Provide Preventive Family Planning Services through Mobile Health Clinics that Serve Rural and Small-Town Communities

Recently, the Rural Task Force of the Colorado Blue Ribbon Commission for Health Care Reform identified a number of characteristics unique to rural Colorado communities that necessitate alternative means of delivering health care services compared to those used in urban communities.[1] Specific to reproductive health care, research carried out by Prevention First Colorado shows that women living in rural and small-town communities in Colorado have less access to public and private transportation, have lower median incomes, are less likely to have completed high school, and are more likely to report having had an unintended pregnancy than their counterparts in urban communities.[2] To increase access to health care among rural and underserved populations, some county health departments and private health care providers have turned to mobile health clinics to deliver select medical services. Prevention First Colorado recommends that mobile health clinics that serve those populations include contraceptive counseling and prescriptions for contraceptives, as well as on-site distribution of condoms, emergency contraception and pre-packaged, pre-labeled contraceptives, to increase access to family planning services in rural areas and small towns in Colorado.

THE NEED FOR MOBILE FAMILY PLANNING

Original research conducted by Prevention First Colorado showed that women who self-identified as living in small towns and rural counties were among the most at-risk for unintended pregnancy. This was particularly true for women with less than a college education. Specifically, the research showed that 39 percent of women living in more remote areas have only a high school degree or less, compared to 34 percent of women in urban areas.[3] In addition, 49 percent of women living in small towns and rural areas reported having had an unintended pregnancy, compared to 40 percent of women statewide.[4] Those women also reported more difficulty in obtaining and paying for contraceptives than their statewide counterparts.[5]

Despite Colorado's large population centers along the Interstate-25 corridor and in Grand Junction, more than three-quarters of the state is considered rural. According to data compiled by the Colorado Rural Health Center (CRHC), an independent, nonprofit, membership-based organization that serves as the State Office of Rural Health, 47 of Colorado's 64 counties are classified as "rural" (24 counties) or "frontier" (23 counties).[6] With the exception of Mesa County on the Western Slope, the state's urban counties are all located on the Front Range and include Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, El Paso, Gilpin, Jefferson, Larimer, Park, Pueblo, Teller and Weld counties.[7]

A comparison of select indicators for Coloradans living in rural versus urban counties shows that residents in rural counties have lower median incomes and are more likely to live in poverty, in a household without a car, and in a family where the mother has not completed high school. In addition, rural counties have higher fertility rates for girls aged 15 to 17 than their urban counterparts, have higher unintended pregnancy rates, and have higher rates of inadequate prenatal care. (See Table 1 on page 40, "Comparison of Demographic Indicators for Residents Living in Urban vs. Rural Counties in Colorado.")

CRHC research also shows that the medical needs of the residents of Colorado's rural counties are provided for by critical access hospitals, rural health clinics, community health centers, public health departments, private rural hospitals and private rural health care providers. Despite that patchwork of health care service points, large numbers of women aged 15 to 44 lack access to critical reproductive health care services.

In 2006, the most recent year for which data are available, Colorado clinics that received funds through the federal Title X family planning program provided services to an estimated 49,950 women. Originally enacted in 1970, Title X was created as the "only federal grant program dedicated solely to providing individuals with comprehensive family planning and related preventive health services."[8] The Title X program was created to give access to contraceptive information and services to "all who want and need them," with priority being given to low-income families.[9] In the four decades since Title X was established, the program has played a large role in providing access to a broad range of family planning services for low-income women and their

Table 1: Comparison of Demographic Indicators for Residents Living in Rural vs. Urban Counties in Colorado[10]

Indicator	Rural Counties	Urban Counties
Average Median Income	$36,892	$53,799
Population Living in Poverty	12.7%	8.6%
Households without a Car	5.8%	4.8%
Fertility Rate for Girls Aged 15 to 17	23.8%	19.4%
Receive Prenatal Care in First Trimester	75.6%	83.9%

families, including counseling, preventive care, examinations, education to prevent sexually transmitted infections (STIs) and HIV, and screenings and referrals for other medical needs. In Colorado in 2006, an estimated 10,300 unintended pregnancies and an estimated 4,300 abortions were prevented through the use of Title X-funded family planning services.[11]

Yet as of October 2008, Title X clinics were located in just half of Colorado's rural counties; collectively, those counties were home to an estimated 81,500 women of child-bearing age.[12] However, nearly 56,000 women aged 15 to 44 living in rural communities did not have access to Title X family planning services in their home counties. Moreover, thousands of women live in counties where there is no identified health care clinic or pharmacy that either prescribes or fills prescriptions for contraceptives. (See Table 2 on page 40, "Women of Child-Bearing Age in Colorado without Access to Select Health Care Needs.")

OTHER STATES AND NATIONWIDE

According to an assessment of mobile health care programs prepared by the Colorado Foundation for Medical Care in 2006,

> "the top reasons for mobile health program implementation [… are] to provide health care services to populations that might otherwise not have services and to remove transportation barriers for special populations that have specific transportation issues."[13]

Generally, patients served by mobile health care units are not in close geographic proximity to established medical facilities and services. As a result, those patients likely face geographic barriers to accessing prescription-dispensing pharmacies. For mobile health care programs to truly increase access to preventive family planning services among underserved Colorado women and their families, condoms and pharmaceutical contraceptives should not only be discussed and prescribed through the mobile units, but also dispensed on-site.

While many mobile health clinics nationwide provide a range of services, including preventive screenings, well-child care, and limited prenatal care, there are few examples of mobile clinics that incorporate preventive family planning services like contraceptive counseling, prescriptions, and on-site distribution of contraceptives into the range of provided services. Within this context, this report summarizes two programs that do offer family planning services through mobile clinics.

The Sierra Mobile Clinic in Northern California was created when the El Dorado County Public Health Department and Marshall Hospital joined forces to address the needs of isolated and rural communities in El Dorado County. The mobile clinic provided services in four cities during the regular five-day week.[14]

The Public Health Department and Marshall Hospital split responsibilities for the mobile clinic vehicle. Marshall Hospital owned the vehicle, and provided supplies and staff, including a full-time family nurse practitioner and a full-time medical officer/driver. The Public Health Department managed the grant, referrals, and outreach and provided a health advocate who provided case management. The mobile clinic was able to offer a variety of services, including primary care, urgent medical care, well-child and infant checks, and oral contraception for females. By the third year of operations, the Sierra Mobile Clinic saw 1,500 patients annually.[15]

In Hale County, Ala., five agencies organized a consortium to address rural health care access challenges by establishing the Hale County Mobile Health Clinic. Each agency provided a unique resource. The HERO Family Resource Center provided a social worker to offer one-on-one assistance, follow-up on patient referrals, and counseling; Hale County Department of Public Health provided a registered nurse,

Table 2: Women of Child-Bearing Age in Colorado without Access to Select Health Care Needs

Indicator	Number of Rural Counties	Number of Women Aged 15 to 44 Affected[16]
No Hospital	14[17]	11,500
No Rural Health Clinic, Community Health Center, or Hospital	3[18]	3,000
No Pharmacies that Fill Prescriptions for Birth Control	10[19]	5,800
No Clinics that Prescribe Some Form of Contraceptive	6[20]	3,300
No Title X Clinic	24[21]	56,000

health care equipment and supplies; the Hale County Department of Human Services and West Alabama Health Services referred clients to the mobile clinic for social services and medical assistance; and the Hale County School System allowed the mobile clinic to come to the school to screen children and staff, give educational presentations, perform routine maintenance and provide a safe parking place for the mobile clinic vehicle.[22]

Services offered by the mobile clinic included immunizations, child health exams, hypertension and blood pressure screenings, counseling about and testing for sexually transmitted infections (STIs) and HIV/AIDS, health education, and family planning supplies. The clinic served more than 2,000 men, women, and children for various programs and countless others for various medical needs.[23] Those two programs demonstrate that select family planning programs can be incorporated into mobile health care clinics as a core health care service.

As described above, resources to support the provision of health care services through mobile clinics tend to come from both the public- and private-sectors through the combined efforts of county health departments, existing health care clinics, nonprofit organizations, and private foundations. One source of public funding that both public agencies and private health care providers may consider to offset costs related to the provision of preventive family planning services is the federal Title X family planning program.

In fiscal year 2009, Congress appropriated approximately $307 million for Title X family planning services.[24] Approximately 4,400 community-based clinics that reach over 5 million people each year receive Title X funding.[25] Those clinics include state and local health departments, tribal organizations, hospitals, university health centers, independent clinics, community health centers, faith-based organizations, and other public and private nonprofit agencies.

CURRENTLY IN COLORADO

A limited number of mobile clinics provide health care services to underserved communities throughout the state, particularly in low-income and rural communities. In 2006, the Colorado Foundation for Medical Care (CFMC) conducted an assessment and identified 25 programs that had previously provided, currently provided, or planned to provide health care services in Colorado via a mobile unit. Of those, approximately 53 percent provided primary care services, 34 percent provided dental care, 35 percent provided immunizations, 18 percent provided mammography services, 11 percent provided blood banking, and 12 percent provided social services.[26] As of this writing, Prevention First Colorado was unable to determine whether contraceptive counseling, drugs and devices are provided through any mobile clinics that offered preventive care services. The CFMC assessment found that mobile health care programs reached populations across multiple demographic sub-groups. (See Table 3 on page 41, "Populations Served by Mobile Health Care Programs as of 2006.")

Table 3: Populations Served by Mobile Health Care Programs as of 2006[27]

Population	Number of Mobile Health Programs
Non-Migrant Children Aged 0 to 5	7
Non-Migrant Children Aged 5 to 18	10
Non-Migrant Adults Aged 19 to 64	9
Non-Migrant Adults Aged 65 and older Eligible for Medicare	5
Migrant School-Aged Children	10
Migrant Adults	6

In 2006, UnitedHealthcare of Colorado pledged $7.5 million over a six-year period to support increased access to health care services in rural communities through mobile health programs.[28] CRHC operated the Colorado Rural Mobile Health Project for one year in 2006-2007 and distributed $1 million dollars to support delivery of health care services through mobile units. The grantees included groups that provided dental services (San Juan Basin Health Department, University of Colorado School of Dentistry, and Kids in Need of Dentistry) and four groups that provided general medical services (Salud Family Health Center, North Colorado Health Alliance, Rocky Mountain Youth Clinics, and Valley-Wide Health Systems). Since then, the grant funds that supported the Rural Mobile Health Project have become the Colorado Rural Health Care Grant Program, which funds primary care service projects in rural areas of the state.[29]

The general model for provision of health care services provided through mobile units includes a two-person staffing structure. In addition, the mobile clinics park at a public location, where patients receive health care services in the mobile unit. The location is determined in advance, and individuals can receive treatment by appointment or as walk-in patients. While there are not a prescribed set of services offered by mobile health care units, most provide immunizations for influenza, pneumonia, tetanus and the like. They screen for chronic disorders such as hypertension, diabetes, tuberculosis, anemia, cholesterol, HIV, and STIs. Some of the units perform limited gynecological services, such as a pap smear screening, but Prevention First Colorado has been unable to confirm that family planning services are provided.

Examples of mobile health care programs currently operating in Colorado include Denver Health's mobile mammography van, which provides women with access to breast screenings. According to the Denver Health Web site, the "fully equipped bus serves as a free-standing clinic as it travels among our nine family health centers offering mammograms, pap smears, pelvic examinations and breast screening exams."[30] The mobile unit is funded through a

combination of public and private dollars, specifically The Avon Foundation, Denver Community Health Services, in partnership with the University of Colorado Cancer Center, the Latino/a Research and Policy Center and the Colorado Department of Public Health and Environment.[31] Likewise, the Denver affiliate of the Komen Foundation and the Saint Joseph Hospital Foundation teamed up to support the provision of mobile mammography services through Exempla St. Joseph Hospital; introduced in September 2005, it served more than 1,600 women in 2006.[32]

The nonprofit Rocky Mountain Youth Clinics (RMYC) also operates two mobile clinics that provide health and dental care services to uninsured youth in Denver and some rural communities. The mobile clinics are part of a national fleet of Ronald McDonald Care Mobiles that provide a range of health care services depending on community needs and resources, including primary care, well-child visits and developmental screenings, immunizations, oral hygiene education, diagnostic, preventive and restorative dental care, prenatal care for pregnant teens, school and sports physicals, nutrition counseling, vision, hearing and lead screenings, among other health care services.[33] Community members can access the schedule for the mobile clinics, which were donated to RMYC by the Ronald McDonald House Charities, through the RMYC Web site.[34] As of March 2009, Colorado Springs-based Peak Vista Community Health Centers also began operating a Ronald McDonald Care Mobile to provide health care services to children through age 20.[35]

Where provision of pap smears and cervical exams already are provided – such as the Denver Health Mobile Mammography Clinic – the opportunity exists to add counseling about and prescriptions for contraceptives, as well as on-site distribution of condoms and pharmaceutical birth control methods, including emergency contraception.

BARRIERS TO IMPLEMENTATION

Mobile health care units typically are staffed by medical practitioners other than physicians, such as physician's assistants, registered nurses, and advanced practice nurses. Because of Colorado statutes that regulate which medical personnel can distribute prescription drugs,[36] mobile health care staff may lack the legal authority to either prescribe birth control products like oral contraceptives, the NuvaRing®, the Ortho Evra® patch, Depo-Provera®, and, for women under the age of 17, emergency contraception, or to distribute those products on-site in the mobile unit. In a companion report entitled, "Allow Advanced Practice Nurses with Prescriptive Authority to Distribute and Administer Prescription Contraceptives," on page 45, Prevention First Colorado aims to mitigate that barrier by changing Colorado law to allow additional medical personnel to prescribe and dispense those products.

According to the CFMC assessment, operators of mobile health programs in Colorado identified limited financial resources and the costs of maintaining mobile units as both short- and long-term barriers to operating mobile health care clinics.[37] For example, one of the 2006-2007 Colorado Rural Mobile Health Project grant recipients priced the purchase cost for a mobile unit at $350,000.[38] Health care providers that currently operate mobile units in Colorado can apply for funds from the Colorado Rural Health Care Grant Program to offset costs of delivering services in rural communities. Funded by UnitedHealthcare of Colorado, $7.5 million is expected to be distributed between 2008 and 2012.[39]

By incorporating contraceptive counseling and prescriptions and on-site distribution of condoms and pharmaceutical contraceptives into the range of health care services delivered through mobile health clinics, such programs may become eligible for funding through the Title X family planning program. In addition, counties can receive funds through the federal Temporary Assistance for Needy Families (TANF) program to support their efforts to prevent and reduce out-of-wedlock unintended pregnancies, which is one of the four stated goals of the program.[40] Consequently, mobile health clinics that collaborate with county health departments to provide health care services may be able to use TANF funds to offset a portion of overall program costs.

Additional public funds may be available through the Colorado Department of Public Health and Environment's Primary Care Office, which receives federal grant monies from the Health Resources and Services Administration (HRSA) in the U.S. Department of Health and Human Services. The HRSA grant funds are meant to be used to "assist in the development and delivery of comprehensive and quality health care services in areas with an identified shortage of health professionals."[41] Mobile health care programs operating in communities that meet federal requirements to be declared a Primary Care Geographic Health Professional Shortage Area (HPSA), Primary Care Population-Based HPSA, Medically Underserved Area, or Governor-designated and Secretary-certified shortage area,[42] may meet the HRSA grant criteria.

FIRST STEPS

To provide comprehensive family planning services to more women in rural areas and small communities in Colorado, the following specific steps are recommended.

1. Conduct a statewide assessment of existing mobile health care programs to determine which, if any, provide counseling about and prescriptions for contraceptives, as well as on-site distribution of condoms and pharmaceutical contraceptives including emergency contraception.

2. Identify opportunities to add mobile health care units to existing health care programs with a specific focus oriented toward providing counseling about and prescriptions for contraceptives, as well as on-site distribution of condoms and pre-packaged, pre-labeled contraceptives, including emergency contraception.

3. Ensure the health care professionals who staff mobile health care units have the authority to prescribe and dispense pharmaceutical contraceptives.
4. Leverage existing funding streams to incorporate counseling about and prescriptions for contraceptives, as well as on-site distribution for pharmaceutical birth control methods, into core health care services delivered through mobile clinics.

Ensuring that preventive family planning care is included in the core health care services delivered by mobile health care clinics in Colorado will mitigate barriers women face, particularly those living in rural and small-town communities, when it comes to preventing unintended pregnancy.

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19. This figure represents the number of rural counties where a statewide assessment was unable to identify pharmacies that reported filling prescriptions for birth control pills, emergency contraception, and the NuvaRing®. It does not include counties where pharmacies refused to provide information. Prevention First Colorado mailed surveys assessing availability of and access to contraceptives in Colorado to 918 pharmacies in April 2008. A total of 853 pharmacy responses were compiled through several contacts including one mailing, between five and 10 targeted phone calls, and three to five attempts at faxing.

20. This figure represents the number of rural counties where a statewide assessment was unable to identify health care clinics that reported writing prescriptions for birth control pills, emergency contraception, the NuvaRing®, Implanon®, intrauterine devices and Depo-Provera®. Prevention First Colorado mailed surveys assessing availability of and access to contraceptives in Colorado to 385 clinics in April 2008. A total of 255 clinic responses were complied after at least five phone calls and multiple faxes.

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