Increasing LARC Uptake in an Urban, Underserved, Primary Care Setting

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Disclosures

- Member of the advisory boards for ContraMed and Afaxys
- Merck trainer for Nexplanon
1. Outline barriers to long acting reversible contraceptive (LARC) uptake.
2. Identify key approaches for integrating LARCs into primary care practice services.
3. Describe three strategies to improve LARC uptake in clinical settings.
Outline

- Unity Health Care Overview
- Unintended Pregnancy: US and District of Columbia (DC)
- Contraceptive Effectiveness
- LARC Effectiveness and Barriers to Uptake
- Goals and Strategies
  - System Changes, Staff Development, Technical Assistance
- Evaluation
- Conclusions and Discussion
Network of federally qualified health centers
29 health centers: including 3 school-based, 8 homeless, and 2 correctional facility sites with mobile medical outreach
Comprehensive primary care services
Family Planning, family medicine, pediatrics
Obstetric/gynecology, Infectious Disease
Specialty care (cardiology, Obgyn, infectious disease, pulmonology, mental health, dental etc.)
Medical campus for Doctor of Osteopathy program
Family medicine residency site
Largest primary care agency (FQHC) in the area with 548,559 visits for 101,613 patients in 2012; 46,697 family planning visits

- 210 Clinicians
- 263 Medical Support Staff (Nurses, MAs, Lab Techs, etc.)
Unity and Title X History

- Became Title X grantee in 2007
- Renewed in 2010 for five years as DC Title X grantee
- 25 Title X (Unity and delegate) sites in DC, including 3 school-based centers
Unintended Pregnancy Data: US

6.7 MILLION PREGNANCIES  
over one year

Intended: 51%  

Unintended 49%  

Unintended births:
- 23%
- 5%

Elective abortions:
- 21%

Fetal losses:
- 5%

59% of all pregnancies unintended in DC
  - compared to 48% nationally

Highest teen pregnancy rate
  - 165/1,000 girls

8th highest teen birth rate
  - 45.4/1,000 live births

STARTING POINTS: Pregnancy and Risks

- Average number of desired children in US is two → a woman will spend approximately **30 years** of her life avoiding pregnancy.

- Key to having a healthy child is to **get as healthy as possible** before becoming pregnant (physically, emotionally, financially).

- Recognize that all contraceptive methods have far **fewer risks** than pregnancy.
"Well, I’m on the pill. I also use a diaphragm with a contraceptive sponge and Alan wears a condom. Plus we abstain completely from sex."
Contraceptive Effectiveness:
1st Year Failure Rates of Select Contraceptives (Typical Use)

- Male sterilization
- Female sterilization
- Implant
- IUS-LNG
- IUD-Copper T
- Injectable (DMPA)
- Pill-Combined
- Condom-Male
- Spermicides
- No Contraception

HOW WELL DOES BIRTH CONTROL WORK?

**Really, really well**
- The Implant (Nexplanon)
- IUD (Skyla)
- IUD (Mirena)
- IUD (ParaGard)
- Sterilization, for men and women

Work, hassle-free, without needing to remember to do anything.

**O.K.**
- The Pill
- The Patch
- The Ring
- The Shot (Depo-Provera)

For it to work best, use it...
- Every week
- Every month
- Every 3 months

**Not as well**
- Withdrawal
- Fertility Awareness
- Diaphragm
- Condoms, for men or women

For these methods to work, you or your partner have to use it every single time you have sex.

What is your chance of getting pregnant?
- Less than 1 in 100 women

- 6-9 in 100 women, depending on method

- 12-24 in 100 women, depending on method

FYI, without birth control, over 90 in 100 young women get pregnant in a year.
choose birth control + condoms
If you’re having sex, use BOTH EVERY TIME to help prevent pregnancy, HIV & STDs.

There are many safe birth control methods. Choose the one that’s right for you.

<table>
<thead>
<tr>
<th>YOUR OPTIONS</th>
<th>HOW OFTEN YOU USE IT</th>
<th>WHERE TO GET IT</th>
<th>EFFECTIVENESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>IUD</td>
<td>Can be left in place for up to 3–10 years</td>
<td>A doctor’s office or clinic</td>
<td>99+ % effective</td>
</tr>
<tr>
<td>Implant</td>
<td>Can be easily taken out if you want to get pregnant</td>
<td>A doctor’s office or clinic</td>
<td>99+ % effective</td>
</tr>
<tr>
<td>Shot</td>
<td>New shot every 3 months</td>
<td>A doctor’s office or clinic</td>
<td>91–94 % effective</td>
</tr>
<tr>
<td>Ring</td>
<td>Leave ring in for 3 weeks, remove for week 4</td>
<td>A doctor’s office or clinic</td>
<td>91–94 % effective</td>
</tr>
<tr>
<td>Patch</td>
<td>New patch once a week for 3 weeks, no patch for week 4</td>
<td>A doctor’s office or clinic</td>
<td>91–94 % effective</td>
</tr>
<tr>
<td>The Pill</td>
<td>One pill at same time, every day</td>
<td>A doctor’s office or clinic</td>
<td>91–94 % effective</td>
</tr>
<tr>
<td>Diaphragm</td>
<td>Every time you have sex</td>
<td>A doctor’s office or clinic</td>
<td>71–88 % effective</td>
</tr>
<tr>
<td>Cervical Cap</td>
<td>Every time you have sex</td>
<td>A doctor’s office or clinic</td>
<td>71–88 % effective</td>
</tr>
<tr>
<td>Sponge</td>
<td>Every time you have sex</td>
<td>Buy at drugstore</td>
<td>71–88 % effective</td>
</tr>
<tr>
<td>Spermicide</td>
<td>Every time you have sex</td>
<td>Buy at drugstore</td>
<td>71–88 % effective</td>
</tr>
</tbody>
</table>

(See back for more details on each method.)

EMERGENCY CONTRACEPTION
If your birth control failed or no birth control was used, get emergency contraception (see back for more info).

FOR CLINICS SERVING TEENS:
Search “NYC Teen” at nyc.gov, call 311, download the Teens in NYC app or scan here

FOR MORE INFORMATION ABOUT CONDOMS:
Search “condoms” at nyc.gov.
LONG-ACTING REVERSIBLE CONTRACEPTION! (LARCs)

- Gold standard of care
- Up to 99.9% effective
- High satisfaction and continuation
- Forgettable/non-user dependent method
- Very few severe side effects

Increasing access to LARCs significantly decreases unintended pregnancy rates and abortion rates

LARC: Satisfaction Rates

- Levonorgestrel IUD (Mirena®)
- Copper T IUD (ParaGard®)
- Single rod hormonal implant (Implanon/Nexplanon®)

*All continuation/satisfaction rates approx 80%
*Much higher than condoms, OCPs, patch, and ring

Reference: CHOICE Project Data (December 2012)
Any Women (including adolescents and nulliparous women) of any reproductive age seeking a long-term (one year or more), discreet, highly effective, convenient, safe, and reversible contraceptive.

- Few contraindications
- Risk of PID and subsequent infertility is dependent on non-IUC factors
- One year should be considered “long term”
Five year costs of contraceptives

Factors Influencing a Woman’s Use of Contraception

- Cultural / Personal attitudes
- Personal situation
- Contraceptive use/knowledge
- Sexual Education
- Media
- Health care system barriers
Factors Influencing LARC Uptake

- **Providers and staff**
  - Lack of knowledge about LARCs
    - Lack of placement skills
    - Misinformation: Eg. Do not view teens as candidates
    - Perception that LARC placement is time consuming

- **Women and Men**
  - Lack of knowledge about LARCs
  - Misinformation about LARCs

- **Service Delivery**
  - Inconsistent availability of LARC devices
  - Inconsistent availability of placement supplies
Goal: Increase uptake of LARCs

- Increase access to devices
- Improve efficiencies
- Affect patient/provider/staff knowledge and attitudes
- Increase number of providers placing LARCs

Strategies

- System Changes
- Staff Development
- Technical Assistance
Strategies Outline

_strategy_1: System Changes
- Get everyone on board
- Obtain management investment
- Standardize across sites
- Promote patient follow-up

_strategy_2: Staff Development
- Teach effective counseling (3 prong approach, teach-back, options)
- Teach management of bleeding and plan for side effects
- Considering Unity approaches for staff development

_strategy_3: Technical Assistance
- Use clinical reference tools and job aids
Strategy 1: System Changes

GET EVERYONE ON BOARD

ADMINISTRATIVE STAFF

CALL CENTER & FRONT DESK

CLINICIANS

SUPPORT STAFF
Strategy 1: System Changes

Obtain Management Investment

- Consider presentation to CMO, COO, and Clinic Directors on importance of a) offering LARC methods and b) having them on site at all times.
- Highlight the decrease in unintended pregnancy and potential cost effectiveness of LARC Methods.
- Create careful inventory system (ready stock with balance of ordering, dispensing, redistributing if needed).
- Research best purchasing opportunities.
Strategy 1: System Changes

STANDARDIZE ACROSS SITES

- Continual availability of LARCs: purchasing based on avg. use and uniform stocking at all sites
- Standardized insertion set-up
- Patient/staff family planning resource centers
PROMOTE PATIENT FOLLOW-UP

☞ Schedule a recheck visit (6-8wks)

☞ Ask follow-up questions:
  • Are you satisfied with your contraceptive method?
  • Consider speculum string check
  • Is there anything you would change?
  • Are you having bleeding problems or other side effects?

☞ Address primary care/annual appointments and STI counseling

TEACH EFFECTIVE COUNSELING

- Get a good sense of your patients, then counsel accordingly
- Would you like to become pregnant in the next year? (onekeyquestion.org)
- What methods have you heard of?
- What methods have you tried in the past?
- What did you like or dislike?
- What are your periods like now?
Strategy 2: Staff Development

Three Prong Approach to Contraceptive Education

- Discuss the Efficacy, Benefits, and Side Effects of Method Chosen
- Employ the “Teach-Back” Method to demonstrate Client Understanding of Method Expectations
- Provide time for Client to Review and Sign Informed Consent Form for LARC procedure
Strategy 2: Staff Development

Employ “Teach-Back” Method to demonstrate understanding

**BENEFITS**
- Tell Me About some of the Benefits of this method.
- How will this method impact you positively?

**SIDE EFFECTS**
- Tell me the 3 most common normal side effects women have when they start this method?
- Tell me what you will use if you experience cramps?

**FOLLOW-UP**
- What would be abnormal symptoms to have on this method?
- Tell me what you will do if you experience spotting that is bothering you?
OPTIONS TO DISCUSS CONTRACEPTION

- Effectiveness
- Duration of use (permanent vs LARC vs condoms)
- Hormonal vs non-hormonal
- Estrogen and progestins
- Barrier vs non-barrier
- Options now abound...need to provide them to our patients
Strategy 2: Staff Development

TEACH MANAGEMENT OF BLEEDING IRREGULARITIES

- Counseling upfront and reassurance
- Naproxen 500mg po bid for 5-7 days
- Ibuprofen 800mg po tid for 5-7 days
- Estradiol 0.5-2mg po qd for 5-10 days
- OCPs for 2-3 cycles

(Consider use of quick reference guide for providers on “Management of Irregular bleeding with progestin-containing FP methods”)
PLAN FOLLOW-UP FOR SIDE EFFECTS

- Ensure client knows to call or return to see you for bothersome side effects
- Create a plan with client about “preemptive” treatment options in the event of bothersome spotting
- Reassure that there will be an adjustment period for the first few months
- Discuss an OTC treatment plan in the event of cramping.
Strategy 2: Staff Development

UNITY STAFF DEVELOPMENT APPROACHES

- Hands-on LARC placement training for PCPs
  - family medicine physicians, pediatricians, NPs/PA
- University of California SF led LARC all-provider training
- Provider LARC survey to identify LARC preceptors and interested trainees
- Counseling training to emphasize LARC effectiveness (expanded on next)
- Pregnancy caregivers educate and assist patients with method choice prior to delivery
- Family planning integrated into new hire orientation
Clinical reference tools

- Managing Contraception guides all new providers
- CDC MEC laminated sheets for all providers
- CDC US SPR for contraception
- Quick reference guides: Family planning coding, on-site, dispensing, irregular bleeding management with progestin method

- Job aids and counseling sheets in multiple languages
- Exam room LARC demo models
- Sexual & Reproductive health email updates for providers
- familyplanning@unityhealthcare.org for questions and support
Strategy 1: System Changes
  o Get everyone on board
  o Obtain management investment
  o Standardize across sites
  o Promote patient follow-up

Strategy 2: Staff Development
  o Teach effective counseling (3 prong approach, teach-back, options)
  o Teach management of bleeding and plan for side effects
  o Considering Unity approaches for staff development

Strategy 3: Technical Assistance
  o Use clinical reference tools and job aids
Annual, Quarterly, and Monthly Reviews
- Title X Family planning annual report (FPAR)
- Monthly stock distribution of methods

Team Meetings: Monthly Title X team admin meeting and weekly Title X clinical meeting

LARC quality indicator measurement for this review
- EMR data analysis conducted from 2009-2012
  - LARC use
  - Placement trends by provider type
Evaluation: LARC Use

LARC Use Among Unity Clients (2008-2012)

No. of Users

<table>
<thead>
<tr>
<th>Program Year</th>
<th>IUD</th>
<th>Implant</th>
</tr>
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<tbody>
<tr>
<td>2008</td>
<td>740</td>
<td>215</td>
</tr>
<tr>
<td>2009</td>
<td>694</td>
<td>219</td>
</tr>
<tr>
<td>2010</td>
<td>924</td>
<td>320</td>
</tr>
<tr>
<td>2011</td>
<td>949</td>
<td>571</td>
</tr>
<tr>
<td>2012</td>
<td>1221</td>
<td>858</td>
</tr>
</tbody>
</table>
## Evaluation: LARC Use at Unity (2012)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Indicators</th>
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<tbody>
<tr>
<td>20.4%</td>
<td>% of women who are on a LARC method out of all women contraceptors on a documented method</td>
</tr>
<tr>
<td>9.2%</td>
<td>% of women of reproductive age (13-50) in need of contraception seen at Unity in 2012 (not sterilized or pregnant, infertile etc.) on a LARC method. (Up from 6.4% in 2009)</td>
</tr>
<tr>
<td>1 in 5</td>
<td>Number of family planning users who are male</td>
</tr>
<tr>
<td>46,697</td>
<td>Number of family planning visits</td>
</tr>
</tbody>
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## Evaluation: LARC User Profile (2009-2012)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Number of LARCs</th>
<th>% of all LARC users</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RACE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Black/Africa American</td>
<td>2,703</td>
<td>52.5%</td>
</tr>
<tr>
<td>2. Unknown/Not reported</td>
<td>1,916</td>
<td>37.2%</td>
</tr>
<tr>
<td><strong>AGE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. 25-29 year olds</td>
<td>1,444</td>
<td>28.1%</td>
</tr>
<tr>
<td>2. 20-24 year olds</td>
<td>1,196</td>
<td>23.2%</td>
</tr>
<tr>
<td>* Teens are 5th highest LARC age group and represent 8.5% of all LARC users</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>INCOME</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. 100% and below poverty</td>
<td>3,565</td>
<td>69.3%</td>
</tr>
<tr>
<td>2. 100%-150% below poverty</td>
<td>730</td>
<td>14.7%</td>
</tr>
</tbody>
</table>
Evaluation: Providers

Between 2009 and 2012:

- **88% increase** in the number of providers placing LARCs at Unity from 34 to 64
  - Staff numbers only increased 24% during that same time period

- **FM physicians/NP/PAs placed 35%** of LARCs in 2012
  - FM physicians/NP/PAs placed 25% of LARCs in 2009

- **300% increase** in overall number of LARCs inserted by family medicine physicians/NPs/PAs
  - 101 in 2009 to 402 in 2012
### Evaluation: LARCs placed by Provider type

<table>
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<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Family/Internal Med Physicians</td>
<td>40</td>
<td>9.7%</td>
<td>230</td>
<td>19.9%</td>
</tr>
<tr>
<td>OBGyn</td>
<td>134</td>
<td>32.6%</td>
<td>333</td>
<td>28.8%</td>
</tr>
<tr>
<td>CNM</td>
<td>174</td>
<td>42.3%</td>
<td>424</td>
<td>36.7%</td>
</tr>
<tr>
<td>NP/PA</td>
<td>61</td>
<td>14.8%</td>
<td>172</td>
<td>14.9%</td>
</tr>
<tr>
<td>Pediatrician</td>
<td>2</td>
<td>0.5%</td>
<td>6</td>
<td>0.5%</td>
</tr>
<tr>
<td>Total</td>
<td>411</td>
<td></td>
<td>1,155</td>
<td></td>
</tr>
</tbody>
</table>
Dedicated family planning team is necessary within an FQHC model to affect change.

Ensure use of both internal and external focused strategies. Eg. Include evaluation methods for patient knowledge/attitude/practices.

Multiple system changes and staff development initiatives are needed to address barriers.

Consider key partners for knowledge sharing and innovation exchange.
Thank you from the Title X Unity Team

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