

**NWX-OS-OGC-RKVL (US)**  
**Moderator: Mona-Lee Belizaire**  
**May 22, 2014**  
**1:00pm CT**

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen-only mode. During the question and answer session of today's call you may press star one to ask a question. Today's conference is being recorded and at this time I'll turn the call over to Amy Margolis. You may begin.

Amy Margolis: Thank you. My name is Amy Margolis. I'm with the Office of Adolescent Health, and I would like to join - thank everyone for joining us for today's Webinar, Working with Expectant and Parenting Teens to Prevent Subsequent Teen Pregnancies. We're really excited this Webinar is being sponsored through a collaboration with the Administration for Children, Youth, and Families, the Centers for Disease Control and Prevention, the Office of Adolescent Health, and the Office of Population Affairs in recognition of May as teen pregnancy prevention awareness month.

And we're really lucky to be joined today by three outstanding speakers. Dr. Lorrie Gavin is a senior health scientist in the division of reproductive health at the Center for Disease Control and Prevention. Her job responsibilities include coordinating the agency's winnable battle on teen

pregnancy, and leading CDC's collaborative efforts with the office of population affairs, Title 10 family planning program.

Dr. Gavin will be presenting today on what the data says about subsequent teen pregnancies. Linda Rogers is the proud and responsible communities grant project director with Iredell-Statesville Schools. She's been a grant project director for the past six years and has overseen the implementation of making proud choices and Be Proud! Be Responsible! be protective in the schools.

Linda will be presenting on the implementation of an evidence-based teen pregnancy prevention program for expectant and parenting girls in the Iredell-Statesville Schools. And last but not least, Laura Pedersen is the founder and executive director of Teen Outreach Pregnancy Services, also known as TOPS. As a former obstetric nurse, she directly witnessed pregnant teens experiencing poor outcomes with their pregnancy and newborns.

This experience is what encouraged her to start TOPS 14 years ago. Laura is going to present an overview of the TOPS program and the evaluation of TOPS that is currently underway. We will have time for questions once our three speakers have concluded their remarks. You'll be able to ask questions online using the Q&A function up at the top of the screen or by waiting for the operator to open your phone line. And we'll just wait until all three of our speakers are done to have the phone lines opened for questions. So with that I'd like to turn it over to Dr. Gavin to get us started.

Dr. Lorrie Gavin: Good morning, or good afternoon, I take that back. My name's Lorrie Gavin and I'm a health scientist at CDC's division of reproductive health. I'm delighted to be here today to talk to you about national patterns of repeat births among teens. I'll describe the results of a study on this topic that was

published last year. Our two main objectives for today, first, I'll describe repeat teen births. Second, I'll describe patterns of post-partum contraceptive use among teen mothers.

The term repeat teen birth is defined in the study as having two or more pregnancies resulting in a live birth before age 20. But first I'd like to give some background information on teen pregnancy. CDC considers teen pregnancy to be an important public health problem, and it's included it in its list of winnable battles, 60 battles, or public health priorities with large scale impact on health that have known effective strategies to address them.

This slide highlights some of the reasons that CDC included teen pregnancy as a winnable battle. Every day, 840 teens 15 to 19 years of age give birth in the United States. Three in ten teen girls in the US will become pregnant by age 20, which accounts for approximately 700,000 teen pregnancies every year. Despite recent declines, the US continues to have a higher teen birth rate than many countries of similar economic status.

Finally in 2010 teen births cost the United States approximately \$9 billion. Now I'll turn to the study that we did last year of repeat teen births in the US. The study covered the years 2007 to 2010 and had three primary research questions. The first question was what number and percentage of teen births are repeat births? Second, what are patterns of repeat teen births by race, ethnicity, by state, and over time?

Third, what are patterns of post-partum contraceptive use among teen mothers by sociodemographic characteristics and by state? To answer these research questions we analyzed birth data from the national vital statistics system and the pregnancy risk assessment mono-trained system from 2007 to 2010. US birth files are compiled annually by CDC's national center for

health statistics, and include demographic information such as maternal age, race, and Hispanic origin for all births in the United States.

Our study included national and state-specific data for the four-year period 2007 to 2010, birth to adolescent females for which information about the number of prior pregnancies ending in a live birth was not available, which was less than 1% of the births in 2010 were excluded. This left us approximately 365,000 births for the analysis.

We examined contraceptive methods use by teen mothers in the post-partum period. We analyzed data from the pregnancy risk assessment monitoring system, known as PRAMS. PRAMS collects state-specific population based data on maternal attitudes and experiences before, during, and after pregnancy. In each participating state, the stratified random sample of mothers with a recent live birth is selected from the birth file.

Women are then surveyed by mail two to six months after the birth of their child, with telephone follow-up as needed. PRAMS data are weighted for sample design, non-response, and non-coverage using birth certificate data provided by vital statistics agencies and the participating states to produce a data set that's representative of the state birth population.

The PRAMS analysis included data from 16 reporting areas. That meant 15 states plus New York City when combined together. The birth in these 16 areas represented 28% of all live births. Respondents were asked are you or your husband or partner doing anything now to keep from getting pregnant. If the response was no, the mother was asked the reason from a list of response choices with instructions to check all that apply.

If the response was yes, respondents were asked to check all applicable responses to the question, what kind of birth control are you or your husband or partner using now to keep from getting pregnant? Contraceptive methods were categorized by level of effectiveness for pregnancy prevention based on the percentage of females who experience pregnancy during the first year of typical use.

The most effective contraceptive methods include tubal ligation, vasectomy, implants, and IUDs. Moderately effective methods included oral contraceptive pills, Depo-Provera or the shot, the birth control patch, and the vaginal ring. The less effective methods included condoms, diaphragms, cervical caps, sponge, rhythm, and withdrawal. Only the most effective method listed by the respondent was used in the analysis.

Although the diaphragm's been categorized elsewhere as moderately effective during typical use, for this study that method was categorized less effective because the PRAMS question combined diaphragm, cap, and sponge as a single response option. However, the eight teens who reported use of a diaphragm also reported use of another contraceptive method with a higher level of effectiveness.

In 2010 among 365,000 births to teens age 15 to 19 years, 18.3% represented teen births. The vast majority of repeat births, 86%, were for a second child. But some teens were giving birth to a third child, about 13%, and a few births were for a fourth to sixth child. That was less than 2% of all the repeat births. The percentage of teen births that represented teen births decreased gradually over the observation period from 19-1/2% in 2007 to 18.3% in 2010, for a 6.2% decline over the four-year period.

The prevalence of repeat teen births varied by race and ethnicity, with the highest prevalence in 2010 among American Indian and Alaskan natives at 21.6%, followed by Hispanics at 20.9%, non-Hispanic blacks at 20.4%, Asian or Pacific Islanders at 17.6%, and non-Hispanic whites at 14.8%. The prevalence of repeat teen births also varied by geographic location.

In the feature on this slide, states in which less than 15% of teen births were repeat births are colored in yellow. States in which 15 to 19% of teen births are repeat births are colored in green. And states in which more than 20% of teen births were repeat births are colored in red. The highest prevalence, 22%, was found in Texas, while the lowest prevalence of 10% was found in New Hampshire. In eight southern and western states more than 20% of all teen births to females age 15 to 19 years were repeat births.

Conversely in seven mostly northeastern states, fewer than 15% of all teen births were repeat births. Now I'm going to switch the PRAMS data. Among post-partum teen mothers in this study, 8% were not sexually active, 1.3% were pregnant, and 90.7% were sexually active. Of the teen mothers who were sexually active, 91% reported using post-partum contraception after the most recent birth. Among these mothers, 22% used the most effective birth control methods. 54% used the moderately effective methods. Fifteen percent used less effective methods, and 9% used no method of contraception.

Among teen mothers who use contraception in the post-partum period more than one out of every five respondents reported using long-acting reversible contraception with 18% reporting IUD use and 3% reporting implants use. Use of oral contraceptive pills and the shot was reported by 29% and 21% of teen mothers respectively. Twelve percent reported using condoms as a method of preventing pregnancy.

Post-partum use of the most effective methods of contraception also varied markedly by geographic locations. Of the 16 PRAMS reporting areas in the sample, Colorado which is shown at the bottom row of the table had the highest percentage of teen mothers reporting use of the most effective birth control methods post-partum, with 50.3% using these most effective methods. This is compared with New York state, which is shown in the top row of the table.

And I want to point out that New York state did not include for this analysis, did not include New York City. That was reported separately, but New York state had the lowest percentage of mothers - teen mothers using the most effective methods at 7.2%. You can see a wide range. The findings in the study are subject to several limitations. First, respondents for PRAMS were interviewed in the period shortly after giving birth.

Later follow-up is needed to better understand longer term use of post-partum contraception and determinants of repeat teen child bearing. Second, the PRAMS data do not include information about the consistency and correctness of contraceptive use. Third, because only 16 PRAMS reporting areas were included, results might not be generalizable to other states. Fourth, the years covered by the analysis spanned the years 2007 to 2010, and averaging estimates over these four years could mask temporal trends in contraceptive use, especially given the declines observed in teen birth rates.

Faced with data only for 2007 and 2008, also might have experienced substantial improvements in later years that were not captured by this study. Finally the data sources used for these analyses permitted examination only of repeat births among teens rather than repeat pregnancies, because miscarriages, stillbirths, and abortions were not included. The prevalence of repeat pregnancy will be higher than repeat births.

In conclusion, although the prevalence of repeat teen child-bearing has declined in recent years, nearly one in five teen births is a repeat birth. Many teens are taking steps to prevent a repeat pregnancy, but only 22% of teen mothers, one out of four, use the most effective contraceptive methods in the post-partum period. Evidence-based approaches are needed to reduce repeat teen child-bearing.

These include offering post-partum contraception to teens, including long-acting reversible methods of contraception, and linking pregnant and parenting teens to home visiting and other and similar programs that address the broad range needs. Finally more research is needed to better understand reasons for the differential patterns in repeat teen births and post-partum contraceptive use. Thank you so much for the opportunity to talk to you today.

Amy Margolis: Thank you, Lorrie. Now we'll turn it over to Linda Rogers who is going to give us an example of how one community is using an evidence-based teen pregnancy prevention program to address the needs of expectant and parenting girls. Linda?

Linda Rogers: Thank you, Amy. I would like to - I'm glad to have everybody here, and I would like to share with you our experiences with the PARC program, which is the proud and responsible communities. It is a school-based intervention funded by the Office of Adolescent Health. Basically we are replicating Be Proud! Be Responsible! be protective. This curriculum was adapted from the Be Proud! Be Responsible! curriculum by Dr. (Debra Coniac-Griffin), a professor at UCLA school of nursing.

BP is an evidence-based program for parenting - pregnant and parenting teens in grades 7 through 12. It is included on the office of health and human

services list of evidence based teen pregnancy prevention programs. The intention of the be proud program is to reduce the incidence of unsafe sex among women and help them make a difference in their lives by making proud and responsible choices for themselves and their child.

It uses the idea of maternal protectiveness to help motivate a change in behaviors, and one of the activities that reinforces that is in module three, the students are shown a magic box and given the opportunity to write two or three dreams for themselves and their child. And then in module 6 they write a letter to my baby, and it's been a very, very powerful activity and three months later we send those to the girls in the program.

It also teaches factual information about the risks of early motherhood and some of the increased risks of subsequent pregnancies, and it stresses that they need to give the children that they have now all their best care and opportunities with the hope that it would reduce subsequent pregnancies. If you'd like more information about this program, it can be found on the OEH web site, and you see the link for that on the slide.

Some of the specific information about PARC program and the Be Proud, we offer that program during school, after school, and on weekends. The during school program lasted about one or two hours per week, and it continued during the school day. We also decided to offer two five-hour sessions on Saturdays and we've also even experimented with one ten-hour session on a Saturday.

What we found was the longer we ran the program, the less we had with attendance. The attendance dropped significantly. It was really difficult to get the girls there on a consistent basis. When we did the two five-hour sessions on a Saturday, we offered child care and that also was a little bit difficult, and

I'll talk a little bit more about the challenges with child care in another slide. We did find that our attendance was supremely better on the two five-hour Saturday sessions and significantly better, 100% attendance and retention on the one 10-hour session because we basically didn't let them go.

We do offer \$100 incentive if they attend all 10 hours of the program. The actual Be Proud curriculum is eight hours. However we've added an hour in the beginning and the end for post surveys - pre and post surveys and also for breaks. We do offer child care for these sessions and we also offer transportation to our participants and also referrals, we provide referrals for them to health care appointments for themselves and their children.

Recruiting for this program has been a challenge. However, we are very fortunate to have a great rapport with our school nurses because we are a district - a school district itself. Our recruiting is a little bit easier than if we were an outside organization, so we have great rapport with our school nurses, our school counselors, and our teachers early on in the program, in the grant.

We provided and met with all of the stakeholders in the school at meetings to identify our program and let them ask questions, and so people in the school district know who we are and know what we do, and so that makes recruiting pretty easy. We also get recruiting ideas from friends of our past and present teens. We have many local partnerships that have been extremely helpful. We partner with our local health department, SCAN, which is stop child abuse now, the partnership for young children, and the state's full housing authority.

And we receive referrals from all of those partners. After a while we were having difficulty with recruitment so we started beating the streets and we've been to nail salons, barber shops. We've planted ourselves at the department

of social services and set up a table so that we could recruit the students when they were coming to the department of DSS. We also offer key factor of this grant is that we offer transportation services.

And this is our transportation graph and you can see that over in - as of the end of year three we have done over - we have done 318 appointments in three years and our goal was 150. We do have as you can see 86 participants which means that we also have quite a few frequent fliers that we have to - that we work with. We also - in our county it is very long and narrow and we have absolutely no public transportation.

So it was very important to us when we were writing the grant is that we would apply for a position that we have with our health services manager, and basically her job is to take students to medical appointments, WIC appointments, anything that they need to assist them in getting appropriate medical care for themselves and their child or children.

We've had a lot of success in our pregnancy data. Back in 2008, we had in the 15 to 19 year old birth rates, we had 318, and we are down to 199 although we always say that in 2012, we say that 199 is 199 too many, but you can see our pregnancy rate has dropped from 56.2% to 37.1% in our county, and within our county we also have a city school district whose stats go into our county, but we do not provide programming there because they are not willing to let us in that school district.

Of our 199 births in 2012, 134 of those 199 were 18 and 19 year olds. In our 15 to 17 year old range, there were 65, so quite a difference in that age group. In terms of repeat pregnancies, you can see that back in 2008 in (Unintelligible) County we had 81 repeat pregnancies and we have slowly decreased that to 2012 we were at 50%.

We also do a pre and post survey. Oh, by the way the (Unintelligible) County repeat pregnancy rate is higher than the North Carolina rate, which is 24%. We also do pre and post surveys as part of our program, and we also replicate making proud choices so you can see that data on this chart also, but of our post survey questions a percent of our participants that intend on using birth control if sexually active was 100% for our BP. Even though we know that's intention based questions, we do feel really positive that the BP program is making a difference.

Our next survey - post survey question was if they plan on using a condom if sexually active, and again we were really pleased with 100% of our be proud girls said they would use a condom. Some of our challenges have been with child care. We set up you know, for instance two Saturdays and the students say, yes, we need childcare and I will be bringing one child, and then we have about ten girls in the group and some are bringing a child, some are not.

And so we plan on child care based on say eight children of various ages, so we have various different age level child care workers and all the equipment that you need for the different ages, and then the day comes and either they bring more children than they said or they don't bring as many children as they said, so that has really been a challenge. Also when we do the two five-day programs, it's five hours - or five - two five-hour programs.

It's five hours of child care in a row, and that has been really difficult not only for the children but for the child care worker. The transportation is also difficult. They'll say they need a ride and we'll organize a special bus to go pick them up and then when the bus gets there they're not there. They've

decided to come with somebody else or they're not at that house, they're at a different house.

So it's been a challenge to be able to provide the services to get them to and from our groups, and also recruitment because as we first started recruiting in the schools, and our first year we had no problem recruiting the number that we needed, but as we started realizing that we were kind of running out of students, teen parents in our schools, or teen moms, that we realized that we had to go out into the community because one of the things we realized pretty early on was that some of the teen moms were not in school.

And so that was a little challenge, and I feel like we've, you know, done a pretty good job of identifying those areas where we can do recruiting, and word of mouth has been very, very successful. A student will take our program and you know, tell their friends, which is something that is really important. However, you know, you still have to be creative in finding out you know, and using your report system and your partners to help you locate the students for the program.

So some of the lessons learned, we felt like the school nurses have been instrumental in identifying and recruiting pregnant and parenting teens for our program services. Our school district had a procedure in place for if a student reported that they thought they were pregnant or they were pregnant, and the process was to go to the school nurse, so we early identified the fact that school nurses would be instrumental.

Part of the grant provided a school nurse in each of their five high schools, which was extremely important in the past before we received grant funding. Our school nurses were at the high schools one day a week, so that continuity of service was not there, and it was - it's bound to be very, very important.

The students mention all the time how wonderful it is to be able to see a nurse when they need it.

I remember somebody - when I was teaching at the high school someone said you know, I need to see the nurse, and I said well if it's not Tuesday, you can't, so here's a mint and let's move on. We also found that it was important to have a health services manager and an adolescent case manager. Our health service manager as I mentioned before does a lot of our traveling and transporting our students, and in that capacity she has become a great mentor to our students that utilize the transportation services.

And our adolescent case manager has been available to help students find the resources that they need in the community and to provide them with mentorship and additional support, and both of those positions have been extremely helpful in our success. It certainly did not - it certainly helped to have an incentive, but students write in their post survey that they signed up for the \$100 incentive, but they learned so much and they enjoyed the program so much that they would take it again even if there wasn't any kind of incentive.

And we realized early we have a governing committee that is composed of many of the members of our local community partners, and we realized early that it was really important to identify and engage our community partners. It really helped us in terms of being able to get our fingers out into the community and see where the support is.

And we tried to be on as many committees in the community as possible so that we really feel like we can get our message and we take every opportunity that we can to speak to rotary clubs and domestic violence task forces and anyplace that we can go out and identify what our program is and

how successful it has been and how - you know, how we need their support.  
And I thank you for your attention and here's my contact information.

Amy Margolis: Great, thank you so much, Linda. Next we'll turn it to Laura Pedersen who will talk to us about the TOPS program. Laura?

Laura Pedersen: Thank you, Amy. First of all thank you for the opportunity to highlight our organization and our research project that we're currently conducting. The objectives obviously - oh, I guess I'm in charge of changing my slides, aren't I? Sorry about that. Here's our objectives, and then I'll give you an overview of Teen Outreach Pregnancy Services, and then give you a basic review of what it is that we are studying, and then focus on our organizational best practices.

First off, I actually am the one who started Teen Outreach in Tucson, Arizona, in 2000. We have since grown into four counties, which includes not only all of Tucson, all of metro Phoenix, and then two smaller rural communities that we focus on, and in the last 14 years we've had over 5000 healthy babies born to adolescents, our youngest being age 12, which is horrifying when you think about it.

We are currently in our fourth year of our PSP project, with a little play on words, personal success pass project, actually to those of us that know it, actually it's preventing second pregnancies, and it is a research funded through outstanding youth services bureau, and it's a promising practice that has never been studied before. And the focus of the research is on preventing the second pregnancy.

The mission of Teen Outreach Pregnancy Services is to provide teen specific pregnancy and childbirth (unintelligible) education so the teen and her

family can experience positive outcomes. So when we look at that, we're like, well, what are we doing about secondary pregnancy? And what we've discovered over the years is that even though we were started to focus on preventing bad outcomes for the teen and her baby when the baby is born, we have morphed into the second piece of preventing that second pregnancy.

So - sorry, lost my place - we've grown into a full range of services provided by professionals, which was started by nurses focusing on (unintelligible), and we've brought in social workers and public health graduates and really have developed a collaborative team of people within our agency as well as with the community partnerships that we have, and that's what has made the program work.

It's a group of dedicated professionals who focus on this population. So our TOPS - our service is the tops, and we do call ourselves TOPS, not to be too cute with a teen outreach program, which is the primary prevention program. We provide healthy pregnancy and childbirth classes, a series of parenting classes, we do primary and secondary pregnancy prevention classes, and I'll talk some more about that in a second.

We do a full range of case management, home visitation, support groups, special events, again, got to keep them enthused and active. Play groups for the teens to come with their baby. We just this past year developed our developing awesome dads program. We also in our offices do free pregnancy tests. Jensen's Corner is a little store for the teens to come in and get items that they need, maternity clothes, baby clothes, diapers, etcetera, and of course we do our community referrals for our teens.

So besides focusing obviously on healthy outcomes as I'd mentioned, we also provide, you know, focus on the pregnancy prevention for secondary

pregnancy. Many have asked us over the years why do we teach abstinence, birth control, and STD prevention to pregnant teens, and of course those of us in the business, we know the answer is obvious. We feel it's the best time to reach the teens, to begin making plans for preventing the second pregnancy or a subsequent pregnancy is during their first pregnancy.

Research indicates that programs that start during pregnancy and provide supportive services through the child's second birthday will not only have the best outcome for the mother and the baby, but also a reduction in a repeat pregnancy. We've been very successful in using this model enrolling our teens during pregnancy, and have found that it's been the most effective in lowering attrition.

Although we do enroll teens after they've had their baby, we don't have as much success in keeping them engaged in the program, and I truly believe that's because of that relationship building that we do during a very vulnerable time for these young ladies. By offering the full range of services, we have found there's something for everybody, as long as they're 21 and under, they're a father or a mother, or pregnant, we welcome them into the program.

And then of course our primary prevention program, we were actually asked by our community partners if we could provide specific education for preventing the first pregnancy, and so that's when we jumped into the pregnancy prevention business rather than just focusing on healthy pregnancies and then healthy birth outcomes.

So we developed a program that focuses on ten key areas surrounding pregnancy prevention. So the outcomes of our pregnancy program in Arizona and again I'm not going to sit here and read the slide, you guys can see that, but we have a high rate of teens breastfeeding. We have a much lower C-

section rate than the national average. Our premature rate is significantly lower, and then the repeat pregnancy rate in Arizona actually has dropped over the last five years.

It's - when we look at the pregnancy rate drop we've actually - Arizona was the highest decrease in adolescent pregnancies with a 29% decrease, and so that has also affected our repeat pregnancy rate. When we first started our term of study, their rates were coming back at about 23%. In our most recent data, 2012, we have a 19% repeat pregnancy rate within our state. We do not have the results of our study yet, and those will be forthcoming next year when we're done with the first study.

Our parenting goals for our teens as they go through our program during pregnancy and then after they've had their child, we're looking at those involved and their own choices that they're making in their lives as well as the choices that they'll be making for their child, and we focus a lot on the health aspect as well as relationships within the child's and the teen and their significant other, or even their relationships that they're having with others that are helping them co-parent their child.

And a big piece of what we do is self-sufficiency. We want these teens to go out and obviously stay in school, and move on into productive members of society. So best practices for child, this is something that we've developed over the last several years, and we still have seen these have worked very well for us. Many of them are what I like to say, no-brainers, I put one too many there, sorry about that.

So what we like to do is - I'm going to go through each one of these and give you a little bit more detail about where we're going with this information, but we do run these ideas across all program components for our pregnant

teens, our parenting teens, our dads, and also for our primary prevention program. So concrete learning in a real world, if we do not get these teens to relate what we're saying to what's going on in their lives, we will be wasting our time.

So you want to make sure your programs are very relatable to their life, to their culture, to their community. Otherwise you're going to miss them and they will drop out of your program. Consistent class times with reminders and support, sometimes we have to remind our teen five times in this - within three days that they have a class coming up next Tuesday.

Part of that is when we look at the teen brain and the research that's been done with that. The teen brain says one thing and then they forget or they - it says one thing but it really needs another thing. You need a lot of reminders. You need to have your staff very well trained on how the teen brain works so that they know what best approaches to use.

And multi-sensory learning, one focus at a time, so many of us talk about multi-tasking, and but do you really think about it? Your brain can only focus, directly focus on one thing at a time, and we look at our teens, and they think that they're focusing when they're on their phones, watching TV, and listening to a lecture, and they're really not absorbing any of that information. We like to think of our teens as technology natives.

So many people haven't heard of that term, and especially for adolescents, they are so plugged in with technology, but that doesn't necessarily mean they're able to multi-task any better now than they could have 20, 30 years ago. Safe environments, obviously keeping our teens comfortable and feeling safe, this information speaks for itself. If teens don't feel safe in your

environment, they're not going to be learning, they're not going to come (unintelligible).

Group and individual assessment sessions, this is something that's really important for us. We feel as an agency that teens need both group activities and one on one. There's a lot of work out there being done in working with pregnant teens and pregnant women as a whole in home visiting, and home visitation is fantastic. With our population that we're working with, these teens are very isolated. They feel like they're the only teen that's ever been pregnant before. They haven't experienced what it means to be an adult and here they're (unintelligible) into this pregnancy.

They can be around other teens that are going through maybe the same thing that they're going through, they can develop some relationships, they build on those relationships, and so those group interactions are critical to this population. It may be their only support network. We have teens time and time again saying once I got pregnant, most my friends drifted away. Once I had the baby I lost all my friends because nobody could understand what I was going through.

And at the same time they still need that one on one time with trained staff to meet their specific needs, so a good balance of both is what we try to offer to our teens in our program. Clear and (unintelligible), again you've got to take your time. Sometimes it's less information is better, otherwise you're doing information overload and they won't remember anything that you've told them. And then use of incentives, obviously you've got to give them stuff.

In RTH, we're dealing with pregnant teens. They're hungry all the time. We're providing food every class. When we're doing parenting classes and

their child is with them and we do keep the child in the room with the teen during parenting classes, and we use immediate parenting advice and guidance throughout our classes when those opportunities arise, when it's maybe a toddler who may be misbehaving a little bit, we show some very positive reactions that the parent could be providing to their child.

Also back to incentives and food, teens may not have the funds to even have nutritious snacks in their lives, so we always have nutritious snacks, and of course for our parenting classes toddler friendly snacks are the best, and then we do have diapers, car seats, strollers, and such and as I mentioned earlier our Jensen's Corner, teens actually receive our help - play money, our TOPS dollars to come into our store and purchase whatever it is that they need for themselves and their child (unintelligible).

There is no actual money changing hands. And the rest of our best practices, we use engage in our curriculum that we've written to help teens make the connection. It's a very non-threatening technique which starts the client - start getting into the mood to learn. It helps decrease the stress in the brain so they know what's coming throughout the rest of the class.

We use a lot of open-ended journal prompts to - embedded within our lesson plan to get those teens to be a little bit more (unintelligible) with the learning environment. Focus helps teens zero in onto the topic, so another key area in our curriculum that we've written. It is important for the teen brain to help isolate the topic so that they can really focus in on what that topic is, rather than trying too many things like that at once, again information overload. They're not going to get anything out of what you're teaching them.

And our closure technique is for that brain function, it connects the new information to the concepts that they already have stored in their brain. It

helps the brain make sense of the new information and yet know how to apply it to their lives, and then that application process helps with their long term memory. And then various teaching modalities, we all learn different ways in different manners, and especially when we're dealing with the teen brain.

We approach every one of our classes that we teach whether it's for pregnancy or parenting, using all these virtually in every class that we do, and then of course repetition. We revisit information quite often. As we know, most people need to hear a thing seven times before they can remember it, and we may be repeating some of the information over a period of several weeks when we're teaching, or some pieces we actually repeat within each class several times, if it's a very important thing.

Of course we think everything we're teaching is very important. And then ongoing one on one support, (unintelligible) this is the key that holds our program together, the case management support that we provide. We have volunteers that come in and work one on one with the teens. That ongoing support throughout that teen's life, which when we start during pregnancy and follow through that child's second birthday, the relationships that we develop with these teens is huge.

And it's what really makes them different in our program, so we've all heard it before, but when you're working with adolescents it's always about relationships, relationships, and relationships. So the primary goals of our program really do all come together. Our pregnancy program, of course we want to see the full-term delivery of a healthy baby, have it breastfeeding at the time of discharge from the hospital.

And we are seeing that with the approaches that we're using. Our personal success pass, we want to prevent that second pregnancy in adolescent mothers

within 24 months. We prefer that their first child - I'm very excited to be able to share that data, hopefully in the next future Webinar, next year after we have completed our - all of our survey collections.

And then our parenting program, and we do want to improve long term health and wellness outcomes for adolescent parents as well as their child. And we all have been exposed to the wonderful stuff healthy teen network has provided, especially this past - during this month where they've given us this straight snapshot of what teen families need to grow and thrive, and I highly encourage you to go to this web site and print this off.

This is the meat of what we do working with pregnant and parenting teens, and the tag piece here, pregnant and parenting teens are extremely motivated to offer their child a good life and with the right support and becoming successful adults and parents. We see this again and again, our society in this day and age still judge this population, and we see if we give them the right type of help and support, they can succeed. They can stay in school. They can go on and do great things with their lives.

Right, I gratefully acknowledge healthy teen network for what they put out this month. And here we go, one of my favorite babies that was just born, he's about nine months old now, his name is (Asher), and so thank you so much for the opportunity to share the information on our organization and our study, and stay tuned for the results.

Amy Margolis: Thank you so much, Laura. Okay, before we move on to the question portion, we did want to let everyone know, if we could pull up the slide with the next Webinar details, we will be hosting the second Webinar for teen pregnancy prevention month next week on May 28th at 2 o'clock eastern time, and the focus is on engaging males in teen pregnancy prevention.

So there's more information where to go for the information to call in and log in for that Webinar on the slide, but we did want to let everyone know. We hope you can join us for that Webinar as well. But now with the time we have remaining, we'd like to open it up for questions and again you can type the questions in the Q&A box or the operator I think will come on and give us some instructions on how to open up your phone lines.

Coordinator: Thank you, we will now begin the question and answer session. If you would like to ask a question, please press star one. You will be prompted to record your name. Again, just press star one to ask a question, and one moment please for our first question. At this time I'm showing no questions. Again, please press star one to ask a question, and we do have some questions coming in. One moment, please.

Amy Margolis: While we wait I think we have one question online. Laura, this is for you. Can you explain what are some of the assets and best practices of TOPS that lead to the breastfeeding outcome?

Laura Pedersen: Sorry, I had you guys on mute. All of our case managers as well as our nurses have gone through a certification course via certified lactation educator, so that right there is key because all of our staff that's working with these teens are very well versed and very well trained and very engaged in the concept that pregnant teens and parenting teens should be breastfeeding.

So that's your first step, your staff has to have the buy-in and the knowledge and the training to give the support to teens. We do a - we weave our pregnancy - excuse me, our breastfeeding education throughout our pregnancy education component. We start planting the seeds early in pregnancy. We do actually six hours of classes early in pregnancy to teach

them how to stay healthy during their pregnancy and that's when we start introducing not just nutrition for the pregnancy, but nutrition for feeding that infant in the future.

And when we get into the childbirth classes, such as delivery, we have a lot more in depth education, and we tell them, you know, we're there for you. We're going to help you every step of the way. We - our nurses go to the hospital and do a hospital visit, bedside teaching, baby at the breast after delivery and give them that additional support, and then we do a one-week home visit or sooner if the teen is in crisis and continue giving additional support after the baby is born.

A lot of people ask us well why are we going into the hospital when nurses in the hospital are doing that work? I used to be a hospital nurse. I worked in post-partum, on a good day you would have 10, 15 minutes to work with a new mom on her breastfeeding issues and pregnant teens, a lot of the nurses unfortunately don't feel they need to spend that much time giving that kind of health and support because they figure the teen's going to quit as soon as they go home anyway. So again, that's the relationship we build with the teens and we give a ton of support to make it happen.

Coordinator: We do have some questions on the phone lines if you'd like to take them.

Amy Margolis: Great.

Coordinator: Thank you. We'll take one from (Tracy Jennings). You may ask your question.

(Tracy Jennings): Hi, I was just wondering if these slides would be available via email or electronically.

Amy Margolis: Yes, we will post the recording of the Webinar along with the slides and a transcript on the Office of Adolescent Health, teen pregnancy prevention resource center. It will take a couple of days to get everything up, but we will send a notice out to everyone who attended the Webinar once those slides are up.

(Tracy Jennings): Thank you.

Coordinator: Thank you, our next question comes from (Valerie Loughton). You may ask your question.

(Valerie Loughton): Yes, this question is for Laura. In her speaking she had mentioned that there was a web site. I did not - I was not able to have the power point up, and I was just wondering if she could verbally give me that web site.

Laura Pedersen: That is just the healthy teen network web site?

(Valerie Loughton): Yes. Yes.

Laura Pedersen: And so have you been to that one? It's healthyteennetwork, I believe, dot gov? And to get actually to that slide it's healthyteennetwork.files.wordpress.com and I believe from there you can get to a 2014/05/picture. It's a long piece, but I'm certain...

(Valerie Loughton): I'll try that, but you're saying healthy teen network?

Laura Pedersen: Yes.

(Valerie Loughton): Okay, thank you.

Laura Pedersen: No problem.

Coordinator: Thank you. We do have a question from (Kendra Hatfield) I believe. You may ask your question.

(Kendra Hatfield): Yes, thank you so much to both of you, all three of you, but this is directed to the two later presenters. I was interested about what - to what extent the role of relationships, the relationship that the teen is in with her current partner or potentially future partners, plays in the training that you're you know, going through with the teens.

Amy Margolis: Laura, you want to go first?

Laura Pedersen: I - let me go ahead and address that real quick. Our teen dads are welcome into all of our programming, and this class here and (unintelligible) they're not part of our study, but this past year and a half we were able to receive some state funding and one of our - well, we have two large areas that we are funding. We actually enroll our teen dads in our program as a participant.

So they're receiving the case management. We're pre and post testing them on the knowledge. They're getting one on one additional support from a male case manager, so we feel that that is going to - if he wants to be involved and he is involved, we're going to make everything possible for him to be engaged. We are also doing some dad-specific support groups. So yes, our dads are definitely involved as much as the relationship is allowing. We actually have some dads that come and the girl, she doesn't want the services, she doesn't find that interesting.

Linda Rogers: And that is for our program, our be proud program, that is one of the gaps that we have identified and are looking for ways to address, because basically the program is for teen moms, and we've been researching other programs that we could use for teen dads.

Coordinator: And are you ready for the next question?

Amy Margolis: Yes, please.

Coordinator: Thank you, and this came in from (Kathy Marquis). You may ask your question.

(Kathy Marquis): Hi. I would like Laura to repeat her email address for me. I didn't get it all.

Laura Pedersen: My email address is Laura, L-A-U-R-A, dot, Pedersen, P-E-D-E-R-S-E-N, at T-O-P-S-A-Z dot org, and you can get to our Web site on tops.org - or not T-O-P-S, I'm sorry. I'm not giving you the right address. T-O-P-S-A-Z dot org.

(Kathy Marquis): Okay.

Laura Pedersen: Laura.pedersen@topsaz.org.

(Kathy Marquis): Okay. I'd like to know too if any statistics have been done about in the second pregnancies, if it was the same father.

Laura Pedersen: We have not tracked that. We have that information for those teens who do come back to us and want to engage in services again for the second pregnancy, so our database would have that information, but it's not information that we have researched.

(Kathy Marquis): Okay, thank you.

Coordinator: Thank you. Our next question comes from (Ray Cassamaindo). You may ask your question.

(Ray Cassamaindo): Hi. How's it going? This is (Ray Cassamaindo) and this question is for Laura Pedersen. My question was what do your participants have to do to qualify for the play money that they use to purchase goods at Jensen's I think it was?

Laura Pedersen: First of all they have to be enrolled in the program, and we don't have any enrollment in the program is age 21 and under and pregnant or parenting. There's no financial issues or housing issues, things like that. If you're under 21 - 21 or under and are pregnant or parenting you're in if you want the services. Coming to the classes, we give out - we're very generous with giving the TOPS dollars.

We also - teens who bring us their report card for school and they are A's and B's, we give TOPS dollars. If they get CPR certified, and they show us that they've been CPR certified, we give them TOPS dollars. And if they do any volunteer work out in the community or anything extra, going and speaking at an event for us out in the community to help raise awareness of what pregnant teens are going through or parenting teens, we also give them the TOPS dollars for that as well.

(Ray Cassamaindo): Okay, great. Thank you.

Coordinator: Thank you, we do have a question from (Colleen Reynolds), go ahead with your question.

(Colleen Reynolds): Hi, my question is for Linda Rogers. I was just wondering how did you calculate the pregnancy rates and statistics?

Linda Rogers: Our pregnancy rates were calculated by APPCNC in North Carolina, and they issue us a rate based on each county each year.

(Colleen Reynolds): Okay, thank you.

Linda Rogers: Thanks.

Coordinator: Thank you, we have a question from (Angela Rhodes). Go ahead with your question.

(Angela Rhodes): Yes, I have facilitated courses with teen moms, and often have a problem with them returning to the sessions after the birth of the baby. What are some of the suggestions that you may have to retain them? I heard a few earlier that were mentioned, and also do you find it effective to have sessions with both mom and dad in the class or separate courses with mom in one class and father in the other?

Woman: I'm going to jump in there since we do include dads. We do both. We have - we encourage the dads to attend the classes with their as they like to say baby mama, and because they're learning together, and we want them both to experience the information together. We have some brief interaction where they would be discussing how they're going to get through the labor and delivery process and how they're going to support each other or how he's going to support her during that.

So it's important for the dad to be part of this process, and as well the same thing with parenting. If they're going to be parenting together, we really

want them experiencing the parenting classes together. We do have group joint support groups where they're both welcome to come to support groups, and we have individual support groups, some just for the moms and just for the dads. So we try to you know, accommodate everything that you could imagine to give the teens what they need, and it seems to be working.

(Angela Rhodes): Thank you.

Coordinator: Thank you, at this time I'm showing no further questions.

Amy Margolis: Okay, I think we had one additional question online for Laura, and the question is, is home visiting a part of your program? And if so can you talk about what home visiting program you use?

Laura Pedersen: So currently our home visits occur either - if it's during pregnancy, if a teen is having a difficult time coming into our office for one on one case management, our nurses and our case managers will go into the home and do that initial case management visit. We try to go into the home again between 34 and 36 weeks gestation for a safety check and to make sure that they have all their needs met to bring the baby home after they leave the hospital.

And then we do a one-week - like, yes, one week post delivery nurse intervention home visit to make sure mom's doing okay, especially if she's having C-section or making sure she's taking care of herself, no signs of infection, check out the baby, see if the feeding's going well, if there's any major signs of jaundice, if they're - you know, make sure they've gone back to their pediatrician appointment and all that.

Depending on our funding source, we will also then go back into the home at one month. During this time we've gotten a baseline and then continued to

do the post-partum depression screen because we feel that's really important, especially for this population. With our research, our intervention group got an extended amount of home visits after delivery.

They had either case manager or a nurse in the home every month doing some additional education and then additional support, especially with the breastfeeding support because one small piece of what we're looking at with our research is if longevity of breastfeeding will help prevent the subsequent pregnancy from happening too soon. It's not a major part of the research. It's just something extra we're looking at.

So as far as the model, we've created all of our own curriculum. We've created all of our own home visiting concepts. We were hoping to, once we've gotten - we're shooting for that evidence based label and once we have that, we're planning on packaging all of our curriculum and all of our concepts and then making that available to others to use.

Amy Margolis: Wonderful. Well unfortunately we are out of time, but I do want to thank all of our speakers. I want to thank all of you for joining us today. Like I said earlier, we will post besides the recording, a transcript up on the web site and send a note out once that's all available. And we do hope that you can all join us on May 28th at 2pm for the next Webinar on engaging males in teen pregnancy prevention. Thank you all so much. Have a great day.

Coordinator: Thank you, and this does conclude today's conference. We thank you for your participation. At this time you may disconnect your lines.

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