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IN THIS ISSUE

- **Patient retention:** How to boost your clinic's rates . . . cover
- **Prevention & treatment:** Check digital resources for addressing sexually transmitted infections 63
- **Vaccine:** Time to accelerate uptake regarding human papillomavirus 65
- **Diaphragm:** Update on barrier contraception 66
- **Teratogenic drugs:** Check contraception 68
- **Teen Topics:** Put Quick Start method to use for your adolescent patients 69

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Retention of patients is critical to family planning financial sustainability

New toolkit helps clinics improve patient experience

A focus on patient experience in family planning is no longer just the right thing to do. "It is now a matter of agency survival," says **Jennifer Kawatu, RN MPH**, a consultant at Boston-based JSI Research & Training Institute, Inc. (JSI), a public health management consulting and research organization.

"If it takes patients three hours to wait for a visit, if they feel like the staff are unfriendly or uncaring, if they don't see evidence of systems being up to date and of providing high quality care, they are likely to say 'that's not worth it' and go elsewhere. The difference is now they *can*," says Kawatu. Kawatu serves as the quality improvement advisor for the Title X National Training Center for Quality Assurance, Quality Improvement, and Evaluation, which JSI operates under a cooperative agreement with the Department of Health and Human Services' Office of Population Affairs (OPA). The center is one of five national training centers funded by OPA to develop and deliver training and technical support to Title X family planning grantees and service sites.

According to statistics from the New York City-based Guttmacher Institute, 8.9 million family planning clients in 2010 received publicly funded contraceptive services, representing 47% of women in need of publicly supported care.¹ Family planning centers provided services to 6.7 million contraceptive clients, with Title X-supported centers serving seven in 10 of those clients.¹

Expansions in public and private health insurance under the Affordable Care Act (ACA) will allow more women and men to gain coverage for family planning and related reproductive health services. It is critical that family planning agencies focus on patient experience, say leaders in the field. "As ACA rolls out, and the number of Americans with insurance increases, they will have more choices of where they can go for health-care," says Kawatu. "We want patients who have been served by family planning agencies to keep coming back and to choose to stay with

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these agencies for their quality care, even if they gain health insurance coverage and their options increase.”

However, to keep patients coming back, patients will need to have a really good patient experience, Kawatu says. The standards for what constitutes a positive patient experience continue to rise, and what used to be acceptable is no longer sufficient,

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Editorial Questions

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she states. Members of the public have much higher expectations for customer service in general, and these expectations apply to healthcare as well, notes Kawatu.

With changes in available coverage, it also will be important to maintain access to care for those who are ineligible for coverage, temporarily uncovered, or choose not to use their families' coverage for confidentiality reasons, such as young adults on their parents' insurance plan, says Kawatu. "Family planning agencies play a vital role in offering access to contraception and other reproductive healthcare, including cancer screening, immunizations, sexually transmitted infection screening and treatment, and it is imperative that we maintain access to care — regardless of healthcare insurance status — even as these changes in the healthcare system take place," she states.

Put toolkit to use

To improve patients' experiences, JSI developed the "Patient Experience Improvement Toolkit: A Guide for Family Planning." (*Download the free toolkit at <http://bit.ly/1m0jxNB>.*)

The toolkit helps family planning agencies by:

- developing patient experience goals;
- measuring and using patient experience data to make such improvements;
- using interpersonal skills to enhance every visit;
- giving the clinic site a makeover (online and offline);
- respecting patient privacy;
- sustaining improvements in the long term.

An important part of the ACA is its focus on the "Triple Aim": improving the experience of care for individuals, improving the health of populations, and lowering per capita costs. To achieve these goals, existing payment models and healthcare delivery systems are being reformed.

EXECUTIVE SUMMARY

A new free resource, "Patient Experience Improvement Toolkit: A Guide for Family Planning," is available to help family planning agencies develop patient experience goals; measure and use patient experience data; enhance interpersonal skills; and improve clinic sites, online and offline.

- Expansions in public and private health insurance under the Affordable Care Act will allow more people to gain coverage for family planning and related reproductive health services.
- The toolkit serves as a resource to help agencies to help retain patients in light of their increased options. It can be downloaded at <http://bit.ly/1m0jxNB>.

For family planning clinics to improve revenue as the ACA rolls out, clinics are contracting with third-party payers. To do that, clinics have had to set up and refine electronic health records to use them for quality reporting, set up assistance for claims administration, and have clients enrolled in health insurance programs. Because health insurance companies and networks of care collect and use patient experience data to measure quality, what are some key ways to make sure an agency will do well in patient experience assessment?

There are three ways that family planning agencies can improve their patient experience while preparing to report data to health insurance companies and networks of care, says **Katie Saul**, MPH, JSI consultant and manager of the Family Planning National Training Center for Quality Assurance, Quality Improvement, and Evaluation. “The first [step] is to create a culture of quality,” says Saul, who co-developed the toolkit with Kawatu. “It is imperative for leadership to embrace quality improvement and promote positive change.”

Second, agencies should regularly measure patient experience, notes Saul. It is important to know how the patient population defines quality and the extent to which services meet their expectations, she explains. To the extent possible, agencies should align patient experience assessments with Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey measures, a multi-year initiative of the Agency for Healthcare Research and Quality (AHRQ) to support and promote the assessment of consumers’ experiences with health care. Such surveys look at items as the timeliness of appointments, care, and information; provider communication with patients; and staff courtesy and respect.

Finally, clinics need to establish quality improvement systems in order to consistently and promptly act on assessment findings, says Saul. Staff members should be aware of what they do well and what needs improvement. Furthermore, they must be empowered to initiate and sustain change. “A supportive work environment provides all employees access to training, resources, and mentorship to help them provide the best patient experience to their patients,” Saul states.

Use videos for training

At the Family Planning National Training Centers web site, www.fpntc.org, clinics can obtain practical guidance developed for family planning service sites to improve patient experience, with

consideration given to service site limitations in staff, time, and funds.

Links to the toolkit are available there, as well as two videos developed by JSI to help family planning clinics in the patient experience improvement process. The first video, “The Family Planning Patient Experience Video: Skills to Improve Every Visit,” helps staff improve their interactions with patients by modeling five key interpersonal skills. The second video, “Prioritizing the Patient Experience: Strategies for Family Planning,” highlights patient experience best practices and successes from Title X-funded family planning clinics. The video includes practical information on ways to reduce patient wait times and to provide patient-centered care. *(To watch the videos, go to the web site and click on “Resources,” “Video,” then the name of the video.)*

“Early experience with healthcare reform in Massachusetts has shown that as people gain more choices for care when they obtain insurance coverage, they often choose to go elsewhere, such as to a primary care provider,” say Kawatu and Saul in a blog entry on the subject. “Patient retention is vital to family planning clinics’ financial sustainability and the availability of high quality family planning services is paramount to comprehensive health care.” *(Read the blog entry at <http://bit.ly/1eqY26b>.)*

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Check digital trends in STI prevention

The Internet and the cell phone are being employed in helping patients in not only seeking testing for sexually transmitted infections (STIs), but also learning their test results and promoting treatment for themselves and their partners.

For those who might be reticent in coming in for STI testing, STD Triage, (www.stdtriage.com) launched in March 2013 by Stockholm, Sweden-based iDoc24, is an anonymous, app-based dermatology service that allows users to submit pictures of possible STI symptoms via Apple iOS and Android smartphones, as well as on the web.

Pictures are reviewed by a team of licensed dermatologists who provide an assessment within 24 hours for \$39.99 (U.S. dollars) per case.

STD Triage has partnered with Chicago-based getSTDtested.com, an online STI testing and treatment service, to provide virtual STI testing and telemedicine consultation options. When symptoms might be caused by an STI, STD Triage doctors recommend a confirmation through STI testing. The getSTDtested.com web site serves as the testing platform, offering fast, same-day STD testing at 4,000 locations nationwide, and it also offers at-home tests for gonorrhea, chlamydia, and trichomoniasis. If results are positive, patients can receive counseling via phone. If the patient wishes to have an internet physician prescribe treatment, a separate \$60 fee is charged.

The traditional route of STI testing with long waits, appointments, and embarrassing exams isn't for everyone, said Benjamin Brown, director of getSTDtested.com, in an announcement of the joint partnership. GetSTDtested.com and STD Triage are committed to providing private, physician-backed telemedicine alternatives, Brown stated. "This partnership connects customers with online resources at every stage of the process — from pre-testing consultations to treatment — for a convenient, accurate testing experience," he noted.

Hula, a free mobile app and online presence, offers a free way to find STI testing centers, obtain results online, and share verified STI status. To register for a Hula account, patients go to www.hulahq.com, select "Hula for consumers," and fill out information about themselves and where they were tested. After patients sign their name

EXECUTIVE SUMMARY

The Internet and the cell phone are helping patients in not only seeking testing for sexually transmitted infections (STIs), but learning their test results and promoting treatment for themselves and their partners.

- STD Triage has partnered with getSTDtested.com, an online STI testing and treatment service, to provide virtual STI testing and telemedicine consultation options. Hula, a free mobile app and online presence, offers a free way to find STD testing centers, obtain results online, and share test status.
- So They Can Know is a website designed to increase rates of STI partner notification. Visitors can look up information and watch videos about how to notify their partners in person, on the phone, via email, or via text message. They also can inform their partners by sending anonymous emails generated by the website.

with their mouse or finger, the site uses the entered personal information to automatically generate a medical records request form that complies with the federal Health Insurance Portability and Accountability Act (HIPAA). The site then attaches the patient's signature and sends the form to the named testing provider.

The provider receives the request and sends the results back to the patient's secure Hula account. The results are encrypted within the Hula system, so no one can see the results except for the patient and the Hula employee processing the data. Once the results are in the patient's account, they can be stored and shared however they choose.

Regarding "virtual" STI services, digital or online services can increase access to STI information or diagnosis, says Andrew Kaunitz, MD, professor and associate chair in the Obstetrics and Gynecology Department at the University of Florida College of Medicine — Jacksonville. One concern, however, is that while a face-to-face encounter with a clinician might result in additional important STI evaluation (such as serologic screening for HIV/hepatitis/syphilis, in addition to screening for lower genital tract infections), such broader evaluations would seem less likely to occur with these new digital/online STI services, says Kaunitz.

Innovations aid patients

STIs present barriers to routine clinical care and diagnosis due to associated stigma, costs, and confidentiality issues.¹ Even when tested, 30%-74% infected patients never return for routine test results or are lost to follow-up for treatment.²

So They Can Know (www.sotheycanknow.org) is a website designed to increase rates of STI partner notification. It is targeted at person who are age 15-24 and have been diagnosed with an STI. At the site, visitors can look up information and watch videos about how to notify their partners in person, on the phone, via email, or via text message. They also can inform their partners by sending anonymous emails generated by the website. These emails provide relevant health information and links to locate nearby testing services. Since its September 2012 launch, the web site has generated 35,114 unique website visitors, and 113 clinics nationwide are promoting the service to their patients.

A companion web site, www.STCKClinic.org, is designed to help evaluate the uptake of So They Can Know (STCK) among patients of STI clinics and family planning services across the United States. The STCK Clinic website also is designed

to elicit feedback from clinicians, nurses, disease intervention specialists, and other public health practitioners.

So They Can Know and STCKClinic are outreach programs developed by New York City-based Sexual Health Innovations, a nonprofit organization dedicated to creating technology to improve sexual health and wellbeing in the United States. It is working with Private Results, developed with the Baltimore City Health Department. The Private Results program is an open-source online and phone-based STI test results delivery system.

The program takes data from laboratories and displays it securely and clearly to patients. It translates confusing results such as “Syphilis RPR Non-Reactive” to “your syphilis test was negative, meaning that you do not have syphilis.” The program is designed to help patients understand what their results mean, what next steps they need to take to keep themselves and their partners healthy, and links to more information and tools. On the provider side, the program allows clinicians to track who has and hasn’t seen their results yet, so they know who needs follow up contact, and it allows providers to easily view trends in STI diagnoses over time for better detection and response to emerging outbreaks.

Baltimore is the only health department working with the Private Results program, says **Jessica Ladd**, MPH, founder and executive director of Sexual Health Innovations. Clinics who are interested in possible participation may e-mail the organization at team@sexualhealthinnovations.org or sign up for updates at www.PrivateResults.org, Ladd says.

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Accelerate HPV vaccine uptake: Time to move

Human papillomavirus (HPV) vaccine uptake has not kept pace with that of other adolescent shots. In 2012, only about one-third of girls ages 13-17 received all three recommended doses,

and less than 7% of males ages 13-17 completed the shot series.¹ (Contraceptive Technology Update reported on the statistics. See “Boost HPV vaccination numbers — next generation is at risk,” *October 2013*, p. 109.)

A new report released by the President’s Cancer Panel emphasizes the need to energize efforts to reach the HPV vaccines’ potential to save lives and prevent millions of avoidable cancers and HPV-related conditions in men and women.² (Read the full report at <http://1.usa.gov/1cAVkYN>. Select “Download Full Report.”)

Barbara Rimer, DrPH, dean of the Gillings School of Global Public Health and member of the Lineberger Comprehensive Cancer Center, both at the University of North Carolina at Chapel Hill, serves as chair of the President’s Cancer Panel. Rimer says she hopes the report will result in more resources available for clinicians to use in talking with adolescents and their parent/caregivers about HPV vaccines.

ACIP makes its recommendations

The vaccines are recommended by the U.S. Advisory Committee on Immunization Practices (ACIP) for males and females ages 11-12 with “catch-up” doses for females up to age 26 and for males up to age 21 who were not vaccinated earlier in adolescence. Various medical specialty recommendations support vaccination of age-eligible adolescents, notes Rimer.

“Clinicians should view the prevention of cervical and other HPV-associated cancers as one of the most powerful forms of prevention in their arsenals,” states Rimer. “It is time to bring HPV use in line with other adolescent vaccines.”

The report outlines three critical goals that must

EXECUTIVE SUMMARY

A new report emphasizes the need to energize efforts to reach the potential of human papillomavirus (HPV) vaccines to save lives and prevent millions of avoidable cancers and HPV-related conditions in men and women.

- Vaccine uptake for HPV has not kept pace with that of other adolescent shots. In 2012, only about one-third of girls ages 13-17 received all three recommended doses, and less than 7% of males ages 13-17 completed the shot series.
- The report outlines three goals to increase vaccine uptake: reducing missed clinical opportunities to recommend/administer HPV vaccines; increasing parents’/adolescents’ acceptance of HPV vaccines; and maximizing access to HPV vaccination services.

be achieved to increase HPV vaccine uptake. They include reducing missed clinical opportunities to recommend/administer HPV vaccines; increasing parents'/adolescents' acceptance of HPV vaccines; and maximizing access to HPV vaccination services, with the ultimate goal being completion of the full three-dose series by all age-eligible adolescents.

According to data from the Centers for Disease Control and Prevention (CDC), missed clinical opportunities are the most important reason why the U.S. has not achieved high rates of HPV vaccine uptake. As many as two-thirds of 11- and 12-year-old vaccine-eligible girls might not be receiving HPV vaccines at healthcare visits during which they receive at least one other vaccine.³ Targeted efforts, including communications strategies for physicians and other relevant health professionals, are recommended to increase the proportion of health providers who strongly recommend HPV vaccines for age-eligible adolescents, the report states.

Use of electronic health records and immunization information systems can help to avoid missed opportunities for HPV vaccination and facilitate completion of the three-dose regimen.

Get men in the picture

As part of the goals outlined in the report, experts outlined two key factors in boosting male uptake of the vaccine: expanding the current Healthcare Effectiveness Data and Information Set (HEDIS) quality measure for HPV vaccination of adolescent females to include males, and create a Healthy People 2020 HPV vaccination goal for males. Both factors would place emphasis on encouraging providers to recommend HPV vaccine to adolescent boys and their parents.

More than 90% of U.S. health plans use HEDIS to measure performance, the report notes. Health plan purchasers often use HEDIS data when selecting plans, the report notes. Plans have an incentive to change practices and make improvements to optimize their HEDIS scores. In 2012, a HEDIS measure was created to assess the percentage of age 13 female adolescents who had had three doses of HPV vaccine by their 13th birthdays. Having a similar measure for boys would boost vaccine uptake, the report notes.

Current Healthy People 2020 objectives include increasing HPV vaccine completion rates for females ages 13-15 to 80%. These objectives should be updated to include an HPV vaccination goal for males equivalent to that for females, states

the report. Noel Brewer, PhD, associate professor of health behavior at the University of North Carolina at Chapel Hill Gillings School of Global Public Health, says, "Males have a disease burden themselves. They get genital warts, they get anal cancer, and this vaccine will prevent both."

Brewer sees men as the "vectors" of HPV disease, as women are getting HPV primarily from men. Given the current U.S. vaccination rates, herd immunity (reached when a critical portion of a community is immunized against a contagious disease) cannot be reached until males are vaccinated, says Brewer, who co-chaired one of four workshops that informed the report.

"To be able to get the vaccine to work the way we need it to, we really need males vaccinated, both to help women, but to also help men as well," Brewer states.

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Diaphragm: Update on this barrier contraceptive

The female diaphragm offers hormone-free contraception that is female-initiated and female-controlled. However, it is used infrequently in the United States. It is listed by less than 1% percent of U.S. women ages 15-44 who say they use other reversible methods outside the Pill, male condom, intrauterine device, contraceptive injectable, ring, patch, and implant.¹

Currently available diaphragms require a pelvic examination and fitting to ensure proper size and placement of the device. According to *Contraceptive Technology*, the effectiveness of all barrier methods such as the diaphragm depends on anticipatory motivation at the time of each coital act. Thus the difference between typical use and perfect use is greater than those methods that don't

rely on such attention.² Typical use rate for the diaphragm is estimated at 12%, with perfect rate estimated at 6%.³

Women who choose a diaphragm must understand that to prevent pregnancy, the diaphragm must be used at every time of intercourse. The diaphragm always should be used with a spermicidal jelly or cream. Women using a diaphragm without spermicide had a pregnancy rate of 29 pregnancies per 100 women within 12 months, while those using a diaphragm with spermicide had a rate of 21 per 100 women.⁴

Instruct women that the diaphragm may be inserted up to six hours before intercourse. If more than six hours have passed between insertion of the diaphragm and intercourse, additional contraceptive jelly or cream should be inserted. The diaphragm does not need to be removed to insert additional spermicide. Women can fill and insert the spermicide applicator, and they can make sure that the jelly or cream is inserted into the upper part of the vagina. The diaphragm should remain in place for at least six hours after intercourse and should be removed soon after that. After a diaphragm has been used, it should be washed with mild soap and water, and it should be stored in a cool, dry place. A diaphragm should not be used if it looks dry, cracked, or has a tear.⁵

Options slim in U.S.

Just two diaphragms are available to U.S. women: the Milex Wide-Seal Arcing Style Diaphragm and the Milex Wide-Seal Omniflex Diaphragm. Both are sold directly to physicians through Trumbull, CT-based CooperSurgical, confirms corporate spokesperson **Jeanie Fusco**. (See

resource listing at the end of the article for company contact information.)

Both diaphragms are made of silicone and are available in eight sizes, ranging from 60 to 95 mm. The Milex Wide-Seal Arcing Style Diaphragm has a tension-adjusted spring that curves in one place, while the Milex Wide-Seal Omniflex Style Diaphragm has a distortion-free spring that provides arc no matter where the rim is compressed. Both devices provide increased suction for added protection.

The Ortho All-Flex Diaphragm was discontinued as of December 2013 by Titusville, NJ-based Janssen Pharmaceuticals “because comparable alternative products are available to women,” says **William Foster**, company spokesperson. A similar Ortho product, the Ortho Coil Spring, was discontinued in 2008.

“One-size” device eyed

In June 2013, European regulators granted the single-size SILCS Diaphragm a CE marking, allowing the product to be sold throughout Europe. The launch marks an important step toward expanding nonhormonal contraception options for women worldwide; regulatory applications for the Food and Drug Administration are under way. (To read more about the device, see the *Contraceptive Technology Update* articles “Multipurpose methods show research advances,” February 2014, p. 19, and “New data emerges on one-size diaphragm,” December 2011, p. 139.)

Marketed in European countries as Caya, the SILCS diaphragm is the first new cervical barrier method to receive regulatory approval and enter the market in more than a decade. Designed through a unique collaboration between Seattle-based PATH (a global health nonprofit) Norfolk-based CONRAD (a reproductive health product development organization operated through the Eastern Virginia Medical School), the United States Agency for International Development (USAID), and other partners, the device was licensed in 2010 to Frankfurt, Germany-based Kessel Marketing & Vertriebs GmbH (Kessel) to accelerate women’s access to the technology.

Results of the device’s contraceptive effectiveness study, a two-year investigation of 450 women implemented at six clinical sites in the United States, showed that effectiveness rates of the new single size, contoured diaphragm are similar to traditional diaphragms.⁶ Its single-size design eliminates the need for a fitting. Study results indicate

EXECUTIVE SUMMARY

The female diaphragm offers hormone-free contraception that is female-initiated and female-controlled. Currently available diaphragms require a pelvic examination and fitting to ensure proper size and placement of the device.

- Two diaphragms are available to U.S. women: the Milex Wide-Seal Arcing Style Diaphragm and the Milex Wide-Seal Omniflex Diaphragm, sold directly to physicians through CooperSurgical. Both diaphragms are made of silicone and are available in eight sizes, ranging from 60 to 95 mm.
- The SILCS diaphragm, marketed in European countries as Caya, is the first new cervical barrier method to receive regulatory approval and enter the market in more than a decade. Regulatory applications to the Food and Drug Administration are under way.

the device is easy to use and comfortable to wear.⁶

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RESOURCE

To get more information on Milex diaphragms, contact CooperSurgical, 95 Corporate Drive, Trumbull, CT 06611. Telephone: (800) 243-2974. Web: www.coopersurgical.com. ■

Teratogenic drug use: Check contraception

About 1.7 million women of childbearing age are prescribed Food and Drug Administration (FDA) Category D or Category X medications each year. Despite label warnings, about 6% of U.S. pregnancies occur in women taking medications with known teratogenic risk.^{1,2} According to the FDA, Category D includes those drugs with which “adequate studies in pregnant women have shown evidence of fetal harm, but potential benefits may outweigh risk,” while Category X encompasses drugs in which “adequate studies in pregnant women have shown evidence of fetal harm; contraindicated in women who are or may become pregnant.”³

The most commonly prescribed Category D and X drugs in the primary care setting are anxiolytics, anticonvulsants, antibiotics, and statins; 45% of such prescriptions are written by family physicians or internal medicine physicians.¹ In a study of 488,175 women ages 15-44 enrolled in a large,

northern California health maintenance organization (HMO), researchers identified 1.01 million filled prescriptions for class A, B, D, or X drugs.⁴ In this study, one of every six women filled a class D or X prescription. Researchers found these women were no more likely than women who filled prescriptions for safer class A or B medications to have received contraceptive counseling, filled a contraceptive prescription, or undergone a sterilization procedure.

Patients might not receive detailed counseling about the potential birth defects associated with certain medications and the importance of using highly effective contraception, says **Sheila Mody, MD, MPH, FACOG**, assistant professor and women’s reproductive health research (k12) scholar in the Department of Reproductive Medicine at the University of California, San Diego. Mody and fellow researchers have conducted a pilot research study to assess the feasibility of an electronic medical record alert/referral to teratogen and contraceptive counseling for women seen in family medicine taking a category D or X medication.

The research team has discovered that many of these women were using the least effective contraceptive methods, says Mody. They also have found that after teratogen and contraceptive counseling, about one-third of participants were willing to use more effective contraception.

“An intervention to improve teratogen and contraceptive counseling is one of the few ways we can potentially decrease the number of pregnancies exposed to teratogens,” says Mody.

Have the conversation

While family planning clinicians are well-versed in discussing effective birth control methods, other providers might be less educated. Surveys of medical schools, residents, and physicians show that training

EXECUTIVE SUMMARY

About 1.7 million women of childbearing age are prescribed Food and Drug Administration Category D or Category X medications each year. However, despite label warnings, about 6% of U.S. pregnancies occur in women taking medications with known teratogenic risk.

- The most commonly prescribed Category D and X drugs in the primary care setting are anxiolytics, anticonvulsants, antibiotics, and statins; 45% of such prescriptions are written by family physicians or internal medicine physicians.
- Patients might not receive detailed counseling about the potential birth defects associated with certain medications and the importance of using highly effective contraception

in contraceptive counseling and provision is insufficient.^{5,6}

Talking about contraception and teratogenic drugs requires a “careful conversation,” says **Eleanor Bimla Schwarz, MD, MS**, director of the women’s health services research unit at the Center for Research on Health Care in the University of Pittsburgh School of Medicine. Some women must take medications to treat health conditions such as asthma, epilepsy, hypertension, or depression, and they might need to continue to take medication to stay healthy during pregnancy. If such conditions are not treated, a pregnant woman or her unborn baby could be harmed.

One way that may help providers identify patients who need preconception or contraceptive counseling, especially when teratogenic medications are prescribed, is through a “contraceptive vital sign,” a routine assessment of women’s pregnancy intentions and contraceptive use.

Schwarz and fellow researchers randomly assigned 26 physicians from a large academic internal medicine practice to an intervention group that added the contraceptive vital sign questions to the intake questionnaire. They randomly assigned another 27 physicians from the practice to a control group that used an intake form with standard questions. During the study period, there were 816 visits to intervention physicians during which they asked the contraceptive vital sign questions, with answers provided by 93% of the women; 7% of the women did not answer the questions or did not finish the questionnaire.

Intervention physicians were notified by the electronic health record’s decision support software to “consider chance of pregnancy when prescribing” in 110 visits (13.5%). For visits involving a potentially teratogenic prescription, documentation of contraception for women visiting intervention-cluster physicians rose from 14.1% at baseline to 72.9% during the study period. For women visiting control physicians, 26.6% had medical record documentation of contraception at baseline versus 25.5% during the study period.⁷

In this same study, provision of new family planning services were increased only minimally with this intervention. When women with documented nonuse of contraception were prescribed potential teratogens, only 7% were provided family planning services.⁷

“A contraceptive vital sign improves documentation of contraceptive use; however, ongoing efforts are needed to improve provision of preconception and contraceptive services,” researchers conclude.

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Quick Start: Why put off what you can do today?

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For the last 15 years, emerging evidence has encouraged clinicians who prescribe hormonal contraception to “quick start” patients

on their chosen contraceptive method on the day of the visit, instead of waiting until after menses begins. For patients using combined oral contraceptives, contraceptive patch, vaginal ring, or injection, Quick Start is a way to ensure that protection against unintended pregnancy begins as soon as possible. Adolescents are most likely to rely on oral contraceptive pills (OCPs) and other combined hormonal methods to prevent pregnancy,¹ so it is especially important that adolescent health professionals are aware of this option for initiating contraception. Proponents of Quick Start believe that this initiation method might improve continuation rates and enhance consistency of pill use among younger patients.

To utilize Quick Start with OCPs, the contraceptive patch, vaginal ring, or injection, a clinician takes a few short steps. First, the clinician identifies the date of last menstrual period (LMP). If it was five or fewer days before the visit, the patient can go ahead and start the method that day. If LMP was more than five days before the visit, clinicians should ask if unprotected sex has occurred during this window to assess if emergency contraception (EC) is appropriate.

If no unprotected sex has occurred since LMP, the patient can start the new method immediately but should abstain from sex or use a backup method such as condoms for one week. If unprotected sex has occurred at any time since the last menstrual period, a urine pregnancy test should be given. Provided the test is negative, the clinician should offer EC if appropriate and at the same time start the patient's new ongoing method the same day. Backup protection is still needed for a week, and the patient should follow up two weeks later for another pregnancy test to rule out the possibility of a pregnancy occurring just before the method initiation visit.

Is Quick Start safe?

Clinicians who recommend a "Sunday start" or conventional initiation timing such as first day of menses start might have concerns about the safety and efficacy of starting hormonal contraception without confirming that the patient is not pregnant by having her menses. This concern is unfounded, as hormonal contraceptives will not harm an early pregnancy.² Additionally, a 2013 review in *Contraception* reported patients who use Quick Start are equally likely to conceive prior to starting contraception compared to

counterparts relying on a conventional start.³ The same systematic review also found there is limited evidence that Quick Start initiation prevents more pregnancies than a conventional start.

The review examined four studies which reported on pregnancy risk after starting a hormonal method using quick or conventional start. Two studies found no pregnancies in either group other than those that occurred before contraception was initiated. One study of 1,716 women under age 25 found 138 pregnancies occurring over six months, but there was no significant difference in the number of pregnancies reported among Quick Start groups compared to conventional start groups (8.2% and 9.1%, respectively).

The final study examined data from 539 females ages 12-17. This study had the most encouraging support for Quick Start, finding more pregnancies in the conventional start group than the Quick Start group; 6.5% of those using Quick Start became pregnant, compared to 10.5% of those using a conventional start. This study and all four of studies reported in the review were not powered to detect differences in pregnancy rates. Further and larger studies are needed to assert a true benefit to Quick Start in decreasing unintended pregnancy.³

Check continuation rates

Evidence also is lacking on the long-term benefits for using Quick Start to improve contraceptive continuation rates.

Studies have demonstrated that women who Quick Start oral contraceptives, patches, or rings report higher continuation rates at early follow-up visits, but these rates fall over time. After one year, rates of continuation are similar between quick and conventional starters.³ One study that focused on method continuation among adolescents affirmed these findings, reporting that while Quick Start patients were more likely to start a second pack of pills than conventional starters, continuation rates were similar across both groups at three and six months.⁴

To truly improve continuation rates and decreased unintended pregnancy, clinicians caring for adolescents (and adults) should consider offering more effective long-acting reversible contraceptives (LARCs). Looking at the widely reported findings of the St Louis Contraceptive CHOICE Project, 81% of LARC users ages 14-19 continued their method for at least 12

months, and 67% continued for 24 months.⁵ Peers using non-LARC methods (such as pills, patches, or rings) had lower continuation rates of 49% and 37% at one and two years, respectively. Additionally, adolescents enrolled in the study had a birth rate of 6.3 compared to a national teen birth rate of 34.3 per 1,000 women ages 15-19.⁶

Regardless of a patient's method of choice, there is no negative effect to a Quick Start initiation, and benefits in terms of continuation rates are seen, at least in the short term. Clinicians should counsel patients to use the most highly effective method available to them and start that method as soon as possible, contraceptive experts agree.

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- identify clinical, legal, or scientific issues related to development and provisions of contraceptive technology or other reproductive services;
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- integrate practical solutions to problems and information into daily practices, according to advice from nationally recognized family planning experts;
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CNE/CME QUESTIONS

- Even when tested, what percentage of patients with sexually transmitted infections never return for routine test results or are lost to follow-up for treatment?
 - Less than 10%
 - Less than 25%
 - 25% to 30%
 - 30% to 74%
- What percentage of 11- and 12-year-old vaccine-eligible girls might not be receiving HPV vaccines at healthcare visits during which they receive at least one other vaccine?
 - As many as one-fourth
 - As many as 33%
 - As many as half
 - As many as two-thirds
- Which two diaphragms are now available in the United States?
 - Milex Wide-Seal Arcing Style Diaphragm and the Milex Wide-Seal Omniflex Diaphragm
 - Milex Wide-Seal Arcing Style Diaphragm and the Ortho Coil Spring Diaphragm
 - Ortho Coil Spring Diaphragm and the Ortho All-Flex Diaphragm
 - Caya Diaphragm and the Ortho All-Flex Diaphragm
- What are the most commonly prescribed Category D and X drugs in the primary care setting?
 - Anxiolytics, anticonvulsants, antibiotics, and hypertensives
 - Anxiolytics, anticonvulsants, antibiotics, and statins
 - Anxiolytics, diuretics, antibiotics, and statins
 - Anxiolytics, anticonvulsants, antifungals, and statins

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