The Current Situation

In the United States teen pregnancy poses both fiscal and health challenges. This is particularly evident in the state of Kentucky. While national expenditures related to the care of teenage mothers total between $9.4 billion and $28 billion in US tax dollars every year, the cost of teen childbearing to taxpayers in Kentucky was an estimated $158 million in 2010 (Office of Adolescent Health, 2015; Planned Parenthood KY, 2015).

Equally important is the impact on the local and individual scale. Teen pregnancy has been found to result in adverse consequences, for both the mother and child, such as increased high school dropout rates, poorer health, and adverse behavioral outcomes (Office of Adolescent Health, 2015; Planned Parenthood KY, 2015). Both nationally and on the Kentucky state level, 50 percent of adolescent mothers received a high school diploma by the age of 22 in comparison to 90 percent of their non-parent counterparts (National Conference of State Legislatures, 2015). In addition to being at an increased risk for low educational achievement, pregnant teens pose health risks to themselves and their children that include increased experiences of violence, higher rates of substance abuse, and a greater incidence of birthing babies that are of low birth weight and have developmental delays which will require ongoing care, and thus increased costs (National Library of Medicine, 2011).

Teen pregnancy rates in Kentucky soar high above the national average, with a rate of 71 per 1,000 live births, compared to 68 per 1,000 live births nationally (Office of Adolescent Health, 2015). The situation in Kentucky can be attributed to several factors including: limited access to preventative sexual education, high poverty rates, limited access to resources, and a conservative political environment (Kagesten et al., 2014). Currently, sexual education in Kentucky is held to lower standards than other states. While sexual education is required, content is determined by local school boards with abstinence being the only required inclusion, and the curriculum does not need to be evidence-based, medically accurate, or include methods of contraception. When looking at the socioeconomic factors related to the situation, Kentucky's high poverty rate of 19.1 percent (in comparison to the national 15.9 percent) demonstrates the tremendous impact that Policy TEN could have by lowering the number of teen pregnancies over a ten-year trajectory (State Health Assessment, 2013). Additional challenges to improving teen pregnancy rates include the lack of access to reproductive resources and the political climate in Kentucky. With the presence of only two Planned Parenthoods in the state and a political environment that may be resistant to the expansion of reproductive health resources and knowledge, Policy TEN embodies a carefully developed plan that will employ meaningful and culturally sensitive changes for the state.
In an effort to confront Kentucky's high rate of teen pregnancy, Policy TEN aims to increase Title X funding in the state and decrease teen pregnancy through various initiatives over the next ten years. The Title X program funds family planning services nationwide, particularly low income and high-risk populations covering approximately 4,100 clinics across the country (Office of Population Affairs, 2012). However, recent national funding for Title X has decreased: “Between 1985 and 2010, cuts to Title X totaled $13.9 million...over just the last five years; Title X funding has been slashed by $39.2 million” (National Family Planning and Reproductive Health Association, 2015). Despite a short-term increase in expenditure due to targeted training for providers and clinic expansions statewide, Title X has proved to provide significant long-term cost savings: for every public dollar spent on contraceptive services, there is an estimated $3.74 in savings (U.S. Office of Population Affairs, 2008). Policy TEN's increase in funding will allow for changes to school sexual health education and professional health care curriculums, establish marketing initiatives, and garner legislative support to build awareness about teenage pregnancy.

Nature of the Problem

Kentucky is a southern state with a homogeneous population. 87% of the population is white and 96% of the population speaks only English. The majority of the population is married. 31% of the population is married with children, and the average household size is 2.5 people. Conservative values dominate the culture and political environment in Kentucky. Fifty-two percent of the population in Kentucky are religious with 31% identifying as Baptist and 8% as Catholic (Kentucky State). Both these denominations traditionally hold and advocate conservative values. Within most conservative religions, there is a stigma associated with sex outside of wedlock and the use of contraception is discouraged. Additionally, abortions are not condoned within these religious communities. Conservative religions are often better at discouraging contraception use than discouraging actual sexual acts. Even though teen sex is prevalent, pregnancy prevention is not openly discussed. From a political standpoint, Kentucky has an inefficient divided government. The State House is controlled by Democrats while the State Senate is controlled by Republicans. A divided government creates an environment which is not conducive to legislative changes.

Figure 1: Marital Status of the Population of Kentucky versus the United States in 2014
Table 1: Kentucky State House and Senate Composition

<table>
<thead>
<tr>
<th>Party</th>
<th>Kentucky State House Composition (as of September 2015)</th>
<th>Kentucky State Senate Composition (as of September 2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Democratic Party</td>
<td>54</td>
<td>11</td>
</tr>
<tr>
<td>Republican Party</td>
<td>46</td>
<td>27</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>38</td>
</tr>
</tbody>
</table>

Although divided, Kentucky traditionally votes for the Republican party. As a state, Kentucky has voted in favor of the Republican candidate in the last four presidential elections (Kentucky General Assembly, 2015).

Interestingly, Kentucky’s conservative values do not filter down to teenage sexual activities. A higher percentage of Kentucky’s high school students have had sexual intercourse in comparison to the United States average.

Table 2: Survey of High School Students’ Sexual History in Kentucky and the United States in 2008

<table>
<thead>
<tr>
<th>Percent of high school students who have ever had sexual intercourse</th>
<th>Kentucky</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>52%</td>
<td>47%</td>
</tr>
<tr>
<td>Male</td>
<td>52%</td>
<td>49%</td>
</tr>
<tr>
<td>Female</td>
<td>52%</td>
<td>46%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percent of high school students who had sexual intercourse for the first time before 13 years of age</th>
<th>Kentucky</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>7%</td>
<td>6%</td>
</tr>
<tr>
<td>Male</td>
<td>9%</td>
<td>9%</td>
</tr>
<tr>
<td>Female</td>
<td>5%</td>
<td>3%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percent of high school students who have had sexual intercourse with 4 or more persons</th>
<th>Kentucky</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>17%</td>
<td>15%</td>
</tr>
<tr>
<td>Male</td>
<td>17%</td>
<td>18%</td>
</tr>
<tr>
<td>Female</td>
<td>16%</td>
<td>13%</td>
</tr>
</tbody>
</table>
Kentucky’s conservative values are reflected in their teen pregnancy and abortion rates, which results in more births from unintended pregnancies. According to The National Campaign to Prevent Teen and Unplanned Pregnancy (2010), the rate of teenage pregnancy in the United States has decreased by 51% since its peak in 1990. While all 50 states have experienced a decline, Kentucky currently is ranked 16/50 with one of the highest teen pregnancy rates: 62 pregnancies per 1,000 girls. When compared to national trends, Kentucky has been slower to curtail teen pregnancy rates (Office of Adolescent Health, 2014).

Table 3: Teen Abortion Rates in Kentucky and the United States in 2008

<table>
<thead>
<tr>
<th></th>
<th>Kentucky</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>7%</td>
<td>6%</td>
</tr>
<tr>
<td>Male</td>
<td>9%</td>
<td>9%</td>
</tr>
<tr>
<td>Female</td>
<td>5%</td>
<td>3%</td>
</tr>
</tbody>
</table>

Table 4: Percent Changes in the Teen Pregnancy Rates from the years 1988 to 2008 in Kentucky and the United States.

<table>
<thead>
<tr>
<th>Age</th>
<th>Kentucky</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 - 19</td>
<td>7</td>
<td>18</td>
</tr>
<tr>
<td>15 - 17</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>18 - 19</td>
<td>11</td>
<td>29</td>
</tr>
</tbody>
</table>

According to The National Campaign to Prevent Teen and Unplanned Pregnancy (2010), the rate of teenage pregnancy in the United States has decreased by 51% since its peak in 1990, and by 15% since 2008. While all 50 states have experienced a decline, Kentucky is ranked 16/50 with one of the highest teen pregnancy rates: 62 pregnancies per 1,000 girls. When compared to national trends, Kentucky has been slower to curtail teen pregnancy rates.

Table 4: Percent Changes in the Teen Pregnancy Rates from the years 1988 to 2008 in Kentucky and the United States.

<table>
<thead>
<tr>
<th>Change in rate of females aged 15-19</th>
<th>Kentucky</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>-26%</td>
<td></td>
<td>-39%</td>
</tr>
</tbody>
</table>

As of 2014, there were only 2 Planned Parenthood clinics and 143 Title X funded health care clinics in the state of Kentucky—the sole locations where teens can receive guaranteed confidential reproductive information and healthcare (National Family Planning & Reproductive Health Association, 2015). According to the Healthcare Workforce Capacity Report for Kentucky, as of 2013, Kentucky is home to 10,475 physicians, 3,057 advanced nurse practitioners, 1,047 physician assistants and 59,863 registered nurses and licensed practical nurses. The ratio of doctors to people in Kentucky is 238.1 for every 100,000 people. This ratio is below the benchmark set by the Association of American Medical Colleges (Banahan, 2013). For advanced nurse practitioners, the accepted ratio is 69.5 for every 100,000 people, and for physician assistants, the ratio is 22.4 for every 100,000 people. In order to expand access to crucial health services and education related to teen pregnancy, Kentucky must work together to enact changes in health policies that...
benefit the population and close these gaps in healthcare. These changes could be delivered through the implementation of Policy TEN.

With increases to Title X funding, a portion of public spending can be mitigated by prioritizing prevention in lieu of a financial focus on unplanned births. In 2010 alone, 15,200 (66.8%) of unplanned births in Kentucky were funded by the public, at a cost of $442 per woman--more than double the cost per woman nationally (Guttmacher Institute). Prevention proves to be much less costly when, according to the Office of Population Affairs in 2008, there was an average of $3.78 cost savings for every public $1.00 spent on contraceptive services (Office of Population Affairs, 2012).

Despite requiring an initial outlay of capital to fund the training of providers and expansion of clinics statewide, the returns on investment in the form of future cost savings are substantial. A similar initiative in Colorado has increased Title X funding alongside a campaign promoting the use of long-acting reversible contraception. As a result of that effort, teen pregnancy rates decreased by 39% in the state (Colorado Department of Public Health and Environment). New Hampshire, the state with the lowest teen pregnancy rate in the country with 12.6/1000 births, has used the Personal Responsibility Education Program (PREP) to implement an evidenced-based approach utilizing behavioral learning styles to reinforce positive experiences regarding safe sex in teens in the school system (New Hampshire Dept of Health and Human Services).

![Policy TEN Diagram](Figure 2: Top Down Approach for Distribution of Title X Funding)
By increasing Title X funding, Policy TEN intends to combat teen pregnancy by implementing the following:

- Standardized comprehensive sexual education curriculum for Kentucky's public schools,
- Standardized reproductive health education and training for Kentucky's healthcare providers,
- Increased access to family planning and sexual health resources, and
- Appraisal of the Teen Pregnancy Prevention Strategic Plan (TPPSP).

These initiatives, taken together, will lower teen pregnancy rates while improving individual knowledge, increasing family planning and sexual health resources, and lowering long term costs for the state of Kentucky.

**Proposed Solutions, Projected Outcomes, and Proposed Strategies for Implementation by Prevention Areas**

**Strengthening Individual Knowledge and Skills**

**Proposed Solutions 1:** Currently Kentucky schools provide sexual education from 6th to 12th grade. However, abstinence and HIV education are the only required curriculum topics (State Policies in Brief, 2015). Contraceptive use is not a required topic. In 2010, Kentucky Cabinet for Health and Family Services received $839,352 in federal funds for abstinence-only-until-marriage programs and allocated most of the funding to 16 local public health departments. The remainder of the funding was available for non-profit/ governmental agencies and was distributed to five crisis pregnancy centers, which do not provide any sexual education or preventative services. These crisis pregnancy centers only provide services to those seeking help while pregnant. In 2008, a study, conducted amongst adolescents aged 15-19 in regards to the type of sex education they received prior to their first experience with sex, revealed that compared to abstinence-only education, comprehensive sexual education resulted in significantly reduced likelihoods of teen pregnancy (Kohler, 2008). With more Title X funding, the state can expand the state's comprehensive sexual education, reduce pregnancy rates, and ultimately reduce accrued expenses.

**Projected Outcomes 1:** Sexual education sessions will incorporate a quiz administered to each student to evaluate the understanding of the material covered. Quiz questions will include multiple choice and true or false questions; for example, “Do birth control pills protect against STIs? True/False.” These evaluations will be used as a measure to tailor education sessions to better suit the population in Kentucky. The number of visits to the pregnancy crisis centers and family planning centers will be counted in addition to the types of services utilized in order to better serve the population efficiently. This will, over time, give the state a better idea of how to distribute funding. The cost of these visits compared to the cost spent on Title X funding over a period of 10 years to assess efficiency.

**Strategies for Implementation 1:** We propose a statewide core curriculum that will be created and implemented by healthcare providers. Topics covered should include prevention of pregnancy through use of condoms, contraceptives, birth control, and safe sex practices. This will replace the current curriculum, which only includes abstinence and HIV education, and will be open to both teens and parents. Incentive
will be given in the form of tax credits or increased welfare benefits, to those who qualify. A study done in 2011 on the long term effects of tax credits shows that an increase of $1000 in tax credit improves students’ test scores, improves the probability of attending college, and reduces teenage birthrate (Chetty, 2011).

Promoting Community Education

Proposed Solutions 2: A statewide core curriculum will be created and implemented by healthcare providers under Policy TEN. This core curriculum will have evidence-based standards for sex education that is: medically accurate, uses unbiased information, is non-religion promoting, and includes comprehensive methods of contraception information. These standards will be instituted in addition to abstinence education and be disseminated to both teens and parents. Furthermore, with support from Title X funding, the state can include considerations for the culture of the community in its new curriculum. In order to target inconsistencies in the sex education curriculum offered in the public school settings, uniform and standardized sex education that is evidence-based must be mandated. Public school teachers will undergo comprehensive sexual education training by a healthcare provider to support this mission.

Projected Outcomes 2: Improving sexuality education for all students in public school programs provides youth with the resources and the knowledge base to prevent pregnancy. With improved regulation, sexual education programs in Kentucky public schools will have content that is age appropriate, thorough, and accurate across counties, by 2025. Students will be able to demonstrate a comprehensive understanding of pregnancy and STI prevention, including knowledge of abstinence, hormonal and non hormonal contraceptive methods, and an understanding of the biological processes of reproduction. Funding will be allocated to create surveys that measure and track student learning progress, which will be used to create an evidenced based approach to preventing teen pregnancy. This will have a positive impact on the overall health and related socio-economic development of adolescents in Kentucky.

Strategies for Implementation 2: We propose to form a legislative committee comprised of leading educators and school board members in Kentucky to review the curriculums of sex education from the top five states with the lowest teen pregnancy rates. Based on the positive outcomes of other states’ sex education programs and current evidence-based standards, this committee will decide on a uniform sex education curriculum that takes into consideration Kentucky’s culture and needs. The Kentucky State Department of Education would then enforce the approved curriculum across all public school boards after a final review of topics. Public schools will be mandated to report on: appropriate allocation of funds for the new education, the educational topics being presented in schools, and a pre-and post test result submission by the students on content and sexual activity to evaluate the effectiveness of the curriculum changes that Policy TEN introduces.

Educating Providers

Proposed Solutions 3: Policy TEN will allocate funds to enhance knowledge and practices related to reproductive health and outreach among existing health care providers. Adolescent sexual health training will be incorporated into provider’s training curriculum in order to prepare providers to meet contraceptive needs of teenagers, family planning research and evaluation to improve and inform family planning services (Office of Adolescent Health, 2014). Currently, Kentucky’s three medical schools have comparatively short Obstetrical/Gynecological (OB/GYN) rotations; six weeks in comparison to eight for other specialities. In addition, OB/GYN clinical residencies are exclusively at surgical sites rather than labor and delivery locations. This shows a lack of clinical training during residency in family planning for OB/GYN specialists.
Policy TEN proposes 100% of the OB/GYN residencies include clinical placements that emphasize preventative family planning training. Dehlendorf (2010) found that, nationally, providers have inconsistent and inaccurate knowledge regarding contraceptive strategies, and Henry-Reid (2010) showed that only about 60% of national pediatrics discussed abstinence, condoms, and STIs with their adolescent patients. These facts demonstrate a need for more comprehensive family planning training for providers. Policy TEN proposes working with existing training resources such as the National Clinical Training Center for Family Planning, which would provide: 1) clinical trainings that cover preceptor training, long-acting reversible contraception, and billing and coding; 2) contraceptive and sexually transmitted diseases updates, 3) webinars on current family planning topics, and 4) outreach strategies for special populations such as adolescents, males and less accessible demographics (Office of Population Affairs, 2012). These training programs would provide a foundation to re-organize school curriculums and establish family planning clinical placements for health care providers in training. These training centers, derived from Title X initiatives, have a track record of decreasing pregnancy rates in Kentucky by 6 percent in 2010-2011 (Office of Adolescent Health, 2013). Since Title X's family planning services are largely implemented by NPs, midwives, MDs, and PAs, (Fowler, Gable, & Wang) and 21 percent of Title X's clients are adolescents, (Dresibach, 2013), we propose that Policy TEN would further decrease its teen pregnancy rate long term.

Projected Outcomes 3: Within 10 years, 100% of health care providers working with adolescents in Kentucky would report spending time during routine visits counseling their patient about reproductive health. In future studies, similar to Dehlendorf (2010), we would evaluate Kentucky providers on accuracy of current contraceptive strategies and time spent educating patients. In this same time frame, we expect to see increased accuracy of information within Health Care Providers as compared to the first year of policy implementation.

Strategies for Implementation 3: We will seek help from the National Clinical Training Center and National Training Center for Family Planning Service Delivery programs which currently offers clinical training to health care providers. These trainings cover topics such as on preceptor training, long-acting reversible contraception, billing, coding, and contraceptive and sexually transmitted diseases updates (Office of Population Affairs, 2012). These training programs provide a foundation for re-organizing school curriculums and establishing family planning clinical placements for health care providers in training. In doing so, health care providers will be furnished with a better knowledge base for addressing adolescent sexual health education.

Fostering Coalitions and Networks

Proposed Solutions 4: For successful implementation of Policy TEN, it will be important to coordinate changes in educational practices between providers and the public school network. A solution for the chaotic and uncoordinated appearance of the state’s teen pregnancy efforts would be to encourage the collaboration and coordination within the state among the various health care agencies and organizations. These initiatives can be implemented by fostering the ties between the public school network, the network of community providers that offer family planning and contraceptive services, and the Title X funded clinics. By increasing the collaboration and cooperation between clinics, community providers, the public school system, and community organizations, we can have further reaching effects and more effectiveness at a minimized cost. In conjunction with the educational based solutions, it would be beneficial to integrate Electronic Health Record (EHR) systems among the various clinics, hospitals, and providers involved in family planning, teen pregnancy, and other aspects of Policy TEN’s goals. This would allow for better continuity of care, improved data collection ability, and better gauging of the effectiveness of the program’s intended
outcomes. Maintaining the continuity of care between the different clinics, providers, and hospitals would increase the ability of facilities to provide appropriate, targeted, and effective care to their patients.

Projected Outcomes 4: By organizing a large number and wide variety of organizations, the implementation of Policy TEN will be more effective and the goals of reducing teen pregnancies in Kentucky will be more easily obtained. The collaboration among and between educators and providers will have significant and far reaching benefits for the educational aspects of our proposed policy. This collaboration will lead to more effective education by ensuring that the most important and appropriate aspects of sexual education are enforced and that information is consistent across the methods and sources of instruction. We plan to measure increases in the educational knowledge base as evidenced by the evaluation of adolescent sexual education. This will be appraised via a standardized student evaluation survey provided to students before and after their participation in the educational aspects of this program. The integration of the EHR systems will allow for more effective and appropriate care and education directed at patients within the state. It will allow for improved identification and monitoring of our most at-risk population and will enable practitioners to become more deeply aware of the status of their patients, regardless of their method of accessing the health care system. Thus, we hope to see more facilities utilizing integrated EHRs and see their practitioners taking advantage of this valuable resource. Our goal is a 10% increase in the amount of patients registered to integrated EHR systems within the next 10 years.

Strategies for Implementation 4: In order to best encourage the collaboration and coordination among and between the providers and educators within the state, we need to create an organizational structure. To do so, we would create a committee in order to spearhead the creation of a sexual education curricula that would be effective, appropriate, and implemented in a reasonable and useful manner, as discussed in Promoting Communication. After a committee or council is created out of state administrators, school educators and principals, health care providers, as well as other large stakeholders in the state, it can begin to outline the plan for this undertaking. Ideally, this new organization would then initiate meetings with the principals of public high and middle schools and pediatric health care providers in order to establish an evidence-based sexual education program for teenagers. This committee will then be tasked to meet a three times per year (prior to the start of school, in between semesters, and at the end of the year) in order to ensure the successful implementation of the established evidence-based sexual education program for students in Kentucky. This includes creating and updating standards related to; milestones within the educational curricula, gauging the effectiveness of the educational efforts of educators in the state, the quality of the material being taught in sexual education classes, and the comprehension of the students as it relates to the material. They will also be given with the job of maintaining the evidence-based aspect of the program, and updating the educational material as necessary so that it will remain scientifically accurate, consisting of best practices and comparatively effective methods of instruction.

The integration of EHR systems from different clinics, providers, and hospitals will be a beneficial development in ensuring the continuity of care, and would provide data about the patients utilizing resources, direct resources to high risk patients, and form the basis for directed and focused educational efforts. Although arduous, there are examples of successful implementations around the country, such as the SHIN-NY (Statewide Health Information Network of New York) system in New York state. In this system, the state is broken up into nine smaller regions, referred to as RHIOs (Regional Health Information Organizations) which enables practitioners at one participating facility to access the health records of their patients who are seen at another participating facility within the organization. This model program is currently working to integrate the different regions into a single, overarching database, allowing providers to look for records for their patients from throughout the state. Currently, the SHIN-NY system boasts an 84%
enrollment among the state’s hospitals along with thousands of medical providers. (New York eHealth Collaborative, 2015). In order to implement a similar model in Kentucky, it would be most effective to contact the administrators of the New York system in order to completely understand their program and to learn from any mistakes they might have made in its creation. We would expect to utilize strategies such as creating a steering committee in order to evaluate the progress of the implementation and guide it towards success, as well as using informatics to process data and best orchestrate the collaboration of different computer systems and to translate between different source code languages.

Changing Organizational Practices

**Proposed Solutions 5:** In order to provide a supportive environment for these new implementations, changing organizational practices in Kentucky will be integral to reducing the high teen pregnancy rate. To address this, Policy TEN proposes using Title X funding to appraise the existing Teen Pregnancy Prevention Strategic Plan (TPPSP) and implement a statewide directory of available healthcare services. TPPSP is a program that has been designed to educate teens and foster individual skills and knowledge in teens to allow them to make choices that may empower them to achieve their goals (Department for Public Health, Division of Women’s Health, 2010). We are choosing to evaluate TPPSP because it is the current organizational structure by which Kentucky is addressing teen pregnancy. By making this established program more efficient, its four subgoals can be implemented more successfully. Continued advocacy for the implementation of the TPPSP will also challenge mainstream conservative ideals in Kentucky, which currently push for abstinence-only education in schools. To reinforce the efforts of supportive programs and clinics, the statewide directory will provide a comprehensive guide to services offered for teens in Kentucky pertaining to family planning and pregnancy. The statewide directory will be a vital tool for improving access to healthcare services and resources for the the teenage population.

**Projected Outcomes 5:** While Policy TEN aims to make TPPSP more effective, it will work towards the TPPSP’s goal of reducing Kentucky teen pregnancy by 20% by the year 2020. Further, Policy TEN will continue to follow the outcomes of the goals of TPPSP for an additional five years after 2020, resulting in tracking progress for a total of “ten” years (in conjunction with Policy TEN). This plan has four subgoals related to age-appropriate personal responsibility for sexual health, parental education, teenage pregnancy awareness, and access to reproductive healthcare and preventative services. Alongside the continuation of this program, yearly evaluation of these subgoals would support its success. Our goal for the statewide directory would be implementation within 5 years of funding. To track the utilization of the directory individual facilities will report the number of patients that found access to their services via the directory and the website itself will record the number of visits to the directory.

**Strategies for Implementation 5:** Evaluation of TPPSP would begin with the formation of a task force to address each of the four subgoals of the program. This task force would come from within the Division of Women’s Health, a subdivision of the Kentucky Department of Public Health. These task forces would assess the progress of TPPSP by appraising the current funding, the number of programs currently implemented, and the number of people affected, allowing the task force to weigh the costs versus benefits of the program. Most importantly would be assessing the rates of teen pregnancy and teen births. Since the program gathered data prior to its inception, those same resources and methods of measurement could be utilized for this evaluation. Information for the directory would begin with the clinics and outreach programs already connected with TPPSP. Beyond that, the task force would reach out to providers in each of Kentucky’s 120 counties to capture the full landscape of services available. Once the data is collected, it will
be organized as a comprehensive web-based listing. Each location listed will include a phone number, the address of the facility, healthcare services offered, ages served, educational resources available, and whether they accept Medicaid or KCHIP. Each location may additionally choose to include: hours of operation, online appointment booking, religious counseling availability, and its privacy policy.

**Influencing Policy and Legislation**

**Proposed Solutions 6:** To overcome resistance for Policy TEN, it will include provisions to make it politically difficult for legislators to vote against it. These provisions will include: 1) thorough sexually transmitted disease education, 2) equal protection clauses that protect pregnant teens from expulsion from school, 3) mandating that both abstinence and evidence-based birth control methods be included in curriculum, 4) utilization of social media to gain popularity and increase awareness, and 5) hosting town hall meetings to educate the community about the current issue of teen pregnancy and the need to place pressure on local representatives to implement evidence based practice solutions.

**Projected Outcomes 6:** We anticipate that Policy TEN will face severe problems receiving sufficient legislative support on this issue in the state government due to the state’s divided political landscape as well as its strong conservative religious and cultural influences. These projected outcomes include incorporating provisions such as increased STI education, equal protection clauses, and comprehensive education such as abstinence and evidenced-based birth control methods into the law. By incorporating these progressive changes into the law, we will facilitate support from Kentucky’s legislature.

**Strategies for Implementation 6:** We will focus our efforts on three main implementation goals. First, we will educate legislators about the policy’s socioeconomic benefits through fact-based presentations. Our goal is to have fifty percent legislative support by April 2016. We will garner the remaining support by January 2017 when the legislature reconvenes. Beyond educating legislators, we will also educate the community on the importance of addressing the issue of teen pregnancy and how Policy TEN will implement solutions within the community and we will empower them to address these issues with their current government through education on the issue of teen pregnancy. There will also be education given to providers in order for them to become more equipped in providing comprehensive and effective care to our target population, as discussed in Educating Providers. If Policy TEN is successfully passed, we anticipate a decrease of teen pregnancy rates in Kentucky.

**Proposed Measures for Future Evaluation of Policy TEN**

Two aspects of survey data will be used to evaluate the effectiveness of the change in provider education. First, existing and graduating providers, who work with adolescents, will identify aspects of their patient teaching including whether they spend time discussing reproductive health, contraceptive strategies, abstinence, and family planning. Secondly, survey questions will address the patients receiving this knowledge in order to determine the accuracy of their contraceptive knowledge.

To evaluate the reach and demographics of Policy TEN, we will gather information on:

1. The number of medical, nursing, and other allied health schools in Kentucky that have incorporated preventative sexual education into curriculums,
2. The percentage of adolescents surveyed who reported that their provider spoke to them about reproductive health, and

3. Percentage of teens who reported choosing to abstain or use contraception as a result of a discussion with their health care provider.

By seeking to improve reproductive health and family planning services among low-income families, Title X will help decrease the number of unintended pregnancies among adolescents. Policy TEN's strategies include coordinating changes in educational practices for both providers and individuals, as well as encouraging access and motivation to seek healthcare at Title X institutions. These strategies can be implemented by fostering the ties between the public school network, the network of community providers that offer family planning and contraceptive services, and the number of Title X funded clinics. We will evaluate this by comparing the rates of adolescent pregnancy before and after implementation in order to determine if there is an increase in the numbers of patients seeking care at Title X funded clinics, and if there is a decreasing cost for results (below medical inflation rates). The implementation of Policy TEN will increase the effectiveness of many educational programs that target at-risk populations; transparency of health services will be increased in the anticipation that the rate of teenage pregnancy will decrease.

To evaluate the community sex education program’s efficacy, the education sessions will incorporate a quiz to evaluate the understanding of the material covered. The results of these evaluations will be used to tailor the sessions to better suit the population in Kentucky. Furthermore, the number of visits to the pregnancy crisis centers and family planning centers will be counted and the cost of these visits will be compared to the cost spent on Title X funding over a period of 10 years. The most important evaluation tool will be the statistics related to the number of teen pregnancies five years after the increase in Title X funding. This will be the diagnostic tool in identifying the effectiveness of Policy TEN post implementation of the new sexual education curriculum.

From a legislative standpoint, future evaluation should be based on the amount of funding that Title X receives in the following legislative budgets. The intended outcome will be to increase funding of Title X by $10 million nationally, last fiscal year's increase was $8.2 million nationally. Part of the Title X allocation breakdown will require funds for this evaluation process. While this sum is taken away from the direct implementation of the policy, it will indirectly serve as an investment towards efficient spending in years to come. Factors that need to accounted for in the evaluation budget include: Personnel - hiring process, and the number of workers who will participate in data collection, Travel - Costs associated with reaching out to schools, facilities, and Equipment and supplies - Computers for data collection and analysis, paper supplies for questionnaires and surveys. Other aspects of evaluation require quality training of data collectors, data entry and report write-ups, and consulting of research experts.
Conclusion

In conclusion, Policy TEN is both an efficient and cost-effective model to reduce teen pregnancy rates and provide comprehensive sexual education in Kentucky. Not only does it provide an extensive plan of action that addresses the higher-than-national-average teenage pregnancy rate, but it also includes aspects of patient, provider, and community knowledge, as well as organizational and policy changes. By increasing Title X funding, Policy TEN would provide much needed services such as family planning, intensive training for health care providers and funding to open more clinics statewide. Policy TEN will also open up opportunities to create a standardized sexual education curriculum focused on evidence-based preventative measures, while building on abstinence and providing more options and awareness for teens and the community on sexual health. These organizational changes will further decrease barriers to healthy sexual practices within the adolescent population, while provisions in the policy will make it more likely to be accepted by legislators. Endorsement of Policy TEN is the next step in a new future for Kentucky.

References


