Immediate Postpartum LARC
The Role of Nursing
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TIPQC Maternal Quality Improvement Specialist

Thank You

Disclosures
- I have no relevant disclosures associated with this presentation.
- All health care providers who perform implant insertions and removals must receive training from the manufacturer. Therefore, the insertion process is deferred to the manufacturer and not covered in this presentation.
Objectives

1. Describe the importance of and identify resources for woman-centered contraceptive counseling
2. Explore operational barriers to IPP LARC provision
3. Discuss the role of nursing in IPP LARC provision and identify resources for support

Definitions

• **Unintended pregnancy:** pregnancy that was either mistimed (occurred earlier than desired) or unwanted (occurred when no children, or no more children were desired).
• **Intended pregnancy:** pregnancy that was desired at the time it occurred or sooner. (Guttmacher, 2016)
• **Immediate postpartum period:** during the delivery “hospitalization”.
• **Birth spacing:** the time from one child’s birth until the next pregnancy (also known as interpregnancy interval) (March of Dimes)

Case Study

A 25 y/o G6P0101 presents to your OB Triage at 36 weeks by stated EGA in early labor, her contractions subside and she will be discharged home. No prenatal care. Her youngest child is 12 months old. She says this was not an intended pregnancy and would like to do something to avoid having another pregnancy so soon. She did not follow-up with a postpartum visit in her prior pregnancy.

Plan: discharge home
Case Study

A 25 y/o G6P0101 presents to your OB Triage at 36 weeks by stated EGA in early labor, her contractions subside and she will be discharged home. No prenatal care. Her youngest child is 12 months old. She says this was not an intended pregnancy and would like to do something to avoid having another soon. She did not follow-up with a postpartum visit in her prior pregnancy.

Plan: discharge home

What is Immediate Postpartum LARC?

When LARC methods are available to women in the hospital after a delivery before discharge

LARC Implant

Nexplanon
- Effective for 3 years
- Approved for women regardless of parity

Potential Side Effects
- Inter-menstrual spotting in the early months.
- Hormone-related: headaches, nausea, breast tenderness, depression, ovarian cyst formation
LARC Copper IUD

ParaGard Copper T
- Approved for women regardless of parity
- Can be used as emergency contraception

Potential Side Effects
- Abnormal, heavier menstrual bleeding
- Higher frequency or intensity of cramps/discomfort

Hormonal IUDs
- Inter-menstrual spotting in the early months
- Reduces menstrual blood loss significantly
- Hormone related: Headaches, nausea, breast tenderness, depression, ovarian cyst formation— all rare

NOTE: all currently available hormonal IUDs use levonorgestrel (LNG) and have the same side effect profile

<table>
<thead>
<tr>
<th>Device</th>
<th>Available Since</th>
<th>Years Effective</th>
<th>Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mirena</td>
<td>2000</td>
<td>5 years</td>
<td>Approved only in parous women, but available to all women regardless of parity.* Approved for treatment of anemia in women desiring contraception</td>
</tr>
<tr>
<td>Skyla</td>
<td>2013</td>
<td>3 years</td>
<td>Approved for women regardless of parity. Smaller “T” and inserter than Mirena and Liletta</td>
</tr>
<tr>
<td>Liletta</td>
<td>2015</td>
<td>4 years</td>
<td>Approved for women regardless of parity</td>
</tr>
<tr>
<td>Kyleena</td>
<td>2017</td>
<td>5 years</td>
<td>Approved for women regardless of parity. Smaller “T” and inserter than Mirena or Liletta. Less LNG daily dose than Mirena and Liletta</td>
</tr>
</tbody>
</table>

*In 2005, the package label for the ParaGard IUD changed. The new label no longer contains language that suggests the IUD is appropriate only for women with one or more children. However, the Mirena label has not yet undergone a similar change (ACOG, 2011).
ACOG Committee Opinion #670, IPP LARC

Immediate postpartum LARC can reduce unintended pregnancy & lengthen interpregnancy intervals

Pregnancy Interval / Birth Spacing

<table>
<thead>
<tr>
<th>Newborn</th>
<th>Maternal</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Congenital anomalies</td>
<td>• Anemia</td>
</tr>
<tr>
<td>• Preterm birth</td>
<td>• Preterm, premature rupture of membranes</td>
</tr>
<tr>
<td>• Low birth weight infant</td>
<td>• Preeclampsia</td>
</tr>
<tr>
<td>• Small for gestational age</td>
<td>• Maternal death</td>
</tr>
<tr>
<td>• Fetal, neonatal, infant death</td>
<td>• Uterine rupture at TOLAC</td>
</tr>
</tbody>
</table>

NOTE: Studies vary re. birth spacing timeline

LARC and Birth Spacing

- Women who used LARC had almost 4 times the odds of achieving an optimal birth interval compared with women who used less contraceptive effective methods
- Associated with longer interpregnancy interval in adolescents compared with less effective methods.
Colorado Data

• Since 2009, the state has provided contraceptive implants or intrauterine devices (IUDs) at low or no cost
• Described as “Seismic impact”
• Estimated savings for CO of $70 million in health-care expenditures associated with teen births.

LARC Continuation Rates Are the Highest of All Reversible Methods

![Graph showing continuation rates for different methods]


One year continuation rates

<table>
<thead>
<tr>
<th>Method</th>
<th>1 year continuation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condom</td>
<td>53</td>
</tr>
<tr>
<td>Injection</td>
<td>56</td>
</tr>
<tr>
<td>IUS + POP</td>
<td>66</td>
</tr>
<tr>
<td>Copper T</td>
<td>78</td>
</tr>
<tr>
<td>LNG IUS</td>
<td>80</td>
</tr>
<tr>
<td>Implant</td>
<td>84</td>
</tr>
</tbody>
</table>
ACOG Committee Opinion #670, IPP LARC

Women's health care providers should support IPP LARC placement after vaginal and cesarean births.

Women should be counseled prenatally about the option of IPP LARC, including its convenience, effectiveness, and increased IUD expulsion rates.
Choice of Contraception

- Patient preference
- Risk/benefit/alternatives

**KEY POINT:**
Provider is reasonably certain woman is not pregnant.

https://www.cdc.gov/reproductivehealth/contraception/mmwr/spr/summary.html

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### When to Start Using Specific Contraceptive Methods

| Contraception Method | When to start (if recommend) | When nonpregnant (if nonprescription) | Additional contraception needed? | Remaining on last method before initiation?
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Copper-containing IUD</td>
<td>Anytime</td>
<td>Not needed</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Copper intrauterine IUD</td>
<td>Anytime</td>
<td>Followed by hormone or back-up method</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Implant</td>
<td>Anytime</td>
<td>Followed by hormone or back-up method</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Injectable</td>
<td>Anytime</td>
<td>Followed by hormone or back-up method</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Combined hormonal contraceptive</td>
<td>Anytime</td>
<td>Followed by hormone or back-up method</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Progesterone pill</td>
<td>Anytime</td>
<td>Followed by hormone or back-up method</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
US MEC (Medical Eligibility Criteria)

<table>
<thead>
<tr>
<th>Postpartum Use</th>
<th>LNG IUD</th>
<th>Copper IUD</th>
<th>Implant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-breastfeeding, starting &lt;21 days 1</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Breastfeeding, &lt;30 days</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Breastfeeding, &gt;30 days</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>ACO Use, with or without breastfeeding</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>&gt;10 minutes after placenta</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>10 minutes to 6 weeks</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>≥ 6 weeks</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Puerperal Sepsis</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

IPP LARC & Breastfeeding

The implant can be inserted at any time following delivery. Advantages generally outweigh real or theoretical risks if placed < 1 month post-partum, and there is no restriction if placed > 1 month post-partum.

Observational studies of progestin-only contraceptives suggest they have no effect either on a woman’s ability to successfully initiate and continue breastfeeding, or an infant’s growth and development.

ACOG Practice Bulletin #121, LARC: Implants & IUDs

“Although data is limited, observational studies of progestin-only contraceptives suggest no effect either on the ability to successfully initiate & continue breastfeeding or on an infant's growth and development.”
IPP LARC & Breastfeeding

ACOG Committee Opinion #670, IPP LARC
IPP placement of the levonorgestrel IUD and implant are rated as MEC Category 2 for women who are breastfeeding.

There are theoretical concerns that exogenous progesterone could prevent lactogenesis, but observational studies of progestin-only contraceptives suggest no effect on successful initiation and continuation of breastfeeding or on infant growth and development.

IPP LARC & Breastfeeding

ACOG Practice Bulletin #121, LARC: Implants & IUDs
• A RTC PP insertion of the etonogestrel contraceptive implant at 1–3 days with standard insertion at 4–8 weeks postpartum
  o The study reported no differences in breastfeeding outcomes between groups, including lactogenesis and the risk of lactation failure

IPP LARC & Breastfeeding

ACOG Practice Bulletin #121, LARC: Implants & IUDs
A prospective nonrandomized comparative study examined breast milk composition using the contraceptive implant vs a non-hormonal IUD, initiated at least 28–56 days after childbirth.
  o Neither breast milk quantity nor composition differed between the groups
  o At 3-year follow-up, there was no difference in neonatal body length, biparietal head circumference, or body weight between the groups
IPP LARC & Breastfeeding

The Copper IUD lacks hormones, which avoids any theoretical effect on breastfeeding, and is classified as MEC Category 1 (no restriction on use) for women who are breastfeeding.

ACOG Committee Opinion #670, IPP LARC

“Given available evidence, women considering immediate postpartum hormonal LARC should be counseled about the theoretical risk of reduced duration of breastfeeding, but that preponderance of the evidence has not shown a negative effect on actual breastfeeding outcomes.”

Patient Counseling

- Review future child-bearing intentions
- Review safety and high user satisfaction
- Discuss theoretical risk of LARC methods, but that this has not been observed in clinical practice
- Review potential rapid return to fertility after delivery

- If the woman desires IPP LARC, it’s provision should be supported in the hospital setting

NURSING CARE: GETTING PREPARED FOR IPP LARC
Establish Policy/Procedure for IPP LARC

- Interprofessional team
- Outline counseling procedure
- Procedure for teen consent
- Contraindication language
- Pain management options
- Equipment and supply needs

- Timing of placement
- Process if expulsion occurs
- Documentation
- Communication
- Simulation

Informed Consent

- Provider required to obtain informed consent
  - Risks, benefits, alternatives to procedure
- Nursing
  - Determine if consented during prenatal care
  - Witnesses consent
  - Verifies consent
  - Answer questions

Device Availability

- Where will devices be stored?
  - Pharmacy/Medication System
- Who is responsible for getting them to the bedside?
- Who is responsible for restocking?
- Which LARC devices will you stock?
Education

- Providers
  - Determine credentialing requirements
- Nursing
- Lactation Consultants
- Surgical Technicians

Patient Education

- Culturally sensitive materials
- Non-English speaking process/materials
- Interprofessional team review materials
- Coordination between inpatient and outpatient providers
- Have LARC samples available for demonstration

NOTE: There is no current validated patient education tool specific to IPP LARC

http://www.health4mom.org/long-term-birth-control-choices/
Patient Education

- Consider talking points
  - **Effective**: more effective than the pill, patch, or ring
  - **Low or no hormones**
  - **Safe**: safe, easy to remove, and won't affect future fertility
  - **Easy to use**: don't have to remember to do anything for it to work
  - **Reversible**: can be removed anytime; can get pregnant right away after removal
  - **Long lasting**: effective for 3, 5, or 10 years

Coding, Billing, Reimbursement

- Determine appropriate billing codes (See toolkit)
- Test billing codes and processes
- Ensure all IT billing systems are in place
- Track reimbursement
- Determine process for opened, but not used devices and implants
- Provider order sets and billing forms

Anticipate Barriers

- Resistance to new policies = CHANGE
- Lack of support or champions
- Concern re. costs and reimbursement
- Time constraints or staffing concerns
- Counseling and/or informed consent not provided
- Concern re. interfering with immediate postpartum care needs
Anticipate Barriers

Concern re. potential complications:
- Maternal vasovagal reaction
- Pain/discomfort
- Uterine perforation
  - Rate: 0.3 – 2.6 per 1000 insertions of hormonal IUDs (Heinemann et al, 2015)
  - Rate: 0.3 – 2.2 per 1000 insertions of copper IUDs (Heinemann et al, 2015)
- Concern re. expulsion

<table>
<thead>
<tr>
<th>C-Section</th>
<th>Vaginal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expulsion</td>
<td>11-14%</td>
</tr>
<tr>
<td>Removal for bleeding/pain</td>
<td>11%</td>
</tr>
</tbody>
</table>

NURSING CARE: ASSISTING WITH LARC INSERTION
Case Study

The woman is counseled about PP LARC at the triage visit and would like placement IPP copper IUD. She then comes in 24 hours later at 6 cm and quickly delivers vaginally with no complications. Unfortunately the chart is not consulted in time and there is no IUD available. 30 minutes later the IUD arrives from the pharmacy, should you place the IUD?

Timing of IUD Insertion

- Post-placental: within 10 minutes
- Immediate: within 48 hours
- Late postpartum: > 4 weeks

Eligibility Criteria

- Healthy women of any reproductive age, desiring highly effective and reversible contraception
- If placing an intrauterine device (IUD), the woman:
  - Has not been ruptured for greater than 18 hours
  - Has no evidence of Triple I or other uterine infections
  - Has normal anatomic uterine cavity (same criteria as when placed unrelated to pregnancy)
Routine Contraindications

- Uterine anomaly or fibroids
  - Depending on severity of anomaly and/or fibroids
- Active gynecologic malignancy
- Allergy to any component of the IUD
- Severe anemia or Wilson’s disease (for copper IUD)
- Breast cancer (for LNG IUS)
- Pelvic tuberculosis

Contraindications for IPP LARC IUD

1. Triple I diagnosis at time of birth, endometritis, and/or puerperal sepsis
2. Uncontrolled postpartum hemorrhage (defined as greater than 1000 mL blood loss for vaginal or cesarean birth with risk of continued bleeding)

Triple I

- Intrauterine inflammation, infection or both
- Diagnostic criteria: maternal fever and 1 or more of the following:
  - Fetal tachycardia
  - Maternal WBC greater than 15,000 in the absence of corticosteroids
  - Purulent fluid from the cervical os (cloudy or yellowish thick discharge confirmed visually on speculum examination to be coming from the cervical os)
  - Biochemical or microbiologic amniotic fluid results consistent with microbial invasion of the amniotic cavity.

IUD Insertion Following Vaginal Birth

- Management of 3rd and 4th stages of Labor
  - Uterine massage and assessments Q15
  - Administration of oxytocin per protocol
- No additional anesthesia required
  - Considerations if birth w/out anesthesia
- Skin to skin may continue
- Initiation of breastfeeding within 1 hour
- Laceration repair after IUD insertion
- No evidence of need for antibiotic administration

IPP IUD Placement Checklist

<table>
<thead>
<tr>
<th>Procedure Checklist</th>
<th>IUD Instruments and Supplies</th>
</tr>
</thead>
<tbody>
<tr>
<td>- IUD availability</td>
<td>- Ultrasound</td>
</tr>
<tr>
<td>- Consent signed and witnessed</td>
<td>- Ring forceps and/or Kelly clamp</td>
</tr>
<tr>
<td>- Instruments available</td>
<td>- Scissors</td>
</tr>
<tr>
<td>- Considerations for pain management as indicated</td>
<td>- Speculum</td>
</tr>
<tr>
<td>- Confirm no contraindications to placement</td>
<td>- Radiopaque surgical sponge(s)</td>
</tr>
<tr>
<td></td>
<td>- Light source</td>
</tr>
</tbody>
</table>

IUD Insertion at Time of Cesarean Birth

- Placement prior to uterine closure
- Change gloves
- IUD manually inserted to the fundus and carefully release
  - Can also use inserter or ring
  - No need to suture
- IUD strings placed at the internal cervical os
  - Trim LNG IUD strings
  - Some describe pushing strings through the cervix with a ring forceps
Postpartum Implant Procedure

**Procedure Checklist**
- Implant availability
- Consent signed and witnessed
- Instruments available

**Instrument Checklist**
- Instrument Checklist
  - 1% lidocaine, 3-5 mL
  - Betadine
  - Band-aid or steri-strips
  - Kerlex

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**Documentation**
- Provider and nurse document procedure
- Lot # and expiration date
- If implant, right or left arm
- Any complications
- Patient tolerance of procedure

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**Potential Barriers**
- **Woman**
  - Doesn’t want a LARC and/or isn’t sure = don’t pressure, just give information
  - Wants more information = where will you get it from?
- **Provider**
  - Doesn’t want to place the device = advocate for the woman if she wants IPP LARC
  - Is someone else available and trained?
- **Device and supplies not available**
  - Plan
  - Restocking device plan
NURSING CARE: POST-INSERTION

Postpartum Care
• Routine postpartum care
• Mild cramping normal
• Assessment for expulsion

Postpartum IUD Instructions
• Postpartum visit within 2 weeks (offer, but not necessary)
  – Strings will lengthen with uterine involution and may need to be trimmed
  – Instruct not to mess with strings
• If woman experiences unusual bleeding accompanied by cramping different from afterbirth pains, see provider for possible partial expulsion
  – Inspect pads for expulsion
Postpartum IUD Instructions

• Instruct woman to remind her provider that an IUD was placed postpartum and to notify a provider if she has:
  - Fevers, chills, severe abdominal pain, or temperature > 100.4°F
  - Heavy bleeding
  - Expulsion of the device

Postpartum Implant Instructions

• Bruising and soreness around the insertion site is normal and should resolve within 1-2 weeks after placement
• Notify provider:
  - Redness, swelling or drainage near the implant site
  - Cannot feel the implant under their skin
• A woman should always remind their provider that they had an implant placed postpartum

NURSING: Take Home Points

• Program cannot be successful without your help! Offering IPP LARC requires a team approach
• Nursing is crucial in helping women understand benefits and risk of IPP LARC
• You are at their bedside frequently – women trust you and listen to what you say
NURSING: Take Home Points

• Women should be counseled prenatally about all postpartum contraceptive options, including IPP LARC
  • Present choices
  • Should included benefits and limitations of IPP LARC

NURSING: Take Home Points

• IPP LARC should be offered as a safe and effective option for postpartum contraception
  • LARC methods have few contraindications, and almost all women are eligible

NURSING: Take Home Points

• Despite higher expulsion rates, evidence from clinical trials and from cost-benefit analyses strongly suggest the superiority of immediate placement in reduction of unintended pregnancy
  • Women considering IPP LARC should be counseled about the theoretical risk of reduced duration of breastfeeding, but that preponderance of the evidence has not shown a negative effect on breastfeeding outcomes
Additional Resources

- The LARC Program at the American College of Obstetricians and Gynecologists
  - www.acog.org/larc
  - www.pcainitiative.org
- CDC
  - https://www.cdc.gov/mmwr/volumes/65/rr/rr6504.pdf