Patient-Centered Family Planning Counseling

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Disclosures

• None
Today’s learning objectives

- Describe strategies for patient-centered contraceptive counseling
- Identify best practices to ensure timely access to long-acting reversible contraception (LARC)
- Discuss the role of primary care practices and OUD Centers of Excellence in family planning care
Patient-centered care

“Patient-centered care is care that is respectful of and responsive to individual patient preferences, needs, and values.”

- Institute of Medicine

- Recognized by IOM as 1 of the 6 critical dimensions of quality
- Associated with improved clinical outcomes
- Aligned with our autonomy-based ethic
Common assumptions that can hamper patient-centeredness

• All people should have clear intentions about whether they want to avoid or achieve pregnancy

• Unintended pregnancies are uniformly negative events

• All people want to use the most effective contraceptive methods
In reality....

- A large proportion of people do not have clear or binary intentions
- People may not necessarily see pregnancy planning as desirable or achievable
- Unintended pregnancies are often happy, welcome events
- Effectiveness is not always the most important factor driving contraceptive decisions
“Sometimes I probably want to get pregnant when I’m 22 or 27… or probably soon. Who knows? Probably when my daughter starts walking, maybe.”

“I already got a kid so you know I’m not opposed to having children. If it happens, it happens….I’d prefer we don’t have children right now but if it happens, okay.”

Gomez: Population Association of America annual meeting, 2016
Formulating intentions or plans may be viewed as irrelevant.

“If you are meant to have a kid, you are meant to have a kid. Why take something to prevent it?”

“Nobody can really plan for a pregnancy, like, you could try but a lot of people that wanna get pregnant don’t get pregnant…then there’s a lot of people that don’t want to get pregnant and it just happens.”

Borrero: Contraception, 2015
Formulating plans may be viewed as unrealistic.

“The lack of a clear plan does not mean there is no desire to get pregnant, yet those who admit—even to themselves—that they’re trying to have a baby invite public contempt and self-reproach, for they know the choice to bear children while young and unmarried is, in many ways, absurd. At the same time, they wonder if their circumstance will ever be ‘right.’”
Formulating plans may be viewed as unrealistic

“They’re engaged but they decided to have this baby before they were going to get married. Like they were striving, like she planned this baby. She started going to the doctor’s and taking prenatal pills before she got pregnant. Like, she planned to have this baby. And I didn’t know that part cause I would have had a issue with that because [they’re] not married.”
Unintended may still be welcome

“I don’t want more kids and was hoping to get my tubes tied. We can’t afford another one. But if it happened I’d still be happy. I’d be really excited. We’d rise to the occasion…nothing would really change.”

“Honestly, although she wasn’t at all planned, I think my baby girl saved me. When I think what I would be doing now if she had never come along.”

“the IUD takes the element of surprise out of when we would have our next kid, which I kind of want. I don’t want to put too much thought and planning into when I have my next kid.”

“[IUDs and implants] really take away the element of surprise of having babies, which some people want and some people really, really don’t want. You can accidentally forget the pill and get pregnant, but an IUD’s not going to pop out and take a jog around the block.”
What are the stages of counseling?

1. Identify family planning needs

2. Counseling about method options and selecting a method

3. Providing information about chosen method
Patient-centered family planning counseling

• How do you start the conversation?

What are you using for contraception?

• Use inclusive, non-judgmental questions to ask about reproductive wishes and goals
  ▪ Opens discussion without having made assumptions about a woman’s thoughts about pregnancy
  ▪ Particularly key for those for whom pregnancy may be stigmatized
  ▪ Allows you to identify need for contraceptive counseling and/or preconception counseling
Patient-centered reproductive goals assessment

Can I help you with any reproductive health services today, such as birth control and/or preparing for a future pregnancy?

**ONE KEY QUESTION**

Would you like to get pregnant in the next year?

**PATH Questions:**

- **Pregnancy Attitudes**
  - Do you think you might like to have (more) children at some point?

- **Timing**
  - If considering future parenthood: When do you think that might be?

- **How important is prevention**
  - How important is it to you to prevent pregnancy (until then)?

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Callegari: AJOG, 2016
Jones: Contraception, 2019
Contraceptive counseling strategies

- Consumerist Counseling
  - Promote patient autonomy

- Directive Counseling
  - Encourages a specific course of action
Consumerist counseling

- "Informed Choice" model:
  - Provides only objective information and does not participate in method/treatment selection itself
    - Fails to assist patient in understanding how preferences relate to method characteristics or tailor information to patients needs

- "Foreclosed" model:
  - Only information on methods asked about by the patient are discussed
    - Fails to ensure that people are aware of and have accurate information about the full range of methods
Shift towards more directive approaches in family planning

- General emphasis on/promotion of LARC methods in family planning
Shift towards more directive approaches in family planning

- Language among providers of “success” or “failure” in counseling based on whether patient selects a LARC method

- Statements by AAP and ACOG referring to LARC methods as “first line”

- Performance metrics based on uptake of LARC methods
Contraception selection is preference-sensitive and shaped by internal assessments of potential outcomes, including pregnancy and side effects.

The importance of the risk of pregnancy, compared to other method characteristics, cannot be judged by the provider.

Does not prioritize autonomy.

Pressure to use specific methods can be counter-productive.

Kalmuss: *Fam Plann Perspect*, 1996
Gomez: *Contraception*, 2017
Contraceptive counseling strategies

- Consumerist Counseling
  - Promote patient autonomy
  - Decision based on patient's informed preferences

- Directive Counseling
  - Increase use of highly effective methods
**Shared decision making**

**PATIENT CONTRIBUTION:**
- Their values
- Their preferences
- Their goals
- Their past experiences

**PROVIDER CONTRIBUTION:**
- Assist in clarifying patient’s goals and preferences
- Provide medical information that is:
  - Relevant
  - Assimilated and integrated by the patient!

Adapted from Patty Cason, Envision SRH
Shared decision making in family planning

- Best method for an individual depends on their preferences
- Consistent with women’s preferences for counseling
- Associated with higher satisfaction with counseling and method satisfaction
- May not be best for everyone, but provides starting point for counseling

Dehlendorf: Contraception, 2013
Dehlendorf: Contraception, 2017
Shared decision making and reproductive health equity

• Historical context of coercion for women of color and low-income women

• Variation in counseling

• Essential that providers explicitly focus on individual preferences, especially when caring for people of color

• Shared decision making provides framework for doing this, without swinging too far to other side

Thorburn: Health Educ Behav, 2005
Bird: J Health Psychology, 2003
The process of shared decision making

1. Explicitly state focus on patient preferences

2. Elicit preferences for method characteristics
   - Effectiveness
   - Frequency of using method
   - Different ways of taking methods
   - Return to fertility
   - Side effects/ menstrual changes
   - Non-contraceptive benefits
   - Need for a discreet method
   - Control over start/stop
   - Impact on sexual life
   - Hormones

3. Provide scaffolding for decision making

   ➢ “Do you have a sense of what is important to you about your method?”

Iterative process focusing on information most relevant to the individual
Don’t assume people know about their options

• Provide context for different method characteristics
  ▪ e.g. “There are methods you take once a day, once a week, once a month, or even less frequently. Is that something that makes a big difference to you?”

• Even if express strong interest in one method, ask for permission to provide information about other methods
Talking about effectiveness

• Effectiveness often very important to people

• Frequent misinformation or misconceptions about relative effectiveness of methods

• Use natural frequencies:
  ▪ Less than 1 in 100 people get pregnant on IUD
  ▪ 9 in 100 people get pregnant on pill/patch/ring

• Use visual aids to highlight relative effectiveness
# Talking about effectiveness

## Birth Control Method Options

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<thead>
<tr>
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<th>Most Effective</th>
<th>Moderately Effective</th>
<th>Least Effective</th>
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<tr>
<td>Female Sterilization</td>
<td>.5 out of 100</td>
<td>.85 out of 100</td>
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<tr>
<td>Male Sterilization</td>
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<td>IUD</td>
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<td>Implant</td>
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<td>Injectable</td>
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<td>Pill</td>
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<td>Patch</td>
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<td>Ring</td>
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<td>Diaphragm</td>
<td>13 out of 100</td>
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<td>Male Condom</td>
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<tr>
<td>Female Condom</td>
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<td>12-24 out of 100</td>
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<td>Withdrawal</td>
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<td>12-24 out of 100</td>
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<td>Sponge</td>
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<td>12-24 out of 100</td>
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<td>Fertility Awareness Based Methods</td>
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<td>Spermicides</td>
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</table>

### Risk of pregnancy
- Surgical procedure: .5 out of 100
- Placement inside uterus: 2 out of 100
- Placement into upper arm: .05 out of 100
- Shot in arm, hip or under the skin: 4 out of 100
- Take a pill: 8 out of 100
- Put a patch on skin: 9 out of 100
- Put a ring in vagina: 12 out of 100
- Use with spermicide and put in vagina: 13 out of 100
- Put over penis: 21 out of 100
- Put inside vagina: 20 out of 100
- Pull penis out of the vagina before ejaculation: 24 out of 100
- Monitor fertility signs, abstain or use condoms on fertile days: 28 out of 100

### How the method is used
- Surgical procedure: Permanent
- Placement inside uterus: Lasts up to 3-12 years
- Placement into upper arm: Lasts up to 3 years
- Shot in arm, hip or under the skin: Every 3 months
- Take a pill: Every day at the same time
- Put a patch on skin: Each week
- Put a ring in vagina: Each month
- Use with spermicide and put in vagina: Every time you have sex
- Put over penis: Daily
- Put inside vagina: Every time you have sex

### Menstrual side effects
- None
- LNG: Spotting, lighter or no periods
- CopperT: Spotting, lighter or no periods
- Can cause spotting for the first few months. Periods may become lighter.
- None

### Other possible side effects to discuss
- Pain, bleeding, infection
- Some pain with placement
- May cause appetite increase/weight gain
- May have nausea and breast tenderness for the first four months.
- Allergic reaction, irritation

### Other considerations
- Provides permanent protection against an unintended pregnancy.
- LNG: No estrogen, may reduce cramps, CopperT: No hormones, may cause more cramps.
- No estrogen, may reduce menstrual cramps.
- Some clients may report improvement in acne, may reduce menstrual cramps and anemia, lowers risk of ovarian and uterine cancer.
- No hormones
- No hormones, no prescription necessary.
- No hormones.

Counsel all clients about the use of condoms to reduce the risk of STIDs, including HIV infection.

*The number of women out of every 100 who have an unintended pregnancy within the first year of typical use of each method.

Other Methods of Birth Control:
- (1) Lactational Amenorrhea Method (LAM) is a highly effective, temporary method of contraception; and

FPNTC | Family Planning National Training Center | December 2017
Counseling about side effects

- Address menstrual changes

- Inquire about particular other areas of interest or concern to patient
  - Previous experiences?
  - Things they have heard from friends or social media?

- Respond to patient concerns about side effects in a respectful manner

- Consider benefits (e.g., acne) as well
Addressing patient’s Concerns

That’s too bad your friend had that experience. I haven’t heard of that before, and I can tell you it definitely doesn’t happen frequently.

Some people don’t like the idea of not having a regular period for a variety of reasons. But I do want to make sure you know that it is safe not to have a period when using these methods, in case safety is a concern for you.
Examples of facilitation

I am hearing you say that avoiding pregnancy is the most important thing to you right now. In that case, you may want to consider either an IUD or implant. Can I tell you more about those methods?

You mentioned that it is really important to you to not have irregular bleeding. The pill, patch, ring and copper IUD are good options, if you want to hear more about those.”
Other best practices in contraceptive care

- Use the CDC Medical Eligibility Criteria (MEC) to assess safety of methods for specific health conditions
- Initiate methods using a Quick Start approach
- Facilitate easy method switching
- Dispense maximum months of supply possible
- Provide anticipatory guidance about side effects
- Trouble-shoot potential issues with adherence (contingency counseling)
- Write advanced prescription for EC
- Ensure easy access to discontinuation of provider-controlled methods
Summary: Practicing patient-centered family planning counseling

- Foster awareness of assumptions that may obstruct delivery of patient-centered care
- Use open-ended, non-judgmental questions to assess reproductive goals and wishes
- Elicit and respond to patient’s preferences for the counseling interaction and during method selection
- Pregnancy options counseling, including referral for abortion care, is part of comprehensive family planning care
Evidence-Based Best Practices for LARC Provision

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Disclosures

- Dr. Chen receives research support from Medicines 360 and Sebela, all managed by Magee-Womens Research Institute, and is on a Merck global contraceptive advisory board.

In order to promote an ethical & transparent culture in research, clinical care, and teaching, faculty members should disclose to students and trainees their industry relationships.
Today’s learning objectives

• Describe strategies for patient-centered contraceptive counseling

• Identify best practices to ensure timely access to long-acting reversible contraception (LARC)

• Discuss the role of primary care practices and OUD Centers of Excellence in family planning care
Barriers to LARC Insertion
Barriers to LARC Insertion

- Myths and misconceptions about LARC
- Insurance coverage/cost of devices
- Challenges with providing contraception on same day as visit
- Unnecessary screening exams and tests
- Unnecessary follow-up procedures
- Training for placement and removals

team work
When and how to initiate a birth control method?

For contraceptive methods other than IUDs, the **benefits of starting a contraceptive method likely exceed any risk**, even in situations in which the health care provider is uncertain whether the woman is pregnant.

**BOX 2. How to be reasonably certain that a woman is not pregnant**

A health care provider can be reasonably certain that a woman is not pregnant if she has no symptoms or signs of pregnancy and meets any one of the following criteria:

- is ≤7 days after the start of normal menses
- has not had sexual intercourse since the start of last normal menses.
- has been correctly and consistently using a reliable method of contraception
- is ≤7 days after spontaneous or induced abortion
- is within 4 weeks postpartum
- is fully or nearly fully breastfeeding (exclusively breastfeeding or the vast majority [≥85%] of feeds are breastfeeds), amenorrheic, and <6 months postpartum
Available for iOS and Android

### Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use

#### Key:
1. No restriction (method can be used)
2. Advantages generally outweigh theoretical or proven risks
3. Theoretical or proven risks usually outweigh the advantages
4. Unacceptable health risk (method not to be used)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Sub-Condition</th>
<th>Cu-IUD</th>
<th>LNG-IUD</th>
<th>Implant</th>
<th>DMPA</th>
<th>POP</th>
<th>CVC</th>
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<td>Menarche to &lt;20 yrs</td>
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<tr>
<td>Key</td>
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<td>2. Advantages generally outweigh theoretical or proven risks</td>
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<td>3. Theoretical or proven risk usually outweigh the advantages</td>
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</table>

**Notes:**
- *CVC: Condom; Cu-IUD: Copper intrauterine device; LNG-IUD: Levonorgestrel intrauterine device; DMPA: Depo-Provera (medroxyprogesterone acetate intramuscular injection); POP: Pill; CVC: Condom; Cu-IUD: Copper intrauterine device; LNG-IUD: Levonorgestrel intrauterine device; DMPA: Depo-Provera (medroxyprogesterone acetate intramuscular injection); POP: Pill; CVC: Condom; Cu-IUD: Copper intrauterine device; LNG-IUD: Levonorgestrel intrauterine device; DMPA: Depo-Provera (medroxyprogesterone acetate intramuscular injection); POP: Pill;* 
- *Theoretical risks include: Hypertension, diabetes mellitus, cardiovascular disease, liver disease, endometriosis, and certain cancers.*
- *Proven risks include: Diabetes, hypertension, and heart disease.*
- *Cervical cancer screening should be performed before initiating contraception.*
- *Gestational trophoblastic disease includes choriocarcinoma, previous subclinical gestation, and gestational trophoblastic disease.*
- *Cervical intraepithelial neoplasia includes dysplasia and carcinoma in situ.*
- *Cystic fibrosis: includes congenital absence of the vas deferens.*
- *Deep venous thrombosis (DVT) Pulmonary embolism (PE): includes DVT and PE.*

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*Abbreviations: Cu-IUD: Copper intrauterine device; LNG-IUD: Levonorgestrel intrauterine device; DMPA: Depo-Provera (medroxyprogesterone acetate intramuscular injection); POP: Pill; CVC: Condom.*

**References:**
- CDC: Centers for Disease Control and Prevention.
- ACOG: American College of Obstetricians and Gynecologists.

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**CDC MEC 2016**
IUDs in adolescents

• ACOG: LARC methods “should be offered routinely as safe and effective contraceptive options for nulliparous women and adolescents”

• American Academy of Pediatrics also endorses LARC use for adolescents

• Contraceptive CHOICE project:
  ▪ High LARC satisfaction and continuation rates in adolescents (82-86% continuation at 1 year)
Local barriers to adolescent LARC access

- QI project assessing adolescent LARC access in 56 UPMC gynecologic practices across 12 counties in western PA
- Investigators posing as nulliparous adolescents followed a pre-set script with questions about how to get an IUD

What do you think were their responses?

What do you think were the responses of the clinic when asked by an adolescent if she could get an IUD?
Responses

• Out of 56 practices, 6 did not insert IUDs
• 76% would not schedule an appointment for a same-day LARC insertion
• 50% did not offer after-school appointments
• 56% stated that a parent was required for the visit
• Some practices (10%) demonstrated LARC-positive language but 56% demonstrated LARC-negative language

LARC-Negative Language

“Would I want the IUD for my daughter? No.”

“No, uh-uh. I'm sorry but we won't do that. Not here.”

“You don't want the pill then? 16 is very young to get the IUD.”

“It [the IUD] is going to cost you thousands of dollars.”

Slide courtesy of Lim and Krajewski 2017
Identified barriers

**IDEOLOGICAL**
- LARCS not offered as first line
- LARC-negative language
- Require parental presence

**INFORMATIONAL**
- Unreliable resources offered
- No insurance information offered
- LARCS not offered as first line

**LOGISTICAL**
- Require insertion over two visits because:
  1. Device not stocked
  2. No insurance authorization
  3. Staff citing outdated guidelines in referencing patient safety
- Will not insert for nulliparous women

Slide courtesy of Lim and Krajewski 2017
PA law for birth control in minors

- Minors can receive contraception on their own consent; includes EC
  - Facilities receiving Title X funding explicitly prohibited under federal law from requiring a minor to get parental consent before providing contraception
- Minors are entitled to confidentiality
- Minors may consent to STD/HIV testing and treatment
- Minors may consent to confidential pregnancy testing and treatment (except abortion)

Insurance coverage of contraception

• Affordable Care Act of 2010 contraceptive mandate:
  ▪ Requires coverage for all 18 categories of FDA-approved contraceptive methods and counseling for all women, including female sterilization
  ▪ Eliminates out-of-pocket costs such as co-payments or coinsurance, even if deductible has not been met

• UPMC Health Plan: covers full range of contraceptive options, including vasectomy

Birth control coverage barriers

•Insurance companies are not complying with the birth control benefit if they:
  ▪ Do not provide coverage for all 18 FDA-approved methods of birth control or impose out-of-pocket cost on them
  ▪ Limit their coverage to generic birth control
  ▪ Fail to cover the services associated with birth control without out-of-pocket cost, including counseling or follow-up visits
  ▪ Impose utilization management within a method category

# Insurance preauthorization*

<table>
<thead>
<tr>
<th>IUD CODES</th>
<th>81025 UPT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NEXPLANON</strong></td>
<td><strong>MIRENA</strong></td>
</tr>
<tr>
<td>Device CPT code</td>
<td>J7307</td>
</tr>
<tr>
<td><strong>INSERTION</strong></td>
<td></td>
</tr>
<tr>
<td>Diagnosis for Insert</td>
<td>Z30.017</td>
</tr>
<tr>
<td><strong>REMOVAL</strong></td>
<td></td>
</tr>
<tr>
<td><strong>INSERT/REMOVAL Same day</strong></td>
<td></td>
</tr>
</tbody>
</table>

If same day insertion, add -25 modifier to indicate 2 distinct services were provided—Evaluation and Management (E/M) services and insertion.

* Confirm correct codes with your office billers

Insurance preauthorization

Online tools to check for authorization/coverage:
- Navinet
- UPMC Health Plan Online Chat
- Payor Web Portals
- CPT Tracker – Infonet

Negative result diagnosis code for UPT (81025):
- Z32.02, pregnancy test, result negative
Same-day LARC access

- Survey of 636 California Family PACT providers found:
  - 58% required 2 or more visits to place an IUD
  - 47% required 2 visits to place an implant
  - Main reasons for delay included:

<table>
<thead>
<tr>
<th>Reasons more than 1 visit needed</th>
<th>IUD* [95% CI]</th>
<th>Implant* [95% CI]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening tests or wait for results</td>
<td>68% (62-74)</td>
<td>24% (17-34)</td>
</tr>
<tr>
<td>Clinic flow, scheduling issues, few clinicians</td>
<td>50% (44-57)</td>
<td>64% (61-80)</td>
</tr>
<tr>
<td>Need to order the method</td>
<td>29% (23-34)</td>
<td>29% (21-39)</td>
</tr>
</tbody>
</table>

* [% (95% CI)]

STI screening at time of IUD insertion

• Overall rate of PID among women with IUDs inserted is low
  ▪ 0-5% among women with STIs at time of insertion
  ▪ 0-2% among women without STIs

• Screening for STIs not required unless risk factors exist, e.g. age <25 or multiple partners

• Asymptomatic woman with risk factors should be tested and IUD can be placed same-day

Same-day IUD insertion

ACOG Committee Opinion No. 615: Access to Contraception

- Should try to initiate and place LARC in a single visit as long as pregnancy may reasonably be excluded
- Two-visit IUD insertion protocols are a barrier to contraceptive access
- STI testing can occur on same day as LARC placement
Creating a LARC-friendly office with LARC kits
Pelvic exams: to do, or not to do

- For healthy women, no baseline exams or tests are necessary before initiation of:
  - Progestin only pills (POPs)
  - Depot medroxyprogesterone acetate (DMPA)
  - Contraceptive implant
- Blood pressure should be checked before:
  - Combined hormonal contraceptives (CHCs)
- Baseline weight/BMI may be useful for all methods
What about STI testing?

NO SWAB
STD TESTING!
STI testing without a pelvic exam

• Self-collected vaginal swabs for NAAT
  ▪ Equivalent in sensitivity and specificity to clinician-collected swabs
  ▪ Highly acceptable

• First-catch urine specimen for nucleic acid amplification testing (NAAT)
  ▪ Slightly less sensitive than vaginal/cervical specimens

CDC STD Treatment Guidelines, 2015.
Follow-up after initiation of hormonal contraception

- No routine follow-up visit needed for implant, DMPA, POPs, CHCs, IUDs
- At routine visits, assess satisfaction, whether she has any concerns, changes in health status that may affect continued eligibility
- IUD: at routine visits, consider checking for strings
- CHCs: at routine visits, assess BP
Follow-up after initiation of hormonal contraception

- Offer options for follow up at any time for side effects/problems, to change the method, or for removal/replacement
- Consider assessing weight changes and counseling as needed
- Specific populations may need more frequent follow-up (adolescents, medical conditions)

Unlink birth control from well woman visits
LARC provision during COVID-19

• Access to contraception is essential, even during a pandemic
• Identify patients who require an in-person visit vs. telemedicine
• Use telemedicine to initiate contraception (e.g. pills/patch/ring) and maintenance
• Consider self-administered subcutaneous DMPA for initiation and maintenance of DMPA
  ▪ Can use telemedicine to ensure correct administration
  ▪ DMPA IM can be given at intervals of up to 15 weeks

Society of Family Planning interim clinical recommendations:
Contraceptive provision when healthcare access is restricted due to pandemic response. Updated 28 May 2020.
LARC provision during COVID-19

- Evaluate side effects of contraception with telemedicine
- Some contraceptive visits require in-person appointments, such as IUD and implant initiation and removal
- Consider self-removal of IUDs
- Consider telemedicine consultation before LARC administration to assess for contraindications and to reduce in-office counseling time
- Offer “bridge” contraception (e.g. pill/patch/ring/self-administered DMPA) until visit if needed
<table>
<thead>
<tr>
<th>LARC device</th>
<th>Dosage</th>
<th>Initial release rate per day</th>
<th>Length of use (FDA)</th>
<th>Length of use (evidence-based)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mirena (Bayer)</td>
<td>52 mg levonorgestrel</td>
<td>20 mcg</td>
<td>5 years</td>
<td>7 years (or more)</td>
</tr>
<tr>
<td>Liletta (Allergan)</td>
<td>52 mg levonorgestrel</td>
<td>19.5 mcg</td>
<td>6 years</td>
<td>7 years (ongoing study to 10 years)</td>
</tr>
<tr>
<td>Kyleena (Bayer)</td>
<td>19.5 mg levonorgestrel</td>
<td>17.5 mcg</td>
<td>5 years</td>
<td>5 years</td>
</tr>
<tr>
<td>Skyla (Bayer)</td>
<td>13.5 mg levonorgestrel</td>
<td>14 mcg/day</td>
<td>3 years</td>
<td>3 years</td>
</tr>
<tr>
<td>ParaGard (Cooper Surgical)</td>
<td>Copper 380 mm²</td>
<td>n/a</td>
<td>10 years</td>
<td>12 years</td>
</tr>
<tr>
<td>Nexplanon (Merck)</td>
<td>68 mg etonogestrel</td>
<td>60-70 mcg/day</td>
<td>3 years</td>
<td>5 years</td>
</tr>
</tbody>
</table>
Conclusions

• Initiate LARC as long as you can be reasonably sure a patient is not pregnant
• LARCs are safe and acceptable in adolescents
• Same-day access to LARC improves uptake
  ▪ Think about the barriers that your office may have, and ways to overcome those barriers
• Create LARC “kits” for your office to facilitate insertions
Conclusions

- STI testing can occur on same day as LARC placement
- Pelvic exams not needed for most methods
- Routine follow-up visits not needed for all methods
  - Can check IUD strings at follow-up visits for IUDs
- Encourage follow-up as needed for any problems
  - Telemedicine if needed in time of COVID pandemic
ARE YOU FOLLOWING LARC BEST PRACTICES?

PROVIDED BY THE REPRODUCTIVE BRIDGES COALITION

✓ INSERT AT ANY POINT IN THE MENSTRUAL CYCLE
  Insertion of an IUD or an implant may occur at any time during the menstrual cycle as long as pregnancy may be reasonably excluded.

✓ HAVE LARC INSERTION KITS READY
  Creating kits with insertion equipment will facilitate efficiency and allow for more same-day insertions.

✓ KNOW REGIONAL COVERAGE PRACTICES
  Under the ACA contraceptive mandate, most insurers provide LARC coverage with no copay. If in doubt, call to the insurer should be made while the patient is in the office so as not to delay insertion.

✗ DON’T WAIT FOR STI TESTING RESULTS
  Intrauterine device insertion should not be delayed while awaiting STI test results. If indicated, send STI testing the day of insertion and treat subsequent positive test results without removal of the IUD.

✗ DON’T USE MISOPROSTOL
  Evidence shows that misoprostol does not improve insertion ease or success and may increase pain side effects. Use only in patients with a previous failed insertion.

✗ DON’T SCHEDULE ROUTINE FOLLOW-UP
  To avoid unnecessary cost and time burden, follow up only as necessary or during other routine visits.

References:

Practice Bulletin Gynecology: Long-Acting Reversible Contraception-Implants and Intrauterine Devices
Questions/Discussion

• What barriers exist in your clinics for contraceptive initiation and provision?

• How can your staff be trained on best practices in contraceptive provision?
  ▪ Nexplanon training (through Merck due to FDA requirements)
  ▪ IUD training (all types of IUDs)

• Where can you refer patients for difficult placements or removals?