



Facilitators and Barriers to Healthy Pregnancy Spacing among Medicaid Beneficiaries: Findings from the National Strong Start Initiative

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ABSTRACT

Background: Closely spaced, unintended pregnancies are common among Medicaid beneficiaries and create avoidable risks for women and infants, including preterm birth. The Strong Start for Mothers and Newborns Initiative, a program of the Center for Medicare and Medicaid Innovation, intended to prevent preterm birth through psychosocially based enhanced prenatal care in maternity care homes, group prenatal care, and birth centers. Comprehensive care offers the opportunity for education and family planning to promote healthy pregnancy spacing.

Methods: As of March 30, 2016, there were 42,138 women enrolled in Strong Start and 23,377 women had given birth. Individual-level data were collected through three participant survey instruments and a medical chart review, and approximately one-half of women who had delivered ($n = 10,374$) had nonmissing responses on a postpartum survey that asked about postpartum family planning. Qualitative case studies were conducted annually for the first 3 years of the program and included 629 interviews with staff and 122 focus groups with 887 Strong Start participants.

Results: Most programs tried to promote healthy pregnancy spacing through family planning education and provision with some success. Group care sites in particular established protocols for patient-centered family planning education and decision making. Despite program efforts, however, barriers to uptake remained. These included state and institutional policies, provider knowledge and bias, lack of protocols for timing and content of education, and participant issues such as transportation or cultural preferences.

Conclusions: The Strong Start initiative introduced a number of successful strategies for increasing women's knowledge regarding healthy pregnancy spacing and access to family planning. Multiple barriers can impact postpartum Medicaid participants' capacity to plan and space pregnancies, and addressing such issues holistically is an important strategy for facilitating healthy interpregnancy intervals.

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Closely spaced pregnancies generate risks for women and infants (Conde-Agudelo, Rosas-Bermúdez, Castaño, & Norton, 2012). Despite the importance of planning any future pregnancies to optimize subsequent pregnancy outcomes, many women face postpartum barriers to healthy spacing for their

next pregnancy. This article investigates postpartum family planning access for women enrolled in the Center for Medicare and Medicaid Innovation's Strong Start for Mothers and Newborns initiative, a program designed to reduce rates of preterm birth and other adverse pregnancy outcomes for Medicaid and Children's Health Insurance Program (CHIP) participants (for simplicity, both programs generally are referred to as Medicaid hereafter).

Approximately one-third of pregnancies among multiparous women are conceived within 18 months of the prior birth, considered a short interpregnancy interval (SIPI; Gemmill & Lindberg, 2013). SIPIs do not allow sufficient time for a woman's body to heal and increase risks for complications such as

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placental disorders that lead to maternal hemorrhage, a primary cause of maternal mortality (Conde-Agudelo, Rosas-Bermúdez, & Kafury-Goeta, 2006; Conde-Agudelo et al., 2012; Creanga et al., 2015). Infants born after a SIPI are at increased risk for being born preterm (before 37 completed weeks' gestation), at low birthweight (less than 2,500 grams) or small for gestational age (Conde-Agudelo et al., 2006, 2012; DeFranco, Stamilio, Boslaugh, Gross, & Muglia, 2007). Preterm birth is a leading cause of infant mortality (Centers for Disease Control and Prevention, 2016).

After a woman has given birth, a subsequent pregnancy may not be planned. Approximately one-half of pregnancies among American women are unintended (Finer & Zolna, 2016), with higher rates among women who are younger, unmarried, Black or Hispanic, low income, or without a bachelor's degree (Finer & Zolna, 2016). Women with unplanned pregnancies are more likely to give birth preterm and to have low birthweight infants (Gipson, Koenig, & Hindin, 2008; Shah et al., 2011), and are at higher risk for depression and long-term negative effects on well-being (Gipson et al., 2008; Sonfield, Hasstedt, Kavanaugh, & Anderson, 2013). As the payer for approximately one-half of births nationally (Markus, Andres, West, Garro, & Pellegrini, 2013), Medicaid covers maternity care for a large proportion of unintended pregnancies at great cost (Guttmacher Institute, 2016; Wind, 2015).

Family planning, including contraception, is the most effective way to ensure healthy birth spacing (Garro, 2015). Women who use contraceptives consistently account for only 5% of unplanned pregnancies (Sonfield, Hasstedt, & Gold, 2014). Multiparous women not using contraceptives have the highest rates of SIPIs, whereas the highest rate of optimal birth intervals is achieved among women using long-acting reversible contraceptives (LARCs) (de Bocanegra, Chang, Howell, & Darney, 2014). However, women, especially Medicaid beneficiaries, often face postpartum barriers to optimal pregnancy spacing. Previous research indicates that contraceptive adoption among Medicaid participants is best achieved through shared decision making that prioritizes women's values and life contexts (Yee & Simon, 2011), but many providers continue to follow physician-centered, paternalistic models (Bernabeo & Holmboe, 2013; Charles, Gafni, & Whelan, 1999) because of time constraints or a belief that shared decision making will not work (Elwyn et al., 2013). Some women are not aware that SIPIs present a health risk (Bryant, Fernandez-Lamothe, & Kupperman, 2012).

Although rates vary, many Medicaid beneficiaries do not attend a postpartum visit (Bennett et al., 2014; Wilcox, Levi, & Garrett, 2016). Especially when a postpartum visit is unlikely, a woman should leave her birth facility with family planning established, but many state Medicaid programs only offer separate reimbursement for family planning at post-discharge outpatient visits (Wachino, 2016; Walls, Gifford, Ranji, Salganicoff, & Gomez, 2016). Even motivated women with supportive providers may have to attend multiple clinic appointments or face other barriers depending on the method selected, state policies, or personal circumstances.

This article investigates experiences of Medicaid participants in the Center for Medicare and Medicaid Innovation's Strong Start for Mothers and Newborns initiative. We explore education about pregnancy spacing, postpartum contraceptive access to prevent unplanned pregnancies and SIPIs, women's family planning choices, and barriers and facilitators to healthy pregnancy spacing.

Methods

The Strong Start Initiative

Strong Start offers enhanced prenatal care through birth centers, group prenatal care,¹ or maternity care homes and is intended to reduce rates of preterm birth and low birthweight among Medicaid- and CHIP-enrolled women. The program began in 2013 with 27 awardees operating more than 200 sites in 30 states, the District of Columbia, and Puerto Rico (Centers for Medicare and Medicaid Services, 2017). Most Strong Start programs focused on relationship-based care and care coordination along with referrals and health education (Hill et al., 2016). Awardees, which included health systems, national organizations, state agencies, and medical practices, began serving women in 2013 and 2014, with all births expected by the end of 2016.

Data collection for the national Strong Start evaluation began in 2013, with approval from the Institutional Review Board of the Urban Institute. The mixed-methods evaluation included participant surveys, chart reviews, and qualitative case studies. Individual-level data were collected through three participant survey instruments and a medical chart review. Participants completed forms at intake, during their third trimester, and postpartum. Strong Start staff completed a medical chart review after delivery or discharge from the program. Forms were submitted with identification numbers, and a crosswalk was sent to a separate site, allowing linking of individuals to the personal information on the forms. See Hill et al. (2016) for additional details on participant-level data collection methods and copies of each form.

As of March 30, 2016, there were 42,138 women enrolled in Strong Start and 23,377 women had given birth. Approximately one-half of those women ($n = 10,374$) had nonmissing responses on the postpartum survey, in which respondents are asked if they are "doing anything now to keep from getting pregnant?" and, if so, "What kinds of birth control are you using?", followed by a comprehensive list of options. Women are asked to check all that apply.

A team of uniformly trained researchers collected qualitative data annually using triangulated case study methods. Over the evaluation's first 3 years (March 2014 to March 2016), data collection included 629 in-person or telephone interviews with key informants selected because they were involved in implementing Strong Start (e.g., awardee program managers, clinic administrators, prenatal care providers, and staff from partner organizations). The semistructured interviews included questions about whether the Strong Start site offered family planning services, the points at which family planning was discussed, which methods were offered, how patients selected methods, how Strong Start's approach to family planning compared to typical prenatal care, and contraceptive access barriers. The team also conducted 122 focus groups with 887 Strong Start enrollees who were recruited because they received care at the provider sites participating in the case study interviews. Using a semistructured discussion guide, focus group facilitators explored participants'

¹ Strong Start awardees implementing group prenatal care predominantly used the CenteringPregnancy approach, an evidence-based model of group prenatal care formalized in 1998 through the Centering Healthcare Institute (CHI), a 501(c) 3 nonprofit organization that assists health care providers in making the changes needed to implement group prenatal care. For more information about CHI or CenteringPregnancy, see <https://www.centeringhealthcare.org/>.

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