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→ INSIDE

Patient-centered care: Put into practice . . . at your facility . . . Cover

Commentary: Impact of patient-centered care76

Adolescent LARC use: Title X clinics see upswing77

Mammograms: USPSTF issues draft guidance79

Transgender patients: Stigma, affordability barriers to care . . .80

Washington Watch: Guidelines to improve contraceptive coverage82

Enclosed in this issue:

• **STI Quarterly:** CDC issues clinical advisory on ocular syphilis; public health officials battle Indiana cases of drug-related HIV outbreak

AHC Media

Implement patient-centered care into your family planning practice

Good patient experiences foster positive impact on healthcare quality

Emphasis is being placed on implementing patient-centered care into all aspects of medical care, including family planning practices. Research indicates it improves clinical outcomes and patient satisfaction, enhances clinical adherence to treatment guidelines, and boosts healthcare delivery system efficiency.^{1,2}

With the advent of healthcare reform, new challenges and opportunities have opened up for the publicly funded family planning network. With expansion of coverage available through the federal Affordable Care Act (ACA), an estimated 10 million people have gained access to Medicaid coverage, with about 19 million expected to access other forms of health insurance.³

As previously uninsured patients gain access to insurance coverage, they have more choices about where to go for healthcare services. Publicly funded family planning health centers need to make the transition from being a

provider of necessity to a provider of choice for existing and prospective patients, according to a case study report by the National Family Planning & Reproductive Health Association.

“Gaining patient loyalty through exceptional service is a critical component of business sustainability — as important as managing costs and revenues,” the case report states.⁴

Patient-centered care

Patients who are seeking an enhanced service experience and greater participation in their healthcare have added further pressure on medical practices to find ways to become more patient- and family-centered. The pursuit for patient perspective is fueled in part by the ACA’s quality improvement provisions and other federal financial incentives, such as the link between Medicare payments and patient satisfaction scores.

Hospitals already are seeking patient input on service delivery. Data from

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2013 indicate 40% of hospitals have some type of patient council in place.⁵

Impact on quality

Patient-centered care is defined as “providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.”⁶

Research indicates that good patient experience has a positive relationship to other aspects of healthcare quality, including engagement with and adherence to providers' instructions, and clinical processes and outcomes.⁷

Why is patient-centered care important in family planning? As family planning providers, clinicians ask patients to make preference-sensitive decisions every day, notes **Justine Wu**, MD, MPH, associate professor in the Departments of Family Medicine and Community Health and Obstetrics, Gynecology, and Reproductive Sciences at New Brunswick, NJ-based Rutgers Robert Wood Johnson Medical School.

These decisions include choices about such issues as childbearing,

contraception, abortion, and infertility, observes Wu. Such choices must be based upon personal preferences and within the context of individual medical and psychosocial factors, she notes.

Adjust counseling

To facilitate this process, family planning providers must put the patient at the center of the process by adjusting their counseling approaches to fit the needs of the patient, states Wu. For example, some women prefer complete autonomy in their decision-making regarding contraception (“just give me the facts”), and others might want more input from their provider (“what do you think is best for me?”), she observes.

Patty Cason, RN, MS, FNP, assistant clinical professor in the School of Nursing at the University of California Los Angeles, points to the five key principles of quality counseling offered in the *Recommendations for Providing Quality Family Planning Services (QFP)*, issued in 2014 by the Centers for Disease Control and Prevention and the Office of Population

EXECUTIVE SUMMARY

Emphasis is being placed on implementing patient-centered care into all aspects of medical care, including family planning practices. Research indicates it improves clinical outcomes and patient satisfaction, enhances clinical adherence to treatment guidelines, and boosts healthcare delivery system efficiency.

- Patient-centered care is defined as “providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.”
- Family planning clinicians can look to the five key principles of quality counseling offered in the *Recommendations for Providing Quality Family Planning Services (QFP)*, issued in 2014 by the Centers for Disease Control and Prevention and the Office of Population Affairs of the Department of Health and Human Services.

Affairs of the U.S. Department of Health and Human Services. (See “New guidance uses best evidence to direct family planning services,” Contraceptive Technology Update, August 2014, p. 85.)

The five principles include:

- establishing and maintaining rapport with the client;
- assessing the client’s needs;
- working with the client interactively to establish a plan;
- providing information that can be understood and retained by the client;
- confirming client understanding.⁸

With the implementation of the ACA, more women of reproductive age have access to insurance that covers the full spectrum of contraceptive options, including long-acting reversible contraceptives and permanent sterilization, says Wu.

“With increased access to more options, patient-centered care must be the core of family planning services such that women and men are given the counseling necessary to make personalized choices,” states Wu. “A team-based approach, such that the providers and staff together assume responsibility for the care of a patient, can facilitate this process during busy day-to-day clinical care.”

What can you do?

Family planning and women’s health providers are educating potential partners, including health plans and other provider organizations, about the scope, quality, and value of their services. Facilities that can share trend data about quality measures, costs of doing business, and patient experience with health plans and regulatory agencies will have greater contracting leverage than those who are unable to offer such types of information.⁹

The National Family Planning & Reproductive Health Association offers a case study of Kachemak Bay Family Planning Clinic of Homer, Alaska, to illustrate how to use patient experience data to implement service quality improvements. The case study looks at the facility’s process of survey development, implementation, data analysis, and quality improvement based on patient feedback. (Review the material at <http://bit.ly/1zUqjNy>.) Kachemak Bay Family Planning Clinic was selected for the case study because it has been engaged in a rigorous, structured process of information collection and use. The facility has more than a decade of experience in capturing key measures of patient experience through an ongoing survey and using the collected information to make operational improvements.

By strategically developing a survey tool to measure patient experience and a standard protocol for survey administration and data analysis, the family planning facility was able to identify and implement changes to improve patient experience and overall quality, the case study states.⁴

Some final tips

How can you improve the patient experience at your facility? Look at implementing the “Plan-Do-Study-Act” improvement model by:

- using patient experience survey data and other assessments to evaluate current performance and set an aim for improvement (Plan);
- developing a strategy to meet the aim and implementing the interventions (Do);
- reviewing data to monitor whether the change strategy has been effective (Study);
- gaining insight from the process to refine the approach and make

it more widespread and sustained (Act).¹⁰

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The ACA has pressed for patient-centered care — How about sexual and reproductive healthcare?

By Wayne Shields
President and CEO
Association of Reproductive Health Professionals

Patient-centered care, an effective healthcare model that has been moving in jumps and starts for more than three decades, received a significant boost several years ago with the implementation of the Patient Protection and Affordable Care Act of 2010 (ACA). Why did this model that emphasizes patient involvement, prevention, and quality improvement become such a fundamental part of healthcare services? And how can we translate this model into effective, high-quality sexual and reproductive healthcare?

Patient-centered care's spectacular rise in the United States during the past three years is rooted in its potential effectiveness at improving healthcare quality and patient satisfaction while reducing costs.¹ But mostly, its recent prominence can be tied to another key motivator for systems change. Patient-centered care is a significant feature of the ACA, which is now the law of the land.²

Even before it had a name, "patient centeredness" was being explored by academicians, health professionals, and socio-behavioral scientists. It was addressed almost 50 years ago, as poor health outcomes associated with disease-oriented, physician-centered models began to come into question. In his 1969 published lecture, Michael Balint proposed the radical notion that each patient "... has to be understood as a complete human being."^{3,4} In 1984, Mack Lipkin presented patient-

centered interviews as the cornerstone for effective care by internists.⁵

In 1987, the phrase "patient-centered care" was coined by the Picker Institute and the Commonwealth Fund to describe an emerging healthcare model focused on active patient involvement. The concept was further advanced in a 1993 book titled *Through the Patient's Eyes*, which outlined seven key elements of the concept.^{6,7} Eight years later, the concept was introduced in the landmark Institute of Medicine (IOM) report, *Crossing the Quality Chasm*, describing patient-centered care as "... care that is respectful of and responsive to individual patient preferences, needs, and values" and that ensures "that patient values guide all clinical decisions."⁸ The federal government's Agency for Health Research and Quality took the next step, with its early focus on patient-centered care and emphasis on the medical home and accountable care organizations as potentially successful environments for effective patient-centered care.⁹ Finally, with ACA passage in 2010, policymakers classified patient-centered care as an essential element of the law, and established the Patient-Centered Outcomes Research Institute to "improve the quality and relevance of available evidence to help patients, caregivers, clinicians, employers, insurers, and policy makers make informed health decisions."¹⁰

We can't yet claim success integrating patient-centeredness into health practice nationwide, especially sexual and reproductive health care. Community health centers, which

make up many of the thousands of safety net clinics across the country, have been the central focus for ACA implementation. But they are struggling to meet the needs of their millions of new patients and are doing their best to incorporate ACA-directed patient-centered services in general. Sexual and reproductive health has yet to become a priority.

Fortunately, our field has expertise to share. For example, Title X family planning clinics have set the standard for incorporating high-quality patient-centered care into their clinics, and some key healthcare systems, such as Unity Health Care in Washington, DC, have integrated patient-centered care into their family planning programs. We have tools for change, including the Centers for Disease Control and Prevention's (CDC's) and the Office of Population Affairs' (OPA's) recent guidelines for providing quality family planning services and coalition work on quality metrics, health professional competencies, and workforce development and training.^{11,12}

Here is what we can do to advance patient-centered care in sexual and reproductive health:

- In the area of workforce development and training, increase the numbers of primary care providers who are trained in sexual and reproductive health.
- Incorporate the CDC/OPA family planning guidelines and well-tested reproductive health metrics into all levels of care, especially in primary care safety net systems.
- Adopt contraceptive and family planning competencies into

post-graduate clinical education and certification standards for all appropriate disciplines and specialties.

- Integrate patient-centered guidelines and metrics into electronic health records.

- Advocate for replicating public health-oriented patient-centered care models in private practice.

We have come a long way from a physician-only medical model toward team-based patient-centered care. For our nation's primary care systems to be truly patient-oriented, we need to recognize sexual and reproductive health as essential elements of care.

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Title X clinics see upswing in use of long-acting reversible contraceptives by teens

Although adolescent use of long-acting reversible contraceptives (LARCs) remains low nationwide, efforts to improve access to LARC among teens seeking contraception at Title X service sites have increased use of these methods, according to research released by the Centers for Disease Control and Prevention (CDC).¹

The teen birth rate in the United States has continued to decline during the past two decades, from 61.8 births per 1,000 ages 15-19 in 1991 to an all-time low of 26.5 births per 1,000 ages 15-19 in 2013. However, the U.S. teen pregnancy rate remains up to seven times higher than in some developed countries.^{2,3} While improved contraceptive use

has contributed substantially to the decline in U.S. teen births, data indicate there were approximately 273,000 births to teens in 2013.²

The *U.S. Selected Practice Recommendations for Contraceptive Use* and an American College of Obstetricians and Gynecologists committee opinion state that LARC methods such as intrauterine contraception and the contraceptive implant are safe, effective, and appropriate options for adolescents.^{4,5} (To read more on the guidance, see the Contraceptive Technology Update article, "What does the US SPR mean for adolescents?" September 2013, p. 99.)

Healthcare professionals have a powerful role to play in reducing teen

pregnancy, noted CDC Principal Deputy Director **Ileana Arias**, PhD, in a released statement accompanying the agency research. Clinicians can encourage teens not to have sex and discuss the use of intrauterine devices and implants as contraceptive options available to teens who choose to be sexually active.

"Long-acting reversible contraception is safe for teens, easy to use, and very effective," stated Arias. "We need to remove barriers and increase awareness, access, and availability of long-acting reversible contraception such as IUDs and implants."

Reported barriers to LARC use prompted the CDC and the Office of Population Affairs (OPA) to analyze

patterns in LARC use among teens ages 15-19 seeking contraceptive services, using 2005-2013 data from the Title X National Family Planning program. The program supports confidential family planning and related preventive services with priority for low-income clients and teens.

The Title X National Family Planning program helps to increase teens' access to long-acting reversible contraception, explained **Susan Moskosky**, the OPA's acting director. It provides comprehensive information to teens, including advice that avoiding sex is the most effective way to prevent pregnancy and sexually transmitted infections. The Title X also applies the latest clinical guidelines on long-acting reversible contraception and other forms of birth control, offers training to providers on intrauterine devices (IUDs) and implant insertion and removal, and provides low- or no-cost options for birth control, she stated.

Analysis of the data indicates that use of LARC methods among teens seeking birth control services increased from less than 1% to 7% from 2005-2013.

When looking at type of LARC, use of IUDs for teens ages 15-19 increased from 3,685 to 17,349, and use of implants increased from 427 to 26,347. Use of IUDs was more prevalent than use of implants during 2005-2011 but was surpassed by implants in 2012 and 2013.¹

Use of LARC methods increased from 0.6% to 7.6% among teens ages 18-19, and from 0.3% to 6.5% among teens ages 15-17. For both age groups, the increase in use of implants exceeded the increase in use of IUDs. For teens ages 15-17, usage changed from 0.05% to 4.5% for implants, and it changed from 0.2% to 2.0% for IUDs. For teens ages 18-19, usage

EXECUTIVE SUMMARY

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- Use of IUDs was more prevalent than use of implants during 2005-2011 but was surpassed by implants in 2012 and 2013.

changed from 0.04% to 4.1% for implants and from 0.5% to 3.4% for IUDs.¹

Use of LARC methods differed by regions. In 2013, among the 616,148 adolescent female clients

... USE OF LARC METHODS AMONG TEENS ... INCREASED FROM LESS THAN 1% TO 7% FROM 2005-2013.

ages 15-19 seeking contraception at Title X service sites, usage was highest in the West (9.5%), followed by the Northeast and Midwest (both 6.4%), and lowest in the South (5.3%) ($p < 0.001$).¹ When analyzed by state, Colorado had the highest percentage of teen clients using LARC (25.8%), followed by Alaska (19.6%), District of Columbia (17.9%), Iowa (16.6%), Hawaii (14.4%), and Vermont (13.8%). The lowest percentage of teen clients using LARC methods was in West Virginia (2.0%), Indiana (1.5%), and Mississippi (0.7%).¹

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Mammograms a personal decision for women in their 40s, panel says

The U.S. Preventive Services Task Force has released draft health recommendations indicating that mammography screening is most beneficial for women ages 50-74, and that women ages 40-49 should make an individual decision in partnership with their doctors in seeking such screening. Based on the evidence, the Task Force found that the benefit of mammography screening increases with age, with women ages 50 to 74 benefiting most. Women get the best balance of benefits to harm when screening is done every two years, the group concludes.

“Mammography is an important tool in reducing the number of breast cancer deaths,” said **Michael LeFevre**, MD, MSPH, the Task Force’s immediate past chair, in a statement. “Based on the evidence, the Task Force found that screening is most beneficial for women ages 50 to 74.”

How should providers approach women with this new information on mammograms?

As women, in concert with their providers, are deciding when to start and how often they should obtain a mammogram, they deserve to know what the evidence says about the potential benefits and the potential harms, explains **Kirsten Bibbins-Domingo**, PhD, MD, Task Force vice chair. The Task Force found that screening every other year starting at age 50 can have an important beneficial impact on women’s lives, she notes. “When we think about screening more often and in younger women, it’s important to consider that there is still a benefit, but there are also significant harms,” states Bibbins-Domingo. “Because of this, the Task Force recommends that

women and their doctors discuss these benefits and harms to decide if screening is right for them.”

Fortunately, breast cancer is an uncommon disease for women under 50, observes Bibbins-Domingo. Despite this fact, the Task Force found an important benefit of mammograms is that they can help women in their 40s reduce their risk of dying from breast cancer. However, in comparison to women in their 50s and 60s, the number of women in their 40s who will benefit is much smaller, and the likelihood of harm is greater than at older ages, notes Bibbins-Domingo.

“Of the potential harms, the most serious is unneeded treatment for a type of cancer that would not have become a threat to a woman’s health during her lifetime,” she says. “The most common is a false-positive test result, which often leads to additional tests and procedures and may lead to anxiety and stress.”

If a woman between age 40 and 49 places a higher value on the potential benefit than the potential

harms, she might choose to begin screening, states Bibbins-Domingo. Women who have a mother, sister, or daughter with breast cancer might benefit more than average-risk women by beginning screening in their 40s. The Task Force’s goal with the draft recommendations is to inform and empower women and their doctors with the best scientific data about the benefits and harms associated with breast cancer screening, so they can make an informed decision that best reflects their personal values, states Bibbins-Domingo.

Where do professional societies stand on the issue? The American Cancer Society recommends annual screening starting at age 40 and continuing as long as the woman is in reasonably good health and a candidate for treatment. The American College of Physicians advises that for women ages 40-49, screening mammography decisions should be made on the basis of individualized assessment of risk for breast cancer. The American College of Obstetricians and Gynecologists,

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- Based on the evidence, the Task Force found that the benefit of mammography screening increases with age, with women ages 50 to 74 benefiting most. Women get the best balance of benefits to harm when screening is done every two years, the group concludes.
- While 3-D mammography offers promise as a new breast cancer detection tool for, the Task Force did not find enough evidence to determine whether it will result in better overall health outcomes for women. It did not issue a recommendation on the practice.

the American College of Radiology, and the Society for Breast Imaging recommend that women begin annual screening mammography at age 40.¹

The Task Force also developed several additional recommendations as part of its draft recommendation statement. For women age 75 and older, the Task Force determined that the current evidence is insufficient to make a recommendation for or against mammography screening. The Task Force is encouraging more research on screening in this group.

While 3-D mammography offers promise as a new technology for the detection of breast cancer, the Task Force did not find enough evidence to determine whether it will result in better overall health outcomes for women. Based on the current paucity of research, the Task Force was unable to make a recommendation for or against 3-D mammography.

“There are promising new technologies to detect breast cancer, but there is just not enough evidence available at this time for the Task Force to clearly evaluate the balance of benefits and harms, and therefore, we cannot make a recommendation for or against these technologies,” says Bibbins-Domingo. “Mammography is a good test, but not a perfect test, and we need better tests and better treatments to truly beat this disease.”

Evidence to recommend a specific screening strategy for women with dense breasts is insufficient, the Task Force says. Women who have dense breasts are at an increased risk for breast cancer, and high breast density also reduces the ability of mammography to find and accurately identify breast cancer. However, the evidence on how additional screening beyond mammography might or might not help women with dense

breasts is unclear, the group said. Additional research is needed in this area, the Task Force states.

To help educate healthcare professionals, stakeholders, and the general public about the draft recommendations, the Task Force has developed additional materials, including a myth-versus-fact slide set, a video, answers to frequently asked questions (FAQs), and a fact sheet for consumers. Check out these materials at <http://screeningforbreastcancer.org>. The video is on the home page. The slide set is at <http://bit.ly/1eaRhX6>. The FAQs are at <http://bit.ly/1cKUDzf>, and the consumer fact sheet is at <http://bit.ly/1IH5M1A>.

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Stigma, lack of affordability keep many transgender people from pursuing care

For many patients, discussing sexual history with a healthcare provider can be an uncomfortable experience. However, for many transgender people, the conversation never takes place because they aren't seeking healthcare, according to a University of Buffalo (NY) researcher.

According to **Adrian Juarez**, PhD, a public health nurse and assistant professor in the University at Buffalo School of Nursing, social stigma, as well as a lack of affordability, keep many transgender people from pursuing needed care. Juarez gathered data during a preliminary study examining HIV testing access and health-based decision-making in urban, transgender populations.¹ The research was partially funded through

a Junior Investigator Award from the American Public Health Association.

“There is evidence that healthcare providers do tend to be judgmental, and it's unwelcoming,” said Juarez in a press statement accompanying the research. “People will refrain from going to healthcare providers if they have to deal with stigma and discrimination.”

Before using the term “transgender,” you should understand a patient's gender identity. The National Center for Transgender Equality defines gender identity as “an individual's internal sense of being male, female, or something else. Since gender identity is internal, one's gender identity is not necessarily visible to others.”² Gender expression

and gender role conformity describe the extent to which a person does or does not adhere to expected gender norms and roles.³

The term transgender refers to individuals whose sex at birth is different from their identity as male, female, or elsewhere along the gender spectrum. People who identify as transgender might live their lives as the opposite gender and might seek prescription pharmacologic therapy and/or surgical transformation. Transgender people might identify as heterosexual, lesbian, gay, or bisexual, or somewhere else along the spectrum of sexual identity.³

According to an April 2015 issue brief from the Kaiser Family Foundation of Menlo Park, CA, data

on those who identify as transgender are limited.³ A 2011 study found that an estimated 0.3% of the U.S. population is transgender, which equates to approximately 700,000 people.⁴

More access to data on the transgender population is coming. The Affordable Care Act has included new data collection requirements on disparities, which include sexual orientation and gender identity. The National Health Interview Survey, which serves as a major source of information on the health of the U.S. population, added a question on sexual orientation in its 2013 survey, with findings issued in July 2014.

The Affordable Care Act has expanded access to health insurance coverage for millions, including transgender individuals, and includes specific protections related to sexual orientation and gender identity. Such coverage is said to be necessary; according to a study of Massachusetts residents, transgender persons are the least likely among lesbian, gay, bisexual, and transgender (LGBT) individuals to self-report their health as “excellent” or “very good” (67% among transgender residents versus 79% for lesbian, gay, and bisexual residents). In the same study, transgender individuals were twice as likely to report limitations in daily activities due to impairment of health problems (33% versus 16% for lesbian, gay, and bisexual residents).⁵

Compounding the issue is the fact that the transgender population is much more likely to live in poverty and less likely to have health insurance than the general population.³ Survey results indicate nearly half (48%) of respondents postponed or went without care when they were sick because they could not afford care.⁶

Transgender women, particularly

transgender women of color, are also at high risk of HIV, according to the Kaiser Family Foundation issue brief.³ Research indicates more than one in four (28%) are HIV positive, and most are unaware that they are infected.⁷

The Centers for Disease Control and Prevention (CDC) is leading programs totaling more than \$185 million in HIV prevention funding for men who have sex with men (MSM) and transgender people, with a particular focus on addressing the needs of MSM of color. The agency announced its multi-faceted strategy in March 2015, with three new programs enabling health departments and local HIV prevention partners to deliver the most effective HIV prevention tools to these populations.

The agency is awarding up to \$125 million over three years to state and local health departments to expand the use of pre-exposure prophylaxis for MSM and transgender people who are HIV-negative but at substantial risk and expand the use of ongoing medical care and antiretroviral treatment for people living with HIV. An additional investment of up to \$60.5 million over four years from the Minority AIDS Initiative Fund from the

Department of Health and Human Services will strengthen prevention efforts specifically for MSM of color.

In a statement, **Jonathan Mermin**, MD, MPH, director of the CDC’s National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, said, “We have more powerful HIV prevention tools than ever before. Now, we need to get them into the hands of the people who need them the most. By harnessing the power of recent scientific breakthroughs, we can change the course of the epidemic among MSM and transgender people, who continue to face the highest risk for infection in this country.”

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EXECUTIVE SUMMARY

Social stigma and a lack of affordability keep many transgender people from pursuing needed care, according to a recent research paper.

- The term transgender refers to individuals whose sex at birth is different from their identity as male, female, or elsewhere along the gender spectrum. People who identify as transgender might live their lives as the opposite gender and might seek prescription pharmacologic therapy and/or surgical transformation. Transgender people might identify as heterosexual, lesbian, gay, or bisexual, or somewhere else along the spectrum of sexual identity.
- A 2011 study found that an estimated 0.3% of the U.S. population is transgender, equating to approximately 700,000 people.

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WASHINGTON WATCH

Guidelines aim to improve contraceptive coverage

By Adam Sonfield
Senior Public Policy Associate
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On May 11, the federal government issued expanded guidance for private health plans about how to implement the Affordable Care Act's (ACA's) requirement to cover dozens of preventive care services, including the full range of contraceptive methods, services, and counseling, without any out-of-pocket costs, such as copayments and deductibles.¹

The guidance comes in the wake of studies released in April by the Kaiser Family Foundation and the National Women's Law Center (NWLC) that provided new evidence that many insurance plans have not been fully complying with the ACA's contraceptive coverage guarantee and many of the law's other coverage requirements.²⁻⁴ Those studies had confirmed earlier anecdotal reports in the media and more limited reviews of plan documents.⁵ The study results also had prompted calls from key Democrats in Congress for the Obama administration to ratchet up oversight and enforcement of the federal guarantee.⁶

Most notably, the new federal guidance clarifies that the contraceptive coverage guarantee encompasses every distinct contraceptive method used by women, and it lists 18 methods as

identified by the Food and Drug Administration. (See box in this issue.) Two other methods, vasectomy and male condoms, are not included in the guidance because they are used by men and have been determined by federal officials to fall outside the legal scope of the ACA's provision.

Prior federal guidance, from February 2013, had not clearly defined the "full range" of methods,⁷ and the national studies identified numerous plans that failed to fully cover certain methods. In some cases, insurers excluded specific methods, such as the vaginal ring, the patch, the implant, or the copper intrauterine device (IUD). Several justified those exclusions by incorrectly claiming that they were medically equivalent to other methods, for example, by claiming that the ring and patch were equivalent to certain generic oral contraceptives. In other cases, insurers limited their coverage to generic contraceptive products, even in cases in which a brand-name product had no generic equivalent; for example, there are no generic IUDs on the U.S. market.

The new guidance also clarifies and expands an earlier statement that the contraceptive coverage guarantee encompasses "services related to follow-up and management of side effects, counseling for continued adherence, and device removal."⁷ Now, plans are on notice that they must fully cover all clinical

services "needed for provision of the contraceptive method."¹

One of the national studies, for example, had identified limits on ultrasounds to assess proper placement of an IUD and even anesthesia for sterilization. In addition, plans were reminded that the preventive services coverage requirements apply to all plan enrollees, including those enrolled as dependents. Several plans identified by the NWLC, for example, had excluded coverage of maternity care or sterilization for dependents.

Plans also were given further guidance on what they can and cannot do in using so-called reasonable medical management techniques, such as drug formularies, prior authorization, and step therapy. They might use such techniques only within a given method (for example, to promote one hormonal IUD over another), but not across methods (for example, to promote oral contraceptives over copper or hormonal IUDs). The guidance also provides more details about the waiver process that plans must have in place if they do use such techniques.

The new federal guidance on contraceptive coverage officially will take effect for new plan years beginning in July, which is in time for student health plans that begin in the fall and for ACA marketplace plans and employer-based plans that begin in January 2016.

The guidance should help to bolster a contraceptive coverage guarantee that already was having a widespread, beneficial impact for women. According to a national survey of women by the Guttmacher Institute, the proportion of privately insured women paying zero dollars out of pocket for oral contraceptives increased substantially, from 15% to 67%, between fall 2012 (before the guarantee was binding on many plans) and spring 2014 (after it had taken root).⁸ The study found similar results for injectable contraception, vaginal rings, and IUDs. A 2014 report from the IMS Institute for Healthcare Informatics had similar findings, including an estimate that women saved nearly half a billion dollars in out-of-pocket costs for contraception in 2013 after the guarantee took effect.⁹

In the meantime, state policymakers have been taking action to provide clarity and to strengthen the contraceptive coverage guarantee. California enacted legislation in 2014 addressing some of the same issues with insurers' coverage, including the failure to cover all methods and all related services and the imposition of inappropriate medical management techniques. Connecticut took similar action in 2014 through an insurance bulletin. In March 2015, Washington State's insurance commissioner extracted commitments from his state's insurers to improve their customer service training about the contraceptive coverage guarantee and make corrections to their formularies. And in May 2015, New York regulators announced they were investigating insurers' contraceptive coverage practices. The state's attorney general introduced legislation to expand on the coverage requirements, including requiring plans to cover a full year's worth of a contraceptive

Contraceptive Methods Covered in Guarantee

- Sterilization surgery for women
- Surgical sterilization implant for women
- Implantable rod
- Copper IUD
- Progestin IUD
- Contraceptive shot/injection
- OCs (combined pill)
- OCs (progestin-only)
- OCs (extended/continuous use)
- Contraceptive patch
- Contraceptive vaginal ring
- Diaphragm
- Sponge
- Cervical cap
- Female condom
- Spermicide
- EC (levonorgestrel)
- EC (ulipristal acetate)

and to fully cover men's methods. Several other states have proposed similar legislation this year.

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COMING IN FUTURE MONTHS

- Get up to speed on STI guidelines
- Science eyes genital herpes treatment
- Recognize, manage early pregnancy loss
- Educate women on signs, symptoms of stroke

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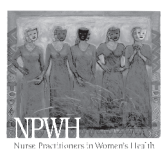
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CNE/CME QUESTIONS

1. Which one of these is NOT one of five key principles of quality counseling offered in the Recommendations for Providing Quality Family Planning Services?
 - A. Establishing and maintaining rapport with the client
 - B. Assessing the client's needs.
 - C. Working with the client interactively to establish a plan.
 - D. Directing a client to a conclusion
 - C. 15 times higher
 - D. 20 times higher
2. The U.S. teen pregnancy rate remains [what number] than in some developed countries?
 - A. Up to seven times higher
 - B. 10 times higher
3. Draft recommendations from the U.S. Preventive Services Task Force indicate that what age women should make individual decisions in partnership with their doctors in seeking mammography screening?
 - A. Women ages 30-39
 - B. Women ages 40-49
 - C. Women ages 50-74
 - D. Women above age 75
4. Research indicates that what percent of U.S. transgender women are HIV positive?
 - A. 8%
 - B. 17%
 - C. 28%
 - D. 33%

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.

CDC clinical advisory: Be on the lookout for ocular syphilis cases in the United States

Since December 2014, 24 cases of ocular syphilis have been reported from California and Washington, with several other states reporting potential cases, according to the Centers for Disease Control and Prevention (CDC). Most cases have been among HIV-infected men who have sex with men, with a few cases occurring among HIV-uninfected persons, including heterosexual men and women, according to a CDC advisory. (*See the advisory, updated as of April 16, 2015, at <http://1.usa.gov/1GCzphe>.*) Several of the cases have resulted in significant sequelae, including permanent blindness.

At press time, no further cases had been identified in Washington or San Francisco since the advisory was updated on April 16, confirms **Robyn Neblett Fanfair**, MD, MPH, a medical epidemiologist in the CDC's Division of STD Prevention. However, California has several unconfirmed, possible cases under review, she notes.

Ocular syphilis is a manifestation of neurosyphilis, which is an infection of the brain or spinal cord. It usually occurs in people with untreated syphilis, states Fanfair. It can occur during any stage of syphilis, including primary and secondary syphilis. Ocular syphilis can involve almost any eye structure, with posterior uveitis and panuveitis the most common manifestations, followed by anterior uveitis, optic neuropathy, retinal vasculitis, and interstitial keratitis. Ocular syphilis can lead to decreased visual acuity, including permanent blindness.

A previous study among HIV-positive men who have

sex with men (MSM) found that the estimated risk for having symptomatic early neurosyphilis was 1.7%, notes Fanfair.¹ Most cases the CDC has seen this year are among MSM, she states.

“Syphilis is on the rise in the United States, in particular among MSM, and neurosyphilis can occur at any stage of syphilis,” says Fanfair. “We are working with select jurisdictions to determine how 2015 case counts compare to previous years to see whether this is a significant increase from previous years or an artifact of increased awareness.”

One agency's response

Six people in Washington have been diagnosed with ocular syphilis since mid-December 2014, with four of them in King County, states **Matt Golden**, MD, director of the HIV/STD Program at Public Health – Seattle & King County in Seattle. All cases occurred in MSM; three of the men also had HIV infection. At press time, the health department had not identified any additional cases of ocular syphilis since January, he states. Two of the individuals have permanent loss of vision, though they have had some recovery with therapy, notes Golden.

The Public Health – Seattle & King County's HIV/STD unit has worked to alert healthcare providers, as well as members of the community, about ocular syphilis, says Golden. “We issued a healthcare alert to healthcare providers and sent a letter about the problem to all medical providers who reported a case of STD in 2014,” Golden

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states. “We also have worked with community-based organizations, particularly those that serve gay and bisexual men, to raise awareness of ocular syphilis among MSM and have also communicated with other health departments in the region and with the CDC.” (*Take a look at the agency’s communications with providers and the community at <http://1.usa.gov/1zSibKL>. The provider fact sheet is accessed at <http://1.usa.gov/1HpReDk>. The community fact sheet is at <http://1.usa.gov/1Gjlhv2>.)*

Public health officials continue to provide syphilis testing in the agency’s STD clinic, through community-based testing sites, and in bathhouses serving MSM, says Golden.

Public Health – Seattle & King County created its SyphilisRising campaign in a response to the rise of syphilis in the area, particularly among gay and bisexual men. In the early 1990s, syphilis was almost eliminated in King County. Now the agency sees almost 300 cases per year, and nine out of 10 infections are in MSM.

According to the agency’s SyphilisRising website, www.syphilisrising.com, there are more new cases of syphilis each year than HIV in the area. Syphilis rates are 15 times higher in MSM who have HIV than in MSM who do not have HIV.

Symptoms are subtle

The symptoms of primary syphilis, caused by the bacterium *Treponema pallidum*, are easy to miss and easy for patients to mistake for something else.

Primary syphilis presents as a painless, raised open sore (chancre) on the genitals, mouth, or rectum. The sore usually shows up one to three weeks after exposure, although it can sometimes take months to appear. While the sore can last several weeks

EXECUTIVE SUMMARY

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- Ocular syphilis can involve almost any eye structure, with posterior uveitis and panuveitis the most common manifestations, followed by anterior uveitis, optic neuropathy, retinal vasculitis, and interstitial keratitis. Ocular syphilis might lead to decreased visual acuity, including permanent blindness.

and go away by itself, the infection is not gone.

Syphilis is passed from person to person through direct contact with a syphilis sore. Sores occur mainly on the external genitals, vagina, anus, or in the rectum. Sores also can occur on the lips and in the mouth. Transmission of the organism occurs during vaginal, anal, or oral sex. Correct and consistent use of latex condoms can reduce the risk of syphilis only when the infected area or site of potential exposure is protected.

Initial symptoms of ocular syphilis also can be subtle and can include:

- blurry vision;
- floaters (spots that float by through one’s vision);
- a blue tinge in vision;
- flashing lights;
- eye pain.

If not treated, these symptoms can progress to loss of vision. If treated early, the symptoms usually will go away. However, delayed treatment can result in permanent blindness.

The CDC classifies the case definition for an ocular syphilis case as follows: a person with clinical symptoms or signs consistent with

ocular disease (i.e. uveitis, panuveitis, diminished visual acuity, blindness, optic neuropathy, interstitial keratitis, anterior uveitis, and retinal vasculitis) with syphilis of any stage.

Clinicians should be aware of ocular syphilis and screen for visual complaints in any patient at risk for syphilis, including men who have sex with men, HIV-infected persons, others with risk factors, and persons with multiple or anonymous partners, advises the CDC. All patients with syphilis should receive an HIV test if their status is unknown or they previously were HIV-negative.

Patients with positive syphilis serology test and early syphilis without ocular symptoms should receive a careful neurologic exam including all cranial nerves, states the CDC. Those patients with syphilis and ocular complaints should receive immediate ophthalmologic evaluation. A lumbar puncture with cerebrospinal fluid (CSF) examination should be performed in patients with syphilis and ocular complaints, according to the CDC.

How should the disease be managed? Use treatment recommendations for neurosyphilis, which include aqueous crystalline

penicillin G by intravenous therapy or procaine penicillin by intramuscular injection with probenecid for 10-14 days, the CDC advises. Cases of ocular syphilis should be reported to your state or local health department within 24 hours of diagnosis. Ocular syphilis cases diagnosed since Dec. 1, 2014, should be reported through local or state health department to the CDC

by e-mail at ocularsyphilis2015@cdc.gov. If possible, pre-antibiotic clinical samples (whole blood, primary lesions and moist secondary lesions, CSF, or ocular fluid) should be saved and stored at -80°C for molecular typing.

Clinicians who need advice from the CDC regarding clinical management of ocular syphilis or assistance with shipment of clinical samples for molecular typing may

contact Fanfair at (404) 639-6044 or iyo5@cdc.gov.

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Drug-related HIV outbreak spurs CDC to issue nationwide alert

The Centers for Disease Control and Prevention (CDC) has issued a national health advisory in light of its investigation with the Indiana State Department of Health of a large outbreak of recent HIV infections among persons in Indiana who inject drugs. Many of the HIV-infected individuals in this outbreak are co-infected with hepatitis C (HCV) virus. (*Review the National Health Advisory, available at <http://1.usa.gov/1bQR2jf>*)

Know that similar cases could be in your area. Injection drug use accounts for an estimated 8% of the approximate 50,000 annual new HIV infections in the United States.¹ The hepatitis C virus (HCV) is the most common U.S. bloodborne infection. Percutaneous exposure via drug-injecting equipment contaminated with HCV-infected blood is the most frequent mode of transmission, according to the Centers for Disease Control and Prevention.

In January 2015, the Indiana State Department of Health in Indianapolis began an ongoing investigation of an outbreak of HIV infection after state disease intervention specialists reported 11 confirmed HIV cases traced to Scott County, a rural county

in southeastern Indiana. Historically, fewer than five cases of HIV infection have been reported annually in this county.²

Syringe sharing

Public health officials noted most cases were in residents of the same community and were linked to syringe-sharing partners injecting the prescription opioid oxycodone, which is a powerful oral semi-synthetic opioid analgesic.

As of late April 2015, 142 individuals had tested positive for HIV; 136 were confirmed, and six were preliminary results.³ Two counties in Indiana (Scott and

Jackson) have reported at least five cases, which is the state's minimum threshold for identifying counties that have positive cases.

“New cases of HIV are still being identified every day, but the number of people seeking services, medical treatment, and substance abuse treatment is also growing,” said **Jerome Adams**, MD, MPH, Indiana's health commissioner. “We likely haven't reached the peak of this outbreak, but we hope to soon through the continued comprehensive response made possible by the joint efforts of so many people and organizations.”

State, local, and federal officials are

EXECUTIVE SUMMARY

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- Injection drug use accounts for an estimated 8% of the approximate 50,000 annual new HIV infections in the United States.
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moving on several fronts, including the establishment of a one-stop shop for services at Scott County's Austin Community Outreach Center, a weekly HIV testing and treatment clinic, a needle exchange program operated by the Scott County Health Department, and an HIV public awareness campaign named "You Are Not Alone." The campaign focuses on substance abuse treatment, safe sex, needle disposal, and HIV testing and treatment. (*Take a look at the campaign at <http://bit.ly/1GL2uo8>.*)

Campaign expanded

The You Are Not Alone campaign is currently being expanded to include messages aimed at reaching travelers and truck drivers along Interstate 65 between Louisville and Indianapolis, says **Ken Severson**, spokesperson for the Indiana State Department of Health. The messages encourage drivers to know their HIV status and to protect themselves by avoiding risky sexual behavior, he notes.

The You Are Not Alone campaign is running on radio, TV, online digital, social media, and in some print publications, notes Severson. The messages include the phone numbers for the Indiana HIV Service Hotline [(866) 588-4948] and the federal Substance Abuse and Mental Health Services Administration National Helpline, also known as the Treatment Referral Routing Service [(800) 662-HELP (4357)]. The Treatment Referral Routing Service is a confidential, free, 24-hours-a-day, 365-days-a-year information service, in English and Spanish, for individuals and family members facing mental health and/or substance use disorders. This service provides referrals to local treatment facilities, support groups, and community-based organizations.

The CDC has been involved with

the state's public health response, through an active emergency response team consisting of disease intervention specialists and epidemiologists in Scott County since March 2015. The federal agency also is assisting state and local officials with their efforts to provide risk reduction education, as well as providing consultation on prevention services that might be implemented

"WE ARE ALSO RECOMMENDING INCREASED TESTING AND FOLLOW-UP OF CONTACTS FOR ALL NEWLY DIAGNOSED CASES OF HIV."

in the response, including substance use treatment, HIV treatment for those who are infected, pre-exposure prophylaxis (PrEP) for those who are HIV-negative, and syringe service programs.

Take steps in your area

The CDC issued its health advisory to alert public health departments and healthcare providers nationwide of Indiana's increasing hepatitis C epidemic and the possibility of current or future HIV outbreaks among people who inject drugs. The advisory also provides guidance on how to identify and prevent such outbreaks.

"We're asking states to take a close look at their most recent data on HIV and hepatitis C diagnoses, as well as overdose deaths and admissions

for drug treatment and drug arrests, to help identify communities that could be at risk for unrecognized clusters of hepatitis and HIV infections, as well as those who would benefit from expanded prevention efforts," says **Donnica Smalls**, MA, CDC spokesperson. "We are also recommending increased testing and follow-up of contacts for all newly diagnosed cases of HIV."

Ensure access to services

Health departments and providers can help ensure that all individuals injecting drugs or at high risk for injecting drugs have access to comprehensive prevention services, including:

- regular HIV and HCV testing;
- rapid links to care and treatment for those infected;
- access to substance abuse treatment, risk reduction counseling, and sterile injection equipment for those who are actively injecting drugs to ultimately help them stop using drugs and to protect them from infectious diseases;
- referrals to PrEP for those who are HIV-negative and at high risk for infection and post-exposure prophylaxis for those recently exposed.

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