

Healthy North Carolina 2020
EVIDENCE BASED STRATEGIES

FOCUS AREA	Sexually Transmitted Disease & Unintended Pregnancy
OBJECTIVE	1. Decrease the percentage of pregnancies among adults that are unintended

EBS PROGRAM DESCRIPTION	Reproductive life planning Use of "Are You Ready Sex and Your Future" guide Recommended as a component of LHD postpartum visit
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EBS LEVEL <i>CDC Ranking</i>	P = Promising
REFERENCE/CITATION <i>Data Supporting Level/Ranking</i>	Content in this booklet is based on the CDC's Preconception Health Recommendations. Focus testing on this booklet has demonstrated that both providers and clinic patients thought it helped initiate patient conversations about preconception health and raised important questions that would lead them to make better health decisions. Patients shared that they liked the interactive nature of the booklet and that it was helpful to have links to NC resources in the booklet.

PROGRAM ATTRIBUTES	
Influence Level	Individual
Target Population	Young
Intervention Setting	Health Department Clinics
Key Measures	
Cost	Low
Time to Implement	<u>Patient/Client</u> : Takes between 5-15 minutes to discuss booklet or parts of booklet with patient during visit, patient takes booklet home for continued reference.
Difficulty to Implement <i>Resource Intensity</i>	Low
ROI <i>if known</i>	Unknown

PROGRAM CONTACT INFORMATION	
Organization	NC Division of Public Health, Women's Health Branch
Contact Person	Alvina Long Valentin
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Web Site	

CURRENT NC-DPH SUPPORT	
T.A. – Yes/No Specific group? Other limitations?	Yes
T.A. Contact	Alvina Long Valentin Sydney Atkinson
Funding – Yes/No Specific group? Other limitations?	Yes
Funding Contact	

EBS PROGRAM IMPLEMENTED BY / NC EXAMPLES	
#1 – Organization Name / Contact Information	
#2 – Organization Name / Contact Information	
#3 – Organization Name / Contact Information	

OTHER COMMENTS / NOTES
Reproductive Life Planning counseling is a recommended component for family planning clinic visits in the Family Planning Agreement Addendum with local health departments. It is also a recommended component for the postpartum visit in the Maternal Health Agreement Addendum with local health departments. Many times the postpartum visit occurs in the family planning clinic setting.

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EVIDENCE BASED STRATEGIES

FOCUS AREA	Sexually Transmitted Disease & Unintended Pregnancy
OBJECTIVE	1. Decrease the percentage of pregnancies among adults that unintended

EBS PROGRAM DESCRIPTION	Provision of Long Acting Reversible Contraceptives (LARC)
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EBS LEVEL <i>CDC Ranking</i>	Emerging (E)
REFERENCE/CITATION <i>Data Supporting Level/Ranking</i>	Trussell, J., Henry, N., Hassan, F., Prezioso, A., Law, A., & Filonenko, A. (2013). Burden of unintended pregnancy in the United States: potential savings with increased use of long-acting reversible contraception. <i>Contraception</i> , 87, 154-161. Committee opinion no. 539: Adolescents and long-acting reversible contraception: implants and intrauterine devices. <i>Obstet Gynecol</i> . 2012 Oct;120(4):983-8. Long Acting Reversible Contraception: Implants and Intrauterine Devices. AGOG Practice Bulletin Number 121, July 2011 Preventing unintended pregnancies by providing no-cost contraception .Peipert JF, Madden T, Allsworth JE, Secura GM. <i>Obstet Gynecol</i> . 2012 Dec; 120(6): 1291-7

PROGRAM ATTRIBUTES	
Influence Level	Multi-Level
Target Population	Women of reproductive age, including adolescents seeking highly effective, reversible contraceptives that have no adherence issues in its efficacy.
Intervention Setting	This can be in both the private sector as well as the public health sector (i.e., Family Planning Clinics in local health departments, Federally Qualified Health Centers, Community Health Centers, etc.).

<p>Key Measures</p>	<p>Increase the use of LARC (intrauterine contraceptives and implant) among women of reproductive age seeking birth control.</p> <p>Implementation: The utilization of LARC has not been evaluated in any long term studies to date and thus cannot be considered a true “evidence-based strategy”; and as such does not include a specific model or program to be delivered with fidelity. However, this does not diminish the proposed effect on unintended pregnancy and use of LARC. A recent study (Trussell et. al., 2013) reported if 10% of women aged 20-29 years switched from oral contraceptives to LARC, total costs would be reduced by \$288 million per year (annual medical costs of unintended pregnancy in the U.S. were estimated to be \$4.6 billion and 53% of these were attributed to imperfect contraceptive adherence). Although much interest has been expressed in North Carolina among many organizations, to date no concerted intervention has occurred at the state level to implement such a program on a population based scale. In the public health arena, emphasis has been placed on the use of LARC in their family planning clinics through face to face meetings and webinars over the past several years.</p> <p>Reach: In the public health sector, all local health departments with a family planning clinic must report their data annually and these data are used to compile the Family Planning Annual Report (FPAR). The FPAR is reported both at the state level as well as the national level. A component of the data that are reported is the number of long-acting reversible contraceptives (i.e., intrauterine contraceptives and implant) used by women seeking birth control in their clinics.</p> <p>Adoption: A vast majority of health departments across the state offer the intrauterine contraceptives (IUC), implant or both for their family planning clients.</p> <p>Effectiveness: The use of LARC as a birth control among our family planning clients have increased tremendously in North Carolina. Between CY2011 to CY2012, combined LARC use (both IUC and implant) increased 11% with the use of the implant witnessing the largest increase with almost 15 percent.</p>
<p>Cost</p>	<p>This program does have a “moderate” cost with the high initial cost of the devices; but when averaged over the duration of action (3-10 years) as well as their high efficacy rates greater than 99.5% of preventing an unintended pregnancy, it is very cost effective. For agencies who receive Title X Family Planning federal funding, the ability to purchase these methods through HRSA’s Public Health Drug Program (340b) makes these devices more affordable with costs ranging from 50-60% below retail price. In addition, state appropriations have provided funding to cover the purchase of long acting reversible contraceptives to non-Medicaid eligible women. There are foundations that also supply devices to eligible clientele such as the ARCH Foundation.</p>
<p>Time to Implement</p>	<p><u>Organization:</u> The time to implement such an intervention would be dependent on the skill level and prior training of the providers in the clinic. The FDA requires providers receive face to face training by the manufacturer of the implant before the device can be ordered and inserted into a client. The three IUCs also have manufacturer recommendations of having such training before these devices are inserted. With those requirements in place, it is not unreasonable to estimate the time for set-up to be several months for an organization.</p> <p><u>Patient/Client:</u> The amount of time for the client to receive services would also vary from agency to agency and their policies on same day insertion or different day insertion schedules. On average, the procedural time for the implant is 10 minutes, the IUCs 15 minutes.</p>
<p>Difficulty to Implement <i>Resource Intensity</i></p>	<p>Moderate level, requires a local “champion” in order to get staff trained, organize paperwork and required equipment.</p>
<p>ROI <i>if known</i></p>	<p>Many studies have shown varied cost savings from \$7- 15 per dollar spent on LARCS, the savings being greatest in younger women (due to highest failure rates with pill patch and ring). D. Eisenberg et al Cost as a Barrier to Long-Acting Reversible Contraceptive (LARC) Use in Adolescents. Journal of Adolescent Health 52 (2013) S59-63</p>

PROGRAM CONTACT INFORMATION	
Organization	NC Division of Public Health – Women’s Health Branch
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Web Site	http://publichealth.nc.gov/

CURRENT NC-DPH SUPPORT	
T.A. – Yes/No Specific group? Other limitations?	Yes Isa Cheren, Cheryl Kovar and 5 Regional Women’s Health Nurse Consultants provide technical support to all 100 local health departments regarding LARC use.
T.A. Contact	Isa Cheren, 919.208.0439, isa.cheren@dhhs.nc.gov ;Cheryl Kovar, 919.707.5719, cheryl.kovar@dhhs.nc.gov ; Betty Cox, 910.425.1025; Dara Dockery, 919.269.4351; Brenda Dunn, 919.663.3717; Pat Horton, 828.757.3022; Laura Pless, 828.689.3124
Funding – Yes/No Specific group? Other limitations?	Yes The Women’s Health Branch located in DPH provides Title X, Title V (MCH), TANF and state appropriations for use in the utilization of LARC among grant funded health department’s family planning clinics.
Funding Contact	Sydney Atkinson, Sydney.atkinson@dhhs.nc.gov ,919.707.5693, Tricia Parish, tricia.parish@dhhs.nc.gov , 919.707.5696

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OTHER COMMENTS / NOTES
Training; funded thru MCH block grant, Medicaid