LARC Learning Community

Federal Partners: CDC, CMS, OPA
National Partners: ACOG, AMCHP, NFPRHA
Agenda

2:00 Welcome and Introductions
2:10 Safety of LARC for Breastfeeding Women
2:30 Lactation and Hormonal Contraception
2:55 LARC Learning Community Data, Monitoring, and Evaluation
3:25 Group State Reports: Success in Numbers
3:50 Next Steps
3:58 Closing
4:00 Adjourn
Webinar Objectives

- Review CDC’s Contraceptive Guidance on safety of contraceptives among breastfeeding women and evidence on safety of LARC devices during breastfeeding, and describe translation and limitations of evidence for breastfeeding and LARC

- Discuss ethical issues raised at the intersection of breastfeeding and family planning counseling at the bedside

- Review key informant interview results from Cohorts 1 and 2

- Examine a tool for evaluation progress towards IPP LARC implementation

- Learn about successes of LARC learning community states over the past year
Welcome and Introductions

Welcome from ASTHO

- Lisa Waddell, MD, MPH
  Community Health and Prevention Chief
Safety of Long-Acting Reversible Contraception for Breastfeeding Women

Naomi K. Tepper, MD, FACOG
Medical Officer, Division of Reproductive Health, CDC
Safety of long-acting reversible contraception for breastfeeding women

Naomi K. Tepper, MD, MPH, FACOG
Medical Officer
Division of Reproductive Health
Centers for Disease Control and Prevention
BACKGROUND
Importance of breastfeeding

Benefits to infant
- Reduced risks of respiratory infections, GI complications, asthma, diabetes, obesity, sudden infant death

Benefits to mother
- Reduced risks of breast cancer, ovarian cancer

Psychological benefits, economic benefits

Importance of breastfeeding

- **Public health priority**
  - **US Surgeon General’s Call to Action**
    - Recommends strategies to support breastfeeding
  - **US Preventive Services Task Force**
    - Recommends providing interventions during and after pregnancy to support breastfeeding
  - **Healthy People 2020 Objectives, e.g.**
    - Increase proportion of infants who are breastfed
    - Increase proportion of employers that have worksite lactation support programs
    - Reduce proportion of breastfed newborns who receive formula within first 2 days of life

Importance of postpartum contraception

- **Prevention of unintended pregnancy**
  - 45% of pregnancies in U.S. are unintended (mistimed and unwanted)
  - Associated with later entry into prenatal care, decreased smoking cessation, increased low birth weight, decreased breastfeeding

- **Prevention of short birth intervals**
  - Associated with low birth weight, preterm birth

- **Immediately postpartum is important time to initiate contraception because women access healthcare, may not follow up for postpartum visit**

Concerns about hormonal contraceptives

- **Effect on breastfeeding performance?**
  - Progesterone plays a role in initiation and maintenance of lactation; exogenous progestins could therefore impact breastfeeding performance

- **Effect on the infant?**
  - Rodent studies show that progesterone receptors are common in the developing brain, higher in male brain
  - Some progestins transfer to breast milk and can be detected in infant serum
  - Theoretical effects of progesterone in reproductive, neuroendocrine and cognitive function; little information in humans
CDC’S CONTRACEPTIVE GUIDANCE
US Medical Eligibility Criteria for Contraceptive Use (US MEC)

- Safety of contraceptive methods among women with certain characteristics or medical conditions
- Includes recommendations for postpartum and breastfeeding women

http://www.cdc.gov/reproductivehealth/unintendedpregnancy/usmec.htm
# US MEC Categories

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No restriction</td>
</tr>
<tr>
<td>2</td>
<td>Advantages generally outweigh theoretical or proven risks</td>
</tr>
<tr>
<td>3</td>
<td>Theoretical or proven risks usually outweigh advantages</td>
</tr>
<tr>
<td>4</td>
<td>Unacceptable health risk</td>
</tr>
</tbody>
</table>
Process for creating recommendations

- Conducted systematic review of evidence on key question
  - Does use of hormonal contraception among breastfeeding women compared with non-hormonal or no contraception have negative effect on breastfeeding or infant outcomes

- Presented evidence to experts in ob/gyn, family planning, breastfeeding, pediatrics, neuroscience, pharmacology

- Discussed translation of evidence into recommendations
Long-acting reversible contraceptives (LARCs)

- **Intrauterine device (IUD)**
  - Copper IUD: 10 years
  - Levonorgestrel-releasing IUD (LNG-IUD): 3 or 5 years

- **Implant**
  - Etonogestrel: 3 years

- **Most effective reversible methods**

- **<1 pregnancy per 100 women per year**
EVIDENCE AND RECOMMENDATIONS
Outline for evidence review

- **Levonorgestrel IUDs**
  - Initiation at <6 wks vs ≥6 wks
  - Initiation at <6 wks vs non-hormonal
  - Initiation at ≥6 wks vs non-hormonal

- **Implants**
  - Initiation at <6 wks vs ≥6 wks
  - Initiation at <6 wks vs non-hormonal
  - Initiation at ≥6 wks vs non-hormonal
Outline for evidence review

- Levonorgestrel IUDs
  - Initiation at <6 wks vs ≥6 wks
  - Initiation at <6 wks vs non-hormonal
  - Initiation at ≥6 wks vs non-hormonal

- Implants
  - Initiation at <6 wks vs ≥6 wks
  - Initiation at <6 wks vs non-hormonal
  - Initiation at ≥6 wks vs non-hormonal
## US MEC recommendations: IUDs

<table>
<thead>
<tr>
<th>POSTPARTUM (Breastfeeding or nonbreastfeeding, including postcesarean)</th>
<th>Copper IUD</th>
<th>LNG-IUD</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. &lt;10 min after delivery of placenta</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>B. 10 min after delivery of placenta to &lt;4 weeks</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>C. ≥4 wks</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>D. Puerperal sepsis</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>
Outline for evidence review

- **Levonorgestrel IUDs**
  - Initiation at <6 wks vs ≥6 wks
  - Initiation at <6 wks vs non-hormonal
  - Initiation at ≥6 wks vs non-hormonal

- **Implants**
  - Initiation at <6 wks vs ≥6 wks
  - Initiation at <6 wks vs non-hormonal
  - Initiation at ≥6 wks vs non-hormonal
Initiation of LNG-IUDs at <6 wks vs ≥6 wks

- **Braniff, 2015**
  - Randomized controlled trial (RCT) of immediate postcesarean (N=25) vs 6 weeks postpartum (N=19)
  - At 6 months, higher proportion breastfeeding in immediate (52%) vs delayed (12%) group

- **Chen, 2011 (RCT)**
  - RCT of immediate postpartum (N=50) vs 6-8 weeks postpartum (N=46)
  - At 6 months, higher proportion breastfeeding in delayed (24%) vs immediate (6%) group
  - At 6 months, higher proportion exclusively breastfeeding in delayed (13%) vs immediate (2%) group
  - No differences in initiation or mean duration of breastfeeding
## Comparison between Braniff and Chen studies

<table>
<thead>
<tr>
<th>Study component</th>
<th>Braniff, 2015</th>
<th>Chen, 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Immediate</td>
<td>Delayed</td>
</tr>
<tr>
<td>Population</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Location</td>
<td>Australia</td>
<td>United States</td>
</tr>
<tr>
<td>Mode of delivery</td>
<td>Planned elective C/S (reason not stated)</td>
<td>Vaginal</td>
</tr>
<tr>
<td>Race/ethnicity</td>
<td>~85% white, ~12% aboriginal/other</td>
<td>~55% white, ~45% black/other</td>
</tr>
<tr>
<td>Parity</td>
<td>&gt;90% parous</td>
<td>~50% parous</td>
</tr>
<tr>
<td>Methods</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate follow up at 6 months overall</td>
<td>21/25 (84%)</td>
<td>17/23 (74%)</td>
</tr>
<tr>
<td>Results</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate BF 6 mos</td>
<td>11/21 (52.4%)</td>
<td>2/17 (11.8%)</td>
</tr>
<tr>
<td>Exclusive BF 6 mos</td>
<td>Not reported</td>
<td>1/50 (2.0%) (0.05-10.6)</td>
</tr>
</tbody>
</table>
Initiation of LNG-IUDs at <6 wks vs ≥6 wks

- Braniff, 2015
  - No statistically significant difference in mean infant weight gain at 6 weeks, 3 months, or 6 months between early vs delayed IUD insertion groups
Outline for evidence review

- **Levonorgestrel IUDs**
  - Initiation at <6 wks vs ≥6 wks
  - Initiation at <6 wks vs non-hormonal
  - Initiation at ≥6 wks vs non-hormonal

- **Implants**
  - Initiation at <6 wks vs ≥6 wks
  - Initiation at <6 wks vs non-hormonal
  - Initiation at ≥6 wks vs non-hormonal
Initiation of LNG-IUDs at <6 wks vs non-hormonal

- **Heikkila, 1982**
  - RCT of LNG-IUD vs copper IUD initiated at 32-56 days postpartum
  - At 75 days, higher percent continuing to breastfeed in copper IUD group (79%) vs LNG-IUD group (56%)
  - No differences at 6 months
  - No differences in mean duration of breastfeeding
  - No differences in infant growth, health and development at 12 months
Outline for evidence review

- **Levonorgestrel IUDs**
  - Initiation at <6 wks vs ≥6 wks
  - Initiation at <6 wks vs non-hormonal
  - Initiation at ≥6 wks vs non-hormonal

- **Implants**
  - Initiation at <6 wks vs ≥6 wks
  - Initiation at <6 wks vs non-hormonal
  - Initiation at ≥6 wks vs non-hormonal
Initiation of LNG-IUDs at $\geq 6$ wks vs non-hormonal

- Shaamash, 2005
  - RCT of LNG-IUD vs copper IUD initiated at 6-8 weeks postpartum
  - No adverse effects on breastfeeding or infant outcomes

- Bahamondes, 2013
  - Cohort of LNG-IUD vs copper IUD initiated at 42 days postpartum
  - No adverse effects on breastfeeding or infant outcomes
Additional IUD-related complications

- **Expulsion**
  - Immediate (<10 min) and delayed (10 min to 72 hours) insertion higher risk for expulsion than interval insertion
  - Risk not higher among breastfeeding than non-breastfeeding women

- **Perforation**
  - Evidence limited, rare events
  - Risk may be higher among breastfeeding than non-postpartum women

- **Infection**
  - Evidence limited, rare events
  - Risk not higher among breastfeeding than non-breastfeeding women
Outline for evidence review

- **Levonorgestrel IUDs**
  - Initiation at <6 wks vs ≥6 wks
  - Initiation at <6 wks vs non-hormonal
  - Initiation at ≥6 wks vs non-hormonal

- **Implants**
  - Initiation at <6 wks vs ≥6 wks
  - Initiation at <6 wks vs non-hormonal
  - Initiation at ≥6 wks vs non-hormonal
US MEC recommendations: Implants

<table>
<thead>
<tr>
<th>POSTPARTUM (Breastfeeding)*</th>
<th>Implants</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. &lt;1 month</td>
<td>2</td>
</tr>
<tr>
<td>B. 1 month to &lt;6 months</td>
<td>1</td>
</tr>
<tr>
<td>C. ≥6 months</td>
<td>1</td>
</tr>
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</table>

* US DHHS recommends infants should be exclusively breastfed during first 4-6 months, preferably full 6 months. Ideally breastfeeding should continue through first year.
Outline for evidence review

- **Levonorgestrel IUDs**
  - Initiation at <6 wks vs >6 wks
  - Initiation at <6 wks vs non-hormonal
  - Initiation at >6 wks vs non-hormonal

- **Implants**
  - Initiation at <6 wks vs >6 wks
  - Initiation at <6 wks vs non-hormonal
  - Initiation at >6 wks vs non-hormonal
Initiation of implants <6 wks vs ≥6 wks

- **Gurtcheff, 2011**
  - RCT of etonogestrel implant 1-3 days postpartum (N=28) vs 4-8 weeks postpartum (N=29)
  - No differences between groups in lactation failure, exclusive breastfeeding at 6 months, supplementation at 6 months

- **Brito, 2009**
  - RCT of etonogestrel implant 24-48 hours postpartum (N=20) vs DMPA 6 weeks postpartum (N=20)
  - No difference in exclusive breastfeeding at 6 or 12 weeks (p-values not reported)
Initiation of implants <6 wks vs ≥6 wks

- **Seth, 1977**
  - Cohort of norethindrone implant 6 days postpartum (N=23) vs 6 weeks postpartum (N=12)
  - No difference in percent breastfeeding at 8 months
  - No difference in infant growth at 9 months

- **Brito, 2009**
  - No difference in infant growth at 6 or 12 weeks
Outline for evidence review

- **Levonorgestrel IUDs**
  - Initiation at <6 wks vs ≥6 wks
  - Initiation at <6 wks vs non-hormonal
  - Initiation at ≥6 wks vs non-hormonal

- **Implants**
  - Initiation at <6 wks vs ≥6 wks
  - Initiation at <6 wks vs non-hormonal
  - Initiation at ≥6 wks vs non-hormonal
## Initiation of implants <6 wks vs non-hormonal

<table>
<thead>
<tr>
<th>Author, year</th>
<th>Design</th>
<th>Contraception</th>
<th>Breastfeeding outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seth, 1977</td>
<td>Cohort</td>
<td>Implant (NET) (6 d pp)</td>
<td>Supplementation 3 months: Implant- 56% Non-hormonal- 40% (controls) (p&lt;0.05) Not significant at 8 mos</td>
</tr>
<tr>
<td>Shaaban, 1985</td>
<td>Cohort</td>
<td>Implant (LNG) (30-42 d pp)</td>
<td>No adverse effects</td>
</tr>
<tr>
<td>Shaaban, 1991</td>
<td>Cohort</td>
<td>Implant (LNG) (5-7 wks pp)</td>
<td>No adverse effects</td>
</tr>
<tr>
<td>Abdel-Aleem, 1996</td>
<td>Cohort</td>
<td>Implant (nomegestrol) (2nd mo pp)</td>
<td>No adverse effects</td>
</tr>
<tr>
<td>Reinprayoon, 2000 and Taneepanichskul, 2006</td>
<td>Cohort</td>
<td>Implant (ETG) (28-56 d pp)</td>
<td>No adverse effects</td>
</tr>
<tr>
<td>Braga, 2015</td>
<td>RCT</td>
<td>Implant (ETG) (48 hrs pp)</td>
<td>No adverse effects (exclusive BF 6 wks)</td>
</tr>
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## Initiation of implants <6 wks vs non-hormonal

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<tr>
<td>Abdulla, 1985</td>
<td>Cohort</td>
<td>Implant (LNG) (30-39 d pp)</td>
<td>No adverse effects</td>
</tr>
<tr>
<td>Shaaban, 1985</td>
<td>Cohort</td>
<td>Implant (LNG) (30-42 d pp)</td>
<td>Slower weight gain 3 mos, no diff 4-6 mos</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Slower length increase 3-6 mos (vs non-hormonal)</td>
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<tr>
<td>Affandi, 1986</td>
<td>Cohort</td>
<td>Implant (LNG) (4-6 wks pp)</td>
<td>No adverse effects</td>
</tr>
<tr>
<td>Shikary, 1986</td>
<td>Cohort</td>
<td>Implant (LNG) (4 wks pp)</td>
<td>No adverse effects</td>
</tr>
<tr>
<td>Shaaban, 1991</td>
<td>Cohort</td>
<td>Implant (LNG) (5-7 wks pp)</td>
<td>No adverse effects</td>
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<tr>
<td>Reinprayoon, 2000 and Taneepanichskul, 2006</td>
<td>Cohort</td>
<td>Implant (ETG)</td>
<td>No adverse effects</td>
</tr>
<tr>
<td>Braga, 2015</td>
<td>RCT</td>
<td>Implant (ETG) (48 hrs pp)</td>
<td>No adverse effects (infant wt 6 wks pp)</td>
</tr>
</tbody>
</table>
Outline for evidence review

- **Levonorgestrel IUDs**
  - Initiation at <6 wks vs ≥6 wks
  - Initiation at <6 wks vs non-hormonal
  - Initiation at ≥6 wks vs non-hormonal

- **Implants**
  - Initiation at <6 wks vs ≥6 wks
  - Initiation at <6 wks vs non-hormonal
  - Initiation at ≥6 wks vs non-hormonal
### Initiation of implants ≥6 wks vs non-hormonal

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<tr>
<td>Seth, 1977</td>
<td>Cohort</td>
<td>Implant (NET) (6 wks pp)</td>
<td>No adverse effects</td>
</tr>
<tr>
<td>WHO, 1994 (2 reports)</td>
<td>Cohort</td>
<td>Implant (LNG) (6-8 wks pp)</td>
<td>No adverse effects</td>
</tr>
<tr>
<td>Diaz, 1997</td>
<td>Cohort</td>
<td>Implant (LNG) (57 d pp)</td>
<td>No adverse effects</td>
</tr>
<tr>
<td>Diaz, 1999</td>
<td>Cohort</td>
<td>Implant (LNG) (57 d pp)</td>
<td>No adverse effects (fully BF, duration BF, through 12 mos)</td>
</tr>
<tr>
<td>Schiappacasse, 2002</td>
<td>Cohort</td>
<td>Implant (LNG) (55 d pp)</td>
<td>Fully BF at 12 mos: lower in implant group vs Cu-IUD group No differences in mean and total duration</td>
</tr>
<tr>
<td>Bahamondes, 2013</td>
<td>Cohort</td>
<td>Implant (ETG) (42 d pp)</td>
<td>No adverse effects (BF continuation at 6 mos)</td>
</tr>
</tbody>
</table>
## Initiation of implants ≥6 wks vs non-hormonal

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</tr>
<tr>
<td>WHO, 1994 (2 reports)</td>
<td>Cohort</td>
<td>Implant (LNG) (6-8 wks pp)</td>
<td>Some comparisons favored non-hormonals, others favored implants, most comparisons similar in developmental tests</td>
</tr>
<tr>
<td>Diaz, 1997</td>
<td>Cohort</td>
<td>Implant (LNG) (57 d pp)</td>
<td>No adverse effects</td>
</tr>
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<td>Cohort</td>
<td>Implant (LNG) (57 d pp)</td>
<td>No adverse effects</td>
</tr>
<tr>
<td>Schiappacasse, 2002</td>
<td>Cohort</td>
<td>Implant (LNG) (55 d pp)</td>
<td>Incidence resp infections and skin conditions higher in implant group, lower incidence of urogenital disease and psychomotor impairment, no differences in growth vs Cu IUD</td>
</tr>
<tr>
<td>Bahamondes, 2013</td>
<td>Cohort</td>
<td>Implant (ETG) (42 d pp)</td>
<td>Smaller increase in tibial length in implant vs Cu-IUD (p=0.03) No difference in infant weight or height</td>
</tr>
</tbody>
</table>
Summary of evidence on LARCsg and breastfeeding

- **IUDs**
  - 1 new RCT found adverse effects on breastfeeding with immediate vs delayed LNG-IUD initiation, 1 new RCT did not
  - Rest of studies found generally no negative impact on breastfeeding or infant outcomes

- **Implants**
  - 1 new RCT found no adverse effects on BF with immediate vs delayed ETG implant initiation
  - Rest of studies found generally no negative impact on breastfeeding or infant outcomes

Cochrane review

- Published in 2015
- RCTs on hormonal contraception vs other hormonal contraception, nonhormonal contraception or placebo
- Conclusion:
  - Most trials did not find significant differences in breastfeeding duration, breast milk composition, or infant growth
  - Limited trials on any particular hormonal method
  - Future research on POCs, including LARCs
  - Future research on effects of initiation time on breastfeeding and infant health

Maternal perception of milk supply

- 15 studies which reported maternal perception of breastmilk supply after starting POCs
  - Variety outcomes, i.e.
    - Impression of milk production
    - Report of decreased milk or not enough milk
    - Report of satisfaction with milk production
    - D/c BF due to insufficient milk
  - 14 studies generally found no difference between POC and non-hormonal group
    - 9 initiated POCs within 1 wk pp
LIMITATIONS OF EVIDENCE
Limitations

- **Population**
  - Healthy women with previous breastfeeding experience; healthy term infants

- **Exposures**
  - Unclear timing of contraceptive initiation, comparison groups
  - **Few studies on POC initiation immediately postpartum**

- **Outcomes**
  - Varied and not well-defined, no long-term follow up for infant growth and development

- **Methodology**
  - Observational studies, methods not clearly described
US MEC recommendations: Lactational Amenorrhea Method

- Lactational Amenorrhea Method (LAM) can be used safely and effectively if all of 3 criteria are met:
  - Amenorrhea
  - Fully or nearly fully breastfeeding
  - <6 months postpartum
- LAM safe for all women
- Breastfeeding not recommended for women or infants with certain conditions (e.g. HIV, H1N1 influenza)
For more information please contact Centers for Disease Control and Prevention

1600 Clifton Road NE, Atlanta, GA 30333
Telephone: 1-800-CDC-INFO (232-4636)/TTY: 1-888-232-6348
E-mail: cdcinfo@cdc.gov  Web: http://www.cdc.gov

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

CDC’s Contraceptive Guidance:
http://www.cdc.gov/reproductivehealth/unintendedpregnancy/contraception_guidance.htm
US MEC recommendations: POP and DMPA

<table>
<thead>
<tr>
<th>POSTPARTUM (Breastfeeding)*</th>
<th>POP</th>
<th>DMPA</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. &lt;1 month</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>B. 1 month to &lt;6 months</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>C. ≥6 months</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

* US DHHS recommends infants should be exclusively breastfed during first 4-6 months, preferably full 6 months. Ideally breastfeeding should continue through first year.
Summary of evidence on DMPA

- **Initiation <6 wks vs >6 wks**
  - Breastfeeding outcomes: no evidence
  - Infant outcomes (2 studies): 1 study with higher incidence of infectious disease with early initiation

- **Initiation <6 wks vs non-hormonal**
  - Breastfeeding outcomes (12 studies): no adverse effects
  - Infant outcomes (7 studies): no adverse effects

- **Initiation >6 wks vs non-hormonal**
  - Breastfeeding outcomes (3 studies): no adverse effects
  - Infant outcomes (3 studies): most comparisons with no adverse effects
Summary of evidence on POPs

- **Initiation <6 wks vs ≥6 wks**
  - Breastfeeding outcomes: no evidence
  - Infant outcomes: no evidence

- **Initiation <6 wks vs non-hormonal**
  - Breastfeeding outcomes (10 studies): no adverse effects
  - Infant outcomes (8 studies): no adverse effects

- **Initiation ≥6 wks vs non-hormonal**
  - Breastfeeding outcomes (4 studies): 1 study with earlier supplementation
  - Infant outcomes (4 studies): most comparisons with no adverse effects
Systematic review of evidence on POCs and breastfeeding

- 51 articles describing 46 studies
- Recently published randomized controlled trials (RCTs)
  - 1 new RCT found adverse effects on BF with immediate vs delayed LNG-IUD initiation, 1 new RCT did not
  - 1 new RCT found no adverse effects on BF with immediate vs delayed ETG implant initiation
- Evidence generally does not show adverse effects of POCs on:
  - Breastfeeding clinical outcomes
  - Infant health, growth, or development in the first year postpartum

US MEC recommendations: CHCs

<table>
<thead>
<tr>
<th>POSTPARTUM (Breastfeeding*)</th>
<th>COC/Patch/Ring</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. &lt;21 days</td>
<td>4</td>
</tr>
<tr>
<td>B. 21 to &lt;30 days</td>
<td></td>
</tr>
<tr>
<td>i. With other risk factors for VTE</td>
<td>3†</td>
</tr>
<tr>
<td>ii. Without other risk factors for VTE</td>
<td>3</td>
</tr>
<tr>
<td>C. 30-42 days</td>
<td></td>
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<tr>
<td>i. With other risk factors for VTE</td>
<td>3†</td>
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<tr>
<td>ii. Without other risk factors for VTE</td>
<td>2</td>
</tr>
<tr>
<td>D. &gt;42 days</td>
<td>2</td>
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* US DHHS recommends infants should be exclusively breastfed during first 4-6 months, preferably full 6 months. Ideally breastfeeding should continue through first year.

† Other risk factors for VTE might increase classification to “4”.

Breastfeeding*
Systematic review of evidence on COCs and breastfeeding

- 15 articles describing 13 studies
- COCs initiated <6 weeks postpartum
  - Breastfeeding outcomes: evidence conflicting, some negative impact
  - Infant outcomes: evidence conflicting, some negative impact
- COCs initiated ≥6 weeks postpartum
  - Breastfeeding outcomes: evidence conflicting, some negative impact
  - Infant outcomes: generally no negative impact

Questions?
Lactation and Hormonal Contraception

Alison Stuebe, MD, MSc
Associate Professor, UNC Department of Obstetrics and Gynecology, Division of Fetal Medicine
Lactation and hormonal contraception

Alison Stuebe, MD, MSc
astuebe@med.unc.edu
Outline

• Progesterone withdrawal is implicated in the physiology of lactogenesis II
• Disrupted lactation is common among women in the U.S.
• There are known risk factors for early lactation difficulties
• Might women at risk of breastfeeding difficulties be more vulnerable to early POC exposure?
• Case presentations and ethical discussion
Falling levels of progesterone postpartum coincide with upregulation of prolactin receptors, onset of lactose synthesis and milk production.

2 out of 3 women wean earlier than they had intended

How old do you think your baby will be when you completely stop breastfeeding?

How old was your baby when you completely stopped breastfeeding and pumping milk?

Did you breastfeed as long as you wanted to?

Breastfed ≥ 12 months 18%

Expected, desired 12%

Expected, undesired 4%

Early, desired 21%

Early, undesired 45%

‘Given uncertainty regarding the true effect of ENG implants on lactation, it seems prudent for healthcare providers to counsel each woman about a possible effect on milk supply so that she can monitor her infant for signs of impaired milk transfer.’

Maternal Risk Factors for Lactation Problems

- History of previous breastfeeding problems or breastfed infant with slow weight gain
- History of hormone-related infertility
- Significant medical problems (e.g., untreated hypothyroidism, diabetes, cystic fibrosis)
- Maternal age (e.g., adolescent mother or advanced age)
- Psychosocial problems, especially depression
- Perinatal complications (e.g., hemorrhage, hypertension, infection)
- Lack of noticeable breast enlargement during pregnancy
- Flat or inverted nipples
- Variation in breast appearance (marked asymmetry, hypoplastic, tubular)
- Previous breast surgery that severed milk ducts or nipple afferent nerves
- Previous breast surgery to correct abnormal appearance or developmental variants
- Previous breast abscess
- Extremely or persistently sore nipples
- Mother and infant separation or mother needing to pump
Infant Risk Factors for Lactation Problems

- Low birth weight or preterm (<37 weeks)
- Multiples
- Difficulty latching on to one or both breasts
- Ineffective or unsustained suckling
- Oral anatomic abnormalities (cleft lip / palate, micrognathia, macroglossia)
- Medical problems (jaundice, hypoglycemia, respiratory distress, infection)

- Neurologic problems (genetic syndromes, hypotonia, or hypertonia)
- Persistently sleepy infant
- Excessive infant weight loss
- Formula supplementation
- Effective breastfeeding not established by hospital discharge
- Early discharge from hospital
- Early pacifier use
Might women at risk of breastfeeding difficulties be more vulnerable to early POC exposure?

- **Prior lactation history**
  - abrupt decrease in milk supply following initiation of hormonal contraception
  - previous breastfeeding problems or breastfed infant with slow weight gain

- **Perinatal complications**
  - hemorrhage, hypertension, infection
  - prolonged second stage, cesarean birth

- **Maternal BMI > 30 kg/m²**

- **Infant complication**
  - mother and infant separation or mother needing to pump
  - low birth weight or preterm (<37 weeks)
  - multiple gestation
Shared Decision Making

- Shared decision making brings at least two experts to the table, the patient and the provider, although family members and other members of the care team may be involved. The provider is an expert in the clinical evidence. Patients are experts in their experiences and what matters most to them.

- Shared decision making honors both experts’ knowledge. And through this process of informing and involving the patient, high-quality decisions that align with patient preferences are achievable.

http://www.informedmedicaldecisions.org/shareddecisionmaking.aspx
… in discussion with the patient, clinicians should discuss the risks, benefits, availability, and affordability of all methods. This discussion should address contraceptive efficacy and possible impact on breastfeeding outcomes, within the context of each woman's desire to breastfeed, risk of breastfeeding difficulties, and risk of unplanned pregnancy.
Data are limited, however, and theoretical concerns exist because progesterone withdrawal after delivery of the placenta is thought to trigger onset of lactogenesis, so exogenous progesterone could prevent onset of milk production. Obstetric care providers should discuss these limitations and concerns within the context of each woman’s desire to breastfeed and her risk of unplanned pregnancy, so that she can make an autonomous and informed decision.

Case

• 15 yo G2P0111 delivered via SVD at 26 weeks
• Lactation consultant entered her room on day of discharge as resident was consenting her for Nexplanon placement
  » LC asked medical student whether breastfeeding was discussed
  » Once prompted, he resident advised the patient of “a possibility” that the implant could impact her milk supply

I just talked to one of the lactation consultants who advises women that immediate postpartum contraception (nexplanon) may decrease milk supply. I'm not aware of any literature to support this. This was in a 15 year on her second preg who just delivered a 25 weeker. Obviously I'm all for her breastfeeding but I feel like presenting her something that is based on the lc's experience is not really neutral and fair especially in such a high risk teen and when the literature on PP immediate contraception is so compelling. Ok rant over....
It's complicated – there are no studies adequately powered to determine whether Nexplanon might disrupt onset of lactogenesis. We know progesterone withdrawal is critical to trigger milk production. For a 25-weeker, mom's milk can be the difference between NEC and no NEC, which is a clinically significant issue. My take is that mom should be informed of a theoretical risk to milk supply, within the context of their risk of recurrent pregnancy.

Yeah, the 15-year-old is about as tough as it gets. However, I think it's appropriate in the spirit of informed consent to cancel the patient: "there is a theoretical risk to your milk supply; however, I am much more worried about your risk of getting pregnant again. We know that Nexplanon will prevent that. Therefore, I recommend that you use this method."

Counsel, not cancel...

Siri is imperfect...

I appreciate the clinical significance of nec and no nec in a 25 Weeker - I am pro boob but I don't think we can weigh a theoretical risk the same as a documented and well studied risk of recurrent pregnancy...
Ethical considerations

- What are the morally relevant distinctions between and tensions across advocacy and clinical care? What are the different ways of relating to postpartum women, morally speaking, and what do they entail?
- What are the goals of informed consent?
- What is meant by respect for autonomy, and what are challenges to achieving it?
- What model(s) of the physician-patient relationship and decision-making are appropriate for the breastfeeding/contraception context?

Adapted from Annie Lyerly’s presentation at BFIC
Questions?
Data, Monitoring, and Evaluation: 
Cohort 1&2 Key Informant Interviews and 
Immediate Postpartum LARC Assessment Tool

- Key Informant interviews
  - Cohort 1 – February/March 2016 (Second Interview)
    – First interview August 2014
  - Cohort 2 – November/December 2015

- Immediate Postpartum LARC tool
  - Technical assistance requests from states
  - How can we streamline the multiple agencies, benchmarks, and goals for LARC immediately postpartum?
  - Voluntary
  - Looking for volunteers to try out the tool
LARC Learning Community Data, Monitoring, and Evaluation

Kristin Rankin, PhD
Assistant Professor, Division of Epidemiology and Biostatistics, University of Illinois at Chicago School of Public Health
Summary of Learning Community Evaluation Activities

Kristin Rankin, PhD, Assistant Professor, Epidemiology and Biostatistics
Carla DeSisto, MPH, Doctoral Student in MCH Epidemiology
Cameron Estrich, MPH, Doctoral Student in Community Health Sciences

University of Illinois at Chicago School of Public Health
Evaluation Team Goal and Activities

**Goal:** Contribute to *Data, Monitoring, and Evaluation* domain of the Learning Community by gathering and disseminating data to advance IPP LARC implementation

**Activities:**

1. In-person meeting participation and dissemination of ideas from meeting:
   

2. Key informant interviews and reports for Cohort 1 and Cohort 2 teams

3. Development of draft IPP LARC State Monitoring Tool to help states evaluate efforts
Key Informant Interviews

• November/December 2015 – Cohort 2 state team interviews
• February/March 2016 – Cohort 1 state team interviews
• Slightly different interview guides
Aims of the Key Informant Interviews

• Understand facilitators, barriers, and strategies under each of the eight domains of the Learning Community

• Summarize technical assistance needs of Learning Community teams

• Characterize strengths and opportunities for the Learning Community (Cohort 1)
Cross-Cutting Themes

• Mentorship of Cohort 1 to Cohort 2 teams for changing reimbursement policy and encouragement to join Learning Community

• IPP LARC during Learning Community events, including key informant interview process, provide dedicated opportunities for teams to meet internally to re-group and plan, when otherwise time is limited or otherwise committed

• Some state teams have hired dedicated staff for IPP LARC implementation as a strategy to ensure progress
Domain 1: Provider Training

Facilitator:
- OB/GYN resident training programs

Barrier:
- Some states do not have the financial or human resources necessary to conduct provider training

Strategies:
- Planning trainings with provider organizations, such as ACOG
- Conducting outreach visits to perinatal networks or hospitals across the state
- Leveraging telehealth for training and technical assistance
- Engaging facility-level clinical champions to conduct peer-to-peer training
Domain 2: Reimbursement and Sustainability

Facilitator:

• Existing partnerships/collaboration with Medicaid Managed Care Organizations

Barriers:

• Concerns at Medicaid agency about unbundling IPP LARC from delivery reimbursement in an era when most new payment strategies are focused on bundling services
• Coders in some hospitals don’t trust that they can submit an outpatient claim at the same time as inpatient claim, despite being trained to do so specifically for IPP LARC

“Placing IPP IUDs is easy - the tough part is convincing [providers and hospitals] they’ll get reimbursed.”

Strategies:

• Leveraging public funds, including Title V and Title X, to support IPP LARC activities
• Engaging private foundations or non-profit organizations to fund implementation efforts
Domain 3: Informed Consent and Ethical Concerns

Facilitator:
• Birthing facilities use existing hospital consent processes for IPP LARC procedures

Barrier:
• For women with late or no prenatal care, efforts to “protect” a woman from coercion by not counseling about and offering IPP LARC during labor at the hospital may create barriers to access for women who may desire IPP LARC if fully informed

Strategies:
• Incorporating discussions about preventing coercion during trainings with providers
• Drafting IPP LARC consent language to distribute to hospitals around the state, which can be modified
Domain 4: Stocking and Supply

Facilitator:
- For large hospitals, “buy and bill” is not a financial burden

Barrier:
- For small hospitals, “buy and bill” can be a financial burden

Strategies:
- Storing devices in a Pyxis on the labor and delivery floor to ensure immediate availability of IUDs; bedside tackle boxes for implant supplies
- Approaching device manufacturers to request that devices be donated or loaned to hospitals and later purchased if used, or returned if not used
- Engaging pharmacy staff in planning efforts for IPP LARC in facilities
Domain 5: Outreach

Facilitators:
- The power of word of mouth among women as LARCs become more popular
- Recent state and national positive media attention about LARC

Barriers:
- Lack of funding for outreach activities
- It is premature to broadly advertise the new reimbursement policy to women served by Medicaid before ensuring that birthing facilities are able to offer IPP LARC
- Political context in some states

Strategies:
- Partnering with Title X and the Campaign to Prevent Teen Pregnancy in general public outreach efforts to educate about and promote LARCs
- Using technology and social media to reach out to the public, specifically to young women
Domain 6: Stakeholder Partnerships

Facilitators:

• Strong existing collaborations in several states between Medicaid and public health department, especially when both are part of a larger super-agency
• Perinatal quality collaboratives are the central hub for IPP LARC activities in some states

Barrier:

• Lack of relationships and alignment of approaches with breastfeeding advocates

Strategies:

• Leveraging existing MCH consortia to reach more partners
• Collaborating with academic partners for research and evaluation
• Partnering with hospital associations to disseminate policies, protocols, and toolkits
Domain 7: Service Locations

Facilitator:

- Teams in states with fewer facilities have intimate knowledge of each

Barriers:

- In states with many birthing facilities, permeating those facilities is challenging
- Resistance by religiously-affiliated birthing facilities

Strategies:

- Developing or adapting an existing toolkit for dissemination to improve facility readiness
- Identifying and developing a provider within each facility to champion facility-wide IPP LARC implementation until it is part of standard care
- Piloting implementation protocols in one or more facility within the state, usually including a large academic medical center
Domain 8: Data, Monitoring, and Evaluation

Facilitator:

• Partnerships with academia to conduct monitoring and evaluation

Barriers:

• Structure of Medicaid claims data makes identification of IPP LARC procedures is challenging
• Lack of analytic capacity to conduct IPP LARC monitoring and evaluation work in many states
• “What does successful implementation look like?”

Strategies:

• Establishing data-sharing and data-use agreements between the health department and Medicaid to analyze and link Medicaid claims data with birth records
• Proposing a new field on state’s birth certificate record to track IPP LARC receipt
• Triangulating with other data sources (e.g., PRAMS) to monitor state trends in postpartum LARC uptake
Remaining Technical Assistance Needs

• Sharing of facility toolkits, protocols, and other resources to improve operations at birthing facilities across state teams

• Sharing provider and pharmacy notices across state teams, which could be modified to communicate how to code, bill, and stock devices in each state

• Sharing strategies across states for covering uninsured women for IPP LARC

• Developing resources for planning effective outreach campaigns for women

• Brainstorming work-arounds or solutions in religiously affiliated hospitals

• Brainstorming strategies for fostering relationships with breastfeeding advocates at a local and national level to facilitate alignment of approaches to improve MCH
Next Steps for Key Informant Interview Data

• Reports disseminated to Learning Community participants

• Further, in-depth qualitative analysis of the transcripts of the recorded interviews

• One or more manuscripts for peer-reviewed journals to disseminate information more broadly within to scientific community
Response to Team Data Needs

• Need expressed by teams during interviews and at the in-person meeting for standard measures to monitor and evaluate state IPP LARC efforts

• IPP LARC State Monitoring Tool developed to assist teams in monitoring efforts
  • Series of measures calculated from existing claims data
  • Table and chart templates for disseminating results to stakeholders
  • Flexibility to modify tool to meet state needs
## Immediate Postpartum LARC Implementation - Year 1 Summary Indicators

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<th>What this evaluates</th>
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<td>10.7%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 1A. Birthing Facility Billing for IPP LARC

Percentage of birthing facilities in the state that have billed for IPP LARC

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Quarter 1</td>
<td>Quarter 2</td>
</tr>
<tr>
<td>Total number of birthing facilities in state that have billed for IPP LARC</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Total number of birthing facilities in state</td>
<td>28</td>
<td>28</td>
</tr>
<tr>
<td>Proportion of birthing facilities that have billed for IPP LARC</td>
<td>7%</td>
<td>11%</td>
</tr>
</tbody>
</table>

#### Graphs

**Birthing Facilities Billing for IPP LARC, Year 1**

- % that have billed for IPP LARC:
  - Quarter 1: 7%
  - Quarter 2: 11%
  - Quarter 3: 11%
  - Quarter 4: 14%

**Birthing Facilities Billing for IPP LARC, Year 2**

- % that have billed for IPP LARC:
  - Quarter 1: 0%
  - Quarter 2: 0%
  - Quarter 3: 0%
  - Quarter 4: 0%
## IPP LARC State Monitoring Tool – Indicator #2

<table>
<thead>
<tr>
<th>Indicator Name</th>
<th>Numerator Description</th>
<th>Numerator #</th>
<th>Denominator Description</th>
<th>Denominator #</th>
<th>Measure % Description</th>
<th>Measure %</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. IPP LARC coverage</td>
<td># of Medicaid-paid deliveries occurred at birthing facilities that have billed for IPP LARC</td>
<td>7788</td>
<td># of Medicaid-paid deliveries in state</td>
<td>19300</td>
<td>Proportion of Medicaid deliveries that take place at facilities that have billed for IPP LARC</td>
<td>40.4%</td>
</tr>
<tr>
<td>Indicator Name</td>
<td>Numerator Description</td>
<td>Numerator #</td>
<td>Denominator Description</td>
<td>Denominator #</td>
<td>Measure % Description</td>
<td>Measure %</td>
</tr>
<tr>
<td>---------------------</td>
<td>------------------------------------------------------------</td>
<td>-------------</td>
<td>------------------------------</td>
<td>---------------</td>
<td>----------------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>3. IPP LARC uptake</td>
<td># of IPP LARCs billed for at facilities that bill for IPP LARC</td>
<td>122</td>
<td># of Medicaid births at facilities that bill for IPP LARC</td>
<td>7788</td>
<td>Proportion of delivering women receiving IPP LARC, where IPP LARC available</td>
<td>1.6%</td>
</tr>
</tbody>
</table>
### 3C. Uptake

**Immediate postpartum LARC placement by patient characteristics**

Among Deliveries in Facilities Billing for IPP LARC

1st year data stratified by patient age

<table>
<thead>
<tr>
<th>Patient Age at Insertion</th>
<th>15-19</th>
<th>20-24</th>
<th>25-29</th>
<th>30-34</th>
<th>35-39</th>
<th>40-44</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Medicaid-paid deliveries with IPP LARC placement claims</td>
<td>61</td>
<td>62</td>
<td>32</td>
<td>26</td>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td>Total # of Medicaid-paid deliveries</td>
<td>935</td>
<td>1644</td>
<td>2054</td>
<td>1587</td>
<td>1134</td>
<td>434</td>
</tr>
<tr>
<td>Proportion of IPP LARCs placed by patient age</td>
<td>7%</td>
<td>4%</td>
<td>2%</td>
<td>2%</td>
<td>1%</td>
<td></td>
</tr>
</tbody>
</table>

**IPP LARC Placements by Age, Year 1**

<table>
<thead>
<tr>
<th>Age at IUD Placement</th>
<th>% with IPP LARCs placed</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-19</td>
<td>7%</td>
</tr>
<tr>
<td>20-24</td>
<td>4%</td>
</tr>
<tr>
<td>25-29</td>
<td>2%</td>
</tr>
<tr>
<td>30-34</td>
<td>2%</td>
</tr>
<tr>
<td>35-39</td>
<td>1%</td>
</tr>
<tr>
<td>40-44</td>
<td>1%</td>
</tr>
<tr>
<td>Indicator Name</td>
<td>Numerator Description</td>
</tr>
<tr>
<td>----------------------</td>
<td>-------------------------------------------</td>
</tr>
<tr>
<td>4. IUD removal</td>
<td># of IUD removal claims within 60 days of IPP IUD placement</td>
</tr>
<tr>
<td>5. Implant removal</td>
<td># of implant removal claims within 60 days of IPP implant placement</td>
</tr>
</tbody>
</table>
## Definitions based on Contraceptive Use Measures

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-9</th>
<th>ICD-10</th>
<th>CPT</th>
<th>Healthcare Common Procedure Coding System Code (HCPCS)</th>
<th>NDC</th>
</tr>
</thead>
<tbody>
<tr>
<td>IUD placement</td>
<td>V25.11, Encounter for insertion of intrauterine contraceptive device 69.7, Insertion of intrauterine contraceptive device</td>
<td>V25.11 Insertion of intrauterine contraceptive device Z30.430 Encounter for insertion of intrauterine contraceptive device</td>
<td>58300, Insertion of IUD</td>
<td>J7300, Intrauterine copper contraceptive J7301, Levonorgestrel-releasing intrauterine contraceptive system, 13.5 mg J7302, Levonorgestrel-releasing intrauterine contraceptive system, 52 mg Q0090, Levonorgestrel-releasing intrauterine contraceptive system, (skyla), 13.5 mg J7297 Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 3 year duration J7298 Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 5 year duration S4981, Insertion of levonorgestrel-releasing intrauterine system</td>
<td>50419042101 50419042201 5128520401</td>
</tr>
<tr>
<td>Implant placement</td>
<td>V25.5, Encounter for insertion of implantable subdermal contraceptive,</td>
<td>Z30.016 Encounter for initial prescription of other contraceptives in ICD-10-CM.</td>
<td>11981, Insertion, non-biodegradable drug delivery implant, Implanon or Nexplanon</td>
<td>J7307 Etonogestrel [contraceptive] implant system, including implant and supplies</td>
<td></td>
</tr>
</tbody>
</table>
IPP LARC State Monitoring Tool Potential Uses

• Communicating with Medicaid analysts about data needs from claims

• Performing internal monitoring of progress over time and goalsetting (for facility-based access indicators only)

• Disseminating results in figures for stakeholders

• Comparing standardized indicators across states

• Others?
Additional Indicators?

• Claim Denial Rate

• Process Indicators (Requiring data collection beyond claims)

• Others?
Next Steps for IPP LARC Monitoring Tool

• Pilot with interested state teams

• Refine based on feedback

• Release to all state teams for their internal use

• Continued technical assistance
Questions?
State Reports: Success in Numbers

- Highlights from all states

- Successes in 6 Domains, many cross cutting
  - Provider Training
  - Reimbursement and Sustainability
  - Stocking and Supply
  - Stakeholder Partnerships
  - Service Location
  - Data, Monitoring, and Evaluation

- Iowa and Texas will present
  - Following state updates, time will be allotted for questions or reactions
State Successes: Training

Texas held a day-long lecture and demonstration on LARCs put on by the Texas Medical Association Committee on Maternal and Perinatal Health: 50 providers completed the training, including an IUD insertion practicum.

Delaware has trained 11 agencies representing 32 sites & 500 clinicians and staff through Upstream USA. Trainings are scheduled through October to include another 32 sites. The goal is to recruit and train between 65-80 provider sites.
State Successes: Reimbursement and Sustainability

- **Colorado** received additional funding and implemented a rural health provider LARC device carve-out for reimbursement
  - $2.5 million through Colorado legislative process
  - $2.6 million through 13 Colorado Foundations

- **Montana’s** Medicaid removed a barrier for all LARC reinsertion in December 2015 by removing a system limit that automatically denied any claim for members who had a LARC inserted in the previous 3 years. The removal of the system limit allows providers to reinsert LARCs at any time.
State Successes: Stocking and Supply

**Louisiana** Medicaid sent a Cheat Sheet with instructions on how to order, bill, and code LARC to their five managed care organizations.
**State Successes: Stakeholder Partnerships**

**Indiana** ACOG’s April meeting highlighted an immediate postpartum LARC insertion framework of provider education.

- Framework is the result of a strong support from the Indiana University School of Medicine Family Planning Division and the Indiana Perinatal Quality Improvement Collaborative facilitated by the Indiana State Department of Health.

**Since August 2014, 11 hospitals participated in Georgia’s statewide perinatal quality collaborative (GaPQC) maternal project which is focused on immediate postpartum LARC insertion.**

- Each hospital has worked to develop internal policies that outline immediate postpartum LARC insertion at their facilities.
State Successes: Service Location

- **New Mexico** identified potential clinical champions with expressed interest in providing immediate postpartum LARC in 4 communities: 1 hospital in Albuquerque and 3 others in geographically dispersed and rural parts of the state:
  - Gallup (west, sits within the Navajo Nation)
  - Silver City (frontier, southwest corner)
  - Las Cruces (second largest city, south, near border with Mexico)
State Successes: Data, Monitoring, and Evaluation (1/2)

- **Iowa** developed code to calculate immediate post-partum LARC insertion (<2% - 2014 data), developed an evaluation plan of IPP LARC project with Harvard students.

- **Maryland’s** Medicaid hospital claims data has been pulled for IPP LARC procedures. The data has provided clarity on how hospitals are billing for the IPP LARCs, which will inform our toolkit and Medicaid transmittal.
  - Key informant interviews with billing, pharmacy, and clinicians at 5 hospitals to address issues and successes that they have faced, which have guided our priorities and will inform our toolkit.
State Successes: Data, Monitoring, and Evaluation (2/2)

- **Massachusetts** Medicaid scanned state reimbursement policy, analyzed MassHealth rapid repeat birth and teen pregnancy data, and held provider and hospital leader focus groups on LARC immediate postpartum insertion.

- **Oklahoma** has seen approximately 160 women had a LARC placed immediate postpartum.

- From FY 2013-2015, **South Carolina** has seen:
  - LARC inpatient insertions increased 110%
  - LARC utilization for outpatient insertion increased 10%
  - Overall, inpatient LARC insertions now make up 17% of total LARC use
State Reports: Success in Numbers

IA

TX
IOWA Updates

- At the April 2016 Statewide Perinatal Conference, we provided a training for nurse practitioners and physicians on insertion of immediate post-partum IUDs

- We are continuing to build our relationship with the Medicaid Medical Director and MCO leaders to promote immediate post-partum LARC insertion

- Advocating to retain status of unbundled immediate post-partum LARC insertion in the new MCO environment
Iowa Successes!

- Since August 2014 of the learning community, developed code to calculate immediate post-partum LARC insertion (<2% - 2014 data), developed an evaluation plan of IPP LARC project with Harvard students, provided educational seminars to 4 hospitals, and provided billing support to 2 high-volume hospitals. The state health department played a key role in developing relationships with these hospitals.
Texas Updates

Statewide Collaboration

- State agencies (HHSC and DSHS) are working with Women’s Health and Family Planning Association (Title X) and Women’s Health Advisory Committee to develop information to share with providers and clients regarding accessibility of LARC
- Core Team working on LARC toolkit and education

Developing new women’s health programs with LARC benefits

- State Legislature invested additional funds for women’s health programs.
- State agencies are developing new programs and revising current programs
  - Healthy Texas Women (new program to replace Texas Women’s Health Program, the former Medicaid Women’s Health Program)
  - Redesign of Family Planning Program
  - Ensuring all LARCs are available to providers, contractors and clients.

Monitor IPP LARC Implementation

- Working with Medicaid billing system to track claims and monitor provider issues
Texas Successes!

- A recent success in Texas was a day-long lecture and demonstration on LARCs put on by the Texas Medical Association Committee on Maternal and Perinatal Health. There were around 50 providers who completed the training, which included an IUD insertion practicum.

- Lesley French, our Associate Commissioner for Women's Health Services, presented at the event.
Questions?
Next Steps

- Emerging Issues Call – Summer 2016
- LARC Learning Community Year 3

Homework: Chat Box/Email
- TA needs in the next year
Closing

Charlan D. Kroelinger, PhD
Team Leader
Maternal and Child Health Epidemiology Program
Field Support Branch
Division of Reproductive Health
Centers for Disease Control and Prevention
Evaluation

Please take our evaluation survey so we can improve for the next call:

http://astho.az1.qualtrics.com/jfe/form/SV_8f86Cvk y2PAFd4N
Thank you!!

Additional tools, materials and recordings available on the ASTHO LARC page:

http://www.astho.org/Programs/Maternal-and-Child-Health/Long-Acting-Reversible-Contraception-LARC/