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Arizona, Teen Pregnancy and the Role of CHCs

Teen pregnancy has always been a problem of significance in the United States. Although the teen birth rate fell 30% from 1991 to 2005, [12] the US has the highest rate of any industrialized country - ten times that of Switzerland. [13] However, there exist large gaps between our 50 states. Arizona, in particular, is home to a rather unique environment and demographic that allows for a high rate of teen births. Phoenix Union High School District alone boasts a 14% rate - the highest documented in the country. [14] Needless to say, there are many negative individual and societal consequences associated with adolescent parenthood, and a solid model of prevention is a pressing need. What are some of the causal factors that influence such differences between states in the same country? And what role could community health centers (CHCs) play in keeping America's teenagers young? In this paper, I hope to set the stage by explaining the history and environment of Arizona, define the purpose and goals of CHCs and explore the problem of teenage pregnancy in hopes of shedding light on how both state and healthcare organization can interact to keep their young people healthy.

To begin, I'd like to give a brief history lesson, which I believe has been crucial in shaping the politics, mindsets and populations that make up the state of Arizona.

One of the several things making Arizona unique as a state is its American Indian presence. Prior to any European or Mexican takeover, several tribes (including the Pima, Papago, Hopi, Navajo and Apache) called Arizona home. In the middle of the

16th century, Francisco Coronado of Spain found his way into the region, and Arizona became a Spanish colony complete with military posts and Roman Catholic missions. [3] Although Mexico gained military control of the state in 1821, after a defeating Mexican War and the Gadsden Purchase, the US took over Arizona. Over the next 20 years, trade flourished, and the onset of the California Gold Rush brought tens of thousands of miners and their families across the region leading to explosive growth in Arizona's population. [1] Towns sprung up across the state, and mining soon became a major driving force behind the economy with southern Arizona's copper smelters and the arrival of railroads making huge profits for the region.

As expected, there was much conflict throughout this time between American Indian tribes who originally lived in the state and new settlers from Spain, Mexico and other parts of the United States. A series of Indian Wars ended in the late 1800s with the surrender of the Apache Indians, which placed almost all of the American Indians in the region on reservations. [3] As a result, Arizona has the highest proportion of its land designated as American Indian tribal land in the US. [2] Also in the late 19th century, droves of Mormons from Utah founded several communities both in northern Arizona and the east valley, setting the stage for future political influence. [1]

With the reduced threat of Indian raids and the arrival of railroads, ranching and farming exploded in Arizona as farmers planted citrus groves and cotton fields all over the rural landscape, making these two huge contributors to the state's economy. Central Arizona, in particular, would become distinct for its large cotton farming operation set up by Paul Litchfield, an executive at Goodyear Tire and Rubber Company, in what are now the west valley cities of Avondale, Litchfield Park and Goodyear. [4]

A few other pieces of Arizona's history are of notable relevance to bring us up to the current day. Firstly, post World War II, Arizona experienced another period of booming growth causing the transformation of its once-expansive citrus groves into miles of housing developments. Retirement residents and manufacturing employers came to the state in droves, making two very different communities (ethnically and situationally) instant neighbors. [1]

Secondly and most recently, Arizona legislators passed several controversial bills that turned many heads after finding their way into the mass media. Under the first bill, HB2625, women wanting their contraception covered by employers must submit proof of a medical condition (i.e. PCOS) requiring treatment with birth control. Employers have the go ahead, in the name of religious freedom, to fire any woman upon discovering that she used contraception to prevent pregnancy. [5] In addition, Arizona has criminalized abortions after 20 weeks - with very little exception for medical emergencies - and allows physicians to withhold information from a woman that could potentially lead her to choose abortion. [6] On top of reproductive rights, immigration has come into Arizona's political arena. Under SB1070, law enforcement may detain a person and ask to see documentation if they find any "reasonable suspicion" that the person is an illegal immigrant. [7] In a state comprised largely of Latino citizens and immigrants, this has clearly created a source of major conflict.

Now that the environment in which I've been working has been pieced together, I'd like to move forward and introduce the idea of community health and the CHC model and then focus specifically on Adelante - the CHC I've been lucky enough to work with this summer in Arizona.

By definition, community health centers are non-profit organizations designed to deliver primary care to, and serve the unique needs of, underserved populations with a particular focus on reducing chronic disease, infant mortality rates and health disparities, improving overall health outcomes and empowering communities through the creation of jobs and personal investment at a local level. In addition, CHCs play an important role - particularly during difficult economic times - in reducing the expenditures of the healthcare system as a whole (via a reduced need for hospital and specialty care) and in providing affordable health services to many. [8] This provision of affordable care transitions the traditional safety net of the unemployed and uninsured from emergency rooms in poor, urban regions of the country to CHCs, effectively saving the country about \$15 billion per year. [19]

What enables CHCs to meet these goals and play this incredibly needed cost-saving role is their organization. As the current model for primary care federal grant funding, CHCs are required to operate under certain standards that designate them as federally qualified health centers (FQHCs). This designation allows them special payment rates under Medicaid, Medicare and CHIP. [9] These rates are more closely matched to the actual cost of care to providers and clinics (vs. normal reimbursement, which falls far below the actual cost of services), and thus, serve as an incentive for physicians and other healthcare providers to invest in the CHC model of care. In addition, malpractice coverage is free under the Federal Tort Claims Act (FTCA) for physicians working in FQHC - further incentive for investment. [19]

Previously mentioned federal standards ensure that each CHC remains focused on underserved populations and in tune with the needs of the community that they

serve. For example, to maintain FQHC designation and federal grant funds, CHCs must “be located in a federally designated medically underserved area (MUA) or serve medically underserved populations (MUP).” [9] They must provide comprehensive primary care and continually adjust care fees based on patient income and a sliding fee scale. In addition, the governing board of each CHC must be made up of at least 51% patients. [9] An additional focus of CHCs that isn’t explicitly written but enables the continued wellness and trust of their communities is the integration of various services and collaboration with local companies and other resources - for example, consolidating primary care, dental and women’s health, counseling, health education, WIC nutrition services, case management and substance abuse interventions. [9]

One of the primary CHCs in Arizona is Adelante Healthcare. Comprised of seven healthcare delivery sites and one Center Support Office, Adelante serves a large portion of Maricopa County (which includes the city of Phoenix) - one of the largest counties in the United States. [10] Services that they provide include family, internal and pediatric medicine, immunizations, WIC nutrition education, dental and Ob/Gyn care.

As a FQHC, Adelante must follow the guidelines set up for CHCs in order to continue receiving federal funding. This includes having over half of their governing board made up of patients that they serve. One such member is Adalberto “Al” Jimenez. A former migrant farm worker, Al picked melon on land that lies just outside Adelante’s Center Support Office in Avondale. After observing the poor health conditions and lack of care available to workers, Al joined Cesar Chavez (and the UFW) as an advocate of migrant workers’ rights. [10] In the late 1970s, he helped establish Clinica Adelante, a part-time clinic staffed by volunteers and the first of its kind dedicated specifically to

caring for migrant workers in Arizona. [11]

Currently, Adelante serves about 30,000 of the almost 700,00 underserved residents of Maricopa county and is currently aiming to increase that number substantially over the next few years. Of the patients being seen, about 75% live below the federal poverty level, and of those, 89% live below 200% of the FPL. 4.8% are migrant farm workers, 52% are covered by AHCCCS (Arizona's form of Medicaid) and 22% are uninsured. Ethnically speaking, Adelante serves about 52% Latino patients, 29% Caucasian and 4.6% African-American, which is a relatively accurate representation of the service area's population (also a federal grant requirement). [19]

I'd now like to switch gears one more time and talk a little bit about teen pregnancy, how it affects the nation (and, more specifically, Arizona) and what role CHCs have in its prevention.

As mentioned earlier, teen birth rates declined by 30% from 1991 to 2005. After a slight increase, rates have again declined - albeit, more slowly - since 2010. [12]

Although this relatively steady decline in teen pregnancy is promising, the US still holds the highest rates of any industrialized nation, which is worrisome for several reasons. [13] Aside from the negative individual consequences - which I will address in a moment - there has been serious societal consequence associated with adolescent parenthood. In 2008, the US spent \$10.9 billion in teen-pregnancy-related costs, which covered things like public healthcare (i.e. Medicaid), welfare, lost taxes (via the lost earnings of unemployed teenagers) and higher rates of incarceration. [12] Given the state of the economy and budget cuts being made across the states, it seems this financial burden would be pressing reason enough to focus significant attention on prevention.

For those that are unconvinced, there are also serious consequences both for teenage parents and their children - all of which indirectly affect the economy and country as a whole. Teen mothers are more at risk for substance abuse, low self-esteem and depression, less educational achievement and intimate partner violence (both as perpetrator and victim) - all of which are linked. [12] Children of adolescent mothers are more at risk for neglect, abuse and lower school readiness (lower language, reading, math skills). [14] Unfortunately, the negative associations don't end there. As young adults, these children are also more likely to become teen parents themselves, have lower educational achievement, lower income levels and have disproportionately higher rates of prison time and mental illness/substance abuse. [12] Although traditionally attributed to solely to young parenthood, newer research shows that these negative associations are more likely due to socioeconomic environment than maternal age.

When other factors are controlled for, one of the strongest predictors of teen pregnancy is poverty, which may also help explain the different state-by-state rates in the US. [15] Another factor found to be influential in these differences is state-specific policies related to contraception access, abortion and sexual education. Even still, more conservative and religious states had higher rates of teen births even with sex education programs in place. [15]

So how do all these things relate specifically to Arizona? First off, Arizona's teen birth rate is three times that of the national benchmark, and their Latino population is double that of the national benchmark. [16] Why is that relevant? Unfortunately, recent research has found a growing Latino population to be a main driving force of an increased teen birth rate, and Arizona's population is about one third Latino. [15] Other

causes? The reproductive rights policies discussed earlier could well be a factor, limiting already tight access to contraception and abortions for young girls. In addition, the number of children living in poverty and the unemployment rate in Arizona are both double the national benchmark. Because poverty has been found to be a strong risk factor for teen pregnancy, these are likely some of the main driving forces behind the state's high teen birth rates. [16]

How has this manifested in Arizona society? Well, the financial burden it has imposed echoes that of the country. In 2008, teen pregnancy costed Arizona taxpayers about \$303 million with expenses channeled towards the same areas mentioned above (public healthcare, welfare, incarceration, etc.). [17] We also see negative effects on the education levels of Arizona's young people. Phoenix Union High School District has only a 45% graduation rate as of this year, and teen pregnancy has long been cited as one of the main reasons young girls drop out of school. [14] About one third of girls that leave high school cite pregnancy as their chief reason, and only 40% of teen mothers finish high school. [14]

To avoid belaboring the point, what we see here is a positive feedback cycle that has found an initiation point in the specific political and demographic landscape that makes up Arizona. A conservative, access-restrictive (in terms of healthcare and contraception) state with a high unemployment and poverty rate made up largely of Latino residents has all the risk factors for turning out a disproportionately large number of teen mothers. In turn, these young girls are less educated, generate less revenue for the economy and themselves and have children who are also more likely to be less educated, generate less revenue and become teen parents themselves - thus, beginning

the cycle once more. Clearly, this is a generalized, blanket statement and not applicable to all teen parents, but unfortunately, it's the cycle that Arizona faces in attempts to come up with a positive prevention model that has decent efficacy.

And what does a successful prevention program look like? The answer to that is still up for debate. Although past programs have focused mainly on delaying first sexual contact and increasing contraceptive awareness and use among young people, the success of these efforts has been mixed. [12] Instead, newer studies call for more comprehensive programs with components channeled through several delivery sites - individual homes, communities, schools and clinics. Broader goals include improvement of the social and economic factors that influence low maternal age with particular focus on increasing educational attainment, preventing repeat pregnancy and improving mother-child interactions. [12] On top of that, simply encouraging parents to talk to their adolescents openly about sex has been found to be extremely beneficial. Across several races/ethnicities (Caucasians, Latinos, African-Americans), equal numbers of teens agreed that their parents most influenced their decisions about sex, and overwhelming reports show that more conversations between young people and their parents is a protective factor against teen parenthood. [18]

To delve a little more deeply into these ideas, we can look at each delivery site and what area each most effectively reaches. Home-based programs would ideally deliver care in a comfortable, convenient environment for young women. Interventions would involve one-on-one contact and be flexible schedule-wise, making for a very individualized and personal mode of care. Motivational interviewing, tutoring and strategy-teaching could help improve educational attainment, repeat pregnancies and

parental attitudes. Additionally, there would be a focus on improving maternal sensitivity as teens tend to exhibit less sensitivity to their babies' cues than older mothers. [12] Similarly, community-based programs would also take place in familiar environments adding that same comfort element for young women - the difference lying in the involvement of group programs/meetings. The benefit here would be in establishing a culturally sensitive peer support system for young people among each other and creating a sense of camaraderie. [12]

In comparison, school-based programs would focus largely on higher educational achievement for young women and mothers, which would theoretically improve parenting on several levels (including better development of children). In addition, child care services and curriculum geared towards relevant issues for teens that are already parents (i.e. personal relationships, parenting, career building) has been shown to increase school attendance and GPA. [12] The downfall here is that this curriculum would miss the large number of girls who do drop out of school.

Clinic-based "teen tot programs" have also been reviewed and are arguably one of the most important legs of care as the medical home for both mom and baby. Integration of care would go beyond simple medicine and include things like social services, parenting classes, mental health support and a social component to help connect young moms. [12] For teens that have not yet become pregnant, this model has also shown efficacy in bringing about awareness and shedding light on the unrealized realities of what adolescent parenthood means. [12]

Programs that connect multiple modes of delivery as explained above have been found to significantly affect the lives of teen mothers - increasing employment,

independent living and contraception use, effectively decreasing repeat pregnancies.

[12] These improvements in social and economic situation would effectively stop the cycle as teen moms are better able to provide financial and emotional/mental support for their children, and children are able to more successfully develop themselves cognitively and socially. Advancements on these levels would create an outlet for this positive feedback cycles and channel children of teen parents towards productive lives in society and away from teen parenthood themselves.

Unfortunately, my time frame of 5 weeks for this summer was much too short to both understand fully the organization/environment I was working in and to enact a program like the one described above. I did manage to come to a solid understanding of the organization and working environment needed to run a CHC, as well as a good look at what the demographics of Arizona means in terms of a clinical picture - i.e. which patients seek care, what they need, etc. In terms of a project, the consensus about primary needs relating to teen pregnancy was that something relating to prevention would be most helpful. We decided the best use of my time would be spent creating a poster that would go up in Adelante's primary care clinics for young girls/women and their parents to see prior to any pregnancies. The following page includes a copy of the poster (sans final formatting), and as you can see, exhibits three key realities about teen parenthood in an attempt to make these very real issues relevant to young girls and their ideas about their futures.

In conclusion, it's been a fulfilling summer, and I feel privileged to have gotten to be in the lives of several patients whose realities include everything I've just written about. Teen pregnancy is more complicated and intricate than I could have ever imagine

and I think to many people's surprise, involves so much more than expanding sex ed programs in high schools. Young parenthood has deep cultural and social roots that would be best affected by passionate policy makers and legislators at a state and federal level. But as that process is often a slow and painful one, community health centers can take up the front lines of prevention with funding help from state and federal governments that have prioritized the health of their young people as a top concern. Never has bringing nurses, social workers, mentors, physicians and healthcare itself into the homes and schools of one's community made so much sense.

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WHY YOU SHOULD WAIT

The National Campaign to Prevent Teen and Unplanned Pregnancy says that “preventing teen pregnancy is the most effective way to reduce poverty and improve overall child well-being.”

HERE'S WHY:

- ◆ Only 40% of teen moms finish high school, and less than 2% finish college by age 30.

(A college graduate makes about \$1 million more than a high school dropout over his/her lifetime.)

THE BOTTOM LINE: Education > Career > Financial Freedom

- ◆ It costs about \$200,000 to raise a child to age 18, not including school and college tuition.

THE BOTTOM LINE: Babies are very expensive, even with just the basics.

- ◆ Research shows that children of teen moms start school with lower math, reading and language skills and don't do as well overall as other children.

THE BOTTOM LINE: *You are your baby's role model.* The more educated and grown up you are, the better chance you give your child to succeed in life.

Enjoy being young, learning about yourself, exploring life's opportunities and

wait to get pregnant.

Ask your doctor about birth control, and to read more info, visit

www.thenationalcampaign.org