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Statistics show more use of LARC — How can you maintain momentum?

Most common methods: the Pill, female sterilization, condoms, & LARCs

The latest national statistics show that long-acting reversible contraceptives (LARCs) now follow the Pill, sterilization, and condoms as the most common methods currently used by women in the United States.[1] However, with 51% of pregnancies unintended in the United States,[2] advocates are pushing to improve access to such effective birth control.

This new data represent good news from the Centers for Disease Control and Prevention's National Center for Health Statistics (NCHS), says **Andrew Kaunitz**, MD, University of Florida Research Foundation professor and associate chairman of the Department of Obstetrics and Gynecology at the University of Florida College of Medicine — Jacksonville. More U.S. women have access to and have chosen to use highly effective reversible contraceptives, he notes.

"Building on this progress will depend, among other things, on reimbursement policies minimizing out-of-pocket cost for women considering the implant or intrauterine devices [IUDs]," states Kaunitz. "As more of our patients choose IUDs and implants, we can look forward to fewer unintended pregnancies and induced abortions."

To prepare the current report, statisticians used data from the 2011–2013 National Survey of Family Growth on contraceptive use in the month of the interview to provide a snapshot of current contraceptive status among U.S. women ages 15-44. Their analysis indicates that in 2011-2013, 61.7% of the 60.9 million U.S. women ages 15-44 were using contraception. The most common contraceptive methods being used were the Pill (16.0%), female sterilization (15.5%), male condoms (9.4%), and LARCs (7.2%).

In the previously prepared report, which looked at use from 2006-2010, analysts did not present a subtotal for LARCs, states **Kimberly Daniels**, PhD, lead author of the current report.

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Although not shown, that percentage for LARCs was 3.8% for 2006-2010 among women ages 15-44, compared with the 7.2% shown in the new report for 2011-2013. That increase is statistically significant, she notes.

When looking at use by age, data from the current report indicates use of LARCs was higher among women ages 25-34 (11.1%) compared with women ages 15-24 (5.0%) and ages 35-44 (5.3%). *(See the overview chart on p. 27.)*

Data were analyzed by level of educational attainment. Current use of female sterilization declined with greater educational attainment; 27.0% of women with a high school diploma or general equivalency diploma (GED) were using female sterilization, compared with 10.3% of women with a bachelor's degree or higher. Current pill use was more common with greater educational attainment. One in five women (21.5%) with a bachelor's degree or higher was using the Pill. Statistics show fewer than one woman in 20 (3.6%) without a high school diploma or GED was using an oral contraceptive. Similar percentages of women across education groups were using condoms (8%–11%) or LARCs (8%–10%).[1]

Use of oral contraceptives was higher among younger women, data reflect. Almost one woman out of four ages 15-24 (22.4%) was using the Pill, compared with about one woman in 12 ages 35-44 (8.7%). Similar percentages of women ages 15-24 (10.1%) and 25-34 (11.5%) were using condoms; use was lower among women ages 35-44 (6.6%), researchers report.[1]

Statisticians also analyzed current contraceptive method use by race/ethnicity. Current use of LARCs was higher among Hispanic (8.7%) and non-Hispanic white (7.4%) women compared with non-Hispanic black women (5.0%), figures show. Current use of female sterilization was higher among non-Hispanic black women (21.3%) compared with non-Hispanic white women (14.0%).

When looking at pill use, statistics suggest current use was higher among non-Hispanic white women (19.0%) than among Hispanic (10.9%) and non-Hispanic black (9.8%) women. Current condom use was similar across the three Hispanic origin and race groups shown, which was about 9%, data indicate.

How to improve access

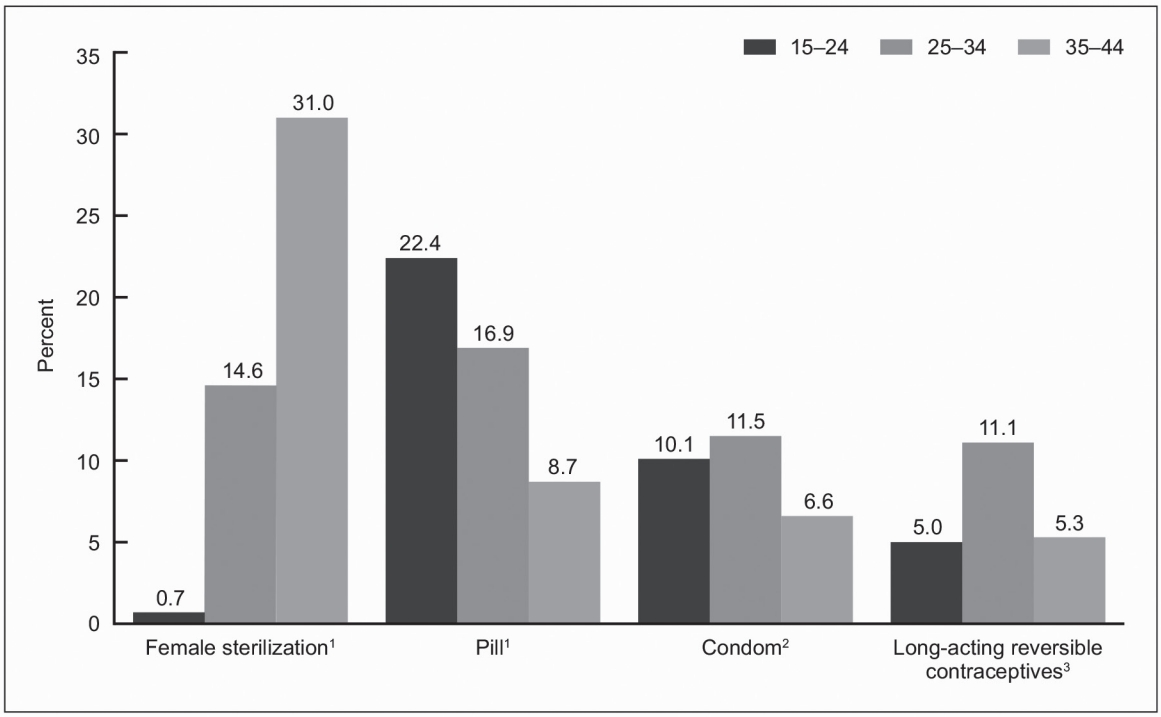
The American College of Obstetricians and Gynecologists is recommending 18 policies and practices that will increase availability of the full range of contraceptive methods and will remove existing

EXECUTIVE SUMMARY

The latest national statistics show that long-acting reversible contraceptives (LARCs) now follow the Pill, sterilization, and condoms as the most common methods used by U.S. women.

- When looking at use by age, data from the current report indicate use of LARCs was higher among women ages 25-34 (11.1%) compared with women ages 15-24 (5.0%) and ages 35-44 (5.3%).
- Use of oral contraceptives was higher among younger women, data reflect. Almost one woman out of four ages 15-24 (22.4%) was using the Pill compared with about one woman in 12 ages 35-44 (8.7%).

Figure 3. Percentage of all women aged 15–44 who were using female sterilization, the pill, the male condom, and long-acting reversible contraceptives, by age: United States, 2011–2013



[1]All percentages are significantly different from each other across age groups.
[2]Percentages for age groups 15–24 and 25–34 are significantly different from age group 35–44.
[3]Percentages for age groups 15–24 and 35–44 are significantly different from age group 25–34.
NOTES: Women currently using more than one method were classified according to the most effective method they were using. Long-acting reversible contraceptives include contraceptive implants and intrauterine devices. Access data table for Figure 3 at: http://www.cdc.gov/nchs/data/databriefs/db173_table.pdf#1.
SOURCE: CDC/NCHS, National Survey of Family Growth, 2011–2013.

and potential barriers.

According to a newly released Committee Opinion, contraception is an essential part of preventive care, and all women should have unhindered and affordable access to all contraceptives approved by the Food and Drug Administration (FDA).[3]

A key focus of this Committee Opinion is informing clinicians across the board about access issues to the various methods of contraception in general and informing them that all women should have access, states **Wanda Kay Nicholson**, MD, professor of obstetrics and gynecology at the University of North Carolina at Chapel Hill. Henderson serves as chair of the College's Committee on Health Care for Underserved Women, which compiled the recommendations.

The new recommendations call for the following:

• full implementation of the Affordable Care Act (ACA) requirement that new and revised private health insurance plans cover all FDA-approved contraceptives without cost sharing, including non-equivalent options from within one method category (for example, both levonorgestrel and copper intrauterine devices);

• easily accessible alternative contraceptive coverage for women who receive health insurance through employers and plans exempted from the contraceptive coverage requirement;

• Medicaid expansion in all states, an action critical to the ability of low-income women to obtain improved access to contraceptives;

• the right of women to receive prescribed contraceptives or an immediate informed referral from all pharmacies;

• inclusion of all contraceptive methods, including LARC, on all payer and hospital formularies;

• over-the-counter access to oral contraceptives with accompanying full insurance coverage or cost supports;

• payment and practice policies that support provision of three- to 13-month supplies of combined hormonal methods to improve contraceptive continuation.[3]

"We can prevent unintended pregnancy and help ensure that women have the contraceptive care necessary to have healthy families if and when they want to," says Nicholson. "But we must remove barriers and promote access for all American women, and we must support policies that will increase and improve utilization of contraceptives."

Robert Hatcher, MD, MPH,

professor emeritus of gynecology and obstetrics at Emory University School of Medicine in Atlanta, says, "The near-to-doubling of the use of LARC methods, from 3.8% to 7.2%, in the two time periods referred to in the NCHS studies is certainly in the right direction. However the use of LARC methods by just over 75% of the 9,256 women in the St. Louis Contraceptive CHOICE Project suggests that all hoping to increase use of IUDs and implants carefully study the counseling techniques employed by the CHOICE Project."[4]

Now that the ACA is covering all the contraceptive costs of an ever-increasing number of women, more and more women can receive LARC methods at no cost, says Hatcher.

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Family planning providers urged to focus on campus sexual violence prevention

One in five women is sexually assaulted while in college.[1]

In 2014, the White House Task Force to Protect Students from Sexual Assault issued a mandate to strengthen federal enforcement efforts and provide schools with additional tools to combat sexual assault on their campuses.[2] It launched the web site notalone.gov to make enforcement data public and provide accessible resources to students and schools.

How can you respond to the challenge? Participate in the April observance of Sexual Assault Awareness Month (SAAM). Coordinated by the Enola, PA-based National Sexual Violence Resource Center, the 2015 observance is centered on campus sexual assault. The theme is "Safer Campuses. Brighter Futures. Prevent Sexual Violence."

The 2015 SAAM campaign will serve as a toolkit for community advocates, campus personnel, students, and allies, says **Laura Palumbo**, prevention campaign specialist at the National Sexual Violence Resource Center. *(Visit the observance's dedicated web site, http://bit.ly/1lA4Lgd, for campaign resources, graphics, and other free material.)*

Healthcare providers have a unique and important role to play in sexual assault prevention and response on college campuses, says **Virginia Duplessis**, MSW, a senior program manager for Futures Without Violence, with headquarters in San Francisco. The nonprofit organization works to end violence against women and children around the world. It launched a social action campaign, "The OTHER Freshman 15," in September 2014 to elevate awareness of sexual assault at colleges across the country. *(Visit the dedicated web site at http://bit.ly/1zudHWV.)* The "Other Freshman 15" refers to the fact that the first 15 weeks of college can be the riskiest for sexual assault.

"Because experiencing sexual assault can have significant, long-term health effects, it is important to address it in the clinical setting," says Duplessis. "Providers do not have to be 'experts' on sexual assault to recognize and help patients. There are simple strategies they can incorporate into their practice."

Research demonstrates that women who talk to their providers about their experiences of violence are much more likely to use an intervention, whether it's calling

EXECUTIVE SUMMARY

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- "Safer Campuses. Brighter Futures. Prevent Sexual Violence" is the April 2015 theme for Sexual Assault Awareness Month, coordinated each year by the National Sexual Violence Resource Center.
- Healthcare providers have a unique and important role to play in sexual assault prevention and response on college campuses. Because experiencing sexual assault can have significant, long-term health effects, address this issue in the clinical setting.

a hotline, seeking counseling, or pursuing legal options,[3] Duplessis states.

Healthcare providers have an opportunity to provide anticipatory guidance on healthy relationships, consensual sexual activity, and bystander interventions aimed at prevention, notes Duplessis. By bringing up the topic, providers also are letting patients know that their clinical setting is a safe space to talk about sexual assault, if the need arises in the future. It is also a way to get information about the local community resources into the hands of students who might not disclose a sexual assault, but who might benefit from having access to those services, she states.

"In the aftermath of an assault, survivors are more likely to seek medical care than to contact a rape crisis counselor, call the police, or access other supportive services, observes Duplessis. "Healthcare providers obviously have a role to play in providing needed medical care, including emergency contraception, sexually transmitted infection testing, and pregnancy testing, but just as importantly they can let survivors know that they are not alone, that the assault was not their fault, and that there is help available."

Making a warm referral to local community resources, such as the rape crisis center or campus safety office, reduces survivors' isolation and increases patients' access to long-term support services, says Duplessis.

To improve the response to and prevention of sexual violence, providers need to enhance their ability to identify risk factors for victimization or perpetration. To develop protocols and practice comprehensive assessments of patients for sexual violence, clinicians can use the National Sexual Violence Resource Center's 2011 resource, "Assessing Patients for Sexual Violence: A Guide for Health Care Providers." *(Download a free copy at http://bit.ly/1IC0VvT).*

Enhance your services for early identification of risk factors for victimization or perpetration, says Palumbo. Risk factors that increase one's risk of committing rape include using alcohol, lacking inhibitions to suppress associations between sex and aggression, holding attitudes and beliefs that are supportive of sexual violence, associating with sexually aggressive peers, and having experienced abuse as a child, Palumbo notes. Refer patients to local organizations and programs to address these risk factors. *(The Centers for Disease Control and Prevention offers a free educational fact sheet,* Understanding Sexual Violence*. Download it at http://1.usa.gov/1vWKruj.)*

Futures Without Violence has developed a sexual assault safety card for use in college health settings, says Duplessis. Designed for college-age women and men, the card details the high prevalence of sexual assaults on campus, defines consent, and offers strategies about how to increase personal safety and prevent sexual assault. It can be downloaded at http://bit.ly/1CqLDGE.

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It's time for a tiered approach to counseling on emergency contraception

A recently published commentary calls for changes in patient counseling for emergency contraception (EC).[1] Why? Typical counseling does not take into account the relative effectiveness of available methods or patient characteristics, it asserts.

Women in the United States now have several options when it comes to emergency contraception, including the insertion of a Copper-T380A intrauterine device (IUD), the ulipristal acetate emergency contraceptive pill (ella, Afaxys, Charleston, SC), and the levonorgestrel emergency contraceptive pill.

Levonorgestrel pill options include:

- Plan B One-Step (Teva Women's Health, North Wales, PA);
- Take Action (Teva);
- Next Choice One Dose (Actavis, Parsippany, PA);
- My Way (Gavis Pharmaceuticals, Somerset, NJ);

• Levonorgestrel 0.75 mg tablets (Perrigo, Allegan, MI);

• AfterPill (Syzygy Healthcare Solutions, Westport, CT).

The ulipristal pill is by prescription only. Levonorgestrel pills are approved for unrestricted sales on store shelves.

The effectiveness of EC pills differs by characteristics outside women's immediate control, such as body mass index (BMI) and the timing of ovulation, states the new commentary. Research indicates that women are at a statistically significant increased risk of pregnancy after taking EC pills when they:

• have a BMI equal to or above 30 kg/m^2 compared to a BMI below 25 kg/m^2;

• have unprotected sex the day before estimated ovulation compared to women outside their fertile window; or

• have additional acts of unprotected intercourse after taking EC compared to women who did not.[2]

Family planning clinicians are familiar with presenting contraception using the tiered effectiveness chart developed by the World Health Organization. *(Download a free copy of the chart at http://1.usa.gov/1oOY2Bw.)* The commentary asks, why not take that same approach when it comes to counseling on emergency contraception?

Planned Parenthood Federation of America is using a tiered approach to EC in its counseling. Known as "EC4U," the program began a few years ago with the development of a toolkit to help Federation affiliate clinicians and staff members talk with women about their EC options, says **Deborah Nucatola**, MD, senior director of medical services. Part of the toolkit contained a "Wait A Minute" chart, developed to educate women on the complete range of EC options, ranked by their typical rates of effectiveness.

"We tried to in a simple way explain that there are three methods — levonorgestrel pills, ulipristal acetate pills, and the copper IUD — and the different factors, such as time since unprotected intercourse and the possibility of BMI or weight that might influence the effectiveness of their EC," explains Nucatola.

Thanks to a grant from the William and Flora Hewlett Foundation of Menlo Park, CA, the Federation was able to launch a second-phase initiative to help affiliates increase the use of copper IUD as emergency contraception, says Nucatola. Nine demonstration projects were funded from that grant. For the nine pilot sites combined, the clinics inserted 101 copper IUDs for EC, where in an equal six-month period, only 20 devices had been inserted, says Nucatola. The pilot projects used an array of approaches to increase IUD for EC usage. Publication of data is pending.

The Federation has received additional funding from the Hewlett Foundation to take the project even further, says Nucatola. The funding will allow the Federation to refine the original toolkit, incorporate some of the lessons learned from the second-phase pilot projects, and implement a "train-the-trainer" project in fall 2015 in which at least one staff member at each affiliate will be deemed the local "champion."

"You really need somebody on the ground who really wants this project to succeed and be the champion and the resource," says Nucatola. "We're going to train that champion for every one of our affiliates, and then we will see what type of effect that has on the Federation as a whole."

Researchers at the Bixby Center for Global Reproductive Health at the University of California San Francisco are looking at the impact of the tiered approach with respect to patient knowledge and health outcomes. Researchers are in process with a study to test the approach in student health centers around the greater San Francisco area, says **Kirsten Thompson**, MPH, project director. Thompson served as a co-author of the current commentary on tiered counseling.

The research team is using an EC effectiveness chart similar to the one shown on the Bedsider.org web site, says Thompson. *(The English version of the EC chart is at http://bit.ly/1xae3Bh.*

EXECUTIVE SUMMARY

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- Women in the United States now have several options when it comes to emergency contraception, including the insertion of a Copper-T380A intrauterine device, the ulipristal acetate emergency contraceptive pill, and the levonorgestrel emergency contraceptive pill.
- The effectiveness of EC pills differs by characteristics outside women's immediate control, such as body mass index and the timing of ovulation, states the new commentary. By presenting EC options in a tiered approach, women can clearly grasp the most effective options available to them.

The Spanish version is at http://bit.ly/14J2YPy.)

Research indicates that while young women in particular might have heard of emergency contraception, they are unfamiliar with the IUD for emergency contraception, says Thompson.[3] There is not great knowledge about ulipristal acetate prescription EC, and many people still don't know that levonorgestrel EC pills are available over the counter, she notes.

"We tried to create a tool that would give a little bit of all that information for people," explains Thompson. "Where can you get it? What are the different options? How soon after unprotected sex do you need to use them? The tool shows all that."

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Boost HPV vaccine uptake in university settings

While public health officials advocate for vaccination against human papillomavirus (HPV) in girls and boys ages 11-12, they also call for vaccination of young women ages 13-26 and males ages 13-21 who have not been previously vaccinated or did not complete the three-dose series.

A 2014 report released by the President's Cancer Panel says the catch-up period for adolescents and young adults not previously vaccinated is an "important window for cancer prevention."[1]

"If failure to vaccinate 11- to 12-year-olds is the first missed opportunity, failure to vaccinate young women ages 13-26 who were not previously vaccinated or did not complete the three-dose series and males ages 13-21 is an additional missed opportunity," the report says.[1]

National statistics from the Centers for Disease Control and Prevention indicate only 30.7% of young women and 0.6% of young men have received at least one dose of the HPV vaccine.[2]

Consider how two university health services have raised awareness and HPV vaccine uptake in their student populations.

Results of an early 2014 survey indicated students at Salem (MA) State University were typical of most U.S. young adults when it came to HPV vaccination. Less than 50% of students who visited the student health center had received even one dose of HPV vaccination, and only about 35% reported completion of the three-dose series. Fewer than 7% of male students seen in the health center had completed the vaccine series, and 80% reported having never received any HPV vaccine.

Kimberly Daly, MSN, FNP, DNPc, associate director of Student Health Services, spearheaded an effort to improve the suboptimal HPV vaccine rates. With grant funding from the New England College Health Association, a campus-wide promotion project was developed to increase student HPV vaccination rates. The outreach project was designed to prevent missed opportunities for providing HPV vaccine during all clinical encounters by doing the following:

- utilizing the electronic medical record (EMR) for providers and appointment reminders for patients;
- increasing the frequency of provider recommendations for HPV vaccine during all patient encounters using targeted messaging;
- increasing community exposure to HPV vaccine awareness and accessibility through multi-component marketing strategies.

The program and intervention were held through the fall 2014

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semester, and they included internal health communication between providers and students to encourage HPV vaccine uptake as well as campus-wide health education strategies. A social norming campaign using the slogan, "Spread Love Not Warts" was used in multimedia, print, social media, and outreach programs on campus. The program was launched at a "Spread Love not Warts" concert held during the annual September block party.

Chart audits using electronic medical records tracked provider engagement during the campaign, with reports looking at provider acknowledgement of HPV vaccine history (preventing missed opportunities to vaccinate), clinician provision of a strong HPV vaccine recommendation at each visit, and scheduling of follow-up appointments at the clinical visit to ensure activation of future visit reminder systems for patients.

The program met all of its objectives but one; only 92% of patients received scheduled follow-up appointments, instead of the stated 100% goal, says Daly. The overall outcome was "substantial," she notes.

"In the previous semester, we administered a total of 12 HPV vaccines to students in our health services," she reports. "At the conclusion of our program, 16 weeks over fall 2014, we reported a total of 158 administered vaccines to a total of 120 unique patients."

Feedback from patients was very positive, says Daly. Nurse practitioner recommendation for HPV vaccine was the most impactful, followed by strategically placed informational posters with the "Spread Love not Warts" logo in all student campus bathroom stalls, she says.

Amy Wongsarnpigoon, MSN, ANP, an adult nurse practitioner at Raleigh, NC-based North Carolina State University (NCSU) Student Health, became a champion for change after noting that many of her male patients were unfamiliar with the HPV vaccine. A review of the center's electronic medical record data found providers were recommending the HPV vaccine to just 9% of males during student health physicals, compared to 70% of females.

Why the low number? Wongsarnpigoon explains that the student health center has two general clinics: a women's clinic and a medical clinic. The women's clinic generally sees females for their well woman visits and already had interventions in its electronic medical records to identify women who might need the HPV vaccine. The medical clinic, on the other hand, did not have a process to remind clinicians to assess and address male HPV vaccination status, nor were there any educational materials geared toward males to inform them about the importance of HPV vaccination, she notes.

A team approach involving personnel from information technology and health promotion, as well as nurses, medical assistants, nursing assistants, nurse practitioners, physician assistants, and physicians, was utilized to implement the quality improvement effort, says Wongsarnpigoon. The staff members added an HPV section for each provider to complete in the EMR during all physicals, and they developed new literature about HPV that was specifically written for males.

The result? Research indicates a 58% increase in the number of HPV vaccines given to males at the student health center during the study period (October 2013 to March 2014). The quality improvement project was awarded one of two 2014 Bernard A. Kershner Innovations in Quality Improvement Awards given by the Institute for Quality Improvement at the Accreditation Association for Ambulatory Health Care.

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Research eyes noninvasive test for endometriosis

Endometriosis is a common health problem for women. An estimated 11% of U.S. women have the gynecologic disorder, which happens when the lining of the uterus grows outside of the uterus.[1] In women with endometriosis, when the endometrial tissue enters the abdominal cavity, it attaches to organs in the abdominal and pelvic cavities, such as the ovaries, the intestines, or other organs or tissues. This tissue continues to follow the monthly menstrual cycle, and the resulting bleeding can cause inflammation, scarring, and pain. It is prevalent in 38% of infertile women and in 71-87% of women with chronic pelvic pain.[2]

Currently, laparoscopy is the only definitive way to diagnose and stage endometriosis that occurs on the pelvic lining and organs. However, the time lag can be more than a

decade from symptom onset to diagnosis, which emphasizes the need for a less invasive, more cost-effective approach.

Researchers at the University of California San Francisco (UCSF) have identified patterns of genetic activity that may be used to diagnose endometriosis and its severity, which possibly offers an alternative to diagnostic surgery through a simple noninvasive procedure.[3] The prototype diagnostic method not only distinguishes endometriosis from other disorders of the uterus, but it also can identify the severity of the disease.

This type of molecular diagnostic approach would not have been possible without advances in genomics and bioinformatics, said **Linda Giudice**, MD, PhD, distinguished professor and chair of obstetrics, gynecology, and reproductive sciences at UCSF in a release accompanying the publication. "Importantly, there are relatively few genes in each 'classifier' of disease or of no disease and endometriosis stage that have the potential for non-surgical diagnostic development," said Giudice, who served as senior author of the paper. "The approach also could be used to detect disease recurrence without requiring surgery, and the newly identified gene profiles and pathways resulting from this approach have opened doors for innovative targeted therapy development for endometriosis-related pain and infertility."

Review the results

To perform the study, researchers used samples from the National Institutes of Health (NIH)/UCSF Human Endometrial Tissue and DNA Bank established by Giudice. Scientists used DNA microarray technology to identify which genes were involved in making protein in each woman's endometrial tissue. They looked at 148 samples:

- 77 samples came from women with endometriosis.
- 37 samples came from women without endometriosis but with other uterine/pelvic problems.
- 34 samples came from women without any uterine conditions.

The investigators used machine learning, a computer-based technology, to analyze the gene activity of endometrium tissue samples. Machine learning allows computers to learn from an activity without explicit programming. Scientists then examine the interactions caused by the information on large numbers of genes being translated into proteins through a process called gene expression.

Not only could investigators in the study determine which samples came from endometriosis patients and those who did not have endometriosis, but they also could tell the difference between samples from endometriosis patients and those from patients with other uterine disorders. The new testing also allowed scientists to tell the difference between lesser and more advanced stages of endometriosis, and they were able to identify endometriosis at different points in the menstrual cycle.

"We're looking ahead to potentially being able to do a test for endometriosis in the office, as opposed to general anesthesia in the operating room," Giudice said. Clinicians could insert a thin plastic catheter through the cervix into the uterus to remove a sample of endometrial cells, a procedure that takes about 5-10 minutes, Giudice explained.

In the study, researchers found distinct patterns of gene expression involving inflammation and in activating the immune system in the endometrium of women with endometriosis. They also reported specific patterns of gene expression involved in building new blood vessels. Women with uterine fibroids and other pelvic disorders also showed signs of immune activation, although the gene expression in these conditions differed from that in women with endometriosis, they noted.

With findings in hand, the Reproductive Medicine Network, funded by the NIH Eunice Kennedy Shriver National Institute of Child

EXECUTIVE SUMMARY

Endometriosis is a common health problem for women. An estimated 11% of U.S. women have the gynecologic disorder, which happens when the lining of the uterus grows outside of the uterus.

- In women with endometriosis, when the endometrial tissue enters the abdominal cavity, it attaches to organs in the abdominal and pelvic cavities, such as the ovaries, the intestines, or other organs or tissues. This tissue continues to follow the monthly menstrual cycle, and the resulting bleeding can cause inflammation, scarring, and pain.
- Researchers have identified patterns of genetic activity that may be used to diagnose endometriosis and its severity, which possibly offers an alternative to diagnostic surgery through a simple noninvasive procedure.

Health and Human Development, has begun a multisite clinical trial that will test the method in a larger number of volunteers, said **Louis DePaolo**, PhD, chief of the NICHD Fertility/Infertility Branch and a coauthor of the current study.

What are the options?

What treatments are available to treat pain linked with endometriosis? The levonorgestrel intrauterine system has been used successfully to treat symptomatic endometriosis.[4,5] The contraceptive injection subcutaneous depot medroxyprogesterone acetate (DMPA-SC, Depo-SubQ Provera 104, Pfizer, New York City) was given Food and Drug Administration approval in 2005 for treatment of pain related to endometriosis after research indicated it was as effective as leuprolide acetate, a gonadotropin-releasing hormone (GnRH) analog, for such use.[6]

According to *Contraceptive Technology*, combined oral contraceptives also decrease the menstrual pain suffered by women with endometriosis. This benefit is enhanced by use of extended-cycle pills, which reduce the number of painful episodes women have.[7] The contraceptive implant (Nexplanon, Merck, Whitehouse Station, NJ) also might be effective in reducing pelvic pain associated with endometriosis.[8] *(Read about upcoming treatments in the* Contraceptive Technology Update *article, "Endometriosis is the focus of new scientific research," May 2014, p. 54.)*

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WASHINGTON WATCH

Medicaid is making an impressive impact

By ***Adam Sonfield***
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The year 2015 is shaping up to be another big one for the joint federal-state Medicaid program. It is the second year of the Affordable Care Act's (ACA's) broad expansion of Medicaid to individuals below 138% of the federal poverty level. Medicaid enrollment surged in 2014, which helped to drive down uninsurance nationwide. By October 2014, 68.5 million individuals were enrolled in Medicaid, an increase of 9.7 million, or 17%, from the average monthly enrollment in July to that of September 2013.[1] That enrollment is in addition to the 950,000-person increase in enrollment among six states and the District of Columbia that had chosen to expand Medicaid prior to 2014.

This impact, which is greater than that from the new "marketplaces" for private insurance, is all the

COMING IN FUTURE MONTHS

- Check developments in cervical cancer screening
- Expedited partner therapy: Weigh the evidence
- The CDC backs the use of circumcision
- Many who get hysterectomy might not need it

more impressive because the ACA's Medicaid expansion had been hobbled by the U.S. Supreme Court's 2012 ruling that converted it from a federal requirement to a state option. Twenty-seven states and the District of Columbia had implemented a Medicaid expansion by January 2015.[2] Those states accounted for most of the enrollment increase in 2014, and enrollment in expansion states rose by 24%.[1] Enrollment increased by 7% in states that had not yet expanded, which most likely was driven by new ACA requirements to streamline the enrollment process and by heightened awareness about Medicaid among those eligible.

Medicaid's importance can be expected to grow further in 2015. Policymakers have shifted their focus from campaigning to governing. Expanding Medicaid is a major priority in several states. Republican governors in Indiana, Tennessee, Utah, and Wyoming are in discussions with the Centers for Medicare and Medicaid Services (CMS), and the independent governor of Alaska and Democratic governors in Montana and Virginia also are proponents of expansion.[2]

Arriving at a proposal that will satisfy CMS and conservative state legislators will be a daunting challenge in at least some of these states. Yet, Medicaid's momentum appears to be building, not only because of mounting evidence about the potential benefits for enrollees, but also because of pragmatic fiscal arguments, such as the vast amount of federal dollars being left on the table.

This news is all good for low-income Americans, for whom Medicaid is often the only path to affordable health insurance. These new enrollees are particularly likely to be young and unmarried, and therefore at heightened risk of unintended pregnancy. Luckily for them, Medicaid's coverage of family planning services is strong, with federal law requiring all states to cover this care without any patient cost-sharing and providing for enhanced federal reimbursement to states as an incentive to cover the broadest possible array of methods and services.

These protections have translated into access to care. Even before the recent expansions, Medicaid was the fulcrum for publicly supported family planning in the United States, which accounts for three-quarters of all public dollars spent on those services.[3] It is also central to maternity care. Notably, Medicaid pays for half of all U.S. births, including two-thirds of unplanned births.[4] As Medicaid enrollment expands, these figures seem all but certain to continue rising.

Because of the ACA's many changes to Medicaid, and because of the ever-increasing role of private-sector health plans in providing coverage for Medicaid enrollees, CMS has announced that it will be overhauling key Medicaid managed care regulations in 2015. That overhaul provides an opportunity for CMS to further bolster Medicaid's protections for family planning patients and providers.

Family planning advocacy groups, including my organization, the Guttmacher Institute, have called upon CMS to do the following:

• clarify and enhance the obligations of states and health plans to cover the full range of family planning methods and services, without cost-sharing or other restrictions, such as prior authorization or inappropriate quantity limits;

• to respect patients' confidentiality, paying particular attention to agency and plan communications about service utilization;

• to facilitate enrollees' access to qualified providers, in-network and out-of-network;

• to ensure that patients have access to the full range of information and care, even if specific providers or health plans have religious objections.

In all of these areas, states and plans should improve communication with patients about their rights, and the federal and state governments should step up oversight and enforcement.

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CNE/CME OBJECTIVES

After reading *Contraceptive Technology Update*, the participant will be able to:

1. identify clinical, legal, or scientific issues related to development and provisions of contraceptive technology or other reproductive services;
2. describe how those issues affect services and patient care;
3. integrate practical solutions to problems and information into daily practices, according to advice from nationally recognized family planning experts;
4. provide practical information that is evidence-based to help clinicians deliver contraceptives sensitively and effectively.

CONTRACEPTIVE TECHNOLOGY UPDATE®

Contraceptive Technology Update is endorsed by the National Association of Nurse Practitioners in Women's Health and the Association of Reproductive Health Professionals as a vital information source for healthcare professionals.

CNE/CME INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

1. Read and study the activity, using the provided references for further research.

2. Scan the QR code to the right or log on to the AHCMedia.com site to take a post-test. Go to "MyAHC" and then "My Courses" to view your available CE activities. Tests are taken after each issue. First-time users will have to register on the site using the 8-digit subscriber number on their mailing label, invoice, or renewal notice.

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CNE/CME QUESTIONS

1. According to an analysis of U.S. contraceptive use in 2011-2013, what percentage of the 60.9 million U.S. women ages 15-44 were using birth control?

A. 33%
B. 45.5%
C. 52.4%
D. 61.7%

2. What is the statistic for the number of women who are sexually assaulted while in college?

A. One in five women
B. One in six women
C. One in eight women
D. One in 10 women

3. What is the most effective form of emergency contraception?

A. Certain types of combined hormonal contraceptive pills
B. Copper T-380A intrauterine device
C. Ulipristal acetate pill
D. Levonorgestrel pill

4. What is considered the catch-up period for the vaccination for the human papillomavirus?

A. Women ages 18-26 who were not previously vaccinated or did not complete the three-dose series and males ages 18-26
B. Women ages 13-26 who were not previously vaccinated or did not complete the three-dose series and males ages 18-26
C. Women ages 13-26 who were not previously vaccinated or did not complete the three-dose series and males ages 13-21
D. Women ages 18-26 who were not previously vaccinated or did not complete the three-dose series and males ages 13-21.