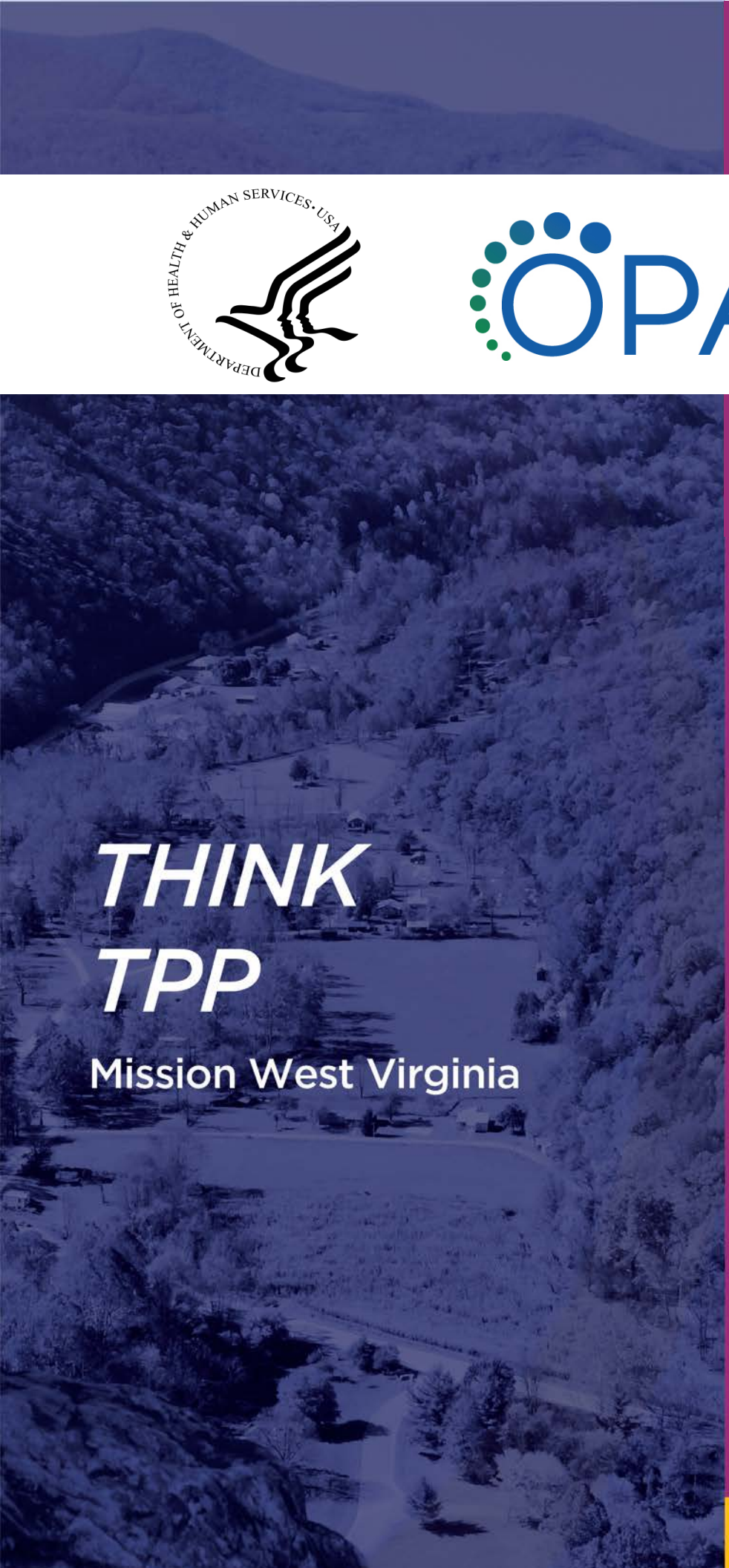

THINK TPP

Mission West Virginia

Replicating Evidence-Based Teen Pregnancy Prevention Programs to Scale in Communities with Greatest Need

Case Study No. 5

December 2018

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EXECUTIVE SUMMARY

Background of the Program

In 2015, the Office of Population Affairs (OPA) awarded 50 Teen Pregnancy Prevention (TPP) grants to replicate evidence-based programs (EBPs) to scale in communities with the greatest need. OPA designed the 2015 TPP grants to have a significant impact on reducing teen pregnancy rates and disparities by using a multi-component, community-wide strategy. The strategy integrated EBPs into multiple safe and supportive settings, mobilized stakeholders around a shared vision, and increased access to youth-friendly services. While implementation approaches varied, all grantees were required to include four key elements:[1]

Deliver EBPs with fidelity in at least three types of settings.

Engage the community around a shared vision to increase the community's ability to prevent teen pregnancy.

Recruit a network of youth-friendly service providers, develop a referral system, and connect youth to needed services.

Ensure programs are provided in safe and supportive environments.

THINK TPP

Mission West Virginia (MWV) implements *Teaching Health Instead of Nagging Kids (THINK) TPP* in nineteen rural counties across West Virginia. The counties are divided into four regions, one of which is served by MWV and the remainder by three regional partner organizations overseen by MWV: Community Action of Southeast West Virginia (CASE WV), Rainelle Medical Center (Rainelle), and Regeneration. The project's intended outcomes are to delay sexual initiation, reduce sexual activity and unprotected sex among teens, connect teens to needed services, and engage the community in prevention efforts. *THINK TPP* provides evidence-based TPP programs to youth in school settings, raises community awareness and integrates teen pregnancy prevention with other youth issues, and promotes access to youth-friendly services. **This case illustrates how the multi-component approach was brought to scale in rural communities across a wide geographic area building on existing adolescent health initiatives and infrastructure.**

[1] See the Funding Opportunity Announcement for details: https://www.hhs.gov/ash/oah/sites/default/files/tier1b-foafile.pdf.

Lessons in Scaling up Evidence-Based Teen Pregnancy Prevention

Statewide coordination among multiple funding streams facilitated full saturation of communities with EBPs. *THINK TPP* coordinated with several programs providing teen pregnancy prevention EBPs to ensure most middle and high schools and community settings offered an EBP without duplication. Having multiple options for EBPs gave communities more choices to ensure they fit with the local context. A state-level advisory group, the Leadership to Prevent Teen Pregnancy Task Force, provided planning and coordination support.

Incorporating teen pregnancy prevention into existing related community coalitions was a promising model for *THINK TPP*. Grant partners worked with other community advisory groups to incorporate teen pregnancy prevention into their missions rather than starting groups from the ground up. This was especially important because these West Virginia communities were dealing with other pressing social issues, such as substance abuse, domestic violence, low high school graduation rates, and child abuse and neglect. Joining with these groups connected *THINK TPP* to key stakeholders, helped keep teen pregnancy prevention top of mind, and acknowledged that issues affecting youth are interconnected.

Community mobilization efforts focused on making teen pregnancy prevention part of local community-building efforts. Regional partner organizations had been collaborating in their respective communities for at least ten years, building relationships with local organizing entities like Family Resource Networks, and becoming part of the social fabric.[2] The regional partner organizations co-sponsored community efforts that helped residents meet basic needs, integrated themselves into the local schools, and were establishing themselves as a trusted resource for adolescent health issues.

***THINK TPP* built on existing infrastructure and community assets to enhance linkages and referrals**. Project leadership leveraged two strengths. First, the state's vast network of Title X clinics and School-Based Health Centers, at least one of which existed in each county, provided opportunities to strengthen linkages between service providers. Second, the state's Family Planning program shared its systematic clinic assessments (that included a youth-friendly component) of Title X clinics with *THINK TPP*; this allowed the project to maximize resources and avoid creating a duplicative assessment process.

[2] Family Resource Networks (FRNs) are local state-funded coalitions of people working to address needs and service gaps for children and families in their communities. FRN's collaborate with partner agencies to develop innovative projects and provide necessary resources for their respective areas. There are 47 FRN's serving all 55 WV counties.

I. INTRODUCTION TO THE CASE STUDY

Mission West Virginia (MWV) is unique because it is implementing the grant strategy in predominantly rural areas on a statewide scale. This case study highlights its implementation of *THINK TPP (Teaching Health Instead of Nagging Kids)* in 19 rural counties in West Virginia.

The case study is based on analysis of interviews and on-site observations, and review of program materials. Data collection included: telephone and in-person interviews with five MWV staff, eight partner organization staff and three CAG members, observation of one CAG meeting, and two YLC focus groups. Data collection also included review of the grant application, annual progress report, community needs assessment, and dissemination materials.

***THINK TPP* At A Glance**

Grantee	Mission West Virginia
Targeted Community	4 regions (19 counties) in West Virginia
Local Teen Birth Rate (2015)	48.3 per 1,000 among 15- to 19-year-olds, average for the 4 regions
US Teen Birth Rate (2015)	22.3 per 1,000 among 15- to 19-year-olds
Annual Reach	12,000
Annual Funding	$1,726,995
Urbanicity	Rural
US Census Region	South Atlantic
Vulnerable Populations	None
Number of Implementation Partners	3
EBPs	• *Draw the Line/Respect the Line* • *Love Notes*
Settings	In-school middle school, in-school high school (traditional & alternative)

OPA's Strategy for Scaling Interventions to the Community Level

The grant program's goal was to have a significant impact on reducing rates of teen pregnancy and disparities by using a community-wide strategy to integrate EBPs into multiple types of settings, ensure youth receive EBPs multiple times over the course of their adolescence, mobilize stakeholders around a shared vision, and increase access to youth-friendly services.

While implementation varied, all grantees were required to include four key elements:[3]

Evidence-based programs. Deliver EBPs with fidelity in at least three types of settings.

Community mobilization. Engage the community around a shared vision to increase the community's ability to prevent teen pregnancy and improve adolescent health. Community Advisory Groups (CAG) and Youth Leadership Councils (YLC) inform the effort.

Linkages and referrals. Recruit a network of youth-friendly, accessible service providers, develop a referral system, and connect youth to needed services.

Safe and supportive environments. Ensure programs are implemented in safe and supportive environments: integrate a trauma-informed approach, assess LGBTQ inclusivity, and put positive youth development characteristics into action.

A logic model for the Tier 1B grant program is shown in Appendix Figure A-1.

Focus of the Case Study

This case study describes MWV's efforts to expand on previous programming to take EBPs to scale in 19 rural counties. MWV proposed to implement EBPs in settings and sites that would complement existing programming funded by other grant programs to achieve full saturation of the target population.

MWV and its three regional partners (Community Action of Southeast West Virginia (CASE WV), Rainelle Medical Center (Rainelle), and Regeneration) designed the following strategies:

- **Scale up EBPs by implementing them in settings not already reached by other programs:**
  - *Draw the Line/Respect the Line (DTL/RTL)* in public middle schools.
  - *Love Notes* in traditional and alternative high schools.
- **Partner with other youth-focused coalitions to ensure teen pregnancy prevention is part of the conversation, and communities see teen pregnancy prevention as one necessary part of improving the overall well-being of youth.**
- **Provide parent education and build awareness by taking part in school-sponsored events and co-sponsoring community-wide events; become a trusted resource in the community.**

[3] See the Funding Opportunity Announcement for details: https://www.hhs.gov/ash/oah/sites/default/files/tier1b-foafile.pdf.

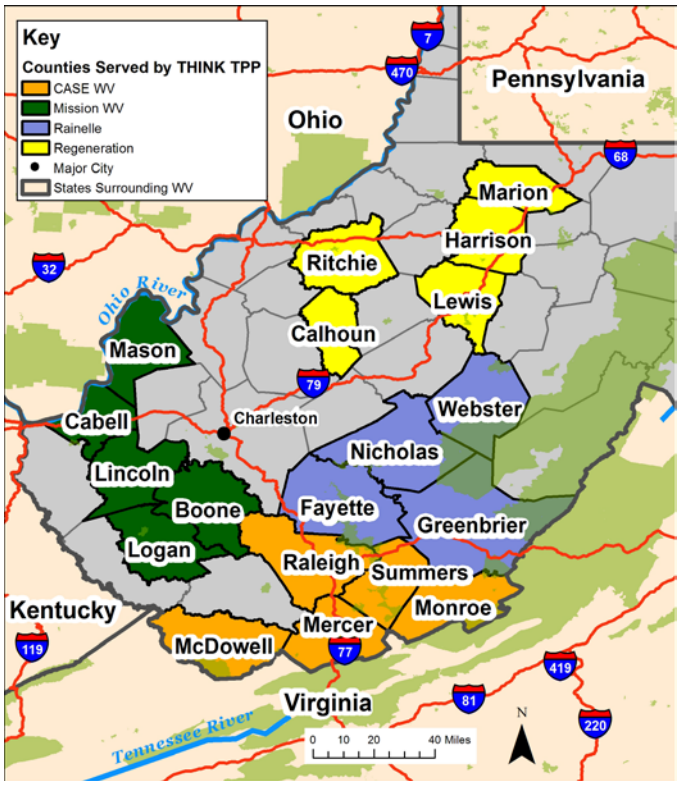
- **Design a standardized referral system for use by health educators across the 19 counties to identify youth needs and give them the information needed to connect to youth-friendly services.**
- **Infuse interactions with youth with an understanding of trauma-informed approaches, inclusivity, and positive youth development.**

The case study begins with a brief description of the community and organizational context in which *THINK TPP* operates and the project structure. The remainder of the report focuses on how the grantee laid the groundwork and began to implement each of the key elements of the OPA Tier 1B strategy.

II. COMMUNITY AND ORGANIZATIONAL CONTEXT

THINK TPP focuses on middle and high school students living in 19 high-need counties across West Virginia. Three contextual factors contributed to communities' readiness for bringing EBPs to scale and mobilizing community members around a shared goal: community characteristics and needs, existing resources in West Virginia, and the specific capacities of project partners.

Figure II-1: 19 Counties served by *THINK TPP*



Community Characteristics

West Virginia is a largely rural state, majority white (94 percent), and ranked fifth in the nation for the percentage of individuals living below the poverty level in 2017.[4] West Virginia has not experienced the same rate of decline in teen birth rates as the rest of the U.S. in recent years. Between 2007 and 2011, when the nation's teen birth rate dropped by 25 percent, West Virginia experienced no significant decrease.[5]

[4] https://www.census.gov/data/tables/time-series/demo/income-poverty/cps-pov/pov-01.html

[5] CDC, May 2013, National Center for Health Statistics National Vital Statistics System. NCHS Data Brief, No. 123

West Virginia had the eighth highest teen birth rate in the country in 2015 (31.9 births per 1,000 women aged 15-19).[6] Nationally, teen birth rates in rural counties are more than twice as high for non-Hispanic white teen girls as they are in urban areas, and are decreasing more slowly. A recent analysis of national datasets suggests this is due mostly to lower access to health services, higher poverty, and lower college enrollment.[7]

Mission West Virginia selected the 19 counties for the TPP grant by working with its three partners to prioritize counties with high teen birth rates. They grouped the counties geographically into four regions (see Figure II-1), to allow each partner to efficiently implement the grant strategy and build on successful collaborations put in place under previous grants. The combined teen birth rate for all four regions was 48.3 in 2015, compared to 22.3 for the U.S. that year.[8]

Table II-1: Target regions and teen birth rates

Region and Implementing Partner	Counties	2015 Teen Birth Rate (per 1,000 females 15-19)
Region 1 (CASE WV)	Five counties in the southeast (Raleigh, Summers, Monroe, Mercer, and McDowell)	54.5
Region 2 (MWV)	Five western counties (Mason, Cabell, Lincoln, Boone, and Logan)	51.3
Region 3 (Rainelle)	Four east-central counties (Webster, Nicholas, Fayette, and Greenbrier)	47.2
Region 4 (Regeneration)	Five northern counties (Marion, Harrison, Ritchie, Lewis, and Calhoun)	40.2
West Virginia		31.9
US		22.3

Existing Teen Pregnancy Prevention Infrastructure in West Virginia

West Virginia has several long-standing initiatives and grant programs related to teen pregnancy prevention that enabled *THINK TPP* to scale up implementation quickly. MWV and the West Virginia Department of Health and Human Resources (DHHR), which between them oversee all of these efforts, provide leadership and coordination to ensure that all service provision fills gaps and avoids duplication.

6 Births: Final Data for 2015, National Vital Statistics Reports, Volume 66 (1). National Center for Health Statistics.

7 Ng, A. S. & Kaye, K. (2015). Sex in the (Non) City: Teen Childbearing in Rural America. Washington, DC: Power to Decide.

8 Kids Count Data Center https://datacenter.kidscount.org/data/tables/5087-teen-birth-ages-15-19-per-1000-females#detailed/2/any/false/573,869,36,868,867,133,38,35,18,17/any/11519

Adolescent Pregnancy Prevention Initiative (APPI). The APPI is a focus area of the Family Planning Program within the Office of Maternal, Child and Family Health in DHHR. The APPI coordinates and oversees statewide teen pregnancy prevention efforts and co-leads with MWV the *Leadership to Prevent Teen Pregnancy (LPTP) Task Force*. The LPTP Task Force serves as the statewide CAG for *THINK TPP*. The APPI also administers the PREP grant program, which funds six organizations, including MWV, to provide nine counties with *Making Proud Choices (MPC)* or *Reducing the Risk (RtR)* in group homes, alternative schools, and juvenile centers. Three of the nine counties are also served by the Tier 1B grant.

School-Based Health Centers (SBHC) and Title X Clinics. West Virginia has an extensive network of SBHCs, which are satellite locations of Community Health Centers housed within a school site. Beginning in 1994, over time the state has established 140 SBHCs across 38 of 55 counties as of 2017-2018.[9] The services provided by SBHCs vary; in addition to primary care, they may also provide behavioral health services, reproductive health care, and dental care. The DHHR Family Planning Program has administered the Title X program since 1970, and currently funds 162 health centers across the state, some of which are also SBHCs. Each county in the state has at least one Title X health center and the Family Planning Program assesses them annually for youth-friendliness.

Sexual Risk Avoidance Education (SRAE). MWV and its partners have received abstinence education and SRAE funding for over ten years, including the discretionary SRAE program, Competitive Abstinence Education (CAE) Program, and the Community-Based Abstinence Education (CBAE) Program. The 2016 SRAE grant supported implementation of *Promoting Health Among Teens-Abstinence Only (PHAT-AO)* and *Love Notes* in group homes, juvenile detention, residential treatment facilities, and youth emergency shelters in seven counties, six of which are also served by the Tier 1B grant. The three regional partners have received Title V sub-grants for years, serving public schools in 13 counties, eight of which are served by the Tier 1B grant.

Background of *THINK TPP* Partners

The three regional partners and MWV have been working together since 2007 with the award of CBAE funds to MWV. They formed "THINK" as a way to unite the partners under one umbrella, and in 2010 received an OPA Tier1 grant to deliver *RtR* and *Becoming a Responsible Teen* to middle and high school students in 11 counties.

Mission West Virginia. MWV is a statewide non-profit agency formed in 1997 to recruit adoptive and foster parents for children in the foster care system. Since then, MWV has expanded to provide teen pregnancy prevention services both as an intermediary and direct

[9] Directory of West Virginia School-Based Health Services and Other Useful Resources, 2017-2018. School Health Technical Assistance Center, Department of Family & Community Health, Marshall University of School of Medicine.

service provider. MWV has experience managing federal grants and convening service providers across the state to build capacity and coordinate services.

Community Action of South Eastern West Virginia. CASE WV began in 1964 as a community action agency, and provides multiple anti-poverty services including family stabilization, Head Start, home visiting, family day care, and senior programs. They have been providing sexual health education in schools since 2000 through Title V, CBAE/SRAE, and TPP.

Rainelle Medical Center. Rainelle operates three primary care centers and four school-based health centers in eastern West Virginia. Founded in 1974, Rainelle has provided sexual health education programming for teens since 2000 through Title V, CBAE/SRAE, and TPP.

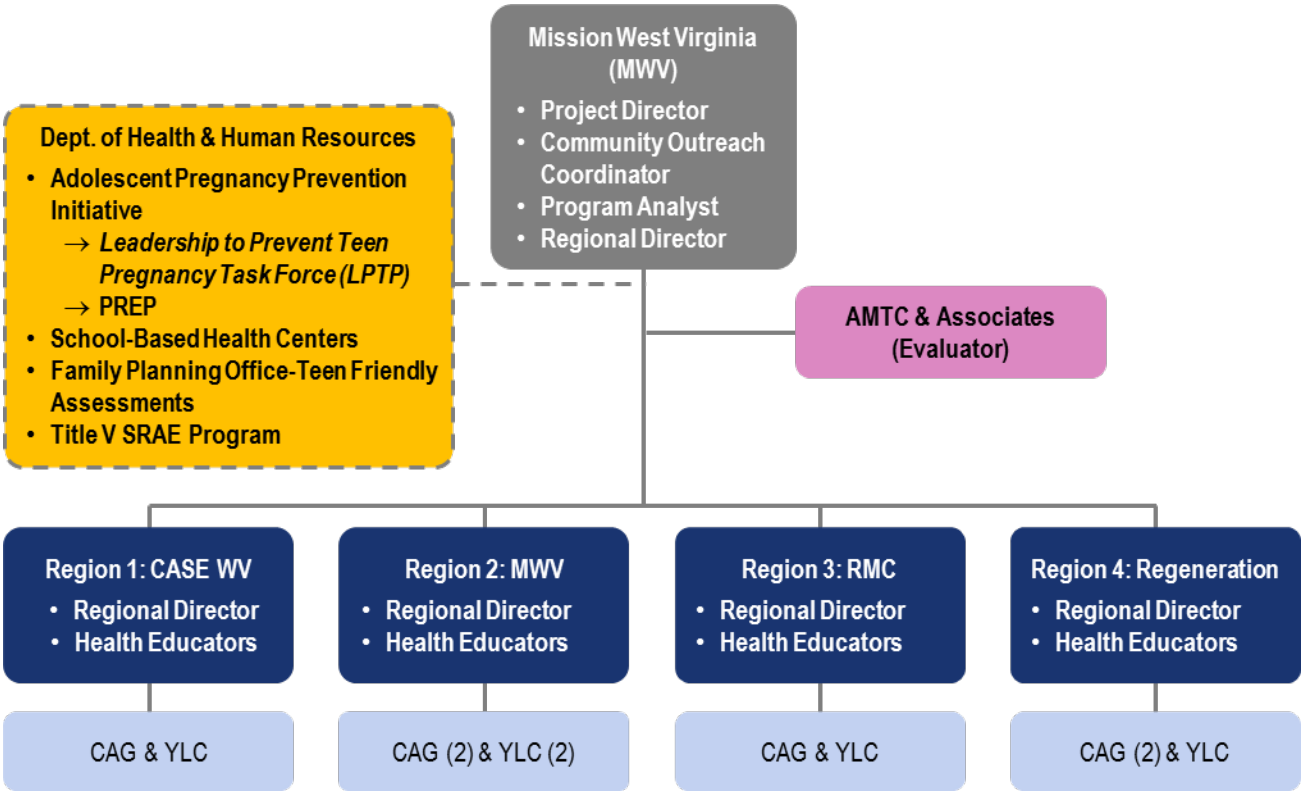
Regeneration, Inc. Regeneration is a small non-profit agency formed in 2005 to provide community-based abstinence education to young people living in north-central West Virginia. Since then, they have continued to provide sexual health and relationship education through various federal grants including TPP since 2010.

III. PROJECT STRUCTURE

MWV, as the grantee, both directed the project and delivered services to one of the four regions. In the intermediary role, MWV funded the other three regional partners, oversaw and coordinated project activities, provided and coordinated capacity-building training, and managed accountability, continuous quality improvement, and reporting. Each of the four regions had a Regional Coordinator, at least one CAG, and at least one Youth Leadership Council (see Figure III-1). There was also a statewide CAG (the LPTP), co-chaired by the APPI director in the state Family Planning Office at DHHR and the MWV outreach coordinator. The MWV outreach coordinator provided guidance to all of the CAGs, YLCs, and the community mobilization efforts for all four regions.

In each of the four regions, staff from the regional partner organization delivered *DTL/RTL* and *Love Notes* to middle and high school students, respectively, during the school day. The CAGs and YLCs were, for the most part, existing community coalitions and youth leadership groups focused on youth issues, led or co-led by *THINK TPP* partner organization staff. *THINK TPP* Health educators provided direct referrals for youth through a confidential referral process, and each regional partner had linkages with school-based health centers.

Figure III-1: *THINK TPP* organizational chart



Coordinating Grant Activities across the Four Regions

With project implementation occurring across a wide geographic area and involving multiple partner organizations, several mechanisms and conditions enabled MWV to efficiently coordinate the four regions:

- Annual meetings with all THINK TPP partner staff across the four regions.
- Quarterly project leadership meetings among the regional directors, the project director, and community outreach coordinator, supplemented by regular ongoing communication.
- A centralized performance management system gives real time information on program outputs and fidelity for each regional director.
- A statewide CAG (the LPTP) helps coordinate EBP coverage across funding streams to ensure service gaps are filled without duplication and regions are fully saturated with programs.
- Dedicated staff at MWV facilitates community mobilization and outreach across the four regions, and manages, tracks, and uses program performance measures for continuous quality improvement.
- Trusted partners with a history of collaboration with MWV and in their respective regions of the state.

IV. THE FOUR KEY ELEMENTS OF TPP SCALE-UP PROJECTS

Implementing Evidence-Based Programs (EBPs)

Key Elements of TPP Scale-Up Projects:

1. **Evidence-based programs**
2. Community mobilization
3. Linkages and referrals to youth-friendly health care and other services
4. Safe and supportive environments

The team implemented *Draw the Line/Respect the Line (DTL/RTL)* for middle school students, which consists of between five and seven sessions delivered in 6th, 7th, and 8th grades. *Love Notes,* a 13-session curriculum, was the high school program. *THINK TPP*'s approach to EBP implementation featured a plan to reach youth multiple times, saturation of communities by leveraging other grant programs, integration of EBPs into school systems, and a robust quality improvement cycle.

Choosing EBPs to Reach Youth Multiple Times

The partners designed the strategy so that youth would receive EBPs more than once throughout their adolescence. The partners and the regional CAGs ultimately chose a combination of two EBPs that would accomplish this: youth would receive *DTL/RTL* every year in 6th – 8th grades, and go on to participate in *Love Notes* when they reached high school. The implementation partners sought feedback from YLC groups, THINK Conference[10] stakeholders including county administrators and school staff, and various community stakeholders to select EBPs that would be a good match for the communities.

After the pilot and planning year, *THINK TPP* adopted *Love Notes* as its high school curriculum. Working with the CAGs and YLCs, the team sought a program that would resonate with West Virginia youth and was short enough to reduce burden on schools. *Love Notes* met these criteria and included a focus on healthy relationships, which the partners felt was important due to the prevalence of domestic violence in West Virginia communities. Due to the need to train staff and complete a pilot, EBP implementation in high schools started later in the second year than planned; but project staff were convinced it would be a better fit and more sustainable in the long run. Some partners felt that *Love Notes* was still too long to fit into school schedules smoothly, and were seeking ways to further shorten the curriculum with permission from the developer.

[10] The project's largest mobilizing event was the annual THINK Conference, designed to increase awareness of THINK programming across the state, provide professional development on the range of challenges faced by WV youth, mobilize stakeholders, and build name recognition for THINK as a go-to resource for teen pregnancy prevention, healthy relationships, and youth development. Participants included school administrators, health teachers, social workers, community organization staff, health educators, and school counselors.

Achieving Scale by Coordinating with Other Grant Programs

The OPA TPP Tier 1B grant was one of four funding sources providing evidence-based teen pregnancy prevention programs in the state. The *THINK TPP* partner organizations also were involved in implementing the other three grant programs in 25 counties across the state. Nineteen of these counties were served by the Tier 1B grant, with each grant focusing on a different target population, setting type, or site to ensure no duplication. By leveraging these complementary resources, *THINK TPP* was able to take EBPs to scale in all four regions.

Table IV-1: EBPs by funding source in Tier 1B counties

Grant Program	Settings	EBPs	Tier 1B Counties	Intermediary	Implementing Organizations or Sub-Grantees
OPA TPP Tier 1B	Middle and High Schools not served by Title V	*DTL/RTL and Love Notes*	19	MWV	MWV, CASE WV, Rainelle, Regeneration
SRAE	Out of home care, juvenile justice, shelters	*PHAT-AO and Love Notes*	6	MWV	MWV, CASE WV, Rainelle
Title V	Middle and High Schools	*PHAT-AO*	8	DHHR	CASE WV, Rainelle, Regeneration
PREP	Alternative schools, group homes, juvenile justice	*Making Proud Choices and Reducing the Risk*	3	DHHR	MWV and five other CBOs

The OPA TPP Tier 1B grant enabled MWV and partners to scale up from 61 school sites served under the previous TPP grant, to 101 school sites. In some cases they added counties to the service area, but mostly they examined the counties they were already serving and added schools to ensure that the majority of the target population in each county was receiving evidence-based programs. They coordinated with other grant programs to ensure that each school and community location was served by one of the programs without duplicating services. MWV estimated they had approximately 100 percent saturation of the target populations in the nineteen counties taking all funding streams into account.

> "Bringing programs to scale…means we are saturating communities, whether with TPP or with another program…we wanted to hit areas with no TPP program – that's what it means to really saturate that county, school system, and community. With counties we were already in, we worked to expand into the schools we weren't reaching in the [previous funded project]."
>
> —Project Director

Having the same organizations involved in most of the grants provided options to the implementation sites to ensure the best fit. For instance, some schools might be a better fit for the curriculum offered by one grant program versus another. In other cases, the grant program itself dictated which settings would be served; one particular grant program specified the highest risk populations were to be served – so that program served the most vulnerable youth in juvenile detention and out of home care, and

the Tier 1B program focused on youth who attended traditional middle and high schools in counties with high teen birth rates.

Integrating EBPs into School Systems

One of the key factors that helped *THINK TPP* fully integrate EBPs into the school day was being able to approach school systems as trusted community members. Having established working relationships with schools beginning in the early 2000s through federal grants such as Healthy Marriage, Title V, CAE, and CBAE, partner organizations kept largely the same staff and became part of the school culture over time. Health educators regularly participated in school events and contributed their time to efforts such as weekend backpack programs that provided school supplies and snacks for students who might otherwise go without. The partners' track record of past successes implementing EBPs in schools also helped build support from schools over time.

Comprehensive Approach to Continuous Quality Improvement

THINK TPP designed a continuous quality improvement (CQI) process that drew on multiple sources of data to ensure the EBPs were resonating with youth and that project leadership could pinpoint areas to improve. The CQI process was driven in part by evaluations completed by classroom teachers about the health educators' performance. The evaluations helped MWV decide what kind of professional development topics to offer at the annual two-day THINK meetings of all grant partners, and was a strategy to increase involvement of teachers in the effort. The annual THINK meetings were also used to review the aggregate report of teacher feedback, results of fidelity monitoring and quality observations, and highlight areas of success and improvement. Health educators also received on-the-spot feedback following each quality observation in the field, and were encouraged to mentor and learn from each other to further develop areas in which they needed improvement.

Mobilizing the Community

Key Elements of TPP Scale-Up Projects:

1. Evidence-based programs
2. **Community mobilization**
3. Linkages and referrals to youth-friendly health care and other services
4. Safe and supportive environments

While each of the four regions had different histories, resources, and infrastructure to support community mobilization, the partners used four similar approaches tailored to the unique contexts of each area:

(1) Using grant- and state-level infrastructure to support community mobilization.

(2) Leveraging existing community advisory groups focused on adolescent well-being.

(3) Becoming a trusted resource in communities.

(4) Using existing groups of motivated youth to serve as YLCs.

CAG members worked collectively to address the many pressing issues facing these communities, of which teen pregnancy was one (substance abuse, poverty, child abuse and neglect were the most critical). *THINK TPP* worked with the CAGs to weave teen pregnancy prevention into ongoing and new efforts, and build community support for EBPs and teen pregnancy prevention generally.

Underlying these approaches was a strong sense of community with a history of collaborating in times of need. Project staff described the communities as tight knit and aware that it takes more than one organization to address the multiple pressures youth face.

Infrastructure to Support Community Mobilization

MWV created a new position for this grant, the Community Outreach Coordinator, dedicated to designing an overall community mobilization strategy and helping the regional coordinators develop and facilitate their CAGs and YLCs in addition to developing the CAGs and YLCs in MWV's region. This centralized oversight and technical assistance from the grantee helped ensure the CAGs and YLCs were working in service of the overall mission of the project. Devoting resources to a dedicated staff position also signaled that community mobilization was a priority for the project, and allowed the grantee to take a lead role in building community collaborations across the state.

> "We were always a part [of community coalitions] but having the time and the resources to actually be as involved as we are now, we were not....But now that there's a designated position, then I'm able to go out and do more."
>
> —Community Outreach Coordinator

The LPTP task force, co-led by APPI and MWV, supported statewide coordination among organizations implementing EBPs. The LPTP consisted of local CAG leaders who met on a quarterly basis in the geographic center of the state to coordinate and share information about educational programming and community mobilization activities. Teens had been invited to the meetings in the past, and the LPTP was continually working on ways to include teens on a regular basis. Though the local coalitions/CAGs often had broader goals, the LPTP focused exclusively on teen pregnancy prevention. The primary benefits of the LPTP were: coordinating to identify gaps in teen pregnancy prevention programming, avoiding duplication of services, and identifying areas for collaboration.

Leveraging Pre-existing Advisory Groups to Form CAGs

Three of the four partners capitalized on established and trusted coalitions focused on adolescent well-being to serve as CAGs, drawing on relationships built through many years of providing sexual health programs in their respective regions. The fourth, MWV, had not previously delivered programs in its five counties. At first, MWV tried to convene a new CAG but found it challenging due to geography and members' busy schedules. After realizing that the same relevant stakeholders tended to sit on the various youth coalitions in the region, MWV decided to join these existing groups that were already dedicated to issues such as substance abuse and

drop-out prevention as a way to bring teen pregnancy prevention into the broader dialogue about adolescent health and youth development

Table III-1 shows the seven CAGs that were operational or in the process of being established during the second grant year. Each group created a strategic plan of activities to meet the needs of their local youth and address the following behaviors: substance use, teen pregnancy, high school dropout, bullying, poor hygiene, poverty cycle, and lack of teen-friendly activities.

Table III-1. *THINK TPP* Community Advisory Groups

THINK TPP Partner	CAG	Focus	Location
Region 1 - CASE WV	Substance Abuse Coalition	Substance Abuse & Teen Wellness	Mercer County
Region 2 - Mission West Virginia	Substance Abuse Coalition - Youth Task Force	Substance Abuse & Teen Wellness	Boone County
	Education Matters Coalition	Drop-Out Prevention	Cabell County
Region 3 - Rainelle Medical Center	Impact Youth Coalition	Substance Abuse & Teen Wellness	Greenbrier County
Region 4 - Regeneration	Ritchie County CAG	Teen Pregnancy & Teen Wellness	Ritchie County
	In progress	In progress	Marion and Harrison Counties
APPI and Mission West Virginia	Leadership to Prevent Teen Pregnancy Task Force	Teen Pregnancy	Statewide

Joining with existing advisory groups that were originally convened for a different purpose was a necessity in a context that prioritized other pressing issues such as substance abuse, poverty, and education. Teen pregnancy prevention integrated naturally with these issues. In all four regions, *THINK TPP* partners focused on making sure they were part of the larger conversation about preventing youth problem behaviors. They positioned teen pregnancy prevention as a correlate of the other issues and a necessary component of any community-wide prevention strategy.

> "Substance abuse prevention is West Virginia's main concern right now. Well we link that in, we see the connection between the two, they see the connection between the two. ....When we serve the youth we do all sorts of prevention with them. So we have a tobacco prevention specialist...the substance abuse prevention... Then we have Mission West Virginia comes in with the teen pregnancy prevention."
>
> —Community Outreach Coordinator

In one county, MWV joined forces with a dropout prevention coalition. The coalition's focus was keeping students in school and creating a dropout prevention plan. Its strategic plan is based on

substance abuse, sexual activity, and education, and how these three issues combine to affect students' futures. Teen pregnancy prevention thus became one arm of the three-armed mission of the group.

Bringing together organizations and community members focused on different youth-related issues was both more efficient, and potentially more effective in that it focused the community's energies on the common underlying factors of all youth risk-taking behaviors. The communities had been addressing various youth risk behaviors in similar ways, and the teen pregnancy prevention EBPs covered topics that applied to these other risk behaviors as well. As one project staff member noted, "the people who join [the meetings] are very appreciative that we're tackling it all in one meeting and not in 12 now."

Rainelle Medical Center's CAG

In Greenbrier County, the CAG is a long-standing community coalition called the Impact Youth Coalition, a sub-committee of the county's Family Resource Network. This coalition focuses on broad issues that affect youth. They organize Teen Expos with workshops and motivational speakers on health-related topics, and fun activities. They started the Impact Pantry with the Elks Club to stock cabinets at schools with hygiene products, socks and underwear for youth in need. The Regional Coordinator recruited new members for the purposes of *THINK TPP*:

> **"It's easier to piggy back on another group rather than forming one from the ground up. We brought some other people in this time – board of education, social workers, mental health workers, etc. It seemed like the perfect fit."**
>
> **—Regional Coordinator**

Lastly, project staff noted that leveraging existing coalitions focused on broader issues than teen pregnancy required an emphasis on reciprocity. That is, to stay engaged, CAG members needed to understand how their individual organizations could benefit from collaborating with *THINK TPP* as well as how their work supported the shared mission of the CAG.

Becoming a Trusted Resource in the Community

In the pilot and planning year, CAGs focused on the community needs assessment and making sure the EBPs chosen were a good fit for the community. Once full implementation began, the CAGs shifted focus to addressing the needs they had identified in their strategic plans. The general strategies across CAGs were to:

- Increase community involvement in and acceptance of the concept of teen pregnancy prevention;
- Increase partnerships to fulfill community needs;
- Provide opportunities for fun and educational activities for teens and parents; and
- Increase parent participation in the project.

While not all of the activities in service of these strategies were overtly about teen pregnancy prevention, they built trust and integrated the *THINK TPP* effort into the social fabric. In each community, *THINK TPP* already was or was becoming an integral part of the resource network.

For example, Regeneration's strategy was to sponsor many community outreach events, and assist community and school partners with their work such as Project Graduation.[11] Regeneration hypothesized that by increasing the visibility of the agency and building trust and relationships in the community, it would be more likely that parents would want their children to attend Regeneration events because they were a known and trusted community organization. The CAG helped generate ideas for the events and helped run them.

Teen Expos and Other Community Outreach Activities

Three of the four partners (MWV, CASE WV, and Rainelle) also used "Teen Expos" as a key strategy to raise awareness and provide a fun and educational activity for youth. Using pooled resources from several community groups, the CAGs and YLCs jointly planned these one-day informational events with input from the YLCs driving the types of workshop topics offered. Other events across the four regions included community pool parties, dances, clothing drives, school sponsored family events, safe graduation night activities, summer camps, information tables at athletic events, and health and community fairs.

Joining Forces with Motivated Youth Leadership Groups

There were five YLCs in the second year of the grant in various stages of development: CASE WV (Region 1) had one, MWV (Region 2) had two, and Rainelle (Region 3) and Regeneration (Region 4) each had one. CASE WV and MWV decided to capitalize on existing youth leadership groups, targeting school-based SADD (Students Against Destructive Decision-making) chapters and a high school Student Advisory Council (SAC).[12] Though these groups did not historically focus on teen pregnancy prevention, *THINK TPP* valued that these youth had been specifically recruited for their leadership potential and interest in promoting teen health, safety, and well-being. *THINK TPP* planned to follow a similar approach as it did for several of its CAGs – show how teen pregnancy is related to other youth risk behaviors and an important part of any effort to address adolescent health and well-being.

MWV and CASE WV found that SADD chapters, which focus on preventing a variety of youth risk behaviors, were a natural fit to serve as the YLC because these teens were recruited specifically to work on a broader prevention mission. For example, CASE WV started its YLC by recruiting high school-aged counselors from the summer basketball camp it sponsored, but soon learned that those youth were not necessarily motivated by the YLC's teen pregnancy

[11] Project Graduation, a longstanding tradition in West Virginia communities, provides a safe way to celebrate high school graduation night.

[12] SADD is a youth-based, peer-to-peer organization that promotes youth empowerment and uses peer influence to spread the message of positive decision-making. For more information, please see: http://wvsadd.org/.

prevention mission. CASE WV planned to co-facilitate the SADD group and incorporate teen pregnancy prevention into the group's agenda every other month.

Challenges Starting New YLCs

Rainelle and Regeneration got off to a slower start, trying to develop new youth leadership groups recruited specifically for this effort. Regeneration struggled with convening a YLC due to the long distances between schools in its geographic region. They pointed out that students do not typically drive, and were often involved in competing after school activities. Staff planned to shift to an in-school focus at multiple schools, offering "lunch and learn" activities focused on soliciting feedback on Regeneration's activities. This seemed like a more feasible option to staff than trying to engage a regular monthly or quarterly group.

Promising youth-adult partnership model

MWV viewed one of the counties it served as a potential model for how *THINK TPP's* other YLCs and CAGs could work together on community mobilization. This county's YLC was a high school Student Advisory Council (SAC) focused on reducing barriers to student success. Three members of the local CAG (the Education Matters Coalition), which was also broadly focused on dropout prevention, participated in the SAC meetings and helped facilitate them with the Community Outreach Coordinator from MWV. Together, the CAG and SAC filmed and produced videos for a media campaign focused on collective responsibility for youth success. The first set of videos focused on improving school attendance; the Community Outreach Coordinator planned to shift the SAC's focus the next year to teen pregnancy prevention and its relationship to school success.

> "[The campaign is] called *Together We Can*. And we're kind of saying that it takes a whole community to work with our youth to [help them] succeed. ...Like if you're the store owner or the store clerk and this kid comes in and he looks all sad and stuff, you can talk to him about it. Or you're the parent of the child; it's your responsibility and it's the teacher's responsibility -- it's everyone's responsibility."
>
> —SAC/YLC member

The CAG also occasionally brought together two SACs (from different high schools) in larger meetings to jointly plan activities. This required busing students to an offsite location with school board permission, made possible in part because a member of the school board is on the CAG. At these joint meetings, the youth and adults broke out into small groups to work on their community engagement ideas and plans. A CAG member moderated each small group to ensure it stayed on track and to take notes, while youth took the lead in generating plans. The Community Outreach Coordinator hoped to replicate this joint CAG-YLC model with other CAGs and YLCs in the coming years of the grant.

Enhancing Linkages and Referrals to Youth-Friendly Health Care Services

Key Elements of TPP Scale-Up Projects:

1. Evidence-based programs
2. Community mobilization
3. **Linkages and referrals to youth-friendly health care and other services**
4. Safe and supportive environments

THINK TPP's strategy for enhancing linkages and referrals was set against the backdrop of West Virginia's network of primary care and reproductive health services. There are 167 Title X-funded family planning clinics across the state, and every county has at least one. Of these, a small number are also school-based health centers (SBHC). All but two of the nineteen counties had at least one SBHC. Drawing on the partnership with DHHR's Title X Family Planning Program and APPI, *THINK TPP* focused on two objectives in the first two years: (1) ensure clinics and SBHCs are youth-friendly, and (2) design a standardized process to connect youth to needed services.

Leveraging a System for Assessing Providers for Youth-Friendliness

The Title X Family Planning Program helped *THINK TPP* identify youth-friendly healthcare providers in the targeted communities and offered on-going technical support to improve clinic practice among its own clinics. Through its Quality Assurance Monitoring Team (QAMT), the Family Planning Program regularly assesses its Title X clinics for youth-friendliness using a tool previously developed in collaboration with its federal funder. The youth-friendly portion of the day-long assessment covers the atmosphere and attitude of the clinic, the exam room, birth control counseling, payment, and confidentiality.

Areas covered by the Quality Assessment Tool related to youth-friendliness:

- **Is the environment welcoming (colors, seating, posters, age-appropriate literature)? How are teens greeted and by whom?**
- **What is the atmosphere and overall attitude of the clinic?**
- **Check-in process: What is asked? What responses do they give to questions teens are likely to ask, and are the responses accommodating?**
- **Exam rooms: Does the provider account for the developmental level of the teen when explaining information and services? Is the décor relatable for youth?**
- **Birth control counseling: Is the information comprehensive? If the teen is pregnant, is she provided all the options without judgment?**
- **Payment, billing, confidentiality: do they use a sliding scale? Does the teen understand the confidentiality process? If the teen marks "confidential" are there systems in place to ensure that this is followed? (e.g., no calls home, no EOBs sent home)**

MWV included in its memorandum of understanding with the Family Planning Program a requirement that each time they assess a clinic they share the results with MWV. They kept MWV informed as they trained and re-assessed clinics, and MWV in turn kept the regional referral guides up to date.[13]

Technical assistance and improving youth-friendliness of providers

Based on the results of the QAMT conducted by the Family Planning Program, APPI staff (which is a separate focus area of the Family Planning Program) followed up to provide technical assistance to the providers as needed. The Family Planning Program also had plans to include teen-friendliness in the annual training that clinics need to keep their Title X funding.

> "We have probably 100 to 150 or more clinics [statewide] that we have to, you know, figure out if it's youth-friendly or not. So we really rely on the kids to tell us what's going on."
>
> —Project Director

There was also a formal process to incorporate student feedback on their clinic experiences. If students reported to health educators that their experience at a health center could have been more youth friendly, *THINK TPP* health educators could submit a form to the grantee describing the situation. Upon further discussion, the grantee could decide to remove the provider from the referral guide, and re-send the guide to all the health educators. APPI would follow up with the provider and create an action plan. The same process was in place across all four regions.

If a SBHC was not Title X-funded, there was no formal process to pro-actively assess its youth-friendliness. During 2016-2017, most SBHCs were not covered under Title X. However, the SBHCs in at least one *THINK TPP* region were continually focused on creating environments where students felt comfortable.

Connecting Students to Youth-Friendly Service Providers

Each regional partner disseminated the referral guide for youth and their families and trained key staff responsible for making referrals to ensure awareness of available services. MWV created a form for students to request a referral, as a way to provide a confidential alternative to directly asking the health educator or teacher. During an early session of the EBP, health educators handed out the form where students could indicate the topics on which they would like assistance or more information. Topics were: reproductive health care, primary health, mental health, vocational training, workforce development, intimate partner violence, and healthy relationships. Health educators commented that the most common requests for information were on reproductive health care, mental health care, and work placement.

After receiving the forms, the health educator followed up with the requested information confidentially (e.g., providing brochures, specific contact information). Health educators also

[13] Under the first TPP grant, in conjunction with the statewide LPTP task force, MWV created lists of youth-friendly facilities by county (based on QAMT assessments) and made laminated referral guides for youth.

proactively worked with the classroom teacher to refer a student to the school counselor if students' comments or actions were cause for concern. In other instances, health educators stayed after class to field questions and made referrals as needed.

In general, if the school had a SBHC, health educators referred students there first. Having SBHCs in rural environments helped ensure access to and continuity of care. In some parts of the counties, the SBHC was the only provider young people could see due to lack of other providers or transportation to them. SBHCs also ensured students could see the same provider each time, and they would not miss a whole or half day of school like they would visiting another provider.

Coordination with school counselors ensured continuity and messaging

Health educators made sure that the teacher and school counselor were aware ahead of time about the referral process and the day that the referral request forms would be handed out. In some cases, the school counselors observed the classes to understand what messages the students were receiving so they could reinforce and better serve the students. Health educators spoke of the importance of having a good working relationship with counselors and teachers because in some cases they are only with the students for a short period of time. By getting buy-in from select school staff, health educators tried to ensure that students would have more adults who could support them in an ongoing way.

Potential Challenges with the Referral Process

THINK TPP partners noted three main challenges with the referral process, one general and two related to the rural settings. First, some students misunderstood the purpose of the form and checked topics on which they were already receiving support from the school. The more common challenges, however, were lack of transportation and challenges of maintaining privacy in small towns. There could be many students needing a service but no way for students to get to where that service could be delivered.

Ensuring Safe and Supportive Environments for Youth

THINK TPP aimed to establish safe and supportive environments for youth programming by practicing inclusivity and trauma-informed approaches.[14] All staff were trained at least annually on these topics. In general, health educators positioned themselves as an approachable, caring, non-judgmental resource for students so they would feel supported asking about any topic. At the classroom level, health educators tended to use three strategies: set the tone, recognize warning signs, and be aware of students' histories.

Key Elements of TPP Scale-Up Projects:

1. Evidence-based programs
2. Community mobilization
3. Linkages and referrals to youth-friendly health care and other services
4. **Safe and supportive environments**

[14] Positive youth development practices were employed primarily through the YLCs rather than in the classroom.

Classroom-Level Skills and Strategies

Set the tone. Health educators noted the value of using the early EBP sessions to create ground rules with the students about class discussion. The rules typically included reminders to be non-judgmental and respectful, and to maintain confidentiality. The process of creating a set of rules together gave students an agreed-upon structure they could trust, which brought a sense of safety to the discussions. A health educator noted that the rules were often helpful not only for class, but also for life and healthy relationships in general. Other rules set by the health educators included the right to not participate in a discussion, or to leave the room.

> "I've been really cognizant now of talking about sexually transmitted diseases. Because if these kids already have one, I don't want to shame them or make them feel like there's anything wrong with them...that if you already have one that you're going to live with for the rest of your life, I try to let them know that they're still going to be able to have relationships with people and live long healthy lives with treatment. We just let them know that they're okay too."
>
> —Health Educator

Setting the right tone also included health educators positioning themselves as a resource for students. They made themselves available before or after class as much as their schedules allowed to answer questions, listen, and potentially provide a referral.

Recognize potential signs of discomfort. Several health educators mentioned that their training in trauma-informed care gave them the tools to recognize when a student might be showing signs of discomfort. They learned to recognize a wide range of behaviors, from an overly argumentative or disruptive student, to one who was quiet but uncomfortable. Their training helped them be able to respond with empathy rather than frustration, and try to stay after class in case a student wanted to talk.

> "It's so easy to get frustrated when you have a kid acting out, but usually there's a reason, and...I think [knowing] that helps you in regards to being more sensitive to dealing with it."
>
> —Health Educator

Recognize diverse life experiences. Part of ensuring inclusivity meant acknowledging students' different life experiences with sexual activity, pregnancy, birth, and STIs, and always presenting the material in a way that avoided shaming them. Developing and maintaining relationships with the classroom teachers helped the health educators understand the range of experiences the student population may have had.

In one example, a health educator had a student in class who was married and had a child. She checked in with him separately to ask how the material was applying to him, and ensure he knew he could ask questions and access resources through her. Health educators were also mindful that there might be young women in the class who had already given birth, and the circumstances of that pregnancy could have been traumatic.

Challenges with Building Safe and Supportive Environments

THINK TPP health educators noted two main challenges with creating safe and supportive environments. The first was that they had limited ability to affect the larger social environment in which students lived, which might be reinforcing messages counter to inclusivity. The second challenge was not having enough time to develop rapport with the students. Sometimes health educators' busy teaching schedules did not allow them that crucial time after class necessary to get to know the students and build a caring connection.

V. CONCLUSION

THINK TPP is an example of coordinating multiple statewide efforts to take EBPs to scale in rural communities. The grant partners set out to complement existing programming to achieve full saturation of the target population, and enhance the focus of community advisory groups and youth leadership councils to support the project.

This project illustrates some effective and creative strategies for building support for teen pregnancy prevention programs even amid very compelling competing needs. It also makes a strong case for building statewide coalitions to provide momentum and to coordinate and share ideas and resources. Taking prevention efforts to scale in one community can be challenging, but MWV's *THINK TPP* project demonstrated that by joining forces with existing coalitions with a shared mission, leveraging infrastructure, and tying into complementary prevention programs, it is possible to extend services and provide evidence-based programs to a large number of disparate communities.

APPENDIX A. OPA TIER 1B LOGIC MODEL

Figure A-1: OPA Tier 1B logic model