NWX-OS-OGC-RKVL (US)

Moderator: Jaclyn Ruiz
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1:00 pm CT

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen-only mode until the question and answer session of the call.

If you'd like to ask a question during that time please press Star then 1. Today's conference is being recorded. If you have any objections you may disconnect at this time.

Now I'd like to turn over the meeting to Jaclyn Ruiz. You may begin.

Jaclyn Ruiz: Thank you and hello everyone. Let me first introduce myself. I am Jaclyn Ruiz, a Public Health Advisor and Project Officer at the Office of Adolescent Health.

I'm happy to be presenting today's Webinar widening our lens co-occurring risk behaviors during adolescence.

This Webinar was developed by Child Trends under contract for the Office of Adolescent Health US Department of Health and Human Services as a technical assistance product for use with OEH grant programs.

Today's Webinar will focus on youth risk behaviors and a correlation between various risks and protective factors during adolescence.

We will explore how teen pregnancy prevention programming might impact those risk factors that overlap with multiple risk behaviors and its implications for partnership and sustainability.

The agenda for today's call is an overview of the youth risk behavior. We'll explore how risk behaviors are related, get some lessons from the field and then any programmatic implications.

We have three speakers with us today who'll be focusing on the various aspects of this topic.

Our first speaker is Dr. Vincent Guilamo-Ramos from New York University's Silver School of Social Work.

Dr. Guilamo-Ramos is a Professor and Director of the doctoral program at Silver School Social Work. He's a licensed Clinical Social Worker and Registered Nurse in New York State and board-certified in HIV-AIDS nursing.

He has an expertise in the role of families in promoting adolescent health with a special focus on preventing HIV-AIDS, sexually-transmitted infections and unintended pregnancies.

Dr. Guilamo-Ramos's has been the principal investigator of numerously federally funded research grants around activities associated with the formation of adolescent romantic relationships and subsequent sexual risk behavior in the Latino youth, the development of a clinic-based family intervention designed to delay and/or reduce sexual risk-taking behavior among Latino and African-American early adolescence in outpatient healthcare settings and examining factors associated with adolescent alcohol consumption along the US-Mexico border communities in Texas.

Our second presenter is Dr. Denise Shervington. Dr. Shervington has a distinguished career in academic psychiatry and public mental health.

She splits her time between being the PTFE Staff Psychiatrist at the Southeast Louisiana Veteran's Health Care System and the Institute of Women's - of Women and Ethnic Studies where she created a community-based post-Katrina mental health recovery division and directs a federally funded teen pregnancy prevention program.

She is also the clinical - she's also a Clinical Professor of Psychiatry at Tulane University. She's certified by the American Board of Psychiatry and Neurology and has also received a Masters of Public Health in Population Studies and Family Planning from the Tulane University School of Public Health and Tropical Medicine.

In 2006 she was awarded the Isaac Slaughter Leadership Award by the Black Psychiatrist of America and resides in New Orleans, Louisiana.

And our final speaker is Katy Suellentrop from the National Campaign to Prevent Teen and Unplanned Pregnancy. Ms. Suellentrop is the Director of state support at the national campaign.

And in this capacity she works with other members of the team to support states and communities on all aspects of teen and unplanned pregnancy prevention including evidence-based programs and the latest data and research on these topics.

Thank you all for presenting on today's call. And I'll now turn the presentation over to Dr. Guilamo-Ramos.

Dr. Vincent Guilamo-Ramos: So thank you very much (Jackie). I want to start by first thinking all the folks that are calling in today for the Webinar. And it's always a pleasure it honored to have the opportunity to talk about things that we all collectively care a lot about which is adolescent health and well-being.

I also want to formally thank the Office of Adolescent Health as well as Child Trends and have the honor speaking today with two colleagues, distinguished speakers, Doctors Shervington and Katherine Suellentrop From the National Campaign and so just want to in advance also think my fellow speakers for the opportunity to share the Webinar.

So I'm going to talk about the co-occurrence of risk behaviors during adolescence and provide an overview of youth risk behaviors and also really try to convey to folks on the call how youth risk behaviors are related in particular how we should be thinking about our prevention programs and the kinds of determinants that shape a young people's decision to be involved in risk behavior or not.

I think later in the Webinar colleagues will provide some input in terms of lessons from the field and then also from programmatic implications.

And so if there are any questions feel free to raise them during the Webinar and we'll be happy to, you know, answer them and see if we can, you know, make sure things are clear.

So I'm going to start by first briefly reviewing what we sort of kind of all know already. But we know that adolescence is a critical developmental period.

And so we know that adolescence is critical because it's an opportunity for really addressing early childhood disadvantaged and cumulative adversity.

It's a very important period in terms of biological changes and cognitive development as well as socio-emotional transitions.

We know that young people develop within a broader context and that that context often shapes health and well-being.

So when we think about adolescent health it's really important that we think about a life course perspective which is really in part what I referenced already, you know, the point of childhood development and how that then turns into sort of a trajectory for adolescent health and well-being.

And probably what's oftentimes not recognized the critical link between adolescent, sort of adolescence as a developmental period and adult morbidity and mortality which we'll get to in a second.

But certainly a life course perspective coupled with recognition that there are many social determinants of health and that young people sort of grow up and make decisions within a broader context which often involves their families, their communities, their schools their healthcare providers -- all of the things

that we would consider ecological factors that reflect policy, reflect the economy, reflect neighborhoods, et cetera, and then also, you know, risk and protective factors that there are many things that can potentially lead to risk-taking.

But there are also -- and this is something that's very I think positive and often gets sort of missed there are lots of ways that we can leverage protective factors including aspects of the individual, their family, their communities and their peers that help young people to transition into young adulthood and to be most productive later in life.

And so I made the point that adolescence is a critical period for not only thinking about, you know, young people during their adolescent years but also for long term health trajectories.

And so on this slide one of the things that I really want to emphasize is that you can see that 70% of premature deaths and 1/3 of total disease burden that we see in adults is associated with processes that begin in adolescents and youth and so really, really important.

You know, we're very much, you know, focused on young people is generally being healthy. And that's absolutely true. Young people overwhelmingly are healthy.

But a lot of the trajectories that we see later in life the morbidity, the mortality has its origins in adolescence.

And so it is really second critical period in development. It's an opportunity to health trajectories. And it's also important beyond health in terms of what we call demographic dividend and, you know, considerations of the future

economic growth of our communities, of our country and broader society that young people who are ill who are not fully engaged -- and what we mean by engaged is youth who are in school or in the workforce -- they represent a significant fiscal burden in terms of their reliance on public entitlement or their lack of potential contribution that they would have made had they been able to reach their full potential.

So in short adolescence matters not only for adolescence and for that particular developmental period but it matters for long-term trajectories.

And I think, you know, one of the things that I'm hoping to convey is to make that link between adolescence and later life and also early childhood development.

So here's a question. We have an audience poll. And, you know, I'm going to ask folks to maybe take a second to respond to this and sort of provide your perspective.

So besides risky sexual behavior what are other behaviors youth might engage in they could lead to poor health outcomes?

Well I think I'm going to maybe just provide some of the results from the poll. It looks like everyone believes that all of the above. And so that's absolutely true that all of these things are potential examples of risk behaviors. And they're risk behaviors that we're concerned about. So thanks folks for, you know, being interactive and providing your perspective.

So let's see. So we know the young people and you guys just reaffirmed that by indicating that all of the above risk behaviors were in fact examples of risk behaviors.

We know that there are different types of behaviors that contribute to the leading causes of death and disability among youth.

And so you can see here that, you know, sort of unintended injuries or violence, risky driving, carrying a weapon as examples or alcohol and drug use, tobacco use clearly sexual risk behavior, dietary behaviors, inadequate physical activity that these represent leading causes of death and disability among youth.

And again you can see that certainly, you know, tobacco use, alcohol use, unhealthy dietary behaviors, inadequate physical activity, these are important risks for not only what happens in adolescence but for long term trajectories.

And a lot of what we see later in life in terms of adult morbidity and mortality you can see that the initiation of these behaviors likely have their origins in adolescence.

I'm going to advance us to the next slide and I'm going to have us look together at examples of risk behaviors.

And so what you see on this slide and what we're hoping to convey is this comes from the youth risk behavior survey.

You can see here that adolescence in grades 9 through 12 that there's variability in risk behaviors. And so these percentages are not all the same.

They represent some young people doing things more and some young people doing things less. And so one question that we might ask ourselves is what

accounts for this variability and how do young people make decisions about whether they should or shouldn't engage in a specific risk or protective factor?

Another important point that we want to highlight is if you look here at that same data that really across time you can see that there's a general tendency for risk behaviors to increase as young people move from earlier sort of high school grades to later high school grades.

And so there's more likelihood of young people reporting that they have in fact engaged in one of these risk behaviors as they transition into later years in high school.

And so another question, so given the variability we see in the risk behaviors that we pointed out in the previous slide and also given this general trend of risk behaviors increasing during transitions from middle school into high school with later high school years being associated with greater percentages of involvement in risk behavior what do you think about teen pregnancy prevention programs?

Where should we as the community of folks interested in preventing unplanned teen pregnancies where should we concentrate our efforts?

Should we concentrate our efforts on what we call common factors? These are more global generic constructs things like educational attainment, socio-economic status that are often associated with several risk behaviors and health outcomes including teen pregnancy?

Or should we focus more heavily on unique factors? These are focused constructs or variables or factors that are directly tied to a given outcome of interest for our purposes now on teen pregnancy. So what do you guys think?

Okay so it looks like the vast majority thinks both common uniques. There's a small group of folks that actually think common or unique.

And I guess we have one very courageous soul I think none of the above. And so I think what's going to be important is that we actually spend a little bit of time talking about what we know about, common unique risk factors.

And so here's a slide that could potentially be a little confusing but I'm going to try to walk us through and help us to understand.

So this is really looking at this notion of common sort of determinants of a specific behavioral health outcome.

So let's envision a scenario where we have two risk behaviors, problem behavior one and problem behavior two which are depicted in, you know, that figure that's on the left-hand side of your screen.

And let's envision there was a common cause. And so a common cause would be that round circular influence with the two lines A and B that are going to the two problem behaviors.

And what this would suggest that this one factor this common determinant is actually influential in both problem behavior one and problem behavior two.

And so many positive youth development programs actually focus on common factors. They assume that the same, you know, problem behavior or excuse me, the same risk factor whether it be individual, family, school or community shapes a number of distinct outcomes.

What's important to consider is that common factors account for basically 1/3, roughly 1/3 of how we can consider variation and whether or not a young person engages in a given behavior.

So a common determinant is going to be 1/3 of the explanation for a decision of a young person to engage or not in the problem behavior.

And so what's also important to consider are unique determinants. And so here what you see on the opposite side of the figure are two additional circles that are leading to one leading to problem behavior one, the other leading to problem behavior two that reflects a very unique determinant which is specific.

It is directly tied to the problem behavior. And it's a well-established determinant of whether or not a young person chooses to engage or not engage in that behavior.

And so here unique influences of a specific behavior or outcome account for about 2/3 of the variability and so they explain 2/3 of why a young person chooses to engage in a behavior or not.

And so what's really important is that we actually need both common and unique factors. And so both of them and so very exciting that most of the people that answered the poll actually indicated and they were absolutely correct that both common and unique factors are what's needed to really have a significant impact.

Having said that I think it's also true that oftentimes there are many programs -- it'll be interesting to kind of hear a little bit later the programmatic example as well as perhaps some questions or exemplars from the folks that are

listening that oftentimes we do one or the other and that we're not necessarily integrating both common unique determinants into our programs.

So here are a couple of steps. I'm going to give you briefly couple of steps that you can think about as you make sort of decisions about how to enhance your teen pregnancy prevention efforts.

And so first we want to be clear that we have a clear outcome of interest, a specific health disparity, a specific health behavior that we're interested in shaping.

And so first step who is it? What populations that are sort of that we're hoping to target that are most disproportionately impacted by that particular problem behavior?

So we want to make sure that we're focusing on groups that typically have that disparity at greater levels and that we prioritize those populations in our efforts.

And so if you look at this example on the slide this would be very familiar to folks on the call. But we know there is a ratio of ethnic disparities in teen pregnancies.

So you can see here that despite the tremendous progress that we've made in reducing our teen pregnancy rates that we still have more work to do and that we still have significant racial and ethnic disparities.

And so how should we approach these disparities and what accounts for these disparities? Those are important questions to consider.

And so on this next slide we want to be clear what are the kinds of determinants that would be of interest? Should we focus on prioritization of unique factors or prioritization of common factors?

And I think that we've already decided as a group that once we've targeted our population of interest that reflects the disparity that we wanted to try to ameliorate or reduce that we're going to focus on both common as well as, you know, unique determinants.

These are some examples of some potential factors that one could focus on. And so another poll, which one of these would you consider a unique factor associated with teen pregnancy?

So interesting, we have some shifting around. We have most people answering absolutely correctly that premature sexual debut is in fact a unique determinate.

I can definitely understand why somebody might select availability of sexually present health providers but that's really getting more at the context. And in a second I'm going to talk about that and sort of tie it to our model.

But the best unique factor of the four that are listed would be premature sexual debut.

And so determining the factors that impact teen pregnancy and so we have two options. We've got our unique factors and our common factors.

And just to review we know that unique factors have stronger associations with the outcome, that they consistently predict the outcomes of interest, that they're very specific and they help to, you know, provide insights into the

outcome of interest that we know there's a adult response relationship that more or less of it we see in affecting the outcome and that we know that the mechanism in which they implement the outcome is theoretically plausible. It's clear to understand how they shape the outcome of interest.

We know that common factors have more modest associations that they are less consistently predicted depending upon the studies that we can have different results.

They have more nonspecific effects. They may in fact have effects but they're not necessarily isolated to a specific outcome of interest. They may focus on more than one outcome.

It's not always clear that the dose response relationship is evident. We're not always clear on the precise mechanism of influence.

And sometimes they're abstract or unclear. And theoretically we don't fully understand the precise mechanism largely because they can play out differently and be sort of less consistently predictive in the same way.

And so some examples, educational attainment, socioeconomic status, availability of providers in their community.

These are going to be more common factors versus unique factors like being involved in, you know, a sort of too serious romantic relationship in adolescence or premature sexual debut or incorrect and inconsistent contraceptive use. That certainly is very specific and very clearly linked to whether or not a young person becomes pregnant.

And so just something to think about as you're sort of, you know, trying to make decisions about how to best organize your pregnancy prevention efforts.

And so what I would argue is that again we need to do both that we need to target our efforts on very specific disparities, that we need to understand the groups that are most disproportionately impacted by those disparities, that we need to think about having prevention programs that really bolster sort of protective factors that are unique and also risk factors weakening those risk factors that are unique.

But we also need to think about the broader context and common factors that will independently impact the outcome of interest or work through the specific unique factors.

And so really being specific is going to be really critical. And so being able to really think through and to delineate how is it that a common factor will exert its influence on a given outcome is going to be quite important.

And so for example if we have in a community a common factor that there isn't a strong sort of presence or availability and providers well that's going to influence the use of the most effective contraceptive methods. And that in turn could in fact shape teen pregnancy.

And so being specific, laying out the causal mechanisms and making those linkages with both unique and common is going to be really important for our program.

The last thought I want to mention really looks at well how do we integrate this and how do we then think about our role in teen pregnancy prevention

efforts? And maybe our programs focus on unique factors, maybe our programs focus on more common determinants or maybe we do both.

Irrespective of what your program does I think the main point of what we're trying to convey is the importance of, you know, targeting our teen pregnancy prevention efforts in this broader framework, that we've got unique factors and we've got common factors and together our programs are going to be more effective than a sole focus on one or the other.

And so if you focus on unique factors, terrific. But perhaps it would be a really good idea to link into other important organizations, programs, institutions in the lives of young people that can help bolster some of the common factors, so schools and the role that school plays in educational attainment or neighborhood dynamics and really looking at ways that we can bolster sort of, you know, safe, you know, housing or recreational programs for young people.

Clinics and health centers and helping young people to be linked into providers that those things are going to be really critical while we also focus on those very unique determinants that are directly tied to adolescent sort of teen pregnancy.

And so I think I'm going to stop. And before I transition the presentation to my colleague Dr. Shervington I just want to highlight my contact information.

I hope there was something that I said that was useful to the group. And I wanted to say thank you because your involvement on the poll was really terrific and many of the responses were - you guys are pretty knowledgeable and an expert group so thank you very much. Dr. Shervington?

Dr. Denise Shervington: Thank you Dr. Ramos. And I would also like to thank the conference organizers for giving us the opportunity to share lessons from the field here in New Orleans at the Institute of Women and Ethnic Studies.

We implement the Believe in Youth NOLA TPP program and it's an OAH Tier 1 funded program.

And somewhat similar to Dr. Ramos' discussion about common and unique factors we utilize the social ecological model to conceptualize our programming.

This theory recognizes an individual's well-being as being impacted by forces that again were mentioned earlier at the interpersonal community and societal levels.

So here at the Institute we have been conducting these assessments since early after Hurricane Katrina and found very high levels of traumatic stress among our youth.

Unfortunately our public mental health system is not adequately resourced to deal with these conditions.

And so this lack of attention to post-disaster mental health needs of vulnerable youth have compounded the impact of other existing traumas in their life such as sexual abuse or domestic violence.

And I would like to note that the high levels of traumatic stress that are prevalent here in New Orleans I think can also be found in other under resourced or disadvantaged communities that experience chronic adversity and toxic stress.

And we do know that high levels of trauma coupled with a lack of services limit young people's self-efficacy, their self-regulation and resilience.

And this of course is a contributing factor to risk-taking behaviors as was mentioned by Dr. Ramos.

So after receiving our Tier 1 funding from OAH we requested and received approval to adopt a trauma informed approach.

So in this presentation I'm going to briefly share some of the data we've been collecting, describe our trauma informed approach and also talk about some of the partnerships with schools to link youth in need of services.

In our TPP program we utilize the NPC curricula. And we've adapted it to include five additional modules on mental health and wellness.

The program is implemented primarily in public charter schools. And to date we have served over 2500 youth, 1200 of whom completed surveys.

And quickly I want to share with you some of this data that OEM people have higher rates of symptoms of posttraumatic stress disorder and depression than the national average.

For example 15% of our youth report current posttraumatic stress disorder symptoms they screen positive whereas the national average is 4%.

Also we check for exposure to violence among our participants. And you can see here high levels of exposure to domestic violence, witnessing shootings, murders, experiencing dramatic death of someone close.

And when we correlate these exposures to violence and mental health symptoms we find that those youth were exposed to such high levels of violence report two to three times higher rates of PTSD and depression and suicidality.

And then regarding the link between traumatic stress disorders and the sexual risk-taking behaviors unfortunately here in Louisiana we cannot ask students about their sexual behaviors.

But our epidemiologic data does show that in Louisiana and in particular New Orleans we have some of the highest teen birth rates, HIV and STD rates in the country which speaks to the extent to which young people are engaging in sexual risk behaviors.

And so even though we have not been able to make that linkage directly I just want to point out a recent study that was done in 2014 that found that among African-American female adolescents higher levels of interpersonal stress was associated with increased sexual risk-taking behaviors.

And this study confirms our anecdotal learning from our parents and our youth that stress influences young people's sexual risk-taking behaviors.

We also survey our young people about worries. And what are they showing that there's high level of worrying about violence and just basic needs among our youth.

And I just want to focus us on that 29% who worry about not being loved because we wonder if that is somehow might contributed to some sexual risk-taking behaviors.

And as you can imagine among those youth who are - worry so much about their basic needs and violence in their community we find higher rates that they report high rates of depression, PTSD and suicidality.

So the data that I just presented a very brief quick run through where we are screening participants in our programs for signs and symptoms of psychological distress, exposure to violence and worries is part of our trauma informed program approach.

Additionally I mentioned earlier that we implement the TPP curriculum with five mental health modules. We provide young people information on trauma and stress, we coach them in positive coping skills and the five Cs of positive development.

We also allow our participants to journal at the beginning of each session which and these journals the young people give us permission to read the journals so our facilitators read them and we respond as needed to any questions that they might ask.

We also conduct trainings with school personnel, interested teachers, social workers on how to recognize signs and symptoms of mental health and work with them to figure out what the referral processes are.

And finally we really do work hard to establish relationships with our schools so that we can assist them in the linking of young people to care.

So what we do at the beginning of our implementation is to meet with the school administrators, the social work staff to determine how to work within their policies and procedures to access mental health services whether those

services are school-based or external. We've had opportunities where we've had to help the school refer young people to outpatient or inpatient mental health services.

We also provide young people upon their graduation resources to youth friendly healthcare, contraceptive services and HIV testing.

Another thing that we've done and we're very glad to have been invited to participate is working with the city in a collaborative that they have developed to help the educational systems here become more trauma informed meaning that they are able to implement and sustain trauma focused services.

And finally we disseminate our data to our institutions. We go back and meet with them and let them know what the data is showing.

We disseminate the information locally to our city health department and when invited the national audiences trying to show the importance of collaborations and partnerships towards risk factors that we think put young people at risk for sexual mistaken behavior.

So this is the end of my participation. Thank you for again allowing us the opportunity to share this data or approach.

And I'm going to return the call now over to Katy.

Katy Suellentrop: Wonderful. Thank you so much Dr. Shervington and thank you Dr. Guilamo-Ramos as well for a wonderful presentation.

I hope that everyone learned something about overall adolescent co-occurring risk as well as how this might be carried out or applied on a programmatic level within a particular community.

So I am going to be spending the next few minutes talking about some of the programmatic implications   .

Now that you've had a chance to listen to a basic model of adolescent risk and protection sort of with a variety of problems or risky outcomes as well as thinking about the unique verses common determinants, thinking about the social ecological model and really thinking about how this might all look tied together and look in a particular program given all this what are three ideas for what you might do next as a result of this Webinar?

So you're going to spend an hour with us this afternoon. What could you do when you turn off your Webinar or go back to your own office?

The first thing I would encourage you to do is to really take a look at your needs and resource assessment.

And many of you conduct or all of you conducted these at the beginning of your project. And hopefully you have been collecting data throughout.

It's a good idea to take a look at some of the ongoing data that you're collecting and really see what other risk factors the youth in your programs are facing that might overlap with other behaviors?

So some questions that you might ask yourself are the youth in your program at risk for other negative outcomes?

Does other programming exist in your community that might adjust to these other negative outcomes?

Are the youths that you're surveying likely already participating in those programs or could there be a benefit for helping connect you to those programs?

So for example Dr. Shervington addressed the fact that in their needs assessment data they found high levels of trauma. They didn't find services in their communities so as a result we're able to develop some modules, some mental health modules to help their youth.

And then they are also able to link them if they need even more intensive services. So looking at your data and deciding what you might be able to do.

So in an effort to get a sense of what folks are already doing I'm going to ask that you click on the Q&A button which is the top left. And if you just chat in what risk factors the youth in your program face and/or experience?

So I'll give you about 15 to 30 seconds and just go ahead and chat in a few things. And I'll - I don't think you're able to see so one person has written in a lack of hope, community violence, other risk factors that your youth might face, mental illness, domestic violence, sexual abuse.

There are really a wide gamut of other issues. And so thinking about if you notice in your - if your data suggests that, you know, youths in your community are exposed to a high level of community violence or there's mental health issues or there's domestic violence or sexual abuse or a lack of hope what are some other services that you can make sure you're provided? So thinking - taking those needs and thinking about your list of partners.

So how are you working with your current partners? How are you working with other organizations who might be serving a similar population of youth?

Are there opportunities to coordinate programming so that it's complementary? Are there opportunities that you can help, you know, recruit these from various programs into each other's programs.

So I'm just thinking, you know, with the thought of risk factors such as domestic violence are there other programming that if perhaps you're partnering or you're implementing an evidence-based program that has a parental component could you help support getting services for the whole family on issues like domestic violence?

Do you know who's providing services for sexual abuse in your community and how do you complement that?

Are there other issues, are there other youth development programs addressing issues of future orientation and career preparedness and thinking about future opportunities for youth and how can you partner with each other?

So coordinating - and everyone on the call already knows this but coordinating efforts with other groups in your community can sometimes allow for better integration of services for our youths.

So of course thinking about the teen pregnancy prevention program as one of a broader collection of safety net programs for our youth and thinking about the strategic partnerships how can we make sure that our net is fully woven together and we're not just offering these services in isolation?

And I will say that OAH has developed a sustainability framework. And securing strategic partnerships has been identified as one of the key factors is factor number seven.

So I would encourage you to take a look at that framework and think about your own partnerships.

So with that in mind if anyone would like to chat in using the same function how have you coordinated your efforts with other youth serving partners?

So have you partnered somehow to recruit, have you partnered to pursue funding? How do you coordinate your efforts so that it's - they're complementary and that you're both meeting the needs of the youths that you're serving in your communities?

Let's go ahead and take about 15 seconds to chat something in in the Q&A box.

All right well I haven't gotten anything in so either no one is coordinating or people have gotten bored of listening to me which I certainly understand.

Coordinator: We do have a question on the phone.

Katy Suellentrop: Oh sure.

Coordinator: And it comes from (Aubery) with Washington Department of Health. Your line is open.

Katy Suellentrop: Go ahead.

(Aubery):   Hi.

Coordinator: You're queued up for a question. Your line is open.

(Aubery):   Hello? Can you hear me?

Katy Suellentrop: Yes.

(Aubery):   Hi. I didn't actually - there must've been a...

Katy Suellentrop: No problem. Okay no question. We'll keep going. The third idea of what you might consider doing is conducting a root cause analysis.

So a root cause analysis is a process that people have used to identify contributing factors and underlying causes of a problem.

I've seen this applied in the medical community in terms of trying to figure out why something was misdiagnosed or how the - an event went wrong -- that sort of thing.

And it's increasingly becoming applied to issues such as teen pregnancy prevention or issues such as teen pregnancy I should say.

So why should you use a root cause analysis? Clearly addressing the root causes of an issue is more effective and efficient than addressing just the symptoms of the problem.

I think all of us on the phone are working on prevention because we believe that. And so a root cause analysis can help to identify how and why something happened with the goal of preventing it from reoccurring.

I think the key to a root cause analysis is that it's conducted in combination with - it's a group of folks going through the process together.

So it includes stakeholders including those who might be nontraditional, for example those from the safe community or those from the business community or other nontraditional, other partners who haven't historically are traditionally focused on teen pregnancy prevention. And they can begin to understand the complexity of teen pregnancy in the community.

It might be particularly helpful for supporting the sustainability of your programmatic efforts. For example we've heard of places where a root cause analysis has involve a safe lead in the discussion. And that safe leader then begins to understand how their work on early childhood education is connected to teen pregnancy prevention and how they're part of a continuum working to improve the lives and future prospects of children and youth in their community.

A root cause analysis coupled with an action planning process can also be used to bring stakeholders to a shared understanding of teen pregnancy and influences within a particular community to spur innovative ideas or things that maybe you haven't thought of before and to think about strategies, kind of a best practice for addressing the factors and underlying causes that impact teen pregnancy in this particular community.

It also might open opportunities to pursue funding that's related to teen pregnancy prevention but isn't clearly identified as such.

I've been asked to talk a little bit about when you might do a root cause analysis. And I think you can do one of these at any time that it sits with your work.

And so it might be nice to do it at the beginning of our project or it might be nice to do this root cause analysis if you're a year or two in and you have your program figured out and you're looking for ways to expand.

So it could be at any point in your programmatic efforts, you know, if you want to expand it to a certain sector or we've heard of it used where folks are having a little bit of trouble getting particular leadership in their community to buy in.

And so could they get them on board for our root cause analysis and then think about how it fits in with some of the other outcomes of interest for that particular community.

So how do you do this? In essence and conducting a root cause analysis could be a whole Webinar unto itself. And so I'm just going to give you a snapshot and next I'll show you some research as for how you can get a little bit more information.

A root cause analysis can be conducted by simply asking the question why as many times as it takes to identify the root cause of an event an event or issue.

And so there's a tool that you can go through and it helps you do that in a more organized way.

The process itself is - it takes about I would give yourself about four hours or half a day. And the key is convening the right group of folks to have a

brainstorming session about teen pregnancy in the community and then going through the series of why questions and finally prioritizing the root causes in developing an action plan to address those root causes.

So as I mentioned there JSI has a wonderful document that will help you conduct a root cause analysis. It's a facilitator's guide.

There's also as you know many tools and resources from both OAH and other external resources. There's a collaboration toolkit and a sustainability toolkit that can help you think about some of the things I mentioned in terms of partnerships and sustainability.

We've included a link to the Youth Risk Behavior Survey here in case you wanted to get even more data on some of the youth risk outcomes. And that survey comes out on a biannual basis. So it's in the field. It just wrapped up being in the field and we'll have the data from 2015 next year.

I'll leave you with my contact information. And now I'm going to turn it over to (Jackie) to talk about what's coming up next.

Jaclyn Ruiz: Hi. Sorry about that. I needed to un-mute myself. Actually before we go into some upcoming resource I want to open up the lines as well as the chat box to see if anybody has any questions for any of our three speakers.

They had a lot to say today and I just wanted to give everybody an opportunity to maybe ask some questions.

You can either hit Star 1 to get into the queue for the operator to open up your lines to you can ask a question or you're more than welcome to use the Q&A box and type something in there.

I'm just going to - and while people are doing that I will go into what's happening next just to give people a chance to type and get in the queue.

In July we're going to have a Webinar on community mobilization. There are two new resources - well there is one new resource currently available on the OAH Web site another one that's still not available but we have included it in the handout in your Webinar that you can download. And it will be on the OAH Webinar soon.

An EBT at a glance chart so you could see all the TPP evidence-based programs from the TPP evidence review sort of at a glance all together if you want to sort of look to see what the link is, what community setting they're supposed to be implemented in -- anything like that and then a trauma informed approach checklist that you can use when thinking about how you could incorporate trauma informed approaches into your TPP program.

And we have a link there are about the Webinar that occurred last month on trauma informed approaches.

So operator do we have any questions on the line by any chance?

Coordinator: Yes we do have one from (Anastasia Coles).

Jaclyn Ruiz: Great.

(Anastasia Coles): Hi. Should I go ahead and start talking now?

Jaclyn Ruiz: Go for it.

(Anastasia Coles): Okay. My question is for Dr. Ramos. And it's in regards to the Hispanic population. We have both foreign born Hispanic adolescents with our program and also state side born.

And it appears when I'm seeing a young pregnant woman that there's some more cultural approval then I see here with, you know, American born.

And I just when I see the pregnancy rates for Hispanics I just want to know if you've been able to tease out, you know, is it because of cultural approval that we're seeing higher rates or do we actually not reaching those youth in regards to birth control or is it all mixed up?

Dr. Vincent Guilamo-Ramos: Well thank you very much for that question. I think it's a question that, you know, many folks have sort of pondered and I myself have often sort of thought about differences in Latino subgroups.

And one of the big ways in which they may differ is whether they're foreign-born or US born. And so I think a couple of things are sort of critical to consider.

I think often there's a cultural argument for a lot of the variability that we see in young people's sexual and reproductive health behaviors and outcomes.

And I would encourage us to sort of look beyond that and...

(Anastasia Coles): Okay.

Dr. Vincent Guilamo-Ramos: ...actually not focus solely on the cultural factors but to think about issues of access to sexual and reproductive health services ability to access health insurance the ability to have access to a provider.

Perhaps - and this effect may be cultural but perhaps linguistic sort of abilities and sort of the match between provider (provisionor) services and linguistic abilities.

I think I would start with some of those more immediate sort of, you know, factors that I think shape important outcomes.

And then maybe secondarily I might think about are there specific aspects of a given group's experience that might make them different?

But, you know, what...

(Anastasia Coles): Sure.

Dr. Vincent Guilamo-Ramos: ...I guess it's a long way of saying I'm not sure there is a culture that would support, you know, teens getting pregnant.

For a long time Latinos have been characterized as a group that, you know, feels happy about sort of childbirth.

And, you know, while many families including Latino families welcome and really celebrate the addition of a new family member I think there's, you know, a lot of evidence that would suggest that for Latino and for many families and including other ethnic minority and racial groups that a teen pregnancy is something they would prefer to delay.

(Anastasia Coles): Thank you. I appreciate that we avoid the stereotyping so I appreciate that.

Dr. Vincent Guilamo-Ramos: Thank you.

(Anastasia Coles): Thank you.

Dr. Vincent Guilamo-Ramos: Thank you so much for the question.

(Anastasia Coles): Sure.

Coordinator: And as a reminder to ask a question please press Star 1. Currently we have no further questions.

Katy Suellentrop: Great. Well if people are still thinking about...

Jaclyn Ruiz: Hi.

Katy Suellentrop: I'm sorry. Go ahead (Jackie).

Jaclyn Ruiz: One question for Dr. Shervington. I was actually trying to ask it and I was on mute.

Dr. Shervington can you talk a little bit about the participation in the citywide initiative? Was it something that occurred after you started the TPP program or during it and did it provide any opportunities in further partnering with any other organizations when it came to the TPP program?

Dr. Denise Shervington: Yes. It actually started after the TPP program. I would like to think that our data has somewhat influenced the decision to look at trauma.

And the city is really very focused on balance reduction. Add as they had been trying to address that they realized that there were high rates of trauma which were contributing to the levels of violence that they were seeing in the city.

So the benefit is that we have been able to participate with this group to partner a lot of the other members of the collaborative through various levels of mental health services and there's some in academia and the Public Health Institute.

So that actually does help to support our TPP program. And but most importantly the young people will be in environments that are more responsive to their needs and treat them less that like they are bad risk-taking children and that perhaps they have emotional needs that need to be met.

So I hope I answered your question.

Jaclyn Ruiz: No, that was very helpful. Thank you. And I know we've reached 3 o'clock so (Brandon) if you can go ahead and open up the feedback box.

Everyone we're going to keep this - this is sort of a satisfaction survey that helps us identify any enhancements that we can make to future Webinars.

You could actually complete it while on this screen. So you can go ahead click and complete it.

The Webinar room will be left open ten minutes at the end of the call for you to complete it so we just strongly urge that you please complete it as soon as possible so that we can get some feedback from you.

And I think I mentioned this before but just in case the TPP trauma informed checklist there is a little area that looks like a bunch of small pieces of paper layered on top of each other.

If you click there it's called handouts if you hover over it. If you click there you're able to actually download those that handout onto your own desktop.

I just want to think again Dr. Ramos, Dr. Shervington, Katy for the - their presentation. The information you guys provided was amazing. And I really hope that our participants learned a lot because I know I did. So thank you again.

Dr. Vincent Guilamo-Ramos: Thank you very much. It was a pleasure.

Dr. Denise Shervington: Thanks.

Jaclyn Ruiz: All right take care of everybody.

Dr. Denise Shervington: Thank you.

Coordinator: Thank you for your participation in today's conference. Please disconnect at this time.

END