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Kayleigh Fischer

Washington University School of Medicine in St. Louis

Lauren S. Chernick

Columbia University

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Contraception Provision in the Emergency Department: Are We Ready to Overcome the Obstacles?

Kayleigh Fischer, MD¹ and Lauren S. Chernick, MD, MSc²

DESPITE RECENT DECLINES in birth rates, adolescent females aged 15–19 years in the United States have one of the highest pregnancy rates among industrialized nations, with the majority of these pregnancies unintended.¹ Adolescent unintended pregnancy has negative medical, financial, social, and emotional consequences for the pregnant adolescent, the child, the medical field, and society as a whole.^{2,3} Adolescent mothers have increased high school dropout rates, with only 50% achieving high school diplomas by 22 years, leading to lower lifetime income potential and perpetuating socioeconomic disadvantages.^{4–6} The children of adolescent parents have higher risk of preterm birth, higher risk of health issues, lower school achievements, higher high school dropout rates, and higher likelihood of incarceration.^{7,8} Strategies are needed to decrease unintended teen pregnancy in novel places caring for high-risk teens.

The reduction of adolescent pregnancy remains a top priority of both the Center for Disease Control and Prevention and U.S. Department of Health and Human Services.^{6,9} They, along with multiple national academies, including The American Academy of Pediatrics and the American College of Obstetrics and Gynecology, have recognized the need for increased contraceptive care, which is the mainstay of pregnancy prevention.^{10–12} Medical providers are encouraged to offer contraception to all adolescents and reduce barriers to allow increased access to effective hormonal contraception. In addition, studies involving choice of hormonal contraception reveal that long-acting reversible contraceptive (LARC) methods such as the implant or intrauterine device, which are highly effective and easy to use, are a preferred method of contraception for women aged 14–45 years.¹³ These options should be explored with teens of all ages.

Our location where adolescent do seek medical care is in the emergency department (ED). More than 18 million adolescents use EDs every year with many being underinsured and having no primary care physician.^{14,15} Previous studies have demonstrated that adolescent females who use the ED participate in high-risk behaviors, in particularly risky sexual behaviors.^{16–18} Effective birth control use is infrequent, with single center studies showing up to one in five adolescent females expected to become pregnant in the subsequent year.¹⁷ Condom use is inconsistent, increasing the risk of sexually transmitted infections.¹⁹ Furthermore, in a national study, sex without contraceptives among teens

aged 13–17 years was associated with other high-risk behaviors, such as binge drinking, depression, and conduct disorder.²⁰ Given the number of high-risk adolescents seen in pediatric EDs, it forces us to wonder if the ED should be a point of access to hormonal contraception.

In this issue of *The Journal of Women's Health*, Gutman et al. explore the reproductive health practices of the adolescent population in the pediatric ED and their desire for contraceptive counseling and initiation in this setting.²¹ They surveyed a convenient sample of 381 females aged 16–21 years in one urban pediatric ED. The authors found that 39% of participants were using contraception, with more than half (57.2%) satisfied with it. Two thirds were interested in learning more about hormonal contraception with one-third (37.5%) interested in a LARC method. More than one quarter (28%) had a history of a prior pregnancy.

The results of this study are consistent with previously published literature that the adolescent population in the pediatric ED have inadequate rates of contraception use but are interested in learning and initiating new methods. Many adolescent females who present to the pediatric ED are interested in initiation of contraception during their ED visit, particularly a LARC method.^{17,22,23} Notably, this study adds to the literature in that it highlights how many of those females using contraceptives are not satisfied with it. One reason for this might be that Gutman's population was older than those populations in other studies, with a mean age of 19 years instead of 16.^{22,23} However, given that dissatisfaction with contraception can lead to discontinuation, this further emphasizes the risk of pregnancy among the ED female population.

The gap in care for this high-risk population exposes a potentially novel access point for initiating contraception, which in turn could lower rates of adolescent unintended pregnancy. However, *should* EDs be offering contraceptive care? First, provider comfort with discussing contraceptive options varies widely; this threatens the standardization of these practices. For example, although the placement of a LARC method such as an implant is quick, which may make it an ideal method for the ED, LARC methods require training for placement and a maintenance of that training. Second, billing and insurance is a major hurdle to the provision of contraception in the ED, especially LARC methods, as many require preauthorization. Third, both parental and provider

¹Department of Pediatrics, Washington University in Saint Louis School of Medicine, Saint Louis, Missouri.

²Department of Emergency Medicine, Columbia University Medical Center, New York, New York.

acceptance of offering contraception in the ED is an area that needs further exploration, as political, social, and ethical barriers may exist. Fifth, there is currently scant literature on the implementation process of contraceptive screening and provision or on the feasibility of offering LARC methods in the ED setting other than case studies.^{24,25}

Yet, despite these barriers, the benefits to providing contraceptives are undeniable. Preventive care already occurs in the ED setting, with certain pediatric EDs implementing other public health, including screening for suicide and domestic violence. Medical directors are receptive to pregnancy prevention interventions.²⁶ If we can design novel ways to weave contraceptive provision in to the ED workflow, such as using technology or outside assistance such as health educators, we may be closer to finding the middle ground in which our female patients are receiving the evidence-based patient-centered reproductive counseling they not only need but also deserve.

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Address correspondence to:
 Lauren S. Chernick, MD, MSc
 Department of Emergency Medicine
 Columbia University Medical Center
 3959 Broadway, CHN 1-116
 New York, NY 10032

E-mail: lc2243@columbia.edu