Integrating Family Planning Services into an STD Clinic Setting

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Background

- Unintended pregnancy is an important and complex problem with significant public health consequences
- Conditions leading to STDs and unintended pregnancy are similar
- Most STD clinics have focused solely on STD treatment and prevention
- However women presenting for care are also at high-risk for unintended pregnancy

Background

- Most FP programs and STD clinic programs began as separate entities to address specific program needs, with minimal overlap
- Since the 1980's most FP programs have successfully integrated STD screening into their routine practices

Background

- STD clinics typically have done less to integrate FP into care; providing only barrier methods of contraception with limited attention to non-STD related contraceptive care needs
- Few STD control programs combine FP with STD services in an STD clinic – e.g., Baltimore, Denver, Philadelphia

History of our Program

- Previous process at the Denver Metro Health Clinic:
  - All women seen for services interviewed regarding their reproductive and contraceptive, as well as their STD history
    - <19 years needing contraception referred to our teen clinic
    - $\geq$19 years needing contraception provided condoms and foam then offered referral to a community health center
- Given the generally poor preventive health care behaviors of STD clinic patients, many women delayed or never received contraceptive care leaving them vulnerable to pregnancy

History of our Program

- Evaluation conducted on contraceptive practices of our STD clients between 1992 and 1994
  - In 1992, 953 women reported no contraceptive use at their visit
  - 299 (31%) had at least one return visit to the clinic for a new STD problem over the subsequent 24 months
  - Among these 299 women, 145 (48%) continued to report no contraceptive use at their latest visit, a median of 12 months later
- Survey of clients seen through our clinic indicated that only 29% of women were using BCM; many barriers to obtaining services reported

Why Consider Providing Initial Family Planning Services in an STD Clinic?

- We screen sexually active women who are at risk for unintended pregnancy
- We obtain a menstrual history, sexual history and current use of contraception
- Women seen in STD clinics are at high risk for unintended pregnancy

Integrating FP into STD Care

- RO1 study-1996-2000
  - Funded through the National Institute of Child Health and Human Development
  - Randomized trial evaluated the benefit of clinic-based initiation of contraceptive services on the implementation of consistent ongoing contraceptive care and prevention of unintended pregnancy
  - Enrolled 877 women (60% women of color)

Shlay et al. Am J OB Gyne 2003;189:473-81

Integrating FP into STD Care

- Intervention Group-
  - Counseling provided on birth control methods
  - Integrated into the STD clinic visit
  - Patient given method - pills, condoms, spermicide, DMPA, diaphragm (3 mo supply)
  - Referral to primary care with appointment made by provider
- Control Group-
  - Counseling on need to obtain birth control
  - Provided condoms and spermicide
  - Referral information on primary care given to patient

Major Findings

- Effective contraceptive use:
  - 4-months: intervention 50%, control 22.3%, $p<0.001$
  - 8-months: intervention 44%, control 26%, $p<0.001$
  - 12-months: intervention 33%, control 27%, $p=0.11$
- PCP contact:
  - 4-month: intervention 51%, control 43%, $p=0.02$
  - 8-month: intervention 65%, control 44%, $p=0.0001$
  - 12-month: intervention 72%, control 70%, $p=0.53$

Major Findings

- Pregnancy rate:
  - Overall: 26.1%
  - Intervention: 24%, control: 28.2%, p=0.16
- Unintended pregnancy rate:
  - Overall: 24.2%
  - intervention 21.9%, control 26.5%, p=0.17

Predicting Incident Pregnancy

- Demographic and behavioral characteristics correlated by univariate analysis with incident pregnancy were combined in sequential manner
- Cumulative risk of pregnancy

  $\geq$ 6 characteristics : 51%

  $\leq$ 5 characteristics : 25.6%
- List of risk factors now used to determine which women $\geq$19 years of age need referral to our continuity clinic

Conclusions of FP Study

- Study demonstrated that women presenting to STD clinics are at high risk for pregnancy
- Intervention promoted effective contraceptive use and transition to PCP
- Trend towards pregnancy reduction with overall pregnancy rate reduction of 15%
- Short term interventions may not be sustainable long-term
- Need intervention strategies that improve long-term effective contraceptive use by sustaining adherence once a method is initiated

How our Research Translated into a FP Program within our STD Clinic

- Results of study shared with various organizations throughout area to increase awareness of issue
- In June 2000, Women’s Health Section of the CDPHE expressed interest in expanding FP services for high-risk women
- We proposed implementing our study’s intervention with the hope of reaching high-risk women who had little access to contraceptive services

How our Research Translated into a FP Program within our STD Clinic

- Project was funded in 2001 focusing only on providing women with initial FP services and teen services
- In 2002 with additional funding implemented continuity clinic for high risk women and providing services for men

Objectives of our Program

- To develop and maintain an integrated family planning program within an existing STD clinic which compliments STD clinical services
- To provide initial evaluation of family planning needs for both men and women, with referral to primary care for ongoing contraceptive and reproductive health care needs
- To offer continuity services for teens and high-risk women who require additional support to avoid unintended pregnancy and STD/HIV

Methods

- Services for women:
  - Seen by STD clinicians trained in family planning services
  - preconception counseling, pregnancy testing, emergency contraception, and initial contraception (3-months)
  - Clinician determines if client meets eligibility criteria for being at high-risk of unintended pregnancy
  - If high-risk or teen, eligible to receive ongoing contraceptive services through our teen/continuity clinic

Methods

- If low-risk, clinician facilitates a referral to a PCP for ongoing reproductive health care needs
- High-risk for subsequent pregnancy:
  - homeless/transitional housing or drug user/drug treatment
  - based on having $\geq$6 of 9 risk characteristics at presentation
- If eligible for continuity/teen clinic services, FP provided for a year

Risk Factors Correlated with Incident Pregnancy

- Age ≤19 years of age
- Non-Caucasian
- ≤ High school diploma or general equivalency diploma
- Previous pregnancy history
- No use of birth control method with last intercourse
- Sex at least once a week
- Previous abortion
- ≥ 3 partners within the past month
- < 17 years of age with first pregnancy

Methods

- For contraception, clinicians medically screen the client; counsels patients about potential options
- Contraception available includes oral contraceptives, contraceptive patch, emergency contraception, DMPA, NuvaRing®, condoms, and spermicide
- The delayed exam approach to provision of initial services is used with quick start method used

Methods

- Referrals made to obtain IUDs, implants, and tubal ligations
- Any woman receiving emergency contraception receives an ongoing method
- Preconceptual counseling includes discussions on use of prenatal vitamins and avoiding risky behaviors (alcohol, smoking, caffeine, etc)
- Pregnancy testing includes counseling on positive test with referrals made to appropriate clinical services

Methods

- Services for men:
  - Seen by STD clinicians trained in family planning services
  - Counseling focuses on their role in family planning

Results

- Services provided since 2001
  - 8,400 women and 6,175 men
  - In 2007 40% of heterosexual clients seen received FP services in 2007
  - Majority of clients $\leq$24 years (63%)
  - By race/ethnicity: 57% white, 23% AA, 25% other; 37% Hispanics and 60% non-Hispanics
  - Most clients indigent-76% $\leq$150% poverty level, most uninsured (66%) or have public insurance (7%)
  - Current STD: 24%
  - Prior STD: 36%
  - For women, 47% had previous pregnancy; of which 38% had previous TAB

Results

- Women:
  - All received education on STD/HIV prevention, SBE, importance of folic acid/calcium
  - Pregnancy testing/options: 4%
  - Preconception counseling: 3%
  - Contraception: OCs-34%, condoms-80%, DMPA-7%, EC-9%, Nuvaring-1%, patch-5%, other-10%

Results

- Emergency contraception:
  - EC requests range from 7% in 2003 to 16% in 2006
  - Women receiving EC in 2007: 11.4%
  - Women receiving an additional method: 92%
  - Characteristics of EC recipients:
    - Age: 15-17: 24%, 18-19: 29%, 20-26: 26%
    - Race/ethnicity: W: 58%, AA: 20%, H: 48%, Non-H: 51%
    - Income: ≤150% of Federal Poverty Level: 88%
    - Risk group: high: 12%, low: 88%

Results

- Men:
  - All receive instruction on how to perform a testicular self-exam and education on integrating STD/HIV and pregnancy prevention
  - Preconception counseling: 3%
  - Contraception: condoms-81%, female-directed-30%

Impact of Program

- Most clients do not return for repeat services (15% repeaters vs. 85% single year visit)
- Assessment of pregnancy risk among repeat users not wanting subsequent pregnancy 2003-2006
  - 642 women; 59 high-risk and 583 low-risk
  - 19.3% had a least one pregnancy (N=124)
  - 37.3% among high-risk women vs. 17.5% among low-risk women ($P<0.01$)
- Low-risk women benefit more from the program
- High-risk women still remain at increased risk and need additional intervention

Predicting Pregnancy Risk

- Using multivariate analysis and controlling for age and race/ethnicity, incident pregnancy associated with:
  - Previous pregnancy-OR 2.57, 95% CI: 1.63-4.04
  - ≤150% Federal Poverty Level-OR 2.22, 95%CI: 1.05-4.71
  - No contraceptive use at last sex (OR 1.67, 95%CI: 1.11-2.52).
  - Incident pregnancy not associated with educational level, sexual frequency, age of first pregnancy, number of partners, prior therapeutic abortion, current STD, prior STD, or provision of effective contraception at the initial STD clinic visit

Cost and Sustainability

- Family planning program funded through Title X Federal program
- CDPHE allows our STD clinic to waive all sliding scale fees due to the impact of implementing a fee structure at an STD clinic setting
- FP funding provides 12% of the total funding of our STD program
- Through word of mouth patients now come to the clinic for contraception with the added benefit of being screened for STDs
- By integrating FP services into the STD clinic, maximized the benefit of the existing clinic infrastructure

Lessons Learned

- Difficult to change mindset of the STD clinicians to focus on both STD/HIV and pregnancy prevention in an integrated fashion
- To address this, slowed implementation of program; initially only one clinician performed program
- Later, after staff became more familiar with program, all clinicians were trained in providing family planning
- Buy-in from clinic management (STD director and program manager) is critical
- Now part of job description for all new hires
- Important to provide ongoing feedback to providers

Public Health Implications

- STD clinics serve high-risk men and women, many of whom use these clinics because they lack access to reproductive health care services
- Dual protection should be the standard of care in all STD programs
- Advantages to program:
  - Focus on common reproductive healthcare problem in STD clients
  - Transitioning low-risk clients to primary care frees up clinic to see others in need for STD-related clinical services
  - Feasible to perform, provides an important and effective clinical service

Future Endeavors

- Determine clinical outcomes of women seen through the STD clinic and then referred to primary care
- Enhance services provided
  - Provision of implanon
  - Provision of IUDs
  - Advanced provision of EC
- Develop an intervention to address issues surrounding unintended pregnancy in the highest risk women seen
- Assist other STD programs in providing initial family planning services with STD clinical services

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Questions