Immediate Postpartum LARC devices and the Choose Well Grant:

Characteristics Associated with LARC Continuation ≥12 Months

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SOAR

UNIVERSITY OF South Carolina
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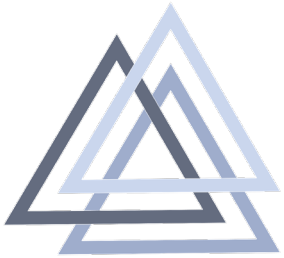
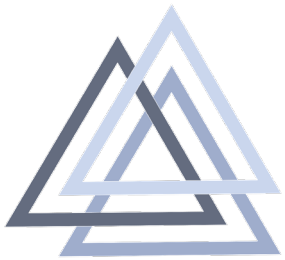
PRISMA HEALTH



Disclosures

I have no disclosures.

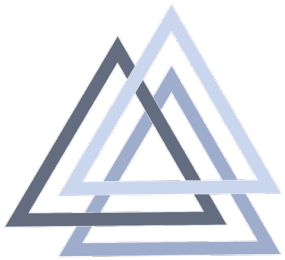


Learning Objective

Understand how long-acting reversible contraceptive (LARC) devices improve patient outcomes, consider which patients are opting to receive LARCs, and identify factors associated with LARC continuation.

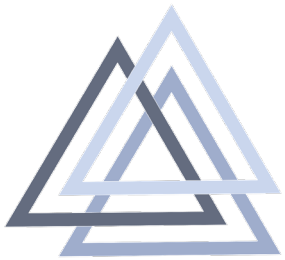
Long-Acting Reversible Contraception

- Hormonal IUD
- Hormonal implant
- Copper IUD



Unintended Pregnancy

- 45% of pregnancies are unintentional[1]
- Disparities exist in unintended pregnancy rates by age, income level, and education.[1]

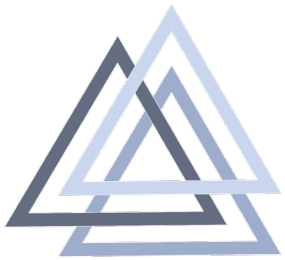


Immediately Postpartum

In 2011, 70% of pregnancies occurring within one year of giving birth were unintentional.[2]

Short term interval pregnancies < 6m associated with higher rates of

- Severe maternal mortality
- Maternal mechanical ventilation
- Maternal sepsis[3]



Immediately Postpartum

- ACOG recommendations[2]

Interpregnancy Interval

Women should be advised to avoid interpregnancy intervals shorter than 6 months.	1B Strong recommendation, moderate-quality evidence
Women should be counseled about the risks and benefits of repeat pregnancy sooner than 18 months.	2B Weak recommendation, moderate-quality evidence
Family planning counseling should begin during prenatal care with a conversation about the woman's interest in future childbearing.	Best Practice

Table 1. Interpregnancy Care Recommendations

Recommendation	Grade of Recommendation
General	
To optimize interpregnancy care, anticipatory guidance should begin during pregnancy with the development of a postpartum care plan that addresses the transition to parenthood and interpregnancy or well-woman care.	Best Practice
Breastfeeding and Maternal Health	
Health care providers should routinely provide anticipatory guidance and support to enable women to breastfeed as an important part of interpregnancy health.	1A Strong recommendation, high-quality evidence
Interpregnancy Interval	
Women should be advised to avoid interpregnancy intervals shorter than 6 months.	1B Strong recommendation, moderate-quality evidence
Women should be counseled about the risks and benefits of repeat pregnancy sooner than 18 months.	2B Weak recommendation, moderate-quality evidence
Family planning counseling should begin during prenatal care with a conversation about the woman's interest in future childbearing.	Best Practice
Depression	
All women should be screened for depression in the postpartum period, as part of well-woman care during the interpregnancy period. Such screening should be implemented with systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.	1B Strong recommendation, moderate-quality evidence
Postpartum depression screening also may occur at the well-child visit with procedures in place to accurately convey the information to the maternal care provider.	1B Strong recommendation, moderate-quality evidence
Other Medical Conditions	
Women should be encouraged to reach their prepregnancy weight by 6–12 months postpartum and ultimately to achieve a normal BMI (calculated as weight in kilograms divided by height in meters squared) of 18.5–24.9.	2B Weak recommendation, moderate-quality evidence
Health care providers should offer specific, actionable advice regarding nutrition and physical activity using proven behavioral techniques.	1A Strong recommendation, high-quality evidence
Nonpregnant adult smokers should be offered smoking cessation support through behavioral interventions and U.S. Food and Drug Administration–approved pharmacotherapy.	1A Strong recommendation, high-quality evidence
In the interpregnancy period, all women should be routinely asked about their use of alcohol and drugs, including prescription opioids, marijuana, and other medications used for nonmedical reasons and referred as indicated. Substance use disorder and relapse prevention programs also should be made available.	Best Practice
Health care providers should consider patient navigators, trained medical interpreters, health educators, and promotoras to facilitate quality interpregnancy care for women of low health literacy, with no or limited English proficiency, or other communication needs.	2C Weak recommendation, low-quality evidence
Women of childbearing age should be screened for intimate partner violence, such as domestic violence, sexual coercion, and rape, and referred for intervention services if they screen positive.	2B Weak recommendation, moderate-quality evidence
Women with histories of sexually transmitted infections before or during pregnancy should have thorough sexual and behavioral histories taken to determine risk of repeat infection or current or subsequent infection with HIV or viral hepatitis.	1A Strong recommendation, high-quality evidence
All women should be encouraged to engage in safe sex practices; partner screening and treatment should be facilitated as appropriate.	1A Strong recommendation, high-quality evidence
As part of interpregnancy care, women at high risk of STIs should be offered screening, including for HIV, syphilis, and hepatitis. Screening should follow guidance set forth by the CDC.	1A Strong recommendation, high-quality evidence
History of High-Risk Pregnancy	
Women with prior preterm births should be counseled that short interpregnancy intervals may differentially and negatively affect subsequent pregnancy outcomes and, as such, the birth spacing recommendations listed in the section "Interpregnancy Interval" are particularly important.	1B Strong recommendation, moderate-quality evidence
Given insufficient evidence of benefit, screening and treating asymptomatic genitourinary infections in the interpregnancy period in women at high risk of preterm birth is not recommended.	1B Strong recommendation, moderate-quality evidence
For women who have had pregnancies affected by congenital abnormalities or genetic disorders, health care providers should review postnatal or pathologic information with the women and offer genetic counseling, if appropriate, to estimate potential recurrence risk.	1C Strong recommendation, low-quality evidence
All women who are planning a pregnancy or capable of becoming pregnant should take 400 micrograms of folic acid daily. Supplementation should begin at least 1 month before fertilization and continue through the first 12 weeks of pregnancy.	1A Strong recommendation, high-quality evidence
All women planning a pregnancy or capable of becoming pregnant who have had a child with a neural tube defect should take 4 mg of folic acid daily. Supplementation should begin at least 3 months before fertilization and continue through the first 12 weeks of pregnancy.	1A Strong recommendation, high-quality evidence
A thorough review of all prescription and nonprescription medications and potential teratogens and environmental exposures should be undertaken before the next pregnancy.	1A Strong recommendation, high-quality evidence
A genetic and family history of the patient and her partner should be obtained. This may include family history of genetic disorders, birth defects, mental disorders, and breast, ovarian, uterine, and colon cancer.	1B Strong recommendation, moderate-quality evidence
Infertility	
Generally, recommendations for the length of the interpregnancy interval should not differ for women with prior infertility compared with women with normal fertility.	2C Weak recommendation, low-quality evidence
Prior Cesarean Delivery	
Women with prior cesarean deliveries, and particularly those who are considering a trial of labor after cesarean delivery, should be counseled that a shorter interpregnancy interval in this population has been associated with an increased risk of uterine rupture and risk of maternal morbidity and transfusion.	1B Strong recommendation, moderate-quality evidence

Abbreviations: BMI, body mass index (calculated as weight in kilograms divided by height in meters squared); CDC, Centers for Disease Control and Prevention; HIV, human immunodeficiency virus; STIs, sexually transmitted infections.

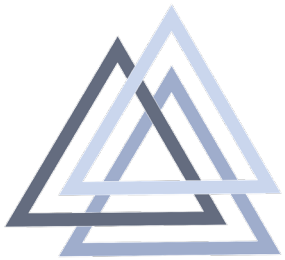
Immediately Postpartum

Barriers to returning to the clinic for post partum care

- Travel
- Time off work

LARCs significantly increase odds of birth-giving patients achieving an optimal 18m intrapartum interval.[4]

SC was first in the nation to reimburse postpartum LARC's separate from the obstetric global billing package.



Choose Well Initiative

Beginning in 2017, the New Morning Foundation began funding the Choose Well initiative for contraception education and access in South Carolina.

This funding effectively removes the burden of cost for any patient without insurance coverage for LARC device insertion if desired.

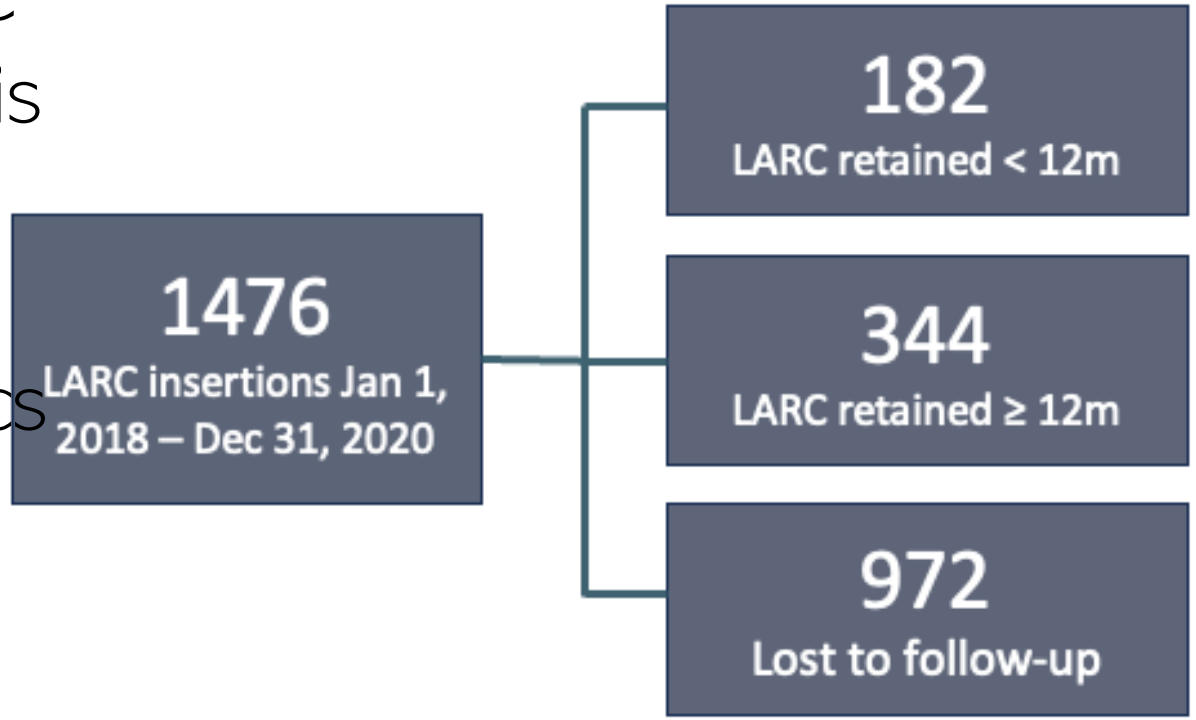
Choose Well℠

A CONTRACEPTIVE ACCESS INITIATIVE
OF NEW MORNING FOUNDATION

Research Questions and Methods

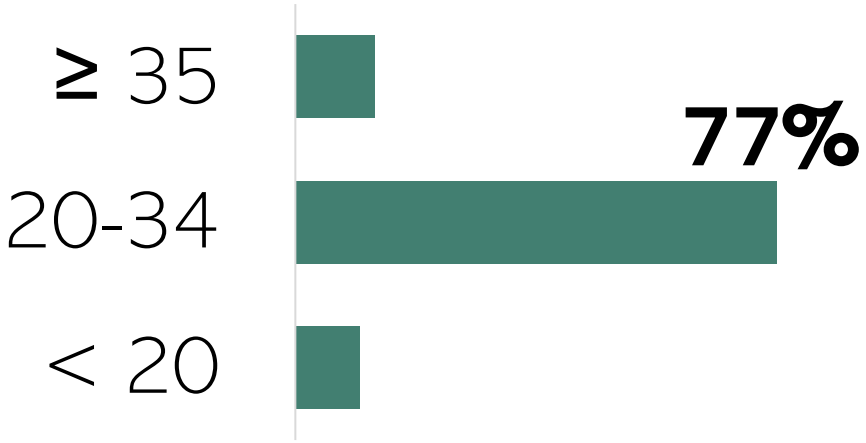
Who are the patients choosing to receive a LARC device when financial cost is eliminated?

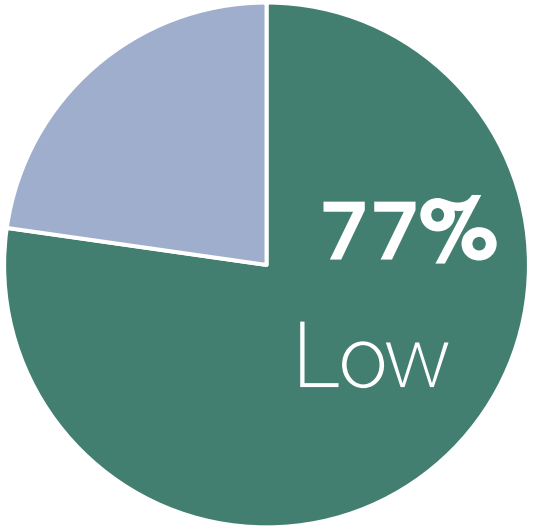
Which patient characteristics have an association with LARC continuation ≥ 12 months?



Patient Characteristics

Maternal Age



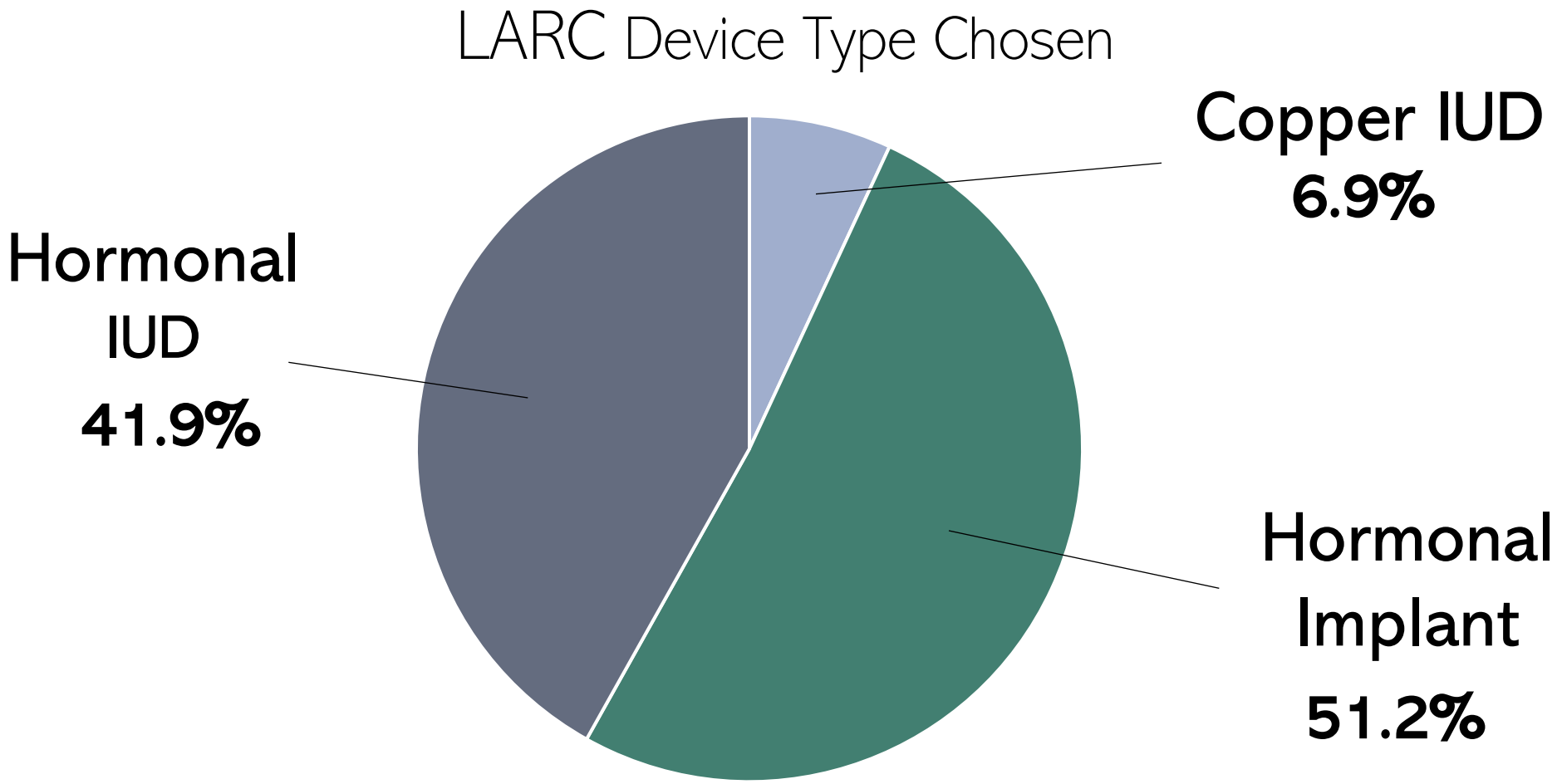


Self-identified Socioeconomic Status

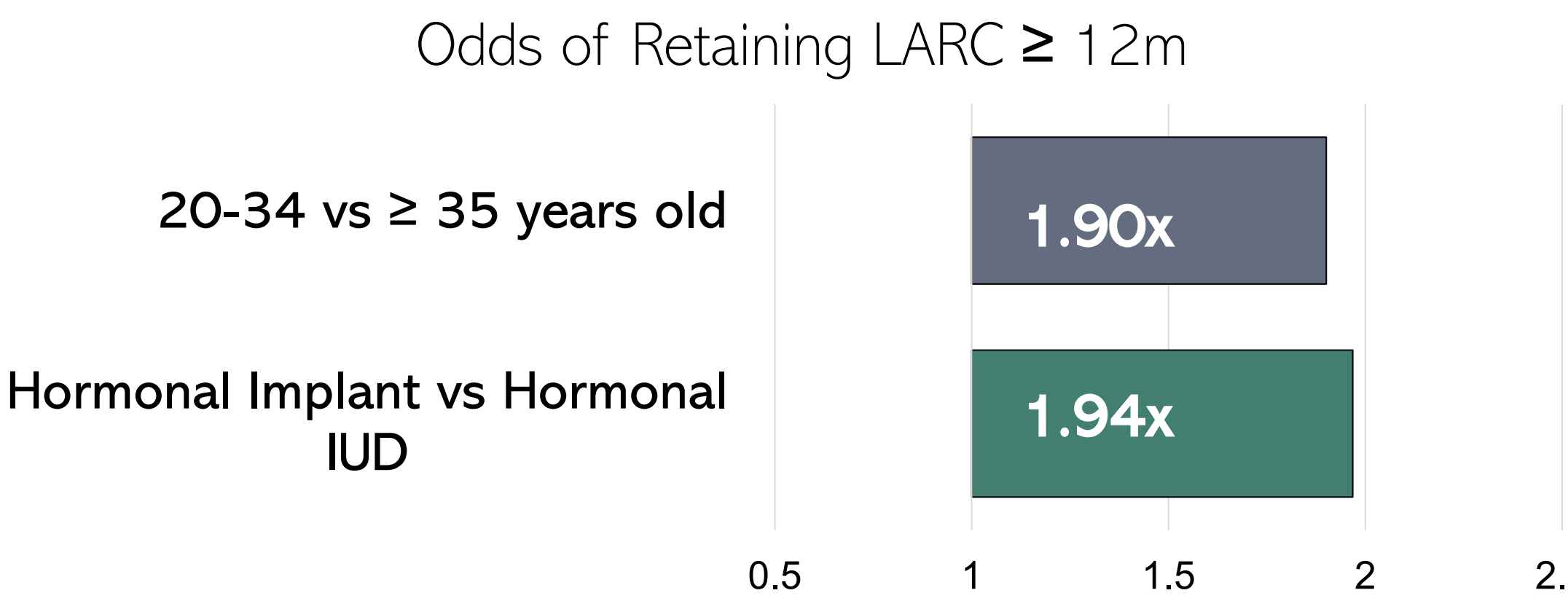
Choose Well Grant Utilization

21%

Results


LARC Device Type Chosen
Copper IUD
6.9%
Hormonal
IUD
41.9%
Hormonal
Implant
51.2%

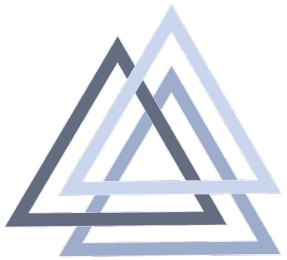
Results


Odds of Retaining LARC ≥ 12m
20-34 vs ≥ 35 years old
1.90x
Hormonal Implant vs Hormonal IUD
1.94x
0.5
1
1.5
2
2.5

Discussion

- LARC device type ($p = .001$) and maternal age ($p = .014$) are significant factors in determining a patients' odds of continuing usage ≥ 12 months.

- Lack of significant difference in other patient characteristics among continuations and non-continuations signals success of the healthcare provider team in limiting disparities to quality, autonomous reproductive care.

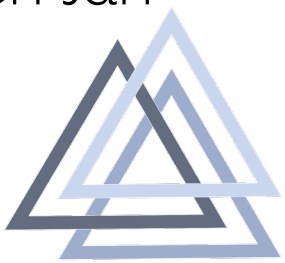


Limitations

This investigation is inherently limited by loss of patients to follow-up, as one of the critical benefits of LARC devices is an ease of burden of returning to providers.

As an ongoing retrospective cohort study, data relies on careful chart review. Further, some patient characteristics such as education level were not well-documented leading to many unknown values.

Current data is limited to those insertions at a single hospital site between Jan 1, 2018 and Dec 31, 2020.



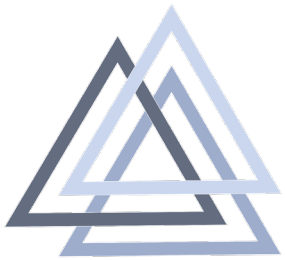
Future Questions

Choose Well initiative is now built into South Carolina state funding.

- Opportunities for this research to extend into years beyond 2020.

Expanded collection could allow temporal trend analysis in LARC utilization research.

- COVID-19?
- Dobbs vs Jackson Women's Health Organization?



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