Patient-Centered Family Planning Counseling

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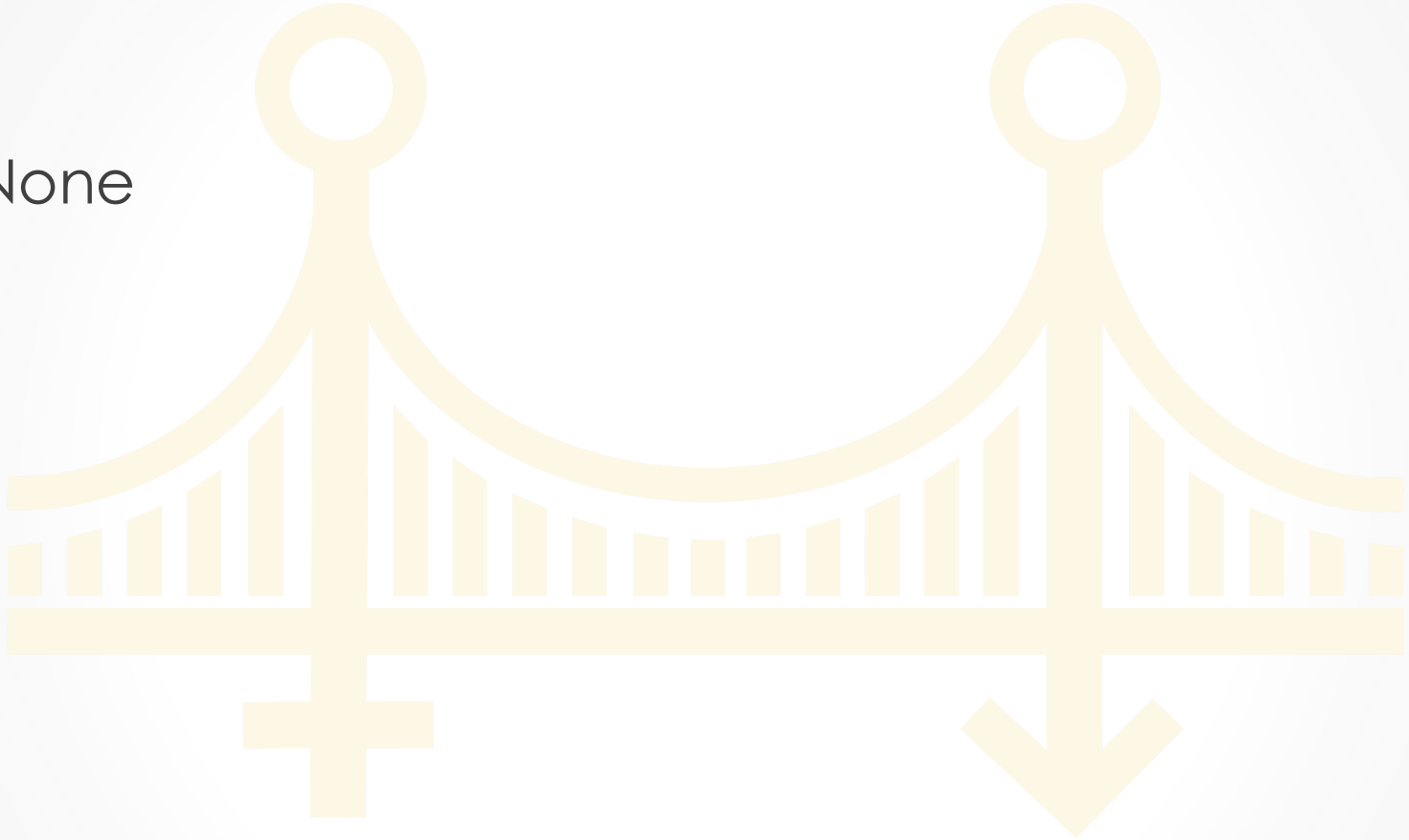
Disclosures

- 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

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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

Ambivalent and indifferent desires

"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

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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

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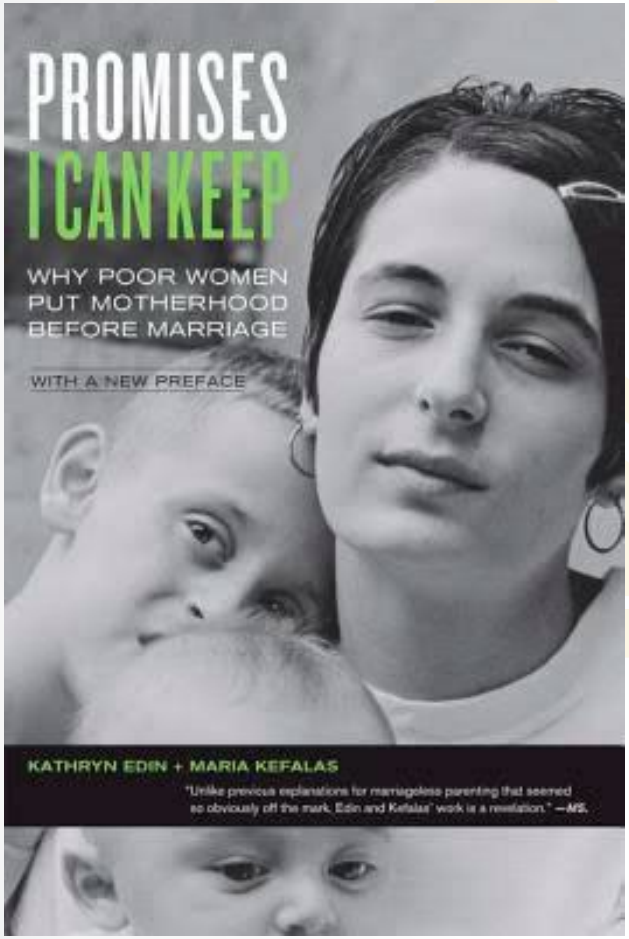
Formulating plans may be viewed as unrealistic



"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.'"

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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."

Borrero: *Contraception*, 2015

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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."

Aiken: *Soc Sci Med*, 2015

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Relationship of ambivalence to contraceptive use

"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."

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Higgins: *Perspect Sex Repro Health*, 2017

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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

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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*

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Patient-centered reproductive goals assessment

ONE KEY QUESTION

Can I help you with any reproductive health services today, such as birth control and/or preconception care?

Would you like to get pregnant in the next year? Preparing for a future pregnancy?

PATH Questions:

Pregnancy **A**ttitudes	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

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Contraceptive counseling strategies

Promote patient autonomy

Encourages a specific course of action

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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

Dehlendorf: *Perspect Sex Reprod Health*, 2014

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

Concerns with directive counseling

- 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

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Contraceptive counseling strategies

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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

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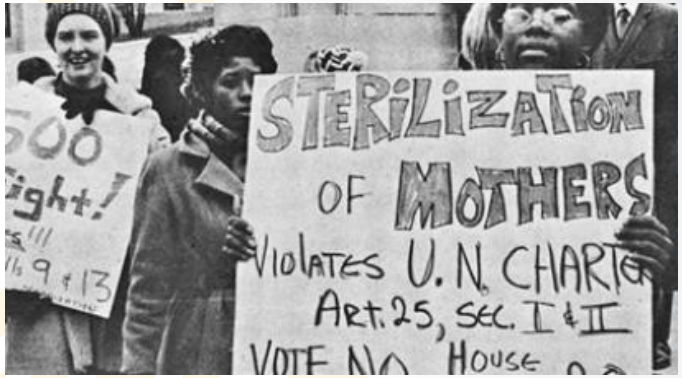
Shared decision making and reproductive health equity

- 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

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Thorburn: *Health Educ Behav*, 2005
Bird: *J Health Psychology*, 2003
Dehlendorf: *Am J Obstet Gynecol*, 2010

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The process of shared decision making

1. Explicitly state focus on patient preferences
2. Elicit preferences for method characteristics
3. Provide scaffolding for decision making

➢ *"Do you have a sense of what is important to you about your method?"*

- Return to fertility
- Side effects/ menstrual changes
- Non-contraceptive benefits
- Need for a discreet method

Iterative process focusing on information most relevant to the individual

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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

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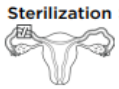
Talking about effectiveness

- 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

	Most Effective				Moderately Effective					Least Effective					
	 Female Sterilization	 Male Sterilization	 IUD	 Implant	 Injectables	 Pill	 Patch	 Ring	 Diaphragm	 Male Condom	 Female Condom	 Withdrawal	 Sponge	 Fertility Awareness Based Methods	 Spermicides
Risk of pregnancy*	.5 out of 100	.15 out of 100	LNG: .2 out of 100 CopperT: .8 out of 100	.05 out of 100	4 out of 100	8 out of 100	9 out of 100		12 out of 100	13 out of 100	21 out of 100	20 out of 100	12–24 out of 100	24 out of 100	28 out of 100
How the method is used	Surgical procedure		Placement inside uterus	Placement into upper arm	Shot in arm, hip or under the skin	Take a pill	Put a patch on skin	Put a ring in vagina	Use with spermicide and put in vagina	Put over penis	Put inside vagina	Pull penis out of the vagina before ejaculation	Put inside vagina	Monitor fertility signs. Abstain or use condoms on fertile days.	Put inside vagina
How often the method is used	Permanent		Lasts up to 3–12 years	Lasts up to 3 years	Every 3 months	Every day at the same time	Each week	Each month	Every time you have sex					Daily	Every time you have sex
Menstrual side effects	None		LNG: Spotting, lighter or no periods CopperT: Heavier periods	Spotting, lighter or no periods	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 few months.			Allergic reaction, irritation			None	Allergic reaction, irritation	None	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	No estrogen. May reduce menstrual cramps.	Some client's 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. Nothing to buy.	No hormones. No prescription necessary.	No hormones. Can increase awareness and understanding of a woman's fertility signs.	No hormones. No prescription necessary.
	Counsel all clients about the use of condoms to reduce the risk of STDs, 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 (2) Emergency Contraception: emergency contraceptive pills or a copper IUD after unprotected intercourse substantially reduces risk of pregnancy. Reference for effectiveness rates: Trussell J. Contraceptive failure in the United States. Contraception 2011; 83: 397-404. Sundaram A. Contraceptive failure in the United States. Perspect Sex Reprod Health 2017;49:7-16 Other references available on www.fpntc.org.

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

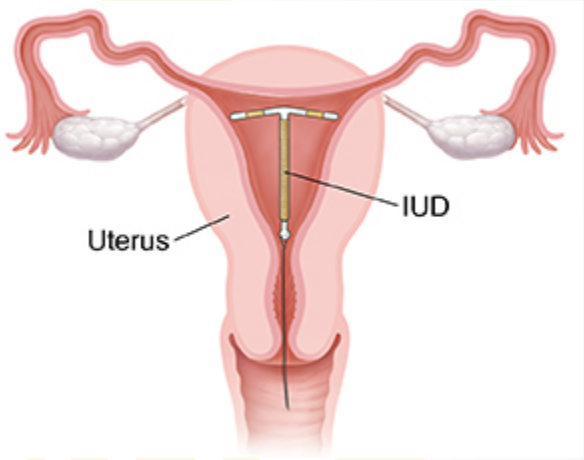
- Dr. Chen receives research support from Medicines 360 and Sebela, all managed by Magee-Womens Research Institute, and is on a Merck global contraceptive advisory board

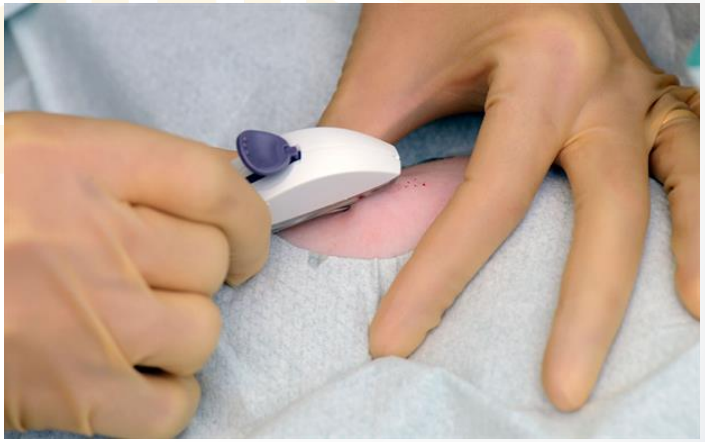
In order to promote an ethical & transparent culture in research, clinical care, and teaching, faculty members should disclose to students and trainees their industry relationships

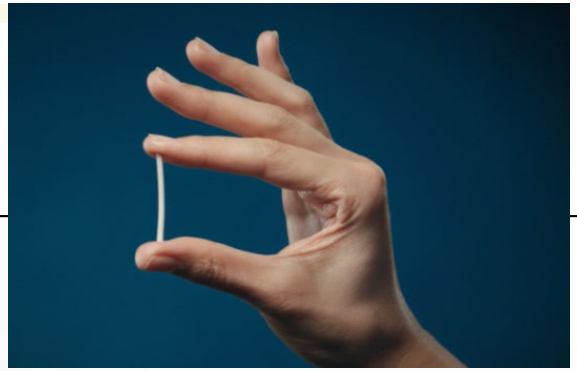
Today's learning objectives

- 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







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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

Olson EM et al. WMJ 2018;117(4): 149–155.
Judge-Golden C et al. J Women's Health 2020 [in press]


team
work

When and how to initiate a birth control method?

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

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

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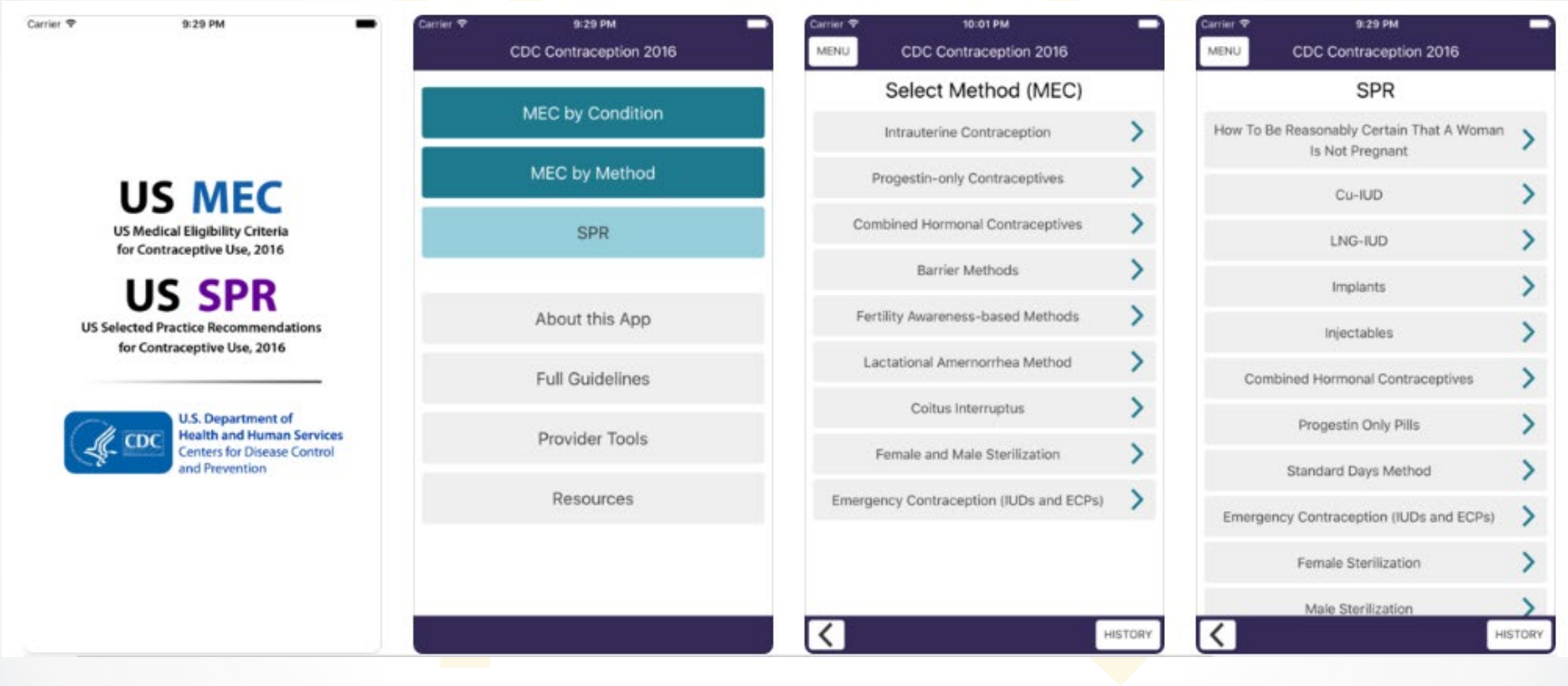
Available for iOS and Android



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https://itunes.apple.com/us/app/contraception/id595752188?mt=8

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

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

Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion

Condition	Sub-Condition	Cu-IUD I	Cu-IUD C	LNG-IUD I	LNG-IUD C	Implant I	Implant C	DMPA I	DMPA C	POP I	POP C	CHC I	CHC C
Age		Menarche to <20 yrs:2		Menarche to <20 yrs:2		Menarche to <18 yrs:1		Menarche to <18 yrs:2		Menarche to <18 yrs:1		Menarche to <40 yrs:1	
		≥20 yrs:1		≥20 yrs:1		18-45 yrs:1		18-45 yrs:1		18-45 yrs:1		≥40 yrs:2	
						>45 yrs:1		>45 yrs:2		>45 yrs:1			
Anatomical abnormalities	a) Distorted uterine cavity	4		4									
	b) Other abnormalities	2		2									
Anemias	a) Thalassemia	2		1		1		1		1		1	
	b) Sickle cell disease‡	2		1		1		1		1		2	
	c) Iron-deficiency anemia	2		1		1		1		1		1	
Benign ovarian tumors	(*including cysts*)	1		1		1		1		1		1	
Breast disease	a) Undiagnosed mass	1		2		2*		2*		2*		2*	
	b) Benign breast disease	1		1		1		1		1		1	
	c) Family history of cancer	1		1		1		1		1		1	
	d) Breast cancer‡												
	i) Current	1		4		4		4		4		4	
	ii) Past and no evidence of current disease for 5 years	1		3		3		3		3		3	
Breastfeeding	a) <21 days postpartum					2*		2*		2*		4*	
	b) 21 to <30 days postpartum												
	i) With other risk factors for VTE					2*		2*		2*		3*	
	ii) Without other risk factors for VTE					2*		2*		2*		3*	
	c) 30-42 days postpartum												
	i) With other risk factors for VTE					1*		1*		1*		3*	
	ii) Without other risk factors for VTE					1*		1*		1*		2*	
	d) >42 days postpartum					1*		1*		1*		2*	
Cervical cancer	Awaiting treatment	4	2	4	2	2		2		1		2	
Cervical ectropion		1		1		1		1		1		1	
Cervical intraepithelial neoplasia		1		2		2		2		1		2	
Cirrhosis	a) Mild (*compensated*)	1		1		1		1		1		1	
	b) Severe‡ (*decompensated*)	1		3		3		3		3		4	
Cystic fibrosis‡		1*		1*		1*		2*		1*		1*	
Deep venous thrombosis (DVT)/Pulmonary embolism (PE)	a) History of DVT/PE, not receiving anticoagulant therapy												
	i) Higher risk for recurrent DVT/PE	1		2		2		2		2		4	
	ii) Lower risk for recurrent DVT/PE	1		2		2		2		2		3	
	b) Acute DVT/PE	2		2		2		2		2		4	
	c) DVT/PE and established anticoagulant therapy for at least 3 months												
	i) Higher risk for recurrent DVT/PE	2		2		2		2		2		4*	
	ii) Lower risk for recurrent DVT/PE	2		2		2		2		2		3*	
	d) Family history (*first-degree relatives*)	1		1		1		1		1		2	
	e) Major surgery												
	i) With prolonged immobilization	1		2		2		2		2		4	
	ii) Without prolonged immobilization	1		1		1		1		1		2	
	f) Minor surgery without immobilization	1		1		1		1		1		1	
Depressive disorders		1*		1*		1*		1*		1*		1*	

Condition	Sub-Condition	Cu-IUD I	Cu-IUD C	LNG-IUD I	LNG-IUD C	Implant I	Implant C	DMPA I	DMPA C	POP I	POP C	CHC I	CHC C
Diabetes	a) History of gestational disease	1		1		1		1		1		1	
	b) Nonvascular disease												
	i) Non-insulin dependent	1		2		2		2		2		2	
	ii) Insulin dependent	1		2		2		2		2		2	
	c) Nephropathy/retinopathy/neuropathy‡	1		2		2		3		2		3/4*	
	d) Other vascular disease or diabetes of >20 years' duration‡	1		2		2		3		2		3/4*	
Dysmenorrhea	Severe	2		1		1		1		1		1	
Endometrial cancer‡		4	2	4	2	1		1		1		1	
Endometrial hyperplasia		1		1		1		1		1		1	
Endometriosis		2		1		1		1		1		1	
Epilepsy‡	(*see also Drug Interactions*)	1		1		1*		1*		1*		1*	
Gallbladder disease	a) Symptomatic												
	i) Treated by cholecystectomy	1		2		2		2		2		2	
	ii) Medically treated	1		2		2		2		2		3	
	iii) Current	1		2		2		2		2		3	
	b) Asymptomatic	1		2		2		2		2		2	
Gestational trophoblastic disease‡	a) Suspected GTD (immediate postevacuation)												
	i) Uterine size first trimester	1*		1*		1*		1*		1*		1*	
	ii) Uterine size second trimester	2*		2*		1*		1*		1*		1*	
	b) Confirmed GTD												
	i) Undetectable/non-pregnant ß-hCG levels	1*	1*	1*	1*	1*		1*		1*		1*	
	ii) Decreasing ß-hCG levels	2*	1*	2*	1*	1*		1*		1*		1*	
	iii) Persistently elevated ß-hCG levels or malignant disease, with no evidence or suspicion of intrauterine disease	2*	1*	2*	1*	1*		1*		1*		1*	
	iv) Persistently elevated ß-hCG levels or malignant disease, with evidence or suspicion of intrauterine disease	4*	2*	4*	2*	1*		1*		1*		1*	
Headaches	a) Nonmigraine (mild or severe)	1		1		1		1		1		1*	
	b) Migraine												
	i) Without aura (includes menstrual migraine)	1		1		1		1		1		2*	
	ii) With aura	1		1		1		1		1		4*	
History of bariatric surgery‡	a) Restrictive procedures	1		1		1		1		1		1	
	b) Malabsorptive procedures	1		1		1		1		3		COCs: 3 P/R: 1	
History of cholestasis	a) Pregnancy related	1		1		1		1		1		2	
	b) Past COC related	1		2		2		2		2		3	
History of high blood pressure during pregnancy		1		1		1		1		1		2	
History of Pelvic surgery		1		1		1		1		1		1	
HIV	a) High risk for HIV	2	2	2	2	1		2*		1		1	
	b) HIV infection					1*		1*		1*		1*	
	i) Clinically well receiving ARV therapy	1	1	1	1	If on treatment, see Drug Interactions							
	ii) Not clinically well or not receiving ARV therapy‡	2	1	2	1	If on treatment, see Drug Interactions							

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

Abbreviations: C=continuation of contraceptive method; CHC=combined hormonal contraception (pill, patch, and, ring); COC=combined oral contraceptive; Cu-IUD=copper-containing intrauterine device; DMPA = depot medroxyprogesterone acetate; I=initiation of contraceptive method; LNG-IUD=levonorgestrel-releasing intrauterine device; NA=not applicable; POP=progestin-only pill; P/R=patch/ring ‡ Condition that exposes a woman to increased risk as a result of pregnancy. *Please see the complete guidance for a clarification to this classification: www.cdc.gov/reproductivehealth/unintendedpregnancy/USMEC.htm.

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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)

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ACOG Practice Bulletin No. 186, 2017.

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?

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Lim and Krajewski. Contraception 2020;101(2):130-131.

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

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Lim and Krajewski. J Pediatric Adolesc Gynecol 2017;30:321.
Lim and Krajewski. Contraception 2020;101(2):130-131.

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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."

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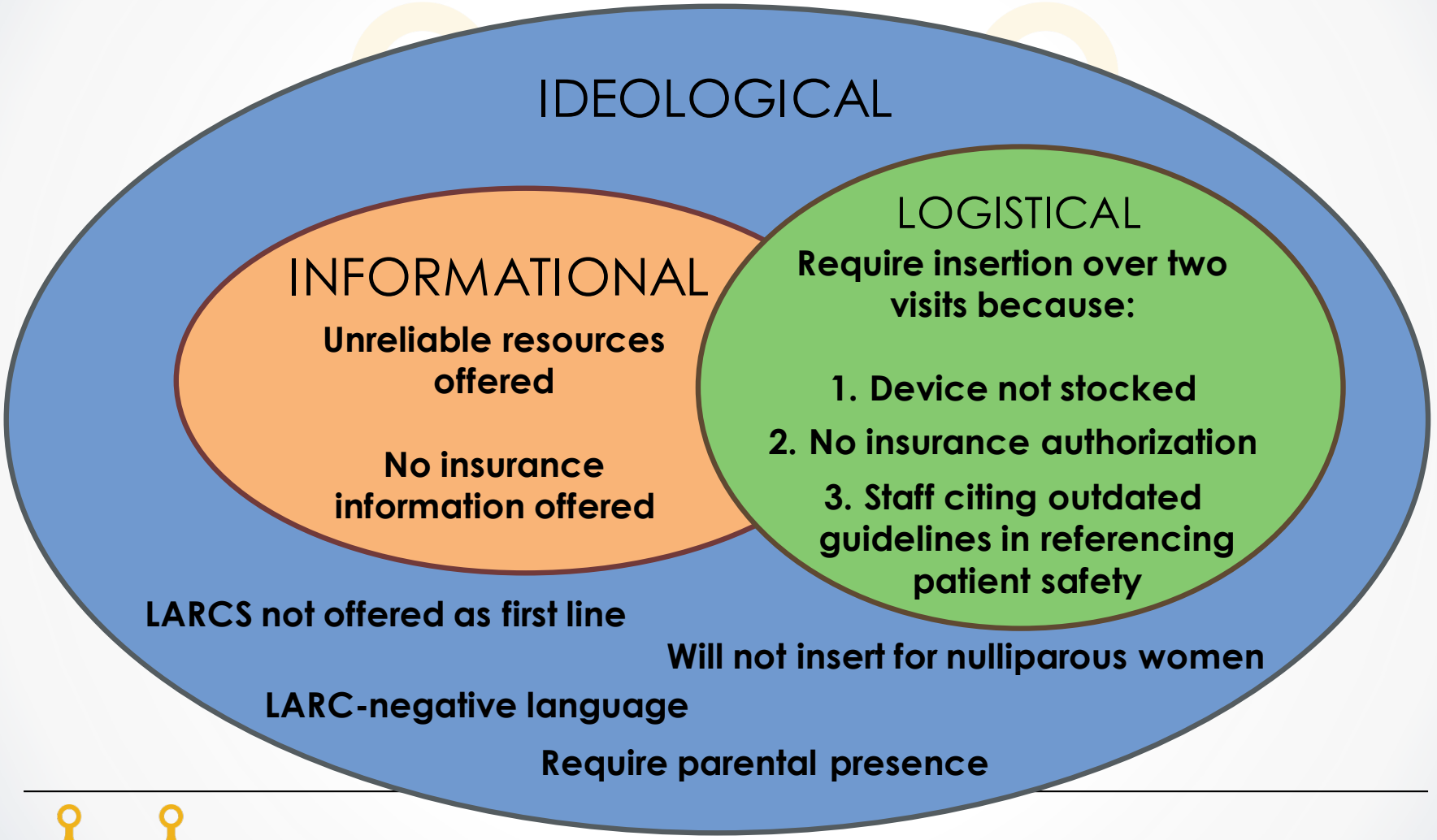
Slide courtesy of Lim and Krajewski 2017

Identified barriers



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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)

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https://www.aclupa.org/our-work/duvall-reproductive-freedom-project/minorsaccesstoconfidential/minors-health-care-and-the-law/

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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

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Guttmacher Institute. Insurance Coverage of Contraceptives. https://www.guttmacher.org/state-policy/explore/insurance-coverage-contraceptives. Accessed 9/18/18.
ACOG. Essential Guide to LARC Coding. ACOG LARC Program: The Essential Guide to LARC Coding Webinar. Accessed 9/20/18.

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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

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ACOG. Essential Guide to LARC Coding. ACOG LARC Program: The Essential Guide to LARC Coding Webinar. Accessed 9/20/18.

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Insurance preauthorization*

IUD CODES						
81025 UPT						
	NEXPLANON	MIRENA	LILETTA	PARAGARD	SKYLA	Kyleena
Device CPT code	J7307	J7298	J7297	J7300	J7301	J7296
INSERTION	11981	58300	58300	58300	58300	58300
Diagnosis for Insert	Z30.017	Z30.430	Z30.430	Z30.430	Z30.430	Z30.430
REMOVAL	11982	58301	58301	58301	58301	58301
Diagnosis for Removal	Z30.46	Z30.432	Z30.432	Z30.432	Z30.432	Z30.432
INSERT/REMOVAL Same day	11983	58300 and 58301	58300 and 58301	58300 and 58301	58300 and 58301	58300 and 58301
Diagnosis for Removal/Re-insertion	Z30.49	Z30.433	Z30.433	Z30.433	Z30.433	Z30.433

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

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* Confirm correct codes with your office billers

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https://pcainitiative.acog.org/wp-content/uploads/QuickGuideReimbursementLARCFINAL.pdf

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:

Reasons more than 1 visit needed	IUD*	Implant*
Screening tests or wait for results	68% (62-74)	24% (17-34)
Clinic flow, scheduling issues, few clinicians	50% (44-57)	64% (61-80)
Need to order the method	29% (23-34)	29% (21-39)

* [% (95% CI)]

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Biggs et al. Obstet Gynecol. 126:338-45, 2015.

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**

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Tepper et al. Contraception 2013;87:645-9.
Mohllajee et al. Contraception 2006;73:145-53.
Sufrin et al. Obstet Gynecol 2012;120:1314-21.

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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

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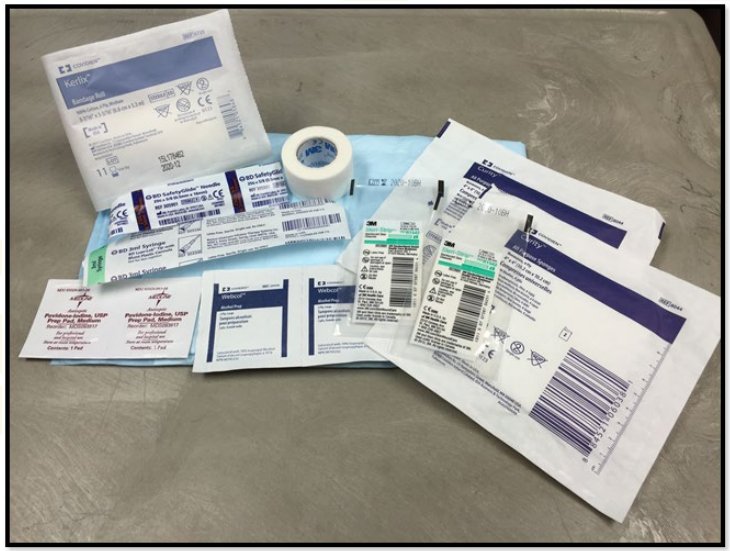
ACOG Committee Opinion No. 615, 2017.

Creating a LARC-friendly office with LARC kits



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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

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What about STI testing?

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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

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CDC STD Treatment Guidelines, 2015.
CDC MMWR 2014;63:1-19.

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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

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

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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

LARC device	Dosage	Initial release rate per day	Length of use (FDA)	Length of use (evidence-based)
Mirena (Bayer)	52 mg levonorgestrel	20 mcg	5 years	7 years (or more)
Liletta (Allergan)	52 mg levonorgestrel	19.5 mcg	6 years	7 years (ongoing study to 10 years)
Kyleena (Bayer)	19.5 mg levonorgestrel	17.5 mcg	5 years	5 years
Skyla (Bayer)	13.5 mg levonorgestrel	14 mcg/day	3 years	3 years
ParaGard (Cooper Surgical)	Copper 380 mm^2	n/a	10 years	12 years
Nexplanon (Merck)	68 mg etonogestrel	60-70 mcg/day	3 years	5 years

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 co-pay. If in doubt, calls 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: Curtis KM, Jatlaoui TC, Tepper NK, et al. U.S. Selected Practice Recommendations for Contraceptive Use, 2016. MMWR Recomm Rep. 2016;65(4):1-66 https://www.acog.org/Clinical-Guidance-and-Publications/Practice-Bulletins/Committee-on-Practice-Bulletins-Gynecology/Long-Acting-Reversible-Contraception-Implants-and-Intrauterine-Devices

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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?