## Table of Contents

## Adolescent Reproductive Health Toolkit

**Introduction**

***One of the most important commitments a country can make for future economic, social, and political progress and stability is to address the health and development needs of its adolescents."***[1]

The Adolescent Reproductive Health Toolkit was created to address a number of the disparities adolescents experience in the health care system. The recent National Research Council and the Institute of Medicine report found "that existing specialty services in the areas of mental health, sexual and reproductive health, oral health, and substance abuse treatment are not accessible to most adolescents, nor do they always meet the needs of many adolescents who receive care in safety-net settings. Even when such services are accessible, many adolescents may not find them acceptable because of the concerns that confidentiality is not fully ensured, especially in such sensitive domains as substance use or sexual and reproductive health."[2] Additionally, adolescents do not easily fit into current models of health care and have the highest rates of being uninsured and underinsured.[3]

School-based health centers (SBHCs), however, present a model in which many of the barriers to accessing health care for adolescents can be overcome. Addressing these barriers requires the provision of integrated and comprehensive services. While comprehensive services encompass a wide variety of health topics, for the purposes of this toolkit "comprehensive services" will be defined only within the area of confidential sexual and reproductive health services, which include sexual health education, behavioral risk assessment, counseling, pregnancy testing, contraception, and the testing and treatment of sexually transmitted infections. "Integrated school health services" refers to comprehensive, coordinated, continuous, and age-appropriate physical, behavioral, and oral health services, provided by a multidisciplinary team to students while they are in school, using a process of care that includes direct delivery, co-management, and referral.

Over the past several decades, the debate about adolescents' accessing comprehensive and confidential health services has been the focal point of many discussions, especially in SBHCs. This toolkit encourages a shift in traditional thinking about how we approach adolescent health. Rather than viewing adolescent health as several distinctly separate components, the toolkit assumes that quality care resulting in healthier adolescents can only be achieved by taking a holistic approach in which every health need of the adolescent is addressed. Comprehensive reproductive and sexual health services are a standard part of primary adolescent health care. Providing these services in SBHCs helps ensure that each student has an opportunity to be healthy and successful in school.

While adolescents as a whole experience inequities in access to health care systems, it is important to note that particular adolescents experience even greater health inequities than others. Marginalized youth, such as youth in foster care, lesbian, gay, bisexual, transgendered and questioning youth, pregnant and parenting teens, rural youth, African American youth, and Latino youth, often experience additional barriers when accessing healthcare. The goal of this toolkit is to increase access to quality care for *all* youth, including those who are most affected by health disparities. To best achieve this, each teen who utilizes the services at the SBHC should feel safe and welcome to express his or her individual and unique needs, without judgment or assumption. It is equally important to approach adolescent health from the viewpoint that all adolescents have the *right* to be healthy and thriving. All teens need to be engaged and supported.

[1] World Health Organization, *Action for Adolescent Health toward a Common Agenda. Recommendations from a Joint Study Group*. (World Health Organization, 1997), http://whqlibdoc.who.int/hq/1997/WHO_FRH_ADH_97.9.pdf . December 2009.

[2] National Research Council and Institute of Medicine, *Adolescent Health Services: Missing Opportunities.* (Washington, DC: The National Academies Press, 2008). 7.

[3] Ibid., 8.



**Why Focus on Adolescent Health and Access to Comprehensive Care?**

The Colorado Youth Risk Behavior Survey continues to reveal that many adolescents are or have been sexually active and consequently need access to comprehensive services and education. In 2007, 62% of 12th graders and nearly 30% of 9th graders surveyed reported having had sex. Of the sexually active students, fewer report using contraception and condoms than in previous years.[4] The rate of chlamydia among adolescents in Colorado is also on the rise. Between 2006 and 2007 youth ages 10-14 experienced a 15% increase and youth ages 15-19 experienced a 25% increase.[5]

Additionally, the connection between unintended teen pregnancy, access to comprehensive services, and success in school is well documented. According to the National Women's Law Center, one-quarter to one-third of female dropouts say that pregnancy or becoming a parent played a role in their decision to drop-out.[6] In another national study, conducted by the Gates Foundation, one-third of female drop-outs reported that becoming a parent was a major factor in their decision to leave school.[7]

While progress has been made to reduce unintended teen pregnancy rates across the nation, the stagnating changes in Colorado and significant increases in other parts of the country over the past few years are reasons for alarm. Many barriers, such as perceived lack of confidentiality, lack of money, insurance or transportation, limited or restricted services, limited provider knowledge, and cultural and linguistic barriers, continue to prevent adolescents from accessing high quality comprehensive health care.

Research has also shown that many clinicians experience barriers that prevent them from providing comprehensive adolescent care. Of the most frequently identified provider barriers, lack of training, insufficient opportunities for practice, a general failure by providers to initiate conversations about sexuality with patients, and reluctance to embrace new contraceptive protocols were most frequently mentioned.[8] However, SBHC users are more likely than teens accessing health care from other providers to report that their provider discussed confidentiality with them and that they received screening for sexually transmitted infections and counseling on condoms, birth control, and HIV.[9]

This toolkit provides ideas about how to address some of these barriers by involving the community, youth, and clinicians in an effort to reduce teen pregnancy and STI rates by increasing access to comprehensive care.

**Toolkit Structure**

It is important to recognize that no single approach to addressing teen risk behaviors can alone prevent unintended teen pregnancy; research tells us that a combination of approaches at various levels is most likely to be successful. With this in mind, the adolescent reproductive health toolkit was developed to assist SBHCs on a variety of levels, taking into account the unique needs of each different school and community. The toolkit is not a one-size-fits-all approach; it should be used as a guide and should not supersede medical judgment or community readiness.

The primary goal of the Adolescent Reproductive Health Toolkit is to increase access to comprehensive adolescent healthcare in school-based health centers across Colorado. Increasing access to comprehensive health care may happen in several different ways: by engaging and mobilizing the community, by engaging youth, by planning appropriately, and by delivering high quality services that meet national standards.

[4] Colorado Organization on Adolescent Pregnancy, Parenting, and Prevention, *The State of Adolescent Sexual Health in Colorado 2009 (Shannon Sainer, 2009),* http://www.coappp.org/images/09SASHreport.pdf.

[5] Ibid.

[6] National Women's Law Center, *When Girls Don't Graduate We All Fail* (National Women's Law Center, 2007), http://www.nwlc.org/pdf/DropoutReport.pdf

[7] Ibid.

[8] Brown, S. and Burdette, L., "Editorial, Looking inward: provider-based barriers to contraception among teens and young adults,"*Contraception Journal* 78 (2008): 355-357.

[9] Klein, J.D., Handwerker, L., Sesselberg, T.S., Sutter, E., Flanagan, E., and Gawronski, B., "Measuring Quality of Adolescent Preventive Services of Health Plan Enrollees and School-Based Health Center Users," *Journal of Adolescent Health* 41 (2007): 153-160.

When SBHCs are either prohibited from providing comprehensive services or are just initiating the conversation about what services the SBHC will provide, they can refer to the community engagement section of the toolkit. This section guides SBHC administrators through the necessary steps involved in engaging the community and includes a sample communication plan to help garner support for comprehensive adolescent health services. It also includes tools such as an example of a memorandum of understanding, a school-board briefing book, and factsheets.

The youth engagement section guides SBHCs in actively engaging youth as advocates who can help garner support for comprehensive services. Youth are the experts in their own experiences and are best equipped to define their healthcare needs. A group of teens voicing their concerns to the community is a very effective way to help the community understand the complex health needs of the adolescents. In addition, youth are effective advocates to other youth, helping their peers become familiar with the SBHC and the services it offers and encouraging them to use its services. This section describes several different approaches to youth advocacy and how using such approaches can result in beneficial social change for adolescents.

Once an SBHC has made the decision to offer comprehensive services, steps must be taken to ensure the SBHC is adequately prepared to offer the services. Planning includes creating a youth friendly space, purchasing the necessary supplies, ensuring all staff receives the appropriate trainings, etc. The program planning chapter outlines necessary steps to consider and builds upon the experiences and strategies of existing SBHCs successfully offering comprehensive services.

Next, SBHCs are responsible for providing the most up-to-date, research-based best practices in adolescent health. "How health services and by whom they are delivered has an important role to play in promoting healthful behavior, managing health conditions, and preventing disease during adolescence."[10] For this reason, the toolkit outlines research-based best practices in protocols to assist providers in delivering quality care that is youth-friendly, comprehensive, and accommodating of the provider's and student's needs. Intake forms, progress notes, brochures, and additional patient handouts are included to ensure adequate assessment, education, and follow-up.

Finally, evaluation of the project has been built into the daily SBHC operations described in the toolkit. Self-assessments are provided to be completed prior to initiating use of the toolkit and then completed after receiving the toolkit and training. Student surveys and chart audits are provided to help determine gaps that need to be addressed. Because initiating birth control for a sexually active student is only the first step, follow-up will be structured to ensure students have a safe space to ask questions and address concerns that may interrupt contraceptive continuity and condom use. For quality assurance purposes, progress notes and a data management tool are included to increase incorporation of best practices and consistency of care.

**Using the Toolkit**

The toolkit works best as a reference tool. Different sections will be relevant for different SBHCs. Start-up SBHCs can benefit from reviewing the entire toolkit, but will likely gain the most useful information from the community engagement, youth engagement, and the program planning sections. For existing SBHCs not offering comprehensive services, the community engagement and youth engagement sections will be beneficial. Once the services can be offered, the program planning, service provision and training and evaluation sections will be helpful. SBHCs already offering comprehensive services may benefit by comparing their current practices with recent updates as outlined in the service provision section. Additionally, if on-going quality assurance measures are not in place, the training and evaluation section will provide the framework to get started.

We hope that you will find this to be a useful resource as you work to increase access to comprehensive care in your SBHC. We applaud your effort and courage to ensure that teens have access to the services they desperately need to make healthy, informed, and responsible decisions.

[10] National Research Council and Institute of Medicine, *Adolescent Health Services: Missing Opportunities.* 1



**Acknowledgements**

CASBHC would like to acknowledge the following individuals who shared their time and expertise during the development of this toolkit:

Lisa Belanger, MSN, NP, Family Health Program Manager, Health and Human Services, City of Portland

Anne-Marie Braga, MSSW, LCSW, Director of Adolescent and School Health Initiatives Colorado Department of Public Health and Environment

Eliza Buyers, MD, FACOG, General Gynecology, Denver, Colorado

Maxwell Ciardullo, Sexuality Information and Education Council of the United States

Deborah Costin, MA, Executive Director, Colorado Association for School-Based Health Care

Sharon L. Edwards, President, The Cornerstone Consulting Group Inc.

Felisa Gonzales, PhD Candidate, George Washington University

Phyllis Hill, MN, MPH, FNP-C, Southwest Open School School-Based Health Center

Heather Hirsch, MS, Philliber Research Associates

Jocelyn Martinez, Colorado Organization on Adolescent Pregnancy, Parenting and Prevention

Betty Pepin, Colorado Association for School-Based Health Care

Susan Philliber, PhD., Philliber Research Associates

Kim Pierce, RN, CPNP, DNP, Community Health Services at Adams City High School Wellness Center

Anita Poole, PNP, MSN, Community Health Services at Lester Arnold High School

Maddalena Ragussin, Bridge Linguatec Translation Services

Joan Neff, CPNP, Community Health Services at Baker Clinic

Shannon Sainer, MSW, Colorado Organization on Adolescent Pregnancy, Parenting and Prevention

Ellen Sato, Colorado Association for School-Based Health Care

Janna Sieber, OMNI Institute Foundation

Todd Soderberg, MA, Colorado Association for School-Based Health Care

Alice Swett, Youth Opportunities Coordinator, City of Boulder

Shannon Wells, LPN, Clinic Coordinator, Southwest Open School School-Based Health Center

Sarah Winbourn, MD, Medical Director, Community Health Services

## Community Engagement

**Introduction**

Among school-based health center (SBHC) practitioners and administrators, there is an understanding that communities need to be substantially involved in planning and designing programs in order to create supportive environments when addressing sensitive issues, such as adolescent reproductive and sexual health.[1] Building the capacity of a community to support the provision of reproductive and sexual health services in school-based health centers requires preparation, time, commitment, and leadership.

Prior to beginning any community engagement effort, it is important to recognize the value of relationships. The following steps provide a framework for community engagement, but for these steps to result in successful outcomes, relationships and trust must be established. The following quote from a parent training sums it up well: "If a parent trusts a teacher, the parent isn't concerned with what is being taught in the classroom because the relationship assumes both the parent and the teacher will do what is best for the child." Community engagement in SBHCs is no different. Throughout the community engagement process, remember the four R's: relationships, respect, readiness, and resilience.

This section of the Adolescent Reproductive Health Toolkit is intended to guide SBHC planning groups and existing SBHCs as they work with their communities to address the comprehensive health care needs of adolescents.

This chapter contains the following steps:

- STEP 1: Research Existing Resources
- STEP 2: Form a Work Group/Coalition
- STEP 3: Gather and Assess Information and Needs
- STEP 4: Create Effective Messages
- STEP 5: Prepare Messages for the Media
- STEP 6: Develop a Strategy
- STEP 7: Prepare for Potential Controversy
- STEP 8: Useful Websites

The following tools may also be useful:

- Quick Tips for Building and Sustaining Relationships
- Principles of Community Engagement
- Community Engagement Checklist
- School Board Briefing Book Template
- Sample Memorandum Of Understanding (Including reproductive health in SBHCs)
- Op-Ed Sample
- One Colorado SBHC's Success Story
- The Colorado Association for School-Based Health Care's Reproductive Health Position Statement

### STEP 1: Research Existing Resources

Before beginning any community engagement process it is important to have a very clear idea of what you are trying to accomplish. Take a moment to ask yourself the following questions:

- What is it that I am trying to accomplish?
- How can I be prepared to convey the importance of my issue?
- Who do we need involved in order to get things done?
- What is the makeup of the community in terms of perspectives and positions people hold, as well as demographics?
- Who can genuinely speak with authority on the challenges we are seeking to address?
- If you feel this is an appropriate strategy, is there an elected official that is willing to support/"champion" your efforts and help increase the profile and political will for teen pregnancy prevention initiatives?

Although teen pregnancy and sexually transmitted infection (STI) prevention measures may be new to your SBHC, it is likely you are not the only entity in the community interested in increasing access to comprehensive services for adolescents. Take a moment to figure out what (if anything) is currently being done in your community around the issue and identify potential partners that may participate in a work group focused on access to comprehensive adolescent health services in the SBHC. You may find that a group already exists in your community. If you are a start-up SBHC, you may try to form your advisory committee with reproductive health in mind, perhaps even asking a reproductive health expert to be part of the committee.

Some organizations or groups to consider researching:

- Existing SBHC Advisory Council
- Public Health Department (Women's Health Section)
- Community Resource Center
- Parent Engagement Network
- Parents who accompany their child to the SBHC
- Schools (teachers, counselors, social workers, school nurses, principals)
- Existing youth groups, both affiliated and unaffiliated with the school
- Teen parent programs (administrators as well as teen parents)
- Planned Parenthood or similar agencies
- School administrators (with a proven track record)

A work group should include diverse representation from the community and may include:

- Health professionals
- Parents
- Youth
- Teachers

### STEP 2: Form a Work Group/Coalition

Once you have done your research and identified potential work group members, host an informal meeting to discuss your plan. Be prepared to discuss the need to expand or to include comprehensive services in the SBHC. The purpose of the meeting is to build consensus around your issue and begin forming relationships. No matter the catalyst, effective partnerships do not emerge overnight. Before moving forward it is important to understand the relationship between each of the partners and the goal of providing reproductive health services. Focusing on increasing access to comprehensive services in SBHCs may prevent some of the potential partners from choosing to move forward.

At the first meeting, set basic ground rules for interaction to create a positive environment. Some typical ground rules include:

- One person speaks at a time
- Be respectful
- Listen
- Be concise and stay focused on the agenda
- Make sure everyone has an opportunity to speak

The first meeting should be substantive and should always include introductions and opportunities for discussion. After introductions, you can begin by sharing an overview of the issue or problem. Facilitate the discussion by asking these types of questions:

[1] Inter-Agency Working Group on the Role of Community Involvement in ASRH, *Community Pathways to Improved Adolescent Sexual and Reproductive Health: A Conceptual Framework and Suggested Outcome Indicators*, (Washington, DC and New York, NY: December 2007).

- Does our community have a problem with unintended teen pregnancy? Sexually transmitted infections (STI)? Lack of health care services?
- What do we need to understand about this issue?
- What are the barriers that might prevent the community from addressing this problem?
- Who are the stakeholders that will need to be engaged?
- Have any of the organizations worked on this issue previously? If so, what was learned? What was the outcome?
- How can we work together to address these barriers as a group?
- Do we have the right people at the table to start this effort? If not, how can we bring key people to the table?
- Are we willing to start a sustained collective effort to tackle this issue?

Before the meeting ends, people interested in participating should discuss next steps and plan accordingly. You may want to consider the following:

- Creating a list with everyone's email to facilitate discussions in the future
- Clearly defining your goal
- Determining tasks that will help achieve your goal, such as information gathering, and assigning responsibility of tasks to specific members
- Creating a basic timeline
- Scheduling the next meeting

## STEP 3: Gather and Assess Information and Needs

Most groups initiate their effort by performing a needs assessment that allows them to gather information specific to their focus. Although a needs assessment may seem daunting, much of the information may already be available. Before starting to gather information, make a list of questions you would like answered, such as:

- Is there a demand for comprehensive services in the SBHC?
- What are the existing services available to adolescents in the community? Are they accessible and affordable?
- Does the community know the facts about the risk behaviors of young people?
- What is the school's policy on teaching comprehensive sex education?

Here are some ideas for gathering information that will support your efforts:

- Chart audits—review existing SBHC charts to determine what percentage of students inquired about reproductive health or received pregnancy or STI testing.
- Student surveys— ask students about their risk behaviors, their desire for comprehensive services, or their access to services elsewhere. The young people on the committee are essential when gathering information from their peers.
  - In one community, young people on the committee were able to survey over 200 students in one day, asking seven questions about sexual risk and potential benefits of offering comprehensive services in the SBHC.
- Parent surveys—administer a survey at a meeting where parents are, such as a Back to School night. The surveys should be concise, and not specifically focused on reproductive health, but rather on the entire SBHC. Language barriers should be taken into consideration, and the surveys should be adapted accordingly.
- Focus groups—provide an opportunity for discussion and for all voices to be heard although they can be time consuming. Guidelines should be discussed at the beginning of the focus group and should include, at a minimum, information about respect, even when people don't agree, allowing everyone an opportunity to speak, and staying on-topic.
- Community meetings—likely the most labor intensive. Community meetings should always be structured and specific guidelines for participation discussed at the beginning.
- Individual stories—it is important to maintain confidentiality, but gathering stories is a great way to demonstrate need.
- Existing data: The following websites have state- and community-specific data related to adolescent reproductive and sexual health. Unfortunately, no specific data is collected by a school unless the school participates in the Youth Risk Behavior Survey or Healthy Kids Colorado Survey. All other data is available either by zip code or county:
  - Reportable Diseases by Age, County, and Month in the State of Colorado http://www.cdphe.state.co.us/dc/CODiseaseStatistics/index.html
  - Youth Risk Behavior Survey Results for Colorado from 1999-2007 http://www.cdphe.state.co.us/hs/yrbs/yrbs.html
  - Colorado Birth Statistics by County, Maternal Age, Maternal Education and Race/Ethnicity http://www.cdphe.state.co.us/scripts/htmsql.exe/cohid/birthquick2.hsql
  - 2006 Birth Data from the CDC http://www.cdc.gov/nchs/data/nvsr/nvsr57/nvsr57_07.pdf
  - The Colorado Organization on Adolescent Pregnancy, Parenting and Prevention's State of Adolescent Sexual Health Report http://www.coappp.org/Publications/index.htm

**Top 10 Compelling Facts**

The top ten facts about adolescent sexual health below clearly define the issue your SBHC wishes to address. Many community members may be unaware of the actual need that exists and why it is so important to provide resources and services to prevent unintended pregnancy as well as to support pregnant and parenting teens to stay in school.

These facts should not focus only on the problem, but should be used to explain the opportunity and resources your SBHC has to address a community health concern. For example, the fact that pregnancy is the number one single reason young women drop out of school presents an opportunity for SBHCs to help prevent drop-outs by preventing unintended teen pregnancy. Additionally, SBHCs can prevent drop-outs by supporting pregnant and parenting teens to help them easily access medical services and thus enable them to stay in school.

Because not everyone relates to numbers, presenting numbers in creative ways can increase their impact. For example, rather than saying, "1 in 4 young women in the U.S between 14 and 19 is infected with at least one of the most common STDs," you might say "In our high school of 400 students, at least 50 youth are likely to have a sexually transmitted infection at any given time."

1. Pregnancy is the number one single reason young women drop out of school.[2]
2. Colorado has the 19th highest teenage pregnancy rate of any state, resulting in 12,130 pregnancies per year.[3]
3. Nearly one in three 9th graders and two in three 12th graders surveyed in the 2007 Youth Risk Behavior Survey reported having had sexual intercourse at least once.[4]

[2] Hardy, J.B. & Zabin, L.S., *Adolescent pregnancy in an unborn environment: Services, programs, and evaluation (*Baltimore, MD: Urban and Schwarzenberg Press, 1991).
[3] Guttmacher Institute, *Contraception Counts: Colorado* (2006), http://www.guttmacher.org/pubs/state_data/states/colorado.pdf
[4] Colorado Department of Public Health and Environment, *2007 Youth Risk Behavior Survey Results*, http://www.cdphe.state.co.us/hs/yrbs/2007COH%20Summary%20Tables.pdf.

4. Thirty-three percent, or one in three, high school students surveyed in the 2007 YRBS reported having sexual intercourse with at least one person during the 3 months before the survey.[5]

5. The CDC estimates that 1 in 4 young women in the United States between 14 and 19 is infected with at least one of the most common STDs.[6]

6. In Colorado, young women ages 10 to 19 make up 29.2% of all reported cases of chlamydia and 23.5% of all cases of gonorrhea.[7]

7. In Colorado, rural and Latino youth experience greater disparities than urban and white youth in teen birth rates.[8]

8. The majority of parents support access to contraception in schools.[9] Latino parents do not think teaching comprehensive sex education and abstinence sends mixed messages to their kids.[10]

9. Providing contraceptives in school-based health centers does NOT increase sexual activity.[11]

10. The national teen birth rate increased 5% between 2005 and 2007—after 15 consecutive years of decline from 1991-2005.[12]

[5] Ibid.
[6] Colorado Organization on Adolescent Pregnancy, Parenting, and Prevention, *The State of Adolescent Sexual Health in Colorado 2008* (Shannon Sainer, 2008), http://www.coappp.org/images/08SASHreport.pdf.
[7] Ibid.
[8] Ibid.
[9] The Henry J. Kaiser Family Foundation, *Kaiser Daily Women's Health Policy: Majority of U.S. Adults Favor Distribution of Contraceptives in Public Schools, Poll Finds* (2007), http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=2&DR_ID=48610.
[10] Vexler, E., *Voices Heard: Latino Adults and Teens Speak Up About Teen Pregnancy* (Washington, DC: The National Campaign to Prevent Teen and Unplanned Pregnancy, 2007).
[11] Kirby, D., *Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases* (Washington, DC: National Campaign to Prevent Teen and Unplanned Pregnancy, 2007).
[12] Hamilton, B.E., Martin, J.A., and Ventura, S.J. "Births: preliminary data for 2007," *National Vital Statistics Reports* 57 no. 12 (2009).

REMINDER: While information is important when discussing comprehensive health care for adolescents, never forget the importance of building relationships. Making the assumption that parents and community members only need information can sabotage the effort. Take time to build relationships and trust. Once trust has been established, the community is a lot more likely to respond positively.

## STEP 4: Create Effective Messages

Any time the subject of reproductive health, including contraception, in school-based health centers is addressed, there are bound to be different opinions and approaches. How the message is framed when the intent of the program is communicated can either help garner support or push away potential allies. When creating messages, keep the following in mind:

- Focus on what can be accomplished by providing comprehensive services to adolescents, such as higher graduation rates or increased likelihood of going to college.
- Rather than framing messages in a negative way, which communicates how overwhelming a problem may be, focus on the positive and discuss youth as part of the solution, not the problem.
- Not everyone is a health professional so keep it simple and use accessible non-technical language.
- Involve youth in the creation of your messages.
- Focus on the larger context, rather than small details.
- Accept that not everyone will agree with your approach.
- Know your facts.
- Since the SBHC provides a variety of services, frame reproductive health as a small part of a larger system.
- Remember that reproductive health care is part of standard health care, not separate or exclusive.
- Stick to your messages and do not allow yourself to be distracted.
- Tell stories.

There are two different tiers of messages. The first tier consists of primary messages. These are messages that appeal to people at a moral level and can often be agreed upon by everyone. Rather than use words like "sex," "reproductive health," or "contraception," teen pregnancy prevention can be framed in a way that avoids the hot button words and conveys a message that more people can relate to, using concepts such as family unity, equality, opportunity, and social justice. For example, framing a teen pregnancy prevention program as a way to **reduce child poverty** can be much more effective than saying the program is a reproductive health program giving condoms to teens. Additional examples are listed below:

- Reducing unintended teen pregnancy increases the chances that all children will get a good start in life.
- Teen pregnancy prevention helps reduce persistent child poverty and builds strong families and communities.
- Despite differing opinions, we all want our children to be ready when they face the responsibilities, complexities, and compromises that intimate relationships bring.
- Preventing unintended teen pregnancy and supporting pregnant and parenting teens gives more students the opportunity to graduate and succeed in life.

Primary messages can be thought of as door openers, but once the door is open, you need to be able to follow-up with relevant information that will appeal to the particular person you are addressing.

Secondary messages are audience specific and are tailored to address audience specific worries and to help avoid typical obstacles and controversy from the on-set.

Remember, it is unlikely that you will convince those who adamantly oppose your approach. Rather than focus on that group, you will be far more successful if you can build relationships and gain support from people who may have a few small concerns or are simply unaware of the need and/or of your efforts. Understanding audience worries will help you present information that eases their concerns. Remember to use credible research to back your point when necessary. Here are some sample audiences, barriers, and tailored messages shared by existing SBHCs:

| Step 1: Specific Audience | Step 2: Identify Potential Barriers/Concerns | Step 3: Tailor Message |
|---|---|---|
| Parents | Offering contraceptive services at the SBHC undermines my right and role as a parent. | Parental consent is required for a student to access services at the SBHCs. |
| | Providing information about and access to contraceptives sends the message that sex is O.K. | Young people need to hear BOTH to postpone sexual activity AND to protect themselves from sexually transmitted infections and pregnancy when they become sexually active. |
| | My children receive information and support from me and don't need it from someone or somewhere else. | Providing comprehensive services helps protect students, especially those who do not have strong support from their parents or do not feel comfortable discussing sexuality with their parents. |
| | I will feel like a bad parent if I am the only one who supports access to contraception. | The majority of parents support access to contraception for teens. |
| | The SBHC is going to influence my child's decision about when to have sex. | The SBHC provides medically-accurate, age-appropriate health information, but it is the role of the parent to discuss their values and expectations about sex with their teen. |
| | My children do not need this type of health care, just the basics. | Assessing for risk of pregnancy, STI infection, and sexual abuse are part of the basics of adolescent health care and are critical to protecting the adolescent's health and safety; these services are part of the national standard for adolescent health care practice. |
| | This is an adult issue, not a teen issue…these are my KIDS we are talking about. | Adolescence is a time of major transitions, when young people develop many of the habits, patterns of behavior, and relationships they will carry into their adult lives. |
| School Administrator/Board | It is the parent's responsibility not the school's to provide access to comprehensive reproductive health services for students. | It is the responsibility of the entire community to ensure young people are receiving information and services that help them develop healthy habits which will be taken into adulthood. |
| | If these services were provided, the school would receive a lot of calls and complaints. | While there may be a few vocal people who do not agree with our plan, the majority of parents support providing comprehensive services. |
| Faith-Based Organizations | Abstinence is the only way to solve teen pregnancy and STI transmission. | Abstinence works best when used correctly and consistently, but safer sex is better than unprotected sex. |
| | Offering contraception to minors is wrong and only approves bad behavior. | Health professionals have an ethical responsibility to provide health services according to the needs of the patient. When contraception is available, sexually active students receive comprehensive risk assessment, counseling, and follow-up, which often results in responsible and potentially life-saving behavior. |
| | Making contraception available increases sexual activity. | Research consistently confirms that access to contraception in SBHCs does not increase sexual activity. |
| Special Interest Groups | There are too many health risks associated with young people taking hormonal contraceptives. | The health risks associated with a pregnancy in a young person far outweigh any health risks associated with the use of hormonal contraceptives. |
| | There isn't enough oversight to ensure that these clinics will comply with the law. | SBHCs are sponsored by X clinic in our community and follow the same set of guidelines. |

Here are a few more sample messages to consider:

- SBHCs can train young people to be advocates for themselves in medical and health settings and specifically in reproductive and sexual health settings, giving them experience talking to doctors and nurses about issues that are often embarrassing in our society.
- SBHCs, by giving young people some experience in meeting their own health needs, help to create young adults who can take care of themselves in future life phases, whether that be during college or when living on their own.
- SBHCs can help address what is often the central sexual health concern/question of adolescents: Am I normal?
- Withholding information from young people is unethical.
- Young people need information so that they can make decisions when adults aren't around (because parents can't always be there).

### STEP 5: Prepare Messages for the Media

Once your messages have been developed, it is extremely important to plan for media inquires and coverage. -Here are a few things to keep in mind:

- Understand the chain of command for media inquiries within the school. Often media requests are directed to the district communications person/ office. These people should be educated about your plan and given your specific messages to use when speaking with the media.
- Should your effort interest the media, try to go straight to the editor of the local newspapers rather than talk to several different reporters. Going directly to the editor allows you to educate and reduces the chances of your messages being lost in translation or taken out of context.
- Consider asking an influential school administrator or health professional to write an op-ed supportive of your effort for the local newspaper.

### STEP 6: Develop a Strategy

Once you have a committed work group, information, and messages, the group can determine the most effective strategy to broach the issue with key stakeholders. Strategies may include:

- Hold one-on-one meetings with the principal and superintendent to present your information and garner support. Small meetings are effective because they allow space for questions to be asked and concerns to be addressed.
- Hold individual meetings with school board members. These are also incredibly helpful because they give you a chance to build a relationship, make your case, demonstrate the support you have gained, present the information gathered, and answer any questions.
- Once you have determined that you can get the support of at least some of the school administrators, assemble a panel of supportive young people, parents, and health officials to state the case to school-board members.
- Get on the agenda for a school-board meeting or arrange for a presentation to the board in order to present the community data and proposed strategies to address the issue.

TIP: Many SBHCs have the school board explicitly approve the memorandum of understanding that is signed between the SBHC and the sponsor agency. Rather than try to get the school board to approve offering reproductive health services in the SBHC, it may be a better approach to have the school board approve an MOU, with reproductive health services as part of standard care, as outlined by the sponsor agency. This allows the medical experts to weigh in on the requirements of comprehensive adolescent health services.

### STEP 7: Prepare for Potential Controversy

Despite having the most carefully and strategically crafted plan and messages, there may still be some controversy and resistance to plans to offer comprehensive health services in the SBHC. Rather than being blind-sided if it does arise, here are some steps to take in preparation.[13]

- Anticipate when you are likely to face controversy; this will allow you to stay cool and focused.
- Plan the meeting structure. Despite efforts to keep a low profile and work "under the radar," supporters of comprehensive services in SBHCs must often include community forums and school-board meetings in the process of getting approval for the plan. Ask the school-board or meeting facilitators to take the following measures:
  - Schedule a 90 minute hearing (otherwise the debate could last for days).
  - Ask speakers to sign a roster.
  - Allow only persons who live in the county and/ or have children in the public school system to speak. People should be asked to identify themselves and whether or not they have kids in the school.
  - Give each speaker a maximum of two to three minutes, a time established before the hearing begins.
  - Allow each speaker only one opportunity to speak.
  - Ask articulate young people to speak about students' needs.
  - Encourage large numbers of youth to attend and show their support. The number of youth present can become the focus of news attention, which most often works in favor of providing comprehensive services.
- Prepare to answer pointed questions in public settings. Follow the rule of the four S's. Keep it simple, short, serious, and straightforward. For an example, see page 24.
- Anticipate "hot potato" questions and practice handling them in advance. When crafting your response, try to incorporate your messages. Here are a few examples:
  - We've tried to raise our children to have good moral values and to remain abstinent until marriage. How can this SBHC possibly teach children about abstinence if it is only focused on handing out birth control?
    - POSSIBLE RESPONSE: The SBHC is focused on helping teens stay healthy. We emphasize abstinence and the importance of parental involvement while providing high quality services that meet the needs of all teens, not just those who choose to be abstinent.
  - As a parent, I decide what is best for my children. The SBHCs cannot take that right away from me by teaching my kids to go behind my back to get birth control.
    - POSSIBLE RESPONSE: Parents absolutely have the right to decide what is best for their children, and SBHCs encourage parental involvement but are also obligated to abide by the minor consent laws.
  - Will students need parental consent to use these services? I need to be informed if my child is trying to use birth control or even thinking about having sex.
    - POSSIBLE RESPONSE: Consent is required to access any services at the clinic, but once consent has been given, clinicians are obligated by state law to maintain confidentiality of certain services.
  - My daughter is just not ready for all this. I resent her learning this information and having access to birth control in school. I should be able to decide when and if she gets birth control. Why don't we just leave all this to the parents and the church where it belongs?
    - POSSIBLE RESPONSE: Open communication between parents and teens is always encouraged, but it is important to remember that not all teens have supportive and open relationships with their parents. Health care providers have an ethical obligation to provide age-appropriate information and services.
  - I've heard that the majority of SBHCs don't provide contraception. Why do you think ours should be any different? Those communities value parents.
    - POSSIBLE RESPONSE: Many SBHCs do provide contraception. The rate of teen births in our area clearly demonstrates that steps need to be taken to help our teens prevent unintended pregnancy and remain in school.
  - When we tell kids to abstain and then tell them they can have condoms and birth control, we are giving them a mixed message. No wonder they are all having sex.

[13] Adapted from Huberman, B., Klaus, T., and Gonzalez, T., *Hot Potatoes: Keeping Cool in the Midst of Controversy and Managing Pressure Cooker Situations as They Arise* (Washington, DC: Advocates for Youth, 2008), http://www.advocates-foryouth.org.

- POSSIBLE RESPONSE: Providing comprehensive services sends the message that all teens can be and deserve to be healthy.

  - When is the school going to wake up? We need sex education and we need school clinics that make condoms and contraception available to anyone who needs them. How many kids are going to have to die?

- POSSIBLE RESPONSE: Teaching students about abstinence and prevention and giving them the tools to make health decisions can be life saving!

Last but not least, as one SBHC provider in Portland, Maine, states, remember:

- Avoiding the topic does not help anyone, especially the teens who desperately need access to services and safe spaces to receive information and ask questions.

- There is a short shelf-life on "hot" stories. Be patient. Ride the wave. The next "hot" story will soon eclipse yours.

- The negative aspects of controversy are often apparent. Look for the positive aspects as well—ironically, controversy can make community, parents, and even policy makers more aware of the great services SBHCs provide.

## STEP 8: Useful Websites and Resources

If you are interested in additional information, we recommend the following resources for further reading on community engagement:

**1. The Community Action Kit**

The *Community Action Kit* provides you with the tools you will need to become knowledgeable about sexuality education, build support in your state or community, work to implement sound policies, and institute or defend an effective comprehensive sexuality education program. The *Kit* is designed to serve as a tool for all advocates whether they are students, parents, teachers, school administrators, health professionals, youth-serving professionals, policymakers, or concerned community members. www.communityactionkit.org

**2. The Community Tool Box**

The purpose of the *Community Tool Box* is to **build the capacity** for people to bring about change and improvement in their communities. The *Tool Box* connects people with resources for learning the many skills required for this work and for applying this knowledge in diverse cultures and contexts by offering practical step-by-step guidance in specific community-building skills. http://ctb.ku.edu/en

**3. Additional Resources**

The following documents may also be useful when engaging the community and creating messages:

The National Latina Institute for Reproductive Health's White Paper Supporting Healthy Pregnancies, Parenting and Young Latinas, which can be found at: http://latinainstitute.org/publications/white-paper-supporting-healthy-pregnancies-parenting-and-young-latinas%E2%80%99-sexual-health.

The Society for Adolescent Medicine's Position Paper on Abstinence-Only Education, which can be found at: http://www.adolescenthealth.org/AM/Template.cfm?Section=Position_Papers&Template=/CM/ContentDisplay.cfm&ContentID=1461.

## The Four Sentence Process[14]

You may want to use a four-sentence process when responding to resistance or concern. For example, let's say that a SBHC administrator is being questioned by a student's parent about the availability of contraception in the SBHC.

- **Sentence One:** We begin with a statement that identifies the questioner's concerns or feelings. For example, we might say: "I know you care deeply about your child's health."

- **Sentences Two and Three:** This is the heart of our response. Respond in one of three ways:

  - **Present your argument and offer evidence to support your position.** For example, "We also care about your child's health and that of all the young people at this school. That is why we have chosen to provide a wide range of services that meet the needs of all teens, using methods that have been proven to help teens reduce sexual risk-taking."

  - **Challenge the credibility of the question or charge by asking for the questioner's evidence.** For example, let's say the parent says that she recently read that teaching teens about contraception and providing it in an SBHC encourages them to become sexually active. You say, "I'm sorry, but that is different from the research of many reputable organizations, like the National Institutes of Health and the World Health Organization. Where did you read it?"

  - **Refute the question or charge and then offer other information or facts.** For example, "I have to respectfully disagree. The research is clear that condoms are effective in preventing pregnancy when they are used correctly and consistently."

- **Sentence Four:** Close by taking the conversation back to the big picture. For example, "Thank you for your question as it serves to remind us that young people need to hear *both* to postpone sexual involvement and also to use protection against pregnancy and disease when they become sexually active."

[14] Ibid.

## Contents: Community Engagement Tools

This chapter contains the following tools. These tools may be useful as you work toward engaging your community to support the provision of comprehensive adolescent health care in your SBHC.

**1. Quick Tips for Building and Sustaining Relationships**

*This tool, adapted from the Community Tool Box, provides tips about the importance of building and sustaining relationships in the community engagement process.*

**2. Principles of Community Engagement**

*Provided by the Centers for Disease Control, this list suggests principles to consider preparing for, starting, and successfully implementing a community engagement effort.*

**3. Community Engagement Checklist**

*This checklist can be used as a guide during the community engagement process. It is intended to help you keep track of the key steps in the process as outlined in the toolkit.*

**4. School Board Briefing Book Template: Best Practice in Adolescent Health Care**

*The briefing book is a tool that can be used with school administrators and school board members. It gives a clear overview of relevant research associated with adolescent health care and provides a compelling list of national organizations supporting the provision of comprehensive services.*

**5. Sample Memorandum of Understanding (including reproductive health in SBHCs)**

*The sample memorandum of understanding provides an idea of key elements that should be included in an MOU. It also provides definitions for confidential health care and outlines state guidance regarding the provision of health services protected by minor consent laws.*

**6. Sample Op-Ed**

*The sample op-ed may be modified and used in your own community. It may be helpful to find a key community member to submit the op-ed once it has been modified.*

**7. A Success Story from one Colorado SBHC**

*This tool outlines the steps one community took to be able to offer comprehensive services in their SBHC.*

**8. The Colorado Association for School-Based Health Care's Reproductive Health Position Statement**

*In 2008 CASBHC issued a position statement supporting the provision of comprehensive services in SBHCs in Colorado. It can be used as yet another reference point during the community engagement process.*

## Quick Tips for Building and Sustaining Relationships

Building and sustaining relationships is the key to successfully mobilizing your efforts. There are no shortcuts, but the ideas that follow might help you get off to a solid start.

**Think strategically**

Remember relationships are an investment of both time and energy. You cannot build and sustain effective relationships with the entire community. Choose your potential allies wisely!

**Make time, ask questions, and listen**

Build time in your schedule to meet individually with potential allies. Ask them questions about themselves, and listen to what they tell you! In other words, really get to know the people that you hope will eventually be avid supporters.

**Be persistent**

Relationships are not built overnight. Building and sustaining effective relationships will take time over many months—or even years! If you do not connect with someone the first time, be persistent! Prioritize time the following month to pay them another visit.

**Communicate regularly**

Building relationships can be challenging, but it's nothing compared to sustaining them. Don't let potential allies slip away from you—keep in touch! Prioritize time to make a telephone call to solicit feedback, drop-in occasionally, and/or find time to "do lunch." Receiving a monthly newsletter, in addition to personal contact, will also support the relationships you have built.

**Identify small, short-term projects of mutual interest**

Planning is an important part of every initiative. However, the sustained involvement of community members will depend heavily on your ability to offer opportunities for action and small wins! Keep individuals that you have developed strong relationships with in mind as project needs arise that might interest them.

Adapted from:

University of Kansas, Work Group for Community Health and Development, Community Tool Box - http://ctb.ku.edu/tools

Downloaded from:

http://www.nasbhc.org/site/c.jsJPKWPFJrH/b.2564543/apps/s/content.asp?ct=3875923



## Principles of Community Engagement

**Before Starting a Community Engagement Effort . . .**

1. Be clear about the purposes or goals of the engagement effort and the populations and/or communities you want to engage.

2. Become knowledgeable about the community in terms of its economic conditions, political structures, norms and values, demographic trends, history, and experience with engagement efforts. Learn about the community's perceptions of those initiating the engagement activities.

**For Engagement to Occur, It Is Necessary to . . .**

3 . Go into the community, establish relationships, build trust, work with the formal and informal leadership, and seek commitment from community organizations and leaders to create processes for mobilizing the community.

4. Remember and accept that community self-determination is the responsibility and right of all people who comprise a community. No external entity should assume it can bestow on a community the power to act in its own self-interest.

**For Engagement to Succeed . . .**

5. Partnering with the community is necessary to create change and improve health.

6. All aspects of community engagement must recognize and respect community diversity. Awareness of the various cultures of a community and other factors of diversity must be paramount in designing and implementing community engagement approaches.

7. Community engagement can only be sustained by identifying and mobilizing community assets and by developing capacities and resources for community health decisions and action.

8. An engaging organization or individual change agent must be prepared to release control of actions or interventions to the community and be flexible enough to meet the changing needs of the community.

9. Community collaboration requires long-term commitment by the engaging organization and its partners.

Downloaded from:

**http://www.cdc.gov/phppo/pce/part3.htm**

## Community Engagement Checklist

**Research existing resources**

- ☐ Determine if any members of the SBHCs existing advisory committee are supportive
- ☐ Identify any existing unintended pregnancy prevention efforts in the community
- ☐ Find community organizations supportive of healthy teens and comprehensive adolescent health services though perhaps not focused on pregnancy prevention

**Form a work group or coalition: Remember the importance of relationships**

- ☐ Identify and target select individuals needed on the coalition to influence school board decisions
- ☐ Actively involve parents supportive of comprehensive services
- ☐ Involve teachers or school staff who can speak to the need for comprehensive services
- ☐ Involve a group of young people who are willing to speak about the need in their school as well as gather information from other adolescents (See Youth Engagement Chapter for more information.)
- ☐ Involve medical professionals considered to be "experts" on adolescent health and national standards in adolescent health care
- ☐ Involve medical sponsors that are supportive and engaged in the issue
- ☐ Look for someone who can be the "champion" for your cause

**Gather and assess information and needs**

- ☐ Collect compelling local data
- ☐ Collect information from teens in the community
- ☐ Compile existing data from state statistics, research, etc.

**Create effective messages**

- ☐ Identify key stakeholders and their potential concerns about your project
- ☐ Create messages focused on what can be accomplished by providing services
- ☐ Compile and disseminate messages

**Strategy**

- ☐ Identify a strategy to contact key people, such as individual school board members
- ☐ Prepare members of the group with talking points and messages
- ☐ Identify spokespeople for the group and prepare them to speak on behalf of the issue
- ☐ Assess political climate
- ☐ Determine the best time to implement your strategy

**Prepare for potential controversy**

- ☐ Identify potential controversy from select stakeholders
- ☐ Prepare members of the group to answer difficult questions
- ☐ Minimize controversy from the onset of the project by setting the stage early



## School-Board Briefing Book Template: Best Practice in Adolescent Health Care

This information is useful for school administrators, board members, and any other stakeholders who may benefit from reviewing relevant research associated with adolescent health care.

**National Medical Standards and Support for Comprehensive Adolescent Health Care**

The **Society for Adolescent Medicine** has issued the following position statements on reproductive health care for adolescents:[1]

**Contraception:** The Society of Adolescent Medicine hereby resolves that **contraceptive education, counseling, and services should be made available to all male and female adolescents desiring such care on the adolescents' own consent without legal or financial barriers.** Parental involvement should be encouraged, but this should not be required through either consent or notification. Low or no cost contraceptive services should be available to male and female adolescents in communities and schools and counseling and screening for sexually transmitted diseases and prevention strategies should be part of contraceptive health care. Follow-up care and compliance should be stressed.

**Sexually Transmitted Diseases**: The Society of Adolescent Medicine hereby resolves that **adolescents should have access to education, counseling, and health care services for the prevention, screening, diagnosis, and treatment of sexually transmitted diseases; and that minors should have access to these services on their own consent. Education and testing for sexually transmitted diseases should be integrated into the delivery of all adolescent health care services,** including those providing contraceptive and prenatal care. Practitioners need to be educated about the signs and symptoms of pelvic inflammatory disease and early diagnosis and treatment instituted in adolescent females. Condoms and foam should be more widely available, and teenagers should be instructed in their use and how to integrate them into their sexual relationships. Messages about risk reduction should be targeted to adolescents.

Many other influential and reputable health organizations support the provision of confidential health services for adolescents:

**The American Public Health Association:** The APHA urges that…**confidential health services [be] tailored to the needs of adolescents, including sexually active adolescents**, adolescents considering sexual intercourse, and those seeking information, counseling, or services related to preventing a pregnancy.[2]

**The American Academy of Pediatrics:** Comprehensive health care of adolescents should include a sexual history….[W]ith the onset of puberty, the **patient's history should include information regarding attitudes and knowledge about sexual behavior, degree of involvement in sexual activity, and use of contraception**.[3]

**The American College of Obstetricians and Gynecologists:** Health care professionals have an obligation to provide the best possible care to respond to the needs of their adolescent patients. **This care should, at a minimum, include comprehensive reproductive health services, such as sexuality education, counseling, mental health assessment, diagnosis and treatment regarding pubertal development, access to contraceptives, and diagnosis and treatment of sexually transmitted diseases.** Every effort should be made to include male partners in such services and counseling. Comprehensive services may be delivered to adolescents in a variety of sites, including schools, physicians' offices, and community-based and other health care facilities.[4]

[1] "Position Paper: Reproductive Health Care for Adolescents," *Journal of Adolescent Health* 12 (1991): 649-661.

[2] Gans Epner, J.E., *Policy Compendium on Reproductive Health Issues Affecting Adolescents* (Chicago, IL: American Medical Association, 1996).

[3] Ibid.

[4] Center for Adolescent Health and Law, *Policy Compendium on Confidential Health Services for Adolescents*, 2nd Edition (Madlyn Morreale, September 2005), http://www.cahl.org/PDFs/Policy%20CompendiumPDFs/PolicyCompendium.pdf

**From the Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behaviors:**[5]

Sexual health is inextricably bound to both physical and mental health. Just as physical and mental health problems can contribute to sexual dysfunctions and diseases, those dysfunctions and diseases can contribute to physical and mental health problems. **Sexual health is not limited to the absence of disease or dysfunction, nor is its importance confined to just the reproductive years. It includes the ability to understand and weigh the risks, responsibilities, outcomes and impacts of sexual actions and to practice abstinence when appropriate**. It includes freedom from sexual abuse and discrimination and the ability of individuals to integrate their sexuality into their lives, derive pleasure from it, and to reproduce if they so choose.

Sexual responsibility should be understood in its broadest sense. While personal responsibility is crucial to any individual's health status, communities also have important responsibilities. Individual responsibility includes: understanding and awareness of one's sexuality and sexual development; respect for oneself and one's partner; avoidance of physical or emotional harm to either oneself or one's partner; ensuring that pregnancy occurs only when welcomed; and recognition and tolerance of the diversity of sexual values within any community. **Community responsibility includes assurance that its members have: access to developmentally and culturally appropriate sexuality education, as well as sexual and reproductive health care and counseling;** the latitude to make appropriate sexual and reproductive choices; respect for diversity; and freedom from stigmatization and violence on the basis of gender, race, ethnicity, religion, or sexual orientation.

**Clinic Based Programs**

Prevention programs based in health clinics that have an impact on sexual health and behavior are of three types: counseling and education; condom or contraceptive distribution; and STD/HIV screening. Successful counseling and education programs have several elements in common: they have a clear scientific basis for their design; they require a commitment of staff time and effort, as well as additional time from clients; they are tailored to the individual; and they include building clients' skills through, for example, exercises in negotiation. Even brief risk-reduction messages have been shown, in some studies, to lead to substantial increases in condom use (Cohen et al, 1991; Cohen et al, 1992; Mansfield et al, 1993; Kamb et al, 1998;) although other studies have shown little effect (Wenger et al, 1992; Clark et al, 1998). More extensive counseling, either individual or small group, can produce additional increases in consistent condom use (Boyer et al, 1997; Shain et al, 1999).

Most school clinic based condom and contraceptive availability programs include some form of abstinence or risk-reduction counseling to address the concern that increased condom availability could lead to increased sexual behavior (Kirby and Brown, 1996). **The evidence indicates these programs, while still controversial in some communities, do not increase sexual behavior and that they are generally accepted by adolescents, parents, and school staff** (Guttmacher et al, 1995; Wolk and Rosenbaum, 1995). Because many STDs have no clear symptoms, STD/HIV screening promotes sexual health and responsible sexual behavior by detecting these diseases and preventing their unintentional spread. Routine screening in clinics has also been shown to reduce the incidence of some STDs, particularly chlamydia infection (Hillis et al, 1995; Scholes et al, 1996).

## Confidentiality and Laws: Caring for the Adolescent Patient

Confidentiality is one of the most important factors young people identify as a reason not to use a health clinic for reproductive health services. In fact, a 2002 study published in the *Journal of the American Medical Association* (JAMA) found that "almost half of sexually active teens (47%) visiting a family planning clinic would stop using clinic services if their parents were notified that they were seeking birth control, and another 11% reported that they would delay testing or treatment for sexually transmitted diseases or HIV; virtually all (99%), however, reported that they would continue having sex."[6] School-based health centers (SBHC) are in a unique situation in that parental consent is required to access most services; however, some services rendered during patient visits are protected by minor consent laws.

**Research**

Since the 1970's, a minor's ability and right to consent to reproductive health services, including birth control, has been an issue of debate. Research done over the past three decades shows the following:

There is no research that supports the notion that mandatory parental involvement requirements for contraceptive services will improve parent-child communication. To the contrary, research suggests that policies requiring parental involvement are potentially harmful to teenagers' health and well-being and highlights the importance of confidentiality to teenagers' willingness to seek care. Half of adolescents surveyed in family planning clinics report that a parent knows they are accessing family planning services, and a 2005 JAMA study revealed that 25% of minors surveyed were there at a parent's suggestion. "According to the 2005 JAMA study, only one percent of the minor adolescents visiting family planning clinics indicated that their reaction to mandated parental involvement would be to stop having sex, while as many as two in 10 said they would practice unsafe sex. Significantly, seven in 10 of those whose parents did not know they were at the clinic said they would not use the clinic for prescription contraception".[7]

Based on this research it is safe to assume that adolescents would be less likely to access reproductive health services in SBHCs if the services provided were not confidential. Public policy and law have long reflected the reality that many minors will not seek important sensitive health services if required to inform their parents. Laws such as the Colorado statutes outlined below have intentionally been created to guarantee confidential access to particular services.

**Ability of Minors to Consent to Health Care: Summary of Revised Statutes in the State of Colorado**

Minors are persons less than 18 years of age. Although no minimum age is specified minors under the age of 12 are typically considered unable to give informed consent. The ability of a minor to consent to care depends upon the type of treatment being sought.

Contraceptive Services: Colorado Revised State Statute 13-22-105 states: Except as otherwise provided in part 1 of article 6 of title 18, C.R.S., birth control procedures, supplies, and information may be furnished by physicians licensed under article 36 of title 12, C.R.S., to any minor who is pregnant, or a parent, or married, or who has the consent of his parent or legal guardian, or who has been referred for such services by another physician, a clergyman, a family planning clinic, a school or institution of higher education, or any agency or instrumentality of this state or any subdivision thereof, **or who requests and is in need of birth control procedures, supplies, or information.**

Sexually Transmitted Infection Services: Colorado Revised State Statute 25-4-402 states: Any physician, upon consultation by a minor as a patient and with the consent of such minor patient, **may make a diagnostic examination for venereal disease and may prescribe for and treat such minor patient for venereal disease without the consent of or notification to the parent or guardian of such minor patient** or to any other person having custody of or parental responsibilities with respect to such minor patient. In any case, the physician shall incur no civil or criminal liability by reason of having made such a diagnostic examination or rendered such treatment, but such immunity shall not apply to any negligent acts or omissions.

[5] Satcher, D., The Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior. *A Letter from the Surgeon General U.S. Department of Health and Human Services* (July, 2001).http://www.surgeongeneral.gov/library/sexualhealth/call.pdf

[6] Dailard, C., "New Medical Records Privacy Rule: The Interface with Teen Access to Confidential Care," *The Guttmacher Report on Public Policy* V 6, no. 1 (March 2003).

[7] Ibid.

HIV Testing: Colorado Revised State Statute 25-4-1405 states: Any local health department, state institution or facility, medical practitioner, or public or private hospital or **clinic may examine…for HIV infection for any minor if such physician or facility is qualified to provide such examination. The consent of the parent or guardian of such minor shall not be a prerequisite to such examination. The fact of consultation, examination, and treatment of such a minor under the provisions of this section shall be absolutely confidential and shall not be divulged by the facility or physician to any person** other than the minor except for purposes of a report required under sections 25-4-1402 and 25-4-1403 and subsection (8) of this section and a report containing the name and medical information of the minor made to the appropriate authorities if required by the "Child Protection Act of 1975," part 3 of article 3 of title 19, C.R.S. **If the minor is less than sixteen years of age or not emancipated, the minor's parents or legal guardian *may* be informed by the facility or physician of the consultation, examination, and treatment**. The physician or other health care provider shall counsel the minor on the importance of bringing his parents or guardian into the minor's confidence about the consultation, examination, or treatment.

Prenatal Care: Colorado Revised State Statute 13-22-103.5 states: Notwithstanding any other provision of law, a pregnant minor may authorize prenatal, delivery, and post-delivery medical care for herself related to the intended live birth of a child.



**Documenting the Need for Comprehensive Reproductive Health Services in Colorado School-Based Health Centers**

| Data | National | State | County | What this means: |
|---|---|---|---|---|
| **2006 Teen birth rate (ages 15-19)** | 41.9 per 1000 (a 3% increase from 2005 and the first increase since 1991) | 44 per 1000 | | **Approximately one baby is born to a Colorado teen every hour and a half.** |
| **2006 Reported cases of chlamydia *(ages 10-14)*** | 65.2 per 100,000 | 44.7 per 100,000 | | Adolescents age 10-19 make up 29.2% of all reported cases of chlamydia in Colorado. |
| **2006 Reported cases of chlamydia *(ages 15-19)*** | 1674.1 per 100,000 | 1299.4 per 100,000 | | **Nearly one in three cases of reported chlamydia in Colorado occurs in adolescents.** |
| **2006 Reported cases of gonorrhea *(ages 10-14)*** | 20.4 per 100,000 | 11.1 per 100,000 | | Adolescents ages 10-19 make up 23.5% of all reported cases of gonorrhea in Colorado. |
| **2006 Reported cases of gonorrhea *(ages 15-19)*** | 458.8 per 100,000 | 236.4 per 100,000 | | **Nearly one in four cases of reported gonorrhea in Colorado occurs in adolescents.** |
| **By 12th grade report having had sex at least once (2007)** | 47.8% | 46.7% (unweighted data) | | In Colorado by 12th grade, almost 1 in 2 students, or half of the student population, have had sex. |
| **Currently report being sexually active (9th-12th grade) (2007)** | 35.0% | 33.0% (unweighted data) | | **One in three students in any Colorado high school is currently sexually active.** |

## Key Elements of a Memorandum of Understanding:

A memorandum of understanding between a school district and a health center is often used to define the scope of services and responsibilities of each involved entity. The MOU is a perfect place to outline state minor consent laws, define confidential services, and outline the scope of care as determined or recommended by health professionals.

- **Include a definition of confidential services:**

  Under general terms and conditions, a definition for confidential services may read: The term, confidential services, as used in this MOU, shall mean interventions and services regarding reproductive health care, prevention and treatment of sexually transmitted disease, treatment for drug or alcohol use, and mental health services for which state regulation allows provision to minors without parental consent. Confidential health care is part of primary health services and interventions.

- **Include a scope of services inclusive of comprehensive reproductive health:**

  Under the responsibilities of the sponsor health agency, the list may read: The sponsor agency agrees to provide the following scope of services: primary health care; age-appropriate reproductive health care including screening and treatment of sexually transmitted diseases and provision of contraception; mental health screening, counseling, case management, and referral; health education and health promotion.

- **Include information about relevant state and federal laws:**

  State Laws: A statement regarding minor consent laws may read: Colorado State law allows minors to independently consent for and receive the following health services: STD testing and diagnosis, HIV testing and diagnosis, contraception, and prenatal care.

  Federal Laws: The Health Insurance Portability and Accountability Act (HIPAA) and the Family Education Rights and Privacy Act (FERPA) are both federal laws that impact school-based health centers. The MOU is the perfect place to determine which entities are governed by which federal laws. Because educational records can be viewed by parents, to maintain patient rights to confidential services it is important to ensure the sponsoring health agency maintains ownership of the health records generated by the school-based health center. Ownership of the health records by a health agency ensures health records are subject to HIPAA regulations.



## Sample Memorandum of Understanding

Memorandum of Understanding

Between

(insert name of) School District or Charter School

And

__(insert legal name of Medical Sponsor)__

For the Provision of School-Based Health Care

This Memorandum of Understanding is made and entered into this _____ day of _____, 20____ by and between _____ School District, hereinafter "District", and _____, (insert "a Colorado non-profit corporation" or other legal designation applicable to Medical Sponsor), hereinafter "Medical Sponsor", to formalize our agreement regarding the implementation and operation of a school-based health center on District property.

The parties hereby agree to collaborate on the implementation and operation of a school-based health center (hereinafter "SBHC") at _____ (name of school) located at _____ (address of school).

Obligations of District:

1. Designate and renovate an interior space of approximately _____ square feet to be occupied by the SBHC rent-free. The space, as renovated, will have a reception/waiting area, one exam room with accessible hand-washing sink, one counseling/health education room, one provider office, a unisex bathroom, designated lab space with clean and dirty areas, a secure area for storage of supplies and medications, and a secure area for records storage. The space will also be electrical, phone and internet ready.

2. Provide all utilities, three telephones, internet access, janitorial services, routine maintenance and repairs, removal of non-hazardous waste, security services.

3. Actively promote the SBHC to school personnel, students and families.

4. Designate the school principal as liaison between school personnel and SBHC personnel in planning and problem solving around issues concerning the SBHC. The principal will assist Medical Sponsor in developing an annual budget for SBHC operations to include the value of in-kind support from District.

5. Designate the school nurse and the school psychologist/social worker to participate in the development and implementation of joint protocols, policies and procedures that ensure continuity, quality, and confidentiality of school nursing, school mental health, and SBHC services.

6. Provide information technology support.

7. Maintain appropriate records and strict accountability for all funds provided to or by District for implementation and operation of the SBHC.

8. At the time of annual school registration, obtain consent from the parents or legal guardians of children under the age of 18 years _____ (describe the eligible population to be served by the SBHC) who wish to be served by the SBHC. The wording of the consent form(s) will be agreed upon in advance by District and Medical Sponsor.

Obligations of Medical Sponsor:

1. Furnish, equip and supply the SBHC as required to ensure quality and confidentiality of SBHC services.

2. Arrange for hazardous/biological waste disposal in compliance with federal and state laws.
3. Manage the operation of all services provided in the SBHC by any and all sub-contractors. Oversee contracts and performance expectations of sub-contracting organizations.
4. Provide the following health services to eligible children:
    - treatment of minor acute injury and illness
    - well-child/well-adolescent exams and sports physicals
    - immunizations
    - routine (CLIA-waived) laboratory tests
    - management of chronic illness
    - mental health assessment and treatment, including drug/alcohol treatment
    - case management and referral
    - age-appropriate reproductive health services, including screening and treatment of sexually transmitted infections and the provision of contraception
    - health education and health promotion
    - medications and/or prescriptions for medications
    - (add any dental services to be provided)

    Services will not include hospitalization, after-hours emergency care, treatment of complex medical or mental health conditions, medical x-rays or any other medical procedure that cannot be performed by an advance practice nurse or physician assistant under state law or that requires facilities beyond those available in the SBHC.

    No health services shall be provided to a child under the age of 18 years by the Medical Sponsor or sub-contracting organization without the prior written consent of his or her parent or legal guardian. However, in a life or health-threatening emergency, employees of the Medical Sponsor may provide life support services without written or oral parent or guardian consent.
5. Ensure that physician assistants and/or advanced practice nurses employed by the Medical Sponsor and providing services in the SBHC are operating within their scope of practice as defined by state law.
6. Ensure compliance with all applicable federal and state regulations regarding medical facilities and medical practice including those of the Occupational Health and Safety Administration (OHSA) and the Clinical Laboratory Improvement Amendments (CLIA) administered by the Center for Medicare and Medicaid Services, and the Colorado Board of Pharmacy.
7. Designate one individual who will represent Medical Sponsor in its relationship with District under this MOU and will serve as the primary liaison to District coordinate the exchange of information between the parties.

8. Ensure that employees and contractors treat all individuals in a nondiscriminatory manner, regardless of race, ethnicity, religion, national origin, citizenship, age, sex, sexual orientation, preexisting medical condition, physical or mental handicap, source of payment, economic status or ability to pay for services provided.

9. Assume responsibility for funding SBHC operations and serve as the fiscal agent for public and private grants and contracts. Develop an annual budget for SBHC operations. The annual budget will include all anticipated sources of revenue for the SBHC including grants, contracts, and donations, reimbursement for services collected from insurance carriers, and the value of in-kind support from District, as well as all anticipated expenses.

10. Maintain appropriate records and strict accountability for all funds provided to or by Medical Sponsor for implementation and operation of the SBHC.

Further Agreements of the parties:

1. The parties will jointly sponsor a Community Advisory Committee made up of representatives of each party to this MOU, representatives of the community at large, and SBHC users (parents and students). The District will convene and support meetings of the Community Advisory Committee at least twice each year. The Committee will review the use and coordination of shared resources for operation of the SBHC, utilization of services provided, need for additional services or programs and coordination between school staff, SBHC staff and any sub-contracting organizations.

2. Medical Sponsor will require its employees and the employees of all sub-contractors to undergo criminal background checks. Notwithstanding the foregoing, Medical Sponsor agrees that upon District's request and at District's expense, each employee of Medical Sponsor or sub-contractor who works in the SBHC may be subject to another criminal background check similar to that which District is legally obligated to perform on any new employee. Medical Sponsor agrees to cooperate with District in obtaining authorizations from such employees consenting to such background checks. Medical Sponsor agrees to honor any request by District to not use any individual to provide services in the SBHC based on the results of the background check.

3. The ownership and right to control of all medical records, test results and supporting documents prepared in connection with the delivery of services in the SBHC will vest exclusively in Medical Sponsor. However, Medical Sponsor agrees that copies of such medical records will be released to a patient, parent or legal guardian, as applicable, pursuant to a valid consent or to a third party as provided by applicable federal or state law. The parties expressly agree that such medical records will not be released to District nor will District have access to any of the contents of such medical records and such medical records will not be considered "educational records" as such term is defined in the Family Education Rights and Privacy Act of 1974. This section will survive termination of this MOU.

4. Medical Sponsor, at its sole expense, will secure prior to the provision of SBHC services, and will maintain during the term of this MOU: (i) commercial general liability insurance covering itself, its respective employees, contractors and agents, with commercially reasonable limits; and (ii) appropriate workers' compensation insurance as required by Colorado law; and (iii) appropriate levels of professional liability insurance which covers the provision of the medical services furnished by the Medical Sponsor's employees at the SBHC. Medical Sponsor will also ensure that sub-contractors and employees of subcontractors are likewise covered for general liability, worker's compensation and malpractice.

5. Children receiving SBHC services shall be charged the usual and customary fee for said services by the Medical Sponsor. However, no eligible child shall be denied services due to an inability to pay. A sliding fee schedule will be implemented by the Medical Sponsor based on the ability of a child or his or her family to pay. It is expressly understood by and between all parties that the District shall, in no event, be liable for any charges for services rendered to its students by the Medical Sponsor, regardless of whether or not payment is made by student or student's parents.

6. The Medical Sponsor will manage the submission of claims to the appropriate insurance carrier, i.e. Medicaid, Child Health Plan *Plus* and private insurers. Reimbursements collected either through co-pays or reimbursement by insurance shall be credited to the SBHC account.

7. The Health Insurance Portability and Accountability Act (HIPAA) and respective regulations guide management and protection of personal health information in medical records kept by Medical Sponsor and all sub-contractors providing health care in the SBHC. Medical Sponsor and all sub-contracting medical providers are HIPAA covered entities. The parties agree that personal health information in medical records maintained by Medical Sponsor in the SBHC will not be released to school personnel without required patient or parental consent.

8. The Family Educational Rights and Privacy Act (FERPA) guides management and protection of personal information in education records maintained by District employees including school nurses and school psychologists, social workers and counselors. Education records, including immunization records, are specifically exempted from HIPAA privacy regulations.

9. Colorado law and regulations allow minors to consent for and receive the following confidential health services: alcohol/drug abuse treatment, outpatient mental health treatment, contraceptives, prenatal care, and STD/HIV diagnosis and testing.

10. Under HIPAA:

    Medical Sponsor and sub-contracting health care organizations are permitted to disclose the following without parental consent:

    - Personal health information related to a child's immunization status may be provided to school nurses. School nurses are recognized under HIPAA as limited "public health entities" for the limited purpose of receiving immunization-related information to prevent and control disease.

    Personal health information may be provided to a medical provider, including a school nurse, who is providing care and treatment to the child if it is reasonable to believe that the provider will (i) take appropriate steps to protect the information and (ii) will not use or disclose the information for any purpose other than the delivery of health care to the child.

    District employees may disclose the following to Medical Sponsor without specific parental consent:

    - Personal health information may be released in any emergency when the information may be necessary to protect the health or safety of the student or other persons; FERPA allows for health information in student education records to be released to SBHC clinicians in an emergency or when the information is necessary to protect the health or safety of the student or other persons.

    Personal health information related to a child's immunization status may be provided as school nurses are recognized under HIPAA as limited "public health entities" for the limited purpose of providing immunization-related information to prevent and control disease.

11. District and Medical Sponsor agree to use appropriate safeguards to prevent use or disclosure of personal health information consistent with HIPAA privacy rules and state regulations; District will not use or routinely disclose students' health status information maintained in educational records in a manner that would violate the requirements FERPA or Colorado laws regarding provision of confidential services to minors.

12. In the case of a medical emergency on school property outside the SBHC facility, the school nurse is the primary provider of first aid and is the first line of response. If the school nurse is not available in an urgent or emergent situation, other appropriate school personnel will respond to the situation. When necessary, SBHC clinicians may be called to the scene, but will follow Medical Sponsor's direction and procedures regarding their involvement in response to urgent or emergent situations. Sub-contracting organizations will communicate information about their procedures and directions to SBHC clinicians, to the school nurse, and to the school principal so that these can be taken into account in emergency response planning.

13. The parties agree to design and annually execute an evaluation of SBHC processes, students' health status, and student health needs. Both parties will identify, collect, analyze and share data necessary to perform the agreed upon evaluation. Evaluation results will be used to improve the SBHC's efficiency, effectiveness, utilization and financing in order to increase students' access to primary health care.

***EXECUTION OF THIS MEMORANDUM OF UNDERSTANDING***

The parties agree that:

1. This MOU shall not become effective or binding on any party hereto until it has been fully executed by all parties.

2. This MOU shall be binding on both parties, their successors and assigns.

3. Both parties shall review terms and conditions of the MOU during March of each year. Any amendment desired by one party to the MOU will be proposed to the other party by April1, will be negotiated and decided upon prior to the last day of the school year, and will become effective and binding on the first day of the following school year.

4. The MOU reflects the entire understanding between the parties with respect to the subject matter hereof and supersedes all other prior oral or written statements, understandings or correspondence.

5. The persons signing the MOU have been fully authorized to execute this agreement and to validly and legally bind District and Medical Sponsor to all the terms, performances and provisions herein set forth.

6. The effective date of this MOU shall be _____, 20 , and the MOU shall continue in effect until one party gives the other party written notice of its desire to terminate. This MOU may be terminated without cause by District or Medical Sponsor. The effective date of termination will be ninety (90) days after a party's written notice of desire to terminate is received by the other party, or upon a mutually agreed upon termination date.

7. Notwithstanding the above termination provision, if at any time any party is unable to perform its obligation under this MOU consistent with such party's statutory and regulatory mandates, the affected party shall immediately provide written notice to the other party and seek a mutually agreed upon resolution.

8. The notice of termination, and all other communication related to this MOU shall be mailed to the parties at the following addresses:

For District:

For Medical Sponsor:

IN WITNESS WHEREOF, the parties have caused this Memorandum of Understanding to be executed.

Dated: _____, 20 BY: _____
Medical Sponsor representative

Dated: _____, 20 BY: _____
District representative

**If Dental Services are to be provided, consider adding:**

*Provision of the Dental Health Services*. Dental services may include oral hygiene education, oral health screenings, dental cleanings, sealants and fluoride varnish. Dental Services will be performed by licensed dental hygienists and licensed dental assistants. Dental Services will not include the provision of dental fillings, extractions or sedations or any other dental procedure that cannot be performed by a dental hygienist or a dental assistant under the Dental Practice Law of Colorado (CRS 12-35-101 *et. seq.*), other applicable state law, or that requires facilities beyond those available in the SBHC

Also consider adding language related to assistance with Medicaid and Child Health Plan *Plus* enrollment if this services is to be provided.



## Sample Op-Ed

An op-ed is the perfect way to set the stage for a discussion about reproductive health services in SBHCs. The op-ed below was published in a local newspaper in Maine following a controversy involving the provision of contraceptives in an SBHC located in a middle school. A similar op-ed would be a great way to help set the stage for a discussion or help ease controversy.

**It's Okay, You Can Say It.**

Lisa Belanger—Maine

If you want to grab people's attention, sex is a sure-fire topic. If you add "teens" to the mix, the reaction will be even stronger—a tidal wave of emotion and scrutiny. In the midst of debate and controversy, most of us have strong opinions about teen sexuality and adolescent pregnancy, but we all want our children to be ready when they face the responsibilities, complexities, and compromises that intimate relationships bring.

The risks are very real; our teens face choices that produce life-long consequences. Honest dialogue about this issue will remain elusive as long as we allow fear to guide our actions. We need to come to terms with our own anxiety about our children's sexuality and face the topic head-on. As a way to start, we offer the following reflections:

**All children need caring adults to whom they can turn for guidance, love, and support.** It's what allows them to grow up feeling whole, knowing that someone believes in them and their dreams. Unfortunately, not all children have this care readily available to them. They are often thrust prematurely into a world of adult choices and may drift into harm's way.

We all bear responsibility for being a positive presence for young people, regardless of whether they are ours or not. Studies about resiliency have shown that having at least one adult with a caring and supportive attitude in a child's life can significantly affect his/her ability to mature safely into adulthood. We need to do more to show not only our own children, but all children, that they matter to us.

**Information is not the enemy.** Plenty of studies have shown that providing information about sex does not prompt kids to go out and try it any more than learning about tobacco addiction produces smokers. The common thread for many teens that have made unfortunate mistakes when it comes to sex is their lack of information or misinformation. They deserve accurate, honest, and thorough information about this and any subject that can impact their lives so significantly.

**Saying that we need to talk to our children about sex is easier said than done.** Most of us remember our own childhood encounters with learning the basics about puberty and sex, and most of us remember it being awkward, scary, or humorous. Few of us can recount comfortable, ongoing lessons about our bodies, relationships, and sexuality. The TV-sitcom scenario of sitting down with the kids for a scripted, birds-and-bees "big talk" at puberty is not an effective means of helping children navigate the overly sexualized maze of messages they get every day. Saying nothing at all is basically the same as handing this responsibility over to the media.

Let's do away with "the big talk" in favor of many small conversations with lots of listening. This lays a foundation and sets the tone that we, as caring adults, are open and available for these curbside consults. Perhaps more importantly, it allows us ongoing opportunities to impart our values and expectations in a supportive and non-judgmental way.

**Abstinence works best, but safer sex is better than unsafe sex.** Health professionals consider avoiding risk to be best practice, but they try to minimize harm when risk is already present. The fact is, by the end of high school more than 50% of our adolescents are sexually active. Even those who know the risks can be hampered by the dual blinders of invincibility and magical thinking and may act without considering consequences. The best experts on adolescent brain development tell us that our children's brains remain "under construction" until they are well into their twenties. Their ability to

process information, regulate their emotions, and act responsibly does not always come easily. Therefore, we cannot assume that our best parenting practices alone will ensure that our children stay safe. To improve the chances that they will choose wisely, teenagers need ready access to many forms of adult guidance. So let's be sure to put grandparents, teachers, trusted friends, and a host of other caring adults and professionals in their path.

This message is supported by multiple organizations, including but not limited to the Real Life Real Talk Coalition, Portland Health and Human Services, the American Academy of Pediatrics/Maine Chapter, and the Maine Assembly on School-Based Health Care. It's Okay, you can say it! If you need help with getting started, contact the Real Life/Real Talk Coalition at 1-800-856-9762 or go to their website at http://www.reallifierealtalk.org.

## One Colorado SBHC Success Story

"Timing is everything and grassroots organizing is key," comments Sherrod Beall, who successfully opened a school-based health center (SBHC) that now offers comprehensive adolescent health services in Durango High School. Her message to the community and school was simple: the SBHC is about prevention and education and providing best practices in adolescent health care.

Using a public health model, Sherrod was very clear about her goal, what was needed to accomplish it, and the importance of partnerships. First and foremost, she emphasizes the importance of partnering with someone in the school, who speaks the language of schools. Having a partner in the school helped make the SBHC a priority that was included in the redesigned floor plan of Durango High School.

In addition to partners in the school, the members of the community advisory council played a fundamental role. The group included representatives from the local health department, mental health, human services, and the San Juan Basin Health Center. The superintendent of schools was fully supportive of the SBHC, and a new high school principal also signed on as an advocate.

Prior to discussing the inclusion of reproductive health services, support was gathered from students and parents using surveys and by meeting with them on every possible occasion. Nine hundred competed student surveys were enough evidence to show the need for comprehensive services! Teachers were also included and educated about the importance of a health center providing comprehensive services.

Once all the information had been gathered and the community had been educated, the principal was approached about the inclusion of comprehensive reproductive health services in the SBHC. All of the planning paid off when the provision of these services received the green light.

Despite the law that allows the SBHC to provide reproductive health services without parent permission, the SBHC decided to require parental consent once per year. To truly address the needs of the community and students, a provision was made for students to be able to use the SBHC once without parental consent due to the high rates of suicide among adolescents in the school. After the student uses the clinic once, the nurse works with the student and the parents to get the consent form signed. Nearly 90% of the student population has signed consent forms.

Sherrod notes that providing comprehensive adolescent health services is a continual process that requires time and commitment. Finesse, timing, partnerships, grassroots organizing, and even a little bit of luck all contributed to her success.



## Colorado Association for School-Based Health Care's Position Statement: The Delivery of Preventive and Primary Reproductive Health Services In School-Based Health Centers

The Colorado Association for School-Based Health Care (CASBHC) promotes access to comprehensive health services for adolescents. Where there is a significant documented need to reduce the prevalence of at-risk behaviors and incidence of sexually-transmitted disease among adolescents, school-based health centers (SBHCs) should meet that need through providing preventative and primary reproductive health services. These services include human sexuality education, behavioral risk assessment, counseling, pregnancy testing, contraception or referral for contraception, and diagnosis and treatment of sexually-transmitted infection. Ultimately, the goal is to keep students healthy, in school, and ready to learn.

### Documenting the Need For Reproductive Health Services

#### Teen Sexual Activity

The Centers for Disease Control and Prevention (CDC) conducted a nationwide survey to monitor health-risk behaviors among students in grades 9 to12 from October 2004 to January 2006. Regarding reproductive health nationwide, 46.8% of students reported having had sexual intercourse. When broken down by ethnicity, 67.6% of blacks, 51.0% of Hispanics, and 43.0% of whites reported having had sexual intercourse.[1] Nationwide, 33.9% of students reported having had sexual intercourse with at least one person in the last three months prior to the survey. Of that 33.9%, 62.8% reported that either they or their partner used a condom during the last sexual intercourse and 17.6% reported that they or their partner used birth control pills before the last sexual intercourse.[2]

In Colorado, 39.3% of students reported having had sexual intercourse. About 30% of students in Colorado reported being currently sexually active, and among these students, 69.3% reported condom use during their last sexual intercourse. Fifteen percent reported using birth control pills before their last sexual intercourse. [3]

#### Teen Pregnancy

Nationally and across Colorado, teen pregnancy rates have declined since the early 1990's. Between 1992 and 2000, the nation saw a decrease in teen pregnancy by 24%.[4] Despite the decline, the United States teen pregnancy rate is still the highest among western nations. The pregnancy rate is twice as high as England, Wales and Canada, three times as high as Sweden[5] and eight times as high as the Netherlands and Japan.[6]

Compared to the nation, Colorado saw a larger decline in teen pregnancy. Between 1992 and 2000 Colorado's teen pregnancy rate declined 26% among 14-19 year olds. Most of the decline occurred among the 18-19 year olds, less among the 15 to 17 year olds. Although there has been a decline, teenage pregnancy is still pervasive in Colorado. Every four hours, a baby is born to a Colorado teen between 15 and 17 years of age.[7]

Colorado has the 22nd highest teenage pregnancy rate among the 50 states. There are approximately 12,130 teenage pregnancies each year in Colorado of which 62% result in live births.[8] The Colorado Organization on Adolescent Pregnancy, Parenting and Prevention (COAPPP), broke down Colorado's fertility rate by county for females 15-17 years old from 2003 to 2005. Lake County had the highest teen fertility rate at 56.9 per thousand, Otero was second at 54.1 and Denver was third at 53.5. The top ten also included Crowley with 48.4, Morgan with 46.3, Castilla with 45.6, Prowers with 42.0, Adams with 40.9, Rio Grande with 39.6 and Huerfano with 38.8 per thousand.[9]

The calculation of rates can be deceptive when the population being measured is small, as it is in many rural counties in Colorado. Therefore, COAPPP created a list of the state's most populated counties having the highest teen fertility rates. At the top of the list is Denver with 53.5. The fertility rates in other highly populated counties are: Adams 40.9, Pueblo 36.4, Weld 35.4, Arapahoe 20.0, El Paso 19.6, Boulder 15.4, Larimer 14.2, Jefferson 13.0 and Douglas 4.3.[10]

#### Sexually Transmitted Infections

Studies show that persons who engage in sexual activity at a young age often have multiple sexual partners

and frequent sexual encounters. Both behaviors can be attributed to increased risk of contracting sexually transmitted infections (STIs). Additionally, adolescent females may be more susceptible to STIs than older women. Teen girls have fewer antibodies to STIs and may have a higher risk of cervical infections.[11] In 2006, the highest rates of chlamydia were in females age 15-19 at 347.8 cases per 100,000, a 5.6% increase from 2005.[12] Approximately 9 million U.S. teens contract an STI every year.[13,14] Compared to other states, Colorado ranks 22nd for chlamydia, 32nd for gonorrhea and 24th for syphilis.[15]

### Consequences of Teen Pregnancy

#### Economic impact

Children of teens born in Colorado cost taxpayers at least $167 million in 2004 ($9.1 billion nationally). Included in the taxpayer costs are medical care for the child, child welfare and lost tax revenue due to decreased earnings and spending of the parents. The average annual public cost associated with a child born to a mother 17 years of age and younger is $4,056.[16]

#### Educational Impact

Pregnancy is the main reason adolescent girls drop out of school.[17,18] Young mothers are less likely to graduate.[19,20] Although little research has been completed on adolescent fathers, it is known that, should they decide to support their child, they too are more likely to drop out of school. [21]

#### Health and Social Welfare Impact

Pregnancy disrupts adolescence which is a time of transition between childhood and adulthood. There are several negative health and social impacts on a teenage parent. Pregnant teens are more likely to experience higher rates of pregnancy-related complications such as toxemia and anemia; and, they are more likely to deliver low birth weight, premature,[22] and developmentally disabled babies.[23] Additionally, teen mothers are more likely to be single parents, have a greater reliance on public assistance and have multiple children over a short time frame.[24]

While teen mothers face difficulties, their children face even more hardships. Children of teen mothers often have poorer health, more developmental delays,[25,26] and are more likely to be abused and/or neglected.[27,28] As children of teen mothers age, they are predisposed to dropping out of school, obtaining low-skilled employment, be incarcerated,[29] and become teen parents themselves.[30] According to The National Campaign to Prevent Teen Pregnancy, if a child's mother gave birth as a teen, if the child's parents were unmarried when the child was born, and if the mother did not receive a high school diploma or GED, the child is nine times more likely to grow up in poverty compared to if none of these factors existed.[31]

### Consequences of Sexually Transmitted Infections

The most common STIs are chlamydia, human papillomavirus (HPV), genital herpes, gonorrhea, syphilis and human immunodeficiency virus (HIV). Some STIs have painful and long-term consequences including birth defects, blindness, cancer, heart disease and death.[32] STIs can also lead to infertility, ectopic pregnancy and long-term emotional suffering and stress.

#### Chlamydia and Gonorrhea

According to the Center for Disease Control and Prevention (CDC), in 2004, 929,462 cases of chlamydia were reported from 50 states and the District of Columbia. However, the CDC approximates that 2.8 million people are infected with chlamydia each year, most going unreported due the absence of signs or symptoms. Like chlamydia, gonorrhea often presents with no symptoms; however, symptoms may occur within thirty days but be mistaken for other infections.[33] Roughly 75% of American gonorrhea infections occur in persons 15 to 29 years old. Additionally, in 1999, 75% of gonorrhea infections occurred in African Americans.[34]

#### Pelvic Inflammatory Disease (PID)

Left untreated, both chlamydia and gonorrhea can lead to pelvic inflammatory disease (PID). [35,36] Many organisms can cause PID; however, most cases of PID are associated with chlamydia and gonorrhea.[37] Approximately one million women develop PID each year in the United States.[38] PID is more likely to occur in sexually active women under the age of 25 verses women older than 25. Due to the lack of maturity, a younger woman's body is more susceptible to contract STIs that, if left untreated, eventually lead to PID. PID usually goes undetected and untreated due to its mild symptoms. Additionally, there are no specific tests to identify PID. However, untreated PID can damage the female reproductive system leading to infertility. One in eight women with PID becomes infertile.[39]

#### Human Papillomavirus (HPV)

HPV is the most common STI in the United States[40] affecting approximately 20 million people.[41] Roughly 50% of sexually active men and women will acquire genital HPV infection at some point in their lives. By age 50, approximately 80% of women will have acquired genital HPV infection.[42] HPV often presents with no symptoms for both men and women. Some people get genital warts and some may have pre-cancerous changes in their reproductive tract. According to the CDC, "Human papillomavirus is the name of a group of viruses that have more than 100 different strains. More than 30 of these viruses are sexually transmitted."

Currently, there is no cure for HPV infection. For most men, the virus will never cause any symptoms or health problems,[43] and for most women, the virus will go away on its own.[44] For 90% of women, cervical HPV infection becomes undetectable within two years.[45] However, about 10 of the 30 genital HPV types can lead to cervical cancer. Therefore, in 2006, the Food and Drug Administration approved the Gardasil vaccine which prevents infection from four common types of HPV.[46]

#### STIs and HIV

All STIs have a link with HIV infection. According to the CDC, having an STI increases a person's susceptibility to HIV.[47] Women infected with chlamydia are up to five times more likely to become infected with HIV if exposed.[48]

#### STIs and Pregnancy

STIs also pose consequences for pregnant women who can pass an STI to their babies before, during or after birth. STIs in babies can cause stillbirth, low birth weight, conjunctivitis (pink eye), pneumonia, neonatal sepsis (infections of the baby's blood stream), neurological damage, blindness, deafness, acute hepatitis, meningitis, chronic liver disease and cirrhosis. [49]

### Defining Preventive and Primary Reproductive Health Services Offered in a School-Based Health Center

Preventative and primary reproductive health services may be offered at school-based health centers in order to reduce the incidence of disease and prevalence of at-risk behaviors among adolescents. Although the services vary among centers, they most often include human sexuality education, a comprehensive behavioral risk assessment, counseling, pregnancy testing, contraception or referral for contraception, and diagnosis and treatment of sexually transmitted infections.

The services provided by each SBHC vary based on the age of students served, student need, community resources, available funding and local school district policy. Most SBHCs located in high schools include a comprehensive behavioral risk assessment as part of a well-adolescent exam, and follow up with health education and counseling when a need is identified. Sexually active students are counseled and informed about the risk of pregnancy and sexually transmitted infection. Some SBHCs provide contraception, while others refer students to another provider in the community. Most SBHCs provide pregnancy testing upon request. If a diagnosis of pregnancy is made, SBHCs provide non-directive counseling, support, and referral as needed. However, in rural areas of Colorado, lack of community resources and inadequate transportation may make referrals impractical and limit access to reproductive health services.

### Human Sexuality Education

***Desired Outcome**: Adolescents make informed, healthy decisions to delay sexual activity.*

#### Program Types

The two main types of human sexuality education programs are Abstinence-Only and Comprehensive.

### Abstinence-Only Programs

There are two sub-types of abstinence-only programs; Abstinence-Only Education and Abstinence-Only-Until-Marriage Education. Abstinence-Only Education promotes abstinence as the "only morally correct option of sexual expression for teenagers." Abstinence-Only-Until Marriage programs are similar but add a component regarding unmarried adolescents and/or young adults.[50] Both programs exclude information about using contraception as a way to prevent unwanted pregnancies and to prevent infections.[51] Another commonly used name for abstinence-only programs is Abstinence-Centered Education. [52]

### Comprehensive Sex Education Programs

Comprehensive sex education programs stress the importance of abstinence as the best way to prevent pregnancy and disease. These programs also provide information on various types of contraception including their benefits, their success and failure rates, and possible side effects.[53] Other names for comprehensive sex education programs are Abstinence-Based Education and Abstinence-Plus Education.[54]

A law passed by the Colorado General Assembly in 2007 (HB07-1292) requires that a school district or charter school that offers instruction in human sexuality must base the content on scientific research and must encourage parental involvement and family communication. The law states, in part, that "Comprehensive sex education programs that complement the involvement and instruction of parents and respect the diversity and values of the state provide Colorado's youth with a foundation of information to help them make responsible, healthy, and informed decisions." [55]

### Evaluation of Abstinence-Only Programs and Comprehensive Sex Education Programs

Numerous studies have been completed about the effectiveness of abstinence-only programs and comprehensive sex education programs. These studies have conclusively shown that, while there are benefits to both, comprehensive sex education programs have been more effective in delaying the initiation of sex, reducing the number of sexual partners and reducing the frequency of sex. [56,57]. Additionally, comprehensive sex education programs do not increase sexual activity. [58,59,60]

As cited in the American Psychology Association Journal Online by the APA Committee on Psychology and AIDS:

> The research on adolescents' sexual behavior shows that comprehensive sexuality education programs that discuss the appropriate use of condoms do not accelerate sexual experiences. On the contrary, evidence suggests that such programs actually increase the number of adolescents who abstain from sex and also delay the onset of first sexual intercourse. Furthermore, these programs decrease the likelihood of unprotected sex and increase condom use among those having sex for the first time.[61]

In addition, "studies of schools with health clinics and schools with condom-availability programs have consistently shown that the provision of condoms and other contraceptives through schools does not increase sexual activity"[62]

### Comprehensive Behavioral Risk Assessment

***Desired Outcome**: Reduce the incidence of risk-taking behavior through collecting information about the type of behaviors in which the adolescent is engaged and educating the adolescent as part of the well-adolescent exam.*

Comprehensive behavioral risk assessments are administered for the purpose of identifying unhealthy behaviors and providing appropriate interventions. One of the most widely used risk assessment tools is the Guidelines for Adolescent Preventive Services (GAPS). GAPS was developed by the American Medical Association (AMA) to organize, restructure and redefine health care delivery for adolescents. GAPS provides twenty-four recommendations to physicians and other health providers on how to best deliver preventative services. [63,64] "The goal of GAPS is to improve health care delivery to adolescents using primary and secondary interventions to prevent and reduce adolescent morbidity and mortality" [65]



### Counseling

***Desired Outcome**: To support students in making healthy choices around reproductive health issues; to increase positive communication around reproductive health issues.*

Counseling is an important aspect of providing reproductive health services as it is vital to understand the motivating factors behind adolescent choices to become sexually active. Clinicians and health educators encourage adolescents to involve their parents in reproductive health decisions. Within the scope of counseling services at SBHCs, staff may counsel adolescents regarding their developmental and/or emotional preparedness for having sex, peer influences, parental values and self-esteem. If the adolescent is in a relationship, discussions may address the components of a healthy relationship.

### Contraception And Pregnancy Testing

***Desired Outcomes:** To reduce the number of unwanted pregnancies; to increase knowledge around ways to prevent unwanted pregnancies and sexually transmitted infections, to encourage early prenatal care and improve the health of babies born to adolescent women.*

Approximately 80% of teen pregnancies are unintended.[66] When teens use contraception during their first sexual experience, they are less likely to get pregnant. Forty-three percent of teen girls who did not use contraception during their first sexual experience reported pregnancy versus 27% of teen girls who used contraception. Likewise, 18% of teen boys who did not use contraception at first intercourse reported involvement in a pregnancy versus 12% who used contraception.[67] According to the National Campaign to Prevent Teen and Unwanted Pregnancy, many teens do not use contraceptives consistently and correctly. Of girls age 15 – 19 who use oral contraceptives, only 70% take a pill every day.[68]

Pregnancy testing is performed in SBHCs upon request. If an adolescent has a negative pregnancy test, the clinician provides education and counseling and, if the adolescent indicates continuing sexual activity, contraception or a referral for contraception. If the pregnancy test is positive, the adolescent is strongly encouraged to inform and involve parents or other trusted adults in decision-making, and non-directive, family-centered counseling is initiated.

### Diagnosis and Treatment of Sexually Transmitted Infection

***Desired Outcome**: Early intervention to lower complications.*

Upon request, adolescents are screened for sexually transmitted infections. Some SBHCs have the capacity to provide treatment for STIs; others refer to providers in the community. In addition to treatment, SBHCs provide education and counseling to address at-risk behaviors.

Antibiotics are most often used to treat bacterial infections such as gonorrhea, chlamydia and syphilis. Viral infections are commonly treated with antiviral medications as needed. Self-care can relieve some painful symptoms related to genital herpes or genital warts.

## School-Based Health Centers and the Law

In the State of Colorado, a minor may consent to the following services: contraceptive services, STI services, prenatal care and general medical care for the minor's child.[69] According to 25-4-402 Colorado Revised Statutes, a minor may consent to examination and treatment of a "venereal" disease without the consent or notification of a parent and a physician may provide an examination and treatment for a "venereal" disease without the consent or notification of a parent without penalty.[70]

Additionally, in the State of Colorado, sexual contact is prohibited if the juvenile is under the age of 15 and the "actor" (other person) is more than four years older.[71] If SBHC personnel suspect sexual abuse, they are mandated to report the information to appropriate officials.

### Confidentiality

Privacy and confidentiality are of the utmost importance in providing medical care to adolescents. Teens are more likely to share important health-related information with trusted adults. SBHCs are bound by

the Health Insurance Portability and Accountability Act (HIPAA). HIPAA guidelines regulate who can access medical records and personal health information and what information can be disclosed. Because Colorado allows minors to consent to reproductive health services, parents of minors are not allowed access to their child's medical records under HIPAA, unless the minor consents.[72] However, SBHC clinicians encourage adolescents to engage in open dialogue with their parents/guardians about all aspects of their health care.

## Conclusion

The services provided in each school-based health center depend upon the age of students served, documented need, community resources, available funding, and local school district policy. Where there is a significant documented need among adolescents for comprehensive reproductive health services, School-based health centers should meet those needs through providing human sexuality education, behavioral risk assessment, counseling, pregnancy testing, contraception or referral for contraception, and diagnosis and treatment of sexually transmitted infection.

Endnotes: CASBHC Position Statement


1 Centers for Disease Control and Prevention. (2006, June 9). *Morbidity and Mortality Weekly Report:Youth Risk Behavior Surveillance - United States, 2005.* Retrieved December 2007, from Centers for Disease Control and Prevention: http://www.cdc.gov

2 Id., at 1.

3 Centers for Disease Control and Prevention. (2006, June 9). *Morbidity and Mortality Weekly Report:Youth Risk Behavior Surveillance - United States, 2005.* Retrieved December 2007, from Centers for Disease Control and Prevention: http://www.cdc.gov

4 Colorado Organization on Adolescent Pregnancy, Parenting and Prevention. (2007). *The State of Adolescent Sexual Health in Colorado 2007.* Retrieved November 27, 2007, from http://www.coappp.org

5 Kreipe, R., MacDonald, C., & McAnamey, E. (1991). Reproductive Health Care for Adolescents. *Journal of Adolescent Health* , 649-661.

6 Guttmacher Institute. (2006, December). *Facts on Sex Education In The United States.* Retrieved December 13, 2007, from Guttmacher Institute: http://www.guttmacher.org

7 Id., at 3.

8 Guttmacher Institute. (2006, March). *Contraception Counts.* Retrieved November 29, 2007, from Guttmacher Institute Web Site: http://www.guttmacher.org.

9 Id., at 3.

10 Id., at 3.

11 Nossel, I. (1996, October). *Pregnancy and Childbearing Among Younger Teens.* Retrieved December 3, 2007, from Advocates For Youth: http://www.advocatesforyouth.org

12 Centers for Disease Control. *National Profile, STD Surveillance 2006.* Washington, DC, 2006.

13 Elliott, A. (2007, March 29). *The Bell Policy Center.* Retrieved December 3, 2007, from The Bell Policy Center Web site: http://www.thebell.org

14 Id., at 5.

15 Id., at 12.

16Id., at 3.

17 Brindis, C., & Philliber, S. (1998). Room to Grow - Improving Services for Pregnant and Parenting Teenagers in School Settings. *Education and Urban Society* , 242-260.

18 Freudenberg , N., & Ruglis, J. (2007). Reframing School Dropout as a Public Health Issue. *Preventing Chronic Disease: Public Health Research, Practice and Policy , 4* (4), 1-11.

19 Kirby, D. (2001). *Emerging Answers Summary: Research Findings on Programs to Reduce Teen Pregnancy.* Washington, DC: National Campaign to Prevent Teen and Unwanted Pregnancy.

20 Gallager, K., & Drisko, J. (2000, July). Building Community Capacity For Teen Pregnancy Prevention. *Evaluation of The Colorado Trust Teen Pregnancy Prevention 2000 Initiative* . Colorado, United States of America.

21 Id., at 16.

22 Id.,at 19.

23 Colorado Department of Public Health and Environment. (2002). *Unintented Pregnancy: Why it Matters.* Retrieved December 13, 2007, from Colorado Department of Public Health and Environment: http://www.cdphe.state.co.us/pdf/upwebdoc2002.pdf

24 Id., at 19.

25 Id., at 22.

26 Id., at 19.

27 Id., at 19.

28 Id., at 24.

29 Id., at 19.

30 Id., at 18.

31 The National Campaign To Prevent Teen Pregnancy. (n.d.). *Linking Teen Pregnancy Prevention to Other Critical Social Issues.* Retrieved November 28, 2007, from Teen Pregnancy: http://www.teenpregnancy.org

32 Haggerty, M. (2002, December). *Health A to Z.* Retrieved December 12, 2007, from Health A to Z Web site: http://www.healthatoz.com

33 Centers for Disease Control and Prvention. (2006, April). *CDC Fact Sheet - Gonorrhea*. Retrieved December 12, 2007, from CDC FAct Sheet: http://www.cdc.gov/std/healthcomm/fact_sheets.htm

34 Id., at 31.

35 Centers for Disease Control and Prevention. (2006, April). *CDC Fact Sheet-Chlamydia*. Retrieved December 12, 2007, from CDC Fact Sheet: http://www.cdc.gov/std/healthcomm/fact_sheets.htm

36 Id., at 32.

37 Centers for Disease Control and Prevention. (2004). *CDC Fact Sheet-Pelvic Inflammatory Disease*. Retrieved December 12, 2007, from CDC Fact Sheet: http://www.cdc.gov/std/healthcomm/fact_sheets.htm

38 Id., at 35.

39 Id., at 36.

40 Alford, S. (2003, January). *Adolescents - At Risk For Sexually Transmitted Infections.* Retrieved December 5, 2007, from Advocates For Youth: http://www.advocatesforyouth.org

41 Centers for Disease Control and Prevention. (2004, May). *Genital HPV Infections - CDC Fact Sheet*. Retrieved December 12, 2007, from Genital HPV Infections - CDC Fact Sheet: http://www.cdc.gov/std/healthcomm/fact_sheets.htm

42 Id., at 40.

43 Centers for Disease Control and Prevention. (n.d.). *HPV and Men - CDC Fact Sheet*. Retrieved December 12, 2007, from HPV and Men - CDC Fact Sheet: http://www.cdc.gov/std/healthcomm/fact_sheets.htm

44 Id., at 40.

45 Id. ,at 40.

46United States Food and Drug Administration. (2008, January 14). *Product Approval Information.* Retrieved February 4, 2008, from Gardasil Product Approval Information: http://www.fda.gov/cber/products/gardasil.htm

47 Centers for Disease Control and Prevention. (2000). *The Role of STD Detection and Treatment in HIV Prevention*. Retrieved December 12, 2007, from The Role of STD Detection and Treatment in HIV Prevention: http://www.cdc.gov/std/healthcomm/fact_sheets.htm

48 Id., at 34.

49 Center for Disease Control and Prevention. (2004, May). *STDs and Pregnancy - CDC Fact Sheet*. Retrieved December 12, 2007, from STDs and Pregnancy - CDC Fact Sheet: http://www.cdc.gov/std/healthcomm/fact_sheets.htm

50 Advocates For Youth. (n.d.). *Sex Education Programs: Definitions and Point-by-Point Comparison.* Retrieved December 6, 2007, from Advocates For Youth Web site: http://www.advocatesforyouth.org

51 Kirby, D. (2007). *Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases.* Washington, DC: National Campaign to Prevent Teen and Unwanted Pregnancy.

52 Id., at 50.

53 Id., at 18.

54 Id., at 50.

55 General Assembly of the State of Colorado. "House Bill 07-1292." *Concerning The Adoption of Science- Based Content Standards For Instruction Regarding Human Sexuality.* 2007.

56 American Psychological Association. (2005, February 23). *Based On The Research, Comprehensive Sex Education Is More Effective At Stopping The Spread of HIV Infection, Says APA Committee*. Retrieved December 5, 2007, from American Psychological Association Online Web site: http://www.apa.org/releases/sexeducation.htm

57 Id., at 18.

58 McKeon, B. (2006). *Effective Sex Education.* Retrieved December 2007, from Advocates For Youth: http://www.advocatesforyouth.org

59 Id., at 51.

60 Marsiglio, W., & Mott, F. L. (1986). The Impact of Sex Education on Sexual Activity, Contraceptive Use and Premarital Pregnancy Among American Teenagers. *Family Planning Perspectives* , 151-154.

61 Id., at 55.

62 Id., at 18.

63 American Medical Association. (1997). *Guidelines for Adolescent Preventive Services (GAPS).* Retrieved December 2007, from American Medical Association: http://www.ama-assn.org

64 Montalto, N. J. (1998). Implementing the Guidelines for Adolescent Preventive Services. *American Family Physician:* http://www.aafp.org/afp/980501ap/montalto.html.

65 Id., at 63.

66 Weiss, D. G. (2007, September). *Pregnancy & Childbearing Among U.S. Teens.* Retrieved December 2007, from Planned Parenthood: http://www.plannedparenthood.org

67 Suellentrop, K., & Flanigan, C. (2006, April). *Science Says: Pregnancy Among Sexually Experienced Teens, 2002.* Retrieved 20 December, 2007, from The National Campaign to Prevent Teen Pregnancy: http://www.teenpregnancy.org

68 Id., at 51.

69 Guttmacher Institute. (2007, November 1). *State Policies In Brief: An Overview of Minors' Consent Law.* Retrieved November 27, 2007, from Guttmacher Institute: http://www.guttmacher.org

70 The Committee on Legal Services for the State of Colorado and Matthew Bender & Company. (2007). *Colorado Revised Statutes.* CRS 25-4-402 Retrieved December 13, 2007, from Lexis Nexis: http://www2.michie.com/colorado/lpext.

71 The Committee on Legal Services for the State of Colorado and Matthew Bender & Company. (2007). *Colorado Revised Statutes.* 18-3-402 Retrieved December 13, 2007, from Lexis Nexis: http://www2.michie.com/colorado/lpext.

72 United States Department of Health and Human Services. (2006, May 16). *Medical Privacy - National Standards to Protect the Privacy of Personal Health Information*. Retrieved December 13, 2007, from United States Department of Health and Human Services: http://www.hhs.gov/ocr/hipaa/

## Youth Engagement

**Introduction**

As SBHCs aim to increase access to comprehensive care, youth can and should be engaged as advocates. Youth participation in social action can help lead to healthier, more just, and more effective youth- serving institutions.[1] When teens are able to clearly and intentionally communicate to adults the need for comprehensive reproductive and sexual health services in their school, they have tipped the scales in favor of care that truly addresses the needs of all adolescents. This chapter of the toolkit will describe several frameworks for youth engagement that can facilitate youth advocacy for reproductive health services in SBHCs.

This chapter includes the following sections:

1. What is a Youth Advocate?

2. Why is Youth Advocacy Effective?

3. Making the Case for Comprehensive Reproductive Health Services

4. Lessons from Research

The following tools may also be useful:

1. Creating a Concept Map

2. Resources

### What is a Youth Advocate?

When we think of advocacy, a few things that come to mind are government, legislation, lobbying, and other potentially esoteric and often out-of-reach decision-making bodies and processes. This can be especially true for adolescents who are not often given a voice in decision-making. Recent studies show that teens often feel disengaged from their communities, removed from the political process, and unable to make a difference in their communities or to affect the political system.[2] Historically, institutions and organizations created to serve adolescents have neglected to solicit youth input in decision-making. More recently, however, these same institutions and organizations are beginning to recognize the value of youth as partners as well as advocates.

School-based health centers often understand the importance of youth engagement and even ask youth for input on many topics. However, SBHCs can become better equipped to serve the adolescent population by engaging youth as advocates. The existing definition for youth advocacy is centered in the juvenile justice system and is defined as activities focused on improving services for and protecting the rights of youth.[3] This definition can be adapted to SBHCs: activities focused on health promotion, protecting the rights of youth, and changing or enhancing existing policies to address the needs defined by youth.

Youth advocates have the potential to define their greatest health concerns and determine the best way to share that information with adults and ultimately influence the decision-making process. When SBHCs are advocating for the availability of comprehensive reproductive and sexual health services, youth are the strongest advocates. Of course, statistics are important, but it is far more compelling for administrators to hear directly from students in the school about the need they experience and see every day.

Engaging youth as advocates first requires that teens feel empowered to use their voice. For many teens, the idea of having a voice that is equal to that of an adult is a new concept. Teens must be properly oriented to the idea of youth advocacy and supported in developing youth-informed solutions reflecting their unique expertise. Upon uncovering their health needs and becoming equipped with skills and knowledge, teens can begin to think about action and, with their adult partners, can begin to strategize how to move from information into action.[4]

[1] Ballonoff Suleiman, A., Soleimanpour, S., and London, J., "Youth Action for Health Through Youth-Led Research," *Journal of Community Practice* 14, no. 1 (2006): 125-145.

[2] Share, R. and Stacks, J. "Youth-Adult Partnership in Community Organizing," *Journal of Community Practice*. 14, no 4. (2007): 113-127.

[3] Definition of youth advocacy from Legaldictionaries.org.

[4] Suleiman et al. *Journal of Community Practice.*



### Why is Youth Advocacy Effective?

When teens take the time to advocate for comprehensive reproductive health services in their SBHC, they are sharing a viewpoint and expertise that is unparalleled. Teens are uniquely qualified as experts in the teen experiences- and in health needs related to their experience. Working with supportive adults, teens are able to influence and directly impact positive changes that can lead to positive health outcomes. For example, in 2007, a new teen clinic was opening in Longmont, Colorado to provide teens with access to family planning services. The City Council was undecided as to whether or not it supported the idea of the new clinic. A group of teens who understood the need for family planning for adolescents in their community decided they needed to make their voice heard on the issue. After a few planning meetings, the group presented the need to the City Council. The City Council voted unanimously not only to provide conceptual support, but also to provide funding during the first year of operation to help get the clinic off the ground.

### Making the Case for Comprehensive Reproductive Health Services

Rather than develop new approaches to youth advocacy, SBHCs can benefit from implementing existing strategies and frameworks. No matter what the approach, youth advocacy requires time, commitment, and flexibility.

**Youth-led Action Research, Evaluation, and Planning**

One very successful approach to youth advocacy is called Youth-led Action Research, Evaluation, and Planning (Youth-REP). Youth-REP is a social action framework that combines community-based participatory research and capacity-building to engage young people in working towards health equity and social justice.[5]

As young people begin to understand the health inequities and public health issues in their community, Youth-REP helps them build a foundation to engage in powerful partnerships with adults and work toward achieving just, democratic, and sustainable social change.[6]

To test whether or not Youth-REP leads to social change, seven SBHCs in California participated in the Youth-REP curriculum during the 2003-2004 school year. The main goals of the project were to increase the capacity of the SBHC staff and youth to engage in research on student health and to improve the quality and breadth of services offered by the SBHCs. Each group participated in a 7-8 month process called Stepping Stones. Stepping Stones helped the groups select a topic and then provided education on research methods, data collection strategies, tool development, data analysis, and data presentation. During the process, each group selected a topic it identified as important to peers and that could be impacted by the services offered at their SBHC.

One of the groups in California selected the topic of condom availability in the SBHC. Initially teens had the support of the principal, but when the time to collect data arrived, they were told they needed to get parental consent. Rather than changing their topic, the teens decided to re-arrange their timeline to accommodate the time necessary to get parental consent. The work started by this group was continued by another group during the second year. The second group researched teen pregnancy by interviewing parenting and non-parenting teens. After two years of intensive research, the group "was able to take the study to the school board resulting in the revision of the school district's condom availability policy, allowing all high schools to dispense condoms and other contraceptive methods through the SBHCs."[7]

SBHCs in Colorado can use a similar approach. While the Stepping Stones curriculum is not available, a similar curriculum is available through Stanford University's John W. Gardner Center. The document, titled "Research and Action" can be found at: http://gardnercenter.stanford.edu/docs/YELL.0712.Unit3.final.pdf. SBHC administrators can use the document to guide a group of youth advocates through a research process that results in action.

[5] Suleiman et al. *Journal of Community Practice.*

[6] Suleiman et al. *Journal of Community Practice.*

[7] Suleiman et al. *Journal of Community Practice.*

**Photovoice**

Another approach to youth advocacy is through youth participation in Photovoice. Photovoice is a participatory action research strategy that enables youth to record their community's strengths and concerns, promote critical dialogue and knowledge about community issues through group discussion of photographs, and to reach policy makers. Photovoice is based on the concept that pictures or images can teach and influence policy.[8]

Photovoice has been used as a strategy in at least one Colorado community to address pregnancy prevention. SBHCs can use this strategy to document gaps in services. These gaps may include potential barriers teens face when attempting to access care outside of the SBHC, such as distance, cost, and lack of confidentiality. They may also include challenges associated with teen parenting, the value of offering comprehensive services in SBHCs, etc. Once the photos have been taken, themes are identified and then shared with policy makers, or in this case, school-board members. The approach allows young people to document their everyday realities and ask questions about why situations exist and how to address them.

Photovoice uses a nine-step strategy to help mobilize young people to carry out social action. The steps are briefly described below:

STEP 1: Select and recruit a target audience of policy makers or community leaders.

*When advocating for comprehensive reproductive health services in SBHCs, the target audience is determined by asking, "Who has the power to make decisions?" It is often the school-board, school administrators such as principals, and parents. It may also be useful to target community leaders such as doctors and educators.*

STEP 2: Recruit a group of photovoice participants.

*When recruiting participants, remember that each participant will be taking pictures so a group of 7-10 is usually ideal.*

STEP 3: Introduce the photovoice methodology to participants and facilitate a group discussion about cameras, power, and ethics.

*The first meeting includes an introduction to photovoice methodology and the ultimate goal of influencing policy makers. It also provides a space to discuss the ethics of when to take pictures, consent to be photographed, and the potential implications the photos may have.*

STEP 4: Obtain informed consent.

*Consent must be obtained for photovoice participants, as well as from each person being photographed. Emphasis is placed on safety as well as the authority and responsibility associated with using a camera.*

STEP 5: Pose initial theme/s for taking pictures.

*Posing the theme of access to contraceptives in SBHCs should include a discussion about how to document the importance of the topic through photos.*

STEP 6: Distribute cameras to participants and review how to use the camera.

*Cameras are provided by the SBHC. Any type of camera can be used, but cost should be considered. Once the camera is selected, each participant should be oriented to use the camera.*

STEP 7: Provide time for participants to take pictures.

*Discuss a timeline for when participants should complete taking their pictures. Remember to consider time for printing or development if necessary.*

STEP 8: Meet to discuss photographs and identify themes.

[8] Wang, C., "Youth Participation in Photovoice as a Strategy for Community Change," *Journal of Community Practice* 14, no. 1 (2006): 147-161.



*Once photos are available, the group can get together and discuss how the photographs tell a story that relates to the importance of access to contraception in SBHCs.*

STEP 9: Plan with participants a format to share photographs and stories with policy makers or community leaders.[9]

*Once the photos have been discussed, the group can determine the best way to present the information to the target audience. This may include the use of a PowerPoint presentation or an exhibit.*

When using the Photovoice methodology, teens have the ability to tell the story about why SBHCs should be allowed to dispense contraception. Pictures taken of peers and a teen's own community make the issue very close to home and very compelling.

**Adolescent Reproductive and Sexual Health Symposiums**

Another approach to youth advocacy is to host a health symposium focused on adolescent reproductive and sexual health. Health symposiums create a space in which experts in the field can meet with adolescents to discuss what is being done for young people currently and what can be done better.

A health symposium, held in New York, allowed teens to share their knowledge, experience, and opinions on how they get information about sexual health; where they go for sexual health services; what their experiences have been; and needs they have that aren't being met. Similarly, in Pueblo, Colorado, an event called World Café took place in 2006. The World Café brought together school administrators, health professionals, parents, and students and created a space where teens could communicate with the decision makers in the community about the true needs adolescents encountered in their particular community. As a result of the World Café, the community wrote pregnancy prevention into their strategic plan.

[9] Wang, C. *Journal of Community Practice*.

## Lessons from Research

SBHCs engaging youth as advocates can benefit from exploring some of the lessons learned in previous youth advocacy activities.

1. The youth process often takes longer and is much less linear than the process adults are used to experiencing.[10]

**It is important to be flexible and help guide the process without dictating how to solve the problems.*

2. Because the process often takes longer with youth, it is important to plan for the ups and downs of the youth engagement cycle, especially for multi-year projects.

**Don't forget to consider the school-year calendar and when students are most likely to be focused on other projects. This is especially important if working with a group of seniors as April and May tend to be focused on graduation.*

3. Systematic barriers may exist when advocating for the availability of age-appropriate reproductive health services in SBHCs.

**Remember to involve necessary school administrators and parents of participants. If a systematic barrier is encountered, regroup and see if a slightly different approach may work better.*

[10] Suleiman et al. *Journal of Community Practice.*

## Contents: Youth Engagement Tools

This section contains the following tools, which can be useful as you work with youth as advocates for positive changes in your SBHC.

**1. Creating a Concept Map**

*Creating a concept map helps youth advocates see the larger context in which they are working and helps them clearly define their approach and goal.*

**2. Resources**

*Additional resources are available should a SBHC decide to use one of the approaches listed in the Youth Engagement Chapter.*

## Creating a Concept Map

Concept maps help groups involved in youth advocacy outline the problem they want to address, the information they want to collect, and the change they want to see as a result of their work. In the case of SBHCs and contraceptive availability, the problem being addressed is often pregnancy and sexually transmitted infections. The information groups collect can vary from student surveys to pregnancy rates. The result they likely will hope to see from their work is a change in policy that results in better access to contraception in the SBHCs.

Here are the steps that help create a concept map:

STEP 1: Identify the general/broad topic that you are interested in. Example: Teen Pregnancy

STEP 2: Brainstorm on the general topic and list all of the concepts and themes that are related to the topic on a large piece of paper. Make sure to keep the concepts as concise as possible.

STEP 3: Using unlined paper, write the main theme in the center of the page

STEP 4: Take the other concepts identified in the brainstorming and connect them to the center concept. You can use other organizational patterns, such as branches, arrows, or groups. More important ideas should be put nearer to the center, and less important ones should be closer to the edge. Identify the relationship between the concepts.

STEP 5: After a map has been created, look at the organizational patterns to see if the pieces fit together and make sense. This is also the time to determine if anything is missing. After the map has been created, it can be referred to throughout the process to help organize and re-organize your plan. It may also be useful to help keep the group on track and to maintain motivation.

## Resources:

**Youth in Focus**

To learn more about youth-led action research visit: **www.youthinfocus.net.**

Youth In Focus is guided by the vision of a world in which youth and adults share knowledge and power to create a more just, sustainable, and democratic society. Since 1990 YIF has pursued this vision by providing training, consulting, and coaching support in youth-led action research (Youth-REP) to underrepresented youth and adult allies working for positive change. Youth-led action research brings young people's energy and information to bear upon social and organizational challenges. Young people play lead roles in designing, doing, and following up on research or evaluation projects that serve to change or initiate a program, organization, community initiative, organizing campaign, or policy that affects them and their peers.

**The John W. Gardner Center**

The John W. Gardner Center provides a curriculum outline that guides youth and adults through the necessary steps to initiate a youth-led action research program. For more information visit: **http://gardnercenter.stanford.edu/docs/YELL.0712.Unit3.final.pdf.**

The John W. Gardner Center maintains that community and youth development go hand in hand: a community only prospers when its young people prosper, and young people only flourish in a flourishing community. The John W. Gardner Center (JGC) at Stanford University partners with local communities to support their efforts to continually renew themselves, by way of developing well-rounded young people who are successful—intellectually, emotionally, physically and socially—and who in turn are motivated to contribute to their communities, both as leaders and as responsible participants.

**Advocates for Youth**

For more information on youth advocacy and sexual and reproductive health visit: **www.advocatesforyouth.org.**

Advocates for Youth was established in 1980 as the Center for Population Options. Advocates champions efforts that help young people make informed and responsible decisions about their reproductive and sexual health. Advocates believes it can best serve the field by boldly advocating for a more positive and realistic approach to adolescent sexual health. Advocates focuses its work on young people ages 14-25 in the U.S. and around the globe.

## Comprehensive Reproductive Health Program Planning

**Introduction:**

This section includes steps to help prepare the school-based health center to offer comprehensive reproductive health services. The steps covered include:

- STEP 1: Assessing Site Readiness and Preparing the Clinic Environment
- STEP 2: Understanding Confidentiality, Minor Consent Laws, and Mandatory Reporting
- STEP 3: SBHC Consent Forms
- STEP 4: Reproductive Health and Billing
- STEP 5: Preparing the Lab
- STEP 6: Other Outlet Pharmacy
- STEP 7: Vaccination Logistics
- STEP 8: Necessary Equipment
- STEP 9: Developing a Referral Network
- STEP 10: Compiling Handouts and Teaching Materials
- STEP 11: Forms and Data Collection Materials
- STEP 12: Funding Considerations
- STEP 13: Policies and Procedures

The following tools may also be helpful:

- Confidentiality Sign, Factsheet, Contract
- Sample Consent Form for General SBHC Enrollment with Information about Contraception
- Sign-In Sheet Template
- CLIA Application
- Teen Rights and Responsibilities
- Family Planning Method Brochures
  - Guide to Getting Started on the Pill
  - Guide to Getting Started on Depo
  - Guide to Getting Started on the Ring
  - Guide to Getting Started on the Patch
  - Guide to Getting Started on Implanon
  - Guide to Getting Started with an IUD
  - Emergency Contraception
  - Safer Sex and Condoms
- Birth Control 101 Brochure
- Potential Funding Sources
- Reproductive Health in the SBHC Policy
- Sexual Education and Counseling in the SBHC Policy
- Confidentiality Policy
- Billing Policy
- Typical Colorado Pharmacy Pricing

### STEP 1: Assessing Site Readiness and Preparing the Clinic Environment

Some environments are more welcoming to teens than others. Clinic settings can be a bit intimidating, so making the space youth-friendly and welcoming is very important. Here are a few ways to make a youth–friendly environment.

- Make the décor appealing to teens while maintaining professionalism. Some SBHCs have asked their youth advisory boards to decorate or have had contests with student artists for a chance to put a mural on the clinic wall.
- Ensure that the literature available in the waiting rooms and exam rooms, such as pamphlets, brochures, posters, magazines, etc., is age-appropriate and appealing to youth. There are several youth-created health publications, such as Sexetc.
- If music can be played, find music that the majority of teens enjoy. Be careful to ensure that the lyrics are appropriate and the environment is still comfortable and not too noisy. One idea is to have the youth advisory board create a few CDs with music mixes to play during clinic hours.
- Post signs with instructions about what to do while in the clinic. Young people are transitioning from seeking healthcare with their parents to seeking it independently. It can help to see signs that say things like “Let the receptionist know you are here” or “Please sign in at the front desk and someone will call your name shortly.”
- Signs noting the confidential nature of reproductive health, mental health, and substance use/abuse services should be prominently displayed.

To help maintain the students’ privacy and comfort, consider creating sign-in sheets that allow students to put their name and reason for visit in writing rather than having to say it out loud in the waiting area where other students might be sitting. Once the form is completed a medical assistant or provider can take the student to a private room to answer questions and address concerns.

All staff should be trained in adolescent development.

- When patients enter the clinic, a staff member should acknowledge their presence and welcome them to sign-in. If patients have questions, ensure privacy by taking them to another room and explaining that they are in the right place to ask questions.
- Teens respond to adults who are open-minded, positive, flexible, non-judgmental, non-patronizing, and professional.
- Teens often offer one another support by going with each other to clinic visits. After triaging the patient, it may be appropriate to ask if she/he has someone in the waiting room who should join them during the discussion part of the exam.

Questions to Consider when Creating a Youth Friendly Environment[1]

Does your office/health center have:

- Magazines that would interest adolescents and reflect their cultures and literacy levels?
- Appropriately sized tables and chairs in the waiting room and exam rooms?
- Private areas for completing forms and discussing reasons for visits?
- Facilities that comply with the Americans with Disabilities Act?
- Decorations that reflect the genders, sexual orientations, cultures, and ethnicities of your clients?

Do you provide:

- Health education materials written for or by teens at the appropriate literacy level and in their first languages?
- Translation services appropriate for your patient population?
- A clearly posted office policy about confidentiality?
- Alternatives to written communications, such as phone calls, meetings, videos?
- Health education materials in various locations where teens would feel comfortable taking them?
- Condoms?

Does your staff:

- Greet adolescents in a courteous and friendly manner?

[1] Monasterio, E., Combs, N., Warner, L., Larsen-Fleming, M., St. Andrews, A., *Sexual Health: An Adolescent Provider Toolkit* (San Francisco, CA: Adolescent Health Working Group, San Francisco, 2010), http://www.ahwg.net/assets/library/104_2010sexualhealthtoolkitmo.pdf.

- Explain procedures and directions in an easy and understandable manner?
- Have up-to-date knowledge about consent and confidentiality laws?
- Incorporate principles and practices that demonstrate cultural and linguistic competence?
- Consider privacy concerns when adolescents check-in?
- Provide resources and referral information when there is a delay in scheduling a teen's appointment?

When you speak to adolescents do you:

- Use non-judgmental, jargon-free, and gender-neutral language?
- Allow time to address their concerns and questions?
- Restate your name and explain your role and what you are doing?
- Ask gentle but direct questions?
- Offer options for another setting?
- Explain the purpose and costs for tests, procedures, and referrals?
- Keep in mind that their communication skills may not reflect their cognitive or problem-solving abilities?
- Ask for clarification and explanations?
- Congratulate them when they are making healthy choices and decisions?

Are you aware:

- That your values may conflict with or be inconsistent with those of other cultural or religious groups?
- That age and gender roles may vary among different cultures?
- Of the varying health care beliefs and acceptable behaviors, customs, and expectations of different geographic, religious, and ethnic groups?
- Of the socio-economic and environmental risk factors that contribute to major health problems among the diverse groups you serve?
- Of community resources for youth and families?

## STEP 2: Understanding Confidentiality, Minor Consent Laws, and Mandatory Reporting

Confidentiality is one of the most important factors young people identify as a reason for using or not using a health clinic for reproductive health services. In fact, a 2002 study published in the *Journal of the American Medical Association* (JAMA) found that "almost half of sexually active teens (47%) visiting a family planning clinic would stop using clinic services if their parents were notified that they were seeking birth control, and another 11% reported that they would delay testing or treatment for sexually transmitted diseases or HIV; virtually all (99%), however, reported that they would continue having sex."[2] School-based health centers (SBHC) are in a unique situation in that parental consent is often required to access services, but some services rendered during patient visits are protected by minor consent laws. Confidential services in the context of reproductive health in Colorado include pregnancy testing, sexually transmitted disease testing and treatment, HIV testing, discussion and distribution of contraceptives and condoms, and prenatal care.

Ability of Minors to Consent to Health Care: Summary of Legal Requirements in the State of Colorado

Minors are persons less than 18 years of age. Although no minimum age is specified, minors under the age of 12 are typically considered unable to give informed consent. The ability of a minor to consent to care depends upon the type of treatment being sought.

- Contraceptive Services: Colorado Revised State Statute 13-22-105 states: Except as otherwise provided in part 1 of article 6 of title 18, C.R.S., birth control procedures, supplies, and information may be furnished by physicians licensed under article 36 of title 12, C.R.S., to any minor who is pregnant, or a parent, or married, or who has the consent of his parent or legal guardian, or who has been referred for such services by another physician, a clergyman, a family planning clinic, a school or institution of higher education, or any agency or instrumentality of this state or any subdivision thereof, **or who requests and is in need of birth control procedures, supplies, or information.**
- STI Services: Colorado Revised State Statute 25-4-402 states: Any physician, upon consultation by a minor as a patient and with the consent of such minor patient, **may make a diagnostic examination for venereal disease and may prescribe for and treat such minor patient for venereal disease without the consent of or notification to the parent or guardian of such minor patient** or to any other person having custody of or parental responsibilities with respect to such minor patient. In any case, the physician shall incur no civil or criminal liability by reason of having made such a diagnostic examination or rendered such treatment, but such immunity shall not apply to any negligent acts or omissions.
- HIV Testing: Colorado Revised State Statute 25-4-1405 states: Any local health department, state institution or facility, medical practitioner, or public or private hospital or **clinic may examine…for HIV infection for any minor if such physician or facility is qualified to provide such examination. The consent of the parent or guardian of such minor shall not be a prerequisite to such examination. The fact of consultation, examination, and treatment of such a minor under the provisions of this section shall be absolutely confidential and shall not be divulged by the facility or physician to any person** other than the minor except for purposes of a report required under sections 25-4-1402 and 25-4-1403 and subsection (8) of this section and a report containing the name and medical information of the minor made to the appropriate authorities if required by the "Child Protection Act of 1975," part 3 of article 3 of title 19, C.R.S. **If the minor is less than sixteen years of age or not emancipated, the minor's parents or legal guardian *may** be informed by the facility or physician of the consultation, examination, and treatment**. The physician or other health care provider shall counsel the minor on the importance of bringing his parents or guardian into the minor's confidence about the consultation, examination, or treatment.
- Prenatal Care: Colorado Revised State Statute 13-22-103.5 states: Notwithstanding any other provision of law, **a pregnant minor may authorize prenatal, delivery, and post-delivery medical care for herself related to the intended live birth of a child.**
- Abortion: The Parental Notification Act was passed in the Colorado legislature in 2003. **The law requires teens under the age of 18 to notify their parents of their intent to have an abortion, unless the teen is emancipated.** (Colorado Revised State Statute 12-37.5)

* The state statute regarding HIV and minor consent accounts for both testing and treatment of HIV. However, testing for HIV and treatment of HIV carry entirely different implications for the patient. Informing the parent when a minor tests positive for HIV and requires treatment is far different than informing the parent when a minor tests negative for HIV on a routine STI screening. When testing for HIV providers should consider involving parents only when the result is positive.

**Mandatory Reporting**

A specific policy with details about confidentiality and mandatory reporting should be created or updated to reflect any changes consistent with providing reproductive health services.

[2] Dailard, C., New Medical Records Privacy Rule: The Interface with Teen Access to Confidential Care (*The Guttmacher Report on Public Policy* 6, no. 1(March 2003): 6-7, http://www.guttmacher.org/pubs/tgr/06/1/index.html.

A clearly displayed and prominent sign addressing confidentiality and its exceptions should be placed in the waiting rooms and exam rooms. It is also a good idea to have students sign a confidentiality agreement that explains their rights to confidentiality and when exceptions are made to confidentiality. A sample agreement is included in the tools section. Each reproductive health intake form should also require students to initial a confidentiality agreement that outlines their rights.

In the event that a minor discloses reportable information, a report should immediately be filed with the local law enforcement agency or the Department of Social Services.

The mandatory reporting guidelines listed on the next page were provided by the Colorado Department of Public Health and Environment's Title X Nursing Manual.

Sexual Assault and Sexual Assault on a Child, Statute: C.R.S. 18-3-402 & 405; C.R.S. 19-3-304, -307, & -309.

| **Definition** | **Who Reports** | **To Whom is Issue Reported** | **What is Reported** | **Penalties for Failure to Report** |
|---|---|---|---|---|
| 18-3-402 Sexual contact by someone not the spouse where "…the victim is less than 15 years old and the actor is at least four years older."<br><br>Or<br><br>"…the victim is at least fifteen years of age but less than seventeen years of age and the actor is at least ten years older than the victim and is not the spouse of the victim…."<br><br>This includes sexual contact, sexual intrusion, and sexual penetration as defined in C.R.S. 18-3-401 Definitions. | 19-3-304 others listed in the statute, but the most common in SBHCs are:<br>• Physicians<br>• Child health associates<br>• Dentists<br>• Registered nurses<br>• Licensed Practical Nurses<br>• Nurse Practitioners<br>• School officials or employees<br>• Social workers<br>• Mental health professionals<br>• Psychologists<br>• Victim's advocates | 19-3-307 County department of social services or local law enforcement agency.<br><br>Third party[1] perpetrators are reported to law enforcement where the crime occurs.<br><br>Intrafamilial[2] cases are reported to the department of social services where the victim lives. | 19-3-307 Name, address, age, sex, and race of child; name and address of person responsible for suspected abuse or neglect; nature and extent of the child's injuries, including previous cases of known or suspected abuse or neglect of the child or the child's siblings; names and addresses of the persons responsible for the suspected abuse or negligence, if known; family composition; the source of the report and the name, address, and occupation of the person making the report; any action taken by the reporting source; any other information the person making the report believes may be helpful. | 19-3-309 Grants immunity to those persons who have made a report of child abuse or neglect, thereby protecting the reporting person from civil and criminal liability as well as termination of employment.<br><br>Failure to report constitutes a class 3 misdemeanor.<br><br>Punishment is up to six months in prison and up to $750 fine.<br><br>Additionally, the person shall be liable for damages proximately caused by failure to report. |

Definitions:

[1]Third party abuse is perpetrated by any person who is not a parent, stepparent, guardian, legal custodian, spousal equivalent…or any person who is not included in the definition of intrafamilial abuse.

[2]Intrafamilial abuse is abuse that occurs within a family context by a child's parent, stepparent, guardian, legal custodian, or relative, by a spousal equivalent…or by any other person who is regularly in the child's home for the purpose of exercising authority over or care for the child…except if the person is paid for such care and is not related to the child.

## STEP 3: SBHC Consent Forms

Although some medical services, such as reproductive health services, are considered confidential, general consent to use any of the SBHC's services is typically required. Most SBHCs in Colorado that currently provide comprehensive reproductive health services list the availability of all types of services, including pregnancy testing, contraception, and testing and treatment for STIs, on the parent consent form. It is typically an "all or nothing consent," meaning parents cannot choose to opt-out of allowing their child to receive any particular services, especially those that are protected by minor consent laws.

In some cases, a student can consent to reproductive and sexual health care independently, but parental consent is still required for other primary care services. To do this, some clinics offering comprehensive services place a provision on the consent form explaining that parents must provide consent for services but students are allowed to consent to confidential services on their own.

The tools section includes templates for consent forms that include comprehensive reproductive health services. The approach that each clinic takes on this issue is dependent upon the sponsor agency, community advisory council, schools, and community. Policies and procedures concerning consent for services should conform to statements on consent forms and vice versa.

## STEP 4: Reproductive Health and Billing

Special consideration should be taken to protecting the confidentiality of minors accessing confidential services. If you have existing policies and procedures related to billing, they should be updated to include a means of protecting the confidentiality of adolescents in billing procedures. Here is an example of a policy and procedure update:

*Confidentiality of students will be protected in accordance with HIPAA and state statutes. Confidentiality policy supersedes any billing concerns.*

Enrolled students who request an SBHC service that may result in an out-of-pocket expense will be screened by the SBHC staff for (1) acuity of the student's presenting problem and (2) confidentiality of the student's presenting problem. Staff will respond to their findings as follows:

*If the problem falls within the range of confidential conditions defined in state statutes and the student desires confidential services, the staff will perform those specific services indicated to address the student's confidential problem and will clearly mark the encounter form "Confidential-do not bill parent."* Procedures in place with billing staff will assure that no bill or statement will go to the parent. The student, him or herself, will be billed in accordance with this policy. The staff will work with the student to involve the parent/guardian at the earliest *opportunity, as appropriate. The staff will request that the student reschedule to address non-confidential, non-urgent problems.*[3]

Here are some ways existing SBHCs have dealt with the billing and confidential services issue:

Example 1:

One Colorado SBHC has successfully navigated the billing and confidentiality issue by partnering with a Title X agency. The Title X agency supplies a nurse practitioner once a week who comes into the SBHC to provide reproductive health and family planning services. The paperwork required by Title X allows teens to receive free services based on the fact that they do not have income and does not require that teens use any existing insurance. All paperwork is then processed by the partner agency, and Title X offsets the costs of providing free reproductive health services to adolescents. This approach prevents confidential services from appearing on the summary of services that is mailed to the student's parents. In this instance, records for reproductive health services are maintained by the Title X clinic, not the SBHC.

Example 2:

Another Colorado SBHC that bills for services has addressed the billing and confidentiality issue by creatively labeling superbills when patients access confidential services. The superbill is labeled with the name "Tinkerbell" or "Peter Pan," and the patient's actual birth date. Although the SBHC maintains the student's records, the billing for confidential services is assigned to a separate account that is not tied to the student's insurance. This allows the SBHC to bill for non-confidential services separately while maintaining the confidentiality of services protected by minor consent laws. If the patient receives additional non-reproductive health related services, a second superbill is generated for the same patient and billed accordingly.

## STEP 5: Preparing the Lab

All tests performed in an SBHC require some form of Clinical Laboratory Improvement Amendment (CLIA) certificate. The most common type of certificate is a certificate of waiver that allows sites to perform CLIA-waived tests such as urine pregnancy tests and qualitative HIV immunoassay antibody tests. To perform microscopy procedures, such as wet preps, a CLIA certificate for provider-performed microscopy is necessary. To apply for either certificate, the SBHC must complete the CLIA application (Form CM-116), which can be found online at http://www.cms.hhs.gov/CLIA/06_How_to_Apply_for_a_CLIA_Certificate_International_Laboratories.asp#TopOfPage**.** A copy of the application is also included in the tools section.

For waived testing, CLIA requires that you:

Enroll in the CLIA program by obtaining a certificate;

- Pay the certificate fee every two years ($150);
- Follow the manufacturers' instructions for the waived tests you are performing;
- Notify your state agency of any changes in clinic ownership, name, address or director within 30 days, or if you wish to add tests that are more complex; and
- Permit inspections by an agent from the Center for Medicare and Medicaid Services, such as a surveyor from the state agency. However, your laboratory is not subject to a routine survey or inspection.

If you wish to provide Provider Performed Microscopy (PPM) testing, you must apply for a CLIA certificate specifically for this type of test; all of the above requirements apply. The PPM certificate fee is $200.

With the PPM certificate, you are able to perform all CLIA-waived tests.

If you currently have a certificate of waiver and wish to provide PPM tests, you must re-apply for the PPM certificate and are not eligible to perform PPM tests until you have been issued the new certificate.

For a list of waived testing and PPM testing, please visit the CLIA website at www.cms.hhs.gov/CLIA.

Colorado CLIA Contact Person:

COLORADO DEPARTMENT OF PUBLIC HEALTH & ENVIRONMENT

Laboratory Services Division

8100 Lowry Blvd. Denver, CO 80230-6928

(303) 692-3681 FAX: (303) 344-9965

Contact: Jeff Groff

E-mail: Jeff.Groff@state.co.us

Useful website: http://www.cms.hhs.gov/clia/

In addition to CLIA certificates, contracts may also be necessary for the additional testing that will not be performed in the clinic's lab, such as chlamydia and gonorrhea screens or pap tests. Depending on your sponsor agency, a contract with a lab may already be in place that can be extended to the SBHC. If not, the Colorado Department of Public Health and Environment runs chlamydia and gonorrhea testing at an affordable price (~$20 per set of CT/GC tests). Ordering is facilitated by an online ordering system.

For information and to set up a contract with CDPHE's lab contact:

Laura Gillim-Ross, Ph.D.
Supervisor, Public Health Microbiology and Serology Laboratory Services Division
Colorado Department of Public Health and Environment
8100 Lowry Blvd
Denver, CO 80230
(303) 692-3484

laura.gillim-ross@state.co.us

You will need to provide the following information to set up an account with the CDPHE lab:

- Customer Name
- Shipping Address
- Contact person
- Contact phone number
- Fax number (a secure fax to which results can be sent)
- Billing Address (if different)
- Anticipated volume of specimens

The lab has a courier service that picks up at designated sites, and the turnaround time for chlamydia and gonorrhea tests is usually 48 hours. The lab performs nucleic acid testing using the Gen-Probe aptima system (chlamydia and gonorrhea) and can test vaginal/cervical swabs or urine. Additional tests are also available and a complete listing with prices can be found at: http://www.cdphe.state.co.us/lr/services/2009%20Labfees_External.pdf

## STEP 6: "Other Outlet" Pharmacy

When SBHCs dispense medications it is necessary to establish an "other outlet" from which they can dispense medications. An "other outlet" is a non-pharmacy outlet from which prescription drugs and/or controlled substances are dispensed to patients. The most important part of establishing an "other outlet" is to identify a consultant pharmacist who will be largely responsible for the application to the state board of pharmacy and overall operation of the pharmacy. The consultant pharmacist will be responsible for requesting an application, writing protocols, conducting annual compliance reviews and quarterly or monthly inspections, and documenting of all actions carried out.

As an administrator, you may want to begin considering compiling the following information as it will be necessary during the process:

- Clientele served
- Services rendered in the clinic
- Hours of operation
- Floor plans of the clinic, including locations of medication storage, type of storage unit, type of lock on unit, and the presence of any windows in the same area

The consultant pharmacist will help develop protocols that address state laws, including information about medication labels, maintaining a record of medications received and dispensed, medication destruction logs, evaluation planning, and packaging records for medications packaged on-site.

For further information regarding the DORA Rules and Regulations, please visit: http://www.dora.state.co.us/Pharmacy/Rules0409.pdf .

## STEP 7: Vaccination Logistics

Integrating the Gardasil HPV vaccine into the clinic practice should also be considered if it is not already provided. Providing the vaccination is recommended by the CDC's Advisory Committee on Immunization Practices, the American College of Obstetrics and Gynecology, and the American Academy of Pediatrics.



Administering the vaccine requires these supplies:

- Vaccine
- Refrigerator, temperature needs to be recorded twice per day
- Sharps container

The Vaccines for Children Program includes Gardasil in its recommended vaccines. If you are already a VFC provider, you may order and administer Gardasil. If you are not a VFC provider, you will need to:

Contact your state VFC Program Coordinator:

- Joni Reynolds RCN, MSN
  Colorado Dept. Public Health & Environ.
  Director, Immunization Program
  DCEED-IMM-A4
  4300 Cherry Creek Drive South
  Denver, CO 80246-1530

  joni.reynolds@state.co.us
  Phone: 303-692-2363
  Fax: 303-691-6118

- Ask for a Provider Enrollment Package to be mailed to you.
- Complete the state's Provider Enrollment Form and return it as soon as possible.
- Prepare your office and staff for a site visit to go over the administrative requirements of the program and to ensure proper storage and handling of vaccines when you receive them.
- In most instances, program processing takes less than two weeks.

Useful websites:

http://www.cdc.gov/vaccines/programs/vfc/providers/faq-hcp.htm

http://www.merckvaccines.com

## STEP 8: Necessary Equipment

Providing comprehensive adolescent services only requires a few supplies that would not otherwise be in the clinic:

- Exam table with stirrups
- Side table (Mayo stand)
- Paper drapes
- Plastic speculums, majority of them small, a few medium and large (teens prefer plastic over metal)
- Stand up light
- Gloves (latex and non-latex)
- KY Jelly
- Microscope
- Normal saline
- KOH and VIP Stain for wet-preps
- Urine cups
- Baby wipes
- Glass slides and cover slips
- HCG test kits
- Urine dip sticks
- Pap tests
- Aptima tests

## STEP 9: Developing a Referral Network

Developing a referral network is essential to providing comprehensive adolescent healthcare. While SBHCs strive to integrate mental, physical, and dental care, adolescents may require services that go beyond the scope available in the SBHC. The following referrals in your network are essential:

- Social workers
- Nutritionists
- Psychologists or counselors
- Abortion and prenatal care service providers
- Providers of family planning methods not provided at the clinic
- STD clinics
- Health Department clinics
- Providers who serve medically complicated patients

All referral sources should be screened for youth-friendliness and more than one option should be available to eliminate potential barriers. This is especially important, and equally challenging, in rural areas where healthcare networks are much smaller.

Because most SBHCs are not open during the summer and do not provide 24-hour on-call service, a partnership should be established to fill these gaps. Some SBHCs providing contraception have decided to stay open one day a week during the summer to facilitate contraceptive continuity when students are not in school.

A referral sheet or binder should be created and placed in an easily accessible location. If your staff uses computers, you may want to put an easily accessible version of the referral network on the desktop, which can be printed as necessary.

### STEP 10: Compiling Handouts and Teaching Materials

Youth-appropriate handouts and teaching materials on the following topics should be available in the SBHC:

- Teen Rights and Responsibilities
- Abstinence
- Preparing for the GYN exam
- Family planning methods, individual factsheets and one with all available methods
- STIs, individual factsheets and one with an overview of the most common
- Emergency contraception

Many providers also find it useful to have a poster detailing all contraceptive methods as well as a visual calendar that can be referenced when determining a patient's last menstrual period.

The toolkit includes several examples you can use. The examples can be found in the tools section. Another very valuable resource for handouts and teaching materials is www.etrassociates.com.

### STEP 11: Forms and Data Collection Materials

The forms used in the clinic can also be used to collect data that will be useful when seeking funding and demonstrating the need for services. Progress notes have been included in the service provision section of the toolkit for both data collection and implementation of quality assurance measures. The progress notes serve several purposes: as visit encounter forms as well as a data collection tools.

### STEP 12: Funding Considerations

To facilitate finding funding for comprehensive adolescent health services, the toolkit includes a list of potential funders. Although they are not possible everywhere, relationships with Title X delegate agencies should be explored as they can help off-set the costs of delivering family planning services.

### STEP 13: Policies and Procedures

In general, it is appropriate to have some policies and procedures that discuss the clinic's approach to age-appropriate reproductive health and comprehensive sex education counseling, confidentiality, and billing. The following examples provided by the National Assembly on School-Based Health Care are included in the tools section.

- Age-appropriate reproductive health
- Sexual education and counseling
- Confidentiality
- Billing

## Contents: Program Planning Tools

This chapter contains the following tools. These tools may be useful as you plan your program.

**1. Confidentiality Sign, Factsheet, Contract**

*The confidentiality sign, factsheet, and contract are all valuable tools that help establish trust with patients. The factsheet can be used to address parent and administrator concerns about adolescents' rights and ability to access services confidentially.*

**2. Sample Consent Form for General SBHC Enrollment with Information about Contraception**

The sample consent forms were adapted from existing SBHCs providing comprehensive services. Two versions are available to accommodate SBHCs that bill and others that do not.

**3. Sign-In Sheet Template**

*The sign-in sheet template was created by a youth advisory board concerned with confidentiality in the waiting room of their new SBHC. Using a sign-in sheet helps ensure confidentiality because students are not required to state why they are visiting the clinic while in the waiting room.*

**4. CLIA Application**

*The CLIA application is available for SBHCs needing approval to provide laboratory services.*

**5. Teen Rights and Responsibilities**

*The Teen Rights and Responsibilities handout can be posted throughout the clinic. It helps orient teens to the health care system, especially since most of them are accessing care for the first time without their parents.*

**6. Family Planning Method Brochures**

*The family planning method brochures are useful for patients initiating or switching birth control methods. The brochures include information about what the method is, how it works, what to expect, and common myths.*

*Brochures are available in English and Spanish and can be purchased at www.casbhc.org.*

-Guide to Getting Started on the Pill

-Guide to Getting Started on Depo

-Guide to Getting Started on the Ring

-Guide to Getting Started on the Patch

-Guide to Getting Started on Implanon

-Guide to Getting Started with an IUD

-Emergency Contraception

-Safer Sex and Condoms

**7. Birth Control 101 Brochure**

*The birth control 101 brochure is a brief overview of all the different birth control options. It may be especially useful for teens who have not chosen a method. Brochures are available in English and Spanish and can be purchased at www.casbhc.org.*

**8. List of Potential Funders**

*The list of potential funders was created to help sustain the provision of comprehensive reproductive and sexual health services in SBHCs.*

**9. Reproductive Health in the SBHC Policy**

*The reproductive health policy outlines what services are provided in the SBHC.*

**10. Sexual Education and Counseling in the SBHC Policy**

*The sexual education and counseling policy discusses the provision of age-appropriate comprehensive sexual health information as included in health care visits at the SBHC.*

**11. Confidentiality Policy**

*The confidentiality policy describes the services that are provided confidentially in the SBHC.*

**12. Billing Policy**

*The billing policy addresses billing practices and how they relate to confidential services.*

**13. Typical Colorado Pharmacy Pricing**

*Knowing the average cost of typical reproductive health prescriptions helps providers provide the most accessible and affordable medications to patients.*



### Confidentiality Sign

This confidentiality sign can be placed in the SBHC waiting room and exam rooms.

# WHAT WE SAY HERE STAYS HERE

# (Unless you give me permission to share it)

**There are a few exceptions to this rule:**

**If you**

- **Tell me you are being abused, physically, and/or sexually**
- **Tell me you are going to hurt yourself, or**
- **Tell me you are going to hurt someone else**
- **Tell me a law has been broken**

**In these cases, I must contact someone to help.**

## FACTSHEET: Confidentiality and Laws, Caring for the Adolescent Patient

Confidentiality is one of the most important factors young people identify as a reason not to use a health clinic for reproductive health services. In fact, a 2002 study published in the *Journal of the American Medical Association* (JAMA) found that "almost half of sexually active teens (47%) visiting a family planning clinic would stop using clinic services if their parents were notified that they were seeking birth control, and another 11% reported that they would delay testing or treatment for sexually transmitted diseases or HIV; virtually all (99%), however, reported that they would continue having sex."[1] School-based health centers (SBHC) are in a unique situation in that parental consent is required to access most services; however, some services rendered during patient visits are protected by minor consent laws.

**Research**

Since the 1970's, a minor's ability and right to consent to reproductive health services, including birth control, has been an issue of debate. Research done over the past three decades shows the following:

There is no research that supports the notion that mandatory parental involvement requirements for contraceptive services will improve parent-child communication. To the contrary, research suggests that policies requiring parental involvement are potentially harmful to teenagers' health and well-being and highlights the importance of confidentiality to teenagers' willingness to seek care. Half of adolescents surveyed in family planning clinics report that a parent knows they are accessing family planning services, and a 2005 JAMA study revealed that 25% of minors surveyed were there at a parent's suggestion. "According to the 2005 JAMA study, only one percent of the minor adolescents visiting family planning clinics indicated that their reaction to mandated parental involvement would be to stop having sex, while as many as two in 10 said they would practice unsafe sex. Significantly, seven in 10 of those whose parents did not know they were at the clinic said they would not use the clinic for prescription contraception".[2]

Based on this research it is safe to assume that adolescents would be less likely to access reproductive health services in SBHCs if the services provided were not confidential. Public policy and law have long reflected the reality that many minors will not seek important sensitive health services if required to inform their parents. Laws such as the Colorado statutes outlined below have intentionally been created to guarantee confidential access to particular services.

[1] Dailard, C., "New Medical Records Privacy Rule: The Interface with Teen Access to Confidential Care," *The Guttmacher Report on Public Policy* V 6, no. 1 (March 2003).

[2] Ibid.



## School-Based Health Center Confidentiality Contract

The confidentiality contract can be used at a patient's first visit each year. It serves as a reminder and an agreement about a teen's right to confidentiality when accessing services at the SBHC.

### RIGHT TO CONFIDENTIALITY

The information you give to the SBHC is confidential. No information will be given to others without your written permission *except* for the following situations, as required by law:

1. **Immediate danger:** to yourself or others.
2. **Child abuse reporting:** any information you give about physical or sexual abuse of a person under 18 years of age will be reported to a social service or law enforcement agency.
3. **Court order:** if a judge orders that your records be released to the court.

I have read the above and understand that my rights to confidentiality will be honored by the SBHC within the limits of the law.

_____ _____

Patient Signature Date

_____ _____

Witness Date

## Sample School-Based Health Center Student Information and Consent Form-Including information about Billing

The school district health program involves the school nurse, school counselors, and, with parental consent, the school-based health center, working together for your student's physical and mental health.

All students with or without parental consent have access to:

The **School Nurse** for:
- Health Screenings
- Emergency Care
- Immunization Data
- Medications
- Health Counseling
- Health Education
- Significant Health Care Needs
- Health Care Plans
- Special Education Assessment

The **School Counselor** for:
- Scheduling
- College and Career Planning
- Student Study Team Coordination
- Conflict Resolution
- Crisis Intervention
- Small Group Counseling
- Individual Counseling
- Family Relations
- Special Education Assessment

With parental consent, students also have access to the **School-Based Health Center** for:

- Acetaminophen
- Sports and Adolescent Physicals
- Young Women's & Young Men's Health
- Family Planning and Contraceptive Services
- HIV Testing and Counseling
- Crisis Counseling
- Suicide Counseling
- Lab Testing
- Health Education
- Abstinence Counseling
- STD Exam/Counseling
- Clinic Counselors
- Bilingual Counseling

---

**Please complete the following information if you are choosing to enroll your student in the SBHC. This information will be shared with SBHC-licensed health care providers.**

Student Name:_____ Sex:____M ____F
Mailing Address:_____ City:_____ Zip code:_____
Home Phone:_____ Grade:_____ Birth date:_____
Allergies, Major Health Problems, Current Medications: _____
_____
_____
Does your child have insurance: ____Yes ____No
If Yes: Name of Policy: _____ Policy # or Medicaid #: _____
Please attach copy of insurance card or Medicaid card.

Father/Guardian Name:_____ Daytime phone: _____
Mailing Address:_____ City:_____ Zip code:_____
Mother/Guardian Name:_____ Daytime phone: _____
Mailing Address:_____ City:_____ Zip code:_____



**PLEASE COMPLETE BOTH SIDES OF THE FORM**
**SCHOOL-BASED HEALTH CENTER**
**GENERAL PARENT CONSENT FORM 2009-2010**

Student Name: _____ Birth date: _____

The School-Based Health Center is a collaboration of the _____School District, public and private health agencies, and community health care providers. The purpose of the SBHC is to provide students with convenient access to basic medical and mental health services in addition to traditional school nurse services and counselor services. SBHC policy requires parental consent prior to the provision of many of these additional services to students.

Please Note: SBHC policy requires parental consent for all medical and mental health services provided to students under the age of eighteen. Colorado law, however, permits minors to seek family planning services regardless of age and all mental health services at the age of 15 without the consent or notification of parents or legal guardians. If you do not consent to treatment of your child by the SBHC and your child requests services to which he or she may legally consent, the SBHC willmay provide information to your child regarding professionals in the community available to provide such services.
In accordance with Colorado law, certain information in a student's medical record may not be available for release to parents, guardians, or third parties (including other service providers) without the student's prior consent.

**All students will receive first aid and emergency care whether this consent is signed or not.**
**Please initial one line in each of the boxes below.**

**I do** consent to the administration of Acetaminophen (Tylenol) _____ (Initial)

**I do not** consent to the administration of Acetaminophen (Tylenol) _____ (Initial)

Consent to the SBHC's provision of the following services to my child as may be deemed necessary and/or advisable by SBHC staff upon consultation with my child is indicated by checking the appropriate line below:
- Physical examinations and well adolescent exams. Examinations may include: routine laboratory tests such as urinalysis, anemia screening, pregnancy testing, STD screening and immunizations
- Care of acute illness and injury
- Prescription for antibiotics and other medications, including contraceptives
- Student health education and counseling, including abstinence counseling
- Assistance in the care of chronic conditions, substance abuse prevention, education, and counseling
- Follow-up care as requested by family physician
- Referrals to other health care professionals
- HIV Testing/Counseling
- Family planning education and counseling
- Mental health services, including counseling visits
- Other customary primary care services and screenings

**I do** consent to the provision of the above services: ____ (Initial) **I do not** consent to the provisions of the above services: ____(Initial)

Release of Information: **I do** authorize_____(Initial) **I do not** authorize_____(Initial)
The SBHC to disclose all or any portion of my child's medical record to our primary care provider as necessary to provide and coordinate care for my child.

Fees: Services provided by the SBHC are without charge, except for immunizations and select services rendered by _____clinic. A fee schedule is available upon request. **I do authorize_____(Initial) I do not authorize_____(Initial)** the SBHC to bill and receive payment directly from my insurance company (or if appropriate, Medicaid) and to release any portion of my child's medical record as necessary to bill and obtain payment for clinic services from my insurance company. I agree to provide applicable co-payments at time of service and agree to provide a copy of my health insurance card.

This consent form shall remain in force for the current school year while my child is enrolled in _____School District. I may revoke my consent to the SBHC's provision of medical and mental health services to my child at any time by providing the SBHC with written notice of my revocation. It is my responsibility to notify the school of any change in guardianship. I further acknowledge that under Colorado law, a student who reaches 18 years of age is deemed to be competent to make his or her own medical decisions whether or not the student is emancipated and that parental consent is inapplicable with respect to the rendering of medical services to a student who is 18 years of age.
**I hereby acknowledge that I received a copy of the medical practice's Notice or Privacy Practices: ____Yes ____No**

**Signature of parent/guardian:_____ Date: _____**

**Print parent/guardian name:_____ Date: _____**

**PLEASE COMPLETE BOTH SIDES OF THIS FORM**

## Example School-Based Health Center Information and Consent Form – Excluding billing information

The school district health program involves the school nurse, school counselors, and, with parental consent, the school-based health center, working together for your student's physical and mental health.

All students with or without parental consent have access to:

The **School Nurse** for:
- Health Screenings
- Emergency Care
- Immunization Data
- Medications
- Health Counseling
- Health Education
- Significant Health Care Needs
- Health Care Plans
- Special Education Assessment

The **School Counselor** for:
- Scheduling
- College and Career Planning
- Student Study Team Coordination
- Conflict Resolution
- Crisis Intervention
- Small Group Counseling
- Individual Counseling
- Family Relations
- Special Education Assessment

With parental consent, students also have access to the **School-Based Health Center** for:

- Acetaminophen
- Sports and Adolescent Physicals
- Young Women's & Young Men's Health
- Family Planning and Contraceptive Services
- HIV Testing and Counseling
- Substance Abuse Counseling
- Crisis Counseling
- Lab Testing
- Health Education
- Abstinence Counseling
- STD Exam/Counseling
- Clinic Counselors
- Bilingual Counseling
- Suicide Counseling

**Please complete the following information if you are choosing to enroll your student in the SBHC. This information will be shared with SBHC-licensed health care providers.**

Student Name:_____ Sex:____M ____F
Mailing Address:_____ City:_____ Zip code:_____
Home Phone:_____ Grade:_____ Birth date:_____
Allergies, Major Health Problems, Current Medications: _____
_____
_____

Father/Guardian Name:_____ Daytime phone: _____
Mailing Address:_____ City:_____ Zip code:_____
Mother/Guardian Name:_____ Daytime phone: _____
Mailing Address:_____ City:_____ Zip code:_____

**PLEASE COMPLETE BOTH SIDES OF THE FORM**



**PLEASE COMPLETE BOTH SIDES OF THE FORM**
**SCHOOL-BASED HEALTH CENTER**
**GENERAL PARENT CONSENT FORM 2009-2010**

Student Name: _____ Birth date: _____

The School-Based Health Center is a collaboration of the _____School District, public and private health agencies, and community health care providers. The purpose of the SBHC is to provide students with convenient access to basic medical and mental health services in addition to traditional school nurse services and counselor services. SBHC policy requires parental consent prior to the provision of many of these additional services to students.

Please Note: SBHC policy requires parental consent for all medical and mental health services provided to students under the age of eighteen. Colorado law, however, permits minors to seek family planning services regardless of age and all mental health services at the age of 15 without the consent or notification of parents or legal guardians. If you do not consent to treatment of your child by the SBHC and your child requests services to which he or she may legally consent, the SBHC will provide information to your child regarding professionals in the community available to provide such services.
In accordance with Colorado law, certain information in a student's medical record may not be available for release to parents, guardians, or third parties (including other service providers) without the student's prior consent.

**All students will receive first aid and emergency care whether this consent is signed or not.**
**Please initial one line in each of the boxes below.**

**I do** consent to the administration of Acetaminophen (Tylenol) _____ (Initial)

**I do not** consent to the administration of Acetaminophen (Tylenol) _____ (Initial)

Consent to the SBHCs provision of the following services to my child as may be deemed necessary and/or advisable by SBHC staff upon consultation with my child is indicated by checking the appropriate line below:
- Physical examinations and well adolescent exams. Examinations may include: routine laboratory tests such as urinalysis, anemia screening, pregnancy testing, STD screening and immunizations
- Care of acute illness and injury
- Prescription for antibiotics and other medications, including contraceptives
- Student health education and counseling, including abstinence counseling
- Assistance in the care of chronic conditions, substance abuse prevention, education, and counseling
- Follow-up care as requested by family physician
- Referrals to other health care professionals
- HIV Testing/Counseling
- Family planning education and counseling
- Mental health services, including counseling visits
- Other customary primary care services and screenings

**I do** consent to the provision of the above services: _____ (Initial) **I do not** consent to the provisions of the above services: ____(Initial)

Release of Information: **I do** authorize_____(Initial) **I do not** authorize_____(Initial)
The SBHC to disclose all or any portion of my child's medical record to our primary care provider as necessary to provide and coordinate care for my child.

Fees: Services provided by the SBHC are without charge. No documentation of insurance is required and no billing of services will occur. Donations are accepted.

This consent form shall remain in force for the current school year while my child is enrolled in _____School District. I may revoke my consent to the SBHC's provision of medical and mental health services to my child at any time by providing the SBHC with written notice of my revocation. It is my responsibility to notify the school of any change in guardianship. I further acknowledge that under Colorado law, a student who reaches 18 years of age is deemed to be competent to make his or her own medical decisions whether or not the student is emancipated and that parental consent is inapplicable with respect to the rendering of medical services to a student who is 18 years of age.

**I hereby acknowledge that I received a copy of the medical practice's Notice or Privacy Practices: ____Yes ____No**

**Signature of parent/guardian:_____ Date: _____**

**Print parent/guardian name:_____ Date: _____**

**PLEASE COMPLETE BOTH SIDES OF THIS FORM**

## Sample Sign-In Sheet for Front Desk

In many SBHCs, the front desk is located in the clinic waiting room and does not provide sufficient privacy for patients to communicate their reason for visiting the clinic. One way to enhance confidentiality is to use a sign-in sheet that allows the patient to indicate the reason for the visit without expressly stating it in the waiting room. Here is an example that was created by one Colorado SBHC's Youth Advisory Board:

**Please sign in:**

Name:_____

Grade:_____ Date of Birth:_____

Is this your first visit to our clinic? Yes No

Do you have an appointment? Yes No

If you do not have an appointment please write or check What you need:

____I have questions

____I need an exam

____Free condoms

____Other:_____

*All mental health and reproductive and sexual health services are confidential.*

Please have a seat and someone will call your name.

## CLIA Application

CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA)
APPLICATION FOR CERTIFICATION

I. GENERAL INFORMATION

❑ Initial Application ❑ Survey
❑ Change in Certification Type ❑ Other Change

CLIA Identification Number
D
(If an initial application is submitted, a number will be assigned)

Facility Name

Federal Tax Identification Number

Telephone No. (Include area code) Fax No. (Include area code)

Facility Address — Physical Location of Laboratory (Building, Floor, Suite if applicable.) No Coupon/Certificate will be mailed to this Address unless mailing address is specified

Mailing/Billing Address (If different from street address, include attention line and/or Building, Floor, Suite)

Number, Street (No P.O. Boxes)

Number, Street

City State ZIP Code

City State ZIP Code

Name of Director (Last, First, Middle Initial)

For Office Use Only
Date Received

II. TYPE OF CERTIFICATE REQUESTED (Check one)

❑ Certificate of Waiver (Complete Sections I – V and IX – X)

❑ Certificate for Provider Performed Microscopy Procedures (PPM) (Complete Sections I – X)

❑ Certificate of Compliance (Complete Sections I – X)

❑ Certificate of Accreditation (Complete Sections I through X) and indicate which of the following organization(s) your laboratory is accredited by for CLIA purposes, or for which you have applied for accreditation for CLIA purposes

❑ The Joint Commission ❑ AOA ❑ AABB
❑ CAP ❑ COLA ❑ ASHI

If you are applying for a Certificate of Accreditation, you must provide evidence of accreditation for your laboratory by an approved accreditation organization for CLIA purposes or evidence of application for such accreditation within 11 months after receipt of your Certificate of Registration.

**III. TYPE OF LABORATORY** *(Check the one most descriptive of facility type)*

- ❑ 01 Ambulance
- ❑ 02 Ambulatory Surgery Center
- ❑ 03 Ancillary Testing Site in Health Care Facility
- ❑ 04 Assisted Living Facility
- ❑ 05 Blood Bank
- ❑ 06 Community Clinic
- ❑ 07 Comp. Outpatient Rehab Facility
- ❑ 08 End Stage Renal Disease Dialysis Facility
- ❑ 09 Federally Qualified Health Center
- ❑ 10 Health Fair
- ❑ 11 Health Maint. Organization
- ❑ 12 Home Health Agency
- ❑ 13 Hospice
- ❑ 14 Hospital
- ❑ 15 Independent
- ❑ 16 Industrial
- ❑ 17 Insurance
- ❑ 18 Intermediate Care Facility for Mentally Retarded
- ❑ 19 Mobile Laboratory
- ❑ 20 Pharmacy
- ❑ 21 Physician Office
- ❑ 22 Practitioner Other *(Specify)* _____
- ❑ 23 Prison
- ❑ 24 Public Health Laboratories
- ❑ 25 Rural Health Clinic
- ❑ 26 School/Student Health Service
- ❑ 27 Skilled Nursing Facility/ Nursing Facility
- ❑ 28 Tissue Bank/Repositories
- ❑ 29 Other *(Specify)* _____

**IV. HOURS OF LABORATORY TESTING** *(List times during which laboratory testing is performed in HHMM format)*

| | SUNDAY | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY |
|---|---|---|---|---|---|---|---|
| FROM: | | | | | | | |
| TO: | | | | | | | |

(For multiple sites, attach the additional information using the same format.)

**V. MULTIPLE SITES** *(must meet one of the regulatory exceptions to apply for this provision)*

Are you applying for the multiple site exception?

❑ No If no, go to section VI ❑ Yes If yes, complete remainder of this section

Indicate which of the following regulatory exceptions applies to your facility's operation:

1. Is this a laboratory that has temporary testing sites?
   ❑ Yes ❑ No

2. Is this a not-for-profit or Federal, State or local government laboratory engaged in immunohematology more than a combination of 15 moderate complexity or waived tests per certificate; public health testing and filing for a single certificate for multiple sites?
   ❑ Yes ❑ No

   If yes, provide the number of sites under the certificate_____ and list name, address and test performed for each site below.

3. Is this a hospital with several laboratories located at contiguous buildings on the same campus within the same physical location of street address and under common direction that is filing for a single certificate for these locations?
   ❑ Yes ❑ No

   If yes, provide the number of sites under this certificate_____ and list name or department, location within hospital and specialty/subspecialty areas performed at each site below.

   If additional space is needed, check here ❑ and attach the additional information using the same format.

| NAME AND ADDRESS / LOCATION | | TESTS PERFORMED / SPECIALTY / SUBSPECIALTY |
|---|---|---|
| Name of Laboratory or Hospital Department | | |
| Address/Location (Number, Street, Location if applicable) | | |
| City, State, ZIP Code | Telephone Number ( ) | |
| Name of Laboratory or Hospital Department | | |
| Address/Location (Number, Street, Location if applicable) | | |
| City, State, ZIP Code | Telephone Number ( ) | |

Form CMS-116 (03/03) Page 2 of 4

In the next three sections, indicate testing performed and annual test volume.

**VI. WAIVED TESTING**

Indicate the estimated TOTAL ANNUAL TEST volume for all waived tests performed _____

❑ Check if no waived tests are performed.

**VII. PPM TESTING**

Indicate the estimated TOTAL ANNUAL TEST volume for all PPM tests performed _____

For laboratories applying for certificate of compliance or certificate of accreditation, also include PPM test volume in the "total estimated test volume" in section VIII.

❑ Check if no PPM tests are performed

**VIII. NONWAIVED TESTING** *(Including PPM testing)*

If you perform testing other than or in addition to waived tests, complete the information below. If applying for one certificate for multiple sites, the total volume should include testing for ALL sites.

Place a check (✓) in the box preceding each specialty/subspecialty in which the laboratory performs testing. Enter the estimated annual test volume for each specialty. Do not include testing not subject to CLIA, waived tests, or tests run for quality control, calculations, quality assurance or proficiency testing when calculating test volume. (For additional guidance on counting test volume, see the information included with the application package.)

If applying for a Certificate of Accreditation, indicate the name of the Accreditation Organization beside the applicable specialty/subspecialty for which you are accredited for CLIA compliance. (The Joint Commission, AOA, AABB, CAP, COLA or ASHI)

| SPECIALTY / SUBSPECIALTY | ACCREDITING ORGANIZATION | ANNUAL TEST VOLUME |
|---|---|---|
| **HISTOCOMPATIBILITY** | | _____ |
| ❑ Transplant | _____ | |
| ❑ Nontransplant | _____ | |
| **MICROBIOLOGY** | | _____ |
| ❑ Bacteriology | _____ | |
| ❑ Mycobacteriology | _____ | |
| ❑ Mycology | _____ | |
| ❑ Parasitology | _____ | |
| ❑ Virology | _____ | |
| **DIAGNOSTIC IMMUNOLOGY** | | _____ |
| ❑ Syphilis Serology | _____ | |
| ❑ General Immunology | _____ | |
| **CHEMISTRY** | | _____ |
| ❑ Routine | _____ | |
| ❑ Urinalysis | _____ | |
| ❑ Endocrinology | _____ | |
| ❑ Toxicology | _____ | |

| SPECIALTY / SUBSPECIALTY | ACCREDITING ORGANIZATION | ANNUAL TEST VOLUME |
|---|---|---|
| **HEMATOLOGY** | | _____ |
| ❑ Hematology | _____ | |
| **IMMUNOHEMATOLOGY** | | _____ |
| ❑ ABO Group & Rh Group | _____ | |
| ❑ Antibody Detection (transfusion) | _____ | |
| ❑ Antibody Detection (nontransfusion) | _____ | |
| ❑ Antibody Identification | _____ | |
| ❑ Compatibility Testing | _____ | |
| **PATHOLOGY** | | _____ |
| ❑ Histopathology | _____ | |
| ❑ Oral Pathology | _____ | |
| ❑ Cytology | _____ | |
| **RADIOBIOASSAY** | | _____ |
| ❑ Radiobioassay | _____ | |
| **CLINICAL CYTOGENETICS** | | _____ |
| ❑ Clinical Cytogenetics | _____ | |

**TOTAL ESTIMATED ANNUAL TEST VOLUME** _____

Form CMS-116 (03/03) Page 3 of 4

IX. TYPE OF CONTROL

| VOLUNTARY NONPROFIT | FOR PROFIT | GOVERNMENT | |
|---|---|---|---|
| 01 Religious Affiliation | 04 Proprietary | 05 City | 08 Federal |
| 02 Private | | 06 County | 09 Other Government |
| 03 Other _____ (Specify) | | 07 State | _____ (Specify) |

X. DIRECTOR AFFILIATION WITH OTHER LABORATORIES

If the director of this laboratory serves as director for additional laboratories that are separately certified, please complete the following:

| CLIA NUMBER | NAME OF LABORATORY |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

**ATTENTION: READ THE FOLLOWING CAREFULLY BEFORE SIGNING APPLICATION**

Any person who intentionally violates any requirement of section 353 of the Public Health Service Act as amended or any regulation promulgated thereunder shall be imprisoned for not more than 1 year or fined under title 18, United States Code or both, except that if the conviction is for a second or subsequent violation of such a requirement such person shall be imprisoned for not more than 3 years or fined in accordance with title 18, United States Code or both.

Consent: The applicant hereby agrees that such laboratory identified herein will be operated in accordance with applicable standards found necessary by the Secretary of Health and Human Services to carry out the purposes of section 353 of the Public Health Service Act as amended. The applicant further agrees to permit the Secretary, or any Federal officer or employee duly designated by the Secretary, to inspect the laboratory and its operations and its pertinent records at any reasonable time and to furnish any requested information or materials necessary to determine the laboratory's eligibility or continued eligibility for its certificate or continued compliance with CLIA requirements.

| SIGNATURE OF OWNER/DIRECTOR OF LABORATORY (Sign in ink) | DATE |
|---|---|
| | |



# THE CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA) APPLICATION (FORM CMS-116)

## INSTRUCTIONS FOR COMPLETION

CLIA requires every facility that tests human specimens for the purpose of providing information for the diagnosis, prevention or treatment of any disease or impairment of, or the assessment of the health of, a human being to meet certain Federal requirements. If your facility performs tests for these purposes, it is considered, under the law, to be a laboratory. CLIA applies even if only one or a few basic tests are performed, and even if you are not charging for testing. In addition the CLIA legislation requires financing of all regulatory costs through fees assessed to affected facilities.

The CLIA application (Form CMS-116) collects information about your laboratory's operation which is necessary to determine the fees to be assessed, to establish baseline data and to fulfill the statutory requirements for CLIA. This information will also provide an overview of your facility's laboratory operation. All information submitted should be based on your facility's laboratory operation as of the date of form completion.

**NOTE: WAIVED TESTS ARE NOT EXEMPT FROM CLIA. FACILITIES PERFORMING ONLY THOSE TESTS CATEGORIZED AS WAIVED MUST APPLY FOR A CLIA CERTIFICATE OF WAIVER.**

**NOTE: Laboratory directors performing nonwaived testing (including PPM) must meet specific education, training and experience under subpart M of the CLIA requirements. Proof of these requirements for the laboratory director must be provided and submitted with the application. Information to be submitted with the application include:**

- **Verification of State Licensure, as applicable**
- **Documentation of qualifications:**
  - **Education (copy of Diploma, transcript from accredited institution, CMEs),**
  - **Credentials, and**
  - **Laboratory experience.**

**Individuals who attended foreign schools must have an evaluation of their credentials determining equivalency of their education to education obtained in the United States. Failure to submit this information will delay the processing of your application.**

**ALL APPLICABLE SECTIONS MUST BE COMPLETED. INCOMPLETE APPLICATIONS CANNOT BE PROCESSED AND WILL BE RETURNED TO THE FACILITY. PRINT LEGIBLY OR TYPE INFORMATION.**

### I. GENERAL INFORMATION

**For an initial applicant, check "initial application". For an initial survey or for a recertification, check "survey". For a request to change the type of certificate, check "Change in certificate type". For all other changes, including change in location, director, etc., check "other changes".**

**For an initial applicant, the CLIA number should be left blank. The number will be assigned when the application is processed. Be specific when indicating the name of your facility, particularly when it is a component of a larger entity; e.g., respiratory therapy department in XYZ Hospital. For a physician's office, this may be the name of the physician. NOTE: The information provided is what will appear on your certificate.**

Facility street address must be the actual physical location where testing is performed, including floor, suite and/or room, if applicable. **DO NOT USE A POST OFFICE BOX NUMBER OR A MAIL DROP ADDRESS FOR THE NUMBER AND STREET OF THE ADDRESS.** If the laboratory has a separate mailing address, please complete that section of the application.

**NOTE: For Office Use Only—Date received is the date the form is received by the state agency or CMS regional office for processing.**

**II. TYPE OF CERTIFICATE REQUESTED**
When completing this section, please remember that a facility holding a—

- **Certificate of Waiver** can only perform tests *categorized as waived.**
- **Certificate for Provider Performed Microscopy Procedures** (PPM) can only perform tests categorized as PPM, or tests categorized as PPM and waived tests.*
- **Certificate of Compliance** can perform tests categorized as waived, PPM and moderate and/or high complexity tests provided the applicable CLIA quality standards are met, and
- **Certificate of Accreditation** can perform tests categorized as waived, PPM and moderate and/or high complexity tests provided the laboratory is currently accredited by an approved accreditation organization **

*A current list of waived and PPMP tests may be obtained from your State agency. Specific test system categorizations can also be reviewed via the Internet on *http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfCLIA/clia.cfm*.

**If you are applying for a Certificate of Accreditation, you must provide evidence of accreditation for your laboratory by an approved accreditation organization for CLIA purposes or evidence of application for such accreditation within 21 months after receipt of your Certificate of Registration.

**III. TYPE OF LABORATORY**
Select the type of laboratory designation that is most appropriate for your facility from the list provided. If you cannot find your designation within the list, contact your State agency for assistance.

**IV. HOURS OF ROUTINE OPERATION**
Provide only the times when actual laboratory testing is performed in your facility. Please use the HH:MM format.

**V. MULTIPLE SITES**
You can only qualify for the multiple site provision (more than one site under one certificate) if you meet one of the CLIA requirements described in 42 CFR 493.

**VI. WAIVED TESTING**
Indicate the estimated total annual tests volume for all waived tests performed.

**VII. PPM TESTING**
Indicate the estimated annual test volume for all PPM tests performed.

**VIII. NON-WAIVED TESTING** *(INCLUDING PPM)*
The total volume in this section includes all non-waived testing, including PPM tests previously counted in section VII. Follow the specific instructions on page 3 of the Form CMS-116 when completing this section. (Note: The Accrediting Organization column should reflect accreditation information for CLIA purposes only, e.g., CAP, etc.)

**IX. TYPE OF CONTROL**
Select the type which most appropriately describes your facility.

**X. DIRECTOR OF ADDITIONAL LABORATORIES**
List all other facilities for which the director is responsible.

Note that for a Certificate of PPM, Certificate of Compliance or Certificate of Accreditation, an individual can only serve as the director for no more than five certificates.

Once the completed Form CMS-116 has been returned to the applicable State agency and it is processed, a fee remittance coupon will be issued. The fee remittance coupon will indicate your CLIA identification number and the amount due for the certificate, and if applicable the compliance (survey) or validation fee. If you are applying for a Certificate of Compliance or Certificate of Accreditation, you will initially pay for and receive a Registration Certificate. A Registration Certificate permits a facility requiring a Certificate of Compliance to perform testing until an onsite inspection is conducted to determine program compliance; or for a facility applying for a Certificate of Accreditation, until verification of accreditation by an approved accreditation organization is received by CMS.

If you need additional information concerning CLIA, or if you have questions about completion of this form, please contact your State agency.



## TESTS COMMONLY PERFORMED AND THEIR CORRESPONDING LABORATORY SPECIALTIES/SUBSPECIALTIES

**HISTOCOMPATABILITY**
HLA Typing (disease associated antigens)

**SYPHILIS SEROLOGY**
RPR
FTA, MHATP

**GENERAL IMMUNOLOGY**
Monomicbrosic Assays
Rheumatoid Arthritis
Febrile Agglutins
Cold Agglutinins
HIV
Antibody Assays (hepatitis, herpes, etc.)
ANA Assays

**PARASITOLOGY**
Direct Preps
Ova and Parasite Preps
Wet Preps

**CHEMISTRY**

**Routine Chemistry**

| | |
|---|---|
| Albumin | ALT/SGPT |
| Ammonia | AST/SGOT |
| Alk Phos | Amylase |
| Bilirubin, Total | BUN |
| Bilirubin, direct | CK/CK isoenzymes |
| Calcium | Cholesterol, total |
| Chloride | Creatinine |
| CO2, total | Iodide |
| Ferritin | HDL Cholesterol |
| Glucose | LDH |
| Iron | LDH isoenzymes |
| Magnesium | Phosphorous |
| pH | Potassium |
| pO2 | Protein, total |
| pCO2 | GGT |
| PSA | Triponin |
| Sodium | Triglycerides |
| Vitamin B12 | Uric acid |

**Urinalysis**
Automated urinalysis
Urinalysis with microscopic analysis
Urine specific gravity by refractometer
Urine specific gravity by urinometer
Urine protein by sulfasalicylic acid

**BACTERIOLOGY**
Gram Stains
Cultures
Sensitivities
Strep Screens
Antigen assays
(H. pylori, Chlamydia, etc.)

**MYCOBACTERIOLOGY**
Acid Fast Smears
Mycobacterial Cultures
Mycobacterial Sensitivities

**MYCOLOGY**
Fungal Cultures
DTM
KOH Preps

**VIROLOGY**
RSV
HPV assays
Cell cultures

**Endocrinology**
TSH
Free T4
Total T4
Triiodothyronine (T3)
Serum-beta-HCG

**Toxicology**

| | |
|---|---|
| Acetaminophen | Procainamide |
| Blood alcohol | NAPA |
| Carbamazepine | Quinidine |
| Digoxin | Salicylates |
| Ethosuximide | Theophylline |
| Gentamycin | Tobramycin |
| Lithium | Valproic acid |
| Phenobarbitol | |
| Phenytoin | |

**HEMATOLOGY**
WBC count
RBC count
Hemoglobin
Hematocrit (Other than spun micro)
Platelet count
Differential
Activated Clotting Time
Prothrombin time
Partial thromboplastin time
Fibrinogen
Reticulocyte count
Manual WBC by hemocytometer
Manual platelet by hemocytometer
Manual RBC by hemocytometer
Sperm count

**RADIOBIOASSAY**
Red cell volume
Schilling's test

**IMMUNOHEMATOLOGY**
ABO group
Rh(D) type
Antibody Screening
Antibody Identification
Compatibility testing

**PATHOLOGY**
Dermatopathology
Oral pathology
PAP smear interpretations
Other cytology tests
Histopathology

**CYTOGENETICS**
Fragile X
Buccal smear



## GUIDELINES FOR COUNTING TESTS FOR CLIA

- For **histocompatibility**, each HLA typing (including disease associated antigens), HLA antibody screen, or HLA crossmatch is counted as one test.
- For **microbiology**, susceptibility testing is counted as one test per group of antibiotics used to determine sensitivity for one organism. Cultures are counted as one per specimen regardless of the extent of identification, number of organisms isolated and number of tests/procedures required for identification.
- Testing for allergens should be counted as one test per individual allergen.
- For **chemistry** profiles, each individual analyte is counted separately.
- For **urinalysis**, microscopic and macroscopic examinations, each count as one test. Macroscopics (dipsticks) are counted as one test regardless of the number of reagent pads on the strip.
- For **complete blood counts**, each **measured** individual analyte that is ordered **and reported** is counted separately. Differentials are counted as one test.
- Do not count calculations (e. g., A/G ratio, MCH, and T7), quality control, quality assurance and proficiency testing assays).
- For **immunohematology**, each ABO, Rh, antibody screen, crossmatch or antibody identification is counted as one test.
- For **histopathology**, each block (not slide) is counted as one test. Autopsy services are not included. For those laboratories that perform special stains on histology slides, the test volume is determined by adding the number of special stains performed on slides to the total number of specimen blocks prepared by the laboratory.
- For **cytology**, each slide (not case) is counted as one test for both Pap smears and nongynecologic cytology.
- For **cytogenetics**, the number of tests is determined by the number of specimen types processed on each patient e.g., a bone marrow and a venous blood specimen received on one patient is counted as two tests.
- For flow **cytometry** each measured individual analyte that is ordered and reported is counted separately.

## Patient Rights and Responsibilities at the School-Based Health Center

**YOUR RIGHTS**

1. You cannot be discriminated against on the basis of race, color, national origin, religion, sex, handicap, or health insurance.
2. You will be treated with courtesy and respect by all health center staff.
3. All information is **confidential**.
4. You will receive the best possible care and have other options for care explained to you.
5. You have a right to refuse treatment.
6. You have a right to review your health center record.
7. You have a right to review a copy of any bills submitted to your insurance company.
8. If you feel that your rights have been violated, you should inform the center staff.
9. You will not be denied services because of inability to pay.

**YOUR RESPONSIBILITIES**

1. Be on time for your appointments.
2. Call the health center at least 24 hours in advance if you are unable to keep an appointment.
3. Give the health center current information on your insurance, address, name, & phone number.
4. Provide a complete and accurate medical history to staff.
5. Tell us if you do not understand any aspect of your treatment.
6. Follow our recommendations and advice.
7. Tell us about unexpected complications that may happen during the course of your treatment.
8. Be considerate of the rights of other clients and of health center staff and property.
9. Pay as you can to help support the services of this center.

## Potential Funding Sources

| Name of Funder | Contact Information | Website | Deadline | Special Instructions |
|---|---|---|---|---|
| Anschutz Family Foundation | Michelle Sturm<br>303-293-1363 | www.anschutzfamily-foundation.org | January 15<br>August 1 | Call to determine if proposal fits within the foundation's funding cycle or submit a letter of inquiry |
| Bright Mountain Foundation | Irene Lopez-Wessell<br>303-381-2244 | www.brightmtnfdtn.org | January 15<br>March 15<br>August 15<br>October 15 | Mail one page letter of intent. See website for additional information |
| Chinook Fund | Neha Mahajan<br>303-455-6905 | www.chinookfund.org | February 21<br>August 21 | Call before applying. Funding guidelines and application on website |
| Daniel's Fund | Tami Brown<br>720-941-4457 | www.danielsfund.org | Year Round | Funding guidelines and application available on website. Youth Engagement priority. |
| Helen K. & Arthur E. Johnson Foundation | John H. Alexander<br>303-861-4127 | www.johnsonfounda-tion.org | January 1<br>April 1<br>July 1<br>October 1 | Letter of intent required if not previously funded. See website for guidelines and application instructions |
| Rose Community Foundation | Whitney G. Connor<br>303-398-7410 | www.rfcdenver.org | Year Round | Guidelines available on website. Accepts common grant application. |

Colorado Common Grant Information and Application: www.coloradocommongrantforms.org

## Sample Policies

SCHOOL-BASED HEALTH CENTER POLICIES AND PROCEDURES

**Age-Appropriate Reproductive Health and STD/STI Services**

POLICY STATEMENT

The School-Based Health Center (SBHC) will provide reproductive health and sexually transmitted disease/infections (STD/STI) services in accordance with state laws, community acceptance, and documented need. While stressing abstinence, students will have access to education, screening, diagnostic testing, and treatment for sexual development and reproductive health concerns.

PROCEDURES

The type of services provided by the SBHC, including specific requirements for family planning services, will be identified and recommended by the center's advisory committee to the sponsoring agency and, if appropriate, to the local school board, consistent with procedures mandated in the legislative language.

Appropriately trained SBHC staff will provide the following reproductive health services:

- Abstinence education
- Screening for sexual development
- Preventive education, including:
  - Breast self-exam
  - Testicular self-exam
  - STD prevention education
- Preventive screening, including:
  - Breast exams
  - Testicular exams
  - Pap smears
- STD testing and treatment
- Pregnancy testing and referral

**Pregnancy Tests**

Pregnancy testing will be available for all walk-ins, following triage to determine if the student meets the criteria to receive the test (to be determined as a clinical protocol, for example, based on date of last menses).

Test results will be available at the time of testing.

Those students with positive results will be scheduled for a visit as soon as possible with the center's clinician or referred to their own provider. In either case, they will receive follow-up within one week.

Students with negative results will be encouraged to attend a reproductive health educational session and scheduled for a family planning appointment as soon as possible if appropriate.

**STD/STI Tests and Treatment**

STD/STI testing will be available for all walk-ins, following triage to determine if the student meets the criteria to receive the test (to be determined as a clinical protocol.)

Test results will be available at the time of testing if possible.

Those students with positive results will receive care as soon as possible with the center's clinician or will be referred to their own provider, and informed of center reporting requirements to the county health department's infectious disease surveillance office. They will receive follow-up within one week.

Students with negative results will be encouraged to attend a reproductive health educational session as soon as possible if appropriate.

Positive results will be reported to the county health department's infectious disease surveillance office.

The health department will also receive notification of those students who do not seek treatment for positive results.

**Sexuality Education and Counseling**

**POLICY STATEMENT**

Sexuality education and counseling of students may take place onsite at a School-Based Health Center (SBHC).

**PROCEDURE**

Definitions:

**Sexuality education** – teaching relating to sexual development, reproduction, contraception, sexually transmitted diseases/infections (STD's/STI's), and sexual abuse.

**Sexuality counseling** – interaction between a staff member and student concerning sexuality education, sexual responsibility, and decision-making.

Age-appropriate sexuality education and counseling will be routine components of health maintenance (check-up) visits or will be provided as directed by the student's presenting complaint.

Students' age-appropriate knowledge of sexual development, reproduction, contraception, STD's/STI's, and sexual abuse will be assessed and corrected if inaccurate or incomplete.

Sexually active students who choose not to abstain from sexual activity will be encouraged to use a contraceptive method and to use condoms to prevent STD's/STI's. Such reproductive health services will be available on site per state statute, minor consent laws, and SBHC and school agreements.

Students will be encouraged to discuss sexual issues and decisions with their parents/legal guardians/ persons acting in loco parentis.

SBHC staff will collaborate with school personnel to provide opportunities for students' parents/legal guardians/persons acting in loco parentis to increase their knowledge about sexuality, to review teaching materials and curriculum, and to enhance their interactions with their adolescents around sexuality issues.





**Confidentiality**

**POLICY STATEMENT**

While we support and encourage parental involvement in a student's health care, all exchanges between health center staff and the student are considered privileged and confidential in accordance with state and federal information acts, the Health Information Portability and Accountability Act (HIPAA), and applicable state and federal laws and regulations. All records will be maintained in compliance with state statutes.

**PROCEDURE**

Students must be informed during their visit that one or more staff members may be involved in their treatment or care plans. If the student does not want certain staff persons informed of their care, this must be documented on the chart.

No discussion of visits can occur outside of the center staff without the student's express written permission.

No verbal or written request for information on a student can be provided to others, without the explicit permission of the student. This includes, but is not limited to, information on whether the student is enrolled in the SBHC, dates of visits, types of services, and requests for referrals.

SBHC staff will encourage students to involve their parents or guardians in all aspects of their care.

The medical director or SBHC coordinator have the discretion not to inform parents in certain cases of suspected parental abuse or neglect, in which case a report must be made to the Protective Services Agency.

The SBHC policy on confidentiality must be posted in a prominent place, and students must be informed during their first visit of the specific conditions in which parents and guardians will be notified by staff.

This discussion must be documented in the medical record.

Each staff member will be oriented to confidentiality regulations and sign a statement verifying such orientation.

SCHOOL-BASED HEALTH CENTER POLICIES AND PROCEDURES

**Billing**

**POLICY STATEMENT**

Parents / guardians, students, staff, and partner agencies will understand the health center's billing policy. Health center billing procedures will be in compliance with requirements of state and federal government and contracting third-party payers.

**PROCEDURE**

The health center will screen all uninsured students for potential eligibility for Medicaid, SCHIP, and all other state or federal programs and will facilitate application to the appropriate program.

Confidentiality of students will be protected in accordance with HIPAA and state statutes. Confidentiality policy supersedes any billing concerns.

The health center will bill uniformly for all services. The parent / guardian or patient is responsible for any out-of-pocket co-payments, deductibles, and/or non-covered services according to a fee scale based on family size and income, documented at least annually. Income levels, fees, and definition of family will be established through a dated addendum to this policy. Waiving collection of such balances will occur only after a reasonable attempt at collection has been made.

All net collections for services delivered by providers who are supported by the SBHC will accrue to the SBHC.

SBHC procedures will promote accurate billing and reimbursement without impeding access to health center services or incurring unexpected expense for parents or students.

No enrolled student will be denied access to on-site health center services because of inability to pay a fee.

Billing for off-site referral services to SBHC-enrolled patients will be the responsibility of the agency or individual providing that service.

Acronyms / Abbreviations:

- CHIP= Children's Health Insurance Program
- HIPAA= Health Insurance Portability and Accountability Act
- SBHC = School-Based Health Center

Patients and partner agencies will address all billing concerns to the Program Coordinator for consideration.

The SBHC will implement a billing compliance process.

At the time of enrollment in the school based health center (SBHC), the enroller will request the following information from the person enrolling the student (either the student him- or herself or parent/guardian of an unemancipated minor student):

- Insurance card (or, if unavailable, the name of primary insured, identification and group numbers).
- Family and/or student income to establish financial need.
- Consent form for SBHC services, including authorization for billing and agreement to notify SBHC if insurance or income changes.

If the person enrolling is the student and if the student cannot provide the above information, the student will be referred to the SBHC social worker to determine whether there is a parent or guardian who can assume financial responsibility for the student. If not, the student will be the person deemed the responsible party for all actions of the "parent" in this policy and will be assisted in submitting a Medicaid application.

Staff will update insurance and income data at the time of each contact with the parent, prior to an off-site referral, and at least annually, and will discuss outstanding accounts annually or as directed by the SBHC coordinator or director.



Any student or parent/guardian who does not provide the above information will sign a form, agreeing to be billed in full for all services provided by the health center. Any student or parent/guardian whose insurance or income changes and who does not provide new information will be billed in full for services provided by the SBHC.

The health center will bill uniformly, according to the established fee scale.

An enrolled student who requests an SBHC service that may result in an out-of-pocket expense will be screened by the SBHC staff for (1) acuity of the student's presenting problem and (2) confidentiality of the student's presenting problem. Staff will respond to their findings as follows:

- If the problem falls within the range of confidential conditions defined in state statutes and the student desires confidential services, the staff will perform those specific services indicated to address the student's confidential problem and will clearly mark the encounter form "Confidential-do not bill parent." Procedures in place with billing staff will assure that no bill or statement will go to the parent. The student, him- or herself, will be billed in accordance with this policy. The staff will work with the student to involve the parent/guardian at the earliest opportunity as appropriate. The staff will request that the student reschedule to address non-confidential, non-urgent problems.
- If the problem does not fall within the range of confidential conditions under state statutes and presents an immediate threat to the student's health, staff will attempt to contact the parent / guardian to discuss the problem and any costs or fees associated with the visit. Whether or not the staff is able to reach the parent/guardian, the staff will document contact or attempted contact(s), proceed with assessment and treatment, and bill the parent
and/or the insurance provider.
- If the problem does not present an immediate threat to health and does not fall within the range of confidential conditions defined in state statutes, staff will obtain parental approval as indicated.

Except as noted above, an SBHC staff member will request prior approval from the parent/guardian for the visit or service when out-of-pocket fees are anticipated.

Staff will follow students' health insurance plan requirements and pre-authorization guidelines or approval processes in developing plans of treatment and referral except in situations where these steps prevent students' prompt access to care needed for urgent and life-threatening conditions.

Staff will document in the medical record all contacts with students, parents/guardians, and insurance carriers about billing issues and all decisions not to bill parents for reasons of confidentiality.

SBHCs will make reasonable attempts at collection of fees billed for services provided on-site. For patients whose families fall at state indicated percentage of the federal poverty level or below, this will consist of a single bill. For others this will consist of three bills.

Parents or students with billing concerns that cannot be satisfied by discussion with the clerical staff will be referred to the SBHC coordinator. The coordinator will consult with the SBHC billing consultant as needed and will inform the program director of all such communications. The SBHC program director will involve the SBHC or sponsoring agency attorney if the concern cannot be resolved to the satisfaction of both parties.

The staff will refer all third-party payers or government officials with billing concerns to the SBHC coordinator. The coordinator will gather data relevant to the concern, involve the billing consultant, and present the issue to the SBHC director, who will assume responsibility for addressing the concern. The director will involve the legal representative if the concern cannot be resolved to the satisfaction of both parties.

The SBHC director will maintain records of all billing concerns referred to the coordinator or director.

The SBHC billing consultant will periodically review charges prior to billing as a part of a billing compliance process developed for the SBHC.

Definitions:

- **Contracting third-party payers**—public and private insurers, including Medicaid, SCHIP, and private insurance plans, that credential SBHC providers.
- **Uninsured students** - students who have no health insurance and students whose health or accident insurance does not cover core services of the health center or services that the health center staff determines are needed by the student.
- **Waive collection** - to completely or partially not insist on co-payments, deductibles, and/or fees for non-covered services based on financial need as determined by family size and income.
- **Reasonable attempt at collection** - single submission of a bill by mail or in person to parent, third-party payer, or student.
- **Net collection** - gross collections from patient and/or third-party payers less billing cost and overhead.
- **Partner agencies** - agencies participating in provision of services in SBHC health centers.



## Typical Colorado Pharmacy Pricing

Common reproductive and sexual health medication costs without Insurance (February 2010):

| | | |
|---|---|---|
| **Wal-Mart** | | |
| Doxycycline 100mg | 20 pills | $4 |
| Acyclovir 200 mg | 30 days | $4 |
| Metronidazole 250 mg | 28 pills | $4 |
| Metronidazole 500 mg | 14 pills | $4 |
| Sprintec 28 days | 28 pills | $9 |
| Tri-Sprintec 28 day | 28 pills | $9 |
| **Target** | | |
| Doxycycline 100mg | 20 pills | $4 |
| Acyclovir 200mg | 30 days | $4 |
| Metronidazole 250 mg | 28 pills | $4 |
| Metronidazole 500 mg | 14 pills | $4 |
| Sprintec 28 days | 28 pills | $9 |
| Tri-Sprintec 28 day | 28 pills | $9 |
| **Other** | | |
| Emergency Contraception | 2 pills | ~$40-$50 |
| Nuva Ring | 28 day | ~$30-$35 |
| Ortho Evra | 28 day | ~$20-$50 |

## Service Provision

**Introduction**

When providing adolescent reproductive and sexual health services SBHCs should adhere to best practices in order to ensure that they are effectively working with adolescents to reduce risk behaviors and improve contraceptive use. The following protocols provide a guide to help providers incorporate research into practice.

The guidelines for each type of clinic service include relevant policy, procedures, and protocols. The policy identifies the purpose, background, and research supporting the guidelines. The procedure outlines each type of visit based on the capabilities of the clinic. The protocol then provides clinical guidelines for each type of visit. The Progress Note forms in the Tools section correspond to specific protocols so that clinicians are quickly and easily guided through all the necessary steps associated with each reproductive health service.

This chapter contains the following protocols:

- Reproductive Health Visits Policy and Protocol
- Pregnancy Testing and Counseling Policy and Protocol
- Quick Start Initiation Policy and Protocol
- Contraception Policy and Protocol
- Emergency Contraception Policy and Protocol
- Sexually Transmitted Infections Policy and Protocol



## SCHOOL-BASED HEALTH CENTER

## POLICIES AND PROCEDURES

**Title: Reproductive Health Visits**

**Date Issued: May 2010**

**PURPOSE:** To assure that all students visiting the school-based health center receive a detailed risk assessment and, if sexually active, have the option to initiate contraception without a pelvic exam, receive education and counseling, and receive follow-up as necessary.

**POLICY:** Adolescent health visits will include patient history, screening and assessment of risk factors, appropriate education and counseling, and necessary follow-up in accordance with protocols. Providers will address reproductive and sexual health at each visit regardless of the reason for the visit.[1]

**PROCEDURE:**

Patients visiting the clinic will be provided with a confidential sign-in procedure that allows them to indicate the reason for their visit if there is not a private check-in space.

Confidentiality of reproductive health services, mental health services, and substance abuse services will be discussed at least annually. At the initial reproductive health visit patients will complete the *Reproductive Health Intake: Student Form* and will initial a confidentiality agreement which outlines the patient's right to confidentiality and the exceptions in accordance with Colorado law.

Note: The reproductive health visits protocol is meant to supplement existing visit protocols and only accounts for the components of adolescent reproductive health visits identified below:

- Detailed Sexual History and Risk Assessment
- Education and Counseling
- Delayed Pelvic
- Dispensing Contraception and Treatment
- Prescribing Contraception and Treatment
- Referring for Contraception and Treatment
- Follow-up on these services

**RELATED TOOLS:**

- Reproductive Health Intake: Student Form
- Reproductive Health Progress Note
- Follow-up/Interval Visit Progress Note

### REPRODUCTIVE HEALTH VISIT PROTOCOL

**1. Overview**

All patients presenting to the SBHC for a reproductive health visit will complete a reproductive health intake form to gather a detailed sexual history, be provided with appropriate education and counseling, receive indicated reproductive health screenings, and receive appropriate and timely follow-up care.

**2. Sexual History and Risk Assessment**

A detailed reproductive and sexual health history should include:

- Menstrual history
- Sexual orientation
- History of forced sexual contact
- Vaginal, oral, anal sex history
- Contraceptive history
- Pregnancy history
- Timing of childbearing plans

[1] Brown, S., Burdette, L., and Rodriguez, P., "Editorial: Looking Inward: provider-based barriers to contraception among teens and young adults," *Contraception Journal* 78 (2008): 355-357.

- Future goals and plans
- Substance use (alcohol/drug use)
- Number of lifetime sexual partners including same-sex encounters
- Number of partners in the last 3 months
- History of STIs

All of this information will be gathered using the reproductive health intake: student form, which will be reviewed by the provider at the beginning of each reproductive health visit.

**3. Education and Counseling**

Providers will use a client-centered yet directive approach when counseling patients and discuss risk reduction measures. Patients will be commended for seeking services, and risk reduction will be tailored to the patient's needs and motivations. All language used when referring to partners or sexual preferences will be gender neutral and avoid assumptions about the patient's sexual orientation and gender identity.

During the visit, all adolescents seeking family planning services for the first time will be provided with information on the following, verbally, and when indicated in the corresponding protocols, in writing. Presentation of client education should be appropriate for client's age, knowledge, language and socio-cultural background.

- Basic female and male reproductive anatomy and physiology
- Details about all available contraceptive methods, myths, and correct condom use
- STI/HIV risk reduction
- Mental health/substance abuse screening

All education provided will be documented and will include information about emergency contraception regardless of gender or sexual activity.

Patients will be encouraged to discuss their health concerns with their parents or a trusting adult and will be given information on risk reduction measures, including abstinence.

**4. Delayed Pelvic**

A pelvic exam is **not** indicated for the provision of contraception.[2]

Patients should be screened as follows:

- Targeted family and personal medical history
- Blood pressure and weight
- Urine pregnancy and STI testing if indicated

All education will be documented on the progress note form and will include all information as outlined in the contraception protocol.

It is a best practice to use Quick Start to initiate contraceptive methods. (See Quick Start Protocol.)

Patients will also be given the option to be screened for STIs using urine-based screening.

**5. Follow-up for Family Planning Requests**

**A. On-Site Dispensing**

When contraception is dispensed on-site, SBHCs should have a mechanism in place to ensure follow-up at one month and three months after dispensing contraception. If providers do not have a system in place, they will use the follow-up calendar provided in this toolkit.

All family planning follow-up visits will include a review of confidentiality and assessment of:[3]

- Satisfaction with the method

[2] Harper, C., Balisteri, E., Bogges, J., et al., "Provision of hormonal contraceptives without a mandatory pelvic examination: The First Stop Demonstration Project," *Family Planning Perspectives* 33 (2001):13-8.
[3] Frost J., Singh, S., and Finer, L., "Factors associated with contraceptive use and nonuse, United States, 2004," *Perspectives Sexual Reproductive Health* 39 (2007):90-9.



- Questions or problems
- Management of side-effects and problems effectively using the method
- Need for condoms
- Need for additional supplies/prescription
- Desire to change methods
- Risk behaviors

The patient's blood pressure will be checked.

Education and counseling will be documented.

Patients will be instructed to contact the clinic *any time for any reason,* including if they experience any problems or if they decide to discontinue their method.

**B. Prescriptions**

hen contraception is prescribed but not dispensed, SBHCs should have a mechanism in place to ensure follow-up within two weeks of prescribing the contraception.

Assessment will include:

- If the patient was able to fill the prescription and if not:
  - Barriers that prevented filling the prescription
  - Ideas/skills to reduce barriers
  - Barriers in the current referral system should be reported to the medical director
- Patient's understanding of how to correctly use the method
- Questions or concerns

Once the patient has successfully obtained the prescription, a follow-up appointment will be scheduled at three months to assess the following:

- Satisfaction with the method
- Questions or problems
- Management of side-effects and problems effectively using the method
- Need for condoms
- Need for additional supplies/prescription
- Desire to change methods
- Risk behaviors

The patient's blood pressure will be checked.

Education and counseling will be documented.

Patients will be instructed to contact the clinic *any time for any reason*, including if they experience any problems or if they decide to discontinue their method.

**C. Referrals for Contraceptives**

When SBHCs are unable to either dispense or prescribe, they should have a formalized active referral process with an accessible and affordable community clinic. The working relationship should accommodate scheduling timely appointments.

If a patient is referred for contraception, the provider should:

- Assess the need for emergency contraception
- Provide a pregnancy test if indicated
- Provide detailed information on all available methods and assist the student in the selection of a method (see contraception protocol)
- If possible, contact the referral clinic while meeting with the patient and guide the patient through scheduling an appointment. Timeliness will be considered if EC is indicated
- Schedule a follow-up appointment within two weeks of referral to assess if completed.

Follow-up assessment will include:

- If the patient was able to attend the visit at the referral clinic and if not:
  - Providers will help the patient identify barriers that prevented them from going
  - Assist the patient in brainstorming ideas/skills to reduce said barriers
  - Barriers in current referral system should be reported to the medical director
- Providers will also help reschedule the appointment if appropriate

Once the patient has successfully attended the visit at the referral clinic, the SBHC will follow up at three months to assess:

- Satisfaction with the method
- Questions or problems
- Management of side-effects and problems effectively using the method
- Need for condoms
- Need for additional supplies/prescription
- Desire to change methods
- Risk behaviors

The patient's blood pressure will be checked.

Education and counseling will be documented.

Patients will be instructed to contact the clinic *any time for any reason*, including if they experience any problems or if they decide to discontinue their method.



**SCHOOL-BASED HEALTH CENTER**

**POLICIES AND PROCEDURES**

**Title: Pregnancy Testing and Counseling**

**Date Issued: May 2010**

**PURPOSE:** To assure that students requesting pregnancy tests or meeting the criteria for pregnancy tests are offered this service in a timely fashion and that staff comply with all requirements for pregnancy testing and counseling.

**BACKGROUND:**

Urine pregnancy tests very reliably detect human chorionic gonadotrophin (HCG), which is present in the urine of pregnant women early in pregnancy. The urine pregnancy test is definitive for pregnancy when results are positive (without confirmatory blood testing) if the results are consistent with the patient's history and clinical presentation. In a woman with regular menstrual cycles a pregnancy test **may** be positive as soon as three to four weeks after the first day of her last menstrual period or as soon as the HCG levels reach 20-50 mIU/mL. As a general rule, if a patient is pregnant, the urine pregnancy test will be positive two weeks from the last unprotected intercourse.*

Pregnancy testing and counseling at the school-based health center will be available to rule out and diagnose pregnancy, as well as identify patients who are at risk for pregnancy, and provide appropriate education and intervention. Research confirms clinic experience that adolescents who receive a negative pregnancy test result are at a very high risk of unintended pregnancy within the next year. In one study, 58% of adolescents aged 17 and younger who received a negative pregnancy test were pregnant within 18 months of the negative test.[4] Additionally, research in SBHCs shows that comprehensive reproductive health services are often not offered to adolescents who receive negative pregnancy test results.[5] This group of students is available at the time of testing for intervention and counseling that can prevent an unplanned pregnancy in the near future. Providers can commend them for recognizing that they are in need of health services and, with a patient centered approach, capture their motivation to use effective birth control.

Availability of urine pregnancy testing on-site ensures easier and quicker access to both emergency contraception and contraception for those students/patients with negative test results, and timely, appropriate pregnancy-options counseling and referrals for those patients with positive test results.

**POLICY:** Pregnancy tests will be available at the SBHC. Providers will use this visit as an opportunity to provide education and counseling on abstinence, safe sex, contraception, and emergency contraception.

**PROCEDURE:**

Pregnancy testing, evaluation, education, and counseling will include a history as outlined in the Reproductive Health Progress Note. A urine sample will be collected for pregnancy and chlamydia/gonorrhea testing. A pelvic exam or other lab testing is not routinely indicated.

Parental involvement will be encouraged with both a negative and positive test result. For students with a positive test result, the provider may offer to mediate to enable the client to involve the parent or guardian in on-going care.

All adolescents with negative pregnancy test results will be given the option to Quick Start birth control and will be provided with information and an advanced prescription for EC. If the SBHC does not prescribe or dispense contraceptives, a referral will be made in a timely fashion.

[4] Zabin, L.S., Emerson, M.R., Ringer P.A., & Sedivy, V., "Adolescents with negative pregnancy test results: An accessible at-risk group," *Journal of the American Medical Association* 275 (1996): 113-117.

[5] Sadler, L. S., "Reproductive care and rates of pregnancy in teenagers with negative pregnancy test results," *Journal of Adolescent Health* 38 (2005): 222-229.

*The urine pregnancy test is the standard used in most medical clinics for determining that a woman is not pregnant before invasive procedures (where a pregnancy could be disrupted), such as a colposcopy with endocervical curettage, endometrial biopsy, and IUD insertion. The protocol most commonly followed is that there has been no unprotected intercourse in the past two weeks, and the urine pregnancy test is negative.

**RELATED TOOLS:**

1. DECISION Model

## PROTOCOL FOR PREGNANCY TESTING AND COUNSELING

**A. Patient Selection**

Screen all patients who request a pregnancy test, birth control, or STI screening. Other patients to be tested may include sexually active females who present for other concerns (e.g., nausea, fatigue, vaginitis) or any patient with late or irregular menstrual periods. Clinical judgment should be used in any other situation, and pregnancy testing can be done if indicated.

**B. Evaluation**

Ensure confidentiality at the start of the intake and explain what this means (exceptions: sexual assault, suicidal or homicidal risk). Teens cite lack of confidentiality as a major barrier to receiving health care. A brief reproductive health history should be taken prior to performing a pregnancy test. This history will help establish the need for emergency contraception and the extent of STI testing (urine CT/GC should be routinely done).

Document the following:

- History of sexual activity (include all types of activity, do not assume heterosexuality)
- Last menses
- History of contraceptive use, if any, including condom use
- Significant medical history

**C. Results**

1. Inform the patient of the results

2. Negative result

Negative and the patient does not desire pregnancy:

- Assess the need for emergency contraception and administer, prescribe, or refer if indicated.
- Patient-centered education begins. Ask the patient if there is a birth control method that she might want to try. Educate the patient on all methods of family planning available using an education tool such as the provided birth control brochure or a poster or handout as a guide. Discuss any myths that the patient may have about certain methods. Discuss perceived or real barriers to a method. Reassure the patient that she will be able to return for any reason at any time if she has questions or concerns.
- Administer, prescribe, or refer for an appropriate, client-selected method.
- If the client is currently using a method of birth control, assess barriers to proper use and address questions or concerns the client may have. Satisfaction with a method is the best predictor of continued use.
- Review the adolescent's knowledge and skills about pregnancy and STI prevention and provide opportunities for skills development. Review correct and consistent condom use and techniques to negotiate for its use.
- If the last unprotected intercourse occurred within 2 weeks prior to the test, instruct patient to return to the clinic in two weeks if no menses.
- If the patient does not desire pregnancy or birth control but is sexually active, consider starting prenatal vitamins and explain the 85% chance of pregnancy per year.
- Document result and plan of care.

Negative and the patient desires pregnancy:

- Discuss importance of pre-conception care; start prenatal vitamins now (available OTC); advise to start three months before conception.
- Provide further counseling regarding parenting plans or refer to counselor.
- If the last unprotected intercourse occurred within 2 weeks prior to the test, instruct patient to return to the clinic in two weeks if no menses.
- Document result and plan of care.

3. Positive result

- Discuss and confirm patient's plans.
- Conduct a screening history to rule out medically urgent/emergent conditions.
- Identify personal circumstances and support systems.
- Address immediate concerns.
- Offer a timeline and discuss next steps.
- If the patient knows how she would like to proceed, active referrals will be made to prenatal care, adoption agencies, or abortion clinics. When possible, phone calls should be made by the patient during the visit with the provider to schedule appointments.
- Consider providing prenatal vitamins or folic acid (400 ucg per day) for those who are unsure or planning to continue the pregnancy.
- Schedule follow-up in one week.
- Document result and plan of care.

**D. Counseling and Education**

When counseling a patient who requests a pregnancy test, the DECISION Model provided by the Adolescent Reproductive Health Education Project and Physicians for Reproductive Choice and Health is a very comprehensive guide:

D: Determine the Reason for the Visit

*What can I help you with today?*

*Why do you think you may be pregnant?*

*When was your last period?*

*Have you ever been pregnant before? If so, what were the outcomes?*

*Are you currently using any form of contraception?*

E: Evaluate Feelings

*What do you hope will be the results of this test?*

*Have you ever wanted to be pregnant?*

*How do you feel about the sexual encounter that brought you here today?*

*Do you have any friends who are pregnant or who have had a baby?*

*How do you feel about their situations?*

C: Confirm Pregnancy Test Results

*Give the results and remain silent to allow the patient to initiate a response.*

I: Identify Personal Circumstances

*How do you view the next year of your life?*

*How does pregnancy fit into this view?*

S: Support

*Who in your life can help you in a supportive way?*

*What is your relationship with the man that you are pregnant by? Does he treat you well?*

*If you have a current partner, how will they feel about you being pregnant?*

*How do you think your parents might feel about this?*

I: Immediate Concerns Addressed

O: Offer Timeline

*If you decide to continue the pregnancy, by what date will you make an appointment for prenatal care?*

*If you decide to have an abortion, by what date will you schedule an appointment?*

*By when will you have discussed your situation with a parent, guardian, or trusted adult? Discuss the importance of telling a parent as soon as possible.*

*Have patient call from your office if possible.*

N: Next Steps

**E. Follow-Up**

All patients who receive a pregnancy test require follow-up. The follow-up plan should be established during the first visit and appropriate appointments scheduled:

Positive pregnancy test: one week follow-up

Negative, desires pregnancy: one month follow-up

Negative, does not desire pregnancy, Quick Start contraception: two weeks if prescribed or dispensed



**SCHOOL-BASED HEALTH CENTER**

**POLICIES AND PROCEDURES**

**Title: Quick Start Initiation**

**Date Issued: May 2010**

**Purpose:** To assure that students motivated to start any birth control method are offered this option and that staff comply with all requirements and best practices for contraceptive Quick Start Initiation.

**Background:** The goal of Quick Start is to provide maximum contraceptive protection as soon as possible rather than waiting for the next menstrual period to begin birth control. Quick Start provides the opportunity for students to initiate contraception the same day they request it, when they are likely to be most motivated. Quick Start can be used to initiate oral contraceptives, the Nuva Ring, the Ortho Evra Patch, and Depo-Provera without delay.

**Policy:** Students will be offered Quick Start as the preferred method of contraceptive initiation as long as a specific set of criteria are met.

**Procedure:**

**A. On-site Dispensing of Contraceptives**

See protocol for Quick Start below.

**B. On-Site Prescription without On-Site Dispensing of Contraceptives**

See protocol for Quick Start attached and then proceed with the following:

1. Patients receiving a prescription for a method not available on-site should be seen within two weeks to assess if the patient was able to fill the prescription.

2. The provider should review instructions for use, answer any questions, and schedule a three month follow-up appointment to assess satisfaction with the method.

**C. Sites without On-site Prescription or Dispensing of Contraceptives**

1. Patients presenting to an SBHC that does not dispense or prescribe contraceptives will have an active referral process in place with an accessible and affordable community clinic.

2. Patients requesting birth control will be counseled about the different methods available and given a brochure outlining the methods.

3. If the patient has already selected a method, the provider will review instructions for using the method, answer any questions, and provide the student with a method-specific brochure.

4. When possible, the patient and the provider will contact the community clinic together to schedule an appointment.

5. Follow-up should occur within two weeks of the scheduled appointment at the community clinic to assess if the patient followed-through with the referral and was able to access contraception. If the patient did not complete the referral, barriers will be assessed and addressed, and if appropriate, another appointment will be scheduled.

6. Once the patient has successfully accessed contraception, the SBHC should follow-up with the patient at three months to review satisfaction and answer specific questions about the method.

## PROTOCOL FOR QUICK START INITIATION

**1. OVERVIEW**

Quick Start is the preferred method of initiation for contraception with adolescents. It provides maximum contraceptive protection and helps patients initiate contraception when they are most motivated.

**2. PATIENT SELECTION**

Quick Start can and should be offered to any student who is requesting a contraceptive method. Prior to Quick Start Initiation, the following procedures must occur:

Discuss confidentiality with the student.

Perform a urine pregnancy test and document negative test results.

Assess student for emergency contraception eligibility and offer/prescribe as indicated.

Measure and document the patient's blood pressure and conduct appropriate screening history to determine any method-specific contraindications as outlined in *Contraceptive Technology*.[6]

Discuss the need for STI screening and offer as appropriate (at least annually for CT/GC).

**3. CONTRAINDICATIONS**

There are no contraindications to the Quick Start initiation of any hormonal method; however, pregnancy and method-specific contraindications should be evaluated.

**4. EDUCATION**

All patients who are initiating the use of contraceptives through Quick Start should be counseled on the use, effectiveness, advantages, and disadvantages of the contraceptive method of choice. Counseling should be patient-centered and should focus on the best method for the student/patient.

The patient should receive a method-specific brochure and sign the completed Birth Control Initiation progress note.

Emphasize that contraception is not immediately effective and ensure that students agree to either abstain from sex or use condoms during the first seven days using the new method. Dual use of condoms should also be encouraged to help prevent the transmission of STIs and HIV.

**5. INSTRUCTIONS FOR USE**

All patients should be provided instructions for the use of the method of choice as outlined in the contraception protocol. Students should always be encouraged to return to the SBHC any time for any reason.

**6. FOLLOW-UP**

Quick Start follow-up includes a visit within two weeks to repeat the urine pregnancy test if indicated and to ensure satisfaction and correct usage of the method. Follow-up helps identify and rule out possible "window" pregnancy and provides a time to answer any questions and offer refills as appropriate.

Follow-up should then be conducted at two weeks if contraception is prescribed or referred out and at three months if contraception is dispensed.

**7. QUICK-START ALGORITHM**

A quick-start algorithm can be found at http://www.aafp.org/afp/20060701/105.html.

[6] Hatcher, R., Trussell, J., Nelson, A., et al., *Contraceptive Technology* 19th Revised Edition (Ardent Media Inc, 2007).



**SCHOOL-BASED HEALTH CENTER**

**POLICIES AND PROCEDURES**

**Title: Contraception**

**Date Issued: May 2010**

**PURPOSE:** To assure that students who meet the criteria for contraception are offered this service and that staff comply with all requirements for dispensing, prescribing, or referring for contraception.

**BACKGROUND:** Research shows that the availability of contraception in an SBHC has consistently been shown not to increase sexual activity.[7] Additionally, when SBHCs can dispense contraception on-site, sexually active females select methods of hormonal contraception sooner and somewhat more consistently.[8] Follow-up must be prioritized as it has been shown to improve contraceptive use and increase consistency of use.

**POLICY:** All students who report being sexually active or considering sexual activity will be screened to determine if they meet the criteria for contraception. For students who meet the criteria, these services will be offered either directly at the school-based health center or through a referral to a back-up clinic. Parental/guardian involvement will always be explored and encouraged.

**PROCEDURE:** All students who meet the criteria for contraception—sexual activity that puts the patient at risk for unintended pregnancy or sexually transmitted infections—will be provided with information about contraceptives. All students who are sexually active should be routinely asked if they are using a consistent method of birth control and if they have any questions or concerns regarding contraception. If the student wishes to initiate a birth control method, the Reproductive Health Progress Note will be used to document the visit.

**A. On-Site Dispensing of Contraceptives**

See Protocols for Contraception below. When select methods, such as the IUD are not available, see section C below.

**B. On-Site Prescription without On-Site Dispensing of Contraceptives**

See Protocols for Contraception attached then proceed with the following:

1. Once visit is complete and prescription has been written, the provider will schedule a follow-up visit within two weeks to assess if the student was able to obtain the prescription and if she has any questions or concerns.
2. At first follow-up visit (two weeks after the prescription is written) the provider will ask the patient to describe how she intends to use the method or how she is using the method and provide any necessary clarification.
3. A follow-up appointment will be scheduled at the SBHC at three months after initiating a new contraceptive method to assess contraceptive continuity, side effects, satisfaction with the method, and any concerns.
4. If a patient fails to attend the appointment, a system to follow-up with the patient will be in place. If students are to be contacted directly, providers will be careful not to breech confidentiality.

C. Sites without On-Site Prescription or Dispensing of Contraceptives

1. Students will receive age-appropriate counseling at the SBHC and the provider will help the student select a contraceptive method. (See Protocol for Assisting with the Selection of a Method.)

[7] Kirby, D., Waszak, C., and Ziegler, J., "Six school-based clinics: their reproductive health services and impact on sexual behavior," *Family Planning Perspectives* 23 (1991):6-16.
[8] Brindis, C., Starbuck-Morales. S., Wolfe, A.L., et al., "Characteristics associated with contraceptive use among adolescent females in school-based family planning programs," *Family Planning Perspectives* 26 (1994):160-164.

2. Students will be given a brochure about all available methods. If they have selected a method, they will also be given detailed information on their selected method, including instructions for use.

3. The provider will assess the need for emergency contraception and refer to the emergency contraception protocol if indicated (unprotected sexual activity within the past 120 hours/5 days).

4. The following forms and tools must be used at the SBHC:

   - Contraceptive brochures
   - *Contraceptive Technology*[9]

5. The provider will contact the back-up clinic while meeting with the student and assist the student in scheduling an appointment. If possible, a same-day appointment will be scheduled. SBHCs will have a working relationship with the back-up clinic that facilitates scheduling timely appointments.

6. Students receiving contraception at the back-up clinic will be seen at the SBHC within two weeks of referral to ensure follow-through and address any barriers that may have prevented follow-through.

7. A follow-up appointment will be scheduled at the SBHC at three months after initiating a new contraceptive method to address any method issues or concerns.

**PROTOCOLS:**

1. General Protocol for All Contraceptive Patients
2. Assisting with the Selection of a Method
3. Combined Oral Contraception Protocol
4. Transdermal Patch Protocol
5. Vaginal Ring Protocol
6. Progestin Only Pills Protocol
7. Depo-Provera Injection Protocol
8. Intrauterine Devices Protocol
9. Male Condoms

[9] Hatcher, R., Trussell, J., Nelson, A., et al., *Contraceptive Technology* 19th Revised Edition (Ardent Media Inc, 2007).

## GENERAL CONTRACEPTION PROTOCOL

**1. OVERVIEW**

Contraception is an important option for pregnancy prevention when an adolescent is sexually active and desires a consistent and effective method of birth control.

All patients will be informed about the confidentiality of the reproductive health services being rendered. The confidentiality of the patient will be maintained per Colorado Revised State Statute 13-22-105.

When contraception is not available on-site, the providers will consider cost as a factor when providing referrals and writing prescriptions.

Providers will discuss abstinence with patients as the most effective option for preventing pregnancy and the transmission of STIs.

If a patient is undecided as to which method she would like to use, she will be provided information on all of the available methods, benefits and side effects of each, and a brochure detailing all methods. (See Protocol for Assisting with the Selection of a Method.)

Providers will have *Contraceptive Technology*[10] available during each visit to assess contraindications and management of contraceptive choices.

Before initiating contraception with adolescents providers will:

- Consider a pelvic exam—not necessary if asymptomatic for STIs, pap smears are not indicated for women under the age of 21.
- Emphasize—hormonal contraceptives do not prevent STIs and dual method use will be encouraged.
- Discuss emergency contraception and write an advance-prescription. All patients, male and female, will receive education about emergency contraception.
- Assess contraindications as described in Contraceptive Technology prior to prescribing or dispensing any form of hormonal contraception.

Quick Start Initiation will be the standard method of initiation for contraception. Quick Start allows the patient to start the method the day she fills the prescription.

For all hormonal methods, patients will be instructed to use a back-up method for one week.

For all hormonal methods with estrogen, providers will discuss the potential side-effects, including breast tenderness, nausea, hypertension, emesis, and medications that can decrease effectiveness.

All patients receiving hormonal contraception will be advised to contact their medical provider if they experience any of the following:

- Abdominal pain
- Chest pain
- Headaches
- Eye or visual changes
- Severe leg pain or swelling

Providers will dispel any misinformation or myths about contraception as well as suggest creative ways to help clients use their method correctly.

Providers will also offer testing for sexually transmitted infections and HIV if available when initiating contraception. If the patient has not already received her Gardasil vaccinations, the provider will discuss the vaccine and encourage the patient to discuss receiving the vaccine with her parents/guardians.

**2. FOLLOW-UP**

All patients initiating contraception will be scheduled for a follow-up appointment at three months after initiation to address any issues or concerns the patient has about the selected method.

If a patient does not return for the scheduled appointment, the SBHC will have a mechanism in place to contact the patient and reschedule.

**PROTOCOL FOR ASSISTING IN THE SELECTION/CHANGING OF A CONTRACEPTIVE METHOD**

**1. OVERVIEW**

When adolescents choose a contraceptive method it is a very important decision that must fit their lifestyle and expectations, and the choice must have a high potential to be used correctly and consistently. The provider will guide patients through the selection process and offer medical expertise, but adolescents should make their own decision about which method to use as it has been shown to increase consistency of use. Most contraceptives pose little risk to most users' health, although personal risk factors should influence personal choice.[11]

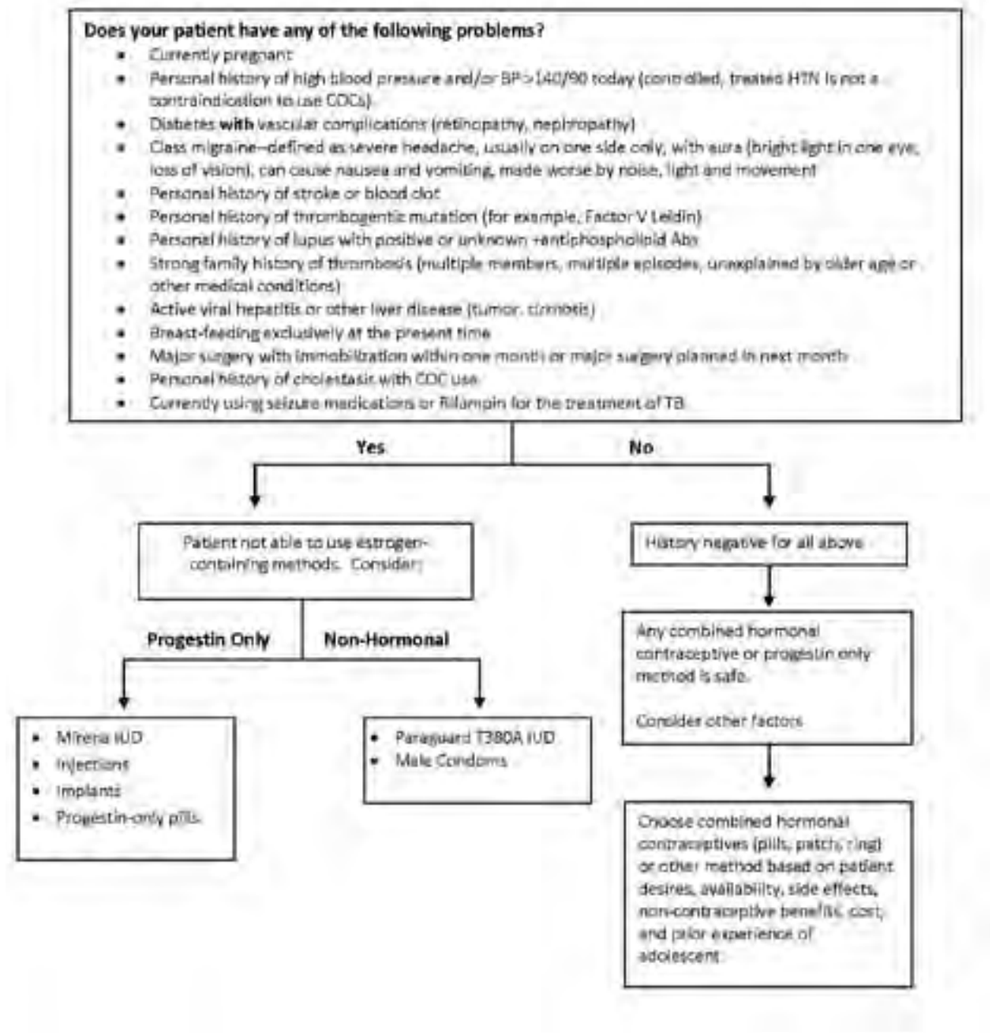
**2. EVALUATION**

When assisting an adolescent in the selection of a contraceptive method, health history, efficacy, safety, cost, non-contraceptive benefits, and personal needs and priorities should all be considered.

Health History: To determine if a patient is eligible for hormonal contraception, follow this algorithm:

[10] Hatcher, R., Trussell, J., Nelson, A., et al., *Contraceptive Technology* 19th Revised Edition (Ardent Media Inc, 2007).

[11] Hatcher, et al., *Contraceptive Technology*, Chapter 3, 19-20.




**(Adapted from *Contraceptive Technology*, 231)**

Efficacy: Some methods that are not highly effective are not recommended for adolescents (diaphragm, withdrawal, Fertility Awareness Method). Providers should discuss the difference between perfect and typical use when discussing efficacy and speak in terms of effectiveness rather than failure rates.

Safety: Because there are many misconceptions about the relative safety of contraception, providers should clear up any misconceptions while informing patients about risks. All patients should be taught to recognize danger signals.

Cost: Providers should explore cost when discussing methods with clients, especially for those patients who do not have insurance or are unable to bill insurance for confidentiality reasons.

Non-contraceptive benefits: Determining whether there are any non-contraceptive benefits that the patient is interested in will help inform the decision.

Personal needs: Explore whether the patient has other needs, such as confidentiality or partner refusal to use contraception.

Providers will explore the patient's prior experiences with family planning, what they have heard about family planning methods, their need for protection from STIs, partner attitudes, and other specific needs or concerns.

When discussing partner attitudes, the provider will address the importance of open communication between partners and if appropriate guide the patient through a role play that addresses developing the skills necessary to negotiate the use of contraception.

Upon determining what is important to the patient, providers will review all available methods, including how they work, efficacy, advantages and disadvantages, and how each relates to the patient's specific needs and priorities.

All patients have the opportunity to receive a handout with facts about each contraceptive method.

Upon selecting a method, providers will also determine the patient's motivation to use the method and use client-centered counseling to help devise a plan that will build on existing motivation.

In addition to pregnancy prevention, the provider will emphasize that hormonal contraception does not protect against STIs and will urge consistent and correct condom use in addition to hormonal methods.

Whatever the method chosen, the provider will give information and an advance prescription for emergency contraception.

Once a method has been chosen, proceed to the appropriate method specific protocol. Brochures included in this toolkit will be used to guide the patient and the provider through the method details.

**CONTRAINDICATIONS:**

Contraindications for oral contraceptives, patch, and ring:

- Classic migraine headaches (usually on one side with a preceding AURA, made worse with light, noise, and movement)
- High blood pressure (above 140/90 at visit)
- Diabetes **with** vascular complications (heart, vision, neuropathy, kidney disease)
- Gallbladder disease
- Liver disease (cirrhosis, infection, tumor, jaundice)
- Current use of seizure medications (barbiturates, carbamazepine, primodone, topiramate)
- Current use of rifampin (anti-TB medicine)
- Personal history of stroke, blood clot, or known thrombophilia (e.g., Factor V Leidin)
- Close family member(s) with stroke or blood clots at a young age

Contraindications for Depo/Implanon

- Hepatic tumor or liver disease

Contraindications for IUD

- PID (current or within the last three months)
- Current chlamydia or gonorrhea
- Allergy to any component of the IUD
- Wilson's disease (for Copper IUD)

## PROTOCOL FOR COMBINED ORAL CONTRACEPTIVE PILLS

### 1. OVERVIEW

Combined Oral Contraceptive (COC) pills are one of the most widely used form of contraception in the world. They are safe for healthy adolescents. There are several new ways to use COCs that should be encouraged, including Quick Start and extended-cycle use.

### 2. PATIENT SELECTION

Providers should rule out pregnancy and any contraindications as described in *Contraceptive Technology* prior to prescribing or dispensing COCs.

Providers will explore the patient's medical history and reproductive health history and her family history to ensure that she has no conditions that would preclude her using birth control pills.

The patient's blood pressure will be measured.

A pelvic exam is NOT necessary to initiate COCs in asymptomatic women, nor is a pap smear. If the patient needs to be screened for STIs, urine-based screening is preferred.

The patient's ability to use the COCs correctly and consistently should be evaluated. If she will have difficulty with daily pill administration, other options, such as the vaginal ring or transdermal patch, should be considered.

Cigarette/tobacco use will be assessed, but is not a contraindication to COC use.

### 3. EDUCATION

When providing education about COCs with adolescent patients, providers will include the following and use the COC brochure as a guide during the visit:

- Explanation of how COCs work: inhibiting ovulation, thickening cervical mucus to prevent sperm from reaching an egg, and inhibiting capacitation of sperm. It may be useful to use a guide for reproductive anatomy to facilitate this discussion.
- Effectiveness of the method, including pregnancy prevention versus STI prevention. The provider should take time to instruct the patient how to correctly use a condom. (See Male Condom Protocol.)
- Possible patterns of use:
  - monthly cycling with three active weeks followed by seven placebo pills
  - shortened pill-free intervals from seven days to four days and
  - extended use, which is a brief manipulation of the cycle and prevents menstruation
- Route of administration: oral, taken daily, +/- 4 hours
- Advantages and Disadvantages

| **Advantages of COCPs** |
|---|
| Highly effective at preventing pregnancy |
| Immediate return to fertility |
| Non-contraceptive benefits<br>• Decreased dysmenorrhea<br>• Decreased menstrual blood loss<br>• May reduce menstrual-related PMS symptoms<br>• Decreased anemia<br>• Improved acne<br>• Reduction of ectopic pregnancies<br>• Endometrial and ovarian cancer risk reductions<br>• Decreased risk of benign breast conditions<br>• Reduced risk of PID |

| **Disadvantages of COCPs** |
|---|
| Requires daily adherence |
| Pills may be discovered by parents/partners |
| Estrogen related side effects and risks<br>• Breast tenderness<br>• Nausea<br>• Hypertension<br>• Emesis<br>• Rare but serious risks include blood clots, heart attack, and strokes |

### 4. INSTRUCTIONS FOR USE

The Quick Start method will be used as the standard method for initiating COCs with adolescent patients.

Patients will receive the following instructions both orally and in written form:

**a. Information on when to start the regimen.**

- For Quick Start, the patient should take the first pill the day she visits the SBHC or the day she fills the prescription.
- The patient should use a back-up method for seven days.
- Emergency contraception should also be prescribed if the patient had unprotected sex within the last 120 hours (five days).

**b. Establishment of a daily pill routine**

- One pill should be taken each day at the same time.
- Use a back-up method if you miss pills, were late starting a new pill pack, had severe vomiting or diarrhea.
- Use condoms every time you have intercourse if you suspect that you or your partner may be exposed to a sexually transmitted infection, if you are late taking your pill, or if you would like additional protection.
- Specific instructions based on pattern of use
  - If you are using pills to have monthly bleeding and have 21 pills in your pack: take 21 pills, take no pills for seven days after completing the pills and then start a new pack.
  - If you are using pills to have monthly bleeding and have a pack of pills with 28 pills, take all 28 pills and start a new pack the day after you finish a pack.
  - If you are using pills to avoid monthly bleeding and the pills you are using are packaged for long-term use, take one pill each day.
  - If you are using conventional 28-day packets, take one active pill each day and then discard the pack once you reach the placebo pills and start a new pack with active pills. The clinician will decide how many packs the patient can take in a row.
- Brainstorm ways to help remind the patient when she should start a new pack and when she should take her pills. This could include setting a daily cell phone alarm or writing something down in a student planner.

- Remind the patient that once she stops taking the pills she is at risk for becoming pregnant if she remains sexually active.

**5. MANAGEMENT**

a. **Side Effects**

All COC users should be counseled on the side effects that are possible, but are not necessarily to be expected. Being forthcoming about potential side effects has been shown to increase continuity of use.

Patients should be advised that side effects are usually transient and often only occur during the first few months.

If side effects do not improve, patients should be instructed to return to the clinic to re-evaluate their choice and potentially change methods, but not to stop using the method until they have consulted with a nurse. They should understand that they are not required to stay on any one method if it is not working for them, and that there are many options available.

b. **Missed Pills**

Providers will inform patients how to handle missed pills, which depends on how much estrogen is in the pills and how many pills were missed.

If the patient had unprotected intercourse in the past five days, she is eligible for emergency contraception. She should be instructed to take the EC, then start a new pack of pills the next day, and finish the pack. A back-up method should be used for seven days.

**6. FOLLOW-UP**

A follow-up appointment will be scheduled for three months after the first appointment to address any issues or concerns the patient has with the method.

If a patient does not return for the scheduled appointment, the SBHC will have a mechanism in place to contact the patient and reschedule.

## PROTOCOL FOR TRANSDERMAL CONTRACEPTIVE PATCH

**1. OVERVIEW**

The contraceptive patch is a highly effective method of birth control. It is a particularly appropriate method of contraception for adolescents because it does not require daily adherence and adolescents are more likely to use the method more consistently and correctly than pills.

**2. PATIENT SELECTION**

Providers will rule out pregnancy and any contraindications as described in *Contraceptive Technology* prior to prescribing or dispensing the contraceptive patch. Typically, patients who are eligible to use COCPs are eligible to use the patch.

Although adolescents are more likely to use the contraceptive patch correctly and consistently than pills, they are also more likely to experience placement site reactions and patch detachment and therefore need to be counseled about how to manage these situations.

Providers will explore the patient's medical history and reproductive health history and her family history to ensure she has no conditions that would preclude her from using the contraceptive patch.

Additional education will be given to patients weighing more than 198 pounds as limited evidence suggests that the contraceptive patch may not be as effective in users at or above this weight.

The patient's blood pressure will be measured.

A pelvic exam is NOT necessary to initiate the contraceptive patch in asymptomatic women, nor is a pap smear.

If the patient needs to be screened for STIs, urine-based screening is preferred.

Cigarette/tobacco use will be assessed, but is not a contraindication to patch use.

**3. EDUCATION**

When providing education about the contraceptive patch with adolescent patients, providers will include the following and use the contraceptive patch brochure as a guide during the visit:

- Explanation of what the patch is, including that it sticks to the skin and releases estrogen and progestin into the blood, with a sample available for the patient to see and touch.
- Explanation of how the patch works: inhibiting ovulation, thickening cervical mucus to prevent sperm from reaching an egg, and inhibiting capacitation of sperm. It may be useful to use a guide for reproductive anatomy to facilitate this discussion.
- Route of administration: New patch applied once a week for three weeks, followed by one week off
- Advantages and Disadvantages

| **Advantages of contraceptive patch** |
|---|
| Highly effective at preventing pregnancy<br>• Perfect use: 0.3% failure rate<br>• Typical use: 8% failure rate |
| No daily maintenance |
| Better compliance rates with adolescents than pills |
| Unclear if it has the same non-contraceptive benefits as COCs |

| **Disadvantages of contraceptive patch** |
|---|
| 60% more estradiol estrogen than COCs |
| Possibly less effective if patient weighs more than 198 pounds |
| Skin irritation or hyper- pigmentation at site |
| Higher detachment rates with teens (up to 35%) |
| More expensive that COCs |
| Privacy concerns |
| Estrogen-related side effects:<br>• Breast tenderness<br>• Nausea<br>• Hypertension<br>• Emesis<br>• Rare but serious risks include blood clots, heart attack, and stroke |

**4. INSTRUCTIONS FOR USE**

The Quick Start method will be used as the standard method for initiating the contraceptive patch with adolescent patients.

Patients will receive the following instructions both orally and in written form:

**a. Information on applying the patch**

- If the contraceptive patch is available at the SBHC, the provider will help the patient apply the first patch.
- The patient will receive information detailing that three patches come in one box and each one is intended for use for seven days during three consecutive weeks.
- The patient will receive an explanation about where to place the patch: buttocks, abdomen, upper torso (not the breast).
- The patient will receive information about the need for the patch to adhere completely and that it should be placed on clean, dry skin without lotion.
- The patient will be advised to use a back-up method for seven days after a Quick Start Initiation.

**b. Information on wearing and removing the patch**

- Using the calendar provided in the insertion pack-

age or on the brochure, the provider will explain to wear each patch for seven consecutive days for three weeks followed by a patch-free week. The cycle should be repeated after the patch-free week.

- The patient should be informed that each patch in a cycle should be removed prior to placing another patch and should be placed in different locations on the body to avoid irritation.
- Patches should be stored at room temperature.
- When removed, patches should be placed in the garbage, not flushed. If a sticky residue remains on the skin, it can be removed with lotions or body oils.

**5. MANAGEMENT**

**a. Side Effects**

Patients should be informed that skin reactions, such as a rash or irritation, at the application site are common, but usually transient. To avoid further irritation, emphasis should be placed on the importance of placing the patch in different locations on the body.

It is more common for patch users that COC users to experience breast discomfort. Patients should be informed that breast discomfort usually subsides within two cycles of use.

Nausea and headaches may also occur. Patients should be informed that these symptoms usually decrease with time and should be encouraged to continue use.

If a patient experiences side effects that are not manageable, she should be encouraged to return to the clinic for a re-evaluation and method switch.

**b. Detached patches**

If the patch detaches for less than 24 hours, the patient should be instructed to re-apply the patch and ensure that all edges adhere to the skin. If it does not adhere, she should be instructed to apply a different patch. No other adhesives should be used to re-apply the patch.

If the patch detaches for more than 24 hours, the patient should be instructed to replace the patch and leave it on for seven days, which will change her patch-change day. If the patient has had unprotected sex in the last 24 hours, she should be prescribed emergency contraception.

**6. FOLLOW-UP**

A follow-up appointment will be scheduled three months after the first appointment to address any issues or concerns the patient has with her method.

If a patient does not return for the scheduled appointment, the SBHC will have a mechanism in place to contact the patient and reschedule.

## PROTOCOL FOR THE VAGINAL CONTRACEPTIVE RING

**1. OVERVIEW**

The vaginal contraceptive ring is a small, flexible ring, about two inches wide, that contains two active hormonal components. Because the vaginal contraceptive ring does not require daily adherence, it is particularly acceptable for use in adolescents. However, no studies have been conducted to determine acceptability of the method in younger women.

**2. PATIENT SELECTION**

Providers should rule out pregnancy and any contraindications as described in *Contraceptive Technology* prior to prescribing or dispensing the contraceptive ring.

Providers will explore the patient's medical history and reproductive health history and her family history to ensure that she has no conditions that would preclude her using the contraceptive ring.

The patient's blood pressure will be measured.

A pelvic exam is NOT necessary to initiate the vaginal ring in asymptomatic women, nor is a pap smear. If the patient needs to be screened for STIs, urine-based screening is preferred.

Since acceptability of the contraceptive ring in the adolescent population is unknown, providers should explore the patient's comfort touching their own genitalia prior to prescribing the method.

Cigarette/tobacco use will be assessed, but it is not a contraindication to vaginal ring use.

**3. EDUCATION**

When providing education about the contraceptive ring to adolescent patients, providers will include the following and use the vaginal ring brochure as a guide during the visit:

- Explanation of what the ring is with a sample ring available for the adolescent to see and touch.
- Explanation of how the vaginal ring works: inhibiting ovulation, thickening cervical mucus to prevent sperm from reaching an egg, and inhibiting capacitation of sperm. It may be helpful to use a guide for reproductive anatomy to facilitate this discussion.
- Clarification that the vaginal muscles keep the ring in place and it should not fall out nor does it require special placement.
- Route of administration: vaginal, remains in place for three weeks of continuous use followed by a ring-free week
- Advantages and Disadvantages

| **Advantages of the vaginal ring** |
|---|
| Highly effective at preventing pregnancy<br>• Perfect use: 0.3% failure rate<br>• Typical use: 8% failure rate |
| Low dose of hormones with fewer side effects |
| Less maintenance required |
| Private; may be noticed only by partner |
| May prevent bacterial vaginosis |
| Unclear if it has the same non-contraceptive benefits as COCs |
| Low incidence of expulsion |
| Increased wetness and discharge, which may help lubrication |

| **Disadvantages of the vaginal ring** |
|---|
| Requires comfort with self-insertion and removal |
| Possible vaginal discomfort |
| Patient and partner may feel the ring<br>• 15% of women and 29% of their male partners reported feeling the ring during intercourse<br>• Only 6% of males partners minded |
| Estrogen-related side effects:<br>• Breast tenderness<br>• Nausea<br>• Hypertension<br>• Emesis<br>• Rare but serious risks include blood clots, heart attack, and stroke |

**4. INSTRUCTIONS FOR USE**

The Quick Start method will be used as the standard method for initiating the vaginal ring with adolescent patients.

Patients will receive the following instructions both orally and in written form:

**a. Information on inserting the ring**

If the ring is available on-site, the provider will show the patient how to insert the ring and then allow her to

practice inserting and removing the ring.

The patient will receive information on how to insert the ring, including that she should not feel any discomfort once the ring is in place. If she does, she should be advised to slide it in a bit further.

**b. Information on use and removal of the contraceptive ring**

The patient should be advised that once the ring is inserted, it should be left in the vagina for three weeks. At the end of the three weeks, she should remove the ring and not use a ring for one week. After the ring-free week, she should start the process over with a new ring.

The patient should be advised that it is not necessary to remove the ring during intercourse.

Some providers have instructed their patients to replace the ring on the same day of each month to improve adherence.[12]

After three weeks of using the ring, the patient should insert her index finger into her vagina, hook it onto the ring and slide the ring out. It should be discarded in the foil wrapper it was packaged in.

Patients using the ring should be advised to use a backup method for seven days after initiating use of the ring because it is not immediately effective.

**5. MANAGEMENT**

**a. Side Effects**

Some patients will experience headache and vaginal symptoms. Vaginal symptoms are associated with greater discontinuation rates. Patients should be informed of the possibility of side effects and encouraged to contact the clinic with questions or concerns.

**b. Expelled Ring**

If a ring is expelled (e.g., during intercourse, a bowel movement, etc.) and has been out for less than three hours, the patient should be instructed to rinse the ring in lukewarm water and replace it. There is no need for a backup method.

If the ring is expelled and remains out for longer than three hours, during week one or two, the patient can rinse the ring in lukewarm water and replace it but must be instructed to use a backup method for seven days. If the patient has had unprotected intercourse in the past 120 hours, emergency contraception should also be prescribed.

If the ring is expelled during the third week and remains out for longer than three hours, the patient may:

1. Leave the ring out for seven days and experience a break-through bleed and then restart with a new ring (this is only an option if the ring had been used consistently during the previous seven days) or

2. Insert a new ring and leave it in for the duration of three weeks.

In both cases, the patient should be advised to use a back up method for seven days.

**6. FOLLOW-UP**

A follow-up appointment will be scheduled for three months after the first appointment to address any issues or concerns the patient has with her method.

If a patient does not return for the scheduled appointment, the SBHC will have a mechanism in place to contact the patient and reschedule.

[12] Physicians for Reproductive Choice and Health's Adolescent Reproductive Health Education Project, "The Essentials of Contraception and Adolescents PowerPoint," (2007), http://www.prch.org/arhepdownloads.



## PROTOCOL FOR PROGESTIN-ONLY PILLS

**1. OVERVIEW**

Progestin-only pills (POPs) are safe for almost all women and often appropriate for women with contraindications to combined oral contraceptive pills. Although slightly less effective than COCPs, POPs are highly effective when used consistently.

**2. PATIENT SELECTION**

Providers should rule out pregnancy and any contraindications as described in *Contraceptive Technology* prior to prescribing or dispensing POPs.

Providers will explore the patient's medical history and reproductive health history and her family history to ensure that she has no conditions that would preclude her using POPs.

Neither a pelvic exam nor blood pressure check is necessary for a woman to start using POPs. If the patient needs to be screened for STIs, urine-based screening is preferred.

**3. EDUCATION**

When providing education about POPs with adolescent patients, providers will include the following and use the POP brochure as a guide during the visit:

- Explanation of how POPs work: inhibiting ovulation, thickening cervical mucus to prevent sperm from reaching an egg, and endometrial changes. It may be helpful to use a guide for reproductive anatomy to facilitate this discussion.
- Explanation that POPs contain progestin only.
- Discussion about acceptability of dramatic menstrual changes.
- Route of administration: oral, taken daily, punctual adherence necessary for efficacy.
- Advantages and Disadvantages

| **Advantages of POPs** |
|---|
| Effective at preventing pregnancy when used regularly:<br>• Perfect use: 1% failure rate<br>• Typical use: 13% failure rate |
| Not confusing; users take the same type of pill every day with no pill-free week |
| Can be taken while breastfeeding |
| No estrogen or estrogen-related complications |
| Non-contraceptive benefits include:<br>• Light menses or no menses<br>• Less anemia<br>• Decrease in cyclic cramps, pain, mood changes, and headaches<br>• Decreased risk of endometrial cancer, ovarian cancer, and PID<br>• Low risk of ectopic pregnancy |

| **Disadvantages of POPs** |
|---|
| Efficacy dependent on regular use (+/- 3 hours). Not as effective as COCPs. |
| Certain medications decrease efficacy |
| Can be less available |
| Irregular bleeding and amenorrhea are common |

**4. INSTRUCTIONS FOR USE**

The Quick Start method will be used as the standard method for initiating POPs with adolescent patients.

Patients will receive the following instructions both orally and in written form:

a. Information about when to start the regimen

For Quick Start, the patient should take the first pill the day she visits the SBHC or picks up her prescription.

The patient should be advised to use a back-up method, such as male condoms, for one week after initiating POPs.

The provider should help the patient establish a set time each day to take the pill. If the client has a cell phone, it may help to encourage her to set a daily alarm to remind her to take her pills.

Emergency contraception may also be indicated if the patient has had unprotected intercourse in the past 120 hours.

Patients using POPs should also be given a prescription for emergency contraception in case of a future lapse in use of POPs.

**b. Establishment of a daily pill routine**

The patient should be instructed to take one pill every day at the same time each day. Emphasis should be placed on the importance of taking a pill at the same time each day to increase efficacy.

The patient should also be informed that there is no placebo week or pill free week with POPs; she should immediately start a new pack once she finishes the previous pack.

**5. MANAGEMENT**

**a. Side Effects**

The most common side effect and reason for discontinuing this method is irregular bleeding. Patients who are counseled thoroughly about potential side effects prior to the initiation of the method tend to have better continuation rates.

The patient should be instructed to return to the clinic prior to stopping use of the POPs for re-evaluation and possible method switch if side effects do not improve.

**b. Missed Pills**

Because POPs are slightly less efficacious than COCPs, it is essential that the patient take the pills at the same time each day.

If a patient misses taking a pill within a three hour period, she should be instructed to take the missed pill immediately and use a back-up method or abstain from sex for 48 hours.

If a patient misses two pills in a row, she should immediately begin using a back-up method and take two pills for two days.

If the patient has already had unprotected intercourse, she should be prescribed emergency contraception.

**c. Missed Periods**

If the patient's menstrual period is late, and she has not taken all of their pills on time and has had sex without a backup method or condom, she should be instructed to get a pregnancy test.

If the patient misses two periods in a row, even if she has taken all of her pills on time, she should be instructed to get a pregnancy test.

Patients who suspect pregnancy should continue using POPs until they get a pregnancy test.

**6. FOLLOW-UP**

A follow-up appointment will be scheduled for three months after the first appointment to address any issues or concerns the patient has with the method.

If a patient does not return for the scheduled appointment, the SBHC will have a mechanism in place to contact the patient and reschedule.



## PROTOCOL FOR DEPO PROVERA

**1. OVERVIEW**

The injectable contraception depo provera is highly effective, private, and can be an important contraceptive option for women who cannot use methods containing estrogen.

**2. PATIENT SELECTION**

Providers will rule out pregnancy and any contraindications as described in *Contraceptive Technology* prior to prescribing or administering Depo Provera.

Providers will explore the patient's medical history and reproductive health history and family history to ensure that she has no conditions that would preclude her using Depo Provera.

Adolescents who have trouble with daily adherence to a method or estrogen-related problems may be ideal candidates for Depo Provera.

The patient's blood pressure and weight should be measured prior to initiating Depo Provera.

A pelvic exam is not necessary in asymptomatic women, nor is a pap smear. If a patient needs to be screened for STIs, urine-based screening is preferred.

Pregnancy testing prior to initiation is recommended. Patients should also return to the SBHC three to four weeks post-injection for a follow-up pregnancy test to confirm that an early pregnancy was not missed at initiation.

**3. EDUCATION**

When providing education about Depo Provera with adolescent patients, providers will include the following and use the Depo brochure as a guide during the visit.

- Explanation that Depo is an injection containing the hormone progestin.
- Explanation of how Depo works: inhibiting ovulation, thickening cervical mucus to prevent sperm from reaching an egg, and endometrial changes. It may be helpful to use a guide for reproductive anatomy to facilitate this discussion.
- Discussion about acceptability of dramatic menstrual changes.
- Route of administration: injection, every three months
- Address common concerns: weight gain and bone loss
  - Average weight gain: 5.4 pounds first year, 8.1 pounds second year, 13.8 pounds after four years of use.
  - Recovery of bone loss occurs within twelve months of stopping Depo; duration of Depo use does not impact speed of recovery.
- Counsel regarding the importance of exercising regularly and avoiding alcohol, tobacco, and other drugs.
- Counsel regarding the importance of dual-use methods. Several studies have shown an association between Depo Provera use and chlamydia acquisition.[13] All patients at risk for STIs should be counseled to use condoms correctly and consistently.
- Advantages and Disadvantages

| **Advantages of Depo** |
|---|
| Highly effective at preventing pregnancy:<br>• Perfect use: 0.3% failure rate<br>• Typical use: 3.0% failure rate |
| High compliance rate in adolescents |
| Does not require daily adherence |
| Minimal drug interactions |
| Private |

[13] Hatcher, et al., *Contraceptive Technology*, 168.

| Progestin-related benefits: |
|---|
| • Light menses or no menses<br>• Less anemia<br>• Decrease in cyclic cramps, pain, mood changes, and headaches<br>• Decreased risk of endometrial cancer, ovarian cancer, and PID<br>• Low risk of ectopic pregnancy |

| **Disadvantages of Depo** |
|---|
| Menstrual irregularities:<br>• Irregular bleeding<br>• Amenorrhea |
| Weight gain |
| Method is irreversible for 3 months |
| Bone mineral loss with increased duration of use |
| Delay in fertility (up to 18 months) |
| Requires office visit every 3 months |

**4. INSTRUCTIONS FOR USE**

The Quick Start method will be used as the standard method for initiating depo with adolescent patients if the patient can be reasonably certain she is not pregnant.[14] If a patient chooses to use Depo and it is initiated through Quick Start, she should sign a consent form agreeing to return to the clinic in four weeks for a pregnancy test. While Depo exposure should be avoided in early pregnancy because it has been found to cause low-birth weight, exposure has not been found to increase risk for birth defects.[15]

Patients will receive the following instructions both orally and in written form:

**a. Frequency of regimen**

The patient should be informed that the Depo Provera injection is administered at 12 week intervals.

If the patient is receiving Depo five to seven days after her last normal period the patient should be instructed to use a backup method for seven days; otherwise, no backup method is necessary.

If a patient receives a Depo injection seven days or more into her menstrual cycle, she should return to the clinic in three to four weeks for a pregnancy test.

**5. MANAGEMENT**

**a. Side Effects**

Menstrual Changes: The possibility of menstrual changes should not be underemphasized. The patient should be thoroughly counseled and advised to return to the clinic if changes are problematic. See *Contraceptive Technology* for strategies to manage breakthrough bleeding.

Weight Gain: Weight gain is a common complaint with Depo users, but research has not shown significant weight increases in Depo users when compared to placebo groups. All Depo users should be encouraged to exercise regularly and eat a healthy diet. However, some women do experience excessive weight gain that cannot be controlled by diet and exercise alone. These women should consider alternative methods.

**b. Missed Injections**

If a patient is late for an injection and has not had unprotected intercourse, she should return to the clinic as soon as possible for her injection and use a backup method until she receives the injection and for one week following the injection.

If the patient has had unprotected intercourse, pregnancy should be ruled out, and the need for emergency contraception evaluated.

[14] World Health Organization, *The Info Project. Family Planning: A Global Handbook for Providers* (World Health Organization, 2008), http://info.k4health.org/globalhandbook/.
[15] Hatcher, et al., *Contraceptive Technology*, 169.



**6. FOLLOW-UP**

The manufacturer suggests a re-injection at 11 to 13 weeks after initial injection. Patients using Depo should be advised to contact the clinic with any questions or concerns; an appointment should be scheduled at 11 to 13 weeks out for the next injection.

If a patient misses the follow-up/re-injection appointment, the SBHC will have a mechanism in place to follow-up with the patient.

## PROTOCOL FOR INTRAUTERINE DEVICES

**1. OVERVIEW**

The World Health Organizations' criteria do not contraindicate IUD use during adolescence. Although the majority of SBHCs do not insert IUDs, the SBHC will have a referral process in place for students opting to use the IUD. Although additional research is needed, current findings show high continuation rates and better compliance with longer acting methods than with daily methods among adolescents.[16]

**2. PATIENT SELECTION**

Although a relative contraindication of the IUD is nulliparity or nulligravity, the WHO classifies the use of IUDs by nulliparous or nulligravida women as a class 2 contraindication, meaning the benefits generally outweigh the risks for use.

**3. EDUCATION**

When discussing the IUD as a contraceptive option for adolescents, the following education will be provided using the IUD brochure to guide the visit:

- Explanation of what an IUD is: small T-shaped device, with a sample IUD available for the adolescent to see and touch.
- Explanation of how the IUD works:
  - TCu 380-Copper IUD: copper ions impair sperm function
  - LNG-IUS-Mirena IUD: thickens cervical mucus, suppresses the endometrium and may suppress ovulation.
- Explanation that the IUD is a long-acting form of birth control that can be reversed when removed.
- Discussion about STD prevention and condom education.

**4. INSTRUCTIONS FOR USE**

Because the SBHC is not likely to insert IUDs, the provider will address all questions and concerns and ensure an appropriate referral.

Providers will also check for strings and manage any side effects as they present after insertion.

**5. MANAGEMENT**

**a. Side Effects**

Patients should be counseled on the possibility of abnormal bleeding and the possibility and signs of expulsion.

**b. Sexually Transmitted Infections**

If the patient is diagnosed with chlamydia or gonorrhea while using the IUD, **no** evidence suggests that the IUD should be removed.

Counseling and treatment should take place as outlined in the STI protocol.

**6. FOLLOW-UP**

Once a referral has been made, a follow-up appointment should be scheduled within a month of the referral to assess outcomes and answer questions.

If the patient did not follow-through on the referral, barriers will be assessed, and if necessary another form of

[16] Grimes, D.A. "Forgettable Contraception" *Contraception* 80, no. 6, (December, 2009): 497-499.

birth control will be considered, at least until the patient is able to complete the referral.

## PROTOCOL FOR MALE CONDOMS

**1. OVERVIEW**

The majority of adolescents use condoms as birth control during their first intercourse. Additionally, condoms are widely used and accepted in the adolescent population because they are inexpensive, easy to use, and do not require a prescription.

**2. PATIENT SELECTION**

Condoms will be available to any student enrolled in the SBHC. If condoms are not available, a detailed list of places patients can receive free condoms will be available and provided to requesting patients.

**3. EDUCATION**

When providing education to adolescents about condoms, providers will include the following and use the condom brochure to guide the visit:

- Questions about *what* the patient knows about how to use a condom, *not if* they know how to use a condom.
- Explanation that correct and consistent condom use can significantly reduce the transmission of STIs.
  - Condoms reduce the risk of gonorrhea, chlamydia, and trichomoniasis infection in both women and men.
  - Genital herpes, HPV, syphilis, and chancroid may be prevented when infected areas are covered.
- Explanation that condoms can also help prevent pregnancy and should be used in addition to hormonal contraception.
  - Correct use: 2% failure rate
  - Typical use: 15% failure rate
- Advantages and Disadvantages

| **Advantages of male condoms** |
|---|
| Protection from STIs |
| Easy accessibility from clinics or drugstores |
| Low cost |
| Encourages male participation |
| Prevention of sperm allergy |
| Portability |
| Minimal side effects |

| **Disadvantages of male condoms** |
|---|
| May decrease sensitivity during intercourse |
| May decrease spontaneity |
| May decrease ability to achieve an erection |
| Embarrassment obtaining or utilizing condoms |
| Less effective at preventing pregnancy than hormonal methods |

- Address common concerns:
  - Decreased sensitivity: ultra-thin and textured condoms or using lubricant can help partners who feel decreased sensitivity.
  - Spermicides: not recommended.
- Provide information about emergency contraception and if appropriate, an advance prescription for emergency contraception.

**4. INSTRUCTIONS FOR USE**

**a. Using condoms**

Use a new condom every time.

Put on the condom before any genital contact.

Unroll the condom to the base of an erect penis.

Hold the condom at the base of the penis when withdrawing and discard.

Use a brochure, video, or demonstration to show how to use a condom correctly.

Patients should be given the opportunity to practice.

**b. Negotiating Condom Use**

Provider should use a client-centered approach when discussing condom negotiation with patients.

Providers should discuss scenarios in which patients may broach the subject and ask patients for their response. The provider will also help patients devise responses should the partner reject the request to use condoms.

**5. MANAGEMENT**

**a. Broken or Slipping Off Condoms**

Patients should be informed that breakage or slippage is rare, but should it occur, they should have additional condoms available for use.

Patients should also be informed that if breakage or slippage occurs, there may be a risk for pregnancy, and they should consider using emergency contraception.

**b. Latex Allergy**

If patients report a latex allergy, they should be instructed to use polyurethane condoms.

Patients should also be told to contact their healthcare provider if they experience an allergic reaction.

**c. Inconsistent Use**

Patients should be advised to use a condom with EVERY act of intercourse or they will not work properly. All factors that lead to non-use should be addressed with patients.

Patients should be advised to use a condom from the beginning to the end of each act of intercourse.

Patients should be instructed that water-based lubricants may help prevent condom breakage.

**6. FOLLOW-UP**

Providers will discuss the use of condoms at each subsequent visit and make patients aware that they can come to the clinic any time to ask questions or receive additional condoms. No appointment should be required to access additional condoms.

**SCHOOL-BASED HEALTH CENTER**

**POLICIES AND PROCEDURES**

**Title: Emergency Contraception (EC)**

**Date Issued: May 2010**

**PURPOSE:** To assure that students who meet the criteria for emergency contraception (EC) are offered this service and that staff comply with all requirements and best practices for providing emergency contraception.

**BACKGROUND:** Emergency contraception (EC) is an important pregnancy prevention option for patients who have unprotected sexual intercourse or who experience contraceptive failure. Emergency contraception is most effective when taken within 72 hours of unprotected intercourse, but current practice allows for its use up to 120 hours (five days) after unprotected intercourse. EC, however, is more effective the sooner it is used. When used, a patient reduces the chances of becoming pregnant by 75-89%.

The most common form of EC is Plan B, now available as a generic under the name Next Choice. Plan B is a progestin-only product packaged in the form of two pills that can be taken simultaneously. It works primarily by delaying ovulation. EC does not cause an abortion: it will not disrupt a fertilized egg that has already implanted in the uterus. EC has also been called the "morning-after pill." EC has NOTHING in common with RU-486 (mifepristone) which is used for medical abortions; however, EC is commonly and incorrectly confused with RU-486 in the media and some medical literature. Many other monophasic combined-estrogen-and-progestin pills are commonly used off-label as EC, but they may cause more side effects.

Current research demonstrates that providing EC in advance markedly increases its use, but does not have any effects on contraceptive use or sexual activity.[17] Additionally, it is safe, and when it is readily available, teens are twice as likely to use EC and initiate it sooner, making it more effective.[18] Best practices suggest that teens who have ever been sexually active, who are considering becoming sexually active, or who are currently sexually active should be provided EC in advance, or at least be given a one year prescription in advance. This is especially important for teens under the age of 17. It is also suggested that all teens, sexually active or not, receive information about EC. EC is over-the-counter for teens age 17 years and older. There is no medical or scientific justification for the over-17 OTC labeling: EC is safe for all women of reproductive age.

**POLICY:** All students who report having unprotected sexual intercourse will be screened to determine if they meet the criteria for emergency contraception (unprotected sex within the past 120 hours/five days). There are no medical contraindications to EC (except a positive pregnancy test). Students who meet the criteria will be offered this service either directly at the school for high school students or through referral to a back-up clinic. Parental/guardian involvement will always be explored and encouraged.

**PROCEDURE:** All students who meet the criteria for emergency contraception—unprotected sexual intercourse in the past 120 hours (five days)—will be provided with information about emergency contraception. All students who are sexually active should be routinely asked when they last had intercourse and if it was unprotected.

**A. On-Site Dispensing of Contraceptives**

See protocol for Emergency Hormonal Contraception attached.

**B. On-Site Prescription without On-Site Dispensing of Contraceptives**

See protocol for Emergency Hormonal Contraception attached and then proceed with the following.

1. Students receiving a prescription for emergency contraception should be informed that they can return to the clinic any time for any reason.

2. If the patient was Quick Started on a contraceptive method, the SBHC provider should review instructions for use with the patient and answer any questions. Refer to Quick Start protocol.

**C. Sites without On-Site Prescription or Dispensing of Contraceptives**

1. Students reporting unprotected sexual intercourse in the past 120 hours (five days) will be seen the same day.

2. Students will receive counseling at the school-based health center.

3. All students will receive brochures and detailed instructions for use of emergency contraception.

   The following forms will be used at the SBHC:

   - Emergency contraception brochures
   - Other contraceptive brochures

4. The back-up clinic should always try to make the emergency contraception visit an opportunity to start on a contraceptive method. Quick Start can be initiated at the same time or within 24 hours of the last Emergency Contraception dose. Students seen at the back-up clinic who use the Quick Start method should be given at least three months worth of supplies.

5. Students receiving referral for emergency contraception should be informed that they can return to the clinic any time for any reason.

6. Patients should be informed to return to the clinic in three weeks for a pregnancy test if they have not received their period.

**RELATED TOOLS:**

1. Emergency Contraception Options Chart

## EMERGENCY CONTRACEPTION PROTOCOL

### 1. OVERVIEW

Availability of emergency contraception to adolescents is considered a national standard of care and is part of standard care at the school-based health center. It is important for providers to counsel teenagers on EC because only 28% of teens know what EC is and at least 16% of teens will experience contraceptive failure during their first year of contraceptive use.[19] Research demonstrates that providing EC does not increase frequency of unprotected sex but increases the use of EC; and advance provision of EC contributes to earlier and thus more effective EC use.[20] Women under the age of 17 require a prescription for EC.

### 2. PATIENT SELECTION

Any student presenting to the clinic and disclosing an episode of unprotected vaginal intercourse within the last 120 hours (five days) will be provided emergency contraception. If the student has had other acts of unprotected intercourse during current cycle, EC is still indicated.

During routine yearly exams, providers will give information on emergency contraception regardless of the contraceptive method the client is using. Consideration should be given to providing the patient with a package of emergency contraception to take home or writing or calling in an advance prescription.

No pelvic examination or pregnancy test is required for EC use. (This recommendation is supported by women's health experts, including ACOG, and is also supported by FDA labeling). A pregnancy test is only suggested if:

- Other episodes of unprotected sex occurred during that menstrual cycle

[17] Kirby, D., *Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases* (Washington, DC: National Campaign to Prevent Teen and Unplanned Pregnancy, 2007), 148.

[18] Gold, M.A., "The effects of advance provision of emergency contraception on adolescent women's sexual health and contraceptive behaviors," *Journal of Pediatric Adolescent Gynecology* 17, no. 2 (April 2004):87-96.

[19] Physicians for Reproductive Choice and Health's Adolescent Reproductive Health Education Project, "Emergency Contraception (EC) and Adolescents" (PowerPoint), (2007), http://www.prch.org/arhepdownloads.

[20] Kirby, *Emerging Answers 2007*.

- Last menstrual period was not normal in duration, timing, or flow
- The student requests a pregnancy test

**3. INDICATIONS AND CONTRAINDICATIONS**

**a. Indications**

- Incorrect, inconsistent, or no contraceptive use
- Method failure such as:
  - Condom breaks or slips off
  - Missed two or more active OCPs
  - DMPA shot more than 14 weeks ago
  - Patch off for more than 24 hours during patch-on weeks
  - More than two days late changing patch
  - Late putting patch on after patch-free week
  - Same ring left in more than five weeks in a row
  - Late putting new ring in week following free week
  - IUD expelling/expelled

**b. Absolute Contraindication**

The only absolute contraindication to emergency contraception is established pregnancy (positive pregnancy test). There are no medical conditions (except for current pregnancy) that prevent use. Cigarette smoking, obesity, high blood pressure, diabetes, or any other condition are **not** contraindications to EC use.

**4. EDUCATION**

Students will be counseled that emergency contraception should be used as an emergency measure and is not recommended as a regular method of birth control. This is not because of safety, but because it is not highly effective.

Counseling should be documented regarding regular use of a birth control method.

When providing education about emergency contraception with adolescent patients, providers will include the following and use the emergency contraception brochure as a guide during the visit:

- Explanation of how EC works: delays ovulation
- Effectiveness of EC: best when used as soon as possible after unprotected intercourse
- Discuss condoms and assess for STI risk and offer testing; urine STI-testing is usually indicated
- Dispel myths about EC: EC does not disrupt a current pregnancy (cause an abortion) and does not cause birth defects in a fetus.

Providers will dispel any other myths, such as the common idea that emergency contraception will protect the patient from pregnancy in subsequent acts of unprotected intercourse.

**5. INSTRUCTIONS FOR USE**

If the clinic dispenses Plan B, the patient will take both tablets at the same time while at the clinic. If Plan B is not available, the provider will refer to *Contraceptive Technology* or the *Practitioner's Guide to Emergency Contraception*[21] for dosing information related to different brands.

Providers will assess the need for a consistent family planning method and will offer the patient the Quick Start option:

- Initiate combined hormonal contraception (pills, patch, or vaginal ring) now or the day after taking EC. The patient should be advised to use condoms for one week following the initiation of these methods.
- Administer Depo Provera now or within 24 hours of taking EC. The client must be counseled that since EC is not 100% effective, pregnancy cannot be ruled out prior to the injection. While there is no clear association of Depo with harmful fetal effects, the client should be informed that the manufacturer does not recommend administering Depo if pregnancy cannot be ruled out. Use condoms for one week following the administration of Depo. Patients using EC and Depo Quick Start should sign a consent stating they understand there is a small chance they may have an early pregnancy. For most women, the benefit of Quick Start and preventing an unintended pregnancy far exceeds the small chance of undetected pregnancy. Reassure that EC, OCs, and Depo will not disrupt an early pregnancy.
- Refer to the Quick Start and contraception protocols for patients wishing to start a method.

**6. MANAGEMENT**

**a. Side Effects**

Nausea and vomiting may occur in women who use emergency contraception, but there is no clear evidence whether it is necessary to repeat the dosing. Current practice for SBHCs in New York only calls for a repeat dose if the patient vomits within two hours of taking the EC. Nausea and vomiting occurs infrequently with progestin-only emergency contraception such as Plan B, and that is the main reason it is preferred to other EC regimens.

**7. FOLLOW-UP**

After dispensing emergency contraception:

- The provider will document patient instructions to return for follow-up visit in one month if she has no menstrual period or if she declined the Quick Start option and desires family planning services.
- If the patient has not had any bleeding one month after taking emergency contraception or has reason to suspect she may be pregnant, a urine pregnancy test should be done.

[21] Physicians for Reproductive Choice and Health, "Emergency Contraception: A Practitioner's Guide" (2010), http://prch.org/emergency-contraception-a-practitioners-guide.

**SCHOOL-BASED HEALTH CENTER**

**POLICIES AND PROCEDURES**

**Title: Sexually Transmitted Infections**

**Date Issued: May 2010**

**PURPOSE:** To assure that student's meeting the criteria for sexually transmitted infection screening are offered this service and that staff comply with all requirements for STI screening, treatment, and reporting.

**BACKGROUND:** All sexually active people under the age of 25 are considered at high risk for sexually transmitted infections and should be screened annually according to the guidelines set forth in the following STI Protocol. In addition to treatment for the STI, a positive test or an STI-scare provides an opportunity to educate patients about STI and pregnancy prevention. For example, research shows that brief interventions by providers for young females who test positive for chlamydia may improve condom behaviors.[22] The intervention must include condom use demonstrations, opportunities to practice applying a condom, and a brief rehearsed scenario (role play) on negotiating condom use. Women who test positive for chlamydia are often at risk for unintended pregnancy and may be motivated to start an effective or back-up form of birth control (refer to separate protocols). For a structured scenario, please refer to the tools section.

**POLICY:** All students who report ever being sexually active will be screened annually for sexually transmitted infections or more frequently if they have new or multiple partners, have been sexually assaulted, or request additional testing. Testing for chlamydia and gonorrhea will be offered directly at the SBHC. Screening for trichomonas, syphilis, HIV, hepatitis, and herpes simplex virus will either be available at the SBHC or through a referral. The CDC's 2006 *STD Treatment Guidelines*[23] will be available for reference purposes.

[22] Kirby, *Emerging Answers 2007*.
[23] Centers for Disease Control and Prevention, "Sexually Transmitted Diseases Treatment Recommendations," *Morbidity and Mortality Weekly Report* 55 (August 2006).

**PROCEDURE:** See protocol for STIs. The Reproductive Health Progress Note should be used when performing STI exams or screening.

**RELATED TOOLS:**

1. State STI reporting form

2. Condom Negotiation Scenario

## SEXUALLY TRANSMITTED INFECTION SCREENING PROTOCOL

**1. OVERVIEW**

Providers will discuss STI prevention with each adolescent, including information about abstinence, monogamous relationships, partner selection, and correct and consistent condom use. Students who have ever been sexually active will be screened in accordance with current CDC recommendations.

**2. EDUCATION**

All education and counseling about STI prevention will integrate education regarding specific actions that can reduce the risk for STI/HIV transmission with general risk reduction messages that are relevant to the client and his/her particular risk behaviors. Providers will address STI myths as provided in the STI brochure.

Patients presenting with STI risks will also be assessed for contraceptive needs if appropriate.

**3. SCREENING GUIDELINES**

**A. Asymptomatic Patients**

1. Chlamydia

Sexually active adolescent females and males should be screened for chlamydia at least annually.

If diagnosed and treated, patients should be re-tested three months after treatment due to high rate of re-infection.[24]

2. Gonorrhea

Routine screening for gonorrhea is recommended for asymptomatic women at high risk for infection, including:

- Women under age 25
- Women with a history of an STI
- Women with new or multiple sex partners
- Women who use condoms inconsistently

Screening male patients under the age of 25 is also recommended and is done concurrently with most chlamydia tests.

3. Syphilis

Routine screening for syphilis is not recommended. Patients who display signs or symptoms of primary infection (ulcer or chancre at the infection site), secondary infection (manifestations that include, but are not limited to, skin rash, mucocutaneous lesions, and lymphadenopathy), or tertiary infection (cardiac or ophthalmic manifestations, auditory abnormalities, or gummatous lesions) should be screened and treated.

4. HIV

CDC recommends that physicians offer voluntary testing to all U.S. residents ages 13-64 as part of routine medical exams in private practices, clinics, hospitals and emergency departments. Guidelines require patients to sign informed-consent forms as well as receive HIV counseling before receiving an HIV test.

[24] Centers for Disease Control and Prevention, "Sexually Transmitted Diseases Treatment Recommendations," *Morbidity and Mortality Weekly Report* 55 (August 2006).

5. HPV

Pap smear testing is recommended at age 21. HPV testing, either alone or with pap screening, is not recommended for adolescents due to the high prevalence rates of HPV in this population. Genital warts caused by HPV are usually diagnosed clinically, and there is also no reason for HPV testing in this scenario. HPV vaccination can be strongly recommended and is best initiated before sexual debut.

6. Herpes Zoster

Current CDC guidelines do not recommend universal screening, but patients should be screened if they present with the following:

- Clinical diagnosis without lab confirmation
- Have a partner with genital HSV
- Have multiple sex partners
- Are MSM
- Are HIV-infected
- Request testing or as part of "comprehensive STI evaluation"

7. Trichomonas

Screening for trichomonas is not routinely recommended unless the patient presents with vaginitis (foul-smelling or green vaginal discharge, vaginal itching or redness), painful intercourse, abdominal discomfort, urge to urinate, and/or dysuria.

**B. Symptomatic Patients**

Treat all symptomatic or exposed patients prior to confirmation of diagnosis.

1. Infections commonly seen in adolescents

- Chlamydia
- Gonorrhea, with or without PID

- Non-STI vaginitis (candida, bacterial vaginitis)
- Trichomonas
- Herpes
- Genital warts (condyloma accuminatum)

2. History

The following information should be solicited and documented when a patient is symptomatic for STIs:

- Detailed history of chief complaint
- Past history of infections
- Information about partners, including number, frequency, and symptoms
- Previous evaluation and treatment of current problem
- Onset, duration, location, and severity of symptoms
- Non-genital symptoms, such as rashes, fever, flu-like symptoms
- Number of partners or timing of newest relationship

3. Evaluation

Evaluate all female patients who complain of pelvic pain, vaginal discharge, inter-menstrual bleeding, genital lumps or sores, or itching for sexually transmitted infections. This is also necessary when a patient states a partner has experienced symptoms or has been treated for an infection. Patients may be infected with multiple simultaneous infections, so do not stop evaluation upon findings of one infection.

4. Physical Examination and Wet Smears

Perform routine examination with emphasis on systems related to the chief complaint.

a. Skin

Examine the color, rashes, swelling, excoriations, ulcers, adenopathy, ectoparsites, and other lesions. This applies to genital and non-genital surfaces.

b. Inspection of vaginal discharge

This discharge can originate in the vagina due to vaginitis, in the cervix due to cervicitis or upper tract infection, or both. A wet smear taken from the vaginal pool will contain discharge from both the cervix and the vagina. This is adequate for the diagnosis of trichomonas, candida, and bacterial vaginosis. To diagnose mucopurulent cervicitis, secretions must be visualized and wiped from the cervix, and this is an indication for treatment.

c. Evaluation of the upper genital tract

- Check for uterine and cervical motion tenderness
- Check for adnexal tenderness or masses
- Check for abdominal tenderness and rebound
- Chart an oral temperature to see if elevated
- If any of these are present obtain a consultation (unless symptom is easily explained by another condition)

d. PID considerations

Per CDC recommendations, if a young woman at risk for STIs is experiencing pelvic or lower-abdominal pain for which no other cause can be identified and exhibits one or more of the following minimum criteria on pelvic exam, initiate empiric treatment of PID.

- Lower-abdominal tenderness, or
- Uterine/adnexal tenderness, or
- Cervical motion tenderness

Additional criteria that support the diagnosis:

- Oral temperature > 101° F
- Abnormal cervical or vaginal mucopurulent discharge
- Presence of WBCs on saline microscopy of vaginal secretions
- Elevated erythrocyte sedimentation rate (ESR)
- Elevated C-reactive protein (CRP)
- Lab documentation of cervical infection with Neisseria Gonorrhea or Chlamydia Trachomatis

e. Labs

- Collect urine specimen or cervical swab for chlamydia/gonorrhea testing
- Consider hepatitis panel and viral cultures
- Wet smears
- UTI
- The diagnosis of warts, molluscum, lice or scabies does not require laboratory testing.

**4. RESULTS**

**A. Asymptomatic patients**

1. Inform patients you will only contact them if their results are positive.

- If positive:
  - Treat according to CDC guidelines.
  - Provide education and counseling on symptoms, treatment, partner treatment, consequences, self protection, and prevention. Ensure confidentiality of diagnosis and treatment. It may be helpful to supply a brochure specific to the STI being diagnosed to help provide information to the patient.
  - Patients testing positive should be provided with an opportunity to practice condom negotiation skills and correct condom application.
  - If the infection is reportable, follow the reporting procedure below.
- If negative:
  - Re-screen annually or as otherwise indicated.

**B. Symptomatic or exposed patients**

1. Treat all symptomatic or exposed patients prior to confirmation of diagnosis.

- Treat according to the most recent CDC guidelines.
- Provide education and counseling on symptoms, treatment, partner treatment, consequences, self protection, and prevention. Ensure confidentiality of diagnosis and treatment. It may be helpful to supply a brochure specific to the STI being diagnosed to help provide information to the patient.
- Patients testing positive should be provided with an opportunity to practice condom negotiation skills and correct condom application.
- If the infection is reportable, follow the reporting procedure below.

**C. Reportable STI Procedure**

Chlamydia, gonorrhea, syphilis, and HIV are all reportable infections in the state of Colorado.

Positive results for chlamydia, gonorrhea, syphilis, and HIV will be reported to the Colorado Department of Public Health and Environment using the STI reporting sheet in the tools section. The primary clinician is usually responsible for ensuring that this form is completed.

**5. FOLLOW-UP**

- Symptomatic patients who are treated presumptively should be instructed to return to the clinic in one week to review results and arrange partner treatment. For positive chlamydia, a test of cure is recommended three months after initial diagnosis due to the high risk of re-infection. Refer to CDC Treatment Guidelines for specific instructions.

## 6. TREATMENT QUICK REFERENCE

Per the CDC's 2006 Treatment Guidelines Updated 06/2009

| Infection | Recommended Treatment | Notes |
|---|---|---|
| Chlamydia | Recommended regimen<br>• 1 gm of azithromycin PO x 1 or<br>• 100 mg doxycycline BID x 7 days<br>• When available, single dose treatment is preferred for adolescents. | Because of high re-infection rates, a test of cure is recommended at 3-4 months.<br>There is some concern over high rates of persistent infection after treatment with azithromycin. |
| Gonorrhea | Recommended regimen<br>• Ceftriaxone 125 mg IM x 1 or<br>• Cefixime 400 PO x 1 | The CDC no longer recommends fluoroquinolones for treatment of gonorrhea.<br>Because of the frequent co-infection of gonorrhea and chlamydia, patients who test positive for gonorrhea should also be treated for chlamydia unless NAAT negative. |
| PID | Recommended regimen<br>• Ceftriaxone 250 mg 1M X 1 AND<br>• Doxycycline 100 mg PO BID X 14 days | Patients should be re-evaluated within 48-72 hours. |
| Syphilis | Recommended regimen<br>Primary, Secondary, and Early Latent<br>• Benzathine Penicillin G- 2.4 million units x 1<br>Late Latent, Unknown Duration, and Tertiary<br>• Benzathine Penicillin G- 2.4 million units x 3<br>Congenital Syphilis<br>• Varies but typically IV for 10 days | Because of the high rate of co-infection, patients who test positive for syphilis should also be tested for HIV. |
| HPV<br>ASC-US<br>LSIL<br>CIN 1<br>HSIL<br>CIN 2,3 | For adolescents whose cytology results in ASC-US, LSIL, CIN 1, HSIL, or CIN 2,3, follow the treatment guidelines outlined in the American Society for Colposcopy and Cervical Pathology's Algorithms for Management of Adolescents with Cervical Cytological and Histological Abnormalities | Treatment guidelines outlined in tools section. |
| HSV | Recommended regimen<br>For first episode:<br>• Acyclovir 400 mg PO TID for 7–10 days, OR<br>• Acyclovir 200 mg PO 5x/day for 7–10 days, OR<br>• Famciclovir 250 mg PO TID for 7–10 days, OR<br>• Valacyclovir 1 g PO BID for 7–10 days.<br>• Suppressive therapy can be used to prevent occurrences and reduce transmission<br>For subsequent episodes:<br>• Antiviral drugs help control symptoms but do not eliminate the virus from the body<br>  • Acyclovir 400 mg PO TID for 7–10 days, OR<br>  • Acyclovir 200 mg PO 5x/day for 7–10 days, OR<br>  • Famciclovir 250 mg PO TID for 7–10 days, OR<br>  • Valacyclovir 1 g PO BID for 7–10 days. | Suppressive therapy can be used to prevent occurrences and reduce transmission |
| Trichomonas | Recommended regimen:<br>• Metronidazole 2 gm PO x 1<br>• Tinidazole 2gm PO x 1<br>Alternative treatment<br>• Metronidazole 500 mg PO BID x 7 days<br>Treatment failure<br>• Retreat with Metronidazole 500 mg PO BID x 7 days<br>• If repeat failure, treat w/ Tinidazole or Metronidazole 2gm PO QD x 3–5 d | |
| Bacterial Vaginosis | Recommended regimen<br>• Metronidazol 500 mg orally 2x/day for 7 days, OR<br>• Metronidazol gel 1 5g applicator intravaginally for 5 days | |

**7. PARTNER EXPEDITED THERAPY**

The CDC currently recommends expedited patient-delivered treatment for partners of patients with chlamydia infection and gonorrhea infection. Expedited partner treatment requires that the medical provider take the following steps:

For chlamydia:

- Ask patient if partner has any known allergies to medications
- Provide a 1g dose of zithromax for the patient to give to the partner(s)
- Provide a chlamydia factsheet for the patient to give to the partner(s)
- Document the discussion of the partner(s) and the provision of medication in the student/patient's medical record

If the partner(s) is (are) at the SBHC or if the patient opts to bring the partner (who is eligible to receive services at the SBHC) to the SBHC, take the following steps:

- Take a brief medical history including:
  - Allergies to medications
  - History of STIs
  - Number of partners within the last three months
  - STI symptoms
- Give basic STI/HIV education and offer testing
- Offer barrier protection
- Treat exposed partner per CDC guidelines
- Counsel on nature of infection, treatment, and prevention
- Physical exam is recommended, but not required if the partner is asymptomatic or presents as a known contact of a partner with a documented STI
- Complete appropriate forms for the partner

**8. DIRECT OBSERVATION**

Whenever possible, provide direct observation of the first dose of STI treatment.



## Contents: Service Provision Tools

This chapter contains the following tools. These tools may be useful as you adopt the service provision protocols.

**1. Reproductive Health Intake: Student Form English and Spanish**

*The reproductive health intake form allows students to provide information prior to meeting with a provider. It addresses all the necessary information for a detailed risk-assessment.*

**2. Reproductive Health Progress Note**

*The reproductive health progress note can be used for reproductive health visits. It guides providers through each of the best practices outlined in the protocols.*

**3. Follow-up/Interval Visit Progress Note**

*The follow-up/interval visit progress note is used for follow-up visits. It prompts providers to address the necessary components of a follow-up.*

**4. DECISION-Model Pregnancy Options Counseling**

*The DECISION Model guides providers through pregnancy options counseling for both negative and positive test results.*

**5. Emergency Contraception Options Chart**

*The emergency contraception options chart reviews the available types of emergency contraception as well as provides information about birth control that can be used as emergency contraception.*

**6. Sexually Transmitted Infections Reporting Form**

*The STI reporting form should be completed when a student tests positive for a reportable infection such as chlamydia, gonorrhea, HIV, or syphilis.*

**7. Sample Scenarios to Improve Condom Negotiation**

*To help build skills around condom negotiation, sample scenarios are provided. Simply reading through a scenario may increase condom use.*

This form is available as a PDF document on the CD included in the toolkit.



Student Name:_____ DOB:_____ Date:_____

## *Reproductive Health Intake: Student Form*

**Confidentiality Promise:** Many students worry that their personal information will not be kept confidential, or worry that others will know why they come to the student health clinic. We will be discussing personal things, and there are many personal questions on this form. We can promise you (based on **Colorado state law and your right to have confidential reproductive health services**) that no one will ever see this form except for you and your health provider. Your health provider will provide you with medical information to promote your health and achieve your health goals. Your answers below will not cause you to be judged or discriminated against in any way by your health provider. You can return to this clinic at any time for any reason.
*The only important exception: Your health provider is required by law to report to the authorities any threat to life (suicidal or homicidal plans) or if you are or have experienced sexual or physical abuse that has not been reported.*

**STUDENT INITIALS:_____**

Answer the following questions as well as you can. If you don't understand a question, or don't want to answer it, you can skip over that question(s).

*** What is the reason for your visit today?** (Check all that apply)
☐ Pregnancy test ☐ Birth Control (discuss, start, continue) ☐ Check for infection ☐ Other: _____

| ***Medical History Questions** | | Provider Notes |
|---|---|---|
| 1. Do you or have you had any of the following mental conditions? (Check all that apply) | ☐ Asthma ☐ Acne<br>☐ Depression ☐ Anxiety<br>☐ Diabetes ☐ Migraines<br>☐ High blood pressure<br>☐ Other | |
| 2. Are you currently taking any medicine(s)? | ☐ NO ☐ YES | |
| 3. Are you currently using any over the counter medicines, herbs, vitamins? | ☐ NO ☐ YES | |
| 4. Have you ever had surgery? | ☐ NO ☐ YES | |
| ***Lifestyle/Mood Questions** | | |
| 5. Who do you live with? | ☐ Both parents ☐ One parent<br>☐ Other family ☐ Other | |
| 6. What do you like to do when not in school? | | |
| 7. What is your favorite part of school? | | |
| 8. What don't you like about school? | | |
| 9. Do you feel safe at school? | ☐ YES ☐ NO | |
| 10. Do you play sports? | ☐ YES ☐ NO | |
| 11. Do you do any other exercise? | ☐ YES ☐ NO | |
| 12. What is causing you the most worry or stress right now? | | |
| 13. How do you feel most days? | | |
| 14. Do you have little interest or pleasure in doing things? | ☐ NO ☐ YES | |
| 15. Do you feel down, depressed or hopeless? | ☐ NO ☐ YES | |
| 16. Have you ever thought about hurting yourself? | ☐ NO ☐ YES | |
| 17. Have you ever smoked cigarettes/pipes or used smokeless tobacco (chew)? If yes, how often?<br>☐ everyday ☐ weekly ☐ monthly ☐ none in past year | ☐ NO ☐ YES | |
| 18. Have you ever used alcohol/beer/wine? If yes, how often?<br>☐ everyday ☐ weekly ☐ monthly ☐ none in past year | ☐ NO ☐ YES | |
| 19. Have you ever used other drugs? If yes, which kind(s)?<br>☐ marijuana/pot/weed ☐ cocaine ☐ crack ☐ meth<br>☐ ecstasy ☐ other: _____<br>How often? ☐ everyday ☐ weekly ☐ monthly ☐ none in past year | ☐ NO ☐ YES | |
| ***Reproductive Health Questions** | | |
| 20. When was your last period? | | |
| 21. How old were you when you started your period? | | |
| 22. Does your period usually come every month? | ☐ YES ☐ NO | |
| 23. Do you usually have (check all that apply): | ☐ Severe cramps<br>☐ Heavy bleeding<br>☐ Irregular or skipped periods<br>☐ PMS | |





| | |
|---|---|
| 24. Have you ever been told you have a sexually transmitted infection (STI or STD), such as chlamydia or gonorrhea? | ☐ NO ☐ YES |
| 25. Have you ever had a pelvic or internal exam before? | ☐ YES ☐ NO |
| 26. Have you ever been forced to have sex or forced to have other sexual contact? | ☐ NO ☐ YES |
| 27. What gender are you attracted to? | ☐ males ☐ females<br>☐ both males and females |
| 28. What gender do you identify as? | ☐ female ☐ male<br>☐ not sure, or don't feel like either |
| 29. Do you have a partner or partners now? (If no, skip to question 33)<br>If yes, how long have you been together? | ☐ YES ☐ NO |
| 30. Do you feel safe when you are with your partner? | ☐ YES ☐ NO |
| 31. Do you ever feel pressured by them to have sex? | ☐ NO ☐ YES |
| 32. Do you date/hook up/ see other people or just each other? | ☐ others ☐ just each other |
| 33. What kind of sexual contact have you had in the past? (If no sexual contact, skip to question 39)<br>Other sexual experience: _____ | ☐ kissing ☐ genital touching<br>☐ oral sex (given or received)<br>☐ anal sex (penis in rectum)<br>☐ vaginal sex (penis in vagina) |
| 34. What age did you have vaginal intercourse for the first time? | |
| 35. How many different partners have you had? | |
| 36. Have you had sexual contact with: | ☐ males ☐ females<br>☐ males and females |
| 37. Have you ever used a male condom? | ☐ YES ☐ NO |
| 38. Did you use a male condom the LAST time you had sex? | ☐ YES ☐ NO |
| 39. Have you ever used birth control before?<br>If yes, what kind? ☐ pills ☐ shot ☐ ring ☐ patch ☐ other | ☐ NO ☐ YES |
| 40. Did you have any concerns or problems using this method? | ☐ NO ☐ YES |
| 41. Are you interested in starting birth control today or receiving a prescription? | ☐ NO ☐ YES |
| 42. Is there a specific method of birth control that you might be interested in starting? If yes, what method? | ☐ NO ☐ YES |
| 43. Have you ever been pregnant before? | ☐ NO ☐ YES |
| 44. How do you feel about getting pregnant right now? | ☐ I am not worried about getting pregnant<br>☐ I absolutely can't get pregnant<br>☐ It's okay if I get pregnant<br>☐ I would like to be pregnant<br>☐ Other: _____ |
| 45. Do you have friends that have gotten pregnant? | ☐ NO ☐ YES |

| ***Questions about Future Plans** | |
|---|---|
| 46. When (if ever) do you want to have children? | |
| 47. How important is graduating from high school for you? | ☐ very important<br>☐ probably important<br>☐ not that important |
| 48. What are your plans after high school? | ☐ college ☐ not sure<br>☐ work ☐ other |
| 49. What are your plans ten years from now? | |

***Other Questions or Concerns?** ☐ NO ☐ YES

Provider notes: _____

_____

_____

_____

Provider signature: _____ Date: _____

This form is available as a PDF document on the CD included in the toolkit.



Nombre del estudiante: Fecha de nacimiento: Fecha:

## *Historial médico del estudiante*

**Promesa de confidencialidad.** Muchos estudiantes se preocupan de que su información no se mantenga confidencial, o bien, de que otras personas sepan por qué asisten a la clínica de salud para estudiantes. Abordaremos asuntos personales y además este formulario contiene muchas preguntas personales. Podemos prometerte (en base a la **ley del Estado de Colorado y a tu derecho a tener servicios confidenciales de salud reproductiva**) de que nadie más sabrá esta información excepto (y a) tu proveedor de atención médica. Tu proveedor de atención médica te proporcionará información precisa para fomentar tu salud y lograr tus objetivos de salud. Las respuestas a continuación no harán que tu proveedor de atención médica te juzgue o te discrimine de manera alguna. Puedes regresar a esta clínica en cualquier momento y por cualquier motivo.
*La única excepción importante: por ley es necesario que tu proveedor de atención médica informe a las autoridades sobre cualquier amenaza a la vida (planes de suicidio u homicidio) o si has experimentado abuso sexual o físico que no se han denunciado.*

INICIALES DEL ESTUDIANTE: _____

Responde a las siguientes preguntas de la mejor forma posible. Si no entiendes una pregunta o no deseas responderla, puedes omitirla(s).

* **¿Cuáles el motivo de tu visita de hoy?** (Marca todas las que correspondan)
☐ Prueba de embarazo ☐ Anticonceptivos (analizar, comenzar, continuar) ☐ Consulta por infección ☐ Otro: _____

| ***Preguntas acerca del historial médico** | | *Nuñu del proveedor* |
|---|---|---|
| 1. ¿Padeces o has padecido alguno de los siguientes problemas de salud? (Marca todos los que correspondan) | ☐ Asma ☐ Acné ☐ Depresión ☐ Ansiedad ☐ Diabetes ☐ Migrañas ☐ Hipertensión arterial ☐ Otro | |
| 2. ¿Estás tomando algún medicamento actualmente? | ☐ NO ☐ SÍ | |
| 3. ¿Estás usando algún tipo de medicamento sin receta, hierbas o vitaminas? | ☐ NO ☐ SÍ | |
| 4. ¿Has tenido alguna intervención quirúrgica? | ☐ NO ☐ SÍ | |
| ***Preguntas sobre estilo de vida/estado de ánimo** | | |
| 5. ¿Con quién vives? | ☐ Ambos padres ☐ Uno de los padres ☐ Otros familiares ☐ Otro | |
| 6. ¿Qué tales haciendo en estás en la escuela? | | |
| 7. ¿Cuál es tu parte favorita de la escuela? | | |
| 8. ¿Qué es lo que no te gusta de la escuela? | | |
| 9. ¿Te sientes segura en la escuela? | ☐ SÍ ☐ NO | |
| 10. ¿Practicas algún deporte? | ☐ SÍ ☐ NO | |
| 11. ¿Realizas algún otro tipo de ejercicio? | ☐ SÍ ☐ NO | |
| 12. ¿Cuál es lo que te causa mayor preocupación o tensión en este momento? | | |
| 13. ¿Cómo te sientes la mayoría de los días? | | |
| 14. ¿Tienes poco interés o gusto por hacer las cosas? | ☐ NO ☐ SÍ | |
| 15. ¿Sientes desmotivación, desánimo o resignación? | ☐ NO ☐ SÍ | |
| 16. ¿Has pensado en hacerte daño? | ☐ NO ☐ SÍ | |
| 17. ¿Has fumado cigarrillos/pipas o mariguana (sahum)? Si es así, ¿con qué frecuencia?<br>☐ todos los días ☐ semanalmente ☐ mensualmente<br>☐ nunca durante el último año | ☐ NO ☐ SÍ | |
| 18. ¿Has bebido alcohol/cerveza/vino? Si es así, ¿con qué frecuencia?<br>☐ todos los días ☐ semanalmente ☐ mensualmente<br>☐ nunca durante el último año | ☐ NO ☐ SÍ | |
| 19. ¿Has usado otras drogas? Si es así, ¿de qué tipo?<br>☐ marihuana/maría/hierba ☐ cocaína ☐ crack<br>☐ metanfetamina ☐ éxtasis<br>☐ otro: _____<br>¿Con qué frecuencia? ☐ todos los días ☐ semanalmente ☐ mensualmente ☐ nunca durante el último año | ☐ NO ☐ SÍ | |
| ***Preguntas sobre la salud reproductiva** | | |
| 20. ¿Cuándo fue tu último período? | | |
| 21. ¿Qué edad tenías cuando tuviste tu primer período? | | |
| 22. ¿Tienes el período generalmente todos los meses? | ☐ SÍ ☐ NO | |
| 23. Generalmente tienes (marca todos los que correspondan): | ☐ Calambres menstruales agudos<br>☐ Sangrado profuso<br>☐ Períodos irregulares (meses en los que no los | |



| | Tienes |
|---|---|
| | ☐ SPM |
| 24. ¿Te han dicho alguna vez que tienes una infección de transmisión sexual (ITS) o ETS (como clamidia o gonorrea)? | ☐ NO ☐ SÍ |
| 25. ¿Te has realizado un examen pélvico o interno anteriormente? | ☐ SÍ ☐ NO |
| 26. ¿Alguna vez te han obligado a tener relaciones sexuales u otro tipo de contacto sexual? | ☐ NO ☐ SÍ |
| 27. ¿Qué sexo/género te atrae? | ☐ masculino ☐ femenino ☐ masculino y femenino |
| 28. ¿Con qué género te identificas? | ☐ femenino ☐ masculino ☐ no estoy seguro o no deseo responder ☐ ninguno |
| 29. ¿Tienes una pareja o parejas en este momento? (si no tienes, pasa a la pregunta 33)<br>Si tienes, ¿cuánto tiempo llevan juntos? _____ | ☐ SÍ ☐ NO |
| 30. ¿Te sientes segura estando con tu pareja? | ☐ SÍ ☐ NO |
| 31. ¿Te sientes alguna vez presionada por tu pareja para tener relaciones sexuales? | ☐ NO ☐ SÍ |
| 32. ¿Salen/tienen sexo/van a otras personas, o sólo entre ustedes? | ☐ otras personas ☐ solo entre nosotros |
| 33. ¿Qué nivel de contacto sexual has tenido en el pasado? (si no has tenido contacto sexual, pasa a la pregunta 39)<br>Otra experiencia sexual: _____ | ☐ besos ☐ caricias genitales ☐ sexo oral (dado o recibido) ☐ sexo anal (el pene en el recto) ☐ sexo vaginal (el pene en la vagina) |
| 34. ¿A qué edad tuviste tu primera relación sexual vaginal por primera vez? _____ | |
| 35. ¿Cuántas parejas has tenido? _____ | |
| 36. Has tenido contacto sexual con: | ☐ hombres ☐ mujeres ☐ hombres y mujeres |
| 37. ¿Has usado alguna vez un condón masculino? | ☐ SÍ ☐ NO |
| 38. ¿Usaste un condón masculino la ÚLTIMA vez que tuviste relaciones sexuales? | ☐ SÍ ☐ NO |
| 39. ¿Has usado métodos anticonceptivos anteriormente?<br>Si es así, ¿de qué tipo? ☐ píldoras ☐ inyección ☐ anillo ☐ parche ☐ otro | ☐ NO ☐ SÍ |
| 40. ¿Tuviste alguna inquietud o problema al utilizar este método? | ☐ NO ☐ SÍ |
| 41. ¿Te interesa comenzar a utilizar un método anticonceptivo hoy o recibir una receta? | ☐ NO ☐ SÍ |
| 42. ¿Tiene un método anticonceptivo específico que te interesaría comenzar a utilizar? Si es así, ¿qué método? _____ | ☐ NO ☐ SÍ |
| 43. ¿Has estado embarazada antes? | ☐ NO ☐ SÍ |
| 44. ¿Qué piensas acerca de quedar embarazada en este momento? | ☐ No me preocupe quedar embarazada ☐ No puedo quedar embarazada por ningún motivo ☐ No es problema si quedo embarazada ☐ Me gustaría estar embarazada ☐ otro: _____ |
| 45. ¿Tienes amigas que han quedado embarazadas? | ☐ NO ☐ SÍ |

| ***Preguntas sobre planes futuros** | | |
|---|---|---|
| 46. ¿Cuándo (si acaso) deseas tener hijos? | | |
| 47. ¿Qué tan importante es graduarse de la secundaria para ti? | ☐ muy importante ☐ probablemente es importante ☐ no es tan importante | |
| 48. ¿Cuáles son tus planes después de la secundaria? | ☐ universidad ☐ no estoy seguro ☐ trabajo ☐ otro | |
| 49. ¿Cuáles son tus planes para diez años más? | | |

***¿Otras preguntas o inquietudes?** ☐ NO ☐ SÍ

Notas del proveedor:

Firma del proveedor: _____ Fecha: _____

## Reproductive Health Progress Note: Female

This form is available as a PDF document on the CD included in the toolkit.

**REPRODUCTIVE HEALTH PROGRESS NOTE- FEMALE** ☐NEW ☐PREVIOUS Page 1 of 2

**Reason for visit:** _____

Reviewed confidentiality: ☐YES ☐NO Allergies: ☐NKDA ☐ _____

LMP: _____ G___ P___ TAB___ SAB___ Menses are usually: ☐Regular ☐Irregular

Sexually active: ☐Currently ☐Previously ☐Never Condom use: ____% of the time

Current Contraception: _____ Previous Contraception: _____

Problems/Concerns: _____

# of Partners past 3 months: ____ Partners: ☐Male ☐Female ☐Both Sites: ☐Oral ☐Vaginal ☐Anal

Last intercourse: _____ ☐Protected ☐Unprotected ☐UPIC last 5 days-EC candidate

Review of birth control contraindications: ☐NO contraindications ☐Contraindications-see below ☐N/A

Review of Systems: ☐ROS NEGATIVE

| | | | |
|---|---|---|---|
| ☐Fever/chills | ☐Abnormal bleeding | ☐Pain with sex | ☐New lesions |
| ☐Nausea/vomiting/diarrhea | ☐Vaginal discharge | ☐Back pain | ☐Other: _____ |
| ☐General malaise/flu-like symptoms | ☐Vaginal odor | ☐Hematuria | _____ |
| ☐Abdominal or pelvic pain/cramping | ☐Itching/burning | ☐Dysuria | _____ |

**Social History** (Reviewed):
☐Home
☐Education/Employment
☐Activities
☐Drugs
☐Suicide/Depression
☐Sexuality
☐ _____

**Medical History** (Reviewed)
Concerns: _____
_____
_____
☐Previous STIs: _____

Comments: _____

**OBJECTIVE:**

Weight: ____ Height: ____ BMI: ____ BP: ____/____ Temp: ____ →If indicated: Pulse: ____ RR: ____

Urine pregnancy test result: ☐N/A ☐NEG ☐POS

Comments: _____

**LABS:**
☐Urine HCG done
☐Urine CT/GC sent
☐Other labs: _____

Pelvic Exam: ☐N/A or deferred ☐Indicated (see below)

| PELVIC EXAM: | NORMAL | ABNORMAL |
|---|---|---|
| Abdominal Exam: | ☐Soft, non-tender, non-distended, active bowel sounds; no masses | ☐ _____ |
| External genitalia: | ☐Normal appearing, no lesions | ☐ _____ |
| Speculum exam: Vagina | ☐Normal, pink, no lesions | ☐ _____ |
| Cervix | ☐Normal appearing, no lesions | ☐ _____ |
| Discharge noted as: | ☐Minimal/moderate, clear | ☐ _____ |
| Bimanual exam: | ☐Uterus normal sized, non-tender, no masses appreciated | ☐ _____ |
| | ☐Ovaries non-tender, no masses | ☐ _____ |
| | ☐Cervix non-tender | ☐ _____ |

Other: _____

☐Vaginal discharge assessed for vaginitis/STI ☐N/A

| | | | | | |
|---|---|---|---|---|---|
| Whiff test: | ☐Whiff positive | ☐Whiff negative | ☐pH < 4.5 | ☐pH > 4.5 | |
| Wet prep | ☐Normal epithelial cells | ☐Clue cells | ☐White blood cells >10/hpf | ☐Yeast/hyphae | ☐Trichomoniasis |

Comments: _____

**ASSESSMENT:**

| Pregnancy | EC | Birth Control | STI | Other |
|---|---|---|---|---|
| ☐HCG NEGATIVE: Not pregnant | ☐EC indicated now | ☐Birth control indicated now | ☐Routine screen/asymptomatic | ☐ _____ |
| ☐HCG POSITIVE: Pregnant | ☐EC not indicated or desired | Method: _____ | ☐History/exam consistent with STI infection | _____ |
| ☐HCG not indicated | | ☐Birth control not indicated or desired | ☐Known exposure | Behavioral Risk: _____ |
| | | | ☐Screening not indicated or desired | _____ |
| | | | | _____ |

Comments: _____

Student Name: _____ DOB: _____ Date: _____ V.2 3/10



Page 2 of 2

**PLAN:**

Patient education provided for:

| | | | |
|---|---|---|---|
| ☐Pregnancy test results: | ☐Counselling for Negative Test | ☐Counselling for Positive Test | |
| ☐Birth Control: | ☐Method Selection | ☐Instructions for use | |
| ☐Emergency contraception: | ☐General information | ☐Instructions for use | |
| ☐STIs: | ☐Safer sex practices/condom use | ☐Instructions for condom use | ☐Condom use skills |
| ☐Healthy Relationships/Partner Selection | | | |
| ☐Other: | | | |

**Emergency Contraception:** ☐EC N/A

☐Plan B or: _____ ☐Dispensed and observed; or ☐Prescribed and called into pharmacy: _____

☐Student given EC Brochure ☐Student advised to return to clinic if no period within 4 weeks of using EC

**Birth Control/Prevention:**

*PRESCRIBE OR DISPENSE* ☐No contraception dispensed, prescribed, or administered

| Oral Contraceptives | Vaginal Ring | Patch | |
|---|---|---|---|
| ☐Rx: _____ | ☐Rx: _____ | ☐Rx: _____ | ☐Depo administered: 150 mg IM x 1 Site: _____ Lot #: _____ |
| ☐Xulane: 1 pill po QD; disp #3 packs; refill: 4 | ☐Nuva Ring: put into vagina x 3 weeks, remove x 1 week; disp #3; refill: 4 | ☐Ortho Evra: apply new patch Q week x 3 weeks, 1 week off; disp #3 boxes; refill: 4 | ☐Next Depo due: _____ |

If Rx given:
☐Dispensed on-site; or ☐Called into pharmacy: _____

☐Quick Start) follow-up in 2 weeks and again in 3 months
☐Repeat pregnancy test in 2 weeks if indicated

☐Quick Start Depo today
☐Follow-up in 2 wks for HCG: UPIC in previous 2 wks
☐Follow-up in 1 month; if HCG not in elevated
☐Follow-up at next visit

☐Condoms dispensed

**STIs:** ☐N/A no testing done

☐Will contact student if positive result

**Treatment:**

| | | | |
|---|---|---|---|
| ☐Chlamydia | ☐Azithromycin 1 g, po x 1 | ☐Other: _____ | |
| ☐Gonorrhea | ☐Ceftriaxone 400 po x 1 | ☐Ceftriaxone 125 mg IM x 1 | ☐Other: _____ |
| ☐Other: _____ | ☐Rx: _____ | | |

If Rx given:
☐Dispensed on-site; or ☐Called into pharmacy: _____

☐EPT mailed/rated
☐PID suspected; follow-up or referral: _____

Comments: _____

**REFERRALS:** ☐No Referrals Made

To: _____ For: _____

**FOLLOW-UP:**

☐Follow-up scheduled and documented in tickler calendar
☐Can return any time for any reason

Notes: _____

Provider Signature: _____ Date: _____

Student Name: _____ DOB: _____ Date: _____ V.2 3/10

## Reproductive Health Progress Note: Male

This form is available as a PDF document on the CD included in the toolkit.

**REPRODUCTIVE HEALTH PROGRESS NOTE- MALE** ☐NEW ☐PREVIOUS Page 1 of 2

**Reason for visit:**

Reviewed confidentiality: ☐YES ☐NO Allergies: ☐NKDA ☐ _____

Sexually active: ☐Currently ☐Previously ☐Never Condom use: ____% of the time

Partner's Contraception: _____ Number of partners in past 3 months: _____

Partners: ☐Female ☐Male ☐Both Site: ☐Oral ☐Vaginal ☐Anal

Last intercourse: _____ ☐Protected ☐Unprotected

Review of Systems: ☐ ROS NEGATIVE

- ☐ Fever/chills
- ☐ Nausea/vomiting/diarrhea
- ☐ General malaise/flu like symptoms
- ☐ Abdominal or pelvic pain/cramping
- ☐ Dysuria
- ☐ Abnormal bleeding
- ☐ Penile discharge
- ☐ Penile odor
- ☐ Itching/burning
- ☐ New lesions
- ☐ Pain with sex
- ☐ Rectal pain
- ☐ Hematuria
- ☐ Other: _____

**Social HX** (Reviewed):

- ☐ Home
- ☐ Education/Employment
- ☐ Activities
- ☐ Drugs
- ☐ Suicide/depression
- ☐ Sexuality
- ☐ _____

☐ Medical History (Reviewed)

Concerns: _____

☐ Previous STIs: _____

Comments: _____

**OBJECTIVE:**

Weight: ____ Height: ____ BMI: ____ BP: ____ / ____ Temp: ____ →If indicated: Pulse: ____ RR: ____

Comments: _____

Exam: ☐ N/A or deferred ☐ Indicated (see below)

**LABS:**

☐ Urine CT/GC sent

☐ Other labs: _____

| EXAM | Normal | Abnormal |
|---|---|---|
| Abdomen | ☐ Soft, non-tender, non-distended, active bowel sounds, no masses | ☐ |
| Penis | ☐ Normal appearing, no lesions | ☐ |
| Urethra | ☐ No discharge, no lesions | ☐ |
| Scrotum/Testes | ☐ Normal appearing, non tender, no masses, no lesions | ☐ |
| Other | ☐ | ☐ |

Comments: _____

**ASSESSMENT:**

| STI | Other | Behavioral Risks |
|---|---|---|
| ☐ Routine screen/asymptomatic<br>☐ History/exam consistent with STI infection<br>☐ Known exposure<br>☐ Screening not desired or indicated | ☐ _____ | |

Comments: _____

**PLAN:**

Patient education provided for:

☐ STIs: ☐ Safer sex practices/condom use ☐ Instructions for condom use ☐ Condom use skills

☐ Emergency Contraception/Partner Birth Control

☐ Healthy Relationships/Partner Selection

☐ Other: _____

Student Name: _____ DOB: _____ Date: _____ V.2 3/10





**DISPENSE** ☐ No condoms dispensed

☐ Condoms dispensed

☐ Information given about where to access free condoms

Comments: _____

**STIs:** ☐ N/A no testing done

☐ Will contact student if positive result

**Treatment:**

☐ Chlamydia ☐ Azithromycin 1 g po x 1 ☐ Other: _____

☐ Gonorrhea ☐ Cefixime 400 po x 1 ☐ Ceftriaxone 125 mg IM x 1 ☐ Other: _____

☐ Other: _____ ☐ Rx: _____

If Rx given:

☐ Dispensed on-site or ☐ Called into pharmacy: _____

☐ EPT indicated: _____

Comments: _____

**REFERRALS:** ☐ No Referrals Made

To: _____ For: _____

**FOLLOW-UP:**

☐ Follow-up scheduled and documented in tickler calendar

☐ Can return any time for any reason

Notes: _____

Provider Signature: _____ Date: _____

Student Name: _____ DOB: _____ Date: _____ V.2 3/10

## Follow-Up Progress Note

This form is available as a PDF document on the CD included in the toolkit.

**PROGRESS NOTE: FOLLOW-UP/INTERVAL VISIT**

LE: Student following-up for:
☐ Repeat HCG ☐ contraception prescription or referral follow-up ☐ established birth control follow-up
☐ post positive pregnancy test evaluation ☐ STI treatment ☐ STI re-screen (3 months after positive CT)
☐ Other: _____

HPI: Student is a ____ year old G ____ P _____
Last Menses: _____ Current contraception: _____ Condom use: ____% of the time
Labs today:
Comments: _____

**BIRTH CONTROL EVALUATION:** ☐ n/a

☐ **Birth control initiation follow-up (prescriptions and referrals)** Date prescription or referral initiated: _____
Prescription filled/referral complete: ☐ YES (date: _____) ☐ NO

If yes:
Contraception initiated: ☐ YES ☐ NO _____
☐ Reviewed questions or concerns about method
☐ Student conveyed instructions for proper use
☐ Follow up scheduled at 1 and 3 months to evaluate satisfaction/established birth control f/u visit

If no:
Reason: _____
☐ Discussed barriers and ideas to overcome barriers
New plan: _____
☐ Follow-up scheduled in 2 weeks

☐ **Established birth control follow-up visit** Initiated: ☐ 1 month ago ☐ 3 months ago ☐ Other: _____
Currently using method: ☐ YES ☐ NO

If yes:
☐ Questions or problems reviewed
☐ Discussed management of side effects
☐ Discussed problems effectively using the method

If no:
Reason: _____
New plan: ☐ Discussed problems/concerns, will start method
☐ Method switch, new birth control prescription
☐ Other: _____

**STUDENT EDUCATION:**
Revisited and reviewed:
☐ Non-contraceptive benefits of birth control use
☐ The need to use method consistently, even if mild side effects
☐ Strategies to remember use (text message, cell phone alarm)
☐ What to do if method is forgotten, missed, etc.
☐ Discussed risk for STI testing
☐ Discussed EC and correct condom use
☐ Other: _____

**OBJECTIVE:** Vitals: Weight: ____ BP: ____/____ Temp. (if indicated): _____ Other: _____
Result of pregnancy test: ☐ NEG ☐ POS ☐ N/A
☐ Urine CT/GC sent

**ASSESSMENT/PLAN:**

**FOLLOW UP**
☐ Reminded student that she can return any time for any reason for additional questions, counseling or services
☐ Follow-up documented in follow-up tickler calendar
☐ Follow up in ____ weeks for _____
☐ No follow-up planned

Student Name: _____ DOB: _____

Provider Signature: _____ Date: _____ V8.8/10

## DECISION Model-Pregnancy Options Counseling

| | | |
|---|---|---|
| **D** | **Determine Reason for Visit**<br>-What can I help you with today?<br>-Why do you think you may be pregnant?<br>-When was your last period? | -Have you ever been pregnant before?<br>-What were the outcome(s)?<br>-Are you currently using contraception? |
| **E** | **Evaluate Feelings**<br>-What do want the result to be?<br>-Have you ever wanted to get pregnant?<br>-How do you feel about the sexual encounter that brought you here today? | -Do you have any friends who are pregnant or that have had a baby?<br>-How do you feel about their situation(s)? |
| **C** | **Confirm Pregnancy Test Results**<br>Give the results and remain silent allowing patient to initiate response.<br>**IF TEST IS NEGATIVE:**<br>-How do you feel about the result?<br>-If she is **relieved**: What are some of the ways that you can prevent pregnancy in the future?<br>-Contraception?<br>-Condom use?<br>-If she is **disappointed**: Refer for further counseling regarding parenting plans. | **IF TEST IS POSITIVE:**<br>-How do you feel about this result?<br>-What does a positive pregnancy test mean to you?<br>-Clarify facts regarding gestational timeline, trimesters, due date<br>-What do you think you want to do?<br>-What other information do you need to help you make your decision? |
| **I** | **Identify Personal Circumstances**<br>-Place pregnancy in perspective of her life<br>-What is the picture of the next year of your life? Five years?<br>-How does this pregnancy affect this? | -How do your personal beliefs affect your decision process?<br>-Validate fears and conflicting emotions. |
| **S** | **Support**<br>-Who in your life can help you in a supportive way?<br>-What is your relationship with the person that you are pregnant by? | -Do you have a current partner?<br>-How would s/he feel about you being pregnant?<br>-Discuss if and when to involve another adult. |
| **I** | **Immediate Concerns Are Addressed**<br>**If Continuing Pregnancy:**<br>-Access to prenatal care<br>-Medicaid enrollment<br>-Finishing school<br>**If Considering Adoption:**<br>-Open vs. Closed<br>-Social Service Organizations | **If Considering Abortion:**<br>-Types of abortion<br>-Access to abortion in Colorado: Mandatory Parental Notification for teens under 18.<br>-Timing<br>-Cost |
| **O** | **Offer a Timeline**<br>-How much time do you need to make this decision?<br>If you decide to continue the pregnancy:<br>-By what date will you make an appointment for pre natal care? | If you decide to terminate:<br>-By what date will you schedule an appointment? |
| **N** | **Next Steps**<br>-Provide the patient with written resources and necessary referrals.<br>-Discuss future contraceptive options and write a prescription for EC. | -Ask if she has anymore questions.<br>-Schedule a follow-up visit. |

Provided by Physicians for Reproductive Choice and Health: Adolescent Reproductive Health Education Project.

## Emergency Contraception Options Chart

FDA-Approved Emergency Contraception Products

| | **Next Choice**<br><br>**(generic prescription-only Plan B)** | **Plan B One-Step** |
|---|---|---|
| Formulation | 2 tablets (each 0.75 mg levonorgestrel) | 1 tablet (1.5mg levonorgestrel) |
| Manufacturer | Watson Pharmaceuticals, Inc. | Teva Pharmaceuticals, Inc. |
| Approval Date | June 24, 2009 | July 10, 2009 |
| Labeling/Over-the-Counter (OTC) and Prescription Access Restrictions | Single product that is "dual labeled" for both prescription and OTC usage with the following restrictions:<br><br>RX: 16 years and younger<br><br>OTC: 17 years and older | Single product that is "dual labeled" for both prescription and OTC usage with the following restrictions:<br><br>RX: 16 years and younger<br><br>OTC: 17 years and older |
| Approximate Cost | ~$41 | ~$45-$50 |

Here is a short list of combined progestin and estrogen pills that can be used for emergency contraception in the United States.[1]

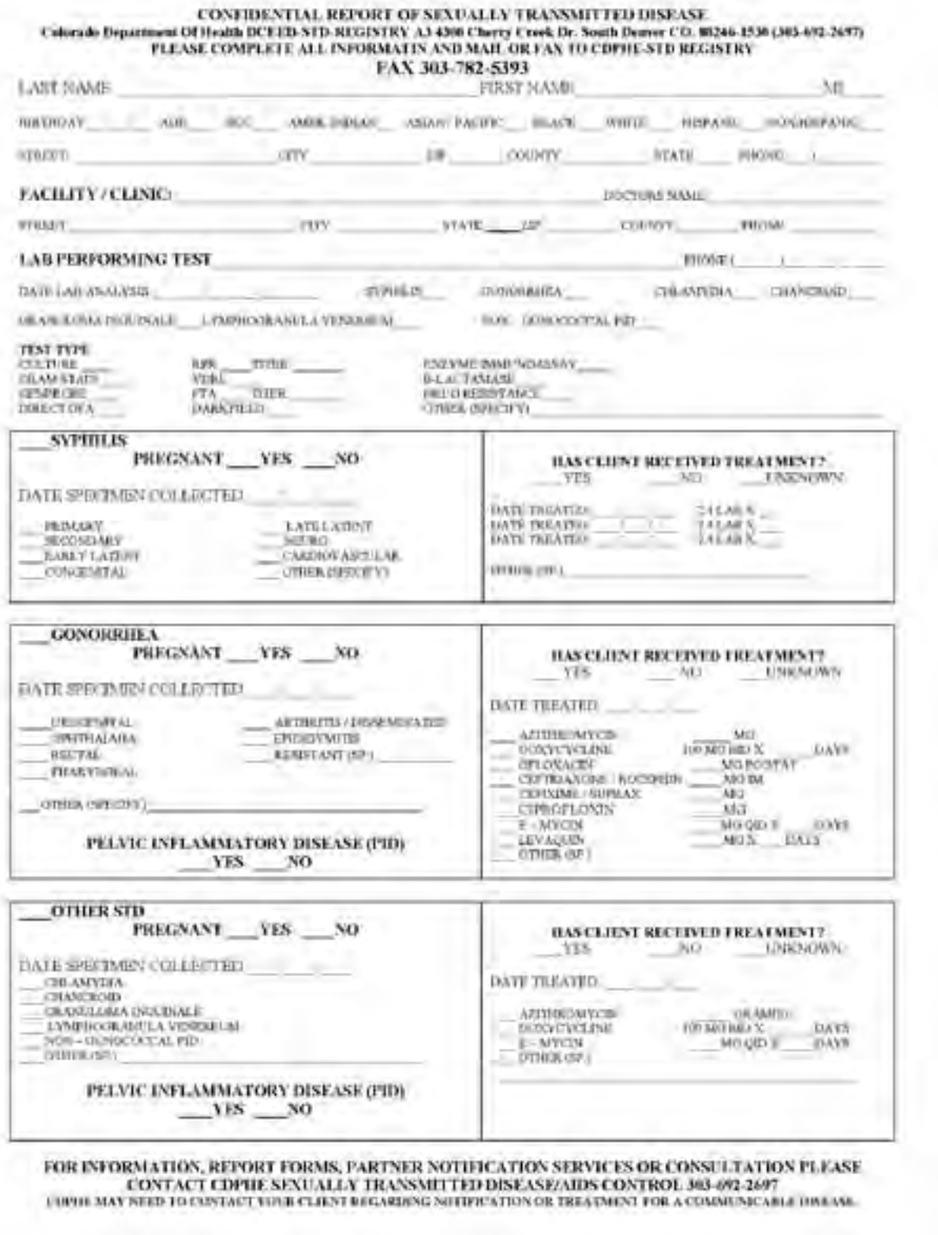
| Brand | Pills per Dose | Instructions for Use |
|---|---|---|
| Alesse | 5 pink pills | Take two doses 12 hours apart. |
| Aviane | 5 orange pills | |
| Cryselle | 4 white pills | |
| Lessina | 5 pink pills | |
| Levlen | 4 light-orange pills | |
| Levlite | 5 pink pills | |
| Lo/Ovral | 4 white pills | |
| Nordette | 4 light-orange pills | |
| Seasonale | 4 pink pills | |
| Seasonique | 4 light-blue-green pills | |
| Tri-Levlen | 4 yellow pills | |
| Triphasil | 4 yellow pills | |
| Trivora | 4 pink pills | |

[1] Physicians for Reproductive Choice and Health, "Emergency Contraception: A Practitioner's Guide" (2010), http://prch.org/emergency-contraception-a-practitioners-guide.



## Sexually Transmitted Infections Reporting Form

This form is available as a PDF document on the CD included in the toolkit.



CONFIDENTIAL REPORT OF SEXUALLY TRANSMITTED DISEASE
Colorado Department Of Health DCEID-STD-REGISTRY A3 4300 Cherry Creek Dr. South Denver CO. 80246-1530 (303-692-2697)
PLEASE COMPLETE ALL INFORMATIN AND MAIL OR FAX TO CDPHE-STD REGISTRY
FAX 303-782-5393

LAST NAME FIRST NAME MI
BIRTHDAY AGE SEX AMER INDIAN ASIAN/ PACIFIC BLACK WHITE HISPANIC NON-HISPANIC
STREET CITY ZIP COUNTY STATE PHONE ( )

FACILITY / CLINIC DOCTORS NAME
STREET CITY STATE ZIP COUNTY PHONE
LAB PERFORMING TEST PHONE ( )
DATE LAB ANALYSIS SYPHILIS GONORRHEA CHLAMYDIA CHANCROID
GRANULOMA INGUINALE LYMPHOGRANULA VENEREUM NON GONOCOCCAL PID

TEST TYPE
CULTURE RPR TITER ENZYME IMMUNOASSAY
DIAM STAIN VDRL DNA PROBE
GENPROBE PTA OTHER PCR RESISTANCE
DIRECT OFA DARKFIELD OTHER (SPECIFY)

SYPHILIS
PREGNANT YES NO
DATE SPECIMEN COLLECTED
PRIMARY LATE LATENT
SECONDARY NEURO
EARLY LATENT CARDIOVASCULAR
CONGENITAL OTHER (SPECIFY)

HAS CLIENT RECEIVED TREATMENT?
YES NO UNKNOWN
DATE TREATED
DATE TREATED
DATE TREATED
OTHER (SP.)

GONORRHEA
PREGNANT YES NO
DATE SPECIMEN COLLECTED
PHARYNGEAL ARTHRITIS / DISSEMINATED
OPHTHALMIA EPIDIDYMITIS
RECTAL RESISTANT (SP.)
PHARYNGEAL
OTHER (SPECIFY)
PELVIC INFLAMMATORY DISEASE (PID)
YES NO

HAS CLIENT RECEIVED TREATMENT?
YES NO UNKNOWN
DATE TREATED
AZITHROMYCIN MG
DOXYCYCLINE 100 MG BID X DAYS
OFLOXACIN MG PO/STAT
CEFTRIAXONE / ROCEPHIN MG IM
CEFIXIME / SUPRAX MG
CIPROFLOXIN MG
E - MYCIN MG QID X DAYS
LEVAQUIN MG X DAYS
OTHER (SP.)

OTHER STD
PREGNANT YES NO
DATE SPECIMEN COLLECTED
CHLAMYDIA
CHANCROID
GRANULOMA INGUINALE
LYMPHOGRANULA VENEREUM
NON - GONOCOCCAL PID
OTHER (SP.)
PELVIC INFLAMMATORY DISEASE (PID)
YES NO

HAS CLIENT RECEIVED TREATMENT?
YES NO UNKNOWN
DATE TREATED
AZITHROMYCIN GRAMS
DOXYCYCLINE 100 MG BID X DAYS
E - MYCIN MG QID X DAYS
OTHER (SP.)

FOR INFORMATION, REPORT FORMS, PARTNER NOTIFICATION SERVICES OR CONSULTATION PLEASE CONTACT CDPHE SEXUALLY TRANSMITTED DISEASE/AIDS CONTROL 303-692-2697
CDPHE MAY NEED TO CONTACT YOUR CLIENT REGARDING NOTIFICATION OR TREATMENT FOR A COMMUNICABLE DISEASE.

## Sample Scenarios to Improve Condom Negotiation

Research shows that even reading a scripted scenario helps improve condom negotiation skills and use. Here are a few scenarios you can try with patients to help them better negotiate using condoms with their partner(s).

Discuss the myths that are being presented in these scenarios and the ways the partners answer each other's objections. Ask the patient if there are any other ways to handle the situation. The provider should read lines said by the "partner," and the patient can read lines said by "you."

**Scenario 1 (Female patient):**

Partner: I know you're on birth control, so why would we need to use a condom? You can't get pregnant.

You: But birth control doesn't protect against STIs. We should both get tested, but I still feel more comfortable and safer using condoms.

Partner: Oh, I guess I was just worrying about pregnancy. I hadn't thought about STIs.

You: How about we go to the clinic together and get tested so we can talk to someone about our concerns and get our questions answered.

**Scenario 2 (Male patient):**

Partner: We shouldn't use condoms when we start having sex; I heard it feels better without one.

You: I don't know about that. Can't you get pregnant or get an infection if we don't use one?

Partner: Nah, I can't get pregnant because it's my first time. And I know you don't have any infections. We both look totally normal, not like those pictures we saw in class. Besides, I trust you.

You: I don't think that is right. Why don't we go to the clinic and talk to someone just to be sure. I am not really willing to take the risk of getting you pregnant or having to worry about STIs. I trust you too and want to make sure we are making the best decisions for each other.

**Scenario 3 (Female patient):**

Partner: I hate using condoms. They are always too tight and uncomfortable. We shouldn't use them anymore.

You: I don't know. Couldn't I get pregnant?

Partner: Nah, not if we do it on certain days. Besides, I can always pull out.

You: That doesn't sound safe, and I absolutely do not want to be pregnant right now. I think we should try some different condoms first. Did you know they come in different sizes?

**Scenario 4 (Female patient):**

Partner: We've never used condoms before, why start now? Are you messing around with someone else?

You: Of course not, I just want to make sure we are as safe as possible.

Partner: Safe? What are you talking about?

You: I know neither of us want to have a baby right now, so if we use condoms that is a lot less likely to happen. Let's just give it a try.



## Training and Evaluation- At a Glance

**WHO:**

This chapter is useful for SBHCs that:

- Want to increase quality assurance and consistency of care
- Would like to gather data to solicit additional funding
- Want to use existing online and local training opportunities to get CMEs
- Would like to identify gaps in current service delivery and use data to guide positive change

**WHAT:**

The evaluation and training chapter outlines the infrastructure that has been created to help facilitate gathering the data necessary to assess clinic operations and outcomes. Using the protocols, progress notes, and best practices, SBHCs will be able to determine how their actions are impacting the students they serve.

**WHY:**

SBHCs have the opportunity to validate the amazing work they do every day in the clinic!

## Training and Evaluation

**Introduction**

The training and evaluation chapter provides SBHC clinicians and administrators with information and tools to assist with quality assurance and on-going training, both of which are necessary for successful programs. Evaluation, as used in the context of this chapter, will refer to program management and on-going quality assurance measures. The tools included in this chapter help establish quality assurance measures and improve data collection processes.

The chapter describes how to use the toolkit's progress notes for quality assurance measures, such as collecting common data across sites, and outlines local and online training opportunities. Additionally, it provides SBHCs with tools to assess their own knowledge and programs operations, allowing them to identify gaps that can help identify further training needs.

The following items are included:

Evaluation:

1. Practice Management and Quality Assurance
2. Follow-up
3. Self-Assessments
4. Long-Term Outlook

Training:

1. Online and Local Training Opportunities
2. Toolkit Training Highlights

The following tools correspond to the contents of this chapter:

1. Provider Self-Assessment
2. Student Satisfaction Survey
3. Data Management Tool
4. Follow-up Calendar

## Evaluation

**Practice Management and Quality Assurance**

In order to assure quality, every well-run program should periodically conduct an assessment of the consistency of its program operations with best practices. Once baseline indicators are established, a program management system can be used to determine if your program is accomplishing its goals. For example, when offering comprehensive reproductive health services in SBHCs, one important measure is whether students are actually using the available services. This can be measured by the number of reproductive health visits, as well as the number of pregnancy tests, chlamydia and gonorrhea tests, treatments administered, and contraceptives dispensed or prescribed.

The toolkit progress notes were developed with practice management and evaluation in mind. Each time a provider uses the progress notes, the infrastructure is in place to assess the consistency of everyday program operations with best practices. The progress notes guide providers through the recommended best practices and prompt them to follow the practices during each visit. The use of the progress notes also ensures consistency of practice among different providers. In addition to the progress notes, the toolkit includes a data management tool that can be used to systematically track the incorporation of best practices. The data management tool is an excel spreadsheet that allows SBHCs to input the following patient information, taken directly from the progress notes, for each visit:

- Reason for visit
- If confidentiality was reviewed and documented
- If emergency contraception was discussed
- If condom use was reviewed
- Percentage of current condom use
- If contraception was initiated and what type
- If a pregnancy test was administered and the result
- If STI testing was completed
- If STI treatment was dispensed

The data management tool is simple, straightforward, and easy to use. Entering the necessary information for each patient only takes a few seconds. Drop-down menus are available for the majority of the categories. Additionally, the tool manages data in an Excel document so it can easily be used with nearly any computer.

Administering patient satisfaction surveys can also help SBHCs determine if students feel that they received care consistent with best practices. The patient satisfaction survey included in the tools allows students to report back on the care they received. In several SBHCs, this has already proven to be helpful for practice management. For example, one provider noticed she was talking with students about emergency contraception at each visit, but the students weren't regularly acknowledging the discussion on their surveys. This prompted her to consider the language she was using and how she was counseling her patients.

**Follow-up**

Another essential element of best practice is follow-up with patients. It is generally accepted that getting a sexually active student started on birth control is only the first of many steps to help prevent pregnancy. When students have a place to ask questions and work through their concerns about potential side effects, they are more likely to continue using their birth control method because their satisfaction with the method will improve. For this reason, the progress notes prompt providers to conduct follow-up in a consistent manner. For example, if students are prescribed contraception but can't access it on-site at the SBHC, the provider is prompted to follow-up with that student in two weeks to ensure that the student obtained the contraception, and if not, to help devise another plan. Follow-up is especially important when students are initiating contraception and when contraception is not available on-site at the SBHC.

SBHCs that do not have a system in place to track follow-up can benefit from using the tickler calendar tool. It takes regular scheduling one step further by making sure patients who miss scheduled appointments are not forgotten. The tickler calendar allows a provider to keep track of when a patient is due back, for what reason, and, if a follow-up appointment is missed, how many times contact with the patient has been attempted.

The follow-up component also allows providers to determine how the services are impacting the patient's behavior over time. Once data is input in the data management tool, SBHCs can measure if students are using condoms with increased frequency or if students who initiate contraception actually continue to use it throughout the year. Establishing consistency of follow-up and data management may provide future opportunities for Colorado SBHCs to be evaluated and potentially shown to be an evidence-based model that enhances access to consistent, high quality, comprehensive care for adolescents in SBHCs.

**Provider Self-Assessments**

The use of provider self-assessments is yet another way to evaluate quality of care and consistency with best practices. The assessment tool allows providers to evaluate their confidence and knowledge of current best practices as well as how frequently they incorporate best practices in their daily interactions with patients. Reviewing the assessments identifies gaps in standards, and training in these topics can be emphasized.

The self-assessment included in the toolkit should be administered prior to using the toolkit and then again after receiving training on the use of the toolkit and implementing it for one school year.

**Long-Term Outlook**

Currently, there is limited research on the effect of SBHCs offering comprehensive services on patient behaviors such as increased condom use and increased use of contraception over a sustained period of time.

Once SBHC programs begin gathering data using a common data collection tool, funding for evaluation of pa-

tient behaviors across sites throughout the state may become available.

In addition to funding, providing high quality services that are regularly assessed and incorporate best practices offers an opportunity for SBHCs to work with teens to address teen pregnancy rates, sexually transmitted infection rates, and potentially even graduation rates. Access to comprehensive health services provides teens with the tools they need to make healthy, informed, and responsible decisions.

## Training

The adolescent reproductive and sexual health field is constantly evolving, and regular training is necessary to stay up-to-date with current best practices and changes in the field.

## Online and Local Training Opportunities

Below is a list of reproductive health trainings that can be found online or in Colorado; many provide continuing medical education credits.

| Organization | Website | Available Trainings | CME | Cost |
|---|---|---|---|---|
| Contraception Online | www.contraceptiononline.org | Counseling Adolescents about Sexual Health | Yes | $0 |
| | | An Adolescent Girl's First Gynecologic Visit and What She Should Know about Contraception | Yes | $0 |
| | | Young Nulliparous Woman Who "Wants to Make her Periods Go Away" | Yes | $0 |
| | | The Sexually Active Adolescent who is Uncertain about Using Contraception | Yes | $0 |
| | | Overcoming Cultural Barriers in Contraceptive Care | Yes | $0 |
| | | | | |
| Denver Prevention Training Center | www.denverptc.org | STD Intensive Clinical Training | Yes | $95 |
| | | STD Annual Update | Yes | $50 |
| | | Wet-Prep Workshops | Yes | $20 |
| | | | | |
| Association of Reproductive Health Professionals | www.arhp.org | Breaking the Contraceptive Barrier: Techniques for Effective Contraceptive Consultations | Yes | $0 |
| | | New Developments in Contraception: The Single Rod Implant | Yes | $0 |
| | | Choosing a Birth Control Method | Yes | $0 |
| | | | | |
| Physicians for Reproductive Choice: Adolescent Reproductive Health Education Project | www.prch.org/arhepdownloads | Adolescent Friendly Health Services | No | $0 |
| | | Adolescent STI Epidemiology, Testing and Treatment Strategies | No | $0 |
| | | Emergency Contraception and Adolescents | No | $0 |
| | | The Essentials of Contraception and Adolescents | No | $0 |
| | | Male Adolescent Reproductive Health | No | $0 |
| | | Gay, Lesbian, Bisexual, Transgender and Questioning Youth | No | $0 |
| | | Pregnancy and Options Counseling and Adolescents | No | $0 |
| | | | | |
| Region 8 Family Planning Training Center | www.region8familyplanning.org | Annual Reproductive Health Updates | CNE, must submit additional information | $100 |

## Toolkit Training Highlights

The Adolescent Reproductive Health Toolkit was developed based on best practices. The best practices highlighted by the Colorado Association for School-Based Health Care include the following:

| ADOLESCENT REPRODUCTIVE HEALTH TOOLKIT BEST PRACTICES | |
|---|---|
| Community Engagement | 1. Engage the community in discussions about comprehensive reproductive health services and education in the SBHC<br>2. Develop a communications plan<br>3. Work with the school-board and medical sponsor to create a memorandum of understanding allowing for the provision of comprehensive services |
| Youth Engagement | 1. Work with youth as advocates to increase access to comprehensive care in SBHCs |
| Program Planning | 1. Create a youth-friendly environment in the SBHC<br>2. Implement clear policies regarding the provision of reproductive health services<br>3. Understand minor consent laws and the right to confidentiality |

| | |
|---|---|
| Service Provision | 1. Assure confidentiality<br>2. Do not require pelvic exams for contraceptive services<br>3. Routinely test for chlamydia and gonorrhea<br>4. Practice partner-expedited therapy<br>5. Teach condom use skills and negotiation skills<br>6. Provide contraceptive counseling following a negative pregnancy test and positive STI test<br>7. Make emergency contraception a routine part of counseling<br>8. Practice Quick Start as the preferred method of birth control initiation<br>9. Increase patient satisfaction by including counseling regarding myths, benefits, and anticipated side-effects of contraception<br>10. Offer forgettable contraception such as IUDs, Implanon, and Depo |
| Training and Evaluation | 1. Attend regular trainings on adolescent reproductive health<br>2. Evaluate the quality of programs on a regular basis |



## Training and Evaluation Tools: At a Glance

This chapter contains the following tools. These tools may be useful as you work on quality assurance measures and training for your program.

**1. Provider Self-Assessment**

*The provider self-assessment helps providers determine strengths and weaknesses and helps identify potential gaps in training.*

**2. Student Satisfaction Survey**

*The student satisfaction survey allows providers to hear feedback from patients about how their perceptions of the visit.*

**3. Data Management Tool**

*The data management tool helps SBHCs track consistency of services as well as continuity of care for patients over time.*

**4. Follow-up Calendar**

*The follow-up calendar was created to formally help providers keep track of when patients are due back for follow-up; if they do not return, it helps ensure those students do not slip through the cracks.*

## Provider Self-Assessment

This assessment is available as a PDF document on the CD included in the toolkit.

# ADOLESCENT REPRODUCTIVE HEALTH TOOLKIT
# PROVIDER SELF-ASSESSMENT

**Please indicate the degree to which you agree with the following statements:**

| | Strongly disagree | Disagree | Neutral | Agree | Strongly agree |
|---|---|---|---|---|---|
| Our community has been engaged in discussions about comprehensive adolescent health care in our SBHC. | | | | | |
| Our SBHC has a communications plan. | | | | | |
| Our SBHC has a school-board approved MOU allowing for the provision of comprehensive reproductive health services. | | | | | |

**Please rate and circle where your SBHC currently falls on the continuum below:**


**Please indicate the degree to which you agree with the following statements:**

| | Strongly disagree | Disagree | Neutral | Agree | Strongly agree |
|---|---|---|---|---|---|
| Youth are meaningfully engaged in our SBHC. | | | | | |
| Our SBHC strives to form youth/adult partnerships. | | | | | |
| Youth help determine the health priorities and focus of the SBHC. | | | | | |
| Brochures and patient handouts are reviewed and approved by teens. | | | | | |
| | | | | | |
| Our SBHC has a youth-friendly environment. | | | | | |
| Posters and patient materials are inclusive and reflect the patient population. | | | | | |
| Confidentiality signs are clearly posted throughout the clinic. | | | | | |
| We have a pharmacy and are capable of dispensing contraception on-site. | | | | | |
| We have a lab and are able to perform CLIA-waived tests and provider-performed microscopy. | | | | | |
| We routinely provide HPV vaccines to eligible students. | | | | | |
| Our SBHC has specific policies regarding: | | | | | |
| • Reproductive health and education | | | | | |
| • Confidentiality and billing | | | | | |
| • Pregnancy testing and counseling | | | | | |
| • STI testing and treatment | | | | | |
| • Availability of contraception | | | | | |
| • Availability of emergency contraception | | | | | |

**Please indicate the degree to which you agree with the following statements:**

| | Strongly disagree | Disagree | Neutral | Agree | Strongly agree |
|---|---|---|---|---|---|
| I am confident in my knowledge of minor consent laws and confidentiality: | | | | | |
| • When it is specific to **contraception** | | | | | |
| • When it is specific to **STI testing/treatment** | | | | | |
| • When it is specific to **HIV testing/treatment** | | | | | |
| • When it is specific to **pre-natal care** | | | | | |
| • When it is specific to **abortion** | | | | | |
| | | | | | |
| I am confident in my ability to provide pregnancy testing and counseling: | | | | | |
| • When the result is negative and the student does not desire pregnancy | | | | | |
| • When the result is negative and the student desires pregnancy | | | | | |
| • When the result is positive and the student desires pregnancy | | | | | |
| • When the result is positive and the student needs options counseling | | | | | |
| • When the result is positive and the student desires an abortion | | | | | |
| | | | | | |
| I am confident using Quick Start: | | | | | |
| • As the preferred way to initiate oral contraceptives | | | | | |
| • As the preferred way to initiate Depo | | | | | |
| • As the preferred way to initiate Nuva Ring | | | | | |
| • As the preferred way to initiate Ortho Evra (patch) | | | | | |
| | | | | | |
| I am confident about my knowledge of extended use birth control for menstrual suppression: | | | | | |
| • Using oral contraceptives | | | | | |
| • Using Ortho Evra (patch) | | | | | |
| • Using Nuva Ring | | | | | |
| | | | | | |
| I am confident about my knowledge of IUDs: | | | | | |
| • When used in nulliparous adolescents | | | | | |
| • When explaining IUD insertion and removal | | | | | |
| • When discussing risks and benefits of use | | | | | |
| | | | | | |
| I am confident in my ability to determine when pelvic exams are necessary. | | | | | |
| I am confident in my ability to perform pelvic exams. | | | | | |
| | | | | | |
| I am confident about my knowledge of emergency contraception: | | | | | |
| • When using Plan B | | | | | |
| • When using off-label forms of emergency contraception | | | | | |
| • As related to prescriptions versus availability over-the-counter | | | | | |
| | | | | | |
| I am confident in my knowledge of STI screening and treatment guidelines. | | | | | |
| I am confident in my knowledge of expedited partner therapy. | | | | | |
| I am confident discussing condom use. | | | | | |
| I am confident with role playing condom negotiation techniques. | | | | | |
| I follow-up with patients at 1 and 3 months following birth control initiation. | | | | | |

| | Strongly disagree | Disagree | Not sure | Agree | Strongly agree |
|---|---|---|---|---|---|
| We have a system in place that ensures appropriate follow-up. | | | | | |
| Follow-up is standardized for specific needs (e.g., 1 week follow-up for a positive pregnancy test result). | | | | | |
| | | | | | |
| The brochures and patient handouts we use are: | | | | | |
| • Teen friendly | | | | | |
| • Up-to-date | | | | | |
| • Inclusive (gender, race, sexual orientation etc.) | | | | | |
| | | | | | |
| The progress notes we use during patients visits: | | | | | |
| Allow me to consistently offer standardized care to all patients. | | | | | |
| Easily guide me through the visits | | | | | |
| Allow me to consistently gather data | | | | | |
| | | | | | |
| OVERALL, I am confident providing reproductive health services. | | | | | |
| OVERALL, I am up-to-date on current practices in adolescent health. | | | | | |

**Please indicate the current frequency of the following:**

| | Never | Rarely | Sometimes | Most of the time | Always | N/A |
|---|---|---|---|---|---|---|
| I discuss confidentiality with students. | | | | | | |
| I explain the laws to students and how they relate to the visit. | | | | | | |
| | | | | | | |
| If a pregnancy test is negative and pregnancy **is not** desired, I provide birth control counseling and the option to initiate birth control during that visit. | | | | | | |
| If a pregnancy test is negative and pregnancy **is** desired, I start the patient on folic acid or prenatal vitamins. | | | | | | |
| If a pregnancy test is positive and the student is unsure how to proceed, I provide that student with information about all of their options. | | | | | | |
| | | | | | | |
| I use Quick Start to initiate students on birth control: | | | | | | |
| If birth control is available on-site, I directly observe the first dose. | | | | | | |
| | | | | | | |
| When discussing contraception I review: | | | | | | |
| • Abstinence | | | | | | |
| • Hormonal methods | | | | | | |
| • Long acting methods (IUDs, implanon) | | | | | | |
| | | | | | | |
| Extended use birth control is available on-site to students requesting it. | | | | | | |
| | | | | | | |
| To initiate birth control, students receive a pelvic exam. | | | | | | |
| For routine chlamydia/gonorrhea screening, students receive a pelvic exam. | | | | | | |
| Pap smears are performed on adolescents who have been sexually active **less than** three years. | | | | | | |
| | | | | | | |
| Emergency contraception is discussed with female patients. | | | | | | |
| Emergency contraception is discussed with male patients. | | | | | | |



| | Never | Rarely | Sometimes | Most of the time | Always | N/A |
|---|---|---|---|---|---|---|
| Advanced prescriptions for emergency contraception are given. | | | | | | |
| | | | | | | |
| I provide expedited partner therapy for students with positive chlamydia, gonorrhea, PID, trichomonas, mucopurulent cervicitis. | | | | | | |
| I have condoms available in my clinic. | | | | | | |
| I discuss condoms and safe sex with patients. | | | | | | |
| Techniques for condom negotiation are reviewed. | | | | | | |
| Techniques for condom negotiation are practiced when a patient is diagnosed with an STI. | | | | | | |

**Please indicate how frequently follow-up occurs after the following:**

| | No routine follow-up | 1 week | 2 weeks | 1 month | 3 months | Unspecified |
|---|---|---|---|---|---|---|
| Writing a prescription to be filled in a different location | | | | | | |
| Referral to a different location | | | | | | |
| Birth control initiation | | | | | | |
| Positive chlamydia test | | | | | | |
| Positive pregnancy test | | | | | | |

**On average, how much time is spent with the patient for the following reproductive health visits:**

| | 15 minutes | 30 minutes | 45 minutes | 1 hour | Other (please specify) |
|---|---|---|---|---|---|
| New patient reproductive health visit | | | | | |
| Pregnancy test only | | | | | |
| Birth control initiation | | | | | |
| Symptomatic STI screening | | | | | |
| Follow-up/interval visits | | | | | |

**Do you currently evaluate your reproductive health services?** (Circle one) **YES** **NO**

If yes, how:

- ☐ Collecting patient satisfaction surveys
- ☐ Collecting the number of reproductive health visits:
  - ☐ New patients vs. previous patients
  - ☐ Pregnancy tests and positive results
  - ☐ Chlamydia and gonorrhea tests and positive results
  - ☐ Prescription fill rates
  - ☐ Contraceptive use at one month after initiation
  - ☐ Contraceptive use at three months after initiation

If no, reason:

- ☐ Lack of infrastructure
- ☐ Lack of time
- ☐ Insufficient staff
- ☐ Insufficient resources
- ☐ Other: _____

**What resources do you currently use?** (Check all that apply)

- ☐ *Contraceptive Technology* by Hatcher, et. al
- ☐ *Family Planning Handbook* by the World Health Organization
- ☐ CDC STI Treatment Guidelines
- ☐ None of the above
- ☐ Other: _____

**How frequently do you attend trainings on adolescent reproductive health?**

- ☐ Rarely (once every 5 years or less)
- ☐ Once every 2 years
- ☐ Every year
- ☐ More than once a year

**THANK YOU FOR TAKING THE TIME TO COMPLETE THIS ASSESSMENT**

## Student Satisfaction Survey

This survey is available as a PDF document on the CD included in the toolkit.

1. **What brought you to the clinic today? (circle one)**
   Pregnancy test  Birth control  STI testing  Other: _____

2. **How did you hear about the clinic? (circle one)**
   Friend  Been here before  Teacher  Flyer/Advertisement  Other: _____

3. **If the clinic wasn't here, where would you have gone? (circle one)**
   Local doctor's office  Planned Parenthood  Not sure  Would not have gone to a clinic
   Other: _____

4. **How satisfied were you with the care you received? (circle one)**
   Not at all  Somewhat  Satisfied  Very satisfied

**Please check yes or no:**

| | YES | NO |
|---|---|---|
| Did the health care provider talk to you about confidentiality today? | | |
| Did the health care provider talk to you about emergency contraception today? | | |
| Did you receive testing for chlamydia and gonorrhea today? | | |
| If no, have you received testing in the past year? | | |
| Were you told to schedule a follow-up appointment today? | | |
| Did you review the importance of condom use and how to use condoms correctly? | | |
| Do you feel like you had all your questions answered? | | |
| Would you recommend the clinic to a friend? | | |

***For birth control only:***

| | YES | NO |
|---|---|---|
| If you requested birth control today: | | |
| Did you receive any brochures? | | |
| Were you told to start the method today or as soon as you obtained it? | | |
| Did you have a pelvic exam? | | |

***For pregnancy tests only:***

| | YES | NO | N/A (positive result) |
|---|---|---|---|
| If you came in for a pregnancy test today were you given the option to start birth control today? | | | |

**Comments or additional information you would like to share about your visit:**

_____

_____

_____

**THANK YOU!!!**

## Data Management Tool

The data management tool is available as an Excel file on the CD included in the toolkit. The file allows input of the following information:

- Reason for visit
- If confidentiality was reviewed and documented
- If emergency contraception was discussed
- If condom use was reviewed
- Percentage of current condom use
- If contraception was initiated and what type
- If a pregnancy test was administered and the result
- If STI testing was completed
- If STI treatment was dispensed

## Follow-up Calendar

This calendar is available as a PDF document on the CD included in the toolkit.

**FOLLOW-UP GUIDELINES:**

BC–Birth Control EC–Emergency Contraception STI–sexually transmitted infection HCG–pregnancy test

| 2 Week Follow-Up | 1 Month Follow-Up | Other |
|---|---|---|
| Birth control prescriptions or referrals | Dispensed birth control evaluation | 2 week follow up for positive HCG |
| Repeat pregnancy test if indicated | Method switch evaluation | 1 week follow-up if unable to reach pt |

**Monday** _____

| Student Name | Appt. time | Follow Up Reason: | Attempt | F/U Outcome |
|---|---|---|---|---|
| 1. | | ☐BC ☐EC ☐STD ☐HCG ☐Other: Notes: | ☐1st ☐2nd ☐3rd | ☐Complete ☐Re-try ☐No Response (3rd F/U) |
| 2. | | ☐BC ☐EC ☐STD ☐HCG ☐Other: Notes: | ☐1st ☐2nd ☐3rd | ☐Complete ☐Re-try ☐No Response (3rd F/U) |
| 3. | | ☐BC ☐EC ☐STD ☐HCG ☐Other: Notes: | ☐1st ☐2nd ☐3rd | ☐Complete ☐Re-try ☐No Response (3rd F/U) |
| 4. | | ☐BC ☐EC ☐STD ☐HCG ☐Other: Notes: | ☐1st ☐2nd ☐3rd | ☐Complete ☐Re-try ☐No Response (3rd F/U) |
| 5. | | ☐BC ☐EC ☐STD ☐HCG ☐Other: Notes: | ☐1st ☐2nd ☐3rd | ☐Complete ☐Re-try ☐No Response (3rd F/U) |

**TUESDAY** _____

| Student Name | Appt. time | Follow-Up Reason: | Attempt | F/U Outcome |
|---|---|---|---|---|
| 1. | | ☐BC ☐EC ☐STD ☐HCG ☐Other: Notes: | ☐1st ☐2nd ☐3rd | ☐Complete ☐Re-try ☐No Response (3rd F/U) |
| 2. | | ☐BC ☐EC ☐STD ☐HCG ☐Other: Notes: | ☐1st ☐2nd ☐3rd | ☐Complete ☐Re-try ☐No Response (3rd F/U) |
| 3. | | ☐BC ☐EC ☐STD ☐HCG ☐Other: Notes: | ☐1st ☐2nd ☐3rd | ☐Complete ☐Re-try ☐No Response (3rd F/U) |
| 4. | | ☐BC ☐EC ☐STD ☐HCG ☐Other: Notes: | ☐1st ☐2nd ☐3rd | ☐Complete ☐Re-try ☐No Response (3rd F/U) |
| 5. | | ☐BC ☐EC ☐STD ☐HCG ☐Other: Notes: | ☐1st ☐2nd ☐3rd | ☐Complete ☐Re-try ☐No Response (3rd F/U) |

**WEDNESDAY** _____

| Student Name | Appt. time | Follow Up Reason: | Attempt | F/U Outcome |
|---|---|---|---|---|
| 1. | | ☐BC ☐EC ☐STD ☐HCG ☐Other: Notes: | ☐1st ☐2nd ☐3rd | ☐Complete ☐Re-try ☐No Response (3rd F/U) |
| 2. | | ☐BC ☐EC ☐STD ☐HCG ☐Other: Notes: | ☐1st ☐2nd ☐3rd | ☐Complete ☐Re-try ☐No Response (3rd F/U) |
| 3. | | ☐BC ☐EC ☐STD ☐HCG ☐Other: Notes: | ☐1st ☐2nd ☐3rd | ☐Complete ☐Re-try ☐No Response (3rd F/U) |
| 4. | | ☐BC ☐EC ☐STD ☐HCG ☐Other: Notes: | ☐1st ☐2nd ☐3rd | ☐Complete ☐Re-try ☐No Response (3rd F/U) |
| 5. | | ☐BC ☐EC ☐STD ☐HCG ☐Other: Notes: | ☐1st ☐2nd ☐3rd | ☐Complete ☐Re-try ☐No Response (3rd F/U) |

**THURSDAY** _____

| Student Name | Appt. time | Follow Up Reason: | Attempt | F/U Outcome |
|---|---|---|---|---|
| 1. | | ☐BC ☐EC ☐STD ☐HCG ☐Other: Notes: | ☐1st ☐2nd ☐3rd | ☐Complete ☐Re-try ☐No Response (3rd F/U) |
| 2. | | ☐BC ☐EC ☐STD ☐HCG ☐Other: Notes: | ☐1st ☐2nd ☐3rd | ☐Complete ☐Re-try ☐No Response (3rd F/U) |
| 3. | | ☐BC ☐EC ☐STD ☐HCG ☐Other: Notes: | ☐1st ☐2nd ☐3rd | ☐Complete ☐Re-try ☐No Response (3rd F/U) |
| 4. | | ☐BC ☐EC ☐STD ☐HCG ☐Other: Notes: | ☐1st ☐2nd ☐3rd | ☐Complete ☐Re-try ☐No Response (3rd F/U) |
| 5. | | ☐BC ☐EC ☐STD ☐HCG ☐Other: Notes: | ☐1st ☐2nd ☐3rd | ☐Complete ☐Re-try ☐No Response (3rd F/U) |

**FRIDAY** _____

| Student Name | Appt. time | Follow Up Reason: | Attempt | F/U Outcome |
|---|---|---|---|---|
| 1. | | ☐BC ☐EC ☐STD ☐HCG ☐Other: Notes: | ☐1st ☐2nd ☐3rd | ☐Complete ☐Re-try ☐No Response (3rd F/U) |
| 2. | | ☐BC ☐EC ☐STD ☐HCG ☐Other: Notes: | ☐1st ☐2nd ☐3rd | ☐Complete ☐Re-try ☐No Response (3rd F/U) |
| 3. | | ☐BC ☐EC ☐STD ☐HCG ☐Other: Notes: | ☐1st ☐2nd ☐3rd | ☐Complete ☐Re-try ☐No Response (3rd F/U) |
| 4. | | ☐BC ☐EC ☐STD ☐HCG ☐Other: Notes: | ☐1st ☐2nd ☐3rd | ☐Complete ☐Re-try ☐No Response (3rd F/U) |
| 5. | | ☐BC ☐EC ☐STD ☐HCG ☐Other: Notes: | ☐1st ☐2nd ☐3rd | ☐Complete ☐Re-try ☐No Response (3rd F/U) |