stable in 2014. Because of this, it isn’t clear whether we will see a continued decline in rates for 2014 once we have updated PRAMS data.

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68 Perinatal Indicators Report for Washington State, 2013 data, October 2015
Appendix 2

Background

Secretary of Health, John Wiesman, asked the Title X Family Planning Program to convene a stakeholder workgroup to discuss what it would take to decrease unintended pregnancy. The workgroup consisted of staff from the Department of Health, Health Care Authority (HCA), Department of Social and Health Services (DSHS) and family planning providers. Secretary Wiesman presented the results of that work to the leadership of the Governor’s Health Cabinet including HCA, DSHS and Department of Early Learning. The Office of Superintendent of Public Instruction (OSPI) was also in attendance. The Health Cabinet leaders agreed that agency representatives would participate in a workgroup to create a state-wide strategy to decrease unintended pregnancy by 10 percent over five years.

The Department of Health led a multi-agency effort during the spring and summer of 2016 to review current programs and initiatives that work to decrease unintended pregnancy and develop new strategies for future efforts to improve the impact on unintended pregnancy. Representatives from HCA, DSHS, OSPI and DOC attended and actively participated on the workgroup. The Department of Early Learning and Office of the Insurance Commissioner were also invited.
Appendix 3
Unintended Pregnancy

There is no way to determine whether an unintended pregnancy will result in a wanted birth. This is a sensitive, deeply personal subject. Some individuals may never want to have children and some may not want children at the time they become pregnant. Many pregnancies are wanted even though mistimed. The impact of an unintended pregnancy extends beyond whether pregnancy and the birth is wanted or not. An unintended pregnancy can exacerbate circumstances that may already be causing stress for an individual or family such as poverty, unemployment, or relationship violence resulting in poorer health for mother and baby. In addition, the unplanned expense of a new baby can also delay or prevent further schooling; an issue of concern especially for teens and young adults.

Part of unintended pregnancy prevention is making sure that men and women, regardless of their desire to be parents, actively attend to their sexual and reproductive health. This may include disease screening, preventive exams, contraceptive needs, and family planning. With regard to public health, two interests must be considered with unintended pregnancy: preventing unintended pregnancy to begin with, and ensuring that women of childbearing age are as healthy as possible, to best handle an unintended or intended pregnancy.

Women not planning to become pregnant may be making health decisions that can negatively impact a pregnancy such as not getting prenatal care, smoking or drinking during pregnancy, or not taking prenatal vitamins. Mothers who give birth as a result of unintended pregnancy are more likely to experience domestic violence during pregnancy and less likely to breastfeed their children than mothers who plan their pregnancies. Babies born to women whose pregnancies are unintended are more likely to have a low birth weight or be born too soon (preterm); two causes of infant mortality. Children from unintended pregnancies are also more likely to have poor physical and mental health and poor educational outcomes. Reducing the unintended pregnancy rate could assist in improving other social outcomes such as graduation rates, earning potential and family stability.

Disparities (Washington and US)
Unintended pregnancies disproportionately affect women of color and those who have low incomes or less education. In Washington, we are seeing the following disparities:

Age: In Washington, the highest rates of unintended pregnancy are seen among women less than 20 years of age, but the highest number of unintended pregnancies (77%) occurs to women between 20 and 34. Nationally, the proportion of unintended pregnancies decreases as age increases. The latest Washington State data from 2011 show a teen birth rate of 19.1 per 1,000 females aged 15-19. Nationally, teen birth rates are at a new low, dropping eight percent between 2014 and 2015.

74 http://www.cdc.gov/teenpregnancy/about/index.htm
75 http://www.cdc.gov/nchs/products/databriefs/db259.htm
**Geography:** Pierce, Mason and Yakima counties have higher rates of unintended pregnancy than the state rate. 76 Nationally, unintended pregnancy rates are higher in the South and Southwest states and in more populated states.77

**Socioeconomic status:** Washington women with a household income less than $26,000 or with less than a college education are more likely to have a birth from an unintended pregnancy than those with higher income and education.78 Nationally, the rates of unintended pregnancy among poor women (ages 15-44 with incomes under 100 percent of the federal poverty level) were five times higher than the rate among women in the highest income level. 79

**Race/Ethnicity:** In Washington, Asian and white women report the lowest percentages of births from unintended pregnancy while Black, American Indian and Alaska Native, and Native Hawaiian and other Pacific Islander women report the highest percentage of births from unintended pregnancy.80 Nationally, black women had the highest unintended pregnancy rate; more than double that of non-Hispanic white women.81

**Risk Factors and Vulnerable Populations**

Risk factors for an unintended pregnancy include: not using contraception (either due to lack of knowledge or lack of access); use of less effective methods of contraception (pill, patch or vaginal ring); or inconsistent/incorrect use of contraception.82

Women make up nearly half of Washington’s Medicaid recipients. Approximately 8% of Washington women are uninsured and may have difficulty accessing contraception83. Many low income women have transitioned to state Medicaid and subsidized insurance since the start of the Affordable Care Act (ACA). However, there is still a group of women who don’t have coverage. A study that polled women 18-49 enrolled in the Take Charge program in early 2014 showed that some lower income women don’t qualify for Medicaid and struggle to pay for or cannot afford the insurance premium so they go without coverage.84 Federally funded Title X family planning services help ensure low-income and undocumented women get access to contraception, but it does not completely fill the gap. Title X began in 1970 and has never kept up with the number of women in need of contraception or with inflation.

According to a 2016 Office of the Insurance Commissioner report on Washington’s uninsured, the ACA has helped thousands get access to insurance through government subsidized insurance premiums and the provision that allows dependents to remain on their parents insurance up to age 26.85 The uninsured rate was 13.9 percent in 2012.86 Preliminary data show that the rate has dropped to 5.8 % in 2016.

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77 http://www.cdc.gov/teenpregnancy/about/index.htm
79 http://www.cdc.gov/teenpregnancy/about/index.htm
81 http://www.cdc.gov/teenpregnancy/about/index.htm
86 Ibid
Those that remain uninsured are more likely to be between 18 and 34, lower income, less educated and Hispanic.\(^87\) Women typically have better rates of insurance coverage than men. \(^88\) The report states that coverage has improved among all races, but disparities remain. Hispanics have a high uninsured rate of 19.2 percent while Caucasians have dropped to 7.4 percent. \(^89\) Medicaid expansion lead to the biggest drop in the uninsured rate among those in 100-137 percent of the federal poverty level. \(^90\)

**Risk Factors Noted for Foster Teens Who Deliver While in Foster Placement** \(^91\)

A 2014 report compares Washington females who deliver a baby while in foster care placement between ages 11-19 with:

- Teens of the same age who deliver while on Medicaid
- Young adults who deliver while on Medicaid between ages 20-24, and
- Non-Medicaid teens ages 11-19. \(^92\)

A majority of foster teens were more likely to be under age 19 at the time of delivery and less likely to have achieved a high school diploma than comparison groups. Only 25% of foster teens were 18 when they delivered compared to other groups. Foster teens were more likely to be receiving Temporary Assistance for Needy Families (TANF) compared to other groups. TANF assistance was reviewed as another indicator of financial stability. Foster youth were also four times more likely to be diagnosed with a mental health condition and substance use disorder than comparison groups. The report noted other risk factors for teen women who deliver in foster care such as low birth weight babies and infant mortality. This at risk population could provide valuable information to state agencies that assists in future policy making to help decrease unintended pregnancy and conditions that put babies and families at risk.

**Risk Factors for Incarcerated Women**

Incarcerated women are more likely to have high risk and unintended pregnancies without prenatal care and complicated by domestic violence, mental health issues and substance use disorder. \(^93\) Ensuring incarcerated (and all) women’s reproductive choice is an imperative. This is an especially sensitive issue for this population with a history of forced or coerced sterilizations within some states of the US prison system. \(^94\)

\(^88\) Ibid
\(^89\) Ibid
\(^90\) Ibid
\(^91\) Ibid
\(^93\) American College of Obstetricians and Gynecologists, Health Care for Incarcerated Pregnant and Post-partum Women and Adolescent Females; Committee Opinion Number 511, November 2011,
\(^94\) Law Students for Reproductive Justice, Reproductive Justice in the Prison System, 2014
Appendix 4
Strategies currently being implemented by Other Groups

Washington is making great strides through numerous channels to improve the overall health of its citizens and increase access to healthcare while decreasing cost. The state applied and received approval for a Medicaid Transformation waiver from the Centers for Medicare and Medicaid Services. Part of the application includes transformation projects proposed through Washington’s accountable communities of health (ACH), including projects increasing access to LARC. In addition to changes through government structure, family planning advocates, community organizations and partners are developing strategies and collaborations to improve access to reproductive care and LARC across the state. Much of this work is inspired by success of colleagues in other states, like Colorado, combined with Washington’s political climate that is typically supportive of women’s reproductive health. The organizations/partners provided descriptions of their work and inspiration below.

Public Health—Seattle and King County
The King County Family Planning Access & Quality Committee is sponsored by the King County Executive Office and facilitated by Public Health – Seattle and King County’s Family Planning Program. This committee is comprised of five Federally Qualified Health Centers, two Title X agencies (Public Health and Planned Parenthood), school-based health centers, University of Washington and City of Seattle. The purpose of this committee is to establish a county-wide partnership between primary care and family planning providers with goals of promoting a more coordinated and integrated safety net system for vulnerable populations to reduce health disparities and improve sexual and reproductive health outcomes. The initial strategies call for collecting and analyzing visit data and client input to assess the current level of access, along with practice assessments that capture the current level of provision of quality family planning services. Based on these assessments, the committee will identify areas for improvement to further improve unintended pregnancy rates.

North Sound Accountable Community of Health (ACH)
Unintended pregnancy prevention represents one of the most significant opportunities to reduce the cost curve in health care.

In 2011, mother’s pregnancy and delivery was the fifth highest cost of health care in America at $55 billion dollars. Number four was newborn care at $43 billion dollars. Considering that just over a third of pregnancies are unintended, dropping the cost curve should start with prevention of unintended pregnancy.

The North Sound Accountable Community of Health is made up of the state’s five most northwest counties: San Juan, Island, Snohomish, Skagit and Whatcom. This ACH responded to the state’s request for “early win” projects with a proposal to expand LARC, which includes intrauterine devices and implants. This project was sent through a competitive process as one of six potential projects and was selected as one of our two “early wins”.

Now, members of North Sound ACH are gathering data and, identifying fund raising and training opportunities to further the LARC expansion project. Close to $70,000 has been raised for this project to date. The Bixby Center from the University of California at San Francisco may conduct training at no charge if there is sufficient provider interest. The goal is to train 30-40 health care workers including front desk staff, nurses, patient care advocates and providers, so that everyone is engaged in making
LARC an option at every step of the process. The group held a successful training in the fall 2016 in Skagit County and then subsequent trainings will be offered in the North Sound ACH region as need is identified. Once the project is operational, the hope is that other ACHs will be interested in offering the same training in their areas so LARC use will increase statewide.

Preventing unintended pregnancy not only helps to bend the Medicaid cost curve, but also contributes to healthy communities and families overall. When pregnancies are planned, families are more engaged in the child’s success and kids start school better prepared to learn. Prevention of unintended pregnancy should be a key component in any state efforts to reform health care.

Families2030 - The Power of Intentional Parenthood

Launched in 2015, Families2030 (F2030) is a Seattle-based advocacy hub that brings together individuals and organizations working to improve reproductive empowerment and birth timing in Washington State and beyond. Through individual and joint projects, members promote policies, practices, research and investments that empower best starts for families and children. F2030 amplifies the work of members by providing mechanisms for information sharing, coordination, and mutual support.

In 2015, F2030 conducted a series of 50 stakeholder interviews ranging in length from 30 to 60 minutes, all structured around a bold question: Imagine a future—say in the year 2030—in which children born in Washington State come into the world because parents have actively chosen to have a child, a future in which a surprise pregnancy would be truly surprising and intentional parenthood is the new normal. What would have to happen to make this aspirational future a reality? Participants discussed strategies, obstacles, key players and “blue sky” ideas. (An anonymized collection of the interviews is available on request as a public resource.) In March of 2016, distilled interview responses were presented back to the community as “Eight Pillars of Intentional Parenthood.”

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<tr>
<td>1. Increase Knowledge</td>
<td>Lifelong sexual and reproductive literacy</td>
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<td>2. Upgrade Contraception</td>
<td>Universal access to family planning technologies that reliably align desires and outcomes</td>
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<td>3. Integrate Services</td>
<td>No wrong door for those seeking reproductive information and care</td>
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<td>4. Expand Autonomy</td>
<td>Inclusion across class, gender and subculture</td>
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<td>5. Diversify Provider</td>
<td>A culturally reflective ecosystem of counselors and providers</td>
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<td>6. Reconceive Family</td>
<td>Popular affirmation of healthy sexuality, evolving families and flexible gender roles</td>
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<tr>
<td>7. Legisl ate Framework</td>
<td>Policies that promote reproductive empowerment</td>
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<td>8. Realign Priorities</td>
<td>Broad recognition of intentional parenthood as a foundation of wellbeing</td>
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The operating hypothesis is that building these eight pillars will create a norm of intentional parenthood (with a host of beneficial ripple effects). F2030 members are working to map long-term strategy and near-term opportunities in each area, identifying and meeting with allies while building an evidence base and communications framework that facilitates collaboration with sectors including education, early childhood, and economic opportunity.
Appendix 5
Aspirational Strategies to Address Unintended Pregnancy

Health Care Authority

RN Family Planning Visit Reimbursement

Need Addressed
There have been mergers, acquisitions and closures of family planning clinics in around the state. Rural communities are especially affected. This reduces the number of available of providers that are contracted with current family planning programs like Take Charge and Title X. The development of Accountable Communities of Health (ACHs), integration of healthcare, encouragement of health homes and increased access to insurance through ACA has focused the need for complete health care services to be available and delivered in primary care settings and in easily accessible sites with in communities around the state.

Population Focus
All reproductively capable women and men in Washington State who are enrolled in an Apple Health program.

Description of Strategy
Reimburse for RN visits to assess and dispense contraception and perform STI/STD testing and treatment under delegation and protocols. This will allow broader use of primary care clinic staff and allow family planning services to be delivered in alternative settings. This should help rural communities improve access to family planning services.

Currently RNs as a provider type may not independently bill for services provided to Apple Health clients. Under Washington State licensure they may perform family planning services under delegation and protocol that would otherwise require a higher level license such as ARNP, MD, DO, or PA. Services that RNs may perform with protocols and standing orders are speculum exams, testing for STI/STDs, assessing the results and dispensing or calling in prescriptions for treatment. Similar services for education, counseling and initiating prescription contraception could be performed with protocols and standing orders. RNs could perform these services at sites where there are not enough higher level licensed providers to see all the clients in need of these services, such as busy FQHCs, RHCs and other primary care community based clinics. They could also perform these services in settings where there are no other licensed providers. Examples of alternative settings are: remote rural towns, public housing, community health fairs, schools and migrant worker housing.

This strategy will help alleviate time pressure in primary care and other clinics, so providers can focus their time on more complicated and urgent visits for their clients. The RN visit option would help improve access time to non-urgent appointments in these clinics improving the ability of clients to receive family planning services on the day they are requested, an intervention that has been shown to increase initiation and compliance with a chosen method.

Return on Investment
The fiscal impact is indeterminate at this time. More research is needed to determine how to model costs and savings. Currently, independent RN visits are not covered or reimbursed by HCA, and there is no historical data. Information from health systems such as FQHCs, RHCs, LHJs, and Title X agencies may
be able to assist with cost analysis for using RNs for delivering delegated, protocol based services. Variables to consider include:

- Savings may accrue due to visits shifting from higher reimbursed visits with other provider types.
- Costs will depend on which codes are allowed and the rate methodology used to determine reimbursement.
- Costs and savings will depend on utilization (If RNs are already doing this work and their services are covered under other mechanisms there may be no change in costs).

It is difficult to determine uptake and breadth of this strategy.

**Measures of Success**

1. Number of Apple Health clients who receive family planning services.
2. Service utilization of RN visits by geographic area to determine if underserved areas are being reached.

**Summary Points**

Improved access to providers that provide family planning services.

**Family Planning Only Program for Undocumented Need Addressed**

Undocumented women are covered by Apple Health during their pregnancy if they are uninsured and at or below 193% federal poverty level (FPL). During this time period they have full health care coverage. Two months after delivery their coverage switches to Family Planning Only, which ends at 12 months after delivery. This extension was implemented to help increase birth spacing, to improve health of the infant just born and reduce complications from short interspaced pregnancies. It does not provide access to continued contraception for those women who do not want to get pregnant one year after the birth of their last child. These women are at high risk of unplanned pregnancies as a result of losing this family planning coverage. Currently there is no coverage for family planning services for undocumented men. Undocumented women and men are not eligible for Qualified Health Plans further limiting options for them to initiate and maintain contraceptive choices.

In calendar year 2015 there were at least 7,344 undocumented women enrolled in pregnancy medical and at least 4,505 undocumented women enrolled in the Family Planning Only extension. Although many of these women choose a LARC or sterilization during their coverage period there were 1,782 cases in which women received contraceptive pills, patches, rings or injections. They may no longer be able to receive these methods once the 12 months of postpartum coverage is up. There were 1,707 LARC insertions to undocumented women who may not be able to replace them when they are at the end of their effectiveness in 3-5 years.

**Population Focus**

As of April 2016 there were 5,327 undocumented women eligible for the Family Planning Only (FPO) extension. All these women received pregnancy coverage for a recent pregnancy and continue to receive family planning only coverage from 2 months through 12 months postpartum.
**Description of Strategy**
A state funded Family Planning Only Program for undocumented women. This program would cover the same family planning and family planning related services that the current family planning only extension covers. The eligibility would be expanded to cover women who have not recently been pregnant. This allows undocumented women to choose how and when to space their pregnancies, thereby creating longer intervals that support healthy children and families. This program also will make long acting reversible contraception and sterilization accessible to women who have not recently been pregnant, significantly reducing the chance of unintended pregnancy in women who no longer want to become pregnant.

**Return on Investment**
This program would be fully state funded. Modeling shows medical costs savings of $1.2 million in the first 2 years with spending $7.8 million over that time. Longer term costs and savings were not projected.

**Measures of success**
1. Number of services provided.

**Summary points**
- Improved access to contraceptive/family planning services for undocumented women.
- Decrease in unintended pregnancies among undocumented women allowing them to better space pregnancies and maintain the health and wellbeing of their families.
- Prevent unintended pregnancies among undocumented women who no longer want to get pregnant.
Appendix 6
Identified Gaps and Proposed Strategies to Address Unintended Pregnancy

The Multi-Agency Unintended Pregnancy Workgroup identified gaps/activities during workgroup meetings to address unintended pregnancy. The gaps are identified below along with strategies to address them.

Gaps left to address and strategies to close these gaps:

Gap: Some Washington residents have health coverage that does not cover all reproductive health services. Grandfathered insurance plans and plans sponsored by religious organizations may not cover contraception and pregnancy termination services. Medicare also does not cover certain services. Enrollees in these plans are not eligible for Apple Health or Take Charge.

Strategy: A sliding scale, premium based family planning only insurance plan for those with inadequate coverage in their primary insurance plan.

Gap: Men and women on Medicare who are still in their reproductive years and are dual or partially dual eligible for Medicaid. This is particularly disabled people, but also includes dependents. Medicare does not cover sterilization and LARCs for contraception purposes or pregnancy termination. This is particularly difficult for low income Medicare beneficiaries who have to meet spenddown requirements before Medicaid can cover these services. Not clear if prescription contraception is uniformly covered by Medicare, but appears it is covered in Part D.

Strategy: Exclude family planning and pregnancy termination services not covered by Medicare from the spenddown requirements.

Gap: Access to providers that provide family planning services. There have been mergers, acquisitions and closures of family planning clinics in around the state. Rural communities are especially affected. This reduces the number of available providers that are contracted with current family planning programs like Take Charge and Title X.

Strategies: Improve family planning services and access in primary care settings.
   a. HCA is transitioning from a family planning waiver program to a Medicaid Statewide Plan Amendment. This will allow Family Planning Only clients to receive services from any Apple Health contracted provider, by allowing them to exercise their “freedom of choice” and ability to self-refer. HCA is already doing this.
   b. Allow all 340B providers to receive a dispensing fee for contraceptive drugs. Limit the dispensing fee to per dispense, rather than per package. This may be affected by new Outpatient Drug rules recently released by federal HHS, which will be implemented April 2017.
   c. Consider identifying all clinics and providers that have within their scope of practice the ability to provide family planning services to be designated to dispense contraceptives onsite. This will allow FQHCs and hospital owned clinics to dispense contraceptives onsite. This requires rewriting RCWs and changing the definition of a family planning provider/clinic.
d. Train primary care clinics on how to integrate the One Key Question (type of family planning screening that asks about pregnancy intention in the next year) or Integrated Care Collaboration strategies into their practices.

**Gap:** Health coverage literacy, especially around reproductive health, including family planning.

**Strategy:** Make sure family planning information, how to apply for coverage, and where to get services is available at places where people seek information.

a. Health Benefit Exchange will provide educational information about family planning coverage and services on Healthplanfinder.

b. Resources already listed on DSHS’s website.

c. Work with Washington Connection to have DOH’s Title X family planning program and resource listed in the medical part of the website.

d. Have information about family planning coverage on OIC’s website and how to find insurance coverage if a person’s plan does not cover contraception, sterilization, or abortion.

e. Make sure information is included on all sites about ACA requirement that family planning is a preventive service without costs to enrollee. Can have ACA link on all the websites mentioned above.

**Gap:** Assurance of confidentiality for everyone for family planning and STI/STD services. It is difficult for clients to ensure that Explanation of Benefits (EOBs) and other insurance paperwork are not sent to their homes. This is especially true when a person has more than one health plan coverage. Policies and forms are different from insurer to insurer and plan to plan.

**Strategies:**

a. Have a universal form that clients can use to request that services be kept confidential and require that all health insurance carriers in Washington State use the standard form and have procedures in place to assure that the request is maintained.

b. Make it universally mandatory that all insurers always suppress EOBs and other notices when it pertains to confidential services, regardless of cause. There would no longer be need to have “good cause.”

There are examples from other states that have made this a universal policy and procedure.

CA: [http://www.myhealthmyinfo.org/sites/default/files/Confidential-Communications-Request.pdf](http://www.myhealthmyinfo.org/sites/default/files/Confidential-Communications-Request.pdf)

OR: [https://www.oregon.gov/DCBS/Insurance/gethelp/health/Pages/confidential-communications.aspx](https://www.oregon.gov/DCBS/Insurance/gethelp/health/Pages/confidential-communications.aspx)


MA: [https://www.hcfama.org/confidentiality-protection](https://www.hcfama.org/confidentiality-protection)

**Gap:** Assure that foster kids aging out of system have access to LARC.

**Strategies**

- On April 1, 2016 this population will be covered under one managed care organization (MCO) – Coordinated Care.
- Ensure continuity of care that includes access to LARC.
Provide education and outreach to the population about access to services.
- Risk factor – vulnerable populations and their view of self-efficacy
- Include teen and unplanned pregnancy prevention in foster care programs, especially for young adults aging out of system.
- Include members and input from vulnerable populations in future policy planning to ensure reproductive justice while preventing unintended pregnancy

**Gap**: Look at current and future use of Pregnancy Intention Screening (example One Key Question) – with mental health and substance use providers.

**Strategies**
- Place holder in integrated managed care
- Emergency room staff may be a better option and similar/same population will access ER at some point as well

**Gap**: Assess/improve youth and adults access to LARC and other birth control methods in county jails.

**Strategies**
- Population has access to medical through jail
- Limited local funding and taxing authority make LARC access difficult because of upfront cost
  - Opportunity to create state/local/Title X/jail partnership for referral to service and access to LARC

**Gap**: Strengthen sex education in public schools

**Strategy**: Strengthen data collection, currently no mandatory reporting requirements
- Schools provide this information on a voluntary basis to OSPI
- Varied access and quality education across the state

**Gap**: Increase the number of school based health centers in high need areas (counties) with low access to care and high rates of unintended pregnancy.

**Strategies/Activities**
- Assess school districts with high rates of teen pregnancy and STDs along with access to medical and family planning related services.
- Develop criteria for priority districts and counties to implement school based health centers.

**Gap**: Increase the number of pregnant and parenting teens and young adults that graduate from high school and achieve a higher education.

**Strategies/Activities**
- Include the input of pregnant and parenting teens in drop-out policies to encourage this population to remain in school.
- Analyze successful policies/programs in Washington high schools and colleges that help pregnant and parenting teens remain in school.
o Develop policies and share successful policies with community colleges, 4-year colleges and technical schools to help young parents successfully complete a higher education after high school graduation.