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Long-Acting Reversible Contraceptives (LARC) Toolkit

Starting, Building, and Maintaining Optimal Care Delivery of LARCs for Adolescents and Young Adults

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Glossary: Throughout the toolkit we will use the intrauterine device (IUD) nomenclature as recommended by the Society of Family Planning (Creinin et al, 2021), referring to the devices currently available in the US as:
Copper 380 mm^2 IUD
Levonorgestrel 13.5 mg IUD
Levonorgestrel 19.5 mg IUD
Levonorgestrel 52 mg IUD

Please Note: In this toolkit, quotations from sources and qualitative data occasionally use the gendered terms women/ girl; please note that this research encompasses those of all gender identities and this toolkit promotes gender inclusive language as set forth by the American Psychological Association inclusive Language Guidelines (2021). The use of the word adolescents, and/or people is specifically used as a replacement of binary gender terms in this toolkit.

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Introduction

Why LARCs for Teens?

Adolescents use long-acting reversible contraceptive (LARC) methods less than adults. Practices that specialize in pediatric and adolescent medicine may be well positioned to help improve adolescent access to these methods, but barriers to implementation exist, including administrative and financial issues as well as provider and patient education. We seek to describe strategies that pediatric and adolescent practices have successfully used to address these barriers.

Long-acting reversible contraceptives (LARCs) are cost-effective, safe and highly effective methods for patients for both prevention of pregnancy as well as for other medical indications to manage periods (Coles and Mays, 2019). Unintended pregnancy in the United States (U.S.) disproportionately affects females under age 24 years, with 59% in 20 to 24 year olds, 76% in 18 to 19 year olds, and 72% in 15 to 17 year olds (Finer 2016, ACOG 2017). For adolescent females, pregnancy is associated with lower lifetime educational and economic achievement, higher risk of reliance of social services, and a greater likelihood of early parenting among their offspring (Monea 2016; Trussell 2013). The most effective approach for reducing unintended pregnancies among sexually active adolescents and young adults (AYA) is by expanding access to contraception (Committee on Adolescent Health Care, ACOG 2017; Committee on Adolescent Health Care, ACOG 2018). Nearly 90% of the decline in teen pregnancy rates observed from 1991 - 2013 is attributable to increased access to and utilization of contraceptives, particularly long-acting reversible methods (Frost 2008; Secura 2013; Martinez 2011; Winner 2012; Rosenstock 2012). Expanded access to LARCs can substantially decrease unplanned pregnancy in adolescents ages 15 to 19 years, as evinced by the Colorado Family Planning Initiative, which expanded access to LARCs across the state and was studied from 2009 to 2015. At a cost of $23 million, this program provided contraceptive access to low income clients, with LARC use increased from 5% to 30% over that time period and birth rates decreased by 20% for youth living within 7 miles of participating clinics (Kelly, 2019).

Widespread support exists from medical and public health organizations for policies that expand LARC access (Peipert 2011; Sucato 2011; Rickert 2007; Lim 1999). Despite endorsement by national medical and public health organizations, a key barrier to increasing adolescent access to these services is that few pediatric providers are trained to place these devices. (ACOG Committee on Adolescent Health, 2012). In recent decades, more than two-thirds of adolescent females seek contraceptive services at private physician's offices, less than a quarter use publicly funded clinics, and only 3.5% utilize family planning clinics (Frost, 2019). Increasingly, primary care providers (PCPs) are front line clinicians providing access to contraception for young people. A survey conducted in 2015-2016 found that only 4% of pediatricians placed LARC devices in their practices (Fridy 2018).

Over the past decade, effort has been made by the specialties of both adolescent medicine and pediatric and adolescent gynecology to train attendees at national medical conferences and via the Reproductive Health Access Project (RHAP). These educational opportunities simultaneously provide support to institutions and private practices to develop the supply chain of clinicians with enhanced competence and confidence in promoting positive outcomes for youth at the start and through the early progression of their reproductive health journey. Traditionally, logistics of practice management including billing, scheduling, and other nuts and bolts practical matters have not always been uniformly covered. Pediatricians and primary care clinicians remain highly valued, highly trusted participants in adolescents' lives. This toolkit is designed to improve pediatric and primary care settings' ability to provide these services in order to increase access, decrease teen pregnancy, and improve the reproductive health of young people.

Developing this Toolkit

The outlook for expanding LARC services to non-OBGYN settings has not been easy given the challenges encountered by prior initiatives. Organizations such as Upstream raised tens of millions of dollars from public and private sources to create LARC access in these settings, making such projects a costly endeavor (NICHQ, 2017). Lower-cost initiatives that can be easily adapted within individual practices or among health systems are much more likely to be adopted.

In the first phase of the study that generated this toolkit, we interviewed pediatric and adolescent practices that had successfully integrated LARC provision into their care settings. We used the Consolidated Framework for Implementation Research (CFIR), an implementation science framework, to identify key factors that make these local initiatives

a success. We next developed this toolkit to support implementation of LARCs in pediatric practices, identifying tools and resources that could be incorporated into the toolkit based on shared experiences, recommendations, and shared resources provided by these interviews. We looked beyond what we learned from the interviews for all available evidence-based guidelines and consensus statements. Based on the feedback of key stakeholders, the toolkit has evolved into an online, easily accessible resource that can be more readily updated. Various sections outline front desk optimization, confidentiality, consent variations, billing (including confidential billing where able), standard operating procedures, template building, frequently asked questions, protocols for managing side effects, and ways to get buy in from key players necessary for implementation.

Methods for Developing the Toolkit

To develop the toolkit, we conducted semi-structured interviews with physicians and staff at practices that successfully provide LARCs for adolescents. The interview guide was adapted from the Consolidated Framework for Implementation Research (CFIR), a methodology designed to understand the implementation of new initiatives across healthcare settings. CFIR focused on the describing implementation characteristics, external and institutional settings, the people involved, and the implementation process, including challenges. Interview transcripts were analyzed using a comparative content analysis approach.

The process involved 3 phases. In Phase 1, we used qualitative, semi-structured interview methodology to describe the characteristics of pediatric clinical sites that insert and remove LARC methods for adolescents and young adults. Our interview questions were grounded in the CFIR framework, which is considered the gold-standard tool for conducting evaluation and implementation research designed to delineate influential factors that affect clinical practice change within and across multiple contexts, to facilitate analysis of pivotal processes and outcomes, and to organize findings of an implementation to explain outcomes (Tinkle, 2013; Keith, 2017). In short, CFIR helps to understand what works and why, and to describe the key people and resource factors. As such, it is a useful tool for understanding how pediatric practices structure and implement multifaceted, multi-level interventions to provide LARC services.

We used a purposive sampling technique, designed to ensure the inclusion of clinical programs that represent Adolescent Medicine sites, school-based health centers, and Federally Qualified Health Centers (FQHCs) that serve a high volume of youth and young adults. This resulted in a sample size of 17 practices.

Interviews were audio-recorded and transcribed verbatim. Transcripts were systematically analyzed independently by two coders using Dedoose 9.0, a qualitative analysis software (2019). A directed content analysis approach was used to identify themes (Corbin, 2008, Hsieh, 2005). The initial coding tree was developed a priori, based on CFIR domains. Novel findings that did not map onto the CFIR domains (nine total) were also identified and incorporated into the codebook. Two coders independently coded each transcript. Discrepancies in coding were resolved via consensus. Interviews were conducted until thematic saturation was reached (within the five CFIR constructs).

In Phase 2, we synthesized the information from the Phase 1 interviews along with available evidence-based guidelines and consensus statements to develop the toolkit. Phase 3 beginning in fall 2022 involves toolkit implementation, with use of pre- and post-surveys to assess implementation knowledge and attitude using a convenience sample of all providers at each site. The survey questions were adapted from Fridy et al. (2018) and included demographics, years in practice and level of training (current resident, attending, NP, PA), perception of competence and comfort with reproductive health counseling, LARC usage, and specific LARCs in particular, and whether providers other than themselves are providing LARCs at their practice site. All site pediatric primary care clinicians, residents, and advanced practice clinicians at each implementation site will be offered participation in the surveys. Key informants including front desk staff, schedulers, nursing, billing staff, practice managers, and clinicians from each site will be interviewed following implementation using the CFIR construct with the same coding used in Phase 1, and qualitative data from each of the sites will be analyzed. We will encourage toolkit users to track other aspects relevant to toolkit use, as in numbers of procedures performed. In the first year, these numbers are expected to be small. Our goal is to introduce and evaluate implementation in a minimum of 7 residency programs in order to help prove the efficacy of the toolkit specifically within pediatric residency primary care clinics. This phase will further refine the toolkit for utility and ease of use in

more diverse clinical settings impacting various subsets of underserved youth, adolescents with chronic health needs who could benefit from LARCs, transgender youth in need of menstrual suppression, and other special populations.

For the post-surveys, we will then study change in knowledge and attitudes about LARC use among participants including pediatric residents pre- and post- being introduced to the toolkit. In the second year of Phase 3, another measure will include the number of LARCs inserted in our targeted clinics as well as changes in attitudes and beliefs about LARCs. Measures that address issues of reproductive justice are also included.

The goal of utilizing seven external residency sites for implementation was chosen as a convenience sample based on interested sites and expectations of feasibility in the two years planned for study conduct. This study is not scaled to serve as a randomized controlled trial for intervention versus no intervention; rather, this pilot study will serve to provide the pilot data prior to a full randomized control study. Proof of utility of this concept will inherently include some selection bias, as interested sites already recognize the lack of accessibility and ease of implementation of LARCs within their primary care practices. This study serves as a pilot to demonstrate utility of the toolkit. The qualitative follow up will help identify barriers and solutions as well as capturing input from front desk, schedulers, billers and others who will be harder to access via survey.

THE TOOLKIT

Why LARCs are Important to Provide

Your individual institution or practice may not have traditionally addressed use of LARCs in adolescents. Many adolescent health leaders have urged pediatric primary care providers to implement LARC services and/or better counsel on reproductive health for all youth. Education about teen pregnancy, menstrual manipulation, and the importance for reproductive health to be addressed in special populations such as youth with chronic illness remains a necessity. Transplant teams, neurologists treating patients with epilepsy or developmental delays, GI clinicians caring for patients with inflammatory bowel disease or other chronic challenges, and pediatric oncologists may be inadvertently serving as primary care clinicians without addressing reproductive health at all for their patients, providing added rationale for these vulnerable populations to have a primary care medical home that also addresses their reproductive health care needs. The concept of suppressing or managing periods also has great relevance for transgender and nonbinary youth, as well as for the developmentally delayed adolescent with hygiene challenges. As noted in the introduction, a decline in teen pregnancies occurs where LARCs are more available and used by adolescents. Advocating for the care of diverse and underrepresented populations can be a compelling rationale for improved LARC services within your practice.

Why LARCs are Important Despite the Effort It Will Take

You may be wondering why you should bother expending the effort it will take to start providing LARCs within your pediatric primary care practices. Adolescents gravitate to a medical home with caring clinicians who see and know them; pediatricians have traditionally filled this role. Young people want to hear about these topics from a clinician they know and trust. Even if a practice chooses not to provide LARCs, improved contraceptive counseling in the primary care setting, accompanied by a “warm hand-off” (“I know this medical provider, and they will take care of you and address all of your needs in a way that will have you feeling safe and cared for”) can improve reproductive choice and care for young people.

LARC Compatibility with Teaching, Quality Improvement and Academic Medicine

Improving access to LARCs provides a fertile area for quality improvement projects, maintenance of certification (MOC4 points for pediatricians), and publishable research for interested clinicians and staff. The Society of Family Planning has had ongoing research funding available for the study of contraception across the lifespan.

Adolescent Medicine and PAG fellowships welcome research in this area; some programs mandate a research project completed during/after fellowship. Quality improvement efforts can include use of the goal-tracking methods mentioned in the previous section.

Adolescent Specific Needs

Adolescent Development

Adolescents seek out their pediatrician or primary care clinician ideally as a trusted source of information. For those teens well connected to their pediatrician, referral to an OB/GYN can delay care and/or be a daunting experience, particularly if the OB/GYN practice does not have staff trained to care for adolescent populations. For example, caring for adolescents requires knowledge of adolescent developmental stages and how to meet adolescent health needs while delivering care that is appropriately tailored to an adolescent's developmental stage.

Adolescent Age	Adolescent Developmental Stage	Adolescent Reproductive Health Needs
10-13 years	Early Adolescence	Knowledge of anatomy, mechanics of sex, safety, prevention of pregnancy and STIs; exploration of self/values; boundary setting and defining healthy relationships. Identity exploration, including sexual identity
14-17 years	Middle Adolescence	Ongoing values clarification, boundary setting and defining of healthy relationships; practice in navigating safety in all/more situations while immersing in peer group (peers may hold more weight than family). Further identity exploration with expected influence by peers. Expanded contraceptive knowledge and ensuring access to options
18-23 years	Late Adolescence	Developing a mature and healthy sexuality; ensuring safer/healthy choices/access in the further exploration of a healthy sexuality

Adolescent development involves the transition in cognitive, physical, and psychosocial changes from early adolescence (11-14 years) through middle adolescence (15-17 years) and into late adolescence (18-21 years), a time when abstract thought and the ability to foresee consequences has developed for most young people. Many pediatricians are uncertain or uncomfortable about how/when to counsel youth on issues of emerging sexuality, including contraception. This uncertainty can lead to missed opportunities to counsel. For those in need of LARCs or other contraceptive options, counseling begins with the pediatrician, even when a referral is needed for LARC placement. Embedding LARC champions within pediatric practices ensures use of contraceptive methods including LARCs as indicated in partnership with the adolescent for all decisions. Including language around the adolescent's personal reproductive health journey can empower youth to be an active partner in their own health and choices.

Our interviews revealed an awareness of what is unique about adolescent medicine and PAG providers that is shareable/usable in pediatric and primary care practices. Many participants identified the importance of understanding adolescent development while providing contraceptive care and incorporating this aspect of care into the adolescent's reproductive health journey and wellness plan. Some of the key takeaways relating to adolescent specific needs from the interviews include:

- A need for confidentiality to be built into adolescent care routinely, and not just for reproductive health issues.
  - SAHM Consent & Confidentiality
  - NASPAG/SAHM Position Statement -the 21st Century Cures Act and Adolescent Confidentiality
- Receiving care with their usual trusted provider may be preferable to the adolescent as opposed to a referral to an adult provider and affords them access to methods they otherwise would not utilize.

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- This bias to stay within their medical home was a strong argument to incorporate LARC placement within a pediatric or adolescent clinic rather than establishing a referral system to gynecology.

- General pediatricians may not feel comfortable or may not routinely provide reproductive health care. General pediatricians may need to refer to adolescent providers or be "coached up" to improve their counseling ability.

- These recommendations are consistent with and supported by the evidence-based guidelines from the North American Society for Pediatric and Adolescent Gynecology (NASPAG), the American Academy of Pediatrics (AAP), the Society for Adolescent Health and Medicine (SAHM) and the American College of Obstetrics and Gynecology (ACOG).

"We're constantly trying to showcase why adolescent medicine is different, …we have a lot of conversations that (are) bigger, you know, it's not just birth control. It's a bigger conversation about maturity, about refusal skills, about positive development."

– Southwest Adolescent Med

"So patients have a chance to learn how to talk about their own healthcare and discuss things that might be hard to talk about in front of other people. But we always want parents to be involved in their health survey. You know, something like that, where if you put it throughout the clinic, everybody can say and do the same thing consistently, since that's what's been shown to ensure that adolescents receive confidential services and that they're aware of those services so that they'll talk about things."

– Southeast Adolescent Med

"We counseled on the IUD and people were interested, they wanted them. And what we were finding is that as soon as they realized they had to leave our institution and go to an adult institution with a provider that (they had) never met before, they were like, Oh, never mind, I'll do something else and then once we were able to do it (with) the person that they counseled with, I think that continues to keep the numbers going up."

– Southeast Adolescent Med

"I do the service right [in their] comfortable area, the clinic they've been coming (to) ever since they were a baby. And they know the staff, they know the setting. So it's a very different level of comfort as opposed to going to a new OB's office."

– Northeast Adolescent Med

"A lot of our patients' pediatricians just don't see that as part of their care, even when (their patients are) teenagers – a lot of them haven't been STD tested and just haven't even had conversations with their pediatricians regarding their sexual health."

–Southeast Adolescent Med

Adolescent Centered Counseling

Optimal use of LARCs involves patient-centric reproductive health discussions, with choices driven by the young person's needs and wants. Our role as health care providers is not just to facilitate these discussions, but to supply adolescents and young adults with the tools to navigate these decisions successfully, to be able to anticipate and manage unwanted side effects, and to empower them to feel autonomous in their decision-making. In a qualitative study of 42 adult females (ages 19 years and up), Dehlendorf and colleagues found that the participants wanted the contraceptive counseling discussion to emphasize their values and preferences, and they wanted comprehensive information about options, especially possible side effects (Dehlendorf et al., 2013). From this data the researchers developed the Person-Centered Contraceptive Counseling Measure, endorsed by the National Quality Forum in 2020. The measure rates the interaction on the following four points:

- respecting me as a person;
- letting me say what matters to me about my birth control method;
- taking my preferences about my birth control seriously;
- giving me enough information to make the best decision about my birth control method.

This measure is available at pcccmeasure.ucsf.edu/

In a study specific to adolescent's ages 15–19 years who chose LARCs, the participants similarly voiced the importance of adequate information about methods and side effects, autonomy in making their own decision, and not feeling "forced" to choose a method because of providers' preferences. Additionally, they stressed the importance of availability for follow up after LARC placement to discuss questions and side effects (Sangraula et al., 2017). Preliminary experience since the emergence of the COVID pandemic found that patient satisfaction increased with use of telehealth, patient portals or other systems that allow for more rapid responses to the young person's questions regarding side effects.

> *"The biggest thing... we try to address... is breakthrough bleeding. We try to... address concerns... before they are like, I just want the device out."*
>
> *– Northeast Adolescent Med*

There is a difference between experiencing breakthrough bleeding and hearing about it. It is important to counsel honestly and have options to manage bleeding if it occurs in addition to potential LARC removal.

How Do You Do Patient-Centered Counseling?

A shared decision-making model of contraceptive counseling is a partnership between patient and provider, with the latter taking into account the patient's preferences and simultaneously providing the scientific evidence to help patients make informed decisions. Implicit in this model is shared and equally valued expertise and perspective, with the provider well-schooled in the pros and cons for each contraceptive method, and the patient as a recognized expert on their own values and preferences (Mays 2019). This model is associated with higher patient satisfaction and longer method continuation (Mays 2019; Chen 2018; Abdel-Tawab 2002).

How Do You Teach Patient-Centered Counseling around LARCs?

- Instill clear and accurate contraceptive information in your trainee/colleagues
- Elicit patient preferences
  - Examples include: "Tell me what is important to you in your choice of birth control." Answers may include menstrual regulation, manipulation, or suppression. Some patients may need to have regular monthly menstrual cycles. Patients may have parents or partners that monitor menstrual patterns and reproductive coercion does exist. Trans masculine youth may be highly distressed by menses. Asking patients about their specific desires can help elucidate patient preferences regarding contraception. Questions regarding opinions on "forgettable contraception", desire for monthly periods, opportunity to pick up refills at the pharmacy, ability to remember to take a medication daily, weekly or monthly, or being able to return to the clinic for administration of DMPA for example can help direct the adolescents to the best contraceptive choice for them.
  - Identify and address patient myths and misperceptions, empowering patients while educating them (e.g., so that they can be "an expert for their friends" as well as for themselves).
  - Ask patients what has and has not worked for them in the past. Use open ended questions in a nonjudgmental fashion in order to understand what each adolescent or young adult prefers or what they prioritize as important for their contraceptive method.

- Avoid fear tactics ("if you don't use an IUD, you will get pregnant"), as well as coercion ("As a homeless person, you definitely need an IUD so that you won't get pregnant on the streets.")
- Help them think through what would work best for them now. Use tools such as reproductiveaccess.org/resource/bc-fact-sheet/ and Bedsider, as well as in office pictures, diagrams or models, to make the information accessible and concrete, WITHOUT imposing your own biases on your patients.
  - OF NOTE: If only one type of LARC is in your own toolbox, you are likely unconsciously encouraging that option. For example, if a provider places arm implants but not IUDs, they may unwittingly push patients towards the implant rather than an IUD. Finding partners who are adolescent-friendly, who are available to place the IUD when it is convenient for the adolescent, can help break down barriers to access. A warm hand-off is more likely to result in a positive experience for the patient.
    - Bedsider.org can help you find your local resources.
    - NASPAG: Search for a Physician can help patients find a LARC clinic finder.
    - Use of a video, app such as the bedsider app, or other tools to anticipate side effects and provide the young person with tools with which to manage them helps with contraceptive adherence and satisfaction.
- Support patients after a contraceptive choice has been made, preparing them for potential side effects and helping them to manage unscheduled bleeding or other challenges. Let them know that they can change or stop methods at any time, for any reason, and allow them to do so.
- Schedule follow up. Variations exist in recommendations for follow up intervals, including, if available, having designated clinic staff call within 2 weeks of placement to address side effects. Some providers schedule routine follow ups at 6 weeks to 3 months to provide an additional opportunity to address specific concerns. These visits also provide the opportunity to reiterate to each patient that yearly follow up for complete care is important, with annual STI testing, mental health screening, and general adolescent well/preventive care.

> *"So I have some patients coming in year five saying alright, I'm ready to have my Nexplanon out and they literally haven't been seen since we placed it five years ago and I'm like hold up, we don't even know this person anymore."*
>
> *– Northeast Adolescent Med*

Building Rapport

Counseling in any reproductive health setting is imperative to ensure positive outcomes in patient satisfaction. When specifically working with adolescent patients, it is important to acknowledge that this may be one of the first discussions they have had with an adult about their sexual and reproductive health.

Building rapport with the patient remains the first and most important step in the counseling process. Pediatric and adolescent providers have a unique advantage in these situations. Many primary care providers already have established rapport with their patients due to the nature and frequency of visits as their primary care doctor. Creating an environment where the adolescent is comfortable disclosing their sexual and reproductive health needs is ideal to allow for comprehensive counseling.

Discussing Confidentiality

Start your visit by outlining confidentiality with your adolescent patient, being sure to include situations that would require you to break confidentiality. Having this conversation upfront may eliminate feelings of uncertainty and allow for the patient to feel comfortable disclosing information about their sexual and reproductive health. Clinicians might establish confidentiality by stating, "Everything we talk about without your parent is private or confidential, meaning I will not share any of what we discuss with your parent unless you tell me something life threatening or dangerous, in which case I will tell you that we have to discuss that with your parent(s)/guardian(s)." Establishing what information can be kept confidential and what information needs to be disclosed to parents/guardians is correlated with trust and better partnering with the adolescent and their parent(s)/guardians to optimize care.

Parental/Guardian Involvement in Shared Decision Making Around Contraception

Navigating differences in desires around reproductive health and contraception between parents/guardians and patients remains a challenge. It is important to be aware who is making the decisions, and wherever possible to help make this a collaborative decision empowering for both patient and parent/guardian. Parent/guardian involvement currently is not mandated in a majority of states, and the adolescent can consent to contraception. Some hospitals require parental/guardian consent for LARCs as a procedure in a minor, while settings in other states do not mandate parental approval.

" We have a lot of support and we don't generally let kids come alone to their LARC appointments – so many kids do not feel great afterwards. Occasionally they come with friends but a lot of times my patients who said I absolutely don't want to involve my mom end up coming with their mom."

– West Adolescent Med

"Big big big number. I mean we haven't actually like sort of calculated this but I would say a big number of our kids who get LARCS have involved a parent in some way or another."

- West Adolescent Med

"Teenagers aren't going to do something if their mom flat out says no."

– Southwest PAG

"...probably pretty regularly parents bring in their adolescent children in wanting specific reproductive health services and have an agenda usually out of fear of pregnancy."

– Southeast Adolescent Med

"(We) try to engage with parents in the decision making to help with preparing for placement and adjustment for side effects and things like that."

– West Adolescent Med

"This girl that wanted it out a week later – her mom was there (when) we inserted it. I don't think she understood what Nexplanon™ was until we were doing it. And it freaked her out, even though they went through the counseling, Mom just didn't get what was happening and then the next week wanted it out. And so I was able to talk to that kid and say like, hey, you know, are you sure you're making this decision yourself? And by the way, if you want to come here by yourself and get it back in again next week … that's fine."

– Northeast Adolescent Med

Some sites noted that parent/guardian-specific education is needed as well. Educating parents/guardians about the medical uses of contraceptives can improve their willingness to allow their children to use LARCs or other contraceptive options. This may include educational material that discusses using LARCs for menstrual management, or that debunks myths about the dangers of contraception.

"Period control is a kind of term to make a lot of parents so much more at ease."

– Northeast Adolescent Med

"And she actually said … 'I can deal with you getting pregnant, but you're not using a birth control pill.' I don't know how to fight that. So … I definitely think … there's some cultural stuff and … it's not always just addressing the kids. It's the parents, because I think the parents have a whole lot of misconceptions about these things and if they're safe and not safe. And so maybe we need some specific info for... (the) parent, you know, to reassure mom … Teenagers aren't going to do something if their mom flat out says no."

– Southeast PAG

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Contraceptive Options: Method Selection

Discussing Options – Education on Birth Control Methods

When it comes to birth control methods, there is a large variety of methods and brands from which to choose. It is your responsibility to educate each patient on options most consistent with their preferences and priorities in order to assist them in making a decision tailored to their individual needs. Currently five intrauterine devices are approved by the FDA for use in adolescents. The mechanism of action for each IUD is to prevent fertilization. The copper 380 mm^2 IUD is also used as emergency contraception for up to 5 days after sexual activity with 99.2% efficacy; there is no lag time in contraceptive efficacy after placement. In other words, its effects are immediate, which is useful in adolescents seeking immediate pregnancy prevention (Shen 2017; Friedman J and Oluronbi R, in Coles/Mays 2019). The levonorgestrel 52mg IUD has also recently been shown to be non-inferior to the copper 380 mm^2 IUD for use as an emergency contraceptive, supporting same-day start of this method (Turok et al., 2021). Lower dose levonorgestrel IUDs have not been studied for this purpose.

Table 1: IUD Information by Type (Paragard®, Mirena®, Kyleena®, Nelson AI., Skyla®, Liletta®), with permission from *Optimizing IUD Delivery for Adolescents and Young Adults* (Coles, Mays, 2019)

Intrauterine Devices					
	Levonorgestrel IUD				Copper IUD
Trademarked Name	Mirena®	Liletta®	Skyla®	Kyleena®	Paragard®
Picture/Size	1.26”	32 mm; 32 MM; T-shaped plastic frame; Hormone reservoir with membrane; Blue removal threads	28 mm; 30 mm; T-body; Silver ring; Drug reservoir; Removal threads	1.18”	1.26”; 1.42”
FDA Approval Date	2000	2015	2013	2016	1988
Approved for	8 years	6 years	3 years	5 years	10 years
Total Hormone	52mg	52mg	13.5mg	19.5mg	N/A
Changes in Menses	Irregular bleeding initially, decreases over time				Heavier period, longer duration, more cramps
Notable Characteristics	String color: Brown FDA approved for heavy menstrual bleeding	String color: Blue Reloadable	String color: Brown Silver ring visible on ultrasound	String color: Blue Silver ring visible on ultrasound	String color: White Can be used as emergency contraceptive
Cumulative Efficacy Over Approved Period of Use	99.3%	99.27%	99.1%	98.6%	>99%

The CDC Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use is an informative resource for practitioners to reference. Printouts of the table with these criteria along with pelvic models can be placed in the office setting to help encourage discussion. Some providers keep different contraceptives in a "show and tell" box which can be highly useful for the concrete thinking early adolescents. Showing adolescents the actual size of an IUD, the correct method for condom usage, or the box and packaging for vaginal contraceptive film can make these methods more acceptable and accessible to young people.

Guidance from the champions

- Some adolescents may prefer contraceptive implants due to fear of a pelvic exam or pain with IUD insertion.

Reproductive Justice and Empowering Youth on Their Own Reproductive Health Journey

Reproductive coercion has been overly experienced in the past, especially among Latinx, African Americans, and other minority people as evinced early in the USA with the eugenics movement in which Native American, African American slaves and other female minorities were forcibly sterilized (Coles/ Mays 2019). In the 1990s, several states' courts gave the option of Norplant (the former 5 rod implantable LARC) in order to reduce prison terms or avoid prison time altogether (Brown and Berlan, in Coles/May, 2019; Walker, 1992). In the same decade, California provided additional financial benefits to females on government assistance who chose to have Norplant inserted. Female minorities receive more frequent and persistent counseling on LARCs then do white women (Brown and Berlan, in Coles/May, 2019; Dehlendorf, 2010). Because LARC methods require provider involvement for removal as well as placement, removal requests can be an especially challenging time when patients may feel that their needs are not being addressed (Amico et al., 2016). Providers require sensitivity and tools to make these discussions patient-centered. Adolescent medicine providers and PAG specialists can also serve as resources to help with teaching residents how to approach this topic.

Innovating education in reproductive health, a project of the Bixby Center for Global Reproductive Health at UCSF has created a self-directed curriculum Structures & Self: Advancing Equity and Justice in Sexual and Reproductive Healthcare available here. This tool was referenced by several Phase 1 participants.

Patient Education

Ask the referring provider or scheduling staff to give the patient desired education resources prior to the appointment.

Provide educational resources in multiple forms and languages (I.e., handout, video, etc.) with copies or links for online information available for the caretaker (if involved) as well as the patient.

Dedicate support staff – nursing, health educator, volunteer staff, resident or fellow – to spend time on education. This person may also follow up after placement to address any early side effects or concerns.

Patient education resource: *A Comprehensive Guide to Birth Control & How to Get It*

> *"So we compared a patient handout to the video. All of these patients had already had standard counseling, which means 'I'm going to tell you where it goes.' You know, I'm going to show you. And then we pretested after standard counseling and then you either got the handout or the video, (and) either intervention increased knowledge like crazy. So my point is, if you're going to counsel someone on IUDs, you can talk to them until you're blue in the face. You have to give them something. You have to give them a handout. Because people learn in different ways."*
>
> *– West PAG*

Patient Expectations Before the Procedure

One provider has patients and trainees look at bedsider.org and then quizzes them on it. This application is user-friendly for both patients and providers.

Fear of pain during IUD insertion can be a significant barrier to choosing this method. Options for managing pain during IUD insertion can be discussed proactively. In a recent meta-analysis, paracervical block with 10ml 1% lidocaine has correlated with reduced pain scores with tenaculum placement and IUD insertion (Pergialiotis 2014). Although nonsteroidal anti-inflammatory agents and topical lidocaine have not been found to be effective to reduce pain during the IUD insertion, naproxen and ketorolac reduce pain scores post insertion (Massey 1974; Ngo 2015).

"And… when I counsel patients, I go through kind of the whole thing. And then I say your homework is to read everything on there. And if you didn't read everything on there, I'm not putting it in. And then they come back and I'll say, …"Did you read everything on there?" They're like, oh, well. And then I kind of quizzed them and go over it. And I don't actually follow through on that, but I make it sound like this is your homework and you have to read Bedsider… and I actually pull up their phone, we pull it up, I show them the stuff and I show them the stories. I show them all the pieces and I say bookmark it. And…then most of the time they go on there and they've read it all."

– West PAG

Prostaglandins have been studied for their potential to reduce pain and increase ease of IUD insertion due to their effects of softening and dilating the cervix. Use of FDA-approved, yet not widely used, self-administered vaginal dinoprostone 3 mg has been shown to decrease pain in a randomized, placebo-controlled trial in nulliparous people ages 18-22 years (Samy 2020; Lopez 2015). A synthetic drug chemically and structurally identical to naturally occurring prostaglandin E2, dinoprostone modulates the inflammatory response to cervical ripening and is well tolerated with side effects of fever, nausea, vomiting, diarrhea, and abdominal pain in fewer than 1% of patients (Samy 2020; Shirley 2018; Bakker 2017). Adolescents reported higher rates of satisfaction and lower pain with the procedure, while providers rated higher ease of insertion in the dinoprostone group, using a levonorgestrel 52mg IUD (Samy 2020). However, dinoprostone is not widely available and is currently cost prohibitive. In contrast, misoprostol, which is more widely available and less expensive, has had conflicting results, with increased ease of insertion in some studies, no improvements in others, and more nausea and abdominal cramping (Mohammed 2018; Swensen 2012; Edelman 2012). Prostoglandins may be considered as an adjunct for a difficult IUD insertion but are not used routinely as a pain control measure.

Side Effects

Discussing Side Effects

Providers can outline the common side effects and provide guidance on what exactly to expect. When counseling on possible LARC side effects, adolescents have requested hearing more about real life examples. For example, instead of saying "irregular bleeding", young people and their parents want to hear descriptions like "spotting every day for weeks" or "the bleeding can come and go and you may not be able to predict when it's coming, so always carry a pad or tampon." They also requested hearing stories about side effects from peers, so consider incorporating videos or other testimonials from other adolescents (Lunde, 2017).

- Provide feedback on how to manage side effects
- Give guidance on when it is appropriate to call the provider regarding side effects
- Let your patient know the best way to reach you if they have any questions (i.e., office phone, texting your work cell, sending a message in the EMR portal such as MyChart)

Managing Side Effects

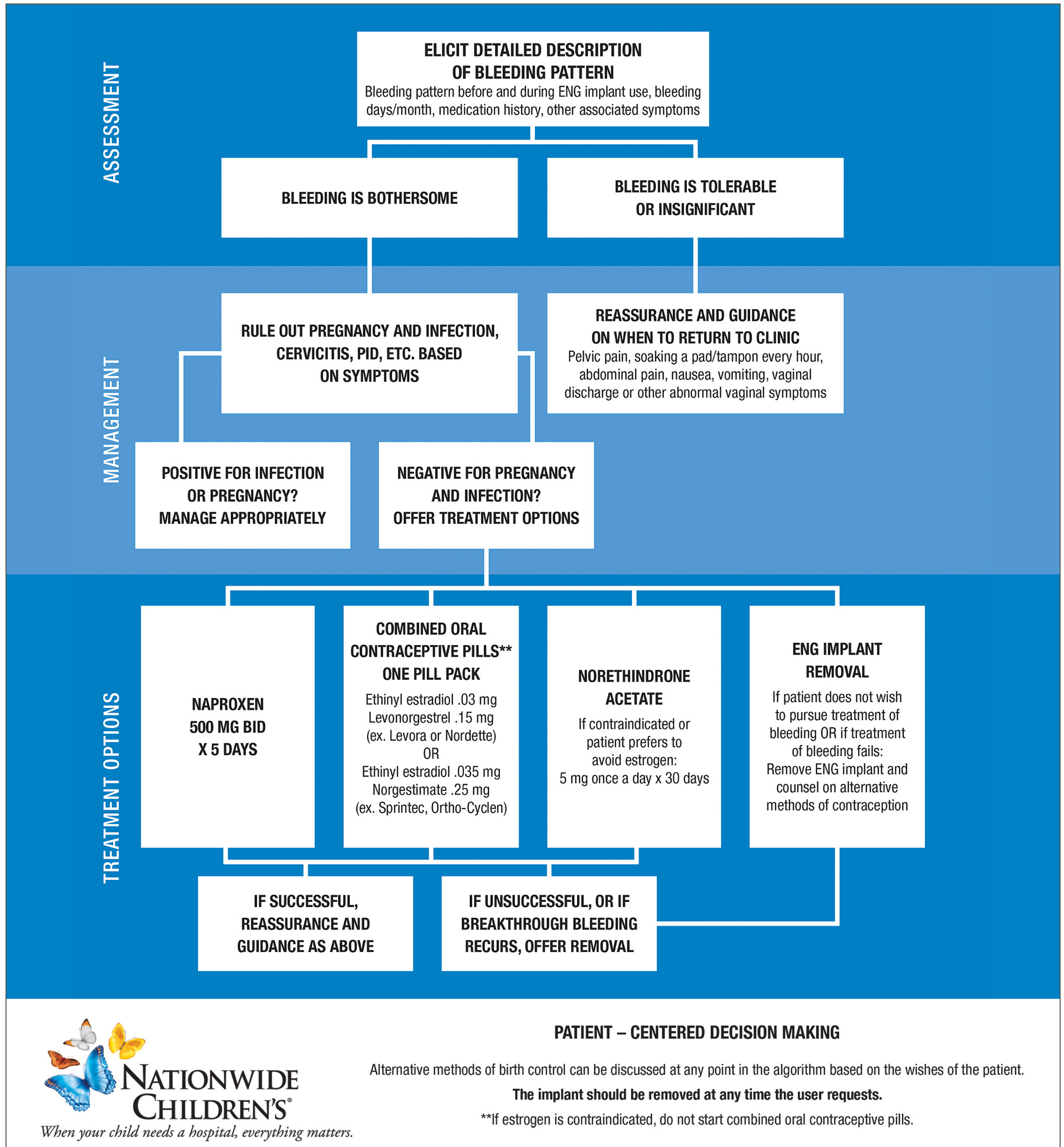
The flowchart below from Nationwide Children's, BC4Teens, outlines the management and treatment options for breakthrough bleeding on Nexplanon®. In addition, one site mentioned their team will often test for infection or pregnancy, even if the patient is reporting tolerant or insignificant bleeding. (see Table 2 on page 15)

Myth Busting for Adolescents and their Parents, Caregivers, Guardians or Support Persons

Fear that IUDs Cause Infections

This specific fear may plague patients, parents/guardians, and providers. Pelvic inflammatory disease (PID) is associated with preexistent chlamydial infection or other pathogens, but many studies have shown that modern IUD users are at the same or even lower risk of PID than non-users (Alton 2012, Grimes 2000, Hubacher 2001, Mohllajee 2006, Toivonen 1991). Risk of infection is elevated within the first 20 days after insertion due to the procedure itself, but is not elevated after that time (Farley 1992). Testing for gonorrhea and chlamydia should be up to date per recommended STI screening guidelines, and can be performed at the time of the IUD placement if due. If testing is positive, appropriate treatment should be initiated. Prophylactic antibiotics in patients without current infection are not necessary or recommended (Grimes and Schulz, 2001).

Table 2: Managing Side Effects of Breakthrough Bleeding with Nexplanon



Used with permission from Nationwide Children's Hospital (Brown, Berlan)
CDC SPR provides the most up to date information and should be referenced for further info

Fear of Ectopic Pregnancy

Given the prevention of fertilization with IUDs, the actual risk of ectopic pregnancy is lower in patients post insertion. However, if a young person with an IUD does get pregnant, there is a higher risk in that setting of ectopic pregnancy (Heinemann 2015; Coles and May 2019).

Fear that the IUD Will Fall Out

This is a common myth based on older data of higher expulsion rates in young, nulliparous people compared to older people. More recent studies have found similarly low rates in both young, nulliparous people and older multiparous people (Coles and Mays 2019; Alton et al., 2021).

Fear of the IUD Causing Infertility

There is a fear/myth that patients cannot get an IUD if they have never been pregnant. This myth comes from both adolescents and adults and has been tied to outdated data from IUDs that are no longer available. Infertility was linked to the Dalkon Shield, an IUD available 50 years ago, but is not accurate for the IUD's modern iterations. Parents/guardians may remember marketing of IUDs to people who have already had children, when a push toward postpartum placement occurred.

Fear that IUDs Cause Abortion

IUDs work by preventing sperm and egg from meeting. Copper 380 mm^2 IUDs also decrease sperm motility and viability, as well as generating an anti-inflammatory endometrial response that may interfere with implantation (Mays and Coles, 2019). IUDs are not abortifacient agents that interfere with embryos that have already implanted (Mays and Coles 2019).

Follow Up Counseling and Appointments

The CDC states adolescents may benefit from frequent follow ups after insertion (Curtis 2016). One interview site started their LARC clinic with follow up scheduled routinely two weeks after placement, partially to do repeat pregnancy tests for quick start patients. They noted this visit had a very high no-show rate, and transitioned to a 4-6 week follow up, which had a lower no-show rate. Another site also had a six week visit to check on side effects, and counsel on issues.

Many providers encouraged patients to prepare for a trial period of 3-6 months to adjust to the methods and may offer additional follow up visits within this time frame. With this counseling, however, it's important to remember that some patients may require removal earlier and this is always ultimately the patient's choice. Be careful to avoid making patients feel like they are forced to continue using a device they do not want for any reason.

Make sure your schedulers are aware of how you want to set up new and follow up visits and which encounters are appropriate for telehealth visits. With post pandemic improvement in telehealth, some settings choose to do a telehealth visit at 2 weeks; if pregnancy is an immediate concern, arrange at that time for an in person visit. Many patients are not sexually active at time of LARC placement, so a telehealth visit might be adequate to answer questions, to mythbust, to build patient and parent/guardian confidence in the LARC, and to demonstrate provider responsiveness to their concerns. In addition, a 4-6 weeks follow up in person visit or telehealth visit could then be arranged. This schedule could be modified depending on the flow of your clinic and depending on what you find works best for your practice's individual population.

The following items may be used as a guide for follow up appointments (Curtis 2016):

- Query for concerns or side effects
- Evaluate patients' level of satisfaction with the method
- Screen for changes in the status of patients' health (including changes in medication) that may alter effectiveness of the current contraceptive method
- For in-person IUD follow up appointments – complete a physical exam, checking for the IUD string

Protocol for Scheduled Nurse Phone Follow Up After Placement

Standard nurse phone follow up may also ease patient and parent/guardian worries over a newly inserted LARC. As one site states,

> *"She'll (the nurse) call them after insertion of an IUD and just follow up and make sure that they're doing okay in answering any questions. So, she's been able to head off a lot of concerns very early on by answering and just being proactive with kind of anticipating questions that patients have."*
>
> *– West OB/GYN*

Many sites commented that the adolescent population needs encouragement, reassurance about side effects experienced after placement, and more follow up attention than adults typically require, with some evidence-based data supporting this process (Sangraula et al., 2017).

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"And one of the reasons I'm available on call is to prevent that I'm having a problem. And I'm reaching that frustration point where nobody's addressing my issue. And now I'm at the point of no return where I just want it out. And we were hearing about that being a problem. We did some qualitative work at the very beginning of providing these services, which was published where kids were saying, like being able to reach someone was really critical and important. And so we really work hard to listen and also respect decisions for removals. But the removal rates are quite low."

– Northeast Adolescent Med

Another site found text messaging to be a helpful way for patients to follow up with a provider about their symptoms:

"And we found, when using a text platform, people were more likely to let us know if they were having symptoms, and let me use a text-based platform to contact them."

– Northeast Adolescent Med

There was some concern over loss to follow up with long-acting devices, missing out on other routine adolescent care. Improved connection through built in procedures for nurse follow up calls and/or telehealth visits may optimize preventive care while improving the experience with a LARC or other contraceptive method.

Reassuringly, however, adolescents who use LARCs have not been found to have increased risk of chlamydia infection compared to short-acting reversible contraceptive users in the first year of use (Mendoza et al., 2020).

Extended Use Data and Recommendations

Data exists for ongoing efficacy past the FDA approved period for many LARC methods.

ACOG supports evidence-based extended use in *Practice Bulletin 186*, see the section "How many years can intrauterine devices and contraceptive implants protect against pregnancy?"

- Copper 380 mm^2 IUD- three studies have reported no pregnancies in parous people for longer than 12 years (few participants were followed for more than 12 years).
- The etonogestrel contraceptive implant is effective for at least 4 years. In 2 studies of 306 participants no pregnancies were reported after 5 years.

The Mirena® levonorgestrel 52 mg IUD is now FDA approved for pregnancy prevention up to 8 years. Liletta® FDA levonorestrel 52 mg IUD is approved for 6 years. Mirena® is also approved for treatment of heavy menstrual bleeding for up to 5 years, and the methods can be replaced at 5 years if used for this indication and bleeding increases after 5 years.

Patient Resources

See page 50 for patient resources.

Confidentiality in Scheduling & Follow Up

Confirmation of Preferred Contact Information

When a patient calls to schedule an appointment related to sexual or reproductive health, it is important for the scheduler in the initial call to verify the correct phone number to contact the patient directly as well as separate numbers for the parents/guardians. Be sure that automated appointment reminders are being sent directly to the patient, with clarity on whether appropriate to also send to the parent/guardian simultaneously. Likewise, confirm with the patient the best way to reach them with confidential results or for follow up sharing of resources (e.g. correct cell number and/or patient email).

Confirmation of Privacy

When on the phone with an adolescent patient, be sure to ask if they are alone or if a parent/caregiver is nearby. It is important to receive confirmation from the patient stating they have privacy to discuss confidential matters regarding their healthcare in that moment.

Confidentiality & Insurance

Adolescents listed as dependents on their parent's or caregivers' insurance policy are faced with a barrier to confidentiality when receiving sexual or reproductive care. As part of the billing process, an explanation of benefits (EOB) is sent out from the insurance company to the policyholder, which includes a statement of services provided. Adolescents may delay or not seek needed reproductive health care out of fear of EOB disclosure on their confidential "right."

Routine screening for STIs, pregnancy, and other reproductive health issues can be "explained" to parents as part of routine care. Placement of a LARC may not always require parental consent (see pages 19-25: State Level Policies and Institutional Policies); yet EOBs will clearly delineate LARC placement which may breach confidentiality for that teen. Settings that do not require insurance reimbursement, such as Title X facilities, would not generate an EOB seen by parents. A number of states have passed policies to protect the confidentiality of dependents. The Guttmacher Institute has compiled a list of current policies, organized by state, that support confidentiality of dependents.

Table 3: Protecting Confidentiality of Dependents, from Guttmacher Institute

Another way to avoid a breach of confidentiality for adolescent patients receiving LARCs is to generate sources of funding for adolescents that do not require contraceptive care to be billed though their parent or caregivers' insurance. Programs available for this type of funding include:

- Title X Service Grant
- Teen Pregnancy Prevention Program
- LARC access programs that may exist specific to your institution, city, or state

Maintaining Confidentiality When Caregiver is Present at Visit

Protecting Confidentiality for Insured Dependents				
State	**State Explicitly Requires Insurer to Provide Confidential Communications Upon Written Request of Insured Dependent**	**Protections Specific to EOBs**	**Protections for Minor Dependents**	
			Confidentiality for STI Treatment	**Broader Confidentiality Provisions**
California	X			
Colorado	X†			
Connecticut			X	
Delaware			X	
Florida			X	
Hawaii				Health care provider must inform insurer when "minors without support" request confidentiality
Illinois	‡			
Maine				Minor may refuse parents' request for EOB or claim denial
Maryland	X			
Massachusetts	X	X		
New York		X		
Oregon	X			
Washington	XΩ	X	X	Insurer may not disclose private health information, including through an EOB, without minor's authorization
Wisconsin		X		
TOTAL	**6**	**4**	**4**	**3**

* An insurer may grant requests for sensitive services or for services whose disclosure may endanger the dependent.
† Applies only to adult dependents.
Ω For adult dependents, applies to sensitive services or to all services if the patient has specified a particular person who may not receive information. For minors, applies to all services unless minor has authorized that information may be disclosed.
‡ Illinois protections only apply to sensitive services provided to Medicaid participants.

**Table 3 was updated as of August 1, 2022 and is being updated regularly based on policy revisions. Check the following link to insure you have the most updated version: Protecting Confidentiality for Insured Dependents

A confidential workflow is important to maintain for all adolescent visits, not just LARC-related visits. Create an environment within your practice to set up your adolescent patient for complete confidentiality from the moment they walk in the waiting room. Parents will often attend appointments with their child and sometimes even join them in the exam room. This can set the stage for an adolescent to refrain from truthfully answering or asking questions about their sexual or reproductive health.

- Having a standardized system for setting up your adolescent patient for confidential care can create a space for diffusion of anxiety and prevent a potential upset. Make the process for adolescent services apparent, specifically for the parent or caregiver. Place parent targeted signs by the front desk and throughout the waiting that list out the expectations and confidentiality of the adolescent's visit. Be sure to include in the brochure: The patient will have one-on-one time with the provider with the parent/caregiver out of the room.

"The other thing that I've really recommended and probably keep pushing on. And it might be something that comes up in adolescent champions, is to have one of those brochure stands, like something that's sitting up the front desk and you can have in exam room that's maybe four or five bullets around adolescent services and confidentiality where on the front, in the patient-parent facing side are bullets about how clinics are going to go, how the patient's gonna spend some time one-on-one with a provider confidentially, that parents will be in the waiting room. And on the backside, the staff facing side, it would have quick bullet point reasoning for each of those bullets."

– Southeast Adolescent Med

Parent(s) & caregiver(s) can also ask for confidential time with the provider as needed.

In the instance that a parent questions or challenges the set expectations, have a pre-made list of responses for staff to reference when responding to the parent. Responses may include:

- The appointment is set up this way to provide your child with the opportunity to talk about their healthcare;
- This provides an opportunity to foster independence & build confidence talking about uncomfortable topics in a safe environment;
- The confidential time allows the young person to practice self-advocacy and negotiating safer choices without the parent directly over their shoulder.

"Triage occurs with the patient and nursing staff alone, then the patient is roomed. And then the parents (are) brought to the room. And they are also made aware that at some point, the provider's going to ask the parent to go back to the waiting room specifically for some confidential time with the adolescent and then brought back at the end of the visit to discuss whatever can be discussed and wrapped up."

– Southeast Adolescent Med

"So patients have a chance to learn how to talk about their own healthcare and discuss things that might be hard to talk about in front of other people. But we always want parents to be involved in their health survey. You know, something like that, where if you put it throughout the clinic, everybody can say and do the same thing consistently, since that's what's been shown to ensure that adolescents receive confidential services and that they're aware of those services so that they know we'll talk about things. As pediatricians, there's a high level of understanding that confidential services for adolescents are important, but there's a low level of protocolization and implementation of those services. And the evidence is that when you don't have that, you know, from front of house to back of house you know, adolescents don't explicitly understand that, or aren't made aware, then they're less likely to, to tell us the things they needed to tell us."

–Southeast Adolescent Med

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Confidentiality & Telehealth

In recent times, there has been a large push for virtual visits. Virtual visits are a great resource to use for contraceptive counseling or follow up appointments that do not require the patient to be physically present in the office. There are some risks associated with these types of visits, but procedures can be put into place to mitigate the risk.

Telehealth Risks & Mitigation	Associated Risk	Mitigation of Risk
Providers	• There is a chance for loss of confidentiality if another person can overhear the conversation	• Begin the virtual visit asking for verbal confirmation from the patient that they are in an environment where they can comfortably talk about private health information
Billers	• Virtual visits are billed differently than office visits & may not have the same procedure associated as in office, which insures confidential billing	• Make sure the practices for confidential billing are in place for all codes related to virtual appointment for sexual or reproductive health

"And the very interesting thing about our Title X family planning, which is true for a lot of our patients, but especially true for the Nexplanon® patients is I would say 90% of our placements, a parent or guardian scheduled appointment recommended the device is aware of it. Um, they may or may not be there. They don't have to sign a consent form, but it's usually their idea, um, almost all the time, which is actually interesting."

– Northeast Adolescent Med

"I think one of the things I'm challenged with in telehealth with this population in general, separate from just contraception is confidentiality and trying to figure out how to do that. Well, and I typically ask the child, if she's alone, if it's sometimes the parent is off to the side, I don't know if they're there or not. And so asking her if she's alone or not, and then asking if I could speak to her alone and just knowing that that means that she will then have some privacy, but I think that's a challenge with telehealth figuring out how to say those words to the mother and the family. It's easier in Ohio in the summer than the than the winter, because the kid can just walk outside. Our colleagues in New York have found that harder, because there's no alone space."

– West OBGYN

Confidentiality

- Tips for Protecting Youth Confidentiality, NASPAG

Even if the patient is able to consent without parental/guardian knowledge, a caregiver may find out about the contraception through insurance records because billing is not confidential. See the section on billing/alternate funding for ideas to obtain devices without using the parents' insurance.

Medical Record Considerations

When documenting IUD insertions or removals in the medical record, it is standard practice for the procedure, testing, and current birth control method to be listed for the patient to access at any time. With adolescents, extra steps must be taken to assure confidentiality in the documentation process, as parents or caregivers often have access to their child's medical records. To mitigate this risk, encounter notes and follow up calls should be marked as confidential consistent with the clinic policy on confidential medical records.

Epic™ open notes and Epic™ proxy access were named as specific areas of concern. Some institutions block **all** parental chart access above the age of 12 years, not specific to contraception care. Much variability exists in rules around confidentiality and reproductive health for adolescents.
(see Table 4 on page 21)

> *"I had just a 20 year old the other day, who's like, when you do call me, can you make sure it's not my mom?....Her mom's number is still the primary contact, even though her cell number's in there. It's like, yeah, of course we'll try to fix this."*
>
> *– Southeast Adolescent Med*

Policies that Affect Provision of LARCs to Adolescents

State Level Policies

Some states allow minors to consent to contraceptive services, while others allow only specific groups of minors such as those who are married or who have delivered a child to consent to those services. The Guttmacher Institute collects updated information on current state policies. As of August 1, 2022, 23 states as well as Washington, DC explicitly allow minors to consent to contraceptive services, and 24 states explicitly allow minors to consent to contraceptives under a specific set of circumstances. These exceptions include:

- Two states (Florida and Illinois) allow a minor to consent to contraceptives if a physician believes their health is in danger without contraceptives.
- 19 states allow a married minor to consent to contraceptives, and 5 states allow a minor who is a parent to consent. 5 states allow minors who have previously been pregnant to consent to their own contraceptives.
- 10 states allow a minor to consent if they meet other requirements, including having reached a minimum age, graduating high school, demonstrating maturity, or receiving a referral from a physician or member of the clergy.
- Four states have no explicit policy on contraceptive access for minors without parental consent (North Dakota, Ohio, Rhode Island, and Wisconsin).

(See Table 5 on page 23)

Table 4: Confidentiality for Adolescent Patients

Confidentiality for Adolescent Patients

Why Confidentiality is Important

- Adolescents are more likely to see a provider and tell them important information about their health when they are told the information will be kept confidential.
- Adolescents who receive assurances of confidentiality are more likely to work with providers in their care and come back for follow up visits.
- Issues that are hard to talk about like violence, depression, anxiety and suicide, care crashes, drug and alcohol use and sexual health concerns are the main causes of illness and death in adolescent patients.

Barriers to Confidential Care

- Compared to young children, twice as many adolescents have no usual place to go for healthcare.
- Less than half of adolescents have had recommended risk screening or confidential time with their provider.
- There is a lack of knowledge about minor consent law.
- There are concerns regarding adolescents confidentiality with insurance and medical records.

What a Confidential Workflow Looks Like

1. During Check-in a member of the front desk staff will inform the patient and their caregiver of confidentiality rights for adolescent patients.
2. A staff member will call the patient back to take vital signs and perform screenings, while informing the caregiver that they will be called to join the patient after the vital signs and screenings are completed.
3. The MA or RN will bring the patient to the exam room, review any screening information and then will bring the patient's caregiver back to the exam room.
4. The provider will begin the visit speaking with the patient and the caregiver. The provider will then ask the caregiver to step out of the room while a discussion continue between the provider and the patient.

TABLE 5: The table below was updated as of August 1, 2022. This table is being updated regularly based on policy revisions. Check the following link to insure you have the most updated version: [Minors' Access to Contraceptive Services (Guttmacher Institute, 2021)]

Minors' access to contraceptive services							
State	**Explicitly allows all minors to consent to services**[ξ]	**Explicitly affirms certain minors may consent to services**					**No explicit policy**[ξ]
		Health	**Married**	**Parent**	**Pregnant or ever pregnant**	**Other**	
Alabama			X*	X*	X*	HS graduate* or 14 years*	
Alaska	X						
Arizona	X						
Arkansas	X						
California	X						
Colorado	X						
Connecticut			X†				
Delaware						12 years‡	
Dist. of Columbia	X						
Florida		X	X	X	X		
Georgia	X						
Hawaii						14 years‡	
Idaho	X						
Illinois		X	X	X	X	Referral	
Indiana			X†				
Iowa	X						
Kansas						Mature minor	
Kentucky	X‡						
Louisiana			X†				
Maine	X‡						
Maryland	X‡						
Massachusetts	XΩ						
Michigan			X†				
Minnesota	X‡						
Mississippi			X	X		Referral	
Missouri			X†				
Montana	X‡						
Nebraska			X†				
Nevada			X†	X*		Mature minor*	
New Hampshire						Mature minor*	
New Jersey			X*		X*		
New Mexico	X						
New York	XΩ						
North Carolina	X						

Guttmacher Institute, https://www.guttmacher.org/state-policy/explore/minors-access-contraceptive-services

Minors' access to contraceptive services							
State	**Explicitly allows all minors to consent to services**ξ	**Explicitly affirms certain minors may consent to services**					**No explicit policy**ξ
		Health	**Married**	**Parent**	**Pregnant or ever pregnant**	**Other**	
North Dakota							X
Ohio							X
Oklahoma			X‡		X‡		
Oregon	X‡						
Pennsylvania	X						
Rhode Island							X
South Carolina			X†			16 years or Mature minor	
South Dakota			X†				
Tennessee	X						
Texas			X†			Φ	
Utah			X†			Φ	
Vermont			X†				
Virginia	X						
Washington	X						
West Virginia			X†			Mature Minor	
Wisconsin							X
Wyoming	XΩ						
TOTAL	**23 + DC**	**2**	**19**	**5**	**5**	**10**	**4**

ξ US Supreme Court rulings have extended privacy rights to include a minor's decision to obtain contraceptives.
* State policy does not specifically address contraceptive services but applies to medical care in general.
† State law confers the rights and responsibilities of adulthood to minors who are married.
‡ Physician may, but is not required to, inform the minor's parents.
Ω The state funds a statewide program that gives minors access to confidential contraceptive care.
Φ State funds may not be used to provide minors with confidential contraceptive services.
Guttmacher Institute, https://www.guttmacher.org/state-policy/explore/minors-access-contraceptive-services

Use the State Legislation Tracker from the Guttmacher Institute to stay up to date on all changes to policies related to sexual and reproductive health in your state.

Reach out to your states public health department to seek additional resources. For example, Jane's Due Process is a non-profit organization that provides resources and guidance to assist minors in navigating confidentiality laws in the state of Texas.

"The STATE statutes on contraception are not very clearly written actually. Our STATE statutes don't give explicit right to minors for confidential care for contraception. It just says, if in the opinion of the provider, bad effects could happen if it's not provided, then the provider can give it, which is pretty loose. You know, like when we were looking at other state statutes, they're much clearer."

– Southeast Adolescent Med

Institutional Policies

Some institutions have established separate requirements for parental consent for procedures for contraception (like IUD or implant insertion or removal) even in states where the minors can legally consent to contraception. Do the homework for your own state/region, solve/plan for logistical challenges, and then present your plan to your institution/department chair and hospital leadership. It is often useful to loop the legal team in regarding hospital wide policy on consent when there are areas that need attention to match national standards and to advocate for change optimally.

> *"We were able to change the hospital policy, which until that time, despite STATE law that allowed confidential services and allowed minor consent, was that anyone under 18 had to have consent (from) a parent or guardian to receive services, unless it was an emergency. We had that changed."*
>
> *– Southeast Adolescent Med*

> *"Can you put in LARCs without parent consent? We can now. Wow. Yes, we couldn't before, but we can now. So that was a hospital policy change. Once that policy changed, then we were able to operationalize that with a confidential workflow that got designed."*
>
> *– Southeast Adolescent Med*

Insurance Policies

Adolescents who use their parents' or guardians' insurance will lose confidentiality when explanation of benefits are sent to the policyholder, even for those over 18 years.

- When insurance coverage is confirmed at check in or ideally before the visit, notify the young person of this issue.
- Determine if other available coverage options exist in your community, if parental awareness is not acceptable to the patient. Title X programs can provide funding for LARCs without using the parent/guardians' insurance, and city or state LARC access programs may exist. Patient assistance plans to cover LARCs or state family planning expansion programs may also help decrease cost to patients. Make this information readily available to providers, nursing, and front desk staff.

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Inside Your Organization

Getting Ready for Implementation

Leadership Engagement

In order to successfully implement a LARC program, buy in and investment from leadership is essential. Leadership engagement involves identifying key stakeholders essential for program implementation and meeting with them to sensitize them to the reasons why the provision of LARCs and reproductive health services for young people will directly and indirectly benefit them. This engagement involves diverse stakeholders, including pharmacy, accountable care organization (ACO) leadership, legal counsel, nursing leadership, business leaders, marketing, youth and/or community representation, as well as hospital/department leadership. Providing your leadership with your specific strategies to implement LARCs into your site(s)/practices and using this toolkit as needed to create your business model can be a useful approach. Seek their input and strategize together on the number and type of sites that will be selected, the personnel needed for successful implementation, and where/how budget requirements can be obtained. Ideally, we recommend that you engage leadership/stakeholders at least 3 months before planned implementation and create opportunities for them to provide input into optimal solutions to all challenges faced at your site.

Strategies for Advocating to Start a LARC Service

Messaging for leadership is simple: improving the reproductive health of young people is the right thing to do for all of the reasons outlined early in this toolkit. Use the rationales that you think will resonate most with your particular leadership, and feel free to borrow any/all of the rationale provided throughout this toolkit. Sample business plans can be adapted to meet your needs, with institutional and staffing commitment, partnership with pharmacy and insurers, with institutional approval and champions helping to make this a reality.

One site simply told their leadership:

"This (provision of LARC services) is standard of care."

– Northeast Adolescent Med

Similarly, another site described the "bandwagon" effect of LARC provision:

"But then I also think it's the whole bandwagon thing. As more providers were trained, they heard of other people who got trained in this practice – so we should do it too."

– Northeast Adolescent Med

One described the urgency of starting a service:

"Just a lot of pushing that this is an urgent thing that needs to happen now, that we were late and behind."

– Northeast Adolescent Med

Links to public health concerns or initiatives can be used to support the need for LARC services as well:

"The openness to adolescent sexual health care came from [our region] having a really terrible infant mortality problem."

– Midwest Adolescent Med

"[Success in LARC programs is supported by those who come] from a public health background who really understand that sexual reproductive health care for women and girls is important to reduce infant mortality as well as maternal mortality and morbidity. It has really led to all of the tremendous work that we've been able to do because it's been embedded in a community public health effort around infant mortality reduction."

– Midwest Adolescent Med

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Practice Setting Considerations

The physical clinic setting has an impact on adolescents' reproductive health. Basics of creating an adolescent-centric environment for your waiting area include the following:

- Create a setting that is visually appealing to youth. When possible, engage youth in the design phase of your space. The clinic space ideally can enhance the visit, with educational materials, audio and/or teaching videos that are safe and engaging for all age groups using the space (obviously with broader content when the space is solely for adolescents than when younger children also frequent that waiting area). All educational materials should be up to date, evidence-based, and designed with youth in mind. Whenever possible, have youth give direct input on whether your materials are a hit or a miss.
- Have educational materials available in English and Spanish or whatever other language a significant percentage of your practice speaks and reads. Visual learning can also reach populations where language is a barrier.
- Some practices have utilized tablets or other computer-based technology to orient youth on available contraceptive methods, management of bleeding or other side effects, and other relevant topics. One urban emergency department found that a tablet based contraceptive video helped build interest in LARCs and was acceptable to the youth served at that site, although it did not result in significantly higher LARC insertions at follow up (Vayngortin et al., 2020).
- Encourage use of patient education that is evidence-based and adolescent-centric or at least adolescent-appropriate, such as bedsider.org (optimally suitable for older adolescents), reproductiveaccess.org, teensource.org, activatecollective.org.
- Include language or images that are gender-inclusive. Putting pronouns ("she/hers", etc) on nametags can be a simple win from front desk staff to nursing and clinicians.
- Privacy screens or other semi-transparent barrier that helps the young person engage in private conversation with the check in desk is useful, so that the adolescent does not have to broadcast to the waiting room that they are here for LARC insertion, or vaginal discharge or other private reproductive health need. White noise can also be similarly used.
- Written materials that introduce or reinforce the clinic's confidentiality guidelines serve as useful reminders that the adolescent may discuss sensitive matters.

Communication Internally and Externally

Building Relationships

One of the key elements to a well-rounded LARC practice is to seek engagement and build relationships with both internal and external individuals and organizations.

Significant value is added when established relationships allow opportunity for referrals, advice, and support while implementing and providing LARC services. Engagement from the following were the most commonly identified across LARC champion providers:

- Family Planning Clinics
- Gynecologists
- Prenatal Care Clinics
- Adolescent Medicine Physicians
- School-Based Health Clinics
- Hospital Medicine
- Family Medicine Physicians
- Local Health Departments
- Non-Profit, Teen Pregnancy Prevention Programs

Situations may arise when you, as the provider, are unable to provide LARC services for a patient. Create a list of specific LARC providers to refer to in those situations. Identify specific clinicians whom you could refer to and who would make the insertion and removal process adolescent-friendly. In this case, provide counseling within your own medical home and transition to a "warm handoff" to one of the previously identified clinicians. Without having those established relationships with other providers, adolescents may not follow through on appointments outside of their medical home.

Outside of direct patient care, support for advocacy can come from your local health departments or teen pregnancy prevention programs run by non-profit organizations.

Going the Extra Mile

One site built an internal contraceptive access collaborative group that meets every six weeks that involves gynecology, prenatal care clinic, adolescent medicine, school-based health and hospital medicine. This committee works on improving access to and use of contraceptives within their health system. They also have a specific person from Epic™ that can make changes that affects all departments.

> *"When I arrived in 2014, they rarely had a family medicine doc there…who (inserted LARCs) at one site, but they sent everything out to the family planning clinic. And as you can imagine, the uptake was poor. I mean, kids are referred regularly. They never got there and they never got large services for a whole variety of things."*
>
> *– Northeast Adolescent Med*

Marketing your Services

Successful implementation sites reached out to other pediatric subspecialties as well as general pediatrics colleagues to make them aware of LARC availability and referral information. Specialties discussed included neurology, rheumatology, cardiology, transplant medicine, hematology, psychiatry, bariatric surgery. Internal marketing via Grand Rounds delivered not just within Children's Hospitals but to other hospital areas that serve adolescents and young adults increased LARC uptake. Educational activities include:

- Grand Rounds
- Talks for school nurses
- Lunch and learn sessions with general pediatricians and other specialties
- Journal clubs and lectures for trainees
- Blog posts by physicians
- Articles for local medical publications

Some sites even noted that residents and medical students who trained with them could be a great source of referrals in the future.

> *"We marketed it specifically to our subspecialties within pediatrics, all of the ones where their patients really shouldn't have an unplanned pregnancy."*
>
> *– Northeast Adolescent Med*

> *"We actually did show after our implementation of that medical home, a reduction in preterm delivery and low birth weight, some evidence of some closing the gap among African-Americans with (infant mortality rate and teen pregnancies). So our thought is that kind of having everything as a one-stop shop with reproductive health and mental health being highlighted is key."*
>
> *– West OBGYN*

> *"We'll hopefully publish some data…Our repeat pregnancy rate, among our patients who receive mental health care is actually lower than our general population, which is counterintuitive. And we think that part of that is due to the fact that we train our…psychologists and healthcare mental health providers and behavioral health care workers, all are trained to talk about reproductive health as well. And so we kind of get a bi-directional referral."*
>
> *– West OBGYN*

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Marketing Mediums

There are a variety of approaches you can take to market LARC services. Marketing strategies include, but are not limited to:

- Print media
- Direct mailing to patients or potential referring physicians
- Ads on Facebook, Instagram, TikTok, Pandora, Spotify, or other social media platforms
- Fax announcements to other physician practices

Marketing could be specific to LARC services or included in material that advertises all Adolescent Medicine or Pediatric Adolescent Gynecologic divisions specialties. Meet with your institution's marketing team to find out what may be available.

Education for other clinicians may be needed to overcome myths about adolescents' eligibility for LARC:

> *"Seeing that, you know, your general practitioner, your pediatricians and family practitioners still very much hearing patients come in and say, Oh, I've been told I'm too young for a IUD."*
>
> *– West PAG*

> *"We get a decent number of OB GYN referrals too. Because again, if they're, especially, if they're on the younger end of the spectrum and they're not comfortable with it, they will, the OB practices will send us patients."*
>
> *– West PAG*

Marketing Pearl: Find your own models! One site discovered this the hard way:

> *"Did you know that in stock photo for marketing, you can't actually use a stock photo of a teenager in a birth control ad? So, even when we were given permission, we had to go back and find teens that we could use, get our own models. I feel like we've really had to do everything from scratch from the beginning."*
>
> *– Midwest Adolescent Med*

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Process

Planning

Scheduling

To create appropriate templates for scheduling LARCs, schedulers need to be mindful that procedure visits require longer visits. Many clinicians aim for at least 40 minutes for an initial LARC, and 20-30 minutes for follow ups. Some clinics aim for a 60 new/30 minute follow up model. When a new provider is training to add LARCs to their repertoire, consider even more time for these appointments.

> *"And so we all met together and they worked on the schedule. So we started off saying, we have to schedule sufficient time, particularly at the beginning when we were doing training. I think ultimately the slots now are 40 minutes slots, but they were an hour and they might've even started off as an hour and a half when we started training. And we also made a point of scheduling LARCs either as the first appointment of the day or closer to the end of the day. So we weren't stuck in the middle of the day when we had our highest volume, because if you can try to do that between 10 and two, it's just too overwhelming."*
>
> *– Northeast Adolescent Med*

Consider dedicated LARC sessions, which may be easier for scheduling and allow for optimal training at the start of a morning or afternoon clinic session, as opposed to at any time in the clinic day. With this set up, a health care setting or hospital could pay an outside provider, such as an OB/GYN or family practice physician to staff this panel and train the staff to provide LARCS themselves.

Provide schedulers with a "skills list" of which providers place which devices, to decrease the detective work of figuring out who inserts contraceptive implants, IUDs, and/or both.

Several nursing models exist for review of appointments to make sure the right patient is on the right clinician's schedule at the right time. Flow for nursing can include the following:

- The nurse reviews all desired/intended LARC referrals for appointments prior to scheduling speaking with the patient when the referral is unclear.
- All new patient referrals (not just LARCs) are reviewed by the nurse to make sure the appropriate referral given
- All new patients speak with the nurse prior to the visit. After speaking with the nurse, they can be scheduled for an additional telehealth visit with the physician or an in-person visit based on the patient's needs.

A telemedicine option for counseling for pre-LARC first visit or for follow up visits improves patient counseling experience and can help to increase reimbursement by providing added time to obtain preauthorization.

Same day insertion can also be done, as long as the provider's schedule has that flexibility. Some providers will set up their schedules to have a same-day insertion slot available. Having mechanisms in place for same day preauthorization, if required, is essential.

Advice for Day of Insertion

For any LARC method, advise the patient that a urine sample for a pregnancy test will be needed at the start of the appointment. For IUDs, discuss the use of analgesia prior to the procedure at home, such as ibuprofen or naproxen prior to the visit for patients without bleeding disorders or allergies to these medications. For sites that do same day placement, they may schedule individuals in a time slot that is long enough to accommodate last minute decisions for same day insertion. Other sites will remind the patient to take ibuprofen on their way into the clinic.

"And so the workflow now is, if you want a birth control conversation appointment, those are almost universally scheduled as phone appointments. And so what we wanted to do was standardize the counseling so that if your colleague talks to the patient, but then they just waltz in and they want you to put your IUD, you want to feel kind of good. They hit all the main points. And so our Smartsets ...are uniform, and everybody should be doing the same counseling around IUD and implants. And so the two step process, which does still exist, is a phone call followed by one in-person visit."

– West Adolescent Med

Front Desk Staff

A reminder on confidentiality: schedulers are responsible for obtaining, confirming, and clearly documenting the adolescent's preferred contact number (read more about this under the Confidentiality in Scheduling & Follow Up section). Having separate numbers for each parent can also enhance communication when necessary.

An example of information on LARC for front desk staff with scheduling reminders is available from Beyond the Pill: Talking Points for Front Desk Staff

Timing of Placement

Some sites noted that they have a nurse work with patients to schedule insertion visits during menstruation. While this has been a common practice, it is not medically necessary.

CDC SPR provides guidance on starting methods, including: How to Be Reasonably Certain That a Woman Is Not Pregnant

Reproductiveaccess.org provides advice on how to switch between methods to reduce pregnancy risk: How to Switch Birth Control Methods

Some providers will place devices outside of the above guidelines to improve access and uptake. Richards (2017) found no increased risk of pregnancy in an adolescent population when implants were placed at any time during the menstrual cycle.

Additional evidence supporting use of the hormonal IUD as emergency contraception has been recently published (Turok, 2021), allowing providers to extend placement windows within 5 days of unprotected sex for the majority of IUDs.

Billing

Medicaid does not require preauthorization for LARCs, and some states such as Massachusetts and California do not require preauthorization, whereas for private insurance in other states such as Ohio, preauthorization may be required. Work with one lead billing specialist to establish a process for preauthorizations and billing, and then have that person train the other billing staff to be able to do the same. Working with billing specialists from gynecology or family medicine at your institution may be very helpful to establish your processes or for trouble shooting.

Having a designated staff member who can be available for same day preauthorizations when needed is highly useful in any clinic that provides LARCs. These preauthorizations can take an hour or more; having a billing staff member who can add that workflow without causing clinic activities to halt can improve success of LARC clinics especially for same day insertions. Of note, Medicaid covers all LARCs and does not require preauthorization. Providers are reminded to bill for both the procedure and device (when appropriate) as well as for the office visit in which STI follow up, menstrual management, or other topics were handled, by billing both an E&M code and modifier 25 for a procedure when appropriate.

Key billing code pearls, adapted from a Maryland fact sheet, include:

- IUDs can only be billed in conjunction with an insertion code for same date of service.
- The CPT procedure codes do not include the cost of supplies. Supplies can be reported/coded separately using an HCPCS code. If the specific J code does not exist, use the unclassified code (e.g. J3490) and indicate the NDC number in the shaded area above the code.
- The diagnosis coding will usually be selected from the Z30 (Encounter for contraceptive management series in ICD-10-CM).

(See Table 6 on page 32)

TABLE 6: Key Billing Codes

Implant Diagnosis Code	Description	
Z30.018	Encounter for initial prescription of other contraceptives	
Z30.49	Removal, implantable contraceptive capsules	
HCPCS	**Description**	**Type**
J7307	Etonogestrel [contraceptive] implant system, including implant and supplies	Nexplanon®
J7297	Levonorgestrel 52 mg IUD	Liletta®
J7298	Levonorgestrel 52 mg IUD	Mirena®
J7300	Intrauterine Copper 380 mm^2 IUD	Paragard®
J7301	Levonorgestrel 13.5 mg IUD	Skyla®
J7296	Levonorgestrel 19.5 mg IUD	Kyleena®
CPT Codes	Description	
58300	Insertion of intrauterine device (IUD)	
58301	Removal of intrauterine device (IUD)	
11981	Insertion, non-biodegradable drug delivery implant	
11976	Removal, implantable contraceptive capsules	
11983	Removal with reinsertion	
IUD Diagnosis Code	**Description**	
Z30.430	Encounter for insertion of intrauterine contraceptive device	
Z30.433	Encounter for removal and reinsertion of intrauterine contraceptive device	

If you are a specialty clinic and patients are referred for LARC placement or the patient is coming to your office with known desire for LARC placement at the time when she/they are scheduled, it is advisable to complete preauthorization when scheduling the visit.

For those institutions/practices in states where private insurance requires preauthorization, have billers and providers keep a list of insurance plans that do not require preauthorization; those patients could easily utilize same day insertion appointments. Medicaid patients do not require preauthorization.

One site successfully advocated with their insurance companies to improve coverage without preauthorization.

"We try to work it out on the backend with contacting insurance after the fact to make sure they know that this is supposed to be a covered benefit and that it needs to be paid for."

– West OBGYN

Three options exist for obtaining LARC devices:

- Pharmacy benefit – a prescription is given for an individual patient and the pharmacy sends the LARC device to the practice.
- Buy and bill – the practice stocks devices onsite and bills the insurance once the device is placed.
- Charity services, such as VaxCare, a LARC access initiative that helps offer contraceptive implants and IUDs on consignment, at no cost to practices to stock, in North Carolina and Ohio currently.

The buy and bill model is more patient friendly, as the devices are immediately available for placement and the patients do not have to wait for the device to arrive. However, the practice does take on some risk for loss if the devices are not used or the insurance does not reimburse adequately.

Some sites were able to obtain startup funds from their institution or grants to establish their initial stock to have on hand.

Ensure that LARC devices are obtained in the most cost-effective manner within your practice, e.g. 340b pricing for all federally qualified health centers, Title X programs, and other qualifying hospitals. List of eligible organizations can be found here.

Paying for LARCs without insurance as of 1/28/2022 remains a costly endeavor for patients, as per the following table. Multiple discount programs remain available for these devices through the companies' websites, with websites listed below.

Out of Pocket Costs (No Insurance)

Brand	Out of Pocket Costs	Reference
Mirena®	$1,049.24	Mirena® – US
Kyleena®	$1,049.24	Kyleena® – US
Skyla®	$1,298.23	Skyla® - US
Lyletta®	$891.78	Lyletta® – US
Nexplanon®	$1,030.64	Nexplanon® – US

Each site utilizes the language from the Affordable Care Act as follows:

"The Affordable Care Act (ACA) generally requires health plans to cover FDA-approved contraceptives, including intrauterine devices (IUDs) at low or no cost to the patient (eg, co-payment, coinsurance). Depending on the specific health insurance plan, patients may still be responsible for the cost of the product and/or product-related costs, such as insertion or removal procedure fees."

Another usable website for investigation of 304b pricing can be found at 340bpvp.com. The actual price may vary based distributor and location.

"That way we could buy them in advance, have them in the clinic, they weren't tied to a specific patient and we could provide the services same day or pretty quickly without having to order a device specific to that patient. And that changed things a lot."

– Southeast Adolescent Med

One site noted that they use mainly Liletta® hormonal IUD due to cost, but that some insurance plans preferentially cover Mirena®. They built a reminder of this into Epic™ to notify them when placing a levonorgestrel 52mg IUD.

Some plans may require the use of the pharmacy benefit, and some programs needed to do this for certain insurance plans (private plans) that they found were not adequately reimbursing for devices in a buy and bill model. In this case the provider may only bill for the insertion (CPT code), not the device (J code).

"Folks got used to it and now we're pretty much a well-oiled machine. We have a little cheat sheet for billing so that anyone who is working that day if it is not our primary billing person they know which insurance we can do and which ones need prior auth."

– Southeast Adolescent Med

Make sure communication occurs between providers and billers, so that denials can be addressed, challenged, and prevented for future patients. Ongoing feedback from billers to providers can improve coding, reimbursement, and hours of work spent on denials. Some sites established programs to monitor reimbursement when initiating LARC services. One site's medical record was able to give feedback on reimbursement using an Epic™ add-on or a separate data analytics platform such as Qlik Sense, software specific to their institution:

"So we have a reporting system called Qlik Sense and so there's a professional billing dashboard that allows you to look at charges and reimbursements based on CPT or ICD 10 provider location."

– Southeast Adolescent Med

For some sites LARC services are actually a money-making endeavor.

"And the good news actually was, it turned out to be a major cash cow for us. So because of our ability to bill insurance, we actually very quickly realized that doing the procedures was a moneymaker for us."

– Northeast Adolescent Med

"That's the question, do they actually get reimbursed? And,we get fully reimbursed for the method and for the procedure. So when we were at our height of doing close to 300 a year mostly at the bigger schools, just because of the sheer volume, we actually were bringing in money for school-based health centers. Usually our motto is lose less."

– Northeast Adolescent Med

However, some interviewees commented that because of low volume they did not get reimbursed adequately for IUDs and had to refer those patients out:

> *"If they have insurance, currently we are referring them to our OB GYN practice. So there's one spot, there's one group of providers that are allowed to do IUDs because they do them in bulk and presumably they can afford to do that."*
>
> *– Northeast Adolescent Med*

If patients do not have insurance or do not want to use their parents' insurance due to privacy concerns, options for alternate funding mechanisms include:

- Title X – establish this fund at your site or know where to refer the patients
- Some states allow the adolescent to establish a new insurance policy in their own name and then you may need to refer the patient to another institution like Planned Parenthood that can open a new chart in her name only
- State family planning programs
  For example in New York
  Contact your state health department for additional information.

- Patient assistance program from the manufacturer
  - Mirena®, Kyleena®, or Skyla®
  - Liletta® Patient Assistance Program
  - Merck Patient Assistance Program
  - Organon Access Program

One program commented that the paperwork required to obtain a device through the patient assistance program is quite onerous.

> *"I think there's a lot of girls who would have gotten that method if they hadn't had to be, you know, cause I mean, by definition, these are unfunded kids who have really chaotic lives and you know, they're going to school and and working and... it's just hard for them to do all this."*
>
> *– Southeast Adolescent Med*

Designated clinic staff or pharmacists may be able to help patients navigate these programs. Similar programs exist for other medications (like HIV PREP and PEP), so work with pharmacy colleagues to see if they already have a workflow for this.

Inpatient billing is a separate challenge. Consider consulting the Ob Gyn department for guidance if they are offering inpatient (generally immediate postpartum) LARC at your hospital.

Billing Resources

Beyond the Pill provides a comprehensive guide for billing here including ICD-10 codes, CPT codes, and coding for common complications

LARC Quick Coding Guide Supplement

National Clinical Training Center for Family Planning, ICD-10 Palm Card

Additional billing resources from UCSF: Intrauterine Devices & Implants: A Guide to Reimbursement

- Coverage
- Reimbursements
- Replacements
- Special Cases
- Removal

ACOG LARC Quick Coding Guide

Nexplanon Billing Tips from Organon

Insurance Verification Process:

- Verify patient has active insurance coverage via website (eg, Availity at availity.com).
- Once verified, contact insurance by phone, and choose the option for "Pre-Cert". You will need to provide the servicing provider's name, NPI, CPT codes and diagnosis code. In some cases insurance plans also want the providers Tax ID #.
  - CPT codes:
    - J7307 (NexplanonTM device)
    - 11981 (insertion)
    - 11982 (removal)
    - 11983 (if removal and then insertion of new device)
    - 81025 (POC pregnancy test)
  - Diagnosis codes:
    - Z30.017 (initial insertion)
    - Z30.46 (checking, reinsertion or removal)
- The insurance rep will check these codes and determine if an authorization is required.

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- Make sure they are aware that LARCs are supplied as a "Buy and Bill" (provider purchase and bill), not patient supplied.

Stocking

> *"We have had a lot of conversations with our pharmacists about exactly how much to stock, when to stock, where to stock."*
>
> *– West OBGYN*

A common initial supply involved having 5-7 of each device in stock. Fewer devices in stock were cited as a barrier to same day placement, as you may run out on the day a patient wants a device placed. For this same reason stock should be re-ordered before you get down to one of any device. One site has a protocol to have a minimum of 2 devices in stock to start a procedure, in case of problem with a device during placement.

Consider stocking fewer copper 380mm^2 IUDs as several interviewees reported that they are not as popular with adolescents.

For levonorgestrel IUDs, some sites felt the 52mg IUD was sufficient to meet patient needs. Others felt one smaller levonorgestrel IUD was helpful and preferred the 19.5mg IUD to the 13.5 mg IUD for the longer duration of use.

Several sites share institutional supply across departments (with gyn or family medicine) so that small volume providers' stock does not expire, and so they can rotate devices that will expire soon to a higher volume clinic.

Build stocking and reordering into part of routine stocking of all clinic supplies. Who does this will depend on where the devices are stored: some sites store them in the PIXUS or other pharmacy system, and so pharmacy staff handle the stocking and ordering. Other sites store them in a secure place in clinic and have nursing or other clinical staff responsible for monitoring and ordering when devices are low.

Additional Resources:

UCSF provides information on stocking including a calculator to estimate stock needed here:

- Intrauterine Devices & Implants: A Guide to Reimbursement
  – Stocking

Vaxcare

- Offers a platform to improve in office availability and access to implants and IUDs by providing LARC inventory on consignment, automated ordering and management and bills the patient's insurance on the back end. This can help to remove the financial risk of stocking implants and IUDs and ensure that inventory is available for visits.

Visit Flow

Create a protocol to send a urine pregnancy test at the start of the visit when the patient checks in or when vital signs are checked. If a vaginal swab or urine GC/CT is indicated (e.g. 3 months after a new partner, or not having been done in the past year in all sexually active patients), that test should be added also.

Follow your institutional time-out policy for procedures. For those practices without this policy, a time-out allows for ensuring that consent has been obtained and documented, that the right device is being put in the right place, that any support staff, clinician and patient are in agreement to proceed, and that procedure is followed the same time, each time, to maximize quality and safety. A sample time-out sheet is included here.

Supplies, Equipment and Room Set Up

See this example from Beyond the Pill:
LARC Materials Checklist for Placement and Removal

Some sites created a pre-made bag or tray with all of the insertion supplies assembled and available for easy prep. Many sites kept these bags in a basket, cart or caddy as might be used for shower supplies.

Sites that saw patients in the same space or near to gynecology or family medicine could benefit from sharing supplies and staff. A room with a gyn exam bed and light is required for IUD insertion and removal. Additional supplies needed may include a Mayo stand and Chux pads.

Medline sells contraceptive implant insertion kit with all supplies except the contraceptive implant and lidocaine. Disposable IUD insertion kits are also available if equipment processing is difficult at your site.

"And then I remember we discovered some issues with…sterile processing, because that was just something that adolescent medicine wasn't used to having any supplies that needed to be cleaned by the hospital. And it turned out it was really a challenge to get them back to our clinic space rather than going into the OR space or somewhere else. An do at some point along the way we discovered these disposable IUD kits that work quite nicely and are literally everything you need except the IUD itself, for $21. And then you don't have to do any of sterile processing or anything."

– Southeast Adolescent Med

Resources for Documentation of Counseling and Procedures

Specific documentation may be required for reimbursement. Providers should work with their insurers to develop documentation templates that will ensure efficient reimbursement.

Documentation examples (shared with permission from New York-Presbyterian Columbia University) include:

Acronym Expansion for IUD Counseling

- **.Iudc:** Reviewed method effectiveness, mechanism of action, benefits, side effects such as changes in menstruation & cramping, steps of IUD insertion, what to expect during and after procedure, potential risks including signs and symptoms of infection, expulsion and perforation, how to manage bleeding/cramping, importance of condom use for STI prevention, and when to return for follow up. Encouraged to track menses. Reviewed how to take NSAIDs (with food) to relieve cramps. Encouraged to get a thermometer for home.

Acronym Expansion for Counseling on IUD insertion after Unprotected Sex

- Used to document counseling when a patient chooses to get an IUD insertion despite unprotected sex in the last 14 days.
- **.Upilarc:** Patient advised that today's pregnancy test may not be accurate due to recent unprotected intercourse and that she should have a repeat pregnancy test 14 days after the last unprotected intercourse. Emergency Contraception was offered and accepted **(if appropriate). Patient still willing to have IUD inserted and understands method needs to be removed if follow up pregnancy test is positive and she chooses to continue the pregnancy. Patient also aware if she chooses to have an abortion that IUD would need to be removed at the time of the procedure and a new IUD placed if that is her choice for future contraception post-abortion.

Acronym Expansion for IUD Insertion

- **.IUDI**
- After consent obtained, patient placed in the dorsal lithotomy position and time out completed. After completing a bimanual examination, a speculum was used to visualize the cervix. The cervix was cleaned with betadine x 3. A tenaculum was placed on the *anterior* (or posterior) lip. The uterus was then sounded to ___ cm. The *Levonorgestrel IUD/ Copper IUD* was then inserted in the normal fashion into the uterine cavity. Strings cut to ___ cm. No complications. Tenaculum removed, sites hemostatic. Pt tolerated procedure well. Patient was given post-procedure instructions including signs and symptoms of infection, expulsion and perforation, how to manage cramping, importance of condom use for STI prevention, and when to return for follow up. Follow up appointment date: xx/xx/xx. Dr. XXX's contact information provided.

Acronym Expansion for IUD Removal

- **.IUDremoval**
- After obtaining consent, patient placed in the dorsal lithotomy position and time out completed. A speculum was used to visualize the cervix. The cervix was cleaned with betadine x 3. The strings of the *Copper IUD/LNG-IUD* were then grasped with a ring forceps and the device was removed easily. No complications. Patient tolerated procedure well.

Placement and Removal Smart Sets

- Contraceptive implant insertion consent: Procedure, benefits, complications, risks and possible alternatives are discussed with patient. All questions answered regarding the progestin contraceptive implant prior to the patient signing the written consent form.

- Preprocedure verification process conducted: yes
  - Consent obtained: yes
  - Correct patient (use 2 identifiers): yes
  - Based on review of relevant information:
  - Correct procedure: yes
  - Correct site: yes
  - o Site marked: yes
  - Correct patient position: yes
  - Equipment/implants available: yes
  - Participants: @ME@

- Procedure
  - The patient's {RIGHT/LEFT:20872} upper inner arm was prepped with hibiclens and the insertion site 8 to 10 cm proximal to the medial epicondyl was

injected with approximately 3 cc of 1% lidocaine with 1/100,000 epinephrine. The contraceptive implant device was inserted subdermally 1 cm below the crease between the biceps and triceps muscles in the usual manner without difficulty. A sterile dressing was applied.
  - Implant palpated by provider - {yes no free text:314490}
  - Implant palpated by patient - {yes no free text:314490}
  - Lot#: ***
  - Expiration date *** was used.
  - Removal date: ***

- Contraceptive implant removal consent:
  - Procedure, benefits, complications, risks and possible alternatives are discussed with patient. All questions answered regarding *** removal prior to the patient signing the written consent form.

- Preprocedure:
  - Preprocedure verification process conducted: yes
  - Consent obtained: yes
  - Correct patient (use 2 identifiers): yes
  - Based on review of relevant information:
  - Correct procedure: yes
  - Correct site: yes
  - Site marked: yes
  - Correct patient position: yes
  - Equipment available: yes
  - Participants: @me@

- Procedure
  - The patient's {RIGHT/LEFT:20872} upper inner arm was prepped with Betadine and the removal site 8 to 10 cm proximal to the medial epicondyl was injected with approximately ___ cc of 1% lidocaine with 1/100,000 epinephrine. A small ___ mm incision was made over the distal end of the contraceptive implant rod. The contraceptive implant device was removed using _________ in the usual manner without difficulty. A sterile dressing was applied.
  - Implant seen by provider – {yes no free text:314490}
  - Implant seen by patient – {yes no free text:314490}

Additional Medical Record Pointers

The order for a LARC device in the medical record may not necessarily populate the MAR with the device or expiration date. Options include working with your institutions' medical record support team to create this workflow in a smart set or order as a historical device (for the MAR) as well as new order (for billing purposes) at the time of placement.

"(With)…the most recent version of Epic,… when you go to discharge them,…you have to do medication reconciliation and it'll pop up and say, Oh, you just prescribed this today. Do you want this added to their med list? So that has actually helped me do better. I was one of those people that was not adding (LARCs to the med list)."

– West PAG

Another time saver is to create dot phrases to answer common patient questions via the patient portal.

Medical record systems may be able to send reminders about follow up:

- One provider used Epic™ to remind her to call patients to follow up post insertion
- Allscripts™ can generate a report of when placed devices will expire so the office can reach out to schedule a removal or reinsertion if desired

Same Day Insertion

Same day insertions can be challenging for many sites and may or may not be possible initially.

One strategy is to hire more providers who are already proficient, so that the site has at least one LARC provider every day in clinic. This shift may happen gradually as your own trainees who received LARC training stay and join the practice. Another strategy involves use of physician extenders who can perform counseling to divide the labor and minimize providers' LARC insertion/removal time. Some practices utilize same day LARC slots, with available procedure and separate recovery room space to allow for these same day procedures. Such practices require staff to help with prior authorizations when needed and correct insurance billing.

"And I think that's really important just to give that model to residents who will then go out into private practice, some of them and, and see that this is feasible to do in the primary care clinic. I'm still skeptical personally about incorporating IUD. Just because the demand seems to be so much lower amongst pediatric patients, you know, that the under 21 crowd but the Nexplanon™'s are flying off the shelves. So I definitely think it's pretty feasible to do though. It tends to be a real, relatively quick procedure. And as long as you've got the supplies on hand, you can do it in, a regular appointment time."

– Southeast Adolescent Med

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Billers and staff need to know which insurances do not require preauthorization; keep a list of policies for common insurances for easy reference.

> *"I mean, I don't want to do same day, but if someone comes in and they're 16 and chief complaint is pregnancy (prevention) yeah, we just gotta make it happen. Um, like I said, I wish that didn't happen. I wish I could at least have a phone call. And even in the complex patients, for instance, you know, in our young, women's bleeding, coming, they come from all over State, sometimes four hours away. So we absolutely will do same day insertions if that's what needs to happen. "*
>
> *– West OGBYN*

One site mentioned financial concerns as a barrier for implementation of same day LARC insertions:

> *"We also tried the model of going and sitting in the clinic and hoping that then there were a couple of patients that needed it. And…that'll kill your business model."*
>
> *– West PAG*

Training

In a study of 5000 adolescents in Massachusetts, Smith and colleagues (2017) found that adolescents were significantly more likely to use LARCs if their primary care doctor was a resident, as opposed to an established pediatrician. Clinic characteristics did not correlate with LARC usage in this study, with most of the youth seen in Title X clinics where funding and insurance was not a consideration (Smith 2017). This study highlights the importance of engaging residents in LARC training early, and then providing them with opportunity to practice these skills safely. This study did not find differences in male versus female resident placements of LARCs. However, other survey studies identified that female providers have been shown to be more likely than male providers to place LARCs (Wilson 2013; Nisen 2016), and that family practice residents place more LARCs than either internal medicine or pediatric residents (Greenberg 2013). This population had a lower adolescent pregnancy rate than national norms, highlighting the utility of embedding ability to insert LARCs and knowledge of how to counsel appropriately about them into pediatric and primary care practices.

LARC Training

Prior to initiation of LARC services within your practice, formal LARC training can be arranged. For sites completely new to LARC provision, outside training resources may be helpful. For example, University of California San Francisco, though the Beyond the Pill program, offers contraceptive training for clinicians, educators, front desk, and billing staff. Types of training available include on-site, virtual, and online training that can be completed at one's own pace.

The FDA mandates that prior to providing Nexplanon™ clinicians complete insertion and removal training including practice with arm models through the manufacturer, Organon.

No similar FDA requirement exists for IUDs. The manufacturers of each device can also provide models and practice devices for insertion training.

LARC Training Resources

Intrauterine Device (IUD) Training by Vendor

Mirena® – Bayer HealthCare Pharmaceuticals
To request a training, call: 1.888.84.BAYER (1.888.842.2937)
For more information, click here.

ParaGard® – Teva Women's Health, Inc.
To request a training, call: 1.877.PARAGARD (727.2427)
For more information, click here.

Skyla® – Bayer HealthCare Pharmaceuticals
To request a training, call: 1.888.84.BAYER (1.888.842.2937)
For more information, click here.

Liletta® – Actavis Pharma, Inc.
To request a live demonstration, call: 1.800.678.1605
For more placement resources, click here.

Contraceptive Implant Training by Vendor

Nexplanon® - Merck & Co., Inc.
To request a training, call 877.467.5266 or fill out this online Training Request form.
For more information, click here.

Many interviewees stressed that this training is not sufficient to feel comfortable with implant provision and additional experience with patients is necessary.

> *"If you don't have actual skills training with the human being, I think it's unlikely you're going to do it in your private practice."*
>
> *– Southeast Adolescent Med*

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Sites reported several different models for initial procedural training of clinicians:

- Send new providers to observe and practice skills in a high volume setting within or outside of the institution. Local Planned Parenthood sites as well as Adolescent Medicine and PAG practices may provide useful connections for this kind of training.
- Pay a skilled provider to staff a procedural clinic at your site and train your clinicians during this time.
- Hire a provider who already has these skills and have them teach others at your site.

> *"So when I joined the practice, we took turns, there was a GYN clinic that had a contraception day. So we went and took three clinical sessions each and observed IUD and Nexplanon™, insertions, and removals, and then brought it back to our practice."*
>
> *– Southeast Adolescent Med*

When a new provider is learning the schedule, templates may need to be adjusted to provide longer appointment times. This adjustment requires the organization's division chief approval for reduced revenue/RVUs on the short term (typically 3-6 months) while the provider's skills level is developing. Transparency of this process with leadership is recommended, noting that for many practices, LARCs can become a profitable product line within pediatric and adolescent practices 6-12 months after initiating usage.

Many interviewees discussed the need for ongoing procedural training support for difficult insertions or removals, or for providers who do the procedures infrequently. Having at least one LARC champion who is available to assist or provide support, for example during administrative time or while seeing patients nearby, can help increase confidence for new providers. Such champions may currently work as part of the institution or practice's existing services. Navigation of how to receive LARC champion support and time for extra training should be discussed up front when building this service line.

Who Needs to be Trained Specifically in Insertion of LARCs?

Some sites chose to have only a couple of providers placing devices to keep up their own skills and volume, other sites strive to have every provider trained in all devices to increase availability. This choice will depend on your setting's demand and clinical interest of providers. For after hours calls and issues, consider designated LARC provider of the day for nurses to contact with issues vs having all providers trained and expected to cover post-insertion problems even if they do not place LARCs.

Training Protocols and Requirements

Number of observed procedures required differed by device and site

- Contraceptive implant insertion: 2 - 10
- Contraceptive implant removal: 5 - 10
- Intrauterine device placement: 5 - 10

Some sites also required ongoing observation of one procedure per two years for maintenance of privileges. This may differ by provider training (physician, nurse practitioner, or physician assistant).

One site recommended that those providers who go on to train others should do 30-40 procedures.

If you are among the first LARC providers in your department, you may need to create the mechanism for privileging of new providers.

For contraceptive implant training or complicated removals, Organon also can help identify resources:

> *"You know, the fact that there was no delineation of privileges to even apply for, you could say that was an obstruction."*
>
> *– Northeast Adolescent Med*

Training Approaches for Learners

Some sites scheduled the FDA required contraceptive implant training for all residents to complete together.

This in-person training was challenging during times of restrictions due to COVID-19.

> *"Because all of a sudden we can't…get 30 residents in a room and do skills training because you can't, …we'd need a football field."*
>
> *–Southeast Adolescent Med*

One site conducted the trainings virtually.

> *"But Merck (the previous manufacturer of Nexplanon™) doesn't recognize them as being certified. So when they graduate those residents who did it during COVID are still going to have to go out to Merck and do another training to be able to order the device. And I tried to get around that multiple different ways."*
>
> *– Southeast Adolescent Med*

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One site also incorporated additional administrative education about LARC to promote future provision.

> *"And the other thing that we do with our residents is we go over all the pearls of this is how you bill, you know, this is the billing code for the device. This is billing code for insertion, you know, removal and insertion or removal. And reinsertion, um, and we talk about ways where you can have your practice buy them."*
>
> –Southeast Adolescent Med

One interviewee modeled continuity of care and encouraged referring residents to place the device with her in adolescent clinic.

> *"They (residents) usually send them (implant placements) to me. So then I call them up and I say, it's your patient. You come to my clinic then, and you can put it into my clinic. And they're like, oh, well, okay. So, so we haven't been as successful at getting the general pediatrics residents to do it in their continuity clinics, but they have done it in adolescent clinic. And we're starting to see a few who are trying to get it done in their own continuity clinic, but logistically they just keep sending them to us. And then the resident comes to us."*
>
> – Southeast Adolescent Med

Keep device models on had in clinic to have the resident or new LARC provider practice before the patient encounter.

> *"It's kind of fun because I've seen the residents do their first one because I make them do it. Like they don't really have a choice, so they do the training and then the first time they put it in, they're so nervous. And by like the second or third time, they're like, this is so easy. I could do this in my practice. I'm like, yeah, like it's a really easy procedure."*
>
> – Southeast Adolescent Med

Education of residents is key no matter what field they go into:

> *"So I do a regular monthly lecture for the residents who are on the adolescent medicine rotation, and it's all contraception. And I … ask them, what do you think you want to go into when you're done? And regardless of what they say, I find a way to apply having this knowledge and information to pass on to patients as critical. (I say,…)there is nothing like being with a provider that you trust, who's giving you reliable information, and then hopefully able to do a soft handoff to the provider who can then actually do the procedure/service."*
>
> – Southeast Adolescent Med

Residents being able to see reproductive health counseling and then LARC placements made them more comfortable. Maybe they would not go on to place LARCs in their future, but they can say to patients:

> *"Hey listen, I have seen the procedure and this is what happens."*
>
> – Southeast Adolescent Med

Challenges in the Education of Resident/Fellow

What do you do if a resident refuses to counsel on LARCs or any reproductive health matters due to religious beliefs? One suggestion for the learner who declines to deliver appropriate nonjudgmental counseling due to their value system would be to have the learner create a presentation or deliverable that addresses the information which they are uncomfortable delivering directly, to help them learn/master the material and ensure that they are aware of a patient's rights to access that knowledge/service.

Table 7: Contraindications to IUD Use (Coles & Mays, 2019)

Absolute Contraindications	• Current mucopurulent cervicitis, esp if known gonorrheal or chlamydial infection (up to 1 week post treatment) • Current PID (up to 3 months post treatment) • Existent pregnancy • Immediately post-septic abortion • Postpartum sepsis • Unexplained vaginal bleeding suspicious for an underlying condition (less relevant for adolescents who have exceptionally low risk for carcinoma or other significant pathology) • Gestational trophoblastic disease • Untreated cervical cancer or cancer awaiting treatment • Mullerian anomalies or other distortion of the uterine cavity that is incompatible with IUD placement • Pelvic tuberculosis (very rare in the USA)
Contraindications to Hormonal Methods	• Endometrial cancer • Concomitant breast cancer • Lupus with positive or unknown antiphospholipid antibodies
Relative Contrindications	• Severe thrombocytopenia • Liver disease such as hepatocellular tumors (for LNG IUD) • Solid organ transplantation complicated by graft failure, rejection, or cardiac allograft vasculoplasty • Pelvic tuberculosis

Teaching Trainees about Reproductive Justice

The concept of reproductive justice and reproductive coercion may be new to residents and colleagues alike. SisterSong defines reproductive justice as the human right to maintain personal bodily autonomy, to choose to not have children, and to parent the children we have in safe and sustainable communities. Adolescent Medicine providers and PAG specialists may have been inundated with messaging about not imposing our biases on the care of the adolescent, but many may have not yet received specific training. Helping to provide concrete examples and implicit bias training can be useful. Case presentations where ethical dilemmas are probed and discussed can be useful, such as when a parent wants a young person to get an IUD but the patient does not want that method. Other scenarios include pregnancy counseling in general, when an adolescent desires pregnancy but the parent/guardian wants to ensure that no pregnancy occurs now. Youth in foster care or in juvenile detention centers also may be subject to reproductive coercion. Providers may encourage certain populations to have a LARC placed, including BIPOC youth, younger adolescents, or those youth who have had a prior pregnancy. Providers may also delay or refuse removals because they believe it is in the best interest of the patient. Discussions with adolescents can include the topics of reproductive justice and what constitutes reproductive coercion, intimate partner violence, and healthy relationships. Bringing the topic up with trainees and colleagues can engender rich discussions with windows of opportunity for growth. Placing these discussions in the context of the young person's reproductive health can empower youth to be an active participant in their journey to create the choices, healthy boundaries, and respectful relationships that can define a healthy sexuality.

> *"I think in adolescent medicine, we're pretty skilled at these conversations. We are much more explicit about what patient centered shared decision-making looks like. And so you really have to mindfully acknowledge your own bias towards Nexplanon™ potentially, and then work to be sure that your counseling and your decision-making process with a patient centers around them."*
>
> *– Northeast Adolescent Med*

"I was going to get the IUD and she (said), …let me just call my mom. I want her to be aware. On the phone, the mom didn't want her to get it and essentially convinced her not to get it. So (for) the mom,..it wasn't about religion, she was in a black family and …was distrustful of sterilizing and the history. She asked that on the phone. I remember her specifically saying, isn't there a history of sterilizing minority women. I said, I'm so sorry that that's happened, but that's not our intention here. And it's not sterilization at all…I went through the whole compassionate response, but ultimately the teen decided to not get the IUD that day and to go home and talk about it."

– Southwest Adolescent Med

"A lot of that language of like this person needs a LARC in them, you know, to prevent them from getting pregnant rather than this is what the patient wants. I've heard providers talk about teens that way."

– Southwest OBGYN

"In foster care the story is – this is my house, you're here. I want to protect you. If you're going to live in my house, you know, then I want you to be protected. I don't want any pregnancies. Even though the child's not having any sex or has never had sex, and it's not even in that frame of mind, there's a strong sense of urgency to want to like prevent that from happening. It's really difficult because eventually you're like, you want to advocate for the teen, but you can't dismiss what the mom's saying. Eventually what happens is the teen acquiesces. And it's just like, fine, whatever, if you want me to."

– Southwest Adolescent Med

"So, and ParaGard™® over Mirena®, if you've got a partner who monitors your periods that, um, you know, that you think about using ParaGard™® and actually one of, one of the strategies I had learned from one of my patients who was experiencing reproductive coercion was to actually cut the string with ParaGard™®."

– Northeast Adolescent Med

Engaging Staff

Staffing Considerations

Cultural competency needs to be more than a buzz word in your practice. Diversity, equity and inclusion and belonging efforts inclusive of training in culturally responsive care can create an office environment that is safe and welcoming to adolescents. Implicit bias training annually as a means of continual quality improvement can help ensure that all comers feel welcome, valued, respected and seen. Clinicians, nursing, front desk staff, lab technicians, pharmacists and others at all levels of health care delivery can impact health care access, accessibility, and reduce inequities. A lack of awareness can lead to challenges in treatment adherence, differences in treatment decisions, and health care outcomes (Hall et al., 2015; Goodman and Bachrach, 2019). Have clinic policies that ensure the same level of high-quality care regardless of gender, ethnicity, socioeconomic status or other factors. Make sure your clinic has clear, unambiguous policies against discrimination in the workplace (Goodman and Bachrach 2019).

Specific training in asking open-ended questions in a nonjudgmental fashion can build skills and inspire confidence in your team. Sessions on destigmatizing youth without housing, those in foster care, or who have been trafficked can also improve skills and thereby improve care at all levels.

Nurses and MAs with previous experience working in gynecology clinics can provide lots of guidance with set-up for the provision of LARCs and other reproductive health services. Create an environment where staff at all levels, from front desk to billing, can partner to improve adolescent-centric care. Capturing youth voices through an adolescent advisory board can also optimize clinic staffing, flow and care. Community stakeholders (health care agencies, schools, and other organizations that serve youth) can be engaged to brainstorm on other ways to optimize care both in and out of the practice setting.

Some sites chose to have only certain nurses and MAs trained to help with LARC, while others decided to train all staff members to be involved.

One interviewee commented that you may not need a dedicated nurse or MA during a training session, because the training faculty can act as assistant to the resident or fellow doing the procedure.

Training Resources

Training / education videos for staff, rotating residents

LARC Insertion and Removal Services by Innovating Education

Medical record counseling templates can be used as educational tool and reminders to cover all materials.

Improving Access to Contraception by Beyond the Pill

Best Practices for Teaching IUD Counseling and Placement Skills

IUD Competency Checklist

In the Exam Room
IUD Screening & Placement Outline

Who to Put on Your Team

Nurses and medical assistants also need to be trained in LARC provision. Some providers have an assistant in the room for device placement and removal while others do procedures independently; this may be a new model for patient visits if you do not otherwise have a dedicated support person with you and may require staffing changes.

Some sites designated specific nurses and medical assistants to become LARC specialists, other sites decided to train all of their staff. If only some staff are trained, schedules may need to be adjusted to have appropriate staff on days that LARC is provided. Consider hiring staff when possible who already have experience with LARC to help train other staff.

Trained nursing staff can also help with scheduling, counseling, phone follow up after placement, and phone service coverage of problems with physician back up.

Staff Training Resources

The LARC First program from National Clinical Training Center for Family Planning provides online training and other resources.

Engaging all clinic staff in the process is helpful.

> *"We were really able to get all the front desk staff, the nursing staff and everyone sort of on board with the care we provide the patients, that we provide it, how we do it and educate them. And from triage back everyone was fairly consistent in their messaging."*
>
> *–Southeast Adolescent Med*

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Nursing staff can be involved in multiple aspects of LARC provision, including streamlining scheduling, providing patient education and coordinating follow up post LARC placement.

"We run all of those kinds of things through my nurse because it hasn't been effective to have schedulers try and make those clinical decisions and what would happen was somebody would come in thinking they were there for their Nexplanon®, insertion and on our schedule they would book it as a birth control appointment and that doesn't help. So what we did is if a patient or patients parent say they want an IUD or Nexplanon® it immediately gets bumped up to clinical staff. So either the nurse of the MA so they can kind of get a clinical history and figure out you get them scheduled appropriately."

– Southwest PAG

"She's (RN) doing a lot of follow-up screening and evaluation, she'll call after insertion of an IUD and follow up and make sure they're doing okay very early on by answering questions and being proactive by anticipating questions patients have."

– West OBGYN

"They (RNs) can handle breakthrough bleeding, we have one dedicated nurse that kind of navigates through the benefits, investigations and things like that."

– Northeast Adolescent Med

"They (RNs) just kind of get it, they provide a lot of reassurance and even questions like is my LARC due to come out or not. So it's very rare we get them, by the time they are getting to us (Providers) the kid needs an appointment."

– Northeast Adolescent Med

- Nurse Manager
- Program coordinator
- MAs

"I mean I can do an IUD on my own but I have to have someone there for the timeout. And those were some of the things that slow us down initially because the hospital policies were like you have to have an MA or an RN but we have no RNs anywhere in our entire school based health center and we only had two MAs at the two biggest schools, so now we have five."

– Northeast Adolescent Med

- Front Desk

"Our role in the LARC initiative was to provide education to sort of everyone that came through, all of the office staff and so the talks themselves were not provider talks they were general talks that included all of the front desk folks and we had the local practice champion move all of those conversations forward."

– Northeast Adolescent Med

- Financial Advisors
  - Family planning benefits/ emergency Medicaid
- Health educator
- Pharmacists
- Provider
  - NP
  - DO
  - MD
  - PA

Champions

Requesting dedicated administrative time for program support can be very helpful. Creating formal titles like LARC Program Director can help facilitate this with leadership.

One site champion coupled LARC roll out with her Epic™ super user status which provided administrative time.

Champions ideally can be encouraged at all levels. One program's very successful LARC initiative was started by residents.

"They (the residents) themselves got trained in Nexplanon™ insertion, and they realized how easy it was. They decided that pediatricians in town should know about LARCs and know about how to talk to teens about LARCs and about birth control in general."

– Northeast Adolescent Med

Where to Find External Support

Beyond the pill training from the Bixby Center for Global and Reproductive Health at the University of California, San Francisco (UCSF) has threefold resources: virtual, onsite, and online (self-paced), as well as provider tools and resources. They have performed randomized controlled trials on use of their evidence-based curriculum in underserved population's ages 18-25 years with efficacy across US state lines (Harper, Lancet 2015). They also provide focused technical assistance to expand contraceptive access, strengthen referral networks, and reduce barriers to provision of LARCs, usable by clinicians, educators, billing and front desk staff, to optimize systems-change at multiple levels.

Some local or state organizations exist to support LARC implementation, for example:

- Texas LARC Toolkit
- Texas Campaign to Prevent Teen Pregnancy

"The north Texas Alliance to reduce teen pregnancy it's called, they have a listing of places where youth can get contraception, including LARCs. So they have a listing of that. We both work with them. And so there is an important distinction, theyre a nonprofit group. So they are doing their own thing. They don't have government support."

– Southwest Adolescent Med

- The LARC Initiative at the University of Rochester

"The LARC initiative isn't a clinical entity at all. But we did outreach and training one practice at a time. When I say trained I mean attended one of our LARC talks about how to talk to teens, how to counsel teens and how to access the State family planning benefit program and how to refer teens if you don't do LARCs in your office."

– Northeast Adolescent Med

Staff Engagement

- Staffing when providers are placing LARCs should include a LARC trained RN and medical assistant
  - For those who desire a medical assistant or RN, it may be time-saving to find RNs that know how to set up LARCs, the procedure, how to prep the patient and how to train new nurses to do all of these things during the LARC procedure
  - Specific training for nurses really helps efficiency
- Some institutions only schedule LARC patients on specific days or clinics or if they know they have a LARC trained nurse
- Protocol for setting up trays

"They go in and they look at their little protocol and they just follow it, they're like we need four sterile two by twos, steri strips, coban."

–Southeast Adolescent Med

- Who covers for side effects?
  - 24-hour nurse consulting service vs adolescent medicine team
  - During office hours- call the office of whoever put it in vs your triage team

The Roll Out: Optimizing

How to Establish Goals and Feedback

Setting goals and receiving feedback are an important step in the process that allows for you, your team, and the hospital administration to track the rate of LARC requests, insertions, and removals. Comparing current volume of LARC requests to current volume of patients receiving LARC services within your practice may create opportunity for identification of a gap in patient care. Once this has been identified, you can use your data to make clear requests to your administrators for additional resources.

One site's champion reviews all notes and billing for new providers.

- It is important to set goals and figure out how to track implementation of LARCs. Billing is another way to evaluate/ track performance and track removals.

"One of the challenges that we have had as an organization is making sure that we use the right metric in our goals around how we operationalize LARC access and preventing teen pregnancy."

– West Adolescent Med

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"One of the things we are able to track is the use of our smart sets throughout the enterprise to see who is using them like family health, women's health."

– West Adolescent Med

"Yeah it's a dashboard of your billing. It's individual to the provider. We get individual provider report cards where they look at the billing codes and so you can see how many LARC devices weve done over that month or a three month period."

– Southeast Adolescent Med

– Follow up can be difficult because not everyone comes back for follow up if the method is working for them. Sites want to make sure that patients are satisfied with their method. If they're not coming back to the same clinic for follow up they may be going somewhere else or getting their LARC removed somewhere else which would then not be represented in the metrics.

"(We educate on) efforts around STD testing with LARC …and making sure that it's consistently happening."

– Northeast Adolescent Med

- Attending providers can role model for residents inclusion of LARC placement in primary care settings, noting that it is feasible and a quick procedure to do in that setting.

"Model to residents who will then go out into private practice and see that this is feasible to do in the primary care clinic. Systems can analyze reimbursement to assess how much insurance is paying in order to remove the concern of placing LARCs not making money.

– Southeast Adolescent Med

"No I haven't done that (analyze reimbursement) yet it would probably help if I had someone do that."

– Northeast Adolescent Med

"It's a really unique situation to have a community wellness initiative written into your strategic plan and a piece of that is teen pregnancy prevention."

– Midwest Adolescent Med

- Patients getting LARCs did not know that was a service their adolescent provider offered.

"A lot of my patients have LARCs but I haven't necessarily put them in."

– West Adolescent Med

"Our patients (adolescents) are kind of uniquely differentiated to be pretty committed to trying their methods and more often than not if we have an expulsion they want to try and get it back in."

– West Adolescent Med

- Scheduling for LARCs happens in a central location different from central scheduling or there are specific LARC scheduling timeslots because a typical appointment time does not have enough time to counsel and place a LARC.
- Managing logistical challenges: It is important to figure out where they will be stored, how will they be billed, confidentiality.
- Providing opportunities for suggestions for improvement
  - Monthly QA meeting with nursing, clinicians who place LARCS to talk about safety, concerns, health equity concerns and metrics.

"How many are we doing on our referral lists? Any issues that have come up. So that has been helpful that we just keep the conversation going."

– Northeast Adolescent Med

"We tracked removals in the beginning. And we used that as a balancing measure to make sure we were not being overzealous in our procedures and doing our counseling. We found that the reversal rate was about 10%. But I think, you know, we should expect that 10 to 20% are going to have them out and that's okay. It does not mean you're doing a wrong job. It means that you're probably counseling them around in a non-coercive way. So they feel comfortable and they're letting you know that they would like to have it out."

– Northeast Adolescent Med

FAQs and Challenges to Consider

Pearls from the Practitioners

- For sites with multiple clinic locations, interviews suggested starting at one site and then have staff from that site train other sites after a trial period. Work with nurses, MAs, schedulers and billers at the primary site to train their colleagues at other sites.
- Some practitioners prefer to manage expected pain with 2% lidocaine gel topically, although it has not been shown to be consistently effective at reducing pain with tenaculum placement or device insertion. However, a 4% formulation reduced pain with insertion in nulliparous people, and a 105 spray formulation reduced pain with insertion in parous people (Lopez 2015). A meta-analysis demonstrated that 1% lidocaine paracervical block reduced pain with tenaculum placement (ACOG 2016; Lopez 2015).

Special Circumstances

LARCs & Amenorrhea

In a patient who is not postpartum and pregnancy has been ruled out, insertion can be performed at any time for both the copper 380mm^2 IUD, levonorgestrel IUDs, and the implant (Curtis 2016).

LARCs as Emergency Contraceptive

The copper 380 mm^2 or levonorgestrel 52mg IUD can be used when a patient is seeking emergency contraception. If a patient is seeking an IUD for this purpose, insertion of the IUD would need to be performed within 5-days of the first occurrence of unprotected sexual intercourse (Curtis 2016, Turok 2021).

LARCs Postpartum

In a patient who is postpartum and pregnancy has been ruled out, insertion can be performed at any time for both the copper 380 mm^2 IUD, levonorgestrel IUDs, and implants (Curtis 2016). For specific guidance after cesarean delivery or while breastfeeding, reference the summary chart of U.S. Medical Eligibility Criteria for Contraceptive Use from the CDC.

LARCs Post Abortion

In a patient who is post abortion, either spontaneous or induced, and pregnancy has been ruled out, insertion can be performed within the first 7 days for both the copper 380 mm^2 IUD, levonorgestrel IUDs, and implants (Curtis 2016).

Inpatient Provision

Many hospitals have not yet mastered how to get LARCs on an inpatient formulary and be able to bill appropriately. Some Adolescent Medicine and PAG service lines are currently working towards increasing inpatient access. Where it is permissible on the obstetrics floors, it should be feasible within a Children's Hospital; recruiting a pharmacist champion may help eliminate obstacles. Similarly, services where a provider has approval to place devices in the operating room can open doors or provide a pathway for how to extend services to a hospital floor. Pediatricians and family practice clinicians can partner with their departments of obstetrics and gynecology to find institutional solutions.

Placement with sedation – Most patients tolerate LARC placement while fully awake and without sedation. For patients who are unable to tolerate an insertion without sedation, or already undergoing a procedure with sedation, it is reasonable to consider LARC placement under sedation, as with youth with developmental delay. Partner with other specialties like neurology, cardiology or bariatric surgery to place LARC when the patient is under sedation for other reasons.

Look for pre-existing sedation resources in hospital – for example within a pediatric procedure unit, gynecology, the emergency department, or the GI unit.

Difficult IUD removals – additional equipment needed: alligator forceps, IUD hook, ultrasound. May decide to refer to gynecology or with ultrasound guidance.

IUD perforation – establish a process for referral to gynecology.

Special Populations: Trafficked Youth

People who are sex trafficked are particularly vulnerable to reproductive coercion through the ways in which they engage with the health care system. Vulnerable populations include adolescents especially who have been victims of childhood abuse and/or neglect, those in the foster care or juvenile justice systems, homeless, runaway, or "throwaway" youth, LGBTQ individuals, especially when lacking family support, undocumented immigrants, youth (and adults) with substance abuse disorders, and those living in communities exposed to intergenerational trauma. Tips for recognizing trafficked adolescents in your office include:

- Tattoos without an explanation, including bar codes (marking them as property)
- Burns, bruises, contusions, fractures, or other signs of physical/sexual abuse
- Presence of a non-related adult at the office/emergency department visit
- Not in control of identifying information (her own ID or passport)
- Not allowed to speak for themselves, especially when a third party insists on being present
- Claiming that is just visiting; unable to clarify/verify address of where staying
- Unclear on where they are (e.g., which city, date)
- Story does not make sense or has inconsistencies
- Chronic vaginal or cervical infections
- Abnormal vaginal discharge
- Abortion complications
- Acting fearful, anxious, depressed, submissive, tense, nervous or paranoid
- Avoiding eye contact
- Excessive reluctance to change into a gown or perform physical exam
- Behavior that does not align with the injury or medical concern ("It's no big deal, in the face of a significant injury)
- Refusing appropriate follow up

From a provider, who recognized reproductive coercion while providing LARCs and reproductive health care for sex trafficked youth:

> *"Because I come (to) one of the homeless sites, 'cause I do a clinic through another hospital system for women that have been sex trafficked on Thursday afternoons, so I'm kind of plugged into their lives, the homeless youth. So I will do it (insert a LARC) if they have a patient that wants it, you know, they can, the, this place is great and they'll let them come here, um, and allow me to place it. So I've done it on a few occasions, but it hasn't been as large a volume as I think it could be. Last thing I want us to think about is somebody putting something else in there? Yeah. That's hard, although safety and you're reversible, but invisible contraception, isn't all bad either."*
>
> *– Southwest PAG*

Contraceptive Care During COVID-19

Before we dive into this section, we wanted to take the time to acknowledge the strength and dedication of everyone, especially those in the healthcare industry, throughout the COVID-19 pandemic. Your commitment to patient care and your flexibility in the rapidly changing world of medicine is both laudable and humbling. From the doctors in the OR, to the nurses screening patients, the COVID-19 pandemic changed the lives of people around the world and our health care industry took a particularly hard hit.

With the rules and regulations changing by the day, our biggest tool here is our ability to be flexible. At this point in time, virtual visits have become a standard of care for patients not requiring in office visits.

Contraceptive Care During COVID-19

Providing Contraception for Young People during a Pandemic is Essential Health Care

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Resources

American College of Obstetricians and Gynecologists (ACOG)
- LARC Program Help Desk
- Practice Bulletin on Long Acting Reversible Contraception
- ACOG LARC Quick Coding Guide

American Academy of Pediatrics (AAP)

Bedsider

Bixby Center for Global Reproductive Health at University of California, San Francisco
- Person Centered Contraceptive Counseling Measure
- Structures & Self: Advancing Equity and Justice in Sexual and Reproductive Healthcare
- Talking Points for IUDs and Implants
- Billing
  - LARC Quick Coding Guide Supplement
  - Intrauterine Devices & Implants: A Guide to Reimbursement
  - Coverage
  - Reimbursements
  - Replacements
  - Special Cases
  - Removal
  - Intrauterine Devices & Implants: A Guide to Reimbursement
- Stocking
- Best Practices for Teaching IUD Counseling and Placement Skills
- IUD Competency Checklist

CDC
- CDC SPR provides guidance on starting methods, including "how to be reasonably certain that a woman is not pregnant"
- Provides advice on how to switch between methods to reduce pregnancy risk

University of Rochester Program – patient rights, programs, maps of providers

Organon
- Nexplanon Billing Tips from Organon

Patient Assistance Programs
- Mirena®, Kyleena®, or Skyla®
- Liletta®
- Merck Patient Assistance Program
- Organon

Guttmacher Institute
- State guidelines for minors access to reproductive services

HRSA
- 340B Eligibility

Kaiser Permanente Guide to Birth Control

LARC First

NASPAG
- Tips for Confidentiality

National Clinical Training Center for Family Planning
- ICD-10 Palm Card

Reproductive Access.org

Patient Resources
- Handouts
  - IUDs and Implants: LARC—Long-Acting Reversible Contraception, NASPAG
  - IUD & Implant Brochure, English
  - IUD & Implant Brochure, Spanish
  - How Well Does Birth Control Work? English
  - How Well Does Birth Control Work? Spanish
  - Emergency Contraception, English
  - Emergency Contraceptive, Spanish
- Websites
  - Bedsider
    - Implant
    - IUD
  - Planned Parenthood
    - Implant
    - IUD
  - Young Women's Health
  - Reproductive Health Access Project
- Videos
  - Birth Control for Your Life
  - Birth Control That Really Works
- Posters
  - Emergency Contraceptive Poster

Society of Family Planning
- https://societyfp.org/research-support/

SAHM
- Consent and Confidentiality

Texas LARC toolkit
- Texas LARC Toolkit
- Texas Campaign to Prevent Teen Pregnancy

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