

CDC *Vital Signs* Town Hall Teleconference

Preventing Teen Pregnancy: A Key Role for Health Care Providers

Q&A Discussion

April 14, 2015

2:00 pm (EDT)

Steve Reynolds: Thank you so much for those three excellent presentations. They were outstanding.

Remember that today if you have a question please press star 1 so that you can get in the queue. Do that at any time.

You can do it now and you'll be placed in the queue. When you ask your question we ask that you direct it to one of the three presenters if you - or just say this is for any of the presenters.

But if you have a question specifically for Lisa Romero or Liz Romer or Rena Dixon, please try to let them know which one you think should answer your question. Say your name when you're - the operator will say your name -- will ask you for your name and then they'll turn you in - open your line and allow you to ask your questions.

I encourage you to take advantage of this opportunity to share your own strategies, lessons learned, challenges and success stories. It doesn't just have to be a question.

Feel free to tell us how it works in your community. Operator we're ready for those questions.

Is there - I see that we have two people in the queue now.

Coordinator: That is correct. Our first question or comment comes from Lisa Gallardo of Family Planning Association of Puerto Rico. Your line is open. Ms. Gallardo your line might be muted.

Lisa Gallardo : Hi Good afternoon. Ok, I'm sorry maybe it was a mistake. I don't have a question. But thank you. Thank you very much.

Coordinator: All right. Our next question and comment comes from Shelly Barth of the Wyoming Department of Health. Your line is open.

Shelly Barth: Hi this is Shelly Barth from the Wyoming Department of Health. It's interesting on that map to see Wyoming next to Colorado.

We have a little bit of work to do. My question is for Liz Romer.

Liz do you have laws in Colorado that allow adolescents to consent to medical treatment? Because I know here in Wyoming to place IUDs or implants is considered medical treatment and therefore requires parental consent.

I'm just wondering if there's specific laws that allow that to be done without parental consent in Colorado?

Dr. Liz Romer: Sure, thanks for the question. You know, we have laws that support adolescents seeking reproductive services here in Colorado.

And we also have support from Title X in terms of their rules and regulations. So with those two we're able to provide contraception to adolescents.

Shelly Barth: Great, thank you.

Coordinator: Once again to ask a question, press star 1 and record your name. To withdraw from the queue star 2.

Our next question or comment comes from Katie Kallstrom of Pepin County Health Department. Your line is open.

Katie Kallstrom: Yes, thank you. And this question kind of piggybacks onto the previous question.

I'm running into, you know, I support the LARCs, I think they're great. But the providers in my area -- we're pretty rural -- my understanding is they're not willing to put them in if, you know, there's not a parent to consent for it.

And so suggestions of how I can go about encouraging them?

Dr. Liz Romer: Sure this is Liz Romer. I'm happy to approach that.

I mean I think that we're all, you know, sort of benefiting because of this great influx of information and data to support using LARCs in teens. And so I really like to, you know, help those who are, you know, LARC minded so to speak to educate their providers.

Because I think, you know, being a provider myself I know that it's sometimes hard to change our practices. And when you have data I think that really helps those with that mindset that, you know, to present that data and say hey here's what's changed.

Here's who's supporting the use. And really continue to provide that information so that they can adopt the practices and move.

It's not always fast. But I think the process is worth, you know, continuing to work with folks, giving them access to the latest and most up-to-date information is always beneficial.

But I understand your struggle.

Dr. Lisa Romero: This is Lisa Romero. I'd also like to answer that.

We really encourage that parents talk with their teens about sex, encourage them when not to have sex and also visit a health provider with their teen to learn about the various birth control methods. And a lot of people say well, I don't know about that.

But there are national studies that say that adolescents attending family planning clinics -- 60% under the age of 18 said their parents knew that they were there and - to use a clinic specifically for sexual health services. And so it's important to encourage those conversations, encourage parent involvement.

But also know that for those teens that feel that they can't inform their parents that confidential family planning services through Title X is a very important option.

Coordinator: Ms. Kallstrom do you have a further question or comment?

Katie Kallstrom: No, thank you. I appreciate it and I'm just going to keep fighting the good fight then and doing, you know, what they suggest. So thank you.

Coordinator: Thank you. And our next question or comment comes from Melanie Mease of Anne Arundel County of Public Health. Your line is open.

Melanie Mease: Hi. I actually have two questions. And the first one is open to any presenter.

Specifically about the IUDs. Which type or brand was encouraged and/or free?

Were teens more interested in receiving the Skyla, Mirena, or the Copper T? Or was that not studied?

Dr. Liz Romer: I'm happy to answer from a Colorado perspective. This is Liz Romer.

You know, we - a lot of the motivation for what we had available was based on cost. And so we only had two IUDs which were the Mirena and ParaGard.

So those were the only two. But both were offered.

Melanie Mease : Okay. Great. And the second question I had for you Liz. Was the number recorded for how many teens returned to the clinic to remove the IUD either to complications or unhappiness?

Dr. Liz Romer: So are - you're asking if we monitored the removal rates?

Melanie Mease : Yes. If - a lot of the teens that I go and talk to I hear mostly about the complications and unhappiness that they've gotten from the IUD or just the side effects.

And I wanted to know if - since you outreach so many women, which I think is just absolutely great, if there was a number that you monitored of people who came back and said they didn't want to use the LARC anymore.

Dr. Liz Romer: Yes I'm so glad that you asked this question. You know, this is - that's a really difficult number to monitor and you have to have a rigorous, you know, study set up.

So I encourage you to look at the choice data because I think that that really - they did a really nice job of following this. And their continuation rates are very impressive...

Melanie Mease : Okay.

Dr. Liz Romer: Even including adolescents which is about 86%. What I'll tell you is I have - I understand what you're experiencing because if you think it through, patients who get LARCs, regardless of their age, don't typically come back to the clinic if they're happy unless it's for routine care.

Melanie Mease : Right.

Dr. Liz Romer: So we tend to sort of have a skewed view - or not view. But we see more patients who are unhappy or have questions about their devices and that can sometimes lead us to think that more people are not satisfied with their method than they are.

And so I think it's important to keep that in perspective. Particularly with this age group. They sometimes just want to come in and know that what they're experiencing is normal.

It doesn't mean it's a failure of the method. It doesn't mean, you know, that they necessarily want to discontinue.

But they're in a developmental place where they want to know that they're normal, what they're experiencing is okay. And sometimes just need a lot of reassurance.

So I understand that continuation rates are of concern. I think there's good data out of Choice to look at that.

And then also just to keep in mind who comes back more frequently.

Melanie Mease : Okay. Thank you so much. That was so helpful.

I'm trying to increase teens to use these LARCs. And you hear a lot of their skepticism in how it's going to work for them and just giving them the confidence to go and use one of these LARCs is huge.

So thank you so much. And thank you everyone for all the hard work that you guys do.

So thank you.

Coordinator: Our next question or comment comes from Jennifer Williams of Florida Department of Health. Your line is open.

Jennifer Williams: Yes, good evening. I was calling because I just wanted - got on the conference because I always keep in tune what's going on in the community. But I work in HIV/AIDS in Florida Department of Health.

And I want to commend you guys for doing such a great job in both states. Because I was a teen mother twice, 16 and 18.

And I currently keep up on what's going on. And I applaud you because most of the teens that are out there and they are pregnant or they want to seek contraceptive - they don't have people to talk to a lot.

They are afraid. And so that makes the comfort zone for them very comfortable to come in and seek help.

And I just want to commend you guys on doing a great job. Thank you.

Coordinator: And our next question or comment comes from Cheryl Kovar from East Carolina University. Your line is open.

Cheryl Kovar: Good afternoon. Thanks and very well done presentation.

And this is a topic near and dear to my heart. My question is specifically to Dr. Dixon in South Carolina.

In North Carolina, you know, we have been promoting LARCs for the last several years. And we are proud we're over that 7% threshold of the national average.

But unfortunately, cost of the LARC methods is a large barrier for our Title X clinics here in North Carolina. And we get a lot of pushback from that.

My question is how are the adolescents assessed for income at The Point as you place them on the sliding fee scale?

Dr. Rena Dixon: All right. We look at all of our adolescents as a household of one.

We are also fortunate in South Carolina to have the state plan amendment for Medicaid. So we tried to get as many young people put on Medicaid so it stretches your Title X dollars further.

But the basics of that is looking at them as a household of one.

Cheryl Kovar: So for the most part they're a 0 pay.

Dr. Rena Dixon: Yes, yes. And that will make them Medicaid eligible. So you don't have to necessarily tap out your Title X resources for...

Cheryl Kovar: Not necessarily - it could be different in South Carolina. North Carolina if we want to then refer them to our Medicaid office it now is going to revert back to the family income.

And that's where our catch 22 comes a lot. That, you know, they could be coming from a family that wouldn't qualify for Medicaid and so that's where our - that's our state issue.

So we don't have that option.

Dr. Rena Dixon: We actually work at the state level with our Department of Health and Human Services here in South Carolina to kind of work some of that out. So they understand how important this issue is as well.

So it helps starting from the very top to help it trickle down.

Cheryl Kovar: Right. Well, thank you. We'll keep working.

Dr. Rena Dixon: Okay.

Coordinator: Our next question and comment comes from Andrea Wenke of the Nebraska Department of Health and Human Services. Your line is open.

Andrea Wenke: Hi there. I have a question for Liz regarding the upcoming vote to provide funds in Colorado for LARC.

I know - I believe there's a vote coming up next month. What - do you have a sense of if there's going to be funds appropriated for it, if it's going to go through?

Or do you have any thoughts on the process?

Dr. Liz Romer: So this is Liz. And I, you know, am hopeful but I don't have any information for you.

Andrea Wenke: Okay.

Dr. Liz Romer: I don't - I really can't predict kind of what direction this is going to go, so.

Andrea Wenke: And do you know how much - is it a funds appropriation type of bill that's - because I know you - they were using...

Dr. Liz Romer: Right.

Andrea Wenke: Private funds before, correct?

Dr. Liz Romer: Right, correct.

Andrea Wenke: And...

Dr. Liz Romer: It is - I think it's - they're looking at several different angles. And I'm sorry that I don't
- I'm not more current on kind of where...

Andrea Wenke: Okay.

Dr. Liz Romer: Things are right now. I know that it's, you know, an important bill that will be looked
at.

I think, you know, at - not only within Colorado, in other states just to see how this
goes. But I think we're still in the process of, you know, fighting for this bill still, so.

Andrea Wenke: Okay. Thanks.

Coordinator: Once again to ask a question or make a comment press star 1 and record your name
when prompted, star 2 to withdraw from the queue.

And our next question or comment comes from Dr. Sheila Overton. Your line is open.

Dr. Sheila Overton: Oh hi. Good day. And I did want to thank everybody who put this, you know,
piece together. It has been truly wonderful.

I've been involved in teen pregnancy prevention for many, many years, back since
1997 and seen the progress that we've made as a country over these past two
decades. It's been truly amazing.

I have to tell you that there are so many obstacles. And as a provider and OBGYN, I
can say that the provider level is a big obstacle.

And I know that you're doing education and training. But what I see is that it's just very difficult to get people to change the way that they practice.

I mean I have providers -- especially some of the older providers who just really still don't want to put an IUD in a nulliparous young woman. And so that's one area that certainly we'd have to continue working on.

The other thing is that I would say in the school system we have issues going on. And I think there are a lot of school environments where there's a thought that we just give condoms and then that's all that, you know, the teens need.

I mean that's the focus that you see. So I just wanted to kind of mention some of those provider - or excuse me some of those obstacles that were - that we continue to come across.

And certainly there are many more. But I actually do have a question.

I work both in the private setting and I work for a basically underinsured community setting that works through a hospital. And so we don't have any of the Title IX programming or availability of services that you have mentioned throughout this session.

So I wonder if you do have - and this would go to any of you -- if you have tips for those of us who don't work in the Title - excuse me, Title X clinics? And because we have so many problems with availability.

It's very, very difficult to get the LARC methods for our teenagers when they come in.

Dr. Liz Romer: This is Liz. I'm happy to - you know, I understand that things are very different in a private setting.

And I think that, you know, in public health we have different obstacles than you. And I think a lot of the things that I hear from private offices is that they do struggle with authorization and so forth.

And so I think as a country we have a lot to look at in terms of what types of barriers are present for providers in accessing the devices and being able to have them on hand. I think, you know, we're hearing about the new levonorgestrel 52 microgram IUD.

And I think that there are some interesting things that will come from that company and how they'll help providers be able to have access to devices. And, you know, I'll be curious to see as more and more women start using long acting reversible contraception to see if we might see the needle move somewhere in this spectrum to really make it easier for those providers who do want to put in LARCs that they don't have to go through a rigorous prior auth process in order to be able to provide those for the women that want them.

Dr. Sheila Overton: Sure. That would make a very big difference. Thank you so much.

Coordinator: And our next question or comment comes from Lisa Huendorf for the Family Planning Association of Northeast Ohio. Your line is open.

Lisa Huendorf: Hi, thanks. I had a question for Liz.

I just wanted to get a little more information on your bridge method that you mentioned for those girls that can't get their birth control choice that they want that day. I think we have a lot of issues with that.

We currently started the electronic medical records in my clinic. And so people get double booked or they're scheduled but they're not on the thing correctly, so they end up having to leave or come back at a different time.

And like I said, I think that when the girls don't get what they want that day, sometimes we don't' ever see them again. So what kind of suggestions might you have to bridge those people to have them come back or be able to make a second appointment to have their method chosen.

Dr. Liz Romer: You know, I think the things that we use most commonly for bridge are a Depo Provera shot or a ring. Because, you know, ultimately a lot of our patients are saying hey, I struggle with using short acting methods and I have a hard time remembering to take them.

And so getting them something where you can actually, you know, get appointment within a month or get an appointment within three months, you know, that's helpful. You know, so that's kind of what we turn to most frequently.

Lisa Huendorf: Okay, no. Yes that makes a lot of sense actually, so they can get something that day to hold them over until we're able to, you know, have the whole visit of the intro and the orientation, the education all that kind of stuff.

That does make sense.

Dr. Liz Romer: Yes.

Lisa Huendorf: Okay, thank you.

Coordinator: And our next question or comment comes from Ashlee Folsom of the Wyandotte County Health Department. Your line is open.

Ashlee Folsom: Actually I just had a comment for those of you who are asking about minors accessing reproductive healthcare. It's different in each state but most states do have provisions that allow for teens to access reproductive healthcare without parental consent.

And you can find a lot more information from the Gutmacher Institute. And it's www.gutmacher.org/statecenter/adolescents.

And that has kind of a breakdown by state law so.

Coordinator: Thank you so much. And our next question or comment comes from Becky Parrish of the Family Planning Council of Iowa. Your line is open.

Becky Parrish: Good afternoon, hi. I have a question for Liz.

On your slide 26, it says quick start method for all methods except IUD. But previously you had mentioned that you do same day insertion of IUD.

So I didn't quite understand that.

Dr. Liz Romer: I'm glad you brought that up. It was one of those ones that I looked at last night and thought oh, wow, I wish I - I'll definitely have to pay attention to make sure I describe that.

So we really focus on same day insertions with IUDs. There is a window of time in which if a patient has had unprotected sex within the past two weeks, you know, we don't have that reasonable assurance that they're not pregnant.

So, you know, for us if there's been an unprotected encounter within those past two weeks then we cannot quick start an IUD. With the exception of using ParaGard for emergency contraception as per, you know, the recommendation for that.

So that, I think when we talk about quick start really thinking about moving away from the starting method during the menstrual cycle. And so we think about quick start with all the short acting methods -- pills, patch, ring, Depo -- as well as, you know, we've had - we've looked a lot at quick start with implants and had a great amount of success with that.

I'm happy to share that with you if you want to email me. But understanding that when you're talking about quick start you do kind of need to mention you can initiate the use of an IUD outside of, you know, anywhere within that menstrual cycle when pregnancy can be ruled out.

You can't rule out pregnancy if they've had that unprotected sex in two weeks. And so that's the timeframe in which we can't quick start.

Becky Parrish: Right, right. Thank you.

Coordinator: Our next question or comment comes from Tracy Ayrhart of the Women's Health and Family Planning Association of Texas. Your line is open.

Tracy Ayrhart: Hi. My - I actually have two questions. And my question is for Liz although I'm happy to hear from any of the speakers.

But it's regarding your slide on removing access barriers. For the scheduling appointments because that makes a lot of sense for the adolescent patients that they would be coming late or, you know, might miss appointments.

But a lot of our clinics really struggle with how to structure their appointment making process. And what they're finding is that they leave room for late appointments or no shows and sometimes they'll have days with no one coming in.

But then if it's too full then they're just at capacity and they can't see the patients that do show up late, unless they stay open until midnight.

And then my second question is about reaching teens in the community with the schools. So we're in Texas and we're right in the middle of the Bible belt.

And our communities are actually very hostile sometimes to family planning. And a lot of our clinics are not allowed in the schools.

And so I was wondering if you had any tips for building those relationship even in a conservative environment.

Dr. Liz Romer: This is Liz. I'm happy to have others chime in.

I'll first answer your second question which is I understand that this can be a cautious relationship. This is really more for me as a provider and our staff connecting with individual RNs within the school to just develop a relationship.

Tell me about the patients, you know, tell me about the students that you see? Are there needs that you feel like your students aren't being met?

Do you need a place to send them? So on and so forth. So it's really, you know, often even within that hostility those school nurses are very aware of the problems of teen pregnancy within their schools.

And they often feel like they can't do anything and they don't know where to send their patients. And so that's how we develop that personal relationship.

She has my direct email and my phone line so we can really work to make sure that if, you know, she can't do any contraceptive discussions at all within the school. But she can give them our clinic number.

As far as access, I get it. It's challenging.

You know, with teens you're going to have some level of no show rate. There are the occasional days where everyone shows up.

And so you have to kind of work to negotiate with that. But we, you know, looking, you can do time studies of your clinic to see how much time, you know, they're really spending there.

And figure out a way to kind of - to make it work. We have, you know, the luxury of having more than one provider most days.

And so they work together to get those patients seen. But it is complicated, I understand that.

Tracy Ayrhart: Okay thank you.

Dr. Rena Dixon: This is Rena. I just wanted to chime in about the outreach in the community.

I think we probably have a closely similar climate here in South Carolina with the conservative nature of our communities. Our outreach worker, she works very, very hard to get out in the community as much as possible so that word of mouth is the main method of communication in regards to marketing.

We make sure that she has a cell phone that's dedicated for the teen line so that young people can call her directly and also text her. And if she's in the clinic she can kind of set up their appointment when they call her directly on the teen cell phone.

So she makes sure she's at every festival, any kind of teen event going on in the community so that young people see her face and refer their friends to her for an appointment.

Tracy Ayrhart: That's a great idea. Thank you.

Dr. Lisa Romero: And this is Lisa Romero. I'd like to add one thing to that.

You know, we have 10 funded projects throughout the US and many of them are in states that declare themselves the most conservative, they have the hardest time.

And what we have found what has been successful is really a multi-component approach. You know, we have mobilized the community.

In many of these communities, why is teen pregnancy an important issue? Educating key stakeholders.

Not only people that we would think would be champions in teen pregnancy but parents, faith leaders, business people. Everybody that could potentially be impacted by teen pregnancy in their community.

Another piece that we do that many communities find very helpful is getting that - their foot in the door with evidence based programs in the schools. Many of our programs then have a clinic linking module.

So within their evidence based program they talked about clinic services. They also build that relationship with clinics in the community that have been identified and that are partnering with them as youth friendly and so forth.

So making those relationships with clinics in the community and having that linkage and referral piece so that when teens who are in these evidence based programs in the schools know about clinical services and know where to go. And then finally working with the clinics within the community to make sure that they are youth friendly, that their providers are educated about the safety and effectiveness of LARC, that they're trained on different methods, insertion and removal, that they're trained about contraceptive counseling, and so forth.

So it take a lot. It's a lot of effort.

But in the long run many of these communities and we're in year five in this project - many of these communities are in schools that they never were in before. They have the support of the faith community.

They have the support of parents. Their clinics are reaching out and they're seen as a good partner in the community.

So, you know, it takes time to build those relationships but it can be done in conservative communities.

Tracy Ayrhart: Great, thank you.

Coordinator: We're going to take the next four questions ending with Ms. Mancini. And our next question or comment comes from Kathleen Morrell of the Physicians for Reproductive Health. Your line is open.

Kathleen Morrell: Hi thank you. I - this is actually just a comment.

I wanted to let people know a little bit more information about the new IUD Liletta that became available that I think will also answer the young woman who was speaking from North Carolina wondering about things that can be helpful for stocking. So they've - it's a - it was originally started by Medicine 360 which is a nonprofit pharmaceutical company which now has partners with a pharmaceutical company that is for profit in order to put it out there.

But the reason why they wanted to bring it out in the beginning was actually so that they could have a discounted 340B pricing. And they just recently released that and it will be \$50 per 340B pricing.

And it is identical to Mirena. It's currently only going to be FDA approved for three years despite the fact that it's identical to Mirena.

And that was just because they wanted it to get to market. They will then reapply for FDA approval for the further along for five and then potentially even seven years going forward.

But that is going to be something that hopefully will become an alternative to people who need to be able to stock the less expensive devices and can help with some of those barriers.

Coordinator: Thank you. And our next question or comment comes from Megan Keeling of ARHP. Your line might be muted. Please check your phone. One moment please. One moment.

Megan Keeling: Hello?

Coordinator: Yes Ms. Keeling please go ahead.

Megan Keeling: Hi, thank you. My name is Megan Keeling.

I'm calling from the Association of Reproductive Health Professionals. And my question was just about using the copper IUD as an emergency contraception.

Is this a service that you were able to offer in Title X clinics? And how many - do you have the data on how many users of ParaGard started using it as emergency contraception?

And that's for anybody.

Dr. Liz Romer: Yes, this is Liz Romer: in Colorado. We do use ParaGard as emergency contraception.

And that is supported by Title X. I've looked at the numbers -- I don't have that information for you.

But you could email me offline.

Coordinator: And our next question or comment comes from Tara Mancini of the National Campaign to Prevent Teen and Unplanned Pregnancy. Your line is open.

Tara Mancini: Hi, thank you. This question is for Rena in South Carolina.

I'm sorry if you could just repeat the stats that you gave for teens at The Point for the percent using reliable methods versus LARCs in 2013/2014?

Dr. Rena Dixon: Sure. We had 97% of females on a reliable method. And we define reliable method as pill, patch, ring, injection, IUD, or implant.

And then specifically for LARC methods 37% of the - 39%, I'm sorry, of the caseload was on an IUD or implant. But the majority of those were implants.

Tara Mancini: Okay. Thank you very much.

Dr. Rena Dixon: Welcome.

Coordinator: And I show no further questions in the queue.

Steve Reynolds: Okay, thank you very much. And thank you for those again - the outstanding presentations and for all the wonderful questions and dialog.

Before we close please take a moment and we'll look at the next to the last slide. Excuse me, it's slide 43 -- the Prevention Status Reports or what we call PSRs are highlighted there for all 50 states and the District of Columbia.

The status of certain policy practices designed to address 10 public health problems including teen pregnancy can be found on our website within the PSRs. The PSRs pull together information about state policies and practices in a simple, easy to use format that decision makers can use to examine their state's status and identify areas for improvement.

There's a link directly to the 2013 Teen Pregnancy PSR. On the April *Vital Signs* Town Hall Teleconference webpage.

Or you can visit the link at the bottom of the slide to see all of the PSRs by state or topic. And finally please let us know how we can improve our teleconferences.

Email your suggestions to ostlsfeedback@cdc.gov. That's OSTLTs, O-S-T-L-T-S feedback, all one word, at cdc.gov. We hope you will be able to join us for next month's town hall on Tuesday, May 12 when we will focus on Hispanic health.

Thank you to all of our presenters and everyone who attended the conference call today. And that will conclude our call for today.

Thank you very much and goodbye everyone.

Coordinator: That concludes today's conference. All participants may now disconnect.