Policymakers, public health practitioners, and social workers share a pressing sense of concern about the recent rise in teenage birthrates across the nation. It is well documented that without effective intervention, the repercussions of teenage parenting reach far beyond individuals and families to affect society at large. Negative outcomes include school dropout, strain on public health and welfare systems, low-birthweight babies, increased medical costs, poverty, stunted workforce development, child abuse and neglect, and developmental delays and disabilities among infants and children (Hoffman & Maynard, 2008). With experts projecting future increases in teenage birthrates (Sayegh, Castrucci, Lewis, & Hobbs-Lopez, 2009), it is imperative that communities invest wisely in support programs for adolescent parents.

The Tandem Teen Prenatal and Parenting Program was founded in 1998, when a group of nurse practitioners and a social worker at People’s Community Clinic in Austin, Texas, recognized that prenatal care alone was insufficient to deal with the complexities of teenage parenting. Grounded in a youth development framework, Tandem operates on the understanding that the challenges associated with teenage parenting are multidimensional and long term in nature and, thus, require a comprehensive continuum of care. The program has evolved into an interagency collaboration that integrates home and school visitation with the medical home model in the provision of medical, mental health, and educational and vocational services to teenagers and their children. At a relatively low cost, Tandem has been effective in improving the health and well-being of teenage parents and their children and has more than halved the national subsequent pregnancy rate of 24 percent among its clients by more than half (Schelar, Franzetta, & Manlove, 2007; Watt, 2008).

HIGH-RISK POPULATION
Tandem serves approximately 120 high-risk teenage mothers annually and accepts approximately 40 new clients each year. Clients remain in services until their children reach age three, they decline further participation, or the staff deems them no longer in need. On average, clients stay in services for 12 to 18 months. At any given time, approximately 25 percent to 35 percent of ongoing Tandem clients are pregnant, and the remaining 65 percent to 75 percent are parenting.

The majority (76 percent) of Tandem’s participants are Hispanic and between ages 14 and 16. Recent years have seen an increase in clients age 13 and younger. Most Tandem participants (90 percent) live in poor, high-risk neighborhoods. At intake almost 40 percent of these pregnant teenagers have dropped out of or are no longer attending school. Typically, those officially enrolled in school have significant attendance and academic problems. Most clients come from single-parent homes or live with their partner, his family, or other relatives. Approximately 30 percent of participants are primarily Spanish-speaking and come from immigrant backgrounds. All of these factors make Tandem’s population one of the youngest and neediest among pregnant adolescent cohorts in the country.

COORDINATING INTENSIVE CASE MANAGEMENT IN A MEDICAL HOME
To help clients address these challenges, Tandem emphasizes a comprehensive, client-centered approach delivered by a multidisciplinary team. Culturally sensitive, bilingual services are offered to a growing Spanish-speaking population. Priorities for each client include the development of a long-term, close, and sustained relationship with a nonjudgmental, caring, and reliable case manager; client-driven
goal setting; positive health outcomes for parent and child; improved emotional wellness; strengthened social support networks; delayed subsequent pregnancies; and progress toward educational goals and self-sufficiency.

Tandem's partners are four agencies and seven staff members. The lead agency, People's Community Clinic, provides Tandem with its director (a licensed clinical social worker) and a nurse practitioner. From the clinic, Tandem clients receive medical case management and program coordination as they access prenatal, pediatric, reproductive, and adolescent health care and health education from the clinic's physicians, nurse practitioners, health educators, and clinical social workers.

Two community-based agencies, Any Baby Can and LifeWorks, furnish four Tandem case managers, all with backgrounds in social work and child development. Case managers, in turn, facilitate linkage to additional services provided by their parent organizations, such as prenatal, parenting, and childbirth classes; fatherhood services; school-based groups; GED classes; vocational training; and emergency shelter.

During prenatal visits at People's Community Clinic, Tandem case managers recruit patients to the program. Once enrolled, clients meet with case managers weekly during pregnancy, bimonthly in the postpartum period, at least monthly thereafter, and more often when needed. Visits take place at home, at school, at the clinic, and in the field. Case managers can provide transportation and are easily accessible to help deal with medical, family, and social crises as they arise. Caseloads are relatively small, typically 20 to 25 clients, which allows for more intensive, individualized services compared with more traditional case management programs.

Mentoring and guidance are intrinsic to the case management role. In lieu of prescribed service plans, case managers use a client-driven goal-setting technique to inform service provision and ensure appropriate intervention in times of crisis. Case managers frequently advocate for clients to address legal, educational, medical, child care, housing, and other issues. In working collaboratively with clients to achieve their goals, case managers are able to teach life skills and problem solving in a modeling role.

Over time, case managers build rapport with clients, seeing firsthand their living conditions, family dynamics, school environment, and parenting skills. They provide one-on-one prenatal education at appropriate intervals, with the aid of topical packets that include print and video material. One-on-one parenting education is also taught using the Born to Learn: Parents as Teachers curriculum (Parents as Teachers National Center, 2005) and other sources as needed.

Tandem's fourth partner, Austin Child Guidance Center, provides a clinical social worker/psychologist who consults weekly with Tandem staff about each client's mental health status and provides direct service to clients when appropriate. With the case manager as the liaison, clients become more likely to use referrals to the Tandem therapist, especially when they can meet in the familiarity of the clinic or their home.

Weekly staff meetings are key to Tandem's collaboration, providing a time in which case managers, the nurse practitioner, the program director, and the therapist pool their expertise and insight about the clients to identify and problem solve about each client's social, physical, and emotional health issues. The collaboration not only allows for a sharing of agency resources, services, expertise, and evaluation processes, but also pulls together a diverse patchwork of funding that has enhanced Tandem's sustainability over the years.

**ADMINISTRATIVE CHALLENGES TO A MEDICALLY BASED INTERAGENCY COLLABORATION**

The Tandem model's challenges are not insurmountable. Many of them, such as limited visibility and name recognition, stem from its interagency structure and the absence of an administrative support staff solely dedicated to Tandem. Open communication and outreach by the Tandem staff have been instrumental in resolving related issues, but they require continual attention.

One challenge involves differences in style, approach, perspective, and function between Tandem and non–Tandem medical and clinic staff, which can result in tension and misunderstandings. To improve the situation, Tandem intermittently delivers presentations at clinicwide staff meetings about its goals, the rationale behind its approach, and the issues faced by teenage patients, individually and as a whole. Also, targeted, frequent communication with relevant medical assistants and other providers has improved working relationships, increased program involvement, and streamlined
operations, such as scheduling medical visits for Tandem clients.

Another challenge has been that Tandem's multi-agency, close-knit team can feel disconnected from parent agencies. Quarterly meetings between each agency's executive directors, related program managers, and project evaluators have helped improve cohesiveness and interagency cooperation.

**QUALITY OVER QUANTITY: CONVINCING STAKEHOLDERS TO INVEST IN SMALLER NUMBERS**

More broadly, a challenge faced by the program is that the number of clients it serves is dwarfed by demand. Policymakers and stakeholders gravitate toward interventions that reach larger numbers. The program continually has to demonstrate that its intensive, long-term approach reaps far-reaching benefits that would be lost if resources were spread too thin.

Program evaluation has been an important tool in maintaining support among partner agencies and external funding streams. At the behest of a major local supporter—the St. David's Community Health Foundation—Tandem underwent a cost analysis in 2008. The foundation renewed its commitment when the report indicated that Tandem was similarly effective and significantly less expensive than the Nurse Family Partnership (NFP), currently the most widely endorsed model of evidence-based parenting programs (Olds et al., 2002). Tandem costs ($1,900 per participant) were less than half those of the NFP program ($4,500) (Watt, 2008). The difference was attributed to NFP's use of nurses for home visitation. Tandem's nurse is based in the clinic, and social work staff conduct home, school, and field visits at less expense. Even with the cost of its nurse, Tandem was only slightly more expensive than other nonmedical, social service home visitation programs. In light of this, the Tandem model appears worth replication.

**REFERENCES**


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Original manuscript received July 23, 2009
Final revision received September 15, 2009
Accepted October 1, 2009