Doctor of Nursing Practice at The University of Texas at El Paso

COMBINATION ORAL CONTRACEPTION/COUNSELING FOR SEXUALLY ACTIVE ADOLESCENT GIRLS 12-18 YEARS OLD
PRESENTATION TO GRADUATE STUDIES COMMITTEE
JUNE- JULY, 2021

COHORT IX

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A Quality Improvement Initiative: Combination Oral Contraception and Counseling for Sexually Active Adolescent Girls 12–18 years old

Angelica del Toro

The University of Texas at El Paso
Abstract

According to the 2016 “U.S. Selected Practice Recommendations for Contraceptive Use” and the “U.S. Medical Eligibility Criteria for Contraceptive Use,” published by the Centers for Disease Control (CDC) and the World Health Organization (WHO), sexually active adolescents benefit from oral contraception and counseling from their primary care practitioners, as they already have an existing relationship. As a family nurse practitioner, I could provide an initial assessment and prescribe the appropriate contraceptive instead of referring them to a gynecologist.

I learned this in my practice during a 10-day reflective practice log. After a literature review and several supporting articles, I received approval from Dr. Yuneisy Garcia for my quality improvement project at her clinic. I received Institutional Review Board (IRB) approval from the University of Texas at El Paso (UTEP). The Doctor of Nursing Practice (DNP) project aimed to provide contraception for sexually active female adolescents and to provide counseling to reduce the risks of unintended pregnancy and contracting a sexually transmitted disease (STD).

Seven patients met the criteria and received counseling on safe sex practices. Only four patients agreed to begin oral combination contraception. Patient follow-up occurred after two weeks to determine the efficacy of the intervention and adherence, side effects, and adverse effects as well as physical exam and safe sex practices. All patients had successfully taken their combination oral contraception without issues; one patient reported not following safe sex practices as counseled.

Keywords: oral contraception, combination oral contraception, adolescents, teenagers, sexually active adolescents, pediatrics, gynecology, safe sex counseling
A Quality Improvement Initiative: Combination Oral Contraception and Counseling for Sexually Active Adolescent Girls 12–18 years old

Adolescence is a period of transition, exploration, and opportunities with a risk of unintended pregnancies and health risks associated with early childbearing and sexually transmitted infections (Oringanje et al., 2016). Teenagers with unintended pregnancies have poor outcomes for themselves, their families, and society. From 2015–2017, Martinez & Abma (2020) reported that 42% of never-married female teenagers aged 15–19 had sexual intercourse. Each year, approximately 750,000 adolescents become pregnant, with more than 80% of these pregnancies unplanned; approximately 20% of abortions are performed on adolescents (Committee on Adolescence, 2007). The most current statistics collected by the National Center for Health Statistics (2020) reveal that the cumulative probabilities of females having sexual intercourse increase continually from age 15, 17, and 20 years of age, from 21% to 53% to 79%, respectively (see Graph 1). Furthermore, Lee, Parisi, Akers, Borrero, and Schwarz (2011) and The Committee of Adolescents (2017), at the American Academy of Pediatrics, argue that prescribing contraceptive counseling in primary care and by a pediatrician is associated with a reduction in and prevention from unintended pregnancy and STDs as a result of their long-term relationship. Incidence and prevalence estimates reported by the CDC’s 2018 STD surveillance program suggest that young people aged 15–24 years acquire half of all new STDs and that one in four sexually active adolescent females currently has an STD (CDC, 2019). About half of adolescents are sexually active, 80% of whom become pregnant and 25% of whom have an STD. It is evident that despite the nation’s best efforts to prevent unwanted teenage pregnancy and safe sex practices, there is an unmet need for effective contraception for this population at the primary care level. Early identification of sexual activity in adolescent females and access to combination
oral contraception and counseling will improve quality of life by preventing unintended pregnancies and STDs.

A systematic review of 53 randomized controlled trials concluded that interventions involving a combination of education and contraception promotion were seen to significantly reduce unintended pregnancy (Oringanje et al., 2016), and the failure rate declined from 12% in 2002 to 10% in 2006–2010. The 2016 “U.S. Selected Practice Recommendations for Contraceptive Use” and the “U.S. Medical Eligibility Criteria for Contraceptive Use” published by the CDC and WHO use systematic reviews and the preferred reporting items for systematic reviews and meta-analyses guidelines to report that unintended pregnancy rates remain high in the U.S.; approximately 45% of all pregnancies are unintended, with higher proportions among adolescents and young women. Both companion documents provide evidence-based guidance to medical providers on safe and effective methods of contraception once they are deemed medically appropriate; combined hormonal contraceptives can be safely used by women of all ages (CDC, 2020).

There are various safe and effective methods to prevent pregnancy in sexually active adolescent girls. The most effective method, long-acting reversible contraception (LARC), is associated with significantly lower condom use than adolescents taking oral contraceptive pills (16.4% and 37.3% respectively), it is invasive, requires specialized training to perform and remove, and often causes bothersome irregular bleeding, requiring oral hormonal therapy (Menon, 2020). Therefore, although it is the most effective, it leaves adolescents at higher risk of contracting a sexually transmitted infection and suffering adverse events. Combination oral contraceptives are reliable, effective, and the most widely used and popular method for contraception among adolescents (CDC, 2020). Using the Translational Knowledge to Action
Framework, a gap in care for sexually active adolescent girls was identified. After reviewing the literature, it was evident that combination oral contraception and counseling are the most accessible and effective ways to prevent pregnancy and STDs in the adolescent population.

There was a perceived benefit associated with pediatricians counseling and prescribing birth control to sexually active adolescent girls, as well as having a better acceptance of the topic than they would with a gynecologist due to their long relationship. Understanding the stage of development from early to late adolescence is vital in choosing medical interventions. According to Allen (2019), during the adolescent years, the frontal lobe, which coordinates complex decision making, impulse control, and the ability to consider consequences, is continuously growing and does not mature until well into early adulthood. Therefore, teenagers do not follow-up with referrals out of embarrassment, access, and the logistics of making and keeping a doctor’s appointment, resulting in unwanted pregnancies. The long-term relationship of pediatricians with adolescents and families allows for a conversation on sensitive topics, such as contraception, allowing them to recommend the use of more effective hormonal methods, such as combined oral contraceptives, as opposed to the widely used condoms (Committee on Adolescence, 2007).

The purpose of this project was the early identification of sexual activity in adolescent females aged 12–18 years, to provide counseling on pregnancy and STD prevention, and to offer access to prescription combination oral contraception and counseling on male condom use to decrease pregnancy and STDs in this high-risk population. Additionally, it improves healthcare effectiveness and access to care by providing contraception and counseling at the primary care level, as opposed to further taxing the healthcare system and delaying care with a referral to a gynecologist.
Methods

Context

The project was carried out in a small pediatric clinic in Aventura, Florida. The patient demographics of the pediatric practice in which the intervention was carried out are as follows: ages newborn to 18 years old, Hispanic, Black, and White non-Hispanic patients. The clinic is owned by Palm Medical Centers and led by Dr. Yuneisy Garcia; the pediatrician. Most common insurance plans are accepted, as well as self-pay, and patients are seen on an appointment, virtual, and walk-in basis. The medical assistant (MA), office coordinator, nurse practitioner, and pediatrician were all part of the team who collaborated to ensure that the project was carried out safely while adhering to confidentiality and clinical best practices.

Intervention

The project was designed based on a 10-day reflection on current practice at a pediatric clinic. After a literature review on adolescent contraception was conducted, the project was reviewed and approved by the program director, chair, and co-chair. A proposal was created and presented to the collaborating physician who approved the project. Once that was obtained, the project was presented to the UTEP IRB for approval. After it was deemed a quality improvement project and without harm to humans, the project commenced. Over six weeks, females between the ages of 12–18 who were being seen in the clinic for a well or sick visit were screened for sexual activity.

On January 25, 2021, and for a month, all females aged 12–18, who were seen in the clinic for well or sick visits, were screened for sexual activity. Confidentiality was maintained by asking the parents to step out of the exam room for the interview. Once permission was provided by the patient, the parents were counseled on the importance of preventing pregnancy and STDs.
Both patients and parents were counseled on the options and efficacy of available contraceptives (Appendix, Figure 2). Counseling also consisted of STD prevention using male barrier contraception, side effects and adverse effects of using combination oral contraception, what to do for late or missed doses, and adherence. Those who met the criteria and agreed to begin contraception were given a urine pregnancy test by the MA. When a negative result was obtained, the patients were prescribed a combination oral contraceptive. Lo Loestrin Fe daily dose pack with 11 refills was the Combination Oral Contraception (COC) chosen, as it has low doses of hormones. Finally, a two-week follow-up appointment was recommended and arranged. Follow-up consisted of an assessment of blood pressure, body mass index (BMI), contraceptive side effects, satisfaction, adherence, changes to health status, medication reconciliation and patient concerns. State guidelines were followed regarding minors and oral contraceptives. The project continued for six weeks; weeks five and six consisted of follow-up appointments for those patients for which the intervention was implemented in prior weeks. Each week from one to six, data collection occurred at the end of each day. The project team met weekly and, as needed, to discuss the project’s barriers and progress. The project ended on March 9, 2021.

**Study of the Intervention**

This project used a non-experimental observational study design to assess the effect of the intervention based on a comparison of outcomes before its use and afterward. The plan, do study, act improvement model was utilized to build and guide the team, set aims, establish measures, select the intervention, and then implement worksite process changes to sustain the change in practice (Figure 5 & 6). To establish whether the observed outcomes were due to the interventions, data were extracted from the Electronic Health Record (EMR) to determine how
many sexually active patients were referred to the gynecologist at the same time a year prior, how many reported seeing the gynecologist, and how many used contraception upon follow-up.

**Measures**

The measures taken for the project were guided by the “U.S. Selected Practice Recommendations for Contraceptive Use” by the CDC. This document provides evidence-based guidance on how to use contraceptive methods safely and effectively. The CDC monitors the literature continuously for new evidence, updates systematic reviews, and facilitates recommendations, as new evidence warrants. This document details each aspect of care involved in prescribing combination oral contraception, including assessment, prescribing, and follow-up recommendations for practitioners.

**Analysis**

A summative impact evaluation of counseling and combination oral contraceptives to prevent pregnancy and STDs found that sexually active adolescent females who received counseling and prescription combination oral contraceptives reported adherence to combination oral contraception and safe sex practices when done at the primary care level as opposed to referring them to the gynecologist for follow-up. This evidence supported the clinical team’s decision to continue screening and offer birth control in the form of combination oral contraception and counseling at the clinic. When appropriate, for confidentiality issues, patients will be referred to a federally funded clinic for free or reduced and confidential reproductive health care.

**Ethical Considerations**

Confidentiality is the idea that the personal and health information a patient reveals to a clinician is private and that there are limits on how and when the information can be disclosed to
a third party. Although most adolescents aged 14–15 have sufficient cognitive capacity and emotional maturity to make health-related decisions similar to those that adults make, many state-mandated barriers exist for adolescent confidentiality and obtaining reproductive health. In Florida, minors under the age of 18 have to get a parent’s or guardian’s permission to receive a prescription for birth control unless they are married, have a parent present, have health reasons, are pregnant, or have ever been pregnant. However, those served at a federally funded family planning office, such as the Florida Department of Health, do not need their parents’ permission to get birth control (Ott, 2014). Additionally, adolescents do not require parental consent to obtain barrier methods, such as male condoms, to prevent pregnancies and STDs. Maintaining adolescent confidentiality was the only ethical concern identified in this project. It was handled by explaining it to the patient as well as to the parent. The guidelines were applied appropriately and ethically, and all medical professionals on the team worked within their legal scope of practice.

The University of Texas’ IRB determined that this project did not meet the definition of human subject research under the purview of the IRB according to federal regulations and was approved prior to commencement of the project. The proposal sections were prepared before project approval and were not included in the six-week time frame. There were minimal risks associated with the prescription of combination oral contraceptives, which were assessed for each patient before initiation. Participation was voluntary by both the patient and the parent.

Results

The project was designed based on a 10-day reflection on current practice at a pediatric clinic. After a literature review on adolescent birth control was conducted, it was discovered that the management of sexually active adolescent females could significantly improve to match the
evidence of national guidelines in the primary care setting. Over six weeks, female patients between the ages of 12–18 who were being seen in the clinic for a well or sick visit were screened for sexual activity. Confidentiality was maintained by asking the parents to step out of the exam room. Patients who verbalized sexual activity or plans to be sexually active were counseled on the need for contraception both to prevent pregnancy and STDs. Patients were then asked if practitioners could talk to their parents separately to discuss the importance of initiation of such measures. Parents were provided with the same counseling as the patient. The patient was then brought back into the room to discuss available options (Appendix, Figure 2), review the plan, and allow for questions and answers. The patient was then weighed and measured, vitals were recorded, and a urine sample pregnancy test was performed by the MA. A full medical history and exam were performed to determine contraindications or the risk of complications. Patients were prescribed a Lo Loestrin Fe daily dose pack with 11 refills. A two-week follow-up appointment was recommended and arranged. Follow-up consisted of an assessment of blood pressure and BMI, side effects, satisfaction, adherence, changes to health status, medication reconciliation, and concerns by the patient or parent. Data were collected at the end of each day for a total of six weeks to document and follow-up with each patient who received the intervention (Figure 3). The project was extended by two days due to practitioner illness; therefore, the official date the project ended was March 9, 2021.

Seven patients were assessed for contraception use and safe sex counseling. One patient, aged 16, requested a long LARC implant and was referred to the county clinic after being counseled on safe sex practices. One patient, age 15, did not want her mother to know she was sexually active; therefore, she was counseled on using male condoms and recommended following up with the county clinic for confidential, free, or reduced-price reproductive health
care. Another patient’s parents, age 16, did not want their daughter to take combination oral contraception and preferred for her to practice abstinence. Both the parent and the patient were counseled on the risks of pregnancy and STDs; the patient was told about county services. A total of four patients, aged 15, 15, 16, and 18, met the criteria and started on the intervention. Upon follow-up at the two-week mark, all participants had no changes to their physical exam and had maintained adherence to combination oral contraception. Only one of the patients reported not using a male condom or any barrier to preventing STDs during their last intercourse as counseled. This patient was counseled again on the importance of using a male condom to prevent STDs. The patient was assessed for signs and symptoms of STDs and told to return if any developed.

The electronic health record was used to collect information on the number of adolescent female patients seen for contraception at the same time last year. Data were collected for the entire month of February 2020. It was found that no patients had been referred to gynecology for contraception, and no patients had been prescribed contraception. One patient had been ordered a urine test for STDs due to symptoms. Two patients had been referred to gynecology for other medical reasons that were not related to birth control.

**Discussion**

**Summary**

The data revealed that primary care practitioners can safely and effectively prescribe a COC and provide counseling to prevent pregnancy and STDs in adolescents. When guidelines are followed together with counseling and follow-up, it is better at promoting safe sex practices and preventing pregnancy than referral to a gynecologist for the pediatric population. All patients who were prescribed combination oral contraception reported adherence to the plan and did not
have any complications. There was one patient who reported compliance with the COC; however, her partner did not use a male condom during the last sexual encounter. All patients involved in the project were adolescents aged 15–18 who received consent from their parents to receive contraceptives.

Although there were patients that could not be involved in the intervention, due to policy barriers of confidentiality for minors, they were successfully referred to a federally funded clinic that provides reproductive care to minors. Additionally, understanding the unintended consequences of prescribing first line recommendation of LARC in adolescents to mean a potential increase in STDs better prepares the primary practitioner to prevent it. Through additional education, reinforcement and monitoring the practitioner can recommend a safer option for this population such as combination oral contraceptives.

**Interpretation**

The project aimed to improve access to contraception and counseling in hopes of decreasing adolescent pregnancy and STDs. Following guidelines in primary care has profound implications for the nursing profession, as nurses, and especially nurse practitioners, are frontline healthcare professionals who play a role in ensuring evidence-based care is being delivered and care is not delayed. Referral to gynecology, as opposed to providing contraception at the primary level, adds a burden to an already overwhelmed healthcare system.

Practitioners caring for adolescents need to be actively seeking these patients and providing counseling.

**Limitations**

The project was limited by the small number of patients seen and for which the intervention was implemented. The complexity of obtaining data to determine all the patients
who were referred to gynecology was a limitation, as it was not clear in the documentation whether they had ever been prescribed birth control or if they followed up with a referral. The time frame of four weeks for the project was also a limitation. Follow-ups at two weeks are insufficient to determine long-term compliance and effectiveness in preventing pregnancy and STDs. A longer project timeline would have allowed for more data to be collected.

For the purposes of this project, counseling meant practicing safe sex practices by using male condoms with every sexual intercourse, how to use them, and monogamy. The nurse practitioner was also allotted more time than would normally be available to dedicate to assessment, confidentiality, and counseling, which may have influenced the decision to begin contraceptives and adherence once prescribed.

**Conclusion**

U.S. guidelines and evidence-based practices for prescribing contraceptives to adolescents have been used to prevent pregnancy and STDs. This project will have the greatest impact on novice and experienced family care nurse practitioners who are either not comfortable with their oral contraceptive prescribing skills or for those practitioners who are used to referring patients to gynecology for contraception and counseling. Having access to this information by practitioners would improve their confidence and, by extension, their likelihood of managing reproductive health for adolescents.

Providing contraception and counseling to adolescents increases access to reproductive health for this population as well as adds value to the practice. Although, this subject is controversial and there exists policy barriers to care, implementing this guideline in practice opens the door to early conversation about the subject. Implementation of this intervention provides patients and parents alike the time to ask questions and consider options to care before
it becomes a problem. Prior to doing this project, sexually active patients were not actively being sought to prevent pregnancy and STDs; only episodically referred to gynecology. Prior to implementing this intervention, it was not known that there was a free or reduced pricing federally funded clinic which offers confidential reproductive care to adolescents.

Acknowledgments

This project was made possible by Dr. Yuneisy Garcia, who allowed access to her pediatric clinic and patients in order to carry out the project, supervise the project, and provide all the necessary means to accomplish the project’s goals and deadlines. I thank the Paso del Norte Health Foundation Fellowship Program for their support of this scholarly DNP Project. I also deeply and sincerely thank Dr. Hector Morales and Dr. Jacob Martinez for their unrelenting efforts in providing guidance, support, and constructive advice. I could not have picked more committed and determined chairs. I thank every instructor and colleague who was at my side during this journey, and most importantly, I thank my family. Thank you for allowing me the time to accomplish this degree and and this project. My success is greatly due to my parents, Ana and Rafael Rubio, who have always believed in me; my mother-in-law, Maria de los Angeles Padron, for continuously supporting me in every way; my husband, Lazaro del Toro, for his understanding and encouragement every step of the way; and my son, Lorenzo del Toro, for his resilience.
References


Figure 2. Probability of having had sex by age 15, 16, 17, 18, 19, and 20 for females and males: United States, 2015–2017.

Notes:
- Male and female teenagers had similar cumulative probabilities of having had sex at ages 15 through 20.
- Estimates are based on females and males aged 15–24 at the time of the interview. Access data table for Figure 2 at [https://www.cdc.gov/nchs/data/ dbbriefs/db385_tables-508.pdf](https://www.cdc.gov/nchs/data/dbbriefs/db385_tables-508.pdf).
Figure 2.
Figure 3.

CONDOMS SHOULD ALWAYS BE USED TO REDUCE THE RISK OF SEXUALLY TRANSMITTED INFECTIONS.

Other Methods of Contraception:
- Emergency Contraception: Emergency contraceptive pills or a copper IUD after unprotected intercourse substantially reduces the risk of pregnancy.
Figure 4.

**Week 1**
- **01/25–01/29**
  - Assess all females, ages 12 to 18, who verbalize being sexually active. Perform a detailed medical history to determine contraindications to combination oral contraception. I will then counsel the patient and the parent, if possible, on the options and efficacy of available contraception. Counseling will consist of STD prevention with barrier contraception, side effects and adverse effects of combination oral contraception, what to do for late or missed doses, and adherence. I will then perform a urine pregnancy test, and if negative, I will prescribe a combination oral contraceptive daily dose pack with 11 refills. Last, I will recommend a follow-up in two weeks. Follow-up will consist of assessment of blood pressure and BMI, contraceptive side effects, satisfaction, adherence, changes to health status, medication reconciliation, and any patient concerns. I will follow state guidelines regarding minors and oral contraceptives.
  - Collect data at the end of each day.

**Week 2**
- **02/01–02/05**
  - Continue with week one activities.
  - Meet with the team to discuss project progress and barriers and provide answers and support.
  - Collect data at the end of each day.

**Week 3**
- **02/08–02/12**
  - Continue with week one activities.
  - Follow-up with patients seen in week one who were counseled and prescribed contraceptives.
  - Meet with the team to discuss the project's progress.
  - Collect data at the end of each day.

**Week 4**
- **02/15–02/19/19**
  - Continue with week one activities.
  - Follow-up with patients seen week two who were counseled and prescribed contraceptives.
  - Meet with the team to discuss the project's progress.
  - Collect data at the end of each day.

**Week 5**
- **02/22–02/26**
  - Follow up with patients seen week three who were counseled and prescribed contraceptives.
  - Collect data at the end of each day.

**Week 6**
- **03/01–03/05**
  - Follow-up with patients seen week four who were counseled and prescribed contraceptives.
  - Collect data at the end of each day.
  - Project data collection ends.
THE UNIVERSITY OF TEXAS AT EL PASO

DNP SYMPOSIUM
Combination Oral Contraception in Sexually Active Adolescents 12-18 years old

Angelica del Toro APRN, FNP-BC
DNP Program
05/12/2021
OBJECTIVES

• Provide background information
• Introduce the Problem
• Discuss Project
• Explain Results
• Q and A
Background Information

Pediatric Practice

RPL

PICOT questions
Combination Oral Contraception for Sexually Active Teenage Adolescents 12-18 years old compared to referring to gynecology

Literature Review
Literature Review

- Adolescent pregnancies
- STDs: adolescents
- Types of Contraception
- Guideline
15-24 year olds account for half of all new STD Infections
Figure 2. Probability of having had sex by age 15, 16, 17, 18, 19, and 20 for females and males: United States, 2015–2017.

Table and female teenagers had similar cumulative probabilities of having had sex at ages 15 through 20.

NOTES: Estimates are based on female and male aged 15–20 at the time of the interview. Access data table for Figure 2 at https://www.cdc.gov/nchs/data/hsa/hsa185.pdf.

Data: Adolescent Condom Use

24% LARC
57% Oral Contraception

CDC (2020)
Types of Contraception

Types of Contraception

<table>
<thead>
<tr>
<th>Mount Effective</th>
<th>Reversible</th>
<th>Male Sterilization</th>
<th>Permanent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implant</td>
<td>LNG - 0.2%</td>
<td>Copper T - 0.8%</td>
<td>0.05%</td>
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<tr>
<td>0.15%</td>
<td>0.5%</td>
<td></td>
<td></td>
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<table>
<thead>
<tr>
<th>How to make your method most effective</th>
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<tbody>
<tr>
<td>After procedure, little or nothing to do or remember.</td>
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<tr>
<td>Vasectomy and hysteroscopic sterilization: Use another method for first 3 months.</td>
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<table>
<thead>
<tr>
<th>Injectables</th>
<th>Pill</th>
<th>Patch</th>
<th>Ring</th>
<th>Diaphragm</th>
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</thead>
<tbody>
<tr>
<td>6%</td>
<td>9%</td>
<td>9%</td>
<td>9%</td>
<td>12%</td>
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</table>

<table>
<thead>
<tr>
<th>How to use each method</th>
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</thead>
<tbody>
<tr>
<td>Injectable: Give repeat injections on time.</td>
</tr>
<tr>
<td>Pill: Take a pill each day.</td>
</tr>
<tr>
<td>Patch, Ring: Keep in place, change on time.</td>
</tr>
<tr>
<td>Diaphragm: Use correctly every time you have sex.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mammal Condom</th>
<th>Female Condom</th>
<th>Withdrawal</th>
<th>Sponge</th>
</tr>
</thead>
<tbody>
<tr>
<td>18%</td>
<td>21%</td>
<td>22%</td>
<td>24% parous women 1.2% nulliparous women</td>
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<table>
<thead>
<tr>
<th>Least Effective</th>
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<tbody>
<tr>
<td>Fertility-Awareness Based Methods</td>
</tr>
<tr>
<td>Spermicide</td>
</tr>
<tr>
<td>24%</td>
</tr>
</tbody>
</table>

CONDOMS SHOULD ALWAYS BE USED TO REDUCE THE RISK OF SEXUALLY TRANSMITTED INFECTIONS.

Other Methods of Contraception

- Lactational Amenorrhea Method: LAM is a highly effective, temporary method of contraception.
- Emergency Contraception: Emergency contraceptive pills or a copper IUD after unprotected intercourse substantially reduces risk of pregnancy.
Data

- Sexual Activity in Adolescence
- Use of LARC
- Use of Condoms
- STDs
The Problem

1. Prescribing Contraception for Adolescents

2. Preventing STDs
Intervention

- Screening for criteria
- Assessment
- Confidentiality and Parental Consent
- Counseled on condom use and how to take the pill
- Prescribed combination oral contraception
  - LoLo Estrin with 11 refills
- Followed up with in 2 weeks
# Results

## Patient 1
Age 16, requested a LARC implant
- Referred to the county clinic after being counseled on safe sex practices

## Patient 2
Age 15, did not want her mother to know she was sexually active.
- Counseled on using male condoms and recommended following up with the county clinic

## Patient 3
Age 16, did not want their daughter to take contraception and preferred for her to practice abstinence.
- Referred to county clinic.

## Patients 4, 5, 6 & 7
Aged 15, 15, 16, and 18, met criteria and started on the intervention.

## Follow-up

All participants:
- had no changes to their physical exam
- had maintained adherence
- Only one of the patients reported not using a male condom or any barrier to prevent STDs during their last intercourse.
Implications to Practice

- Quality.
- Access.
- Prevention.


Questions
Background

Despite the prevailing myth of contraception and minors’ authority to use it over the past 10 years, one third of childbirths among women of reproductive age do not occur in a setting that is consistent with national guidelines or potential contraceptive use. The prevalence among the population of adolescents, with very high proportions among adolescents. Unintended pregnancies occur at a rate for their age and their counterparts in the United States; approximately 90%, with high proportions among adolescents. Unintended pregnancies increase the rate for their age and their counterparts in the United States; approximately 90%, with high proportions among adolescents. Approximately half of the unintended pregnancies are among women who were not using contraception at the time they became pregnant. The JPP project aims to facilitate contraception to women, refer patients, and provide counseling to reduce the risk of unintended pregnancy if the risk of unintended pregnancy is high. Preventing and counseling on oral contraception in the primary care setting, the quality of care being provided by following best practices, preventing unintended pregnancies and STDs through access and adherence to the foundation and idea that birth control is not evidence based but best practice.

Methods

Purpose

The measures taken for the project were guided by the “U.S. Selected Practice Recommendations for Contraception Use” by the CDC. The document provides evidence-based guidelines for practitioners on how to prescribe contraceptive methods safely and effectively, including how to assess potential for adverse reactions, and follow up recommendations. The CDC creates the practice guidelines for safe removal, updates systematic reviews, and facilitates recommendations, as new evidence warrant. The quality improvement project was approved by The University of Texas at El Paso’s Institutional Review Board and carried out in a small pediatric clinic in El Paso, Texas.

The patient demographics of the pediatric practice in which the intervention was carried out are as follows: ages newborn to 18 years old, Hispanic, Black, and White non-Hispanic patients. The clinic is owned by Palom Medical Centers and led by Dr. Yuneisy Garcia, the pediatrician. Three common misconceptions are accepted; as well as, every patient, and all patients are seen on an appointment, virtual, and walk-in basis. The medical assistant (MA), office coordinator, and providers were all part of the team who collaborated to ensure that the project was carried out safely while adhering to confidentiality and clinical best practices.

The Knowledge to Action Framework

1. Model for Improvement

Results

<table>
<thead>
<tr>
<th>Patient 1</th>
<th>Patient 2</th>
<th>Patient 3</th>
</tr>
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<tbody>
<tr>
<td>Age 16, required a LARC implant</td>
<td>Age 15, no LARC implant</td>
<td>Age 15, referred to county clinic</td>
</tr>
<tr>
<td>Met with team to discuss project's progress</td>
<td>Followed up with patients seen week 3 who were counseled and prescribed contraceptives</td>
<td>Collected data at the end of the day</td>
</tr>
<tr>
<td>01/25 - 01/29</td>
<td>02/15 - 02/19</td>
<td>02/22 - 02/26</td>
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Discussion

The data revealed that primary care practitioners can follow national guidelines to safely and effectively prescribe a COC and provide counseling to prevent pregnancy over the past 30 years, one third of childbearing women at risk for unintended pregnancy still do not have access, nor could they obtain a prescription for available contraception. Unintended pregnancy rates remain high in the United States; approximately 45%, with higher proportions among adolescents. Approximately half of the unintended pregnancies are among women who were not using contraception at the time they became pregnant. The JPP project aims to facilitate contraception to women, refer patients, and provide counseling to reduce the risk of unintended pregnancy if the risk of unintended pregnancy is high. Preventing and counseling on oral contraception in the primary care setting, the quality of care being provided by following best practices, preventing unintended pregnancies and STDs through access and adherence to the foundation and idea that birth control is not evidence based but best practice.

References


“The hardest thing is not to get people to accept new ideas; it is to get them to forget old ones”

—John Maynard Keynes
ANGELICA del TORO, MSN, APRN, FNP-BC

DNP Scholarly Project Chair:
Dr. Hector R. Morales, APRN, PMH/CS-BC

DNP Scholarly Project Co-Chair:
Dr. Jacob Martinez, RN

DNP Scholarly Project:
Combination Oral Contraception and Counseling for Sexually Active Adolescent Girls 12-18 years old

Abstract:
According to the 2016 U.S. selected practice recommendations for contraceptive use and the US medical eligibility criteria for contraceptive use published by the CDC and WHO, sexually active female adolescents benefit from oral contraception and counseling from their primary care practitioner/pediatrician; as they already have an existing relationship and it prevents delay in care. As a Family Nurse Practitioner, I could provide initial assessment and prescribe the appropriate contraceptive instead of referring them to a gynecologist. I learned this in my practice during a 10-day Reflective Practice Log (RPL). After a literature review and several supporting articles, I received approval from Dr. Yuneisy Garcia for my Quality Improvement Project Proposal, at her clinic. I received IRB approval from The University of Texas at El Paso. The DNP project, aimed to facilitate contraception to sexually active female adolescents and provide counseling to reduce the risk of unintended pregnancy and the risk of contracting an STD. Seven patients met criteria and received counseling on safe sex practices. Only four patients agreed to begin oral combination contraception. Patient follow up occurred after two weeks to determine efficacy of intervention and on adherence, side effects and adverse effects of oral contraceptives. These patients returned to the clinic for follow up at 2 weeks to assess for changes in physical exam, side effects, compliance with pills and safe sex practices. All patients had successfully taken their combination oral contraception without issues; one patient reported not following safe sex practice as counseled

Student Biography:
Angelica discovered her passion for patient care in 2004 after graduating from Miami Dade College and passing Florida state certification. She began working at Palmetto General Hospital while pursuing her nursing degree at Miami Dade College School of Nursing. In 2007, she graduated and passed FL boards to become a Registered Nurse. In 2008, In 2012, she enrolled in Barry Universities’ BSN to DNP Acute care program before the military moved her family to Texas. Angelica completed her MSN degree at University of Texas at El Paso and became board certified in Family Practice in 2019. Unfortunately, her and her family had to move back to Florida. She continued with her DNP program. COVID-19 created a problem in obtaining employment. In order to complete her DNP Project, from Florida, she worked with Dr. Yuneisy Garcia, in her pediatric clinic. A long commute from her home to Miami.

After graduation, Dr. del Toro, plans on opening her own nursing practice in Florida, focusing on evidence, preventative, holistic, and personalized family care.