Person-Centered Contraception Counseling for Family PACT Clients Webinar Transcript October 13, 2022

Nicole Nguyen:

Hi everyone. Good afternoon and thank you for joining us today for our webinar titled Person-Centered Contraception Counseling for Family PACT Clients. We hope you are all doing well and staying safe. My name is Nicole Nguyen, I'm the program manager of the Family Planning program here at the California Prevention Training Center. The CAPTC under contract with the California Department of Healthcare Services Office of Family Planning is sponsoring today's event and we welcome you.

Nicole Nguyen:

But before we get started, we just want to go over some really quick housekeeping slides though unless you are familiar with Go-to Webinar. So first please check your audio and select your desire setting. So you can either join through the computer audio or call in through your phone. If your internet is a little bit shaky, we highly recommend that you call in through your phone for the best possible sound.

Nicole Nguyen:

And then second, please check that you're able to see the viewer screen with the slides on the left and the GoToWebinar control panel on your right. And then there's this orange box with the white arrow in case you want to hide or show the dashboard or you accidentally clicked it, this is how you can make it appear again. And then under the audio tab, we have the option where you can change your audio preference at any time. And then of course, please submit all your questions and comments via the questions box in the chat box.

Nicole Nguyen:

Today's webinar will take about 90 minutes and will include time at the end for the presenter to answer all your questions. So send in the questions throughout the webinar and our speaker will try to address as many of them as possible. The webinar will be recorded and responses to any questions not answered today by our presenters will be sent out to participant later along with the recording and the slide deck. There is an evaluation at the end, so please fill it out when you get a chance because your feedback is really extremely important to us and help us guide us in developing our future contents.

Nicole Nguyen:

And before I introduce our presenters, I want to acknowledge that we are working with the University of Nevada, Reno School of Medicine to provide CMEs for this event. So this webinar qualifies for 1.5 CME credit and only available to those who watch the entire webinar live today. Those who watch a recording afterward will unfortunately not be eligible for the CME credit, and we will send out the link to access the certificate in the follow up email along with all the recording slides and the materials around about four weeks after the webinar ends. And our presenters have disclosed that they have the financial relationship with a commercial interest with the following entities for transparency and then anyone else involved and their partners do not have any commercial interest with the content of this activity.

Nicole Nguyen:

All right. And now we will have Dr. Policar, who is our amazing Medical Consultant who work with Family PACT for a very long time to introduce our presenters. And Dr. Policar will also be present during this

webinar as well to answer any questions related to Family PACT or the Family PACT benefits. So take it away, Dr. Policar.

Dr. Michael Policar:

Okay, great. Thanks Nicole. Thank you all for joining us. So let me start by introducing our speakers and then I'm just going to give a little bit of background information without slides about the two topics that they are going to cover. So first is Patty Cason, who is a nurse practitioner. Many of you met her a couple of months ago when she and I did a webinar for the Office of Family Planning on the new HPV immunization benefit in Family PACT. Patty is a family nurse Practitioner, Trainer, Educator in sexual and reproductive health. She's an Assistant Clinical Professor in Guest Lecture at the UCLA School of Nursing, and I'm proud to say that she is the senior author on the upcoming 22nd Edition of Contraceptive Technology, the textbook that hopefully will be out early next year. And she is the lead author and also the author of a number of chapters in CT.

Dr. Michael Policar:

She is on the Board of Directors for the ASCCP, the American Society for Coloscopy and Cervical Pathology, is on the National Medical Committee of Planned Parenthood, works with the Clinical Training Center for Family Planning in Kansas City on a number of projects related to the Federal Title10 program. And Patty was actually the person who developed the path framework and the ASA cycle for person-centered conversations that you'll be hearing about in a few moments. She also wanted me to express the fact that all of her work is sex positive, anti-racist, and very inclusive in both the teaching that she does and the care that she provides. Our second speaker is Joely Pritzker, who is also a nurse practitioner. She's a family nurse practitioner who specializes in reproductive and sexual health, has worked in a variety of clinical settings and currently practices at the Vista Community Clinic, a federally qualified health center in Vista, which is near San Diego.

Dr. Michael Policar:

In addition to her clinical work, she's a reproductive and sexual healthcare consultant and trainer and is passionate about reproductive justice. So we'll hear for them in just a second. But what I wanted to add is a little bit of historical context to the two topics that Patty and Joely are going to be talking about. The first being person-centered contraceptive counseling and the other being reproductive goals counseling. So first let me just mention a little bit of history about reproductive goals counseling because when you first heard about that maybe 15 years ago, it at that point was referred to a reproductive life plan. And that whole term came from the CDC in 2006 in their guidelines about providing what was then called preconception care. Nowadays, of course, we call it pre-pregnancy care and it was six or seven different questions about pregnancy intention that had never been validated.

Dr. Michael Policar:

So that evolved into another approach to asking about reproductive goals, which was called one key Question. You probably heard about that as an initiative throughout the State of Oregon and there were 13 or 14 different organizations that were cooperating with that. It is now instead administered by a group called Power to Decide in terms of how one key question works. And then that evolved into the gold standard, which are the path questions. And Patty and Joely are going to be discussing the path questions in great detail, how to apply them as you care for patients. So that's how we started and got to where we are now with reproductive goals counseling. The other thing I wanted to mention is contraceptive counseling because the way that historically started is it kind of has a long acronym, but it basically boils down to what you want is what you get.

Dr. Michael Policar:

People would come in and ask for a method. We as clinicians would make sure that it was safe for them to use a particular method, and that's really the method that they got. The next step, next iteration, next phase was fairly directive counseling where we would interact with a patient and then we would give the patient advice about what we thought the best method was for them. There is a good deal of research to show how ineffective that is, that if we simply give our advice without having input from the patient, a shared decision making conversation with the patient, they're unlikely to be happy with the method and continue to use it. The next step was something called informed choice. And remember in that phase what the expectation was is that you would use the tiered effectiveness chart, tier one being the most effective, tier three being the least effective, and basically tell every patient about every method. And it was a really inefficient use of time. And so now what we've finally evolved to is what we're going to be talking about today is person-centered contraceptive counseling. Great, thank you, Patty. Where the main feature is the development of shared decision making skills. And with that, I am going to pass the microphone to Patty, turn off my camera and I'll see you again for Q and A.

Patty Cason:

Okay, can everybody see the screen where it says person-centered contraceptive counseling? Tell me yes. Hello.

Joely Pritzker:

Yes.

Nicole Nguyen:

Yes, we can see it.

Patty Cason:

So, these are our disclosures, you've already seen these. Our learning objectives are basically twofold and the first you'll see is about learning and learning how to and using really effective questioning when you're having conversations with patients. And then really suggesting that you do have those conversations with patients around the reproductive desires. And also, when you do that, do that with clean language. Use language that pretty much everybody would understand, the language that you would've used before you ever became a healthcare provider. And then we're going to go into some detail about the affirm, share, ask or ASA cycles for communication with patients. And I want to say right at the outset, these the suggestions that we're going to make for you today, we are very invested in centering the patient.

Patty Cason:

I think that's the top goal for all of us. But I also want to say that these strategies we're going to talk about are meant to be efficient. We don't have a lot of time with our patients in the exam room or virtually if we're having a virtual visit. We just don't have that much time, so we've tried with everything we do with these suggestions we're going to give you today to make things efficient. Meaning that what we're going to describe should not take you longer. In fact, hopefully it would even take less time. But the goal being overall, you're going to get a lot of information about what the patient really needs, wants, cares about in a short period of time so you can help get them the services that they need. We have to help you with using the framework that we're going to be outlining today, there are a lot of job aides.

Patty Cason:

I'm not going to go through them all, but this is just a small hand card, it's two sided, you can slip in your pocket, just to remind you the actual words of the questions. The questions that are in the path framework have all been worked on iteratively for really maybe two decades. So, they are really very specific. And we would encourage you, if you're not averse to trying, we would really encourage you just to go ahead and memorize these exact questions with all the words because all the words were chosen specifically if you don't like them, once you've practiced with them, change whatever you like. And certainly, if you don't want to remember memorizing them, then that's your choice. But I would think that you would get a more efficient day at work, and you'd get really great information with these questions.

Patty Cason:

And so, I can only vouch for these. This is another job aid. This is an eight and a half by 11, what it looks like. And if you can see my picture and it's two sided. So, all of these are available. We've put them all for you available here today. And they're also available on both of the Title 10 training center websites nationally. And these are just PDFs for you to print out. And I would print them out on both sides and then laminating them is wonderful if you want to. Now, this is another tool for you to use. This is a preconception counseling checklist. Yes, Dr. Policar, the word is pre-pregnancy care now but at the time when this was developed by the training center, I developed this in conjunction with the training center, they were using nationally the word preconception.

Patty Cason:

And I'd like there are two times during this conversation today that we're going to ask you to type things into the chat so that we can get your ideas. And this is the first one. So, if you could please just type in your idea about why when you're having a conversation with a patient about their reproductive desires or about their need for family planning, contraception, why are we doing that? What is the goal of that for you? And Joely, if when you get any, please just interrupt me and we'll hear what other people have to say. When I've thought about this over the decades, I've come down to a pretty simple thing. Many of us came from a perspective of we just wanted to reduce rates of unintended pregnancy, and there hasn't been any really strong data showing that whether a pregnancy is intended or unintended has anything to do with the outcome of that pregnancy.

Patty Cason:

So that's one reason why I wouldn't have that as my goal. But I also wouldn't have, as a goal, a population level thing like reducing STD rates globally or nationally. I want to have a conversation with a patient so that they will actually have their STD rate lowered for themselves if they won't get an STD. So, this is personal care, individual care with a patient. So that's not a reason I would give for why I do these conversations, but maybe it's to help patients clarify what they want. That's the first step is helping people clarify what they want.

Patty Cason:

When Dr. Policar was talking about the menu approach where you just say to the person, here are all your options and you lay them all out, which would you like, that's not really helping them to make a decision. It's not helping them clarify what it is that they want so that you can help them to most likely approximate what they want, getting what they want. With the contraceptive method, we're going to really frame everything today around getting the contraceptive method that you want if you're the patient. So, first thing would... Yeah, go ahead Joely.

Joely Pritzker:

I was going to jump in. We're seeing a lot of that coming through the chat to provide what's best for the patient to understand their needs, to determine if they need education on contraception to get to know them better. A little bit coming in along what you said about that thought that the planning pregnancies leads to safer pregnancies or leads to better outcomes, which as you mentioned Patty, is a complex topic and we talk about actually in the upcoming addition of CT. We dive really deep into that. So, for those of you who are wanting to nerd out with us on this topic, Patty and I dive really deep into this because as Patty mentioned, it's not as simple as a planned pregnancy equals necessarily a healthier pregnancy. Though we're going to talk today about how to ask clients if they would like to have a conversation about ways to be prepared for a healthy pregnancy. Certainly.

Patty Cason:

Yeah, that's a really good phrase. Be prepared. So, we're going to try to keep that in our mind instead of using the word planned pregnancy or even intended, it's really just to be prepared. That's really our goal. Any others, Joely, before I move on with these?

Joely Pritzker:

Just helping them achieve their own goals and still some more about the avoiding unplanned pregnancy. The other thing I'll say, obviously we're all practicing in California where they're a different climate than in a lot of other parts of the country, but that we still need to be continuing to center our clients, even as we're wanting to make sure that they have all the information that they need if avoiding a pregnancy is something that's very important to them.

Patty Cason:

And when we talk about the term intended pregnancy or unintended pregnancy or unplanned pregnancy, the thing that we've been able to see in the medical literature as being the thing that's the most important determinant of whether that pregnancy's going to have a bad outcome or not, is whether that pregnancy was deemed unacceptable to the individual that's pregnant. So, if the individual determined that the pregnancy was unacceptable and presented to have a termination of that pregnancy and was turned away, that's the situation in which that person would be most likely to have adverse outcomes. So, it's really about the acceptability of the pregnancy much more than about the intent or the plan for that pregnancy. If somebody's open to pregnancy, if it's a thing that they would find acceptable, we would like to give them preconception care or pre-pregnancy care is what it all comes down to.

Joely Pritzker:

The last thing, I'll put it because I think this was interesting, somebody kind of pointed out that they want to know if somebody is in a course of relationship and that is impacting their contraception care and their contraceptive decision making. And we're going to spend a little bit of time further in the webinar talking about how do you explore what people need from their contraception depending on what's going on in their lives.

Patty Cason:

Absolutely. So, I don't know what for some reason... Okay, so what should be the focus of these conversations? We've established that we want to be able to help somebody figure out what's important to them, what they want and help them get it. So how do we do that? How do we focus that conversation? And Dr. Policar mentioned shared decision making and this is the contraception counseling definition of shared decision making. There are many situations where a person is ill and

they're having a shared decision-making conversation with their provider and there are many options for them and some of those options are way better than others, or maybe there's some options that are equal. That's a slightly different conversation because there's a lot of very strong recommendations that we would make as providers. Any of you attended the webinar on HPV immunization that a strong recommendation from us is one of the most beneficial things for somebody in terms of getting themselves protected.

Patty Cason:

So shared decision making in this context doesn't freely involve a strong recommendation on our parts. That's not part of our shared decision making for contraception counseling because we consider it to be basically a decision that is purely up to the patient and what the patient wants in terms of having children or preventing having children. So, what we each contribute to this in terms of providers and patients, the patient is the one who's really contributing their own preferences. And that's based on their values and their goals. Also, based on a lot of times their past experiences with us and with contraception also the people in their community, their friends, their family's experiences with contraception. So, they're bringing all of that into the room and that's relevant. We want to know if any of those things are going to be leading towards a decision for them about which contraceptive method or methods they would like to use or start or continue.

Patty Cason:

We're only contributing the assistance in helping them clarify what it is that they do prefer, what it is that is consistent with their values. And then we need to be able to figure out what information do they need in order to get themselves to the decision-making place that they want to be. So, if they want to decide about a contraceptive method that day, I would like to say our role is to make sure they get that information they need to make an informed choice and that's on us. We need to not only give that information in a way that they can understand it and remember it and use it when they need it to make that informed choice. And that means that information has to be relevant. And we are in a lot of ways responsible for whether the patient actually in assimilates that information, whether they take that information in, because if we give the information in a way that they can't understand, they're not going to be able to actually use that information. So that's [inaudible 00:20:05]-

Joely Pritzker:

And I want to say to what you mentioned at the beginning about efficiency. I like, for those of you who also work in pretty fast-paced clinics like I do, we don't have that much time. I wish I had 30 minutes to have these conversations with clients. And that really gets to the relevant piece. I think we've all had that experience where we're sharing information and the client just zones out and you realize I'm not giving them what they're interested in talking about today. And so, both for what the client needs, but also for us, it's a waste of our time to be talking about information that is irrelevant to clients. And so really the more we can spend time briefly at the beginning to figure out what's important to somebody, the more we are efficient with our time and what we're talking with clients about.

Patty Cason:

Yes. Can you see this picture right here? A little? So, this is the full list of contraceptive methods. And if I were to go down each single method and tell you something about all of them, that's too much information for you to be able to hold in your head. And if half of these are not relevant to anything that you're interested in, why would I waste your time and my time talking about that? So that's one of the ways it can be efficient. We're not going to delve deep into any of these, but these are just ideas about how to start the conversation. And the top two are basically introductory questions that you use just to

ask the patient about what services they may want or consider that they may need. So, the first one on the top is Meredith Mans came up with this question.

Patty Cason:

There's another here, self-identified need for contraception, the sync screening question. This is really putting the autonomy on the patient to basically say, do you want or need any services. One key question, Dr. Policar mentioned, would you like to become pregnant in the next year? Now the path questions we're going to really start to delve into now because for all the reasons we've said, and again efficiency, what you'd learn when you use these questions. The first thing we always hear is, "Wow, I got a tremendous amount of information in 45 seconds". So, the first question is, do you think you might like to have children at some point? If the persons already had a child, you put a more in there. So, do you think you might like to have more children at some point? The next question, if they have said yes or anything other than no to the first question, or if they haven't already told you the timeframe when they answered the first question, which often happens, then you ask, when do you think that might be?

Patty Cason:

And that's very specifically not giving you a specific timeframe like 12 months or any particular amount of time. It's really leaving it to the person you're asking the question, of leaving it to the patient to define what's most important to them. And about a third of people will respond to this with a timeframe, years, months, decades. And about a third of people will respond with a life event, a career move, a getting out of school, a partner returning. And about a third of people will respond with some combination of the two. If we look at the first question, you're going to see that it's not talking specifically about pregnancy, it's talking about parenting. Therefore, anybody can have this question asked of them. And I would [inaudible 00:23:17] should have this question asked of them. And as I said, each word is very, very carefully chosen.

Patty Cason:

Do you think you might allow us for the possibility that the person hasn't thought about it before? It's giving them the space and time to go ahead and think about it for a moment. It's allowing that they may not be sure, which is quite important. It's not expecting them to have an answer that's very concrete because people do not. People's reproductive desires are quite complex and quite nuanced. We focus on children because the end result of the pregnancy that might be asked about in other formats, like when you say the one key question, would you like to become pregnant in the next year, that actually is about pregnancy. So, it's focusing on the actual act of getting pregnant or being pregnant as opposed to the end goal of pregnancy, which for most people, most of the time is a child at the other end.

Patty Cason:

Whether it's a surrogacy or it's a child you want to raise, it's still a child at the other end, is for the most part because people would want to become pregnant. And then the last question is one that I must say gets left off most of the time, but it's super helpful because it actually allows the patient to verbalize what matters to them about effectiveness if they're looking for contraception. So, the last question is, how important is it to you? And this is to you. It's not how important is it for you in an objective way. It's how important is it to you to prevent pregnancy? And then until you would use, only if you didn't know anything else about what mattered to them, if you already had found out that yes, they would love a child, but they don't want to do that until they're married, then you would say, how important is it to you to prevent pregnancy until you're married again?

Patty Cason:

Can be used by men or women, anybody, any with any anatomy. Sorry, for the men or women, I'm really trying to de-gender my language, but sometimes I slip. So, the other thing is the until then can just be used as until then. So, if you know that the person does at some point in the future want a child, you can just say, how important is it to you to prevent pregnancy until then? But it's better to individualize it whenever you can. But don't forget this question, it gets left off all the time and it will give you so much information very quickly.

Joely Pritzker:

And along those lines, I'll just point out that when we ask people, ask clients how these questions land for them, when we just anecdotally, people feel like it feels very conversational, that it doesn't feel often intrusive. Specially that first question is not a medical question. And so, it both gives you that information that will be helpful for potentially a future conversation about contraception or pre-pregnancy care, which might be a more medical conversation, but it's a way to enter into it from a way that allows its rapport building while also information gathering. And so, I think that that is something that can be very helpful in our person-centered care.

Patty Cason:

And anybody who's spent any time seeing patients, which I presume most of you have, know how time consuming it is when there is not rapport and how time saving it is if there's already rapport. If your patient trusts that you're really on their side, that your motivation is to help them get what they want and help them figure out what that is and give them the information they need. The conversation is wholly different than if they think that you're trying to coerce them into doing something that you think is best for them or worse, that you're trying to prevent them from having babies that they don't really care about preventing, which is a real [inaudible 00:26:54]-

Joely Pritzker:

And someone just put in the chat, and I know you all can't see the chat. We can see what you all put in, just so you know. Somebody talked about the patient, or the client is absolutely capable of.

Joely Pritzker:

But the patient or the client is absolutely capable of having these conversations, making decisions for themselves. And I think that when we ask questions in this way, I really want to highlight that, that we are really kind of acknowledging that they are the experts on their lives. And our goal is to get information that kind of helps them achieve whatever they want for themselves.

Patty Cason:

We've just called out that this is designed for all. You can see that from the questions. You do not need to change the questions one iota for any particular demographic. The reason for doing this is so that we can really clarify what the reproductive desires are, and at the end of the day, is a pregnancy acceptable to this person at this time? That's what we really care about because if a pregnancy is not acceptable to the person at this time, then we can offer to help them prevent a pregnancy. If a pregnancy is acceptable to them at this time, and in fact they seek it, then we would like them to have a conversation about how to have a healthy pregnancy, preconception, pre-pregnancy care. And if for that person, a pregnancy is acceptable, but it's not what they really, really would love, it's not the first choice for right now, then we would offer both. So that's the only thing. Do we do both preconception care and contraception counseling, or do we do one or the other?

Patty Cason:

And obviously in some cases people will not want to have a child anytime soon but will not want contraception because maybe they aren't in a relationship or having any kind of sex with anybody with whom a pregnancy could happen. So, let's go ahead and play for a moment. We're going to assume; I'm going to stop sharing for just a moment. And what we're going to do at this point is...

Joely Pritzker:

You have stopped your sharing.

Patty Cason:

Going into a little model for you. What did you say?

Joely Pritzker:

I just wanted to let you know, your share stopped.

Patty Cason:

That's good to have that feedback. Thank you. Yeah, so we were just going to do a modeling for you about what this might look like, and you can see how quick this happens. So, I am a 23-year-old. Wait, I'm trying to think of who I'm actually being a real person. I'm a 23-year-old and I've never had any children and I don't have any medical problems.

Joely Pritzker:

All right. And we're going to imagine we've already done all the other points; we're jumping right into these questions. So, I wouldn't necessarily have this be the first thing out of my mouth if I were the provider, but there's been some segue into this question.

Patty Cason:

And segues would look like things like I have my little niece with me, and you think she's cute, and you ask me, "Well, do you think you might like to have children at some point?" Or, I have my child with me. And you might say, "Do you think you might like to have more children at some point?" Or perhaps we've just had a little conversation with some small talk, and you just say, "Would you like to have children? Do you think you might like to have children at some point?" So that's the point where I'm at in this conversation.

Joely Pritzker:

And often my segue is sometimes, especially if it's the first time I'm meeting somebody, as I'll say, "Since this is the first time we're meeting, I'm just curious and all. But Patty, do you think you might like to have children at some point?"

Patty Cason:

"Oh yeah. Yeah, definitely. In fact, we've been, I think for the last four months we've been actually not using anything."

Joely Pritzker:

"And how has that been for you?"

Patty Cason:

"It's fine. I mean, I didn't expect to get pregnant right away. I went off of the pill about four months ago. But yeah, that's fine. It's good. We're excited."

Joely Pritzker:

"That's great. So, it sounds like since you've been trying, would you like to have a conversation about ways to be prepared for a healthy pregnancy?"

Patty Cason:

"I would love that, yes." Okay. So that's the end of that one. And we're going to do one more. And now I am 21 and I have never had any children and I also don't have any medical problems. We're making them easy right now.

Joely Pritzker:

All right. "So, Patty, do you think you might like to have children at some point?"

Patty Cason:

"Yeah, definitely. I've always wanted to be a mom. It's one of the most important things to me."

Joely Pritzker:

"I can see that. I can see it's something that you're really excited about. And when do you think that might be?"

Patty Cason:

"Oh, I want to be married first. And that's definitely not happening anytime soon."

Joely Pritzker:

"Okay, gotcha. And so given that, how important is it to you to prevent pregnancy until you're married?"

Patty Cason:

"Oh, so important. Oh my God. Yeah. It's incredibly important to me."

Joely Pritzker:

"I also see that kind of just in how and in how you kind of responded to that question. So given that, would you like to talk about ways to prevent pregnancy?"

Patty Cason:

"Sure, yeah. That's one of the reasons I'm here. Yeah."

Joely Pritzker:

"Great."

Patty Cason:

Okay. And so those would be yeses. I'm going to go back to the slide for just a moment. So again, in my case, I did not tell her anything about when I might want to get pregnant in the future, when I might want to have a child in the future. I've just said I do. And then she asked me, "When do you think that might be?" And I told her when I was married, but I might have said, "Yes, absolutely. I want to be a mom someday, but I definitely want to be married first. And that's not going to happen anytime soon." So, then you wouldn't ask the question, when do you think that might be? That's just a thing you would leave out. And in general, it's all very logical. You leave out questions that don't make any sense. If you say, do you think you might like to have a child at some point? And you say, "No, never." Then you don't ask, "When do you think that might be?" Right? Because that doesn't make sense. So, this is all logical. Then very important is for "how important" question, whenever you can, individualize it based on what

that person just said to you. So, I might have said, "Yeah, no, I am not ready until I'm out of school." And then you would say, "Well, how important is it to you to prevent pregnancy until you're out of school?" Or I might have said, "My partner will kill me if I get pregnant before he returns." And then you might say, "How important is it to you to prevent pregnancy until your partner gets back?" For example. So, you saw that Joely offered me, given what I'd said about wanting to prevent pregnancy, would I like to talk about birth control options?

Patty Cason:

Now, there's one little caveat to this and I'm just going to stop sharing for a moment. One little caveat to that is what if you don't know whether they ever have sex with anybody with whom a pregnancy could occur? You may be working in a facility where you have already had a conversation or somebody who has already asked questions and that the person has sex with somebody with whom a pregnancy could happen. It doesn't matter what the gender of everybody is because we all know it just takes egg and sperm and whatever way those are getting together. So, if you know that the person has sex with somebody whenever, with whatever frequency that a pregnancy could happen, that's when you would offer a conversation around contraception. But what if you didn't know? Let's see what that would look like. So, I am 16 and I have one child.

Joely Pritzker:

All right. "So, Patty, do you think you might like to have more children at some point?"

Patty Cason:

"Yeah, I think so. Yeah."

Joely Pritzker:

"Okay. And it sounds like maybe something you've been thinking about a little bit, but I imagine with the little one at home, it's probably a lot right now."

Patty Cason:

"This is a lot. Yeah"

Joely Pritzker:

"And if you were to have more kids, when do you think that might be?"

Patty Cason:

"I want to wait until he's at least three. Okay. Maybe even four. Yeah."

Joely Pritzker:

"Yeah, I can see that you've definitely spent some time thinking about this one. Now I don't want to make any assumptions, but if right now you're having sex with anyone with whom pregnancy could happen, how important is it to you to prevent pregnancy until your kiddos a little bit older?"

Patty Cason:

"Well, yeah, I am. I mean, I see the father of the baby sometimes. And no, it's important to me right now. It's important to me."

Joely Pritzker:

"Gotcha."

Joely Pritzker:

Just some language for making... So, we talked about the first two questions you can ask of anyone without any caveats. It's just that third question, how important question that assumes that somebody is potentially having sex with someone with whom pregnancy can happen. And if you don't know the answer to that, then you can just ask, can say, I don't want to make any assumptions, but if you do, and then that gives them the opportunity to say, actually if in the case of Patty, if she was a cis woman, "Actually, I'm in a relationship with a woman right now and it's not something that I really have to worry about."

Patty Cason:

And let's do one more.

Joely Pritzker:

Sure.

Patty Cason:

So, I am a 40-year-old cis male, and I know I don't look like one, but I am. And I have two children.

Joely Pritzker:

All right. "So do you think you might like to have more children at some point?"

Patty Cason:

"Absolutely not. No. No. I mean, I love my kids, don't get me wrong, it's fantastic. But no, under no circumstances. I can barely afford the two I've got."

Joely Pritzker:

"Gotcha. I can hear you saying that you're pretty clear on being happy with the two you got and it's not in the cards moving forward. So, it sounds like it's really important to you to not have any more children, but I just wanted to make sure, it's like how important it to you is to not have a partner get pregnant?"

Patty Cason:

"Super important."

Joely Pritzker:

"Okay, gotcha. So would you like to have..."

Patty Cason:

"But what am I supposed to do? I mean, it's her choice."

Joely Pritzker:

"Yep."

Patty Cason:

"How do you stop it?"

Joely Pritzker:

"I hear that a lot from men that they feel like they don't have as many options as they'd like when it comes to preventing pregnancy. Since you're really clear on not wanting any more children, has anyone offered a conversation about permanent contraception, like vasectomy?"

Patty Cason:

"Like the snip-snip?"

Joely Pritzker:

"Yeah, the snippet of the tube so that you're, there's no sperm in the semen anymore."

Patty Cason:

So, I'm just stopping sharing for a minute. Yeah. So, we want you to see that it is one of the least utilized forms of birth control that is incredibly effective. Every man, I'm just going to use gendered language for a second. Anybody with vas deferens who has a vasectomy, nobody that person has sex with is going to get pregnant. So, it's really a multiplier effect unless the persons in a monogamous relationship, in which case it's only going to be one person that doesn't get pregnant. But that person's going to have very effective birth control. So, we really want to emphasize not forgetting to talk to male clients about permanent contraception when they don't want any children or anymore children.

Joely Pritzker:

Patty, I was going to just, before you bring up the slides, wanted to address a couple things that are coming in the chat, but then also just wanted to point out that sometimes you're pretty clear in the case of this most recent client that it's very important to them. And I think it's okay to reflect that because sometimes, based on what Patty said, if I was just like, "So how important is it to you to prevent pregnancy at this time?" It might land a little flat because based on everything that they said, I'm making an assumption, but I'm wanting to clarify that assumption without, before immediately offering permanent contraception. So, it's okay to reflect, oh, it sounds like this is really important. Is it really important to you? Just because sometimes those things aren't always congruous.

Patty Cason:

And it's funny because Joely and I have seen this so many times that the person looks and sounds like it should be important to them from the way that they're saying that they would not like to have a child anytime soon. But when you ask how important it is, they say, "Hmm, it's pretty important." You do not get the answer that you're expecting some of the time. A lot of times you do get the answer you're expecting, but sometimes you don't. And it's shocking, but just realize how important it is that you know this, if your patient's telling you absolutely, they don't want a child anytime soon and they're not really very interested in preventing pregnancy, but they seem clear that they don't want a child anytime soon, that doesn't make any sense to you unless you ask them how important is it to pregnancy? And you hear from them that it's not very important to them to prevent pregnancy, they'd be fine either way, which is a very important thing to know.

Joely Pritzker:

And then a couple things that have come in in the chat, somebody was asking about, and we'll get into this a little bit more when we talk about methods-specific counseling, but when people identify that pregnancy is totally acceptable, but also not using a highly effective method, how we have that conversation. And so, I just wanted to flag that, that's something we'll get to when we start talking about the specific methods. Somebody also mentioned that there's no teach-back opportunities in, this is an information gathering moment. Again, when we move into talking about specific methods, talking about concerns about IPV, that all comes next. This all just sets us up for how we have the next part of the conversation. Go ahead Patty.

Patty Cason:

Just that this is a way to get into the conversation that's the most relevant in a quick way. And you wouldn't use teach-back that because this part of the conversation is questioning. This is that questioning part of the conversation and using these questions are meant to help you make the conversation happen in a natural way that is also efficient.

Joely Pritzker:

Yes. And then somebody mentioned they're like, "It's not always so easy. There exists a lot of ambivalence." A hundred percent. I think we were starting just with some more straightforward examples so that you can see how it plays out. Cause sometimes it is straightforward, sometimes you do get a really clear answer. But I'm thinking, "Patty, would you be somebody who maybe is a little bit more ambivalent about pregnancy at this time?"

Patty Cason:

"Sure. I'm 23 and I have no children."

Joely Pritzker:

Gotcha. And we're going to assume that I already knew that Patty was having sex with somebody where pregnancy could happen. "So, Patty, do you think you might like to have children at some point?"

Patty Cason:

"Yeah, definitely."

Joely Pritzker:

"Okay. And when do you think that might be?"

Patty Cason:

"I would've told you when I'm 30 because that's what I sort thought I was going to be. I had an abortion about six months ago and ever since I was like, every baby I see. So, it doesn't make sense. But yeah, when I'm 30."

Joely Pritzker:

"Okay. It sounds like there's..."

Patty Cason:

"Yeah, it's hard."

Joely Pritzker:

"Yeah. So given that you're feeling kind of a lot of different feelings about this, how important is it to you to prevent pregnancy until you're 30 or several years down the line?"

Patty Cason:

"It's pretty important, but if it happened, I don't know, I might not be so unhappy. Don't tell my boyfriend."

Joely Pritzker:

"This conversation's just between us and I just want to acknowledge that that's a really common experience that people have. Our feelings about having kids aren't always, or not getting pregnant or getting pregnant aren't always super cut and dry. So given that you're feeling those different things, we

could have a conversation about ways to prevent pregnancy and also depending on what works for you, we could also talk about ways to be prepared for a healthy pregnancy if it did happen."

Patty Cason:

"Well why don't we start by talking about ways to prevent pregnancy?"

Joely Pritzker:

"Sounds good."

Patty Cason:

"Because ideally, I need some time [inaudible 00:43:38]."

There's a lot of different types of ways that people have ambivalence, as many types of ambivalence as there are people. Probably everybody has a little bit of ambivalence because the whole process of having babies is scary even if you're super excited. But I want to point out that not all ambivalence is ambivalence. And there's actually interesting and good data at this point to show that we classify things as ambivalent when they aren't actually ambivalent. They're just complex and the person may not actually have any kind of divide inside of themselves. A divide inside of myself would be, "I really, really, really want a baby right now. I really, really, really can't have a baby right now.", or, "I don't think I should have a baby right now. I'm struggling", with whatever it is.

As opposed to something you might characterize as closer to indifference, which is very commonly what is misinterpreted as ambivalence. And if a person's truly ambivalent, I'd like to spend a second just to see whether I can help them figure out where they land on that ambivalence, on this hand or on that one. But if somebody's indifferent, there's not a problem that needs to be solved, they just are fine either way or they're just, "If it happens, it happens. I'd kind of like to be surprised but it's not a really great time." There's a lot of complicated ways that people approach their feelings about having babies that don't really necessarily make sense if you're looking at it from a "Do you, or don't you?" Perspective. Cause many people don't fall in the "Do you, or don't you?".

Joely Pritzker:

Well and there's been quite a few things coming in the chat about working with teens and teen ambivalence and that sometimes it's that teens certainly don't get the sex education that they deserve, and they maybe are having unprotected sex and it hasn't happened yet. And now they think that they're infertile and they're worried about it because they don't want a baby now, but they want to have a baby at some point. And these questions can sometimes get at that.

Joely Pritzker:

They'll say, "Yes, I want a kid, not anytime soon. “How important is it to you? “Well, I kind of want to know that I can."

Joely Pritzker:

And we want to know that because that's a very different conversation than someone who's actively seeking pregnancy.

Patty Cason:

Many people do what Joely just said is not uncommon, and you've all seen it. People are sort of testing their fertility and if you don't know a lot about anatomy and you don't know that maybe you've never had sex at a time when you could have gotten pregnant, it could seem to you, "Well I've had sex, I haven't gotten pregnant, I do want to be a parent at some point. Maybe I'm not fertile." And those

thoughts may be conscious, they may be just a little bit below consciousness, but it's a lot of times it's a driver for being a little bit less conscientious about contraception as we might think somebody would be given that they don't want to be pregnant.

Patty Cason:

And I do think that we have very specific things in the ASA cycle that help you address misconceptions so that if what's happening is your patient's actually having a misconception or misunderstanding of the science about their fertility, then there're ways that you can talk to them about that that really are better than just reassuring and better than just saying, "No, no, don't worry about that." Telling somebody not to worry about something is generally not going to work anyway. Telling somebody they're wrong is tough for anybody but specifically a teen. So, we're going to talk about something called a "Yes, and..." So, you're going to find some positive ground and then add to it with an "and".

Joely Pritzker:

Two last things and then I'll get back to your slides Patty, because I know this always happens to us because you all ask such great questions, and we really want to try and engage with them as you're asking them because they're relevant to the conversation that we're having right now. Somebody mentioned that the language around, "Are you having sex with anyone with whom pregnancy could happen?" I mean it is kind of wordy. We've thought so much, if think of more succinct ways to ask that question, please let us know, because that's something that we're definitely open to.

Joely Pritzker:

But also, that if a teen doesn't really understand what that means, because sometimes, depending on their level of sexual literacy, if they are looking at you like you're speaking Greek, then you can say, "Do you ever have penis in vagina sex?" That's something actually I've learned that a lot of young people are using that language. And so that's really straightforward, instead of saying, "Are you having vaginal intercourse?" Or there're all sorts of ways we say it that sometimes people don't know what we're saying. But I think increasingly young people when they are having vaginal penetrative sex, they're saying either penis in vagina or PIV. That was new. I love young people because they constantly keep me on my toes with my language.

Joely Pritzker:

So, I was just going to mention that. And someone asked about having family planning services for trans folk. This is something we talk about in the chapter of the upcoming edition. There's some really great literature out there about this is a population that is not asked about their reproductive desires as much as they should be. And I think sometimes it's because providers, we get weird about asking questions about people having kids when maybe you don't know what their kind of reproductive status is. But the question, it can be very therapeutic to ask people who don't get this question asked of them, "Do you think you might like to have children at some point?"

Patty Cason:

You wouldn't believe the response, if the person is trans, all of a sudden you have just given them this gift instead of a trauma.

Joely Pritzker:

Because it also acknowledges that there are lots of different ways that people kind of build their families. And this is not just about whether or not you can or cannot carry a pregnancy yourself. This acknowledges that people build their families through adoption, through surrogacy, through sperm donors. There's just so many ways that people build their families, and we want to make sure people

have the information that they want and need to have the families that they want. So, I would say if you're working with trans folk, that asking these questions is really, really important as a way of acknowledging that you see them as the full complete person that they are.

Patty Cason:

And when you talk specifically around contraception, counseling, and options for trans men or gender nonconforming, but people that have equipment that they could become pregnant, actually the contraception conversation is exactly the same. All the questions we have are the same. So, you don't actually have to do anything different. Some trans patients may want to avoid estrogen containing products. So that is probably a safe assumption for a lot of people that are on testosterone. But there are guidelines. We're going to have an entire chapter in the next edition of Contraceptive Technology by incredible authors. It's a great chapter about care, contraceptive care for LGBTQ. And they've got a lot of very specific points and language, but the questions we're presenting to you today and the counseling skills, the communication stuff, it's all the same. It doesn't change. Okay. Oops, I got to fresh share my screen. All right, so we just showed you this. This is when you can reiterate a little bit of what they've said, a little bit of sort of letting them know you heard them. "I'm hearing you say, ideally you don't want any more children right now, but if you were to get pregnant, you'd be okay with that. So would you like to talk about," and essentially exactly what Jo did, an offer of contraception conversation and an offer of a preconception conversation. And we really want to focus on those words, "being prepared for a healthy pregnancy". It's just less triggering. It doesn't tell somebody that they're actually planning something that they're not actually planning for. They're just open to, or maybe they're not even open to it, but push comes to shove, it would be acceptable. So that's really our goal is to find out do they have any part of them that would make pregnancy right now acceptable? Because we want to get those people on folic acid. We want to have a conversation about teratogens that they may be taking.

Patty Cason:

Okay, so now we come to the best question about birth control itself. I will say that for the main part of my career, I always asked, "What method are you interested in?" Because that just seemed like a really patient-centered way to let the person be in control. Now, as I've practiced over 40 years, we've gotten a lot more birth control methods. So, it becomes a really unwieldy conversation if you're going to list them all. But plus, it's too many for any one person really to know all about. And you can be pretty certain, since probably all of us on this call, there's many of us who might not know every single method that's available. So certainly, our patients don't. So instead, this is a strong recommendation from researchers on contraception counseling, specifically Christine Dehlendorf, who many of you may know, she's suggesting the question, "Do you have a sense of what's important to you in your birth control?"

Patty Cason:

Okay, so it's focusing on what characteristics are you looking for? Essentially, "What are you looking for in your birth control? What's important to you about your birth control?" This question doesn't always land as well as we would've liked. This is an alternative question, "Can you tell me something that's important to you about your birth control?" Now, when you ask somebody that question, sometimes they'll tell you right away, they know something. And when you've heard what they say, you can say, "Okay, I'm hearing this, and what else is important to you? Oh, that, okay, this and this is important to you. Okay, what else is important to you?" Until you've really gotten an idea of the things that they care about. And maybe it's one thing that is the most important thing to them, maybe it's five things that they care about. Maybe the five things you can get them all in one method. Hooray. Maybe the five things you can't get all in one method. Maybe the person wants something to treat their acne and they really strongly want nothing with any hormones in it. That's not going to work. They're not going to get

both of those things in one method. So, at that point you would have to say, "Well, okay, this is something you've said you want, and this is something that you've said you want".

Patty Cason:

... point you would have to say, well okay, this is something you've said you want, and this is something that you've said you want. And you could use at that point a nice little birth control options chart at that point to say, "Well this method will give you these things that you want, and this method will give you that thing you want. Do you have a sense of what's most important to you?"

Patty Cason:

Because that's when you would have to ask what's most important because they can't have everything. But a lot of the time you can say, "Can you tell me something that's important to you about your birth control?" They'll tell you three things, and they can have all of them in one method. And that's not uncommon. So, it's really important not to say to somebody, "What's most important to you about your birth control?" That's what is the most common thing people do when they hear this question? So, I'm just anticipating that and saying just ask about characteristics.

Patty Cason:

It's the idea of not focusing or even mentioning, and I know this sounds really different than the way most people approach these conversations, but not saying anything about a particular contraceptive method until you've gotten a pretty good sense of all the things they're looking for. This is the way to save time because the list of things the person is open to, given their values, their preferences and their health is not this entire list for most people.

Patty Cason:

So almost everybody you talk to, many of these methods will be stricken from the list, they're not going to be options for that person so don't talk about them. Only talk about the things that are consistent with their answer to this question.

Patty Cason:

Okay. So now we'd like you to put in the chat and I'm going to come out again, if you could put in the chat things that you think would be important for somebody to express their opinion about if they had one. If they didn't have an opinion about it, obviously then we don't want them to.

Joely Pritzker:

And their opinion about characteristics in a method.

Patty Cason:

Yes, thank you. Characteristics. So, bleeding pattern for example. How do they feel about amenorrhea for example? So, what many times you'll say to somebody... Let's do a role play, Joely, where I don't know.

Joely Pritzker:

Okay.

Patty Cason:

So, at the point where we already know that I want birth control.

Joely Pritzker:

So, can you tell me something that's important to you in your birth control?

Patty Cason:

What do you mean?

Joely Pritzker:

So sometimes, yeah, and I know sometimes that question seems a little bit odd. Sometimes there are methods where it might change how your period comes or it might make your period lighter. There are methods that can help with acne or sort of skin stuff or any of those type of things important to you?

Patty Cason:

I don't want anything that's going to mess... I want to have a baby and I don't want anything that's going to mess with that.

Joely Pritzker:

Okay, gotcha. So, it sounds like you're not wanting a baby right now but being able to have a baby in the future is something that's really important to you.

Patty Cason:

Mm hmm (affirmative)

Joely Pritzker:

One thing I can tell you is that other than the... Pretty much all the methods, your ability to get pregnant goes back to whatever's normal for you immediately when you stop them. There's one exception, which is the depo shot, the injection, but all the other ones actually, it doesn't affect your ability to get pregnant in the future. And your ability to get pregnant goes back right away.

Joely Pritzker:

So, that leaves us a lot of great options on the table. Is there anything else that's important to you? Sometimes people want something that they don't have to think about or they're fine with taking something like a pill every day.

Patty Cason:

I'm fine with a pill every day. I've been on a pill. I take a pill every day. I do. That's not a problem for me.

Joely Pritzker:

Okay.

Patty Cason:

We're out of role play now... I'd probably take that opportunity to say, "Oh, nobody does that. You're so amazing that you can do that." Okay. So, we have in the chat some of the characteristics.

Joely Pritzker:

We do. Sometimes people are worried about weight gain, monthly periods or not, not wanting to take a pill every day, how much to remember, they need something hidden, cycles, again, side effects, something non-hormonal, parent finding out, opinions on a method or of getting their period... Period or weight gain I think are probably the two that are showing up a lot, which I think are things that show up a lot for clients as well.

Patty Cason:

Absolutely. And right. So, it's very important. Side effects are almost always in any study that they look at, side effects are really important to patients and it's really important that they feel that we are absolutely honest and clear and above board about side effects. Sadly, a lot of methods don't have that many side effects in large numbers, but still, that's very, very, very important to patients.

Joely Pritzker:

And I don't think we have this in the deck, but just language sometimes especially people will bring stuff to the table where they'll say, "Oh, my cousin gained 50 pounds with the IUD," which we know from a medical standpoint is not super common.

Patty Cason:

I'll do the [inaudible 00:59:14]

Joely Pritzker:

All right [inaudible 00:59:14]

Patty Cason:

Is that something important to you about your birth control?

Joely Pritzker:

Well, I definitely don't want something where I'm going to gain weight. Because my cousin used the IUD, I don't know which one, but used one of the IUDs and she gained 50 pounds on it. And so, I know that one's not for me.

Patty Cason:

Wow. I have not heard that before. What a drag for your cousin.

Joely Pritzker:

Yeah, she was pretty bummed about it.

Patty Cason:

Well, I can definitely tell you it doesn't happen often. I haven't heard of that before. So, this is a way of... This is a Christine [inaudible 00:59:48] suggestion of a way of not making the person feel like you're basically telling them they're dope, that nobody can gain weight from having a copper IUD. But still letting them know, "Not so much," this isn't actually a thing that we're scientifically really very worried about.

Joely Pritzker:

And you can also add, I haven't really heard of that, or I know that it doesn't happen often. I'll often add, "But everybody body is different," just as a way, an added kind of acknowledgement of whatever happened to the person, to person themselves, to the family member, to a friend was their experience. And we don't want to dismiss that. So, we can provide the information while also acknowledging that that person had a very real experience. Somebody put in the chat not wanting to touch their vagina, with the ring. Yep. [inaudible 01:00:40] huge

Patty Cason:

Very, very important.

Joely Pritzker:

Yep.

Patty Cason:

All right. Let's see if we have any others that nobody got. We've got the need to conceal contraception. And I want to say for this one it is really important if the person says that they need to conceal it from a partner or a parent, to find out how they need to conceal it. Is it they can't have supplies in their drawer in their home? Or is it that they need to pony up a regular period once a month? Somebody's checking to see how often they get their period.

Patty Cason:

So, once you find out how they need to hide it, you can help to guide to a method that's going to be consistent with that. And I find and probably you all have found this as well, a lot of times if this need to conceal is a strong need, it's going to trump all the other needs for the most part.

Patty Cason:

Non contraceptive benefits are things that your patients do not for the most part know about. So, it's very important when they're interested in a method that's in that realm of things that would have a non-contraceptive benefit. Like, they want something for their acne and they're thinking of something like a pill patch or ring. It's very important to bring up proactively the things that your birth control can do for you in addition to preventing pregnancy.

Patty Cason:

People do not know that hormonal methods of birth control prevent uterine cancer. They don't know that many types of hormonal contraception reduce the risk of ovarian cancer. These are things patients don't know and it would be very helpful for them to have that as part of their decision making.

Patty Cason:

Side effects, people mentioned. Important menstrual cycle and bleeding profiles right up at the top. Joely found that in the chat. And so, we like to not call it menstrual cycle or bleeding profile. We'll give you some other language in a moment, but if somebody hasn't brought up anything about their changing the way their periods come or what they're looking for in terms of their menstrual cycles, that's a good one to bring up proactively.

Patty Cason:

Impact on sexual life almost never gets studied or brought up, but it is something that we do know from studies matters to patients. So, this is another one you could, in some circumstances if you felt comfortable bringing up, you could bring up as well.

Patty Cason:

Effectiveness is assumed by healthcare providers to be the most important thing, above all else. It's very important for us as healthcare providers to back down from that because that's not necessarily what's important to the person who's going to be in front of you next. It may be, it often is, it's the most common characteristic that patients prioritize is effectiveness, just like we do. But it's important for us not to prioritize it unless the patient is the one who's prioritizing it.

Patty Cason:

Hormones or not, I would not bring up this one proactively. I would not say, for example, some methods have hormones in them, and some don't. I would let the person opine about what they think about that and if they haven't said anything about it, I wouldn't bring it up. And when you mention a method, like they say they'd like something for their acne and you mention these methods, pills, patches and rings, things that have estrogen in them, the person will then know that they have estrogen in them. Or for a progestin method, a progestin only method, they'll know that it has that in it because you've just told them. They may then respond to it, but at least you haven't put the idea in their head that this is something they may object to if it isn't.

Patty Cason:

Length of use. Joely and I are going to get up on a soapbox. I'm going to do it really as quickly as I can. But length of use, I'm going to ask you to think about decoupling completely from a patient's choice of birth control method, as close to completely as you can. Unless your patient says, "I want a method of birth control that is going to last as long as it possibly can. This is the thing that matters to me," well then you can say, "Well this method is good for this length of time," and you're going to look for something that is working for a long time because that's what they're asking for.

Patty Cason:

But otherwise, every single method of birth control can be used from the moment the person goes into puberty until the moment they get go into menopause, unless they have medical problems. And any method of birth control can be used. They start it today and they stop it tomorrow, any of them. So, to pin somebody down to a length of use, having anything to do with what they choose doesn't actually logically make sense. We do know that by and large, every dollar spent on highly effective contraception from a payer perspective is going to have costs, not only savings, but it's very cost effective and even saves like the payer, which in this case is the State of California, saves the payer a lot of money.

Patty Cason:

So, you cannot worry about your fiduciary responsibility with the payer and know that when you're seeing a larger volume of patients or even a small volume of patients, it'll all come out that the payer will, on every dollar you spend on effective, highly effective contraception, they will get their money's worth. So just don't worry about the payer and just think about the individual in front of you and know that if you can help them pick a method that's consistent with what it is they're looking for, they don't have to use a three-year method for three years. They don't have to only choose a five-year method if they're going to use it for five years. There should be no encouragement to use it for the maximum length of use. It's effective for as long as the person uses it up to the time when it-

Joely Pritzker:

I do want to put the caveat on that a little bit, especially since we're all family. Oh perfect. Control over removal is a good segue on this. Because sometimes specifically with family pack, there are limits on how often people can initiate a method, especially an implant or an IUD. And where it comes up sometimes is in someone's requesting a removal after a very short interval, like, they've been using it for a month or two.

Joely Pritzker:

And a lot of times providers ask, "Well how do I let them know that this, if they get it removed, it wouldn't be an option for them for another nine months or a year if they were to come back in?" Just want to throw that out. And that's information that we can say, "I totally hear that you want this

method out today and I will absolutely take it out for you today." And they'll be like, "Great. I did just want you to be aware of something which is that if you have it removed today," again with emphasizing which we'll totally do, "this particular method might not be an option for you for another year just at no cost [inaudible 01:07:04]

Patty Cason:

[inaudible 01:07:05] if there's a medical reason for removal then that waiting period [inaudible 01:07:11]

Joely Pritzker:

...or there's a pregnancy in the interim, there's lots of caveats to that. But we can present that information in a way that's still really client centered. And that might make someone sort of reevaluate their decision or it might not. But we can give that information so that clients have the information that they need.

Patty Cason:

And people often feel like it's a really patient-centered thing to encourage somebody to continue using a long-acting method like an implant or an IUD if they come in to ask to have it removed. Because, we feel like a lot of times providers feel like, they've got a great method, it's working for them. If they would just hold on a little longer, maybe their symptoms would get better, their side effects would get better.

Patty Cason:

And I just want to emphasize that across the country people are actually experiencing, patients experiencing and expressing pretty significant coercion to have their methods continue to be in their bodies after they've expressed a desire to have one of us take it out of their body. So, we want to really sort again stand up on a soapbox and say if somebody says they want a method out of their body that you put or somebody else put in there, it's not patient-centered to try to convince them to do otherwise. And we're going to show you some example [inaudible 01:08:25] conversation.

Joely Pritzker:

I was just going to say, someone put in the chat that length of use make sense in terms of patients who find it burdensome to have to go to the pharmacy. Absolutely. That's them identifying something for themselves that's important to them-

Patty Cason:

Yes.

Joely Pritzker:

...that they don't have to worry about on a daily, weekly basis.

Patty Cason:

Exactly. Absolutely. Object in the body is also something I would not bring up proactively. In other words, I wouldn't say, "Well for example, some methods we have to put into your body with a placement procedure and some we don't." I would not go there because once you have handed the patient an implant or an IUD, they will understand that it's being... Because you're going to show them where it's being placed in their body, and they will then have a response to that, or they won't. So, I wouldn't ask proactively about that. But many people may say, "I don't want anything that you're going to put in my body."

Patty Cason:

Return to fertility is a really important one and we just gave you an example of that. But that phrase, "Your ability to get pregnant goes back to whatever's normal for you." So, it's not a return to fertility, return to fecundity, it's your ability to get pregnant goes back to whatever's normal for you immediately as soon as you stop whatever this is.

Patty Cason:

We are not going through all of these because we want to get more contact for you. But please, please, please, after this webinar keep this slide and look at each one of them, see if any of these are things you might want to consider changing in terms of the words you use with your patients. Effect on the menstrual cycle or the bleeding profile instead of how this affects your period. Some methods are easier to hide than others. So, it's really just for you to have in the future. And here's some more plain language. This is called plain language. It's not medical jargon.

Joely Pritzker:

And somebody else in the chat, if somebody says, "Well what do you use?" Because that comes up a lot. And this was something that I found interesting in diving into the literature that there's been some work on this and in a nutshell-

Patty Cason:

Self-disclosure.

Joely Pritzker:

What's that?

Patty Cason:

[inaudible 01:10:26].

Joely Pritzker:

Self-disclosure. Provider Self disclosure. And in a nutshell, patients like it, and providers don't. Patients appreciate when we share some of our own personal experiences in appropriate ways and providers feel really uncomfortable doing it. And so sometimes if somebody asks me, "What methods do you use or what do you think I should use," I'll then say, "I'm happy to share that information with you and we can talk about that. But first I want to know what's important to you," and then get their information. Because maybe it lines up with something that you've used and then you're like, "Oh, based on what you've shared an IUD might be kind of a good fit given that you want something you don't have to think about and that might make your periods lighter."

Patty Cason:

But what we don't want you to be saying, 'This is the best method. I myself have one."

Joely Pritzker:

Exactly.

Patty Cason:

"It's so good I have it and so do all my friends." So that's probably not where you want to be going with that. And you probably only want to do that in response to a question. So, we're going to do another

model for you and this time I'm going to be the provider and Joely's going to have some response to Amenorrhea.

Patty Cason:

So, you'll see the language that we use and also something that we call, I referred to before as "Yes, and." "Yes, and" means I'm going to find something in what Joely says to agree with and then I'm going to build on it with science. Okay.

Patty Cason:

So, we're stepping into a conversation where she has already told me that she's interested in the contraceptive implant, and this is what we're going to have a conversation now about the bleeding.

Patty Cason:

So, most people who use this are very, very happy with their bleeding. Some people who use it... Oh I'm sorry. Most people who use it either get very little bleeding, no bleeding at all or maybe just occasional spotting, light bleeding. How would it be for you if you didn't get your period while you were using this?

Joely Pritzker:

Well, I mean my mom told me that it's not okay to not get my period. So, I think that would be kind of weird.

Patty Cason:

Yeah, your mom's absolutely right. When you're not using a method of birth control that has hormones in it's very important for you to get your period every month. I'm really glad that you know that. Knowing that, how would it be for you if you didn't get your period while you're using this? No, that's, sorry...

Joely Pritzker:

I don't really like getting my period because sometimes I have to skip school because my period's really heavy and crampy. So, I mean that sounds okay.

Patty Cason:

Wow. Okay. I'm sorry you have to deal with that. Let's do another one where you're having other objections. People who use this are really, really happy with their method usually. So, the bleeding that they have where they're using this method, most people either don't get their period at all or just some light bleeding or spotting. How would it be for you if you didn't get your period while you were using this?

Joely Pritzker:

Well, I would think I'm pregnant. I mean need to get my period to know that I'm not pregnant.

Patty Cason:

I could see how that would be concerning if you thought that you were pregnant every month. Have you ever tried anything else when you were trying to make sure you weren't pregnant besides noting that you had your period?

Joely Pritzker:

Well yeah, I mean I've gone to the store to get a pregnancy test before.

Patty Cason:

And those are really very accurate. The thing is, you don't see this but, in our clinic, everyday people come in, they think they're having their period and they're pregnant because getting your period doesn't necessarily tell you you're not pregnant because sometimes people bleed when they're pregnant. So how would it be for you if you used a pregnancy test to reassure yourself? Would that make you feel like you were not scared about being pregnant?

Joely Pritzker:

Well yeah, I mean if I had a negative pregnancy test, if it was like told me I wasn't pregnant then that might be okay.

Patty Cason:

So those are just some languages, that's just language to use part of the ASA cycle we're going to get into in a minute. But it's basically not telling her, "No you're wrong," it's telling her you're right or it's empathizing with something she said or validating something she said and then giving the science around it.

Joely Pritzker:

I want to give us a quick time check where we've got about 15 minutes until 1:30.

Patty Cason:

So, this one is another one about bleeding and very important to use.

Joely Pritzker:

Can't see your slides.

Patty Cason:

Oh well, there you go.

Nicole Nguyen:

[inaudible 01:14:54] And I also just want to remind that both of our providers have also graciously agreed to stay on for just an extra 15 minutes because we're getting a lot of really good questions coming in.

Joely Pritzker:

So many good questions.

Nicole Nguyen:

So, if you all have to make a hard stop and leave at 1:30, continue to submit your questions, we'll collect them and send it out in a later Q&A. But if you're able to stay for an extra 15 minutes and continue to ask your questions, our speakers will continue to answer as much as they can. Thank you.

Patty Cason:

So, my mom said it's not healthy to get my period, which is the thing that Joely was just talking about. Another thing you can offer is a visual aid. If the concern is about health or if the concern is about blood building up in the uterus, using a visual aid at that point... Well, you don't need to see my visual aid. But using a visual aid at that point allows you to point to the uterine lining, explain what a uterus is in very simple language very quickly and the person will understand better why it is not unhealthy. So, Joely, we're going to take [inaudible 01:15:53]

Joely Pritzker:

Yeah, so this is really just a summary of what we've been talking about that when really that shared decision-making process in contraception counseling. First is about establishing rapport, whether that's by asking the path questions, just engaging in rapport building through other ways. And then, shifting the conversation to focusing on preferences through that question, eliciting those informed preferences and potentially clarifying misinformation if needed. And then sharing information based on those stated preferences. I mean that makes it looks all nice and easy and straightforward, just one thing after the other.

Joely Pritzker:

Now if a client has expressed a strong desire for a particular method, they come in and say, "Oh I'm coming in today because I want to start on the shot." "Great. Tell me about what interests you about this method," just to make sure that they have the information that they need. And then usually I'll say something, "It sounds like you're really clear on what you want to use. Would you like to have a conversation about any other methods?" And then often they're like, "Nope, I'm good on the shot." And then you're like, "Great." We have a quick visit where I can catch up with the rest of my day.

Joely Pritzker:

So, I think we can always offer that conversation but not feeling like we need to go over every method when someone is making an informed choice about a method that they'd want to use.

Joely Pritzker:

After we go through the slide, I think Patty and I can do a quick demo of what somebody brought up in the chat, which is when somebody states things that are not necessarily, that don't go together, they say, "It's the most important thing for me to not get pregnant and I'm using withdrawal. What do we do about that?" And I think we can show kind of how you can address that.

Joely Pritzker:

I'm not going to read all of these, but these are just ways of recognizing whatever information you've gotten from the rapport building information gathering part of the conversation, and then offering the discussion of methods and getting the information. So, "I'm hearing you say that avoiding pregnancy is very important to you right now. In that case you might want to consider options that work the best to prevent pregnancy."

Joely Pritzker:

I'm offering highly effective methods because the client has identified that as the most important thing. "Like an IUD or an implant. Can I tell you more about those methods?" So, when we make an offer to talk about a specific method, we want to tie it to what the client has shared that's important to them. And that helps us avoid clients feeling like we're being coercive or putting kind of our own agenda on them because we are reflecting what they have said themselves, what's most important to them or important to them.

Patty Cason:

And I mentioned earlier that you really want to delay any offer of, or discussion of, or education around methods until you've already gotten that information about what it is that's important to them. Because once you know that that's when you go to this step. But just the one thing that happens most often in real life is that we start talking about methods extremely early in the conversation, way too early and it's

a big waste of time actually. So, we're in an effort to make the visit as patient-centered and streamlined as possible, find out as much as you can about what they want before you offer this.

Joely Pritzker:

Yes. Now Patty, before we get into the ASA cycle, a quick back and forth. Let's say you are somebody who has identified that preventing pregnancies is very important and you and your partner have been using withdrawal.

Patty Cason:

Okay. So, take it from wherever you're going to, and I'll just respond.

Joely Pritzker:

Okay. So, I heard you say earlier that when we were talking about thinking about having kids or not having kids, that it's really important to you to not have kids right now or any time soon.

Patty Cason:

Yeah, absolutely.

Joely Pritzker:

You also mentioned that you and your partner have been using withdrawal and you've been pretty happy about that. Do I have that right?

Patty Cason:

Yeah, yeah, absolutely. We've been doing it for a long time actually. We did it between our kids and we did it before we had kids. He doesn't love it. But yeah, it works really well for us.

Joely Pritzker:

Okay. And what's interesting is that we're learning that when people kind of know how to use withdrawal correctly, it actually can work pretty well, a little bit better actually than we thought than what we used to think. That said, it's not the most effective method and if 100 people were to be using withdrawal, maybe depending on how people are using it, somewhere between 5 and 15 people might get pregnant in a year. Knowing that, does change your thoughts on using that method as your primary method?

Patty Cason:

No, I think we're doing good with it.

Joely Pritzker:

Okay. It sounds like that you're pretty clear on that there are some newer methods actually that sometimes people will use with withdrawal to kind of boost how effective it is, like some new contraceptive gels. Are you familiar with those?

Patty Cason:

No.

Joely Pritzker:

Would you be interested in hearing a little bit more about that-

Joely Pritzker:

All right. Would you be interested in hearing a little bit more about those?

Patty Cason:

Yeah, yeah, sure. So, in other words, she's going to offer a second method. The thing is that withdrawal is more effective than a lot of us think, especially if the person's been using it successfully for five to seven years, so don't just assume out of the gate that it's the worst thing since sliced spread.

Joely Pritzker:

And somebody pointed in the chat, that gap between, there is a difference. There is an effectiveness difference between an implant and IUD and a pill and withdrawal. And it's not patient-centered to pretend like that's not true.

Patty Cason:

Absolutely.

Joely Pritzker:

And it's just whether or not that impacts how somebody perceives their use of the method.

Patty Cason:

I may have said to her, "We used withdrawal for 10 years. I got pregnant once. I had an abortion. It's working great for me. That's good. For me, that's good. And a pregnancy the person doesn't want and is going to terminate may not be the end of the world. This person may not want a child and it may be very, very, very important to them not to have a child, but it might be acceptable to them, we live in California, to have an abortion at some point in their reproductive life. And it's not up to us to say whether that is or isn't anything. It's just all about what matters to them about that.

Joely Pritzker:

And there's lots of conversations happening about what happens when you live somewhere where abortion is not easily accessible, and that... We can't dive into that today because there are ways to have that conversation too, in ways that are super patient-centered, but because fortunately, we all live in California and are practicing in California, we're going to focus on the fact that that is an option for people in California.

Patty Cason:

All right, drill me.

Joely Pritzker:

All right. We could spend... This slide in and of itself could be a whole hour and a half or longer training. I just want to point out that really when we're having these conversations with clients, it's really at the intersection of the individual in the systemic. And there are factors that... And when we're talking about providers specifically, there's things that happen on a provider level that do perpetuate oppression, both conscious and unconscious bias, all of that. There's what's happening at the systems level, what's reimbursed by insurances, what are things that have to happen, information that's gathered about clients and how we ask those things, and really, it's about figuring out, how do we have this interpersonal connection with clients that recognizes who they are as full, complete people, but in how they're having to navigate the individual experiences and the broader systemic factors? And sorry, I didn't realize my cat was still in here. They were hiding in the closet and just jumped up. Sorry about that. And part of how we can do that is through the ASA cycle. We've got five minutes to talk about this.

Patty Cason:

I can do the ASA cycle in five minutes.

Joely Pritzker:

All right.

Patty Cason:

Because we've really talked about a lot of this stuff already.

Joely Pritzker:

It's true, yeah.

Patty Cason:

The point of this is nothing more than to package the communication skills and the counseling skills that you already have and that we're going to suggest all into one acronym that you can remember, because you can see this is an affirm, right? It goes right into a sharing. It goes right into an asking. So, what we as providers often do is launch into long explanations and patient education content without first acknowledging something the person has said or acknowledging something about the person. And we give too much information, and then we don't ask a follow-up question, so this is just going to break that up a little bit. We want you to go ahead and do many of these repeatedly throughout the visit, acknowledge your patient, share a small amount of information that's in a way they can understand it, and then ask them a follow-up question about it.

Patty Cason:

That's all an ASA cycle is. So, the first step; affirming or acknowledging. You can either do that by a display of empathy if the person has just said something that was a feeling. You can agree with something they just said. If the person just said that they lost... Oh, they were smoking, and they finally quit, and they've been free of cigarettes for three months, acknowledge that. So, an acknowledgement of some kind or validate. I hear that all the time if they've got misinformation. I hear that all the time. I can totally see why you would think that. An empathy statement is such a simple thing to do. If a person expresses a feeling and you don't acknowledge it, that's not acceptable. They're going to feel unacknowledged. If you express a feeling, it's socially appropriate to acknowledge that feeling. It doesn't mean you have to say, "Oh, you seem really angry," and you shouldn't.

Patty Cason:

Or "Oh, you seem sad," or "You seem anxious." You just need to be generically responsive. "Wow." Just, "Wow, that must be... I can see how that would've been really hard to deal with." You just want to get the level right. Not to say, "Oh my God, how difficult that is. I feel horrible for you that you forgot your pill." You give the amount of empathy that's the same as the feeling they're having. And obviously, everyone knows not to say, "Yeah, I know how you feel." So, I said earlier the yes/and, so try not to correct. Try not to tell somebody they're wrong. Try not to say, "No, no" to them. As a matter of fact, just in the next few weeks, just do an exercise with yourself at home and with your friends and family. Anytime you're about to say no or disagree, see if you can flip it and find a yes, something.

Patty Cason:

Find something genuine that's a yes, something positive. And then, say, and instead of saying but, or anytime you're going to say but, just think, "Oh, could I just replace that with an IUD?" Because saying yes, but means no, really, if you think about it. These are just ways to validate. You're doing it all the

time anyway. "Yeah, wow." A lot of people have that question. The last three people I just talked to have the same idea, not the right idea, but it was the same one. Then, sharing information really is what we're uniquely bringing into the situation, right? They're going to get information from us that's scientific, that's accurate, and that's specifically relevant to them, not generic information you give everybody. Find out what information they need, give them their specific pieces of information that they need, a digestible amount using plain language, limiting the amount to that digestible amount, and whenever possible, using the patient's own words.

Patty Cason:

And did you see how Joely didn't say 5%? She said five out of 100. Actually, it was a different number, but that's what she used. Use visual aids as much as possible. People learn through their eyes, through their ears, through their touch. Use tactile aids. Visual aids when you're talking about anatomy, particularly. Tactile aids if anybody's going to be putting a ring in their vagina, or using a patch, or any of these methods, they really should be holding them, and feeling them, and knowing what they're about before they make a decision, particularly if you're going to be putting something in their body that they aren't going to be able to see.

Joely Pritzker:

If you're someone who does a lot of IUD removals where you're not the one who placed them, one thing you might start noticing is that people say, "Oh, I didn't realize it was that big, that's small, that flexible." And to me, that is always a sign that they didn't see it before it went in their body.

Patty Cason:

Yeah. And you can also teach what the strings feel like. You don't have to hand it to them after you've cut them, which is not the time when somebody's going to learn, right after they've had an IUD placed. Please don't ask the person to feel their own IUD strings right after you take out their speculum when you've placed their IUD, because if you have a demo unit to show them beforehand when you're having that conversation, that is the time when they can take in new information. The only other part of an ASA cycle is please, after you've given a little bit of digestible information, ask them how that information landed. "How would that be for you? Has that ever happened to you before? How did you manage it? How do you think you would manage it?"

Patty Cason:

Teach back. Very simple. We want to do it early, often, but don't make the person feel like you're patronizing them. So, you don't say, "Please tell me what I just told you." You take it on yourself. "We've got over a ton of information. I'm not always as clear as I'd like to be." Or "Just to be sure I don't forget to tell you anything, can you tell me how you're going to take generic Aleve before your period starts to lessen the bleeding that you get with the copper IUD?" This is after you've already told them about how to use NSAIDs to lessen the bleeding. And then finally, asking somebody, "Do you have any questions?" Is going to be pretty certain that they're not going to ask, because they'll feel like you're assuming they shouldn't. Asking, "What questions to you have?" is better, but it's wide open. "What questions do you have?" Well, they could ask you anything, and you really want to keep this focused conversation. So, you'd say, "What questions do you have for me about... " And then, say the thing that you just were discussing.

Joely Pritzker:

This is my number one tip for nursing students because inevitably, if you ask... I did this a ton as a new provider. "Oh, what questions do you have?" "Oh, well I tweaked my back the other day," and da, da, da. And I'm like, "I cannot help you with your back pain today." And then, it's all this whole weird song.

So, "What questions do you have about started on the pill?" Or whatever, but the "What questions do you have?" Or, "Do you have any other questions today?" Then, opens the door to having a whole separate visit that you just don't have time for.

Patty Cason:

Okay, so let's go ahead and get some questions. We have...

Joely Pritzker:

All right. We got a lot that we... that people have questions. We've answered some of them. I'm going to go... How do you talk about using withdrawal correctly, using patient-friendly language? Thoughts on that one, Patty?

Patty Cason:

You mean in terms of if somebody is using it and wanting to use it, they ask how to use it more? I don't find that people do ask about how to use it effectively. I've probably never had somebody actually ask me, but I have actually volunteered the information. This is something you're going to proactively be talking about.

Joely Pritzker:

Yep.

Patty Cason:

So, that would be a situation where you say you're using it. "Has anybody ever talked to you about the ways to do that and the way that it'll work the best for you?" Whenever you're thinking about words like effective or efficacy, thinking about working, it works the best.

Joely Pritzker:

Yep. There's also a question about depo for two years or less. It's not really a specific contraceptive counseling question, but it comes up a lot.

Patty Cason:

Right. So, I think in the interest of time, we would say that all the national guidelines and all of the professional organizations that are opining about this have come to the conclusion that there is no time limit on DNPA based on its fracture risk, because it's thought that there is not an increased fracture risk. There's only a decrease in bone mineral density, which is regained when they stop, so that is not considered to be something you have to do.

Joely Pritzker:

Yep. I'm looking through which ones we haven't asked. Someone asked about condoms and if there's updated evidence on how effective they are at preventing pregnancy as a non-hormonal method. I'm not... Go ahead.

Patty Cason:

Yeah, we're going to have a new table coming out in contraceptive technology with all the methods. We've taken every single scrap of data that was any good from every place and crunched it all together and come up... That's where we came up with these tiered effectiveness charts to begin with. So that will be coming out and I do not know whether there's any newer data on condom effectiveness. I do know that there's a huge difference between condoms where they're used appropriately, which means get the size right, do all the things we know to do with condom use, but also consider it sexuality impact,

the impact on somebody's sexuality, and suggest a small amount of lubrication in the tip of the condom that can be... it'll be surrounding the penis underneath the condom. Don't put it low down on the shaft just right up at the tip, which may make it more acceptable to the person, which means they might use it. But definitely, fit and use is critically important for effectiveness.

Joely Pritzker:

Somebody asked about weight limits and method effectiveness, and pretty much just there are methods where weight is a consideration. Certainly, the oral emergency contraception is something to be aware of, and also-

Patty Cason:

Particularly the levonorgestrel.

Joely Pritzker:

Levonorgestrel and ulipristal above a certain weight as well. Higher weight limit, but still.

Patty Cason:

So, anybody with over 25 BMI probably is not going to have nearly the effectiveness with the 11 or levonorgestrel emergency contraceptive as they will with the ulipristal acetate emergency contraceptive. By the time you get over 30, it's really not very effective at all. Ulipristal acetate is still effective, but when you get over 35 BMI, it's also becoming really increasingly less effective. We do have the copper IUD and the 52 milligram levonorgestrel IUDs, both of which are excellent as emergency contraception.

Joely Pritzker:

And then, you also have the patch.

Patty Cason:

Both patches, yeah. BMI over 30.

Joely Pritzker:

Yep, BMI. Yep, exactly. But all for with other methods, there's not weight concerns, as far as a weight limit goes. I'm seeing what else has come in. We talked a bit about ambivalence, and I think Patty meant... Because there were multiple questions about that, especially with teens. One thing we know about working with adolescents is that often, the more directive we get, the more pushback we get from them, and that's developmentally appropriate for teenagers. And so, I think the more that we can come from a place of, we're respecting their decision-making autonomy and recognizing that they may not have as much information, because they haven't had as much experience, necessarily, navigating contraceptive choices. And so, just acknowledging, "It sounds like you're really wanting something where it would work pretty well to not get pregnant, and a lot of the methods we've talked about seem weird to you," if they use that language, or whatever. And just holding space for that, and then moving on to diving a little bit deeper into it. Another thing that-

Patty Cason:

You talked about adolescence.

Joely Pritzker:

Yeah.

Patty Cason:

Did you want to say something before I said that?

Joely Pritzker:

No. Go on. I'll put my thing in at the end.

Patty Cason:

One thing is that there's a stark difference in an adolescent brain, ability to make rational decisions when they are hot versus when they are cold. So, in a cold setting, which hopefully is what's happening when they're seeing us, they can make rational decisions. They have a fully functioning cognitive processing unit up there. They should be able to do that, but they also have these wild swings of emotions which put them at risk of not making rational decisions when they are hot, but we're not seeing them then. So, we need to give them a little bit... a lot of a benefit of the doubt. And if we don't find something honestly to respect in that individual, they will know it 1,000 miles away, so you really need to just find something to respect in each patient that you see, or you won't be able to have a person-centered conversation with them, because they'll feel your judgment. The other thing... Well, I was going to bring up teen pregnancy, but never mind. Go ahead.

Joely Pritzker:

Well, what I was going to say too, this sometimes happens with the older clients, though sometimes can happen with teens as well, is the client, when they come in and you offer and you're like, "Well, would you like to have a conversation about birth control options?" "Well, I have tried everything." And sometimes, that is immediately, for all the providers here-

Patty Cason:

Oh!

Joely Pritzker:

But what I have trained myself to hear is that they have tried lots of things because they really want to find something that works for them. You don't try six different methods if it's not important to you to not get pregnant, right? And so, I think it's really important to lead from that place of, "Ugh, that sounds a huge drag and I'm really sorry that you haven't been able to find something that's worked for you." And then, not necessarily focus on all the things that haven't worked, but then say, "Well, what would you like from your birth control? What would a method that worked for you look like?" Because you don't want to spend 20 minutes rehashing all of their negative experiences with contraception. What you want to find out is, what do they want? And is there something that potentially meets that, or not? Or kind of meets it? Or whatever it is. So, that's just something that comes up a lot when we do contraception counseling.

Patty Cason:

So, you want to be sure not to brush it off. They need acknowledgement at that moment. They need to get that empathy statement about what a drag that is.

Joely Pritzker:

Yes.

Patty Cason:

Just validate what they have experienced, because otherwise, they just want to tell you about how bad all the methods are, which isn't going to get them any closer to what they want. And they may need to talk about what's bad, what happened to them that's bad. Just don't ask questions about what was bad, but acknowledge, empathize, and then give information. And then, ask a follow-up question. An ASA cycle works beautifully in that context. So, if you put together the questions that we're sharing with you and the ASA cycle, a problem like that one will just go away. You'd be amazed how many problems aren't problems when you ask these questions and use acknowledgement and follow-up questions.

Joely Pritzker:

Yeah. So, I think this was maybe regarding the table that's going to be in the new CT. Will the new table, new data, include Phexxi? Which I'm assuming yes. I hope so because I worked on that chapter. And it says the month-long patch. I'm not sure if that's referring to Twirla, to the new patch that's-

Patty Cason:

There's not a month-long patch.

Joely Pritzker:

Right. I don't know if that meant month where you use it three patches per month. So anyway, I'm not sure if they want to clarify what they were asking about with that. How about the patch for people with high or borderline blood pressure? I feel like this comes up a lot.

Patty Cason:

Yeah. So, I am an adherent to the US Medical Eligibility Criteria. I go specifically... I just plug in the numbers. If they have borderline blood pressure, I'll plug it into that. The patch is exactly the same as a ring or a pill that's combined estrogen and progestin. They all have the same contraindication. So, if you don't know about the US Medical Eligibility Criteria, there is an app, and it will just give you an answer about whether something is or is not safe. And I don't... Look it up because we only have a few minutes left, but if you go to the app store or to the play store if you have an Android, and just type in CDC, like the Centers for Disease Control and Prevention, CDC contraception, it's the only guideline in the United States.

Patty Cason:

It's all about is it or isn't it safe for somebody to use X method or Y method if they have a particular medical condition, so that's where you're going to get the definitive answer. Along with that medical eligibility criteria on that app, which is very easy to navigate and learn how to use, is a selected practice recommendation. It'll tell you treatments for bleeding, like NSAIDs and estrogen for progestin-only methods. It'll give you all kinds of good information about frequently asked questions for practice considerations.

Joely Pritzker:

So, when-

Patty Cason:

It doesn't say anything about counseling though.

Joely Pritzker:

Well, they clarified that they'd heard from patients coming from another country that they used a month-long patch.

Patty Cason:

Yeah, we used to have a month-long shot. I loved it. Patients loved it.

Joely Pritzker:

And somebody asked, "Would you recommend for patients interested in the implant but worried about possible mood or depression side effects?" I would also direct you to the US Medical Eligibility Criteria, and I'm pretty sure it's a two. It's a one or a... It's one! Thanks, Patty, for knowing that off the top of your head. So certainly, if somebody had a pre-existing depression, anxiety, any sort of mood issue, you would want to just let them know, "Check in with us if you feel like you're... ", but we'd probably tell that to anybody. But just letting them know that if they feel like their mood symptoms are changing or worsening to please check in and let us know, but there's no contraindications to use.

Patty Cason:

There are a lot of things that are not well studied. Weight gain with various progestins is not well studied. Depression with various hormonal contraceptives is not well studied. Obviously, sexual impact. But that said, the data that we have does not show an association with depression and mood, so it's... However, the data are not complete. They're not that good, just not that much. And so, when you're talking to somebody with a history, as Joely's saying, it's really important to acknowledge that this is something you want to hear about, but it's also important to acknowledge that everybody's different and that if a person's coming in and saying they have a mood change, or depression, or something that's bothering them with their... maybe they're anxious, not to dismiss it.

Patty Cason:

Just because the US Medical Eligibility gives it a one which means no restrictions on use does not mean that person's not experiencing something that is real. And even if there were not any science behind it, if a person expresses, and this is a very important foundational concept for counseling, if a person expresses a side effect or a symptom and they're experiencing it, please don't try to talk them out of it because you will not be successful. It will damage rapport potentially, and that will take longer, and they won't get what they want. So, you have to come from a place of acknowledging what their experience is first, and then moving on to the science.

Joely Pritzker:

All right. I think-

Patty Cason:

Quitting time, children.

Joely Pritzker:

Yeah. And if there was a question that we didn't... You all had so many great questions, and I really tried to make sure we got through pretty much all the questions that were relevant, but if we missed it, definitely put it in the chat and we can answer it written or put it in the questions.

Patty Cason:

And you have access to-

Nicole Nguyen:

We will collect all the questions.

Joely Pritzker:

Okay, good.

Nicole Nguyen:

Go ahead, Patty.

Patty Cason:

No, I was just going to say, you have access to the slide deck and if there's anything else that you want around this, we have a lot of videos, a lot of instructional aids, and you can go to the websites that are on those slides, and we answer the messages. We or one of our other trainers.

Nicole Nguyen:

Yes. No, I think... Yeah, no, that concludes it. I think you got through most of it too. That was such a great presentation. Patty, Joely, thank you both. And yeah, I think that concludes ours, so the survey will pop up once you exit this webinar. And we will get you the slide, the CME link, all the information in handout that Patty mentioned during the webinar, along with the Q&A. We'll collect all the questions. And thank you so much. Thank you to you both for giving this amazing presentation. The feedback has been coming in and everyone is like, "You're both amazing presenters," and they so appreciate this presentation.

Joely Pritzker:

Thank you to the people out there that we can't see, because we can't see you, but we felt the engagement through the questions, so thanks so much.

Patty Cason:

Thank you so much.

Nicole Nguyen:

Thank you all, and we wish you a great rest of your week.

Joely Pritzker:

Bye.