NWX-OS-OGC-RKVL

Moderator: Jaclyn Ruiz
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Operator: Hello, this is the Operator. At this time I would like to remind all parties that the conference is being recorded. If you object to this please disconnect at this time. Thank you, you may begin.

Jaclyn Ruiz: Today we'll be interviewing Doctors Rene Sieving and Jennifer Oliphant as part of our developer interview series. The Office of Adolescent Health will be hosting a series of interviews with developers of those programs identified by the Department of Health and Human Services, teen pregnancy prevention, evidence review and having shown effectiveness in reducing teen pregnancy, sexually transmitted infections or sexual risk behaviors.

The goal of these interviews is to ask developers some of the most frequently asked questions by OAH grantees. The Webinar series was developed as a technical assistance product for use with OAH grant programs to provide additional guidance on selecting, planning and implementing an evidence based program for teen pregnancy prevention.

This Webinar should not be used on its own but is a complement to various other resources available online. Additional resources are identified later in this power point presentation.

Please note an inclusion on the HHS teen pregnancy prevention evidence review does not indicate HHS or OAH endorsement of a program model.

As I mentioned today we are interviewing Doctors Rene Sieving and Jennifer Oliphant. Dr. Sieving is an associate professor with the School of Nursing in department of pediatrics at the University of Minnesota.

She is a deputy director of the Healthy Youth Development Prevention Research Center, which conducts community partnered research and disseminates actionable knowledge to promote positive youth development and health equity among young people.

Dr. Sieving's research focuses on the application of a positive youth development paradigm to the design, implementation and evaluation of clinic based services and community based programs aimed at preventing multiple health risk behaviors during adolescence.

Recently she has been principle investigator on several substantial programs of community engaged intervention research including prime time, a clinic linked intervention focused on reducing risky sexual behaviors, violence involvement and school failure among adolescent girls that are high risk for early pregnancy.

Dr. Oliphant is a Research Associate with the Division of General Pediatrics and Adolescent Health in the University of Minnesota's Department of Pediatrics.

She is the community outreach coordinator for the Healthy Youth Development Prevention Research Center with a background in public health and education.

Dr. Oliphant has created and implemented adolescent sexual health and peer leadership programs with diverse populations of youth. Welcome to you both.

I believe I'm handing it over to Dr. Oliphant to briefly describe the program prime time.

Dr. Jennifer Oliphant: That's correct, thank you for that introduction. We're going to begin with our program goals. The goals of the prime time program are to reduce the pre-cursors of teen pregnancy including sexual risk behavior and school disconnection.

Our target population for the prime time program is adolescent girls at increased risk for pregnancy and sexually transmitted infections, STI's. There are two main components of this program prime time.

The first main component is a one-on-one case management session. These sessions are conducted throughout the time that prime time is running and they are monthly for approximately 18 months.

The one-on-one case management is client centered and it focuses on counseling style guided by the principles of health youth development.

The second component is the peer educator group. This model is a education model where it is designed for young people to reach and teach others. There are 16 sessions in the main peer education model with an available 7 session

group practicum that is in addition to the 16 and not required for this OAH grant.

The interactive Bureau of Education's methods that are used are lively and engaging and teach young people about themselves and how they as a healthy youth can interact in a positive way with their peers. They're focused on sexual health education as well as some job skills and social skills.

Jaclyn Ruiz: Are there any technology requirements for the program?

Dr. Jennifer Oliphant: Neither the case management nor the peer education groups require any significant technology. Of course like any curriculum piece there may be some copying that needs to happen but there isn't any DVDs or other kinds of significant technology needed.

Jaclyn Ruiz: Thank you and can you please briefly talk about the previous evaluation results?

Dr. Jennifer Oliphant: You bet, so we've evaluated prime time through a rigorous randomized control trial that was funded by the National Institute of Nursing Research at NIH.

This trial, this study which involved about 250 adolescent girls we were able to look at effects of prime time and the prime time program on sexual risk behaviors as well as other behaviors that are pre-cursors of teen pregnancy.

And a long story short we saw with prime time that we had substantial effects on sexual risk behaviors of the teens involved starting at an interim point during the program at sort of 12 months into the program.

And those effects on reducing risky sexual behavior continued we saw them again at the end of the 18 month program, we saw them continue on at 6 months and 12 months after the completion of the program.

So in this trial girls who were in the program group reported more consistent use of condoms, more consistent use of hormonal contraception and more consistent use of dual contraceptive methods that is hormonal method plus condoms and their use was greater than a control group of girls who were getting good usual clinic services.

And interestingly at the time of the final followup survey so 30 months after the teens enrolled in the study and 12 months after the program ended we saw that 15% of girls who were in the program condition versus about 6% of girls in the control condition reported that they had abstained from having intercourse in the past six months.

And then one other thing I want to mention and this is more a positive indicator of, you know, emerging adulthood. We saw that prime time had substantial effects on college or technical school enrollment.

For example at the time of the final followup survey a year after the program had ended, of the girls who had graduated from high school 72% of those who were in the program were enrolled in college or technical school and that compares to about 37% of girls in the control or comparison group.

Jaclyn Ruiz: Rene can you talk a little bit about the evaluated population as well as any other populations that you think that this program may be applicable for?

Dr. Rene Sieving: You bet, so the randomized trial that I just mentioned really involved a very ethnically diverse group of sexually active girls who are between the ages of

13 and 17 at the time they enrolled in the study and they were all at high risk for early pregnancy meaning that each of the participants met at least one risk criteria.

And those criteria were coming to clinic for a pregnancy test that was negative, being recently involved in violent or violent behavior, high risk sexual behaviors or behaviors that indicated some level of disconnection or disengagement from school.

So those – that was a group of teens that we involved in our randomized trial. And I would just say in terms of population that this program is intended for, given the intensity and the duration of prime time we feel it's most appropriate for adolescent girls that are at high risk for early pregnancy and sexually transmitted infections. It's really not designed as a universal program for all teens.

Jaclyn Ruiz: And do you have any suggestions I know some other programs have this of how one would screen for these – for this criteria? I know that and we'll get into evaluated settings afterwards I believe this was done in a clinic.

Dr. Rene Sieving: Right.

Jacklyn Ruiz: So is it…

Dr. Rene Sieving: In our randomized trial we used a very brief paper pencil survey that teens filled out while they were waiting for their usual clinic appointment and that survey asked about 10 to 15 questions getting at sort of kids level of engagement in school, their sort of sexual behaviors and their sort of levels of involvement in violence.

So the questions are very similar to screening questions that young people fill out in clinic settings anyway and as I said it takes – the screening questions we used took teens about five minutes to complete.

So I can see other settings either using the screener that we have because we know that it really did help us to enroll a higher risk group or to develop a similar screening, you know, that is confidential and that kids can easily complete, you know, in a short period of time.

Jaclyn Ruiz: Thank you for that and so I sort of let the cat of the bag that I know it is evaluated in clinics but do you want to talk a little bit more about the evaluated setting as well as any other settings that you think this program may be applicable for?

Dr. Rene Sieving: You bet, so teens that were involved in the randomized trial that I mentioned, we enrolled from school and community based clinics in the Twin Cities of Minneapolis and St. Paul, Minnesota.

Now while we enrolled kids from clinic settings it's important that people understand that both are case management visits and our peer educator groups took place outside of the walls of clinics, they took place in community settings that were convenient that were safe and that were comfortable for the teens involved.

So for example case managers often met with teens in places that were, you know, convenient for individuals maybe at school, after school hours or maybe, you know, in a neighborhood coffee shop.

So I'm just going to also mention possible other settings if that's okay (Jackie).

Jaclyn Ruiz: Of course.

Dr. Rene Sieving: So this program was really kind of originally designed to be implemented by clinic staff, you know, and it's a program for clinic settings but we do feel that prime time could be implemented in a range of community settings as long as those settings and the organization have access and can offer teams in the program ready access to use friendly sexual and reproductive health services that are provided by maybe a partner clinic.

Jaclyn Ruiz: And I'm so glad that you mentioned that the actual case management and peer education occurred outside of the clinic because that is very helpful to know. And (Jen) you may have gone into this and I missed, I didn't hear it but the peer educator group does it occur simultaneously during the monthly case management contact?

Dr. Jennifer Oliphant: Where peer education, the peer education groups are not unlike other typical peer education groups where we need enough youth enrolled to create a group. We recommend between 8 and 12 young people that are – to participate in those groups.

And so the actual one-on-one case management happens outside of that group time and that's a special time for the young person and their case manager to discuss and work on issues that are specific to that young person and her needs.

In peer education we're obviously following a more specific curriculum where each lesson builds on the past and all the young people were together on that particular lesson.

And as Rene was saying these can be at different settings as long as the setting is comfortable for the young person and accessible in terms of location.

Dr. Rene Sieving: And (Jackie) just to clarify, so case management takes place over an 18 month period and then teens are involved in peer educator groups and, you know, the peer educator program sometime during that 18 month period.

Jaclyn Ruiz: Okay perfect yes that's what I was wondering thank you Jenny and Rene. So this sort of leads well into this next slide. So while adaptations require OAH prior approval and at times approval by the developer it can be helpful for organizations to get a sense of previous adaptations that may have been successfully implemented.

I know for your program you might not have a lot of examples of other people who have done adaptations but do you have any examples of some adaptations that grantees may want to consider and what that might look like?

Dr. Rene Sieving: Sure, so we've already talked a little, we've talked some about, you know, implementing in locations outside of settings, outside of clinics in settings outside of clinics I'll get my words right.

And again I just want to stress that, you know, if this was a program that was taken on by a school or a community organization the key piece would be that that community organization or school has an existing partnership and can provide girls in the program with ready access to sexual and reproductive health services that are offered through a clinic.

In terms of languages I think both case management and our peer educator group sessions can be offered in languages other than English. We would be

happy to talk with interested groups more about adapting, you know, in other languages.

Right now the curricula and the case management guidelines are written in English but I think it's both can be adapted. The other thing that Jenny mentioned that adaptation that we think is important to stress is that our original study prime time, the peer educator groups included both a 16 session curriculum a training to be peer educators and then a 7 session sort of group practicum.

We feel like the group practicum the seven sessions is really optional and really can be tailored, groups can decide to use it or not depending on where they're implementing the program.

So for example in our randomized trial we had school based clinics implementing the program and with a combination of the 16 session training and the 7 session practicum that full range of 23 sessions fit well into a semester long health class.

But there may be other settings where the practicum is not as easy and wouldn't need to be included.

Jaclyn Ruiz: Thank you for that information. Can you describe any staffing recommendations that you have as well as any training opportunities that are available?

Dr. Jennifer Oliphant: Absolutely. So for the staffing considerations we really feel that an overall program coordinator is necessary. Working with the youth in this kind of (realm) with case managers requires somebody overseeing the

ongoing clinic supervision as well as the peer education groups. So a overall program coordinator would be in that position.

This also requires case manager and case manager – that word case manager can be used in many different ways. In our way of utilizing that phrase we are talking about a small or a group of adults who are experienced with diverse youth who can meet with a case load of approximately 25 teens to work on the issues that they may have around high risk behaviors as well as working on including some of their strengths and their behaviors.

So it really does include sort of a two tiered staff model and that would be again the program coordinator and case managers.

How that plays out with peer education is really dependent on the staffing situation at a community level that is hosting the prime time program. We have done this in multiple ways in our setting but generally the case manager is involved in teaching the peer education program and we have also used our program coordinators to be a co-lead in that.

I think there's strength in that using a peer, one of the case managers as a teacher in the staffing helps them know the young people in the group and further some of the relationships that are so important to build with adults.

I also do recommend though it's not required that the peer education program be run with two adults in the room when you have 8 to 12 young people. It's always an excellent practice I think to have two adults in the room to work with those young people.

The training that we would provide or technical assistance from the University of Minnesota would be a train the trainer model and in that we would be

trying and working hard with the designated program coordinator to give them some pre-service training.

This would be an intensive three to five days training so that they could turn around and work with their case management staff on learning the application of the peer program as well as the case management.

The University of Minnesota would also provide booster trainings and ongoing technical assistance and if it were needed and wanted we could also do some specific training on the peer education itself to a group if that was ever requested.

Jaclyn Ruiz: And Jenny correct me if I'm wrong, is there any sort of specific education requirement especially for the case manager because I know at the beginning you said that there is counseling being provided for them but it's counseling style guided by PYD principles so I didn't know if that's, that they necessarily need an MSW if it's not, you know, actual counseling, counseling.

Dr. Jennifer Oliphant: That's a very good question. They – we have had different levels of training that our case managers have had. I think the biggest thing that they need is a very strong skill set around resources in the community and engaging with young people.

We like to have youth magnets and by that we mean people who really connect well with young people. What a program coordinator would be doing is making sure that they have the skill set to guide the case managers through some of the challenging issues that they would be working with.

So we do not require an MSW but we do think it is important to have health education or social work skill and that could be through a nursing, somebody

with a nursing background, a health education background or a social work background or a youth development background that maybe is reflected in their past history of working with young people.

Jaclyn Ruiz: Thank you for that clarification. Can you describe some implementation challenges that you're aware of that if possible any strategies that you know to overcome the challenges?

Dr. Rene Sieving: Yes so some of the main challenges I think in implementing prime time it really has to do with working with vulnerable populations of young people. So while high risk teens or vulnerable youth aren't a homogeneous population they commonly do have sort of developmental needs and are dealing with situations that really requires some very creative and unique approaches to engaging them.

So many vulnerable young people are living in unstable conditions and some just as a result of past interactions may be cynical about working with adults in helping roles.

So we also know that, you know, from previous research that the evidence suggests that higher risk youth are more likely to totally engage in programs and in services that acknowledge their strengths and acknowledge their resilience rather than focusing on their deficits.

Now our experience with adolescent girls who begin the prime time program is that they come into the program with sort of different levels of readiness to engage with our case managers.

Ranging from those who connect easily and are open and really willing and eager to build a relationship with their case managers to girls who really have

difficult engaging often because of their extreme crisis situations that they're facing or substantial mental health issues either that they themselves have or that, you know, close family members are dealing with.

I think it's important in terms of strategies when case managers are working with teens that are difficult to engage it's very important for case managers to be patient and to be acknowledging of the teams sort of stressful life circumstances.

Also to provide resources that are immediately helpful to that teen and to be very clear about sort of establishing kind of the limits of the case management relationship.

Some additional strategies for suggest – strategies for success excuse me are really focusing on establishing and building a trusting relationship. That trusting relationship is core to both the case management and the peer educator programs success.

I think it's within relationships that trust exists and that are respectful that case managers and teens really work together to address some of the psychosocial influences and the behaviors that are program really intends to change.

Another strategy for success is that both case management and our peer educator groups are designed to happen in locations that are convenient for the teens involved.

So as I mentioned earlier case managers may meet with individual teens in places that are super convenient for that teen. It might be a fast food restaurant or a coffee shop and, you know, in addition to meeting the case

manager may offer to buy the teen a light meal or, you know, some food just as a, you know, a welcoming kind of gesture.

I'm going to give Jenny a chance to really speak to some of the strategies that we found have guaranteed the success of our peer educator groups.

Dr. Jennifer Oliphant: I think that one of the most exciting parts about the prime time program in peer education just in time is that we have a mixed – I always utilized a mixed age group.

By that the young people enrolled in the peer education component just in time were between the ages of 13 and 18. And that mixed age group really lent itself for across age teaching.

Certainly we know that when we're working with young people that a 13 year old can be very wise and savvy and act more like an 18 year old or an 18 year old can be more like a 13-year-old.

By having those mixed age groups we saw that the overall program would generally work up towards a higher age and a higher sort of expectation of each other as peer educators.

So this is one question we are asked a lot and that's why I want to emphasize it. So we really did not have issues with older youth being with younger youth and in fact we think it is a great strength.

We also always used a restorative practice versus expulsion as we have identified many of these youth come to us from having been not very successful in other peer programs or group situations.

And at times they would employ strategies that worked for them in the past or got them the expectation that they would be thrown out of the group. In our thinking we would never remove a young person from the group but instead work to restore some of the behaviors that are more positive in them to keep them in the group.

And I have to say some of the, personally some of the most rewarding times I've had teaching peer education have been when some of our youth have said this is the only group I never got thrown out of and I could see them blossom and grow throughout the process.

We also used a payment for peer educator contacts. Contacts are 15 minutes or more of talking about a lesson or talking about a topic that they have been trained on in the peer education lessons.

The payment was really important at first for getting young people to come but it was really what kept them there. The engagement of the group itself and the learning and the pride that they had in becoming what we talked about and peer education talked about in prime time is a job.

And many of these young people hadn't been successful in other jobs and they saw this as a way to launch themselves. So the payment honored that and it also got them there in the first place and then we saw as I was saying, them staying for other reasons.

Jaclyn Ruiz: Thank you. I just want to note that on slide 13 you'll see some possible additions to the program that may be occurring in the future so I would encourage grantees to get in contact with Jenny or Rene if you have any questions about these.

And then finally on slide 14 and 15 you'll find additional resources on prime time and the references for the evaluation results discussed on Slide 7. We hope that these resources in conjunction with today's Webinar will provide a comprehensive understanding of this evidence based teen pregnancy prevention program and will assist you in making not only an informed decision on which evidence based program to select for your community but how to best prepare for and implement this program.

Do you each, either one of you I should say (unintelligible) to the program?

Dr. Jennifer Oliphant: Can you ask that last question again we were unable to hear?

Jaclyn Ruiz: I'm sorry, I was just going to ask if you guys have any final words?

Dr. Jennifer Oliphant: No I think we're really enthusiastic about this program and we're really excited to share this with our colleagues and young people across the nation.

Dr. Rene Sieving: And thank you for this opportunity to share today.

Jaclyn Ruiz: Thank you, well I want to thank you both again for taking time away today to put this information together and present it to our grantees. I know they'll definitely find this information incredibly helpful.

And just to know on the last slide, Slide 16 is where you'll find Dr. Sieving and Dr. Oliphant's contact information if you guys have any additional questions about the program prime time. So thank you.

Dr. Jennifer Oliphant: Thank you.

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