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Contraceptive Continuity of Care During the COVID-19 Pandemic—A "Voice of Patient" Curriculum

Announcer:
Welcome to CME on ReachMD. This activity, entitled **"**Contraceptive Continuity of Care During the COVID-19 Pandemic—A "Voice of Patient" Curriculum**"** is provided by **Omnia Education**.

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Dr. Creinin:
The in-office delivery of sexual and reproductive healthcare services was markedly restricted for 2 years during the COVID-19 pandemic. Now in 2022, in-office access to these services has begun to improve. But what have we learned since 2020 that has prepared us for future periods of reduced access, whether that be in a pandemic or something new that we haven't experienced yet? And further, what strategies have we initiated during the pandemic that remain useful even in times of full in-office access?

Now, I've just returned from San Diego, where Dr. Sheila Mody of the University of California, San Diego, and Dr. Sarah Prager of the University of Washington joined me to address these topics at a conference conducted for a gathering of obstetrics and gynecology clinicians. I'm here to provide a recap of the data that we presented, as well as the conclusions that we reached during our presentations and panel discussion.

This is CME on ReachMD, and I'm Dr. Mitchell Creinin.

My presentation was entitled "Counseling Patients about LARCs." The key points that I addressed in this discussion included achieving optimal contraceptive counseling using tools, such as the World Health Organization contraceptive tiered effectiveness chart. Now this chart explains all of the available methods pictorially, with those that are most effective at the top and those that are less effective at the bottom. Now importantly, this tool isn't there to encourage people to use the most effective method, but it helps them understand the trade-offs as they are considering how much efficacy is important to them, what type of side effects that they're thinking about, their past experiences, and when and if they're planning a future pregnancy.

This is really patient-centered counseling so that we can talk to patients in a way that allows for shared decision-making so that they can make informed choices based on what is important to them, not what is important to us. Those are our inherent biases that it's important that we understand we truly have and that we make every effort possible to allow the patient to choose what she thinks works best for her. Now this counseling, even though it may sound complex, is not. It's talking with your patient. And what we've learned during the pandemic is that this counseling can occur very effectively through telemedicine.

And sometimes, even for patients interested in LARC [long-acting reversible contraception], providing this counseling through telemedicine first can help lead to that more rapid in-office visit to provide LARC services.

Dr. Mody was up next, and her presentation was entitled "Contraceptive Continuity in Sexual and Reproductive Healthcare." Now the key points Dr. Mody addressed in this discussion included how COVID impacted patients' desires related to future fertility. We learned that about 1 out of every 3 patients was opting to delay childbearing or even had decided for the future to have fewer children as a result

of the pandemic. These are impressive outcomes from going through the pandemic so we can understand what our patients were going through. But importantly, these effects were seen more commonly in marginalized patients. Those patients that are racial and ethnic minorities or they're economically disadvantaged.

So, as we turn to other modes of care like telemedicine to help patients through times like a pandemic that may impact their desires for sexual and reproductive health services, knowing that this affects marginalized patients more, we have to remember that those same patients are the ones that may have more difficulty with access to telemedicine. So it reminds us that we really need to make sure that we allow all services to be available to all of our patients and that not everyone may be able to be served through telemedicine.

Dr. Prager's presentation was entitled "Contraceptive Options for Today's Reproductive Health Challenges." And the key points that Dr. Prager addressed in her discussion focused on unintended pregnancy rates in the US and that they've declined in the recent past. And we've all been celebrating this decline. It's great. In the last couple of decades, we've seen numbers come down. However, when we look in more detail at this decline, what we've noticed is that there's this gap between low- and high-income patients. And that gap has continued to widen over the past 2 decades. Even though the overall rates have come down, and they've come down in both low- and high-income patients, the divide has become even greater so that the majority of unintended pregnancies come from low-income patients. Their rate has come down, but still not in the same proportion as it's continued to come down in high-income patients.

And these points really underscore the importance for your patients when they want LARC services, even during a pandemic, that those that are more economically disadvantaged, those that find it harder to obtain those services, we need to be understanding of that and go that extra step. Those patients may not have the same telemedicine access. But importantly, we need to make sure we make LARC services available even during a pandemic because we know of the differential effects on unintended pregnancy.

Now, we concluded the session with a panel roundtable discussion because we wanted to talk about things that we have seen in practice during the pandemic and as we've started to come out of the pandemic that really are important lessons for us to learn overall in providing sexual and reproductive health services.

For those just tuning in, you're listening to CME on ReachMD. I'm Dr. Mitchell Creinin, Director of Family Planning at the University of California Davis, and I'm discussing what we've learned since 2020 that can prepare us for future periods of reduced sexual and reproductive health access, what we learned from going through the recent COVID-19 pandemic. I'm also reviewing the strategies we've initiated during the pandemic that remain useful even in times of full office access.

We all live in states where there's a lot of laws that help improve access. And not everybody can benefit from those, because your state may not have the same laws. But it is important for you to know about these laws and perhaps even advocate for better care for your patients.

So, the laws that we talked about specifically were about 12-month supply of pills, patches, and rings so that patients don't have to go back every month or every few months to get more supply, because studies show time after time that patients that have a 1-year supply actually are more likely to continue their method, have lower unintended pregnancy rates, and the overall costs to the healthcare system are lower when we provide that 1-year supply.

The other thing that is helpful in our states is pharmacists' prescribing of hormonal contraception so that patients don't have to go to the doctor and then to the pharmacy, that they can go directly to the pharmacy and make one stop, which during a pandemic, minimizing exposure is important. But all of these things, which we know improve contraceptive access, become even more important in a pandemic.

We discussed the physical positioning of patients during implant placement, especially because that's a situation where, during a pandemic, we may have to get closer to the patient. And we discussed the ability for the patient to look away, wearing of masks, putting up a barrier between the patient's face and the provider can all help us to ensure that patients who want implants and want to prevent pregnancy with a highly effective method can still do so during the pandemic.

Now, some interesting discussions we had around IUDs [intrauterine devices] got to some things that many of us may not even realize still go on. So, we talked about the lack of a need for string checks with IUDs. It's been known for years that we don't need to do this, that there's information about string checks and labels, because that's how the studies were done for FDA approval, but that there's no medical necessity for it. And even research has shown that patients don't want to do it. And even when they try to do it, the majority of them can't feel it. So important to not make your patients go through this because it also creates unnecessary visits.

We also discussed the importance of maintaining appointments for IUD and implant insertions and removals to maintain reproductive autonomy. If a patient wants to get pregnant, even during a pandemic that is still her right. And making her stay infertile by making her keep an implant or an IUD is really not appropriate. And just as important is maintaining appointments so that women can get a highly,

highly effective method like an IUD or an implant if they want it. Because at a time when they may want to be sure they are avoiding pregnancy, like during a pandemic, it's important they still receive this care.

We also discussed, with implants and IUDs, the extended use of the products. There is lots of evidence about how long these methods are truly effective. So that levonorgestrel 52-mg IUDs, which are approved for up to 7 years, we know that the data has been released showing that they're effective for at least 8 years. And the same thing with the implant, even though it's FDA-approved for 3 years, there's a large World Health Organization study showing that it's good for 4 to 5 years, not just 3 years. So, allowing patients to continue the method through its full duration of efficacy and not have to go through a procedure unnecessarily is important both during and after a pandemic. And especially during the pandemic, they don't need to come in and get something done when it remains just as effective for that extended use.

We talked about some interesting things that have gone on in California during the pandemic related to Depo-Provera and the availability of a subcutaneous formulation. That, through a champion at the University of California system, working with the state and medical assistance first, but it went over more broadly, is the state agreed to cover subcutaneous Depo-Provera, which it had not previously covered, and included it in its 1-year supply so that patients could pick up 4 subcutaneous Depo-Provera syringes and provide themselves with an injection just like they would for insulin, but they could treat themselves. And the state has already declared that it's going to continue this inclusion of subcutaneous Depo-Provera, even beyond the pandemic.

We also discussed something that healthcare providers have not perhaps been as comfortable with, which is online consumer portals for the purchase of hormonal contraceptives, pills, patches, and rings. But during a pandemic, that is another way a telemedicine method would decrease the need for patients to come in for services. And these apps are very good at screening patients for contraindications to hormonal contraceptives. But it's yet another way for patients to access contraception that they need. It can be delivered directly to their door, so they don't even need to go to a pharmacy. So, there's nothing wrong with practitioners recommending to patients, especially in a pandemic if your office is not open, that there were other portals for accessing their desired contraception.

And this really brings us back to the provider. If we're talking about apps and telemedicine, it really does come back to us. And in the group of attendees at our meeting, we talked a lot about how many have increased their telehealth and telemedicine services during the pandemic and that this has now become the new norm. We've all seen the ebb and flow of these services as the pandemic has come and gone and come back again, as PPE [personal protective equipment] availability has changed, as immunizations have entered into our world, and patients feel more comfortable coming in to see us, but it hasn't eliminated the value of telehealth to ensure that we can reach everybody in a way that improves care and access. But part of that is, as we discussed, remembering that not everybody has that same equitable access. So, if we turn to a practice in another pandemic that is more focused on telehealth, we know that not everyone can do those visits equally as well because they don't always have the same resources. So, the need to see people in our office will still never go away. And we need to make sure we maximize our ability to provide care for all.

So, to wrap this up, I'd like to share a few final thoughts. What we learned is that the pandemic really affected patients' access to sexual and reproductive healthcare in many ways, patients feeling that they wanted to delay childbearing or change their mind about future childbearing, and that these changes occurred differently in different populations. And a lot of it was what we see commonly in medicine, that those that have economic disadvantages or are marginalized populations are affected more than others, that telemedicine really did help make up part of the issues that became a problem with accessing care but that we realize not everyone has the same access. So as we move forward, either into another stage of the pandemic or even post pandemic, it's important for us to maintain the services to ensure that we have good continuity of care and can provide all the sexual and reproductive healthcare that our patients need and that we learn from the pandemic that it's not always accessible to everyone and that we need to maintain services that are still required in our office like IUD and implant placements and removals.

I want to thank our audience for listening in and thank my colleagues, Dr. Sheila Mody from the University of California, San Diego, and Dr. Sarah Prager from the University of Washington, for their constructive insights and clinical expertise at the conference.

Announcer:
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