00:00:03:11 - 00:00:24:00
Nicole
Hi everyone. Good afternoon, and thank you for joining us today for our webinar titled Equity-Center Sterilization Counseling Evidence, Consent, and Practical Pearls. We hope you are all doing well and staying safe. My name is Nicole Nguyen, program manager of the Family Planning, Access, Care and Treatment program, or also known as Family PACT at the California Prevention Training Center (CAPTC).

00:00:24:02 - 00:00:47:23
Nicole
CAPTC under contract with the California Department of Health Care Services, Office of Family Planning, is sponsoring today's event. And so before we get started, I like to go over some housekeeping slides. If this is your first time with us using the go to webinar platform. The top right ribbon on your screen is the control panel. The questions icon controls where you can submit questions and comments.

00:00:48:00 - 00:01:07:06
Nicole
The paperclip icon controls where you can access any handouts, and the settings icon controls your audio connection preference. This three dot icon is how you can switch to full screen mode and then to check your audio. Click on the settings icon. From there, select your desired setting to join either to your computer or by calling into your phone. If your internet

00:01:07:06 - 00:01:25:21
Nicole
connection is shaky. We highly recommend you call in to your phone for the best possible sound, and then please use the questions icon to submit questions and comments for our presenters throughout the webinar. Today's webinar will take about 90 minutes and include time at the end for Q&A. So please send in your questions. Our speaker will try to address as many of them as possible.

00:01:26:00 - 00:01:45:21
Nicole
The webinar will be recorded and we will send out a follow up email with the recording. The slide deck and evaluation at the end for you to fill out. So please fill that out. Your feedback is extremely important to us and really help us develop our future content. And then I want to acknowledge that we are working with the University of Nevada, Reno School of Medicine to provide CMS for this event.

00:01:45:23 - 00:02:14:18
Nicole
This webinar qualifies for a 1.5 CME credits and only available to those who watch the webinar live today. Those who watch the recording afterward will not be eligible for any

CME credits. The link to access your certificate will be included in the follow up email, along with the recording, the slides, and the evaluation survey. And then for transparency, I want to disclose that all of our presenters, planners or anyone in a position to ensure the content of the CME activity have indicated that neither they nor their spouse or legally recognized.

00:02:14:18 - 00:02:37:19
Nicole
domestic partner has any financial relationships with commercial interests related to the content of this activity. All right, now I get to introduce our awesome presenters. We are thrilled to have three presenters with us today. First is doctor Eleanor Bimla Schwarz. Doctor Schwarz is a professor of medicine at the University of California, San Francisco, and chief of the Division of General Internal Medicine at San Francisco General Hospital.

00:02:37:21 - 00:02:55:03
Nicole
She previously served as a senior medical expert for the U.S. Department of Veterans Affairs and on the FDA's Advisory Committee on Reproductive Health Drugs, and as medical consultant for a California Office of Family Planning from 2014 to 2016.

00:02:55:05 - 00:03:20:08
Nicole
And then our second presenter is Finn Wilder-Piper. Finn is an out loud, visibly queer, non-binary nurse practitioner. They provide comprehensive sexual and reproductive health care, gender affirming care, and abortion care in midcoast Maine, as well as via telehealth. They approach care and education from a background in reproductive as village of justice, with the goal of increasing access to competent, equitable, and compassionate care for all.

00:03:20:10 - 00:03:43:04
Nicole
Outside of work, been enjoy spending time with their family, cooking delicious food, going on outdoors adventures, gardening, tending to farm animals and having spontaneous dance parties. And then lastly, our third presenter is Lyndsey Wilder-Piper. Lindsay is the sexual reproductive health nurse practitioner. She trains and sees patients in Massachusetts at health quarters, also in New Hampshire, at the Joan G.

00:03:43:04 - 00:04:07:02
Nicole
Lovering Health Center and in Maine at the local FQHC. They provide medication and procedure abortion care, other family planning care, gynecologic care, cancer screening, vasectomies, gender affirming hormone care, STI testing and treatment, and intrauterine insemination. In addition, to be enthusiastic about providing and talking about abortion, Lindsay loves to run and garden, to hike and play, and be with close friends and family.

00:04:07:04 - 00:04:24:11
Nicole
Lindsay parents, three lovely young people who are social justice savvy in their own right, and with her partner, Lindsay runs a small farm. So thank you for joining us today. We are really excited that all three of you are presenting at this very important topic. Lindsay is not here right now because they're in a L&D situation right now,

00:04:24:12 - 00:04:42:03
Nicole
labor and delivery, but they will be joining us later. And then with that, I will hand the mic over to Bimla first. Thank you. Okay, so let me stop sharing.

00:04:42:05 - 00:04:56:16
Nicole
And. Make them. Go ahead Bimla you should be able to present. All right.

00:04:56:18 - 00:05:24:09
Bimla
Thank you all for zooming in. And again, no financial relationships with any organizations that might be influencing my thinking on these topics. I do recognize that gender, sexuality, and family planning are inherently personal and complex topics, and that not all individuals who pursue tubal sterilization identify as women, even if I default to talk about women seeking tubal sterilization.

00:05:24:11 - 00:06:04:02
Bimla
So we're going to be talking today about equity centered contraceptive counseling, and in particular, sterilization counseling. And I want to frame this conversation with this cartoon, which may be familiar to many of you, but I want to just remind ourselves that what equity focused counseling means is that we are not providing the exact same counseling to all individuals, but we are first striving to understand what that individual might need to be learning from us, and then trying to provide the information that will be most useful in helping that individual see clearly and make decisions that will best suit their own needs.

00:06:04:04 - 00:06:41:24
Bimla
Our, official learning objectives are to recognize historical and ongoing injustices in reproductive health, to apply reproductive justice principles to patient centered contraceptive counseling and care, to make sure that you're able to effectively compare the safety and effectiveness of tubal sterilization, vasectomy, and long acting reversible contraceptives when you're talking with patients. To balance this goal of providing patient centered care with the federal consent requirements, which we do have to, observe and to identify best practices for referrals and options for procedural training.

00:06:41:24 - 00:06:53:22
Bimla
If these procedures are not, things that you are currently offering to patients.

00:06:53:24 - 00:07:42:10
Bimla
So I want to start with this beautiful piece of artwork, which is from an Australian artist. It was created in honor of Sorry Day, which, Australia recognizes, and offers a period of reflections on the injustices experienced by Aboriginal people in, Australia. And we do have a need in this country for our own sorry day to recognize that there have been historical injustices in reproductive health where people have undergone forced and coerced sterilization, and that the echoes of these experiences continue to affect patient care today, despite how much we would like to say otherwise, our patients still report that they are having biased counseling and that their personal characteristics are shaping that and

00:07:42:10 - 00:08:05:11
Bimla
the history of truly forced and, of course, sterilization is really not that far back. I grew up with a dear friend who was an only child and could clearly articulate from the earliest I could remember, that the reason she was an only child was because she had darker skin than I did, and her mother had been involuntarily sterilized when my friend was born.

00:08:05:13 - 00:08:31:14
Bimla
Our goal in, thinking about how we're counseling our patients is always to be delivering high quality health care. We want to be doing the right thing for the right patient, at the right time, in the right way, to achieve the best possible results. And when it comes to contraceptive counseling, that means we want to make sure our patients really, truly feel they have access to all methods of birth control that might be relevant to them.

00:08:31:16 - 00:08:51:11
Bimla
And when we think about what access actually means, it's a complicated concept that involves a number of different things. We need to make sure not just that our patients have heard of the method, but ideally that they've also talked to a clinician about the method and understand that that would be a safe method for them given their personal health circumstances.

00:08:51:13 - 00:09:16:15
Bimla
They also need to know whether their clinic actually offers the method, and if not, they need to know where they would go if they wanted that method, and ideally, how hard it would be for them to get there. A lot of us take for granted the fact that we in California have

a commitment to making sure that patients can access all methods without any cost or co-pay, but not all of our patients know that.

00:09:16:15 - 00:09:39:09
Bimla
And questions about affordability really run high on many patients minds even today. And it's important that we make sure we're telling anybody who's enrolled in the Family PACT program, they can have any method of their choice, and it will be free. Because the best contraceptive for any given person is the one they want to use at this point in their life.

00:09:39:11 - 00:10:18:16
Bimla
Understanding that these things can change over time and usually do. We need to approach these conversations with cultural humility. We need to avoid assumptions as we try to identify our patients individual personal goals. We need to invite them to share their personal and their family and friends experiences with these various methods. Understanding that we will have one point of view and one perspective, but that being laid out with many other, pieces of information and often the personal experience the peer, family friends will be those that are most valued.

00:10:18:18 - 00:11:06:01
Bimla
We need to understand that views on fertility vary in different communities, and we need to address internet misinformation, which unfortunately remains prevalent. Being mindful of the fact that for many of our patients, reading and thinking about numbers and probabilities are things that they haven't had as much practice with as people who've done a whole bunch of schooling. Person centered contraceptive counseling involves making sure we're letting our patients know that we are taking their preferences about birth control seriously, that we're striving to give them enough information to make the best decision about birth control for them as a person, that we're respecting them as a person and letting the patient say what mattered to them about

00:11:06:06 - 00:11:32:07
Bimla
their birth control options. And as we do that, we need to recognize there are a lot of different things that matter to my patients, and I'm sure to your patients, and that can read evolve around things related to their skin, acne, bleeding, their menstrual period, how birth control method may impact their risk of cancer, whether they can keep the method confidential, how convenient it is.

00:11:32:07 - 00:11:54:05
Bimla
Again, this issue of cost always, at the background of many people's lot, is whether the method will impact their future fertility, whether it's going to affect their sex drive, whether

it's going to affect their mood, whether it's going to cause pain, whether it's safe, whether it's going to cost, weight gain. And in many parts of the country, blessedly not in California right now.

00:11:54:05 - 00:12:28:24
Bimla
But this question about whether or not they would, potentially end up with a need to seek abortion services, whether that would be available, whether that would be something that would be acceptable to them as a person, which often leads to questions around effectiveness and how well does the method actually work? And then as we're thinking about reproductive justice and our historical injustices, we also need to keep in mind patients autonomy and if they want to try a method, will they be able to change their mind if it's not something that they're finding is working for them?

00:12:29:01 - 00:12:55:14
Bimla
Which is a reminder to me to put a star highlighting the option of IUD self removal. If we leave the thread long enough, it's very easy for patients to remove an IUD when it's not easy. It's, something that we're always happy to help with in clinic. And I would say the thing we really don't want to be doing is turning anybody away who says today is the day they would like their IUD or their implant out.

00:12:55:16 - 00:13:23:00
Bimla
So, question for all of you for with Nicole's help, I think I can, get your sense what form of birth control is currently most used in the United States. We've got some options here, and you can go ahead and vote. Abortion, pills, condoms, tubal surgery, intrauterine device. It's fun to see all the answers coming in. My understanding is we had a couple hundred people log on, so,

00:13:23:11 - 00:13:26:10
Bimla
Oh, good to see the numbers percolating up here.

00:13:28:09 - 00:13:35:15
Nicole
Yes. And I'm waiting until at least, 80 or 90% has voted. And then I will share the results.

00:13:35:15 - 00:13:37:16
Bimla
Perfect.

00:13:37:16 - 00:13:47:23
Nicole

So give me a few more seconds.

00:13:50:02 - 00:13:55:10
Bimla
Our next goal is just to try to make sure we get that many people out and voting in the next national elections.

00:13:56:20 - 00:14:05:10
Nicole
Yes. Okay, so I think we have right now at 75. So I'm going to close and share the results.

00:14:09:10 - 00:14:19:11
Nicole
So it looks like the highest is pills, 40% followed by condoms at 33 and an IUD at 18.

00:14:21:07- 00:14:38:08
Bimla
And that may reflect many clinicians experiences where they're spending a lot of time talking about pills and a lot of time talking about condoms. But in fact, tubal surgery is the most for most commonly used form of birth control.

00:14:38:09 - 00:15:17:22
Bimla
In the U.S., 11.5% of U.S. women under the age of 50 have had a tubal surgery. That means that of those who are currently using contraception. Sorry for the typo there. Or I guess we just say it differently. 22% of all contraceptive women in the U.S. are relying on a tubal surgery. So this is a really common method of contraception in the U.S., and it's a method that has been increasing in prevalence since the Dobbs decision, as there are people who are having more reasons to worry they may not be able to access abortion services if that would be needed for them.

00:15:18:02 - 00:15:28:10
Bimla
We are seeing increasing rates, both of tubal sterilization and vasectomy among young adults. Across the country.

00:15:28:12 - 00:15:54:12
Bimla
And one of the challenges that we really want to address with this webinar is the issue that very few women in the U.S. report any counseling about sterilization when asked in the past year? Not everybody gets any birth control counseling at all. Only 17.1% of U.S. women report that they got any birth control counseling in the past year.

00:15:54:14 - 00:16:31:05

Bimla
But when we look at that, even among those who are getting birth control counseling, very few of them are getting any counseling about sterilization, which means there's, a lot of possibility that people's understanding of, how sterilization compares to their other options may not really be up to date or evidence based. And so one of my big goals for all of you listening in is to make sure that when you're talking to your patients about sterilization, you have at least some discussion of this as an option, even if it's not the option that they're interested in right now.

00:16:31:05 - 00:16:49:13
Bimla
Because what we want to do is try to make sure our patients are well informed about all of their options. Now, we don't often talk about surgical sterilization in Sex Ed 101. We don't think this is a good option for teens and, that most people in this country end up wanting to have a pregnancy at some point in the future.

00:16:49:19 - 00:17:19:20
Bimla
But I would argue, given how many people end up opting for surgical sterilization, we need to be talking about it more than we are, because we have people who may not be fully informed about their options. We also have this habit of using inconsistent and inaccurate terminology. The most commonly used phrase in this country means having your tubes tied, and that isn't, reflective of what's actually being done.

00:17:19:22 - 00:17:45:09
Bimla
Sometimes people are talking about tubal ligation, that is also not usually what is being done. So preferred terms are probably in this day and age, female sterilization, tubal sterilization, salpingectomy, permanent contraception or things that I think highlight the fact that this actually is a surgery, such as a birth control surgery, or talking about surgical contraception.

00:17:45:11 - 00:18:11:05
Bimla
One of the big problems with the idea of having your tubes tied is that it makes it sound like it's really easy to have your tubes untied, and that is not true. And I know in our pre-session survey, it sounded like this audience is very clear on the fact that these surgeries tend to be permanent and not reversible, but Google is not so clear on that.

00:18:11:11 - 00:18:34:16
Bimla
And many of our patients who look on Google end up thinking like this might be a pretty easily reversible method. In fact, these misperceptions are extremely common. In a

number of studies, we've seen that 40% of women believe it's easy to reverse their tubal surgery. The flip of that, only 42% know the tubal surgery is not easily reversible.

00:18:34:18 - 00:19:00:08
Bimla
Only 46% believed it would be hard to get pregnant in the future after having a tuple surgery. And even after reviewing the federal consent form that has been in place for many, many years now and was designed to try to protect people from coercive sterilization, 34% still incorrectly believe that sterilization is reversible, and maybe that's because we're having people try to use these forms who aren't able to read easily.

00:19:00:08 - 00:19:19:24
Bimla
Maybe it's because the font is too small, but we need to be doing a better job of making sure that our patients really understand that if you have a tubal surgery, the chance of pregnancy after that is very, very low. The other thing we need to be working on making sure our patients understand is that IUDs don't adversely affect future fertility.

00:19:20:00 - 00:19:30:18
Bimla
And unfortunately, here we also have misperceptions where people still believe that if they use an IUD, it may make it hard for them to get pregnant in the future.

00:19:30:20 - 00:20:00:05
Bimla
So, what proportion of U.S. women who undergo tubal surgery report regrets or a desire for tubal reversal after their permanent contraceptive surgery? You think it's one out of 100, one out of 25%, one out of 10, 10%, or one out of 5, 20%.

00:20:00:07 - 00:20:04:05
Nicole
The poll has been launched and waiting for everyone to get a chance to vote.

00:20:05:10 - 00:20:08:20
Bimla
Thank you so much, Nicole. You're doing it all very seamlessly.

00:20:08:20 - 00:20:11:19
Nicole
Thank you.

00:20:23:08 - 00:20:32:06
Nicole
Okay, we're almost at I'll close at 80. We're at 78.

00:20:32:08 - 00:20:34:22
Bimla
All right.

00:20:34:22 - 00:20:55:09
Nicole
Yep. Good. Share the results. So it looks like the most is, one out of 20 at 5%, followed by one out of 100 at 1%. And then third is one out of 10%. And then one out of five is the last one.

00:20:56:06 - 00:21:01:04
Bimla
And again, I think that reflects a sense of, that would be great.

00:21:01:17 - 00:21:25:00
Bimla
Only one out of 100 people who had a permanent contraceptive surgery ended up with regrets. But what we have seen is that actually the number is, one of every five, it's over 20% of U.S. women who end up with a report of a desire for a reversal. This is our most recent data from the National Survey of Family Growth.

00:21:25:00 - 00:21:47:12
Bimla
You can see in red here that, we've been maybe getting better. If you're a glass half full person, you'd say like, yeah, those numbers are better than they had been. We had numbers that were up in the 26, 27% of the not so distant past, where one of every four people who are having one of these surgeries were reporting that they had a desire for reversal.

00:21:47:14 - 00:22:17:21
Bimla
But I really think this means we have some ways to go because, of those who desire reversal, less than 1% are actually able to achieve that. Fertility treatments are expensive. They're rarely covered by insurance. And so, this is not to say that this isn't a good option for some patients. Again, over, you know, 80% of people are happy, and that's better than we get with our birth control pills, where only 50% want to keep using them at one year.

00:22:17:23 - 00:22:37:01
Bimla
So it's not to say this is never a good option for patients. It's just to say we want to make sure they're really well counseled, because it's really different to have a desire for reversal or regrets, and know that you were well, counseled and well-educated before you had your procedure, then to end up with regrets and say, I wish somebody had told me.

00:22:37:01 - 00:22:58:10
Bimla
I didn't realize that was the case. So when, might tubal sterilization be a good option for someone who is sure they will never want to be pregnant in the future? And when they're thinking about their options, they may have other questions, even if they're sure they never want to be pregnant. What's the safest form of birth control?

00:22:58:12 - 00:23:30:22
Bimla
What's the most effective form of birth control? So when we're thinking about safety, when we're thinking about procedural complications, again, we want to make sure we're comparing what it's like to actually have a surgery to have another office based procedure. So if we're looking at risks of infection when you have a laparoscopic tubal ligation procedure, 3% of those procedures end up with infectious complications as opposed to 0.3% after placement of an entry uterine contraceptive.

00:23:30:22 - 00:24:06:09
Bimla
So again, about a ten fold difference there. When we look at bleeding complications, 0.8% of tubal sterilization surgeries end up with those complications. A number that's much lower after intrauterine contraceptive placement, 20 times safer to have an IUD placed. Again, doesn't mean one's the better or the worse option for any particular individual, but that if safety is a concern, then we need to recognize that the intrauterine contraceptive is definitely safer than a tubal surgery.

00:24:06:11 - 00:24:39:20
Bimla
How about pain after the procedure? We've had a lot of, coverage in the media about concerns that pain, with IUD placement may be dismissed by our patient by providers and that patients are having more pain than they're being credited with. And again, it's not that nobody has pain with, IUD placement. But when we looked at claims, from Medi-Cal clients in the state of California, we see that, pain after IUD placement is much less common than after tubal surgery.

00:24:39:22 - 00:25:05:16
Bimla
And that's not just on the day of the procedure where we might expect tubal surgery is a much more involved procedure. But two days to three months after the procedure, we see, 11.5% of those who had tubal surgery have some claims, meaning they sought health care for pelvic pain, compared to only 4.5% of those with an IUD placed 3 to 6 months after the procedure

00:25:05:18 - 00:25:40:02

Bimla
6.6% of those who had tubal surgery had claims for seeking health care related to pelvic pain, compared to 3.4% of those who had a hormonal IUD placed and 6 to 12 months again, still more common with tubal surgery. So, safety and pain, not reasons to try to have a tubal surgery. What about the effectiveness? And when we're talking about real world effectiveness, we want to be thinking about, long acting reversible contraceptives, which are shown here in blue.

00:25:40:02 - 00:26:13:13
Bimla
The IUDs and the implants and the ways those compare to injections like Depot Medroxyprogesterone Acetate shown in orange and are commonly used pills, patch, or ring is shown here in green. And this is data from the Saint Louis Choice Study, which was a prospective observational cohort study. And we saw in that—that, about 4.8% of patients who got started with a pill, patch and ring had a contraceptive failure, meaning a pregnancy in their first year of use.

00:26:13:15 - 00:26:41:03
Bimla
In their second year, that number had up to 7.8%, and by the third year, that was up to 9.4%. Well, those using IUD or an implant had low rate below 1% even out to three years. Depo-Provera, you will see, is, rates of failure that are similar to an IUD or an implant if our patients are getting all four shots a year.

00:26:41:05 - 00:27:02:00
Bimla
But it's important to note that in this, study, only half of the patients actually managed to get to clinic to get all of those four shots. So this is not really all patients who are trying to use Depo-Provera. Which is a reminder, though, that if your patient likes the idea of Depo-Provera, we do have the option of allowing them to self inject their Depo-Provera.

00:27:02:02 - 00:27:23:14
Bimla
And, a lot of reason to think patients who are self injecting are more likely to get all four shots over the course of a year than those who have to make arrangements to get to clinic to get their shots. So one of the big takeaways from this session today is the idea that surgical contraception may not be the most effective form of birth control for women.

00:27:23:17 - 00:27:50:05
Bimla
It should not be considered the gold standard. It doesn't mean that it's not the right option for some patients, but we also need to think about other options. If effectiveness is what's really important to our patients. Tubal surgery methods have evolved over time. Back in the

1880s when, Doctor Lungren first, performed a tubal sterilization to the early 2000 when we had Essure

00:27:50:06 - 00:28:12:17
Bimla
the hysteroscopic option approved by the FDA. Essure was removed from the market in 2018 due to market concerns. But for anybody who has those coils still in place, we need to be clear. Not because of concerns of safety, not because of concerns of efficacy seems to have worked as well as the other approaches we have.

00:28:12:19 - 00:28:34:15
Bimla
And then more recently, we've had, a shift towards doing more bilateral salpingectomy in part because of the belief that this will help people decrease their risk of ovarian cancer. But it's important to remember that it's not the only contraceptive method that will decrease your rate of ovarian cancer. Any of the hormonal methods decrease ovarian cancer risk.

00:28:34:21 - 00:29:03:21
Bimla
And if that's what our patients priority is, then we need to have a conversation about how to prevent ovarian cancer. But that shouldn't be a reason to—to choose a method in and of itself. So even bilateral salpingectomy has failed, all forms of contraceptive have, failed some patients. Which means that, yeah. And there have been at least five intrauterine pregnancies reported after bilateral salpingectomy.

00:29:03:21 - 00:29:42:11
Bimla
So we need to be clear that there is still some chance that you could end up pregnant when you don't want to, regardless of what form of contraception we provide. And it's important, therefore, for us to also be familiar in how to help our patients and pregnancies if they don't want to be pregnant at this point, that can be easily done using Mifepristone, which some people refer to as plan C, can be ordered either through the mail or through like brick and mortar certified pharmacy, to then followed by Misoprostol, four pills, as you can see here on the screen, that are either placed under the tongue or in the

00:29:42:11 - 00:30:03:09
Bimla
cheek or in the vagina and, left there for about 30 minutes to soak in. If this is not something you are directly providing your patients, you can refer them to PlanCpills.org, to find a telehealth provider who can. But if this is something you want to add to your practice, it's really easy to do so.

00:30:03:11 - 00:30:31:12

Bimla
And I would encourage you to, visit this other, online training abortion pill, CME, which posted at the teachtraining.org group. And just to be clear that any of our Family PACT clients who become pregnant are presumptively eligible for a Medi-cal, whether they desire prenatal care, labor delivery, 365 days of postpartum care, or they are seeking abortion, all of those services are available to them for free

00:30:31:12 - 00:30:57:21
Bimla
in the state of California. So coming back to this idea that surgical contraception may not be the most effective form of birth control, what is the data that's leading me to say that? So one of those is a study we did of Medi-cal claims data. And what we saw there was that within one year, 2.9% of our Medi-Cal clients had, claims related to pregnancy.

00:30:57:23 - 00:31:25:15
Bimla
And by three years post procedure, 8.4% had claims related to pregnancy. So I would say those are numbers that are really far from 100% perfect. And make us think there is still some chance that, you could get pregnant, even if you go through all the days of work and pain of having a tubal surgery. Is it just that one study that makes us think that.

00:31:25:19 - 00:31:49:10
Bimla
No, there's also data, actually, from the National Survey of Family Growth. This is actually four separate, data sets, that we, analyze them and put them together in this one publication that was published, in 2024, in the New England Journal of Medicine evidence paper. In this paper, we did a survival analysis of time to pregnancy.

00:31:49:10 - 00:32:15:15
Bimla
After, somebody reported a tuple sterilization. Participants were censored at the time that they tried to have their tubal reversed, or they had any infertility treatment, or they had something else, that would have prevented pregnancy, like a hysterectomy or a bilateral oophorectomy. And this is what that data shows. Again, very far from nobody ever gets pregnant.

00:32:15:19 - 00:32:30:21
Bimla
It's not to say that, it's not still a highly effective method, but depending on the wave, we saw rates of pregnancy within one year that ranged from 1.4 to 2.9%.

00:32:30:23 - 00:33:08:12
Bimla

In the most recent, data from the National Survey of Family Growth. And I should be clear, this is not the most recent, data, because NSFG is always continuing on and there are more recent waves. We just have not been able to analyze those as yet because they are no longer publicly accessible. So from our most recent publicly accessible National Survey of Family Growth data, we can say that 2.9% were pregnant by 12 months after tubal sterilization and 8.4% reported for a pregnancy by 120 months, or five years after their sterilization.

00:33:08:14 - 00:33:53:22
Bimla
Any pregnancy at all across all of those waves was reported by 2.9 to 5.2% of participants. How does that compare to our medical claims data from similar time periods? It's actually pretty aligned pregnancy within 12 months in that California, Medicaid or Medi-Cal data was 2.6% in the National Survey of Family Growth. It was 2.9%. So that's a whole lot different than what we're often, historically been quoting from the 1996 CREST trial, which was, done in academic centers, which reported that less than 1.5% of these sterilization procedures failed within five years.

00:33:53:24 - 00:34:18:20
Bimla
And I think it's important for our patients to know it doesn't mean it's not a good option, doesn't mean it's not a good option for them. It just means that it isn't something that will never fail. Other data on this, topic comes from Utah, where we had some colleagues look at, 1752 permanent contraceptive procedures that had been done in their health system.

00:34:18:22 - 00:34:44:00
Bimla
Of those, they identified 693 that had interval placement of the Filshie clips. And there they found 15 pregnancies or again, a failure rate that was above 2%, 2.2%. What they published was, drift down to look further about those who had their Filshie cliffs placed per instruction, and when the Filshie clips were placed per instruction.

00:34:44:00 - 00:35:12:07
Bimla
The failure rates are lower. But I don't think our patients necessarily know when we're taking to them to have a procedure whether we're going to succeed or not, and I think we have to be honest with them about failure rate for all comers, because not every time these clips are attempted to be used are they placed perfectly. So, conclusion of this part of our talk is that tubal sterilization appears less effective than many have anticipated.

00:35:12:09 - 00:35:28:21
Bimla
So how does surgery compare to an IUD? And this is one thing that I would also hope that you guys are taking away from this talk. As you think about your approach to counseling, is

that you're always clarifying for patients, whether they're thinking about having an IUD placed or they're thinking about having a tubal surgery.

00:35:28:21 - 00:35:56:19
Bimla
What this comparison is, and what we saw among our California Medi-Cal clients, is that those who had a copper IUD placed were no more likely to end up pregnant. And in fact, look to be a little bit less likely to become pregnant than those who had tubal surgery. You can see the adjusted incident rate ratio here is below one 0.92, although that confidence interval does cross one, meaning it's not a statistically significant difference.

00:35:56:21 - 00:36:20:10
Bimla
And the hormonal IUD, which we know is usually more effective than the copper IUD, was significantly less likely to be followed by pregnancy than people who had tubal surgery. With Medi-Cal funding. In fact, our hormonal IUD users were 28% less likely to become pregnant than those who had tubal surgery. Which doesn't mean you should never have a tubal surgery.

00:36:20:10 - 00:36:31:08
Bimla
It just means that because you never want to get pregnant and effectiveness is super important to you. Be the reason that you're making that choice.

00:36:31:10 - 00:36:55:15
Bimla
This is that data again. Looking at the absolute pregnancy rates. And again, we saw more pregnancies following IUD placement than, might be expected in the state of California as well. Although, again, the IUDs were more effective than the tubal surgery. So when we're comparing contraceptive effectiveness in the first year per 1000 patients, what do we know about all the data?

00:36:55:15 - 00:37:28:05
Bimla
That's been put out there? We know that the contraceptive implant that slides into people's arms looks to be actually our most effective option. With failure rates of 0.2 to 0.5 per 1000 patients, vasectomy, it's likely the next most effective option, with only 1.5 per 1000 failures. Hormonal IUD looks like it comes out ahead of tubal sterilization surgery, at least in our data from about a decade ago.

00:37:28:07 - 00:37:58:12
Bimla
And, then we have the Non-Hormonal IUD. And then just so we're clear, periodic abstinence, though there are some folks who end up saying that would be their most

effective option. Does have a pretty high typical use failure rate, so a reminder that Nexplanon is easier to place than an if it's a single rod of, you know, gestural, it doesn't have estrogen, so it has no risk of causing blood clots for people who have chronic medical conditions.

00:37:58:14 - 00:38:20:15
Bimla
I should have updated this slide because just recently the FDA effect, updated the labeling. So it's now not just labeled for five, label for it is now labeled for five years. It consistent with the data that we've had for a good number of years, 80% are happy and want to continue at one year. That's a similar continuation rate to IUDs.

00:38:20:17 - 00:38:47:14
Bimla
Again, better than pills, patch, or ring. Similar happiness to what we see with tubal sterilization. The big difference is that you can get rid of your implant easily if you would like to. Most common reason for discontinuation is spotting. And if you don't like it, we can take it out. So one last question for you: When were you trained to place and remove contraceptive implants?

00:38:47:16 - 00:39:32:07
Bimla
Do we have anybody, who was trained in the last year, 1 to 5 years ago, 5 to 10 years ago, more than ten years ago? Do we have anybody who is providing family planning services, who has not yet completed the Nexplanon training? How the workers thank you so much.

00:39:32:09 - 00:39:57:02
Bimla
So it looks like we've got some people being shy on this one. And we can move on because it looks like we have a good number of people who have not yet completed the Nexplanon training. And I would say if I have one takeaway for you from this presentation, it would be that it is really easy to get trained, and I am trained originally,

00:39:57:02 - 00:40:18:12
Bimla
I'm a board certified general internist. I don't really like procedures. I don't like blood. Nexplanon placement and removal is totally my type of procedure, and you can get trained to just visit this website and you can get signed up for training today. And again, this is a really important service to be offering your patients because it is more effective than tubal surgery.

00:40:18:12 - 00:40:47:06
Bimla

And if they don't like it, it's easily reversible. And it's very, very safe even for the patients I take care of, many of whom have chronic medical conditions. Really, the only contraindication to use of an implant is current breast cancer. So lots of information for us to compare and contrast for our patients. I want to share with you a resource that hopefully can make that easier for you to do when you're speaking with your patients.

00:40:47:08 - 00:41:25:01
Bimla
There's a website we developed called Advancing Access. And it's freely available to you if you go to AdvancingAccess.ucsf.edu, there is a side by side chart you can download that puts all of the information together about how tubal surgery compares to the other long acting methods. But if it's easier for folks to click through the—the aspects they're actually interested in, whether that's the safety, whether that's how long they have to wait to have it placed, whether it's how long it takes to recover from the procedure, whether it's pain or, how well it works.

00:41:25:01 - 00:41:46:14
Bimla
All of that information is there and available. And I think what I would really like to see as we move forward is that all of our patients have reviewed all of this information that might be useful as they are trying to make their own decisions before anybody goes forward with a surgery that will not allow them the chance to change their mind.

00:41:46:16 - 00:42:15:23
Bimla
And so with that, I'm happy to turn the, microphone and slide sharing over to my colleagues on the other side of the country who it's been a pleasure to collaborate with. I think I, have stopped sharing. And hopefully you are now able to take it away. All right. Thank you so much. That was excellent. Hi.

00:42:15:23 - 00:42:48:16
Finn
My name is Finn. I'm a nurse practitioner out in Maine. And, start us off with some information about vasectomy. So fun little comic here. And people come in right with a lot of, a lot of questions about vasectomies. You know, is it castration? Does it affect libido? How about erectile function? And so, you know, when we're doing counseling for our patients, it's really important to help them understand what this is and what it isn't.

00:42:48:18 - 00:43:23:21
Finn
As we're looking at sterilization methods, like Bimla was saying, vasectomy is more effective than tubals. If, proper use is done, as in, there is a backup method for the first three months, lifetime is about 1 in 2000 pregnancies with a vasectomy versus somewhere around one and 200 with the tubals. So vasectomy, usually a three visit service.

00:43:23:23 - 00:43:49:09
Finn
There's an intake visit and a consult. This is where we get an idea of the patient's goals and perceptions about vasectomy. We do education. We talk about pre and post procedure recommendations. We get medical, social history, trauma of course we always want to be coming from a trauma informed model. Oftentimes there is a physical exam done here if this is an in-office visit.

00:43:49:11 - 00:44:13:05
Finn
Just to make sure that the vas deferens are easy to find, we go through informed consent, talk about, what support it's going to look like. And that exam is, part of what determines if a patient is appropriate for an outpatient vasectomy. The other thing being that this is done under local, and so we go through that as well.

00:44:13:07 - 00:44:48:06
Finn
Then they have their procedure visit and then their, microscopy follow up. You know, when we're talking about informed consent, shared decision making. So, with shared decision making, we want to hold space for the patient to be connected to the process. We want to offer all of the options, looking at values and preferences, I think Bimla did an excellent job of kind of going over how we can hold all of that for our patients.

00:44:48:08 - 00:45:20:09
Finn
And then, you know, in—in giving, doing informed consent where we're maintaining awareness of that history of forced sterilization, we're educating about the procedure, risks, benefits. We answer the questions, we make sure that the patient understands what's going to be happening to their body. And that they're clear and confident in their decision. So getting a history in the console, going through preconceptions.

00:45:20:09 - 00:45:47:13
Finn
So, you know, does a vasectomy involve losing your testicles? Does it, make you impotent? Does it make it so that you get prostate cancer? Lots of things that, there—there's lots of misunderstandings out there. And we, we try to really carefully, reassure our patients that this is not going to affect their sexual function.

00:45:47:15 - 00:46:12:24
Finn
There's no cancer risk. There's no cardiovascular risk. That was a myth for a while. You know, overall, that this is very safe. You know, we do talk about anytime we're breaking skin,

there is a risk of infection. Generally very low. This is considered a minimally invasive procedure with a low risk of infection.

00:46:13:01 - 00:47:06:07
Finn
Of course, our patients, you know, who have suboptimal glucose management if they're on immunomodulators, if they have prosthetics, you know, those sorts of folks, those may be people you consider a pre-op dose of an anti-microbial for. You know, again, just taking patient, history into account, but generally that's not something that's, that's needed. Looking into history of trauma, healthcare trauma, sexual trauma, because of the ways that people access reproductive health services and the needs, people with uteruses and vaginas and vulvas tend to have a lot more exams, have a lot more, interaction with healthcare.

00:47:06:13 - 00:47:31:01
Finn
People with penises and testicles tend to have very little, they're—they're not, you know, they may like, turn and cough once for a hernia check. But but it's usually pretty uncomfortable for them to—to have this area of their body examined and touched. So that's something to be really aware of. And, and thinking about, and preparing for patient needs during the procedure.

00:47:31:01 - 00:48:02:00
Finn
So, you know, going over this is done under local, it is possible to get it done under general anesthesia. However, depending on insurance, depending on cost, depending on availability, that—that can really change things. But if somebody feels like truly, I'm not going to be able to handle doing this under, just local with an anxiolytic, then—then that's a really important thing to know.

00:48:02:02 - 00:48:26:23
Finn
We go over the procedure in the console. I think the images are huge. We talk about the location. This does incision. Incision, we are moving away from saying incision because most of us activities now are done without a scalpel, but there is still a skin opening. You know that, like, no scalpel and no needle vasectomy label can be misleading to people.

00:48:27:04 - 00:48:52:11
Finn
They think, oh, well, then you don't have to, like, make any kind of break in the skin. But that's not true. We do have to. You know how it's done. Why it works. We want people to bring supportive undergarments. Don't take aspirin for ten days before because that, you know, increases bleeding risk. They're going to need some time afterwards.

00:48:52:11 - 00:49:23:19
Finn
A couple of days, I tell them, really chill on the couch. Compression ice. No intercourse for 7 to 10 days, and vasectomy is not permanent right away. That is something that we really have to emphasize with our patients. For most providers, that's what we're going to say about 25 ejaculations in three months. And then we want to check a semen sample because, sperm survive in those upper parts of the tubes in the prostate for a good long while.

00:49:23:21 - 00:49:34:21
Finn
And so when we talk about, like, post vasectomy pregnancies, it's.

00:49:34:23 - 00:50:03:00
Finn
I don't have the I don't have the data in front of me. But it's more common that that is happening directly after somebody has had a vasectomy. And then the, there isn't another backup method on board until they've had their semen analysis. And like I said, no link between vasectomy and prostate cancer, cardiovascular disease, no change in sexual function or testosterone levels, just letting them know all that.

00:50:03:02 - 00:50:40:19
Finn
Patients ask about reversal a lot. Similarly to tubal, they should expect this to be a permanent option. There are a lot of myths that vasectomy is easily reversible. It's not easily reversible. Reversal is costly. Pregnancy rates after reversal are pretty varied. There's about a 6% rate of seeking reversal after getting a vasectomy. So, you know, the regret rates are a lot lower with vasectomy than with tubal.

00:50:40:21 - 00:51:05:03
Finn
So certain factors that predict, reversal success. So older patients have lower success the longer it's been since the vasectomy. And then of course, partner fertility. So when we're looking at an older patient with a longer time since their vasectomy, and then if their partner is then also older, you know, so it's a, it's a two sided process.

00:51:05:03 - 00:51:11:01
Finn
Of course, getting having a successful pregnancy.

00:51:11:03 - 00:51:43:09
Finn
With regret. Post vasectomy, one of the biggest reasons that was cited for regret post vasectomy was somebody getting into a new relationship, particularly men getting divorced

and then coming into a new relationship and then wanting to, parent a child, a biological child with this new partner? Other things that increased regret rates were people who were childless at the time of their vasectomy or under age 30.

00:51:43:11 - 00:52:08:12
Finn
However, when we're talking about regret rates, all of this is pretty low. So if we talk about childless, men, there was quite a large study that was done immediately after their vasectomy. Their regret rate was 4.4%, and at the time of the study, the regret rate was 7.4%. So a little higher, but still less than tubals.

00:52:08:14 - 00:52:40:21
Finn
And in childbearing, people in the study, their regret rate after was only 1.2%. And at the time of the study had only increased to 3.5%. And again, about 6% of all people who get vasectomies do seek reversal. So, while regret is—is, it's not like it never happens. It is a lot lower, than when we're looking at, tubals, which is, you know, kind of the other surgical sterilization option.

00:52:40:23 - 00:53:07:01
Finn
When we're doing a physical exam again, thinking about being trauma informed, talking about bodily and genital self-awareness, some providers do the counseling virtually. So this first kind of appointment with the patient is virtual, and then the exam is just done on the day of the procedure. In that case, there just has to be a disclosure that rarely a patient may need to be referred elsewhere.

00:53:07:03 - 00:53:38:04
Finn
For certain, physiology, an in-office minimally invasive procedure just might not be possible. So that's just something to consider. You know, does the patient get, an in-person consult, which means going to an office and having to have, you know, transportation? Although then they are kind of reassured for sure that they are a good candidate for the exam.

00:53:38:06 - 00:54:03:14
Finn
The other benefit is that if they, do their console in person and they're able to sign their forms in person and all of that, then the day of their exam, when they take their Valium, before they, you know, have their procedure, they can take that, you know, enough in advance that they don't have to be waiting around at the clinic.

00:54:03:16 - 00:54:27:23
Finn

Just a note on state and federal insurance. When you're signing the consent for sterilization form, make sure that it is not expired. This is happened at clinics. Sometimes, you know, it's just it's a little expiration date up in the corner. Somebody overlooks it, and then the patient signs it, and then it's invalid. And then they come in for their procedure.

00:54:27:23 - 00:54:55:16
Finn
Oh, your, you know, consent is invalid. Now, you have to wait a whole nother 30 days, to get this done. This is, for California residents who are Family PACT and Medi-Cal clients. So again, noting the expiration date on the form, this is what it looks like. Has to be signed at least 30 days before their procedure can't exceed 180 days.

00:54:55:16 - 00:55:16:22
Finn
Right? So, they have to wait at least a month, but if it's been more than 180 days, then they have to have a new console and sign the form again. So I wanted to go in a little bit. I know this is about counseling. And to me, in order to do effective counseling, you have to know what the procedure looks like.

00:55:16:24 - 00:55:40:14
Finn
And I think not as many people are familiar with what vasectomies look like. So when we're looking at doing a vasectomy, under local, these are kind of the techniques for doing local anesthesia. The no needle option is the—the MadaJet, as you can see on, figure B here. And that is, air injected lidocaine.

00:55:40:16 - 00:56:07:23
Finn
The pros there. You use less lidocaine. You don't have to use a needle. You can tell patients you're not using a needle. It can create a small hematoma at the skin level. But, you know, I think people really like them. There's no data that says there's better outcomes with the MadaJet or with a needle. I think a needle is also a totally fine way to do, I mean, that's how I do it.

00:56:08:00 - 00:56:43:15
Finn
But, yeah, we put lidocaine on the skin and also around the vas deferens. Then we isolate the vas deferens. Conventionally, it was done with a scalpel and an incision. Generally. Now, most, vasectomies are minimally invasive. The official no scalpel vasectomy term has to be done exactly in the steps without any variation, in the way that it was outlined by the person who coined the no scalpel vasectomy.

00:56:43:15 - 00:57:03:08
Finn

So minimally invasive is, essentially no scalpel. But if there's any variation in the step. So most people call it minimally invasive. And the American Urological Association recommends either minimally invasive or no scalpel. That's really trying to move away from that. The scalpel incision.

00:57:03:10 - 00:57:34:17
Finn
This is kind of what it looks like as we're isolating the vas deferens. So you can see there's a very small opening there that's made grasping the vast difference and bringing that up out of the scrotum. Then we need to occlude the vas deferens. So there's different ways to do that. Cautery. Something called fascial interposition. So you bring, sperm, all fascia, spermatic fascia in between the two ends, usually.

00:57:34:17 - 00:58:07:00
Finn
Then you clip that, the AUA guidelines recommend doing some kind of, occlusive technique that combines cautery fascial into position and usually clips as well. Basically what they don't want is for people to just cut out a piece. And I think that's often what, or just clip it. And again, with the myths, people think, oh, you get a, vasectomy, you just get a little clip put on that, they can just take off.

00:58:07:00 - 00:58:32:19
Finn
Well, now that has a super high failure rate. So we we don't want to do that. And if we just cut out a small piece, the vas deferens segments can actually grow back together. So that's what some of these, occlusion techniques look like. That's what it looks like in real life, doing cautery into the mucosa of the, vas deferens.

00:58:32:21 - 00:58:58:11
Finn
And then this is what facial interposition looks like. The fascia is pulled up over the end of the vas deferens and then clipped. And so you can see that one end of the vas deferens is clipped away from the other end. Therefore, they can't grow back together. This is what the procedural opening looks like. Very small, very minimal.

00:58:58:13 - 00:59:25:01
Finn
There providers who do not suture this, I do throw in one small stitch that's dissolvable. I think, people feel a little more comfortable when they, see a stitch rather than a hole. Even though generally without a stitch, it's going to heal just fine. Potential complications. So really important to, counsel on all of these.

00:59:25:01 - 01:00:01:19
Finn

Of course. You know, when people are coming in for their consult. Of note, all of these are pretty low risk. I typically tell people that the one that's most common is, bruising or hematoma. Hematoma, formation occurs in somewhere between 0.1 to 2%, of people getting a vasectomy. So pretty low as far as complication rate goes there.

01:00:01:21 - 01:00:32:15
Finn
Anecdotally, most of those people did not stay on the couch long enough. And they got up and they were up on their feet and running around, and then they ended up with bruising. So again, low complication rate, their, infection rate also super low, about 0.2 to 1%. There was one study that said up to 4%.

01:00:32:21 - 01:01:13:13
Finn
It's a little tricky because, outcomes are different with the different techniques and with different providers. But the, the larger study that that seems to be more commonly quoted is somewhere from point 2 to 1% risk of infection. Congestive epididymis. When you say that people's eyes get big, they're scared. But really, you know, there is going to be some degree of feeling of fullness, afterwards it does resolve, for some people it's more uncomfortable, especially if they do get like a true epididymitis.

01:01:13:13 - 01:01:44:10
Finn
It might as like, you know, inflammation happening. But most often this resolves just fine. And, it's, you know, they, they handle it pretty well. A sperm granuloma. And this is something to know if you're especially if you're doing an exam, a testicular exam on somebody who has had, a vasectomy. This is a small ball of scar tissue on the vas deferens.

01:01:44:12 - 01:02:07:23
Finn
It is caused by the body's reaction to any sperm leaking out of the area. And really, you know, it's not painful. It's not dangerous. But it does feel like a small ball of tissue there. And so I always counsel patients. You know, you may feel this as long as it's not on your testicle. It's something to be less.

01:02:08:00 - 01:02:34:15
Finn
Less worried about. Persistent fertility. We really want people to get their post vasectomy semen analysis done. You know, we want them to come in at that three month mark, and bring their sample, and we look at it under the microscope for my patients that are further away, especially if they do have, some form of insurance and they don't want to drive all the way back to the clinic.

01:02:34:15 - 01:02:56:09
Finn
You know, I, I live and work in Maine. It's a, it's a spread out state. I have some people who drive a couple a few hours. Then we can always order it to a local hospital lab to, but we really recommend getting that done. Because then they can be confident that their partner, if desired, can discontinue their other contraception.

01:02:56:11 - 01:03:19:20
Finn
But not before that. Any time we use, lidocaine, of course. Risk of reaction. Their post-vasectomy pain. You know, we are, as I told my patients, mucking about in tissue and there will be a little bit of soreness, but generally it's very manageable with ice and Tylenol. And need for hospitalization is extremely rare.

01:03:19:20 - 01:03:54:11
Finn
Extremely rare. You know, if somebody has an infection that they ignore, you know, some people get hematomas and they go in to be seen, but, the—the risk of actually being hospitalized for something like that is, is almost nothing. Again, talking about the post procedure follow up, we don't consider a vasectomy failed until, we see motile sperm a full six months post-op.

01:03:54:13 - 01:04:26:18
Finn
So usually if somebody comes in at their 12, 12 week spot, and there's any motile sperm, we have them come back in another month. If I see a very rare non-motile sperm, you know, 1 or 2 on a slide, I'm not that worried about it. Assuming that the sample is, not too old, so it really needs to be, capped at body temp and less than two hours old to have a good, PSA done.

01:04:26:20 - 01:04:39:14
Finn
And with that, I am going to hand it over to Lindsay to talk about, benefits of getting vasectomy into your practice and, some pearls on that.

01:04:43:11 - 01:05:06:07
Lindsey
All right. Hi, folks. Unfortunately, I'm having some technical difficulties with my camera, so, you'll have to, see my face at another time. But I'm happy to talk to you about, adding vasectomy to your practice. This is something that I've been able to do at a few different practices, in, a few different New England states.

01:05:06:18 - 01:05:36:20
Lindsey

And, I went back to speak with administrators, as a part of developing this portion of the presentation, just to kind of get pearls from those individuals who were part of making that happen, you know, for their, for their organization. So that's, you know, partly what I'm, you know, I'm sharing my personal experience of, doing that and then, you know, just following back up with, folks who I've done it with.

01:05:36:22 - 01:06:03:03
Lindsey
So, you know, as, as the slide here talks about, that it, you know, it's minimally invasive. It's permanent. It doesn't cost a lot to start it up. And it's, not as costly for patients, especially when done outpatient. And that it can be a way if you're looking to, you know, increase your retention of your professionals, whether they be the prescribers or the people who are assisting the prescribers.

01:06:03:05 - 01:06:25:07
Lindsey
So, you know, medical assistance, nurses, etc., who can learn new skills or assist in a new procedure, I think are more interested in sticking around with their job. So that's kind of a, a positive to that. So, you know, speaking with providers who have become vasectomy, skilled, they like expanding their skills and scope.

01:06:25:09 - 01:06:53:19
Lindsey
And just, you know, being able to increase access to patients in that way. And then I think, you know, just noting, our political climate that there I have seen an increase in patients, of all genders coming in and asking about, more permanent or long term, contraception. And so I think, you know, adding this not only, is a way to diversify your clinical offerings, but also meeting the moment.

01:06:53:21 - 01:07:36:14
Lindsey
And so that's just, you know, a sidebar about that. So, on my next slide, it just has, a discussion of kind of a, a stepwise process of how do you add that to your practice. So, and I'll kind of go into each point here, and then know. Yeah, that's great. Thank you. So I think it's really important to, you know, if you have a clinical champion, making sure that that person has the support of admin, of billing, you know, other decision makers in the practice, because you, you know, if one clinician is sort of leading the charge, but then let's say that person goes out on

01:07:36:14 - 01:08:14:12
Lindsey
leave or leaves the practice or whatever, we want the service to, be able to continue on. And so, you know, thinking about how, how are you going to secure the funding to, frontload getting this started, buying your equipment, paying for training. And then when I talk about

training of the whole team, you know, wanting to make sure that the front desk staff have enough of a good script and confidence and training to be able to on the fly, answer patient questions, or do appropriate screening of patients, or know when to escalate, a patient issue or question to the office nurse or one of the providers and

01:08:14:12 - 01:08:37:02
Lindsey
then similarly, you know, training for the medical assistance or the people who are going to be assisting the clinician doing the procedure. And then of course, assisting or training the people who are actually performing the procedure. So next slide, so training provider. So—so I've done this in a couple of different ways. I've in two locations, been a salaried staff clinician.

01:08:37:02 - 01:09:06:07
Lindsey
So had my own patient panel there. And, you know, trained people on the job, with me kind of like, you know, set aside some days and they'd travel to my clinic or I'd travel to their clinic. And then I've also been hired as a contract trainer specifically to travel to that clinic, and train the provider there who was learning the skill, you know, helping them develop their clinical documents and their protocols and, education materials.

01:09:06:07 - 01:09:28:03
Lindsey
And it's really helpful, to involve the clinicians who will be doing the learning in the development of their policies and procedures so that they can kind of take what's standard and then tailor it to their own organization. And it just, I think gets more buy in, from everybody on the team if they have some ownership over, you know, implementing a new service.

01:09:28:05 - 01:09:55:20
Lindsey
And there are a lot of different training documents that, can be used to prepare the learner before they do hands on training. And one idea, is to kind of get the learner trained up in, assist, observing and then, assisting and then being the lead and consultant because once they get great at that, the trainer doesn't need to be a part of that anymore, especially if you're paying a contractor to come on site.

01:09:55:22 - 01:10:34:14
Lindsey
And that clinician who is on site will just kind of build up a panel of vasectomy patients, and then the trainer can come down on a designated vasectomy day. And so, you know, then they'll have like two, three, 4 or 5, patients. And so you can have a, you know, you can try the model of having a heavy, procedure training day, which, in my experience, has been superior for learners to be able to see them, in a chunk of procedures rather than one, and

then waiting a few weeks and seeing another and then waiting, you know, just, you know, for style of learning.

01:10:34:16 - 01:11:05:24
Lindsey
And then typically what I've done, is, you know, and, and it's tricky to put a number on procedural training. And I think that there's a lot of discourse, right now in, especially in sexual and reproductive health and an abortion care about leading or leaning away from, specific numbers, because some people come in with some really good proprioception and spatial skills and spatial awareness, and they're just really great with hand skills.

01:11:06:01 - 01:11:35:24
Lindsey
And then there are other providers who, don't necessarily have it. It's harder for them to master that. And so those would be the people who probably need more numbers. And so just kind of when you have an adult learner, a clinician learner, it's great to have a collaborative relationship, you know, to discuss, you know, what is your goal for today and kind of help them come to a reasonable assessment of what their level is, as they move through their training?

01:11:36:01 - 01:12:01:00
Lindsey
And so also incorporating the clinician learner as a teacher of like, if you have a student or if you have the MA in the room, they can kind of teach that person what's happening. And that's the way for them to own the knowledge of—of what they're actively learning. And so you'll kind of see here, that I'll lead and kind of slowly have the learner take over, different aspects of it.

01:12:01:02 - 01:12:26:06
Lindsey
And then I'll do one side, you know, further down the line in their training, I'll do one side and then they'll do the other side, and then I step back as the lead and I become the assist. And then at a certain point when they've trained, their MA up to speed. Then I'll just be on site and, then they just have access to me in the building, but they're, alone in the room with their, designated assistant, and they're doing the procedure.

01:12:26:06 - 01:12:41:21
Lindsey
So, you know, we put a ballpark around 20 procedures. And then again, just to reiterate that their independence is determined, collaboratively. So next.

01:12:41:23 - 01:13:01:10
Lindsey

Okay, so I think that, you know, we touched on this a little bit, making the, documents specific to your clinic and, your state laws and all of those things. And then Finn already mentioned the, making sure that the Medicaid consent form, is up to date. And, you know, what is your consent form in your clinic look like?

01:13:01:10 - 01:13:21:06
Lindsey
And I guess that also depends on what kind of consult is that you're doing, whether it's a tele consult or in-person or that kind of thing. And then just a reminder about the scripts that you want to offer your colleagues. So who's going to take call for the very, very, very rare, you know, triage call about, oh, vasectomy procedure

01:13:21:06 - 01:13:46:12
Lindsey
complication. How do they feel that? When do they call the lead clinician, etc.? You know, just creating your EMR templates, for that. And there are some really nice pre crafted ones, then you can kind of tweak to your practice specifically, you know, what are the front facing like patient materials going to look like. So that's another thing that you want to you know, just kind of get excited about.

01:13:46:14 - 01:14:11:00
Lindsey
And I guess we can go to the next slide. So this is another thing that you want to think about when you're adding this. Eventually, what will this what will you use for your model? Will you have a specific day of like, all right, that every Thursday is vasectomy day or whatever, or will you integrate it, throughout your day, interspersed with other types of visits?

01:14:11:02 - 01:14:28:16
Lindsey
And I think, you know, if you have a very efficient team or if you have a very high demand or high volume, you could certainly do, a heavy procedure day. And if you have enough equipment, and your team is quite efficient, you could theoretically get, you know, a dozen or more vasectomies done in an eight hour day.

01:14:28:16 - 01:14:51:08
Lindsey
That's a lot of standing. And, you know, just thinking about, like, body mechanics and that sort of thing. But, it also I would say is maybe you could change your, flow, like you could do, like the heavy procedure day while you're getting the people trained up and then move into an integrated model. It really, you know, really depends on how much money you have to buy equipment.

01:14:51:08 - 01:15:09:01
Lindsey

You know, thinking about autoclave. So if you only have two, you know, vast forceps, you have to get the first one into the autoclave so that by the time the third patient rolls around, you're not having to do it old school style, which is. I say that, as a personal pearl of wisdom. This happened to me last week in my clinic.

01:15:09:01 - 01:15:25:17
Lindsey
I was training somebody, and I was like, where's the sweet piece of equipment that I love to use? And I was like, oh, darn, we're going to have to do it the old school way, which is not my favorite. But anyway, so that that was a learning moment and, I was like, yeah, maybe we can have more than, two full kits.

01:15:25:19 - 01:15:51:15
Lindsey
So anyway, that's—that's something to think about. Procedure flow wise. And then when you're kind of frontloading, money to buy, equipment. All right. Next. So scheduling, you know, there for many practices there are going to be three appointments needed. And so helping your schedulers know what are the correct time slots with which provider who can do them.

01:15:51:16 - 01:16:15:24
Lindsey
You know, who signed off for this type of visit or that type of visit at one of the clinics where I work, all of the, advanced practice clinicians are signed off for, doing the vasectomy consults and initial exam. Incidentally, at that clinic, only, a physician is doing the vasectomies. And then all of the, APCs are doing the first and third visit.

01:16:15:24 - 01:16:34:15
Lindsey
And the third visit is, just the, you know, looking under the microscope and doing this, sperm count, at another clinic where I work, it's that, you know, APCs are doing, you know, the whole kit and caboodle, but they actually, they don't do. And I think it has to do with their Clea designation.

01:16:34:15 - 01:16:55:12
Lindsey
They send, they send, their specimens off to a lab that can, read them quickly for their patients. So anyway, that's just kind of some, you know, detailed information about clinic specific things, you know, determining who is doing which part of the visit and making sure that they have the right information to be doing the visit.

01:16:55:14 - 01:17:14:03
Lindsey

You know, do you train your, do you train your nurse or your MA to do the initial counseling and going through the consent form, or is that something that the provider does? You know, that sort of thing? Certainly the provider would be doing like a pre-vasectomy exam, if that's what your practice has determined to do.

01:17:14:05 - 01:17:39:22
Lindsey
And then making sure just timing wise that you're, signing the consent forms with enough, lead time for, you know, Medicaid to pay for it. And then who's getting the room set up for the clinician? Are they doing it themselves? Has the person learned proper sterile technique? All those kind of things. And then, it's sometimes really nice to have pictures of what a kit should look like, what a setup should look like.

01:17:39:24 - 01:17:58:10
Lindsey
Having the To-Go bags with the proper dressings and the specimen cup, ready to go, or with the bacitracin in it. You know who's prepping the patient? Will the medical assistant do this for the clinician? Well, you know, are they going to be the ones to take the peanut stuff out of the way? Use the hippo cleanse to kind of cleanse the surgical field?

01:17:58:10 - 01:18:19:01
Lindsey
Or is the clinician going to do all of that? You know, so kind of working through all of these things and some of this stuff is like you learn as you go, but these are important things to be thinking about upfront. We can go on to the next one. And this is regarding billing. So the first one, you know, the first visit and some people will charge for the first visit.

01:18:19:03 - 01:18:36:17
Lindsey
Some people charge just for the second visit, kind of a bundle. And visit one, two and three will just be paid for at that time. Some people will charge for the consult a little bit, and then they'll charge it the bulk for the, for the best activity itself. And then the, follow up. The microscopy is free.

01:18:36:19 - 01:18:58:16
Lindsey
So it really varies, depending on what people are using. But definitely these are the codes that you'll want to use, for your initial counseling. And then your procedure code and then what is your ICD ten for the, that's after the encounter. And then these are just kind of like a range of what the cost can be.

01:18:58:18 - 01:19:18:00
Lindsey

And so, you know, at a health center versus a private office. And then, of course, I didn't include anything that would include, like an O.R. fee, because that would be, you know, that's just an extraordinary fee. But that's those are patients that we're sort of risking out of the outpatient, setting. And then, yeah.

01:19:18:00 - 01:19:39:18
Lindsey
So, so I guess just kind of noting what is important. Per state and in your sort of practice area and your population, all right. We can look at the next slide. The other thing to do, is to see who—who is going to be providing the service. Is this something that you expect all of the providers to be able to do?

01:19:39:18 - 01:20:01:19
Lindsey
What will that take to train them all up? What kind of pace of training everybody. Can EPCs do this? In your state? I think that's, a good thing to learn upfront. And then, you know, figuring out the budget to either bring in, contract trainer, or, you know, send people somewhere to get some training done.

01:20:01:21 - 01:20:31:22
Lindsey
You know, I think cross-pollinating and working together with other programs is, generally always a benefit to us in, sexual and reproductive health. And then, knowing who your local referrals are going to be as far as, you know, sort of out of range complications or if you have a, odd or interesting finding on an exam that you want a urologist to take a look at, just kind of getting your provider who's in your corner, who is going to be doing this?

01:20:31:24 - 01:20:59:09
Lindsey
All right. And then other considerations. Next slide. You know, knowing what your requirements are and these are sort of specific from, from managers or administrators or executive directors that I spoke with. You know, so what is your a fixed, fee that if you work in FQHC, are there are creative ways to subsidize the fees for people who are uninsured or under-insured.

01:20:59:11 - 01:21:22:04
Lindsey
And then, you know, what is your reimbursement allowance? You know, just kind of taking all of those into account before you try to launch. It would be premature to launch if you don't haven't taken these things into consideration. And then on the next slide, this is, you know, this is another way to drum up, like you need to have the patients to provide the service.

01:21:22:06 - 01:21:43:22

Lindsey
How are you going to do this? Do you have somebody in your practice who's quite talented at this? You know, I've, I've worked at different locations, as I've said, and, there have been different levels of skill as far as, like getting the word out. Funny word of mouth anecdote is that, at one clinic, we did the entire fire department in that city because they all just like, chatted to each other.

01:21:44:03 - 01:22:04:23
Lindsey
But then once they're done, they're done, you know? And so we need to, like, find, try a new set of patients. But that was that was funny. One of the executive directors said that was a fantastic word of mouth. Next slide. So these are just kind of reiterating, you know, words of wisdom and some of them are direct quotes.

01:22:05:00 - 01:22:32:05
Lindsey
So, you know, making sure the Medicaid forms are completed correctly so that you get paid, the scheduling appropriately. It can't be understated, because it can really throw off a clinic flow. If people are on the same page, the cost of the training actually is pretty, low. And, adding the, you know, adding to your met mal doesn't, you know, it's not a very heavy lift.

01:22:32:07 - 01:22:50:08
Lindsey
As far as, like, adding this procedure, you know, and then the answer was like, well, it may not make us big money, but it's the right thing to do. And we're a lot less expensive than like, private offices. This is, you know, speaking from the, nonprofit. So next, and this is kind of a continuation of words of wisdom.

01:22:50:08 - 01:23:14:14
Lindsey
If you have title ten, there's nothing that should be holding you back. Dive right in. It's an asset, to have the service and, you know, checking your liability coverage. Like I said, it's not that expensive. Making sure that you have your clear designation set up or what your plan is for post as analysis. And then, you know, patients ask a lot about the technique, which Finn kind of went into, pretty well.

01:23:14:14 - 01:23:42:16
Lindsey
So I think that's really important to make sure your staff can answer those questions, and then making sure you identify your key learners internally. So yeah, so that, yeah, we can go to the next one. And I think that that was my quick overview of how to start the service in your practice. So thanks.

01:23:42:18 - 01:24:00:01
Nicole
All right. Well that was awesome. Thank you Lindsay for doing that. I know the tech trouble, but that was awesome. And thank you for advancing those slides. So now we can get started on our Q&A. So we have a couple Q&A in. And what I'll do is I'll just, switch off. I'll ask one question to our doctor Schwartz, and then I'll ask one for often on vasectomy.

01:24:00:01 - 01:24:09:24
Nicole
So the first one is, do we know what the regret is about? Is it the inability to have more children? Is it because of complications or pain or body dysmorphia?

01:24:12:14 - 01:24:26:18
Bimla
I think all of those things have happened. The known world is full of lots of reasons why people end up with regrets, with, the question being, do we know at a national level, the National Survey of Family Growth doesn't, collect that type of additional detail.

01:24:27:03 - 01:24:57:24
Bimla
So I think we're left with just the anecdotes that each of us probably have collected from our own, clinical practice. But I would say there's nothing sadder for me than, having a patient say they want me to help them get pregnant after they've had a tubal sterilization procedure, and have to explain to them that, unfortunately, with our, publicly funded health care system, as trim as it is, the options are very limited.

01:24:58:01 - 01:25:10:10
Nicole
And then this would be for fun. But I think the mechanics of this, too, are there any states allowing for a virtual 30 day consent form signatures consistent with telehealth? Could this be done as a digital signature through the Telehealth Consult?

01:25:11:19 - 01:25:18:16
Finn
Yeah, so I didn't have a ton of experience with this because I only do my consults in person.

01:25:18:16 - 01:25:34:17
Finn
However, I took a quick peek and it actually it can be, the consents can be signed virtually as long as it has a date and time stamp on it. Which most like virtual signing like Docusign that sort of thing, have a date and time stamp.

01:25:35:13 - 01:25:45:12
Nicole

Okay. The next what data exist on the efficacy of salpingectomy specifically, given the increasing practice of opportunistic or preventative, salpingectomy,

01:25:47:08 - 01:25:50:13
Bimla
this is a really, important question for us.

01:25:50:13 - 01:26:14:04
Bimla
And I think there are, people who have theorized that salpingectomy would be more effective than some of the older approaches, but as yet, we don't have any population level data. I would love to see some. Unfortunately, our data sets, like the National Survey of Family Growth, do not differentiate between what type of sterilization procedure a patient underwent.

01:26:14:19 - 01:26:40:05
Bimla
So with the National Survey Family Growth data, we can't tell Essure. From, tubal sterilization from salpingectomy, with the claims data, it is also, difficult to distinguish between, tubal sterilization and salpingectomy. One could do it using electronic health record review, natural language processing type approaches, and we are trying to make that happen.

01:26:40:06 - 01:26:45:05
Bimla
But, it's actually harder than one might think. And we don't have any of that data ready to share us yet.

01:26:46:03 - 01:26:57:11
Nicole
Okay. And then before I jump, the next question is going to remain when our presenters will be staying on for an extra 50 minute to 1:45 to answer these questions. So if you have to leave right away, still put your questions in and we'll get it.

01:26:57:23 - 01:27:15:23
Nicole
Answer. And you can watch in the recording, but you will still get your full 1.5 CME credits if you have to leave right at 1:30. So. All right. So next one is for Finn, how would you talk to teens and counselor them on vasectomy.

01:27:17:07 - 01:27:23:24
Finn
Yeah. So when I do talks for teens and I you know I frequently do talks for like high school classes and stuff like that.

01:27:25:02 - 01:27:50:10
Finn
I always include vasectomy is an option that's available. With the caveat that most insurances, like private insurances, won't cover till 18, state insurance till age 21. And that it is permanent. And it's something that they may consider in the future. Unlikely something that they'd be looking into right away. I like to put it in there because then it's kind of in their head.

01:27:50:10 - 01:28:01:06
Finn
They know about it. And then they've already heard it from me that it's a permanent sterilization option. And so that kind of combat, some of the misinformation that's out there on the internet.

01:28:03:24 - 01:28:22:18
Nicole
So for this one, obviously, patient centered care is a primary consideration and individualized discussions should take place. But what are your thoughts on patients who are undergoing cesarean section and have been clear that they desire permanent sterilization, and especially those who would have significantly have significant risk of morbidity or mortality from a subsequent pregnancy.

01:28:25:07 - 01:28:49:03
Bimla
And, I want to be really clear. If a patient has been well counseled and thinks that such a surgery is the right option for her, then they've got my full support and I think that's a great option. What I do take a little bit of issue with is our many patients who have chronic medical conditions, who think that birth control isn't safe for me, and that the only thing that might be safe for me would be to have a surgery.

01:28:49:03 - 01:29:12:04
Bimla
And with that, I actually have a lot of concern because clearly surgery is not our safest option. And it's important for people to know that we have a lot of options that don't contain estrogen. If you have a risk of clotting, whether that's because you have diabetes complications or high blood pressure or heart disease, doesn't mean that your only option is to undergo a surgical sterilization procedure.

01:29:12:06 - 01:29:38:21
Bimla
And yet, we do see that people with diabetes are much more likely to have surgeries than people without diabetes. People with high blood pressure are much more likely to have these surgeries than other patients. Only patients who are actually more likely to have

vasectomy than any other patients are our patients with breast cancer, and somehow the, breast cancer oncology community seems to be doing a really good job making sure those patients know that they have a lot of options and that those options include vasectomy.

01:29:38:23 - 01:29:54:20
Bimla
But again, it would be really great for all of our patients to have been really thoughtful about all of those options. Again, recognizing not all of our patients have only one partner and one partner who's willing to have a vasectomy, which is what's needed for a female patient to be able to rely on that vasectomy.

01:29:54:20 - 01:30:21:03
Bimla
But in the circumstance where that is the situation, it's great to give that full consideration. I think the other really important takeaway, for all of us is where is my vasectomy provider? And that's not always super easy to figure out. And I love, the call to do some of our training. And in California, that is an MD or, required, background to start that training.

01:30:21:03 - 01:30:49:11
Bimla
Hopefully, maybe we can get that changed. And in California, we can have more advanced practice clinicians clearly capably doing these procedures. But short of that, sometimes it's a little hard to know where in your community that, vasectomy referral would go to. And so I would say that would be another request of all of you do that homework, know where that is so that you can actually be meaningfully counseling your patients on like this is an option if this is what you wanted to do, this is where you would have to go.

01:30:49:13 - 01:31:21:01
Bimla
And again, being clear in California, these are all free options. There is no out-of-pocket cost. I think some of the differences we see in terms of postpartum sterilization have to do with women having health care coverage for a limited time period while they're pregnant and postpartum, and not necessarily knowing that their male partner also has coverage in the state of California, and their male partner could get a vasectomy just the way they have this pregnancy related, contraceptive access.

01:31:21:03 - 01:31:28:03
Nicole
Yes. So for Finn. And I heard that it feels different when I ejaculate. Is this true?

01:31:28:03 - 01:31:47:22
Yeah. So sperm is such a small percentage of ejaculate, there's really no appreciable difference in the volume of ejaculate. So I think that's the first thing to, you know, just

reassure people about they—they may not realize that, really the amount of ejaculate is not changing.

01:31:48:18 - 01:32:16:07
Finn
They don't maybe realize how small of a percentage, sperm actually is out of the whole ejaculate. There's no change in erectile or ejaculatory function. We can never know what each individual person's experience is, right? You know, the research typically says there's no change in how it feels, in how it works. That means that in the first couple of months, there's going to be a little residual soreness.

01:32:16:07 - 01:32:48:12
Finn
So if, if this is like at some of these follow up visit or like right away, there typically is like, oh, maybe that felt a little sore or you know, that that was a little off. But but usually that's just because somebody has just had a procedure. And like I talked about with that, sort of like feeling of fullness and maybe a little bit of swelling in the testicular and the epidermal area, until the body kind of figures out kind of consistently.

01:32:48:12 - 01:33:02:16
Finn
Re absorbing the sperm. So I think early on it can feel a little different. But, what the data says is that there's no appreciable difference, post vasectomy for the majority of people.

01:33:05:24 - 01:33:15:09
Nicole
So then that is there an age requirement for sterilization? From the slide title comparing contraceptive effectiveness, what made abstinence had the highest rate out of 1000 patients.

01:33:17:06 - 01:33:44:08
Bimla
And so Finn nicely took us through. Some of the age requirements depend on who is paying and for those getting government funded health care, you have to be at least 21 years of age to have a tubal sterilization or a vasectomy. That being said, we do also know that rates of regret are higher among younger people, likely because they have more opportunities to have life transitions with new partners where, their desires may change.

01:33:44:10 - 01:34:10:12
Bimla
So, officially, 21 is what I would say with that in terms of why does abstinence have such a, high failure rate in the real world? That is because so often people's, intentions remain. Abstinence are not things that end up, being the reality when—when their behaviors are taken into account and a lot of people are planning on staying abstinent, don't manage to.

01:34:10:12 - 01:34:29:21
Bimla
And these—these are things that we actually do have good data about people who this is what they thought they were doing, and this is where they are at one year. So I think, really important for people who have been sexually active to know that, it's a fairly addictive behavior. It's hard for people to stay away from.

01:34:29:23 - 01:34:39:10
Nicole
So what kind of objections did you get from community urologist or your organization malpractice carrier for you to begin performing vasectomies or insurance companies?

01:34:39:15 - 01:34:57:08
Finn
Yeah. Very little overall. So community, at least in our area, and I imagine it's probably not so different in many places. Urologists have a long waitlist and they see a lot of different patients, for a lot of different things.

01:34:57:22 - 01:35:39:08
Finn
And in fact, one of the urologists that, I referred to locally for other issues is like, yeah, you can have all my vasectomies. I hate doing them. Take them away. So I think they actually don't mind a little help with the patient load. Maybe there's some urologists. You know, certainly when we talk about the, you know, I'm an APC, I'm an NP, and so we talk about kind of like some of the funky relationships between, physicians and advanced practice clinicians, they, you know, oh, you can't possibly have the same training or the same outcomes.

01:35:39:15 - 01:36:06:04
Finn
We do have the, you know, as good if, you know, if not, in some cases, better outcomes. So there's no, no change in outcome there in vasectomies, regardless of who's doing it, as long as you're well trained. As far as malpractice, really easy to add on. You know, especially if you're already doing any kind of minimally invasive procedures on your, malpractice insurance.

01:36:07:03 - 01:36:34:07
Finn
Not—not too big of an issue there. So I think overall, you know, not—not major objections. I don't know, maybe there's a urologist in your town that's really aggressive about their vasectomy turf and that's entirely possible. But I think we need to be, increasing access for patients. And part of that increasing access is making sure that, they can find the services.

01:36:34:07 - 01:37:04:22
Finn
Right. And so if it's like, I would like a vasectomy now I'm going to go on an eight month urology waitlist and oh, okay, two months later, their partners end up seeing me for their medication abortion. Right. So instead, let's get these people in and get them seen. And—and Bimla, I really liked what you mentioned about, oncologists counseling about vasectomy with, their—their cancer patients.

01:37:04:22 - 01:37:40:05
Finn
Because I think one thing that we don't do is bring up vasectomy when we're talking with our assigned female at birth patients. In all of my exam rooms, I have a big sign that says, you know, like, now offering vasectomy. It's not a new service, but it still says that. Or have you considered a vasectomy? Because more often than not, male patients end up considering it because their female partners bring it to them as a possibility.

01:37:40:07 - 01:38:03:14
Finn
Especially when female partners bring it to them and say, you know, I really am trying to get off of x, y, z birth control. Whether it really isn't feeling like it's working for them or there's just those myths that Bimla talking about, about how it's not safe, etc., etc.. But, you know, when female partners bring it to them and, and suggest it and then they get talking about it.

01:38:03:14 - 01:38:16:15
Finn
So, bringing it up to your female patients, you know, as, as one of their options if they are in a mutually monogamous partner situation where that makes sense.

01:38:18:22 - 01:38:26:19
Nicole
And then for Bimla, what's that do you quote to patients about effectiveness of tubal, taking into account the studies that you showed?

01:38:29:22 - 01:38:57:06
Bimla
So I generally find that my patients have a really hard time thinking about statistics and proportions, the way that many folks who have more advanced statistical training do. And I think it can be really helpful to use pictures such as, one that is on the website. I put the link into the chat there that, lets you see that really, it's a highly effective method.

01:38:57:06 - 01:39:16:20
Bimla
People are unlikely to get pregnant. But then the question really, I think for many of my patients is not a specific number, but more how does it compare to the other options? And I

think when we're talking about how does it compare to the other options, then I also have to be clear from what I know, this is not the most effective method.

01:39:16:20 - 01:39:39:02
Bimla
If the most important thing to you is the most effective method, then that is not a reason to have a table surgery.

01:39:25:05 - 01:39:34:02
Nicole
And I'm going to combine these two. This is for Lindsey. One is how can I come train with you in Maine? And would you be willing to share your protocols?

01:39:39:04 - 01:40:03:20
Finn
You may have had to jump off to go deliver a baby. But, I'll just jump in real quick. A good way to, get connected with training is through an organization called Repro TLC that connects learners with training sites based on their, kind of like, repro health needs that they're looking to get trained in.

01:40:03:20 - 01:40:30:08
Finn
So that's one way, another way is to find a local urologist that is, willing to take on students. I know that's how Lindsey train. She got connected with one of the local urologists. And she trained with him, so lots of different ways. And, and she can certainly, provide more information about training ideas.

01:40:30:10 - 01:41:00:22
Finn
And I missed the second part. It was training. And then

01:40:36:11 - 01:40:37:07
Nicole
would you be willing to share your protocols?

01:40:37:07 - 01:41:00:06
Finn
Oh, yes. Yeah, we can we can certainly share. I think, you know, protocols. There's—there's, you know, techniques that are used and, whether that's a specific clinic protocol or not, it's more provider specific, which technique a provider uses.

01:41:00:24 - 01:41:27:24
Finn

But we can certainly share things like what we counsel patients on, you know, our informed consent, paperwork. Happy to share that, you know, the, the, determining patient eligibility as far as, like, via physical exam, that's not really a protocol thing. That's more. Can you find the vast difference easily. That's more of a physical exam thing.

01:41:28:01 - 01:41:34:09
Finn
But yeah, I'm, I'm happy to, between the two of us, rustle up some, some paperwork that we can share.

01:41:34:09 - 01:41:42:16
Nicole
Wonderful. I think this is our last question to, for Bimla. How can one check on the efficacy of tubal ligation in the long run?

01:41:48:23 - 01:42:16:21
Bimla
I'm not sure I fully understand the question. I guess there's two levels. One is at the individual patient level. And, at the patient level, we don't currently recommend any, follow up testing. When we were doing Essure procedures, we were having everybody have their, tubes evaluated after the procedure. But that not is not standardly done for people who are having other, approaches to tubal surgery.

01:42:16:23 - 01:42:36:18
Bimla
Again, when people are having vasectomy, that follow up sperm count, does, remain very important before people feel that they can rely on it? When we're trying to end up with population level data, that requires that we start with a very clear understanding of everybody who's had the procedure, and then follow up on what happens with them.

01:42:36:20 - 01:43:06:24
Bimla
And that's hard to do in the U.S because we don't have, access to health care for all. We can do some things like looking at Medi-Cal claims data because Medi-Cal does, provide comprehensive care for at least, one section of—of people in California. And hopefully there will be perhaps some data coming out from our international colleagues who do provide health care for all and follow, their data and data sets a little more

01:43:07:01 - 01:43:25:01
Bimla
consistently than we are able to do for all comers here in the U.S. But I think, it's really important to take a look at that claims data and think about it alongside what we see in survey data, because we know that in survey data, there is a tendency for people to underreport abortion because there is stigma around abortion.

01:43:25:01 - 01:43:50:18
Bimla
Still in this country. So, we know that when we survey people and say, hey, did you end up having an abortion after you were trying to use this contraceptive? What we see are lower failure rates than what we would see in a system like Medi-Cal that does cover abortion services. So we will be seeing, you know, arguably all of those procedures without that underreporting that might be otherwise seen in survey data.

01:43:50:20 - 01:44:12:04
Nicole
Okay. And then with that, that concludes our webinar. I want to say thank you so much to Finn, Doctor Schwartz and Lindsay for presenting. That was awesome. And then we you will get an email at the end that will include all the information, the slides, the recording, the link to the CME certificate, and then the protocols and any additional handouts that, you want to share with us.

01:44:12:04 - 01:44:31:17
Nicole
I also want to, point out we have four materials in the handout. If you click on the paper clip, the top we have, the new client education material that we just updated and develop on sterilization and vasectomy in both English and Spanish. So you can share that with your clinic and your clients. And then with that I want to thank our presenters for this wonderful presentation.

01:44:31:17 - 01:44:39:14
Nicole
Thank you so much. And with that, I hope you everyone is staying safe and have the rest of the great rest of your day. Thank you so much. Thank you.