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INSIDE

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American Cancer Society's shift adds confusion on breast screening

Conference to focus on developing uniform national guidelines

The New Year might bring more changes when it comes to breast cancer screening recommendations. A January 2016 consensus conference, called by the American College of Obstetricians and Gynecologists (ACOG), will bring together major organizations and women's healthcare providers to evaluate and interpret available data and to develop uniform national guidelines on breast cancer screening.

The conference comes on the heels of American Cancer Society's (ACS) October 2015 recommendations that indicate that women should begin having yearly mammograms at age 45 and should change to having mammograms every other year beginning at age 55. The new guidance does not recommend clinical breast examination for breast cancer screening among average-risk women at any age.[1]

THE UPDATED ACS GUIDELINES SHOULD RESULT IN MORE WOMEN RECEIVING MAMMOGRAMS LATER IN LIFE.
— ANDREW KAUNITZ, MD, UNIVERSITY OF FLORIDA

A review of the evidence considered in making the recommendations was co-published in *The Journal of the American Medical Association,* along with the guidance.[2] *(To help providers explain the new guidance, the* Journal *developed a handout that may be copied for patient use. Download it at http://bit.ly/1kmCNXc.)*

"These recommendations are made with the intent of maximizing reductions in breast cancer mortality and years of life saved while being attentive to the need to minimize harms associated

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with screening," said **Kevin Oeffinger**, MD, chair of the ACS breast cancer guideline panel and a family physician at Memorial Sloan Kettering Cancer Center in New York City, in a statement accompanying the guidance. "The benefits, burdens, and judgment about that balance differ depending on a woman's age, health, values, and preferences. These recommendations recognize and reflect those differences."

In the United States, an estimated 231,840 women will be diagnosed with breast cancer in 2015.[3] The disease continues to rank second after lung cancer as a cause of cancer death in women in the United States, and it is a leading cause of premature mortality in women. Statistics show that in 2012, deaths from breast cancer accounted for 783,000 years of potential life lost and an average of 19 years of life lost per death.[4] While progress has been made in decreasing mortality, estimates indicate 40,290 women in the United States will die of breast cancer in 2015.[3]

The ACS guidance, the first issued since 2003, looks at screening mammography for average-risk women, defined as those with none of the following: personal history of breast cancer, a confirmed or suspected mutation associated with elevated risk, or history of chest wall radiation at a young age. The ACS group classified recommendations as "strong" when the benefits of guidance recommendation adherence outweigh undesirable impacts, or "qualified" when "there is clear evidence of benefit of screening but less certainty about the balance of benefits and harms, or about patients' values and preferences, which could lead to different decisions about screening."[1]

The new recommendations are as follows:

- Women with an average risk of breast cancer — most women — should begin yearly mammograms at age 45. (Strong)
- Women should have the opportunity to begin annual screening between the ages of 40 and 44. (Qualified)
- At age 55, women should have mammograms every other year, though women who want to

EXECUTIVE SUMMARY

A January 2016 consensus conference will bring together major organizations and women's healthcare providers to evaluate and interpret available data to develop uniform national guidelines on breast cancer screening.

- The conference comes on the heels of the American Cancer Society's October 2015 recommendations, which advise that women should begin having yearly mammograms at age 45 and should change to having mammograms every other year beginning at age 55. The new guidance does not recommend clinical breast examination for breast cancer screening among average-risk women at any age.
- The American College of Obstetricians and Gynecologists continues to recommend that women, starting at age 40, continue mammography screening every year. It recommends a clinical breast exam ever year for women ages 19 and older.

continue yearly mammograms should be able to do so. (Qualified)

• Regular mammograms should continue for as long as a woman is in good health and has a life expectancy of 10 years or longer. (Qualified)

• The ACS does not recommend clinical breast examination for breast cancer screening among average-risk women at any age. (Qualified)

The American Cancer Society is encouraging women that the best way to know when to begin screening for mammograms and how often to get screenings is to talk to their medical providers. Women should initiate discussions about breast cancer screening with medical providers by age 40 and should share family history and personal medical history to determine whether they are at average risk or higher risk for breast cancer.[5]

"This guideline relies on the best evidence to offer new, more precise guidance taking into account a woman's age, health, and personal values and preferences," said **Elizabeth "Terry" Fontham**, founding Dean of the School of Public Health at Louisiana State University Health Sciences Center in New Orleans and chair of the ACS Guideline Development Group. "Though the evidence shows that there are some benefits from mammography screening starting at age 40, those benefits more clearly outweigh the harms from age 45 onward."

Some women will choose to begin screening between age 40 and 44, because they are concerned about their risk of breast cancer, either in general or because they are at higher risk, and are less concerned about the chances of experiencing false positive findings, noted Fontham in a press statement. Those women should have the opportunity to start screening at 40 if they choose, she stated.

Seeking consensus

In calling for the January 2016 consensus meeting, the American College of Obstetricians and Gynecologists (ACOG) noted its differences with the new ACS guidance and released a statement saying that it holds a "different interpretation of data and the weight assigned to the harms versus the benefits."[6]

It maintains its current advice that women starting at age 40 continue mammography screening every year, and recommends a clinical breast exam ever year for women ages 19 and older.

"ACOG strongly supports shared decision-making between doctor and patient, and in the case of screening for breast cancer, it is essential," reads the organization's statement. "We recognize that guidelines and recommendations evolve as new evidence emerges, but currently ACOG continues to support routine mammograms beginning at 40 years as well as continued use of clinical breast examinations."

In 2009, the US Preventive Services Task Force developed guidance that calls for women ages 50 to 74 to receive a screening mammogram every two years. For women younger than 50, some might choose to be screened based on individual risk factors, the guidance notes.[7] The Task Force's recommendation for fewer mammograms was based on its assessment that more frequent mammograms increase the risk of false positive studies, overdiagnosis, and overtreatment. The ACS guidance is based on its analysis of evidence indicating that more screenings are necessary to catch more tumors at an earlier stage.

The updated ACS guidelines should result in more women starting mammograms later in life, notes **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. Because the guidance endorses biennial screening for many women, patients following ACS protocol will have fewer lifetime screens than with earlier recommendations, observes Kaunitz.

In performing fewer breast examinations during well woman visits, clinicians now will have more time for assessing family history and other risk factors for breast cancer, as well as for encouraging dialogue regarding screening recommendations, Kaunitz notes.

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More women reported to be moving to long-acting reversible contraceptives

Results from two analyses of national data indicate that women are increasingly turning to use of long-acting reversible contraceptives (LARCs) such as the intrauterine device (IUD) and implant for birth control.[1,2]

In the first report, statisticians with the Centers for Disease Control and Prevention's National Center for Health Statistics looked at contraceptive use among women ages 15-44 collected in the 2011-2013 rounds of the National Survey of Family Growth (NSFG), a national compilation of information on family life, marriage and divorce, pregnancy, infertility, use of contraception, and men's and women's health.

In their analysis, the researchers found that the most commonly used methods were the pill (25.9%, or 9.7 million women), female sterilization (25.1%, or 9.4 million women), the male condom (15.3%, or 5.8 million women, and LARCs (11.6%, or 4.4 million women). Use of LARCs has almost doubled since the report on the 2006 to 2010 National Survey of Family Growth, when the rate of LARC use was only 6.0%, researchers note. Use of IUDs made up the bulk of this category, with 10.3% of current contraceptors using an IUD during 2011-2013.[1]

The second report, prepared by researchers with the New York City-based Guttmacher Institute, found that use of the IUD and the contraceptive implant by female birth control users ages 15-44 increased from about 9% in 2009 to nearly 12% in 2012, with increases seen across virtually all groups of women.[2] Comparison with previous studies shows that this increase is a part of a decade-long trend. In 2002, only about 2.4% of U.S. women using contraception were using LARC methods.[3]

The Guttmacher Institute report, which looked at NSFG data from 2009 to 2012, notes that while LARC use increased across nearly every group of women studied, the most significant increases were among Hispanic women (from 8.5% to 15.1%), those with private insurance (from 7.1% to 11.1%), those with fewer than two sexual partners in the previous year (from 9.2% to 12.4%), and those who were nulliparous (from 2.1% to 5.9%).[2]

"LARC methods have the potential to significantly decrease unintended pregnancy in the United States because they are 'set and forget,' meaning they require no intervention from women, resulting in greater effectiveness," said **Megan Kavanaugh**, DrPH senior research associate at the Guttmacher Institute, in a release accompanying the report.

Look at other benefits

While many women might choose an IUD or implant for the high level of effectiveness offered, some women might consider the two methods for their benefits outside of birth control.

Anne Burke, MD, MPH, associate professor in the Department of Gynecology and Obstetrics at the Johns Hopkins University of School of Medicine in Baltimore, spoke on the noncontraceptive benefits of LARC methods at the 2015 *Contraceptive Technology* Quest for Excellence conference in Atlanta.[4] While all progestin-containing methods reduce menses, the levonorgestrel IUD is the most effective, notes Burke.

According to *Contraceptive Technology*, the levonorgestrel IUD reduces dysmenorrhea and menstrual

EXECUTIVE SUMMARY

Results from two analyses of national data indicate that women are increasingly turning to long-acting reversible contraceptives (LARCs) such as the intrauterine device (IUD) and implant for birth control.

- In the first analysis, the most commonly used methods were the pill, female sterilization, the male condom, and LARC. Use of LARCs has almost doubled since the report on the 2006 to 2010 National Survey of Family Growth, when the rate of LARC use was only 6%, researchers note.
- In the second analysis, data indicates use of the IUD and the contraceptive implant by female birth control users ages 15-44 increased from about 9% in 2009 to nearly 12% in 2012, with increases seen across virtually all groups of women.

blood loss from a variety of causes; overall blood loss drops about 90%, and at least 20% of women stop bleeding.[5]

In studies looking at the contraceptive implant, 48% of women saw a decrease in dysmenorrhea, and 61% saw a decrease in acne, states Burke.[6-7]

The levonorgestrel IUD and the implant have been eyed for use in relieving pain from endometriosis. Data indicates that the levonorgestrel IUD relieves symptoms and is effective as other methods, but offers better compliance.[8]

In a small study looking at use of the contraceptive injection depot medroxyprogesterone acetate (DMPA) and the implant, researchers report during a one-year follow-up period, clear improvement in pain intensity was seen for both treatment options.[9] After six months, the average decrease in pain was 68% in the implant group and 53% in the DMPA group.[9]

Remember that side effects are low in LARC users, says Burke. Such bothersome side effects as weight gain, mood changes, depression, nausea, low back pain, breast tenderness, headaches, and acne are observed in less than 5% of LARC users, she states.

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Family planners can look into the future — What contraceptive options are in the pipeline?

What new methods can clinicians look to add to their arsenal of family planning options in the upcoming years? With the recent upsurge in interest in long-acting reversible contraceptives (LARCs), it's no surprise that several possible LARC options are moving through the research pipeline.

In the realm of hormonal intrauterine devices (IUDs), a 19 mg total dose levonorgestrel IUD that releases approximately 13 mcg/24 hours during the first year is under review at the Food and Drug Administration (FDA), says **Anita Nelson**, MD, professor emeritus in the Obstetrics and Gynecology Department at the David Geffen School of Medicine at the University of California in Los Angeles.[1] In a study of the efficacy and safety of two levonorgestrel intrauterine contraceptive systems (one with 13.5 mg and the other with 19 mg), over the three-year study period, 0.33 pregnancies per 100 women-years (95% confidence interval [CI], 0.16-0.60) were observed with the 13.5 mg intrauterine contraceptive system compared with 0.31 per 100 women-years (95% CI, 0.15-0.57) with the 19.5 mg intrauterine contraceptive system.[2]

Another intrauterine device in research is the VeraCept copper contraceptive IUD, says Nelson. A low dose of copper is loaded on the device's biologically inert, spring-shaped, nitinol frame with tailstrings, with the copper concentrated near the tubal ostia and internal cervical os, Nelson states. Early research on the device's efficacy, cramping, bleeding, expulsion, performed

EXECUTIVE SUMMARY

What new methods can clinicians look to add to their arsenal of family planning options in the upcoming years? Several possible options are moving through the research pipeline.

- A 19 mg total dose levonorgestrel IUD that releases approximately 13 mcg/24 hours during the first year is under review at the Food and Drug Administration.
- Another intrauterine device in research is the VeraCept copper contraceptive IUD. A low dose of copper is loaded on the device's biologically inert, spring-shaped, nitinol frame with tailstrings, with the copper concentrated near the tubal ostia and internal cervical os.
- Scientists are studying use of polidocanol foam, approved as a treatment for varicose veins, as a nonsurgical permanent contraception option.

in the Dominican Republic, was presented at the 2015 American College of Obstetricians and Gynecologists annual meeting.[3] ContraMed of Campbell, CA, developer of the device, announced the first enrollments in its U.S. Phase 2 clinical study of the device in July 2015. A total of 10 centers are participating in a study designed to evaluate the safety and effectiveness of VeraCept in a study population of parous and nulliparous women seeking long-acting, reversible contraception.

How about new options for women who are considering permanent contraception? In a new analysis of U.S. women using contraception, female sterilization was the second most-used option by current contraceptors. About one-quarter (25.1%, or 9.4 million women) named it as their current method of birth control.[4]

Jeffrey Jensen, MD, MPH, and his team at Oregon Health & Science University in Portland are looking at a safe, effective, and accessible nonsurgical permanent contraception for women around the world using polidocanol foam, which has been approved by the FDA as a treatment for varicose veins. Jensen is the Leon Speroff professor and vice chair of the research department of obstetrics & gynecology at the school.

"Polidocanol foam [PF] is currently being tested as a method of nonsurgical permanent contraception for women using a nonhuman primate model," says Jensen. "We have shown that a single transcervical treatment with 5% PF can block the intramural portion of the fallopian tube without adverse non-target effects and that the occlusion that develops appears to be permanent."[5]

Although the team has completed a contraceptive study in baboons, it has not published these results, says Jensen. The scientists are evaluating modifications of polidocanol foam aimed at increasing safety and effectiveness while reducing the dose, he notes.

Polidocanol foam is one of several approaches to nonsurgical permanent contraception under investigation at the Oregon Permanent Contraception Research Center, says Jensen. The Center was established at the Oregon National Primate Research Center at Oregon Health and Science University in November 2014 through a grant from the Bill and Melinda Gates Foundation in Seattle. The long-term goal of the center is focused on the development of a highly effective, safe, low-cost, nonsurgical, and highly portable method of permanent contraception to meet the unmet needs of women who have completed desired family size and voluntarily seek permanent contraception. Center Scientific Director Ov Slayden, PhD, and his team at the Oregon National Primate Research Center are working with Jensen's team to develop such options for women around the globe.

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Pills, patches, and rings — What's the latest on the second-tier methods?

What are the benefits and disadvantages of such second-tier methods as pills, patches, and rings, and which women can safely use them? These Tier 2 methods, designated by their effectiveness ranking as adapted by the World Health Organization (WHO), depend on user behavior such as taking a pill every day or changing the patch or the ring on time.[1]

It's best to use the *Effectiveness of Family Planning Methods* chart in discussing these contraceptive options with women to give a pictorial-based representation of where these methods fall on the effectiveness chart, says **Carrie Cwiak**, MD, MP, associate professor of gynecology and obstetrics and division director of family planning at Atlanta-based Emory University. *(The chart and contraceptive fact sheets are available at the federal Family Planning National Training Centers site. Go to http://bit.ly/1MKCbp8 to download these resources.)*

Combined oral contraceptives (COCs) continue to be the most-used of all combined hormonal options, states Cwiak, who spoke at the 2015 *Contraceptive Technology* Quest for Excellence conference in Atlanta.[2] Despite the pill's popularity, however, continuation is less than desired, notes Cwiak.

Just 55% of women continued on COCs at 12 months, compared to 86% of LARC users, in the Contraceptive CHOICE Project, a prospective cohort study of reproductive-aged women designed to promote the use of long-acting reversible contraceptives (LARC) by eliminating cost, access, and knowledge barriers.[3]

One way to help women stay consistent in their pill-taking is to supply multiple packs of pills, says Cwiak. In one California study, women who received a one-year supply were less likely to have a pregnancy (1.2% compared with 3.3% of women receiving three cycles of pills and 2.9% of women receiving one cycle of pills).[4]

Counsel on adherence

The efficacy of any combined hormonal method depends on compliance to its correct use. To help prepare women for the eventuality of missed pills, clinicians can use the Family Planning National Training Center's chart at http://bit.ly/1NpChyM or a simplified explanation from *Contraceptive Technology*:

- If she is late (less than 12 hours) taking a pill, take it immediately and continue with the other pills at the usual time.
- If she is more than 12 hours late taking the pills, she should take the last missed pill right away and also take the pill she should take on time. She should use emergency contraception (EC) if she has had any unprotected intercourse in the past seven days. She should use condoms or abstain until she has used seven pills in a row.[5]

Management of forgotten patches depends on which patch is missed and for how long. If forgotten or missed in the first week, women should be provided EC if they have had unprotected intercourse and advised to place a patch immediately. An additional method (such as condoms) or abstinence should be used for seven days. Remind the patient to change the patch each week from now on, beginning on the day she started the new patch.

If missed or forgotten on the second or third week, if the patch is one to two days late, the women can remove the old patch and replace it with a new one immediately. She will need no additional contraceptive method or EC.

However, if the patch is more than two days late, she should remove the old patch, place one immediately, and be provided EC if

EXECUTIVE SUMMARY

Many women continue to choose combined hormonal contraceptives. However, these methods are dependent on user behavior, such as taking a pill every day or changing the patch or ring on time.

- Combined oral contraceptives continue to be the most-used of all combined hormonal options. To help women stay consistent in their pill-taking, supply multiple packs of pills.
- Management of forgotten contraceptive patches depends on which patch is missed and for how long.
- If the contraceptive vaginal ring is out of the vagina for more than three hours during the first two weeks, a woman might not be protected against pregnancy. She should reinsert the ring as soon as possible and use an extra method of birth control until the ring has been used for seven days in a row.

e has had unprotected intercourse. Advise additional contraception or abstinence for seven days.

If, during the fourth week, a woman recognizes she has forgotten to remove her third patch, she can remove it at that time. She will need no additional contraceptive method or EC. She then should place a new patch on the usual day.[5]

With the contraceptive vaginal ring, if the ring is out of the vagina for more than three hours during the first two weeks, a woman might not be protected against pregnancy. She should reinsert the ring as soon as possible and use an extra method of birth control until the ring has been used for seven days in a row. If the ring has been out for more than three hours during the third week, she can choose from two options:

• She can insert a new ring immediately. This step begins the next three-week use period. She might not have withdrawal bleeding, but she might experience breakthrough spotting or bleeding.

• Or, she can wait for withdrawal bleeding, and insert a new ring no later than seven days from the time the previous ring was removed or expelled. This option should be chosen only if the ring was used continuously for the preceding seven days. In addition, she must use a barrier method until she has used the ring for seven days in a row.[5]

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Get up to speed on ICD-10 coding for reproductive health services

While the purpose of ICD-10 is to improve clinical communication and accuracy, it will require more precise documentation of clinical care. Clinicians received vital tips on how to integrate the new coding in their family planning practices at the recent *Contraceptive Technology* Quest for Excellence conference in Atlanta.

The new ICD-10 codes allow healthcare providers to better capture data on signs, symptoms, risk factors, and comorbidities to better describe overall clinical issues and support reimbursement for the level of care provided, says **Michael Policar**, MD, MPH, clinical professor of obstetrics, gynecology, and reproductive science at the University of California, San Francisco. Policar presented on the subject at the conference.[1]

The ICD-10 system classification system is being used by most. The United States was the only industrialized nation not using an ICD-10-based classification system prior to the switch on Oct.1, 2015.

Not only will the new coding structure more effectively measure quality, safety, and efficacy of care, but it will reduce fraud and make sure that healthcare dollars are used most efficiently, said **Lynne Thomas Gordon**, MBA, RHIA, CAE, FACHE, FAHIMA, chief executive officer of the American Health Information Management

EXECUTIVE SUMMARY

The new ICD-10 codes allow healthcare providers to better capture data on signs, symptoms, risk factors, and comorbidities to better describe overall clinical issues and support reimbursement for the level of care provided.

• The ICD-10 system classification system is used by most of the world. The United States was the only industrialized nation not using an ICD-10-based classification system prior to the switch on Oct. 1, 2015.

• In the new structure, diagnosis codes break down into up to seven characters. The first three characters describe the category; the next three point to cause, location, and severity; and the seventh character is for greater specificity.

Association. "ICD-10 will enhance the value of information for population and public health and research," said Gordon in a released statement. "Ultimately, this will lead to improved patient care and better health outcomes at reduced cost."

What you need to know

The new coding structure accommodates new codes; the old ICD-9 configuration was unable to add new diagnoses and procedures, explains Policar. CPT coding for outpatient and office procedures is not affected by the ICD-10 transition, he notes.

In the new structure, diagnosis codes break down into up to seven characters, explains Policar. The first three characters describe the category; the next three point to cause, location, and severity; and the seventh character is for greater specificity.[1] The seventh digit also is used to identify the timing of the patient encounter, he notes.

Categories of interest to reproductive health professionals include:

- A 00-B 99, infectious and parasitic diseases;
- C 00-D 49, neoplasms;
- N 00-99, diseases of the genitourinary system;
- O 00-9A, pregnancy, childbirth, and puerperium;
- R 00-99, symptoms, signs, and abnormal clinical and laboratory findings, not elsewhere classified;
- Z 00-99, factors influencing health status and contact with health services.

The Z codes will become quite familiar to those in family planning, with such codes as:

- Z 30, encounter for contraceptive management;
- Z 31, encounter for procreative management;
- Z 32, encounter for pregnancy test, childbirth, and childcare instruction;
- Z30.02, counseling and instruction in natural family planning to avoid pregnancy;
- Z30.09, encounter for other general counseling and advice on contraception, no method prescribed;
- Z30.2, encounter for sterilization.

Check the methods

The good news: Improvements in coding for family planning visits include codes for injectable contraception visits (Z30.013 for initiation, Z30.42 for surveillance) and a code for initial prescription of an intrauterine device (IUD) (Z70.014), which is used for a visit when an IUD is ordered, but not inserted, says Policar.

> "FOLLOW CODING GUIDELINES, AND ONLY CODE WHAT IS CONTAINED IN THE MEDICAL RECORD."

The not-so-good news: There still are no specific ICD-10 visit codes for the contraceptive patch and ring, and there are no crossover codes for visits for the contraceptive implant or barrier methods. The American College of Obstetricians and Gynecologists (ACOG) has submitted requests for specific codes to the National Center for Health Statistics and the Centers for Disease Control, the agency tasked with revisions to the ICD-10 diagnosis code set. If the codes are approved, they will become part of the first regular ICD-10-CM release scheduled for Oct. 1, 2016.

Look at the four possible coding options for the four methods without a specific code, and check with payers to determine which codes they want used:

- Z30.018, initial prescription of other contraceptives;
- Z30.49, surveillance of other contraceptives (which is recommended by ACOG for implant visits and may be used for patch, ring, and barrier method visits);
- Z30.019, initial prescription of contraceptives, unspecified;
- Z30.40, surveillance of contraceptives, unspecified.

What should clinicians do to enhance their documentation habits? Policar advises that providers should continuously improve their coding sheets, as well as take a full coding course every few years. Reading a monthly obstetrical/gynecological coding newsletter is helpful as well, and if your office has an in-house coder, get to know him/her on a first-name basis, Policar suggests. Also, www.icd10data.com is a good Web-based resource for converting ICD-9 codes to ICD-10, and vice versa, he notes.

"If you didn't write it down, you didn't do it," says Policar. "Follow coding guidelines, and only code what is contained in the medical record. Reimbursement will follow."

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Over-the-counter oral contraception is caught up in politics

By ***Adam Sonfield***
Senior Public Policy Associate
Guttmacher Institute
Washington, DC

Over the past several years, a small cadre of socially conservative policymakers and candidates, often hailing from swing states, have started to promote the idea of moving oral contraceptives over the counter (OTC) as a supposed compromise in the political fight over contraception and, more broadly, reproductive health.

Sen. Cory Gardner (R-CO), for example, used the issue to help win his 2014 race. He relied on it to counter his record of opposing the Affordable Care Act (ACA), its contraceptive coverage guarantee, and other policies supporting contraceptive access. Sen. Gardner and Sen. Kelly Ayotte (R-NH) built on that strategy by introducing legislation in 2015 that would create special incentives for manufacturers of oral contraceptives to file an OTC-switch application with the FDA. The issue can be expected to play a significant role in some 2016 elections as well.

As my Guttmacher Institute colleague Sneha Barot writes, there is, in fact, a strong evidence-based case for moving oral contraceptives OTC.[1] Numerous medical groups and other reproductive health proponents, including the Guttmacher Institute, have been studying and working toward that step for many years.[2] Lifting the prescription requirement could lower barriers to accessing oral contraceptives, and oral contraceptives meet the FDA's OTC criteria for consumers' ability to safely, effectively, and correctly use the medication without professional guidance. Yet, an OTC application is a long and expensive process for manufacturers to undertake, and it must be done separately for each specific drug.

Proposal has flaws

One serious criticism of the Gardner/Ayotte proposal is that it would politicize and undermine the FDA's scientific and evidence-based process by substituting the judgment of politicians for scientists.

That attitude leads to a second problem: The proposal would prohibit OTC access for anyone younger than age 18. That requirement not only would interfere with adolescents' contraceptive access, but it also would effectively require government-issued photo identification, which could limit access for many other women, such as undocumented immigrants.

Moreover, the Gardner/Ayotte bill would do nothing to help low-income women facing potential cost barriers to OTC oral contraceptives. Its sponsors are simultaneously on record wanting to repeal the ACA and its guarantee that all women's contraceptive options must be covered by most private health plans without any patient out-of-pocket costs. These limitations are particularly salient for the millions of women relying on methods other than oral contraception or on oral contraceptive products other than the specific ones that might be granted OTC status. Notably, many experts believe a progestin-only pill, a type used by only 4% of pill users, might be the first granted OTC status, because it has fewer and rarer contraindications than combined oral contraceptives.[3]

Alternatives pushed

Reproductive health advocates in Congress, led by Sen. Patty Murray (D-WA) and Rep. Tammy Duckworth (D-IL), have introduced their own proposal on OTC oral contraceptives.

In contrast to the Gardner/Ayotte approach, Murray's bill focuses on access and affordability, by amending the ACA's contraceptive coverage guarantee to include coverage of any OTC pill, without out-of-pocket costs and without a prescription. Currently, the ACA policy requires coverage of women's contraceptive options with OTC status, such as levonorgestrel emergency contraception, but only if the woman obtains a prescription. That requirement essentially negates the benefits of OTC status for women concerned about costs.

Murray's bill also rejects the idea of an age restriction, is deferential to the FDA's approval process, and includes protections for consumers against interference by retailers with objections to OTC contraceptives, which is another potential barrier to access. The bill is limited in its scope, however: It is designed to apply to private insurance, but not Medicaid, and it would not remove the prescription requirement for other

contraceptives with OTC status.

Meanwhile, state-level policymakers and advocates have been taking intermediate steps to remove barriers to hormonal contraceptives. California and Oregon have passed laws granting pharmacists the authority to prescribe some hormonal contraceptives. Once the states promulgate regulations to implement these laws, this "behind-the-counter" model might improve access by eliminating, for many women, the expense and hassles of a doctor's visit. In addition, Oregon and the District of Columbia have enacted laws requiring insurance plans to cover a full year's supply of oral contraceptive pills at one time. That approach might promote more consistent contraceptive use.[4,5]

These intermediate approaches, as well as an actual OTC switch for oral contraception, would complement the wide range of other policies and programs needed to fully address people's contraceptive needs. That list includes the ACA's contraceptive coverage guarantee; the ACA's broader expansions to Medicaid and private insurance; support for safety-net family planning providers, including through the Title X national family planning program; comprehensive sex education; and research and development of new contraceptive technologies.

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Congenital syphilis on rise — What you can do

Are you testing your pregnant patients for syphilis at the first prenatal visit and treating them if infected? If not, it's time to step up your efforts. An analysis from the CDC shows that after years of decline, the number of congenital syphilis cases reported in the United States increased between 2012 and 2014.[1]

A closer look at the data indicates that cases of congenital syphilis increased by 38% from 2012-2014, from 8.4 to 11.6 cases per 100,000 live births. The number of congenital syphilis cases increased from 334 in 2012 to 458 cases in 2014, statistics show. Of the reported cases in 2014, 22% of mothers received no prenatal care. In women who received prenatal care but never were treated, 15% were never tested for syphilis during their pregnancy, data indicate.[1]

Babies who are infected with syphilis during pregnancy might have developmental delays or other poor outcomes. Up to 40% of babies born to women with untreated syphilis might be stillborn or die from the infection, the CDC states. Treating pregnant women at least 30 days before delivery is 98% effective at preventing illness in infants, says the CDC.

Clinicians should be aware of syphilis trends in women and men who have sex with women (MSW), as well as local congenital syphilis trends, said **Gail Bolan**, MD, director of the CDC's Division of STD Prevention in its National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, in a Nov. 12, 2015, "Dear Provider" letter.

"Public health departments can reduce syphilis transmission within the community through partner services and screening programs for women and MSW," said Bolan.

REFERENCE

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COMING IN FUTURE MONTHS

- Vaginal estrogen option for post-menopausal women
- Increase HIV pre-exposure prophylaxis in at-risk patients
- HPV and cervical cancer: Update your knowledge base
- Tips on discussing health issues with LGBTQ youth

CONTRACEPTIVE TECHNOLOGY UPDATE®

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3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.

4. After successfully completing the test, your browser will be automatically directed to the activity evaluation form, which you will submit online.

5. Once the completed evaluation is received, a credit letter will be emailed to you instantly.

CNE/CME QUESTIONS

1. **According to October 2015 recommendations from the American Cancer Society, at what age should all women should begin having yearly mammograms?**

   A. 35
   B. 45
   C. 50
   D. 55

2. **While all progestin-containing contraceptive methods reduce menses, which is the most effective, according to Anne Burke, MD, MPH, associate professor in the Department of Gynecology and Obstetrics at the Johns Hopkins University of School of Medicine?**

   A. Contraceptive implant
   B. Progestin-only pill
   C. Combined oral contraceptives
   D. 52 mg levonorgestrel intrauterine device

3. **What is the frame composition of the VeraCept copper contraceptive intrauterine device now under research?**

   A. Silicone
   B. Nitinol
   C. Nestorone
   D. Urethane

4. **What percentage of women continued on combined oral contraceptives at 12 months in the Contraceptive CHOICE Project in St. Louis?**

   A. 45%
   B. 50%
   C. 55%
   D. 60%

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®

Reproductive health clinicians report slight salary gains in midst of staffing cuts

Declines in funding continue to affect almost one in four local health departments

Those in the family planning and reproductive health field who survived staffing cuts were able to garner slight increases in pay, according to results of the 2015 *Contraceptive Technology Update* annual salary survey.

Those in public health, who represent a large percentage of *Contraceptive Technology Update* survey respondents, have seen decreases in staffing since the beginning of the recession of 2008.

That trend has continued: One-third of local health departments reported losing at least one position due to layoffs/attrition in 2014, according to a recent report from the National Association of City and County Health Officials.[1]

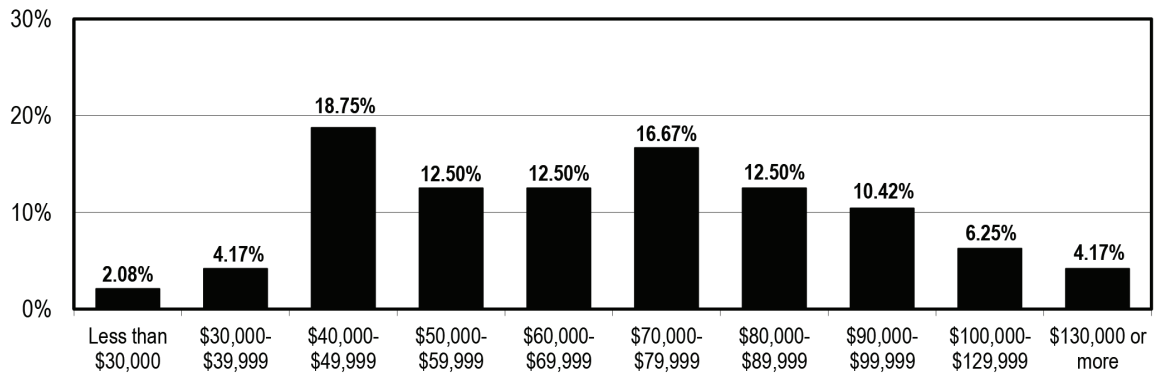
Large health departments, which are those serving populations of 500,000 or more, continue to feel the blow. More than half (61%) reported job losses in 2014, while 26% of small departments, which are those serving populations of less than 50,000 people, reported decreases that were simillar.

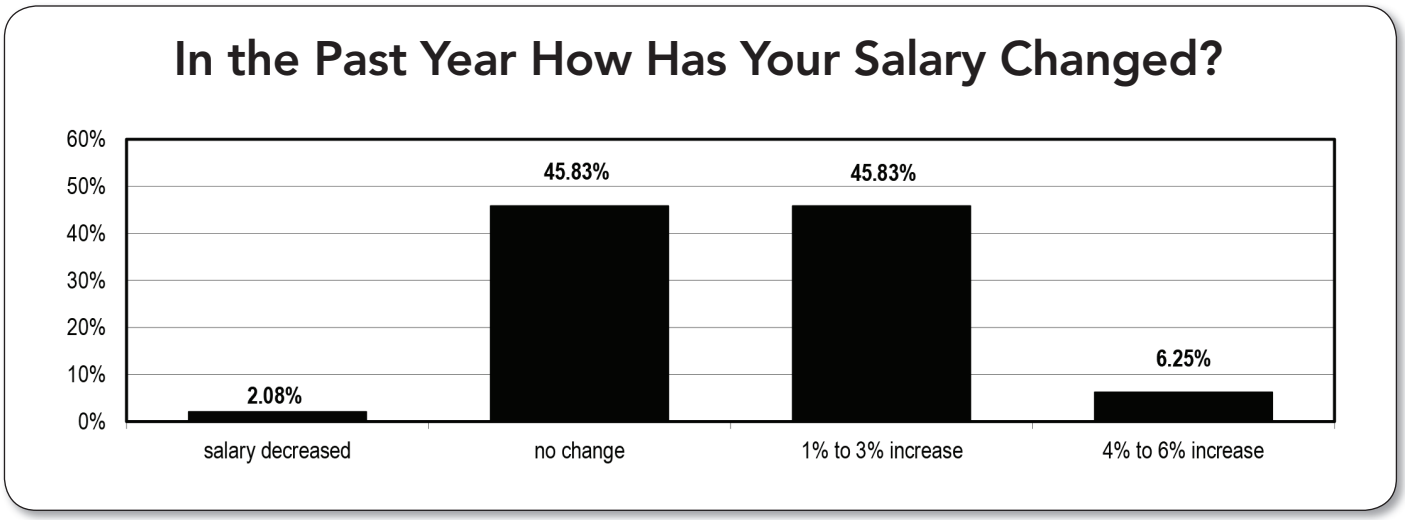
While budget cuts have tapered since 2008, declines in funding continue to affect almost one in four local health departments, according to the National Association report. Almost one-quarter of departments reported budget cuts in 2014, and more expected budget cuts in their next fiscal year.[1]

Where are you going?

If you are considering a job change due to impending cuts, don't forget the power of networking, says **Renee**

What Is Your Salary Level?





Dahring, MSN, NP, nurse practitioner and career coach. Dahring operates a career coaching web site, www.nurse practitionerjobsearch.com, and pens a *Career Coach* blog at http://bit.ly/1H11rap.

Despite all of the new technology, networking is still the number one way to land a new position, says Dahring. Employers who call for a reference might think that they aren't obtaining a full picture of a prospective employee; however, a referral from an employee will signal that the applicant might be a good fit for the position at hand, she notes.

Don't overlook the importance of working within contacts in your professional organizations as well, says Dahring. Be active in such groups. Participate in professional organizations' online forums, and take part in their social media efforts.

Many employers are looking at applicants' Facebook interactions, notes Dahring. Participating in meaningful ways on organization sites will show your interest in your chosen profession, she states.

Part-time jobs drop

If you are looking to decrease your hours to part-time work due to family demands, or you're looking for a less-hectic work schedule, chances are that you will find fewer opportunities for work, says Dahring.

New regulations that require employers to offer a full complement of benefits to part-time employees are causing many employers to think twice about picking up new part-time positions, she notes.

"Demand for nurse practitioners is strong, but you won't see many two- to three-days-a-week positions among the job listings, especially with the larger healthcare entities," Dahring observes.

What if you have been applying for full-time work but haven't received responses to your queries? Dahring says it's time to look at your job-searching tactics if it seems your qualifications are solid, but your inbox is empty. Consider her suggestions:

• Check your resume.

Be sure that your resume is tailored specifically for the job at hand.

Be sure that you emphasize the skills that are required for the potential position, and eliminate skills that are not relevant. By taking the time to create a customized resume, you are demonstrating that you are a serious job contender, she notes.

• Ask yourself: Are you applying for every opening at one organization?

If you are, you are committing what Dahring calls "death by mass application." Choose the job opening that is best suited to your skills, and stick to one application within that organization, she states.

No one can be a good fit for every job, observes Dahring. When applying for every open position within an organization, particularly through its digital portal, know that such applications often stay in the system for a very long time, which is a mistake, Dahring comments.

• Ask yourself: Are you applying for specialty jobs unrelated to your current specialty?

If working with a recruiter, prepare a cover letter that succinctly explains your motivation.While there is nothing wrong with wanting to make a practice change, if you don't provide some context for that change, the assumption might be that you are motivated by other reasons, such as salary or hours, rather than the position, says Dahring. *(Check the snapshot in this supplement for an overview of 2015 respondents.)*

REFERENCE

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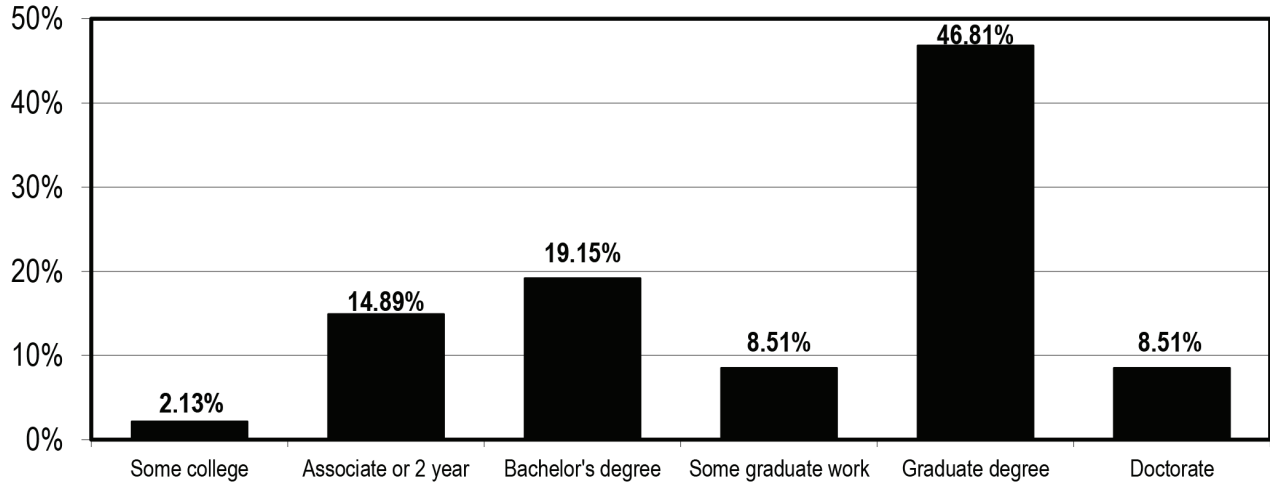
What Is Your Highest Academic Degree?



Overview of respondents and responses to annual *CTU* Salary Survey

About 54% of the 2015 *Contraceptive Technology Update* Salary Survey respondents identified themselves as nurse practitioners (NPs), with about 17% of survey respondents identifying themsleves as registered nurses, and about 4% identifying themselves as nurse-midwives.

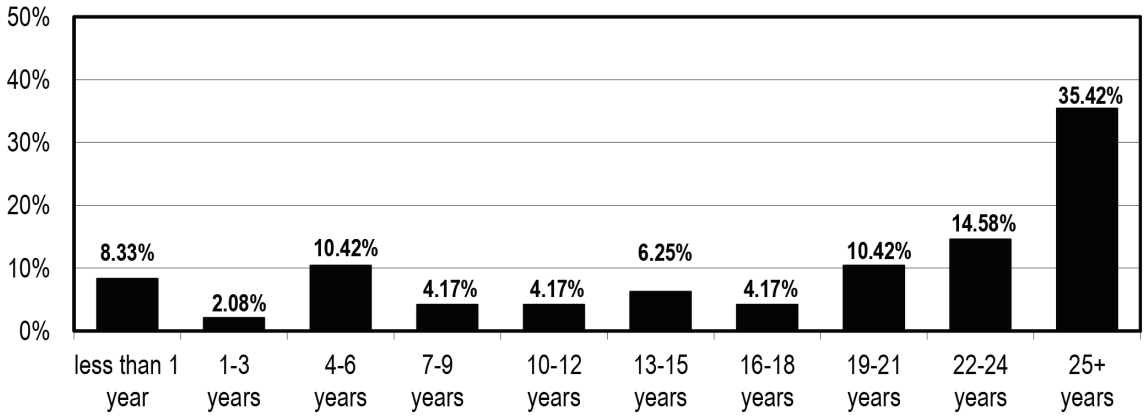
Administrators comprised about 21% of the current year's responses. About 2% identified themselves as physicians.

The *Contraceptive Technology Update* survey was mailed in September 2015 to 414 subscribers with 48 responses, for a response rate of 11.6%.

About 52% of all *CTU* survey respondents reported salaries between $60,000 and $99,999; about 38% of survey respondents indicated that they made $59,999 or less. About 10% of survey respondents said they earned a six-figure salary. *(See the graphic titled "What is your salary level?")*

About 46% of *CTU* survey respondents say they

How Long Have You Worked in Your Current Field?



received a 1-3% increase in pay in 2014, while a similar percentage reported no change in salary levels. Six percent of survey respondents received a 4-6% raise. About 2% of respondents reported a decline in pay. *(See the graphic titled "In the past year how has your salary changed?")*

About 35% of respondents said staffing levels dropped in the last year, while 38% said staffing levels stayed steady. About one-quarter of respondents (27%) saw an increase in staff positions.

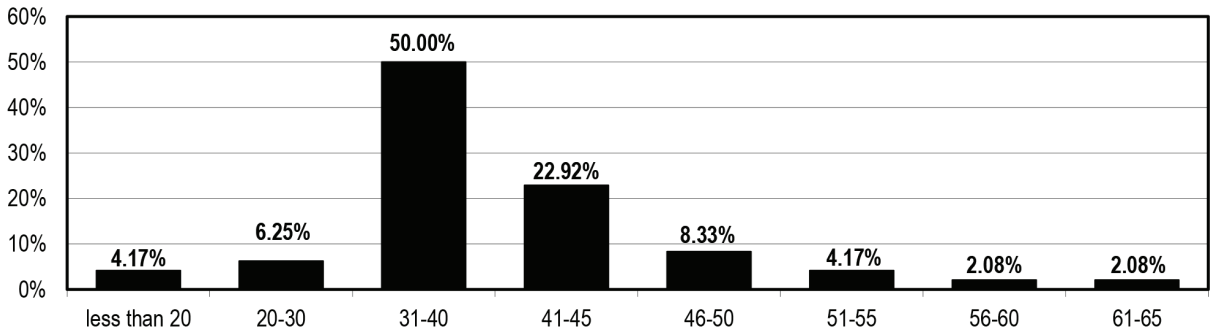
Extra hours don't enter into the picture for most survey respondents. About 60% of respondents reported working 40 hours or less a week. *(See the graphic titled "How many hours a week do you work?")*

More than half (57%) of respondents said they supervise between 1-3 people. *(See the graphic titled "How many people do you supervise?")*

Does location make a difference in pay? About half (43%) of *CTU* survey respondents reported working in a rural area, with about 25% in an urban location. About 20% said they worked in a medium-sized city, with 11% in a suburban location.

While most survey respondents said they worked in a public health agency, some 29% of respondents reported clinic employment. About 17% of survey respondents said they worked in a college health service environment, with 6% at an agency. ■

How Many Hours Per Week Do You Work?



How many people do you supervise?