

Long-Acting Reversible Contraception (LARC)

RESOURCE GUIDE



Reproductive Health Planning Task Force
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Introduction

Approximately 70% of reproductive-aged women in the United States are sexually active and at risk of unintended pregnancy in the absence of a contraceptive method. ⁽¹⁾ Estimates show that approximately half of pregnancies in the U.S. are unintended. The vast majority (95%) of unintended pregnancies occur among the one-third of women who do not use contraception or who use it inconsistently. ⁽²⁾ Therefore, more effective use of contraception can prevent unintended pregnancy.

In 2010, for every dollar spent to avoid unintended pregnancy, more than \$7 was saved in healthcare costs. This is because in Indiana in 2008, public insurance paid for approximately 62% of unintended births. ⁽²⁾ Improving access to contraception for women of reproductive age in Indiana would help to decrease the incidence of unintended pregnancies. The most effective methods of contraception are long-acting reversible contraception (LARC). ⁽³⁾

Despite this, substantial barriers remain to access and education surrounding contraception in general, and LARC specifically. In 2015, the Indiana State Department of Health (ISDH) sponsored the Labor of Love conference, which recommended focusing the state's effort on the reduction of unintended pregnancies for all women, especially teens (ages 15-19), by increasing access to the most effective contraception. Subsequently, the Indiana Perinatal Quality Improvement Collaborative (IPQIC) Subcommittee on Preconception and Interconception Care offered the following recommendations: 1) expand access to postpartum LARC by developing tools for health care providers to facilitate billing and coding; 2) increase the use of LARC methods by addressing barriers, such as lack of health care provider knowledge or skills and low patient awareness; and 3) continue the 2015 expansion of Indiana Medicaid coverage for immediate postpartum LARC placement in hospital settings.

This LARC Resource Guide reaffirms these guidelines, updates the available resource lists, and includes the following additions:

- Inclusion of an intentional reproductive justice framework for medical providers and support staff involved in reproductive health care provision. The reproductive justice framework means that it is a “human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities.” ⁽⁴⁾
- Recommendations around universal pregnancy intention screening to identify needs for patient-centered contraceptive counseling and initiation.

- Guidance for LARC initiation both in the office as well as in-hospital during the immediate postpartum period
- Considerations and best practices for providing trauma-informed care.
- Acknowledgement of the role that historical trauma, implicit bias, and institutional racism play in reproductive health care decisions and delivery and how we can continue to work to address these issues.

Goal

The goal of the Reproductive Health Planning Task Force is to develop and update a guidance document related to the counseling and use of LARC. The 2021 LARC Resource Guide is the outcome of the work of the Task Force and is intended to provide evidence-based recommendations surrounding the choice and use of LARC. The goal of the Resource Guide is to enable medical providers to empower people to make informed choices about reproductive planning options, including contraception, that enable flexibility and autonomy surrounding pregnancy intentions. This guidance document is intended to be used by providers and support staff, as well as people seeking information about contraceptive care and access in Indiana.

LONG-ACTING REVERSIBLE CONTRACEPTION RESOURCE GUIDE

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Section I: Background

Unintended pregnancy can have significant negative consequences for individual people, their families, and society, especially related to teen pregnancy and potential risks of maternal and infant mortality. In 2011, the last year for which national-level data are available, 45% of all pregnancies in the United States were unintended. Economically disadvantaged women are disproportionately affected by unintended pregnancy and its consequences. In 2011, the unintended pregnancy rate among women with incomes lower than the federal poverty level was more than five times higher than the rate among women with incomes > 200% of poverty (112 vs. 20 per 1,000). ^(5,6)

Maternal and Infant Mortality

In a statewide data analysis in Indiana in 2014, inadequate prenatal care, Medicaid enrollment, and maternal age less than 20 years were found to be predictive factors for adverse birth outcomes like low birth weight and infant mortality. These high-risk subpopulations accounted for only 1.6% of all births, but they accounted for 50% of total infant mortality. ⁽⁷⁾ Preterm births and low birth weight are together the second most common causes of infant mortality in the United States. In 2017, the mortality rate for infants born < 32 weeks of gestation was much higher than that for term infants (188 vs 2 deaths per 1000 live births). ⁽⁸⁾ In Indiana, the infant mortality rate fell to 6.5 deaths per 1000 live births in 2019, but according to CDC reports, remains in the bottom quartile of states for infant death. ⁽⁹⁾ Unintended pregnancy has severe consequences for maternal and infant mortality. Someone who is not planning to have a child may not be physically, psychologically, and financially ready for childbirth. Existing research links births resulting from unintended or rapid repeat pregnancies (pregnancy within 1-2 years of a previous birth) to adverse maternal and child health outcomes and a myriad of social and economic challenges. ^(10, 11) Unintended pregnancies, including rapid repeat pregnancies, are associated with delayed or absent prenatal care and corresponding adverse perinatal outcomes such as higher risk of low birth weight, preterm, and small-for gestational age births. ^(12, 13) The national percentage of rapid repeat pregnancies is 33%, which is similar for Indiana. ⁽¹⁴⁾ Decreasing unintended pregnancies would decrease inadequate prenatal care, premature births, babies born with low birth weight, and thus infant mortality. Evidence shows that access to and utilization of LARC prevents unintended and rapid repeat pregnancy, contributing to healthy pregnancy spacing and making it an important part of the public health effort to reduce infant mortality. ⁽¹⁵⁾

Teen pregnancy

Statistics surrounding adolescent reproductive health and teen pregnancy in the United States are stark, ⁽¹⁶⁾ including that 75% of teen pregnancies are unintended. The adolescent birth rate

(ages 15-19) for Indiana in 2017 was higher than the national average (22.8 vs. 18.8 per 1,000 live births).^(17, 18) Rapid repeat pregnancies are also more likely to occur to people <25 years of age, with 67% of teen mothers experiencing a rapid repeat pregnancy⁽¹⁹⁾ and accounting for 18% of teen pregnancies.⁽²⁰⁾ As discussed before, short interbirth intervals increase morbidity and mortality for both infants and mothers,⁽¹¹⁾ and this risk is elevated among the adolescent population.⁽²¹⁾

Adolescent moms who start LARC within 8 weeks of delivery are significantly less likely to have a rapid repeat pregnancy, while those who do not are up to 35x more likely.^(20, 21) Despite data showing the high effectiveness of LARC options, a study on trends in LARC use among teens from 15-19 years of age seeking contraceptive services showed that only 1.5% of teens in Indiana use LARC methods.⁽²²⁾ In a large study in St. Louis county where many of the barriers to LARC access were removed, researchers found that continuation of LARC amongst teens was significantly higher than for other methods of contraception, and the pregnancy rate in the county dropped significantly.⁽²³⁾ Access to effective contraception to prevent unintended pregnancy and provide adequate birth spacing for adolescents contributes to improvements in social, health, and economic circumstances for these youth.^(18, 24)

The 2014 American Academy of Pediatrics (AAP) Policy Statement on Adolescent Contraception recommends that, *“Pediatricians should be able to educate adolescent patients about LARC methods, including the progestin implant and intrauterine devices (IUDs). Given the efficacy, safety, and ease of use, LARC methods should be considered first-line contraceptive choices for adolescents”*.⁽²⁵⁾ The 2020 *Pediatrics* article further supports this by reaffirming the efficacy and safety of LARC in adolescents and providing information for providers to improve accessibility of LARC to adolescents in their own practice.

Postpartum LARC

By 6 weeks postpartum, 40% of non-breastfeeding people have ovulated, which may occur as early as 25 days postpartum. Further, by 6 weeks postpartum >50% have resumed sexual activity, and teens - especially those living with a partner - are more likely to have resumed intercourse.⁽²⁶⁾ Despite these metrics, many women leave the hospital without contraception. No-show rates for the 6-week postpartum visit are as high as 55%. Among those who do not receive postpartum contraception, 47% of women with unfulfilled sterilization requests will become pregnant within a year of delivery, the majority of which are unintended.⁽²⁷⁾

Data show that contraceptive options and access are important in the immediate postpartum period.⁽²⁸⁾ While 80% of postpartum people want to wait at least 2 years before having another

child, many do not receive contraception in the days or months after a pregnancy. ⁽²⁰⁾ The provision of immediate postpartum LARC (which includes IUD insertion immediately following delivery or implant insertion prior to discharge) is a safe and effective way to prevent unintended and rapid repeat pregnancy and the risks associated with these outcomes.

Barriers to postpartum LARC counseling and access exist among at the system, provider, and patient-levels. ^(29,30, 31, 32, 33) Important information for patients to understand for immediate postpartum LARC insertion include that the risks of infection, perforation, and abnormal bleeding are not increased when the IUD is inserted immediately postpartum; however, expulsion rates are higher than with later placement. After a vaginal delivery, expulsion rates may be up to 20%, after a cesarean section this rate may be as high as 8%, and this may be more likely with for levonorgestrel-releasing IUDs compared to copper IUDs. The contraceptive implant can be inserted at any point after delivery and is associated with significantly lower rates of rapid repeat pregnancy in adolescents (23% vs. 3%).

For more information about Postpartum LARC Insertion Training see the *Provider Resources* section on page 22.

Breastfeeding

The potential effects of postpartum LARC on breastfeeding are a concern for some women and providers. ⁽³⁴⁾ To date, there is no clinical evidence of an effect on breastfeeding for any LARC methods, including the progestin-only hormonal intrauterine devices (e.g., Mirena[®] and Liletta[®]) and contraceptive implant (Nexplanon[®]). ⁽³⁵⁾ Multiple studies have shown no difference in onset of milk production, overall or exclusive breastfeeding rates, or infant growth when comparing women who received a hormonal IUD immediately after delivery to those who waited until 4-8 weeks after delivery, or when comparing women who received a hormonal IUD vs. a non-hormonal IUD at 6-8 weeks postpartum. ^(36, 37, 38) Evidence shows that the contraceptive implant also does not impact breastfeeding. Multiple studies showed no difference in onset of milk production, overall or exclusive breastfeeding rates, or infant growth for women who received the implant within 5 days of delivery vs. women who did not receive any contraception or who received an implant 4-8 weeks after delivery. People should speak with their medical providers about their postpartum breastfeeding and family planning plans when selecting a contraceptive method. ⁽³⁹⁾

Section II: Resources for Providers

Pregnancy intention screening

Universal pregnancy intention screening is recommended as a core component of high-quality, primary preventive care services to provide pre-pregnancy counseling and referral and/or

contraceptive counseling to improve maternal and newborn outcomes. Pre-pregnancy counseling is appropriate whether the reproductive-aged patient is currently using contraception or planning pregnancy. Because health status and risk factors can change over time, pregnancy intention screening along with pre-pregnancy and contraceptive counseling should occur multiple times during a reproductive lifespan, increasing the opportunity for education and improving reproductive and pregnancy outcomes.

Determining whether and when someone wants to become pregnant or wants their partner to become pregnant can provide opportunities for counseling and referral for care to improve pre-pregnancy health and pregnancy outcomes for parents and their babies. This care includes:

- screening and referral for early pregnancy care (by 12 weeks gestation)
- prevention of pregnancy and healthy birth spacing through access to and effective use of contraception
- general preconception counseling (such as the use of folic acid)
- immunizations
- screening and treatment for chronic diseases (e.g., hypertension, diabetes, and depression) as well as infectious (including sexually transmitted) diseases
- screening and treatment for substance use and addiction
- screening and referral for exposure to violence, intimate partner violence, and reproductive and sexual coercion
- screening and referral for healthy weight management
- screening and referral for medication management (such as discontinuation of teratogenic medication prior to conception)

One goal of universal pregnancy intention screening is to specifically address health disparities that contribute to poor health outcomes. This includes specific issues that impact communities of color, persons with disabilities, those living in poverty, and those with poor access to comprehensive health care. We encourage organizations and institutions to include representation from these communities in determining which pregnancy intention screening strategy might be most effective and how to implement this strategy. Similarly, we recommend organizations and institutions include education for providers about biases and judgments that may affect counseling around reproductive health and pregnancy intention.

Multiple strategies have been developed for universal pregnancy intention screening that can be incorporated into different sites of health care provision. All strategies have similar steps:

- 1) Ask all persons of reproductive potential about their pregnancy intentions.
- 2) Determine their needs regarding their health and pregnancy intentions.

- 3) Make referrals to appropriate providers/interventions based on their pregnancy intentions and reproductive health needs.

We recommend that institutions determine which strategy for universal pregnancy intention screening would be ideal for their setting and adopt it into routine practice. Different sites may utilize different cadres of providers to perform screening, different ways of screening, and different methods for facilitating necessary referrals. Resources are available to help institutions adapt the strategies and troubleshoot issues that may arise during implementation.

Strategy #1: One Key Question®

The One Key Question® strategy was developed by Power to Decide, a public, non-profit, non-partisan campaign to prevent unplanned pregnancy. The notion behind One Key Question® is simple: It asks all health providers and champions who support women to routinely ask, “*Would you like to become pregnant in the next year?*” Equal support is given to those who want to become pregnant, those who do not, and those who are unsure or would be open to pregnancy. OKQ® helps people consider their own goals for pregnancy and ensures that they have access to services and support to achieve those goals. Many organizations and institutions nationwide use One Key Question®, including home visiting programs and primary care practices, as well as other innovative locations, such as food assistance programs and dental offices. Power to Decide offers training and technical assistance to provider networks, community organizations, and others interested in being certified as a One Key Question® provider or institution. One Key Question® has been endorsed by more than 30 prominent national organizations, including the American Public Health Association, the American College of Obstetricians and Gynecologists, and the National Association of Nurse Practitioners in Women’s Health. For more information and training information see <https://shop.powertodecide.org/trainings.html>

Strategy #2: The PATH (Parenthood/Pregnancy Attitude, Timing, and How important is pregnancy prevention) Questions

The PATH Questions strategy was developed by Envision Sexual and Reproductive Health (SRH), a non-profit organization that provides innovative, accessible resources and learning support for sexual and reproductive health with a patient-centered focus. PATH Questions help clarify your patients’ reproductive goals and needs. PATH is designed to yield a maximal amount of relevant information in an efficient way that leads to patient-centered conversations about pre-pregnancy care, contraception, and fertility, as appropriate. The PATH questions are:

1. *Do you think you might like to have (more) children at some point?*
2. *When do you think that might be?*
3. *How important is it to you to prevent pregnancy (until then)?*

The purpose of PATH Questions is to help people explore their thoughts and feelings and gain clarity about what they want in terms of reproductive planning so they can make choices that are aligned with their goals, as well as let the person know that your priority is helping them figure out what is important to them and inform the provider about the direction of the visit (offering to discuss pre-pregnancy care, fertility support, and/or contraception). The purpose of the PATH Questions is NOT for the provider to decide which intervention or contraceptive method is best for the patient, make the patient feel like they "should" have a plan, or to create a concrete plan that the patient should commit to. For more information and training information, see <https://www.envisionsrh.com/about-path>

Strategy #3: IMPLICIT (Interventions to Minimize Preterm and Low birthweight Infants through Continuous Improvement Techniques) Interconception Care (ICC) Model

The IMPLICIT Interconception Care Model was developed by the IMPLICIT Network, a family medicine maternal-child health learning collaborative focused on improving care for women, infants, and families through faculty, resident, and student development and quality improvement, supported by the March of Dimes Foundation. The goal of the IMPLICIT ICC Model is to address at every well-child visit from birth to 24 months of age a mother's health risks that affect her child and family. The Model is brief and targets four risk factors for which there is evidence of effectiveness: 1) smoking, 2) depression, 3) family planning/contraception, and 4) multivitamin/folic acid use. These interventions have a robust base of evidence for affecting birth outcomes, specifically preterm birth, in future pregnancies. Interventions in the model include:

- 1) Ask the mother about smoking, depression, family planning/contraception and multivitamin/ folic acid use,
- 2) Advise and educate her about desired healthy behaviors,
- 3) Assess any positive screens, and
- 4) Assist in and arrange for interventions.

The model also includes analyzing collected data for QI research to develop strategies to improve care delivery and patient outcomes. The model is adaptable in a variety of settings, including family medicine practices, pediatric care, health departments, community health centers, and public health programs. The toolkit offers strategies, work flows and guidance to implement the IMPLICIT ICC model and presents solutions that have worked for others. For more information and training information, see <https://www.marchofdimes.org/professionals/implicit-interconception-care-toolkit.aspx>

Additional Resources/Training:

- One Key Question Training:
 - <https://shop.powertodecide.org/trainings.html>
- PATH Training:

- <https://www.envisionsrh.com/about-path>
- IMPLICIT Interconception Toolkit:
 - <https://www.marchofdimes.org/professionals/implicit-interconception-care-toolkit.aspx>
- Family Planning National Training Center:
 - <https://www.fpntc.org/>
- The American College of Obstetricians & Gynecologists Prepregnancy Counseling and Interpregnancy Care
 - <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2019/01/prepregnancy-counseling>
- Recommendations to Improve Preconception Health and Health Care in the United States: A Report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care
 - <https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5506a1.htm>

Patient-Centered Contraceptive Counseling

As with many medical treatments, the most effective therapy is the one the patient will use. Therefore, the most important thing any provider can do to help a patient choose a method for contraception is to explore a patient’s values and priorities and to use this information to guide contraceptive choice. Negative prior experiences and preconceived notions about contraception, in particular LARC, are common. It behooves providers to develop an approach to counseling that recognizes this and asks patients to share concerns, while also encouraging them to consider all options considering their personal priorities. For example, many people express that effectiveness is their highest priority in a contraceptive method yet are not using LARC. Discussing effectiveness as one of potentially many priorities can help someone choose the method that best fits them.

It is also important to ensure patients will have access to expeditious removal when and if they choose to have a LARC device removed. It is consistent with best medical practice and the reproductive justice framework that LARC devices are removed at any time this is requested by a patient without additional requirements. Patients may also be counseled about IUD self-removal if this is desired by the patient.

Prenatal Counseling on Postpartum LARC use

Birth spacing is an evidence-based strategy known to reduce maternal and infant mortality and morbidity. ^(40, 41, 42) Counseling about postpartum contraception to promote healthy birth spacing should begin during prenatal care and be reinforced through shared decision-making across multiple visits during care. A plan should be made prior to delivery to facilitate access to their

method of choice, including immediate postpartum LARC or sterilization. This discussion should include expectations for return to fertility following delivery, timing of desired next pregnancy, when and where the contraceptive methods are available and recommended for initiation, and whether contraceptive use may impact breastfeeding (if applicable). It should also include a discussion about expected medical insurance status following delivery to ensure a chosen contraceptive method is initiated prior to potential loss of any pregnancy-related insurance.

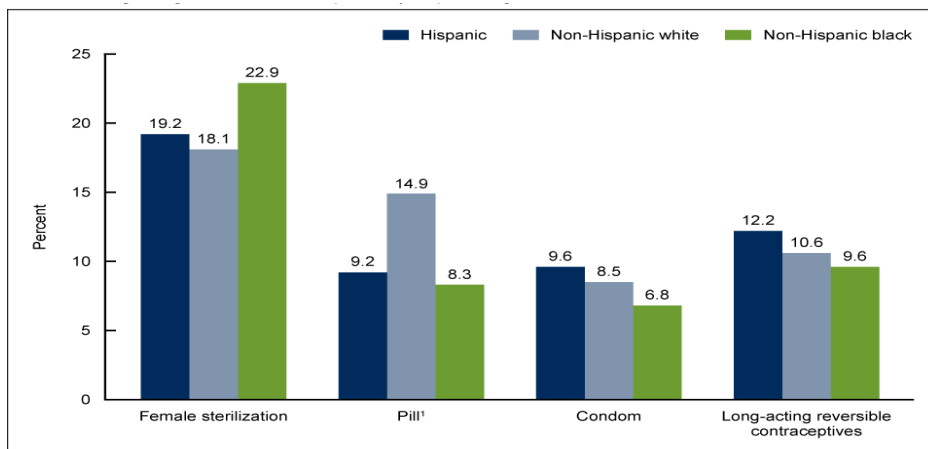
Cultural competency

Cultural competency is an important element that is integral to care for all patients, especially people of reproductive age. Thirty-eight percent of women in the US are members of a racial or ethnic minority, and while Indiana has a lower proportion of minorities, those demographics are changing over time. ^(43, 44) As a health care community, institutions must raise awareness of racial and ethnic disparities in health care and health outcomes. These issues are complex, and this document will not be able to fully address all the aspects that should be considered; however, a brief overview of data and topics factors to consider are discussed below.

Reproductive Planning and Use Disparities

There are marked racial and ethnic differences in the use of contraception in the US. ⁽⁴⁵⁾ Rates of hormonal contraceptive use are lowest for Black women when compared with their Hispanic, Asian, and White counterparts; however, Black women have the highest rates of sterilization. While informed consent and shared decision-making have been shown to increase patient knowledge and uptake of contraception, particularly LARC, more information about the root of these disparities is needed to help empower patients in their family planning decisions. ⁽⁴⁶⁾

Percentage of all women aged 15-49 using Contraception by Race/Ethnicity, US 2015-2017 ⁽⁴⁷⁾



[†]Percentages for Hispanic and non-Hispanic black are significantly different from percentage for non-Hispanic white.

Factors Leading to Health Disparities

While not exhaustive, the following factors could underly the racial and ethnic differences in contraceptive use:

Historical Trauma

Many Black women were forced to reproduce during slavery and federally funded forced sterilization, which disproportionately affected Black women, was legal in 32 states until the late 1970's. ⁽⁴⁸⁾ These discriminatory practices disrupted the relationship between women of color and family planning providers and has not yet been adequately addressed by the medical community. This legacy has implications for contraceptive use today. Implementing reproductive justice has been a hard-fought battle and is an important goal given this historical context.

Access to Services

Access to healthcare is a barrier that is tied not only to race, ethnicity, and income, but also geography. Families in rural areas often live prohibitively far from family planning services. Indiana has large areas where primary care, including obstetric and contraceptive care, are not available. ^(49, 50, 51) Public transportation is not always an option and the Medicaid cab system does not support trips to non-medical appointments, including those to family planning providers, such as Planned Parenthood.

Clinician Knowledge and Bias

Comprehensive and culturally specific patient-centered care for family planning and contraception are not core components of medical and nursing school education or requirements for continued licensure/certification. Furthermore, research has shown that reproductive health counselling differs based on the racial and ethnic identity of patients, indicating the role that bias plays in the care of women of color. ^(52, 53)

Patient Factors

Knowledge regarding contraceptive options is not universal for all women. ^(54, 55) Lack of access to knowledgeable providers and inexperience interacting with the health care system may exacerbate this issue. Additionally, immigration status affects not only insurance coverage but also people's comfort and ability to seek family planning services. ⁽⁵⁶⁾ Data has shown that if providers do not speak their native language or have appropriate interpreter services, they are less likely to consent to contraception. ⁽⁵⁷⁾

Social Norms

People also hold personal beliefs about seeking health care, contraception, sex, and pregnancy that are framed by family, friends, religion, culture, and society. ^(58, 59, 60, 61, 62, 63, 64) An ambivalence towards pregnancy can also be a reason for using less effective contraception. ^(65, 66)

Employment and Insurance

People of lower socioeconomic status often lack paid or unpaid leave to attend medical appointments or are not supported by their employers, despite federal laws. ⁽⁶⁷⁾ Insurance coverage for contraception is provided under the Affordable Care Act in 36 states plus the District of Columbia, but persistent barriers to coverage exist and pregnancy-related coverage typically ends at 60 days postpartum currently in Indiana. ^(68, 69) Uninsured, underinsured, and women of color are most affected by lack of coverage.

Implicit Bias & Institutional Racism

Implicit bias and institutional racism are also major contributing factors to contraceptive use. Disparities in contraceptive counselling and provision have been noted in the literature. ^(70, 71, 72) Providers may not know the history, social and cultural behaviors, or barriers related to family planning and breastfeeding in Black, Latinx, or other communities' cultures. However, factors such as implicit bias and racial stereotyping by health care providers contribute to disparities in health, and all providers must be educated on their role in providing culturally sensitive care to differing ethnic groups. In addition, institutional systems must openly and honestly address inherent biases and train providers to recognize and mitigate those biases, creating a system for more equitable outcomes in family planning.

Summary/Conclusion

Acknowledging the importance of cultural competency and incorporating this into reproductive health planning are critical elements. In addition, efforts to ensure diversity in the family planning workforce are critical to ensuring representation reflects the communities served. Community-engagement strategies must be designed to disseminate information to all communities, especially ones that have a history of exclusion.

Trauma-Informed Care

Trauma occurs when an individual experiences an event or set of circumstances as physically or emotionally harmful or life-threatening. ⁽⁷³⁾ Examples of trauma include physical, sexual, and emotional abuse, neglect, and other types of violence and loss. Many elements of healthcare can be challenging for patients with a history of trauma including but not limited to: power differentials (within a provider-patient relationship, the provider inherently has greater power than the patient), being asked to remove clothing, physical examination, venipuncture, closed

doors, and the gender of providers. For survivors of trauma in general, and sexual trauma specifically, gynecologic care including pelvic exams, discussions about sexual history and activity, and contraceptive decision-making can be particularly difficult. This may be especially pronounced when addressing LARC, as placement of both IUDs and contraceptive implants involve some discomfort and invasive procedure and both methods typically rely on a provider for discontinuation. Utilizing a trauma-informed approach to care with a focus on sensitivity to the when and where concerns of power and control (as well as other possible triggers) may be present is paramount.

Providing trauma-informed care can improve patients' experience and decrease re-traumatization by the healthcare system. One component of trauma-informed care is to avoid asking "what is wrong with this patient?" and instead ask, "what happened to this patient?" Patients may or may not choose to disclose a history of trauma. However, because trauma is so prevalent, with 1 in 3 women and 1 in 4 men experiencing sexual violence in their lifetimes, ⁽⁷⁴⁾ a best practice is to approach each patient with a mindset of universal precautions and integrate trauma-informed care throughout each patient encounter.

Adopting a trauma-informed approach is not accomplished through any single technique or checklist. It requires constant attention, caring awareness, sensitivity, and possibly, cultural change at an organizational level. ⁽⁷⁵⁾ A trauma-informed approach is one that:

- 1) Realizes the widespread impact of trauma and understands potential paths for recovery
- 2) Recognizes the signs and symptoms of trauma
- 3) Responds by fully integrating knowledge about trauma into policies, procedures, and practices
- 4) Seeks to actively resist re-traumatization ⁽⁷⁶⁾

Resources for Trauma-Informed Care

- SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach: https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf
- Clinical Pearls for Trauma-Informed Pelvic Exams <https://www.reproductiveaccess.org/resource/trauma-informed-pelvic-exams/>
- Recommendations to minimize physical and psychological discomfort with pelvic examination. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3101979/>

Dual Method Use

Dual method contraception refers to using condoms as well as another method of contraception, given the higher failure rate for pregnancy prevention with condoms alone. ⁽⁷⁷⁾ This strategy is intended to ensure protection against both unintended pregnancy as well as sexually transmitted infections (STIs), including HIV, which can cause long-term health implications, including chronic disease and infertility. This is particularly important to emphasize when counseling people at higher risk for STIs, including adolescents and young adults <25 years of age and those with multiple or anonymous sexual partners. Clinicians can help patients engage in conversations with partners regarding dual protection use as partners are not always present during these clinical encounters. People using LARC methods are not at increased risk for STIs or pelvic inflammatory disease (PID). Therefore, it is recommended to screen and treat LARC users like non-users based on CDC guidelines. <https://www.cdc.gov/std/treatment/default.htm>.

Section III: Available LARC Methods

Non-hormonal/Copper Intrauterine Device (IUD)	
What types are available?	Paragard® is the only FDA approved device in the US and can be used up to 10 years per FDA (although evidence shows they continue to be effective for up to 12 years).
How does it work?	The copper IUD prevents pregnancy by killing/paralyzing sperm.
How do you use it?	A copper IUD is inserted through the cervix and into the uterus by a clinician.
How well does it work?	With typical use, less than 1 person out of 100 (0.8%) will become pregnant during the first year of use. ⁽⁷⁸⁾
When can this be started?	It can be placed immediately after delivery or any time after 30 days postpartum. It can also be placed within 5 days of unprotected intercourse as the most effective form of emergency contraception. ⁽⁷⁹⁾ When IUDs are placed immediately after a vaginal delivery, there is an ~10-20% risk of expulsion (falling out), compared to <10% risk when they are placed immediately after a Cesarean delivery or when they are placed >4 weeks after delivery. ⁽⁸⁰⁾
Is there evidence of an effect on breastfeeding?	No. Because the copper works locally on the uterus, it has no systemic effect and thus, no effect on breastmilk production. ⁽⁸¹⁾
Does it increase risk of thromboembolic disease?	No.
Risks/Disadvantages	<ul style="list-style-type: none"> • Discomfort with placement

Non-hormonal/Copper Intrauterine Device (IUD)	
	<ul style="list-style-type: none"> • Menses may become heavier, crampier, and/or longer lasting, especially in first few cycles. • Expulsion of IUD • Pelvic infection (rare, <1% risk at time of insertion, does not increase risk of PID after insertion) • Uterine perforation (rare, <1/1000 risk) • Pregnancy complications (in the rare event that pregnancy occurs with IUD in place)
Benefits/Advantages	<ul style="list-style-type: none"> • Few contraindications • Reduced risk of endometrial & cervical cancer • Highly effective emergency contraception • Rapid return to fertility • Good candidate in cases of reproductive coercion secondary to no/minimal disruption in menstrual pattern and ability to be undetected by partner with removal of strings

Progestin-only hormonal intrauterine device (IUD)	
What types are available?	The most commonly used hormonal IUDs are the two brands of 52mg levonorgestrel-releasing IUDs (Mirena® and Liletta®), which are both FDA-approved for pregnancy prevention for up to 5 and 6 years of use (although evidence shows they continue to be effective for up to 7 years). There are also two lower dose levonorgestrel-releasing IUDs, the Skyla® (13.5mg, approved for up to 3 years) and the Kyleena® (19.5mg, approved for up to 5 years). There have not been any studies that compare side effects (including insertion pain) of the different hormonal IUDs.
How does it work?	It works by thickening cervical mucus to prevent sperm entry, thinning the lining of the uterus, and preventing ovulation.
How do you use it?	An IUD is inserted through the cervix and into the uterus by a clinician.
How well does it work?	With typical use, less than 1 woman out of 100 (0.2%) will become pregnant during the first year of using this method. ⁽⁸²⁾
When can this be started?	IUDs can safely and easily be placed immediately after delivery (either vaginal or Cesarean) or at a postpartum follow-up visit (as early as 2 weeks after delivery). However, when IUDs are placed

Progestin-only hormonal intrauterine device (IUD)	
	immediately after a vaginal delivery, there is an ~10-20% risk of expulsion (falling out), compared to <10% risk when they are placed immediately after a Cesarean delivery or when they are placed >4 weeks after delivery. ⁽⁸³⁾
Is there evidence of an effect on breastfeeding?	No. While there is concern that insertion immediately after delivery may interfere with early hormonal changes required for breastfeeding, most evidence shows there is very low risk of difficulty with breastfeeding due to receiving a hormonal IUD immediately after delivery or at your postpartum visit. Multiple studies have shown no difference in onset of milk production, overall or exclusive breastfeeding rates, or infant growth when comparing those who received a hormonal IUD immediately after delivery vs. waited until 4-8 weeks after delivery or when comparing those who received a hormonal IUD vs. a non-hormonal IUD at 6-8 weeks postpartum. ^(84, 85, 86)
Does it increase risk of thromboembolic disease?	No
Risks/Disadvantages	<ul style="list-style-type: none"> • Discomfort with placement • Changes in menstrual pattern (including irregular bleeding/spotting, especially in first 3 months, and amenorrhea or no periods) • Expulsion of IUD • Pelvic infection (rare, <1% risk at time of insertion, does not increase risk of PID after insertion) • Uterine perforation (rare, <1/1000 risk) • Pregnancy complications (in the rare event that pregnancy occurs with IUD in place)
Benefits/Advantages	<ul style="list-style-type: none"> • Few contraindications • Reduced risk of endometrial cancer, ovarian, pancreatic, and lung cancers • Rapid return to fertility • Reduced menstrual blood loss (bleeding with periods) • Reduced dysmenorrhea (pain during periods)

Progestin-only hormonal intrauterine device (IUD)	
	<ul style="list-style-type: none"> • Good candidate in cases of reproductive coercion secondary to ability to be undetected by partner with removal of strings

Contraceptive Implant	
What types are available?	Nexplanon® is the only available contraceptive implant in the US. It is a single-rod etonogestrel-releasing implant, which is FDA-approved for pregnancy prevention for up to 3 years (although evidence shows it continues to be effective for up to 5 years).
How does it work?	It works by preventing ovulation, thickening cervical mucus, and thinning the lining of the uterus.
How do you use it?	The implant is a small rod that is inserted under the skin of the upper arm. It may be able to be felt if your arm is touched, but it cannot be seen.
How well does it work?	With typical use, less than 1 woman out of 100 (0.05%) will become pregnant during the first year of using this method. ⁽⁸⁷⁾
When can this be started?	Implants can safely and easily be placed during your hospital stay after delivery (either vaginal or Cesarean) or at a postpartum follow-up visit at any time.
Is there evidence of an effect on breastfeeding?	No. Because the implant contains similar hormone to the hormonal IUD, there is the same concern that insertion immediately after delivery may interfere with early hormonal changes required for breastfeeding. But similar to the hormonal IUD, many studies have shown that it does not impact breastfeeding. Multiple studies showed no difference in onset of milk production, overall or exclusive breastfeeding rates, or infant growth for women who received the implant within 5 days of delivery vs. women who did not receive any contraception or who received an implant 4-8 weeks after delivery.
Does it increase risk of thromboembolic disease?	No

Risks/Disadvantages	<ul style="list-style-type: none"> • Procedure-related risks with placement and removal (including need for ultrasound-guided removal if not palpable at time of desired removal). • Changes in menstrual pattern (irregular bleeding/spotting is common, especially in first 3 months, and amenorrhea or no bleeding) • Migration of implant (very rare)
Benefits/Advantages	<ul style="list-style-type: none"> • Few contraindications • Most effective method of contraception • Reduced menstrual blood loss (bleeding with periods) • Reduced dysmenorrhea (pain during periods) • Rapid return to fertility

Contraceptive method	When to start (if the provider is reasonably certain that the woman is not pregnant)	Additional contraception (i.e., back-up) needed	Examinations or tests needed before initiation*
Copper-containing IUD	Anytime	Not needed	Bimanual examination and cervical inspection†
Levonorgestrel-releasing IUD	Anytime	If >7 days after menses started, use back-up method or abstain for 7 days.	Bimanual examination and cervical inspection†
Implant	Anytime	If >5 days after menses started, use back-up method or abstain for 7 days.	None

Source: <https://www.cdc.gov/reproductivehealth/contraception/mmwr/spr/appendixb.html>

Section IV. Resources for Providers: Counseling about, providing, and managing contraception, including LARC

[CDC Contraceptive Guidance for Health Care Providers](#)

This resource includes several contraceptive tools you can download or order, including updated guidance documents, provider tools (including the *CDC: Contraception* App for Android & iOS), and other electronic resources, including:

- [The United States Medical Eligibility Criteria for Contraceptive Use, 2016 \(US MEC\)](#) includes recommendations for using specific contraceptive methods, including LARC, by people who have certain characteristics or medical conditions (e.g., hypertension, cervical dysplasia). A [wall-chart summary](#) and hand-held wheel for easy reference are available on the website

- [U.S. Selected Practice Recommendations \(US SPR\) for Contraceptive Use, 2016](#) addresses many common, as well as controversial or complex, issues regarding initiation and use of specific contraceptive methods, including LARC.
- CDC Selected Practice Recommendations for Contraceptive Use – IUDs
<https://www.cdc.gov/reproductivehealth/contraception/mmwr/spr/intrauterine.html>
- CDC Selected Practice Recommendations for Contraceptive Use - Implants
<https://www.cdc.gov/reproductivehealth/contraception/mmwr/spr/implants.html>
- Guidance on [Providing Quality Family Planning Services \(QFP\)](#) including *what* services should be offered in a family planning visit and *how* these services should be provided, including detailed guidance on contraceptive services for special populations, and how to use the family planning visit to provide selected preventive health services.
- “Quick Start” Algorithms to guide providers in how/when to start birth control methods:
 - <https://www.reproductiveaccess.org/wp-content/uploads/2014/12/QuickstartAlgorithm.pdf>
- Manufacturer websites on side effects and safety information
 - <https://www.nexplanon.com/side-effects/>
 - <https://www.paragard.com/safety-information/>
 - <https://www.mirena-us.com/safety/>
 - <https://hcp.mirena-us.com/>
- The Partners in Contraceptive Choice & Knowledge (PICCK) website, which has assembled many provider resources, including a Toolkit for providing contraception during the COVID-19 pandemic: <https://picck.org/>
- Difficult LARC insertions and removals should be referred to local experts in family planning care. The IU School of Medicine, Department of OBGYN has a Division of Family Planning that can receive referrals through IU Health (317-944-8231) or Eskenazi (317-880-6000). They provide ultrasound-guided implant removal for non-palpable or deeply implanted contraceptive devices.

LARC in Adolescents:

- [Long-Acting Reversible Contraception: Specific Issues for Adolescents](#)
- <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/adolescent-sexual-health/Pages/Contraception.aspx/>
- <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/adolescents-and-long-acting-reversible-contraception-implants-and-intrauterine-devices>

Trauma-Informed Care

- SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach: https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf
- Clinical Pearls for Trauma-Informed Pelvic Exams <https://www.reproductiveaccess.org/resource/trauma-informed-pelvic-exams/>
- Recommendations to minimize physical and psychological discomfort with pelvic examination. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3101979/>

LARC Insertion Training for Providers

- In-office Training:
 - National Clinical Training Center for Family Planning: The Office of Population Affairs has provided funding to the Clinical Training Center for Family Planning to arrange for long-acting reversible contraception (LARC) training, which includes intrauterine device (IUD) and NEXPLANON placement, in different regions across the nation. For more information, contact them at 1-866-91-CTCFP (1-866-912-8237)
 - The Beyond the Pill Program: this program partners with health care providers, researchers, and educators to improve access to effective contraception and reproductive health care, including through LARC training. To view an online training, visit <http://beyondthepill.ucsf.edu/online-training>. To request an on-site training, contact Julia Hankin at Julia.Hankin@ucsf.edu or (415) 502-0331
 - Upstream USA: provides onsite, comprehensive consulting and technical training to health centers, including CME/CE accredited LARC training. In addition, it offers counseling tips for health educators, counselors, and medical assistants as well as in-depth revenue cycle management assistance and/or coding review for billing and financial staff. To request a training, email Peter Belden at peter@upstream.org. For more information, visit <http://www.upstream.org>

To request method-specific training opportunities from their companies:

- Mirena® , Skyla® or Kyleena® (LNG IUS)—Bayer HealthCare Pharmaceuticals
To request a training, call: 1-888-84-BAYER (1-888-842-2937) or visit their website: <https://hcp.mirena-us.com/SSL/email-signup-registration/>
- ParaGard® (Copper IUD)—Teva Women’s Health, Inc.
To request a training, call: 1-877-PARAGARD (727-2427) or visit their website: <https://hcp.paragard.com/request-information/>.
- Nexplanon® (Contraceptive implant)—Merck & Co., Inc.
To request a training, call 877-467-5266 or visit their website: <https://www.nexplanontraining.com/request-clinical-training/in-person-training/>.

Postpartum Insertion Training:

The following links include video demonstrations showing correct postpartum IUD (PPIUD) insertion technique, best practices for insertion and managing complications, & an optional video about how to construct a model for simulation/practicing IPPIUD insertion:

- <http://www.cardeaservices.org/resourcecenter/inserting-long-acting-reversible-contraception-larc-immediately-after-childbirth>
- [Immediate Postpartum Intrauterine Device Insertion Training Workshop](#)

Family Planning National Clinical Training Center

- For a list of training opportunities, including virtual trainings, visit <http://www.ctcfp.org/larc/>
- For more information, contact them at 1-866-91-CTCFP (1-866-912-8237)

Resources for Billing for LARC

One of the major barriers to providing same-day LARC insertion is the cost of the devices. Many offices cannot afford to have devices sitting on the shelf waiting to be inserted. In most cases, LARC are part of the medical benefit for health insurance plans, which allows for providers to bill directly for the device. However, if the device is listed as a pharmacy benefit, it may impact the ability to receive reimbursement.

To improve same-day insertion access, clinics should collect and verify patient's insurance coverage, and all required demographic information prior to the visit (name of insurance, member ID, group ID if the patient is the policy holder or information related to the policy holder).

Correct coding is the first step in recouping the costs of the device and insertion. Creating a cheat sheet of most frequent ICD-10 codes utilized can help providers. The National Clinical Training Center has developed a pocket card for clinicians to carry in their jacket pocket: <http://www.ctcfp.org/wp-content/uploads/ICD-10-Pocket-Card.pdf>

These codes are also used for immediate postpartum insertion. Guidance specific to Medicaid reimbursement for postpartum LARC insertion can be found at <https://www.acog.org/programs/long-acting-reversible-contraception-larc/activities-initiatives/medicaid-reimbursement-for-postpartum-larc>

Coding guidance for specific LARC clinical scenarios can also be found on the [ACOG LARC Program website](#) and the [ACOG Department of Coding and Nomenclature website](#).

Common Codes for Billing: Contraceptive Management Visits

For dates of service POST October 1, 2016



LARC's (Long Acting Reversible Contraception)			
IUD	E/M	Z30.014	Encounter for initial prescription of IUD (not coded with IUD insertion procedure)
	58300/J7300, J7301, J7297, J7298	Z30.430	Encounter for Insertion of IUD
	58300, 58301/J7300, J7301, J7297, J7298	Z30.433	Encounter for Removal and Re-insertion of IUD
	E/M	Z30.431	Encounter for routine checking of IUD
	58301	Z30.432	Encounter for Removal of IUD
	E/M	Z97.5	Presence of IUD
Implant	I1981 / J7307	Z30.017	Encounter for insertion of subdermal implant contraceptive
	I1982	Z30.46	Encounter for surveillance of subdermal implant contraceptive (includes checking, removal and reinsertion)
	E/M		
	I1983 / J7307		
	E/M	Z97.5	Presence of Implant

The Indiana Health Coverage Programs (IHCP) allows separate reimbursement for certain long-acting reversible contraception (LARC) devices implanted during an inpatient hospital or birthing center stay for a delivery. For applicable HCPCS codes, see Obstetrical and Gynecological Services Codes, accessible from the Code Sets page at <https://www.in.gov/medicaid/providers/>

Where to refer patients who need low-cost LARC insertions and/or removals:

- **Medicaid Family Planning Eligibility Program** provides services and supplies for the primary purpose of preventing or delaying pregnancy. This program is for people who do not qualify for any other category of Medicaid and have income that is at or below 133% of the federal poverty level. Call the Division of Family Resources (DFR) toll-free at 1-800-403-0864, 8:00 a.m. to 4:30 p.m., Eastern Standard Time for any questions.
- **Indiana Family Health Council** runs Title X-funded health centers in Indiana that provide reproductive health services and counseling for low-income, working poor, and teens. These include family planning clinics within the Eskenazi Health system. Self-pay patients are placed on a sliding fee scale: www.ifhc.org or call 317-247-9151
- **Indiana Primary Health Care Association** will provide information on location of Federally Qualified Health Centers which provide medical services on a sliding fee scale: <http://www.indianapca.org/page/FindaCHC>.
- **The PATH4You Program** provides a pre-visit personalized reproductive health planning tool, comprehensive contraception, and preconception counseling, and same-day access for all reversible contraceptive methods. This IU-based project utilizes telemedicine and partners with multiple clinic locations to support access to full spectrum contraceptive care: <https://www.path4you.org/>

- **Power to Decide**, an organization that works to prevent teen pregnancy and unplanned pregnancy, has a website to help patients find clinics that provide LARC: <https://powertodecide.org/sexual-health/your-sexual-health/find-clinic#zip=46220>
- **The LARC Foundation**, a grassroots organization aimed at providing education, promoting and spreading awareness, and alleviating the financial barrier to women in low income and high risk environments, has a website to help patients find low-or no-cost LARC: <http://www.larc.freeiud.org/locator.html>
- Bayer HealthCare Pharmaceuticals has the [ARCH Patient Assistance Program](#) that will determine if patients qualify for free Mirena, Skyla or Kyleena products. Both patient and clinician must fill out the paperwork.
- ParaGardDirect does not have a patient assistance fund, but they do have an installment method. Patients should call 1-877-PARAGARD to find additional information.
- Curascript and CVS Caremark are distributors of Nexplanon, and they offer installment payment options for patients. Providers should contact the distributors for an application.

Additional Resources for billing & reimbursement:

Intrauterine Devices & Implants: A Guide to Reimbursement:

<https://larcprogram.ucsf.edu/>

How to Develop Systems for Same-Visit Provision of All Contraceptive Methods:

https://www.fpntc.org/sites/default/files/resources/fpntc_systems_same_visit_2017-12.pdf

How to purchase LARC:

https://www.fpntc.org/sites/default/files/resources/fpntc_smvst_how_purchase_iuds_2018-07.pdf

Section V: Patient Materials

- Patient-directed fact sheets providing an overview of birth control methods (including emergency contraception) including how to use, effectiveness, risks, benefits, & FAQs:
 - <https://www.pharmacyaccessforms.org/fact-sheets>
 - <https://www.reproductiveaccess.org/resource/bc-fact-sheet/>
 - <https://www.reproductiveaccess.org/resource/non-prescription-birth-control-methods/>
 - <https://www.reproductiveaccess.org/resource/permanent-birth-control-sterilization/>
 - <https://www.reproductiveaccess.org/resource/emergency-contraception-ec-right/>
 - <https://shop.powertodecide.org/educational-materials.html?p=3>
- Patient Education Materials Toolkit & resources from PICCK:
 - Toolkit: <https://picck.org/wp-content/uploads/2020/01/Patient-Education-Materials-Toolkit.pdf>
 - Other resources: https://picck.org/practice-resources/?fwp_resource_category=patient-counseling-and-education

- Patient education on health benefits of child spacing from the March of Dimes: <https://www.marchofdimes.org/pregnancy/how-long-should-you-wait-before-getting-pregnant-again.aspx/>
- Bedsider Printables: <https://providers.bedsider.org/>

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