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Women's Health: Reproductive Health Services in Rural Minnesota

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Reproductive health [is] a "state of physical, mental and social well-being in all matters relating to the reproductive system at all stages of life … and implicit in this are the right of men and women to be informed and have access to safe, effective, affordable and acceptable … health care services."
— World Health Organization

A woman's initial entry to a lifetime of health care often happens with her need to obtain reproductive health services. However, rural areas of the United States frequently lack basic reproductive health services that many women living in more urbanized settings may take for granted. Preserving access to health care overall is a challenge for many rural communities, but in addition to the usual barriers like geographical isolation and limited public transportation, a declining number of providers are willing to practice obstetrics, and local family planning programs are disappearing. Lack of access to reproductive health services may lead to delays in seeking recommended prenatal care, regular Pap or mammogram screenings and timely sexually transmitted disease testing and treatment. Studies analyzing the impact of local access to reproductive services in rural areas are limited. However, using national data in conjunction with data specific to Minnesota, plus highlighting successful, local reproductive health programs, can provide some insight into the trends and challenges of ensuring reproductive health care for women living in rural Minnesota.

Defining rural

Inherent in any discussion about rural health care services is the question: What exactly defines "rural?" While some people may argue they know it when they see it, there is no single, universally accepted definition for rural. Instead, multiple definitions present

various implications for health policy. At a national level, the Office of Management and Budget (OMB) and the U.S. Census Bureau have developed their own definitions of rural. Since the federal government most frequently uses the county-based OMB metropolitan (metro), micropolitan (micro) and rural classifications as policy tools, most references to "rural Minnesota" will be using OMB's definition unless specified otherwise. Metropolitan areas are classified as regions with at least one urbanized area of 50,000 or more residents plus outlying counties with 25% or more of the employed population commuting daily. Micro counties are counties with one or more urban clusters of 10,000-50,000 persons and include outlying counties with 25% or more commuting daily. Rural counties are all non-metro counties not meeting the micro classification. A complete list of OMB's classification of Minnesota's counties is available in Appendix A.

Reproductive health care services equal prevention

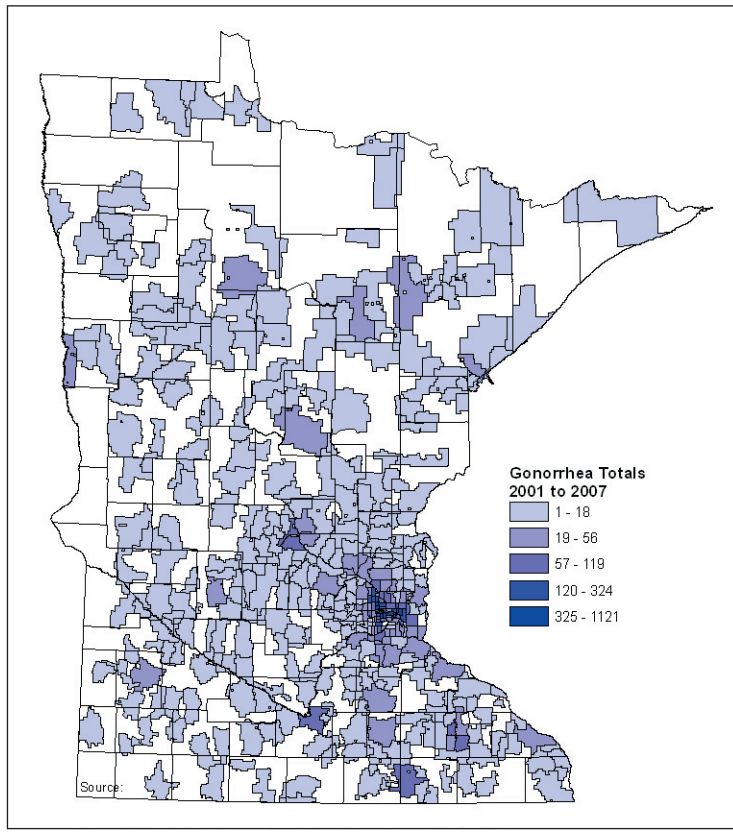
Reproductive health care services in rural communities often serve as an access point to primary care for women young and old. When providers are available, common types of reproductive health care services include sexually transmitted infection (STI) testing and treatment, teen pregnancy prevention programs, cancer screenings, and prenatal care.

Sexually transmitted infections

Sexually transmitted diseases are preventable and curable, making timely access to testing very important. STIs can lead to lifelong health problems and even death if undiagnosed. For women, special concern should be taken since STIs have been linked to tubal pregnancies, miscarriage, birth defects and infertility.

The older demographics characterizing rural Minnesota combined with a concentration of the population living in the Twin Cities metropolitan area often lead people to think that teen pregnancy and STIs are only urban issues. While it is true that STI statistics for 2007 continue to be highest in the Twin Cities, the greatest increase in STIs reported in 2007 occurred in Greater Minnesota (8% for chlamydia and 34% for gonorrhea). More attention is being given to the increasing rates of gonorrhea infection in rural areas of Minnesota. Although the cities of Minneapolis and St. Paul accounted for the highest rates of gonorrhea infection, incidence rates increased dramatically in Greater Minnesota for women (46%) (Figure 1).

Figure 1: *Reported gonorrhea infections (females only), Minnesota, 2001-2007.*



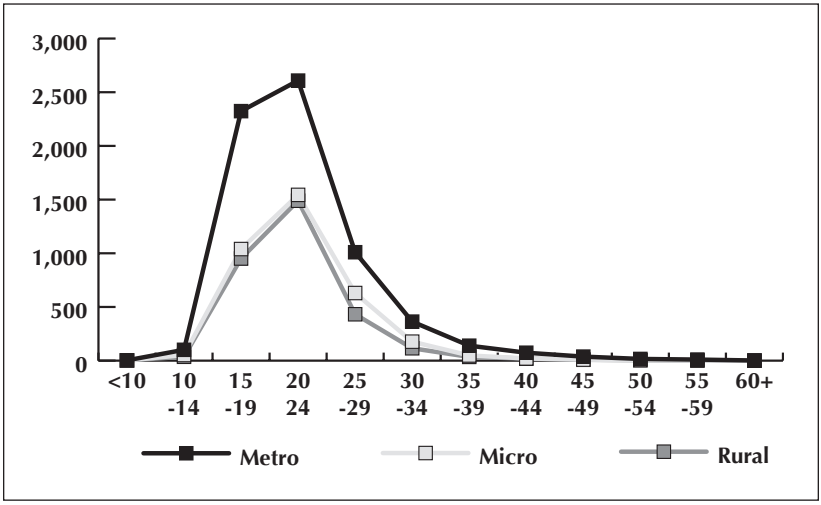
Source: MDH Infectious Disease Epidemiology, Prevention and Control Division.

Adolescent and young adult populations account for higher rates of STIs compared to other age groups whether they live in rural or urban regions of Minnesota (Figure 2).

Teen pregnancy

Teen pregnancy and childbearing has significant economic and social costs. According to the National Campaign to Prevent Teen Pregnancy, teen childbearing in Minnesota cost taxpayers at least $142 million in 2004. Of these costs, 35% were federal costs and 65% were state and local costs. Minnesota's costs associated with *both* teen parents *and* their children in 2004 totaled $149 million, including $38 million for health care, $56 million for child welfare, $18 million for incarceration, and $37 million in lost tax revenue. The average

Figure 2: *Gonorrhea and chlamydia rates (per 1,000 females) by age group and region, Minnesota, 2001-2007.*

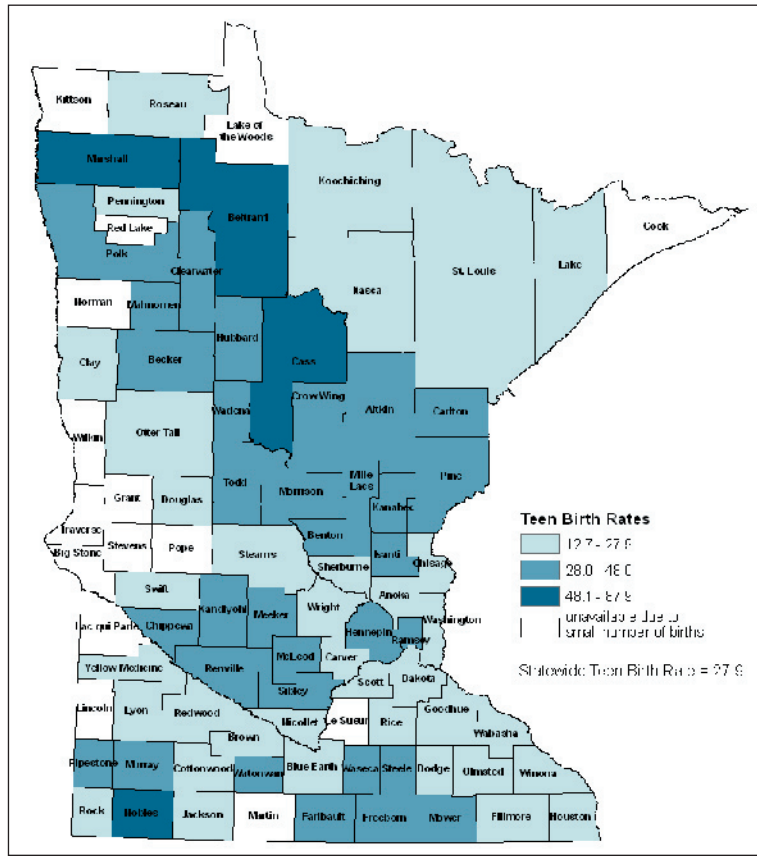


annual cost in Minnesota of teen childbearing (ages 13-19) is $1,898 per teen birth, and costs associated with births to teens age 17 or younger is higher, at $5,506. Nationally, the overall cost to taxpayers is estimated to be at least $9.1 billion per year. Prevention of teen pregnancy offers a clear return on investment by improving the well-being of teens and their families and reducing the financial burden on taxpayers.

Giving birth as a teen is strongly associated with disadvantages in later life. Teen mothers are more likely to drop out of school, remain unmarried, live in poverty, and have additional children. In 2005, approximately 17% of births to teens in Minnesota were second births (www.childtrends.org). Children born to teens are more likely to have low birth weight, experience abuse and neglect, and enter the child welfare system. According to the National Campaign to Prevent Teen Pregnancy, daughters of teen mothers are 22% more likely to repeat the cycle as teen parents and sons of teen mothers are 13% more likely to be incarcerated. Some of the highest teen birth rates in Minnesota are in rural counties (Figure 3).

The U.S. teenage birth rate remains the highest in the developed world and about four times the European average. Teenagers in the United States begin having sexual intercourse on average a year or two before their European counterparts. More than 400,000 children are born to teen mothers in the United States each year. In contrast, Germany, Netherlands and France have the lowest teen pregnancy and STI rates in the world (Figures 4 and 5). These positive trends

Figure 3: *Teen birth rates by county, Minnesota, 2004-2006.*

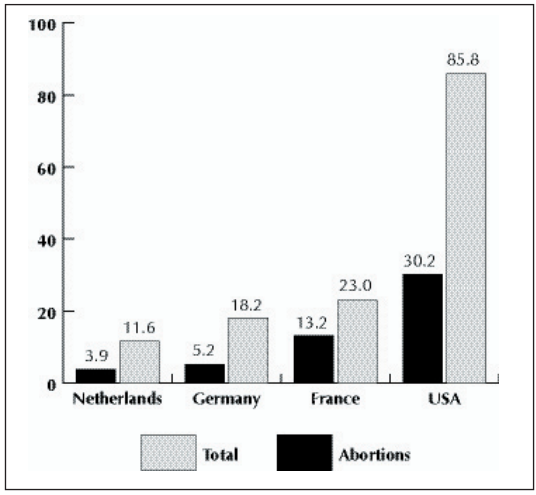


Source: Minn. Department of Health, Center for Health Statistics.

date back to a mass campaign started 20 years ago that uses a single consistent message: Safe Sex or No Sex. Three Rs underline the social philosophy toward adolescent sexual and reproductive health in these countries: Rights, Responsibility and Respect.

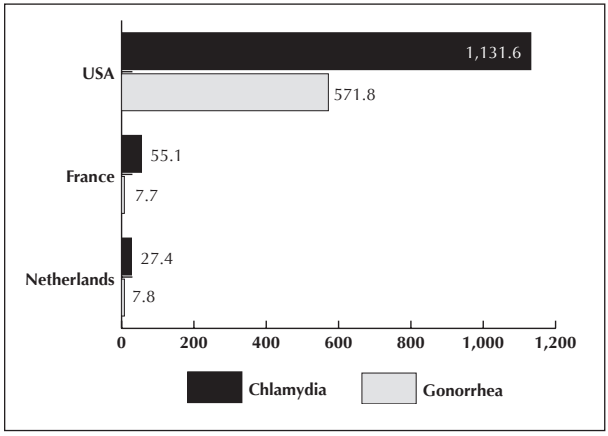
In Europe, discussions about healthy sexuality start at an early age. Mandated sexuality education is consistent in every school from kindergarten to 12th grade. Early discussion centers around respect for the human body. These early lessons help to minimize embarrassment about sexuality and prevent the mixed signals that the time has come to start having sex. When Europeans reach puberty, their educators spend less time and effort preventing young people from having sex and invest more time and effort educating and empowering young people to be responsible when

Figure 4: *Teen conception rates, 15- to 19-year-olds per 1,000.*



Source: Unicef's report on Teenage Births in Wealthy Nations, July 2001.

Figure 5: *Teen STD rates, per 100,000.*



Source: Alan Guttmacher Institute report on Sexually Transmitted Diseases Among Adolescents in Developed Countries, Feb. 2000.

they decide to have sex. This European approach creates greater social acceptance around sexuality, fostering a societal willingness to ensure access to reproductive health services for teens. With more social acceptance also comes a greater willingness among teens to seek out reproductive health services without facing stigma.

Cervical cancer screening

Minnesota has one of the lowest incidence and mortality cervical cancer rates in the United States. A failure to screen along with the failure to detect abnormalities during screening or adequately follow up on detected abnormalities are considered to be the primary reasons that approximately 175 Minnesota women are diagnosed with this preventable disease each year (Perkins, 2005).

Minnesota statistics indicate that women living outside the seven-county Metro area are 30% more likely to be diagnosed with an invasive cervical cancer compared to women living in the Metro area and are also somewhat more likely to be diagnosed at a later stage and at an older age (Table 1). Less effective cervical cancer screening is considered to be a factor explaining these urban/rural differences (Perkins, 2005).

Obstetric services and prenatal care

The disappearance of obstetrical services (OB) is a growing problem for many rural communities. In 2005, the National Advisory Committee for Rural Health and Human Services (NACRHHS) examined the viability of OB services in rural communities nationwide and reported that factors such as declining birth rates, excessive professional demands on OB physicians, physician payment and increasing cost of malpractice insurance were contributing to the "erosion of OB services in rural communities" (U.S. Department of Health and Human Services, 2005). Given

Table 1: *Cervical cancer incidence and mortality among non-Hispanic white women by residence, Minnesota, 1998-2002*

	Incidence			Mortality		
Residence of diagnosis	**Cases**	**Rate**	**(95% CI)**	**Deaths**	**Rate**	**(95% CI)**
Metro	328	5.5	(4.9, 6.1)	73	1.2	(0.9, 1.5)
Non-metro MSA	136	6.8	(5.7, 8.1)	41	2.0	(1.4, 2.7)
Rural	253	7.0	(6.2, 8.0)	56	1.3	(1.2, 1.6)

Metro: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, Washington
Non-Metro MSA: Benton, Chisago, Clay, Houston, Isanti, Olmsted, Polk, St. Louis, Sherburne, Stearns, Wright.
Rural: Remaining counties.
Source: Minnesota Cancer Surveillance System (April 2005) and Minnesota Center for Health Statistics.

that most rural communities lack an obstetrician, family practice physicians working with other mid-level providers frequently fill the gap.

Physician workforce surveys are one of the best assessment tools available for knowing if OB services are declining in rural Minnesota. Workforce surveys ask physicians to select prenatal care, delivery, or both, to describe the obstetrical services they provide regardless of their specialty. A comparison of physicians practicing from 2003 to 2007 indicates an overall decline in the provision of OB care across rural, metropolitan and micropolitan areas of the state. However, similar to national trends, Minnesota's workforce data shows a greater decline over time in the number of rural physicians providing obstetrical services (Table 2).

Access to obstetric care and its effect on birth outcomes was the subject of a study in 1990 in rural areas of Washington State. Researchers discovered that women living in rural communities lacking obstetrical providers in proportion to the number of births were less likely to deliver in their local hospital and had a greater proportion of complicated deliveries, higher rates of prematurity and higher costs associated with neonatal care compared to women from communities where most delivered in the local hospital (Nesbitt, 1990). While studies like this suggest there may be an association between a decrease in local availability of obstetric services and poorer birth outcomes, more research is necessary to confirm a causal relationship exists.

Delaying or receiving no prenatal care increases the risk of infant death. Analysis of birth outcome data in Minnesota suggests there is room for improvement in infant mortality rates specifically in

Table 2: *Physicians providing obstetrical services regardless of specialty, 2003-2007.*

	2003	2004	2005	2006	2007	Change of prenatal/ delivery responses from 2003 to 2007	Change of total survey responses from 2003 to 2007
Metro	1,389	1,334	1,175	796	852	-39%	-26%
Micro	271	249	202	168	182	-33%	-21%
Rural	262	220	184	126	136	-48%	7%

Source: Office of Rural Health & Primary Care Physician Workforce Surveys.

rural regions of the state. A comparison of the infant mortality rates (IMRs) aggregated by time period for Minnesota's metropolitan, micropolitan and rural counties, indicate that despite improvements in IMRs occurring in both metropolitan and micropolitan regions, infant deaths in rural Minnesota during the same time period remain the same (Table 3). Ensuring better access to reproductive health services in rural regions of the state could be the answer. The NACRHHS suggests this could be achieved by expanding the federal Maternal and Child Health (MCH) Services Block Grant program (Title V) to address the needs of rural communities lacking OB services or simply tracking the percentage of federal grants flowing to rural communities through the MCH block grant. The decision to live and raise a family in a rural area may be influenced by the availability of OB services.

Publicly funded reproductive services

Being uninsured or underinsured is common given the part-time, seasonal and low-income employment found in rural areas, making access to health care in rural areas a challenge for women with low incomes who cannot afford to pay out of pocket for preventative health services. Having publicly funded reproductive health programs ensures women are provided access to essential reproductive health services regardless of their financial circumstances. Five such programs are available: The Sage Screening Program, Title X, The Minnesota Family Planning Program, Family Planning Special Projects, and Positive Alternatives.

Table 3: *Number and rate of infant deaths (per 1,000), Minnesota, 1996-2000 and 2001-2005*

	1996-2000			2001-2005			
Region	**Births**	**Deaths**	**Rate***	**Births**	**Deaths**	**Rate***	**% Change in rate**
Metro	246,875	1,463	5.93	261,659	1,286	4.91	-17%
Micro	43,004	254	5.91	46,379	224	4.83	-18%
Rural	36,896	203	5.50	38,195	208	5.45	-1%
Minnesota*	326,784	1,920	5.88	346,245	1,722	4.97	-15%

**Includes births and deaths in which county of residence was missing.*
Source: MDH Minnesota Center for Health Statistics.

The Sage Program

Administered by MDH, The Sage Screening Program (Sage) was established in 1991 with the purpose of increasing women's accessibility to breast and cervical cancer screening in Minnesota. Sage provides free breast and cervical cancer screening and diagnostic follow-up for women whose household incomes are at or below 250% of the federal poverty line and are uninsured or underinsured. Since its inception, Sage has served over 110,000 women, provided more than 353,000 mammograms and Pap tests, arranged for or provided coverage for more than 38,775 diagnostic procedures for women with abnormal screening results, developed a service delivery network of more than 380 medical providers around the state, and funded Community Health Service Agencies and community-based organizations to recruit underserved women for screening. Sage is funded by a grant for the Centers for Disease Control and Prevention, the Susan G. Komen for the Cure and the State of Minnesota.

Title X

A long-time source of public funding helping women obtain reproductive health care services is the Title X family planning program launched in the 1970s. Title X has been the nation's only program solely dedicated to ensuring access to reproductive health services for women who are low-income. Title X funding is distributed by the federal government to more than 80 grantees nationwide who then distribute funds to 4,480 health centers in the program (Fowler, 2008). Health centers, like Planned Parenthood Centers, play an integral role in providing reproductive health services in underserved rural areas largely because of Title X funding. A large proportion of reproductive health services currently available to women living in Greater Minnesota is due to the presence of Planned Parenthood. Planned Parenthood of Minnesota/South Dakota South Central receives $2.67 million of Title X money per year for Greater Minnesota which is used at 17 sites around the state, plus at 17 other sites run by three delegate agencies. The only other entity in Minnesota receiving federal Title X funds is St. Paul-Ramsey County Department of Public Health.

The Minnesota Family Planning Program

The Minnesota Family Planning Program (MFPP), administered by the Minnesota Department of Human Services (DHS), is a recent, five-year demonstration program approved by the Centers for Medicare and Medicaid (CMS). In 2001, the Minnesota Legislature

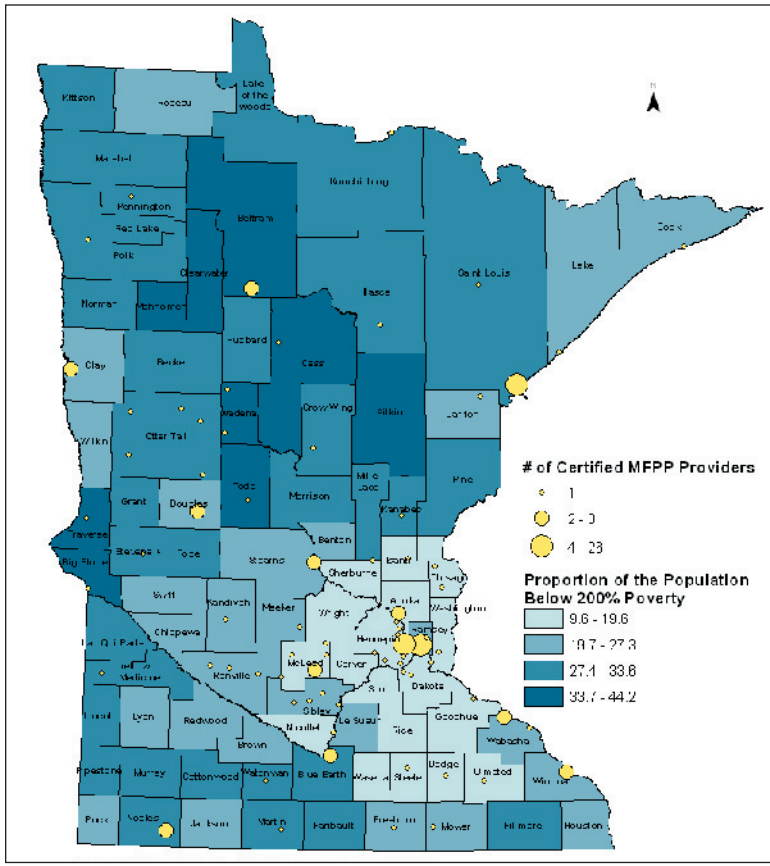
directed DHS to extend access to reproductive services for low-income individuals not enrolled in Minnesota's public assistance programs to determine if access to pre-pregnancy family planning services would reduce Medical Assistance and welfare costs. Services covered under MFPP must be provided by a Medicaid-certified provider and include office visits, family planning, testing and treatment for STIs, birth control and sterilizations. According to DHS Reports and Forecasts Division, data from July 2008 indicate that 25,562 people were served during fiscal year 2007 with a monthly average enrollment of 9,000. The cost effectiveness of the program is still being determined.

Providers are given the opportunity to become a "presumptive eligibility" (PE) provider under MFPP, which certifies them to make an immediate eligibility determination of a patient who qualifies for MFPP without delaying her need for reproductive health services. Presumptive eligibility is most suitable for smaller providers such as Federally Qualified Health Clinics, local community clinics and school clinics because it provides MFPP coverage for a minimum of one month and up to two months for women who qualify while also guaranteeing payment for services provided. There are currently 136 providers certified to make MFPP eligibility decisions throughout the state, with the largest concentration located in urbanized areas of Minnesota (Figure 6). Possible factors contributing to a scarcity of PE certified providers in some rural areas of Minnesota may be the lack of a provider presence and a certification process that has been described by some providers as complex and time consuming.

Family Planning Special Projects

Family Planning Special Projects (FPSP) is administered by the Minnesota Department of Health (MDH) and is a competitive grant program established in 1978 by the Minnesota Legislature. Grant funds are available for local public health departments, tribal governments and 501(c)3 nonprofit organizations to provide reproductive health services to low-income, high-risk individuals in Minnesota. Funding is distributed to each of the program's eight geographic regions, one being the seven county metro area and the seven remaining regions located in Greater Minnesota. Each region's allocated amount is calculated as a proportion of the total available dollars based on the number of women of reproductive age who are eligible for Medical Assistance. These grants are awarded through a competitive process so funding is not assured beyond each grant period. The FPSP Program is also subject to appropriation by the legislature every two years. In 2006, the program reported that 65,322

Figure 6: *Certified Minnesota family planning program providers as of June 2008.*



Source: Minnesota Department of Health, U.S. Census Bureau.

people were given information about family planning services, 28,045 women received family planning counseling, and 24,536 women obtained family planning method services of their choice. Currently, there are 24 grantees in Greater Minnesota receiving a total of $2.63 million in FPSP grants per year. The money is used at clinic sites in 48 different counties. The FPSP program is another important resource for raising awareness about the importance of maternal and child health among rural women and provides much needed reproductive health services.

Positive Alternatives

The Positive Alternative Act, established by the Minnesota Legislature in 2006, makes $2.5 million in public funds available annually through MDH for alternatives to abortion programs that support, encourage, and assist women in carrying their pregnancies to term and caring for their babies after birth. Grantees receive funds to connect women to community services including parenting classes, adoption services, and housing and employment assistance. Some grantees provide a limited amount of reproductive health care services including ultrasounds, prenatal medical care and STI testing and treatment. Recipients of the 2008-2010 grant funding cycle are concentrated primarily in urbanized areas of Minnesota with 10 in metropolitan, 11 in micropolitan and four in rural counties. Among the grantees in rural counties, one provides STI testing and treatment, one provides off-site ultrasounds in first trimester of pregnancy and none make prenatal care services available on-site. The program just completed it first two-year grant cycle; a detailed report assessing the program's impact on women's access to reproductive health care services in Minnesota is due this fall.

The strengths of rural communities

Rural areas are culturally unique, which paradoxically contributes both positively and negatively to the health care status among women living in a rural community. Women living in rural areas are less likely to have easy access to health care services, especially specialty care, specifically obstetric care and reproductive services. National studies have shown that rural residents tend to be older, lower-income, uninsured, more likely to have chronic health conditions and less likely to receive necessary preventive health care services (Eberhardt, 2001). However, women in rural areas often have strong social networks and social ties of long duration, allowing for easy collaboration and cooperation in improving their health status, regardless of the obstacles they may face. The following case studies highlight the strengths and challenges faced by rural clients who seek reproductive health services, their health care providers, and the champions who fight to maintain access to these services in rural Minnesota.

The Center Clinic — Dodge County

The Center Clinic is a volunteer-based clinic created to respond to the need for subsidized reproductive health care services in Dodge County. It provides women's yearly health exams and lab tests, healthy lifestyle counseling and information, pregnancy testing, birth

control supplies, diagnosis and treatment of sexually transmitted infections (STIs), and classroom and group presentations. It also provides mental health counseling and support groups for Latino women and teens. The Center Clinic is the sole provider of reproductive health services in the area outside of Rochester and Owatonna.

The strength of the clinic is the committed volunteers and their belief that rural teens and women deserve the same level of services enjoyed by their urban counterparts. The clinic began serving 35 clients in August of 2004. By 2007, The Center Clinic provided access for 580 patients, including 203 clients making initial visits and 377 client revisits. Most clients learn about the clinic from friends or relatives. The caseload at The Center Clinic is about half teens and half Latino women.

Rural teens face unique challenges to receiving reproductive health care services. Poverty, transportation challenges, and a lack of services add to the complexity. Raising social awareness for parents and teenagers is an important focus area for The Center Clinic. Many local parents do not believe that teens in rural areas face the same risks as those in large cities, while teens may feel their parents do not understand the issues they face and have a hard time talking to them. Local teens may also not believe that STIs are an area of concern for them.

Confidentiality is a major concern for adolescents seeking reproductive health care services. The Area Learning Center, an alternative high school, used to be in the same building as The Center Clinic. The building was owned by a private individual and not a public school, so students could access reproductive health care services during lunch or before and after school. These students, many considered high-risk for unplanned pregnancy and STIs, had easy access to health education and services. When the Area Learning Center moved to a neighboring town, these teens faced the challenge of locating another confidential and affordable reproductive health care provider.

Most Latino women who go to The Center Clinic have low incomes and are uninsured. The majority also need interpreter services. Many Latino clients are anxious when accessing health care services. The Center Clinic helps clients feel as though they are in control while at the clinic, since many do not feel very powerful in their day-to-day existence. The Center Clinic staff ensures that while they are cared for, nothing will happen to them that they do not approve of or agree with. The hope is that this empowerment will spill over into other arenas of their life, or at least help to sustain

them as they deal with the challenges of living and raising a family in poverty.

Romana Gonzalez, a community health outreach worker, interpreter and general office manager, is key to the clinic's success serving the Latino population. She is highly respected in the local Latino community. Trust is a huge concern and Romana lays the foundation of trust that gets clients in the door. Clinic staff then strive to deliver compassionate and culturally appropriate care by treating every patient with respect, dignity and kindness. They help clients navigate the complex human service and medical care systems. Many Latino women have partners who do not understand the importance of preventive health screening. Many will not allow their wife to be examined by a male health care provider. To address this cultural taboo, The Center Clinic attempts to have at least one female provider available during clinic hours.

Even with the health care services provided through The Center Clinic, there are still unmet needs due to resource constraints. Clinical services are limited to serving women and their partners seeking reproductive health services. The original goal was to provide a range of health care services to the entire uninsured population in Dodge County. Until this happens, staff must be creative when linking clients to other health care services because available services are limited or often not affordable. Resource constraints also impact STI screening efforts, although the MFPP will increase the clinic's screening capabilities.

Transportation is another huge issue for women who access services at The Center Clinic. Getting to Rochester, the nearest big city, can be compared to "getting to the moon" for many clients. To address this need, clinic staff have been known to transport a client who cannot find a ride or hand-deliver their contraceptives. Breaking down the transportation barrier enables their clients to take charge of their health.

Funding is an ongoing challenge. The Center Clinic received a $5,000 start-up grant from a local collaborative in 2004 and again in 2005. The clinic received additional funding from the Office of Rural Health and Primary Care's Community Clinic Grant Program for several years. Currently, the only grant funding is through the Family Planning Special Projects program. The Center Clinic bills for some services through MFPP and the Sage program. Larger office space is needed to expand services and the clinic is moving toward this goal with help from the local United Way and a private memorial.

Jan Lueth, a public health nurse who championed the volunteer-based clinic from its inception, knew funding would be a challenge. "When we started this project, we said we would keep going until we hit a brick wall. Instead of walls, we have found stepping stones. It's been an interesting, challenging, but encouraging journey!" She serves as the volunteer clinic director and sees patients at weekly walk-in clinics and at two monthly evening clinics. She also does grant writing and other administrative duties.

Dr. Matthew Bernard serves as the Volunteer Medical Director and also works at a majority of the evening clinics. He believes that volunteers are the heart and soul of The Center Clinic. The physicians and nurse practitioners donate their time. A psychiatric resident sees clients at monthly evening clinics and leads a support group of Latino women, which is very well attended. A dedicated pool of volunteer nurses and a volunteer dietitian work clinics and provide other programs. The volunteer dietitian started walking groups in four communities and sees clients for individual assessments. Paid staff positions include a part-time registered nurse, a part-time community health outreach worker who provides interpreter services, and a part-time clerical/billing position. The individuals in these paid positions also volunteer their time. In-kind contributions were estimated at $104,000 for 2007, which exceeds the clinic's general operating budget.

The clinic also relies on various community partners. Dodge County Human Services serves as the volunteer fiscal agent to manage grants. Kasson Mayo Family Practice Clinic provides physician services for the clinic. Weber and Judd provide medications at 5% over their cost. Mayo Regional Lab provides discounted lab prices. The food shelf next door allows the clinic to use their space at times. In 2007, The Center Clinic honored over 100 individuals and agencies for their contributions.

In 2008, The Center Clinic was honored by MOAPPP (Minnesota Organization on Adolescent Pregnancy Prevention and Parenting) as the Outstanding Program of the Year. A core of volunteers accepted the award with celebration of past achievements and anticipation of future success. "To receive recognition from an organization like MOAPPP is seen as truly an honor and a challenge to keep working towards our goals for our clinic and our clients," Lueth said.

The Center Clinic contributes to the future health care workforce in Minnesota by exposing students to the realities of caring for the uninsured. Augsburg nursing students and Mayo medical residents spend time at the clinic. They must consider how to access limited

community resources and cannot order every test they are trained to think is required. It may be their first exposure to teenagers sharing their social histories, including the number of sexual partners, depression, self mutilating behaviors and substance use. Rather than retaining long-held opinions about access to reproductive health care services without parental consent, they find themselves overwhelmed by the need for teens to have services available to them.

Lueth says students are often bewildered by the dedication and compassion of clinic staff toward the clients they serve. "It is like a messy closet. Once you have seen the mess, you can always shut the door, but now you know the mess is there hiding behind the door. Even if these professionals never set foot in a free clinic again, we hope they will use their position, education, influence and resources to impact our underserved populations."

Cass-Todd-Wadena County Public Health

The overall goal of Cass-Todd-Wadena County Public Health when providing reproductive health services is to increase capacity and resources to ensure rural health delivery of quality programming for women's health. The primary focus is on providing family planning and risk reduction services. Program goals include improving access to family services, reducing unintended pregnancy, improving the quality of women's health care services, and improving communication among providers through technology and collaboration. Ane Rogers, Family Health Supervisor from Cass County Public Health, Heidi Brings, Family Health Supervisor from Todd County Public Health, and Cindy Pederson, Family Health Supervisor from Wadena County Public Health, lead these efforts in their respective counties.

Unintended pregnancy is a high-priority public health issue in Cass, Todd and Wadena counties. This project targets all women of reproductive age with an emphasis on women with low incomes who are uninsured or underinsured. The majority of the population served is Caucasian, although there is a growing Latino community in Todd County (currently around 8% of the population). The American Indian population receives most reproductive health services from the Indian Health Service, but in outlying clinic areas they are often served through county programs.

This project uses a community clinic model of service delivery and works with family planning and general practitioners to serve women in a holistic manner. Public health nurses and midlevel practitioners use a risk assessment tool to screen for depression,

chemical use, domestic violence and other health related issues that may be addressed through available community resources. They also screen for a primary provider to ensure women have regular ongoing health care.

Many residents of Cass, Todd and Wadena counties live in isolation, miles away from medical services, and must travel 75-80 miles to receive subsidized family planning services. Thirty percent of these women delay or fail to seek medical care because of cost or insurance barriers. The most at-risk women have unreliable transportation. All three counties are designated Medically Underserved Areas and Health Professional Shortage Areas for primary care.

Funding is an ongoing challenge to maintaining reproductive health services in Cass, Todd and Wadena counties. Family Planning Special Project (FPSP) grants were not received after 2004 and as a result, clinics that had been operating under FPSP grant funding closed. The public health advisory committees from these counties viewed unintended pregnancy as a high priority and looked for other funding sources. In 2005, Cass-Todd-Wadena public health agencies were awarded a three-year federal Rural Health Services Outreach Grant for Women's Health Community Clinics. This grant program encourages the development of new and innovative health care delivery systems in rural communities that lack essential health care services through an emphasis on collaboration. Local public health departments, private medical clinics and community agencies are involved in collaborative activities to maintain reproductive health services in their area. Consortium members include Cass County Health, Human and Veterans Services, Todd County Public Health, Wadena County Public Health, CentraCare Clinic, Innovis Health – Walker, Innovis Health – Menahga, Pine River Family Center, Wadena Medical Center and Ottertail Wadena Community Action Council.

Open Door Clinic — Mower County Public Health

The Open Door Clinic in Mower County serves about 160 clients each year, including teens seeking birth control and STI screening, young adults who cannot afford care through traditional medical systems, Latino women without insurance or access to other reproductive health care services, and young males seeking STI diagnosis and treatment. Each year the number of clients served at the clinic increases.

Clients find out about Open Door Clinic services in a number of ways. Signs are posted in the Health and Human Services lobby,

laundromats, the public library and local community college. Pamphlets are available at the college, local schools, through the WIC program, and the multilingual Welcome Center. Several local providers refer clients to the clinic. Media efforts include articles in the local paper, occasional radio spots, and an ad on the back of local grocery store receipts. A common referral source is word of mouth.

A public health nurse coordinator and three public health nurses staff the Open Door Clinic. The coordinator manages the clinic, provides client counseling, and performs other duties as needed. One nurse provides lab services and helps with dispensing of medications. Another nurse assists the provider in patient rooms and helps with dispensing. A part-time clerical staff works on clinic nights. An interpreter is present at all clinics. Medical providers take turns rotating and volunteering their services; most work at the clinic twice a year.

One of the biggest challenges facing the Open Door Clinic is interpreter services. Scheduling the growing number of Latino clients is difficult because of the limited number of available interpreters. Currently all clinic appointments are in the evenings, although it would be optimal to offer daytime hours for clients who work second shifts. Another challenge is the number of different medical providers serving clients. While it is easier to recruit volunteer medical providers for a limited-time commitment, the drawback is that the clients seldom see the same provider.

Rural communities have come a long way in removing the stigma of family planning and STI testing, but more work needs to be done. The Open Door Clinic has filled a gap by providing confidential reproductive health services that many young people feel they desperately need. In smaller, rural areas where so many people know each other, teens seeking reproductive health services often avoid medical centers for fear of running into family, neighbors or friends. The local medical center does not have evening appointments for students who attend school, so the Open Door Clinic offers extended evening hours.

Financial barriers hinder access to reproductive health services. Janne Barnett, a family planning nurse at the Open Door Clinic, believes the demand for reproductive health services in rural areas will continue to increase. "Because STI and unintended pregnancy are here in rural areas just as they are in the urban areas, we need to continue to offer family planning services. With the economy, we are seeing more people who need these services."

Barnett believes the MFPP is a huge step to addressing this need. Because it is a newer program, many women who qualify

are unaware it exists. Getting on the program requires time and diligence on the part of patients and their health care provider. A public media campaign to inform rural providers and patients about the MFPP could be a step in the right direction.

Double Dutch Campaign — Redwood-Renville Community Health Services

Redwood-Renville Community Health Services staff were impressed by the success of international teen pregnancy prevention programs and decided to incorporate aspects of the European educational approach called "Double Dutch" to start their own campaign. Double Dutch emphasizes that abstinence is the best approach; however, if and when individuals decide to have sex, they will always use protection. The Double Dutch message is the woman always uses the pill or other contraceptive and the man always uses a condom. The pill protects from pregnancy and the condom prevents STIs. The program targets young men in particular to understand their responsibility for safer sex.

After a community assessment and input from a public hearing, the Redwood-Renville Board of Health took a clear position on family planning. Their position is: (1) family planning is proactive and needed, (2) a clear consistent message is Safe Sex or No Sex, (3) abstinence should be promoted as safeguarding against pregnancy and diseases, (4) preconceptual care and family planning are to preserve a woman's ability to have a healthy baby and (5) educating people on how not to conceive is necessary to decrease unintended pregnancy and abortion rates. The Double Dutch campaign fit with their position and was funded entirely through a county tax levy.

Both men and women have been targeted with the Double Dutch campaign through condom distribution sites. Over 8,000 condoms were distributed in 2007 and are available 24/7 in baskets in the hallways of the county office building. Volunteers prepare the condom packets for distribution and minimal staff time is used to sustain the campaign. People hear about the campaign through word of mouth, newspaper ads, community presentations and brochures.

The program has not faced many challenges to date. Program champion Jill Bruns states, "When the facts are presented in a caring and respectful way, it is difficult to dispute the facts!" When one mother was upset after finding the condom packet and information in her son's room, she was reminded that her son voluntarily took the packet and it presented a good opportunity to talk with him about her values and expectations. No matter how uncomfortable it is for parents to discuss sex, the lives and health of their children depend on it.

Community partners are on board with the Double Dutch campaign and see it as filling a gap in services and education around healthy sexuality, especially for young men. The opportunity to expand the campaign is promising. The Double Dutch concept was presented to other public health departments in southwest Minnesota and is being replicated in some counties. With STI rates climbing in Minnesota and nationally, especially among teens, the Double Dutch campaign provides a consistent message and approach for teens, their families and communities to reverse these trends.

Rice County Public Health

Rice County Public Health serves 350-400 women with low incomes in need of reproductive health services each year. The women are primarily under 30. A significant proportion of the women have a primary language other than English. The program aims to serve working women without health insurance through their employers and those who are not eligible for public programs such as Medical Assistance and MinnesotaCare.

The services provided are reproductive health examinations, diagnosis and treatment of sexually transmitted diseases for women and their partners, sexuality education and contraceptives. Clients find out about services through word of mouth, outreach materials available in English and Spanish, and through referrals from social services and health care providers.

There are two main barriers to access for women seeking reproductive health services in the area: transportation and cost. The nurse assigned to care for women living outside the two main population centers in Rice County has office time in both Faribault and Northfield to address the transportation issue. The subsidized program addresses the high cost of contraceptive methods. Compared to the cost of an unplanned pregnancy, contraception is not expensive.

Rice County Public Health also works with schools, nonprofits and other local organizations to comprehensively address the issue of adolescent pregnancy, which has increased in recent years. They partner with Project SIGHT, a countywide teen pregnancy prevention effort, and other organizations to augment education and outreach efforts.

The major source of funding for subsidized reproductive health services in Rice County is the Family Planning Special Project grant available through the Minnesota Department of Health. Because of the uncertainty around FPSP funds, Rice County Public Health is

not able to inform providers and clients if services will be available beyond the end of the grant period.

Rice County Public Health is the sole provider of subsidized reproductive health services in Rice County. Since the program contracts with four local clinics for services, it is important to communicate with practitioners and administrative staff about the details of the services and clients covered through the FPSP program. Community partners for clinical services include Cannon Valley Clinic/Mayo Health System, Allina Medical Clinic Faribault, Allina Medical Clinic Northfield, and the Women's Health Center of the Northfield Hospital. These clinics are generous in providing physical exams and other services at a reduced cost.

Mary Ho, Community Health Services Director in Rice County, sees hope in the statewide expansion of the Minnesota Family Planning Program (MFPP). "This program is available statewide, covers a broad range of services, and is not dependent on grant funding or constrained to a limited number of women who can participate. If women eligible for the MFPP could be served on that program, FPSP funds could be more available throughout Minnesota rather than limited to areas receiving the grants."

Conclusion

Reproductive health services are frequently a woman's introduction to a constellation of essential preventive health care services. Navigating the path leading to reproductive health care services can be a real challenge for women living in rural areas, especially given the declining number of practicing obstetricians, limited venues for accessing reproductive health care, mounting financial barriers and diminishing resources. Despite these challenges, Minnesota's rural communities have demonstrated the capacity for innovation and commitment to preserving the reproductive health care safety net for women. Passionate advocates working in partnership with rural communities provide the necessary leadership and lay the foundation for success. Collaboration between health care providers, consumers, educators, churches, employers and local government can increase access to rural health care services and improve overall population health. State and local policymakers can learn from rural health professionals what is required to provide reproductive health care services that are safe, effective, patient-centered, timely, efficient and equitable.

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Appendix A: *Classification of Minnesota counties according to U.S. Office of Management and Budget (OMB).*

Metropolitan	**Micropolitan**	**Rural**
Anoka	Beltrami	Aikin
Benton	Blue Earth	Becker
Carlton	Brown	Big Stone
Carver	Cass	Chippewa
Chisago	Crow Wing	Clearwater
Clay	Douglas	Cook
Dakota	Freeborn	Cottonwood
Dodge	Goodhue	Faribault
Hennepin	Kandiyohi	Fillmore
Houston	Lyon	Grant
Isanti	Martin	Hubbard
Olmsted	McLeod	Itasca
Polk	Mower	Jackson
Ramsey	Nicollet	Kanabec
Scott	Nobles	Kittson
Sherburne	Otter Tail	Koochiching
St. Louis	Rice	Lac qui Parle
Stearns	Steele	Lake
Wabasha	Wilkin	Lake of the Woods
Washington	Winona	Le Sueur
Wright		Lincoln
		Mahnomen
		Marshall
		Meeker
		Mille Lacs
		Morrison
		Murray
		Norman

		Pennington
		Pine
		Pipestone
		Pope
		Red Lake
		Redwood
		Renville
		Rock
		Roseau
		Sibley
		Stevens
		Swift
		Todd
		Traverse
		Wadena
		Waseca
		Watonwan
		Yellow Medicine