Same-Day Placement of Implants and IUDs: Solutions to Common Barriers

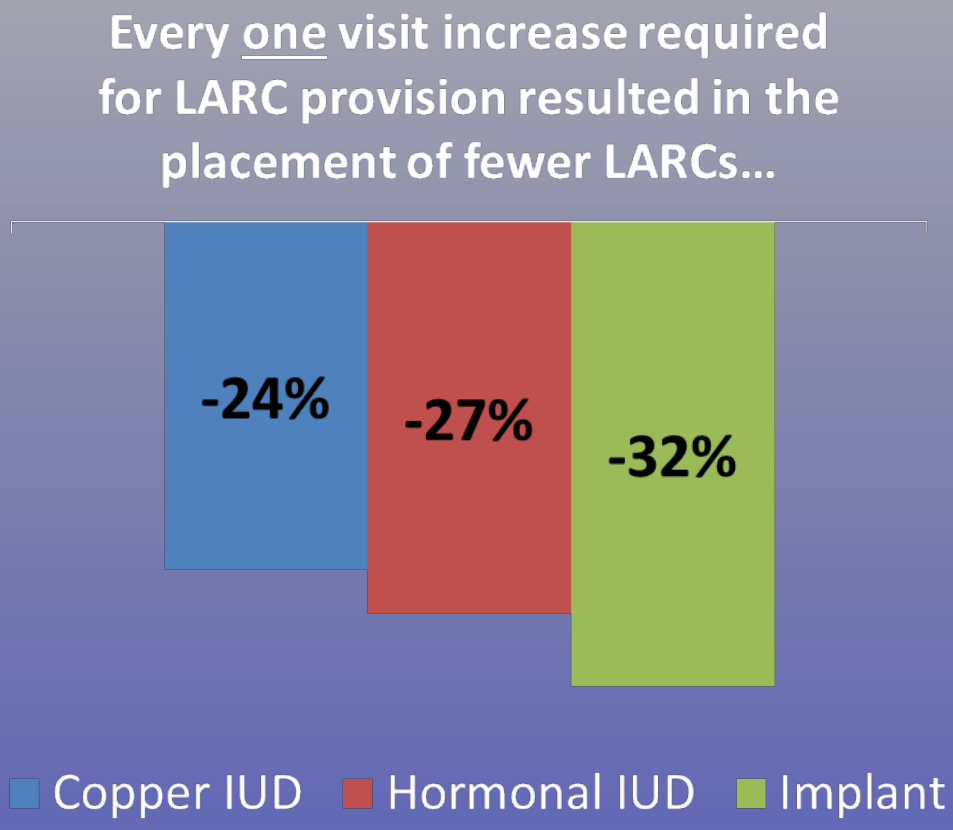
Patty Cason, MS, FNP-BC
Envision SRH
envisionsrh.com

Outline

1. Efficient practices for same-day placement of IUDs
2. IUD counseling tips, including optimal language during client counseling
3. Nuances of informed consent…terms to explain to possibility of…

More Visits → Fewer Patients Getting Method of Choice

National Clinical Training Center for Family Planning online survey of APRNs (n=390)



Source: National Clinical Training Center: Findings from a National APRN LARC Survey. Presented at the National Family Planning and Reproductive Health Association Meeting April 19, 2016

Copper T: Emergency Contraception

- Prospective, multicenter cohort clinical trial: 1,963 women in China; CuT380 placed within 120 hours of unprotected intercourse
- No pregnancies at 1 month follow-up visit
- 94% parous women and 88% nulliparous women continued at 1 year

Barriers to Same Day Placement

- Provider(s) not trained or confident of abilities
- Staff not trained
- Provider misconceptions
- Office practice logistics
- Payment misconceptions

Training Resources

- U.S MEC and U.S. SPR Guidelines
- CDC Guidelines: www.cdc.gov/mmwr
- National Clinical Training Center for Family Planning: www.ctcfp.org
- LARC Practice Resources: www.acog.org/goto/larc
- Beyond the pill UCSF http://beyondthepill.ucsf.edu/
- ParaGard®: www.paragard.com
- Mirena®: www.mirena-us.com
- Skyla®: www.skyla-us.com
- Kyleena®: www.kyleena-us.com
- Liletta®: https://www.lilettahcp.com/

Provider Misconceptions

"GC and CT screening test results are necessary"

"Wet mount is needed and can not place an IUD if she has vaginitis"

"Must have a normal pap result in the chart"

Pre-IUD placement Screening

- **Pelvic exam**
- No *routine* screening tests
  - Any indicated screening test can be performed at time of placement
- Baseline Hgb-may be helpful for later management

Pre-IUD placement Screening

- CT/GC:
  - If age <25 and due for annual screening
  - Or if high risk for STI

- Cervical cancer screening if due

- Pregnancy test if indicated

Provider Misconceptions

"IUDs can be placed only with menses"

- Quickstart is preferred for all methods

Timing of IUD Placement

- Can be placed anytime in cycle-as long as patient is not pregnant

- No benefit to placement during menses
  - No impact on pain/discomfort

- Immediate post-partum
- Immediate post-abortion

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

How to be reasonably certain that a woman is not pregnant

- 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

Provider Misconceptions

"Adolescents, nullips or women with multiple sexual partners are not candidates for IUD"

- Refuted by ACOG, AAP, CDC MEC and SPR

Office Practice Logistics

"Placement adds too much time to a scheduled visit"

- Adds no more than 5-10 minutes if each exam room is well stocked and the staff is prepared
- Trained staff with consistent policies/instrument list

Office Practice Logistics

"Placement only at scheduled placement visits"

- Any clinic visit is a potential placement visit
  - Well woman visit
  - Post-partum visits
  - Pregnancy test visits
  - Emergency contraception visit
  - Other concerns or complaints

Payment Barriers

- "IUD can be placed only after delivery from a PBM"
  - Keep extra devices in the office
  - Replenish with the device delivered from PBM
- "Method counseling and placement cannot be billed on the same date of service"
  - It can be done...see ACOG and UCSF "Beyond the Pill" billing guides

Particular Characteristics Of IUDs

- Do you have a sense of what is important to you about your method?
- Do you have a sense of what you are looking for in a contraceptive method?

Choosing Which IUD

Brand Name	Skyla®	Kyleena®	Mirena®	Liletta®
LNG content (mg in reservoir)	13.5	19.5	52	52
Release rate (mcg/24 hrs) -- at end of life	14 5	17.5 7.4	20 +/- 10	19.5 17, 14.8, 12.9, 11.3, 9.8
Max duration, years	3	5	5 (7)	3 (5-7)
T-frame, mm	28 x 30	28 x 30	32 x 32	32 x 32
Insertion tube diameter	3.80	3.80	4.40	4.80
String color	Brown	Blue	Brown	Blue
Silver ring	Yes	Yes	No	No

How to Choose IUD Type

Copper T IUD

- Doesn't want or tolerate hormonal contraception
- Wants her regular period
- Seeking the "longest-acting" method possible

LNG IUS

- Wants less menstrual flow
- Seeks a non-contraceptive benefit
- Wants to treat her dysmenorrhea

Elicit Her Attitudes About

- Effectiveness
- Hormones
- Menstrual cycle and bleeding profile
- Return to fertility
- Non-contraceptive benefits
- Side effects

Re-phrasing

- “So I hear you saying …(you really like the idea of using a method without hormones) do I have that right?”

- “It sounds like….(it’s super important to you have a method that you can rely on) is that what you mean?”

Amenorrhea with LNG IUD

Don't…

- Assume you know why she objects to amenorrhea or hormones or _____
- Ask her "why"

Do…

- Ask what about not getting her period or hormones or ____is concerning to her
- Let her know many women feel that way

Meena 29 G1P1

"What is it about not getting your period that is concerning to you?"

"I would always worry that I might be pregnant"

"I can see that it's very important to you not to get pregnant until you are ready"

"Many of my patients like to get their period every month because they feel like it lets them know they aren't pregnant"

Meena 29 G1P1

“Interestingly many women still bleed in the beginning of a pregnancy...”

“Pregnancy tests at the 99 cent store are plentiful and can be very reassuring!”

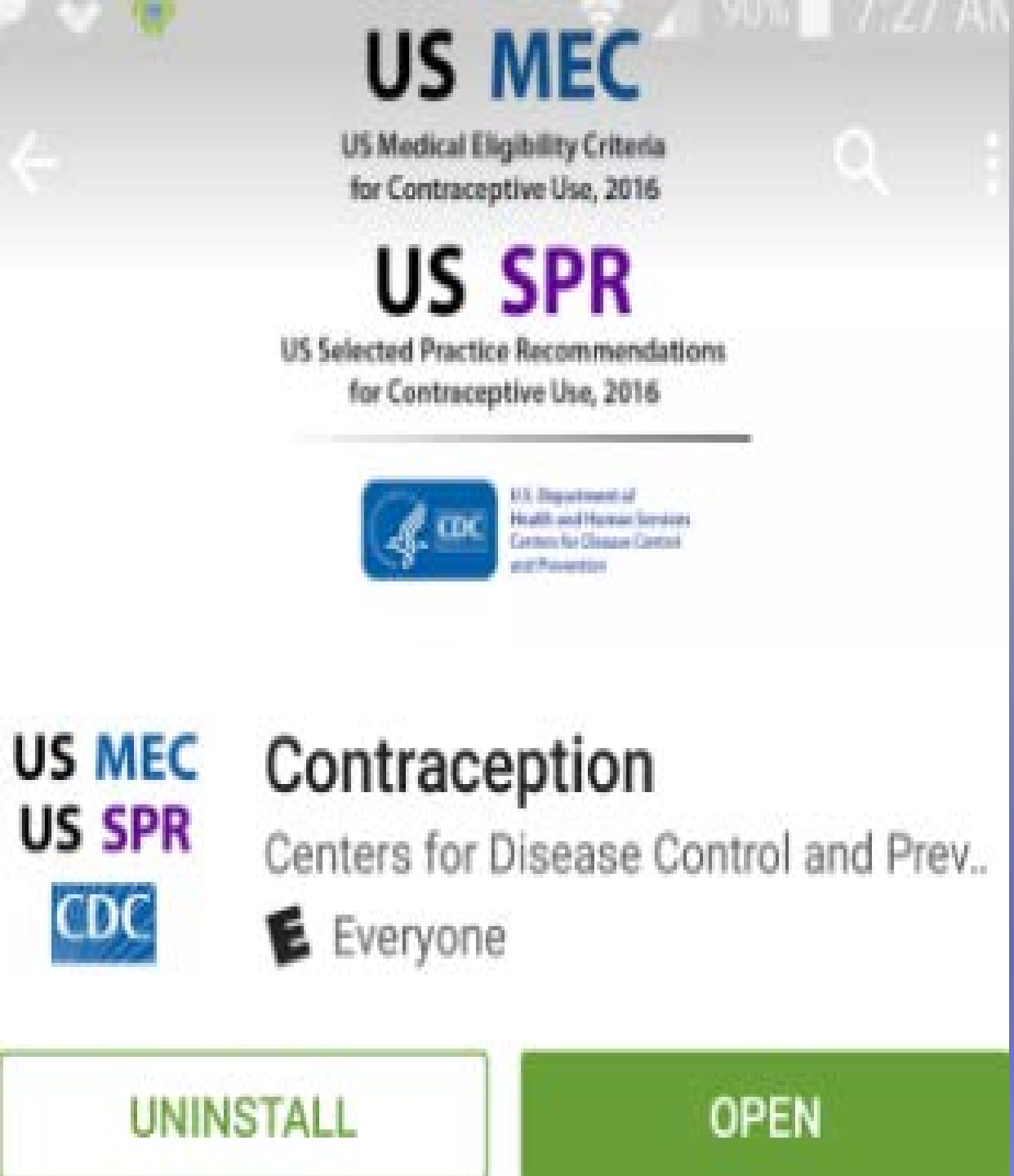
Ask A Follow Up Question

“Knowing that, how would it be for you not getting periods?”

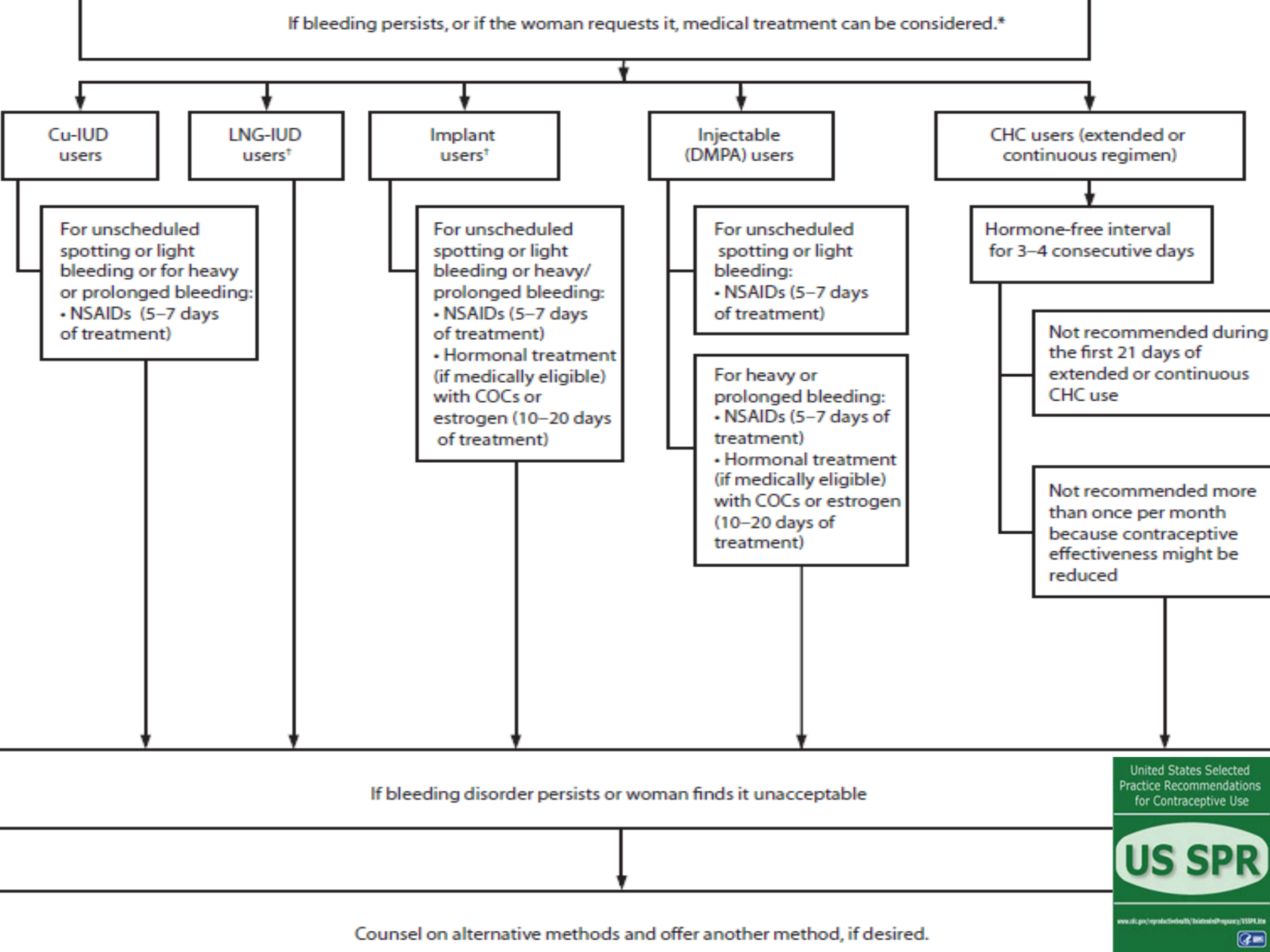
Nuances of Informed Consent

Informed Consent

- Expulsion
- Infection
- Perforation
- Method failure (pregnancy)



2016 CDC MEC and SPR phone app


If bleeding persists, or if the woman requests it, medical treatment can be considered.*
Cu-IUD users
LNG-IUD users†
Implant users†
Injectable (DMPA) users
CHC users (extended or continuous regimen)
For unscheduled spotting or light bleeding or for heavy or prolonged bleeding:
• NSAIDs (5–7 days of treatment)
For unscheduled spotting or light bleeding or heavy/ prolonged bleeding:
• NSAIDs (5–7 days of treatment)
• Hormonal treatment (if medically eligible) with COCs or estrogen (10–20 days of treatment)
For unscheduled spotting or light bleeding:
• NSAIDs (5–7 days of treatment)
For heavy or prolonged bleeding:
• NSAIDs (5–7 days of treatment)
• Hormonal treatment (if medically eligible) with COCs or estrogen (10–20 days of treatment)
Hormone-free interval for 3–4 consecutive days
Not recommended during the first 21 days of extended or continuous CHC use
Not recommended more than once per month because contraceptive effectiveness might be reduced
If bleeding disorder persists or woman finds it unacceptable
Counsel on alternative methods and offer another method, if desired.
United States Selected Practice Recommendations for Contraceptive Use
US SPR

Longer or Heavier Menses

NSAIDs prophylactically WITH FOOD

- Pre-emptive use for 1st 3 cycles
- Start before onset of menses
  - Naproxen sodium 220mg x2 BID (max 1100mg/d)
  - Ibuprofen 600-800mg TID (max 2400mg/day)

Alternatives for Implant Bleeding

- Tranexamic acid*
  - 250 mg QID x 5d
  - 500mg BID x 5d
  - 500md TID until bleeding resolves
- Progestin-only pill
  - Continuous use

*Lysteda

Vasovagal Response, Episode Or Attack AKA: Non-cardiogenic Syncope

- Mechanism
  - Starts with peripheral vasodilation
  - Bradycardia + drop in B/P
- More likely with
    - Pain with cervical manipulation
    - Previous episodes of vaso-vagal fainting
    - Dehydration or NPO

Grubb BP N Engl J Med 2005

Presyncopal Signs

- Facial pallor (distinct green hue)
- Yawning
- Pupillary dilatation
- Nervousness
- Diaphoresis
- Slurred or confused speech

Grubb BP N Engl J Med 2005

Presyncopal Symptoms

- Weakness/light-headedness
- Visual blurring/tunnel vision
- Nausea
- Feeling warm or cold
- Sudden need to go to the bathroom
- Tinnitus

Grubb BP N Engl J Med 2005

Vasovagal Prevention

- Good hydration (electrolyte/ sports drink)
- Eat before placement
- Prophylactically contract muscles if known history

Grubb BP N Engl J Med 2005

How to Abort a Vasovagal

- Isometric contractions of the extremities
- Intense gripping of the arm, hand, leg and foot muscles
- No need to bring the legs together or change position– just tense the muscles
- These contractions push blood back into the center of the body
- ….and abort the reflex

Encounter Coding for IUD Services

ACOG LARC Coding

https://www.acog.org/-/media/Districts/District-II/Public/PDFs/QuickGuideReimbursementLARCFINAL.pdf?dmc=1&ts=20170605T0122586345

Codes Numbers Tell A Story

	Encounter content	Code book
What	• Services performed • Drugs, supplies provided	• CPT • HCPCS II
Why	• Diagnoses	• ICD-#-CM
Additional Explanation	• Modifier	• CPT

- To establish medical necessity, for every ***what*** there must be a ***why***
- Unusual circumstances explained with ***modifier***

CPT Codes for Contraceptive Procedures

CPT	Description
58300	Place IUD
58301	Remove IUD
11981	Place non-biodegradable drug delivery implant
11982	Remove non-biodegradable drug delivery implant
11983	Removal with reinsertion of non-biodegradable drug delivery implant

HCPCS II: IUD J-Codes

HCPCS	National code description
J 7297	LNG-releasing IUS, 52 mg, (Liletta)
J 7298	LNG-releasing IUS, 52 mg, (Mirena)
J 7300	Intrauterine copper contraceptive (PARAGARD)
J 7301	LNG-releasing IUS , 13.5 mg (Skyla)

Encounter for Contraceptive Management

Z30.01 Encounter for initial prescription of contraceptives

ICD-10	Description
Z30.011	Initial prescription of contraceptive pill
Z30.012	Prescription of emergency contraception
Z30.013	Initial prescription of injectable contraception
Z30.014	Initial prescription of IUD (not placement!)
Z30.018	Initial prescription of other contraceptives • Medi-Cal: use for implant placement
Z30.019	Initial prescription of contraceptives, unspecified

Encounter for Contraceptive Management

Z30.4 Encounter for surveillance of contraceptives

ICD-10	Description
Z30.40	Surveillance of contraceptives, unspecified
Z30.41	Surveillance of contraceptive pills
Z30.42	Surveillance of injectable contraceptive
Z30.430	Placement of IUD
Z30.431	Routine checking of IUD
Z30.432	Removal of IUD
Z30.433	Removal and reinsertion of IUD
Z30.49	Surveillance of other contraceptives • Medi-Cal: use for implant surveillance and removal

IUD Placement Modifiers

#	Definition	Possible Clinical Scenarios
-22	Increased procedural services	• Complex or difficult placement
-25	Significant, separately identifiable E/M service	• Patient came in for general contraceptive counseling, ends up choosing IUD or implant, and it is placed that day
-51	Multiple procedures on the same day, during the same session	• Removal of IUD and placement of a new IUD on the same day • Removal of implant and placement of new implant on the same day

IUD Placement Modifiers

#	Definition	Possible Clinical Scenarios
-52	Failed procedure	• Provider couldn't complete procedure for anatomic reasons (eg. stenosis)
-53	Discontinued procedure	• Patient changed mind during procedure • Severe pain • Vasovagal • Clinician feels there is a threat to the patient's well-being and discontinues procedure
-76	Repeat procedure	• Successful placement but the IUD is expelled, followed by repeat placement

ACOG on CPT + E/M Visit

- If she states “I want an IUD,” followed by discussion, consent, and placement, an E/M code is not reported
- If all options are discussed and an implant or IUD is placed, an E/M and CPT codes may be reported
- If seen for another reason and a procedure is performed, E/M and CPT codes may be reported (turn-around visit)

ACOG; LARC Quick Coding Guide

ACOG on CPT + E/M Visit

- **Modifier -25 added to *the E/M code***
- **If reporting E/M and CPT code, documentation must indicate a "significant, separately identifiable" service**
  - **E/M level using "3 key components" or time**

ACOG; LARC Quick Coding Guide

ACOG on Ultrasound with IUD Placement

- An ultrasound to check IUD placement is not bundled into the IUD placement (code 58300), and it is not common practice to use ultrasound to confirm placement. This should not be billed.
- Ultrasonography may be used to confirm the location when the clinician incurs *a difficult IUD placement* (e.g., severe pain)
  - Code 76857 Ultrasound, pelvic, limited or follow-up, or
  - Code 76830 Ultrasound, transvaginal
- Occasionally, ultrasound is needed to guide IUD placement. Code 76998 (Ultrasonic guidance, intraoperative)

ACOG; LARC Quick Coding Guide

Case Studies

Bixby Center for Reproductive Health Research & Policy

UCSF University of California San Francisco

Case Study 1: STI Check and IUS Insertion

- Mr. L is 19 year-old established client who presents with concerns about STI and wants to be tested
- She also received contraceptive counseling (10 minutes); asked to have a 3 year LN-IUS inserted
- Samples sent for GC/CT NAAT, HIV serology
- Office urine pregnancy test negative
- Bimanual exam performed; then IUS inserted easily
- Pelvic ultrasound with vaginal probe to check placement

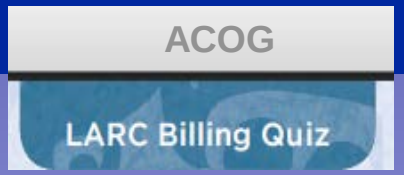
Case Study 1: Answer

	CPT/ HCPCS II Code	ICD-10-CM Code
Procedure	58300 IUD placement	Z30.430 Placement of IUC
Supply	Check with payer	
Drug	J7301 LNG-IUS, 13.5 mg	Z30.430 Placement of IUC
Lab	81025 UPT	Z32.02 Preg exam or test, negative
E/M	99212	Z 30.09 Other FP advice
Modifier	99212-25	

- -25 indicates that a significant and separately identifiable E/M was provided on the same date of service as a procedure

Case 2: IUD Removal and Implant Placement

- Ms. P, an established patient, sees Dr. Q
- She had an IUD placed 5 years ago but is now experiencing bleeding and cramping
- Dr. Q does an expanded problem-focused exam and takes additional history
- They discuss removal of the IUD and other possible contraceptive methods.
- After a brief discussion, Ms. P requests an implant
- Dr. Q removes the IUD and places an implant



Case Study 2: Answer

	CPT code	ICD-10-CM code
Procedure	11981 (implant placement)	Z30.018 (implant placement)
	58301-51 (IUD removal)	Z30.432 (IUD removal)
Supplies	Check with payer for IUC removal, none for implant	
Drug	J7307 (ETG implant)	Z30.018
Lab	None	
E/M	99212 or 99213	N92.6 (Irreg.menstruation)
Modifier	11981-51	

- Code 11981 reported 1st because it has higher RVU (2.67 vs. 2.54)
- Modifier 51 (multiple procedures) is added to the lesser procedure

Case 3: Difficult IUD Placement

- Ms. T sees Dr. U, and requests placement of a copper intrauterine contraceptive
- Ms. T weighs 220 lbs and has a BMI of 40.2
- Dr. U places an IUD with some difficulty due to Ms. T's body habitus
- How should Dr. U code for this visit?

ACOG

LARC Billing Quiz

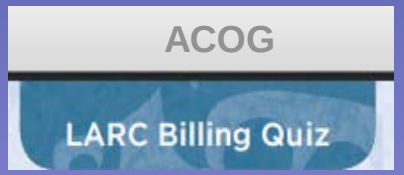
Case Study 3: Answer

	CPT code	ICD-10-CM code
Procedure	58300 (IUD placement)	Z30.430 (placement of IUD) Z68.41 (BMI of 40-44.9)
Supply	Check with payer for IUC placement	
Drug	J7300 (copper IUC)	Z30.430
Lab	None	
E/M	None	
Modifier	58300-22	

- Dr. U documents the additional work, complexity, and risk to the patient to support use of the modifier – 22
- Include med record note or explain in claim "remarks box"

Case Study 4: Discontinued IUD Placement

- Ms. X, a new patient, requests placement of an IUD
- After consent, Dr. Y attempts to place a copper IUD
- Dr. Y tries to place the IUD several times, but the patient has a stenotic cervical os and having pain. Dr. Y desists
- Dr. Y discusses other methods of contraception with Ms. X and she decides to try OCs
- This conversation lasts 20 minutes. The total time of the office visit was 35 minutes



Modifier-52 vs. Modifier-53
Failed or Discontinued Procedures

- **Modifier-52 (reduced services)**: procedure is started but can't be finished for technical reasons
  - Essure procedure: 1 coil successfully placed in one tube but the second could not be placed
    EMB attempted but not completed 2º to stenosis
- **Modifier -53 (discontinued procedure)** owing to concerns regarding patient toleration of the procedure
  - Vaso-vagal episode during sounding
  - Perforation during IUD placement

Case Study 4: Answer

	CPT code	ICD-10-CM code
Procedure	58300 IUC placement	Z30.430 (IUD placement)
Supply or Drug	J7300 (intrauterine copper contraceptive)	Z30.430 (IUD placement)
Lab	None	
E/M	99203-25 (new patient office visit) for counseling	Z30.09 Encounter for other general counseling and advice on contraception
Modifier	58300-53	

- Modifier -53 indicates that the procedure was attempted but discontinued because of pain

Kristin 29 year old G_0 In the office for a LNG IUD

- On DMPA for the last 3 years
- LEEP for CIN 3 at age 25; negative cytology since

- Tenaculum applied, but the clinician is unable to pass a metal sound

What would you recommend?

Tenaculum

1. Change the amount of traction

2. Apply traction in different direction

At what point would you recommend or offer a block?

Uterine Sound

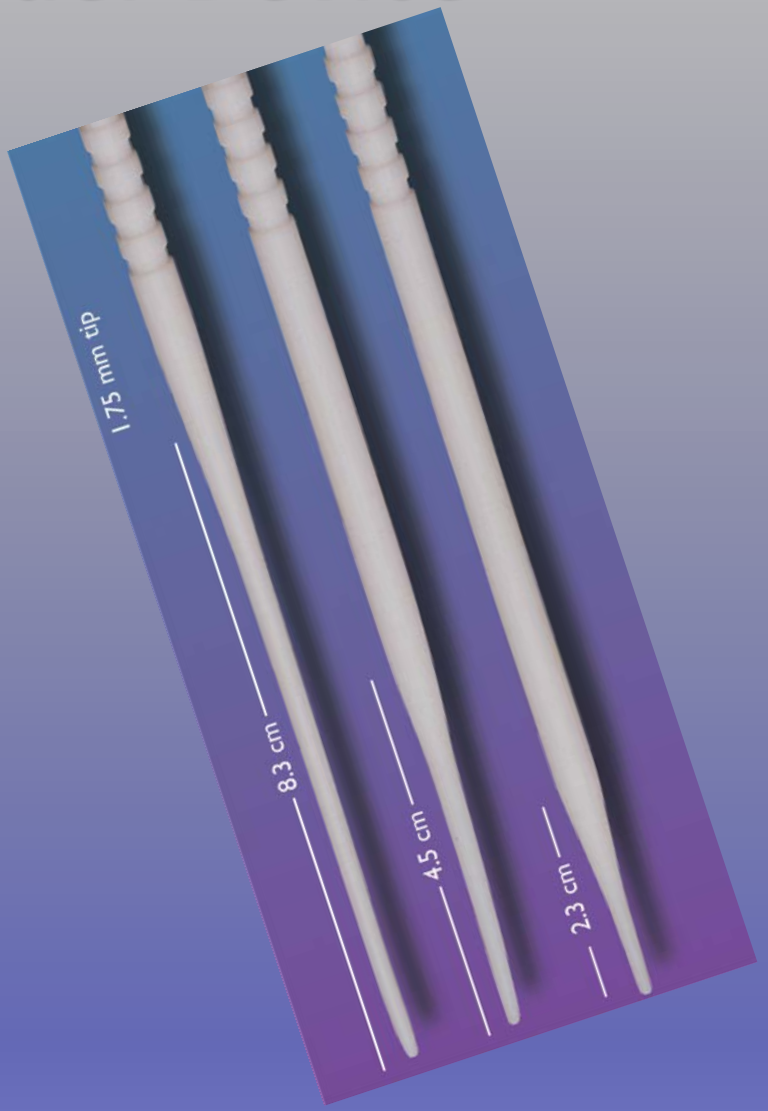
3. Gently hold the sound at the internal os and then wait --to allow the os to yield
4. Change the curvature of the sound (if metal)
5. Apply light pressure at various angles 360^{o} and positions with the sound looking for an opening
6. Approach more anteriorly or posteriorly

Have you used ultrasound guidance?

Still Unable To Pass Through the Internal Os

7. Use os finder device
8. Use a thinner sound (endometrial sampler)
9. Dilate internal os with small metal or plastic dilator
10. Try a shorter wider speculum
11. Reposition the tenaculum onto a different place

Os Finder Device



Cervical Os Finders (Disposable Box/25)
Cervical Os Finder Set (Reusable Set of 3)

Dilators

- Dilate internal os with metal dilators
- #13 french
  - Divide by 3.16 to get mm (4.1 mm)
- Double ended
- Tapered ends ease passage through os

"Failed First Attempt"

12. If unsuccessful, return after misoprostol 200 mg per vagina 10 hours and 4 hours prior to placement

13. Place paracervical *or* intracervical block at any point

Bahamondes, M. V. (2015). *Hum Reprod,*

Passed Through with Sound
…But not the Device!

1. Choke up on the handle
2. Sterile lubricant on tip
3. Leave a (small) sound in the canal and come alongside the sound with the inserter

References

- American College of Obstetricians and Gynecologists. Long-acting reversible contraception: implants and intrauterine devices. Practice Bulletin no. 121, July 2011. Obstet Gynecol 2011;118:184-96. Reafirmed 2013
- Bahamondes, M. V., Espejo-Arce, X., & Bahamondes, L. (2015). Effect of vaginal administration of misoprostol before intrauterine contraceptive insertion following previous insertion failure: a double blind RCT. *Hum Reprod, 30*(8), 1861-1866.
- Bates, C, Carroll, N and Potter, J. The challenging pelvic examination. JGIM. (2011) 650 – 657.
- Caliskan, E., Ozturk, N., Dilbaz, B. O., & Dilbaz, S. (2003). Analysis of risk factors associated with uterine perforation by intrauterine devices. *Eur J Contracept Reprod Health Care, 8*(3), 150-155.

References

- Cowman, W. L., Hansen, J. M., Hardy-Fairbanks, A. J., & Stockdale, C. K. (2012). Vaginal misoprostol aids in difficult intrauterine contraceptive removal: a report of three cases. *Contraception, 86*(3), 281-284.
- Darney PD. Etonogestrel contraceptive implant www.uptodate.com
- Dean G, Goldberg AB. Management of problems related to intrauterine contraception. www.uptodate.com
- Dermish, A. I., Turok, D. K., Jacobson, J. C., Flores, M. E., McFadden, M., & Burke, K. (2013). Failed IUD insertions in community practice: an under-recognized problem? Contraception, 87(2), 182-186.

References

- Dermish A, Turok DK, Jacobson J, Murphy PA, Saltzman HM, Sanders JN., (2016) Evaluation of an intervention designed to improve the management of difficult IUD insertions by advanced practice clinicians. *Contraception*. Jun;93(6):533-8.
- Dijkhuizen K, Dekkers OM, Holleboom CA, et al. Vaginal misoprostol prior to insertion of an intrauterine device: a randomized controlled trial. Hum Reprod 2011:26:323-9.
- Edelman AB, et al. (2011) Effects of prophylactic misoprostol administration prior to intrauterine device insertion in nulliparous women. Contraception. Contraception. Sep;84(3):234-9

References

- Grubb, B. P. (2005). Clinical practice. Neurocardiogenic syncope. *N Engl J Med, 352*(10), 1004-1010.
- Guney M, Oral B, Mungan T. Efficacy of intrauterine lidocaine for removal of a “lost” intrauterine device: A randomized, controlled trial. Obstet Gynecol 2006;108:119-23.
- Hagemann, C., Heinemann, K., Moehner, S., Reed, S., Unwanted pregnancies among women using intrauterine devices: final results from the Euras-IUD 5-Year Study. *Contraception, 94*(4), 416.

References

- Heinemann, K., Reed, S., Moehner, S., & Minh, T. D. (2015). Comparative contraceptive effectiveness of levonorgestrel-releasing and copper intrauterine devices: the European Active Surveillance Study for Intrauterine Devices. *Contraception, 91*(4), 280-283.
- Heinemann, K., Reed, S., Moehner, S., & Minh, T. D. (2015). Risk of uterine perforation with levonorgestrel-releasing and copper intrauterine devices in the European Active Surveillance Study on Intrauterine Devices. Contraception, 91(4), 274-279.
- Heinemann, K., Reed, S., Moehner, S., & Minh, T. D. (2016). Intrauterine devices and the risk of uterine perforations: final results from the EURAS-IUD 5 years study. *Contraception, 94*(4), 387.

References

- Li YT, Kuo TC, Kuan LC, et al. Cervical softening with vaginal misoprostol before intrauterine device insertion. Int J Gynaecol Obstet 2005;89:67-8.
- Lopez, L. M., Bernholc, A., Zeng, Y., Allen, R. H., Bartz, D., O'Brien, P. A., & Hubacher, D. (2015). Interventions for pain with intrauterine device insertion. *Cochrane Database Syst Rev*(7),
- Kaislasuo, J., Suhonen, S., Gissler, M., Lahteenmaki, P., & Heikinheimo, O. (2012). Intrauterine contraception: incidence and factors associated with uterine perforation--a population-based study. *Hum Reprod, 27*(9), 2658-2663.
- Mansour D. The benefits and risks of using a levonorgestrel-releasing intrauterine system for contraception. Contraception 2012;85:224-34.

References

- Reed, S., Heinemann, K. (2016). Events associated with nexplanon insertion and removal: interim results from the nexplanon observational risk assessment study (NORA). *Contraception, 94*(4), 409.
- Marchi NM, Castro S, Hidalgo M, et al. Management of missing strings in users of intrauterine contraceptives. Contraception 2012;86:354-8.
- NEXPLANON® (etonogestrel implant) Full prescribing information. Merck Revised: 07/2014
- Prabhakaran, S., & Chuang, A. (2011). In-office retrieval of intrauterine contraceptive devices with missing strings. Contraception, 83(2), 102-106.

References

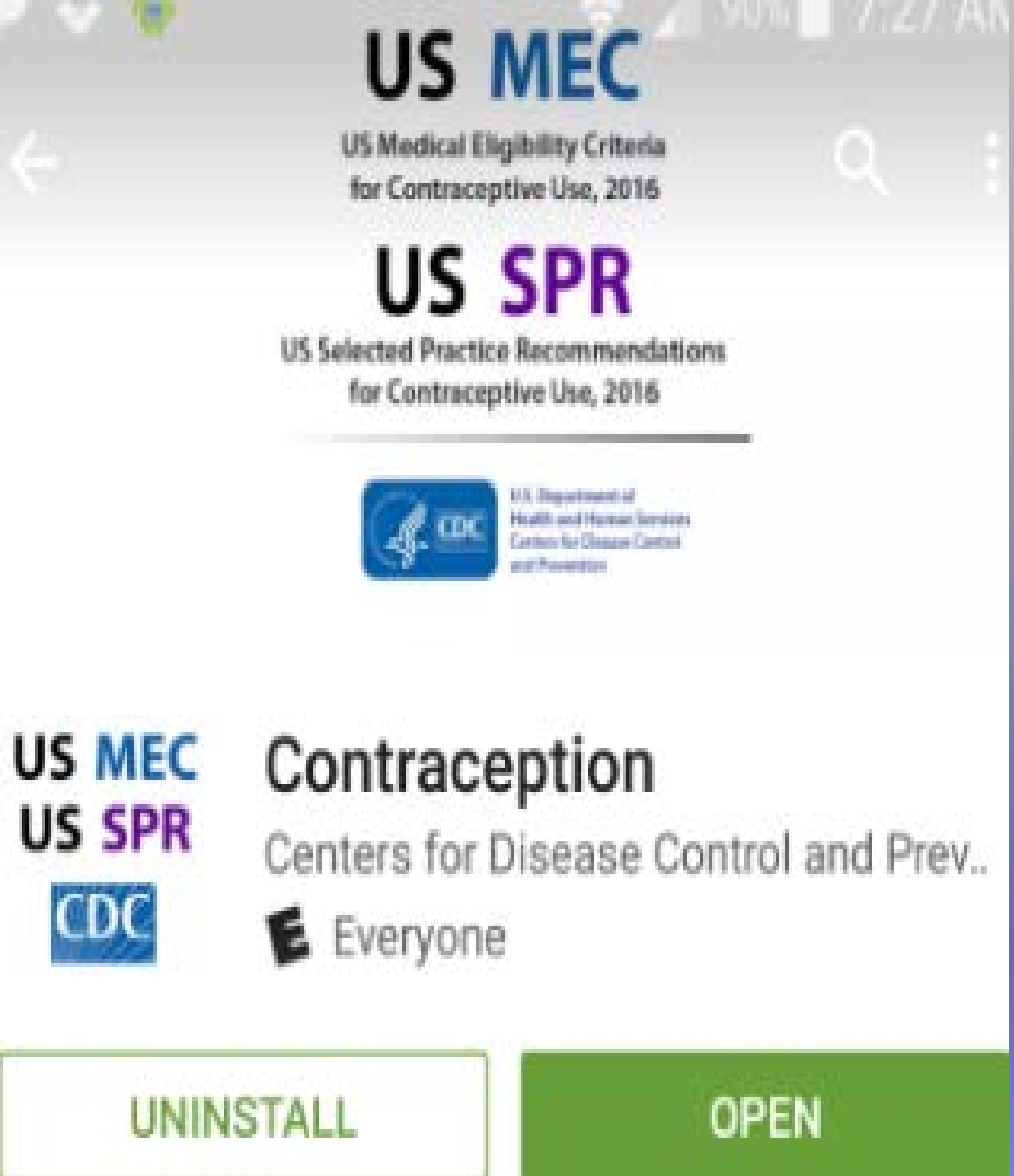
- Renner, R. M., Nichols, M. D., Jensen, J. T., Li, H., & Edelman, A. B. (2012). Paracervical block for pain control in first-trimester surgical abortion: a randomized controlled trial. Obstet Gynecol, 119(5), 1030-1037.
- Renner, R. M., Edelman, A. B., Nichols, M. D., Jensen, J. T., Lim, J. Y., & Bednarek, P. H. (2016). Refining paracervical block techniques for pain control in first trimester surgical abortion: a randomized controlled noninferiority trial. Contraception.
- Saav I, Aronsson A, Marions L, et al. Cervical priming with sublingual misoprostol prior to insertion of an intrauterine device in nulliparous women: a randomized controlled trial. Hum Reprod 2007;22:2647-52.

References

- Swenson C, Turok DK, Ward K, et al. Self-administered misoprostol or placebo before intrauterine device insertion in nulliparous women: a randomized controlled trial. Obstet Gynecol 2012;120: 341-7.
- Swenson, C., Royer, P. A., Turok, D. K., Jacobson, J. C., Amaral, G., & Sanders, J. N. (2014). Removal of the LNG IUD when strings are not visible: a case series. *Contraception, 90*(3), 288-290.
- Turok, D. K., Gurtcheff, S. E., Gibson, K., Handley, E., Simonsen, S., & Murphy, P. A. (2010). Operative management of intrauterine device complications: a case series report. *Contraception, 82*(4), 354-357.

References

- Vickery Z, Madden T. Difficult intrauterine contraception insertion in a nulligravid patient. Obstet Gynecol 2011;117:391-5.
- Ward, K., Jacobson, J. C., Turok, D. K., & Murphy, P. A. (2011). A survey of provider experience with misoprostol to facilitate intrauterine device insertion in nulliparous women. *Contraception, 84*(6), 594-599.



2016 CDC MEC and SPR phone app

References

- ACOG Committee Opinion: Motivational Interviewing: A Tool for behavior Change; 423; Jan 2009.
- Borrero, S., Nikolajski, C., Steinberg, J. R., Freedman, L., Akers, A. Y., Ibrahim, S., & Schwarz, E. B. (2015). "It just happens": a qualitative study exploring low-income women's perspectives on pregnancy intention and planning. Contraception, 91(2), 150-156.
- Dehlendorf C et al. Preferences for decision-making about contraception and general health care among reproductive age women at an abortion clinic. Patient Educ Couns. 2010;81:343–348
- Dehlendorf C et al. Women's preferences for contraceptive counseling and decision making. Contraception. 2013 Aug;88(2):250-6
- Gold Melanie et al. Motivational Interviewing Strategies to facilitate Adolescent Behavior Change. Adoles Health Update. 2007;20(1):1-7.

References

- Kennedy, S., Grewal, M., Roberts, E. M., Steinauer, J., & Dehlendorf, C. (2014). A qualitative study of pregnancy intention and the use of contraception among homeless women with children. *J Health Care Poor Underserved, 25*(2), 757-770.
- Kols AJ, Sherman JE, Piotrow PT. Ethical foundations of client-centered care in family planning. J Womens Health. 1999 Apr;8(3):303-12.
- Langston AM, Rosario L, Westhoff CL. Structured contraceptive counseling — a randomized controlled trial. Patient Educ Couns. 2010;81:362–367.
- Lopez LM et al. Theory-based interventions for contraception. Cochrane Database Syst Rev. 2009 Jan 21;(1):CD007249.
- Madden T, et al. Structured contraceptive counseling provided by the Contraceptive CHOICE Project. Contraception. 2013 August; 88(2);243-249.

References

- Petersen R, et al. Applying motivational interviewing to contraceptive counseling: ESP for clinicians. Contraception; 69(3):213-7.
- Rinehart W, Rudy S, Drennan M. GATHER guide to counseling. Popul Rep J. 1998;48:1–32.
- Rollnick S, et al. Motivational Interviewing in Health Care. New York: Guilford Press; 2008
- Secura GM, Allsworth JE, Madden T, Mullersman JL, Peipert JF. The Contraceptive CHOICE Project: reducing barriers to long-acting reversible contraception. Am J Obstet Gynecol. 2010;203(115):e111–e117.
- Shih, G., Dube, K., & Dehlendorf, C. (2013). "We never thought of a vasectomy": a qualitative study of men and women's counseling around sterilization. Contraception, 88(3), 376-381.

References

- Petersen R, et al. Applying motivational interviewing to contraceptive counseling: ESP for clinicians. Contraception; 69(3):213-7.
- Woodsong, C., Shedlin, M., & Koo, H. (2004). The 'natural' body, God and contraceptive use in the southeastern United States. Cult Health Sex, 6(1), 61-78.
- Yee, L., & Simon, M. (2011). Urban minority women's perceptions of and preferences for postpartum contraceptive counseling. *J Midwifery Womens Health, 56*(1), 54-60.