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http://www.familypact.org

fampact@dhcs.ca.gov

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Time	Slide	Speaker	Audio
[00:00:00.07]	1	Renyea	Ask questions and provide feedback during the presentation. We ask that you turn your computer speakers on so you can hear us clearly, and mute your microphone to avoid any feedback. This webinar is approximately one hour, including time at the end for questions and answers. After the webinar, you will receive an evaluation via Survey Monkey. Please complete that and we will begin in a few minutes. Further, this webinar is eligible for one AMA, PRA, category one credit. The recorded version of this webinar will be available in the next several weeks. And can be found on the OFP website, as well as the CAPTC website. Again, today's webinar will be delivered by Dr. Michael Policar. Dr. Policar currently serving as a clinical professor of obstetrics, gynecology, and reproductive sciences at the University of California San Francisco School of Medicine. From 2005 to 2014, he was the medical director of the UCSF program support and evaluation for the Family PACT Program. The Family Planning and STI Program operated by the California State Office of Family Planning. He currently serves on expert advisory panels of the Centers for Disease Control and the US Office of Population Affairs that are engaged in developing national clinical practice guidelines for contraceptive management. Dr. Policar.
[00:01:35.03]	1	Dr. Policar	Thank you Renyea, and thank you all for hanging in there. I know we all needed to be very patient in order to get started. So I'm planning on making this really worthwhile for you given our initial delay. So, as you know, we're gonna talk about how the well woman visit has been changing relative to a number of updates in national guidelines on this topic. All of which I think will have a significant impact on our practice.
[00:02:06.01]	2	Dr. Policar	As is the usual pattern, I need to tell you about the disclosures. I am a litigation consultant to Bayer Healthcare about a class action suit related to the Mirena IUD, but that topic has nothing to do with what we're going to be discussing this afternoon.
[00:02:25.04]	3	Dr. Policar	So let's start with just a quick review of why we ask people to come in for periodic health screening visits in the first place. According to the US Task Force, the major reasons for asking people to come in for check-up visits is really two things. Number one, for anticipatory guidance, another words, having counseling and conversations about prevention. And number two, screening for asymptomatic medical conditions. The research has shown that when women, and for that matter, men come in for health screening visit, it can increase their sense of well-being, particularly if they're told that everything is okay. It gives us an opportunity to see healthy patients every few years in order to be able to maintain our relationship with them. And

			there's also some data which says that people who come in for health screening visits are more likely to do things to maintain their health. Now, because this is a webinar, which is sponsored by the State Office of Family Planning, I'm also gonna be talking about the well woman visit in the context of a family planning visit. Where much of the visit is focused on some very specific topics. Number one, for us to be able to support her in the correct and consistent use of her chosen method of contraception. Oops, somehow I just lost our slides, hang on. Over on the Oakland side, can you tell where the slides have gone? There we go, I think we're coming back. Okay, thank you. At any rate, in the family planning context, we want the support, the correct and consistent use of a woman's chosen contraceptive method. And now they're not advancing. And we try this. There we go. I'll talk a few minutes about reproductive life planning and then additional topics to help optimize a woman's reproductive health. Particularly around the prevention of sexually transmitted infections.
[00:04:50.09]	4	Dr. Policar	Now before we actually get into the guidelines, one of the things that's changed really significantly in the world of family planning provision over the last five years, is the fact that as more and more women have gotten insurance as a result of the Affordable Care Act, either through Medi-Cal expansion in California or less commonly through Cover California. Women have a primary care provider that they see for many of their, or for that matter, almost all of their primary care services. So we want to make sure that the family planning care that we give women and the primary care that they may be obtaining from another source are coordinated. So be sure, particularly if you work in a family planning clinic, to ask the client or patient if she has a primary care provider. When was the last time she was seen by her primary care provider, which tests were performed, and if she knows what the results of those tests were. And the reason it's so important to try to coordinate care between a family planning or women healthcare provider and a primary care provider if the woman is seeing both, is that in her well woman visit today, we have to decide is this going to be a comprehensive well woman visit. The type of periodic health screening visit that would be done by her primary care provider or is it going to be much more focused on issues that are related to family planning. You want to make sure that the services that are necessary within the context of preventive care an well woman visit are provided, but on the other hand, we want to make sure that services aren't duplicated if she's already received certain tests or intervention from her primary care provider. For example, if she's seen in a family planning context or vice versa.

[00:06:40.03]	5	Dr. Policar	So, time to get into the guidelines. But first what we need to do is define who is it that defines what we should be doing in well woman visits. Of course, the mother of all guidelines that relate to preventive care are the guidelines that are developed and distributed by the US Preventive Services Task Force. Most primary care specialty societies, including the American College of Physicians, the American Academy of Family Physicians have adopted the US Preventative Services Taskforce guidelines as their own. And most commercial health plans have done that as well. On the other hand, the American College of Obstetricians and Gynecologists has developed their own approach to well woman care. Some of which is informed by the US Preventative Services Taskforce, but in other areas, ACOG has had their own opinions about what should be done at the time of a well woman visit. In addition, the American Academy of Pediatrics, and their Bright Futures guidelines says what should be done at the time of a well adolescent visit for women. There are a number of advocacy groups that have put together guidelines that define what should be done for preventive health screening for men and women, particularly well-known one was developed by the American Cancer Society, the American Heart Association and the American Diabetes Association and that's used widely in the internal medicine world. At the very end we'll have time to talk about the definition of well woman services through the Affordable Care Act, where specified women's preventive services have to be available without any cost sharing. In other words, first dollar coverage without copayments or deductibles. But it is important to point out that these are not practice guidelines about what should be done, instead they define in an evidence based way what should be available as a preventive service without the barrier of out-of-pocket cost.
[00:08:44.00]	6	Dr. Policar	Now there's one more guideline to mention that those of you who provide family planning services should know about, and that's one which is called the Providing Quality Family Planning Services guideline, usually referred to as the QFP that was jointly developed by the Centers for Disease Control and the US Office of Population Affairs, the OPA, of course who's responsible for the Title Ten Program in the United States. And it is a companion volume to the medical eligibility criteria and the selective practice recommendations that discuss evidence based high quality planning services. And what the QFP does, is to fill in the gaps of things that are not addressed by those other guidelines. So topics like pregnancy testing and counseling, helping women to achieve pregnancy and advice about basic infertility, preconception health, and preventive health screening of women and men who are seeking family planning services.

			Not only do we have the comprehensive guidelines that come from the US Task Force, ACOG and others, but also the more focused well woman visit guidelines for well woman visits that occur in the context of a family planning visit, which are distributed by the Office of Population Affairs.
[00:10:07.08]	7	Dr. Policar	Just one more word about the US Preventative Services Taskforce, because you need to know how their grading system works as we talk about various types of interventions. The US Taskforce is actually empaneled by a governmental branch in the Department of Health and Human Services, which is called the Agency for Healthcare Research and Quality, the AHRQ. The US Taskforce has a process of a rigorous evidence based review that's ongoing that looks at the evidence about various types of preventative interventions. The Taskforce itself has a variety of different types of primary care providers and does its best to avoid any sort of industry bias. And they make screening recommendations based on about 60 different diseases and by four age groups and then the fifth is women who are pregnant. One of the things that the US Taskforce does is to support what's called the opportunistic prevention model. Where they acknowledge the fact that about half of men and women simply don't come in for checkup visits or periodic health screening visits. What we should do for them is when they come in for a problem oriented visit. Headaches, a twisted ankle, a skin problem, is to take the opportunity at that visit, to offer them the screening test that they need given their age group and their risk factors that they might not get at the time of a well woman or a well male visit.
[00:11:41.08]	8	Dr. Policar	And just to quickly remind you that they have a grading system for how strong a recommendation is for particular screening intervention. Basically, A's and B's have very good evidence that the fact that there is more benefit than risk and these are screening interventions that should be offered. A fee, and we'll be talking about a number of them. Means that in a population of individuals, the benefits of doing routine screening and the harms of screening are about an equal balance with one another. And therefore, the decision should be made on a case by case basis given a person's risk factors, their family history, genetic history and so on. We'll see that when we talk about mammography for women in their 40s. A quality de-recommendation is basically one that says we shouldn't be doing a particular test. Either because they really have no particular benefit or because of the fact that the harms are greater than the benefit and in that case, we should abandon it. We'll also see a few I's where there's not enough evidence to be able to make a recommendation about whether a particular screening test should be done or not.

[00:12:55.05]	9	Dr. Policar	What we'll do is just quickly go through the kinds of recommendations that the US Taskforce makes. For a majority of women, we would see in a family planning context to where between 25 and 64 years of age. I realize this leaves out the adolescents and early 20s, but there's very similar guidelines that the US Taskforce publishes for women in that age group. So it starts with a lot of counseling, anticipatory guidance. And this lists the various topics that we should be discussing at the time of a well woman visit about the use of tobacco and if she hasn't started to avoid that, if she has to give her advice about how to stop smoking. To avoid alcohol use, particularly when driving, boating, or swimming, advice about diet and adequate calcium intake, as well as regular physical activity and how much exercise a person has. We should be giving messages about injury prevention. Not only seatbelts, but if you're a road biker or skateboarder to use a helmet. To have working smoke detectors in your house. Of course, in our context, we routinely discuss sexual behaviors about pregnancy, intention, use of contraception, where the people can prevent STD's. And then there's also advice about dental health in terms of flossing and brushing with fluoride toothpaste, at least once a day. For chemoprophylaxis in this age group, the only recommendation is for folic acid. And specifically for women who are planning a pregnancy.
[00:16:43.04]	10	Dr. Policar	Now, it's also worthwhile to say there are a number of things that are not recommended and are given quality D recommendations. To say that either they don't help or they are more risk than benefit. And again, this is at the time of the check-up visit for a person who has no complaints. But things on this list include a routine dip stick to look for bacteria, screening for genital herpes and asymptomatic individuals either with a culture or with a serologic test. Screening for Hepatitis B or C, we'll talk more about that in just a moment. Syphilis screening and low risk women and men. Ovarian cancer screening in women and BRCA mutation testing for low risk women. It's important to emphasize that they're not neutral on this topic, they are literally telling us that these are tests which either don't work or have the potential of false positives and may do more harm than good. And therefore, we should not be doing them routinely.
[00:17:47.00]	11	Dr. Policar	Now, the next group that comes up with guidelines regarding well woman visits is the American College of Obstetricians and Gynecologists. Over the years, every two or three years, they update these guidelines. In 2015, they did a rather extensive update of their guidelines and they published them in different age brackets in the way that they are for the US Preventative Services Taskforce. ACOG has the opinion that well woman visits should be done annually.

			The physical exam should routinely include an examination of the neck, breast, abdomen, and a pelvic exam for women who are 21 or older. And for women 40 and older, to include a look in the mouth and examination of the arm pits or axillae for lymph nodes and a skin exam if she's at high risk for skin cancer. And in addition they recommend a number of laboratory and imaging tests that are not included in the US Taskforce guidelines. So for example, screening for primary hypothyroidism, with a TSH of women who are 50 and older and younger women if they're increased risk. Screening for diabetes starting at 45. Lipid profile starting at 45. Mammography starting at 40 and then bone density screening with a DEXA scan every two years starting at 65 years of age and for women who are 50 and older who are an increased risk of osteoporotic fractures.
[00:19:14.09]	12	Dr. Policar	So there are some significant differences then between ACOG and the US Preventative Services Taskforce. One of those questions is, how often should a woman be advised to come in for a well woman visit? And the US Taskforce says that can be done basically every one to three years, depending upon the health status of the patient and her personal risk behaviors. That is to say, if a woman is quite healthy and doesn't have risky behaviors, no chronic illnesses, that it would be reasonable for her to come in every two, every three years for her checkup visit. While she has risky behaviors or chronic illnesses, then it would make more sense to have her come in annually. ACOG on the other hand, makes the recommendation that all women should have a check-up visit once a year. Now, the next questions is the one at the top of the slide and that is, is a physical exam or assessment necessary with every check-up visit or well woman visit? Certainly as needed for scheduled screening tests. So, if she's on a three year cycle for cervical cytology testing, then every three years she needs to have a speculum exam. Certainly a diagnostic exam whenever she has symptoms or signs that might indicate that she has a disease condition that needs to get evaluated. But again, I want to stress that in people who are in between the years when they would have cervical cytology screening, and they have no complaints, that some visits will consist solely of lots of counseling and education without a physical assessment that goes beyond a blood pressure check.
[00:20:55.01]	13	Dr. Policar	Now, let's go back into some of the interventions that we would actually do at the time of a well woman visit. The first I want to mention is a discussion about reproductive intentions. You have probably been hearing a lot about this over the last five years in the context of the reproductive life plan. But I will tell you that in the family planning world there's been lots of controversy, particularly in the last year

			or two about whether or not we should even be using the term reproductive life plan. Because it implies that virtually everyone plans a pregnancy. And what the evidence would say, that's usually not the case. Many pregnancies, in fact, occur because a woman is hoping in becoming pregnant, but not necessarily because it was an intended pregnancy or a planned pregnancy. So one of the approaches which is now very popular in the family planning world, is to ask about reproductive intentions with three questions. First question is, would you like to have kids some day? Or if a woman already has children, say would you like to have more children someday? And if the answer to that is no, I'm done with my childbearing, then that may be an opportunity to discuss female or male sterilization. Second question is about timing. If you would like to have more kids someday, when do you think that might be? Or to be more specific to ask the question, would you like to become pregnant in the next year? And that may help in discussing long acting reversible contraceptive methods, which of course are the IUD's and implants versus the shorter acting reversible contraceptive methods, the old patch ring, injections, barrier methods, or even natural family planning for some women. The third question has to do with resolve. And that is, if you want to have more kids, you think you might want to become pregnant at some point, but that may not be now, how important is it to you to prevent pregnancy until then? And for women who say it's very important to prevent pregnancy, that's a circumstance where we want to craft our counseling mainly about how effective a method is. There are other women who will say, you know, it's not particularly important to me to prevent pregnancy for a year or two. I'm hoping to become pregnant even though I'm not planning on that. Then there may be other concerns about contraceptive methods for example, how easy it is to use or side effects that are more important to the woman than the efficacy of the method.
[00:23:33.01]	14	Dr. Policar	Then once we've had the discussion about reproductive intent, about a contraceptive method or ongoing use of her current method, we want to ask questions about sexual behaviors. Taking a part of the sexual history that helps us evaluate her risk of sexually transmitted infection. And the CDC has a nice way of doing that based on what are called the five “P”s of sexual health. The first P has to do with partners. How many partners do you have? Have you had a new partner in the last 90 days? Have you had more than one partner in the last year? Maybe kinds of questions that would be kind of helpful to tell you about the partner picture. Another is, when we're doing a well woman visit is to ask the woman, are your partners men, women or both? Next has to do with practices. And that has to do, for women, not only

			whether they engage in vaginal intercourse, but oral intercourse or anal intercourse. Third P has to do with what do you do to protect yourself from acquiring sexually transmitted infections? The fourth P is to ask questions about her past history of STD's, particularly in the last two years. And the fifth P is a topic which we already discussed, which is about the things that the woman is interested in doing to prevent pregnancy. Assuming that that is her goal.
[00:24:59.08]	15	Dr. Policar	Now, we don't have enough time today to talk about all of the detail guidelines that have to do sexually transmitted infection screening that should be done at the well woman visit. But this table basically summarizes what the guidelines for the Center for Disease Control and the US Preventative Taskforce now recommend. That is for women who are sexually active through 24 years of age, up until 25. It is recommended that they are screened once a year for both gonorrhea and chlamydia. And then at an age of 25 or older, they receive what's called targeted screening. Only if they have risk factors. And we have very good guidance from the sexually transmitted disease branch in California about which questions to ask. Therefore, have you been treated for an STD or pelvic inflammatory disease in the last two years? Have you had more than one partner in the last year? Have you had a new partner in the last 90 days? And the fourth is do you have reason to believe your partner is having sex with someone else? If the answer to any of those questions is yes, then that woman 25 and older should be screened for gonorrhea and chlamydia. But if the answer to all four questions is no, then she doesn't require screening, in fact, she should not receive screening for gonorrhea and chlamydia. I've already mentioned about HIV screening, that even for low risk people a once in a lifetime HIV screen is recommended. After that, only based on risky behaviors. The same is true with syphilis, for vaginal trichomoniasis. Only women with risky sexual behaviors or women who are HIV positive should be screened annually.
[00:26:42.00]	16	Dr. Policar	And I'll tell you a little bit more about Hepatitis C, right now, as a matter of fact. And that is that we don't screen for Hepatitis C in the context of sexual behaviors. The CDC STD guidelines have a list of indications to screen for Hep C. Sexual behaviors is not one of them. But just to remind you that there is a CDC recommendation that for all adults who were born between 1945 and 1965, that they should receive a one-time test for Hepatitis C without any questioning about their risk factor for Hep C. The reality is that in this baby boom generation, there may have been those who were exposed to Hep C because of needle use or other risky behaviors and they've had Hep C for years and don't know it. Now that we have very good treatments and even a cure for Hepatitis C, is the reason that the CDC is

			recommending that these individuals born in that 20 year period be screened for Hepatitis C.
[00:27:44.09]	17	Dr. Policar	Now, the next topic, after we talk about screening for sexually transmitted infections is screening about sexual problems. Here we ask a number of open-ended questions. For example, are you satisfied with the sexual relationship between you and your partner? Or are you satisfied with the frequency and the quality of your sexual experiences with your partner? Or is there anything in your sexual life you'd like to be different than what you have now? And if the patient answers yes to any of those questions, there are follow-up questions that can be asked as well. Do you have problems with lack of desire, with your ability to become aroused? Are there problems with erections or ejaculation with your partner? Do either of you have problems around orgasm? Is there a pain problem for either of you? And if you have any of these, do they cause personal distress? And if you do any of these problems, what do you think might be the cause of that problem?
[00:28:44.02]	18	Dr. Policar	The next question has to do with screening for depression. During the last month have you been bothered by little interest or pleasure in doing things? Or have you felt down or depressed or hopeless? If the answer to both of those screening questions is no, then there's really no further reason to pursue it. But on the other hand, if either of the questions were answered yes, then there are more detailed questionnaires that can be used in order to delve more into the question of depression and the need for treatment or referral.
[00:29:19.02]	19	Dr. Policar	Next issue which is important in the context of periodic panel screening is routine metabolic screening. And here we have a number of different groups that might be giving us guidelines in that regard. The ATP is a federal panel that has given advice about lipid screening. And of course, I've already mentioned the US Taskforce. Everyone is in agreement that adults 18 and older should have a blood pressure and a BMI check at least every two years. Some would say at every office visit. The recommendations about screening for Type 2 diabetes, according to the American Diabetes Association, is that individuals who are at high risk for having Type 2 diabetes should be screened every three years until the age of 45 and then starting at 45, even average risk people should be screened. US Taskforce is much more conservative and says to screen for Type 2 diabetes only in people who have established hypertension. And then when it comes to lipid screening, the ATP panel says that people should have a lipid panel done every five years, irrespective of risk factors. While the US Taskforce recommends that only be done for individuals who are at high risk.

[00:30:38.05]	20	Dr. Policar	Now let's go on to really the center piece topic, which is cancer screening that would be done at the time of the well woman visit. I'm going to tell you in much more detail about cervical cancer an breast cancer screening in just a moment. But the table also contains recommendations about how often mammographic screenings should be done and there are significant differences between the American Cancer Society and the US Taskforce as well as colorectal cancer screening.
[00:31:06.07]	21	Dr. Policar	So let's start with breast screening guidelines because they have changed quite significantly just in the last year. So, the first column lists the guidelines that we use in the United States in the late 1990s and into the early 2000s. And that is that women should do a self breast exam once a month. That she should have a clinical breast exam once a year and that mammography should start at 35 years of age, be done every other year between 40 and 49 and then yearly at age 50. The US Taskforce updated those guidelines in 2009 and recommended that a self breast exam, or at least a teaching of self-exam is not recommended because of a couple of huge randomized controlled trial that it showed that it didn't change breast cancer mortality at all to do a breast self-exam, but it did increase the likelihood of biopsy for benign conditions. They have new recommendation about clinical breast exams. And the recommendations about mammography was that for women between 40 and 49, that that decision should be one that's quite individual based on the individual woman decision regarding risks and benefits of mammography for her. And if she chose to do a mammogram, to do it every other year. For women between 50 and 74, that mammography should be done routinely every two years. And for women 75 and older, there was no specific recommendation. Last year, the American Cancer Society updated their recommendations about breast cancer screening. They also said that breast self-exam was not recommended. And probably the most important part of their new recommendation was to say that women should not receive routine clinical breast exams as well. I want to emphasize that we're talking about screening clinical breast exams and not diagnostic breast exams for women who have complaints. Their mammography recommendation is that for women in their early 40s, that mammography is optional. Between 45 and 55, they should be done annually. And for women who are 55 and older, that mammography should be done every other year.
[00:33:27.09]	22	Dr. Policar	So I want to be very specific about the ACS guideline in regard to clinical breast exam, and they looked at all the reasonable world literature on this topic and came to the conclusion that clinical breast exam as a screening test in asymptomatic women had really not benefit and potentially

			more harm than risk. So they said that they do not recommend clinical breast exams for breast cancer screening in average risk women at any age. The Q refers to the fact that this is a consensus guideline, basically. They go on to say there's no evidence of any benefit of a clinical breast exam alone or when it's done in conjunctions with mammography. Next is that there is moderate quality evidence that adding clinical breast exam to a mammogram actually increases the false-positive rate and that there are only a very small number of breast cancers that are only found in asymptomatic women on a screening breast exam that wouldn't have been found by mammography or one of the other screening interventions. This is rather wordy, but I think it really encapsulates what they are trying to say. And that is that recognizing the time constraints in the typical clinic visit, clinicians should use the time that they used to spend doing clinical breast exams and instead use that time to ascertain family history and to counsel women about the importance of being alert to breast changes and the potential benefits limitations in harms of screening mammography. So basically what they're doing is abandoning screening clinical breast exams. Adopting this idea of breast awareness. That we should be counseling women to stay aware of changes that they may notice in their breasts. And that it's important for women to understand the benefits and risks of mammography. That taking that time in the exam room should be replaced by counseling.
[00:35:33.02]	23	Dr. Policar	Now let's switch over to cervical cancer screening. This summarizes a number of guidelines based on different age groups in terms of how often cervical cytology should be done. The various groups in the US Taskforce, AAA refers to a guideline that comes from the American Cancer Society, the ASCCT and a topology group. The third row refers to ACOG in 2012. Basically what they recommend is that we do not start cervical cytology ever until a woman is 21 years of age. Between 21 and 29, we do standard cervical cytology every three years. Between 30 and 65, women can either have liquid based cytology every three years, or a co-test, which is liquid based cytology and HPV test done together every five years. For women 65 and over, who have had adequate screening with negative results, they can now exit cervical cancer screening and women who had a hysterectomy for benign disease, can stop cervical cancer screening as well. There are very slight differences among these guidelines, but for the most part, they say the same thing.
[00:36:46.00]	24	Dr. Policar	The guidelines also say that we should not lengthen the screening interval beyond once a year for women who are HIV positive, women who are immune suppressed because

			they've had a major organ transplant or women who were exposed in utero to DES. So, in those circumstances, we still do annual cervical cytology.
[00:37:09.00]	25	Dr. Policar	So other important messages about cervical cytology screening, is that women any age should not be routinely screened annually by any screening method. The only time that women get annual Pap smears, is if they are in a follow-up surveillance pathway after having had an abnormal Pap smear in the past, or having been treated. But for women who have not been treated, in the last 20 years, they're screened every three or every five years. For women 65 and older, adequate screening is defined as three negative Pap smears in the last 10 years. Or two negative co-tests, most recently one within the last five years. And if you stop screening at 65, there's no reason to restart for any reason, particularly if a woman has a new sexual partner at over 65. There's no reason to restart doing Pap smears in her circumstances. On the other hand, if she was treated for a CIN II or worse, or Adenocarcinoma In Situ, let's say 50 years of age, for example, she needs to be regularly screened for the next 20 years. So until 70, rather than stopping cervical cytology screening at 65.
[00:38:21.06]	26	Dr. Policar	Now, lastly on this topic, other common questions about cytology intervals are the virginal women need Pap smears? The answer to that is they have an extremely low risk of cervical cancer, but not zero, so at least they should be offered, but not necessarily recommended. Are intervals any different for women with multiple sexual partners who are using hormonal contraceptives, who are menopausal hormone therapy? The answer to that is no. How about for women who only have female partners? At this point the recommendation is that women who only have female partners or who only have sex with women, should still have cervical cytology screening at the same intervals as other women. Same is true for women who are pregnant. And then this will now get us into our last topic of discussion and that is, if this Pap smear, cytology is not scheduled or necessary. Let's say she had a negative last year and the year before, what about the need of the time of the well woman visit to perform of bimanual pelvic examination.
[00:39:28.00]	27	Dr. Policar	Well, that discussion occurs within the context of ovarian cancer screening. The options for ovarian cancer screening are pelvic exam, transvaginal ultrasound, where a tumor marker called CA-125. The US Taskforce does not recommend any of those for low risk, asymptomatic women. 'Cause none work very well, ovarian cancer is not very common, and it would not be cost effective to do that, that screening. US Taskforce in 2012 said that screening asymptomatic women with ultrasound, tumor markers, or pelvic exam, is explicitly not recommended, a D quality

			recommendation. And they didn't make any recommendations about women who are at high risk for ovarian cancer, although there are other guidelines in the oncology literature that recommend the screening intervals for women who are an increased risk.
[00:40:21.08]	28	Dr. Policar	Now, as you likely know, probably one of the reasons you joined us today, there is a large debate going on in the world of clinical practice and public health about the value of pelvic examinations. And here I want to differentiate at least three things. One is a screening pelvic exam, which is routine. External inspection, inspection of the vulva, speculum exam and a bimanual exam at the time of a well woman visit in a asymptomatic patient. That is a very different than a diagnostic pelvic exam. And that's when we would do a pelvic exam to evaluate symptoms like pelvic pain or dyspareunia, signs like abnormal bleeding or abnormal vaginal discharge, or other abnormal findings like cysts, which would be found on incidentally on an abdominal or pelvic ultrasound. The third issue about pelvic exams is just putting in a speculum in order to do a cervical cytology. We won't talk about that other than doing that every three, every five years.
[00:41:22.04]	29	Dr. Policar	So, the debate really is about screening pelvic exams. So, ACOG recommends, based on their most recent publication that women under 21 years old should have a pelvic exam, only when indicated by medical history. In other words, to evaluate a complaint. But otherwise, we don't do screening pelvic exams in women under 21, according to ACOG. But for women 21 or older, ACOG recommends an annual screening pelvic exam although they do admit that no evidence supports or refutes a written, routine public exam in a low risk patient. And in fact, they go on to say that if a woman has no symptoms and is in for a well woman visit. That the pelvic exam should be a shared decision between the clinician and the patient. And the kinds of things that would mitigate whether or not she has a screening pelvic exam would be her individual risk factors whether she wants a pelvic exam.
[00:42:22.05]	30	Dr. Policar	And then medical legal concerns influencing those decisions. Now, at the other end of the spectrum, is a statement made by the American College of Physicians, that's the group representing internal medicine physicians. Who published a guideline in 2014 saying that screening pelvic exams are not recommended. They say that the accuracy of screening pelvic exams for detecting ovarian cancer or bacterial vaginosis is low. That it rarely detects non-cervical cancer or other treatable condition. And that there's no evidence that having regular pelvic exams in asymptomatic women actually improves their outcomes. There are potential harms on unnecessary laparoscopies, or

			laparotomies, fear and anxiety about the exam or its findings, as well as embarrassment, pain and discomfort. And that it adds unnecessary cost to the healthcare system. And that's primarily about the cost of working up a false positive. So basically, what the ACP has recommended, basically, is that they say that they recommend against performing screening pelvic exams in asymptomatic, non-pregnant adult women. And that they acknowledge that many clinicians include the screening pelvic exam as part of the well woman visit. But they should no longer do so, because it's low value care and therefore, it should be omitted.
[00:43:53.06]	31	Dr. Policar	Needless to say, this has sparked quite a debate in the United States with the OB/GYNs on one side and the internal medicine docs on the other side. And so the US Taskforce is now actually in the process of coming up with their own statement about screening pelvic exams. And at least as of last month, their draft recommendation is that the current evidence is insufficient to assess the balance of benefits and harms in performing screening pelvic exams in asymptomatic, non-pregnant women and they give that an I recommendation. So they basically have taken a pass by saying we just don't think there's enough good studies one way or the other to make a decision about the value of this screening pelvic exam.
[00:45:30.02]	32	Dr. Policar	So let's wrap up then and hopefully we'll have some time for some questions afterwards. What you're seen, basically, is a shift in the direction of more counseling and anticipatory guidance and less and less in terms of physical assessment in the exam room. Particularly with this change in recommendations about screening breast exams and screening pelvic exams. And here I want to wrap up with a really wonderful article written by an internal medicine doctor over a decade ago about what is the real value of the well woman or health screening exams. And that is that it carves out a time and a place for prevention. It gives an opportunity for anticipatory guidance. Again, to establish and consolidate the relationship between clinicians and their patients. Many patients will have a sense of well-being after they're told their check-up exam is normal and they'll continue to do things to maintain their health and they're more likely to seek care when a problem does occur.
[00:46:35.00]	33	Dr. Policar	Now lastly, I just want to say a quick word how the Affordable Care Act addressed the issue of the well woman visit. And like I said, they didn't create guidelines about what should or should not be done, but they did create regulations that have to do with what women have to pay for in terms of preventive services. So basically, anything which is a US Taskforce A or B recommendation, anything which is recommended by the American Academy of Pediatrics, by

			future recommendations and any of the vaccinations which are recommended by the CDC Advisory Committee on Immunization Practices needs to be covered without any out-of-pocket costs.
[00:47:18.02]	34	Dr. Policar	But in addition, there are eight more preventive services that need to be covered for women who have insurance or Medicaid for that matter, Medi-Cal in California without any out-of-pocket costs. When you add in those conditions, you have now this full table of all of the women's health care preventive services that have to be available without cost sharing. The first column having to do with primarily contraception and STIs. The second having to do with cancer screening. The third having to do with counseling about alcohol, tobacco use, diet, and you'll also notice that the cost of the well woman visit in itself have to be fully absorbed by the patient's payer, the health insurance coverage and with no out-of-pocket cost. There are pregnancy related conditions, immunizations and screening for chronic conditions which the ACA guarantees without any out-of-pocket cost.
[00:48:15.03]	35	Dr. Policar	So again, to leave you with just a couple of important messages, how your practice can deal with these changes in the well woman visit is if you are a primary care provider or a community health clinic or an FQAT, ask every one of your patients do they also go to a family planning clinic. And conversely, if you're a family planning clinic, ask your patients whether or not they have a primary care provider. Try to coordinate those services as much as possible so that they're not duplicated and then nothing falls between the cracks. Number two is, determine the screening policies for your practice. So develop your own policy, you and your partners, you and other clinicians in your practice. About how do we want to handle the periodicity of cervical cancer screening or a breast cancer screening with clinical breast exams. And then make sure that all of your staff are aware of your policy. Because it's very disconcerting to a patient if a particular clinician, for example, follows the guideline that a woman who had a hysterectomy for benign disease never needs another cytology in her life. And then when she's leaving, someone at the front desk says well we need to see you next year for your Pap smear. So, that sounds very contradictory. The reality is make sure that all your staff follows the policy that you set in your practice. Inform your clients, your patients of the changes that apply to them, particularly about periodicity of cervical cytology screening and of breast exams. And you have to be a little flexible for people who are still expecting, they're no longer recommended, but on the other hand, negotiate that in the future, you will no longer be doing those. And keep track of benefit changes that have been made by your payers. And

			only a few have changed their screening benefits yet, but more and more I think you will see payers that will only pay for a cervical cytology screening for example, every three years in women who need it at that interval.
[00:50:17.00]	36	Dr. Policar	So the final take home visits are that we will continue to see this debate regarding the value, the timing and the components of well woman visit. Particularly screening pelvic exams and screening breast exams. What I've done for you is to outline the content of those debates, but to make it clear that there is no one way to do it in regard to screening pelvic exams and screening breast exams. It all depends on which of these guidelines you're following. Number two is that not all recommended components of well woman visits have to be done at the same visit or by the same provider. Many of these things will be sort of divided between the primary care provider and the woman's health provider and may take more than one visit to do them. The third point is that shared decision making sessions between the clinician and the client are becoming more and more prominent, rather than directive counseling. Instead of us sort of giving our best advice to patients, so they can take it or leave it, there's much more of structured share decision making discussions about family planning, whether or not a woman wants to have a screening pelvic exam, whether she wants to have a screening breast exam, and the age at which she should begin mammography. And then lastly I reminded you about the fact that the Affordable Care Act has removed virtually all out-of-pocket costs that are associated with well woman visit.
[00:51:45.04]	37	Dr. Policar	So with that, I'll wrap up and I'm available for as long as our Oakland folks are in terms of answering questions.
[00:51:55.06]	37	Renyea	Okay, Dr. Policar, thank you, thank you very much for that informative presentation. We do have several questions here and I'll just read them to you in the order that we received them. First question, where does preconception health fit into a comprehensive well woman care?
[00:52:14.07]	37	Dr. Policar	I'm so glad you asked that. The guidelines for preconception care come from the CDC, last published in 2006. And on one hand, there are those people who believe that every time that a person comes in for a well woman visit, whether or not she wants to become pregnant, that she should be getting some advice about preconception care and about things that she can do to have a healthy pregnancy when she's ready to have it. There are other people, though, who believe, that for women, particularly who are using highly effective methods of contraception, if they're using and implant or an IUD, or they're effective users of even middle care contraceptives, that in that circumstance, the discussion about preconception care can be deferred until the time that a woman discontinues that method and has

			more interest in becoming pregnant. To me, the one big exception to that, is women who are Type 2 diabetics. I think, even in women who are Type 2 diabetics and are using implants or IUDs, that every time we see them for a well woman visit, we need to remind them that when they discontinue that method, it's going to be very important to get their sugars under control before they get pregnant. That's kind of where we are with the preconception counseling part of it.
[00:53:38.06]	37	Renyea	Okay, next question. Do pregnant women need a pelvic exam during pregnancy? And what about a physical exam if the woman is asymptomatic?
[00:53:50.06]	37	Dr. Policar	The only group that has guidelines about that, is ACOG. And consistent with the other guidelines about what should be done for women who are not pregnant, at the time of the initial OB visit, they do recommend a neck exam to look for goiters, listening to heart and lungs, a breast exam, and a pelvic exam, with our without evaluation of the bony pelvis. What we used to call clinical pelvimetry. So, ACOG explicitly does recommend that the new OB visit that those components be evaluated, including a bimanual exam. But that's primarily to evaluate dates and uterine size and so on. And then they consider clinical pelvimetry to be more optional. And US Taskforce and others actually don't have any specific recommendations about the difference, about doing anything differently in pregnancy.
[00:54:58.09]	37	Renyea	Okay, next question, why does Family PACT not cover a pregnancy counseling visit?
[00:55:19.04]	37	James	I'm sorry, Renyea, go ahead.
[00:55:20.05]	37	Renyea	Why does Family PACT not cover a pregnancy counseling visit?
[00:55:25.02]	37	James	Oh, okay, we'll address that in the Q & A, I believe it's best for that one.
[00:55:31.09]	37	Renyea	Okay.
[00:55:33.01]	37	Dr. Policar	Let me just say something really quickly about it. I think that what is a little confusing is the way that the question is asked about a pregnancy counseling visit. If you're talking about a woman who comes in for a pregnancy determination visit, in order to find out am I pregnant, not pregnant, then the Family PACT policy on that, depends on whether at the beginning of the visit you know whether or not she's pregnant. Particularly based on a positive pregnancy test. Remember that Family PACT is a program that is there to prevent unintended pregnancy and in a very small way, helping women who are not pregnant become pregnant. But if you're already known to be pregnant, then you're basically excluded from Family PACT. So you'll get a much more detailed answer in the published Q & A that happens after this. But just remember that Family PACT is there to cover

			certain things, but pregnancy and abortion are things exclusively excluded from Family PACT and there are other ways to get at those services through Medi-Cal.
[00:56:46.01]	37	Renyea	Okay, next question. Is yearly cervical cytology recommended for women on immune suppressants like RA or Lupus?
[00:56:56.09]	37	Dr. Policar	Yeah, also an area of some amount of controversy because of the fact that there's not good data. So, what the older guidelines say, is that for women who are significantly immune compromised, that might be a woman who's getting multiple chemo therapy drugs as she's being treated for cancer, a woman who's on high dose steroids for Lupus for an extended period of time. A woman who's recently had radiation therapy, something like that which really reduces her immune defenses. In those circumstances, it's very – or for that matter, a woman who's had a major organ transplant, kidney transplant, heart or lung transplant, who's on anti-rejection drugs. All of those women are number one more likely to get dysplasia and they have faster transit times. Where they go through the various stages of dysplasia and they're more likely to develop invasive cervical cancer. That's why for those women, the recommendation is to be screened once a year. However, for some of the biologicals like Remicade and a few of the others, they cause a minor degree of immune suppression. At least at this point, none of the guidelines directly say that those women should have once a year screening, rather than the more standard every three years or every five years. So, basically what I would say is this. For women who are receiving those types of biological things like Lupus or more recently for Psoriasis and so on, even though they cause a minor degree of immune suppression, at least at this point, the guidelines have not changed to include those women in the category of those that are much more immune suppressed. So I would still go every three or every five for women who use those kinds of medications for conditions like Lupus, for example.
[00:58:46.00]	37	Renyea	Next question. Are we still following the 2008 Family PACT guidelines or following them with abnormal results?
[00:58:57.06]	37	Dr. Policar	Well, go ahead, James.
[00:58:59.05]	37	James	Go ahead doctor.
[00:59:07.03]	37	Dr. Policar	No, that should not be the case, and then again, it will be dealt with in the questions and answers that come from the Office of Family Planning. But, my understanding is that what Family PACT, and for that matter, what Medi-Cal covers is now reflected in the ASCCP guidelines that were published in 2012. And if you look in the PBBI, the Policies, Procedures and Benefits Information for Family PACT, it will give you very specific information in the family planning

			related services section that has to do with the guideline that's being followed as it relates to benefits for women who have abnormal Pap smears. But that was clearly updated so that it is consistent with the more recent ASCCP guidelines than the 2008 version.
[01:00:05.03]	37	Renyea	Okay, next question. Does a patient with a history of cervical HPV and normal colposcopy and repeat Pap require a yearly Pap for three years? The second part of that question is how long does a woman with a history of CIN III need annual surveillance?
[01:00:25.07]	37	Dr. Policar	Okay, it's actually easier to answer the second part than the first part. First part is when you get into these questions about what are the various surveillance pathways in women who have had various kinds of cytology abnormalities. There's no question that a place to look is in the ASCCP algorithms and I don't have them in front of me right now. But we should all have them either at our fingertips and particularly it's worth the $10 to spend on a phone app in order to have the ASCCP guidelines in front of you. It will tell you exactly how to manage people based on their HPV test results from their abnormal cytology results. In the second question, in a person who's had treatment, let's say with a lead procedure with cryotherapy or cone biopsy, how do you follow them and how often? And the answer is, after the original surveillance period which is a year, basically what the guidelines say, if you can go back to every three or every five year screening, it has to be for a period of at least 20 years. So they say, after you've had this initial year of close surveillance, you can go back into the regular follow-up pool. Like in the example I used a moment ago, if you were treated with a CIN III with a leap when you're 50, and then for the first year you have no evidence of recurrence, you could go back to, let's say, every three years cytology, every five year cone testing, but you have to do it until age 70. It has to be for a full 20 years after you were treated. At San Francisco General Hospital we do that a little differently, where we follow people with annual cytology and not co-testing, but that's something that's rather unique to us. I would otherwise follow the ASCCP guideline.
[01:02:11.02]	37	Renyea	Okay, I just want to quickly acknowledge that we are 15 minutes past our start time, which puts us at exactly a one hour webinar. It looks like you guys are still typing in really good questions, so I want to let you all know that we will get to all of your questions and we will be communicating with Dr. Policar so that he provides answers to those after the webinar.
[01:02:33.05]	37	Dr. Policar	Will be happy to do that.
[01:02:35.01]	37	Renyea	Sending out a Q and A document to everyone who registered for the webinar at the same time that we send the

			recording and the supplemental material. Thank you everyone for your participation. And your patience, absolutely for your patience. And you have our contact information, so feel free to e-mail us if you have any additional questions or comments. And thank you to Dr. Policar and OFP as well. This concludes our webinar. You guys have a great day!
[01:03:14.09]	37	Dr. Policar	Are you still there?
[01:03:21.04]	37	Renyea	Yes, Dr. Policar, we're still here.

END OF TRANSCRIPT