



Commentary

Incorporating Long-acting Reversible Contraception Into Primary Care: A Training and Practice Innovation



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As the Affordable Care Act (ACA) reduces cost sharing as a barrier to long-acting reversible contraceptive (LARC) use (Becker & Polsky, 2015), attention has turned to other barriers that limit LARC's availability to patients (Weisman & Chuang, 2014). Two key barriers are the limited availability of on-site LARC services at primary care clinics, and inadequate numbers of providers trained in LARC insertion and removal, particularly among non-obstetrician-gynecologists. The importance of expanding the number of providers and facilities offering LARC is widely recognized by women's and adolescent health experts (Harper, et al., 2013; Lunde, et al., 2014; Potter, Koyama, & Coles, 2015). However, LARC provision in the context of primary care by non-obstetrician-gynecologists has received less attention, despite the Institute of Medicine's emphasis that contraception is an essential preventive service for women (Committee on Preventive Services for Women, 2011). As the ACA improves access to primary care, including for younger patients, expanding LARC's availability in primary care settings is of critical importance (Pace, Cohen & Schwarz, 2011).

Across specialties, many outpatient primary care practices do not offer LARC and require patients seeking LARC to be referred elsewhere (Beeson et al., 2014; Centers for Disease Control and Prevention, 2011). In 2011, only 56% of office-based obstetricians/gynecologists, family practitioners, and adolescent medicine specialists offered on-site IUDs; only 32% offered implants (Centers for Disease Control and Prevention, 2011). Although we are not aware of published estimates, on-site availability of LARC

in general internal medicine settings is unquestionably lower given the lack of routine LARC training in internal medicine residency programs. However, 41% to 45% of preventive care visits among reproductive-age women are made to family practitioners or internists (Stormo, Saraiya, Hing, Henderson, & Sawaya, 2014). Compared with women who receive primary care from obstetricians/gynecologists, a greater proportion of women receiving primary care from general internists and family practitioners have chronic medical conditions (Edwards, Mafi, & Landon, 2014) and are at particular risk of complications from unintended pregnancy (Campbell et al., 2013; Chor, Rankin, Harwood, & Handler, 2011; Creanga et al., 2015). Therefore, referring patients from family practice or internal medicine clinics to other facilities for LARC may pose an access barrier to those who could most benefit from highly effective contraception.

Although most obstetricians/gynecologists are trained in LARC, this skill set is uncommon among generalist primary care providers. In national surveys, only 42% and 11% of family practitioners were comfortable inserting an IUD and implant, respectively (Harper et al., 2012; Harper et al., 2013). We are not aware of a national survey assessing internists' LARC provision, but it is likely that even fewer internists receive LARC training. Even when providers are trained, facility-level barriers, including upfront costs and logistics complicate the incorporation of LARC into outpatient clinics (Beeson et al., 2014). This may be particularly true in primary care facilities where gynecologic procedures are less commonly performed.

A recent study demonstrated increased rates of LARC use and reductions in unintended pregnancy rates after LARC provider training in specialized family planning clinics (Harper et al., 2015). Despite clear patient benefits from provider training, we are not aware of published educational or practice models to guide introduction of LARC in a generalist primary care setting. We describe a clinical innovation to foster on-site LARC provision

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in our general internal medicine practice at a large, urban, academic medical center. We sought to 1) create a model to train general internists to competence in IUD and implant placement, 2) develop a systems-level protocol to provide LARC services on-site, and 3) build the foundation for comprehensive internal medicine resident training in LARC.

Our outpatient internal medicine practice sits within Brigham and Women's Hospital in Boston, Massachusetts. Staffed by 60 to 80 residents and 40 faculty members, the practice cares for 19,000 patients, including 68% women. Although practice clinicians routinely provide contraceptive counseling and prescriptions, before this project, patients requesting LARC were referred to obstetricians/gynecologists.

Planning and Implementing the Training

Our LARC project was initiated by 1 clinic faculty member who sought support from the clinic medical director and an obstetrician/gynecologist specializing in family planning. After review of the clinic's capacity and care model, this team determined that the most sustainable strategy for on-site LARC provision would be through intensive training of one or two attending physicians. These providers could develop an on-site LARC practice where other internists could refer patients, creating consistent volume to maintain provider skills, and ultimately provide internal resident training opportunities.

Several challenges arose in developing this LARC training program. Because no internists in our institution provided LARC, the effort needed to rely on obstetrician/gynecologist department facilities and staff while minimizing disruption of obstetrician/gynecologist residents' training opportunities. Training also required a high-volume setting to allow repetitive and efficient procedural experience. Practice staff also required training to schedule procedures and follow-up.

The obstetricians/gynecologists developed a stepwise training strategy addressing these requirements. First, the obstetrician/gynecologist trained the internist using a pelvic IUD trainer model (Gaumard Scientific, Coral Gables, FL, Model S502). After the internist demonstrated proficiency using models, the obstetrician/gynecologist trained the internist within the hospital abortion service, allowing a high volume of IUD insertions

in a setting that obstetrics/gynecology residents did not rely on for training. The third phase occurred in the general gynecology clinic. The internist recruited her own and colleagues' patients desiring LARC and scheduled them into the obstetrician/gynecologist mentor's schedule for precepted teaching. The internist spent 7 half-days in the family planning and gynecology clinics, placing 10 IUDs under supervision. Subdermal implant training was accomplished via established Food and Drug Administration-mandated Nexplanon certification procedures (Merck, Kenilworth, NJ) followed by supervised practice. The most challenging aspect of LARC training was identification of mutually convenient clinic sessions for obstetrician/gynecologist, internist, and patients.

Before the last phase of training, all preparatory steps for on-site LARC provision (Text box 1 and below) took place to create a dedicated LARC clinic within the internal medicine practice. The final training phase took place during the LARC clinic's first three sessions, allowing the obstetrician/gynecologist to oversee clinic processes and ensuring that both physicians felt the internist was ready for independent LARC provision.

Planning and Implementing an On-site LARC Clinic

Developing the clinic required close interdisciplinary collaboration. With the clinic director and obstetrician/gynecologist, the internist developed LARC practice protocols. LARC placement and removal equipment were obtained and a limited initial number of IUDs and implants (about \$650 each), were purchased upfront from the hospital's central pharmacy. Practice leadership assigned the following LARC clinic tasks to an existing licensed practicing nurse: a) monitoring supplies and working with the hospital's central pharmacy and sterilizer to maintain stocks, b) creating and maintaining LARC kits, and c) intraprocedural support. Clinic team members worked with laboratory services to obtain authorization and training in point-of-care pregnancy testing, an essential component to the clinic's protocol, given patient and fetal risks if an IUD is placed in a gravid uterus. The internist trained administrative staff to prepare visit paperwork, including consent forms, specimen labels, laboratory slips for periprocedural testing, and follow-up information.

Text box 1. Steps to facilitate LARC provision within a primary care practice

Steps

1. Obtain clinic leadership buy-in; identify team leadership, providers and obstetrician/gynecologist collaborators/trainers.
2. Identify and obtain any additional malpractice coverage needed.
3. Train provider(s).
4. Develop practice clinical protocols, including scripted counseling materials for referring physicians.
5. Train ancillary clinical staff in clinical support.
6. Develop scheduling protocols and billing templates.
7. Develop strategy for device restocking and equipment monitoring and sterilization.
8. Develop strategies for point-of-care pregnancy testing, if not currently available.
9. Purchase equipment for insertion and removal of prespecified number of devices:
IUD: specula, tenacula, uterine sounds, scissors, ring forceps, with or without cervical dilators.
Implant: mosquito snaps/forceps, scalpel, ruler.
10. Purchase on-hand LARC devices and needed consumables.
IUD: antiseptic solution, sterile gloves.
Implant: antiseptic solution, Steri-Strips, Band-Aids, sterile marker, lidocaine, 22G 1.5-inch needle, gauze.
11. Develop evaluation and quality/safety monitoring strategy.

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