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Commentary

Immediate postpartum long-acting reversible contraception: the time is now

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Timely access to contraception is vitally important after childbirth. One third of US pregnancies are conceived less than 18 months after a prior birth [1]. These short-interval pregnancies are often unintended and are associated with increased risk of adverse maternal and child health outcomes [2–8].

Use of highly effective contraception is a critically important strategy to prevent unintended pregnancy and achieve appropriate birth spacing. Women using highly effective, long-acting reversible contraception (LARC) have nearly four times the odds of achieving an optimal birth interval than women using a barrier or no method [9]. However, only 6% of US women have received LARC at 3 months postpartum [8]. Low LARC utilization does not seem to reflect patient preferences but rather, barriers to access, such as need for additional visits and potential loss of insurance coverage postpartum [10]. Up to 40–75% of women who plan to use LARC postpartum never obtain it [11–15]. The standard practice of providing contraception at the outpatient postpartum visit has proven inadequate to make LARC accessible or to reduce short-interval pregnancy rates.

One promising strategy to overcome access barriers is to provide LARC immediately after childbirth, during the delivery hospitalization [16]. Immediate postpartum contraception is associated with high patient satisfaction, longer contraceptive coverage, fewer unintended pregnancies and cost savings for payers and healthcare systems compared to outpatient postpartum insertion [14,17–24]. However, despite evidence of safety, efficacy and patient enthusiasm [13,25–28], immediate postpartum LARC is not currently available in most maternity settings in the US and is rarely utilized by patients (one study estimates intrauterine device (IUD) insertion during the delivery hospitalization at 0.27 per 10,000 deliveries) [29].

Improving access to immediate postpartum LARC is increasingly recognized as a pressing national priority to improve the health of women. The newly released 2016 US Medical Eligibility Criteria (US MEC) for contraceptive use reiterated the safety of immediate postpartum LARC. The American College of Obstetricians and Gynecologists (ACOG) has identified the immediate postpartum period as "particularly favorable" for LARC insertion and recently recommended that "obstetric care providers should incorporate immediate postpartum LARC into their practices" [10,26]. Finally, in October 2016, the National Quality Forum endorsed three new contraceptive quality measures, including a measure of postpartum contraceptive utilization that will monitor initiation of LARC within 3 days of delivery. Despite this recognition, significant barriers still exist to providing immediate postpartum LARC to those who desire it.

1. Implementation challenges

While the clinical safety and effectiveness of immediate postpartum LARC are well documented, much less is known about how to implement this service in real-world settings.

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There are a number of implementation challenges for patients, clinicians and payers that must be overcome. These include:

Billing and reimbursement: Historically, a major barrier to immediate postpartum contraception has been the resistance of private and public insurers to provide specific payment for inpatient insertion of LARC [30]. This is rapidly changing for Medicaid beneficiaries, with 22 Medicaid agencies beginning to provide such reimbursement since 2012 [31,32]. Additional states may begin providing coverage in response to a 2016 Informational Bulletin from the Center for Medicaid and Children's Health Insurance Program (CHIP) Services focused on postpartum LARC utilization [33]. While reimbursement for inpatient LARC provision is necessary for access, implementation of payment changes has been challenging, with hospitals unsure how to properly code inpatient LARC services, payer systems unfamiliar with inpatient LARC claims and reimbursement rates too low to cover clinicians' and health systems' actual costs [34,35].

Clinician expertise: Both qualitative and survey data indicate that providers need training in implant and postplacental IUD insertion before services can be fully implemented [34,36]. Some providers have outdated views about the safety, effectiveness and eligibility criteria for immediate postpartum LARC [37–39]. Inadequate immediate postpartum LARC knowledge and experience seriously undermine the maternity care workforce's capacity to provide highly effective contraception to all postpartum women who desire it.

Service delivery processes: A successful immediate postpartum LARC program will require new coordination among several components of obstetrical care. Outpatient clinicians will need to routinely counsel about immediate postpartum LARC and alert intrapartum clinicians — who may be different from outpatient prenatal caregivers — about a patient's desire for immediate postpartum LARC. Staff availability for device insertion may be challenging on busy and high-acuity labor and delivery units. Device stocking on delivery units is another potential barrier, particularly for IUDs being inserted within 10 min of placental delivery. The significant diversity of maternity care sites — in terms of organization, culture and populations served — creates another potential obstacle for widespread adoption of immediate postpartum LARC services. Implementation activities and tools that work in one setting may be ineffective in other settings.

2. Addressing implementation challenges

Immediate postpartum LARC services remain new in most settings. At least one academic site has documented outcomes in the medical literature [14,20], and the implementation experiences of stakeholders in 13 states are also available online [40]. These early experiences suggest that women's health clinicians, hospital leadership, payers and researchers each have roles in strategies aimed at making immediate postpartum LARC a universal option for interested women. Efforts from each of these stakeholders are needed to ensure that immediate postpartum LARC realizes its potential to help women meet their family planning goals and to improve population health outcomes (Table 1). A variety of resources are increasingly available to assist in efforts to implement immediate postpartum LARC services (Table 2).

Table 1
Multistakeholder efforts to accelerate the availability of immediate postpartum contraception

Stakeholder	Activities
Clinicians	- Advocate for reimbursement - Create clinician training opportunities - Generate implementation tools
Hospital Leaders	- Create protocols for device ordering and stocking - Train billing/coding staff and monitor reimbursements - Identify and address institutional barriers to inpatient contraceptive services
Payers	- Provide adequate, specific reimbursement for immediate postpartum LARC - Provide clear information about payment policies - Teach maternity site staff how to bill outside the global fee
Researchers	- Identify and monitor training needs in the maternity workforce - Identify unique implementation needs of different maternity care settings - Evaluate and disseminate population-level health and cost outcomes

Recent reimbursement changes have created a novel opportunity for women's health clinicians to act as champions for immediate postpartum LARC. They can communicate with local payers and policymakers about the health benefits of immediate postpartum LARC and advocate for its widespread coverage. Family planning experts may be particularly well positioned to train colleagues to provide immediate postpartum LARC. Such training may involve workshops in one's home institution, around one's state or at national meetings. Standardized simulation workshops may improve clinician knowledge and comfort with immediate postpartum IUD insertion [41]. Clinician champions are respected opinion leaders who can provide peers and hospital leadership with key data demonstrating why they should support immediate postpartum LARC efforts and, in this way, play a critical role in changing culture.

Making immediate postpartum LARC a routine part of inpatient postpartum care requires the support of hospital leadership, such as chief clinical, nursing, pharmacy and revenue officers. Hospital leaders can support immediate postpartum LARC services by ensuring that hospitals are technically prepared to provide immediate postpartum LARC services. Hospital leaders can assist inpatient pharmacies in developing new protocols for procuring and