

## **WEBINAR VIDEO TRANSCRIPT**

Office of Population Affairs

### **TPP Tier 2 Showcase Webinar, Day 2**

4 March 2020

INA RAMOS: Good afternoon, everyone. My name is Ina Ramos, and I'd like to welcome you to today's webinar brought to you by the Office of Population Affairs.

An important note. We will not answer any questions related to open funding opportunity announcements during this webinar. Any questions about open FOAs should be directed to OPA and/or OASH Office of Grants Management.

I'm now going to turn things over to Richmond Pajela for a brief introductions and to talk a little about the purpose and format of the webinar.

RICHMOND PAJELA: Thank you, Ina. So today the purpose of the webinar series is to showcase OPA Teen Pregnancy Prevention Tier 2 programs with promising results. The series will showcase grantees from our Tier 2A and Tier 2B grant programs. These grantees are finishing a five-year grant program and have focused on rigorously evaluating TPP programs or innovating new TPP interventions.

Our Tier 2A a guaranteed support and enable early innovation to advance adolescent health and prevent teen pregnancy. They're also providing funding and community-based services to sub-awardees. Today we will be hearing from many of the sub-awardees.

Also, the series will focus on Tier 2B grantees conducting rigorous evaluations of new or innovative approaches to prevent teen pregnancy with a focus on the implementation of programs and evaluations. Please note that this webinar will only highlight promising results, as final outcome results are not currently available.

So this is a three-part series. The first webinar was yesterday, March 3. And this is the second webinar. We will be focusing on, like I said earlier, our Tier 2A grantees. And tomorrow, Thursday, March 5 at the same time, we will be having our third and final webinar, and we will be featuring the following grantees.

#### **Webinar Series Schedule**

[Displays webinar series schedule: Tuesday, March 3, 2020: EngenderHealth, Inc., University of New Mexico Health Sciences Center, Healthy Teen Network.

Wednesday, March 4, 2020: Planned Parenthood of Greater New York, Boston Children's Hospital, MyHealthED, Inc., Waikiki Health

Thursday, March 5, 2020: Center for Innovative Public Research, Johns Hopkins University, Planned Parenthood of the Great NW & Hawaiian Islands.]

And so we would like to introduce ourselves. First, myself. My name is Richmond Pajela. I'm a project officer here at the Office of Population Affairs. Also joining us is MayaTech Corporation, the TA Team. We have Ina Ramos, who is the TPP TA lead. And today's webinar will feature a four Tier 2A grantees and an ITP 3 Innovator sub-awardees who are supporting implementing early innovation to advance adolescent health and prevent teen pregnancy.

We have the Planned Parenthood of New York City's Capacity Building for Foster Care or Innovation Intervention, which is a multilevel intervention intended to increase organizational ability to communicate with foster youth about sexual health. We have Boston Children's Hospital's Momentary Effect Regulation Safe Sex Intervention, which combines brief clinic-based counseling with mobile self-monitoring and responsive messaging. We also have MyHealthEd, Incorporated's Real Talk mobile app that connects teens 13 to 15 years old with authentic stories and trusted resources. And finally, we have Waikiki Health's Wahine Talk, Texting, and Social Media Interventions for Homeless and At Risk Youth.

We will now be hearing from our grantees. First we will hear from Lisa Colarossi, who is the Vice President for Research and Evaluation and Randa Dean, who is the Associate Vice President of Education and Training at Planned Parenthood of Greater New York.

### **Capacity Building for Foster Care Organizations**

RANDA DEAN: Hi, everyone. Thanks so much. We are based in New York City. And thanks to ITP 3 funds that we received, we sought to build a systems intervention to ensure that youth in foster care had the access to the sexual and reproductive health information and care that they need in the settings where they spend the most time.

### **Acknowledgement and Disclaimer**

[Displays acknowledgement and disclaimer language: This opportunity is made possible by Grant Number TP2AH000046 from the HHS Office of Population Affairs as part of the Innovative Teen Pregnancy Prevention (ITP3) project. Contents are solely the responsibility of Planned Parenthood Greater New York and do not necessarily represent the official views of the Department of Health and Human Services, the Office of Population Affairs, or Texas A&M University.]

### **Brief Project Overview: Capacity Building for Foster Care Organizations**

So our objectives were really to create organizational policies and practices that support sexual health education and referrals, to implement a training series for foster care professionals, and to enhance the overall physical environments of these agencies with information and healthy materials.

Our population of focus was on the foster care administrators and direct service providers, but in their role interfacing with foster youth. So they were really ultimately who we were trying to support. And the setting were foster care organizations, and very specifically, the residential facilities.

### Intervention Overview

So our intervention is, as we said, a sexual and reproductive health capacity building multi-level systems intervention. So the very first thing that we do in our intervention is we help a foster care organization develop clear sexual and reproductive health policies and practices for all staff so staff at every level know exactly what and how they should be interacting with young people in care around sexual and reproductive health. So this is everything from the timeliness with which they need to make a sexual and reproductive health referral, or what kind of information they need to be providing proactively and responsibly to youth in care.

So after we outline those policies with key administrators, we train a large number of staff to build their knowledge and skills to be able to implement those policies. So we teach communication skills as well as basic sexual and reproductive health knowledge so that staff can be a trusted resource for the young people in their care.

And lastly, we look at the environment, and we think about the kinds of materials that can support staff and youth in having these conversations. So everything from posters to pamphlets, resource guides, referral lists that are vetted, and condoms and other anatomy models so that when you have questions, or situations come up, staff have access to the resources that they need. The materials also serve the purpose of sending cues to young people that they can get this kind of information in the foster care setting.

So we really wanted to build a systems intervention to supporting youth in foster care because we know that a lot of the teen pregnancy prevention programs focus on intervening directly with the youth. And after those, for example, as evidence-based curriculum are completed, often by educators coming into the setting, that sex educators leave, and we wanted to make sure that young people in those settings day after day had access to trusted resources in the setting.

To create the model, we reached out to and sought input from foster care professionals, policymakers. We met with foster parents and youth in foster care to inform the model. And there's really a sustainability planning component of this model so that even after the six-month intervention, foster care agencies are prepared to continue the intervention after we

leave, to continue to ensure that the policies are used, that staff are trained, and materials remain in the environment.

So with this intervention we're looking to really support the youth where they are on a regular basis and ensure that the staff in those environments are our trusted resources around sexual and reproductive health and know how to make timely referrals to care.

So with that, I'm going to go to Lisa to share a little bit about our outcomes.

## Project Highlights

LISA COLAROSS: OK. Hi. Randa mentioned that we spent one year doing formative research with professionals, parents, and youth to develop this program. And then I'm going to talk now about after we integrated that research into development, then we tested for one year with a longitudinal evaluation design over three times at baseline in the middle of the program, and then again at the end of a year, which was about three months after all of the interventions were complete.

And during that longitudinal evaluation, we had surveys of staff and administrators, qualitative data from conversations in group meetings, observations of fidelity of the curriculum that we had put together. And here, what you see in this slide really is just the outcomes from the survey data that we had.

[Displays line graph with three data points. The y axis representing percent correct, ranging from 50% to 100% and three time points (Time 1, Time 2, Time 3) on the x axis. Valued from left to right are as follows: T1: 65%, T2: 88%\*, and 92%\*. An asterisk is marked on values with significant increase from prior time at  $p \leq 0.05$ ]

The first thing you see is the change in the average knowledge score over time. That was measured with 29 different questions that had to do with policy-related directives, sexual and reproductive health, medically accurate information about birth control and STIs. And there was one other component of knowledge. That was knowledge about how to communicate specific messages to youth, so basically communication skills knowledge.

And we can see a baseline. The two organizations that we tested with were residential treatment facilities, both very large and New York City-based. The beginning knowledge was very low at only a 65% correct score on those items when we began. After all the training components were complete, we increased that score to 88%.

And then over time, as we did one more booster training, and then they had a chance to practice and really put this into full implementation across the agency, we got another significant boost in knowledge at time three to 92% accuracy on that. So we were really happy

with, really, the very large amount of change that we got in what people knew about sexual and reproductive health in these organizations.

[Displays bar graph of changes in staff reports over time: Change is displayed on the y axis, ranging from 1 to 5; Support are displayed on the x-axis, with three time points for each type of support. From left to right, Organizational Support (T1: 3.01, T2: 3.83\*, T3: 3.83), Preparation (T1: 4.01, T2: 4.54\*, T3: 4.64), Attitudes (T1: 4.16, T2: 4.38\*, T3: 4.51\*), and Communication (T1: 3.07, T2: 3.22\*, T3: 3.42\*); An asterisk is marked on values with significant increase from prior time at  $p \leq 0.05$ ]

And then at the bottom, you see four different other measures that we used. Organizational support, which was four questions related to staff perceptions of whether the agency was supportive of talking about sexual and reproductive health, supportive with referrals that would be available, and materials.

And a lot of this had to do at the beginning, at baseline, with people being afraid they might get in trouble from the organization if they said something wrong about sexual health or talked about it at all. They weren't really sure what would be OK to do. And so we increased that score significantly, and we were able to maintain it at the end of one year with staff feeling far more supported by the organization to be able to do those kinds of activities.

Preparation was the staff's report of feeling prepared to have conversations about a variety of different sexual and reproductive health topics. We also got a significant improvement on that that was retained at the end of the year. And then attitudes, really, was asking staff and administrators, did they think this was important to do? Did they think it was part of their job role? Did they perceive this was extra something they shouldn't have to do? Did they have attitudes like teens would have more sex if they were given more information about sex, condom distribution, those kinds of things.

We started out with fairly positive attitudes right from baseline, but we also significantly improved those. And then that made another significant jump again by the end of the year as the more they practiced and the more they implemented, the attitudes continued to improve over time about the importance of doing this work organization wide.

And the third one is the frequency of communication, that staff reported talking to the youth in their care about a variety of different sexual and reproductive health topics. Communication is the hardest because behavior always follows these other things, follows feeling prepared, follows having a good attitude about something. And so we did make a significant improvement in the frequency of communication in the middle of the program. And then again, as they practiced throughout the year the frequency significantly improved again in our third time frame.

So we were happy with these outcomes. We have been able to, this year, begin replicating the model with additional foster care agencies in New York City. Now that we are greater New York, we hope to replicate that broader across the state. And we also have a [manual](#) ready for dissemination for the full organizational capacity building for other people to use as well. And you can see that link here.

So I think that's all for us.

### **Thank you (Contact Information)**

[Displays the following contact information and citation:

Lisa Colarossi, PhD, LCSW  
Vice President, Research & Evaluation  
Phone: 212-274-7282  
[lisa.colarossi@ppgreatemy.org](mailto:lisa.colarossi@ppgreatemy.org)

Randa Dean, MPH  
Associate Vice President, Education and Training  
Phone: 212-274-7265  
[Randa.dean@ppgreatemy.org](mailto:Randa.dean@ppgreatemy.org)

Citation:

Colarossi, L.G., Dean, R., Stevens, A., Ackeifi, J., Noonan, M. (2019). Sexual and reproductive health organizational capacity building for foster care organizations: A systems model. *Children and Youth Services Review*, 105, 104423.]

RICHMOND PAJELA: All right. Thank you, Lisa and Randa. So if you guys have any questions, please don't hesitate to enter them into the chat box, and we will address them at the end of the webinar.

### **Momentary Affect Regulation – Safer Sex Intervention**

Next up we have Pam Burke, who is the Co-Investigator with the MARSSI Project at Boston Children's Hospital.

PAMELA BURKE: Thank you, Richmond. Good afternoon, everybody. On behalf of my colleague and the project PI, Dr. Lydia Shrier and our entire MARSSI team, I'm pleased to provide an overview of MARSSI, our acronym for Momentary Affect Regulation Safer Sex Intervention. Our work was made possible by a subaward from Texas A&M University, who was funded by the Office of Adolescent Health for the ITP 3, or the Innovative Teen Pregnancy Prevention programs.

## Disclaimer

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And as an acknowledgment and disclaimer, basically our presentation is solely the responsibility of Boston Children's Hospital and does not necessarily represent the official views of DHHS, OEP, OAH, or Texas A&M University.

## Brief Project Overview

So we know that adolescent and young adult women with depression are more likely than their non-depressed peers to engage in sexual and reproductive health risk behaviors. As both clinicians and researchers, we recognize that emotional, cognitive, behavioral, and relational factors may all contribute to young women's risk for pregnancy and STIs.

Thus our objectives when developing MARSSI were to design an intervention aimed at preventing unintended pregnancy and sexually transmitted infections among young women with depression and high risk sexual behavior. Our target population was females ages 15 to 24 who screened positive for depressive symptoms and had a history of high risk sexual behavior. And the setting for which we designed MARSSI was primary care clinics.

## Momentary Affect Regulation – Safer Sex Intervention

As a backdrop, we did conduct formative design and development work, which included interviewing 16 depressed young women who fit the profile of our target group. We explored their experiences relative to depression and sexual and reproductive health care services, and ultimately developed MARSSI to consist of the three components.

So for the first, which is risk reduction counseling, we developed a manualized IV session and training for our sexual health counselors, who, for us, were nurses experienced in working with adolescents. The counseling was designed to incorporate the use of motivational interviewing to help a young woman identify her own risk-reducing goal and develop a change plan, and also to provide depression education and skills based on cognitive behavioral therapy.

In selecting their primary goal, the young women could choose from things such as using effective birth control, using condoms correctly and consistently, or choosing not to have sex. And the sessions lasted approximately 60 to 75 minutes.

The second component, following the counseling session, the young woman was introduced to the smartphone app, which she loaded on her phone. She selected the message voice, I versus you, and style, directing versus encouraging. And for the next four weeks, she participated in

momentary self-assessment, which we all understand is also referred in the literature to EMI, or ecological momentary intervention. It involved completing app-prompted reports three times a day plus a scheduled daily report.

If she reported such things as poor affect, low condom use, low self-efficacy for sex refusal, et cetera, then she received personalized messages prompting healthy behavior and use a cognitive behavioral skill that she had learned in the counseling session. Of note, the messages had been pre-programmed using an algorithm, and thus these were not live or real time responses.

And the third, the booster counseling. So after the four-week momentary intervention, the young woman met with the counselor either in clinic or by video call for a booster counseling session. This session consisted of a review of her behavior and relationships, discussion of the progress toward her goal, and learning a new cognitive behavioral skill.

We believe that MARSSI is innovative because it's uniquely designed for depressed young women with high risk sexual behavior. It's tailored to their specific needs, addressing depressive symptoms, as these relate to sexual and reproductive health risk behaviors. Further, MARSSI can be delivered in a primary care setting where young women typically receive both sexual and reproductive health care, as well as behavioral health care.

### **Project Highlights: MARSSI Pilot Study**

After developing MARSSI, we did conduct a small pilot to determine its feasibility and acceptability. The eligibility criteria—which is not on your slide, but I just want to highlight—females between the ages of 15 to 24 years. They needed to be a patient in our primary care clinic. They needed to score positively on a depression screen. And we used the Patient Health Questionnaire 9, or the PHQ 9. And so a score of five or greater was considered for depressive symptomatology.

Also, they needed to report penile vaginal sex at least once a week on average, and in the past three months to report at least one pregnancy or STI risk behavior such as inconsistent or no condom use, no birth control, or condoms only, sex under the influence.

And they also needed to own their own smartphone. And this was related to prior research that we had done in the area of a substance use, where our data safety monitoring board felt it critical that for minors under 18, if they were given a study phone to use for those purposes, that could potentially threaten the confidentiality, as parents would obviously want to know what's that phone for? Where did you get it? And we did have, for our study, a waiver of parental consent. But interestingly, all our participants were 18 and over.

So 17 young women ages 18 to 23 completed the initial counseling session. 15 took part in the smartphone momentary intervention. And then 14 returned for the booster session, 10 of

which did so in person, four by video call. And they also completed three months of follow-up, which they could do either in clinic or video call.

We found that overall, the app engagement was high throughout the momentary intervention period, although there was moderate decline over the course of four weeks. And participants rated positively the counseling sessions as well as the smartphone, noting that the messages made them feel better, helped them to make changes that they wanted to make.

Post-intervention, they reported decreased depressive symptoms, increased confidence to use cognitive behavioral skills taught in the counseling session, increased confidence to change their self-directed risk behavior, and condom and contraceptive knowledge also improved.

At three months, compared to baseline, depressive symptoms scores still remain low–lower– and confidence to use cognitive behavioral skill remained higher. So there's more work to be done, and we do plan to conduct a fully powered, randomized controlled trial to determine whether the changes in cognitions, mental health, and behaviors can be attributed to MARSSI. And in preparation for this, we are piloting implementation and training at two of our local community clinics.

And this is the contact information for Dr. Lydia Shrier, who is the Principal Investigator for this. Lydia is also the author of Safer Sex Intervention, which was one of the interventions vetted by the Rand Corporation when, 10 years ago, Office of Adolescent Health began funding for pregnancy prevention programs.

### Contact Information (Lydia Shrier)

[Displays the following contact information:

Dr. Lydia A. Shrier, MD, MPH  
[Lydia.shrier@childrens.harvard.edu](mailto:Lydia.shrier@childrens.harvard.edu)]

So that's it for MARSSI. And I look forward if anyone has questions in our question and answer period at the end. Thank you.

RICHMOND PAJELA: All right. Thank you very much, Pam. I also just want to remind everyone again to please put any questions that you may have in the chat box.

Next up, we will hear from Christina Leos, who is the co-founder and CEO of MyHealthEd, Inc.

### Real Talk Mobile App

CHRISTINA LEOS: Hi, everyone. My name is Christina, and I lead MyHealthEd, Inc., which is a non-profit dedicated to using human-centered design to improve the health and well-being of

youth of every identity. We were one of the grantees in the first cohort of the Innovation Next accelerator hosted by The Power to Decide.

So the purpose of my presentation today to provide an overview of the Real Talk mobile app, which is the program that we designed through the innovation accelerator, the design process that we used to create the app, and also some key learning along the way, and then conclude with information about where we are now.

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So disclaimer. Again, the content of our work does not represent the official views of OPA or HHS. And that's the award number for the original grant.

## Brief Project Overview: Real Talk Mobile App

[Displays image of an iPhone screen with three colored panels and examples of messages found on the app]

Just an overview of Real Talk. So the Real Talk mobile app provides authentic teen stories and trusted resources on sensitive health topics like sexual health, mental health, and identity to help teens know that they are not alone in their experience of growing up. We focus primarily on teens ages 13 to 15 years old, although we have a pretty engaged audience between 13 and 17 and beyond. And our app was initially designed for youth living specifically in low income and rural communities.

## Our Team

I'll describe how the app works in greater detail a little bit later in the presentation, but I wanted to give you a high level overview now. A little bit more about our team. I co-founded Real Talk with two colleagues, Liz Chen and Vichi Jagannathan.

Liz Chen, after completing a master's degree and doctorate in health behavior, is now an assistant professor at the UNC Gillings School of Global Public Health. Her research focuses on understanding the acceptability of health apps for teens in order to enhance adoption in the real world. She's a former Teach for America educator who taught in rural Eastern North Carolina.

Vichi was trained as an engineer before also joining Teach for America and teaching in rural Eastern North Carolina. She then went on to get a business degree from the Yale School of

Management, and she is now the co-founder of the Rural Opportunity Institute and uses human-centered designed to support healing from trauma in rural Eastern North Carolina.

I also received a master's degree in health behavior prior to earning my doctorate at the UNC Gillings School of Global Public Health. My research focuses on identifying structural and interpersonal determinants of health inequities among adolescents. And I have now spent nine years investigating lifestyle and technological interventions to improve health.

## Design Thinking Process

[Displays three circle Venn Diagram, with the following labels: Ideation, Inspiration, Implementation, all connecting to each other.]

An overview of the design thinking process we used. So the innovation Next accelerator was intended to spark innovation by applying design thinking to the issue of teen pregnancy prevention. This graphic is a very broad strokes representation of that process.

In a nutshell, there are three phases to the design thinking process. First, the inspiration phase, where you immerse yourself in the lives of the people that you are designing for. Next, the ideation phase, where you creatively identify and test potential innovative solutions. And then finally, the implementation phase, where you build and refine a product or service for actual use. Each phase includes distinct questions, tools, activities, and processes for innovating. And I'll share a little bit more about what we did in each of these phases to develop Real Talk.

A little bit more about where we started, how we framed our recent question and challenge. When we submitted our proposal for the accelerator, we were interested in leveraging mobile technology to make sex education more relevant, accessible, and effective for teens. We know that millions of teens in the US are not receiving high quality sex education, even in states like North Carolina, where it's actually legally required to deliver sex education in public school. In many of these places, particularly in low income and rural schools, the schools simply lack the capacity, training, and resources to deliver a high quality curriculum.

## Design Challenge

[Displays the following question: How might we deliver personalized sex education to middle school students using mobile technology?]

So our team had previously designed an online sex education curriculum for high school students. And we saw the Innovation Next Accelerator as an opportunity to build on what we had learned. First, we wanted to focus on a younger population, focusing on middle school students rather than high school students, since we know that sex education delivered in high school often arrives too late, and especially considering that rates of sexual initiation nearly double between the eighth and ninth grade among teenagers.

Second, we also know that mobile devices are the primary way that young people engage with technology now, so we wanted to explore this as a part of the innovation design challenge.

## Inspiration Phase

[Displays, from the left to the right, the following phases: Inspiration, Spring 2016; Ideation, Summer 2016; Implementation, Fall 2016; Beta Launch, Fall 2017]

A little bit more about our timeline for this project. We began this work in Spring 2016, where we spent a couple of months in the inspiration phase, really getting to know young people and their experiences with sex education. Then in late spring and summer, we began testing prototypes, refining potential ideas for how the app would work, and finalizing the concepts that eventually became Real Talk.

In fall 2016, we were selected to receive additional funding from OPA to develop and implement the Real Talk mobile app, and then we publicly launched the first version of the app in Fall 2017.

On the next slide, I start digging in a little bit deeper into each of the phases and the method that we used to develop Real Talk. In the inspiration phase, the purpose, again, is to deeply understand your audience. Your goal is to understand their pain points and desires, and to also be inspired by the events and experiences in their day-to-day lives.

## Inspiration Phase: Methods

Many of the methods used in this phase are quite similar to those used in traditional qualitative research, for example, interviews, focus groups. However, there are some key differences that make the methods different when they're being used in the design thinking context compared to traditional research. Now I won't go into detail for these now, but this is the brief list of the data collection methods we used to try and deeply understand the lives of the young people we wanted to build this solution for.

[Displays list of the following methods: interviews with extremes & mainstreams, cards sorts, observations, and analogous experiences]

## Inspiration Phase: Key Findings

On the next slide, I share some of our finding at this phase. We learned several important findings, some of which were quite unexpected. So for example, we learned that schools are actually not the preferred place where teens want to learn about sex and relationships, and that in fact, schools are often a hostile environment for them to engage with these topics, and certainly in the communities we were working with.

So this eventually led us to steer away from creating a classroom-based tool and pushed us to think more creatively about how well we might be able to reach teens with this information. We also saw big concerns over privacy, safety, and credibility of this information online that's available on sexual relationships. Teens were very aware that the information available online or on social media might not be accurate or helpful, and they also expressed a deep need for privacy when accessing this information. Even things like following a social media account with a conspicuous name or someone finding their browser history was a big concern for most teenagers.

Finally, we learned that mobile apps were preferred over websites or other digital tools for accessing sensitive information like this.

### **Ideation Phase: Methods**

On the next slide, I describe a bit about our ideation phase. So the purpose during this phase is to creatively identify potential solutions and to rapidly test and iterate your concepts, usually using low fidelity versions, very scrappy versions of your potential solution.

So taking all the data and insights we learned from the previous phase. Our first step here was to brainstorm and identify new opportunities to innovate. The goal was to generate lots of ideas and to really try to think creatively about the issue, which includes generating wild ideas that might seem ridiculous at first.

So for example, one of our early ideas included creating a kid friendly sex shop where teens could interact with exhibits. Another idea was creating something like annotated pornography, just crazy things that don't exist and that kind of required our to-too took them outside of the traditional public health education curriculum mindset. So we did not go on to pursue either of these ideas, but this exercise was really, really important to get us to think more creatively, more broadly and generatively about what an innovative solution could look like.

We also worked very closely with teens to co-create what a potential sex education mobile app would look like. So as the picture here shows, we literally worked with students, brought them in, had them draw out what it might look like, including the design, the visual aesthetic, the name, the content, the features. And teens contributed directly to many of the early designs for what later became Real Talk.

From there, we began testing some of the most promising ideas and iterating them based on actual teen feedback in a very short period of time.

### **Ideation Phase: Prototypes**

[Displays the following list of prototypes: games, videos, Q&A, avatars, messaging groups, scavenger hunts, and text stories]

On the next slide, I provide some examples of the prototypes that we tested during this phase. So you'll notice that many of these are very simple drawings or pictures that are just pasted together. And that's intentional because early on in the prototyping phase your goal is to test ideas as quickly and cheaply as possible. You want to get real feedback from teens. What is working, what seems like a great idea, what's promising, what's not.

We tested a range of different ideas, including something listed here. Games, videos, messaging platforms. And on the far right of the screen, you can actually see an early version of the storytelling concept that later evolved into the Real Talk mobile app.

### **Ideation Phase: Key Findings**

On the next slide, I share similar findings during this phase. One important thing we focused on was identifying key emotions that drive a lot of teen behavior when it comes to accessing information on sex and relationships. One key emotion we discovered was that teens want to know that they are not alone, that others have experienced something similar, and that they can learn from someone who has been through it before.

The second key emotion was that they do not want to be judged by anyone. And that includes their peers, friends, teachers, and parents. So we knew that these were two core emotions that we needed our tool to address. Regardless of what we designed, we needed to address these two core emotions.

The next finding was that teens preferred receiving information as stories rather than facts and statistics. There's a little bit of science that supports this, but we were very intrigued to learn this through our research. Similarly, text-like conversations were more engaging to teens than prose or videos or images.

And also, teens were very curious to hear about the experiences of people who were different from them. So for example, a girl using the app was very curious to read about the experiences of a boy, or of a parent, or of someone who lived in a very different place. So again, these were all elements that we knew we wanted to tap into as we started developing the app more formally.

### **Implementation Phase: Methods**

[Displays image of hand holding an iPhone, displaying a screen of “Weekly Issues” and four topic areas]

On the next slide, I move on to the implementation phase. The goal of this phase in design thinking is to begin building an actual product or service for youth, but still continuing with the spirit of rapidly testing and learning along the way. So some of our strategies during this phase

were really aimed at using scrappy, basic, simple strategies for assessing interest in the app and viability of the app before we actually built anything.

So for example, we ran a \$100 social media campaign describing what the app concept was, and it resulted in over 200 teen sign-ups. To test how the story submission process might work, we began by creating a very simple Google form soliciting anonymous stories from teens. And we experimented with language, questions, and structure of the storytelling process to learn a great deal about how we would do it once we were ready to develop the app.

When we were a little bit further along, we also created a web app version of Real Talk to understand more complex user behaviors before we built out the full native mobile app. After we launched the first full version of the app in 2017, we continued running small in-app experiments and working with groups of teens to gather feedback and continue iterating to improve the content and features.

### **Implementation Phase: Iterations**

On the next slide, I share some of what we learned and did as a part of the testing during this phase. We eventually integrated the story submission process directly into the mobile app using a chat bot tool. So now teens, directly from the app, could be messaging with a chat bot in a conversational manner to submit their stories to us.

We also got feedback from teens that they actually wanted to learn about other topics, other awkward and taboo topics beyond sexual health. So we have actually now expanded our topic areas to include mental health and identity. And we also made some small changes to our content and features based on these experiments in order to boost engagement.

### **Real Talk Mobile App (2)**

So on the next slide, I can share a little bit more about what the result was. So through that whole process, we arrived at what is now the Real Talk mobile app. So as a reminder, Real Talk provides authentic teen stories and trusted resources on sensitive health topics to help teens know that they are not alone in their experience of growing up.

We crowdsource stories from teens on puberty, sexual health, mental health, and identity. We carefully screen and curate every story prior to publishing it to the app. And every story that's published is also paired with a high quality online resource so that teens can learn more about that topic. Teens can browse stories, they can search content, and they can submit their own stories directly within the app. They can also use little emojis to react to different parts of the story. We also use information from user searches and from stories submitted in order to inform additional content areas for us to select in the future.

### **User Demographics, Engagement, & Impact**

[Displays the following data:

Gender: 74% female 23% male 3% non-binary

Sexual orientation: 28% LGBTQ

Race: 48% identify as non-White

Total users: 16,000+

# of stories read: 165,000+# of resources accessed: 9,000+# of stories submitted: 2000+

77% report learning something new after using Real Talk

77% say the stories they read are helpful.]

On the next slide, I provide a little bit of data regarding our audience and engagement. About 3/4 of our users identify as female, 20% identify as LGBTQ, and nearly half identify racially as something other than white. So we're very excited to be reaching some populations that typically don't have access to high quality health information.

Since 2017, we have reached just over 16,000 teens in all 50 US states and around the world. And collectively, our users have read over 155,000 stories and access over 9,000 health resources. In addition, nearly 80% of our users report learning something new after using Real Talk, and also that the stories they read are helpful.

### Real Talk: Next Steps

On the next slide, I share a little bit of our upcoming plans. We are now working to update the administrative tool we use to review, publish, monitor, and analyze our content. And we actually have funding from OPA and Power to Decide to help carry out a big portion of this work, and we're very grateful to be able to do that together.

We are also updating the story submission experience to better support teens in telling their stories from directly within the app, and we're experimenting with some new strategies. And we are also exploring school-based partnerships by incorporating Real Talk stories into curricula and other tools for educators and school personnel.

And just a thank you, a wrap up. Thank you all for joining us, and I'm happy to take any questions about Real Talk at the end of the presentation.

[Displays the following contact information: Cristina Leos, PhD; [cristina@myhealthed.org](mailto:cristina@myhealthed.org).]

RICHMOND PAJELA: Thank you, Christina. And yes, if you have any questions, please enter them into the chat box.

And so finally, our last presenter will be Elizabeth Aparicio, who is the Assistant Professor at the University of Maryland and the lead author of Wahine Talk at Wikiki Health's Host Youth Outreach Program.

## Waikiki Health: Wahine Talk

ELIZABETH APARICIO: Thanks so much. So it's really a pleasure to be with you today to present on behalf of our team. I'm the external evaluator for Wahine Talk and would like to just start with acknowledging and thanking our study participants, Waikiki Health as well as the Youth Outreach Program and our amazing interventional research team. You can find us on Twitter with the hashtag WahineTalk, and this opportunity was made possible by the Office of Population Affairs as part of the Innovative Teen Pregnancy Prevention program's ITP3 project. And those are the authors.

[Displays disclaimer message: This opportunity is made possible by Grant Number TP2AH000046 from the HHS Office of Population Affairs as part of the Innovative Teen Pregnancy Prevention Programs (iTP3) project.]

Contents are solely the responsibility of authors and do not necessarily represent the official views of the Department of Health and Human Services, the Office of Population Affairs, or Texas A&M University.]

## Acknowledgements & Mahalos

[Displays acknowledgements; see following list]

- Study Participants
- Waikiki Health & the Youth Outreach (YO!) Program
- Amazing intervention & research team
- iTP3 program at Texas A&M University
- Twitter Hashtag: #WahineTalk
- Twitter: @commTHRIVESLab
- Twitter: @DrLizAparicio

## Wahine (“woman”) Talk: Context & Brief Project Overview

[Displays map of the world highlighting the state of Hawaii. Displays map of Oahu. Displays pictures of research team.]

Before I begin, I wanted to give some geographical context. This study was conducted in the state of Hawaii, which is the island chain there in the middle of the Pacific Ocean that's pictured first, and specifically on the island of Oahu, which is pictured directly below it.

And the other pictures are some of our team members, our awesome research team site at the youth drop-in center where Wahine Talk is facilitated. So you can see they have this sort of outdoor space that's a courtyard, and then there's also some indoor parts to the youth drop-in center as well.

So Wahine Talk is a holistic, comprehensive sexual health program that operates at multiple levels, which I'll talk about in a minute. And it's specifically for female youth experiencing homelessness aged 14 to 22. And we developed Wahine Talk over three years of feasibility testing with three cohorts of youth, really starting with asking what the youth wanted and what the staff were seeing over time, and iteratively developing that program over three years. We're still following up with our third cohort. The 12 months I'll be focusing today on are outcomes among the youth in our first two cohorts.

### **Wahine Talk: Rationale**

So just a bit of background here. So both youth homelessness and teen pregnancy remain major public health issues in the United States, particularly when they intersect. Our national estimates of there being about 35,000 unaccompanied homeless youth out in a given night is likely an undercount given the hidden nature of youth homelessness. Many youth are couch surfing or otherwise difficult to count.

The vast majority of homeless youth are young adults aged 18 to 24. Hawaii has a very high cost of living and its residents are significantly impacted by homelessness. Nationally, black, Hispanic, LGBTQ youth and youth who dropped out of school are more likely to be homeless. And in Hawaii specifically, native Hawaiian and other Pacific Islander youth are disproportionately homeless.

Among youth experiencing homelessness, there's a high risk of violence and exploitation, including sexual violence and exploitation, making a focus on supporting sexual health particularly important for this population. Homeless youth are at particularly high risk for pregnancy both nationally and in Hawaii, and nearly 1/3 of homeless youth on the Hawaiian island of Oahu have had a child.

At the youth drop-in center, Youth Outreach, YO for short, that's linked to my partner, Waikiki Health they were seeing these statistics really play out year after year with the youth that they were serving. And youth were not only getting pregnant once unintentionally, but also having rapid repeat pregnancies that were unplanned, and just really struggling with how to cope was not just being homeless, but also having to then care for a child while homeless.

### **Wahine Talk: Intervention Overview**

So in response, YO and Waikiki Health decided to develop a program to holistically address sexual health among the young women that they were serving. They designed a program with four complementary components, basic needs and social services, peer mentoring, sexual health education, and linkage to and provision of sexual health care. Wahine Talk integrates technology throughout, providing youth with a cell phone when they enter that's used to connect with their peer mentor, who's a staff person, a young woman on staff with us, and also to connect to one another in the program.

And youth actually report using their cell phones for a multitude of other ways, or other reasons, rather, including staying connected with family that they might not feel safe living with, but they want to keep in touch with, and staying connected to potential and current employers.

So youth can then earn data boosts and an upgraded cell phone as they participate in the program. And the Wahine Talk staff is really careful to provide alternative pathways for youth to be able to get these benefits both outside of Wahine Talk and within the program if youth don't want to participate, such as supporting job referrals, enrollment in medical assistance programs where they can get a free cell phone, and even working on site at the drop-in center.

Wahine Talk's integrated use of technology and its ecological approach, given that homeless youth are in a position of needing to address basic needs and social services in order for them to feel trusting enough to then engage in sexual health education and care.

### **Wahine Talk: Ecological Design**

So based on that, the program functions at an individual, interpersonal, and system level to improve homeless female youth's overall well-being, linkage to sexual health care, and uptake of contraception. At the individual level, a tailored approach is provided to each participant based on their stage of readiness to change various sexual health behaviors. And we also do a lot of outreach to existing homeless youth encampments to bring youth to the program, as well as basic needs and social services that are offered four times a week when the youth drop-in center is open.

At the interpersonal level, we really work to facilitate a connection first with our peer mentor, who's on staff and is available as needed for 24/7 support. We then work on helping the youth to make connections to one another while learning about sexual health during sexual health education group sessions, which are offered in 10-session cycles. And youth can enter at any time. This is a rolling admission. So if they come in in week three, they can finish weeks three to 10 and then get sessions one and two after that.

At the systems level, youths' sexual health care was addressed using more handoffs directly to a medical provider. It often took multiple handoffs in order for that first appointment to be made. And then ongoing provision of sexual health care by a network of both on site at the drop-in center, as well as external providers.

So as mentioned, Wahine Talk was conducted at a youth drop-in center, and it was specifically in the neighborhood of Waikiki in Honolulu, Hawaii. So people don't always think of Waikiki as a place where we would need to have homeless youth intervention. But there's actually a very large population of homeless youth in Waikiki. And again, this is on the island of Oahu.

### **Wahine Talk: Project Highlights**

So 51 homeless female youth participated in Wahine Talk during the first two cohorts. Participants' ages ranged from 14 to 22, though they were, on average, around 18 years old. 88% of youth had ever had sex before when entering the program, and approximately 1/3 had had a prior pregnancy. Nearly half had had a history of foster care. Initial findings from our third cohort are very similar. But as I said, we haven't finished collecting our follow-up data so aren't presenting those findings today.

[Displays bar graph on sample race/ethnicity with the x axis representing racial group, and the y-axis with the frequency; from left to right, the values are: Hawaiian: 22; Filipino: 15; Samoan: 7; Tongan: 1; Micronesian: 14; Other Pacific Islander: 7; Chinese: 10; Japanese: 6; Caucasian: 5; African American: 3; Hispanic: 11 ]

Regarding the racial and ethnic composition of the sample, 55% of study participants identified as being of multiracial or m ethnic background. 37% identified as native Hawaiian and other Pacific Islander, 4% as African-American, and 2% as Hispanic and 2% as Caucasian. And you can see down on the last part of this slide just how diverse this sample was. It's an incredibly diverse group of young women.

[Displays a pie chart titled "Linked to Sexual Health Care", with 37.30% respondents stating "No" and 62.70% respondents stating "Yes"]

So by the end of Wahine Talk, approximately 2/3 of youth were successfully linked to sexual health care, meaning that they had at least one visit with the on site medical provider. And this was really quite a feat given how scared of seeing a provider many of the youth were, as they shared with us during the focus groups after the intervention.

[Displays bar graph of data at two time points (Pre-WT, Post-WT), with the data as follows: Pre-WT – 15.70%, 1% Depo-Provera, 0% LARC; Post-WT – 51% Any Birth Control, 19% Depo-Provera, 25.40% LARC]

Readiness to use any type of birth control, as well as linkage to sexual health care, increased from pre- to post-test. And specifically, birth control usage rates tripled at post-test. So 51% of youth in the program are using birth control at post-test compared to 15% at pre-test, which you can see there in red.

Any birth control use was collected at pre- and post-test. And then, to account for what we knew would be a steep dropoff rate after that in terms of being able to follow the youth, we also used clinic data to supplement our longitudinal data collection efforts. So we used those to track LARC as well as Depo-Provera quarterly after Wahine Talk was completed.

[Displays bar graph of data at three time points (3 month follow up, 6 month follow up, 9 month follow up), with the data as follows: 3 months follow up - 3.90% Depo-Provera, 29.40%

LARC; 6 month follow up – 3.90% Depo-Provera, 31.40% LARC; 9 month follow up - 0% Depo-Provera, 33.30% LARC]

So you can see dark blue here for Depo-Provera and green for LARC. So Depo-Provera and LARC, including both IUDs and implants, were the most popular types of birth control used. All of the youth who adopted Depo-Provera initially in that pre- to post-test time either stopped getting their Depo-Provera injections or switched to using LARC within nine months of the program.

Nine months after Wahine Talk, 1/3 of the youth in the study, or who had been through Wahine Talk, were using long acting reversible contraception, or LARC, which can be compared to 0% at pre-test and a national general population youth usage rate of just under 6%.

So we often get questions about STA prevention. Condom negotiation is covered during the sexual health education groups and can be addressed as needed through sessions with a peer mentor. Although condoms are somewhat less popular among the youth in this sample, condom use before Wahine Talk began is just under 4% of youth and just under 8% after Wahine Talk.

### Wahine Talk: Next Steps

[Displays photo of man holding little girl on the beach]

So as we look to the future, I just want to share a bit about Wahine Talk from the perspective of the girls who went through the program.

This is a picture here of one girl's partner and child that was taken as part of our Photo Voice project. And it just really emphasizes how critical it is to be inclusive of youth who are already parenting, as was a need to expand to have a Kane Talk version of Wahine Talk for young men, kane meaning man in native Hawaiian.

The Photo Voice group that came together and was working on this project captioned the photo "Life's too short. Hold your family close." And the youth really spoke in our Photo Voice session sessions about the importance of caring for one another and looking out for one another in the midst of the difficulty of homelessness.

Our team recently finished developing a version of Wahine Talk for young men called Kane Talk, and an opportunity for those who've already been through Wahine Talk and want to give back as leaders and peer educators called Alaka'i Talk. So we have not yet tested these two programs but are looking forward to doing so in the future.

We also plan to test Wahine Talk in a larger sample where we can examine treatment mechanisms and potential subgroup differences. And as part of this effort, we'd like to conduct

hybrid effectiveness implementation studies. So those will allow us to look at both the effectiveness of Wahine Talk and the characteristics of sites that implement the program. So we're working on partnerships with new implementation sites now.

We're also continuing to disseminate the initial findings from the Wahine Talk project. So you can find our first three journal articles, a brief film, as well as other products at [go.umd.edu/WahineTalkProducts](http://go.umd.edu/WahineTalkProducts), and those are case sensitive.

So I just want to close with a final Photo Voice project photo, which the group captioned, "Having a baby can wait. Life is full of adventures to take, and make it great."

Thank you very much for your time today.

[Displays the following contact information: Elizabeth Aparicio, PhD, [MSWaparicio@umd.edu](mailto:MSWaparicio@umd.edu); Twitter: @DrLizAparicio, Hashtag: #WahineTalk]

[Displays image of cohort participant from Photo project on beach, with the following quote from the participant below: "Having a baby can wait. Life is full of adventures to take and make it great."]

INA RAMOS: Thanks so much to our grantee presenters for providing us with such excellent examples of their innovative work that they are doing. So now we'll transition to our question and answer period, and we will answer as many of your questions as time allows.

So I will start with this first question for Planned Parenthood. You described your target population as foster care administrators and direct service providers. How did youth inform this choice in the development of your intervention?

RANDA DEAN: Hi. Thanks for the question. So we were originally Planned Parenthood of New York City when we started this grant. We're now Planned Parenthood of Greater New York. About 10 years ago we built a systems intervention that was very similar to this, and we implemented it with after school programs with community-based organizations and other community-based providers.

It was well received, we had good outcomes, and we hypothesized that it would be a feasible and acceptable intervention for the foster care settings. And so when we began our formative research, we actually began with that hypothesis. And so we brought our model to foster care professionals, to foster parents, and to youth in care, walked them through the model, and talked them through what we wanted to create, got their input, and revised the model in several ways based on that feedback.

And so we kind of did come to the youth with this intervention and asked them to input into it, as opposed to asking youth from the beginning what is it that they wanted, and how did they

want sex ed. I hope that answers the question. If you want us to clarify anything else, we are happy to elaborate.

INA RAMOS: Thank you. I think it does answer the question. OK. This next question is for Pam at Boston's Children's Hospital. How does MARSSI address cultural competence within the study? For example, what if the young woman doesn't identify as depressed, doesn't engage in heterosexual sex, or did not have means to a cell phone?

PAMELA BURKE: Excellent question. The last one is from a research perspective, we did require that they had a phone. And again, that was historically something—if they were under 18, since we had a waiver of parental consent, an adolescent under 18 in Massachusetts could participate in research and health related to sexual health. But to provide a cell phone during that four-week period would potentially put somebody at risk for them discovering that they are participating in a study and so forth. So that's the easiest question to answer.

In terms of cultural responsiveness and competency, one of the things that related to a further study with clinic providers is the need for having a broader approach in terms of recognizing that adolescents, young adults, or people in general, are fluid in their gender identity and their attraction, et cetera. And so that's definitely one of the areas that, as we continue to develop MARSSI, we need to pay more attention to.

One of the things that I hadn't mentioned was that as we are continuing to develop the implementation piece of it, we conducted interviews with 28 informants from each clinic—and they included mental health providers, physicians, nurses, clinic administrators—to ask them what they saw as the facilitators and barriers to providing ideal sexual health for depressed adolescent young women.

And we followed that up with another study with providers from three clinics using design-centered approaches to really drill down on, well, how would this really look in your clinic? How could this be useful to folks that might have fewer resources in their clinic than we would in our hospital? So we're still trying to tease all that out.

There was a third part to the question. I'm wondering if I missed the first—cultural.

INA RAMOS: Yes. I think the third part was regarding a young woman who doesn't identify as depressed, I think with the third part. And I'd also like you to address that.

PAMELA BURKE: Well, in the research sense, the way our clinic works, and also in a just primary care sense, we screen all of our patients routinely for depressive symptomatology, as many places are trying to be more informed about what our young women and our young men have been dealing with and trying to be more sensitive to the need for trauma informed care.

So from the research perspective, the way we conduct our research is it's done through the primary clinician. So a research assistant would review the patients coming for the day, would put on notice—we have what called research flags because we have a number of studies going on at any one time. And if a person might be eligible for a study, it's not the research assistant's decision. It is the primary provider or the clinician seeing the patient that day to determine whether or not to even broach the topic with the patient. Particularly if the patient comes in and they're under a great deal of stress, you're not going to ask they want to participate in the study.

That said, if they seem potentially eligible, if they seem interested, they are provided with information. But then it is the study coordinator that does the screening to determine eligibility. So there's a multi-step process, realizing that sometimes what might be disclosed to a provider might be different than what might come out in screening.

And in fact, when we conducted our pilot, as it turned out, we had two that were ruled ineligible because, in fact, for the past three months, they had not engaged in vaginal penile sexual activity, which was one of our study criteria, so that they would not be enrolled. Hope that isn't too confusing.

INA RAMOS: No, thank you for those additional details. And so another question that was received for you, Pam. Do you have concerns about how clinicians will be able to implement the intervention in settings where cycle time and billable services and productivity and things of that nature are priorities?

PAMELA BURKE: Absolutely. As a clinician, time is money and money is time. But I also realize that as a clinician, so many times when a patient leaves, we may be feeling that, did we really deliver what they wanted and they needed? Clearly an intervention like MARSSI is not something that everybody in the clinic, every provider would be trained to do or would need to be trained to do.

So based on our research with the seven clinics and follow-up with our design discussions with providers in three other clinics—or some of them overlapped—what we came away with was that it's really more of a model of clinic champions where there would be a select number of people that would need to be trained. That does mean that there would need to be some time set aside in their schedules to be available.

It also is very important for it to be driven by the context of the clinic. So what might work in one clinic or community health center may not work in another, so sensitivity to flow, to provider education training needs, and to patients.

And as a plug, the results of those interviews with the 28 clinic providers is impressed in The Journal of Pediatric and Adolescent Gynecology. And the summary of the design thinking is available. First author of the interviews, the qualitative study about facilitators and barriers is

Sabra, Katz with a K, Wyse, W-Y-S-E, one of our study team co-investigators. And then Lydia Shrier's first author on an article that's been recently published in mHealth on design thinking for implementation.

INA RAMOS: Thank you so much, Pam. So the next few questions are for MyHealthEd. Real Talk is very interesting. How do you feel this app compares to Planned Parenthood Roo? And the Roo app is a free and private app that answers all your awkward questions about sexual health, relationships, growing up, and more that's targeting youth.

CHRISTINA LEOS: Yeah. That's a great question. So Roo actually came out a couple of years after s Talk launched in beta. And it is leveraging a new technology, so the Roo app is using artificial intelligence and machine learning to respond to people's questions. Super important because teens have lots of questions. I think the target audience is a little bit older than what we focus on. So I believe it's somewhere like 16 to 24. So again, the population is slightly different, and it's also strictly Q&A.

Real Talk is focused on a much younger population. Again, our priority population is 13 to 15 years old, which is in general, there are much fewer resources for such a young teen audience. Their developmental needs are quite different from those of older teens and young adults.

And then the piece that really distinguishes us from Roo as well as other apps that exist is the focus on storytelling, so using authentic teen stories as the primary way that we engage teens with information, with role modeling, with positive conversations, and also connecting them through additional resources. I think those are the primary distinctions there.

INA RAMOS: Thank you. The next question for you is, were teens required to have a personal cell phone to be in the study?

CHRISTINA LEOS: For some parts of it, yes, because of course, some elements of texting required that they could access the app or access a version of it or somehow use the technology in some way. However, we were able to conduct many design research activities and much of the prototyping not even using technology.

And I mentioned during the presentation that especially early on, our goal was to learn and answer questions as cheaply and quickly as possible. So oftentimes that meant that we were not going to build an entire website. We were not going to build an entire app. We were just going to kind of quickly test small components of it. So it was a mix.

INA RAMOS: OK. Next question is, is real Talk Available on Android devices?

CHRISTINA LEOS: It is currently not available on Android. But it's actually on our plan, it's on our roadmap to actually launch an Android this year. So please don't quote me, but our goal is to be able to launch on Android by summer and early fall.

INA RAMOS: OK. Thank you. And the last question for you. Are any primary care clinics using Real Talk?

CHRISTINA LEOS: We are not formally working with primary care clinics as of now, but we are having early conversations with interested partners. There are a couple of ways that we see that happening. For example, in the past we have collected stories on how teens interact with their doctors, access health resources, and generally their experiences with health care providers. And so that, of course, is really important information that can be valuable for improving health care services, youth friendly health care services.

We also serve as a resource. So when health care providers feel like one of their patients could benefit from an ongoing resource, then they can absolutely refer them to Real Talk, and we're happy to serve as a resource that way.

And then the final piece is that we connect teens to resources that exist. And right now we primarily do that with articles and information, videos, things that are not directing them to a physical location. But we actually are hoping to have a more sophisticated referral process where we could eventually refer them to an actual provider or a clinic or something. So we don't do that currently, but these are areas we hope to move into next.

INA RAMOS: Thank you so much, Christina. And the final two questions are for Liz at Waikiki Health. First, you mentioned that many of the youth in the program were scared of seeing a provider. So how do you help establish a rapport between providers and youth?

ELIZABETH APARICIO: Yeah, that's a great question. So just to kind of talk a little bit about why that is, so youth experiencing homelessness are often disconnected from the school system, so they haven't had to have those annual—or actually, as they're older, they often are not up to date with immunizations or things like that and haven't been to see a doctor in a long time.

And so we really work to have them build a connection first with a peer mentor and health educator that are part of a team. And those are the members of our team who go out to do the outreach to bring youth into the youth drop-in program, and they're the ones who are doing the day-to-day connections.

So we kind of get them used to just talking about the idea of getting to see a provider, and also assess their stage of readiness to see that provider using stages of change model, and then motivational interviewing techniques that are targeted to their stage of change.

The YO Youth Outreach program is really fortunate to have an on site physician's assistant a couple of times a week. And so that person will often just kind of sit in that courtyard that I showed you all outside of the clinic, just kind of hanging out a little bit in between appointments as her time allows. And like having that sort of neutral space just to say, hey, how

are you doing, to have that warm handoff before an actual clinic appointment where you go in and shut the door was also really helpful for the youth.

And also, our provider's really great about allowing that first appointment to just really be getting to know you and not going too deep into conversations about sexual health, but just more about health generally, and how are you doing. So they really take it slow and at the youth's own pace.

INA RAMOS: Thank you. And so the last question is how do you address program efficacy given the transient nature of people who are experiencing homelessness?

ELIZABETH APARICIO: Yeah. So I didn't present some of our dosage outcomes today. But in that link that I shared with you, you can read the article that talks a little bit more about this.

So people have varying degrees of engagement with all the different four components. And we, as part of a trauma informed care approach, really emphasize choice as part of Wahine Talk. And so the transient nature of youth, some of them actually were really around a lot and engaged quite a bit, came to the drop-in center often, came to group often. And others preferred to use their cell phone to text the peer mentor, or they would often also use direct messaging for social media. So that's something that doesn't require data. They can go to a mobile hotspot area or a library or something like that to be able to stay connected.

So by using technology in that way, we really were able to stay connected with the youth quite a bit over time and kind of overcome some of that transience.

INA RAMOS: Thank you, Liz. So this concludes the question and answer period. Richmond, I'll turn it back over to you.

### **Current OPA Funding Opportunity Announcements (FOAs)**

[Displays the following text:

Optimally Changing the Map of Teen Pregnancy through Replication of Programs Proven Effective (Tier 1) (AH-TP1-20-001)  
Teen Pregnancy Prevention (Tier 2) -Phase II Rigorous Evaluation of Promising Interventions (AH-TP2-20-001)  
Innovation and Impact Network Grants (Tier 2) –Achieving Optimal Health and Preventing Teen Pregnancy in Key Priority Areas (AH-TP2-20-002)]

RICHMOND PAJELA: Thank you, Ina, and thank you to all of our presenters as well. So before we wrap up, I would like to mention our three open funding opportunity announcements for the Teen Pregnancy Prevention Program. We have right here one Tier 1 and 2 Tier 2 FOAs available.

I do want to note that the original grant numbers, or FOA numbers, have changed. So the prefix has changed from PA, and now they are AH.

[Displays link the following link to FOAs and FAQs: [hhs.gov/ash/oah/resources-and-publications/webinars.htm](https://hhs.gov/ash/oah/resources-and-publications/webinars.htm)]

So if you're having trouble finding these, please [contact OPA](#) or OASH OGM. You can find the FOAs and FAQs on [our website](#), on the URL provided below here.

I just want to thank everyone again, to our presenters and the participants, for all the great questions that they provided as well. And we hope that you will join us tomorrow, March 5 at 2:00 PM Eastern time, for the final showcase of this webinar, when we'll be highlighting promising results from more of our Tier 2B grantees.

And that is the conclusion of this webinar.

### **Learn more about OPA**

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