**Beyond the Pill**
Contraception Management and Quality Measures in Primary Care
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**Objectives**
- Describe common side effects, contraindications, and special conditions of birth control methods
- Identify techniques to incorporate contraceptive discussions and management into primary care practice
- Identify expert resources, including patient handouts, on contraception found on the internet
- Describe the Oregon Health Authority (OHA) Birth Control quality measure and how to effectively code visits to meet the quality measure

**Outline**
- Common misperceptions/myths
- Combined hormonal methods
- Short-acting progestin-only methods
- Long-acting reversible methods
- Incorporating BC in your practice
- Tools to use and where to find them
- Coding visits and the Oregon Quality Measure

**Abbreviations used**
- BC = BCM = birth control or birth control method
- CHC = combined hormonal contraceptive
- COC = combined oral contraceptive
- DMPA = Depo = depot medroxyprogesterone acetate
- IUC = IUD = IUS = intrauterine contraceptive/device/system
- LARC = long-acting reversible contraceptive(s) = any implant or IUC
- LNG = levonorgestrel
- PID = pelvic inflammatory disease
• POP = progestin only pills

5 Misperceptions – patient and provider
• You need to wait for a period to start a BCM
• You need to do these exams/evaluations before starting BC:
  –Pap
  –Breast exam
  –Pregnancy test
• Women in their late 40’s don’t need BC anymore
• All birth control makes you gain weight

6 When to start your BCM
• Start it now
or....
• Start it now

“For contraceptive methods other than IUDs, the benefits of starting to use a contraceptive method likely exceed any risk, even in situations in which the health-care provider is uncertain whether the woman is pregnant. Therefore, the health-care provider can consider having patients start using contraceptive methods other than IUDs at any time, with a follow-up pregnancy test in 2–4 weeks.” (U.S. SPR 2013)

8 Quick Starting BCM
• Use a back up method
  –7 days for pill, patch, ring, DMPA, LNG IUDs, implant
  –2 days for POPs
  –None for copper IUD
• Check a urine pregnancy test in 2-4 weeks if needed
9 Exams Required
  • Blood Pressure for CHCs
  • Bimanual exam and cervical inspection prior to IUD insertion

10 Pregnancy Tests
  • Useful tool
  • Not accurate if unprotected sex was very recent
  • Using specific criteria has a 99-100% negative predictive value for ruling out pregnancy WITHOUT a pregnancy test

11

12 Contraception for women > age 44
  • Birth control, birth control, birth control
  • Keep using contraception until:
    – Menopause
    or
    – Age 50-55

13 Weight Gain
  • DMPA is a bit more notorious than the others
  • Most methods are weight neutral
  • When non-hormonal methods were studied, women gained weight with age

14 While we’re talking about weight
  • CHC use for women with high BMIs?
    – U.S. SPR 2013 tells us it’s fine

15 IUD Myths
  • You can’t have an IUD if you:
    – Haven’t been pregnant or had a delivery
    – Are a teen
    – Aren’t in a mutually monogamous relationship
–Have an abnormal Pap
• Misoprostol prior to inserting an IUD helps
• IUD users have a higher risk of PID
• IUD users have a higher risk of ectopic pregnancy
• IUDs cause a “mini abortion” each month


17 • Routine pre-insertion use of misoprostol was not shown to decrease insertion pain
• Routine pre-insertion use of misoprostol was not shown to to improve ease of insertion


18 Studies on PID risk
“Our findings indicate that PID among IUD users is most strongly related to the insertion process and to background risk of sexually transmissible disease. PID is an infrequent event beyond the first 20 days after insertion. ”

19 Pill Myths
• There’s some sort of science behind selecting a first pill for a patient
• 28 pills with 11 refills is enough to get you through the year
• Skipping periods is harmful/not natural
• There’s something special about extended cycle or triphasic pills

20 Selecting a Pill

• Eenie, meenie, miny, moe

• Side effect profiles are pretty similar across pills
• Nearly all use the same estrogen
• Might be lower risk to use of an older-generation progestin

21 Pill Quantities

• 28 x 12 = 336
• 28 x 13 = 364

“The more pill packs given up to 13 cycles, the higher the continuation rates. Restricting the number of pill packs distributed or prescribed can result in unwanted discontinuation of the method and increased risk for pregnancy.” (U.S. SPR 2013)

22 extended cycling

• The whole “having a period” thing while on hormonal BC is not founded on any medical or scientific evidence
• So... How do I know I’m not pregnant?
  – You took your pill
  – You’re not having any pregnancy symptoms
  – Taking the pill continuously actually increasing the effectiveness

23 While we’re at it...

• Continuous/extended use of the ring is equally awesome
• Continuous/extended use of the patch is less well studied (but probably still awesome)

24 Extended Cycle Packs and Triphasic Pills
• Same hormones in single-cycle packs
• Single-cycle packs can be cheaper if patient does not have insurance
• Continuous cycling on triphasics is possible...

25 BIRTH CONTROL METHODS
The Pill, The Patch, The Ring

26 Combined hormonal methods – the Pill, the Patch, and the Ring
• Short acting
• Have the most contraindications (estrogen)
• Return to fertility is quick after stopping method
• Woman is in control of using (or not using) the method

27 Continuous Use
Pill, Patch, or Ring
• Use it every day without breaks
• Your uterus is in charge, if you start to bleed (for multiple days), take a short break and go right back in to using it
  –RULES:
    • Must take/use it for 3 full weeks before taking any days off
    • Must not take more than 7 days off in a row

28 Absolute contraindications to CHCs
• Breast cancer
• Cardiovascular disease
• Diabetes – longstanding, with nephr/retin/neuropathy, or vascular disease
• DVT current or h/o with high risk
• Hypertension
• Liver disease/adenocarcinoma/malignant tumor (severe)
• Lupus (positive or unknown antiphospholipid antibodies)
• Major surgery with prolonged immobilization
• Migraines with aura
• Postpartum < 21 days
• Pulmonary embolism
• Smoker (heavy) age 35 or older
• Stroke
• Thrombogenic mutation

29 Think thrombosis risk

30 Possible contraindications to CHCs
• Breastfeeding
• Diabetes with *opathy or vascular disease
• Drugs – certain anticonvulsants and heavy-duty antibiotics
• DVT history at lower risk for recurrence
• Gallbladder disease (active)
• Hepatitis flare
• Hypertension (controlled)
• Hyperlipidemias
• Malabsorptive bariatric surgery (orals only)
• Migraines, no aura, age 35 and older
• Smoker (not heavy) age 35 and older

31 If she develops migraines while on CHC
• And is age 35 or older.... discontinue use

32 A note about migraines and aura
• Starts before the headache
• Usually lasts no more than an hour
• Stops with the onset of headache
• Almost always visual
• Ask her to describe it – look at her hands as she does
• Not the same as photophobia

33 BIRTH CONTROL METHODS
Short acting progestin-only methods

34 **DMPA**
- Medium acting (longer than most short-acting methods)
- Can have the most users who have weight gain
- Generally users become amenorrheic
- Very compatible with breastfeeding
- Has a delay in return to fertility after discontinuation

35 **Progestin-only Pills (POPs)**
- Short acting
- Woman is in charge of taking (or not)
- Back up method needed for only 2 days
- Return to fertility is quick after stopping method
- Very compatible with breastfeeding

36 **Absolute contraindications to DMPA and POPs**
- Breast cancer

37 **Possible Contraindications to DMPA**
- Breast cancer history (> 5 years)
- Cardiovascular disease
- Diabetes with *opathy or vascular disease
- Hypertension (uncontrolled) or with vascular disease
- Liver disease (severe)/adenocarcinoma/malignant tumor
- Lupus (pos or unknown antiphospholipid antibodies)
- Rheumatoid arthritis on immunosuppressive therapy
- Stroke
- Unexplained vaginal bleeding

38 **Possible contraindications to POPs**
- Breast cancer history (> 5 years)
• Liver disease (severe)/adenocarcinoma/malignant tumor
• Lupus (pos or unknown antiphospholipid antibodies)
• Malabsorptive bariatric surgery

39 If she develops migraines with aura while on DMPA or POPs
• Consider discontinuing use

40 LARC methods
• Efficacy
• Ease of use
• Least contraindications
• Quick return to fertility
• More choices each year

Fun fact: More providers use LARC methods than the general population

41 Absolute contraindications to IUD
• Breast cancer (LNG only)
• Cervical cancer awaiting treatment
• Cervicitis, Chlamydia, or Gonorrhea (current)
• Distorted uterine cavity
• Gestational trophoblastic disease (molar pregnancy) with persistent elevated beta hCG levels
• Pelvic infection (current) – PID, tuberculosis, septic abortion
• Pregnant
• Unexplained vaginal bleeding
• Allergy to copper or Wilson’s disease (copper IUD only)

42 Possible contraindications to Copper IUD
• AIDS
• Complicated organ transplant
• Gestational trophoblastic disease with falling beta hCG levels
• Lupus and severe thrombocytopenia

43 Possible Contraindications to LNG IUD
• Breast cancer history (> 5 years)
• Complicated organ transplant
• Gestational trophoblastic disease with falling beta hCG levels
• Liver disease (severe)/adenocarcinoma/malignant tumor
• Lupus (pos or unknown antiphospholipid antibodies)

44 Absolute contraindications to Implant
• Breast cancer

45 Possible Contraindications to Implant
• Breast cancer history (> 5 years)
• Liver disease (severe)/adenocarcinoma/malignant tumor
• Lupus (pos or unknown antiphospholipid antibodies)
• Unexplained vaginal bleeding

46 Grouping Contraindications
• Breast cancer = stay away from hormones
• Clotting event currently or high risk = stay away from estrogen, use progestin with caution (look up the many variants for DVT history)
• Liver disease (severe) = stay away from hormones
• Pregnancy = stay away from IUDs
• Gallbladder = avoid estrogen
• Lupus w/ antiphospholipid antibodies = stay away from hormones
• Diabetes with complications = use hormones with caution
(decision based on severity of complications)

47 Incorporating BCM in Everyday Practice
   • One Key Question® Initiative

Would you like to become pregnant in the next year?

48 Presenting Methods from Most to Least Effective
   • CDC Effectiveness chart
   • Can group methods together to talk about effectiveness, side effects, risks
     – Hit the high points (and low points)
     – Get started on a less effective method while she’s still thinking about that LARC method

49 What’s most important for her?
   • Let her goals for reproduction/contraception help guide the discussion
   • You can make recommendations, though the choice is ultimately hers

50 Once You’ve Picked a Method
   • Clear instructions on how to use the method
   • Clear instructions on back up methods (if needed)
   • Common side effects
   • Warning signs
     – Head and shoulders, knees and toes it hurts really bad, call or come in right away
     – Infection symptoms post-IUD
   • How to fill her prescription or get refills

51 Patient Resources
   • Great handouts available from Reproductive Health Access
ICD-10 codes to know

My daily experience #1

June is 23 and has been using pills for the past 4 years, she’s here today for a refill with no complaints.

– When asked: When might you want to become pregnant (if ever)?
  – She answers: oh, at LEAST 5 years, but maybe more like 7, I have way too much going on.

– Here’s an opportunity to ask: Have you thought about any of the long-acting reversible methods, or talked with anyone about them?

My daily experience #2

Jill is a 31 year G2 P2 also here for a pill refill, she has been on a medium dose monophasic for 7 years between and after pregnancies and has no complaints today.

– When asked: Do you like to skip periods or spaced out periods when you take your pill?
  – She answers: I didn’t know you could do that, is that a new thing?

– Here’s an opportunity to talk about continuous cycling, or even other methods.

Jill (continued)

So after blowing Jill’s mind by telling her she can skip periods as much or as little as she wants (you’re now her favorite provider, by the way), you ask her about plans for future pregnancies.

– She and her long-term partner don’t think they want any more kids, but she doesn’t have time to take off work to get her tubes tied and isn’t totally sure about it...

Permanent Methods
• Hysteroscopic tubal ligation (Essure)
  – Need a good method of contraception for at least 12 weeks post-procedure
• Vasectomy
  – Need a good method of contraception for at least 12 weeks post-procedure
• Tubal ligation (surgical)

56 Bleeding issues
• Jackie is 25 and taking Portia continuously, she comes in because she wants a different method because she has been bleeding daily for about 3 and a half weeks and is totally over it!
• Questions for Jackie: what time of day are you taking your pill? Are you pretty consistent taking it at that time? Any other symptoms? How many weeks/months have you been taking the pill continuously?

57 Jackie’s answers
• She is on time with her pill every day
• No vaginal infection symptoms, no new meds or anything new since we saw her 4 months ago
• She has been taking pills every day for those 4 months because we told her to

58 Take a break
• Sorry, not that kind of a break
• Jackie likely needs to have a hormone free interval 3-4 days off and then right back in to taking it
• Remember: her uterus is still in control, don’t fight it
• Remember: if she quick starts her BCM, she might have more bleeding irregularities

59 What if Jackie’s using the ring or patch?
• Same thing:
  – Ring out, rinse off, leave out for 3 days in that little foil
pouch
– Same ring goes back in (or a new one)
– You can keep the same ring change day if you want

60 Oregon Health Authority
Effective Contraception Quality Measure
• Denominator: women on Medicaid ages 15-50
• Numerator: Tier 1 or 2 contraceptive use coded within the 12 month measurement period
• Exclusions: hysterectomy, oophorectomy, early menopause, pregnancy
• Methods included: sterilization, all the methods we talked about today, diaphragms

61 What are they looking at?
• CCOs in Oregon (16 of them)
  – Are the patients cared for by the CCO receiving effective contraception?
• Incentivizes CCOs to set up systems for women to have access to effective contraception
• Does not pay to individual providers
• Does not pay women for using BCM

62 CPT and ICD codes count
• Both CPT (procedure codes) for contraception methods as well as diagnosis ICD codes will count for the numerator

63 ICD-10 codes to know