

Florida Perinatal Quality Collaborative



Partnering to Improve Health Care Quality
for Mothers and Babies

ACCESS LARC

INCREASING ACCESS TO IMMEDIATE POSTPARTUM LONG-ACTING REVERSIBLE CONTRACEPTION

Chapter 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).

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

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.

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).

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.

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.

Copper IUD:

ParaGard®

Levonorgestrel
IUDs:

Skyla®, Kyleena®,
Liletta®, Mirena®

Contraceptive
Implant:

Nexplanon®

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 RCTs 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)

References

- ACOG Practice Bulletin Number 121. Long-Acting Reversible Contraception: Implants and Intrauterine Devices. July 2011. Accessed October 23, 2017. <https://www.acog.org/-/media/Practice-Bulletins/Committee-on-Practice-Bulletins---Gynecology/Public/pb121.pdf>
- ACOG Committee Opinion Number 670. Immediate Postpartum Long-Acting Reversible Contraception August 2016.
- Branum AM, Jones J. Trends in long-acting reversible contraception use among US women aged 15–44. NCHS data brief. 2015(188): 1-8.
- Brito MB, Ferriani RA, Quintana SM, Yazlle ME, Sá MF, Vieira CS Safety of the etonogestrel-releasing implant during the immediate postpartum period: a pilot study. *Contraception*. 2009;80(6):519-526. doi:10.1016/j.contraception.2009.05.124
- Centers for Disease Control & Prevention. US Medical Eligibility Criteria (US MEC) for Contraceptive Use, 2016. Accessed October 23, 2017. <https://www.cdc.gov/reproductivehealth/contraception/mmwr/mec/summary.html>
- Centers for Disease Control & Prevention. Vital signs: Preventing teen pregnancy. 2015. Accessed May 20, 2015. <https://www.cdc.gov/vitalsigns/larc/index.html>
- Chen BA, Reeves MF, Creinin MD, Schwarz EB. Postplacental or delayed levonorgestrel intrauterine device insertion and breast-feeding duration. *Contraception*. 2011;84(5):499-504. doi:10.1016/j.contraception.2011.01.022
- Conde-Agudelo A. Maternal morbidity and mortality associated with interpregnancy interval: cross sectional study. *BMJ*, 2000;321(7271):1255-1259. doi:10.1136/bmj.321.7271.1255
- Connolly A, Thorp J, Pahel L. Effects of pregnancy and childbirth on postpartum sexual function: a longitudinal prospective study. *International Urogynecology Journal*. 2005;16(4):263-267. doi:10.1007/s00192-005-1293-6
- Dahlke JD, Terpstra ER, Ramseyer AM, Busch JM, Rieg T, Magann EF. Postpartum insertion of levonorgestrel–intrauterine system at three time periods: a prospective randomized pilot study. *Contraception*, 2011;84(3):244-248. doi:10.1016/j.contraception.2011.01.007
- Elsedeek MS. Puerperal and menstrual bleeding patterns with different types of contraceptive device fitted during elective cesarean delivery. *International Journal of Gynecology & Obstetrics*. 2011;116(1):31-34. doi:10.1016/j.ijgo.2011.07.036
- Garipey AM Duffy JY, Xu X. Cost-Effectiveness of Immediate Compared With Delayed Postpartum Etonogestrel Implant Insertion. *Obstetrics & Gynecology*. 2015;126(1):47–55.

- Gurtcheff SE, Turok DK, Stoddard G, Murphy PA, Gibson M, Jones KP. Lactogenesis after early postpartum use of the contraceptive implant: a randomized controlled trial. *Obstet Gynecol*. 2011 May;117(5):1114-21. doi: 10.1097/AOG.0b013e3182165ee8.
- Guttmacher Institute. Unintended Pregnancy in the United States. (2017). Retrieved October 24, 2017, from <https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states>
- Heil SH, Jones HE, Arria A, Kaltenbach K, Coyle M, Fischer G, Stine S, Selby P, Martin PR Unintended pregnancy in opioid abusing women. *J Subst Abuse Treat*. 2011 Mar;40(2):199-202. Epub 2010 Oct 30.
- Jackson E. Controversies in postpartum contraception: When is it safe to start oral contraceptives after childbirth? *Thrombosis Research*, 2011;127. doi:10.1016/s0049-3848(11)70010-x
- Kapp N, Curtis K, Nanda K. Progestogen-only contraceptive use among breastfeeding women: a systematic review. *Contraception*. 2010 Jul;82(1):17-37. doi: 10.1016/j.contraception.2010.02.002. Epub 2010 Mar 29.
- Lopez LM, Bernholc A, Hubacher D, Stuart G, Van Vliet HAAM. Immediate postpartum insertion of intrauterine device for contraception. *Cochrane Database of Systematic Reviews* 2015, Issue 6. Art. No.: CD003036. DOI: 10.1002/14651858.CD003036.pub3
- Phillips SJ, Tepper NK, Kapp N, Nanda K, Temmerman M, Curtis KM. Progestogen-only contraceptive use among breastfeeding women: a systematic review. *Contraception* 2016;94(3):226-252. doi:10.1016/j.contraception.2015.09.010
- Simmons KB, Edelman AB, Li H, Yanit KE, Jensen JT. Personalized contraceptive assistance and uptake of long-acting, reversible contraceptives by postpartum women: a randomized, controlled trial. *Contraception* 2013;88(1):45-51. doi:10.1016/j.contraception.2012.10.037
- Turok DK, Leeman L, Sander JN et al. Immediate postpartum levonorgestrel intrauterine device insertion and breast-feeding outcomes: a noninferiority randomized controlled trial. Epub. *Am J Obstet Gynecol* 2017 Aug 23.
- Zerden ML, Stuart GS, Charm S, Bryant A, Garrett J, Morse J. Two-week postpartum intrauterine contraception insertion: a study of feasibility, patient acceptability and short-term outcomes. *Contraception*. 2017 Jan;95(1):65-70. doi: 10.1016/j.contraception.2016.08.005. Epub 2016 Aug 20.