

## ASTHO Immediate Postpartum LARC Learning Community: Findings from Key Informant Interviews with Cohort 2 States

### Background

Half of all U.S. births in 2010 were publicly funded, and half of these publicly-funded births, or about one million births, were unintended.<sup>1</sup> Long-acting reversible contraception (LARC), which includes implants and intrauterine devices (IUDs), are evidence-based methods for preventing unintended pregnancies.<sup>2</sup> Unintended pregnancies<sup>3</sup> and short inter-pregnancy intervals<sup>4</sup> are associated with poor maternal and infant outcomes. Improving women's access to LARC is a promising strategy for supporting women and improving maternal and infant health.

Under the current standard of care, postpartum contraception, including LARC, is provided at the four- to six-week postpartum visit, but attendance at this visit varies, especially among younger and low-income women who face access barriers.<sup>5</sup> The immediate postpartum period—after delivery and before hospital discharge—is an opportune time to provide LARC because women are actively engaged with the healthcare system during pregnancy and delivery.<sup>6</sup> There are no contraindications to immediate postpartum implant insertion, and recent clinical guidelines recommend IUD placement in the first 48 hours post-delivery, ideally within 10 minutes of placental delivery to minimize expulsion rates.<sup>7</sup> A recent study estimated that immediate postpartum IUD placement resulted in 88 fewer unintended pregnancies per 1,000 women over two years compared with routine IUD placement at the postpartum visit, leading to cost savings of \$282,540 per 1,000 women.<sup>8</sup>

Although providing immediate postpartum LARC has potential for increasing women's access to effective contraception, barriers have prevented widespread adoption across birthing facilities. The cost of LARC devices and associated procedures (e.g., LARC insertion and removal) are not fully reimbursed by many payers when placed immediately postpartum.<sup>9</sup> To address this barrier, several state Medicaid agencies have recently changed reimbursement policies for immediate postpartum LARC.<sup>10</sup> While hospitals bill for all labor and delivery costs using a single bundled diagnosis-related group (DRG) code, immediate postpartum LARC policies allow hospitals to be reimbursed for the device, and in some states, the procedure as well.<sup>11</sup> Currently, 17 states and Washington, DC, have implemented policies on immediate postpartum LARC with accompanying coding documentation and guidance for billing.<sup>12</sup>

The experiences of states that were early adopters of immediate postpartum LARC reimbursement demonstrate that policy revision alone is insufficient for overcoming implementation barriers. States must overcome several other systems challenges to fully integrate immediate postpartum LARC into their birthing facilities. To address these challenges, CDC and the Association of State and Territorial Health Officials (ASTHO) convened a multi-state immediate postpartum LARC Learning Community in partnership with other federal agencies and maternal and child health (MCH) organizations. The first learning community cohort began in August 2014 with six states; a second cohort of seven states was added in October 2015. The learning community aims to improve state capacity to successfully implement immediate postpartum LARC policies through cross-state collaboration, state peer-to-peer learning, and technical assistance.<sup>13</sup> The purpose of this report is to summarize the results of key informant interviews conducted with the second cohort of learning community state teams to assess facilitators and barriers to, and strategies for implementing immediate postpartum LARC policies.

## Key informant interview methods

From November-December 2015, we conducted key informant interviews by teleconference with seven cohort 2 teams in the immediate postpartum LARC Learning Community representing Delaware, Indiana, Louisiana, Maryland, Montana, Oklahoma, and Texas. The interviews were recorded and a research assistant took extensive notes during the calls.

The interview guide was structured according to the learning community’s [eight domains](#): provider training, reimbursement and sustainability, informed consent and ethical concerns, stocking and supply, outreach, stakeholder partnerships, service locations, and data, monitoring, and evaluation.<sup>14,15</sup> We asked about facilitators, barriers, and strategies under each domain. We also asked the teams about the impetus for changing their state Medicaid reimbursement policy, reasons for joining the learning community, and what their priority technical assistance needs were from the learning community.

Themes from these interviews are summarized in this report, and encompass the time period leading up to the policy change, as well as the time since the policy change in each state. The month and year of the policy change for each cohort 2 state is provided in Table 1.

**Table 1.** Dates of immediate postpartum LARC Medicaid reimbursement policy change in cohort 2 states

| Cohort 2 State | Effective Date of Policy |
|----------------|--------------------------|
| Louisiana      | 06/20/2014               |
| Oklahoma       | 09/12/2014               |
| Maryland       | 09/24/2014               |
| Montana        | 01/01/2015               |
| Indiana        | 06/01/2015               |
| Delaware       | 07/15/2015               |
| Texas          | 01/01/2016               |

## Findings

### *Impetus for Changing State Medicaid Policy Change to Reimburse for Immediate Postpartum LARC*

State teams discussed several factors that provided an impetus for policy change in their states. The following is a list of factors common to most states.

- 1) **Examples set by early-adopting states:** Several state teams cited the early successes in South Carolina and Colorado as motivators for policy change in their own states, with one team reporting that it asked: “Why can’t we do that here?” A majority of the cohort 2 teams reported that leaders in early-adopting states provided them with direct technical assistance during policy change efforts and encouragement to join the learning community.
- 2) **Intersection of immediate postpartum LARC with other state and national MCH priorities and initiatives:** Teams saw the immediate postpartum LARC policy change as a strategy to address several current health improvement priorities in their states, including infant mortality and prematurity, maternal morbidity, unintended and rapid-repeat pregnancy, and neonatal abstinence syndrome.
- 3) **Confluence of clinical guidance supporting the safety and efficacy of immediate postpartum LARC:** Recent guidance disseminated by CDC<sup>16</sup> and American Congress of Obstetricians and Gynecologists (ACOG)<sup>17</sup> supporting the placement of IUDs and implants in the immediate postpartum period prompted OB/GYNs and clinical stakeholders in participating states to

approach their Medicaid agencies to advocate for a reimbursement policy change for immediate postpartum LARC.

- 4) **Evidence of cost savings and return on investment for immediate postpartum LARC:** Most teams acknowledged that the economic argument for immediate postpartum LARC was a key driver to getting the policy changed, especially within their Medicaid agencies.
- 5) **Leadership at several levels:** All states indicated that strong leadership was necessary to endorse the policy change, but states differed on who provided that leadership, suggesting that stakeholders at a variety of levels could be influential. While one state reported that the governor and Medicaid medical directors were key supporters of immediate postpartum LARC, others named clinical champions and OB/GYN residents as leading change agents in their states. Prior to the policy change in one state, medical residents treating patients across several hospitals saw it as an equality issue that women delivering in some hospitals did not have the same access to immediate postpartum LARC as those delivering in a facility that implemented immediate postpartum LARC using donated devices. They strongly advocated for a more global solution for all women in the state. In another state, a medical resident's quality improvement initiative on immediate postpartum LARC garnered interest from the wider provider community, thereby prompting policy action. Other states mentioned the state health official as providing strong leadership.

### ***Impetus for Joining the ASTHO immediate postpartum LARC Learning Community***

The cohort 2 state teams value their participation in the ASTHO immediate postpartum LARC Learning Community, citing the following benefits.

- The learning community gives credibility and validity to states' immediate postpartum LARC efforts.
- The learning community's structure helps them organize their team across multiple state agencies and provides structure that allows them to identify and solve implementation issues.
- The learning community provides an opportunity to learn from the successes and challenges of other states at similar and different stages of implementation.

### **Learning Community Domains**

Although the teams described instituting the Medicaid reimbursement policy change as a big win, they acknowledged that the real challenge lies in successfully implementing and disseminating immediate postpartum LARC across their states. The following sections cite some of the barriers and strengths that cohort 2 states experienced or anticipate, as well as implementation strategies teams are using to support this effort. Findings are reported according to the leaning community domains.<sup>18, 19</sup>

#### ***Domain 1: Provider Training***

Most cohort 2 states have not yet undertaken large-scale provider training efforts. State teams vary in the extent to which they see their role in training providers in placing IUDs and implants. While some teams anticipate planning large-scale provider training efforts, others will leave the responsibility for planning trainings to their provider organizations or coalitions. Many states cited local ACOG chapter annual meetings as likely settings for training and outreach.

Several teams mentioned prioritizing OB/GYN resident training. Upon completing their programs, residents will disperse across different facilities, where they can promote immediate postpartum LARC

and train colleagues. In states with provider shortages, teams are interested in training nontraditional family planning providers, such as family medicine specialists who attend many deliveries in the state, though the teams have not yet initiated these efforts.

## ***Domain 2: Reimbursement and Sustainability***

Teams discussed Medicaid reimbursement payment strategies, engaging private insurers, and funding strategies for implementation activities as part of the reimbursement and sustainability domain.

- 1) Medicaid payment strategies:** Most state teams reported satisfaction with how reimbursement is structured for immediate postpartum LARC outside of the DRG for labor and delivery. States see separate payment structures for devices and insertion as critical for making practice change effective. One state, however, reported tension within the Medicaid agency over adopting this policy due to concerns about unbundling immediate postpartum LARC from delivery reimbursement when most new payment strategies are focused on bundling services. Opponents are concerned about setting a precedent that may lead hospitals to request unbundling for other expensive services outside of the DRG.
- 2) Private insurers:** One state team has made targeted efforts to encourage private insurers in the state to reimburse for immediate postpartum LARC through standing monthly meetings of their Medicaid agency leadership with private insurers. Other states have not yet engaged their private payers. Several expressed hopes that their efforts within Medicaid managed care organizations (MCOs) will spill over to the private insurance market, especially among MCOs with a private arm. Provider representatives, who are most familiar with clinical flow, acknowledged that private-payer reimbursement would significantly improve implementation efforts, even among Medicaid clients, because it would allow providers to globally counsel about and offer immediate postpartum LARC, regardless of the patient's payer. Some cited the disparity in payer policies as an equity issue from two perspectives:
  - Allowing immediate postpartum LARC reimbursement for Medicaid clients only may be perceived as an effort to control childbearing among low-income women, given historical context.
  - Privately-insured women who desire immediate postpartum LARC may currently be unable to access it.
- 3) Funding strategies for implementation activities:** A few state teams have engaged private foundations or nonprofits to fund implementation efforts, while others have acquired funds from Medicaid, Title V, Title X, and other public mechanisms. Teams cited the value of establishing public-private partnerships to leverage public funding for implementation activities, such as provider trainings and staff time. Others have capitalized on ongoing complementary initiatives in the state or in-kind assistance to support functions, such as training. A few teams mentioned applying to the [Ryan Residency Program](#)—a residency training program—as a source of free LARC devices available to hospitals training OB/GYN residents.

## ***Domain 3: Informed Consent and Ethical Concerns***

State team members placed high value on women making fully-informed choices about their contraceptive method. They saw implementing immediate postpartum LARC as a strategy for making LARC widely available by lowering barriers to access, rather than a strategy for increasing immediate postpartum LARC uptake among women who may not desire it. Teams emphasized the importance of providers educating women about immediate postpartum LARC throughout the prenatal period and

ideally before hospital delivery, but did not necessarily think developing protocols for the timing and location of consent was part of their role. They suggested that birthing facilities currently offering immediate postpartum LARC obtain women’s consent for immediate postpartum LARC procedures in the same way as for other hospital procedures, and suggested that consent should continue to be addressed at the facility level. One team mentioned plans to include consent considerations as a component of the facility toolkit that it will disseminate throughout the state. Another state described plans to discuss the issue of coercion with providers in the state. A team member from academic medicine in another state is researching women’s satisfaction with informed consent and will share results to inform the state’s implementation efforts.

#### **Domain 4: Stocking and Supply**

Most states employ a “buy and bill” strategy for reimbursing hospitals for inpatient LARC devices. Under this strategy, hospitals and birthing centers purchase and stock LARC devices and are reimbursed through a Medicaid claims process for each patient who receives a device. Although early-adopting states cited this as a significant barrier to implementation,<sup>20</sup> most cohort 2 teams did not anticipate the same barrier in their states, suggesting that the cost of the devices was minor relative to the birthing hospitals’ overall operating budgets. One participant said, “This should be nothing for a hospital.” Some acknowledged that smaller hospitals may face more barriers as a result this payment mechanism. Another team expressed uncertainty about hospitals’ current barriers to stocking devices, and was waiting for data reports of IPP LARC procedure by hospital to better understand stocking’s potential impact on implementation. Some teams reported plans to reach out personally to hospital pharmacy directors to encourage stocking.

#### **Domain 5: Outreach**

State teams discussed outreach activities in terms of four different audiences: birthing facility administration, providers, Medicaid clients, and the general population of women across the state.

- 1) **Outreach to birthing facilities:** Most teams reported engaging in outreach to birthing facilities beyond circulating the original Medicaid bulletin about the policy change. One team initially announced the new policy to facilities through a letter from the state health department, which it cited as unsuccessful. While this policy effort stemmed from a collaboration between the health department and Medicaid agency, birthing facility administrators are accustomed to receiving and trusting correspondence about reimbursement policies from Medicaid or the hospital association, not the health department. Thus, early implementation was hampered because birthing facilities did not trust that they would be reimbursed, prompting the team to revise its dissemination strategy.
- 2) **Outreach to providers:** Cohort 2 teams reported that provider outreach is ongoing, with outreach strategies varying by state. In states with smaller populations, team members know most of the key players and communicate informally with their personal networks to disseminate information about policies, while teams in larger states more heavily rely on provider champions to spread the word to their colleagues across the state. Teams stressed the importance of reaching and engaging the full team providing care for women, including prenatal care and medical home providers, nurses, health educators, home visitors, case managers, and lay health workers, especially with messaging about immediate postpartum LARC’s safety and efficacy.

- 3) **Outreach to Medicaid beneficiaries and the general public:** Most teams expressed a need for technical assistance to support patient outreach efforts. To date, teams have relied on providers in clinical settings or case managers to educate women about LARC and its availability in the inpatient setting. Most teams stressed that it is premature to broadly advertise the new reimbursement policy to women served by Medicaid before ensuring that birthing facilities are able to offer LARC in the inpatient setting. Many teams see patient outreach about immediate postpartum LARC as fitting within their state's broader public education campaign to teach people about LARC's effectiveness and dispel myths.

## ***Domain 6: Stakeholder Partnerships***

When asked about key partnerships and stakeholders necessary to support the immediate postpartum LARC policy change and implementation, teams cited eight categories as essential.

- 1) **Medicaid agency and health department partnership:** Most teams reported that having a strong existing collaboration between these state public agencies drove success for the immediate postpartum LARC initiative. Many states have standing meetings between the health department's Title V programs and Medicaid partners to discuss MCH initiatives, now including immediate postpartum LARC. Agency structure facilitates this in several states where the health department and Medicaid agency are part of a larger agency or are led by a common director. Teams also cited parallel national MCH efforts, such as the Collaborative Improvement and Innovation Network to Reduce Infant Mortality and the Alliance for Innovation on Maternal Health, for convening partners and paving the way for cross-agency collaboration. One participant attributed much of their team's success to the opportunity to "get to know each other as people" through their close inter-agency collaboration. While Title X and other family planning program engagement varied across states, all states cited the importance of involving Title X in the process.
- 2) **Provider organizations:** Across states, teams cited provider organizations as strong partners supporting implementation. Local ACOG chapters, midwife and family practice physician organizations, and primary care associations were the most frequently named provider groups. One state also plans to engage its local American Academy of Pediatrics chapter, which it described being on the cutting edge for innovations to help young, vulnerable women. Primarily, teams saw these organizations as ripe venues for spreading the word about the policy, developing provider champions across the state, and supporting provider training efforts, especially during annual member meetings.
- 3) **Existing MCH consortia:** State teams commonly mentioned existing consortia for addressing MCH issues as important partners. In one state, the consortium has a special task force that meets monthly to address a range of MCH topics, with a broader stakeholder group that meets less frequently, but is not as much "in the weeds" with implementing MCH initiatives.
- 4) **Perinatal quality collaboratives:** Some state teams plan to engage perinatal quality collaboratives to help spread the policy, while others were involved from the outset in supporting policy change. In one state, the collaborative's finance committee investigated and presented payment strategies to support the reimbursement policy change process.
- 5) **Academic partners:** About half of the teams have research partners from academic institutions to help compile evidence, design evaluation plans, and conduct follow-up studies.
- 6) **Hospital association:** Several state teams are partnering with their hospital association to disseminate policies, protocols, and toolkits across the state.



- 7) **Managed care organizations:** In states with a high proportion of Medicaid clients assigned to MCOs, teams listed MCOs as partners, though at different levels of engagement across states. While a few states have well-established relationships with their MCOs, which are supportive of these efforts, other teams are more uncertain about the level of cooperation and support they would receive from their states' MCOs.
- 8) **Other stakeholders:** Some states identified associations for rural health, minority health, and other populations that they plan to engage. One team mentioned vendor drug teams and pharmaceutical companies as other key stakeholders for breaking down barriers to LARC. Additionally, several states have developed partnerships with nonprofits and foundations, such as Upstream USA, to provide in-kind support or funding for implementation activities.

### ***Domain 7: Service Locations***

Cohort 2 teams vary widely in the number of birthing facilities in their states, leading to diverse challenges and strategies for engaging facilities across contexts. In general, teams in states with a moderate to high number of birthing facilities do not seem to have an effective method for assessing birthing facility readiness, other than acknowledging that specific academic medical centers have been early adopters. One team reported that spreading the practice across birthing facilities will be the biggest challenge to implementing immediate postpartum LARC. Teams in states with fewer facilities had a more intimate knowledge of each, and were able to summarize the readiness of almost all of their facilities. To engage facilities in implementation, teams are using the following strategies.

- 1) **Disseminating a toolkit for facilities:** Many teams are developing a new toolkit or adapting an existing one for dissemination to improve facility readiness. To inform its toolkit, one state is systematically conducting key informant interviews at hospitals delivering a substantial number of Medicaid births. It plans to engage partners to review the toolkit and the hospital association to disseminate it because the hospital association holds a respected role within the state.
- 2) **Identifying facility-level provider champions:** Most teams value identifying and developing a provider within each facility to champion implementing immediate postpartum LARC facility-wide until it becomes part of standard care. One state emphasized the importance of choosing the right clinical champion at each facility, described as someone respected by their peers, but not too busy or overwhelmed to ensure immediate postpartum LARC is available to women delivering in their facilities. Another state team reported a more hands-off approach, suggesting that the OB/GYN champions in the state who advocated for the reimbursement policy change are now charged with approaching hospital administration in their facilities to ensure successful implementation at the facility level.
- 3) **Educating other facility-level staff:** Some teams in states with few facilities saw it as their role to provide outreach to administrative, pharmacy, and billing staff within each of their state's facilities, in addition to providers, to coach them through the process and provide clarity about their roles in implementing the new policy.
- 4) **Piloting implementation in one or more facility:** Several states are piloting implementation protocols in one or more facility, usually including a large academic medical center. In most states, pilot hospitals were identified organically, either because the facility was providing immediate postpartum LARC prior to the Medicaid policy change using donated devices, or because clinical champions active in promoting the policy change practice at those facilities. One state is planning a more intentional piloting strategy with a representative sample of facilities serving different patient populations (e.g., remote-community-based hospitals, county hospitals,

and large urban academic medical centers) because it anticipates a different set of barriers across these diverse settings. This state is modeling this approach from another initiative addressing neonatal abstinence syndrome.

- 5) **Addressing facility resistance to implementation:** Teams reported that several religiously-affiliated hospitals in their states were unlikely to allow LARC placement in their institutions, and considered this a non-starter. However, one team plans to engage the medical director in one such institution to discuss possible strategies for making immediate postpartum LARC available to women who deliver there.

### ***Domain 8: Data, Monitoring and Evaluation***

State teams vary widely in their approaches for using Medicaid claims and other data sources to monitor progress and evaluate efforts to implement immediate postpartum LARC. The discussion of this domain fell into three general areas: Medicaid agency reporting, collaborative cross-agency data activities, and other data activities. Throughout the discussion of data monitoring efforts, several teams stressed that successful implementation should not be measured by increases in uptake of immediate postpartum LARC, but by the less easily measureable outcome of increased access to immediate postpartum LARC for women who desire it.

- 1) **Medicaid agency reporting:** While some states have dedicated Medicaid analysts who are generating ongoing reports to track immediate postpartum LARC procedures in birthing facilities, other teams cited challenges to developing the right algorithm to effectively identify inpatient LARC procedures in the claims data. Several teams reported that they are not yet certain about how best to report the data to inform implementation efforts. A few states mentioned that their Medicaid agency will be required to report on the fiscal implications and progress of the new reimbursement policy to their agency oversight or cost containment committees, so they will be preparing these reports in the future.
- 2) **Collaborative cross-agency data activities:** Several states have ongoing partnerships between their Medicaid agency and health department to monitor MCH indicators and evaluate MCH strategies. Those states have existing data-sharing agreements to facilitate this cross-agency collaboration to monitor outcomes. One team mentioned a blanket memorandum of understanding between the health department and Medicaid agency that allows health department epidemiologists access to Medicaid claims to link with birth records. This linkage allows them to monitor a variety of MCH conditions and initiatives, including immediate postpartum LARC.
- 3) **Other promising data activities:** One team has been especially proactive in planning for immediate postpartum LARC surveillance by proposing a new field on its state's birth certificate record to track immediate postpartum LARC receipt on a population level. Another state described plans to use Medicaid claims data to identify outpatient clinics placing a lot of LARC, which may be targeted for efforts to reach collaborating hospitals in which to implement immediate postpartum LARC. In addition to monitoring data from existing systems, academic partners in a few states are tracking women receiving immediate postpartum LARC and following up with them in the postpartum period to evaluate the consent process, breastfeeding rates, and patient satisfaction.



## ***Cross-Cutting Theme: Leadership for Implementation***

Across all eight domains, leadership is an important theme that emerged from the state team interviews. The extent to which teams have established membership, roles, and structures to lead implementation efforts varies.

- 1) **Team membership and roles:** In some states, implementation team members were first assigned to this effort as part of the learning community application process. In other states, teams seemed more established and had been working together prior to the learning community launch. While most teams named one member, often from the Medicaid agency, as responsible for leading implementation efforts, one team felt that all of the agencies represented on the team owned the effort equally and it did not have one point person.
- 2) **The right person to lead the team:** Teams engaged in the most immediate postpartum LARC access and learning community activities seemed to have at least one member who leads the effort. Across states, this person does not have a common job title and is not necessarily in the highest position of power, but rather has emerged as a leader due to the energy and passion they bring to the effort and inspire in their teammates. In most states, this person also appears to have strong connections with providers across the state and is savvy about leveraging funding, mobilizing coalitions, and connecting with academic partners.
- 3) **Paid staff to facilitate implementation:** While most teams are made up of volunteers, two teams are utilizing public Title V and private foundation funding to hire staff to support immediate postpartum LARC implementation. In the first state, a 50 percent FTE with a clinical background who is familiar with the birthing facility context is facilitating the team's efforts. The team sees this as a way to allow other busy key stakeholders to participate because they know the dedicated staff member will do the heavy lifting. In the second state, two full-time employees are currently being hired for two years to align both outpatient and inpatient LARC promotion efforts across the state to support sustainability.
- 4) **Team meetings:** Few teams have meeting times scheduled to specifically focus on immediate postpartum LARC implementation efforts, though many meet regularly across agencies to discuss a wide range of MCH initiatives, including immediate postpartum LARC implementation. A few teams seem to meet only during learning community events, and even used the key informant interview call as an opportunity to communicate amongst themselves and regroup to plan next steps—a positive unintended consequence of this data collection process.

## **Technical Assistance Needs**

Moving forward, states most commonly listed the following technical assistance needs:

- Planning effective outreach campaigns for women.
- Developing relationships with breastfeeding advocates at the local and national levels to facilitate alignment of approaches to maximize MCH outcomes.
- Learning about strategies in other states for covering uninsured women for immediate postpartum LARC.
- Gathering facility toolkits, protocols, and other resources from other states to improve operations at birthing facilities.
- Receiving provider and pharmacy notices from other states that could be modified to communicate how to code, bill, and stock devices in each state.
- Brainstorming workarounds or solutions for religiously-affiliated hospitals.

## Summary and Conclusions

Although the cohort 2 state teams are at different stages of early implementation, all teams have prioritized immediate postpartum LARC as an important strategy for addressing MCH priorities. Teams have integrated or modeled implementing immediate postpartum LARC on related initiatives, especially within the domains of stakeholder partnerships, reimbursement and sustainability, service locations, and data, monitoring, and evaluation.

State teams see value in participating in the learning community both as an opportunity to learn from other states and elevate the importance of immediate postpartum LARC within their own states. Teams acknowledge that immediate postpartum LARC is complex and challenging, but believe that learning community participation will accelerate implementation in their states.

Promising strategies that teams employed and should later be evaluated for effects on implementation outcomes include:

- Leveraging public and private funds for training, outreach, and staffing.
- Maximizing existing MCH coalitions to support implementation efforts.
- Creating toolkits for immediate postpartum LARC.
- Piloting implementation efforts at select birthing facilities.
- Utilizing various data sources to understand the extent of penetration of implementation efforts.
- Partnering with private insurers to improve statewide access to LARC.
- Developing clinical champions to lead efforts in birthing facilities.

While the learning community is primarily focused on implementing immediate postpartum LARC, state teams view increasing access to LARC in inpatient settings as one component of a larger effort to improve access across the state. State teams discussed broader public education campaigns to educate women about LARC through social and other media, as well as payment strategies within Medicaid to improve reimbursement for LARC in the outpatient setting at federally qualified health centers and rural health clinics, which face similar barriers as hospitals to reimbursement for LARC outside their global payment for clinic visits. In the future, learning community activities could be broadened to encompass complementary strategies that work in tandem to support women's access to knowledge and services and improve maternal and infant health.

## Acknowledgments

The interviews and brief were made possible through funding from the CDC Building Capacity in Maternal and Child Health Programs (Cooperative Agreement 1U38OT000161). ASTHO is grateful for its support.

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