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State-Identified Implementation Strategies to Increase Uptake of Immediate Postpartum Long-Acting Reversible Contraception Policies

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Abstract

Background: In 2014, the Association of State and Territorial Health Officials (ASTHO) convened a multistate Immediate Postpartum Long-Acting Reversible Contraception (LARC) Learning Community to facilitate cross-state collaboration in implementation of policies. The Learning Community model was based on systems change, through multistate peer-to-peer learning and strategy-sharing activities. This study uses interview data from 13 participating state teams to identify state-implemented strategies within defined domains that support policy implementation.

Materials and Methods: Semistructured interviews were conducted by the ASTHO team with state team members participating in the Learning Community. Interviews were transcribed and implementation strategies were coded. Using qualitative analysis, the state-reported domains with the most strategies were identified.

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Results: The five leading domains included the following: stakeholder partnerships; provider training; outreach; payment streams/reimbursement; and data, monitoring and evaluation. Stakeholder partnership was identified as a cross-cutting domain. Every state team used strategies for stakeholder partnerships and provider training, 12 reported planning or engaging in outreach efforts, 11 addressed provider and facility reimbursement, and 10 implemented data evaluation strategies. All states leveraged partnerships to support information sharing, identify provider champions, and pilot immediate postpartum LARC programs in select delivery facilities.

Conclusions: Implementing immediate postpartum LARC policies in states involves leveraging partnerships to develop and implement strategies. Identifying champions, piloting programs, and collecting facility-level evaluation data are scalable activities that may strengthen state efforts to improve access to immediate postpartum LARC, a public health service for preventing short interbirth intervals and unintended pregnancy among postpartum women.

Keywords

learning community; implementation strategies; stakeholder partnerships; long-acting reversible contraception; reimbursement; provider training

Introduction

Approximately 45% of pregnancies in the United States are unintended, defined as mistimed or unwanted pregnancies.[1] Increasing access to contraception is a strategy to reduce unintended pregnancies that have been associated with adverse outcomes, such as preterm birth, low-birth-weight deliveries, and postpartum depression.[2–7] Long-acting reversible contraception (LARC; intrauterine devices [IUDs] and contraceptive implants) is the most effective form of reversible contraception, and may be more convenient for women than user-dependent methods (*e.g.*, pill, patch, ring,and condom) because it does not require frequent repeat visits to a health care provider, action on a weekly or daily basis, or with every act of intercourse/coitus.[8,9] Integrating LARC into women's preventive health and reproductive services' options may improve birth outcomes by reducing unintended pregnancies.[10]

Although LARC use has steadily increased since 2002, in 2014, only 14% of women aged 15–44 years using contraception were using a LARC method.[11,12] However, use of LARC by postpartum women (*i.e.*, up to 6 months postdelivery) aged 15–44 years is higher, potentially impacted by availability of insurance coverage or services during the postpartum period (*e.g.*, Medicaid or other time-limited insurance plans), opportunity for contraceptive services during engagement with the health system, and motivation to avoid rapid repeat or unintended pregnancy.[10,13–17] Moreover, the US Medical Eligibility Criteria (MEC) for Contraceptive Use indicates implants are safe and effective for postpartum women and IUDs can safely be inserted immediately postpartum (*i.e.*, 10 minutes after delivery of the placenta) with continuation rates similar to LARC insertions at other times.[18–20] Finally, immediate postpartum LARC is cost-effective, saving up to $280,000 by preventing 88 unintended pregnancies per 1,000 women over 2 years.[21–23] Recognizing these benefits, some states have implemented statewide policies to increase access to LARC immediately postpartum. However, there are numerous barriers to provision of immediate postpartum

LARC including issues of provider training, reimbursement, device availability, and ensuring adequate and informed client-centered counseling.[24–30]

To understand the successes and challenges of immediate postpartum LARC policy implementation, and identify barriers and facilitators to statewide policy uptake, a group of states participated in a national activity to share experiences from implementing statewide systems change. Beginning in 2014, the Association of State and Territorial Health Officials (ASTHO) convened the Immediate Postpartum LARC Learning Community (described as the LC throughout the article), a cross-state collaboration to facilitate information sharing and support states in improving access to immediate postpartum LARC through policy implementation, in collaboration with Centers for Disease Control and Prevention (CDC).[31] The purpose of this article is to describe the strategies used by LC state teams to facilitate implementation of immediate postpartum LARC policies at the state level, to inform other states considering similar policy implementation.

Materials and Methods

ASTHO utilized a learning community model consisting of the following: (1) developing cohesive state teams, (2) holding an in-person meeting to identify successes and challenges in implementing policy changes, (3) presenting virtual peer-to-peer learning sessions, (4) encouraging state-to-state collaboration and information sharing, (5) collecting baseline key informant interview data, and (6) developing resources for state use.[31] A total of 13 states (*i.e.*, Colorado, Delaware, Georgia, Indiana, Iowa, Louisiana, Maryland, Massachusetts, Montana, New Mexico, Oklahoma, South Carolina, and Texas) participated in the LC over 2 years (2014–2016). States selected for participation in the LC had either implemented a statewide immediate postpartum LARC policy or had developed innovative processes to provide reimbursement outside the bundled postpartum services reimbursement. Some state policies were recently approved indicating early efforts of implementation, whereas others had previous policies in place, giving them more implementation experience. Each state developed a core team consisting of state leadership, including state health officials, Medicaid medical directors, directors of maternal and child health or family planning programs, hospital administrators, and clinical provider champions.

The LC was evaluated using an implementation science framework. This framework offered a methodology for understanding strategy development, adoption, and sustainability of clinical practices and public health program interventions.[32] Implementation strategies, based on the framework, measure multilayered social interventions and offer assessment of complex systems at multiple levels, service settings, staff interaction or training, and practice. Strategies were grouped by domains, previously identified by state teams that included the following: provider training; payment streams and reimbursement; informed consent and client-centered counseling; stocking and supply of devices; outreach; stakeholder partnerships; service availability in rural or smaller facilities; and data, monitoring, and evaluation. Further detail about the implementation of the LC and synthesis of information into domains is provided elsewhere.[31]

Semistructured key informant interviews were conducted in groups through teleconference with participating state team members. Preliminary results of initial informal interviews with state teams at an earlier in-person meeting provided the framework for the key informant interviews that took place between November 2015 and March 2016. Interview questions were grouped by domain and were designed to solicit more detailed information on state-implemented strategies. Some strategies were previously mentioned by states, and the interviews allowed for a more detailed discussion. Interviews were designed and conducted by the University of Illinois at Chicago (UIC), a part of the ASTHO team. If any state team members were unavailable during the interview, a follow-up interview with absent members was conducted to ensure full representation of the state team. The interview guide was organized by domain (Table 1) and included questions assessing barriers, facilitators, and strategies within each domain. A detailed description of the data collection process has been described elsewhere.[33] Audio recordings of key informant interviews from the 13 state teams were transcribed, and excerpts were extracted, de-identified, coded, and aggregated by state.

Excerpts describing implementation strategies were identified and independently coded by strategy into eight LC domains (Table 1).[31,34] Validation checks were performed and codes assigned to excerpts were reviewed for consistency. Lead researchers met to review, discuss, and resolve discrepancies identified in coding. Strategies in each domain were reviewed, disagreement in interpretation noted, and then resolved through consensus discussion.

The number of states implementing strategies in each domain was counted. Domains with strategies used by the most states were identified, including a cross-cutting domain embedded within other domains. Interview excerpts were used to better define, describe, and summarize implementation strategies by all domains including the cross-cutting domain. All qualitative analyses were conducted in Dedoose, a web-based application for mixed methods research.[35] The project received an exemption from the Institutional Review Board (IRB) at UIC, and did not require IRB approval by the CDC.

Results

Every state team described implementation strategies in at least three domains, with one state describing strategies in all eight domains (Table 2). All 13 states identified strategies within the domain of stakeholder partnerships and provider training, the domains most referenced by states for strategy implementation; 11 of the 13 state teams also mentioned using stakeholder partnership building to further strategies implemented across other domains (data not given). Twelve state teams reported using implementation strategies within the domain of outreach and 11 in payment streams and reimbursements. Finally, 10 state teams identified implementation strategies within the domain of data, monitoring, and evaluation, with fewer states identifying strategies for service locations ($n = 6$), stocking and supply of devices ($n = 6$), and informed consent ($n = 2$). Most referenced domains are described, with quotes included to provide further context. Specific strategies for how states implemented immediate postpartum LARC policies in all domains are presented in Table 3.

Stakeholder partnerships as a cross-cutting domain

Stakeholder partnerships were identified as a cross-cutting domain emphasized by states as a critical component required to implement strategies in all other domains. Most often, state teams implemented partnership-focused strategies within the domains of payment streams and reimbursement (8 of 13 states) and provider training (7 states; data not given). As payment streams and reimbursement changes require the partnership and support of the state health department, clinical facilities, device manufacturers, and insurers including the state Medicaid agency, the cross-cutting strategy of stakeholder partnerships was necessary to assure policy implementation throughout a state. Strategies included consistent communication with insurers, primarily Medicaid and Medicaid Managed Care Organizations, to implement changes in encounter rates, fees, and reimbursements (Table 3). State teams also developed strategies to partner with other in-state programs, identify state initiatives that promote health outcomes linked to improved contraceptive use (infant health, etc.), and better engage executive leadership of facilities to enhance policy implementation. One state described how partnership was essential in implementing a statewide process in facilities:

> I'm wondering, if [to] make this commitment go to a larger number of hospitals that are actively doing this—that's why I'm glad we had a presentation last week where the CEOs were in the room. It's almost like you need to have that administrative clinical partnership for it to work. You need the clinical champion, and you need a senior person in a hospital that are working together. As we go back out now, hopefully, it'll be easier for us to get the other partners, other people in the room, so to speak, that will need to make sure this happens in the hospital, so the coding folks get a comfort level. We work with the pharmacy folks to figure out the best way to make it easy for access, and we have a strong clinical champion that's driving that forward.

Stakeholder partnerships provided additional opportunities to enhance education and training of providers in immediate postpartum LARC insertion. State teams described engaging national clinical membership organizations to support information and resource sharing for state and facility clinical champions (Table 3). One state team described how provider champions in the state are well-positioned to engage stakeholders across various settings:

> Our main clinical champion [is] our chair of the state ACOG [chapter], a professor, and the Medicaid medical director. She has great reach through those different professional streams.

State teams partnered with academic institutions to promote provider training in teaching hospitals and collaborated with nonprofit agencies to obtain resources for provider training in facilities.

Provider training

A range of activities were developed to support provider training, including skill-building activities for specialists, subspecialists, and nonclinical staff on topics ranging from IUD insertion techniques on the immediate postpartum uterus to accurate administrative and

pharmacy billing and coding (Table 3). Implementation strategies for strengthening clinical practices consisted of hands-on training using pelvic models and simulators, providing resources to clinical staff addressing misperceptions about LARC safety and effectiveness (*e.g.*, US MEC, US Selected Practice Recommendations for Contraceptive Use [US SPR], and the Recommendations for Providing Quality Family Planning Services [QFP]), and telehealth training for remote service provision.[8,36,37] State teams noted the relationship between well-trained providers and patient outcomes:

> Making sure that residents and clinicians are well trained in LARC placement postpartum is something that we really want to focus on because of the connection with expulsion rates of LARC, and the experienced providers or clinicians having lower expulsion rates.

Many state teams emphasized identifying and engaging provider champions to disseminate tools and information on immediate postpartum LARC in facilities. State teams also acknowledged the importance of champions in clinical and nonclinical roles to support the implementation of immediate postpartum LARC policies:

> It seems like every hospital that we work with should have a physician champion and then an administrative, roll up their sleeve person to drive the real work.

Outreach

State teams described outreach as the recruitment of stakeholders supportive of immediate postpartum LARC policy implementation, and an increase in communication activities engaging the public on LARC. Teams focused on identifying internal stakeholders at birthing facilities, addressing stakeholder misperceptions about LARC methods, developing toolkits on implementation of LARC policies, and disseminating resources to assist with client conversations during prenatal care visits (Table 3). State teams also shared resources on the safety and effectiveness of contraceptive methods for postpartum women to providers and hospital staff, as expressed by one state team:

> We proactively provided people with the CDC's Medical Eligibility Criteria with a practice recommendation that really do support an immediate post-placental, postpartum placement even if that's not what the [product label] says…we also have some literature that can also reinforce those conversations to make that process a little bit easier.

Some state teams focused outreach efforts on public health education programs and social media campaigns. One state team described engaging women from a specific region of the state in focus groups to discuss perceptions of LARC methods, then providing feedback to the local facility:

> One thing that we're working on very closely with the other areas, is what are the myths that surround LARCs and what can we do to address those and educate the population…we conducted a focus group with 22 women in the valley. It was quite astonishing the myths that surround LARCs right now, and shows how much work we have to do.

Payment streams and reimbursements

State teams emphasized strategy development for identifying streamlined processes for facility and provider reimbursement of contraceptive devices and insertion fees. Teams approached the reimbursement process in two ways: (1) developing resources for understanding the process of reimbursing for services, and (2) engaging insurers and manufacturers in discussions about service costs (Table 3). To understand current processes, state teams developed resources, clarification letters, policy memoranda, and medical bulletins to explain device purchase, inventory, coding, and reimbursement for devices in facilities:

> Our ACOG president [has] been sending out bulletins and sort of spotlight[ing] on Medicaid. As soon as we finish this LARC one-pager about how to order, what's the reimbursement, what's the coding, what do the pharmacies buy, each of the five health plans…we'll send it to every member. It's just a lot for a provider to understand.

Some state teams described piloting resources, including billing and coding protocols or toolkits, in one or more facilities before promoting use among all facilities. Once current processes were understood, state teams recommended changes to the system by collaborating with the state Medicaid agency or managed care organizations to identify carve-in or carve-out populations for services, negotiate capitation rates for device purchases, develop state plan amendment language, and engage provider champions to facilitate clinical discussions. One state team described the process of working with the state Medicaid agency in detail:

> Once we get CMS [Centers for Medicare and Medicaid Services] approval—we will be required to get CMS approval on the SPA [State Plan Amendment] change in order to carve out these devices from our inpatient hospitals. Once we get those and the methods of payment associated, we are really gonna strongly depend on our colleagues at [the health department] to help us inform those champions and those providers on how to actually do the billing. We also recognize that we're gonna have to work with administration and hopefully the pharmacies at these facilities, too.

Data, monitoring, and evaluation

State teams focused on strategies to access the data necessary to measure uptake of immediate postpartum LARC in facilities, develop quality assurance and improvement indicators, and evaluate policy implementation efforts. Many states worked with the state Medicaid agencies to ensure access to Medicaid claims data at the state level. State teams proposed linkage of claims data to other data systems to provide the basis for examining associations between contraceptive use and other maternal and child health outcomes such as birth spacing, unintended pregnancy, Neonatal Intensive Care Unit (NICU) admissions, or preterm birth (Table 3). For those state teams with challenges to accessing administrative claims data, other proxy measures were identified to measure policy uptake (*e.g.*, number of providers trained in LARC insertion, number of facilities providing immediate postpartum LARC):

> We recognized early on that our baseline data couldn't be the number of IUDs and implants placed because we just weren't there yet…Our approach was to collect on other things that might show some sort of progress or forward movement on that idea of implementing at the institutional level. How many places have gotten through the pharmacy? What percentage of clinicians who can deliver at your institution have also received training? Similar kind of data point for nurses who are on Labor and Delivery [L&D]? What kind of other stakeholders will be directly involved and need to have some elements of training? Those kinds of things.

Many state teams initiated cost benefit and effectiveness analyses. Several states established data work groups to analyze or evaluate data outcomes:

> We have our own internal experts really looking at the number of births that didn't happen and the effects of those births that didn't happen on other public support programs, like Special Supplemental Nutrition Program for Women Infants Children [WIC], TANF [Temporary Assistance for Needy Families], Childcare Assistance Program. We have about eight different programs we're looking at some cost avoidance analysis on.

The domains of stocking and supply of devices, service locations, and informed consent were not identified as domains with large numbers of strategies, but were considered important areas of focus for further strategy development by state teams (Table 2).

Discussion

Of the eight domains for implementation of strategies to increase uptake of immediate postpartum LARC policies, states developed most strategies to address barriers in the areas of provider training, outreach, payment streams and reimbursement, and data, monitoring, and evaluation; stakeholder partnerships were identified as cross-cutting among these domains. Fewer states implemented strategies in the domains of stocking and supply of devices, service locations, and informed consent, indicating less focus on these areas during the LC. Using partnership itself as a strategy furthered development and implementation of strategies in other domains.

States offered numerous examples of strategies requiring partnership for successful implementation. Public health partnership as a strategy to implement policy change is evident at the community level through participatory research, collective impact, and academic partnership.[38–40] Fewer efforts exist at the state level, as coordination of collaboration among public health agencies is complicated and requires long-term, sustained efforts, often difficult with continuous changes in administrations.[41] Recognizing the complexity of the clinical and public health system, ASTHO used the LC as the platform for states to initiate and strengthen stakeholder partnership, a model for networking across state agencies and organizations, and as a lever to achieving successful policy implementation.[33] States identified and used strategies such as provider champions and pilot facilities to engage stakeholders in the process of policy uptake.

Provider champions and implementation of pilot sites

Provider champions (*e.g.*, clinical, nonclinical, or change agents with the knowledge, experience, and training to support applying evidence into practice)[42] in a health setting were described as a ''driving force behind the implementation'' of activities or policy changes promoting favorable perception of particular clinical practices necessitating organizational change.[43–47] State teams identified champions as necessary for strategy implementation in all domains except informed consent, and data, monitoring, and evaluation, indicating a critical need. In the context of the LC, these providers championed device purchasing at facilities, led LARC insertion training and information sharing on best practices, worked with provider groups to increase uptake of immediate postpartum LARC in facilities (*e.g.*, residency programs in teaching hospitals), and garnered buy-in from hospital administration. Champions were noted to function at two different levels—state and facility. State-level champions built administrative consensus to implement immediate postpartum LARC practices statewide, whereas facility-level champions utilized professional credibility and standing within facilities to establish protocols addressing institutional barriers.[48–51]

Some state teams tested strategies before statewide implementation through single-site pilot testing. Teams partnered with single facilities to develop protocols to define, test, and adapt key processes, including reimbursement and stocking and supply strategies. State teams expanded on these approaches by developing pilot protocols adapted for smaller and rural facilities and clinics focused on provider training, reimbursement for services, and availability of devices, which were identified as barriers in previous studies.[30,52,53] In addition, state teams developed indicators of immediate postpartum LARC uptake, evaluating facility administration perceptions of provider experiences, and conducting cost projection, benefit, and effectiveness analyses. Results were disseminated statewide in toolkits for other facilities to use in policy implementation.

Areas of focus for further strategy development

Only half of state teams described efforts focused on stocking and supply of devices, six focused on strategy development for rural or smaller facilities, and two implemented efforts on client-centered counseling and informed consent. The high and increasing cost of devices are institutional barriers to stocking devices at facilities,[54,55] which in turn may influence contraceptive counseling strategies and provision.[56,57] Not surprisingly, providers are less likely to counsel clients on contraceptive methods that are not available at their clinic location or through referral networks.[58] To encourage adequate stocking of LARC devices in facilities, state teams engaged facility pharmacies to add LARC to inpatient formularies, leveraged relationships with providers to promote stocking in hospitals, developed protocols for hospital staff on medication ordering and purchasing procedures, and encouraged hospital administration to stock LARC proximal to maternity units. Administrative and logistical issues like stocking and supply may be next steps in the implementation process, as only states successfully working in almost all other domains were focused on this area.

Beeson et al. identified evidence of limited access to contraceptive implants in rural areas.[30] Access to contraception in rural areas may be influenced by the training and capacity of

clinic staff (*e.g.*, presence of an obstetrician/ gynecologist), funding mechanisms (*e.g.*, earmarked family planning funding), and patient knowledge and acceptance of contraceptive methods.[30,52] In some states, limited opportunities to interact with the health care system may influence women's decisions to use highly effective contraceptive methods.[59] To increase contraception access for specific populations including services in rural or remote areas, teams leveraged existing residency programs to provide funds for stocking of devices and other resources for family planning services.

State teams may benefit from facility development of informed consent protocols on inpatient LARC insertion. State teams acknowledged that facilities should train providers on applying ethical and client-centered contraceptive counseling on all contraceptive method options, following ACOG guidance for informed consent.[60] Many state teams recognized a need to strengthen resources on informed consent and confidentiality for inpatient LARC insertion by focusing on development of protocols that use a reproductive justice framework within the comprehensive contraceptive counseling process.[34]

There are some limitations to the interpretation of these findings. First, these findings represent states that reported enacting activities across the eight domains. It is possible that more states are engaged in such activities, but did not describe these efforts in the interviews. Second, these data may not be generalizable to the entire United States, as we only interviewed the 13 states participating in the LC. Despite this limitation, we included states with varying degrees of resources, health department structures, at different stages of implementing immediate postpartum LARC policy, and from different geographic regions across the country. Third, we interviewed in a team setting, rather than individually with each team member. This method allowed for observation of group interaction, but may have influenced individual responses. Finally, we do not measure the impact of implementation strategies, as the LC was not designed to test differences among states that do and do not implement strategies.

Proctor et al. recommend implementation strategies be clear in description, operational definition, and measurement.[32] Successful strategies result in improvement of feasibility, cost, penetrability, and sustainability.[61] Although the LC was not designed to test implementation strategies, the LC evaluation attempts to define, operationalize, and justify each strategy within each domain. These results describe the benefits of using state-developed strategies to support immediate postpartum LARC policy implementation. The findings from this descriptive study suggest that leveraging partnerships is a cross-cutting strategy for advancing implementation efforts that increase access to immediate postpartum LARC. Results also provide examples of domains in which strategies were implemented to address barriers to immediate postpartum LARC uptake and areas of focus for future strategy development. Further research quantifying feasibility, adherence, and sustainability of strategies implemented may help support policy change.

The LC provided an environment for state teams to discuss strategies most often related to increasing provider training, outreach, payment streams and reimbursement, and data, monitoring, and evaluation. To ensure that all clients have access to confidential and ethical reproductive health services regardless of birthing facility location, more states may consider

stocking devices in all types of facilities and strengthening informed consent protocols. Provider champions may serve to promote evidence-based client-centered contraceptive counseling, increase training and capacity of facilities based in rural and underserved areas, and promote on-site stocking of LARC in hospitals. Pilot testing of toolkits and protocols can inform scale-up of policies throughout a state, and measurement of program impact provides the data necessary to replicate and adapt a policy framework in diverse settings. Providing LARC immediately postpartum is a convenient and cost-effective strategy to optimize birth spacing and reduce unintended pregnancy for women who are actively engaged in the health care system; states may consider these identified strategies to facilitate policy implementation and increase access to contraception and preventive health services.

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Table 1.

DESCRIPTIONS OF STATE-IDENTIFIED LONG-ACTING REVERSIBLE CONTRACEPTION LEARNING COMMUNITY DOMAINS

Domain	*Description*
Provider training	Implementing skill building for providers on immediate postpartum LARC insertion, training pharmacy staff on stocking and billing, and training administrative, pharmacy and clinical staff on billing and coding for nonpharmacy use of LARC devices
Pay streams and reimbursement	Understanding how Title X family planning programs (42 U.S.C. 300 et seq.) approach immediate postpartum LARC, the variability in how private insurers reimburse for LARC, the availability of Medicaid coverage of immediate postpartum LARC through a State Plan Amendment or a section 1115 family planning waiver, and the billing and coding process for Medicaid claims
Informed consent	Defining timing and content of informed consent
Stocking and supply of devices	Providing concrete examples of device-stocking procedures and supply policies in both hospital pharmacies and clinics
Outreach	Recruiting advocates to develop and implement immediate postpartum LARC policies by identifying effective strategies for contacting providers and policymakers, and providing examples of successful communication strategies to use with the public and clients
Service locations	Differentiating strategies for rural settings including developing engagement strategies with federally qualified health centers, family planning clinics, and the role of telehealth to reach providers in states
Data, monitoring, and evaluation	Developing more information regarding appropriate quality assurance and improvement indicators for immediate postpartum LARC, measurement of uptake, and documentation on how to access existing data, particularly on safety monitoring and insertion rates
Stakeholder partnerships	Identifying ways to engage national and federal partners on the issues of immediate postpartum LARC and determining which internal and external state partnerships are essential for successfully implementing policies

LARC, long-acting reversible contraception.

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Table 2.

STATE-IDENTIFIED LEARNING COMMUNITY DOMAINS FOR IMPLEMENTING IMMEDIATE POSTPARTUM LONG-ACTING REVERSIBLE CONTRACEPTION POLICIES

	State-identified learning community domains							
Participating states[a]	***Stakeholder partnerships***	***Provider training***	***Outreach***	***Payment streams and reimbursement***	***Data, monitoring, and evaluation***	***Service locations***	***Stocking and supply of devices***	***Informed consent***
A	X	X	X	X	X	X	X	X
B	X	X	X	X	X	X	X	
C	X	X	X	X	X	X		X
D	X	X	X	X	X	X		
E	X	X	X	X	X		X	
F	X	X	X	X	X		X	
G	X	X	X	X	X		X	
H	X	X	X	X	X		X	
I	X	X	X	X		X		
J	X	X	X		X	X		
K	X	X	X	X				
L	X	X		X	X			
M	X	X	X					
Total	13	13	12	11	10	6	6	2

[a]States de-identified because of the sensitivity of some domains.

Table 3.

STATE-IDENTIFIED STRATEGIES FOR IMPLEMENTING POLICIES TO INCREASE ACCESS TO IMMEDIATE POSTPARTUM LONG-ACTING REVERSIBLE CONTRACEPTION BY DOMAIN

Domain	*Strategies implemented by states*
Stakeholder partnerships	Engage national clinical membership organizations to support information sharing on identifying and retaining clinical champions (ACOG, AAFP, AHA, AWHONN, AAP, etc.)
	Coordinate with other statewide initiatives (Perinatal Quality Collaboratives, Baby-Friendly Hospital programs, Centering Pregnancy programs, etc.) to link contraception with improved health outcomes and identify potential resources
	Partner with colleagues in the state working on infant mortality (Governor's initiatives, infant mortality committees/working groups, etc.) and behavioral health activities (departments of mental health, drug and alcohol agencies, behavioral health workgroups, etc.) to identify strategies to increase uptake
	Engage nonprofit organizations, through public–private partnerships, to obtain resources and training for facilities and providers
	Engage other states with success in implementing facility-level, statewide changes to identify new strategies
	Expand the network of champions to include pharmacy, patient safety, and administrative facility champions to partner with facility executive leadership
	Establish formal relationships with academic institutions to promote immediate postpartum LARC implementation in teaching hospitals among residency groups, develop quality measures of uptake, and publish research briefs
	Consistently communicate with state Medicaid agency, Medicaid MCOs, and non-Medicaid MCOs to customize changes in encounter rates, insertion fees, and reimbursement
	Apply a collective impact model to engage diverse group of stakeholders in provision of blended resources for immediate postpartum LARC
Provider training	Offer training on insertion techniques to obstetrician/gynecologist providers, medical residents, and maternal–fetal medicine specialists in a wide variety of locations, including professional meetings, clinical conferences, academic institutions, hospital and clinic grand rounds, and online
	Provide hands-on training and resources, including pelvic models and simulators, to support LARC trainings for providers for immediate postpartum (*i.e.*, vaginal and cesarean section) and outpatient LARC insertion
	Provide resources addressing misperceptions about LARC (*e.g.*, US MEC, SPR, and Quality Family Planning guidelines) to providers
	Provide resources on misperceptions about LARC payment to hospital administrators and staff
	Identify and engage provider champions to disseminate information about immediate postpartum LARC at facilities and clinics
	Develop trainings on billing and coding for clinical and hospital administrative staffs
	Develop provider memoranda summarizing immediate postpartum LARC policies Partner with academic institutions, nonprofit organizations, and/or device manufacturers to offer LARC trainings for providers
	Provide telehealth LARC training and refresher courses
	Engage pharmaceutical companies that have training requirements for device purchase to provide hands-on LARC trainings
Outreach	Increase public awareness of Title X services and clinic locations, and birthing facilities for accessing LARC
	Conduct site visits with birthing facilities, and address misperceptions about LARC and the effectiveness of contraceptive methods immediately postpartum
	Disseminate patient-friendly resources (*e.g.*, NFPRHA, ACOG) to providers and clinics on immediate postpartum insertions for discussions before patient delivery
	Distribute resources on the safety and effectiveness of contraceptive methods for postpartum women (*e.g.*, CDC US MEC and US SPR guidelines) to hospital staff
	Collaborate with national and state-led organizations to develop newsletters, infographics, and/or brochures focused on contraception, healthy birth spacing, and preconception health

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Domain	*Strategies implemented by states*
	Develop and distribute comprehensive toolkits on LARC policies, billing, and coding for providers and administrators
	Engage in vendor drug outreach and train hospital staff about ‘‘buy and bill’’ programs
	Develop and promote public education campaigns on the safety and availability of LARC
	Conduct focus groups with women to determine appropriate messaging on contraceptive method options
	Implement social media campaigns on LARC to garner public attention
	Develop success stories on implemented immediate postpartum LARC programs
	Contact obstetrician managers in facilities to communicate policy notices and protocols, and identify provider champions for training
Payment streams and reimbursement	Develop resources explaining the processes for purchasing devices, managing inventory, and seeking reimbursement of device costs by hospitals, and steps for coding and reimbursement of provider fees (*e.g.*, pilot resource in one or more facilities, then expand use)
	Develop resources for supporting information technology systems in reimbursement management at hospitals, including added features for EMR billing and coding, and verification of reimbursement with received payments
	Collaborate with Medicaid-managed care organizations to identify carve-ins or carve-outs for device purchasing and insertion fees separate from the bundled encounter rate
	Understand the implications of managed care plan capitation rates on the purchase of and reimbursement for devices, and identify for hospital administrators, billing staffs, and specialty pharmacies examples of cost-neutral options, including billing outside of diagnostic-related group codes
	Identify state programs, foundations, and/or external organizations that can partner with hospitals and clinics to purchase devices for immediate postpartum LARC Collaborate with insurers to offer fair and equitable reimbursement rates for LARC devices
	Issue clarification letters, policy memoranda, and/or bulletins related to LARC billing and reimbursement Develop resources for engaging private payers in reimbursement discussions
	Identify provider champions to obtain buy-in from all providers at facilities to advocate for reimbursement of device purchasing and insertion fees Engage pharmacy staff to ensure billing and coding procedures are documented
	Identify example language to include in a Medicaid SPA to implement LARC billing and reimbursement
Data, monitoring, and evaluation	Ensure access to Medicaid claims data to analyze LARC uptake
	Collect process indicator data on the impact of immediate postpartum LARC uptake (clinicians trained, integrated EMR, etc.), and develop indicators
	Analyze state-level claims data on immediate postpartum LARC insertions
	Identify data linkages between immediate postpartum LARC utilization data and data sources for other maternal and child health outcomes (preterm birth, unintended pregnancy, NICU admissions, birth spacing, etc.)
	Establish internal and external working groups to analyze or evaluate data outcomes
	Conduct cost projection, avoidance, benefit, and effectiveness analyses of immediate postpartum LARC
	Ensure consistent data entry from insurers and providers to support accurate LARC cost and utilization estimates
	Collect and evaluate data on hospital administration perceptions of immediate postpartum LARC to compare with provider experiences
	Collect data on impact of immediate postpartum LARC on postpartum visit attendance
Service locations	Educate providers in rural areas on facility-level policies focused on immediate postpartum LARC services, to inform referral patterns
	Encourage providers to educate clients in rural areas about delivery options and existing facility-level policies on LARC

Domain	*Strategies implemented by states*
	Convene provider champions through in-person regional conferences or webinars to develop solutions for facility-level barriers including availability of certain devices in rural areas
	Encourage engagement with FQHCs to explain outpatient purchasing options to offset the cost of LARC devices, capacity to bill for devices, use of specialty pharmacies, and referral of clients to facilities where providers place LARC immediately postpartum
	Work with rural hospitals to reduce barriers, such as lower encounter rate reimbursements from payers (*e.g.*, by developing LARC carve-out from the global fee), and higher device costs (*e.g.*, by adding LARC to the pharmacy inpatient formularies)
	Tailor community-driven, location-specific messages and education campaigns in rural areas to increase awareness of LARC, focusing on myths associated with LARC
	Engage smaller or rural facilities in piloting of immediate postpartum LARC insertion programs
Stocking and supply of devices	Encourage facility pharmacies to add LARC to inpatient formularies and clearly communicate costs to ensure device stocking
	Develop economic savings models for facilities to justify continuous stocking of devices
	Leverage relationships with providers and provider champions to promote hospital stocking of LARC
	Develop protocols and/or toolkits for hospital staff on medication ordering and purchasing procedures for piloting in single facilities
	Develop state-level funding opportunities or programs for purchasing devices for facilities
	Encourage hospitals to stock LARC proximal to maternity units or on labor and delivery floors
	Leverage existing programs (*e.g.*, Ryan Residency Program) or foundation funds to stock devices for patients without insurance
Informed consent	Develop and apply ethical, client-centered language for providers to appropriately counsel women on all contraceptive method options
	Develop protocols for clinics before labor and delivery to ensure patient consent for immediate postpartum LARC
	Disseminate examples of protocols to delivery facilities and clinics on appropriate timing of patient consent for LARC
	Distribute examples of consent forms to delivery facilities, pharmacies, and clinics

ACOG, American College of Obstetricians and Gynecologists; AAFP, American Academy of Family Physicians; AHA, American Hospital Association; AWHONN, Association of Women's Health, Obstetric, and Neonatal Nurses; AAP, American Academy of Pediatrics; CDC, Centers for Disease Control and Prevention; EMR, electronic medical record; FQHCs, Federally Qualified Health Centers; MCO, Managed Care Organizations; MEC, Medical Eligibility Criteria; NFPRHA, National Family Planning and Reproductive Health Association; NICU, Neonatal Intensive Care Unit; SPA, State Plan Amendment; SPR, Selected Practice Recommendations for Contraceptive Use.