

Navigating the Complexities of Contraceptive Care

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The logo for FMX, consisting of the letters 'FMX' in a bold, white, sans-serif font, positioned on the right side of an orange horizontal bar with diagonal white stripes.

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Dr. Ti earned her Master of Public Health from Johns Hopkins Bloomberg School of Public Health, and is a graduate of the University of Michigan Medical School in Ann Arbor, Michigan. She completed her residency in Family and Community Medicine and a fellowship in Family Planning at the University of California, San Francisco, conducting research on the family planning values and preferences of incarcerated girls. Dr. Ti also completed a 2-year research position in the Division of Reproductive Health at the Centers for Disease Control and Prevention (CDC), working on the CDC contraception guidance. She is now faculty in the Division of Family Planning, and is the medical director of the Title X clinic at Grady Memorial Hospital. She currently provides primary care, transgender care, and family planning care. She also serves on the Georgia AFP Public Health Committee and the Georgia Department of Public Health Maternal Mortality Review Committee Action Committee.

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Dr. Wheat earned her medical degree from the University of Illinois College of Medicine at Chicago, and she earned her Master of Public Health (MPH) degree at the University of Illinois at Chicago School of Public Health. She completed a residency in family medicine at Northwestern McGaw Family Medicine Residency at Humboldt Park in Chicago, Illinois. Dr. Wheat has a strong interest in reproductive health and social determinants of health, and she works with a largely Spanish-speaking patient population at a federally qualified health center (FQHC) in Chicago. She provides full primary care to patients living with HIV/AIDS and hepatitis C. Dr. Wheat is the program director for the Northwestern McGaw Family Medicine Residency. She runs an outpatient procedure clinic with the residents in her program and is part of the maternity care team.

FMX

Learning Objectives

1. Consider screening for pregnancy intendedness and offering preconception and/or contraception counseling in the primary care setting for all patients at risk of unintended pregnancy.
2. Assess the special contraceptive needs for women with chronic diseases, for women who are planning to have bariatric surgery, and for trans-men at risk of undesired pregnancy.
3. Counsel patients on the appropriate use and access to emergency contraception, including advanced provision prescription.

FMX

Associated Sessions

- (PBL) Navigating the Complexities of Contraceptive Care

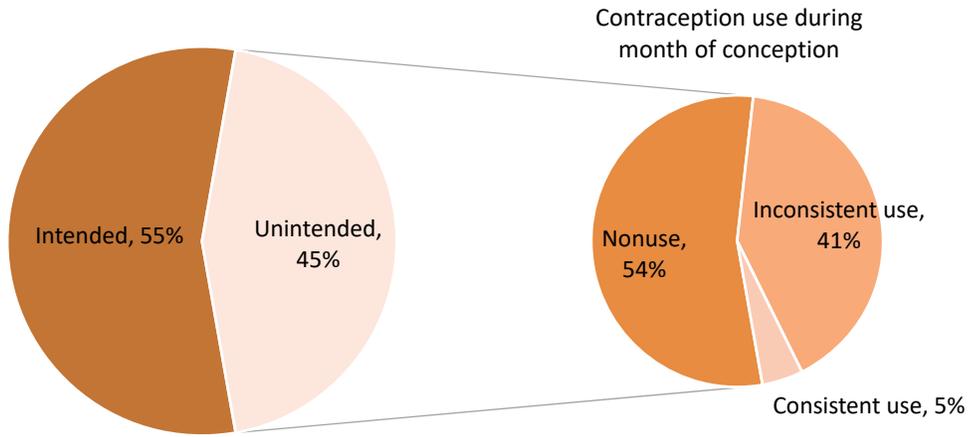
FMX

Audience Engagement System



FMX

Pregnancy in the US



Data from Guttmacher Institute, *Unintended Pregnancy in the United States*, Sept 2016.

Increasing rates of chronic disease among reproductive-aged women

Age groups (years)	Depression	Diabetes	Hypertension	Overweight/Obesity
18-24	19%	1.0%	5.0%	33%
25-34	23%	2.4%	9.2%	57%
35-44	23%	5.3%	17%	62%

Robbins C., et al. *Disparities in Preconception Health Indicators - Behavioral Risk Factor Surveillance System, 2013-2015, and Pregnancy Risk Assessment Monitoring System, 2013-2014*. MMWR Surveill Summ. 2018 Jan 19;67(1):1-16.

Why does this matter?

Preventable Pregnancy Deaths in America Are 'Alarmingly' High

HEALTH

The New York Times

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KFF

New Title X Regulations: Implications for Women and Family...

New Title X Regulations: Implications for Women and Family Planning Providers

Laurie Sobel, Alina Salganicoff, and Brittini Frederiksen

Published: Mar 08, 2019

ns have higher

ective abortion legislation aimed at

So where do we start?



Amy



24 year old patient comes to the office for a same-day appointment with new UTI symptoms.

AES Polling Question 1

- How frequently do you ask patients about their pregnancy intentions?
 - A) I ask nearly all patients
 - B) I ask nearly all female patients
 - C) I sometimes ask, depending on the visit type
 - D) I never or rarely ask
 - E) What do you mean, “pregnancy intentions”?

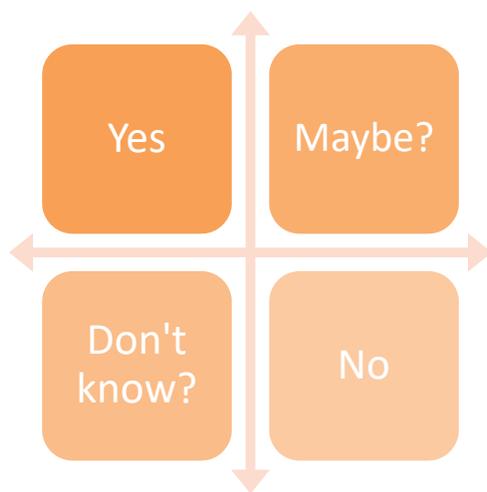
Screening for pregnancy intention

- One Key Question
- Intention-oriented vs service-oriented
 - “Do you want to get pregnant soon?”
 - “Can we help you today with birth control or pregnancy planning?”

“Power to Decide, One Key Question”: <https://powertodecide.org/one-key-question>

Shah SD, et al. *Feasibility study of family planning services screening as clinical decision support at an urban Federally Qualified Health Center network.* Contraception. 2019 Jan; 99(1):27-31.

Screening for pregnancy intention



- Starts a conversation
- Proactively identify need for **contraception** or **pre-pregnancy planning**
- Will change as individual circumstances change

Alice

- 36 year old patient with hypertension comes for a routine follow-up visit and a med refill.



Alice

- BP 145/90, BMI 32
- Not planning pregnancy and open to discussing contraception

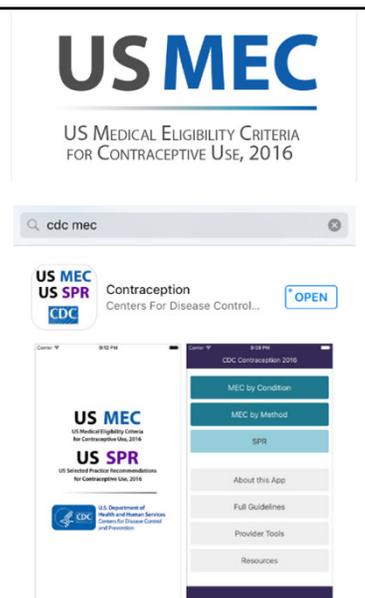


AES Polling Question 2

- What contraception is safe for Alice?
 - A) Non-hormonal methods
 - B) Progestin-only methods
 - C) Estrogen-containing methods
 - D) A & B
 - E) All of the above

CDC contraception guidance

- US Medical Eligibility Criteria for Contraceptive Use (MEC)
 - Safe use of contraceptive methods by patients with certain characteristics or medical conditions
 - More than 1800 recommendations for over 120 medical conditions and sub-conditions



US MEC

Summary Chart of U.S. Medical Eligibility Criteria

Condition	Sub-Condition	Co-RD		LNG-IUD		Implant		DMPA		POP		CIC	
		1	2	1	2	1	2	1	2	1	2	1	2
Age				Menarche <18 yrs	Menarche <20 yrs	Menarche <18 yrs							
Genitourinary abnormalities	a) Distorted uterine cavity	2	4										
Anemias	b) Other abnormalities	2	2										
	a) Thalassemia	2	1	1	1	1	1	1	1	1	1	1	1
	b) Lacks cell storage ¹	2	1	1	1	1	1	1	1	1	1	1	1
Benign neoplasms	c) Iron deficiency anemia	2	1	1	1	1	1	1	1	1	1	1	1
	a) Involving cervix	1	1	1	1	1	1	1	1	1	1	1	1
Breast disease	b) Involving uterus	1	2	2*	2*	2*	2*	2*	2*	2*	2*	2*	2*
	a) Unchallenged mastitis	1	1	1	1	1	1	1	1	1	1	1	1
	b) Benign breast disease	1	1	1	1	1	1	1	1	1	1	1	1
	c) Family history of cancer	1	1	1	1	1	1	1	1	1	1	1	1
Cervical cancer	d) Breast cancer ²	1	1	1	1	1	1	1	1	1	1	1	1
	e) Current	1	4	4	4	4	4	4	4	4	4	4	4
	f) Past and no evidence of current disease for 5 years	1	3	3	3	3	3	3	3	3	3	3	3
	g) 21 to <30 days postpartum		2*	2*	2*	2*	2*	2*	2*	2*	2*	2*	2*
Enrolment	h) 31 to <30 days postpartum												
	i) With other risk factors for VTE			3*	3*	3*	3*	3*	3*	3*	3*	3*	3*
	j) Without other risk factors for VTE			2*	2*	2*	2*	2*	2*	2*	2*	2*	2*
	k) 30-42 days postpartum			1*	1*	1*	1*	1*	1*	1*	1*	1*	1*
Cervical ectropion	l) With other risk factors for VTE			1*	1*	1*	1*	1*	1*	1*	1*	1*	1*
	m) Without other risk factors for VTE			1*	1*	1*	1*	1*	1*	1*	1*	1*	1*
	n) 42 days postpartum			1*	1*	1*	1*	1*	1*	1*	1*	1*	1*
	o) 30-42 days postpartum			1*	1*	1*	1*	1*	1*	1*	1*	1*	1*
Cervical intraepithelial neoplasia	p) Cervical intraepithelial neoplasia	1	2	2	2	2	2	2	2	2	2	2	2
	q) Cervical intraepithelial neoplasia	1	2	2	2	2	2	2	2	2	2	2	2
Cervical stenosis	r) Mild (compensated)	1	1	1	1	1	1	1	1	1	1	1	1
	s) Severe (uncompensated)	1	3	3	3	3	3	3	3	3	3	3	3
Cystic fibrosis ³	t) Cystic fibrosis ³	1*	1*	1*	1*	1*	1*	1*	1*	1*	1*	1*	1*
	u) Cystic fibrosis ³	1*	1*	1*	1*	1*	1*	1*	1*	1*	1*	1*	1*
Deep venous thromboses (DVT) and pulmonary embolism (PE)	v) History of DVT/PE, not receiving anticoagulant therapy	1	2	2	2	2	2	2	2	2	2	2	2
	w) Higher risk for recurrent DVT/PE	1	2	2	2	2	2	2	2	2	2	2	2
	x) Lower risk for recurrent DVT/PE	1	2	2	2	2	2	2	2	2	2	2	2
	y) No acute DVT/PE	2	2	2	2	2	2	2	2	2	2	2	2
Diabetes mellitus	z) DVT/PE and established anticoagulant therapy for at least 3 months	2	2	2	2	2	2	2	2	2	2	2	2
	aa) Higher risk for recurrent DVT/PE	2	2	2	2	2	2	2	2	2	2	2	2
	ab) Lower risk for recurrent DVT/PE	1	1	1	1	1	1	1	1	1	1	1	1
	ac) Family history (first-degree relative)	1	1	1	1	1	1	1	1	1	1	1	1
Major surgery	ad) Major surgery	1	2	2	2	2	2	2	2	2	2	2	2
	ae) With prolonged immobilization	1	2	2	2	2	2	2	2	2	2	2	2
	af) Without prolonged immobilization	1	1	1	1	1	1	1	1	1	1	1	1
	ag) Minor surgery without immobilization	1	1	1	1	1	1	1	1	1	1	1	1
Depressive disorders	ah) Depressive disorders	1*	1*	1*	1*	1*	1*	1*	1*	1*	1*	1*	1*
	ai) Depressive disorders	1*	1*	1*	1*	1*	1*	1*	1*	1*	1*	1*	1*

Risk Level	
1	Method can be used without restriction
2	Advantages generally outweigh theoretical or proven risk
3	Theoretical or proven risks usually outweigh the advantages
4	Unacceptable health risk (method not to be used)

Curtis KM., et al. U.S. Medical Eligibility Criteria for Contraceptive Use, 2016. MMWR Surveill Summ. 2016 Jul;65(3).

Hypertension[§]

b. Elevated blood pressure levels (properly taken measurements)

i. Systolic 140–159 mm Hg or diastolic 90–99 mm Hg

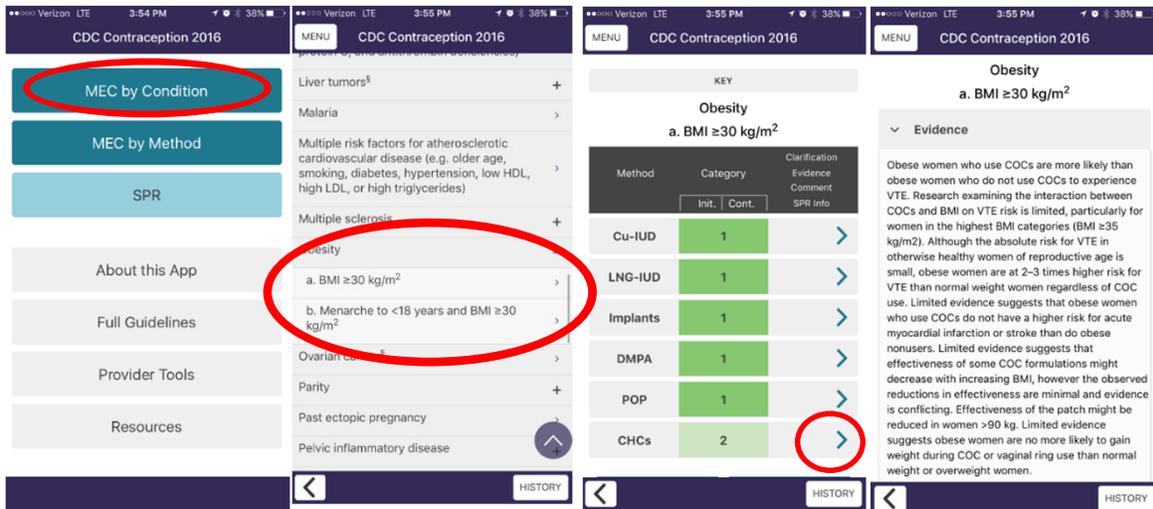
† Clarifications

For all categories of hypertension, classifications are based on the assumption that no other risk factors exist for cardiovascular disease. When multiple risk factors do exist, risk for cardiovascular disease might increase substantially. A single reading of blood pressure level is not sufficient to classify a woman as hypertensive.

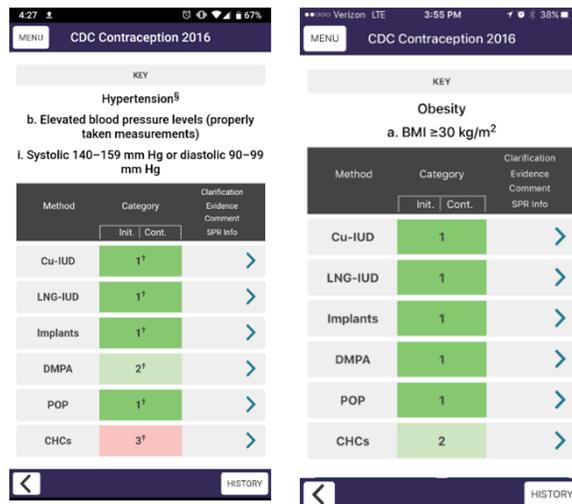
The screenshot shows the app interface for hypertension. At the top, it says "Hypertension[§]". Below that, it lists "b. Elevated blood pressure levels (properly taken measurements)" and "i. Systolic 140–159 mm Hg or diastolic 90–99 mm Hg". There is a "Clarifications" section with a dropdown arrow, and a "View SPR" button at the bottom.

The screenshot shows the app's main menu. The menu items are: "MEC by Condition" (highlighted with a red circle), "MEC by Method", "SPR", "About this App", "Full Guidelines", "Provider Tools", and "Resources".

Look at the US MEC

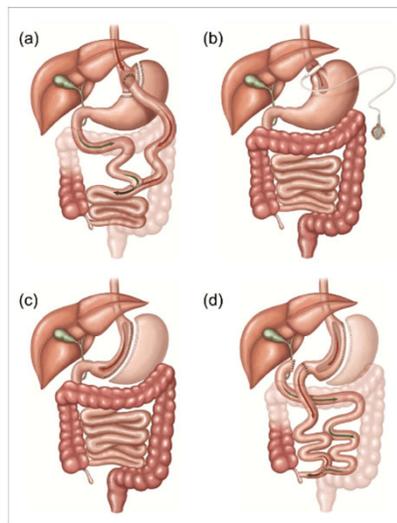


Look at the US MEC



Anna

- 31 year old patient who is scheduled for bariatric surgery next month. She was referred to primary care for contraception.

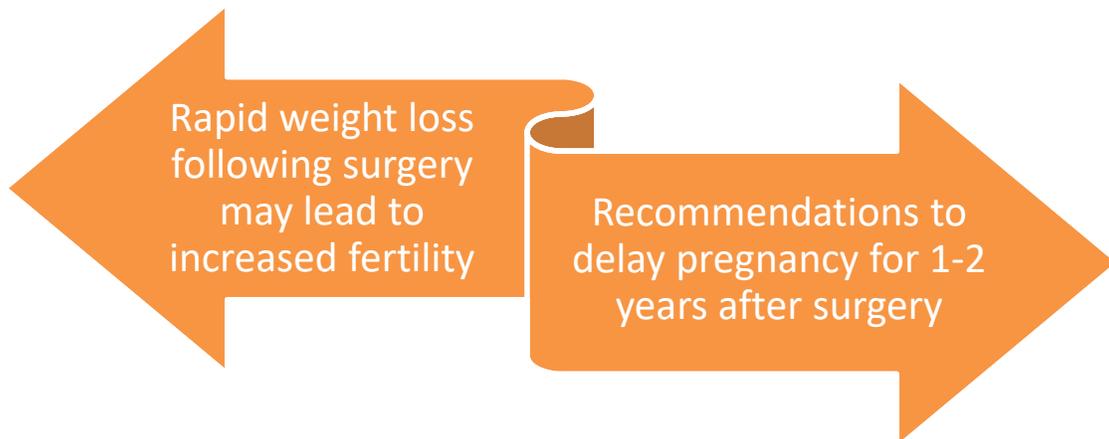


Increased maternal risks in pregnancy

- Breast, endometrial, or ovarian cancer
- Complicated valvular heart disease
- Cystic fibrosis
- Diabetes
- Epilepsy
- Hypertension (>160/100)
- History of bariatric surgery in last 2 years
- HIV (uncontrolled)
- Ischemic heart disease
- Hepatoma
- Peripartum cardiomyopathy
- Severe cirrhosis
- Sickle cell disease
- Solid organ transplantation with in the last 2 years
- Thrombogenic mutations

Curtis KM., et al. *U.S. Medical Eligibility Criteria for Contraceptive Use, 2016*. MMWR Surveill Summ. 2016 Jul;65(3):5.

Bariatric surgery and reproductive health



ACOG. ACOG practice bulletin no. 105: bariatric surgery and pregnancy. Obstet Gynecol. 2009 Jun;113(6):1405-13.

AES Polling Question 3

- What contraception can Anna use?
 - A) Any method
 - B) Any non-oral method
 - C) Only the most effective methods- LARC or sterilization
 - D) It depends on the type of surgery

6:38 MENU CDC Contraception 2016 61%

History of bariatric surgery^s

b. Malabsorptive procedures: decrease absorption of nutrients and calories by shortening the functional length of the small intestine (Roux-en-Y gastric bypass, biliopancreatic diversion)

▼ Evidence

Limited evidence demonstrated no substantial decrease in effectiveness of oral contraceptives among women who underwent a biliopancreatic diversion; however, evidence from pharmacokinetic studies reported conflicting results of oral contraceptive effectiveness among women who underwent a jejunioileal bypass.

Method	Category		Classification Evidence Comment SPR info
	Init.	Cont.	
Cu-IUD		1	>
LNG-IUD		1	>
Implants		1	>
DMPA		1	>
POP		3	>
CHCs		COCs: 3 Patch and Ring: 1	>

Emergency Contraception Additional Methods HISTORY

Anna

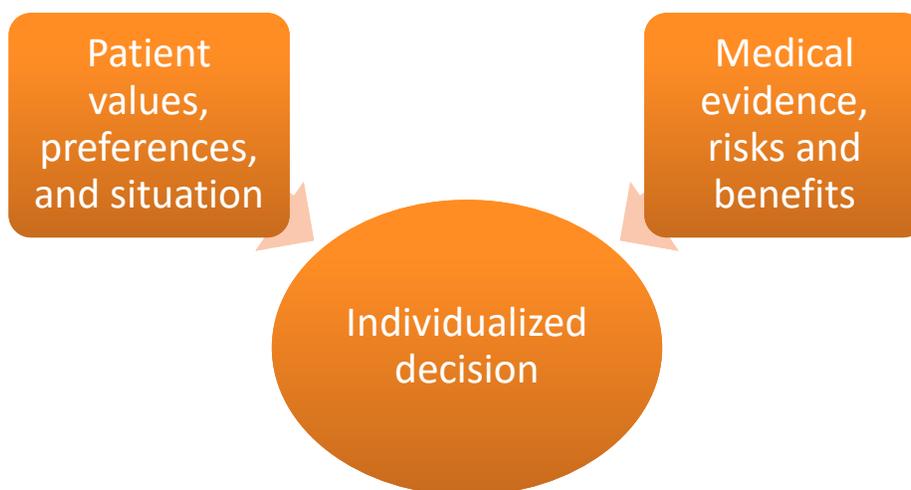
- Anna has been struggling with infertility for many years and tells you that she actually plans on trying to get pregnant as soon as she's recovered from her surgery.

Pregnancy risks after bariatric surgery

- Misdiagnosing pregnancy vs surgical complications
- Continued obesity
- Micronutrient deficiencies
- Inconclusive evidence for patient-oriented outcomes

ACOG. ACOG practice bulletin no. 105: bariatric surgery and pregnancy. Obstet Gynecol. 2009 Jun;113(6):1405-13.

Shared decision-making



Andy

- 24 year old patient, assigned female at birth who is about to start gender-affirming testosterone.
- Not interested in pregnancy



AES Polling Question 4

- Which contraceptive methods are safe for Andy?
 - A) All of them
 - B) Any method without estrogen
 - C) Any method without hormones

Contraception & testosterone

- Amenorrhea ≠ anovulation
 - Category D in pregnancy
- Method-specific considerations:
 - Estrogen is safe when taken with testosterone, but may counter its effects
 - Testosterone can cause vaginal dryness

Reproductive Health Access Project. *Contraception Across the Gender Spectrum*. June 14, 2018. Available at <https://www.reproductiveaccess.org/resource/bc-across-the-gender-spectrum-pearl/>
UCSF. *Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People*; 2nd edition. Deutsch MB, ed. June 2016. Available at transcare.ucsf.edu/guidelines.

Andy

- After discussion options, Andy would like to start depo-medroxyprogesterone (DMPA). Last menstrual period was 2 weeks ago, and last unprotected vaginal sex was 3 days ago.

CDC contraception guidance

US SPR

US SELECTED PRACTICE
RECOMMENDATIONS
FOR CONTRACEPTIVE USE, 2016

- US Selected Practice Recommendations for Contraceptive Use (SPR)
 - Guidance for common contraceptive management topics such as:
 - How to be reasonably certain a patient is not pregnant
 - When to start contraception
 - Medically indicated exams and tests
 - Follow-up and management of certain problems

Curtis KM, et al. U.S. Selected Practice Recommendations for Contraceptive Use, 2016. MMWR Recomm Rep 2016;65(4).

CDC pregnancy checklist

- You can be reasonably certain Andy is not pregnant if any of the criteria apply:
 - Is ≤ 7 days after the start of normal menses
 - Has not had sex since last menses
 - Has been correctly using contraception
 - Is ≤ 7 days after spontaneous or induced abortion
 - Is within 4 weeks postpartum
 - Meets criteria for lactational amenorrhea

Curtis KM, et al. U.S. Selected Practice Recommendations for Contraceptive Use, 2016. MMWR Recomm Rep 2016;65(4).

What about that unprotected sex?



Emergency Contraception (EC)

- Indications:
 - Unprotected sex
 - Concern for contraceptive failure
 - Incorrect use
 - Sexual assault
- Timing: within 5 days (120 hours)

WHO. *Emergency Contraception*. 2 Feb 2018. Available at: <https://www.who.int/news-room/fact-sheets/detail/emergency-contraception>

Available methods of EC

	Copper IUD	Ulipristal Acetate Pills	Progestin Pills
			
What is it?	Emergency contraception (EC) is birth control you can use after unprotected sex.		
What does it do?	EC prevents a pregnancy after unprotected sex. EC does not end a pregnancy and will not work if you are pregnant.		
Medication	Copper	Ulipristal acetate	Levonorgestrel

RHAP. *Emergency Contraception: Which EC is Right for Me?* August 2017. Available at: <https://www.reproductiveaccess.org/wp-content/uploads/2014/12/emergency-contraception.pdf>

Additional considerations for EC

- Failure (pregnancy) rates:
 - LNG EC: 1.2-2.1%
 - Increased with higher BMI, >72 hours since unprotected sex
 - UPA EC: 1.2%
 - Cu IUD: <1%
- Combined oral contraceptives (Yuzpe method)

WHO. *Emergency Contraception*. 2 Feb 2018. Available at: <https://www.who.int/news-room/fact-sheets/detail/emergency-contraception>

AES Polling Question 5

- Andy doesn't want a pelvic exam so chooses EC pills. Can Andy also start DMPA today?
 - A) Yes
 - B) No
 - C) Depends on what kind of EC he chooses

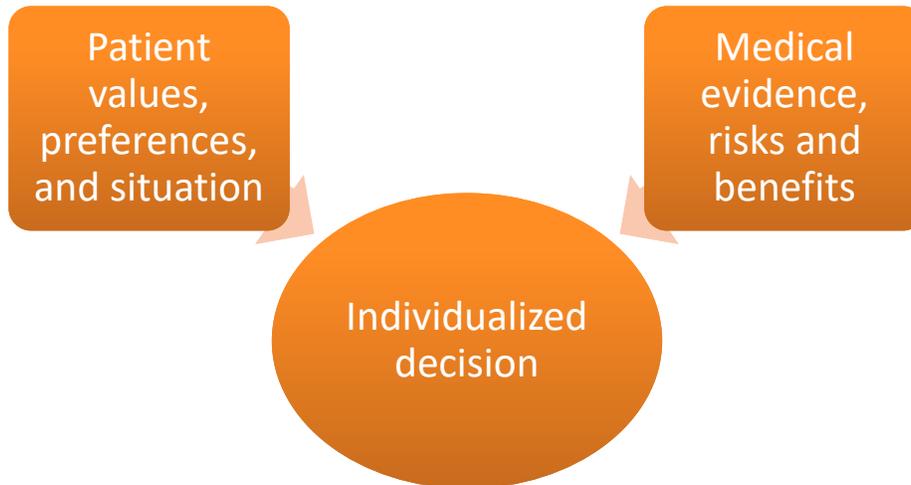
Contraception after EC



- Copper IUD: none needed!
- Levonorgestrel (LNG) EC: can start same day as EC
- Ulipristal acetate EC: starting hormonal contraception within 5 days may decrease effectiveness of EC
- Pregnancy test in 3 weeks if not withdrawal bleed

Curtis KM, et al. U.S. Selected Practice Recommendations for Contraceptive Use, 2016. MMWR Recomm Rep 2016;65(4).

Shared decision-making



Increasing access to EC



- Advanced provision leads to increased use and more timely use
- One form of LNG EC is available over the counter for ~ \$50/pill
 - Availability to other brands varies by state, insurance, age

Polis CB, et al. *Advance provision of emergency contraception for pregnancy prevention*. *Cochrane Database Syst Rev*. 2007 Apr 18;(2):CD005497.

Guttmacher Institute. *Emergency Contraception: State Laws and Policies*. July 1, 2019.

Practice recommendations

- Screen patients regularly for pregnancy intention: intention-oriented vs service-oriented
- Utilize evidence-based guidance to provide contraception safely to all patients, including those with chronic medical conditions
- Assess the need for emergency contraception and recognize best practices for implementation

Billing & Coding

ICD 10 Codes:

- Z30.011 Initial, contraceptive pills
- Z30.012 EC prescription
- Z30.013 Initial, Injection
- Z30.014 Initial, IUC
- Z30.015 Initial, Ring
- Z30.016 Initial, Patch
- Z30.017 Initial, Implant
- Z30.41 surveillance, contraceptive pills
- Z30.42 Surveillance, Injection
- Z30.43 Surveillance, IUC
- Z30.44 Surveillance, Ring
- Z30.45 Surveillance, Patch
- Z30.46 Surveillance, Implant

Billing & Coding

Procedure (CPT) Codes:

- 58300 Insertion of IUD
 - Z30.430 encounter for insertion of IUC
 - J7298 Mirena, J7297 Liletta, J7300 Paragard, J7301 Skyla,
- 58301 IUD removal
 - Z30.432 encounter for removal of IUC
- 58300 & 58301 for IUD removal & reinsertion
 - Z30.433 & relevant J code

Billing & Coding

CPT Codes:

- 11981 Insertion Implant
 - Z30.017 encounter for insertion of Implant
 - J7307 Nexplanon
- 11982 Removal Implant
 - Z30.46 encounter for surveillance of Implant
 - J7307
- 11983 Removal & Reinsertion Implant
 - Z30.46

Billing & Coding

Other helpful codes:

- J2000 Lidocaine
- A4550 Surgical Tray
- 53 modifier can be used for attempted, but unsuccessful, IUD insertions

Some useful resources

- Bedsider: <https://providers.bedsider.org/>
- CDC contraception guidance: https://www.cdc.gov/reproductivehealth/contraception/contraception_guidance.htm
- Reproductive Health Access Project: <https://www.reproductiveaccess.org/>
- UCSF transgender guidelines: <https://transcare.ucsf.edu/guidelines>

Contact us with questions!

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Questions



FMX