

BEST PRACTICES IN LARC COUNSELING

Stephanie Teal, MD, MPH

University of Colorado School of Medicine

Learning Objectives

After this presentation the attendee will:

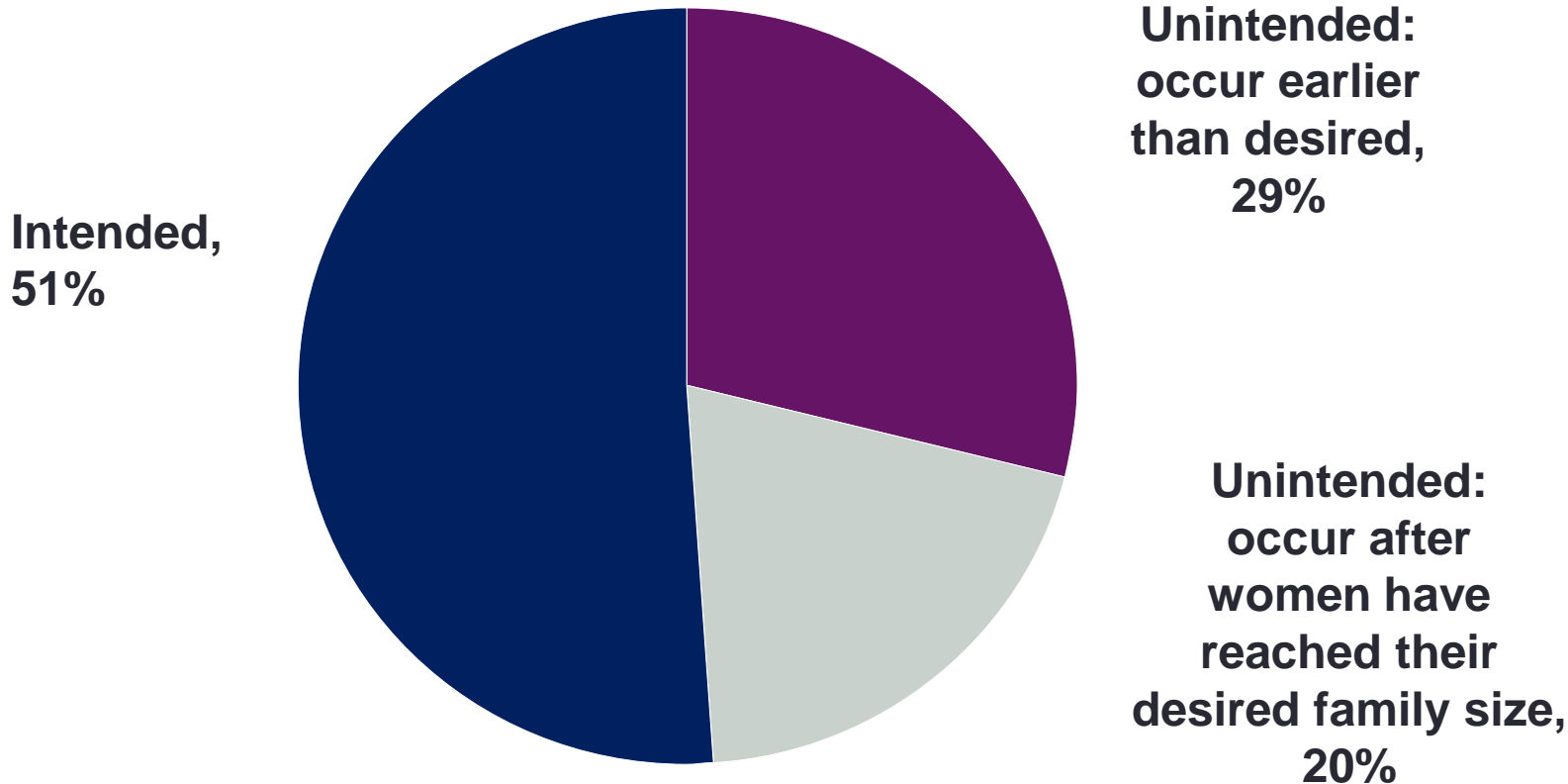
- Take a patient-centered approach to contraceptive counseling
- Develop individualized strategies for provision of contraception
- Address common patient concerns and misconceptions about LARC

Why is counseling different for LARC?

- Cannot be self-discontinued
- “Long-acting” sounds like a major commitment
- Not normative
- Myths and misconceptions

Why LARC for family planning?

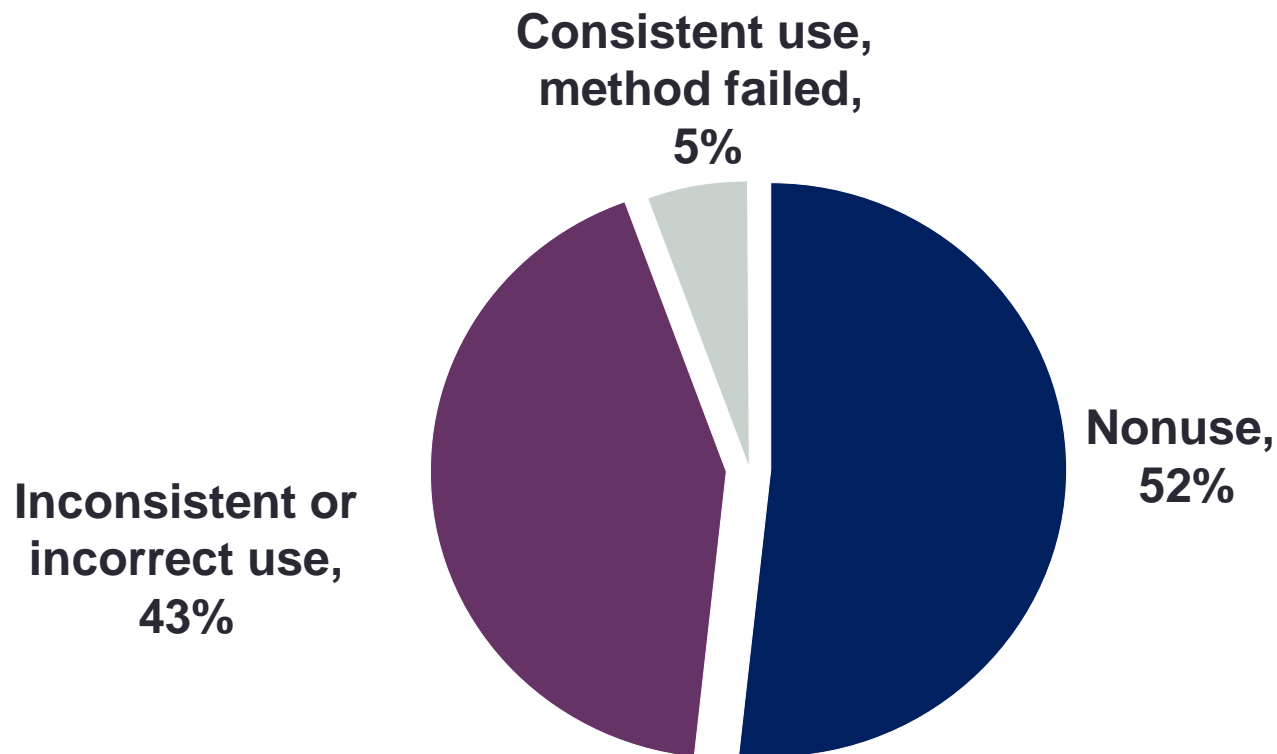
Unintended Pregnancy Rates



Approximately 6.4 million pregnancies per year

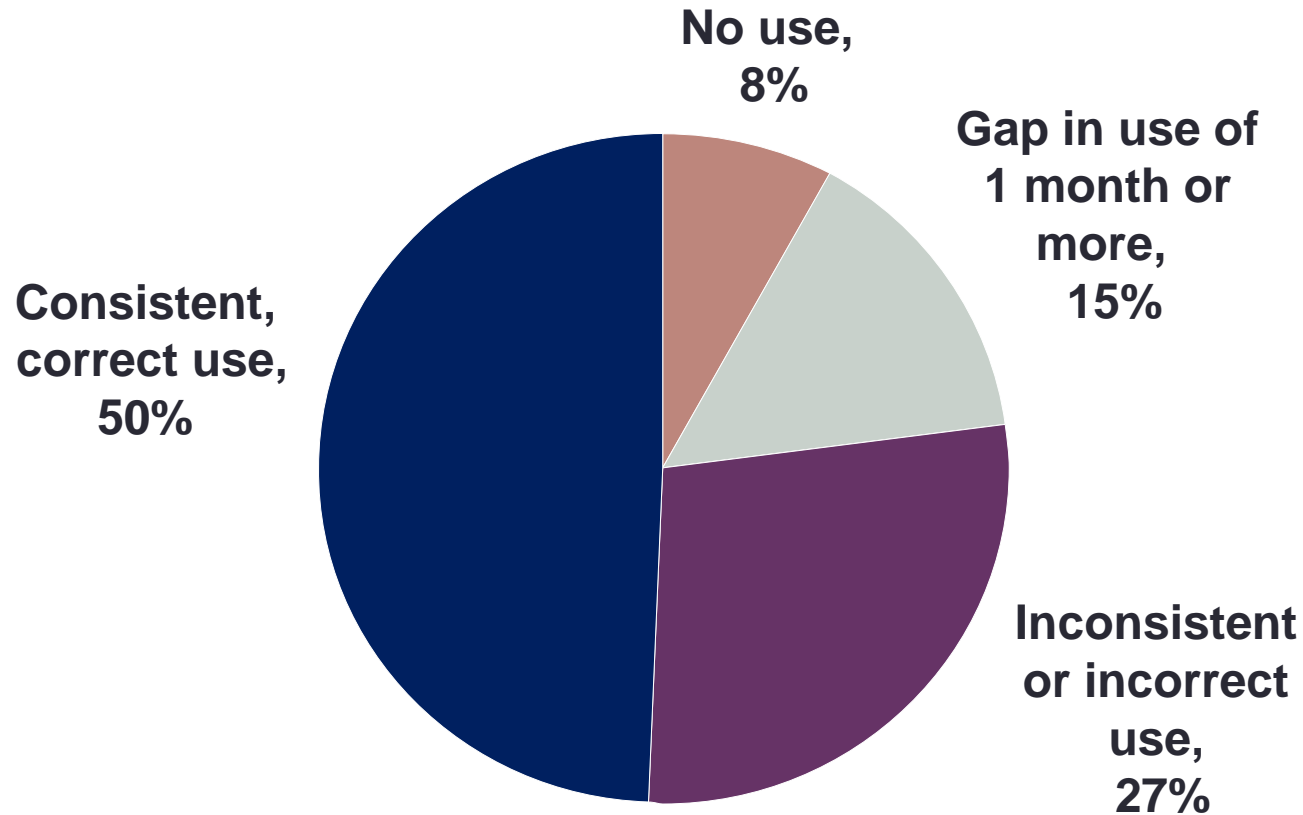
Frost JJ, Darroch JE, Remez L. *In Brief*. 2008.

Unintended Pregnancy and Contraceptive Use



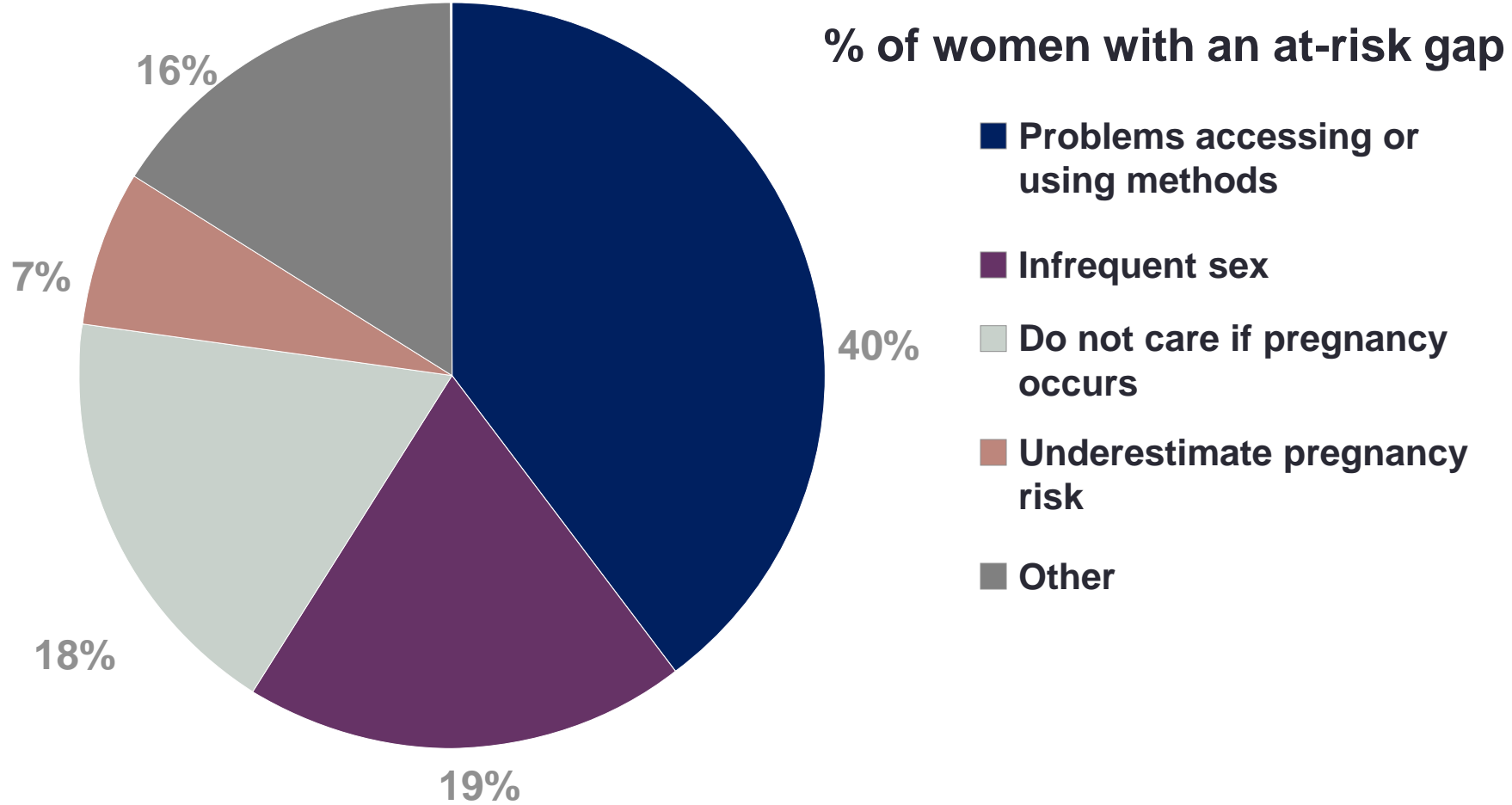
3.1 million unintended pregnancies,
by women's contraceptive use during month of conception

Women's Risk of Unintended Pregnancy and Contraceptive Use



28 million adult women at risk for unintended pregnancy

Reasons for Contraceptive Nonuse

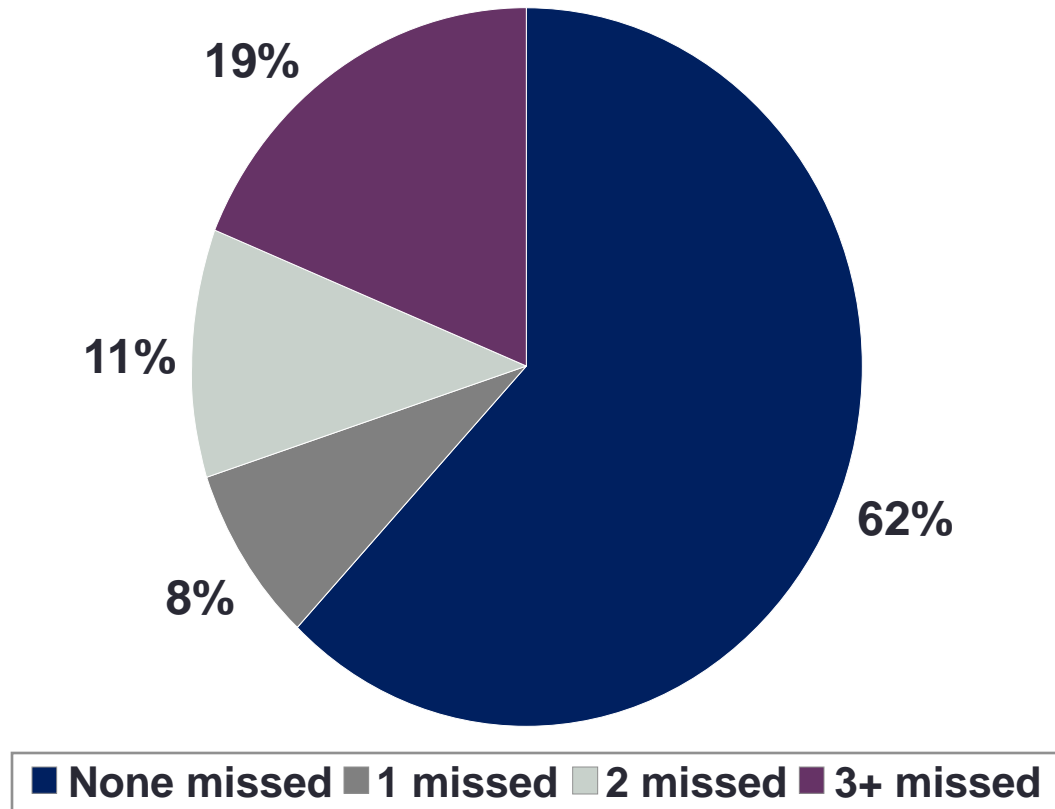


Frost JJ, Darroch JE, Remez L. *In Brief*. 2008.

*Inconsistent Method Use is
Common for Many Reversible
Contraceptives*

Contraceptive Pill Usage Rates

% of pill users according to use during the past 3 months

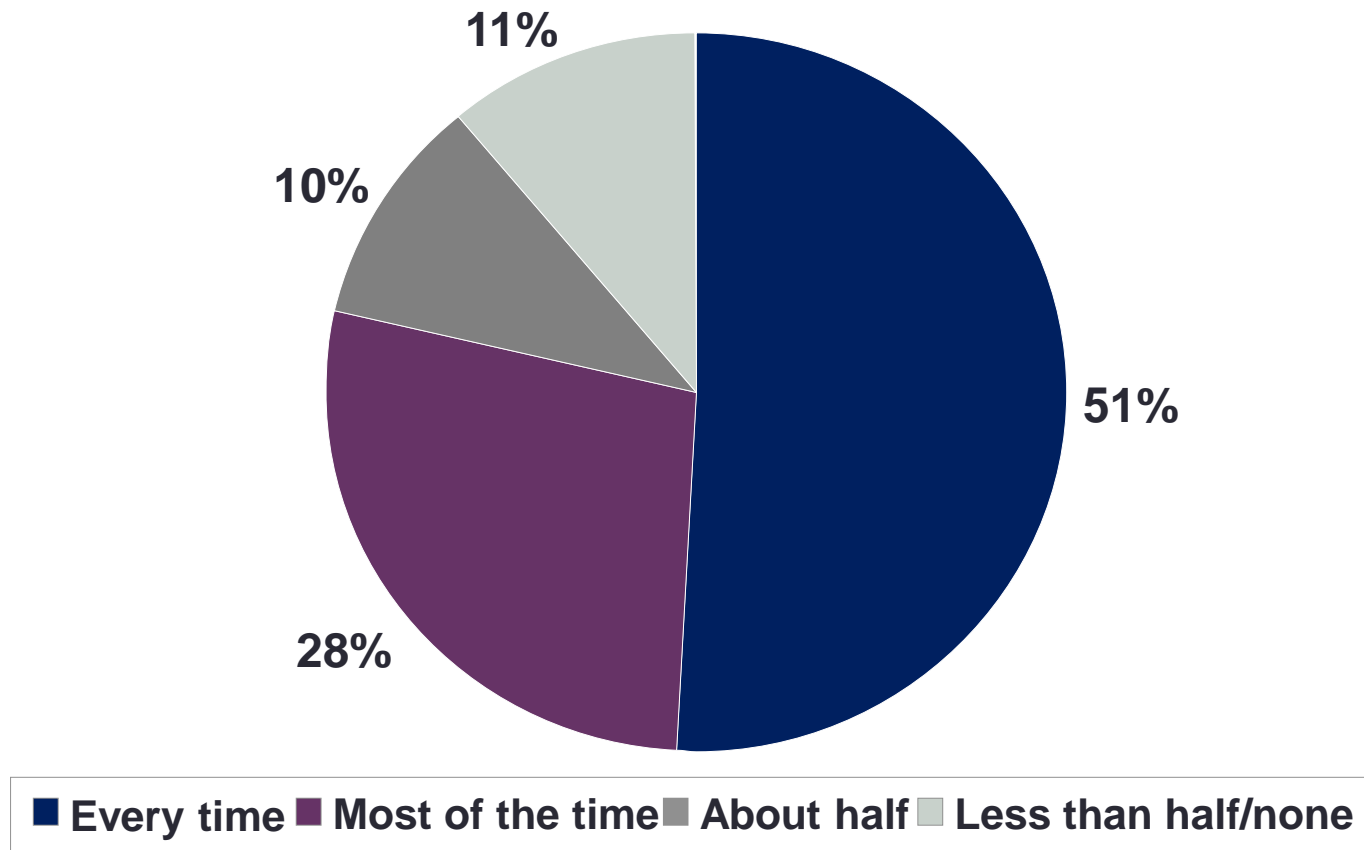


High rate of OC discontinuation

- Real-world prescription refill
- After 30 days: 59-75% refilled on a timely basis
- 3 months: 48-61%
- 12 months: 16-34%
- few women had the potential for correct and consistent contraceptive use

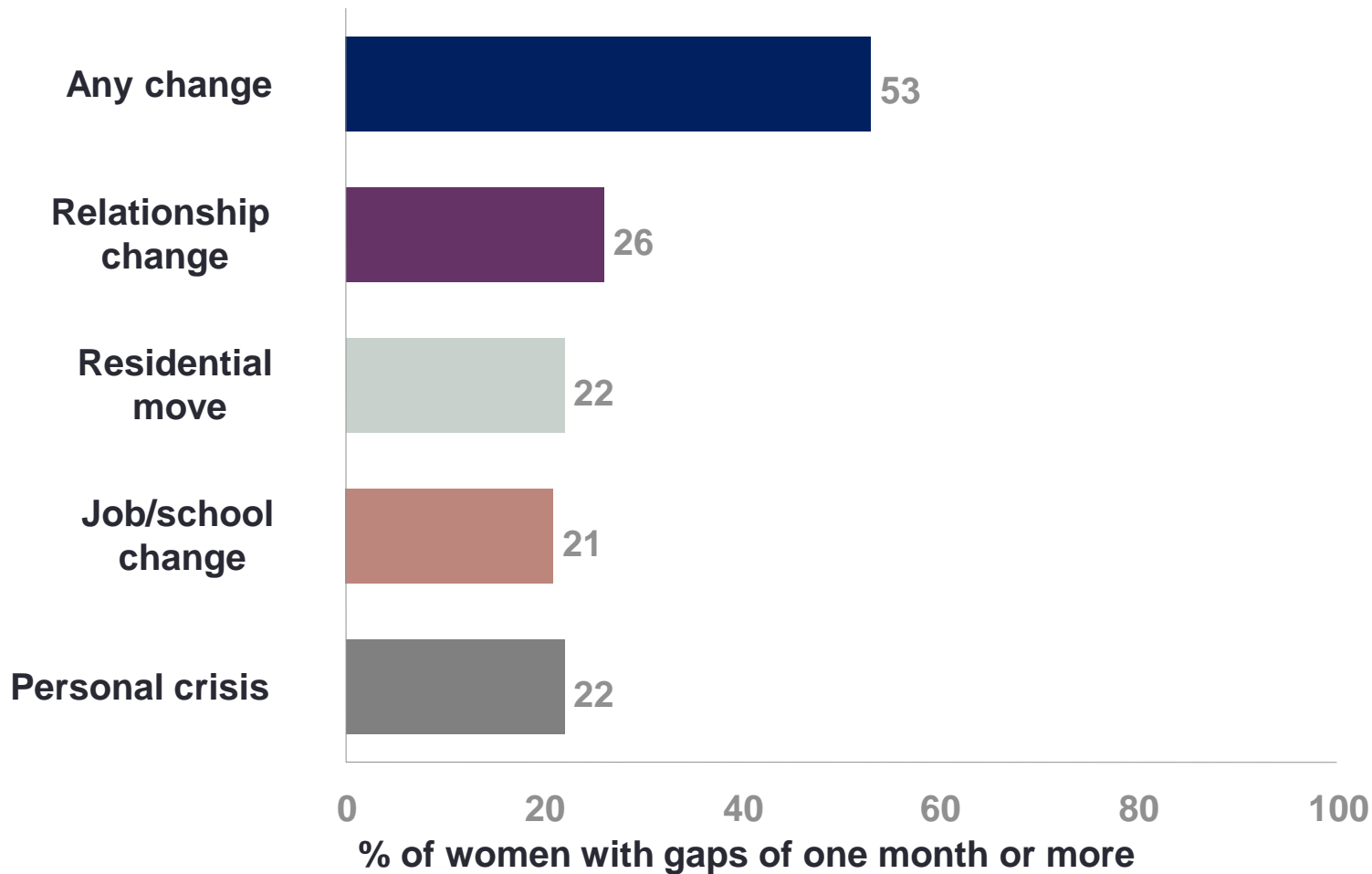
Condom Usage Rates

% of condom users by use during the past 3 months



*Difficulties in Contraceptive Use
Are Linked to Life Changes*

Contraceptive Use and Life Changes

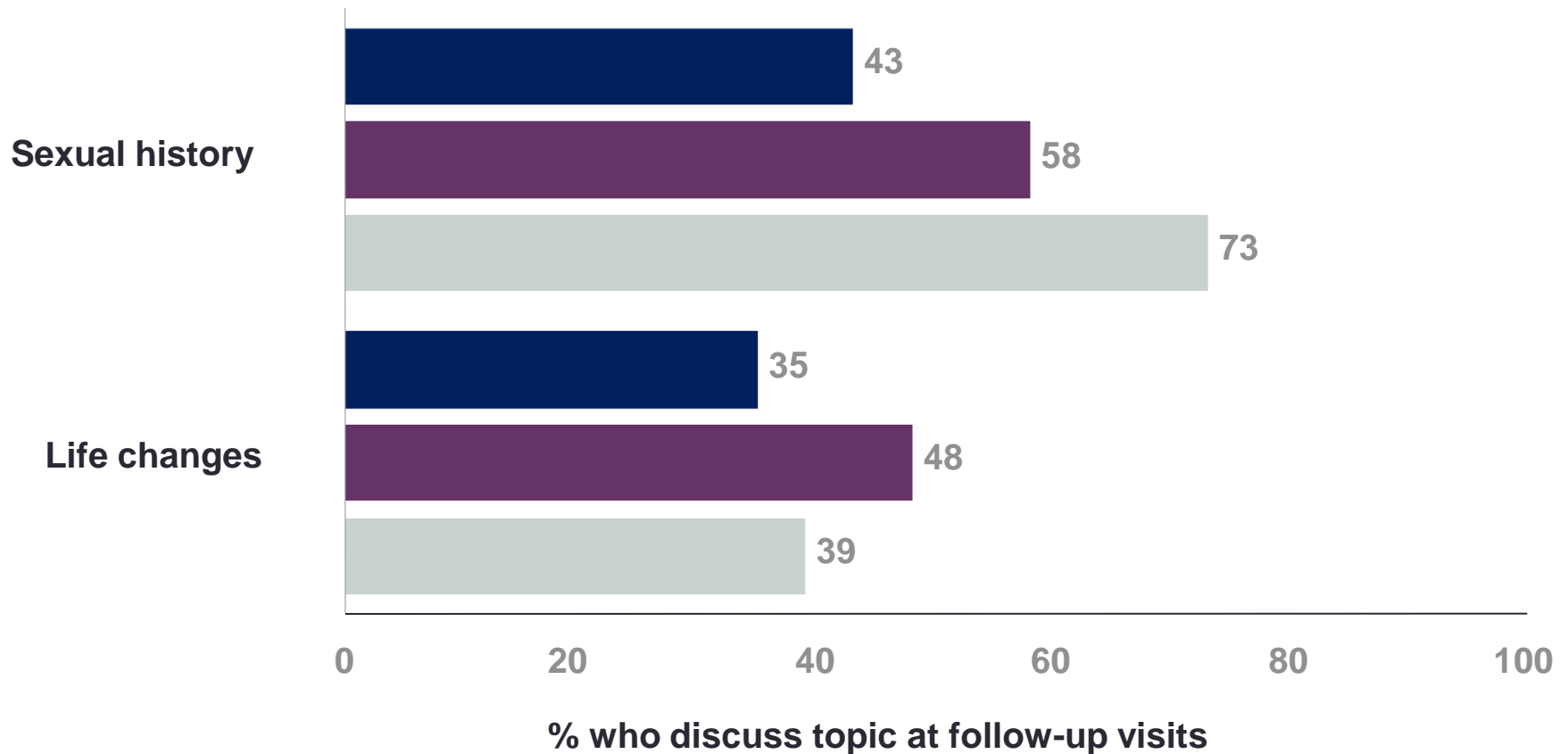


Frost JJ, Darroch JE, Remez L. *In Brief*. 2008.

Variables in contraceptive use

- Some women have more difficulty than others with continuous method use
 - little education
 - belong to minority groups
 - poor
 - covered by Medicaid
- disadvantaged women are more likely to
 - experience frequent life changes
 - be dissatisfied with methods and providers
 - feel ambivalence toward pregnancy

Contraceptive Provider Discussions about Life Changes



■ Public provider ■ Private obstetrician/ gynecologist ■ Private family practice physician

Frost JJ, Darroch JE, Remez L. *In Brief*. 2008.

*Personal, Relationship and
Cultural Issues Play a Role*

What are family planning providers trying to do?

- prevent teen pregnancy?
- prevent unintended pregnancy?
- Prevent STI transmission?

- What is the goal of family planning?

Re-framing the question

- **How do we help our clients meet their reproductive health goals?**

Reproductive Health Plan

- How important is it to you to avoid pregnancy now?
- What would you do if you became pregnant now?
- Desired family size?
- Intended timing for pregnancy?
- Are there health issues you need to address before pregnancy?

Reproductive plan and LARC

- Having a reproductive health plan
 - Allows visualization of contraception over a longer horizon
 - Allows contemplation of use of a long-acting contraceptive
 - Increases acceptability of a passive method

“Passive” Contraception

- Separation of contraceptive use from
 - Daily motivation/ambivalence
 - Impact of life changes
 - Infrequent intercourse
 - Recurring economic impact
- The default state is non-pregnant
 - Default state can be changed to “pregnant” with action

LARC counseling: Recommendations for Providers

1

Reduce impact of life changes on
contraceptive use

2

Improve women's experience with
contraceptive care

3

Reduce impact of disadvantage on
contraceptive use

more...

Recommendations for Providers

(continued)

4

Reduce impact of ambivalence

5

Anticipate and address method-related barriers to contraceptive use

Patient-centered counseling

- Avoid recitation of facts
- Appreciate link to sexuality
- Sexual history, partner status, reproductive life plan
- Recognize past experience with contraceptives

Best practices: initiation

- Elicit preferences
- Directly address trepidations
- Avoid the “nocebo” effect
- QuickStart

Is QuickStart a good idea for LARC?

- Immediate start of contraceptive method at counseling visit
 - Maximal motivation
 - Needs contraception
 - Must include
 - Back-up x 7 days
 - EC as needed
- Risk of undetected pregnancy
- No published data on QuickStart for LARC

Ensuring no post-insertion pregnancies

- History
 - LMP
 - Sexual intercourse
- Pregnancy test
 - Turns positive about 12-16 days after conception
 - \pm Cycle day 26
- Emergency contraception
 - Has value up to 5 days after intercourse

QuickStart protocol

- Method initiation
- Back-up x 7 days
- Follow-up pregnancy test
 - 2-3 weeks

Problem with LARC QuickStart

- Undetected pregnancy for an extended period
 - LNG-IUS
 - Implanon
- Pregnancy disruption now/complications later
 - LNG-IUS
 - Cu-T
- Cost

Is she a good candidate for an IUD?

- How long does she want to remain non-pregnant?
 - At least 6 months
 - At least 1 year
- STD history
- STD risk
- Monogamous
- Parous
- Contraceptive experience

Is she a good candidate for an IUD?

- None of the above
- Does either IUD fit the preferences you have elicited?
- Does either IUD fit her reproductive health plan?

Misconceptions that prevent IUD uptake

- Causes abortions
- Migration
- Low efficacy
- Causes PID
- Causes infertility
- Partner will feel it
- Insertion will be painful

Is she a good candidate for an Implanon?

- How long will she keep it?
 - At least 6 months
 - At least 1 year
- Can tolerate the bleeding profile
- Not too heavy
- Tried DepoProvera first

Misconceptions that prevent Implanon uptake

- Weight gain
- Patients bleed “all the time”
- Patients don’t tolerate irregular bleeding
- Difficult or time-consuming to place/remove
- Women don’t keep them

Anticipatory guidance

- The nocebo effect
 - if women are told to expect noxious side effects, these complaints occur because of the power of suggestion.
- “Because Level I evidence documents no important increase in nonspecific side effects with OCs, counseling about these side effects or including them in package labeling is unwarranted and probably unethical.”

Take home message for LARC

- Explain COMMON experiences
- “Most women who choose this method are highly satisfied with it”

Continuation

- Realistic “menu” counseling
- Review reproductive health plan questions
- Review what side effects are tolerable, or desirable
- Think ahead together

Side Effect Management

- Management of undesired bleeding pattern
- Evaluate for
 - infection, dysplasia, pregnancy
- Expectant
- Estrogen
- Doxycycline
- Method change

Switching

- What to expect with switch?
- Is back-up needed?
 - If ovulatory method (both IUDs), switch with cycle or 7-day back-up
- Avoid gaps!!

Best practices in LARC counseling

- If LARC meets the needs of your patient's reproductive life plan, suggest it
- Avoid over-restrictive exclusion criteria
- Address misconceptions up-front
- Avoid the nocebo effect
- Normalize the experience
- Address problems promptly