

CDC *Vital Signs* Town Hall Teleconference

Preventing Repeat Teen Births

April 9, 2013
2:00–3:00 pm EDT

Coordinator: Welcome, and thank you for standing by. At this time all participants are in listen-only mode.

After the presentation, we will conduct a question and answer session. To ask a question, please press star 1.

Today's conference is being recorded. If you have any objections, you may disconnect at this time.

Now I'd like to introduce your host for today's conference, Dr. Dan Baden. You may begin.

Dr. Dan Baden: Thank you, Jeff. Good afternoon, everyone. As Jeff said, I'm Dr. Dan Baden. I'm the Associate Director for Field Services Outreach and Engagement at CDC's Office for State, Tribal, Local and Territorial Support. I'm glad you could join us today.

Before we get started, I'd like to go over some housekeeping details. Remember to go online and download today's presentation so you can follow along with the presentation. The website is www.cdc.gov/stltpublichealth—that's S-T-L-T public health.

There's a link directly to the town hall website under highlighted products and resources on the right side of the page.

On this page, you can also view bios for each of the presenters. I'm going to give a short intro, but you can get a lot more information on this site.

That is where we'll add the audio recording and transcript from today's teleconference as well. They should be there next week.

Today we're here to discuss the latest *Vital Signs* report on preventing repeat teen births. It's an important public health topic because teen pregnancy and birth rates are substantially higher in the US than those in other Western industrialized nations.

Nearly one in five births to teen mothers ages 15 to 19 is a repeat birth. Teen pregnancy and childbearing, especially when unintended, can carry immediate and long-term effects for teen parents and their children.

On today's call, we're going to hear from three esteemed colleagues. They'll share the latest insights regarding the prevention of repeat teen births.

First, we'll hear from Dr. Lorrie Gavin, a senior health scientist in the Division of Reproductive Health at CDC's National Center for Chronic Disease Prevention and Health Promotion. She will provide a summary of this month's *Vital Signs* report.

Dr. Gavin will then give the call over to Dr. Kristen Plastino, director of UT Teen Health and associate professor in the Department of Obstetrics and Gynecology at the University of Texas Health Science Center at San Antonio.

Dr. Plastino will share information about what UT Teen Health is doing to decrease repeat teen births, the program's accomplishments, and lessons learned.

Dr. Plastino will then turn the call over to Ms. Shelby Pons, the state director of Teen Parent Programs at the Connecticut State Department of Education.

Ms. Pons will discuss the Connecticut support for the Pregnant and Parenting Teens Project, a school-based team parenting support program for pregnant and parenting teens in grades 9 through 12.

Please note there will be time for questions after presentations today, but you can get in queue anytime you like to ask a question during the teleconference. Just press star 1 and record your name when prompted.

And now I'll turn the call over to Dr. Gavin.

Dr. Lorrie Gavin: Good afternoon. Thanks very much for taking the time to listen to our town hall today. I'm delighted today to talk about a recent CDC report that was entitled "Repeat Births Among Teens, 2007 to 2010," that's on slide 4 of your slide deck.

I'm going to move to slide 5. I have two main objectives for today's talk. I'm going to briefly remind us why we care about teen pregnancy. And, second, describe the recent CDC study on repeat teen births and postpartum contraceptive use.

On slide 6 is a summary of why we care about teen pregnancy. Approximately 750,000 teens 15 to 19 years of age become pregnant each year.

And in 2010, about 365,000 gave birth. That translates into 1,000 teens giving birth every day. Rates in the US are much higher than in other developed countries and the costs are high, yet we have several highly effective interventions and the potential to substantially reduce teen pregnancy rates. As a result, CDC has designated teen pregnancy as a winnable battle.

On slide 7—now I'm going to switch to description of our recent study. It examined repeat teen births, which we defined as a teen who's had two or more pregnancies resulting in a live birth before she turns age 20.

The study was designed to answer three main questions. What number and percentage of teen births are repeat births? What are the patterns of repeat teen births by race, ethnicity, by state, and over time? What are the patterns of postpartum contraceptive use among teen mothers by sociodemographic characteristics and by state?

Next slide, we use two types of data. The first was birth data from the National Vital Statistics System. Birth data is compiled annually from all 50 states and the District of Columbia and includes demographic information, so we could look at birth to teens to 19 years of age and also by live birth order.

We excluded births for which information about birth order was not available.

We also used the data from the Pregnancy Risk Assessment Monitoring System, known as PRAMS. In this surveillance system, women are sampled from the birth file and interviewed two to six months after giving birth.

They're asked a series of questions about their attitudes and experiences before, during, and after the most recent live birth.

Next slide: for this study we used PRAMS data from 15 states and New York City over the period 2007 to 2010 and aggregated data across that four-year period.

Responses to the following questions were analyzed. Are you or your husband or partner doing anything now to keep from getting pregnant? If yes, what kind of birth control are you using?

We coded the data about contraceptive methods in a manner that's based on how well the contraception prevents pregnancy during typical use.

Most effective methods included tubal ligation, vasectomy, implant, and IUD. Moderately effective included pills, shot, patch, and ring. And the least effective were condom, diaphragm, cervical cap, sponge, rhythm, and withdrawal.

I want to make a few notes about the coding. If the teen mother said that she was using more than one method, we categorized it according to the most effective method.

Also the diaphragm, cap, and sponge were listed as a single response option on the questionnaire, so we could not distinguish between them.

I'm now on slide 10. A key finding is that in 2010, of more than 365,000 teen births, 18.3% were repeat births. Most were for a second child, but 15% were in teens giving birth to a third to sixth child.

The percentage of teen births that were repeat declined 6.2% over the four years of the study. And the percentage of teen births that were repeat vary by

race ethnicity as shown on this slide, with the highest percentage in American Indian and Alaska Natives and the lowest in non-Hispanic whites.

Next slide: there is also substantial variation by state with the percentage of all teen births that were repeat ranging from 10% in New Hampshire to 22% in Texas.

In eight states, more than 20% of all teen births were repeat. And in seven states, less than 15% were repeat teen births. Those are the ones marked in yellow.

Now, I'm going to switch to results from the PRAMS data on postpartum contraceptive use, and I'm on slide 12.

A major finding is that the vast majority of teen mothers, more than 90%, were using contraception. This is good news.

Of these, however, only 22% used the least effective methods, 54% used moderately effective methods, 15% used less effective methods, and 9% used no method of contraceptive at all.

On slide 13, you'll see which types of methods were most commonly used. Within the most effective category, the IUD was used much more frequently than implant and sterilization.

Within the moderately effective category, the pill and shot were most common. And within the least effective category, the condom was most frequent.

On slide 14, you'll see the patterns of postpartum contraceptive use by state, where we saw a wide variation of the percentage of teen mothers using the most effective methods. The range was from 7% in New York State to more than 50% in Colorado at the bottom of the slide.

An additional point on variations that's not in the slide—but I wanted to mention—are variations by race/ethnicity. Non-Hispanic blacks were half as likely to use the most effective methods compared to non-Hispanic whites and Hispanic teen mothers.

I'm on slide 15. The study has several limitations. We had no information about the correctness and consistency of contraceptive use. Findings may not be generalizable to other states. Data were aggregated over several years and may therefore mask temporal trends.

Further, some states only had data from 2007 and/or 2008. And subsequent improvements may have occurred that we were not able to capture in the study. Finally, the data sources examined births rather than pregnancies.

On slide 16, despite these limitations, we think the study has several important findings and implications. One in five teen births is a repeat birth. Many teens are taking steps to prevent a repeat pregnancy and we need to support those efforts, but only 22% were using the most effective methods of contraception.

Efforts to support pregnant and parenting teens should include counseling about birth spacing and providing or offering contraception, including IUDs and implants. And, also, linking teen parents to home visiting programs, as well as other evidence-based programs that decrease sexual risk, repeat teen births, and provide needed support.

Finally, more research is needed to understand reasons for the wide state variation in postpartum use of the most effective methods and reasons for lower use of the most effective methods among non-Hispanic blacks.

Slide 17 is the last slide, and a big thank you to you all for listening to our presentation. And, with that, I'm going to hand it off to Dr. Kristen Plastino from the University of Texas in San Antonio.

Dr. Kristen Plastino: Thank you very much Dr. Gavin. Can you hear me?

Dr. Lorrie Gavin: Yes.

Dr. Kristen Plastino: Great. I want to first thank you Dr. Gavin as well as my project officer, Trish Mueller, for inviting me to speak today. I'm going to move on now to slide number 19 in the slide deck.

I am from San Antonio, Texas. And we have a program here that is funded by the Office of Adolescent Health (Health and Human Services) and the Centers for Disease Control and Prevention to implement a community-wide, teen pregnancy prevention initiative.

And this is focused specifically on the south side of San Antonio with our catchment area defined by school district lines.

The school districts we are within are Southwest, South San, Southside, Somerset, and Harlandale.

Now, even though we've described—our catchment area is described by these district lines—it doesn't mean we just work with the schools.

We're working with all of the community-based, youth-serving organizations within that catchment area.

Our goals are to decrease the teen birth rate by 10%, as well as decrease the repeat teen birthrate by 10%, and mobilize the community in sustained teen pregnancy prevention beyond the end of this cooperative agreement, which is beyond the year 2015.

Moving to slide 20, the way we're going to decrease this repeat teen births and initial teen birthrate is utilizing five main components.

We're looking at having community mobilization. And we have started a community action team, a core partner team, as well as a youth leadership team. We can't forget to make sure our youth are engaged in this teen pregnancy prevention effort.

The second component is utilizing evidence-based programs. And we've pooled our evidence-based programs that we are using from the list from the Office of Adolescent Health website that have been shown to change behaviors.

We're also looking at linking teens to clinical and preventative services. So this is not just for reproductive health but really for preventative health services.

The fourth component is educating stakeholders, and, for us working at UT Health Science Center, it's non-elected officials.

So, for instance, superintendents, the head of the health department in San Antonio, hospital administration—those are the key stakeholders that we're trying to educate on this initiative.

And then, finally, working with a diverse community is very important. In our catchment area, we have some areas that are over 97% Latino. And it is very important that we remain culturally competent with our population.

Moving to slide 21, you'll see that the US teen birthrate, as we know, has declined for the second year in a row to 39.1 births per thousand.

And this is again based on 2009. But Texas still ranks fourth in the highest proportion of these teen births.

In 2008, the latest data that I had, the girls age 15 to 19 had a birthrate of 64.6 per thousand in San Antonio.

And when you look specifically in our catchment area, it was 99.2 births per thousand, so really about double what the Texas average was.

Slide 22. Now let's talk specifically about repeat teen birth rates. Now, Dr. Gavin just enlightened us with the new 2010 data, which showed that 18.3% of teen births in the US were repeat births, which is down from 19% in 2009.

Now, the data I'm going to show in the next three bullets is actually from the 2008 and 2009 data that we had.

Texas has the second highest proportion of teen births, at 22%. And San Antonio has a 24% repeat teen birth rate.

But in our catchment area, again in South San Antonio, it's even higher at 25% of girls experiencing repeat teen births.

So, what did we do to try and decrease this significant amount of repeat teen births? Well, as we move to slide 23, you'll see that the first thing we did was partner with an organization called Nurse Family Partnership (NFP).

There are two Nurse Family Partnerships in San Antonio, one with the children's shelter, and one with our hospital system, University Health System.

Nurse Family Partnership is a home visitation program that is for first time Medicaid eligible moms.

What's unique about Nurse Family Partnership is that it utilizes registered nurses as being the home visitor.

And they have good evidence to show many different outcomes, but let me just give you a few. They increase breast feeding, they have a decreased rate of prematurity in their clients as well as decreased low birthrate, and they do have a decrease in their repeat births.

What we did was the partnering with this NFP program was we began to provide informal linkages between our community youth serving organizations and NFP.

We basically began to advertise for this evidence-based program with such great outcomes. Now remember the CBYOs, or the Community Based Youth Serving Organizations, include the schools.

We also provided these nurses with best practice updates. For instance, long acting, reversible contraceptives that it was okay to use an IUD in a teen, that teens really did not need a pap smear when they were under 21 years old. And so these practice/best practice updates were given to the clinicians.

We also then helped to allow peer-to-peer health seminars where basically other teen parents began to educate new teen parents coming into the program on things such as refusal skills, goal setting, talked about coercion.

And the peers or the teens actually came up with these programs themselves, thinking what did they really think they needed to hear when they were first starting out his teen parents?

And then finally with NFP, we helped to build networks to provide condoms to the clients that needed them.

So in San Antonio there is some other federally funded programs that are specifically for HIV and STD prevention that were providing condoms to different areas in San Antonio. And we helped to link their clients to these programs to be able to get the condoms.

Other partnerships we'll look at, on slide 24, were the community colleges. Here in San Antonio, the community colleges do not have student health services because of the lack of funding.

So where do these college students, or as we know the highest population of unintended pregnancy 18- and 19-year-olds, how do you link the students to local clinics?

And so we started looking at getting peer educators on these college campuses so that they could link students to the local clinics.

With regard to the hospitals, a nurse liaison was hired to do rounds on all of the postpartum patients. So teen patient delivers, this nurse would see them after they deliver to discuss contraceptive methods, schedule appointments for their follow up postpartum visit, or to get their contraceptive method placed, or they would leave the hospital with a contraceptive method because she had counseled them on it.

And so they might get a shot of the Depo-Provera or the Medroxyprogesterone acetate.

She would also then do follow-up calls at two and six weeks with the client to see if they were able to continue their contraceptive method and if not, what she could do to link them to clinical services.

We also partnered with the WIC clinics, Women, Infants, and Children clinics, to help ask intake questions to get clients referred to clinical services.

So for instance, the question would have been do you want to have more children? And if the answer was no they would give them information to go to a clinic nearby, or yes we do want to have more babies.

Well, did you know that spacing your babies is healthier for you and the baby? And here's a clinic we can get you to for some preventative care?

Finally juvenile probation, we developed a really great relationship with them because they had many programs in and out where grants ran out. It wasn't a sustainable program. One-time programs here and there.

And they were really looking for a long-term teen pregnancy prevention model that could be sustained, and so we help them to implement evidence-based curriculum to basically hit all 5,000 of their probationers.

So on slide 25, we can talk about the accomplishments we've had. We are currently in grant year three of five.

We have accomplished having school board approval of an evidence-based curricula in all the area high schools. In all those area high schools, the five districts I had listed earlier serve pregnant and parenting teens.

With Nurse Family Partnership in 2012, of the 48 teens that entered the program our organization was able to collaborate with schools and other community-based organizations to really provide 32 of those 48 teens that entered that evidence-based program.

The nurse liaison at the hospital, that was seeing the patients after they delivered and getting them linked to a contraceptive method, saw 155 postpartum patients and of which that 62% received an IUD, implant, or an injection as a method.

Now I know when Dr. Gavin was talking she said that the injection was kind of the medium-range effectiveness for contraception and that's because you have to go back every three months and get it.

But for us the reason we consider that a success with that 62% is because they would get that injection before they leave the hospital.

And then we had three months to find funding or some type of way to get them the contraceptive method without them getting pregnant in those three months immediately postpartum.

Finally, UT Teen Health educated over 300 probation department staff members in just a basic sex 101 talk.

And that included anatomy, adolescent reproductive health, STDs, contraception, and how youth get to clinical services when they're in custody.

Slide number 26 looked at Nurse Family Partnership with regard to what lessons we learned. One thing we learned was after we gave all these great evidence-based practices to the nurses that were going in the houses they started to update their clients.

And then they started following up to see, you know, were their clients getting these LARCs, or long acting reversible methods?

Well they found out they weren't. Many of these OB/GYN physicians were saying, "Yeah, yeah we'll talk about contraception later."

So what they did was we decided to make a letter so that the client would be able to hand it to their OB/GYN that basically had on there, "Dear doctor, this is a contraceptive method I want postpartum." And we really promoted LARCs.

With the community colleges, we had these peer educators going into freshman 101 classes and telling what services were available and where students could go.

But what happened was the students weren't going. And so after looking back and assessing what was happening, we realized that the freshman did not want that huge group being presented to about such sensitive topics.

They wanted more intimate one-on-one time to be able to talk about clinical services and what was available.

And the college student suggested that we go to doing this during like volleyball games and different intramural activities, as well as putting information in the bathrooms.

With regard to the hospital with our postpartum educator, it was great. We got the doctors writing for Depo-Provera before the patient was to leave.

But then the nurses, as we became a more breastfeeding-friendly hospital, didn't want to give it to the patient because they felt it was going to decrease their breastfeeding efficacy.

And so ensuring that evidence-based practice was done, and knowing that Depo-Provera did not decrease breast milk supply or the initiation of breastfeeding, allowed us to ensure that patients were getting the Depo before discharge.

With regard to the WIC clinics on slide 27, when we started first talking to the WIC clinics, they were like, "Oh the state won't let us do it, you know, the state tells us exactly what we're allowed to say during these visits."

So we went to the state WIC and basically presented it to their administration and they gave us the go to pilot this in San Antonio. So instead of just saying, "Oh, we can't do it at WIC," we just went to the next level.

Juvenile probation has been really interesting and great to work with because probation officers play such a vital role with these youth that are in custody that we wanted to make sure those probation officers knew where can kids get preventative care?

Where can they get immunizations? Where can they get sexual health taken care of? And so, we needed to equip them with those resources.

So we've had a lot of conversations and discussions with this department to ensure that these people were equipped with what they needed to be able to link teens to adolescence sexual health or reproductive services.

So with that, I'm going to turn it over to Ms. Shelby Pons.

Shelby Pons: So my first slide that I'm going to talk about is, it doesn't have a number on it's called Bringing Systems Together.

And the Connecticut State Department worked to put the project together with the Connecticut Department of Public Health and Social Services, and the Hispanic Health Council, and a Capital Region Education Council, which is ARESC in Connecticut.

The Department of Ed served as the lead in the fiduciary of the program. It worked together with the Department of Public Health and Social Services to support staff coordination efforts in these targeted communities.

In this way it provided for an evidence-based core service in the mainstream-school setting that was less costly, reach more students, and provided access

to educational health financial self-service opportunities while avoiding duplication of standalone, often underutilized, and hard-to-find services.

Fatherhood Initiative provided services specifically targeting teen fathers. This included a focus on co-parenting skills, and increasingly, the ability of dad's to meet the financial and medical needs of their children through workforce development training, employing of services, child support, and other parenting measures.

The Hispanic Health Council provided cross-cultural training using its cross-cultural diversity and inclusiveness training curriculum.

The Hispanic Health Council also hosted a statewide website for available services for pregnant and parenting teens.

The Department of Ed also worked with the Nurturing Family Network to collaborate to provide comprehensive home visiting to identified expectant parenting teen mothers and fathers, with twice a month home visiting using evidence-based curriculum to support healthy parenting and co-parenting relationships.

I'm going to move to the next slide which is demographics.

School districts with the highest teen birth rate and high school dropout rates where the proposed target areas.

In 2010, the Department of Education worked with the Department of Public Health to conduct an analysis of the data that identified the geographic areas that would best be served by this project.

The Connecticut data indicated that there was a high correlation between teen birth rates and school dropout rates. The relationship was most predominant in Connecticut's five largest cities—New Britain, Hartford, Bridgeport, Waterbury, and New Haven.

The table shows the percentage of births to teen mothers and the school district's cumulative dropout rate.

The latter represents the annual loss of students who started at ninth grade and left before finishing four years. These data points are compared to the state mean.

Here are two data reports that 273 students were served—92 teen mothers, 142 pregnant teens, and 39 teen dads.

Currently, all programs are at capacity for services to expectant and parenting teen mothers, however work must be done to reach more teen fathers.

The current policy support services for teen fathers in rural and comprehensive high schools. This policy prevented programs from servicing fathers who had dropped out of school or who are attending adult education or alternative education opportunities.

The goals of this program were to improve the education health and social outcomes for expectant and parenting teens to promote healthy child development for the children of expectant and parenting teens, and to educate teen parents about the services that are available to support their education, graduation, health, and parenting skills.

The purpose of the project was to develop school-based, teen parent support programs.

These programs, we felt, were important to be in the schools because in these schools there was no natural advocate for the teen parent.

It would support these teen parents in grades 9 through 12 with the primary purpose to improve the student success as measured through high school completion and the health and wellness outcomes of the students and their children.

Each school-based program has a team of professionals. It hires one full-time social worker, a part-time registered nurse, and a full-time Nurturing Families Network home visitation caseworker.

These school-based professionals service the advocates for expectant and parenting teen students by providing and/or linking to the identified core services through the development of individualized service plans.

The local school-based teams of professionals embrace the seamless approach to services that extend beyond the school day or year providing summer education, credit recovery opportunities, transportation, and child care.

This allows for a creative approach to providing this vulnerable population with individualized, focused, medically accurate, and culturally competent services.

These school-based professionals serve as the advocates for the expectant and parenting teens by providing and/or linking to the identified core services through the development of these individualized plans.

The home visitation is provided through the Department of Social Services Nurturing Families Network (NFN). It's an evidence-based, home visiting model that creates passive change in families to promote positive parenting and reduce incidence of child maltreatment and trauma.

The rate of child abuse and neglect among families helped by NFN is approximately 2% compared to approximately 20% in vulnerable populations that don't get home visits.

One of Connecticut's programs reported that out of 44 students who have been served in the program 36, which is 81% of them, have experienced some sort of trauma.

Two students have experienced sexual assault that lead to pregnancy. Several students have experienced childhood trauma that included sexual and/or physical abuse, family violence, and death of a loved one.

The core services include flexible quality schooling to help young parents complete high school, case management and family support, referrals to health services, quality child care for children, parenting and life skills, education and support services including home visiting, and fatherhood—or father involvement services and support.

These services come from the Center for Assessment and Policy Developments Publication school-based program for adolescent parents of young children.

These fast-track decisions for working in teen parents and their children, Connecticut professionals believe are the core services that will structure and framework the necessary supports for these school-based programs.

The outcomes that we have to date are 80% of our seniors enrolled in the program graduated or remained in school. Ninety-eight percent of our children are up-to-date on immunizations and well-child visits.

Ninety-nine percent of children meeting developmental milestones are receiving appropriate services to address developmental delays, and less than 5% experience repeat pregnancy.

When the core services are delivered through a coordinated approach, research suggests the following: increased school retention and completion, reduce risk of course failure, reduced rate of school dropout, reduced second pregnancies, increased access to health services, increased access to licensed child care centers and increased access to case management, social services, and services for teenage fathers.

The next slide is called increasing public awareness and education.

There's a social marketing research component to this project as well. Connecticut conducted social market research on the most effective messages and messengers to communicate with teen parents, particularly Hispanic and black families.

The results of the research showed that messages must be positive and promote staying in school and goal setting, including career and further education.

Teen parents want to hear from successful community members who were once teen parents and who are now successful adults.

In addition, programs will showcase successes by highlighting successful college students who were once teen parents or current teen parents who are successfully pursuing their education.

For example, in Connecticut one of the teen program graduates was the valedictorian of her high school class and received the prestigious Gates Millennium Scholarship, and is now attending Wilson College in Pennsylvania with her 2-year-old son. Her success story will be the focus of a public service campaign that will be launched this summer.

The next slide, state and local advisory council.

Statewide and local advisory committees were developed to help make linkages with community-based organizations and create inventories of existing resources to increase awareness of, and access to all resources for expectant and parenting teen mothers.

Examples of these types of resources are diaper banks, workforce development social services, hospitals, daycare centers, family research centers, legal advocates, bank foundations, and housing.

A subcommittee of the Local Advisory Committee, school medical advisor, a public health department representative and representatives from the Hispanic Health Council and other local community-based organizations serving minority populations review the programs components and print materials to ensure that information and services are culturally and linguistically appropriate, medically accurate, and complete.

Lessons learned, go to the next slide, emphasizing the importance of post-secondary education using an intergenerational approach involving all dads.

Pregnant and parenting teens and these five cities are now remaining in their comprehensive high schools, on track for and graduating because of the critical support services they are receiving through this program.

Lessons learned include holding students to higher expectations. High school diploma attainment should not be the end goal. An emphasis must be placed on post-secondary education.

School districts and higher education leaders have to work collaboratively to make sure that the needs of pregnant and parenting teens are prioritized.

Using an intergenerational approach, programs should involve multi-generations of the teen's family and roles of academic support and family literacy involving grandparents and child care providers.

Programs need to broaden the client definition from the individual teen to the whole family as a unit of service and target younger siblings who are at increased risk for pregnancy.

Teen fathers that are not enrolled in high school need to be included in the programming and receive training on co-parenting. This means father-friendly policies that are supportive and creative.

And the presentation ends with a poem from one of our teen mothers.

Thank you.

Dr. Dan Baden: Thank you very much for that presentation.