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EXECUTIVE SUMMARY

The Community Engagement in Reproductive Health Services project involved more than 100 people in a productive dialogue about the challenges of improving reproductive health outcomes in Clark County by ensuring access to and utilization of comprehensive reproductive health care. During a five-month process, a Community Stakeholders group heard presentations on a variety of reproductive health topics, reviewed data, convened focus groups, and engaged in lively conversation to identify innovative approaches that could help Nevada, and particularly Clark County, improve outcomes.

Stakeholders found that their individual professional disciplines gave them different insights and knowledge about the complicated reproductive health care system. Working together the stakeholders were able to design an integrated approach to improving care, especially for those populations most affected by lack of access to affordable, quality, and comprehensive reproductive health services.

Stakeholders identified six major areas of focus for the Community Action Plan and detailed strategies to improve access to reproductive health services. These are presented below and expanded upon in the body of the Community Action Plan in an effort to put the pieces of the reproductive health care puzzle together to benefit Nevadans now, and in the years to come.

INCREASING ACCESS TO COMMUNITY REPRODUCTIVE HEALTH CARE

- ✓ Locate additional community-based clinics with comprehensive services in underserved neighborhoods, using creative funding models to strengthen service delivery
- ✓ Encourage new approaches to prenatal care such as Centering Pregnancy programs and Supportive Pregnancy Care
- ✓ Use Community Health Workers, Promotoras, and Doulas to provide education and linkages to services
- ✓ Experiment with innovative hours, mobile clinics in specific areas, on-site reproductive health specialists in medical practices, and co-scheduling of postpartum visit with well-baby check
- ✓ Recruit more Medicaid providers
- ✓ Encourage development of private pay plans for self-pay clients
- ✓ Ensure clinicians are operating at their full scope of services in reproductive health, including pediatricians who can provide reproductive health education

EXPANDING HEALTH INSURANCE COVERAGE

- ✓ Extend Medicaid presumptive eligibility for pregnant women to community settings
- ✓ Extend Medicaid postpartum coverage from 60 days to one year

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- ✓ Extend Medicaid eligibility to lawfully residing immigrant pregnant women
- ✓ Continue and expand outreach efforts to enroll those eligible for Medicaid or Health Exchange subsidies
- ✓ Leverage services and funding for undocumented population

PROMOTING LONG-ACTING CONTRACEPTIVES (LARC) USAGE

- ✓ Unbundle Medicaid reimbursement rates to increase immediate post-partum and post-abortion LARC placements for those desiring LARCs
- ✓ Work with hospitals to overcome concerns about stocking LARC on-site
- ✓ Encourage continuing education of obstetric professionals about efficacy of post-partum and post-abortion LARC placements
- ✓ Provide provider incentives for same-day LARC placements for those desiring LARCs
- ✓ Increase LARC providers by addressing rate parity concerns
- ✓ Defray cost of LARC in community clinics
- ✓ Increase educational communication between providers and patients about LARC

ENCOURAGING PROVIDER EDUCATION

- ✓ Review and update reproductive health curricula in Nevada's medical schools, nursing programs, and physician assistant program
- ✓ Consider legislation to require implicit bias continuing education for obstetric professionals
- ✓ Emphasize cultural competency by reproductive health providers, including office staff, to ensure culturally sensitive care
- ✓ Increase attention to maternal morbidity, infant mortality, and preterm birth disparities and improve provider communication skills with populations of color
- ✓ Consolidate patient complaints of implicit bias concerns in one agency and publicize complaint procedures widely
- ✓ Encourage pediatricians to increase opportunities for reproductive health education

PREVENTING CONGENITAL SYPHILIS

- ✓ Increase community education about the risks of contracting syphilis, screening availability, and access to treatment
- ✓ Provide continuing education about syphilis screening mandates to health professionals, including hospital triage areas
- ✓ Enforce existing syphilis screening laws for reproductive health providers working with pregnant women
- ✓ Educate social services providers about syphilis and congenital syphilis
- ✓ Provide additional case management services to pregnant women to ensure treatment, including partner screenings

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- ✓ Develop home health services to provide antibiotic syphilis treatment

IMPROVING REPRODUCTIVE HEALTH LITERACY

- ✓ Encourage comprehensive sexual education in schools
- ✓ Utilize innovative outreach techniques to educate youth and young adult population through an integrated media campaign, in Spanish and English
- ✓ Promote education about importance of post-partum appointment and ongoing reproductive health care for new mothers
- ✓ Increase education on sexually transmitted infections
- ✓ Increase education and awareness of reproductive health issues in male population
- ✓ Increase education about how to access prenatal care for those who are unable to be insured

At the conclusion of the five-month community engagement process, stakeholders expressed a strong commitment to continue their collaboration with the goal of improving reproductive health outcomes for Clark County residents. Everyone will have a role to play in one or more of the focus areas and increased collaboration will be needed to implement corresponding strategies.

The six focus areas provide a starting point for action. Designating a leader to convene interested stakeholders to prioritize strategies and identify planning steps for implementation will provide a structure for evaluating progress. The community stakeholders should continue to meet on at least a quarterly basis, to share data and information about new program approaches and keep the conversation going. New reproductive health concerns are emerging rapidly such as the congenital syphilis epidemic and a forum is needed to regularly exchange information and provide opportunities for increased collaboration.

Finally, the state and its reproductive health partners must continually reach out to our most vulnerable and underserved communities – low-income people, minority populations, and the undocumented immigrant community – to create relationships and increase trust. One child death to congenital syphilis, as an example, is one too many.

INTRODUCTION AND BACKGROUND

The purpose of the Community Engagement in Reproductive Health Services project was to improve reproductive health outcomes in Clark County by reducing barriers that women experience related to reproductive health. These include ensuring access to:

- annual reproductive health exams,
- safe and effective contraception including long-acting reversible contraception (LARC),
- prenatal and postpartum care, and
- prevention services and treatment of sexually transmitted diseases.

The project was designed to operate within the framework of reproductive justice, attending to the underlying social injustices and daily obstacles which prevent some people from seeking and/or receiving necessary and vital reproductive health care. These populations often include women who are low income, women of color, young women, women who are immigrants, and women with disabilities. The reproductive justice framework acknowledges there is often difficulty for these women in seeking the full range of family planning services, abortion care, and even routine preventive care.¹

At the request of the Nevada Department of Health and Human Services (DHHS), a community stakeholders group was assembled to consider this important issue. The group consisted of representatives from public and private sectors, all of whom have a strong interest in reproductive health services and community access. Stakeholders were asked to commit to monthly meetings over a five-month period during the summer and fall of 2019 to contribute their expertise and experience to the development of a Community Action Plan. The purpose of the Action Plan was to identify strategies designed to address specific reproductive health topics, populations experiencing disparities, and policy concerns.

The Stakeholders group was formed amid the backdrop of significant changes in federal policy regarding family planning services under Title X and a renewed interest in family planning funding at the state level. Nevada health leaders were also concerned with the state's recent surge in adult syphilis and congenital syphilis rates, high teen pregnancy and birth rates, and increasing perinatal substance exposure. In addition, data indicated low rates of contraceptive use, especially usage of LARC. Finally, the uncertainty of Federal support of the Affordable Care Act and corresponding funding to continue Medicaid expansion efforts contributed to concerns

¹ STD Prevention National Electronic Disease Surveillance System Base System. August 2019 submission. Reportable Disease Data Congenital Syphilis Report. Accessed September 2019.

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about protecting access to the full range of reproductive health services for everyone in Clark County.

Community stakeholders agreed that many more resources are needed in underserved areas of Clark County, as identified through a series of mapping exercises which found that the zip codes located in the older areas of downtown have the highest number of women in their teens receiving inadequate prenatal care, inadequate reproductive health providers, a high number of abortion clinics, high numbers of congenital syphilis cases, and high rates of teen pregnancy. (See Appendix A) Stakeholders indicated these areas also have large numbers of low-income residents and people of color. Stakeholders and focus group participants also agreed there are far too few community-based clinics serving the uninsured or underinsured populations of Clark County and those that exist, such as Volunteers in Medicine, are reported to be at or nearing capacity.

Despite significant decreases in Nevada's uninsured population in recent years, approximately 400,000 people still have no health insurance. Nevada has the sixth highest uninsured rate in the nation and the second highest uninsured rate among Medicaid expansion states. Clark County residents represent 77.2% of the uninsured population, translating to 307,434 people or 14.7% of the County's population.²

Nevada's uninsured populations may be categorized as follows:

- Eligible but unenrolled (225,000)
- Ineligible due to immigration status (109,000)
- Affordability challenges in the marketplace (69,000)³

Each of these uninsured groups require different approaches to address their health care needs and improve reproductive health outcomes.

The number of Nevada births that are covered by Medicaid have been steadily rising, from 48.4% of all Nevada births in Calendar Year 2014 to 57.8% in Calendar Year 2018.⁴ Decisions by Medicaid regarding reimbursement or pre-authorization requirements are often copied by commercial insurance products, further increasing the influence of Medicaid policies.

Lack of access to the full range of reproductive health services can have devastating consequences for families and communities in Nevada. Costly health outcomes from inadequate prenatal care include premature birth, low birth weight, congenital syphilis and

² *Nevada's Uninsured Population*, The Guinn Center, 2019

³ *Nevada's Uninsured Population*, The Guinn Center, 2019

⁴ DHHS, Office of Analytics, 2019

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neonatal or maternal mortality. Drop-in deliveries are expensive and difficult for hospitals to manage and they can be dangerous for women who have not had prenatal care or testing.

The ability to space births and access regular preventive care can lead to much better health outcomes for everyone and lower costs, overall. According to Healthy People 2020, one-third of U.S. pregnancies are conceived less than 18 months after a prior birth. Without access to contraception, women are at risk of short-interval pregnancies which can lead to adverse birth outcomes such as preterm birth, low birth weight and/or neonatal morbidity. Pregnancies that are close together may also lead to increased risk for perinatal death and maternal depression.

According to the Guttmacher Institute, abortion rates in the United States have reached an historic low since legalization in 1973. The Guttmacher report suggests one of the top reasons may be increased access and use of LARC.⁵

Historically in Nevada, LARC devices and implants have been financially and logistically difficult to access for many women seeking to prevent pregnancy or space their children. Nationally, it is estimated that about 60% of pregnancies are unintended, and these unplanned pregnancy rates are highest among older teens and young women in their 20s, women living in poverty, and women of color.⁶ Benefits of LARC usage include higher efficacy than other types of birth control, higher continuation rates, higher satisfaction rates, and few complications, even for adolescents.

Cost and availability of LARC devices (intrauterine devices or IUDs) and non-biodegradable drug delivery implants are covered for Nevada Medicaid patients, but usage is low. According to Nevada's Behavioral Risk Factor Surveillance System, the most common forms of contraception used by Nevada adults, ages 18 and up, are male condoms (22.24%) and birth control pills (21.69%).

Reproductive health providers need initial and ongoing education and training in their field, especially as new contraceptives become available and best practices change over time as they do in any medical field. A current issue of educational concern in the medical field is implicit bias of health care providers which can dramatically affect a patient's willingness to continue seeking care. Stakeholders discussed implicit bias concerns which can affect minority populations from the moment they walk in the door of a medical office and interfere with maintaining a healthy and honest doctor/patient relationship.

Community stakeholders reviewed data on maternal deaths in Nevada from 2003 to 2014, including pregnancy-associated deaths, which include the death of a woman while pregnant or

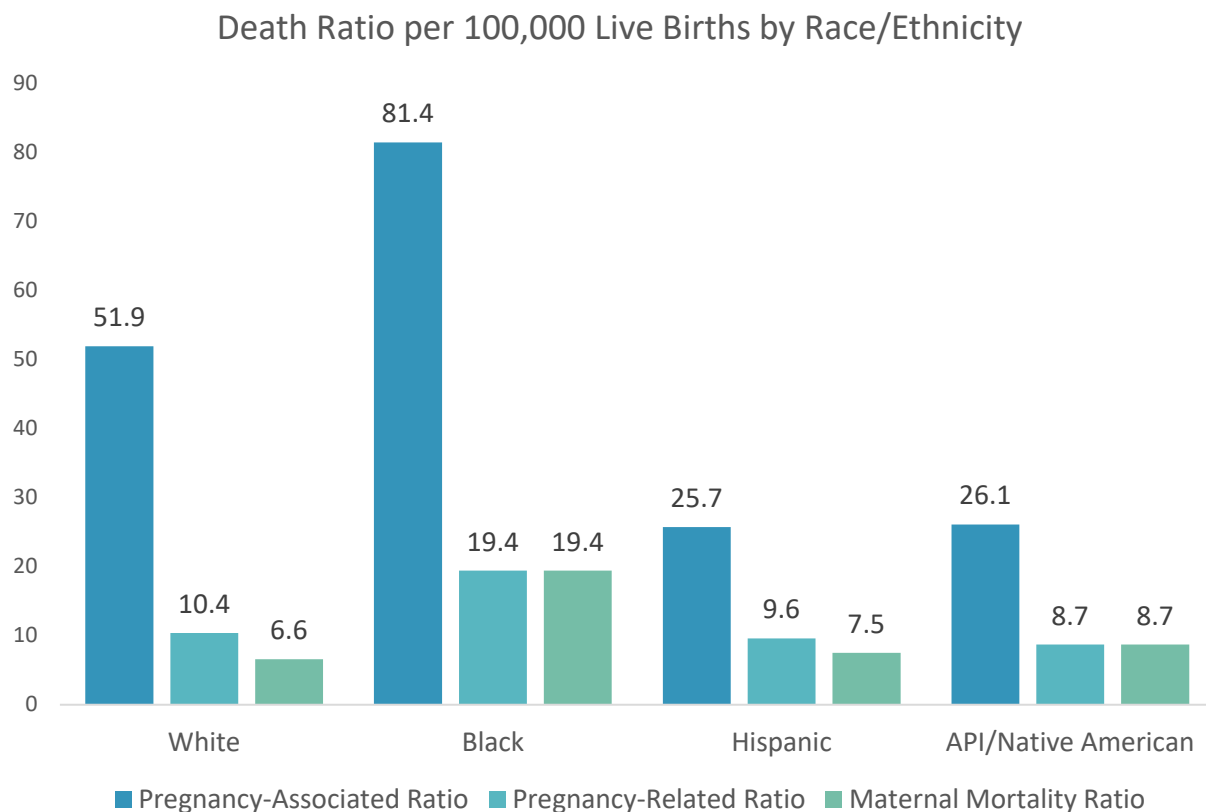
⁵ *Abortion Incidence and Service Availability in the United States*, Guttmacher Institute 2017

⁶ *Preventing Unplanned Pregnancy*, National Conference of State Legislatures, 1/7/2018

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within one year of the termination of pregnancy, from any cause. Nevada’s rate for the 2003-2014 time period for pregnancy-associated deaths was 38.5 deaths per 100,000 live births. Clark County accounted for 75% of those deaths. The top causes of pregnancy-associated deaths in Nevada were related to pregnancy, childbirth, and the puerperium time period.^{7,8}

Healthy People 2020 has an objective to reduce maternal deaths (the death of a woman while pregnant or within 42 days of the end of pregnancy, from any cause related to or aggravated by pregnancy or its management, but not from accidental or incidental cause) to a rate of 11.4 per 100,000 live births. In Nevada, from 2008-2014, Black women had the highest ratio of pregnancy deaths by race/ethnicity.



Death Ratio per 100,000 Live Births by Race/Ethnicity
Nevada 2008-2014

Office of Public Health Informatics and Epidemiology, Office of Vital Records – Nevada Electronic Birth and Death Certificates, August 2016

Of particular concern to Nevada’s public health community are the rising rates of syphilis and congenital syphilis as Nevada leads the country in syphilis rates and is 2nd in the nation for congenital syphilis rates. As of early December 2019, Clark County has recorded 31 syphilis

⁷ The period of about six weeks after childbirth during which the mother’s reproductive organs return to their original nonpregnant condition.

⁸ *Deaths During and After Pregnancy in Nevada, 2003 to 2014*, DHHS Office of Analytics

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cases, exceeding the 2018 total of 24 cases.⁹ The Department of Health and Human Services convened a Congenital Syphilis Workgroup led by the State Epidemiologist and a position was created to hire a Syphilis Program Coordinator to implement cross-sector strategies to address rising syphilis rates and to share surveillance and disease investigation information to leverage efforts. Statewide awareness campaigns using materials and messaging developed by the Workgroup took place in partnership with Local Health Authorities and area hospitals in print, social media, and in partnership with Nevada 2-1-1 to develop a congenital syphilis information page on their website. Non-traditional partner engagement to reach women who may not seek prenatal care also was an area of emphasis.

At the request of the Stakeholders, a review of 28 syphilis cases in Nevada from January 2019 to September 2019 by Jennifer Somdahl, then the state's Syphilis Coordinator, found that 75% had no prenatal care and 82% indicated drug and/or alcohol use during pregnancy. Three infant deaths in Clark County in 2019 were linked to congenital syphilis, lending even more urgency to the need to improve the adequacy of prenatal care and testing. Educational efforts must be increased dramatically in innovative and modern ways as the Community Action Plan strategies are further developed and implemented.

During community stakeholder meetings, the issue of reproductive health literacy was often raised, and members were united in their belief that much more education is needed in Clark County to increase reproductive health literacy among women, men, and teenagers.

⁹ *Congenital Syphilis: How to Stop the Rising Rate in Nevada*, Jennifer Somdahl, RN, BSN, Syphilis Coordinator, December 2019

PLANNING METHODOLOGY

The methodology for the Community Action Plan included the formation of a community stakeholders group in Clark County to review key data sets regarding reproductive health and explore the intersectionality of the related issues of access to the full range of contraceptive choices, prenatal and postpartum care access and utilization, screening and treatment of sexually transmitted diseases, and prevention of congenital syphilis, a current issue of major concern in Nevada. Stakeholders met monthly from August through December 2019. Other project activities that informed the Action Plan were site visits to key community partners, a series of surveys and focus groups representing underserved populations, and the gathering and distribution of current research related to reproductive health topics via the project's listserv.

During the initial planning stages, a list of interested community stakeholders was compiled by publicizing the project among related interest groups such as the Nevada OMNI ASTHO Advisory Team and the Maternal and Child Health Advisory Board, identifying key contacts within public and private health organizations, and securing recommendations of potential stakeholders from a variety of health leaders. A listserv was created which grew to more than 100 members, most of whom live and work in Clark County, although there was significant interest in the project from Northern Nevada organizations.

To further inform the project and understand the context of these issues in Clark County, site visits were conducted with various community partners who provided essential background information and perspective for community engagement activities. These strategic partners included Planned Parenthood, Visión y Compromiso, state Senators Yvanna Cancela and Melanie Scheible, Children's Advocacy Alliance, Make It Work Nevada, and the Maternal and Child Health Advisory Board. Throughout the project, stakeholder meetings and activities were coordinated with the Nevada ASTHO OMNI Advisory Team, whose members have demonstrated interest in the project and who provided excellent guidance.

Stakeholders who actively participated in the project represented a variety of public and private interest groups, including representatives from the Nevada Legislature, Southern Nevada Health District, NICRP – UNLV School of Public Health, UNLV School of Nursing, UNLV Clinic, UNLV School of Medicine, UNR School of Medicine, Make It Work Nevada, March of Dimes, the three active Medicaid Managed Care Organizations (Anthem, Silver Summit, and Health Plan of Nevada/United Health Care), Visión y Compromiso, Planned Parenthood, Children's Advocacy Alliance, Renown Health, Nevada State Medical Association, and the Dept. of Health and Human Services – Division of Public and Behavioral Health and the Division of Health Care Financing and Policy.

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The stakeholders met monthly to hear presentations on reproductive health topics, engage in discussion, and develop specific strategies for improving access and outcomes. Summaries of each meeting were published via the listserv, along with copies of presentations and meeting materials.

Five community stakeholder meetings were convened from August to December 2019. All were held at the Southern Nevada Health District, with a live teleconferencing link available to those wishing to join the meeting by telephone. Agendas focused on reviewing data and policies, identifying barriers and potential strategies, and reviewing research and evidence to improve reproductive health. A synopsis of agenda items discussed at each meeting can be found in Appendix B.

At the first Stakeholder meeting participants discussed the importance of seeking input on access concerns directly from the populations most affected, primarily low-income and minority communities. After discussion with organizations serving these communities, two groups agreed to conduct focus groups under their auspices, 'Make It Work Nevada' and 'Visión y Compromiso'.

Make It Work Nevada is a private, non-profit entity dedicated to finding new solutions to help families "make it work". The organization focuses on issues of childcare, equal pay, safe workplaces, and reproductive justice, with a special emphasis on serving the African American community. Visión y Compromiso is a non-profit entity based in California whose mission is to enhance community well-being by supporting Promotoras and Community Health Workers who act as liaisons and natural helpers between their communities and health and social service providers.

A written survey was distributed to members of each focus group who completed it on their own. A round-table discussion was then held, facilitated by the focus group leader as summarized in the Focus Group Findings section of this report. At the conclusion of each focus group, participants were given a small gift card as an incentive for contributing their time and expertise; these incentives were funded through private donations.

FOCUS GROUP FINDINGS

In an effort to gain additional insight into the barriers to accessing reproductive health services in Clark County, four focus groups were held with women from low-income and minority communities. Their responses informed stakeholder discussions regarding the barriers to care that certain populations encounter when seeking reproductive health services.

The major findings from the focus groups are summarized below. A full report of the focus group findings, and copies of the survey and focus group questions may be reviewed in Appendix C.

Three focus groups were held under the auspices of Make It Work Nevada, an organization serving the African American community during October 2019, facilitated by Erika Washington, the group's Executive Director. Participants were all African American women, ages 25 to 45.

The majority of the focus group participants felt they were not adequately listened to by their physicians who often talked down to them and minimized their concerns. The women noted that prescribed medications were often not covered by their insurance, further reducing their opportunity for appropriate treatment. The women reported they did not have enough conversation about birth control options with their providers and needed to conduct their own research to find the option best for them. One woman who is transgender indicated she experienced discrimination based on being transgender.

Women reported traumatic childbirth experiences and generally felt their preferences and opinions were overlooked, ignored, or not taken into consideration by their medical providers.

The focus group participants generally felt their medical symptoms aren't taken seriously enough and when they bring in their own research to their health care provider, it is often brushed off. Without access to doctors who listen to them, many women decide not to return for subsequent appointments.

One focus group was held under the auspices of Visión y Compromiso in November 2019, with a bilingual facilitator, Miriam Cadenas, and notetaker. These women were all immigrants, primarily from Mexico. They shared the concerns of the women from the Make It Work Nevada focus groups regarding implicit bias of health care providers, noting they often felt disrespected by front office staff as well as professionals who did not listen sincerely to their concerns.

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These women spoke of the difficulties of accessing health care by the Hispanic immigrant community without health insurance who must seek care through clandestine doctors or “parteras” (midwives) with little experience, through community low-income clinics that are nearing capacity, or by going out of state for care, mostly to California which has more resources and support for pre-natal care for their population. They also indicated many women simply don’t get prenatal care.

The focus group participants said more services were needed in their neighborhoods, with clear indications about who is eligible in terms of documentation status. They indicated some women are afraid to accept help because they don’t want it to count against them on their immigration application. Special mention was made of the need to provide pregnant and postpartum women with psychiatric care as many suffer from depression due to their undocumented and low-income status, exacerbated by a language barrier.

Quality of care was another concern of the focus group. They stated their community perceives much of their health care to be inferior, illustrating this concern with the Spanish proverb, “tanto pagas, tanto valgas” (what you pay is what you’re worth).

The focus group participants believe more education is needed in their community about contraceptives in general, including LARCs, especially for young women who don’t have the money to pay for LARCs and don’t know how to get them

According to the participants, women in their community go to Planned Parenthood to access testing for sexually transmitted infections or they go to underground doctors and botánicas (unlicensed pharmacies). They noted that some of the underground doctors practiced medicine in their home countries but are not licensed in the United States; others have never had formal medical training but hold themselves out to the undocumented community as physicians.

Participants agreed that it is common to “self-diagnose” medical conditions and to share prescriptions among friends and family. Medicine from Mexico is often sold illegally in botánicas and home remedies are used when prescription medicine is unavailable or inaccessible.

The focus group participants were enthusiastic about the idea of a home-visiting model to help new mothers cope with the stress of caring for a newborn or multiple young children. They stressed that in order to be effective, the program would need to be available without affecting someone’s ‘public charge’ and without requirements for social security numbers.

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Strategies to Improve Access to Reproductive Health Services

The innovative approaches to improving reproductive health outcomes in Clark County are presented on the following pages as strategies to be considered when implementing the Community Action Plan. The six focus areas are designed to work together to improve reproductive health care, especially for those populations most affected by lack of access to affordable, quality, and comprehensive services.

INCREASING ACCESS TO COMMUNITY REPRODUCTIVE HEALTH CARE

Improving reproductive health outcomes in Clark County depends upon the availability of affordable and accessible annual reproductive health exams, contraception of choice, prenatal and postpartum care, and testing and treatment of sexually transmitted infections.

Over the course of the five months of community stakeholder meetings, as data were reviewed, particular zip codes were identified where several issues converged, including inadequate prenatal care, fewer reproductive health care providers, high rates of congenital syphilis, and higher than normal rates of teen pregnancy. More analysis is needed to determine if there are additional reasons behind the concentration of concerns in these downtown neighborhoods, but clearly the barriers associated with reproductive health care are highest in these low-income areas with large numbers of residents who are people of color.

BARRIERS TO INCREASING ACCESS TO COMMUNITY REPRODUCTIVE HEALTH CARE

There are far too few community-based clinics serving the uninsured or underinsured populations of Clark County and those that exist, such as Volunteers in Medicine, are reported to be near capacity. The lack of low-barrier community clinics located in the downtown neighborhoods where large populations of low-income, undocumented, and minority populations reside prevents thousands of women from accessing reproductive health services in Clark County, as demonstrated by the mapping exercises undertaken by community stakeholders during the community engagement process. (See Appendix A) The overlays show these neighborhoods as having high levels of inadequate prenatal care, low availability of providers, high numbers of congenital syphilis cases, and high rates of teen pregnancy.

Although more sophisticated data analysis is needed to isolate specific difficulties contributing to these poor reproductive health indicators, focus group results suggest lack of health insurance, lack of reliable and usable public transportation, lack of culturally competent providers, and poverty as significant barriers to accessing needed reproductive health care, especially prenatal care.

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While more community-based clinics are needed, stakeholders also noted several innovative approaches to serving the most vulnerable populations that could be implemented right away through additional training and awareness of providers and exploration of new models of care.

STRATEGIES FOR INCREASING ACCESS TO COMMUNITY REPRODUCTIVE HEALTH CARE

Stakeholders reviewed services provided through the Renown Women's Health Pregnancy Clinic, a program which has been in operation since 1984, and agreed that similar clinics are needed in Clark County, located in neighborhoods with high levels of inadequate prenatal care. These community clinics, like Renown's, should provide prenatal care and testing along with a broader range of obstetric care such as a perinatal mood disorder program and a Centering Program, an evidence-based practice that creates connections among patients.

Another promising programmatic approach is Supportive Pregnancy Care, a flexible group prenatal care program serving groups of 8 to 12 women with similar due dates, to maximize interaction and provide patient-centered sessions on pregnancy, labor and delivery, infant care, family planning and postpartum maternal care. At group sessions, women are empowered to perform their own self-care by measuring and recording their own weight, blood pressure and gestational age. A licensed obstetric provider meets individually with each woman to perform a physical assessment and discussion specific concerns in a semi-private area within the group space. It is similar to Centering Pregnancy programs but is more economical and has more flexibility for implementation. Medicaid coverage of these programmatic enhancements would spur this innovation strategy in Clark County.

Creative financing strategies will be needed to sustain these comprehensive women's health clinics if they are to offer care to currently unserved populations, especially those who need more flexibility with appointments and more assistance in accessing ancillary services, such as prescription care, transportation, or home health care. In the medical field, time is money, and a chronically under or uninsured population will have many challenges that need attention. A workgroup of potential providers and knowledgeable Medicaid officials should be convened to develop a financing scheme to support new clinics and strengthen existing resources.

Another strategy embraced by focus group participants and community stakeholders is the expansion of Community Health Workers (CHWs), Promotoras, and Doulas to provide community-based direct services to women in underserved areas including reproductive health education and linkages to services. Women who are pregnant and/or parenting young children can be more effectively reached at home or in their neighborhoods, by using trained peers who understand their circumstances and can transcend language barriers. Medicaid funding for these reproductive health care extenders who provide outreach, education, informal

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counseling, and cultural supports in neighborhood settings would assist community agencies in developing these resources.

Other innovative approaches can extend the reach of existing clinics or medical providers hoping to improve participation in prenatal and postpartum care, such as extending hours clinics are open, forging stronger partnerships with private transportation services eligible for Medicaid reimbursements, and using mobile clinics in key areas with poor public transportation. Medical practices in underserved areas could host reproductive health specialists one or two days a week, to make it easier to provide comprehensive education on contraceptive choices and reproductive health resources. Providers could also look for ways to be more flexible about appointment times when clients are using public transportation, and which could avoid then canceling appointments due to bus delays. Another innovation would be incentivizing providers to make the effort to co-schedule a postpartum visit with a well-baby check in order to improve participation in postpartum care.

After reviewing zip code data, community stakeholders agreed that additional Medicaid providers should be recruited in the downtown zip codes with the most inadequate prenatal care. These areas tend to have larger numbers of women who qualify for Medicaid coverage during labor and delivery but cannot access coverage for prenatal care in their communities.

Rate parity for midwives and other Advanced Practice Nurses who provide prenatal services would help expand the provider base along with expansion of Medicaid coverage to cover prenatal care outside of a hospital setting.

Focus group participants and community stakeholders discussed the need for the development of reasonable and formalized payment plans for private pay clients who should be encouraged to keep all their prenatal and postpartum visits regardless of their ability to pay that particular day. Uninsured patients deserve the same quality of care as insured patients and the dignity of arranging for reasonable payment mechanisms according to their individual circumstances.

Finally, clinicians should be encouraged to operate at their full scope of services in reproductive health, including pediatricians and doctors in family practice who can provide reproductive health education to new mothers during well-baby checks and to older teens on their caseloads. Rate parity with physicians for Advanced Practice Registered Nurses, including nurse midwives, would be an incentive for these providers to expand their reproductive health services in underserved areas.

EXPANDING HEALTH INSURANCE COVERAGE

Medicaid expansion through the Affordable Care Act has greatly increased the number of Nevadans who depend on Medicaid for health coverage. In Calendar Year 2018, Medicaid was the payer of nearly 58% of births in Nevada and continues to drive many reimbursement and policy issues in the private insurance market as well.¹⁰

As Nevada works to decrease the numbers of uninsured people living in the state, different outreach strategies will be needed to address barriers affecting the three major groups of uninsured – those eligible for Medicaid but unenrolled, those ineligible for Medicaid due to immigration status, and those uninsured due to affordability challenges.

BARRIERS TO EXPANDING HEALTH CARE INSURANCE

A number of barriers to health care insurance remain in Nevada, including the lack of options for those who are undocumented and the problem of affordability for low-income people whose income is just over the limit to qualify for Medicaid or for subsidies from the Exchange. Knowledge of public insurance programs and/or willingness to enroll in them is another significant barrier to coverage. Other barriers include the lack of income to purchase health insurance on the open market and underinsurance issues due to high deductibles and co-pays associated with employer-sponsored plans.

Lack of coverage is also related to Nevada Medicaid policy, such as the inability to provide presumptive eligibility for pregnant women outside of a hospital setting or the restrictions on postpartum coverage to just 60 days after delivery. Without access to reproductive health coverage, it is much more likely that women will not be able to access the full range of contraceptive options, including highly effective LARCs.

In Nevada, Health Effectiveness Data, and Information Set (HEDIS) data shows that:

- 40% of women in Southern Nevada do not return for a postpartum care visit with their provider after delivery, which greatly reduces the opportunity for discussion about future contraception choices.
- Using pharmacy claims and encounters for reimbursement for LARC devices, it determined that fewer than 8% of women enrolled in Medicaid through Health Plan of Nevada received a LARC at 12 months postpartum.

¹⁰ DHHS Office of Analytics, 2019

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- This data also revealed that 67% of women do not receive any form of contraception postpartum.

STRATEGIES FOR EXPANDING HEALTH INSURANCE COVERAGE

Community stakeholders identified several Medicaid policy changes to increase access to reproductive health services, including prenatal and postpartum care, and to reduce the number of walk-in deliveries in Clark County birthing hospitals.

One of the key Medicaid policy changes is presumptive eligibility for pregnant women in community settings. Currently presumptive eligibility for pregnant women is available only in hospital settings, with an eye toward covering labor and delivery costs, but does not extend to community settings where women could receive access to contraception education and prenatal care.

Another key Medicaid policy change would be to expand coverage for pregnant women from the current 60 days postpartum to one year. This change would allow for continuity of reproductive health care, including contraceptive access and education services for a full year, making it far more likely women will be able to appropriately space children and also attend to any postpartum concerns that arise during that timeframe, such as depression, severe maternal morbidity, substance use, or other pregnancy-related chronic illnesses including diabetes, heart disease, and high blood pressure.

The Centers for Disease Control and Prevention estimate three out of five postpartum deaths could be prevented with appropriate medical attention. The Helping Medicaid Offer Maternity Services Act of 2019, a bipartisan bill in Congress, would provide states with a financial incentive to adopt this policy, by increasing the federal government's share of funding by five percentage points.

A third Medicaid policy change would provide eligibility for lawfully residing immigrant pregnant women, ending the five-year exclusion rule. Nevada has implemented this policy for lawfully residing immigrant children and should consider expanding it to their mothers as well.

Although Nevada has made a concerted effort to sign up people who are eligible for Medicaid, additional innovative outreach strategies are needed to encourage enrollment in Medicaid or coverage through subsidies available on the Health Exchange.

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Outreach strategies should focus on publicizing the program where people go to receive ongoing basic medical care, such as flu shots in community pharmacies.

Increased educational efforts should be directed to low-income communities with a focus on how to sign up for Medicaid and potential benefits of health insurance through the Exchange. Medicaid officials should continue to review steps in determining eligibility to see if further streamlining can be accomplished during the application process.

Finally, the community must find ways to leverage services and funding for reproductive health care, including the full range of family planning services, for undocumented populations. More education about the public charge ruling and current injunction is needed in immigrant communities to encourage use of available services without the fear of negative consequences on immigration applications. More innovation is needed to explore different types of medical providers who can be utilized to increase participation in prenatal care in uncovered populations, such as promotoras, doulas, community health workers or home visiting programs.



PROMOTING LARC USAGE

Data on LARC usage in Nevada is difficult to obtain, although a 2013 Title X Family Planning Report ranked Nevada in the lowest usage category for teens, ages 15 – 19, seeking birth control at a Title-X funded Center, at 0-5%.

Access to immediate postpartum LARC placement is viewed as a promising strategy to overcoming access barriers. For those desiring immediate postpartum LARC placement, advantages include higher motivation levels, immediate confirmation the woman is not pregnant which eliminates the need for an additional doctor’s visit, and insurance for women with presumptive Medicaid coverage for the delivery. Removal of the LARC may not be covered, however, if Medicaid coverage has terminated.

Providing immediate postpartum LARC placement is “associated with high patient satisfaction, longer contraceptive coverage, fewer unintended pregnancies, and cost savings for payers and healthcare systems compared to outpatient postpartum insertion.”¹¹

The American College of Obstetricians and Gynecologists released recommendations for reproductive health providers in 2016, advising its members to incorporate immediate postpartum LARC into their practices as a safe option. The practice has also been supported by the American Academy of Family Physicians due to its potential to reduce unintended and rapid repeat pregnancies. Yet, this practice is not currently available in most maternity settings in the United States due to implementation challenges of billing and reimbursement, clinician expertise, and service delivery processes.

BARRIERS TO PROMOTING LARC USAGE

Barriers to LARC usage are a patient’s lack of familiarity with LARCs, potentially high cost of initiation, low parental acceptance, low patient knowledge, personal or religious beliefs, difficulty in making required co-pays, devices not available on site, and misconceptions in the health care provider community about the safety of LARC use in adolescents. Most providers require a separate visit for outpatient LARC placement to ensure a woman is not pregnant and many patients find the multiple appointments a burden due to transportation issues, taking additional time off from work, childcare expenses, and other life challenges. As a result, many

¹¹ *Immediate Postpartum Long Acting Reversible Contraception: The Time Is Now*, Moniz, Chang, Heisler, Dalton, April 2018

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do not return to complete the process, sometimes leading to a new short interval pregnancy that may be undesired and risky.

One recent study found that low rates of LARC utilization were related more to access barriers, “such as need for additional visits and potential loss of insurance coverage postpartum” rather than patient preference for this type of contraception.¹²

Although 648,896 Nevadans now receive health coverage through Medicaid,¹³ the low reimbursement rates when compared to private insurance can offer disincentives for providers to accept these patients. Nevada’s Medicaid reimbursement rates are often significantly lower than rates in other states. For example, in 2018 Nevada had the fourth lowest rate in the country for LARC insertion (Code 58300) at \$38.64. As a comparison, a more typical rate was in the \$50 to \$80 range.

One major reimbursement barrier for LARCs is reflected in the reimbursement practice of “bundling” or lump sum payment for labor and delivery, impacting the opportunity for a hospital to be reimbursed for device costs associated with providing postpartum LARCs immediately following delivery or during the hospital stay. However, a pathway was created for Nevada Medicaid reimbursement of LARC intrauterine insertion immediately postpartum using the Current Procedural Terminology code 58300-51 as billable for a number of provider types separate from the bundled payment (please refer to Announcement 1200: 08/09/2016 Medicaid Service Manual Chapter 600 online at <http://dhcfp.nv.gov> for additional family planning information and the most recent guidance on billing information). A perceived lack of payment understandably discourages providers from offering immediate postpartum LARC placement as a contraceptive option. The cost of stocking LARCs in community clinics is also a barrier, preventing uninsured populations from being able to choose this type of contraception because it is not available through their clinic.

Finally, reproductive health providers may not have the most current information regarding the efficacy of LARCs or newer contraceptives. Providers in Las Vegas also note heat and efficacy are issues if they have to transport LARCs in their vehicles to have on hand as hospitals don’t stock the devices.

STRATEGIES FOR PROMOTING LARC USAGE

Stakeholders suggest the Department of Health and Human Services create a small workgroup consisting of representatives from Medicaid, key birthing hospitals, Medicaid Managed Care

¹² *Immediate Postpartum Long Acting Reversible Contraception: The Time Is Now*, Moniz, Chang, Heisler, Dalton, April 2018

¹³ Division of Health Care Financing and Policy, October 2019

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Organizations, and commercial insurance companies to determine the best way to increase awareness of the Medicaid unbundled intrauterine insertion of the LARC payment and unbundling from the global payment for delivery in non-Medicaid births and resolve billing issues to encourage implementation of immediate post-partum LARC placement upon request of the patient. Individual hospitals should be encouraged to stock LARC devices on-site near the delivery room or in the pharmacy to facilitate immediate post-partum placement. These efforts would build on the successes of the Nevada National Governors Association on Improving Birth Outcomes workgroups which included cross-sector participation on the topic of LARC utilization in addition to other key topics related to improving birth outcomes such as decreasing early elective deliveries and reducing substance use among pregnant women.

Outreach should be conducted to abortion clinics to ensure they are aware of the option to enroll in Medicaid as a specialty clinic and receive reimbursements for post-abortion LARC placements upon a patient's request.

Another strategy to encourage LARC placements is to increase continuing education and training opportunities for physicians and other obstetric professionals about the efficacy of postpartum and post-abortion LARC placements to address medical concerns regarding expulsion rates. Other states have found great value in identifying physician and hospital champions to lead education efforts by providing roadmaps and check lists to others about how they overcame obstacles such as on-site storage and billing.

Pilot programs should be designed and implemented to determine what incentives or practices would encourage providers to avoid a two-day appointment requirement for patients desiring LARC. Same-day appointments to choose and receive LARCs would address barriers such as lack of childcare or transportation and increase the number of women who are able to successfully access this form of contraception.

Additional LARC providers can be recruited by addressing rate parity for prenatal care and family planning services for mid-level clinicians and pediatricians and increasing reimbursements for contraception education and services. Nevada Medicaid will reimburse a broad spectrum of provider types for family planning services, including physicians, specialty clinics, Advanced Practice Registered Nurses (APRNs), Indian Health Service and tribal health clinics, Indian Health Service Hospital Outpatient (tribal and non-tribal), pharmacies, Certified Nurse Midwives (CNMs) and Physician's Assistants (PAs). Rate parity combined with additional outreach and education to these provider groups will incentivize additional professionals to provide LARC access and placement.

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Community clinics and practices serving uninsured or underinsured populations should be made aware of the state's Expanded Contraceptive Access Program grant guidelines, criteria, and timeframe in order to defray the cost of LARCs.

Finally, community stakeholders agreed that all Nevada women should be able to discuss LARC as a potential contraceptive choice with their reproductive health care provider, with minimal cost constraints or access concerns. Increased educational communication between providers and patients about the range of contraceptive options, including LARCs, should be patient-centered and for pregnant women, should occur well before delivery. While some women prefer contraceptives with low failure rates, others prefer to avoid additional doctor visits when they wish to end contraceptive use.

It is important to emphasize that women must not be pressured to select one contraceptive method over another, and providers should respect an individual's cultural and religious considerations and personal preferences.

ENCOURAGING PROVIDER EDUCATION

Continuing education of reproductive health providers is a critical component of patient-centered services to ensure quality of care and patient satisfaction. Focus group participants consistently expressed implicit bias concerns such as not being adequately consulted or listened to during reproductive health visits. Often, poor communication skills at reception set the tone for the office visit, providing little motivation for women to return for additional prenatal or reproductive health care.

BARRIERS TO INCREASING PROVIDER EDUCATION

Stakeholders identified barriers in provider education in a number of areas, such as immediate postpartum LARC placement or a lack of knowledge or particular provider bias about LARCs or other specific contraception methods, leading to inappropriate influence over a woman's choice of contraception. Patients are sometimes not adequately counseled about their family planning options and are unable to identify the type of contraception that would work best for their needs. Some commercial insurance products require a pre-authorization for a LARC which may also discourage use.

Focus group participants revealed a number of barriers to care that relate to reproductive justice concerns among the health care provider community due to perceived implicit bias they experience from the receptionist's greeting to medical personnel who shrug off their concerns.

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The lack of sufficient bilingual and bicultural office and medical personnel is a particular barrier for Latino communities.

STRATEGIES FOR INCREASING PROVIDER EDUCATION

Curricula in Nevada’s medical schools, nursing programs, and the new physician assistant program should be regularly reviewed and updated to ensure they reflect current best practices in reproductive health, accurate information regarding the variety of contraceptive choices, and the best ways to engage in patient-centered education including training on empathy and listening to patients, particularly women of color. Provider training should be current in related topics such as lactation and postpartum depression. Training should emphasize family planning during the third trimester of pregnancy.

California has recently passed legislation to require continuing education on implicit bias in medical treatment for physicians, registered nurses, and physician assistants.¹⁴ The majority of community stakeholders believe this is a strategy Nevada should also consider working to increase communication and quality of care in populations that often do not obtain adequate levels of prenatal care or other reproductive health services. The March of Dimes will begin offering this training at Health Equity Sites in 2020 on a limited basis.

Stakeholders encourage implicit bias training for the entire office to improve a patient’s experience from the initial contact and throughout the office visit.

Focus group participants also spoke of their desire for culturally sensitive care, starting with the way they are greeted and attended to in the front office. They shared experiences of office staff who would not look up from their desk or engage in conversation while shoving paperwork across the counter. They told stories of doctors and nursing assistants who didn’t listen to their concerns or preferences. Immigrant Hispanic women indicated they would feel much more welcome in a bi-lingual office where people from their own culture would welcome them and explain the complexities of insurance coverage or make private pay arrangements and believe more women would follow through with prenatal care and postpartum visits if services were provided in a culturally sensitive manner. Given the extreme health disparity of maternal deaths in the Black community, much more attention is needed to discover the reasons behind the high maternal death rates in all populations experiencing disparities in maternal mortality.

¹⁴ Assembly Bill 241

https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200AB241

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Focus group participants in the Make It Work Nevada groups reported they often don't go back to their health provider because they don't trust them, and they feel that their medical symptoms aren't taken seriously.

Providers need to be aware of trust issues articulated in the Black community and improve their communication and service delivery skills with this minority population.

Tracking of patient complaints about implicit bias concerns should be centralized in one place, such as Nevada's Equal Rights Commission, with complaint procedures that are easy to follow and publicized widely. An on-line tracking mechanism for complaints will help document these concerns and provide a forum for patients to recount their experiences which can be used to create better training components for providers.

Finally, pediatricians should be provided information about how to access reimbursement for family planning services during well child checks to increase opportunities for reproductive health education with new mothers.

PREVENTING CONGENITAL SYPHILIS

The dramatic increase in Nevada's congenital syphilis rate is shocking, especially since this disease is completely preventable. From 2016 to 2018, Nevada has almost tripled the number of reported congenital syphilis cases, along with a consistent increasing trend of syphilis among women.

In Southern Nevada, the number of reported congenital syphilis cases demonstrates this trend.

Years	Number of Reported Congenital Syphilis Cases
2016	9 cases
2017	18 cases
2018	24 cases
2019 through 12/13	31 cases

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BARRIERS TO PREVENTING CONGENITAL SYPHILIS

Nevada is currently experiencing rising rates of syphilis and congenital syphilis cases, including infant deaths from this preventable disease. Sexually transmitted diseases have surged for the fifth consecutive year, reaching an all-time high, caused by a combination of factors including barriers associated with lack of knowledge about these diseases and missed opportunities to screen and treat pregnant women for STDs. Barriers to testing and treatment include a person's social, cultural, and economic environments, such as poverty, unstable housing, drug use, lack of medical insurance along with new and changing transmission patterns.

Education barriers are also contributing to Nevada's current epidemic of congenital syphilis, as stakeholders discovered that health providers and community agencies serving high-risk populations may be unaware of state law requiring testing of all women in their first and third trimesters of pregnancy.

Anecdotal accounts of physicians who don't believe the population they serve in their private practice is at risk of sexually transmitted infections like syphilis indicate a need for continuing education about screening mandates and increased monitoring for compliance.

Barriers to screening and treatment may also include the cost of testing and access to treatment, and a lack of emphasis on male screenings and treatment compliance.

STRATEGIES FOR PREVENTING CONGENITAL SYPHILIS

Stakeholders agreed that more community education is needed about the risk of contracting syphilis and the locations where the public can seek syphilis screening and treatment, especially during pregnancy. These recommendations align with the efforts of the Department of Health and Human Services Congenital Syphilis Workgroup and the multi-modal education and outreach launched to prevent congenital syphilis.

Obstetrical professionals should be reminded of state law requiring syphilis testing of pregnant women at their first prenatal visit and again early in the third trimester (NRS 442.010). State health officials should make a renewed effort to enforce state testing laws and publicize fines in the medical community to bring additional attention to the issue. Consideration should be given to mandating screening in Nevada at the time of delivery for all patients, regardless of prenatal care status.

Health care and social services communities must be re-educated about state requirements for syphilis screening and treatment during pregnancy, including hospital triage areas and

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community-based programs serving high-risk populations such as substance treatment centers, homeless shelters, needle exchange programs, WIC, and Child Protective Services.

Greater emphasis should be placed on case management of women who are currently pregnant who have been tested and treated for syphilis to ensure third trimester and time of delivery screenings are completed. More attention should be paid to partner screenings and treatment as well, to prevent reinfections.

Finally, innovations should be pursued to ensure antibiotic treatment is provided for everyone testing positive for syphilis. Home health services should be encouraged to develop resources capable of providing treatment at home when necessary to ensure treatment compliance and lower the risk of reinfection.

IMPROVING REPRODUCTIVE HEALTH LITERACY

Stakeholders believe Nevada has low levels of reproductive health literacy, especially among youth and young adult populations who do not receive adequate sex education in local schools. The general population may also be relying on outdated education about contraception, gender identity, and lack knowledge about how to access community reproductive health services. Programs providing youth education include, but are not limited to, the federal Office of Adolescent Health-funded Teen Pregnancy Prevention Program and the Administration for Children and Families-funded Personal Responsibility Education Program which provide evidence based comprehensive reproductive health curricula in Nevada.

BARRIERS TO IMPROVING REPRODUCTIVE HEALTH LITERACY

During one stakeholder meeting, the Southern Nevada Health District teen pregnancy prevention supervisor described efforts by his staff to engage youth in family planning issues by standing across the street from local high schools, handing out flyers about family planning clinics, and engaging youth in spontaneous street education about pregnancy prevention and sexually transmitted infections. While laudable, these efforts are inadequate to the challenge of reaching large numbers of youth in an educational environment, currently precluded by the lack of a comprehensive, medically accurate sex ed curriculum in Clark County schools.

The lack of a reproductive health education budget is a barrier to a major community education campaign on reproductive health issues as demonstrated by Colorado's integrated website, phone-based app, and digital billboard campaign branded as "BeforePlay," which is described under strategies for improving health literacy.

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The lack of attention given to reproductive health concerns in routine medical visits was also raised as a barrier to accessing contraception and other needed services. Women could be asked the key question of whether she wants to get pregnant in the next year at every medical visit, similar to mental health and substance use questions that providers are now trained to ask. Barriers to implementing this type of systemwide change were identified as resistance from already-busy providers and a perceived lack of reimbursement for providing education and access to contraception at routine medical visits.

STRATEGIES FOR IMPROVING REPRODUCTIVE HEALTH LITERACY

Stakeholders believe comprehensive sexual education should be provided in area schools, noting the political controversies in recent years as Clark County has attempted several times to overhaul its sex ed programs. The state Legislature has also failed to pass statewide standards for sexual education curricula that are developmentally and age appropriate, medically accurate, evidence-based, and complete. Nevertheless, quality school-based sexual education efforts are vital to providing youth with the information they need to stay healthy and avoid unintended pregnancies.

Stakeholders agreed that a large community education campaign in Spanish as well as English is needed to overcome lack of information about the importance of prenatal and postpartum care, contraceptive choices, sexually transmitted infections, where to access affordable reproductive health services, and reproductive health issues in the male population. For example, the Statewide Maternal and Child Health Coalition, in partnership with the state Title V Maternal and Child Health Program and Local Health Authority Maternal and Child Health programs, launched a statewide, “Go Before You Show” campaign to encourage early prenatal care.

In 2012, the Colorado Family Planning Initiative launched a public awareness campaign to encourage youth and young adults to make healthy sexual decisions. With the assistance of communication professionals, the Beforeplay campaign developed a website www.Beforeplay.org, a phone app, and digital billboards to “normalize the statewide conversation about reproductive health and increase the visibility of Title X clinics and other health centers offering affordable reproductive health services.”¹⁵ The website provides easily accessed internet-based education on topics such as selection of birth control methods, accessing emergency contraception, learning about sexually transmitted diseases, testing and

¹⁵ *Taking the Unintended Out of Pregnancy: Colorado’s Success with Long-Acting Reversible Contraception*, Colorado Department of Public Health and Environment, January 2017

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treatment, and assessing readiness for pregnancy. The location of health care centers for reproductive health services and information on health care coverage options are also featured.

Stakeholders believe a Nevada-specific public awareness campaign similar to Colorado's Beforeplay initiative, featuring a professional and multi-faceted website and mobile phone app should be pursued with the goal of improving reproductive health literacy among teens and young adults. Private donors and in-kind contributions from a leading public relations firm could be enlisted to cover development costs. Professional sports teams, the casino industry, and other major businesses could participate by sponsoring billboards, bus inserts, or other marketing materials.

Another area of reproductive health care that was identified by the Stakeholders as needing more attention is education about the importance of postpartum appointments and ongoing reproductive health care, including access to contraceptives, for new mothers. Several states have addressed this concern by promoting initiatives focused on training doctors in all health care settings, even during flu shot visits or wellness checks, to routinely ask women of child bearing ages the key question 'Do you want to get pregnant in the next year?'. If her answer is no, clinicians are trained to ensure she gets immediate access to her contraceptive of choice, that day if at all possible. If she says yes, a conversation about healthy pregnancy planning and the importance of prenatal care can take place.

Delaware has dramatically decreased the number of unplanned pregnancies since it enacted a similar initiative in conjunction with Upstream, a non-profit organization working to reduce unplanned pregnancy by expanding equitable access to the full range of contraceptive options. Massachusetts, North Carolina, and Washington all have similar Upstream campaigns while South Carolina has a comparable initiative called Choose Well.

Given the huge concerns around the high rates of syphilis infections in Nevada, education efforts should be expanded beyond existing campaigns to focus on prevention and treatment of sexually transmitted infections, with special attention given to increasing awareness about congenital syphilis, reproductive health issues in the male population, and community locations where screening and treatment is provided at little or no cost.

Finally, an education campaign should be designed to increase education for the undocumented community about how to safely access prenatal care and the dangers of relying on underground medical care, sharing prescriptions, and utilizing botánicas to obtain illegal prescription medicine. A campaign of this nature would be most effective when combined with marketing efforts regarding new resources where this community can obtain reproductive health care without fear.

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DATA BENCHMARKS

The development of the Reproductive Health Community Action Plan was informed by national, state, and Clark County data. Stakeholders identified benchmark data to guide Nevada in measuring improvements in reproductive health outcomes over time. By collecting and analyzing this data at regular intervals, results can be objectively measured, and course corrections implemented as needed.

Much of this data is reported regularly now, but other data sets have been difficult to obtain, such as the number of immediate postpartum LARC placements financed through Medicaid. Determining the data benchmarks before any large initiatives are undertaken will greatly assist in evaluation efforts.

The suggested data benchmarks follow

- 1. Prenatal Care Adequacy by County and Zip Code*
 - 2. Nevada Residents NICU Births, by Medicaid Enrollment, by County, and by Level of Prenatal Care*
 - 3. Teen Birth Rates in Nevada*
 - 4. Teen Pregnancy Rates by Maternal Residence County*
 - 5. Induced Terminations of Pregnancy in Nevada*
 - 6. Perinatal Substance Exposure, NAS*
 - 7. Congenital Syphilis Rates by County*
 - 8. # of Immediate Post-Partum LARC Placements - Medicaid*
 - 9. Nevada Contraceptive Usage including LARCs*
 - 10. Maternal Deaths in Nevada, During, and After Pregnancy*
-

CONCLUSION

In order for Nevada to improve its reproductive health outcomes, more conversation and action is needed in both public and private sectors. Creative public funding models must be designed to support reproductive health providers as they implement new evidence-based models of care. For example, economic disincentives to prescribing LARCs could be addressed following the lead of states like Washington and California who have aligned reimbursement rates across all types of contraceptives.¹⁶

The private sector can assist by contributing its expertise and funding towards a modern and professional public education campaign to increase the knowledge base of sexual and reproductive health topics and available community resources, especially among youth and young adults. The business community has a large stake in reproductive health concerns in Nevada, especially Managed Care Organizations and commercial insurance companies.

At the conclusion of the five-month community engagement process, stakeholders expressed a strong commitment to continue their collaboration with the goal of improving reproductive health outcomes for Clark County residents. Everyone will have a role to play in one or more of the focus areas and increased collaboration will be needed to implement corresponding strategies.

The six focus areas provide a starting point for action. Designating a leader to convene interested stakeholders to prioritize strategies and identify planning steps for implementation will provide a structure for evaluating progress. The community stakeholders should continue to meet on at least a quarterly basis, to share data and information about new program approaches and keep the conversation going. New reproductive health concerns are emerging rapidly such as the congenital syphilis epidemic and a forum is needed to regularly exchange information and provide opportunities for increased collaboration.

Finally, the state and its reproductive health partners must continually reach out to our most vulnerable and underserved communities – low-income people, minority populations, and the undocumented immigrant community – to create relationships and increase trust. One child death to congenital syphilis is one too many.

¹⁶ *National Family Planning and Reproductive Health Association, State Case Studies: Aligning Reimbursement Rates Across All Contraceptive Methods, September 2018*

ACKNOWLEDGEMENTS

This report was developed in partnership with SagePine Strategies LLC and Social Entrepreneurs, Inc. (SEI).

SagePine and SEI would like to thank the 100+ community stakeholders who attended meetings and offered their time, insights, and opinions.

Special appreciation is extended to the following stakeholders whose extraordinary contributions informed much of the project's work.

Dr. James Alexander

Suzanne Bierman

Miriam Cadenas

Raquel Cruz

Margarita DeSantos

Dr. Aaron Dieringer

Xavier Foster

Allison Genco

Lindsey Harmon

Kyra Morgan

Katie Nease

Julia Peek

Quentin Savwoir

Jennifer Somdahl

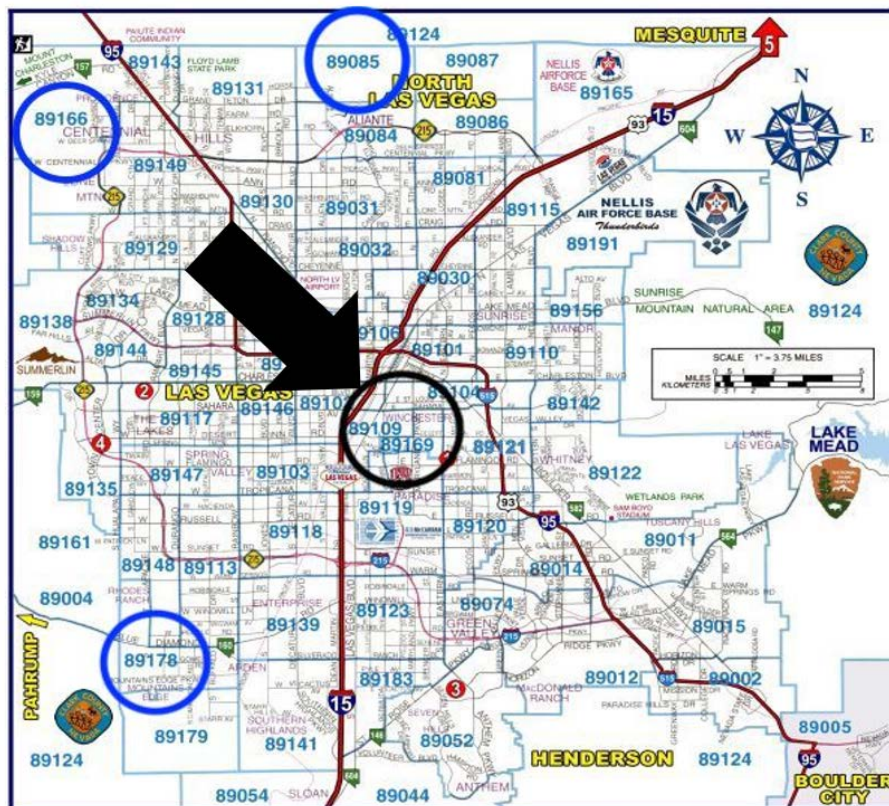
Erika Washington

DuAne Young

APPENDIX A – DATA MAPS

During the community stakeholders meetings, a series of mapping exercises were conducted to determine if there were geographic considerations linked to the reproductive health concerns of inadequate prenatal care, availability of health providers, congenital syphilis cases, and rates of teen pregnancy. The mapping exercises found the older areas of downtown zip codes have the highest number of women receiving inadequate prenatal care, the highest number of abortion clinics, the least amount of reproductive health providers, and the highest rates of teen pregnancy.

Stakeholders began by analyzing prenatal care adequacy by zip code, using the Kotelchuck index, also called the Adequacy of Prenatal Care Utilization (APNCU) Index. The Kotelchuck index defines inadequate prenatal care as prenatal care begun after the 4th month of pregnancy or less than 50% of recommended visits received. In a presentation by DHHS Reproductive Health Coordinator Allison Genco, the zip code with the highest percentage of inadequate prenatal care, using 2016, 2017, and 2018 data was 89169, illustrated by the black arrow in the following graphic. For comparison purposes, in 2016 this zip code’s inadequate care rate was 22.0% while 89085, represented by a blue circle at the top of the graphic, had the lowest rate, at 1.7%.



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The next data set considered by the Stakeholders group was the availability of health care providers in the downtown zip codes, 89169 and 89109, that consistently showed the highest percentage of inadequate care and lowest percentage of adequate care, as documented in Ms. Genco’s presentation, *Relationship of Pre-Natal care Adequacy and Availability of Providers, October, 2019*.

These two zip codes lie within an area that is often referred to as the Medical District, where the University Medical Center, Valley Hospital Medical Center, UNLV Women’s Health Center, Sunrise Hospital, and Planned Parenthood Las Vegas Health Center are located. The High-Risk Pregnancy Center and Women’s Health Associates of Southern Nevada also maintain offices there. Of particular interest to the stakeholders were the additional clinics in these zip codes providing abortion services. The two zip codes and major health providers are represented in the map below.

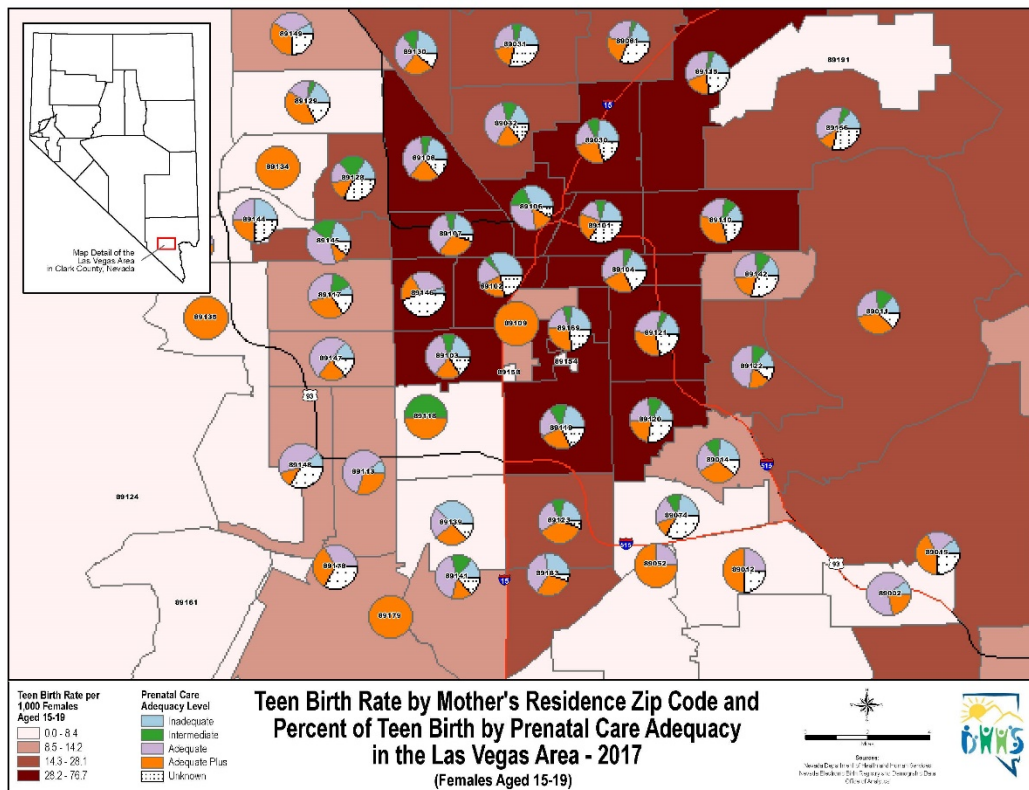


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Stakeholders discussed the reasons preventing access or utilization of prenatal care in these zip codes. They suggested that poverty and lack of insurance coverage to be a significant factor, along with a general lack of transportation, provider growth that has not kept up with population growth and has not been concentrated in these neighborhoods, and difficulties with public insurance that covers labor and delivery but not prenatal care in certain circumstances.

In November, stakeholders reviewed an analysis by Allison Genco and Julia Peek to determine if there was a strong correlation between the location of congenital syphilis cases with zip codes that had high levels of inadequate prenatal care. At that time, there were 25 cases of congenital syphilis reported in Clark County. Their analysis showed that 89169 and its neighboring zip codes showed higher levels of low prenatal care adequacy, both inadequate and intermediate, in 2016, 2017, and 2018 and a high number of cases of congenital syphilis in 2019.

Finally, after hearing a presentation on Teen Pregnancy Prevention from Xavier Foster, M.Ed, Health Education Supervisor of the Southern Nevada Health District, stakeholders requested another data overlay with the downtown zip codes. The data analysis, prepared by the DHHS Office of Analytics as depicted in the graphic below, reveals a high teen birth rate in the downtown zip codes in 2017.



DHHS Office of Analytics, December 2019

APPENDIX B – COMMUNITY STAKEHOLDERS MEETINGS

Five Community Stakeholders meetings were convened from August to December 2019 at the Southern Nevada Health District Red Rock Conference Room in Las Vegas. A synopsis of agenda items and topics discussed at each meeting is presented below.

August

Overview of Project

Highlights of community engagement activities utilized in similar projects in Colorado and Georgia

Legislative updates on recent family planning efforts in Nevada, including the Account for Family Planning

Nevada data review on LARC and other contraceptive usage, teen pregnancy and birth, abortion, perinatal substance exposure and congenital syphilis

Nevada Medicaid LARC reimbursement policies

Identification of opportunities for increased community engagement

September

Barriers to promotion of immediate postpartum LARC placement

Family planning efforts through UNR Med School's Student Outreach Clinic

History of Renown Women's Health Pregnancy Clinic and overview of current services

Data on LARC usage in Nevada

Data on adequacy of prenatal care in Clark County by zip code

October

Development of strategies to promote access to LARCs

Relationship of Prenatal care adequacy and availability of providers

Congenital syphilis in Nevada and development of prevention strategies

Uninsured populations in Clark County and potential outreach strategies

November

Systemic racism in reproductive health services and development of prevention strategies

Teen pregnancy prevention

Development of strategies for promoting prenatal care adequacy and availability of providers

December

Review of benchmark data

Review of Colorado's outreach website, www.beforeplay.org and development of outreach strategies

Focus Group results

California legislation on implicit bias training

Male STD testing in Nevada

Zip code data overlay with teen birth rate data

Review of Nevada's Medicaid policy options

Overview of Community Action Plan

APPENDIX C – FOCUS GROUP REPORTS AND MATERIALS

Visión y Compromiso Focus Group

Seven women attended the Focus Group held at the Planned Parenthood office in Las Vegas on November 19th. The seven women were all immigrants – 6 from Mexico and 1 from Venezuela. Their current immigration status ranged from undocumented to legal resident. The majority of women did not have health insurance and none of them felt they had complete health coverage.

Individual surveys of these Hispanic women revealed the following key points:

- ✓ 57% do not feel they have access to the contraceptives of their choice
- ✓ The women had varying familiarity with the different types of contraceptives with the most known types being depo (the shot), condoms, the patch, IUDs, and diaphragms
- ✓ Women learned about contraceptives from a variety of sources with the most common source being school in Mexico (3 women) and the gynecologist (2 women)
- ✓ 86% of the women have never felt pressured into using contraception when she didn't want to. One woman did feel pressured, after giving birth in the hospital.
- ✓ 43% of the women said their pregnancies were planned, another 43% said their pregnancies occurred sooner than expected, and 14% said the pregnancies were not planned
- ✓ The biggest barrier to receiving contraceptives was the lack of health insurance (3 women), followed closely by the expense of required co-pays for those with insurance (2 women).
- ✓ When asked if their health care provider took their concerns, symptoms, and questions around reproductive health seriously, 43% said "never, not at all" and 29% said "some of the time".
- ✓ Women indicated they have honest and candid conversations about reproductive health with (in priority order) their partner, their doctor, nurses, other health professionals, friends/mentors, themselves, and family members.
- ✓ 100% of the women support comprehensive sex education in schools
- ✓ 57% of the women indicated they know where to get tested for sexually transmitted infections; the remaining 43% do not know where to go

After completing the individual surveys, the focus group was facilitated by Miriam Cadenas, a promotora and trainer for Visión y Compromiso who also works part time for Planned Parenthood. The major finding of the focus group presented below.

Women in the Hispanic immigrant community who do not have health insurance access care through clandestine doctors or "parteras" (midwives) with little experience, through

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community low-income clinics which the women noted are at capacity, or go out of state for care, mostly to California which has more resources and support for pre-natal care for their population. They also indicated many women simply don't get prenatal care.

The focus group participants believe that women in their community would be more likely to engage in pre-natal care if more services were available in their neighborhoods, with clear indications about who is eligible in terms of documentation status. These services need to be well publicized as people are afraid to ask questions or enroll in programs if they don't know if they will qualify. Some women are afraid to accept help because they don't want it to count against them on their immigration application (public charge issue). Special mention was made of the need to provide pregnant and postpartum women with psychiatric care as many suffer from depression due to their undocumented and low-income status, exacerbated by a language barrier.

The participants also noted the need for more Latino and bilingual office staff who are trained to greet people appropriately. Several told stories of going to a medical office where the office staff would not look at them or greet them appropriately.

Quality of care was another concern of the focus group. They stated their community perceives much of their health care to be inferior, illustrating this concern with the Spanish proverb, "tanto pagas, tanto valgas" (what you pay is what you're worth). The inferior care, including a lack of medical tests, can result in pregnancy and birth complications. They do not have much confidence in the quality of prenatal care they are getting and believe doctors are taking advantage of them.

The underground medical system was also mentioned as taking advantage of Latinos. One example given was a health fair that offers free bloodwork but charges a person \$70 to get the results or forces the person to make multiple unnecessary appointments.

The focus group participants believe more education is needed in their community about contraceptives in general, including LARCs, especially for young women who don't have the money to pay for LARCs and don't know how to get them. They noted a lot of bad information is communicated via informal networks, and many do not understand, for example, that Plan B is for emergencies and is not an everyday contraceptive.

According to the participants, women in their community go to Planned Parenthood to access testing for sexually transmitted infections or they go to underground doctors and botánicas (unlicensed pharmacies). They noted that some of the underground doctors practiced medicine in their home countries but are not licensed in the United States; others have never had formal medical training but hold themselves out to the undocumented community as physicians.

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Participants agreed that it is common to “self-diagnose” medical conditions and to share prescriptions among friends and family. Medicine from Mexico is often sold illegally in botánicas and home remedies are used when prescription medicine is unavailable or inaccessible.

The focus group participants were enthusiastic about the idea of a home-visiting model to help new mothers cope with the stress of caring for a newborn or multiple young children. They stressed that in order to be effective, the program would need to be available without affecting someone’s ‘public charge’ and without requirements for social security numbers. They believed that a ‘promotora’ model, utilizing members of their own community, would work best, and added that the promotoras would need to be paid for their time, gas, and childcare for their own children.

In summary, this focus group reflected the need for many more low-barrier resources in their community, providing services in Spanish by people from their own backgrounds, in order to increase access to prenatal care and STD testing. At the conclusion of the focus group, participants expressed deep appreciation for the community stakeholders being willing to listen to their concerns and their community’s needs.

Reproductive Health Care Focus Group Survey Questions

(Note: these questions were translated into Spanish for the Visión y Compromiso Focus Group)

1) Do you feel like you have control over your body and the decisions associated with your body?

- Yes
- No
- No opinion

2) Do you feel like you have adequate access to healthcare right now, including medical insurance, dental, vision, etc.?

- Yes
- Yes, but only medical
- No
- I don't have insurance

3) Generally speaking, do you feel like you have access to the contraceptives of your choice?

- Yes
- No
- I don't use contraceptives.

4) Please select the following types of contraceptives that you are familiar with. Select all that apply.

- Cervical Cap
- The pill
- "The morning after" pill (plan B)
- Condoms
- Contraceptive implant
- DEPO (The shot)
- The patch
- Diaphragm
- Female condoms
- IUDs
- NuvaRing

5) Where and who taught you about contraceptives? _____

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6) Have you ever felt pressured into using contraception when you didn't want to?

- Yes
- No
- I've never used contraception

7) If you answered, yes, to question six, who pressured you into feeling like you had to use contraceptives? _____

8) What, if any, barriers do you feel like you have to receive contraceptives? Select all that apply.

- I don't have barriers in getting access to contraceptives
- My doctor's office doesn't offer the contraceptives I want
- I have had bad experiences with certain types of contraceptives
- I don't have health insurance
- I have insurance, but contraceptives are too expensive
- Social pressures (from family, friends, faith community, etc.)
- Other

9) What, if any, barriers do you feel like you have to receive adequate healthcare? Select all that apply.

- I don't have barriers in getting access to healthcare
- I don't have insurance
- I don't trust doctors and refuse to see one
- I don't have reliable transportation to get to a doctor's office
- I require a specialty doctor that isn't in Southern Nevada
- I can't get time off from work to go to a doctor's appointment
- My deductible to see a doctor is too high for me to afford
- I do not have adequate childcare so I could not schedule a visit

10) How old were you when you first visited a gynecologist?

- Under 12
- 12 to 15
- 16 to 20
- 21 to 30
- Over 30
- Once I got pregnant
- I've never seen a gynecologist

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11) When you visit your healthcare provider, do you feel like your concerns, symptoms, and questions around reproductive health are taken seriously and answered properly? Select one.

- All of the time
- Some of the time
- Most of the time
- Never, at all
- I don't have insurance
- I don't trust doctors

12) What, if anything, keeps you from having (more, if applicable) children. Select all that apply.

- I don't want children
- I don't have insurance
- I don't have access to good healthcare in Las Vegas.
- The current political landscape
- Cost of living is too high (rent, groceries, etc.)
- Cost of childcare
- The schools here in Nevada aren't very good
- I don't feel financially secure.
- I can't afford the time off from my job
- Lack of partnership/spouse
- Limited family/support network
- I'm concerned about having kids at my age
- Unable to have kids due to medical condition

13) If you have children, were those pregnancies planned?

- Yes
- Yes, but my pregnancy occurred sooner than expected
- No
- I don't have children

14) If you are/were pregnant, would/did you have access to prenatal care and services?

- Yes
- No
- What are prenatal care and services?

15) What type of prenatal to postpartum care and services would you be interested in?

Select all that apply.

- Having a doula
- Having a midwife
- Opportunity to attend parenting classes run by Visión y Compromiso
- Water births

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- Homebirth
- Co-op childcare groups
- Therapy for post-partum depression

16) Who do you have HONEST and CANDID conversations about reproductive health with?
Select all that apply.

- Your partner
- Your doctor
- Nurses
- Other health professionals
- Family members
- Friends/mentors
- Faith leaders
- Yourself
- No one
- Other: _____

17) Do you support comprehensive sex education in schools?

- Yes
- Yes, I received it
- No
- No opinion

18) Do you know where to get tested for sexually transmitted infections?

- Yes
- No
- There is no need for me to get tested
- I am not sexually active

19) Have you received tests for sexually transmitted infections?

- Yes, I requested it
- Yes, my healthcare provider requested it at my annual visit
- No

Reproductive Health Care Focus Group Questions for Discussion

1. Where do women in your community, with no health insurance, go for pre-natal care?
2. What would women in your community need to be more likely to engage in pre-natal care?
3. Is more education needed about contraceptives, especially LARCs, in your community?
4. Where do women in your community go to access testing for sexually transmitted infections?
5. Would a home-visiting model work in your community to help new mothers cope with the stress of a newborn or multiple young children?
6. What else would you like to tell us about these issues in your community (prenatal care, contraceptives, sexually transmitted infections)?