



EAST TENNESSEE STATE  
UNIVERSITY

Center for Applied Research and  
Evaluation in Women's Health

# Choose Well: Summary of Mid-Point Evaluation Findings

*This report summarizes key findings related to the evaluation of the Choose Well Initiative at the mid-point. Results are not complete but provide a brief summary of key findings and evidence to date.*

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# DISCLAIMER

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This report summarizes key findings from the external evaluation of the Choose Well Initiative at the mid-point of the evaluation. ***Results are not final and should not be interpreted as causal evidence of the impact of Choose Well on contraception use and long-term reproductive health outcomes.***

Important studies related to the evaluation are not complete, and data collection is ongoing and will continue into 2025. Results presented are not an exhaustive summary of all findings but represent a summary of what is known across studies with published findings (either peer-reviewed or from reports to Choose Well).

The key findings presented do provide an overview of what is known about the impact of Choose Well across multiple studies and specific population groups of interest up to the disruption of services occurring in 2020 as a result of the COVID-19 pandemic, which approximates the mid-point of the evaluation.



## EXECUTIVE SUMMARY

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While the impact of Choose Well (CW) on long-term reproductive health outcomes is not available at this time, findings at the mid-point of the evaluation suggest that CW is on target. Implementation activities have largely been successful in changing clinic policy/practices and provider behaviors at partner organizations, which has translated to increased access, provision, and utilization of contraceptive methods. Considering the collective studies embedded in the evaluation, four important findings have emerged.

**Key Finding 1:** Statewide trainings offered by CW were successful in influencing family planning staff and providers' intent to improve their contraceptive practices and increased stated clinical capacity for providing contraceptive services—this was particularly true among Federally Qualified Health Centers (FQHCs).

**Key Finding 2:** CW activities to improve access to contraceptives translated to increased clinical capacity for stockpiling and providing contraceptive methods, particularly among FQHCs.

**Key Finding 3:** The majority of women receiving care in CW-participating clinics reported receiving high-quality, person-centered contraception counseling.

**Key Finding 4:** The use of highly effective contraceptive methods, particularly intrauterine devices (IUDs), increased following the CW intervention beyond what would have been expected otherwise, particularly among adolescents and younger women (<25 years of age).

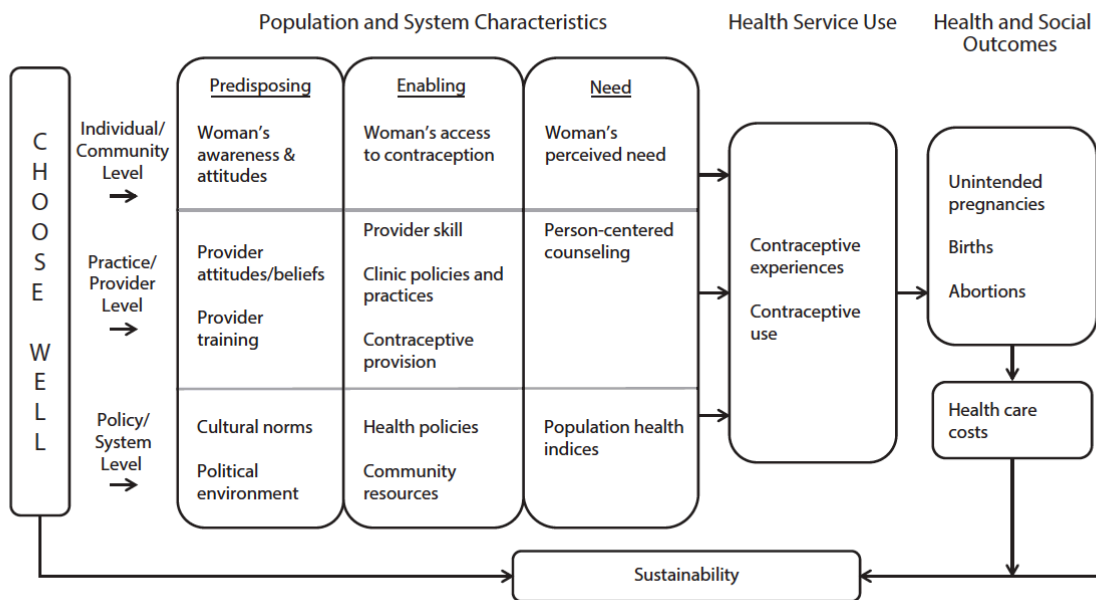


# INTRODUCTION & CONCEPTUAL MODEL

New Morning (NM) launched a six-year statewide contraceptive access initiative in 2017, Choose Well (CW). The mission of CW is to promote equitable access to contraception without judgment or coercion, ultimately targeting a 25% reduction in unintended pregnancy statewide by 2023. CW is a statewide initiative with clinical partner sites in 45 of the state's 46 counties as of 2022. Although the initiative is designed to address gaps in contraceptive access among uninsured and underinsured people, all patients at CW clinics benefit from high-quality service provision, regardless of their insurance status or ability to pay. CW provides financial and operational support to all participating clinical partners, community organizations, and educational institutions. In brief, the initiative centers around four key areas: infrastructure and workforce; capacity building and training; integrated marketing and communications; and strategic learning and sustainability. A full description of the CW implementation can be [found here](#).<sup>1</sup>

East Tennessee State University (ETSU) is the external evaluator for the CW Initiative. Given the broad nature of the CW Initiative, ETSU designed a mixed-methods evaluation that examines the extent to which important predisposing, enabling, and need factors at the individual, practice or provider, and policy or system levels influence contraception use and reproductive health outcomes (Figure 1). The underlying premise of the evaluation design is that CW is intended to improve factors at the individual, practice or provider, and policy or system levels and, in doing so, will have a positive impact on contraceptive experiences and use that will subsequently impact health and social outcomes.

**Figure 1: Conceptual Model for the Choose Well Evaluation**



Establishing the causal impact of CW on short (contraception use) and long-term outcomes (unintended pregnancy, births, abortions, etc.) requires establishing sequential relationships between program investments, method utilization, and ultimately, outcomes. This report is focused on the first relationship—the impact of select CW activities on increasing access, provision, and utilization of contraceptive methods. The extent to which any observed changes translate to changes in long-term reproductive health outcomes cannot be established at this point in the evaluation; however, determining the extent to which CW activities translate to changes in method utilization is a critical first step.



## KEY FINDING #1

**CW trainings were successful in influencing family planning staff and providers' intent to improve their contraceptive practices and increased clinical capacity for providing contraceptive services—this was particularly true among Federally Qualified Health Centers (FQHCs).<sup>2,3</sup> While trainings were positive, anticipated barriers in translating training into practice remained a salient issue.**

Important clinical, administrative, and counseling-related barriers to contraception provision have long been noted in the literature. While not all barriers can be removed, many can be addressed through the implementation of evidence-based policies and practices. As part of initial CW implementation activities, national and state-based consultants were used to provide statewide trainings specific to contraceptive counseling, long-acting reversible contraception (LARC) provision, shared decision-making, revenue cycle management, and other topics to clinical and non-clinical professionals in CW-partnering organizations. In addition, ongoing technical assistance related to Medicaid billing and coding and electronic health record development was also provided.

Results from evaluation studies focused on examining the effectiveness of these trainings have noted overwhelmingly positive findings. A peer-reviewed study published in *Contraception* examined providers' intent to improve contraceptive practices following participation in CW trainings.<sup>2</sup> Participants completed surveys following contraceptive care trainings provided to family planning clinic and hospital obstetric providers and staff. Data were collected from 160 contraceptive training sessions provided to 4,814 clinical and administrative staff between 2017 and 2019. Post-training surveys were completed by 3,464 participants (72%), and of these, 2,978 answered questions related to the study outcomes. Most respondents ( $n = 2,390$ ; 80.7%) indicated intent to change their practice and 35.5% ( $n = 1,044$ ) anticipated barriers to implementing intended changes. Across all training categories, organizational factors (time constraints, policies and practices, infrastructure/resources) were the most frequently perceived barrier to improving contraceptive services. Structural factors related to cost for patients were also identified as barriers to IUD and implant provision.

Another published study used semi-structured key-informant interviews with FQHC clinic and systems-level staff occurring from July 2018 to September 2019 to assess staff perceptions of the impact of CW trainings on clinic operations and contraception provision.<sup>3</sup> Training opportunities provided through the initiative were noted to have enhanced and increased capacity for contraceptive counseling, increased overall clinical capacity to provide contraceptive care, and specifically increased provider capacity for IUD and implant provision. Half of the respondents highlighted the benefits of training for patient education and community outreach as a component of contraceptive counseling. Respondents also emphasized the benefits of an expanded perspective on reproductive health, such as “gaining viewpoints,” “becoming more open,” and “creating dialog” about contraceptive methods, sexuality, unintended pregnancy, and contraceptive counseling. Improved quality of contraceptive care services was also noted. However, provider factors (beliefs and comfort level) emerged as a barrier among a few respondents, for instance, the perception that some providers were “not comfortable with doing an IUD” or “have strong beliefs that's always going to be a barrier.”



## KEY FINDING #2

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### **CW activities to improve access to contraceptives translated to increased clinical capacity for stockpiling and providing contraceptive methods, particularly among FQHCs.**

Increasing access to all contraceptive methods is central to the CW Initiative. In addition to trainings and other infrastructure supports, having contraceptive methods available on-site at a free or reduced cost at partner clinics across the state is critical for establishing a relationship between CW and increased method utilization, particularly IUD and implant methods.

A baseline manuscript from a survey of publicly funded clinics (health department and FQHC clinics) in South Carolina and Alabama noted variation in on-site contraceptive method provision among clinics.<sup>4</sup> While almost all clinics provided at least one short-acting hormonal method, nearly 1 in 3 clinics did not offer IUDs or implants on-site at baseline.

Follow-up reports provided to NM by ETSU and additional studies currently under peer review note that the ability of partner FQHC clinics to stockpile and provide contraceptive methods has increased substantially with CW implementation. Table 1 displays the proportion of FQHC clinics offering each of the eight contraceptive methods in the baseline and midline surveys by CW participation status. The on-site provision of the full range of contraceptive methods, and specifically the on-site provision of IUDs, increased significantly in CW-participating FQHC clinics relative to non-participating clinics. At baseline, 37% of CW participating FQHC clinics offered any IUD on-site. At midline, 85% of CW participating FQHC clinics offered any IUD on-site. While CW is focused on ensuring access to all contraceptive methods, IUDs represent a costly and clinically challenging method to provide on-site. IUDs were also among the contraceptive methods least likely to be provided at FQHC clinics at baseline.



**Table 1: On-Site Contraceptive Provision among CW Participating and Non-Participating FQHCs at Baseline and Midline of the Evaluation**

FQHC Clinics Providing Each Method On-Site			
		CW Non-Participating N (%)	CW Participating N (%)
Any IUD**	Baseline	16 (21.1)	7 (36.8)
	Midline***	24 (32.9)	41 (85.4)
Contraceptive Implant	Baseline**	22 (29.7)	12 (63.2)
	Midline***	26 (34.7)	39 (86.7)
Oral Contraceptive	Baseline	74 (97.4)	19 (95.0)
	Midline	67 (89.3)	46 (93.9)
3-month hormonal injection	Baseline	64 (81.0)	17 (85.0)
	Midline*	53 (72.6)	40 (88.9)
Patch	Baseline	50 (64.9)	15 (83.3)
	Midline	44 (68.0)	35 (77.8)
Ring	Baseline	40 (53.3)	12 (63.2)
	Midline**	33 (46.5)	35 (77.8)
Diaphragm	Baseline	23 (31.1)	6 (33.3)
	Midline**	21 (30.0)	24 (54.6)
Male Condom	Baseline	55 (71.8)	21 (100.0)
	Midline	54 (75.0)	44 (93.6)

\*p<0.05

\*\*P<0.01

\*\*\*p<0.0001



## KEY FINDING #3

### The majority of women receiving care in CW-participating clinics reported receiving high-quality, person-centered contraception counseling.

The CW evaluation assessed the quality of contraceptive care by recruiting patients from the waiting rooms of CW-participating clinics in South Carolina and from the waiting rooms of similar clinics that were not participating in CW in another Southeastern state. Patients in both CW-participating and non-participating clinics were surveyed about their goals and expectations for their contraceptive care visit prior to meeting with their provider and surveyed about their contraceptive experience after meeting with their provider. The data that follows reflects the results of surveys from 2,027 patients (942 from CW-participating clinics and 1,085 from non-participating clinics) recruited between October 3, 2018 and August 11, 2021.

A high-quality contraceptive care visit with a health care provider must meet several key criteria. One of the most important criteria for a high-quality contraceptive care visit is the provider and patient discussing key reproductive health topics. Table 2 displays the percentage of patients receiving care in CW-participating and non-participating clinics who reported that their provider discussed key topics with them during their contraceptive care visit. A majority of patients recruited from both CW-participating and non-participating clinics reported that their provider discussed key topics with them. This is not surprising given that these patients were going to the clinic to receive contraceptive care. However, a statistically significantly greater percentage of patients receiving care in CW-participating clinics reported that their provider discussed possible side effects of their birth control method(s) and the safety and efficacy of IUDs and implants than patients receiving care in non-participating clinics. Furthermore, a statistically significantly greater percentage of patients receiving care in CW-participating clinics completely agreed that their provider was very knowledgeable about birth control compared to patients receiving care in non-participating clinics (Figure 2).

**Table 2: Percentage of Patients Reporting that their Contraceptive Care Provider Talked to them about Key Topics During their Family Planning Visit**

Topic	% of CW Clinic Patients	% of Non-CW Clinic Patients
<b>Did your provider talk to you today about...</b>		
Your future pregnancy plans	56.4%	60.5%
Your sexual health and practices	86.5%	85.0%
How to use your birth control method correctly	83.8%	83.6%
Possible side effects of your birth control method(s)*	83.2%	78.3%
Sexually transmitted diseases	70.0%	66.1%
The safety and efficacy of IUDs and implants***	64.2%	50.8%

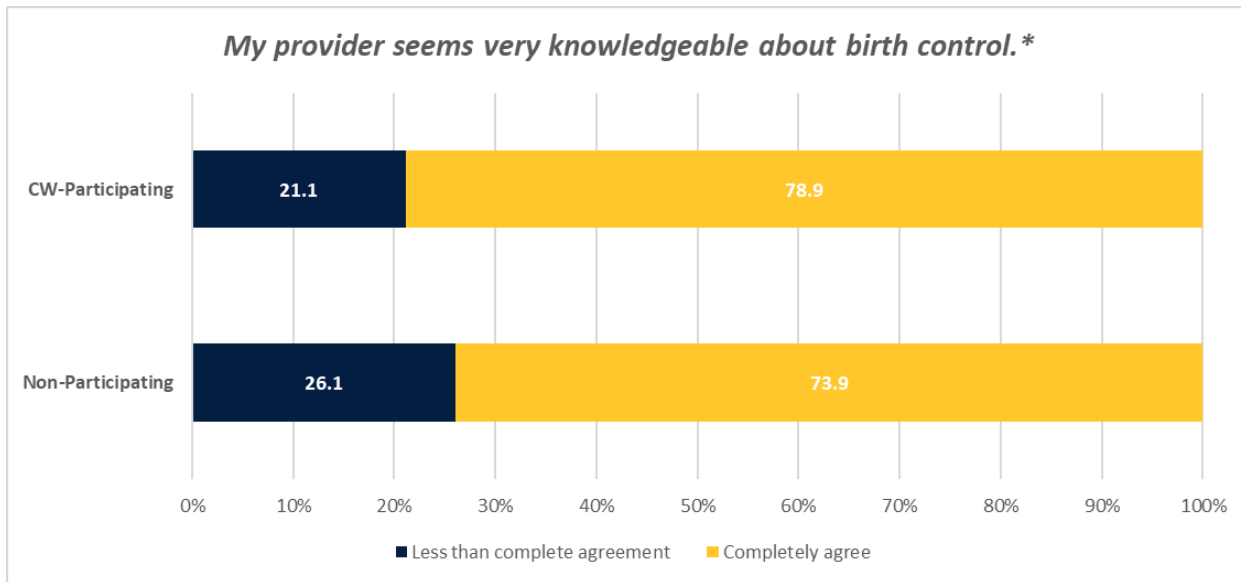
\*p<0.05

\*\*p<0.01

\*\*\*p<0.0001



**Figure 2: Percentage of Patients Reporting that their Contraceptive Care Provider Seemed Very Knowledgeable about Birth Control**



\* $p < 0.05$

Another important criterion for high-quality contraceptive care is the provider showing respect to the patient and counseling them in a patient-centered manner. Table 3 presents the percentage of patients from CW-participating and non-participating clinics who completely agreed with different statements assessing aspects of provider respect and patient-centered contraceptive counseling. A majority of patients recruited from CW-participating and non-participating clinics agreed with each statement. However, a statistically significantly greater percentage of patients recruited from CW-participating clinics completely agreed that their provider clearly respected them as a person, their provider took their preferences about birth control seriously, and their provider let them say what mattered to them about their birth control method.

**Table 3: Percentage of Patients Who Completely Agreed with Statements about their Provider's Contraceptive Counseling Style**

Contraceptive Counseling Statement	% of CW Clinic Patients Who Completely Agree	% of Non-CW Clinic Patients Who Completely Agree
<b>My provider...</b>		
Is definitely looking out for my best interests	76.7%	73.0%
Clearly respects me as a person*	81.8%	77.1%
Took my preferences about birth control seriously*	75.0%	70.1%
Gave me the information I needed to choose the best birth control method for me	67.0%	63.0%
Let me say what mattered to me about my birth control method*	72.0%	66.8%

\* $p < 0.05$

## KEY FINDING #4

**The use of highly effective contraceptive methods, particularly IUDs, increased following the CW intervention beyond what would have been expected otherwise, particularly among adolescents and younger women (<25 years of age).**

Multiple studies specific to contraception utilization are relevant for summarizing the impact of Choose Well on utilization patterns. A published study provided an early baseline examination of contraception use patterns at the state level among women of reproductive age using the statewide survey of women.<sup>5</sup> This study found that baseline method use distributions among women in South Carolina and another Southeastern state of evaluation interest were equivalent. This statistical equivalency at baseline is important for establishing differences in method use over time. This study also found that 26.5% of women reported not using any contraception at baseline, and non-use was more common among women with some college/associate's degree, incomes between \$25,000 and \$50,000, no health insurance, and longer gaps in care relative to their counterparts. This group of women represents an important population of interest for CW.

A second published study examined baseline contraception utilization among women enrolled in the state Medicaid program.<sup>6</sup> This study examined contraception use and pregnancies among women 15-45 years of age who were newly eligible for South Carolina Medicaid from 2012 to 2016 by program eligibility type. This study established that the likelihood of pregnancy during a given year was lower among women using short-acting hormonal methods during the previous year and markedly lower among women using LARC methods, compared to women with no evidence of contraception. While the association between LARC method use and lower pregnancy events is well-documented nationally—this study established direct effects using data from South Carolina. This study also highlighted differences in the potential effect of increasing LARC use among the varying Medicaid eligibility categories. Overall, the likelihood of a pregnancy was lower among women enrolled in the limited eligibility Family Planning program and among teens enrolled in the Partners for Healthy Children program relative to women enrolled in full-benefit programs. More variability in pregnancy events by method type was observed among women in the full-benefits Medicaid program. These findings suggest that expanding the availability of LARC methods to women in traditional Medicaid programs who desire those methods could have a more substantial impact on pregnancy prevention each year.

A third published study extended this analysis forward and examined the cost-effectiveness of specific contraceptive methods among South Carolina women enrolled in Medicaid between 2012 and 2018.<sup>7</sup> Incremental cost-effectiveness ratios, defined as the additional cost of contraception provision per live birth averted, were estimated for four contraceptive methods (IUDs, implants, injectable contraceptives, and pills), relative to no prescription method provision, and savings per dollar spent on method provision were calculated. This study found that IUDs and implants were the most cost-effective with cost savings of up to \$14.4 and \$7.2 for every dollar spent in method provision, respectively. Injectable contraceptives and pills each yielded up to \$4.8 per dollar spent. An important finding from this study relates to the duration of Medicaid enrollment and cost-effectiveness. While IUDs and implants were by far the most cost-effective over an extended period of time, Medicaid expenditures for these methods occurred at the time of placement. The relative break-even point in the context of Medicaid expenditures was approximately two years. Up to that point, oral contraceptives and injectables were more cost-effective. This study is important in that it uses South Carolina-specific method utilization, pregnancy outcomes, and average method costs for establishing cost estimates that can be used in future studies estimating the impact of increased method use.

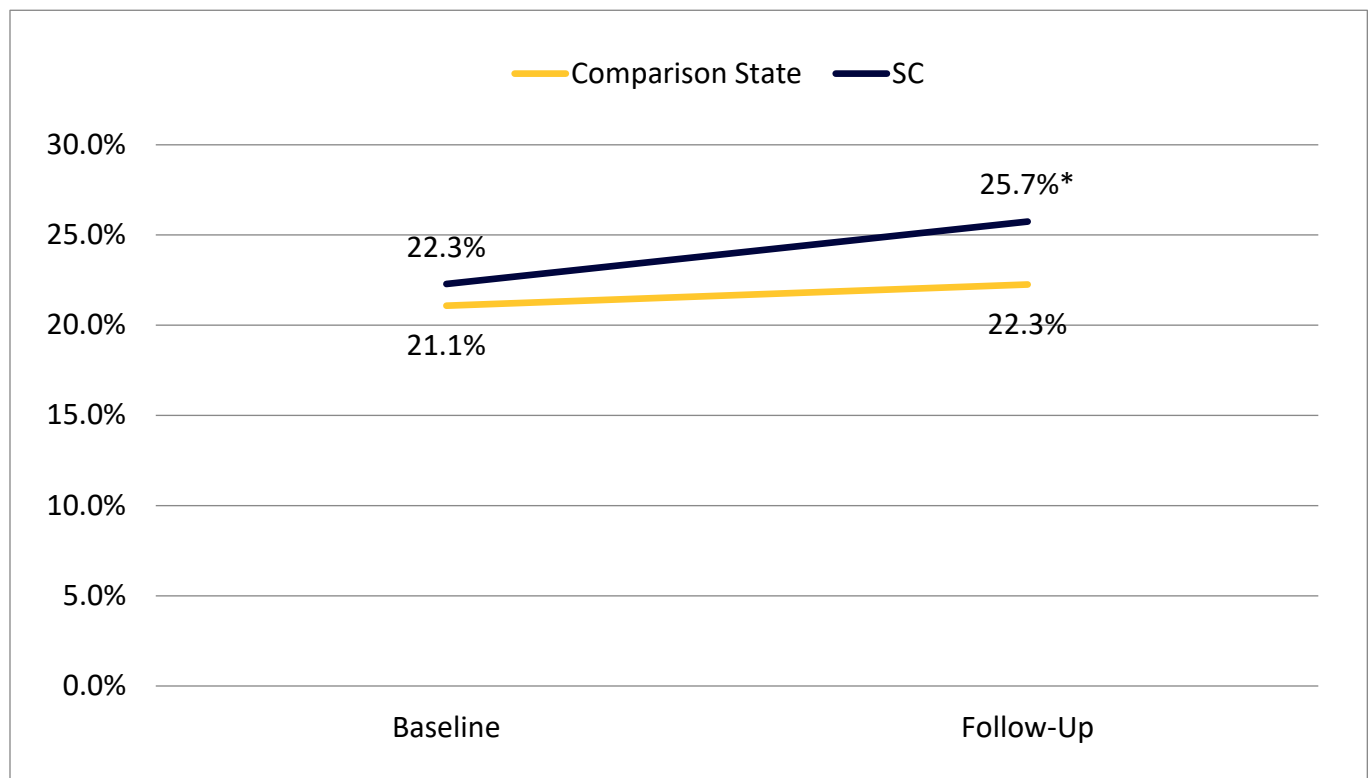
A fourth study currently under review provided the most direct, compelling evidence for increased method use associated with CW. This study used an interrupted time series regression analysis to assess the impact of Choose Well on IUD and implant use, stratified by age groups. This study found that LARC use increased from 7.7% during the pre-CW period to 10.4% during the CW period ( $p < 0.001$ ), with IUD use increasing from 4.3% to 5.6%



( $p < 0.001$ ) and implant use increasing from 4.0% to 5.6% ( $p < 0.001$ ). The change in the level of use after CW was positive for IUDs (0.493 percentage points; 95% CI=0.311-0.675). The effect was stronger among women 20-25 years of age. CW significantly increased the trend in IUD use among all women by a positive 0.013 percentage points (95% CI= 0.006-0.020) per month beyond expected values. Additional follow-up analysis suggested that approximately half of the increase in IUD use over the four-year implementation period (2017-2020) among women enrolled in Medicaid may be attributed to CW-related activities. This study demonstrates that CW efforts to expand contraceptive care have translated to the increased use of effective contraceptive methods among an important sub-group of women likely to benefit from CW-related activities.

A final unpublished study used the statewide survey of women to examine longitudinal changes in IUD and implant use among a cohort of women in South Carolina and a comparison state completing the initial baseline survey. This study found that a higher proportion of South Carolina women reported the use of an IUD method at one of three follow-up surveys compared to women in the comparison state (Figure 3). These differences were significant in both unadjusted and adjusted models. No differences in implant use were noted.

**Figure 3: IUD Use at Baseline (2017) and Follow-Up (2018-2020) among a Cohort of Reproductive Aged Women in South Carolina and a Comparison State**



\* $p < 0.05$



# CONTACT INFORMATION

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**Please send any questions, comments, or correspondence to:**

Nathan Hale, PhD, MPH  
Associate Professor  
Department of Health Services Management and Policy  
Phone: (423) 439-4429  
Email: [halenl@etsu.edu](mailto:halenl@etsu.edu)

Mike Smith, DrPH  
Assistant Professor  
Department of Health Services Management and Policy  
Phone: (423) 439-4443  
Email: [smithmg1@etsu.edu](mailto:smithmg1@etsu.edu)

Amal Khoury, PhD  
Professor & Department Chair  
Department of Health Services Management and Policy  
Phone: (423) 439-4937  
Email: [khoury@etsu.edu](mailto:khoury@etsu.edu)

Kate Beatty, PhD, MPH  
Associate Professor  
Department of Health Services Management and Policy  
Phone: (423) 439-4482  
Email: [beattyk@etsu.edu](mailto:beattyk@etsu.edu)



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