Family Planning Stakeholder Meeting

August 24, 2022

10 a.m. to 12 p.m.

DHCS

Meeting Agenda

10:00 – 10:05	Welcome and Introductions
10:05 – 10:30	DHCS Updates
10:30 – 10:55	Stakeholder Updates
10:55 – 11:25	New Family PACT Benefits: Dr. Michael Policar
11:25 – 11:50	Contraceptive Use and Family Planning: Jacqueline Silva
11:50 – 11:55	Closing Remarks

Welcome & Introductions

DHCS Coverage Ambassadors

- **DHCS Top Goal:** Minimize beneficiary burden and promote continuity of coverage for Medi-Cal beneficiaries
- **How you can help:**
  - Become a **DHCS Coverage Ambassador**
  - Download the Outreach Toolkit on the DHCS Coverage Ambassador webpage
  - Join the DHCS Coverage Ambassador mailing list to receive updated toolkits as they become available.

DHCS Coverage Ambassadors (Continued)

- **Phase One: Encourage Beneficiaries to Update Contact Information**
  - **Already lanched**
  - Multi-channel communication campaign to encourage beneficiaries to update contact information with county offices
  - Flyers in provider/clinic offices, social media, call scripts, website banners
- **Phase Two: Watch for Renewal Packets in the mail. Remember to update your contact information.**
  - **Launch 60 days prior to COVID-19 PHE termination**
  - Remind beneficiaries to watch for renewal packets in the mail and update contact information with county office if they have not already done so.

DHCS Updates

DHCS Updates

- CalHEERS
- Family PACT Regulations
- Remote Client Enrollment Policy
- PAVE
- Provider Enrollment and Responsibilities Policy

Stakeholder Updates

Putting New Family PACT Benefits to Work in Patient Care

Michael Policar MD, MPH
Professor Emeritus of Ob, Gyn, & RS
UCSF School of Medicine
Medical Consultant, Office of Family Planning, CAPTC

DHCS

New Contraceptive Products

- One-year contraceptive vaginal ring [CVR] (Annovera)
- Contraceptive vaginal gel (Phexxi)
- Lower dose contraceptive patch (Twirla)
- Generic version of NuvaRing (EluRyng)
- DMPA-SQ (not new, but "discovered" by many clinicians and consumers since the public health emergency)
- Drospirenone progestin-only pill (Slynd)
  - *Not a Family PACT or Medi-Cal benefit*

EE/SGA (Annovera) Contraceptive Vaginal Ring (CVR)

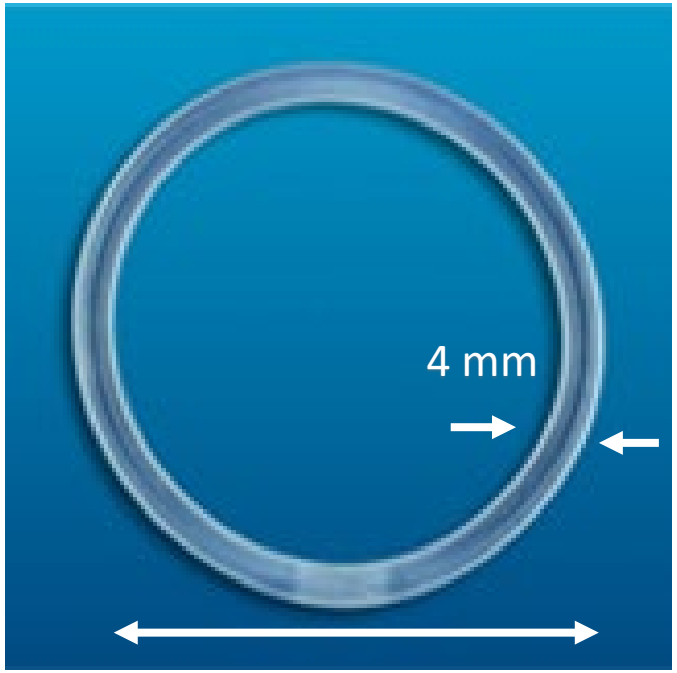
Comparison of CVRs

	EE/ETG (NuvaRing)	EE/SGA (Annovera)
Lifespan	30 days	1 year
Progestin release rate	Etonogestrel (ETG) 120 mcg/day	Segesterone (SGA) 150 mcg/day
EE release rate	15 mcg/day	13 mcg/day
Diameter Thickness	54 mm 4 mm	56 mm 8.4 mm
'Plastic'	Ethylene-vinyl acetate	Silicone

EE: Ethinyl estradiol

Contraceptive Vaginal Rings

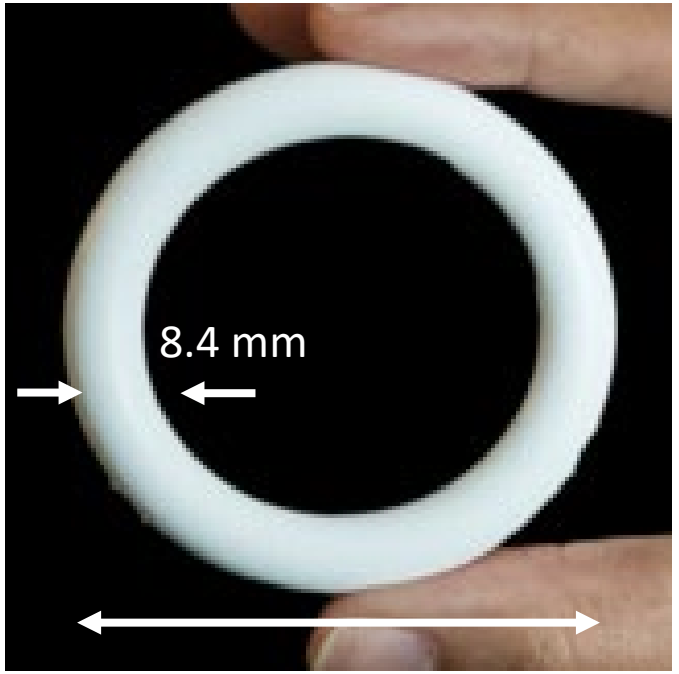
NuvaRing®



54 mm

NuvaRing®

Annovera®



56 mm

Family PACT Contraceptive Benefits

Contraceptive vaginal rings (October 1, 2021)

- J7294 CVR (EE/SGA; Annovera)
  - One ring per dispensing
  - Maximum of two dispensings in a 12-month period
- J7295 CVR (EE/ETG; NuvaRing)
  - Up to 13 rings
  - Maximum of two dispensings in a 12-month period
- TAR is required for 3rd supply of the same product requested < 1 year

Contraceptive Vaginal Gel (Phexxi®)

- Lactic acid, citric acid, and potassium bitartrate vaginal gel
  - Acidic pH (3.5-4.5) reduces sperm motility
  - Effective only before sex; not afterward
  - 1 applicator ≤ 1 hour *before each* episode of vaginal sex
- Prescription only…to optimize counseling about correct use
- *7-cycle* typical use pregnancy rate: 13.7% (= to diaphragm)
  - Pearl Index (est): 27.5 failures per 100 couples/year

Family PACT Contraceptive Benefits

Phexxi® Contraceptive Vaginal Gel (July 2021)

- HCPCS Code: A4269 U5
- 1 box (12 single-use applicators)
- 3 dispensings per 75-days
- Restricted to NDC labeler code 69751

EE/LNG (Twirla®) Contraceptive Patch

- Twirla: EE 30 mcg + levonorgestrel 120 mcg/ day
  - Compared to Xulane®: EE 35 mcg + norelgestromin 150 mcg/day
- Two "Black Box" warnings (for both patches)
  - Contraindicated in women with BMI ≥30 kg/m^2
    - Reduced effectiveness
    - May have a higher risk for venous TE events
  - Same cardiovascular contraindications as OC, ring
- Twirla efficacy (typical use): 5.8 pregnancies/100 women/year
  - BMI <25 kg/m^2: 3.5 "
  - BMI ≥25 and <30: 5.7 "

Comparison of Contraceptive Patches

	EE/NGMN (Xulane)	EE/LNG (Twirla)
Progestin	150mcg/day NGMN	120mcg/day LNG
Estrogen*	35mcg/day EE	30mcg/day EE
Size	14 cm^2	28 cm^2
Lifespan	1 week New patch weekly	1 week New patch weekly
Materials	Polyethylene outer Polyester inner	Skinfusion® (no latex)

Comparison of Contraceptive Patches

Xulane

Twirla

Family PACT Contraceptive Benefits

Contraceptive patches

- Norelgestromin/EE (Xulane) J7304-U1
- Levonorgestrel/EE (Twirla) J7304-U2
  - The dispensing of up to the maximum quantity is intended for clients on continuous cycle (4 x 13 cycles = 52)
- A 12-month supply of the same product of patches may be dispensed twice in one year
- A TAR is required for the third supply of up to 12 months of the same product requested within a year

Alternatives to DMPA-IM

- In-person visit, IM injection in clinic
- In-person visit, curbside injection
- In-person visit, IM injection in pharmacy by pharmacist
  - Effective 9/1/20
- Switch to self-injected DMPA-SQ
- Switch to a “bridge” method
  - Progestin-only pills
  - Combined hormonal methods: OC, patch, ring
  - Barrier method

Family PACT Contraceptive Benefits

DMPA-SQ 104 mg

- DMPA-SQ can be dispensed by a pharmacy directly to a Family PACT client for self-administration at home
- Temporary pharmacy benefit, Sept 2020
- Permanent pharmacy benefit, June 2021
- Earliest refill: 80 days

Reminder: the FPACT Pharmacy Formulary is on Medi-Cal Rx Website (no longer in the FPACT Policies, Procedures, and Billing Instructions (PPBI) manual)

https://medi-calrx.dhcs.ca.gov/home/

For assistance, call the Medi-Cal Rx Customer Service Center at 800-977-2273, 24 hours a day, 7 days a week, 365 days per year.

CA.GOV

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Welcome to Medi-Cal Rx

Medi-Cal Rx is Live! All administrative services related to Medi-Cal pharmacy benefits billed on pharmacy claims from the existing Medi-Cal Fee-for-Service (FFS) or Managed Care Plan (MCP) intermediaries have transitioned to Medi-Cal Rx.

LEARN MORE

Medi-Cal Rx and Family PACT

- Administration of Medi-Cal pharmacy benefits, including Family PACT, through the fee-for-service delivery system
- Includes all pharmacy services billed as a pharmacy claim
  - Family PACT ***pharmacy claims*** will be processed through the Medi-Cal Rx secure provider portal
- ***Does not*** include pharmacy services billed as a medical (professional) or clinic-dispensed, or institutional claim
- https://familypact.org/wp-content/uploads/2021/12/Flyer_MCalRx.pdf

UPDATE: Duration of Use For LARC

	FDA-Approved	Evidence-Based
Paragard	10 years	12 years
Mirena	7 years	7 years
Liletta	6 years	7 years
Kyleena	5 years	5 years
Skyla	3 years	3 years
Nexplanon	3 years	5 years
DMPA-IM	13 weeks	15 weeks
DMPA-SQ	13 weeks	15 weeks

Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Recommendations and Reports / Vol. 70 / No. 4
July 23, 2021

Sexually Transmitted Infections Treatment Guidelines, 2021

Family PACT Benefit for HPV Vaccination

- Coverage is restricted to individuals ages 19 to 45
- Use the following CPT codes for HPV vaccine and administration
  - 90651: 9vHPV vaccine
  - 90471: Immunization administration
- For individuals ages 27-45, the CDC ACIP recommends vaccination based on *shared decision-making*
  - The shared decision-making discussion must be documented
- Bill with the ICD-10 code that identifies the client's contraceptive method
  - Not reimbursable with diagnosis codes Z30.012, Z30.09, or Z31.61

Family PACT STI Benefits

Multi-site GC and CT screening

- Family PACT (and Medi-Cal) frequency limits for GC/CT are up to three tests per recipient, per day (as of Sept. 2018)
- Use separate NAAT test kits regardless of genital, anal, or oropharyngeal sample site
- CPT codes are the same, so label samples clearly
- Don’t forget to include ICD-10 diagnosis codes on lab slips

Family PACT STI Benefits

Treatment of GC and CT

- PPBI has been modified to include 2021 CDC recommendations
- All CDC recommended regimens are covered

Expedited Partner Treatment (EPT)

- CDC, 2021: Responsibility for discussing partner treatment rests with diagnosing provider and the patient
- Bring Your Own Partner ("BYOP")
  - Bring their partner(s) with them at the time of treatment
- Patient-delivered partner therapy (PDPT)
  - Provide patient with drugs intended for partners
  - Prescribe extra doses in the index patients' name
  - Write prescriptions in the partners' names
  - Ideally with written instructions for the partner(s)

Family PACT STI Benefits

Patient Delivered Partner Therapy (PDPT)

- If a Family PACT client is diagnosed with GC, CT and/or trichomoniasis and EPT is medically necessary to prevent reinfection of the client, the provider may either
- Dispense medication directly to the client to provide to his/her partner(s), or
- Provide the client with a prescription (in the client's name) for medications with a quantity and duration of therapy sufficient to treat the acute infection in the client and partner(s)

Family PACT STI Benefits

Mycoplasma genitalium

- *M gen* test 87563 added as a *diagnostic test* for recurrent urethritis, cervicitis, and in some cases of PID (effective 5/1/22)
- For persistent and/or recurrent cervicitis or nongonococcal urethritis of penis that has not responded to treatment with doxycycline or azithromycin, Family PACT covers
  - Doxycycline mg PO BID for 7 days, then
  - Moxifloxacin 400mg PO once daily for 7 days
    - Pharmacy dispensing only; requires a TAR
    - Reference: ben grid, page 22

Family PACT STI Benefits

Diagnosis and Treatment of Trichomoniasis

- NAAT (87661) and OSOM Rapid Trich® (87808) tests covered as
  - Diagnostic tests
  - Annual screening for asymptomatic women with HIV infection
  - "Might be considered for asymptomatic women at high risk for infection, including those with multiple sex partners, those who engage in transactional sex, and those with a history of drug misuse or STIs"
- New CDC-recommended treatments are covered
  - Females: metronidazole 500 mg orally twice a day for 7 days
  - Males: metronidazole 2gm single dose
  - Reference: ben grid, page 22

Expanded Syphilis Screening Recommendations for the Prevention of Congenital Syphilis

Guidelines for California Medical Providers

2020

Required in CA by SB 306, signed by Gov. Newsom on 10.4.2021

These guidelines were developed by the California Department of Public Health (CDPH) Sexually Transmitted Diseases (STD) Control Branch in conjunction with the California STD/HIV Controllers Association, and the California Prevention Training Center.

https://files.medi-cal.ca.gov/pubsdoco/publications/misc/Expanded_Syphilis_Screening_Recommendations_for_the_Prevention_of_Congential_Syphillis.pdf

Syphilis Screening for All People Who *Could* Become Pregnant

Two new, important recommendations

- All sexually active people who could become pregnant should receive at least one lifetime screen for syphilis, with additional screening for those at increased risk
- All sexually active people who could become pregnant should be screened for syphilis at the time of each HIV test

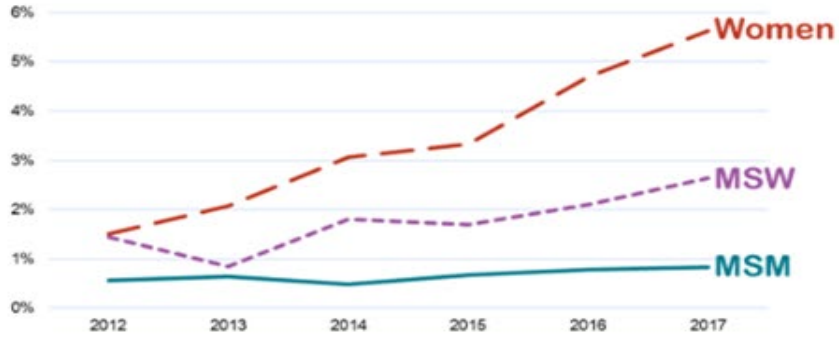
Syphilis Screening

- MSM (men having sex with men), MSMW (a man who has sex with men and women) & TGW (transgender women): screen annually; more frequently if at increased risk
- HIV-seropositive (all genders): screen annually; more frequently if at increased risk
- Using HIV PrEP (all genders): screen every 3 months
- History of syphilis infection
- Diagnosis of another STI within the past 12 months
- Pelvic pain or a diagnosis of pelvic inflammatory disease (PID)
- Multiple sex partners
- Sex partners who are MSMW or who have other concurrent partners

Drivers and Determinants for the Rising Incidence of Syphilis in Women

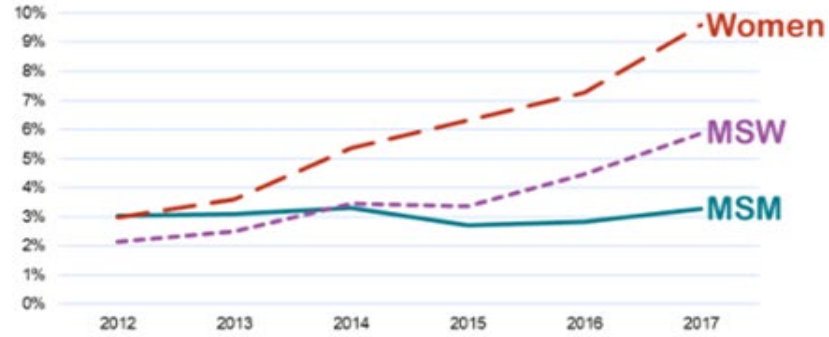
Substance Use Among Syphilis Cases

Heroin Use



Meth Use

Injection Drug Use



Crack Use

Kidd SE et al., *MMWR* 2019

Syphilis Screening

- Social determinants
  - Recent incarceration or a sex partner who was recently incarcerated
  - Individuals with a history of commercial sex work
  - Having sex in exchange for resources, such as money or drugs
  - Having sex under the influence of alcohol or drugs
  - Methamphetamine use, intravenous drug use
  - Homeless or unstable housing
- Regional variations (hot spots): living in a local health jurisdiction with
  - High syphilis rates among females
  - High-congenital syphilis rates

Syphilis Screening: Traditional Algorithm

Non-treponemal tests (RPR, VDRL)

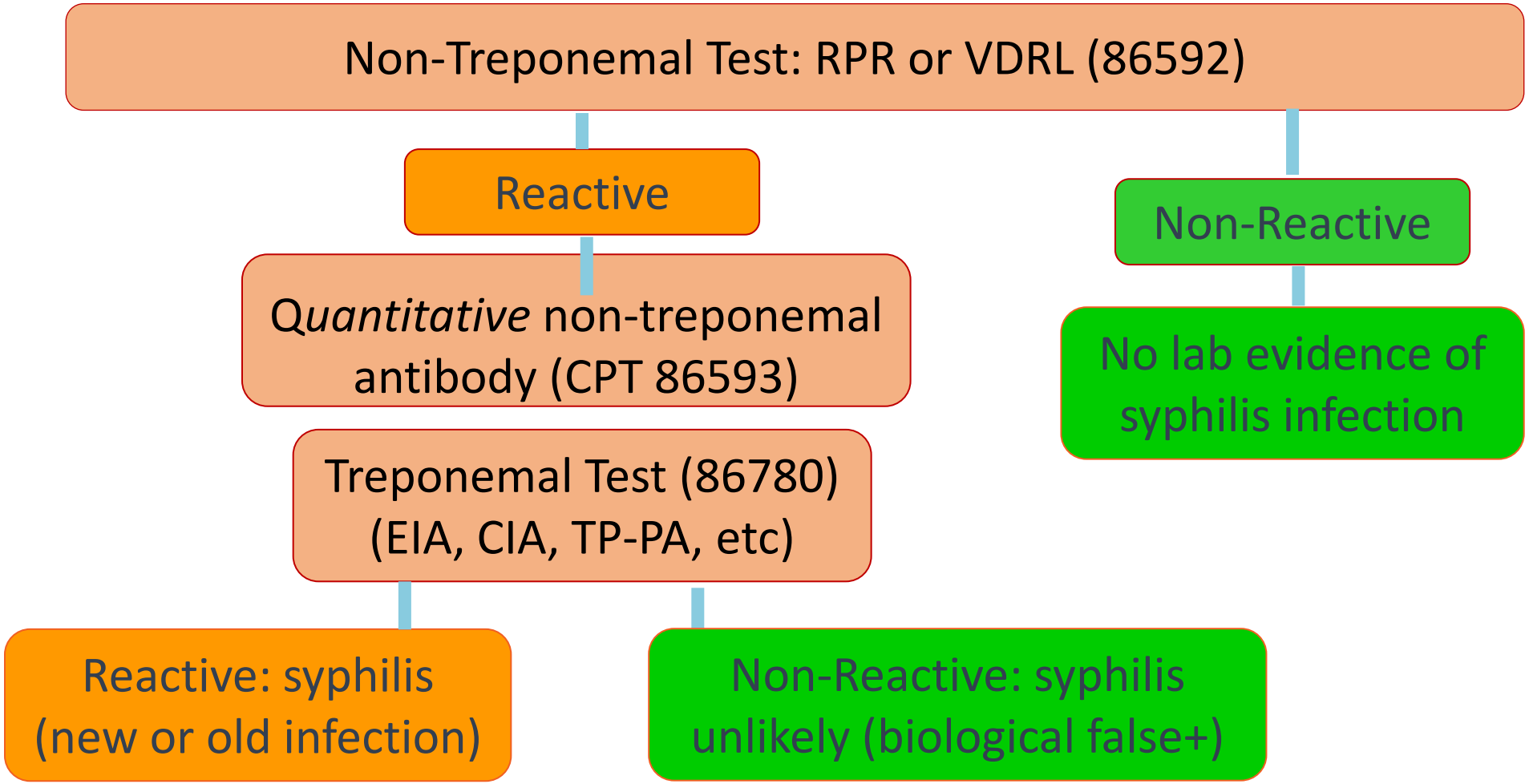
- Non-specific to *Treponema pallidum*
- Qualitative or quantitative
- Reactivity declines with time

Reflex to

Treponemal tests (EIA, CIA, TP-PA, FTA-Abs)

- Specific to *Treponema pallidum*
- Qualitative
- Reactivity persists over time

Syphilis Screening: Traditional Algorithm



Source: LA DPH Division of HIV and STD Programs

Syphilis Screening: *Reverse Sequence* Algorithm

Treponemal tests (EIA, CIA, TP-PA, FTA-Abs)

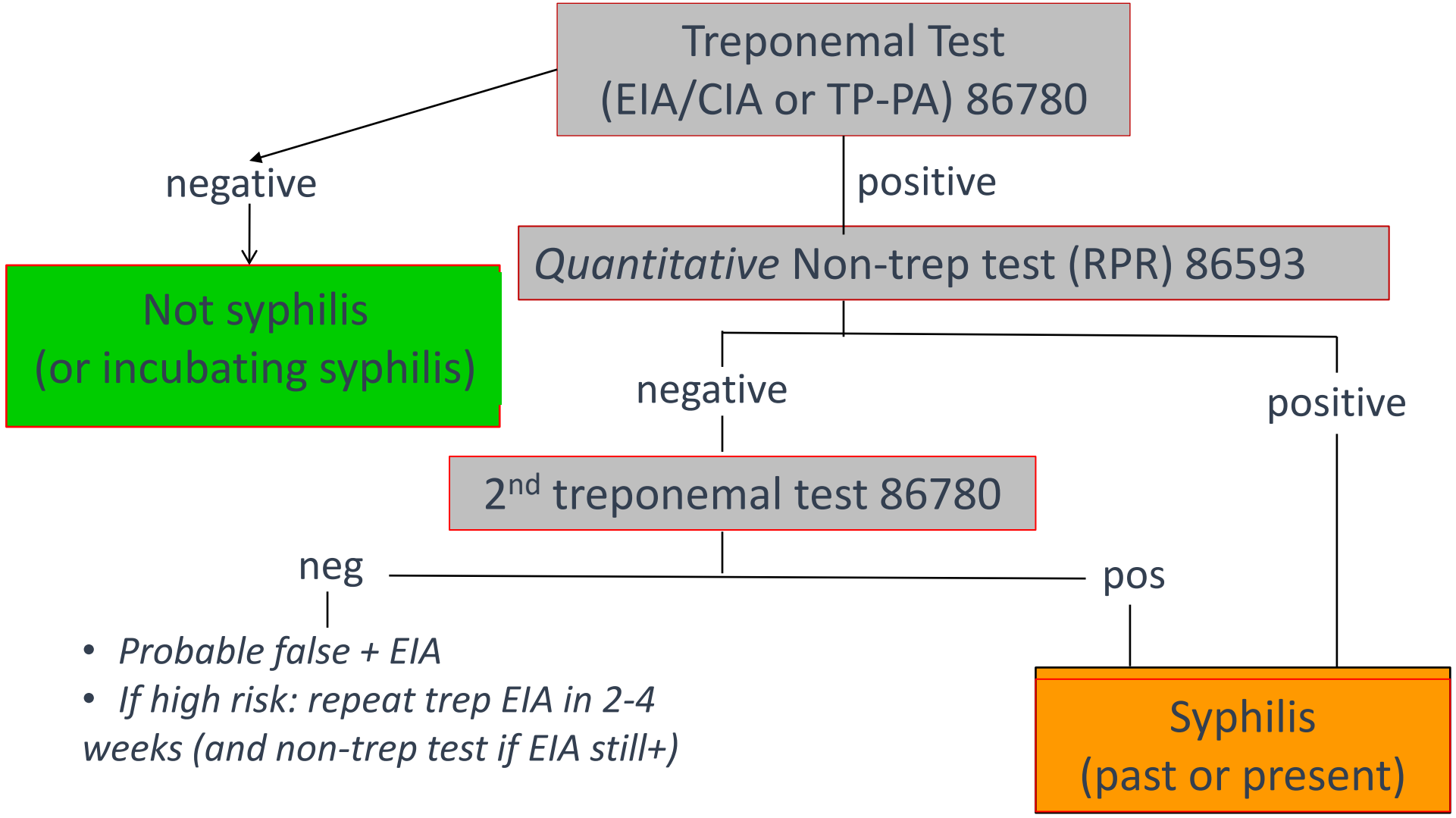
- Specific to *Treponema pallidum*
- Qualitative
- Reactivity persists over time

Reflex to

Non-treponemal tests (RPR, VDRL)

- Non-specific to *Treponema pallidum*
- Quantitative
- Reactivity declines with time

Reverse Sequence EIA/CIA Algorithm



Why Switch to EIA/CLIA for Syphilis Screening?

- Automated (high throughput)
- Faster results
- Low cost in high volume settings
- Less lab occupational hazard (pipetting)
- No false negatives due to prozone reaction
- Objective results

Syphilis Screening Algorithm Comparison

	Traditional	Reverse
Advantages	• Recommended by CDC • Cost effective • More familiar	• Higher specificity (less false positives) • Higher sensitivity (less false negatives)
Disadvantages	• May miss very early or late infection	• Result interpretation can be challenging • May require additional testing for discordant results (ex. Non-reactive RPR, reactive TPPA)

Source: Dunseth, et al (2017). Traditional versus reverse syphilis algorithms: A comparison. Prac Lab Med.
Ortiz et al (2020). The traditional or reverse algorithm for diagnosis of syphilis: Pros and cons. Clinc Infec Diseases.
Theel & Binnicker (2014). Reverse sequence screening for syphilis. Clinc Lab News.

Family PACT STI Benefits

Diagnosis of Syphilis

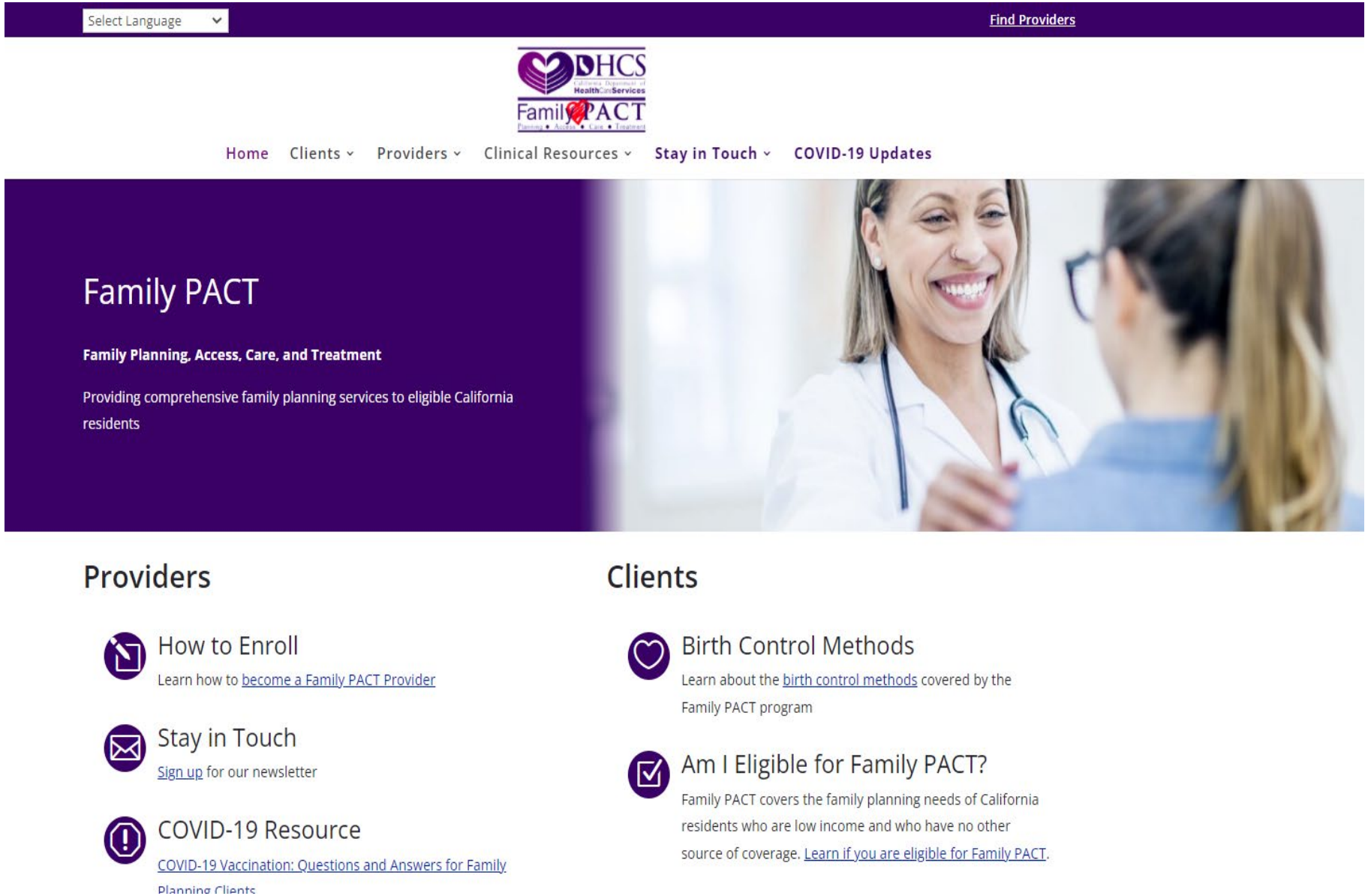
- Both traditional algorithm and reverse screening algorithm are now Family PACT benefits
- Ensure that your clinicians are following the 2020 CDPH syphilis screening guidelines

Syphilis: What Can Reproductive Health Providers Do?

- Check with your local or state health department to determine whether you are in a “hot spot” area
  - Ask your lab to supply a two-year syphilis positivity rate
- In-service clinicians re: USPSTF syphilis screening guidelines
- Offer screening: intending pregnancy, infertility w/u, IUD or implant removal for pregnancy, pregnancy test visit negative
- Offer treatment for confirmed syphilis cases, or have established referral pathway for treatment
- Collaborate with health department initiatives

Keeping Up with Family PACT Benefits

Familypact.org



https://familypact.org/clinical-resources/

Clinical Resources

Providing family planning providers with the most updated and evidenced-based clinical resources to enable the highest standards of care.

Filter by: All Types | Keyword search | Search | Reset

Policy

Family PACT Update Bulletin: April

Visit site

PPBI

Full PPBI

Visit site

PPBI

Family PACT Benefits Grid

Open PDF

All FPACT benefits

PPBI

Family PACT Program Standards

Open PDF

PPBI

On-Site Medication Dispensing Price Guide

Open PDF

PPBI

Family PACT Program Publications

Visit site

Contraceptive Use and Family Planning

Jacqueline Silva

DHCS

California Health Interview Survey (CHIS)

- Largest state survey on health topics
- 90% web-based,10% RDD Survey
- Administered bi-annually, ~50,000 households
- 5 Languages: English, Spanish, Chinese (Mandarin & Cantonese dialects), Vietnamese, & Korean
- Interviews 1 adult and when children in home
  - Interviews 1 teen (12-17) and asks about 1 child <12
- CHIS is a collaborative project of the UCLA Center for Health Policy Research, CDPH, DHCS, & PHI

CHIS Data, Weighting, & Limitations

- Registration & Access
  - AskCHIS
  - Public Use Files (PUFs), requires statistical software
  - Confidential Data Files, requires IMD protocols

- Sample Weighting
  - Compensate for differential probabilities of selection for households & persons
  - Reduce biases occurring because non-respondents may have different characteristics than respondents
  - Adjust for under-coverage in the sampling frames and in the conduct of the survey
  - Reduce the variance of the estimates by using auxiliary information

- Limitations
  - Cross-sectional
  - Respondent bias
  - Low Ns for certain race/ethnic groups

Family Planning Survey Topics

- Pregnancy Plans (females)
- Birth Control Use
- Birth Control Methods Used
- Reason for Not Using Birth Control
- Family Planning Counseling and Information
- Provision of Birth Control and Location Type

CHIS 2019-2020
Family Planning Respondents Demographics

Gender	Age	Group	Universe
Female	18-44	Adult	• Heterosexual/straight or bisexual • At least one opposite-sex sexual partner in the past 12 months • Not currently pregnant • Able to become pregnant
Male	18-54	Adult	• Heterosexual/straight or bisexual • At least one opposite-sex sexual partner in the past 12 months • Able to cause a pregnancy
Female	12-17	Teen	
Male	12-17	Teen	

CHIS 2019-2020 Adult Respondents

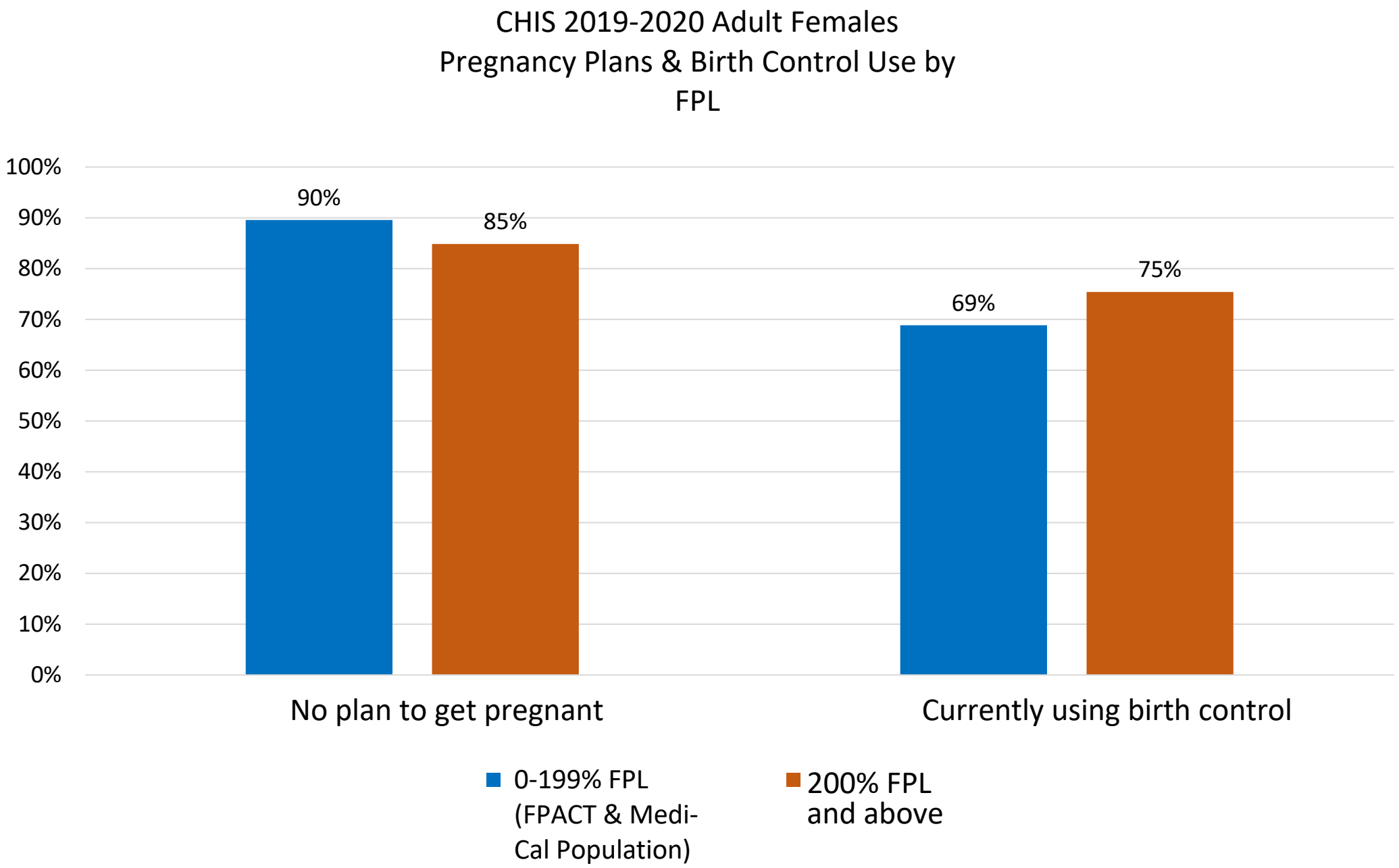
Pregnancy Plans and Birth Control Use

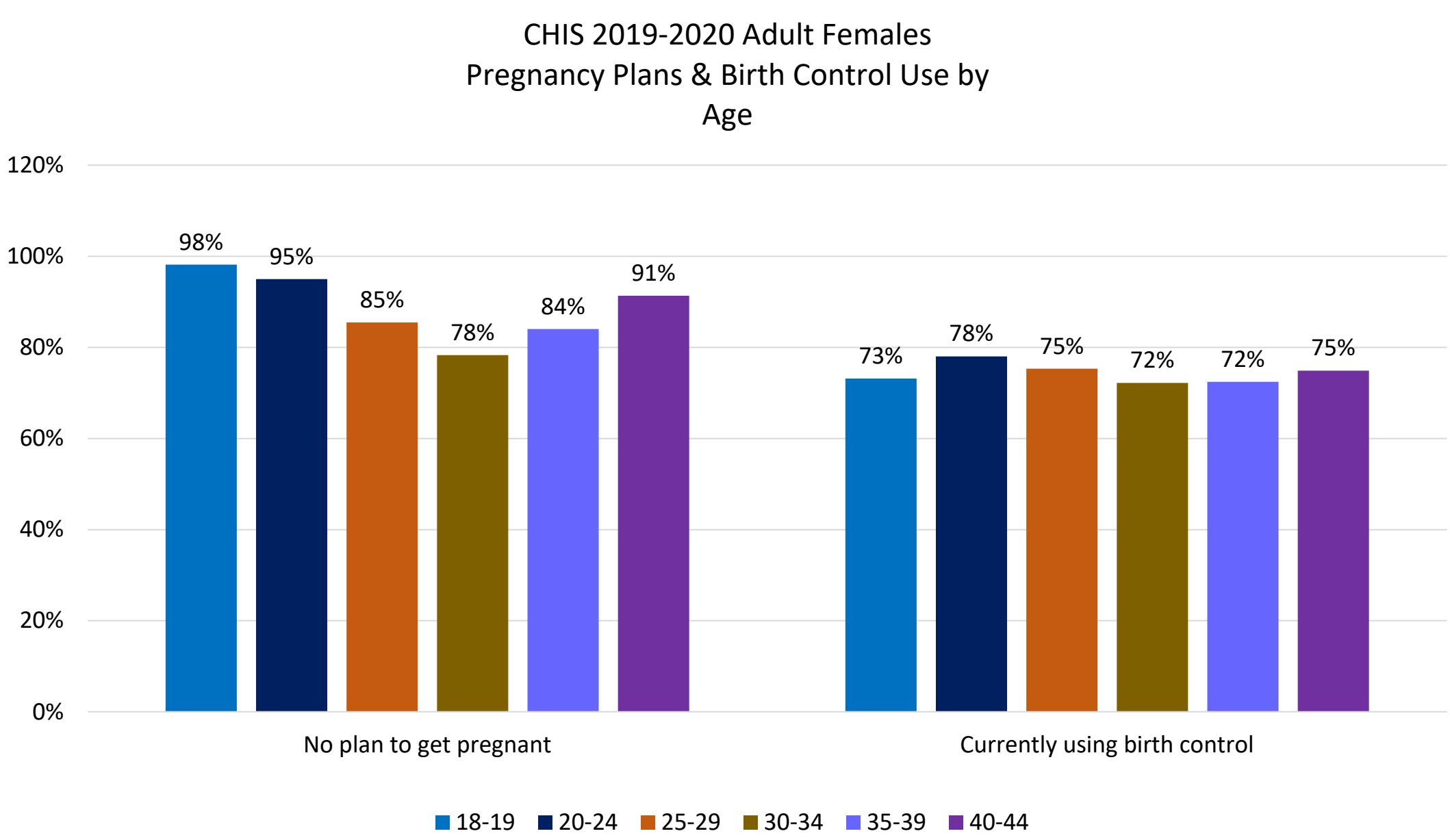
Respondents:

- Adult females
- Not currently pregnant
- Have ability to get pregnant / cause a pregnancy

Definitions:

- FPL: respondent Federal Poverty Level based on Federal Poverty Guidelines

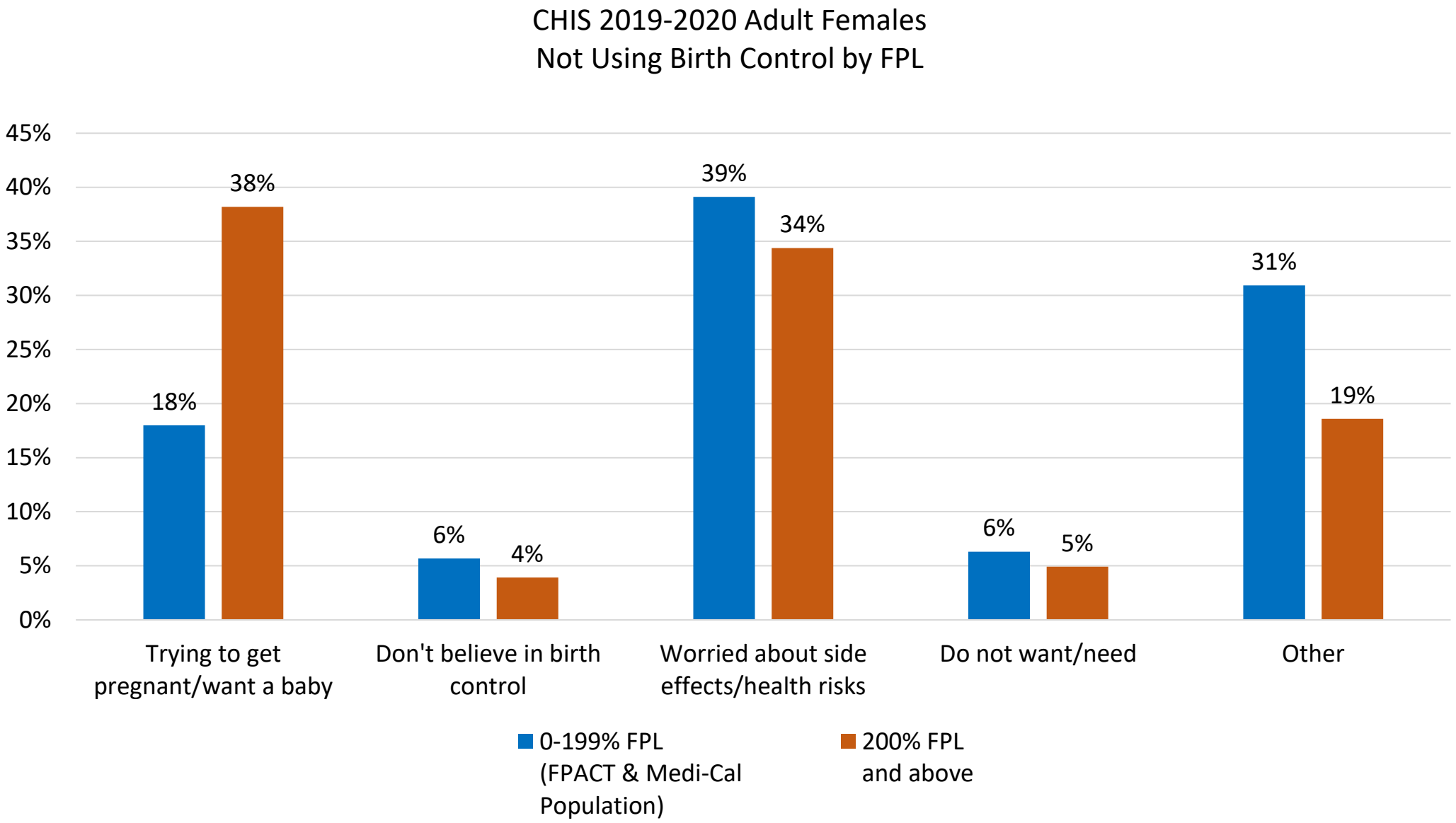

CHIS 2019-2020 Adult Females
Pregnancy Plans & Birth Control Use by FPL
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
90%
85%
69%
75%
No plan to get pregnant
Currently using birth control
0-199% FPL (FPACT & Medi-Cal Population)
200% FPL and above

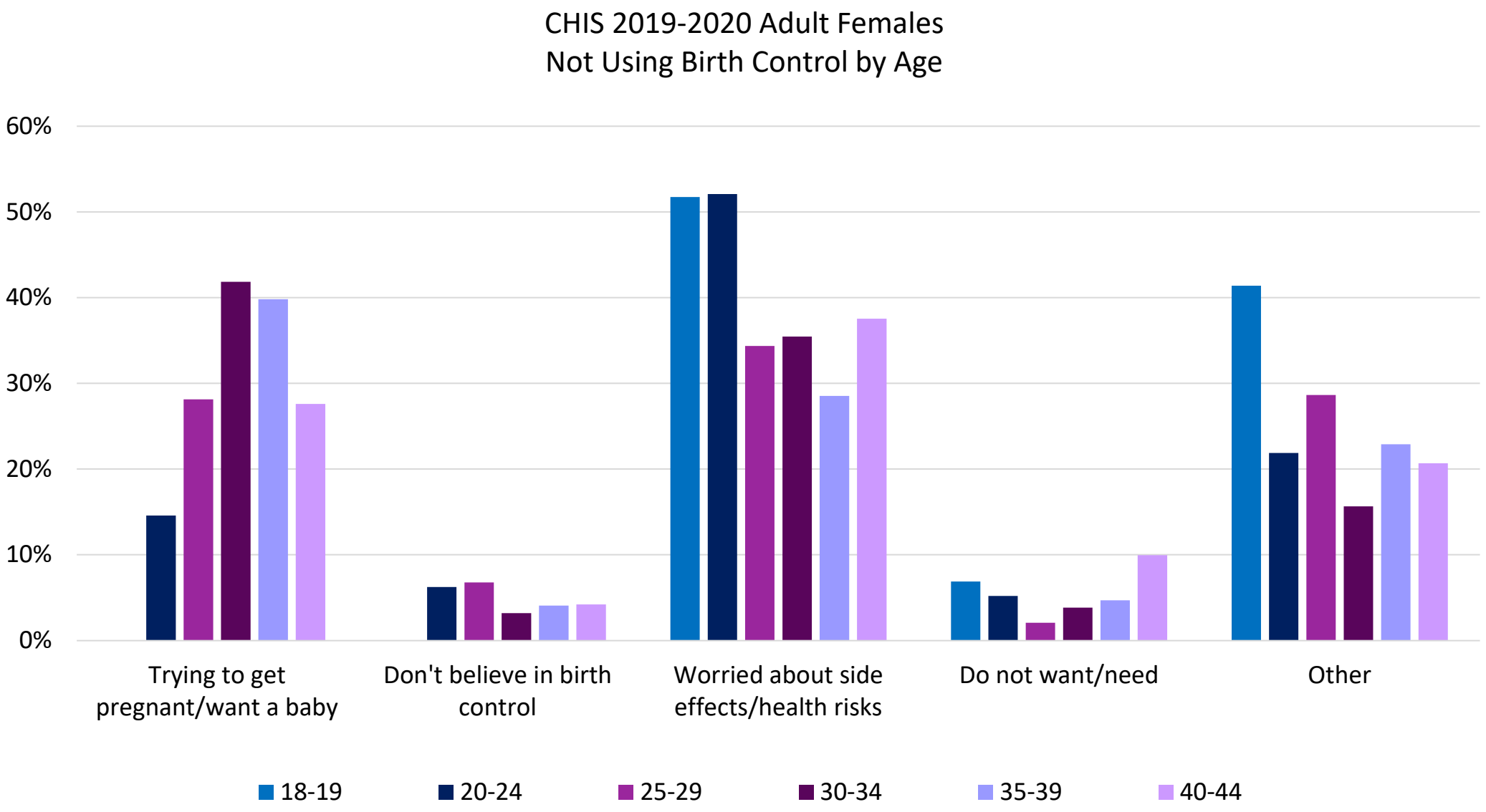

CHIS 2019-2020 Adult Females
Pregnancy Plans & Birth Control Use by Age
120%
100%
80%
60%
40%
20%
0%
98%
95%
85%
78%
84%
91%
73%
78%
75%
72%
72%
75%
No plan to get pregnant
Currently using birth control
18-19
20-24
25-29
30-34
35-39
40-44

Not Using Birth Control

Respondents:

- Adult females
- Not using birth control with opposite-sex sexual partner
- Not currently pregnant
- Have ability to get pregnant / cause a pregnancy


CHIS 2019-2020 Adult Females
Not Using Birth Control by FPL
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
18%
38%
6%
4%
39%
34%
6%
5%
31%
19%
Trying to get pregnant/want a baby
Don't believe in birth control
Worried about side effects/health risks
Do not want/need
Other
0-199% FPL (FPACT & Medi-Cal Population)
200% FPL and above


CHIS 2019-2020 Adult Females
Not Using Birth Control by Age
60%
50%
40%
30%
20%
10%
0%
Trying to get pregnant/want a baby
Don't believe in birth control
Worried about side effects/health risks
Do not want/need
Other
18-19
20-24
25-29
30-34
35-39
40-44

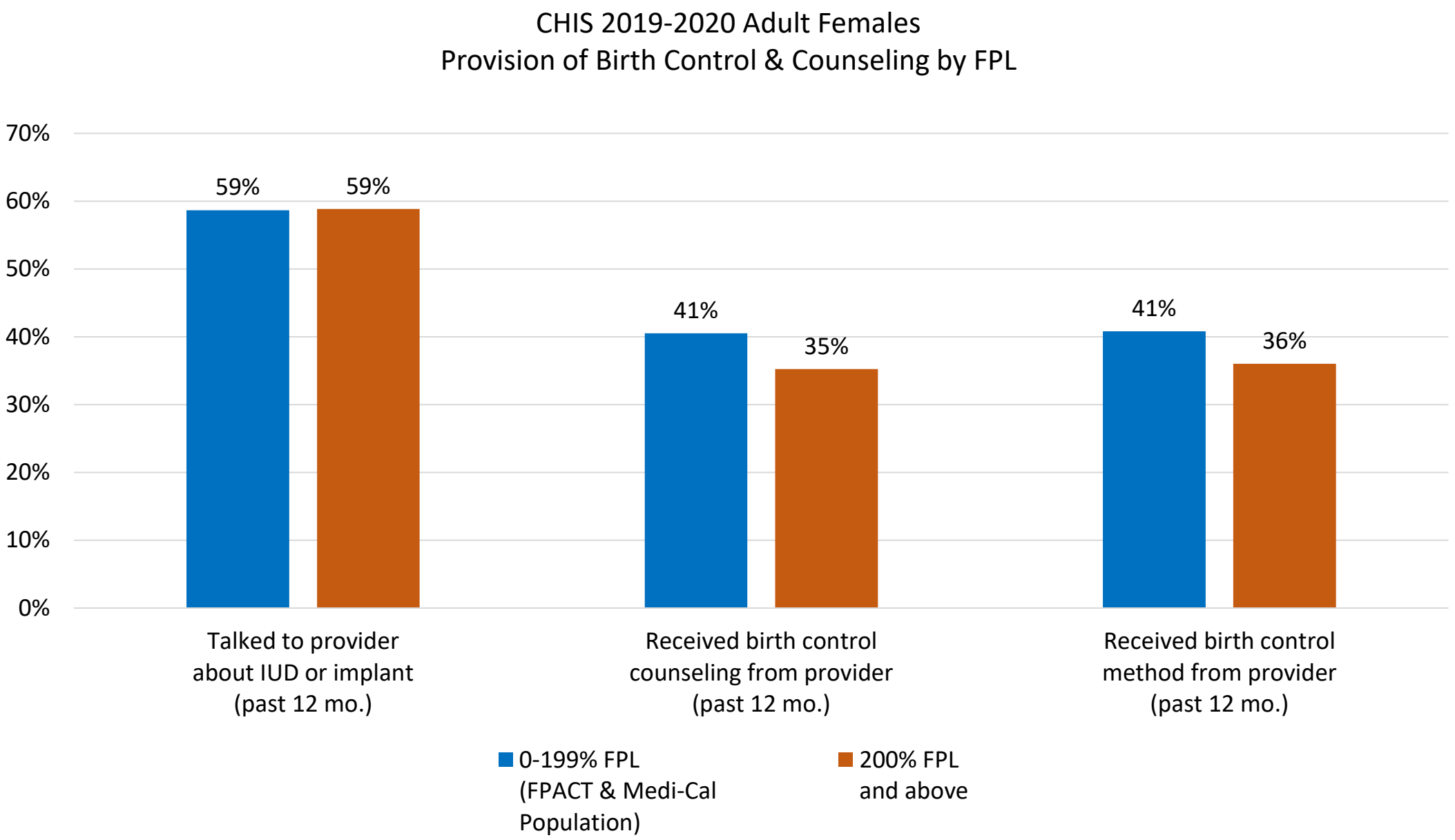
Provision of Birth Control & Counseling

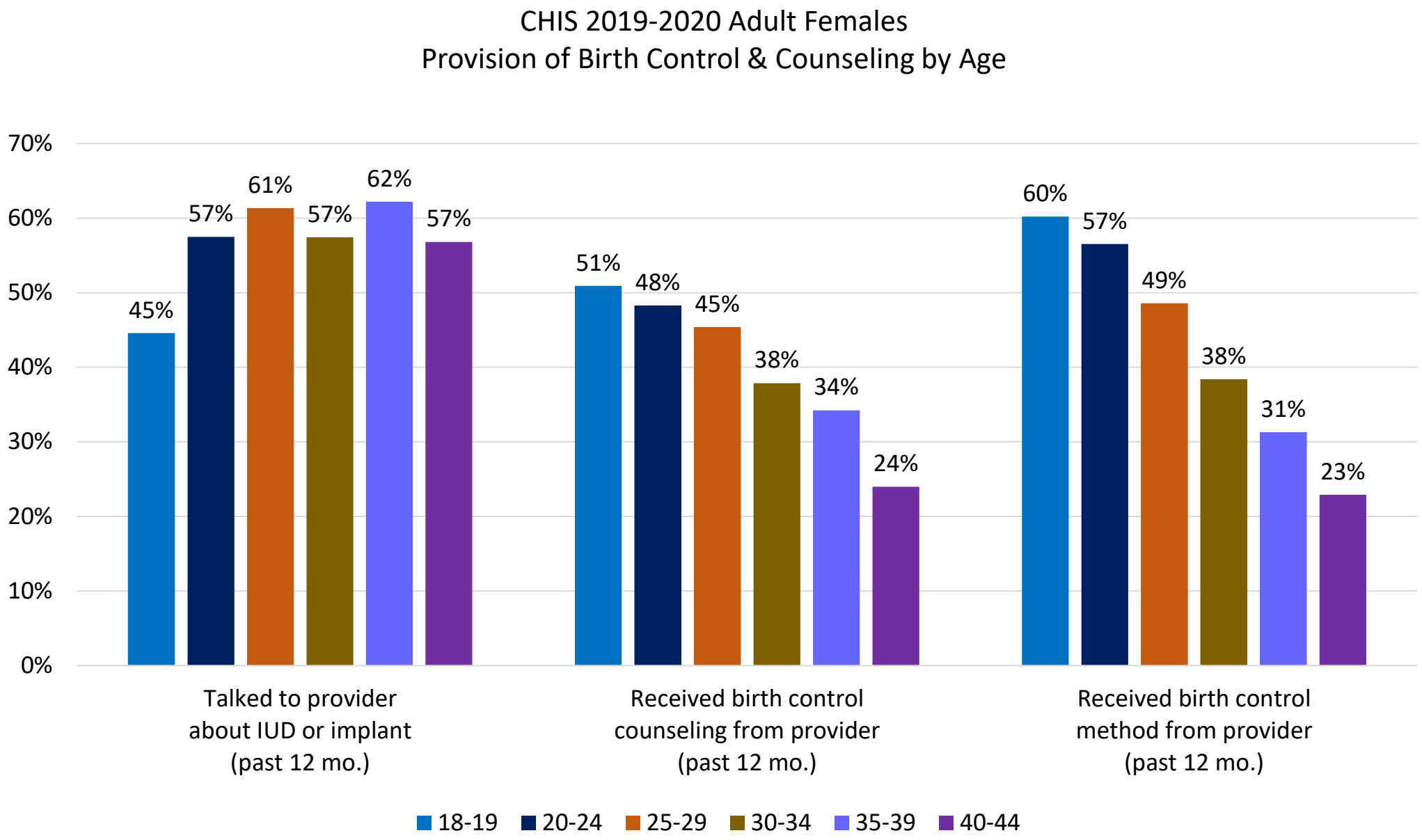
Respondents:

- Adult females

Definitions:

- Provider: doctor, family planning counselor, or another clinic provider
- Provision of birth control: receiving a birth control method or birth control prescription from a doctor or clinic


CHIS 2019-2020 Adult Females
Provision of Birth Control & Counseling by FPL
70%
60%
50%
40%
30%
20%
10%
0%
59%
59%
41%
35%
41%
36%
Talked to provider about IUD or implant (past 12 mo.)
Received birth control counseling from provider (past 12 mo.)
Received birth control method from provider (past 12 mo.)
0-199% FPL (FPACT & Medi-Cal Population)
200% FPL and above


CHIS 2019-2020 Adult Females
Provision of Birth Control & Counseling by Age
70%
60%
50%
40%
30%
20%
10%
0%
45%
57%
61%
57%
62%
57%
51%
48%
45%
38%
34%
24%
60%
57%
49%
38%
31%
23%
Talked to provider about IUD or implant (past 12 mo.)
Received birth control counseling from provider (past 12 mo.)
Received birth control method from provider (past 12 mo.)
18-19
20-24
25-29
30-34
35-39
40-44

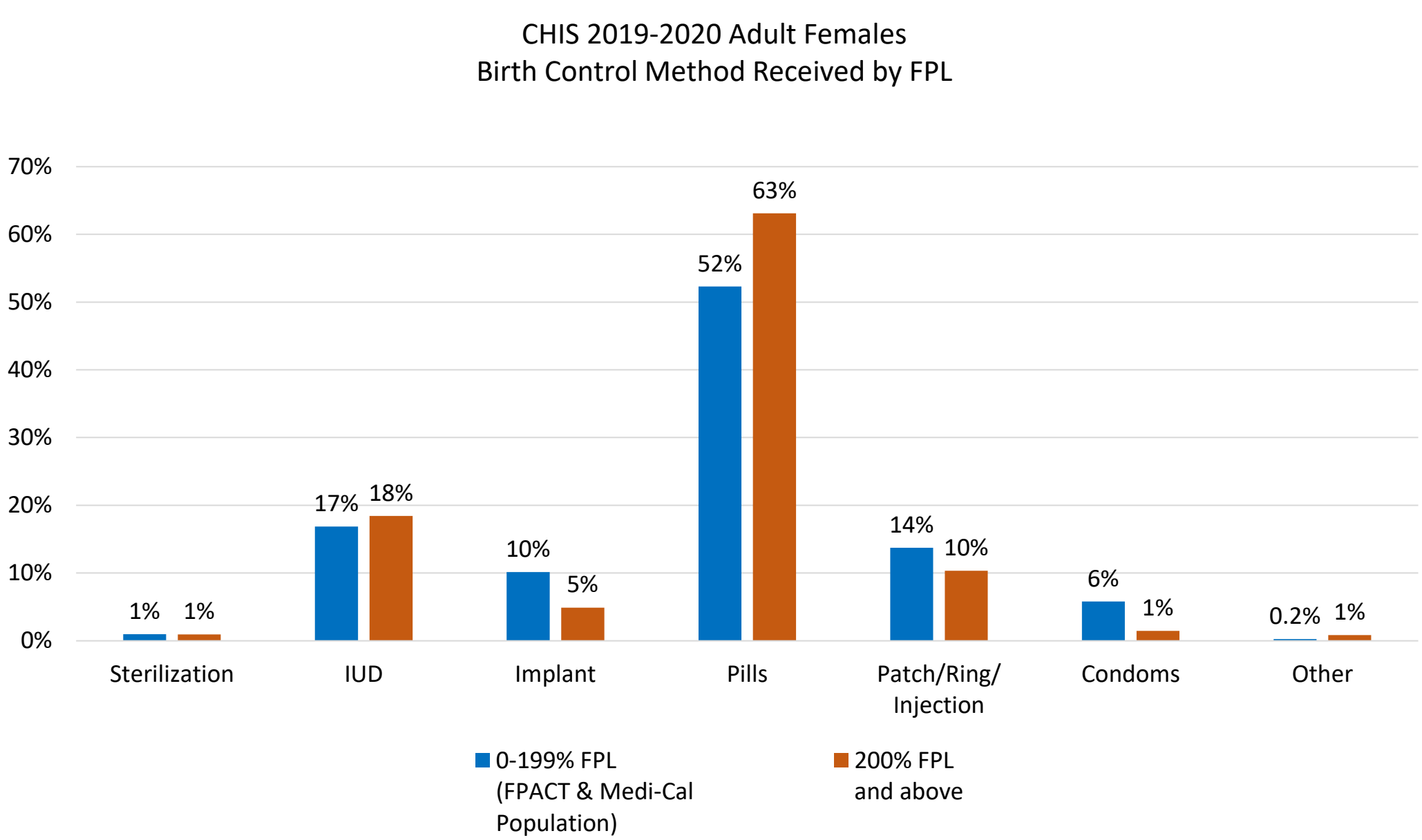
Birth Control Methods Received

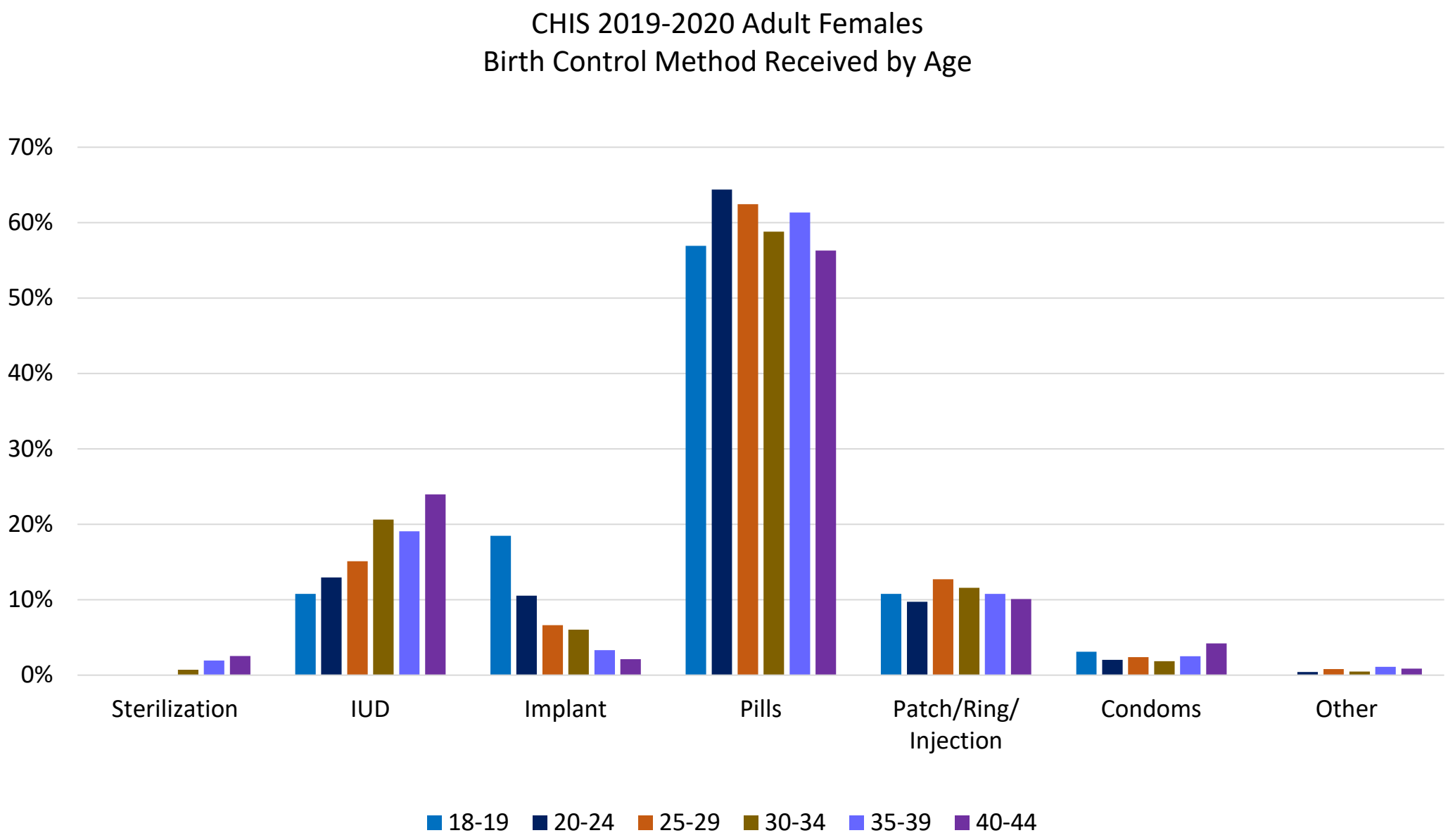
Respondents:

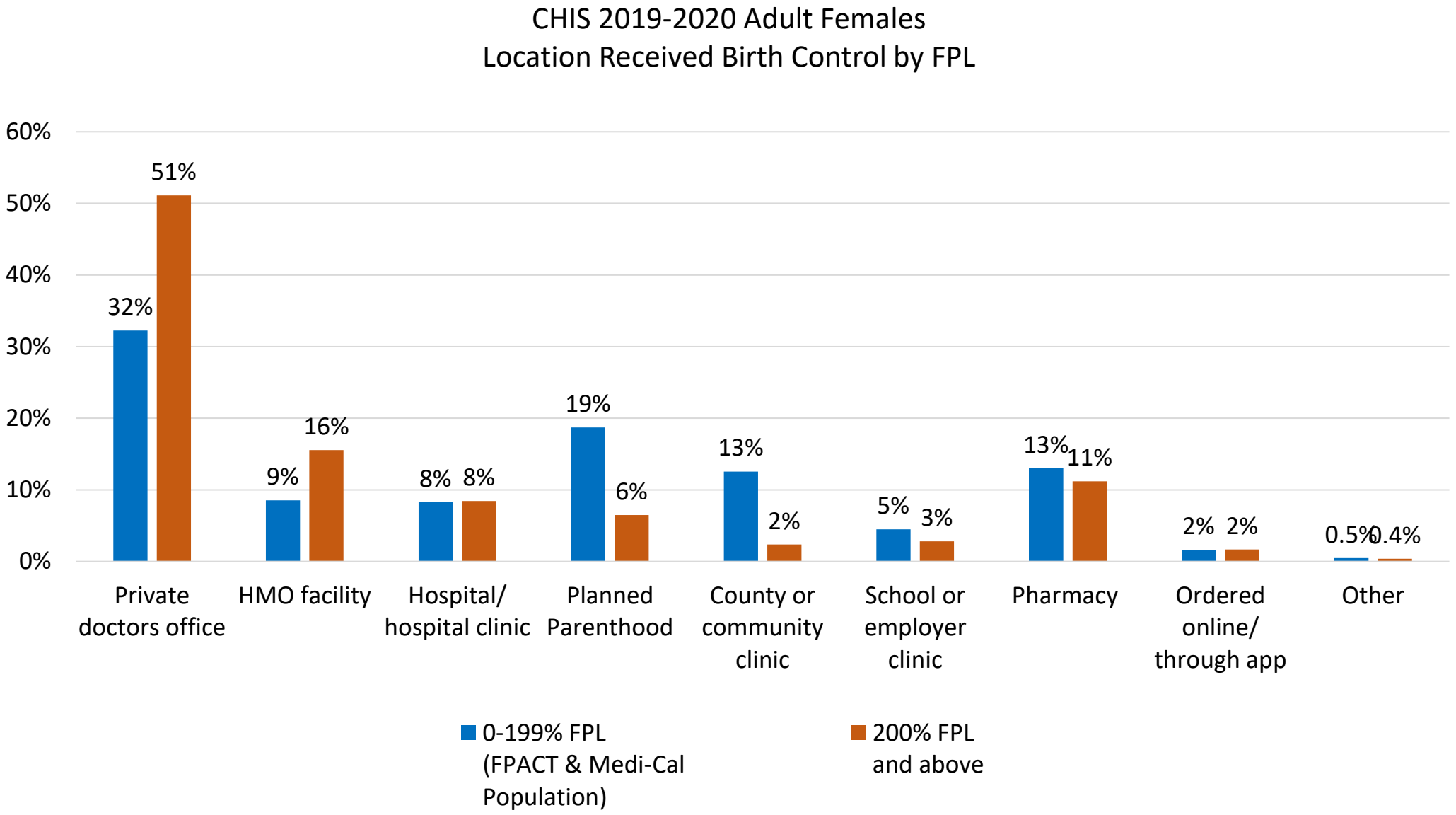
- Adult females
- Provision of birth control in the past 12 months

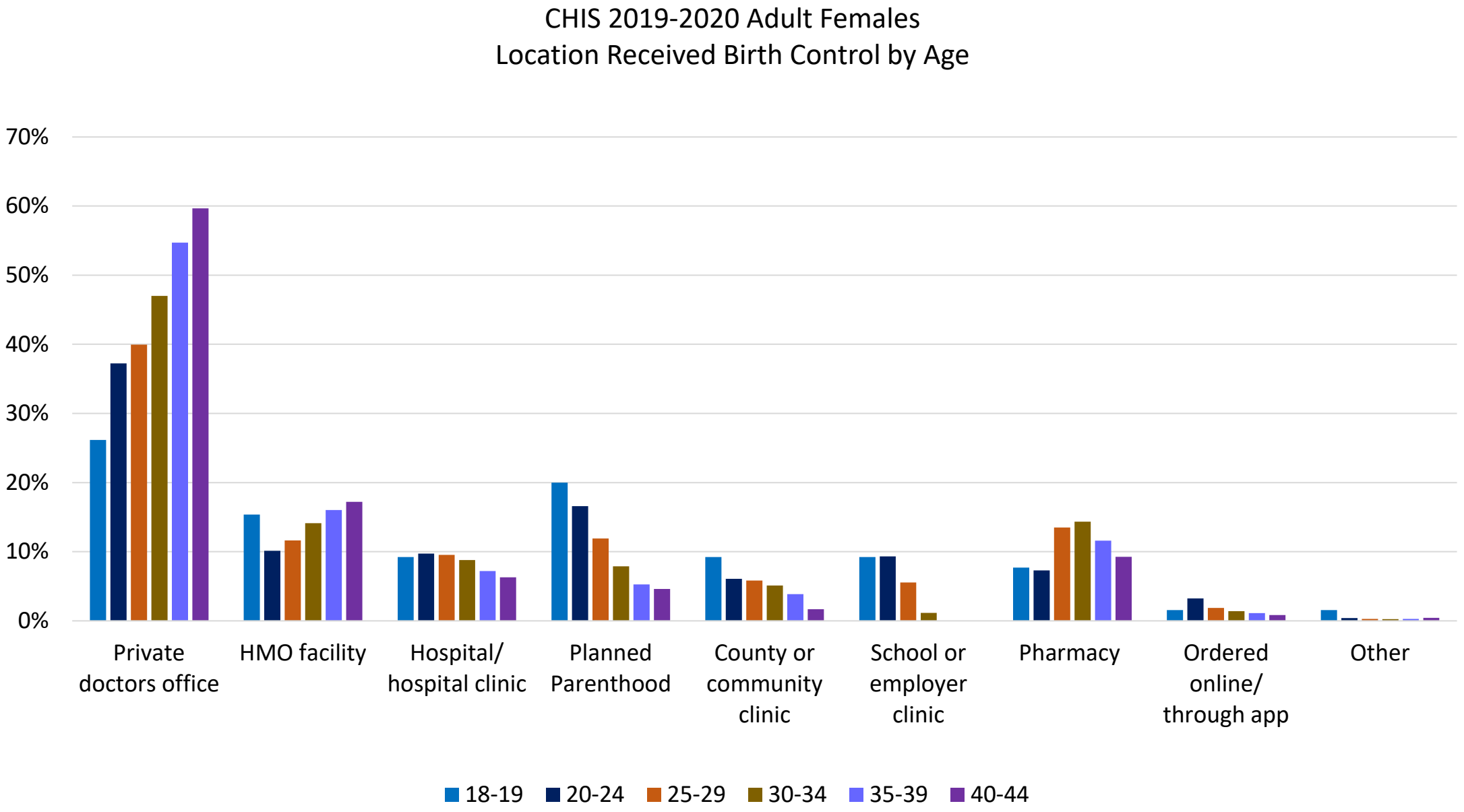
Definitions:

- County or community clinic: county health department, family planning clinic, or community clinic


CHIS 2019-2020 Adult Females
Birth Control Method Received by FPL
70%
60%
50%
40%
30%
20%
10%
0%
1%
1%
17%
18%
10%
5%
52%
63%
14%
10%
6%
1%
0.2%
1%
Sterilization
IUD
Implant
Pills
Patch/Ring/ Injection
Condoms
Other
0-199% FPL (FPACT & Medi-Cal Population)
200% FPL and above


CHIS 2019-2020 Adult Females
Birth Control Method Received by Age
70%
60%
50%
40%
30%
20%
10%
0%
Sterilization
IUD
Implant
Pills
Patch/Ring/ Injection
Condoms
Other
18-19
20-24
25-29
30-34
35-39
40-44


CHIS 2019-2020 Adult Females
Location Received Birth Control by FPL
60%
50%
40%
30%
20%
10%
0%
32%
51%
9%
16%
8%
8%
19%
6%
13%
2%
5%
3%
13%
11%
2%
2%
0.5%
0.4%
Private doctors office
HMO facility
Hospital/ hospital clinic
Planned Parenthood
County or community clinic
School or employer clinic
Pharmacy
Ordered online/ through app
Other
0-199% FPL (FPACT & Medi-Cal Population)
200% FPL and above


CHIS 2019-2020 Adult Females
Location Received Birth Control by Age
70%
60%
50%
40%
30%
20%
10%
0%
Private doctors office
HMO facility
Hospital/ hospital clinic
Planned Parenthood
County or community clinic
School or employer clinic
Pharmacy
Ordered online/ through app
Other
18-19
20-24
25-29
30-34
35-39
40-44

CHIS 2019-2020 Teen Respondents

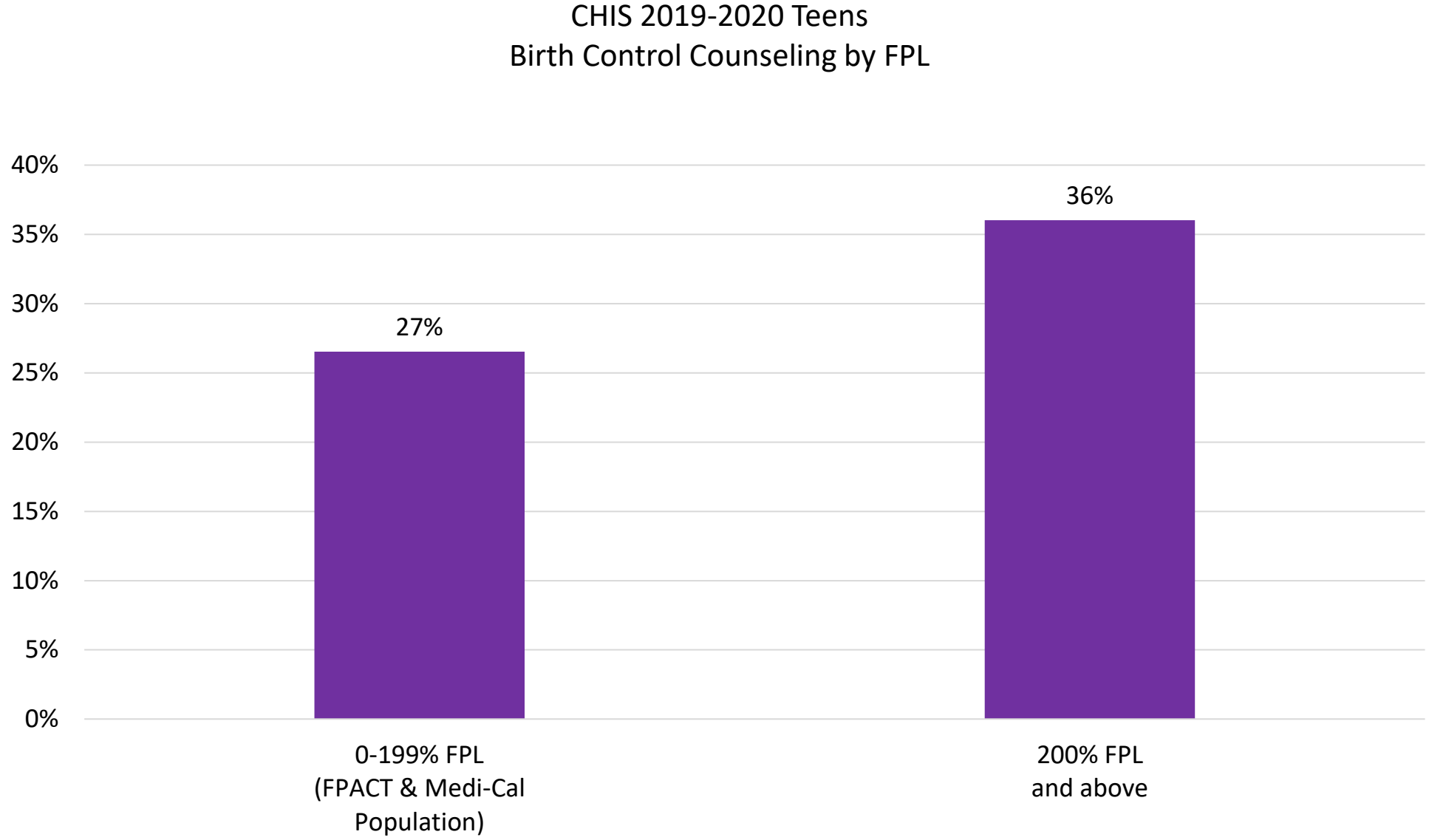
Birth Control Counseling

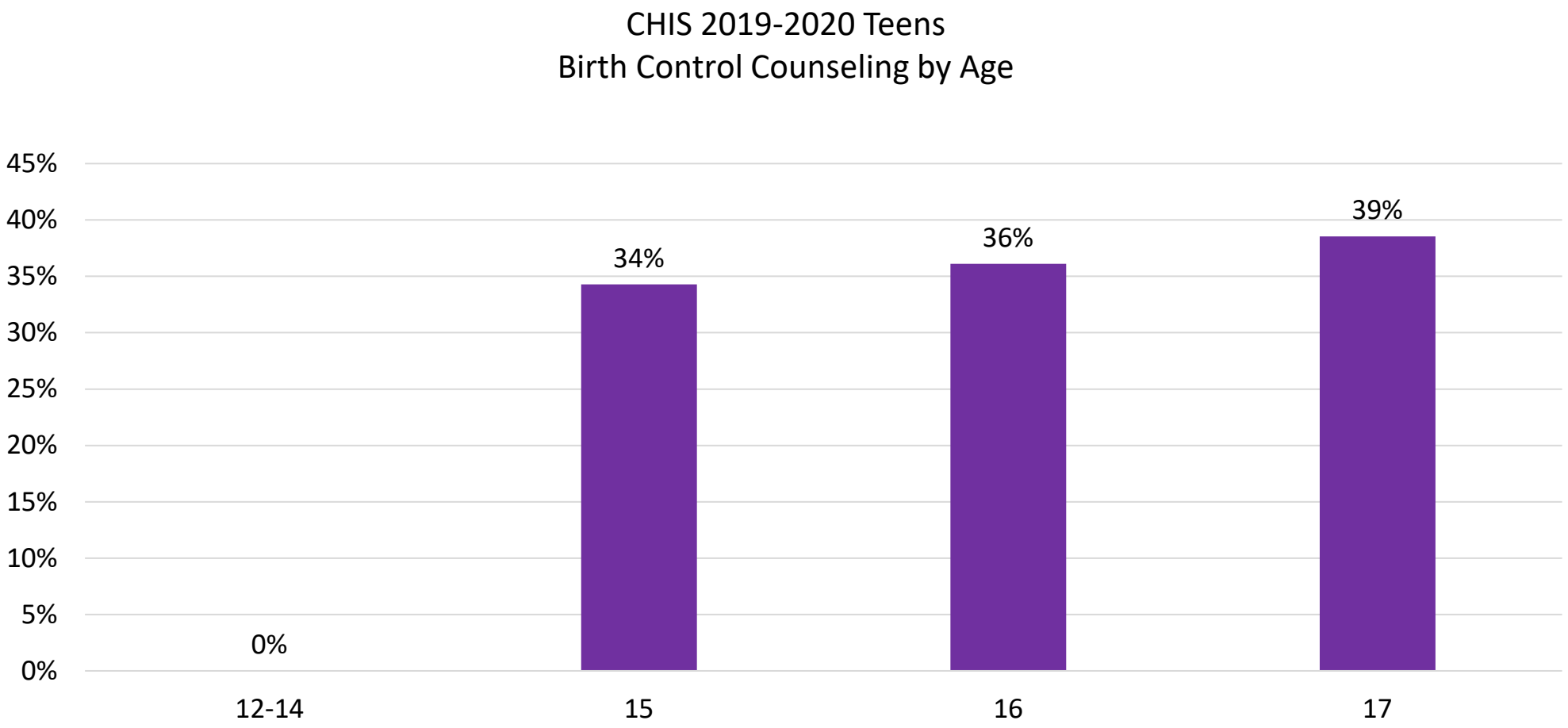
Respondents:

- Teen females
- Teen fales
- Have had sexual intercourse

Definitions:

- Birth control counseling: Received birth control information or birth control counseling from a provider in the past 12 months

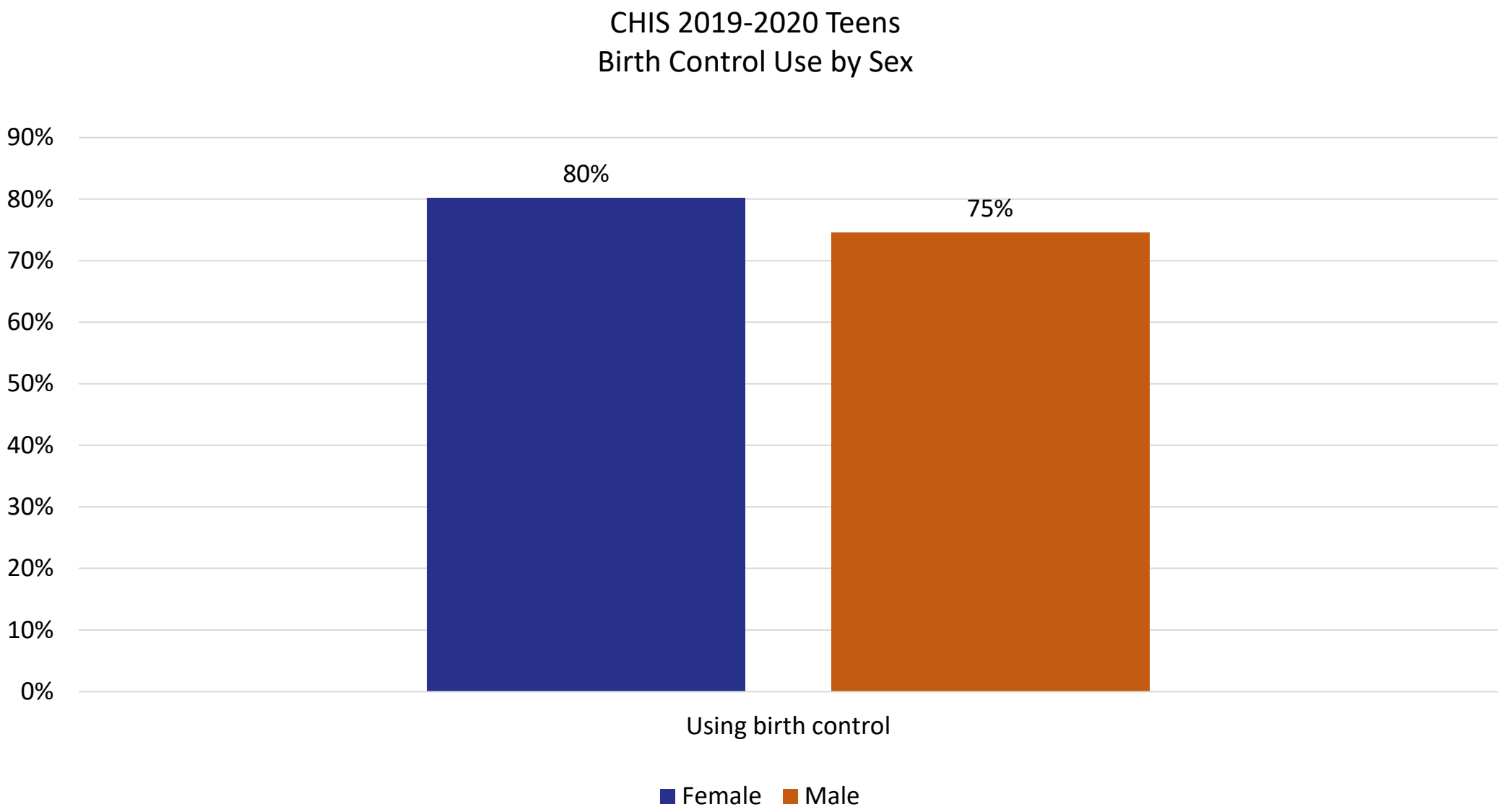

CHIS 2019-2020 Teens
Birth Control Counseling by FPL
40%
35%
30%
25%
20%
15%
10%
5%
0%
27%
36%
0-199% FPL
(FPACT & Medi-Cal
Population)
200% FPL
and above

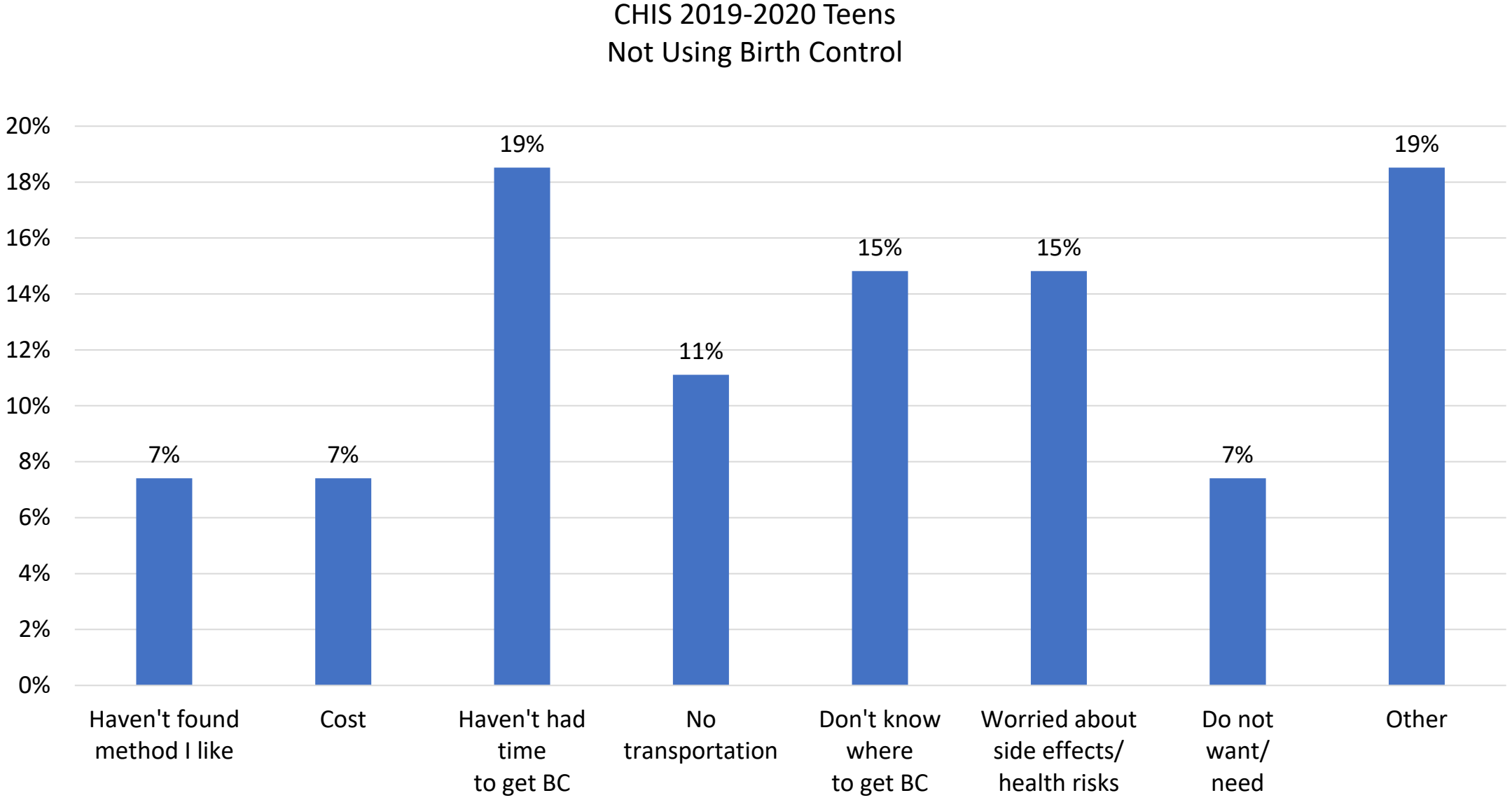

CHIS 2019-2020 Teens
Birth Control Counseling by Age
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
0%
34%
36%
39%
12-14
15
16
17

Birth Control Use and Method

Respondents:

- Teen females
- Teen males
- Have had sexual intercourse
- Ages 15-17

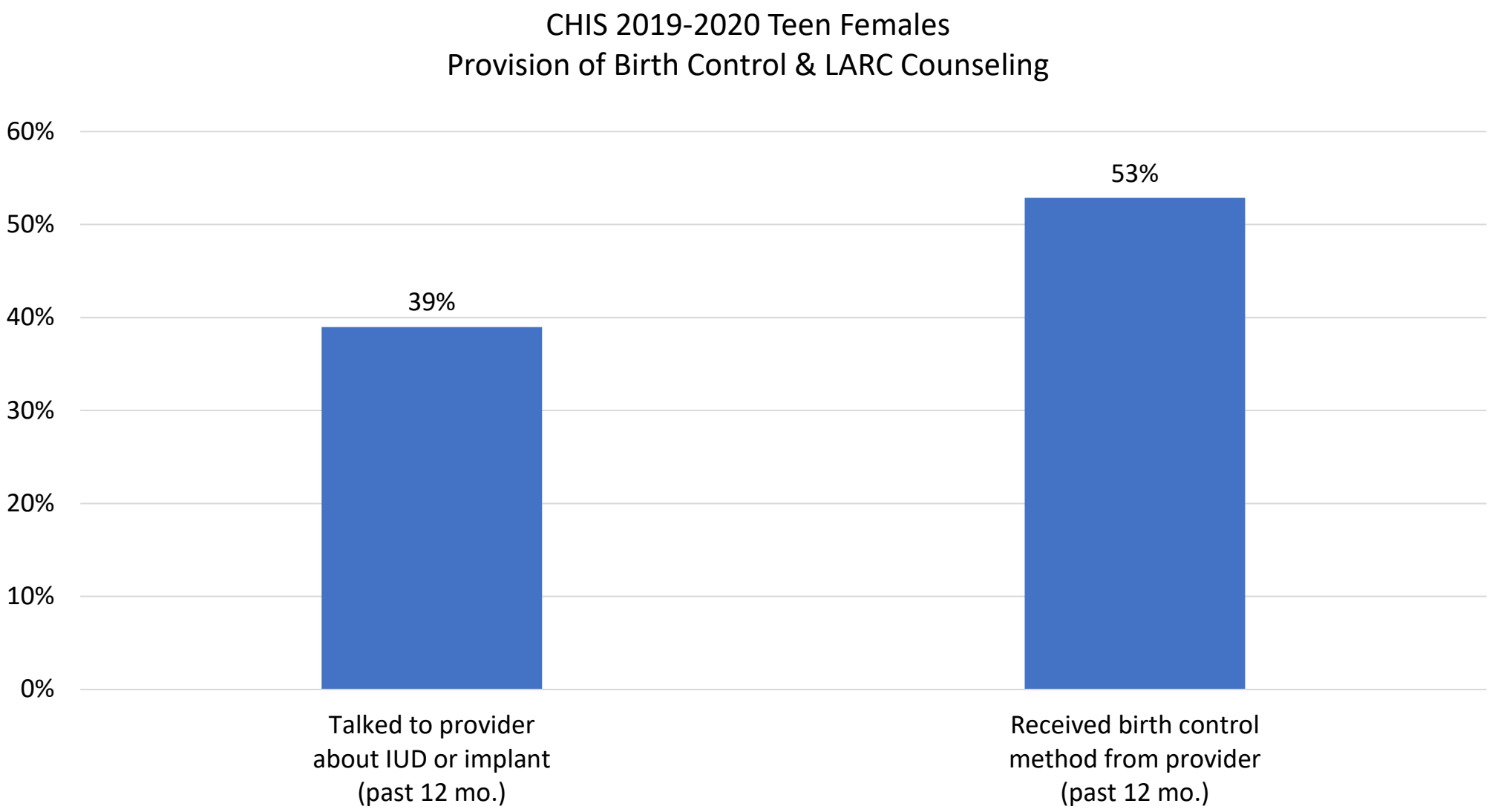

CHIS 2019-2020 Teens
Birth Control Use by Sex
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
80%
75%
Using birth control
Female
Male

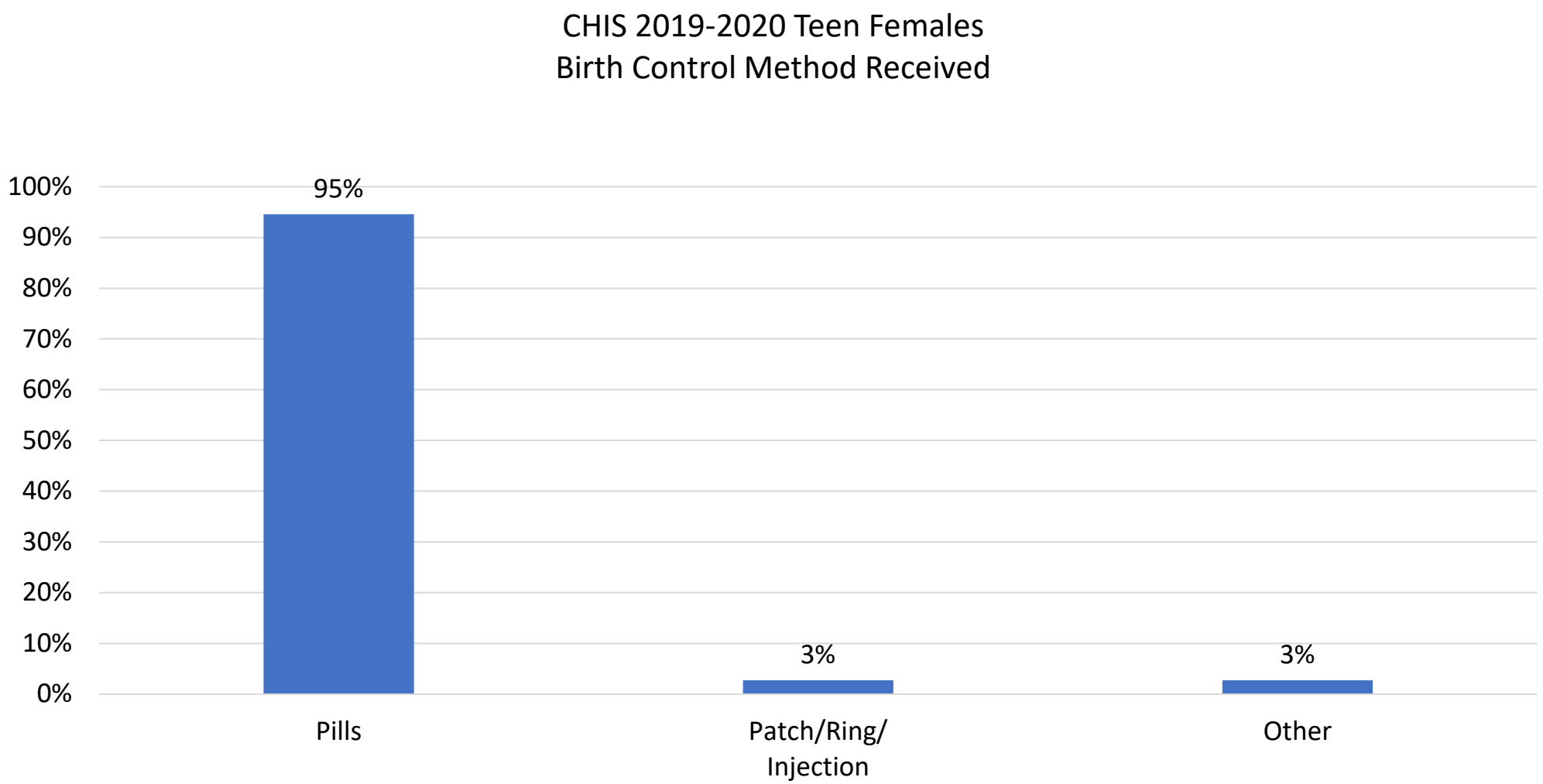

CHIS 2019-2020 Teens
Not Using Birth Control
20%
18%
16%
14%
12%
10%
8%
6%
4%
2%
0%
7%
7%
19%
11%
15%
15%
7%
19%
Haven't found method I like
Cost
Haven't had time to get BC
No transportation
Don't know where to get BC
Worried about side effects/ health risks
Do not want/ need
Other

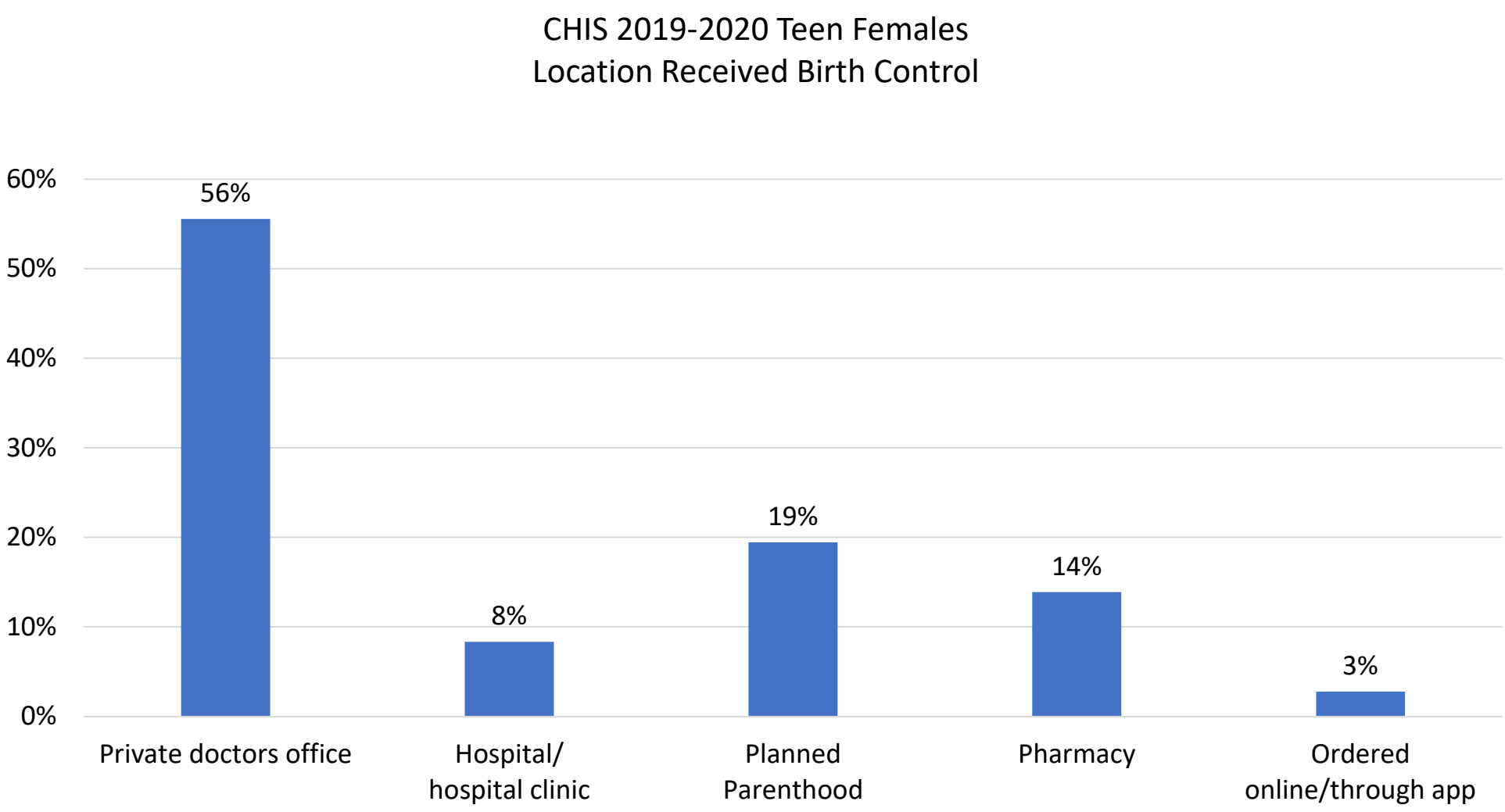
Provision of Birth Control

Respondents:

- Teen females
- Have had sexual intercourse
- Ages 15-17


CHIS 2019-2020 Teen Females
Provision of Birth Control & LARC Counseling
60%
50%
40%
30%
20%
10%
0%
39%
53%
Talked to provider about IUD or implant (past 12 mo.)
Received birth control method from provider (past 12 mo.)


CHIS 2019-2020 Teen Females
Birth Control Method Received
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
95%
3%
3%
Pills
Patch/Ring/
Injection
Other


CHIS 2019-2020 Teen Females
Location Received Birth Control
60%
50%
40%
30%
20%
10%
0%
56%
8%
19%
14%
3%
Private doctors office
Hospital/
hospital clinic
Planned
Parenthood
Pharmacy
Ordered
online/through app

CHIS 2019-2020 Family Planning Adult Summary

- Women*
  - 85-90% have no plan to get pregnant within the next 12 months
  - Nearly 60% say they've talked to a provider about an IUD or implant and approx. 25% received an IUD or implant
  - The majority of birth control (BC) received across income levels and age continues to be pills

- Younger Women*
  - More likely to receive implants
  - 18-19 were the least likely to intend on becoming pregnant and had one of the lowest BC use rates
  - 18-24 were the most concerned about the health risks/side effects of using BC

- Older Women*
  - More likely to receive sterilization, IUDs

** sexually active, heterosexual or bisexual, with an opposite-sex sexual partner within the last 12 months, of childbearing age, able to get pregnant or cause a pregnancy*

Adult Summary (Continued)

- Lower Income Women*
  - More likely to receive condoms, implants, patch/ring/injection than higher income
  - More likely to receive BC from a county or community clinic or a Planned Parenthood
  - Less likely to intend on becoming pregnant as well as less likely to use BC
  - Concerned about health risks/side effects (the number one reason given for not using BC)

- Higher Income Women*
  - More likely to receive IUD, pills than lower income
  - Much more likely to receive BC from a private doctor's office or HMO facility than lower income
  - Twice as likely to give "trying to have a baby" as the reason they were not using BC compared to lower income
  - Concerned about health risk/side effects of BC (second highest reason)

- *sexually active, heterosexual or bisexual, with an opposite-sex sexual partner within the last 12 months, of childbearing age, able to get pregnant or cause a pregnancy*

CHIS 2019-2020 Family Planning Teen Summary

- Teens*:
  - Lower income were less likely to have received BC counseling than higher income
  - Over half not using BC reported some barrier to access (cost, transportation, time, knowledge of where to get it)
  - More than half receiving BC received from a private doctor's office and nearly 20% from a Planned Parenthood
  - 95% of females teens* receiving BC from a provider received pills

**sexually active*

Questions?

Family PACT Program Assistance

To better serve providers and stakeholders, the Family PACT Program has established the following email boxes:

- For questions regarding Family PACT provider enrollment and recertification, please contact ProviderServices@dhcs.ca.gov
- For questions regarding provider training and orientation, please contact OFPProviderTrainings@dhcs.ca.gov
- For all Stakeholder related inquiries, please contact OFPStakeholder@dhcs.ca.gov
- For questions regarding provider reviews, please contact OFPcompliance@dhcs.ca.gov

Next Family Planning Stakeholder Meeting: 2023