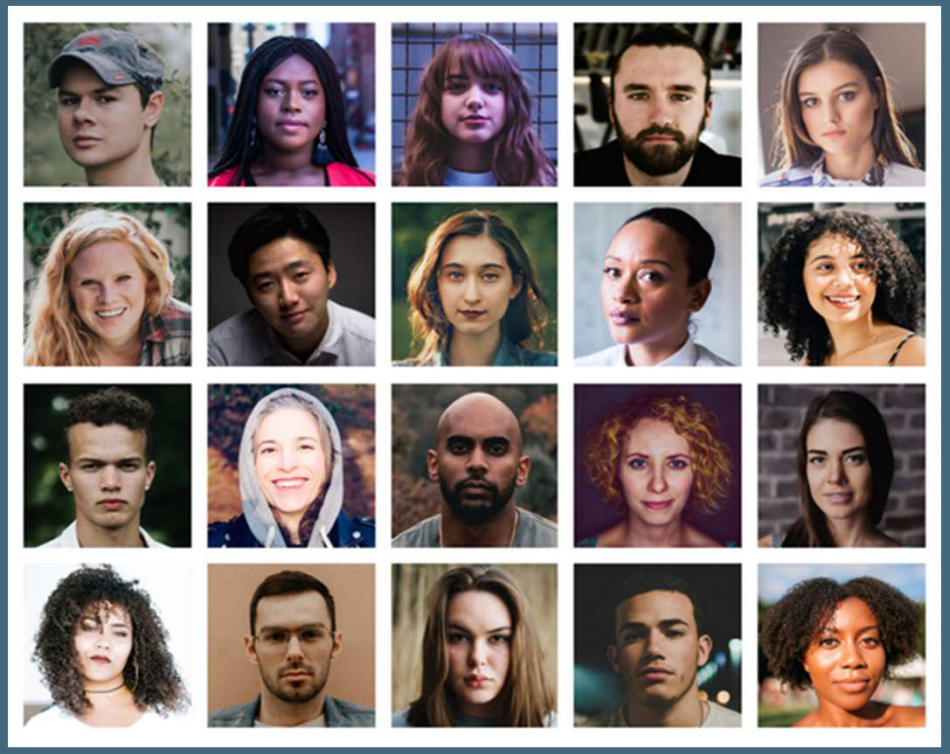
CALIFORNIA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR CALIFORNIA

Reproductive Health Care



Conversations for Clinicians and Their Patients

California Academy of Family Physicians | 2018

Catherine McCarthy, MD

Professor

University of Nevada, Reno School of Medicine

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This initiative is supported by a grant from the California Academy of Family Physicians Foundation.

Declaration of Interest Statements

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Congenital anomalies can occur with use of which of the following?

A. Statins
B. Isotretinoin
C. Methotrexate
D. All of the above

What is needed before prescribing combined hormonal contraceptives?

A. Blood pressure
B. Pap
C. Pelvic exam
D. All of the above

Which of the following has a failure rate of about 6% per year?

A. Implant
B. IUDs
C. Injectable (DMPA)
D. None of the above

Objectives

By the end of this session, participants will be able to:

- Normalize discussions about sex in the primary care setting
- Recognize the diversity in patient needs and preferences around reproduction and contraception
- Provide patient-centered counseling
- Use evidence-based guidelines while prescribing contraceptives

Background

- **45%** of US pregnancies are unintended.
- Most unintended pregnancies occur when no or less effective methods are used.
- Our patients are diverse, and part of that diversity is the complexity of feelings about sexuality, contraception, and reproduction

Finer LB and Zolna MR, Declines in unintended pregnancy in the United States, 2008–2011, *New England Journal of Medicine*, 2016, 374(9):843–852


Healthy pregnancy
General health
Career
Relationships
Education
Avoidance of teratogens
Finances
Prenatal care
Management of chronic medical conditions

"Would you like to become pregnant in the next year?"

Would you like to become pregnant in the next year?

YES (preconception planning)

- Lifestyle modification
- Nutrition/weight management
- Chronic disease management
- Folic acid
- Avoidance of toxins
- Vaccines

NO

- Is there any chance that you might get pregnant in the next year?
- What are you doing to prevent pregnancy?

But what about the third answer……."I don't know"?

- Pregnancy ambivalence is common
- That's ok
- It is an opportunity to explore some more with the patient

Katherine

25-years-old, presenting with UTI

Katherine is a type 2 diabetic; she's not always under control

Her latest A1C was 10.5%

You ask check in with her about pregnancy intention

Time Out to Talk

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Incidence of Congenital Anomalies by Exposure

Rate	Exposure
3%	Low dose methotrexate
5%	Hgb A1C 6.9-8.8
8%	Carbamazepine
11%	Phenytoin
13%	ACE-I
16%	Hgb A1C >10.4
16%	Methamphetamine use
20%	Divalproex
38%	Statin
46%	Isotretinoin

Best Practices for Katherine

- Ask about pregnancy intention
- Preconception counseling
- Prenatal vitamins
- Harm reduction
- Discuss diabetes control
- Review of medications

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Louise

42-years-old, with two teenagers who comes in for a routine visit and believes she is peri-menopausal.

BP 148/92

You ask about pregnancy intent

Time Out to Talk

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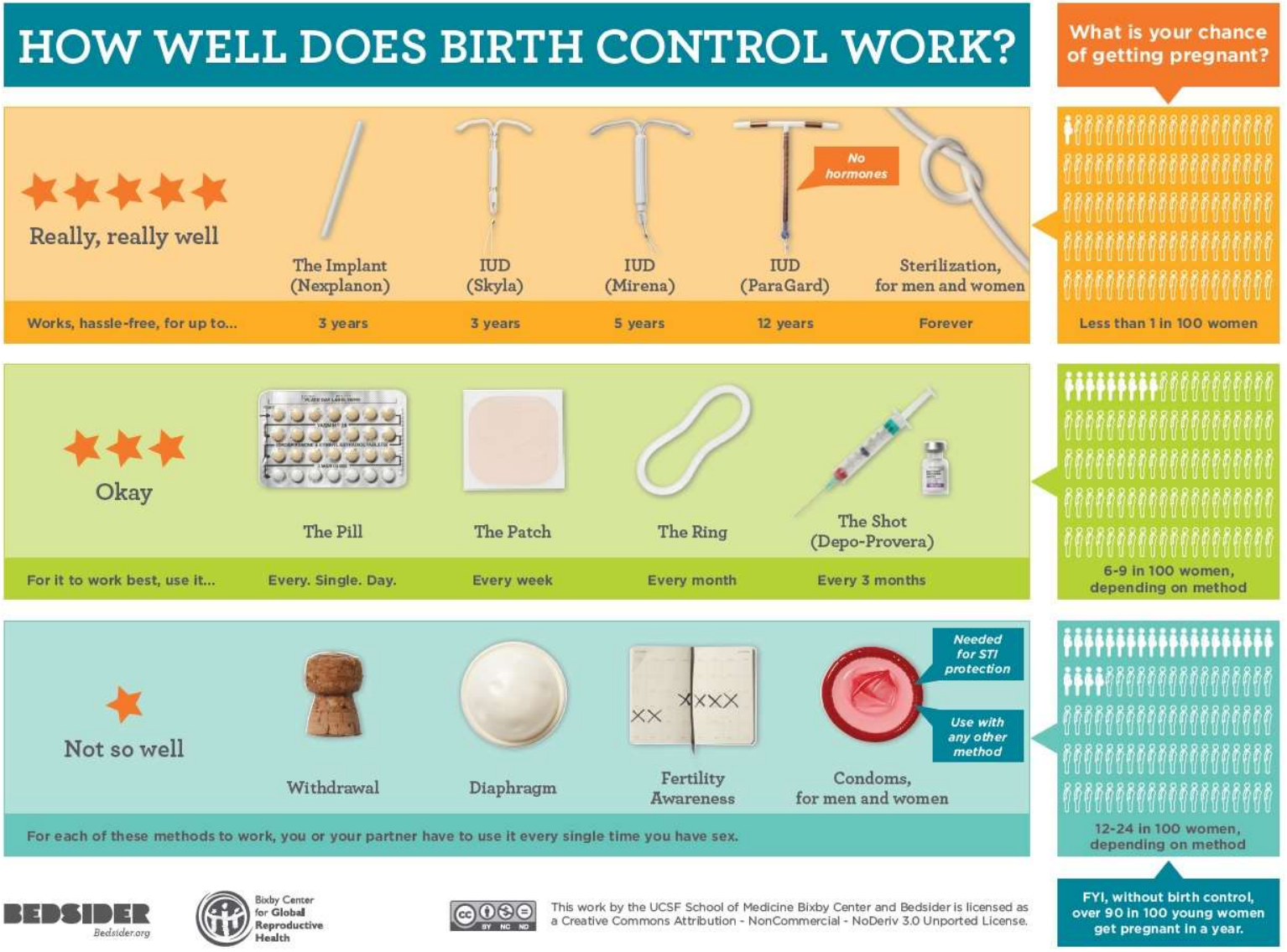
HOW WELL DOES BIRTH CONTROL WORK?
What is your chance of getting pregnant?
Really, really well
The Implant (Nexplanon)
IUD (Skyla)
IUD (Mirena)
IUD (ParaGard)
No hormones
Sterilization, for men and women
Works, hassle-free, for up to...
3 years
3 years
5 years
12 years
Forever
Less than 1 in 100 women
Okay
The Pill
The Patch
The Ring
The Shot (Depo-Provera)
For it to work best, use it...
Every. Single. Day.
Every week
Every month
Every 3 months
6-9 in 100 women, depending on method
Not so well
Withdrawal
Diaphragm
Fertility Awareness
Condoms, for men and women
Needed for STI protection
Use with any other method
For each of these methods to work, you or your partner have to use it every single time you have sex.
12-24 in 100 women, depending on method
FYI, without birth control, over 90 in 100 young women get pregnant in a year.
BEDSIDER
Bedsider.org
Bixby Center for Global Reproductive Health
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Need a handy app for everyday reference?

- Go to the app store
- Search “contraception”
- Select the first option “Contraceptive Pont of Care”
- OR the second option “Contraception” by the CDC

What is Needed Before Prescribing Combined Hormonal Contraceptives?

REQUIRED	RECOMMENDED	NOT REQUIRED
Medical history Blood pressure	BMI	Pap Pelvic exam STI testing Hemoglobin

US Selected Practice Recommendations for Contraception Use. CDC, 2016.

Stewart F, et al. Clinical breast and pelvic examination requirements for hormonal contraception: Current practice vs evidence. *JAMA.* 2001;285:2232-9.

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		LNG-IUD		Implant		DMPA		POP		CHC	
		I	C	I	C	I	C	I	C	I	C	I	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		LNG-IUD		Implant		DMPA		POP		CHC	
		I	C	I	C	I	C	I	C	I	C	I	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:

Abbreviations: C=continuation of contraceptive method; CHC=combined hormonal contraception (pill, patch, and, ring); COC=combined oral contraceptive; Cu-IUD=copper-containing

1	No restriction for the use of the contraceptive method for a woman with that condition
2	Advantages of using the method generally outweigh the theoretical or proven risks
3	Theoretical or proven risks of the method usually outweigh the advantages – not usually recommended unless more appropriate methods are not available or acceptable
4	Unacceptable health risk if the contraceptive method is used by a woman with that condition

Condition	Sub-Condition	Cu-IUD		LNG-IUD		Implant		DMPA		POP		CHC	
		I	C	I	C	I	C	I	C	I	C	I	C
Hypertension	a) Adequately controlled hypertension	1*		1*		1*		2*		1*		3*	
	b) Elevated blood pressure levels (*properly taken measurements*)												
	i) Systolic 140-159 or diastolic 90-99	1*		1*		1*		2*		1*		3*	
	ii) Systolic ≥160 or diastolic ≥100‡	1*		2*		2*		3*		2*		4*	
	c) Vascular disease	1*		2*		2*		3*		2*		4*	

https://www.cdc.gov/reproductivehealth/unintendedpregnancy/pdf/legal_summary-chart_english_final_tag508.pdf

But, what about last night's unprotected sex?

OOPS! EMERGENCY CONTRACEPTION: BIRTH CONTROL THAT WORKS *AFTER* SEX

Types of emergency contraception	How well does it work?	How soon do I have to use it?	How do I use it?	Where can I get it?
 ParaGard IUD	Almost 100% effective (1st)	Within 5 days	It's placed in the uterus by a doctor or nurse. Keeps working as super effective birth control.	From a doctor, nurse, or at a clinic. Say it's for EC so you are scheduled quickly.
 Ella	(2nd) Less effective if over 195 pounds. Try an IUD.	ASAP. Works better the sooner you take it, up to 5 days.	Take the pill as soon as you get it. Remember to use it every time you have unprotected sex.	From a doctor, nurse, or at a clinic. Get an extra pack for future emergencies.
 Plan B One-Step or a generic	(3rd) Less effective if over 165 pounds. Try ella or an IUD.	ASAP. Works better the sooner you take it, up to 3 days.	Take the pill as soon as you get it. Remember to use it every time you have unprotected sex.	At a pharmacy, no prescription needed. Get an extra pack for future emergencies.

BEDSIDER Bedsider.org

Bixby Center for Global Reproductive Health

For more information, check out not-2-late.org

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Emergency Contraception

FOR _____ DATE _____

ADDRESS _____

℞ REFILL _____ TIMES

Ulipristal 1 tab PO x 1 within 120 hours of unprotected intercourse.

_____ _____

DISPENSE AS WRITTEN PRODUCT SELECTION PERMITTED

DEA NO. _____ ADDRESS _____

Reorder Item #6100 Total Pharmacy Supply, Inc 1-800-878-2822

FOR _____ DATE _____

ADDRESS _____

℞ REFILL _____ TIMES

Levonorgestrel 1.5mg 1 tab PO x 1 ASAP within 120 hours (best within 72 hours) of unprotected intercourse.

_____ _____

DISPENSE AS WRITTEN PRODUCT SELECTION PERMITTED

DEA NO. _____ ADDRESS _____

Reorder Item #6100 Total Pharmacy Supply, Inc 1-800-878-2822

OOPS! EMERGENCY CONTRACEPTION: BIRTH CONTROL THAT WORKS *AFTER* SEX

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Best Practices for Louise

- Ask about pregnancy intention
- Use patient-centered counseling
- Consider a tiered-effectiveness visual tool
- Always consult the MEC when prescribing birth control
- Offer emergency contraception and condoms

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Michael

18-years-old, a high school student, who comes to you because his girlfriend of four months told him she tested positive for chlamydia.

After reviewing presumptive treatment and discussing ways to reduce future risk of STI transmission …

You ask about pregnancy intention

Time Out to Talk

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Why Should We Ask Men?

- Adolescent men rarely discuss sexual and reproductive health with their health care providers.
- Opportunity to provide accurate information and guidance on everything from obtaining consent to decreasing risk of an unintended pregnancy or STI
- More likely to support their partners in decisions on contraceptive use and family planning

Best practices for Michael

- Ask about pregnancy intention
- Create an opportunity to ask about sexual and reproductive health
- Encourage him to discuss contraception with his partner
- Other great topics to discuss: negotiating consent, STI prevention, male sexual health

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Anne

17-years-old, they have an appointment to renew their birth control prescription before they head to college next month. Their mom made this appointment for them.

Time Out to Talk

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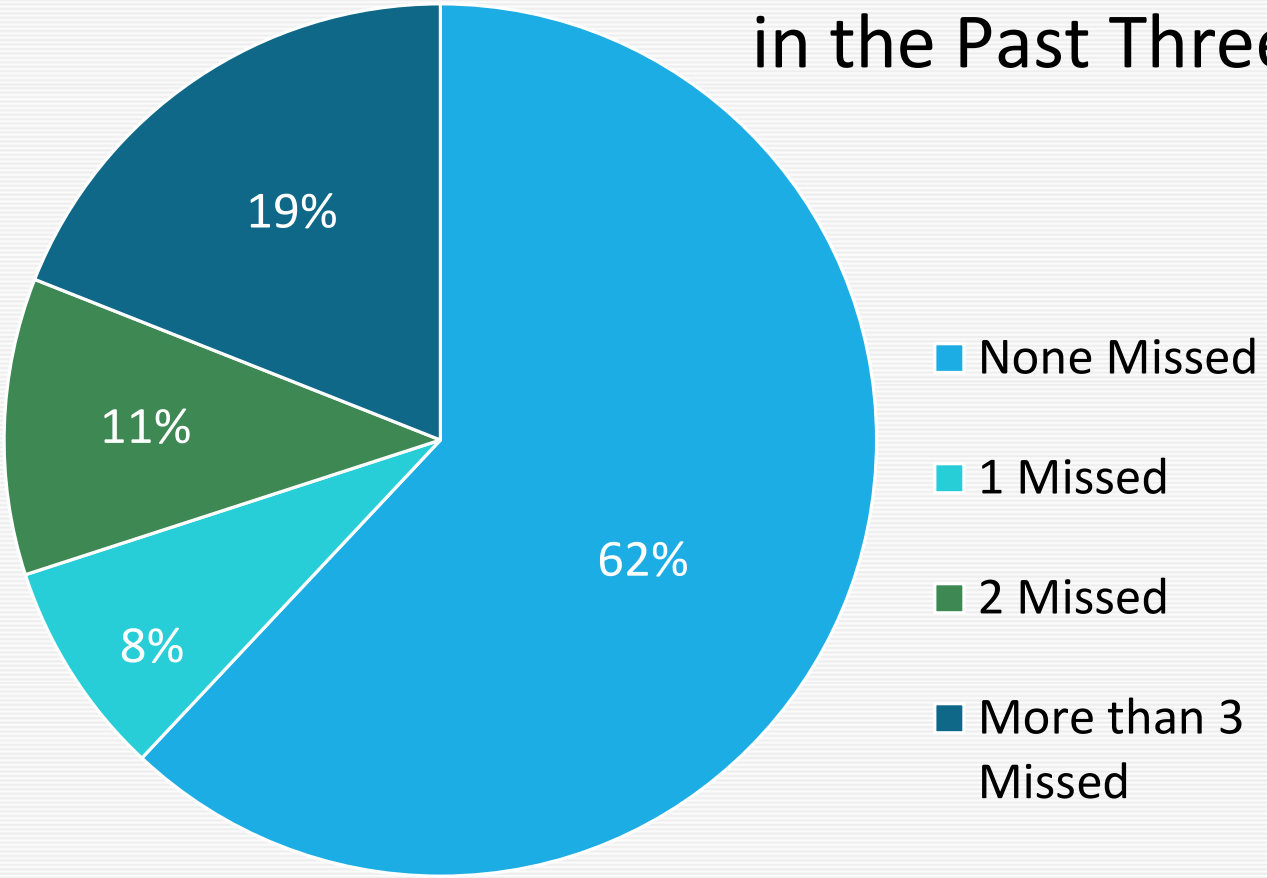
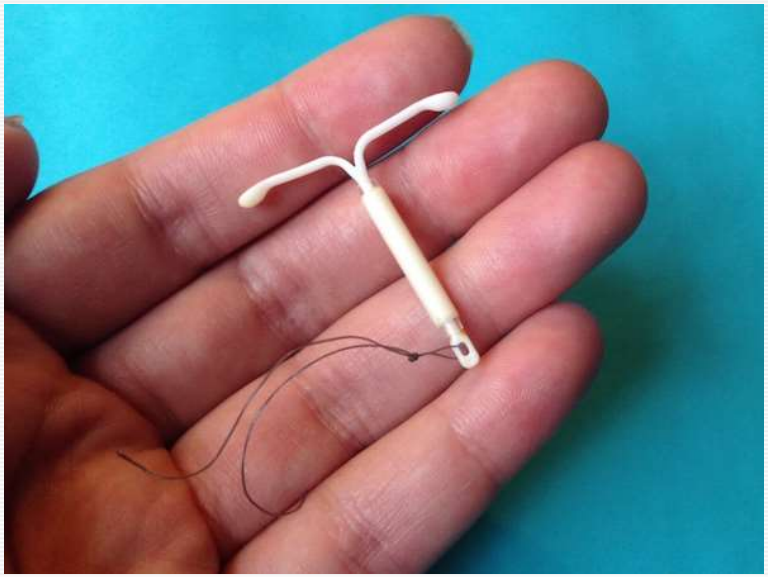
Pill-users Who Missed a Dose in the Past Three Months





- 1 IUD used for 3 years = 1,095 pills
- 1 contraceptive implant used for 4 years = 1,461 pills
- 1 IUD used for 5 years = 1,826 pills
- 1 IUD used for 12 years = 4,380 pills

One Year Failure Rates

Effectiveness	Contraceptive	Typical-Use Pregnancy Rate
Ineffective	Chance	85%
Less effective	Condoms	18%
More effective	Pill/patch/ring	9%
	Injectable	6%
Highly effective	IUDs	0.2-8%
	Sterilization	0.15-0.5%
	Implant	0.05%

Best Practices for Anne

- Use patient-centered counseling to identify barriers and solutions for patients
- Remember that many birth control methods have non-contraceptive benefits
- Offer same-day LARC insertion whenever possible

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Marian

31-years-old, has migraines with aura, a mother of two young children. You have seen her three times in the past two years, and she is coming into today for a “woman’s” visit.

You ask about pregnancy intent.

Time Out to Talk

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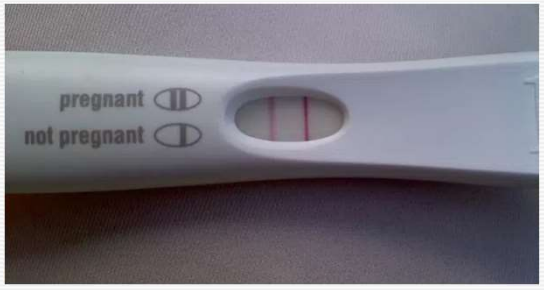
What do you need to know before you can insert a contraceptive implant?

- Hint: Look at the “Quickstart” Algorithms

CDC Selected Practice Recommendations

CDC recommends that you must be reasonably certain a patient is not pregnant prior to inserting an implant.

- Marian tells you she had unprotected sex six weeks ago (when she wasn't taking her progestin-only pill regularly), so you do a pregnancy test, which reveals she is pregnant.
- Her implant appointment is suddenly converted to a pregnancy options visit.



- The right way to deliver a positive pregnancy test result
  - Assume nothing about how the patient will react
  - Have no agenda yourself
  - Allow time for the patient to process the information
  - Use completely neutral language.
  - Example: “Your pregnancy test result is positive, which means that you are pregnant.” PAUSE “Is that the result you were expecting? How are you feeling?”

But what do I say?

- VALIDATE: “It can be really overwhelming to learn that you are pregnant when you weren’t expecting it.”
- OFFER ASSISTANCE: “Sometimes it is helpful to go over your options, so you have all the information you need to make an informed decision.”
- SUPPORT: “Whatever you end up deciding, I will help you get the care you need.”

What are the three pregnancy options?

- Continue the pregnancy and *become a parent*
- Continue the pregnancy and *make an adoption plan*
- End the pregnancy by having an *abortion*

Best Practices for Marian

- Offer same-day LARC insertion
- Follow the CDC Selected Practice Recommendations and use the Quickstart algorithms when initiating contraception
- Be ready to deliver unexpected news
- Provide options counseling
- Use the techniques: validate, offer assistance, and support

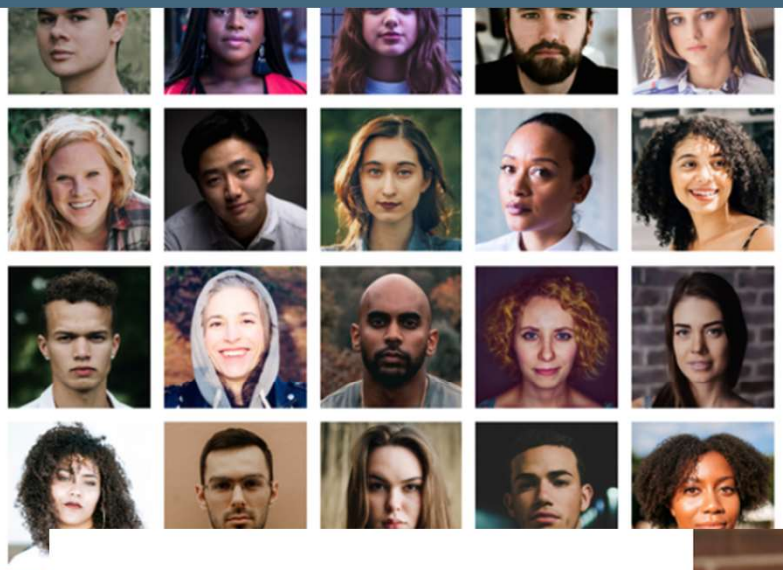
Final Thoughts

- Trust your patient
- You are listening without an agenda
- You present options and information
- The patient knows what they need
- Be comfortable with ambivalence

LEARNER SELF-ASSESSMENT

You are encouraged to participate in this online assessment. The knowledge and attitude assessment will give you a sense of practice gaps and assist you in planning educational interventions to close the gaps. Colleagues from every state will be participating, and you'll be able to see where you fall in the scoring. The assessment also includes the correct answers and all citations and rationales. The LSA is sponsored for .25 AAFP Prescribed or *AMA PRA Category 1 credits™* and is free to all health care clinicians.

GO TO ASSESSMENT



MAINTENANCE OF CERTIFICATION

CAFP, in partnership with Interstate Postgraduate Medical Association, has developed an ABFM Part IV Improving Performance in Practice module. This module is designed to increase the use of One Key Question® for reproductive health planning, enhance physician-patient communication, and improve team approaches to care. The module is approved for ABFM Part IV credit, includes 30 AAFP Prescribed credits upon completion and is based on a team-approach [*AMA PRA Category 1™* credit also is available]. The Part IV module is appropriate for any family physician, family medicine resident or other primary care physician plus your teammates. Questions? Contact Shelly Rodrigues at srodrigues@familydocs.org.

GO TO MODULE

California Academy of Family P

Designed

for family physicians …
by family physicians

www.familydocs.org/rhi

What Tools and Resources are Available?

Start at **www.familydocs/rhi**

- OneKeyQuestion
- Bedsider.org
- www.reproductiveaccess.org
- Contraception Point-Of-Care app (Android and IOS)
- CDC US Medical Eligibility for Contraceptive Use

https://wwwn.cdc.gov/pubs/CDCInfoOnDemand.aspx?ProgramID=195 (for add'l free handouts)

Congenital anomalies can occur with use of which of the following?

A. Statins
B. Isotretinoin
C. Methotrexate
D. All of the above

Reference: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2810038/

What is needed before prescribing combined hormonal contraceptives?

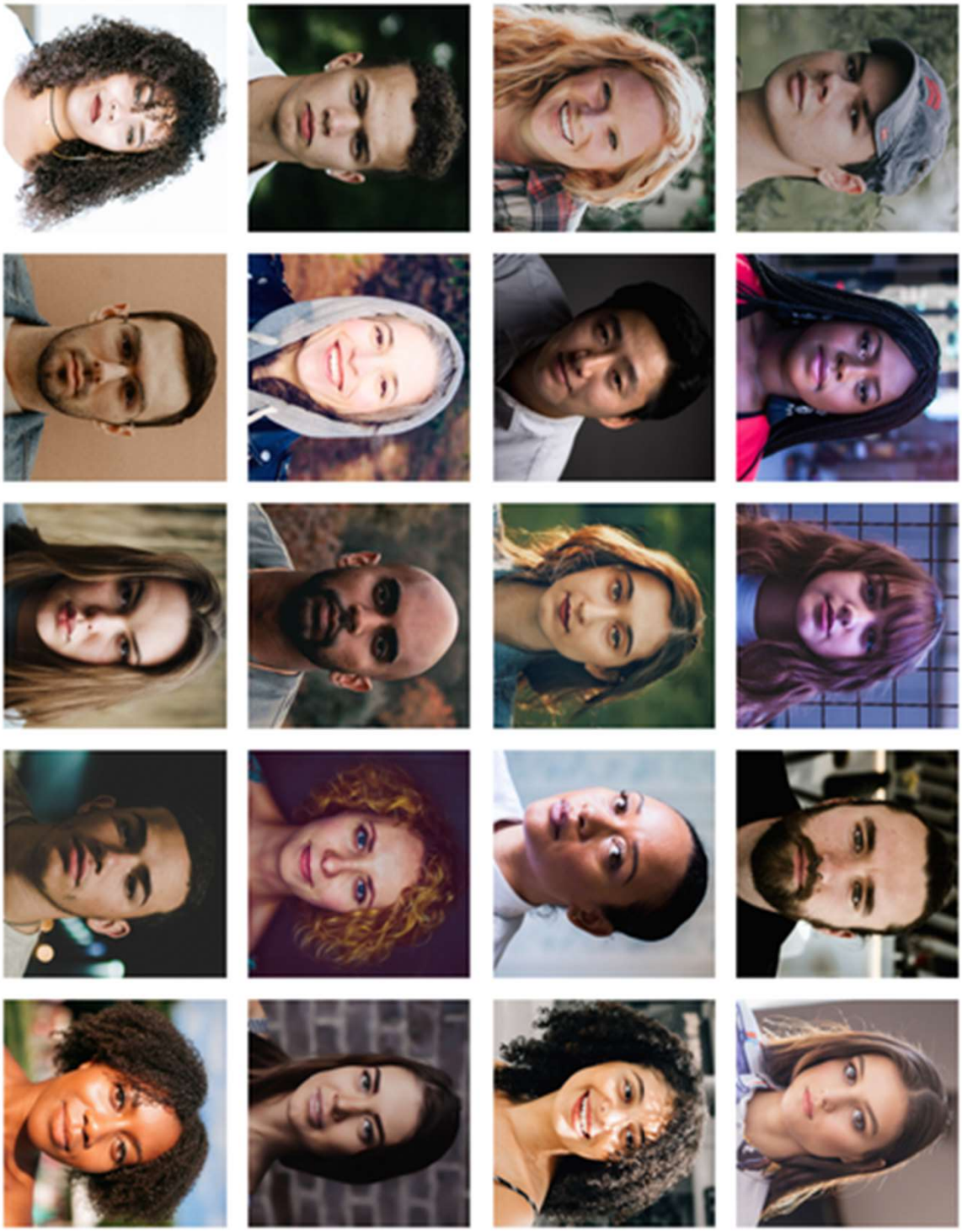
A. Blood pressure
B. Pap
C. Pelvic exam
D. All of the above

Reference: US Selected Practice Recommendations for Contraception Use. CDC, 2016.
Stewart F, et al. Clinical breast and pelvic examination requirements for hormonal contraception: Current practice vs evidence. *JAMA.* 2001;285:2232-9.

Which of the following has a failure rate of about 6% per year?

A. Implant
B. IUDs
C. Injectable (DMPA)
D. None of the above

Reference: http://www.contraceptivetechnology.org/wp-content/uploads/2013/09/Contraception-Effectiveness.pdf



Thank You

Questions?

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Rapid Fire Myth-Busting: Is it a Fact or a Myth?

It is evidence-based to place an IUD in a nulliparous non-monogamous teen.

FACT

CDC guidelines for assessing pregnancy status without a pregnancy test

No signs or symptoms of pregnancy and meets at least one of the following criteria:

- Less than 7 days from the start of a normal menses
- No intercourse since the start of last normal menses
- Correctly and consistently using a reliable method of contraception
- Less than 7 days from a spontaneous or induced abortion
- Within 4 weeks postpartum
- Fully breastfeeding, amenorrheic and less than 6 months postpartum

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A history of PID (such as Gonorrhea and/or Chlamydia) is an absolute contraindication to IUD insertion.

MYTH

US Selected Practice Recommendations from CDC

- *IF* patients have been appropriately screened in the past, STI testing is unnecessary for IUD insertion
- *IF* patients have not been screened per guidelines, then CDC says to do same day screening and IUD insertion
- *IF* women have purulent cervicitis or symptomatic chlamydia or gonorrhea should delay IUD insertion

Contraceptive use does not affect fertility and will not make it "harder" to get pregnant in the future.

FACT

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Intrauterine contraceptives increase the risk of ectopic pregnancy.

MYTH

Amenorrhea caused by continuous use of contraception is associated with major depressive disorder.

MYTH

Continuous use of OCPs is safe for patients.

FACT

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It's important to check a patient's blood pressure before prescribing birth control pills.

FACT

Long term use of depot medroxyprogesterone acetate (DMPA) is associated with an increased risk of femoral neck fractures.

MYTH

42% of family planning providers use IUDs, compared to 12% of the general population.

FACT

Depot medroxyprogesterone acetate (DMPA) is too dangerous for teens.

MYTH

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Transgender men and women have sexual and reproductive healthcare needs that can be met in a family medicine clinic.

FACT

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The placement of IUDs increase the risk of abortion.

MYTH

The CDC MEC provides evidence-based recommendations about birth control prescriptions.

FACT

Liletta® does NOT have bio-equivalency to Mirena®.

MYTH

Scheduled bleeding every four weeks on combined hormonal contraceptives is the same thing as a period.

MYTH