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INSIDE

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Use Best Practices to Screen Patients for Substance Use Disorder

Universal screening is most fair

Around 20 million Americans have a substance use disorder, and one out of eight adults struggle with both alcohol and drug use disorders at the same time, according to data from American Addiction Centers.[1]

Recent guidelines from the American College of Obstetricians and Gynecologists' Committee on Obstetric Practice recommend anyone who enters a physician's office for reproductive health services receive a screening for a substance use disorder (SUD).[2]

"THERE CERTAINLY IS A STRONG ROLE FOR REPRODUCTIVE HEALTH PROVIDERS TO ASSESS BEHAVIORAL HEALTH CONDITIONS LIKE SUBSTANCE USE, MISUSE, AND ADDICTION."

"The most important thing for folks to know is substance use disorders cut across all demographics and all ethnicities and layers of society," says **Marcela Smid**, MD, MA, MS, assistant professor in the division of maternal fetal medicine at the University of Utah Health. "Some populations are more affected, and screening is more important to do universally, especially in this time when we have heightened awareness and are doing a lot of reflection on the way it has discriminated against certain groups of people. If we screen, we need to do it universally. We

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don't know who is at high risk and who is not, so everyone should be considered high risk."

The other important point is to think of substance use disorders as a medical problem like any other medical condition, Smid notes. "We're trying to identify and treat it so we can help people live healthier, happier lives. Everyone deserves that," she adds.

Clinicians should think of substance use as a continuum, says **Mishka Terplan**, MD, MPH, FACOG, associate medical director at Friends Research Institute in Baltimore. Terplan also serves as adjunct faculty at the University of California, San Francisco, where he is a Substance Use Warmline clinician at its Clinical Consultation Center. "There is use, misuse, and addiction," he says. "Use should be self-evident; misuse is using a substance in a way that is potentially harmful."

The most salient feature of addiction is when a person cannot stop a behavior, and it is not necessarily related to physical withdrawal symptoms. "The American Society of Addiction Medicine has a two-sentence definition, which I helped write," he adds.

The society's definition calls addiction a "treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences."[3]

"There certainly is a strong role for reproductive health providers to assess behavioral health conditions like substance use, misuse, and addiction," Terplan says. "One reason is that there is a parallel overlay between ages in which people use and misuse substances and ages when people seek reproductive health services. Another reason is that some people get almost all of their healthcare through reproductive healthcare."

Providers Can Collaborate

Behavioral health issues can overlap with reproductive health objectives. "There is resonance between behavioral health, substance use, and other domains of reproductive health, including sexual risk-taking, adherence or nonadherence to contraception, etc.," Terplan says.

Terplan has worked on several collaboration projects that could require training OB/GYN and family planning staff to screen and assess patients for SUD. They also need to connect with local providers, he says.

EXECUTIVE SUMMARY

OB/GYNs and family planning clinicians should screen all patients for substance use disorders, as recommended by researchers and professional guidelines.

- Substance use disorders affect people in all demographics, ethnicities, and economic backgrounds.
- Addiction occurs when a person is unable to stop a behavior. It is not necessarily related to physical withdrawal symptoms.
- Clinicians should avoid using the term "substance abuse." Instead, they should describe it as substance use, misuse, and addiction.

"For example, we had a small grant to integrate reproductive health into drug treatment," Terplan explains. "I had a mobile clinic that provided reproductive healthcare directly into their facility."

These kinds of programs might begin with grant money, but the goal could be to use Title X or other state or federal funding and place a dedicated professional in charge. *(See story on collaboration between contraceptive services and substance use treatment centers in this issue.)*

When screening for substance use, clinicians should communicate clearly that these are questions they ask all of their patients. They can say, "We want to identify if there is anything we can help you with, and we would like to ask these questions," Smid suggests.

Most providers fail to screen for substance use, partly due to misperceptions and partly because they believe prescreening questions about smoking, drinking, and drugs are the same thing as screening, Smid explains.

"Also, many providers did not receive a great education about substance use disorders in their training," she adds.

Clinicians sometimes assume women with SUD are not interested in or do not care about contraceptives or their reproductive health. This assumption is a mistake, says **Sarah H. Heil**, PhD, professor of psychiatry and psychological science at the University of Vermont in Burlington. "They are interested, and they do want to be able to make decisions around their reproductive health," she says. "Giving them a chance is important."

To screen patients for substance use disorders, use a validated screening tool, Smid says. One example is the NIDA-Modified ASSIST tool, developed by the National Institute on Drug Abuse (NIDA), to screen for drug use in general medical settings.[4]

"A few tools focus on women of reproductive age, and many are validated," she adds. "The important thing is to understand that screening is not asking patients if you use drugs — that's prescreening, It's not drug testing on urine."

While drug testing on urine can be a useful tool, it is not a good screening tool, Smid says. If biologic testing is used or suggested, patients need to be aware of potential harm.

"It can be useful, but it also can be incredibly harmful, particularly for pregnant and parenting women because of laws that criminalize drug use in pregnancy and parenting women," Smid explains. "It's important the clinician and patient have an understanding of when biologic testing will be used, how it is used, and what the results will be used for."

If an open and honest discussion about the testing is held, and patients understand what the testing is used for, then it can be helpful in monitoring patients. If clinicians do not fully disclose how the testing is used, then there could be circumstances in which women are criminalized for substance use and even have their children taken away, Smid adds.

"That's why I advocate, especially in a family planning centers where many women are parenting and are seeking services to plan their families, that we use a validated screening tool for identification of substance use and to offer referrals and services for those women," she explains.

Treat Patients with Respect

Family planning providers should keep in mind that women with SUD sometimes have been treated poorly by healthcare professionals. When they enter a new provider's office or clinic, they might be worried about being stigmatized or treated badly, Heil says. They might fear being talked into a birth control method they do not want to use, or even being coerced into a tubal ligation.

"Treating them nicely and with respect goes a really long way," Heil says. "Being more flexible with them in terms of appointments and things like that also helps."

Heil often hears women with SUD say their providers will no longer see them after the women missed several appointments.

"These women are living very chaotic lives, having difficulty finding child care, and have trouble with transportation," Heil says. "They have issues with unstable housing and having to get enough food."

Also, the women might have competing demands from social services agencies. For instance, a woman might have to show up at the Women, Infants, and Children office at a certain time of the day, or meet with her probation officer or face being jailed. Those appointments might conflict with a reproductive health visit.

"If they don't show up, then it's likely that they don't care," Weil explains. "It's more likely there are circumstances beyond their control."

Clinicians should be willing to meet patients however they can. If patients miss appointments, then clinicians could keep trying.

"They're often very happy to get to the appointment, and they often really do want family planning and try to make the best decisions they possibly can and get professional input to meet those goals," Weil says.

Some substance use treatment centers and reproductive health clinicians are collaborating to make

contraceptives and reproductive health services more readily available to women with SUD.

Terminology can be important when dealing with substance use issues, particularly because it can increase stigmatization when used without sensitivity. *(See story on stigma in this issue.)* For instance, clinicians might use the word "assessment" instead of "screening," because it's a broader term, Terplan says.

A term clinicians should avoid is "substance abuse." Instead, refer to substance use, misuse, and addiction. This is a change over the past five years.

"Use 'addiction' or 'substance use disorder' as terminology," Terplan suggests. "The term 'abuse' is considered stigmatizing, and there are randomized, controlled trial data showing that when we use the term 'abuse,' people are more likely to endorse punitive responses and not a biomedical model." ■

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Collaboration with Substance Use Treatment Clinics Can Reach More Patients

Women want integrated services

Women who receive treatment for a substance use disorder (SUD) would welcome services that integrate their treatment with family planning and contraceptive services, the authors of a recent study found.[1]

"Historically, both reproductive health and substance use have been siloed," says **Lauren MacAfee**, MD, MSc, FACOG, OB/GYN and assistant professor at the University of Vermont Medical Center. "That creates big disparities for patients who may need multiple models of care and domains of care."

Integrated care models for SUD and reproductive healthcare are a method of increasing access to both types of care. Investigators interviewed women of reproductive age who were in residential treatment. They found that 85% of the women expressed a desire to prevent pregnancy in the next year, although only one-third were using a form of contraception. Nearly 70% of the women said they preferred the integration of contraceptive care and treatment for SUD, and about 29% said they preferred a long-acting reversible contraceptive (LARC) if cost was not an issue.[1]

"It was a descriptive study," says **David Phillippi**, PhD, a lecturer at Belmont University in Nashville, TN.

The data show that women in an SUD clinic are interested in integrated contraceptive care. "The primary purpose of the study was to measure the interest in integrative contraceptive care at an integrated substance use disorder treatment facility, and to assess which providers were likely to be well-received by the women in terms of who they could have that conversation with," Phillippi says.

Researchers identified many barriers to reproductive health services among women in SUD treatment programs. These included women not being asked about family planning, or being unable to fill prescriptions for birth control. They also had difficulty making and getting to appointments.

"It's important to develop bi-directional relationships between reproductive health providers and substance use services," says **Mishka Terplan**, MD, MPH, FACOG, associate medical director at Friends Research Institute in Baltimore. Terplan also serves as adjunct faculty at the University of California, San Francisco, where he is a Substance Use Warmline clinician at its Clinical Consultation Center.

This relationship begins with reproductive health providers giving universal assessment for behavioral health and substance use disorders. "I'm working with Los Angeles County in a pilot project to integrate reproductive health assessment, referral, and treatment for people in the publicly funded drug treatment system," Terplan explains. "It's already started, and there's a strong educational component to it." The COVID-19 pandemic has slowed the program, although it is still underway, he notes.

One model for integrating contraceptive services with SUD treatment is to create a reproductive health office in or adjacent to a methadone clinic. With grant funding, researchers incorporated a contraceptive clinic at a methadone clinic for research purposes. The reproductive health clinic was one floor above the methadone clinic so women could receive treatment and head upstairs for contraceptive counseling and services, MacAfee says.

The study has not been published, but some early data, published in 2019, revealed increases in contraceptive use among women with opioid use disorder when they had access to integrated family planning and SUD services.[2]

Researchers found some positive results in preliminary data for a new study comparing several ways of providing contraceptives to women with SUD. This unpublished research suggests that free, onsite contraceptive care with counseling can result in a higher rate of contraceptive uptake than in the usual care group, says MacAfee, one of the study's investigators. *(More information is available at: https://bit.ly/2KXLn1s.)*

"If you add vouchers to incentivize women to return to their reproductive health provider after initial counseling and contraceptive services, it worked even better," she adds.

Investigators theorized that women with SUD often lack the skills and motivation to call their physicians if their first contraceptive choice does not work out. Instead, they might just stop using the contraceptive. Providing the women with an incentive to seek a follow-up appointment may make them more likely to return to their provider and sort out any problems, which would lead to higher rates of contraception use. The data show this to be true, MacAfee says.

"Having those visits allowed them to transition to new methods if they were having problems, and the highest uptake was in the group with a clinic on site and vouchers," she adds.

The pragmatic challenge is funding this level of integration and the vouchers. "The big issue with healthcare vouchers is sustainability," MacAfee says. "Who pays for the vouchers? Health insurance companies?"

Integrating reproductive healthcare and SUD treatment begins with staff training. "Step one is training the staff; step two is integrating some form of reproductive health needs at the patient level," Terplan explains. "Step three is forming referral relationships with people who want LARC so they can go to the reproductive health clinic to get it."

The program's reproductive health clinicians visit drug treatment facilities to provide education and referral services. But that is only one model for collaboration.

"There are many different ways you can achieve integration," Terplan says. "These range from comprehensive co-located services to physically separated services with tight connections and warm handoffs within those domains."

Family planning clinicians should think about how to incorporate addiction treatment into the reproductive health setting, Terplan says.

"There might be Title X providers that are waived to provide drugs [buprenorphine] for opioid use disorder, and some do prescribe it," he says. "There is a need not just for a relationship between a reproductive health center and a specialty addiction service, but also for integrating addiction treatment in the reproductive health center."

One reason integration between contraceptive services and SUD treatment works so well is because women want the warm handoff between one clinic and another. They do not want separate appointments, and they do not want to explain to their physician that they are taking methadone, MacAfee says.

"Any opportunities you can take to bridge the gaps and minimize the barriers to patients will make a big difference," she says. "We know transportation is a problem, so anytime you can have services on site, even a [reproductive health bus] in a parking lot, or have a soft handoff, it helps."

Family planning clinics could create mutually beneficial agreements with SUD treatment centers and other providers. "There is no one-size-fits-all model for any clinic or setting," MacAfee says. "It's thinking about, 'Here are the barriers to care, and how can we reduce any of those barriers and make it easier for patients to access these services?'"

Integrated services also give both reproductive health and SUD treatment providers confidence in handling health needs outside their comfort zone. For instance, a collaboration or integrated program allows family planning clinicians to send patients back to the SUD treatment center if there are recurring issues related to substance use. When the patient is stabilized, the treatment center can send her back to the family planning center, MacAfee explains.

"My pie in the sky hope is having a nurse practitioner who goes to all the [SUD] clinics on a rotating basis and provides contraceptive services on site," she adds. "That would be great to incorporate these services."

Robert A. Hatcher, MD, MPH, chairman of the *Contraceptive Technology Update* editorial board, says

"The American Academy of Pediatrics could not be more clear about alcohol use in pregnant women. Here is their summary statement: 'There is no point during pregnancy when drinking alcohol is considered safe.'" ■

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Clinicians Can Help Reduce Stigma Around Substance Use Disorder

Stigma is a major barrier to women with substance use disorder (SUD) receiving reproductive healthcare and contraceptives.

"Women may not feel like they can talk to their substance use providers about their healthcare needs, or they don't feel they can tell providers about their substance use," says **Lauren MacAfee**, MD, MSc, FACOG, assistant professor at the University of Vermont Medical Center. "They also believe their babies will be taken away from them. That's a huge fear for them if they already have children or are pregnant and planning to parent," she says.

The stigma is felt bi-directionally. "They feel stigmatized by substance use disorder providers when they want to talk about reproductive health, and they feel stigmatized by health providers when they talk about substance use disorder," MacAfee says. "To some extent, yes, this stigma happens; we see a lot of stigma for women who report a substance use disorder during pregnancy, even when they're in treatment."

There is a natural inclination for clinicians to be concerned about a woman using substances that could harm her baby. "It brings us against everything we know about motherhood, so there is a lot of stigma and shame," MacAfee says.

This viewpoint was reinforced in the 1980s when governments arrested women who used cocaine, and the stigmatized image of the "crack baby" was reinforced in the media. Words were used to reinforce stereotypes and increase stigma during the 1980s war on drugs. Now, this viewpoint has shifted, and there is a better understanding that addiction is not a moral issue, but a healthcare issue, MacAfee says.

"We've shifted. We thought it was a moral failing for someone to use drugs, and if they made bad decisions it was because they were bad people, and we needed to approach that from a police services perspective," she explains. "Now, we recognize that substance use is a mental health and public health issue. It shouldn't be criminalized, and it needs to wrap around medical and mental health services."

Stigma also could play a role in contraceptive counseling and recommendations. Family planning providers should be aware of any bias that might result in their recommending long-acting, reversible contraceptives (LARC) more often to women with SUDs or suspected of having SUDs.

"I think if LARC is targeted at a particular population, like women who are low income, have a large number of children, or who are actively still using drugs, that's just unethical," says **Sarah H. Heil**, PhD, professor of psychiatry and psychological science at the University of Vermont. "If we believe LARC is effective and a good option, we should talk about it with everybody. There's a lot of emphasis now about talking with patients and doing shared decision-making."

Clinicians should ask women, including those with SUD, about their goals, values, and what they find most important in contraception, Heil says. "Then, offer recommendations that would fit with what they talked about."

If clinicians want to use the right words, they could follow suggestions by the National Institute on Drug Abuse (NIDA). NIDA published a guide, titled "Words Matter: Terms to Use and Avoid When Talking About Addiction." *(The guide is available at: https://bit.ly/3mB7GYu.)*

For example, NIDA says that stigma about people with SUD could include inaccurate thoughts that they are dangerous, cannot manage treatment, or are at fault for their condition. NIDA also lists words to avoid, such as the word "addict," which can be replaced with "person with substance use disorder." Other words to avoid are "junkie," "substance- or drug-abuser," "alcoholic," "drunk," "former or reformed addict," and "habit."

Research shows that stigma is reduced when people believe a person did not cause their problem. For example, if the language used

to describe someone's substance use included the words "junkie" or "abuser," clinicians might react more negatively to the patient than if the words used were "substance use disorder." One study revealed that health professionals held greater negative associations with the term "substance abuser" than they did with the term "substance use disorder."[1,2]

"The responses are very different, depending on the words used," MacAfee says.

Robert A. Hatcher, MD, MPH, chairman of the *Contraceptive Technology Update* editorial board, shares his personal experience.

"Thirty-four years ago, I went to my first Alcoholics Anonymous meeting. I never had another drink. The success of the Alcoholics Anonymous message immediately struck home, but the word 'alcoholic' and the name of the organization were quite difficult for me to deal with. 'Alcoholic' is a word which definitely carries a stigma. Almost immediately, I felt great about Alcoholics Anonymous because I wasn't drinking. It was, for me, very straightforward. However, I can remember a woman at a meeting in the first few months who said, 'I am a grateful recovering alcoholic.' I listened to her say that repeatedly, and I said to myself 'How could she use the words 'alcoholic' and 'grateful' in the same sentence? I hated the word 'alcoholic' for a long time. But I no longer think that, and there are a lot of people who have difficulty around it. The take-home message: Don't be afraid to refer peopole having problems with alcohol to AA. It costs no money, and it works for some people. When it works, it provides so much more support around issues other than alcohol."

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Family Planning Providers Can Reduce Negative Perceptions of IUDs

Despite the safety and efficacy of the intrauterine device (IUD) and the reduction of cost barriers since the Affordable Care Act (ACA), only about 12% of American women use that method of contraception.[1,2]

Research shows that the women most likely to use an IUD or implant are ages 25 to 34 years, were born outside of the United States, live in a Western state, and report their religious affiliation as "other."[2]

Researchers recently studied age and race differences in women's knowledge and attitudes toward the IUD to find clues about why it is underused in the United States, compared with similar nations.[1]

"The main question behind the study came out of some work I had been doing at a homeless shelter in Philadelphia, where, very often, I saw young women interested in IUDs, and their mothers and older friends would discourage them," says **Sara Edwards**, MD, principal investigator of the study and a resident at the University of Illinois at Chicago. "I wanted to look at whether older women had more negative views, based on older IUDs like the [Dalkon Shield]. We found that was not the case in our study's population, at least."

The Dalkon Shield, manufactured in the 1970s, was withdrawn from the market after more than 200,000 lawsuits worldwide alleged side effects of bleeding, pain, uterine perforations, pelvic inflammatory disease, sterility, ectopic pregnancies, and unplanned pregnancy. *(More information is available at this link: https://bit.ly/33biwgq.)*

Researchers also examined data for racial differences in attitudes, education, and perceptions. "We wanted to look at everything by race because of well-documented differences in how women use contraception," Edwards explains. "We did find some differences in our study, and the one that was the most interesting was self-reported: confidence in their knowledge of whether they felt they had sufficient knowledge about IUDs to make a decision."

Women of all races showed the same level of knowledge about IUDs, but Black women rated their knowledge much lower. "This means we should be more reflective as clinicians in how we're discussing these contraceptive options with our patients," Edwards explains. "Whether we intend to or not, Black women are hearing things from their providers that make them think they know less."

Investigators also found more negative perceptions about IUDs among Black women. The question is why this is true when Black women's IUD knowledge is the same as white

women's IUD knowledge. "If I were to guess about why these sorts of attitudes persist, it's probably because of real [problems] in the past," Edwards says. "There are studies showing that non-white women more often feel like they get coercive birth control counseling in the hospital, and that kind of thing."

While studies have not pinpointed how much providers are being coercive in contraceptive counseling, this perception should be treated as a real factor, she adds.

OB/GYNs and family planning clinicians can prevent bias from seeping into their patient conversations by making sure they have a standardized starting conversation with every patient, Edwards suggests. They could ask themselves: "Why did I suggest that to this woman? Did I have some bias?"

"I go through in a broad overview of general effectiveness of the most common forms of contraception, and I let patients drive the conversation," Edwards says. "I think IUDs should be used more than they are, but it's very hard to walk that line of trying to encourage someone to use something without it coming across as coercive to some patients. I let patients steer the conversation."

To approach conversations with patients, clinicians can break down the options and ask patients when they plan to have a baby. "That makes people think, 'Oh, maybe years,'" Edwards says. "Then, I say, 'You might want to think about these options.' I talk about IUDs and implants, and I say, 'These are the options that work about as well as getting your tubes tied, but they're all reversible.'"

Edwards also hears what patients want and do not want in a birth control method. "It might be that putting something in their uterus is scary to them, or having something implanted in their arm," she explains. "Or maybe having hormones is something they don't want."

If women express interest in the IUD, Edwards speaks candidly about how the IUD's placement can be painful, especially if they have never given birth. "If women go into it thinking it's no big deal, then they will be unpleasantly surprised and it may be crampy going in," Edwards says. "I tell them what to expect so it's not a shock."

Clinicians need to help reduce logistical barriers to IUDs, which remain common despite the no-cost mandate of the Affordable Care Act. Because of the contraceptive mandate, two-thirds of American women with private insurance do not have to pay out-of-pocket costs for IUDs. For women on Medicaid, the IUD is covered without cost-sharing.[3]

"It's very common for there to be some sort of logistical barrier to IUDs, which is most frustrating," Edwards says. Lack of peer and family support and familiarity is another barrier to IUD use. For example, many women have not heard much about the IUD and may not know women who use it, or know that most insurance plans will cover it. This can be a barrier to its adoption, she adds.

"Personally, in a residency with a lot of very hard-working, young, professional women, a vast majority of OB/GYN residents are choosing to use IUDs," Edwards says. "We think about that [contraceptive method] much more often than the average person does." ■

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Researchers Suggest It Is Time to End the Default Pelvic Exam

Women who seek most forms of contraception do not need a routine pelvic examination before they are prescribed a contraceptive. Still, these exams are routine for many OB/GYN offices and reproductive health clinics, and this creates a barrier for some women — particularly those who have experienced sexual assault and intimate partner violence, according to new research.[1]

"I think what prompted this study is that contraception has been recommended since 1994 to be safely prescribed without pelvic examination," says **Hunter Holt**, MD, co-author of the study and a clinical fellow in the department of family and community medicine at the University of California, San Francisco. Holt notes that, except for IUDs, contraceptives can be provided without a pelvic exam.

For example, the American College of Obstetricians and Gynecologists

(ACOG) recommends that pelvic examinations be performed when indicated by medical history or symptoms. ACOG also recommends that the decision to perform a pelvic exam should be a shared decision between the patient and her physician.[2]

Recent evidence shows that a large number of providers still require pelvic exams before prescribing contraceptives, Holt says. This poses a problem to women who have experienced sexual violence. This is a vulnerable population that includes about one in five or six women in the United States.[3] Women who have experienced sexual violence or were pressured by an intimate partner into having sexual intercourse may be reluctant to visit a reproductive health provider because of their fear of the pelvic exam, Holt explains.

"It can cause retraumatization for these people," he adds.

Holt's research revealed that 32.4% of 1,490 women participants reported experiencing pressured sex. Also, 19.4% of the women said they had experienced verbal abuse, and 10.2% said they had been physically abused. Women who experienced pressured sex often were significantly more likely to delay a clinic visit for birth control. Also, 13.2% of participants reported delaying obtaining contraception to avoid a pelvic examination.[1]

"We didn't find any association with physical abuse or verbal abuse in reluctance to go to the clinic," Holt says.

The best method for family planning providers is to not require a pelvic exam for contraception. "For cancer screening, or if someone is having symptoms, they need a pelvic exam," he says. "I think that should be communicated to the patients."

For instance, clinicians can tell patients over the phone, "We do not require a pelvic exam for contraception," he says. It might complicate things for clinics, but it is a conversation that can be held in a trauma-informed manner.

Several decades ago, pelvic exams were widely used for screening for sexually transmitted infections (STIs). But the exams are no longer as necessary for STI screening. "With the availability of urine and gonorrhea-chlamydia testing, there is less need for a pelvic exam for STIs," Holt explains. "If physicians are suspicious of pelvic inflammatory disease, then they might perform the pelvic exam."

In this case, the patient might report discharge or pain in the abdomen or in the vaginal area. Since the person is symptomatic, the provider can initiate a discussion about the pelvic exam, he adds.

"It's really important to just have open communication with patients," Holt says. "Acknowledge their history and experiences and how these affect them, and talk through what's required and every aspect of the exam."

If a patient with a history of intimate partner violence or sexual trauma needs a Pap smear, then the provider can talk it through and go very slowly, using neutral terminology, Holt suggests. For example, instead of asking patients to lie down on the bed, ask them to lie on the table. Also, do not use the word "stirrup." Instead, call it a foot rest, he adds.

"Giving patients dignity and autonomy is super important, and that's how I approach every patient," Holt says. "Show them dignity and respect, and try to make it as painless as possible."

Given the study's findings that the pelvic exam can be a significant barrier to a vulnerable population of women seeking contraceptive services, family planning clinics and providers should offer these services without the pelvic examination, he says. ■

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New Research Reveals State Reproductive Rights Affect Risks for Newborns

The authors of a recent study found that Black women in the United States have a lower risk of giving birth to low birth weight babies if they live in states with less restrictive reproductive rights, when compared with women who live in states with more restrictive policies.[1]

"Our study found that, overall, women in states with less restrictive reproductive policies give birth to healthier babies," says **May Sudhinaraset**, PhD, associate professor in the department of community health sciences at the University of California,

Los Angeles. "Low birth weight risk was 8% lower among Black women living in states with the least restrictive reproductive rights policies, compared with their counterparts in the most restrictive states."

The study was a retrospective, cross-sectional analysis of all births within 50 states and the District of Columbia, using 2016 birth record data. "The United States has a long history of reproductive policies that have worked against women of color, particularly Black women, including involuntary sterilizations or targeting Black women for contraceptive technologies," Sudhinaraset says. "This has led to infringements on Black women's reproductive autonomy and results in mistrust of the broader healthcare system."

The study results provide evidence that less restrictive reproductive rights policies may improve outcomes for women, their children, and their communities, she adds.

Restrictive policies include:

- restricted access to information or essential health services;
- requiring parental consent for minors seeking abortions;
- mandatory waiting periods for abortion services;
- lack of public funding for abortions;
- living in counties without an abortion provider;
- lack of expanded access for Medicaid family planning services;
- little or no access to evidence-based sex education in schools.

"States were categorized into three categories of most restrictive, moderately restrictive, and least restrictive," Sudhinaraset explains.

Sudhinaraset and colleagues studied the reproductive rights policies of 2015, which was the preconception period before women delivered in 2016. It did not compare results within a state that might have changed its policy over the years.

"We did not look at individual policies, and, therefore, did not look at states pre- and post-policy," Sudhinaraset notes. "This is an area of great interest for future research, given the increasing attacks on reproductive autonomy and reproductive policies in our country."

State efforts to improve prenatal care and reduce the rates of low birth weight babies have not reached all women, which is a problem the study results highlight. "While there have been efforts to improve quality of care and state campaigns to improve prenatal care, there are still women who are left behind," Sudhinaraset says. "This includes studies that have found that Black women and women of color are more likely to be disrespected and mistreated during childbirth and less likely to use prenatal care, despite efforts to improve prenatal care."

The study sheds light on how reproductive rights policies are an overlooked social determinant of health, she adds.

"Restrictive reproductive rights may not only restrict access to essential healthcare services, but it can also cause stress during pregnancy, leading to adverse birth outcomes," Sudhinaraset explains. "The cumulative exposure to restrictive policies have disproportionately impacted women of color and have served as a form of structural racism and tool of oppression." ■

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Study: The Affordable Care Act Improved Contraceptive Use

Data comparing changes in birth rates before and after the Affordable Care Act (ACA) was passed suggest that reducing out-of-pocket costs is associated with increased contraceptive use.[1]

Investigators evaluated changes in birth rates by income level among women with commercial insurance before the ACA was fully implemented, from 2008 to 2013, to after its implementation, from 2014 to 2018.

"We were looking at the one part of the Affordable Care Act that eliminated women's out-of-pocket spending at the time of getting a contraceptive method," says **Vanessa K. Dalton**, MD, MPH, director of the program on women's healthcare effectiveness research at the University of Michigan Medical School.

Researchers studied a sample of 5 million women over 10 years, but the data were not analyzed on a state-by-state basis. "We adjusted for regions, where you are in the country, but I'm not sure what it would mean to look at individual states because the sample is not selected in a way that the message [with state data] could be meaningful," Dalton says.

The ACA enabled women to

choose more expensive methods of birth control because most women can obtain their contraceptives at no out-of-pocket costs because of the ACA's mandates. More expensive methods often are more effective methods, Dalton says. The cost of contraceptives is important to both low-income women and to women with commercial insurance.

"We demonstrated that not only do women who are commercially insured increase their use of more effective methods or any method, but it ultimately leads to a faster decline in birth rates," Dalton explains.

Birth Rates Declining

Although birth rates are falling among many subpopulations of women, there are complicated differences in their birth rates — particularly among low-income women and other vulnerable populations. "Some of this is due to higher rates of unintended pregnancy," Dalton adds. "Cost barrier is one of the reasons why unintended pregnancy rates are higher in some populations than others."

After the ACA was passed, a greater decline in birth rate occurred among some low-income women. As a result, the birth rate gap has been shrinking between low-income and affluent women since the ACA was enacted.

"One of the questions that we get asked about our work in general is why we are looking at commercially insured women," Dalton says. Investigators are interested in uninsured women and women on Medicaid, but most women insured in the United States are insured by their employer. Also, many people with relatively low income do not qualify for Medicaid, even in states that accepted Medicaid expansion. For these women, choosing a $1,000 device is not feasible, Dalton says.

While not all commercially insured women have access to contraceptives with no out-of-pocket costs, most do. This population can be studied more easily for patterns in their contraceptive use and how the ACA affected these patterns.

"The message is that the Affordable Care Act was effective at removing the cost of contraception, and was followed by an increase in prescription contraception use that was followed by a further decline in the birth rate," Dalton says. "The effect is not huge, but you don't have to change birth rates much to have a long-term impact."

While not all unintended pregnancies are unwanted, there is a societal cost for mistimed births, she notes. "We're concluding that, to some degree, understanding how to prevent unintended pregnancies is not going to be solved with one approach; it's a complicated problem," Dalton says. "But the ACA appeared to be successful in what it was meant to do: decreased cost, increased access, and this is followed by a decline in birth."

More Action Needed to Address Inequities

The ACA addressed some inequities in healthcare coverage, but it is a basic minimum of what is needed to improve healthcare access, Dalton says. "Just because someone is insured doesn't mean they are not experiencing financial stress because of the cost of medical care," she explains. "The ACA was basic — the minimum of what you have to do to remove systemic inequities, at least in the employer-based health insurance world."

The ACA was one step toward leveling the playing field in terms of healthcare access. "Also, we don't need the ACA to make these decisions," Dalton says. "States can decide to implement regulations that would require health plans in their states to come in line with this."

Providing contraception to women with no out-of-pocket expense also is a fiscally sound policy. "Employers and payers have an investment here," Dalton says. "Health insurance companies' biggest expense for this age group is pregnancy and delivery."

From the health insurance payer's standpoint, covering contraception is cost-effective. "Does [saving] $100 or $1,000 change behavior?" Dalton asks. "I would say it looks like it does."

Stakeholders and legislators might get on board with offering women no-cost contraception options if it appears this is worthwhile from a business standpoint, she adds.

"For me, the really important message is the equity piece," Dalton says. "The fact that this sample includes low-income workers and high-income workers, and we know their health plans worked very differently in the beginning."

If the ACA were reversed by legislative or court actions, then the most vulnerable families would be at risk for having some financial consequences related to their contraceptive coverage, as well as healthcare coverage in general, Dalton adds. ■

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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.

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CME/CE QUESTIONS

1. **Words can create stigma for women who use substances and are seeking reproductive health services. Which words are recommended for clinicians to use instead of the term "drug abuser"?**

   a. Junkie
   b. Reformed addict
   c. Person with substance use disorder
   d. Person with opioid habit

2. **The American College of Obstetricians and Gynecologists and researchers say clinicians should perform a pelvic exam only when necessary and as a shared decision with patients. Why might the routine pelvic exam be harmful to some women, according to Hunter Holt, MD?**

   a. It can cause discomfort.
   b. It can retraumatize women who have experienced sexual violence.
   c. It can create inhibition issues for young and sexually inexperienced women.
   d. It is no longer the best screening method for most conditions.

3. **New research found that which group of women had more negative perceptions about intrauterine devices (IUDs) than other groups?**

   a. Women older than age 40 years
   b. Black women
   c. Hispanic women
   d. Women younger than age 25 years

4. **Women in states with less restrictive reproductive rights policies are more likely to:**

   a. give birth to healthier babies.
   b. regret having had an abortion.
   c. use an IUD.
   d. have low birth weight infants.

CME/CE 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.