Long Acting Reversible Contraception (LARC) Learning Community Launch Report

Aug. 19, 2014, Arlington, VA

Contents

Background 6

Overview and Methods for LARC Learning Community 7

Key Informant Interviews: Key Themes 8

LARC Learning Community Launch 13

Technical Assistance Needs 18

Next Steps 19

Participant List 21

Meeting Agenda 23

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Executive Summary

One-half of pregnancies in the United States are unintended. Unintended pregnancy is associated with an increased risk of poor birth outcomes such as preterm birth and low birth weight babies.[1] Long-acting reversible contraception (LARC) is safe and highly effective in preventing unintended pregnancies. Unlike other forms of birth control, such as barrier methods, birth control pills, and sterilization, LARC requires no user intervention, works over long periods of time, and can be reversed. LARC includes intrauterine devices (IUDs) and contraceptive implants that prevent ovulation, egg fertilization, or implantation. Despite recent advances in safety and effectiveness, these devices are not widely used in the United States.

ASTHO, with support from CDC, CMS, and the Office of Population Affairs (OPA), has convened an Immediate Postpartum LARC Learning Community to assist selected states in implementing postpartum LARC initiatives. This learning community brings together these states over 18-24 months to provide technical assistance and identify promising practices that will assist all states in increasing utilization of LARCs postpartum.

Overview of Methods

Preparation for the LARC Learning Community involved three phases: (1) identifying states to invite and participate; (2) conducting key informant interviews; and (3) hosting a LARC Learning Community Launch. This report summarizes each of these three phases and shares key outcomes and themes related to current state successes, challenges, and technical assistance needs.

State Identification: ASTHO collaborated with CDC to identify seven states (California, Colorado, Georgia, Iowa, Massachusetts, New Mexico, and South Carolina) that currently have Medicaid policies that reimburse for LARC insertion in an in-patient setting—a necessary precursor for sustainable postpartum LARC initiatives.

Key Informant Interviews: Once states were identified, 18 key informant interviews were held with stakeholders from the seven states. Topics covered in the interviews included the current status of their initiatives, challenges and barriers they are facing, and technical assistance needs they have. Key themes from these interviews are summarized in the "Key Informant Interviews" section of this report.

LARC Learning Community Launch: On Aug. 19, 2014, ASTHO convened a one-day "launch" with the six states participating in the learning community, CDC, and other national partners.

Key Themes from the Learning Community Launch

Throughout the course of the launch, themes emerged related to state successes in implementing postpartum LARC Medicaid policies and initiatives, challenges and barriers, and technical assistance needs.

[1] Mohllajee AP, Curtis KM, Morrow BMA, Marchbanks PA. "Pregnancy Intention and Its Relationship to Birth and Maternal Outcomes." *Obstetrics and Gynecology.* 2007;109(3):678-686. Available at: http://journals.lww.com/greenjournal/Abstract/2007/03000/Pregnancy_Intention_and_Its_Relationship_to_Birth.15.aspx . Accessed 1-9-2015.

Successes—Even though the states are generally in the early stages of postpartum LARC implementation, there have been a number of early successes. These include: (1) all six states have Medicaid policies in place for postpartum LARC; (2) establishing or strengthening collaboration between the Medicaid and public health agencies has been a key factor in developing postpartum LARC policies; (3) well-respected champions have been identified; (4) broad coalitions of partners have been established; (5) provider training is being initiated; (6) postpartum LARC programs have begun in some hospitals; and (7) Georgia conducted a cost-effectiveness analysis showing a $4.20 savings for every dollar spent on IUDs.

Barriers and Challenges—States identified a number of barriers and challenges that hindered their progress in postpartum LARC implementation, as well as strategies to address them. For example, although Medicaid policies are in place, there are a number of challenges to implementing the policies in hospitals. Many hospitals do not have protocols to offer and implement LARC in the immediate postpartum period.

Additionally, there are different payment structures and rates for reimbursement of inpatient LARC services across the states (e.g., through or outside the diagnosis-related group [DRG] system and at different payment levels). Some states have experienced problems receiving the Medicaid reimbursement for services provided. Medicaid expulsions and removal policies are unknown across the states. Coverage for LARC inpatient services among private payers general unknown; there may be missed opportunities for additional coverage for women. Moreover, the availability of 340B pricing for inpatient LARC services is not well understood; there may be missed opportunities for additional funds.

Other issues include that (1) experience with LARC is unknown because of the availability of data (e.g., claims data) and limited analyses completed; (2) some states have rural areas that are more difficult to reach and have limited numbers of providers for LARC insertions; and (3) there are concerns that there are consent and confidentiality issues with inpatient LARC programs.

Technical Assistance Needs—States identified a number of technical assistance needs throughout the launch meeting. These needs and requests generally aligned with those identified during the key informant interviews, and fell under several categories: The need for help (1) identifying and building the evidence base supporting postpartum LARC; (2) supporting strategic planning for implementing state postpartum LARC initiatives; (3) developing guidance related to Medicaid policy development and other financing options; (4) identifying, compiling, and developing implementation resources; (5) maximizing peer-to-peer learning opportunities through the learning community; and (6) building support at the national level.

Next Steps

During the launch meeting, the participants determined next steps for state teams, ASTHO and national partners, and the learning community. State teams in particular identified immediate and longer-term next steps to support advancing postpartum LARC in their state. These next steps fall into several broad categories: continue action planning; explore current and future data capacity; continue developing partnerships; explore additional financing options; support provider training and implementation; and conduct more outreach and communications activities.

Based on the outcomes and technical assistance requests expressed during the key informant interviews and learning community launch, possible next steps for ASTHO and national partners include: providing learning

opportunities on specific topics of interest; connecting with federal and national partners to build technical assistance plans with states; and coordinating peer group calls.

The findings from the key informant interviews and the learning community launch will continue to inform the learning community's content and structure over the next 18 months. ASTHO will continue to work closely with the seven state teams, as well as federal and national partners, to facilitate a meaningful, productive learning community that advances postpartum LARC initiatives in the participating states and identifies best practices and technical assistance opportunities to support other states.

Additional resources and information, including presenters' slides, may be found at http://www.astho.org/Programs/Maternal-and-Child-Health/Long-Acting-Reversible-Contraception-LARC/.

Background

One-half of pregnancies in the United States are unintended. Unintended pregnancy is associated with an increased risk of poor birth outcomes, such as preterm birth.[2] One in nine infants are born prematurely in the United States, and preterm birth-related causes of death account for 35 percent of all infant death.[3] Unintended pregnancies are also associated with low birth weight babies, late access to prenatal care, and a decreased likelihood of breastfeeding.[4] Approximately half of unintended pregnancies in the United States are caused by contraceptive failure.[5] Long-acting reversible contraception (LARC) is safe and highly effective in preventing unintended pregnancies.[6] Unlike other forms of birth control, such as barrier methods, birth control pills, and sterilization, LARC requires no user intervention, works over long periods of time, and can be reversed. LARC includes intrauterine devices (IUDs) and contraceptive implants that prevent ovulation, egg fertilization, or implantation.

There are several barriers to the use of LARCs, including patient, provider, and systemic barriers. According to ACOG, although providers generally have positive attitudes about IUDs and implants, they may be overly restrictive in identifying candidates based on clinical indications and patient histories. A 2008 survey of providers showed significant misinformation about clinical considerations for LARC use. More than half of the responding providers mistakenly identified some patients as ineligible for IUDs who are appropriate candidates, These included: nulliparous, immediate post-partum or after abortion, and teenage patients, as well as those with histories of pelvic inflammatory disease, ectopic pregnancies, and positive-HIV status.[7] Additionally, because LARCs have not been widely used, providers may not have had training or experience with placing IUDs. Other barriers to use include patient misconceptions and reimbursement issues, such as lack of insurance coverage and onerous billing policies and procedures.

Among patients, there are many myths and misconceptions about the use of LARCs and their effects on health. IUDs. Although not supported by evidence, IUDs have been thought to cause abortion, pelvic inflammatory disease, ectopic pregnancies, and infertility.[8] For women who do not have LARC coverage, the up-front, out-of-pocket costs of LARCs are often between $500 and $1,000, which can be cost prohibitive for women, particularly for low-income women. Furthermore, providers and patients may also be burdened and

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[2] Orr, ST. et al. Unintended pregnancy and preterm birth. Paediatric Perinatal Epidemiology. 2000. 14: 309-313.
[3] Centers for Disease Control and Prevention. "Preterm Birth." Available at http://www.cdc.gov/reproductivehealth/maternalinfanthealth/pretermbirth.htm. Accessed 1-9-2015.
[4] Kost K, Lindberg L. "Pregnancy Intentions, Maternal Behaviors, and Infant Health: Investigating Relationships with New Measures and Propensity Score Analysis." *Guttmacher Institute.* 2015. Available at: http://link.springer.com/article/10.1007/s13524-014-0359-9/fulltext.html?utm_source=Master+List&utm_campaign=afe3548e62-Demography_KKost_Preg_Intent&utm_medium=email&utm_term=0_9ac83dc920-afe3548e62-244275441. Accessed 1-12-2015.
[5] Winner B, Peipert JF, Zhao Q, *et al*. "Effectiveness of Long-Acting Reversible Contraception." *The New England Journal of Medicine.* 2012;366:1998-2007. Available at: http://www.nejm.org/doi/full/10.1056/nejmoa1110855. Accessed 1-12-2015.
[6] Ibid.
[7] Russo JA, *et al*. "Myths and Misconceptions About Long-Acting Reversible Contraception (LARC)." *Journal of Adolescent Health.* 2013: 52: S14-S21.
[8] Ibid.

discouraged by misperceptions and misinformation that multiple visits and certain tests are required for placement. ACOG supports efforts to increase education and offers hands-on training opportunities.[9]

Current LARC-Related Initiatives

ASTHO and federal and national organizations are conducting a number of activities related to LARC and the LARC Learning Community.[10]

ASTHO: Key initiatives include The Healthy Baby Challenge to Reduce Prematurity by 8 percent in 2014 (all 50 states, the District of Columbia, and Puerto Rico have taken the pledge); the Collaborative Improvement and Innovation Network to Reduce Infant Mortality (CoIIN); and neonatal abstinence syndrome efforts.

American Congress of Obstetricians and Gynecologists (ACOG): ACOG established a LARC Program and Work Group, which has created, reviewed, and revised clinical and educational materials and tools; LARC advocacy on behalf of patients and providers; relationship-building with family planning colleagues and organizations; LARC trainings; updates through newsletter and other media; and research on LARC knowledge, attitudes, and practice patterns. ACOG has also issued a practice bulletin and two committee opinions on LARCs.

Centers for Disease Control and Prevention (CDC): CDC's *Morbidity and Mortality Weekly Report* (MMWR) issued clinical practice recommendations on family planning and contraceptive use. Future efforts include: Participation in CMS' Maternal and Infant Health Initiative, work with OPA on Title X clinical guidelines, and partnering with the National Association of Community Health Centers to implement quality family planning in health centers. Teen pregnancy, which is a CDC winnable battle, is being addressed through promoting LARC (and other effective contraceptive methods) among sexually active teens.

Center for Medicaid and Medicare Services (CMS): CMS initiatives include the Maternal and Infant Health Initiative, Text4Baby pilot in four states; November 2014 launch of quality improvement webinar series on postpartum care; core set of maternity measures for Medicaid and CHIP; Strong Start – Early Elective Deliveries Reduction and Enhanced Prenatal Care; and convening an Expert Panel in Improving Maternal and Infant Health Outcomes in Medicaid and CHIP.

Office of Population Affairs (OPA). OPA initiatives related to LARC include developing standards for family planning services (as the administrator of Title X), and encouraging access to LARC methods through multiple methods, including grants supplements, the 340B Drug Pricing Program, webinars, funding announcements, public support, and support for innovative practices (e.g., postpartum LARC insertion).

Overview and Methods for LARC Learning Community

To set up the LARC Learning Community, ASTHO and CDC identified states to participate, conducted key informant interviews, and held the LARC Learning Community Launch. Each of these phases is briefly described

[9] Gavin L, Moskosky S, Carter M, *et al*. "Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs." *MMWR*. April 25, 2014. 63(RR04);1-29. Available at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6304a1.htm. Accessed 9-13-2014.

[10] ASTHO. "Long Acting Reversible Contraception." Available at http://www.astho.org/Programs/Maternal-and-Child-Health/Long-Acting-Reversible-Contraception-LARC/. Accessed 12-16-2014.

below, and in-depth findings from the key informant interviews and launch are included in the remaining sections of this report.

State Identification. ASTHO collaborated with CDC to identify seven states (California, Colorado, Georgia, Iowa, Massachusetts, New Mexico, and South Carolina) that currently have Medicaid policies in place that reimburse for LARC insertion in an in-patient setting. Each of these states was invited to participate in the LARC Learning Community and key informant interviews.

Key Informant Interviews. In preparation for launching the Learning Community, ASTHO hired a consultant to conduct key informant interviews with stakeholders in each of the invited states. Eighteen interviews were held with key stakeholders from the seven states. Participants were identified through a combination of referrals from CDC and other ASTHO partners, and interview participants recommending additional stakeholders within their states to interview. Topics covered in the interviews included the current status of their initiatives, challenges and barriers they are facing, and their technical assistance needs. Key themes from these interviews are summarized in the "Key Informant Interviews" section of this report.

LARC Learning Community Launch. On Aug. 19, 2014, ASTHO convened a one-day "launch" with the six states that agreed to participate in the learning community, CDC, and other national partners. The desired outcomes of this meeting were to:

- Improve the states' capacities to successfully implement LARCs immediately postpartum by facilitating state-to-state sharing of promising strategies and common challenges.
- Provide an opportunity for states to hear from ASTHO, as well as other federal and national partners, about related activities and implementation barriers and possible solutions.
- Create an opportunity for multidisciplinary state teams to identify immediate action steps for the next year.
- Begin to highlight best practices to share with other states looking to adopt LARC policies.

Proceedings and outcomes of the meeting are described in the "Learning Community Launch" section of this report.

Key Informant Interviews: Key Themes

Prior to the LARC Learning Community launch, 18 telephone interviews were conducted with 51 key informants from the six participating states and California to inform ASTHO planning activities for the learning community. The interviews covered topics including each state's Medicaid policy covering postpartum LARC insertion, current status of their postpartum LARC initiatives, successes and challenges, and technical assistance needs. Key informants included state health officials, state Medicaid directors, staff from state health and Medicaid agencies, healthcare providers (including physicians and pharmacists), hospital administrative staff, researchers, representatives of healthcare professional associations, and community advocates. A summary of the key themes from these interviews is included below and fall into three key areas: keys to success; barriers and challenges; and technical assistance needs and requests.

Keys to Success

Most states very recently implemented the Medicaid changes and are in either early training stages or haven't taken additional steps yet. The actual type of Medicaid payment/reimbursement structure for postpartum

LARC varies from state to state. Some states are paying for postpartum LARC as an add-on payment in addition to the "global delivery fee." Other states cover postpartum LARC as part of a DRG.[11] Despite these differences, several common keys to success emerged.

Establish and leverage positive relationships between the state health agency and Medicaid. For several states, an existing productive relationship between the state health agency (SHA) and the state Medicaid agency was critical to achieving a successful, swift policy change. These states cited positive, longstanding relationships between the SHA and Medicaid agencies as critical factors in moving forward quickly.

Identify provider-champions. On-the-ground stakeholders consistently said that having a provider-champion was key to establishing and maintaining a successful postpartum LARC program at their site. These providers may be a physician, nurse practitioner, midwife, or pharmacist who can help keep efforts focused and coordinated, and can also be advocates with their peers across the state. It may also be helpful to designate a staff member who is designated to oversee the program as part of his or her job. For example, one hospital had both a physician champion, who provided overarching leadership and support, as well as a nurse practitioner champion who managed the day-to-day aspects of the program because he or she was on the floor every day. At another site, a NICU pharmacist was designated to manage device stocking and billing, which was critical for successful implementation. At other sites communities/hospitals, lack of a provider-champion is a barrier to effective implementation.

Get buy-in from all stakeholders. At the state level, engaging and getting buy-in from a diverse group of stakeholders is critical for coordinated, comprehensive efforts to provide information and implementation support. For example, the South Carolina Birth Outcomes Initiative, which brings together a diverse group of public health, healthcare, and advocacy groups, has been a critical asset in leveraging collective resources, gaining access to providers, and creating accountability for performance.

At the hospital level, the process for initiating a postpartum LARC program varied from site to site. Some sites used a formal quality improvement model—such as the Lean rapid improvement event model—to bring together an interdisciplinary team to establish their protocols. Other sites conducted less formal individual meetings with key hospital staff.

Regardless of the method used to establish the program, all stakeholders discussed the importance of engaging and getting buy-in from every department that needs to be involved. This includes: leadership, head nurses, unit leaders on labor and delivery, mother and baby, pharmacy (which orders and stocks the LARC devices), and the hospital billing department. Pharmacy staff, in particular, were key stakeholders to bring on board from the beginning to make sure they understood how they would be paid for the LARC devices, which are a significant up-front investment. Ensuring all team members are on the same page for each individual patient is also key to ensuring a successful insertion procedure.

[11] The DRG system classifies "any inpatient stay into groups for the purposes of payment. The DRG classification system divides possible diagnoses into more than 20 major body systems and subdivides them into almost 500 groups for the purpose of Medicare reimbursement. Hospitals are paid a fixed rate for inpatient services corresponding to the DRG group assigned to a given patient." (SOURCE: Health Law Resources. "Diagnosis-related group (DRG)." Available at http://www.healthlawyers.org/hlresources/Health%20Law%20Wiki/Diagnosis-related%20group%20(DRG).aspx. Accessed 12-16-2014.)

Identify and address provider concerns. Two concerns that providers have raised in offering post-partum LARC devices to women are the expulsion rates of IUDs and the effects of hormonal implants on breastfeeding. Although the expulsion rates of IUDs are higher in the immediate post-partum period, compared to interval insertion, the disadvantage of expulsion may well outweigh the advantages if the post-partum woman engages in unprotected sex between delivery and follow-up, does not go to her follow-up visit, or does not obtain the contraceptive device at the follow-up visit. There are theoretical concerns about the placement of hormonal implants, but observational studies, as well as randomized controlled trials, found no evidence to support these concerns.[12]

Communicate with all stakeholders that the program exists. Within the hospital, this may involve writing articles for the hospital web page or other provider communications such as emails to physicians, residents, attending physicians, nurse midwives, and others. Across communities and the state, key partners include state leadership (e.g., the governor and state legislators), local public health agencies, safety net providers, March of Dimes, breastfeeding coalitions, state hospital associations, and the general healthcare community. Other examples of broader communications strategies at the state level are described below.

Understand and engage patients. Understanding each unique hospital's patient population is important to assessing the level of need for postpartum LARC services, as well as perceptions and barriers to women choosing LARCs. Coordinating with prenatal/antenatal/interconception care providers can be helpful to provide women with information they need to make informed decisions before they deliver.

Barriers and Challenges

States are at different stages of implementation, so specific barriers and challenges vary from state to state. However, a number of challenges seem to be present across most states.

Addressing myths and misperceptions about LARC among providers. For providers, these mostly relate to higher expulsion rates of inserting LARCs postpartum, however the rate is slightly higher and does not detract from its benefits. In some states certain faith-based health systems will not administer LARCs due to directives on some forms of contraception. In these situations, clarification about the mechanism of action for the devices (particularly IUDs) may help. In addition, having strong data on the health outcomes and cost effectiveness of women using LARCs may help "de-politicize" these services and support their place as a mainstay in health and healthcare.

Raising awareness and promoting postpartum LARC as a covered service. It requires time and resources to identify and outreach to partner organizations and other key stakeholders who can provide access to key target audiences, including physicians, lactation consultants, pharmacists (who are gatekeepers for purchasing off of Medicaid formularies), other formulary managers, and administrative staff. Some states are just beginning to identify the partners and stakeholders and outreach to them. Partners such as state professional associations, ACOG chapters, and state OB/GYN societies are specific targets that may be able to spread the word among their members. In addition, finding provider-champions who can lead efforts to implement postpartum LARC programs in their facilities has been a challenge.

[12] COG Practice Bulletin. Long-Acting Reversible Conception: Implants and Intrauterine Devices Number 121, July 2011.

Understanding and implementing Medicaid reimbursement policies and processes. Some states have encountered challenges with the actual billing process. One state encountered challenges to changing electronic claims systems to align with new Medicaid policies, and educating hospital claims department staff about those changes. In this case, state health agency staff did not know for nearly a year that hospital billing departments had not been paid for submitted claims due to a flaw in Medicaid's electronic claims system. These staff recommend involving billing and IT stakeholders from the beginning to avoid similar technical barriers. In addition, the actual reimbursement policy in each state varies, and getting clarification on the details of the policy (for example, if LARC is reimbursed outside of the DRG or not) has been challenging in some cases.

Addressing logistical challenges to implementing postpartum LARC programs. South Carolina, which has significant experience implementing a state-level program to support postpartum LARC, cited several logistical challenges: (1) stocking LARC devices by getting buy-in from multiple departments, including pharmacy; (2) educating hospital claims departments and managed care providers about the process for billing for in-patient postpartum LARC insertion; and (3) educating healthcare providers and clearing up myths about postpartum LARC insertion.

Technical Assistance Needs and Requests

The states' technical assistance needs vary based on where they are in the implementation process. States that are in relatively early implementation stages may not yet know the logistical needs that may arise in the future. However, a number of key areas for current technical assistance emerged during the key informant interviews.

***Understanding reimbursement policies and billing/revenue process*:** Key informants, including state Medicaid agency directors and staff and hospital administrative staff, are interested in learning about the other learning community states' Medicaid reimbursement policies and payment processes for LARC, as well as those of private insurers. Specific requests from key informants include: (1) sample announcements from other state Medicaid agencies about their postpartum LARC reimbursement policies; (2) examples and guidance on troubleshooting the actual reimbursement process (this may require working directly with Medicaid billing staff); (3) facilitating a conversation among state Medicaid directors to learn specifically how other states are approaching coverage; and (4) if and how other states are working with private payers to support postpartum LARC insertion for patients who are privately insured.

Addressing LARC device cost: Offering LARC in an inpatient setting is significantly more expensive than in outpatient because the devices aren't covered under the 340B pricing program. The high cost of the devices (at least $700 per device) is a significant barrier to achieving hospital finance/billing department and pharmacy buy-in—even if they will be reimbursed, the upfront cost and concerns about not getting reimbursed may be a barrier. In addition, because some states are reimbursing for LARC as part of the DRG system, hospitals are actually not receiving additional reimbursement funds. In some cases, hospitals that have postpartum LARC programs in place stop offering them once they hit a pre-determined number of insertions to avoid incurring additional costs for the rest of the year. Key informants are interested in addressing federal regulatory barriers to bringing down cost (for example, expanding 340B eligibility to include immediately postpartum women), as well as how managed care entities could seek greater reimbursement in the inpatient setting.

Implementation tools and resources*:* Key informants in several states said a comprehensive "A to Z guide" for implementing a postpartum LARC program in the inpatient setting would be a critical resource. This type of resource could be particularly useful for states that are just beginning to address this issue. This guide could take the form of a physical binder with different sections/modules, or a webinar. It should include: (1) general best practices for implementing a postpartum LARC program; (2) sharing models for identifying key stakeholders to include within the hospital, conducting internal action planning, developing protocols and procedures, and systems; (3) guidelines for providers on criteria and exclusions for identifying the appropriate candidates for a postpartum LARC; (4) how to develop a toolkit or "tackle box" that includes the equipment needed for the insertion procedure; and (5) how to work with the hospital billing department and pharmacy, which is typically in charge of stocking and storing the LARC devices, to ensure supply chains and billing procedures run smoothly. Key informants in several states (primarily local hospital staff and researchers) have developed several different types of model materials/resources that could be useful to share with the rest of the learning community.

Provider training**:** Both state health agency staff and on-the-ground providers identified provider training as an important need, primarily around IUDs (Mirena and Paragard). Hormone implants (Nexplanon) are less logistically complicated to offer and present fewer concerns for providers than IUDs. This may be due to the fact that they can be inserted at any point in a woman's inpatient stay before discharge, rather than the ideal 10-minute window immediately after the placenta is delivered, to reduce IUD expulsion. The procedure for inserting an implant is the same postpartum as at any other time, while a postplacental IUD insertion is slightly different and many providers want training to increase their confidence in the procedure. For the postplacental IUD insertion, the placement should be done within 10 minutes of placental delivery and be high in the uterine fundus to minimize expulsion. Some key informants discussed that providers must get certified in IUD insertion, which is issued through the device manufacturer. Implants also do not have issues related to expulsion, and do not have exclusion criteria like IUDs do. The content of trainings should address common concerns and misperceptions among providers about LARCs (for example, impact of hormone IUDs and implants on lactation, higher IUD expulsion rates when inserted immediately postpartum, etc.), legal/liability concerns, and didactic and hands-on training for providers to practice the actual IUD insertion procedure. Training aids suggested by stakeholders include: (1) a standard pelvic model to allow physicians to practice the new type of insertion; (2) access to a simulation center or expert trainers to help healthcare providers develop skills in postpartum IUD insertion (other countries, including Israel, have these types of facilities available); (3) training videos similar to the YouTube video developed by Stanford University faculty (key informants in several states have also developed training modules); (4) training manuals and other resources, such as those from the Johns Hopkins Center for Communications Programs; and (5) training for floor staff about how to document the procedure correctly to be sure the device is billed appropriately.

Educational materials: Key informants said that they need information and materials to help raise awareness about the benefits of LARC and address misperceptions with several key stakeholder groups, including physicians, non-physician healthcare team members, hospital billing departments, the general public, pregnant women, and at-risk women. Specific needs for different target groups emerged:

- ***Healthcare providers***: As described above, healthcare professionals including providers, pharmacists, lactation consultants, and others may have misinformation or misperceptions about the risks of postpartum LARC. There is not a large body of evidence on differences in expulsion rates in the postpartum

uterus versus non-postpartum, so the way the issue is framed with providers may impact how likely they are to be supportive. One key informant believes focusing on the benefits of spacing pregnancies, such as reductions of preterm birth and associated poor birth outcomes,[13] and how this supports the process of family planning, rather than just "preventing unintended pregnancy," may get some providers on board. Partnerships with managed care organizations (MCOs) and ACOG chapters could be very beneficial to reaching Medicaid providers. Conducting a survey with key healthcare team members (physicians, nurse practitioners, midwives, etc.) to assess perceptions and barriers to implementing postpartum LARC in individual states would be useful. Gaining access to more research, evidence, and communications materials demonstrating the benefits of postpartum LARC (and LARC in general) and cost effectiveness is also needed. Other useful resources that would help "make the case" for postpartum LARC include best practice guidelines or an endorsement from a national-level organization.

- ***Hospital finance and billing staff****:* Hospital finance and billing departments, including leadership and billing specialists, could benefit from learning about the business case for LARC and how they are cost-effective over time. Specific information about the actual reimbursement process for postpartum LARC is also needed to allay concerns about whether hospitals will actually receive reimbursement. This process will vary from state to state but was cited by multiple states because billing departments are key decisionmakers in whether a hospital moves forward with implementing postpartum LARC.
- ***Pregnant women and the general public***: Key informants discussed the need to address perceptions of pregnant women and other barriers to encourage them to consider postpartum LARC. Several states cited misperceptions among certain populations that LARCs are used as a sterilization method. Coordinating with prenatal care providers could be advantageous to help women make a decision about family planning methods ahead of time. Antenatal contraception counseling for women was also cited by key informants as potentially useful.

Evaluation support: Key informants in several states said support and resources to help them monitor and evaluate impact and outcomes would be very useful. Types of support requested include: (1) providing a team of evaluation experts to conduct site visits and an evaluation at the local and/or state level; and (2) technical assistance to develop a statewide monitoring and evaluation system to track impact of the initiative over time. Types of indicators and outcomes of interest include: (1) uptake and patient demand for postpartum LARC services; (2) claims data; and (3) cost-benefit analysis.

LARC Learning Community Launch

On Aug. 19, 2014, ASTHO convened a one-day launch with the six states that agreed to participate in the Learning Community, CDC, and other national partners. The goal of the launch was to identify technical assistance needs and promising practices to assist current and future states to increase utilization of LARCs. The desired outcomes of this meeting were to:

- Improve the capacity of the states to successfully implement LARCs immediately postpartum by facilitating state-to-state sharing of promising strategies and common challenges.

[13] DeFranco EA, Ehrlich S, Muglia LJ. "Influence of interpregnancy interval on birth timing." *BJOG: An International Journal of Obstetrics and Gynecology.* 2014;121(13):1633-1640. Available at: http://onlinelibrary.wiley.com/doi/10.1111/1471-0528.12891/abstract?systemMessage=Wiley+Online+Library+will+be+disrupted+Saturday%2C+7+June+from+10%3A00-15%3A00+BST+%2805%3A00-10%3A00+EDT%29+for+essential+maintenance. Accessed 1-9-2015.

- Provide an opportunity for states to hear from ASTHO, as well as other federal and national partners, about related activities and implementation barriers and possible solutions.
- Create an opportunity for multidisciplinary state teams to identify immediate action steps for next year.
- Begin to highlight lessons learned to share with other states looking to adopt LARC policies.

Launch Overview and Approach

Thirty participants attended the launch, including representatives from Colorado, Georgia, Iowa, Massachusetts, New Mexico, and South Carolina, as well as partner organizations including ACOG, the Association of Maternal and Child Health Programs (AMCHP), CDC, CMS, and OPA. The participant list and agenda are attached at the end of this report.

The session opened with a presentation by ASTHO on its initiatives related to LARCs. Representatives from each state next provided background information on their states and their LARC activities and plans, including their successes and barriers/challenges, with discussions following the presentations. Each state next met to further discuss their activities, identify opportunities and challenges, and conduct a SWOT (Strengths, Weaknesses, Opportunities, and Threats) analysis.

During the lunch session, the national and federal partners presented on their LARC-related activities and resources. Following lunch, the session participants convened in one of four peer groups—logistic challenges to implementation, patient/provider education, Medicaid reimbursement policies and procedures, and leadership and systems—to discuss lessons learned and opportunities for partnerships. These group discussions were followed by a facilitated discussion synthesizing the information from the state presentations and the peer group discussions. Finally, each state team met again to identify steps to increase utilization of LARC.

Current Status of State Postpartum LARC Initiatives

The six states participating in the LARC Learning Community vary by location, size, geography, number of births, population characteristics, and organization of maternity services, but all have significant numbers of pregnant women covered by Medicaid. All states currently have Medicaid coverage for postpartum LARC, but for many of the states, the coverage took effect very recently so there is limited experience with this reimbursement. Additionally, the status of private insurance coverage is generally unknown across the states.

***Colorado*—**Colorado has a population of 5 million, many rural communities, and about 300,000 women in need of subsidized reproductive health services. The state has seen a 40 percent drop in the teen birth rate over the past four years, in part due to LARCs. Colorado has had Medicaid coverage for postpartum LARC since 2013, and is continuing to work through the billing and reimbursement process. Colorado received anonymous donations totaling $23 million to support its LARC work. Colorado used these funds to pilot a postpartum LARC program in one major hospital that sees the majority of low-income and teen births.

Georgia—Georgia has 134,000 annual births and 84 maternity hospitals. Medicaid covers 60 percent of the state's births, and those covered by Medicaid have worse outcomes compared to non-Medicaid births, including higher rates of low birth weight and prematurity. Georgia has had Medicaid coverage for postpartum LARC insertion since April 2014; Medicaid reimburses for postpartum LARC as add-on payments to the global delivery fee, outside the DRG system. In addition, the state uses $9 million from the Temporary Assistance for Needy Families (TANF) Family Planning Fund to support LARC. Georgia also conducted a cost-effectiveness analysis that showed a $4.20 savings for every dollar spent on IUDs, and is developing an implementation

toolkit. Partners are working with MCOs and six perinatal regional centers across the state to implement trainings for providers.

Iowa—Iowa, with a population of about 3 million, has about 39,000 births annually and 77 maternity hospitals. Nineteen percent of the hospitals in Iowa are Catholic-affiliated, and they deliver about one-third of the state's newborns. Medicaid covers 40 percent of the births. Iowa's coverage went into effect in March 2014, and partners are just beginning postpartum LARC implementation in one hospital. Iowa is also using its Title X funds to send a multidisciplinary team to visit all hospitals and do provider training. Iowa also received anonymous donations in the amount of $11.1 million to support its LARC work.

Massachusetts—Massachusetts has about 72,000 births annually across 46 maternity hospitals. About 50 percent of the births occur in six hospitals, and more than 10 percent occur in a single hospital. Forty percent of the births in Massachusetts are covered by public payers, mostly Medicaid. Massachusetts has seen significant decreases in teen births in recent years, reaching a record low of 14.0 births per 1,000 women aged 15-19 in 2012. Medicaid reimburses postpartum LARC through a standard payment per adjusted discharge payment structure, but the state is moving to a new Medicaid DRG billing system in October 2014, and the effect on LARC postpartum coverage is unknown. Massachusetts is just beginning its postpartum LARC implementation activities. The Massachusetts Department of Public Health and MassHealth staff are currently engaging providers and other stakeholders across the state, including the Massachusetts Perinatal Quality Collaborative and the state OB/GYN association. In addition, stakeholders are working with a teen advocacy organization to ask questions about postpartum LARC in key informant interviews with teens.

New Mexico—New Mexico's teen birth rate has been cut in half since 2000, but it still has one of the highest rates (47.5 per 1,000 15-19 year olds) in the United States[14], with particularly high numbers of teen births in its rural areas. Additionally, 47 percent of the state's births are unintended. New Mexico has 138 practicing OB-GYNs, but 80 percent of them are concentrated in Albuquerque and the surrounding counties. Medicaid covers 70 percent of its births. New Mexico's Medicaid coverage for postpartum LARC began in November 2013, and reimburses for postpartum LARC insertion as an add-on payment to the global delivery fee. Fewer providers have used the new reimbursement than policymakers had hoped—only a small number of the LARC insertions done since November 2013 have actually been reimbursed. New Mexico is beginning to explore Medicaid coverage of postpartum LARC for non-U.S. citizens.

South Carolina—In South Carolina, Medicaid covers almost 60 percent of the total births and 85 percent of the teen births. There are about 1 million Medicaid births annually in South Carolina. Medicaid coverage for postpartum LARC insertion began in 2012, and reimburses for postpartum LARC insertion as an add-on payment to the global delivery fee. In March 2014, South Carolina developed a process with the hospital pharmacy ("white bagging"[15]) to manage the Medicaid billing. Approximately one year after the Medicaid policy went into effect, stakeholders discovered that bills were not getting paid due to Medicaid electronic billing system flaws. The system was updated to accommodate the LARC policy change, and South Carolina has

[14] Martin JA, Hamilton BE, Osterman MJK, et al. Births: Final data for 2012. National vital statistics reports; vol 62 no 9. Hyattsville, MD: National Center for Health Statistics. 2013. Available from: http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62_09.pdf#table02. Accessed 12-29-2014.

[15] "White bagging" refers to payers (e.g. Medicaid) purchasing drugs through a specialty pharmacy, which then ships them to the provider for administration to a patient. This practice is also called "buy and bill."

been working with hospital claim departments on the changes. The South Carolina Birth Outcomes Initiative is spearheading efforts to support widespread implementation of postpartum LARC in hospitals across the state, including addressing logistical challenges hospitals face to implementing LARCs inpatient, including estimating proper stocking, storage and inventory, obtaining patient consent, and changing provider practices. The group is also educating hospital staff, including lactation consultants, to provide information about LARCs and clear up misperceptions related to expulsion rates and impact on breast milk production.

Successes

Even though the states are in the early stages of postpartum LARC implementation, there have been a number of early successes.

All six states have Medicaid policies in place for postpartum LARC. Although these policies differ significantly in their structure and forms of reimbursement, they help lay the foundation for implementing postpartum in hospitals statewide.

Establishing or strengthening collaboration between the Medicaid and public health agencies has been a key factor in developing postpartum LARC policies. States including Colorado, Iowa, and New Mexico cited these relationships as critical to developing and enacting their Medicaid policies quickly, and necessary for ongoing trouble-shooting related to facilitating the billing and reimbursement processes. This observation aligns with findings of the key informant interviews.

Well-respected champions have been identified. These champions are often healthcare providers, and they provide leadership to LARC efforts as well as serve as liaisons with their peers to share information and correct misperceptions about postpartum LARC that might otherwise prevent adoption of the practice.

Broad coalitions of partners have been established. These coalitions are engaging stakeholders to support the LARC work. Coalition members often include state ACOG chapters, March of Dimes, state hospital associations, and state perinatal initiatives, such as Perinatal Quality Collaboratives and Birth Outcomes Initiatives. These coalitions may serve several roles, including establishing statewide priorities and goals, coordinating stakeholder efforts, and supporting outreach and communication with key stakeholders.

Provider training is being initiated. Several states are focusing on provider training as one component of their initial postpartum LARC implementation strategies. For example, Georgia has implemented provider trainings across the state in collaboration with perinatal centers, the state's OB-GYN society, and Medicaid MCOs.

Postpartum LARC programs have begun in some hospitals. In some states, pilot initiatives in select hospitals informed the state Medicaid policy's development. In other cases, the Medicaid policy paved the way for states to begin supporting implementation in hospitals through targeted technical assistance and resource development. The lessons learned through these initial sites will inform efforts to expand to other hospitals.

Georgia conducted a cost-effectiveness analysis. This analysis showed a $4.20 savings for every dollar spent on postpartum IUDs, and is being used to support broader implementation of postpartum LARC across the state. This type of analysis could be replicated in other states to make the business case for why postpartum LARC should be a covered service.

Challenges, Barriers, and Strategies to Address Them

States identified barriers and challenges to LARC utilization, as well as strategies to address them.

Although Medicaid policies are in place, implementing the policies in hospitals can be challenging. Many hospital providers, including physicians, nurses, and pharmacists, and hospital administrative staff, such as billing staff, do not have information about Medicaid coverage availability and how to access the coverage and receive reimbursement. Some strategies to combat this include determining which hospitals to target and conducting outreach and education to all involved in hospital postpartum LARC activities. Developing and distributing written materials, conducting in-person meetings/sessions, and holding webinars are some strategies that can improve LARC implementation processes at the hospital level. Additionally, some providers and hospitals have misperceptions about LARC, or have not been trained in IUD insertion. Providers need education and training to dispel the misperceptions and ensure proper insertion. For hospitals systems (e.g., religiously affiliated systems) that will not offer LARC, additional outreach strategies may need to be developed.

Many hospitals do not have protocols to offer and implement LARC in the immediate postpartum period. States expressed that assistance to develop or refine protocols or toolkits is critical to provide assistance to hospitals. Toolkits or protocols mentioned include: information for women about postpartum LARC and its availability; consent and confidentiality process and materials (see Title X language regarding coercion); and logistic information related to managing a LARC program, including how to request, stock, and provide the devices, and billing for the devices and insertions, as stipulated in the individual state's Medicaid policy and procedures. These protocols could include a strong role for the hospital pharmacy.

The Medicaid payment structures and reimbursement rates for postpartum LARC vary from state to state. In some cases, Medicaid reimburses for postpartum LARC as part of the DRG system. In other cases, it reimburses additional payment outside the DRG system. States also reimburse at different payment levels. This may impact the extent to which hospitals and providers are incentivized to offer postpartum LARC services. Key informants said that advocating to change these structures and rates with the state Medicaid agency and legislation is one possible strategy to address this issue.

Some states have experienced problems receiving the Medicaid reimbursement for services provided. To develop solutions to problems in reimbursement, it will be important for stakeholders to research the reasons behind these issues and communicate and hold meetings with the Medicaid agency to resolve them. Lack of reimbursement may result from problems on the providers' end (e.g., not understanding or adhering to the coverage rules and reimbursement processes) or may be due to internal Medicaid systems problems.

Medicaid expulsions and removal policies are unknown across the states. Policies across the states may vary. Some may pay for new devices for those expelled, but the timeframes may vary; others may not. Reimbursement also may not be available in some states for removal of LARC devices before their expiration. Once the policies are determined, there may be a need for advocacy with the Medicaid agency to change the policies around expulsions and removal policies and payments.

Coverage for LARC inpatient services among private payers is generally unknown; there may be missed opportunities for additional coverage for women. Determining coverage among the state's private insurers

will help states advocate or educate for coverage as needed. Cost-effectiveness analyses could be used to help make the case for coverage with the private payers.

The availability of 340B pricing for inpatient LARC services is not well understood; there may be missed opportunities for additional funds. Section 340B of the Public Service Act started its requirement in 1992 that drug wholesalers offer considerable discounts to qualifying hospitals (disproportionate share hospitals) for outpatient medications. Determining the availability of 340B pricing and setting up processes may help add additional funding streams to LARC procurement and billing.

Experience with LARC is unknown because of unknown data availability (e.g., claims data) and limited analyses completed. Research into available data sets and potential datasets (e.g., building body of data on IUD expulsion rates and removals) will enhance public health information around postpartum LARC use, billing, and other measures. Determining the availability of data and conducting analyses will help develop and improve LARC process and outcomes measures.

Some states have rural areas that are more difficult to reach and have limited numbers of providers for LARC insertions. States said they need outreach plans that include innovative strategies to reach providers and women, including telemedicine and mobile units for education and services.

There are consent and confidentiality concerns with inpatient LARC programs. All women, including adolescents, have the right to decline the use or removal of LARC (or any other contraceptive methods). Patient choice and consent is essential. For inpatient post-partum LARC insertion, consent should be given during the prenatal period. Confidentiality is also of particular importance to adolescents. In many states, adolescents have the right to confidential contraception services, and providers must be knowledgeable about the laws in their states Strategies to address these concerns include determining the issues related to consent and confidentiality, and ensuring that they are included in LARC protocols and education (e.g., written materials) for providers and women.

Technical Assistance Needs

States identified a number of technical assistance needs during the launch meeting. These requests generally aligned with those identified during the key informant interviews, and fell under the following categories.

Identify and build the evidence base supporting postpartum LARC. Almost all of the states identified a need for more or better data to better understand their target populations, current LARC use, IUD expulsion rates, and other issues. They requested guidance around how to best identify and use data to support postpartum LARC initiatives, as well as how to conduct cost-effectiveness analyses of postpartum LARC using Georgia's ROI model. They also requested more guidance on how to define success and measurements to track impact.

Support strategic planning for implementing state postpartum LARC initiatives. Participants raised several strategic planning questions that they would like covered at the learning community sessions, such as whether the private or public sectors drive change, whether it is easier to implement change in urban or rural hospitals, and who the earlier and late adopters of postpartum LARC services are. Other specific topics participants would like to see addressed include: questions state health departments should be asking before developing LARC policies; developing public awareness strategies; and developing strategies specific to rural LARC access.

Develop guidance related to Medicaid policy development and other financing options. Participants were very interested in hearing the details of other states' Medicaid policies, and requested an assessment and comparison of these policies to better understand their differences. In addition, participants would like assistance identifying additional potential funding sources for inpatient LARC (e.g., 340B pricing, TANF).

Identify, compile, and develop implementation resources. Participants identified the need for a range of resources to support implementation, including raising awareness and gaining buy-in, developing clinical implementation protocols and tools, conducting provider training, and sharing best practices. Specific resource requests included: (1) a comprehensive postpartum LARC toolkit or sample of hospital protocols; (2) a resource depot that includes toolkits, webinars, and other policy and implementation materials, such as sample Medicaid policies and provider training resources; (3) resources addressing implementation barriers in hospitals; (4) guidance on how to use pharmacy programs (white bagging) for postpartum LARC; (5) resources addressing consent and confidentiality issues and forms related to postpartum LARC; (6) FAQs for patients and providers to address topics that are controversial or commonly misperceived (e.g., breastfeeding and LARC, expulsion rates, LARC use in teens); and (7) state stories of successes and processes.

Maximize peer-to-peer learning opportunities through the learning community. Participants were very interested in additional peer-to-peer learning opportunities outside of formal sessions, including general requests for support in building connections between learning community state team members, providing photos of participants, and hosting an annual face-to-face meeting.

Build support at the national level. Participants also cited specific roles ASTHO and national partners could play in building support at the national level for postpartum LARC. These roles included: (1) gaining support from federal and national partners to ensure alignment and coordination of efforts and resources at the national level; (2) co-writing a joint LARC statement from ACOG/ASTHO; and (3) determining where there is a role for the Joint Commission in inpatient LARC services.

Next Steps

Throughout the launch meeting, participants identified next steps for state teams, ASTHO and national partners, and the learning community process. These next steps are summarized below.

State Teams

Through action-planning time, teams identified immediate and longer-term next steps to support advancing postpartum LARC in their states. These next steps fell into several broad categories:

Explore current and future data capacity. Several states plan to explore existing data sources and identify opportunities to expand data sources to make the case for postpartum LARC. Specific data they plan to explore include: IUD expulsion, insertion, and removal rates; and Medicaid claims data. Additional activities include developing an ROI for LARC use and establishing data use agreements with care management organizations.

Continue developing partnerships. Some states are just beginning to focus on implementing postpartum LARC, and attending the launch taught them about additional partners they may need to bring on board for a successful initiative. They plan to engage provider/OB-GYN champions, hospitals, MCOs, the Indian Health

Service, and pharmaceutical representatives and industry sponsors. Some states plan to engage their state Medicaid agencies to address current reimbursement and billing issues.

Explore additional financing options. Several states plan to identify 340B pricing opportunities. Others plan to explore LARC coverage by private payers, reimbursement for advanced practitioners, Medicaid coverage of LARC for non-citizens, or using Title X funding for postpartum LARC.

***Support provider training and implementation*.** Some states will develop (or continue developing) implementation tools, such as a LARC toolkit. One state hopes to explore a mobile service model that could be used for specific populations, such as rural communities.

***Conduct more outreach and communications activities*.** Some states plan to focus efforts on sharing information and reaching out to specific stakeholder groups, such as the state family planning program, public health districts, hospital billing departments, and healthcare providers.

ASTHO and National Partners

Based on the outcomes and technical assistance requests expressed during the key informant interviews and LARC Learning Community Launch, next steps for ASTHO and national partners include:

Coordinate additional learning opportunities on specific topics of interest. ASTHO will develop and host two or three virtual technical assistance learning sessions focused on issues, including the 340B pricing program and South Carolina's white bagging initiative. Other topics will be identified throughout the course of the learning community.

Connect with federal and national partners to build support at the national level. ASTHO will engage CDC, OPA, and other partners to explore ways in which additional support can be provided to the states. This support could include sharing information and materials during the learning community sessions and conference calls, and targeted technical assistance to individual or groups of states.

Develop and disseminate resources. In addition to disseminating the findings of the LARC Learning Community launch, ASTHO will populate its website with examples of policies and other tools and resources to support postpartum LARC implementation.

Developing technical assistance plans. ASTHO will work with national partners and individual states to develop meaningful technical assistance plans and begin implementation.

Conclusion

The findings from the key informant interviews and the LARC Learning Community launch will inform the learning community's content and structure throughout the project. The learning community will meet virtually four times virtually through June 2015. For the second year of the project, ASTHO, CDC, and the states will work together to develop a plan for future virtual and in-person technical assistance. ASTHO will continue to work closely with the six state teams, as well as federal and national partners, to facilitate a meaningful, productive learning community that advances postpartum LARC initiatives in the participating states and identifies best practices and technical assistance needed to support other states.

Long Acting Reversible Contraception (LARC) Learning Community Launch
Aug. 19, 2014, ASTHO, Arlington, VA
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Meeting Agenda

Long Acting Reversible Contraception (LARC) Learning Community Launch

Aug. 19, 2014
Time: 8:00 a.m. – 4:30 p.m.

Colorado ✧ Georgia ✧ Iowa✧ Massachusetts ✧ New Mexico ✧ South Carolina

Goal: This learning community will focus on the implementation aspects of LARC policy changes in states in order to identify technical assistance (TA) needs and promising practices to assist current and future states as they work to advance the increased utilization of LARCs.

Desired Outcomes:

- Launch LARC Learning Community, creating an opportunity for multi-disciplinary state teams to identify priority action steps and outcomes for the project year
- Improve the capacity of states to successfully implement LARCs immediately postpartum by facilitating state-to-state sharing of promising strategies and common challenges.
- Provide an opportunity for states to hear from ASTHO and other federal and national partners on implementation barriers and working through solutions.
- Begin the process of highlighting lessons learned to share with other states looking to adopt LARC policies.

8:00-8:30	**Arrival**
8:30	**Welcome and Introductions**
8:40	**Meeting Purpose and Agenda Review**
8:45	**Overview of LARC Learning Community, ASTHO's Healthy Babies Initiative and other key Maternal and Child Health initiatives** *Objective: ASTHO will provide participants with a context for the working session by noting current ASTHO initiatives/work, highlighting priority areas related to reproductive health, identifying the gaps that currently exist and partnerships that need to be initiated or developed, addressing health equity issues*
9:00	**Highlighting Promising State Practices and Challenges** *Objective: provide participants with examples of promising practices or programs and challenges states are having around LARC Implementation, particularly postpartum.* *State presentations and discussion: Massachusetts, New Mexico, South Carolina*
9:50	**Highlighting Promising State Practices and Challenges** *State presentations and discussion: Colorado, Iowa, Georgia*

Meeting Agenda, Continued

10:45	***Wellness Break***
11:00	**State Team Time** *Objectives:* • *State health agency to provide overview of state statistics and current policy situation* • *Discussion and Initial identification of opportunities/challenges for implementation*
12:00	**Lunch – Presentations and Discussion with Federal and National Partners: ACOG, CDC, CMS, HHS Office of Population Affairs** *CMS- Lekisha Daniel-Robinson, Division of Quality, Evaluation & Health Outcomes within the Children and Adults Health Programs Group* *CDC-Lorrie Gavin, Senior Health Scientist, Division of Reproductive Health* *OPA- Sue Moskosky, Acting Director* *ACOG- Betsy Wieand, Health Policy Analyst*
1:15	**Peer Group Discussions and Report-Out** (with ASTHO notetaker) Objective: Each peer group will reflect on state presentations – lessons learned and potential opportunities for partnership to prepare for facilitated discussion
2:00	**Wellness Break**
2:15	**Facilitated Discussion: Synthesis of First State Team and Peer Group Discussions and Existing Models and Opportunities for Replicating** *Objective: Reflect on small group discussions – themes, successes, barriers to frame the rest of the afternoon and identify innovative ways that state health departments can work with partners to implement LARC policy changes* • *How are state health departments and partners working together?* • *Best practices at overcoming barriers to vulnerable populations use of LARC* • *What programs or policies are currently in place?* • *What opportunities exist to work together?*
3:00	**Facilitated State Team Time** • *Identify 1-3 actions state teams can take in short and medium term to increase utilization of LARC.* • *Identify 1-3 actions ASTHO can take immediately and over medium term to support states in this work.* • *What partnerships are missing?*
3:45	**State Report Out** *Each team to highlight one action step they will take*
4:15	**Final Comments and Next Steps**
4:30	**Adjourn**