Contraceptive implant training: perspectives from Family Medicine residencies in New Jersey

Kenya Cabrera MD, Stephanie Mischell MD, Tiana Acosta, Jeffrey Levine MD MPH, Anna Sliwowska MD, Jennifer Amico MD MPH

Department of Family Medicine and Community Health, Rutgers Robert Wood Johnson Medical School

Objectives

1. List potential barriers to contraceptive implant trainings cited by family medicine residents and preceptors
2. List potential enablers to influencing comfort and experience with contraceptive implant training cited by family medicine residents and preceptors
3. Identify areas of potential intervention to increase access to contraceptive implant training in family medicine residencies

Background

- Only 20% of family physicians provide intrauterine devices (IUDs) and 11% of family physicians provide contraceptive implants, suggesting a need for increased access to long-acting reversible contraception (LARC) in family medicine settings
- Majority of studies about physician attitudes, knowledge and training around LARC are focused on IUDs over contraceptive implants
- Factor most associated with LARC provision in practice is training in procedures during residency training
- New Jersey is an ideal place to study residencies: home to academic and community hospital centers and urban, suburban and rural communities

Methods

Study Design: Exploratory semi-structured interviews
Study Sample: Family medicine residents and attendings in NJ
- All residents and family medicine preceptors surveyed about experience with contraceptive implant
- Residency programs stratified based on average number of contraceptive implant insertions and removals per resident
- Top 25% and Bottom 25% invited to interview: anticipate 8 interviews per each subgroup = 32 total interviews

Data Collection: Interviews conducted over Zoom, audio recorded and transcribed
- Interview Guide structured to identify types of barriers and facilitators to contraceptive implant use

Data Analysis: Coding and analysis conducted on a rolling basis
- Use memoing to identify saturation
- Develop codebook using collaborative and iterative process
- Compare findings in top 25% programs and bottom 25% programs

Results

Tables 1-2: Barriers and Facilitators to Contraceptive Implant Training Among High and Low Volume Residency Programs

Barrier	Group A—High Vol Resident	Group B—High Vol Attending	Group C—Low Vol Resident	Group D—Low Vol Attending
Scheduling appts		X	X	X
Coverage/buy and bill		X	X	X
Paperwork/logistics to get devices	X	X	X	X
MA training to set up			X	
Availability of GYN clinic or PP			X	X
Lack of Training in preceptors			X	X
Lack of knowledge of preceptors (non evidence based barriers)	X		X	X
Coverage of precepting sessions			X	X
Limited GYN procedure availability (lack of procedure/gyn clinic, inadequate time)			X	X
Lack of formalized hands-on training			X	X
Lack of didactic training			X	X
Site only allows female learners			X	
Miss opportunities to discuss contraception		X	X	X
Being uncertain of logistics/ease of OCP Rx (no time to discuss)		X	X	X
Knowledge barriers (inaccurate vs uncertainty)	X	X	X	X
Bias about who wants it	X			X
Lack of awareness of patients (perceived lack of interest/awareness/wanted something else)		X	X	X
Pt discomfort with arm	X			
Pts want female provider			X	X
Low #'s repro age patients				X
Appropriate age for contraception/parents of adolescents	X			X
Pandemic		X	X	X

Facilitator	Group A—High Vol Resident	Group B—High Vol Attending	Group C—Low Vol Resident	Group D—Low Vol Attending
Patients think its easy/pt interest/pts like it	X	X		
Residents want experience doing it	X	X	X	
Provider interest in discussing contraception	X	X		
Support people/champion for getting devices/RN/scheduling/logistics	X	X		
Stocking devices/coverage for devices	X			
MA training/resources for set up	X			
GYN/procedure clinic staffed w/trained preceptor	X	X		
Trained preceptors	X	X		
Workshop/didactics (Merck and repro curriculum)	X	X		
Opportunities for procedures	X	X		

Twenty-five subjects including 14 residents and 11 preceptors completed interviews.
Common themes describing barriers are as follows:

Coverage for device
"We have a lot of uninsured patients. …. I think it's $350 for a [contraceptive implant] or an IUD, and they can't afford it… Even if they do have insurance, we still need it to run by insurance and make sure that it's covered before they come into the procedural clinic." Attending, High Volume

Overwhelming logistics
"I think sometimes the logistics of [providing the implant] – people don't wanna go there – and the logistics of it is, oh, shoot, I'm gonna have to talk to the preceptor. And how do I order this? And who's in charge of scheduling it? And who's precepting that day? And I'm looking in my schedule because I wanna do it myself if I'm a resident, but I'm on night float for the next whatever number of weeks. … just not knowing where to start or being overwhelmed by the logistics of everything in the office." Attending, High Volume

Delay in getting device to clinic
"I wish I could do [contraceptive implants] a little more on the spur of the moment. And I wish the billing was a little differently so that we could have stuff stockpiled … Because it doesn't take that long to put it in a [contraceptive implant]." Resident, High Volume

Lack of trained preceptors
"It's difficult when the attending is not comfortable doing these things, or that's not something that they offer to their patients. As a primary care physician, there's so much that you can do and that you can choose to do. … But if that's not something that they do, it's just going to be difficult to offer it." Resident, Low Volume

Lack of patient interest
"There is some hesitancy sometimes from some patients about having something put in their arm." Resident, High Volume

Ease of providing other options
"Well, honestly, I recommend the oral contraceptives for everybody first, because that's without doubt, the easiest to start. It doesn't mean that it's the most effective, or easiest to continue." Attending, Low Volume

Inaccurate information
"And I know that there's some evidence looking at the impact on somebody's obese, and I don't know off the top of my head exact criteria for BMI, the effectiveness isn't quite as good." Attending, High Volume

Not making time to discuss contraception
"Not making [contraception] part of every conversation with every patient. … I would say that probably the single most common thing with residents, if you're precepting and watching on a monitor is, that when a patient says something, and you think, man, there is your opportunity and it's missed. … because, oh, shoot, I'm 25 minutes behind and if I start talking about contraception, I'm gonna be an hour behind. … so, I think, probably, the biggest barrier for patients that come into the office is our failure." Attending, High Volume

Conclusion

Contraceptive implants can be provided by family medicine physicians with adequate support and training. Potential interventions: formal implant training sessions, dedicated procedure office sessions, stocking of product in office, and support staff focused on reproductive health that can aid in scheduling, obtaining device, and setup prior to visit.

Acknowledgments

This study is funded through the Merck Investigator Studies Program.