



HHS Public Access

Author manuscript

J Community Health. Author manuscript; available in PMC 2024 April 11.

Published in final edited form as:

J Community Health. 2020 June ; 45(3): 615–625. doi:10.1007/s10900-019-00781-z.

The Teen Access and Quality Initiative: Improving Adolescent Reproductive Health Best Practices in Publicly Funded Health Centers

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Abstract

Quality adolescent sexual and reproductive health (ASRH) services play an important role in supporting the overall health and well-being of adolescents. Improving access to this care can help reduce unintended pregnancies, sexually transmitted diseases (STDs), and human immunodeficiency virus (HIV) infection and their associated consequences, as well as promote health equity. The Centers for Disease Control and Prevention funded three grantees to implement a clinic-based ASRH quality improvement initiative complimented by activities to strengthen systems to refer and link youth to ASRH services. The purpose of this study is to describe the initiative and baseline assessment results of ASRH best practice implementation in participating health centers. The assessment found common use of the following practices: STD/HIV screening, education on abstinence and the use of dual protection, and activities to increase accessibility (e.g., offering after-school hours and walk-in and same-day appointments). The following practices were used less frequently: provider training for Long-Acting Reversible Contraception (LARC) insertion and removal, LARC availability, same-day provision of all contraceptive methods, and consistent sharing of information about confidentiality and minors' rights with adolescent clients. This study describes the types of training and technical assistance being implemented at each health center and discusses implications for future programming.

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Disclaimer The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

Electronic supplementary material The online version of this article (<https://doi.org/10.1007/s10900-019-00781-z>) contains supplementary material, which is available to authorized users.

Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interest.

Keywords

Community health center; Reproductive health; Teen pregnancy; Adolescent health; Quality improvement

Introduction

In 2018, the US teen birth rate reached a historic low of 17.4 births per 1000 females aged 15–19 years [1]. Yet US teen pregnancy and teen birth rates remain considerably higher than other Western industrialized countries [2], and racial/ethnic and geographic disparities persist. In 2018, the teen birth rates among Black (26.3) and Hispanic (26.7) teens were more than twice as high as rates among White teens (12.1) [1]. Further, teens in families with lower education and income levels [3] and those in the child welfare system [4] are at increased risk of teen childbearing. The social and economic consequences of teen childbearing in the United States, especially among marginalized populations, have been well-documented [5, 6].

Access to quality adolescent sexual and reproductive health (ASRH) services (e.g., gynecologic services; contraceptive services; and sexually transmitted diseases [STD] counseling, screening, or treatment) can reduce rates of unintended pregnancies, STDs, and HIV infection and their related consequences [7, 8]. Yet many adolescents do not have adequate access to ASRH services [9]. Even with access, low-quality ASRH services may dissuade young people from using these services [10]. All of these factors may contribute to health disparities [11]. Barriers to adolescents accessing ASRH services include confidentiality concerns, cost of care and lack of insurance, inadequate provider training, unwelcoming environment, transportation obstacles, inconvenient health center hours, and lack of walk-in appointments [12, 13]. These challenges can be exacerbated for young people who are low income, live in foster care or group homes, or are incarcerated or in the juvenile justice system [9]. In an analysis of 2006–2010 data on US adolescents aged 15–19 years, one-quarter of sexually experienced females and one-third of sexually experienced males reported that they had not received a reproductive health service in the past year [14]. Only about one-third of sexually active adolescents report receiving information on contraception from a health care provider [15], yet adolescents describe health care providers as a desirable source for sexual health information [16].

Long-acting reversible contraceptives (LARCs) are safe for adolescents, have higher continuation and satisfaction rates among adolescents than shorter-acting contraceptives, and are more effective than user-dependent methods like the pill and condoms, which can fail because of inconsistent or incorrect use [17–19]. Yet multiple factors impede LARC access among adolescents. These factors include high initiation cost, limited adolescent awareness and knowledge, inadequate provider training for LARC insertion and removal, and provider misconceptions about the safety of adolescent LARC use [20–22].

Academic and clinical associations, including the Society for Adolescent Health and Medicine and the American Academy of Pediatrics, have recognized the importance of quality ASRH services and recommend strategies for reducing barriers to care [23–25].

Strategies for improving access and quality of ASRH services include ensuring that opportunities to offer ASRH services are not missed. For example, at every visit, health centers can ensure that adolescents have time alone with providers and identify those who are sexually active. They can also assess adolescents' pregnancy intentions and STD/HIV risk and, if needed, initiate contraception at the time of the visit rather than waiting for next menses (the "quick start" approach) if the provider is reasonably certain [26, 27] that the client is not pregnant. Other strategies include LARC insertion and removal training and client-centered counseling that is "respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions" [28–31].

Structural changes, such as provisions to ensure confidentiality, also help improve care [23, 24, 32–34]. Without the assurance of confidentiality, adolescents may not seek needed health services, which increases their risk for unintended pregnancy, STDs and HIV infection [23, 35]. Systems changes that reduce client costs and offer more convenient hours for adolescents (e.g., after-school hours) and walk-in appointments can also help improve access [36].

Various interventions have been implemented to increase access to and quality of ASRH services. They include provider training, procedures to ensure confidential services, free services, in-depth counseling, education tailored to an adolescent's level of development, follow-up phone calls, and drop-in health centers or weekend and after-school hours. These interventions have been associated with improved behavioral outcomes [37–41] and enhanced client knowledge and satisfaction [37, 42, 43]. Innovative initiatives designed to increase access to the full range of contraceptive methods (including LARC) by educating providers, conducting client-centered counseling, and reducing or eliminating client costs have been associated with reductions in teen pregnancy and births [17, 44].

Despite these promising efforts, gaps and inconsistencies have been identified in the implementation of many proven strategies and best practices. To help address these problems, the Teen Access and Quality (TAQ) initiative was developed. This initiative builds on lessons learned from a 2010–2015 communitywide initiative [45] designed to reduce rates of teen pregnancy and births in communities with the highest rates. The TAQ initiative seeks to improve access to and quality of ASRH services at publicly funded health centers and to link young people from communities most affected by teen pregnancy and childbearing to care. The purpose of this article is to describe TAQ's programmatic approach and the results of health center and provider baseline assessments on ASRH best practice implementation. These assessments identified common practices that can be considered program strengths and less common practices that represent opportunities for improvement. We consider training and technical assistance that might help sustain strengths and address gaps, and we discuss implications for future programmatic efforts.

Methods

The TAQ Initiative

Three nonprofit organizations from Georgia, Mississippi, and North Carolina were funded by the Centers for Disease Control and Prevention to implement the TAQ initiative during 2015–2020 in communities with teen birth rates higher than the national average. Grantees partner with publicly funded health centers in their community (e.g., Federally Qualified Health Centers, health departments) and provide training and technical assistance to measure, through collection and assessment of data, and improve the implementation of ASRH best practices. Grantees also partner with local youth-serving organizations (e.g., juvenile justice organizations, foster care agencies) to create policies and procedures to promote screening and referral of young people to ASRH services. The youth-serving organization component of the project will be described elsewhere.

We identified TAQ ASRH best practices through a previously described process [42], with updates based on current clinical guidelines and recommendations [18, 27, 30, 46] and lessons learned in the 2010–2015 communitywide initiative [47]. Best practices address the following five areas: Structure, Tasks: Nonclinical Staff, Tasks: Clinical Staff, Supporting Youth-Friendly Best Practices, and Client Outreach (Fig. 1).

Grantees partner with a national ASRH training and technical assistance provider, Cicatelli Associates Inc. (CAI), to identify and address common gaps in the implementation of best practices. To support this work, CDC and CAI developed the TAQ Adolescent Sexual and Reproductive Health Framework (Fig. 1), which is informed by implementation science [48–51] and provides a process for grantees and partner health centers to effectively implement, measure, improve, and sustain ASRH best practices.

Implementation science literature [48] describes discreet implementation phases: assessment, preparation, initial and full implementation, and sustainment. Each TAQ framework phase (Fig. 1) addresses drivers that help health centers move through each phase toward sustainment. For example, in Phase 1, health center adoption of ASRH as a quality improvement initiative is the foundation that facilitates later tasks, such as allocating staff training time.

Through a literature review, ASRH implementation drivers were identified [51]. Drivers occur at the organizational level (e.g., leadership commitment to ASRH policies and procedures to support best practices), staff level (e.g., skills and motivation to deliver quality contraceptive counseling), and client level (e.g., client awareness, satisfaction). Drivers also occur at the community level (e.g., state minors' rights policies), but these are beyond the scope of this project and not included in the framework.

Health centers were asked to develop a change leadership structure [52–54], which involves a site-level, multidisciplinary quality improvement team; a change agent who works with leaders who have the authority to ensure sufficient resources for program improvement; and site-level mentors to provide coaching to colleagues throughout the improvement process.

Needs assessment surveys were developed with grantee staff to gather baseline and annual data to guide training and technical assistance for partnering health centers. The Health Center Organizational Assessment (Online Appendix A) measures organizational policies and practices that support ASRH best practices and includes a section for the health center and its respective practice settings. The Health Center Provider Survey (Online Appendix B) assesses provider knowledge, attitudes, and practices associated with TAQ framework best practices. Youth surveys measure youth satisfaction with health center services and client-centered approaches. Youth surveys were not implemented until the second year and are not included in this study.

CAI developed a tailored staff training curriculum for each community, delivered through web-based or cluster training. Training topics included improvement science, adolescent development, confidentiality, and minors' rights. Core training for clinicians included contraception methods, client-centered contraceptive counseling, LARC insertion/removal, management of LARC side effects, and STD/HIV screening and treatment. For nonclinical staff who provide contraceptive counseling, training included client-centered contraceptive counseling, contraceptive methods, and common contraception myths. For front-line staff, training included how to provide basic and factual information about adolescent reproductive health services availability.

CAI trained select staff from each grantee organization to act as Practice Facilitation Coaches (PFCs) for each health center. The PFC model has been described as a key component of translating research findings into practice [55–57].

Data Collection

Participants—All eight health center partners of the grantees responded to the Organizational Assessment. Four identified as FQHCs, two as community health centers, two as local or state health departments, and two as family planning clinics. (Two chose more than one category.) Combined, there were 16 practice settings within these health centers: seven were primary care or family practice settings, four were family planning settings, three were pediatric settings, and two were obstetrics/gynecology settings. All providers (N = 58) in the participating practice settings were invited to complete a Provider Survey. Forty-five providers, from seven of the eight participating health centers, responded to the baseline Provider Survey. One health center did not participate in the survey until the second project year because it joined slightly later than the other health centers.

Data Collection Procedures—Baseline data collection occurred during each health center's period of planning and initial training. The primary contact at each health center completed the Organizational Assessment, with assistance from the appropriate staff (e.g., medical director, finance staff). Similarly, grantees provided their health center contact with copies of the Provider Survey, which the contact distributed to providers (e.g., family physicians, general practitioners, internists, obstetricians/gynecologists, pediatricians, other specialty physicians, nurse practitioners, physician assistants, certified nurse midwives). Providers completed the survey anonymously and returned it to the primary contact, who

returned the surveys to the grantee. Initially, providers were asked to complete the survey online and some did so, but there was a strong preference for completing it on paper.

Measures and Statistical Analysis—The Organizational Assessment consisted of questions developed for the TAQ initiative, as well as items taken or adapted from a similar questionnaire used for the 2010–2015 communitywide initiative [36] and a 2013 survey of administrators of publicly funded health centers that provide family planning [58]. A collaborative process between CDC, grantees, their partners, and CAI to develop the Organizational Assessment involved iterative drafting and revision to account for grantee and evaluator needs. The Provider Survey consists of questions taken or adapted from a 2013 survey of health care providers [59] and questions developed for the TAQ initiative. A similar collaborative process between CDC, grantees, their partners, and CAI was followed to develop a survey that met grantee and evaluator needs.

We focus on the results from four key ASRH best practice categories: structure, tasks for nonclinical staff, tasks for clinical staff, and supporting youth-friendly best practices. Our selection of these (Table 1) was based on their relevance for teen pregnancy prevention in evidence-based contraception guidance [18, 27, 30], sexually transmitted disease treatment guidelines [46], or stated importance among adolescents in published literature [13]. (Appendices C and D display the selected questions from the Organizational Assessment and Provider Survey, respectively.) We combined clinical and nonclinical staff tasks because they often overlap in clinical practice. We present frequency counts and percentages, calculated using SAS version 9.4.

Results

Structure

Trained Staff—In the Organizational Assessment, we assessed the number of practice settings that had limited training for all staff (e.g., doctors, nurses, health educators, medical assistants) for several key topics. “Limited Training” was defined as less than half of the staff being trained in the topic in the past year. Ten of the 16 practice settings had limited training on ensuring that adolescent clients had time alone with providers and on adolescent development. Eight had limited training on confidentiality and minors’ rights. We also assessed the number of practice settings that had limited training for clinical staff. Eight had limited clinical staff training on client-centered birth control counseling. Ten had limited clinician training on LARC insertion and removal and 11 had limited training on managing LARC side effects (Table 2).

For each training-related question discussed here from the Provider Survey, the number of responses varied, ranging from 37 to 38 of 45 total survey respondents (Table 3). Fewer than half of respondents to the Provider Survey reported that they had been formally trained in the insertion and removal of LARC methods (37% in copper IUD, 38% in hormonal IUDs, and 41% in implant). Among respondents who reported that they had not provided implants (N = 17) and IUDs (N = 16) to nulliparous adolescents in the past year, *not being trained in insertion* and *not feeling comfortable inserting* were among the main reasons (Table 4).

LARC Availability—Among the 16 practice settings that responded to the Organizational Assessment, four reported that one or more hormonal IUD was currently available in the practice setting, four reported that the copper IUD was available, and nine reported that the implant was available. Among respondents to the Provider Survey who reported not providing implants (N = 17) or IUDs (N = 16) to nulliparous adolescents in the past year, *My practice does not provide the method* was among the main reasons (Table 4).

Addressing Client Cost Barriers (Financing, Reimbursement, Payment Options)—In the Organizational Assessment, five of eight health centers reported that at least half of their adolescent clients paid for visits using Medicaid or other federal or state assistance (data not shown). Seven health centers reported that they offer free or sliding scale services to any adolescent, had participated in the federal 340B drug discount program, had systems in place to facilitate billing third-party payers, and had provided hormonal contraception to adolescents regardless of their ability to pay (Table 5). Four of the health centers were receiving federal funding from the Title X Family Planning Program, provided IUDs and implants regardless of adolescents' ability to pay, and offered a low flat fee for any adolescent (Table 5).

Tasks: Clinical and Nonclinical Staff

Responses to questions on the Organizational Assessment (Table 6) indicated that 12 of the 16 practice settings often/always provide time alone at every visit (*ensuring time alone*), 11 often/always conduct sexual health assessments (i.e., assessment of sexual activity, current and future contraceptive options, sexual partners, condom use and protection from STDs, and past STD history) (*identifying sexually active adolescents*), and 11 often/always assess adolescent pregnancy/fatherhood intentions or risk (i.e., asked about intentions regarding timing of pregnancies or reproductive life plan) in the context of their personal values and life goals (*explore pregnancy intentions*).

To *provide information about all FDA-approved birth control methods and assist client in birth control selection*, 12 of 16 practice settings often/always present information on a wide range of contraceptive methods approved by the US Food and Drug Administration (FDA). They present the most effective methods first, then discuss how well each method meets the client's needs. Thirteen practice settings often/always let their clients know that IUDs are safe for adolescents, 13 often/always offer contraception to sexually active clients at every sexual health visit, and eight often/always offer contraception at nonsexual health client visits (e.g., primary care visit).

In terms of *providing comprehensive STD/HIV prevention information/messages*, 14 of 16 practice settings often/always educate on abstinence and 15 often/always educate on dual protection to prevent pregnancy and STDs. All 16 practice settings often/always conduct STD screening annually and 15 often/always offer HIV screening, addressing the *provide STD/HIV screening/diagnostic testing and treatment per CDC guidelines* best practice.

For the *review method use and anticipated side effects and ensure understanding* best practice, 11 of 16 practice setting often/always help clients think through potential barriers to their adopted contraceptive method. Twelve of 16 often/always provide another

contraceptive method to use when the client cannot start the chosen method right away (*offer bridge method if needed*), and 15 often/always offer same-day contraceptive services to adolescents who have a negative history and negative pregnancy test and do not want to become pregnant (*provide method same-day*).

Of the 15 practice settings that responded to the question about using the quick start approach for contraceptive initiation (*provide method same day*), eight often/always offer quick start for the pill, patch, ring, or Depo; two often/always offer it for the IUD; and three often/always offer it for the implant.

Supporting Youth-Friendly Best Practices

Confidentiality—According to the Organizational Assessment, four of the eight health centers consistently informed minors at every visit about state laws governing minors' rights to consent to sexual and reproductive health care or treatment, four reported consistently informing clients of the center's confidentiality policies verbally, and two informed clients of the center's confidentiality policies in writing (Table 7). Six health centers reported that they had billing procedures to ensure confidentiality (data not displayed).

Convenience—Among the 16 practice settings, 14 offered walk-in appointments, 15 offered same-day appointments, 14 offered afterschool hours, and five offered weekend hours (data not shown).

Discussion

The publicly funded health centers participating in the TAQ initiative had implemented several best practices for ASRH services at baseline, including screening for STD/HIV infection, providing education on abstinence and dual protection for the prevention of pregnancy and STDs/HIV infection, offering contraception to sexually active clients at every sexual health visit, and informing clients that LARC methods are safe for adolescents. Most reported offering after-school hours, walk-in and same-day appointments, and same-day contraception to patients with a negative pregnancy test. Tailored training and technical assistance are focusing on sustaining these best practices, and routine data collection is being used to help health centers monitor implementation.

The needs assessment process also identified several opportunities for improvement. Few practice settings were using the quick start approach for initiation of LARC contraception. Our data concur with other studies [60] that have found low levels of quick start contraceptive initiation at publicly funded health centers, despite recommended guidelines [61] that recognize its potential to reduce unintended pregnancy. Only eight of 15 practice settings reported offering contraceptive services at nonsexual health visits (e.g., sick visit or sports physical). These findings demonstrate potential missed opportunities to provide ASRH for adolescents visiting the health center, as they may not return for another visit. Technical assistance to address these missed opportunities includes training staff to be able to operate at the top of their license. For example, training of medical assistants or health educators to conduct contraceptive counseling could give clinical providers more time to conduct the needed medical procedures without impeding other scheduled appointments.

Although six of eight health centers reported practices to ensure confidentiality in billing procedures, other efforts to ensure confidentiality (i.e., informing minors at every visit about state consent laws and health center confidentiality policies) were less common. As a result of these findings, the TAQ initiative focused on training to ensure that providers understand their state and federal consent and confidentiality laws for adolescent health care delivery and that they can communicate this information to parents and adolescents. Technical assistance to help develop communication materials that relay information about confidentiality and consent to parents may also be beneficial.

Limited LARC availability was a key reason providers cited for not providing a LARC method. As a result of this finding, health centers received training and technical assistance to help them focus on logistical barriers (e.g., purchasing and stocking methods) and client cost barriers. Health centers also received training to help them increase their use of the federal Health Resources and Services Administration's 340B Drug Pricing Program to buy devices at reduced costs and to help them improve their systems to maximize third-party payer reimbursement.

Among Provider Survey responses, two other main reasons for not providing LARC were not being trained in insertion or not being comfortable inserting LARC devices. Although insertion and removal of LARC devices is a key focus of trainings, misperceptions about the safety of LARC for adolescents and other reasons for provider discomfort are also covered. The TAQ initiative also provides training on client-centered counseling to ensure reproductive autonomy and to assess adolescents' preferences for certain contraceptive methods [28, 29]. Youth surveys were conducted annually beginning in the second year of the initiative to assess patient satisfaction with the contraceptive counseling and selection process.

Although these assessments provided valuable information to guide the TAQ initiative and its training and technical assistance, they have some limitations. Certain items on the assessment responses were missing data. The assessments used self-reports of best practice implementation, not clinical records data. They also focused primarily on the health center perspective and do not illuminate the perspectives of adolescent clients on service quality and access. Findings from the youth survey are not discussed here, but are being used to guide training and technical assistance in the TAQ initiative overall.

Another limitation is that our assessments did not collect information on specific barriers and facilitators to quality improvement. For example, establishing a change leadership team and ensuring leadership support for site-level mentors to provide staff coaching have been identified as essential for successful innovation in clinical settings [52–57]. Collecting metrics on quality improvement practices like these could advance the field by documenting implementation successes and challenges that may affect the successful adoption of ASRH best practices and, ultimately, ASRH outcomes. Similarly, the capacity of health centers to systematically collect, review, and report reliable data on a regular basis was not assessed at baseline, yet such capacity plays a critical role in the ability to evaluate the extent to which high-quality ASRH services are being implemented. Assessing and bolstering this capability

is vital for ASRH quality improvement initiatives and warrants a focus in future research and programmatic efforts.

Quality ASRH services play an important role in supporting the overall health of adolescents. Improving access to this care can help reduce unintended pregnancies, STDs, and HIV infections and their associated consequences [7, 8] and promote health equity. Publicly funded health centers are particularly well-suited to offer ASRH care to adolescents who might otherwise lack access to these types of core preventive services because they are mandated to provide care to low-income and medically underserved populations [62]. In 2018, these health centers served over 2.1 million adolescents aged 15–19 years, making them a prime source for meeting the reproductive health care needs of this population [63]. Our study identifies strengths to build on and opportunities for improvement among publicly funded health centers. CDC, CAI, and grantees are using this information to provide training and technical assistance tailored to each health center’s unique context, strengths, and identified gaps, which is essential for implementing and sustaining ASRH best practices.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

Funding

This study was funded by National Center for Chronic Disease Prevention and Health Promotion (Grant No. CDC-RFA-DP15-1508).

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Fig. 1.
TAQ Adolescent Sexual and Reproductive Health Framework

Selected best practices from the TAQ Adolescent Sexual and Reproductive Health Framework

Table 1

Category	Selected best practices
Structure	<ul style="list-style-type: none"> Trained staff LARC availability Client cost barriers
Tasks: nonclinical and clinical staff	<ul style="list-style-type: none"> Ensure time alone at every visit Identify sexually active adolescents For adolescents who do not want to be pregnant or are unsure: <ul style="list-style-type: none"> Explore pregnancy intentions Provide accurate and unbiased information about all FDA-approved birth control methods Assist client in birth control selection Provide comprehensive STD/HIV prevention information/messages Provide STD/HIV screening/diagnostic testing and treatment per CDC guidelines Review method use and anticipated side effects and ensure understanding Provide method on the same day, reschedule or refer, or offer bridge method if needed
Supporting youth-friendly best practices	<ul style="list-style-type: none"> Confidentiality Convenience

Table 2Number of practice settings with limited training^a in each topic, by staff type (N = 16)

Topic	Number of practice settings with limited training
All staff	
Time alone	10
Adolescent development	10
Confidentiality/Minors' rights	8
Clinical staff	
Client-centered birth control counseling	8
LARC insertion/removal	10
Managing LARC side effects	11

^aDefined as less than half of staff being training in the topic in the past year

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Number of providers reporting they had been formally trained in the insertion and removal of a LARC method

Table 3

Contraceptive method	Number responding to this question ^a	Number (%) reporting yes
Copper Intrauterine Device (Cu-IUD or P araGard®)	38	14 (36.8)
Levonorgestrel-releasing Intrauterine Device (LNG-IUD LILETTA™, Skyla® or Mirena®)	37	14 (37.8)
Contraceptive implant (Implanon®)	37	15 (40.5)

^a 45 providers completed survey

Table 4

Number of providers reporting not providing method for this reason

Reason	Number staff reporting no for this reason	Number staff reporting no for this reason
	Implant (N = 17 do not provide)	IUD (N = 16 do not provide)
Adolescents are more likely to have it removed within a year of insertion, compared to adults	0	0
My practice/health center protocol does not allow it	0	0
I am concerned about recommending the method for adolescents	1	3
I am concerned about the effects on future fertility	1	1
Providing adolescents with this method makes them less likely to use a condom	1	1
I am concerned about difficult insertion	2	3
There are financial-related issues with billing, coding, and reimbursement processes that make the process very difficult	2	2
I rarely have nulliparous adolescents as patients	3	2
My nulliparous adolescent patients generally prefer a different method	3	5
Other	3	2
I do not feel comfortable inserting this method	8	9
My practice does not provide the method	10	9
I am not trained in insertion of this method	10	9

Table 5

Number of health centers reporting specific best practices

Best practice	Number of health centers reporting practice (N = 8)
Participate in the federal 340B Drug Pricing Program	7
Have systems in place to facilitate billing third-party payers for family planning services	7
Offer free services or a sliding fee scale for any adolescents	7
Offer a low flat fee for any adolescents	4
Provide IUDs and implants to teens regardless of their ability to pay	4
Provide other forms of hormonal contraception to teens regardless of their ability to pay	7
Receive federal Title X Family Planning Program support	4

Practice settings that reported often/always engaging in identified best practices (N = 16 practice settings)

Table 6

Practice	Number practice settings reporting often/always
Quick start IUD after negative pregnancy test ^a	2
Quick start implant after negative pregnancy test ^a	3
Offer contraception every non-sexual health visit ^a	8
Quick start pill, patch, ring, depo after negative pregnancy test ^a	8
Assess pregnancy/fatherhood intention	11
Help think of barriers to using selected method	11
Conduct sexual health assessment	11
Present information on wide range of contraceptive methods	12
Provide another contraceptive method until patient can start the chosen method	12
Provide time alone at every visit	12
Inform that IUDs and implants are safe for adolescents	13
Offer contraception every sexual health visit ^a	13
Educate on abstinence to prevent pregnancy and STDs in all counseling	14
Educate on dual protection to prevent pregnancy and STDs in all counseling	15
Offer same-day contraceptive services to adolescents with negative pregnancy test	15
Offer HIV screening annually for sexually active teens	15
Offer STD screening annually for sexually active teens	16

^aFifteen practice settings responded to questions

Table 7
 Number of health centers reporting often/always following selected best practices

Best practice	Number of health centers reporting often/always (N = 8)
Inform at every visit about rights of minors to consent to sexual and reproductive health services	4
Inform verbally of confidentiality policy at every visit	4
Inform in writing of confidentiality policy at every visit	2