Welcome to the Pregnancy Medical Home “First Tuesdays” Webinar: Reproductive Life Planning and Postpartum LARC in the Medicaid Population

Webinar will begin at 7:30am
Connect to audio by computer
Submit any questions through chat

Funding for this project is provided in part by The Duke Endowment

- Partnership
  - UNC Center for Maternal and Infant Health
  - UNC School of Medicine Division of Maternal-Fetal Medicine
  - Community Care of North Carolina’s Pregnancy Medical Home Program

- Statewide initiatives:
  - CLEAR certification for sonographers in cervical length measurement
  - Evidence based clinical guidance for OB providers: Pregnancy Medical Home Pathways and related materials

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Pregnancy Medical Home

- The Pregnancy Medical Home (PMH) program is a statewide model to improve quality of care, improve outcomes and reduce health care costs in the pregnant Medicaid population
  - Primary focus is on preterm birth prevention
  - Funding/oversight from NC Division of Medical Assistance (Medicaid), operated by Community Care of North Carolina, a private, non-profit population management organization
  - CCNC has 14 networks and a central office in Raleigh
    - “OB teams” in each network/central office include physician champions and nurse coordinators
  - 1,700 maternity providers in 380 practices
  - 57,000 “non-Emergency” Medicaid deliveries/year in NC
PMH Care Pathways

- PMH physician leadership from across the state (network OB Champions) collaborate to create clinical guidance for maternity providers

- Evidence-based guidance to promote best practices, improve quality and improve outcomes

- PMH Care Pathways shared on PMH webpage on CCNC’s website
Currently available PMH Care Pathways:

- Hypertensive Disorders of Pregnancy
- Induction of Labor in Nulliparous Patients
- Perinatal Tobacco Use
- Postpartum Care and the Transition to Well Woman Care
- Preterm Birth Prevention: Treatment with Progesterone and Cervical Ultrasound Screening
- Substance Use in Pregnancy

Coming Soon:

- Reproductive Life Planning and Postpartum LARC in the Medicaid Population

https://www.communitycarenc.org/population-management/pregnancy-home/pmh-pathways/
Previous Webinars:
- Management of Perinatal Tobacco Use
- Postpartum Care and the Transition to Well Woman Care
- Management of Substance Use in Pregnancy

Today’s session:
Reproductive Life Planning and Postpartum LARC in the Medicaid Population

Upcoming Webinars:
- October 6: Progesterone and Management of Patients with History of Spontaneous Preterm Birth
- November 3: Assessing Cervical Length and Management of Patients with Short Cervix
- December 1: Management of Obesity in the Perinatal Period

Funding for this project is provided in part by The Duke Endowment
Reproductive Life Planning and Postpartum LARC in the Medicaid Population
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OB/GYN Hospitalist at WakeMed Hospitals
Clinical Assistant Professor, Division of Family Planning,
Department of Obstetrics and Gynecology, UNC School of Medicine

Funding for this project is provided in part by The Duke Endowment
Reproductive Life Planning and Postpartum LARC in the Medicaid Population PMH Care Pathway Team

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- Jessica Phipps, MPH
- M. Kathryn Menard, MD, MPH
- Isa Cheren, MD
- Velma V. Taormina, MD, FACOG
- Matthew Zerden, MD, MPH
Reproductive Life Planning and Postpartum LARC in the Medicaid Population PMH Care Pathway

- Introduction
- Pathway & Goals
- Specifics on each LARC method
- Breastfeeding
- Reproductive life planning
- Logistics & financing

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Opportunity of the postpartum period

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Opportunity of the postpartum period

Motivated patient
Opportunity of the postpartum period

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Opportunity of the postpartum period

Motivated patient

Patient-provider Relationship

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Opportunity of the postpartum period

Motivated patient

Patient-provider Relationship
Opportunity of the postpartum period

- Motivated patient
- Expanded insurance coverage
- Patient-provider relationship

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Opportunity of the postpartum period

Opportunity for effective contraception: LARC

Motivated patient

Expanded insurance coverage

Patient-provider Relationship

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Reproductive Life Planning and Postpartum LARC in the Medicaid Population PMH Care Pathway: Introduction

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Reproductive Life Planning and Postpartum LARC in the Medicaid Population PMH Care Pathway: Introduction

- Short interpregnancy intervals 1/3 births
  - Poor health outcomes for mother & baby
- LARC, first line contraception: ACOG & AAP
- Few contra-indications:
  - Immediate postpartum LARC, a new opportunity
- Challenges:
  - Reimbursement
  - Training
  - Hospital participation

Conde-Agudelo 2006; ACOG Comm Opinion
Reproductive Life Planning and Postpartum LARC in the Medicaid Population PMH Care Pathway: Goals

- Facilitate LARC insertion in the postpartum
- Partnership between patients & providers
- Evidence-based resource for providers
  - Immediately after delivery
  - As early as possible in the clinic
- Reduce unintended pregnancies
- Support breastfeeding
- Maintain high levels of patient satisfaction

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### CDC’s Medical Eligibility Criteria (MEC)

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No restriction for the use of the contraceptive method for a woman with that condition</td>
</tr>
<tr>
<td>2</td>
<td>Advantages of using the method generally outweigh the theoretical or proven risks</td>
</tr>
<tr>
<td>3</td>
<td>Theoretical or proven risks of the method usually outweigh the advantages – not usually recommended unless more appropriate methods are not available or acceptable</td>
</tr>
<tr>
<td>4</td>
<td>Unacceptable health risk if the contraceptive method is used by a woman with that condition</td>
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</tbody>
</table>


Funding for this project is provided in part by The Duke Endowment
<table>
<thead>
<tr>
<th>Condition</th>
<th>COC/P/R</th>
<th>POP</th>
<th>DMPA</th>
<th>Implants</th>
<th>LNG-IUD</th>
<th>Cu-IUD</th>
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</thead>
<tbody>
<tr>
<td><strong>Postpartum (nonbreastfeeding women)</strong></td>
<td></td>
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<tr>
<td>a. &lt;21 days</td>
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<td>b. 21 days to 42 days</td>
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<tr>
<td>i. With other risk factors for VTE (such as age ≥35 years, previous VTE, thrombophilia, immobility, transfusion at delivery, BMI ≥30, postpartum hemorrhage, postcesarean delivery, preeclampsia or smoking)</td>
<td>3†</td>
<td>1</td>
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<tr>
<td>ii. Without other risk factors for VTE</td>
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<td>1</td>
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<td>c. &gt;42 days</td>
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<tr>
<td><strong>Postpartum (breastfeeding women)</strong></td>
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</tr>
<tr>
<td>a. &lt;21 days</td>
<td>4</td>
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<td>b. 21 to &lt;30 days</td>
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<td>i. With other risk factors for VTE (such as age ≥35 years, previous VTE, thrombophilia, immobility, transfusion at delivery, BMI ≥30 kg/m², postpartum hemorrhage, postcesarean delivery, preeclampsia or smoking)</td>
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<tr>
<td>ii. Without other risk factors for VTE</td>
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<td>c. 30--42 days</td>
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<tr>
<td>i. With other risk factors for VTE (such as age ≥35 years, previous VTE, thrombophilia, immobility, transfusion at delivery, BMI ≥30, postpartum hemorrhage, postcesarean delivery, preeclampsia or smoking)</td>
<td>3†</td>
<td>1</td>
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<tr>
<td>ii. Without other risk factors for VTE</td>
<td>2</td>
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<td>1</td>
<td>1</td>
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<td>1</td>
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<tr>
<td>d. &gt;42 days</td>
<td>2</td>
<td>1</td>
<td>1</td>
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<tr>
<td><strong>Postpartum (breastfeeding or nonbreastfeeding women, including postcesarean delivery)</strong></td>
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<tr>
<td>a. &lt;10 min after delivery of the placenta</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>b. 10 min after delivery of the placenta to &lt;4 wks</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>c. ≥4 wks</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>d. Puerperal sepsis</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
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</tr>
</tbody>
</table>

**Abbreviations:** COC = combined oral contraceptives; P = combined hormonal patch; R = combined vaginal ring; POP = progestin-only pill; DMPA = depot medroxyprogesterone acetate; IUD = intrauterine device; LNG-IUD = levonorgestrel-releasing IUD; Cu-IUD = copper-bearing IUD; VTE = venous thromboembolism; CHC = combined hormonal contraceptive; BMI = body mass index (weight [kg] / height [m²]).
Mobile Apps

U.S. Medical Eligibility Criteria for Contraceptive Use

Available for iPad and iPhone
Available LARC in the postpartum

- Paragard®
  intrauterine copper contraceptive
- Mirena®
  (levonorgestrel-releasing intrauterine system) 20µg/day
- Liletta™
  (levonorgestrel-releasing intrauterine system) 52 mg
- Nexplanon®
  (etinogestrel implant) 68 mg
  Radiopaque
- Skyla
  (levonorgestrel-releasing intrauterine system) 13.5 mg

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IUDs in the postpartum

When?

- Immediate postpartum (< 10 min after vaginal delivery)
- Early postpartum (< 48 hrs after vaginal delivery)
- Intraccesarean
- 2-3 weeks postpartum (investigational)
- 4-6 weeks postpartum (standard)

Dr. Paul Blumenthal: https://www.youtube.com/watch?v=uMcTsuf8XxQ
IUDs in the postpartum: Immediate post-placental, vaginal delivery

- Within 10 min of placenta delivery
- Expulsion rates vary (10-38%)
  - High-risk patients: 50% no show
- Similar user rates at 6 months
  - High patient acceptability
- Learning curve of providers
  - Experience of clinician matters

IUDs in the postpartum: Early postpartum, vaginal delivery

- Different than immediate post-placental:
  < 48 hours postpartum, morning after delivery
- Higher expulsion rates: 5-70%
- Copper IUD less expulsion than LNG-IUS
- Learning curve of providers
  - Experience of clinician matters
- Increased role internationally

IUDs in the postpartum: Intraclesarean

- Post-placental, at time of cesarean delivery
- Expulsion rate lower than vaginal insertion
- Requires minimal training
- Challenges:
  - String visibility in office
  - Reimbursement
  - Logistics

Levi 2015, Lester 2015

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IUDs in the postpartum: 2-3 weeks postpartum

- Uterus 66% involuted, day 14 postpartum
- Pregnancy is physiologically impossible
- Benefit of a 2 week postpartum visit
  - Convenience for mom
  - Combining pediatric & maternal visits
- Ongoing studies to investigate expulsion & patient satisfaction
- Uncertain role of ultrasound

Belachew, 2012; Speroff 2008
IUDs in the postpartum: 6 weeks postpartum

- Standard protocol for most providers: 6 weeks

- Problems:
  - Ovulation in those not exclusively breast feeding
  - Resumption of intercourse
  - Poor adherence to 6-week visit among high-risk
  - 2 visit protocols

- Potential solution: 4 week visit with same day insertion

CDC 2010; Stuart 2014; Teal, 2015; Zerden, 2015

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Postpartum LARC: Contraceptive Implant, Nexplanon

- CDC MEC: Non-breastfeeding = 1
  - Breastfeeding = 2
  - RCT: No difference in breastfeeding when placed 1-3 days vs. 4-8 weeks postpartum

- Challenges:
  - Reimbursement
  - Hospital participation
Breastfeeding considerations

- Integrate into prenatal care
- ACOG/ AAP: 6 months exclusive, 12 months continuation
- Infant benefits, reductions:
  - Infectious risk (GI, otitis media, respiratory infections); chronic diseases (obesity, autoimmune conditions including asthma and diabetes mellitus type I); infant mortality from SIDS
- Maternal benefits, reductions:
  - Breast & ovarian cancer risk; diabetes mellitus type II; hypertension; hyperlipidemia; & cardiovascular diseases

Stuebe, 2010
Breastfeeding considerations: LARC

- Copper IUD (ParaGard): No concerns
- Levonorgestrel IUD:
  - Small systemic progesterone levels
  - Limited evidence, reduction in breastfeeding
  - Now with 3 available types in the US
- Contraceptive Implant (Nexplanon)
  - Higher systemic progesterone levels
  - Best evidence: no change in breastfeeding

Chen, 2011; Gurtcheff, 2011
Reproductive Life Planning

- Begin in the prenatal period
- Align future pregnancy intentions with contraception method
- Use PMH risk screening form to determine intendedness of current pregnancy
- Goal: facilitating reproductive life plan, guide patient to the most effective contraception
Immediate Postpartum LARC: Insurance / Medicaid

- Challenges limit availability of hospital reimbursement for devices
- Success in other states: South Carolina
- NC exploring expanding access:
  - Key stakeholders working together
- Medicaid has capacity to reimburse providers for PP LARC & for insertion

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Medicaid Coverage

- All contraceptive methods, including LARC
- ** Local CCNC OB team is willing to provide leadership **
  - Work with your hospital to discuss processes for reimbursement for immediate PP insertion
- PMH practices need to optimize LARC provision
  - LARC stocking/ reimbursement
  - Reach out to CCNC OB team for assistance

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Available LARC in the postpartum

ParaGard®
intraterine copper contraceptive

Mirena®
(levonorgestrel-releasing intrauterine system) 20µg/day

Liletta™
(levonorgestrel-releasing intrauterine system) 52 mg

Nexplanon®
(etonogestrel implant) 68mg Radiopaque

Skyla®
(levonorgestrel-releasing intrauterine system) 13.5 mg

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Available LARC in the postpartum

<table>
<thead>
<tr>
<th>LARC product</th>
<th>CPT/ HCPCS Code</th>
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<tbody>
<tr>
<td>Mirena IUD</td>
<td>J7302-FP</td>
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<tr>
<td>Nexplanon</td>
<td>J7307-FP</td>
</tr>
<tr>
<td>ParaGard IUD</td>
<td>J7300-FP</td>
</tr>
<tr>
<td>Skyla IUD</td>
<td>J7301-FP</td>
</tr>
<tr>
<td>Liletta IUD</td>
<td>J7302-FP</td>
</tr>
</tbody>
</table>

*Liletta and Mirena currently share a billing code (J7302)*

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Postpartum LARC Pathway: Resources

- CDC MEC Contraception
- Larcfirst.com
  - Counseling videos and scripts for providers
- Bedsider.org
- ACOG Publications
  - Committee Opinion No. 450
  - Committee Opinion No. 539
- Dr. Paul Blumenthal’s video PP vaginal IUD insertion: https://www.youtube.com/watch?v=uMcTsuf8XxQ
References

- Speroff L, Mishell DR. The postpartum visit: it’s time for a change in order to optimally initiate contraception. Contraception. 2008. 78:90-8.
- Shimoni N, Davis A, Westhoff C. Can ultrasound predict IUD expulsion after medical abortion? Contraception. Published online: 21 January 2014
- Chen BA, Reeves MF, Creinin MD, and Schwarz EB. Postplacental or delayed levonorgestrel intrauterine device insertion and breast-feeding duration. Contraception. 84 (5). 2011. 499-504.
- Dahlke JD, Terpstra ER, Ramseyer AM, Busch JM, Rieg T, Magann EF. Postpartum insertion of levonorgestrel-intrauterine system at three time periods: a prospective randomized pilot study. Contraception. Sep 2011;84(3):244-248
Questions?

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