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Launching The Right Time Initiative:

A baseline evaluation and learning report for a comprehensive and equity-focused reproductive health strategy in Missouri

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Acknowledgments

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Motivation for The Right Time Initiative

Empowering women to decide whether and when to have a child can improve the well-being of not only her and her families but also her entire community. Poor reproductive health—which unintended pregnancies serves as a key indicator—often results in babies with poor birth outcomes and other developmental challenges (Kost and Lindberg 2015). The costs to society of unintended pregnancy alone are substantial; one study estimated public costs of abortions and miscarriages from unintended pregnancy at about $21 billion in 2010, or half the costs spent on publicly funded pregnancies in the country (Sonfield and Kost 2015).

Conversely, the benefits of reducing barriers and increasing access to quality contraception counseling and services for *all* women regardless of socioeconomic status, race, ethnicity, education, or income; their families; and society are considerable. Several studies established health, educational, workforce, family income, and stability benefits of planned pregnancies to women and children (Frost et al. 2014; Kavanaugh and Anderson 2013; Sonfield 2014). These societal benefits could help address gender, racial, ethnic, and economic inequities since younger women, women of color, and women with financial hardships experience the highest rates of unintended pregnancy (Guttmacher Institute 2019). Advocates have argued that being able to choose how and when to become pregnant helps us progress toward a more equitable society across psychological, social, political, economic, and legal domains (Prata et al. 2017).

Despite the benefits of contraceptive access and use, nearly three million women experienced an unintended pregnancy in the United States in 2011, comprising 45 percent of all pregnancies that year (Finer and Zolna 2016; Guttmacher Institute 2018). Although the rate of unintended pregnancy is at its lowest since 1981, rates could be significantly reduced with increased and appropriate contraceptive use (Guttmacher Institute 2019). Most (95 percent) unintended pregnancies occurred among women who did not consistently and correctly use contraception (Guttmacher Institute 2018).

Several factors play a role in whether women use contraception. About 19 million women in the United States live in so-called contraceptive deserts without reasonable access to a publicly funded clinic offering a range of birth control methods (Power to Decide n.d.). These include 3 million women who live in counties with no publicly funded clinics. Clinics might also lack the funding, staff, and operational supports to provide comprehensive contraceptive options.

People might choose not to use the services that do exist, possibly fueled by a lack of awareness in the community on the topic. Historical experiences with discrimination and unethical practices toward people of color have generated distrust of the medical community among women of color (Higgins 2014). Furthermore, unsupportive political climate and policies could discourage use, as conversations about contraceptives often become conflated with abortion rights.

The issues surrounding contraceptive access and use call for a multidimensional strategy, but few initiatives to date have used a multipronged approach to address these barriers. In light of its commitment to health for all Missourians, and for its potential value to the field, Missouri Foundation for Health launched The Right Time in 2019. Its goal is to increase contraceptive access and use by improving clinical supply, community awareness, and environmental supports so Missouri women and families are empowered in their own health care decisions.

EXECUTIVE SUMMARY

Inequitable access to and use of reproductive health services across socioeconomic, geographic, linguistic, racial, and ethnic groups is a serious public health concern in Missouri. In particular, Missouri women under age 18 with public or no health insurance and multiple children experience barriers in accessing and using family planning services (Guttmacher Institute 2019, Kranker et al. 2018). In some parts of the state, contraceptive deserts prevent women's convenient access to all contraceptive methods. These conditions, among other societal and environmental factors, contributed to about 4.6 percent of Missouri women of reproductive age experiencing an unintended pregnancy in 2010, slightly more than half of the roughly 101,000 pregnancies in the state that year. In response, Missouri Foundation for Health (MFH) launched The Right Time (TRT) in 2019 with the principle that "everyone should have the opportunity to pursue the future they want, including if, when, and under what circumstances to get pregnant." Specifically, TRT seeks to empower people to make decisions about their own reproductive health by improving information on, and removing barriers to, contraceptive services and use.

A complex and multipronged program, TRT could have many impacts on women, families, practitioners, and the social and policy environments. Evaluating TRT will generate learning, help us understand whether and why the program had the anticipated outputs and outcomes (or why it did not), and inform future initiatives in Missouri and elsewhere. In TRT's first year, the evaluation sought to capture how providers implemented it and measure baseline progress to assess future outcomes. The evaluation observed whether health centers receiving training and technical assistance (TA) improved delivery of comprehensive contraceptive care, communications drove uptake of contraceptive services, and legislative influence and community mobilization increased adoption of policies to ensure all women's access. Focused on equity, TRT and its evaluation infuse considerations of whether activities serve to promote health for *all* people, especially those facing economic and societal hardships.

A. Implementing TRT

TRT has three core strategies: building *supply* of comprehensive contraceptive care, increasing *demand* for the care, and promoting policies fostering an *environment* in which all women can access quality and comprehensive contraceptive care. To support these core strategies, MFH funded Missouri Family Health Council (MFHC) to serve as TRT's coordinating program office and to implement supply and advocacy-environment related activities. Power to Decide was engaged to carry out demand-related activities.

- **Supply.** In the first year, 6 health centers across 14 clinic sites comprised the first TRT cohort of providers. Infrastructure and capacity, how they provided long-acting reversible contraception (LARC), and self-assessed skill level varied among providers. Yet all participated in trainings on contraceptive counseling, providing evidence-based and medically accurate information, and delivering culturally competent care. Health centers received some form of TA for contraceptive counseling and operations in the first year, with more receiving TA on contraceptive counseling.
- **Demand.** TRT's communications approach has two key components: (1) reaching out via the media to eligible women and their families who might not yet receive services at participating clinics and (2) engaging existing patients at participating clinics. The media outreach included a standalone website, social media platforms, paid media, and earned media; the client referral efforts ranged from posters for clinics to palm cards for patients.

- **Environment.** To support advocacy and community mobilization, MFHC hired (1) an advocacy manager to engage stakeholders, coordinate the policy agenda, and support the overall campaign; and (2) five community mobilization coordinators to generate support and action for access to contraception. These staff and community mobilizers reached 193,279 people through 94 outreach events; engaged with 58 coalitions and work groups to promote relevant policies; and worked with 79 legislators to strengthen and coordinate reproductive health policy efforts.

B. A baseline against which to assess progress

In 2019, the initiative helped train about 170 clinic staff, engaged 3,752 community members through the TRT website, and collaborated with 58 coalitions and 79 legislators. These activities had various effects:

- **Uptake of contraception among women.** Before TRT launched in 2019, health centers served about 5,000 women in the last quarter of 2018. After its launch, the number and demographics of women served at TRT health centers slightly increased, with about 6,000 served in a quarter. Most of them were non-Hispanic and proficient in English; 92 percent already used contraception when they came into the clinic, 20 percent of whom switched from a less-effective to a more-effective method. Of the 8 percent not using contraception at intake, 3 percent switched to using a method at exit. Specifically, LARC use increased by 5 percent, with a 3-to-5 percentage point increase regardless of income level or insurance status. LARC uptake was highest among teens.
- **Organizational infrastructure and capacity in health centers for delivering equitable contraceptive care.** Two-thirds of health centers in the first cohort entered with strong knowledge and infrastructure to help provide comprehensive contraceptive care. Yet participating in TRT increased their ability to deliver same-day LARC insertion, offer all patients a full range of contraceptive options, and strengthen nonclinical staff capacity to help deliver services.
- **Community norms and policies related to contraceptive access and use.** Public opinion of access to birth control in Missouri was mixed when the initiative began. Legislators ranked contraceptive access low on their lists of policy issues. In implementing the environmental strategy, MFHC tried to focus the contraception narrative on health and well-being, but making headway has been difficult. Recent Missouri legislative actions have politicized the reproductive health conversation. To educate policymakers, community partners have stressed access and use of contraception as key factors to reducing unintended pregnancies.

C. TRT's promise

By the end of the five-year initiative, TRT strives to reach 21 health centers and 95,900 women through media campaigns, mostly women at highest risk of an unintended pregnancy. It will engage and mobilize legislators and communities to influence policy and change social norms to ensure access to comprehensive contraception for all. By increasing availability and use of contraceptive services, TRT anticipates reducing unintended pregnancies by 10 percent in Missouri as a key indicator of reproductive health. Over five years, this could avert 200,000 unintended pregnancies, avoid 144,000 abortions, and save taxpayers almost $2 billion. It would also affect health and well-being, as planned pregnancies lead to healthier babies and more women and families thriving socioeconomically. Lessons learned could help scale-up in Missouri and other states, possibly improving lives of many more women and their families.

I. INTRODUCTION

According to the 2019 America's Health Ranking Annual Report, Missouri ranks 39th of 50 states across more than 30 metrics of health, including clinical care, policy, community and environment, and behaviors (America's Health Rankings 2019). In light of these poor rankings, Missourians might benefit from learning about existing, ongoing efforts to improve their health. One such initiative, The Right Time (TRT), aims to empower women and families to decide whether, when, and how to have children as a way to improve women and families' well-being and reproductive health. TRT uses unintended pregnancies as a key indicator of reproductive health because many studies have linked unintended pregnancy to poor birth outcomes and longer-term and wider-ranging adverse outcomes related to child development, mothers' educational attainment, and family income and stability (Frost et al. 2014; Kavanaugh and Anderson 2013; Sonfield 2014, Sonfeld et al. 2013).

A. Need for TRT

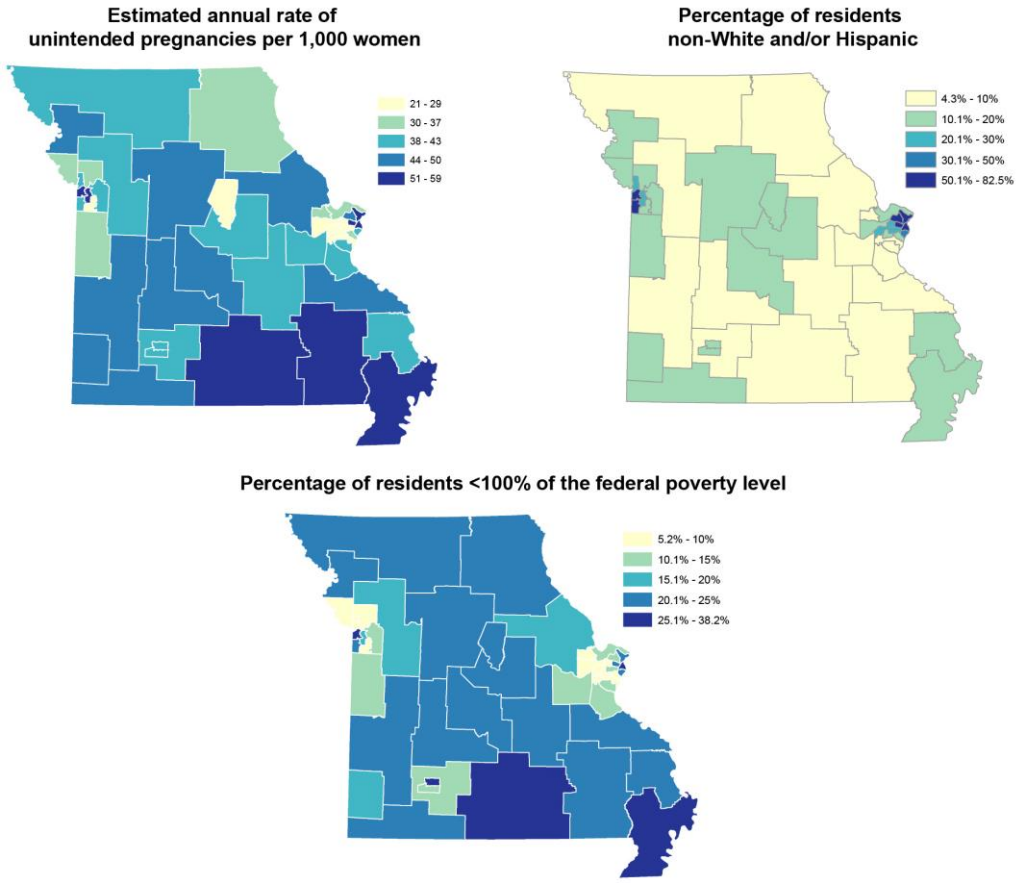
The need for programming to increase access to contraceptive supplies and services in Missouri is pronounced: two-fifths of the pregnancies in the state are unintended or mistimed[1] (Kranker et al. 2018). Missouri also ranks among the lowest (44th of 50 states and Washington DC) in reproductive health and rights according to contraceptive coverage, access to abortion, family planning available through Medicaid, and other resources (Institute for Women's Policy Research 2015). Moreover, unintended pregnancy in Missouri disproportionately affects those striving to overcome economic and societal hardships, including adolescents and young women, racial and ethnic minorities, and families with lower socioeconomic status. As shown in Exhibit I.1, geographic regions with the highest estimated rates of unintended pregnancy also have the highest percentages of minorities and residents living in poverty, including areas of St. Louis, Kansas City, and counties in the Missouri Bootheel (Dunklin, Mississippi, New Madrid, Pemiscot, and Stoddard counties).

TRT's multipronged intervention model could increase awareness of contraceptive options and access to services, potentially preventing tens of thousands of unwanted or mistimed pregnancies, averting thousands of abortions, and saving millions of Missouri's taxpayer dollars (Exhibit I.2). In addition, the results and lessons learned from TRT might prove valuable to other philanthropic institutions, policymakers, and practitioners interested in understanding the effect of a comprehensive and equity-driven approach to improving reproductive health (Exhibit I.3).

Only **5 percent** of the unintended pregnancies in 2011 occurred among women who consistently and correctly used contraception (Guttmacher Institute 2018).

[1] An unintended pregnancy occurs when a woman does not want to become pregnant. A mistimed pregnancy occurs when a woman becomes pregnant earlier than desired (Santelli et al. 2003).

Exhibit I.1. Unintended pregnancy, race and ethnicity, and federal poverty level by Missouri county



Sources: Mathematica's analysis of Pregnancy Risk Assessment Monitoring System data for Missouri from 2012 to 2015; Vital Records birth certificate data for Missouri from 2014 to 2016; National Survey of Family Growth data from 2013 to 2015; American Community Survey microdata from 2011 to 2015 5-Year Estimates; data sources on health care providers in Missouri from the Missouri Family Health Council 2017 encounter data; Missouri Primary Care Association 2017 data on contraceptive methods provided at FQHCs; Planned Parenthood Advocates in Missouri 2017 data on contraceptive methods provided at FQHCs; and Power to Decide 2017 data on contraceptive deserts.

FQHC = federally qualified health center.

Exhibit I.2. Estimated unintended pregnancies in Missouri in 2010

	Number	Percentage
Pregnancy	101,000	100%
Unintended pregnancy	40,000	40% of pregnancies
Mother receives publicly funded medical care for pregnancy	28,800	72% of unintended pregnancies
Abortion	16,800	42% of unintended pregnancies

	Costs of unintended pregnancy	Savings from averting unintended pregnancies[a]
Public funding	$518,400,000	$381,800,000
Public funding per woman	$440	$98

Sources: Pregnancy information was estimated from Kost 2015 and Kranker et al. 2018. Cost information was sourced from Sonfield and Kost 2015.

Note: Costs and savings include public funding dollars at both state and federal levels.

[a] Cost of averting pregnancies differs from costs of unintended pregnancy because even if all women had timed their pregnancies, some resulting births still would have been publicly funded. The estimated savings do not include costs for family planning services and other interventions.

Exhibit I.3. TRT and other state initiatives to improve reproductive health

Initiative	Years	States	Provider types	Program strategies: Supply	Program strategies: Demand	Program strategies: Environment	Equity focused	Access to all methods
The Right Time	2019–	MO	All provider types	Provider training, reimbursement	Social media, community events, patient education	Legislative engagement	✓	✓
Beyond the Pill (UCSF)	2011–	National	All provider types	Provider training	Targeted educational sessions	Research and evidence[a]		✓
Choose Well SC	2019–	SC	All provider types	Provider training, reimbursement	Social media and marketing campaign, patient education	---	✓	✓
Colorado Family Planning Initiative-LARC4CO	2008–	CO	All provider types	Provider training, reimbursement	Social media and marketing campaign, community events	Coalition building	✓	✓ [b]
Contraceptive CHOICE Project	2007–2008	MO	University, abortion, and community clinics	Reimbursement	Patient education	---		✓ [b]
FPE CAP	2018–	UT	All provider types[c]	Provider training, reimbursement	Marketing campaign	---	✓	✓
Iowa Initiative to Reduce Unintended Pregnancy	2007–2013	IA	Title X	Provider training, reimbursement	Community outreach, marketing campaign	Legislative engagement	✓	✓ [b]
Upstream USA	2014–	DE, MA, NC, WA	All provider types	Provider training	Patient education	---		✓
LARC Initiative	2018–	VA	All provider types	Reimbursement	---	---	✓	

Sources: University of California San Francisco 2020; Choose Well 2019; Colorado Department of Public Health and Environment 2017; Secura et al. 2010; Family Planning Elevated n.d.; Philliber Research Associates 2012; Upstream USA n.d.; Virginia Department of Health 2020.

Notes: Equity focused refers to initiatives that promote health for all people, especially those facing economic and societal hardships. Access to all methods refers to initiatives that offer the full range of contraceptive methods.

[a] Research and evidence to support policy change.

[b] Has a strong focus on IUDs and implants.

[c] Must serve uninsured, underinsured self-pay, and Medicaid patients and be eligible or enrolled in the federal 340B Drug Pricing Program.

FPE CAP = family planning elevated contraceptive access program; FQHC = federally qualified health center; IUD = intrauterine device; LARC = long-acting reversible contraception; TRT = The Right Time; UCSF = University of California, San Francisco.

Building on other programs that have focused on increasing contraceptive access and use, TRT is notable for its multidimensional approach and emphasis on achieving health equity.

Though many other initiatives have an equity focus, their framing is to improve access for women experiencing poverty rather than achieving equitable access and outcomes for all women, regardless of income, race or ethnicity, disability status, sexual orientation, gender identity, immigration status, and age.

TRT aims to improve clinical services (supply), increase community awareness (demand), and create a supportive policy environment (environmental). Reflecting the foundation's strong commitment to equity, TRT focuses on reaching subgroups at the highest risk for unintended pregnancy.

B. About this report

This report documents the launch of TRT in early 2019 and presents baseline information and learning from implementing TRT that year. These findings will support course corrections, inform decision making, and maximize overall learning from TRT.

Because an equitable evaluation approach underpins TRT's evaluation and learning work, the evaluation contractor will examine how results can promote equity, how inequities shape implementation and observed results, and whether the interpretation and conclusions are valid to and owned by those providing the information (Center for Evaluation Innovation et al. 2017). In collecting and analyzing information, we put our best foot forward to adhere to the principles of equitable evaluation, to approach the work with humility, and to examine and check our biases. We applied these principles in focus groups with women in service communities; online surveys with providers; observing clinics; and interviewing legislators, community organization staff, and implementing partners. Future rounds will engage these stakeholders in examining results, providing new insight based on their interpretation of results, and informing actions to support health and health equity in their communities. Appendix A includes further information about our methods and approach to collecting and analyzing data.

Objectives of TRT evaluation and learning

1. Assess the effect of a multipronged approach to address inequities in access to comprehensive contraceptive services and use of contraception as a mechanism to improve reproductive health (assessed through reductions in unintended pregnancy)
2. Identify best practices to further assess the methods that work for the most underserved groups and what drives the gap between those who are well off and those striving to overcome economic and societal hardships
3. Build evaluation and learning infrastructure and systems that sites can replicate and scale to address inequities across the state and provide learning to other national and state-level stakeholders
4. Inform regulatory and legislative funding on preventing unintended pregnancy and sustaining positive health outcomes for residents
5. Leverage lessons learned to support TRT's sustainability and scale-up and inform others interested in similar social issues

II. ROLLING OUT THE PROGRAM TO ADDRESS INEQUITIES IN REPRODUCTIVE HEALTH

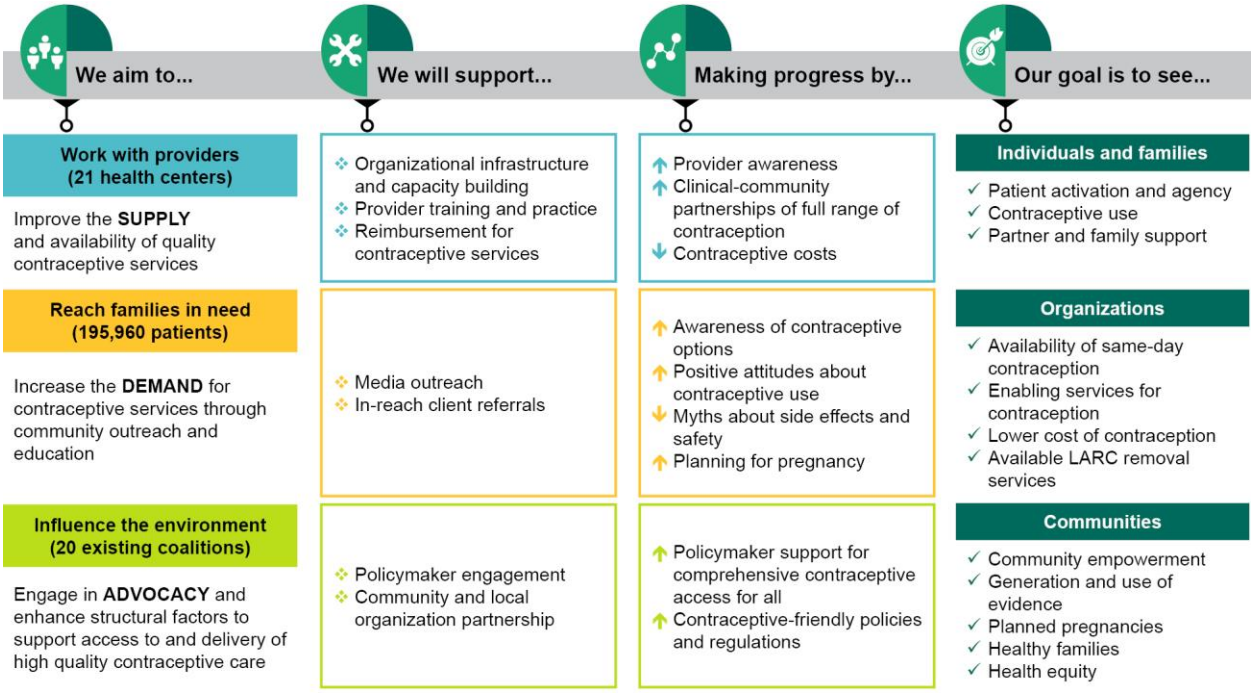
Missouri Foundation for Health (MFH) brought together implementation and evaluation partners to design the initiative from spring 2017 to 2018. Partners included Missouri Family Health Council (MFHC), a private nonprofit organization supporting equitable access to quality, culturally sensitive sexual and reproductive health education and services; Power to Decide, a nonpartisan and non-ideological campaign to prevent unplanned pregnancy; and Mathematica, an evaluation and research organization seeking to improve public well-being for all through objective, high quality, and action-oriented research.

"One thing that strikes me is how important that planning year was in order for us to be successful …[and] to really ensure that we have some roadmap of how the next five years are going to unfold."

— TRT partner

Partners began with the overarching structure of a multipronged approach with supply, demand, and environmental supports as the key strategies upholding the initiative. Working together and supported by four subcommittees—provider reimbursement, clinical supply and training, program office, policy and advocacy—the initiative's partners set an ambitious goal to reduce unintended pregnancy, as the key indicator for reproductive health, in Missouri by 10 percent within five years. To do so, they developed specific approaches under each mutually reinforcing strategy shown in Exhibit II.1. The supply strategy will support up to 21 health centers (each with one or more clinic sites) to help provide comprehensive contraceptive care by training providers and removing cost barriers to accessing contraceptive services. At the same time, the demand strategy will increase awareness of these services through a website; various social media platforms such as Facebook, Instagram, and Twitter; paid advertisements; and an earned media campaign. The environmental strategy will lay the groundwork for mobilizing the community and engaging policymakers to advocate for reproductive health and rights. (Appendix B, Exhibits B.1 to B.4 provide detailed logic models for the overall initiative and for each strategy.)

Exhibit II.1. Contributing to a 10-percent reduction in unintended pregnancy under TRT

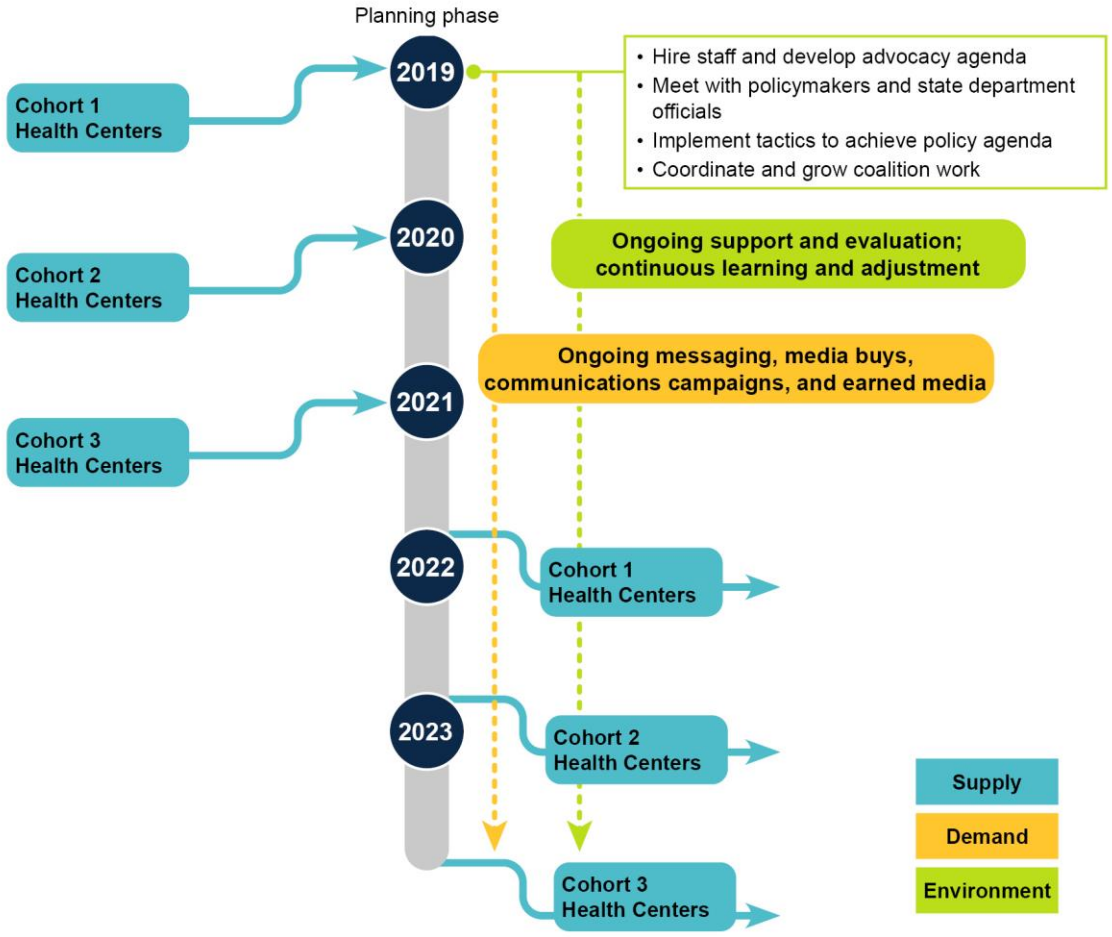


LARC = long-acting reversible contraception; TRT = The Right Time.

To implement and evaluate the initiative, MFH renewed its relationship with its planning phase partners. In addition to these partners, MFHC—in its continued role as the coordinating program office—collaborated with MFH to establish a state advisory group to guide implementation and brought in community mobilization organizations to generate support and action for the advocacy agenda. In addition, MFHC is responsible for supporting the 21 health centers, with their staggered onboarding over a three-year period, and providing each health center with three years of training and technical assistance (TA) under the program. Power to Decide manages a communications campaign that continually disseminates messages through social, earned, and paid media; messaging and media buys are revised based on feedback and tracked media metrics. Media efforts focus on reaching women ages 18 to 29 across certain demographics, including women with a high school education or less (about 59,000 women, including 12,000 African American and 2,000 Hispanic women) and women working in specific industries (about 36,900 women, including 8,900 African American and 2,000 Hispanic women) for a total of 95,900 women over the course of the initiative.[2] For the environmental strategy, MFHC engages representatives and mobilizes local stakeholder support through partnerships with community organizations. Exhibit II.2 provides an overview of the timeline for rolling out the five-year program.

[2] Industries targeted include administrative services, cleaning and maintenance, construction and extraction, food and restaurants, food preparation and services, installation and repair, health and medical services, sales, personal care, and transportation and moving.

Exhibit II.2. Implementing The Right Time



A. Work with providers (supply)

In January 2019, MFHC released a request for applications to identify the first cohort of TRT health centers. Eligibility criteria for application to the program included being within the MFH service area, offering family planning services, meeting requirements for enrollment or ongoing participation in the 340B Drug Pricing Program, and having existing practice management systems to facilitate billing and reimbursement.[3]

Of the 12 health centers who applied to participate in the initiative, MFHC in consultation with MFH selected 6 for the first cohort (Exhibit II.3).[4] They considered location in areas identified with high need and diversity in levels of readiness, services offered, and clients' demographic profiles when selecting the

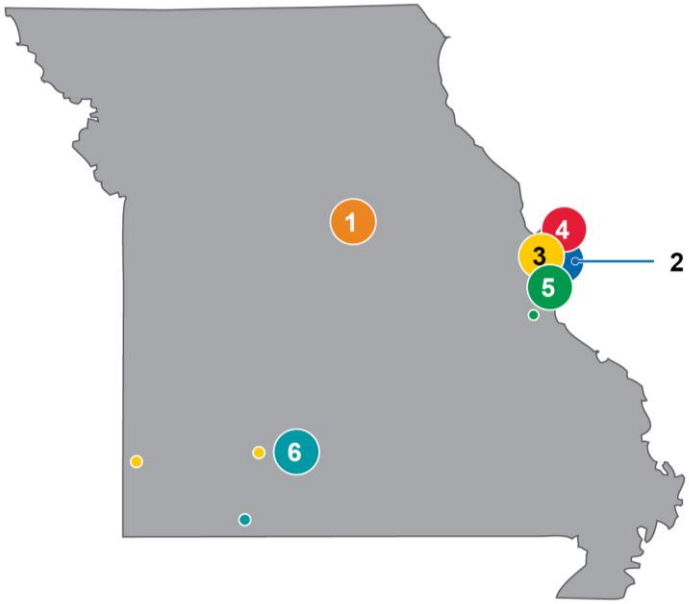
[3] MFH's service area includes five regions in Missouri that cover 84 counties in Northeast, Central, Southwest, and Southeast Missouri and the St. Louis Metro area.

[4] Seven health centers were selected through the request for applications. After the initial assessments, one center deferred participation until the second cohort because it did not have a system ready to meet required reporting requirements. To increase the diversification and inclusivity of health centers, Cohort 1 included three health centers that lacked electronic health records.

cohort.[5] The first cohort of selected health centers were located throughout the state. It included four Title X health centers that already focused on providing reproductive health services and two federally qualified health centers (FQHCs) specializing in primary care; they varied in infrastructure and capacity, long-acting reversible contraception (LARC) provision, and self-assessed level of provider skill (Exhibit II.4). The variation in health center characteristics enabled the MFHC to understand the range in TA needs of health centers and better inform assistance provided to future cohorts.

Among Missouri's 114 counties, 32 do not have any publicly funded clinics in which women could receive free contraception. In 88 counties, no publicly funded clinics offer the most effective forms of contraception (Power to Decide n.d.).

Exhibit II.3. The Right Time Health Centers: Cohort 1



Source: Program documentation from Missouri Family Health Council, 2019.

[5] Health centers completed a self-assessment and categorized themselves as beginner, intermediate, or advanced based on their capacity to carry or administer all contraceptive methods and facilitators of or barriers to providing services (that is, issues with same-day availability or provision of services, staff trained to consistently deliver patient-centered counseling, and health center leaders' support in providing or improving family planning services).

Exhibit II.4. Baseline health center capacity

		Health center 1	Health center 2	Health center 3	Health center 4	Health center 5	Health center 6
Characteristics	Sites	1	3	4	1	3	2
	Type	Health Dept., Title X	FQHC	Title X	Title X	Title X	FQHC
	Readiness	Intermediate	Intermediate	Advanced	Advanced	Intermediate	Beginner
Infrastructure and capacity	Staff size	Small	Large	Large	Small	Medium	Medium
	Women served	233	2,697	14,357	1,676	1,087	1,844
	EHR ready	⊘	⊘	⊘	✓	✓	✓
	Engages in culturally competent practices	✓	✓	✓	✓	✓	✓
	Methods in stock at clinic	11	11	6	7	9	14
LARC provision	Offers same-day LARCs	⊘	✓	✓	✓	✓	⊘
	Inserts and removes IUDs	✓	✓	✓	✓	✓	✓
	Inserts and removes implants	✓	⊘	✓	✓	✓	✓
Self-assessed provider skill	Addressing myths and providing medically accurate information	●	◐	●	◐	○	○
	Providing contraceptive counseling	●	◐	●	●	◐	◐
	Managing contraceptive supply	◐	●	●	●	○	●

✓ Yes ⊘ No ● High ◐ Medium ○ Low

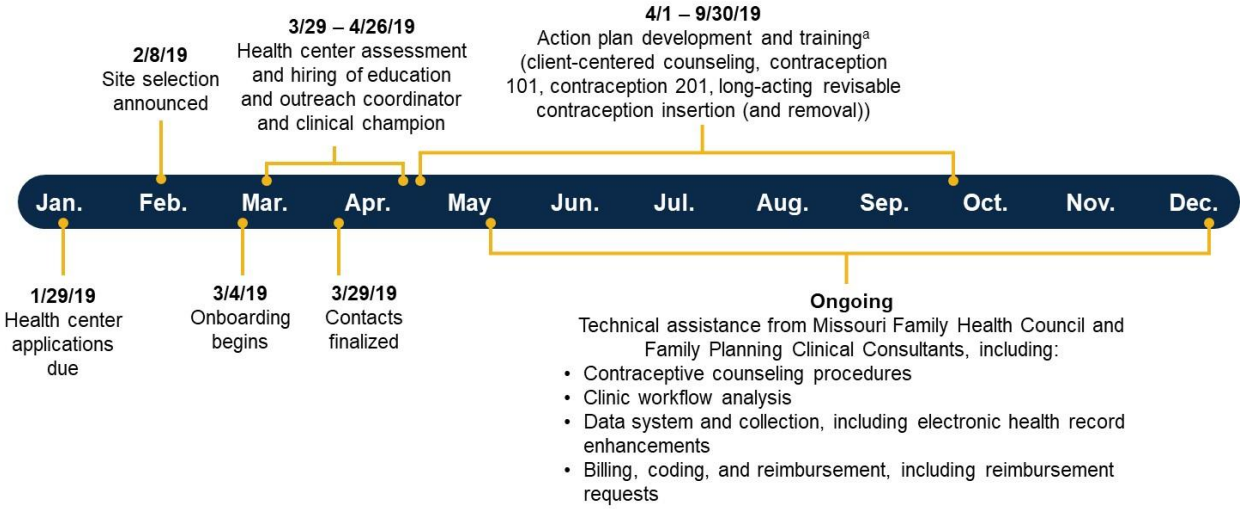
Sources: Staff size: MFHC assessment of relative staff size; number of women served: Program documentation from MFHC, 2019; EHR-ready and same-day LARCs: MFHC health assessments, 3/29/19 to 4/23/2019; all other categories: Mathematica's analysis of clinic administrator survey for six health centers (six clinic administrators), 5/6/2019 to 6/13/2019.

Note: Staff size refers to the number of full- and part-time staff currently working at the health center with small meaning fewer than 30 staff, medium meaning 31 to 74 staff, and large meaning over 75 staff. Women served refers to the number of patients served in 2018 across all health center locations. The category Engages in cultural competent practices is based on clinic administrator responses to "Does your clinic engage in any of the following activities around providing care to patients with different cultural, racial, ethnic, or religious backgrounds: provide interpretation or bilingual services for patients; have a clinic-based committee to address culture-related issues in providing contraceptives; offer cultural competency training for clinic staff who provide contraceptive services (in-house or external); require cultural competency training for clinic staff who provide contraceptive services (in-house or external)?" Health centers that engage in one or more practices are coded as Yes. The category Methods in stock at clinic is based on clinic administrator responses to "Do you offer the following contraceptive methods in the clinic either by having it in stock, providing it through a prescription, a mix of having it in stock and through prescription, or is it not offered at all?" Responses that the method is either "in stock at clinic" or available "through prescription" are included in the count; responses for "sometimes in stock/ sometimes through prescription" and "not offered through clinic" are not included. Addressing myths and providing medically accurate information, providing contraceptive counseling, and managing contraceptive supply are self-reported confidence on a scale of very confident (high), somewhat confident (medium), or not at all confident (low).

EHR = electronic health record; FQHC = federally qualified health center; IUD = intrauterine device; LARC = long-acting reversible contraception; MFHC = Missouri Family Health Council.

Over the first six months, MFHC engaged health centers in a series of TRT activities to bring providers on board (Exhibit II.5). To begin, MFHC collaborated with health centers to create an initial health center assessment and develop an action plan to enhance their delivery and quality of reproductive health services. Over the coming months, health centers received training and guidance documentation, one-on-one TA, and financial support for key staff positions, electronic health record (EHR) enhancements for data reporting, and contraceptive method reimbursement.

Exhibit II.5. 2019 Health center onboarding activities



[a] Only the client-centered counseling and Contraception 101 trainings are required; all other trainings are optional.

TRT training, TA, and reimbursement needed and received

The trainings and TA needs varied by health center types and self-assessed level of readiness. FQHCs typically had more staff and fewer systems in place to provide contraception than Title X clinics and health departments did. The FQHCs needed additional training and TA about workflows and operations to help provide comprehensive contraception. Regardless of health center type, the funding to supplement hiring, technology updates, and method reimbursement was available to all health centers.

Focus on equity

MFHC offered health centers the opportunity to attend various trainings part of the 2019 State Family Planning Conference. This conference had several sessions on providing equitable reproductive health care. In all, 138 people received training through sessions such as Understanding the Reproductive Justice Framework, LGBTQIA Healthcare, and the Impact of Trauma on the Delivery of Reproductive Healthcare.

Compared with advanced-level health centers, intermediate and beginner health center administrators tended to want staff trained on contraceptive counseling and insertions; these health centers likely had new staff or staff wanting a refresher on training topics (Exhibit II.6). Four of six health center administrators said they wanted more training on addressing myths, and five of six health center administrators said they wanted more training on contraceptive counseling. Yet perceived needs for training among administrators were not necessarily tied to receipt of trainings, as all health center staff providing TRT-related services had to attend trainings on Contraceptive Methods 101 and Client-

Centered Counseling. This requirement ensured that TRT health center staff started with the same core knowledge required to deliver TRT services. Health center staff only received other trainings, Contraceptive 201 and LARC insertion, if they requested it.

Exhibit II.6. Health center needs and training received

Self-assessed level	Advanced		Intermediate		Beginner	
HC	**HC 3**	**HC 4**	**HC 1**	**HC 2**	**HC 5**	**HC 6**
Providing evidence-based and medically accurate information responsive to patient needs						
Baseline experience	●	◐	●	◐	○	●
Need training	⊘	✓	⊘	✓	✓	✓
Received training	✓	✓	✓	✓	✓	✓
Contraceptive counseling						
Baseline experience	●	●	●	◐	◐	◐
Need training	⊘	✓	✓	✓	✓	✓
Received training	✓	✓	✓	✓	✓	✓
Cultural competency						
Baseline experience	●	◐	●	●	●	◐
Need training	NA	NA	NA	NA	NA	NA
Received training	✓	✓	✓	✓	✓	✓
LARC insertion						
Baseline experience	●	●	●	●	●	● (IUD) ◐ (implant)
Need training	⊘	⊘	✓	⊘	⊘ (IUD) ✓ (implant)	⊘ (IUD) ✓ (implant)
Received training	⊘	⊘	✓	⊘	✓	✓

✓ Yes ⊘ No ● High ◐ Medium ○ Low

Sources: Baseline experience and training needs from Mathematica analysis of clinic administrator survey for six health centers (six clinic administrators), 5/6/2019 to 6/13/2019. Training received from MFHC programming tracker, 1/1/2019 to 9/30/2019.

Notes: Providing evidence-based and medically accurate information, counseling on contraceptives, and inserting LARCs are self-reported confidence on a scale of very confident (high), somewhat confident (medium), and not at all confident (low). Providing culturally competent care is self-reported as engaging in three or more culturally competent practices (high), one to two culturally competent practices (medium), or no cultural competent practices (low).

IUD = intrauterine device; HC = health center; LARC = long-acting reversible contraception; MFHC = Missouri Family Health Council; NA = not available.

Trainings. Most health centers already provided contraceptive services before the initiative, stocked or prescribed a range of options, and had providers who could insert LARCs.[6] The beginner health centers, however, cited a need for contraceptive counseling in particular. To cover this range in health center implementation readiness levels, MFHC subcontracted with the Collaborative to Advance Health Services at the University of Missouri-Kansas City (UMKC) School of Nursing to provide training and further ensure standardized knowledge across all TRT health center staff.[7] Overall, the collaborative trained 170 people (Exhibit II.7). Whereas health center staff from advanced health centers found the trainings repetitive given they already engage in the practices discussed, participants in intermediate and beginner health center focus groups saw the trainings as an opportunity to provide education to everyone that comes in contact with the patient, from the front desk staff to clinicians.

"We come from a culture of providing a lot of patient education around contraception and really trying to focus on removing barriers, so I think that for us… we're already doing a lot of the evidence-based practices."

– Advanced health center focus group participant

"We all went through that training. It was good because it lets everybody that touches the patient or has contact with the patient know a little bit more about what exactly [happens during an appointment]."

– Intermediate health center focus group participant

Exhibit II.7. Number of people trained as part of TRT

Self-assessed level	Advanced		Intermediate			Beginner	Total trained
HC	HC 3	HC 4	HC 1	HC 2	HC 5	HC 6	
TRT orientation and modules	33	22	15	22	25	53	170

Source: MFHC programming tracker, 1/1/2019 to 9/30/2019.

HC = health center; TRT = The Right Time.

TA. Beyond the technical skills taught through the trainings, health centers required further assistance across several topics to implement TRT. They noted a need for TA on revising their counseling protocols to be more client-centered and adjusting their processes to account for same-day LARC placement (Exhibit II.8). Logistical concerns also prompted many health centers to request operations-related TA, such as how to adjust workflows to handle a potential influx of new patients looking for contraceptive services, enhance EHR systems to support reporting, and improve accounting processes to support TRT reimbursement to providers. To assist with these needs, Family Planning Clinical Consultants, who are family planning practitioners contracted through MFHC, provided one-on-one or group technical assistance on addressing objectives in health center action plans. All health centers received some form of TA for contraceptive counseling and operations in the first year, with more receiving TA on contraceptive counseling.

"There's been a lot of questions about operationalizing reimbursement."

– Advanced HC provider

[6] The percentage of clinics' total outpatient caseload that received contraceptive services varied greatly, from 15 percent at the beginner health center to 90 percent at two more advanced health centers.

[7] The Collaborative to Advance Health Services at the University of Missouri-Kansas City conducted trainings for each module either in person, virtually, or as a combination of in-person and virtual sessions.

Exhibit II.8. Number of times HCs received TA as part of TRT

Self-assessed level	Advanced		Intermediate			Beginner	Total TA
HC	HC 3	HC 4	HC 1	HC 2	HC 5	HC 6	
Contraceptive counseling	5	1	0	4	4	2	16
LARC insertion	0	0	1	0	0	1	2
Operations[a]	4	0	0	4	1	2	11

Source: MFHC programming tracker, 1/1/2019 to 9/30/2019.

Note: TA data on evidence-based and medically accurate information and cultural competency is unavailable.

[a] Operational TA includes support on billing, coding, and reimbursement procedures.

HC = health center; LARC = long-acting reversible contraception; MFHC = Missouri Family Health Council; TA = technical assistance; TRT = The Right Time.

Reimbursement. To accompany the provision of training and TA, MFHC also financed several key staff positions, EHR system enhancements, and purchase of contraception. Positions financed included that of a clinical champion to provide on-site monitoring and ensure compliance with TRT ($10,000 per year for three years); and an outreach and education coordinator to build community relationships, provide education presentations, and promote TRT to the target audience ($50,000 per year for three years). Most often, health centers opted to have a licensed nurse practitioner or physician within their staff fulfill the clinical champion role. Conversely, outreach and education coordinators were more often hired from outside of the health centers. At any time during its participation, a health center was also eligible to receive a one-time nominal payment to enhance its EHR system for collection of TRT data. Finally, health centers could receive an advance to purchase an initial stock of contraception and reimbursement at 340B cost plus a $50 fee for contraception supplied to women without contraceptive coverage for the method of choice.

Financing for TRT

- **Clinical champion**: $10,000/year for 3 years
- **Outreach and education coordinator**: $50,000/year for 3 years
- **EHR enhancements**: one-time $5,000 payment
- **Contraceptive method reimbursement**: 340B cost plus $50 fee

Four of six health centers provided same-day LARCs before the initiative. Clinic administrators noted problems with insurance preauthorization and reimbursement as well as high cost to uninsured patients as the largest barriers to using LARCs. To reduce cost barriers, TRT provides funds for the purchase of contraceptive methods to create an initial inventory. MFHC administers these funds and reimburses health centers within 30 days of receiving a valid claim.

Lessons learned from implementing supply strategy

The initiative successfully recruited a diverse set of health centers. Through targeted outreach and networking, the initiative aims to further diversify health center participation in future cohorts to other types of providers, such as FQHCs, county health departments, and hospital-based clinics. Though the first cohort included two FQHCs, the goal is to increase the initiative's reach to more FQHCs and other non-Title X providers that might not have as much existing contraceptive service capacity as a Title X clinic. Other providers, however, also do not have reporting and reimbursement systems like Title X clinics, and this lack of infrastructure has deterred many of these providers from applying to participate in the initiative. MFHC hopes lessons learned during this first cohort can help improve the reimbursement process in later cohorts, which might encourage applicants from a broader range of health centers. The initiative has several key strategies for increasing the capacity of health centers' reimbursement systems:

- Providing front desk staff with tools to answer patients' questions about TRT, such as charts about what TRT covers and workflow templates
- Offering funding to modify EHR templates to collect data and export reports
- Involving Cohort 1 staff as mentors to provide lessons learned and best practices for new health centers
- Creating frequently asked question documents that address implications of participating in TRT on other programs' service delivery (for example, the services covered under Title X versus TRT)
- Developing an additional training module that focuses on coding, billing, and reimbursement strategies
- Engaging with Family Planning Clinical Consultants to provide ongoing monitoring and technical assistance to health centers
- Conducting an on-site orientation to develop a baseline understanding of technological and workflow limitations, to understand facilities' individual needs, and to address deficiencies earlier in the process

Implications for equity. Additional non-Title X providers in areas with the highest rates of unintended pregnancy (such as the Southeast) could help the initiative reach those with the most limited access to contraceptive services.

B. Reach families in need (demand)

To empower women and families to make informed decisions about contraception, Power to Decide developed a comprehensive media plan informed by stakeholders' input on local contexts in Missouri. Power to Decide conducted a series of polls and listening sessions with more than 700 Missouri residents to determine the best channels of communication and messaging content to increase awareness about the benefits of contraception and visibility of the initiative. This groundwork led to a communications approach with two key components: (1) media outreach to eligible women and their families who might not yet receive services at participating clinics and (2) in-reach referrals at participating health centers to existing patients. The media outreach included a standalone website, social media platforms, paid media, and earned media, and the in-reach client referrals ranged from posters for clinics to palm cards for patients (Exhibit II.9).

Exhibit II.9. TRT communications approaches

Approach	Description	Intended audience	Metrics
Outreach			
TRT website	Pages on where to get birth control, methods, testimonials, articles, videos, and about us	General population	• 11,827 page views
Social media pages (Facebook, Instagram, and Twitter)	Posts of most up-to-date information about the initiative and its activities	General population	• 31 posts (1,035 page views) on Facebook • 71 posts (905 page views) on Twitter
Paid media (ads on social media and Google)	Ads to drive digital traffic to TRT website	Specific ages and demographics	• 2,101,208 impressions (163 social interactions) on Facebook • 547,919 impressions on Instagram • 224 social interactions on Twitter • 5,537 clicks across paid media • 178 conversions (0.21 percent conversion rate)
Earned media (news releases, stakeholder talking points, and initiative announcements)	Press releases to inform the community about the initiative (and reinforce partner organizations engagement)	General population	• 1 press release to 467 media outlets
In-reach			
Peer-to-peer education campaign	Concise, engaging phrases to educate women on birth control facts	Women ages 18 to 29	• 6,000 palm cards produced for TRT educators to use and for women to share with others
Provider education program	Brochures to help providers engage with patients	Providers, partners, and medical facilities	• 170 people trained
Community support and connections	Materials to connect existing community priorities and identify partnership opportunities	Community members	• 10,000 postcards produced • 2,500 posters or tear sheets produced
Activating spokespeople	Contact lists to identify influencers to serve as voice for the campaign	Spokespeople, partner groups, and health centers	• TRT playbook developed

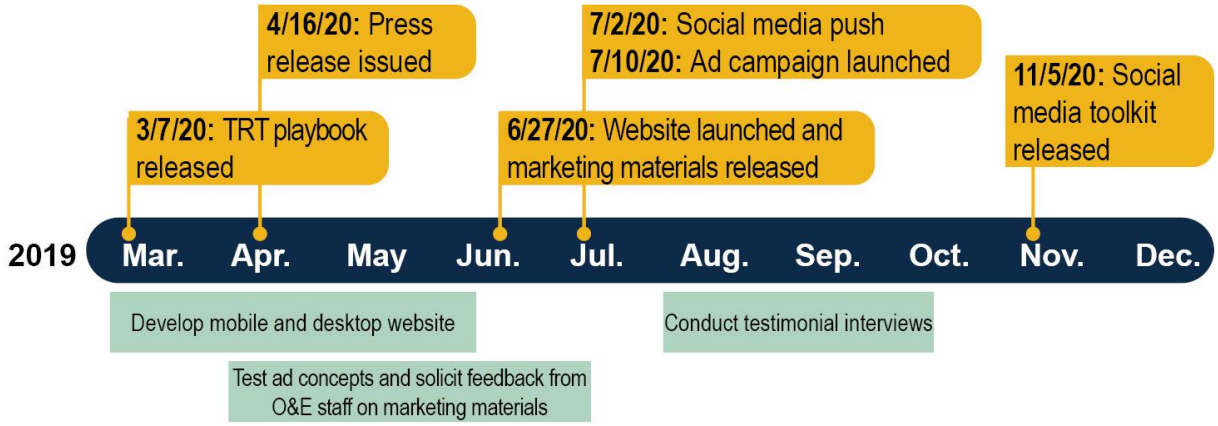
Source: Power to Decide TRT administrative data, 1/1/2019 to 9/30/2019.

TRT = The Right Time.

Communication channels and their reception

Providing an ongoing drumbeat of accurate, positive information about birth control requires a variety of communication channels to reach, inform, and engage all audiences. Considering the diverse landscape in Missouri and five-year horizon of the initiative, communications rolled out in a staggered manner over time (Exhibit II.10). Channels varied by mode of contact (online or in person); intended audience (women of reproductive age, influencers, providers, and community members); and types of supporting materials (social media posts, brochures, and news articles). This section discusses the outreach methods, benefits, and key metrics for the various communication vehicles.

Exhibit II.10. 2019 Rollout of TRT communications



O&E = outreach and education; TRT = The Right Time.

TRT website (launched June 2019). This outreach method serves as a public-facing resource center for women interested in learning about different birth control methods and TRT. The website includes information about where to obtain birth control, types of birth control, and testimonials from Missourians. It also contains feature articles, fact-or-fiction animated shorts, a "guy's guide" to contraception, and provider perspective articles. From January to September 2019, the website had 11,827 page views (by an estimated 3,752 different people). Almost three-quarters (72 percent) of those who accessed the website during this time did so on a mobile device. Having a link on other media outlets helped drive traffic to the website. TRT partners said that the testimonials from real women and men are effective in learning about different experiences with birth control methods. It remains to be seen whether the clinic locator is effective in driving additional traffic to health centers; none of the clinic staff interviewed indicated patients mentioning the website as a factor for coming into the health center. Exhibit C.1 in Appendix C contains a screenshot of the TRT website.

"I think connecting it to the website is super important because there are a lot of people who will hear a message about birth control or family planning services and then want to know more before they maybe try to access them."

– TRT partner

Social media (launched July 2019). This outreach method reaches women of child-bearing age in real time. From July to September 2019, there were 31 posts on Facebook and 71 posts on Twitter, leading to a total of 1,940 page views. Popular articles on social media include: "Three Plus Size Women Share the Birth Control Methods That Work for Them," "Things Your Provider Wishes You Knew About Birth Control," and "Just Diagnosed with an STI? Here's How to Stop Freaking Out." Nearly all interviewed stakeholders pointed to social media as the most appropriate and effective media outlet to reach the target age group. Furthermore, patients and nonpatients participating in focus groups explained that they receive most of their information from Facebook and they particularly like evidence-based posts that help them better disentangle fact from fiction. Exhibit C.2 in Appendix C contains a screenshot of the TRT social media accounts.

"Social media is obviously so huge…that's where [women of reproductive age] get a lot of their information from."

– TRT provider

Paid media (launched July 2019). This outreach method seeks to engage audiences from specific demographics, such as race and ethnicity (African American and Hispanic), age (18 to 29), industry (administrative services, cleaning and maintenance, construction and extraction, food and restaurants, food preparation and services, installation and repair, health and medical services, sales, personal care, transportation, and moving), and education level (some high school, high school graduate, associate degree, some college) to help reach those most at risk for unintended pregnancy. Sponsored posts on Facebook and Twitter contain messages such as "the right way is your way," "stay your course," "control where your journey leads," and "do it for you." From July to September 2019, there were 2,649,127 impressions (the number of times a TRT advertisement appeared on a person's screen), 5,537 clicks (the number of times a person clicked on a TRT advertisement), and 178 conversions (the number of times a person clicked on the "find a health center" button on the website), resulting in a conversion rate of 0.21 percent (the number of conversions divided by the number of clicks). This is below the average conversion rate of 2.35 percent (Austin 2019). The education metric (for all women, Hispanic women, and African American women) led all calculated metrics, and the work metric for the same populations had fewer clicks and a lower click through rate. Media data suggest that this might be because of the larger size of the education metric audiences.[8]

"… We want stakeholders in the state to know about this effort and support it, and we want the press to write about it, and we want other ways of … keeping this front and center."

– TRT partner

Earned media (launched April 2019). This outreach method broadens TRT's influence by gaining publicity through third parties that spread the word about the initiative. From April 2019 to September 2019, the initiative distributed a press release to 467 media outlets. In all, 20 newspapers, radio stations, and television stations disseminated the press release through their outlets.

[8] That is, women with some high school education, who have graduated from high school, with some college education, or who have graduated with an associate's degree.

> **"… It all depends on whether or not the person had a good experience. So, that's A. And then, B, they would actually share it with a friend. And then, C, that the friend would actually follow through with it."**
>
> – Community partner

Peer-to-peer education campaign (launched June 2019). This outreach method capitalizes on trusted and built-in networks across peers to reach women in Missouri communities. Distribution of palm cards, which contain facts about contraception and are easily carried in a handbag, acts as the major prop to exchange evidence-based information between peers; women receive these cards to hand out when they visit a TRT health center or attend a community event.[9] From June 2019 to September 2019, the initiative distributed 6,000 palm cards to six health centers. Thus far, this channel has served mainly as an informal promotional channel to increase patient demand. Exhibit C.3 in Appendix C contains samples of the palm cards.

Provider education program (launched May 2019). This outreach method educates providers on promoting culturally competent care. From January 2019 to September 2019, 170 people across six health centers received training about client-centered counseling in a family planning setting. Family planning clinical consultants also provided biweekly support to health centers to promote clinical, educational, and counseling best practices.

> **"Any way we can talk more about contraception, the better; the more that we are used to hearing it, the more it's a comfortable conversation, and the more they'll get medically accurate information."**
>
> – Community partner

Community support and connections (launched April 2019). This outreach method involves working with trusted community members and organizations that understand how to tailor messaging to a community's context and authentically pitch messaging for successful receipt. These trusted community partners distribute postcards about TRT across the community and talk about contraception use as a positive tool for health and well-being.[10] From June 2019 to September 2019, 10,000 postcards and 2,500 posters or tear sheets were provided to six health centers for distribution. Exhibit C.4 in Appendix C contains samples of the postcards and posters/tear sheets.

Spokespeople activation (launched April 2019). This outreach method provides broad reach by employing local celebrities to serve as a voice for the campaign. Since its launch, TRT has developed a playbook with talking points, key messages, templates for news releases, and best practices for securing media. Data on recruitment of local celebrities to serve as spokespeople for the initiative was unavailable at the time of this report.

[9] At health centers, outreach and education coordinators, as well as clinical staff, use palm cards as a method for educating women. Then, women can keep the palm cards and share them with others

[10] Partner organizations include Generate Health, Planned Parenthood of the St. Louis Region & Southwest Missouri, NARAL Pro-Choice Missouri, Reproaction, and National Council of Jewish Women – St. Louis Chapter. Data are not available on the number of postcards received or distributed by these organizations.

Lessons learned in implementing the demand strategy

The initiative developed a communications approach involving various stakeholders to incorporate a variety of perspectives and facilitate positive receipt of the initiative messaging across all stakeholder groups.

- **Elected officials** provided insight into the political priorities and issues surrounding reproductive health and highlighted the difficulty of talking about contraception without entering into the more controversial territory of abortion.
- **TRT partners** provided feedback on language and nuance in marketing materials from on-the-ground knowledge and decades of experience working with health centers and community members.
- **Providers, outreach and education coordinators, and clinic staff** shared feedback on marketing materials based on reactions from patients and community members and suggested additional materials to help promote the program.
- **Community advisory committee members** provided insight into local context and suggested language to consider when developing materials.
- **Missouri women** provided insight into how the intended audiences would use the website, respond to social media messages, and react to different advertisements.
- **User experience professionals** shared feedback on the structural design of the website to make it more fluid and easier to interpret.

Implications for equity. Communication approaches and materials must consider the historical and cultural contexts of the patients likely reached by the messages. Because some health centers have large Hispanic populations, developing Spanish outreach materials would help Hispanic women feel more welcome at TRT health centers. In addition, because of disparities in education across the state, reading levels among reproductive-age women vary; materials written at a 6th-grade or lower reading level would improve awareness of the program among all families and women. Finally, more complete demographic data would deepen our understanding of the extent to which messages reach the intended audiences. Polling, consumer focus groups, and outreach can provide insight into whether these messages resonate with the intended audiences.

C. Influence the environment (advocacy)

Sustaining access to quality contraceptive care begun under TRT will require demonstrating to policymakers the value of eliminating cost and other social barriers to care. Partners also understood, however, that policymakers represent only one side in the United States' multifaceted political process. Therefore, to complement engaging legislators, TRT also sought to mobilize coalitions to coordinate the voices of community members to ask their representatives to expand access to all types of contraception through Medicaid and other state programs.

To support advocacy and community mobilization efforts, key TRT staff hired included (1) an advocacy manager to lead stakeholder engagement, coordinate the policy agenda, and support the overall campaign and (2) five community mobilization coordinators working across three areas to engage with local stakeholders to generate support and action related to access to contraception (Exhibit II.11). TRT staff and community mobilizers held meetings and organized community events to advance the advocacy agenda, engaged with coalitions and work groups to promote relevant administrative and regulatory policies, and worked with policymakers to strengthen and coordinate policy efforts related to reproductive health (Exhibit II.12).

Key Missouri reproductive health legislation

2001: Missouri Revised Statue 376.1199 requires insurances that cover prescription drugs to provide contraceptive coverage; exempts abortion drugs and religious entities

2016: State-funded Women's Health Service Program replaces federal family planning waiver program and allows state to deny reimbursement to organizations providing or counseling on abortions

2018: Medicaid reimbursement to facilities that provide abortions is banned, creating a funding for crisis pregnancy centers

2018: A LARC prescribed to and obtained for a Medicaid patient can be transferred to another Medicaid patient if unopened and unused

2019: Women age 18 and older can get their oral contraceptives directly from pharmacists

Exhibit II.11. Advocacy partners and health center locations

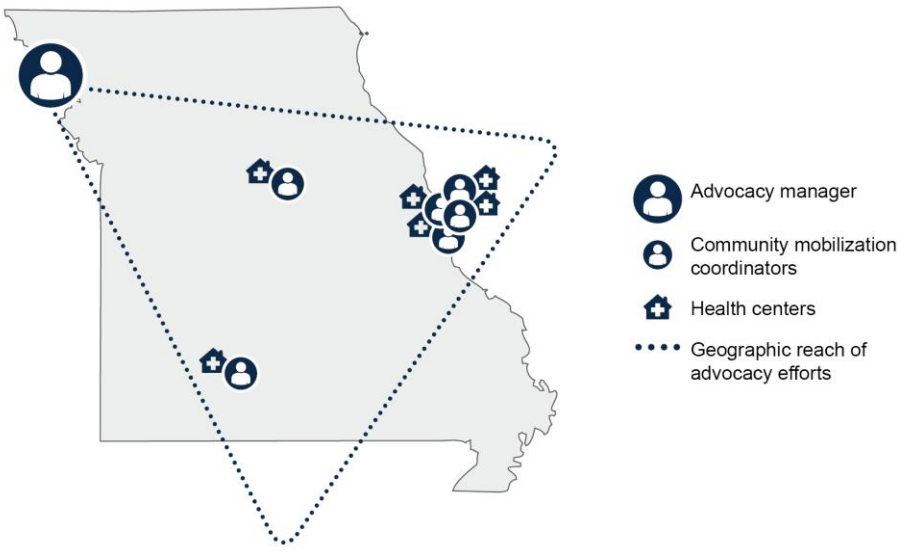


Exhibit II.12. TRT advocacy and community mobilization efforts

Community and local organization partnership

5 actions; total reach = 71 individuals

Advocacy topics include:

- Hot topics brunch to encourage participation in reproductive rights
- Photo campaign
- Letter to the editor to overturn HB 126, which places new limits on abortion
- Testimony on language of postpartum coverage waiver
- Testimony guidance

58 groups engaged over 71 meetings; total reach = 381 individuals

Engagement topics include:

- TRT promotion
- Women's Health Service Program expansion
- STI screening and prevention
- Legislative priorities
- TRT replication in other states
- Postpartum coverage
- Partnership with other Missouri initiatives

Policymaker engagement

9 Democratic senators and 24 Republican senators (97 percent)

22 Democratic representatives and 34 Republican representatives (34 percent)

Influence topics include:

- MFHC promotion
- Healthy Families priorities
- WHSP expansion
- Postpartum Medicaid expansion[a]
- Planned abortion bill[b]
- Telehealth legislation[c]
- Syringe access bill[d]
- Pharmacist-prescribed contraception bill[e]
- 13-month contraception dispensing[f]
- Sexual education legislation[g]

[a] Current legislation only extends the benefit 12 months for those with a history of substance use.

[b] Bans abortion at eight weeks gestation.

[c] Enables virtual visits to reduce access barriers.

[d] Distributes clean syringes to intravenous drug users.

[e] Requires a prescription to obtain contraception.

[f] Provides coverage for up to a 13-unit supply of contraception.

[g] Promotes evidence-based information in schools.

Sources: Outreach and education tracker from MFHC 1/1/2019 to 9/30/2019. Community mobilization trackers from four community partners 1/1/2019 to 9/30/2019. Community mobilization tracker from one health center, which includes outreach and education data, 1/1/2019 to 9/30/2019.

HB = House Bill; MFHC = Missouri Family Health Council; STI = sexually transmitted infection; TRT = The Right Time; WHSP = Women's Health Service Program.

Making headway through influence

Key activities during the first year of TRT focused on engaging key community leaders and influencers to increase awareness and generate support for the initiative. With an overall goal of building community support for the project, community mobilizers engaged in a series of activities to build public education, promote legislative policy solutions, and mobilize supporters and community members (Exhibit II.13).

Exhibit II.13. Key advocacy activities

Dates	Activity	Objective
March 2019	Congressional visits to advocate for nonrestrictive Title X funding	Educate legislators about negative consequences of new proposed Title X rules
April to August 2019	Four meetings with Department of Social Services and Department of Health and Senior Services to promote streamlining and improving Women's Health Service Program	Contribute to ongoing conversations about streamlining Medicaid enrollment in Missouri
July to December 2019	Eight meetings to align community mobilization organizations around a collective impact model	Foster shared policy priorities among community mobilizers
September to December 2019	Three planning meetings of Healthy Families Priorities Coalition	Develop shared legislative priorities, including access to family planning and general health care, infant and maternal health, sexually transmitted infection prevention, and family coverage and support
November 2019	Four-day canvassing to collect signatures for Medicaid expansion ballot initiative	Gather 128 signatures to influence participating electorate and health care and social service professionals

At the end the first year, community mobilizers executed their action plans by educating the public on policies affecting TRT; connecting and engaging with the target audience, key leaders, and allied organizations; and raising broad public awareness of TRT and potential policy solutions. Specific policy goals included addressing high up-front costs of stocking LARCs, opposing legislation that will negatively affect family planning providers, and removing barriers around related to reimbursement for oral contraceptives for nonpharmacy providers. These activities will continue to be ongoing policy goals of community mobilization.

Lessons learned in implementing the advocacy strategy

At the launch of the initiative, 12 bills were introduced related to abortion, dominating much of the conversation about reproductive health in newspapers and among policymakers. Most notably, HB 126 requires using a fetal heartbeat detection test before an abortion and prohibits an abortion if a fetal heartbeat is detected.

Despite this, TRT partners have developed unique ways to steer the conversation toward the importance of contraception. They have discussed the importance of increasing access to quality contraceptive counseling and services as a measure to improve overall maternal and child health. In addition, they have pointed out that when women have their preferred method of contraception, women tend to have better adherence.

Implications for equity. Formal partnerships and relationships with organizations embedded within local communities, especially in the rural areas of the state in which contraceptive access is limited, can advance TRT's reach. TRT plans to expand its reach to all corners of the MFH service region, and especially strengthen activities in Southeast Missouri, which currently does not receive much outreach related to reproductive health. Activating community mobilizers in locations that require contraceptive services can also generate further support and action around reproductive health.

III. BASELINE INEQUITIES IN REPRODUCTIVE HEALTH

In 2019, TRT trained about 170 clinic staff, reached 3,752 members of the general public through the TRT website, and engaged 58 coalitions and 79 legislators on the benefits of increasing access to and use of high quality contraceptive services. This chapter describes the initial outcomes resulting from these TRT implementation activities and provides benchmarks against which to assess future progress. When the initiative has had more time to mature and broaden its reach, subsequent reports will review its potential contributions to health outcomes and shifts in social norms.

A. Uptake of contraception among women

Foot traffic to TRT health centers increased only slightly with the launch of TRT. Because of the large number of Title X clinics in the first TRT cohort, many women already went to TRT health centers for contraceptive services in these health centers' service area. In addition, local women and health center staff participating in focus groups in fall 2019 cited the need to further disseminate information about the program to increase its visibility and reach. Many women in these communities said that they had not yet heard of TRT.

Exhibit III.1. Characteristics of women receiving services before and after the launch (percentages)

	Pre-launch	Post-launch
Hispanic	9	6
Limited English proficiency	9	3
White	61	59
Black	28	33
Asian	4	2
Other race[a]	6	2
Missing race	0	4
Public insurance	30	22
Private insurance	26	34
Uninsured	43	45

Sources: Pre-launch data from Mathematica's analysis of clinic administrator survey for five health centers (five clinic administrators), 5/6/2019 to 6/13/2019. Data excludes one health center (two clinic administrators). Post-launch data from health center encounter data, 4/1/2019 to 9/30/2019. Data exclude one health center for which information is unavailable.

Notes: Data for age and poverty status not available at pre-launch stage. Race categories (White, Black, Asian, other race, missing race) might not sum to 100 percent because of rounding. Insurance categories (public insurance, private insurance, uninsured) might not sum to 100 percent because of rounding.

[a] Other race includes American Indian, Alaskan, Native Hawaiian, Pacific Islander, and mixed race.

Is the initiative reaching those at highest risk for poor reproductive health outcomes, such as unintended pregnancy? When examined by demographic group, no single group had disproportionately larger representation in the TRT health centers before versus after the launch (Exhibit III.1). Women receiving TRT services were predominately non-Hispanic with proficiency in English. The percentage of women with private insurance had the largest change pre- to post-launch—the percentage of women going to the health centers with public insurance decreased by 8 percentage points and the percentage with private insurance increased by the same amount.[11] Details from an analysis by Kranker et al. (2018) point to insurance status as a key predictor of unintended pregnancy, with women on Medicaid, other nonprivate, or no insurance being 8 percentage points more likely to have an unintended pregnancy than

[11] Over this same period, Missouri HealthNet enrollment declined roughly 9.5 percent from May 2018 to May 2019 (Ranji et. al 2019). Although Missouri's state government attributes this decline to improvements in the economy, a study by the Center for Children and Families at the Georgetown University Health Policy Institute suggests it resulted at least in part from flawed redetermination processes. An article by St. Louis Public Radio estimates that about 120,000 people lost their Medicaid coverage since the beginning of 2018 (Fentem 2019).

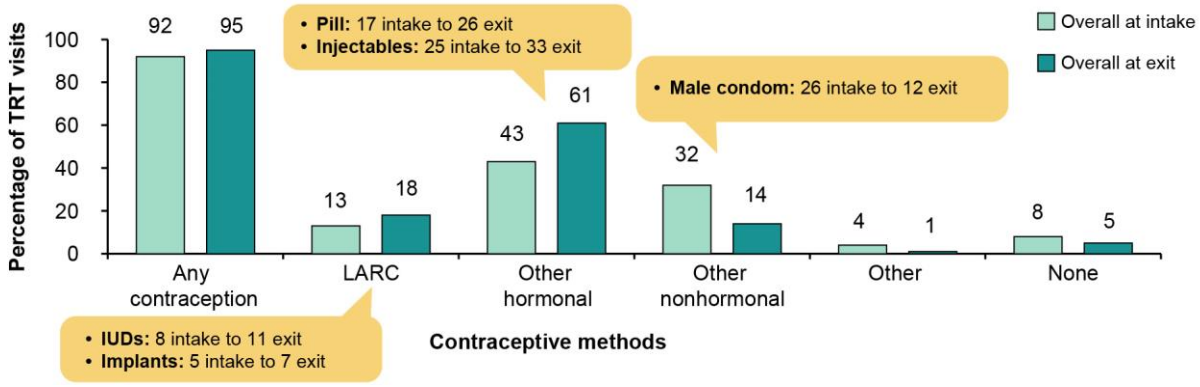
women who have private insurance.[12] This context implies that the initiative might have to focus on reaching more publicly insured or uninsured women as it progresses.

What is the change in contraceptive use among health center patients? Although the program has not resulted in many new patients, participating clinics have seen a slight increase in contraceptive use among their patients (Exhibit III.2). Overall, analysis of TRT data from health centers showed that the number of women using contraception increased by 3 percent between visit intake and exit. In addition, more than 20 percent of TRT women switched from less-effective nonhormonal methods to more-effective hormonal methods. And, within the clinic environment that offered women the option of low-cost contraception—no matter the type—LARC uptake also increased by 5 percent.

In general, patterns of contraceptive uptake varied significantly across various demographic groups. For example, Asian women were more likely to use LARC at exit than women of other races (24 percent compared with 15 to 20 percent; see Appendix D, Exhibit D.1). Not surprisingly, women ages 45 and older were significantly less likely to use LARC at exit than younger women were (11 percent compared with 17 to 20 percent; see Appendix D, Exhibit D.2). Women with higher incomes, those above 250 percent of the federal poverty level, were more likely to use LARC at exit than women with lower incomes were (22 percent compared with 17 to 20 percent; see Appendix D, Exhibit D.3). Similarly, women with private insurance were more likely to report using LARC at exit than women with public insurance or no insurance were (22 percent compared with 16 to 17 percent; see Appendix D, Exhibit D.4).

In particular, Black women switched to LARC at a statistically significantly lower rate than women of other races (5 versus 10 percent, results not shown). Conversely, the increase in LARC uptake was statistically significantly highest among women younger than age 18 (15 versus 8 percent among other age groups, results not shown). About 8 percent of women switched to LARC with no significant difference in uptake by income level or insurance status (that is, whether having public, private, or no insurance, results not shown).

Exhibit III.2. Contraceptive method at intake and exit



Source: Health center encounter data, 4/1/2019 to 9/30/2019.

IUD = intrauterine device; LARC = long-acting reversible contraception; TRT = The Right Time.

[12] Other characteristics associated with being more likely to have an unintended pregnancy included being unmarried, being younger, having multiple children, and delaying prenatal care.

What are the implications for achieving the initiative's goal? At this early stage, it is difficult to accurately predict the initiative's impact on unintended pregnancy. The projected reduction in unintended pregnancy is about 3 percent based on the contraceptive behaviors of women in this first cohort of health centers.[13] The minimal new foot traffic to the health centers and small change in new contraceptive uptake in Cohort 1 likely means the health centers would have to serve more women to observe substantial reductions in unintended pregnancies. But, as the initiative expands its reach to areas with high rates of unintended pregnancy and lower contraceptive access and use, the numbers of women that must be served to achieve the initiative's goal could decline substantially. At the same time, the impacts of coronavirus disease 2019 (COVID-19) on health services, especially delivery of contraceptives requiring in-person visits, and prescription access could influence uptake of contraception and slow progress.

[13] This rate is estimated based on assumptions about (1) the number of women served, (2) the change in contraceptive behavior among women served (for example, the percentage of women who changed from using no contraceptives to LARCs), (3) the likelihood of becoming pregnant using each method (assuming typical use, Guttmacher Institute 2020). Assuming that the number of women served in the second and third cohorts remains constant as the first, and that the change in contraceptive behavior among women served in the second and third cohorts remains the same as the women served in the first cohort, then we reach the estimate of a 3-percent reduction of unintended pregnancy overall.

Missouri women report costs as the leading barrier to using or switching contraceptive methods

Women participating in focus groups—especially younger women and those without insurance—said the largest barrier to using contraception or switching contraceptive methods was the cost. Without access to a preferred method, women often compromised and used more affordable generic brands. Although generic brand birth control has identical active ingredients to its name brand counterpart, it might not contain the same fillers and preservatives. Though not clinically supported, people complain of differences in side effects. In addition to costs of purchasing the contraceptive method, other factors associated with corresponding procedures (for example, LARC insertions and removal), copays, time off from work, child care, and transportation can further prohibit use of or switching methods. Without considering costs, many women said they would switch to a different method.

"I pay $9 a month for my pill. Because it's an off brand, it works, it's fine. I just hate it … and that makes it hard to stick to since I'm forgetful. I was on the NuvaRing before, but it just got so expensive that I just could absolutely not afford it anymore. You go to pick it up, it's 175 bucks."

– Focus group participant

"I've literally seen one of my co-workers give birth to a child because of a long wait to get into an appointment…."

– Focus group participant

"I think there is a real difference in reaction based on class. I think the way in which people asking for services are treated is based on race too."

– Focus group participant

"They forced the pill on me. I wanted to get the implant. And [the providers said], 'No, this is not good for you, we have so many people complaining about it.' It was like, 'Take the pill, take the pill, take the pill' and just forced it down my throat."

– Focus group participant

Analysis of information from 10 focus groups with 116 women showed that other barriers to using a preferred contraceptive method included difficulty obtaining timely or convenient follow-up appointments, lack of complete information about various options, and providers with little cultural competence to understand a patient's needs. If a health center does not provide same-day insertions for LARCs, women must set up a follow-up appointment; many prefer to leave their appointment with a method in hand, which often means they leave with a less-effective method. Women also perceive providers as treating women differently based on their insurance status and other demographic characteristics. Nearly all women think that providers push certain methods on them because the provider receives a monetary kickback. Because providers do not discuss the full range of options with women, women feel the burden is on them to research before appointments and advocate for themselves during the visits.

TRT seeks to eliminate these barriers to access by providing upfront funding to allow for initial stock of all available contraception so that all methods are available at the appointment. In addition, by training staff on LARC eligibility and same-day insertions, it seeks to increase same-day availability of all contraceptive methods. Trainings on contraceptive counseling, unconscious bias, and health equity aim to increase providers' awareness and support of patients' autonomy in making their own choice when comprehensive information is provided. As providers continue with these practices, it is hoped that patients become educated about all their options, feel empowered to make the right decision for themselves, and trust in the care they receive.

"The ultimate goal is to collect data to understand what the barriers are in the community. There will be different barriers for different areas, different zip codes, different communities, and different ethnic groups. [We need to look] at that data and then [put] some programs in place that move them forward."

– TRT provider

B. Organizational infrastructure and capacity in health centers for delivering equitable contraceptive care

The first cohort of health centers and their providers entered TRT with a strong knowledge base about providing contraceptive services and infrastructure to accommodate the full range of contraceptive services. But provider interviews and focus groups highlighted several key changes in their approach to contraceptive care under the initiative:

- Increased availability of same-day LARC insertion (five of the six health centers)
- Increased ability to offer full range of contraceptive options to all patients (four of six health centers)
- Removed cost as a key consideration to provider's recommendation of method (four of six health centers)
- Expanded nonphysician staff role in providing contraceptive care (three of six health centers)

These observed changes will be further quantifiable as these health centers enter subsequent years under the initiative. Responses to provider surveys will provide an opportunity to compare initial reports of baseline capacity against self-assessed capacity after one and a half years of TRT participation.

"And if you don't like it you don't have to keep it, you can come back and try something different, and that's a little different because I wouldn't want to talk someone into getting a $400 IUD, and then say if you don't like it don't worry about it. You know I wouldn't do that you might want to think about this a little more if you [are] having some reservations."

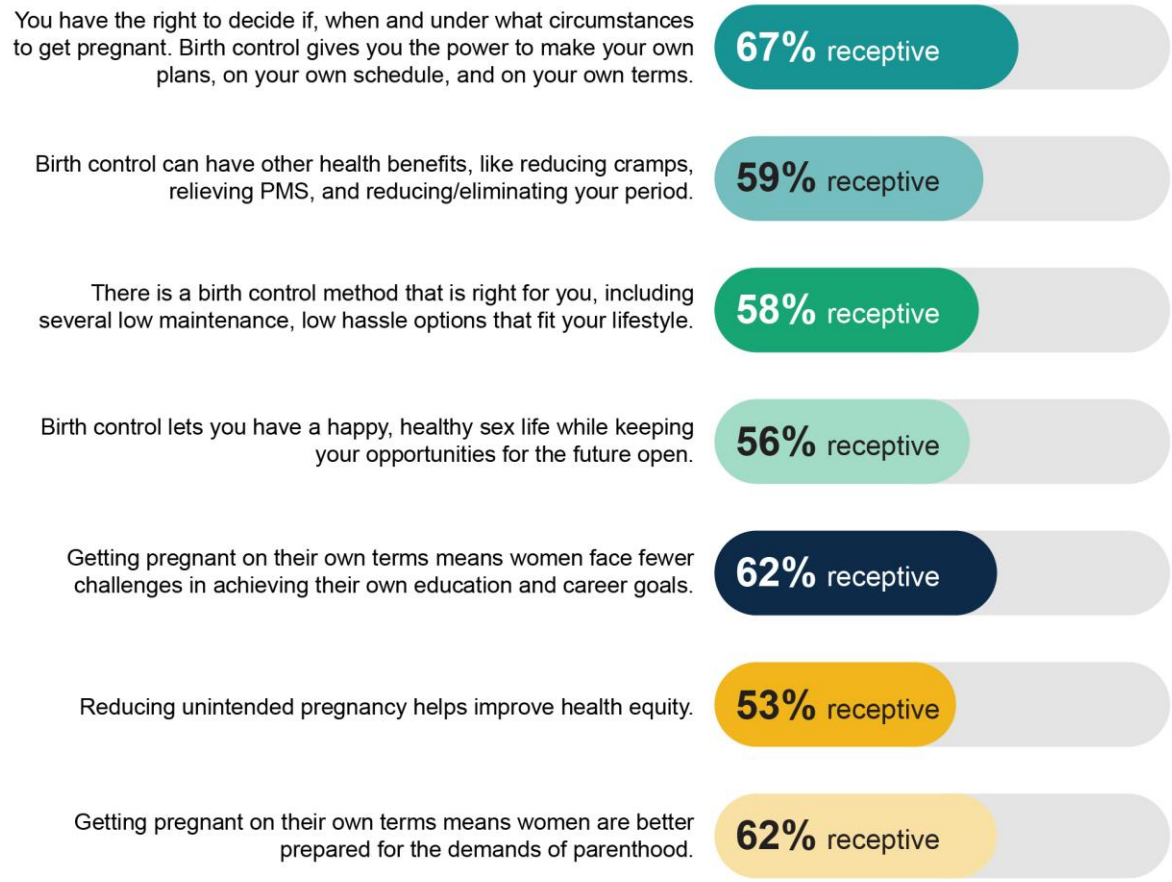
— TRT provider

C. Community norms and policies related to contraceptive access and use

In the year before TRT's launch, a telephone poll of 750 Missourians—conducted by random digit dialing—showed that little more than half of the public agreed with each of seven messages highlighting the benefits of access to birth control (Exhibit III.3). Less than half of the public, however, supported mandating access to birth control through legislative policy.[14] Thus, at the start of the initiative, public opinion in support of access to birth control was mixed. Reflecting these community norms, legislators ranked contraceptive access as low among their list of policy issues.

[14] The message "Missouri voters want sound policies that ensure access to birth control, an issue that has bipartisan support" had only 45 percent receptivity among those polled.

Exhibit III.3. Public opinion on birth control



Source: Power to Decide poll of 700 Missouri residents ages 18 to 49, 2018. All highlighted supportive statements had 53 to 66 percent receptivity of those polled.

PMS = premenstrual symptom.

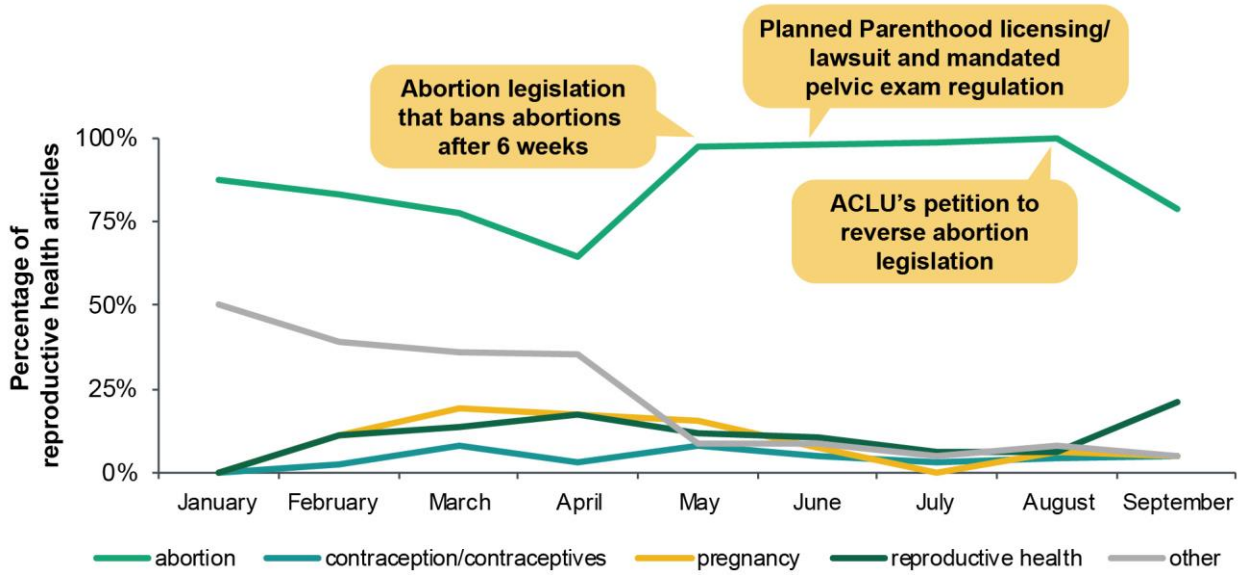
How has the narrative about contraception and unintended pregnancy trended in Missouri? TRT tried to focus the narrative about contraception on health and well-being, but making headway has been difficult because of the current Missouri legislative actions on abortion. Contraception has become easily entangled in this highly politicized conversation.[15] One policymaker noted that in Missouri "…the landscape and the legislature is a very conservative super majority right now…and one of the political challenges is…talking about family planning." The absence of contraceptive access-related legislation was another sign of abortion dominating the current conversation about reproductive health. Of the 330 Missouri bills introduced in 2019, only 35 discussed sexual and reproductive health. Of the 35, only 7 had to do with contraceptive access, another 12 discussed abortion, and 16 discussed other reproductive health issues. Not surprisingly, media coverage during the same year followed suit, with 88 percent of reproductive health-related articles framed around abortion (Exhibit III.4).

[15] House Bill 126 would establish the "Missouri Stands for the Unborn Act" that places new limits on abortion and was introduced by Rep. Nick Schroer (R). The bill bans abortion at eight weeks' gestation and would trigger a statewide abortion ban if the U.S. Supreme Court overturns *Roe v. Wade.*

Contraceptive access legislation in Missouri

- **HB 312:** Authorizes a tax credit for certain contraception costs
- **HB 487:** Changes the laws regarding the dispensing of contraceptives
- **HB 755:** Adds new provisions related to contraceptive coverage
- **HB 787:** Prohibits pharmacies in the state from providing emergency contraceptives over the counter
- **HB 1015:** Adds provisions relating to insurance coverage of prescription contraceptives
- **SB 338:** Excludes emergency contraception from MO HealthNet family planning coverage
- **SB 346:** Requires health benefit plans providing coverage for prescription contraceptives to cover a 13-month supply of the contraceptives

Exhibit III.4. Media coverage of reproductive health issues, January to September 2019



Source: Mathematica's analysis of relevant news articles published 1/1/2019 to 9/30/209 through LexisNexis databases.
Note: Articles can fall into multiple categories, therefore adding to more than 100 percent.
ACLU = American Civil Liberties Union.

Although the current reproductive health narrative in Missouri seems strongly focused on abortion, community partners point out this political environment offers an opportunity to educate policymakers on current facilitators of and barriers to accessing and using contraception to potentially reduce the need for abortions, while also stressing the importance of abortions as a reproductive right. In particular,

"While I believe right now is the time for these conversations across the state…I don't know that the legislature will be receptive. There is such a negative connotation around [family planning organizations that are associated with abortion], a challenge will be making sure to distinguish [TRT] from those organizations…"

— Legislator

partners believe that the most successful approach for engaging policymakers is to highlight how providing contraceptives benefits the state budget. In the first year of the initiative, however, little has changed in policy and community norms; these systems changes are often much slower and might be observable only after several years.

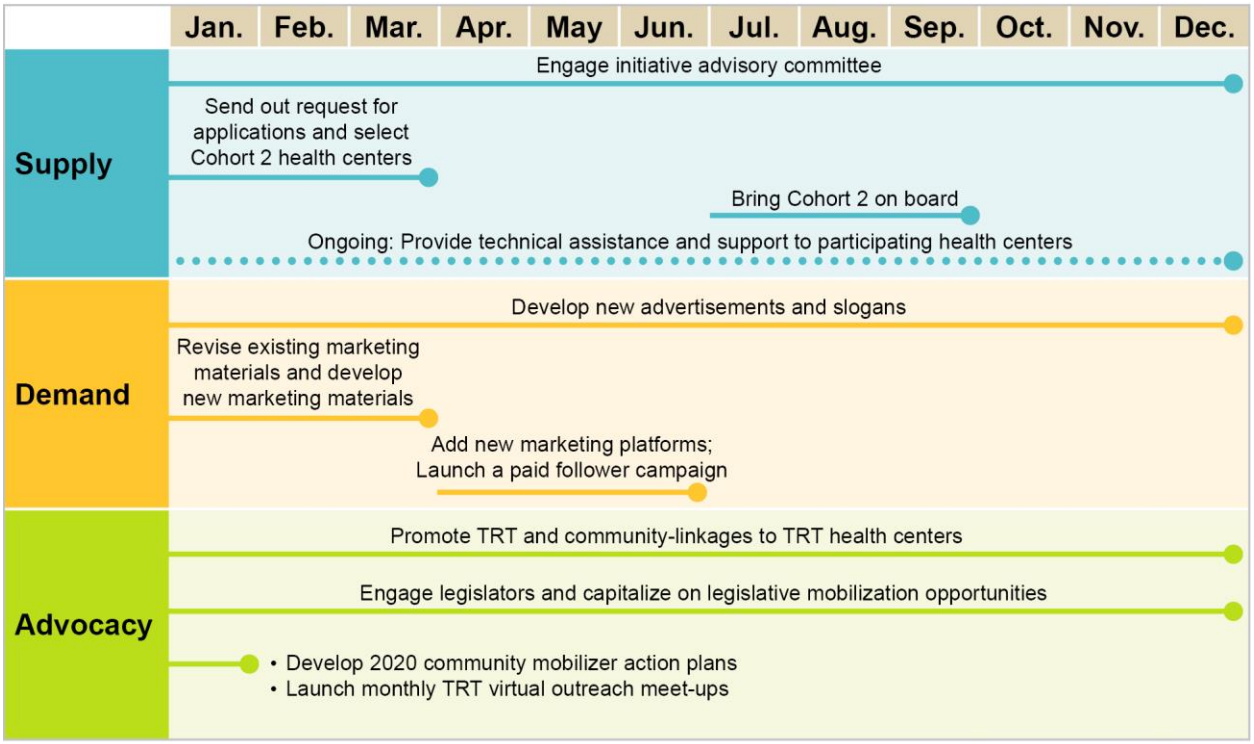
What key policy issues could improve access to comprehensive contraceptive options for populations experiencing poverty and other socioeconomic hardships? Beyond contraceptive access-specific policies, policymakers, community partners, and providers identified Medicaid expansion and the Women's Health Service Program as other avenues to removing obstacles to comprehensive contraceptive care.

- **The postpartum waiver for Medicaid** could extend coverage for new mothers from 60 days postpartum to 12 months after delivery (Stuebe et al. 2019). This would provide more time for new mothers to obtain and select the right contraceptive option for them without concerns about coverage and cost. Statewide efforts are underway to sway public opinion to put Medicaid expansion on the November 2020 ballot. If passed, about 271,500 people with low income—including 19,000 postpartum women—would receive additional coverage (Center for Health Economics and Policy 2019).
- **Women's Health Service Program** offers contraception and family planning education and services to women with incomes slightly too high to qualify for Medicaid; the program covers women for family planning services up to 200 percent of the federal poverty level. Streamlining the current application form could increase access to contraceptive services for many un- or underinsured women in the state. From January to September 2019, MFHC, as part of its TRT advocacy work, met 19 times with various legislators to discuss maintaining full funding of the Women's Health Service Program and removing provider restrictions. In addition, MFHC has ongoing meetings with the Missouri Department of Health and Senior Services to discuss opportunities to reduce the burden of the current application process and promote the program.

IV. GEARING UP FOR THE NEXT PHASE OF TRT

As the initiative enters its next year, it prepares to enroll another cohort of providers in summer 2020, expand its media campaign—including adding new channels for outreach—and collaborate on legislation and legislative mobilization opportunities (Exhibit IV.1).[16] With lessons learned from the first cohort of health centers, the supply strategy will focus on recruiting health centers in areas with lower contraceptive use and with potentially less experience in contraceptive care. The demand strategy will revise existing marketing materials based on health centers' and patients' feedback from the first round; add methods cards and trifold brochures to consumer materials for dissemination; and adopt new paid media strategies to promote advertisements on Google word searches, on Pandora, and through paid followers on Twitter and Facebook. Finally, the advocacy strategy will continue to press for including Medicaid expansion on the state's August ballot and persuade legislators to understand unintended pregnancy as an issue preventable through comprehensive contraception and with broad consequences to their constituents.

Exhibit IV.1. TRT activities 2020



TRT = The Right Time.

To date, TRT has only begun to fill gaps in access to contraception. Initial program data show that one-third of women are not seeking pregnancy at intake to a TRT health center; of these, 2 percent find out they are pregnant by the time of exit. As the program continues to roll out, we anticipate the number of women in these circumstances to decline. Time will reveal the effect that a multifaceted approach to reproductive health in a conservative state can have on improving health and equity.

[16] Because of COVID-19, Cohort 2 health centers join TRT in July instead of April 2020.

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Appendix A:

Baseline Evaluation Methods

Because of the importance of evaluation and evaluative work in service of equity in reproductive health, this study seeks to address how structural and historical decisions contribute to contraceptive access, use, and reproductive health outcomes. It acknowledges the differential effect The Right Time (TRT) had on various groups, its effect on underlying systemic drivers of inequity, and its entanglement with structural conditions and the cultural context. Because this study aligns with values of equity, including multiculturalism and community ownership, the evaluation uses a mixed-methods approach to elevate equity and ask additional questions across multiple perspectives.

Applying principles of equitable evaluation

- Address inherent and common biases in evaluation (for example, evaluations typically focus on accountability for investments rather than equity)
- Engage communities to shape how the evaluation happens
- Apply culturally appropriate and valid methods for communities
- Reveal structural and systems drivers of inequity
- Consider diversity in team member's disciplines, beliefs, and lived experiences

Adhering to equity principles to be inclusive in approach and viewpoints, the specific methods of the baseline evaluation include a variety of approaches and sources. A descriptive analysis leverages administrative data from TRT partners, the media, and other publicly available sources. The qualitative analysis relies on information from key informant interviews with TRT implementing partners, legislative and community representatives, and health center staff as well as focus groups with health center providers, their patients, and women of child-bearing age who were not patients. Finally, survey data and analysis provide insight from administrative and clinical providers on baseline characteristics of the participating health centers. The number of health centers and people represented through each data source and analysis approach varies. Therefore, the number of people contributing to specific findings in the report depend on the method used to collect and analyze the data. The study obtained institutional review board clearance to protect participating human subjects.

1. Descriptive analysis

Secondary data for the descriptive analysis come from sources shown in Exhibit A.1. Using an equitable evaluation lens, data are analyzed with consideration to structural drivers that affect health center participation (supply), lived experiences that influence interpretation and utility of messages (demand), and history of community interactions to promote or hinder engagement (environment). Stratifying data by health center enables close analysis of potential structural drivers across geography and demographics, such as ethnicity, race, age, and income level. Analyzing data for the same time period across various sources provides insight on alignment and differences across perspectives.

Exhibit A.1. Secondary data sources

Data source	Overview	Dates of data	Description	Mode	Strategy and research question(s)
MFHC programming tracker	Planning office training and technical assistance data	January to September 2019	6 trainings across 2 FQHCs and 4 non-FQHCs (also Title X) (collectively referred to as HCs)[a] 6 technical assistance contacts across 6 HCs	Electronic files	Supply: • How many and what types of HCs participated in the intervention?
HC encounter data[b]	Planning office HC level data	April[c] to September 2019	1 of 6 FQHCs and 4 of 6 non-FQHCs (also Title X)[d] 6,306 women receiving TRT services at visit 7,630 visits[e] including TRT services	Electronic files	
Power to Decide TRT administrative data	Communications office media data	January to September 2019	Counts vary by Google Analytics type	Electronic files	Demand: • How many people were exposed to TRT messages?
LexisNexis	Database of news articles	January to September 2019	788 reproductive health news articles[f,g]	Web-based database	Environment: • Which state policies are relevant to reproductive health? • What was the extent of outreach to community organizations and policymakers?
Outreach and education tracker (MFHC)	Planning office media data	January to September 2019	41 reproductive health articles	Electronic files	
Missouri Foundation for Health legislative tracker	Missouri legislative data	January 9 to May 30, 2019	35 sexual and reproductive health bills	Electronic files	
Outreach and education trackers (MFHC and 5 HCs) and community mobilization trackers (4 community partners and 1 HC)	Planning office advocacy, outreach, engagement, and legislative data	January to September 2019	94 TRT events and 193,279 participants reached Counts of advocacy, legislative, and engagement related activities vary by type	Electronic files	

[a] Title X agencies not part of TRT also participated in these trainings and received technical assistance from MFHC.

[b] Encounter data include information from a client visit record form that includes demographics, pregnancy status, and intention information.

[c] HCs began seeing women under TRT in April 2019, though the initiative launched in January 2019.

[d] One HC did not submit data because of an unforeseen data breach that made its data inaccessible.

[e] 211 visits were dropped as duplicates; the number of individual women remained the same.

[f] Articles contained the following key words: contracept* (captures contraceptive(s) and contraception); abortion; pregn* (captures pregnant, pregnancies, pregnancy); reproductive; family planning; fetal; birth control; maternal health; sex* ed* (captures sexuality education, sex ed, sex education); Missouri; MO; The Right Time.

[g] Categorized using Nobias, which "tracks media bias, credibility, authenticity, and politics in the press you read."

FQHC = federally qualified health center; HC = health center; MFHC = Missouri Family Health Council; TRT = The Right Time.

2. Qualitative analysis

To promote the viewpoints of a wide variety of participants, and to improve the quality and credibility of evaluation findings, Mathematica conducted the following activities:

- **Stakeholder interviews with bellwethers, policymakers, community partners, foundation and TRT partner staff, and TRT clinic trainers (n = 16).** These interviews captured information on the successes and challenges of deploying TRT. They provided insight into the factors that promote or impede contraceptive and reproductive health care, perceptions of contraception and state policies relevant to reproductive health, and other programs or services to help women avoid unintended pregnancy.
- **Health center staff interviews with clinic administrators, clinicians, and outreach and education coordinators (n = 19).** These staff provided insight into health center practices, key challenges in service delivery, operational procedures that support providing contraceptive care, delivery of contraceptive counseling and education to patients, and health center organizational policies. Health center staff shed light on the specific approaches used to implement TRT; emerging, promising, and best practices of implementation; and areas for course corrections.
- **Focus groups with health center staff and women of reproductive age (health center patients and nonpatients) (n = 16).** Health center patients and women of reproductive age offered their perspectives on knowledge, attitudes, and intentions related to contraception and unplanned pregnancy among the population of focus for the initiative. They also spoke about the types of information received from various sources on contraception and their contraceptive behavior and decision making processes. Focus groups with health center staff captured the views of staff who are not clinicians or administrators but are still affected by implementing the initiative.

Trained facilitators collected all qualitative data using a semistructured guide; the mode varied by respondent type. Facilitators used empathy interview techniques to take a human-centered approach to build rapport and trust, understand feelings and perspectives of interviewees, and encourage open and authentic conversation about experiences related to contraception. Facilitators obtained verbal consent before all phone interviews and written consent for all in-person interviews and focus groups. They recorded all discussions with permission and transcribed them to facilitate analysis. Exhibit A.2 shows the number and types of interviewees, Exhibit A.3 illustrates the process for selecting and recruiting participants, Exhibit A.4 shows the topics of interviews by type, and Exhibit A.5 presents the categories for qualitative coding and analysis.

Exhibit A.2. Overview of key informant interviews and focus groups

Interviewee category	Number of people interviewed	Interviewee characteristics	Length of interview, in minutes (mode)
Stakeholders			
Bellwethers and policymakers	5	1 Democrat state representative 1 Republican state representative 3 policy professionals	60 (phone)
Community partners	6	3 policy-level partners 3 service-level partners	60 (phone)
TRT partners[a]	3	Implementation partner Communications partner Planning office	90 (phone)
Trainers	2	1 curriculum developer 1 trainer	45 (phone)
HC staff			
Clinic administrators	6	1 clinic administrator from each HC	60 (phone)
Providers	12	2 providers from each health center	60 (in-person)
Outreach and education coordinator[b]	1	1 outreach and education coordinator	45 (in-person)
Focus group participants			
HC staff	54	Clinic administrators, clinicians, contraceptive counselors, outreach and education coordinators, billing staff, and front desk staff at each HC	60 (in-person)
Patients of reproductive age (ages 18 to 44)	69	Patients from each HC	60 (in-person)
Nonpatients of reproductive age (ages 18 to 44)	47[c]	Reproductive age women living in area served by HCs	60 (in-person)

[a] Group interviews of two or three people.

[b] Unplanned interview conducted during site visits.

[c] Two focus groups covered three HCs located in the St. Louis area. One focus group had no attendees.

HC = health center; TRT = The Right Time.

Exhibit A.3. Recruiting key informants and focus group participants

Selection and recruitment criteria

Stakeholders

- Ask partners for list of in-state people knowledgeable about contraception-related issues in Missouri and TRT
- Select stakeholders based on awareness of TRT; understanding of barriers to and facilitators of contraceptive care; knowledge of other programs for women to avoid unintended pregnancy; experience with advocacy efforts; awareness of state policy context; availability; and ability to add diversity of perspective to group
- Contact stakeholders via introductory email and schedule interviews

Health center staff

- Contact clinic administrator to identify health center staff with awareness of TRT; experience with training and technical assistance; and understanding of patients' experiences to interview
- Contact identified staff via introductory email and scheduled interviews

Focus group participants

- Health center staff
  - Coordinate with clinic administrator to identify staff to participate in the focus group across clinical (providers, nurses, and contraceptive counselors), operational (front desk and billing staff), and outreach (OECs) aspects of implementing TRT
  - Send an email invitation to identified staff and a reminder email three days before the focus group
- Patients of reproductive age
  - Collaborate with health center staff and external vendor to recruit patients
  - Provide incentive of $100 gift card to participants
- Nonpatients in community of reproductive age focus group
  - Distribute flyers at local organizations, set up a toll-free telephone line, and post on social media[a]
  - Collaborate with an external vendor to recruit participants
  - Provide incentive of a $100 gift card to participants

[a] No attendees showed up to this focus group.

OEC = outreach and education coordinator; TRT = The Right Time.

Exhibit A.4. Topics of interviews and focus groups, by participant type

Category	Type	Unintended pregnancies in community	TRT and related initiatives	Contraceptive care provision	Clinical action plan and reimbursement	Training and TA	Engagement with partners	Information: materials, sharing, and decision making	Experiences with birth control services and providers	Sustainability
Key informants	Bellwethers or policymakers	X	X					X		
	Community partners	X	X				X	X		X
	TRT partners		X				X			X
	Trainers	X	X			X	X			
Health center staff	Clinic administrators	X	X	X	X	X	X			
	Providers	X	X	X		X				
	Outreach and education coordinators	X	X	X		X				
Focus group participants	Health center staff	X	X	X		X				
	Patients of reproductive age							X	X	
	Nonpatients of reproductive age							X	X	

TA = technical assistance; TRT = The Right Time.

Exhibit A.5. Categories for qualitative coding

Code	Subcode	Description
Background	Participants' background	Role, time with health center or agency, responsibilities, and educational background and training
Community context	Issue	Whether unanticipated pregnancies are an issue
	Contributors	Biggest contributors to unintended pregnancies
	Prevention and rationale	What MFH, health centers, other organizations are doing to help prevent unintended pregnancies, and the reasons for and likelihood of addressing unintended pregnancy
	Gaps	Activities needed to reduce unintended pregnancy
The Right Time	Knowledge of and initial engagement	How, why, and in what ways respondents learned about TRT
	Materials and information sharing	Information or materials received, including the most and least useful, and needs for more information; information shared and reaction to information sharing
	Purpose and goals	Purpose, goals, and interests in TRT and how likely the initiative will reach its goals; any risks to achieving goals
	Activities	Main activities (administrative, technical, and financial); frequency; and resources devoted
	Benefits	Benefits to participating
	Successes (supply)	Successes (or potential successes) related to improving supply and availability of contraceptive services
	Successes (demand)	Successes (or potential successes) related to increasing demand
	Successes (advocacy)	Successes (or potential successes) related to advocacy prong
	Barriers and challenges (supply)	Challenges related to improving supply and availability of contraceptive services
	Barriers and challenges (demand)	Challenges related to increasing demand
	Barriers and challenges (advocacy)	Challenges related to advocacy prong
	Barriers and challenges (implementation)	Challenges related to implementing TRT
	Other initiatives	Other initiatives related to reducing unintended pregnancy or increasing LARCs
Contraceptive care	Health center workflow	Health center workflow, including what works well and what needs improvement, any challenges encountered and changes made
	Approach to contraceptive counseling	Approach to providing contraceptive counseling, the full range of contraceptive options, and providing LARCs, including what works well, challenges encountered, and changes made
Clinical action plan	Key aspects	Key aspects of the clinical action plan
	Implementation	Aspects of the clinical action plan that have been easy, difficult, or not possible to implement
	Effectiveness	Aspects of the clinical action plan that have been most and least effective in increasing the use of contraception
	Assistance	Types of assistance received from MFHC, including whether the assistance addressed any challenges or barriers in implementing the clinical action plan
	Resources	Resources and funding used for the clinical action plan

Code	Subcode	Description
Reimbursement plan	Key aspects	Key aspects of the reimbursement plan
	Implementation	Aspects of the reimbursement plan for uninsured patients that have been easy, difficult, or not possible to implement
	Effectiveness	Aspects of reimbursement for uninsured patients that have been most and least effective in increasing the use of contraception
	Assistance	Types of assistance received from MFHC, including whether the assistance addressed any challenges or barriers related to the reimbursing uninsured patients
	Resources	Resources and funding used for reimbursing uninsured patients
Training and TA	Content	Training and TA received
	Usefulness	Most and least useful type of training and TA for self and staff
	Needs	Training or TA needs for self or staff
Partnerships	Internal initiatives	Collaboration, frequency of interaction, what has worked well, challenges, and what could be done differently [MFH–MFHC; MFH–Power to Decide; MFHC–Power to Decide]
	Community level	Collaboration, frequency of interaction, what has worked well, challenges, and what could be done differently [MFHC–health centers; MFHC–community partners; Power to Decide–community partners; community partners–others; health centers–other agencies]
Patients' experiences	Birth control services	Where and how patients access birth control services, including likes and dislikes related to services sought and received
	Challenges	Challenges related to accessing birth control services
	Providers	Experiences with providers, including likes and dislikes, trust, and counseling received
	Contraceptive knowledge	Sources of information on birth control, knowledge about LARCs, and additional needs and of TRT
	Decision making	Decisions about birth control methods, including importance of information by clinician and partner's feelings
Sustainability	Sustainability	Sustainability vision, planning, and feasibility, including components that might be easy or difficult to sustain

LARC = long-acting reversible contraception; MFH = Missouri Foundation for Health: MFHC = Missouri Family Health Council; TA = technical assistance; TRT = The Right Time.

3. Provider survey and analysis

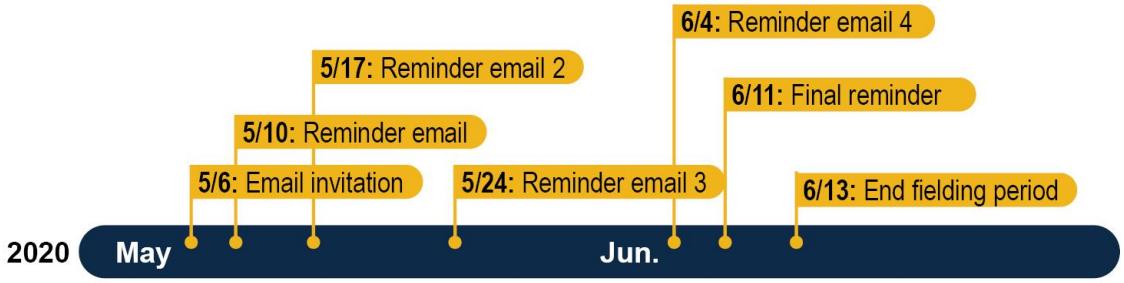
Surveys with clinic administrators (n = 7 people representing six health centers) and clinicians (n = 21 people representing six health centers) yielded information on the pre-launch health center operations and staffing, practitioners' behaviors, and patients' demographics. Survey instruments adapted questions from the Survey of Clinics Providing Contraceptive Services (Guttmacher Institute 2010), Contraceptive Access Assessment (Family Planning National Training Center 2017), LARC First Practice Survey (Contraceptive Choice Project 2013), LARC Needs Assessment Survey (Vermont Child Health Improvement Program n.d.), and Clinical Cultural Competency Questionnaire (Robert Wood Johnson Medical School 2001) and included questions developed specifically for the purposes of the initiative. The administrator survey had 168 questions and the clinician survey had 80 questions across the following modules: health center type (clinic administrator only), staff roles and responsibilities, daily work and work environment, training and technical assistance, and demographic and background

information. Two providers at a non-TRT Missouri Title X health center pre-tested each survey to solicit feedback on its content, framing, and completion time. The final web-based survey took respondents an average of 21 minutes (clinician survey) or 56 minutes (clinic administrator survey) to complete. (The initiative will administer the same surveys at 18 and 42 months after baseline to capture data on any changes in these domains.) Exhibit A.6 provides additional detail on the recruitment and fielding processes, and Exhibit A.7 provides the response rate. Both surveys underwent descriptive analyses to assess baseline clinic infrastructure, capabilities, and staff training needs.

Exhibit A.6. Survey recruitment and fielding processes

Selection and recruitment criteria

- Ask partners for list of clinic administrator and clinician names and email addresses for all participating health centers
- Send email introducing survey and with a link to web survey
- Send reminder emails over the five-week fielding period



Note: Dates differ slightly by health center.

Exhibit A.7. Survey respondents' response rate

Type	Complete	Partial complete	Incomplete	Total	Response rate
Clinic administrator[a]	7	0	0	7	100%
Clinician[b]	19	2	9	30	65%[c]
Total	**28**		**9**	**37**	**76%**

[a] Includes one clinic administrator from five health centers and two clinic administrators from one health center.

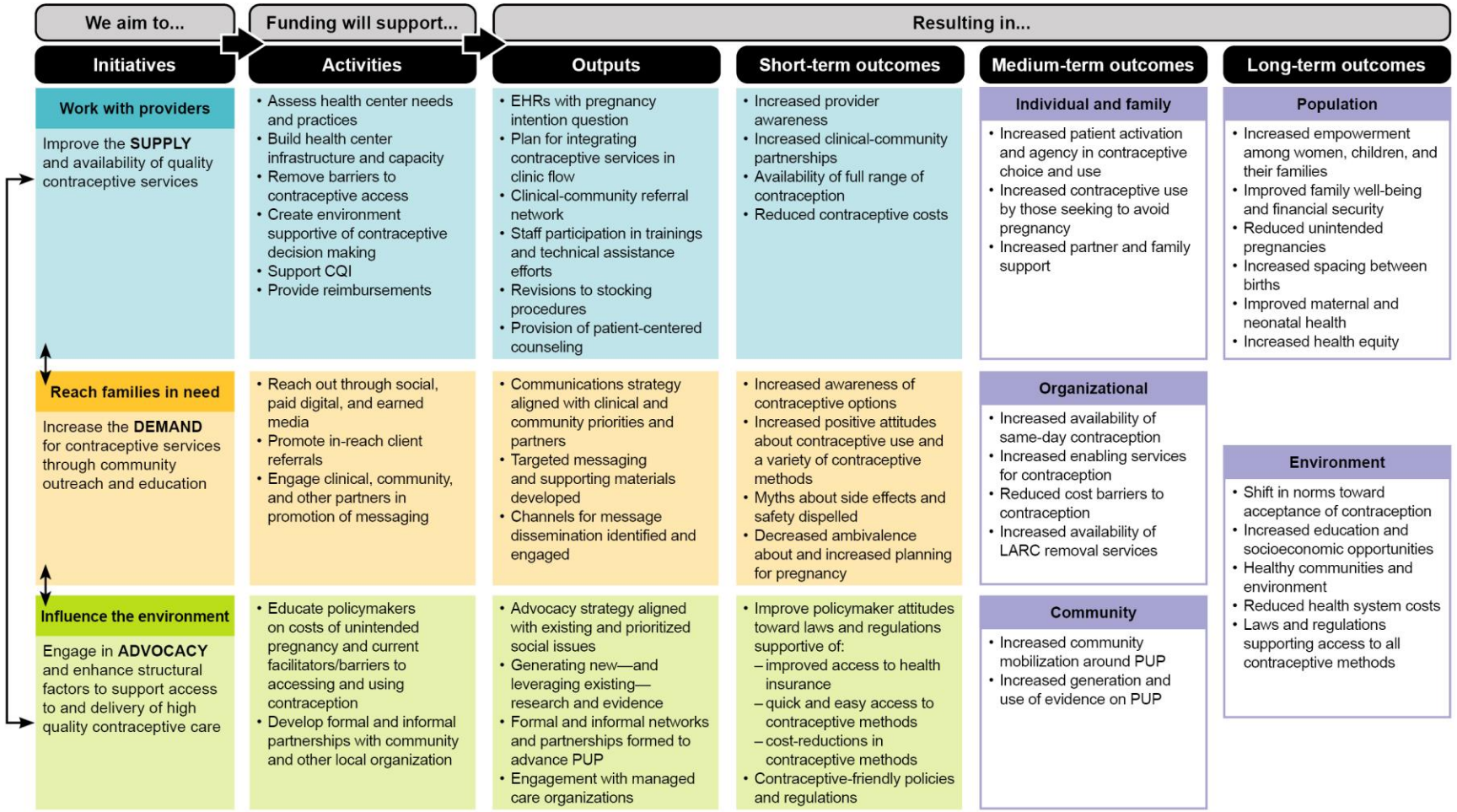
[b] Includes at least two clinicians from each health center.

[c] Response rate by health center ranges from 50 to 100 percent.

Appendix B:

Logic Models

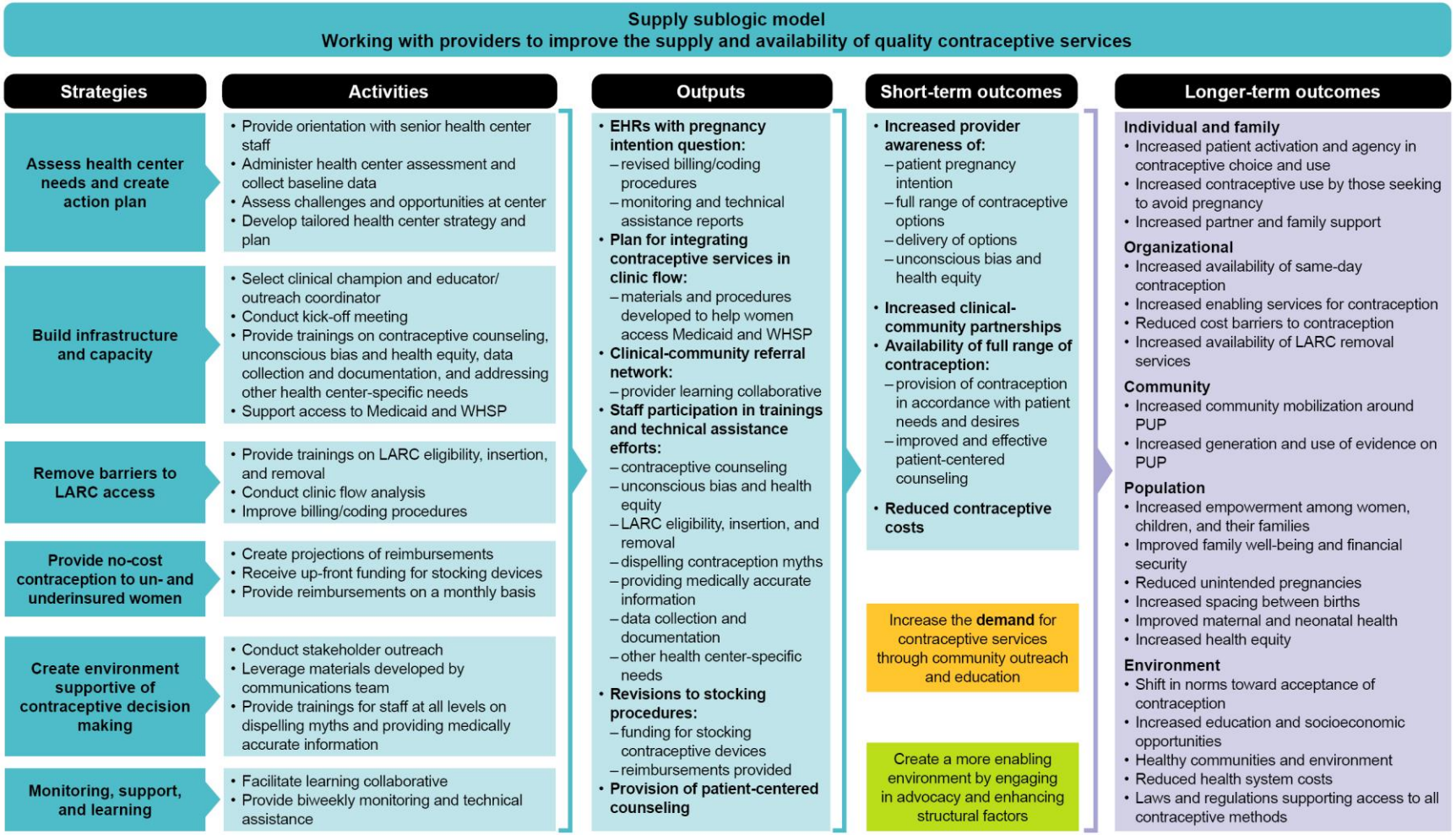
Exhibit B.1. Detailed TRT logic model



Note: Interventions are implemented in areas identified and prioritized as hot spots.

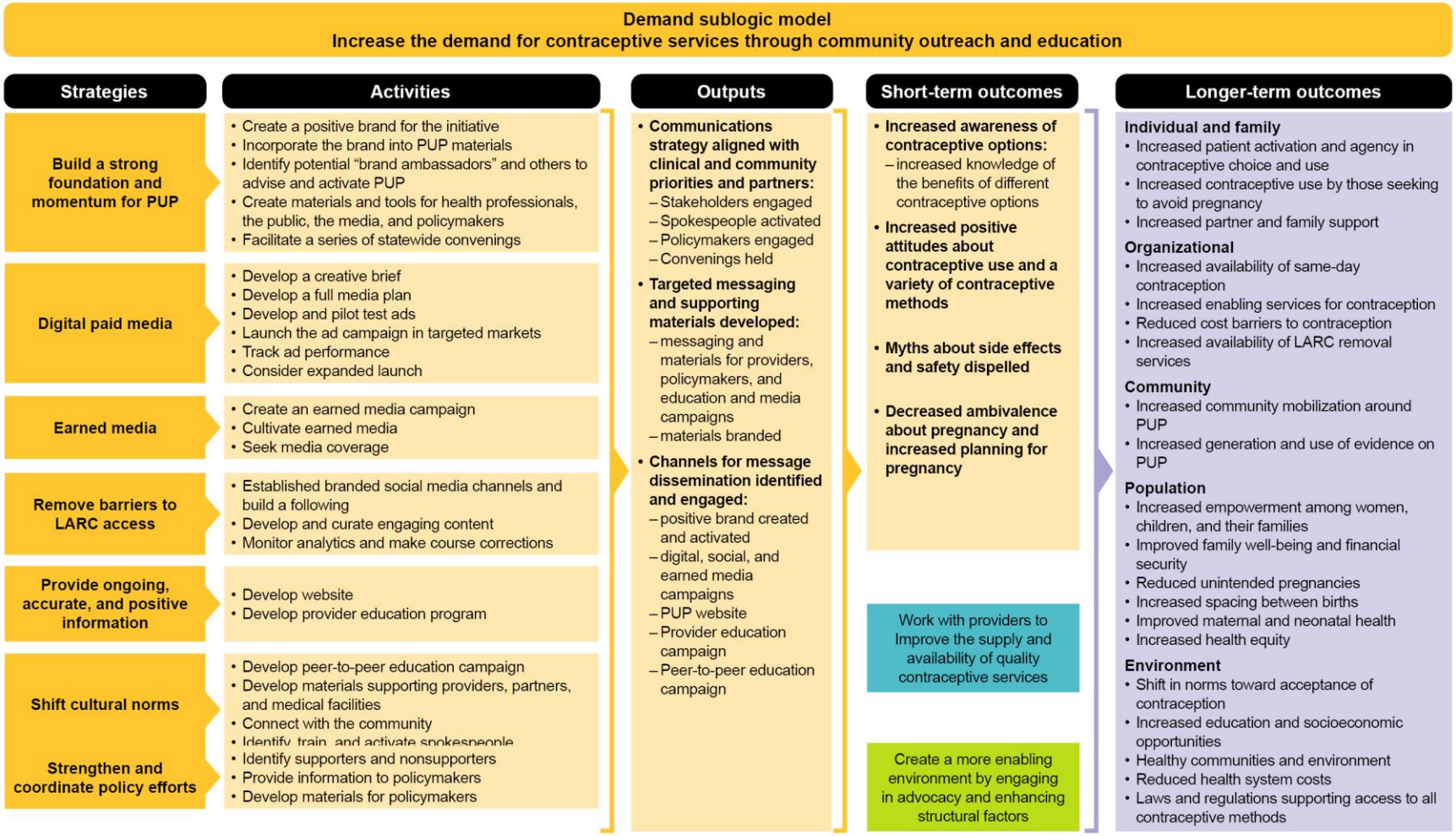
CQI = continuous quality improvement; EHR = electronic health record; LARC = long-acting reversible contraception; PUP = prevention of unintended pregnancy; TRT = The Right Time; WHSP = Women's Health Service Program.

Exhibit B.2. Supply strategy sublogic model



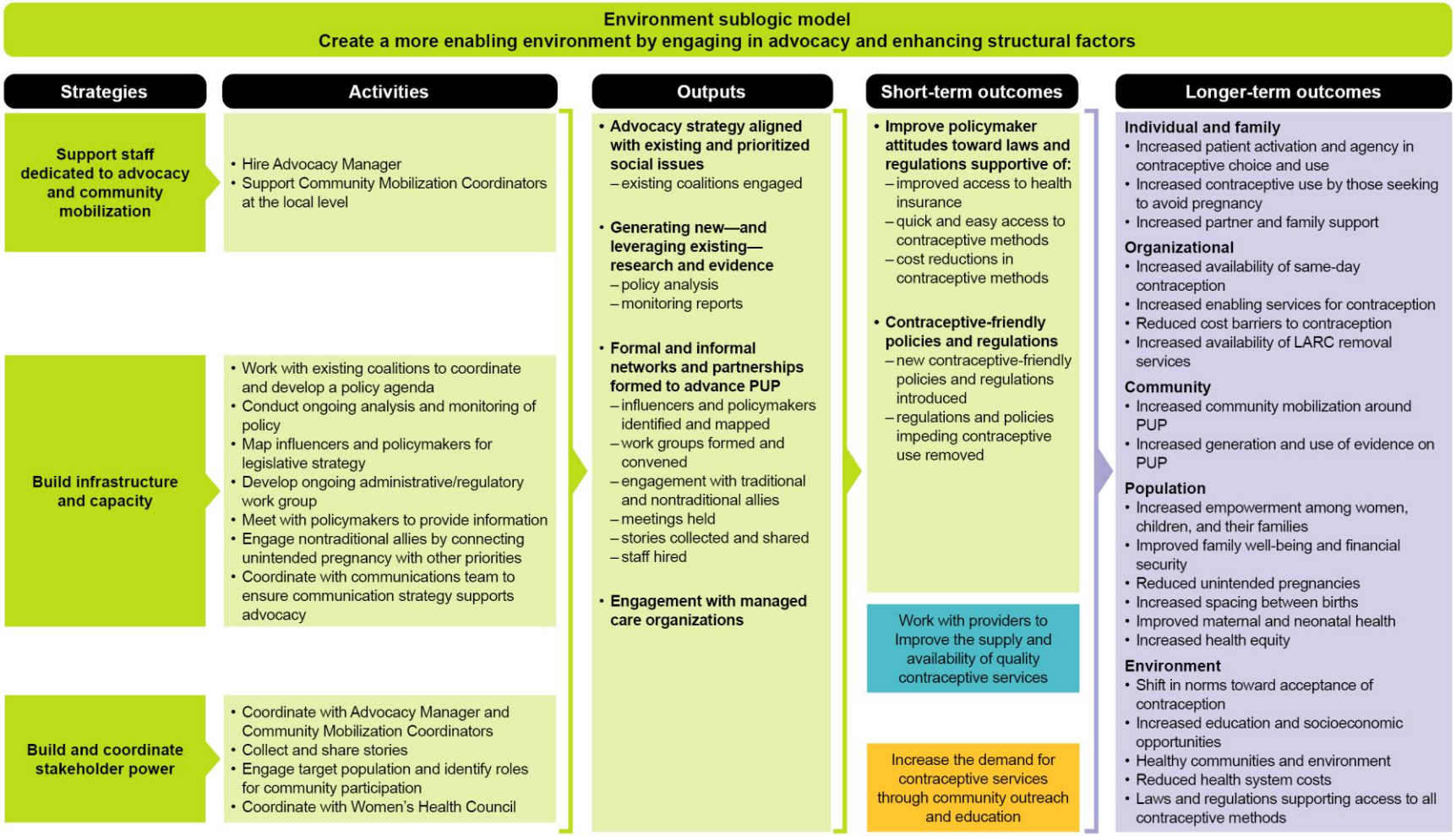
LARC = long-acting reversible contraception; PUP = prevention of unintended pregnancy; WHSP = Women's Health Service Program.

Exhibit B.3. Demand strategy sublogic model



LARC = long-acting reversible contraception; PUP = prevention of unintended pregnancy.

Exhibit B.4. Advocacy strategy sublogic model

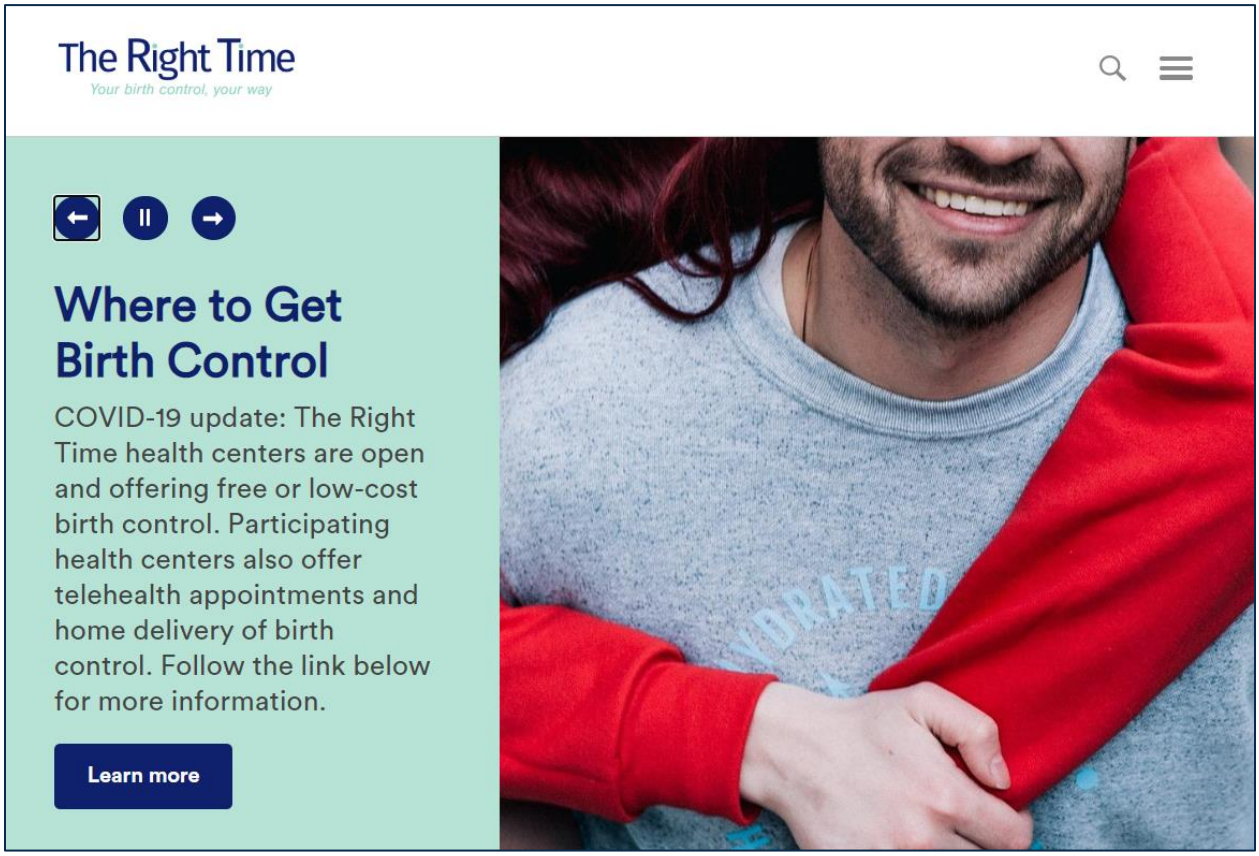


LARC = long-acting reversible contraception; PUP = prevention of unintended pregnancy.

Appendix C:

TRT marketing materials

Exhibit C.1. TRT website screenshots



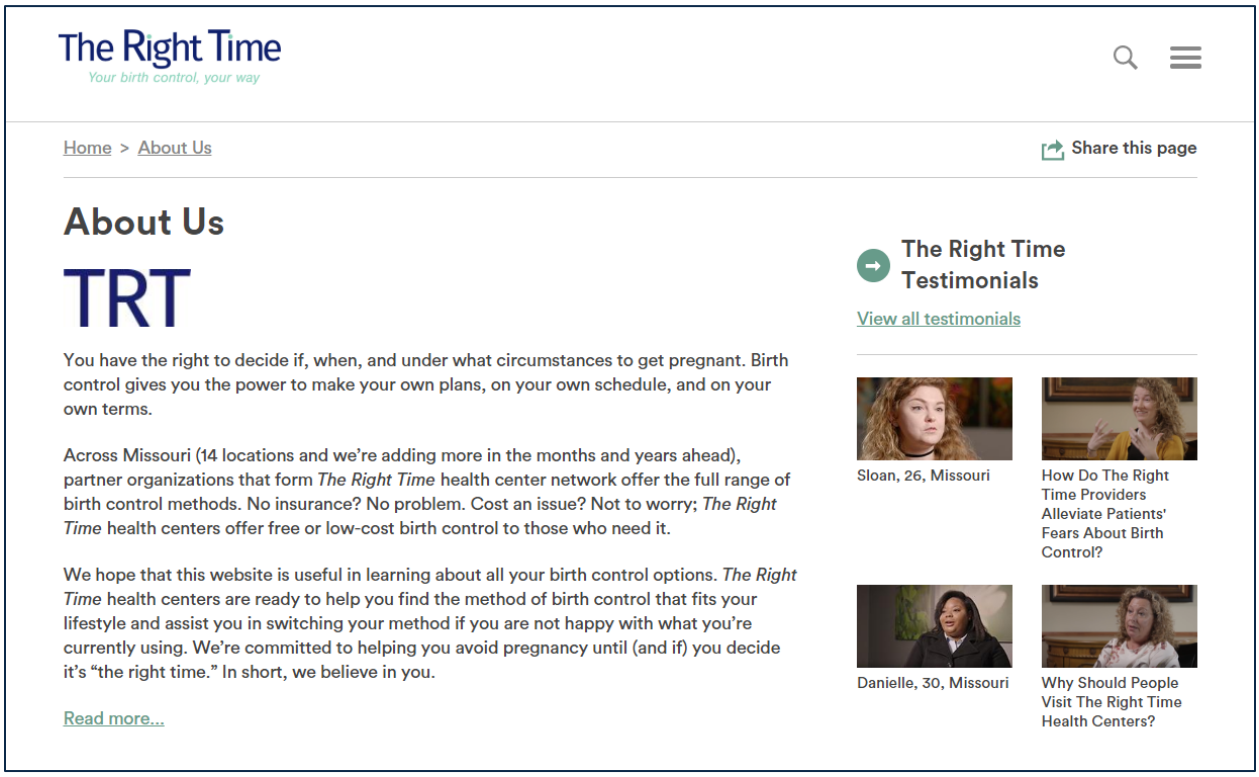


Exhibit C.2. TRT social media account screenshots

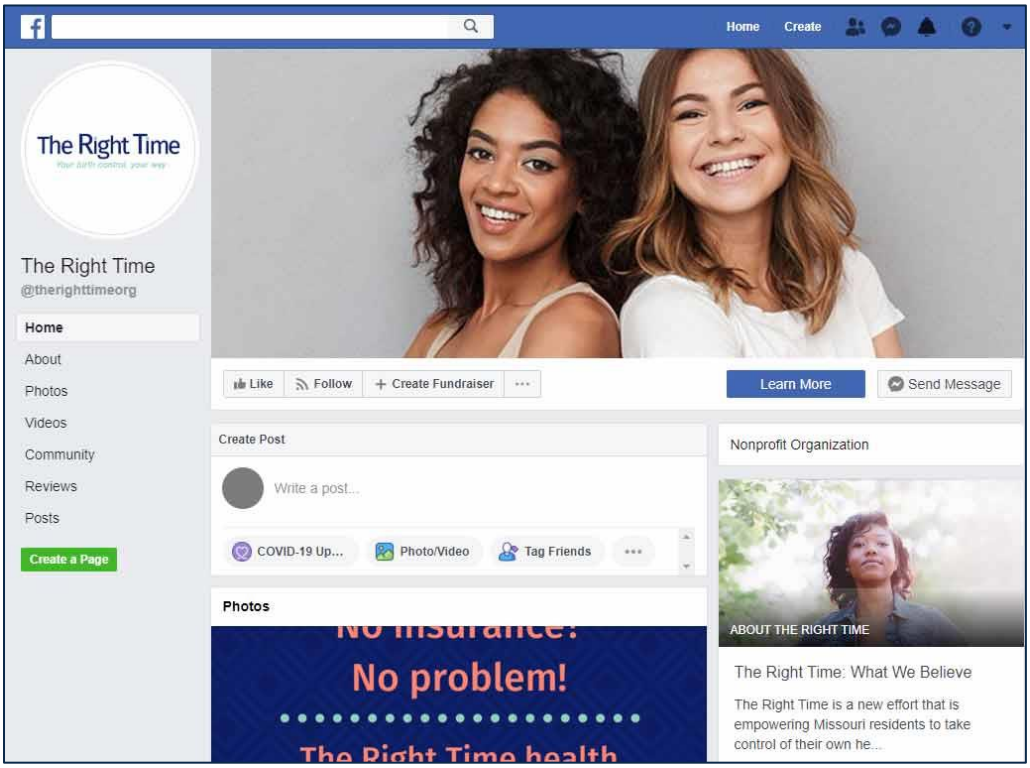
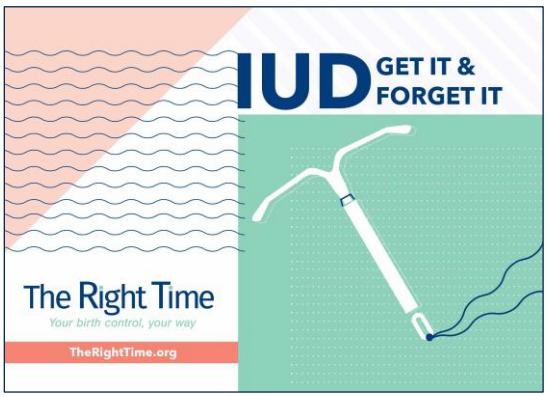
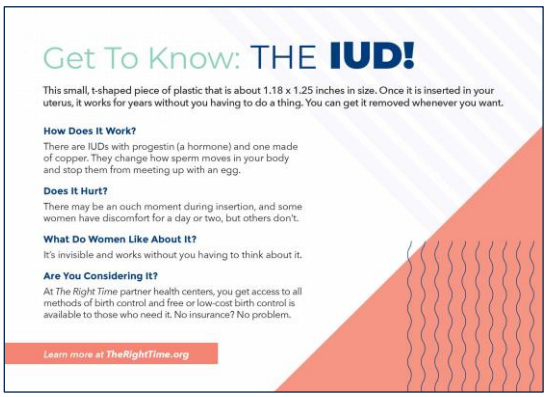


Exhibit C.3. Samples of palm cards





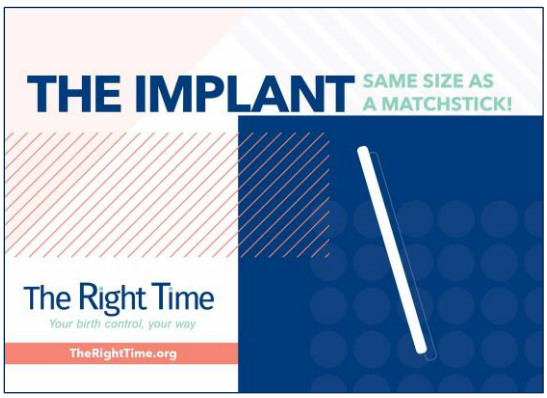
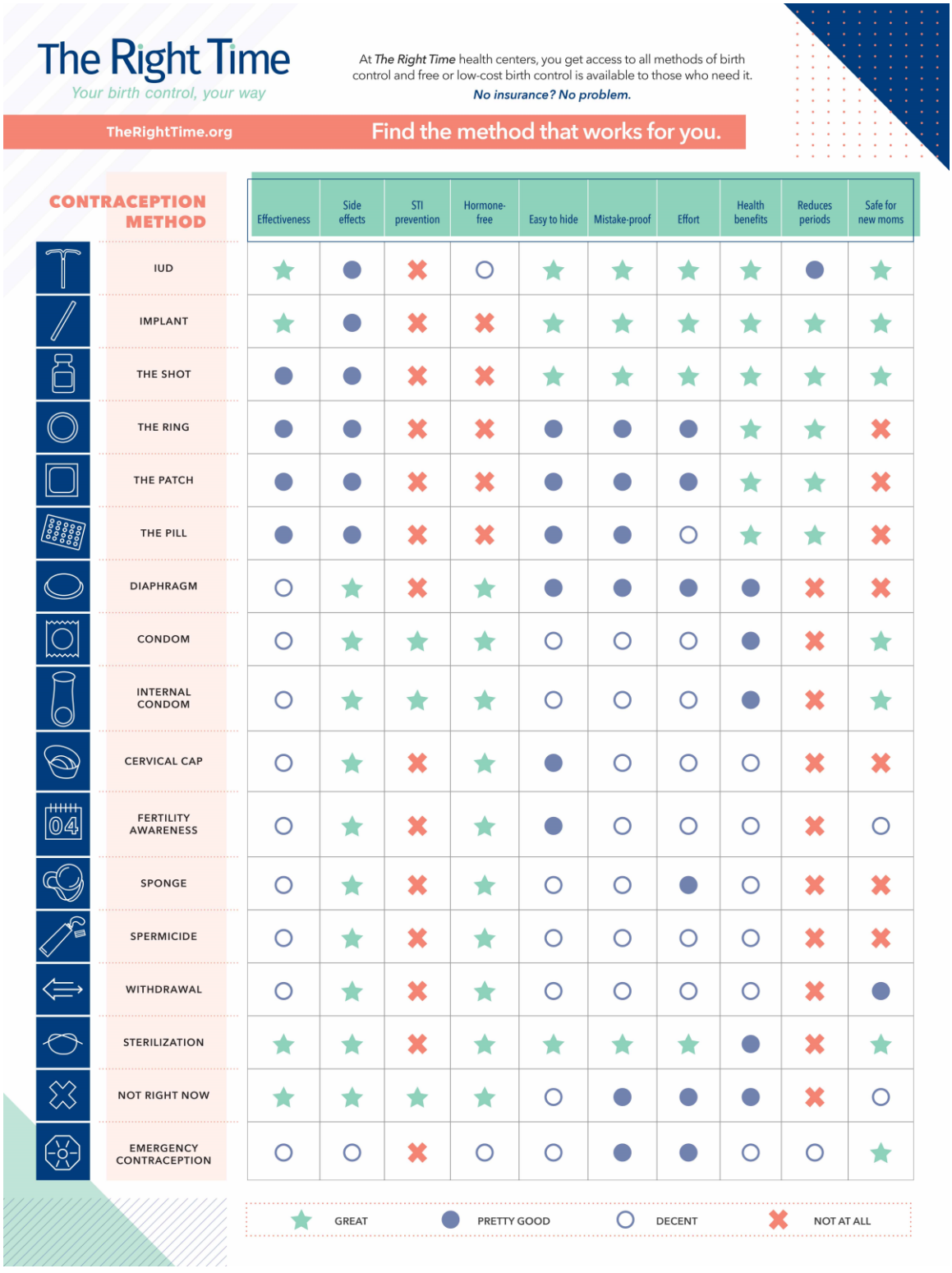


Exhibit C.4a. Samples of postcards and posters/tear sheets

Exhibit C.4b. Samples of postcards and posters/tear sheets



Appendix D:

Supplemental Exhibits

Exhibit D.1. Contraceptive methods used at TRT visit intake, by English proficiency, race, and ethnicity, April 2019 to September 2019 (percentages)

		Demographics***						
	Overall	Limited English proficiency	Hispanic	White	Black	Asian	Other race	Missing race
Number of visits among nonpregnant women and women not seeking to become pregnant	**7,320**	**215**	**419**	**4,157**	**2,520**	**166**	**168**	**309**
Percentage of TRT visits among nonpregnant women and women not seeking to become pregnant								
Contraceptive method at intake								
Any contraception	92	94	92	91	93	94	95	91
LARC	13	33	23	14	13	14	10	11
Other hormonal	43	38	36	43	44	48	49	42
Other nonhormonal	32	20	29	30	33	31	31	36
Other	4	4	4	4	2	1	4	2
None	8	6	8	9	7	6	5	9
Contraceptive method at exit								
Any contraception	95	95	95	96	93	96	95	92
LARC	18	40	32	20	15	24	15	17
Other hormonal	61	44	50	62	59	58	68	61
Other nonhormonal	14	10	11	13	18	13	11	15
Other	1	2	1	1	1	1	0	0
None	5	5	5	4	7	4	5	8

Source: Health center encounter data, April 1, 2019, to September 30, 2019.

Notes: Excludes data for one health center. Excludes 223 visits for women who were pregnant. Contraceptive method categories (LARC, other hormonal, other nonhormonal, other) might not add up exactly to the Any contraception row because of rounding. Contraceptive method subcategories (for example, IUD and implant) might not sum to the contraceptive method categories (for example, LARC) because of rounding.

These data include 7,320 visits with 6,027 individual women (average 1.21 visits per woman).

Other race includes American Indian, Alaskan, Native Hawaiian, Pacific Islander, and mixed race.

*** Difference in distribution of types of contraceptive methods used by each demographic class (limited English proficiency versus not, Hispanic versus not Hispanic, and among each race category) is significantly different from zero at the 0.01 level.

IUD = intrauterine device; LARC = long-acting reversible contraception; TRT = The Right Time.

Exhibit D.2. Contraceptive methods used at TRT visit intake and exit, by age, April 2019 to September 2019 (percentages)

	Overall	Age				
		Younger than 18	18 to 24	25 to 34	35 to 44	45 and older
Number of visits among nonpregnant women and women not seeking to become pregnant	**7,320**	**686**	**2,657**	**2,663**	**1,066**	**248**
Percentage of TRT visits among nonpregnant women and women not seeking to become pregnant						
Contraceptive method at intake* **						
Any contraception	92	92	91	92	92	88
LARC	13	5	13	16	15	8
Other hormonal	43	42	45	42	43	45
Other nonhormonal	32	42	31	30	31	30
Other	4	3	3	4	3	4
None	8	8	9	8	8	12
Contraceptive method at exit* **						
Any contraception	95	98	94	94	95	94
LARC	18	19	18	20	17	11
Other hormonal	61	74	64	57	57	58
Other nonhormonal	14	5	11	16	21	25
Other	1	0	1	1	1	1
None	5	2	6	6	5	6

Source: Health center encounter data, April 1, 2019, to September 30, 2019.

Notes: Excludes data for one health center. Excludes 223 visits for women who were pregnant. Contraceptive method categories (LARC, other hormonal, other nonhormonal, other) might not sum to the Any contraception row because of rounding. Contraceptive method subcategories (for example, IUD and implant) might not sum to the contraceptive method categories (for example, LARC) because of rounding.

These data include 7,320 visits with 6,027 individual women (average 1.21 visits per woman).

*** Difference in the distribution of type of contraceptive methods used among age groups is significantly different from zero at the 0.01 level.

IUD = intrauterine device; LARC = long-acting reversible contraception; TRT = The Right Time.

Exhibit D.3. Contraceptive methods used at TRT visit intake and exit, by poverty status, April 2019 to September 2019 (percentages)

	Overall	Poverty status				
		≤ 100%	101 to 150%	151 to 200%	201 to 250%	> 250%
Number of visits among nonpregnant women and women not seeking to become pregnant	**7,320**	**4,131**	**1,153**	**639**	**374**	**1,023**
Percentage of TRT visits among nonpregnant women and women not seeking to become pregnant						
Contraceptive method at intake* **						
Any contraception	92	91	91	92	92	93
LARC	13	12	14	14	16	17
Other hormonal	43	44	43	44	42	41
Other nonhormonal	32	32	31	31	30	32
Other	4	4	4	4	4	3
None	8	9	9	8	8	7
Contraceptive method at exit* **						
Any contraception	95	95	94	96	95	94
LARC	18	17	19	1	20	22
Other hormonal	61	6	61	59	61	5
Other nonhormonal	14	14	13	18	14	17
Other	1	1	1	2	1	1
None	5	5	6	4	5	6

Source: Health center encounter data, April 1, 2019, to September 30, 2019.

Notes: Excludes data for one health center. Excludes 223 visits for women who were pregnant. Contraceptive method categories (LARC, other hormonal, other nonhormonal, other) might not sum to the Any contraception row because of rounding. Contraceptive method subcategories (for example, IUD or implant) might not sum to the contraceptive method categories (for example, LARC) because of rounding.

These data include 7,320 visits with 6,027 individual women (average 1.21 visits per woman).

*** Difference in distribution of type of contraceptive methods used among poverty status groups is significantly different from zero at the 0.01 level.

IUD = intrauterine device; LARC = long-acting reversible contraception; TRT = The Right Time.

Exhibit D.4. Contraceptive methods used at TRT visit intake and exit, by insurance type, April 2019 to September 2019 (percentages)

	Overall	Insurance type		
		Women with public insurance	Women with private insurance	Uninsured women
Number of visits among nonpregnant women and women not seeking to become pregnant	**7,320**	**1,558**	**2,510**	**3,252**
Percentage of TRT visits among nonpregnant women and women not seeking to become pregnant				
Contraceptive method at intake* **				
Any contraception	92	92	93	91
LARC	13	13	17	11
Other hormonal	43	43	42	45
Other nonhormonal	32	33	31	31
Other	4	3	3	4
None	8	8	7	9
Contraceptive method at exit* **				
Any contraception	95	96	95	94
LARC	18	17	22	16
Other hormonal	61	62	57	64
Other nonhormonal	14	16	16	13
Other	1	1	1	1
None	5	4	5	6

Source: Health center encounter data, April 1, 2019, to September 30, 2019.

Notes: Excludes data for one health center. Excludes 223 visits for women who were pregnant. Contraceptive method categories (LARC, other hormonal, other nonhormonal, and other) might not sum to the Any contraception row because of rounding. Contraceptive method subcategories (for example, IUD or implant) might not sum to the contraceptive method categories (for example, LARC) because of rounding.

These data include 7,320 visits with 6,027 individual women (average 1.21 visits per woman).

*** Differences in distribution of type of contraceptive methods used among insurance groups is significantly different from zero at the 0.01 level.

IUD = intrauterine device; LARC = long-acting reversible contraception; TRT = The Right Time.

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