CONNECEENT FAMILIES: IMPROVING TEEN FAMILY CARE COORDINATION IN HENNEPIN COUNTY
Julen N. Harris, MPH¹, Emily Ruedinger, MD², Abigail Z. Johnson, MSW³
¹University of Minnesota Medical School; ²Seattle Children's Hospital/University of Washington; ³Novu, LLC

Purpose: Adolescent-headed families are disparately burdened by socioeconomic instability, lack of social support, and high stress conditions. Coordinating services that are multi-disciplinary, culturally sensitive, and tailored to the developmental stage of adolescence may optimize parenting teens' opportunities for success. The goal of the Conneceen Families project was to increase understanding of the care landscape for adolescent-headed families in Hennepin County, Minnesota, including perspectives of parenting teens and service providers. This information will be used to guide the advancement of local initiatives that successfully support the needs of adolescent-headed families.

Methods: Discussions were conducted with the Hennepin County Teen Parent Connection, a community-based coalition of education, social service, and health organizations serving adolescent-headed families. Key stakeholder interviews with individuals who work with parenting teens were used to inform development of a structured focus group interview guide. Four focus groups with parenting teens ages 15-21 (n=23, 2 male, 21 female, mean age 18 years) were conducted during fall 2014 in schools and community centers in Hennepin County, MN. Participants identified as American Indian (n=2, 9%), Black (n=6, 26%), Caucasian (n=6, 26%), and Hispanic (n=9, 39%). The vast majority (n=21, 91%) were enrolled in school or a GED program. Transcribed interviews were analyzed using summative content analysis. Project funding: American Academy of Pediatrics, Community Access to Child Health (CATCH) Grant.

Results: Major barriers to accessing health and social services included: teens feeling disrespected in clinical settings; providers not engaging in collaborative decision-making; providers' lack of cultural awareness; short/rushed appointments; complex benefit enrollment processes; and unreliable transportation. Identified assets that aid in overcoming these barriers included: teens' perceptions of belonging in clinical settings; teens' active efforts to seek high quality care and independently research health concerns; nurses, case managers, and school counselors who connect teens to resources; social support via partners, fellow teen parents, and family members; quality communication with providers; and transportation assistance. Focus group participants were each connected to an average of 3 services, including: food, housing, and transportation assistance; case management; and home visiting nurses. Main considerations in choosing services included: location/proximity, multi-disciplinary service offerings, and perceptions of reliability/trust in providers. Two-thirds of participants were amenable to the idea of signing an optional, universal release form to facilitate improved communication between providers.

Conclusions: Lessons learned: Many of the qualities that parenting teens desire in their interactions with providers are the same qualities desired by adult consumers: respect, empathy, effective communication, and collaborative engagement in decision-making. For many pregnant and parenting adolescents, interactions with providers during this time are their first autonomous healthcare experiences. As such, these encounters are particularly salient, shaping the teens' perception of
healthcare and their desire to seek future care. Individual providers and care coordination initiatives should account for the unique developmental context of adolescence, recognizing the discrimination and socio-environmental stressors many parenting teens face. Next Steps: Disseminate report highlighting the voices of parenting teens to providers and local organizations that serve adolescent-headed families. Report to be utilized in advancing care coordination initiatives, advocacy, trainings, and grant proposals.

Sources of Support:

37.

ENGAGING FUTURE RESEARCHERS THROUGH OUTREACH
Nikita A. Midamba, MS1, Megan Moreno, MD, MPH2
1Seattle Children's Research Institute; 2Seattle Children's Hospital

Purpose: Disparity exists in disease and morbidity among certain US subpopulations. One possible reason for this is the reluctance of underserved populations to participate in clinical research, which is further exacerbated by the fact that few scientists conducting research are representative of such populations. SMAHRT (Social Media and Adolescent Health Research Team) outreach is centered on the goal of reaching out to local community organizations that work with youth, with the hopes of better understanding the issues and concerns affecting youth, assessing our current research practices, encouraging collaboration opportunities, and engaging underserved youth in research.

Methods: Stage 1: Emails were sent to organizations in the surrounding community to pursue collaboration discussions. Materials were also developed to better communicate our SMAHRT research goals, mission, and past/current projects to the general public using lay person language. Stage 2: A week long Summer Scholars program was created to recruit underserved youth to learn about opportunities in clinical research. Recruitment for the program targeted 16-18 year old high school students from diverse backgrounds that are underrepresented in science and research in the surrounding Seattle area. Special emphasis was placed on students who qualified for free or reduced lunch and those who lacked prior research experience. Care was taken to identify any barriers that might prevent students from participating such as transportation, food costs, and missing a week from work. These barriers were addressed by providing free transportation, food, and a $100 stipend. Recruitment efforts involved emailing individual science teachers and visiting classrooms to give presentations about the program to potential applicants.

Results: Stage 1: Visits were set up with 7 community organizations, including Oasis Youth Center and the North Portland Area Indian Health Board. Highlights from these established partnerships included SMAHRT presenting on problematic internet use and cyberbullying at a youth summit, learning how the consent process deters LGBTQ youth from participating in research, and partnering with organizations on 2 research projects. Stage 2: The 25 students accepted to the program were 12% male; 16% Black or African American, 8% Hispanic, 28% Asian, and 4% Native Hawaiian or Pacific Islander. 84% received assistance with transportation and 56% qualified for free or reduced lunch. 72% stated they would be interested in becoming stakeholders for future projects, and 80% stated they are more interested in
research now than before the program began.

Conclusions: Building relationships with community organizations has helped inform our research practices as well as provided new research opportunities. The Summer Scholars program was effective at not only recruiting students who represented underserved populations, but also for sparking these students’ interest in pursuing research careers. Next steps from stage 1 include continuing to foster relationships with community organizations. Future directions for stage 2 include working on ways to engage these students in ongoing research. One way this can be done is with the formation of a youth stakeholder panel.

Sources of Support:

38.

UNACCOMPANIED MINORS: BREAKING DOWN BARRIERS TO HEALTH
Naomi A. Schapiro, PhD, RN¹, Juan Raul Gutierrez, MD, MPH², Jasmine Leonella Gonzalez, MA³, Jessica S. Dai, BA⁴, Ivette Gutierrez, MA⁵
¹University of California, San Francisco; ²La Clinica de la Raza; ³Alameda County Health Care Services Agency; ⁴Oakland Unified Unified School District; ⁵University of California School of Nursing

Purpose: The Affordable Care Act excludes many immigrants, including all undocumented immigrants, further increasing inequities in access to care. In 2014, the State of California was the third largest recipient of unaccompanied minors, fleeing violence and poverty in the Northern Triangle of Central America, crossing the border without a parent or guardian, and being released after detention. The large influx of youth in 2014-2015 were released to sponsors with an immigration hearing date but with no guarantee of legal assistance. However, up to 75% of unaccompanied minors gain asylum with proper legal representation, which also gives them eligibility to health services. A multidisciplinary collaboration of educators, legal advocates, public health officials, behavioral health and primary care providers, academics and graduate health science students worked together to leverage creative funding and other resources to connect youth with legal representation, ensure school-based support, provide for youth development activities, and deliver comprehensive primary care and mental health services to this vulnerable population.

Methods: Oakland Unified School District (OUSD) placed the majority of the 346 Central American immigrant youth and 254 additional newcomer youth in schools with comprehensive newcomer support services and convened a Newcomer Task Force with community groups to improve outcomes. OUSD and Alameda County Center for Healthy Schools and Communities each assigned a case manager to work only with unaccompanied minors. The City of Oakland contributed $500,000 for legal services, to ensure youth had adequate representation at their immigration hearings. The County of Alameda donated $500,000 to parallel EPSDT services in order to provide behavioral health services for this population. La Clínica de la Raza, an FQHC operating 8 SBHCs, used a model developed with UCSF School of Nursing and and their nurse practitioner students to screen all newcomers in one HS for confidential service, psychosocial and legal assistance needs. This strategy leveraged confidential services funding and temporary Medi-Cal (Medicaid) or County undocumented funds for in-depth follow-up, as indicated.
A flow chart was developed to maximize funding sources for different physical and behavioral health needs of the minors. SBHC in schools serving Newcomer youth also provide youth development opportunities and connect youth to mentors.

**Results:** 346 newcomers from Central America, of whom over 200 were unaccompanied youth, were assigned to OUSD. On-site legal services were available to students and families at high needs schools. Of the 81 newcomers at one high school, 72 newcomers screened at one health center: 35 were unaccompanied minors, 15 were referred to legal services on site, 64 received follow-up medical service, and 35 received dental. This model will be replicated in additional sites during the 2015-2016 school year, and outcomes of the first wave will be presented.

**Conclusions:** Coordinated services from multiple agencies can improve tracking and service delivery for a vulnerable population of undocumented immigrant youth. Public health, legal and safety-net health providers can collaborate with school districts serving immigrant youth to provide on-site services. Universities can contribute evidence-based models of care and health science students can increase clinic capacity while earning clinical hours.

**Sources of Support:**

39.

**FROM CHOICE TO THE REAL WORLD: ADVOCATING FOR TEEN PREGNANCY PREVENTION THROUGH THE GREATER ROCHESTER LARC INITIATIVE**

Katherine Greenberg, MD, Sara Catherine Jenks, MS, Andrew Aligne, MD, MPH  
*University of Rochester Medical Center*

**Purpose:** Research through the Contraceptive CHOICE Project and the privately funded Colorado Family Planning Initiative showed that young women overwhelmingly choose long-acting reversible contraception (LARC) over less effective short-acting methods when the barriers of cost, access, and provider bias are removed. In the real world of typical clinical practice, however, LARC methods are underutilized, particularly among adolescent women, which likely contributes to the nationwide public health issue of unintended teen pregnancy. The teen birth rate in the City of Rochester, NY, is nearly seven times higher than that of the surrounding suburbs, and in some zip codes is among the worst in the country, approaching 125 births per 1000 women ages 15-19. A local needs assessment found that adults in positive youth development (PYD,) who are dedicated to improving psychosocial outcomes for Rochester’s youth, did not have adequate knowledge or confidence in promoting LARC. In response to both this need, and gap between typical and optimal use of LARC, we developed this low-cost, high-impact advocacy intervention, which spreads the word about LARC and its availability.

**Methods:** This initiative is an advocacy project partnering community pediatrics at the University of Rochester Medical Center (URMC) with local family planning, teen pregnancy prevention, and PYD organizations. We additionally work with the New York State Family Planning Benefit Program with Presumptive Eligibility (FPBP), which is a Medicaid product offering free and confidential same-day family planning services, including LARC for adolescents. Our multifaceted community-based intervention focuses on raising awareness about LARC and FPBP among adults who work with youth. Our community presentations empower the adults with whom youth have established, trusting
relationships (health teachers, pediatricians, recreation center leaders, counselors, etc.) to talk about the most effective pregnancy prevention methods and how to obtain them.

**Results:** We have created a coalition of local agencies aligned in increasing LARC use among Rochester’s sexually active youth, and attracted interest from local government about the utility of LARC for preventing intergenerational poverty. We have helped to form a group of health educators focused on community education for LARC. Between August 2014 and August 2015, we have presented to over 300 adults who work with youth in 25 sites, including five primary care pediatrics offices; these 300 adults interact with thousands of teens each year. We facilitated an increase in the number of Rochester clinics offering FPBP. Additionally, we see evidence of increased demand for LARC training among pediatric health care providers, and have facilitated a project to train pediatrics residents within the URMC system in LARC insertion.

**Conclusions:** This advocacy program connects local PYD groups and pediatric health care providers with existing infrastructure providing free, confidential, same-day contraceptive services. For other communities with FPBP programs, this project provides a model for mobilizing PYD and family planning agencies around a common goal of teen pregnancy prevention, and focuses that energy on the winnable battle of increasing teen LARC use.

**Sources of Support:**

40.

**YOUTH IN CONTEXT: PREPARING FOR LIFELONG HEALTH AND WELLNESS WITH LESSONS LEARNED IN OPENING A HIGH SCHOOL BASED HEALTH CLINIC**

Tami L. Thomas, PhD, RN, FAANP, FAAN, PhD, Raquel Vera, PhD, Ora L. Strickland, PhD, RN, FAAN, PhD

*Florida International University*

**Purpose:** The purpose of this project was to develop an interprofessional school-based, family-centered, nurse-managed clinic to provide access to high quality primary care; and, enhance health outcomes for students and families in Liberty City. Liberty City, once a thriving community, is one of Miami’s poorest and most precarious neighborhoods. The area covers 5.968 sq. miles and is plagued by several major negative social determinants of health – racial segregation, poorer environment, and poverty. By developing a team-based collaborative practice that provides interprofessional training opportunities for students/trainees in health sciences and cultivates collaborative problem-solving, and care coordination; the goal is to increase access to culturally-competent public health interventions that focus on preventive health and environmental issues that affect the health of students and families in the Liberty City area.

**Methods:** After outreach meetings occurred with local community leaders the authors of this grant established partnerships with Jessie Trice Community Health Care, the Children’s Trust, Miami-Dade county schools and the Miami-Dade county Health Department. Theses community partnerships led to the grant submission and subsequent funding to open a nurse managed interprofessional collaborative partner (IPCP) clinic in an area with limited access to primary care for both adolescents and the local community. Qualitative research was conducted in Liberty City, the community where the nurse
managed IPCP clinic would open. Focus group data and advisory board meetings has led to an implementation plan that is inclusive and seeks to address not only the physical needs of the adolescent but the social, emotional and developmental needs. Faculty and students will provide primary care from APRNs in collaboration with physicians to include occupational therapy, physical therapy, speech and communication disorders, athletic training, behavioral health and health services administration services for optimal outcomes for students and their families. Data from focus groups includes spiritual leaders, parents, teens, teachers and healthcare leaders. As a result of this preparation, four advisory boards have formed and are guiding the implementation and opening of the high school based clinic in Liberty City – Miami, Florida.

**Results:** The NMHS clinic has provided teens and community members’ access to primary healthcare including behavioral health. The presence of an interprofessional collaborative practice including occupational therapists, physical therapists, language and speech disorders, athletic training and APRNS (Family and Pediatric) with health services administration embedded with students from has deepened the understanding of all parties about key determinants of health developed outside the clinic including community, family, peer interactions; participation in athletics, artistic pursuits, academic pursuits; personal experience of violence, health risk behaviors, and spiritual and cultural values.

**Conclusions:** Currently the implementation of a structure, process and outcomes focused evaluation plan that assesses the quality, safety, efficiency, and effectiveness of clinic operations; its team-based collaborative environment; its public health focused interventions, and related health outcomes for students and their families in the Liberty City community is underway. The multiple contexts identified are currently informing the planning of adolescent health care at the clinic and other local clinics are interested in adapting these approaches.

**Sources of Support:**

41.

**CREATING PATIENT-CENTERED QUALITY STANDARDS FOR SCHOOL-BASED HEALTH CARE**
Margaret E. Rogers, PhD, RN¹, Neal D. Hoffman, MD, FSAHM¹, Jodi Bailey, MA¹, Maia Bhirud, MPH²
¹Montefiore Medical Center; ²Primary Care Development Corporation

**Purpose:** The Patient-Centered Medical Home (PCMH) model is a well-documented set of quality standards used by national accrediting institutions to reorganize the delivery of primary care services. School-based Health Centers (SBHC) promote and utilize an integrated, comprehensive health care service model. Many SBHC, despite being an effective delivery model for high-need pediatric and adolescent populations, struggle to meet many elements of the PCMH model. In order to bring these two care models into alignment, quality standards that maintain the rigor of PCMH and add elements that reflect the preventive care and population management strengths of SBHCs were created and piloted in five sites in New York City. Added emphasis was given to standards in confidentiality, behavioral health, and reproductive health. Many of the lessons learned in the Patient-Centered School Based Health Care (PC-SBHC) pilot process will assist SBHCs nationwide to improve the quality of patient-centered care in their home sites.
**Methods:** Development of the PC-SBHC standards was facilitated by a team of experienced SBHC practitioners, PCMH experts, and school health regulatory agents. The group evaluated each PCMH standard against the SBHC model and proposed elements that better facilitated the delivery of patient-centered care in the SBHC setting. From August 1, 2014 through June 26, 2015, pilot sites worked with practice coaches on a variety of clinical projects designed to support PC-SBHC practice transformation. Sites were assigned individual work plans that outlined transformation goals with extra attention given to must-pass elements and areas for improvement. Practice coaches met with sites individually and as a group to support collaboration, which allowed sites to discuss issues and concerns, as well as share ideas and tools throughout the pilot. Individualized work plans helped sites monitor their progress toward transformation by tracking completed elements. A post-pilot assessment, following PCMH procedure, determined the final PC-SBHC level achieved by each site.

**Results:** Three sites achieved Level 2 recognition, and post-pilot assessments are underway for the final two sites. The implementation of standards for Population Management, Care Management, and Care Coordination were challenging to operationalize in the SBHC context. Structural barriers to the implementation of these standards include: inconsistent levels of practice standardization, EHR functionality, level of integration with sponsoring institution, availability of data to inform practice, and small clinic staff.

**Conclusions:** PC-SBHC reflect a real-world patient-centered quality standard for adolescents and school-aged children because it captures those unique aspects of their health needs, such as behavioral health and reproductive health services, which go unaddressed in the traditional PCMH model. This project demonstrates that SBHCs provide high quality patient centered care and can transform to achieve recognition when measured by appropriate standards. The next crucial step is to achieve recognition of the standards as the basis for financial policy to provide stable long-term funding based on outcomes and value. The PC-SBHC quality standards will be utilized as the foundation to demonstrate, advocate and secure a role for SBHCs in the increasingly value based funding of health care at the federal, state and local levels.

**Sources of Support:**

42.

**THE ADOLESCENT PATIENT CENTERED MEDICAL HOME INITIATIVE OF RHODE ISLAND**
Joanna Brown, MD, MPH; Patricia Stebbins, MA; Victoria Adewale, MSc; Lauren Chan; Annie Gjelsvik, PhD; Roberta Goldman, PhD

1Alpert Medical School of Brown University; 2Memorial Hospital of Rhode Island; 3University of Virginia School of Medicine; 4Brown University

**Purpose:** A Think Tank with more than 100 local stakeholders and national experts, held in 2013, identified key adolescent health needs in the state, including better access to care and enhanced adolescent-friendly services. The design of this pilot initiative grew out of this Think Tank and a state-level Adolescent Action Collaborative. The Adolescent Patient Centered Medical Home Initiative (APCMHI) aimed to enhance access to, and quality of, care for adolescents in Rhode Island through a
community-based effort linking health care sites, community agencies and schools. This project also sought to foster youth engagement in their own health care.

**Methods:** At five clinical sites across Rhode Island (two community health centers, an adolescent clinic, a reproductive health/primary care clinic, and a private practice) APCMHI provided tools, assessments, and one-on-one practice facilitation with the objectives of improving adolescent-responsiveness, increasing access, improve clinical benchmarks, addressing behavioral health needs, and engaging adolescents in their healthcare. Data were collected throughout the practice transformation process in the form of surveys and interviews with both providers and patients to both guide and gauge the success of practice transformation efforts. In addition, APCMHI sought input from local policymakers, national and local health professionals, a youth advisory board, and other key stakeholders. The project held regular steering committee meetings to provide project updates, offer a collaborative learning venue, obtain feedback on project progress and guide future directions.

**Results:** Across the five healthcare sites, noteworthy practice improvements were made on behalf of adolescents. Practices used the Adolescent Friendly Environment (AFE) assessment (University of Michigan) as a means of identifying barriers and guiding improvements. Practice improvements included: revising confidentiality policies, implementing behavioral health screening and services, creating open access hours for teens, and improving waiting room accessibility. All five practices successfully established collaborations with a school and community partner, sharing resources and referrals, and, in some cases, providing educational materials and seminars. In addition, most sites improved clinical benchmarks (such as screening for chlamydia and behavioral health) as well as increasing patient encounters. The project’s youth advisory board was highly successful: the group provided feedback to health sites on issues of access, care provision, and preferred methods/styles of communication; and was valued by youth participants as an educational venue. Data findings from project surveys are reported elsewhere.

**Conclusions:** APCMHI was a successful project in its ability to support adolescent-responsive practice transformation within the five participating health care sites, to address the community-level dimension of adolescent health care delivery, and to raise the visibility of the unique challenges and opportunities facing adolescent health care within the state. Project staff presented at local community meetings, national conferences, and symposia and secured a federal grant to continue some of this work. The needs of adolescents require attention in the PCMH arena and this project offered one model for addressing such needs. Adolescents care deeply about their health care and should be engaged by practices to provide feedback into future medical home transformation efforts. This project was supported by the RIGHA Foundation Fund at the Rhode Island Foundation.

**Sources of Support:**
43.

A RE-VISION OF THE ADOLESCENT SEXUAL HEALTH CURRICULUM: ADVANCING YOUTH THROUGH COMMUNITY COLLABORATIVE ACTION
Kristina Kaljo, PhD, Seema Menon, MD
Medical College of Wisconsin

Purpose: While unintended teen pregnancy has declined across the United States, an increase of sexually transmitted diseases and risk-taking behavior has been observed among adolescents. Coupled with other societal ills, such as economic and academic inequities, today's youth face extraordinary barriers. Thus, this project aims to collaborate with students, their community, and educators in one of the most segregated cities in America - Milwaukee, Wisconsin. Here, students of minority populations are hard-pressed to receive continuous health care or a rich health education. The over-arching goals were: (1) Build relationships between adolescent students, school stakeholders, adolescent ob/gyn specialists, and a medical education specialist, (2) design and implement a sexual health curriculum that was community-centered, student-centered, inquiry-based and applicable to today’s adolescent student, and (3) provide the students and school with resources and insights to modernize their school building’s medical clinic.

Methods: The project is a collaborative effort between the Medical College of Wisconsin’s Department of Obstetrics and Gynecology and an urban, alternative charter school, located in Milwaukee, Wisconsin. Students first visited the Medical College to gather design ideas and learn of the various medical tools and supplies necessary for any health clinic. Additionally, students had the opportunity to interview the Ob/Gyn adolescent specialist and collect information regarding ob/gyn and women’s health care. After the visit, four 2-hour workshop sessions were designed and implemented for students to examine and critically appraise their own sexual health and wellness. Each workshop was constructed with the forethought of the adolescent ob/gyn specialist, a medical education specialist, teachers, and participating students.

Results: Upon the project’s conclusion, the school built and moved into a new building, which includes a functioning health resource room. A culminating survey was provided to the students in order to gather their insights of the workshop. Data indicated that students were exceedingly satisfied of how the sexual health content was prepared and facilitated, commenting on the usefulness of learning about various sexually transmitted infections, relationships, and contraception. Seniors who assisted with the project presented their information at graduation and are interested to seek positions in health sciences. Students requested that the adolescent ob/gyn specialist and education specialist return to continue expanding the sexual health curriculum.

Conclusions: A great deal of enthusiasm was observed among students, staff, and facilitators of the sexual health curriculum. Lessons learned include the need for urban students to be immersed in the medical health culture to further advance their interests of content and health care within their local community. Initially, our project was designed solely for female students. While facilitating the workshop, 3 male students joined the sessions, which emphasizes a need for appropriate sexual health curriculum for all students, regardless of gender. The seniors were empowered by the project as they
gave a presentation to parents and peers on the risks and prevention of teen-pregnancy, sexually transmitted infections, and risky adolescent behavior. Following this design model, a similar curriculum can be adapted or developed to meet the specific needs of diverse communities, with consideration for the adolescents, families, and health providers.

Sources of Support: