

CDC *Vital Signs* Town Hall Teleconference

Preventing Pregnancies in Younger Teens

April 15, 2014

2:00 pm EDT

Coordinator: Thank you for holding.

Parties will be in a listen only mode until the question and answer session of today's conference. At that time you can press star 1 to ask a question.

This conference is being recorded.

And I'd like to introduce your speaker, Dr. Dan Baden.

Dan Baden: Thank you Julie.

Good afternoon everyone. I'm Dr. Dan Baden, the Associate Director for External Partner Outreach and Connectivity at the CDC's Office for State, Tribal, Local and Territorial Support.

Welcome and I'm glad you could join us today. We'll be discussing the latest *Vital Signs* report on preventing pregnancies in younger teens.

Before we get started let's go over some housekeeping details.

You can go online if you haven't already, and download today's presentation so you can follow along with the presenters. The web address is [www.cdc.gov/stltpublichealth](http://www.cdc.gov/stltpublichealth) - again S-T-L-T public health.

There's a link directly to the *Vital Signs* Town Hall web page under Highlighted Products and Resources on the lower right side of the page. On this Town Hall web page you can also view bios for each of the presenters. And this is where we will add the audio recording and transcript for today's teleconference. They should be available next week.

Back to our topic, although teen births in the US have declined over the last 20 years, more than 86,000 teens ages 15 to 17 gave birth in 2012. Giving birth during the teen years has been linked with increased medical risk and emotional, social, and financial costs to the mother and her children.

More can be done to prevent younger teens from becoming pregnant, particularly in healthcare. On today's call we're going to hear from three colleagues.

First we'll hear from Shanna Cox, a health scientist in the Division of Reproductive Health at the National Center for Chronic Disease Prevention and Health Promotion at CDC. She'll provide a summary of this month's *Vital Signs* report.

Ms. Cox will then hand the call over to Alicia Mathis, a clinical coordinator and nurse educator for the Think Teen Pregnancy Prevention Initiative at the Mobile Teen Center in the Mobile County Health Department in Alabama.

Ms. Mathis will discuss how Mobile County, Alabama is addressing the sexual and reproductive health needs of their adolescents and their successes. She will then hand the call over to Deborah O'Uhuru, the Clinical Linkage Coordinator for the Bronx Teen Connection at the New York City Department of Health and Mental Hygiene.

Deborah will talk about connecting the youth in south Bronx, New York to care using the clinical linkages model.

There will be time for questions after our presentations today. But you can get in queue at any time during the teleconference. Just press star 1 and record your name when prompted.

And now I'll turn the call over to Shanna.

Shanna Cox: Good afternoon and thank you for joining this month's *Vital Signs* Town Hall on preventing pregnancy in younger teens.

So I will be starting with slide 5. Today I aim to describe the impact of teen pregnancy on younger teens age 15 to 17, and discuss the recent CDC analysis on births to younger teens and opportunities for prevention. Change slide.

CDC defines teen pregnancies as pregnancies to females age 15 to 19. And this year we chose to focus on the younger subset that gives birth between the ages of 15 and 17, an age where they typically have not completed high school.

An analysis by Child Trends using the National Longitudinal Survey of Youth found that teens who gave birth at ages younger than 18 are less likely to receive a high school diploma or GED as compared to teens who give birth at ages 18 to 19. High school completion is an important economic indicator and social determinant of health that has impact over the life course. Change slide.

So for this year's *Vital Signs* analysis, we assessed the following research questions: What are the patterns of childbearing among younger teens age 15 to 17? What proportion of births to teens 15 to 19 are to younger teens age 15 to 17? And then describe sexual experience, contraceptive use, and level of exposure to prevention opportunities among this age group. Change slide.

We used vital statistics data to examine births to females age 15 to 17. The National Survey of Family Growth (NSFG) was used to provide estimates of sexual activity and exposure to prevention opportunities among never married female teens age 15 to 17. Change slide.

The pregnancy prevention opportunities evaluated using NSFG data include information about birth control and how to say no to sex, either through receipt of formal sex education or via parent communication about sex. Among those that are sexually active, we evaluated receipt of clinical birth control services in the past 12 months and contraceptive use at last sex.

Contraceptive use was classified by effectiveness based on the percentage of females who experienced pregnancy during the first year of typical use. The most effective methods include the implant or IUD. Moderately effective methods include hormonal pills, patch, shot, or ring. And the least effective methods included condoms, cervical cap, sponge, rhythm method, and withdrawal. Change slide.

So here are our results. The birth rates for teens age 15 to 17 declined 63% from 38.6 per a thousand teens in 1991 to 14.1 per thousand teens in 2012. There are noted disparities in teen birth among this group however.

In 2012 the birth rate for Hispanic, non-Hispanic blacks, and American Indian Alaskan Native were two to three times higher than the rates for non-Hispanic whites. Change slide.

In 2012 over one quarter of all teen births were to teens age 15 to 17. As this graphic displays, the overall number of teen births declined as well as the proportion of teen births that are to younger teens. This percentage declined steadily from 36% in 1991 to 28% in 2012. Change slide.

Using NSFG data, we found that 27% of 15 to 17 year olds report ever having sex with sexual experience increasing with age. Only 18% of 15 to 17 year olds report being currently sexually active which is defined as having sex within the last three months.

Ninety one percent of females age 15 to 17 report some form of formal sex education. Seventy six percent report talking to their parents about sex. But only 44% say they talked about both birth control and how to say no to sex.

Eighty three percent of sexually experienced female teens in this age group say they did not receive formal sex education before the first time they had sex. Change slide.

Among currently sexually active 15 to 17 year old teens, 58% received a clinical birth control service in the past month. And most used some form of contraception at last sex. But only 1% used the most effective methods - IUDs or hormonal implants. Change slide.

There are limitations to this analysis. Vital statistics data on births do not include other pregnancy outcomes such as miscarriages, still births or abortion. NSFG data are self-reported, and no information is available on the quality or quantity of formal sex education or parent communication about sex. Change slide.

So in conclusion there is good news. Fewer teens 15 to 17 are giving birth. And the majority of teens in this age group are not having sex. And most of those that are sexually active report using some method of contraception.

However, we must not become complacent and this analysis highlights opportunities for pregnancy prevention including delivering evidenced-based programs to youth before they initiate sex, resources for parents in talking to their teens about sex, and access to teen friendly reproductive healthcare services for those that are sexually active. Change slide.

Please find my contact information for any follow up questions you have that are not answered today.

And now I would like to hand the presentation over to Ms. Alicia Mathis.

Alicia Mathis: If you will please forward to the next slide.

A place to call my own - addressing the sexual and reproductive health needs of adolescents in Mobile County, Alabama.

Good afternoon. My name is Alicia Mathis and I am the nurse educator and clinical coordinator for the Mobile County Health Department's Think Teen Pregnancy Prevention Project.

Today I will introduce you to our very successful adolescent clinic model which has been integral in providing adolescents with sexual and reproductive healthcare services within target communities in Mobile County, Alabama. Next slide.

This slide shows a few highlights of Mobile County, Alabama. In 2012 the teen pregnancy rate was 32.5 which is down from 38.3 in 2010. Seventy percent of high school seniors graduated high school in 2012. And 32.5% of children in Mobile County lived in poverty in 2009. Teen child bearing cost Alabamians \$192 million in 2008. Next slide.

Despite the significant decline, disparities in teen pregnancies and births still exist across the nation and in Mobile County. When compared to their white counterparts in the same age range, black and other minority adolescents have disproportionately high rates of birth. Next slide.

As part of the President's Teen Pregnancy Prevention Initiative, the Office of Populations Affairs provided a portion of the funding needed by the Mobile County Health Department to implement Think Teen, a Pregnancy Prevention Initiative.

The goal of the Think Teen Program is to reduce teen birth rates in the target area by 10% by 2015. In 2011 birth rates among 15 to 19 year olds in the targeted area was 59.6 compared to 40.0 in Mobile County overall.

Think Teen has an onsite teen center at the local health department where teens can receive prevention education and participate in teen focused

activities. We also have a website that offers information on the program and links teens to clinical partners in the community.

We partner with ten community based organizations and six clinical partners who work together to provide teen friendly, culturally competent, evidenced based prevention programs and clinical services to adolescents. Next slide.

To get a better understanding of what youth and parents thoughts were about adolescent sexual and reproductive health, we conducted surveys in 2012 to help identify gaps in needed services in the community. The youth survey revealed that among teens 13 to 19 years old in Mobile County, 47% reported having sex.

Of these, 70% indicated they used a condom at last sex. And 59% of teens surveyed reported they felt uncomfortable talking to their parents about sex. Data collected from the parents survey revealed that 82% think it's important for their child to learn about sex education in public school, while 73% think learning about abstinence in public schools is important.

This information was critical for several reasons. It helped us design activities to meet the needs of parents and youth for our project. And additionally the survey revealed that almost half of the youth in Mobile County were sexually active, indicating a need for access to comprehensive sexual and reproductive healthcare and pregnancy and STI prevention education. Next slide.

I will now highlight a great success story related to Think Teen where we created a teen friendly adolescent clinic. Next slide.

With this slide we took a closer look at one pediatric clinic that is part of the health department. Our program had heard concerns raised by staff and adolescents regarding service provision at the clinic.

In talking directly with the staff, they mentioned that adolescents raised a number of concerns such as many adolescents revealed that they did not feel comfortable talking with their parents about sex or birth control. Additionally because pediatricians were not routinely prescribing birth control, adolescents were confused about where to go to get contraception.

And also, adolescents realized that they weren't like younger children, yet didn't fit into the adult mold either. They were a special group with unique needs. So as we advance to the following slide, I will tell you what we focused on when working with this particular pediatric clinic.

Armed with information regarding the teen birth rates in Mobile County, the lack of contraceptive prescribing and the specific needs of the adolescents, the Think Teen program staff approached the Mobile County Health Department administration with the idea of developing a clinic specifically designed for adolescents.

The blueprint for the adolescent clinic included offering privacy and convenience for clients, having enthusiastic staff who are trained to provide teen friendly practices, and having a welcoming, accepting atmosphere. Next slide.

To better address the unique needs of adolescents, a link was needed to connect adolescents to education and clinical services. Because the provider's time is limited, the role of contraceptive care coordinator was

developed. Nurses or licensed social workers, the contraceptive care coordinators bridge the gap between the adolescents and providers by providing education on the various forms of birth control available, following up with the adolescents on the method of contraception they chose, and making follow up appointments.

They also provide referrals to comprehensive services. I would also like to highlight our use of male contraceptive coordinators, specifically utilized to fill the gap in services for males and address the needs of young men.

We are pleased to say that our adolescent focused clinic opened in February 2013. Next slide.

The pediatric clinic has the largest adolescent clientele, yet adolescents reported that they were being asked about sexual activity but not being asked about or offered contraceptives. In taking feedback from adolescents and staff, the adolescent clinic model shown here was developed.

It is designed to meet the unique needs of adolescents. As you see, the adolescent is at the center of this model. All of the gear for progress are linked and connected to the adolescent which begins when a teen seeks services at the clinic.

Next the clinicians rely on the contraceptive care coordinators to educate the adolescents and address their reproductive health needs which now sets all the gears in motion. The adolescent gets the core reproductive and sexual health related clinical services they need, including education which empowers them to make informed decisions about their own healthcare needs. Next slide.

So by implementing the adolescent care model, we were very excited to witness significant increases in the number of adolescents that were receiving contraceptives. Based on the most recent clinical provider needs assessment, data shows that prior to the development of adolescent clinic, very little contraception was prescribed.

After the creation of the adolescent clinic, prescriptions for hormonal contraceptives have increased by almost ten percentage points from 3.1% to 12.8% among adolescent clients 12 to 19 years of age.

There is more work that still needs to be done. But these efforts and the related findings are important steps toward insuring that Mobile youth are provided access to comprehensive sexual and reproductive healthcare services, especially access to contraceptives. Next slide.

In conclusion, the adolescent clinic model has been successful in creating access to teen friendly sexual and reproductive health services in Mobile County. As show on the previous slide, prescription of hormonal contraceptives has more than tripled since the clinic opened.

By focusing on the unique needs of adolescents, a welcoming clinic environment has been created for adolescents to feel safe and have their needs met. The education provided by the contraceptive care coordinator continues to empower adolescents to make informed choices necessary to take charge of their own reproductive health.

This adolescent clinic thus is a potential model of how health departments and other clinics within Mobile County can provide youth with optimal sexual and reproductive health services.

Thank you for your time. For additional information please feel free to contact myself, Marie Chastang or Pebbles King.

At this time I'd like to turn the call over to Deborah from the Bronx in New York.

Deborah O'Uhuru: Thank you very much Alicia.

Good afternoon. My name is Deborah O'Uhuru and I'm the clinic linkage coordinator for the Bronx Teen's Connection. The Bronx Teen's Connection is a project of the New York City Department of Health and Mental Hygiene. Next slide.

The good news as we are all aware is that teen birth rates have been steadily declining. The not so good news is despite the significant decline, the Bronx rate still remains consistently higher than the rest of New York City. Next slide.

The Bronx Teen's Connection is funded by the CDC and OAH through September of 2015. This funding has enabled us to expand upon the successful work of previous health department efforts.

The goal, a 10% reduction of birth rates in females ages 15 to 19 in two south Bronx community districts—Hunts Point and Morrisania. Our hope is to establish a model which can be replicated throughout New York City and

beyond. Our work will be and has been accomplished through creating strong community wide partnerships. Next slide.

Our project consists of five components which were defined by the CDC. Today's presentation will focus on linking teens at local high schools and other youth serving organizations with high quality, adolescent friendly clinical services. This is one strategy within the access to quality clinical services component of our initiative. Next slide.

So this slide has some animation, and you need to click three times to get through it. So in an effort to link youth to services, we have designed a clinic linking model to connect youth receiving an evidenced based sex education curriculum in schools or youth serving organizations to neighborhood clinics.

The linkages are created based upon capacity and proximity. Clinic staff serving as a health educator act as a pivot in this model. Next slide.

So this slide represents our linkage model as it appears today, 30 active linkages. Our community clinics are represented in light blue across the top. Our school based health centers are represented in purple, also across the top. Our high schools are in the green boxes and our youth serving organizations are in the white boxes.

For us currently, youth serving organizations means a homeless and a runaway center, several foster care agencies, alternative to incarceration programs, and transfer high schools serving slightly older teens seeking high school diplomas. So as you can see this is a very large model and it has many moving parts. Next slide.

For this portion of the presentation we will focus specifically on the clinic to school linkages. So as a Bronx Teen's Connection partner, we ask each of our schools to make the following commitment - that they will implement an evidence-based sex education program as part of the school curriculum in the ninth and/or tenth grade, provide a confidential space for the health educators to physically sit onsite, allow the health educator to present in classrooms and at school gatherings on available clinic services, advertise and promote both the health educator and the clinic services, and insure that all students receiving an evidenced based curriculum participate in a clinic tour field trip. Next slide.

Simultaneously we ask our partnering clinics to make a commitment to achieve a set of best practices in adolescent sexual health as outlined by the CDC, provide a health educator to conduct presentations on clinic sexual reproductive health services, meet one on one with students, conduct condom demonstration and provide condoms, provide information on contraceptive options, schedule expedited appointments or make referrals to the clinic, and co-facilitate the clinic tour field trip. Next slide.

So we've integrated the clinic tour field trip and made it a requirement of our partners implementing evidence based programs. In reducing the risk, the curriculum used by our high school, we've made the clinic tour a mandatory part of Lesson 8.

Currently in Lesson 8 the students had the option to call a clinic. As per Doug Kirby with regard to experiential learning, learning is promoted when new knowledge is demonstrated to students rather than simply being described.

So as part of the clinic tour students learn the location of the clinic, they can meet the clinic staff, they meet an adolescent doctor or clinician, understand the registration process, see exam rooms, ask questions, register for the clinic or schedule an appointment if they would like to.

So we were confident that students would benefit from the clinic tour. But a surprise result was how much teachers and staff benefited. The staff was pleased to create a connection with a local clinic where they could be confident referring their students. Next slide.

So in terms of evaluation, we are using lots of tools to try to truly evaluate the work we are doing. We attempt to track activity from both ends of the linkage - at the clinic end and also at the high school end.

Our health educators use a tracking sheet to track the number of contacts they have with students. They also track the number of referrals and appointments made. We assess changes in student knowledge via a pre- and post-test survey used with our evidenced based programs.

We receive feedback on our clinic tour in several different ways. So here we highlight a few of the results to date. Our health educators have had in excess of 8,000 contacts with students and teens, both in group settings and one on one.

There's been a 21% increase in the number of teens seen by our clinic partners from late 2011 to late 2012. So this is an average increase across seven of our clinic partners who shared full data for both years. We know that our clinics are seeing lots of teens.

We've reached over 4,000 youth with evidence-based programs through schools and youth serving organizations. And to date, 83 classes or cohorts have participated in a clinic tour field trip. Next slide.

Our students evidencing an increase in knowledge - so based on preliminary analysis, there has been a 15% increase in student knowledge across all domains measured. I'd like to bring your attention to the bottom two measures where we looked at pregnancy prevention which reflected a 41% increase in knowledge, and clinic services including minor's rights which reflected a 32% increase in knowledge. Next slide.

We piloted a post-clinic tour field trip survey last spring where we sought to test what students had learned after completing the tour. As you can see overwhelmingly the majority of students agreed that they had learned about confidentiality, that parental permission was not necessary, and that services were low or no cost. Next slide.

So this slide has about five clicks that you need to use to get through. So in addition to quantitative findings, we also looked at qualitative findings where the students' responses were similar and indicated they had learned about minor's rights, confidentiality, and cost. In feedback from school staff and clinic staff, our findings were also in line.

And if I may draw your attention to the last bullet point where our clinic health educator indicates "although I introduce the clinic and let them know what services they can receive, it's not until the tour that they actually get it." So this ties us back to experiential learning. Next slide.

Partner staff turnovers - so we've asked each of our partners to send more than one staff member to trainings and planning meetings around the linkage model. However clinics are limited in human resources and surrendering more than one staff member at a time is often tough.

Data collection and evaluation is an ongoing challenge, but it's critical to the project. We try to assist our partners in getting the most out of their emergency health records and ask them to make an investment in data collection.

We analyze and share the data with them so they can see the marked improvements they've made and also see areas that require additional improvements like law coverage and contraceptive coverage in general.

So at the health department we make efforts to work collectively with other programs implementing teen pregnancy prevention initiatives in the Bronx. Stakeholder buy in is key. It's essential, and without compromise that you must have stakeholder buy in from the top.

We gained buy in and partnered with the New York City Department of Education and the Administration for Children's Services that oversees all foster care agencies in New York City as well as a host of other partners.

Adjust the model and be prepared to adjust it again if necessary. So based upon feedback from our partners, our students, teachers, our clinicians, we are continuously working to improve the model.

Collaborative learning works when we gather our medical directors, clinic champions, principals, teachers, case workers together. We know that

getting the right people around the table and getting them to talk to one another about successes, challenges, barriers, and solutions is key.

We know that this works because our clinics are improving on best practices from year to year, sharing information and helping one another. And our linkages are becoming stronger. Next slide.

So with the CDC's help we plan to continue to refine and perfect our model and make it the best that it can become through 2015. Next slide.

I'd like to thank our funders who make this all possible, the New York City Department of Health and Mental Hygiene, the Bureau of Maternal, Infant and Reproductive Health, the Bronx District Public Health Office, the New York City Department of Education, and my exceptionally dedicated Bronx Teen's Connection team. Next Slide.

Thank you for your attention. My name is Deborah O'Uhuru. I am the clinic linkage coordinator for the Bronx Teen Connection. And I'm going to turn the line back over to Dr. Dan Baden.

Dan Baden: Thank you very much. Thank you all for those excellent presentations.