

AAPP meeting with Juneau Teen Health Clinic (THC) Staff March 6, 2009

In Attendance: From AAPP: Mary Grisco, Jon Lyon, Tari O'Connor; With THC: Kristi West (Zach Gordon Youth Center), Kate Slotnik (DH&SS), Deana Darnall, ANP (private practice), Rachel Brown (AWARE), Angel Dudley (JYS), Mary Tonsmeire THC

- The meeting included a discussion with THC staff and providers, then a tour of the new Thunder Mountain HS clinic site with Mary Tonsmeire. Some key topics that arose during the discussion follow.
- **Establishing the THC**
 - THC began operating in Jan 1993
 - Physician opinion leaders were important to getting the public and community leaders to accept the idea of including reproductive health services, and used data to show that teen pregnancy and STIs were real issues for Juneau teens.
 - SEARHC was heavily involved in advocating for establishment of the THC. The Juneau clinic coordinator was also a Native leader and Juneau School Board member, and was interested in a teen clinic to address teen pregnancy, HS drop outs, and teen suicide. SEARHC physicians were strongly and visibly supportive at a series of public forums held on the subject, and were additionally good at using data to show the need for a teen clinic. They also initiated petitions in support of the clinic among local physicians; over 70 ultimately signed.
- **Partnership structure**
 - THC is not a legal entity, but a partnership whose members contribute some funding but mostly in-kind support (providers).
 - “Partnerships give people choices” – (both clients and providers)
 - The coordinator is an employee of the City and Borough of Juneau, but other staff are a combination of contract staff and employees of partner organizations. Those who are employed by partner organizations are simply assigned to the THC for a portion of their time.
 - There is no lead agency, which reduces the reliance on any one agency; key is coordinator and advisory board.
 - The number of partners allows any one agency’s contribution to be more manageable, for example 3-4 hours/wk of a provider’s time.
 - The number and diversity of the partners has the additional benefit of diffusing issues related to any negative public perception of any one agency.
 - This structure is quite similar to AAPP’s structure (MOUs are used for services).
- **Services Provided**
 - If target high risk population for behavioral health services then is advantage to have medical clinic to draw teens in, make the clinic appeal to parents, and to provide volume to justify program, and in addition bring reproductive health to school. The folks in Juneau feel that it’s very important to have all three services. However, “If you go into schools with only one service- go in with behavioral health”

- Some antibiotics are available in the clinic, but teens are referred to SEARHC or the Juneau Public Health Center for most medications. Staff also write a small number of prescriptions (in accordance with their sponsor agency and/or licensing protocols, by practice), and try to send kids to discount pharmacies (e.g. WalMart).
 - There is no formal medical director, though staff sometimes consult a physician on THC's advisory board for advice.
- **Parental Consent**
 - Teens have three levels of access to services at THC, based on the level of consent provided by parents.
 - Parent signs consent form allowing child to access clinic – teen can be provided any service (all or nothing for services)
 - Parent signs form indicating that child is not allowed to access clinic – teen cannot be provided any service, including reproductive health services
 - Parent does not do anything – child can provide own consent for reproductive health services only, in accordance with state law
 - Staff at THC felt that allowing parents the option of excluding their child from the clinic has kept the clinic's existence from being too much of an issue with those parents.
 - Staff gave one example of a teen who came in for “sports physical” and afterwards handed in parents refusal of further services- but while there for sports physical, of course could talk about whatever.
 - There are teens who have permission who never use the clinic (20-30% a year)
- **Coordination with Medical Homes**
 - THC sees their role as connecting kids to services, and don't feel the clinic is a threat to kids having a medical home. Information is shared with primary care providers; the clinic does not manage chronic conditions. Local pediatricians report the same.
 - SEARHC physicians advocated for THC from the beginning, and their public support of the clinic among their colleagues helped address these types of concerns.
 - There was some feeling that for many of the services teens receive at THC, they would have not received them anywhere had they not received them there.
- **Relationship with key school staff**
 - THC staff felt strongly that the school principal and school nurse needed to be onboard with having a clinic at the school in order for it to work; if this wasn't the case, it may not even be worth attempting to have a clinic there.
 - The school nurse continues to refer to medical and counseling services (including to THC), maintain immunization records, and work with all of the kids who have chronic health issues.
 - It's a good idea to send the school nurse to conferences, trainings, etc. along with clinic staff.
 - Contrast “school counselors” who are school staff and focus on career/academic guidance, and behavioral health “counselors” at THC

- **Local Advisory Board**

- These folks include support base (pediatrician), parents, teen (clinic user) and identified community leaders.
- Regular meetings provide guidance, sounding board, planning and community face for clinic.