



# Project Connect Los Angeles Case Study



## Project Overview

The Project Connect Health Systems Intervention (Project Connect) was originally implemented as one component of a multilevel, structural intervention to prevent STD, HIV, and teen pregnancy, fielded as part of an eight-year research study.

The health systems component is a structural intervention designed to alter the school environment to facilitate the referral and linkage of youth to needed sexual and reproductive health care services in the community. By referring students out for care, as opposed to bringing services to them (e.g., STD screening blitz on campus), Project Connect provides students with the opportunity to learn to

navigate the health care system on their own, an important skill which should also serve them well in adulthood. Although the original iteration of Project Connect was a funded research study, the process of identifying schools and providers, and of creating the referral guide itself, can and has been applied outside of the research context.



**Centers for Disease  
Control and Prevention**  
National Center for HIV/AIDS,  
Viral Hepatitis, STD, and  
TB Prevention

## Context and Setting

Despite high rates of STD and unintended pregnancy among Los Angeles (LA)-area high school students, relatively few youth receive sexual and reproductive health care. At the start of the research study, just 17% of Project Connect high school students reported ever being tested for an STD. Students whose parents went with them for their last health care visit were 72% less likely to have been tested for an STD than those who sought care on their own.

Working in highly stressed schools, with limited resources, high transience rates among students, and high staff turnover (e.g., among nurses), investigators recognized the need for practical, feasible, low-cost prevention efforts that would have significant impact and could be sustained over time. Thus, the decision was made to make use of existing school staff to make referrals and to identify a set of community providers who were already doing a good job of meeting the sexual and reproductive health care needs of youth.

## Implementing Core Components

### Environmental Scan

#### *Experience*

As part of the research proposal development process, Project Connect investigators developed a relationship with the Los Angeles Unified School District (LAUSD), one of the nation's largest public school districts, and planned to implement the study in a large enough number of high schools to permit comparisons between intervention and control schools. Investigators at the Health Research Association and the Los Angeles County Department of Public Health selected 26 schools in LAUSD (12 high schools and 14 feeder middle schools), divided into two distinct geographical areas, to implement and evaluate Project Connect. Although the overall study was conducted in middle schools as well, the health systems intervention was implemented only in the high schools. Project Connect high schools were selected by mapping rates of chlamydia and births among 15–19-year-olds by high school attendance areas (the geographic boundaries that define which high school a student attends, according to his/her home address). Twelve high schools in areas with teenage STD and birth rates exceeding Healthy People 2010 goals participated; six of the schools had a school-based health center, and all twelve had a school nurse.

#### *Lessons Learned*

Despite efforts to choose high schools with high teenage STD and birth rates, the actual prevalence of chlamydia among those tested in the Project Connect high schools overall was low (<3%). This may have been due, in part, to the larger study recruitment process, in that the students less at risk for STDs were more likely to agree to participate in the study, and because screening was not connected to a student's reports of sexual activity, making it possible that some students who were not sexually active were screened. However, it is an important consideration for replication—although targeting the most at-risk students within the selected settings is important, it is also important to choose settings in which the most at-risk students may be reached. What those settings are will vary from community to community and is a critical first step in developing this intervention approach.

## **Health care Infrastructure Scan**

### ***Experience***

To develop their initial provider pool, the investigators (which included staff from the local health department), identified community providers in their schools' catchment areas who had reported 10 or more cases of chlamydia among 15–19-year-olds in the past year, as an initial step in finding providers who were already doing a good job of meeting the sexual and reproductive health care needs of youth. Identified providers were then faxed a survey to determine the extent of their adolescent-friendliness and interest in being included in the provider referral guide. Follow-up phone calls were made only to those providers who failed to complete and return the survey.

Criteria for inclusion in the referral guide:

- Providers were active screeners (10 or more cases of chlamydia among 15–19-year-olds reported in the past year);
- Asked all adolescent patients about sexual activity;
- Screened all sexually-active adolescents for STDs;
- Accepted Family PACT (California's Office of Family Planning's Family Planning Access, Care, and Treatment Program) or MediCal (California's Medical Assistance Program), or offer other means of obtaining free services;
- Provided confidential services for adolescents;
- Accepted new adolescent patients; and
- Treated adolescent patients on site.

### ***Lessons Learned***

In-person visits to selected providers were critical in LA for identifying potential barriers to receiving care. For example, a number of clinics were hard to find or were explicitly focused on prenatal care.

Additionally, identification of adolescent male-friendly providers for inclusion in the referral guide may require additional efforts. This was not a specific focus of Project Connect efforts in LA and may have been partly responsible for the weaker results among male adolescents.

## **Development of the Referral Guide**

### ***Experience***

Meetings were held with LAUSD nursing administrators to identify barriers to referring youth for sexual and reproductive health care. These included concerns about safety when sending students off-campus, including school liability for students' safety and nurses' personal liability and feelings of responsibility for the students' welfare; lack of information about provider practices; and lack of awareness of free services available. Investigators then sought to address these concerns through the information provided in the guides, as well as in the training developed to accompany the guide.

## Implementing Core Components

Continued...

Based on feedback from school nurses, two forms of the provider referral guide were created in Los Angeles: 1) a large, laminated poster version of the provider referral guide that could be displayed prominently on the wall in the nurse's office (and other areas in the school), both for easy referral by the nurse, and also to advertise the guide to students who came into the nurse's office; 2) an 8x11 inch tear-off pad version of the provider referral guide that could be given to students who were being referred out for services, thus allowing the nurses to discuss the available service options with a student and then hand them the printed information to take with them. Additionally, two distinct lists of providers were created, due to the large geographic area covered by LAUSD. There was a provider referral guide for South LA, and one for the Valley, with school-specific versions being created to allow for distance to the clinics to be specific to each school. The provider referral guide for South LA contained 26 clinics, whereas the provider referral guide for the Valley contained 13 clinics and four prenatal clinics.

Information in the guide contained the following information for each provider/clinic:

- Location and phone number, including bus routes and distance from high school;
- Clinic websites, if available;
- Whether evening and weekend appointments were available (students were instructed to call for specific clinic hours, as hours of operation were subject to change);
- Cost, particularly if they offered free services through MediCal (California's Medical Assistance Program), or FamilyPACT (California's Office of Family Planning's Family Planning Access, Care, and Treatment Program), or LA County;
- Types of services offered, including urine-based chlamydia tests, male and female condoms, hormonal contraceptives, emergency contraception (as needed, or in advance);
- Gender of patients seen; and
- Whether the clinic had teen-friendly clinic features, including one or more of the following: teen chat group, teen check-in area, teen coordinator, teen input, teen materials, and/or teen waiting room.

### **Lessons Learned**

Student input on the design and content of the provider referral guide was not sought and would have been helpful in determining what students needed most in a provider referral guide and how to maximize their use of a provider referral guide. Since the original study ended, the Los Angeles Department of Public Health has continued to implement Project Connect, and has continued to make use of paper copies of the referral guide, while recognizing that an online version of the guide would be a useful tool for those making referrals, and would likely increase its use by young people.

## **Dissemination and Training**

### ***Experience***

An in-service meeting was held for school administrators, school nurses, and other school personnel who had regular contact with students regarding matters concerning their sexual and reproductive health (e.g., condom distributors, counselors, coaches). Topics covered included the following:

- Information on the sexual and reproductive health care needs of students, based on formative data collected for the study;
- LAUSD policy on confidential medical services;
- California Department of Education Code; and
- Discussion of barriers and concerns.

Additionally, two “Link Over Lunch” meetings were held each year to foster relationships between district and school nurses and clinic staff. Meetings were facilitated by personnel from the Los Angeles County Department of Public Health STD Program. Topics included a discussion of the specific services provided by clinics, as well as brainstorming on perceived barriers to making referrals and solutions.

With the exception of the provider referral guide posters displayed in nurse’s offices, there was no targeted advertising of the Project Connect provider referral guide in schools. Students had to seek out the school nurse or other staff person who had been trained in the use of the provider referral guide in order to be referred for care.

### ***Lessons Learned***

Sharing information with both school administrators and nursing staff was a critical step in securing school-level support for Project Connect. Additionally, raising staff awareness of the sexual and reproductive health care needs of students was equally important for motivating nurses to make use of the referral guide. Investigators presented local data on the sexual risk behavior of area high school students, as well as on STD rates among 15–19-year-olds in the community. The majority of nurses then became champions for student sexual and reproductive health care access. Another important issue addressed was nurses’ concerns about putting students in danger when sending them off-campus during the school day. Best practices of other school nurses who had experience successfully making referrals were shared to increase nurses’ comfort in making referrals.

In hindsight, the Project Connect provider referral guide would have benefitted from marketing efforts within the school environment. Some evidence has suggested that students were sharing the guide information amongst themselves, however, a concerted effort to make the service known to students may have increased the number of referrals made, and thus the number of youth connected to care.

## Considerations for You

Investigator presence in schools was considerable during the development phase of the project, which may not be a possibility when Project Connect is being implemented with existing staff and funds. In Los Angeles, training materials were not developed. Rather, if there was staff turnover at a given project school, project staff members went in person to orient the new staff person on the rationale, purpose, and use of the referral guide. A more practical way of addressing staff turnover may be needed, such as a binder or webinar of basic information about the sexual and reproductive health care needs of students; district and other relevant policies regarding access to confidential services by students; background on the development of the guide, an explanation of the information contained in the guide; and how to make referrals to students, including how to talk with students about the need for sexual and reproductive health care, given their level of sexual activity and risk. When possible, however, some amount of face-to-face contact in schools can really help to keep the intervention going. Brief visits a few times a year to deliver guides and address concerns and questions can go a long way toward keeping staff invested in the intervention.

## Difficulties or Obstacles Encountered

Implementation of the full Project Connect intervention placed additional stress on already overburdened schools and school staff. Despite this, many members of the school staff were actively involved in the implementation of Project Connect, which demonstrates commitment on the part of schools to improve the lives of students outside the classroom. Obstacles encountered by working in a school environment also included high staff turnover and the possibility that the most at-risk adolescents in the community were not reached by intervention efforts.

Finally, Project Connect was not successful in increasing male adolescents' receipt of sexual and reproductive health care. No special attempts were made to identify male-friendly providers in the community. Likewise, school staff was not trained on the specifics of sexual and reproductive health care needs of male youth. School staff may have been less likely to make referrals to males as a result. Although reports of STD and HIV testing improved among intervention school males, they also improved among control school males, indicating no intervention effect. Efforts to address the needs of adolescent males, including young men who have sex with men, have been subsequently made in other sites implementing Project Connect.

## Conclusion

Implementation of Project Connect in Los Angeles demonstrated the success of a low-cost, structural intervention using existing resources to connect sexually-active youth to sexual and reproductive health care in the community. Despite this, opportunities for improvement and adaptation were made clear. Because Project Connect was implemented in schools, there was no evidence of its potential to reach at-risk youth outside of the school setting. Likewise, absence of improvement to linkage to care for males highlighted the need to investigate methods for increasing the engagement of this key target population. As a critical first step, however, Project Connect in Los Angeles identified the core components necessary for successful intervention: identification of areas of great need for sexual and reproductive health care by youth; development of a pool of providers already doing a good job of providing needed services; and, a pathway for linking the two.