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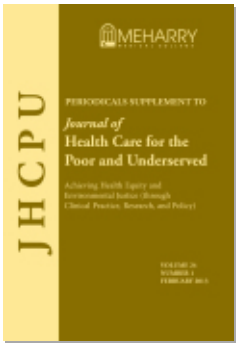

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Whenever I see a woman who has an unintended pregnancy, I make a point of looking through her chart to see if she had a recent office visit. About 75% of the time, I find she did *have a visit within the previous three months, but contraception was not addressed.*
—Family physician and medical director of a federally qualified health center

Federally qualified health centers, also known as community health centers (CHCs), care for our nation's neediest populations. By latest count, 1,128 federally qualified health centers operate more than 8,500 sites serving 20.2 million men, women, and children.[1] These numbers are expected to grow with expanded funding via the Patient Protection and Affordable Care Act.

Community health centers are charged with providing a wide scope of preventive health services to people of all ages—including prenatal care, immunizations, cancer screening, and family planning.[2] Community health centers form an integral part of the communities they serve. In some areas, these health centers offer the *only* medical resources available for miles around.

Community health centers have demonstrated excellent outcomes in reproductive health. Community health center patients are less likely to have pre-term births or low-birthweight babies,[3] and are more likely to obtain Pap tests and mammograms than other low-income patients.[4] However, CHCs' effectiveness at providing family planning services is unclear.

A 2001 study[5] by the Guttmacher Institute found that only 60% of CHC sites provided contraception. Community health centers provided contraception to about 28% of their female patients of reproductive age. More recent studies by Guttmacher and others found that while most publicly funded clinics offered oral contraceptives, CHCs were less likely to provide the most effective contraceptive methods (namely the IUD and implant) and were not as likely to follow evidence-based contraceptive practices such as *quick start* (that is, same-day initiation of contraception).[6]

The role of CHCs in caring for our nation's most underserved populations is unquestioned. Community health centers serve one in five low-income women[7] and are also more likely than other publicly funded family planning providers to serve men, special

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needs groups, minorities, and patients with limited English proficiency.[6] Yet, CHCs can do more to prevent unintended pregnancy in the United States.

The Impact of Unintended Pregnancy

We know a lot about unintended pregnancy in the United States. We know that most families in the United States want two children. We know that most people want to plan childbearing and avoid unintended pregnancies.[8] One way of looking at this is that most women spend about 75% of their reproductive years trying to avoid pregnancy.[9]

We also know that nearly half of all pregnancies in the United States are unintended.[10] Our rate of unintended pregnancy is far higher than that of most other developed nations. We know that poor and low-income women, the very women CHCs serve, are much more likely to experience an unintended pregnancy than other women.[11]

Unintended pregnancy can have lasting consequences. In 2001, the latest year of available data, 3.1 million unintended pregnancies in the U.S. resulted in 1.3 million abortions, 400,000 miscarriages, and 1.4 million births. Women with unintended pregnancies are less likely than women with intended pregnancies to initiate prenatal care promptly,[12] to quit smoking cigarettes,[2,13] to consume adequate amounts of folic acid,[14] and to breastfeed their infants.[15] Teens who have a child are less likely than others to graduate from high school or complete college.[16] Children born of unintended pregnancies are more likely to have a premature birth, to die in the first year of life, to suffer abuse, and to fail in school.[17]

Consistent use of effective contraception can make a difference. Most women who experience unintended pregnancies are not using contraception at all or are using it inconsistently during the month of their conception.[18] Teen pregnancy rates have dropped to all-time lows as a result of increased access to effective contraception.[11]

How Can Community Health Centers Lower the Rate of Unintended Pregnancy?

> *I've been Amalia's family physician since she was a baby. When she was 15, she came to me for a sprained ankle. Her mom stayed in the waiting room while I taped up Amalia's ankle. We talked about her life, school, boys, everything. It turned out that she had just started having sex and was not using any contraception. While treating her sprain, I also prescribed birth control pills and emergency contraception, and I screened her for chlamydia and HIV. Ever since then, it doesn't matter why teens come to see me; I always spend time alone with them so I can ask about their sexual health and birth control needs.*
>
> *—Family Physician*
> *Community Health Center, urban setting*

As safety-net providers, CHCs serve millions of low-income people of reproductive age. Community health centers provide these patients with treatment for chronic illnesses, preventive services, and maternity care. Now that CHCs are expanding to accommodate newly insured patients, we have an opportunity to sharpen the focus

on contraception. Community health centers can prevent unintended pregnancy by making high-quality contraception more readily available to patients. Accomplishing this requires work on several levels: offering the widest possible range of contraceptives, breaking down barriers related to cost and access, and providing culturally sensitive, proactive contraceptive counseling.

Most CHCs provide low- and medium-efficacy contraceptives, such as barrier methods and the pill/patch/ring.[6] These methods require substantial effort from the women who use them. The IUDs and implant require no effort from patients beyond the office visit for insertion. Unfortunately, these high-efficacy methods are offered by comparatively few CHCs.[6] If all CHCs offered patients the full range of contraceptives (including IUDs and implants) and if CHCs followed expanded eligibility guidelines (providing IUDs even to nulliparous women and teens) the U.S. might approach the rate of IUD use seen in other developed nations. Greater use of high-efficacy methods would lead to substantial decline in our unintended pregnancy rate.

Community health centers can enhance patients' access to contraception through evidence-based practices. First, we must de-link contraception from other clinical services. Although cervical cancer and sexually transmitted infection screening are key priorities for CHCs, neither should be a prerequisite for most contraceptives.[19] Once we stop requiring Pap smears and pelvic exams before ordering or renewing prescription contraceptives, we make contraception more easily available to patients. A second way to improve patients' access is to prescribe (or better yet, to dispense) contraceptives in the longest possible increments.[20,21] For example, electronic prescribing systems should default to 84 pills with three refills. Prescription contraceptives are chronic care medications, which patients may take for many years before they want to conceive; linking the prescription interval to follow-up visits serves only to restrict patients' access to much-needed ongoing medication.

Contraceptive care for teens presents special challenges and tremendous opportunities. Because state laws on teen confidentiality vary, CHC staff members must make themselves aware of their state's guidelines.* However, even in states where teens cannot get contraception without a parent's permission, clinicians should routinely spend part of each visit speaking with teens alone. Many teens feel able to speak frankly about sexuality only when parents have left the exam room. Letting parents of younger children know that their teens should meet with the clinician alone helps to ease this transition. In states where teens can give their own consent for birth control, providing high-efficacy contraception is simpler. Clinicians should counsel teens about contraception at every opportunity, using a patient-centered approach that recognizes and values teens' personal preferences. Displaying contraceptive posters and information sheets in the waiting room demonstrates openness to this issue, encouraging shy teens to discuss sexuality. Providers should gently encourage use of high-efficacy contraceptives, remembering that nearly every teen is eligible for an IUD or implant. For a 15-year-old girl who began having sex last month, an IUD represents the opportunity to finish high school and college without worrying about unintended pregnancy. Community health centers can provide that opportunity.

*The Guttmacher Institute monitors state laws regarding minors' access to contraceptive services. http://www.guttmacher.org/statecenter/adolescents.html

To achieve patient-centered contraceptive care, clinicians must listen carefully to patients and respect their concerns. A patient who requests a particular contraceptive method (for instance, a specific pill brand) should receive that method unless it is contraindicated. Studies show that women who get the method they want are more likely to adhere to that method.[22] Patients who believe that a particular method will harm them (for example, that a pill causes weight gain or that hormones cause cancer) should receive a method that takes these concerns into account, even when there is no evidence to support the patient's belief. All contraceptives have side effects. Anticipating the most common side effects may help to prevent patients from stopping a contraceptive unnecessarily. Even more important, CHCs should encourage continuity of care and allow patients easy access to clinical staff for questions and concerns. Patients who believe that their clinician is available to answer questions are more likely to adhere to contraception. If patients can access their clinician only by scheduling an office visit, a minor concern about an early side effect may lead to premature discontinuation of a contraceptive. In contrast, patients who can easily reach their health provider *via* phone, email, or a patient portal may get the quick reassurance or simple advice that enables them to continue taking their contraceptive. Studies show that when women get contraception from a clinician they know and trust, they have better adherence.[23]

Cost remains a significant barrier to contraception. While the Affordable Care Act will expand Medicaid to cover residents of participating states with incomes up to 125% of the poverty level, and by 2014 all health plans will cover contraceptives without deductibles and co-pays, millions of women and teens will continue to lack coverage for birth control. Undocumented women living in the U.S. will not have access to Medicaid or the health insurance exchanges under the ACA. Given the recent studies at Washington University in St. Louis that documented a huge decrease in unintended pregnancy when birth control was provided free to women,[24] it is unfortunate that many American women will face financial barriers to contraception even after 2014. Community health centers can address financial barriers to birth control in several ways. They can use federal 340B programs to obtain contraceptives at the lowest cost possible. Clinicians can prescribe low-cost generic contraceptives in one-year increments (84 pills with three refills).* These measures can help uninsured and under-insured patients obtain contraception at low cost.

> *The largest hospital system in this part of the state is opening a Rural Health Center about an hour away from where I live and they have hired me to be the provider. I will be there on my own (with an LPN and Patient Service Representative) most of the time (the medical director comes for a few hours once per week). In many ways this is a very exciting opportunity for me. I will be heavily involved in/responsible for the day-to-day operations of the health center, including hiring my staff, creating templates, managing flow, etc. But the hospital system that is opening the clinic is Catholic, which of course*

*Many pharmacies offer low-cost generic contraception. The Reproductive Health Access Project has a list of options available at national chains. http://www.reproductiveaccess.org/contraception/lowcost_pills.htm

means that the reproductive health services I can offer will be limited. I will not have the ability to offer contraception or provide pregnancy options counseling within the office.
—Family Nurse Practitioner
Southwestern state

Community health centers have become the safety-net providers of family planning services for millions of low-income Americans. As CHCs expand the population served, we must offer the most effective contraceptive methods with the fewest possible barriers. This means providing IUDs and implants on site, offering same-day initiation of most contraceptives, prescribing contraceptives in the longest possible increments, removing outdated rules that link Pap smears to contraception, spending part of each teen's office visit without a parent in the room, providing patient-centered contraceptive counseling, and assuring patients easy access to clinicians for questions, concerns, and refills. We can address financial barriers by using the 340B program and by prescribing low-cost generic birth control pills. As reimbursement for CHCs is more closely linked to quality of care, family planning outcomes should be measured (just as chronic disease treatment outcomes are measured), and success should be rewarded. Healthy families start with wanted children. Adequate spacing between pregnancies leads to better outcomes for mothers and children. We must ensure that everyone, everywhere has access to high-quality, low-barrier contraceptive care.

Notes

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