The Evolving Well Woman Visit

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I have no commercial disclosures for this lecture

Case Study

- 28 year old woman is seen for periodic health screening visit (aka, a “Well Woman” visit)
- She has been in monogamous relationship for the past two years
- Feeling well; no complaint of vaginal discharge, abnormal bleeding, dyspareunia
- Last cervical cytology was 24 months ago: benign result
- Currently using the Evra contraceptive patch
- According to the USPSTF, what should be done?

Check Up Visit: 28 Year Old Female

1. Clinical breast exam
2. Cervical cytology (Pap smear)
3. Bimanual pelvic exam
4. Chlamydia NAAT
5. 1,2,3 only
6. All of the above
7. None of the above
Who Defines Well Woman Services?

US Preventive Services Taskforce
- Agency for Healthcare Research & Quality
- Rigorous evidence-based review process
- Multidisciplinary, non-industry expert panel
- Screening recommendations by disease and by four age groups + pregnancy
- Supports “opportunistic prevention” model

USPSTF 2007: Strength of Recommendation

<table>
<thead>
<tr>
<th>Comment</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Recommend</td>
<td>Net benefit is substantial; Offer or provide</td>
</tr>
<tr>
<td>B Recommend</td>
<td>Net benefit is moderate; Offer or provide</td>
</tr>
<tr>
<td>C Recommend against providing</td>
<td>May be considerations that support the service in an individual patient; Offer only if other considerations to support</td>
</tr>
<tr>
<td>routinely</td>
<td></td>
</tr>
<tr>
<td>D Recommend against</td>
<td>No net benefit (or) harms outweigh benefits; Discourage the use of this service</td>
</tr>
<tr>
<td>I Evidence is insufficient</td>
<td>Evidence is lacking, poor quality, or conflicting; Benefits/harms can not be determined</td>
</tr>
</tbody>
</table>

New web site: www.uspreventiveservicestaskforce.org

Female cancer deaths % Deaths Screening Test
- Lung 27% None
- Breast 15% Yes
- Bowel, Rectum 10% Yes
- Lymphoma/Leukemia 7% None
- Pancreas 6% None
- Ovary 6% None (low risk)
- Uterus 3% None
- Cervix 1% Yes

Breast Cancer Screening Guidelines

<table>
<thead>
<tr>
<th></th>
<th>Previous Guideline</th>
<th>ACS 2003</th>
<th>USPSTF 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Self Exam</td>
<td>Monthly</td>
<td>Optional</td>
<td>[D]</td>
</tr>
<tr>
<td>(BSE)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Breast</td>
<td>Annually</td>
<td>20-39: Q3 yrs</td>
<td>[I]</td>
</tr>
<tr>
<td>Exam (CBE)</td>
<td></td>
<td>&gt; 40: annually</td>
<td></td>
</tr>
<tr>
<td>Mammogram</td>
<td>• Baseline @ 35</td>
<td>&gt; 40: annually</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 40-49: Q2 yrs</td>
<td>40-49: [C]</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• &gt; 50: yearly</td>
<td>50-74: [B], every 2 yrs &gt;75: [I]</td>
<td></td>
</tr>
</tbody>
</table>

Screening tests available to prevent 26% of cancer deaths
Breast Self-Examination (BSE)

- Two very large RCTs (Shanghai, Russia)
  - Mortality, survival equal in treatment and controls
  - SBE no better than coincidental discovery of mass
- USPSTF 2009: [D] recommends against teaching BSE
- American Cancer Society 2003
  - At ≥ 20 years old, inform of benefits, limitations
  - If BSE chosen, provide instruction in use
  - Acceptable not to do BSE or to do irregularly
  - Goal of BSE is “increased breast awareness”

Breast Self-Awareness (BSA)

- BSA is defined as women’s awareness of the normal appearance and feel of their breasts
- Endorsed by ACOG, ACS, PPFA, and the NCCN
- The effect of BSA education has not been studied
- Rationale
  - ½ of breast cancer cases ≥50 y.o. and 70% of cases in younger women detected incidentally by themselves
  - New cases can arise during screening intervals, and BSA may prompt women not to delay in reporting breast changes based on a recent negative screening result

Clinical Breast Exam (CBE)

- Most studies evaluate MG + CBE, not CBE alone
- Accuracy of CBE
  - Sensitivity: 54%, specificity: 93-94%
- 10% of breast cancers detected on CBE alone, especially in younger women
- USPSTF 2009: [1] recommendation
- Most recommendations: start CBE at 40; perform annually (concurrent with mammogram) except
  - ACS 2012: 20-39 every 1-3 years, then annually
  - ACOG 2011: 20-39 every 1-3 years, then annually

USPSTF: Screening Mammography

November 2009

The USPSTF recommends
- Biennial mammography 50-74 years [B]
- Against routine mammography 40-49 years [C]
- Evidence is insufficient to assess benefits, harms of
  - Mammography in women ≥75 years old [1]
  - Digital mammography or MRI (vs film) [1]
**USPSTF: Screening Mammography**  
*December 2009*

- The USPSTF recommends against *routine* screening mammography in women aged 40 to 49 years [C]
  - “The decision to start regular, biennial screening mammography before the age of 50 years should be an individual one and take patient context into account, including the patient’s values regarding specific benefits and harms”
  - Even with 15% mortality reduction, there is “moderate certainty that the net benefit is small”

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**Efficacy of Mammography By Screening Interval in RCTs**

<table>
<thead>
<tr>
<th>Screening Interval</th>
<th>Mortality Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>50-74 years old</td>
<td></td>
</tr>
<tr>
<td>1 year</td>
<td>23%</td>
</tr>
<tr>
<td>2 years</td>
<td>23%</td>
</tr>
<tr>
<td>40-49 years old</td>
<td></td>
</tr>
<tr>
<td>1 year</td>
<td>11%</td>
</tr>
<tr>
<td>2 years</td>
<td>17%</td>
</tr>
</tbody>
</table>


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**Screening Mammography: Benefits**

- Sensitivity (positive when cancer present): *80-95 %*
  - Community based mammography: 75 %
  - False negative (neg if cancer present): 5-25 %
- Specificity: (negative when cancer absent): *93-97 %*
  - False positive (pos in absence of cancer): 3-7 %
- Breast cancer deaths after >10 yrs screening
  - ACS meta-analysis: 24% reduction
  - Women 50-69 years old: 20-35% reduction

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**Screening Mammography: Harms**

- Harms more likely in younger women
- Physical and psychological harms of *over-diagnosis*
  - Unnecessary diagnostic imaging tests
  - Biopsies in women without cancer
  - Inconvenience due to false-positive screening results
- Harms of *over-treatment* of a breast cancer that would
  - Not become apparent during a woman’s lifetime
  - Have become apparent, but wouldn’t shorten life
- Radiation exposure (minor concern)
Screening Mammography Guidelines
USPSTF 2009

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>25-39</td>
<td>Screen if specified high risk factors</td>
</tr>
<tr>
<td>40-49</td>
<td>Discuss pros and cons of screening*</td>
</tr>
<tr>
<td>50-59</td>
<td>Encourage screening*</td>
</tr>
<tr>
<td>60-69</td>
<td>Strongly encourage screening*</td>
</tr>
<tr>
<td>70-74</td>
<td>Discuss pros and cons of screening*</td>
</tr>
<tr>
<td>&gt;75</td>
<td>Little data</td>
</tr>
</tbody>
</table>

*When done, perform routine mammography biennially

Cervical Cancer Screening

- Most successful cancer screening program in the US
  - 70% reduction in cervical cancer deaths in past 60 years
  - 2010: 12,000 new cervical cancers; 4,200 deaths per year
- Public health messages have impacted public attitudes and behaviors...but they need to evolve!
- Advances in cervical cancer prevention since 1940s
  - Liquid-based cytology (LBC)...better test throughput
  - hrHPV-DNA testing...co-testing and triage of test results
  - HPV vaccination...primary prevention of cervical cancer
  - Evidence-based cytology screening guidelines

Evolution of Cervical Cancer Screening Intervals

- **1940-1989**: annual “Pap smear” for all women
  - Linkage of annual Pap smear to “annual health exam”
- **1987**: Walton Commission (British Columbia)
  - Cytology screening every 3 years
- **1989**: AMA, ACOG, AMWA Consensus Statement
  - Annually, starting @ sexual activity or 18 years old
  - After 3 negative smears, testing may be done less frequently
  - Longer intervals are based on the absence of risk factors

Evolution of Cervical Cancer Screening Intervals

- **2002**: American Cancer Society
  - Start 3 years after first intercourse or at 21 years old
  - Stop screening
    - After hysterectomy for benign disease or
    - At 65-70 if 3 normal and no abnormals in prior 10 years
  - Everyone else: every 2-3 years
  - Virginal women: inform of screening “benefits and harms”
HPV DNA + Cytology ("Co-testing")
Wright, Obstet Gynecol 2004;103:304

Indications
• Women 30 years old and older
• Immunocompetent
• Cervix in place

• Improves sensitivity over cytology alone or HPV-DNA alone
• Very high negative predictive value; screen women who are HPV negative/cytology negative “no earlier” than 3 years

Cervical Cytology Guidelines
ACOG 2009

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women under 21 yrs old</td>
<td>Avoid screening</td>
</tr>
<tr>
<td>21-29 years old</td>
<td>Screen every 2 years</td>
</tr>
<tr>
<td>30 to 65 or 70 years old</td>
<td>May screen every 3 years</td>
</tr>
<tr>
<td>65 or 70 years old and older</td>
<td>May discontinue screening</td>
</tr>
<tr>
<td>HIV-positive</td>
<td>Screen annually</td>
</tr>
<tr>
<td>Immunosuppressed</td>
<td></td>
</tr>
<tr>
<td>Exposed in utero to DES</td>
<td></td>
</tr>
</tbody>
</table>

USPSTF Cervical Cytology Guidelines
March 2012

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Recommendation</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>21 to 65 years old</td>
<td>Every 3 years</td>
<td>A</td>
</tr>
<tr>
<td>Cytology + HPV combination, 30-65 years old</td>
<td>Every 5 years</td>
<td>A</td>
</tr>
<tr>
<td>Women under 21 yrs old</td>
<td>Avoid screening</td>
<td>D</td>
</tr>
<tr>
<td>Age &gt;65 with adequate prior screening and not high risk</td>
<td>Avoid screening</td>
<td>D</td>
</tr>
<tr>
<td>Total hysterectomy for benign disease</td>
<td>Avoid screening</td>
<td>D</td>
</tr>
<tr>
<td>HPV testing, alone or in combination, &lt; 30 years old</td>
<td>Avoid screening</td>
<td>D</td>
</tr>
</tbody>
</table>

Triple A Guideline: ACS, ASCCP, Am Society for Clinical Pathology
CA CANCER J CLIN March 2012

<table>
<thead>
<tr>
<th>Years of Age</th>
<th>Screening</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;21</td>
<td>No screening</td>
</tr>
<tr>
<td>21-29</td>
<td>Cytology alone every 3 years</td>
</tr>
<tr>
<td>30-65</td>
<td>Preferred: HPV + cytology every 5 years* OR Acceptable: Cytology alone every 3 years*</td>
</tr>
<tr>
<td>&gt;65</td>
<td>No screening, following adequate neg prior screens</td>
</tr>
<tr>
<td>After total hysterectomy</td>
<td>No screening, if no history of CIN2+ in the past 20 years or cervical cancer ever</td>
</tr>
</tbody>
</table>

*If cytology result is negative or ASCUS + HPV negative
**Triple A: HPV Positive, Cytology Negative**

- Occurs in 2.6% (age 60-65) to 11% (age 30 to 34)
- **Option 1:** repeat co-testing in 12-months
  - If co-test positive or LSIL+: colposcopy
  - If co-test negative or HPV-negative ASC-US: rescreen with co-testing in 5 years
- **Option 2:** reflex test for HPV16 or HPV16/18 genotypes
  - If HPV16 or HPV16/18 positive: colposcopy
  - If HPV16 or HPV16/18 negative: co-test in 12-months
  - Then manage as in option 1
- **Do not** immediately colposcope HPV positive/ cyto negatives

**Other Important Messages**

- Women at *any age* should not be screened annually by *any* screening method
- **For women 65 and older**
  - “Adequate screening” is defined as...
    - 3 consecutively negative results in prior 10 years, or
    - 2 negative co-tests, most recently within 5 years
  - If screening stopped, do not restart for any reason
- Women *treated for CIN 2+ or AIS* must be *regularly screened* for 20 years, even if 65 or older
  - With cytology alone Q 3 years or HPV+ cytology Q5 years

**USPSTF: Co-Testing Caveat**

- Co-testing is most appropriate for women who want to extend their screening interval to every 5 years
- **But…**
  - “Women choosing co-testing... should be aware that positive screening results are more likely with HPV-based strategies... and that some women may require prolonged surveillance with additional frequent testing if they have persistently positive HPV results”

**Co-testing Strategy as Health Policy**

**Pros**
- Slightly more accurate than cytology alone
- Higher negative predictive value than cytology alone
- Longer screening interval available if desired by patient

**Cons**
- More false positives, esp. if done too frequently
- High cost/year of life saved if done too frequently
- Many providers do not have EMRs or other systems to prevent overuse
### Summary of Cervical Cancer Guidelines

<table>
<thead>
<tr>
<th></th>
<th>Under 21 years old</th>
<th>21-29 years old</th>
<th>30-65 Years old</th>
<th>&gt;65 years old</th>
<th>Hyst, benign</th>
</tr>
</thead>
<tbody>
<tr>
<td>USPSTF 2012</td>
<td>[D]</td>
<td>Every 3 y</td>
<td>Co-test: Q5</td>
<td>None*</td>
<td>[D]</td>
</tr>
<tr>
<td>Triple A 2012</td>
<td>None</td>
<td>Every 3 y</td>
<td>Co-test: Q5</td>
<td>None*</td>
<td>None</td>
</tr>
<tr>
<td>ACOG 2012</td>
<td>“Avoid”</td>
<td>Every 3 y</td>
<td>Co-test: Q5</td>
<td>None*, unless new partner</td>
<td>None</td>
</tr>
<tr>
<td>hrHPV test</td>
<td>Never</td>
<td>Reflex only</td>
<td>Co-test or reflex</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

* If adequate prior screening with negative results

Co-test: cervical cytology plus hrHPV test
Cytology: cervical cytology (Pap smear) alone

### Common Questions About Pap Intervals

- Do virginal women need Pap smears?
- Are the intervals any different for women
  - With multiple sexual partners?
  - Using hormonal contraceptives, menopausal hormone therapy?
  - Who only have female partners?
  - Who are pregnant?
- If a Pap is *not* scheduled or necessary, what about the need to perform a bimanual pelvic exam?

### Ovarian Cancer Screening

- **Options for screening**
  - (Bimanual) Pelvic examination
  - Transvaginal pelvic ultrasound (TVS)
  - Serum Tumor Marker: CA-125
- **Not recommended for low risk asymptomatic women**
  - Low sensitivity, specificity for early disease
  - Low prevalence of disease
  - High cost of evaluation

### Ovarian Cancer Screening

**USPSTF (2012)**

- Screening asymptomatic women with ultrasound, tumor markers, or exam is *not recommended* [II]
- Insufficient evidence to recommend for or against in asymptomatic women at increased risk [I]
Pelvic Exam at the Well-Woman Visit
ACOG Committee Opinion 524; August 2012

- Women younger than 21 years
  - Pelvic exam only when indicated by medical history
  - Screen for GC, chlamydia with vaginal swab or urine
- Women aged 21 years or older
  - “ACOG recommends an annual pelvic examination”
    - No evidence supports or refutes routine exam if low risk
    - If asymptomatic, pelvic exam should be a “shared decision”
    - Individual risk factors, patient expectations, and medico-legal concerns may influence these decisions
  - If TAH-BSO, decision “left to the patient” if asymptomatic

The Prostate, Lung, Colorectal and Ovarian (PLCO) Cancer Screening Randomized Controlled Trial

- Randomized trial of 78,216 women aged 55-74
- Annual screening with CA-125 for 6 years + transvaginal U/S for 4 years (n=39,105) versus usual care (n=39,111)
- 10 US screening centers
- Followed a median of 12 years
- Bimanual examination originally part of the screening procedures but was discontinued

JAMA. 2011;305(22):2295-2303

Ovarian Cancers: PLCO Cancer Screening RCT

<table>
<thead>
<tr>
<th>Screen for</th>
<th>Preferred test</th>
</tr>
</thead>
<tbody>
<tr>
<td>GC, Ct</td>
<td>NAAT: vaginal swab or urine sample</td>
</tr>
<tr>
<td>Cervical cancer</td>
<td>Not recommended until 21 years old</td>
</tr>
<tr>
<td></td>
<td>Cytopology every 3-5 yrs afterward</td>
</tr>
<tr>
<td></td>
<td>None, if total hyst for benign disease</td>
</tr>
<tr>
<td>Ovarian cancer</td>
<td>USPSTF rec. against bimanual exam</td>
</tr>
<tr>
<td>Vulvar lesions</td>
<td>Unnecessary if asymptomatic</td>
</tr>
<tr>
<td>Vaginal infxn</td>
<td>Unnecessary if asymptomatic</td>
</tr>
<tr>
<td>Myomas</td>
<td>Unnecessary if asymptomatic</td>
</tr>
</tbody>
</table>

JAMA. 2011;305(22):2295-2303

Is The “Screening Pelvic Exam” Outdated?

- Cumulative cases and deaths over the years for Cases and Deaths.
### Routine Cancer Screening in Women

<table>
<thead>
<tr>
<th>Age</th>
<th>18-20</th>
<th>21-25</th>
<th>26-29</th>
<th>30-39</th>
<th>40-49</th>
<th>50-59</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervix CA</td>
<td>None</td>
<td>None</td>
<td>Q 3 yrs</td>
<td></td>
<td></td>
<td>Q 3 yrs</td>
</tr>
<tr>
<td>• Cytology</td>
<td>None</td>
<td>None</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Co-testing</td>
<td>None</td>
<td>None</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CBE</td>
<td>None</td>
<td>Q 3 yrs</td>
<td></td>
<td></td>
<td>Annual with MG</td>
<td></td>
</tr>
<tr>
<td>• ACS</td>
<td>None</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mammogram</td>
<td>None</td>
<td>Hi Risk</td>
<td>Annual</td>
<td>Q2y [C]</td>
<td>Q2y [B]</td>
<td></td>
</tr>
<tr>
<td>• ACS</td>
<td>None</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• USPSTF</td>
<td>None</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colorectal cancer</td>
<td>None</td>
<td>Hi Risk</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ACOG: Am College of Ob-Gyn  
ACS: American Cancer Society  
CBE: Clinical breast exam  
CDC: Centers for Disease Control  
USPSTF: US Prev Services Task Force

### Routine STI Screening

<table>
<thead>
<tr>
<th>Age</th>
<th>18-20</th>
<th>21-25</th>
<th>26-29</th>
<th>30-39</th>
<th>40-49</th>
<th>50-59</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT (Both)</td>
<td>Annually</td>
<td></td>
<td></td>
<td></td>
<td>Targeted</td>
<td></td>
</tr>
<tr>
<td>GC (Both)</td>
<td>Targeted</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV</td>
<td>Once, then Hi risk only</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- CDC</td>
<td>Hi Risk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- USPSTF</td>
<td>Hi Risk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Syphilis</td>
<td>Hi Risk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Both</td>
<td>Hi Risk</td>
<td></td>
<td></td>
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</tbody>
</table>

ACOG: Am College of Ob-Gyn  
ACS: American Cancer Society  
Both: CDC+USPSTF  
CDC: Centers for Disease Control  
USPSTF: US Prev Services Task Force

### Routine Metabolic Screening

<table>
<thead>
<tr>
<th>Age</th>
<th>18-19</th>
<th>20-25</th>
<th>26-29</th>
<th>30-39</th>
<th>40-49</th>
<th>50-59</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP</td>
<td>&lt;Q2 yrs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BMI</td>
<td>&lt;Q2 yrs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T2DM</td>
<td>Hi Risk</td>
<td>HTN [B]</td>
<td></td>
<td>Q3y</td>
<td>HTN[A]</td>
<td></td>
</tr>
<tr>
<td>• ADA</td>
<td>Hi Risk</td>
<td>HTN [B]</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• USPSTF</td>
<td>Hi Risk</td>
<td>HTN [B]</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lipids</td>
<td>Q5 yrs</td>
<td></td>
<td></td>
<td>Hi Risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• ATP</td>
<td>Q5 yrs</td>
<td></td>
<td></td>
<td>Hi Risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• USPSTF</td>
<td>Q5 yrs</td>
<td></td>
<td></td>
<td>Hi Risk</td>
<td></td>
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</tr>
</tbody>
</table>

ATP: Adult Treatment Panel  
CHD: coronary heart disease  
HTN: hypertension  
T2DM: Type 2 diabetes mellitus  
USPSTF: US Prev Services Task Force

### Family Planning Preventive Services  
The “Musts”

Discuss and counsel

- Reproductive life plan
- Safe and effective contraceptive use
- Screen for reproductive coercion, BC sabotage
- Sexual behaviors and STI risk screening
- Screen for tobacco, alcohol, and drug use
- Family history of breast and ovarian cancer
Reproductive Life Plan Questions

• Do you hope to have any (more) children?
• How many children do you hope to have?
• How long do you plan to wait until you next become pregnant?
• How much space do you plan to have between your pregnancies?
• What do you plan to do until you are ready to become pregnant?
• What can I do today to help you achieve your plan?

What May Be the Real Value of Health Screening Visits?

• “Carves out a time and a place for prevention”
• Opportunity for behavioral anticipatory guidance
• Establishment of the clinician-patient relationship
• Increased sense of patient well-being; positive action toward self-maintenance of health
• More likely to seek care when a problem occurs
• Desirable tests more likely to be done than at HS visits than during problem-oriented care

How Can My Practice Prepare?

• Ask every patient if she also sees a GYN....if so, avoid duplication of services
• Determine the screening policies for your practice
  – Make sure that all staff are aware of your policy
• Inform your patients of changes that apply to them
  – During transition, leave decisions to patient
  – Inform patients with a personal letter or newsletter
• Keep track of benefit changes made by your payers
  – Few have changed screening benefits yet

Promoting Prevention through the Affordable Care Act
Howard K. Koh, M.D., M.P.H., and Kathleen G. Sebelius, M.P.A.

- Specified preventive services must be covered with no cost-sharing for deductibles and co-payments
- Preventive services include
  - USPSTF grade [A] or [B] recommendations
  - AAP Bright Futures recommendations for adolescents
  - CDC ACIP vaccination recommendations
- 2011: IOM recommended additional women’s preventive services not addressed by USPSTF... to “close the gaps”
When Do Eight “Women’s Preventive Services” Start?

<table>
<thead>
<tr>
<th></th>
<th>Definition</th>
<th>Cost-sharing?</th>
<th>Cost-sharing prohibited</th>
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</thead>
<tbody>
<tr>
<td>New Plan</td>
<td>Created after 8/1/2012</td>
<td>None</td>
<td>Now</td>
</tr>
<tr>
<td>Non-grandfathered plan</td>
<td>Created 3/23/10-8/1/12</td>
<td>Yes*</td>
<td>Next “new plan year”; mostly by 1/1/2013</td>
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<tr>
<td>Grandfathered plan</td>
<td>Created before 3/23/2010</td>
<td>Yes*</td>
<td>Once plan changes; mostly in 2014</td>
</tr>
</tbody>
</table>

* Unless plan agrees to remove cost sharing earlier than deadline

Contraception as a Preventive Service... as of September 2012

- **Exempt employers** (mainly churches)
  - Exists for the purpose of Inculcating religious values
  - Primarily employs & serves persons who share religious tenets
  - Meets certain provisions of the tax code
- **Accommodation (mainly hospitals, universities)**
  - Religiously-affiliated employers who do not meet exemption but who have a religious objection
  - Insurer offers rate that excludes contraceptives, but health plan covers contraceptive benefit
  - One year safe-harbor from enforcement