

## ASTHO Immediate Postpartum LARC Learning Community Findings from Key Informant Interviews with Cohort 1 States

### Background

Half of all U.S. births in 2010 were publicly funded, and half of these 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 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 IPP 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 - Cohort 1 States**

In February and March 2016, ASTHO conducted key informant interviews by teleconference with the six Cohort 1 teams in the ASTHO Immediate Postpartum LARC Learning Community (representing Colorado, Georgia, Iowa, Massachusetts, New Mexico, and South Carolina). Teams are made up of high-level officials from the state health department and Medicaid agency, as well as champions from the provider community. The interviews were recorded and a research assistant took extensive notes during the calls.

The interview guide began with several questions to qualitatively evaluate the activities of the learning community during the approximately 18 months since its 2014 launch. The rest of the guide was structured according to the [eight domains](#) of the learning community: provider training, reimbursement and sustainability, informed consent and ethical considerations, stocking and supply, outreach, stakeholder partnerships, service locations, and data, monitoring and evaluation.<sup>14,15</sup> ASTHO asked about facilitators, barriers, and strategies under each domain. Themes from the interviews are summarized in this report and encompass the time period from the Cohort 1 kick-off meeting in August 2014 to the time of the interview.

## **Findings**

### ***Impetus to Join the Learning Community***

In May 2015, ASTHO sent an invitation to join the LARC Learning Community to the state health official and other key contacts in six states known to be working on policies for immediate postpartum LARC. The six Cohort 1 state teams joined the learning community generally to improve access to immediate postpartum LARC in their states and some teams joined at the encouragement of their state health official. Furthermore, state teams explained that they wanted to join the learning community for the opportunity to:

- Learn from other states.
- Share lessons learned with other states.
- Network with others working on shared MCH goals.
- Focus their efforts on immediate postpartum LARC.

### ***Benefits of Participating in the Learning Community***

The Cohort 1 state teams value their participation in the ASTHO immediate postpartum LARC Learning Community, citing the following benefits:

- Being part of a national learning community keeps teams focused and puts pressure on partners in the state to move the effort forward.
- The learning community helps teams accelerate corrective action by learning from lessons shared by states at more advanced stages of implementation.
- The required state team structure has helped develop and strengthen partnerships between public health and Medicaid agency staff to achieve common goals.

### ***Feedback about the In-Person Learning Community Meetings***

ASTHO launched the Immediate Postpartum LARC Learning Community with the six Cohort 1 states during an in-person kick-off meeting in August 2014. It followed up in October 2015 with a kick-off to add seven new Cohort 2 states to the community. Cohort 1 state teams' opinions varied about whether the most appropriate people from their state were present at the in-person meetings. While some team

members said that involvement of senior leadership was positive because it helped communicate and garner buy-in from those individuals, other team members felt that including the people who are working day-to-day on immediate postpartum LARC activities would have fostered more effective peer-to-peer interaction within and across state teams.

Overall, state teams found the in-person meetings beneficial for the following reasons:

- National partners such as American Congress of Obstetricians and Gynecologists (ACOG), Centers for Medicare and Medicaid Services (CMS), and Association of Maternal and Child Health Programs (AMCHP) have been present at in-person meetings, allowing state teams the opportunity to align their work with national efforts.
- Meeting other state teams and listening to dialogue during presentations demonstrates there are different ways to implement immediate postpartum LARC and helps prepare states that are not as far along in the implementation process.
- State team members often do not work in the same office and have many competing priorities, so the in-person meeting allows for dedicated time together, focusing on immediate postpartum LARC.

### ***Feedback about the Learning Community Website and Virtual Learning Sessions***

Cohort 1 state teams find the [ASTHO LARC Learning Community website](#) and virtual learning sessions to be useful resources. While state team members reported that they do not visit the website often, they know it exists and view it as a resource where they can search for contact information and brief memos about immediate postpartum LARC when needed. Further, the state team members find it helpful that all virtual learning sessions are archived on the website.

State teams value virtual learning sessions for the information gleaned from presenters, as well as the reminder to check-in with internal team members about progress with action steps. The state teams were said the chat box available during the learning sessions and the question and answer sessions were especially useful.

### ***Additional feedback about the ASTHO immediate postpartum LARC Learning Community***

Overall, state teams look to ASTHO for organizing, liaising, and convening, and said that ASTHO is supportive of their immediate postpartum LARC activities. However, some state teams felt that there could have been additional clarification regarding expectations for Cohort 1 teams participating in the second year of the learning community. In addition, a few state teams said the focus on IPP LARC was too limiting, noting that immediate postpartum LARC was just one minor component of broader LARC efforts in their states.

### **Learning Community Domains: Barriers, Facilitators, and Strategies**

While instituting the Medicaid reimbursement policy change was described as a big win by teams, they acknowledged that the real challenge lies in successfully implementing immediate postpartum LARC across their states. The following sections cite barriers and facilitators to implementation experienced or anticipated in Cohort 1 states, as well as implementation strategies teams are using to support this effort. Findings are reported according to the [eight domains](#) set forth by the learning community.<sup>16,17</sup>

## **Domain 1: Provider Training**

In the domain of training, teams discussed the existence and format of formal provider training initiatives, the opportunity for developing clinical champions at trainings, the role of residency training programs, and training with important nonprovider partners.

- 1) **Provider training initiatives:** State teams varied in the intensity of their provider training efforts, from informally connecting interested providers with expert trainers and existing training resources from partners like ACOG and the National Family Planning and Reproductive Health Association (NFPHRA), to academic training in residency programs and formal provider training initiatives specifically for immediate postpartum LARC. Among teams engaged in formal efforts, some train using outreach visits to perinatal networks or hospitals across the state. One team used a mobile coach stocked with training materials for immediate postpartum LARC. At least two state teams reported using a pelvic model designed to mimic the postpartum uterus, and cite this as an effective, “hands-on” training tool. One team has employed telehealth for training and technical assistance, while another is planning a LARC symposium, which will include provider training opportunities for the placement of LARCs both within and outside of the immediate postpartum period. The state reported granting some scholarships to attend the symposium, encouraging participation by a wide array of providers from across the state.
- 2) **Training as opportunity to develop clinical champions:** Two teams at later stages of implementation cited provider training initiatives as opportunities to identify and develop clinical champions at hospitals across the state, encourage and monitor implementation activities locally, and provide peer-to-peer education to their colleagues. Through experiences with providers during training over the past several years, one team reported that providers have begun to embrace the idea of immediate postpartum LARC, moving from general apprehension, to willingness and, more recently, excitement about the opportunity to provide access to immediate postpartum LARCs for patients.
- 3) **Residency training programs:** Whether teams were engaged in formal training efforts or not, most reported that residents in many of the training programs across the state were exposed to and trained on immediate postpartum LARC procedures when possible. In states where the Medicaid reimbursement policy has not been implemented in any or all hospitals, some academic medical centers have obtained devices through other means to train the next generation of providers in anticipation of wider access to immediate postpartum LARC.
- 4) **Training nonprovider partners:** Some teams noted that provider training was a minor issue for implementation compared to establishing and implementing the logistics of the reimbursement policy and claims process, as well as convincing providers that they will get reimbursed for immediate postpartum LARC procedures and devices. One state stressed that training staff in hospital pharmacies and claims departments on their roles in this effort should not be overlooked, as they are often key to ensuring that devices are purchased, stocked, and reimbursed by Medicaid.

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

In this domain, teams discussed challenges with claims systems for Medicaid reimbursement to hospitals, engaging private insurers, and funding strategies for implementation activities.

- 1) **Reimbursement challenges:** During one interview, a state team member said, “Placing immediate postpartum IUDs is easy. The tough part is convincing [providers and hospitals] they’ll get reimbursed.” This reflects the technical barriers encountered by some states in

reimbursing hospitals for qualifying procedures and devices. Despite learning from states further along in implementation and attempting to avoid the same issues, some states report that technical barriers to claims reimbursement have stalled efforts in individual hospitals and momentum across the state. Word spreads quickly after early-adopting hospitals face reimbursement challenges, making administrators at other hospitals hesitant to initiate or further implement postpartum LARC roll-out in their facilities. Statewide planning and implementation efforts often then become out of step with stalled efforts at individual facilities. Two states are actively trying to forge partnerships between Medicaid and hospital claims representatives to collaboratively troubleshoot and identify the source of errors in claims processing. One state that earlier solved similar issues reported that a change to the automated billing structure at hospitals was necessary to ensure successful reimbursement for immediate postpartum LARC. In many hospitals, coders still do not trust that they can submit an outpatient claim at same time as an inpatient claim (as many of the policies are structured), despite being trained to do so specifically for immediate postpartum LARC.

- 2) **Managed-Care Organizations:** While most state teams have successfully engaged Medicaid managed-care organizations (MCO), timing of immediate postpartum LARC reimbursement roll-out has differed across states for MCO versus Medicaid Fee-for-Service policies. One state just switched to an MCO and is working with MCO contracts to ensure that their success at being reimbursed for immediate postpartum LARC through Fee-for-Service Medicaid is extended to the new MCO structure.
- 3) **Private insurers:** A few of the state teams have reached out to private insurers in an effort to expand access to women covered by exchange, employer-sponsored, or other private plans. Those reporting contact with private insurers had not gained much traction to date. One team reported a concern among a private insurer that women would not return for a postpartum visit if they obtained LARC at delivery, threatening performance on the plan's Healthcare Effectiveness Data and Information Set (HEDIS) measure for postpartum visit attendance. Most state teams said that reaching out to private insurers is a future action item for the implementation team.
- 4) **Funding strategies for implementation activities:** Teams reported garnering financial support from a number of sources to support implementation efforts, including public funds such as Title V and X, as well as private foundation funds and support from organizations such as the March of Dimes. In one state, one of the Medicaid MCOs financially supported many of the training efforts. A few teams have been successful at leveraging public and private funds through a broad stakeholder coalition to support implementation activities. Of teams who have not yet received external funds, several had plans to seek foundation, grant, or other funding, though one team struggling to achieve a reimbursement policy solution stated that "money isn't what we need to solve the problem."

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

Members of Cohort 1 teams clearly placed high value on women making fully informed choices about their contraceptive method and described consent as "a process, not a piece of paper." Several team members stressed that postpartum contraception, including immediate postpartum LARC, should be discussed throughout pregnancy, with a more detailed conversation and signed informed consent in the third trimester. For women with late or no prenatal care, team members from more than one state expressed concern that efforts to protect a woman from coercion by not providing counseling on

immediate postpartum LARC during labor may create barriers to access for women who may want immediate postpartum LARC if fully informed. This highlights the ethical complexities of honoring reproductive justice while expanding LARC access to all.

With respect to the contents of the informed consent document, one team pointed out that legal departments are different across states and hospitals, so their perinatal quality collaborative drafted language to distribute to each hospital for their legal department to modify. Some state teams do not see it as their role to develop a centralized informed consent process, so instead they have incorporated discussions about preventing coercion during training sessions with providers, but have left it up to individual birthing facilities to develop the consent process.

Beyond the specific process of consent, teams more broadly discussed the importance of appropriate messaging throughout efforts to expand access to LARC. One team partnered with a local reproductive health social justice group to ensure that language used as part of promoting LARC in the state fundamentally respects women making fully informed choices about their contraceptive method, based on their own needs and desires. One team explained that, while they wish to increase access to LARC, it is crucial not to suggest LARC is the only option. The team added that increasing media attention on LARCs makes this particularly important.

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

Themes in the stocking and supply domain focus on differences in ability to purchase devices by birthing facility context, other funding sources for devices, and the logistics of storing devices within facilities.

- 1) **Birthing facility context and device purchasing:** Teams were consistent in acknowledging that the process for purchasing and stocking LARC devices is greatly influenced by hospital context, calling into question a one-size-fits-all approach. One source of variation between smaller and larger hospitals is the difference in resources available to purchase devices that will not be reimbursed by Medicaid until eligible women receive them. One team member suggested that this buy-and-bill method doesn't cost hospitals a lot of money up front, but sometimes serves as justification for smaller hospitals to not offer immediate postpartum LARCs. One team reported that many smaller hospitals in their state overcame their initial negative reaction to fronting the cost of devices and are now offering inpatient LARCs. She suggested that hospitals often have to purchase other expensive supplies, so this is ultimately feasible for most hospitals. Other state teams expressed uncertainty about the ability for hospitals within their states to buy and bill.
- 2) **Other funding sources for LARC devices:** As a strategy for facilitating stocking at hospital sites, one team approached two device manufacturers to request that devices be donated or lent to hospitals and later purchased if used, or returned if not used. To date, this strategy has not yet been approved or employed, however. Another team reported inquiring about bulk ordering, or using a coupon to stock devices in hospital pharmacies, similar to the process available to retail pharmacies. In some facilities where Medicaid reimbursement for LARCs is not yet available, providers are using free devices from an anonymous donor, or the [Ryan Residency Program](#), in order to offer women immediate postpartum LARC. The latter strategy, however, is limited to hospitals with residency training programs.
- 3) **Stocking and storing devices in birthing facilities:** To optimize clinic flow, several large hospitals with central pharmacies located far from the Labor and Delivery unit are storing devices in a Pyxis to ensure availability of IUDs within 10 minutes of delivery of the placenta. One state,

however, reported that hospital pharmacists are nervous about storing \$800 devices next to low-cost items in the Pyxis. As a strategy to pre-empt and allay questions and concerns from hospital pharmacy committees, one team developed and disseminated a frequently asked questions document. Additionally, most teams suggested having a local clinical champion as a facilitator for ensuring pharmacy staff persist in stocking LARC devices and maintaining supply.

## **Domain 5: Outreach**

Within the domain of outreach, state teams discussed a variety of efforts to communicate with clients and the public about LARCs, focusing on word of mouth and outreach campaigns, the use of technology, and the distribution of educational materials.

- 1) Word of mouth and outreach campaigns:** Several states discussed the power of word of mouth among women, which teams often see as the “biggest advocate” for LARC methods. A few states reported that positive media attention about LARCs indirectly supports their outreach efforts as well. Some states are actively engaged in general public outreach efforts to educate about and promote LARCs, typically through their Title X programs, and often in partnership with the National Campaign to Prevent Teen and Unintended Pregnancy. None of the states have conducted widespread outreach specifically about immediate postpartum LARCs, however, primarily due to the early stage of implementation, as well as lack of access to immediate postpartum LARCs in many parts of states at this time. Some states reported insufficient funding as the largest barrier to conducting public outreach about LARCs moving forward.
- 2) Use of technology:** A common theme across several state teams was the use of or desire to use technology to reach out to the public, specifically young women. One state incorporated LARC information on an existing texting hotline, allowing parents and teens to submit questions about sex. The same team also applied for funds to develop a smartphone app, while another team plans to employ social media in future outreach efforts.
- 3) Distribution of educational materials:** More traditional modes of education and outreach are also being used, including distributing tear-off sheets by [Bedsider.org](http://Bedsider.org) that outline the effectiveness of different contraceptive methods to postpartum women. Another state perinatal quality collaborative developed and distributes a two-page handout about postpartum birth control intended for providers across the state to share with patients.

## **Domain 6: Stakeholder Partnerships**

Each team reported having several public, private, and nonprofit partners supporting immediate postpartum LARC efforts in their state, but the level of involvement of each clearly varied. State teams mentioned Title X, their state’s CoIN Infant Mortality team, the local hospital association, ACOG chapter, American Academy of Pediatrics (AAP), family planning fellowship programs, March of Dimes, and United Way, among other state partners. Some teams expressed interest in strengthening partnerships with family practice physicians, midwives, and nursing organizations.

In two states, perinatal quality collaboratives form the hub for immediate postpartum LARC implementation and serve as a resource for identifying clinical champions in facilities across the state, introducing immediate postpartum LARC protocols in hospitals through an improvement process, and collecting data about each facility’s stage of implementation. In another state, the coalition is larger in number and scope than a perinatal quality collaborative, but acts in a similar way, convening partners around immediate postpartum LARC activities and other state MCH initiatives. That particular state

team described organizing the vision and structure of their coalition to achieve collective impact. With a backbone of two dedicated staff from the Medicaid agency, a core vision team of 20, six work groups, and monthly meetings for the past four to five years, this coalition has leveraged funding and catalyzed efforts across stakeholders to implement several inter-related MCH initiatives, with the common goal of improving MCH outcomes in the state.

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

Within Cohort 1 states, anywhere from one to nine birthing facilities currently offer immediate postpartum LARC. Birthing facility readiness, local clinical champions, and birthing facility resistance were key themes discussed within the service location domain.

- 1) Birthing facility readiness:** State teams varied in their knowledge of implementation success in facilities across the state. A partner to one state team is conducting a study of birthing facility implementation across the state and is intimately knowledgeable about facilitators, barriers, and stage of implementation, while another state does not have a clear understanding of the number or location of facilities offering immediate postpartum LARC. One state reported reaching a critical mass of facilities offering LARCs, so that now several birthing facility administrators are contacting the health department for information about implementing immediate postpartum LARC, whereas previously the health department had to provide outreach to convince birthing facilities to introduce immediate postpartum LARC.
- 2) Local clinical champions:** Many teams named local clinical champions as key facilitators of birthing facility readiness, especially when the champions forge a partnership with hospital administrators, pharmacy staff, and fellow providers to bolster institutional support. Some teams reported using peer-to-peer training and exchange within and across perinatal regions to develop clinical champions in non-adopting birthing facilities.
- 3) Birthing facility resistance:** A few teams reported that some birthing facilities are not ready to begin implementing immediate postpartum LARC. In states experiencing claims system glitches, birthing facilities are hesitant about increasing access without assurance of reimbursement. Many religiously-affiliated birthing facilities across states are also resistant to offering immediate postpartum LARC. Teams discussed strategies for connecting providers who deliver across these facilities to discuss solutions to this access issue. Others suggested educating women in early pregnancy about barriers to immediate postpartum LARC services in certain hospitals, so they are empowered to choose a different delivery hospital. This option, however, isn't available to many women, especially those living in rural areas.

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

Within this domain, states discussed their capacity for data monitoring and evaluation, use of Medicaid claims data, and other activities.

- 1) Capacity:** State teams have varying levels of capacity for data monitoring, from having no dedicated staff, to having a data committee of doctoral-level scientists to guide and interpret immediate postpartum LARC reports produced by Medicaid analysts.
- 2) Use of Medicaid claims data:** Only two of the states have a health department epidemiologist or Medicaid analyst actively using Medicaid claims data to monitor immediate postpartum LARC placements in birthing facilities. One such state reported earlier barriers to using "messy" MCO encounter data for immediate postpartum LARC reporting, but has since changed MCO requirements to ensure that it is documented in the field outside of the diagnosis-related group



(DRG), even though MCOs are reimbursed for devices and procedures as part of the capitated rate paid by the state Medicaid agency.

- 3) **Other data-related activities:** Other data-related activities reported by states include monitoring contraceptive performance measures through an initiative with the Center for Medicaid and Medicare Services and Pregnancy Risk Assessment Monitoring System (PRAMS) analyses to assess changes in the use of LARC over time. Several states hope to do more data-related activities in the future.

## Summary and Conclusions

In summary, Cohort 1 teams generally expressed a high level of satisfaction in their participation as one of the original teams in the ASTHO Immediate Postpartum LARC Learning Community. Teams found in-person meetings, virtual learning sessions, and networking opportunities to be helpful in moving their state's work forward.

Cohort 1 teams are at varying stages of implementation, as is evident in their reflections about each of the learning community domains. States with dedicated staff supporting immediate postpartum LARC implementation seem to be further along in their efforts, while states without dedicated staff rely on busy team members with multiple competing responsibilities, slowing the pace of progress. Having a clinical champion at the state level is also vital for keeping the state team connected with what is going on in state birthing facilities and promoting implementation among provider colleagues in the state.

Teams acknowledged that time is a major barrier given all of the inter-related MCH initiatives currently taking place among many of the same partners. Even with a high level of effort among dedicated staff, teams have realized that an initiative of this magnitude takes time to implement, including the time needed for stakeholders to accept new ideas, thus overcoming rumors and myths. In addition, time is needed for the initiative to permeate the multiple "layers" of each state hospital, including administration, pharmacy staff, coders, providers, and others.

While the learning community is primarily focused on implementing immediate postpartum LARC, it is clear that state teams view increasing LARC access in inpatient settings as one component of a larger effort to improve LARC access and reduce unintended pregnancies in their states. In the future, learning community activities could be broadened to encompass complementary strategies to immediate postpartum LARC, including LARC in outpatient settings, supporting women's access to knowledge and services, and improving maternal and infant health.

---

<sup>1</sup> Sonfield A, Kost K. "Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010." Guttmacher Institute, 2015. Available at <http://www.guttmacher.org/pubs/public-costs-of-UP-2010.pdf>. Accessed 12-17-2015.

<sup>2</sup> World Health Organization Department of Reproductive Health and Research (WHO/RHR) and Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP), Knowledge for Health Project. "Family planning: A global handbook for providers (2011 update)." 2011. Available at [http://www.who.int/reproductivehealth/publications/family\\_planning/9780978856304/en/](http://www.who.int/reproductivehealth/publications/family_planning/9780978856304/en/). Accessed 12-17-2015.

- <sup>3</sup> Mohllajee A, Curtis K, Morrow B, *et al.* "Pregnancy Intention and Its Relationship to Birth and Maternal Outcomes." *Obstetrics & Gynecology*. 2007. 109(3):678-686. doi:10.1097/01.aog.0000255666.78427.c5.
- <sup>4</sup> Zhu B, Rolfs R, Nangle B, Horan J. "Effect of the Interval between Pregnancies on Perinatal Outcomes." *NEJM*. 1999. 340(8):589-594. doi:10.1056/nejm199902253400801. Available at <http://www.nejm.org/doi/full/10.1056/NEJM199902253400801>. Accessed 6-2-2016.
- <sup>5</sup> Bryant AS, Haas JS, McElrath TF, *et al.* "Predictors of compliance with the postpartum visit among women living in healthy start project areas." *Matern Child Health J*. 2006. 10(6):511-516. Available at <http://www.ncbi.nlm.nih.gov/pubmed/16807794>. Accessed 12-17-2015.
- <sup>6</sup> Rodriguez MI, Evans M, Espey E. "Advocating for immediate postpartum LARC: Increasing access, improving outcomes, and decreasing cost." *Contraception*. 2014. 90(5):468-471. Available at <http://www.ncbi.nlm.nih.gov/pubmed/25107639>. Accessed 12-17-2015.
- <sup>7</sup> American College of Obstetricians and Gynecologists. "ACOG practice bulletin no. 121: Long-acting reversible contraception: Implants and intrauterine devices." *Obstet Gynecol*. 2011. 118(1):184-196. Available at <http://www.ncbi.nlm.nih.gov/pubmed/21691183>. Accessed 12-17-2015.
- <sup>8</sup> Washington CI, Jamshidi R, Thung SF, *et al.* "Timing of postpartum intrauterine device placement: A cost-effectiveness analysis." *Fertil Steril*. 2015. 103(1):131-137. Available at <http://www.ncbi.nlm.nih.gov/pubmed/25439838>. Accessed 12-17-2015.
- <sup>9</sup> Rodriguez MI, Evans M, Espey E. "Advocating for immediate postpartum LARC: Increasing access, improving outcomes, and decreasing cost." *Contraception*. 2014. 90(5):468-471. Available at <http://www.ncbi.nlm.nih.gov/pubmed/25107639>. Accessed 12-17-2015.
- <sup>10</sup> ASTHO. "Long-Acting Reversible Contraception (LARC) Medicaid Policies, Codes, and Guidance." Available at <http://www.astho.org/Programs/Maternal-and-Child-Health/Long-Acting-Reversible-Contraception-LARC/Medicaid-Policies>. Accessed 12-17-2015.
- <sup>11</sup> Moniz MH, Dalton VK, Davis MM, *et al.* "Characterization of Medicaid policy for immediate postpartum contraception." *Contraception*. 2015. 92(6):523-31. Available at <http://www.ncbi.nlm.nih.gov/pubmed/26452327>. Accessed 12-17-2015.
- <sup>12</sup> ASTHO. "Long-Acting Reversible Contraception (LARC) Medicaid Policies, Codes, and Guidance." Available at <http://www.astho.org/Programs/Maternal-and-Child-Health/Long-Acting-Reversible-Contraception-LARC/Medicaid-Policies>. Accessed 5-17-2016.
- <sup>13</sup> ASTHO. "Maternal and child health: Long-acting reversible contraception." Available at <http://www.astho.org/Programs/Maternal-and-Child-Health/Long-Acting-Reversible-Contraception-LARC/>. Accessed 12-17-2015.
- <sup>14</sup> Kroelinger CD, Waddell LF, Goodman DA, *et al.* "Working with state health departments on emerging issues in maternal and child health: Immediate postpartum long-acting reversible contraceptives." *J Womens Health (Larchmt)*. 2015. 24(9):693-701. Available at <http://www.ncbi.nlm.nih.gov/pubmed/26390378>. Accessed 12-17-2015.
- <sup>15</sup> ASTHO. "ASTHO Long Acting Reversible Contraception Immediately Postpartum Learning Community: Eight Domains for Success." Available at <http://www.astho.org/MCH/LARC/LARC-8-Domains-for-Success/>. Accessed 1-29-2016.
- <sup>16</sup> Kroelinger CD, Waddell LF, Goodman DA, *et al.* "Working with state health departments on emerging issues in maternal and child health: Immediate postpartum long-acting reversible contraceptives." *J Womens Health (Larchmt)*. 2015. 24(9):693-701. Available at <http://www.ncbi.nlm.nih.gov/pubmed/26390378>. Accessed 12-17-2015.
- <sup>17</sup> ASTHO. "ASTHO Long Acting Reversible Contraception Immediately Postpartum Learning Community: Eight Domains for Success." Available at <http://www.astho.org/MCH/LARC/LARC-8-Domains-for-Success/>. Accessed 1-29-2016.