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Original Research Article

Obtaining buy-in for immediate postpartum long-acting reversible contraception programs in Texas hospitals: A qualitative study ☆,☆☆

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ABSTRACT

Objective: To understand the specific ways in which champions lead efforts to obtain and sustain buy-in for immediate postpartum long-acting reversible contraception (LARC) programs.
Methods: We conducted a qualitative study with 60 semistructured interviews at 3 teaching hospitals in Texas with physicians, nurses, administrators and other staff who participated in the implementation of immediate postpartum LARC. Physicians self-identified as champions and identified other champion physicians and administrators. Two researchers analyzed and coded interview transcripts for content and themes.
Results: We found that champions draw on institutional knowledge and relationships to build awareness and support for immediate postpartum LARC implementation. To obtain buy-in, champions needed to demonstrate financial sustainability, engage key stakeholders from multiple departments, and obtain nurse buy-in. Champions also created buy-in by communicating goals for the service that focused on expanding reproductive autonomy, improving maternal health, and improving access to postpartum contraception. Some staff, especially nurses, identified reasons for the program that run counter to reproductive justice principles: reducing birth rates, poverty, and/or unplanned pregnancy among young women and high-parity women. Respondents at 2 hospitals noted that not all women had equitable access to immediate postpartum LARC.
Conclusion: Physician and non-physician champions must secure long-term support across multiple hospital departments to successfully implement an immediate postpartum LARC program. For programs to equitably serve all women in need of postpartum contraceptive care, champions and other program leaders need to implement strategies to address access issues. They should also explicitly focus on reproductive justice principles during program introduction and training.
Implications: Successfully implementing immediate postpartum long-acting reversible contraception programs requires champions with institutional networking connections, administrative and nursing support, and clearly communicated goals. Champions need to address access issues and focus on reproductive justice principles during program introduction and training to equitably serve all women in need of postpartum contraceptive care.

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1. Introduction

Offering immediate postpartum placement of long-acting reversible contraception (LARC) is widely endorsed in the United States [1–3] but barriers to implementation and sustainability [4] have prevented its widespread adoption. Examining the experiences of hospitals that have successfully implemented immediate postpartum LARC provision provides a roadmap for other hospitals to initiate immediate postpartum contraceptive options that meet patient demand [5].

In 2012, South Carolina became the first state to change its Medicaid payment policy to allow for separate billing for immediate postpartum LARC [6]. Other states followed, implementing new types of reimbursement including an increased bundled payment, separate payment for the device, separate payment for the insertion, or separate payment for both the device and insertion [7,8]. In 2016, Texas changed its Medicaid policy to allow separate reimbursement for immediate postpartum LARC devices and the insertion fee [9].

As hospitals and physicians adopted these changes, evaluators of the implementation of immediate postpartum LARC programs consistently noted the importance of champions – defined as those who "dedicate themselves to supporting the intervention in an organization" [10,11] – in identifying the goals of immediate postpartum LARC [12,13]. These champions introduced key stakeholders to the clinical evidence for and overall health benefits of immediate postpartum LARC, facilitated connections between stakeholders [14], and some focused on reproductive autonomy as an implementation goal for achieving reproductive justice [13]. Less understood are detailed ways in which champions bring together stakeholders in a hospital to facilitate buy-in [13] for an immediate postpartum LARC program and how information and ideas are disseminated within and across departments.

In order to understand the specific ways in which champions lead efforts to obtain buy-in for immediate postpartum LARC within hospital systems, we interviewed staff who self-identified as program champions, other champions they identified, and others involved in the implementation of immediate postpartum LARC at 3 Texas hospitals. We examine the role champions played in creating buy-in and describe the key steps needed to facilitate buy-in. We also describe which program goals champions communicated, conflicting objectives others identified, and providers' concerns about providing equitable access to these immediate postpartum methods.

2. Material and methods

In this qualitative study, we drew on an interpretivist paradigm [15] and used inductive techniques [16] to achieve study objectives. We conducted 60 semistructured interviews from November 2017 through February 2019 about the implementation and provision of immediate postpartum LARC at 3 teaching hospitals in Texas. We selected these hospitals because they participated in a previous study about women's experiences with postpartum contraception [5] and had implemented an immediate postpartum LARC program. All 3 have large maternity services and obstetrician/gynecologist (OB/GYN) residency programs. They differ in their ownership status and public/private physician mix. One is a for-profit physician-owned hospital and 2 are non-profit county safety net hospitals. One of the county safety net hospitals has a closed-staff model in which medical school faculty and residents exclusively staff the OB/GYN service, while the other has an open-staff model in which both medical school OB/GYN faculty and residents and private physicians staff the OB/GYN service.

2.1. Physician-owned hospital

Medical school faculty and residents at the physician-owned hospital began providing immediate postpartum LARC in February 2017. They provide these methods to all medically-eligible patients through the residency service. Medicaid covers the costs for Medicaid beneficiaries while an educational grant program covers the costs for patients without insurance or whose insurance does not cover immediate postpartum LARC. Private physicians who see patients with Medicaid insurance, private insurance, and without insurance also staff this hospital's OB/GYN service. Based on informal conversations with private physicians at this site, we hypothesize that few private physicians offered immediate postpartum LARC, preferring to offer these methods during a follow-up office visit due to concerns about receiving optimal reimbursement from insurance.

2.2. Closed-staff hospital

In August 2014, prior to the state Medicaid policy change, the closed-staff hospital began providing immediate postpartum LARC using county safety net funds and grants to defray the costs of devices and physician fees. Since January 2016, Medicaid has covered immediate postpartum LARC provision for Medicaid beneficiaries and, with additional funding streams, patients with other payor sources are eligible to receive immediate postpartum LARC.

2.3. Open-staff hospital

Physicians at the open-staff hospital began providing immediate postpartum LARC in March 2017. Only women with Medicaid insurance and those whose deliveries were attended by medical school faculty or residents were eligible for the program. Private practice physicians at the open-staff hospital did not offer immediate postpartum LARC to their patients with Medicaid coverage during the study period.

2.4. Recruitment, implementation, and analysis

KH worked with CWH, LDM, RMH, SDR, and TO, who self-identified as immediate postpartum LARC champions at the study hospitals, to identify additional champions at their institutions and facilitate recruitment. KH contacted potential participants via email before arriving at the hospitals and used snowball sampling to identify additional potential participants when she was on-site. Eligible participants included those involved in the implementation and/or the provision of immediate postpartum LARC. We did not predetermine the sample size, instead using a purposive sampling strategy to interview a wide range of staff at each site. We obtained institutional review board approval from each hospital. The University of Texas at Austin Institutional Review Board originally approved the study as expedited and subsequently reclassified it as exempt. All participants provided oral consent to participate.

We developed the interview guide to assess key components of immediate postpartum LARC implementation, based on previous research on implementation, concepts in Hofler and colleagues' interview guide [14], and discussions with medical and administrative staff at the physician-owned hospital. This analysis focuses on the buy-in process for implementation. Specifically, we asked champions to describe their role in bringing immediate postpartum LARC to their hospital, how they obtained program buy-in, and which resources and supports were needed for program success. We asked all participants what advice they had for others wanting to implement the program, why they thought the program was implemented, and how they thought it contributed to

Table 1
Description of staff interviewed and characteristics of immediate postpartum long-acting reversible contraception (IPP LARC) programs at 3 Texas hospitals, 2017–2019

Hospital	Physician-owned hospital	Closed-staff hospital	Open-staff hospital	Total
Date of interviews	Nov 2017 to Feb 2018	Aug to Nov 2018	Jan to Feb 2019	
Staff interviewed				
Hospital administrators	1	1	1	3
Faculty physicians	6	4	4	14
Resident physicians	2	4	3	9
Nurses	9	5	7	21
Billing and coding staff	2	3	2	7
Pharmacists	2	1	1	4
IT staff	2	0	0	2
Staff interviewed, total	24	18	18	60
Date IPP LARC program started	Feb 2017	Aug 2014	Mar 2017	
Duration of IPP LARC program[a] at the time of interviews	1 y	4 y, 3 mo	1 y, 11 mo	

[a] Duration defined as date of start of IPP LARC program through month in which last staff interview completed at the corresponding hospital.

the hospital's mission. Finally, we collected information on each participant's job title and gender.

KH led all interviews, either in-person or over the phone; ME and a research assistant each participated in 2 phone interviews; CWH was present at 6 in-person interviews and 1 phone interview with participants at the institution where she was employed during the study period. We audio-recorded all interviews with participant permission; professionals transcribed them.

KH, ME, and another researcher used an inductive approach to develop a coding guide of key topics that arose from the interviews and iteratively revised it as we coded more transcripts. To reduce coding bias, 2 researchers read each transcript and independently assigned codes to all quotations in the documents and then met to reach consensus on all codes. After completing coding, KH, ME, and CR (the non-champion authors) analyzed the codes or groups of codes for key themes and selected all the quotations for inclusion. We remained mindful of our positionality as researchers and academic clinicians in interpreting interviews from hospital staff with different training and race/ethnic, gender, and social class backgrounds [17]. We used NVivo 12 to manage the qualitative data.

3. Results

We interviewed 60 people (46 women and 14 men): 24 at the physician-owned hospital and 18 each at the closed-staff and open-staff hospitals (Table 1). We interviewed 22 OB/GYNs (13 faculty MDs – 5 who self-identified as champions who in turn identified another 6 physician-champions – and 9 residents), 3 administrators (2 of whom physician-champions identified as champions), 21 nurses and smaller numbers of billing and coding staff, pharmacists, and IT staff (at 2 hospitals, champions did not identify IT staff to interview). Interviews averaged 31 minutes (range: 5–88 minutes). Staff at these hospitals had offered immediate postpartum LARC from 1 year to over 4 years when the interviews took place.

We describe our findings related to 2 of our domains of inquiry that detail the process of obtaining buy-in at these hospitals: the role champions play in generating buy-in and key steps needed to obtain buy-in. We also describe an additional theme we identified that underscores the importance of communicating the goals of an immediate postpartum LARC program. We highlight sub-themes and present key quotations for each below.

3.1. Champions draw on institutional knowledge to build awareness and maintain support

Respondents at all 3 sites emphasized the role champions played in gathering support for immediate postpartum LARC. Champions recounted that they capitalized on the institutional knowledge and connections across departments at their respective hospitals. For example, a champion at the closed-staff hospital noted: "I was the lead physician for implementing our enterprise electronic medical record, I knew who to call, and [so] I knew what people needed to hear in order for them to feel like something was safe and effective and cost conscious." Champions also highlighted the importance connecting with outside resources, including funding sources. Indeed, multiple champions credited connections to providers at other institutions in helping establish protocols for immediate postpartum LARC. Several champions noted the importance of engaging administrator champions to establish a program, for example, "[Champions] can't just be a provider. You've got to have an administrative champion because the reasons that it will fail are administrative, not clinical" (champion, physician-owned hospital). Others pointed to needing an identifiable point person with widespread support within the institution: "You need spokespeople to be promoting these projects, and you need a point person that's going to be on the floors whether day or night, talking it up. Somebody that has influence. Somebody that people respect and like and know" (champion, physician-owned hospital).

As the programs got underway, respondents indicated that "[a] lot of it was simply raising the awareness with nursing and pharmacy that this was a recommendation… from professional societies, and that it made good sense for our patient population" (champion, closed-staff hospital). After champions obtained this initial buy-in, they provided continued support for the program. This included troubleshooting problems and reassuring nurses about their concerns, particularly expulsion rates, as described by this nurse at the physician-owned hospital: "Initially, the nurses had concerns about expulsion rates and [asked] "Is this even going to be successful?" If you can get the education out there before you implement it, that kind of helps allay those fears and they're a lot more supportive of it once it rolls out."

3.2. Key steps to obtaining buy-in

Champions and other staff at all sites recounted that they took a series of steps to obtain buy-in from administration, individual departments, and other staff at their institutions. First, champions recognized that obtaining buy-in for immediate postpartum LARC from key decision makers required them to communicate its financial sustainability. A champion at the physician-owned hospital noted: "[I]t had been about a year since Texas Medicaid had approved payment of [immediate postpartum] LARC devices as part of the postpartum period, and so we included that information [when we presented to an administrative committee]. I think that's really what helped us get this off the ground because had it not been for that, then people would have not been able to clearly see how this program would be financially sustainable."

Second, champions noted the need to bring together key stakeholders from multiple departments, including pharmacy, billing, coding, and administration to "[j]ust get as many people as you can think of that will be involved in the process, communicate with everybody, understand their concerns, fears" (champion, open-staff hospital).

Finally, in addition to nurses themselves, champions emphasized the importance of obtaining buy-in from nurses for the success of any immediate postpartum LARC program. To facilitate nurse buy-in, 1 champion noted the importance of communicating that OB/GYN and nursing professional associations share similar goals of providing high-quality postpartum care, which includes improving access to postpartum contraceptive methods. Moreover, respondents recounted that nurses need to be on board to provide patients consistent information about the program, as this nurse at the physician-owned hospital explained: "I think patients pick up on nursing perceptions and if I'm displaying support, they're less anxious about the procedure... If the nurse is skeptical and saying maybe some negative things, she [the patient] may back out of it or have more questions or be more anxious."

Champions experienced some challenges in obtaining nurse buy-in. In addition to concerns about higher immediate postpartum IUD expulsion rates, others recounted concerns about the additional workload required to facilitate immediate postpartum LARC. A champion at the closed-staff hospital noted that nurses had expressed "a little bit of reluctance…if we add more things for people to do." Moreover, after nurses bought into the program, some mentioned that physicians needed to keep nurses' competing duties in mind. As a postpartum nurse at the open-staff hospital recounted: "sometimes when [residents and their attendings] are ready to [insert an implant], my nurses are busy. So that's why I try to tell them, "Let us know a little bit ahead of time…" Because sometimes we can't just drop what we're doing so we can help you out." Ultimately, achieving nurse buy-in occurred by fully addressing nurses' concerns and integrating these programs into the culture of the hospital. A champion at the closed-staff hospital noted that they engaged with nurses by explaining "the nurses have the same goal in mind as all of us, which is helping our patients with access and getting contraceptive devices that they want."

3.3. Importance of communicating goals of immediate postpartum LARC

Champions also obtained buy-in by communicating the goals of an immediate postpartum LARC service. These messages focused on how immediate postpartum LARC increased reproductive autonomy and improved maternal health and contraceptive access. For example, a nurse at the closed-staff hospital was clear that, "We're here to serve the community, so we're giving them choices; we're giving them an opportunity to have a voice in their care." Many staff were clear that these goals are particularly important for patients who find it difficult to attend postpartum visits, as recounted by this nurse at the physician-owned hospital: "With our population…they're not going to follow up. It's very difficult for them, especially having no child care. ... There's a lot of barriers in the community for them to get [contraception] after they leave the hospital so this really enables them to have control over their reproductive health in a setting that's in their favor."

Champions encountered some challenges in communicating these goals. For example, early in the implementation approval process, a champion at the physician-owned hospital presented at an immediate postpartum LARC working group with representatives from pharmacy, nursing, and billing and coding. The representatives worried that physicians might coerce some patients into accepting a LARC device. "Some of the concerns were 'we're just going to start sticking these devices into people'." The physician assuaged concerns by clarifying that the goal of the program was to offer LARC only to patients who choose it, saying "No, we're not just going to do that. … We provide counseling for patients, and then they can accept [LARC] or decline them or use pills or use whatever they're going to use."

Some staff voiced reasons for starting an immediate postpartum LARC program that run counter to the goals of improving reproductive autonomy and better access, including to reduce birth rates, reduce poverty and/or unplanned pregnancy among young and high-parity women, or to benefit the community. Nurses at all 3 sites, like 1 at the closed-staff hospital, voiced a focus on "trying to decrease women having too many babies." However, nurses at the physician-owned hospital most commonly described these reasons, typically expressing hope that the immediate postpartum LARC program could help reduce future unplanned pregnancies among indigent women who had already experienced many unplanned pregnancies. For example, "Maybe because we're in an area where there's lots of moms, they're delivering too much. … And of course, the children also won't be really well taken care of if they have a lot of members of the family." Some also referred to immediate postpartum LARC as benefitting the community through effectively managing limited resources by investing in contraception now to save money on prenatal care, delivery and beyond for women who have unplanned pregnancies.

Finally, respondents at the open-staff and physician-owned hospitals voiced concerns about their ability to achieve their stated goal of expanding contraceptive access equitably because they could only do so for some of their patients. A physician at the open-staff hospital said: "I'd say three-quarters of them can't even get [immediate postpartum LARC] in the hospital anyway because they don't have the right sort of Medicaid." Similarly, a champion at the physician-owned hospital noted: "…ideally, these devices would be made available to everyone, which as of today is not the case."

4. Discussion

Buy-in for immediate postpartum LARC programs is a dynamic process, involving frequent communication among stakeholders, the development of ownership of the program across hospital departments, and clearly communicating the vision to advance women's reproductive autonomy and expand their contraception options. In this study, we build on previous research about the importance of champions and their roles in identifying goals of immediate postpartum LARC [10,12,14,18] to identify the specific ways in which champions work within their institutions to obtain buy-in for immediate postpartum LARC. Like Hofler and colleagues [14], we found that champions need to demonstrate financial sustainability of immediate postpartum LARC to key decision makers prior to implementation. We extend that work by detailing the ways in which champions interact with internal and external stakeholders to demonstrate its sustainability. We also presented details of how champions engaged staff from multiple departments in the planning stages and showed that key staff need to provide input early on for buy-in to succeed.

Nurses and physicians both observed that obtaining buy-in from nursing staff was among the most important for successfully launching and maintaining immediate postpartum LARC programs. One successful strategy was acknowledging the shared goal of OB/GYNs and nurses to provide high-quality care. These institutions also successfully obtained buy-in from nurses by involving them in program planning and responding to their concerns [19] such as expulsions and scheduling issues. In contrast, institutions that have attempted to start new programs using a top-down approach without involving the front-line staff are met with

less success [20]. Finally, nurses who embraced the importance of offering immediate postpartum LARC assisted with and reinforced education and support for their patients' decisions regarding contraception [21].

Our work suggests that the goals to improve contraceptive choice and reproductive autonomy are well-understood by nurses and physicians. However, several nurses also identified that implementation of immediate postpartum LARC programs was to reduce high parity among their largely indigent patient populations. Others noted that it saved community resources. These findings potentially point to coercion in favor of LARC methods for their patients [22,23] and run counter to reproductive justice principles. It is therefore critical to acknowledge that reproductive coercion is a potential reality, particularly for women who are low-income and women of color [24]. Necessary components of programs that guard against coercion need to focus on training providers, empowering patients to make fully informed decisions, and working to transform health care systems to be more equitable [25].

This study's strengths include a sample of hospitals with differing organizational and payor mixes that had recently initiated an immediate postpartum LARC program. But this study is not without limitations. First, all hospitals are affiliated with academic training programs for resident physicians, which may be more likely than non-teaching hospitals to adopt innovative healthcare approaches [26]. Moreover, focusing exclusively on Texas-based study sites may limit its applicability to other settings. On the other hand, we believe many of the lessons described here are applicable to other settings using Medicaid and other funds to reimburse for immediate postpartum LARC. In addition, no private physicians participated in the study; gathering feedback from them would have provided more information on the level of buy-in from the obstetrics and gynecology community at large. We also acknowledge the positionality of the researchers and champions as senior-level experts, which may affect the interpretation of results from respondents with different training and background, as well as the potential for social desirability bias from respondents completing an interview related to their job responsibilities [17]. Moreover, several of the champions we interviewed are authors and many of their quotations are included here, which is another source of potential bias. However, similar to Skračić and colleagues' experiences interviewing champions [27], we found that the champions we interviewed appeared forthcoming about the challenges involved in implementation of immediate postpartum LARC at their hospitals.

Champions of immediate postpartum LARC programs, who can draw upon their institutional knowledge and connections, are necessary to educate key decision makers about the financial sustainability of the endeavor. It is critical to engage nurses early as partners to implement this innovation and to sustain buy-in. Champions need to more clearly communicate that the primary goals for immediate postpartum LARC programs are to increase women's reproductive autonomy, improve maternal health, and improve access to contraception postpartum. Immediate postpartum LARC programs should equitably serve all women in need of postpartum contraceptive care, and champions must incorporate an explicit focus on reproductive justice principles to combat concerns about and the potential reality of coercion.

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