Teen Options to Prevent Pregnancy (TOPP)

A Program Using Motivational Interviewing to Guide Teens in Choosing Birth Control Methods

A Manual for Clinicians

OhioHealth
BELIEVE IN *WE*™

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The TOPP program was made possible by Grant Number 90AP2668 from the Department of Health and Human Services, Administration for Children and Families. Its contents are solely the responsibility of OhioHealth and do not necessarily represent the official views of the Department of Health and Human Services, Administration for Children and Families.

Acknowledgments

The Teen Options to Prevent Pregnancy Team would like to thank the following:

The Family and Youth Services Bureau
Itege Bailey, Project Officer

Mathematica Policy Research
Alicia Meckstroth's Congressional Implementation Report and Kim Smith's Interim Report were used in the creation of this toolkit

Nationwide Children's Hospital
Jack Stevens, PhD., Local Evaluator, Dr. Patricia Litts MD, Mitzi Moody LISW-S, Molly Spanger, RN, BSN, Mica McCord, RN,BSN, Sonia Booker, RN, MSN and the Community Health and Wellness Department of OhioHealth

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Introduction

Introduction

Although teen birth rates in the United States have been on the decline in recent years, they are still the highest in the industrialized world (United Nations 2011). One in six young women give birth before their twentieth birthday and one in five goes on to have a second child as a teenager (Martinez et al, 2011; Centers for Disease Control and Prevention 2013). Becoming a teen mother is linked with negative outcomes for both mother and child. For example, teen mothers are more likely than older mothers to have a preterm delivery, receive welfare, and have children with emotional and behavioral problems (Hoffman 2008). Outcomes are even worse when a teen mother has more than one child, especially if a second child comes soon after the first. Teen mothers who experience rapid repeat pregnancies (within 18 months of the prior birth) are less likely to receive prenatal care and more likely to experience a stillbirth, a preterm birth, or a child with a low birth weight (Conde- Agudelo et al 2006). They are also less likely to stay in or complete school, work or maintain economic self sufficiency, and have children that exhibit school readiness when older (Klerman 2004). Adolescent mothers have the highest risk of a closely spaced repeat pregnancy (Copen et al. 2015). More than one in three recently pregnant teens experience a repeat pregnancy within two years of a previous birth or abortion (Baldwin et al 2013). The majority of these pregnancies are reported as unintended, with about half ending in births (Mosher et al. 2012). Although most teenagers at risk of unintended pregnancy report using a contraceptive method (roughly 80 percent), they rarely select the most effective methods. Adolescents most commonly use methods with relatively high typical use failure rates, such as condoms, withdrawal, and birth control pills. Less than five percent of women ages 15 to 19 who are currently using a modern contraceptive method use a long-acting reversible contraceptive (LARC) method — either intrauterine devices (IUDs) or the contraceptive implant — which have the highest continuation rates and lowest pregnancy rates among reversible birth control methods (American College of Obstetricians and Gynecologists (ACOG) 2012). Reported barriers to LARC use by adolescents include a lack of familiarity with or misperceptions about the methods, high upfront financial costs of insertion, and lack of access to healthcare providers (Fleming et al. 2010; Spies et al. 2010).

In 2010, health professionals affiliated with the OhioHealth in central Ohio developed the Teen Options to Prevent Pregnancy (TOPP) program in response to high repeat teen birth rates and low family planning utilization rates among teens in the Columbus area (Center for Disease and Control Prevention 2013; Ohio Department of Health 2007, 2010). The program was funded through the Personal Responsibility Education Innovative Strategies grant program with the Administration on Children, Youth and Families U.S. Department of Health and Human Services.

TOPP's goal is to reduce rapid repeat teen pregnancies and promote healthy birth spacing through telephone and home-based care coordination that encompasses motivational interviewing and access to family planning and other services. The services are delivered by nurse educators and a program social worker over an 18 month period. The core component of TOPP— motivational interviewing — is delivered by trained nurse educators. Motivational interviewing is an individualized, client driven, collaborative and non-confrontational form of communication aimed at promoting individual change (Barnet et al 2009; Hettema et al 2005). In the case of TOPP, the individual change refers to the process of teen mothers learning about birth control options, selecting their own method of birth control, and making contraceptive decisions that promote healthy birth spacing and prevent unintended pregnancies.

In addition to motivational interviewing, TOPP provides personalized access to contraception (via transportation to clinics or hospitals, home and community visits, or a TOPP clinic) and referrals by a social worker to additional services as needed. The program targets young women between the ages of 10 and 19 who are pregnant (at least 28 weeks into their pregnancy) or have given birth (up to eight weeks postpartum) and who are on Medicaid or eligible for it. Participants were recruited from twelve OhioHealth care sites (five hospitals and seven clinics) at the time of their prenatal appointments, the birth of their baby, or during their postpartum visit.

Logic Model

Pedagogy/ Enabling Factors	Implementation	Interim Goals	Long-Term Goals
Effective use of Motivational Interviewing during every patient interaction + OARS, Spirit of MI, Change talk, The Four Processes	MI training and follow up with coaching so that RN can facilitate MI based conversation	Increased use of Contraception	Reduction of Rapid Repeat Teen Pregnancy
Personalized Access + Transportation available if needed	One-on-one sessions/home visitation in order to assist patient in achieving birth control goals	Increased use of Long Acting Reversible Contraceptives (LARC)	Reduction of Rapid Repeat teen Births
At least 12 monthly phone calls/ home visits + 18 months is preferred	Social Worker or RN –led referrals to community resources as needed. Familiarity and systems in place to assist with health care/health insurance enrollment as needed.	Increased Adherence to Contraceptive Regimens	
Edinburgh Postnatal Depression Scale (EPDS)	RN as nurse educator (experience in Women's Health preferred)		
Abuse Assessment Screen and HITS modified for adolescents	System in place to assist with transportation: program van, bus passes, or cab passes		
Ask client pros and cons of birth control	Create a relationship with a licensed healthcare provider who provides LARCs or hire a provider and establish a clinic.		
Content	Home delivery of Depo		
Efficacy- based contraceptive counseling- Use Guttmacher Chart to show most effective to least effective	Birth control sample bags		
STI protection and dual protection	ETR Contraceptive Educational Brochure Nurse educator Flow Sheet in Attachments		
Birth Spacing (18 months from birth to conception)			
Common myths about birth control			

Theory

The intervention draws on the Behavioral Model of Health Service Use which suggests that contraceptive behavior will be changed by altering a woman's perspective of her need for birth control and providing her easy access to it. *(Babitch et al. 2012; Andersen 1995).*

Anderson's Behavioral Health Use Model incorporates both individual and contextual determinants of health. Anderson describes three main components which determine health services use:

Predisposing Factors — in this case the predisposing factors are teen mothers who are from underserved areas whose attitudes and beliefs are influenced by their access to care, as well as their perceived need for care.

Enabling Factors — in this case the behavior change will occur due to Medicaid coverage of birth control, transportation services, and the nurses' use of motivational interviewing to provide education in regard to birth spacing. This enabling factor will heighten the awareness of the teen mother's understanding of her need for available forms of birth control. Referrals to social support services are delivered by nurse educators and a social worker to program participants over an 18-month period.

Need Factors — In this case, population health indices regarding birth spacing and its relationship to prematurity and low birth weight infants (Babitsch et al. 2012; Andersen 1995). Additionally, prematurity and low birth rate infants are the leading cause of infant mortality in our nation.

Teen Options to Prevent Pregnancy (TOPP) Program and Evaluation — A Snapshot

+ **TOPP aims to** prevent rapid repeat pregnancy (a pregnancy that occurs within 18 months of a prior birth) and thereby promote healthy birth spacing.
+ **Part of the national multiyear Evaluation of Adolescent Pregnancy Prevention Approaches:**
  - Funded by the Office of Adolescent Health, U.S. Department of Health and Human Services
  - Conducted by Mathematica Policy Research, with Child Trends and Twin Peaks Partners
  - Assessing effectiveness of seven programs

+ **Served 297 low-income female adolescents ages 10 to 19 who were at least 28 weeks pregnant or up to eight weeks postpartum at time of enrollment:**
  - Recruited from 12 OhioHealth care sites (five hospitals and seven clinics) in the Columbus area
  - Rolling enrollment from October 2011 to January 2014
+ **Three components:**
  - Telephone-based, one-on-one motivational interviewing sessions with a trained nurse educator
  - Access to contraception via transportation to clinics/hospitals, in-person visits from a TOPP nurse educator, or services at a TOPP clinic
  - Access to a TOPP social worker to screen for risk factors (e.g., domestic violence or depression) and provide service and resource referrals as needed
+ **Topics commonly covered:** Importance of birth spacing and preventing rapid repeat pregnancy; birth control methods (ranging from abstinence to long-acting reversible methods); misconceptions that inhibit contraceptive use; future planning for achieving birth control and birth spacing goals.
+ **Program impacts measured by three follow-up surveys:** Six months, 18 months (upon program completion) and 30 months (12 months after program completion) after enrollment.

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Pedagogy and Enabling Factors

Telephone-Based Care Coordination Using Motivational Interviewing

Definition

What is motivational interviewing (MI)? A collaborative, person-centered form of guiding to elicit and strengthen motivation to change. According to William Miller and Stephen Rollnick, there are three definitions of MI. The 'Layperson's' definition of MI is "a collaborative conversation style for strengthening a person's own motivation and commitment to change." The 'Practitioner's' definition is "a person-centered counseling style for addressing the common problem of ambivalence about change." The 'Technical' definition is defined as "a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion" (Miller and Rollnick, 2013, p. 29). Though we focus on change talk and sustain talk, the tone of MI is nonjudgmental, empathetic and encouraging. It provides a supportive environment where clients feel comfortable expressing both positive and negative aspects of their behaviors (Resnicow, Davis, & Rollnick, 2006). The four processes of MI include engaging, focusing, evoking and planning. To understand MI you must understand the spirit of MI. The spirit includes creating a partnership, acceptance, compassion and evocation.

Why Use MI?

MI is a proven way to help people change or adopt a new behavior; the 'Spirit' of MI teaches the provider to honor and respect the patient, because ultimately it is the patient's decision. MI teaches the provider about the 'righting reflex' (the desire to fix what seems wrong with people and to set them promptly on a better course, relying in particular on directing (Miller and Rollnick, 2013, p. 6)) and how important it is to avoid that when seeking behavioral change. Using MI emphasizes the patient's personal choice and control regarding their behavioral change and it teaches a way of communicating with the patient that shows a clear understanding of what the patient is expressing. It allows the provider relief of responsibility for the choices the patient makes. This counseling technique is patient-focused and allows them to tell their story while reminding providers that this a human being. As a provider, it can be hard to refrain from telling them what they should do. So, MI sees the patient as the world's expert on their self while developing a collaborative working relationship with the patient. It is much more productive and effective to have the patient talk themselves into changing as opposed to the provider talking them into changing. Importantly, MI teaches the provider how to guide an interaction while keeping the patient free and in charge, and how to give needed information in the most understandable way possible. In conclusion, MI helps the provider not 'wrestle' with the patient — the metaphor in MI is 'dancing'.

How to choose an MI trainer

Highly desired qualifications include choosing a trainer that is a member of the MINT (Motivational Interviewing Network of Trainers) organization, which is an international organization of trainers in motivational interviewing. In addition to being a MINT trainer, he or she should provide a record of references. An MI trainer should also be up-to-date on the latest motivational interviewing standards of practice, including the teaching from the third edition MI book, entitled Motivational Interviewing: Helping People Change. The trainer should also be able to provide options for follow-up coaching and training for the trainees. They will use both MI in their work with clients and during the training, as well as setting an agenda with goals and objectives of training for evaluation by the facility. Using a variety of training methods, such as videos, role/real plays, demonstrations and PowerPoint presentations, are specifically — helpful as well as offering cheat sheets and basic guides for handouts. The role/real plays in conjunction with offering a variety of activities and exercises to involve the learner in actual practice of the skills being trained are extremely beneficial to the trainees. Thus, choosing an MI trainer with the qualities listed above are of utmost importance when searching for a MI trainer.

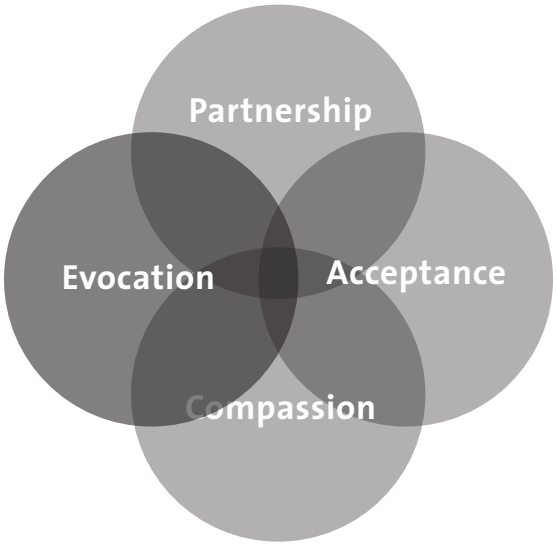
Coaching and the use of MITI

Motivational interviewing is the counseling technique used by the TOPP nurse educators with all participants in the treatment group. Generally, a two-day training covering the 'SPIRIT', OARS (Open-ended questions, Affirmations, Reflections and Summarizations), the four processes, dealing with sustain talk and discord will cover the basics of motivational interviewing. All TOPP staff attended a two-day workshop at the beginning of the study and attended ongoing biweekly trainings conducted by a Motivational Interviewing National Trainer (MINT). Research is showing that continuous evaluation beyond the two day training will help to integrate MI into your practice. MI sessions were conducted in person or over the telephone. TOPP nurse educators were audio taped during each conversation and evaluated using the Motivational Interviewing Treatment Integrity (MITI) form. The MITI is a behavioral coding system that is used to rate how well the practitioner is using motivational interviewing. It is used as a treatment integrity measure and as a means of providing feedback. Global scores and behavior counts are the two components of the MITI. A global score requires the coder to assign a single number on a five-point (one is lowest and five is the highest) scale to characterize the entire interaction. This is meant to capture the rater's global impression or overall judgment about the dimensions (Evocation, Collaboration, Autonomy/ Support, Direction, and Empathy). Thus, each MITI review will contain five global scores. The behavior count requires the coder to tally instances of particular interviewer behaviors. The coder simply counts without requirement to judge the quality or adequacy of the event. In order to score a session, a randomly selected, 20-minute interaction must be used. The MITI is not designed to be used for interventions in which a target behavior cannot be identified (Moyers, Martin, Manuel, Miller, Ernst, 2010).

The Four Processes

1. Engaging
2. Focusing
3. Evoking
4. Planning

The Spirit of MI



O	**Open-ended questions**
A	**Affirmations**
R	**Reflections**
S	**Summaries**

3 Curriculum

The Use of Long Acting Reversible Contraceptives in Teens

Curriculum Content — Efficacy-Based Contraceptive Counseling:

Healthy birth spacing has been found by the evidence to be an important aspect of reproductive education.

The following statements contain important findings to convey to patients and caregivers.

"Interpregnancy intervals shorter than 18 months and longer than 59 months are significantly associated with increased risk of adverse perinatal outcomes" (Conde-Agudelo A, JAMA. 2006, 295: 1809–1823).

The American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG) recommend counseling women about birth spacing and contraceptive use during pregnancy.

ACOG, the Committee Opinion on Intrauterine Device and Adolescents concluded that "because adolescents contribute disproportionately to the epidemic of unintended pregnancy in this country, top tier methods of contraception, including IUDs and implants, should be considered as first-lined choices for both nulliparous and parous adolescents. After thorough counseling regarding contraception options, healthcare providers should strongly encourage young women who are appropriate candidates to use this method."

Contraception

Also important, is to ensure that the most current educational books, tools and webinars are utilized by nurse educators throughout study ('Contraceptive Technology' 21st ed. (ISBN # 978-1-59708-005-7).

Using brochures provided by ETR associates (etr.org/pub), T.O.P.P nurses counseled patients with knowledge gained from the sources above. The Contraceptive Choice Study at Washington University reported that an important concept in educating patients is to start with the most effective method and then go to the least effective method, including abstinence.
See Guttmacher Chart on next page.

Guttmacher Chart

To enable efficacy based education, please use Guttmacher Chart to present options from most effective to least effective.

Contraceptive Effectiveness

Proportion of women who will become pregnant over one year of use, by method:

METHOD	PERFECT USE	TYPICAL USE
Implant	0.05	0.05
Vasectomy (male sterilization)	0.10	0.15
• Intrauterine device (IUD)		
• Levonorgestrel-releasing	0.2	0.2
Copper-T	0.6	0.8
Tubal (female) sterilization	0.5	0.5
Injectable	0.2	6
Pill	0.3	9
Vaginal ring	0. 3	9
Patch	0.3	9
Diaphragm	6	12
Sponge**	9/20	12/24
Male condom	2	18
Female condom	5	21
Withdrawal	4	22
Fertility awareness methods***	0.4–5	24
Spermicides	18	28
Emergency contraception	*	*
No method	85	85

Notes: "Perfect use" denotes effectiveness among couples who use the method both consistently and correctly; "typical use" refers to effectiveness experienced among all couples who use the method (including inconsistent and incorrect use). *The effectiveness of emergency contraception (EC) is not measured on a one-year basis like other methods. EC is estimated to reduce the incidence of pregnancy by approximately 90 percent when used to prevent pregnancy after one instance of unprotected sex. **For sponge, first figure is for women who have not given birth while the second if for women who have given birth. ***Includes cervical mucus methods, body temperature methods and periodic abstinence (guttmacher.org).

Proceed with the following concepts in mind as you guide the participant in determining the contraceptive that will meet her specific needs and desires.

Clinical Pharmacology — How does it work?

List each from ETR brochure. (We also listed effectiveness, strong points and weak points from the ETR brochure — "Birth Control Facts.")

+ **Pharmacokenetics —** for staff who knows common side effects, efficacy, adverse events, dosing and medication safety. Also use U.S. Medical Eligibility criteria Wheel or Chart provided by CDC.
+ **Strong/Weak Points —** assess from patient's perspective first, and then present as described: From most effective to least effective.
+ Appendix A has nurse educator flow sheet to guide this process.

Our list of contraceptive options:

+ **Abstinence —** The only 100 % effective method to protect against pregnancy, sexually transmitted infections (STIs) and human immunodeficiency virus (HIV).

Subdermal Implant (Nexplanon®)

+ **Pharmacology —** How it works: Small rod placed under the skin by a healthcare provider. Rod slowly releases a hormone called etonogestrel which stops the ovaries from releasing an egg each month. It also thins the lining of the uterus while thickening the mucus in the cervix/opening to the uterus which makes it difficult for sperm to enter.
+ **Effectiveness —** more than 99 percent.
+ **Strong Points —** will keep working for three years if you want to keep it in for that long. It will stay in place and it does not interfere with sex.
+ **Weak Points —** may have some spotting between periods or have irregular periods (lighter, longer or no period at all). Need minor surgery to remove rod. No protection from STIs, including HIV.

Common Myths verbalized by participants

+ **Subdermal Implant**
  - "It will move to my heart"
  - "It looks gross in my arm"
  - "It will make me fat"
  - "It will explode in my arm"

Important to Inform regarding breastfeeding:

"The World Health Organization (WHO) and the CDC find that it is acceptable to place either Nexplanon or the Levonorgestrel IUD in postpartum women with minimal impact on breastfeeding" (Gurtcheff SE, Turok DK, Stoddard G, Et al., 1114-21).

Copper-T IUD (Paragard®/"10 year IUD")

+ **Pharmacology —** How it works: Device is placed inside the uterus by a healthcare provider, which contains Copper-T. The copper kills the sperm which prevents it from fertilizing an egg.
+ **Effectiveness —** more than 99 percent.
+ **Strong Points —** can stay in for 10 years if you wish. Does not interfere with sex and stays in place.
+ **Weak Points —** Copper-T may cause more bleeding and cramping during periods. No protection from STIs including HIV.

Levonorgestrel IUD (Mirena®/"5 Year IUD"/IUD with hormones)

+ **Pharmacology —** How it works: Device is placed in the uterus by a healthcare provider. It contains a hormone called levonorgestrel which thickens the cervical mucus preventing passage of the sperm into the uterus and alters the lining of the uterus.
+ **Effectiveness —** more than 99percent.
+ **Strong Points —** last five years if you want to keep it in that long. May lighten periods or cause no periods at all. Always stays in place and does not interfere with sex.
+ **Weak Points —** most people have irregular bleeding for the first three to six months. Does not protect against STIs, including HIV.

Common Myths verbalized by participants regarding IUD's

+ **The IUD is dangerous —** it can cause infections and infertility
+ **The IUD commitment —** it's best for women who are older, married or already have kids
+ The IUD could puncture my womb
+ Your partner will be able to feel the IUD poking him
+ Getting the IUD is all pain and no gain
+ Adolescents should not have a Mirena inserted

Medroxyprogesterone acetate (Depo-Provera®/"The Shot")

+ **Pharmacology —** How it works: The shot releases a synthetic form of progesterone which protects against pregnancy for 11 to 14 weeks. This hormone stops the ovaries from releasing an egg and causes the lining of the uterus to thin and the cervical mucus to thicken.
+ **Effectiveness —** if you get it on time, it is 99 percent effective.
+ **Strong Points —** lasts three months; often decreases bleeding and cramping with periods; less chance of endometrial cancer; does not interfere with sex.
+ **Weak Points —** Must make an appointment every three months and be able to go to a healthcare provider to get a shot on time; may cause irregular periods; may not be able to get pregnant for several months after the shot is stopped; may cause weight changes and decrease calcium levels in your blood; no protection from STIs, including HIV.

Important to Share in Regard to Breastfeeding:
"Numerous studies have found the initiation of Progestin-only contraceptives after six weeks to be safe for both the breastfeeding infant and mother, resulting in statements from the World Health Organization and International Planned Parenthood Foundation" (World Health Organization. Medical eligibility criteria for contraceptive use; 2009).

Pill/Patch/Ring

+ **Pharmacology —** How they work: All three methods release hormones which stop the ovaries from releasing an egg and thicken mucus in cervix so it is hard for sperm to enter the uterus — a prescription is required from a healthcare provider.
+ **Effectiveness —** if you remember how to use them each time they are 99 percent effective, however if you are not careful they are only 92 percent effective.
+ **Strong Points —** does not interfere with sex; less bleeding and cramping during periods; less chance of ovarian and endometrial cancer with pill.
+ **Weak Points —** may cause weight changes and moodiness; not ideal while breastfeeding; may not be a good method for women over 35 who smoke or women who have a family history of strokes; no protection from STIs, including HIV.

Natural Family Planning — How It Works

Women learn to recognize the fertile days of their menstrual cycle by understanding their cycle through length of cycle, temperature changes during ovulation, and changes in vaginal discharge during ovulation.

+ **Effectiveness —** 75 to 95 percent.
+ **Strong Points —** approved by all religious groups; can improve a couple's communication; helpful when ready to become pregnant and low cost.
+ **Weak Points —** if periods are not regular, it may be difficult and not as effective; no protection from STIs, including HIV.

Condoms ("Rubbers") — How It Works

It fits over an erect penis and catches the sperm when a man ejaculates.

+ **Effectiveness —** 85 to 98 percent (to be most effective, you need to use it correctly all the time).
+ **Strong Points —** can buy in the drugstore; easy to use and easy to carry; use it only when needed; latex condoms protects you from STIs, including HIV.
+ **Weak Points —** must be put on every time during sex; may irritate the vagina or penis; some people may be allergic to latex.

In the program we provide condom education with each participant and provide condoms to participants who request them and to all those that were seen in the TOPP clinic.

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Program Components

Program Components

Staff

Consider physicians, registered (RN) and social workers to perform motivational interviewing. RN's with OB/GYN experience can best assist patients by recognizing potential problems that can happen during prenatal and postpartum periods. RN's are able to provide education on all contraceptive methods and are also able to administer medications necessary for the clinic setting and in-home care. Social workers conduct the Edinburgh Postnatal Depression Scale (EDPS) and Abuse Assessment Screen & HITS Modified for Adolescents (Hurts, & HITS Insults, Threaten with Harm or Scream) screening on all intervention patients. In addition to the scales and a psychosocial assessment, the social worker provides a multitude of community resources, such as housing, employment, education, food, diapers, formula and household goods — this is an excellent way to provide trauma informed care.

The motivational interviewing expert consultant plays an important role in providing training and ongoing technical assistance around motivational interviewing. The expert consultant's role — from the initial two-day training provided to staff to the ongoing technical assistance and support — appears important not only in preparing staff to interact using motivational interviewing, but also in ensuring fidelity to the technique. Part of the expert consultant's role involves listening to a sample audio-recorded interactions, coding them for fidelity, and then basing feedback to educators on this fidelity assessment. On average, in addition to the initial two-day training, the consultant's time commitment to and contract with TOPP in its first year, represented about two hours per week, and then a little over one hour per week on an ongoing basis. Any efforts to replicate or scale up motivational interviewing should allow for adequate staff training and technical assistance. Its individualized and flexible nature means that the technique is constantly being applied in very individual ways that vary from staff member to staff member and participant to participant. This necessitates ongoing guidance and technical assistance to ensure that staff members' use of the technique adheres to established motivational interviewing guidelines.

STAFF LOAD AND DOSAGE:
Each nurse spoke with their patients roughly once per month for 18 months. Most of the birth control decisions were completed within six months if nurses were able to reach patients; however, because the dosage was 18 months as designed by research staff, the nurse was there to field questions when patients had problems with their birth control. 18 months was chosen due to eighteen months being the recommended birth spacing from birth to subsequent conception.

Each nurse carried approximately 40 patients at one time, and approximately 120 over the duration of the study. Project director carried 60 of the 297 patients over the duration of the intervention. Social workers called each patient in the intervention to do the screening for depression and domestic violence, and then called and visited as the need for resources arose.

Recruitment

To identify eligible women, program staff conducted regular queries in the OhioHealth electronic scheduling system, producing lists of potentially eligible women and their next appointments — including prenatal and postnatal appointments at the clinics and postpartum appointments in the maternity wards of hospitals. After potentially eligible patients were identified, they were approached by an OhioHealth standard-of-care provider during their next scheduled clinic appointment, or in the postpartum unit of the hospital, and told about the opportunity to learn about the study. Among those women who agreed to learn more about the study, TOPP program and/or local evaluation staff followed up with more detailed information about the study, the potential opportunity to participate in the TOPP program, and consent procedures. For most women, this follow-up occurred while they were still at an OhioHealth care site.

Transportation

To transport patients and their children in order to comply with OhioHealth guidelines and Ohio Laws, TOPP staff:

+ Completed a four hour car seat testing class offered by the Public Health Department, which is supported by AAA (AAA.com/ChildSafety).
+ Completed a computerized test through Hartford Insurance.
+ Instituted and signed a van lease yearly (initiated by project director only).

OhioHealth runs drivers' licenses annually to check for driving offenses.

EXCLUSIONS
This service provides transportation to and from clinic appointments for participants who either do not have their own transportation or have difficulty using public transportation. Furthermore, participants can bring their infants to these contraceptive appointments, if they are unable or choose not to arrange child care services. Car seats are required.

The van was primarily used for birth control. On rare occasion, it was used for emergency purposes such as food pantry, formula for the baby, or emergency housing/shelter.

Only research participants, children of participants, and/or the guardian of the participant were to be transported by OhioHealth.

MILEAGE:
Use of staff's own automobiles for home visits. Staff calculated mileage and put information into an online system for reimbursement of gas. If van not available, program must provide cab/bus passes.

Phone Calls and Home Visits

PHONE CALLS:
TOPP staff utilized a standard "flip-style" cellphone to call all participants. In addition, each staff member had a recording device which was used during each phone conversation conducted with a participant to ensure motivational interviewing was being used.

HOME VISITS AND NURSING CARE IN HOME:
Conducted by TOPP nurse educators and social worker. The birth control bag was taken and education provided along with sample condoms. If participant was a patient of the TOPP clinic and Depo Provera was the birth control of choice, Depo could be administered by the registered nurse at patient's home.

TOPP was developed as a unique, new program that focuses specifically on adolescents while combining and modifying key elements from existing program approaches. Similar to many home visiting programs, the TOPP program is delivered individually to program participants over an extended 18-month period by trained nurse educators. However, unlike most home visiting programs, TOPP is delivered primarily by telephone and is more narrowly focused on promoting healthy birth spacing and use of effective contraception, including highly-effective LARC methods. These features of the TOPP program allow nurses to serve much higher caseloads than the nurses in traditional home visiting programs. In addition, TOPP aims to reduce possible barriers to contraceptive use, through motivational interviewing techniques (described above), and the provision of transportation assistance and other logistical support designed to improve access to clinic-based contraceptive services. Finally, TOPP does not base program eligibility on participants' current use of or attitudes toward specific contraceptive methods — distinguishing TOPP from some existing pregnancy prevention programs.

Clinic

TOPP also provides direct access to contraceptive services through a program clinic. The TOPP clinic was originally designed as a mobile clinic that could be stationed in different parts of the program service areas. However, due to insufficient attendance, the mobile clinic was discontinued after a few months and replaced by a stationary clinic in the TOPP offices. In the TOPP clinic, a part-time obstetrician/gynecologist is available to provide contraceptive services to participants who are not already affiliated with another physician or who are struggling to receive timely or effective contraceptive care from their existing provider. Program participants needing transportation to and from the TOPP clinic could use the program's van service.

TOPP offered all contraceptive methods at a TOPP clinic and suggests replication staff should consider checking into 340B pricing if serving the underserved. When establishing a clinic, order all necessary supplies applicable to family planning. If unable to offer clinic, ensure relationship with LARC provider is established.

PATIENT QUOTES
"I'm motivated to go on with my life and to be on some type of birth control so I won't get pregnant again."

"Realizing that I don't want to have another kid and the fact that I am already a young mother makes it easier for me to carry out my plan."

"The TOPP program has made it easier for me to carry out my plan because it has helped educate me."

"It's a good program. [It] helps you with birth control and safe sex. Someone always has your back. It's caring."

Lessons Learned

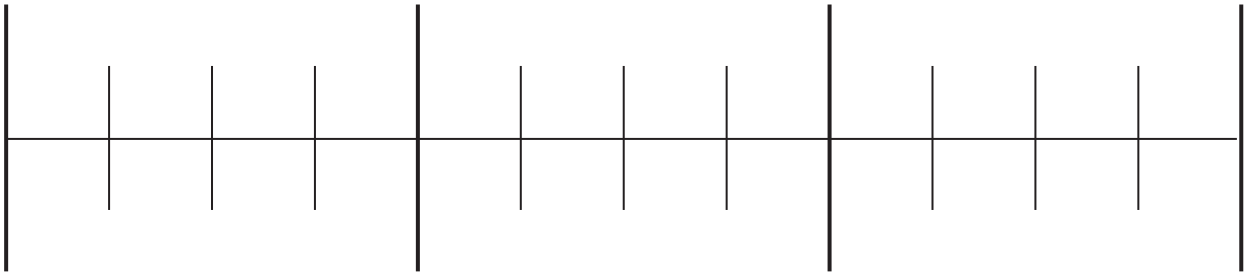
"I think the [contraceptive bag] is really helpful — it gives them a visual of what these things look like ... A lot of them see the Mirena and are like, 'Wow — I didn't know it was that small!'" A participant identified the program component that facilitated her use of birth control as "knowing more information about the birth control and [the fact that] my nurse shows me demos on what each birth control is, and how it is used."

"Transportation ... So important. It has been so helpful, very, very valuable, to get them to the appointment and sit in the car and talk to them ... It's nice, gives them a sense of, 'Hey this person isn't so bad.' [You can say], 'Pick a radio station, what do you want to listen to, what have you been up to?' [Which] gives them a sense that [the nurse educator is] not intimidating; gives the girl a sense of control.' The teen mothers seemed especially appreciative that this transportation helped them get contraceptive services. One participant said she was able to start using contraception because she 'actually had one of the TOPP workers come out and take me — made it easier!' Preventing rapid repeat teen pregnancy. One in five participants receive a van ride through the program during her first six months."

"We realized that many young women used the emergency room for pregnancy and STI testing. Helping them to navigate their appointments was an important aspect of the program to avoid this misuse of the healthcare system."

Self-Evaluation Ruler

On the following scale, which point best reflects your feelings about birth control?



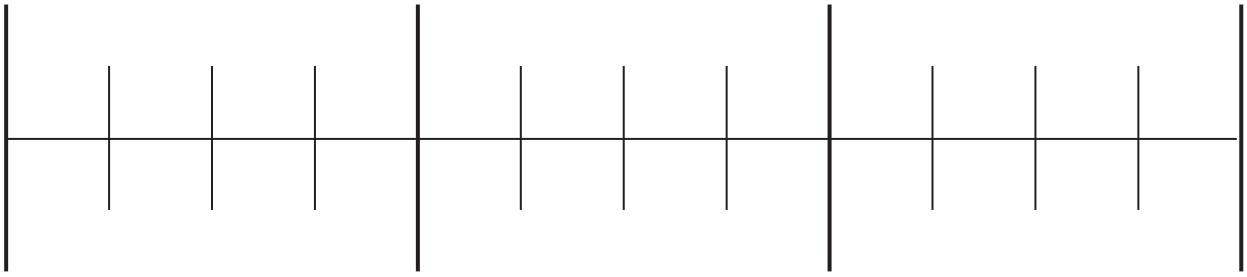
Not at all ready to use birth control

Thinking about using birth control

Committing to use birth control

Actively using birth control

On the following scale, which point best reflects your feelings on getting pregnant again?



Not at all ready to get pregnant again

Thinking about getting pregnant again

Committing to get pregnant again

Actively wanting to get pregnant again

Worksheet for Change

My goal is: _____

_____

_____

_____

_____

Some barriers that could get in my way:

_____

_____

_____

_____

Pros of staying the same: _____

_____

_____

Cons of staying the same: _____

_____

_____

Pros of changing: _____

_____

_____

Cons of changing: _____

_____

_____

Solutions to overcome these barriers:

_____

_____

_____

_____

People who can support me:

_____

_____

_____

_____

_____

The steps I will take to change:

_____

_____

_____

_____

I will know my plan is working if:

_____

_____

_____

_____

Nurse Educator Flow Sheet

1. Tell me the pros and cons of getting pregnant again in the next 18 months?

Pros	Cons

2. Tell me what you know about birth control options?

	Pros	Cons
Abstinence		
Contraceptive Implant		
Etonogestrel Releasing IUD		
Copper T IUD		
Injectable Shot		
Pill		
Vaginal Ring		
Patch		
Male Condom		
Female Condom		
Withdrawal		

What was positive/negative from past?_____

_____

_____

3. Is it OK if I tell you some things I know about birth control options?
(Please record patient's comments after each method if made during description.)

	Pros	Cons
Abstinence		
Contraceptive Implant		
Etonogestrel Releasing IUD		
Copper T IUD		
Injectable Shot		
Pill		
Vaginal Ring		
Patch		
Male Condom		
Female Condom		
Withdrawal		

4. What do you think about the information that I shared with you?

Date/Time:_____

_____

Date/Time:_____

_____

Date/Time:_____

_____

Date/Time:_____

_____

5. What problems do you think you might have with using this type of contraceptive?

Date/Time: _____

Date/Time: _____

Date/Time: _____

Date/Time: _____

6. Describe any resistance here.

Date/Time: _____

Date/Time: _____

Date/Time: _____

Date/Time: _____

7. Does the patient have an action plan in place?

Date/Time: _____

Date/Time: _____

Date/Time: _____

Date/Time: _____

8. Did patient verbalize understanding of different birth control?

Date/Time: _____

Date/Time: _____

Date/Time: _____

Date/Time: _____

9. Does patient verbalize understanding of how to use the birth control method they chose?

Date/Time: _____

Date/Time: _____

Date/Time: _____

Date/Time: _____

10. What problem-solving assistance did you offer about birth control:

Date/Time	RN	Birth control method	Pros/Cons	Interventions

INTERVENTION KEY

+ Positive Reinforcement
+ Readiness Ruler
+ Envelope Scenario
+ Teaching on Birth Control
+ Worksheet for Change
+ Educational References/Pamphlets
+ Referrals
+ Goal Setting (if ambiguous, or BC change made)
+ See Nurse Assessment Section

11. Open-Ended Narrative (Describe any other information that you obtained from the patient that were not described above.)

Date/Time: _____

_____

Date/Time: _____

_____

Date/Time: _____

_____

Date/Time: _____

_____

RN SIGNATURES:

_____ _____

_____ _____

Abuse Assessment Screen & HITS Modified for Adolescents

Does your significant other ever:

1. Insult you or talk down to you?

2. Threaten you with harm?

3. Scream or curse at you?

4. Within the last year, have you been hit, slapped, kicked, choked, or otherwise physically hurt by someone? If yes, by whom?

5. Since you have been pregnant, have you been hit, slapped, kicked, choked, or otherwise physically hurt by someone? If yes, by whom?

6. In the last year, has anyone forced you to have sexual activities? If so, whom?

7. Are you afraid of your partner or anyone else? If so, whom?

Positive responses to questions four through seven indicates abuse. Positive responses to questions one through three are especially important in combination with four through seven.

Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____

Your Date of Birth: _____ Baby's Date of Birth: _____

Address: _____

_____

Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST SEVEN DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- ☐ Yes, all the time
- ☐ Yes, most of the time
- ☐ No, not very often
- ☐ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past seven days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5. I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time. I haven't been able to cope at all
   - ☐ Yes, sometimes. I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7. I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8. I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9. I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10. The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

Administered/Reviewed by: _____ Date: _____

[1] Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of Postnatal Depression: Development of the 10–item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry,* 150:782-786.

[2] Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression, N Engl J Med, vol. 347, No 3, July 18, 2002, 194-199.

Edinburgh Postnatal Depression Scale[1] (EPDS)

Postpartum depression is the most common complication of childbearing.[2] The 10–question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt ***during the previous week***. In doubtful cases it may be useful to repeat the tool after two weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the website of the National Women's Health Information Center (4women.gov) and from groups such as, Postpartum Support International (chss.iup.edu/postpartum) and Depression after Delivery (depressionafterdelivery.com).

SCORING

QUESTIONS 1, 2, & 4 (without an*)
Scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 510 (marked with an*)
Reversed scoring — with the top box scored as a 3 and the bottom box scored as 0.

Maximum Score: 30
Possible Depression: 10 or greater

Always look at item 10 (suicidal thoughts)

Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous seven days.
2. All the items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

[1] Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. British Journal of Psychiatry, 150:782-786.

[2] Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression, N Engl J Med, vol. 347, No 3, July 18, 2002, 194-199

Motivational Interviewing Treatment Integrity Code (MITI)

Coding Sheet | Revised June 2007

Tape # _____ Coder: _____ Date:_____

Global Ratings

Evocation		1 2 3 4 5 Low High
Collaboration		1 2 3 4 5 Low High
Autonomy/Support		1 2 3 4 5 Low High
Direction		1 2 3 4 5 Low High
Empathy		1 2 3 4 5 Low High

Behavior Counts

Giving Information			
MI Adherent	Asking permission affirm emphasize control, support.		
MI Non-adherent	Advise, confront, direct.		
Question **(subclassify)**	Closed-ended Questions		
	Open-ended Questions		
Reflect **(subclassify)**	Simple		
	Complex		
	TOTAL REFLECTIONS:		

First sentence: _____

Last sentence: _____

Revised January 22, 2010 (minor text revisions)

5

Adaptations and Fidelity

Teen Options to Prevent Pregnancy Fidelity Toolkit

Activity	Intervention Goals- *Before* Patient Interaction
Recruitment Planning	**NURSE EDUCATOR** ☐ Establish relationship with hospital system IT services for recruitment (With hospital permission, may use hospital billing code for delivery and age parameters) ☐ Orientation to health-care technology system that can identify potential participants for recruitment ☐ Ensure technology system meets privacy and HIPPA requirements for patients
Motivational Interviewing Network of Trainers (MINT) Training	**NURSE EDUCATOR** ☐ Find MINT trainer in your local community for staff training (list available www.motivationalinterviewing.org/ website) ☐ Minimum two day workshop. ☐ Preferred six months to one year of coaching.
Transportation	**NURSE EDUCATOR** ☐ Car seat training required for all staff who transport patients. ☐ Renting van for program (optional)/obtain bus or cab passes ☐ Create car seat and seat belt policy for patients and their children ☐ Create centralized staff calendar for scheduled use of van for patient transportation
Contraception	**NURSE EDUCATOR** ☐ RNs educated on safe birth spacing according to Agustin Conde-Agudelo, MD, MPH JAMA meta-analysis (at least 18 months from birth to conception) ☐ Training of all RNs on medically accurate and efficacy based delivery of contraceptive options ☐ Practice responses to common myths and side effect questions with the use of MI ☐ Create bag with all contraceptive method samples and medically accurate and approved brochures in preparation to demonstrate during in-person home visits ☐ Obtain condoms to hand out to patients ☐ Create list of providers who offer LARC placement ☐ Consider creating a relationship with a provider willing to oversee in-home Depo (optional)
Resource and Referral Directory	**NURSE EDUCATOR** ☐ Obtain list of local resources for housing, diapers, food pantries, furniture, counseling, formula, education completion, support groups, jobs, domestic violence, smoking cessation, car seats, cribs, and childcare ☐ Social Worker/RN obtains HITS abuse assessment and Edinburgh post-natal depression scale assessment tools (supplied in toolkit)

(Continued)

Teen Options to Prevent Pregnancy Fidelity Toolkit (continued)

Activity	Intervention Goals- *Before* Patient Interaction
OPTIONAL: Training for RNs	**NURSE EDUCATOR** ☐ Breastfeeding techniques and promotion ☐ Safe Sleep Practices ☐ Newborn Assessment ☐ Immunization Schedule ☐ Infant Nutrition Schedule by age ☐ STI training
Recruitment	**NURSE EDUCATOR** ☐ Introduction of the program ☐ Use of transportation to postpartum or birth control related appointments discussed ☐ Discuss car seat and seat belt policy ☐ Consent for participation obtained ☐ Discuss confidentiality, duration, and goals of program ☐ Ascertain best time to call
	YOUTH ☐ Verbalizes understanding of program ☐ Verbalizes understanding of transportation provision availability including car seat and seat belt policy ☐ Signs consent for participation (consider parental consent for patients under 18 years of age) ☐ Verbalizes understanding of confidentiality agreement and program goals ☐ Patient provides nurse with best times to communicate with program staff
Motivation Interviewing Components	**NURSE EDUCATOR** ☐ Motivational Interviewing techniques used during every patient interaction ☐ Conversation incorporates components of the SPIRIT of MI, The Four Processes, and Open-ended questions, Affirmations, Reflections, Summarizations (OARS) ☐ Attempts monthly phone calls for at least 12 months with participant
	YOUTH ☐ Youth verbalizes readiness for change in regard to birth control choice

(Continued)

Teen Options to Prevent Pregnancy Fidelity Toolkit (continued)

Activity	Intervention Goals- *Before* Patient Interaction
Transportation	**NURSE EDUCATOR** ☐ RN checks out van according to centralized calendar for patient's appointments or offers cab/bus pass ☐ Reminds patient of need for car-seat on date of appointment
	YOUTH ☐ Notifies RN of need for transportation/cab pass/bus pass and appointment date
Contraception	**NURSE EDUCATOR** ☐ At least one home visit completed with the use of the contraceptive bag visual aids ☐ RN discusses the importance of safe birth spacing to protect mother and baby with permission ☐ RN reviews all birth control options from most effective to least effective with patient's permission ☐ Include side-effects, pros/cons specific to patient, and common myths as needed ☐ Offers condoms to patient and discusses use of dual protection/ STI protection with the use of birth control ☐ Offer in-home Depo if available according to patient's birth control goal (optional) ☐ Utilize Nurse Educator Flow Sheet ☐ Complete Self-Evaluation Ruler with patient ☐ Complete Worksheet for Change
	YOUTH ☐ Schedules home visit with RN ☐ Patient verbalizes understanding of birth spacing (makes goal statement to achieve safe birth spacing) ☐ Makes goal statement for birth control ☐ Verbalizes understanding of all birth control methods and pros/cons of their birth control choice ☐ Verbalizes understanding of the proper use and need for condoms including STI risk/dual protection ☐ Complete Self-Evaluation Ruler ☐ Complete Worksheet for Change
Resource and Referral Directory	**NURSE EDUCATOR** ☐ Assist patient in learning the use of Medicaid assistance including scheduling transportation through insurance services and making their appointments ☐ Educate patient on establishing a medical home vs. Emergency Room use as primary care ☐ Refer as needed to resources
	YOUTH ☐ Patient schedules their own postpartum visit ☐ Patient schedules their own initial appointment with Family doctor or Pediatrician for infant ☐ Patient obtains necessary information for access to resources

(Continued)

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