

FUTURE OF PEDIATRICS TALKS!

A VIRTUAL SUMMER SERIES

Pediatric Health Network
 Children's National.



A few notes about today's Webinar

- All lines are muted throughout the webinar.
- Please use the Q&A box to ask questions or make comments.
- Today's Webinar recording and slides will be posted to the PHN website following the presentation. You can find past FOP presentations on our website at <https://pediatrichealthnetwork.org/future-of-pediatrics/>

PHN Grand Rounds

September 22 @ 12-1pm

**Liberating Black Wellness: Grappling with the History of Anti-Black Racism, its
Modern-Day Impact, and the Way Forward for Pediatric Practices**

Nia Heard-Garris, MD, MSc, FAAP

Nevin Heard, PhD

This interactive session will allow participants to join break out groups to discuss addressing racism and implicit bias in their own practice. The main session will be recorded and the handouts and guidelines reviewed during the Grand Rounds will be available on pediatrichealthnetwork.org

Speakers



Amy Dyett, MEd



Asad Bandealy, MD, MPH



Heidi Schumacher, MD



Brooke Bokor, MD, MPH



Natasha Ramsey, MD, MPH

No conflicts to disclose:

- No financial or business interest, arrangement or affiliation that could be perceived as a real or apparent conflict of interest in the subject (content) of their presentation.
- No unapproved or investigational use of any drugs, commercial products or devices.

Meeting Teens Where They Are: the Contraceptive Discussion



Brooke Bokor, MD, MPH

Division of Adolescent & Young Adult Medicine

Natasha Ramsey, MD, MPH

Fellow in the Division of Adolescent & Young Adult Medicine

FUTURE OF PEDIATRICS

At the session's end, participants will be able to ...

- Apply shared decision making and patient-centered counseling to contraception management
- Identify strategies to adapt current history taking and counseling to the telemedicine environment

Importance of Shared Decision Making (SDM)

- History of reproductive coercion and oppression in the US, especially experienced by women of color and low-income women
- Prioritizing one method over others can undermine patient autonomy, satisfaction, and continuation.

Need to improve patient experience with contraceptive counseling

- Shared decision making roles
 - Health care provider- contributes medical knowledge
 - Patient- provides expertise on her own values and preferences
- Together, the provider and patient collaborate to achieve the goal of the patient making a decision that is most consistent with their preferences.

You have a busy day ahead of you:

Appointment Time	Patient Name and Age	CC
1:00	Jill- 16 yr old	Follow up
1:30	Susan- 17 yr old	Pre-College Appointment
2:00	Jane – 15 yr old	Vaginal Discharge
2:30	Tina – 19 yr old	Irregular Periods

Your first patient has logged in:

Appointment Time	Patient Name and Age	CC
1:00	Jill- 16 yr old	Follow up
1:30	Susan- 17 yr old	Pre-College Appointment
2:00	Jane – 15 yr old	Vaginal Discharge
2:30	Tina – 19 yr old	Irregular Periods

Patient 1: Jill

- Jill is 16 yrs old and lives in Maryland.
- She scheduled a telemed visit for “cramps,” but while her mother is in the kitchen she shares that she wants to learn more about birth control.
- She’s been having sex for about 6 months and doesn’t want her parents to know.
- How can you ensure her confidentiality during a televisit?



Setting the Stage for a Successful Televisit

- Make sure they are in a safe place where they can discuss sensitive topics (room, basement, on a walk)
- Remind them that the visit is still confidential
- Set expectations: remind them what you can and cannot do over video
- Headphones
- Write things down/chat function
- Follow up over email, confirm their cellphone #



Patient 1: Jill

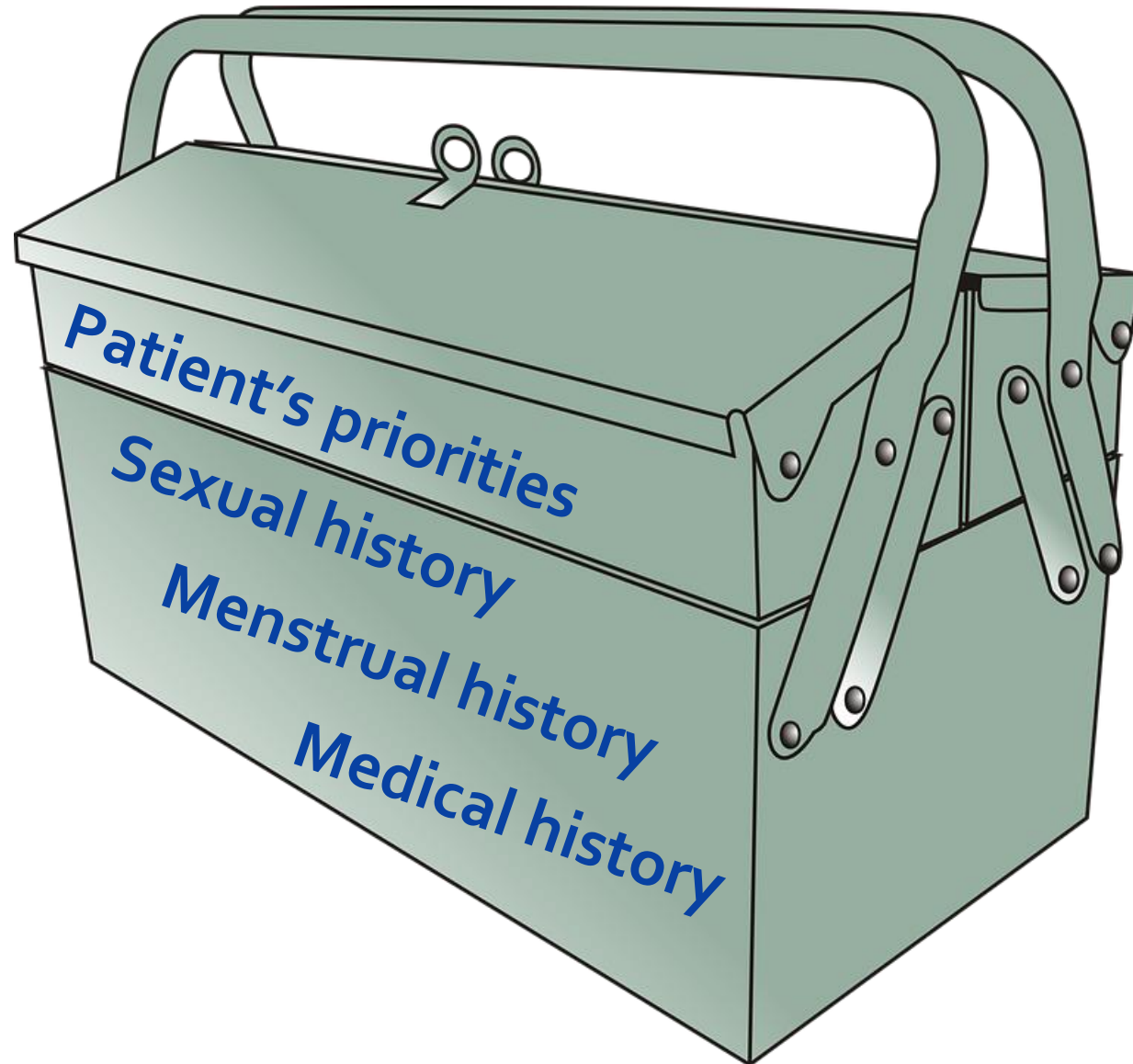
You review the confidentiality and consent rules with her

- In MD*, DC, and VA: All teens have the right to confidential reproductive health services including contraception and STI testing/treatment
- Privacy extends to the medical record, but may not be kept by EOBs

* In MD: Physicians may, but are not required to, inform the young person's parents.



CONTRACEPTIVE TOOLBOX



Sexual History

- Review confidentiality
- Be aware of judgmental questions and behaviors
- Acknowledge positive behaviors
- **Focus on behaviors not labels**
- **Last unprotected vaginal sex?**

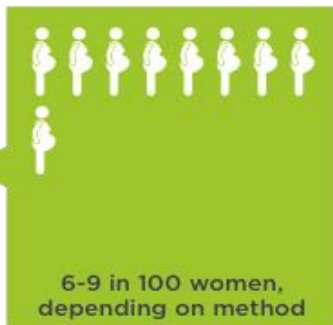
Menstrual History

- **LMP**
- **Pain and quality life?**
- Regular or Irregular?
- How long?
- Intermenstrual bleeding?
- Heavy bleeding?
- Previous medication for menstrual suppression?

HOW WELL DOES BIRTH CONTROL WORK?



What is your chance of getting pregnant?



FYI, without birth control, over 90 in 100 young women get pregnant in a year.

Shared Decision Making

Elicit patient needs, concerns, and preferences

- Adherence issues
 - Effort: years vs. every 3 months, monthly, weekly, daily
 - Needle/procedure required: fears, access
 - Discreetness: obtaining (quarantine access), storage, use
 - Control in starting/stopping
- Side effects
 - Weight changes
 - Changes to menstrual flow:
 - Unpredictable vs. predictable
 - Induce amenorrhea or keep periods
 - Ovulatory suppression:
- Timing desired for return of fertility
 - Non-contraceptive benefits
 - How it will feel for them or partner(s)
- Effectiveness
 - Parallels frequency of administration

*The best method is
what works for the
patient*

Patient 1: Jill

- Jill is leaning towards a pill but wants to think it over some more.
- You are about to end the visit when Jill asks if she has to come in to the office to start the pill when she is ready.
- Does she?



Do Not Defer Contraception Initiation

- Pelvic exam: Not necessary unless
 - she has STI symptoms
 - provider is going to place IUD
- Pap smear: Not necessary
 - 2020 ACS : 1st cervical cancer screen at age 25
- Telemedicine considerations:
 - Use recent BPs on record (160/100 is a contraindication)
 - Progestin only methods if worried about lack of BP measurement
 - Home pregnancy test

How To Be Reasonably Certain that a Woman Is Not Pregnant

A health care provider can be reasonably certain that a woman is not pregnant if she has no symptoms or signs of pregnancy and meets any one of the following criteria:

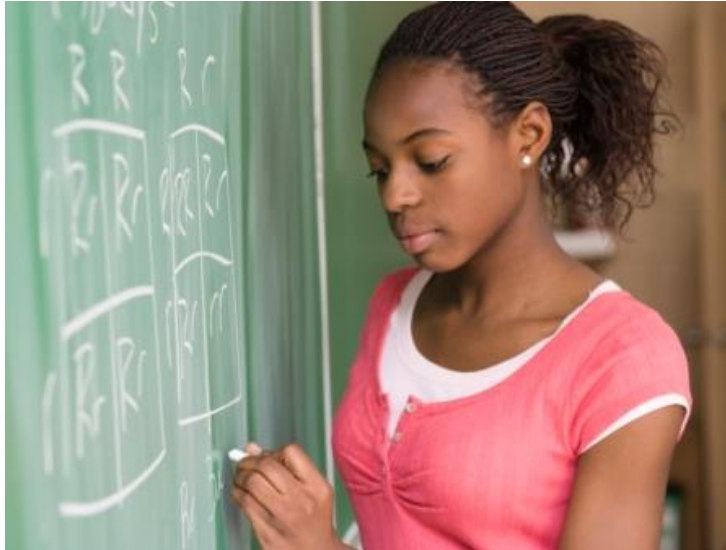
- is ≤ 7 days after the start of normal menses
- has not had sexual intercourse since the start of last normal menses
- has been correctly and consistently using a reliable method of contraception
- is ≤ 7 days after spontaneous or induced abortion
- is within 4 weeks postpartum
- is fully or nearly fully breastfeeding (exclusively breastfeeding or the vast majority [$\geq 85\%$] of feeds are breastfeeds), amenorrheic, and < 6 months postpartum

www.cdc.gov/reproductivehealth/contraception/mmwr/spr/notpregnant.html

Your second patient has logged in:

Appointment Time	Patient Name and Age	CC
1:00	Jill- 16 yr old	Follow up
1:30	Susan- 17 yr old	Pre-College Appointment
2:00	Jane – 15 yr old	Vaginal Discharge
2:30	Tina – 19 yr old	Irregular Periods

Patient 2: Susan



- Susan is starting college and wants to start the pill
- She is in a committed relationship and her last unprotected sex was 1 month ago
- PMH: migraines (without aura)
- Fhx: denies history of blood clots.

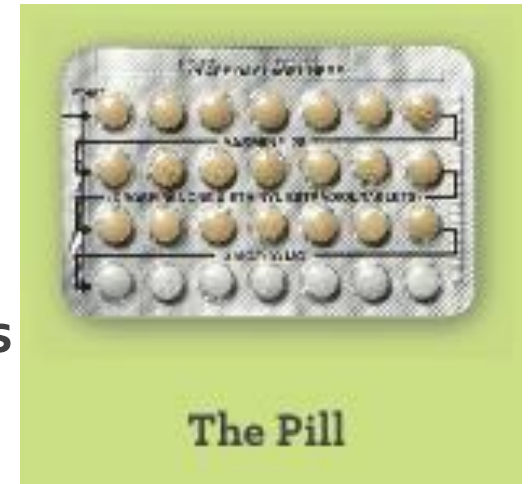
Which methods do you think are best for Susan?



Shared Decision Making -Susan

Combined estrogen-progestin oral pill

- Adherence issues
 - Maintenance: daily around same time of day
 - Needle/procedure requirement: none
 - Discreetness: Ensure pill storage accessible
 - Control in starting/stopping: **Full control; option to skip periods**
- Side effects
 - Weight changes: **≤ 5 lbs in 1st year**
 - Changes to menstrual flow: **predictable, possibly lighter**
 - Fertility and ovulation suppression: **1-2 weeks to suppress or return fertility**
 - First few months: **Take pill at night if nausea; mood changes or breast tenderness**
- Effectiveness
 - 91%



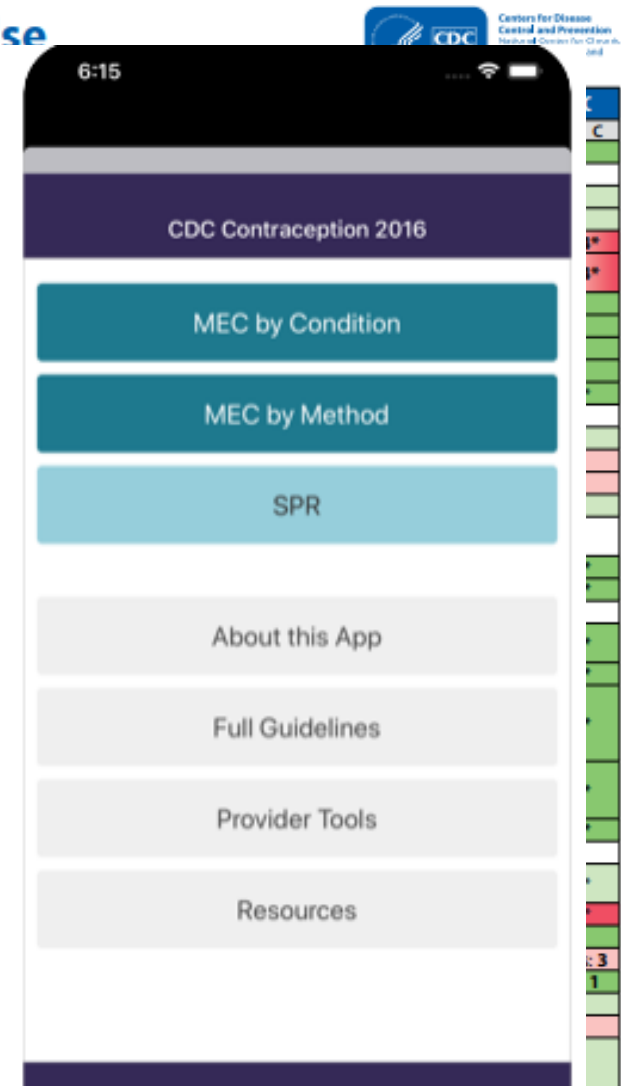
Medical Eligibility Criteria for Contraceptive Use 2020

www.CDC.gov

iPhone/iPad app

Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use

Condition	Sub-Condition	Cu-IUD		LNG-IUD		Implant		DMPA		Pill
		I	C	I	C	I	C	I	C	
Age		Menarche to <20 yrs:2		Menarche to <20 yrs:2		Menarche to <18 yrs:1		Menarche to <18 yrs:2		Menarche to <18 yrs:1
		≥20 yrs:1		≥20 yrs:1		18-45 yrs:1		18-45 yrs:1		18-45 yrs:1
Anatomical abnormalities	a) Distorted uterine cavity	4	4							
	b) Other abnormalities	2	2							
Anemias	a) Thalassemia	2	1	1	1					
	b) Sickle cell disease ²	2	1	1	1					
	c) Iron-deficiency anemia	2	1	1	1					
Benign ovarian tumors	(including cysts)	1	1	1	1					
Breast disease	a) Undiagnosed mass	1	2	2*	2*					
	b) Benign breast disease	1	1	1	1					
	c) Family history of cancer	1	1	1	1					
	d) Breast cancer ²									
	i) Current	1	4	4	4					
Breastfeeding	ii) Past and no evidence of current disease for 5 years	1	3	3	3					
	a) <21 days postpartum					2*	2*			
	b) 21 to <30 days postpartum									
	i) With other risk factors for VTE					2*	2*			
	ii) Without other risk factors for VTE					2*	2*			
	c) 30-42 days postpartum									
	i) With other risk factors for VTE					1*	1*			
	ii) Without other risk factors for VTE					1*	1*			
Cervical cancer	d) >42 days postpartum					1*	1*			
	Awaiting treatment	4	2	4	2	2	2			
Cervical ectropion		1	1	1	1					
Cervical intraepithelial neoplasia		1	2	2	2					
Cirrhosis	a) Mild (compensated)	1	1	1	1					
	b) Severe ² (decompensated)	1	3	3	3					
Cystic fibrosis ²		1*	1*	1*	2*					
Deep venous thrombosis (DVT)/Pulmonary embolism (PE)	a) History of DVT/PE, not receiving anticoagulant therapy									
	i) Higher risk for recurrent DVT/PE	1	2	2	2					
	ii) Lower risk for recurrent DVT/PE	1	2	2	2					
	b) Acute DVT/PE	2	2	2	2					
	c) DVT/PE and established anticoagulant therapy for at least 3 months									
	i) Higher risk for recurrent DVT/PE	2	2	2	2					
	ii) Lower risk for recurrent DVT/PE	2	2	2	2					



Condition	Sub-condition	Combined pill, patch, ring		Progestin-only pill		Injection		Implant		LNG--IUD		Copper-IUD	
Headaches		I	C	I	C	I	C	I	C	I	C	I	C
	a) Non-migrainous	1*	2*	1*	1*	1*	1*	1*	1*	1*	1*	1*	
	b) Migraine												
	i) without aura, age <35	2*	3*	1*	2*	2*	2*	2*	2*	2*	2*	1*	
	ii) without aura, age ≥35	3*	4*	1*	2*	2*	2*	2*	2*	2*	2*	1*	
	iii) with aura, any age	4*	4*	2*	3*	2*	3*	2*	3*	2*	3*	1*	
Drug Interactions													
Anticonvulsant therapy	a) Certain anticonvulsants (phenytoin, carbamazepine, barbiturates, <u>primidone</u> , <u>topiramate</u> , <u>oxcarbazepine</u>)	3*		3*		1		2*		1		1	
	b) Lamotrigine	3*		1		1		1		1		1	

Medical Eligibility Screening, the Highlights

Higher risk for hormonal contraception:

- Migraines with aura
- Active liver disease/hepatitis
- Uncontrolled HTN (>160/100)
- DM with end organ damage
- Precancerous cervical changes
- Interfering medications: antiepileptics, HIV meds, rifampin, oral antifungals, St. John's Wort
- History of stroke (e.g., in sickle cell disease)
- History of blood clots, thrombophilia or high risk for DVT
- History of breast cancer

Not an issue for initiation:

- Fhx blood clots
- Migraines without aura
- Obesity
- IBD
- Ovarian cysts
- Postpartum >6 weeks
- Smoking <35 years old

Oral Contraceptive Prescribing Tips

- Monophasic, 30 mcg estrogen and 2nd or 3rd generation progestin
 - lower EE doses risks breakthrough bleeding; ≤ 35 mcg EE are all “low”
 - No evidence for bi/triphasic as more “physiologic” or less side effects
 - 2nd gen progestin: Levo/Norgestrel; 3rd gen progestin: Desogestrel
- Progestin only pills (Norethindrone): take at same time daily without placebo pill break
- 28d pack rather than 21d pack for placebo pill placekeepers
- Dispense 12 month supply for pickup at pharmacy
 - DC, MD, and VA have laws to support, but pharmacies are inconsistent
- Dispense 90 day supply by mail order for delivery to house
- For teens afraid of EOBs or confidentiality breaks
 - \$4-\$10 generic medication lists at Target or Walmart or with [GoodRx.com](https://www.goodrx.com) coupon
 - Planned Parenthood: teen self-pay pricing list
 - Prescribe for “menstrual cramps” or “heavy period” control

Patient 2: Susan

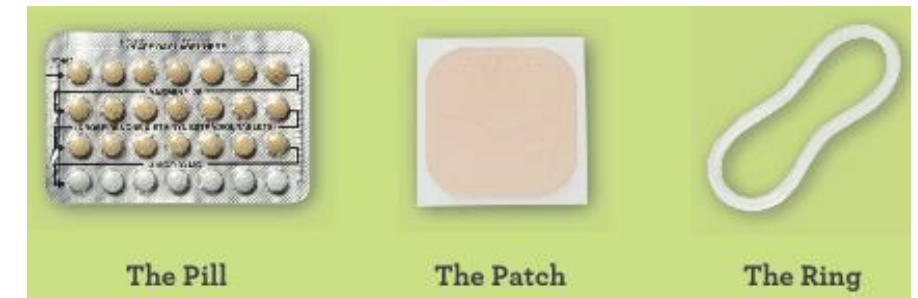


You start Susan on a 30mcg pill and send a 12 month supply.

You warn her about complications to look out for.

Counseling on Safety for Estrogen-Containing Methods

- Review common, transient side effects (resolve in 2-3 months)
 - Elevated blood pressure
 - Nausea
 - Mood Swings
- Review serious but rare side effects (incidence lowers after 1st year)
 - Formation of blood clots
- Instruct and document patient to stop medication and notify provider immediately with any of the following ACHES symptoms:
 - Abdominal Pain (severe)
 - Chest Pain
 - Headache (severe)
 - Eye problems, visual disturbances
 - Severe localized leg pain (calf or thigh)
- Other key messages
 - Condoms still required for STI protection
 - Package insert includes more potential side effects, e.g., benign liver adenoma



Your third patient has logged in:

Appointment Time	Patient Name and Age	CC
1:00	Jill- 16 yr old	Follow up
1:30	Susan- 17 yr old	Pre-College Appointment
2:00	Jane – 15 yr old	Vaginal Discharge
2:30	Tina – 19 yr old	Irregular Periods

Patient 3: Jane

- Jane scheduled an appointment today because of new vaginal discharge.
- She has both female and male partners and uses condoms sometimes.
- Her periods are regular and she just had her period last week.
- You bring up the topic of birth control: she is interested
- Patient priorities
 - Nothing with daily frequency
 - No long procedures to initiate
 - Confidentiality from parents



Which methods do you think are best for Jane?



Shared Decision Making in Choosing the Combined estrogen-progestin Patch

- Adherence issues
 - Maintenance: **weekly**
 - Needle/procedure requirement: **none**
 - Discreetness: **visibility on skin**
 - Control in starting/stopping: **Full control; can use continuously to skip periods**
- Side effects
 - Predictable bleeding patterns
 - Skin irritation from adhesive
 - No delay in fertility return
 - Theoretic risk of VTE higher due to bypass of liver filtration
- Effectiveness
 - 91%



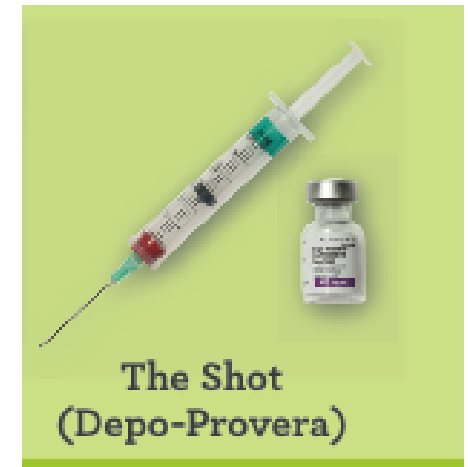
Shared Decision Making in Choosing the Combined estrogen-progestin Vaginal Ring

- Adherence issues
 - Maintenance: **Monthly**
 - Needle/procedure requirement: **none**
 - Discreetness: **may notice during sex**
 - Control in starting/stopping: Full control; **can use continuously to skip periods and can take out for 3hrs**
- Side effects
 - Requires touching yourself; better with tampon users
 - Predictable bleeding patterns
 - Vaginal irritation
 - No delay in fertility return
- Effectiveness
 - 91%



Shared Decision Making in Choosing the Depot Medroxyprogesterone Acetate (DMPA) shot

- Adherence issues
 - Maintenance: **every 3 months**
 - Needle/procedure requirement: **Office placement; also subQ**
 - Discreetness: **very discreet**
 - Control in starting/stopping: **fertility may take 9-12 months to resume**
- Side effects
 - unpredictable bleeding, eventual amenorrhea
 - ~10 lbs weight gain in 1st year
 - temporary osteopenia (unique to this progestin only method)
- Effectiveness
 - 94%



Patient 3: Jane

Jane decides on the “shot” and schedules a follow-up appointment in person for tomorrow to have the injection.



Your fourth patient has logged in:

Appointment Time	Patient Name and Age	CC
1:00	Jill- 16 yr old	Follow up
1:30	Susan- 17 yr old	Pre-College Appointment
2:00	Jane – 15 yr old	Vaginal Discharge
2:30	Tina – 19 yr old	Irregular Periods

Patient 4: Tina

- Tina is a teen mom and has irregular bleeding that is sometimes heavy.
- You discuss birth control as a way to help with her periods and as contraception.
- Patient concerns and preferences:
 - Remembering while being a busy mom
 - Worried about weight gain
 - Really wants an effective birth control
 - Lighter periods



Which methods do you think are best for Tina?



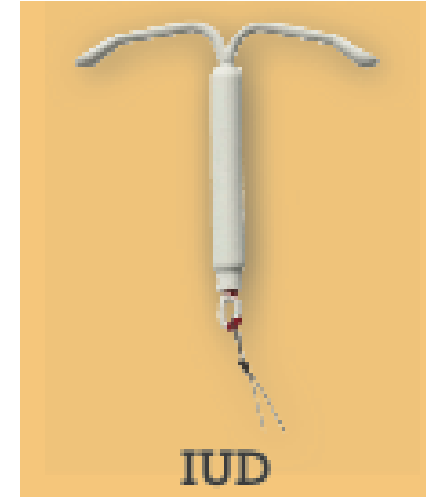
Long Acting Reversible Contraception (LARC): The Implant and IUDs

- LARC methods should be considered first-line contraceptive choices for adolescents
- Counsel about LARC methods at all visits with sexually active adolescents
- Describe IUDs and the Implant as “low maintenance” methods, not “long acting”

AAP (2014) and ACOG (2012) Recommendations

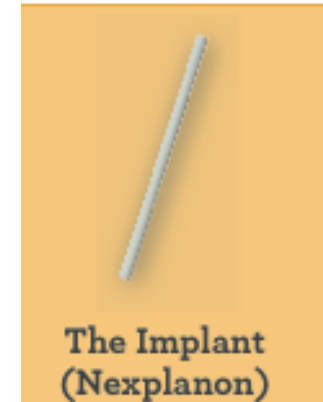
Shared Decision Making in Choosing the Levonorgestrel IUD

- Adherence issues
 - Maintenance: 3-5 years
 - Needle/procedure requirement: Office placement/removal
 - Discreetness: Not visible; string palpable in vagina
 - Control in starting/stopping: no delay in fertility return
- Side effects
 - Cramping with insertion; Progestin-IUD: no impact on bone density; 50% amenorrhea within 2 years
 - may not suppress ovulation/PMS/dysmenorrhea
- Effectiveness
 - 99.2%



**Copper IUD: heavier cramps and bleeding;
doesn't stop ovulation; lasts 10 years**

Shared Decision Making in Choosing the Implant



- Adherence issues
 - Maintenance: 3 years
 - Needle/procedure requirement: Office placement/removal
 - Discreetness: Not visible; palpable only
 - Control in starting/stopping: "Takes 3-6 months to establish bleeding pattern and we can help to make it better"
 - no delay in fertility return
- Side effects
 - Progestin-only; no impact on bone density; few discontinue due to weight gain; *unpredictable bleeding pattern*; only slight burning of lidocaine with insertion
- Effectiveness
 - 99.8%

Patient 3: Tina

Tina decided on the IUD.

You advise her to schedule her for follow up at the CNH Adolescent Health Clinic (AHC)



Referrals to Adolescent Medicine

- Contraception and Menstrual Co-Management
 - Virtual consult appointment line, 202-476-5464
 - In person: Adolescent Health Center (AHC) at Main Hospital & Montgomery County ROC
 - Peer-to-peer consultation (referring providers only): ask for Adolescent Medicine, Outpatient Consults, 202-476-4880
- Implant and IUD Placement

Adolescent Health Center, 202-476-5464, ages 12-21 years

 - Same day placement possible if pre-counseled
 - Nexplanon placement/removal: ongoing
 - IUD placement: resume in October 2020

COMPARE METHODS /

Side-by-side View

Build Your Own

Side-by-side Vi



	T	I	B	
effectiveness	★	★	★	
side effects	★	★	★	
do me now	★	★	★	effectiveness
STI prevention	✗	✗	✗	
hormone-free	☾	✗	✗	side effects
easy to hide	★	★	★	
easy to get	★	★	★	do me now
mistake-proof	★	★	★	
cost	☾	☾	☾	STI prevention
effort	★	★	★	
health benefits	★	★	★	hormone-free
reduces periods	★	★	★	easy to hide

Implant

★ The implant is among the most effective methods.

★ Irregular bleeding is the most common side effect of the implant.

★ Some women say the spontaneity allowed by the implant increases sexual pleasure.

✗ The implant doesn't protect against STIs.

✗ Yup, the implant has a type of progestin in it.

★ Once it's in your arm and the skin heals, the implant is invisible.

Withdrawal

☾ Withdrawal's somewhat effective, but depends on your guy always pulling out in time. Always.

★ The good news about withdrawal—no hormones, no devices, no side effects.

☾ Relying on the withdrawal method could create some anxiety for the guy to pull out at the right time.

✗ Withdrawal doesn't protect against STIs.

★ No hormones involved in the withdrawal method.

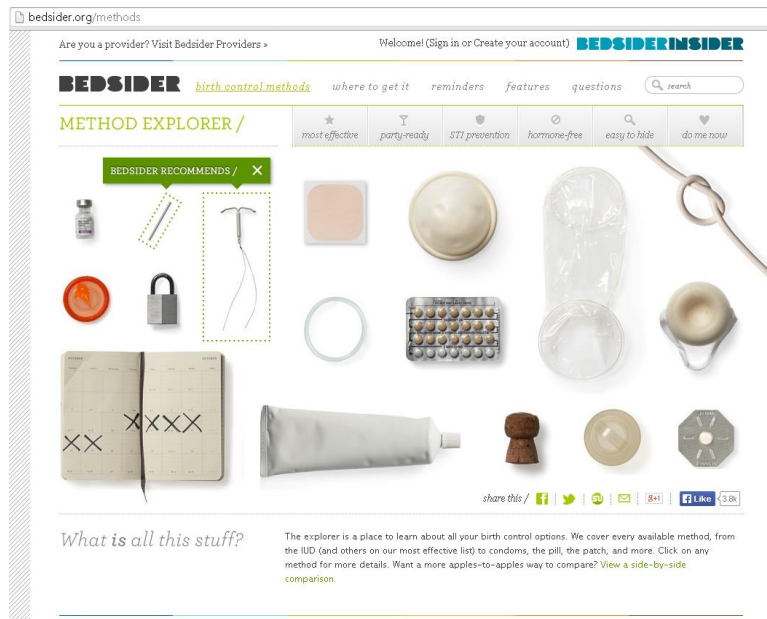
☾ Withdrawal requires the cooperation of your partner, so you certainly can't hide it from

method #3

Choose a method to compare.

Resources for Youth

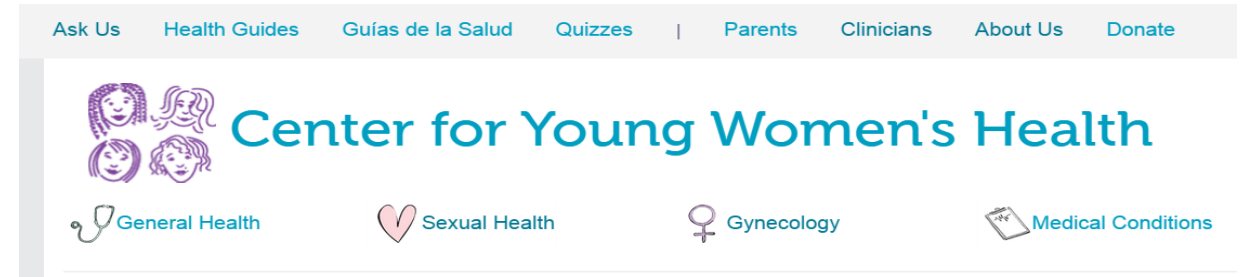
www.bedsider.org



Also... www.YoungMensHealthSite.org

FUTURE OF PEDIATRICS

www.YoungWomensHealth.org



Social Media Sites

Covid And Beyond @covid_and_beyond
Whitman Walker Health @whitmanwalker
LAYC Health Programs @layc_healthprograms
La Clinica del Pueblo @laclinicadelpueblo
SMYAL @smyal_dmv
The DC Center @thedccenter
Sex, Etc @sexetc
Teen Clinic by Facts @teenclinic_facts
Healthy Teen Network @healthyteennetwork
Scarleteen @scarleteenorg
DC Office of the Student Advocate @dc.advocate
COVID-19 Support @covid19studentsupport

Shared Decision Making

Elicit patient needs, concerns, and preferences

- Adherence issues
 - Effort: years vs. every 3 months, monthly, weekly, daily
 - Needle/procedure required: fears, access
 - Discreetness: obtaining (quarantine access), storage, use
 - Control in starting/stopping
- Side effects
 - Weight changes
 - Changes to menstrual flow:
 - Unpredictable vs. predictable
 - Induce amenorrhea or keep periods
 - Ovulatory suppression:
- Timing desired for return of fertility
 - Non-contraceptive benefits
 - How it will feel for them or partner(s)
- Effectiveness
 - Parallels frequency of administration

*The best method is
what works for the
patient*

PHN Handouts for this session

- Referral Guidelines for Adolescent & Young Adult Medicine at CNH
- OCP Prescribing Tips
- Contraception Education Visual Aid for Counseling
- Medical Eligibility CDC Handout
- Contraception Resources for Providers
- Contraception Resources for Youth

What we didn't get to talk about:

- Non hormonal methods: ie diaphragms, withdrawal method, condoms
- Emergency contraception: Levonorgestrel, Ullipristal, Copper IUD
- Intimate partner violence screening
- LGBTQ youth
- Reproductive Justice
 - www.ncjw.org/wp-content/uploads/2017/12/RJ-RH-RR-Chart.pdf

Co-management with a contraception specialist

- Implant or IUD placement
- Patients with complex medication regimens or medical problems:
 - ie Seizure disorder, Uncontrolled hypertension, HIV, Lupus, Migraines
- Benefits Beyond Contraception:
 - Dysmenorrhea and menorrhagia control
 - Functional ovarian cyst recurrence prevention
 - Cancer risk
 - PCOS treatment
 - Acne and Hirsutism improvement
 - Endometriosis treatment
 - Patient with developmental delay

Resources for Providers

- AAP Policy Statement Contraception for Adolescents. Sept 2014, <https://doi.org/10.1542/peds.2014-2299>
- Guttmacher Institute: <http://www.guttmacher.org/statecenter/>
- ACOG.org
- National Campaign to Prevent Teen and Unintended Pregnancy: <http://thenationalcampaign.org/>
- Bixby Center for Global Reproductive Health: <http://bixbycenter.ucsf.edu>