CME/CNE Activity Inside and Online

City Health Information

March 2005 The New York City Department of Health and Mental Hygiene Vol. 24(3):13-20

CONTRACEPTION: ENCOURAGING ITS USE

- **Take a sexual history of all patients.**
- **Encourage the appropriate use of contraception.**
- **Offer emergency contraception in advance.**
- **Provide abortion information and referral when needed.**

Unintended pregnancy can have serious adverse effects on the health of women and children.[1–3] Half of all pregnancies and more than 3 in 4 adolescent pregnancies in the United States are unintended.[4]

In 2003, more than 100,000 unintended pregnancies occurred in New York City; most (about three-quarters) ended in induced abortion.[5,6] *Over the past 10 years, the proportion of pregnancies that are unintended has remained unchanged, at approximately 60%.*

Contraceptive counseling can reduce unintended pregnancy and abortion.[7] Yet nationally fewer than half of the clinicians who care for women talk to them about contraception or provide counseling.[8] While primary care and reproductive health providers in New York City do somewhat better (57% say they provide counseling),[9] we can do much more.

Despite high rates of unintended pregnancy and the need for contraception, many health care providers get little training in contraceptive counseling. Reproductive health care and other primary care providers (including pediatricians) can help reduce unintended pregnancy rates by:

1. Routinely assessing the reproductive health needs of all patients — including adolescents.

A careful sexual history is very useful in guiding discussion and addressing contraceptive and other reproductive health needs (*Tables 1,2*).

Both federal and New York State law give adolescents the right to consent to certain health services without parental permission or knowledge (*Table 3*).

2. Encouraging the appropriate use of contraception, including emergency contraception.

Current contraceptive methods are summarized and compared (*Table 4*). For practical guidance, clinical scenarios are offered (*Table 5*).

Emergency contraception is discussed *on page 15*, including the importance of offering advance prescriptions.

When unintended pregnancy occurs, abortion information and referral should be provided to patients who need it. Both surgical and medical abortion are available for women who choose to terminate pregnancy (*page 19*).

TABLE 1. TAKE A BRIEF SEXUAL HEALTH HISTORY

General Approach

- Be matter-of-fact, sensitive, and non-judgmental.
- Ensure confidentiality. Make sure adolescents know that you will *not* share information with parents.
- Use simple terms and encourage questions.

Sample Questions

Sexual health is an important part of general health, so I always talk to my patients about it. If it's okay with you, I'd like to ask a few questions.

1. Have you ever engaged in sexual activity (vaginal, anal, oral)?
2. Do you have sex with men, women, or both?
3. Do you know your HIV status? I recommend that all sexually active persons be tested for HIV. Do you have any objection to getting an HIV test today?
4. Have you ever had a sexually transmitted infection? Do you use condoms to protect yourself and others against HIV and other sexually transmitted infections?
5. Are you trying to become pregnant (or father a child)? If not, what kind of birth control method do you use?

TABLE 2. ADDRESS NEEDS AND ENCOURAGE CONTRACEPTION

1. **Explain the importance** of contraception to general good health.
2. **Dispel myths** about its safety.
3. **Discuss emergency contraception,** and offer a prescription or pill-pack in advance.
4. **Help your patient choose an appropriate method** based on the medical history. Consider age, weight, sexual risk behaviors, smoking status, general (including mental) health status, and socioeconomic factors.
5. **Urge all patients to use latex or polyurethane condoms** to protect against HIV and other sexually transmitted infections – no matter what kind of contraception they use.
6. **Take advantage of opportunities.** The desire for hormonal contraception, for example, may motivate some patients to quit smoking.
7. **Discuss potential adverse effects,** explaining that many are temporary. Explain how to contact the office should serious adverse effects occur.
8. **Provide patient education materials (***see* **Resources** ***on page 20*****).**

TABLE 3. MINORS CAN PROVIDE THEIR OWN CONSENT

Both federal and New York State law give adolescents 17 and younger the right to consent to certain health services without parental permission or knowledge.[10]

These services include:

- Contraception, including emergency contraception.
- Pregnancy testing.
- Abortion.
- Testing for HIV.
- Testing and treatment for sexually transmitted infections.
- Prenatal care.

While no minimum age is specified, *and each situation should be considered individually*, a child younger than 12 would generally be considered *not* to have the capacity for informed consent.

Offer Emergency Contraception to All Women of Reproductive Age

Emergency contraception can prevent unintended pregnancy. In 2000, as many as 51,000 pregnancies in the U.S. that would otherwise have ended in abortion were averted by emergency contraception.[11]

Emergency contraception should be offered:
- When contraception fails.
- When no contraception was used.
- When a woman is sexually assaulted.

New York State law requires that emergency departments offer emergency contraception to rape victims.[12]

Two Emergency Methods Are Available

1. Pills are the most common.

Emergency contraception pills are *most* effective when taken as soon as possible after unprotected sex, ideally within 72 hours. Recent evidence indicates they are moderately effective when taken between 72 and 120 hours after unprotected sex.[13, 14] *The sooner they are taken, the more effective they are.*[15]

Because emergency contraception pills act *before* implantation, they are regarded as contraceptives, not abortifacients.[16]

Based on many studies of oral contraceptives, there is no evidence that these products, when they fail to prevent pregnancy or are inadvertently used after implantation occurs, adversely affect fetal development.[17,18]

The first-line therapy is Plan B, the only currently available FDA-approved product marketed exclusively for emergency contraception. Plan B is highly effective (89% when taken within 72 hours after unprotected sex). Each of its 2 pills contains a high dose (0.75 mg.) of a progestin (levonorgestrel). Product labeling directs the second pill to be taken 12 hours after the first; recent evidence, however, indicates that a single 1.5 mg. dose is just as effective, without increasing adverse effects.[19]

If Plan B is not available, other products can be used for emergency contraception:

- *Ovrette (a "mini-pill")* is a low-dose, progestin-only (norgestrel) contraceptive that matches Plan B for efficacy and low risk of adverse effects. It is more expensive, however, and not as widely available. In addition, it takes 40 tablets (compared to Plan B's 2) to obtain 1.5 mg. levonorgestrel, making it a much less attractive option.

- *Combined oral contraceptives* have long been used for emergency contraception. They are less effective than Plan B and Ovrette (about 74% versus 89%) and more likely to cause nausea unless an anti-emetic is administered. The continued use of combined oral contraceptives for emergency contraception is largely because they have been more widely available than Plan B. *That is changing, however:* the Health Department and others are working with pharmacists to make Plan B more easily obtainable throughout New York City.

For detailed, up-to-date protocols on the progestin-only and combined oral contraceptives that can be used for emergency contraception, visit: www.nyc.gov/html/doh/html/ms/ms6.html

Advance prescriptions are recommended. Prescriptions or pill-packs provided in advance will ensure quick access.[20] (Plan B has a shelf life of 4 years.) Providing emergency contraception either on demand or in advance has *not* been found to encourage unprotected sex.[21,22]

2. The copper IUD can also be used.

Emergency insertion of the copper IUD is nearly 100% effective in preventing pregnancy. It can be inserted up to 5 days after sex. A woman may choose to keep the IUD in place for ongoing contraception.

The use of ongoing contraception immediately after emergency contraception should be strongly encouraged.

TABLE 4. CONTRACEPTIVE METHODS*

	Method	Effectiveness: Typical Use (Perfect Use)	Non-Contraceptive Advantages	Okay to Breast-Feed?	Precautions/ Contraindications	Cost (Length of Use)	Adverse Effects
NON-HORMONAL METHODS	**Male Condom**	85% (98%)	• Prevents HIV and other STIs.	YES	• Latex allergy (polyurethane available).	$0.50/EA (1 time)	N.A.
	Female Condom (Reality)*	79% (95%)	• Prevents HIV and other STIs.	YES	N.A.	$2.50/EA (1 time)	• Toxic shock syndrome (TSS) (rare).
	Diaphragm	84% (94%)	• May protect against PID, cervical neoplasia, tubal infertility.	YES	• Latex allergy (silicone available). • Used with N-9 spermicide (*see page 19*).	$15 – $75 (up to 2 yrs)	• Vaginitis. • UTI. • TSS (rare).
	Cervical Cap	**Nulliparous:** 84% (91%) **Parous:** 68% (74%)	• *See* **Diaphragm.**	YES	• *See* **Diaphragm.**	$15 – $75 (up to 2 yrs)	• Cervical erosion. • *Also see* **Diaphragm.**
	Spermicides	71% (82%)	N.A.	YES	• All contain N-9 (*see page 19*).	$0.50 – $1.50 (1 time)	• Vaginal/penile irritation.
	Copper IUD (Paragard)*	99.2% (99.4%)	• May protect against endometrial cancer.	YES	• Copper allergy. • *Also see* **Levonorgestral IUD.**	$175 – $400 (up to 10 yrs)	• Uterine perforation during insertion. • Increased risk of ectopic pregnancy if method fails. • Spontaneous expulsion. • PID.† • Menstrual changes: heavier/ longer menses, dysmenorrhea. • Spotting between cycles.
	All hormonal methods can be associated with one or more of the following (usually temporary) symptoms: spotting between periods, nausea, headache, breast tenderness.						
HORMONAL METHODS	**Levonorgestrel IUD (Mirena)***	Nearly 100%	• Controls menorrhagia. • Can be used by smokers 35 and older (unlike combined hormonal methods).	YES	• HIV+ (marker for STI risk). • STI or PID in past 3 mos. • Uterine fibroids with distortion of uterine cavity. • Recent endometritis.	$175 – $400 (up to 5 yrs)	• Amenorrhea. • *Also see* **Copper IUD.**

	Combined Oral Contraceptives	92% (99.7%)	• Regulates menstrual cycle.
			• Controls menorrhagia.
			• Reduces PMS symptoms.
			• Reduces risk of:
			  • Endometrial, ovarian, colorectal cancers.
			  • PID.
			  • Osteoporosis.
			  • Ectopic pregnancy.
			  • Iron-deficiency anemia.
				NO	• History of ectopic pregnancy.
					• Smokers 35 and older.
					• History of:
					  • Thromboembolism.
					  • Migraine w/aura.
					  • Breast, ovarian, endometrial cancers.
					  • MI or stroke.
					• Concurrent use of certain antibiotics or anti-convulsants.
						$15 – $35 (1 mo)	• Weight gain/loss.
							• Thromboembolism, MI, and stroke, esp smokers 35 and older and those w/other CVD risk factors.

	Method	Effectiveness: Typical Use (Perfect Use)	Non-Contraceptive Advantages	Okay to Breast-Feed?	Precautions/ Contraindications	Cost (Length of Use)	Adverse Effects
HORMONAL METHODS	**Progestin-Only Oral Contraceptives ('Mini-Pills')**	92% (99.7%) (decreased efficacy if not taken at same time each day)	• Decreases menstrual bleeding. • Can be taken by smokers 35 and older (unlike combined hormonal methods).	YES	• Breast cancer in last 5 years. • Active hepatitis, hepatic failure, or jaundice. • Concurrent use of certain antibiotics or anti-convulsants.	$15 – $35 (1 mo)	• Amenorrhea.
	Contraceptive Skin Patch (Ortho Evra)*	92% (99.7%)	• *See* **Combined oral contraceptives.**	NO	• Body weight > 198 lbs. • *Also see* **Combined oral contraceptives.**	$30 – $35 (1 mo)	• Skin irritation or allergic skin reaction. • *Also see* **Combined oral contraceptives.**
	Vaginal Ring (NuvaRing)*	92% (99.7%)	• *See* **Combined oral contraceptives.**	NO	• Pronounced pelvic relaxation. • *Also see* **Combined oral contraceptives.**	$30 – $35 (1 mo)	• Vaginal irritation. • *Also see* **Combined oral contraceptives.**
	Depot medroxy-progesterone acetate (Depo-Provera)*	97% (99.7%)	• May reduce risk of seizures. • May protect against ovarian and endometrial cancers. • Can be used by smokers 35 and older (unlike combined hormonal methods).	YES	• Breast cancer in past 5 years. • Active hepatitis, hepatic failure, or jaundice. • Concurrent use of certain antibiotics or anti-convulsants.	$30 – $75 (3 mos)	• Possible loss of bone mineral density. • Amenorrhea. • Depression. • Weight gain. • Change in body hair. • Change in sex drive. • Increased blood cholesterol.
STERILIZATION METHODS	**Tubal Ligation or Trans-Cervical Occlusion+**	99.5% (*average*: failure rates vary by method)	N.A.	YES	• Under age 21.	$2,000 – $6,000 (permanent)	• Increased risk of ectopic pregnancy if methods fail. • Increased risk of infection with trans-cervical occlusion.
	Vasectomy+	Nearly 100%	N.A.	N.A.	• Under age 21. • Local skin or lower genital tract infections.	$240 – $520 (permanent)	• Chronic Pain (usually only first year post-surgery)

* For complete information, check package insert or pharmacology text. The use of brand names anywhere in this issue does not imply endorsement by the New York City Department of Health and Mental Hygiene.

† The risk of pelvic inflammatory disease (PID) associated with copper and hormonal IUDs is highest in the first month post-insertion and dependent on personal risk factors.

+ According to NYC law, the standard waiting period between consent and sterilization is 30 days. The waiting period can be shortened to 72 hours if preterm delivery occurs or emergency surgery is needed. Sterilization of people under 21 is against the law.

Adapted with modifications from:

1. Hatcher RA, Trussell J, Stewart F, et al. Contraceptive Technology. 18th revised ed. New York, NY: Ardent Media Inc.; 2004.
2. Planned Parenthood Federation of America. *Your Contraceptive Choices.* Available at: www.plannedparenthood.org/pp2/portal/files/portal/medicalinfo/birthcontrol/pub-contraception-choices.xml. Accessed April 2005.

TABLE 5. CLINICAL SCENARIOS: TRUE OR FALSE?

For copies of this poster, call (212) 720-7136

1. A 15-year-old with more than one sex partner does not want to take a daily birth control pill. She asks for "the shot".

- *Depo-Provera is an option, but not for more than 2 years.*

  True: Depo-Provera is a highly effective, long-acting contraceptive. Because of recent evidence that long-term use may result in significant bone loss, however, it should generally *not* be used continuously for more than 2 years (*page 19*).

- *Bone loss attributable to Depo-Provera is completely reversible upon discontinuation.*

  False: It is unknown whether such bone loss is completely reversible, a factor to consider when prescribing Depo Provera in adolescence (a period of active bone accretion).

- *An IUD (either copper or hormonal) would be a good method for her.*

  False: IUDs are not a good choice for women with multiple sex partners. Additionally, adolescents may not tolerate the increased cramping and bleeding.

- *Condoms offer additional, needed protection.*

  True: Latex and polyurethane condoms are the *only* contraceptives that prevent HIV and other sexually transmitted infections.

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2. A college athlete wants to try the patch, but worries about news reports of deaths from its use.

- *The patch has a safety profile similar to that of other hormonal contraceptives.*

  True: Serious adverse effects are rare, especially in young, healthy nonsmokers.

- *The patch is not a good choice for an athlete because sweating will decrease its adhesiveness.*

  False: The adhesive works well.

- *The patch has no convenience advantage over oral contraceptives.*

  False: The patch is applied *weekly*, a reason some women prefer it to daily pills.

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3. A 25-year-old working mother with a 6-month-old in day care is married to the baby's father. They are mutually monogamous. She does not like hormonal contraceptives. She is adamant about not wanting another baby right now. She has a diaphragm at home that was fitted before pregnancy.

- *Condoms are an option, though perfect use is difficult to achieve.*

  True: Typical use effectiveness for condoms is 85%.

- *The cervical cap – a non-hormonal barrier method – is a good choice.*

  False: The cervical cap is not a good choice for parous women, as typical use effectiveness is only 68%.

- *The copper IUD is an appropriate choice.*

  True: Its effectiveness is high (more than 99%), and it offers long-term pregnancy protection, offsetting the initial high cost.

- *The diaphragm is the best choice for this patient.*

  False: Typical use effectiveness of the diaphragm is 84%, far less than the copper IUD or hormonal methods. (If the diaphragm is chosen, it should be re-fitted after pregnancy or a 20% weight change.)

Provide Abortion Information and Referral for Patients Who Need It

Abortion performed by a trained clinician is safe. Serious morbidity occurs in less than 1% of abortions; death, in less than 1 in 100,000 (less than the risk of full-term pregnancy). The risk of complications increases with gestational age.[23] Abortion can be performed through week 24 in New York State.

Discuss abortion options with patients who choose to terminate pregnancy. While most abortions performed in the United States are surgical, medical abortion agents (available since 2000) provide an effective non-surgical option. In some European countries, medical abortion is used in more than half of early abortions.

In contrast to surgical abortion, early medical abortion typically does not require invasive procedures, can be performed very early in pregnancy, and does not require surgical training, allowing more providers to offer this option to their patients.[24] Medical abortions do, though, require more clinical follow up than surgical abortions.

Strongly encourage the use of ongoing contraception beginning immediately after abortion.

> All abortions (spontaneous or induced) must be reported to the New York City Department of Health and Mental Hygiene. Call (212) 788-4585 for information.

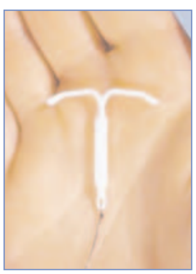
Updates

New Products

- **Seasonale** is an extended-use combined oral contraceptive. Pills are taken for 84 days, followed by 7 days of placebo pills, resulting in a menstrual period once every 3 months.[25] Patients may, especially at first, have more bleeding and spotting between periods than women taking a conventional, 28-day cycle oral contraceptive.[26]

  Useful for: Women with menorrhagia, anemia, bleeding disorders, polycystic ovary syndrome, and endometriosis.

- **Mirena** is a levonorgestrol-releasing hormonal intrauterine device. It is nearly 100% effective for up to 5 years.[26] Menstrual bleeding may be heavier the first few months, then becomes scanty or absent. Training in the insertion technique (different than the copper-T) is available by calling Berlex at (888) 237-5394.



  Useful for: Women who want long-term but reversible contraception and those with dysmenorrhea.

- **Implanon** is an implantable, progestin-only, single-rod system that is expected to become available in 2005.[24] It provides pregnancy protection for up to 3 years.

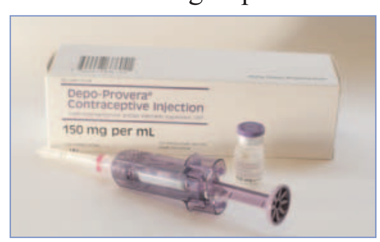
  Useful for: Women who want long-term but reversible contraception and those with contraindications to combined hormonal contraceptives.

Discontinued Methods

Two hormonal contraceptives, **Norplant** and **Lunelle**, and the emergency contraceptive **Preven** are no longer available in the United States, largely because of marketing performance. All Norplant rods should be removed, as the product has passed its expiration date. Patients with financial need can seek assistance in having Norplant removed by calling (800) 760-9030 or visiting: www.contraceptionfoundation.org/norplant_removal.jsp.

Warning on Depot Medroxyprogesterone Acetate (Depo-Provera)

The FDA warned in 2004 that use of Depo-Provera may result in significant loss of bone mineral density.[27] The risk increases with use and may not be completely reversible after discontinuation. It is unknown whether use in adolescence and early adulthood (a period of active bone accretion) reduces peak bone mass and increases the risk for fractures later in life.[28] Depo-Provera should not be used continuously for more than 2 years unless other birth control methods are inadequate or contraindicated. Bone density should be monitored when use exceeds 2 years. Patients using Depo-Provera should be encouraged to eat calcium-rich foods, take calcium and vitamin D supplements as needed, and engage regularly in weight-bearing exercise.



HIV Risk and Nonoxynol-9 (N-9)

All spermicides in the United States contain N-9. Because N-9 has been found to contribute to vaginal irritation that could increase the risk of HIV, the World Health Organization has issued recommendations on its use.[29] For women at low risk for HIV, N-9 spermicides are considered safe, provided they are used no more than once a day. Women at higher risk for HIV should not use N-9, especially if they have sex more than once a day.

RESOURCES

New York City Department of Health and Mental Hygiene
www.nyc.gov/health/maternity or call 311.

The Women's Healthline
Provider referrals and free patient education materials. Call 311.

Planned Parenthood of New York City
(212) 274-7316 or www.ppnyc.org

American College of Obstetricians and Gynecologists
(202) 638-5577 or www.acog.org

National Family Planning and Reproductive Health Association
(202) 293-3114 or www.nfprha.org

Centers for Disease Control and Prevention
(770) 488-5200 or www.cdc.gov/reproductivehealth/index.htm

National Women's Health Information Center
(800) 994-9662 or www.4woman.gov

Alan Guttmacher Institute
Sexual and reproductive health research, policy analysis, and public education: (212) 248-1111 or www.agi-usa.org

The Emergency Contraception Hotline
(888) 668-2528 or www.not-2-late.com

Managing Contraception
Contraception and abortion resources
www.managingcontraception.com

EDUCATIONAL MATERIALS

- **Providers** call (212) 720-7136
- **Patients** call 311.

SOURCES/ADDITIONAL READING

- Hatcher RA, Trussell J, Stewart F, et al. *Contraceptive Technology*. 18th revised ed. New York, NY: Ardent Media Inc.; 2004. Available via: www.managingcontraception.com
- Henshaw S. Unintended pregnancy in the United States. *Fam Plan Persp*. 1998;30:24-29.
- Grimes DA & Raymond EG. Emergency contraception. *Ann Intern Med*. 2002;137:180-189.
- **References Available Online:** www.nyc.gov/html/doh/pdf/chi/chi24-3-ref.pdf

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CME/CNE Activity Contraception: Encouraging Its Use

1. Teenagers have a right to: (*Check one.*)

❑ **A.** Contraception without the consent of a parent or guardian.

❑ **B.** Pregnancy care without the consent of a parent or guardian.

❑ **C.** HIV testing without the consent of a parent or guardian.

❑ **D.** All of the above.

2. All are true of emergency contraception EXCEPT: (*Check one.*)

❑ **A.** Plan B pills can be taken together or 12 hours apart.

❑ **B.** Emergency contraceptive pills are *most* effective when taken as soon as possible within 72 hours after unprotected sex.

❑ **C.** Combined oral contraceptive pills used as emergency contraception are less likely to cause adverse effects than Plan B.

❑ **D.** Emergency contraception provided in advance is *not* associated with an increase in unprotected sex.

3. A 31-year-old, HIV-negative, 225 lb. woman is in a long-term, monogamous relationship with an HIV-negative man. Adhering to a daily pill-taking regimen is difficult for her. Which of the following would NOT be a suitable method for her? (*Check one.*)

❑ **A.** Copper IUD

❑ **B.** Levonorgestrel IUD

❑ **C.** Contraceptive skin patch

❑ **D.** Vaginal ring

4. A 38-year-old woman, G1 P1, with a history of menorrhagia is breastfeeding. Which of the following is the best contraceptive option? (*Check one.*)

❑ **A.** Mini-pill

❑ **B.** Contraceptive skin patch

❑ **C.** Copper IUD

❑ **D.** Cervical cap

5. A 22-year-old, HIV-negative woman is having sex with a man who has other sex partners. She was treated for chlamydia last month. Which of the following are suitable contraceptive options? (*Check all that apply.*)

❑ **A.** Copper IUD plus condoms

❑ **B.** Combined oral contraceptive pills plus condoms

❑ **C.** Vaginal ring plus condoms

❑ **D.** Mini-pill plus condoms

6. How well did this continuing education activity achieve its educational objectives?

❑ **A.** Very well ❑ **B.** Adequately ❑ **C.** Poorly

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Continuing Education Activity

This issue of *City Health Information*, including the continuing education activity, can be downloaded from the publications section at nyc.gov/health. To access *City Health Information* and Continuing Medical/Nursing Education online, visit www.nyc.gov/html/doh/html/chi/chi.html

Instructions

Read this issue to find the correct answers to the questions. To receive continuing education credit you must answer 4 of the first 5 questions correctly.

To Submit by Mail

1. Complete all information on the response card, including your name, degree, mailing address, telephone number, and e-mail address. PLEASE PRINT LEGIBLY.

2. Select your answers to the questions and check the corresponding boxes on the response card.

3. Return the response card (or a photocopy) postmarked **no later than April 15, 2006.** Mail to:

CME/CNE Administrator, NYC Dept. of Health and Mental Hygiene,
125 Worth Street, CN-29C, New York, NY 10213-2188.

To Submit Online

Visit www.nyc.gov/html/doh/html/chi/chi.html to complete this activity online. Your responses will be graded immediately, and you can print out your certificate.

Continuing Education Activity
Contraception: Encouraging Its Use

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THE NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE (DOHMH)
CITY HEALTH INFORMATION
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Objectives

At the conclusion of the course, the participants should be able to:

1. Take a brief sexual history.
2. Assess a patient's contraceptive needs.
3. Help patients identify a contraceptive method that is right for them.
4. Inform patients about current emergency contraception and abortion options when appropriate.

Accreditation

The DOHMH is accredited by the Medical Society of the State of New York to sponsor continuing medical education for physicians. This continuing medical education activity is designated for a maximum of 1.0 hour in Category One credit toward the AMA/PRA (Physician's Recognition Award). Each physician should claim only those hours of credit that were spent on the educational activity.

Participants are required to submit name, address, and professional degree. This information will be maintained in the Department's CME program database. If you request, the CME Program will verify your participation and whether you passed the exam.

We will *not* share information with other organizations without your permission, except in certain emergencies when communication with health care providers is deemed by public health agencies to be essential or when required by law. Participants who provide e-mail addresses may receive electronic announcements from the Department about future CME activities as well as other public health information.

The Continuing Nursing Education (CNE) activity is open to nurses. The DOHMH is an approved provider of continuing education by the New York State Nurses Association, which is accredited as an approver of continuing education in nursing by the American Nurses Credentialing Center's Commission on Accreditation. A total of 1.2 contact hours will be awarded to nurses for participation in this activity.

Participants must submit the accompanying exam by April 15, 2006.

CME/CNE Activity Faculty:
Robertson V, Kaplan D, Brown G, Labor N, Sinclair Y, Bassett M.

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