

**JSI RESEARCH AND TRAINING INST**

**Moderator: Eliza Buyers  
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Operator: Good morning. My name is (Lisa) and I will be your conference operator today. At this time I would like to welcome everyone to the Best Practices and Contraceptive Counseling conference call.

All lines have been placed on mute to prevent any background noise. After the speaker's remarks, there will be a question and answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you, Miss Adrienne Christy, you may begin your conference.

Adrienne Christy: Thank you. Welcome and thank you for joining us for JSI's Region VIII Family Planning Training Center audio conference, Best Practices and Contraceptive Counseling, presented by Dr. Eliza Buyers.

Our training center is funded by the Department of Health and Human Services Office of Population Affairs. My name is Adrienne Christy and I am from the Region VIII Family Planning Training Center.

There will be continuing nursing education units available from the Colorado Nurses Association for today's call. In order to receive your contact hours, please stay on the line through the end of the question and answer session and complete the online evaluation.

After the call, please fill in the continuing education registration form included in the conference packet and fax it to JSI at 303-262-4395. I will now turn the call over to Dr. Eliza Buyers.

Eliza Buyers: Hi, everyone thanks for hopefully coming back for another audio conference. I'm going to go off the slides that have been sent to you, and this time they are numbered. It's the very small number in the bottom corner. But I'm going to be referring to those numbers as I move along and I will try to go in order.

The **first slide** shows a copy of the Health TeamWorks Contraception guideline. And I'd like to give you guys a little bit of background with the guidelines. This is a guideline that was done by an organization in Colorado. It used to be called the Colorado Clinical Guideline Collaboration, or something like that, CCGC.

It was formed to take many of the guidelines we have around issues, like, let's say asthma care or depression and really take the best practices for all those guidelines and put them together.

Now, what's so interesting about contraception is – I don't know about you – but I've never seen a guideline when it comes to contraception. It was an interesting guideline to write, although the makeup of the committee, we all felt very strongly that there were best practices.

And so when you have a chance, if you haven't yet, I encourage you to go back, go through this guideline one by one, the front and the back which you see there and really look and notice some of the best practices.

The committee was made up several people, nurse practitioners and physicians from Title X clinics, Denver Health. There was also input from Dr. Stephanie Teal who runs a fellowship in family planning and abortion, and she's kind of like our local expert on this kind of thing.

There really was a lot of thought that went into this, and so I want you to know what's behind these guidelines. Also if you want copies, a beautiful green laminated copy; you can go to the Health Team website and order those. Actually, I think they're free. Request them and they'd be sent to you.

So that's what's behind this. And then for you all, you have to also realize that this guideline really was intended for primary care providers who may be less familiar with contraception. But also it is directed at people like you and me who deal with contraception all the time, but maybe for whatever reason haven't adopted best practices yet; whether that's quick start or whatever that may be.

All right, so two is my interest **slides, three** is my hello. I'm an OB/GYN in Denver, if you remember from last time. I actually now run a teen clinic and a pediatric practice; but clinically, my focus is on contraception and female reproductive health. And I have nothing to disclose really into this talk.

**Slide four** is the learning objectives. You can see in light grey are the learning objectives from last time. And if you remember last time, we really went through methods one by one. We looked at the pill, and Depo and IUD, and really said, OK, before I start a woman on this method, what do I need to tell her; what are the expected side effects; how does the method really work, that kind of thing.

Today, we're going to kind of step back almost and talk about more, how do I provide the contraception. And then if I have a client who walks through the door, who either knows what she wants or doesn't know what she wants, what are some best practices related to that.

And so you can see, one is to discuss those best practices, two is to review the guidelines and three, I would like to give other resources because a lot of us read things at least 20 times before we get it. At least I do.

**Slide five**, I couldn't copy the website; but I just want, again, to show you all where you can find everything at [healthteamworks.org](http://healthteamworks.org). If you go to their guidelines and then you go to contraception guidelines you will find this. There are the wall charts which we'll talk about, and then the patient handouts, I think, are probably the most useful thing, at least in the day to day practice; at least in my day to day practice.

The first two items are birth control methods summarized in English and Spanish and then there is a handout for each method. And those handouts are what we covered last time. So they address myths, they address misperceptions; they address side effects that should be expected and normal versus those that are not.

And I really encourage you, if you're just going to read one, to read the birth control pill one; because I know in your practice, and as are most practices across the United States, birth control pills are the most commonly used method especially in younger women. Older women can have their tubes tied.

But for your practice, we've looked at that before and 65 percent of your clients use birth control pills, so that's something that you want to really, really get out of this talk and last talk if you can.

I'm going to skip over the next slide, that's **slide six** with the four pictures of women. We're going to go over that at the end if we have time.

All right, so slide seven is the first – if you look at the guideline itself, it's the first step, asking about birth control. Now, I know that this may seem silly for you all because you work in a family planning clinic and of course you think it's important to ask about birth control.

But I want to say that even in my practice, a gynecologist's office, sometimes when people come in with vulva itching or with pain, it sometimes just doesn't seem related to ask about birth control. I just want to encourage you all to ask a very direct question; what are you doing about birth control?

Obviously, in an ideal situation, we will pick a sexual history every single time and we would kind of go into depth; but at least to ask the basic question, I think is really important. The other thing I want highlight on this one is that confidentiality really matters. We're going to talk a little bit more about that and I think the important point is whether we're talking about teens or whether we're talking about a woman with her partner.

It is up to us as the provider to make sure that one-on-one discussion happens. There is no way a teen can ask her parents to leave – I mean that is just like,

are you kidding me? You know – I mean that’s just – it’s not developmentally normal.

It needs to be a normal thing that you do – you say, every time I see a teen, I spend one-on-one time with them. And then you ask the parent to leave and you spend that one-on-one time. And then I would say it’s more challenging to get in that habit with women and their partners or women and their mothers if they’re older women; but I think it’s what their practice could do.

You know – this topic is not on domestic violence treating but that is a good point right there to think about how effective that would be with a partner there compared to not with a partner there.

The next slide, we can read the **slide eight**, it’s a poster that I have up in my office. What we say here stays here. You wouldn’t maybe necessarily use this but I think it’s some signage that addresses confidentiality. And some of this is confidentiality, but some of this is just HIPAA.

I think we sometimes assume that patients know that their information is protected; but you know – in this world where everything’s on the internet and especially if you have electronic medical record and I think it’s hard for patients to grasp that what you write in there is really protected. And so that’s important.

And I think it’s also important to disclose what isn’t protected; if they’re suicidal, if they’re being abused; if someone’s life is at risk – you know – you are going to report that. I also do a lot of work with the GLBT community and it has been shown again and again and again and again that you the provider may be the only person that that person can talk to if in their family and in their friends, being gay is not accepted.

So it really can be just another way to encourage communication. All right, so step two then, moving on to **slide nine**, really answers the question, what is required before prescribing contraception.

I realize there are protocols that sometimes can't be overcome in your practice if you practice via a very strict protocol. But I can tell you people like me are looking to change some of those protocols or to create some flexibility.

Because it does not make sense that a woman who needs contraception, who wants to do a responsible thing and prevent an unintended pregnancy should be held hostage because she doesn't want to pass near, or because she can't pee in a cup.

It's important, of course, to recommend indicated screening and to make it as easy as possible for people to get the screening they need. But at the same time I think it's really important to recognize that when it comes to prescribing contraception, the one key piece that needs to be done is taking the patients blood pressure and then a detailed medical history.

And that is what's good there on the contraception guidelines the contraindications to estrogen, the clot, migraines with aura, uncontrolled hypertension, smoking and over 35. Those are the real red flags, those are the women, who should not be given estrogen.

But pretty much everything else, I think there is a lot of myth and misperception about. And so I'm going to go over all these things listed on slide nine, one by one now.

\_\_\_\_\_Stop\_\_\_\_\_ So moving to **slide 10**, I want to tell you about an amazing tool that came out right before the guideline, thank goodness; because – or that's why we started making the guidelines, because I think we would have spent the entire time trying to make something like this.

This is a tool from the CDC and the World Health Organization which is a tool that alerts over 60 medical conditions. Everything from bariatric surgery to sickle cell disease, to arthritis to Lupus and what it does is that it uses the World Health Organization's grading.

One and two are represented by green that means "go ahead", use that method with that specific medical condition. Three and four are "no"; don't use. There probably are some exceptions, but I would like to refer those to an expert and let the expert make that decision.

This document it's a two-page document, it's in color and black and white. The color's much easier to read. It's available on healthteamworks website and it's also available there at that CDP site. The abbreviation for it is USMEC which means the Medical Eligibility Criteria.

And it's a great tool to use when you're sitting in the office and a patient's sitting in front of you with rheumatoid arthritis, and you're someone like me who's like, "oh I think it's OK for me to give her the pill; but I can't remember and I'm a little bit obsessive compulsive. The last thing I want to do is give her this when I shouldn't." So you can just pull this out and find it and go ahead and do the right thing. So that's a great tool for you to know about.

The next slide, **slide 11**, addresses a Pap smear issue. I think you all are probably pretty aware that around 2009, recommendations changed related to when to initiate Pap screening. And in red there you can see that the recommendation is to start screening for cervical cancer with a Pap test at age 21.

And this isn't required when the teen starts to have sex, and that's the change because it used to be three or four years after first sexual intercourse. And that has gone away, it's age 21, the only exception is teens with HIV.

Otherwise, whether they have had a pap before, whether they're pregnant, whether they have had STDs, it just doesn't matter, you start at 21. And the reason why is not because we're trying to save money or because we don't care about women, it's because screening women before the age of 21 does nothing to impact the cervical cancer survival rate, either in young women or in older women.

I spent my entire residency doing colposcopies and leaks on women under the age of 21. We really did a lot of harm and we induced a lot of pain. We were treating admirable Pap smears and not treating cervical cancer. And so that's the big important message there.

And that word really needs to still get out and you may be put in the situation of explaining to someone or actually calling someone and saying, “hey did you know the recommendations changed, I know you did this Pap smear, but that wasn’t a Pap smear you needed to do.”

All right, moving on to **slide 13**, you all who work in a family planning clinic are actually by far superior at doing Chlamydia screenings than any other provider group. But I think the big point discussed again and again is that we do not screen for Chlamydia based on symptoms.

That’s what I was taught that, a woman walks in your office, she’s either going to have symptoms or she’s going to have irate behavior, that is she has lots of partners. But it turns out that AIDS is really the receptor for Chlamydia.

So you see a 24 year old woman who is monogamous, married, has three children, you fail to screen her for Chlamydia. And that’s based on all kinds of data from the CDC, which you can find there.

It is absolutely fine to use urine, in fact it’s a better test. And then the other thing the new CDC recommendations talk about is a self-collected vaginal swab, that is also fine.

Moving on to **13**. So we’ve kind of dealt now with step one, asking about birth control; and step two, the targeted clinical evaluation. Now we’re getting more into the actual providing of the contraception, and slide 13 has a little picture of the wall charts.

Then I get bored with some of the messages, which again, I think are directed more towards primary care providers who don’t focus on family planning, but again, I think they’re things that are good to say to patients.

We can get you started on the birth control pill without doing a pelvic exam. We can find a method that is safe and will work for you, especially in a patient who is ambivalent about birth control or that feels like they’ve tried them all and nothing works.

The final message for a patient who's not interested or not needing birth control now; having this discussion will plant a seed and let her know that she can call you and get started, that is a really important piece.

Next, **slide 14**. That is a cutout of the patient handout on slide 15. This a one page, black and white patient handout that you can use with patients who walk in or who you're counseling about birth control.

I would say I use this whether or not the patient knows what they want to do. I talk about what's important to them. Let's say a patient comes in and she knows she wants birth control pills. Well, that's great, so let's talk about what matters to you most.

If it's something like, effectiveness matters to her most, the pill may be a fine option for her, but if effectiveness and convenience matters to her most or privacy, then the birth control pill may not be her best option, because taking a pill every day isn't the most convenient thing for some women.

The other thing this does, which may be something you haven't seen before, is it addresses method effectiveness; which I think is a difficult concept for all of us, let alone maybe our patients – they think about statistics all the time.

What this does, and it graphically shows them, if you take 100 women, how many of those women would get pregnant in a year using that method. And you can see down at the bottom, if they don't use any method, 85 women will get pregnant in the year.

Condoms, 15; withdrawal or pulling out is in the middle there, and that's a very commonly practiced method, especially – well I'd say by all these groups, but especially by teens.

Then you can move up and you'll see that the most effective methods, the IUD, implants, sterilization – less than one in 100 women get pregnant – the (insulin) is actually one in 1000.

Those are the methods. If you have a patient who tells you – I cannot get pregnant, pregnancy is not an option, then I would encourage them to get to that top tier method.

The next **slide 15**, view again those two tools that I want you to be aware of. They're very similar but the green – the handout – wall chart has more on it. They're both available in English and Spanish, which is wonderful because if you have Spanish-speaking patients you can communicate with them.

Step three, and start a method today. This is the Quick Start Protocol. I'm not going to go over it again, we spent probably 10 minutes on it last time; but go ahead and read it again. I would encourage you to look at this Quick Start Protocol. If you work in a clinic where you've got lots of providers, get together, talk about it and how you're going to implement it.

The bottom-line with it is that – and this is the bottom-line because I get a lot of questions about this -- well, how do I switch a patient from one pill to another or how do I do one thing or another. Quick Start really addresses that.

The bottom-line is if you have any questions you do a pregnancy test. If that pregnancy test is negative, go ahead and start the method today. That is the bottom-line.

The other thing I wanted to mention to all of you is, even if you have a patient that you're referring for a long acting method, an IUD or implant; I commonly see those patients in my practice and the provider who has referred them did not consider starting them on a method until they got to me.

What will happen is, I'll see them for an IUD and they've been having unprotected sex for the last two weeks; so I can't put the IUD in. Then I have to give them a double check so that they come back and get the IUD.

Because you can't put an IUD or implant or do a sterilization if there's that risk of pregnancy, it just complicates matters too much. So, we have to reconsider that.

The other thing, of course, is that women don't always follow up for the IUD or implant. So if you can get them started on a short-term method, I think that's a noble thing to do.

The bottom-line to an MRP 17, the bottom-line of page one of the contraception guidelines, is that for healthy women no testing is required before initiating contraception and start it today.

Pelvic exams, Pap smears, testing for STDs, all those things are important to women's health, they are very, very important, but it is important that we recognize that there are two bowls to address here.

There is the issue of unintended pregnancy and there's the issue of health screening, and we should not hold one out by the carrot; it doesn't work. First of all, it just doesn't work. You will be more successful and your patients will come back and see you for these needed things if you help them prevent unintended pregnancy or help them through their side effects or whatever their issues may be.

Looking on to page two of the guideline, this is the methods and other considerations section and there is nothing new on this graph sheet.

In fact, I don't think we talked about EC last time, but the top three quarters of it we went over last time when we talked about every method. This will tend to be more of a quick review and then we'll have lots of time for some questions.

I took guard the second point on **slide 18**; long acting reversible methods based for all women, of all ages including teens and women who have not had children – we could do a whole talk on that and why it's true.

I can give you lots of wonderful articles. There's a great review article in the green journal this month; a 10-page article on the IUD, which goes over all the data again and again and again.

So there is literature supporting that statement. The other thing to remember which, again, I'm not sure how many patients you all see with lots of medical

conditions, really complicated patients, but in general the IUD is the preferred method for those patients.

Especially, for example, a morbidly obese patient; an IUD does a wonderful job of being incredibly effective and not interfering with their other medications or other medical issues.

**Slide 19**, you've seen this slide before from the last class. It shows you where we are in the United States with our long lasting method usage. This is an incredible jump. Six percent of women now use the IUD; five or ten years ago that was one percent.

An incredible increase – it's wonderful, but we hopefully in another five to ten years it will be as great as the OCP piece of the pie there.

There are a couple of clinics showing data from counseling young women. This is a Title 10 clinic, a children's hospital in Denver, they have data that shows women under 25 walk through the door, they meet with the health counselor, they're counseled on all options, all options are free – and 25 percent of these women under 25 choose an IUD; 30 percent choose an implant and then Depo, and then birth control pill.

It is like a reversed pie. When you do evidence-based counseling and when you offer methods equally, that's what you get. In that circle, it says all methods save money.

With the funding, and I actually have a great website for you guys with end related to that, I heard someone from the Guttmacher Institute speak last week, and the most conservative estimate that is only talking about the direct cost of pregnancy that year is that for every dollar spent on contraception, you save \$4.

In this time of cutting budgets, we all need to stand up and remind everyone that contraception is the most cost-effective thing you can imagine.

**Slide 20** moves on to talk about Depo. The only thing I want to highlight here, because I know there are still a lot of concerns about the black box warning on Depo addressing the issue of bone loss.

When you have a patient who is on Depo and she is nearing that two year mark where the black box warning is going to apply to her, you need to have counseling with her as you would for any patient on any method.

The important thing to know is that Depo is the best option for her; that is she knows her other options but Depo is the one she wants because it is private, it works well, she can't remember to take a pill, she doesn't want an IUD, etc. You document that.

She's aware, of course, of its theoretical risk potentials as for loss of bones, which can be similar to that occurring with breastfeeding or pregnancy – you document all that. It doesn't matter if she's been on Depo for two years, 10 years, 20 years; she can continue that Depo if she makes that informed choice.

That is the documentation that needs to occur the most – I think the best article on that is that it has many opinions listed right there, and I think if you want to read it and get the nice summary of all the data.

Remember that you can also tell your patients that this is concerning, these findings on scan but there has never been a show of study proving increased fracture risk. We all know that sometimes treating a study is not an interest – treating an image is not as different. It's really the fractures that we care about and there has not been an increased fracture risk.

The next slide, **slide 21**, is the middle fraction of that clause that talks about Estrogen and Progestin methods. The thing I want to highlight here is what it says about oral contraceptive pills.

It says, start with most cost-effective pills. That means you all do have a formulae of generics. That's great. Do not feel insecure about that, do not apologize for that; your generics hold up to the most expensive, newest pill with the best ad on the market. Please let your patients know that this is marketing we're talking about.

The other thing it says is, despite advertising, blinded studies show little or no differences between pill brands, in efficacy; that is how well they work or in side effects. I get lots of questions about what's the best pill. Should I use the monobasic, should I use a tribasic, should I use this one, should I use that one?

There are subtle differences and there are definitely individual differences. By individual differences, I don't know if I'm talking about placebo effect or things we don't understand.

But based on random controlled trials which are the gold standard, differences in pills are minimal. Pills work by preventing ovulation, all pills contain estrogen and progestin, that is how a pill works.

A woman who is on a pill, may have breakthrough bleeding, the most important thing for her is that breakthrough bleeding does not mean the pill is not working. The pill is working; it's preventing ovulation, unless she's not taking it. The breakthrough bleeding is an effect on her uterus.

What happens when you're on the pill in general is the lining gets really thin and sometimes unstable and so she'll have breakthrough bleeding. She can sweat it out and see if it goes away, she can switch to another pill, that's fine too.

The biggest thing to know when you're switching pills is to know where you are in your placebo. Because you don't want to be off the pill for more than seven days or you're going to ovulate.

That is the most important thing, I think for all of you to understand is, understand how pills work; understand that most of what's going on is marketing. All the pills on your formulary currently are standard 21 days on, seven days off pills.

There are some new pills, they're not generic yet. Moving to the 24, three kind of way; but that's not an issue for you right now. You can also instruct your patients to take the pill in any way you would like. A lot of my patients are on extended or continuous.

The next slide, **slide 22**; I don't really have anything to say, except that I think this is another really good handout. The last bullet point on the condom. The Health TeamWorks condom and safer sex handout is great. It talks a lot about negotiation for condom use, which is something we forget.

We teach clients to have them, we teach them how to use them, but we commonly forget to teach them or to help them with getting their partner to use them.

Emergency Contraception and then we're almost done with the content. We didn't talk about Emergency Contraception at all before. The most important evidence-based message for emergency contraception is it works by preventing ovulation, just like the pill.

I work for clinics that give pills away all day long, but they don't do EC. It's frustrating because there is nothing special about EC. The way EC works is it prevents ovulation. This is based on lots and lots of studies, both in vitro, which means in a test tube with mouth models; and also in vivo; which means actually in women where they do lots of studies before eggs come out.

If a woman takes EC, and she's already ovulated, it doesn't do a darn thing. The sperm and egg may or may not meet, it may or may not implant, levonorgestrel which is plan B EC does nothing.

That is why it's so important to take EC right after that unprotected sex, because that's much more likely to stop her ovulation before it occurs. I have the other points there that you need to know. There's nothing wrong with using EC a couple times a month.

You have to stretch your head and say, what's going on here? Why doesn't this woman want a more effective method? What did she like about the anxiety of calling me and asking for plan B? Why do condoms keep breaking?

Sometimes, that's the only thing a woman can do. Maybe her partner won't let her have pills around or whatever. I would say, don't waste any energy

worrying about, oh my gosh she's calling me for EC again, what's wrong, or this could be dangerous.

Spend your energy trying to understand what's going on in her life making her rely on such an unreliable method, using it several times a month, your chances are it's not going to work, one of them.

Some quick cases for discussion. Patient number 25, Alisa; she's 25 years old; she's had one pregnancy which resulted in a miscarriage. She wants birth control pills.

You find out she's got diabetes, not well-controlled, she's got fibroid, and she's got depression. And you're like, oh my gosh I think that might be OK, but that's a lot of medical history can I give her the pill?

What I would recommend to you is if you pull out that U.S. Medical Eligibility Criteria just to confirm, you will find diabetes down there. For a patient with diabetes who does not have vascular disease and does not have renal disease, she is fine to use birth control pills.

Fibroids are not a contraindication to pills, in fact, women who have fibroids use the pill to regulate the bleeding and then again with depression there's actually no method that is contraindicative.

You would feel fine then and there having a trusted confident answer to her that, yes. Then also with her, the other point I have in there is quick starting her because, again, we need to practice quick starting patients; that really should be the only way we start people on methods, I think.

If you have the luxury of doing direct observe start in your office, that's even better; opening the pill pack right then and there and having the patient take it with you, is awesome. They learn so much from seeing how to get the pill out of the pack. Especially if they got crazy-long fingernails.

**Slide 26.** Here is Shelby, she's 44 years old, she's never been pregnant before. She comes in, to see you for itching, and she's 250 pounds. You all know, of course, you're going to ask her about birth control.

I found that women that have never been pregnant before probably have some keen belief, whether it's conscious or subconscious, that they can't get pregnant. There's enough hysteria and we all know people who are troubled with infertility so it's based on something real as well.

Whenever you talk about something that could cause infertility, many times people have told me that their doctor told them they couldn't get pregnant.

I hear that every day, and we all need to be aware of it. Some of the things we say are heard incorrectly because a lot of people actually walk around thinking they can't get pregnant. That has been identified in some research from the National Campaign to Prevent Teen Pregnancy as the reason why so many young people get pregnant.

Not only do they not think they're at risk, they actually think they can't get pregnant, and that's true for men, not getting pregnant, but being sterile. 10 to 20 percent of men actually think they're sterile. That goes across both genders. That's something to address with your patients.

Then there's the obesity issue. The important thing to know about obesity is that obesity in itself does not preclude any method. If you go to the U.S Medical Eligibility Criteria and you look at obesity, all methods are safe to use with obesity. The issue is that some methods may be less effective and then counseling needs to be done.

Remember that a woman even on a less effective method is in a much better place than if she is on no method at all. If for example, the only method she can take is birth control pills and she's morbidly obese, in the end that's better than nothing.

**Slide 27** is Gabriella, and this will be our last slide of new content. Eighteen year old Gabriella, never pregnant before; she's going off to college in one month and she wants an IUD. Is Gabriella a good candidate for the IUD?

Well, no one who wants contraception for longer than two years is a great candidate for long acting. When you look at the cost-effectiveness it depends what you include.

If you include even three months of using an IUD is cost-effective in my book but I know it's a lot of upfront cost. I would say most literature talks about two years, so if you have a patient who wants to avoid pregnancy for the next two years, then an IUD or an implant is a great method for them.

I have listed there again, the things that are not exclusions. AIDS is never an exclusion; never having children is not an exclusion; multiple partners is not an exclusion because this is another thing that gets confused.

We're talking about pregnancy prevention; the issue with multiple partners is related to STDs, so you've got to spend time talking about STDs, STD prevention, coming in for regular checks, using condoms correctly and consistently.

But people with IUDs are more likely to get STDs and when they do get STDs, they're not any more likely to get PID. That was over 40 years ago, and it's not the way current IUDs are designed. I can show you all the studies that show that. That's just good information to know.

The last slide, well **slide 28** then, our summary point to sum it all up. Ask about birth control, start a method today. A pelvic exam is not required before providing contraception, it may be indicated for other reasons, but it's not a requirement.

Long acting reversible methods are top tier in efficacies they promise to all women and majorly under-utilized, and we should all work to change that. Then the next few points are from February, but I wanted to go over them again.

Recognize and address common misperceptions, myths and outdated protocols. Finally, the counseling and support that you provide, that is you, on the frontline working with your patient is one of the biggest predictors. It's the biggest predictor of how satisfied she is with that method, and how

satisfied she is predicts whether she's going to continue and efficacy really has to do with continuation.

The pill does not work if you don't take it and only 40 percent of young women who started the pill are still on it a year later. That's not because they're not having sex, it's because they had breakthrough bleeding or they couldn't come in for refills or they got scared because their friend got pregnant on the pill etc.

The counseling and support that you provide upfront, but then also ongoing matters so, so much. The last **slide 29**, additional resources lists most of the resources sited in the guidelines. The Association for Reproductive Health Professionals has a wonderful curriculum on its website called the core curriculum.

There's probably 40 PowerPoint slides related to contraception counseling, they are wonderful to flip through. Better than anything I would do, I think, and you can do them on your own. Then again, the Alan Guttmacher Institute has now come up with fact sheets for title 10, based on states.

Every state has its own fact sheets, talking about who gets Title 10, what kind of patients and how much more programs based in a state. It's a wonderful resource and a wonderful organization.

All right, (Lisa), I'm ready for questions.

Operator: Certainly, at this time I would like to remind everyone, in order to ask a question, press star then the number one on your telephone keypad. We'll pause for just a moment to compile the Q&A roster.

And again if you would like to ask a question, please press star then the number one on your telephone keypad. Your first question comes from (L--); your line is now open.

Eliza Buyers: Go ahead, (L--).

(L--): You mentioned that urine is a better test for Chlamydia than the cervical swab; is there a recommendation on how long patients need to wait before avoiding to have that test done?

Eliza Buyers: Great question. When you read it, it actually says it could be a first appointment urine. I think that's problematic. I think the most important thing is that the word for instructions had to do a clean test and you want to take that sign down. This is not a clean test. You want as much shmoo for a lack of a better word from the vaginal walls to end up in that urine.

So if you're doing a pelvic exam, it's probably more cost-effective. Well, that's not necessarily true, I would check to see if there is a cost issue there. Because if it is a woman having a pelvic exam, at least where I used to work, it was more cost effective if she's having a pelvic exam to do the endo-cervical swab. Saving 30 bucks, great.

We're talking about a couple percentage points here. If you're doing a pelvic exam I do not think it matters which one she does but if it's not having a pelvic exam, it's preferable to have her pee in a cup. We pick up plenty of Chlamydia in my clinic and we are not having people do the first flow of the day.

I would just have them pee in a cup, but still have them wipe off, and if they do wipe off, that's OK, send it anyway, it'll probably still be positive.

(L--): Thanks.

Operator: And your next question is from (P--), your line is open.

(P--): Yes, doctor, I would like you to comment on the practice of routinely recalling patients at 10 weeks for Depo.

Eliza Buyers: OK, so, the one place that I have seen that done would be with obese patients. Are you still on, (P--); is that what you're referring to?

(Peggy Sawyer): Yes but not specific to any particular type of patient, that just happens to be the practice in this clinic.

Eliza Buyers: I would question that clinic and that practice. I would find out what research that's based on, it may be the kind of thing that is tried that worked in the past but I just want to go over what the evidence says.

The recommendation is that patients come back between 11 and 13 weeks, right around 12 weeks, which is three months. That is the recommended you are completely following FDA – not my favorite if you haven't gotten that -- but you are following. So, there should be no issues between 11 and 13 weeks.

Obesity, actually this is a size, definitely it's as effective in a weak woman as it is in normal weight women, so even for the obese patients there should not be a change there. The other piece I want to add, to complicate matters even more but to give you some more flexibility, is in my clinic we have a protocol where even if she doesn't come in until 16 weeks, she can have shot, no extra testing.

Because her risk of ovulation at 16 weeks is less than one percent, and less than one percent is pretty darn good, I would strongly encourage you to look at that protocol and consider reviewing it to reflect current evidence.

There are some wonderful reviews on Depo in the contraception journal, from that (ARHP) website. Just reading contraceptive technology on Depo, that would go over all that.

(P--): Thank you.

Operator: And again if you would like to ask a question, press star then the number one on your telephone keypad. Your next question is from (D--), your line is open.

(D--): Yes, you mentioned giving us a website about the cost effectiveness of contraception.

Eliza Buyers: Yes, I would go to the Alan Guttmacher Institute; that's on the last slide, and I think it's [agi.org](http://agi.org).

- (D--): You could just Google Alan Guttmacher and it breaks it down by fee. So it tells you how many Title 10, well I'm talking about Title 10 now; but it also has some great articles just on the cost-effectiveness of contraception.
- (D--): Thank you.
- Operator: And your next question from (S--), your line is open.
- (S--): Dr. Buyers, I was wondering about what you thought about giving Depo off-label, our clinic seems to be doing it more and more. If there are any dangers about that concerning hypospadias.
- Eliza Buyers: Sorry, I don't understand the question. Off-label for what – what's the indication?
- (S--): For Depo-Provera, if you can't rule out pregnancy and they're late for the injection, I guess, after 16 weeks and they've had unprotected intercourse, so you go ahead and give them the Depo as long as we understand the risk factor the hypospadias.
- Eliza Buyers: All right, so to answer your question; go to the contraception guidelines, to number three on the front where it says "Start Method Today". That is the patient who's being quick-started. After 16 weeks she's kind of on no method. You're going to quick start her and like you said, she's had some unprotected sex, plus her pregnancy test today is negative.
- You're going to have to quick start her on the Depo. You're going to let her know that there is a chance she could be pregnant because she's been having unprotected sex but the good news is that the pregnancy test is negative today, there is probably less than a three percent chance that she is going to be pregnant.
- She should come back in two weeks for a pregnancy test but that is absolutely the right thing to do – to give her the shot today. The last thing you want to do is send her away and say, sorry you could be pregnant. That would be – I would just classify those patients as quick start – you're quick-starting her on the Depo.

(S--): OK, thank you very much.

Eliza Buyers: Yes.

Operator: Your next question from (E--), your line is open.

(E--): Yes, doctor, I had a question for the indicated screening for Chlamydia, I missed that part. You said the most important consideration is their age and even if they are married and in a monogamous relationship you would screen them annually for the Chlamydia, is that right?

Eliza Buyers: Yes.

(E--): OK.

Eliza Buyers: I would and that was a hard one for me to spot, I can tell you that I was not doing that until probably about four years ago when I really looked at the evidence. And Chlamydia, just like any other communicable disease, the prevalence of it has to do with the incidents in the population.

So just like when in the middle of the winter, when everyone in your office has a cold, no matter what you do – even if you are the most responsible person ever and you wash your hands ever second. The metaphor here is you're the responsible person, you're the monogamous married person.

Even if you do everything right, your chance of getting that cold is pretty darn high because your population that you're in has Chlamydia. Chlamydia rates are so high in young people, whereas in the middle of the summer, as the people I'd say older population, no one has the cold in your office, you're very unlikely to get that infection because the disease prevalence is so much lower.

I would encourage, and so with the CDC, to screen all sexually active women under the age of 26 every year for Chlamydia. Certainly people, that doesn't mean you can't screen them more often. If they have highly sexual behavior, and have had multiple partners in this year and they need treatment additional to that.

But even that, quote-unquote, very low-risk patient who is monogamous needs screening.

(E--): Thank you.

Operator: And your next question comes from (J--), your line is open.

(J--): Yes, we have a question about the Chlamydia screening. Are you saying that the urine screening is more effective than the vaginal swab?

Eliza Buyers: You want that information?

(J--): Which is more effective, the vaginal swab or a urine screening?

Eliza Buyers: If you go to the CDC website or its most recent copy of the WM or the MWMMR, it lists them. The best, that is the way you are going to pick up the most diseases, talking about sensitivity here, the way you are going to pick up the most disease, is a self-collected vaginal swab.

That's where you give the woman a test tube and a swab and you say, I want you to put this swab in your vagina and then I want you to put it in this test tube and I'm going to step outside. .

That actually gets more in terms of picking up the most disease. Then the next one after that and I do not do that in my practice because I just don't like my patients to be like what.

But for patients who are doing testing at home or in populations, they might be really open to that. So that's the best and that's included in the new CDC information listed there. The second best is to have them pee because the urine, that dirty catch, you know having them pee in a cup is going to get more – pick up more Chlamydia.

The least sensitive, but still a great test, is when you are doing a pelvic exam, you then swab in the posterior fornix, leave it in there for a couple of seconds, I think it's actually 20 or 30 seconds longer than seems reasonable and then

you send that. I would say don't get hung up on which screening you are doing, just do one.

But if the patient doesn't need a pelvic exam, don't make her have a pelvic exam just to do the screening. The most important thing is to screen. Does that help?

(J--): Yes, thank you.

Operator: And again if you would like to ask a question, please press star then the number one on your telephone keypad. Your next question comes from (N--), your line is open.

(N--): That might have answered my question. For a patient who has just urinated right before their exam, is it best to get vaginal swab and not a urine sample?

Eliza Buyers: Yes. In the clinic I used to work at, it was cheaper for me to collect the Chlamydia and this has changed but the urine test is still a lot more expensive. We just provided hybrid information and if we were doing a pelvic exam, we were going to save some money and get the Chlamydia when we did the pelvic exam.

Whether or not she has peed or not, if I'm doing a pelvic exam, I was going to do the Chlamydia. Now, in the practice I work in, it's all equal and I work with teens and none of them want to, so now I just let everyone pee in a cup.

So, there may be some cost information that you need to be aware of so that you can flex one way or the other, but it really doesn't matter. And patients sometimes wander away without peeing in the cup, so if you are doing a pelvic exam and you have all the stuff right there just do the Chlamydia unless you have some other information that for whatever reason, the urine is cheaper.

OK. I'm ready for one more question; I think that's going to be our last question for today.

Operator: Actually there are no more further questions at this time. I turn the call back over to you.

Adrienne Christy: OK, did you want to say anything? Just to thank everyone for participating today. If you would like to get continued nursing education credit, please complete your form and either fax it to us or e-mail it to the contact information included in your packet and we will send out a post of that e-mail with the link to the Guttmacher's site for the guides I mentioned as well as a Frequently Asked Question document.

So thank you all, and thank you Dr. Buyers.

Eliza Buyers: You are welcome.

Operator: And this concludes today's conference call, you may now disconnect.

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