Effective Contraception Use Metric

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Effective Contraception Use metric

- **Effective contraception use among women at risk of unintended pregnancy**
- **Denominator:** women 15-50 who are physiologically capable of getting pregnant
- **Numerator:** claims for contraception prescriptions or procedures for Tier 1 or 2 methods: female sterilization, IUD, implant, pills, patch, ring, depo shot, diaphragm

Effectiveness of Family Planning Methods

Most Effective

Less than 1 pregnancy per 100 women in a year

6-12 pregnancies per 100 women in a year

18 or more pregnancies per 100 women in a year

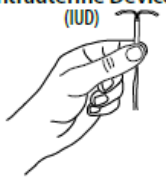
Least Effective

Reversible

Implant

0.05 %*

Intrauterine Device (IUD)



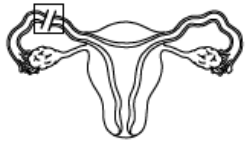
LNG - 0.2 % Copper T - 0.8 %

Permanent

Male Sterilization (Vasectomy)

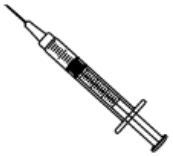
0.15 %

Female Sterilization (Abdominal, Laparoscopic, Hysteroscopic)



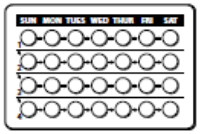
0.5 %

Injectable



6 %

Pill



9 %

Patch

9 %

Ring

9 %

Diaphragm

12 %

Male Condom

18 %

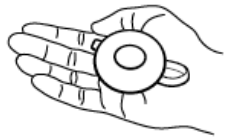
Female Condom

21 %

Withdrawal

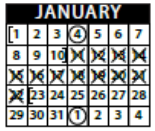
22 %

Sponge



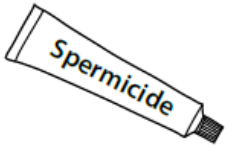
24 % parous women
12 % nulliparous women

Fertility-Awareness Based Methods



24 %

Spermicide



28 %

* The percentages indicate the number out of every 100 women who experienced an unintended pregnancy within the first year of typical use of each contraceptive method.

How to make your method most effective

After procedure, little or nothing to do or remember.

Vasectomy and hysteroscopic sterilization: Use another method for first 3 months.

Injectable: Get repeat injections on time.

Pills: Take a pill each day.

Patch, Ring: Keep in place, change on time.

Diaphragm: Use correctly every time you have sex.

Condoms, sponge, withdrawal, spermicides: Use correctly every time you have sex.

Fertility awareness-based methods: Abstain or use condoms on fertile days. Newest methods (Standard Days Method and TwoDay Method) may be the easiest to use and consequently more effective.

CS 242797

CONDOMS SHOULD ALWAYS BE USED TO REDUCE THE RISK OF SEXUALLY TRANSMITTED INFECTIONS.

Other Methods of Contraception

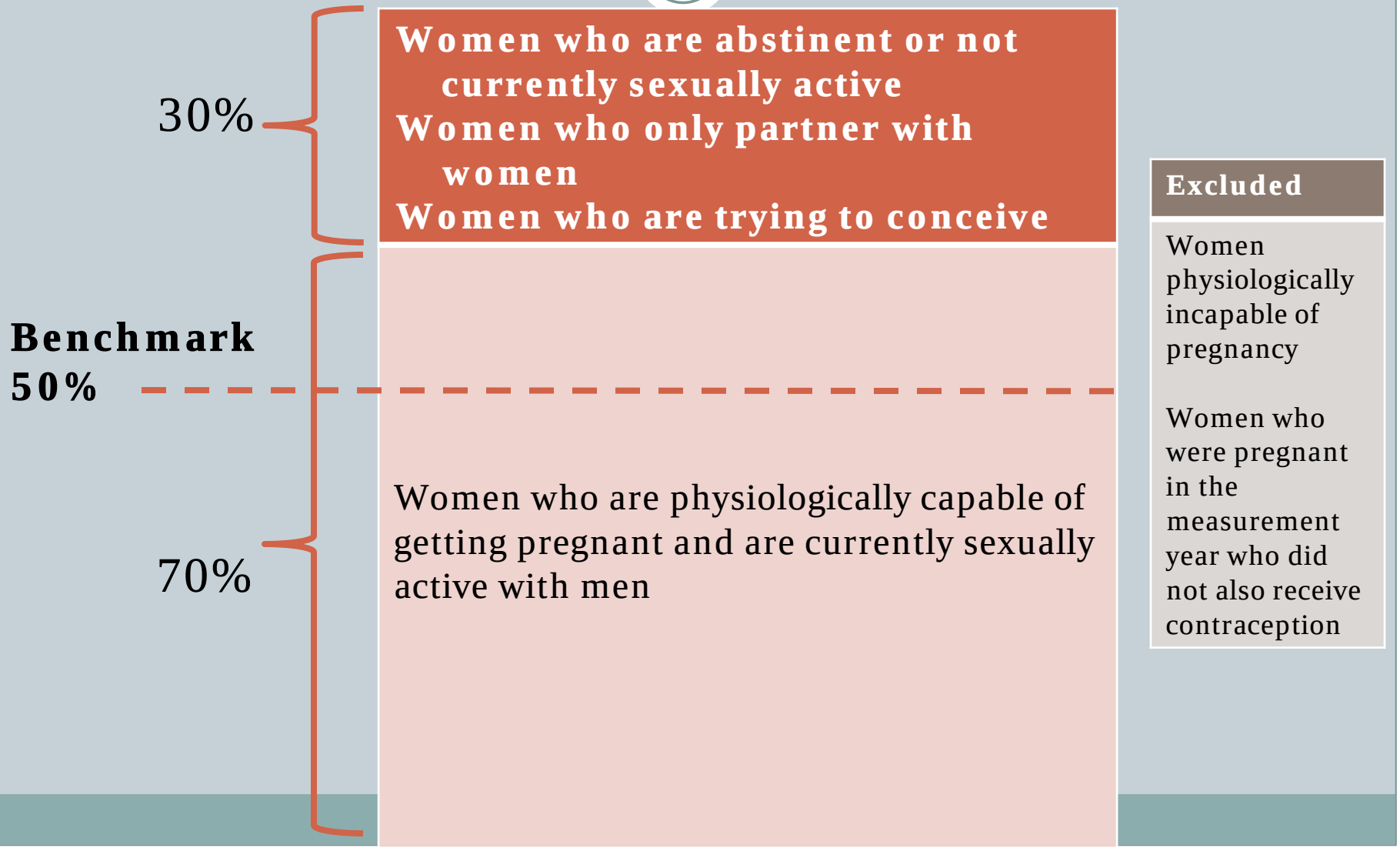
Lactational Amenorrhea Method: LAM is a highly effective, temporary method of contraception.

Emergency Contraception: Emergency contraceptive pills or a copper IUD after unprotected intercourse substantially reduces risk of pregnancy.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Adapted from World Health Organization (WHO) Department of Reproductive Health and Research, Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP). Knowledge for health project. Family planning: a global handbook for providers (2011 update). Baltimore, MD; Geneva, Switzerland: CCP and WHO; 2011; and Trussell J. Contraceptive failure in the United States. Contraception 2011;83:397–404.

Who is in this metric?



What about men?

- Important to include men in the conversation
- Since most contraception is for women, cannot find claims in man's record, so not included

Why is this important?

Goal is to prevent unintended pregnancy

A <u>woman with an unintended pregnancy</u> is:

- less likely to seek early prenatal care
- more likely to expose the fetus to harmful substances
- at greater risk of depression
- at greater risk of physical abuse
- at greater risk of having her employment, education and relationship with her partner derailed

Brown, S. S., & Eisenberg, L. (Eds.). (1995). The best intentions: Unintended pregnancy and the well-being of children and families. Washington, DC: National Academies Press

Why is this important?

Goal is to prevent unintended (unwanted) pregnancies

A child of an unintended conception is at greater risk of:

- being born at low birthweight
- dying in his/her first year of life
- being abused or neglected
- not receiving sufficient resources for healthy development

Brown, S. S., & Eisenberg, L. (Eds.). (1995). The best intentions: Unintended pregnancy and the well-being of children and families. Washington, DC: National Academies Press

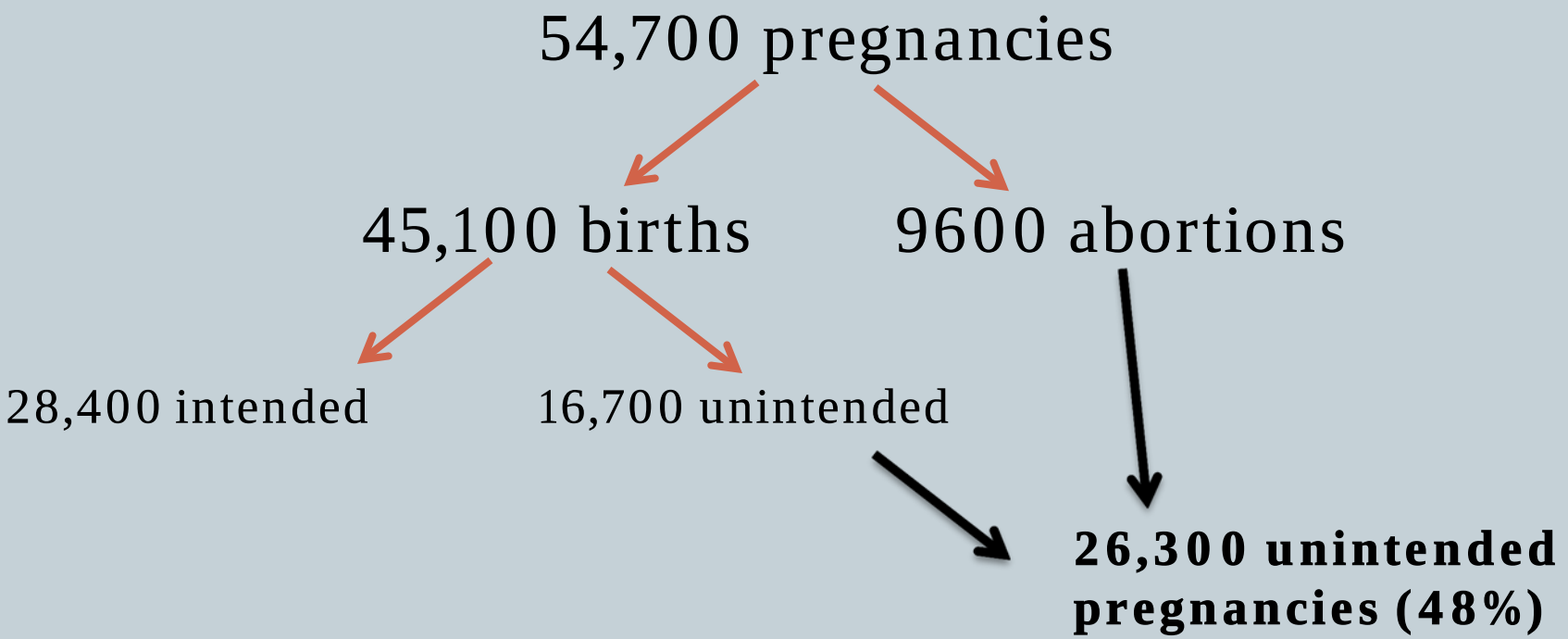
Medicaid coverage

Medicaid in Oregon pays for 48% of all births

Among births to women who say the pregnancy was unintended, Medicaid paid for 63% of the births

How are we doing with contraception now?

2011 data



Source: Oregon Vital Statistics and Oregon PRAMS 2011

How are we doing with contraception now?

"When you got pregnant with your new baby, were you doing anything to prevent pregnancy?"

Yes 49% → Half of women who had a baby in 2011 were using contraception when they got pregnant (method didn't meet their needs)

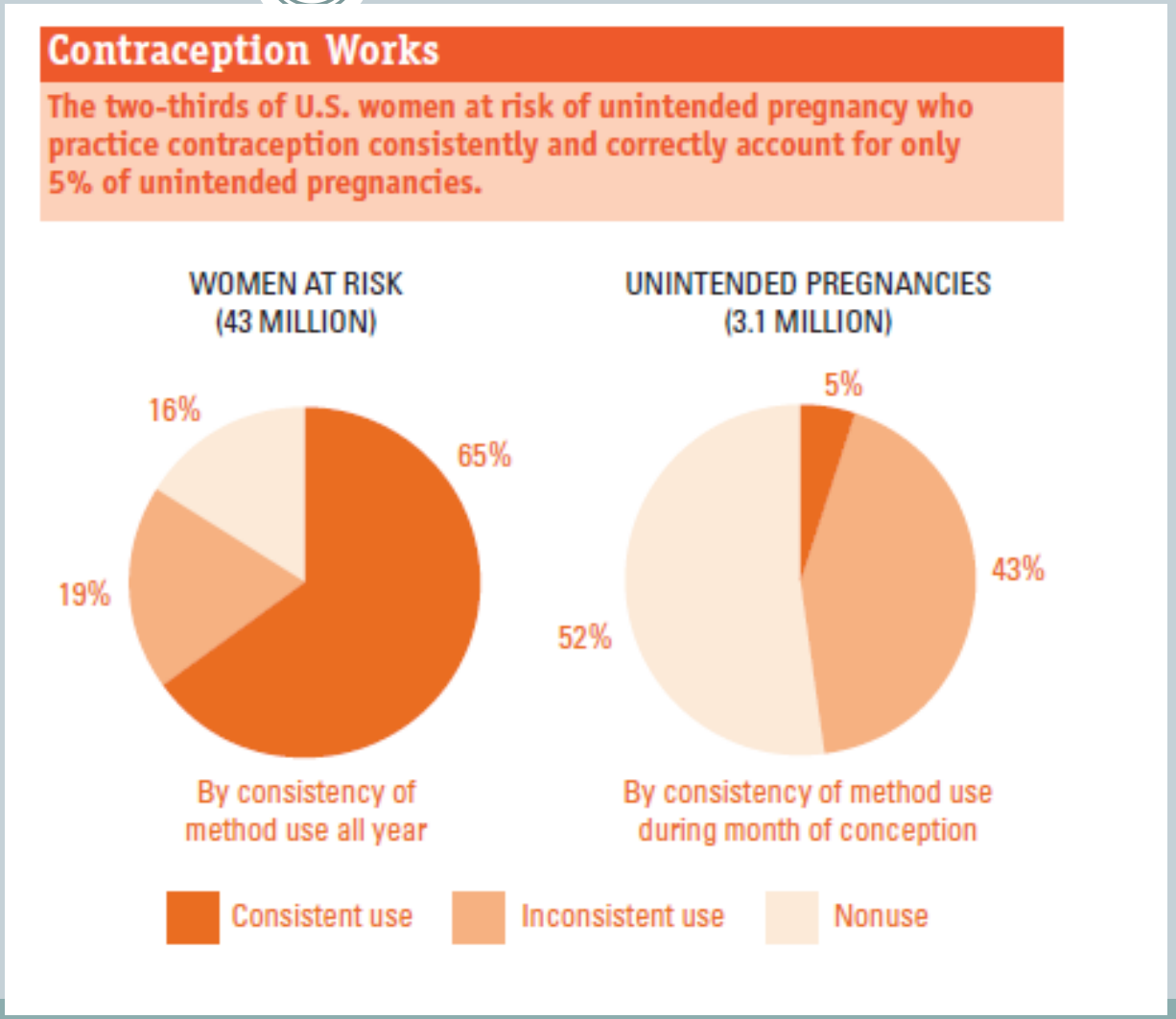
No 51% → One quarter of women did not want to get pregnant but were not using anything (lack of knowledge/access to contraception)

→ One-quarter of women were ok with getting pregnant

Source: Oregon PRAMS 2011

National Data on Contraception Use

35% of women at risk of unintended pregnancy are either using NO method or are using a method incorrectly or inconsistently



What does this metric ask providers to do?

- Talk about pregnancy intentions at least once a year
- Support her needs
  - Abstinence
  - Highly effective contraception
  - Preconception health
- Code for the care
  - Contraception prescriptions and procedures count
  - Surveillance codes for sterilization and long-acting methods

V25.4, Surveillance of previously prescribed contraceptive methods*

V25.40, Contraceptive surveillance, unspecified*

V25.41, Surveillance of oral contraceptive.

V25.42, Surveillance of previously prescribed contraceptive method, intrauterine device.

V25.43, Surveillance of previously prescribed contraceptive method; implantable sub-dermal contraceptive.

V25.49, Surveillance of other contraceptive method*

V25.9, Unspecified contraceptive management*

V45.59 Presence of other contraceptive device

How can we improve our contraception care?

- Screen all women for pregnancy intentions
- Improve your contraception provision with evidence-based support
- Help more women obtain LARCs (IUDs and implant)
- Partnering with other professionals

Screen for pregnancy intentions

One Key Question® initiative

Ask: Would you like to get pregnant in the next year?

www.onekeyquestion.org

Motivational interviewing approach

Ask: Would you like to have any (more) children?

If so, when?

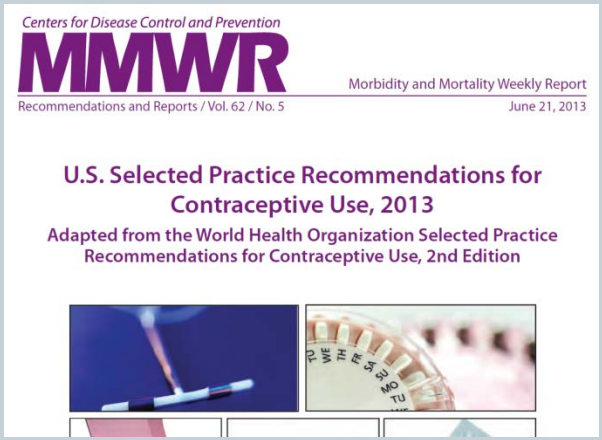
How important is it to you to prevent pregnancy until then?

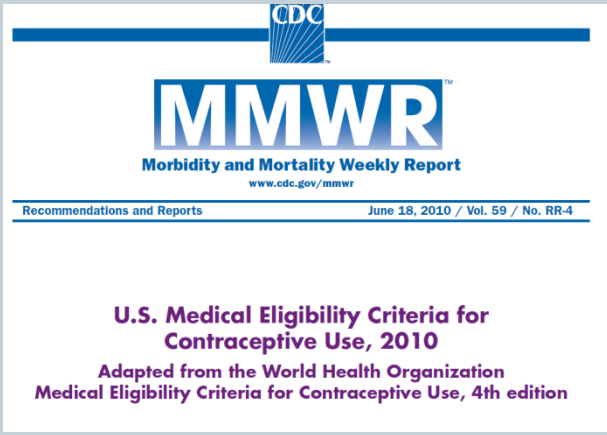
Improve your contraception provision

http://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf

http://www.cdc.gov/reproductivehealth/UnintendedPregnancy/USSPR.htm

http://www.cdc.gov/reproductivehealth/UnintendedPregnancy/USMEC.htm





Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use

Key:

1	No restriction (method can be used)
2	Advantages generally outweigh theoretical or proven risks
3	Theoretical or proven risks usually outweigh the advantages
4	Unacceptable health risk (method not to be used)

Updated June 2012. This summary sheet only contains a subset of the recommendations from the US MEC. For complete guidance, see: http://www.cdc.gov/reproductivehealth/unintendedpregnancy/USMEC.htm

Most contraceptive methods do not protect against sexually transmitted infections (STIs). Consistent and correct use of the male latex condom reduces the risk of STIs and HIV.

Condition	Sub-condition	Combined pill, patch, ring		Progestin-only pill		Injection		Implant		LNG—IUD		Copper-IUD	
		I	C	I	C	I	C	I	C	I	C	I	C
Age		Menarche to <40=1		Menarche to <18=1		Menarche to <18=2		Menarche to <18=1		Menarche to <20=2		Menarche to <20=2	
		≥40=2		18-45=1		18-45=1		18-45=1		≥20=1		≥20=1	
				>45=1		>45=2		>45=1					
Anatomic abnormalities	a) Distorted uterine cavity									4		4	
	b) Other abnormalities									2		2	
Anemias	a) Thalassemia	1		1		1		1		1		2	
	b) Sickle cell disease‡	2		1		1		1		1		2	
	c) Iron-deficiency anemia	1		1		1		1		1		2	
Benign ovarian tumors	(including cysts)	1		1		1		1		1		1	
Breast disease	a) Undiagnosed mass	2*		2*		2*		2*		2		1	
	b) Benign breast disease	1		1		1		1		1		1	
	c) Family history of cancer	1		1		1		1		1		1	
	d) Breast cancer‡												
	i) current	4		4		4		4		4		1	
	ii) past and no evidence of current disease for 5 years	3		3		3		3		3		1	
Breastfeeding (see also Postpartum)	a) < 1 month postpartum	3*		2*		2*		2*					
	b) 1 month or more postpartum	2*		1*		1*		1*					
Cervical cancer	Awaiting treatment	2		1		2		2		4	2	4	2
Cervical ectropion		1		1		1		1		1		1	
Cervical intraepithelial neoplasia		2		1		2		2		2		1	
Cirrhosis	a) Mild (compensated)	1		1		1		1		1		1	
	b) Severe‡ (decompensated)	4		3		3		3		3		1	
Deep venous thrombosis (DVT) /Pulmonary embolism (PE)	a) History of DVT/PE, not on anticoagulant therapy												
	i) higher risk for recurrent DVT/PE	4		2		2		2		2		1	
	ii) lower risk for recurrent DVT/PE	3		2		2		2		2		1	
	b) Acute DVT/PE	4		2		2		2		2		2	
	c) DVT/PE and established on anticoagulant therapy for at least 3 months												
	i) higher risk for recurrent DVT/PE	4*		2		2		2		2		2	
	ii) lower risk for recurrent DVT/PE	3*		2		2		2		2		2	

Condition	Sub-condition	Combined pill, patch, ring		Progestin-only pill		Injection		Implant		LNG—IUD		Copper-IUD	
		I	C	I	C	I	C	I	C	I	C	I	C
Diabetes mellitus (cont.)	(i) non-insulin dependent	2		2		2		2		2		1	
	(ii) insulin dependent‡	2		2		2		2		2		1	
	c) Nephropathy/ retinopathy/ neuropathy‡	3/4*		2		3		2		2		1	
	d) Other vascular disease or diabetes of >20 years' duration‡	3/4*		2		3		2		2		1	
Endometrial cancer‡		1		1		1		1		4	2	4	2
Endometrial hyperplasia		1		1		1		1		1		1	
Endometriosis		1		1		1		1		1		2	
Epilepsy‡	(see also Drug Interactions)	1*		1*		1*		1*		1		1	
Gallbladder disease	a) Symptomatic												
	(i) treated by cholecystectomy	2		2		2		2		2		1	
	(ii) medically treated	3		2		2		2		2		1	
	(iii) current	3		2		2		2		2		1	
	b) Asymptomatic	2		2		2		2		2		1	
Gestational trophoblastic disease	a) Decreasing or undetectable β-hCG levels	1		1		1		1		3		3	
	b) Persistently elevated β-hCG levels or malignant disease‡	1		1		1		1		4		4	
Headaches	a) Non-migrainous	1*	2*	1*	1*	1*	1*	1*	1*	1*	1*	1*	
	b) Migraine												
	i) without aura, age <35	2*	3*	1*	2*	2*	2*	2*	2*	2*	2*	1*	
	ii) without aura, age ≥35	3*	4*	1*	2*	2*	2*	2*	2*	2*	2*	1*	
	iii) with aura, any age	4*	4*	2*	3*	2*	3*	2*	3*	2*	3*	1*	
History of bariatric surgery‡	a) Restrictive procedures	1		1		1		1		1		1	
	b) Malabsorptive procedures	COCs: 3 P/R: 1		3		1		1		1		1	
History of cholestasis	a) Pregnancy-related	2		1		1		1		1		1	
	b) Past COC-related	3		2		2		2		2		1	
History of high blood pressure during pregnancy		2		1		1		1		1		1	
History of pelvic surgery		1		1		1		1		1		1	
HIV	High risk	1		1		1*		1		2	2	2	2
	HIV infected	1*		1*		1*		1*		2	2	2	2

Improve your contraception provision

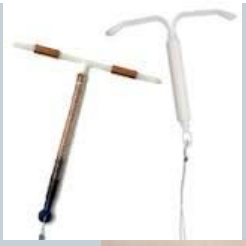
OPRHAC

Oregon Preventive Reproductive Health Advisory Council

- Convened by the Reproductive Health Program of the Public Health Division
- Developing checklists for primary care practices to use to assess their own provision of contraception care and preconception care, based on national guidelines and local expertise

Help more women obtain LARCs

- Long Acting Reversible Contraception
  - Paragard, Mirena or Skyla IUD
  - Nexplanon implant



- Highest effectiveness rate among any reversible contraception method (22 times more effective at preventing pregnancy than pills)

- Highest satisfaction rate for any contraception method (86% vs average 54% for other methods)

Source: Choice Project website: http://www.choiceproject.wustl.edu/

Help more women obtain LARCs

- LARCs are appropriate for
  - Nulliparous women
  - Teens
  - Any woman who desires long-acting contraception
- LARCs should not be use for women with
  - Current intrauterine infection
  - Current purulent cervicitis
  - Unexplained vaginal bleeding
  - Pelvic TB, liver tumors, SLE

Source: US MEC for contraceptive use
http://www.cdc.gov/reproductivehealth/UnintendedPregnancy/USMEC.htm

Partner with other professionals

Local Family Planning Clinics

- Experts available for collaboration
- Contractually obligated to assure provision of contraception in your area
- Care at Family Planning clinics counts toward the metric in the first year, may not count in future years unless you have a contract
- Every community is different – primary care, gynecologists and county FP clinics should meet and strategize locally
  - How do referrals work (both ways)
  - Who provides iuds and implants?
  - Difficult cases/consultation

Thank you!