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# Providing Long-Acting Reversible Contraception Services in Seattle School-Based Health Centers: Key Themes for Facilitating Implementation

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A B S T R A C T

**Purpose:** The purpose of this study was to describe the implementation of a program that provides long-acting reversible contraception (LARC) services within school-based health centers (SBHCs) and to identify barriers and facilitators to implementation as reported by SBHC clinicians and administrators, public health officials, and community partners.
**Methods:** We conducted 14 semistructured interviews with key informants involved in the implementation of LARC services. Key informants included SBHC clinicians and administrators, public health officials, and community partners. We used a content analysis approach to analyze interview transcripts for themes. We explored barriers to and facilitators of LARC service delivery across and within key informant groups.
**Results:** The most cited barriers across key informant groups were as follows: perceived lack of provider procedural skills and bias and negative attitudes about LARC methods. The most common facilitators identified across groups were as follows: clear communication strategies, contraceptive counseling practice changes, provider trainings, and stakeholder engagement. Two additional barriers emerged in specific key informant groups. Technical and logistical barriers to LARC service delivery were cited heavily by SBHC administrative staff, community partners, and public health officials. Expense and billing was a major barrier to SBHC administrative staff.
**Conclusions:** LARC counseling and procedural services can be implemented in an SBHC setting to promote access to effective contraceptive options for adolescent women.


**IMPLICATIONS AND CONTRIBUTION**

This article describes a program that provides long-acting reversible contraception (LARC) services to adolescents in Seattle school-based health centers (SBHCs) and complements research supporting the safety, efficacy, and acceptability of LARC use in adolescents. We offer practical information for SBHCs interested in providing LARC services.

The United States has the highest adolescent pregnancy rate of any high-income country [1]. Adolescent pregnancy often leads to developmental, behavioral, and financial hardships for teen mothers and their children, and it is the single biggest contributor to U.S. girls dropping out of school [2,3]. Providing long-acting

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reversible contraception (LARC) services to adolescents is an emerging strategy to reduce teen pregnancy rates [1,4–6].

LARC devices are safe and highly effective contraceptive methods for all women, including nulliparous women and teens [7–10]. Devices currently available in the United States include the levonorgestrel intrauterine system, copper T380A intrauterine device (IUD) and etonogestrel subdermal contraceptive implant. Long-acting methods have been shown to have superior continuation rates at 1 year (81% vs. 44%) and are 20 times more effective at preventing pregnancy in teens than combined hormonal methods [7,11–13]. The World Health Organization, Centers for Disease Control and Prevention, American Congress of Obstetricians and Gynecologists (ACOG), and American Academy of Pediatrics endorse LARC devices as safe contraception methods for adolescents [8–10,14–16].

Inadequate knowledge and training among providers is a barrier to LARC distribution in the United States. Misconceptions about the safety of IUDs among providers at all levels are common [17–19]. Providers who have recently completed their training and those who have had procedural training in women's health are more likely to offer LARC to adolescents [20].

Multiple barriers contribute to low LARC utilization among U.S. adolescents [21]. Several studies have found that in settings where costs are low and adolescents are educated about LARC, young women choose LARC methods in surprisingly high numbers; 69% of 15- to 17-year-olds in the Contraceptive Choice Project chose a LARC method; in the Colorado Family Planning Initiative, LARC usage increased from 5% to 19% among 15- to 24-year-olds [4,5].

To our knowledge, there are no descriptions or evaluations of programs that implement LARC services in SBHCs in the United States. SBHCs offer comprehensive youth-friendly health care to children and adolescents [22,23], are easily accessible, and provide confidential services [22,24]. SBHCs face unique obstacles to providing contraceptive services, including policies that restrict contraceptive discussions, lack of funds to cover contraceptive costs, inability to dispense contraceptives on-site, and policy constraints for minors seeking confidential services [25–27]. Half of U.S. SBHCs are prohibited from distributing contraceptives by state law, school district, or health center policy [26,28].

Since 2009, Neighborcare Health, a Federally Qualified Health Center and provider of school-based health services in the Seattle Public School District, has offered LARC services in three high school SBHCs and three middle school SBHCs. This article describes the implementation of LARC services in the Neighborcare Health SBHCs.

### *Program description*

SBHCs in Seattle are partially funded through a city levy and are operated by local health care agencies with oversight by Public Health Seattle and King County (PHS&KC). In 2009, PHS&KC acquired a grant from the National Campaign to Prevent Teen and Unplanned Pregnancy (The National Campaign) to promote access to LARC services. PHS&KC chose to focus on adolescents, who are less likely to be offered or to receive LARC services, by organizing LARC trainings for SBHC clinicians.

The National Campaign funding allowed Neighborcare SBHC clinicians to participate in didactic and interactive trainings on LARC recommendations for adolescents, insertion training on pelvic models, and on-site shadowing and insertion training with PHS&KC clinicians. IUD insertions and removals were practiced first on pelvic models; implant trainings were provided by the implant pharmaceutical company. As each clinician felt prepared, their SBHC would start scheduling LARC insertions for interested patients, and an experienced LARC provider (a nurse practitioner (NP) from PHS&KC) would be present to assist the clinician while they performed the insertion.

SBHC clinicians adjusted their contraceptive counseling practices by adopting a tiered contraceptive counseling approach (presenting contraceptive methods in order of efficacy) from the Contraceptive Choice Project [5] and using clear and honest descriptions of LARC insertion pain and common side effects.

The SBHC program addressed cost and confidentiality concerns. The SBHCs are equipped to enroll teens in the *Take Charge!* Program, a Washington State Medicaid program that provides reproductive health services for low-income women and minors unwilling to use parental health insurance because of confidentiality concerns [29]. The *Take Charge!* Program covers any contraceptive method, including LARC, at no cost to the patient. Any provider that serves low-income patients with family planning needs can become authorized to accept *Take Charge!* [29]. *Take Charge*! reimbursement for LARC device placement ranges from $600 to $800 [30]. Although Washington State law allows minors to access reproductive health care services independently, it is standard practice for Neighborcare Health clinicians to encourage all teens to discuss sexual activity with their parents [31].

Neighborcare Health staff delivered proactive educational messages about LARC to key stakeholders before the introduction of LARC services. Neighborcare Health staff attended Parent, Teacher and Student Association meetings to explain SBHC services including LARC. These presentations to parents covered adolescent brain development, decision making, and the importance of keeping girls in school. The presentations also explained that LARC services are part of comprehensive primary care service delivery consistent with services provided in the community.

The rate of LARC insertions has steadily increased over the 4 years this program has been in place. As of January 2015, more than 410 LARC devices have been inserted among the six schools; there have been no adverse reactions requiring the use of emergency services. This article documents the process of implementation and reflects on lessons learned 4 years into the provision of LARC devices at Neighborcare Health SBHCs.

## Methods

We sought perspectives from key stakeholders regarding the implementation of LARC services in Seattle SBHCs.

### *Participants*

We used a combination of purposive and snowball sampling to identify appropriate interview participants, prioritizing individuals directly involved in the planning and implementation of LARC service delivery in Neighborcare Health SBHCs.

### *Procedures*

Semistructured interviews were conducted between June and December 2013. The lead author conducted the interviews using an interview guide. Interview questions were tailored to four groups of key informants based on their unique role in implementing LARC services: SBHC clinicians, Neighborcare Health executive staff, public health officials, and community partners (see Table 1). Informants were queried about the history of the