Children's Hospital of Philadelphia PolicyLab

Setting Teens Up for Success after They Get a LARC Device

Adolescent Health & Well-Being

Date Posted:

Nov 19, 2019

Unintended pregnancy among adolescent and young adult women is a well-known public health problem. Pediatricians and adolescent medicine providers care for young women at a time when addressing contraceptive needs and building skills for accessing contraception are an essential part of supporting their long-term health. Despite well-established evidence that long-acting reversible contraceptives (LARC)—intrauterine devices (IUD) or subdermal implants—are the most effective form of birth control, adoption of these methods has been slow among adolescent and young adult women compared to older women. Between 2015-2017, only 8.2% of young women ages 15 to 19 years had used a LARC compared to 13.1% and 11.7% among women ages 20 to 29 and 30 to 39, respectively. Further, adolescent LARC users are more likely to discontinue this birth control method than older adult women.

To encourage young women to keep using LARCs, physicians must understand why they stop and what services we can provide that may support them in continuing this highly effective form of birth control. However, to date there has been little research that characterizes how young women engage with health providers after starting to use LARC. Key questions remain unanswered such as, “How often do they visit their doctors for LARC-related services?” and “What brings young women back into the office?” Uncovering these answers can help providers understand how to best support young women in starting and continuing a new LARC method.

When Do Adolescents Seek Services After Starting to Use LARCs?

Although no evidence-based guidelines exist regarding follow-up care after LARC insertion, the American College of Obstetricians and Gynecologists (ACOG) and the Centers for Disease Control and Prevention advise that adolescents who uses these methods may benefit from more frequent follow-up visits. Yet, it is unclear how soon after LARC placement young women should be seen by a physician and how frequently those visits should occur. To address this gap in knowledge, we studied a group of young women who used LARCs to understand their follow-up care patterns and continuation rates during the first six months of having their device placed.

The clinic in which we conducted this study routinely recommends follow-up visits after LARC placements. However, we found that having a predetermined follow-up visit schedule may not be beneficial for young women. Most patients went back to the clinic an average of almost three times within the first six months after receiving a LARC. However, when they came back did not coincide with the clinic’s recommended schedule. Moreover, if a young woman did attend a scheduled follow-up visit, it did not mean she was more likely to continue using her LARC. Taken together, these findings suggest that a one-size-fits-all follow-up visit schedule may not be an effective way to promote LARC continuation.

How Do We Engage with Adolescents on Their Terms?

> What we did find was that young women were most likely to contact their doctor's office in the first month after getting their LARC. In the majority of instances, young women reached out by phone and did so because of concerns or misconceptions about their new birth control method. This suggests that young women need support early on.

These early encounters represent opportunities for patient counseling, providing guidance about side effects and managing patient expectations regarding their chosen method.

Still, the optimal way for providers to follow up with patients (phone, electronic medical record, messaging, text message or office visit) is not clear and deserves further exploration. Not all patients want to come to the office to follow up and they shouldn't have to, but we do need to provide them with easy access to clinicians for the inevitable questions that will arise.

For practices with sufficient volume and resources, having a dedicated clinician who can manage LARC issues over the phone may provide patients with adequate support, while freeing up other providers to focus exclusively on inserting and removing devices. The clinicians could identify patients who may benefit from a trip to the office for more involved counseling and evaluation, which helps reserve appointment slots for only those with issues that can't be resolved over the phone.

Of course not all practices could support such a model. Therefore, attention is being increasingly devoted to equipping general pediatricians to support adolescents with LARCs. Though most general pediatricians will not be the ones initiating LARCs, they too play an integral role in fielding questions, discussing side effects and encouraging LARC continuation. More and more primary care residencies, such as pediatrics and family medicine, are incorporating LARC training to ensure competency for pre-insertion counseling, device placement, and removals and post-insertion management. Professional organizations such as ACOG and family medicine's Reproductive Health Access Project provide a range of resources that primary care providers can utilize. Finally, peer-to-peer education models, in which young women who have had a device placed can provide support to new users, might also be beneficial.

If we want to get serious about preventing unintended adolescent pregnancy then we need to take a multi-pronged approach and utilize clinical staff across specialties and at all levels to employ creative solutions to keep patients engaged in care.

Amanda E. Jones is an MD candidate at the Perelman School of Medicine at the University of Pennsylvania.

Aletha Y. Akers
Aletha Y. Akers
MD, MPH, FACOG
Faculty Scholar