Long-Acting Reversible Contraception: Clinical Education for Providers

Friday, February 3, 2017
12:00 pm – 1:00 pm

I am your host, Debbie Farb

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Our presenters

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julia.oat-judge@mahec.net

Objectives

1. Increase knowledge about why improved LARC access is important

2. Increase awareness about how reproductive justice applies to LARC

3. Better understand objections, barriers and misconceptions with LARC

4. Learn about LARC best practices

5. Find out how to become trained in LARC insertion/removal
Long-Acting Reversible Contraception (LARC) 101: Matthew Zerden, MD, MPH

What is LARC, and why should you prescribe it?

- Long-acting reversible contraception (LARC)
- Highly-effective reversible contraception (HERC)
- Low-maintenance
- Forgettable
Unintended pregnancy

**Pregnancies by Intention Status**

Nearly half of pregnancies are unintended.

- 19% Intended
- 29% Mistimed
- 52% Unwanted

Note: Percentages do not add up to 100 due to rounding.

https://www.guttmacher.org/pubs/FB-Unintended-Pregnancy-US.html

Unintended pregnancy

**Contraception Works**

The two-thirds of U.S. women at risk of unintended pregnancy who practice contraception consistently and correctly account for only 5% of unintended pregnancies.

<table>
<thead>
<tr>
<th>WOMEN AT RISK (43 MILLION)</th>
<th>UNINTENDED PREGNANCIES (3.1 MILLION)</th>
</tr>
</thead>
<tbody>
<tr>
<td>16% Consistent use</td>
<td>5% by consistency of method use all year</td>
</tr>
<tr>
<td>65% Inconsistent use</td>
<td>43% by consistency of method use during month of conception</td>
</tr>
<tr>
<td>19% Nonuse</td>
<td>52% Nonuse</td>
</tr>
</tbody>
</table>

https://www.guttmacher.org/pubs/FB-Unintended-Pregnancy-US.html
Contraception in the U.S.

QuickStats: Use of Selected Contraception Methods Among Women Aged 15-44 Years Currently Using Contraception — National Survey of Family Growth, United States, 1995 and 2006-2010

Weekly
December 23, 2013 / 61(50):1031

<table>
<thead>
<tr>
<th>Contraception method</th>
<th>1995</th>
<th>2006-2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female sterilization</td>
<td>25%</td>
<td>20%</td>
</tr>
<tr>
<td>Male sterilization</td>
<td>5%</td>
<td>10%</td>
</tr>
<tr>
<td>Pill</td>
<td>30%</td>
<td>35%</td>
</tr>
<tr>
<td>Condom</td>
<td>15%</td>
<td>20%</td>
</tr>
<tr>
<td>Other hormonal methods</td>
<td>5%</td>
<td>10%</td>
</tr>
<tr>
<td>IUD</td>
<td>5%</td>
<td>10%</td>
</tr>
</tbody>
</table>

Abbreviation: IUD = intrauterine device.

Increasing LARC use in U.S. by parity

Parous
Nulliparous

Branum, 2015
Increasing LARC use in U.S. by race/ethnicity

Increasing LARC in U.S. 2002-2012

Branum, 2015
LARC: Local health departments, North Carolina, all ages

HIS, FP 066 Report, FY2007 to FY 2015

LARC: Local health departments, adolescents in North Carolina

HIS, FP 066 Report, FY2007 to FY 2015
Why LARC?

- No daily /weekly/monthly medications
- No coitus specific actions
- Always perfect use
**Available LARC in U.S.**

- Nexplanon® (etonogestrel implant) 68mg Radiopaque
- Kyleena® (levonorgestrel-releasing intrauterine system) 190mcg
- Liletta® (levonorgestrel-releasing intrauterine system) 52mg
- Paragard™ intrauterine copper contraceptive
- Skyla™ (levonorgestrel-releasing intrauterine system) 13.5 mg

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**LARC: Intrauterine Devices (IUDs)**

- Efficacy: 99%
- 2 types: Copper and hormonal/levonorgestrel (LNG)
- Duration of use: 3-10 years
- Contraindications:
  - Active uterine infection or cancer
  - Severe uterine distortion
  - Allergy to IUD components
  - Liver disease or hormonal cancer (progesterone)
  - Copper allergy (copper)

## IUD Comparison

<table>
<thead>
<tr>
<th>Name / amount LNG in device</th>
<th>LNG released per day</th>
<th>FDA duration of use</th>
<th>Benefits/unique features</th>
<th>Percent users w/ amenorrhea</th>
<th>Efficacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mirena® 52 mg LNG</td>
<td>20 mcg</td>
<td>5 years</td>
<td>Has been on the market the longest. Possible effectiveness to 6 years of use. Only approved IUS for AUB-H.</td>
<td>20% &gt; 99%</td>
<td></td>
</tr>
<tr>
<td>Skyla® 14.5 mg LNG</td>
<td>14 mcg</td>
<td>3 years</td>
<td>28 mm width, compared to 32 mm of others. Marketing targeted nulliparous patients</td>
<td>6% &gt; 99%</td>
<td></td>
</tr>
<tr>
<td>Liletta® 52 mg LNG</td>
<td>18.6 mcg</td>
<td>3 years*</td>
<td>Can be purchased for $50. Will likely gain FDA approval for 5 years.</td>
<td>20% &gt; 99%</td>
<td></td>
</tr>
<tr>
<td>Kyleena® 19.5 mg</td>
<td>17.5 mcg</td>
<td>5 years</td>
<td>Same narrow device &amp; inserter as Skyla, but with 5 years of approved use</td>
<td>12% &gt; 99%</td>
<td></td>
</tr>
<tr>
<td>ParaGard® N/A</td>
<td>N/A</td>
<td>10 years</td>
<td>Copper IUD without hormones. Some women cannot or prefer not to use hormonal contraception</td>
<td>N/A &gt; 99%</td>
<td></td>
</tr>
</tbody>
</table>


## LARC: Implant

- **Efficacy:** 99%
  - Only 1 in use in the U.S.
  - Nexplanon®

- **Duration of use:** 3 years

- **Contraindications:**
  - Blood clots
  - Breast cancer
  - Liver disease
  - Hypersensitivity to any component

20 Curtis, 2016; ACOG 2011 and 2015
**LARC: Mechanism of Action**

- **IUD:** prevent fertilization
  - Copper: causes immune response to create a hostile environment for sperm
  - Hormonal/Levonorgestrel: in addition to causing hostile environment for sperm, also thickens cervical mucus, preventing sperm motility & function
- **Implant:** prevents ovulation
  - Thickens cervical mucus
  - Causes endometrial atrophy, prevents implantation

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**LARC: Evidence**

Endorsed by:

- American Congress of Obstetricians and Gynecologists (ACOG)
- American Academy of Pediatrics (AAP)
- American Academy of Family Physicians (AAFP)
- And others
LARC: Evidence

2 large studies/programs: Clinical & patient-centered outcomes

• CHOICE Project, St. Louis:
  • 10,000 patients
  • 75% LARC uptake
  • Reduction of main barriers:
    • Provider education
    • Patient education
    • Cost

Winner, 2012; Peipert, 2012

LARC: Evidence

Effectiveness of Long-Acting Reversible Contraception

Brooke Winner, M.D., Jeffrey F. Peipert, M.D., Ph.D., Quhong Zhao, M.S., Christina Buckel, M.S.W., Tessa Madden, M.D., M.P.H., Jenifer E. Allsworth, Ph.D., and Gina M. Secura, Ph.D., M.P.H.


**LARC: Evidence**

Regional impact of LARC studies/programs:

- **CHOICE Project, St. Louis:**
  - 10,000 patients
  - 75% LARC uptake

- **Colorado:**
  - Offered > 30,000 LARC devices
  - 40% reduction in teen birth

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**Reproductive justice**

- The economic, social and political power and resources to make healthy decisions about our bodies, sexuality and reproduction for ourselves, our families and our communities

- The right to have children, the right to not have children or not, the right to raise children with dignity and in safety.

http://strongfamiliesmovement.org/; www.dissentmagazine.org/
Reproductive (in)justice: then and now

• Historical context:
  • Forced sterilizations women of color/disabilities

• Current implications: LARC
  • Norplant (6-rod) implant, now off market
  • In 1990’s, 13 states introduced bills with incentives for Medicaid recipients
    • Mandated insertion in postpartum women with substance abuse during pregnancy
  • Patients who cannot afford LARC removal

Gordon, 2003; Ward, 1986

References: LARC 101(Zerden)

• http://www.acog.org/About_ACOG/ACOG_Departments/Long_Acting_Reversible_Contraception/Coding_and_Reimbursement_for_LARC/~/media/Departments/LARC/HMAPostpartumReimbursementResource.pdf
  accessed March 19, 2014


• ACOG Practice Bulletin 121, 2011 & 2015

• http://strongfamiliesmovement.org/

• www.dissentmagazine.org/

• https://www.guttmacher.org/


• HIS, FP 066 Report, FY2007 to FY 2015

References: LARC 101(Zerden) (continued)


- https://www.mirena-us.com/

- https://www.liletta.com/

- https://hcp.kyleena-us.com/

- http://paragard.com/

LARC Objections, Barriers, and Misconceptions:
Julia Oat-Judge, MD
Provider Barriers

• Technical skills
• Device procurement
• Billing & reimbursement
• Workflow
• Volume

Misconceptions

**MYTH:**
• *LARCs cause abortions*

**FACT:**
• LARCs are not abortifacients

**MYTH:**
• *Patients always request early removal*

**FACT:**
• 12 month continuation rates
  • 88% levonorgestrel IUD
  • 84% copper IUD
  • 83% contraceptive implant
  • 55% oral contraceptives

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31 Hatcher, Contraceptive Technology; ACOG Practice Bulletin No. 121; Peipert, Continuation of Reversible Contraception
Misconceptions

MYTH:
• Timing of insertion is restricted:
  • Must be during menses
  • Must have negative pregnancy tests 2 weeks apart
  • Must return for a separate insertion visit.
  • Must wait for results of STI screen or pap smear
  • Must wait 6 weeks postpartum
  • Must wait weeks following abortion or miscarriage

FACT:
• U.S. Selected Practice Recommendations for Contraceptive Use address timing of LARC
• Available as an app: https://www.cdc.gov/reproductivehealth/contraception/usmec.htm

Misconceptions

MYTH:
• Negative urine pregnancy test is required before LARC insertion

FACT:
• Reasonably certain not pregnant criteria
  • No symptoms or signs of pregnancy AND
  • Any one of the following:
    ▪ ≤ 7 days after the start of normal menses
    ▪ no sexual intercourse since the start of last menses
    ▪ consistently using a reliable method of contraception
    ▪ ≤ 7 days after spontaneous or induced abortion
    ▪ exclusively breastfeeding, amenorrhoeic, and <6 months postpartum
    ▪ ≤ 4 weeks postpartum
**Misconceptions**

**MYTH:**
- Contraindications include:
  - Breastfeeding
  - Nulliparity or adolescence
  - History of PID, STI, or ectopic
  - Non-monogamous relationship

**FACT:**
- U.S. Medical Eligibility Criteria clearly define contraindications for LARC
- Available as an app: [https://www.cdc.gov/reproductivehealth/contraception/usmec.htm](https://www.cdc.gov/reproductivehealth/contraception/usmec.htm)

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**Misconceptions**

**MYTH:**
- LARC increases risk of:
  - Future infertility
  - PID
  - Ectopic pregnancy

**FACT:**
- No increase in infertility, PID or ectopic

**MYTH:**
- Teens need parental consent

**FACT:**
- Minors can consent to LARC placement in NC
References: LARC Barriers, and Misconceptions (Oat-Judge)

- NC General Statutes: Chapter 90, Article 1A: Treatment of Minors.

Same-Day LARC Access:

Velma V. Taormina MD, MSE, FACOG
Box 2. ACOG: Best Practices for Long-Acting Reversible Contraception Insertion

• Provide long-acting reversible contraception (LARC) methods the same day as requested, whenever possible, if pregnancy can reasonably be excluded.

• Offer LARC methods at the time of delivery, abortion, or dilation and curettage for miscarriage.

• Screen for sexually transmitted infections at the time of intrauterine device (IUD) insertion; if the screening test result is positive, treat the infection without removal of the IUD.

• Offer the copper IUD as the most effective method of emergency contraception.

Practice Assessment

• Provider training needs

• Staff training needs

• Availability of LARC devices onsite

• Schedule

• LARC insertion protocols
**Provider Assessment**

- Assess provider competency for performing LARC insertions and removals
- Assess clinic staffing patterns
- Assess provider knowledge about LARC
  - Tiered contraceptive counseling
  - NC Minors' Rights to Consent and Confidentiality laws
  - Same-day insertion protocols
  - STI and pap smear testing is NOT required
  - Determine pregnancy status
- Assess Billing and Coding knowledge

**Staff Training Assessment**

- Assess staff knowledge about LARC
  - LARC device knowledge
  - Same-day insertion protocols
  - All options counseling
  - Tiered contraceptive counseling
  - NC Minors' Rights to Consent and Confidentiality laws
**LARC Availability**

- Goal is to stock LARC devices onsite
  - LARC budget
  - Determine your inventory par levels
  - Work with device reps to streamline ordering process
  - Standardize room or mobile cart supplies

**Schedule**

- Goal should be to have a provider available every day that clinic is open
  - Trained provider available during all working hours
  - Reserve slots every day to incorporate same-day scheduling
  - Take or update a reproductive health history or assessment at every encounter
LARC insertion protocols

- Map out process pathways to streamline patient visit
- Use Quality Initiatives to remove duplication of effort
- Map out clinical process to “flip” appointment if patient desires same-day insertion

Clinic flow for annual exam plus LARC

Registration (10 min)  Interview (5 min)  Provider (20 min)  Lab (10 min)  Exit Interview (15 min)
Postpartum LARC:
Matthew Zerden, MD, MPH

Risk of rapid, repeat pregnancy

- Optimal interpregnancy interval:
  - 18 months – 5 years
  - Reduction in preterm birth

- 38% of U.S. pregnancies have short intervals

- LARC: demonstrated reduction in rapid, repeat pregnancy

- State-wide data from California showed improved, ideal birth spacing with LARC

Postpartum LARC

- Fertile population
- Patients with contraceptive insurance coverage
- Multiple interactions with healthcare team
  - Ability to address contraception
- Motivated to consider reproductive life planning
- Challenges:
  - Reimbursement
  - Provider and patient education about safety
  - Changing practice patterns

CDC’s Medical Eligibility Criteria (MEC)

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No restriction for the use of the contraceptive method for a woman with that condition</td>
</tr>
<tr>
<td>2</td>
<td>Advantages of using the method generally outweigh the theoretical or proven risks</td>
</tr>
<tr>
<td>3</td>
<td>Theoretical or proven risks of the method usually outweigh the advantages – not usually recommended unless more appropriate methods are not available or acceptable</td>
</tr>
<tr>
<td>4</td>
<td>Unacceptable health risk if the contraceptive method is used by a woman with that condition</td>
</tr>
</tbody>
</table>

TABLE 3. Summary of recommendations and risk classifications* for hormonal contraceptive methods and intrauterine devices during the postpartum period

<table>
<thead>
<tr>
<th>Condition</th>
<th>COC/P/R</th>
<th>POP</th>
<th>DMPA</th>
<th>Implants</th>
<th>LNG-IUD</th>
<th>Cu-IUD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postpartum (non-breastfeeding women)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. &lt;21 days</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. 21 days to 42 days</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. With other risk factors for VTE (such as age &gt;/= 35 years, previous VTE, thrombophilia, immobility, transfusion at delivery, BMI &gt;/= 30 kg/m², postpartum hemorrhage, postcesarean delivery, preclampsia or smoking)</td>
<td>3*</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ii. Without other risk factors for VTE</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>iii. &gt;42 days</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postpartum (breastfeeding women?)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. &lt;21 days</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. 21 days to 30 days</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. With other risk factors for VTE (such as age &gt;/= 35 years, previous VTE, thrombophilia, immobility, transfusion at delivery, BMI &gt;/= 30 kg/m², postpartum hemorrhage, postcesarean delivery, preclampsia or smoking)</td>
<td>2*</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ii. Without other risk factors for VTE</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. 30–42 days</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. With other risk factors for VTE (such as age &gt;/= 35 years, previous VTE, thrombophilia, immobility, transfusion at delivery, BMI &gt;/= 30 kg/m², postpartum hemorrhage, postcesarean delivery, preclampsia or smoking)</td>
<td>3*</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ii. Without other risk factors for VTE</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. &gt;42 days</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postpartum (breastfeeding or non-breastfeeding women, including postcesarean delivery)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. &lt;10 min after delivery of the placenta</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. 10 min after delivery of the placenta 1–8 wks</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. 9–14 wks</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Peripartum sepsis</td>
<td>4</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Abbreviations: COC = combined oral contraceptives; P = combined patch; R = combined vaginal ring; POP = progesterone-only pill; DMPA = depot medroxyprogesterone acetate; IUD = intrauterine device; LNG-IUD = levonorgestrel-releasing IUD; Cu-IUD = copper-bearing IUD; VTE = venous thromboembolism; BMI = body mass index (weight [kg]/height [m²])


Postpartum LARC: CDC’s Medical Eligibility Criteria

MMWR 2016 update with specific postpartum information:

https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6503.pdf
IUDs in the postpartum

• When appropriate?
  • Immediate postpartum (< 10 minutes after vaginal delivery)
  • Intra-cesarean
  • 2-3 weeks postpartum (investigational)
  • 4-6 weeks postpartum (standard)

IUDs in the postpartum: Immediate post-placental, vaginal delivery

• Within 10 minutes of placenta delivery

• Expulsion rates vary (10-38%)
  • Patients with high risk conditions: 50% no show

• Similar user rates at 6 months
  • High patient acceptability

• Learning curve of providers
  • Experience of clinician matters

Dr. Paul Blumenthal: https://www.youtube.com/watch?v=uMcTsuf8XxQ

Dahlke, 2011; Chen 2010; Stuart, 2014; Lopez 2015
**IUDs in the postpartum: Intra-cesarean**

- Post-placental, at time of cesarean delivery
- Expulsion lower vs. post-placental vaginal insertion
- Requires minimal training
- Challenges:
  - String visibility in office
  - Reimbursement
  - Logistics

Levi, 2015; Lester, 2015

**IUDs in the postpartum:**
**2 - 3 weeks postpartum**

- Uterus 66% involuted by day 14 postpartum
- Pregnancy is physiologically impossible
- Benefit of a 2 week postpartum visit
  - Convenience for mom
  -Combining pediatric & maternal visits
- 3 recent publications supports its use

Belachew, 2012; Speroff, 2008; Baldwin, 2016; Zerden, 2016; Chen, 2016
**IUDs in the postpartum:**
*6 weeks postpartum*

- Standard protocol for most providers: 6 weeks

- Problems:
  - Ovulation in those not exclusively breastfeeding
  - Resumption of intercourse
  - Poor adherence to 6-week visit among patients with high risk conditions
  - 2 visit protocols

- Potential solution: 2 - 3 week visit with same day insertion

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**Postpartum LARC: Contraceptive Implant (Nexplanon®)**

- **CDC Medical Eligibility Criteria:**
  - Non-breastfeeding = 1
  - Breastfeeding = 2
  - Random Control Trail (RCT): No difference in breastfeeding when placed 1 - 3 days vs. 4 - 8 weeks postpartum

- **Challenges:**
  - Reimbursement
  - Hospital participation
**Breastfeeding considerations**

- Integrate into prenatal care
- ACOG / AAP: 6 months exclusive, 12 months continuation

**Infant/Child benefits:**
- Reduced infectious risk (GI, otitis media, respiratory infections); chronic diseases (obesity, autoimmune conditions including asthma and diabetes mellitus type I); infant mortality from SIDS

**Maternal benefits:**
- Reduced breast & ovarian cancer risk; diabetes mellitus type II; hypertension; hyperlipidemia; & cardiovascular diseases

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**Breastfeeding considerations: LARC**

- Copper IUD (ParaGard): No concerns
- Levonorgestrel IUD:
  - Small systemic progesterone levels
  - Limited evidence, reduction in breastfeeding
  - Now with 3 available types in the US
- Contraceptive Implant (Nexplanon®)
  - Higher systemic progesterone levels
  - Best evidence: no change in breastfeeding

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59  Stuebe, 2010

60  Chen, 2011; Gurtcheff, 2011
Implications for perinatal health

- Importance of reproductive life planning
  - Improve unintended pregnancy rates
  - Focus on those with history of high risk pregnancy
    - Post-NICU clinics

- LARC – powerful tool
  - High efficacy & patient satisfaction
  - Few contraindications

- Engage partners and family

Postpartum LARC NC Medicaid updates

- Recent Medicaid update:

- Making incremental progress, but we are hopeful
References: PP LARC (Zerden)

- Speroff L, Mishell DR. The postpartum visit: it’s time for a change in order to optimally initiate contraception. Contraception. 2008. 78:90-6.
- Levi EE, Stuart GS, Zerden ML, Garrett JM, Bryant AG. Intrauterine device placement during cesarean delivery and continued use 6 months postpartum: a randomized controlled trial. Obstetrics & Gynecology. 2015 Jul 1;126(1):5-11.
- Chen BA, Reeves MF, Creinin MD, and Schwarz EB. Postplacental or delayed levonorgestrel intrauterine device insertion and breast-feeding duration. Contraception. 84 (5). 2011. 499-504.

Copper IUD as Emergency Contraception (EC):
Julia Oat-Judge, MD
Copper IUD as Emergency Contraception (EC):

Advantages over pills:
• Superior efficacy
  • Pregnancy rate 1 month after EC use:
    • 1/1000 copper IUD
    • 14/1000 ulipristal acetate
    • 20/1000 levonorgestrel
  • Longer timeframe for administration
    • No decrease in efficacy over time from intercourse
    • Efficacy not decreased with overweight or obesity

Mechanism of action:
• Copper ions toxic to sperm
• Dysfunctional sperm cannot fertilize ovum
• Decreased endometrial receptivity

Eligibility Criteria:
• Within 5 days of FIRST unprotected intercourse

Trussell, Last Chance to Prevent Unintended Pregnancy; IUD for EC, International Consortium.

Ortiz, Biological bases of action; Gemzell-Danielsson, EC Mechanisms of action; Curtis, Selected Practice Recommendations
Copper IUD as Emergency Contraception (EC)

Costs:

- Increased up-front cost
  - EC pills: $40 - $50
  - Copper IUD: $500 - $1000

- Time/effort
  - Office visit vs. trip to pharmacy for over-the-counter (OTC) medicine

- Long term benefit
  - At least 10 year highly effective contraception

- Cost-effective if remains in place just 4 months
  - 94% continuation rate at 1 year

References: Copper IUD as Emergency Contraception (Oat-Judge)


LARC Training Resources:
Velma V. Taormina MD, MSE, FACOG

• ACOG LARC website

• Clinical Training Center for Family Planning (CTCFP)

• CHOICE Project website

• Reproductive Health Access Project

• U.S. Medical Eligibility Criteria

• Device websites—free trainings available
ACOG Resources

- ACOG LARC Program website includes:

  - Web-based trainings for staff and clinicians: http://www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception/LARC-Clinician-Education-and-Training

  - Clinical Trainings opportunities: http://www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception/LARC-Clinician-Education-and-Training

  - Billing and Coding: http://www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception/Coding-and-Reimbursement-for-LARC


ACOG Resources (con’t)

- ACOG LARC Program website includes (continued):

  - Immediate Postpartum – various ACOG resources: http://www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception/Immediate-Postpartum-LARC


    - Also includes practice bulletins and committee opinions, including: ACOG Practice Bulletin #121 (Reaffirmed 2015): Long-Acting Reversible Contraception: Implants and Intrauterine Devices.
Clinical Training Center for Family Planning

• Goal is to prepare clinical preceptors to provide education, mentoring and skills assessment of clinical family planning providers.

• Great for Title X providers.

• Has a complete listing of all conferences and website links for various trainings.

• http://www.ctcfp.org/larc/

CHOICE Project

• Landmark research project that showed effectiveness of LARC

• Site has web-based trainings for staff and clinician trainings on the subject

• http://www.choiceproject.wustl.edu
Reproductive Health Access Project

- Training and support site for health care providers

- Quick Start Algorithm

U.S. Medical Eligibility Criteria

- U.S. Medical Eligibility Criteria clearly define contraindications for LARC
  - [https://www.cdc.gov/reproductivehealth/contraception/usmec.htm](https://www.cdc.gov/reproductivehealth/contraception/usmec.htm)
Mirena®, Skyla®, and Kyleena® - Bayer HealthCare Pharmaceuticals

• Contact your local representative

• To request a training, call:
  • 1-888-84-BAYER (1-888-842-2937)

• For more information, visit website:
  • http://hcp.mirena-us.com/contact.php
  • http://hcp.skyla-us.com/contact-us/
  • https://www.kyleena-us.com

ParaGard® (Copper IUD) – Teva Women’s Health, Inc.

• Contact your local representative

• To request a training, call:
  • 1-877-PARAGARD (727-2427)

• For more information:
  • http://hcp.paragard.com/
Liletta® – Medicines 360/Allergan

- Contact your local representative
- Call Customer Relations
  - 855-545-3882 → choose option 9 for a Field Rep
- Online:
  - https://www.lilettahcp.com/resources/insertion

Nexplanon®, Merck & Co., Inc.

- To request a training,
  - 877-467-5266

- David Idzi → NC Public Health Representative
  - 919-818-3219

- Sallie Cune → - NC Manager
  - 704-277-8291
  - She can direct anyone to all representatives and correct counties/geographies
**Additional LARC Training Resources**

- Bedsider website: [https://www.bedsider.org/](https://www.bedsider.org/)


- NC DPH webinar February 2016: [http://whb.ncpublichealth.com/provPart/training.htm](http://whb.ncpublichealth.com/provPart/training.htm), go to “Women’s Health Non-Required Trainings”


- Conferences

**Questions?**
Evaluation

• Please go to the following link to access the evaluation


• At the end of the evaluation, there will be an opportunity to access and print your Certificate of Attendance.

Our presenters

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