

CDC *Vital Signs* Town Hall Teleconference

Preventing Teen Pregnancy: A Key Role for Health Care Providers

April 14, 2015

2:00 pm (EDT)

Coordinator: Welcome and thank you for standing by. At this time, all lines are in a listen-only mode. During our question and answer session you can ask a question by pressing star 1 and recording your name when prompted.

This conference is being recorded. If you have objections you may disconnect.

And I'd like to turn today's conference over to deputy director, Steve Reynolds. Thank you and you may begin.

Steve Reynolds: Hi, good afternoon everyone. I'm Steve Reynolds, the deputy director for the Office for State, Tribal, Local and Territorial Support. I'm glad you could join us today. We'll be discussing the latest *Vital Signs* report on teen pregnancy prevention.

Before we get started, let's go over some housekeeping details. You can go on line and download today's PowerPoint presentation so you can follow along with the presenters.

The web address is www.cdc.gov/stltpublichealth. That's S-T-L-T public health. Let me give that to you one more time. It's www.cdc.gov/stltpublichealth.

Look on the far right side of the page for the Vital Signs teleconference link. Or you can Google CDC *Vital Signs* Town Hall and click on the top link. That should get you there.

On the same web page you can access bios for today's presenters. And the audio recording and transcript will be available next week.

There will be time for questions after today's presentation, but you can get in the queue at any time to ask a question. Just press star 1 and say your name when prompted.

Back to our topic for today, Preventing Teen Pregnancy: A Role for Healthcare Providers. We're going to hear from three colleagues.

First we will hear from Dr. Lisa Romero, a health scientist in the Division of Reproductive Health at CDC's Center for Chronic Disease Prevention and Health Promotion. She will talk about this month's *Vital Signs* Report.

Then Liz Romer will present. She is the director of the Family Planning Program at Children's Hospital Colorado. She will discuss teens and Long-Acting Reversible Contraception use or LARC, and then hand the call over to Dr. Rena Dixon, the health services Coordinator for the South Carolina Campaign to Prevent Teen Pregnancy.

She will talk about their community-wide teen pregnancy prevention initiative and increasing the LARC access. And now I'll turn the call over to Dr. Romero.

Dr. Lisa Romero: Thank you Steve and good afternoon. Today I will be presenting key data and findings from our latest *Vital Signs* report on the use of Long-Acting Reversible Contraception, also called LARC, among teens ages 15 to 19. And I'm on slide 4 for those that are following along. Next slide.

In this presentation I will describe the burden of teen pregnancy in the United States; describe a recent analysis in trends in the use of the most effective birth control among teens, ages 15 to 19 seeking contraceptive services, and describe strategies that healthcare providers can use to increase awareness and availability of Long-Acting Reversible Contraception for teens. Next slide.

Teen pregnancy in the United States is a public health problem. Every day 750 teens, ages 15 to 19 give birth in the United States. One in four teen girls in the US will become pregnant before the age of 20, which accounts for over 614,000 teen pregnancies every year among 15 to 19-year-olds.

Despite recent declines, the US continues to have a higher teen birth rate than many countries of similar economic status. And teen births cost the US \$9.4 billion every year. Next slide.

What we know from previous research is that few sexually active female teens use the most effective types of birth control. About 43% of female teens, ages 15 to 19 have ever had sex. More than 86% of female teens used birth control the last time they had sex. But less than 5% of female teens used the most effective types of birth control.

Most female teens use birth control pills and condoms, which when not used consistently or correctly, are less effective for pregnancy prevention. Next slide.

Long-Acting Reversible Contraception or LARC, meaning intra-uterine devices or IUDs and implants is a safe and effective choice for birth control for teens, requires no effort to use after insertion, and can prevent pregnancy for three to ten years.

And with LARC, less than 1% of teens would be expected to become pregnant versus 9% using birth control pills, and 18% using condoms.

So why don't teens use LARC? Reported barriers for teens using LARC include, teens report that they know very little about LARC and they mistakenly think that they cannot use LARC because of their age.

Many health providers report barriers including the high upfront costs for supplies which are often not fully reimbursed, misplaced concerns about safety and appropriateness of IUDs for teens, and the lack of training on LARC in insertion and removal. Next slide.

The reported barriers to LARC use prompted the CDC and the Office of Population Affairs to analyze patterns of LARC use among female teens, ages 15 to 19 seeking contraceptive services using data from the Title X National Family Planning Program.

The Title X National Family Planning Program provides cost effective and confidential family planning and related preventive health services for low

income women and men, and serves approximately one million teens each year.

The Title X Program also encourages healthcare providers to offer LARC as an option for sexually active teens. These efforts include increasing awareness of clinical guidelines on LARC for teens, training providers on LARC insertion, training providers on client centered contraceptive counseling, and helping service sites reduce financial barriers to LARC by securing low or no-cost options for birth control. Next slide.

For this analysis our research questions were, what are the patterns of use of LARC among teens, age 15 to 19 seeking contraception at Title X service sites by type of service site, region, and state; use of moderately effective and least effective contraceptive methods compared with the Long-Acting Reversible Contraceptive methods, and LARC type. Next slide.

The data source we used for this analysis was the 2005 to 2013 Family Planning Annual Report or FPAR. It is compiled annually by the Title X National Family Planning Program from all entities that receive Title X grants to support delivery of family planning related preventive services and includes approximately 4,200 service sites.

The steady population included female family planning users, ages 15 to 19. And female clients were excluded from our analysis if they were pregnant or seeking pregnancy, sterile, or refraining from sexual intercourse.

Our analysis examined trends over time in the use of LARC among 15 to 19-year-old female clients. Next slide.

What we found was among approximately 7.5 million clients, ages 15 to 19 who sought contraceptive services during 2005 through 2013 from Title X service sites in the US, the percentage who adopted or continued use of LARC at their last visit increased from 0.4% in 2005 to 7.1% in 2013.

From 2005 to 2014 the use IUDs increased from 0.4% to 2.8%. And the use of implants increased from 0.4% to 4.3%. Next slide.

We also looked at the trends of US female teens, ages 15 to 19 years using moderately effective methods such as birth control pills, and least effective methods such as condoms, compared with LARC.

We found that the use of moderately effective methods decreased from 76.9% to 73.4%. The use of least effective methods decreased from 22.7% to 19.5% compared to the use of LARC which I mentioned previously, increased from 0.4% to 7.1%. Next slide.

Finally, we found that the use of LARC varied widely by state. In 2013 the highest rate of use of LARC among teens was in Colorado with a rate of 26% and ranged from less than 1% to 20% in the remaining states. Next slide.

Our study was not without limitations. Our limitations included the FPAR data provide only summary information about services aggregated by grantees. And our results are not representative of the population of teens nationally. Next slide.

In conclusion, efforts to improve access to LARC among teens seeing contraception at Title X service sites have increased use of these methods more than 15 fold from 2005 to 2013.

Strategies for removing barriers to LARC include one, educating providers that LARC is medically safe for teens. Two, training providers on LARC insertion and use of a client-centered counseling approach. And three, providing contraception at no or reduced cost to the client.

By removing barriers to LARC we can increase the array of options available to teens while also contributing to the continuing declines in teen pregnancy in the United States. Next slide.

I'd like to thank you and now I'm going to be turning it over to Liz Romer.

Liz Romer: Thank you. It's my pleasure to be here today and to talk about Long-Acting Reversible Contraception in adolescents. I'm on slide 18, just for slide check.

I look forward to introducing you to our program which is one of several in Colorado that have effectively increased LARC use in teens. Slide 19

We've talked about the consequences of unintended pregnancy in this population, and we've also touched on the safety and efficacy of LARCs. I'd like to dive more into what we know about teens, as well as LARCs.

We know that 64% of teens report having sex by the time they graduate from high school, and most don't want to have their first baby until their mid to late 20s. This means there's about a ten-year risk for unintended pregnancy.

We know that LARCs can effectively protect them through this long period of risk.

CDC, the federal Title X Program, the American College of Obstetrics and Gynecology (ACOG), and most recently, the American Academy of Pediatrics (AAP), all recognize the safety of IUDs and implants and recommend their use in adolescents.

It's also important to note that many, including AAP and ACOG recognize recommend that IUDs and implants be considered first line methods for adolescent patients. Slide 20

So what is BC4U? BC4U is the Adolescent Family Planning Program at Children's Hospital Colorado. Children's Colorado has had an existing Title X Program for over a decade within their Adolescent Medicine Clinic.

In 2009 an anonymous donor offered opportunities in Colorado for Title X recipients to apply for additional funding. We saw this is an ideal opportunity to create a separate family planning clinic that focused on reducing barriers to contraception and increasing LARC use in teens.

Asking ourselves what would an ideal contraception clinic for teens look like, our proposal identified three areas we wanted to build from.

First, reducing barriers of awareness, access, availability, cost, and confidentiality. And second, changing our administrative approach and clinic and third, dispensing more LARCs, three daunting tasks. Next slide, 21.

From the BC4U was born on the premise that we would provide 100% free and 100% confidential reproductive health services for anyone under the age of 25. This became our tag line as free and confidential were the most important client level barriers to overcome. We'll move on to slide 22.

In order to develop - or in order to deliver on our promise of 100% free and 100% confidential, we first approached access barriers, many of which were internal, administrative issues.

Our centralized scheduling process was cumbersome and not teen-friendly, so we hired a dedicated scheduler to become a familiar voice who would understand the challenges of making and keeping appointments for this population.

We built a brand that would resonate with teens, and that included the development of a website and the ability to request appointments online.

We also trained our front desk staff and medical assistants in what was reasonable to expect from teens. An example of this is our appointment times. We do have set times, but we honor any patient's effort to get to the clinic because we often don't know what it took for her to get here. And if turned away, we couldn't ensure that she would come back.

We recognize that for teens, requests for pregnancy tests and Plan B are an emerging cry for help. So we see this as an opportunity to see them same-day or as walk-in patients.

Last, we had to find a way to reach teens in our community. We're a small program in a large, intimidating hospital system and few knew about us. We used a health educator and reached out to our school nurses; invited them to our clinic to tour so that they could relay the experience to their students when they referred them to our clinic. Slide 23

Awareness was our next barrier to address, and we believed that educating young women, particularly around reproductive health, gives them the power to make decisions and have control over their life's path.

So when counseling adolescents on contraception we try to meet each individual where they are in their developmental process.

First, understanding what the teens want from us. They want autonomy in decision-making. They want to be treated with respect and not be judged for their choices. They want to be trusted with complete and accurate information about all methods. And they want to have a voice in the decision.

We deliver what teens want by guiding the discussion and not dictating what we think is best. Often asking questions like how old do you want to be when you have your first baby; what do you want from your birth control, what is the most important thing for you about your birth control method, and can you foresee any problems with your chosen method?

We flipped the old approach of counseling to always begin our conversation with the most effective methods. We have found it important to be direct,

but also optimistic about the side effects. And we also inquire about what they have heard from their friends.

At this age friends are among the most trusted sources of information, and it's important to acknowledge this. We also work to dispel any myths that they have heard. Slide 24

So we've looked at our assistance barrier and how we approach counseling. Next, we looked at how to put our mission into practice and shift the clinic culture to become a LARC focused clinic.

Through our experiences and feeling limited in what we had to offer, we came to the belief that LARC are among the best mechanisms to prevent teen pregnancy.

Here we have a highly effective, long-acting, forgettable contraception that is perfectly matched with a population that is highly fertile, often ambivalent about pregnancy, and hard-wired for risk. Developmentally, LARCs are a great fit for adolescents.

So to become LARC focused, we made sure that we made changes to support providers in using LARC and inserting them same-day; opening up the possibility to any woman, anytime, anywhere. Slide 25

So having talked about our approach to counseling and shifting our focus to LARCs, I wanted to take a minute to talk about how patients felt about the method they chose when they left the clinic.

These were all same-day starts and this graph represents those patients that answered either very confident or completely confident for the following three questions.

Made the right choice of birth control method; will be highly satisfied with your choice of birth control method; and will still be using the same method within one year.

As you can see, interestingly IUDs and implant users scored highest in all three questions. Not only were teens able to make the decision on the day that they came into the clinic, but they were confident about the decisions that they had made.

This is useful on the occasion that questions come up about same-day insertions and if teens are being coerced or if LARCs are being pushed. Next slide, 26.

The last step was to make LARCs available. When a young woman presents to the clinic she is highly motivated to maintain her status as not pregnant. Honoring her effort and motivation, we want to do everything in our power to get the young woman her method of choice that day.

ACOG states, "LARCs, including IUDs, can be inserted at any time during the menstrual cycle as long as pregnancy is reasonably excluded." This statement from a major medical group helped validate the changes we made and gave us additional support to continue same-day LARC insertions.

We hired a dedicated provider that understood the unique needs of adolescents and was comfortable inserting LARCs in young women and nulliparous patients.

We trained providers who had not yet been trained, and we made sure we had devices on hand at all of our clinic locations, again all with the goal of connecting teens with their method of choice.

We quick-start for all methods, except we're unable to do so for an IUD. And we provide a bridge method for those who can't initiate their method of choice.

We adopted the position that there's no benefit to multiple pre-insertion visits, recognizing that this can put undue burden upon patients. And there's no data to support that continuation rates are higher with multiple visits. Next slide, 27.

So when we made our services 100% free; 100% confidential and did everything to address the barriers of access, awareness, and availability, here are the results.

In 2013 when we looked at just our Family Planning Clinic, 675 of our patients chose an implant or an IUD. Next slide, 28.

It's almost impossible for me to not quote Field of Dreams saying, "If you build it, they will come."

With other clinics making similar changes in Colorado, Colorado has shown that teens want LARCs and LARCs largely contribute to decreasing pregnancy rates. Next slide.

I just wanted to thank all the folks on this slide for their continuing support and belief in the model that we've presented. And I'm going to go ahead and turn it over to Rena Dixon.

Dr. Rena Dixon: Thank you Liz. Good afternoon everyone. If you're following along with your slides, I'm on slide 30. And we're going to talk about Increasing LARC access in a South Carolina Title X clinic. Next slide.

South Carolina's teen birth rates are at an all-time low. There's been a 54% decrease in teen birth rates since 1994. However there is still progress to be made.

South Carolina still ranks twelfth in teen birth rates across the country and are still higher than the national average.

We began working with the CDC in 2010 to work intensively in Horry and Spartanburg counties to decrease teen birth rates in each of those counties by 10%. Next slide.

As part of the community-wide initiative we'll focus today's presentation on the clinical services component of the community-wide initiative.

This initiative was funded by the CDC and the Office of Adolescent Health as part of the President's Teen Pregnancy Prevention Program. The goal was to

decrease the teen birth rate among 15 to 19-year-olds and there are five key components: evidence-based programs, clinical services, community mobilization, stakeholder education, and working with diverse communities.

Overall, South Carolina partnered with five clinics in Spartanburg to increase their capacity to provide youth friendly services in the full range of contraceptive methods, including LARC method.

We will focus this presentation on the success of one of our clinical partners, The Point at Tobias which is a Title X family planning clinic located in Spartanburg, South Carolina and is one of 58 clinics statewide, supported by Title X in South Carolina. Next slide.

We did a needs assessment at the beginning of our project in 2010, and we know that 2010 data from South Carolina's Title X family planning clinics show that only 1% of adolescent females received a LARC in 2010.

Our baseline data from our clinical partner, The Point at Tobias showed that in 2010, 324 adolescent clients were served and no LARC methods were provided.

As a larger needs assessment was done for the community-wide initiative, we surveyed 397 male and female youth, ages 15 to 19 in 2011 and conducted through the community, with youth who administered the survey door-to-door in selected neighborhoods.

We found that only 20% of youth surveyed had heard of the IUD. Only 17% had heard of the implant, and 53% felt that using contraception was too much trouble and not worth it. Next slide.

As part of our training and technical assistance efforts with our clinic partners, we focused on improved clinical services. With our findings from our needs assessment we specifically focused our improvement efforts on monthly leadership team meetings which included high level staff, such as the region health director, administrator, nursing director, site supervisor, administrative lead, and clinical staff who worked at The Point at Tobias.

This helped to develop buy-in from clinic leadership, and also allowed us to problem solve on the spot during those meetings.

We focused on training. We made sure that contraceptive counseling trainings were provided for all clinic staff. And this training included information on motivational interviewing and adolescent growth and development.

Advanced practice nurses (AP RNs) were used to staff the teen clinic to allow for same-day insertion. Since the clinic is only open two days each week, our AP RNs duties at other sites were shifted to accommodate the restructure.

In the South Carolina Title X system, AP RNs are used as the primary clinician instead of MDs.

We also developed a teen-friendly clinic setting. The clinic was remodeled and furnished to provide a more welcoming atmosphere. Staff were also

hand-picked to work at the clinic based on their potential to work well with teens.

Items added included a Wii, which is a video game system, teen-focused print materials, and teen-focused videos and movies.

We also reviewed the progress towards increasing the number of patients, and on a LARC method.

The SC campaign developed data workbooks in Excel which entailed setting and monitoring yearly goals for case load and LARC. The data was reviewed monthly at the leadership team meetings.

We utilized bar graphs and pie charts for visuals to ensure the progress was accurately communicated with the staff at the clinic. Next slide.

A large part of this focus to address stigma included rebranding the clinic. We have youth that associated that to address stigma associated with youth receiving services from the local health department. The health center was rebranded from The Tobias Health Department to The Point Teen Health Center at Tobias.

Prior to this project the Spartanburg - it was known as Spartanburg County Health Department or DHEC for short.

We also engaged local funders to provide financial support for the expansion of the Tobias clinic. And our expansion included a new logo and signage. Next slide.

Outreach efforts were a large part of our increasing case load at the clinic which led to our increase in LARC methods. There was an outreach coordinator hired. The outreach coordinator also served as the administrative position for the health center. This allowed for a familiar face for youth upon entering the health center.

The clinic was promoted through bus shelter ads and billboards. Local funders were engaged to provide the SC campaign for support for the billboards and bus shelter ads and other marketing and outreach efforts.

There was also a partnership created with the Department of Transportation to obtain road signs to direct traffic to the health center location.

The community-wide initiative also includes implementation of evidence-based programs. All partners implementing were provided referral cards and a presentation from clinic representatives about the services offered and location and hours of the clinic. Next slide, please.

There has been a strong emphasis on training staff to become more teen-friendly on - and on contraceptive counseling.

While data trends across the state have seen decreases in caseloads, The Point at Tobias has seen an increase in caseloads. We trained 55 staff in teen friendliness, and these staff were from all areas of the county because we do realize that staff rotate through Tobias sometimes, and you need train all staff that have come in contact with teens. We also trained 15 staff in contraceptive counseling.

The Point at Tobias served 31% more adolescent male and female family planning patients from 2010 to 2014.

Title X clinics across the state of South Carolina have seen a decrease in both adolescent male and female planning patients during that same time. Next slide.

During the fiscal year 2013/2014, the percentage of adolescent females using a reliable method -- and we count pills, patches, rings, injections, IUDs, and implants, as reliable methods -- as 97%. And the percentage of female adolescents using a LARC increased to 39% at The Point at Tobias.

In contrast, statewide in all Title X clinics, only 75% of adolescents were using a reliable method, and 7% of adolescents were using a LARC method in fiscal year 2013/2014. Next slide.

We have a lot of lessons learned associated with our project. Rebranding the teen clinic has helped with decreasing the stigma associated with seeking services at the local health department.

This is a team effort and we realize that support from all areas of the agency from administration to nurses on the floor, must occur to increase LARC insertion.

Staff must be using evidence-based practices regarding contraceptive counseling to make changes in contraception coverage.

Agencies that can provide training and technical assistance such as ours, are needed to help focus efforts on working with adolescents in a clinical setting. There must be a staff champion working for working with adolescents. This includes support for providing LARC for adolescents in the health center.

And changing health center staffing is necessary to optimize time with adolescents. Staffing and advance practitioners for complex appointments allows time for same-day insertions.

Thinking about next steps, we would like to see a possible expansion of services to three days per week compared to only two days presently, expanding the lessons learned to other clinics in Spartanburg and the DHEX system as a whole would be beneficial. And increasing community outreach activities to ensure the point at Tobias is a top referral clinic for teen reproductive healthcare.

So through additional funding in the community there will also be a focus on increasing LARC usage with parenting teens through the point at Tobias. And we also see that other regions in the state health department system are seeing the success of the point at Tobias and beginning to implement changes.

Thanks to the CDC for allowing this opportunity for us. My contact information is displayed on the next slide.

And I'm going to turn it over for questions and answers.

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