Quick Start Implementation Guide

A companion to the CHCANYS Quick Start webinar

Objectives

With this guide, and webinar presentation, users will understand the benefits of Quick Start and be able to lead a discussion with their practice on how to integrate this practice into their current work. This guide also provides an introduction to Quality Family Planning and Quickstart as a recommended practice. Also within the guide, are the complete webinar slides and accompanying activities that are intended to facilitate a conversation with all staff about the realities of implementing Quickstart in your organization.

Quality Family Planning (QFP)

Family planning is an integral part of care for women and men of reproductive age. As such, a number of recommendations have been developed by the Centers for Disease Control (CDC) and the Office of Population Affairs that outline how these services can be provided with the highest quality.

Known as the QFP, these recommendations serve a guide for organizations to provide these services with the following goals:

- provide contraception to help women and men plan and space births, prevent unintended pregnancies, and reduce the number of abortions;
- offer pregnancy testing and counseling;
- help clients who want to conceive;
- provide basic infertility services;
- provide preconception health services to improve infant and maternal outcomes and improve women's and men's health and;
- provide sexually transmitted disease (STD) screening and treatment services to prevent tubal infertility and improve the health of women, men, and infants.

In order to address one of these goals, providing contraceptive services, the recommendation to Quick Start individuals on the method of their choice has been made. By beginning contraception at the time of the visit rather than waiting for the next menses, providers can help women avoid unintended pregnancy and ensure that they receive the method that is right for them.

Activities to do with Staff

We encourage you to integrate the webinar into a regular staff meeting. Ideally, at a meeting that pulls the whole healthcare team together. Including providers, nursing staff, medical assistants, health educators, front line staff to discuss implementing Quick start will ensure that you address all barriers patients may face in getting timely access to contraception.

The meeting facilitator should watch the webinar all the way through prior to sharing with the team. Familiarize yourself with the cases and think about how you can engage your team members in actively participating in the discussion.

If you have 30 minutes

1. **Watch the webinar with your team.** The webinar is 20 minutes long, so you have 10 minutes to discuss key aspects with your team.
    a. Suggestion 1: Pause the webinar when prompted. Ask your team members to discuss how they would manage the case. Use a flip chart to note the team's suggestions. Continue the webinar and note the similarities and differences between your team's answers and the webinar presenters.
    b. Suggestion 2: Watch the webinar all the way through. Spend 10 minutes talking about quick start. Does your health center do it? What makes it work? What makes it difficult? Identify three things your health needs to do to make quick start accessible the standard of care in your health center.

If you have 45 minutes – 1 hour

1. **Watch the webinar with your team.** (30 minutes)
    Pause the webinar when prompted. Ask your team members to discuss how they would manage the case. Use a flip chart to note the team's suggestions. Continue the webinar and note the similarities and differences between your team's answers and the webinar presenters.
2. **Distribute the Quickstart Algorithm and Your Birth Control Choices (15-30 minutes)**
    Discuss these questions with the group:
    - Is your health center doing Quick start now? What makes it work? What makes it difficult?
    - Are all birth control options available at the health center? If not, what is the process for ensuring patients have access to all methods?

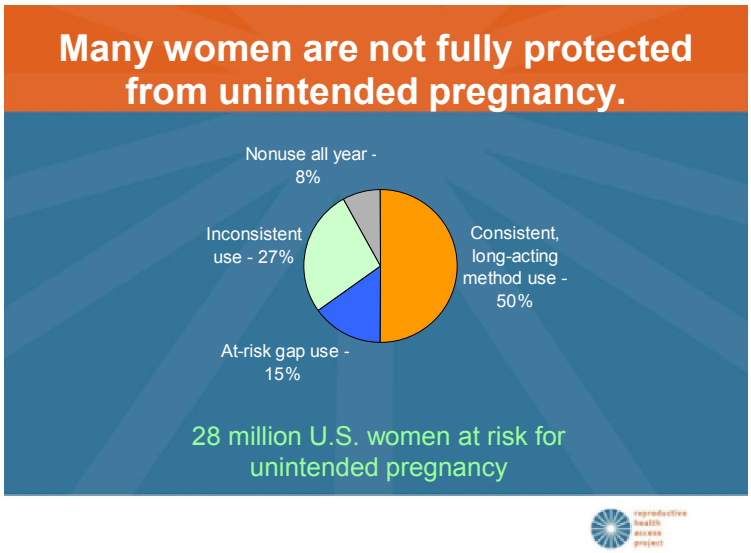
- Is emergency contraception on-site? How can your health center make sure all sexually active patients have emergency contraception?
- Does your health center offer IUDs and implants on-site? Can patients get them the same day?
- Is your health center assessing contraceptive needs at all visits or just family planning visits?
- Identify three things your health can do to make quick start accessible the standard of care in your health center.
- What role does each person play in making contraception accessible in your health center?

Presentation Guide

The following pages include the complete series of slides in the Quick Start webinar presented by CHCANYS along with some helpful notes that will guide your facilitation of the webinar should you choose to pause along the way.

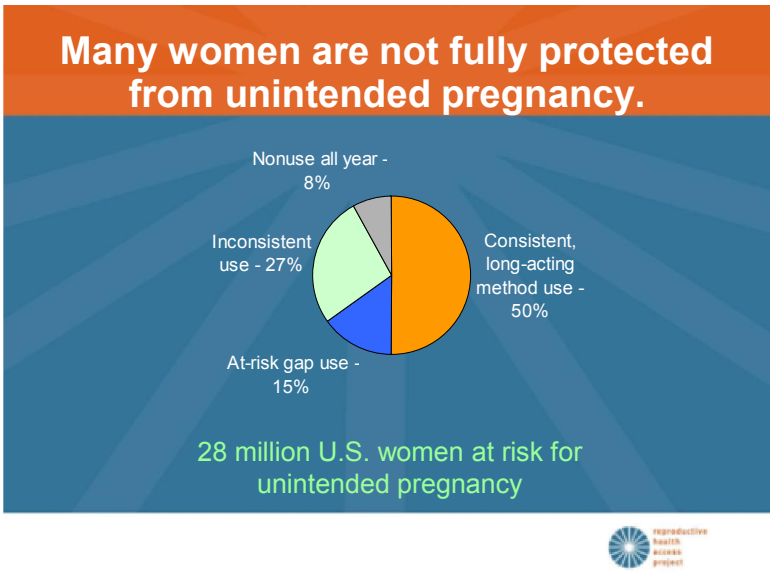
Slide 1:

Slide 2:



- Combining the information on nonuse of contraceptives and inconsistent use, we can classify all women who are at risk of unintended pregnancy according to their practices during that year:
    - Half of women were protected from unintended pregnancy by their consistent use of contraceptives, including use of long-acting methods or LARCs
    - 8% were non users all year
    - 15% had a gap in use when they remained sexually active and not trying to be pregnant
    - 27% used their method inconsistently

Slide 3:



Recent trends in unintended pregnancy:

- Overall, teen pregnancy in the US has declined over the past decade
- However, unintended pregnancy rates have increased among low-income teens and women
- The gap between rich and poor women's abortion rates has widened steadily since 1987
- Abstinence-only education has been shown not to reduce teen pregnancy rates

- Source: Finer LB and Henshaw SK, Disparities in rates of unintended pregnancy in the United States, 1994 and 2001; *Perspectives on Sexual and Reproductive Health* 2006, 38(2):90–96.

Slide 4:

<PAUSE HERE TO ALLOW YOUR STAFF TIME TO ANSWER>

- **Contraceptive failures**
  - No method is perfect. For example, even after surgical sterilization, one woman out of every 200 becomes pregnant. Contraceptives are not easy to use exactly right--pregnancies happen when condoms break, or pills stay in their package.
- **Contraceptives are unavailable, difficult to obtain or too expensive**
  - a woman may run out of birth control pills or not be able to get refill promptly; insurance may not cover her birth control or she may be uninsured.
- **Lack of understanding of reproduction/fertility**
  - Many women do not understand when risk of pregnancy is greatest.
- **Sexual assault/abuse/coercion**
- **A woman' s religion or her partner may forbid her to use contraception**
- **Emotional/psychological reasons**
  - Denial about the possibility of getting pregnant, ambivalence about having a child or the desire to be sure she is fertile sometimes lead women to have unplanned pregnancies.
- **Many women still don't know about or aren't able to get emergency contraception!** which we'll talk about more in a few minutes

Slide 5:

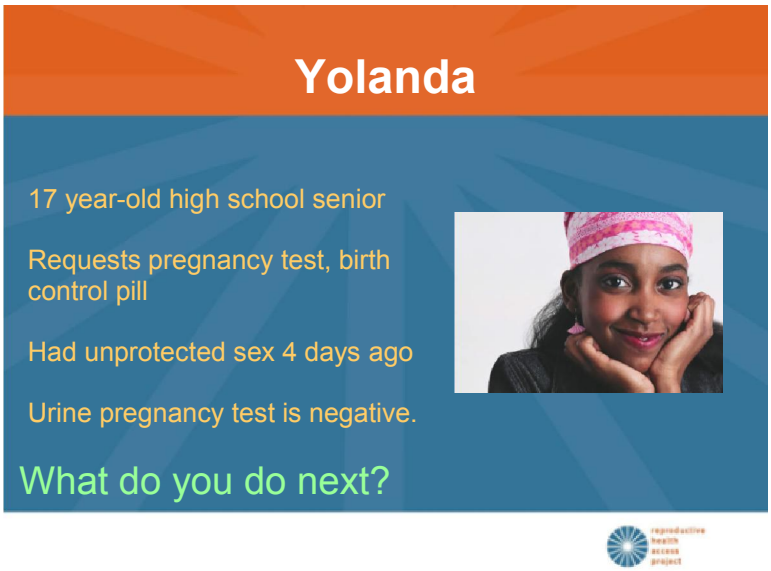
One-year Failure Rates

Effectiveness	Birth Control Type	Typical-Use Pregnancy Rate	Perfect-Use Rate
Ineffective	Chance	85%	85%
Less Effective	Condoms	14%	3%
More Effective	Pill, patch, ring	8%	1-3%
Highly Effective	IUDs	0.8%-2%	0.8-2%
	Injectible (Depo)	0.1-0.3%	0.1-0.3%
	Implant/Sterilization	0.1-0.3%	0.1-0.3%

Zieman M, Hatcher RA. Managing Contraception. Tiger, Georgia: Bridging the Gap Foundation, 2010.

- User dependent methods are much more likely to have inconsistent or incorrect use.
- Source: Zieman M, Hatcher RA, Allen AZ *Managing Contraception 2015-2016*. Tiger, Georgia: Bridging the Gap Foundation, 2015.

Slide 6:



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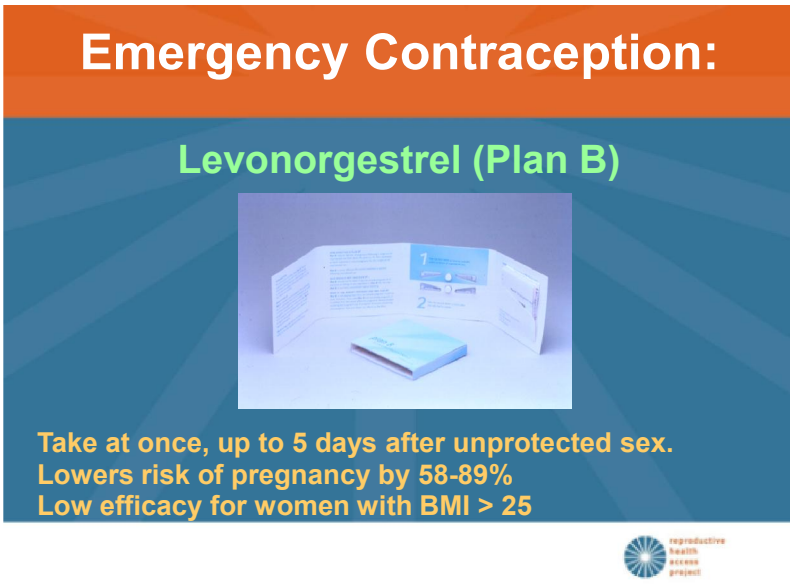
- Case study time! Here's the situation:
  - Yolanda comes into your office as a walk-in.
  - She asks for a pregnancy test and a prescription for birth control pills.
  - Her pregnancy test is negative: phew!
  - On further questioning, she says that she had sex without a condom 4 days ago.
  - What do you do?
- After they submit their brainstorm ideas, or speak them aloud, go to the next slide

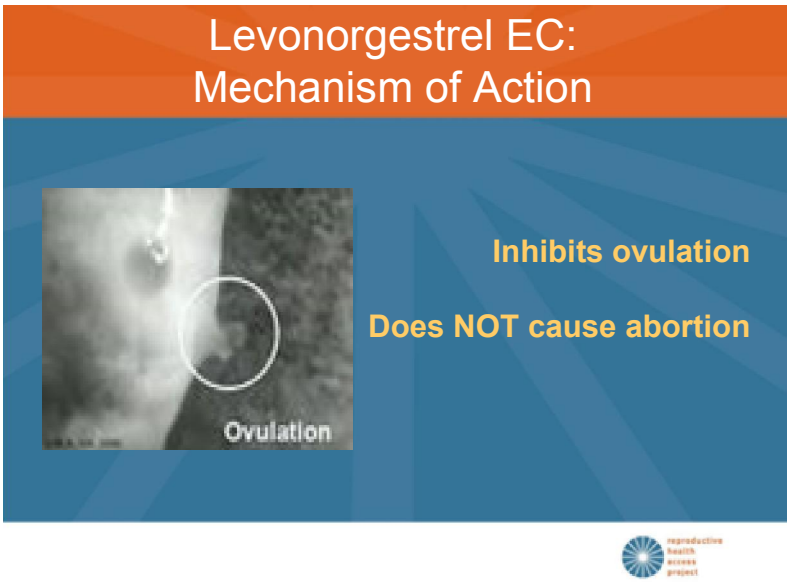
Slide 7:



- Levonorgestrel is a progestin
  - It works by delaying ovulation.
  - It doesn't disrupt an implanted pregnancy, and it's not teratogenic.
  - Its efficacy declines over the 5-day window after unprotected intercourse: the sooner it's taken, the more effective it is.
- New forms, generic and "One Step" - remember that patients under age 17 need a prescription.

- Source:
  - Rodrigues I, Grou F and Joly J, Effectiveness of emergency contraceptive pills between 72 and 120 hours after unprotected intercourse, *American Journal of Obstetrics and Gynecology,* 2001, 184(4):531-537.
  - von Hertzen H, Piaggio G, Ding J, Chen J, Song S, Bártfai G, Ng E, Gemzell-Danielsson K, Oyunbileg A, Wu S, Cheng W, Lüdicke F, Pretnar-Darovec A, Kirkman R, Mittal S, Khomassuridze A, Apter D, Peregoudov A. Low dose mifepristone and two regimens of levonorgestrel for emergency contraception: a WHO multicentre randomized trial. *Lancet* 2002;360:1803-1810.
  - Population Council. Emergency Contraception's Method of Action Clarified. *Population Breifs*. 2005 May;11(2).
    Available http://www.popcouncil.org/publications/popbriefs/pb11(2)_3.html
    (the Population Council on the Chilean study showing implantation is not a mechanism of EC)

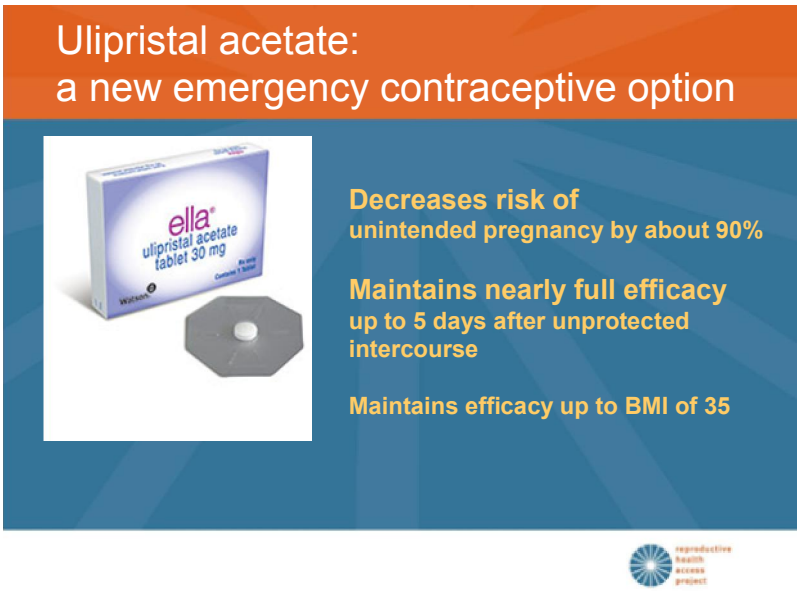
Slide 8:



- There has been lots of controversy regarding EC's mechanism of action. Many people mistakenly consider EC an abortifacient.
- Progestin-only EC DOES NOT DISRUPT AN IMPLANTED PREGNANCY– instead, it:
  - Inhibits ovulation
  - Traps sperm in thickened cervical mucus
  - Inhibits tubal transport of egg or sperm
  - May interfere with fertilization or early cell division
- Ulipristal,too, seems to work mainly by inhibiting ovulation

- Source:
  - Gemzell-Danielsson K, Marions L. *Hum Reprod Update*. 2004 Jul;10(4):341-8. Epub 2004 Jun 10.Mechanisms of action of mifepristone and levonorgestrel when used for emergency contraception.Gemzell-Danielsson K, Marions L.
  - Population Council. Emergency Contraception's Method of Action Clarified. *Population Breifs*. 2005 May;11(2).
    Available http://www.popcouncil.org/publications/popbriefs/pb11(2)_3.html
    (the Population Council on the Chilean study showing that disrupting implantation is not a mechanism of EC)

Slide 9:



- Ulipristal is a mixed progestin agonist/antagonist.
  - It can be taken up to 5 days after unprotected intercourse.
  - In contrast to levonorgestrel, it maintains nearly full efficacy on the 4th and 5th day.
  - It's available only by prescription.
  - Like levonorgestrel, it works by delaying ovulation.

- For Yolanda, it's a better idea than Plan B/levonorgestrel, because its efficacy is much higher on day 4.

Slide 10:

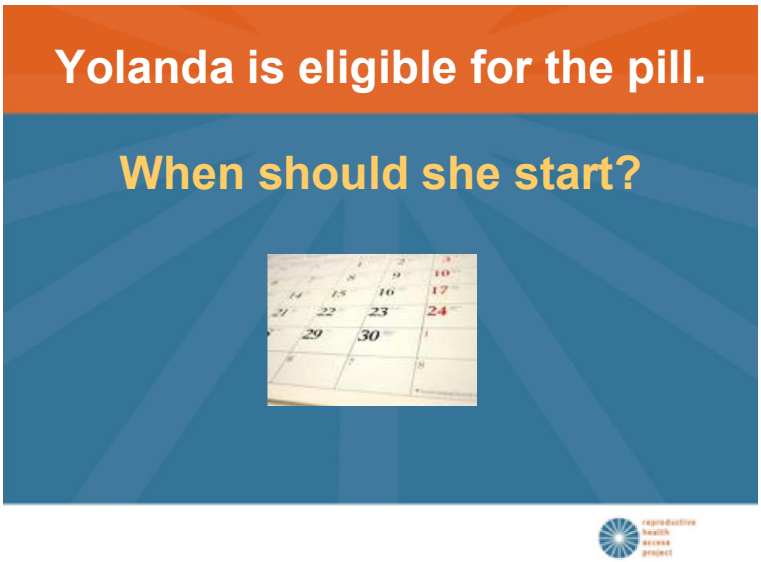
- A complete medical history is needed in order to rule out contraindications to hormonal contraception.
- Physical exam, STI screening, Pap smear, etc… NOT REQUIRED.
    - These interventions may be helpful for other reasons– but are not needed in order to prescribe hormonal contraception safely.
- This applies to young teenagers who may be embarrassed or afraid of having a physical exam, and is particularly helpful in new patient visits.

- **Source:**
    - Stewart F, et al. Clinical breast and pelvic examination requirements for hormonal contraception: Current practice vs evidence. *JAMA.* 2001;285:2232-9.

Slide 11:

- Smoking
  - **Absolute** contraindication in women over age 35 who smoke MORE than 15 cigarettes/day
  - **Relative** contraindication in women over age 35 who smoke LESS than 15 cigarettes/day

Slide 12:



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- **Quick Start:**
  - For Yolanda, she should be started on pills the day of the visit instead of waiting for the Sunday after the next period.
  - She should have a negative UCG to rule out pregnancy

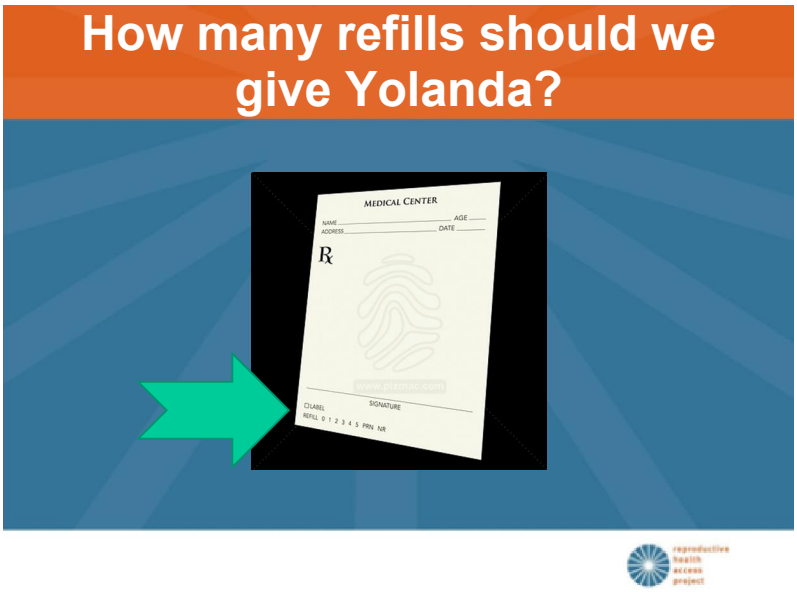
- Westoff studies showed more women on the pill by month 3, and fewer pregnancies
  - If OCs are prescribed with Sunday or 1st-day-of-menses start, as many as 25% of women do not start.
  - No increased bleeding or spotting
  - OCPs not teratogenic
  - Can use quickstart immediately following miscarriage or abortion

- Source**:**
  - Westhoff C, Kerns J, Morroni C, Cushman LF, Tiezzi L, Murphy PA. Quick start: novel oral contraceptive initiation method. Contraception. 2002 Sep;66(3):141-5.
  - Westhoff C, Morroni C, Kerns J, Murphy PA. Bleeding patterns after immediate vs. conventional oral contraceptive initiation: a randomized, controlled trial. Fertil Steril. 2003 Feb;79(2):322-9.

Slide 13:

- When methods are begun in the office, on the day of first visit, there has been an increase in adherence.

Slide 14:



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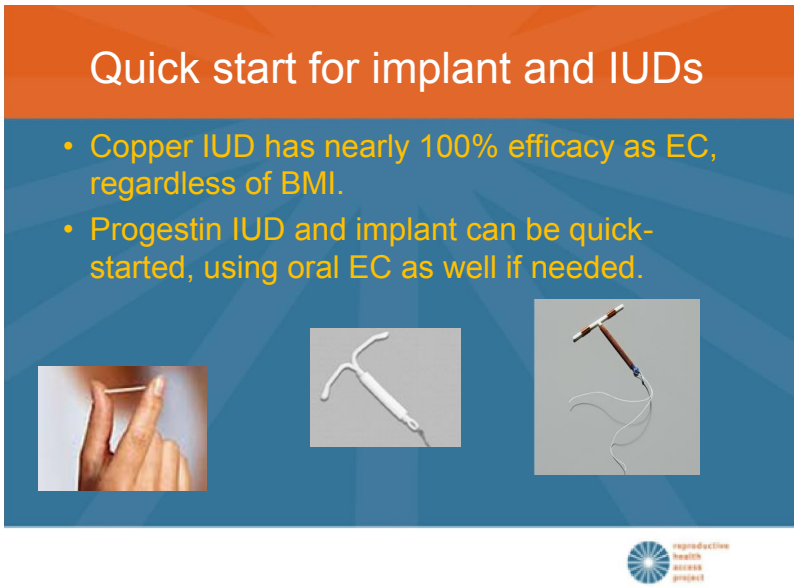
- To increase adherence, write for a full year's supply: even if Yolanda needs a follow-up visit.
    - That's a 3-month supply with 3 refills.
- We have been taught to link refills to follow-up visits: but this stems from an authoritarian model of care.
    - Patient-centered practice = many refills on chronic medications.

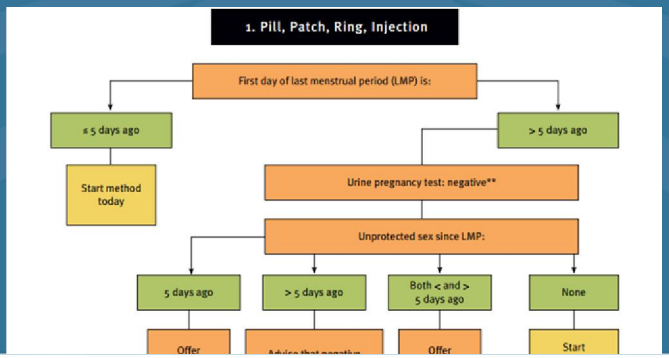
Slide 15:



- Starting LARC methods is more complex if there is any concern about early pregnancy
  - Unprotected intercourse > 5 days ago

Slide 16:

Quick start algorithm has helpful details for each method.



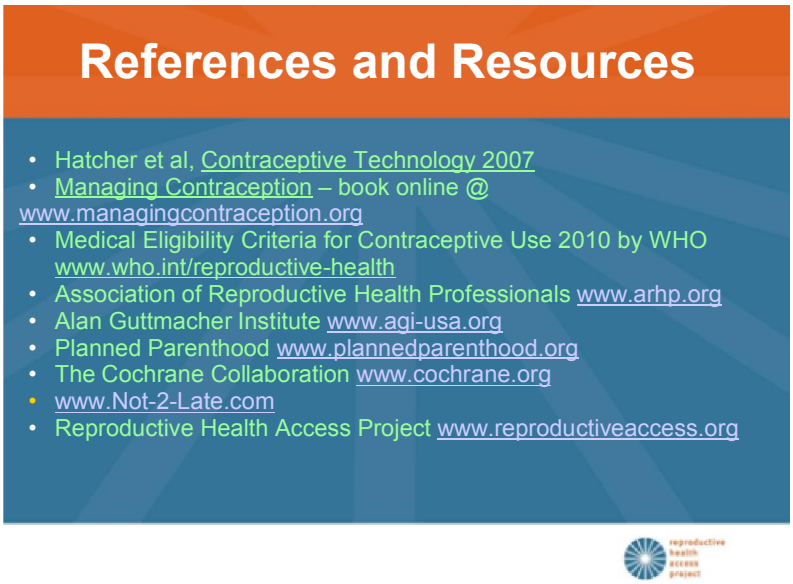
Slide 17:

Take-home message: Be pro-active with contraception!

Ask about contraceptive needs at all types of visits.

Don't delay: start the new method today!

Slide 18:


References and Resources
• Hatcher et al, Contraceptive Technology 2007
• Managing Contraception – book online @ www.managingcontraception.org
• Medical Eligibility Criteria for Contraceptive Use 2010 by WHO www.who.int/reproductive-health
• Association of Reproductive Health Professionals www.arhp.org
• Alan Guttmacher Institute www.agi-usa.org
• Planned Parenthood www.plannedparenthood.org
• The Cochrane Collaboration www.cochrane.org
• www.Not-2-Late.com
• Reproductive Health Access Project www.reproductiveaccess.org

Resources

Quick Start Algorithm

Providing Quality Family Planning Services: Recommendations of the CDC and the U.S. Office of Population Affairs (QFP)

Your Birth Control Choices - patient information sheet

Emergency Contraception: Which EC is Right for Me? - patient information sheet

Medical Eligibility for Initiating Contraception

Contraceptive Pearls - archive of past issues of the Contraceptive Pearls

Sign up to received the Contraceptive Pearls via email every month.

References

Lopez LM, Newmann SJ, Grimes DA, Nanda K, Schulz KF. Immediate start of hormonal contraceptives for contraception. *Cochrane Database Syst Rev* 2008; 2: CD006260.

Westhoff C, Kerns J, Morroni C, Cushman L, Tiezzi L, Murphy P. Quick start: a novel oral contraceptive initiation method. Contraception 2002; 66: 141–145.

Westhoff C, Heartwell S, Edwards S, Zieman M, Cushman L, Robilotto C, et al. Initiation of oral contraceptives using a quick start compared with a conventional start: a randomized controlled trial. Obstet Gynecol 2007; 109: 1270–1276.

Rickert VI, Tiezzi L, Lipshutz J, Leon J, Vaughan RD, Westhoff C. Depo now: preventing unintended pregnancies among adolescents and young adults. J Adolesc Health 2007; 40: 22–28.

Sneed R, Westhoff C, Morroni C, Tiezzi L. A prospective study of immediate initiation of depo medroxyprogesterone acetate contraceptive injection. Contraception 2005; 71: 99–103.

Murthy AS, Creinin MD, Harwood B, Schreiber CA. Same-day initiation of the transdermal hormone delivery system (contraceptive patch) versus traditional initiation methods. Contraception 2005; 72: 333–336.

Nelson AL, Katz T. Initiation and continuation rates seen in 2-year experience with same day injections of DMPA. *Contraception* 2007; 75: 84–87.