

Guidance for Developing a Toolkit on Immediate Postpartum Long-Acting Reversible Contraception



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The Impact of a State-Specific Immediate Postpartum Toolkit

Placing long-acting reversible contraception (LARC) immediately postpartum allows patients to receive an effective, convenient form of contraception while still in the hospital. A [retrospective cohort study](#) found that only 4 percent of enrollees who received Medicaid-covered immediate postpartum LARC had the device removed within six months, and only 12 percent total had it removed within 12 months.

As more states recognize the value of immediate postpartum LARC, Medicaid programs are increasingly [unbundling](#) the cost of the device and insertion from other postpartum services to increase reimbursement rates, incentivizing providers to offer immediate postpartum LARC. As of November 2017, 39 states have [issued](#) guidance on Medicaid reimbursement for immediate postpartum LARC.

Although states must change Medicaid policies to facilitate immediate postpartum LARC uptake, policy change alone does not ensure that hospitals will take advantage of it. After the South Carolina Department of Health and Human Services (SCDHHS) [enacted](#) a 2012 Medicaid policy to allow hospitals and providers to be reimbursed for immediate postpartum LARC outside the global fee for delivery, many hospitals in the state were unsure of how to implement the policy. Some struggled with basic questions, like where to stock the LARC devices in their postpartum units.

“We thought everyone would pick it up because it was such a great idea, but we talked to people at the Birth Outcomes Initiative and learned that it wasn’t that easy,” [says](#) Melanie “BZ” Giese, director of the South Carolina Birth Outcomes Initiative (SCBOI), a SCDHHS initiative.

To educate hospitals and providers on how to use the policy and offer immediate postpartum LARC to patients, SCBOI partnered with [Choose Well](#), a contraceptive initiative of the reproductive health nonprofit, the New Morning Foundation, to create the [South Carolina Postpartum LARC Toolkit](#). The 13-page guide includes sections on:

- Implementation planning.
- Clinical resources and training.
- Contraception counseling.
- Patient procedures.
- Pharmacy ordering and stocking.
- Billing and reimbursement.

“There’s always a gap [in the] transition from policy to practice, so people need to understand what the policy does, but also the step-by-step on how to implement it,” says Deborah Billings, director of Choose Well. “We’re committed to making sure our Medicaid policy doesn’t just stay on paper. People need tools.”

South Carolina’s toolkit has since inspired other states, such as Indiana, Texas, and West Virginia, to create their own immediate postpartum LARC toolkits: the [Indiana Perinatal Quality Improvement Collaborative’s LARC Toolkit](#), [Texas LARC Toolkit](#), and [West Virginia Postpartum LARC Toolkit](#). Their experiences further demonstrate how states and territories can create impactful immediate postpartum LARC toolkits.

First Steps

Like many successful public health projects, South Carolina’s immediate postpartum LARC toolkit began with a strong partnership. In 2014, Billings proposed the idea of creating a toolkit to help hospitals and providers implement the state’s new Medicaid policy. She had previously worked at a women’s rights nonprofit that used toolkits and had seen the power of a comprehensive toolkit to help practitioners and health systems understand issues, implement policies, and engage in good practice. Billings reached out to SCDHHS and SCBOI and they agreed to implement the idea.

Drawing on its membership’s expertise, SCBOI acted in an advisory capacity in the development of the toolkit. SCBOI had monthly meetings at which members shared their experiences of trying to launch LARC promotion and the barriers they encountered. Their conversations provided background information for Choose Well and helped decide what the toolkit needed to include.

Billings had funding through Choose Well to pay for writing, designing, and printing the toolkit. She was also affiliated with the University of North Carolina’s Gillings School of Public Health, where she previously taught. Having a connection with the university allowed her to hire and pay two graduate students with maternal and child health experience to co-author the toolkit. Billings says that being able to tap into the university as a resource and hire the students helped keep costs low and maintain an efficient process.

SCBOI and Choose Well chose not to copyright their toolkit so others could utilize it as needed. This allowed other states to use South Carolina’s toolkit as a template, which simplified the development processes.

Like South Carolina, Indiana, Texas, and West Virginia gathered teams of experts to guide and write the content for their toolkits—responsibilities that were facilitated by their involvement in the ASTHO [Increasing Access to Contraception Learning Community](#), a project in which 27 states and territories and national partners disseminate strategies and best practices to implement policies and programs that increase access to contraception. Indiana and Texas joined the learning community as members of Cohort 2 in 2015, while West Virginia became a member of learning community with Cohort 3 in 2016. With resources from the learning community, they used South Carolina’s toolkit as inspiration for their own.

“We learned that South Carolina had done an incredible job over several years of educating people about LARCs,” says Velvet Miller, a state team member in the learning community and program manager at the Indiana University School of Medicine’s OB/GYN department. “It seemed logical for us to do a toolkit. We have a very high unintended pregnancy rate and our uptake of LARC is among the lowest in the United States. Based on our status, we thought a toolkit to help inform our target audiences would be helpful, and South Carolina had done a great job.”

Lessons Learned

- Partner with other organizations, experts, or national groups to create a toolkit.
- Leverage the resources at your disposal to advance the toolkit, such as connections to academic institutions or private funding.
- Use other states’ toolkits as a template. If it is not copyrighted, you may use its sections as is or adapt them to meet your needs.

Choosing Toolkit Topics

SCBOI members provided essential feedback on which topics the South Carolina toolkit needed to include to be impactful for hospitals implementing immediate postpartum LARC. Based on their input, SCBOI and Choose Well selected six major areas for the toolkit to cover: (1) planning for implementation, (2) clinical resources and training, (3) contraception counseling in prenatal care, (4) patient procedures in the hospital, (5) pharmacy ordering and stocking, and (6) billing and reimbursement.

“We learned about a lot of education that needed to be done, not just for clinicians, but the village of people who needed to be involved, such as pharmacy, labor and delivery, and claims,” says Giese.

As they broke down what each section should include, a guiding principle was that SCBOI and Choose Well wanted the toolkit to be practical for hospitals and applicable to their on-the-ground experiences. For example, the South Carolina toolkit team decided to focus its toolkit on Nexplanon implants because it found that hospital staff were more comfortable inserting the arm implants than IUDs at that time, mostly due to fears about the possibility of immediate postpartum IUD expulsion. As the toolkit authors interviewed hospital staff, they learned that one issue hospitals encountered as they implemented the Medicaid policy with Nexplanon implants was that staff were unsure of where to store the devices.

“We’re talking about putting the devices in a part of the hospital where they’re not usually kept,” says Billings. “It seems like a small detail, but it’s a very important detail, so people can become hung up on it.”

The team also wanted to make sure that the final toolkit took a comprehensive approach to the immediate postpartum LARC process. “Provider training is probably the easier part of this process. You need to engage different stakeholders from the very beginning with a real emphasis on prenatal contraceptive counseling and making sure that’s in place as well,” says Billings. “It’s not just about getting a Nexplanon or an IUD before you leave the hospital. There’s a process that includes the prenatal experience that needs to be included to conclude this process is the most complete and effective way.”

The updated version of the South Carolina toolkit includes a section on prenatal contraceptive counseling (p. 10) that advises healthcare providers to start discussing contraceptive options with patients at their first appointment using a shared decision-making approach, reproductive life planning questions, and motivational interviewing techniques. For guidance on how to use the [shared decision-making model](#) in prenatal contraceptive counseling, the toolkit recommends a webinar from the American College of Obstetricians and Gynecologists (ACOG) on [Contraceptive Counseling and LARC Uptake](#), which provides the following takeaways:

- “Focus on women’s preferences. Ask them what is important to them about their contraceptive method. Probe for preferences related to effectiveness, how the method is used, returning to fertility, and side effects.”
- “Describe effectiveness and side effects in easy-to-understand frequencies.”
- “Address misconceptions respectfully by validating women’s experiences or beliefs and providing information.”

In 2017, Choose Well and SCBOI revised the South Carolina toolkit, expanding its sections to include information on IUDs in addition to Nexplanon. In the “Patient Procedures at the Hospital” section, the

toolkit team included detailed steps on how providers should place IUDs in various settings and situations, including IUD insertion after vaginal delivery and IUD placement at the time of a C-section. These covered everything from how to prepare the IUD applicator or ring forceps and stabilize the uterus for an IUD insertion to where to place the IUD in the uterine fundus after a C-section ([South Carolina Postpartum LARC Toolkit](#), p. 11). The revised toolkit also added new statistics on LARCs' effectiveness and growing use in the United States (p. 4); the ICD-10 code for Kyleena, a new hormonal IUD (p. 14); the latest LARC resources from ACOG, the National Campaign to Prevent Teen and Unplanned Pregnancy, and other organizations and researchers (p. 16); and a contraceptive IUD checklist for providers (p. 18).

In Texas, Janette Ingram, medical director of Women's Health and Education Services in the Texas Health and Human Services Commission (Texas HHSC), says she views a LARC toolkit as a medical document, so it is important to provide evidence-based information that not only educates healthcare providers, but that healthcare providers can use to educate their patients in prenatal counseling. "There's a great deal of literature being published all the time that can help inform your patient counseling and help you understand what the level of training for the provider should be," says Ingram. "There's a fair amount of disconnect between providers and patients about the benefits of LARC and understanding that can help you tailor your counseling to the patient you're treating."

As they wrote their toolkits, Indiana, Texas, and West Virginia had the benefit of being able to use South Carolina as an example and, where appropriate, adapt its sections to their target audiences. According to West Virginia learning community team member Jennie Yoost, assistant professor in the department of obstetrics/gynecology at Marshall University, the West Virginia team reviewed the South Carolina toolkit section by section to decide what it could use wholesale for its audience and what it needed to adapt.

The West Virginia team drew heavily from the South Carolina toolkit's implementation section, making slight adjustments to better reflect the specific implementation experience at Marshall University. It also included South Carolina's bullet points from the [Contraceptive CHOICE Project](#) in St. Louis, Missouri, which found that 75 percent of women chose a LARC after receiving standardized counseling on contraceptive methods and 86 percent of women who chose a LARC method were still using it a year later.

However, the West Virginia team also wanted to include a section on its participation in the ASTHO learning community. Yoost said that they believed it would give the document and concept of immediate postpartum LARC greater credence to their readers. They also took a different approach to the methods section than South Carolina, because they found that most of the people looking at the toolkit were not going to be very familiar with IUD and implants, they made the language simple and included illustrations of the different types of LARC.

As states considered how to adapt the South Carolina toolkit, they also looked at priorities that were unique to their states. Indiana, for example, had a strong, preexisting commitment to addressing infant mortality, which helped further drive its toolkit process. Two of the state's previous health commissioners championed infant mortality issues and believed that the state's unintended pregnancy rate and the lack of awareness around evidence-based contraception were linked to infant deaths. Their commitment to infant mortality issues laid the foundation for the state's toolkit.

The Indiana Perinatal Quality Improvement Collaborative brought together a multidisciplinary team of OB-GYNs, family physicians, nurse practitioners, pediatricians, and healthcare administrators who examined

state data on teen pregnancies, unintended pregnancies, uptake of LARC, and infant mortality to compose an informed LARC toolkit. Ultimately, they decided to include sections on outcomes from unintended pregnancy, the public cost of unintended pregnancies in the state, and the link between the state’s infant mortality rate and unintended pregnancy.

Similarly, West Virginia’s team decided to include a section on neonatal abstinence syndrome (NAS), a group of conditions caused when a baby is exposed to substances in utero. According to the CDC, West Virginia has the [highest NAS rate](#) in the nation, with 33.4 babies born with NAS per every 1,000 births. The West Virginia team believed that discussing how increasing access to LARC could decrease West Virginia’s NAS rate would resonate with providers in the state.

At Texas HHSC, Ingram and other policy staff reviewed the South Carolina toolkit for insights on what the Texas toolkit should cover. Initially, they thought about focusing on the immediate postpartum period, like South Carolina, but ultimately decided to broaden the scope to include all potential settings where their patients might receive LARC.

“Because we had multiple programs that would be providing LARC, and they all have different client populations, we needed to make sure we were addressing all of those different populations,” according to representatives from the Texas team.

To meet the needs of its different patients and providers, Texas needed to make sure it had a robust section on billing and reimbursement. According to Ingram, Texas has 18 Medicaid managed care organizations (MCOs) for hospitals, and their billing requirements are not standardized. Additionally, different populations are eligible for different state-funded or administered coverage options, which have their own unique billing and reimbursement processes, too. Addressing this complexity was going to be key to the toolkit’s success.

When a state or territory is trying to decide on topics to cover in an immediate postpartum LARC toolkit, “think about why this service would be important to your state,” Yoost advises. “Wanting to prevent unintended pregnancy is true for everyone, but in West Virginia, there’s very poor compliance with prenatal care and postpartum follow up. A lot of our patients will travel a long way for healthcare because we’re a rural state with healthcare deserts. Look at your state picture and why this is important to women.

Lessons Learned

- Ask stakeholders about their actual experiences with immediate postpartum LARC, and use their feedback to create a practical toolkit that reflects on-the-ground issues.
- Leverage existing maternal and child health commitments in your state to build momentum for a toolkit.
- Examine your state data to identify how an immediate postpartum LARC toolkit can best meet your state’s needs and let those findings guide your content.
- Include prenatal contraceptive counseling section in your toolkit with evidence and messaging techniques that use the shared decision-making model.
- Update your toolkit as needed to reflect new statistics and feedback from users.

Gathering and Collating Toolkit Information

To create a practical, impactful immediate postpartum LARC toolkit, the writers should interview and collect resources from hospitals and healthcare providers in their states that are already offering immediate postpartum LARC or are currently in the process of implementing immediate postpartum LARC. Their experiences will typically mirror those of the toolkit's target audience.

In South Carolina, Choose Well worked with SCBOI to identify hospitals that had implemented the state's immediate postpartum LARC Medicaid policy successfully. They used three criteria: (1) the hospitals' staff needed to be interested in collaborating to create the toolkit; (2) they needed to provide in-patient postpartum services; and (3) the team wanted hospitals of different sizes that served different populations in different parts of the state. Based on these criteria, Choose Well and SCBOI selected the Greenville Health System, Palmetto Health, and Spartanburg Regional Health System as sources of information for the toolkit. They scheduled interviews with frontline staff, including billing and coding personnel, pharmacists, clinicians, and nurses.

To obtain relevant information for the toolkit, the team created a brief set of interview questions. The graduate students, who were co-authors on the toolkit, went to the three hospitals and interviewed key staff and walked through the immediate postpartum LARC processes. Questions for physician champions included:

- “Can you describe the patient counseling and informed consent process?”
- “How do you make sure implants/IUDs are readily available on the labor and delivery ward?”
- “Where are they stored? What about the other supplies needed for insertion? Where and how are those stored?”
- “Who were the key people you needed to involve in the development of the hospital policy?”
- “Who needed to be trained (across all levels of implementing) – counseling, insertion procedure, pharmacy, billing?”
- “What needed to change on the billing side?”ⁱ

For the full list of questions for physician champions, please see [appendix A](#).

The questions for hospital pharmacists included:

- “What is the role of the pharmacy in ordering IUDs and implants for postpartum contraceptive services?”
- “What is the process that is followed?”
- “Are devices ordered per woman or in bulk? Has [white-bagging](#) been used?”
- “How do the devices get from the pharmacy to labor and deliver or where women are recovering postpartum?”
- Please share experiences with payment/reimbursement, including Medicaid.

For the full list of questions for pharmacists, please see [appendix B](#).

ⁱ Author's email correspondence with SCBOI and Choose Well, March 27, 2017.

The toolkit authors also included photographs of healthcare providers at the three hospitals demonstrating an aspect of their immediate postpartum LARC process (see page 12 of the South Carolina Postpartum LARC Toolkit).

West Virginia is in the beginning stages of offering immediate postpartum LARC, according to Yoost, so its team had fewer hospitals from which it could draw information. To work around this challenge, Yoost used resources from her own academic institution, Marshall University, which is implementing immediate postpartum LARC. The West Virginia toolkit includes Marshall University's postpartum implant and IUD supply checklists, postpartum implant and IUD patient checklists, postpartum implant and IUD patient instructions, postpartum implant and IUD procedure notes, and a postpartum IUD order set. Physician champions at two other academic institutions, which also offer immediate postpartum LARC, also reviewed Marshall University's lists for accuracy.

Additionally, a West Virginia team member contacted all the payers in the state to obtain their billing codes. The team put the professional services codes, diagnostic codes, and devices covered in an easy-to-read table to facilitate timely reimbursement of healthcare providers.

In Texas, the toolkit creators worked closely with their claims adjudicator and Medicaid to capture their billing methodologies and apply them to different billing scenarios. The Texas team's goal for its billing and reimbursement section was to provide a step-by-step guide beginning with acquiring the device to billing for it to insertion.

"It's one of the most challenging topics," says Ingram. "There are so many threads you can follow. For example, if you take access to LARC in the clinic setting, you have to consider this patient's coverage eligibility. We have three or four different programs that might make LARCs accessible for someone who is uninsured or underinsured, so which are they eligible for? And what are the rules for billing that payer? What are the rules for acquiring that device? What overhead does that incur for the provider?"

The Texas toolkit details when clinics, hospitals, and federally-qualified health centers can bill for devices using the [buy-and-bill method or the pharmacy method](#), how this would work with Medicaid or other state women's health programs, graphic summaries that visually illustrate the processes, and relevant procedure codes. For states looking to write their own toolkits, Ingram recommends including as much detail as possible on successful billing and making sure the toolkit writers are checking their assumptions about how the processes work.

Texas released its toolkit in June 2016 and is currently working on an updated version. For its first version, much of the content came out of preexisting relationships and informal conversations that the team had with state stakeholders. Several stakeholders, including the then-chair of the Texas ACOG chapter, reviewed drafts and offered suggestions. Since then, Texas HHSC has set up a bimonthly stakeholder meeting on LARC best practices and accessibility, which has offered a new pool of sources from which the team can learn about LARC implementation and how the toolkit is working for providers.

Toolkits should take readers through the immediate postpartum LARC process one step at a time, and are most effective when they are written in a clear, simple style that is easy to understand and uses terminology

with which the toolkit’s target audiences are familiar. South Carolina’s toolkit team recommends hiring writers with expertise in the area if possible.

“You have to understand the world in which the healthcare provider works every day,” says Billings.

“Keeping [the toolkit] within the realities and the ways in which they understand things and speak is really important.”

Marketing and Dissemination

Once a toolkit is complete, stakeholders need to disseminate it to their target audiences throughout the state. About a year after they first conceptualized South Carolina’s immediate postpartum LARC toolkit, Choose Well and SCBOI launched it at the 2015 SCBOI Symposium during a breakout session. In the past, about 300-350 attendees from 10 states have attended the annual symposium, allowing the toolkit to spread widely to healthcare providers and public health professionals. Billings, Giese, and the two graduate student writers delivered the [toolkit launch presentation](#), where they provided printed copies of the toolkit and shared background information about South Carolina’s unintended pregnancy rate, the immediate postpartum LARC Medicaid policy, an overview of the toolkit’s content, and key takeaways.

Additionally, the South Carolina Hospital Association promoted the toolkit, issuing a [news release](#) for its members. The news release provided background information about the Medicaid policy, why the toolkit was created, the toolkit writing process and the three health systems’ roles as sources, and why it was a valuable tool for hospitals and South Carolinians generally. “In all, the resource should assist more hospitals implement the Medicaid policy which will lead to better birth outcomes and have a lasting effect on the ability of low-income South Carolinians to plan their families,” it states.

Finally, Choose Well published the toolkit on its website and shared the link on Twitter and Facebook. After the toolkit launch at the SCBOI Symposium, Choose Well promoted it on Facebook and Twitter (see examples below).





Check us out! We have the Postpartum LARC toolkit posted here as well as other references! Choosewellsc.org
ow.ly/VIGab

9:20 AM - 16 Dec 2015

1 Retweet 1 Like



Marketing and disseminating an immediate postpartum LARC toolkit can be particularly challenging in a state that has traditionally been hesitant to expand access to contraception. In Indiana, Miller says they had the benefit of a health commissioner who was leading the collaborative and was a committed champion of addressing infant mortality. Indiana also leveraged its relationships with the state hospital association and other partners to help educate target audiences about its toolkit. Like South Carolina, the Indiana Hospital Association wrote a [news release](#) about the toolkit, while members of the Indiana Perinatal Quality Improvement Collaborative (IPQIC) committed to distributing it through their own networks. One of the benefits of this approach is that IPQIC has about 200 members from all parts of the state representing a diverse set of interests and communities, according to Miller.

“The members had committed to helping move the toolkit. We reserved that to the overall collaborative, gave it to them, and they said they’d assume accountability for moving it,” Miller says. “Many members did just that.”

Some of the stakeholders who did the best job disseminating the toolkit to their networks were early adopters and community leaders who were committed to reducing infant mortality and unintended pregnancy. For states and territories that may also need to delegate marketing and dissemination activities to partners, Miller recommends tracking from the beginning who has fulfilled their commitment to promoting the toolkit and following up as needed.

As a state is marketing and disseminating a LARC toolkit, it is important to remember that the stakeholders who helped provide its content and guidance are also likely going to use it themselves. Consequently, Texas found that it was useful to check in with the people who had acted as champions for the toolkit or were generally interested in the area.

“See how they’re doing, how their program is doing, and if they’re successful or facing pitfalls,” recommends Ingram. “Whoever’s helped create the toolkit has an interest in LARC in the state, so give support to them to implement it.”

Texas also conducted a utilization review of its 2016 data to pinpoint which providers and hospitals were using immediate postpartum LARC. According to Texas HHSC, the utilization review has been an important tool to identify whom to contact to find out what is working and what is not on immediate postpartum LARC, which has been useful in identifying the effectiveness of immediate postpartum LARC policies.

Lessons Learned

- Introduce the toolkit at a well-attended meeting. Big events provide a large, captive audience and help create buzz around new resources.
- Share the toolkit in multiple messages across different social media platforms.
- Ask partners to help disseminate the toolkit, particularly ones who are passionate about contraceptive access. For example, your jurisdiction’s hospital association can write a news release about the toolkit and send it out to members.
- Follow up with the stakeholders who contributed to the toolkit and are interested in LARC and give them the support they need to implement the toolkit.
- Perform a utilization review to identify providers and hospitals that are using immediate postpartum LARC and those that are not. They can shed light on best practices and barriers.

Additional Resources

ASTHO. “Increasing Access to Contraception.” Available at: <http://www.astho.org/Programs/Maternal-and-Child-Health/Increasing-Access-to-Contraception/>. Accessed on 9-21-2017.

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Appendix A

Question Guide: Physician Leader/Champion

- In general, does your hospital offer IUDs, implants, or both?
 - [If only offering implants] Do you have plans to expand to IUDs?
- When did your hospital start providing postpartum LARCs?

We'd like for you to walk us through the steps for how a woman get an IUD/implant immediately postpartum, that is, before she leaves the hospital.

- Can you describe the patient counseling and informed consent process?
 - What counseling happens during prenatal care? When does it take place? How many times throughout prenatal care? Who provides the counseling? What materials do you have to assist/support counseling?
 - What counseling happens on the labor and delivery floor? When? By whom? Materials used?
 - How does this get documented in charts?
 - What training do providers receive regarding counseling?
 - Do providers use any written materials/decision aids during the counseling process? If yes, could we see them? (May we have a copy or take photos of them?)
 - What about consent? When does that take place? Who needs to sign?
- How do you make sure implants/IUDs are readily available on the labor/delivery ward? Who are staff responsible?
 - How does the pharmacy order IUDs and implants for postpartum contraceptive services?
 - How do these get to the floor/ward?
 - Where are they stored? What about the other supplies needed for insertion? Where and how are those stored?
- Who inserts the LARCs (ask separately for IUD/ implants)? When? What staff are trained to insert? Do you have sufficient staff trained to do insertions?
- What is your process for billing the postpartum LARC—the procedure and device? Any challenges you know of?
- What is working well? Any remaining barriers/needed changes to your current process?
- Do you do any tracking of insertions and removals? Any other internal monitoring of the process? Any results you could share with us?

Now, we'd like to ask you to think back to the process you went through to get this policy in place.

- What specifically were the steps you went through to get this policy in place?
- Who were the key people you needed to involve in the development of the hospital policy?
- Who needed to be trained (across all levels of implementing)—counseling, insertion procedure, pharmacy, billing?
- What needed to change on the billing side?
- What were some of the barriers you encountered in adding postpartum LARC services?

- About how long did this process take—from when you first decided to implement, to offering the service to women with all policies in place?
- Do you have written policies? Would you be willing to share them with us? May we include them in the toolkit?
- What recommendations would you have for hospitals starting this process? (Would you do anything differently? What worked well?)
- Who else should we talk to at your hospital to make sure we have all the perspectives that are critical for helping other hospitals implement this?

Thank you so much for taking the time to talk with us today. If we have any additional questions, can I call you or email you?

Appendix B

Question Guide: Pharmacy

- What is the role of the pharmacy in ordering IUDs and implants for postpartum contraceptive services?
- What is the process that is followed?
 - Who makes the order?
 - What central pharmacy is used (name and phone #)?
 - Are there ever delays or problems?
 - Are devices ordered per woman or in bulk; has “white-bagging” been used?
 - Are there any barriers or difficulties you have faced and how have those been resolved?
- Where are the devices stored?
- How do the devices get from the pharmacy to labor and delivery or where women are recovering postpartum?
- What policies have been helpful (and which are followed) to ensuring that LARCs are in stock (get copies of these policies)?
- Experiences with payment/reimbursement
 - Medicaid
 - Other (e.g., Blue Cross and other providers for private insurance)
- May we take photos of storage areas, and could you share policies, codes, or procedures (or any other documents you think would be helpful)?