Same-Day Placement of LARC: Solutions to Common Barriers
March 24, 2016

Linda DeSantis:

So, good afternoon, I think we're going to get going right now. It seems like we have a number of participants logged in, so if our presenters are ready, I think I'll get started. I want to welcome everyone to the Family PACT webinar, Same-day Placements of LARC Solutions to Common Barriers. My name is Linda DeSantis, and I'm from the California Prevention Training Center. The California PTC is under contract with the California Department of Health Service Office of Family Planning, and together we are sponsoring this event. You should have received instructions along with the links for the webinar regarding our Adobe systems which utilizes audio for the presenters only. The presenters are our guest speaker, Patty Cason, members of the Office of Family Planning, and members here at the California Prevention Training Center. There's a chat box in the lower right-hand corner of your screen that we hope you will utilize to ask questions or provide comments. We ask that you turn on your computer speakers to hear us and mute your computer microphone to avoid any feedback. The webinar will be approximately an hour long. We will be saving time at the end for questions and answers. After the webinar you will be sent a SurveyMonkey evaluation. It will be sent to the email you used for registration, so please look for it and take a few moments to fill it out. This webinar is eligible for one AMA PRA category one credit. A recording of this webinar will be available in the next several weeks and can be found at the OFP website as well as on the California PTC website. Today's webinar will be delivered by Patty Cason. And Patty Cason is a Family Nurse Practitioner. She has practiced for over 30 years in a wide variety of clinical settings and is an Assistant Clinical Professor and guest lecturer at the UCLA School of Nursing. Patty is contracted with numerous governmental and training agencies. Patty recently completed writing a chapter on sexuality for the third edition of the textbook, "Women's Gynecological Health". She has been published in the "Journal of Lower Genital Tract Disease", has written a LARC toolkit, has written a manual for “Incorporating Sexual and Reproductive Health Services into Primary Care”, and is completing a comprehensive, 10-part online series on Intrauterine Contraception for the CAL. Patty is actively promoting innovative patient-centered counseling techniques through train-the-trainer programs and research. Patty was named Family Planning Champion in 2015 by the California Family Health Council. We want to welcome Patty today and look forward to hearing from her.

Patty Cason:

Great, thank you for such a lovely introduction. And I'm hoping today we're going to move the needle a little bit in the direction of being able to provide wonderful birth control for our clients the day and time that they're asking for it. Now I would say, in an overview sense, we'd like that to be all birth control methods that are available to our clients for same day use and for starting on that same day that they ask for them. But today, we're specifically going to talk about the long-acting reversible contraceptive methods, which are implants and IUDs.

Patty Cason:

These are my disclosures. I do either speak or consult on behalf of all of the products that are considered long-acting, reversible contraceptives in this country. I also am a trainer for products that are in development that have not yet actually gone to FDA.

Patty Cason:

Here are our objectives. My general objective is I'd like to, as I said, move the needle a little bit within each site and for all the folks that are attending, in terms of thinking about being able to operationalize getting birth control for our clients at the day and time that they're asking for them. To that end, hopefully folks will become very comfortable with the concept of talking about bleeding changes for the methods that we're going to be talking about today so the patients can really get a really efficient way to ask their questions and have their questions answered about bleeding. Also, there are medical eligibility criteria and other guidelines that are put out by CDC, and I wanted to at least have everybody become familiar with those if they aren't going to be fully able to practice use of the tools today, with these guidelines, at least hopefully everybody will become a little bit familiar with the guidelines today. We're going to get into a little bit of the weeds talking about what kinds of tests need to be done before placing an implant or an IUD, specifically because those can sometimes be barriers, so that's why we want that to be an objective. And then in general, just discussing some of the barriers.

Patty Cason:

We are going to talk about off-label use of products. Off-label means that the company has gotten that little piece of paper from the Food & Drug Administration, and that little piece of paper describes everything, it's called their label, and it describes everything that the FDA has said that they are allowed to say about their IUD or their implant. And in some cases, we use the evidence to utilize products in a way that goes beyond what is said in the package labeling. So, when we do that, I'm going to have this little icon here that describes that it's off-label. Hopefully, that makes it simple to know that we're dealing with something that's an off-label use.

Patty Cason:

First of all, I just want to say, from a top-level perspective, any clinic visit, my hope would be that any clinic visit can become a placement visit. I would say in the broader context, any clinic visits for somebody that is in need of planning, planning services at all, which is going to be all of our family PACT clients, hopefully any clinic visit can become a visit where they walk out with whatever birth control method, they want that day. In a broader in sense, but specifically, when it comes to these products that have to place in the patient's body, we'd like for any clinic visit to be able to be turned around and become a placement visit. If somebody's in for emergency contraception, a pregnancy test, if it's negative, a Well-Woman exam, or a regular routine healthcare maintenance exam, someone who's coming in with complaints, vaginitis or UTI, or obviously if they're asking for family planning, but just the concept that somebody's coming for a pregnancy test or emergency contraception, by definition means that they are telling you that they have had unprotected sex with somebody that could get them pregnant and that's why they're asking for the service that they're asking for, either emergency contraception or a pregnancy test. So that is a way to have your little red flag go up. This patient needs contraception, a conversation about it, and hopefully to be able to provide it that day for that person.

And if the contraception she would like is something that you have to place, then hopefully you can make that visit happen that day.

Patty Cason:

What are some of the barriers? You have to think in terms of the big picture here because there's so many. So, I've broken them down into provider level, clinic level, and also thinking about just the myths that are out there regarding, specifically regarding IUDs, but there's a few less myths regarding implants, but these barriers need to be looked at in some kind of detail. And I would suggest that probably everyone on this call has a pretty clear sense if you look at your particular system, your particular clinic, or your particular understanding of the literature, you can probably yourself identify barriers. And if we had more time, it would be very interesting to have people give me an opinion about what you think the barriers are at your particular site. Some of the ones that we've identified are that people are not across the board always trained, either to place an implant or an IUD. Obviously, IUDs require a little bit more training. The implant, you go to the training that the company provides. But it is my sense that, and I think a lot of people who work a lot in family planning tend to have this sense, that it would be great if all providers that are in the situation where they're interfacing with reproductive age women, were, at least as much as possible, trained to be able to provide both implants and IUDs. So where does that start to break down? It starts to break down with providers that aren't pure GYN. So, people that are primary care providers, people who are in family medicine, and also pediatrics is the place where we're really trying to focus on because the American Academy of Pediatrics has already put out a statement saying that they think for adolescence that these long-acting reversible contraceptive methods should be first line. That just in terms of the technique of being able the place these and being certified, in the case of the implant, to place these. But what about providers that are actually not up-to-date particularly in terms of the literature. We have a lot of myths, as I referred to earlier. There's also the issue of how protocols within the site itself been keep up to date so that they are really appropriate for the current understanding we have about the safety of these methods. Are we sure that there's nothing in the person's, excuse me, either the protocol or the provider's mind that creates a barrier, like misunderstanding about what a contraindication might be?

Patty Cason:

Not just in terms of the actual technical ability to place an implant or an IUD, there may be other ways that a provider is not fully trained. For example, if really you have to obtain an informed consent before you place either an implant or an IUD in someone's body, and to do that informed consent can either be a long tedious process, or it can be quite efficient. So, are providers really comfortable that they can go through the four biggest risks? So, infection and perforation, expulsion, and method failure pregnancy, can they go through those risks of complications very quickly and efficiently but in such a way that the client really does understand what the risks, what the complications are, with the risks for complications are so that they're doing a good job of giving informed consent while at the same, obtaining informed consent while at the same time doing it efficiently? Our providers who are otherwise trained to place implants and IUDs, are they able to actually accomplish a successful placement if there's initial resistance? Let's just say, they go in to place an IUD, and they aren't able to get through the internal os? Does the provider have enough training so that they know what tricks and tips to utilize at that point, or is the provider just going to give up and say, "didn't work, let's just have you come back another day"? And I want to preface all of this by saying we understand that clients who are not given their implant or

IUD that day will frequently not come back. About 50% of the time, clients won't come back for another visit to get that implant or IUD. So, it's really best to think about strategies if you have difficulty getting through the internal os, for example, strategies for how to go ahead and accomplish that and be successful with your placement and while also being safe. And we're going to talk about that a little bit. Providers that don't feel confident that they would be able to manage a complication appropriately may be hesitant to place that day if they themselves don't feel like if a complication comes up, they would be really able to manage anything well. That's another barrier.

Patty Cason:

When we look at clinic level barriers, there are probably many other, by the way, provider level barriers, but I was just giving you a few. When we look at the clinic level barriers, I referred to protocols. So, it may be that the clinic has very complicated or outdated placement protocols that make it actually very time-consuming to place an implant or an IUD where you may otherwise be able to change the protocol such that, or the policies as well, that you could change them so that it becomes simplified, and it becomes more, less time-consuming, and much easier to go ahead and just do a same-day placement rather than doing multiple visits. Perhaps if you have a clinic where there's only one or two sets of instruments, it would be difficult to think about letting anyone who wants an implant or an IUD, and it's medically appropriate to have one get one that day, it would be difficult if all you have is two sets of instruments, because what if you have an IUD scheduled for later in the afternoon, and you have one scheduled for the morning? Well, if your patient in the middle of the morning says, "I also want one." You may not have enough sets for her. You might want to think about increasing the number of sets of instruments that you have. The main concern we always hear is scheduling concern because to talk about placing an implant or an IUD requires counseling, and we are going to talk about some tips for how to counsel today during this talk, but that becomes a scheduling concern. So, looking at creative ways to create a schedule that allows for an expanded visit, doesn't have to be a very long and intense expanded visit, but it does need to sometimes be given a little bit extra time for that counseling prior to getting the, to having the patient decide what she'd like as well as the time to do the counseling once she's decided she wants the placement, to do that informed consent we were talking about before. This requires flexibility in the schedule. And some clinics have done this by putting in extra slots that are left blank and that are meant to be filled by an implant or an IUD placement as the day unfolds. Sometimes what's happened is all visits are just made a little bit longer so that's there's a little bit of a slush there, a slush time. Sometimes clinics have looked at keeping any visits that are available on the schedule for later in the day that may be open for something else, transferring those over and making them placement visits. So, an example of that would be the client comes in at 10 in the morning and there happens to be an appointment available at 11:30, but it's for something else. You understand that she would like an implant, or an IUD placed that day, so what you do is you just hold that other clinic slot, that other scheduling slot, and you fill it up with her. And you make her now a placement visit.

Patty Cason:

In terms of the myths that I was referring to, these have been standard for a couple of decades now. So, for the last 10 years or so, we've started to really come out from under some of these myths. I don't want to spend a lot of time because most of the people on the call probably understand that IUDs are fine for women who haven't had children. They are good for adolescents. In fact, remember the American Academy of Pediatrics wants these methods to be used first line for adolescents. They're fine

for women with a history of ectopic pregnancy, a history of pelvic inflammatory disease, a history of having had sexually transmitted diseases, and history of abnormal pap.

Patty Cason:

Now when it comes to barrier in terms of just operationalizing things, there have been traditionally some sites that asked that before a patient get, particularly, an IUD placed, these barriers are more for an IUD, these particular ones, before some sites have had traditionally, that before you get an IUD you need to have a negative chlamydia and gonorrhea done within the last three months or so. There are various protocols, but that's the typical kind. They need to have a recent pap test. They need a pregnancy test. They need a wet mount. These are all hurdles, barriers, that need to be overcome if they are going to be in place a policy. We would argue doing an evidence-based approach, which would be in line with the Centers for Disease Control and Prevention's guideline called SPR, or Selected Practice Recommendations. And I'll going to be talking about that in minute, but it's a guideline from CDC that gives you management guidance regarding specific questions like what tests need to be done before I place an IUD, or what tests need to be done before I place an implant? What they will say, and we will reiterate, is that there is no testing needed. You don't need to have a chlamydia, gonorrhea test, pap test, wet mount. You do a pregnancy test if it needs to be done to rule out pregnancy, and then any other tests are only as indicated. Gonorrhea or chlamydia if she's due for screening, or if she's found to be at risk and needs to be screened. Pap, only if she's due for it. Hemoglobin or hematocrit if you're planning to place a copper IUD and she has an indication by her history that she may have had heavy periods or had anemia in the past. This is a clinical decision, but all of these tests, please note, can be done the same visit when you're placing. This is not any reason to have somebody have to come back.

Patty Cason:

Another barrier is cost. We hear this a lot, and I'm going to defer a lot of the questions or concerns regarding billing, coding costs that are specifically related to the Family PACT program to the Family PACT folks themselves to answer later if those come up. It is, I want to note, that there's a couple of little points to this. One is that it's really important if you're going to have same day placement to have stock available offsite, to have IUDs and implants available so that you don't have to order it the day that the patient asks for it and then there be a delay. You have to wait until it gets delivered. It's better to have those devices in stock. It's also really good to mention that you can bill an E&M code on the same day as a placement, depending on what the scenario is. And so, that's something you'd want to really check and get very specific about so you know which kinds of E&M visits you can bill on the same day as a placement visit. But not to assume that that's not possible. Also, an extra source of revenue is to recapture your counseling time money that you've spent by you use the resource in your clinic of staff time to do really good counseling, and so go ahead and bill for that with an E&M code.

Patty Cason:

I referred to national guidelines, and these are the icons that show you what they look like. And there's three of them actually, but I'm only going to talk about two of them today. One of them is the US Medical Eligibility for Contraceptive Use, excuse me, US Medical Eligibility Criteria for Contraceptive Use, and that's the blue on the left. And then there's the US Selected Practice Recommendations that I referred to earlier, and that's the one that's on the right.

Patty Cason:

The Medical Eligibility Criteria is the only guideline like it, and it's about safety. And it is the national guideline that all professional organizations that have anything to do with family planning or contraception all sign onto. So ACOG agrees with these criteria, these guidelines. This was originally from the World Health Organization. It was adapted for use in the United States in 2010, and there is, for anyone who's interested, I certainly am, there is an update coming out, hopefully in June, for the US Medical Eligibility Criteria. There have been two updates since 2010 and they are incorporated in the app that you hopefully will download and use for this guideline.

Patty Cason:

The guideline tells us whether it is or isn't safe to use a given method in a given woman on a given day. I have a woman, and she is a certain age. She has a certain medical background, medical history, and I get to decide for each of the methods that she might be considering whether it is or is not safe for her to use it. If the Medical Eligibility Criteria says it's a one or a two, it's fine to use it. If the Medical Eligibility Criteria says it's a four, which you could see here is red, we do not use it. That's an absolute contraindication. If the US Medical Eligibility Criteria says that it's a three, then it's almost as if you would think about proceeding with caution. Usually, the risks of use outweigh benefit, but if you've got a patient that is medically complicated, a lot of times she is the person who is at most need of effective contraception because she medically from a safety perspective needs to plan that pregnancy, needs to have that pregnancy something that she's prepared for physically. That three categories are a little bit confusing because sometimes that's exactly the person that requires a three, the person that is getting a three on their Medical Eligibility Criteria may be the person that's at highest risk. So always pay attention. If the person's being given a three, think about maybe they need really good birth control. But in general, risk outweighs benefit. And what they do with these guidelines, is they think about, in addition to all methods, they consider many, many, many medical conditions, cardiovascular conditions, neurologic conditions, rheumatologic conditions, many, many conditions. Most of the things that our reproductive age patients will have. And then they also think about personal characteristics such as age, weight, whether the person is postpartum, whether they smoke, these sorts of things. And then they come up with an answer with a number.

Patty Cason:

They'll also be able to give you the data if you look at the little footnotes, but if you just want to know the answer, is it, isn't it safe? They will give you a number. This is a link to the PDF that's on the Reproductive Health page of the CDC's website.

Patty Cason:

But I think for most people, using the app is probably the easiest way to access the guideline, and it's very, I think it's very easy to use, but you do need to practice and play with it a little bit. It's only available for iPhone and iPad for now, but in June it will also be available with the update for Android.

Patty Cason:

The Selected Practice Recommendations that I referred to earlier are a set of frequently asked questions. And in that format of frequently asked questions, answers many questions that are of concern to providers who are providing contraceptive care.

Patty Cason:

It's about contraception, and it is broken down into a series of tables, appendices, and in some cases, there's a little checklist. It gives you very usable tools. This is what it looks like as an entire PDF. It's not yet available in an app, but again, in June, CDC has reassured us that it will not only be updated, but it will also be available as an app for Android and for iPhone, iPad, and other platforms.

Patty Cason:

One of the things that they are very clear about in the Selected Practice Recommendations is, thank goodness, that an implant, an IUD that's copper, an IUD that is levonorgestrel can all be placed at any time if it's reasonably certain that the woman is not pregnant. There's no need to wait for menses.

Patty Cason:

And this is one of the checklists that they provide. It's called Box 1, How to Be Reasonably Certain That a Woman Is Not Pregnant. I would recommend if this seems like it's valuable to you to go ahead and utilize this in your electronic health records or put it in your clinic so that you can have this available as a simple checklist for how to be reasonably certain that a patient not pregnant. If by this checklist you've determined that it's reasonably certain she's not pregnant, you can choose to also do a pregnancy test or not as appropriate, and then you can go ahead and place that day.

Patty Cason:

When you ask the question, what specific tests need to be done, or what specific timing should there be? They give it to you in appendices. So, for example, they have other appendices also that relate to this, but this is just an example of Appendix B about when to start using the method. And you can see here that it not only tells you it's fine to start at any time, but then the next column tells you whether or not, you need backup. If you place the copper IUD any time in the cycle that it's reasonably certain the patient's not pregnant, you do not need to use any backup after that because it's actually extremely effective as an emergency contraceptive, therefore, it's retroactive. With a levonorgestrel releasing IUDs as well as the implant you'll see that if the product is placed anything other than the first portion of her menstrual cycle, the first five days of her menstrual cycle or first seven days of her menstrual cycle, then use backup for seven days. And I think it's very simple. The idea is place it any time it's reasonably certain she's not pregnant and backup for seven days.

Patty Cason:

What about use of the copper IUD off-label, and you'll see the icon on the lower right, as an emergency contraceptive? They have very clear rules about how to do that, and that's, you can just go ahead and grab that little piece right out of the SPR and put it, again, into your electronic health records or just print it out for your site. And you'll be able to know exactly how to calculate whether it's appropriate to place that copper IUD as an emergency contraceptive that day. Because you can do it within five days of the first act of sexual intercourse, or if you can determine the day of ovulation, then you can go ahead and go five days out from the day of ovulation.

Patty Cason:

These questions are questions that I like to talk to people about because they're a way of talking about reproductive life plan or pregnancy intention or reproductive intention, depending on how you like to

think of it, but the important thing to point out about this is that when you're trying to get to the heart of what your client would like about contraception, it begins with understanding does she want to protect herself against pregnancy? And if she wants to protect herself against pregnancy, how important is it to her? So, the first question, do you think you'd like to have kids at some point, or would you like to have more kids at some point? Is really just to frame, help the woman frame her thinking about her future goals, her future preferences, what she wants. Does she want to have children in her life? The second question, and it really is a much longer conversation for me to describe all of these and to talk about all the benefits of each one and how to use them, but it's just a good way to open up the conversation. It does not, it would seem like it would be a big of waste of time. It doesn't actually take a long time. If you ask this question, you don't end up with an open-ended question that just goes on and on. The patient's usually actually answering the question in a way that gives you a ton of information fairly efficiently. The second question, when do you think that might be? You only ask if she has said yes to the first question. "Yes, at some point, I would like more kids," or "yes, I would like more kids now." You ask that question only if she said yes to the first question, and by the way, these questions can be used for men, but for the purposes of today, these are only for women because women are the ones who get implants and IUDs. The purpose of the second question is not so that you can decide whether she should have a three or a five-year or a 10-year or a one-day contraceptive. The purpose of that is just to help her advance her ability to understand for herself what she wants. It's to help her gain agency over her own life by understanding more about what she wants in the future. This is just a timing question. But it's very important to understand that if a patient, if it's very important to a patient to prevent pregnancy, a long-acting reversible method is very appropriate, regardless of how long she does or doesn't want to use it. People are not actually often adhering to the amount of the time that they think they have until they want to start having a child or having their next child. What somebody says that they want in terms of timing and what they actually do are not very aligned, so if somebody had said, "Yes, I'd like to have kids someday, "not any time soon as it's very important to me "not to get pregnant until I'm ready," that's a person that you'd like to offer emerge, excuse me, long-acting reversible contraception to.

Patty Cason:

This is a wonderful resource for our patients, another way to save time. If your client has already gone online and found out about methods of birth control, and answered a lot of her own questions, then you'll be able to give a lot more specific, targeted information to her about the questions that she has. This is bedsider.org, B-E-D-S-I-D-E-R .org, like by the side of the bed, bedsider.org, and they've got a lot of tools and tips and videos and video testimonials, lots of things. It'll help your client to be able to have accurate information on all of the contraceptive methods in a way that she can really utilize the information because she's going online and interacting with this website. It's very market-tested for a young adult. And it is very appropriate for young adults' educational level and understanding of new media. It also, if you sign up for it, can give you the ability to sign up as a provider, get lots of tips and tricks, but also get $100 worth of free stuff, one of which is this wonderful, tiered effectiveness chart.

Patty Cason:

You can ask them to send you a tear sheet stack of them, and you can have this tiered effectiveness chart just sitting in every room. And as you can see, the top tier, which are less than 1% failure, you look over the far right, there's a little, one little pregnant belly, and then the second tier are between

anything more than 1% failure but less than 12, so you've got pills, patches, rings, and injection. And then on the third tier is more than 12% failure, and that's everything else. This is just a lovely tool for patient education to just have in the room. You don't even need to go through the entire thing. Just having it here in the, having it available in the room when you're talking to somebody may frame their thinking very nicely just to let them know which tier, they're interested in. Because, for example, if the patient answered to the third question that I mentioned earlier, if she says, "Oh, yeah, no it is super important to me "not to get pregnant until I get out of school. "Oh, my goodness, yes, it's the most important thing "in the world to me to make sure that I'm with the man "that I want to spend the rest of my life with "before I have a baby." Whatever she has said is important to her will inform where she thinks of going on this chart. If she's already told you, "Yes, it's critically important," then it's a pretty natural fit for her to be in that top tier.

Patty Cason:

The next question you'll want to ask her that's going to be efficient and very patient-centered is a question that asks her what she's looking for in a method. So not, "What method are you interested in?" That's probably the worst question you could ask, and it's probably the one we all ask all the time. Not, "What are you thinking about using?" But "What are you interested in "in your birth control method? "What seems important to you about a method? "Is it effectiveness? "Is it bleeding patterns? "It controls of your acne. "Is it that you can never get a period again, "or that you can schedule a period? "What is important to you? "Is it cancer prevention that's important to you?" If she has told you that she has a goal that she'd like to get through college, or she would, whatever she has said is her goal, you can ask her, put it on her, "What are you considering of these options "that might help you get there?" Whatever her goal is.

Patty Cason:

I just want to put out a suggestion that this sentence exactly the way it is, I would recommend all counselors, anybody discussing contraception with a patient this is a great sentence to memorize because it gives you a ton of information all in one sentence, and then a very easy-to-digest format. Let's say we were talking about the implant. This implant is good for up to, and the up to is critically important, for a long-acting reversible method. "This method is good for up to three years, "but if you want to get pregnant before then, "or you'd like it removed for any reason, "come in, we'll remove it for you. "And your ability to get pregnant "will return to whatever is normal for you immediately." I would suggest we almost never use the term three, five, 10 years, without saying up to before it so the patient doesn't feel like she has to make some sort of a commitment to a length of use. Also, so she understands that from an ethical and justice perspective, the moment she wants the foreign body out of her body, we will do it for her. That's a very important thing from an ethical perspective. And then the other thing you're telling her and reassuring her about is, not only are we going to take it out the moment that you ask, but the moment it's out, your ability to get pregnant returns. Now, what if she wasn't fertile before she had this method put in? She's not going to be any more fertile having it taken out. So, we can't say to her, you will be able to get pregnant as soon as we take it out. And you notice I also wouldn't say, you have returned to fertility, because that doesn't necessarily mean anything to somebody. But what does mean something to somebody is, your ability to get pregnant returns to whatever's normal for you. And then that word immediately, because it is, with all of these products, it's

immediate, rapid reversibility. The minute these products are out of the body, the person can get pregnant.

Patty Cason:

Whenever you do give information to somebody, especially when you're talking about something where you do need to actually give some information, because you have to get informed consent, so you need to be able to know that she has understood the information you've given her, give it to her not only in patient-centered language, but in small doses so that she can digest the information. And then a wonderful tip is just to sandwich that piece of information between two questions. Any time we sandwich a piece of information between two questions, it's more likely that the person will be able to hear and digest the information you asked her, excuse me, the information you gave her because in asking her questions, you have engaged her learning ability so that she's actually paying attention, especially if you ask questions that are related to the topic that you're telling her about.

Patty Cason:

Language, we don't like to use the term LARC or long-acting methods with patients. Long-acting might be triggering for somebody. They may feel like you're saying to them that they need to use it a long time. The point of these is that they're highly effective, not they are long-acting because they're as long-acting as she wants them to be. And that's a really important distinction. You could call them top-tier or the most effective. You could call them highly effective, but I would say LARC means nothing to patients, and it shouldn't be a word that they ever hear. They should hear about levonorgestrel IUD or a copper IUD or a contraceptive implant and then more information about each of those things as appropriate to their desires and preferences and values.

Patty Cason:

Let's do a case. One of the most common things that people are worried about when it comes to placing implants and IUDs is that somebody's going to have a vasovagal. Let's talk about how to prevent a vasovagal. Then maybe you'll be a little more confident that even if something went awry, you would not have a whole of time spent on this complication because we have a way of averting it. This is a way to avoid syncope. Betsy is having her contraceptive implant placed, and she says, "Is this going to take much longer? "I really need to go to the bathroom." Most of the time patients are not telling us when they need to go to the bathroom, so that's a little bit of an overshare on Betsy's part. Maybe something's happening to Betsy. Maybe she's starting to have a vagal. What is vasovagal response? It's an irrational response, just like a knee-jerk reflex.

Patty Cason:

And the first step in that response is peripheral vasodilation. She'll have pooling of blood in her extremities as her first step. She hasn't passed out yet. She's just had pooling of blood in the extremities. That sudden pooling of blood in the extremities, which as I said, is a reflex, so don't try to make sense of it, but the next thing that happens is she starts to have a drop in her blood pressure and her pulse at the same time, which as you know if you're a healthcare provider, those things don't usually happen together. Usually if you a have blood pressure drop, your pulse will compensate. If you have a drop in your pulse, your blood pressure will compensate by coming up. In this case, that doesn't happen. We

know the triggers, cervical manipulation, fear, somebody who's a fainter, somebody who's dehydrated, someone who hasn't eaten.

Patty Cason:

And we know the signs, and this is what's important, you need to watch for the signs. So that icky green, gray color, or a patient yawning, pupillary dilation is a sign that somebody may be starting to have a vasovagal. Someone who appears nervous or starts to slur their speech or have some sort of confusion. If they start to say, "I feel," and anything funny at all, assume she might be starting too vagal. Certainly, any sweating.

Patty Cason:

People may feel lightheaded. They may complain of weakness, visual changes, blurring or tunnel vision, double vision. Someone may feel nauseated, complain of feeling suddenly cold, suddenly warm, sudden need to go to the bathroom, tinnitus.

Patty Cason:

Any of these signs or symptoms immediately assume she's having a vagal and ask her to then, in a very isometric way, so she does not need to move her extremities whatsoever, she just needs to intensely grip her hand, her arm, her feet, and her legs, not her abdomen, not her thorax, not her face, just the extremities and just contract the muscles, not pumping, just contracting, and holding. And what that will do is it'll shunt the blood immediately back to the center of the body and abort the reflex.

Patty Cason:

Another tip if you're having a conversation with somebody about an implant or an IUD, for example, if she says, "I don't want to use that," or let's say that you ask her how does she feel about not getting her period? Let's say with the implant, most the time, the majority of the time, women either have less bleeding than they normally would, or they don't get their period at all. And I say to my patient, "How would that be for you?" And she says, "Well, that's not healthy. "I have to get my period." I could choose to say, "Oh, no, no, you're wrong. "It's actually fine when you're using contraceptive hormones "not to get your period," and I could explain why. Or I could say, "Yes, and." Whenever you can say, yes, find something she's saying that's correct or he's saying that's correct and then add "and yes, you're right and," instead of saying no or but. Because she'll hear it more. I would say, "You're completely right. "I'm so glad you know that when you're not using "contraceptive hormones a person needs "to get their period regularly. "I wish all of my patients knew that when they're not "taking contraceptive hormones, if they don't get a period, "they need to come see me because we need to see "what's going on. "I'm so glad that you know that when you're not using "contraceptive hormones, getting your period "is a sign that everything's functioning well." In this way, I have acknowledged that she knows something, and I have built on it instead of arguing with her or disagreeing with her.

Patty Cason:

This is a wonderful tool. It's called Appendix E by the US Selected Practice Recommendations, and it gives you management strategies for each and every one of the birth control methods regarding irregular bleeding. If the person is having bleeding that is irregular and unacceptable, you go directly to this little algorithm, and then you have management strategies for her.

Patty Cason:

What does the bleeding look like? As I described, with the implant, a majority of patients either have amenorrhea or no bleeding at all, or a little bit of light bleeding or a little bit of light spotting, but from a counseling perspective, most women are very happy with their bleeding pattern and that's what I lead with when I describe the bleeding. That is what I describe with all of the methods because it is the truth from multiple studies. I start by saying that and then I'll say, "Women will have less bleeding "than they would naturally, "but the bleeding pattern is unpredictable." But it's very good if you're going to be offering these same days to get a nice, easy comfortable way of thinking about and talking about the bleeding pattern with each of these methods. If the bleeding pattern is good initially with an implant, it probably predicts what the pattern's going to continue to be like, but if in the beginning the bleeding pattern is not so good and there's frequent or prolonged bleeding, it does tend to get better with time. Many women don't get their period at all or don't experience. They may bleed occasionally, but they will tell you, "I don't get my period." Interestingly, many women still do get periods. One in five, may have frequent or prolonged bleeding, and that's also important from a counseling perspective and also so that you know when you have this conversation with the patient and you're describing the bleeding and you say, "and one in five may have frequent bleeding "or prolonged bleeding," that you know to share with them that are these management strategies that we saw from the Selected Practice Recommendations.

Patty Cason:

With a copper IUD, people may have heavier, longer, or crampier periods. Lovely, we have something for that. So, when I counsel about the copper IUD, before I even place it, I tell a patient that she can use the NSAIDs prophylactically every month before her period. I would suggest she start it the first time she has a period and then continue for the first three or four cycles, and then if she wants to try without it, she can. But she would want to start before the onset of her menses so that she gets that full antiprostaglandins effect. I've written here naproxen sodium. I like that. That's the generic of Aleve, and you do two of those tablets twice a day. Ibuprofen would be TID or QID, so this is only twice a day, which is a little bit better for adherence. And I just tell the patient that she should buy the generic of Aleve and double the dose that's on the package and make sure she doesn't have any kind of ulcer problem. But this will reduce menstrual bleeding by up to 70%, and it certainly will take care of any cramping she may have had.

Patty Cason:

With the levonorgestrel IUDs, there's not a great management strategy, but what there is the natural history of the bleeding is such that most people's bleeding if they are going to have any spotting or irregular bleeding, it's usually only in the first three to six months. And that's a very reassuring thing, to know that that will, that pattern is very predictable, that not everyone gets frequent spotting or light bleeding, but if they do get it, it goes away by three to six months. And by a year, 20 to 50% have amenorrhea. It's 20% by the clinical trials, but 50% by patient definition. It's not strict amenorrhea, but its patients reporting I don't get my period anymore. They may still get a little bit of bleeding now and then. And by one to two years, as the time progresses, their bleeding goes down by 90%. It's real significant decrease in bleeding.

Patty Cason:

I have a section here that I wanted to finish with, and we're running low on time. This is really just about if you have tried to get into an internal os that you're having difficulty passing through, what can you do about it? Kristin is in her copper IUD. She's graduated just now from her nursing program. She has not had a period in quite a while because she's been on DMPA. And I will say that for people who have been on DMPA, sometimes these have been challenging placements so there's some strategies here for how to deal with it. She did have a LEEP three years ago. She has a little bit of cervical stenosis as result, but she had a negative pap as a follow-up.

Patty Cason:

Here's how you would approach it, and I've got these numbered because you want to think about going from one down. The first thing you think about is using more or different traction on your tenaculum. The second thing you would think about is changing the bend in the sound, either making it straighter or making it more bent. And that's only in distal six to nine centimeters. Another option is to try applying light pressure at various angles 360 degrees with the sound, so just keep going around in a circle looking for an opening. One way we think about this for tip four, which is you place the sound gently against the internal os and wait. And that just allows the os to yield without any real serious increase in pressure, just time. And that's like knocking at a door and waiting for it to open.

Patty Cason:

Then you might try considering using an os finder device, which I'll show in just a moment or a dilator. So, either a small dilator, metal, or plastic or an os finder. Now in the case of either of these, these are not meant to sound the uterus. These are just meant to get through internal os, and then you would come up back behind that in sound. Very important, shorter speculum, if you need a wide one, that's fine, but don't go long because it can splint the cervix and make tenaculum usage ineffective which can make it impossible sometimes to pass through the internal os. And then the last things you would try would be to reposition the tenaculum or there is some data, one trial so far, one trial that was very well-done. It showed that we show there's many trials saying use of misoprostol before a placement prophylactically, like in the case of nulliparous patient, does not work. All it does is increase side effects. But in this one trial, they looked at what about in the case of an unsuccessful placement? Is it worth it to try having the patient return with misoprostol? Yes, it is actually worth it to try that.

Patty Cason:

This is what an os finder device looks like. They're plastic. They're tapered at the tip. There are many different types, but they are extremely easy to use and helpful. And here's what other ones look like. And then finally this is what a plastic dilator would look like or a metal dilator would look like this. And any of these will work. You certainly would not use any of the fatter ones at the end of this. You'd use some of the ones of the first three. I'll pause now, stop now, and see if there are any questions and thank you very much for your time today.

Linda DeSantis:

Thank you, Patty. At this time, we don't have any questions that have been written in the comments or the chat box, but while we do have a few minutes left, I'm wondering if anyone has any question at this point that they'd like to type in. The first question is, where can we get the SPRs?

Patty Cason:

Oh, what a great question. My favorite question is to how to access these wonderful guidelines. What I would do is type into either Google or whatever your search engine is, just type in US SPR. It's very simple. Or you could type in CDC SPR. Now the problem is, the first thing that comes up could be the reproductive health page at CDC, but it also could be Strategic Petroleum Reserve. You might have to go down a couple. You could type in Selected Practice Recommendations, but it's harder to remember when you're out away from today. All you have to do is find the one that says CDC on it, and then you click on that, and it'll bring you right to the reproductive health page at CDC. The reproductive health page at CDC has the PDF document of the Selected Practice Recommendations, but it also will allow you to download it as an eBook or an iBook, which is searchable. It'll also allow you to download each one of the appendices, and you could just print it out if you prefer having hard copy. For example, for Appendix E that has the management of bleeding irregularities, you could just download that document, and have it laminated at your practice site. Now they will have the Selected Practice Recommendations available as an app in June if Zika doesn't derail them too much. But they promised that these should be coming out in June. Their updates should be coming out in June, and they said that their apps, both the Medical Eligibility Criteria app update and the Selected Practice Recommendations app, which is not an update because there's never been an app before, those should both be available sometime right after June. I also want to say, there's another guideline from CDC that's a joint guideline with the Office of Population Affairs. So, the Office of Population Affairs is the governmental agency that administers Title X. Title X as you all probably know because you are Family PACT providers, so you probably know about Title X is the federal family planning program. So, the federal family planning program administrators and the CDC got together and wrote a whole document called "Quality Family Planning", and it represents all best practices in the world of provision of family planning services. It's lovely. It's got a lot of detail, but it also has a beautiful app. And I probably shouldn't say beautiful because I did work on it. So, I do have an emotionally vested interest in there. The app is available, that app is available for iPhone, iPad, no, not iPad, I'm sorry, iPhone, laptops, Android, and it's very easy to get. You go to your App Store or your Play Store, and you just type into the search field Quality Family Planning. And it's a very pretty app. It's got a bunch of colored circles on there, colored balls on there, so it's pretty distinctive. And you download that. So that will be able to tell you all kinds of tips, tricks, and guidance about how do I know I'm providing top-shelf, really high-quality, state of the art, evidence-based, family planning services? That was a long answer.

Linda DeSantis:

Great. We have a couple more questions. The next one is, "do studies show "that continuation rate for same-day placement "versus later placement has the same "or better continuation rate?"

Patty Cason:

So, in general, they show that they have the same continuation rates. There's at least one study that showed that it didn't have as good continuation rates, and then there's other studies that show that it's better continuation rates. On average, we expect it to be similar. There's a really important caveat to this, which is how good is your counseling? The one thing we know is highly associated with better continuation and better patient satisfaction, which is a very important, I think, outcome to measure, is how well did that patient feel like her questions got answered, and how well was she informed about bleeding patterns, potential side effects, potential risks? If you have done a really good job with getting

all of her questions answered and making sure she's really having a good, informed consent process, you should expect to have an excellent continuation rate. Now that said, the continuation rates are a great thing, but some patients are not going to want to continue with their method, and I think we need to be very patient centered in the way we manage the person who comes back asking to have it removed, that we don't try to have an argument with somebody. That they understand that it comes out if you want it out, and would you like to talk about ways to manage whatever it is that's bothering you?

Linda DeSantis:

Great, well, that actually leads into the next question where a participant has a client, or excuse me, a patient coming in this afternoon who has NEXPLANON placed five days ago, at another clinic, and she is adamant she wants it out due to dizziness and feeling funny. Any suggestions on that?

Patty Cason:

Absolutely and I'm so glad somebody brought that up. This is the kind of thing that triggers healthcare providers because we think, oh my goodness, this was such an expensive thing. We put it in. Now she's taking it out five days later. That's a failure. Try to put your own feelings about that aside, and just treat this as a patient-centered conversation just like anything else. I think that's the first step is to try to get rid of our own biases about this. So, the way we manage this is to ask her probing questions to understand as much as possible about what it is that's bothering her and why it's bothering her. Is she afraid? Is there a symptom that she thinks is going to be harmful to her health? Is it that she just doesn't like the way she feels, and she wants it fixed? What is her issue? Try to really get to the source of her issue. What this participant has just typed, what I just read while you were reading this, while you were reading this out loud, what I read was a very top-level concern. But we would need to do would be to have that conversation to get to the deeper levels of what's really going on for that person, to really understand, which is a quite different attitude than trying to talk her into keeping it. The first to do is to try to really get a very good idea of what's bothering her and what she wants out of the visit. Does she want reassurance? Does she want to be not scared? Does she want the side effect to go away? Does she need more information? Does she just want to really complain about how terrible something is? Not this patient in particular, but some patients, that's what they want is to be really heard. How does somebody get heard? You give active listening tips by looking at her with your eyes and making eye contact, leaning in, keeping your hands down by your side, not crossing your legs, watching her face, and talking to her rather than looking at a computer screen while you're talking to her, and then most important, rephrase back to her what she said to you. "So, I'm hearing you say that you're feeling," da, da, da. You don't repeat exactly what she said. You paraphrase so she really understands that you've heard her. You could summarize with that paraphrase. You can make, you can extrapolate from something else she said and try to do a best guess, but the point is your rephrasing back to her what she said so she knows that you've heard her. You want her to know you're on her side. You want her to know that you will take this out for her if she wants. That is not the issue, that what you want to do is make sure you have addressed what it is that really matters to her. And that's our best chance of being able to not have things removed that aren't really probably medically needed to be removed. That's probably our best way of being able to accomplish that is to really know that the patient, is to do whatever we can to make sure the patient feels heard.

Linda DeSantis:

Great, well, we're just about out of time, but we have two more questions that have come in, and I want to check in with you Patty if you have a few moments to answer them.

Patty Cason:

Yeah, that's fine. I see the question about the tenaculum, so you can go ahead and read it, and then I'll...

Linda DeSantis:

Sure, one of the participants, they have stated they found that it is easier to place IUDs of all types with the tenaculum placement at five and seven o'clock. However, the manufacturer instructions advise 10 and two. Does it matter?

Patty Cason:

That's an excellent question, and the tenaculum question is, everybody's always asking about that. The thing about the tenaculum is, you put it wherever you feel comfortable. You can put it on the posterior lip. You can put it on the anterior lip. You can go horizontally. You can go vertically. You don't want to put it right over the vessels of three and nine, but otherwise, you're really pretty okay putting it wherever you like. The manufacturers really shouldn't have any instruction about where to put the tenaculum. It's not really their place. And the 10 and two is nothing but tradition. You will find very experienced and people that are really doing a lot of teaching for our people, you'll find them suggesting, "I like this particular way to use a tenaculum." And then you'll find another expert who says, "Oh, I like this other totally different way." Very little data about what any of them, and if five and seven is working for you, then I think five and seven is the perfect place for your tenaculum. One thing to know about tenacula is that if you have a cervix that is pointing in a particular orientation where you haven't gotten great visibility, because remember, I said you don't want to use a super long speculum, sometimes you're going to use a short, stubby one, a Klopfer, something really short. That means you might not get the best, perfect visualization of the entire cervix. If a part is presenting to you, go ahead and grasp that part with your tenaculum, and bring the cervix into view with the tenaculum. That's a way to not have to use a longer speculum than you need. There's really no data saying that one area is best to place it. Long answer again.

Linda DeSantis:

Great. And then our final question is, a participant, "I have noticed the biggest problem "with the implants is irregular bleeding "despite treatment with ibuprofen and COCs "and often leads to early removal. "Any suggestions?"

Patty Cason:

So, it is true that the largest reason that people discontinue implants, so in the clinical trials that the company did, about 11%. Very similar numbers, actually, when we look at audits from large healthcare organizations or the COHICE project. They didn't parse out those numbers in the CHOICE project, but when I've talked to the investigators, they had a sense also that bleeding was probably a pretty big majority reason because when we think about bleeding as a discontinuation reason, 11% is not a very big number at a year. But it seems like a big number because it's really the big hitter. It's the thing that most people will have as their reason for discontinuation. If you put it in context, there will, you have to

think that probably, if we're doing our job right, in terms of the science in 2016, probably about 10% of people in a year aren't going to like their bleeding pattern, and they're going to have removed their implant by that year mark. Maybe that implant removal was at two months. Maybe it was at seven months, but by a year, we expect about that number of people will not be continuing with the implant because they didn't like the bleeding. You're right that we want to use the management strategies, the combined oral contraceptives. We can use NSAIDs. We could try estradiol. We could try conjugated equine estrogens. Those are on the Family PACT formulary also. We could try Lysteda, except it's expensive. There are other things. We could also try for progestin-only pills. If a person's contraindicated to use estrogen, there's some anecdotal evidence that that works, and it's certainly worth a try because it's not a big intervention. But if that doesn't work, and the patient's not happy with their bleeding, there will be some discontinuations. And that's something to just feel fine about because when you think about it in general, every other reason for discontinuation is under 3%, which is nice, really low numbers. And so, if we think about it in total, we've got a very, very high continuation rate of this very, very effective method at a year. And I'm perfectly happy just to be comfortable with that 10, 11, 12% removal for irregular bleeding that they don't like because I've got almost 90% of patients didn't remove it because of their bleeding. I think about in the reverse. And at a year in most clinical trials, most studies, you're right about 80% continuation for the implant at a year, pretty much in all the studies. Pretty much IUDs and implants are at about 80% continuation, which we think is actually quite high.

Linda DeSantis:

Okay, well that's going to conclude our webinar for today. Thank you all for participating. Patty, thank you so much for all the important information. We have a series of questions that we'll be typing up as a Q-and-A. The slides will be available. This recorded webinar will also be available, and we are sending out a SurveyMonkey evaluation, which is also linked to collecting your CMEs for the webinar. So, thank you all stay tuned for future webinars.