Access to Highly Effective Postpartum Contraception: The Time Is Now

Courtney A. Schreiber, MD MPH FACOG
Associate Professor of Obstetrics/Gynecology

Philadelphia's Public Health Priorities

- Heart Disease and Cancer Prevention
- Reproductive Health
- Healthy Start to Life

- EFFECTIVE POSTPARTUM CONTRACEPTION CAN HELP ACHIEVE 2/3 OF OUR GOALS
Unplanned Births in Pennsylvania: 2010

- 53% of pregnancies in Pennsylvania were unplanned

- Public spending for unplanned pregnancies in Pennsylvania estimated at $727 million

http://thenationalcampaign.org/data/state/pennsylvania
Birth Control Prevents Unplanned Pregnancy

**HOW WELL DOES BIRTH CONTROL WORK?**

<table>
<thead>
<tr>
<th>Method</th>
<th>Effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contraceptive Pill</td>
<td>1 year</td>
</tr>
<tr>
<td>Long-Acting Progestin</td>
<td>3 years</td>
</tr>
<tr>
<td>Copper IUD</td>
<td>5 years</td>
</tr>
<tr>
<td>Progestin IUD</td>
<td>5 years</td>
</tr>
<tr>
<td>Intrauterine Device</td>
<td>12 years</td>
</tr>
<tr>
<td>Vasectomy</td>
<td>16 years</td>
</tr>
</tbody>
</table>

What is your chance of getting pregnant?

- Less than 1 in 100 (pill)
- Less than 1 in 1000 (implant)
- Less than 1 in 10000 (vasectomy)

For each of these methods to work, you and your partner must use it every single time you have sex.

**LARC Continuation Rates Are the Highest of All Reversible Methods**

<table>
<thead>
<tr>
<th>Method</th>
<th>One year continuation rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condom</td>
<td>53</td>
</tr>
<tr>
<td>Injection</td>
<td>56</td>
</tr>
<tr>
<td>OC + POP</td>
<td>68</td>
</tr>
<tr>
<td>Copper T</td>
<td>78</td>
</tr>
<tr>
<td>LNG-IUS</td>
<td>80</td>
</tr>
<tr>
<td>Implant</td>
<td>84</td>
</tr>
</tbody>
</table>

Postpartum Contraception

Traditionally addressed at the 6 week visit

What's the problem with waiting?
- Up to 35% of women do not attend their 6 week postpartum (PP) visit.
- 50% ovulate and 60% resume sex before 6 weeks postpartum
- Over half of unintended pregnancies occur within 2 years following delivery
- High interest in LARC among postpartum women, particularly those with a recent unintended pregnancy and women who do not desire pregnancy for at least 2 years

Timely access to PP contraception
- Can prevent rapid repeat pregnancy
- Improve next pregnancy outcomes
- Prevent abortion

Potter et al., 2014; Tang et al., 2013

Immediate Postpartum LARC

- Progestin only or nonhormonal methods preferred
- Convenient for patients
- Assist with healthy birth spacing
- Safe
Almost 60% of Women Request Immediate PP LARC When Offered

<table>
<thead>
<tr>
<th>Method</th>
<th>Method requested n &amp;%</th>
<th>Method received by 6 months n &amp;%</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Abstinence</td>
<td>4</td>
<td>19</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>0</td>
<td>25</td>
</tr>
<tr>
<td>Condoms</td>
<td>1</td>
<td>34</td>
</tr>
<tr>
<td>Hormonal methods</td>
<td>36</td>
<td>32</td>
</tr>
<tr>
<td>Implant</td>
<td>24</td>
<td>25</td>
</tr>
<tr>
<td>Hormonal IUD</td>
<td>21</td>
<td>0</td>
</tr>
<tr>
<td>Copper IUD</td>
<td>12</td>
<td>0</td>
</tr>
</tbody>
</table>

*Some women reported using more than 1 method

---

Method and Timing Options

- **For an Implant**
  - Before discharge from the hospital postpartum
  - no concerning effects on:
    - maternal health
    - breastfeeding outcomes

- **For an Intrauterine Device**
  - Immediate postplacental = within 10 min of placental delivery
  - Delivery type: Vaginal or Cesarean section
  - More data needed on risk of expulsion, but can be mitigated when recognized and IUD replaced

Post Partum Implant Continuation Rates are High

Etonogestrel implant placed postpartum prior to hospital discharge (HUP)
January 2008-March 2009
n=262

Table 2
Cumulative Implant continuation rates at 1, 2, and 3 years

<table>
<thead>
<tr>
<th>Follow-up (%)</th>
<th>Removed (n)</th>
<th>Continuation* (%) CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 year</td>
<td>78.2</td>
<td>27</td>
</tr>
<tr>
<td>2 years</td>
<td>75.2</td>
<td>53</td>
</tr>
<tr>
<td>3 years</td>
<td>72.9</td>
<td>68</td>
</tr>
</tbody>
</table>

*Estimated from survival analysis; CI, 95% confidence interval

Average length of pill use = 5 months

Contraception 90(3):259-64, Sept 2014

Implant Decreases Rapid Repeat Birth

Repeat Pregnancy among PP adolescents in Colorado

![Graph showing implant decrease in repeat pregnancies](chart.png)

- PP Implant
- control

P<0.001

12 months: 2.6% (4/153), 18.6% (38/204) P<0.001
24 months: 8.2% (11/138), 41.2% (65/159)

Courtesy of K. Tocce, Colorado

Page 6
Contraception: Timing is Everything

Is immediate postpartum IUD the "next big thing"?

By Sarah McGovern

SAN FRANCISCO — International placements of loop-shaped intrauterine devices are gaining popularity among health care providers, particularly because they offer multiple advantages and are generally safe and effective for preventing repeat pregnancies, according to Dr. John P. Ryan.

"I personally think there's a lot of potential for IUDs in the obstetric field," said Dr. Ryan, a clinical associate professor of obstetrics, gynecology and reproduction at the University of California, San Francisco, and chair of the American College of Obstetricians and Gynecologists Committee on Obstetrics and Gynecology.

The biggest barrier to increasing the number of postpartum IUD placements is that, in most states, IUD placements can't be done during the global fetal delivery, but that is changing, said Dr. Ryan, who is director of the Department of Obstetrics and Gynecology at the University of California, San Francisco.

There are laws in some states—Medicaid has agreed to opt out postpartum placement of IUDs on colposcopy and transfixed tissues in the global fetal delivery, she said. That is not the case in Alabama, Colorado, Georgia, Texas, Louisiana, and Pennsylvania.

Insurance Company Payment is the Barrier

- CDC recommends placement of IUDs within 10 minutes of placental delivery and implant placement before discharge

- Current State Medicaid policies do not have payment mechanism for inpatient LARC reimbursement

- Cost effectiveness remains a concern
Implants for Teen Moms are Cost Effective

Costs per 1000 Women

- IPI
- Control
- Net savings/loss for Medicaid

6 months: -$17,283.00
One year: $567,271.58
Two years: $2,382,389.93

Courtesy of K. Tocce, Colorado

Cost Effectiveness of LARC

- On average, four patients need to receive an implant during the immediate postpartum period to prevent one additional rapid repeat pregnancy.

<table>
<thead>
<tr>
<th>Cost of four LARC devices</th>
<th>Cost of one Medicaid birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2800</td>
<td>$30,000-50,000</td>
</tr>
</tbody>
</table>

Penn Medicine
Postpartum Contraception: Seize the Day

NEARLY 1 IN 5
TEEN BIRTHS IS
A REPEAT BIRTH

VitalSigns
www.cdc.gov/vitalsigns

LARC and Birth Spacing: Health Disparities

- Short intervals between pregnancies carry health risks for both mom and baby.
- LARC users had 4x the odds of achieving an optimal birth interval compared with women who used less contraceptive effective methods.
- Implant associated with longer interpregnancy interval in adolescents compared with less effective methods.

Why Now?

- In 2012, just South Carolina allowed reimbursement in this way.
- By 2014 the list included:

  South Carolina  New York
  Colorado        Louisiana
  New Mexico      Iowa
  Georgia         California
  Alabama

Maternity Billing in Hospitals

- Deliveries are billed and paid for with just one “package” code.
- That code generates a flat fee for the hospital
- In exchange, the hospital provides all pregnancy related services from the first prenatal visit up to the immediate postpartum period. Including anything that occurs in the hospital during/related to the birth.
  Fewer services given = more profit
Hospital Incentives and Financing

<table>
<thead>
<tr>
<th>If Hospital Provides LARC Immediately Postpartum</th>
<th>If Hospital Provides LARC 6 weeks Postpartum</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Device and Insertion fees wrapped into global payment for delivery.</td>
<td></td>
</tr>
<tr>
<td>- No additional compensation.</td>
<td></td>
</tr>
<tr>
<td><strong>Cost to Hospital:</strong> $500-1500</td>
<td></td>
</tr>
<tr>
<td><strong>Benefit to Hospital:</strong> $500-1500</td>
<td></td>
</tr>
</tbody>
</table>

Coding Logistics

- Some states provide a credit adjustment inpatient LARC codes submitted at the same time as the pregnancy claim.
- Other states allow providers to add a modifier to their pregnancy claim
- **Only CMS Requirement:**
  - Coverage for LARC is considered an add-on benefit to the Diagnostic Related Group
  - hospitals are required to use the Healthcare Common Procedure Coding System Code that represents the device, along with the ICD-9 Surgical Codes and the ICD-9 Diagnosis Codes
The Yellow Brick Road to Reducing Rapid Repeat Births

IMMEDIATE PP LARC

The Time is Now

Better Parenting Through Postpartum Contraception

Postpartum LARC is first choice for many Women

Safe and provides long lasting efficacy

Allows women to have adequate birth spacing which improves maternal and infant outcomes

Main barrier is reimbursement and logistic of in hospital insertion including having devices available and having provider time reimbursed

Many other states have succeed in overcoming these barriers and can serve as role-models for Pennsylvania.
Thank You

Acknowledgments: Elizabeth Gurney, MD
Callie Langton, PhD

Disclosures: Research Funded by NICHD; Medicine360;
Society for Family Planning; Consultancies include
Bayer Pharmaceuticals and Planned Parenthood
Federation