NFPRHA Regional Meeting
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Special Topics in Quality Family Planning (QFP) Services

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So...What’s The “Big Deal” About The QFP?

• Completes, and ties together, the CDC “suite” of family planning guidelines
• Prioritizes the core content of contraceptive services
• Defines the “borders” between family planning and other preventive services
• Specifies which interventions are recommended *for each* of the 7 family planning service types
• Emphasizes the role and content of contraceptive counseling
• Refines the content of male family planning services
The QFP in 4 Sound Bites

• Scope of **family planning services**
  – Pregnancy prevention ➔ prevention + achievement

• Focus of **the family planning visit**
  – Exam room ➔ consultation room

• Model of **contraceptive counseling**
  – Directive ➔ informed choice ➔ shared decision making

• Content of **clinical care**
  – Five CDC Guidelines + QFP “fills in the gaps”
The “Suite” of CDC Family Planning Recommendations

- Achieving Pregnancy Guidelines
- Contraception Guidelines
- Preconception Guidelines
- STD & HIV Guidelines

United States Medical Eligibility Criteria for Contraceptive Use
United States Selected Practice Recommendations for Contraceptive Use
Show Your Love Preconception Health

STD Treatment Guidelines 2010
Filling The “Gaps”

- Pregnancy testing and counseling
- Achieving pregnancy
- Basic infertility
- Preconception health
- Preventive health screening of women and men
- Contraceptive counseling

Continuing Education Examination available at http://www.cdc.gov/mmwr/cms/contents.html
# Checklist

Family planning and related preventive health services

## for women

<table>
<thead>
<tr>
<th>Screening components</th>
<th>Contraceptive services</th>
<th>Pregnancy testing and counseling</th>
<th>Basic infertility services</th>
<th>Preconception health services</th>
<th>STD services</th>
<th>Related preventive health services</th>
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<tbody>
<tr>
<td><strong>History</strong></td>
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</tr>
<tr>
<td>Reproductive life plan</td>
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<td>✓</td>
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<tr>
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<td>✓</td>
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<tr>
<td>Current pregnancy status</td>
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<tr>
<td>Sexual health assessment</td>
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<td>✓</td>
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<td></td>
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<tr>
<td>Intimate partner violence</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Alcohol &amp; other drug use</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tobacco use</td>
<td>✓ (combined hormonal methods for clients ≥35 years)</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Immunizations</td>
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<tr>
<td>Folic acid</td>
<td>✓</td>
<td></td>
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</table>
**Family planning services**  
*(provide services in accordance with the appropriate clinical recommendation)*

<table>
<thead>
<tr>
<th>Screening components</th>
<th>Contraceptive services¹</th>
<th>Pregnancy testing and counseling</th>
<th>Basic infertility services</th>
<th>Preconception health services</th>
<th>STD services²</th>
<th>Related preventive health services</th>
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<tbody>
<tr>
<td><strong>Physical examination</strong></td>
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<tr>
<td>Height, weight &amp; BMI</td>
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<td></td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
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<tr>
<td>Blood pressure</td>
<td>✓ (combined hormonal methods)</td>
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<td></td>
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</tr>
<tr>
<td>Clinical breast exam</td>
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<td>✓</td>
<td>✓</td>
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<tr>
<td>Pelvic exam</td>
<td>✓ (initiating diaphragm or IUD)</td>
<td>✓ (if clinically indicated)</td>
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<td>Signs of androgen excess</td>
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<tr>
<td>Thyroid exam</td>
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<td><strong>Laboratory testing</strong></td>
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<tr>
<td>Pregnancy test</td>
<td>✓ (if clinically indicated)</td>
<td></td>
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<tr>
<td>Chlamydia</td>
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<td></td>
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<td></td>
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<tr>
<td>Gonorrhea</td>
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<td>Syphilis</td>
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<tr>
<td>HIV/AIDS</td>
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<tr>
<td>Hepatitis C</td>
<td>✓</td>
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<td></td>
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<tr>
<td>Diabetes</td>
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<td></td>
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<tr>
<td>Cervical cytology</td>
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<tr>
<td>Mammography</td>
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</table>
Does The QFP “Add New Services” to Title X?

• Non-contraceptive family planning services historically have been a part of Title X, but not well defined...
  – Achieving pregnancy and basic infertility
  – Preconception health
  – Pregnancy testing and counseling

• Not expected that these services will be provided to every client, but should be available to those in need of them
QFP: Achieving Pregnancy

• Address needs of clients who have been trying to get pregnant for less than 12 months
• Screening including medical history, current IPV/SV, alcohol & other drug use, tobacco use
• Counseling on fertility awareness & techniques to predict ovulation, lifestyle influences

ASRM (2008), ACOG (2007)
QFP: Basic Infertility Services

• Address needs of clients who
  – Have failed to achieve pregnancy after 12 months or more of regular unprotected intercourse
  – Earlier assessment may be justified in some cases (e.g., for women aged >35 years)
  – Screening history and exam for female clients

  • Medical history
  • Alcohol & drug use
  • Tobacco use
  • Blood pressure
  • BMI

  • Thyroid enlargement
  • Breast secretions
  • Signs of androgen excess
  • Pelvic exam

  (ASRM 2004)
QFP: Preconception Health Services

• Preconception health services should be offered to female and male clients

• Priority populations
  – Removal of IUC or implant to become pregnant
  – Trying to achieve pregnancy, including negative preg test visits
  – Basic infertility services
  – Clients at high risk of unintended pregnancy
QFP: Preconception Health Services

• Aim to identify and modify biomedical, behavioral, and social risks

• Promote health **before** conception, reducing pregnancy-related adverse outcomes
  – Low birth weight
  – Premature birth
  – Infant mortality

• Improve women’s and men’s health even if they choose not to have children
QFP: Preconception Services for Men

• Address men as partners in both preventing and achieving pregnancy including:
  – Direct contributions to infant health & fertility
  – Role in improving the health of women

• Improve the health of men, regardless of pregnancy intention
QFP Recommendations: Counseling & Education
Approaches to Contraceptive Counseling

Client Centered
- WYW
- IWYG

Clinician Centered
- Directive
- Shared Decision Making
- Consumerist Aka Informed Choice
What You Want Is What You Get

- **Example:** “if you want the Pill, let’s make sure it’s safe for you”
- Little or no information sharing beyond medical history
- Client is active; clinician is passive, unless there is a method contraindication
- **Risks to the client**
  - Client may not know (much) about other options
  - Client choice may be biased by misinformation
  - Clinician has no input, unless contraindications
Directive Counseling

- **Example:** “here’s my opinion of the best method for you”
- Fits the illness model of a clinician-client relationship
- Clinician is active; client is passive
- Advice may be biased by the client’s age, sexual or pregnancy history, socio-economic status, or race/ethnicity

- **Risk to the client**
  - The client may feel pressured by the clinician
  - The method may not be best for her lifestyle, relationship, or acceptance of side effects
  - Relatively higher risk of discontinuation
Consumerist Counseling
(aka: Informed Choice)

- **Example**: “here are all of the methods available to you, including the pros and cons”
  - *Foreclosed*: info about a limited number of methods
- Clinician is active but makes no recommendation; the client is passive until the time to make a decision
- Maximizes client autonomy
- **Risk to the client**
  - Clinician has no input, unless contraindications
  - Client may not integrate the information given with her values and personal preferences
Tiered Effectiveness

Informed Choice+ Directive Counseling

Most Effective

- Implant: 0.05%*
- Reversible Intrauterine Device (IUD): LNG - 0.2% Copper T - 0.8%
- Male Sterilization (Vasectomy): 0.15%
- Permanent Female Sterilization (Abdominal, Laparoscopic, Hysteroscopic): 0.5%

Injectable: 6%

Pill: 9%

Patch: 9%

Ring: 9%

Diaphragm: 12%

Male Condom: 18%

Female Condom: 21%

Withdrawal: 22%

Sponge:
- 24% parous women
- 12% nulliparous women

Fertility-Awareness Based Methods

Spermicide: 28%

* The percentages indicate the number out of every 100 women who experienced an unintended pregnancy within the first year of typical use of each contraceptive method.
Shared Decision Making

- **Example:** “what are you looking for in a method?”
- *Relational communication:* explore the client’s “back-story”
- *Task oriented communication*
  - Provide information about potential methods
  - Account for the client’s medical history
  - Identify client method preferences
  - Ensure that preferences are not biased by misinformation
  - Reach a mutually acceptable decision
- **Risks**
  - Takes clinician time and skill
Shared Decision Making

Explore the client’s “back-story”

• Attitude about future fertility
  – “Would you like to have kids someday?”
  – If yes, “When do you think that might be?”

• Attitude about prevention vs. delay of pregnancy
  – “How important is it to prevent pregnancy until then?”

• Prior experience with contraceptive method(s)

• Attitude toward side effects

• Interest in non-contraceptive “life-style” attributes of method

• Women controlled method vs. shared with partner
Five Principles of Quality Counseling

1: Establish and maintain rapport with the client
2: Assess the client’s needs
3: Work interactively to establish a plan
4: Provide materials that can be understood and retained
5: Confirm client understanding
Contraceptive Counseling in a Nutshell

• Not...
  – What method do you want?

• Instead...
  – What do you want in a method?
Case Study

• 33 year old G₃P₃ established patient seen for family planning health screening visit
• Using metformin for type 2 diabetes
• Mutually monogamous relationship
• Recent fasting lipid profile normal
• LMP 3 weeks ago; using condoms for contraception
• Cervical cytology test 2 years ago was negative
• Screened negative for HIV in each of her 3 pregnancies
Case Study

- Would like to start oral contraceptives...today if possible
  - 13 cycles of monophasic dispensed
- Face-to-face time: 23 minutes; 18 minutes counseling
- What needs to be done in regard to...
  - Counseling?
  - Method choice?
  - Screening tests?
  - Encounter coding?
  - Out-of-pocket cost sharing (e.g., co-payment)?
Reproductive Life Plan Questions

- Do you hope to have any (more) children?
- How many children do you hope to have?
- How long do you plan to wait until you next become pregnant?
- How much space do you plan to have between your pregnancies?
- What do you plan to do until you are ready to become pregnant?
- What can I do today to help you achieve your plan?
One Key Question

Would You Like to Become Pregnant in the Next Year?

Do I want to become pregnant in the next year?

www.onekeyquestion.org
# US MEC 2010: Diabetes

<table>
<thead>
<tr>
<th>Health Condition</th>
<th>OC/P/R</th>
<th>POP</th>
<th>DMPA</th>
<th>Impl</th>
<th>LNG-IUD</th>
<th>Cu-IUD</th>
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<tr>
<td><strong>Hx gestational diabetes</strong></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
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<tr>
<td><strong>Nonvascular disease</strong></td>
<td></td>
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</tr>
<tr>
<td>i. Noninsulin-dependent</td>
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<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
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<tr>
<td>ii. Insulin-dependent</td>
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<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
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<tr>
<td><strong>Nephropathy/retinopathy/neuropathy</strong></td>
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<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>1</td>
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<tr>
<td><strong>Other vascular disease or diabetes of &gt;20 yrs’ duration</strong></td>
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<td>2</td>
<td>3</td>
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<td>-------------------------------------------</td>
<td>-------------------------------------</td>
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</tr>
<tr>
<td>Blood pressure</td>
<td>OC, patch, ring</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical breast examination</td>
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</tr>
<tr>
<td>Weight (BMI)</td>
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<tr>
<td>Bimanual examination, cervical inspection</td>
<td>IUC, cap, diaphragm</td>
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<tr>
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<tr>
<td>STD screening with laboratory tests</td>
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<tr>
<td>HIV screening with laboratory tests</td>
<td>None</td>
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# CDC 2010: Routine STI Screening in Women

<table>
<thead>
<tr>
<th>Age</th>
<th>18-20</th>
<th>21-25</th>
<th>26-29</th>
<th>30-39</th>
<th>40-49</th>
<th>50-59</th>
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<tbody>
<tr>
<td>CT (Both)</td>
<td>Annually</td>
<td>Hi risk</td>
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<tr>
<td>HIV</td>
<td>Once, then Hi risk only</td>
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<tr>
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<td></td>
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<tr>
<td>Vag trich</td>
<td>Hi Risk</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Hepatitis C - CDC 2012</td>
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<td></td>
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</table>

- **Routine annual screening of sexually active women under 26**
- **One time screening of adults born 1945-1965**
<table>
<thead>
<tr>
<th>Age</th>
<th>18-20</th>
<th>21-25</th>
<th>26-29</th>
<th>30-39</th>
<th>40-49</th>
<th>50-59</th>
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<tbody>
<tr>
<td>Cervix CA</td>
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</tr>
<tr>
<td>• Cytology</td>
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<td>None</td>
<td>Q 3 yrs</td>
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<tr>
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<td>Q 3 yrs</td>
<td>Q5 yrs</td>
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<td></td>
<td></td>
<td>X</td>
<td>Annual</td>
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</tr>
<tr>
<td>• ACS</td>
<td>None</td>
<td>Q 3 yrs</td>
<td></td>
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<td>Annual with MG</td>
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<td>Mammogram</td>
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<tr>
<td>• ACS</td>
<td>None</td>
<td>Hi Risk</td>
<td></td>
<td>Annual</td>
<td>Q2y [C]</td>
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<tr>
<td>• USPSTF</td>
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<td>Hi Risk</td>
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<td>Q2y [B]</td>
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<tr>
<td>Colorectal cancer</td>
<td>None</td>
<td>Hi Risk</td>
<td></td>
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<td>[A]</td>
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</tbody>
</table>

ACOG: Am College of Ob-Gyn
ACS: American Cancer Society
CBE: Clinical breast exam
CDC: Centers for Disease Control
USPSTF: US Prev Services Task Force
Summary of Patient Management

- QFP: counseling based upon shared decision making
- MEC: can use oral contraceptives with same day start
- SPR: assess BP, BMI only (no other physical exam)
- STD: no STI screening tests indicated
- HIV: screening not necessary
- Cancer screening: clinical breast exam Q 1-3 years
- Preconception care:
  - *Discuss preconception glucose control with all diabetics*
- How should I code this visit???
Problem Oriented E/M Visits

Either:
- Composite of 3 key components (Hx + PE + MDM)

Or
- TIME, when greater than 50% of time is spent in counseling
### Problem Oriented E/M: Face-to-Face Time “Midpoints”

<table>
<thead>
<tr>
<th>New</th>
<th>Time (typical)</th>
<th></th>
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<tbody>
<tr>
<td>99201</td>
<td>&lt; 15 (10)</td>
<td></td>
</tr>
<tr>
<td>99202</td>
<td>16-25 (20)</td>
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</tr>
<tr>
<td>99203</td>
<td>26-37 (30)</td>
<td></td>
</tr>
<tr>
<td>99204</td>
<td>38-53 (45)</td>
<td></td>
</tr>
<tr>
<td>99205</td>
<td>&gt; 53 (60)</td>
<td></td>
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<table>
<thead>
<tr>
<th>Established</th>
<th>Time (typical)</th>
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<tbody>
<tr>
<td>99211</td>
<td>&lt; 7 (5)</td>
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<tr>
<td>99212</td>
<td>8-12 (10)</td>
<td></td>
</tr>
<tr>
<td>99213</td>
<td>13-20 (15)</td>
<td></td>
</tr>
<tr>
<td>99214</td>
<td>21-33 (25)</td>
<td></td>
</tr>
<tr>
<td>99215</td>
<td>&gt;33 (40)</td>
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Problem Oriented E/M Visit: *Time Factor*

- “Face-to-face Time” supersedes key indicators if > 50% of total FTF time is spent in counseling & care coordination
  - Includes time spent with patient *and/or* family members
  - Includes time spent on key components (e.g., exam)
  - Excludes pre- and post-encounter time
  - Excludes accommodation for disability or language

- Must document
  - Total FTF time *and* counseling time (or √ box for >50%)
  - Counseled regarding outcome, risks, benefits of...
  - Answered her questions regarding...
Patient Management

- QFP: counseling based upon shared decision making
- MEC: can use OCs with same day start
- SPR: assess BP, BMI only
- STD: no STI screening tests indicated
- HIV: screening not necessary
- Cancer screening: clinical breast exam Q 1-3 years
- Preconception care:
  - *Discuss preconception glucose control with all diabetics*
- E/M level: 99214 *based on time*
- ICD-9 diagnosis: V 25.01 (prescription of oral contraceptives)
Summary: What’s the Impact of the QFP on Clinical Services?

- Endorses a suite of integrated clinical guidelines
- Endorses “shared decision making” counseling
- Emphasizes that achieving pregnancy is as much a part of family planning as preventing or delaying it
- Provides clinical detail about non-contraceptive FP services for those clients who need it
- Acknowledges the shift that most family planning visits occur in the consultation room, and not the exam room