Florida Perinatal Quality Collaborative

Partnering to Improve Health Care Quality for Mothers and Babies

ACCESS LARC

INCREASING ACCESS TO IMMEDIATE POSTPARTUM LONG-ACTING REVERSIBLE CONTRACEPTION

Chapter Six: Patient Education and Counseling

Chapter At-a-Glance:

Overview

The information in this chapter is based on an extensive review and synthesis of established patient-centered care processes and principles. Resources in this chapter have been adapted for contraceptive counseling specifically for the prenatal and immediate postpartum periods. These resources will facilitate assessment of women's contraceptive needs and respect cultural diversity and sensitivity.

Primary objectives of this chapter are to:

1. Describe the importance of comprehensive contraceptive counseling during the prenatal period
2. Explain four steps to comprehensive contraceptive counseling and shared decision-making that can appropriately address women's contraceptive needs and preferences
3. Encourage providers to work in teams and across institutions and organizations to provide the best possible care to pregnant and postpartum women

Importance of Patient Education and Counseling during the Perinatal Period

Why Counsel Women about Contraception during the Perinatal Period?

- The U.S Department of Health and Human Services and the American College of Obstetricians and Gynecologists recommend women wait *at least* 18 months after delivery before becoming pregnant again (Maternal and Child Health Bureau 2013; Office of Disease Prevention and Health Promotion 2016; American College of Obstetricians and Gynecologists 2016)
- Nearly half of women who become sexually active after delivery do not use any form of contraception (Sok et al. 2016)
- Up to 40% of women do not return for their 6-week postpartum visit (ACOG 2016)
- Women may not realize risks of unintended pregnancy after delivery
- Prenatal care visits are an opportune time to discuss postpartum contraception
- Women counseled prenatally are more likely to use contraception postpartum
- Women (and families) need time to make healthcare decisions

QUICK TIPS FOR COUNSELING WOMEN ON CONTRACEPTION

Assess a woman's interest in using Contraception postpartum

If interested, inquire about her preferences for contraception, then offer appropriate education

If the woman is unsure, use motivational interviewing techniques to assess her fertility plans

Devise an action plan with her and provide continued support

Revisit conversation throughout prenatal care and post-delivery visits

ASSESS → PLAN → REVIST

Why Counsel Women about Long-acting Reversible Contraception (LARC) during the Perinatal Period?

- Providers play an important role in a woman's contraceptive decision-making
- Women may be unfamiliar with or have misconceptions about LARC, such as:
  - How it works
  - Potential side effects
  - Whether LARC impacts their milk supply
  - Whether their insurance will pay for LARC or that they can get it immediately postpartum
  - Beliefs about LARC methods being permanent forms of birth control or impacting their future fertility
- LARC may align with a woman's reproductive experiences, preferences and values such as:
  - Prior contraceptive failure
  - Desire to delay another pregnancy
  - Motivation to obtain a non-daily, "forgettable" method
  - Ease of placement immediately postpartum

Providing Contraceptive Counseling During the Perinatal Period

When Should Counseling Take Place?

During Contraceptive Counseling, Women May:

1. Choose to use LARC immediately postpartum or later
2. Choose a non-LARC method
3. Decide to use no contraception
4. Choose to wait to decide

Ideally, a patient-centered approach to contraceptive counseling would begin during the prenatal period and continue beyond postpartum care (see Figure 1). However, a woman may not have postpartum contraceptive plans or had time to consider their plans. Additionally, some women may need additional time to make their decision. This chapter will provide patient-centered strategies for supporting the needs of all women across the perinatal period.

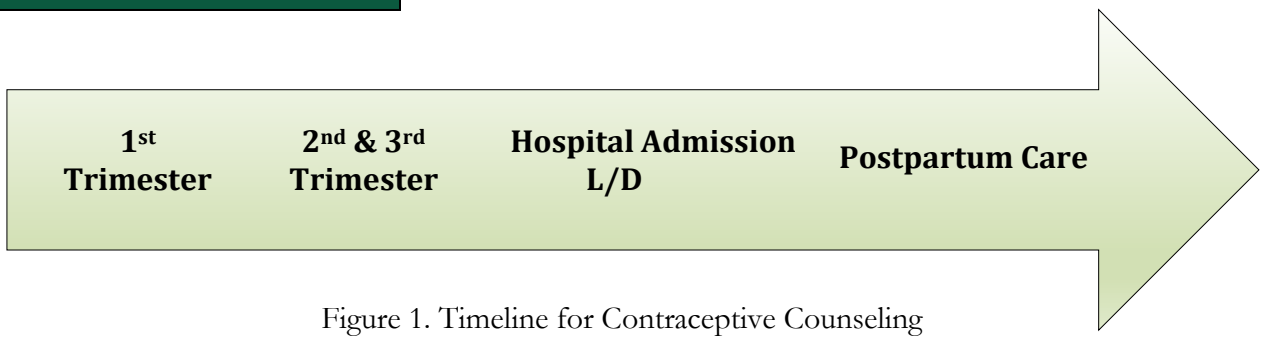

Figure 1. Timeline for Contraceptive Counseling

During the 1st Trimester:

Providers should initiate conversations with women regarding contraception during the 1st trimester. These conversations may be brief, to introduce the potential risk of a rapid repeat or unintended pregnancy. Providers should give women information to review with them during the visit, on their own, or at a later time (See below for more). One suggestion is to provide a handout or pamphlet, since women may not be interested in an in-depth conversation at this point in time. Providers should document interactions in the patient chart so that follow-up can be conducted at a later visit.

During Follow-up Prenatal Care Visits (2nd and 3rd Trimester):

Women and providers should discuss postpartum contraceptive use in more detail. Providers should review the patient chart and address questions or concerns from previous or the current visit. This time may be used to review patient resources or provide more in-depth education to women. This includes discussing the recommendation of delaying the next pregnancy for at least 18 months after birth. If contraceptive counseling has not begun or been documented in the second trimester, this should occur in the third trimester.

If women have decided to use contraception or have decided they do not wish to use contraception, providers should document this in the patient chart by the 36th week. If a woman decided not to use contraception, document the reason (or document if the method is natural/non-hormonal). For some women, their postpartum fertility plan may develop after several conversations with their provider. Deferring a decision to the postpartum period is also an acceptable choice.

At Hospital Admission/Labor and Delivery:

Admission of a woman to the antepartum floor might be an opportune time to discuss her reproductive life plan. The impact of a short interval pregnancy on both the mother and her infant can be emphasized. Once nurses establish a rapport with the patient (see below), they can begin a discussion about postpartum contraception by using the guide in Figure 3. The woman may seek advice several times before making a decision, and it is important to support her autonomy. A variety of patient counseling and education resources, including written materials and a video are available on the FPQC website.

If she is admitted intrapartum and has the time and opportunity to receive counseling, an educational video or pamphlet (e.g. early induction period, or while they have an epidural) may be appropriate. Women may not be interested in receiving information or counseling during active labor. Depending on available time, providers should:

1. Confirm the plans discussed during prenatal care, or
2. Introduce and discuss women's contraceptive options and intentions prior to delivery.

These interactions should still be patient-centered—if women have gaps in their knowledge and understanding of contraceptive use following delivery, then they may not be able to make a decision during their hospital stay. Remind women that they may be able to get contraception at a later date pending insurance status and benefit coverage. While providers and nurses may not have an opportunity to provide counseling, they may be able to confirm or note in the patient's chart whether or not she has made a postpartum contraception plan.

During Postpartum Care:

In a hospital postpartum or mother/baby unit, the provider should educate women on contraceptive options, including options she could receive prior to discharge or in the immediate postpartum period (e.g. the implant). This is another opportunity to provide written information or show an educational video. Any additional contraception choice counseling should be noted in the chart. The importance of her postpartum visit should be emphasized in light of her contraception choices, either to check the placement of her immediate postpartum LARC or to follow up on other contraception choices.

At postpartum visits, providers should follow-up with women's contraception decisions, including satisfaction with their chosen method. If a woman is unsure of what method to choose or is unsatisfied with the chosen method, providers should help women further explore contraceptive options. Continued support should also include LARC removal and reinsertion as appropriate.

Who Should Counsel and Educate Women on Contraception?

Women receiving prenatal care interact with an array of providers. Therefore, it is the responsibility of each member of the care team to support women and the Access LARC initiative. Each team member may have varying degrees of responsibility but should be equipped to answer basic questions about immediate postpartum LARC or connect women to a resource person who is more informed.

Physicians, Midwives and Nurses

Physicians and midwives should be able to provide detailed information about contraceptive options, information about associated benefits and side effects, and conduct follow-up with women to ensure they are well-informed about

their options, including immediate postpartum LARC. Nurses should be prepared to provide detailed information as well and conduct follow-up.

Health Educators, Lactation Consultants, and Others

Hospital systems may choose to integrate other support staff into the Access LARC initiative. These team members may have a role in educating and communicating with women about contraceptive options including receiving LARC immediately postpartum. Health educators, lactation consultants and other providers should have a basic knowledge of the initiative and the hospitals policies and procedures related to offering immediate postpartum LARC to women. These team members are included to minimize confusion and to reinforce information women receive during their care. Lastly, these team members should be aware of a contact person(s) women can talk to about their options or more detailed information.

REMINDER

Consistent contraceptive information and patient-centered counseling provided by all team members will make it easier for women to consider their options

Team-based Collaborative Patient-centered Care

What is team-based care?

ACOG defines team-based care as "care that strives to meet patient needs and preferences by actively engaging patients as full participants in their care while encouraging all health care providers to function to the full extent of their education, certification, and experience" (ACOG 2016a).

This toolkit promotes both patient-centered and team-based care. Team-based care has the potential to improve the quality of care women receive and enhance comprehensive care delivery. Teams may include doctors, nurses, midwives, medical assistants, health educators, lactation consultants, and administrators—and different departments—labor and delivery, pharmacy, postpartum, outpatient care, etc.

Cohesion and communication between team members ensures that a woman's concerns are documented and understood by the care team.

Team-based Care and Perinatal Care

Women rely on providers to assist them in contraceptive decision-making. Pregnant women tend to see a range of providers when they initiate early prenatal care. Important topics, such as postpartum contraception may not emerge during prenatal visits or the information women receive from information sources about contraception may conflict. This kind of confusion can be avoided if providers and health care staff work together to provide comprehensive care to all women.

Strategies for Providers to Work Collaboratively with Women

- Consider women (and families) as team members
- Create a unifying purpose, goal, and message
- Align team member roles with job characteristics and experiences
- Provide opportunities for team members to communicate and share information
- End education and counseling sessions with action steps or an action plan that women agree to carry out using strategies and language that resonate with them (See FAQs and Resources)

Prioritizing Team-based Care in Hospitals

Hospitals should:

- Decide how and when pregnant women receive contraceptive counseling
- Inform all applicable staff about the Access LARC initiative and give similar messaging to provide consistent information to women
- Develop a formal document describing hospital procedures for antenatal/intrapartum counseling to all staff members and external health care workers such as lactation consultants and health educators
- Develop a protocol for administration of immediate postpartum LARC and the administration of other forms of contraception prior to or after hospital discharge
- Create a documentation system in the Electronic Health Record (EHR) to record women's wishes and to inform other providers

Patient-Centered Contraceptive Counseling Considerations

Patient Diversity and Cultural Sensitivity in Contraceptive Counseling

Use of the National Academy of Medicine (formerly known as the Institute of Medicine) definition of patient-centered care includes providing care to women (and families) that incorporates women's needs, wants, and preferences (Institute of Medicine 2001). Providers see a variety of women with different backgrounds, experiences, beliefs, and pregnancy intentions.

Patient Needs Differ by Various Factors

Patient needs differ based on various factors including age, race, ethnicity, culture, religion, language, country of origin, sexual orientation, gender identity, disability and other patient-identified characteristics. Currently, there are many terms that reflect a desire to demonstrate respect for women—*cultural sensitivity*, *cultural respect, patient-centered care*, *woman-centered care*, *cultural competence*, *cultural humility*, and *cultural awareness*. While the objective is to identify a woman's needs, one must be cautious to not assume they understand her needs without having a full discussion with her (See Rapport-building).

Cultural Sensitivity to Patient Groups

Providers should be aware that historically low-income, minority or indigenous, unmarried and young women faced discrimination and sometimes mistreatment during clinical encounters. To provide equitable and competent care to women and families, providers may first have to address potential bias, which may not be conscious. Exercises such as self-reflection and self-assessment may help mitigate challenges when communicating with women who are or

think differently than their providers. Provider's preferences should not overshadow women's preferences. Communication models presented in this toolkit advocate for providing women with the best possible information, deliberating about options to assist in informed decision-making, coming to a joint decision with women that incorporates their needs and preferences, and following through with a plan.

Promoting Reproductive Choice and Patient Autonomy

Not all women will want contraception, and some women who are interested in contraception may not want to use LARC. Women should be encouraged to spend time reflecting on their needs and preferences and should be provided with contraception resources as appropriate. Additionally, women should be encouraged to ask questions and should be reminded that they can change their mind at any time, stop a method or have a (LARC) method removed upon request.

Contraception Options

Contraception allows a woman to plan if and when she wants to have children. Currently, there are about a dozen methods available that women can use to help them achieve proper birth spacing or avoid pregnancy. See Chapter 2 for more information about contraception.

ACOG encourages all providers serving childbearing age women to inquire and appropriately counsel women about contraceptive use (ACOG 2016b). Patient-centered tools can assist providers when having this conversation with women. Resources such as Bedsider.org (Figure 2) or the Centers for Disease Control and Prevention's (CDC) Family Planning Effectiveness chart can help providers share information in a concise, easy-to-understand manner.

The options in Figure 2 are presented in order of efficacy. Although methods are displayed based on effectiveness, a woman may use other criteria to decide what method works best for her.

Providers should engage women in a discussion about their preferences and needs while presenting the full range of options, not just highly effective forms of contraception.

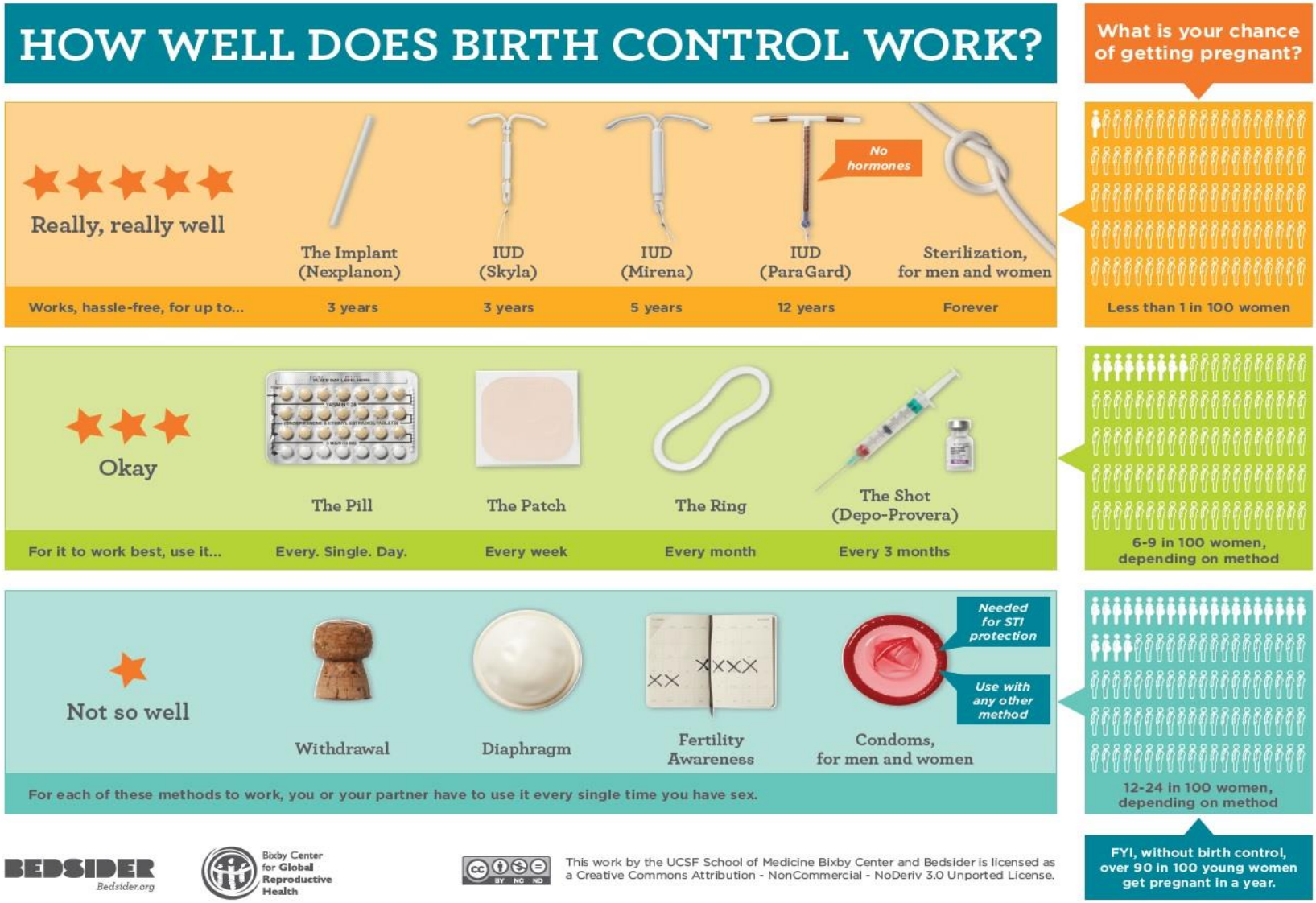

Figure 2. Bedsider Birth Control Effectiveness Poster

LARC: What it is and How It Works

Long-acting reversible contraception (LARC) includes the intrauterine device (IUD) and the hormonal arm implant. These methods provide long-lasting protection from pregnancy depending on which method women choose and can be removed to re-establish fertility. See chapter 2 of this toolkit for more information.

Hormonal LARC methods release small doses of hormones (i.e., progesterone) to women over time to prevent pregnancy from occurring. The copper IUD does not contain any hormone; this may be a good option for women who do not wish to use hormonal birth control or who have medical contraindications to hormones. The U.S. Medical Eligibility Criteria for Contraceptive Use (MEC 2016) is a web-based and application-based resource from the CDC that reviews contraceptive methods and safety based on medical conditions (See FAQs below).

LARC: Benefits and Side Effects

Key benefits to using LARC for pregnant women include (ACOG 2015):

- Highly effective reversible contraception
- User-friendly method
- Forgettable

Some side effects may lead to the discontinuation of LARC including (Dickerson et al. 2013):

- Irregular or increased bleeding
- Pain
- Amenorrhea
- Depression

Providers should discuss potential side effects with women and encourage them to have plans/strategies to cope.

REMINDER

Providers can ask women about how they might deal with potential side effects.

Ex: *"Some women experience irregular bleeding between periods while using this method. How would you handle that situation? How about another way you might deal with that?"*

LARC Removal and Re-insertion

Providers should encourage women to wait at least 18 months after delivery before becoming pregnant again. Depending on the type of LARC method, a pregnancy can be prevented for 3 to 10 years. If a woman chooses a LARC method, she is free to have it removed at any time. Some women may elect to have LARC method removed earlier for a variety of reasons. However, those who are aware of side effects before having a LARC method inserted are more likely to continue use. Often women have concerns about side effects or other issues that can be addressed without removing the device.

REMINDER

Ensure women know that LARC can be removed at any time and that once removed it allows the return of fertility. If they do not wish to become pregnant soon, they should consider receiving another LARC or using another contraceptive method.

Before insertion and as issues arise, providers should describe potential strategies to handle common side effects with women, so they can feel confident in their ability to sustain LARC use. If a woman wants to have her LARC removed, review her wants and needs for contraception. Reassure her that after a brief discussion, the option to have the method removed is available. Deliberation with women can be non-confrontational and help women remember why they initially chose LARC. If the final decision is to remove LARC, women should be directed to their obstetric provider, local county health department or Title X provider.

It is recommended that providers have a conversation with women about reasons for removal, fertility plans, and if they have considered an alternative method of birth control if they do not want to become pregnant.

Patient-Provider Communication and Shared Decision-Making

Providers can assist a woman in choosing a birth control method that works best for her or reassure her that she can choose a method at another time.

This section presents how providers can support pregnant and postpartum women during contraceptive education and counseling. These strategies are summarized in the table below (Table 1) and are adapted from motivational interviewing techniques that help women navigate their own health care needs and determine potential solutions that can work best for them. The strategies outlined here present the suggested process to assist hospitals and providers in implementing contraceptive counseling with pregnant and postpartum women.

Table 1. Patient Provider Communication and Contraceptive Counseling Process

Process	Summary	Resource
Build Rapport with Women (and Families/Partners)	Establish trust and facilitate dialogue between providers and women to prepare for patient assessment and education	See below
Assess and Educate Women (and Families/Partners)	Initiate discussion with women about postpartum contraception and assess values, preferences and potential plans to tailor information	*Options Infographic What is immediate postpartum… LARC? Implant? IUD?
Document and Reinforce Education with Follow-up	Document conversations and decisions appropriately and provide education as needed	Family Planning Counseling EHR Questionnaire (*Example*)
Ensure Informed Consent and Provide Ongoing Support	Ensure informed consent and provide ongoing follow-up regarding satisfaction with method choice, potential side effects, other questions and concerns	Consent document template

The following decision-matrix illustrates how providers can initiate the contraceptive conversation with pregnant women. Ideally, providers will begin this conversation early in prenatal care as many women will not have considered future fertility plans and may need time to consider their options. Additional resources can be found at the end of this section, which providers can use during conversations or as patient handouts.

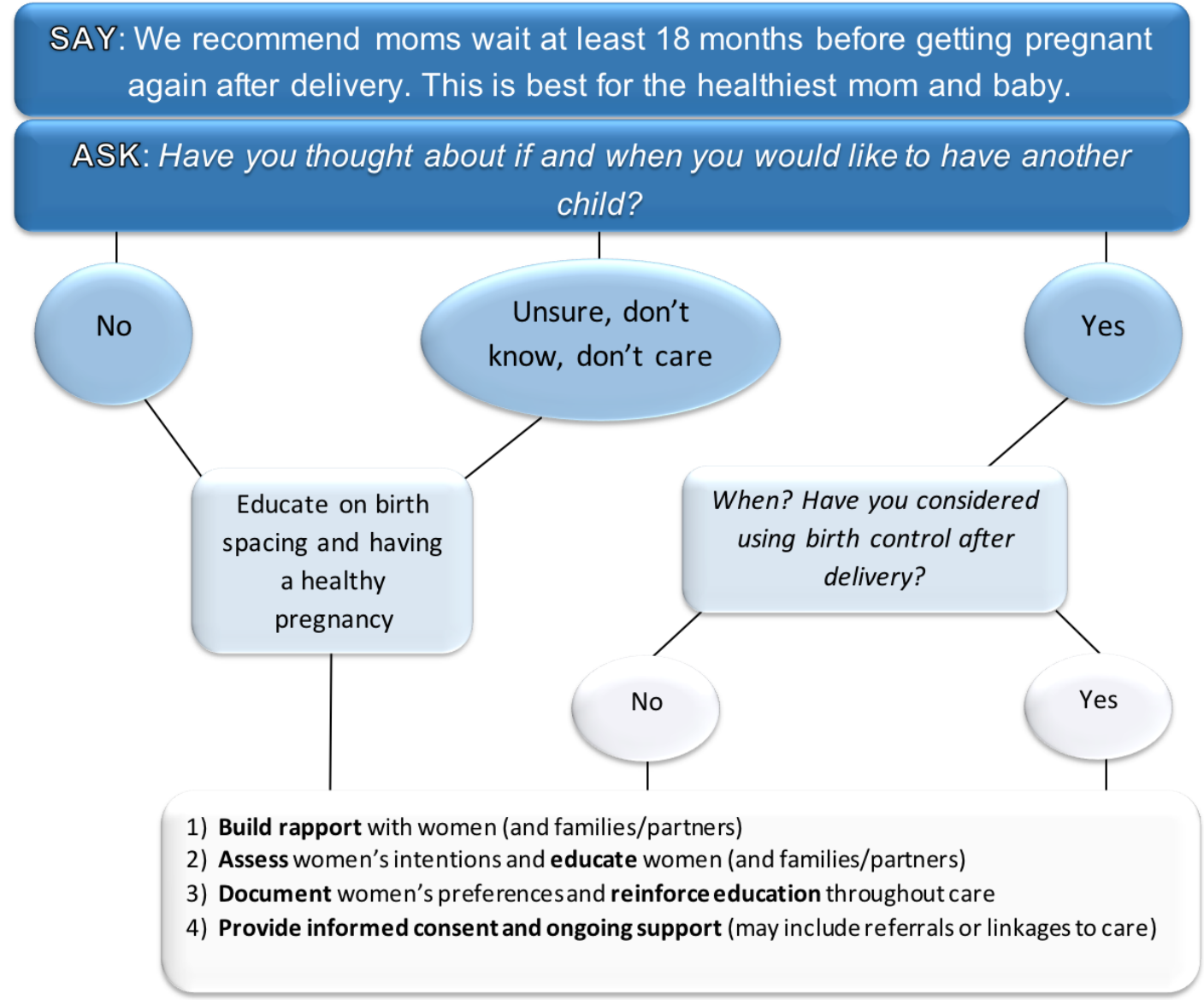

Figure 3. Contraceptive Decision-making Matrix

Step 1. Rapport-building

Providers can foster a collaborative and open environment with women and families/partners from the first visit. Strategies to create an environment conducive to open communication includes:

1. Greeting women warmly with a handshake and stating your name upon entering the room.
2. Asking women and other guests about their well-being.
3. Taking a seat as soon as possible to reduce the perceived power differential (standing over women may make them feel uncomfortable).
4. Ensuring women of privacy and confidentiality.

Hello, I am _____. It is a pleasure to (see you again/meet you).

Before we begin, we tell all our patients that whatever is discussed remains between you and me and other members of the care team

Do you have any questions before we get started?

5. Inquiring about questions or concerns they may have before getting the visit started (pregnant and postpartum women may need to use the bathroom, be uncomfortable in a particular position or have other practical questions or concerns like parking, waiting family members, etc.). When women are comfortable, they may be less agitated and more attentive during the visit.

When appropriate, introduce the topic of future pregnancy intentions, desires and plans. The U.S. Department of Health and Human Services and ACOG **recommend women wait at least 18 months after delivery before becoming pregnant again**. During the first and second trimesters it may be difficult to have a full birth control consult but the conversation can be initiated early to help women consider their options and plans. It is also a teachable moment because women may not even realize their risk for pregnancy after delivery.

We recommend moms wait at least 18 months after delivery before getting pregnant again. This is best for the healthiest mom and baby. Have you thought about if and when you would like to have another child?

When do you think that might be? How important is it to you to prevent pregnancy until then?

Help me understand through your eyes the good things about [X].

What are some of the not so good things about [X]?

So, on the one hand _[PROS]_, and on the other hand _[CONS]_.

Help women consider the pros/cons of their choice. Allow them to openly share their thoughts and opinions about a subsequent pregnancy. After she shares, summarize what she said. Depending on what is shared, you can help educate women about the benefits of delaying another pregnancy for at least 18 months. Women may not realize that it is actually healthier for them and their offspring to wait to give birth again.

Some women may prefer specifics such as facts and statistics to demonstrate the importance of using birth control immediately after delivery. Give information and feedback as appropriate, providing women with basic health information about risks and benefits.

Step 2. Patient Assessment and Education

Data suggest that across a woman's lifespan, about 90% of those who are sexually active will report using contraception at some point in their lives (Guttmacher Institute 2015). Before beginning a conversation about contraception, providers should ask women about what methods they have previously tried. Additionally, it is important to hear about women's experiences with those methods.

What forms of birth control have you used before? What about before this pregnancy?

What did you like about that method? What did you dislike?

What method(s) do you think you would like to use following your pregnancy?

Provide Comprehensive Education on Contraceptive Methods

Give women an overview of options while considering their insurance coverage and availability of methods. Inform women that they may be able to access birth control immediately after delivery, at their postpartum visit or later. Pregnant women who qualify for Medicaid due to their pregnancy are eligible for ongoing Medicaid coverage for contraceptive services for at least a year after delivery. Many women are unaware of this benefit, which extends their choice of contraception options past their postpartum visit, including insertion or removal of LARC.

Step 3. Documentation and Education Reinforcement

To provide continuity of care, providers should document all conversations with women about contraception. After deliberation and consideration for family planning options, providers should summarize the discussion and create an action plan with women. An action plan is a strategy facilitated by the provider but devised by women to guide next steps.

Will you summarize the steps you will take to [X]? I've written down a summary of things I will follow-up with you next time.

Next steps should be clearly defined and agreed upon together. The steps may be as simple as reviewing a flyer, talking to partners or family about contraceptive options or coming to the next appointment with questions. Summary information can also be given to women in written form, added to their prenatal care packet (if available), included in summary notes in their patient portal or another summary method.

Contraceptive decision-making is complex because it is a values-based decision. Contraceptive education and counseling may occur over several visits and each visit may conclude with an action plan or may be a continuation of the original plan. This ensures that women have adequate resources, education, support and time to make an informed decision.

What are some options that will work for you? What do you think you can do to stay healthy? Prevent pregnancy?

Birth control methods can sometimes cause side effects. How do you plan to handle these? What is another way you could handle these?

Reinforcing education and revisiting prior discussions is useful for helping women to consider risks and benefits, potential side effects and ways that they can cope or resolve issues that arise. Providers can use other tools to supplement verbal information provided during education and counseling.

Link Women to Resources (including online and web-based resources) (*As Appropriate*)

- Websites
- Apps
- Handouts and information
- Primary care providers, including Federally Qualified Health Centers/free clinic

- Local family planning clinic

Step 4. Ensure Informed Consent and Provide Ongoing Support

If Immediate Postpartum LARC is Chosen

Unlike other methods of birth control, LARC requires a quick procedure administered by a trained clinician. Therefore, when women choose to have a LARC inserted immediately after delivery, information about the specific procedure should be shared. Items to discuss during this part of the conversation should cover:

I would like to now share information with you about the specific procedure…

What questions do you have?

- Procedure duration
- When the procedure will be conducted (bedside, after delivery)
- Potential pain or pain management
- What to expect immediately after
- When the method becomes effective/when vaginal intercourse may resume
- Brief overview of how the device would be removed
- Information about IUD expulsion/re-insertion

If LARC is Not Chosen

Over the course of prenatal care, women may have additional questions that they would like answered. Following up periodically with women based on information discussed in previous visits or checking on their preferences again prior to delivery allows women time and space to consider their options and ask questions. Reassuring women throughout their care that they can revisit topics or change their mind is a way to demonstrate continued support.

FAQs

Question: How do I know who is eligible for immediate postpartum LARC?

Response: The U.S. Medical Eligibility Criteria for Contraceptive Use, 2016 (MEC 2016) is a web-based and application-based resource from the Centers for Disease Control and Prevention (CDC) that reviews contraceptive methods and safety based on medical conditions.

When using the chart, the rule of thumb is "green means go". Therefore, conditions that have are designated category "1" or "2" are various shades of green and indicate that there are no known contraindications or that the benefits outweigh the risks, respectively. Category 3 is a light shade of red indicating that this method is typically not recommended unless there are no other suitable alternatives. Lastly, the red shade, category 4 means that the contraindications for the method are too great and that use of the method is not recommended.

Access the chart by visiting at the CDC website, or in earlier chapters of the Access LARC Toolkit.

Question: Do all pregnant women have health coverage for immediate postpartum LARC?

Response: Before providers offer LARC to women, they should check women's insurance coverage. Pregnant women who qualify for Medicaid due to their pregnancy are eligible for ongoing Medicaid coverage for contraceptive services for at least a year after delivery. Women with private insurance should check with their insurer.

If women are unable to receive LARC before discharge, providers can connect women to contacts in the community that offer these methods at little or no costs: Florida health departments or Federally Qualified Health Centers (FQHCs).

Question: Do expulsion rates increase with immediate postpartum insertion?

Response: Yes, expulsion rates are higher in women who get immediate postpartum LARC compared to those who get LARC after discharge. However, the benefit of providing these methods outweigh costs since the majority of women fail to return for follow-up appointments.

Question: What are the side effects of LARC?

Response: Of women who discontinue LARC early, most report the following symptoms:

- Irregular bleeding
- Nausea
- Depression or anxiety
- Headaches

These symptoms may or may not be related to LARC but may be a significant concern for some women. Discussing potential side effects with a woman prior to initiation can help increase LARC continuation. Additionally, continuation for LARC methods are significantly higher than for non-LARC methods (Diedrich et al. 2015).

Question: Does LARC affect breastfeeding?

Response: To date, professional organizations support women's use of LARC in the immediate postpartum period, even if women are breastfeeding. Currently, there is limited evidence to suggest that LARC methods should not be used during this period.

Supporting organizations:

- American College of Obstetricians and Gynecologists (ACOG)
- Association of State and Territorial Health Officials (ASTHO)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicaid and Medicare Services (CMS)
- Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN)

Supporting literature has found that progestin-based contraceptives are acceptable and safe for breastfeeding moms and babies.

- A randomized controlled trial showed little difference in breastfeeding between those with immediate postpartum insertions and those with interval insertions (Turok et al. 2018)

- Other studies showed no evidence of adverse effects from LARC use and breastfeeding (Kapp and Curtis 2009) or adverse events in infants whose mom used LARC while breastfeeding (Shaamash et al. 2005)

Question: How do I engage in "action planning" with my patients?

Response: Action planning is based on the same principles presented throughout this toolkit chapter: motivational interviewing and patient-centered communication strategies. When it is time for a woman to make a decision about postpartum family planning, providers should: 1) assess how motivated/confident she is with her decision; 2) work with her to identify potential barriers (i.e. side effects, etc.); 3) provide a summary of what was discussed or decided for the action plan (i.e. patient summary, etc.); and 4) follow-up with her after the visit and continuously monitor her satisfaction with the action plan. The most important piece is that women and families work with providers to decide a course of action and everyone is accountable for follow-up and making sure communication continues to flow.

Patient Scenarios

Scenario 1. Contraceptive Counseling and Education for Women Who Access Prenatal Care Early and Often

Ideally, women will initiate prenatal care early in their pregnancy. These women will visit their provider through all three trimesters. This way, a provider can slowly introduce information to women.

A potential concern for providers and women is how often this information should be discussed. During the 1st trimester, providers should opt for a brief introduction to the topic of postpartum contraception and document information discussed and potential action steps. The 2nd trimester is the optimal time for a provider to spend additional time giving tailored education and counseling. Women may decide on a method then or want more time to consider her options. Near the end of the 3rd trimester (i.e., at or around 36 weeks), the provider should confirm and document women's contraceptive plans. At this time, women may need additional education and support to make a decision. Women may decide that this is not the best time for them to make this decision or may not wish to use any birth control immediately after delivery. Women and providers can discuss back-up options or alternatives that reflect the woman's wants, needs and preferences.

If immediate postpartum LARC is chosen, the prenatal care provider should obtain written informed consent and transfer this decision to the birth hospital to assure supplies/devices are available at delivery.

Women should be informed that they may be able to get contraception at a later date.

Scenario 2. Contraceptive Counseling and Education for Women Who Enter the Hospital System at Time of Delivery

Not all women access prenatal care early and often. A woman may be admitted to a hospital and unsure of their plans for postpartum contraception use. This may indicate that the patient has not received any education or options, or that the patient's wishes and preferences have not yet been documented.

In these instances, a provider should quickly assess where in the labor process the patient is and modify any counseling and education based on the patient's ability to engage in that conversation. Women should always receive

comprehensive contraceptive education and counseling so they can make an informed decision. If a decision is not reached, then women should be assured that they can access contraception at another time.

Scenario 3. Contraceptive Counseling and Education for Women Who's Pregnancy Results in Fetal Demise or Stillborn

Discovery of fetal demise or stillborn has traditionally been a time of duress at which long-lasting decisions should not be made. Providers should recognize that amidst the grief, there is an opportunity for bonding and developing a trusting relationship with a woman. In fact, some women not only desire their physician to be supportive with bereavement and grief, but also greatly appreciate physician guidance in the organization of their care.

Providers may be reluctant to discuss future fertility plans with women in this instance, but many women will have already been introduced to postpartum contraceptive options at prior prenatal visits. Some women may have already considered their options and made a decision. In women who have not had this counseling or made a decision prior to her stillbirth or fetal demise, this may be a difficult topic to address. The provider should approach the conversation of contraception with sensitivity and carefulness and assess the patient's responsiveness to the discussion.

After delivery of the stillborn fetus and prior to hospital discharge, the woman should be offered education on available methods of contraception, if she is interested. Because fetal demise may occur in the setting of other obstetric complications or maternal illness, the surrounding context and situation should be considered when discussing contraceptive options. A woman may choose a specific method prior to discharge or may choose to wait until her postpartum visit. Women should be assured that they can access contraception at a later time, if a decision is not reached prior to discharge from the hospital.

Scenario 4. Contraceptive Counseling and Education for Women Who Decline LARC Immediately Postpartum

Although immediate postpartum LARC is known to be safe and is the most effective contraceptive method, there are some women who do not want any form of immediate contraception.

If a woman does not want to get LARC immediately postpartum, she should receive counseling on other available contraception methods prior to hospital discharge.

A woman may opt for a LARC, but might prefer to have it inserted at her postpartum visit. In an effort to increase access to contraception, it is recommended that this visit be scheduled prior to discharge. She should also understand that her fertility might return prior to the postpartum visit and a temporary contraceptive method should be agreed upon.

If a woman elects to use another method of contraception, she should receive comprehensive counseling about her chosen method and recommendations for initiation of this method.

Scenario 5. Contraceptive Counseling and Education for Women with Contraindications to Immediate Postpartum IUD Placement

ACOG's Committee Opinion 670. Immediate Postpartum LARC Insertion states, "Immediate postpartum IUD placement is contraindicated in the setting of intrauterine infection at time of delivery, postpartum hemorrhage, and puerperal sepsis."

Providers may find it beneficial during prenatal contraceptive counseling sessions to ask the patient to consider a primary and secondary contraceptive choice. It may be helpful to explain to women during these counseling sessions that sometimes contraindications may occur, and an alternative or temporary option may be needed until the IUD can safely be placed.

If a woman expresses a desire for immediate postpartum IUD but experiences hemorrhage or infection during delivery, this contraindication should be discussed with the patient and alternatives offered. Providers should make women aware that although an IUD is contraindicated in these instances, a contraceptive implant (Nexplanon) could be inserted during her postpartum stay.

If a woman is adamant about wanting an IUD for contraception, she should be counseled about other contraceptive options that could be used until the contraindications to the IUD have resolved. Regardless of their decision, women should be assured that they can access their chosen form of contraception at a later time.

Scenario 6. Contraceptive Counseling and Education for Women Who are Misinformed about LARC

In this era of pervasive media including social media and television, it is not uncommon to encounter women who have heard negative or untrue information about LARC. Examples include stories about migration of IUDs or contraceptive implants, exaggerated reports about side effects, or unplanned pregnancies with LARC.

Women who have heard and are now expressing misinformation about LARC should be assured of LARC's safety and reminded of its effectiveness. Additionally, it is important to validate women's concerns as dismissal could impede effective patient-provider communication. Women who desire more information can be referred to specific safety information or literature. Some providers may also find it prudent to discuss what is known about the effects of short interval pregnancy.

Providers must realize that they may have to spend some extra time educating and redirecting women who are misinformed about LARC and other methods of contraception, however, the concepts of shared decision-making, non-coercion and patient autonomy are never more important than with contraceptive counseling.

Scenario 7. Contraceptive Counseling and Education for Women Who Desire Contraception after Preterm Birth

Preterm delivery is one of the most common complications of pregnancy. Addressing contraceptive options with a woman who has just completed a preterm delivery should be similar to a woman who completed a delivery without complications. Providers should keep in mind that any time a woman has a complication during pregnancy or delivery, her risks associated with different contraceptive options may change.

In this instance, considerations for the cause of preterm deliveries may slightly change the contraceptive counseling dialogue. For example, if intrauterine infection was the cause of or associated with the preterm delivery, then an immediate postpartum IUD would be contraindicated. Otherwise, her options for contraception are the same as other postpartum women. In addition, child spacing may be even more important for her in order to give her body adequate time to heal and to decrease the risk of a poor outcome in a subsequent pregnancy.

Scenario 8. Contraceptive Counseling and Education for Women Who are Planning to undergo Sterilization but Encounter Obstacles

In some cases, a woman who had planned to undergo sterilization at the time of her delivery or during the immediate postpartum period may not be able to obtain sterilization for a variety of reasons. Some examples of this are delivering at a different hospital than planned that does not conduct sterilization; insufficient time between consent and labor or second thoughts about her reproductive future.

If a woman cannot receive sterilization at the time of her delivery, she should be counseled on all other options for contraception. Immediate postpartum LARC may be an excellent alternative to a sterilization procedure as efficacy is similar and often with lower risks as it eliminates the need for a surgical procedure and anesthesia later.

LIST OF RESOURCES

Oregon Health Plan One Key Question® Algorithm Slide
CDC Reproductive Life Plan
ACOG Motivational Interviewing (2009)
ACOG The Process of Informed Consent (2009)
AHRQ Health Literacy Universal Precautions Toolkit, Make Action Plans
Family Planning Counseling EHR Questionnaire (Template)
Informed Consent (Template)
What is…Immediate Postpartum LARC/Implant/IUD? (Patient Resources)

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