

# Access LARC

A Quality Improvement  
Toolkit



Increasing Access to Immediate  
Postpartum Long-Acting  
Reversible Contraception



The Florida Access LARC toolkit is intended to provide guidance to hospitals and health care providers in the development of individualized policies and protocols related to increasing access to immediate postpartum long-acting reversible contraception. It is not to be construed as a standard of care; rather it is a collection of resources that may be adapted by local institutions in order to develop standardized protocols. **The toolkit will be updated as additional resources become available.**

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# ACCESS LARC

## INCREASING ACCESS TO IMMEDIATE POSTPARTUM LONG-ACTING REVERSIBLE CONTRACEPTION

### TOOLKIT INTRODUCTION

Beyond preventing unplanned pregnancies, research indicates that effective contraception helps prevent poor birth spacing, thereby reducing the risk of low-birthweight and/or premature birth (Conde-Agudelo, 2006). It is also beneficial for a woman's physical and emotional health to be able to follow a reproductive life plan. LARCs (Long Acting Reversible Contraceptives), including intrauterine devices (IUDs) and contraceptive implants, have been identified by the Centers for Disease Control and Prevention as among the most effective family planning methods.

LARCs are effective for between three and 10 years (depending on the method) and do not require any upkeep or user effort. Insertion of the IUD or implant after a delivery and prior to discharge has the additional benefit of eliminating access barriers, since the provider and patient are both available during the hospitalization and insurance has not lapsed. This is a time when it is known that the woman is not pregnant and may be highly motivated to avoid a short-interval repeat pregnancy.

Many organizations are working toward educating women about the full range of contraception options, from most effective to least effective. LARCs have

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*Long-Acting Reversible Contraceptives are among the most effective family planning methods – insertion of the IUD or implant after a delivery and prior to discharge eliminates access barriers in a time where women are highly motivated to avoid a short-interval repeat pregnancy*

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been endorsed by the American Congress of Obstetricians and Gynecologists (ACOG), the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), and the Centers for Disease Control and Prevention (CDC) as among the most effective family planning methods. Florida's Healthy Start program includes LARCs in contraception choice counseling in their newly-developed interconception education curriculum. The March of Dimes has provided community funding for LARC education. Florida Medicaid and several managed care organizations have also committed resources to providing education and reducing barriers to immediate postpartum LARCs (see Chapter 2 of this Toolkit).

## Access LARC Initiative

The Florida Perinatal Quality Collaborative (FPQC) works to advance perinatal health care quality and patient safety for all of Florida's mothers and infants through the collaboration of FPQC stakeholders in the development of joint quality improvement initiatives, the advancement of data-driven best practices and the promotion of education and training. With the support of professional organizations and a change in Medicaid policy allowing the unbundling of LARCs in the immediate postpartum period, the Florida Perinatal Quality Collaborative (FPQC), as guided by a multidisciplinary advisory panel, has established the Access LARC Initiative. The aim of Access LARC is to work with participating Florida hospitals to improve hospital policies, procedures, and collaboration to increase rates of postpartum LARC usage, and to work with Medicaid, and other payers and state partners, to facilitate their use.

The FPQC's Access LARC Advisory Group consists of representatives from the American College of Obstetricians and Gynecologists (ACOG) District XII, the Florida Chapter of the Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN), the Agency for Healthcare Administration (AHCA), the Florida Department of Health (DOH), United Healthcare and Aetna Medicaid Managed Care Organizations, representatives from provider practice groups, hospitalists, hospital nurses and administration, lactation consultants, and public health professionals.

Because this initiative is expected to take significant effort for hospital teams to get all the pieces in place for successful implementation, the initiative is divided into two phases: Pre-implementation and Implementation.

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*Our goal is for 80% of participating hospitals to provide immediate postpartum LARCs by the end of the 15-month initiative.*

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AGENCY FOR HEALTH CARE ADMINISTRATION





## Initiative Phases

**The Pre-Implementation Phase** focuses on creating and modifying hospital systems to enable acquisition and availability of and reimbursement for immediate postpartum LARC placement. Initial decisions regarding which LARC method (IUD or implant) as well as which hospital sites (L&D, postpartum, outpatient clinic) will be included in the initiative will guide the implementation process. The pharmacy department will need to address formulary revisions, determine pharmacy costs (device, local anesthetic, stocking charge), inventory levels, stocking locations and order system revisions. Billing and collections departments may need to create new billing processes (device, facility, provider), initiate contract amendments with managed care organizations, customize the claims process, and test billing revisions to assure reimbursement. Collaborations will also need to occur across departments to facilitate the creation or revision of policies and procedures, as well as to establish guidelines and work flows for labor and delivery, obstetric operating rooms, and postpartum floors. Administration support and close collaboration with managed care organizations at the highest level will be critical during this phase to assure the various departments work together and that the initiative continues to make timely progress given other hospital priorities. See Appendix A for the Pre-Implementation Key Driver Diagram.

**The Implementation Phase** focuses on the delivery of this new service. It includes assuring that providers are trained in immediate postpartum LARC insertion and in contraception choice counseling that includes the option of postpartum LARCs. This is the phase during which providers will actually begin offering and providing immediate postpartum LARC.

Experiences reported from other states indicate that the planning and implementation process for instituting postpartum LARC services took about six months. The timeline will vary depending on how quickly different hospital departments can convene for planning, the amount of effort needed to adjust the billing processes to meet the policy requirements, the process to expand the formulary, order and stock the devices, to modify or create policies and procedures and IT revisions and the training needs for clinical staff.

## The Access LARC Toolkit

Based on experiences in other states and input from the Access LARC advisory committee, this toolkit was developed and includes the guidance, tips and resources for:

<b>Pre-Implementation</b>	<b>Implementation</b>
<ul style="list-style-type: none"> <li>● Building a successful initiative</li> <li>● Key stakeholder education</li> <li>● Hospital/Managed care organization collaboration</li> <li>● Policies and procedures</li> </ul>	<ul style="list-style-type: none"> <li>● Provider and staff education on procedures and device insertion</li> <li>● Comprehensive choice counseling</li> </ul>

As with all of the FPQC toolkits, this document was developed as a general guide to assist hospitals with the steps expected to be necessary to provide immediate postpartum LARCs. Only the pre-implementation chapters have



been included for the kick – off meeting. The final chapters as well as additional guidance and tools will be developed as the project evolves.

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## INTRODUCTION



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## CHAPTER ONE: BUILDING A SUCCESSFUL INITIATIVE

### General Quality Improvement Tips

**It takes a multidisciplinary team to implement systematic change.** Quality improvement (QI) work often involves multiple disciplines and hospital departments. Engaging key stakeholders at the very beginning of a proposed QI project is key to successful implementation. It is important to strategically identify who needs to be at the planning table. These projects may require input and cooperation from departments that you don't traditionally interact with in your institution. Understanding the aspect of the project that impacts them as well as how the project will benefit their department is important to address for their initial buy-in. After leaders are identified, it will be important to engage them in planning and implementing evidence-based practice changes.

For the Access LARC initiative, gaining top level administrative support is key to successful implementation. Because so many departments are involved, it is especially important to obtain initial buy-in as well as ongoing support of senior level administration. In addition, it will be critical to have hospital representatives or liaisons affiliated with the managed care organization(s) that will be providing payment for immediate post-partum LARCs. Identifying a physician champion and nursing leader within the hospital who can facilitate the administrative coordination, lead the clinical process development, and ensure that clinical staff receives sufficient training is critical for success. Lactation consultant leadership will also be helpful to build support. It will be especially important that the planning team members are consistent. One representative and an alternative for each department is recommended and further substitutions of team members is discouraged.

Multi-disciplinary Implementation Team Disciplines and Departments
Obstetric Providers
Nursing (L & D, OB, OR, Mother/Baby)
Lactation Consultants
Billing/Collections
Contracts/MCO Liaison
IT/EMR
Pharmacy
Others (for example: QI, social work)

### Creating and Maintaining Successful Teams

The Institute for Healthcare Improvement (IHI) recommends that every team include at least one member who has the following roles:

- ✓ **Clinical leadership.** This individual has the authority to test and implement a change and to problem solve issues that arise in this process. This individual understands how the changes will affect the clinical care process and the impact these changes may have on other parts of the organization.
- ✓ **Technical expertise.** This individual has deep knowledge of the process or area in question. A team may need several forms of technical expertise, including technical expertise in QI processes, health information technology systems needed to support the proposed change, and specifics of the area of care affected. For example, a team implementing an intensive care management clinic for people with poorly controlled diabetes might need technical expertise in change management, the clinic's electronic health record, and the patient treatment protocols that will be used.
- ✓ **Day-to-day leadership.** This individual is the lead for the QI team and ensures completion of the team's tasks, such as data collection, analysis, and change implementation. This person must work well and closely

with the other members of the team and understand the full impact of the team's activities on other parts of the organization as well as the area they are targeting.

- ✓ **Project sponsorship.** This individual has executive authority and serves as the link to the QI team and the organization's senior management. Although this individual does not participate on a daily basis with the team, he or she may join periodically and stays apprised of its progress. When needed, this member can assist the team in obtaining resources and overcoming barriers encountered when implementing improvements.

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*Creating Quality Improvement Teams and QI Plans (2013) Practice Facilitation Handbook; Agency for Healthcare Quality and Research,ahrq.gov*

Once champions are identified and a team is assembled, the following tips can be used to guide team meetings:

- ◆ Because this will be a multidisciplinary effort, all members of the team must be respected and their needs identified and addressed
- ◆ Teams should establish and maintain a routine meeting schedule
- ◆ It is important to provide an open and safe environment that encourages:
  - Listening
  - Sharing
  - Questioning
  - Negotiating
  - Respecting
  - Participating
- ◆ A very important product of successful teams is that members are likely to begin to broaden their understanding to an expanded system rather than only their particular unit. Create a QI culture – a team environment that emphasizes quality and patient safety
- ◆ As many team members as possible should participate in collaborative events – each team member can learn from other hospitals
- ◆ Sharing important information, progress and successes with everyone keeps the work of the team in the spotlight
- ◆ Be creative and flexible

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### ***Easy Wins Matter***

*Demonstrating some early, straightforward successes builds confidence and enthusiasm for continued improvement. For the Access LARC initiative, an important early win is the establishment of an influential, effective and comprehensive quality team.*

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### Goals and timelines are very useful

It is suggested that highly effective teams develop implementation plans with specific goals and timelines. By providing this degree of structure for their work as well as assigning responsibility for specific actions, the teams are given a sense of progress and momentum that is encouraging. The figure below is an example of a suggested timeline for implementing Access LARC, which has two phases (Pre-Implementation and Implementation) over 15 months.

	Pre-Implementation						Implementation								
Activity	Mo 1	Mo 2	Mo 3	Mo 4	Mo 5	Mo 6	Mo 7	Mo 8	Mo 9	Mo 10	Mo 11	Mo 12	Mo 13	Mo 14	Mo 15
Recruit champions for multidisciplinary team	█														
Conduct scheduled monthly team meetings	█	█					█								
Add devices to formulary	█														
Assure timely access to devices	█	█													
Assure billing mechanism in place for pLARC	█	█													
Revise policies/procedures to provide pLARC			█			█									
Modify IT systems to assure accurate tracking, billing and documentation of pLARC			█			█									
Educate all appropriate staff on advantages and clinical recommendations of pLARC	█	█					█								
Train clinicians on pLARC insertion							█								
Educate providers and community partners about contraceptive choice counseling and informed consent							█								

### Data matter

The old adage “what gets measured gets done” is true for all quality improvement initiatives. Data are needed to test changes, provide feedback, and answer the essential question, “How do we know the change was an improvement?” For the Access LARC initiative most of the data to be collected will be measuring hospital progress in completing structural measures that must be in place to assure successful immediate postpartum LARC insertion.

### Small tests of change matter

A key principle of implementation science is to fit the scope of the intervention to context it is used in. The exact manner in which project elements are deployed in each hospital needs to be adapted to each unit. While all improvement requires change, not all change results in an improvement. It is important that the quality improvement team be willing to test multiple ideas while searching for the changes that result in improved care at the local level. In the IHI Model for Improvement, these multiple small tests of change are referred to as the PDSA, or Plan Do Study Act cycle. PDSA cycles should be run among smaller groups (for example, one nurse, one

physician, and during one shift to start) before gradually expanding to a larger population within the system or organization if the change is determined to be successful.

For the Access LARC initiative, an example of a PDSA cycle might be the testing of billing procedures developed to assure timely reimbursement for inpatient LARCs.

The PDSA cycle is an improvement tool which promotes improvement via the implementation of rapid-cycle tests among an increasingly larger population and a wider range of conditions. The “**Plan**” step in the cycle involves identifying and planning the change to be tested. Plans should be as specific as possible and include information about where the test will take place, who will participate, resources needed, and how the effectiveness of the change will be measured. The “**Do**” portion of the cycle is the actual act of carrying out the test. Initial tests should be small and local. For example, an initial test of a new form could be performed with one nurse and one patient on one nursing unit. If the test proves successful, the new form can be tested with several nurses and several patients in several different units. The “**Study**” phase of the PDSA cycle involves rapid data collection that is done during testing through a “huddle” or “debrief” with the staff or patients involved in the newly designed process. The results of testing will be analyzed and will help to determine whether a change process will be abandoned, adapted, or adopted. Testing periods should not last more than a month and can usually be completed within a few days, allowing for multiple testing cycles if needed. Finally, the “**Act**” portion of the cycle occurs when the decision to Adapt, Abandon or Adopt is made, based on the analysis of rapidly-collected information. If revisions and changes are indicated, the process is revised or “adapted,” and a new testing cycle is instituted. If the trials have been unsuccessful, the change idea may be “abandoned.” The decision to “adopt” a new process occurs after it has been tested broadly under various circumstances and settings.



*Implementation Guide for the Toolkit to Support Vaginal Birth and Reduce Primary Cesareans (2016) California Maternal Quality Care Collaborative*

### Administrative support matters

Successful quality improvement project implementation may require staff time and budgetary resources for equipment/supplies, education/training, and data collection. Administrative support may be needed in identifying departmental champions for the QI team. For the Access LARC initiative, implementation teams may need administrative support in identifying organizational stakeholders and resources, purchasing supplies, moving order sets and policies through committees, and obtaining integration of best practices. Facilities also need to provide resources and staff support for entering and analyzing data collection. This will often involve working collaboratively with information technology and quality departments. Staff need release time or additional support to complete these activities successfully.

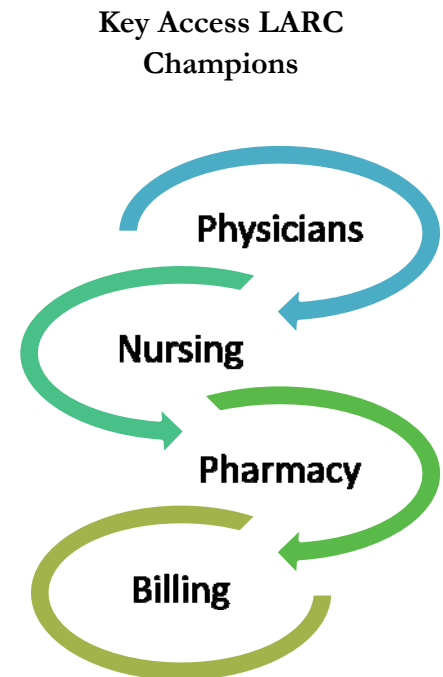
### It takes time and persistence to get systems running smoothly

In most quality improvement initiatives, overall success often takes time and persistence; this is especially true for the Access LARC initiative. With the need to revise multiple systems (pharmacy, billing, labor and delivery, etc.)

persistence, follow-up and strong communication are critical to keeping the project on track. Other states have reported setbacks and failed PDSA cycles requiring one or more revisions. It is understood that refining systems is a work in progress. Sustainability requires steady effort and attention by committed leaders and front line staff.

### Champions are essential

Formal leaders, opinion leaders, and early adopters are important to overall success since the changes can be uncomfortable and take a long time. Champions, however, are essential. Champions are individuals who actively associate with the project and dedicate themselves to incorporating best practices within the structure of each unit. For the Access LARC initiative, nursing, pharmacy, billing and physician champions are core components of successful implementation and especially with leading culture change. Nursing champions typically play a central role in testing, implementing, coordinating, and disseminating clinical practice refinement and changes. They also often provide counseling to the patient regarding contraception choices. Pharmacy champions are key to assuring that devices are obtained and stocked for timely insertion. While the pharmacy and billing champions work behind the scenes, their roles are crucial in establishing or modifying systems to ensure a successful implementation. Physicians and midwife champions are particularly important since they often provide contraception counseling to include this new choice for the patient and must be trained to insert the IUD or implant. They are often particularly visible stakeholders.




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*Champions are individuals who actively associate with the project and dedicate themselves to incorporating best practices within the structure of each unit*

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### Sustainability

Successful sustainable efforts must reflect the foundation provided in the initial phases of the project. For the Access LARC initiative many systems changes, such as an expanded formulary, successfully revised billing procedure and contract amendments are easily sustainable. However, processes assuring that contraceptive choice counseling including immediate postpartum LARC as an option continues to be discussed prenatally must be continuously monitored. Assuring that this option is offered and continues to be available to women prior to discharge will solidify the necessary cultural change within your institution. This can be facilitated by continuing to track and highlight the number of postpartum LARCs provided and assuring that staff and provider training remains required. Periodic review of managed care plan policies is also important to assure continued seamless provision of postpartum LARCs.

### Why Join a Collaborative

Participation in a collaborative helps your hospital implement evidence-based quality improvement recommendations by bringing together institutions with similar goals and providing resources to advance those goals. It offers an environment to learn together with others on the best strategies, methods and tools to adapt and implement in your hospital. Hospitals that participate in multi-organization quality improvement collaboratives achieve more gains faster than those who do so alone. Past participants have found it useful to not have to “reinvent the wheel.”

Identification of potential barriers to your project are important to consider and solve prior to sharing with staff. It is possible that additional challenges may occur during implementation, but it will be in your favor to remove as many barriers as possible prior to the start.

Potential Implementation Barriers & Strategies to Overcome	
Potential Barrier Drivers	Strategies to Overcome
<b>Clinician</b> <ul style="list-style-type: none"> <li>Resistance to change</li> <li>Don't see the need for change</li> <li>Lack of understanding and/or knowledge deficit</li> </ul>	<ul style="list-style-type: none"> <li>Build compelling story with respected peer to speak to the importance of initiating proposed changes</li> <li>Provide peer based education to all clinicians with education on the initiative and goals</li> <li>Provide peer-reviewed evidence to support change</li> <li>Share goals of the proposed QI project/change</li> <li>Provide opportunities to answer questions and/or concerns</li> </ul>
<b>Upper management</b> <ul style="list-style-type: none"> <li>Lack of knowledge of Perinatal QI</li> <li>Lack of resource support</li> </ul>	<ul style="list-style-type: none"> <li>Share data on outcomes of facility in relation to like facilities</li> <li>Provide high quality peer-reviewed research and evidence to support change</li> <li>Instill the importance of resource (people, financial) support for project to ensure success</li> <li>Share plan for implementation and sustainability</li> </ul>
<b>Time limitations</b>	<ul style="list-style-type: none"> <li>Utilize efforts of many staff members – consider use of nurse clinical ladder to support project</li> <li>Make sure meetings are organized and succinct to decrease the impact on available time</li> <li>Offer meetings at multiple times; consider web-based meetings for those who may be off site</li> <li>Utilize regularly scheduled department meetings to highlight project and results                             <ul style="list-style-type: none"> <li>Be succinct</li> <li>Be prepared to answer questions</li> </ul> </li> </ul>
<b>Resource limitations</b>	Connect with other hospitals or QI leaders for potential solutions or sharing resources through collaborative work
<i>Bingham, D., &amp; Main, E. (2010). Effective implementation strategies and tactics for leading change on maternity units. Journal of Perinatal and Neonatal Nursing, 24(1) 32-42.</i>	

## CHAPTER TWO: KEY STAKEHOLDER EDUCATION

### Overview

During the pre-implementation phase, key healthcare providers and staff should be educated on the definition, components, and importance of postpartum long-acting reversible contraception in order to facilitate buy-in, foster champions, and ease adoption of new processes. It will ensure hospital awareness of the project to increase access to LARC prior to discharge, and standardize department knowledge in preparation for creation of a policy or protocol on this topic.



Key staff and specific reasons for LARC education include:

#### ✓ **Physicians and Midwives**

- **Delivering physicians/midwives:** Universal acceptance of this new contraceptive option is ideal, although not all health insurance plans reimburse for inpatient LARCs separate from the global delivery fee. All obstetric providers should be aware of the option and provide the same choice counseling to their patients.
- **Non-delivering community physicians/midwives** – Choice counseling is most effective when initiated prenatally, thus providing time for questions and careful consideration of all the contraception options prior to the woman's delivering. It is important to educate community OB providers about the full array of choices now available to women as well as informing prenatal care providers about Access LARC.

#### ✓ **Nurses**

Nurses in L&D as well as on the postpartum unit provide important support for reproductive life choices made by pregnant women and new mothers. Immediate postpartum LARC is a relatively new contraceptive choice, so it is important for nurses to be able to provide comprehensive information. Their input into process changes necessary for implementation will also be important. Identifying a champion in each area will be critical in the successful implementation of Access LARC.

#### ✓ **Pharmacy**

This innovation will require assistance from pharmacy to obtain approval to add IUDs and implants to inpatient formularies. It may also require new processes, since the trend is to bundle services together rather than separate them. Providing the benefits and the science behind this change can greatly enhance cooperation and success.

#### ✓ **Lactation Consultants**

Lactation consultants are an important part of a woman's postpartum hospital stay, assisting with establishing successful breastfeeding. Traditional teaching has often recommended against any immediate postpartum hormonal contraceptives in breastfeeding women due to concerns regarding delayed lactogenesis. Currently available literature does not show that the hormonal IUDs or implants impair

breastfeeding, and therefore educating Lactation Consultants on newer literature is imperative in gaining their support for patients desiring immediate postpartum LARC.

✓ **Administration**

As with any new initiative, obtaining administrative support is crucial before attempting any of the other steps in providing immediate postpartum LARC.

**This broad education is a pre-cursor to training related to how to counsel and educate patients and the more focused education that some providers will receive on placement and insertion of IUDs and implants, which will be provided in the implementation phase.**

## Educational Topics

### Unplanned Pregnancies

Approximately 45% of all pregnancies and 75% of teen pregnancies in the U.S. are unintended (Finer, 2016). In Florida, the unintended pregnancy rate was 59% in 2010, and 71% of unplanned births were publicly funded (compared to 68% nationally) (Sonfield and Kost 2015). The total public costs for unintended pregnancies in 2010 was \$1.3 billion. This equates to \$371 per woman aged 15-44 in Florida, compared with \$201 per woman nationally (Sonfield and Kost 2015).

The consequences of unintended or closely spaced pregnancies include poor pregnancy outcomes (i.e., low birth weight, preterm birth, small for gestational age, neonatal and infant death), delayed initiation of prenatal care, lower breastfeeding rates, and higher risk of maternal depression and potential future child maltreatment (Guttmacher Institute 2017). Short interpregnancy intervals are also associated with worse perinatal outcomes: maternal bleeding, anemia, death, preterm birth, and low birth weight (Jackson et al 2011; Conde-Agudelo 2006).

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*The total public costs for unintended pregnancies in 2010 was \$1.3 billion.*

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### Long-Acting Reversible Contraception

LARC has been endorsed by the American Congress of Obstetricians and Gynecologists (ACOG), the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), and the Centers for Disease Control and Prevention (CDC) as among the most effective family planning methods. Clinical practice guidelines from CDC and ACOG support immediate postpartum insertions for both IUDs and contraceptive implants, with few contraindications.

Studies indicate that fewer than 1 in 100 women will get pregnant using an IUD or implant. Typical use of the birth control pill results in 9 out of 100 women becoming pregnant within a year and the use of male condoms results in 18 out



of 100 women becoming pregnant. The number is higher if not used correctly and consistently. While LARC use is growing, only 7.2% of women aged 15-44 and less than 5% of teens use LARCs in the U.S (CDC 2015).

### Terminology

- **Immediate Postpartum** refers to the placement of the IUD or implant within the delivery hospitalization period.
- **Immediate Post-Placental** refers to the placement of an IUD within 10 minutes of delivery of the placenta and is a subgroup of immediate postpartum.
- **Late Postpartum** refers to placement after 48 hours and before four weeks post-delivery.
- **Standard or Interval** refers to placement of a LARC four weeks or more postpartum, or unrelated to a pregnancy event.

In an effort to expand contraception choice, this initiative focuses on immediate postpartum and post placental LARC placement on an inpatient basis.

In 2015, the CDC convened national experts to review scientific evidence for the use of various contraceptive methods for men and women with specific characteristics or medical conditions and update the 2010 U.S. Medical Eligibility Criteria for Contraceptive Use (US MEC 2016). Results of that review were published in the US MEC, 2016. Immediate postpartum LARCs MECs are listed on the table below.

**Immediate Postpartum LARCs**

Condition	Sub-Condition	Cu-IUD	LNG-IUD	Implant
Postpartum (in breastfeeding or non-breastfeeding women, including cesarean delivery)	a) <10 minutes after delivery of the placenta			
	i) Breastfeeding	1	2	2
	ii) Nonbreastfeeding	1	1	1
	b) 10 minutes after delivery of the placenta to <4 weeks	2	2	1*/2**
	c) ≥ 4 weeks	1	1	1
	d) Postpartum sepsis	4	4	1

LNG=levonorgestrel; Cu=copper; IUD=intrauterine device.      \*Nonbreastfeeding women, \*\*Breastfeeding women

Categories:  
 1 = A condition for which there is no restriction for the use of the contraceptive method.  
 2 = A condition for which the advantages of using the method generally outweigh the theoretical or proven risks.  
 3 = A condition for which the theoretical or proven risks usually outweigh the advantages of using the method.  
 4 = A condition that represents an unacceptable health risk if the contraceptive method is used.

*Adapted from Centers for Disease Control and Prevention Medical Eligibility Criteria Classifications for Postpartum Long-Acting Reversible Contraception (2016)*

### Intrauterine Devices (IUDs)

The copper IUD (ParaGard®) can be used for 12 years, and the levonorgestrel IUDs (Skyla®, Kyleena®, Liletta®, and Mirena®) for three to five years, with failure rates similar to female sterilization. The ACOG Practice Bulletin on LARC (2017 update) provides guidance on patient counseling for complications and side effects.

Copper IUD:

ParaGard®

For all IUDs, immediate postpartum insertions are considered safe and effective. When inserted within 10 minutes of placental delivery, the copper-containing IUD (ParaGard) has no restrictions on its use (medical eligibility criteria category 1). After this period and up to four weeks' postpartum, the advantages of insertion generally outweigh the theoretical or proven risks (medical eligibility criteria category 2). For the levonorgestrel IUDs, the advantages of immediate postpartum insertion generally outweigh the theoretical or proven risks (medical eligibility criteria category 2) in breastfeeding women, and there are no restrictions on its use in nonbreastfeeding women (category 1).

Levonorgestrel  
IUDs:

Skyla®, Kyleena®,  
Liletta®, Mirena®

Contraindications for immediate postpartum IUD insertion include peripartum chorioamnionitis, endometritis, and puerperal sepsis.

### Contraceptive Implant (Hormonal)

The contraceptive implant (Nexplanon®) can be used for up to four years, and is a highly effective method of reversible contraception. The advantages of using this method in the immediate postpartum period generally outweigh the theoretical or proven risks (medical eligibility criteria category 2). Suggested counseling about the devices, advantages, contraindications, etc., including a shared decision-making model, are covered in detail in Chapter 6 of this toolkit.

Contraceptive  
Implant:

Nexplanon®

## **Immediate Postpartum LARC**

Between 40 and 57% of women resume sexual activity before their postpartum check-up (Brito 2009, Connolly 2005). These women may not recognize their risk for unintended pregnancy so soon after delivery. Postpartum women may be highly motivated to obtain contraception and delay another pregnancy.

Immediate and early postpartum is an ideal time to initiate contraception because women are currently accessing the healthcare system. Up to 40% of women do not return for their 6-week postpartum visit (Gurtcheff 2011) and 40-75% of women who plan to use an IUD postpartum do not obtain one (Simmons 2013). According to an August 2016 ACOG Committee Opinion, expulsion rates for immediate postpartum IUD insertions are higher than for interval insertions, vary by study, and may be as high as 10–27%. Despite the higher expulsion rates, a 2015 Cochrane Review (Lopez et al 2015) found that IUD placement immediately postpartum was associated with higher use of LARC at six months compared to standard insertion.

Up to 40% of women do not return for their 6-week postpartum visit.

40-75% of women who plan to use an IUD postpartum do not obtain one.

Although the initial cost of LARCs is greater than other forms of contraception, it is more effective in preventing pregnancies, since as many as 57% of women have resumed intercourse prior to their postpartum visit. When taking into account the cost of an avoided pregnancy, immediate postpartum implant insertion is expected to save \$1,263 per patient. (Garipey, Duffy, Xu 2015). South Carolina’s initial efforts to cover LARCs through Medicaid resulted in a first year cost for oral contraceptives (including the cost of expected unintended pregnancies) almost double that of immediate postpartum LARCs.

While there is limited research on this subject, unintended pregnancy is significantly more prevalent in women using opioids. In a study aimed to estimate the prevalence of unintended pregnancy among opiate-abusing women, researchers found that almost 9 of every 10 pregnancies were unintended (86%), with comparable percentages mistimed (34%), unwanted (27%), and ambivalent (26%). (Heil, 2011). Unfortunately, women undergoing treatment for opiate addiction demonstrate low contraceptive knowledge and use, and therefore may certainly benefit from the availability of immediate postpartum LARC.

### IPP LARC Coverage Movement

Insertion of LARCs immediately postpartum has been proven to be safe, effective and is supported by clinical guidelines. As noted in the US Medical Eligibility Criteria for Contraceptive Use, the IUD and the contraceptive implant may be inserted prior to hospital discharge after vaginal or cesarean delivery in both breastfeeding and non-breastfeeding women.

However, reimbursement policies have traditionally posed a barrier to inpatient LARC placement. Medicaid and private insurers bundle labor and delivery related care into one global fee. The high cost of IUDs and implants, which would be included in that global fee, discouraged implementation of immediate postpartum LARCs. In 2012, South Carolina became the first state to “unbundle” LARCs, thus allowing separate payment for the device and associated costs by Medicaid. Since that time other state Medicaid agencies have followed suit and provided various funding methodologies. Currently, over half the states in the US have implemented or are exploring ways to implement such policies.

In 2014, the Association of State and Territorial Health Officers (ASTHO) and CDC created a LARC Immediately Postpartum Learning Community with an initial cohort of six states and an addition of seven states in cohort 2 (2015). In 2016, the scope and size of the learning community was expanded to include 22 states addressing increasing access to contraception.

Florida joined the Increasing Access to Contraception Learning Community in October 2016 as part of Cohort 3. As a member of Cohort 3, Florida’s aim has been to implement system-wide changes to eliminate barriers of access to reproductive health care while addressing health disparities. Florida will focus on all women of reproductive age with a special emphasis on the under-insured and Medicaid populations. Florida will accomplish these activities through two goals:

1. Implementing statewide policy change to provide immediate postpartum LARC in an inpatient hospital setting.

2. Removing barriers to same day access to highly effective, reversible methods of contraception in clinic settings.

In addition to the ASTHO Learning Community, other national and statewide efforts to encourage the use of the most effective forms of contraception include:

- ✓ National objectives included in Healthy People 2020
- ✓ HEDIS measures reported by health plans
- ✓ Clinical opinions/guidelines endorsed by ACOG, AAP, AAFP, and CDC
- ✓ US Medical Eligibility Guidelines for Contraceptive Use
- ✓ Education and training for Title X providers
- ✓ Medicaid family planning waiver
- ✓ Healthy Start program emphasis
- ✓ March of Dimes emphasis

### Provider FAQs

#### 1. How soon after delivery can a LARC be placed?

- Implants can be placed anytime immediately after delivery
- IUDs can be placed within 10 minutes of placental delivery in both vaginal and cesarean deliveries.

#### 2. What is the rate of expulsion for an IUD placed soon after delivery?

- For an IUD placed at the time of delivery there is an increased risk of expulsion reported to range from 10 – 27%. However, women who had an IUD placed immediately after delivery were more likely to continue with the method compared with women who had an interval placement. This is especially important in women who are not likely to follow up postpartum.
- A recent study showed that levonorgestrel IUDs placed 2 weeks after delivery have an expulsion rate of 4%, which is similar to that of interval placement.

#### 3. What are the advantages of LARC placement immediately postpartum?

- Confirmation that a woman is not pregnant at the time of insertion
- The woman and the clinician are at the same place at the same time, eliminating access barriers to insertion
- Women are highly motivated to avoid unintended pregnancy following delivery, therefore there may be higher rates of adherence.
- LARC use requires only one motivated act, while other contraceptive options require continuous user motivation, dependence, and adherence.

#### 4. What are contraindications to immediate postpartum LARC placement?

- There are no additional contraindications to etonogestrel implant placement during the postpartum period compared to interval insertion.
- Immediate postpartum IUD placement is contraindicated with women with an intrauterine infection at the time of delivery, postpartum hemorrhage, or puerperal sepsis.

### 5. **What is the effect on breastfeeding?**

Although there is a theoretical risk of decreased lactogenesis associated with administration of progesterone, several studies have shown that there is no difference in lactogenesis in women who underwent postpartum LARC placement. In addition, there was also no difference in the length of time women reported breastfeeding. In women who remain very concerned about this despite the evidence, placement of a copper IUD may be appropriate.

For non-breastfeeding women, the implant has no restrictions on immediate postpartum use (medical eligibility criteria category 1). Limited data on hormonal methods' effects on breastfeeding indicate no negative effects on breastfeeding outcomes. Because of theoretical concerns related to hormonal effects on milk production and infant growth and development, the advantages of insertion generally outweigh the theoretical or proven risks (medical eligibility criteria category 2).

- Progestin-based contraceptives are safe for breastfeeding moms and babies. A systematic review of 43 studies showed no evidence of adverse effects (Kapp, Curtis & Nanda, 2010)
- A recent noninferiority study showed time to lactogenesis and breastfeeding at eight weeks were both noninferior in women receiving an immediate postpartum LNG IUD compared to those receiving a delayed device (Turok DK 2017)
- One randomized control trial (RCT) of immediate LNG IUD suggested possible impact on breastfeeding performance. Two RCT's of early implant insertion found no impact. (Phillips, et al. 2015, Chen 2011, Dahlke 2011, Elsedeek 2012)

### 6. **Is backup contraception (i.e. barrier method) needed when a LARC is placed immediately postpartum?**

No backup method of contraception is needed when a LARC is placed immediately after childbirth.

### 7. **Why not wait until the postpartum visit to insert LARCs?**

- Up to 40% of women do not return for their 6-week postpartum visit (Gurtcheff 2011) and 40-75% of women who plan to use an IUD postpartum do not obtain it (Simmons 2013).
- Between 40 and 57% of women resume sexual activity before their postpartum check-up (Brito 2009, Connolly 2005).

### 8. **What if a woman wants to have the LARC removed?**

Long acting reversible contraceptive devices can be removed at any time by a trained practitioner in the provider's office and a woman's fertility is reestablished. If the woman no longer has a provider, county health department family planning clinics can remove the IUD or implant.

### 9. **Why is prenatal choice counseling important?**

Ideally, choice counseling and reproductive life planning options should be discussed, at a minimum, during the third trimester of pregnancy. This enables women to make an informed decision in advance of their

delivery date. Health care providers should inform their patients about all the reproductive planning options during the prenatal visits and ensure that the individual's priorities, needs and preferences guide her decision

### **List of Staff Education Resources**

FPQC Education slide deck (21017)  
 ACOG Immediate Postpartum LARC (2016)  
 ACOG Practice Bulletin on LARC devices (2017)  
 Academy of Breastfeeding Medicine Contraception statement (2015)  
 CMS info bulletin on State Medicaid approaches to improve access (2016)

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## CHAPTER THREE: HOSPITAL/MANAGED CARE ORGANIZATION COLLABORATION

### Overview

Implementing immediate postpartum LARC insertion requires a variety of changes, both on the hospital side and on the managed care reimbursement side. It is critical to have the hospital managed care liaison on the planning team. At a minimum, billing and pharmacy benefits must be addressed and contract amendments may be necessary. Each Medicaid managed care plan may have a different and complex set of coverage rules and requirements. Billing methodologies may include billing for the device and services separately or might involve using a specific billing code which denotes LARC insertion associated with delivery to increase the global delivery fee. Therefore, it is important for provider hospitals to understand the details of each managed care plan and not assume all reimbursement policies, coding and billing steps are the same among the plans.



### **Medicaid Managed Care Organizations (MCOs)**

The managed care plan's role is pivotal in the successful implementation of the Access LARC quality initiative in clarifying and collaborating on policy, billing, and reimbursement barriers at the hospital level. There are several steps that health plans must implement to begin reimbursing for this inpatient service which include:

- ✓ Determining the adequacy of payment
- ✓ Engaging internal stakeholders/champions (administration, medical director, contracting and billing experts, quality representation)
- ✓ Promoting provider and member education and awareness of the program
- ✓ Assessing baseline utilization and improvement
- ✓ Negotiating contracts with hospitals
- ✓ Establishing/implementing internal systems to support billing methodologies of contracted hospitals
- ✓ Addressing programmatic edits that would impede reinsertion or removal of device

### **Contract Amendments**

Plans may have multiple contracts given their flexibility to negotiate with various hospitals and given their individual policies, procedures, and framework. Content to be addressed in contract negotiations includes:

- Formulary Drug/Device for Reimbursement in the hospital
- Hospital Billing & Reimbursement Process and Agreement for Drug/Device



- Physician Billing & Reimbursement Process and Agreement for Service Rendered
- Enhancement of the communication and follow-up process between the health plan and physician to the hospital labor and delivery department to convey consent for immediate postpartum LARC insertion.

*Refer to the Medicaid Health Plan LARC Access Guide for additional information*

## Billing & Reimbursement Methodology

Claims submitted for inpatient LARCs must include the exact billing codes specified by each MCO's policy, involving varying levels of customization to claims processes depending on the hospital's system. Hospitals also should identify a mechanism to reconcile the Medicaid reimbursements with patient accounts and monitor and resolve denials.

There may be a need to create order sets or add to billing forms for physicians to use when inserting a LARC to ensure that the supplies, device, and procedure are appropriately billed. Order sets should include the contraceptive device, local anesthetic, and steps for printing the consent form, garnering final consent, and performing the procedure before discharge.

## LESSONS LEARNED FROM OTHER STATES IMPLEMENTING POSTPARTUM LARC

- Determine whether the billing system is adaptable to allow for line items outside the DRG and when possible altering the program to streamline billing for LARCs.
- Submit all required information exactly according to the policy to avoid claims being denied.
- Identify a mechanism to reconcile reimbursements with patient accounts and monitor and resolve denials.
- Test all elements of the claims process and resolve any system glitches prior to implementation.

## Billing and Reimbursement

In the fee for service (FFS) delivery system, Florida Medicaid reimburses for immediate postpartum placement of long acting reversible contraceptives separate from the inpatient hospital labor and delivery Diagnosis Related (DRG) payments. This system change was implemented to support the Agency for Healthcare Administration's goal of improving birth outcomes.

Providers rendering services through the fee-for-service delivery system can seek reimbursement for LARC by utilizing the codes listed in the tables below.

### Device Insertion and Removal Procedure Codes

CPT CODE	DESCRIPTION
11981	Insertion, non-biodegradable drug delivery implants
11982	Removal, non-biodegradable drug delivery implants
11983	Removal with reinsertion, non-biodegradable drug delivery implant
58300	Insertion of IUD
58301	Removal of IUD

### LARC Device Codes

HCPCS CODE	DESCRIPTION	NDC
J7297	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM (LILETTA), 52 MG	52544003554; 00023585801
J7298	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM (MIRENA), 52 MG	50419042101; 50419042301; 50419042308
J7300	INTRAUTERINE COPPER CONTRACEPTIVE (Paragard)	51285020401
J7301	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM (SKYLA), 13.5 MG	50419042201
*Q9984	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE (KyleEna), 19.5 MG	50419042401
J7307	ETONOGESTREL (CONTRACEPTIVE) IMPLANT SYSTEM, INCLUDING IMPLANT AND SUPPLIES (Nexplanon)	00052433001

\* systems are currently being updated to include this temporary code  
**Note:** National Drug Codes (NDC) should be included. The only limit on these products is 1 unit per claim, up to 3 claims per year.

The complete Florida Medicaid Health Alert clarifying immediate postpartum LARC payment can be found in Appendix B. This alert outlined Medicaid's fee-for-service billing and reimbursement methodology. Each plan can follow this example or use other payment methods.

Hospitals may want to review different payment methodologies used by other states in the following documents:

- **Alabama Medicaid** (March 2014) [published a provider alert](#) to their hospitals and physicians. Please note that ICD-9 codes are used given the timing of when they issued their alert.
- **Connecticut Medical Assistance Program** (April 2016): [issued a policy transmittal](#) (PT) to providers and managed care plans.

- **Illinois Department of Healthcare and Family Services (June 2015):** [published a hospital and reimbursement provider notice](#) to enrolled hospitals, physicians, advanced nurse practitioners, Federally Qualified Centers, and Rural Health Clinics.

## Pharmacy

The hospital pharmacy's role in providing postpartum LARCs involves changing institutional procedures to support practitioners providing immediate postpartum LARCs. Hospital pharmacies should make sure the devices are included in their order system then determine initial inventory levels. Because IUDs must be inserted within ten minutes after delivery of the placenta, it is critical to stock the devices near the delivery site (labor and delivery or obstetric operating room) rather than in the central pharmacy to avoid potential delays.

Hospital pharmacies should make sure the devices are included in their order system then determine initial inventory levels.

Because it can take six months or longer to add a medication or device to the hospital formulary, it is helpful to inventory what data will be needed to pass the formulary committee and present the answers in advance. Typically, a physician submits the request to the formulary committee. Information often requested in the application, and suggested responses, are included below.

1. Delineate the clinical ADVANTAGES and DISADVANTAGES of the requested product compared to existing formulary product(s). Please be thorough and specific.

### Sample Response:

Beyond preventing unplanned pregnancies, research indicates that effective contraception helps prevent poor birth spacing, thereby reducing the risk of low-birthweight and/or premature birth. It is also beneficial for a woman's physical and emotional health to be able to follow a reproductive life plan. LARCs (Long Acting Reversible Contraceptives), including intrauterine devices (IUD) and contraceptive implants, are safe and highly effective in preventing unintended pregnancies. LARCs have been endorsed by the American Congress of Obstetricians and Gynecologists (ACOG), the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), and the Centers for Disease Control and Prevention (CDC) as among the most effective family planning methods.

LARC methods are effective for between three and 12 years (depending on the method) and do not require any upkeep or user effort. Immediate postpartum LARC placement, insertion of the IUD or implant after a delivery and prior to discharge, has the additional benefit of eliminating access barriers, since the provider and patient are both available during the hospitalization and insurance has not lapsed. This is a time when it is known that the woman is not pregnant and may be highly motivated to avoid short-interval pregnancy. Offering women the option to choose a contraceptive method and providing LARC methods directly reimbursed by their health care coverage before hospital discharge is critical for increasing contraceptive access and reducing the number of repeat, unintended pregnancies.

2. Provide published literature which demonstrates in controlled, comparative studies a superior therapeutic advantage of this product versus comparable products currently on the formulary. If such studies are unavailable, please furnish the literature which has convinced you to prescribe this product and request it for addition to the formulary.

Sample Response:

LARCs are clearly the most effective form of reversible contraception. Fewer than 1 in 100 women using a LARC will get pregnant within one year. Compared to typical use of birth control pills and male condoms, 9 out of 100 and 18 out of 100 women will get pregnant within one year, respectively. The number is higher if not used correctly and consistently (Guttmacher Institute, 2016).

The American College of Obstetricians and Gynecologists endorses immediate postpartum LARCs as noted in Committee Opinion Number 670 (2016). ACOG's general endorsement of LARCs is described in ACOG Practice Bulletin #186 - Long Acting Reversible Contraception: Implants and Intrauterine Devices.

The Intrauterine Devices and Implants: A Guide to Reimbursement (2015) describes public and commercial coverage of LARCs and provides resources for stocking, reimbursement, and other issues related to LARC. The Guide was developed by the American College of Obstetricians and Gynecologists, the National Family Planning & Reproductive Health Association, the National Health Law Program, the National Women's Law Center, and the University of California, San Francisco Bixby Center for Global Reproductive Health.

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## CHAPTER FOUR: POLICIES AND PROCEDURES

### Overview

This procedure outline is a pre-cursor to detailed procedures related to how to insert IUDs and implants during the immediate postpartum period. In the implementation phase, some providers will receive more focused education on insertion and placement.

### Postpartum LARC Approval Process

Prior to offering an immediate postpartum LARC device, it is important that individual hospitals seek administrative approval. Individual hospitals may have their own processes for approving the use of immediate postpartum LARCs. It is important to work with hospital administration and individual labor and delivery units to ensure support. Please refer to Chapter One – Building a Successful Initiative for details on how to effectively gain support within your hospital. Throughout the pre-implementation as well as the implementation phases, it will be important to have regular communication channels and processes, and to ensure that all necessary departments remain represented.



### Develop an Infrastructure Designed to Succeed

Once hospital approval has been obtained, the multidisciplinary team developed in Chapter One can get to work. The process of obtaining the necessary LARC devices on a hospital formulary can take up to six months, and should be started early in the pre-implementation phase. Each hospital has its own procedure for formulary revisions but general steps are outlined in Chapter Three.

### IT Modifications and Documentation Data Tracking

Members of the Access LARC team will need to work closely with their IT department as well as billers to ensure not only that the appropriate billing codes are set up in their electronic health record (EHR), but that the codes have been tested and reimbursement is timely. Details on working with your hospital's EHR and billing are also described in Chapter Three – Hospital/Managed Care Organization Collaboration.

Tracking data obtained from this initiative will be important in ensuring success. In addition, FPQC will be requesting specific data related to planning and systems development, as well as the actual service provision. The FPQC suggests several process, structural, and outcome measures that facilities track, although individual facilities may choose to track additional data as well.

### Unit-Specific Policies and Procedures

Each unit a woman interacts with during her prenatal, intrapartum, and postpartum care will need to have unit-specific policies and procedures. The following section provides information about establishing policies in each of

these units. In addition to the following units, pharmacy will need their own postpartum LARC-specific procedures, as will hospital billing. These are each addressed in Chapter Three, Hospital/Managed Care Organization Collaboration.

### Prenatal Procedures

Effective implementation of immediate postpartum LARC begins with counseling during the prenatal period. Women who receive contraceptive counseling during prenatal care are more likely to use contraception, and specifically more effective contraception, than those who do not receive counseling during their prenatal care (Zapata, Murtaza, Whiteman et al, 2015). **Please refer to Chapter 6: Comprehensive Choice Counseling** for more information on how to appropriately and effectively counsel patients on their contraceptive choices during the antenatal course.

**Prenatal**  
 Clinic  
 Health Department  
 Private Office

In addition to being appropriately counseled about the expected and possible side effects of IUD and implant use, women should be counseled about the following risks of IUD placement at the time of delivery:

- **Risk of Expulsion:** the best data estimates that the risk of IUD expulsion following placement at the time of cesarean delivery is approximately 10% and the risk of IUD expulsion following placement at the time of vaginal delivery is approximately 25-30% (Chen, Reeves, Hayes, Hohmann, Perriera, and Creinin, 2010; Celen, Möröy, Sucak, Aktulay, and Danişman, 2004)). The risk of expulsion decreases with provider training and experience. Women should be counseled regarding the symptoms of expulsion and told to seek care immediately if they suspect they have had an IUD expulsion. If they do not have a source of care, women can contact the family planning program in their county health department for an appointment.
- **No visible strings:** Women should be counseled that IUD placement at the time of cesarean delivery increases the risk that the IUD strings will not be visible. If IUD strings are not visible, IUD location will therefore have to be confirmed by ultrasound, and, if necessary removal may be more difficult.
- **Impact on breastfeeding:** the majority of evidence does not show any impact of IUDs or contraceptive implants on breastfeeding success (Chen, Reeves, Creinin, and Schwarz, 2011; Phillips, Tepper, Kapp, Nanda, Temmerman, and Curtis, 2016; Gurtcheff, Turok, Stoddard, Murphy, Gibson, and Jones, 2011; Turok, Leeman, Sanders et al, 2017).

### Consent

Women expressing interest in using an immediate postpartum IUD or implant should sign a consent form during their prenatal care. This form should be included in the prenatal record transferred to the hospital prior to delivery. When women present to labor and delivery, their intention to receive an IUD or implant should be verified, and a new consent should be signed at that time per hospital-specific policies.

### Insurance Verification

Not all insurance providers pay for immediate postpartum IUDs and implants or pay separately from a global delivery fee, even if the plan covers an interval insertion. Providers may consider maintaining an ongoing list of what insurers pay for insertion during the immediate postpartum period. Women should be counseled that should their insurance change between the time they sign a consent and the time of delivery, the device may no longer be

covered, and they may need to return during the postpartum period for insertion. While attempting to verify coverage during the antenatal course, consider working with your surgical scheduler, who should be familiar with the process of obtaining insurance verification. For women without any insurance coverage for LARCs, consider investigating other resources, such as grants or devices from the ARCH, a patient-assistance program that provides no-cost IUDs for women meeting program eligibility requirements.

### Intrapartum Procedures

**Please refer to Chapter 6: Comprehensive Choice Counseling** for more information on how to appropriately and effectively counsel patients on their contraceptive choices during intrapartum.

**Intrapartum**  
**Labor and Delivery**

#### Consent

Upon presentation to labor and delivery, confirm with a woman that she still desires a postpartum LARC, and have her sign the appropriate consent. If she is presenting for a scheduled cesarean delivery, insertion of an IUD should be included in the procedure consent. Women first presenting to care in triage, or those who have not been previously counseled on the availability of immediate postpartum LARC, should receive LARC counseling at the initial time of presentation.

In addition to the hospital-specific consent form, women must sign the FDA consent included in the package of the IUD or implant. This consent states that the woman has received and reviewed the package insert, and is required prior to placing a LARC device. See Chapter 6 on Patient Counseling for more informed on how to counsel and obtain informed consent.

#### Insurance Verification

Even if a woman's insurance was verified during her prenatal care, her insurance should be again verified to ensure it is current, and that immediate postpartum LARC is covered separate from the global delivery fee to ensure reimbursement for the device.

#### Review Contraindications

Guidance from the CDC Medical Eligibility Criteria for Contraceptive Use should be used to determine eligibility for postpartum LARCs. Table 1 shows a chart of the conditions relevant to immediate postpartum LARC.

Additional considerations are as follows:

- Chorioamnionitis
- Hemorrhage not adequately controlled with medication
- Prolonged rupture of membranes >24 hours should be considered, but is not an absolute contraindication to IUD placement in the absence of chorioamnionitis

If a woman who previously desired an IUD is no longer a candidate due to infection or hemorrhage, counsel her on an implant placement as an alternative LARC device.

**Immediate Postpartum LARCs**

Condition	Sub-Condition	Cu-IUD	LNG-IUD	Implant
Postpartum (in breastfeeding or non-breastfeeding women, including cesarean delivery)	a) <10 minutes after delivery of the placenta			
	i) Breastfeeding	1	2	2
	ii) Nonbreastfeeding	1	1	1
	b) 10 minutes after delivery of the placenta to <4 weeks	2	2	1*/2**
	c) ≥ 4 weeks	1	1	1
	d) Postpartum sepsis	4	4	1

LNG=levonorgestrel; Cu=copper; IUD=intrauterine device.      \*Nonbreastfeeding women, \*\*Breastfeeding women  
 Categories:  
 1 = A condition for which there is no restriction for the use of the contraceptive method.  
 2 = A condition for which the advantages of using the method generally outweigh the theoretical or proven risks.  
 3 = A condition for which the theoretical or proven risks usually outweigh the advantages of using the method.  
 4 = A condition that represents an unacceptable health risk if the contraceptive method is used.

*Adapted from Centers for Disease Control and Prevention Medical Eligibility Criteria Classifications for Postpartum Long-Acting Reversible Contraception (2016)*

Detailed IUD and Implant Insertion Procedures

**Please see Chapter 5 on Provider and Staff Education related to LARC Insertion** for detailed instructions on immediate postpartum insertion of both the IUD and implant.

Supply Availability on Labor and Delivery

In order to ensure IUDs are available to be placed within ten minutes of placenta delivery, the devices should be stocked in or near Labor and Delivery and surgical areas where cesareans are performed, ideally within a Pyxis system on the unit. This will help avoid unpredictable delays that may occur if IUDs are stocked elsewhere, such as a centralized inpatient pharmacy. Labor and Delivery units and surgical areas will need to work with their pharmacy and hospital supply chain staff to ensure devices are readily available at the appropriate time.

Implants do not need to be inserted within ten minutes of placenta delivery, and individual hospitals may choose whether to stock these on Labor and Delivery, Postpartum unit, and/or a centralized inpatient pharmacy.

Additional supplies for IUD insertion should also be stocked on Labor and Delivery. For a full checklist on what supplies are needed, please see Chapter Five on Provider and Staff Education on Insertion Procedures in the “Implementation” section of this toolkit.



## Postpartum Procedures

### IUD

Women receiving an IUD during a cesarean delivery or immediately following a vaginal delivery should have routine postpartum care, including fundal checks and fundal massage as needed. If a woman has significant pelvic pain, feels a portion of the IUD in the vagina, or sees the IUD has fallen out, the physician should be notified. If any of these problems occur after hospital discharge, the woman should follow up with the provider who placed her LARC device, or can contact their local Department of Health family planning clinic if they are unable to see that provider for any reason.

**Postpartum  
Recovery  
Mother/Baby**

#### Additional Considerations:

- Women diagnosed with postpartum endometritis with an IUD in situ should be treated with antibiotics. There are *no data* as to whether the IUD needs to be removed in this setting. However, data from women with pelvic inflammatory diseases who have an IUD in situ suggests uterine infection can be effectively treated with IV antibiotics without IUD removal (Tepper, Steenland, Gaffield, Marchbanks, and Curtis, 2013). If there is no response to antibiotics within 24-48 hours, it is reasonable to consider IUD removal.
- Women should receive information at the time of discharge regarding when and where to follow up for an IUD check. This includes a phone number to call regarding any concerns for the IUD or implant. See Chapter 5 on Insertion Training for more information.

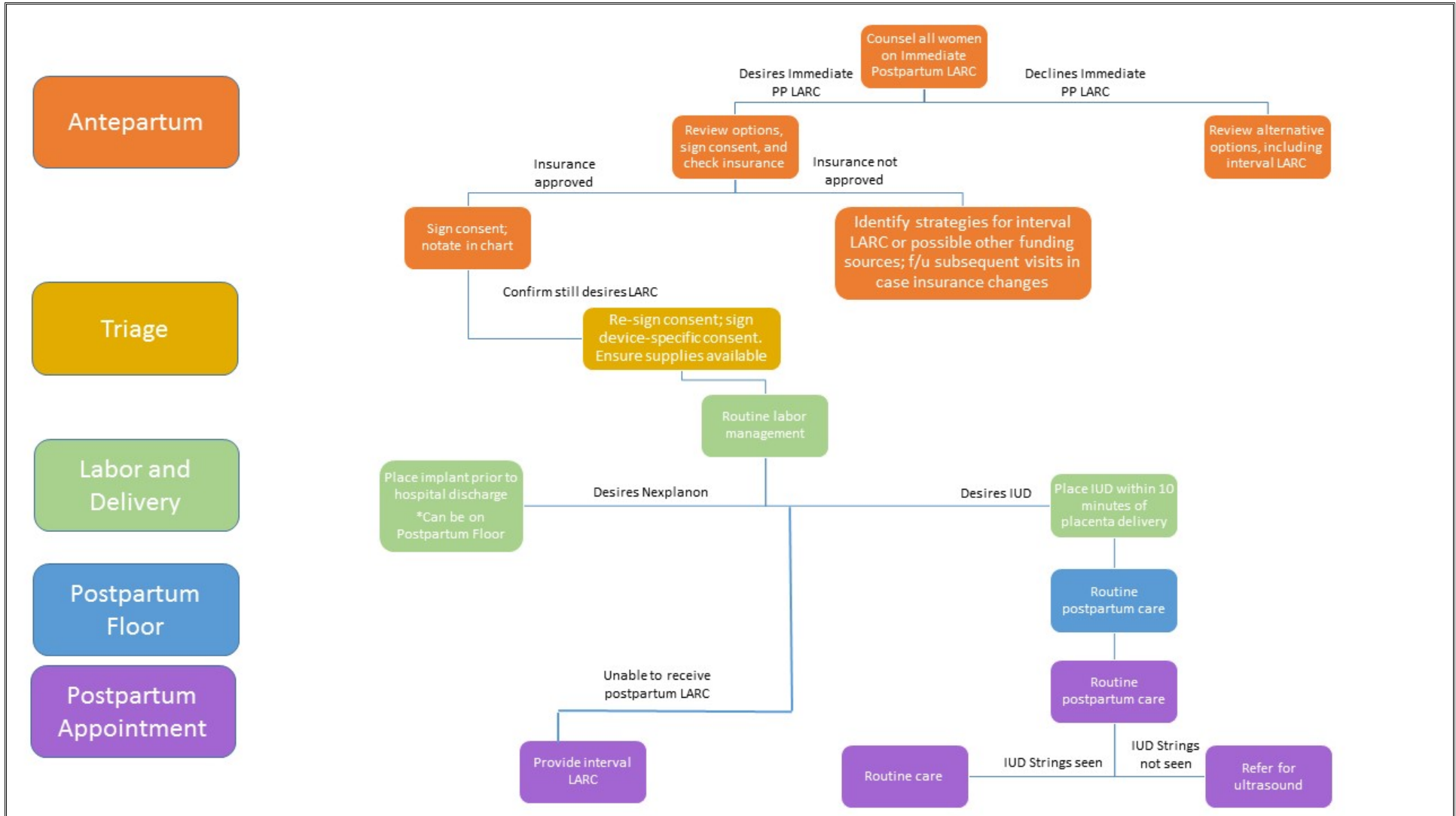
### Subdermal Contraceptive Implant (Nexplanon)

The subdermal contraceptive implant can be safely placed during the immediate postpartum period. The implant can be placed at any time following delivery and before discharge from the hospital. The process of placing the implant during the postpartum period is identical to the standard procedure used for interval placement. The FDA requires that any provider who is placing the contraceptive implant receive appropriate training and certification from Merck®. Hospital staff and providers should develop plans and procedures on the best time(s) and place(s) for performing insertions.

If the patient experiences severe pain, swelling or redness at the insertion site, the patient's provider should be notified. The mother should also be provided a phone number to call if these problems develop soon after discharge.

An overview of all of the unit-specific policies and procedures is summarized on the Modified Workflow Diagram below. This diagram outlines the course a woman will take starting with her prenatal care and following her through to the postpartum appointment to ensure she receives her LARC device.

Model Modified Workflow Diagram



## Create Consent Documentation Process

The EHR should be modified to facilitate informed consent through automatic creation of a consent form to be signed in-house, even if a consent was signed during the prenatal period. Sample consent forms for immediate postpartum IUDs and implants can be found in Chapter Six and can be modified by individual hospitals to best suit their needs.

## Checklists

The following checklist has been developed to ensure all necessary steps are taken during the pre-implementation phase to allow for not only progression to the implementation phase, but also to capture all data necessary to for the FPQC Access LARC initiative.

### PRE-IMPLEMENTATION CHECKLIST

- Identify key champions in all pertinent departments
- Establish and test billing codes; test processes for timely reimbursement
- Add LARC devices to formulary and identify appropriate storage location
- Educate clinicians, nurses, pharmacy, and lactation consultants about postpartum LARC
- Modify IT systems to document acquisition, stocking, ordering, placement, counseling, consent, billing, and reimbursement for postpartum LARCs.

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## CHAPTER FIVE: PROVIDER AND STAFF TRAINING ON CLINICAL PROCEDURES

### Overview

Clinical and support staff should receive training for immediate postpartum IUD and implant insertion in the delivery room or OB operating room, and in identifying and treating any difficulties or complications that arise. This chapter outlines clinical procedures for post-placental IUD insertion and postpartum subdermal implant insertion.

Clinical staff in the obstetrical service (antepartum, labor and delivery, postpartum) should also be trained in comprehensive contraceptive counseling (see Chapter 6). Additionally, appropriate hospital staff should be trained in ordering and acquisition of LARC devices according to the protocol established by the hospital, to ensure the device is immediately available to the practitioner when needed.

**Staff in labor and delivery** should be trained in setting up and assisting with IUD and/or subdermal contraceptive implant insertion, with attention to sterile technique as well as care for the patient before, during and after the procedure according to hospital policy.

**Staff in the postpartum unit** should be trained in setting up and assisting with subdermal contraceptive implant insertion, with attention to sterile technique as well as care for the patient before, during and after the procedure according to hospital policy.

To ensure providers are adequately trained, please contact FPQC to set up a training session. The ACOG LARC Program's Postpartum Contraceptive Access Initiative (PCAI) also provides additional training and support for immediate postpartum LARC implementation.

### Post-Placental IUD Insertion Procedures

The technique for placing an IUD during the immediate postpartum period is different than during interval IUD insertion. There are several variations of techniques used to place a postpartum IUD, including manual placement and forceps placement, as well as inserter placement when used at the time of cesarean delivery. Additionally, an ultrasound may be used to confirm proper placement, but is not necessary. Individual hospitals may choose whether or not to recommend any specific technique, as well as whether or not they will be able to ensure access to an ultrasound.

This chapter outlines the techniques used to place postpartum IUDs. Prior to actually placing postpartum IUDs, providers should undergo training, which the Florida Perinatal Quality Collaborative can help arrange. After completing a training session, provider may begin placing postpartum IUDs. There is no proctoring required, or minimum amount of training necessary prior to placing IUDs.

Before delivery, obtain informed consent for the procedure and review the following:

- ✓ expulsion risk,
- ✓ possibility of not being able to place due to obstetric complications,
- ✓ more difficult removal if strings not visible,
- ✓ duration of efficacy,
- ✓ bleeding profile of device,
- ✓ infection and perforation risk,
- ✓ efficacy, and risk of ectopic pregnancy should pregnancy occur with LARC method in place.

## Vaginal Delivery

1. Following placental delivery, review contraindications for immediate post placental insertion including chorioamnionitis and ongoing postpartum hemorrhage
2. Place IUD within 10 minutes of placental delivery. An IUD may be placed beyond this period if patient accepts the potential increased risk of expulsion
3. Perform uterine massage and administration of uterotonic medications as clinically indicated. If bleeding from laceration is not heavy, insertion should occur before perineal repair.
4. Gather appropriate supplies (Figure 1):
  - 2 Ring forceps or 1 ring forceps and one Kelly placental forceps
  - Speculum or retractor
  - 4x4 sterile gauze or cotton swabs
  - Antiseptic solution (Betadine or Hibiclens)
  - IUD device
  - Sterile gloves
  - Sterile gown
  - Sterile towels/drape
  - Scissors
  - Ultrasound readily available is useful but not required for placement
5. Palpate the uterus to evaluate fundal height.
6. Cleanse the external genitalia with antiseptic.
7. Insert retractor or speculum into vagina and visualize cervix.
8. Cleanse the cervix and vagina with antiseptic using sponge stick or cotton swab.
9. Gently grasp the anterior lip of cervix with ring forceps.



Figure 1

### Using Forceps:

10. Open the IUD packaging:
  - i. For the copper IUD open the bottom of the IUD package and remove the plastic applicator leaving only the IUD inside.

- ii. For the LNG IUD remove inserter from packing and grasp the IUD directly from the tip of the inserter.



Figure 2a: Grasping the IUD from the tip of the inserter



Figure 2b: grasping the Copper IUD within the packaging

- iii. Using the placental forceps or the ring forceps grasp the arm of the stem of the IUD and remove it from the package or inserter. **Do NOT click down or lock** as this can disrupt the copper or levonorgestrel containing plastic.
- iv. Using sterile gloves adjust the IUD placement in the ring forceps. The IUD should be held by its vertical arms; the horizontal arms should be slightly out of the ring (Figure 2a and 2b).
- v. Apply gentle traction on the anterior lip of the cervix and insert the forceps holding the IUD through the cervix into the lower uterine segment. Avoid touching the vagina with the IUD.
- vi. Release the hand that is holding the cervix-holding ring forceps. Move this hand to the abdomen placing it over the uterine fundus.
- vii. With the abdominal hand, stabilize the uterus and apply firm downward pressure.
- viii. Direct the IUD-holding forceps in an upward motion toward the fundus. The lower uterine segment might be contracted and slight pressure might be necessary to achieve fundal placement. Confirm the tip of the forceps are at the fundus with the abdominal hand.
- ix. Open the forceps wide to release the IUD. Sweep the forceps slightly laterally to avoid entanglement with the string.
- x. Slowly retract the forceps from the uterine cavity. If the IUD becomes dislodged during placement, the IUD should be removed, re-grasped sterilely and immediately reinserted.
- xi. Consider use of ultrasound to verify fundal location of IUD.
- xii. Cut the strings of the IUD flush against the cervical os.

The Paragard strings are shorter than the LNG IUDs and will unlikely be visible at the cervical os after insertion.

### Manual Insertion:

11. Change into sterile gloves
12. Remove the IUD from packaging and inserter and place between index and middle finger
13. Place the other hand on the abdomen to externally stabilize the uterus and apply downward pressure.
14. Insert the hand holding the IUD through cervix and place the IUD arms at the top of the uterine fundus.
15. As the internal hand is removed, rotate it about 15 degrees to avoid dislodging the IUD.
16. Consider use of ultrasound to verify fundal location of IUD.
17. Cut the strings of the IUD flush against the cervical os.

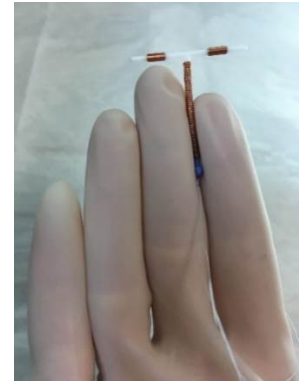


Figure 3: correct positioning for manual insertion

The Paragard strings are shorter than the LNG IUDs and will unlikely be visible at the cervical os after insertion.

### **Cesarean Delivery**

1. Review contraindications for immediate post placental insertion including chorioamnionitis and ongoing postpartum hemorrhage
2. The IUD can be placed with package inserter, ring forceps or manually

### Package Inserter:

- i. For the LNG IUD, position the IUD in inserter so the arms of the IUD are out. Cut the LNG IUD strings to 10cm. (Figure 4a)
- ii. For the ParaGard, position IUD so arms are out of the clear plastic tube, the white plunger is not needed (Figure 4b). The strings are shorter and do not need to be cut.
- iii. Place the device through the hysterotomy and place at uterine fundus.
- iv. For the LNG IUD slide the slider down to carefully deploy the IUD. For the ParaGard remove the tube inserter leaving the IUD at the fundus.



Figure 4a



Figure 4b



### Ring Forceps:

- i. Grasp the stem of the IUD and remove it from the package or inserter. **Do NOT click down or lock.** The IUD should be held by its vertical arms; the horizontal arms should be slightly out of the ring (Figures 2a-2b).
- ii. Place the device through the hysterotomy and place at uterine fundus.
- iii. Open the forceps wide to release the IUD.

### Manual Insertion:

- i. Remove IUD from packaging and inserter and place between index and middle finger (Figure 3).
  - ii. With the IUD arms out place the device through the hysterotomy and place at uterine fundus.
3. Once IUD placed at fundus, assistant places hand on exterior of uterus to stabilize IUD in place at fundus.
  4. While the assistant continues to stabilize the IUD externally use a ring forceps to guide the IUD strings into the cervix. If the cervix is closed, dilate from above with ring forceps before passing strings. The ring forceps should then be removed from the sterile field.
  5. Prior to closing the hysterectomy confirm fundal IUD placement, incorrectly positioned, adjustments can be made manually.
  6. Complete the cesarean per routine.
  7. Abdominal fundal massage is permitted; do not manually express the uterus of clots after the cesarean. Uterotonics may be given as medically indicated.

An instructional video by ACOG can be found here for both vaginal and cesarean delivery  
[https://cfweb.acog.org/district\\_ii/larc/section4.html](https://cfweb.acog.org/district_ii/larc/section4.html)

## Postpartum Subdural Implant Insertion Protocol

Prior to placing any Nexplanons, either postpartum or interval, Merck requires that providers complete a 2-hour in-person training course. Individual courses can be requested from the Merck website at <https://www.nexplanontraining.com/request-clinical-training/in-person-training/>. Additionally, please contact FPQC for a list of your local Merck representative, who can set up a training for your providers.

Unlike an IUD, which must be placed within 10 minutes following delivery of the placenta, a contraceptive implant device can be inserted any time after delivery and prior to patient's discharge from the hospital. The insertion can be done on L&D or on the postpartum floor.

Prior to insertion, verify insurance coverage, obtain informed consent for the procedure and review the risks and potential side effects after insertion, such as:

- ✓ Risks include:

- pain, irritation, swelling or bruising at the insertion site,
  - scar tissue may develop around the implant,
  - if you become pregnant there is a slightly increased chance of having an ectopic pregnancy than in women who do not use birth control.
- ✓ Side effects include:
- longer or shorter bleeding during periods,
  - absence of periods, spotting between periods, and varying amounts of time between periods
  - implant migration, making it difficult to be removed. (Consult the Nexplanon consent form for full details of risks.)

## Procedure

1. Collect all necessary supplies for insertion (Figure 5):
  - i. Sterile gloves
  - ii. Nexplanon device
  - iii. Local anesthetic (1% Lidocaine with or without Epinephrine)
  - iv. 2 mL syringe
  - v. 18 gauge needle (for drawing up anesthetic)
  - vi. 25 gauge-1.5cm needle (for administering anesthetic)
  - vii. Antiseptic solution: Povidone Iodine/Betadine (Chlorhexidine if patient is allergic)
  - viii. Sterile cup
  - ix. 4x4 sterile gauze
  - x. A sterile marking pen (to mark insertion site)
  - xi. Sterile towels/drape
  - xii. Adhesive dressing (Steri-strips)
  - xiii. Pressure dressing (Kerlex)



Figure 5

2. Set up sterile field on stand or table using sterile towels or sterile drapes:
  - i. Sterilely lay drape/towel on field
  - ii. Using sterile gloves place supplies on sterile field
  - iii. Use sterile cup to hold antiseptic solution
  - iv. Sterilely draw up 1-2mL of 1% lidocaine with or without epi into the 2 mL syringe with the 18 gauge needle
  - v. Remove the 18 gauge needle and dispose of it in the sharps container
  - vi. Place the 25 gauge-1.5cm needle on the syringe with the lidocaine
  - vii. Remove sterile gloves and discard

3. Position patient on bed in the supine position with her non-dominant arm flexed so that her hand lies next to her head with her palm facing the ceiling.

4. Place a towel or drape under the patient's arm in case blood or antiseptic solution runs down the patient's arm.

5. Put on sterile gloves and clean the insertion site with antiseptic solution and 4x4 sterile gauze

6. Using the sterile marking pen, mark the insertion site (Figure 7). The implant should be inserted 8-10cm (3-4inches) above the medial epicondyle of the humerus. Insert subdermally avoiding the sulcus between the biceps and triceps muscles. When inserting the implant, avoid inserting directly through the pen mark as to avoid tattooing the skin.



Figure 6

7. Remove the Nexplanon from its sterile packing and hold the applicator between the thumb and forefingers on the textured area of the device
8. Slide the transparent protection cap horizontally away from the device
9. The implant can be visualized by looking at the needle tip
10. The insertion of the implant is best done while sitting to have better visualization of the applicator from the side
11. Use counter-traction with your free hand as you insert the needle at a 30° angle (Figure 7).

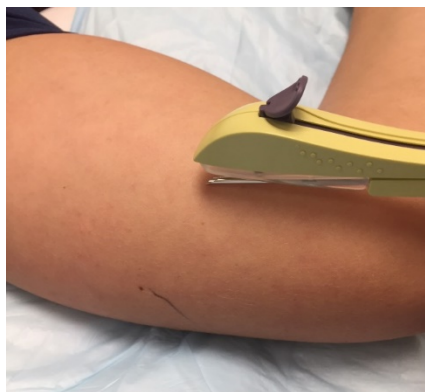


Figure 7

12. Once the needle has punctured the skin, hold the applicator horizontal to the skin and tent the skin upward with the applicator as the rest of the needle is inserted into the subdermal space
13. Hold the applicator in place and using your index finger unlock the purple slider by pushing the slider downward and backward until it locks in place
14. The implant is now inserted and the applicator needle should be checked to ensure the implant is no longer in the device
15. Palpate the implant to ensure proper placement
16. Place adhesive dressing over the insertion site
17. Clean excess antiseptic solution and blood from patient's arm
18. Have the patient feel the implant prior to placing pressure dressing
19. Place pressure dressing around the arm over the insertion site
20. Instruct patient to wear the pressure dressing for 24 hours and to wear a small adhesive bandage for 3-5 days after the pressure dressing is removed
21. Instruct the patient to return to clinic if she is unable to feel her implant, it has broken under the skin, or it is more painful than it should be

### Additional Resources

Florida Perinatal Quality Collaborative Access LARC Online Toolbox for Hospital Implementation:

<https://health.usf.edu/publichealth/chiles/fpqc/larc/toolbox>

ACOG LARC Program Help Desk: [www.acog.org/LARChelpdesk](http://www.acog.org/LARChelpdesk)

Postpartum Contraceptive Access Initiative: <https://pcainitiative.org/>

ACOG District II: Long-Acting Reversible Contraception – A Hospital-Based Physician Initiative Video Series:

<https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Long-Acting-Reversible-Contraception-LARC>

ACQUIRE Project Postpartum IUD Curriculum (supported by USAID):

<http://www.acquireproject.org/archive/html/10-training-curricula-and-materials/resources.html>

CARDEA Inserting LARC Immediately After Childbirth eLearning Course:

<http://www.cardeaservices.org/resourcecenter/inserting-long-acting-reversible-contraception-larc-immediately-after-childbirth>

Stanford Program for International Reproductive Education and Services (SPIRES) Postpartum IUD Insertion Model and Technique Demonstration: <https://www.youtube.com/watch?v=uMcTuf8XxQ>

## CHAPTER SIX: PATIENT CHOICE COUNSELING

### Chapter At-a-Glance:

- I. Overview
- II. Importance of Patient Education and Counseling during the Perinatal Period
- III. Providing Contraceptive Counseling during the Perinatal Period
- IV. Team-based Collaborative Patient-centered Care
- V. Patient-Centered Contraceptive Counseling Considerations
- VI. Contraception Options
- VII. Patient-Provider Communication and Shared Decision-Making
- VIII. FAQs
- IX. Patient Scenarios



### 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

### 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

#### 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**

## Providing Contraceptive Counseling During the Perinatal Period

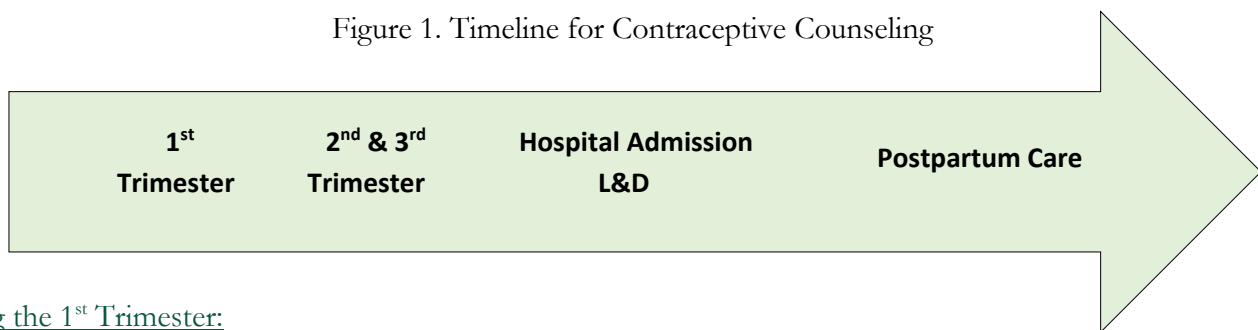
### When Should Counseling Take Place?

#### 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 1<sup>st</sup> Trimester:

Providers should initiate conversations with women regarding contraception during the 1<sup>st</sup> 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 (2<sup>nd</sup> and 3<sup>rd</sup> 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 36<sup>th</sup> 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.

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### REMINDER

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

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## 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.

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*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.*

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### 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.

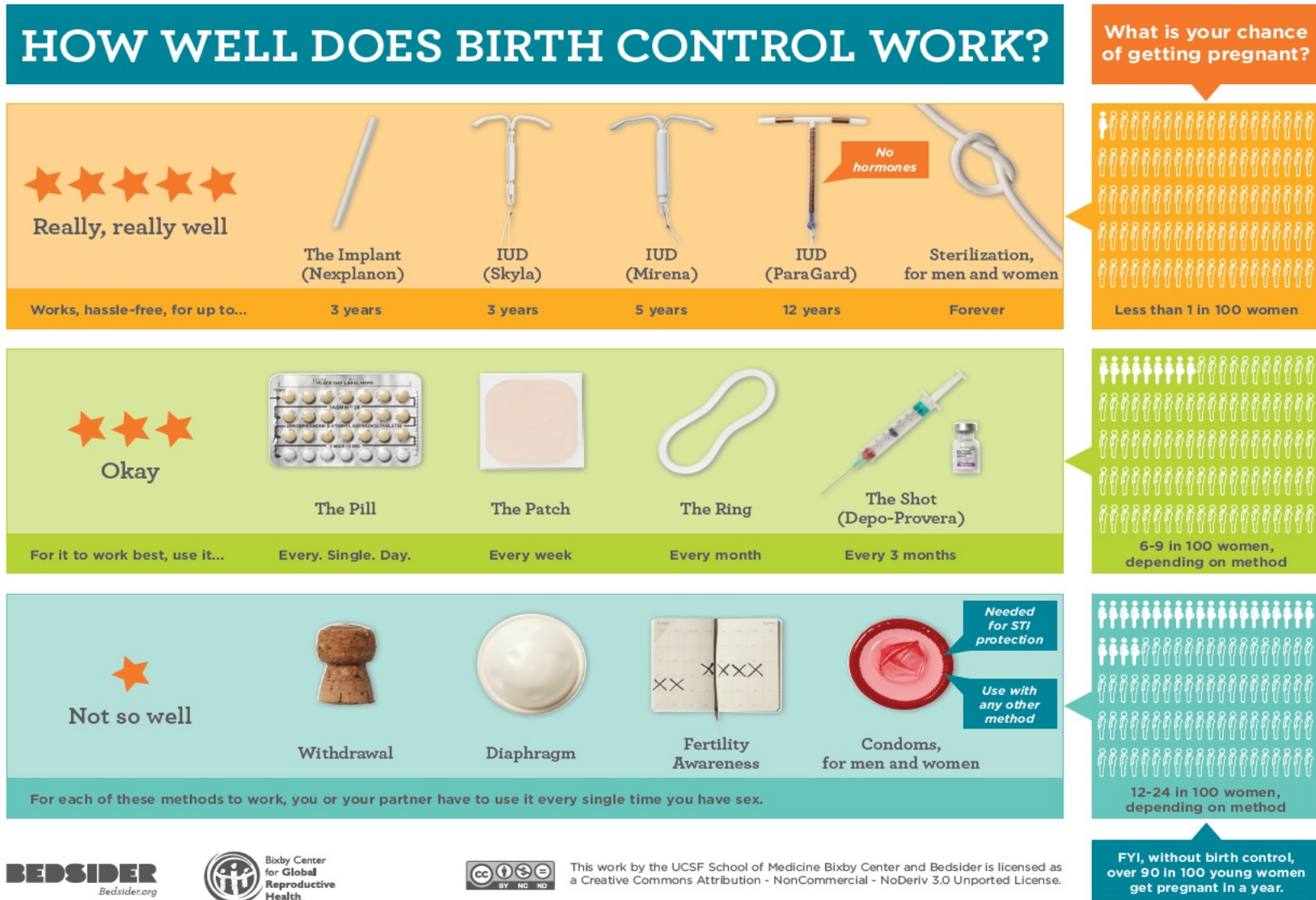
Hormonal LARC methods release small doses of hormones (i.e., progesterone) to women over time to prevent pregnancy from occurring. The copper IUD does not contain any hormone; this may be a good option for women who do not wish to use hormonal birth control or who have medical contraindications to hormones. 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 at the end of this chapter).

### LARC: Benefits and Side Effects

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

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

Figure 2. Bedsider Birth Control Effectiveness Poster



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.

### 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.

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.

#### 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?”*

#### 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.

**Table 1. Patient Provider Communication and Contraceptive Counseling Process**

Process	Summary	Resource
<b>Build Rapport with Women (and Families/Partners)</b>	Establish trust and facilitate dialogue between providers and women to prepare for patient assessment and education	See below
<b>Assess and Educate Women (and Families/Partners)</b>	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?
<b>Document and Reinforce Education with Follow-up</b>	Document conversations and decisions appropriately and provide education as needed	Family Planning Counseling EHR Questionnaire ( <i>Example</i> )
<b>Ensure Informed Consent and Provide Ongoing Support</b>	Ensure informed consent and provide ongoing follow-up regarding satisfaction with method choice, potential side effects, other questions and concerns	Consent document template



The decision-matrix below (Figure 3) 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 are listed at the end of this section, which providers can use during conversations or as patient handouts.

**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.

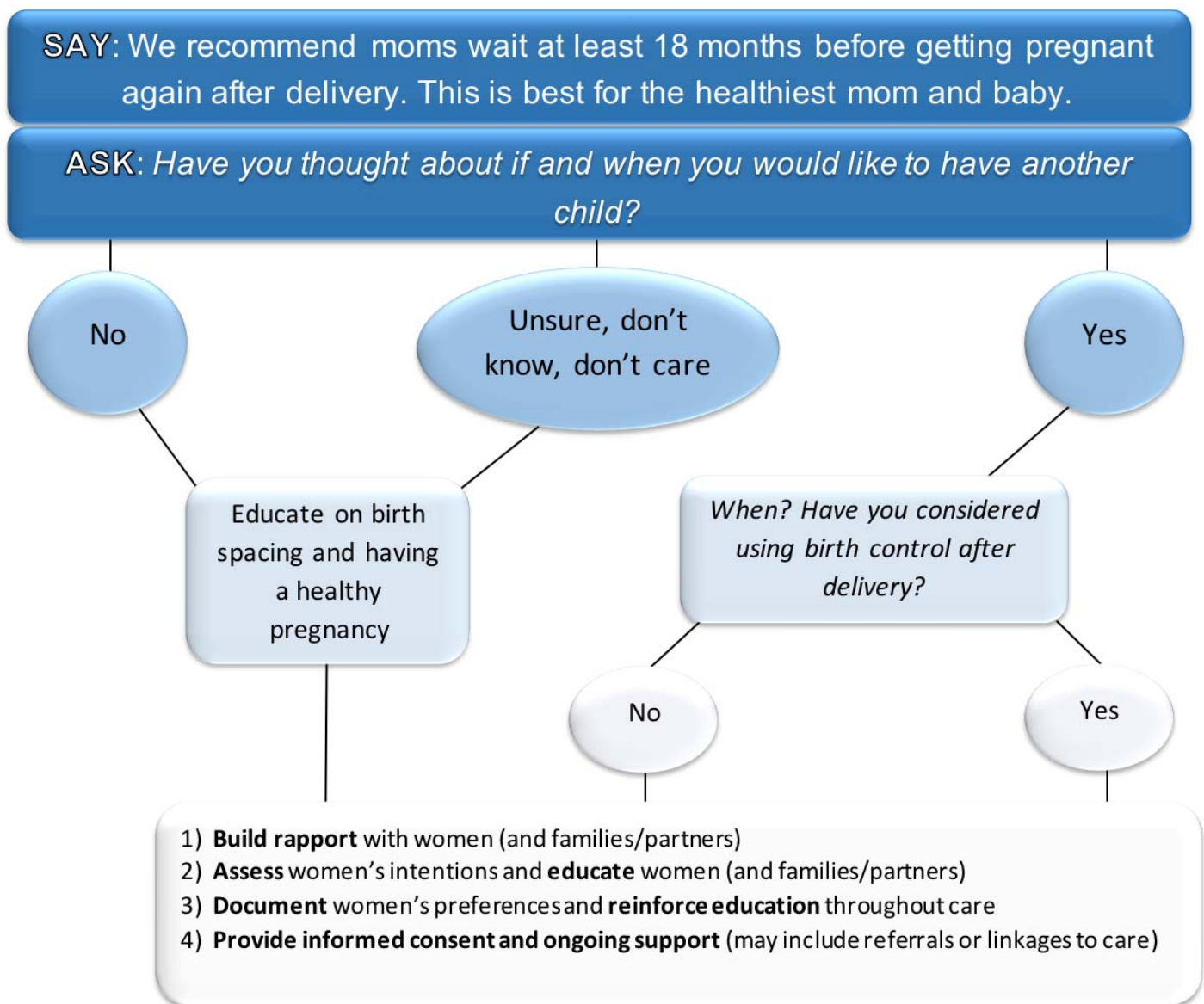
*Hello, I am \_\_\_\_\_. It is a pleasure to (see you again/meet you).*

*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?*

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.
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.

**Figure 3. Contraceptive Decision-Making Matrix**





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.

The chart is available on the CDC website or in previous chapters of this 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 2<sup>nd</sup> 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 3<sup>rd</sup> 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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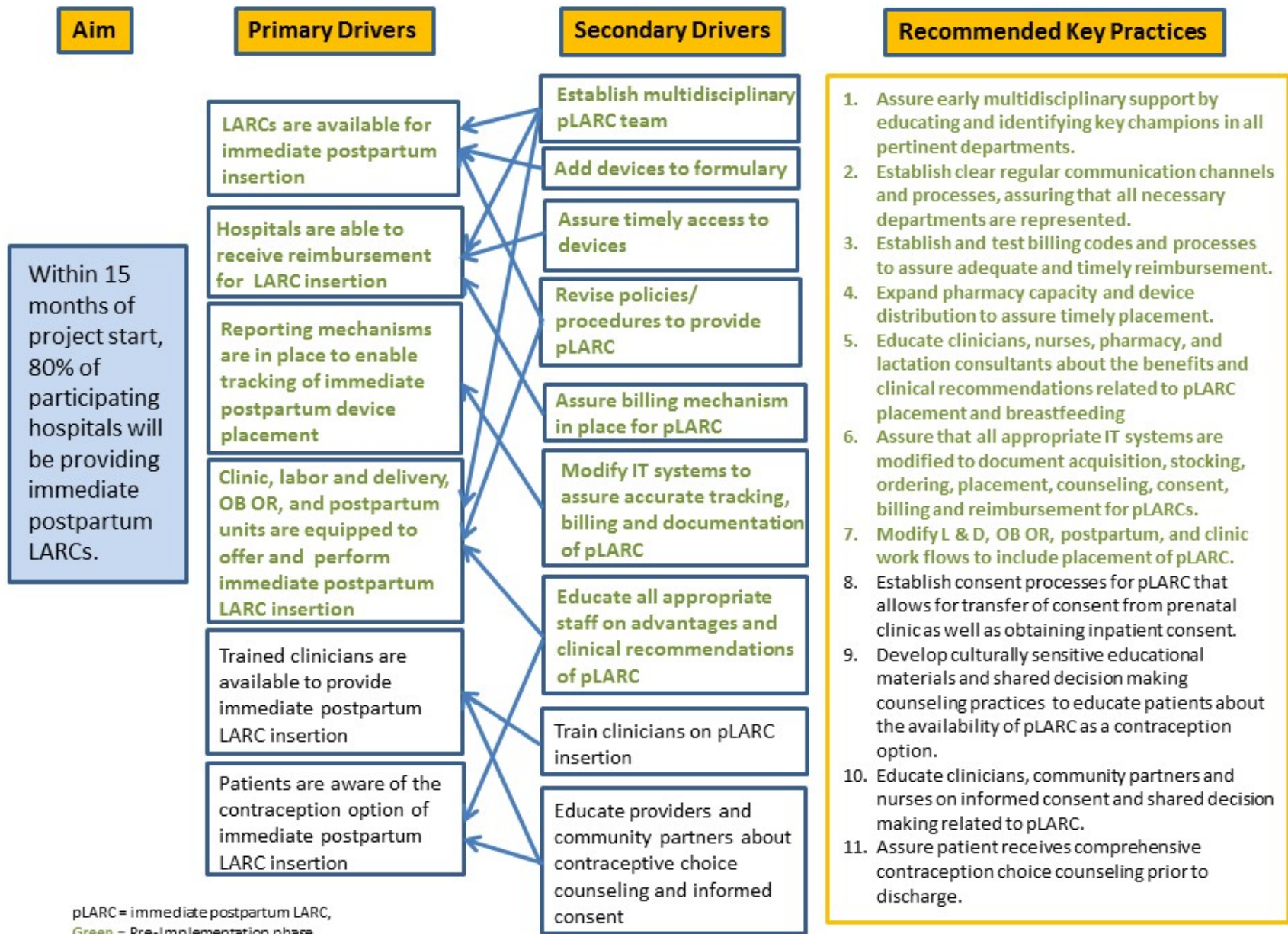
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pLARC = immediate postpartum LARC,  
 Green = Pre-Implementation phase


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# FLORIDA MEDICAID

*A Division of the Agency for Health Care Administration*

## Florida Medicaid Health Care Alert

August 15, 2017

**Provider Type(s): 01, 25, 26, 29, 30, 32, 34, 66, 68, 69, 70, 77, 78**

### **(Clarification) Long-Acting Reversible Contraceptive Inpatient Reimbursement (Fee-for-Service Delivery System)**

In the fee-for-service delivery system, Florida Medicaid reimburses for immediate postpartum placement of long-acting reversible contraceptives (LARCs) separate from the inpatient hospital labor and delivery Diagnosis Related Group (DRG) payments. Medicaid health plans have the flexibility to negotiate mutually agreed upon reimbursement arrangements with their network providers. For more information on reimbursement of LARC devices immediate postpartum for health plan enrollees, please contact each health plan directly.

Providers rendering services through the fee-for-service delivery system can seek reimbursement for LARCs by utilizing the codes listed below. This reimbursement policy change became effective October 1, 2016 and was communicated to Medicaid providers via the updated [Inpatient Hospital Services](#) coverage policy, effective July 11, 2016. This system change was implemented to support the Agency's goal of improving birth outcomes. Research shows that LARCs are effective in reducing unintended pregnancies, premature and low birth weight births, and prenatal drug exposure.

#### **Device Insertion and Removal Procedure Codes**

<b>CPT CODE</b>	<b>DESCRIPTION</b>
11981	Insertion, non-biodegradable drug delivery implants
11982	Removal, non-biodegradable drug delivery implants
11983	Removal with reinsertion, non-biodegradable drug delivery implant
58300	Insertion of IUD
58301	Removal of IUD

**LARC Device:**

HCPCS CODE	DESCRIPTION	NDC
J7297	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM (LILETTA), 52 MG	52544003554; 00023585801
J7298	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM (MIRENA), 52 MG	50419042101; 50419042301; 50419042308
J7300	INTRAUTERINE COPPER CONTRACEPTIVE (Paragard)	51285020401
J7301	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM (SKYLA), 13.5 MG	50419042201
*Q9984	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE (KyleEna), 19.5 MG	50419042401
J7307	ETONOGESTREL (CONTRACEPTIVE) IMPLANT SYSTEM, INCLUDING IMPLANT AND SUPPLIES (Nexplanon)	00052433001

\* systems are currently being updated to include this temporary code

**Note:** National Drug Codes (NDC) should be included. The only limit on these products is 1 unit per claim, up to 3 claims per year.

The Agency's effort to facilitate access to LARCs immediately postpartum is in collaboration with community partners, Medicaid health plans and other state partners, which include the Florida Perinatal Quality Collaborative (FPQC). The FPQC has established the "Access LARC" Initiative to provide training and resources in efforts to help Florida hospitals set up delivery and billing systems needed for immediate postpartum placement of LARC implementation. If a hospital is interested in participating in this initiative, then visit the [Access LARC website](#) for more information.

Send an email to the Florida Perinatal Quality Collaborative at [FPQC@health.usf.edu](mailto:FPQC@health.usf.edu) to obtain a list of recruited hospital contacts participating in this initiative.

If you need assistance, please contact a Medicaid representative at [1-877-254-1055](tel:1-877-254-1055).