

NWX-OS-OGC-RKVL

**Moderator: Marilyn Keefe
November 26, 2012
1:00 pm CT**

Coordinator: Welcome and thank you for standing by.

At this time all participants are in listen-only mode.

We will conduct a question-and-answer session during the conference. At that time to request to ask a question please press star 1.

Today's conference is being recorded. If you have any objections, you may disconnect at this time.

I would like to turn the meeting over to your host today, Ms. Marilyn Keefe. Ma'am, you may begin.

Marilyn Keefe: Hi everyone sorry for the short delay. We had a little bit of a technical difficulty and I think we've cleared that up.

I'm Marilyn Keefe, the Deputy Assistant Secretary for Population Affairs of Department of Health and Human Services.

Welcome to today's webinar on the Iowa initiative to Reduce Unintended Pregnancies.

We're pleased to have with us a number of the key individuals who made this initiative happen.

Launched in 2007, the initiative is a five-year, privately funded demonstration project with the goal of tackling the high rate of unintended pregnancy among women 18 to 30 in Iowa.

Along with providing direct services, the project has undertaken research to better understand the issues related to contraceptive knowledge, attitudes and behavior as they relate to unintended pregnancies.

Our first speaker is Sally Pederson, the Executive Director of the Iowa Initiative. Throughout her career, Sally has been a devoted advocate for developmentally disabled women, children, racial minorities and LGBT youth and adults. Sally focused on these issues during her tenure as lieutenant governor of Iowa from 1999 to 2007.

She's also served as the president of Polk County Health services as board president for the Autism Society of Iowa and a member of the board of the National Alliance for Autism Research, Blank Children's Hospital, the Mid-Iowa Health Foundation and the state Special Education Advisory Panel.

Sally's going to provide an overview of the project.

Our second speaker will be Jodi Tomlonovic, the Executive Director of the Iowa Family Planning Council, to talk about the role that family planning providers have played in the initiative.

Jodi has been with the Iowa Family Planning Council for more than 25 years. She's also served as the past president of the Family Planning Councils of America, (unintelligible) board member for the National Family Planning and Reproductive Health Association, former chair of the Iowa Breast and Cervical Cancer Coalition and she's currently a governor's appointee for the Iowa Medical Assistance Advisory Council.

Next up will be Susan Philliber, Founder and Senior Partner of Philliber Research Associates -- which provides evaluation services and assistance with program planning for human services, journalism and arts and cultural programs.

She's served as the lead evaluator on many national projects related to youth development, teen pregnancy, school achievement, community development and juvenile crime prevention.

Susan will describe the evaluation and research related to the initiative.

Next will be Shelly Campo, an Associate Professor at the University of Iowa College of Public Health and Director of the Center for Health Communication and Social Marketing.

Her areas of expertise include health campaigns, (unintelligible) communication and persuasion. She's worked a range of health topics focusing on how to adopt new or reinforce existing health attitudes and behaviors using innovative theory and data-driven communications research.

Shelly was responsible for the development and implementation of the Avoid the Stork campaign of the initiative.

Lastly we'll come back to Sally who will discuss recommendations and lessons learned followed by a question-and-answer session for any of the speakers.

This webinar as you heard is being recorded and should be posted on the OPA Web site within the next two weeks.

So with that I'd like to turn things over to Sally.

Sally Pederson: Thank you, Marilyn.

Well we're very pleased to be invited to share the preliminary results of some really exciting work we've been doing here in Iowa.

As all of you know, about half of all pregnancies in the U.S. are unintended and that's one of the highest levels in the developed world.

Because Iowa mirrors these national figures pretty closely and because Iowa has been gathering data on unintended pregnancies for a couple of decades, we were considered an ideal site for a study examining strategies to reduce unintended pregnancies.

I should also say that because Iowa is a relatively small state with a population of 3 million the investment that's required to make an impact here is less than say Illinois or California.

So those were the reasons that we were chosen by a private foundation for this important project to reduce unintended pregnancies.

So Jodi and I are going to be sharing the information with you first and what I'd like to do is describe what our project looks like.

The Iowa Initiative to Reduce Unintended Pregnancies is a privately funded, five-year demonstration project and it began in late 2007.

We work in partnership with the Iowa Department of Public Health, the Family Planning Council of Iowa, Planned Parenthood of the Heartland and researchers at the University of Northern Iowa, the University of Iowa and the University of Alabama-Birmingham.

The goals of the Iowa Initiative are to reduce unintended pregnancies and abortions, to increase the number of uninsured and underinsured Iowans who have access to family planning services, to increase the use of long-acting reversible contraceptives and to increase public support for family planning.

Over the past five years, the Iowa Initiative has helped women learn about and get access to affordable, safe, long-acting reversible contraceptives through publicly funded family planning clinics that serve low-income women.

Iowa Initiative grants have allowed clinics to expand hours and locations, to train clinical nurse practitioners and physicians on the benefits of LARCs and how to use them and to purchase LARCs so clinics can offer them at low cost or no cost to their patients.

Prior to this initiative clinics could not afford to offer LARCs to their patients due to the high cost.

During this same five-year period, our research partners at the University of Iowa, Northern Iowa and Alabama-Birmingham conducted interventions

designed to increase knowledge about contraceptives, to persuade women to use contraception if they wish to avoid pregnancy and to improve behaviors on contraceptive use. You'll hear more about one of those interventions from Shelly Campo.

Let me return for a minute to the slide listing the goals of the Iowa Initiative. I'd like to describe the role of the team of the three of us who work in the Iowa Initiative office.

We're not medical professionals and we don't provide any direct family planning services. Our efforts primarily focus on the last goal you see there of increasing support for publicly funded family planning.

We did this by coordinating efforts and messaging among the agency partners and through extensive outreach and networking to raise public awareness. We educated through public-speaking engagements, one-on-one meetings with medial leaders, business leaders, elected officials and government agency directors.

We partnered with the AAUW -- the American Association of University Women -- to host community conversations in cities and towns across the state. And we've published articles in newsletters, magazines and newspapers to educate Iowans about the impact of unintended pregnancies in both social and economic costs.

All of these efforts combined have made a real difference. During the past four years, the use of LARCs by women served by publicly funded clinics in Iowa has quadrupled while unintended pregnancies and abortions have declined. And you will hear more about those numbers from Susan Philliber.

Right now I'd like to turn the presentation over to Jodi Tomlonovic, Executive Director of the Family Planning Council of Iowa.

Jodi Tomlonovic: Thank you, Sally.

The Iowa Initiative was a great opportunity for the family planning community and for the obvious reasons. But I would like to speak a bit about some of the takeaways from this project.

First of all, when LARCs are available and when women are educated about them, they will choose LARCs. In 2011, almost 12% of Iowa's (unintelligible) family planning users used LARCs.

And of course funding is a huge issue when we're talking about providing LARCs. Hopefully with ACA that will be less of an issue as more people may up their (unintelligible) coverage.

But beyond that there are areas that we can look at as we review the project.

As usual trainings is a major point. The project allowed us to ensure very quickly that all the clinicians in our system were trained in insertions and removals.

And in addition there was significant focus on training all clinic staff not just the clinicians on client education and counseling for LARCs. We developed a contraceptive counseling guide to be used in the clinics with specific emphasis on information about the LARCs.

But we did find that we needed to work with all clinic staff -- both the clinicians and nonclinicians on their perception of LARCs -- particularly

IUDs. Getting all staff to understand that anyone - understand and accept who can receive IUDs takes constant reinforcement reminding them of the new standards is ongoing -- especially as it relates to teen and (unintelligible) women.

The project did allow clinics to conduct more marketing and outreach not just about LARCs but about the clinic services in general and the clinics found this to be very helpful. It was certainly something that we would like to see be able to continue in the future.

And then on the (unintelligible) part of the initiative with referral from private practices as the word spread across the state thanks in large part to Sally and Christi Vilsack that LARCs were available at no cost some private practices referred their patients to the clinics for LARCs.

I think we can explore the idea of promoting the insertion and removal skills of our clinicians to primary care providers and encourage them to send their patients to us for LARCs thus establishing a relationship that could be built on as we move through ACA and other aspects of health care reform.

And finally I would like to say that the Iowa Initiative team was invaluable in taking the message on unintended pregnancies to new venues. They provided a public face for the project and were able to keep the discussion focused on unintended pregnancies.

We were very fortunate to get two high-profile (unintelligible) Christie Vilsack, the former first lady of Iowa, and Sally Pederson, former lieutenant governor of Iowa. They opened so many doors for this issue. They were able to get the media's attention and they were able to get community leaders to talk about this issue.

And our clinics were not able to speak at Rotary Clubs about unintended pregnancies, but Christie and Sally both traversed the state talking to Rotary Clubs and other community groups.

And this was probably one of the most difficult parts of initiative to replicate. But if it is all possible, it is one that I highly recommend be tried.

We will definitely miss their constant support on these issues.

And now Susan Philliber will give you a more scientific evaluation of the project.

Susan Philliber: Good afternoon.

I do not have video control here, so if someone could help me, let's move to the second slide on data collection.

For the purposes of the evaluation of this initiative, we collected various kinds of data. First from family planning agencies throughout Iowa, we did patient surveys, clinic director interviews and surveys and we collected data from a sample of clinicians working in those Iowa family planning clinics.

In addition we tracked statewide data on births, unintended pregnancies, abortions as you will see in a moment. We conducted policy interviews throughout the state and we collected individual program data on special initiatives there.

Next slide.

This first data slide shows you the percent of women using an implant as their primary method from 2005 well before the initiative began until 2011, the most recent year for which we currently have data. And we had a quite a large increase in the percent of women using an implant as their primary method over that period of time.

Next slide.

This one is the percent of women using an IUD as their primary method by year and it also increased by 208% since 2007 when the initiative began.

This next slide is the percent of contraceptives currently using IUDs or implants in the U.S. and in Iowa. And we looked up these numbers so that we could tell whether or not it was something different going on in Iowa than in the United States. And as you can see, the increase in LARCs use was greater than the increase in LARCs use for the United States as a whole.

Next slide.

This is the percent of unintended pregnancies by year in Iowa and you can see here that we also saw a decrease here in unintended pregnancies over this time period of the initiative so that it's now dropped below the 47.6% that it was in 2006.

This next slide shows the percent change in unintended pregnancy in Iowa and other states from 2005 to 2008. This is an analysis that we still have in progress, but we decided to at least look around to some of Iowa's neighbors and say is the same thing happening there. And the answer is no, that Iowa had a greater decrease in unintended pregnancies over those years tracked in the graph than did Minnesota, Nebraska or Ohio.

This next slide shows the percent of pregnancies terminated by abortion by year and that reached a high of 14.2% in 2006 in Iowa. And since then it has decreased 24%.

The next slide compares that percentage change in abortion ratio -- again Iowa versus some other states -- and you can see that we have a much greater decrease in that percent of pregnancies that are terminated by abortion relative to a 1000 live births in Iowa -- all positive indicators that something positive was happening during the time of this initiative.

We also looked at some other interim outcomes that were important. For example I mentioned we collected clinic data and asked them what changes did you make as a result of the initiative. And you can see them listed on this slide -- wait time was shorter, they added ParaGard, they added Mirena, they added Implanon, they said that they were offering more hours of service and that their no-show rate was somewhat lower.

We also asked these family planning agencies to tell us about the marketing they were able to do under the initiative and they described the strategies that you see there in the slide and reported a greater reach of their marketing efforts through the support that they had in the initiative.

In the next slide we look at the comfort levels of clinicians and this is where we began to see that we're not completely finished yet. We show you here the percent of clinicians in these Iowa family planning clinics who say they are not very comfortable -- they're less than very comfortable -- in inserting Mirena, ParaGard and Implanon.

And we assessed this twice during the evaluation -- once in 2010 and once in 2012. And while the number who are not comfortable is going down, we've still got work to do here in terms of improving clinicians' comfort levels.

The next slide shows clinician approval for LARC methods. We gave them various groups of women -- women who never had children, teenagers, women with a previous history of ectopic pregnancy -- and we asked them do you think that these methods are safe and suitable for these women.

And you can see the percentage of those groups that they said they approved these methods for fewer for ParaGard than for Mirena or Implanon. But in the case of the IUDs, improving over time.

The next slide just shows you that we still do have work with these clinicians because ACOG has said -- the American College of Obstetrics and Gynecology -- that the immediate postpartum period is a particularly favorable time for IUD or implant insertion.

However when we asked our clinicians in Iowa whether they approved of immediate postpartum insertion and was it suitable and safe, you can see that the percentages there were fairly low -- particularly for the IUDs where fewer than a third of the clinicians said that they thought this was appropriate in spite of the ACOG guideline.

These same results show when you ask these clinicians about immediate post-abortion or miscarriage insertion, they're approval rate is not 100%. It's lower than that. They're more liberal about the Implanon.

Policy change slide tells you a little bit about some of the policy work that we monitored. These folks as part of this initiative worked on the Medicaid

waiver expansion to increase eligibility for family planning among individuals up to 300% of the federal poverty level, men and women up to age 55. And during the life of the initiative in September 2010, those expansions were indeed passed.

The next slide shows some of the policy successes and challenges that people talked to us about. One of the goals here was not to lose ground. As one respondent told us, we've not let this get politicized everywhere in Iowa and we've helped to prevent that from happening.

Others pointed out while it's hard to count what you avoided, generating a groundswell of support had a strong preventive factor. So some of the policy work as part of this initiative was not losing ground on things already gained.

So let me just summarize some of the things that we found worked. During the time of the initiative, the number of providers offering LARC methods increased, access to family planning services went up and the number of clients choosing LARC methods went up.

Next slide.

The outreach and marketing successes included more clients coming into the clinics seeking LARC methods, more community support and the visibility of the individual clinic grantees. One grantee said to us our name is now out in the community.

In the third What Works slide, we've listed some policy successes -- awareness of and support for family planning amongst stakeholders, legislators and the public and many people all over the state coming to bat for this issue.

The next What Works slide emphasizes again the increased use of LARCs, fewer unplanned pregnancies and fewer abortion that seemed to parallel this initiative.

Thank you.

Woman: Thank you, Susan.

Shelly Campo: A few were sideways.

Susan Philliber: I was sideways?

Shelly Campo: Yes the slides -- at least on my view. This is Shelly Campo. Is there a way to...

Coordinator: And this is the operator. Unfortunately there's no way to change the orientation at this time.

Shelly Campo: Okay. I just lost it.

Okay so make sure everybody in the audience turns sideways and we'll be perfectly fine.

So I would like to talk about a statewide social marketing campaign which eventually was called UntilYou'reReadyAvoidtheStork.com -- which was a surround campaign effort that reached all 99 counties in Iowa.

It was one of a series of behavioral interventions conducted in the state. The others in collaboration with the University of Northern Iowa and the University of Alabama at Birmingham and included the development of two radio dramas, some interventions in pharmacies and some interventions in

salons with stylist to talk to their clients and which I will not talk about today. But those were smaller-scale interventions going on and I'm happy to take questions about them.

All of the behavioral interventions were developed using a lot of formative research and included three statewide surveys. One was of 18 to 30-year-old women, another was right before the pilot intervention was done also with 18 to 30-year-old women. We also did a statewide survey of 18 to 55-year-old men and women. We did focus group and in-depth interviews extensively around the state trying to get an idea of how people viewed this issue and where the barriers and the places to intervene would most likely be.

We looked outside the target audience because when you do a media campaign, you can't actually get down to the level exactly only getting at 18 to 30-year-old women. And since others would be exposed to this campaign, we wanted to be careful about what they were being exposed to and we didn't want to insult anybody. But we also saw those broader groups as available to influence the people we really most cared about -- which were the 18 to 30-year-old women.

When we started, we thought we would have two different campaigns -- one for college and one for non-college. But in the formative evaluation, we saw that people viewed this issue very similarly.

Woman actually believed that they knew very little about contraceptives. That health class in tenth grade was a long time ago and they weren't really - it was relevant to them at the time and so they didn't really pay much attention.

In addition there were a lot of newer methods that were available that they knew very little about beyond pill and condom and they didn't really necessarily know where to get more information.

There was a clear lack of planning for sex. Somehow it was just something that spontaneously happened -- particularly when alcohol was present -- and so that inhibited people's use of family planning.

And women were really ambivalent about unintended pregnancy. So on the one hand, they didn't really want to be pregnant right now. On the other, maybe they've been with their partner for a long time or they can envision having kids and kids obviously are for many people very happy instances and so there's a lot of conflicting ideas.

We also saw in terms of the messages we needed to send that people needed to be reminded that there were a lot of birth control methods out there. And that if one isn't working right for you, you can find one that fits you, your body, your budget and your lifestyle.

We heard a lot from women and men in our focus groups that they didn't want to be preached at and they definitely didn't want to be scared to death -- that they wanted messages that respected them.

And despite the fact that we were going after women as our primary target audience, they were very clear that we needed to include partners so that women were not unintentionally blamed for the unintended pregnancies.

And so we took all that information and worked with Worldwide Social Marketing in Denver, Colorado, to develop three creative concepts.

Before we went out into full-scale implementation, we tested those concepts in 18 focus groups in non-college audiences and four focus groups in college audiences around the state.

And very clearly one concept came to the front and that winner was the Avoid the Stork campaign.

So this is a humor-based campaign where the stork makes unexpected deliveries to couples, to women and to men who are not planning a pregnancy but didn't use birth control consistently and appropriately.

So the stork is awkward, geeky, funny, people laugh at the stork and the crazy thing he does but not at the baby or the couple. So we were very careful in the development of using humor that we weren't trying to make fun of couples who'd had an unintended pregnancy where the baby that resulted but of the circumstance that could have been avoided.

And so we used this concept to develop materials that would appeal to a broad range of 18 to 30-year-old women from those who were married and already had multiple children to the 18-year-old college student who hadn't even come close to thinking about that.

So we developed a bunch of materials -- both mediated and non-mediated campaign materials -- and pilot tested in the northwest part of our state and in one university and one community college in 2009. And we did some pre/post surveys, some intercept interviews and got a lot of anecdotal feedback at events we attended.

We were very well received. We received very little backlash and we were seeing changes in antecedents to behavior like attitudes and knowledge and

intentions that seemed to be looking like they would actually impact behaviors.

And so we used the information that we had there to expand the offerings of what we had available as it related to the campaign and you'll see that in a minute.

So for the statewide implementations, we were live for a little over a year between June 2010 and August 2011. We paid for media statewide and that's really important. We got matches but we weren't only on at 2:00 a.m. in rural Iowa. We were on at - you know, we were on MTV and we were on American Idol.

And so we paid for TV, radio, billboards, newspapers, movie theater ads, Facebook and Google ads.

We also had nontraditional placements. We worked with business -- local businesses -- throughout the state in coffee shops, restaurants, bars, bowling alleys -- places that 18 to 30-year-olds frequented.

We also sponsored events and we had a live delivery team that made appearances with the stork around the state where they gave out lots of giveaway items.

And you can see lots of materials connected to the campaign at our Web site - - which is still live for another month.

So in all, we had a lot of executions of things that we actually produced. We had eight different TV spots, nine radio commercials, seven different Web

banners and ads, a host of print media and a lot of giveaway items and we were out in the community.

This is a picture of our Web site -- which was designed to look like a baby delivery service. And it had sections on the Web site that dealt with the issues that had come up in the focus groups, so information about birth control and its side effects and its cost and how effective they were.

But it also had places you could go. There was a link to a clinic locator to get to Title X family planning clinics in the state and some information about STIs as well as communication with partners and other family members about these issues.

I'm just going to flip through the next few slides to give you some examples. These are billboards that actually appeared in the state. This is a snap of a TV commercial where the man in the bar is actually the one getting the delivery.

Here's a whole bunch of posters and you can see the various images that we used. So you can see the woman in a bottom with a child and then you can see another woman on top who's working out at a local gym who looks much younger and then there's a couple in a movie theater for example.

In all we gave away almost three-quarters of a million items -- most of them items in bars and restaurants. But we also gave away close to 200,000 condoms statewide.

Here's some photos from events and again some more giveaway items. The ChapStick that we gave away was highly popular and you might even find it on eBay. We have at various points. People are very hot to get it.

But you can also see some photos of the stork actually physically out. These are some pictures of the stork delivery team at some live events -- including at the top on the right-hand side there's a picture from the NASCAR race that we sponsored at the Iowa Speedway.

So in terms of evaluation -- and I just want to give you a quick overview of what we have and I obviously can't go through it in any detail -- but we did a lot of process outcome and even impact evaluation. So it was very complex.

You know, we paid attention to Google Analytics. We looked at viral buzz in terms of just tracking the kinds of information that people were sharing on the Web.

We did intercept interviews. We obviously had gross rating points from our media placements. But we also had post-survey data -- both in terms of Web and random digit dialing. We had outcomes from Medicaid and from private insurance claims data. And then statewide obviously we're also looking just like Susan was at the statewide unintended pregnancy and termination data.

So the Web site actually had a lot of hits and a lot of those hits corresponded to periods where we peaked either in media or in terms of actually being at a physical event.

And we were surprisingly popular outside of Iowa, so we were definitely viewed in all 50 states. But we were in every continent and we had 200 hits in Malaysia, so we were getting picked up in some interesting places.

We had very wide-scale self-reports of exposure. So statewide 72% of women reported having seen or heard the campaign. And on college campuses

specifically, it was 97.3%. And of those who had seen them, most had seen them in three or more formats -- like newspapers, TV, radio, et cetera.

About half of our college students had an Avoid the Stork item and about a third had seen the stork live, so it was very positive.

People also rated the stork as being very funny, interesting, informative and having laughed when they saw the campaign.

What we know from humor is that what we saw in our campaign was that those who had seen the campaign were a lot more likely in the college population and we saw this too in the population of those over age 30 statewide that they talked to others about the campaign and they showed the campaign to others. So the more they thought it was funny the more likely they were to do those things, so the humor was causing a lot of sharing.

We also saw from changes in the pre and posttest data statewide that there were changes in norms, attitudes and knowledge as well as talking to the others. So statewide more people had heard about LARCs, there were more accurate perceptions of the effectiveness of various types of contraceptives, they knew more family planning clinics, they believed more of their single friends used contraceptives. College students reported talking more with best friends and partners and perceiving that they were at greater risk of unintended pregnancies.

We also saw that there were increases in self-efficacy -- both statewide and in college populations. So women believed that they could actually use contraceptives consistently and effectively and they were more likely to report concrete intentions to actually use birth control the next that they were having sex.

We also know in a very general way that both the private and the public insurance claims data showed increases over time in the percent of those who were contracepting - choosing to LARCs as their contraceptives.

This was particularly true in younger women and in lower income women in the public insurance data who were much more likely to use LARCs and much of the surge was prior to the statewide implementation of the stork, although there was some continuation of it after.

So part of the question is too that there's a market saturation point. Not every women in the age range of 18 to 30 would actually choose to use a long-acting contraceptive and so some of that may actually be because we were close to reaching whatever that upper point is. And I think that's particular true in the Medicaid population and maybe less true in the private insurance population.

All right I think we're ready for questions.

Coordinator: Thank you. We will now begin a question and answer session. To ask a question please press star 1. Please unmute your phone and record your name when prompted.

If your question has been answered, you may withdraw it by pressing star 2.

Once again to ask a question press star 1.

One moment please as questions queue.

Once again to ask a question press star 1. One moment please.

All the speakers do have an open line. You can ask a question at any time if you're a speaker.

Sally Pederson: Well, you know, one of the things we might do while we're waiting on questions from the audience -- this is Sally Pederson -- is just share with you our recommendations.

We feel that Iowa's experience can be a model for the nation and provide policymakers and health care professionals with important data to guide future decision-making.

And so as a result of the work that we've done in Iowa, we made four recommendations and I have those on the slide on your screen. Those recommendations include investments, training, collaboration and education.

And the first one is to enhance investments in publicly funded family planning services so that clinics can educate patients through outreach and advertising about the most effective birth control options.

The second recommendation is actually educating those health care professionals who, you know, see the patients about the safety and efficacy of LARCs and providing trainings on their use. That's incredibly important if we're going to increase the use of LARCs.

Our third recommendation was just really to get people to collaborate and seek, you know, kind of in one voice about the importance of reducing unintended pregnancies and abortions and what an impact that has on social and economic benefit.

And the final recommendation is to work with community colleges, private colleges, any universities to help students avoid unintended pregnancies and that will help improve academic success.

Want to share those and now maybe there are some questions.

Coordinator: And we do have several questions in queue.

Our first question will come from Cheryl. Your line is open.

(Cheryl Kovar): Thank you very much. This is (Cheryl Kovar) from North Carolina. Excellent presentation.

I just was curious about the dip in 2010 on the utilization of both. I think it was in both the IUDs and Implanon. Was there anything going on that kind of countered that dip and then you went back up in 2011? Was there any other confounding factors?

Woman: Susan, do you want to respond to that? Maybe Susan is not still on the line.

Shelly Campo: I have a hypothesis. This is Shelly Campo.

Woman: Yes.

Susan Philliber: This is Susan.

Woman: That's fine. Yes just like just what would be your thoughts -- the hypothesis on that.

Shelly Campo: Okay. My guess is that the initial push from the clinics, you know, drove some level of market saturation. They really got out there and everybody who was ready to get one at that point, you know, had really begun to do so and so there were fewer women available.

In 2010, we launched the stork campaign statewide, so my guess is that that produced a second push of women into the clinics. So the dip may have been just a reaching a temporary market saturation point and then more women aging in for example -- which happens too.

Woman: Good point yes.

Susan Philliber: This is Susan and I want to endorse what Shelly said there. That's certainly possible as an explanation.

And the other thing I should point out is that these state data from which we're working while enormously helpful and by and large accurate are not perfect and the counting IUD and implant use often has involved counting procedure codes, the method a person came in with and left with. There are a variety of ways to count it plus a variety of ways to record it. And so the recording strategies may not have been entirely consistent year to year either.

(Cheryl Kovar): So it could have just been an artifact of the reporting too.

Susan Philliber: It might have been.

(Cheryl Kovar): Yes.

Susan Philliber: But Shelly's explanation is a good one too. I like it.

(Cheryl Kovar): And that makes sense and here in North Carolina as a clinician too I think you - I really do applaud you for doing the education with the clinicians because that's something we're doing here in our state.

It was amazing how many - how in the degree of inaccuracies that were out there among the clinicians. And, you know, we know in health care if a clinician isn't onboard with a method, they're not supposed to be coercive, but you can have a reverse coercion of saying Joe do you really want that IUD or I don't know about that implant.

And then so by giving them the education that kudos to you. That's all. Thank you.

Coordinator: And our next question in queue comes from (Linda). Your line is open.

(Linda Snyder): Hi thank you. This is (Linda Snyder) at Adagio Health in Pittsburgh, Pennsylvania.

I wanted to know what effect your increase in patients using LARCs had on your annual return visit rate. Did you see a drop in clients and/or in the provision of routine (gyne) care, you know, such as annual breast exams and so forth because you increased clients using LARCs?

Jodi Tomlonovic: (Linda), this is Jodi Tomlonovic and that is something that we haven't quite been able to get our hands around. I know for those of you in the (unintelligible) community and often feeling like this is all emphasis on numbers. It is something we're trying to determine.

One of the problems is, you know, again I talked a bit about referrals from outside providers and whether or not people then came back. But the issue

around returning patients is one we're going to - is I think our next area that we're really going to have to try to look at and then the problem is determining if the return was just because - if the not returning was just because they have a LARC as opposed to another method.

But we haven't been able to really get a very good grasp of that. It is something that both the Iowa Department of Health and the (unintelligible) grantee in Iowa and the council have been trying to figure out a way to really gather that information.

(Linda Snyder): Okay thank you.

Coordinator: And our next question in queue comes from (Mark). Your line is open.

(Mark Hathaway): Hi this is (Mark Hathaway) from Washington, D.C. I'm curious. I had heard that you did the campaign and had initially a six-month window when patients could come in. And it struck me as a novel marketing concept that if you tell folks that you can get this for the next six months so come quickly kind of that it may have increased your numbers initially. Is there someone there that can comment on that or is that just a myth that I heard?

Sally Pederson: (Mark), this is Sally Pederson. (Unintelligible) you've had some (unintelligible) correct. The Planned Parenthood of the Heartland did a promotion where they said, you know, come in now and you can get these LARCs free and then they had just a window of opportunity. It was not six months. It was a much shorter period of time.

They did that campaign twice. And when they did that and advertised on television, they had a spike immediately following the advertising campaign. But the six-month period is not correct, but yes there is a campaign time

limited that saw, you know, a spike and yes actually you could go in the same deal.

Woman: And I should add, (Mark), (unintelligible) that they discontinued that at one point in time. They did a short period and then they discontinued it and then they did it again and the data followed. The LARC adoption went up, down when they quit, up again when they started it again, down when they quit. So it produced instant response both times.

(Mark Hathaway): Fantastic stuff you guys are doing so congrats.

Woman: Thank you.

Coordinator: And our next question in queue comes from (Les). Your line is open.

(Les): Yes my question has to do with the patients' acceptance of the implant versus IUD. When educated, do you think patients have a preference of one over the other -- especially teenagers?

Jodi Tomlonovic: Hi, (Les), this is Jodi. We're going to look at that a little more. I think it was interesting that when we were looking at - when I was looking at some of the numbers from both the Department of Health, (FPAR) and the council's (FPARs), we saw that the council about twice as many of its LARCs were IUDs and the health department was reversed.

And, you know, we think that some of that really had to do with the clinicians and the clinic staff and their feelings about what they would support because they're level of LARCs overall were about the same among both groups.

But teens we have - you know, we've had quite a few teens that are on LARCs and we can get you some, you know, more information clearly off our (FPARs) on that. But we've found them pretty accepting of even IUDs.

And again for the council delegates we have quite a few teens on LARCs or on IUDs. I'm sorry. But on both but on IUDs. So they've been pretty accepting.

I will say that one thing that happened real early in on in this was really important was really training the clinic staff -- clinicians and your patient educators -- about the side effects. I think you all know that if, you know, a patient has a lot of bleeding that they didn't expect, they don't like that method. And so, you know, you really have to make sure your staff understand the side effects and can counsel their patients on how to deal with that.

(Les): Thank you.

Coordinator: And we show no further questions at this time.

Marilyn Keefe: Hi this is Marilyn at OPA. I just have a quick question. Do you guys have any longer term evaluations planned to assess for sustained changes in LARC use or unintended pregnancies?

Susan Philliber: This is Susan. Yes the funding for evaluation on this project will continue for at least another year -- which is past the time that the program folk will be funded. And the emphasis of our work over that year will be sustainability -- not only sustainability on the LARC use but sustainability of the clinic activities that made the increase LARC use presumably possible.

So we will be looking at these family planning agencies and saying now that you've seen, you know, what marketing can do and now that you've see what these increased hours can do and so and so forth, are you able to keep it up, are there other sources of funding for these LARCs. So there will be at least another year of tracking in this state.

Marilyn Keefe: Thanks. And I guess if we have no other questions, just a final sort of open-ended question for most of the Title X grantees on the phone who are unlikely to experience a large influx of cash. Are there any other lessons that you'd like to talk about that might come the project? I don't know if this is a...

Woman: I guess think, you know, there needs to be, you know, a constant effort to educate the public about the cost benefit as well as the, you know, societal benefit to helping women avoid unintended pregnancies.

You know, we demonstrated by reducing unintended pregnancies but we also reduced abortions and so this makes it an issue that the vast majority of people support and can get behind. And in doing this, you know, you save taxpayer dollars.

So I just think to continue to try to help people understand that, you know, this is something that people support and not to be overly cautious about talking about this as a public health issue.

(Sue Motkowski): I have one - this is (Sue Motkowski) at the (unintelligible) population affairs and I have a question about what publications might be planned as a result of this study, because any information that would be in the press I think would be able to be utilized by anybody in terms of being able to, you know, promote the idea or promote what you all have achieved in Iowa.

Susan Philliber: Yes. Well this is Susan. And along with my partner in evaluation (Claire Brendis) at UCSF we have already begun to prepare (unintelligible). And if you go to the Iowa Initiative Web site, you will find some of the papers we recently delivered at the American Public Health Association meeting. And if they're not directly on that Web site, there will be a note on that Web site of how to find them on my Web site or (Claire)'s Web site.

And we will be posting everything that we write out of this on a regular (unintelligible) noting it on that Iowa Web site.

Woman: And the Web site -- IowaInitiative.org -- will continue to be up for another full year as more information is gathered and analyzed. So I would urge you to go there. Our press briefing is there and, you know, other information and detailed PowerPoints that Susan and (Claire) presented at our conference in September.

Marilyn Keefe: There are no other questions. Thank you very much to Sally, Jodi, Susan and Shelly. This was terrific and we really appreciate you taking the time to talk about the Iowa Initiative with us.

And for folks on the phone, just know that this will be posted on our Web site within a couple of weeks. Thank you.

Woman: Thank you.

Coordinator: Thank you for participating in today's conference. You may now disconnect.

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