ACKNOWLEDGEMENTS

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SUGGESTED CITATION
EXECUTIVE SUMMARY

While the rates of teen pregnancy have declined over the last two decades in the United States and in Montana, teen pregnancy continues to be a public health problem because of the social and financial consequences it bears. Teen childbirth results in a higher likelihood of adverse health outcomes, including giving birth prematurely and giving birth to babies with lower birth weights compared to children born to older mothers. Additionally, teen mothers experience lower education attainment and high poverty rates. Teen pregnancy bears a significant social cost for individual teen moms, and a great financial cost for United States tax payers at large. These costs include public health care and child welfare costs, as well as lost tax revenue from teen parents who have decreased employment opportunities.

Healthy Montana Teen Parent Program (HMTTP) is a federally funded program administered by the Montana Department of Public Health and Human Services (MT DPHHS) and implemented by the Flathead City-County Health Department (FCCHD). The FCCHD was one of nine HMTTP grantees in Montana. The HMTTP of the FCCHD utilizes a community-based approach to provide services to expectant and parenting teens and young adults and their children through contracts with school and community-based providers.

The MT DPHHS contacted the University of Montana School of Social Work to conduct an implementation evaluation of the Healthy Montana Teen Parent Program administered by the Flathead City-County Health Department. The implementation evaluation focused exclusively on the Flathead City-County Health Department’s Healthy Montana Teen Parent Program. The specific program is referred to throughout the report as HMTTP-FCCHD.

The primary goals of the HMTTP-FCCHD implementation evaluation are:
1) to understand teen participant perceptions of the overall program as well as their perceptions of curricular content,
2) to explore teachers’ knowledge and attitudes towards the program, and
3) to explore the willingness and capacity of community collaborators to participate in the teaching of individual classes.

The target groups were:
1) current and past teen program participants,
2) community stakeholders,
3) high school teachers and staff, and
4) Flathead City-County Health Department (FCCHD) staff.

A qualitative approach was used to gather feedback from teen participants, school partners, community stakeholders and FCCHD staff via semi-structured face-to-face and over-the-phone interviews and focus groups. A total of 36 respondents from the four target groups contributed feedback to the evaluation.

OVERALL FINDINGS

The following findings, organized by target groups, emerged from individual interviews and focus groups.

Teen Participants

Teen participants experienced three stages of engagement in the HMTTP-FCCHD:
1) pre-engagement,
2) initial engagement, and
3) sustained engagement.

Prior to enrollment in HMTTP-FCCHD (pre-engagement phase), the participants interviewed experienced fear, worry, isolation and judgment. All participants cited either the need for support as a reason for initial engagement in HMTTP-FCCHD or a desire for knowledge about pregnancy and parenting; several participants indicated a combined desire for knowledge and support. Participants also unanimously cited the warm, caring relationships they formed with HMTTP-FCCHD staff and fellow participants as the primary reasons for sustained engagement in the program.

Unreliable transportation was the most frequently reported barrier cited by teen participants. Currently, the HMTTP-FCCHD program addresses this barrier by meeting clients at locations that are convenient for the client. Participants also reported that flexibility in meeting times and days can be helpful to ensuring they can participate in meetings.

Teen participants felt that offering the courses at school was a great way to incentivize participation as it offered a familiar, convenient place for meetings. Some suggested that more meetings would increase participation by offering more times for participants to possibly make it to meetings. They also suggested that assistance with transportation could assist in increasing participation, as well providing meals and items for the babies.
COMMUNITY STAKEHOLDERS

Community stakeholders with high knowledge of the HMTPP-FCCHD have frequent contact with HMTPP-FCCHD staff. They describe the referral process as “seamless.” These stakeholders know who to call and how to connect pregnant and parenting teens to the program. They witness first-hand the positive rapport built among teens and HMTPP-FCCHD staff, and the benefits of the program for these teens. They also perceive that the program serves a critical need in a community, and with the program in place, vulnerable teens are better served. These positive interactions reportedly lead to increased referrals from these community stakeholders, which then lead to additional opportunities for positive interactions with the program. Continued positive interactions with the program perpetuate additional appropriate referrals to the program. These multiple events create a positive feedback loop.

The feedback loop is disrupted among community stakeholders with low knowledge of HMTPP-FCCHD. Stakeholders with misinformation or limited understanding of the program have less interaction with HMTPP-FCCHD staff in their agencies and/or follow-up from referrals and have few to no opportunities to witness the benefits of the program. This then leads to a weaker perception of the program and/or a misunderstanding of how participants served in their agency/clinic would benefit from the program, and consequently a decline in appropriate referrals. Low knowledge, therefore, leads to a negative or broken feedback loop.

HIGH SCHOOL STAFF

All high school staff interviewed reported high knowledge of the HMTPP-FCCHD. Similar to the community stakeholders, high school staff with high knowledge of the program have frequent contact with HMTPP-FCCHD staff, and have positive perceptions of the overall program and the referral process. Because the program meets in the schools, school staff know the HMTPP-FCCHD staff, build trust with the staff, and rely on the outside expertise and support. These positive interactions with HMTPP-FCCHD staff reportedly lead to increased referrals, which then lead to additional opportunities for positive interactions with the program. Continued positive interactions with the program perpetuate additional appropriate referrals to the program. These multiple events reinforce the positive feedback loop.

FLATHEAD CITY-COUNTY HEALTH DEPARTMENT STAFF

Similar to the community stakeholders and high school staff, FCCHD staff with high knowledge of the program have frequent contact with HMTPP-FCCHD staff, and have positive perceptions of the overall program and the referral process. They work closely and collaboratively with HMTPP-FCCHD staff and these positive interactions with HMTPP-FCCHD staff reportedly lead to increased referrals, which then lead to additional opportunities for positive interactions with the program. Continued positive interactions with the program perpetuate additional appropriate referrals to the program. These multiple events reinforce the positive feedback loop.

All target groups provided suggestions to increase participation for teens eligible for the HMTPP-FCCHD. Suggestions include increase in-person outreach efforts, improving and clarifying the referral process, decreasing teen barriers to participation, and increasing incentives for teen participation.

RECOMMENDATIONS

The following recommendations are proposed to improve and refine HMTPP-FCCHD:

Recommendation 1: Create pregnant teen-specific recruitment strategies and continue programming that sustains their engagement.

Recommendation 2: Address the barriers to teen participation by identifying transportation alternatives and by maintaining flexibility in meeting location and times.

Recommendation 3: Continue to offer the HMTPP-FCCHD groups in schools, while reinforcing the option for visitation outside of the school setting.

Recommendation 4: Close the feedback loop. Improve the feedback loop with community stakeholders and high school teachers and staff by:

1) increasing follow-up efforts after referrals are received,
2) strategic in-person outreach.

Recommendation 5: Leverage the support of community partners. When HMTPP-FCCHD staff does outreach to community partners, assess each stakeholder’s interest and availability for future engagement.

Recommendation 6: It is recommended that the HMTPP-FCCHD create an online, fillable referral form that can be submitted electronically to make it easier for agencies to refer to the program. Additionally, clarify the referral process and contact on the website by increasing and/or highlighting the font of the program contact information.
TEEN PREGNANCY – Definition and Scope of the Problem

Over the last two and a half decades the United States has seen a decline in the rates of teen pregnancy. Teen pregnancy is defined as pregnancy in females under the ages of 20. In 2015, The Office of Adolescent Health (OAH) reported that the national rates of teen pregnancy have declined 64% since its peak in 1991 (OAH, “Montana Adolescent Reproductive Health Facts,” n.d.). The Center for Disease Control (CDC) also reports a consistent decline in nation-wide live birth rates. In 2007, the CDC reported 41.5 births per 1,000 females aged 15-19 compared to 2015 where the live birth rate was 22.3 births per 1,000 females in the same age group. This decline was seen in all races and ethnic groups (CDC, “Teen Pregnancy Rates”, 2017). The CDC reports that increased access to contraceptives and increased rates of abstinence from sexual activity among teens may explain the decline in teen pregnancy rates.

Montana has experienced similar rates of decline. Since 1991, the live birth rate per 1,000 females aged 15-19 has declined 46% (OAH, “Montana Adolescent Reproductive Health Facts”, n.d). In 2010, the number of births to females ages 15-19 years was 35.2 per 1,000 live births. By 2015, the rate had declined 30% to 25.3 per 1,000 live births. Though Montana saw a 46% (OAH, “Montana Adolescent Reproductive Health Facts,” n.d.). In 2010, the number of births to females ages 15-19 years per 1,000 females in 2015 (see Table 1), a 30% decline in the teen pregnancy rates.

The following data, highlighted in the DPHHS Montana Adolescent Sexual Health Report (2016), demonstrates the change in Montana teen pregnancy rate for females ages 15 to 19, decreased from 44.8 pregnancies per 1,000 females in 2010, to 31.2 pregnancies per 1,000 females in 2015. Though Montana saw a decline in teen birth rates, the decline was not as significant as the national teen birthrate decline of 35% (see Table 1). The years was 35.2 per 1,000 live births. By 2015, the rate had declined 30% to 25.3 per 1,000 live births. Though Montana has experienced similar rates of decline. Since 1991, the live birth rate per 1,000 females aged 15-19 has declined 46% (OAH, “Montana Adolescent Reproductive Health Facts,” n.d.). In 2010, the number of births to females ages 15-19 years was 35.2 per 1,000 live births. By 2015, the rate had declined 30% to 25.3 per 1,000 live births. Though Montana saw a decline in teen birth rates, the decline was not as significant as the national teen birthrate decline of 35% (see Table 1). The Montana teen pregnancy rate for females ages 15 to 19, decreased from 44.8 pregnancies per 1,000 females in 2010, to 31.2 pregnancies per 1,000 females in 2015 (see Table 2), a 30% decline in the teen pregnancy rates.

The following data, highlighted in the DPHHS Montana Adolescent Sexual Health Report (2016), demonstrates the change in Montana teen birth rates and Montana teen pregnancy rates from 2010 to 2015.

<table>
<thead>
<tr>
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<td>853</td>
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</table>


Flathead County has also seen a decrease in teen birth rates. The Montana DPHHS Office of Vital Statistics (2016) reported the teen birth rate in Flathead County as 26.4 births per 1,000 females ages 15-19. While this rate has declined 30% since 2006, it remains higher than the national rate of 22.3 teen births per 1,000 females ages 15-19.

While teen birth rates in the Flathead County, the state of Montana and the United States as a whole are noteworthy, the rates of teen pregnancy in the United States are among the highest compared to other industrialized countries in the world (Solomon-Fears, 2016; Cherlin, 2009; Darroch, Frost, & Singh, 2001). Teen pregnancy prevention and intervention programs are necessary in order to prevent and address the adverse health and social outcomes due teen pregnancy.

**Risk Factors.** A review of the social determinants of health provides an important approach to understanding risk factors for teen pregnancy. The CDC describes social determinants of health (SDOH) as, “conditions in the environments in which people are born, live, learn, work, play, worship, and age, that affect a wide range of health, functioning, and quality-of-life outcomes and risks,” (CDC, 2016, para 2). These social factors are typically complex, interdependent and overlapping. Social determinants such as high unemployment, low education and limited income are risk factors for teen pregnancy (CDC,
Family-level factors such as being from a single parent household and growing up with frequent conflict in the home (youth.gov) increases risk as does a history of maltreatment, including sexual abuse and neglect (Garwood, S. 2015; Noll, et al. 2013; Noll, et al. 2009). Penman-Augilar, et al. (2013) reviewed twelve studies that evaluated the socioeconomic influences on teen pregnancy. The authors’ analysis of the research highlighted that of the 12 studies considering socioeconomic factors as influences on teen childbearing, all reported at least one statistically significant association with social determinants such as housing insecurity, unemployment, low education attainment to teen birth. This research suggests that prevention and intervention efforts should be a collaborative and multi-disciplinary approach that addresses individual, family and community-level socioeconomics as underlying social determinant to sexual health.

**THE CONSEQUENCES OF TEEN PREGNANCY**

**HEALTH.** Teen childbirth results in a higher likelihood of adverse health outcomes. Teen mothers are more likely to give birth prematurely and give birth to babies with lower birth weight compared to children born to older mothers (Martin et al., 2009; Hoffman, 2006; Martin, et al. 2007). Additionally, children of teen mothers are more likely to have chronic health conditions and rely on health care (Holcombe, et al., 2009).

**EDUCATION.** Though education policies shifted in the 1970’s to accommodate teen mothers in high schools (Title IX of the Educational Amendments Act of 1975) and public programs are in place to support high school completion (Hofferth, et al. 2001), only 50% of teen mothers get a high school diploma by the age of 22 compared with 90% of teen girls who do not give birth (National Center for Health Statistics, 2010). Among teen parents, younger mothers struggle more to complete a high school diploma. Only 34% of teens who had a child before the age of 18 earn a high school diploma by the age of 22, compared to 60% of teens who give birth at the age of 18 or 19 years old (Perper, et al., 2012). Thirty percent of teen girls who drop out of high school report pregnancy as the primary reason (Ng and Kaye, 2013).

Teens who do not receive a high school diploma or equivalent (GED or Montana High school equivalency test: HiSET) are more likely to encounter financial hardships in the future due to limited economic opportunities including stable employment opportunities that pay a living wage. Similarly, parents who hold a GED face barriers compared to teens who obtained a high school diploma. Individuals with GEDs earn less and are less likely to attend two- or four- colleges compared to high school diploma recipients (Zhang, et al. 2011; Cameron, et al.1993).

**POVERTY.** A lack of educational and employment opportunities for teen mothers increases their vulnerability to living in poverty. The National Campaign to Prevent Teen and Unplanned Pregnancy (2012) reported that between 2009 and 2010, roughly 48 percent of all mothers age 15 to 19 lived below the poverty line. While only 34 percent of teen mothers still living with their own family were living below the poverty line, teen mothers who did not were particularly at risk for living in poverty, with a rate of 63 percent. (Holcombe, et al., 2012). Additionally, teen mothers are more likely to receive public assistance and less likely to receive child support payments.

**THE FINANCIAL COSTS.** The National Campaign to Prevent Teen and Unplanned Pregnancy (2010) reported that the total cost of teen childbearing to United States taxpayers is about $9.4 billion dollars each year. Data collected in Montana show that in 2010 teen childbearing cost Montanans at least $26 million dollars. These costs include public health care and child welfare costs, as well as the cost of a child’s increased risk of incarceration as a young adult and the subsequent loss of tax revenue due to incarceration. (National Campaign, 2010, para. 5). These costs also include an estimation of lost tax revenue from teen parents who have decreased employment opportunities.

**DATA COLLECTED IN MONTANA SHOW THAT IN 2010 TEEN CHILDBEARING COST MONTANANS AT LEAST $26 MILLION DOLLARS**

**BEST PRACTICES FOR TEEN PREGNANCY AND PARENTING PROGRAMS**

While numerous teen pregnancy prevention interventions have been well studied, less is known about working with teen parents (LaChance, Burrus, & Scott, 2012; Beers & Hollo, 2009). Factors such as funding, study design and federal policy have prevented a rigorous study of existing interventions and thus has led to a lack of evidence-based interventions for practitioners to rely on. Despite the lack of rigorous evaluation, some evidence does exist that current interventions can improve the lives of pregnant and parenting teens.

Many existing interventions for pregnant and parenting teens are home visiting programs. Home visiting programs have been found successful in the promotion of positive parenting in populations at risk for child abuse and neglect, including young mothers (Rodriguez, et al., 2010). Specifically, nurse home visiting programs have shown to increase subsequent birth intervals for young mothers and improve mental health outcomes for their children (Olds, et al., 2004).
Evidence shows that school-based interventions encourage completion of high school and have been found to improve educational outcomes for parenting teens and reduce subsequent pregnancies (Sadler, et al., 2007). Barnet, Arroyo and Devoe (2004) found that offering school based prenatal services increased attendance rates of pregnant teens. Many school-based interventions for teen parents also include school based childcare.

Many interventions for parenting teens focus on preventing rapid repeat pregnancies. Twenty five percent of all teen parents bear another child within two years (Barnet, et al., 2009). These rapid repeat pregnancies compound the risks for poorer long and short-term medical, financial and educational outcomes for families.

Successful interventions should consider the psychosocial, developmental, educational, and relationship issues that influence adolescent parenting (Beers & Hollo, 2009). The risk factors that may have led to a teenage pregnancy often continue to play out after the birth and present a unique set of risk factors for pregnant and parenting teens. To respond to these unique life circumstances, interventions must be comprehensive and multidisciplinary, as well as responsive to the developmental stages of the parent and the child (Beers & Hollo, 2009).

FLATHEAD CITY-COUNTY HEALTH DEPARTMENT
HEALTHY MONTANA TEEN PARENT PROGRAM

HISTORY
In 2011, the Flathead City-County Health Department, located in Kalispell, Montana was one of nine Healthy Montana Teen Parent Program (HMTPP) grant recipients in the state. HMTPP is administered by the Montana Department of Public Health and Human Services (MT DPHHS) and the monies originate from the Pregnancy Assistance Fund through the Office of Adolescent Health (OAH). The Pregnancy Assistance Fund (PAF) is a $25 million grant program that funds state and Tribal programs to support pregnant and parenting teens and their families. The MT DPHHS received PAF funds and initiated a statewide effort to address teen parenting in higher risk areas of the state. Grant priority areas are to:

- Facilitate participants’ self-sufficiency (life skills classes such as nutrition and money management, job skills training, resume building, transportation assistance to prenatal and child-wellness appointments, housing advocacy, and tutoring);
- Build parenting capacity;
- Encourage post-secondary education and workforce preparedness; and,
- Improve the healthy growth and development of their children (DPHHS, n.d., para 2).

The Flathead City-County Health Department implements the HMTPP-FCCHD through a community-based approach and provides services to pregnant and parenting teens (ages 14 – 24) and their children through contracts with school and community-based providers. The FCCHD received PAF funds in 2011 and started services in January of 2012 under the name of the Montana’s Initiative for the Abatement of Mortality in Infants (MIAMI) Project. The program was later renamed Baby Steps and is currently referred to as The Healthy Montana Teen Parent Program (HMTPP). PAF grant funding for the Flathead County HMTPP ends July 31st, 2017.

Pregnant or parenting teens participating in the program receive one-on-one and group support and education provided by the parent educator, a registered nurse and health department employee. Program participants receive services in the high schools (Linderman Education Center, Glacier High School, Flathead High School, Columbia Falls High School, Big Fork High School or Whitefish High School), the Flathead City-County Health Department, the teen’s home, or another convenient location such as a coffee shop or park. Academic course credit is available for participants enrolled at Linderman Education Center.

In the summer of 2016, with the support of an outside consultant, the Flathead City-County Health Department created a curriculum to be implemented with the help of community partners. The curriculum focused on the following standards:

- **Standard 1**: Pregnant/parenting teens will have knowledge and understanding of concepts to support their child’s health, safety and social/emotional development
- **Standard 2**: Pregnant/parenting teens will be able to relate in a healthy manner to themselves and others
- **Standard 3**: Pregnant/parenting teens will demonstrate improved self-sufficiency

Standard one is achieved via education on topics such as prenatal development and health literacy, and car seat safety. Standard two is achieved through topics such healthy stress management techniques, and standard three is facilitated by connecting teens to financial resources such as WIC, postpartum healthcare and breastfeeding information. Additionally, post-secondary education and workforce preparedness are encouraged by career counseling, resume building information and support to complete high school diploma or HiSET.
Since inception, student participation has been intermittent, and referrals from school staff and teachers have been low. It was originally planned that the parent educator of the program would collaborate with community agencies to facilitate the weekly class. Due to low and intermittent participant attendance, the parent educator taught the life skills classes on behalf of the partner agencies.

While the HMTPP-FCCHD has served pregnant and parenting teens since 2012, the Flathead City-County Health Department changed its database, and the specific number of clients served prior to fiscal year 2014 is unknown. The HMTPP-FCCHD has served the following teens since fiscal year 2014:

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Clients Served</th>
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<tr>
<td>FY14</td>
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<tr>
<td>FY15</td>
<td>31</td>
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<tr>
<td>FY16</td>
<td>30</td>
</tr>
<tr>
<td>FY17</td>
<td>25</td>
</tr>
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</table>

Since 2013, the program has received 122 referrals from 24 agencies ranging from schools to healthcare settings to social services.

**PROGRAM EVALUATION PLAN, SAMPLING AND LIMITATIONS**

The Montana Department of Public Health and Human Services (MT DPHHS) contacted the University of Montana School of Social Work to conduct an implementation evaluation of the Healthy Montana Teen Parent Program administered by the Flathead City-County Health Department.

The implementation evaluation focused exclusively on the Flathead City-County Health Department’s Healthy Montana Teen Parent Program. This evaluation was designed to identify the reasons for low attendance and low referrals in an effort to improve program impact. In addition, the evaluation explored the willingness and capacity of community collaborators to participate as a community partner and, if applicable, as a potential presenter of life skills classes.

**IMPLEMENTATION EVALUATION**

An implementation evaluation is designed to better understand how a project was implemented and to identify critical program components that contribute to the program success or create barriers to implementation. The W.K. Kellogg Foundation (2004) highlights the primary purposes of implementation evaluation, and the following were prioritized in the HMTPP-FCCHD evaluation:

**Implementation Evaluation Purposes:**
- identifying and minimizing barriers to implementing activities;
- measuring the community’s perceptions of the project;
- monitoring clients’ and other stakeholders’ experiences with the project, and their satisfaction with and utilization of project services (Kellogg, 2004, p. 25).

**HMTPP-FCCHD IMPLEMENTATION EVALUATION GOALS**

The primary goals of the HMTPP-FCCHD implementation evaluation were:
1. to understand teen participant perceptions of the overall program as well as their perceptions of curricular content,
2. to explore teachers’ knowledge and attitudes towards the program, and
3. to explore the willingness and capacity of community collaborators to participate in the teaching of individual classes.

Initially, there were three main target populations in this program evaluation:
1. expecting and/or currently parenting teens who:
   a) currently participate in the program,
   b) formerly participated but are no longer enrolled, and
   c) are eligible but neglected to participate;
2. staff and teachers at Linderman Education Center;
3. community partners who have contributed content to the curriculum.

With the guidance of the HMTPP-FCCHD staff, these targets were modified during the evaluation process to better meet evaluation goals. In the teen participant group, the evaluators were unable to access teens who were eligible for the program, but neglected to participate (target group 1c). Limited to no participation in the program also meant little to no rapport with teens making their involvement in this voluntary evaluation difficult. Additionally, a brief online survey was created for not only the staff and teachers at Linderman Education Center, but also for staff and teachers at Glacier High School and Flathead High School. Also, we originally planned to focus community stakeholder interviews on partners who have contributed content to the curriculum. We extended this target group beyond potential presenters to also include:
1. agencies who refer to HMTPP-FCCHD and/or
2. agencies who receive referrals from HMTPP-FCCHD. Additionally, HMTPP-FCCHD staff recommended that Flathead City-County Health Department colleagues also be interviewed to gauge knowledge and perception of the program.
Below lists the goals for each target group.

**TARGET GROUP #1: TEEN PROGRAM PARTICIPANTS**  
**Current/Former Participants**  
**GOAL 1:** Identify students’ perception of the program, and specifically the aspects students find both favorable and unfavorable  
**GOAL 2:** Identify barriers to participation  
**GOAL 3:** Gather feedback on ways to incentivize meaningful participation

**TARGET GROUP #2: HIGH SCHOOL STAFF AND TEACHERS**  
**GOAL 1:** Identify staff and teachers’ knowledge and perception of the program  
**GOAL 2:** Identify reasons and barriers for referrals to the program  
**GOAL 3:** Gather feedback on ways to increase program participation

**TARGET GROUP #3: COMMUNITY STAKEHOLDERS**  
**GOAL 1:** Identify community partners’ perception of the program, including perceptions and feedback on the referral process  
**GOAL 2:** Identify willingness of community collaborators to participate in the program  
**GOAL 3:** Gather feedback on ways to improve the program

**TARGET GROUP #4: FLATHEAD CITY-COUNTY HEALTH DEPARTMENT (FCCHD) STAFF**  
**GOAL 1:** Identify FHCCHD staff knowledge and perception of the program  
**GOAL 2:** Identify reasons and barriers for referrals to the program  
**GOAL 3:** Gather feedback on ways to increase program participation

**EVALUATION APPROACH**  
The HMTPP-FCCHD implementation evaluation utilized a qualitative approach to gather feedback from teen participants, school partners, community stakeholders and FCCHD colleagues. Originally, we intended to use a mixed methods approach; qualitative data collected through individual semi-structured interviews and focus groups, and quantitative data collected through online surveys. We planned to survey teachers and school staff; however, the start date of the evaluation project was later than anticipated. The survey was created and disseminated to high school teachers and staff with the help HMTPP-FCCHD staff with ten days remaining in the academic year. As a result of our timing, we received few responses (n=6). Due to the low response rate, these responses are not included in the analysis.

**Semi-structured interviews**  
The evaluation team created a draft interview/focus group questions for each target group, and HMTPP-FCCHD program staff provided input on language and content. A purposive sample informed by the HMTPP-FCCHD staff was used.

The evaluator(s) spent four days in Kalispell, and the HMTPP-FCCHD parent educator arranged in-person interviews and one focus group with current and former teen participants, FCCHD staff, and school partners, and community stakeholders. Community stakeholders were also interviewed over the phone. Interviews and focus groups lasted 10-45 minutes in length. Participation in the evaluation was voluntary; the FCCHD offered gift card incentives to teens for their time and participation in the evaluation. All interviews were recorded and transcribed.

As indicated above, the community stakeholders were selected by HMTPP-FCCHD staff and fit one of the following criterion:  
1) community partners who have contributed content to the curriculum,  
2) community partners who refer to HMTPP-FCCHD and/or  
3) community partners who receive referrals from HMTPP-FCCHD. Key community stakeholders were selected from several sectors (see Table 3).

A total of thirty-six former or current teen participants, school partners, community stakeholders and Flathead City-County staff were interviewed for the evaluation. See charts below for the specific breakdown of interviews per target group.

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<tr>
<th>TARGET GROUP</th>
<th>TOTAL NUMBER OF RESPONDENTS PER TARGET GROUP</th>
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<tbody>
<tr>
<td>#1 PROGRAM PARTICIPANTS</td>
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<td>#2 SCHOOL PARTNERS</td>
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<td>#3 COMMUNITY STAKEHOLDERS FROM THE FOLLOWING SECTORS:</td>
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<td>Mental Health/Addictions Treatment</td>
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<td>Youth Probation/Restorative Justice</td>
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<tr>
<td>Employment Services/Job Training</td>
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<tr>
<td>Housing Assistance/Financial Literacy</td>
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<td>TOTAL RESPONDENTS</td>
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</table>

**TABLE 3:** Target group responses for HMTPP-FCCHD evaluation with subgroups
The research team relied on core principles of thematic analysis to identify themes among the target groups. Following the guidelines for thematic analysis set out by Braun and Clarke (2006), each researcher independently reviewed transcripts of the interviews, and identified initial codes, patterns and themes within each data set. Researchers met frequently throughout the initial coding to discuss emerging themes for each target group. After all coding was complete researchers met and created a final coding system. External consultation was sought to ensure the coherence of the coding system.

HMTTP-FCCHD staff guided the sample selection process based on their professional relationships with each respondent in each target group. While we believe our approach includes multiple perspectives, particularly from community stakeholders on the HMTTP-FCCHD, the voices not included are teens that are eligible and not engaged in the program. We assume their specific reasons for their lack of engagement are varied; however, their overall perception of the program is not included in this evaluation. Another limitation was the timing and start date of the project. Funding for the project began several weeks before the end of the academic calendar for high school teachers. Because of this timing, we were not able to capture the perceptions of high school teachers and staff at large via the survey. Also, the project timeline did not give us much of an opportunity to survey high schools staff at large.

This section includes the key results of the evaluation organized by
1) the target group and
2) the guiding evaluation questions.

A primary goal of the evaluation was to identify perceptions and experiences of teen participants currently and previously enrolled in HMTTP-FCCHD. The research questions focused on their experiences with the HMTTP-FCCHD, the barriers to participation, and the elements of the program that allowed for meaningful participation. It is important to note that HMTTP-FCCHD is voluntary. None of the program participants interviewed cited a requirement to attend, or coercion, as the reason they participated in HMTTP-FCCHD. All the participants chose to enroll and continue participating of their own volition.

Through the interview and focus group process, three stages of teen engagement were identified:
1) pre-engagement,
2) initial engagement, and
3) sustained engagement.

The following describes the themes that emerged in these three stages; these themes illustrate the teen’s overall perception of the program.

**PRE-ENGAGEMENT.**

“Finding out that I was pregnant was definitely terrifying. And, I was like, ‘I don’t know anything about babies.’ So, I definitely took advantage of it.”

Current and former teen participants described a similar pre-condition experience prior to their engagement in the program. Prior to enrolling in HMTTP-FCCHD, participants reported feeling a sense of isolation from their original support systems, such as their families or peer groups.

“So, when I first got pregnant I told everyone and I like lost all of my friends… So I needed mommy friends.”

In addition to the loss of the original support systems, many participants reported experiencing judgment in school and in the community.

“We all feel slightly targeted because we are young and we are pregnant.”

Many participants also experienced fear and worry during the initial stages of their pregnancies. Frequently, these worries were about their lack of knowledge or experience in pregnancy and parenting.

“Finding out that I was pregnant was definitely terrifying. And, I was like, ‘I don’t know anything about babies.’ So, I definitely took advantage of it.”

Another participant stated:

“I was scared and terrified.”
In the second engagement phase, the initial program engagement, respondents indicated two primary reasons for joining HMTPP-FCCHD:
1) to gain knowledge about pregnancy and parenting, and
2) to gain emotional support during and after their pregnancies.

The desire to gain knowledge. Most participants expressed concerns about a lack of knowledge about pregnancy and parenting.

“I’m gonna have this child and I don’t know anything about it.”

Another participant noted:
“Finding out that I was pregnant was definitely terrifying. And, I was like, ‘I don’t know anything about babies.’”

The desire to gain emotional support. The second common theme among current and former teen participants during the initial engagement phase was the desire to gain emotional support.

Teen participants shared:
“…I didn’t know if it was the right decision to have a child in the first place. And then there were people to help me? Yes! That would be awesome.”

Teens shared the need for additional support.
“I didn’t really have like, I mean I had my mom and my sister and stuff, but I didn’t really have someone I could talk to if I needed something outside my family. I guess it was just a good way to have someone there if I needed someone.”

The third phase, sustained engagement, captures the reasons why participants continued to participate. While the participants’ desire for knowledge and support were both strong in the initial engagement phase, participants unanimously reported that the need for support transformed into the development of a caring and non-judgmental relationship with HMTPP-FCCHD staff and group members. The relationship with HMTPP-FCCHD staff and fellow teen participants are what sustained their engagement in the program.

Support from HMTPP staff. Participants repeatedly cited the HMTPP-FCCHD staff person’s warm, non-judgmental and supportive approach as reasons to continue with HMTPP. These qualities resulted in many participants reporting a sense that the HMTPP-FCCHD staff cared for them and their babies.

The relationship built with the HMTPP-FCCHD staff kept the participants returning each week.
“(HMTPP-FCCHD program staff) keeps me coming back because she actually listens.”

Through this relationship, teens felt accepted.
“(HMTPP-FCCHD program staff) was like the only adult that was okay with [my pregnancy].”

Teens reported feeling support for themselves and their babies.
“I know she cares…she went all momma bear about the father of the baby cause there were some issues. And she said it’s not healthy for me or healthy for the baby or any of that”

The support received from HMTPP-FCCHD staff helped teens navigate the challenges of pregnancy and parenthood.
“And then there would be days where I was just super stressed and kind of sad. I wasn’t working, I can’t provide for my kid. And she was like, ‘It’s okay. Just calm down. We will figure it out. What do you need? What can I help you with?’”

And, through this support from HMTPP-FCCHD staff, teens reported feeling inspired to do better.
“She really made sure we knew just because we were young parents, didn’t mean we were going to be bad parents. And that was what my family made me feel like. And, I was like ‘heck no. I’m going to be a rock star.’ And [HMTPP-FCCHD program staff] helped with that.”
Support from peers. In addition to the one-on-one sessions with HMTPP-FCCHD staff, some participants attended group sessions with other pregnant or parenting teens. These small groups held at the high school during the school day offered an opportunity to meet peers with the shared experience. These groups provided opportunities for peer support and mutual aid, in addition to combating the common feelings of isolation reported by participants.

“That’s the main thing with the program I enjoyed. I am not alone. Lots of times being a single mom you really feel alone and the stress. But it just doesn’t make you feel that way, which I highly enjoy.”

Participants obtained knowledge that could then be shared with other teen parents.

“Oh yeah another thing she covered that was helpful was car seat safety. That is so important. And I see so many girls who just have no idea what they are doing. And it’s nice that I know how to help other people.”

Participants also reported feeling more comfortable learning with a peer group, as opposed to older pregnant and parenting persons.

“It was nice to be around people my age so I knew I wasn’t just by myself. It’s a little more reassuring.”

“I liked being with the other girls who are going through the same thing as me because it is really, really scary.”

The HMTPP-FCCHD group provided an opportunity for participants to exchange information and bond with those also going through the experience of teenage pregnancy.

| QUESTION #2: |
| What are the barriers to participation? |
| The current and former teen participants were also asked about barriers they may have experienced, or identified, while participating in the HMTPP-FCCHD. Though not strongly emphasized, teen participants identified barriers that fell into two categories: 1) life circumstances, and 2) program logistics. |

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Unreliable Transportation. The primary barrier cited by participants was transportation. While the HMTPP-FCCHD staff has the ability to meet with clients anywhere, participants who were still in school and attended HMTPP-FCCHD groups in school cited an inability to reliably get to school as a barrier participating in regular program meetings. Most rural areas, including the Flathead Valley, lack a strong public transportation system. As a result, many teens are still dependent upon others, such as parents, for transportation. One participant noted,

“My mom works all the time so it’s hard for me to get here.”

While the lack of reliable transportation was identified as a barrier to participation, the teens noted that the flexibility the HMTPP-FCCHD program offers helped to alleviate issues with transportation.

“I couldn’t make it to the office one time because my dad didn’t have a car. So I didn’t have a ride and she came to my house.”

“So there is no real excuse to miss a Baby Steps appointment...They will meet you anywhere.”

One participant suggested that assistance with overcoming transportation barriers could come in the form of a “Mommy Van” for HMTPP-FCCHD staff to transport participants and their children.

Pregnancy and Childrearing. Other barriers included the unavoidable consequences of pregnancy and parenting, including morning sickness and the inability to attend meetings in the first month postpartum.
QUESTION #3: What are ways to incentivize meaningful participation?
The third goal of the participant interviews was to explore what current and past participants found helpful and enjoyable about the program. They were asked about ways to increase participation and about what elements of the program generated meaningful participation. Participants who were involved in HMTPP-FCCHD in the schools all suggested keeping the program within the school setting. They also suggested more meetings to allow for additional opportunities to participate in the group and also suggested incentivizing participation with meals and items for the baby. The most valued course curricular content was content that related directly to pregnancy and parenting such as child development and breastfeeding.

**WAYS TO INCENTIVIZE PARTICIPATION**

- School as the venue for group meetings
- More frequent meetings
- Baby gear
- Meaningful program curriculum
- Childbirth & pain management
- Pregnancy & child development
- Breastfeeding & formula feeding
- Connecting & community resources

**School as the venue for group meetings.** Several participants noted that holding groups at school was convenient, more comfortable and incentivized attending school.

“We don’t have to go to some weird location... we were already at school. That’s why I think a good part about it was the being at school.”

“You gotta go to group, so you gotta go to school.”

**More frequent meetings.** Some participants requested more meetings, both group and one-on-one. This was in line with the finding that the close relationships formed within HMTPP-FCCHD were the basis of all participants continuing to attend meetings regularly.

“I’d want it more often...Like Monday, Wednesday, Friday.”
**Baby gear.** Participants also noted that support in the form of gift cards and physical goods for the baby were very helpful and suggested that more of it may be helpful to incentivize participation. Several participants also noted the snacks provided at meeting for them as well as their children.

“I think they should have more resources for parents who actually need the help.”

**Meaningful program curriculum.** Participants were largely pleased with the content presented in the program. They listed several ideas that were helpful to them in their pregnancy and parenting and also emphasized some of the already covered content as more important.

**Childbirth and pain management.** Several participants noted that conversations and lessons on childbirth and pain management were very helpful to them.

“Most teens have no idea what the heck is going on with their bodies, what is gonna happen in the delivery room.”

**Pregnancy and child development.** Participants also appreciated the information on pregnancy and child development during and after pregnancy. This information helped some to feel less worry and stress.

“It (HMTTP-FCCHD) helped me learn more about pregnancy than I ever thought I would ever know.”

“She explained that the first month is gonna be wicked. And it was wicked.... I mean just knowing that it was coming was nice.”

“Probably coming in and her giving us the books and pamphlets on the baby’s development. It’s like the fear went away more and the excitement increased. I really liked that.”

**Breastfeeding and Formula feeding.** Participants also appreciated the information and support they were offered around breastfeeding. Several spoke about frustrations with breastfeeding and appreciated the support from HMTTP-FCCHD staff.

“Breastfeeding didn’t make any sense to me. I was like, ‘I’m just a child myself.’”

“And breast feeding cause my mom never breast fed me so I was really nervous.”

“As a parent I thought, I have breasts, breast feed. But it’s not as easy as I thought.”

Notably, one participant spoke up about not breastfeeding and felt that while the videos presented were, “targeted towards just breast feeding,” she would be supported in HMTTP-FCCHD if she breastfed or not.

**Connecting to community resources.** Several participants noted that HMTTP-FCCHD staff were very helpful in finding outside resources and making useful referrals to other sources of support in the Flathead Valley.

“And then there was WIC and Baby Steps [HPTPP-FCCHD] referred me to Hope Pregnancy and they helped me more.”

Another participant stated:

“When we would come she would have pamphlets for other things going on in the community. It was just nice. “

In general participants found the course content useful and helpful in pregnancy and parenting. Content that covered information specific to pregnancy and childbearing including childbirth and breastfeeding was valued by most participants. This concurs with the findings that participants preferred learning about these topics in groups of their peers as opposed to in community courses, such as hospital Lamaze classes, which they perceived to be for older persons.
COMMUNITY STAKEHOLDERS

QUESTION #4: What are the community stakeholders’ perceptions of the Healthy Montana Teen Parent program?

A primary goal of this implementation evaluation was to assess community stakeholders’ perception of HMTPP-FCCHD, including their overall perceptions of the program and their perceptions of the referral process. While we expected to find community agencies that knew nothing about the program, all sixteen community stakeholders interviewed had some familiarity with the program.

The perception of the program and the referral process was greatly influenced by the community stakeholders’ knowledge of the program. Stakeholders fell into two groups: low knowledge and high knowledge.

LOW KNOWLEDGE GROUP. Stakeholders who fell into the low knowledge group had limited information and limited contact with HMTPP-FCCHD staff. The low knowledge group were unclear about the services offered by the program, including no knowledge that HMTPP-FCCHD program staff can meet teens at various agencies, parks, or coffee shops, school, or home, and were confused about the program name. Additionally, some stakeholders within the low knowledge group believed HMTPP-FCCHD to be exclusively a home visiting program.

LOW KNOWLEDGE GROUP-COMMUNITY STAKEHOLDERS

- Limited information about program services
- Program name confusion
- Limited to no contact with program staff
- Misconception that HMTPP-FCCHD is exclusively a home-visiting program

"I didn’t know that [program staff] can meet teens at our program- which would address barriers of transportation but also lack of teen buy-in because they don’t know about the program”

Limited information about program services. The low knowledge group also lacked important information that might increase referrals to the program.

“I didn’t know that [program staff] can meet teens at our program- which would address barriers of transportation but also lack of teen buy-in because they don’t know about the program”

Program name confusion. Among the low knowledge group, confusion about the name of the program emerged as a theme.

“They were the MIAMI Project. Then they became Baby Steps, and now they are Healthy Montana Families. Someone from that office came and visited me otherwise in a million years I wouldn’t have known. To me, that is confusing.”

Limited to no contact with program staff. Stakeholders in the low knowledge group reported little contact with HMTPP-FCCHD staff.

“We have been here four years, and this is the first time we have done a meet-and-greet with anyone from the program.”

Limited contact with staff also meant a lack of clarity about whether or not the teens referred to HMTPP-FCCHD had been contacted by HMTPP-FCCHD program.

“So honestly, we have no idea unless we made the phone call ourselves that the patient is working with the [HMTPP-FCCHD] program.”

Community stakeholders with low knowledge expressed a desire for more Follow-up information from HMTPP-FCCHD staff after a referral has been made.

Misconception that HMTPP-FCCHD is exclusively a home-visiting program. Some community stakeholders perceive HMTPP-FCCHD to be exclusively a home-visiting program. While the program does offer home-visits, this lack of clarity about the program overlooks important features of the program, such as: 1) its flexibility to meet teens in a variety of convenient locations, and 2) the school-based aspect of the program which supports academic achievement.

Stakeholders with low knowledge have less contact with HMTPP-FCCHD staff, make fewer referrals, and understand less about the benefits of the program for pregnant and parenting teens.
High knowledge group. Community stakeholders who fell into the high knowledge group understood the referral process and the benefits of the program for pregnant and parenting teens. Stakeholders with high knowledge either had accurate information, or were familiar with most aspects of the program. While, there was some confusion about the intricacies of the program such as name of the program, mixed up with other programs, or age criteria, all community stakeholders with high knowledge had a positive perception of the program and its impacts on pregnant and parenting teens. Both those who had accurate knowledge and those who had a general understanding of the program but were unfamiliar with some program aspects agreed that HMTPP-FCCHD is a reliable resource for pregnant and parenting teens. They believed that HMTPP-FCCHD is a flexible program that literally meets participants where they are with staff that create strong and supportive relationships with teens to help meet their bio-psycho-social needs.

HMTPP-FCCHD is a reliable resource and a warm hand-off. A strong theme among stakeholders with high knowledge was confidence in a “warm handoff” from their agency/clinic to the HMTPP-FCCHD.

“Honestly, having this program, we know they [the teens] are going to be taken care of…. [we] are looking for a warm hand-off, and we can do that with them (HMTPP-FCCHD).”

HMTPP-FCCHD is a flexible program that meets participants in convenient locations. These stakeholders also described the flexibility and accommodating nature of the program to meet the teens in a variety of convenient locations.

HMTPP-FCCHD creates a supportive relationship with teens. Community stakeholders with high knowledge of the HMTPP-FCCHD program described the positive and meaningful relationship made between teen participants and program staff.

“They go out of their way to make connections with patients, so it is not something done to them, but done with them.”

Stakeholders identified that emotional safety was created between the teens and HMTPP-FCCHD staff.

“I just noticed that there was safety amongst the group…she [HMTPP-FCCHD staff] was attuned to the needs of her clients, her participants.”

Stakeholders noted the safety created in the group was critical for teens that had limited emotional supports.

“I know that these kids feel trust and safety with [HMTPP-FCCHD staff], and I can see they know they have a safe place to come to with questions when they are not sure where else to go.”

HMTPP-FCCHD addresses the bio-psycho-social needs of the pregnant and parenting teens. Through education and resource brokering, the community stakeholders perceive the program addressed the bio-psycho-social needs of the teen participants.

“A pregnant teenager doesn’t know about the resources, some haven’t even had a job yet, so they don’t know how to do resource management and stuff like that. This program works because they take time to sit down and take a look at everything in their life, not just the pregnancy. Whereas a doctor is just focused on pregnancy.”

Bio-psycho-social needs are met by removing barriers. As one community stakeholder noted:

“[HMTPP-FCCHD staff] remove barriers. And, they try to keep them educated and on top of them...They get them where they need to be. They are there as an education source, advice about decision-making. I think they try as best as they can to be proactive instead of reactive which is key to managing these kids or anyone who is sick and pregnant.”
RESULTS SUMMARY

THE FEEDBACK LOOP. Community stakeholders with high knowledge have frequent contact with HMTPP-FCCHD staff. They describe the referral process as "seamless." These stakeholders know who to call and how to connect pregnant and parenting teens to the program. They witness first-hand the positive rapport built among teens and HMTPP-FCCHD staff, and the benefits of the program for these teens. They also perceive that the program serves a critical need in a community, and with the program in place, vulnerable teens are better served. These positive interactions reportedly lead to increased referrals from these community stakeholders, which then lead to additional opportunities for positive interactions with the program. Continued positive interactions with the program perpetuate additional appropriate referrals to the program. These multiple events create a positive feedback loop.

The feedback loop is disrupted among community stakeholders with low knowledge of HMTPP-FCCHD. Stakeholders with misinformation or limited understanding of the program have less interaction with HMTPP-FCCHD staff in their agencies and/or follow-up from referrals and have few to no opportunities to witness the benefits of the program. This then leads to a weaker perception of the program and/or a misunderstanding of how participants served in their agency/clinic would benefit from the program, and consequently a decline in appropriate referrals. Low knowledge, therefore, leads to a negative or broken feedback loop.
QUESTION #5: What is the willingness of community stakeholders to participate in HMTPP-FCCHD?

HMTPP-FCCHD staff identified a subgroup of the community stakeholders as potential presenters, agencies who have been contacted in the past to present on a topic of their expertise to the teen participants. These agencies were asked about their willingness to present curricular topics for teen participants in the program in the future. These identified community stakeholders responded in one of two ways:

1. **Direct supporters:** “Yes, we can present and it is a function of our program,” or…
2. **Indirect supporters:** “We cannot commit to presenting topics, but we can offer indirect support, such as serving as a referral source, including the participation in HMTPP-FCCHD as a tenant of the juvenile probation, and writing letters of support for future funding.”

QUESTION #6: What are ways in which the HMTPP can improve?

Community stakeholders were asked for their feedback on ways to improve the HMTPP-FCCHD program. Feedback fell into two main categories:

1) a need for increased in-person outreach, and
2) suggestions to improve the referral process.

**Increase in-person outreach.** Most community stakeholders identified that additional outreach was needed in order to increase awareness of the program and referrals to the program. All agencies expressed confusion about the name on the program. Despite the name change, both stakeholders with high and low knowledge continue to call the program by “Baby Steps” or the “MIAMI Project,” the HMTPP-FCCHD’s previous names. The confusion with the name leads to overall uncertainty about the project, particularly among stakeholders with limited information about the program.

Most community stakeholders stated that once per year or biannual in-person in-services at the agency or clinic would be an effective way of increasing outreach with their agency staff. While the director of the agency or primary provider of the healthcare clinic may be aware of the HMTPP-FCCHD, there was little confidence that staff at-large were informed. It was suggested that the in-person outreach efforts include information on program details, instructions on making referrals, as well as emergent data and/or trends on teen pregnancy in the Flathead Valley. Additionally, a face-to-face visit from HMTPP-FCCHD staff will help build ongoing relationships with community stakeholders, and a plan to visit yearly or biannual will help inform staff that is new to the agency.

**Suggestions to improve the referral process.** As mentioned above, community stakeholders with high knowledge of the program also have a positive perception of the referral process. One stakeholder described the referral process as, “Seamless. I just pick up the phone and leave a message.”

Most community stakeholders, including stakeholders with both high and low knowledge, suggested automated or electronic referral process. Specifically, stakeholders suggested replacing hard copy referrals that require faxing or scanning with an online, fillable referral form that can be submitted online. It was also suggested that there be efforts to improve the website by optimizing it for mobile use and bolding and increasing the font of the contact information to clarify the referral process.
QUESTION #7: What are high school staff’s knowledge and perception of HMTPP-FCCHD?

Teen program participants receive services in the high schools (Linderman Education Center, Glacier High School, Flathead High School, Columbia Falls High School or Whitefish High School), and as a result, HMTPP-FCCHD staff has frequent contact with the high school staff, particularly the school nurses, the administrators, and the school resource officers. The high school staff interviewed were the most familiar target group; all respondents reported having high knowledge of the HMTPP-FCCHD program and a positive perception of the program and its impact on pregnant and parenting teens. Specifically, they relied on outside expertise and a “warm handoff” to meet the supportive and educational needs of pregnant and parenting teens in the school-based setting.

HIGH-KNOWLEDGE GROUP – HIGH SCHOOL STAFF

Similar to community stakeholders, high school staff noted the supportive relationship between HMTPP-FCCHD and teens, and the value of the warm handoff from school staff to the HMTPP-FCCHD program. Not noted by community stakeholders, high school staff commented that it was particularly important to be able to do the warm handoff with an outside expert, a nurse with experience in adolescent reproductive health.

“They are the experts in reproductive health. So it really takes a lot off my plate, not having to care for their reproductive health.”

Another school staff noted:

“It is really great for us to be able to call and to know that there is somebody out there to help them...We know that it is being taken care of and we have the resource.”

School staff depend on HMTPP-FCCHD, and find it to be a critical resource for their students.

“I would hate to lose the program. Even if we had just one student. It is really great for us to be able to call and to know that there is somebody out there to help.”

Reliance on HMTPP-FCCHD was particularly important in communities where adolescent reproductive health services are limited.

“Before this grant started we were having such problems [with teen pregnancy rates]. And we didn’t have as much outreach...so we went awhile without reproductive health services up here and I was terrified”... “It’s a necessity in our area and so valuable.”

HMTPP-FCCHD educates pregnant and parenting teens. Also, unique to this target group, high school staff highlighted the pregnancy and parenting education offered by HMTPP-FCCHD staff. Specifically, they perceive that teen participants receive accurate health information, including information on formula best practices and over the counter medication safety for pregnant women.

“Every week [HMTPP-FCCHD staff] would bring [teen participant] resources, and she would say, ‘So, I read this [program material] and I’m gonna do this,’ or ‘Oh, I was taking ibuprofen and this [program material] said not to.’ And we’d tell her ‘no, you’re not suppose to take ibuprofen when you are pregnant. It was just really good”

HMTPP-FCCHD provides benefits as a school-based program. Additionally, all high school staff interviewed noted the importance of a school-based teen-parenting program. Respondents agreed with teens that they are more likely to participate in the program and more likely to come to school due to the school-based program approach.

“The teens would make sure they were here [at school] on the day [HMTPP-FCCHD staff] was supposed to be here. So they wanted to be here, they wanted to meet with her.”

The staff also mentioned the benefit of negotiating their class schedules to meet with HMTPP-FCCHD staff without missing critical classes that could affect their success at school.

“I have access to their schedule so I can pull them out of study hall and not math.”

School staff also noted the importance of providing these teens additional support so they can stay in school and obtain a high school diploma.
QUESTION #8: What are the reasons for and barriers to referring teens to the program?

The high school staff interviewed refer teens to the program when they hear of or suspect a high school student is pregnant. All respondents had a positive perception of the referral process. They have a relationship with the HMTPP-FCCHD staff and describe the referral process as seamless.

“We hardly have a lag time. Sometimes she is here so fast it is unbelievable.”
“I just call. And then they come. It’s great!”

QUESTION #9: What are the ways HMTPP-FCCHD can increase program participation for teens eligible for the program?

High school staff respondents were asked feedback on ways increase program participation for teens eligible for the program. Feedback fell into two categories:

1) Increase outreach to both students and teachers, and
2) Address barriers to participation.

WAYS TO INCREASE PARTICIPATION FOR ELIGIBLE TEENS

Increase outreach
Outreach to Teens
Outreach to school teachers & staff
Address barriers to participation
Provide additional support for teen life circumstances

Increase outreach. High school staff identified the need for increased outreach to both students and teachers so that knowledge of the program and its impact are more widely known. One respondent noted, “How do we catch students who fall through the cracks?,“ students who drop out of school after they get pregnant and before they engage with the program. It was suggested that student outreach include information about adolescent healthcare privacy laws to quell students’ concerns that parents will be billed and/or find out that they accessed reproductive healthcare.

Address barriers. While teen participants identified unreliable transportation as the primary barrier to participation, high school staff identified teen life and teen mom circumstances as barriers to participation. Because childcare is not offered in the schools, some teen parents do not make it to school because they do not have reliable childcare. Other respondents noted the unpredictable lives the teen parents lead, navigating parenting with limited external supports and in a resource-scarce environment.

“They are trying to support themselves and school becomes secondary.
So when school is secondary, they are not here.”

If they do not attend school, they miss the HMTPP-FCCHD groups held at school.

RESULTS SUMMARY

The feedback loop. Similar to the community stakeholders, high school staff with high knowledge of the program have frequent contact with HMTPP-FCCHD staff, and have positive perceptions of the overall program and the referral process. They also witness first-hand the positive rapport built among teens and HMTPP-FCCHD staff, and the benefits of the program for these teens. These multiple events reinforce the positive feedback loop.
QUESTION #10: What are FCCHD staff’s knowledge and perception of the HMTPP?

The HMTPP is a program of the Community Health Services Division of the Flathead City-County Health Department (FCCHD). FCCHD staff from WIC, Family Planning and the Health Montana Families program were interviewed to better understand colleagues’ perception of the program. All respondents reported having high knowledge of the HMTPP-FCCHD program and a positive perception of the program and its impact on pregnant and parenting teens. Similar to the high school staff target group, FCCHD staff’s overall impression was that the HMTPP-FCCHD staff meet the supportive and educational needs of pregnant and parenting teens in the school-based setting. Additionally, they highlighted the importance of the continuity of care provided for the pregnant and parenting teens by HMTPP-FCCHD staff and the positive effect of good collaboration and coordination among the health department.

**HIGH-KNOWLEDGE GROUP—FLATHEAD CITY-COUNTY HEALTH DEPARTMENT**

- **HMTPP-FCCHD creates a supportive relationship with teens**
- **HMTPP-FCCHD educates pregnant and parenting teens**
- **HMTPP-FCCHD provides a continuity of care for pregnant & parenting teens**
- **Good collaboration and coordination among the FCCHD leads to a warm handoff**

**HMTPP-FCCHD creates a supportive relationship with teen participants.** Similar to community stakeholders with high knowledge and high school staff, FCCHD staff perceive the program to provide important, nonjudgmental emotional support in a way that meets the specific needs of teen parents.

**HMTPP-FCCHD educates pregnant and parenting teens.** Also, similar to high school staff, FCCHD staff perceived the program to offer important education for pregnant and parenting teens.

**HMTPP-FCCHD provides a continuity of care for pregnant & parenting teens.** Unique to this target group, FCCHD staff noted the importance of HMTPP-FCCHD support through pregnancy as well as continued postpartum support.

“It makes me feel better that when I do my handoff I know that they are in good hands. I know they are going to be taken care of, not only for nine months, but for years after if wanted. And that the babies are taken care of.”

**Good collaboration and coordination among the FCCHD leads to a warm handoff.** Also unique to FCCHD, staff noted the importance of collaboration among the health department. The FCCHD programs operate under one roof, share time in staff meetings, and serve an overlapping patient population. Staff concluded that this leads to good collaboration and successful coordination of care. For example, if a pregnant teen shows up to WIC or the Teen Family Planning clinic for services and is not already connected to HMTPP-FCCHD, FCCHD staff will either send an electronic referral or will walk the teen to HMTPP-FCCHD office to for a face-to-face introduction to HMTPP-FCCHD staff. This is similar to the “warm handoff” described by community stakeholders and high school staff.

“We have a memo of understanding where we don’t need a release of information to make specific referrals or if we have concerns. So, a lot of it can be face-to-face, which is beautiful. It works so well for us because we are in the same location.”

Consistent with HIPPA guidelines, the FCCHD release of information covers all services in the Flathead City-County Health Department allowing referrals and warm handoff to other programs in the building such as the Family Planning Clinic, the Flathead County Community Health Center, and Women, Infants, Children Food and Nutrition Service (WIC).

Another FCCHD staff member noted:

“I prefer doing a warm handoff. If [HMTPP-FCCHD staff] is not isn’t available, then one of the other home_visitors will do a warm handoff so at least they [the teens]are making contact and feel like they’re having that relationship. We just make sure someone sees them before they leave the doors.”

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QUESTION #11: What are the reasons for and barriers to referring teens to the program?

FCCHD staff described a seamless referral process. As mentioned above, the health department electronic referral system, a release of information among health department programs, and the convenience of sharing one roof all lead to a positive perception of the referral process.
QUESTION #12: What are the ways HMTPP-FCCHD can increase program participation for teens eligible for the program?

Feedback on increasing program participating for teens eligible for the program fell into two categories:
1) increase outreach, and
2) increase incentives for teens to participate.

In increase outreach. FCCHD suggested additional outreach to increase awareness of the program:
1) to teens, and
2) to community stakeholders who work with teens.

RESULTS SUMMARY

The feedback loop. Similar to the community stakeholders and high school staff, FCCHD with high knowledge of the program have frequent contact with HMTPP-FCCHD staff, and have positive perceptions of the overall program and the referral process. These multiple events reinforce the positive feedback loop.

CONCLUSIONS AND RECOMMENDATIONS

This section highlights the evaluation conclusions and links conclusions to recommendations.

FINDING 1: Three stages of teen engagement were identified:
1) pre-engagement,
2) initial engagement, and
3) sustained engagement.

These stages are noteworthy because they inform the ways in which HMTPP-FCCHD can:
1) recruit eligible teens to the program, and
2) sustain their engagement in the program.

RECOMMENDATION 1:
Create pregnant teen-specific recruitment strategies and continue programming that sustains their engagement.

RECOMMENDATION 1A:
Pregnant teen-specific recruitment: Outreach efforts should consider the preconditions to inform program messaging. For example, the former and current teen participants expressed feeling isolated and afraid when they found out they were pregnant. Messaging that normalizes this response and invites them into a welcoming, nonjudgmental, and supportive environment may be the hook to increase participation. Since the desire for increased support and knowledge propelled pregnant and parenting teens into the program, HMTPP-FCCHD should advertise that its services will meet these primary needs. It should be noted that support may come from peers, in addition to the one-on-one individualized support from HMTPP-FCCHD staff. Outreach should also include the type of knowledge provided including pregnancy, birth, and infant care, and should clarify adolescent reproductive healthcare privacy laws.

RECOMMENDATION 1B:
Continue to focus on relationships as a way to sustain teens’ engagement in the program: Continue to build a program that prioritizes support between HMTPP-FCCHD staff and teen participants. While outside community partners may present useful information, positive, trusting relationships between participants and HMTPP-FCCHD staff sustains participant engagement. Exercise caution with program development that removes the strengthening of relationships from the core of the program.

FINDING 2: Barriers to participation fell into two categories:
1) life circumstances (i.e. lack of reliable transportation, morning sickness), and
2) program logistics (i.e. the timing of the teen group).

RECOMMENDATION 2:
Address the barriers to teen participation by identifying transportation alternatives and by maintaining flexibility in meeting location and times. While it may not be feasible for program staff to transport teens, researching alternative transportation options for teens may prove to be a helpful endeavor. Also reinforcing to teens in school groups that meeting outside of school is also a possibility. Respondents favorably noted the flexibility of the HMTPP-FCCHD staff to meet at a variety of locations and at a variety of times. This flexibility should be maintained in future program planning.

FINDING 3: Participants who were involved in HMTPP-FCCHD in the schools all suggested keeping the program within the school setting due to convenience and as a motivator to attend school. School staff also noted the advantages of a school-based program as a way to encourage school attendance.

RECOMMENDATION 3:
Continue to offer the HMTPP-FCCHD groups in schools, while reinforcing the option for visitation outside of the school setting as well.
FINDING 4: Community stakeholders, high school staff and FCCHD staff with high knowledge of the program also had consistent contact with HMTPP-FCCHD staff, and relied on “warm handoff” of the teens to HMTPP-FCCHD staff. High knowledge of the program and consistent contact with HMTPP-FCCHD staff led to a positive perception of the program and its impact on pregnant and parenting teens. This positive perception reportedly increases the potential of appropriate referrals; thereby, creating a positive or closed feedback loop. Additionally, a positive feedback loop and increased interactions with HMTPP-FCCHD staff lead to more discourse about the program which then leads to opportunities to correct misinformation and fill the gaps when there is missing information. The goal is that every community stakeholder, high school staff and FCCHD staff has high knowledge with accurate information.

RECOMMENDATION 4: Close the feedback loop. Improve the feedback loop with community stakeholders and high school teachers and staff by: 1) increased follow-up efforts after referrals are received, 2) strategic in-person outreach.

RECOMMENDATION 4A: Increased follow-up efforts after referrals are received. It is recommended that HMTPP-FCCHD staff follow-up with referring agencies to confirm that the program has reached out to teens. This referral follow-up will create more opportunities for the “warm handoff,” an important theme that emerged among high knowledge groups, and a critical step to close the feedback loop.

RECOMMENDATION 4B: Increase in-person outreach. HMTPP-FCCHD staff should increase outreach to community stakeholders and high schools. Community stakeholder outreach should be done in-person to create opportunities to meet new staff in the agencies. Outreach to schools can be done via in-person staff meetings and/or electronically via all-school emails approved by school administration. Outreach efforts should clarify the program name, and include information on program details, instructions on making referrals, as well as emergent data and/or trends on teen pregnancy in the Flathead Valley. Sharing Flathead Valley teen pregnancy data and trends to community stakeholders can increase awareness of teen pregnancy as a public health issue as well as leverage community-wide support for education, prevention, and intervention. Continue collaborative relationships and coordinated care among FCCHD staff emphasizes the “warm handoff” and creates a positive feedback loop. It should also be noted that many community stakeholders identified “small town networking” as the primary way they stay updated on the different services that support pregnant and parenting teens. For example, if they have a relationship with a person in the agency, they pick up the phone and call their contact person. In-person outreach efforts will build off this networking approach and create additional opportunities to build relationships among agency and clinic staff.

FINDING 5: Community stakeholders identified their willingness to support the program in the future as either: 1) a presenter or, 2) an indirect support.

RECOMMENDATION 5: Leverage the support of community partners. When HMTPP-FCCHD staff does outreach to community partners, they will need to assess each stakeholder’s interest and availability for future engagement. It is recommended that while doing outreach, HMTPP-FCCHD staff asks the following questions: 1. Are you able to present curricular topics? 2. If so, are outreach and trainings functions of your program? Agencies who respond affirmatively to both of these questions will be key stakeholders. HMTPP-FCCHD should continue to maintain these relationships via annual or biannual in-person in-services.

3. Are you willing to support the program indirectly (refer teens to the program)? Agencies who respond affirmatively to this question should also be included in outreach efforts, including annual or biannual HMTPP-FCCHD updates so that accurate program information is disseminated from the agencies and so that HMTPP-FCCHD continues to receive appropriate referrals.

While the community stakeholders interviewed all indicated an interest in supporting the program via presentations and/or indirect support, it may be necessary with future outreach efforts with additional agencies to include a fourth question:

4. Are you unable to support the program through presentations and referrals? Agencies who respond affirmatively to the fourth question will not need to be included in future outreach plans. Outreach efforts can then be maximized towards agencies that favorably identify as potential presenters and/or potential referral sources.

FINDING 6: Community stakeholders offered specific feedback on ways to improve the referral process.

Recommendation 6: It is recommended that the HMTPP-FCCHD create an online, fillable referral form that can be submitted electronically to make it easier for agencies to refer to the program. Additionally, clarify the referral process and contact on the website by increasing and/or highlighting the font of the program contact information.