Serving Expectant and Parenting Youth and Their Families in Rural Communities

Overview of the Pregnancy Assistance Fund

Finding ways to address the diverse needs of expectant and parenting youth and their families (EPY) to improve their health, education, and well-being is a long-standing priority of the Department of Health and Human Services (HHS). The HHS Office of Population Affairs (OPA) funded the Pregnancy Assistance Fund (PAF) grant program from 2010 to 2020. The PAF program supported states and tribes to provide a wide range of services in settings such as high schools, community service centers, and/or institutions of higher education.

PAF services focused on five areas: (1) personal health (e.g., case management, prenatal care, health insurance enrollment support, behavioral health, violence prevention); (2) child health (e.g., home visiting, nutrition, access to healthcare, well-child visits); (3) education and employment (e.g., tutoring, academic support, assistance with college applications, employment and job-readiness training); (4) concrete supports (e.g., food, housing, transportation, baby supplies including diapers, cribs, car seats, etc.); and (5) parenting supports (e.g., parenting and healthy relationship education, child development education, child care). PAF grantees determined which areas to focus on to improve outcomes for EPY in the areas of health, parenting, education, and economic stability.

About the Study

HHS/OPA contracted Abt Associates to identify successful strategies and lessons learned from the Pregnancy Assistance Fund grant program (see https://opa.hhs.gov/research-evaluation/pregnancy-assistance-fund-paf-program-evaluations/evaluation-key-strategies). The study produced six topical briefs and corresponding in-depth case studies. The six topics were identified from a review of grantee documents and input from OPA staff. They reflect the range of approaches PAF grantees took to best serve EPY needs. The topics are (1) serving system-involved (justice or child welfare) youth; (2) serving youth in Tribal communities; (3) serving youth in rural communities; (4) cross-sector partnerships; (5) policy and systems-level strategies; and (6) strategies for improving educational outcomes. For each topic, the study selected grantees from the pool of 26 grantees funded in the most recent cohort (2018-2020) and in at least one other cohort.

The briefs and case studies draw from review of grantee documents, performance data, and semi-structured phone interviews with grantee and grantee partner staff.

Focus of this Brief

This brief summarizes the implementation experiences of three PAF grantees and their efforts to serve EPY in rural communities: the Kansas Department of Health and Environment, the Mississippi Department of Health, and the Montana Department of Public Health. We describe their key challenges, opportunities, strategies, and lessons learned as they worked toward increasing educational attainment, reducing unplanned repeat pregnancies, supporting the health and overall well-being of young parents and their children, and helping participants set personal and professional goals.

Key Findings:

- PAF programs were an essential resource for EPY in rural communities and offered a way to mitigate some of the many challenges they faced such as transportation and access to health services.
- PAF program staff built on the strong sense of social cohesion, family, and trust present in many communities when brainstorming solutions to service delivery challenges.
- PAF grantees in rural areas used service strategies including case management, parent education, and home visiting, often expanding pre-existing case management programs to reach more of the target population. Home visiting was a viable option to enhance access to services for rural EPY, but there were also challenges with this approach.
- Working with multiple generations was essential to successfully delivering services to EPY. In addition, building on and maintaining relationships were critically important at every level when serving rural communities.

The Rural Context

Why focus on rural communities? Rural communities are in high need of PAF program services. Adolescents and young adults living in rural communities are more likely to engage in sexual activity, less likely to use contraception, and more likely to be parents than their counterparts living in urban areas.[1] Adolescent birth rates are significantly higher in rural counties than urban counties for all age groups, regardless of race or ethnicity. Repeat births are also more common for adolescents in rural counties.[2] Moreover, while adolescent birth rates in the United States have been steadily decreasing over recent years, the rate of decline has been slower for rural youth. For example, from 2007 to 2015, birth rates for ages 15–19 decreased by 50 percent in large urban counties but only fell by 37 percent in rural counties.[3] Among all PAF grantees in 2018–2019, 20 percent of 223 implementation sites were in rural areas; and in 2019–2020, 24 percent of the 284 were rural.

Rural communities across the United States vary widely in terms of geography, values, and culture; and are becoming increasingly diverse racially and ethnically.[4] However, rural populations share some general characteristics that are important for understanding the needs of EPY. Residents of rural areas are more likely to face economic and health disparities compared to their urban counterparts, including overall higher poverty rates, a lack of healthcare infrastructure, and poorer health outcomes. Access to health care such as emergency services and primary and preventive care remains the most frequently identified rural health priority.4 Rural communities have well-documented shortages of healthcare professionals and have seen a recent rise in hospital closures.[5,6]

Health care access and health outcomes are also different for infants and toddlers in rural areas in general, regardless of the mother's age. For instance, mothers in rural areas are less likely to receive timely prenatal care and more likely to give birth outside of a hospital. Their infants and toddlers are less likely to receive a preventive medical or dental visit, or recommended vaccines. Low-income families in rural areas are also less likely to have health insurance when compared to their counterparts in urban areas. Higher percentages of pre-term births and babies born with low birth weights are also challenges in rural areas for some states.[7]

Defining Rural

There are multiple ways to define "rural." PAF defined it as nonmetropolitan areas, which include those with an urban cluster population of 10,000–49,999, and those with no urban cluster population.8 Grantees and their partners often characterized "rural" based on long distances between towns and the absence of major grocery stores and other services.

Three Grantees Serving EPY in Rural Communities

Each of the grantees described below recognized the unique challenges of serving rural communities and found opportunities to use community strengths to meet the unique needs of EPY. The three grantees used a combination of service strategies, including case management, parent education, and home visiting. The individual case management approach helped programs target a wide range of intended program outcomes depending on the needs and goals of participants. Kansas and Mississippi expanded pre-existing case management programs to reach more EPY in rural areas. Montana partnered with seven sub-awardees, each of which designed a unique approach tailored to their respective community needs. In addition to direct service, Mississippi and Montana also created a statewide resource guide for teens, developed statewide training sessions for rural providers who served EPY, or held state-level meetings focusing on adolescent health and social justice. Goals they expected to achieve from these activities included capacity building, sustainability, and increased consistency of service delivery across all providers in the state, including many in rural areas.

- **The Kansas Department of Health and Environment (KDHE)** administered the state's PAF grant and coordinated communication between local sites and state-level programs. The grantee supported sites by providing tools for case management, referrals, and reporting, including a web-based tool that service providers could use to find referral sources, and make and track referrals. Five sub-awardees provided direct services in four specific, high-needs areas (two counties in central Kansas, one county in northeast Kansas, and a four-county region in southeast Kansas). PAF filled service gaps in the state by allowing them to provide an existing case management program to an expanded age group of EPY (21 – 24) and to include fathers who were not being served by other state programs. The flexibility of PAF funding made it easier to fill gaps among multiple federal and state funding streams such as Title V, WIC, and the existing Teen Pregnancy Targeted Case Management program. PAF sub-awardees also received funding from one or more of these funding streams, which meant they could coordinate program enrollment and avoid gaps or duplication.
- **The Mississippi Department of Health (DOH)** chose a three-tiered approach for their PAF grant. This included developing a state-wide comprehensive resource directory, implementing capacity-building training sessions with providers throughout the state, and providing direct services by expanding a pre-existing case management program (the Perinatal High Risk Management/Infant Services System or PHRM/ISS). The direct service component of the grant in 2019–2020 focused on 15 rural or mostly rural counties across the state, with services offered through county health departments.[a] The program included an interdisciplinary team approach of a case manager, nurse, and nutritionist, who together provided parent education and in-home visiting services.
- **The Montana Department of Public Health (DPH)** oversaw the state's PAF grant, called the Healthy Young Parent Program (HYPP). In 2019–2020 the grantee had seven sub-awardees providing direct services: three tribal organizations serving the Confederated Salish and Kootenai Tribes and the Blackfeet Nation in western and northwestern Montana, respectively; two city/county health departments serving the urban areas of Butte and Kalispell; one rural school district adjacent to the Crow Reservation in southeast Montana; and one local domestic violence services contractor also in southeast Montana. Each sub-awardee designed its own programming and approach, which included case management, in-home visits, onsite school childcare, and victim services.

a While the focus was on these 15 counties, any EPY in any Mississippi county receiving case management via the local health department had access to providers trained to serve EPY.

Profiles of Three Grantees Serving Rural EPY and Their Families

KANSAS

Grantee (state agency)

Kansas Department of Health and Environment

PAF Grant Periods (fiscal year)

2010–2012, 2013–2016, 2017–2018, 2018–2020

Number of EPY Served (annual average for 2018–2020)

175

Service Areas

Four high-need county and multi-county areas (located in southeast, northeast, and central Kansas); two were rural

Key Implementation Partners

County health departments, a school of medicine, a community health center, and a maternal /infant health community-based organization

Primary Approach(es)

- Case management, designed to fill in need for EPY not served by other state-funded programs
- Prenatal education
- Job readiness

MISSISSIPPI

Grantee (state agency)

Mississippi Department of Health

PAF Grant Periods (fiscal year)

2015–2017, 2018–2020

Number of EPY Served (annual average for 2018–2020)

371

Service Areas

15 focal counties (across all regions of the state), mostly rural

Key Implementation Partners

Statewide technical assistance provider and county health departments

Primary Approach(es)

- Case management
- Three-tiered approach, which includes developing a state-wideresource guide, capacity-building training sessions for providers, and direct service

MONTANA

Grantee (state agency)

Montana Department of Public Health

PAF Grant Periods (fiscal year)

2010–2012, 2013–2016, 2018–2020

Number of EPY Served (annual average for 2018–2020)

171

Service Areas

Six implementation sites across three regions: west, northwest, and southeast Montana. Across these three regions, four implementation sites were rural and two of those were Indian reservations

Key Implementation Partners

Three tribal social services organizations, two city/county health departments, a rural school district, and a local domestic violence services provider

Primary Approach(es)

- Case management
- Evidence-based home visiting
- Onsite school childcare
- Victim services
- Coordinated statewide approach allows for multiple funding streams to work together

Sources: Grant applications, progress reports, performance measures reported to OPA, and information provided in interviews.

Key Challenges for Serving EPY in Rural Communities

The grantees and their partners noted several common challenges affecting PAF service provision specifically in rural areas, providing insights into how grantees navigated these barriers.

Transportation is one of the largest barriers to providing services. While many young people in communities across the United States do not have access to a car, rural areas present the additional challenge of a lack of public forms of transportation. Taxis and transportation network companies such as Uber and Lyft are rare or non-existent, and the long distances would make them unaffordable. Youth rely on friends or family members with cars who are willing to provide rides, but this also requires financial resources to reimburse them for gas. In the rural areas served by the Kansas grantee, services may be 45 minutes away for families, and they may need to travel several hundred miles to receive specialized health and mental health services.

> *Having adequate transportation is definitely a luxury for many people in the [Mississippi] Delta. Families often don't have a vehicle and have to rely on others in their community to get where they need to go. –Partner*

Limited availability of health services and other resources presents challenges to providing primary care, specialty and mental health care, and other services such as nutrition education. Rural areas often do not have the array of services or resources that may be available to youth in more urban areas. This challenge can affect young people's health and the frequency at which they choose or are able to access health care, especially if they also lack transportation. While county health departments are an important and often sole resource for EPY in rural areas, some health departments do not have the staffing or resources to be open every day of the week (e.g., offices may be open only two–three days/week). Residents of rural communities served by these grantees also often need to travel a significant distance to access fresh foods or larger grocery stores, which can create barriers to nutritious food choices.

Some rural areas are more susceptible to disruptions in critical services. Natural disasters such as flooding, tornadoes, and hurricanes also can also have a greater negative impact on rural communities due to the more isolated locations and potentially vulnerable or inadequate infrastructure (e.g., these events can affect housing, transportation, and electricity and water supply in these areas). In addition, winter snowstorms can greatly affect northern rural areas, sometimes causing entire towns to shut down and roads to be inaccessible for days at a time.

Other structural and systemic challenges create difficulties in serving EPY. Grantees noted a lack of quality childcare, living in economically depressed areas, and the intergenerational cycle of teenage pregnancy and parenting within some families as significant barriers. Additionally, schools may not offer comprehensive sexual health education in these areas, so young people may tend to be less aware of how to prevent additional pregnancies or protect themselves from sexually transmitted infections (STIs).

Key Strengths and Strategies for Serving Rural Communities

While rural communities present certain challenges for service provision, these communities also have important strengths on which service providers can build. Grantees spoke of a **strong sense of social cohesion and family that can ease cross-sector collaboration and service provision**. For example, different types of service providers within the community are likely to know each other and can more quickly connect their participants to services through informal partnerships. Individual staff from service provider organizations are often well-known by families and may have grown up in the same community; this trust built over several years and even generations is a critical advantage for engaging EPY in services. While there may be fewer services than in an urban area, there may be fewer barriers to collaboration for case workers in a rural community who can build on trusting relationships with participants and their families. Young parents in rural communities also may be able to rely on extended family, supportive friends, or their faith institutions to help them when they need material or social support. Some grantees referred to this as the "It takes a village" mindset that characterizes some rural communities.

> *Everybody knows everybody, and so it's easy to build those partnerships and those relationships because, chances are, they're somebody that you've known for years and that you've had a relationship with or somebody in your family knows somebody. So, that's the advantage of small-town America is really that those relationships are kind of generational too. –Partner*

To address the challenges of rural settings, PAF projects implemented a variety of strategies to either help participants get to services or to bring services to them.

Supporting participant travel to services

Co-located services helped mitigate transportation barriers. Sometimes the co-location of multiple services was an intentional part of service design, and in other cases it was a natural part of the rural setting. For example, county health departments are often the only community service hub for all residents, and there is great benefit in a PAF participant being able to visit the Supplemental Nutrition Program for Women, Infants, and Children (WIC) and other essential services at the same time as her PAF case manager if they are co-located. Case managers used this knowledge to strategically schedule appointments for times they knew participants would be in the building to access other services.

> *They're already having transportation issues, so you're getting them all the needed services they need at one time when they're there at that moment - helps to prevent those missed appointments and no-shows. –Grantee*

Resource guides informed participants where they could find services not available locally. One grantee contracted with a partner organization to develop a statewide resource guide for young people to find all types of services they may need. The guide was organized by larger regions instead of by county, to ensure that there was always an option available for each type of service provider. Of course, this could mean that young people may need to drive a long distance to access a particular service. However, the guide was still an important resource for a rural area where young people are more likely to be unaware of where to find certain services outside of their immediate town.

Medicaid transportation or Title V transportation vouchers could be difficult to use. Some case managers arranged transportation using federal benefits for eligible participants and helped them schedule back-to-back appointments to maximize the

Co-locating Services

One grantee developed "parenting stations" inside county health departments to help prepare youth for parenthood. These stations were rooms set up like infant nurseries with realistic, racially diverse baby dolls with which to practice skills. This approach allowed youth to gain hands-on learning experiences during which they could first watch a live demonstration or video of a skill, and then practice that skill using a baby doll and receive immediate feedback. For example, a young mom-to-be could practice feeding and burping a baby, or safely giving a baby a bath. This grantee noted the importance of hands-on, experiential learning when teaching adolescents. They may retain more information by physically practicing a skill, rather than simply being told how to do it or reading it in a book or brochure.

Where sexual health education was not consistently provided in schools, PAF projects also tried to include it in their parenting education strategies. Staff noted that they hoped this additional knowledge would help participants avoid future unintended pregnancies as well as STIs.

use of these options. While Medicaid transport was available to all Medicaid enrollees and cost-free to use, one must schedule it in advance, and some participants found it to be unreliable. In addition, Medicaid transport is available only for medical appointments—not other valuable activities such as parenting classes. It cannot accommodate friends or family members (including EPY's parents, co-parents, or children), and some young people simply refused to use it. Some projects used PAF or other grant funds to occasionally pay for participants' transportation to appointments, such as a taxi where available.

> *When we're working with an adolescent population, we're still very much working with a group of people who learn by observation. And so, having the ability to extend that demonstrative teaching where you're modeling a behavior, and then test the behavior and you provide feedback, and they do it again until they feel really comfortable and show mastery, it's hugely important to working with this population.... That's where I think they show the most success is these young people feel more prepared to hold a newborn in their arms, to be the sole caregivers at times for these babies. –Grantee*

Informal ridesharing was a common strategy for facilitating access to services. "Ride shares" in this context refer to arranging for a ride with a family member or friend with a vehicle. This strategy is bolstered by the strong sense of community and family support in rural areas. Case managers often helped their participants problem solve by brainstorming which friend or family member may be available and willing to give the individual a ride to their appointment or for other important errands. However, this could still present a challenge if the participant was unable to reimburse the friend or family member for gas.

Grantees often offered incentives for traveling to programming and services. Given the barriers to traveling to appointments, some programs also tried to motivate EPY to attend by offering incentives for keeping appointments. For example, one program offered free "pack 'n play" style cribs to new moms, which was a valuable incentive that also encouraged safe sleep practices. Other incentives included diapers, bottles, strollers, and infant safety items.

Bringing services to participants or helping participants access services remotely

Home visits helped address the transportation barrier in rural areas, but it did have challenges. Grantees implemented various home visiting curricula, such as *Parents as Teachers, Partners for a Healthy Baby*, and *Family Spirit*. Having a case manager visit was often easiest for the participants, but home visits in rural areas often required case managers and nurses to travel long distances for each appointment, sometimes with one provider or team of providers covering several geographically large counties. The allowable number of home visits could be limited by Medicaid. The flexibility of PAF funding helped some service providers fill these kinds of gaps or limits in services. Other challenges included some participants not feeling comfortable meeting in their homes, having their case manager or nurse see where they live, or having others in their household overhear their private conversations with home visiting staff.

One grantee was beginning to implement "mobile parenting stations" as part of their in-home visits. This idea took the hands-on learning approach of the parenting station nursery room described above "on the road." For example, a case worker could bring a realistic baby doll and a mini crib to teach a lesson on safe sleep, or baby bottles to teach proper feeding techniques.

Videoconferencing technology brought essential providers into a home visit when they were unable to attend due to long travel distances. For example, a social worker (i.e., case manager) meeting with a young parent at home could use Skype to call a nutritionist or nurse on the team to provide input on relevant issues or additional education.

One grantee provided distance education through a combination of online learning and alternative credentialing using two web-based platforms. This approach helped equip EPY with parent education and job skills, as well as a range of other cognitive and personal competencies.

- **Rocket 21**, a secure online platform designed particularly for youth in rural areas, allowed participants to engage in career exploration by helping them identify their interests and connect those interests to careers. It also gave participants access to professional mentors who worked in these careers.
- The grantee used the **Digital Badg.es** platform to help young people develop employment-related skills such as those related to creating resumes, cover letter writing, and job interviews, as well as other health and parenting skills. For example, a participant could earn a reproductive health digital badge for learning about family planning and contraceptive options and for working to develop their own individualized reproductive life plan.

Both platforms could be used by participants alongside their case manager or individually at their own pace, provided they had access to an internet-ready device and reliable internet connection.

Serving EPY in Rural Communities: Reflections from Grantees

Grantees and their implementing partners offered several insights into what they learned about successfully serving EPY in rural communities:

Serving young parents often includes working with their extended family. Project staff came to recognize the importance of the role that older generations played in ensuring the safety of the child and began including all family members. Young mothers often still live at home with their parents or other extended family. Older generations may be unaware of infant care practices that are considered the safest today (e.g., grandparents may not know current car seat safety guidelines or recommended safe sleep practices such as putting the baby to sleep only on his or her back). As the matriarch of the family, the grandmother may also act as a gatekeeper for information; project staff focused on gaining her understanding and buy-in to increase the likelihood of the new mother adopting the new practices.

Although rural areas tend to have smaller labor pools, PAF project staff found high-quality staff dedicated to serving their communities. As one grantee explained, "To be successful you need to be able to hire the right people." PAF project staff in these rural areas did not appear to have trouble hiring qualified staff. Sometimes project staff had grown up in the same rural area or a similar one and wanted to give back to the communities after finishing their education. They were often embedded in the communities and thus able to help participants navigate their needs locally. Successful staff were relatable, dependable, and positive role models for EPY; some had life experiences with being a young parent.

Building relationships across organizations and individuals is critically important at every level in rural communities. Grantees agreed that working to create and maintain strong relationships across stakeholders was key to their success. This included grantees' relationships with key partners; partners' relationships with other service providers in the community; and case managers' relationships with their participants, which allowed them to best identify participants' needs. It was helpful for state grantees to partner with local organizations that were already well-established in their communities. New grant projects were able to leverage those pre-existing relationships and community trust to make project start-up as well as overall implementation smoother.

For implementation partners, building collaborations with partner entities was "the primary core component of any successes we have." Moreover, building the relationship and trust between the case manager and participant was essential, regardless of the community resources available.

Summary

Rural grantees must overcome many challenges to successfully offer programming to young families. EPY in rural communities face different challenges than youth in more urban areas. These include a lack of transportation and limited access to health services and other important resources. The PAF grant provided the necessary flexibility for grantees and their partners to tailor approaches built on the unique strengths of communities such as strong community connections and family bonds. PAF projects used these relationships to their advantage to ease cross-sector collaboration and help brainstorm solutions to challenges with youth.

In rural areas, PAF grantees used a mix of service strategies including case management, parent education, and home visiting. Parent education took on various forms, including hands-on learning through parenting stations. Home visiting had many benefits in rural areas since it reduced the need for youth to travel, but it also came with challenges. Co-locating services for EPY helped mitigate transportation barriers as well. Programs also relied on Medicaid transportation, Title V transportation vouchers, or informal ride-sharing with friends and family. Grantees offered material incentives such as cribs and other baby items to help motivate youth to attend their appointments. To address the limited access to resources, one grantee worked with a partner to create a statewide resource guide of available services by area. This way youth would be more aware of where they could access all types of services from mental health and medical services to employment assistance and childcare.

Through their experiences, PAF partners involved in direct service learned that to be successful they needed to involve multiple generations within the family. Additionally, building on and maintaining relationships were key to success at every level in rural areas. This included everyone from the grantee and implementation partner to the relationships between case managers and participants.

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Disclaimer: This publication was made possible by Contract Number HHSP233201500069I, Task Order Number 75P00119F37014 from the HHS Office of Population Affairs. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Office of Population Affairs or HHS.

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