



National Institute for  
**Reproductive Health**

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# **INCREASING ACCESS TO LARC THROUGH DEVELOPMENT OF AN INNOVATIVE CLINICAL PATHWAY**

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**A CASE STUDY FROM  
BRIGHAM AND WOMEN'S HOSPITAL**

Using a framework that centers patient autonomy and choice, the National Institute for Reproductive Health (NIRH)'s LARC Access Project supports organizations across the country who are working to address barriers to LARC, with the ultimate goal of increasing access to the full range of contraception. In 2016, NIRH partnered with organizations in Massachusetts, New Mexico, New York, Tennessee, and Utah to implement innovative strategies that addressed challenges impacting LARC access in their states. This resource is based on NIRH's partnership with the Connors Center for Women's Health and Gender Biology at Brigham and Women's Hospital in Boston, as part of the 2016 LARC Access Project.

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# BRIGHAM AND WOMEN'S HOSPITAL LARC ACCESS PROJECT: A QUALITY ASSESSMENT STUDY

It is widely recognized that long-acting reversible contraception (LARC) are among the most effective forms of contraception, safe for most women, and acceptable to patients.<sup>1</sup> Nonetheless, a range of barriers pose challenges to full access for all patients, including patient and provider knowledge and attitudes,<sup>2</sup> low rates of LARC skills and provision among primary care providers,<sup>3,4</sup> and variable availability of on-site LARC services even in reproductive health clinics,<sup>5</sup> due in part to payment and reimbursement uncertainty.<sup>6,7</sup>

This case study describes the Connors Center for Women's Health and Gender Biology ("Connors Center") Core Team (Core Team)'s quality assessment study – including its objectives, process, and findings – and outlines possible measurement strategies to assess access to LARC services at Brigham and Women's Hospital (BWH) and similar settings.

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## BWH PROJECT OBJECTIVES

- Define the elements of a high-quality LARC referral within the BWH system.
- Assess barriers to a high-quality referral process.
- Develop strategies to overcome these barriers at the provider and health system levels.

Clinicians at BWH have noted occasional long delays between referral and LARC placement, and high rates of missed visits among patients who are referred for LARC.<sup>8</sup> Attrition during the referral process may reflect barriers similar to those seen at clinics that require a two-visit LARC placement protocol<sup>9</sup> and when patients are required to return for a separate visit for a LARC insertion instead of receiving an insertion immediately postpartum or post-abortion.<sup>10,11</sup>

While many primary care providers offer same-day LARC care in accordance with national standards,<sup>12</sup> other providers with patients seeking LARC refer them to colleagues who are trained in LARC care. With NIRH support, the Connors Center proposed to study the systems and processes used to refer patients for LARC within the vast and diverse network of providers and service locations that comprise BWH. Through a multifaceted quality assessment process, the Core Team aimed to identify the clinical pathways to LARC, the systemic factors that restrict LARC access, and potential interventions to improve the referral process and access to LARC within the BWH system.

# THE QUALITY ASSESSMENT PROCESS

The Core Team for the BWH LARC Access Project was small: an internist primary care provider who provides LARC on site at her practice, a social scientist specializing in reproductive health with an appointment in the Department of Obstetrics and Gynecology, a research assistant, and a reproductive health consultant.

While there are multiple potential pathways by which a patient can access LARC in the BWH system, the Core Team decided to focus specifically on the pathway beginning with a primary care provider or specialist who does not provide LARC on site and refers patients to a LARC provider within the BWH provider network.

To understand the components of a patient's experience from the point of a patient's request for LARC from a non-LARC provider through the patient's receipt of a LARC method, the Core Team enlisted the help of a Steering Committee of providers from an array of specialties and locations and conducted qualitative interviews with staff from several levels of patient care at BWH.

## THE STEERING COMMITTEE

The Core Team recruited members of the wider BWH system to a LARC Steering Committee that would provide local insight, information, and intervention ideas for this quality assessment. Through their relationships with members of the Core Team, committee members were identified as having a vested interest in expanding access to LARC and/or being in a position to effect change once possible interventions were identified. Members included:

- staff from the Community Health and Public Payer Patient Access program at Partners HealthCare
- representatives of primary care and OB/GYN physician groups across BWH settings
- representatives of key specialties that care for patients of childbearing age

The Steering Committee met twice as part of the LARC Access Project. In the first meeting, the Steering Committee did the following:

- defined the characteristics and outcomes of a high-quality LARC referral
- identified facilitators of, and barriers to, high-quality LARC referral pathways within the BWH system
- identified key personnel to be interviewed to understand strengths and weaknesses in existing processes

In the second meeting, the Steering Committee:

- analyzed interview findings and intervention ideas
- ranked potential institutional interventions in terms of anticipated impact, feasibility of implementation, and scalability
- identified methods of measuring access to LARC

# DEFINING HIGH-QUALITY REFERRALS FOR LARC

The first project objective called for defining the elements of a high-quality LARC referral within the BWH system. With input and guidance from the Steering Committee, the team developed a set of guiding principles, [Making and Receiving Effective Referrals for Long-Acting Reversible Contraception](#). The goal of this document is to guide individual providers affiliated with BWH as well as to identify BWH system improvements that would ensure expeditious access to care while protecting patient autonomy. Since providers are less likely to adopt new practices if recommendations are cumbersome or require extensive additional training, a desire to minimize the clinical burden further shaped final recommendations. The document was designed to be widely applicable in large health care settings as well as adaptable for use in other settings or in discussions with a variety of target audiences.

[Making and Receiving Effective Referrals for Long-Acting Reversible Contraception](#) identifies responsibilities for the referring provider, LARC provider, the patient, and the system. An effective referral for optimal patient care means “closing the loop” for patients.<sup>13</sup> All parties involved – the referring practice, the providing practice, and the patient – need to communicate effectively to ensure the patient’s needs are met and the patient is not lost in follow-up processes without a contraceptive method of their choice.

The document, provided in full in the [Appendix](#), offers guidance on the minimum services a patient needs when receiving a referral for LARC, including ruling out pregnancy, ensuring informed choice, and supporting timely access.

## EXCLUDE PREGNANCY

**Providers must be reasonably certain that a patient is not pregnant prior to initiating LARC methods, particularly intrauterine devices (IUDs).**

**Whenever possible, the process of excluding pregnancy should not cause any delay in initiating contraception.**

## TIMELY ACCESS

**Patients should have access to an effective contraceptive method of their choice as soon as possible upon request.**

## INFORMED CHOICE

**Complete and accurate information should be provided in a patient-centered manner to enable patients to make an informed choice about which method of contraception to initiate.**

# ASSESSING BARRIERS TO EFFECTIVE REFERRALS

## IDENTIFYING KEY INFORMANTS FOR QUALITATIVE INTERVIEWS

To get a complete picture of existing referral processes and to identify challenges, barriers, and opportunities for improvement, it was critical to interview staff in different roles and locations. Seven key informants who serve different roles within the BWH network were identified as sources who could provide detailed information about strategies currently used to facilitate LARC access at BWH, and who could provide diverse perspectives on existing barriers and opportunities. Using a semi-structured interview guide, provided in full in the [Appendix](#), the Core Team interviewed these seven key informants, each of whom served in clinic and administrative roles that received and/or provided LARC referrals at six different clinical sites.

From key informant interviews and Steering Committee discussions, four factors emerged as major barriers to patients being given an effective referral for LARC in the BWH system.

### 1. NO FORMAL PROCESS FOR LARC-SPECIFIC REFERRALS

Non-LARC providers can refer a patient to a LARC provider via the generic electronic health record (EHR) referral to the OB/GYN service; however, this process can be confusing to some providers, does not guide the referring provider through considerations of counseling or eligibility, and can take several weeks, particularly if a patient is new to the OB/GYN clinic. In contrast, providers who have experience referring patients for contraceptive services and who particularly prioritize this service might email or call a LARC provider directly to schedule an appointment for a patient. Referring providers reported that this is the best strategy for ensuring a patient gets a LARC method after requesting it. It seems that the most effective referrals depend on a strong professional relationships between non-LARC providers and LARC providers.

### 2. GAPS IN PROVIDER KNOWLEDGE OF LARC

While many providers in the BWH system have extensive knowledge of LARC methods and many provide them on site, there are just as many providers who have limited knowledge of LARC and are not trained to provide or remove them. A limited pool of LARC providers can contribute to long wait times for an appointment, and providers with limited knowledge of LARC may not be able to provide effective referrals for patients to access care.

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\*While under the Patient Protection and Affordable Care Act (ACA) there should be no patient cost-sharing for contraceptives, there are instances where reimbursement for the device is denied globally to the abortion procedure. This clinic also pre-verified LARC services for non-participating or out-of-state plans that tended to have more exclusions for services (e.g., grandfathered plans or plans with coverage for in-state providers only).

### **3. GAPS IN PROVIDER TIME TO DISCUSS CONTRACEPTION**

Comprehensive, patient-centered counseling on reproductive life planning and contraception takes time. Patients see primary care doctors and specialists for a myriad of reasons other than preventing or planning pregnancy, and time to discuss all of the patient's needs is limited in each visit.

### **4. LONG WAIT TIMES FOR LARC APPOINTMENTS**

While there are many LARC providers in the BWH network who can accept any BWH-affiliated patients, the wait time for a new patient to see an OB/GYN for a LARC appointment can vary depending on practice type and provider availability – a wait of three or more weeks is not uncommon in some practices.

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## **IDENTIFYING STRATEGIES TO OVERCOME BARRIERS: INTERVENTIONS AND PLANS**

During the second Steering Committee meeting, committee members developed five possible interventions that could help overcome barriers that had been identified in the qualitative interviews, and improve LARC access in the BWH system. Committee members ranked these interventions for anticipated impact, feasibility of implementation, and scalability/dissemination factors. Discussion of how change typically happens within the large BWH system guided feasibility rankings. Interventions are presented below in order of feasibility rank.

### **1. ADAPTATIONS TO THE ELECTRONIC HEALTH RECORDS SYSTEM**

The Steering Committee identified adapting the BWH EHR (Epic) to enable LARC referrals as the most feasible and highest-impact intervention. Both referring and LARC providers had identified deficiencies in, and lack of follow-up to, EHR referrals as a theme in many of the qualitative interviews. As described above, the general referral system in the EHR does not allow specification or prioritization of LARC services or provide any decision support that could optimize referral effectiveness and efficiency. The Core Team collaborated with the EHR team and the OB/GYN department to develop LARC-specific options within the existing OB/GYN electronic referral processes and to make the referral system more user-friendly overall. Within the “patient plan” section of the patient record, providers are able to make an electronic referral for LARC along with other referrals, lab orders, prescriptions, etc. This also permitted BWH to measure the frequency and effectiveness of LARC referrals going forward. Since the EHR was being revised, this option was both feasible and a relatively simple change to make. Once the EHR was updated with new referral pathways, the Core Team planned to begin an education campaign to raise awareness about how to make effective

referrals through the new electronic referral pathway among OB/GYNs and primary care providers at BWH.

## 2. DISSEMINATION OF LARC REFERRAL PRINCIPLES AND GUIDELINES FOR BWH

The guiding principles in [Making and Receiving Effective Referrals for Long-Acting Reversible Contraception](#) were to be disseminated internally at BWH at the same time the EHR was updated. By promoting this document as the standard for effective referral-making and introducing it alongside an electronic process for referrals and tracking LARC referrals, the Steering Committee expected that LARC providers and referring providers would be encouraged to adjust their referral processes accordingly.

## 3. CLINICAL SESSIONS DEVOTED TO LARC

Increasing availability of LARC appointments through adding clinical sessions devoted to LARC, e.g., an evening LARC clinic, would be an important way to reduce wait times for appointments and increase accessibility of LARC services. This strategy had the added benefits of occurring at a set time and being staffed by experienced LARC providers, so referring providers without a professional relationship with the LARC clinic could feel confident referring patients to it. This intervention relies on existing LARC providers' willingness to add time in their schedule and/or on non-LARC providers to obtain the necessary training and experience to offer LARC at their practice. Given enthusiasm from Steering Committee members, several of whom are LARC providers, it is likely that new clinical sessions dedicated to LARC will be added in the future at BWH.

## 4. CREATION OF A FAMILY PLANNING NAVIGATOR ROLE

The Core Team and Steering Committee were enthusiastic about creating a family planning navigator position that would provide contraceptive counseling and schedule appointments for multiple sites at BWH.

### DEFINING A FAMILY PLANNING NAVIGATOR



A non-LARC provider could refer a patient to this family planning navigator, who would provide non-directive, patient-centered contraceptive counseling, schedule an appointment with an appropriate provider, and give the patient anticipatory guidance on how to prepare for the visit and what to expect for an insertion visit at that specific practice.

The Core Team and Steering Committee agreed that this was a highly desirable option because of the potential to streamline a scheduling process and ensure consistent messaging for patients requesting LARC care. However, this option was recognized as less feasible than others due to the costs and resources associated with creating this position, including the hiring and training of a new staff member to serve as a point person for multiple practices.

## **5. LARC TRAINING AND EDUCATION FOR REFERRING PRACTICES**

Enabling primary care providers to provide comprehensive and accurate information to patients on all available contraceptive methods and to use best practices in family planning counseling would be ideal; however, it is not realistic to expect all clinicians to obtain the extensive training and gain the experience needed to safely and effectively provide LARC. After receiving LARC training and supervision, it is important for clinicians to provide LARC often enough to maintain the level of comfort and skill required to provide high-quality care. The patient mix in some primary care practices may not offer enough opportunity for providers to maintain their skills. While it may not be feasible for all physicians to provide comprehensive LARC care, health educators, medical assistants, and nurses could be trained to provide essential counseling and education on contraceptive options when a patient must be referred out to a LARC provider.

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## **MEASURING ACCESS TO LARC CARE**

As of 2018, no systems existed at BWH to measure access to, or quality of, LARC care. Along with the development of the guidelines and principles for making and receiving referrals, the Core Team identified methods of measuring access to LARC care that were framed by considerations of reproductive justice, current measures of access to contraception, and system feasibility.

## **REPRODUCTIVE JUSTICE AND CONTRACEPTION**

Research shows that when patients receive high-quality counseling and education when deciding upon a contraceptive method, they are more likely to continue using their chosen method.<sup>14</sup> Research has also shown that black and Hispanic women are more likely to feel pressured to limit their family size and use contraception.<sup>15,16</sup> The recent focus on promoting LARC use at a population level based on contraceptive efficacy research, coupled with the availability of new and less expensive methods, has raised concerns that providers may lean toward promoting LARC rather than using effective counseling methods that are patient-centered. This style of provider-patient interaction infringes on patient rights and independent decision-making.

In response to concerns that when providers focus on increasing patient LARC use, contraceptive counseling becomes coercive, SisterSong: National Women of Color

Reproductive Justice Collective and the National Women’s Health Network published the [Long-Acting Reversible Contraception Statement of Principles](#)<sup>17</sup> in 2016. Since then, leading reproductive health and justice experts and organizations, as well as medical institutions and individuals, have signed on to endorse this Statement of Principles, which greatly influenced the BWH LARC Access Project.

## MEASURING ACCESS VS. USE

In a parallel effort to shift the focus from increasing LARC use to improving LARC access for patients choosing LARC methods, the National Quality Forum published a quality measure, *Contraceptive Care - Access to LARC*, in 2016 that was submitted by the Office of Population Affairs (OPA):

### NATIONAL QUALITY FORUM: CLINICAL PERFORMANCE MEASURE OF CONTRACEPTIVE CARE – ACCESS TO LARC



“Percentage of women aged 15-44 years at risk of unintended pregnancy that is provided a LARC, i.e., implants, intrauterine devices or systems. It is an access measure because it is intended to identify situations in which women do not have access to the LARC.”<sup>18</sup>

While the outcome measure here is a “percentage of women,” OPA does not provide a recommended optimal percentage. The idea is that the proportion of patients using LARC should not be zero percent, which would clearly indicate that there is no access to LARC. OPA has sought to clarify further by saying that the percentage should not be too high either, which could indicate patients are being coerced into choosing LARC. The real significance of this quality measure is that it highlights the importance of measuring access to LARC rather than promoting LARC use.

***It is important to note that patients may change their minds about their contraceptive method at any time and for any reason, and providers must be receptive and supportive of patient preferences. Alternatives to LARC methods must be available at the time of a LARC insertion visit in the event that a patient’s preferences change. Any patient who chooses to have a LARC device removed should receive prompt, efficient, and respectful device removal and discussion of other contraceptive methods as needed or desired.***

## BWH RECOMMENDED ACCESS MEASURES

Using the tools in the previous section as a foundation, the Core Team considered ways to measure quality of LARC care, including access, in the BWH system. At the outset of the project, there was no reliable way to measure or track system wide access to LARC. Adaptations to the EHR enabled a standardized tracking system to be put in place for referrals and services. Once this system was established and all providers were trained to use it, the following metrics could be used to assess the quality of LARC care:

### 1. TIME FROM REFERRAL TO INSERTION VISIT

Although the American College of Obstetricians and Gynecologists recommends same-day LARC placement,<sup>19</sup> it is unrealistic for all BWH providers. In [Making and Receiving Effective Referrals for Long-Acting Reversible Contraception](#), the Core Team recommends no longer than two weeks wait time from a patient receiving a referral to their LARC visit. Provision of “bridge methods” while patients wait for the LARC appointment is an essential part of a high-quality referral to support the patient in preventing unplanned pregnancy until the LARC appointment.

### 2. NO-SHOW RATE

A LARC visit no-show rate would capture the proportion of scheduled LARC visits when patients do not come for their appointment. The no-show rate should consider a patient’s first scheduled visit for LARC, any subsequent rescheduled visits, and visits scheduled for LARC removals. If a LARC provider’s no-show rate is high, it might be an indication that one or more issues arose during the referral process, which may include the following:

- A patient was not effectively counseled on their options.
- There is a mismatch between the patient’s and provider’s interest in a LARC method.
- A patient is underprepared for a LARC visit.
- The LARC visit was not convenient for the patient.

### 3. NON-PLACEMENTS

A non-placement measure would track the proportion of scheduled LARC visits during which a patient referred for LARC arrives at the appointment but no LARC method is provided. This would include visits with patients who eventually return to get LARC as well as those who never end up getting a LARC method. There are several possible reasons that LARC may not be provided at a visit, including the following:

- Pregnancy could not be ruled out.
- Active cervicitis is noted at visit for IUD placement specifically.
- Patient changed their mind about method choice.
- Provider-specific protocols (e.g., requires multiple visits before providing LARC to allow for adequate counseling or requires results from sexually transmitted infection testing).

A high proportion or a trend of non-placements and/or no-shows could indicate that there are procedural inefficiencies and/or inconsistencies in provider protocols. In this case, additional work would need to be done during the referral process to elicit patients' values and preferences and support patients' decision-making.<sup>20, 21</sup>

#### **4. NUMBER OF VISITS WITH A LARC PROVIDER POST-REFERRAL AND PRE-INSERTION**

Looking at the average number of visits a patient makes to a LARC provider before receiving a LARC can help paint a picture of what happens between a referral for a LARC (for example, from a primary care provider) and LARC placement. This measure includes "non-placement" visits for those patients who eventually get LARC. The reasons for multiple visits are the same as reasons for non-placements, and a high number of patients who required multiple visits between referral and LARC provision can indicate that there are inefficiencies with protocols and/or counseling and education messages in the provider network.

### **THE LIMITATIONS OF THESE METRICS**

None of these measures adequately assess the degree of integration of and adherence to principles of reproductive justice. Using only administrative data to assess quality leaves an important gap regarding patient satisfaction, so it is advisable to prospectively collect data to assess patients' experience.

In addition, while it may seem to some that patient satisfaction and care quality can be approximated by the proportion of patients who choose to have their LARC method removed before the device's expiration, it is important to underscore that patients choose to remove a LARC for many reasons that may or may not be related to their visit experience when receiving the method. For example, patients may be more likely to remove LARC devices if they are coerced into receiving them, in which case a low removal rate could suggest that patients were fully engaged in decision-making about insertion. However, patients may also request removal of LARC devices they fully desired. They might seek removal because of unacceptable side effects, new medical diagnoses, or changes in life circumstances and reproductive goals. Therefore, the Core Team did not want to place a positive or negative focus on patients' choice to remove a LARC method.

# CONCLUSION

Quality assessments in a hospital system can result in improved understanding of clinical pathways to LARC and the strengths and weakness of the current referral systems and technology infrastructure.

People of childbearing age need comprehensive family planning services to support their decisions regarding whether, when, and how to become a parent. Since many patients require a referral from their primary care doctor to a LARC provider, building systems to facilitate and measure effective, patient-centered referrals is as important as expanding the cadre of providers who provide LARC placements themselves.

As described in this case study, effective referrals for contraceptive services, particularly LARC, often take place outside the formal referrals system, relying on professional relationships between providers to meet patient need for family planning services. While it is clear that patients benefit from provider relationships, to ensure that all patients have equal access to high-quality care, standardized and measurable systems provide essential scaffolding that supports effective referrals for critical services such as contraception, including LARC.

The BWH LARC Access Project demonstrates the importance of engaging providers across a hospital system and across disciplines to design an informative quality assessment process, identify possible interventions using a reproductive justice framework, and take into account patient satisfaction when assessing high-quality LARC care.

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APPENDIX:

# INCREASING ACCESS TO LONG-ACTING REVERSIBLE CONTRACEPTION THROUGH DEVELOPMENT OF AN INNOVATIVE CLINICAL PATHWAY

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## KEY STAKEHOLDER INTERVIEW GUIDE

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**This interview guide is designed to be used to interview staff in clinical and administrative roles at different clinical sites locations across a health care system. The goal of these semi-structured interviews should be to understand existing referral processes for long-acting reversible contraception and to identify challenges, barriers, and opportunities for improvement.**

**Interview date (mm/dd/yyyy):** \_\_\_\_\_

**Interviewer:** \_\_\_\_\_

**Study ID:** \_\_\_\_\_

## 1. FOR CLINICIANS

(If interviewee is not a clinician, skip to section 4)

### 1a If one of your patients is interested in obtaining an IUD or implant, how do you typically proceed?

*For those interviewees who refer patients to another provider:*

If you refer to another provider, where does that provider practice?

- Within your practice?
- In a different practice?
- Other (please describe)?

## 2. FOR REFERRING CLINICIANS

(If clinician is not a referring clinician, skip to section 3)

### 2a If you refer patients for long-acting reversible contraception (LARC), please tell me about the process that you use to make the referral.

- To whom do you refer patients?
- Who makes the actual appointment?
- What do you give the patient when you make the referral?
- Do you do any routine testing prior to referral?
- Who in your practice helps the patient with the referral process?
- Is there any routine follow-up by you or your colleagues to ensure that the referral happens?

### 2b Describe for me what an ideal LARC referral process would look like in your opinion.

### 2c Please estimate the average length of time it takes your patient to get a LARC, if you can.

### 2d What kinds of challenges, if any, have you faced in referring patients for LARC methods? For other contraceptive services?

- For example, tell me about a time you tried to refer a patient and they weren't able to receive the device as quickly as you hoped.

### 2e Describe for me any feedback you've received from patients on the referral process.

### 2f How could this referral process be improved?

*Probes for follow-up could include:*

- Do you feel that patients generally get timely appointments?
- Do you feel that they receive LARC devices in a timely way, or are there changes that could be made in the referral process that could improve this?
- Do patients receive all the information they need?

**2g What additional information, if any, would be helpful for you or other providers to have in order to counsel and refer patients for LARC methods?**

**2h What additional resources, if any, would be helpful in counseling and referring patients for LARC methods?**

*Probes for follow-up could include:*

- Grand rounds or continuing medical education credits?
- Training for your staff?
- Written resources? What types of written resources?
- Educational videos or apps for patients?

### **3. FOR PROVIDING CLINICIANS**

**3a Please estimate the average length of time it takes a patient referred to you to get a LARC, if you can.**

**3b What kinds of challenges, if any, have you encountered when you see patients who have been referred for LARC? For other contraceptive services?**

**3c What feedback have you heard from patients on the referral process?**

**3d What feedback have you heard from your frontline staff on the referral process?**

**3e How could this referral process be improved?**

**3f What are some of the key elements to a successful LARC referral?**

- For example, when someone refers a LARC patient to you, what makes things go well?

### **4. FOR OTHER STAFF INVOLVED IN CONTRACEPTIVE CARE OR REFERRALS**

**4a If you are working with a patient who is interested in obtaining an IUD or implant, how do you typically proceed?**

*If a referral is required:*

Tell me more about the referral process.

- To whom do you refer patients?
- Who makes the actual appointment?
- What do you give the patient when you make the referral?
- Do you do any routine testing prior to referral?

- Who in your practice helps the patient with the referral process?
- Is there any routine follow-up by you or your colleagues to ensure that the referral happens?

*If interviewee receives a referral:*

Tell me more about the scheduling process:

- Who makes the actual appointment?

**4b Please estimate the average length of time it takes patients in your practice to get an IUD or implant once they have expressed interest (or once they have been referred), if you can.**

**4c What kinds of challenges, if any, have you faced in referring patients for LARC or scheduling patients who have been referred to your practice? For other contraceptive services?**

- For example, tell me about a time you tried to refer or schedule a patient and they weren't able to receive the device as quickly as you or they had hoped.

**4d Describe for me any feedback you've received from patients on the referral process.**

**4e How could this referral process be improved?**

**4f What are some of the key elements to a successful LARC referral?**

- For example, when someone refers a LARC patient to you, or you help a patient with a LARC referral, what makes things go well?

**4g What additional information, if any, would be helpful for you other staff to have in order to facilitate LARC referrals?**

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APPENDIX:

# MAKING AND RECEIVING EFFECTIVE REFERRALS FOR LONG-ACTING REVERSIBLE CONTRACEPTION

Health care providers from all specialties encounter patients in need of effective contraception. For many patients, preventing or delaying pregnancy is essential to maintaining well-being while managing other medical and psychosocial needs. Ideally, providers from all disciplines would have adequate time and resources to discuss reproductive life planning with patients and engage in patient-centered care around contraception. However, referral to providers with expertise in contraception is often needed, particularly when a patient desires long-acting reversible contraception (LARC, i.e., intrauterine devices and contraceptive implants), which requires providers trained in LARC insertion and removal.

LARC methods are the most effective forms of contraception<sup>1</sup> and can be inserted during a single visit with a trained provider. At Brigham and Women's Hospital (BWH), clinicians have noted high rates of missed visits among patients who are referred for LARC<sup>2</sup> and long delays between referral and placement. Attrition during the referral process may reflect barriers similar to those that have been documented as contributors to high rates of loss to follow-up when two-visit LARC placement protocols are in place with the same provider (one for counseling/education and a separate visit for insertion)<sup>3</sup> and when patients are required to return for a separate LARC visit following delivery or abortion, in lieu of immediate insertion.<sup>4,5</sup>

Identified barriers to patient-centered, efficient, and effective LARC referrals at BWH include: no formal process to refer for LARC, gaps in provider knowledge of contraceptive methods, lack of knowledge about how and where to refer patients for LARC, providers' limited time to counsel patients, and long wait times for LARC appointments. Efforts to reduce these barriers could facilitate patient access to contraception and reduce the risk of unintended pregnancy.

Standard procedures for counseling and referring patients for LARC may help reduce some of these barriers. This document provides guidance on the minimum services a patient needs when receiving a referral for LARC: excluding pregnancy, supporting timely access, and ensuring informed choice.<sup>6</sup>

## EXCLUDING PREGNANCY

***Providers should be reasonably certain that a patient is not pregnant prior to initiating LARC methods, particularly intrauterine devices (IUDs). Whenever possible, the process of excluding pregnancy should not cause any delay in initiating contraception.***

The Centers for Disease Control and Prevention (CDC) recommends that health care providers be reasonably certain a patient is not pregnant prior to initiating IUDs.<sup>7</sup> Specifically, pregnancies in people with IUDs are at higher risk for complications such as spontaneous abortion, septic abortion, preterm delivery, and chorioamnionitis.<sup>8</sup> For contraceptive implants, the 2016 *U.S. Selected Practice Recommendations for Contraceptive Use* indicates that "in situations in which the health care provider is uncertain whether the woman might be pregnant, the benefits of starting the implant likely exceed any risk; therefore, starting the implant should be considered at any time, with a follow-up pregnancy test in two to four weeks."<sup>9</sup>



## REFERRING PROVIDER RESPONSIBILITIES

- Assess the likelihood of pregnancy at the time of referral in accordance with the most current *U.S. Selected Practice Recommendations for Contraceptive Use*.<sup>10</sup>
- If needed, provide a “bridge” method of contraception until the LARC appointment (e.g., DMPA injection, oral contraceptive pills, contraceptive ring or patch, condoms, or emergency contraception).
- Provide routine screening and counseling for sexually transmitted infections (STIs) in line with CDC guidelines.<sup>11</sup>



## LARC PROVIDER RESPONSIBILITIES

- Use protocols to reasonably exclude pregnancy at the LARC insertion visit in accordance with the most current *U.S. Selected Practice Recommendations for Contraceptive Use*<sup>12</sup> and provide single-visit insertion whenever possible and clinically appropriate.
- Test for STIs at the time of IUD insertion in line with CDC and American College of Obstetricians and Gynecologists (ACOG) guidelines<sup>13</sup> among patients who have not undergone routine STI screening or who are at increased risk based on their history.



## PATIENT RESPONSIBILITIES

- Take steps to prevent pregnancy and STIs prior to the LARC insertion appointment.



## SYSTEM RESPONSIBILITIES

- Ensure timely processing of pregnancy and STI test results.
- Facilitate easy communication of test results to the LARC provider.
- Provide decision support that enables providers to adhere to national standards of care (e.g., EHR reminders).

# TIMELY ACCESS

*Patients should have access to an effective contraceptive method of their choice as soon as possible upon request.*

According to ACOG, it is a best practice to provide LARC the same day a patient requests it as long as pregnancy can reasonably be excluded.<sup>14</sup> Since not all health care providers and facilities provide LARC on site, we recommend that a patient be scheduled for a LARC insertion appointment within two weeks of being referred for a LARC method. This timeframe allows flexibility for provider availability; further, adequate counseling and provision of effective “bridge” contraception can facilitate providers’ ability to reliably exclude pregnancy at the placement visit.

In addition to timely access to receiving LARC, all patients should be able to discontinue LARC devices promptly upon request.<sup>15</sup>



## REFERRING PROVIDER RESPONSIBILITIES

- Provide a referral to a LARC provider during the visit when a patient requests it.
- Counsel about all methods in a patient-centered manner. If a LARC appointment is not available immediately, provide a “bridge” method until the appointment and advise condom use to prevent STIs.
- Refer to a local LARC provider that has appointment availability within two weeks.
- If a patient misses their LARC appointment, it is the responsibility of the referring provider to follow up with the patient to discuss a contraceptive management strategy, including additional referrals as needed.



## LARC PROVIDER RESPONSIBILITIES

- Schedule appointments for LARC insertions and removals within two weeks of a patient request or provider referral.



## PATIENT RESPONSIBILITIES

- Arrive on time to the LARC insertion appointment or reschedule the appointment in advance if more time is needed to make an informed decision about contraception.



## SYSTEM RESPONSIBILITIES

- Track wait times for LARC insertions and removals.
- Ensure data are available so managers and clinicians can monitor scheduling practices and adjust accordingly to ensure timely appointments with a LARC provider for insertions and removals.
- Enable providers to schedule appointment times that are convenient for patients.

# INFORMED CHOICE

***Complete and accurate information should be provided in a patient-centered manner to empower patients to make an informed choice about which method of contraception to initiate.***

Individual patients' contraceptive needs vary and so does their need for information, counseling, and support in obtaining a contraceptive method. To determine if a patient is a good candidate for LARC, it is important to use a patient-centered approach that takes into account patient clinical characteristics, preferences regarding contraceptive methods, and reproductive goals. A good candidate for LARC will understand the benefits, contraindications, insertion process, and considerations around discontinuation of the chosen method well. High-quality contraceptive counseling prior to referral could minimize the likelihood of no-shows for the insertion visit and increase the likelihood of satisfaction with a method.<sup>16</sup> Failure to present for a scheduled contraceptive visit increases patient wait time to receive a preferred contraceptive method, which thereby increases patient risk of unintended pregnancy. It also decreases access for other patients who desire timely appointments and wastes provider time.



## REFERRING PROVIDER RESPONSIBILITIES

- Provide counseling on contraceptive methods in accordance with national standards of care described in *Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs* prior to insertion visit.<sup>17</sup>
- If needed, provide the patient with the phone number of the referring LARC provider or a patient navigator who can provide additional contraception counseling prior to the insertion visit.
- As needed, refer the patient to evidence-based web resources for medically accurate information on contraception prior to the insertion visit.

Recommended sites include the following:

1. Bedsider: [www.bedsider.org](http://www.bedsider.org)
2. Planned Parenthood: [www.plannedparenthood.org/learn/birth-control](http://www.plannedparenthood.org/learn/birth-control)
3. Reproductive Health Access Project: [www.reproductiveaccess.org/contraception/](http://www.reproductiveaccess.org/contraception/)



## LARC PROVIDER RESPONSIBILITIES

- Provide a variety of LARC options on site.
- Ensure the patient is confident in their choice at the LARC visit prior to insertion.
- Remove the LARC method and provide another contraceptive method of choice upon a patient's request. Ensure timely access to removal appointments.
- Test for STIs if indicated by CDC and ACOG guidelines.



## PATIENT RESPONSIBILITIES

- Share preferences with providers, ask questions, and take steps prior to the LARC insertion visit to feel confident in the decision to get a LARC method during the scheduled insertion visit.



## SYSTEM RESPONSIBILITIES

- Ensure the availability of accurate and comprehensive patient education materials that can be shared with patients electronically and/or in print in multiple languages.
- Ensure that informed consent materials reflect current evidence in multiple languages.

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