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## Title

*Improving contraceptive care quality at community health centers through a quality improvement learning collaborative model*

## Priority 1 (Research Category)

Healthcare Services, Delivery, and Financing

## Presenters

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## Abstract

Context: Community health centers (CHCs) provide critical safety-net health care for millions of underserved patients in the U.S., including one-third of low-income women of reproductive age. Ensuring access to quality contraceptive care at CHCs is crucial to achieving reproductive health equity.

Objective: To assess the impact of a year-long quality improvement learning collaborative (QILC) on contraceptive care at CHCs.

Study Design: Implementation evaluation to evaluate impact of the QILC.

Setting or Dataset: Ten CHCs, representing 30 clinical sites across eight states.

Population Studied: 1) People with the capacity for pregnancy receiving care at CHCs; and 2) providers and staff engaged in reproductive health care provision at CHCs

Intervention: CHCs participated in a QILC that included monthly sessions on topics related to reproductive health equity and person-centered contraceptive care practices. They developed quality improvement plans informed by performance measure scores evaluating person-centered quality of contraceptive counseling (PCCC) and electronic health record (EHR) data assessing contraceptive use. CHCs shared their team's quality improvement progress in sessions to facilitate peer learning. Between sessions, we provided individualized technical assistance to each CHC.

Outcome Measures: Implementation measures included key informant interviews and observations of QILC sessions and technical assistance calls.

Results: Baseline average PCCC scores (n=653) ranged from 37% to 93% across CHCs, and EHR-documented contraceptive use ranged from 12.9% to 72.5%, suggesting a wide range of quality. Individualized QI plans focused on improving areas of inequity in PCCC scores and improving screening for contraceptive need. Participants reported that foregrounding racial equity informed improvement

strategies and contextualized the importance of high-quality contraceptive care. Resources provided through the QILC encouraged organization-wide conversations and trainings on contraceptive care equity and that data facilitated leadership buy-in and informed quality improvement strategies.

Conclusions: A structured QILC facilitated cross-organization learning prioritizing equity-informed contraceptive care. Baseline data and individualized technical assistance provided awareness of deficits and a roadmap for improvement. This project can serve as a model for how other QI initiatives can facilitate change through structured peer-learning.