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Issue Paper Topic: Improving Care Outcomes in Medical Practices, Clinics, Health Center and Managed Care Organizations

Problem Description: The rates of STDs and unintended pregnancies in Milwaukee county are among some of the highest in the state of Wisconsin. This paper examines issues related to access of family planning services and STD screening and treatment at Federally Qualified Health Centers (FQHCs) and other public clinics, Managed Care Organizations (MCOs) and private medical providers. Specific barriers are identified and recommendations are made as to how to increase the services provided.

Issue Paper Summary

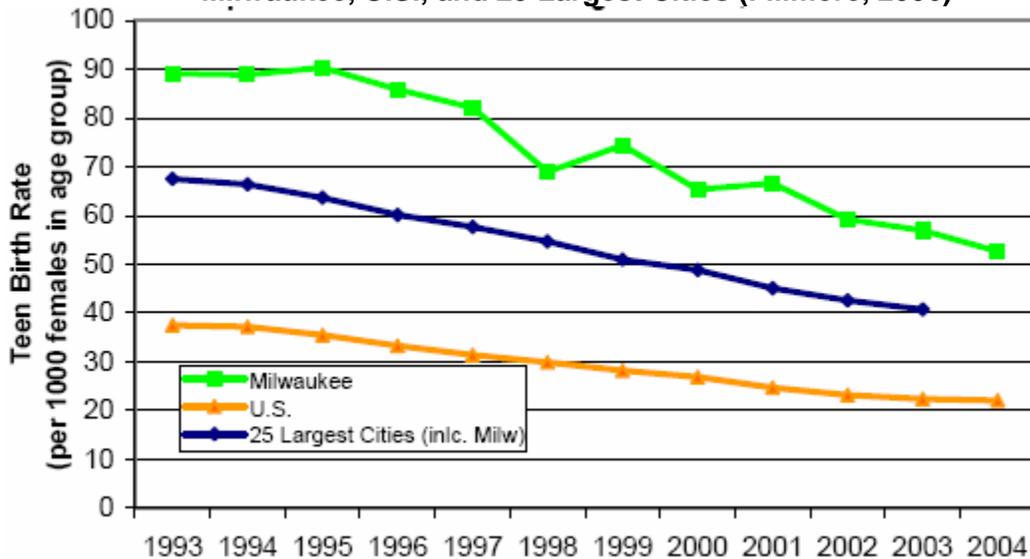
Milwaukee has some of the highest rates of teen pregnancy and adolescent STDs in the state of Wisconsin. Primary care providers have a unique opportunity to provide screening, education, and prevention services to help address this problem. This paper reviews some of the research done involving public and private clinics and reproductive health services delivery to adolescents. Later, we examine research into how to make such services more “youth friendly” and accessible to adolescents. Barriers and gaps are identified, and specific recommendations are made.

Background

Teen Pregnancy

In 2004, the teen pregnancy rate for Milwaukee was 52.67 per 1000 15-17 year old girls, more than double the national average. Milwaukee has the 2nd highest percentage of total births to adolescent mothers among the 50 largest cities in the United States. While rates have decreased as a whole, the teen birth rate in Milwaukee continues to be extremely elevated compared to the national average (Figure 1).

Figure 1: Teen Birth Rates (15-17 yr olds)- Comparison of trends for Milwaukee, U.S., and 25 Largest Cities (Fillmore, 2006)

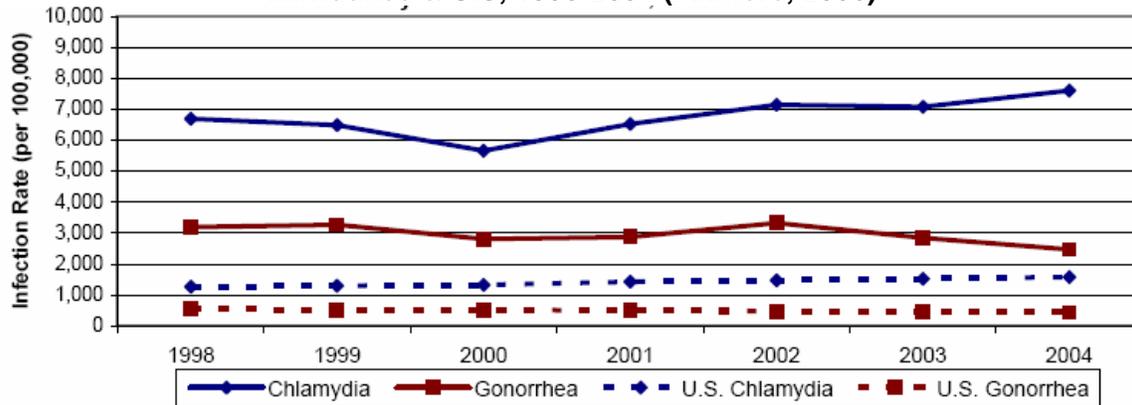


A number of studies have linked teen pregnancy with a variety of negative outcomes. In *Kids Having Kids*, a special report commissioned by the Robin Hood Foundation, they found that boys born to teen moms are 2.7 times more likely to become incarcerated; girls born to teen mothers are 83% more likely to become teen mothers themselves; and that children born to teen mothers are twice as likely to be abused or neglected (*Kids Having Kids Report*, 1996).

Adolescent STDs

In addition to high rates of unintended adolescent pregnancies, STDs (chlamydia, gonorrhea, and syphilis) in Milwaukee are extremely elevated. When compared to other cities, Milwaukee was among the worst ranked for chlamydia and gonorrhea incidence. Among adolescents, the 2004 infection rate of chlamydia in 15-19-year-olds was 7,600/100,000 which is 5 times the national average. The infection rate of gonorrhea in the same age group was 2,467/100,000, which is 6 times the national average (Figure 2)

Figure 2: Chlamydia and Gonorrhea Infection Rates in 15-19 year olds, City of Milwaukee & U.S, 1998-2004 (Fillmore, 2006)



Routine Adolescent and Young Adult Health Care Visits

Every year, adolescents comprise over 61 million office visits in the United States (Ziv, 1999). Of these, 68% are made to general/family physicians, pediatricians, or internal medicine physicians. Clearly, primary care clinics remain one of the most important venues with which adolescents seek medical attention.

Compared to adults, adolescents face a number of unique barriers when seeking reproductive health care services. Often times the clinic where they can receive such services is located some distance from their school or home, and transportation can be difficult. Financial access is problematic: availability of free services may be limited, and billing services to parental plans can compromise youths' confidentiality. Issues relating to privacy and confidentiality are often of the utmost concern and are one of the most important factors adolescents mention when asked about barriers to reproductive health care (McKee 2004).

Data show that health risks among adolescents are more social in origin than medical, and that these unhealthy behaviors can be recognized and interventions can be applied at an earlier age to reduce adolescent mortality and morbidity. The same has been shown to hold true for reproductive health. **The US Preventive Services Task Force USPSTF recommends that physicians take a sexual history, discuss risk prevention, and provide confidential care (within legal limits) for all adolescent patients.** Numerous physician and adolescent advocacy groups make similar recommendations (Shuster, 1996). For this reason, an approach centered on primary prevention rather than crisis intervention has become the organizing theme for the redesign of adolescent health services.

Despite efforts to encourage and incorporate preventive health education into adolescent visits, recent surveys of adolescent health reveal that a substantial proportion (40-49%) of providers offer no counseling or education during routine check-ups of adolescents (Ziv 1999; Fiscus 2004; Tilson 2004). One study showed that of the counseling topics commonly recommended for adolescents, sexually transmitted diseases or reproductive health is the 2nd least common type of counseling to be provided (Ziv, 1999). Provision of sexual health services is particularly rare for all boys and girls for whom English is a second language (Lafferty, 2002).

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Routine screening for certain sexually-transmitted diseases is recommended by the US Preventive Services Task Force. A more aggressive screening regimen appropriate to Milwaukee's high disease incidence was adopted by local medical authorities including at least one MCO. (Community Collaboration on Healthcare Quality (CCHQ) and MHD, 2003). These recommend annual screening for chlamydia and gonorrhea for all sexually-active patients up to age 30. In addition, the US Centers for Disease Control and Prevention advocate routine voluntary screening for HIV infection in clinical settings serving high-risk populations. (CDC 2006). The cost-efficacy of screening may be increased in laboratories by using a pooled-urine approach. (Kohl 2003) Screening for STDs is associated with adoption of safer sexual practices in youth and thus complements behavioral counseling. (Fortenberry 2002)

Screening for STDs is not performed in the majority of at-risk youth. One study of HMOs in Massachusetts revealed that only 18% of females age 15-19 received a Pap smear and only 11% received an STD test, despite professional recommendations that all of the estimated 53% of sexually active teens receive such screening (Thrall, 1998). Recent reports indicate that FQHCs and other public clinics are more likely to provide such screening, perhaps because they work with more at-risk teens and are more cognizant of their needs (Geisler, 2006). The availability of gonorrhea and chlamydia screening using urine samples can greatly simplify such screening in primary care.

Furthermore, adolescents at all ages (11-18) underutilize physician offices relative to their population proportion. One survey revealed that adolescents made up 9.1% of all physician office visits, while making up 15.4% of the population (Ziv, 1999). In all age groups, female adolescents account for more office visits than do male adolescents, and this gap widens as adolescents age. White adolescents make up 78.5% of the visits, while comprising only 67.6% of the population. Conversely, African American and Hispanic teenagers are under-represented in office visits.

Thus interventions directed solely at scheduled primary care may fail to reach many high risk youth. Assessing and arranging care for sexual health issues during acute primary care visits and visits to emergency departments [see separate paper on Emergency Departments] is needed to ensure that many youth receive any services.

Financial Barriers to Care

In the United States, the ability of an adolescent to access reproductive health services is often contingent on their health insurance status, their ability to pay directly for services, or their access to Title X family planning programs. Given that adolescence and early adulthood are age groups most likely to be uninsured, and complexity of many public assistance programs, the perceived financial barriers to reproductive care can be significant for teens seeking services (Tilson 2004; Hock-Long 2003; Oberg 2002). Furthermore, use of parental insurance creates a real or perceived risk of unintended disclosure of otherwise confidential care through the receipt of Explanation of Benefits forms and other insurer-insured communications. Issues of confidentiality and financial barriers are thus intertwined since the use of parental insurance may compromise the confidential provision of services. At least three types of governmental programs seek to address this problem: Title X services are available without insurance (albeit at times with some financial contribution by the patient); the Medicaid Reproductive Health Waiver offers a separate payment system for youth desiring confidential services; and the Milwaukee Health Department offers free services. In addition, some donated or sponsored medical services (free clinics, school health services) also provide the same

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combination of affordability and confidentiality. However, this permits a relatively limited spectrum of providers to youth seeking care, which may inhibit utilization.

Vouchers are one system that appear to be effective for providing access to multiple sources of care while simplifying financial access and confidentiality issues. Ideally vouchers would only be redeemable at clinics offering comprehensive and effective services, and ideally would not undercut existing free services in the community. (Koumans 1999; Borghi 2005)

Making Services More Acceptable

In recognition of the unique barriers that adolescents face when seeking reproductive health care services, a great deal of literature has been generated examining steps that clinics can take to make services more “youth-friendly” That is, making services more accessible and attractive to adolescents. Neither children nor adults, adolescents have traditionally existed in a grey zone between pediatrics and internal medicine. More recently, increased attention has been paid to adolescents as a separate sub-section of the patient population, with unique needs and requirements. There are a wide variety of topics discussed in the literature about what makes a clinic youth-friendly, but I will only discuss what many authors have listed as being the most important.

Privacy and Confidentiality: The importance of providing confidential reproductive services for adolescents cannot be over-emphasized. Numerous surveys and focus groups have reported that the perceived confidentiality of reproductive services is one of the most important factors determining adolescent utilization (Senderowitz 1999; Schuster 1996; Oberg 2002; Tilson 2004). The most common fear of breach of confidentiality is that the provider will alert the teen’s parents that the adolescent sought reproductive health services. While a majority of adolescent patients use Title X family planning services with the knowledge of their parents, only about 60% of such users (and about 30% of those using the service without parental knowledge) said they would utilize the services if parental consent were mandated. (Jones RK 2005). Professional associations such as the American Medical Association and the American Academy of Pediatrics (AAP 2006) strongly advocate access to reproductive health services without required parental consent.

Specially-Trained Staff and Staff Behavior: In addition to provider training concerning adolescent physiology and development, staff that receive interpersonal training skills tailored to adolescents are better received by adolescents. Teens are particularly less likely to seek services if providers or other staff are perceived as being negatively judgmental to their behavior. These skills are important not only for providers but also for frontline staff such as receptionists which are often the first point of contact for young people. (Schuster, 1996; Tilson 2004; Senderowitz, 1999)

Special Time/Convenient Hours: Many studies have shown that having clinics open at times when adolescents can conveniently attend is of key importance for attracting clients. As the majority of teens attend school, convenient hours typically include evening and weekend hours. (Senderowitz, 1999; Hock-Long, 2003)

Short Waiting Times/Drop-Ins Welcome: Many adolescents report that their highest stress levels when seeking services occur when making their initial appointment and when sitting in the waiting rooms. For this reasons, clinics should be designed so that time in a common-space waiting room is minimized. Furthermore, adolescence is widely

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considered to be a time of life that is characterized by being “present-minded” with little planning ahead. For this reason, the option of receiving services without an appointment has been found to increase adolescent access to reproductive health services. If the client is turned away or made to make an appointment for more than one week in the future, he or she is significantly less likely to show up for the appointment (Senderowitz, 1999; Reddy, 1996; Fortenberry 1997)

Welcoming to Young Men: Recently more attention has been paid to the reproductive health care needs of young men, who have traditionally not been targeted by adolescent health programs. Outreach performed by adolescent clinics should make it clear that young men are welcome, and clinics should foster environments that encourage shared responsibility for decision making and contraception. (Porter 2000; Finer 2003).

Peer Counselors and Social Marketing: Numerous investigations have revealed that teens are often more comfortable discussing sensitive topics with their peers. Several pilot programs have demonstrated the effectiveness of peer counselors as tools for community outreach, and one study showed that trained peer counselors in the clinical setting increased contraceptive compliance among adolescents compared to similar counseling from other nurses. (Senderowitz 1999, Fortenberry 1997, Kirby 2001) Furthermore, adolescents in the community need to be aware both of the clinic’s existence and the services they provide, as well as be reassured that adolescents are welcomed and that confidentiality is reassured. Marketing the availability of youth-welcoming, confidential clinical services can utilize adolescent-outreach programs or other youth-service organizations. Community outreach, outside of the school, is particularly important for adolescents who no longer attend school (Senderowitz 1999)

Other Facility Characteristics: Having a clinic that is separate from other clinics seems to be more attractive for younger teenagers, first-time clinic users, and non-sexually active clients. Older teens and sexually active teens express concern that be seen using a separate clinics might compromise their confidentiality. (Senderowitz 1999, Fortenberry 1997, Hock-Long 2003) Adolescents are more likely to seek care from a clinic if they are assured that the clinic can meet their diverse needs. The more referrals to other clinics that need to made, the more barriers of time, payment, transportation, and comfort are likely to be encountered (Senderowitz 1999, Oberg 2002) Various studies have given mixed results on this topic. Surveys and interviews have revealed that some teens would be more likely to go to a clinic outside of their neighborhood, so that they are less likely to be seen by friends or neighbors. Other teens have reported lack of transportation as a major barrier to reproductive health services, suggesting that they would be more likely to attend clinics located within the neighborhood would. Regardless, clinics should be located in a safe surrounding and should be easily available by public transportation (Senderowitz 1999, Reddy 1996)

Delay of Pelvic Exam: Several studies have identified fear of pelvic exam as a major deterrent for young women seeking reproductive health services, who believe that in order to receive contraception they must first get a pelvic exam. One experimental program in the US showed that more young teens sought reproductive services is they had the option of delaying the pelvic exam for 6 months while still being able to obtain oral contraceptives (Senderowitz 1999, Hock-Long 2003, McKee 2004, Fortenberry 1997)

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The Role of Payers

Each of the above recommendations increases the cost of the operation of primary care practices, and must compete with multiple other “priorities”. Managed care organizations and other insurers can raise the level of priority of reproductive health care through monitoring quality performance (chlamydia screening in women is one of the Health Employer Data and Information Set (HEDIS) measures monitored for private and Medicaid MCOs by NCQA. (<http://www.ncqa.org/programs/hedis/2006/index.htm>) Activities must be incentivized by making them fully-paid services in health plans, which may require collaboration between payers and public health authorities and action by government and private employers, Medicaid officials, insurance regulators and legislators. MCOs can also help providers access tools or training to improve their performance of reproductive health care (Chorba 2004).

Barriers and Gaps

Although primary care clinics are widely considered to be the best venue for primary prevention, education, and screening for STDs and risky sexual health behaviors, research indicates that these services are not provided to a substantial proportion of patients that seek them. Possible barriers to delivery of such care include:

- Time constraints on provider
- Provider uncomfortable with sensitive topics of sexual health
- Adolescent sexual activity is viewed and treated by many adults as deviant behavior, which influence teens willingness to discuss such topics
- Provider unaware of screening, prevention, treatment guidelines
- Clinic not open at a time convenient to teens
- Clinic location not convenient to teen
- Confusion regarding financial issues for adolescent access to reproductive health services

Community Strengths and Opportunities

There are many community strengths that can aid in the effort to improve quality of reproductive health care services offered to adolescents. These organizations include:

- Milwaukee Adolescent Health Program
- Keenen Health Center (Health department STD clinic) and other MHD services
- Planned Parenthood of Wisconsin Clinics
- Four federally-funded community health centers and Health Care for the Homeless Milwaukee
- Children’s Hospital and Aurora school-based clinics
- All pediatrics and family medicine practices
- All urgent care facilities
- Milwaukee Health Department, Adolescent School Health Program
- Milwaukee Teen Pregnancy Prevention Network
- All youth peer outreach and youth serving agency outreach workers
- Milwaukee Consortium for Health Care Quality

Recommendations

1. Assuring consistent history-taking, risk management counseling, and STD screening in primary care.

As discussed above, even when adolescents are seen by a physician for a regular check-up, often there is little or no discussion of sexual health or reproductive health services. Each primary care provider serving youth should establish protocols to assure

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that sexual histories are sensitively obtained, and risk factors are addressed through effective assessment and counseling. Consistent practice requires both organizational and individual provider commitment, training and resources, as well as standards and performance management integrated into the practice's routine quality improvement programs. Practices and clinics should:

- engage clinical staff in the establishment of standards of sexual health care (history-taking, risk reduction counseling, family planning and STD screening) in the routine quality management system
- continuously measure performance against standards and innovate to improve performance (CQI)
- support these standards with appropriate provider training and patient-contact time (possibly using non-physician staff)
- support these standards with standardized protocols, chart forms, and reminders
- support these standards with needed patient education materials
- support these standards with needed space, privacy and equipment

Professional guidelines and associated tools may provide a useful starting point for protocol development, although they may not be fully appropriate for a community with such high incidence of STDs and unintended pregnancy. (ACOG 2006, AMA 1997). Because adolescence and issues of sexuality, gender relations, family formation and family authority are highly culturally-bound concepts, tools to assist culturally-competent care may be critical such as (Fleming [year unstated]). Sensitivity and competence in dealing with youth and young adults of various sexual orientations is critical. (Catalozzi 2004)

Adoption and continuous improvement of such sexual health care protocols would be accelerated by including measures of sexual health care quality in comparative evaluations such as the Wisconsin Healthcare Quality Consortium (<http://www.wchq.org/>)

Because of the substantial barriers that inhibit use of primary care services by young people, sexual health care protocols should provide long-acting or continuous access to effective prevention whenever possible (i.e., long-acting contraception or multiple refills for contraception) since the risks from unintended pregnancy tend to exceed those from contraception. Unrealistic expectations should be avoided (e.g., demanding a clinic visit every three months for birth control pills). In addition, protocols should emphasize preventive activities that can be taken by patients without healthcare visits, including condom use and emergency contraception.

There are real costs associated with these practices. Insurers and managed care organizations and public health agencies should:

- provide adequate coverage for counseling and screening services appropriate to a high-incidence community like Milwaukee,
- provide economic incentives to provide sexual health care to adolescents and young adults (e.g., increased fees for specific CPT codes),
- incorporate sexual health care standards into MCO quality improvement systems similar to HEDIS measures,
- encourage sharing and adoption sharing of best practices,
- provide educational materials for patients and providers, and
- provide or arranging training of providers.

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Because a significant proportion of at-risk patients may not attend routine preventive visits, an appropriate set of standards should also address young people attending urgent care visits.

The increasing availability of urine and rapid-result testing for STDs may allow streamlining of recommended screening and treatment in the primary care setting. For example, when time does not allow careful history-taking and risk assessment (as in acute visits) routinely offering voluntary testing for STDs could be offered as part of a routine nursing protocol in practices with sufficiently high disease incidence to make this cost-effective. Again, this requires payer support through appropriate coverage of these services.

Finally, care providers serving populations with high HIV prevalence in Milwaukee should be identified and encouraged to make routine voluntary screening for HIV part of their health care protocols, as outlined in CDC 2006 (2006 CDC HIV Testing Recommendations).

2. Assuring that service providers are perceived as welcoming and accessible to youth for sexual health care.

Practices and clinics that intend to provide sexual health care to adolescents and young adults may need to survey their services objectively with an eye toward accessibility and acceptability to youth. Offering valid assurances that reproductive health services are confidential and will not be revealed to parents or others may be paramount. Providers should have frank discussions with patients about privacy, and what they are and are not required to report (abuse, neglect, etc). Furthermore, clinics that serve adolescent patients should design their practices so as to incorporate aspects such as evening/weekend hours, decreased waiting-room time and the ability to accommodate walk-in appointments, so as to increase the ability of adolescents to receive services.

It may be useful to create an instrument for assessment of primary care accessibility and acceptability that incorporates issues related to confidentiality and privacy, financial access, youth-friendly hours, scheduling, reception and other practice flow, other physical environment issues and staff training. Peer advocate "mystery shoppers" to assess services can provide valuable feedback. (Sykes 2006)

Insurers, managed care organizations and public health agencies could incentivize assessment and achievement of high levels of access and acceptability. Those clinics meeting a certain standard can be actively promoted among youth.

3. Reducing financial and confidentiality barriers.

If broadening access to more sources of care avoiding financial access and confidentiality issues is assessed a priority by community-based planning (i.e., if existing free and confidential care systems are considered inadequate) then consideration could be given to a voucher system. A funder would need to be recruited or created; the voucher program would contract for services by acceptable providers (presumably those with comprehensive, high quality services as described above); care must be taken not to reduce overall care availability by reducing funding to existing sources of care without firm assurance of the quality and persistence of voucher-based care. Even among existing care providers, a voucher or pseudo-voucher system (a coupon advising where

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to go for free care) may increase the perceived choice of and satisfaction with services among youth.

Legislative or administrative mandates for greater parental involvement in reproductive care of adolescents will likely reduce utilization of services among youth who most need them.

4. Improve the ability to find comprehensive, youth-friendly reproductive health services.

Greater knowledge of the relatively rich range of sources of reproductive care in Milwaukee might invite better utilization. Directories that permit comparison of cost, hours, etc. may be useful, especially if distributed in widely-used youth media like entertainment weeklies, at clubs and on youth-oriented Internet sites. The directory should emphasize services offering comprehensive and youth-oriented services. "Single option" services that strongly emphasize a single approach (such as abstinence) should be clearly identified if included at all. Directory maintenance is a time and resource intensive process and should be planned for sustainability.

Peer outreach workers and youth-serving agency outreach workers should become familiarized with every available source of care (e.g., a "reproductive care tour" or a "mystery shopper" program (Sykes 2006)). Indeed, they may provide valuable advice and feedback regarding the design of services. They should be invited to help guide potential clients to services and should distribute directories of services.

5. Assure prompt partner treatment of STDs

The identification of STDs in the clinical setting is almost invariably an opportunity to identify and treat additional cases through partner notification and treatment.

Notification and treatment of contacts should probably assume higher priority than the screening of asymptomatic patients in general, given contacts' extremely high likelihood of infection. Rapid reporting of STD cases to public health is one critical aspect, but unfortunately not sufficient, since the Milwaukee Health Department states it lacks resources for universal partner notification and treatment.

Primary care practices can themselves undertake to notify and treat partners, or could equip patients with written information detailing the diagnosis in question, the directory of available treatment resources, and possibly vouchers or even partner delivered prescriptions (if authorized in Wisconsin law) to help assure a larger proportion of contacts achieve prompt treatment.

Given the powerful effects of social networks on STD transmission, primary care physicians should immediately notify public health authorities about cases who state they have multiple simultaneous partners, and these cases should be prioritized for contact management.

6. Collaboration

These are ambitious recommendations that may best be implemented by a collaborative of clinics, health plans and public health agencies working in a long-term collaboration to share strategies, tools and lessons learned.

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References

1. Fillmore , Capri-Mara et al “Just the Facts: Teen Risky Sexual Behavior in Milwaukee” City of Milwaukee Health Department, accessed June 2006 at (<http://www.city.milwaukee.gov/DISPLAY/router.asp?docid=16576>)
2. Senderowitz, Judith “Making Reproductive Health Services Youth Friendly” FOCUS on Young Adults, Washington DC 1999
3. Schuster, MA et al “Communication Between Adolescents and Physicians about Sexual Behavior and Risk Prevention” *Archives of Pediatric and Adolescent Medicine* Sept 1996 v. 150 (9): pp. 906-913.
4. Sexually Transmitted Diseases in Milwaukee County and other High Risk Areas: Screening, Testing and Treatment Recommendations. Community Collaboration on Healthcare Quality (CCHQ) and MHD, 2003
http://www.city.milwaukee.gov/display/displayFile.asp?docid=15224&filename=/Groups/healthAuthors/DCP/PDFs/STD_Screening.pdf.
5. Routinely Recommended HIV Testing as Part of Regular Medical Care Services. CDC 2006.
(http://www.cdc.gov/hiv/topics/prev_prog/AHP/resources/guidelines/print/Interim_routine.htm accessed July 8, 2006).
6. Fortenberry JD “Clinic-based service programs for increasing responsible sexual behavior” *Journal of Sex Research* Feb 2002 vol. 39(1) pp: 63-6.
7. Oberg, Charles et al “Health Care Access, Sexually Transmitted Diseases, and Adolescents: Identifying Barriers and Creating Solutions” *Current Problems in Pediatric and Adolescent Health Care* Oct 2002 v. 32 (9): pp 320-339.
8. Reddy DM, et al “Adolescent Contraceptive Behavior: The Impact of the Provider and Structure of Clinic-Based Programs” *Obstetrics and Gynecology* 1996 v. 88 (3): pp. 57-64.
9. Tilson, Elizabeth et al “Barriers to Asymptomatic Screening and Other STD Services for Adolescents and Young Adults: Focus Group Discussions” *BMC Public Health* June 2004, v. 21(4): pp. 26-33.
10. Jones RK et al “Adolescents’ Reports of Parental Knowledge of Adolescents’ Use of Sexual Health Services and Their Reactions to Mandated Parental Notification for Prescription Contraception” *Journal of the American Medical Association* 2005 v. 293 pp. 340-348.
11. American Academy of Pediatrics (AAP) “The Adolescent’s Right to Confidential Care When Considering Abortion” *Pediatrics* May 1997 v. 97(5) pp. 746-751.
12. McKee DM, Karasz A, Catherine M “Health Care Seeking Among Urban Minority Adolescent Girls: The Crisis at Sexual Debut” *Annals of Family Medicine* Nov/Dec 2004 v. 2(6) pp. 549-554.

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13. Kirby D "Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy" Washington DC: National Campaign to Prevent Teen Pregnancy, 2001.
14. Fiscus, Lynne C et al "Infrequency of Sexually Transmitted Disease Screening Among Sexually Experienced U.S. Female Adolescents" *Perspectives on Sexual and Reproductive Health*, 2004 v. 36 (6): pp. 233-238.
15. Fortenberry J "Health Care Seeking Behaviors Related to Sexually Transmitted Diseases Among Adolescents" *American Journal of Public Health* 1997 87(4) pp. 417-420.
16. Hock-Long, Linda et al "Access to Adolescent Reproductive Health Services: Financial and Structural Barriers to Care" *Perspectives on Sexual and Reproductive Health* June 2003 v. 35 (3) pp: 144-147.
17. Koumans EH et al "Patient-led partner referral enhances sexually transmitted disease service delivery in two towns in the Central African Republic" *International Journal of STD & AIDS* June 1999 v.10 (6) pp: 376-82.
18. Borghi J et al "The cost-effectiveness of a competitive voucher scheme to reduce sexually transmitted infections in high-risk groups in Nicaragua" *Health Policy and Planning* July 2005 v. 20(4) pp: 222-231.
19. Finer LB, Darroch JE, Frost JJ "Services for Men at Publicly Funded Family Planning Agencies" *Perspectives on Sexual and Reproductive Health* Oct 2003 v. 35(5): pp 202-207.
20. Porter, LE and Leighton Ku "Use of Reproductive Health Services Among Young Men, 1995" *Journal of Adolescent Health* Sept 2000, v. 27(3): pp. 186-194.
21. Shafer MB et al "Effect of a Clinical Practice Improvement Intervention on Chlamydia Screening Among Adolescent Girls" *Journal of the American Medical Association*, Dec 2002 v. 288(2): pp: 2846-2852.
22. Ziv Amitai et al "Utilization of Physician Offices by Adolescents in the United States" *Pediatrics* July 1999 v. 104 (1): pp. 35-42.
23. Kohl KS, Markowicz LE, Koumans EH "Developments in the screening for Chlamydia trachomatis: a review" *Obstetrics & Gynecology Clinics of North America* Dec 2003 vol. 30(4) pp: 637-58.
24. Geisler, William M et al "Health Insurance Coverage, Health Care-Seeking Behaviors, and Genital Chlamydial Infection Prevalence in Sexually Active Young Adults" *Sexually Transmitted Diseases* June 2006 v. 33(6): pp. 389-396.
25. Chorba T et al : Sexually transmitted diseases and managed care: an inquiry and review of issues affecting service delivery" *American Journal of Medical Quality* July-August 2004 v 19(4) pp.145-56.
26. American College of Obstetricians and Gynecologists (ACOG) "The Initial Reproductive Health Visit" *Obstetrics & Gynecology* May 2006 v. 107(5) pp. 1215-

-- FOR DISCUSSION ONLY --
DRAFT DATE: JULY 10, 2006

1219.

27. American Medical Association. Guidelines for Adolescent Preventive Services: Recommendations Monograph. 1997 and GAPS Questionnaires. <http://www.ama-assn.org/ama/pub/category/1980.html> (accessed July 8, 2006).
28. Fleming M and Towey K *Delivering Culturally-Effective Care to Adolescents* American Medical Association (year of publication not listed) <http://www.ama-assn.org/ama1/pub/upload/mm/39/culturallyeffective.pdf> (accessed July 8, 2006).
29. Catalozzi M and Rudy B "Lesbian, gay, bisexual, transgendered, and questioning youth: the importance of a sensitive and confidential sexual history in identifying the risk and implementing treatment for sexually transmitted infections" *Adolescent Medicine Clinics* June 2004 v. 15(2) pp. 353-367.
30. Sykes S and O'Sullivan K. "A 'mystery shopper' project to evaluate sexual health and contraceptive services for young people in Croydon. *Journal of Family Planning & Reproductive Health Care*. January 2006 v. 32(1) pp. 25-6.