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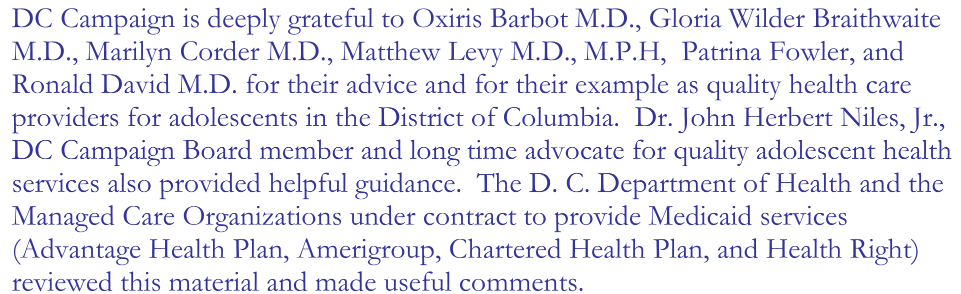
DC Campaign to Prevent Teen Pregnancy®

NOT YET ADULTS

A Manual of Adolescent Health Care for District of Columbia Providers

July 2003



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FORWARD

The mission of DC Campaign to Prevent Teen Pregnancy is to cut the District of Columbia teen pregnancy rate in half by 2005. Our work promotes a new conversation in the District about the factors that protect teens from pregnancy. Research[1] suggests that teen pregnancy is less likely when boys and girls, regardless of income or race: feel strongly connected to their parents or other caring adults; experience success in school from an early age; make a clear plan; have a sense of belonging; have safe places to learn and fun things to do; and have easy access to teen-friendly, comprehensive health care services.

The exceptionally high rate of teen pregnancy in the District of Columbia presents a serious health hazard because of the connection between early child bearing, school failure, persistent poverty and poor pregnancy outcomes. Teen mothers are more likely than older mothers to experience poor health, to have less pre-natal care, and to have a higher percentage of low birth weight babies, leading to later health vulnerabilities for their children. Teen pregnancy takes a toll on young parents, their children and the city.

As young people become adults, age appropriate health care can reduce risky behaviors and unwanted pregnancies and create sound health care practices. Therefore, public and private health care providers have a special obligation to reach out to adolescents to provide health care education and preventive services.

Quality health care can help adolescents postpone pregnancy and lead healthier lives. Yet, adolescents use health care services less than any other age group.[2] In order to change this situation, DC Campaign consulted extensively with numerous sources. These sources include: experienced adolescent health care physicians in the District, the D.C. Department of Health, Medicaid Managed Care Organizations (MCOs), parents, and teens. Their recommendations serve as the basis for this easy-to-use manual.

This manual is designed for physicians, administrators and managed care organizations that are, or could be, delivering health care to adolescent patients. Nationally recognized guidelines for comprehensive adolescent health care and information about practices that create effective health services for adolescents appear in an accessible format. This manual recommends how adolescent services should be made available, and offers specific tools and resources to use with adolescent patients.

[1] National Campaign to Prevent Teen Pregnancy. (May 1997.) Whatever Happened to Childhood? The Problem of Teen Pregnancy in the United States. Author: Washington, DC.
[2] Center for Disease Control., *National Ambulatory Care Medical Survey*, 2001. National Center for Health Statistics.

I. INTRODUCTION

Adolescents, regardless of their age, gender, marital status, race, or socioeconomic level, should receive quality, comprehensive, preventive health care services that are appropriate to their developmental stages. A public health care strategy that provides effective education and care to adolescents can help them lead healthier, longer and more productive lives.

- Many of the major health problems faced by adolescents nationwide are preventable conditions. Proper health care can mitigate the toll in preventable deaths and morbidity, and save health care system costs.

- One in three children under 18 in the District lives under the federal poverty threshold. These young people, and children of other low and moderate-income households, are especially vulnerable to stress, poor nutrition, substance abuse, depression, and other related conditions. While the obstacles caused by poverty are not easily overcome, an investment in the health of adolescents can make a difference.

- Many life threatening health conditions occur in adolescence, and can be reduced by relatively inexpensive health education and support. For example, each year, almost one quarter of newly diagnosed HIV infections and other STIs are among teenagers.

- Good health habits established in adolescence can forestall many chronic and untreated health problems that would otherwise lead to unnecessary morbidity and early mortality, which have proven very costly to the private and public health care systems. Teens who learn to use health care effectively are more likely to continue that practice into adulthood.

Families, schools and governments are essential in encouraging adolescents to use health care effectively and in providing sites and resources to make that possible. ***However, health care providers have an especially important role to play.***

II. A PICTURE OF ADOLESCENT HEALTH IN THE DISTRICT OF COLUMBIA

Many factors contribute to the current health status of DC teenagers. Some of which are common to young people nationwide. Others are exacerbated by higher than average rates of poverty and the lack of accessible health care services that affect District adolescents, especially low-income youth.

The District of Columbia has one of the highest death rates in the United States. Diseases such as hypertension, diabetes, obesity, HIV/AIDS, depression and addiction, which are associated with lifestyle conditions, can be prevented or controlled by early attention.

"Poverty … is the single most important factor correlated with poorer access to health care and health status of adolescents."[3] A significant portion of the negative health conditions facing adolescents in DC is associated with high rates of poverty and its consequences. The U.S. Census Bureau 2000 Survey statistics reported in *Every Kid Counts in the District of Columbia 2002* show that 31.7 percent of all children under 18, nearly one child in three, lives below the poverty threshold,[4] which equates to more than 36,000 children. Associated with poverty, is the additional risk factor that over 60 percent of children in the District live in families headed by a single parent.

Studies of adolescent health status are now generally based on recognition that while most teenagers appear healthy, their risk-taking behavior can have long-range medical and psychological implications. The Centers for Disease Control and Prevention (CDC) identified six categories of risk-taking behaviors as being responsible for a large percent of adolescent mortality, morbidity, and social problems. The six categories are:

1. unintentional injury and violence,
2. tobacco use,
3. alcohol and other drug use,
4. sexual behavior,
5. dietary behavior, and
6. physical inactivity.

The CDC national Youth Risk Behavior Survey (YRBS) measures the prevalence of such risk-taking every two years. The 2001 survey of 1,400 District high school students indicate an alarmingly high rate of risk across the board.
(See Appendix 6)

[3] Ozer, E.M., Brindis, C.D., Millstein, S.G., Knopf, D.K., & Irwin, C.E., Jr. (1998). America's adolescents: Are they healthy? San Francisco, CA: University of California, San Francisco. National Adolescent Health Information Center. P.9
[4] Every Kid Counts in the District of Columbia: Ninth Annual Fact Book 2002. Washington DC: D.C. Children's Trust Fund

This research correlates with much of what we know about District youth. Adolescents are suffering from high rates of drug, alcohol and tobacco use, violence, involvement in the criminal justice system, teenage pregnancy and parenting, sexually transmitted infections, poor nutrition and malnutrition, and mental health problems.

Sexually transmitted diseases, for example, represent a significant health problem among teenagers in the District and nationwide. While gonorrhea and syphilis, two of the most common sexually transmitted diseases, have declined in recent years, chlamydia is rapidly spreading, and is the leading cause of sterility among women. In 2001 there were 1,331 reported cases of chlamydia in young people under 20 years of age.[5]

In spite of this overwhelming need for health care and education, adolescents continue to be the least frequent users of health care services of any age group. In general, adolescents see providers in brief, specific problem-related visits that do not result in adequate prevention and education oriented care. A change in this pattern could make an enormous difference in the health of young people now and in their futures.

The barriers to health care commonly associated with adolescents, in addition to the lack of insurance coverage include: lack of experience navigating the health care system, doubts about confidentiality of services, inconveniently located services, fragmentation of services, scheduling or appointment problems, co-payment requirements, and transportation. These factors affect all teenagers regardless of economic status, but can be more extreme for many low-income teenagers.

Beyond these systematic problems lie other personal issues. The lives of some adolescents are mired in circumstances that seem beyond their abilities to control. Social, environmental, and economic pressures may cause medical symptoms. The provision of comprehensive preventive services can help to overcome these negative impacts only when health care providers take the opportunity to get to know their patients, help them deal with these issues, and identify caring adults who can help them through these critical developmental stages.

Working with adolescents is a specialized matter. Some of the problems that adolescents face: reproductive health needs, abuse by adults, suicidal thoughts, and substance abuse, are hard to discuss and can even lead to legal complications. When these problems are not addressed, however, the results are costly: teen pregnancies, STIs, suicides, violence, and chronic adult health problems.

Health care providers cannot be the only "first responders," but they stand in a critical position to make a difference.

[5] Ibid

III. KEY COMPONENTS OF AN ADOLESCENT-SPECIFIC HEALTH CARE MODEL

In many places in the District, health services are already organized to attract and treat adolescents in a high quality manner. National expertise is also available, and some of the resources are listed in the Appendix of this report. Age-appropriate preventive care is the starting point, and nationally accepted guidelines are referenced in the next section of this report. But experience makes it clear that in the absence of certain **key elements** of health care service delivery, clinical care will not be effective and many adolescents will not seek it.

A. Confidentiality

The issue of confidentiality is of utmost importance for many teens and needs to be taken very seriously. For a variety of reasons, many teens feel unable to share their need for medical services with a parent or guardian. Fear that a visit will be reported prevents many teens from accessing services and obtaining needed care.

The laws regarding confidentiality of services for adolescents need to be fully understood by all staff and explained accurately to both patients and parents or guardians. A recent study of 210 Washington-area doctors' offices by researchers at Johns Hopkins University revealed that information about confidentiality policies given over the phone by office staff conflicted with physicians' written accounts of those policies in as many as 63 percent of practices. Co-author Tina Cheng warns that "such confusion may have a chilling effect on teens seeking help with contraception and pregnancy issues, substance abuse and sexually transmitted diseases."[6]

Confidentiality should be discussed during the first visit with the patient as well as with the parent or guardian. It is important to clarify to both the adolescent and the parent that all information obtained during the medical visit will remain confidential with the exception of any information deemed harmful or life threatening to the adolescent or others. Understanding these boundaries will reduce or eliminate future conflicts over the sharing of information.

Putting this recommendation into effect should include:

- A written policy on confidentiality and a separate policy on parental consent requirements, in the language spoken by patients and their parents or guardians, should be available in every waiting room and specifically given to all new patients and their parents or guardians at the time of the first visit.

[6] Akinbami, L., Gandhi, H., & Cheng, T., *Availability of Adolescent Health Services and Confidentiality in Private Practices*, Pediatrics, February 2003. Quotation from *Washington Post*, February 25, 2003

- A sample *Youth Bill of Rights,* such as the one in Appendix 4, should be posted in the waiting room and examination rooms to give adolescent patients a clear message about the commitment to adolescent health.

- Continuing education on confidentiality as part of all staff training requirements.

- Paying attention to billing procedures and copies of insurance claims that should not be sent to home addresses without the permission of the patient. This issue should be discussed with the patient in advance. Some may prefer to pay the bill themselves over time, or may want a referral to a free clinic.

Confidentiality requirements need not preclude talking to parents about important issues and recommendations, with the knowledge of the adolescent client. Engaging parents without violating confidentiality is one of the challenges of adolescent care for which training and explicit guidelines are important.

B. Consent

There are clear written guidelines which govern the medical and non-medical services that require parental consent and which do not. Federal and state laws are shaped by decisions of the Supreme Court. In the District of Columbia the following consent privileges prevail:[7]

Minor authorized to consent for	Contraceptive Services Prenatal Care STI/HIV Services Treatment for alcohol and/or drug abuse Outpatient mental health services Abortion services Medical care for child Placing child for adoption
Minor may not decide to	Drop out of school
Required reporting	Evidence of physical or sexual abuse[8] Suicide or homicide ideation or threats Gun shot or knife wounds Reportable communicable diseases[9]

Consent privileges and consent requirements, like confidentiality requirements, should be an ongoing part of staff training.

[7] The Alan Guttmacher Institute, *Minors and the Right to Consent to Health Care.* Issues in Brief, 2000 Series, No.2. The Allan Guttmacher Institute, New York and Washington
[8] Further guidance on reporting sexual or physical abuse is contained in Appendix 7
[9] Note that communicable diseases must be reported to health authorities, but not necessarily to parents

C. An Adolescent-Friendly Environment

Waiting rooms send a message. Offices or clinics can make teens feel welcome by having posters, teen magazines and informative brochures on display. Young men in the District report that they are put off by pediatricians' offices that seem geared entirely to maternal and child health with décor, including toys or color schemes that appeal to infants. Small inexpensive changes can make a difference.

D. Staff

In addition to developmental changes, many social, cultural, and environmental factors are at play in the lives of adolescents that directly affect their health. All staff that a client encounters need to be aware of the psychosocial issues that surround many adolescent problems.

First Impressions Matter

Receptionists, for example, can understand that adolescents are frequently nervous or reluctant about seeing a provider, and can set a tone of welcome. They can offer written policies on confidentiality and consent to reassure teens. Nurses and lab technicians can take a few extra minutes to explain first time tests. Young people want to be treated with respect, even if their behavior may appear challenging.

Everyone Has a Role

All health care providers involved in an adolescent's life (physicians, social workers, nurses, psychologists, psychiatrists, counselors, dentists) should be prepared to discuss risky behaviors, observe potentially negative patterns of behavior and provide the necessary education and referrals to encourage changes in behavior. Communication skills are not necessarily taught in medical school, MCOs should consider training in effective interviewing and counseling.

A Doctor Who Cares about Adolescents

Many pediatricians prefer to work with babies and young children. MCOs need to be sure that they have sufficient providers who want to work with teenagers, and have the necessary comfort level and a teen-friendly practice.

The physician must have knowledge of other resources to offer during clinic visits. Many adolescent concerns call for other professionals (e.g.. mental health professionals, social workers, nutritionists) that are available for consultation.

Specialized Staff

A staff that understands and is comfortable working with adolescents will result in more adolescent patients willing to seek services and share the necessary information to make the comprehensive health visit as hassle-free as possible. Assigning a dedicated or particular staff person to operate teen clinics and other teen services would encourage teens to develop an ongoing relationship with health care providers, which would in turn promote continuous use of health care services and develop a pattern of preventive health care maintenance.

Ideally, an adolescent patient should have at least one provider who knows all of their health issues, and can coordinate care. Having a "medical home" is always important in primary care, and especially in establishing a trusting relationship with teenagers.

Staff Training

Continuous training for all staff should include information and educational materials on issues and topics relevant to adolescent health such as adolescent development, consent for services, confidentiality, sexually transmitted diseases, reproductive health and contraception, mental health and depression, suicide ideation, sexual orientation, physical and sexual abuse, violence, and community referral sources for teen services.

Beyond the factual information, training should concentrate on how to work with adolescents in building trust, rapport, respect, cultural sensitivity, and a healthy provider-patient relationship. DC Campaign to Prevent Teen Pregnancy offers a curriculum and workshop for adolescent health providers and staff entitled, "Talking to Teens About Love, Sex, and Relationships" that has proven effective.

Culturally Appropriate Staff

Staff diversity in terms of race, ethnicity, and gender that reflects the patient population also provides another avenue to connect with adolescent patients. It builds another level of trust and confidence in the services offered. By implementing the staff diversity, service providers will be effective in reaching teens and providing health services in the least threatening manner.

E. Hours and Scheduling

In order to reach out to adolescents, there may need to be appointment times set aside for them. Because of school schedules and after school activities, teens often require appointments outside of normal school hours such as late afternoons and weekends. Scheduling teen clinic hours a couple of afternoons or evenings a week or on Saturdays would carve out specific times for teens to access the health facility.
As teens may be less likely to call weeks in advance to schedule an appointment, offering many flexible methods for making appointments such as walk-ins and teen hotlines or advice lines that offer scheduling options, would increase adolescent health visits.

F. Getting to Know the Patient

Initial Visit

In a first office visit, an adolescent is likely to be accompanied by a parent or guardian. This may be the first time that a clinician suggests meeting first with the patient and parent together, then with each alone. The patient may be nervous in the first encounter alone. Initially, parents often feel surprised as their child is being transitioned towards autonomy. They too need reassurance that they will be an active and crucial part of the child's care. This is a good time to have a

conversation about confidentially and consent for health care services. Finally, at the end of the visit it is generally helpful to bring the parent and patient together again for any concerns or questions.

Patient History

The interview is not only the primary vehicle for assessing the health and risk factors of the teen, but is also serves as a means of building rapport and a relationship between the clinician and the teen. Prefacing questions with "I ask these questions of all my patients" can help to reassure the teen that he/she is not being singled out for questioning due to the way they look or any prior answers they may have given.

Time should be allowed with all new adolescent patients for a complete medical and family history. Some providers find that this is easier to accomplish this by means of a preprinted form filled out in private. There are sample guided history techniques available, such as the "HEADSS" check up form.[10] Whatever guide is used, it should cover important information and behaviors including: home & family, education & school, activities & associates, drugs, alcohol & cigarettes, sexuality & sexual activity, exercise & nutrition, suicide & depression, safety, violence & abuse.

The interview with the patient alone is the time to seek information beyond just the presenting illness or need. Even a sports physical visit can provide an opportunity to take a complete history, and establish the basis for ongoing preventive health care.

G. Health Education and Prevention

An ongoing component of a health visit ought to be at least a brief conversation aimed at increasing the adolescent's knowledge of good health practices and available resources. In national research studies, adolescents report that many doctors do not provide any counseling or education in their visits. Very few discuss pregnancy or STI prevention. Opportunities are lost to reassure teens about normal physical and psychosocial changes and advise them about what to expect. Teaching young people to do routine breast and testicular exams can establish good lifetime patterns. Exploring school progress, mental health or depression, and gender identity can often open up topics of great concern to adolescents who may have no other adults with whom they can confidentially discuss such matters.

Approaching teens on sensitive subjects of reproductive health and substance abuse requires some skill and patience. It is often useful to begin with general matters, and ease into sensitive issues. Direct questions without particular definitions (Are you having sex? Do you use drugs?) are usually less effective than using open-ended questions. Helping adolescents describe their sense of what is right or wrong, and with problem solving, can be advanced in a health care visit. Some physicians find it helpful to have a teenager fill out a questionnaire.

[10] Complete definition can be found in Lawrence S. Neinstein, Adolescent Health Care (2002), Lippincott Williams & Wilkins Publishers

Whether or not a patient brings up topics of concern, providers can have on hand written material on common issues: nutrition, reproductive health, exercise, and emergency contraception. Emphasizing health education during the visits is vital and can help to reduce or eliminate the burden of preventable diseases in the long-term. Encouraging the patient to read material, and ask questions about it at another visit may help in raising awkward issues.

H. Coordination With Other Health and Social Service Providers

Other health, social service and education programs are frequently essential to meeting the physical and mental health needs of adolescents. Coordinating care, or at least maintaining a useful referral system, should be part of a health care provider's responsibility. This referral system should not be limited to specialized care information, but include referrals to address wider social and economical challenges the teen may experience. Uninsured patients may be eligible for a public program, or for family income assistance. Referrals to Title X family planning clinics, Title V maternal and child health services, or substance abuse or HIV programs may be appropriate. Physicians can help teens make use of counseling and educational resources offered by community organizations, or special education or developmental disabilities resources.

I. Outreach

Word of mouth is still the most effective form of outreach. Ask your adolescent patients to tell their friends about your practice. Clinics can also let adolescents know they are welcome by making available inexpensive written summaries of services, costs of services, and appointment procedures, which can be distributed at health fairs, schools, neighborhood organizations and churches.

Establishing a collaboration or referral network with community-based organizations can play a major part in outreach efforts. Reaching out to teens through established and trusted relationships makes the information about services available in an atmosphere in which teens are comfortable.[11]

Health care systems in general are not often geared toward the special needs of adolescents. Providers, and especially MCOs, can review many aspects of their services to be sure they are doing everything possible to meet the needs of young people. A comprehensive checklist prepared by the National Adolescent Health Information Center is a useful tool for self-assessment by MCOs (Appendix 1).

[11] E.g. the Latin American Youth Center maintains links to the Unity Health Care clinic at Upper Cardoza, Health Street, to encourage regular attendance of their teen members.

IV. ACCESS TO HEALTH CARE

A. Paying for Health Care

Teenage children of working parents sometimes have private health insurance. Many others are eligible for Medicaid participation.

In 1997 Congress established the State Children's Health Insurance Program (SCHIP) to nationally respond to the large number of uninsured children. It allowed states to enroll children under age 19 in families up to 200 percent of the poverty level in subsidized health insurance. The District of Columbia, like most states, chose to add these children to the Medicaid rolls. Young people covered by Medicaid are entitled to the full range of medical services, including reproductive health and family planning services.

In the District, there are about 115,000 children under 18 years of age. Studies indicate that about 60,000 of them are eligible for regular Medicaid or the SCHIP program. In 2002 the District Medicaid office reported an enrollment of over 66,000, including 18 year olds and some disabled children above the income thresholds.[12] Estimates suggest that private insurance covers many of the remainder, but that about 14,000 children are still uninsured.[13]

Although the District's Income Maintenance Administration has enrolled an impressive number of children, recruiting immigrant children, financing and billing systems and covering older adolescents present many challenges.

- ***Access for Immigrants:*** The 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) denied undocumented immigrants access to public programs.

  Fear of being deported makes illegal immigrants reluctant to complete an application even for their children who are citizens. Legal immigrants may also be reluctant to apply for SCHIP, fearing that use of a public benefit will adversely affect their application for permanent residence or citizenship.

  The Immigration and Naturalization Service (INS) and the Department of Justice (DOJ) released guidelines in 1999 clarifying that immigrants who receive non-cash assistance programs such as Medicaid, SCHIP, Women, Infants and Children (WIC), immunizations and prenatal care will not be subject to deportation or "public charge" status that would negatively impact their chance for citizenship. In addition, the U.S. Department of Health and Human Services has officially indicated that states may not deny benefits to otherwise qualified legal alien children under Title XXI SCHIP programs.

[12] Lurie, N., Stoto, M., *The Uninsured in the District of Columbia* (2002). Rand Corporation, District of Columbia
[13] *Kidbits*, 2002, DC Action for Children

Both qualified and unqualified immigrant children may be served using the 10 percent of funds that states can use for outreach, administration, and purchase/provision of direct services.

- ***Financing care:*** In addition to the contracted MCOs, a group of "safety net clinics" provide primary care to the medically vulnerable without regard to their ability to pay. They are supported by funding from the D.C. Health Care Alliance, a recently created comprehensive health care system now temporarily under the management of the D.C. Department of Health. The Ryan White funding for HIV primary care and Title X funding for reproductive health care are also important sources of support. But providers must bill according to both the status of the patient (insured or not) and the type of service (e.g. HIV or not) and the ever-changing budget and organization of the Alliance creates problems both for patients and for providers.

- ***Older Adolescents:*** The SCHIP program covers young people through the age of 18. Single adolescents of 19 and older are not eligible to continue Medicaid coverage unless they have a child. Efforts to establish good health habits of prevention and the trusting relationship of a medical "home" are thus thwarted when young people age out of Medicaid and are unlikely to have access to an employer-sponsored or private health care.

B. Locating and Using Health Care

Historically, the distribution of primary health care resources in the District has not been related to the needs of the most vulnerable populations. The federal government documents several medically underserved areas in the city.

MCOs should evaluate the extent to which their adolescent members are using their services, and how they can increase utilization by reducing geographic, transportation and scheduling barriers. The Department of Health should monitor and evaluate utilization patterns.

In recent years, a movement has grown to bring health care to where the kids are: in school. The District of Columbia now has a few school health clinics, but serious barriers prevent them from full effectiveness. The District public school system narrowly interprets existing regulations about providing medical care, and is frequently insistent on parental consent for any services, even when not required by law.

V. GUIDELINES FOR ADOLESCENT CLINICAL SERVICES

All national health organizations recommend an annual preventive health care visit for adolescents. Several have developed generally accepted standards for such care:

The American Medical Association (AMA), Guidelines for Adolescent Preventive Services (GAPS) (updated 2000)

www.ama-assn.org
http://www.ama-assn.org/ama/pub/category/1980.html

http://www.ama-assn.org/ama/pub/category/1947.html

The Academy of Pediatrics, *Recommendations for Pediatric Preventive Health Care*
www.aap.org

http://www.aap.org/policy/re9939.html

The Department of Health and Human Services, *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, (2000)

www.brightfutures.org/bf2/about.html

The federal government also mandates a minimum benefits package to be available to all children and adolescents who are enrolled in Medicaid:

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements.

Most basic guidelines are quite similar. Only the AMA and EPSDT are reproduced here, as they provide commonly accepted guidelines. Access to others is available through the sources listed in the appendices.

A. American Medical Association
Major Recommendations for Adolescent Preventive Care

Recommendation 1: From ages 11 to 21, all adolescents should have an annual preventive services visit.

Recommendation 2: Preventive services should be age and developmentally appropriate, and should be sensitive to individual and sociocultural differences.

Recommendation 3: Physicians should establish office policies regarding confidential care for adolescents and how parents will be involved in that care. These policies should be made clear to adolescents and their parents.

Recommendation 4: Parents or other adult caregivers should receive health guidance at least once during their child's early adolescence, once during middle adolescence, and, preferably, once during late adolescence.

Recommendation 5: All adolescents should receive health guidance annually to promote a better understanding of their physical growth, psychosocial and psychosexual development, and the importance of becoming actively involved in care.

Recommendation 6: All adolescents should receive health guidance annually to promote the reduction of injuries.

Recommendation 7: All adolescents should receive health guidance annually about dietary habits, including the benefits of a healthy diet, and ways to achieve a healthy diet and safe weight management.

Recommendation 8: All adolescents should receive health guidance annually about the benefits of physical activity and should be encouraged to engage in safe physical activities on a regular basis.

Recommendation 9: All adolescents should receive health guidance annually regarding responsible sexual behaviors, including abstinence. Latex condoms to prevent STIs including HIV infection, and appropriate methods of birth control should be made available, as should instruction on how to use them effectively.

Recommendation 10: All adolescents should receive health guidance annually to promote avoidance of tobacco, alcohol and other usable substances, and anabolic steroids.

Recommendation 11: All adolescents should be screened annually for hypertension according to the protocol developed by the National Heart, Lung, and Blood Institute Second Task Force on Blood Pressure Control in Children.

Recommendation 12: Selected adolescents should be screened to determine their risk of developing hyperlipidemia and adult coronary heart disease, following the protocol developed by the Expert Panel on Blood Cholesterol Levels in Children and Adolescents.

Recommendation 13: All adolescents should be screened annually for eating disorders and obesity by determining weight and stature, and asking about body image and dieting patterns.

Recommendation 14: All adolescents should be asked annually about their use of tobacco products including cigarettes and smokeless tobacco.

Recommendation 15: All adolescents should be asked annually about their use of alcohol and other substances, and about their use of over-the-counter or prescription drugs for non-medical purposes, including anabolic steroids.

Recommendation 16: All adolescents should be asked annually about involvement in sexual behaviors that may result in unintended pregnancy and STDs, including HIV infection.

Recommendation 17: Sexually active adolescents should be screened for STDs.

Recommendation 18: Adolescents at risk for HIV infection should be offered confidential HIV screening with the ELISA and confirmatory test.

Recommendation 19: Female adolescents who are sexually active or any female 18 or older should be screened annually for cervical cancer by use of a PAP test.

Recommendation 20: All adolescents should be asked annually about behaviors or emotions that indicate recurrent or severe depression or risk of suicide.

Recommendation 21: All adolescents should be asked annually about a history of emotional, physical, and sexual abuse.

Recommendation 22: All adolescents should be asked annually about learning or school problems.

Recommendation 23: Adolescents should receive a tuberculin skin test if they have been exposed to active tuberculosis, have lived in a homeless shelter, have been incarcerated, have lived in or come from an area with high prevalence of tuberculosis, or currently work in a health care setting.

Recommendation 24: All adolescents should receive prophylactic immunizations according to the guidelines established by the federally convened Advisory Committee on Immunization Practices.

Archives of Pediatric Adolescent Medicine 1997 Feb; 151(2): 123-8.

B. American Medical Association
Guidelines for Adolescent Preventive Services (GAPS)

Annual Screening and Diagnostic Tests

- Exposure to tuberculosis
- Sexually transmitted infections
- Risk of pregnancy
- HIV testing
- Cervical cancer
- Anemia
- Eating disorders and obesity
- Substance abuse (alcohol, anabolic steroids, tobacco, ingested and injected drugs)
- Clinical depression
- Witnessing or participating in violence or trauma
- History of emotional, physical, or sexual abuse
- Learning difficulties and academic problems
- Contraceptive methods to include emergency contraception
- Hypertension
- Hyperlipidemia

Laboratory Tests

- TB
- LES (males)
- Chlamydia (males and females)
- GC screening (females)
- Papanicolaou smear (females over 18)
- HPV screen
- VDRL
- HIV
- Blood pressure
- Height and weight
- Cholesterol

Immunizations

- Booster Td
- Second MMR
- Hepatitis B#1
- Hepatitis B#2
- Hepatitis B#3
- Varicella

C. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Requirements

Federal law requires that a minimum benefits package be available to all children and adolescents who are eligible for Medicaid. The EPSDT program mandates:

- Comprehensive health and developmental history, including assessment of physical and mental health and development
- Comprehensive unclothed physical examination
- Appropriate immunizations as specified in the schedule established by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), according to age and health history
- Appropriate laboratory tests, including lead blood level assessment appropriate for age and risk factors, and including STD testing and drug dependency testing
- Health education, including anticipatory guidance

Sources: 42 U.S.C. § 1396(r)(1); HCFA, State Medicaid Manual § 5123.2

APPENDIX ONE

A Quality Checklist for Planning and Evaluating Components of Adolescent Health Care

The following tool has been revamped by the National Adolescent Health Information Center from a checklist originally prepared by the San Francisco Adolescent and Managed Care Working Group. This tool was created for MCOs to evaluate the key components of comprehensive, accessible and coordinated health care for adolescents. It is divided into six categories: Access for Adolescents, Adolescent-Appropriate Quality Services, Coordination of Services, Adolescent-Sensitive Authorization and Review Processes, Coordination with Core Public Health Functions, and Adolescent Participation in the System of Care.

This checklist provides a useful scale for MCOs to evaluate current practices of adolescent care and will be helpful in designing improved care delivery systems to meet the needs of adolescents. Each of the following items is a scale for evaluating the degree the managed care plan fulfills this aspect for adolescents.

1= No current provision in the plan for this component.
2= Some limited provision of this component in the plan, but not adolescent-specific.
3=Some limited provision of this component in the plan, specifically tailored for adolescents.
4= Fairly complete provisions of this component in the plan, either through general provisions or adolescent-specific services.
5= Comprehensive inclusion of this component in the plan, specifically designed for adolescents.
*(*EPSDT in the text indicates an Early and Periodic Screening, Diagnosis, and Treatment standard.)*

A. Access for Adolescents

1. Institute policies and procedures to assure confidential care including:

a) Establish confidentiality policies regarding family planning and reproductive health services, sexually transmitted disease care, substance abuse treatment, and/ or mental health treatment, consistent with state and federal law.

1 2 3 4 5

b) Establish policies and procedures for adolescents to give informed consent consistent with state guidelines.

1 2 3 4 5

c) Establish financial policies and procedures for adolescents to enable access to specified confidential services, consistent with state law:

i. limit deductibles to ensure adolescent affordability.
1 2 3 4 5

ii. establish procedures in billing and statement of benefits, which ensure confidentiality, consistent with state law.
1 2 3 4 5

2. Enable access to adolescent-oriented providers:

a) Clearly identify adolescent providers and services in marketing materials.
1 2 3 4 5

b) Establish mechanisms to assure adolescent choice of provider different and independent from other family members and to inform adolescents and family members of this option.
1 2 3 4 5

3. Assist adolescents to reduce barriers to access:

a) Educate adolescents regarding their rights to confidential health care and the meaning of informed consent.
1 2 3 4 5

b) Inform adolescents regarding the laws and policies that apply in their state which allow minors to consent to health care, protect confidentiality, and/or otherwise facilitate adolescents' access to care.
1 2 3 4 5

c) Educate adolescents and their families on how to access their plan's services (e.g. enrollment procedures and requirement, disenrollment, information lines).
1 2 3 4 5

d) Establish an adolescent hotline to provide information to adolescents on how to most effectively enroll and utilize their health plan.
1 2 3 4 5

4. Other adolescent-specific policies or procedures designed to facilitate access:
1 2 3 4 5

B. Adolescent-Appropriate Quality Service

1. Implement guidelines for care:

a) Regular annual comprehensive preventive health care visits with modifications for setting/location and special populations. Specify which:
Bright Futures (Maternal and Child Health Bureau)
1 2 3 4 5

Guidelines for Adolescent Preventive Services (GAPS/AMA)
1 2 3 4 5
Put Prevention into Practice (UPHS/DHHS)
1 2 3 4 5

Other_______________________________
1 2 3 4 5

Own standards
1 2 3 4 5

b) If the managed care organization has developed its own standards, does it include protocols for:

Dental
1 2 3 4 5

General health problems
1 2 3 4 5

Health guidance
1 2 3 4 5

Immunizations
1 2 3 4 5

Mental health
1 2 3 4 5

Physical exams
1 2 3 4 5

Referrals
1 2 3 4 5

Reproductive health
1 2 3 4 5

Risk-screening
1 2 3 4 5

Substance abuse-screening
1 2 3 4 5

c) Reimbursement or capitation rates to enable sufficient staff time to establish rapport and complete comprehensive preventive health visits.
1 2 3 4 5

d) Developmentally appropriate and personnel skilled in health education should provide culturally sensitive health education and guidance for adolescents, parents, and other family members, and partners.

1 2 3 4 5

e) Criteria for referral for those with complex medical problems.

1 2 3 4 5

f) Criteria for referral for those with complex mental health problems.

1 2 3 4 5

g) Rehabilitation services including outpatient and residential drug treatment.

1 2 3 4 5

2. Clearly identify providers with skills working with adolescents:

a) Encourage self-designation as an adolescent primary health care provider by those who are committed to working with adolescents and who have training and skills in care coordination and in providing primary care in reproductive health, mental health, and substance abuse treatment.

1 2 3 4 5

b) Identify Board eligible/certified Adolescent Medicine Specialists to serve as primary care providers, subspecialty consultants, and referral sources for primary care gatekeepers.

1 2 3 4 5

3. Establish a quality improvement process within each provider group to monitor and improve adolescent access, quality of care, coordination, collaboration, and member participation in planning and evaluation.

1 2 3 4 5

4. Establish adolescent health resource mechanisms for consultation on adolescent health issues and problems:

a) Establish user-friendly and systematic access to subspecialty advice and formal consultation, including mental health and substance abuse treatment.

1 2 3 4 5

b) Provide up-to-date resources and reference materials, which can be available for clinical use where services are provided.

1 2 3 4 5

5. Other adolescent-specific policies and procedures to improve quality of adolescent services:

1 2 3 4 5

C. Coordination of Services

1. Establish collaboration mechanisms for information about referral to providers, organizations, and systems dealing with:

Developmental disabilities
1 2 3 4 5

Education/special education
1 2 3 4 5

Foster care
1 2 3 4 5

Mental health
1 2 3 4 5

Probation
1 2 3 4 5

Reproductive health care
1 2 3 4 5

School based/linked health centers
1 2 3 4 5

Social services
1 2 3 4 5

Substance abuse
1 2 3 4 5
Temporary Assistance to Needy Families (TANF)
1 2 3 4 5

Other special issues (e.g. teen pregnancy/parenthood, HIV/AIDS, violence)
1 2 3 4 5

2. Conduct outreach services to inform adolescents, parents, and adolescents-serving agencies about health plan services to encourage entry to services, appropriate referrals, ready communication, continuity, and commitment to care. *EPSDT
1 2 3 4 5

3. Implement case-management systems for high-risk adolescents including activities such as transportation assistance, translation, supportive counseling, home/community visits, and brokering of services. Clients to be considered for referrals should include: adolescents with HIV/AIDS, multiple sexually transmitted diseases, substance abuse problems, history of repeated medical non-compliance, chronic diseases, and/or complex health risks (e.g. homeless, and/or runaway adolescents, adolescents waiting for mental health services). *EPSDT

1 2 3 4 5

4. Encourage contractual agreements with established essential community providers (such as school-based health centers, local health agencies, family planning clinics, substance abuse treatment programs) for services such as adolescent-specific outreach, health education, and case management.

1 2 3 4 5

5. Other adolescent-specific policies and procedures to enhance coordination

1 2 3 4 5

D. Adolescent-Sensitive Authorization and Review Processes

1. Use reviewers with expertise in adolescent health for establishing prior authorization and utilization policies.

1 2 3 4 5

2. Use broad definition of "medical necessity" in authorization and review processes. The EPSDT definition includes screening, preventive, diagnostic, and treatment services necessary to address physical, mental, and developmental problems regardless of etiology. *EPSDT

1 2 3 4 5

3. Other adolescent-specific means to enhance authorization and review processes.

1 2 3 4 5

E. Coordination With Core Public Health Functions

1. Collaborate with public health agencies and other care providers in adolescent epidemiology and surveillance, in the development of adolescent health outcome measures, in quality assurance, and in monitoring access and satisfaction. *EPSDT

1 2 3 4 5

2. Provide opportunities for input from adolescents, families, and service delivery providers in the managed care organization's policy-making process.

1 2 3 4 5

3. Develop a community planning process, which includes adolescents, their families, advocates, and providers.

1 2 3 4 5

4. Monitor quality using adolescent access, satisfaction, health outcomes, system navigation landmarks, and compliance, as well as other indicators, such as chart reviews.

1 2 3 4 5

5. Other adolescent-specific means to enhance core public health functions.

1 2 3 4 5

F. Adolescent Participation in the System of Care

1. Involve adolescents in outreach, orientation, marketing, and peer education.

1 2 3 4 5

2. Include adolescents in establishing formal mechanisms for consumer input, including surveys, focus groups, and advisory panels.

1 2 3 4 5

3. Provide adequate support for adolescent involvement in planning and evaluation through training, guidance, and mentors.

1 2 3 4 5

4. Other adolescent specific means for enhancing participation.

1 2 3 4 5

National Adolescent Health Information Center. (1998). Assuring the health of adolescents in managed care. San Francisco, CA: University of California, San Francisco, and National Adolescent Health Information Center.

APPENDIX TWO

AMA Guidelines for Adolescent Preventive Services: Sample Questionnaires

The American Medical Association web page makes available for downloading from its website useful questionnaires to implement the GAPS clinical guidelines:

http://www.ama-assn.org/ama/pub/category/2280.html

Younger Adolescent Questionnaire
Younger Adolescent Questionnaire (Spanish)
Middle/Older Adolescent Questionnaire
Middle/Older Adolescent Questionnaire (Spanish)
Parent/Guardian Questionnaire
Parent/Guardian Questionnaire (Spanish)

Adolescent Developmental Stages

Adolescence is a time of rapid changes: physically, mentally and socially. It is divided into stages that roughly categorize the types of changes that the patient and parent can anticipate.

Central Issues in Early, Middle, and Late Adolescence

Variable	Early Adolescence	Middle Adolescence	Late Adolescence
Age (yr)	10-13	14-16	17-20 and beyond
Sexual Maturity Rating	1-2	3-5	5
Somatic	Secondary sex characteristics; beginning of rapid growth; awkward	Height growth peaks; body shape and composition change; acne and odor; menarche; spermarche	Slower growth
Sexual	Sexual interest usually exceeds sexual activity	Sexual drive surges; experimentation; questions of sexual orientation	Consolidation of sexual identity
Cognitive/moral	Concrete operations; conventional morality	Emerge of abstract thought; question-ing values; self centered	Idealism; absolutism
Self-concept	Preoccupation with changing body; self consciousness	Concern with attractiveness, increasing introspection	Relatively stable body image
Family	Bids for increased independence; ambivalence	Continued struggle for acceptance of greater autonomy	Practical independence; family remains secure base
Peers	Same-sex group; conformity; cliques	Dating; peer groups less important	Intimacy; possible commitment
Relationship to society	Middle-school adjustment	Gauging skills and opportunities	Career decisions (e.g., drop out, college, work)

Adapted from **Behrman: Nelson Textbook of Pediatrics, 16th ed.,**
Copyright © 2000 W. B. Saunders Company

APPENDIX FOUR

Sample Youth Bill of Rights

Advocates for Youth developed this Sample Bill of Rights for youth in Washington, D.C.

As a youth interacting with the (*Name of Managed Care Organization (MCO)*) health care system, I have the right:

- ✓ To take responsibility for my health and physical fitness.
- ✓ To be treated with respect by all staff without regard to my gender, culture, language, appearance, sexual orientation, color, presence of disability, HIV status, transportation ability, or source of payment.
- ✓ To get good care and the right types of health services, which include health education, regular check ups, dental and vision care, mental health, STD checks and sexual health, and drug and alcohol treatment by staff who are comfortable and experienced with young people.
- ✓ To be presented with honest and thorough health education, guidance, and care to improve my health and well being especially in regards to nutrition, exercise, safety, sex and sexual identity, drugs, alcohol, tobacco use and preventing violence.
- ✓ To include family, friends, and partners in my care at my request.
- ✓ To have explained fully to me what's confidential and what's not. If my doctor or other staff has a duty to talk with my parents or caretaker about certain issues, the information will also be discussed fully with me.
- ✓ To be introduced to my doctor, nurse, or other health care provider at the beginning of each visit or encounter.
- ✓ To be given a clear explanation of my health care benefits and health plan procedures.
- ✓ To be informed about where to find services and how to get them.

APPENDIX FIVE

Healthy People 2010 CRITICAL OBJECTIVES
for Adolescents and Young Adults

16-03. Reduce deaths of adolescents and young adults.

15-15. Reduce deaths caused by motor vehicle crashes.

26-01. Reduce deaths and injuries caused by alcohol and drug-related motor vehicle crashes.

15-19. Increase use of safety belts.

26-06. Reduce the proportion of adolescents who report that they rode, during the previous 30 days, with a driver who had been drinking alcohol.

18-01. Reduce suicide rate.

18-02. Reduce the rate of suicide attempts by adolescents.

15-32. Reduce homicides.

15-38. Reduce physical fighting among adolescents.

15-39. Reduce weapon carrying by adolescents on school property.

26-11. Reduce the proportion of persons engaging in binge drinking of alcoholic beverages.

26-10. Reduce past-month use of illicit substances.

06-02. Reduce the proportion of children and adolescents with disabilities who are reported to be sad, unhappy, or depressed.

18-07. (Developmental) Increase the proportion of children with mental health problems who receive treatment.

09-07. Reduce pregnancies among adolescent females.

13-05. (Developmental) Reduce the number of cases of HIV infection among adolescents and adults.

25-01. Reduce the proportion of adolescents and young adults with Chlamydia trachomatis infections.

25-11. Increase the proportion of adolescents who abstain from sexual intercourse or use condoms if currently sexually active.

27-02. Reduce tobacco use by adolescents.

19-03. Reduce the proportion of children and adolescents who are overweight or obese.

22-07. Increase the proportion of adolescents who engage in vigorous physical activity that promotes cardio respiratory fitness three or more days per week for 20 or more minutes per occasion.

Adapted from Healthy People 2010

APPENDIX SIX

2001 Youth Risk Behavior Survey Data
District of Columbia

The federal Center for Disease Control in Atlanta biannually conducts a survey of high school students in six categories of risk-taking behaviors identified as being responsible for a large percent of adolescent mortality, morbidity and social problems. It includes information about the prevalence and age of initiation, whether risk behaviors increase or decrease over time, the co-occurrence of health risk behaviors. It also provides local, state and national data for comparison. Of the 1,400 District of Columbia 9th –12th graders surveyed regarding those risk taking behaviors in 2001, the results indicate that:

Unintentional Injuries/Violence—

- Percentage of students who were ever hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend during the past 12 months- **17.2%**
  17.1% Females
  17.0% Males

- Percentage of students who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months- **28.6%**
  29.4% Females
  27.4% Males

- Percentage of students who made a plan about how they would attempt suicide during the past 12 months- **14.2%**
  14.4% Females
  14.0% Males

- Percentage of students whose attempted suicide during the past 12 months resulted in injury, poisoning, or overdose that had to be treated by a doctor or nurse- **5.7%**
  5.5% Females
  5.7% Males

- Percentage of students who did not go to school on one or more of the past 30 days because they felt unsafe at school or on their way to or from school- **12.0%**
  11.3% Females
  12.2% Males

- Percentage of students who carried a weapon such as a gun, knife, or club on one or more of the past 30 days- **20.3%**

  13.9% Females
  26.5% Males

- Percentage of students who carried a weapon such as a gun, knife, or club on school property on one or more of the past 30 days- **9.3%** ***(8.9% 1999)***

  7.2% Females
  10.8% Males

- Percentage of students who have ever been physically forced to have sexual intercourse when they did not want to- **12.6%**

  13.9% Females
  11.0% Males

Tobacco Use—

- Percentage of students who ever tried cigarette smoking, even one or two puffs- **56.7%**

  55.2% Females
  58.1% Males

- Percentage of students who smoked a whole cigarette for the first time before age 13- **15.3%**

  12.7% Females
  17.9% Males

Alcohol/Other drug use—

- Percentage of students who used marijuana one or more times during their life- **36.5%**

  34.0% Females
  39.2% Males

- Percentage of students who used any form of cocaine, including powder, crack, or freebase one or more times during their life- **6.0%**

  4.6% Females
  7.1% Males

- Percentage of students who had at least one drink of alcohol on one or more days during their life- **58.9%**

  59.9% Females
  57.6% Males

- Percentage of students who had at least one drink of alcohol on one or more of the past 30 days- **28.3%**

  27.4% Females
  29.1% Males

- Percentage of students who had five or more drinks of alcohol in a row, that is, within a couple of hours, on one or more of the past 30 days- **10.6%**

  10.3% Females
  10.9% Males

- Percentage of students who had their first drink of alcohol other than a few sips before age 13- **25.6%** ***(27.9% 1999)***

  22.3% Females
  29.2% Males

- Percentage of students who were offered, sold, or given an illegal drug on school property by someone during the past 12 months- **25.4%**

  21.2% Females
  29.5% Males

Sexual Behaviors—

- Percentage of students who had sexual intercourse- **61.6%** ***(64.8% 1999)***

  53.5% Females
  71.7% Males

- Percentage of students who had sexual intercourse for the first time before age 13- **16.6%** ***(20.3% 1999)***

  6.8% Females
  28.7% Males

- Of students who had sexual intercourse during the past three months, the percentage who used a condom during last sexual intercourse- **72.9%** ***(74.2% 1999)***

  64.8% Females
  82.2% Males

- Of students who had sexual intercourse during the past three months, the percentage who used birth control pills during last sexual intercourse- **8.4%** ***(9.0% 1999)***

  11.0% Females
  5.1% Males

- Of students who had sexual intercourse during the past three months, the percentage who drank alcohol or used drugs before last sexual intercourse- **15.9%** ***(18.3% 1999)***

  12.2% Females
  19.7% Males

- Percentage of students who had sexual intercourse with one or more people during the past three months- **41.1%**

  39.3% Females
  43.4% Males

- Percentage of students who had sexual intercourse with four or more people during their life- **23.8%** ***(29.5% 1999)***
  18.8% Females
  29.9% Males

- Percentage of students who had ever been taught about AIDS or HIV infection in school- **91.0%** ***(88.9% 1999)***
  93.0% Females
  88.8% Males

- Percentage of students who had been pregnant or gotten someone pregnant one or more times- **9.7%**
  12.7% Females
  6.3% Males

- Percentage of students who have ever had sexual intercourse but have not had sexual intercourse during the past three months- **33.4%**
  27.0% Females
  39.4% Males

Dietary Behaviors—

- Percentage of students who ate five or more servings of fruits and vegetables per day during the past seven days- **18.5%**
  19.5% Females
  17.5% Males

- Percentage of students who are overweight- **14.6%**
  13.1% Females
  16.1% Males

- Percentage of students who are at risk for becoming overweight- **15.0%**
  16.6% Females
  13.3% Males

- Percentage of students who exercised to lose weight or to keep from gaining weight during the past 30 days- **48.3%**
  48.0% Females
  48.7% Males

- Percentage of students who went without eating for 24 hours or more to lose weight or to keep from gaining weight during the past 30 days-**14.8%**
  15.3% Females
  13.7% Males

- Percentage of students who vomited or took laxatives to lose weight or to keep from gaining weight during the past 30 days- **7.3%**
  6.3% Females
  7.7% Males

Physical Activity—

- Percentage of students who watched three or more hours of TV per day on an average school day- **52.6%**

  55.2% Females
  50.6% Males

- Percentage of students who did not participate in at least 20 minutes of vigorous physical activity on three or more of the past seven days and did not do at least 30 minutes of moderate physical activity on five or more of the past seven days- **56.7%**

  61.5% Females
  50.8% Males

APPENDIX SEVEN

CHILD ABUSE REPORTING REQUIREMENTS

Know the Facts About Child Sexual Abuse Laws (also known as Statutory Rape)

Answers to Important Questions When Working With Young Teens

If I am working with a young person under the age of 16 and he/she tells me that he/she is in a sexual relationship with a person four or more years older, is it my responsibility to report?

Yes, you are required to report suspected child sexual abuse if you are a physician, psychologist, medical examiner, dentist, social worker, nurse, social service worker, school official, teacher, counselor, law-enforcement officer or administrator working with a young person. (DC Law § 2-1352)

Know your agency's protocol.

If I report an incident of suspected child sexual abuse, what do I need to provide?

You need to provide all available information. If possible, the report shall include, but not be limited to the following:

(1) the name, age, sex, and address of:

(a) the child who is the subject of the report;

(b) each of the child's siblings; and

(c) the parents or other persons responsible for the child's care;

(2) the nature and extent of the abuse, if known;

(3) any other information that may be helpful. (DC Law § 2-1352)

Am I required to investigate?

No, the Child and Family Services Agency (CFSA) and the Metropolitan Police Department will handle the investigation and follow-up. All cases are forwarded to the US Attorney's Office for prosecution, if deemed appropriate.

Can I be held liable if I do not make a report?

Yes, if you are required to report child sex abuse and do not, you can be fined not more than $100 or imprisoned for not more than 30 days or both. Violations will be prosecuted by the Office of the Corporation Counsel of the District of Columbia or his or her agent in the name of the District of Columbia. (DC Law § 2-1357)

How do I make a report?

In the District of Columbia, you can report all suspected child sexual abuse to 202-671-SAFE (7233). You do not have to give your name.

APPENDIX EIGHT

Adolescent Health Information Resources

Adolescent Directory On-Line (ADOL)
The Indiana University-Center for Adolescent Studies
http://www.education.indiana.edu/cas/adol/adol.html

Advocates for Youth
1025 Vermont Avenue, NW
Suite 200
Washington, DC 20005
(202) 347-5700
http://www.advocatesforyouth.org

Alan Guttmacher Institute
1120 Connecticut Avenue, NW
Suite 460
Washington, DC 20036
(202) 296-4012
http://www.agi-usa.org

120 Wall Street, 21st Floor
New York, NY 10005
(212) 248-1111

American Academy of Child and Adolescent Psychiatry
3615 Wisconsin Avenue, NW
Washington, DC 20016
(202) 966-7300
http://www.aacap.org

American Academy of Pediatrics
Department of Federal Affairs
601 13th Street, NW
Suite 400 North
Washington, DC 20005
(202) 347-8600
http://www.aap.org

National Headquarters
141 Northwest Point Blvd
Elk Grove Village, IL 60007
(847) 434-4000

American College of Obstetricians & Gynecologists
409 12th Street, SW
Washington, DC 20024
(202) 638-5877
http://www.acog.org

American Medical Association
Department of Adolescent Health
515 N. State Street
Chicago, IL 60610
312-464-5000
http://www.ama-assn.org

Annie E. Casey Foundation
701 St. Paul Street
Baltimore, MD 21202
(410) 547-6600
http://www.aecf.org

Campaign for Tobacco Free Kids
1400 Eye Street, NW
Suite 1200
Washington, DC 20005
(202) 296-5469
http://www.tobaccofreekids.org

Carnegie Council on Adolescent Development
Carnegie Corp of New York
437 Madison Avenue
New York, NY 10022
(212) 371-3200
http://www.carnegie.org/sub/pubs/ccadpubs.htm

Centers for Disease Control and Prevention
Best Practices in Youth Violence Prevention
http://www.cdc.gov/ncipc/dvp/bestpractices.htm

Center for Adolescent Health & the Law
211 North Columbia St.
Chapel Hill, N.C. 27514
(919) 968-8870
http://www.adolescenthealthlaw.org

Children's Defense Fund
25 E Street, NW
Washington, DC 20001
(202) 628-8787
http://childrensdefense.org

Children NOW
1212 Broadway
5th Floor
Oakland, CA 94612
(510) 763-2444
http://www.childrennow.org

Child Welfare League of America
440 First Street, NW
Third Floor
Washington, DC 20001
(202) 638-2952
http://www.cwla.org

DC Action for Children
1616 P Street, NW
Suite 420
Washington, D.C. 20036
(202) 234-9404
http://www.dckids.org

Families USA
1334 G Street, NW
Washington, DC 20005
(202) 628-3030
http://www.familiesusa.org

Federal Interagency Forum on Child and Family Statistics (ChildStats)
http://www.childstats.gov

The Henry J. Kaiser Family Foundation
1330 G Street, NW
Suite 250
Washington, DC 20005
(202) 347-5270
http://www.kff.org

Headquarters
2400 Sand Hill Road
Menlo Park, CA 94025
(650) 854-9400

Maternal and Child Health Policy Research Center
http://www.mchpolicy.org/chip.html

National Adolescent Health Information Center
3333 California Street
Box 0503
San Francisco, CA 94143
(415) 502-4856
http://youth.ucsf.edu/nahic

National Black Child Development Institute
1101 15th Street, NW
Suite 900
Washington, DC 20005
(202) 833-2220
http://www.nbcdi.org

National Campaign to Prevent Teen Pregnancy
1776 Massachusetts Avenue, NW
Suite 200
Washington, DC 20036
(202) 478-8500
http://www.teenpregnancy.org

National Center for Education in Maternal and Child Health
2115 Wisconsin Avenue, NW
Suite 601
Washington, D. C. 20007
(202) 784-9770
http://www.ncemch.org

National Health Law Program
1101 14th Street, NW
Suite 405
Washington, DC 20005
(202) 289-7661
http://www.healthlaw.org

National Institute on Out-of-School Time
Wellesley Centers for Women
106 Central Street
Wellesley, MA 02481
(718) 283-2547
http://ww.wellesley.edu/WCW/CRW/SAC

National Resource Center for Youth Services
The University of Oklahoma
College of Continuing Education
Schusterman Center
4502 E 41st Street
Building 4 West
Tulsa, OK 74135
(918) 660-3700
http://www.nrcys.ou.edu

Planned Parenthood Federation of America
1780 Massachusetts Avenue, NW
Washington, DC 20036
(202)785-3351
http://www.ppfa.org

Headquarters
810 Seventh Avenue
New York, NY 10019
(212) 541-7800

The Robert Wood Johnson Foundation
PO Box 2316
College Road East and Route 1
Princeton, NJ 08543
(888) 631-9989
http://www.rwjf.org

Social Policy Action Network
444 North Capitol Street, NW
Suite 309
Washington, DC 20001
(202) 434-4770
http://www.span-online.org

Society for Adolescent Medicine
1916 N.W. Copper Oaks Circle
Blue Springs, MO 64015
(816) 224-8010
http://www.adolescenthealth.org

Stand for Children
1420 Columbia Road, NW
Third Floor
Washington, D. C. 20009
(800) 663-4032
http://stand.org

Surgeon General's Report
Reducing Tobacco Use
http://www.cdc.gov/tobacco

U.S. Department of Health and Human Services
Administration for Children and Families
370 L'Enfant Promenade, SW
Washington, DC 20447
http://www.acf.dhhs.gov

U. S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration (SAMHSA)
5600 Fishers Lane
Rockville, MD 20857
http://www.samhsa.gov

Center for Substance Abuse Prevention
http://samhas.gov/csap

Center for Substance Abuse Treatment
http://www.samhsa.gov/csat

Center for Mental Health
P. O. Box 42490
Washington, DC 20015
(800) 789-2647
http://mentalhealth.org

U. S. Department of Health and Human Services
Health Resources and Services Administration,
Maternal and Child Health Bureau, Division of Child, Adolescent and Family Health
18-05 Parklawn Building
5600 Fishers Lane
(301) 443-2170
Rockville, MD 20857
http://www.mchb.hrsa.gov

U. S. Department of Health and Human Services
Office of Minority Health Resource Center
P. O. Box 37337
Washington, DC 20013
(800) 444-6472
http://www.omhrc.gov

U. S. Department of Justice
Office of Juvenile Justice and Delinquency Prevention
810 Seventh Street, NW
Washington, DC 20531
(202) 307-5911
http://ojjdp.ncjrs.org