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Credentialing Internal Medicine Physicians to Expand Long-Acting Reversible Contraceptive Access

Short Title: Contraception Credentialing in Internal Medicine

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Introduction

The provision of contraceptives is an essential component of preventive healthcare. Long-acting reversible contraceptive methods (LARCs), including intrauterine devices (IUDs) and contraceptive implants, are effective, reversible, and safe forms of contraception with very few contraindications.[1] IUDs are also effective forms of emergency contraception.[2] Many obstacles prevent patients from receiving these methods, including a critical lack of access in internal medicine (IM) primary care clinics.[3]

A subset of patients, including those at risk for adverse reproductive health outcomes, prefer to receive their contraceptive care in primary care.[4] One third of United States (US) primary care physicians (PCPs) are trained in IM.[5] IM PCPs have a duty to support patients' contraceptive preferences and prevent unintended pregnancies, especially recognizing that pregnancy complications can be life-threatening. Unfortunately, few IM clinics offer on-site LARC care due to a critical lack of training and credentialing of IM physicians.[3]

The Importance of LARC Training in IM

LARC placement is part of family medicine (FM) and obstetrics and gynecology (Ob/Gyn) residency training, but has not traditionally been part of IM training.[3] In response, the Society of General Internal Medicine's (SGIM) Women and Medicine Commission developed core competencies for training in sex- and gender-based women's health. These competencies include education for IM trainees on reproductive planning, abortion care, and all forms of contraception.[6] This document also outlines standards for LARC credentialing; it suggests the FDA-mandated training and one direct observation are required to place and remove

68 contraceptive implants, focused training to place IUDs, and minimal training for IUD removal.[6]

69 These recommendations are informed by reassuring safety data; with IUD placement, for

70 example, serious complications such as uterine perforation are rare (1/1,000).[7] Core IM

71 privileges often include higher-risk procedures, such as paracentesis, which is 10 times more

72 likely to result in serious complications than IUD placement.[8]

73 **Current Credentialing Practices in IM: A Barrier to LARC Access**

74 The absence of credentialing standards is a major barrier to the provision of LARC care

75 by IM clinicians. To better understand this issue, we reviewed privileging practices in 17 IM

76 departments—the authors' departments and a convenience sample of SGIM members—from all

77 geographic regions in the US. In this sample, we found no consensus for LARC credentialing.

78 LARC credentialing was not available at several institutions, and in departments where LARC

79 credentialing is available, there were wide variations in the requisite number of directly observed

80 procedures for privileging. The required number of proctored subcutaneous implant placements

81 for clinicians who completed the FDA-mandated training ranged from 0 to 6, with one outlier

82 institution requiring 20. The range of observed IUD placements ranged from 3 to 10, with the

83 same outlier institution requiring 20. These variations highlight inconsistencies in credentialing,

84 reveal barriers for patient access, and suggest a need for standardized approaches. We developed

85 our recommendations through 6-months of consensus-development meetings which relied on our

86 clinical experience and the SGIM core competencies (Table 1).[6]

87 **Recommendations for LARC Training and Credentialing in IM**

88 IM leaders who empower PCPs to provide LARC services can expand access to

89 contraception and prevent unintended pregnancies. We suggest IM leaders ensure adequate

90 procedural experience is available to clinicians who are committed to providing LARC as part of

91 comprehensive primary care. For IUD placement, which does not require a specific
92 manufacturer training, institutional IM leaders can develop half-day procedure clinics precepted
93 by LARC-credentialed faculty to concentrate opportunities for training. For contraceptive
94 implants, we suggest arranging to host the FDA-mandated training at a time and location
95 convenient for trainees. A method for organizing LARC training is detailed in Table 1.

96 Leaders should update credentialing forms to include placement and removal of LARC as
97 core privileges, paralleling credentialing for FM. When credentialing IM physicians for LARC
98 care, leaders may consider recommendations based on the SGIM Women's Health Core
99 Competencies[6] and expert consensus opinion (Table 1). First, it is important to distinguish
100 between contraceptive implants and IUDs and between placement and removal procedures.
101 Contraceptive implant placement and removal require completion of the FDA-mandated training
102 —demonstrated with a certificate. This training is available to clinicians at no cost; once
103 completed, physicians are not obligated to have proctored procedures, though one observation
104 may be considered. Physicians can develop competency in IUD removal with minimal training,
105 and it should be routinely included as a core privilege for IM physicians with no direct
106 observation required; clinicians may benefit from talking through the procedure to ensure proper
107 technique. IUD placement is a more advanced clinical skill requiring additional hands-on
108 training. For credentialing faculty with prior experience, we recommend reviewing their
109 procedure log or obtaining an equivalent attestation of competency. For those with extensive
110 experience and for those who logged more than five IUD placements in the past two years, we
111 recommend expedited privileging without requiring direct observation. For those without prior
112 experience, we recommend online training resources such as Innovating Education in

Reproductive Health,[9] followed by five proctored IUD placements. Once IM physicians are credentialed, they can train other IM clinicians.

Summary

Contraceptive care is a fundamental clinical service, particularly important for medically-complex patients who seek this care from their PCP.[4] With training, IM physicians can become qualified to place, manage, and remove LARCs. Unfortunately, we observed wide variations in credentialing requirements for IM physicians seeking to offer LARC care, and PCPs face barriers to LARC provision in many communities.[3] These barriers are unnecessary given the safety of LARC procedures, especially when compared with typical IM core privileges.[1,7,8] Credentialing decisions should be informed by procedure type and prior experience. Given the national crisis of reproductive healthcare following the Supreme Court's ruling in *Dobbs*, there is an urgent need to streamline credentialing and increase provision of contraceptive services by IM physicians.

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158 *Table 1*: Recommended Standards for LARC Care Implementation in Internal Medicine
159 Departments

Implementation Factors	Recommendations for IM Leadership
Early considerations	• Name institutional and practice champions. • Update credentialing forms to include LARC. • Create policies to credential eligible IM faculty with prior LARC experience. • Identify clinic leadership to order and maintain LARC supplies. • Engage practice managers to address billing and prior authorization processes. • Train staff to assist with LARC procedures. • Develop relationships with Ob/Gyn or FM colleagues to provide initial training and consultation for rare complications that arise.
Opportunities for LARC training	• Host the FDA-mandated training for subdermal contraceptive implants. This information is available at https://nexplanontraining.com/. • Identify preceptors for LARC training, potentially including IM, Ob/Gyn, FM, or Advanced Practice Practitioners (APPs) who are credentialed in LARC. • Consider half-day procedure clinics to concentrate IUD training experience. • Encourage all physicians to keep a log of cases to prevent delays in credentialing, and for future reference.
LARC credentialing standards	• Contraceptive subcutaneous implant placement and removal* o Complete FDA-mandated manufacturer training AND o 0-1 direct observations after completing FDA-mandated training • IUD placement** o Review procedure log with attestation of competency for physicians with extensive experience and/or who placed 5 or more IUDs in the past two years; we recommend expedited privileging without requiring direct observation o Direct observation of 5 IUD placements for physicians without prior experience • IUD removal*** o No direct observation requirement, but consider one “talk-through”
Long-term considerations	• Ensure adequate LARC numbers to maintain procedural skills. • Formulate procedural competency standards for re-credentialing. For IUD placement, we suggest 5 every 2 years. • Implement LARC training for all residents and new faculty as part of core competencies. • Encourage credentialed IM faculty to educate and train new faculty and residents. • Consider expanding LARC, especially subdermal contraceptive implants, to hospital medicine services for patients desiring contraception during admission.

160 **There is only one type of FDA-approved contraceptive implant in the US as of 2023 (Nexplanon®). The FDA-*
161 *approved training to remove Nexplanon® is adequate to remove any type of contraceptive implant placed outside of*
162 *the US.*

163 ***All 5 brands of IUD in the US use the same placement technique, with slight differences in how to eject the IUD*
164 *from the placement device. Use of different IUD brands would not require additional training or direct oversight,*
165 *but should include reading or reviewing the brand's placement mechanism.*
166 ****IUD removal technique is the same, regardless of the IUD type.*