The Foster Friendly Healthcare Toolkit

A practitioner's guide to delivering quality sexual and reproductive health care to youth in foster care.

DEVELOPED BY
Reproductive Health Equity Project for Foster Youth

Welcome

Systems too often are built, or evolve, to meet and maintain the needs of the system rather than the people within them. The world might be very different if our systems centered around people. RHEP is asking the question - what if we try to build something that works for humans?

It can feel overwhelming to think about that change. But it is possible, through small and bigger steps, and through asking the question over and over - does this work for the people working in the system and for the people being served by the system?

That's what we tried to do here.

Why
A Toolkit

We set out to create a resource to help healthcare providers center youth in their practice and champion change in their clinics while being mindful of their work flows and learning preferences. That's why we landed on a toolkit. A toolkit is easy to use, action-oriented and multi-functional.

This toolkit is a collection of easily accessible tools and information that support you on your journey to make change in your practice and in your clinic. Depending on where you are and your needs in the moment, there are tools to help you gain knowledge, build skills and bring people together to address challenges.

This is NOT a textbook. It does not need to be read from cover to cover before being useful. There is always more to discover each time you return to it!

Driving Action

In this toolkit you'll find:

- Our recommended **Pathway to Change.**
- **Care Models** of best practices.
- Printable **Practice Tools** for use in your practice.
- **Links** to external resources for more context.
- A **Youth Feedback Questionnaire** for continuous assessment of progress from youths' perspective.
- A **Resource Hub** for sharing resources with other providers.

About *RHEP*

The Reproductive Health Equity Project is a collective impact campaign made up of multi-disciplinary organizations, government agencies, and youth. The National Center for Youth Law convenes and coordinates RHEP's work. Our original project was founded by a cross-sector leadership team based in LA County.
Our statewide expansion in California added additional agencies and a statewide perspective to our RHEP partnership.

What We Do

The Reproductive Health Equity Project for Foster Youth brings together youth in foster care and the agencies that serve them to promote systems that normalize, support, and promote the bodily autonomy and healthy sexual development of youth in foster care. Health, education, and child welfare systems have failed to reach, engage, and guide youth in foster care across a sexual and reproductive health service journey that meets their needs, circumstances, and goals. This gap fuels disparities in sexual and reproductive health.

RHEP works to change this by uplifting youth voices, supporting policy change, creating connections between systems, and piloting innovative programs designed in collaboration with stakeholders and youth to better meet their needs–because healthy development is on all of us!

About *the Authors*

Erica Monasterio*, MN, FNP-BC, Clinical Professor, Emerita, formerly on faculty in the Division of Adolescent and Young Adult Medicine at the University of California, San Francisco.*

Ms. Monasterio has 35 years of clinical experience working with youth and their caregivers both at UCSF and in the San Francisco Department of Public Health. She focuses on training health care and social service professionals to increase their knowledge, sensitivity and skills in working with adolescents and young adults, providing care to vulnerable populations and developing primary care-based interventions to address health, mental health, behavioral and social issues impacting on health from a trauma-informed perspective.

Through collaborative work with community-based organizations at the local, state and national level, she provides training in the areas of sexual and reproductive health, healthy sexuality for youth with disabilities, healthy adolescent relationships, minor consent and confidentiality, and the care of LGBTQ and out-of-home youth.

Rebecca Gudeman, *JD, MPA, Senior Director, Health, National Center for Youth Law.*

Ms. Gudeman has over 25 years of experience representing and advocating on behalf of young people. She specializes in legal issues of health equity and access for youth who have been marginalized by traditional systems. She also is an expert on adolescent consent, confidentiality and information sharing law. Among other things, she is a founder of the Reproductive Health Equity Project for Youth in Foster Care.

About *the Advisory Panels*

We are grateful for the invaluable feedback and advice provided by our health provider and youth advisory panels while developing the toolkit.

Provider Advisory Panel
Sonal Desai, M.D., Noah Nattell, M.D., Karinne Van Gronigen, M.D., Tiffany Lambright, MPH, M.S., R.N., and Roni Diamant-Wilson, Ph.D., MSW, MSN, RN.

Youth Advisory Panel
Daniel Bisuano, Alexis Obinna, Jaci Cortez, Johnny Lopez.

Funding:
This guide was made possible by a grant to RHEP from the Conrad N. Hilton Foundation.

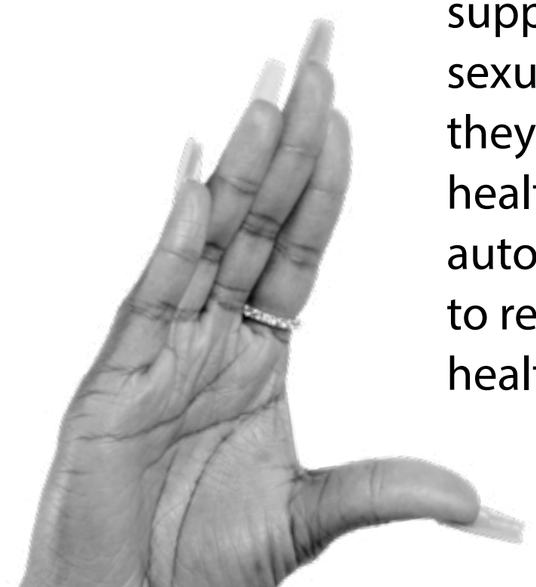
Design:
SuperDeep Studio

Recommended Citation:
Reproductive Health Equity Project. (2022).
The Foster Friendly Healthcare Toolkit: A practitioner's guide to delivering quality sexual and reproductive health care to youth in foster care.

Vision

Supporting and Empowering

We envision a future in which the systems serving youth have imbedded practices, tools, and cultures designed in partnership with young people that actively normalize, support and promote the bodily autonomy and healthy sexual development of youth in state custody and care.



A future in which youth in the foster care system feel seen, empowered, and supported in their health and their healthy sexual development. Where they know they have the right to healthy relationships, healthy sexual development and bodily autonomy, and know how, and are able, to realize their sexual and reproductive health goals.

“Poor health outcomes are not the failing of our youth, rather, they’re the failing of complex, intertwined systems that don’t allow us to put youths’ needs at the center of their care experiences.”

Rebecca Gudeman
Senior Director, National Center for Youth Law,
convener of the Reproductive Health Equity Project

Foundation

Information and Growth

With the right information and tools, healthcare providers can support healthy sexual development for all youth in their care.

Promoting Healthy Sexual Development Is Part Of Providing Health Care To Teens

Promoting healthy sexual development is part of that care (as stated in AAP's Bright Futures guidelines). The American Academy of Pediatrics (AAP) recognizes that healthy sexual development and sexuality is a component of healthy development and that "healthy sexuality is an important component of a healthy, happy life." Healthy sexual development begins in infancy and includes nurturing the development of the biological and physical foundations of healthy intimacy, and as a youth matures, includes supporting an understanding of the physical changes of puberty, consent and bodily autonomy, gender identity, sexual orientation, and human relationships as well as healthy decision-making and safety.[1] Promoting health sexual development is part of the AAP's Bright Futures guidelines for health supervision of infants, children and adolescents.

Bright Futures recognizes that "confidential, culturally sensitive, and nonjudgmental counseling and care are important to all youth" and advises health care professionals to integrate sexuality education and care into their relationships with adolescents and pre-adolescents.[2]

Youth In Foster Care Need This Support In Particular

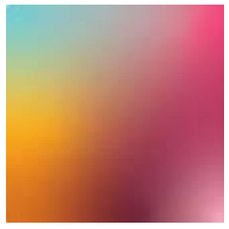
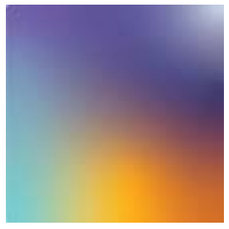
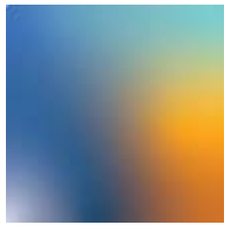
Unfortunately, youth in foster care are more likely to face barriers that make access to sexual health education and care more challenging, leading to disproportionately poor health outcomes. A person's health is impacted, positively or negatively, by a number of factors, including biological, environmental, and socioeconomic factors. Environmental and socioeconomic factors are often referred to as social determinants of health (SDOH): "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health functioning and quality-of-life outcomes and risks."[3] Examples of SDOH include housing conditions, poverty, educational opportunities, literacy skills, and racism and discrimination. Youth in foster care are more likely to face SDOH that negatively impact their health opportunities.[4]

“Though the AAP advises health care professionals to integrate sexuality education and care into annual visits with adolescents and pre-adolescents, less than 29% of youth ages 12-20 in foster care in LA reported that their health provider discussed sexual & reproductive health with them during the last year.”[5]

RHEP

Foundation: The 4 Knowledge Zones

Highlighted below are some of the biggest BARRIERS that limit effective engagement about healthy sexual development, from a healthcare perspective. As providers, you can reduce these barriers and improve youths' health outcomes by knowing the 4 KNOWLEDGE ZONES.

Barriers	Not understanding the foster system context and its implications on care delivery	Confidentiality concerns	Not engaging in trauma-responsive practices	Not staying updated on the latest best practices for performing sexual and reproductive health care
	↓	↓	↓	↓
	Know FOSTER CARE*	Know CONFIDENTIALITY & CONSENT LAWS*	Know TRAUMA-RESPONSIVE & HEALING-CENTERED CARE	Know SEXUAL & REPRODUCTIVE HEALTH
Knowledge Zones				

* Each state is unique in how it approaches this knowledge zone.

Opportunity

By working together to address these barriers through collective action, healthcare providers can contribute to shifting prevailing mindsets and ending the "youth as the problem" orientation.

Healthcare providers play a central role in changing the sexual and reproductive healthcare experiences of youth for the better – both through the services that they provide and the information that they share.

It is important to acknowledge that many SDOH and barriers to sexual and reproductive health access are outside the purview of the health care system itself. Although health providers don't have the power to fix or fully mitigate their impact, being tuned into the foster experience and context youth are coming from is critical to how you provide care. By learning the knowledge zones, providers and clinics can change their practices and systems in ways that allow youth to effectively access the care they want and need, leading to better health outcomes.

Pathway to Change

This Pathway to Change helps you reflect on what you already know and do, then quickly get to the points in the toolkit that will lead you to change.

USE THE PATHWAY TO CHANGE TO:

IDENTIFY A STARTING POINT
Find your starting point to champion change in your clinic.

NAVIGATE
Quickly access tools/information you need when interacting with youth or your clinic champion team.

SELF ASSESS
Assess progress towards championing change.

PITCH FOR CHANGE
Get buy-in to adopt this toolkit's approach in your clinic by showing how it ladders up to change beyond the clinic.

Pathway to Change

This is our recommended path to create change using the content in this toolkit. It is composed of 4 main phases. The following pages will walk you through the steps in each phase and suggest links to toolkit sections that support those steps.

Take Action as an Individual

to educate yourself and implement better practices

Take Action as a Team

to champion change in your clinic

Track & Progress Actions

centering youth voices, expertise and lived experiences

Share Feedback & Stories

to support other advocates making change

Pathway to Change

Take Action as an Individual

to educate yourself and implement better practices

Action Steps:

- [ ] **Try introducing a set of principles to center youth experiences**
- [ ] **Review practice change opportunities for providers to better serve youth in foster care**
- [ ] **Try foster-specific care practices**
- [ ] **Go deep to understand the driving issues and context for youth in foster care**

Links to Learning/ Tools:

ENGAGE IN SHARED DECISION-MAKING WITH YOUTH	CHANGE OPPORTUNITIES FOR PROVIDERS FOSTER CARE TOPICS	CARE MODEL FOSTER CARE TOPICS	STUDY MODULE FOSTER CARE TOPICS
RESPECT AND ACCOMMODATE INDIVIDUAL NEEDS & PREFERNCES	CHANGE OPPORTUNITIES FOR PROVIDERS CONFIDENTIALITY TOPICS	CARE MODELS CONFIDENTIALITY TOPICS	STUDY MODULE CONFIDENTIALITY TOPICS
CENTER THE IMPACT OF, RESPONSE TO, AND RECOVERY FROM TRAUMA	CHANGE OPPORTUNITIES FOR PROVIDERS TRAUMA-RELATED TOPICS	CARE MODELS TRAUMA-RELATED TOPICS	STUDY MODULE TRAUMA-RELATED TOPICS
	CHANGE OPPORTUNITIES FOR PROVIDERS SRH TOPICS	CARE MODELS SRH TOPICS	STUDY MODULE SRH TOPICS

Pathway to Change

Take Action as a Team

to champion change in your clinic

Action Steps:

Links to Learning/ Tools:

Form a team to champion change and establish working relationships

- ◯ ECOSYSTEM OF ALLIES FOSTER CARE TOPICS
- ◯ ECOSYSTEM OF ALLIES CONFIDENTIALITY TOPICS
- ◯ ECOSYSTEM OF ALLIES TRAUMA-RELATED TOPICS
- ◯ ECOSYSTEM OF ALLIES SRH TOPICS

Set goals and targets with your clinic champion team

- ◯ PRACTICE CHALLENGES FOSTER CARE TOPICS
- ◯ PRACTICE CHALLENGES CONFIDENTIALITY TOPICS
- ◯ PRACTICE CHALLENGES TRAUMA-RELATED TOPICS
- ◯ PRACTICE CHALLENGES SRH TOPICS

Try RHEP's best practices for teams to champion change

- ◯ CHANGE OPPORTUNITIES FOR TEAMS FOSTER CARE TOPICS
- ◯ CHANGE OPPORTUNITIES FOR TEAMS CONFIDENTIALITY TOPICS
- ◯ CHANGE OPPORTUNITIES FOR TEAMS TRAUMA-RELATED TOPICS
- ◯ CHANGE OPPORTUNITIES FOR TEAMS SRH TOPICS

For providers who are trying to make change, we recommend that you form a clinic champion team.

To learn more about how, see:

- Whole Health Clinical Champions: Lessons Learned from Flagship Sites
- Gaining Leadership Buy-in for Organizational Change in Health Care

Even if you don't have a team yet though, it may still be helpful to check out the tools/information linked on this page.

Pathway to Change

Track & Progress Actions

centering youth voices, expertise and lived experiences

Action Steps:

Assess clinic environment, training, policy and practice from a youth perspective

Track progress in your clinic from the youths' perspective

Implement new clinic-wide practices based on collective learnings

Links to Learning/ Tools:

- YOUTH FEEDBACK OPPORTUNITIES
- YOUTH FEEDBACK QUESTIONNAIRE
- YOUTH FEEDBACK TRACKER
- YOUTH FEEDBACK
- TOP TIPS
- EXTERNAL RESOURCES

Pathway to Change

Share Feedback & Stories

to support other advocates making change

Action Steps:

- [ ] **Share your clinic's progress and youth feedback**
- [ ] **Review toolkit updates from RHEP based on progress in all participating clinics**
- [ ] **Share your experiences to support advocacy work to shift the narrative and address structural drivers of inequity**

Links to Learning/ Tools:

- ◯ YOUTH FEEDBACK
- ◯ TOP TIPS
- ◯ TOOLKIT UPDATES
- ◯ PROVIDER TESTIMONIALS

“Our goal is to create a tool and ultimately a community for health care providers interested in engaging in small and larger ways to center the people serving and being served by the health care system.”

Rebecca Gudeman
Senior Director, National Center for Youth Law,
convener of the Reproductive Health Equity Project

HOW TO USE

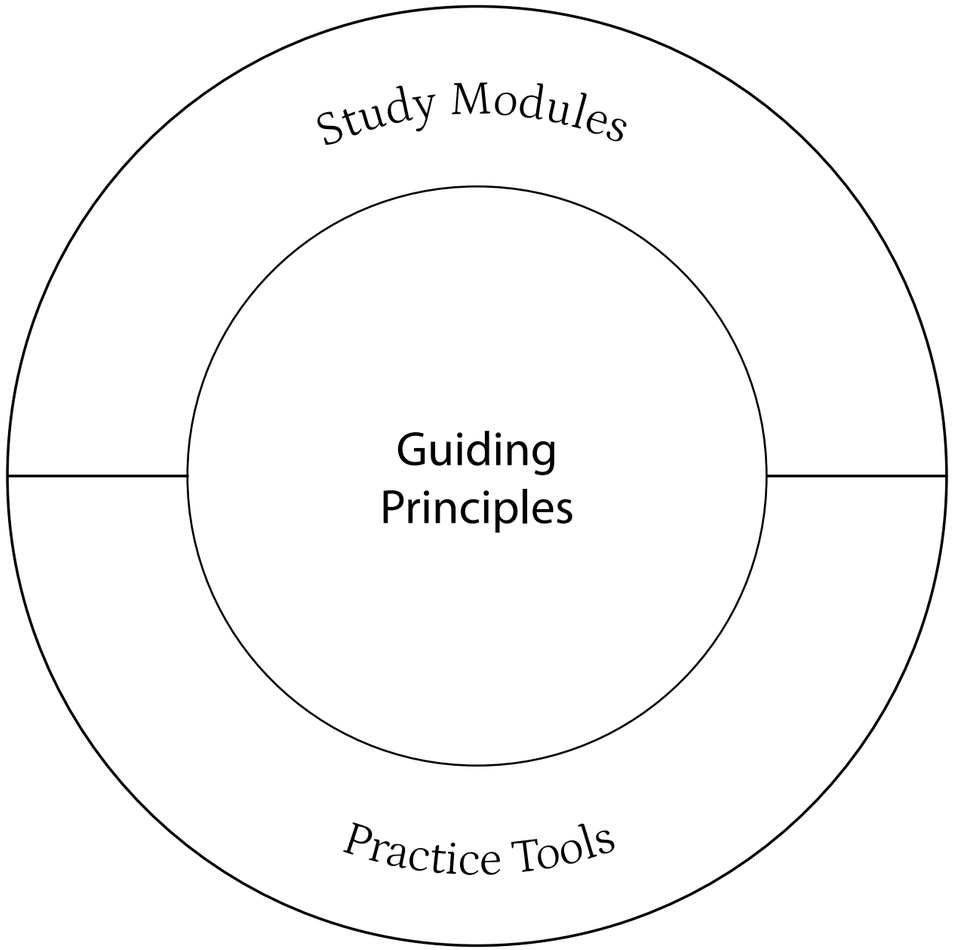
The following 3 chapters provide information that will guide you to change the practices and culture in your clinic. Each chapter serves a different function and need not be read in chronological order.

DEPENDING ON WHERE YOU ARE IN YOUR PROCESS, FLIP TO:

GUIDING PRINCIPLES
For a foundational understanding of the core beliefs that drive our strategies to deliver better care.

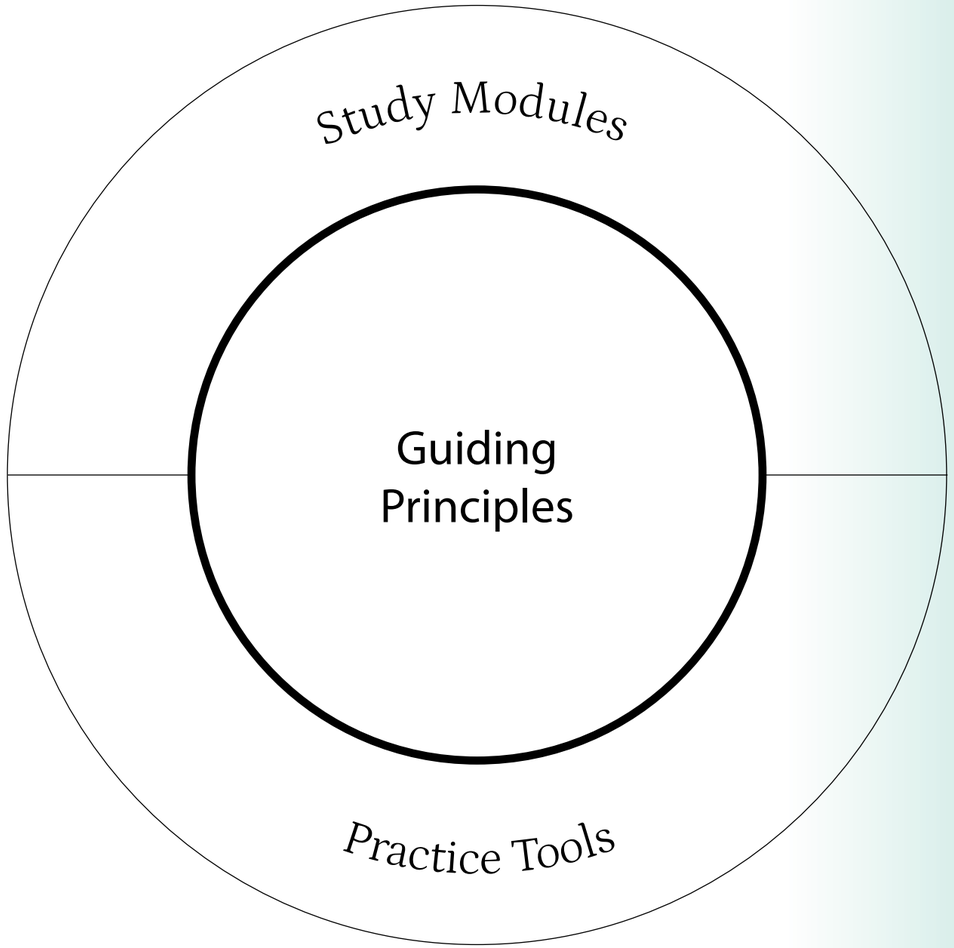
STUDY MODULES
For deeper learning with detailed information and care models across critical knowledge zones.

PRACTICE TOOLS
For quick action recommendations to improve sexual and reproductive health outcomes for youth in foster care.



GUIDING PRINCIPLES

In this chapter, we will walk through the core beliefs that drive our strategies to deliver better care. In all of our reform efforts, these principles serve as a foundation. We come back to them time after time. They are based on what youth told us matters most to them and are grounded in research. From planning how to move the effort forward to reflection on what we've done and brainstorming how to do better for youth, we are always striving to incorporate these three principles. Return to them as you move through the toolkit and throughout your advocacy journey.



Guiding Principle #1:

Engage in Shared Decision-Making with Youth

Support youth in incorporating health choices and healthy behaviors into their lives.

Build a partnership with your patient, making a commitment to do things WITH, rather than "to" or "on" the youth.

Options and autonomy matter. Young people want to know adults will keep them safe by providing options and the time, space, and support to choose what is right for them. They want balanced perspectives on sex and their bodies so they can learn without fear.

For young people just establishing their autonomy, agency is vital to their ability to engage in decision-making about health choices and healthy behaviors.

The Shared Decision-making Model (SDM)[6] centers this approach and requires providers to dismiss their own biases and treatment preferences in order to offer information about all treatment options and support the patient in incorporating health information into their own decision-making process.

SDM as a counseling approach is particularly salient when working with populations that have a history of cultural and historical trauma rooted in medical racism. Fears of being forced to make a particular treatment decision are based in a history of being denied a voice in or choice of options. It is incumbent upon the provider to acknowledge this history, validate concerns, and assist the patient in exploring the right choice for them, rather than pushing for a decision that matches the provider's assumptions about the needs, desires or abilities of the patient.

Reproductive Justice, as defined by the organization SisterSong, is "the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities."[7]

Utilizing the approach of shared decision-making is one way of implementing the fundamental principles of reproductive justice in providing SRH care for youth in foster care.

Client-Centered

Strengths-Based

Culturally Humble

Centers the concept of Reproductive Justice

“The provider may be an expert in clinical care, but the youth is the expert in their own life. Only the youth can determine what care best accommodates their particular health concerns, beliefs, needs, relationships and lifestyle.”

Youth in Foster Care

Guiding Principle #2:

Respect and Accommodate Individual Needs & Preferences

Take the time to get to know youth and their priorities as individuals.

Relationships and connection matters. According to our youth advisors, a positive vibe encompasses rapport and relationship-building. Vibe ensures youth comfort, normalizes youth inquiries and experiences, and results in youth sharing their experiences, questions, and concerns.

Building trust takes time. Get to know your patient and give them a chance to get to know you. Despite the many issues that providers may feel compelled to address, the most important concern to address is the concern that the patient brings to the visit. By allowing the patient to determine the priorities for the visit you also allow for the formation of a trusting relationship. Remember, the provider may be the expert in clinical information, but the youth is the expert in their own life.

Client-centered services require understanding the interests, desires and needs of the client. They must recognize that youth are the experts in their own lives. Youth in care may not have the same infrastructures and family support to facilitate access to care, and each youth comes in with their own unique circumstances and experiences. Youth are in the best place to know what their needs are and how to make services accessible.

Young people seeking healthcare services present a variety of thinking, learning and interactional styles, and a one-size-fits-all approach does not meet the range of needs.

Youth who identify as lesbian, gay bisexual, transgender or questioning (LGBTQ) experience barriers to care and health disparities related to heterosexism, homophobia and transphobia in the healthcare delivery system and society as a whole. Assumptions of heterosexuality and cis-gender identity interfere with LGBTQ youth's access to quality, equitable, acceptable care. LGBTQ sensitive approaches provide the space for youth to define their identities as they experience them and access the information, health education and care that will enhance their health and well-being.

Black, Indigenous and people of color (BIPOC), as individuals, families and communities, experience inequities in health outcomes due to systemic racism in American society as a whole as well as in the healthcare system. With the goal of eliminating these disparities, healthcare delivery systems and the individuals who work in them must work to become anti-racist.

Inclusive of Sexual & Gender Minorities

Anti-Racist

Neuro-Inclusive

Strengths-Based

Client-Centered

Empowering

Developmentally Appropriate

“I’ve had a couple of doctors, and I always see if their energy is good, and depending on that, I might open up...If you don’t approach me right, or I feel like I’m not welcome, I won’t feel comfortable.”

“I’ve had so many doctors rush, and I feel like I’m trying to tell them what is going on, but they just rush me out.”

Guiding Principle #3:

Center the Impact of, Response to, and Recovery from Trauma

Provide care for all youth based on knowledge of the impact of traumatic childhood experiences.

Youth in foster care have, by definition, endured multiple Adverse Childhood Experiences (ACES)[8] resulting in trauma. ACES include abuse, neglect, and household instability, and the ACES impact health and well-being in a dose-response fashion. Systems that serve these youth must utilize trauma-responsive, healing-centered approaches to effectively meet their healthcare needs.

Healing-centered approaches allow the youth and the helping professional to refocus from past trauma to future goals and aspirations, supporting the youth in regaining a sense of holistic well-being.

Experiences of Trauma

100% of youth in foster care have experienced trauma. Involvement in the child welfare system is by definition traumatic, including surveillance, involvement in court processes, and removal from family homes. Additionally approximately 90% of youth in foster care have experienced abuse and/or neglect.[9] Almost half of young people in care report exposure to four or more types of traumatic violent events.[10]

In addition to interpersonal trauma, many youth in foster care come from communities which have experienced collective trauma.

Examples of collective trauma, experienced by individuals, families and communities, include:

- Cultural Trauma: an attack on the fabric of a society/culture/identity community, affecting the essence and identity of the community and its members.
- Racial Trauma: the experiences of ongoing prejudicial treatment, which may include violence, threats of harm, shaming and the vicarious trauma of seeing harm done to other Black, Indigenous and people of color (BIPOC) individuals or groups. It can be considered as a type of complex trauma.[11]
- Historical Trauma: cumulative exposure of traumatic events that affect an individual and continue to affect subsequent generations.
- Intergenerational Trauma: when trauma is not resolved and subsequently is internalized and passed from one generation to the next.

Trauma-Responsive

Healing-Centered

Confidentiality Conscious

Client-Centered

"A program, organization, or system that is trauma-informed **realizes the widespread impact of trauma and understands potential paths for healing**; recognizes the signs and symptoms of trauma in staff, clients, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, practices, settings and seeks to actively resist re-traumatization."[12]

SAMHSA
SOURCE: SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach

Treat your patients with dignity, respect, acceptance and kindness.

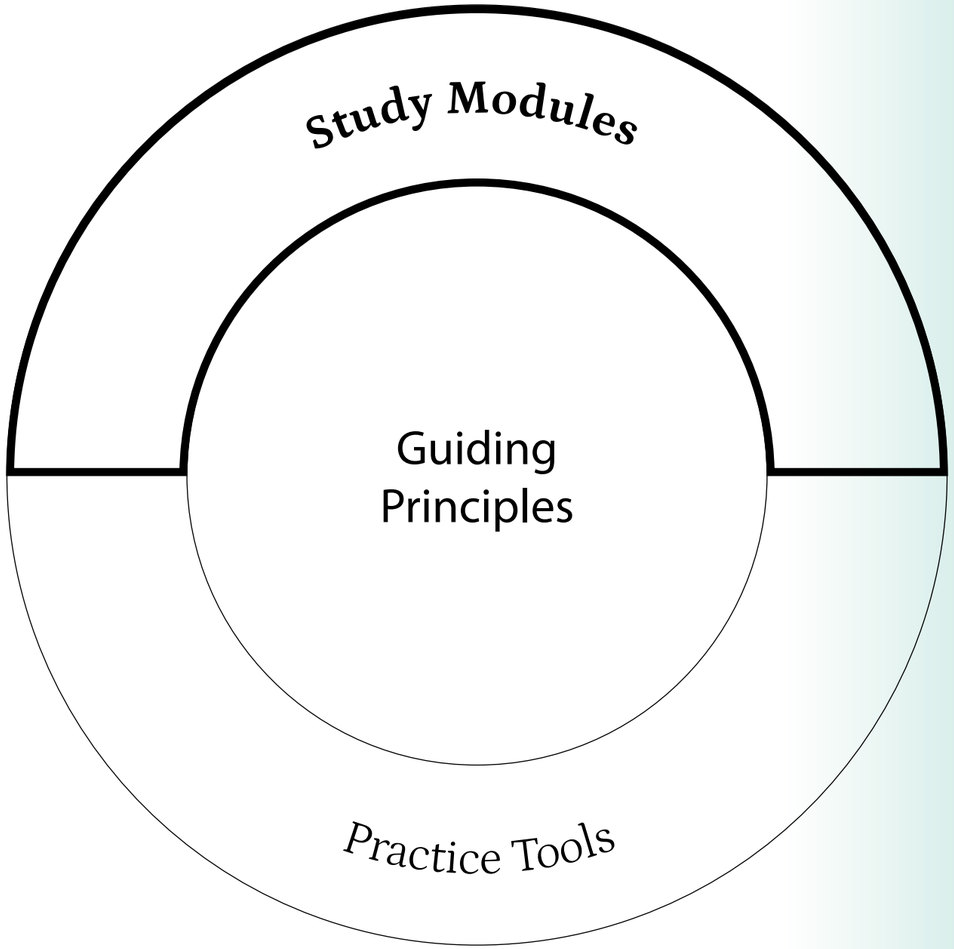
Set and maintain high but realistic expectations.

Doing so acknowledges the personhood, individuality, strength and resilience of the youth that you intend to engage with and provide care for.

STUDY MODULES

In this chapter you will find detailed information and care models across critical knowledge zones that equip care providers with the proficiency needed to improve health outcomes for youth. By knowing these zones, you'll be able raise awareness of them and how they lead to inequity. It will support better care delivery and connection with patients. You'll also be better equipped to identify opportunities to enhance care within systems.

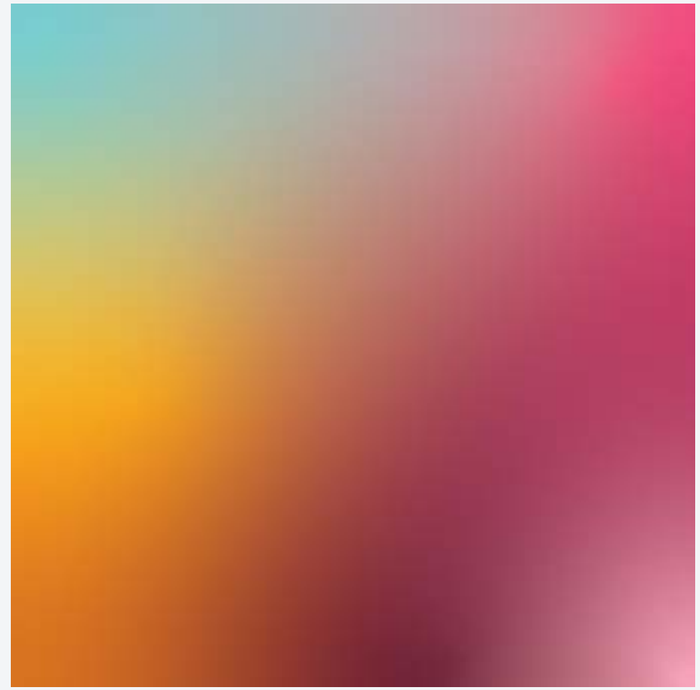
This chapter is composed of 4 sections, which correspond to the 4 knowledge zones introduced earlier: Foster Care, Confidentiality and Consent Laws, Trauma-Responsive and Healing-Centered Care, Sexual and Reproductive Health. In each knowledge zone section, you'll find study materials: **long-form explanations** that provide context, **youth voice** that emphasize the impact of these issues from youths' perspectives, and **care models** that demonstrate best practices.



STUDY MODULES

Foster Care

In this section you will develop an understanding of the circumstances and contexts of youth in the foster care system in California.



Caregivers, including relatives and foster placements, have the responsibility to support youth's healthy sexual development.

The Basics of Child Welfare in California

Typically youth enter foster care after a report of child abuse or neglect is made. Allegations are evaluated by the county child welfare agency in the county in which the child lives to determine whether they warrant investigation. Investigations fall into one of three categories: unfounded, unsubstantiated, or substantiated. The vast majority of reports are not substantiated. If deemed substantiated, the county typically will file a petition with the juvenile court to declare the child a "dependent" and remove the child from their home of origin. The petition is heard in the juvenile court for the county, and if "sustained," the youth is declared a dependent. Children also may enter foster care through voluntary placement or because they have been "abandoned" including through the death of their parent/guardian. The first goal in child welfare is to reunify youth with their families; however, that does not always happen. If youth reach the age of 18 while in foster care, they have the option to leave the system or to remain until age 21 as a "non-minor dependent."

Once declared a dependent, the court will issue placement and service orders. Placement may be with a relative foster parent or a non-related foster parent. In California, foster parents are called "resource families." Resource families must go through a licensing process to take youth into their homes. Youth also may be placed in residential settings. In California, some youth are placed in "Short Term Residential Therapeutic Placements" (STRTPs). These are often referred to as group homes. Older youth, including youth aged 18-21, may live in special transitional housing placements. Placement may be far from a family of origin and placement changes are common.

Families who identify as black, latino/latina or native american are more likely to have reports of abuse or neglect filed than those who identify as white. Youth who identify as black, latino/latina or native american are disproportionately more likely to be in care than those who identify as white.[13] There also are a higher percentage of youth who identify as LGBTQIA in foster care.[14] Youth who have babies while in foster care are also more likely to be reported and to have their children removed.[15]

California has a county administered child welfare system. The state establishes basic rules and obligations for running the child welfare system, but each county can implement these obligations in their own way. In theory, this allows each county to be responsive to its unique population and needs.

56,000 youth

Approximately 56,000 youth in foster care in California as of January 2022.[17]

46%

ages 11-21.[18]

20%

19 year old youth in foster care in California who identified as something other than "heterosexual" or "straight".[19]

1/3 of youth

Approximately a third of youth in foster care in California live in LA county.[20]

4 every 3 years

Youth ages 11-15 in foster care experienced on average 4.04 placement (family housing) changes every 1000 days in 2022.[21]

Related Practice Tools

- FOSTER CARE TEAM
- FOSTER CARE TEAM OBLIGATIONS

Definitions

CASE PLAN
A written document used in child welfare cases that specifies the type of home in which the child will be placed; the agency's plan for ensuring that the child receives proper care and protection, and the services to be provided to the child, the child's family, and the foster parents, in order to meet the child's needs while in foster care.

CHILD WELFARE
Child welfare is a continuum of services designed to ensure that children are safe and that families have the necessary support to care for their children successfully.[16] Learn More

HEALTH & EDUCATION PASSPORT
A summary of the child's health and education information. It includes the child's current and past medical problems, medications and other relevant health and mental health information. Provided to caregivers within 48 hours of a placement.

RESOURCE PARENT
A person who is trained and licensed to be a foster or adoptive parent. May be a related or non-related caregiver.

Child Welfare and Health Care

Once youth enter dependency, the child welfare agency in their county takes legal responsibility for their care, custody, and control, including the responsibility to support their healthy development and ensure their educational and health needs are met.[22] Caregivers, including relative and nonrelative caregivers and such residential placements as group homes, also have responsibility to support youth's healthy development and meet their education and health needs.[23] Among their duties, caseworkers and caregivers must ensure youth in foster care receive annual health exams. Child welfare agencies also must develop case plans for each youth that include information on the youth's health providers and relevant health information.[24] This plan must include a summary of the child's health information, often referred to as the child's Health and Education Passport (HEP).[25] Because of their obligation to keep the HEP updated, social workers, foster caregivers, and others may reach out to medical staff to request confidential health information. For this reason, it is critical to understand relevant confidentiality and information sharing law.

All youth in foster care are eligible for Medi-Cal, as are former foster youth until age 26.

There are foster care public health nurses affiliated with child welfare and probation in every county who provide public health nurse expertise to these agencies to help them in meeting the medical, dental, mental and developmental needs of children and youth in foster care. They may help with medical case planning, coordinating health services and expediting referrals, providing medical education, and supporting updates to the Health and Education Passport.[26] How foster care public health nursing programs are run varies by county.

Child Welfare Obligations to Support Healthy Sexual Development

Both caseworkers and caregivers, including relative and nonrelative caregivers and residential placements, have responsibilities to support youth's healthy sexual development.

Here are some examples.

Starting at age 10, caseworkers must:[27]

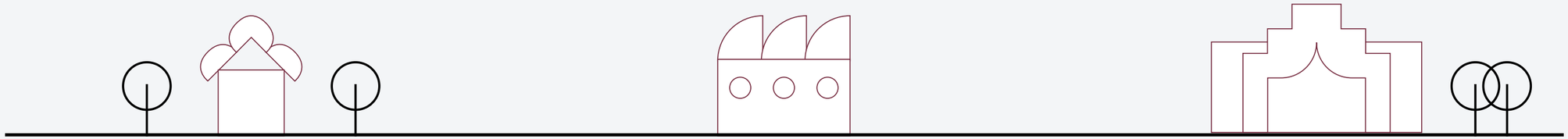
- Each year inform all youth on their caseloads aged 10 years and older and non-minor dependents (youth ages 18–21) of their rights to access age-appropriate, medically accurate information about reproductive and sexual health care; to consent to SRH services; and to confidentiality regarding those services.
- Each year inform all youth on their caseloads aged 10 years old and older and non-minor dependents (youth ages 18–21) about how to access reproductive and sexual health care services and facilitate youth access to that care, including removing any barrier to care, if the youth requests such support.
- Ensure that youth in foster care receive comprehensive sexual health education at least once in middle school and at least once in high school. If they are not able to receive it in school, the caseworker must connect them with comparable education in the community.

Caregivers must:[28]

- Facilitate access and transportation to reproductive and sexual health related services unless otherwise arranged.
- Notify the caseworker of any barriers to care.
- Assure youth receive annual health exams.
- Use the reasonable and prudent parent standard to create normalcy and to support the healthy sexual development of youth and NMDs based on their individual needs.
- Not impose their personal biases, judgements or religious beliefs.

YOUTH'S FOSTER CARE TEAM

The following resource provides a guide to the people that become part of a youth's "case" when they enter foster care.



FOSTER PLACEMENT

CHILD WELFARE

COURTS

FOSTER PLACEMENT/ CAREGIVER

This placement may be with a relative foster parent or a non-related foster parent. In California, foster parents are called "resource families." Resource families must go through a licensing process to take youth into their homes. Youth also may be placed in residential settings. In California, some youth are placed in "Short Term Residential Therapeutic Placements" (STRTPs). These are often referred to as group homes. Older youth, including youth aged 18-21, may live in special transitional housing placements.

- may not remain consistent over course of youth's dependency case

FOSTER CARE PUBLIC HEALTH NURSE:

Affiliated with child welfare and probation in every county and may work with some youth in their agencies. They help foster youth with their medical, dental, mental and developmental needs. They may help with medical case planning, coordinating health services and expediting referrals, providing medical education, and supporting updates to the Health and Education Passport.

- may not remain consistent over course of youth's dependency case
- available to some but not all youth

COUNTY SOCIAL WORKER:

(case worker or probation officer)

Responsible for visiting with the youth in their homeplacements, school and other locations to gather information and ensure that services are being implemented and needs met.

- may not remain consistent over course of youth's dependency case

ATTORNEY:

Appointed to represent them in the juvenile court and advocate for their best interests. Maintains client confidentiality. The attorney may work with the youth, the youth's social worker, the judge and other attorneys to advocate for the youth.

- may not remain consistent over course of youth's dependency case
- available to some but not all youth

JUDGE:

Oversees youth's case. Once in care, youth have their cases reviewed by the court at least every six months. The judge can issue orders that determine what care, treatment and placement youth get and make the final decision about whether or not a youth will reunify with their parents.

- consistent

COURT APPOINTED SPECIAL ADVOCATE (CASA):

Appointed by the court to some youth. This specially trained volunteer serves as a fact finder for the judge and speaks on behalf of the youth in the courtroom.

- may not remain consistent over course of youth's dependency case
- available to some but not all youth

YOUTH VOICE

"Please understand that finding transportation is often really hard for us and we might move placements, so it might be **hard to come back for another appointment**."

"I had to ask [the group home staff] to make me an appointment because the group home knew where we were supposed to be all the time and controlled all the transportation. I was not allowed to make doctor's appointments for myself."

"Moves mean new school, new house, new everything. Then with the complication of often medical records not going with you, it feels like nobody knows you, over and over and over again."

"Personally I did not have a regular clinic. I moved around too many times, over 16 different locations just in high school...each time I moved, it was a different clinic."

"I think **having some type of opportunity to speak with a former foster youth while in the clinic is going to be significant.** Designing a program for that or having something like that will build that trust. So, when you first come in, most of the time you're talking to a social worker or somebody ... and you're expecting us to build trust from them. And I just feel like it's really not going to happen, as more significant as having a former foster youth position just to be there to be their advocate."

Youth in Foster Care

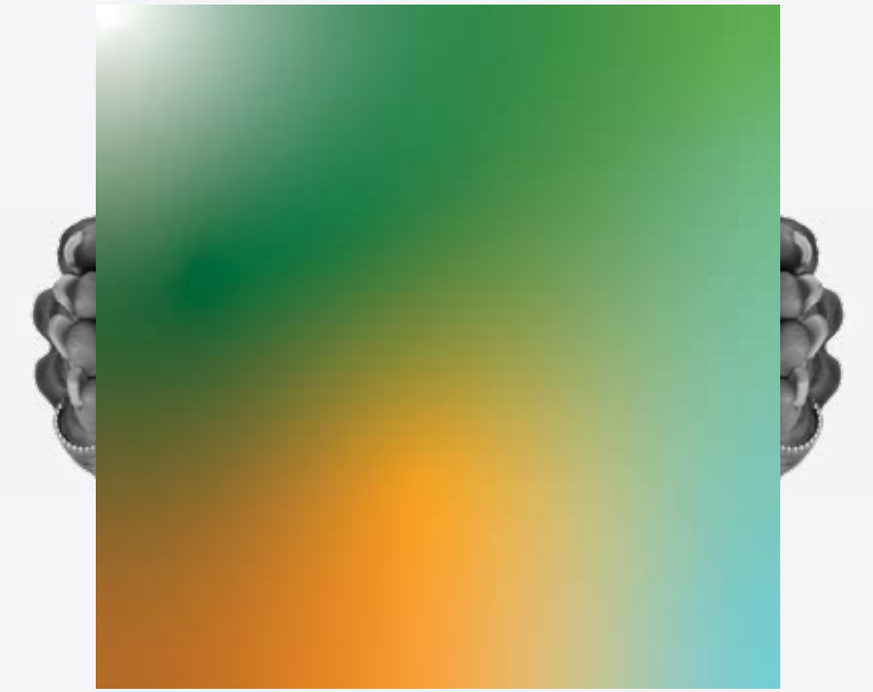
STUDY MODULES

Confidentiality & Consent Laws

In this section you will develop an understanding of California consent and confidentiality laws as they relate to the provision of sexual and reproductive healthcare to youth in foster care, and the opportunities in your practice and system to support and uphold youths' rights.

Care Models In This Section

- EXPLAINING CONFIDENTIALITY IN PLAIN LANGUAGE
- TRAUMA-INFORMED APPROACH TO MAKING A MANDATED REPORT



While a parent/guardian typically must consent to health care on behalf of a minor child, California law allows minors to consent to certain health care services, including most sexual and reproductive health care services, on their own behalf.

Youth aged 18 and older consent for their own health care unless a guardian/conservator has been put in place to make medical decisions on their behalf. These rules don't change when someone enters foster care.

Confidentiality and Consent Laws

Adolescents are more likely to seek care, disclose sensitive information and engage with healthcare providers when their confidentiality is assured.[29,30,31] For this reason, minor consent and confidentiality laws exist in all US states and territories, though they vary in scope and specificity. California law authorizes minors to consent to a range of health services on their own accord.

For more information, see practice tool:

- Minor Consent Rights

If a youth consented or could have consented to their own health care, then California law says the youth holds the right of confidentiality in the information. In general, this means that confidential medical information about a youth's sexual and reproductive health care cannot be shared with others without written authorization from the youth patient.[32]

Confidentiality and Collaboration

Cross-system coordination of services and collaboration has been shown to improve outcomes for youth.[33,34]

Concerns related to confidentiality can limit collaboration, though failing to honor confidentiality can result in breaches as well as loss of trust in

Definitions

AUTHORIZATION
Giving written permission to share confidential health information with others. Usually requires a written form that complies with federal and state law requirements.

CONFIDENTIALITY
A commitment to keep medical information private. The provider can only share patient information with permission of the patient. Note: Every confidentiality law includes exceptions that allow or require disclosures in some cases.

CONSENT
Giving permission to receive health services.

Related Practice Tools

- MINOR CONSENT RIGHTS
- ADDITIONAL RIGHTS OF YOUTH IN FOSTER CARE
- REPORTABLE SEXUAL ABUSE CHART

both the professionals and the process by the young person. The law is set up in a way to center the youth's desire for privacy while still allowing opportunities for appropriate sharing of information.

There are many exceptions in federal and state confidentiality laws that allow or require providers to share health information without written authorization in certain situations. In all cases, disclosure must be limited to the requirement of the law, and in general the recipient of the shared information is restricted from further disclosure of the information without an authorization.

Examples of permitted disclosures include (but are not limited to) the following:

- Reporting Certain Diseases and Conditions to a Public Health Authority
- Disclosure to Other Health Care Providers for Diagnosis and Treatment Purposes
- For Billing/Payment Purposes
- Child Abuse Reporting

Confidentiality and Disclosure - Best Practice

Youth in foster care can feel particularly sensitive about protecting their confidentiality. Many have had very personal and sensitive information about their lives and histories shared in court, across systems and with strangers, without their consent. It can be very disempowering and traumatic.

Although there is no requirement to inform the youth that specific health information is being shared, trust and communication are enhanced when the provider explains to the youth what information is being shared, why the information is being shared, and how the information will be protected or communicated by the receiving party. As an added protection, all referrals/ consultations should be flagged as confidential or include a notation related to the confidentiality concerns of the youth.

Confidentiality and Sharing with Social Workers, Foster Caregivers, and the Courts

The youth's social worker, probation officer, or caregiver may request protected reproductive and sexual health information from the health care provider. No exception in confidentiality law allows for such disclosures unless the youth has provided written authorization or there is a court order requiring the disclosure. If the information is being requested for purposes of court, this may implicate medical privilege as well.[35]

Child Abuse Reporting - An Exception to Confidentiality

Child abuse reporting is an exception to confidentiality. Mandated reporters of child abuse must make a child abuse report when they have a reasonable suspicion of child abuse or neglect. This may require disclosing what otherwise would be confidential medical information, without a youth's permission to make that disclosure. These reports go to child protective services or to law enforcement. They do not go to a youth's current social worker or caregiver.[36] Reporting obligations are the same regardless of whether the youth is living in foster care, experiencing homelessness, has run away, or is currently housed and living with a parent/guardian. When sexual activity is reportable as child abuse.

Sexual activity with a minor is reportable as child abuse in three circumstances:

1. When coerced or in any other way nonvoluntary
2. When it is a part of sexual exploitation or trafficking
3. Based on the age difference between the two individuals in a small set of situations

The document, The California Child Abuse and Neglect Reporting Act: Reporting rules for mandated reporters, found in the Resource Hub, provides more information as does the care models:

- Explaining Confidentiality in Plain Language
- Trauma-Informed Approach to Making a Mandated Report

Neither pregnancy nor an STI is considered sufficient evidence on its own to establish a reasonable suspicion of abuse and require reporting. This means it should not be reported absent other information that suggests abuse or neglect.[37]

Collaborative Approach to Reporting Abuse

The process of completing a suspected child abuse report has the potential for being a traumatizing/ re-traumatizing experience for the youth who is seeking care. It can be disempowering to be informed that a report will be filed regardless of the patient's desires or preferences, and revisiting traumatic experiences can be a triggering event for someone who has experienced trauma.

Including the youth in the reporting process as much as possible can decrease the anger, fear and sense of lack of control that the youth may understandably experience when informed that a report will be filed. For many youth in foster care, this will not be their first experience with suspected abuse reporting and may prompt responses based on previous negative or traumatic experiences. The care model, Trauma-Informed Approach to Making A Mandated Report, below, provides an approach to reporting designed to minimize the traumatic impact of the abuse reporting process.

YOUTH VOICE

"Because we're going through a system that is continuously repeating itself through so many different processes, like intake, like medical exams—those rules or those rights that we kind of just skim through and agree with, they're kind of a checkbox for the doctor.

Now, as I get older, I wish that wasn't looked at as a checkbox, that it was actually looked **not just as, 'Here's your rights.' but as 'Hey, let's have a 15-minute discussion before we start our process on how important what I'm saying is. Do you understand [these rights]? Let's go down the list together.'**

Implementing that into the whole experience is really crucial because then you're uplifting that youth and then you're also educating them on these policies that you're trying to teach them and trying to have them understand."

Youth in Foster Care

YOUTH VOICE

"I wouldn't really reach out to my doctors to talk to them because **they would say everything to your foster parents,** and I just wouldn't want them to see something or judge me."

"I feel like as a foster youth, I was never really taught that I had rights or just even reproductive rights."

"The group home staff gave the doctor a form to fill out. The form asked the doctor to tell what I saw the doctor for, what was wrong with me, what the cause was, and what medication was needed."

"I didn't get to choose what [group home] staff went with me when I would go to these clinics. And that was pretty crucial, because if it was an individual that I felt I was already disconnected with and going to a clinic so personal and then they receiving my chart, or my medication, or whatever I'm supposed to be doing after that fact, that conversation—even though **maybe it was supposed to be confidential, it doesn't always land confidential**; getting back to the facility or going back to the group home and them giving them (other staff) the rundown of what's going on with me."

Youth in Foster Care

"Your foster mom doesn't need to know, your parent doesn't need to know, I am not going to tell the social worker. Yes, there's a lot of reassurance that goes on. They're just as afraid of their parent finding out, or their foster parent finding out, [more] than DCFS. Anybody. Any authority figure, they don't want [them] to know."

"I think that a lot of our foster kids are just very cautious. They've just been through so much."

Healthcare Providers

CARE MODEL

EXPLAINING CONFIDENTIALITY IN PLAIN LANGUAGE

The following resource provides approaches to explaining confidentiality to a youth in plain language. It's very important to fully explain minor consent, confidentiality and reporting obligations in plain language prior to obtaining sensitive information from the patient. Youth notice when the way you speak is rote. To avoid that: use plain, understandable, non-technical language; provide specific examples; check in as you talk for the youth's understanding.

DISCUSS

CONSENT

For more info, see practice tool: Reportable Abuse Chart on p.84.

"Even though you are not legally an adult yet, when you come to the clinic for things like questions about sex or sexuality, or for a pregnancy test, birth control, condoms or a check-up for sexually transmitted infections, you can consent (give permission) for your own care."

Provide examples

CONFIDENTIALITY AND ITS LIMITS

"Before we begin, I want you to know that the things we talk about today about sex, sexuality, and sexual health care are between you, me, and the other staff who work here on a need-to-know basis. It is what we call 'confidential' - the only time things are not confidential are if you tell me you are in danger of hurting yourself or others or if someone has hurt you. If those things come up, for safety, we may need to contact someone for help.

Use non-technical language

Some people wonder what their caregiver or social worker might find out.
You do not have to tell a parent, guardian, social worker or group home staff about your care, and I cannot tell them either unless you give me written permission.
You have control."

If the youth is under 14 years old, add:
"If you tell me that you are having sex with a partner who is 14 or older, I would also need to contact someone for help, but you do not have to tell me how old your partner is if you do not want to."

If the youth is 14 or 15 years old, add:
"If you tell me that you are having sex with a partner who is 21 or older, or with someone who is under 14, I would also need to contact someone for help, but you do not have to tell me how old your partner is if you do not want to."

ASK

Does that make sense?

Check for understansing

Do you have any questions before we begin?

Check for understansing

CARE MODEL

TRAUMA-INFORMED APPROACH TO MAKING A MANDATED REPORT

The following resource provides approaches to explaining and implementing a mandated child abuse report in a trauma-informed way.

PRIORITIZE

YOUTH'S REASON FOR SEEKING CARE

"It sounds like there are a whole lot of things going on for you, and I am worried about your health and your safety. Let's start with why you came in today?"

Address the youth's reason for seeking care first

Concerns about abuse and reporting must be addressed but should not hijack the visit

DISCUSS

PROCESS

Advise youth that you need to file a report

"Remember at the beginning of your visit, when we talked about situations that I might have to share information with other people in order to make sure that you get the help you may need? Well, this is one of those situations... what has happened/is happening to you is dangerous, I am very worried about your safety, and I need to share what you have told me with a social worker/police."

Frame this in the context of making sure that they are safe and that they get the help that they may need, rather than using the rationale that "I have to file a report because it's the law"

Acknowledge that this can be a frightening and disempowering process, and provide messages of support

"I understand that this may be scary and that you are worried about what might happen. You may even feel really angry with me about this, but we still need to do it. You can be part of each step in the process, and I will show you what I write down in the report. I'll let you know what usually happens with these reports, but remember, every situation is special and different."

Recognize the courage it takes to disclose information about abuse

"It was really brave of you to talk with me today about what has been happening. You are so strong. Even though things may feel frightening and out of control right now, you have taken the first step to getting things in control by sharing your story."

Provide strengths-based messages of empowerment

YOUTH'S CHOICES

Invite youth to participate in the reporting process

"Even though you don't have a choice about whether or not I fill out this report, you do have some choices. You can decide how much information you want to share with me, we can complete the paperwork together, and you can see everything I write down and hear the phone conversation when I call the report in. We can ask the social worker/police officer to meet with you in a place that you feel safe at a time that works for you."[38]

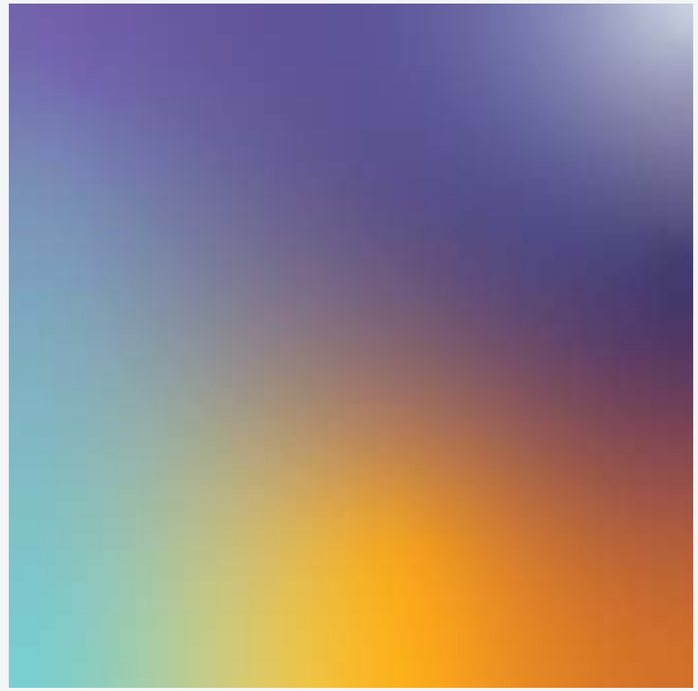
Show them the paperwork that you are filling out

Give them the option to be present when you call the report in

* Specific to California law

STUDY MODULES

Trauma-Responsive & Healing-Centered Care



In this section you will develop an understanding of trauma-responsive, healing-centered engagement in the context of providing SRH to foster youth.

Individuals who have experienced trauma often feel they lack control and are vulnerable. Environments where the youth feels disempowered or not in control (e.g. hospitals, clinics) may exacerbate this feeling.

It is important to balance an awareness of the possible negative impacts with the real opportunity for healing and resilience. A trauma-responsive program does this by realizing the widespread impact of trauma and incorporating an understanding of the potential paths for healing.

Trauma

A traumatic event is a dangerous or distressing experience, outside the range of usual human experience, that overwhelms the capacity to cope and frequently results in intense emotional and physical reactions, feelings of helplessness and terror, and threatens serious injury or death. Complex trauma "describes both children's exposure to multiple traumatic events—often of an invasive, interpersonal nature—and the wide-ranging, long-term effects of this exposure. These events are severe and pervasive, such as abuse or profound neglect. They usually occur early in life and can disrupt many aspects of the child's development and the formation of a sense of self."[39]

Early exposure to trauma is particularly impactful in adolescence. It can negatively affect adolescent self-esteem, coping skills, school performance, self-regulation, critical thinking, self-motivation, and the ability to build healthy relationships.[40] It also can impact how youth experience, engage with, and present in a health setting.

The infographic "Impacts of Childhood Trauma" at the end of this chapter describes some of the possible short and long term impacts of trauma.

100%
100% of youth in foster care have experienced trauma. Involvement in the child welfare system is by definition traumatic, including surveillance and removal from family homes.

45%
45% of 17-year-old, female-identifying youth in Cailfornia foster care reported having experienced sexual molestation before entering care. 7% of youth who identify as male reported the same.[43]

40%
Upwards of 40% of youth in care run away from placement at least once during their teen years. Youth in foster care are most likely to become victims of CSEC during a runaway episode.[44]

Related Practice Tools

- COMMON REACTIONS TO CARING FOR SURVIVORS OF TRAUMA
- KEYS TO REDUCING RE-TRAUMATIZATION
- RESPONDING TO TRAUMA SYMPTOMS
- FINGERHOLD PRACTICE: STRESS MANAGEMENT STRATEGY

Definitions

CSEC (Commercial Sexual Exploitation of Children)
Commercial sexual exploitation of children and youth is a form of human trafficking that includes recruiting, harboring, or trafficking of a minor by force, fraud, or coercion for the purpose of sexual exploitation in exchange for something of value. Force, fraud, or coercion need not be present if the individual engaging in commercial sex is under 18 years of age.

TRAUMA
A traumatic event is a dangerous or distressing experience, outside the range of usual human experience, that overwhelms the capacity to cope and frequently results in intense emotional and physical reactions, feelings of helplessness and terror, and threatens serious injury or death.

RC (Reproductive Coercion)
Reproductive coercion is a form of relationship abuse that includes attempts to impregnate a partner against their will, control outcomes of a pregnancy, coerce a partner to have unprotected sex, or interfere with contraceptive methods.

The Possibility and Consequences of Re-traumatization

Every young person's trauma experience, trauma reaction, and triggers that may activate a maladaptive response are unique. Simple questions, procedures or activities in the clinical setting (such as how a question is phrased, getting undressed, or being touched) may trigger individuals who have been traumatized.

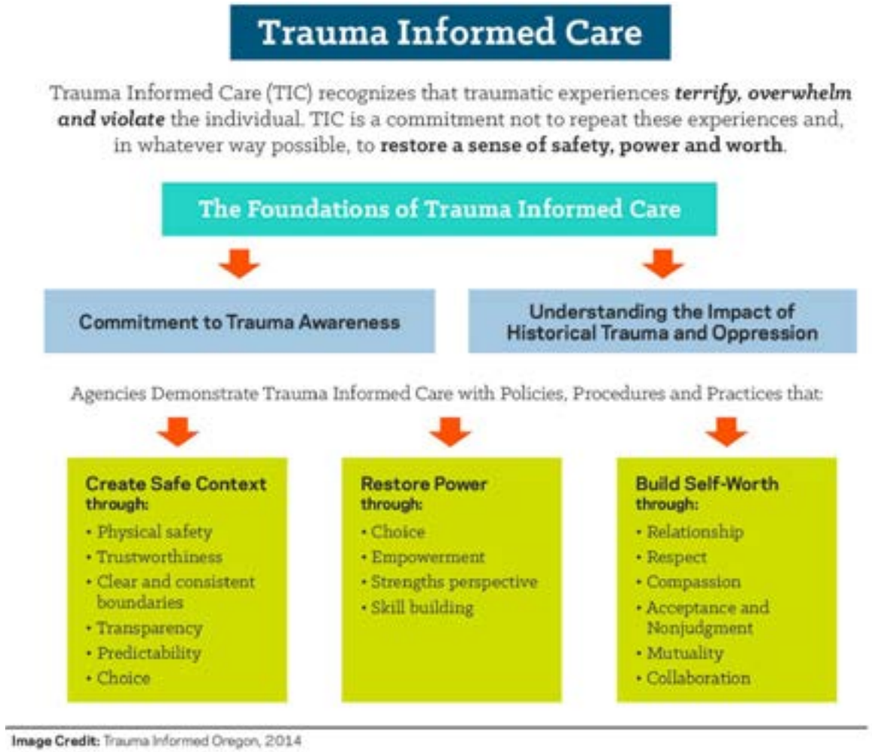
Individuals who have experienced trauma often feel they lack control and are vulnerable. Environments where the youth feels disempowered or in which they are not in control (such as hospitals, clinics, etc.) may exacerbate this feeling. If triggers or feelings of re-traumatization occur, individuals often disengage from care.

Some potentially triggering situations/ interactions include:

- Invasive procedures, removal of clothing, physical touch, vulnerable physical position
- Personal questions that may be embarrassing/distressing
- Unequal power dynamics of the relationship
- Lack of privacy
- Patient's voice not reflected in goal setting or treatment planning
- Processes not fully explained to patient
- Negative past health care experiences
  - Personal questions asked in absence of trusting relationship
  - Racist/sexist history of health care institutions
  - Changes in service providers that occur with little or no notice
  - Models of care that are focused on diagnosis/ pathology rather than strengths and resilience
  - Deficit based language

Adolescents who have experienced trauma may:

- Become anxious or depressed.
- Engage in premature separation/independence or age-inappropriate dependence.
- Be at risk for affiliation with a peer group with negative behaviors.
- Be at risk for engaging in risky sexual behaviors, substance misuse and self-harm.
- Attempt to control self and environment, sometimes through dysfunctional approaches.
- Have difficulty forming trusting relationships.
- Fail to develop age-appropriate coping strategies.
- Develop a negative self-identity.
- Adopt a negative view of people and society.[45]



Reproduced with permission from Trauma-Informed Oregon[46]

Evolving to Healing-Centered Care

It is important to balance an awareness of the possible negative impacts with the real opportunity for healing and resilience. A "trauma-responsive" program does this by realizing the "widespread impact of trauma" and incorporating an understanding of the "potential paths for healing." Healing-Centered Engagement is another approach. Healing-Centered Engagement takes trauma-informed care to the next level, focusing on the collective context of trauma and offering a holistic approach to healing. Traditionally, we encourage providers of trauma-informed care to change their perspective of their patients from "what's wrong with you?" to "what happened to you?" A healing centered approach to addressing trauma "requires a different question that moves beyond "what happened to you" to "what's right with you" and views those exposed to trauma as agents in the creation of their own well-being rather than victims of traumatic events."[41]

This concept, developed by Shawn Ginwright, PhD, proposes that trauma is experienced collectively, not just individually, and focuses on restoration, not just reduction of symptoms. Additionally, it acknowledges the trauma that helping professionals may have experienced as well as the impact of secondary or vicarious trauma and supports adult providers in their own healing. Healing happens on three levels: individual, interpersonal, and institutional. As a strategy, healing-centered engagement centers on the intersectionality of culture, race and identity, the importance of a sense of agency and a future goal orientation, coupled with support so that youth can achieve those goals, the primacy of relationships, and a sense of meaning and having aspirations.[42] Healing-centered engagement is a perspective that is strengths-based and allows the youth and the helping professional to refocus from past trauma to future goals and aspirations, supporting the youth in regaining a sense of holistic well-being.

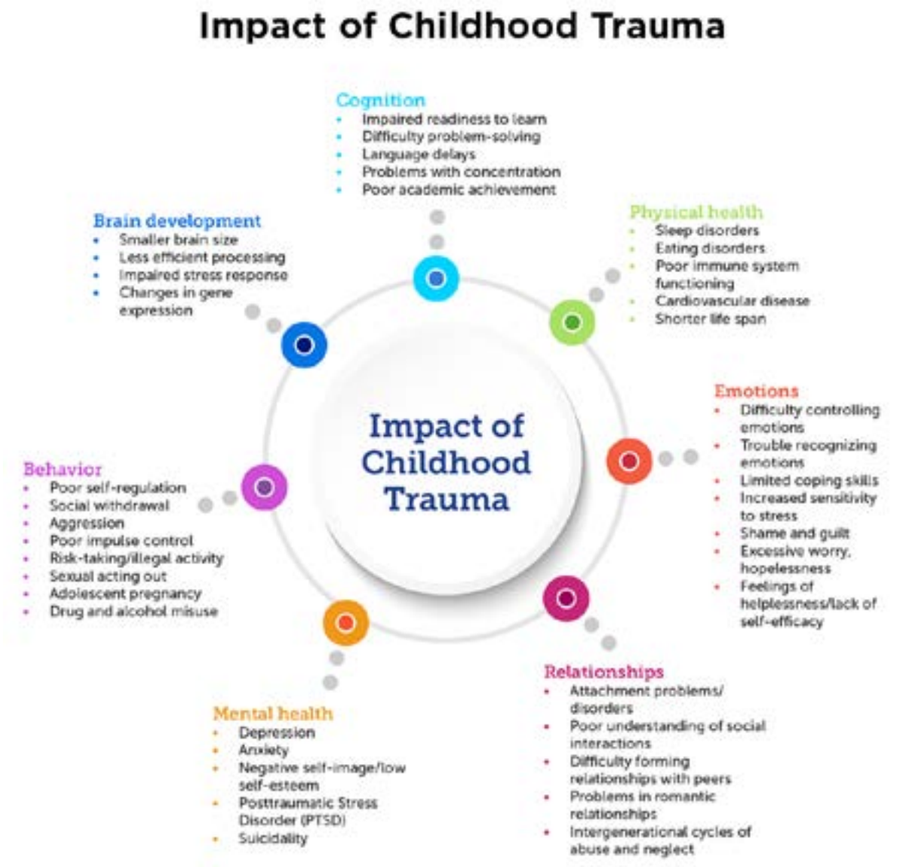
Because healing-centered engagement is a newer field, this section focuses on evidence informed best practices for trauma-informed care. However, we encourage readers to explore more information on healing-centered engagement in the Resource Hub.

Self-Care and Self-Awareness of Adults Engaged in Service Provision

Secondary (or Vicarious) Trauma is a change in one's world view due to exposure to other peoples' trauma stories. It is an occupational hazard for those providing care to trauma survivors. Helping professionals and non-professional staff/youth workers who have their own history of trauma are more vulnerable to secondary trauma.

For more on secondary trauma, see practice tools:

- Common Reactions to Caring for Survivors of Trauma
- Trauma-Responsive Practice Change Opportunities (Protect Staff by Providing Organizational Interventions to Respond to Secondary Trauma)



Reproduced with permission from Child Trends[47]

YOUTH VOICE

"When I went to the doctor, the doctor asked if I had ever had sex. I didn't know how to answer. I went into foster care at 6 years old and had an STI then. Does that count? I try not to tell people that because I feel like they judge me and think I am dirty or something. But I was just a kid."

"There've been many times where I felt that my doctor had certain stereotypes about me because I was in foster care."

"I've had a couple of doctors, and I always see if their energy is good, and depending on that, I might open up...If you don't approach me right, or I feel like I'm not welcome, I won't feel comfortable..."

"I really like this idea of **continuous care - to be able to come back to one doctor**, if I felt comfortable with them. That sounds like a really great concept."

"It is important that everyone the youth comes in contact with is professional – from the receptionist on up."

Youth in Foster Care

STUDY MODULES

Sexual & Reproductive Health

In this section, given the importance of healing centered care and upholding confidentiality in foster youth healthcare, you will develop an understanding of how to apply patient-centered care to specific SRH practices like obtaining a Sexual History, Contraceptive Counseling and Reproductive Planning.

Care Models In This Section

- SEXUAL HISTORY INTERVIEW GUIDELINES
- TALKING WITH YOUTH ABOUT SEXUAL HEALTH
- TRAUMA-SENSITIVE APPROACH TO A PHYSICAL EXAMINATION
- APPROACHES TO REDUCE TRAUMA DURING PHYSICAL EXAMINATION
- SHARED DECISION-MAKING APPROACH TO CONTRACEPTIVE COUNSELING
- APPROACH FOR STI RISK REDUCTION COUNSELING
- AN APPROACH TO UNBIASED PREGNANCY TESTING (2 MODELS)

All young people, including young people in foster care, can benefit from enhanced access to developmentally appropriate sexual and reproductive health care that supports their healthy sexual development.

Sexual and Reproductive Health Care is a Routine Adolescent Service

The expectation that sexual and reproductive health care is a standard component of routine adolescent care has been well established and accepted for decades. Leading professional organizations, including the American Academy of Pediatrics,[48] Society for Adolescent Health and Medicine,[49] American College of Obstetricians and Gynecologists,[50] and the American Academy of Family Physicians[51] recommend the inclusion of anticipatory guidance, education and sexual and reproductive health (SRH) care as a routine aspect of comprehensive adolescent care. These recommendations are based on the data related to adolescent sexual activity, pregnancy and sexually transmitted infection rates with a goal of supporting health care providers to engage in education, counseling, prevention and early intervention to improve SRH outcomes for young people. All young people, including young people in foster care, can benefit from enhanced access to developmentally appropriate sexual and reproductive health care that supports their healthy sexual development.

SRH Interview

The sexual and reproductive health interview can be a challenging interaction for any young person, and for those who have experienced trauma, it may be particularly difficult. To avoid re-traumatization, a central goal of trauma responsive care, the interviewer must be alert to the impact of their own attitudes, biases, judgment and communication style on their patient, as well as the unwanted sexual experiences and other traumatic events that may be impacting on the youth. When re-traumatization occurs, it may result in the patient disengaging from care due to the negative experience.

A key component of a trauma-informed SRH interview is keeping possible trauma history in mind throughout. It can be helpful to acknowledge the impact of a history of sexual trauma by stating explicitly that you understand that for some people who have experienced sexual trauma, it can be difficult to get SRH care, and that you, as a provider, are sensitive to this and will work with and support the youth in getting the care all young people need to be healthy.

This also applies to how you frame questions. For example, asking "Have you ever had sex?" or "How old were you when you had sex for the first time?" can be triggering for youth with a history of sexual abuse. Instead, you can acknowledge trauma with

18%
18% of 19-year-old youth in California foster care had their first sexual intercourse between 10-12 years old. (Remember not all sex is consensual.)[73]

99%
PrEP has been shown to reduce the risk of HIV acquisition through sexual contact by roughly 99%.[74]

75%
Pregnancy, birth and abortion rates for 14-19 year olds reduced by 75% as compared to the national rate when no cost, reversible contraception is offered and youth are allowed to choose their preferred contraceptive method.[75]

Related Practice Tools

- **EMERGENCY CONTRACEPTIVE CONSIDERATIONS**
- **ACCESSING CONTRACEPTION OUTSIDE A CLINIC: YOUR COMMUNITY RESOURCES**
- **SEXUAL HEALTH PROMOTION RELATED** (2 TOOLS)
- **SCREENING APPROACHES** (3 TOOLS)
- **EXPLAINING ABORTION OPTIONS**
- **PREGNANCY RELATED** (3 TOOLS)

Definitions

ARA (Adolescent Relationship Abuse)
Adolescent relationship abuse (ARA), also known as teen dating violence or intimate partner violence (IPV), includes physical, sexual, or psychological/emotional abuse of a romantic, sexual, or intimate partner that occurs in person, through texting, online, or through someone else (e.g. a peer who delivers a threat or message).

CONTRACEPTIVE COUNSELING
An interactive process between provider and client intended to help the client achieve a reproductive health goal.[70] Learn more

EC (Emergency Contraception)
Contraceptive methods that can reduce the risk of pregnancy when used after unprotected/under-protected vaginal intercourse.

HEEADSSS
The HEEADSSS interview focuses on assessment of the Home environment, Education and employment, Eating, peer-related Activities, Drugs, Sexuality, Suicide/depression, and Safety from injury and violence.[71] Learn more

PRECONCEPTION COUNSELING
Preconception health refers to the health of women and men during their reproductive years, which are the years they can have a child. It focuses on taking steps now to protect the health of a baby they might have sometime in the future.[72] Learn more

a statement and question such as: "Unfortunately, many of the young people I see in clinic have had painful, difficult experiences with unwanted or forced sex and sexual abuse. We can talk about that today if you want to, but we don't have to talk about that. I do want to ask about your experiences with sex as something you want to do…have you ever had sex voluntarily, because it's what you wanted?"

Your nonverbal engagement is also important. It is important to maintain a nonjudgmental stance and a neutral facial expression. If possible, you should avoid doing data entry while conversing so that you can focus on the youth, including watching for nonverbal clues to stress. The staging of the exam room also can contribute to minimizing possible trauma.

Strengths-Based Interviewing

Healthy development is encouraged when adolescents feel empowered and when they form healthy social connections. Health care providers are encouraged to use strengths based, trauma informed, motivational interviewing and shared decision-making to help adolescents build confidence for behavioral change.[52] SSHADESS (strengths, school, home, activities, drugs, emotions/eating, sexuality, safety) is a mnemonic to facilitate collection of a psychosocial history of critical life dimensions which emphasizes identifying strengths while assessing for risks. Embedding a SRH interview within a general psychosocial interview establishes rapport, helps the clinician understand the youth's context and normalizes the inquiry.

If there is not time to complete a full SSHADESS assessment, the provider should inquire about current stressors and explore hidden agendas for the visit using strengths based question formats. For example, the provider may ask "Tell me how school is going" as a proxy for well-being. Because healthy social connections are so important to healthy development, providers should also always ask about relationships – for example "Do you have anyone in your corner?" This kind of question can open the door to universal relationship education described below and SRH discussions.

Physical Exams

Traditionally, SRH services have included physical exam components, such as a pelvic exam or an external genital exam, which may be triggering or traumatic for youth who have experienced sexual abuse and other forms of trauma. Although there are specific clinical indications for these exams and trauma-informed approaches to reduce the impact of these sensitive exams, much routine SRH care can be provided to youth without them. While taking recommended physical exam components into account, a trauma-informed approach requires that the clinician respects the youth's preferences and limits, and offers reasonable alternatives to exams that the youth finds unacceptable. Below are some indications and non-indications for specific physical exams which can reduce the traumatic aspects of clinical SRH services.

Breast/Chest Exams

Bright Futures guidance from the American Academy of Pediatrics recommends breast inspection for sexual maturity rating (SMR) annually or until full maturity (SMR 5) for youth assigned female at birth 11-16 years old, with a clinical breast examination after age 20. For youth assigned male at birth they recommend annual chest inspection for gynecomastia throughout adolescence (11-21 years old).[53] Other recommending bodies, including the National Comprehensive Cancer Network and the American Congress of Obstetricians and Gynecologists recommend onset of screening clinical breast exams at 25 years old and, in the case of the American Cancer Society, no screening clinical breast exams at any age.[54]

External Genital Exams

For youth assigned female at birth, Bright Futures guidance recommends inspection for SMR annually or until full maturity (SMR 5) ages 11-16 years old. For youth assigned male at birth, Bright Futures and the Society for Adolescent Health and Medicine guidance[80] recommends inspection of external genitalia for SMR (until fully mature), and palpation of scrotum and testes for hydrocele, varicocele, hernias or masses annually.

Pelvic Exams

For youth assigned female at birth, Bright Futures guidance recommends a pelvic examination at age 21 years to obtain first Pap smear or at any age without a Pap smear if sexually active with signs and symptoms of STI, pregnancy, or pelvic infection, or to evaluate abnormal pubertal development or abnormal vaginal bleeding.

Rectal Exams

There are no recommendations for routine rectal exams in adolescence.

For more info, see care model:

- Trauma-Sensitive Approach To A Physical Examination
- Approaches To Reduce Trauma During Physical Examination

Definitions *(continued)*

PrEP (Pre-Exposure Prophylaxis)
Medicine that reduces your chances of getting HIV from sex or injection drug use. When taken as prescribed, PrEP is highly effective for preventing HIV.[76] Learn more

REPRODUCTIVE PLANNING
The Reproductive Life Plan (RLP) is a protocol consisting of a set of questions to guide a conversation about if and when a person might want to become a parent.[77] Learn more

SEXUAL HEALTH PROMOTION
The process by which individuals achieve the ability to control and improve their sexual health. The promotion of sexual health should enhance sexual and emotional well-being and help people to reduce the risk of sexually-transmitted diseases (STDs), HIV, and unwanted pregnancies.[78] Learn more

SRH
Sexual and Reproductive Healthcare

SSHADESS
Strengths, School, Home, Activities, Drugs, Emotions/Eating, Sexuality, Safety: is a mnemonic to facilitate collection of psychosocial history of critical life dimensions emphasizing strengths within a youth's life experience instead of solely focusing on risks, which in isolation can provoke feelings of shame.[79] Learn more

Universal Reproductive Planning

Choice and empowerment are the essential experiences for youth in deciding whether and when to become pregnant. Reproductive health advocates have designed One Key Question ® to be asked at least annually of all patients who have the ability to get pregnant: "Would you like to become pregnant in the next year?"[55] Although not currently explored in the research, asking clients who have the ability to impregnate another person a similar question about pregnancy intentions/acceptability and attitude is advisable as a best practice.

If the answer to this question is "no" or "not sure" or even "whatever happens is okay with me" then further exploration of contraceptive methods is appropriate. Ambivalence, confusion and distress are common responses to an unintended pregnancy. Youth who are ambivalent may need more time to consider their options, may desire the input and support of significant people in their life, or may benefit from a decision-making structure and support.

If the answer is "yes" then preconception counseling, rather than contraceptive counseling, is indicated. Based on the response to this question, the provider can determine which avenue to explore and partner with the youth to discuss options and support them in engaging in a reproductive life plan that aligns with their intentions.

By respecting the youth's desires and pregnancy intentions and partnering with them to identify behaviors and situations that can contribute to improved health during the pregnancy and once the baby is born, providers can support youth in foster care in achieving healthier pregnancy outcomes.

New research suggests the dichotomy of pregnancy planning by asking about intention may "be less likely to be a salient or realistic concept" for women who are low income, of color, or young.[56] This may tie to feelings of agency, or lack thereof, relationship stability, and acceptability. Indeed, researchers posit that "acceptability" of pregnancy may be a more relevant measure than intentionality. The question of acceptability might be phrased as : "Are you okay with getting pregnant in the next year?" or "How okay would it be with you if you got pregnant in the next year?"
Asking about "acceptability" rather than "intention" may allow more gradations in a response and for more fruitful conversations about options, such as the desire for long or short term contraception, and education and resource needs.

Keep in mind that not only cis-gender heterosexual females get pregnant. Anyone with a uterus and ovaries, even if taking testosterone, can get pregnant if they have vaginal-penile sex and should be asked this question.

When counseling transgender and gender diverse youth who were assigned female at birth, educate yourself first and use a counseling tool that is oriented to this population, such as Birth Control Across the Gender Spectrum by the Reproductive Health Access Project.

Universal Emergency Contraception (EC) Counseling

Education about emergency contraception (contraceptive methods that can reduce the risk of pregnancy when used after unprotected/ under-protected vaginal intercourse), is essential information for all patients regardless of reported sexual activity, pregnancy intention, or sexual or gender identity. Because adolescence is a time of experimentation, self-discovery and identity development, many youth who do not identify as heterosexual or as cisgender may explore their sexuality, including exploring sexual behaviors which could result in a pregnancy. Adolescents are also more likely to confide in their friends than in adults, so a broad knowledge of pregnancy prevention options by all youth contributes to their ability to provide timely and accurate information to a friend or partner when they need it. Youth in foster care may face additional barriers that make it more difficult to access consistent care and/or refills of prescribed medications.

Additionally, emergency contraception is the only method available to avoid unintended pregnancy for a young person who experiences a sexual assault and is not already using contraception.

The AAP recommends providing prescriptions and/ or a supply of Emergency Contraceptive Pills (ECPs) (with refills and condoms) to adolescents so that they have easy access to EC if and when they need it. "Advanced provision of ECPs increases the likelihood that teenagers will use EC when needed, reduces the time to use, and does not decrease condom or other contraceptive use. Levonorgestrel ECPs are available to male and female patients regardless of age without a prescription but may be expensive when purchased over the counter and are often covered by insurance with a prescription."

Accessing contraception outside of a clinic visit

For youth who prefer a high level of flexibility and privacy and want a hormonal method that does not require a procedure to initiate, pharmacy prescribed or online access may be an option. Ideally, the health care provider should provide support for the youth in finding a resource that will work for them. Due to the instability of placements of youth in foster care, these options may be the best approach to access, but require a high degree of self-efficacy and/or a high degree of support to explore and establish.

Sexual Health Promotion

All sexually active youth, regardless of their sexual or gender identity, gender of their partners, or the sexual behaviors that they engage in, can benefit from a discussion about sexual risk reduction and STI and HIV screening/testing as appropriate. Although there is no national data on STI and HIV rates for youth in foster care, multiple studies show higher STI and HIV rates among youth in foster care, as well as among young adults who were previously in foster care, than among their peers who are not in care.

For counseling for risk reduction, see care model:

- Approach For STI Risk Reduction Counseling

Universal PrEP Counseling

Universal education and counseling regarding PrEP as prevention is appropriate for all patients, since recommendations for offering PrEP are based on a detailed assessment of sexual behaviors, and disclosures of risky behavior are dependent on the level of comfort and trust that a youth has in the provider. Providing information to all youth empowers them to seek more information and treatment if they are interested, motivated, and believe it would be of benefit to them.

For those young people identified to be at significant risk for HIV (internal link to criteria below labeled "Current 2021 CDC criteria…), an in-depth discussion of the recommendation of a preventative medication that reduces the risk of acquiring HIV (PrEP) is appropriate. All providers should be prepared to discuss PrEP with their patients and either refer to a provider who is comfortable with PrEP and working in a system that provides adequate monitoring and adherence support or develop the skills and system supports to provide PrEP on-site in consultation with more experienced PrEP prescribers. PrEP has been shown to reduce the risk of HIV acquisition through sexual contact by ~99% and through injection drug use by ~74-84%.[57]

Introducing PrEP as a risk reduction option in the context of offering HIV testing contributes to normalizing the conversation and opens the door to further discussion.

In California, minors who are >12 years old can consent to taking PrEP on their own, without the need of parental/guardian permission. Additionally, PrEP can only be prescribed for patients who weigh at least 77 lbs.

Ongoing adherence (taking medication as directed) and persistence (continuing with treatment over time), the primary limiting factors on efficacy of PrEP in HIV prevention, are significant issues among adolescents as well as among adults. Innovative approaches such as flexible scheduling with after-hours options, frequent visits, peer navigators, adherence buddies and screening for adherence barriers such as transportation problems and insurance changes (issues that are particularly salient for youth in foster care and non-minor dependents) can all contribute to improved adherence.[58]

Screening Approaches

Screening for Relationship Quality and Adolescent Relationship Abuse (ARA)

The quality of an adolescent's intimate relationship(s), particularly as it relates to the balance of power, communication, and autonomy within the relationship, impacts on the youth's physical and mental health, pregnancy risk and STI/HIV risk. Adolescent relationship abuse (ARA), also known as teen dating violence or intimate partner violence (IPV), includes physical, sexual, or psychological/emotional abuse of a romantic, sexual, or intimate partner that occurs in person, through texting, online, or through someone else (e.g., a peer who delivers a threat or message). ARA/IPV can impact any adolescent relationship regardless of the gender identity or sexual orientation of the partners and is a significant health concern.[59]

Sexual and Gender Minority (SGM) youth are at elevated risk for ARA. Of students participating in the 2015 national Youth Risk Behavior Survey, 30% of lesbian or bisexual female students and over a quarter of gay or bisexual male students reported sexual and physical violence victimization as compared with 20% of heterosexual female students and 8% of heterosexual male students participating.[60] Although there are limited data on ARA in gender diverse youth, one large statewide representative survey of students in Colorado found up to 8.6 times greater odds of experiencing physical violence among transgender youth than among their cis-gender peers.[61]

One form of ARA, reproductive coercion (RC), is particularly impactful on a young person's ability to control their own reproductive health. Reproductive coercion "includes explicit attempts to impregnate a partner against her will, control outcomes of a pregnancy, coerce a partner to have unprotected sex, and interfere with contraceptive methods."[62] Common examples include hiding or throwing away birth control, tampering with physical barrier methods such as condoms, or verbally shaming a young person who asks to use a condom.

Youth in foster care are at higher risk for RC and IPV through multiple pathways, including their own history of exposure to violence and trauma in childhood.[63] In a recent study of young women in foster care, nearly a third reported experiencing RC, with even higher rates among young women who reported sex with both women and men than among exclusively heterosexual young women.[64]

Screening for intimate partner violence in "women of childbearing age" with follow-up and support services for those who disclose IPV has been endorsed by professional organizations and governmental agencies including the The American Academy of Family Physicians, American College of Obstetricians and Gynecologists (ACOG), American Academy of Neurology, American Academy of Pediatrics, Institute of Medicine Committee on Preventive Services for Women, and the HRSA-supported Women's Preventive Services Guidelines, and has received a "B" rating from the USPSTF.[65] There is currently insufficient evidence to recommend screening in other populations, including men and gender diverse populations. Although there are a number of validated screening tools which are often incorporated into commonly used EHRs, rates of disclosure, particularly among adolescents, are low which limits access to support, interventions and referrals.[66]

Screening Using Universal Healthy Relationship Education

Universal healthy relationship education is recommended by domestic violence and adolescent health experts as an approach which is not disclosure-driven, can be strengths based, and allows youth to access information and services even if they do not endorse ARA.[67] Clinical settings that serve adolescents are strategic sites to provide universal education on safe, consensual and healthy relationships and engage in targeted interventions to identify and intervene with reproductive coercion and other forms of ARA utilizing trauma-informed responses to disclosures of ARA.

Screening for Human Trafficking/CSEC (Commercial Sexual Exploitation of Children)

Commercial sexual exploitation of children and youth is a form of human trafficking that includes recruiting, harboring, or trafficking of a minor by force, fraud, or coercion for the purpose of sexual exploitation in exchange for something of value. Force, fraud, or coercion need not be present if the individual engaging in commercial sex is under 18 years of age. CSEC is a form of child abuse which can involve prostitution, pornography, sex tourism, stripping, escort services, phone sex lines, and private parties.

Youth in foster care are at higher risk for CSEC through multiple pathways. Youth are most vulnerable in early adolescence, and although girls are more likely to be targeted by traffickers, significant numbers of boys are also recruited. A significant number of CSEC have foster care experience. Youth in foster care are most likely to become victims of CSEC during a runaway episode, and by self-report, upwards of 40% of youth in care run away from placement at least once during their teen years.[68] That said, traffickers also target youth living in group placements, and youth initially identified as "runaways" may actually have been recruited out of their placements by traffickers. Youth who identify as SGM, already over-represented in the foster care population, also make up a larger proportion of youth who run away from foster care placements,[69] making them additionally vulnerable to trafficking.

Universal Education about CSEC and the "Leading Question" Approach to Screening

Universal education is an approach that is not disclosure driven, can be strengths based, and allows youth access to information and services, even if they do not identify as CSEC.

So called "key indicators" of CSEC involvement, such as clothing style, "branding" tattoos, the use of street slang to refer to sex work and an unwillingness to identify as a victim are not universally reliable indicators of CSEC involvement. With the goals of providing options and support to youth experiencing CSEC, rather than simply identifying those youth based on their disclosures, Asian Health Services in Oakland, CA recommends the use of universal education and a "leading questions" approach with all patients.

For more information about the leading question approach see the practice tool:

- Leading Question Approach To CSEC Screening

YOUTH VOICE

"She made me feel better. She didn't try to push me to talk about it. Like, she got to know me, you know? And, like stuff I do."

"There's this one lady, she checks up on me every time I go. She's like, I'm just checking to see how it is. She was noticing that I wasn't able to make certain appointments...I was like, I'm not able to make them because, I don't have the ride. So she's like, oh, there's a service for that. And she got me connected to that service, so quickly."

"People should really hear out foster kids and youth in general... and they shouldn't just be like, oh well, you know, doing their job. If you don't even like kids, or if you're going to hate your job, don't get into it. People that really want to work there, they really listen. And they really like their job. Like you could just tell, they listen and they are there for you. And they make you feel safe in a way. Then it's easier for a youth to express how they feel."

"I think if they started pushing more preventive ways on guys...that would change a lot...I feel like we put a lot of pressure on females, like, oh you need birth control. Oh, you need to make sure you don't get anything. The same pressure needs to be on guys."

Youth in Foster Care

“I usually will discuss with the patient every single type and why it might be good for them, why it might not be good for them. But I like to make it an open conversation, because I don’t know their lives, and I don’t know what’s going to be easier for them.”

Healthcare Providers

“As much as I’d love them to do the long-term, I try to keep it more about what their lifestyle is and what would be best for them.”

CARE MODEL

SEXUAL HISTORY INTERVIEW GUIDELINES

The following resource provides a guide to conducting a sexual history interview that is both youth appropriate and trauma-senstive. It's very important to maintain a non-judgemental stance and to watch closely for signs of their discomfort. Be prepared to change communication tactics as you go.

* Adapted with permission from general guide to client-centered sexual history taking for youth, developed by the Adolescent Health Working Group

PROCESS STAGE	KEY STEPS	GUIDELINES
ENTER EXAM ROOM		◦ Meet and interview the patient while they are fully clothed ◦ Sit at eye-level and engage the patient with eye contact • If the patient's non-verbals indicate that eye contact is uncomfortable for them, do not insist ◦ Maintain a non-judgmental stance • Be aware of verbal and non-verbal indicators of judgment
START CONVERSATION		◦ Introduce yourself, letting your patient know your preferred name and pronouns and then inquire as to their preferred name and pronouns
INQUIRE YOUTH CONCERNS	Start the visit with inquiry into the patient's concerns, not with data entry or chart review on the computer.	◦ Listen and respond to the patient's concern(s) prior to typing in your notes ◦ Communication Tips: • Avoid jargon or complex medical terminology • Use inclusive language(Practice Tool: Inclusive Language) • Listen and don't assume or jump to conclusions • Respect the youth's experience and autonomy
ADDRESS SEXUAL HEALTH	Sexual health should be addressed with all patients. However, establish rapport before asking about sexual health. Let youth know you'll be asking sensitive questions about sex and sexuality before getting into their sexual history.	◦ If time permits, embed the SRH interview in a general psychosocial interview, such as a HEEADSSS or SSHADESS ◦ Acknowledge that youth may have been asked these questions before
ASK PERMISSION TO PROCEED		◦ **If they say NO:** honor their choice and make space to explore alternatives • Ask if they would be open to discussing it at another visit in the future ◦ **If they say YES:** get specific and arrange a future visit for SRH care • Ask if they prefer to engage in SRH care at another clinic or with a different provider. If yes, facilitate a referral when necessary
ACKNOWLEDGE IMPACT OF TRAUMA		◦ State explicitly that people who have experienced sexual trauma often avoid getting SRH care, that you, as a provider, are sensitive to the issue and will work with/support them in getting the care that all young people need to be healthy
WATCH FOR SIGNS OF DISCOMFORT	Watch for body language that signals a youth is uncomfortable. Acknowledge it and use it as a sign to change communication tactics.	◦ Faraway look ◦ General Anxiety ◦ Rubbing their neck

CARE MODEL

TALKING WITH YOUTH ABOUT SEXUAL HEALTH

The following resource provides examples of phrases and language to use when speaking with youth about sexual health. In order to become a trusted care provider and information source, the provider should strive to speak to youth on and with their terms.

CONSIDER

CONVERSATION OPENERS

Be sensitive to questions about sexual debut

"Unfortunately, many of the young people I see in clinic have had painful, difficult experiences with unwanted or forced sex and sexual abuse. We can talk about that today if you want to, but we don't have to talk about that. I do want to ask about your experiences with sex as something you want to do…have you ever had sex voluntarily, because it's what you wanted?"

REFRAMING QUESTIONS

Be inclusive, strengths-based & with trauma in mind

"Sexuality and relationships are things that many teens are dealing with, and different people are at different points in exploring these issues. Have these issues ever come up for you?"

Don't assume all youth are sexually active

"Do you have someone to talk to about sex and relationships?"

"I am going to ask you a few questions about your experiences and knowledge of sex so that I can help you in keeping/making these experiences fun, positive and healthy"

"What do you consider is 'having sex'?"

"How do you feel about having sex? Is it a good thing or a bad thing?"

"Do you have a partner?"

Don't assume sexual orientation

Instead of "Do you have a boyfriend/girlfriend?"

SUPPORT CUES

Be non-judgmental in your words and body language

"Let me know if there is any way I can help you."

"If you have questions and I don't know the answer, we can look them up together or figure out how to find the answer."

"If I say something wrong, please stop me and let me know, I am here to help you and don't mean to hurt you."

Phrases youth say they would like to hear

DON'T frame questions like:

- "Have you ever had sex?"
- "How old were you when you had sex for the first time?"

These can be triggering for youth with a history of sexual abuse.

Tips for Talking to Foster Youth from Foster Youth:

- Listen and believe us
- Ask us what we are comfortable with
- Let us know that you are there to help us
- Let us know that we can come forward with questions

CARE MODEL

TRAUMA-SENSITIVE APPROACH TO A PHYSICAL EXAMINATION[81]

The following resource provides approaches to a trauma-sensitive physical examination. The provider's goal should be to communicate respect and maintain/restore a sense of safety, autonomy and trust to avoid triggering feelings of fear, shame, vulnerability and powerlessness.

DISCUSS

While explaining the procedure, watch for signs of anxiety, fear or discomfort

Provide adequately sized gowns/ drapes for modesty (cloth rather than paper if possible)

BEFORE EXAM

"Before we get started, I'm going to walk you through what we will be doing during the exam.":

- What parts of the body will be examined
- What tools will be used
- How long it will take

"This is something I do whenever a patient has _____ (name symptoms)." | Normalize the exam

If youth need to remove clothing - "When needed, I will ask you to lift the left side of your shirt up to _____ so we can inspect _____." Be specific

If using gown - "You'll wear this with the opening in the back."
If using drape - "You can use this as a sheet over your lap."

"I will step outside so you can change.
When you're ready, let me know and I'll come back in."
Knock & wait for permission before re-entering

DURING EXAM

"First I'm going to ___." | Let youth know what you're doing prior to each step

Say - "First I will inspect the outside of the vaginal area"
NOT - "First I'm going to look at the outside of your vaginal area"

Say - "Allow your knees to fall towards the walls"
NOT - "Spread your legs"

Say - "Exam table"
NOT - "Bed"

Say - "Foot rests"
NOT - "Stirrups"
| Use simple, impersonal & non-clinical language

Say - "Take deep breaths"
NOT - "Relax"

AFTER EXAM

"I'm going to leave the room now so that you can get dressed. Once you're ready, I'll be back to share my findings and make a plan with you about what to do next."

*
(share results & make treatment plan)

ASK

"Any questions/concerns before we get started?"

"Would you like to have someone else in the room during the exam for support?" | Offer option to bring someone for support

"What words do you prefer to use when talking about your body?" | Ask youth's preferences

"Would it be alright if I placed my hand ___?"
Ask for permission before touching

"Any questions so far?" | Discuss findings & ask for questions

"How are you feeling about the plan?"
"How do you see this working best for you?" | Negotiate treatment plan

CARE MODEL

APPROACHES TO REDUCE TRAUMA DURING PHYSICAL EXAMINATION

The following resource provides approaches to a trauma-sensitive physical examination. The provider's goal should be to communicate respect and maintain/restore a sense of safety, autonomy and trust to avoid triggering feelings of fear, shame, vulnerability and powerlessness.

CONSIDER

For all 4 types of exams, refer to the **modeling example for trauma-sensitive physical exams on p.46**

DURING BREAST/CHEST EXAMS

- In a gowned patient with bra or binding removed, breast inspection can be done during the cardiac exam without calling attention specifically to the breasts.
- In the absence of any complaints, providers can feel comfortable foregoing a clinical breast exam in adolescence and young adulthood based on expert recommendation.
- If the patient has breast/chest complaints a clinical breast exam is indicated and an approach of Trauma-Sensitive Physical Examinations should be applied.

DURING EXTERNAL GENITAL EXAMS

- If the patient has vulvar complaints, an exam is indicated and an approach of Trauma-Sensitive Physical Examinations should be applied.
- Palpation of external genitalia may be triggering, and an approach of Trauma-Sensitive Physical Examinations should be applied.
- For youth who decline this exam, information about what findings the exam evaluates for (using diagrams) and asking the youth if they have noticed any of these findings, as well as reinforcing that if they have concerns/ questions they can come back for an evaluation may be the best alternative.

DURING PELVIC EXAMS

- If the youth has vulvo-vaginal complaints, an abdominal exam and a vulvar exam with KOH prep and wet mount can be done from vaginal discharge collected from the introitus. Offer the option of a self-swab if the youth is comfortable with that. This may be sufficient if candida or bacterial vaginosis is diagnosed as long as STI screening is also done if the youth is sexually active. If a STI, including trichomonas, is diagnosed on a wet mount, consider follow-up with a full pelvic exam to evaluate for cervicitis and PID.
- Pelvic exams may be triggering for youth who have experienced sexual abuse or other trauma. An approach of Trauma-Sensitive Physical Examinations should be applied.

Consider using The Reproductive Health Access Project's suggested approach for pelvic exams:

- Trauma-Informed Pelvic Exams

DURING RECTAL EXAMS

- If the youth engages in receptive anal intercourse or there are ano-rectal complaints, an inspection of the peri-anal area[82] should be performed using an approach of Trauma-Sensitive Physical Examinations.
- Allow the patient to choose what position the exam is done in.
  - Positioning for anal or rectal exams can be done standing, leaning, lying on the side, supine, and supine with the feet together and knees apart to expose the perineum. Studies suggest that most patients prefer having the exam lying on their side.
- Providers should use adequate lubricant, describe all steps of the procedure to the patient, and ask permission prior to proceeding.[83]

Related Principle

CENTER THE IMPACT OF CHILDHOOD EXPERIENCES

CARE MODEL

SHARED DECISION-MAKING APPROACH TO CONTRACEPTIVE COUNSELING

The following resource describes a step-by-step approach to shared decision making, contraceptive counseling. Choice and empowerment are the essential experiences for youth in deciding what, if any, form of contraception they want to use. The provider's role is to assure that the youth has the information and support that they need to act on their choice.

ASK

PAST EXPERIENCE WITH CONTRACEPTIVES

"What methods have you tried?"
"What did you like/dislike about the method?"
"What concerns did you have about the method?"

Start by listening to avoid assumptions

PREFERENCES

"What (if any) method are you interested in using now?"
"What do you know about the method?"
"What questions do you have?"

READINESS TO DECIDE

"Are you ready to make a decision today?
No pressure either way."

DISCUSS

PRIORITIES

"Let's talk about what's important to you in a method.":

- Ease of use
- Impact on bleeding pattern
- STI/HIV protection
- Side effects
- Possible pain with insertion/fear of needles
- Time of use - in the moment (e.g. condoms) or routinely (e.g. daily or long-acting contraceptives)
- Logistical issues that may impact use behavior (e.g. housing instability or access to a pharmacy)
- Need/desire for privacy from caregiver and/or partner
- Requirements for visits with a provider

Provide Access to an Interactive Decision-Making Tool like:

- Bedsider Method Explorer
- My Birth Control Decision-Making Tool

CONCERNS

"Now let's talk about concerns.":

- Contraindications
- Effectiveness of contraceptive options
- Privacy
- Relationship issues that may impact method use
- Desire for decision support from people in youth's life
- Physical exam and process of method initiation
- Side effects and reversibility

Consider using a youth-friendly graphic

Consider using a youth-friendly graphic that is organized by effectiveness, such as the 'Tiered Effectiveness Model':

- Beyond the Pill
- Contraceptive Options: How Well Do They Work
- CAP Birth Control Grid

PLAN TO EXECUTE CHOSEN METHOD

If yes - "Let's start the process to get you on your chosen method.":

Setup method during visit if possible

- Review method-specific concerns
- Respond to method-specific questions
- Initiate method
- Make a follow-up plan
  - Determine your potential role in facilitating next steps
  - Agree on what steps the youth will take before follow-up
  - Schedule a follow-up appointment (a prioritizing phone/telehealth visit if physical exam is needed)
  - Discuss how to refill prescriptions, obtain supplies, etc.
- Offer Plan B as part of standard practice

If no - "Let's talk about what you might need to decide on the best method for you.":

Discuss support needs

- Further explore options or consult someone you trust
- Try accessing information in a different way
- Return with a support person if a procedure is required
- Consider a different contraceptive care site or provider

CARE MODEL

APPROACH FOR STI RISK REDUCTION COUNSELING

The following resource describes a step-by-step approach to STI risk reduction counseling. Asking for permission to discuss sensitive topics and assessing a youth's current understanding are important to delivering individualized information and support.

ASK

Always begin this conversation by listening to what the young person knows about risk reduction, and asking what they do to reduce their risk

PERMISSION TO ASK SENSITIVE QUESTIONS

"In order to decide what tests you need, and what parts of your body should be tested, I need to ask you some very personal questions about your sex partners and your sexual behaviors. Is that okay with you?"

CURRENT UNDERSTANDING

"Because young people experience the highest rates of sexually transmitted infections in the US and worldwide, I always talk with all my patients about how to reduce their risk of STIs and HIV. What do you already know about risk reduction? What steps are you taking to reduce your risk?"

Reinforce correct information and positive risk reduction actions. Correct misconceptions of risks and risk reduction actions.

DISCUSS

Review risk reduction approaches, individualizing your messages based on the information that the youth has shared with you

APPROACH OPTIONS

ABSTINENCE

"Just because you have had sex with someone in the past, or even with this partner in the past, does not mean that you have to choose to have sex at any given time."

Abstinence, including intermittent abstinence, is always an option if it is a safe alternative in your relationship(s)

LIMITING NUMBER OF PARTNERS

"The more people you have sex with, the bigger the possibility is that you will be exposed to an STI, although we know that having sex with even one person can expose someone to an STI. One option for decreasing the chance that you are exposed to an STI is to limit the number of people you have sex with."

TALKING TO PARTNER(S) ABOUT RISK REDUCTION

"When you have sex with a new partner, get tested for STIs and encourage your new partner to get tested too."

"Have you ever had this kind of conversation? How do you think your partner(s) will react if you bring up risk reduction?"

"If you have a main partner who you do not use condoms with, talk about making an agreement for both of you to use condoms with any other (side) partners."

"Talk with your partner about STI testing. Get tested and ask your partner to get tested too."

CONDOMS

"How do you currently use a condom?"

- Assess condom knowledge and skills
- Teach correct condom use with a penis model as appropriate
- Discuss both external ("male") and internal ("female") condom use

DENTAL DAMS

"Have you considered using dental dams and other ways to limit skin to skin contact? STI transmission can occur with skin to skin contact and does not require penetrative sex."

MEDICATION

"Have you considered taking medicine to prevent and treat HIV(PrEP)?

- See Practice Tool: CDC Criteria for PrEP

CARE MODEL

AN APPROACH TO UNBIASED PREGNANCY TESTING: BEFORE THE TEST

The following resource describes an unbiased approach to prepare youth for pregnancy testing. It's important to check-in with youth around their feelings about pregnancy before providing education and not to make assumptions about their situation or desires.

CONSIDER

PREPARATION BEFORE TEST

Listen first before giving information.

It's helpful to know whether the youth is hoping for a positive or negative test result prior to disclosing results.

"Are you hoping that the test will show that you are pregnant, or that you are not pregnant today?"

Ask when handing specimen cup to youth

- Reassure the youth that no matter what the result is, you are there to support them in making a plan
- Remember that the patient is an expert in their own experience and that pregnancy decision-making is their choice

Receive the answer without bias or judgment, and refrain from exploring reasons and rationales at this point

DO NOT ASSUME

- You do not know the youth's hopes and fears, motivations, specific situation, support system or moral stance until and unless the youth shares these things with you
- You do not have "the answer" and cannot provide it for the youth
- By not making assumptions, you can learn from the youth and support them in their own process

SELF REFLECT

- We all have biases, beliefs and attitudes about pregnancy decisions. In order to maintain an unbiased stance you must recognize and contain your own biases regarding what you think is the best decision for the youth
  - Remember that judgment is communicated both verbally and non-verbally
- Avoid attempting to influence a youth by leveraging their own experiences in foster care.
  They are not responsible for the fact that they are in care, and as a provider you cannot know or interpret the impact or meaning of their lived experience as youth in foster care. Allow space for the youth to surface these experiences if that is what they choose to explore with you

CARE MODEL

AN APPROACH TO UNBIASED PREGNANCY TESTING: SHARING RESULTS

The following resource describes an unbiased approach to share the results of pregnancy tests with youth. It's important to check-in with youth around their feelings about pregnancy and to understand their support systems and access if ongoing care will be required.

ASK

SHARE TEST RESULTS

Share & check for understanding

If results are negative -"Your test result is negative... that means that you are not pregnant, or that it is too soon for the test to show a pregnancy. How are you feeling about that information?"

- If they do not want to be pregnant:
  - Leverage the negative result to discuss EC and a contraceptive plan
  - See Practice Tool: EC Considerations
  - See Care Model: Contraceptive Counseling

Share & check for understanding

If results are positive -"Your test result is positive... that means that you are pregnant. How are you doing with that information?"

After disclosing test results, leave space for processing and validate

- Make space for the youth's response to their results
- Be prepared for a range of possible responses to an unintended pregnancy, including intense feelings, shock, ambivalence or certainty about pregnancy decision-making
- Regardless of the youth's initial reaction, the provider's response should be to:
  - validate their feelings, reactions and concerns
  - normalize their response, including ambivalence or mixed feelings
  - reassure them that you will support them in figuring out their next steps

ASSESS SUPPORT | Adult and/or peer

"Do you have anyone who you confide in, trust, and will support you in making your own decision?"

"Does anyone know that you might be pregnant? What advice or support have they given you?"

"Do you have a partner who knows that you might be pregnant? Do you want a partner involved in your decision-making?"

"Do you have someone to help you set up and go to appointments with you?"

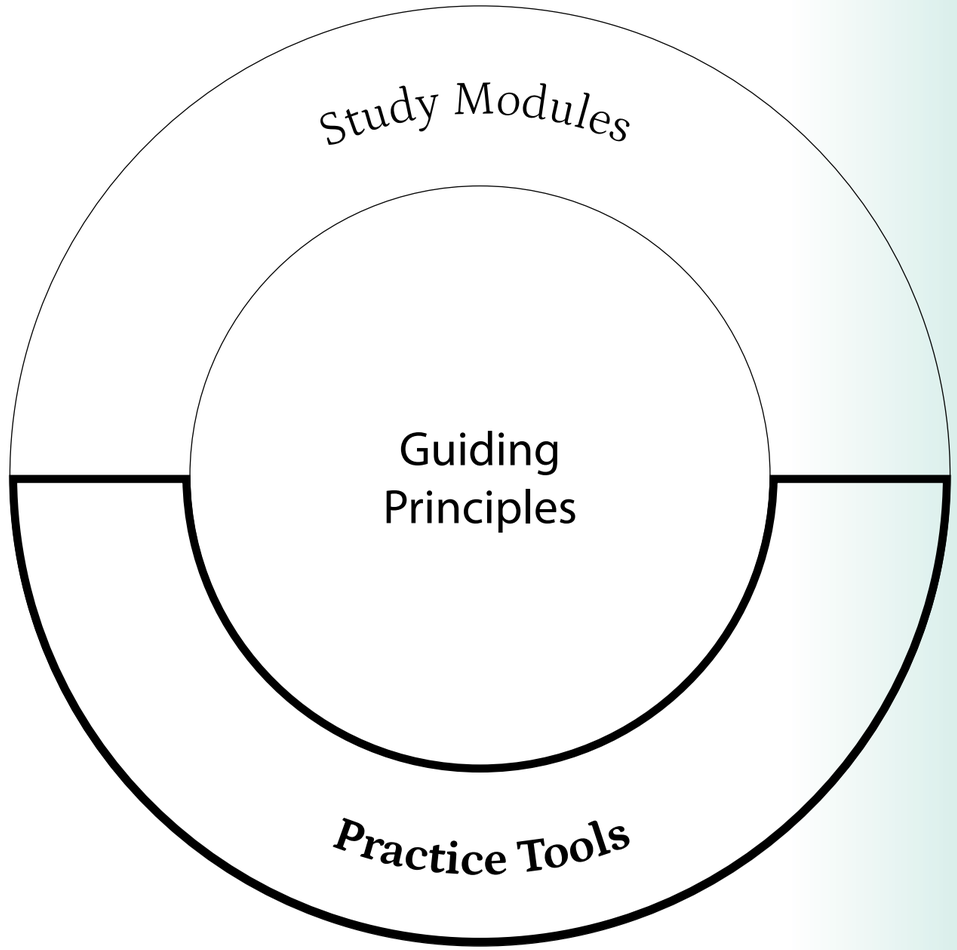
When Explaining Options:

- Start with a general overview of options
- Use plain language and check for understanding
- Remind youth that it's entirely their choice and that they do not need to make a decision today
- Be prepared to describe options in greater detail and provide appropriate information/referral resources when needed

PRACTICE TOOLS

In this chapter you will find practice tools we recommend based on data related to adolescent sexual activity, pregnancy and sexually transmitted infection rates. The goal is to support health care providers to engage in education, counseling, prevention and early intervention to improve sexual and reproductive health outcomes for youth in foster care.

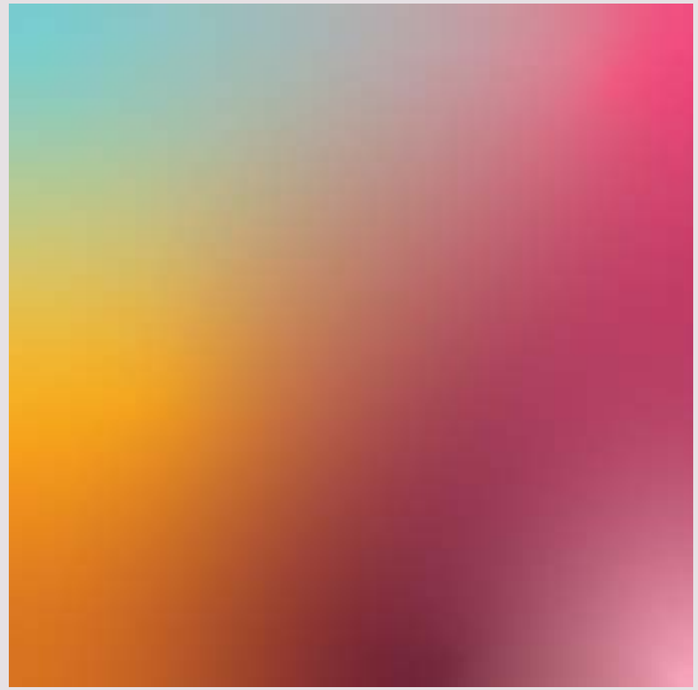
This chapter is composed of 4 sections, which correspond to the 4 knowledge zones introduced earlier. In each knowledge zone section, you'll find practice tools for: **clinic champion teams** to use as collaborative worksheets, **providers** to use as quick reference and **providers & youth** to use as discussion prompts.



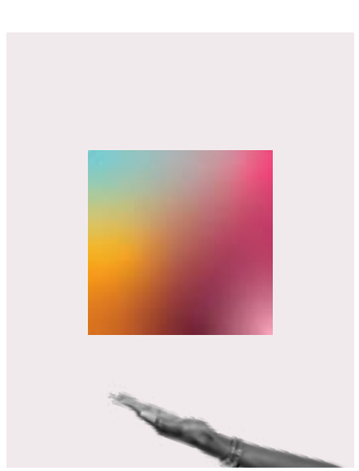
PRACTICE TOOLS

Foster Care

We all bring biases and assumptions to our interactions with patients. The first step towards addressing bias and projecting a non-judgmental stance is to surface those assumptions and bring them into conscious awareness. Build your knowledge about the population you are serving and use that knowledge base to inform but not determine your approach with each individual youth that you interact with. Avoid a “one size fits all” approach, individualizing care to the needs and interests of each patient.



Practice Tools in this Section



For Clinic Champion Teams

- PRACTICE CHALLENGES
- PRACTICE CHANGE OPPORTUNITIES FOR THE CLINIC
- ECOSYSTEM OF ALLIES IN THE CLINIC

For Providers

- PRACTICE CHANGE OPPORTUNITIES FOR INDIVIDUAL PROVIDERS

For Providers & Youth

- FOSTER CARE TEAM
- FOSTER CARE TEAM OBLIGATIONS

FOR CLINIC CHAMPION TEAMS

Practice Challenges

The foster system exists outside the walls of the clinic (i.e. courts, child welfare and foster placement). Challenges in these spaces can hinder youths' ability to access sexual and reproductive health care provided by the clinic. As providers in the clinic, there are opportunities to understand foster care better as a means to increase youths' access to care for their healthy sexual development.

BIASES & STEREOTYPES

Youth in foster care, particularly those who identify as part of a marginalized community, may delay healthcare due to fear of discrimination, or limit what they share or request in an appointment for fear of judgment.[85]

LACK OF SUPPORT NAVIGATING SYSTEMS

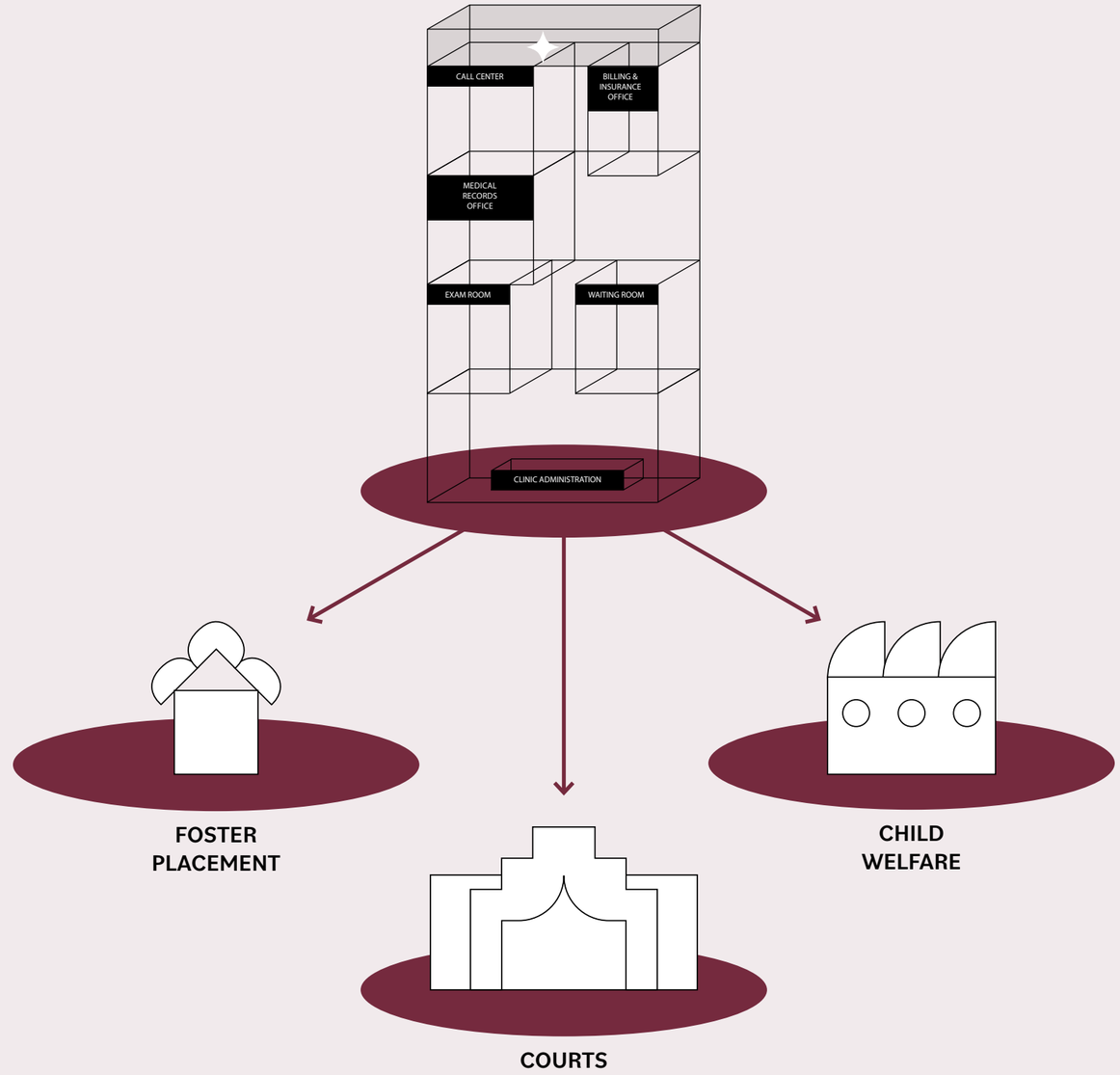
Experiences in foster care may cause some youth to not trust professional support, and they may not have a trusted adult to turn to, leaving them to navigate systems like healthcare on their own.[86]

PLACEMENT CHALLENGES

Frequent placement changes, and foster residence restrictions and geographically distant placements can often create scheduling, financing and transportation barriers; make follow-up appointments more difficult; and limit the ability of providers to build long-term relationships with patients.[84]

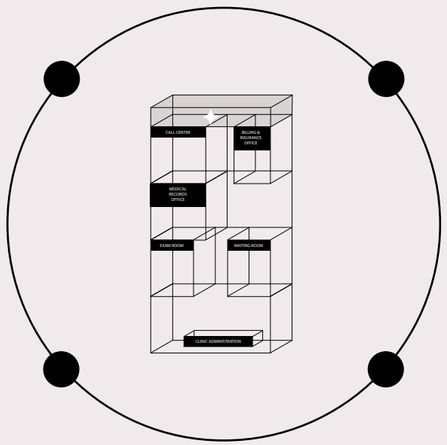
CONFIDENTIALITY & LEGAL CONSIDERATIONS

Youth are sensitive to third parties asking for their private medical information. They already may have experiences of their rights to confidential care being ignored. Because many systems and individuals may ask for their private information, it is critical for providers to understand the parameters of confidentiality. Concerns about custody of their child and other legal questions are added considerations for expectant pregnant and parenting youth in foster care.



FOR CLINIC CHAMPION TEAMS

Practice Change Opportunities For the Clinic



DEVELOP INCLUSIVE FORMS TO MITIGATE BIAS

- Develop/modify forms to be more inclusive of all communities and identities (including those completed through the EHR).
- Offer explicit options to capture a young person's current gender identity if it differs from the sex they were assigned at birth.
- Utilize a two-question process to collect gender identity information (i.e. first asking current gender identity and then asking sex assigned at birth).
- Include the option for youth to note their pronouns.
- Offer the opportunity to input their chosen name if it differs from their legal name.
- Offer the opportunity to input sexual orientation if they choose to volunteer that information.
- Offer explicit options for recording same-sex parents/caregivers and other diverse families as well as non-familial living situations.[87]
- Ask questions that allow the young person to share examples of their interests and strengths.
- Don't ask sensitive questions on intake forms (e.g. sexual history or substance use).
- Avoid questions that might trigger mandated reporting before you have met the young person.

PROVIDE FLEXIBLE SCHEDULING OPTIONS TO ADDRESS PLACEMENT CHALLENGES

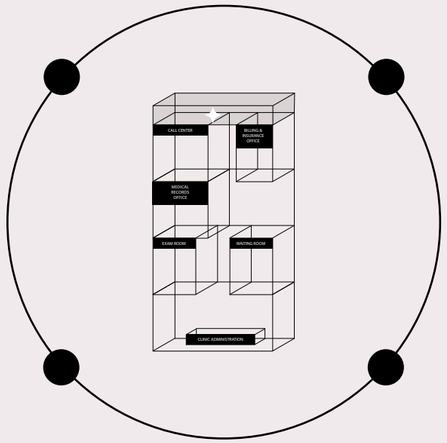
- Include options for appointments after school hours.
- Reserve some "same day" slots for emergent issues
- Incorporate the option for "drop-in" appointments.
- Attempt to accommodate youth who arrive late for an appointment rather than reschedule them.
- Recognize that often the young person is not able to make their own appointment.
- Maximize the opportunity for one stop services in your clinic.

PROVIDE EMOTIONAL SUPPORT NAVIGATING SYSTEMS BY CONSIDERING PEER SUPPORT OPTIONS

- Consider implementing a peer health educator or advocate program.
- Consider implementating a near-peer patient navigator programs.
- Train patient navigators to help address SRH disparities experienced by youth in foster care.
- Enhance youths' access to care by having navigators assist with paperwork, appointment reminders, transportation, childcare, etc.
- Peer educators or navigators can promote self efficacy and support relationship building by:
  - Providing condition or need-specific health education (ie. contraceptive choice or STI)
  - Facilitating shared decision-making.
  - Providing informal emotional support.
  - Educatinge youth regarding their rights in the healthcare system.
- Sustaining engagement in care through:
  - Coordinating follow-up care, referrals, laboratory testing and obtaining prescriptions.
  - Arranging and facilitating referrals.
  - Providing consistency and continuity by being an accessible point of contact for the youth in the system of care.[88]
- For guidance on developing a patient navigator program, see the Patient Navigator's Training Collaborative's online resources.

FOR CLINIC CHAMPION TEAMS

Ecosystem of Allies in the Clinic



Who would you bring in to help address practice change opportunities identified on previous pages?

SENIOR LEADERSHIP

Who in SENIOR LEADERSHIP can help estabish new bias training and policies throughout the clinic?

FRONTLINE STAFF

Who in FRONTLINE STAFF can help establish flexible scheduling options to address placement challenges?

PEER PROVIDERS

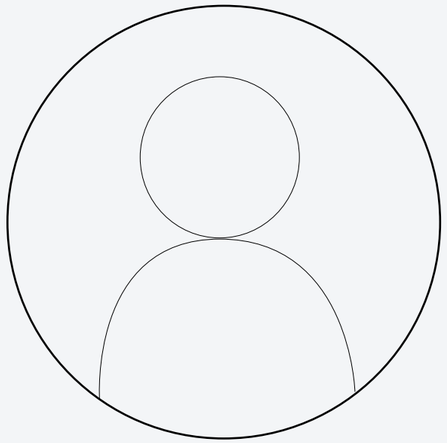
Who among OUR PEERS can help us establish new practices to mitigate bias?

YOUTH

Who among YOUTH can provide for their peers, emotional support navigating systems?

FOR PROVIDERS

Practice Change Opportunities For Individual Providers



MITIGATE BIAS

- Ask questions that allow the young person to share examples of their interests and strengths.
- Practice using inclusive language.
- Wait until you have had a chance to interact with youth, develop rapport and tailor questions to them before asking for sensitive information.

CONSIDER PLACEMENT CHALLENGES

- Address their priority questions first. Remember that although a health care provider may not consider a pregnancy test, for example, as emergent, it may be an extremely pressing issue for a young person.
- Consider the effort it has taken for the youth to actually get to the clinic and attempt to accommodate their needs even if they don't have an appointment.
- Attempt to accommodate youth who arrive late for an appointment rather than rescheduling them.
- Spend time understanding the youth's network to make appropriate referrals for follow up care (See practice tool: Foster Care Team)

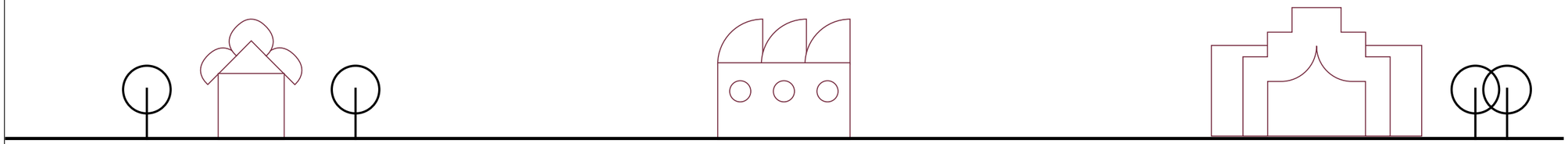
CONFIDENTIALITY & LEGAL CONSIDERATIONS

- Address and review confidentiality at every appointment.
- Understand how to respond to requests for sexual and reproductive health information from child welfare, foster caregivers and other professionals in the system.
- If youth don't consent to disclosures, complete requests for health information, such as the 'Required Medical Diagnosis' and 'Medication/ Treatment' sections on child welfare forms, with the word "confidential".
- If pregnant, help youth clarify their questions and discuss the implications of their foster care related issues on their pregnancy plans.
- If pregnant, support and empower youth by providing them with resources like TeenParent.net from the Alliance for Children's Rights, Public Counsel and Children's Law Center.
- Refer youth to their lawyer for definitive answers regarding any specific legal concerns related to consent, confidentiality or pregnancy options.

FOR PROVIDERS & YOUTH

FOSTER CARE TEAM

Tell me about your foster care team and support network - who do you trust to help you with your care?



FOSTER PLACEMENT

CHILD WELFARE

COURTS

GUARDIAN/ FAMILY MEMBER

FRIEND

TRUSTED ADULT

CASE WORKER

FOSTER NURSE

_____

ATTORNEY

JUDGE

ADVOCATE (CASA)

FOSTER CARE TEAM OBLIGATIONS

The child welfare agency has certain obligations to ensure minors receive the SRH services and information they want and need:

Your Foster Care Team MUST[89]...

- Inform you of your sexual & reproductive health rights.
- Give you information about accessing SRH education and services.
- Help you address barriers to care if the youth requests that help.

Your Caseworker MUST[90]...

- Ensure that you receive comprehensive sexual health education that meets state standards.
  - At least once in middle school and once in high school.
  - If you didn't receive it in school, the agency is responsible for connecting you to an appropriate course in the community.

Your Foster Caregiver MUST[91]...

- Ensure that you receive annual medical exams.
- Create normalcy for you related to healthy sexual development.
- Facilitate access and transportation to sexual health related services.
  - Unless otherwise specifically arranged, and they cannot impose their personal biases, judgments and/or religious beliefs on your sexual and reproductive health, sexual orientation or gender identity.

Your Foster Care Nurse MAY...

- Provide any of the following services to support you to access to health care
  - Health care case planning, support access to timely health assessments, referrals, medical education to foster team members and help in creating/updating your Health and Education Passport

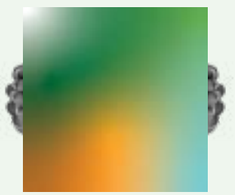
* Although the caseworker has the responsibility to assure that youth living in foster care are aware of their rights, healthcare providers can reinforce these messages and support youth awareness of their rights.
For an example, see Know Your SRH Rights

PRACTICE TOOLS

Confidentiality & Consent Laws

Develop an understanding of minor consent and confidentiality laws in your state, as well as the special protections afforded to youth in foster care. Be prepared to explain these rights and protections in developmentally appropriate language with examples that will resonate with your patient. Assure that the system you work in is designed to honor and protect these rights and work to prevent breaches in confidentiality.

Practice Tools in this Section



For Clinic Champion Teams

- PRACTICE CHALLENGES
- PRACTICE CHANGE OPPORTUNITIES FOR THE CLINIC
- ECOSYSTEM OF ALLIES IN THE CLINIC

For Providers

- PRACTICE CHANGE OPPORTUNITIES FOR INDIVIDUAL PROVIDERS
- REPORTABLE SEXUAL ABUSE CHART

For Providers & Youth

- MINOR CONSENT RIGHTS
- ADDITIONAL RIGHTS OF YOUTH IN FOSTER CARE

FOR CLINIC CHAMPION TEAMS

Practice Challenges

CALL CENTER BREACH

Confidential info leaks from appointment reminders and confimation calls or emails.

CLINIC ADMINISTRATION BREACH

Confidential info leaks to a parent/guardian from clinic communication (calls or emails).

MEDICAL INFORMATION & RECORDS BREACH

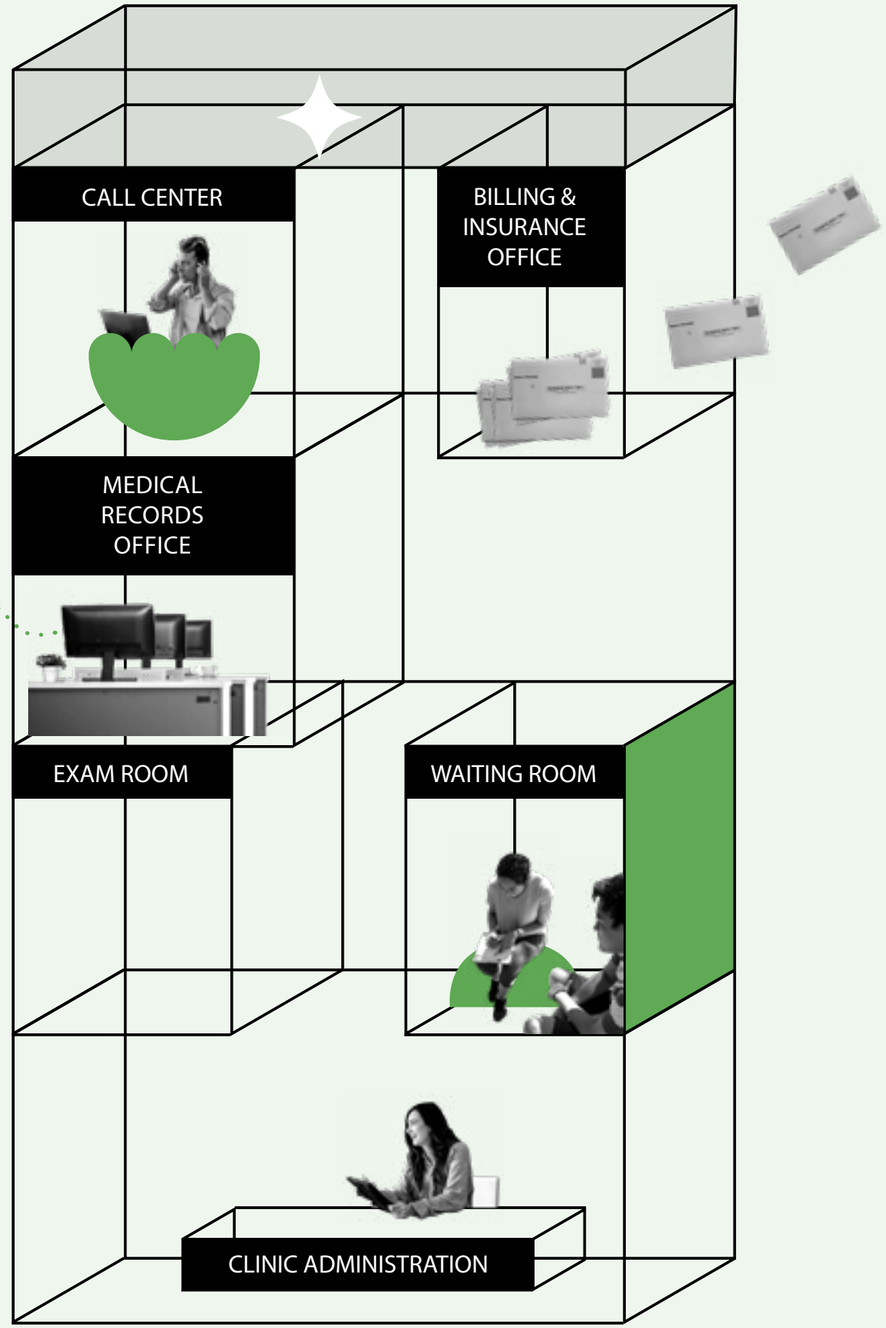
Confidential info leaks to a third party by disclosing medical information without patient authorization, allowing accompanying adults in the exam room without patient consent or from proxy access to electronic health records.

BILLING & INSURANCE BREACH

Confidential info leaks to the insurance policyholder from billing communication sent by insurers.

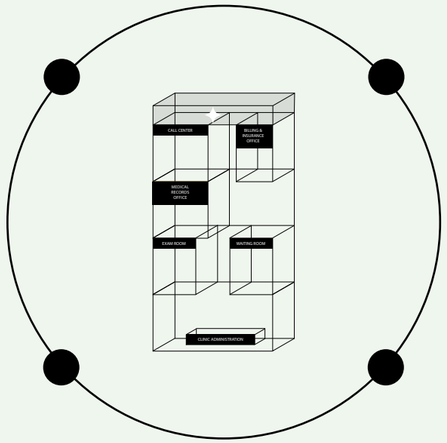
WAITING ROOM BREACH

Confidential info leaks to accompanying adults from paperwork that include sensitive questions.



FOR CLINIC CHAMPION TEAMS

Practice Change Opportunities For the Clinic



MAINTAINING CALL CENTER CONFIDENTIALITY

- Implement confidentiality/ minor consent scripts and training for all call center staff.
- Disable automatic appointment reminders (which may go to a parent or caregiver).

MAINTAINING CLINIC ADMINISTRATION CONFIDENTIALITY

- Disable automatic appointment reminders for all youth.
- Only allow staff trained in confidentiality to contact youth.
- Train patient navigators or health educators to contact youth.
- Note when youth have access to a phone and only call during that timeframe.
- Don't leave messages with foster parents/group home staff without noted permission from youth (in their chart).
- Agree upon a code name with youth for follow up calls.
- Invest in a HIPAA compliant texting service to assure direct communication with youth via cell phone.

MAINTAINING MEDICAL RECORDS CONFIDENTIALITY

- Have mechanisms to flag confidential visit notes in the Electronic Health Record (EHR).
- Ensure the EHR allows for partitioning to prevent proxy access to confidential records.
- Assist youth to set up their own EHR profile (with the youth's contact info).
- Have an easy way to exclude confidential info from the After Visit Summary (AVS).
- Set up a confidential AVS.
- Set up a policy for how confidential minor consent records are released.
- Train medical records staff in confidentiality & minor consent.

MAINTAINING BILLING & INSURANCE OFFICE CONFIDENTIALITY

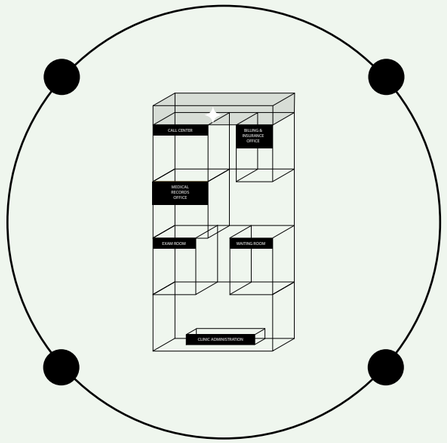
- Offer youth the option to complete a "Confidential Communication Request" (CCR) to avoid having an Explanation of Benefits (EOB) sent to the individual providing insurance coverage (parent/caregiver).
- Train clinic staff on how to assist youth to submit a CCR.

MAINTAINING WAITING ROOM CONFIDENTIALITY

- Provide a private space for youth to complete paperwork with sensitive questions.
- Allow youth to be seen privately, in the exam room, without accompanying adults present.
- Remind accompanying adults that youth have the right to confidential time with their providers.
- Provide materials to support providers in having affirming conversations with accompanying adults.
- Include posters and other visuals with reminders of confidentiality rules.
- Remove sensitive questions from intake forms when possible.
- Train clinic staff to not disclose SRH info when completing a Medical Contact form for the caregiver or social worker, without permission from youth.
- If youth don't consent to disclosures, complete 'Required Medical Diagnosis' and 'Medication/ Treatment' sections on forms with the word "confidential".

FOR CLINIC CHAMPION TEAMS

Practice Change Opportunities For the Clinic (continued)



POLICY

Policies to ensure confidentiality should be in place and ALL staff, regardless of their role or whether they have direct patient contact, must be trained in the policies and processes in place to assure patient confidentiality.

Establish policies to:

- Ensure youth have private time in the exam room.
- Respond to requests for protected minor consent health information.
- Review what should/shouldn't be disclosed in an after visit summary.
- Establish communication protocols, such as leaving messages or sending email reminders.

TRAINING

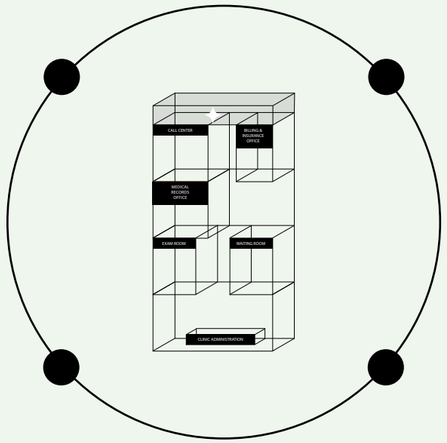
Training is important because many helping professionals have significant misunderstandings about the rights of youth in foster care, and often assume that youth rights to confidentiality are curtailed due to their dependency status. Training should be available for all staff, including medical records and intake staff.

Train all staff in:

- SRH rights of youth in foster care, including consent, privacy in exams, and confidentiality of information vis a vis the child welfare system.
- Appointment and communication policies
- Paperwork documentation without disclosure of confidential information
- How to affirm supporting adults when refusing to disclose confidential information or requesting an adult leave an exam room
- How to support youth to setup preventive measures
- Setting up their own EHR profile
- Submitting a Confidential Communications Request for those with private insurance
- Clarifying their communications preferences, including any code names.

FOR CLINIC CHAMPION TEAMS

Ecosystem of Allies in the Clinic



Who would you bring in to help address practice change opportunities identified on previous pages?

SENIOR LEADERSHIP

Who in SENIOR LEADERSHIP can help establish new confidentiality training and policies throughout the clinic?

FRONTLINE STAFF

Who in FRONTLINE STAFF can help establish new appointment reminders, billing and/or medical records related behaviors?

PEER PROVIDERS

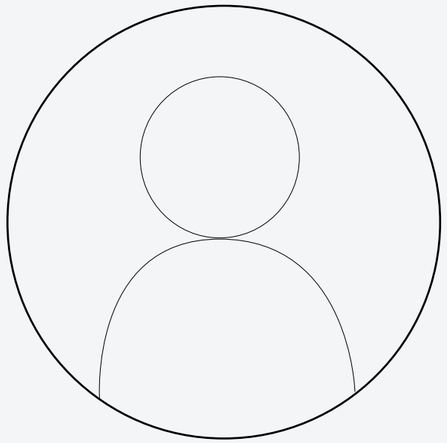
Who among OUR PEERS can help us establish new exam room protocols?

YOUTH

Who among YOUTH can help lead contact with their peers for clinic administration?

FOR PROVIDERS

Practice Change Opportunities For Individual Providers



MAINTAINING MEDICAL CONFIDENTIALITY

- Develop an understanding of minor consent and confidentiality laws in California, as well as the special protections afforded to youth in foster care. (see practice tool: Minor Consent Rights)
- Be prepared to explain these rights and protections in developmentally appropriate language with examples that will resonate with your patient.
- Be prepared to ensure each patient has alone time with their clinician.
- Understand how to respond to requests for sexual and reproductive health information from third parties.
- If youth don't consent to disclosures, complete requests for health information, such as the 'Required Medical Diagnosis' and 'Medication/ Treatment' sections on child welfare forms, with the word "confidential".
- Don't leave messages with foster parents/group home staff without noted permission from youth (in their chart).
- Agree upon a code name with youth for follow up calls if appropriate.

All clinical encounters with an adolescent should begin with an explanation of the minor's consent and confidentiality rights.

Undoubtedly a visit for SRH care will likely involve invoking these rights, but so might a visit for a sore throat, rash or other chief complaint.

* It is helpful to have posters and handouts/brochures to reinforce the messaging.

Minors hold the right to confidentiality when they consent or could have consented to their own sexual and reproductive health care.

Such services must be provided confidentially, and information from that engagement must be maintained as confidential and not disclosed to a parent/caregiver, unless a written authorization from the youth allows for disclosure.[92]

MINOR CONSENT RIGHTS[93]

Youth in California CAN consent to the following SRH care services:

At Any Age
◦ Abortion (Medication or In-Clinic)
◦ Family Planning, including Contraception (all methods including LARC but excluding sterilization)
◦ Pregnancy Testing, Prenatal Care, Postnatal Care
◦ Sexual Assault Treatment (including evidence collection)
12 Years of Age or Older
◦ HIV/AIDS testing and treatment including Pre and Post Exposure Prophylaxis (PrEP and PEP)
◦ Sexually Transmitted Disease prevention, diagnosis and treatment
◦ Injuries resulting from Intimate Partner Violence

* Health care providers are not permitted to share minor consent health information with a social worker or caregiver without the minor's consent. Providers can only share the minor's medical information with them with a signed authorization from the minor.

ADDITIONAL RIGHTS OF YOUTH IN FOSTER CARE[94,95]

Minors in foster care maintain all the same consent and confidentiality rights as non-dependent minors. They also have these additional protections:

Rights	***Summaries***
PRIVACY	Right to privacy in examination by a provider, unless the youth specifically requests otherwise.
INFORMATION	Right to age-appropriate, medically accurate education/information about sexual and reproductive health.
CHOOSE PROVIDER	Right to choose their own provider of SRH care, as long as the provider accepts MediCal or other approved insurance.
TRANSPORTATION	Right to transportation (by caregiver, group home or social worker) to obtain SRH care in a timely manner.
CONTRACEPTION	Right to obtain, possess, and use contraceptives of their choice, including condoms without interference by caregiver or social worker.
POSSESSION	Right to maintain birth control method, including condoms, in a private storage space in their home placements.
REPORT RIGHTS VIOLATIONS	Right to make a confidential complaint to the California Foster Care Ombudsperson if youth has concerns about violations of their rights.

* In order to reduce barriers and address frequent areas of confusion, the California Department of Social Services has issued guidance clarifying that youth in foster care also have these rights related to SRH support and care.

Health providers must decline any requests to disclose SRH-related information unless the youth has signed an authorization to release the information or there is a court order requiring the disclosure.

"Youth in foster care have reproductive and sexual health care rights that allow them to consent to medical services, without obtaining consent from their parent or guardian, and any information regarding those services remains confidential between them and their provider to the extent required by law. As such, a medical provider cannot share a youth's protected health information with a third party such as the youth's child welfare social worker (SW) or probation officer (PO) without the written consent of the youth or through a court order.

A foster youth has the right to authorize or deny disclosure of their health information, or portions thereof, with persons specifically selected by the youth. When a SW or PO obtains protected health information from a medical provider, that information cannot be shared with others except as allowed by applicable confidentiality and privilege laws."[96]

Guidance from the California Department of Social Services (CDSS)

FOR PROVIDERS

REPORTABLE SEXUAL ABUSE CHART

Sexual activity with a minor is reportable as child abuse in three circumstances:

1. When coerced or in any other way nonvoluntary
2. When it is a part of sexual exploitation or trafficking
3. Based on the age difference between the two individuals in a small set of situations

Mandated reporters must report sexual activity with a minor in a few situations based solely on the age difference between the minor and their partner.

Sexual activity includes vaginal, anal and oral intercourse as well as sexual penetration.

AGE OF PARTNER

AGE OF YOUTH	12-13	14-15	16-20	21+
12-13		■	■	■
14-15	■			■
16-20	■			
21+	■	■		

SOURCE: NCYL When Sexual Intercouse is Deemed Child Abuse in California

KEY:

Report if you suspect coerced or nonvoluntary acts, exploitation or trafficking

Report based on age alone

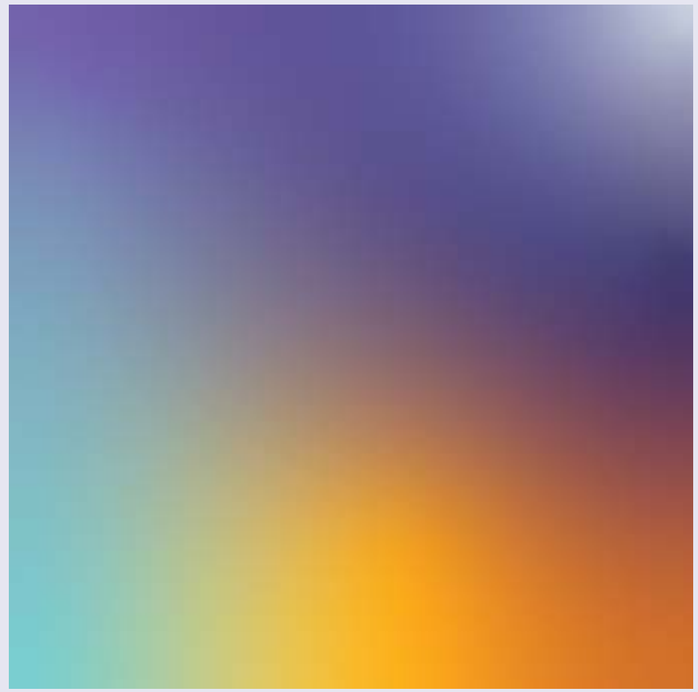
Related Learning

- CHILD ABUSE REPORTING - AN EXCEPTION TO CONFIDENTIALITY
- TRAUMA-INFORMED APPROACH TO MAKING A MANDATED REPORT

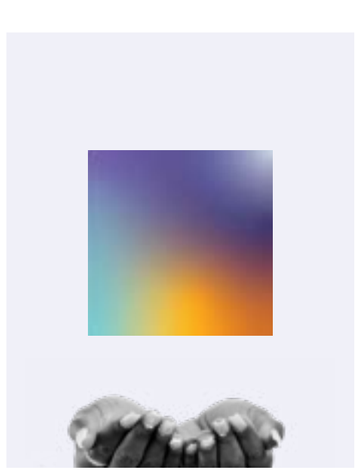
PRACTICE TOOLS

Trauma-Responsive & Healing-Centered Care

Given that youth in foster care have experienced trauma, and that many suffer from complex trauma, the universal application of principles of trauma-informed care in the delivery of clinical services is essential. Developing trauma-informed services is a multilevel undertaking which involves changes at the system level as well as the interpersonal level.



Practice Tools in this Section



For Clinic Champion Teams

- PRACTICE CHALLENGES
- PRACTICE CHANGE OPPORTUNITIES FOR THE CLINIC
- TRAUMA-RESPONSIVE GUIDEPOSTS FOR THE CLINIC
- ECOSYSTEM OF ALLIES IN THE CLINIC

For Providers

- PRACTICE CHANGE OPPORTUNITIES FOR INDIVIDUAL PROVIDERS
- COMMON REACTIONS TO CARING FOR SURVIVORS OF TRAUMA
- KEYS TO REDUCING RE-TRAUMATIZATION
- RESPONDING TO TRAUMA SYMPTOMS

For Providers & Youth

- FINGERHOLD PRACTICE: STRESS MANAGEMENT STRATEGY

FOR CLINIC CHAMPION TEAMS

Practice Challenges

"Too frequently, providers and health systems attempt to implement trauma-informed care at the clinical level without the proper support necessary for broad organizational culture change. This can lead to uneven, and often unsustainable, shifts in day-to-day operations.

This narrow clinical focus also fails to recognize how non-clinical staff, such as front desk workers and security personnel, often have significant interactions with patients and can be critical to ensuring that patients feel safe."

- Trauma-Informed Care Implementation Resource Center

UNHEALTHY POWER DYNAMICS

Power differences between providers and patients and among organizational staff from direct care providers to administrators.

LACK OF TRUST & TRANSPARENCY

Lack of trust and transparency in operations and decisions conducted among providers, youth, and support systems of those served.

LACK OF RECOGNITION

Lack of recognition and validation of patient and staff strengths.

UNSAFE INTERACTIONS

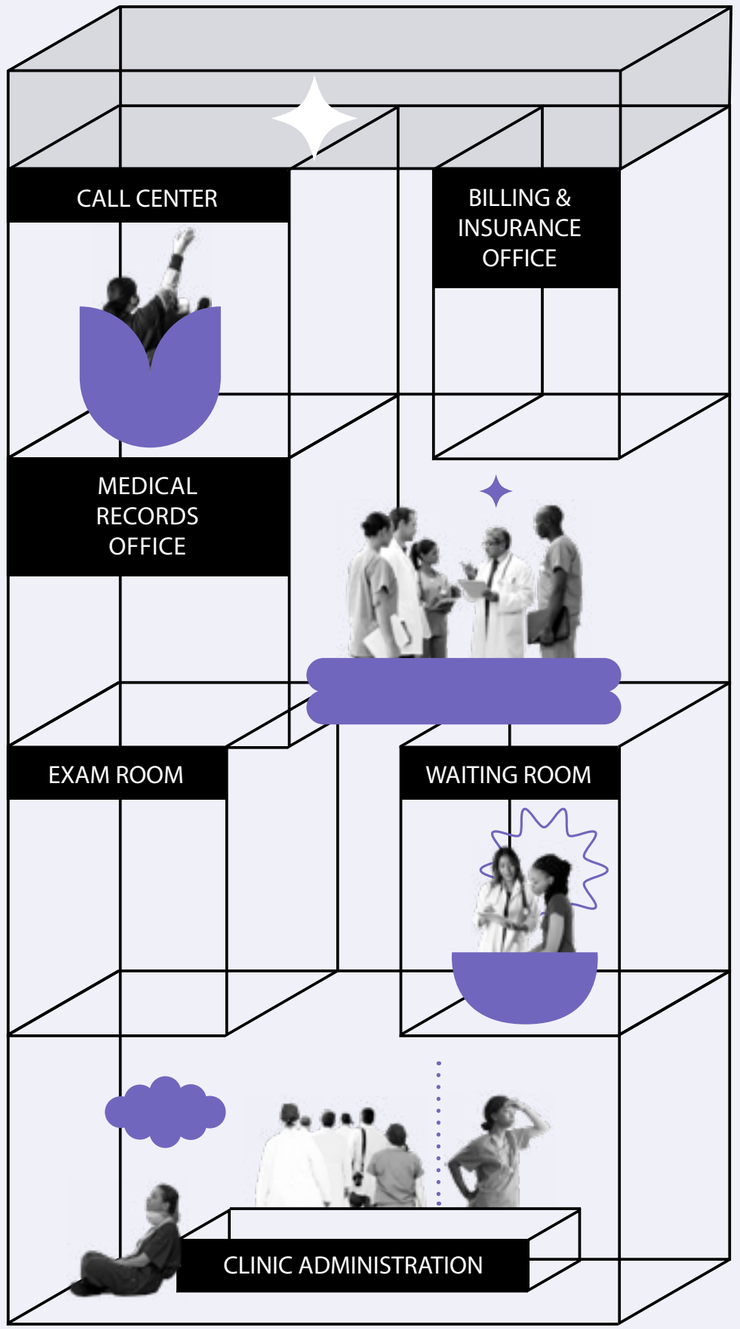
Providers and people served feel physically and psychologically unsafe; including physical settings and interpersonal interactions.

BIASES & STEREOTYPES

Biases and stereotypes prevent staff, providers and youth from engaging.

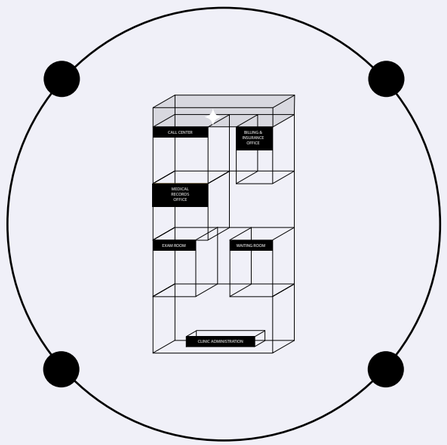
RISK OF RE-TRAUMATIZATION

Lack of support and awareness to prevent re-traumatization of staff, providers and/or youth.



FOR CLINIC CHAMPION TEAMS

Practice Change Opportunities For the Clinic



HAVE LEADERSHIP PROMOTE WAYS T0 ADDRESS CHALLENGES: UNHEALTHY POWER DYNAMICS, TRANSPARENCY, RECOGNITION & TRUST[97]

- Promote trauma-responsive approaches.
- Allocate resources to train staff.
- Create a culture of wellness and reduce staff burnout.
- Change organizational policies and practices to promote trauma-responsive approaches.
- For more info, see Make Your Pitch for TIC

PROTECT FRONTLINE STAFF BY PROVIDING ORGANIZATIONAL INTERVENTIONS TO SECONDARY TRAUMA[98]

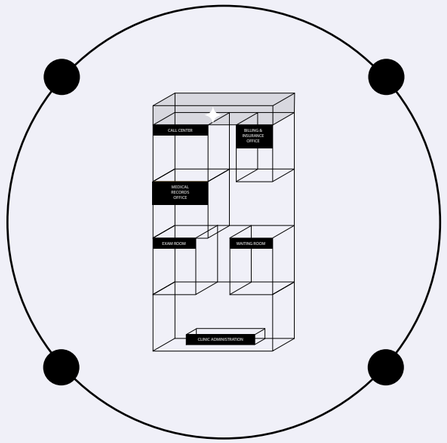
- Provide training that raises awareness of secondary traumatic stress.
- Offer opportunities for staff to explore their own trauma histories in a safe environment.
- Offer staff space and the option to take time to self process after making mandated reports.
- Encourage and incentivize self-care through physical activity, yoga, and meditation.
- Allow flexible scheduling with “mental health days” for staff.

GROW UNDERSTANDING OF BIASES & STEREOTYPES AMONG PROVIDERS

- Support reflective supervision, in which a service provider and supervisor meet regularly to address feelings regarding patient interactions.
- Help providers understand the impact of trauma on health and behavior for both youth and staff.
- Support providers in practicing strengths-based communication with youth and staff.

FOR CLINIC CHAMPION TEAMS

Trauma-Responsive Guideposts For the Clinic



A system of care is trauma-responsive when the following guideposts undergrid system policies and practices.

SAFETY

Providers and people served feel physically and psychologically safe; including physical settings and interpersonal interactions.

TRUST & TRANSPARENCY

Operations and decisions are conducted with transparency and the goal of building and maintaining trust among providers, patients, and support systems of those served.

EMPOWERMENT

Patient and staff strengths are recognized, built on and validated, based in the belief in resilience and the ability to heal from trauma.

VOICE & CHOICE

The organization aims to strengthen patients' experience of choice and recognizes that every person's experience is unique and requires an individualized approach.

INCLUSIVENESS & SHARED PURPOSE

The organization recognizes that everyone has a role to play in a trauma-informed approach and every interaction has the potential to be therapeutic.

PEER SUPPORT & MUTUAL SELF-HELP

The role of non-professional peer support is integral to the organizational and service delivery approach and understood as a key vehicle for building trust, establishing safety, and empowerment.

RESILIENCE & STRENGTHS-BASED

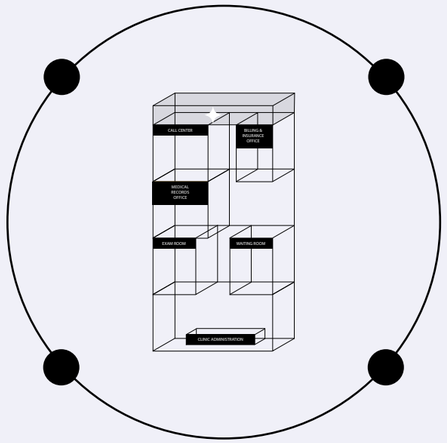
Belief in resilience and the ability of individuals, organizations, and communities to heal and promote recovery from trauma is foundational to the organization. This perspective builds on what patients, providers, and communities have to offer rather than responding to their perceived deficits.

COLLABORATION & MUTUALITY

Leveling of power differences between providers and patients and among organizational staff from direct care providers to administrators is an organizational goal. This goal is based on the recognition that healing happens in relationships and in the meaningful sharing of power and decision-making.

FOR CLINIC CHAMPION TEAMS

Ecosystem of Allies in the Clinic



Who would you bring in to help address practice change opportunities identified on previous pages?

SENIOR LEADERSHIP

Who in SENIOR LEADERSHIP can help us communicate the benefits of care to generate clinic-wide buy-in?

FRONTLINE STAFF

Who in FRONTLINE STAFF can help us raise awarenss of secondary traumatic stress and incentivize self-care for all staff?

PEER PROVIDERS

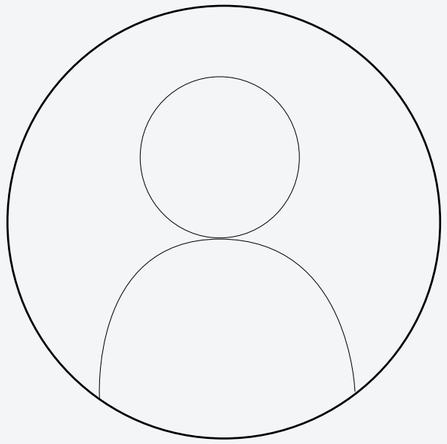
Who among OUR PEERS can help us grow our understanding of the impact of trauma on health/behavior for both youth and staff?

YOUTH

Who among YOUTH can help us reduce the risk of re-traumatization for their peers?

FOR PROVIDERS

Practice Change Opportunities For Individual Providers



BUILD SAFETY & EMPOWERMENT

- Learn and practice conducting a trauma-informed sexual health interview.
- Learn and practice conducting a trauma-informed physical exam.
- Learn the shared decision-making model of health counseling.

PROTECT YOUTH FROM RISK OF RE-TRAUMATIZATION

- Reduce risk of re-traumatization for youth.
- Share tools/strategies with youth on stress management.
- Educate youth abouth healthy relationships.
- Review the physical space and set up to reduce potential triggers.

FOR PROVIDERS

COMMON REACTIONS TO CARING FOR SURVIVORS OF TRAUMA[99]

Secondary (or Vicarious) Trauma is a change in one's world view due to exposure to other peoples' stories of trauma. It is an occupational hazard for those providing care to trauma survivors. Helping professionals and non-professional staff/youth workers who have their own history of trauma are more vulnerable to secondary trauma.

HELPLESSNESS	◦ Depressive symptoms ◦ Feeling ineffective with patients ◦ Reacting negatively to patients ◦ Thinking of quitting clinical [contact with patients] work
FEAR	◦ Recurrent thoughts of threatening situations ◦ Chronic suspicion of others ◦ Sleep disruptions ◦ Physical symptoms/somatization ◦ Inability to relax or enjoy pleasurable activities
ANGER	◦ Reacting angrily to youth, staff or colleagues ◦ Feelings of guilt ◦ Decreased self-esteem ◦ Negative self image
DETACHMENT	◦ Avoiding patients ◦ Avoiding emotional topics during patient encounters ◦ Ignoring clues from patients about trauma ◦ Failing to fulfill social or professional roles ◦ Chronic lateness
BOUNDARY VIOLATION & TRANSFERENCE	◦ Taking excessive responsibility for the youth ◦ Seeing youth after hours ◦ Doing something out of usual practice ◦ Difficulty separating personal & work lives ◦ Sharing own problems with youth ◦ Youth trying to care for service provider
MALADAPTIVE COPING MECHANISMS	◦ Failure to nurture and develop non-work related aspects of life ◦ Increased use of alcohol ◦ Initiation or use of drugs ◦ Misuse of prescription medication

FOR PROVIDERS

KEYS TO REDUCING RE-TRAUMATIZATION

Every young person's trauma experience, trauma reaction, and triggers that may activate a maladaptive response are unique.

Simple questions, procedures or activities in the clinical setting (such as how a question is phrased, getting undressed, or being touched) may trigger individuals who have experienced trauma.

If triggers or feelings of re-traumatization occur, individuals often disengage from care.

COMMUNICATION & TRANSPARENCY	◦ Make sure you communicate clearly regarding processes or procedures in the clinic ◦ Take time to answer questions and concerns
RESPECT OF INDIVIDUAL POWER & CHOICE	◦ Always ask for permission before touching the patient. ◦ Continue the explanation of steps as they occur. ◦ Look for signs of distress and stop until the patient is comfortable to proceed. * If youth remains uncomfortable, renegotiate the procedure based on what, when and who will help them feel more comfortable.
ENGAGEMENT & EMPOWERMENT	◦ Ask patients during and after a procedure if they have questions about what is happening and why. ◦ Ask and address patients' biggest health concerns directly as a priority. ◦ Respect patients' limits on interest/willingness to discuss certain aspects of their health.

Related Learning

THE POSSIBILITY AND CONSEQUENCES OF RE-TRAUMATIZATION

FOR PROVIDERS

RESPONDING TO TRAUMA SYMPTOMS

PRACTICE CO-REGULATION

- Express empathy and warmth.
- Use a soothing tone of voice.
- Acknowledge/validate youth's distress.
- Use supportive silence (LISTEN!).
- Invite the youth to engage in reflective problem-solving with you.

PROVIDE "FIDGET TOYS"

- Fidget toys are self-regulation tools to help with focus, attention, calming, and active listening.
  - Stress balls, pipe cleaners, playdough
  - Paper and pens/markers for doodling

DEMONSTRATE TRUSTWORTHINESS

- Demonstrate empathy in your interactions with patients by:
  - Minimizing distractions
  - Engaging in active listening (of facts & emotions)
  - Being deliberate with your non-verbal communication (ex. lean forward, maintain eye contact, nod, avoid crossed arms)
  - Offering concrete feedback (ex."Let me see if I've got this right…")
  - Making space for youth to correct/confirm your understanding (ex. "Did I miss anything?")

BUILD COUNSELING & LISTENING SKILLS (B.A.T.H.E.)[100]

- **Background** - What is going on in your life?
- **Affect** - How do you feel about that (or how does it affect you)?
- **Trouble** - What about the situation troubles you most?
- **Handling** - How are you handling that?
- **Empathy** - That must be very difficult for you.

PROVIDE CULTURALLY HUMBLE & RESPONSIVE CARE

- Surface, acknowledge and address your own biases.[101]
- When you make a mistake, acknowledge it and apologize.
- If the relationship is damaged to the point that the patient remains uncomfortable, defensive or disengaged, offer the option of changing to a different provider, if feasible.

SUPPORT YOUTH & SHARE COPING TECHNIQUES

- Normalize the stress response.
- Share techniques that you have found helpful.
- Offer simple coping techniques to manage the visit. **(Have handouts or posters in the exam room with diagrams of these techniques to normalize use.)**
- Encourage interested patients to develop a stress management plan that works for them. For more info, see Youth-Friendly Stress Management Planner

Many young people who have experienced trauma have challenges with self-regulation and may not have mastered this skill yet. As a result, providers may encounter patients who express anger, frustration, impatience and fear in the clinical environment.

Although the clinical encounter is not generally the appropriate place to teach self-regulation, the following approaches may help to reduce patients' fear and anxiety and diffuse anger and frustration.

Related Learning

- IMPACT OF CHILDHOOD TRAUMA (DIAGRAM)

FINGERHOLD PRACTICE: STRESS MANAGEMENT STRATEGY

The fingerhold practice can be used during a challenging situation or in preparing for one. Using the technique can help ease feelings of stress.[102]

Steps[103]

1. Hold each finger with the opposite hand for 2-5 minutes. You can work with either hand.

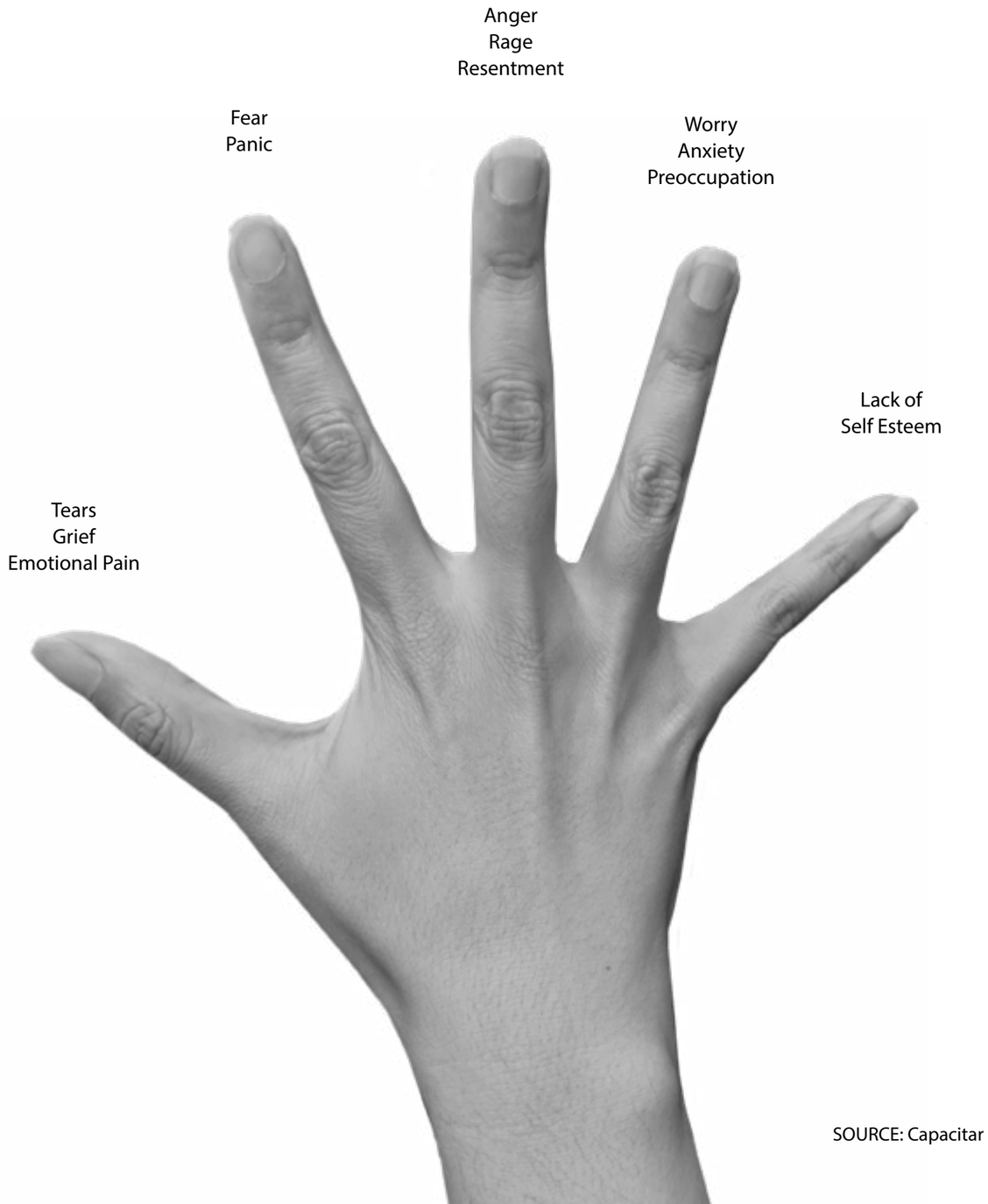
2. Breathe in deeply. Recognize and acknowledge the strong or disturbing feelings or emotions you hold inside yourself.

3. Breathe out slowly and let go. Imagine the feelings draining out your finger into the earth.

4. Breathe in a sense of harmony, strength and healing.

5. Breathe out slowly, releasing past feelings and problems.

6. As you hold each finger, feel the pulsing sensation as the energy and feelings move and become balances.



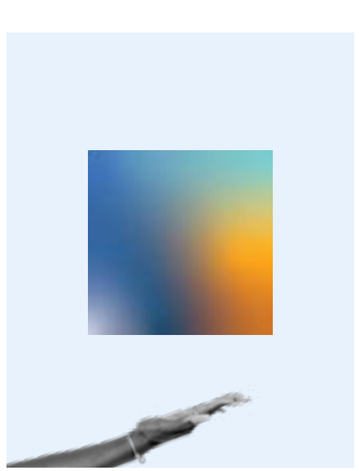
SOURCE: Capacitar

PRACTICE TOOLS

Sexual & Reproductive Health

All sexually active youth, regardless of their sexual or gender identity, gender of their partners, or the sexual behaviors that they engage in, can benefit from a discussion about sexual risk reduction and STI/HIV screening or testing, as appropriate. Additionally, youth in foster care experience challenges in their daily lives like frequent school changes that prevent them from accessing SRH education and care. At every step, we can look for ways to help youth outside the clinic.

Practice Tools in this Section



For Clinic Champion Teams

- PRACTICE CHALLENGES
- PRACTICE CHANGE OPPORTUNITIES FOR THE CLINIC
- ECOSYSTEM OF ALLIES IN THE CLINIC

For Providers

- PRACTICE CHANGE OPPORTUNITIES FOR INDIVIDUAL PROVIDERS
- EMERGENCY CONTRACEPTIVE CONSIDERATIONS
- SEXUAL HEALTH PROMOTION RELATED (2 TOOLS)
- SCREENING APPROACHES (3 TOOLS)
- EXPLAINING ABORTION OPTIONS
- EXPLAINING PREGNANCY NEXT STEPS

For Providers & Youth

- ACCESSING CONTRACEPTION OUTSIDE A CLINIC: YOUR COMMUNITY RESOURCES
- KEY ISSUES THAT IMPACT PREGNANCIES
- RESOURCES FOR EXPECTANT AND PARENTING YOUTH IN FOSTER CARE

FOR CLINIC CHAMPION TEAMS

Practice Challenges

Sexual and reproductive health education and access to care is provided by a mostly uncoordinated mix of resources (through school, work and the community). Challenges in these spaces can lead to gaps in youths' sexual development. As providers in the clinic, there are opportunities within our reach to help fill those gaps.

FREQUENT SCHOOL CHANGES

Missed sex education due to frequent caregiver and school changes.[104]

SMALLER SAFETY NETWORK

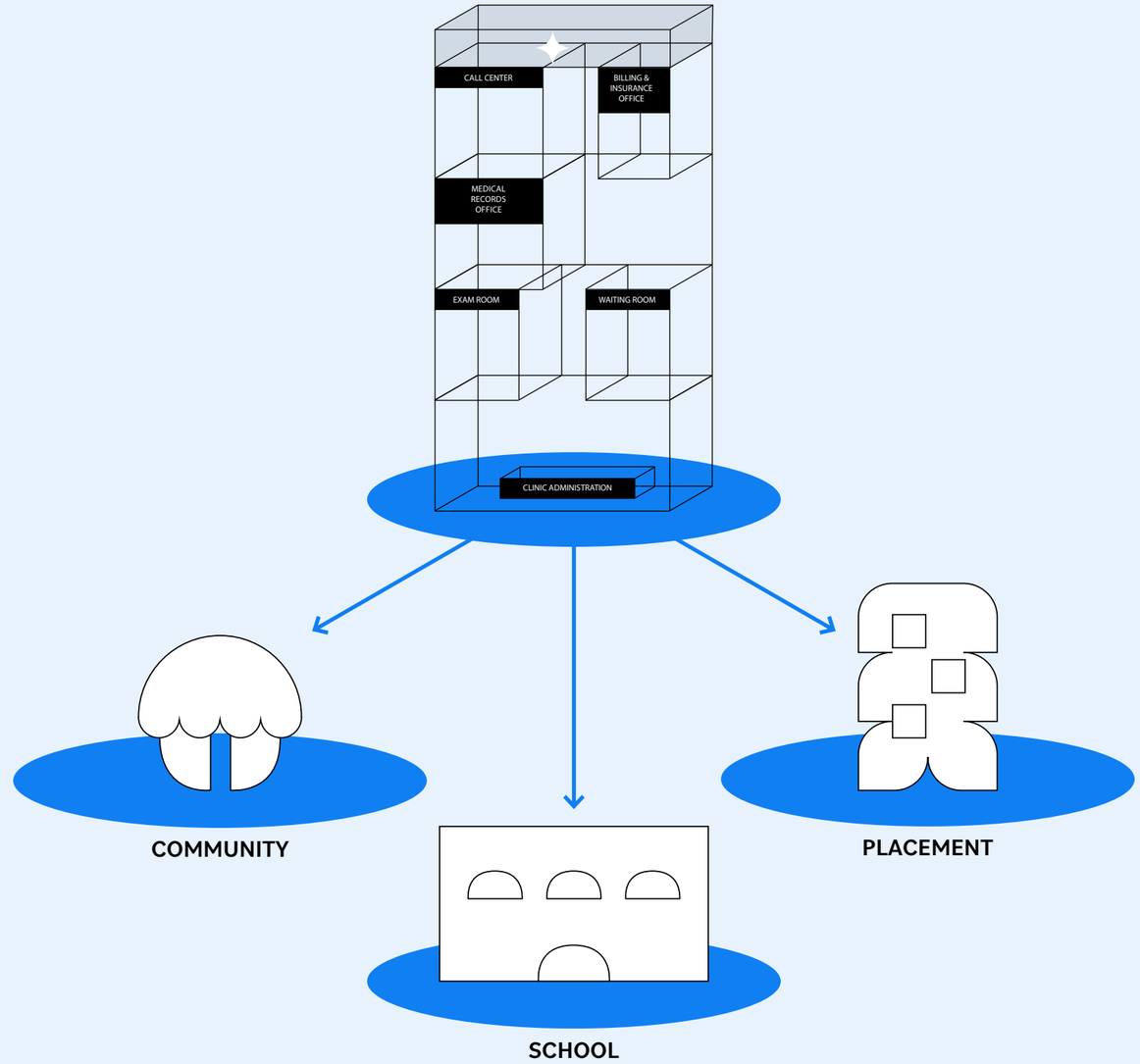
Youth with experience in the foster care system tend to have smaller communities/people to lean on. Therefore, less people to turn to in times of crisis.[106]

INFLEXIBLE/UNPREDICTABLE SCHEDULES

Restrictive schedules often prevent youth from being able to make appointments to access SRH care.[105]

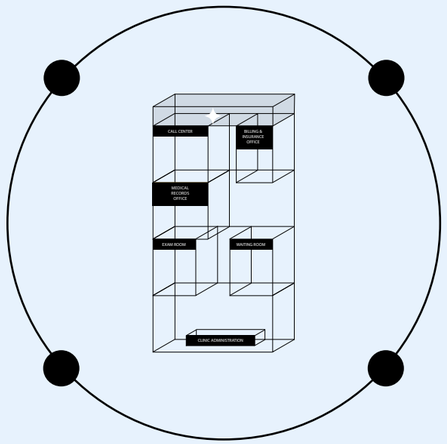
LACK OF SUPPORT FOR PARENTING YOUTH

Parenting youth in the foster care system often lack access to support/services to help them care for their child.



FOR CLINIC CHAMPION TEAMS

Practice Change Opportunities For the Clinic



SHIFT POLICIES TO REDUCE NEED FOR RETURN VISITS FOR SRH CARE, OFTEN MISSED DUE TO UNPREDICTABLE SCHEDULES[107]

- Create/adopt policies that enable same-visit provisions of contraceptive method of choice when possible.
- Assess and adjust clinic workflow as needed to make "same-visit method provision" implementation possible for providers and staff.
- Arrange for phone/text follow-up for visits where education/reinforcement/check-in on method or treatment initiation and adherence are the focus and a physical exam is not necessary.
- Collect data on revised clinic workflow measures to track improvements over time.
  - To learn more about how to track improvements, see Youth Feedback Tracker.

PROVIDE TRAINING FOR STAFF TO BE PROMOTERS OF HEALTHY SEXUALITY & SHARE INFO OFTEN MISSED DUE TO LACK OF SUPPORT[108,109]

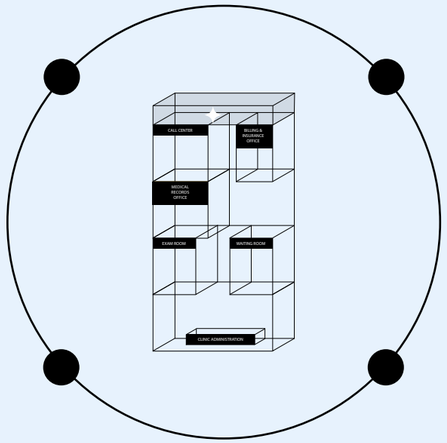
- Train all staff to challenge assumptions about adolescent sexuality and pediatric primary care, and understand how sexual health is a critical part of overall healthcare.
- Help staff develop skills to support the healthy sexuality of all youth (including sexual/gender minorities and people who are neurodivergent).
- Train and support all staff to answer common questions about sexual and reproductive health.
- Provide sample language for responding to questions about sexual and reproductive health to all staff.
- Use role-playing exercises to help staff practice responding to youths' questions.

INCREASE IN-CLINIC ACCESS TO SRH EDUCATION & OPTIONS, OFTEN MISSED DUE TO SCHOOL CHANGES & SMALLER SAFETY NETWORKS

- Create space for discussion.
- Ensure availability of a wide range of contraceptive options during youths' visit.
- Assure access to plain language health education materials.
- Train and utilize peer educators/counselors for in-clinic SRH education.
- Provide digital access to interactive sexuality education, sexual risk reduction and contraceptive choice websites.

FOR CLINIC CHAMPION TEAMS

Ecosystem of Allies in the Clinic



Who would you bring in to help address practice change opportunities identified on previous pages?

SENIOR LEADERSHIP

Who in SENIOR LEADERSHIP can help us communicate the benefits of care to generate clinic-wide buy-in?

FRONTLINE STAFF

Who in FRONTLINE STAFF can help us raise awarenss of universal sexual and reproductive health best practices?

PEER PROVIDERS

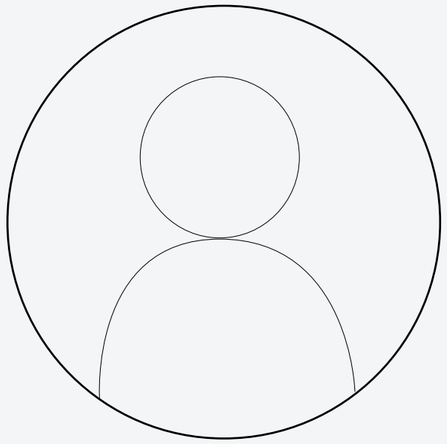
Who among OUR PEERS can help us establish new practices to increase access to sexual and reproductive care?

YOUTH

Who among YOUTH can help us provide support for their peers?

FOR PROVIDERS

Practice Change Opportunities For Individual Providers



PROVIDE SRH CARE FOR ALL PATIENTS, OFTEN MISSED DUE TO UNPREDICTABLE SCHEDULES & LACK OF SUPPORT

- An expectation should be that SRH is addressed with all adolescent patients.
- Anticipatory guidance, education and sexual and reproductive health care is considered a standard component of routine adolescent care.
- While it is important to identify and address the patient's concerns first, sexual health should be addressed in all visits.
- It can be embedded in a general psychosocial interview such as the HEADDSSS or SSHADESS.

PROVIDE UNIVERSAL EDUCATION & GUIDANCE FOR ALL PATIENTS, OFTEN MISSED DUE TO SCHOOL CHANGES & SMALLER SAFETY NETWORKS

- Certain information should be provided to all patients and can be used as a screening tool, including:
  - Universal healthy relationship education
  - Sexual health promotion (risk reduction)
  - Universal emergency contraception (EC) guidance
  - Universal education about PrEP

FOR PROVIDERS

EMERGENCY CONTRACEPTIVE CONSIDERATIONS

OVER THE PHONE	LISTEN FOR * When a visit is not possible, ECPs can safely be prescribed over the phone without requiring a pregnancy test.	◦ Signs EC may help prevent an unintended pregnancy[110] • "I'd like a prescription for the morning after pill OR Plan B OR emergency contraception." • "I had sex and didn't use birth control, can I do anything to prevent pregnancy?" • "The condom broke and I don't want to get pregnant." • "I was sexually assaulted and I need something to prevent pregnancy." ◦ For a sample, see Phone Room Guidance on Emergency Contraception
IN CLINIC	CONSIDER BEFORE PRESCRIBING	◦ Patient's BMI (higher BMI impacts efficacy of levonorgestrel methods) ◦ Time since 1st episode of unprotected vaginal intercourse ◦ Number of days since LMP ◦ Does the patient want an IUD as an ongoing contraceptive method (NOT that the provider wants youth to use an IUD) ◦ What method does the youth want to use in the future, and when can they initiate the method

Related Learning

UNIVERSAL EMERGENCY CONTRACEPTION COUNSELING

FOR PROVIDERS & YOUTH

ACCESSING CONTRACEPTION OUTSIDE A CLINIC: YOUR COMMUNITY RESOURCES

Community Resource	*Resource Assessment*	*Additional Variables*
LOCAL PHARMACIST	Which local pharmacists near the youth's placement can help ensure the youth has access to emergency contraception and contraceptive options of their choice if they cannot return to you?	• Hormonal methods such as oral contraceptives, the transdermal patch, vaginal rings and Depo Provera, as well as emergency contraceptive pills can be prescribed by pharmacists in California and a number of other states. • Many insurance plans, including MediCal, cover all or most of the cost, but some pharmacies don't accept MediCal for this service. • Although patients of any age can legally obtain contraception from a pharmacist in California, many pharmacies limit this service to patients >18 years old. • Check Birth Control Pharmacies to find participating pharmacies and call the pharmacy to confirm age restrictions/MediCal coverage.
ONLINE APPS & DISTRIBUTORS	Which apps & online distributors can help youth access the contraceptive option of their choice?	• Hormonal methods such as oral contraceptives, the transdermal patch, the vaginal ring and emergency contraceptive pills can be obtained without a clinic or pharmacy visit. • There are several distributors that accept public insurance programs, including MediCal and Family PACT, and offer services to minors. • Check Free the Pill for information about the various online distributors, including services, age restrictions, costs, and coverage.
OTHER CLINICS (EX. SCHOOL-BASED HEALTH CENTERS)	If youth cannot return to your clinic or do not feel comfortable seeking SRH care in your clinic, which clinics do they trust? Which clinics can help ensure youth in foster care are provided SRH education and care?	• See TeenSource for a clinic finder. • Check out the List of School-Based Health Centers by county in California
OTHER CLINICAL PROVIDERS	Which providers and counselors can help provide emotional/mental health support for youth?	
OTHER: _____ (FAMILY, FRIENDS, TRUSTED ADULTS)	Who else can help support youths' healthy sexual development outside the clinic?	

FOR PROVIDERS

STI SCREENING CONSIDERATIONS

In California, minors who are 12 years old and older can consent to STI screening, without the need of parental/guardian permission.

Screening for STIs can be an invasive process that triggers retraumatization. To reduce trauma, consider the following approaches.

EXPLAIN IMPORTANCE	◦ Clearly explain what you are screening for, why it is important to identify the potential infection, and the process of specimen collection, including options for self-collection
USE NON-INVASIVE METHODS	◦ Use non-invasive/less invasive screening tests for gonorrhea and chlamydia when possible • Offer urine-based or high vaginal swab for specimen source when available • Explain options for specimen collection and follow the youth's preferences • Self-swabs for vaginal/rectal specimens may be preferable for youth comfortable doing so
CHOOSE TEST SITE BASED ON SEXUAL BEHAVIOR	◦ Sites of specimen collection (vaginal, rectal, pharyngeal) should be based on sexual behaviors as reported by the youth. Urethral screening should be done by urine-based tests
OFFER NON-INVASIVE HIV SCREENING	◦ Non-invasive HIV screening should be offered with a clear explanation of the need for confirmatory testing of positive results
ASSURE BLOOD DRAW COMPLETION	◦ Blood draws for HIV and syphilis should ideally be performed in the clinic to enhance adherence. If the youth must go to a lab for a blood draw, make a specific plan for where and when the draw will be completed and follow-up to assure completion

Related Learning

SEXUAL HEALTH PROMOTION

CARE MODEL: APPROACH FOR STI RISK REDUCTION COUNSELING

FOR PROVIDERS

CDC CRITERIA FOR PrEP

Universal education and counseling regarding Pre-Exposure Prophylaxis (PrEP) as prevention is appropriate for all patients, since recommendations for offering PrEP are based on a detailed assessment of sexual behaviors, and disclosures of risky behavior are dependent on the level of comfort and trust that a youth has in the provider.

Providing information to all youth empowers them to seek more information and treatment if they are interested, motivated, and believe it would benefit them.

PrEP CONSIDERED	People who are HIV negative + HAD ANAL OR VAGINAL SEX IN THE PAST 6 MONTHS, AND:	◦ Have a sexual partner with HIV (especially if the partner has an unknown or detectable viral load), or
		◦ Have not consistently used a condom, or
		◦ Have been diagnosed with a sexually transmitted infection (STI) in the past 6 months
PrEP RECOMMENDED	People who are HIV negative + INJECT DRUGS AND:	◦ Have an injection partner with HIV, or
		◦ Share needles, syringes, or other equipment to inject drugs[111]

Related Learning

UNIVERSAL PREP COUNSELING

FOR PROVIDERS

CUES: UNIVERSAL HEALTHY RELATIONSHIP EDUCATION

"CUES" is an easily remembered mnemonic for a universal education approach developed by a national domestic violence organization, Futures Without Violence.

C: Disclose Limits of **CONFIDENTIALITY**	◦ Aways review limits of confidentiality with youth prior to any assessment. ◦ See care model: Explaining Confidentiality in Plain Language
UE: **UNIVERSAL EDUCATION** & Empowerment Regarding Healthy Relationships	◦ Have resources available that you use to educate all youth about healthy relationships. For an example, see, Hanging Out or Hooking Up: Teen Safety Card ◦ Encourage youth to share resources if a friend or family member is experiencing IPV.
S: **SUPPORT**	◦ Discuss youth-friendly resources and make a facilitated referral, offer support, validation, and harm reduction strategies if abuse is disclosed. ◦ Give every patient support and access to referrals for themselves or for a friend – regardless of disclosure through the use of a safety card (see link above).

Related Learning

SCREENING USING UNIVERSAL HEALTHY RELATIONSHIP EDUCATION

FOR PROVIDERS

LEADING QUESTION APPROACH TO CSEC SCREENING

The leading question approach for universal CSEC screening was developed by Asian Health Services in Oakland, California.

"Over the years, we've noticed that more and more young people are turning to the streets to make money for themselves or for other people. Sometimes patients tell us that: they're exchanging sexual services or 'going on dates' for money, clothes, a place to stay, drugs, etc. or in a situation where they're being asked or forced to let other people touch them or do sexual things to them.

Because we think that these activities can have a big impact on your health, we've started to offer resources to people who want some help to get out of a situation like this. Would you like some more information on this and how to get help for either yourself or a friend?

We can refer you to an individual that will contact you and help you meet folks who can: help you in court - tell you about programs that may help you - get re-enrolled in school - find employment opportunities - help you find a therapist - find out if you're eligible for any benefits."[112]

SOURCE: Journal of Applied Research on Children

Related Learning

- UNIVERSAL EDUCATION ABOUT CSEC AND THE "LEADING QUESTION" APPROACH TO SCREENING

FOR PROVIDERS

RESPONDING TO ARA/IPV, RC & CSEC

VALIDATE YOUTH'S EXPERIENCE	◦ Consider using phrases like: • I'm so sorry this is happening in your life. • You don't deserve it. It's not your fault. • I'm worried about your safety.
OFFER OPTIONS	◦ See care model: Shared Decision-Making Approach to Contraceptive Counseling
SHOW SUPPORT	◦ Let youth know you will support them unconditionally without judgment
REVIEW STRATEGIES	◦ Review harm reduction strategies
ASK ABOUT SAFETY	◦ Ask about immmediate safety concerns & discuss options • If appropriate, refer youth to the National Human Trafficking Hotline
REFER COMMUNITY RESOURCES	◦ Refer youth to community resources, such as a teen-friendly domestic violence advocate
CONSIDER REPORTING ABUSE	◦ Consider abuse reporting • Respect youth's confidentiality rights • Report abuse when necessary using a trauma-responsive approach ◦ See care model: Trauma-Informed Approach to Making a Mandated Report
FOLLOW UP	◦ Follow up at next visit

Related Learning

SCREENING APPROACHES

The provider's role in pregnancy counseling is to present unbiased information about options and facilitate the youth's ability to follow through on their choice.

While not all pregnancies are unintended, an unintended pregnancy forces a young person to make decisions and take action. They will need both information and non-judgmental support to do so.

FOR PROVIDERS

EXPLAINING ABORTION OPTIONS

(use when youth have chosen this option)

In order to counsel effectively about abortion options, the provider should first determine approximately how long the patient has been pregnant.

This may be indicated by LMP if the youth has regular periods, but keep in mind that many women have some implantation or 1st trimester bleeding that may be mistaken for a period.

Make sure the youth understands that an ultrasound may be done prior to either option.

	MEDICATION ABORTION	IN-CLINIC ABORTION
TIME LIMIT	9-11 WEEKS depending on prescriber/clinic	23 WEEKS depending on the clinic
PROS	◦ Doesn't require a procedure, can be more private, can feel more "natural" (like a miscarriage).	◦ Usually requires only one appointment, immediate results, option from weeks 6-23 of pregnancy, procedure is quick with minimal bleeding after procedure.
CONS	◦ A follow-up appointment may be needed. ◦ Causes heavy bleeding for several hours and bleeding may continue for up to 2 weeks (bleeding timing and duration is unpredictable).	◦ Requires a procedure, can cause cramping during or after the procedure, may have light bleeding up to two weeks after the procedure.

Related Learning

- UNIVERSAL REPRODUCTIVE PLANNING
- CARE MODEL: AN APPROACH TO UNBIASED PREGNANCY TESTING: BEFORE THE TEST
- CARE MODEL: AN APPROACH TO UNBIASED PREGNANCY TESTING: SHARING RESULTS

For more patient info, see

- Planned Parenthood: The Abortion Pill
- Planned Parenthood: In-Clinic Abortion Procedures
- Planned Parenthood: Considering Abortion
- Bedsider: Abortion

FOR PROVIDERS

EXPLAINING PREGNANCY NEXT STEPS

(use when youth have chosen this option)

REFER TO PRENATAL CARE	◦ Address barriers to prenatal care, such as pregnancy disclosure, transportation, school/work schedule.
	◦ Actively engage in problem-solving with the patient to facilitate follow through.
	◦ Discuss issues of support, involvement of partner, placement concerns, health behaviors in pregnancy, alcohol, tobacco, cannabis and other substance use, medication use (including OTC).
EXPLAIN OPTIONS	◦ Explain that there are options for those continuing a pregnancy, parenting or adoptions.
	◦ Only refer to agencies that will provide non-judgmental support throughout the pregnancy regardless of the decision the youth ultimately makes about their pregnancy plan.
PRESCRIBE PRENATAL VITAMINS	◦ Start youth on prenatal vitamins while awaiting 1st prenatal appointment.

Related Learning

- UNIVERSAL REPRODUCTIVE PLANNING
- CARE MODEL: AN APPROACH TO UNBIASED PREGNANCY TESTING: BEFORE THE TEST
- CARE MODEL: AN APPROACH TO UNBIASED PREGNANCY TESTING: SHARING RESULTS

For more patient info, see

- Planned Parenthood: Considering Parenthood
- Bedsider: Parenting
- Planned Parenthood: Considering Adoption
- Bedsider: Adoption

KEY ISSUES THAT IMPACT PREGNANCIES[113]

(use when youth have chosen this option)

Let's discuss behaviors and situations that can contribute to improved health during pregnancy and after the baby is born:

Key Issues	***Positive Behaviors***
LIFESTYLEHABITS	◦ Healthy diet ◦ Regular exercise routine
MEDICAL CARE	◦ Screening/ treatment for STIs ◦ Immunization updates ◦ Medication impact review ◦ Chronic disease management
RELATIONSHIPQUALITY	◦ Universal education about relationship quality and screening for intimate partner violence
SUBSTANCE USE	◦ Use of cessation tools/support for nicotine, alcohol and other pregnancy interfering substances
CHEMICAL EXPOSURE	◦ Discussion of concerns regarding exposure to environmental contaminants
SUPPLEMENTS	◦ Start prenatal vitamins to reduce the risk of neural tube defects before there's any chance of a pregnancy

FOR PROVIDERS & YOUTH

RESOURCES FOR EXPECTANT AND PARENTING YOUTH IN FOSTER CARE

(use when youth have chosen this option)

Click on the icons to learn more about each resource:

EXPECTANT PARENT PAYMENT BENEFIT

$900 a month available to pregnant minors and nonminor dependents (NMDs) three months prior to the expected due date to help them prepare for their child.

EXPECTANT PARENT AND PARENTING SUPPORT HUB

This site provides expectant and parenting minors and nonminor dependents (NMDs) with resources to support themselves and their child(ren), run by the California Department of Social Services. Includes information on financial resources, pre and post partum support (including doulas), housing, child care, parenting support, and more.

TEENPARENT.NET

A website for foster youth who are expecting or parenting to find out how to get the things they need and who can help them, and for caregivers of expecting or parenting youth, to find out how to help them. Includes legal information.

DEPENDENCY COUNSEL

Every youth in foster care has a dependency attorney. The dependency counsel can be an important resource for information and advice, and can help an expecting youth make plans for supportive and appropriate housing and services. Because of attorney-client privilege, the attorney will not share pregnancy information without the youth's permission.

BRINGING IT ALL TOGETHER

The following is a youth feedback questionnaire, practice change progress tracker and recommendations that can help create a welcoming clinic environment and services for youth in foster care. As you and your clinic champion team experiment with the tools, remember to track progress from youths' perspectives. Their feedback will guide implementation of new, clinic-wide practices that drive effective change.

USE THIS SECTION TO

CAPTURE YOUTH FEEDBACK

Practice asking youth for feedback on their clinic experience during their visits, using the Youth Feedback Questionnaire as a guide. Use this information to establish your baseline, set goals, and track progress.

REVIEW REMINDERS

Review recommendations for critical opportunities to enhance youths' experience, leading to higher trust in the healthcare system and better health outcomes.

Youth Feedback

Youth feedback can be used to establish baselines, set goals and measure progress.

There are different ways to engage youth and capture youth feedback. Here are some suggestions:

Youth Feedback Opportunities

YOUTH FEEDBACK QUESTIONNAIRE

- Focus can be broader – and also more specific.
- Can be completed in person or online.
- Can include qualitative and quantitative measures.
- More extensive than a survey.
- Appropriate to offer compensation if the questionnaire is extensive.

PATIENT SATISFACTION SURVEYS

- Focus is the patient's perception of delivered health care. They can measure the difference between what the patient expected and what the patient received.
- Can include qualitative and quantitative measures.
- Can be completed in person or online.
- Anonymous.
- Usually brief and do not involve providing incentives.

YOUTH TASK FORCE

Like a youth advisory board, but brought together for a time limited term to achieve a specific goal.

YOUTH ADVISORY BOARD

Youth Advisory Boards (YAB) can function both as an empowering experience for the youth who participate on the board as well as an approach to enhancing the quality and appropriateness of services for youth.

Consider the following in developing a YAB:

- Define the terms of the adult-youth partnership.
  - Role of staff facilitator
  - Role of YAB members (including time commitment)
  - Role of YAB within organization
- Involve a "critical mass" of young people (8-10 youth board members).
- Identify a half-time staff position to coordinate/ facilitate YAB.
- Assure that the YAB is representative of the target population.
- Have youth apply for board positions.
  - Have a panel, rather than an individual, review applications.
- Provide stipends for youth board members.
- For more info, see
  - Tips on Developing a YAB
  - A Comprehensive Guide/Toolkit on Developing and Supporting YABs

Click on the icon to see examples of surveys and questionnaires

Including Youth Voices: Changing the Power Dynamic in a Clinic

Peer educators can play a powerful role in a clinical space. They can provide directed education, informal emotional support, answer questions before and after an appointment, and help create a more welcoming and trustworthy space.

Create opportunities for young adults with lived experience. One way to make a clinical space feel more welcoming and safe is to hire people with diverse experiences, including experiences in systems like foster care. Create entry level positions that have the opportunity for growth.

The use of patient navigators is "a patient-centered intervention that uses trained personnel to identify patient-level barriers, including financial, cultural, logistical, and educational obstacles to health care and then mitigate these barriers to facilitate complete and timely access to health services."[114] The role of the navigator is usually grounded in providing logistical support to meet a specific patient need. Through the process of meeting the defined need, the navigator can develop a trusting relationship with the patient and broaden the benefits to both the individual patient and the care delivery system.

Youth Feedback Tracker

Based on youths' feedback, track progress towards the goals you set as a team. Follow the steps below inspired by the PDCA cycle.[115]

PLAN

- [ ] **Regularly capture feedback from youth on their clinic visit experiences.**
- [ ] **Use the feedback to establish a baseline and identify practice change opportunities for your clinic.**

DO

- [ ] **Set goals, plan and test changes.**

CHECK

- [ ] **Continue to capture feedback from youth in order to assess effectiveness of changes.**
- [ ] **Review youth feedback as a team. Compare feedback to ones collected before the changes as a way to assess progress.**
- [ ] **Reflect on what you've learned through testing the changes.**

ACT

- [ ] **Identify next steps based on youths' feedback, refine goals/ plan and start next round of test changes.**
- [ ] **Scale and implement changes that resonate with youth.**
- [ ] **Repeat process.**

Reminders

The following reminder pages provide recommendations for critical opportunities to enhance youths' experience, leading to higher trust in the healthcare system and better health outcomes.

Website & Promo Material

Remember:

1. **Images of Diversity**
   Websites and promotional materials should include images that reflect the diversity (race/ethnicity, gender, sexual identity) of the population served.
2. **Youth-Focused Web Content**
   Have designated space on website for youth-focused content (separate section).
3. **Easy Web Navigation**
   Make sure all webpages are easy to navigate to and from the general clinic site.
4. **Material Distribution**
   Have ways of easily distributing materials to group homes, county social workers, schools and other appropriate venues.
5. **Confidentiality Statement**
   Include an explicit statement on confidentiality for all services, including SRH services.

Appointment System

Ease of appointment making and flexibility related to appointment keeping are essential aspects of access. Young people often do not have control over their own schedules and may lack timely transportation to appointments. If they are concerned about confidentiality, they may opt to make and attend appointments alone, without guardian, staff or social worker assistance.

Remember:

1. **After School Appointments**
   Include options for appointments after school hours.

2. **Same-Day Appointments**
   Reserve some "same day" slots for emergent issues.
   - Remember that although a health care provider may not consider a pregnancy test appointment, for example, as emergent, it may be an extremely pressing issue for a young person.

3. **Drop-In Appointments**
   Incorporate the option for "drop-in" appointments.
   - Consider the effort it has taken for the youth to actually get to the clinic and attempt to accommodate their needs even if they don't have an appointment.

4. **Late Arrivals**
   Attempt to accommodate youth who arrive late for an appointment rather than reschedule them

5. **Opt-Out Option for Auto Appointment Reminders**
   Protect confidentiality by allowing youth to opt-out of automatic appointment reminder systems and/or assuring that the contact number in the reminder system is the youth's number, not the guardian's/group home's or social worker's number.
   - This can be best accomplished by developing a "confidential visit" appointment type and a script to accompany this appointment type that addresses if and how the youth wants to be reminded of their appointment.

Waiting Room

Adolescent services are often provided in pediatric clinics/offices and share waiting room space and exam rooms with younger children and the adults who accompany those children to medical appointments. The goal of making these spaces appropriate for children often results in creating spaces that are neither welcoming or appropriate for adolescents and young adults. A separate waiting room, or a separate area in the general waiting room that is designed for youth contributes to creating a welcoming space.

Remember:

1. **Youth Input**
   Establish a means to obtain youth input, such as though a youth advisory board (YAB) that reflects the population served.
   - Solicit their input, listen to their recommendations and ACT on them

2. **Reading Material**
   Provide reading material and other media of interest to a wide range of youth. Include positive and inspiring content, such as materials about extracurricular arts, sports and educational opportunities for young people.
   - Solicit and follow the recommendations of the YAB

3. **Health Education Material**
   Invest in youth-appropriate health education materials.
   - Obtain sample pamphlets/posters etc. for review and approval by the YAB prior to purchase. Youth report that these materials can help them start conversations with their provider.

4. **Wifi**
   Post the WiFi password.

5. **Posters**
   Have posters and artwork that reflect the diversity of the population served.
   - Include youth confidentiality posters
   - Post visual cues (rainbow stickers, pamphlets, etc.) to indicate that LGBTQ+ youth are welcomed
   - Include positive images and inspiring messages

6. **Privacy Barrier**
   Provide a barrier or spacing to enhance privacy at the check-in counter.

7. **All-Gender Bathroom**
   Have an all-gender bathroom in a convenient location.

8. **Health Educators**
   Utilize waiting time as an opportunity to interact with health educators (particularly peer or near-peer health educators who share the experience of living in foster care).

Exam Room

The exam room is another space that can be made more welcoming in simple ways by making them more responsive to privacy and safety concerns.

Remember:

1. **Conversation Privacy**
   Do not discuss patient issues (with patients or with other staff) in public areas like hallways, stairways, waiting rooms etc.
   - If a patient overhears, they may assume you speak about them too.
   - When discussing patient issues in a room, speak in a quiet voice (the walls are thin).
   - Always knock and wait for acknowledgement before opening a door.
2. **Visual Privacy**
   Position the exam table in the exam room so that there is visual privacy should the door have to be opened during a visit.
   - Use privacy filters on all computer screens.
3. **Seating Arrangement**
   Position chairs in the exam room (and the waiting area) so that patients do not have their backs to the door.
4. **Clothing**
   Meet and interview the youth while they are fully clothed.
   - Leave the room to allow them to disrobe and to dress.
   - Provide adequate size gowns/drapes for modesty.
5. **Conversation with Youth**
   Treat youth with respect.
   - Begin with open ending questions, such as “what brings you in today?”
   - Strive to assure uninterrupted time with the patient during the visit.
   - If you must leave the exam room during the visit, apologize for the interruption, keep the time taken by the interruption to a minimum, and give the patient a realistic timeframe for when you will return.

Follow-up System

Many clinics rely on the patient attending a subsequent appointment to assure timely and appropriate follow-up care. This approach can be problematic for young people living in foster care due to the many challenges they may encounter in making and keeping follow-up and referral appointments.

Remember:
WHEN FACILITATING ADHERENCE...

1. **Contact Info**
   Ask the youth for their best contact number, best time to reach them, and for a number for someone who would know how to get in touch with them if their contact number doesn't work. Confirm the number at every visit.
   - Assure them that you will not disclose any confidential information to their back up person if you need to contact them.

2. **EHR Info**
   Assure that the email address in the electronic health record (EHR) is the youth's email. Frequently, the guardian's or social worker's email is entered into the EHR on registration and then becomes the default email for all communication.

3. **Telehealth/Phone Appointments**
   Offer the option of telehealth or telephone appointments for follow up if appropriate to the diagnosis.

4. **Contraceptive Choice**
   Provide the youth with their contraceptive choice at the time of the visit when possible.

5. **Prescription Refills**
   Provide adequate prescription refills to allow for missed follow up appointments.
   - For example, if you would ideally like to see the patient back in 3 months, include sufficient prescription refills to cover 4+ months of treatment.

6. **Referral Systems**
   Develop youth-friendly referral systems and designated staff to support youth in completing referrals.

Continuity of Care

Remember:

1. **Time**
   Developing a trusting relationship with a health care provider takes time and effort on the part of the youth and the provider.

2. **Provider Consistency**
   Assuring that, when possible, youth will see the same provider each time that they come in for a visit contributes to the potential for building trust.
   - Clinics should develop an internal process for identifying the "primary" care provider within the care system to facilitate continuity of care.

3. **Attending Consistency**
   In clinics with rotating trainees and rotating attendings, assigning the patient to a "primary" attending and assuring that the attending spends some time with the patient during each visit will provide some measure of continuity.

APPENDIX

Resource Hub

As you all know, sharing resources (like a list of youth-friendly local pharmacists) is the best way to create collective change. That's why we created a living library in google drive for you to continuously share resources with other providers in your clinic and across all participating clinics using this toolkit.

Click on any of the icons to access resources in the folder. To contribute to the folders, please send your input to: fosterreprohealth@youthlaw.org

Speaking of resources, check out our podcast!

External Resources: For Providers

Learn more or share resources with other providers

External Resources: For Youth

Share recommended resources with youth

Top Tips: From All Clinics

Get advice/inspiration through change efforts in other clinics

Youth Feedback: From All Clinics

Get a sense of how youth across all clinics are responding to practice changes recommended by the toolkit

Provider Testimonials: From All Clinics

Share your experience championing change using this toolkit

Toolkit Updates: From RHEP

Check for the latest toolkit updates

Youth Resource Links

This QR code takes you to a google doc with links to our recommended external resources for youth. Share the code with youth and encourage them to explore this one-stop resource for sexual and reproductive health information.

Print & post around clinic where youth can access

Endnotes

1 American Academy of Pediatrics, Promoting Healthy Sexual Development and Sexuality, Bright Futures Guidelines for Infants, Children, and Adolescents. https://brightfutures.aap.org/Bright%20Futures%20Documents/BF4_HealthySexuality.pdf

2 American Academy of Pediatrics, Promoting Healthy Sexual Development and Sexuality, Bright Futures Guidelines for Infants, Children, and Adolescents. https://brightfutures.aap.org/Bright%20Futures%20Documents/BF4_HealthySexuality.pdf

3 U.S. Dep't. Health & Hum. Servcs. https://health.gov/healthypeople/objectives-and-data/social-determinants-health

4 Rosenberg, Woods, Naylon and Tallant, Incorporating Social Determinants of Health and Equity in Practice to Address Sexual and Reproductive Health for Young People Involved in Foster Care, Activate Collective 2022

5 Gudeman, R., Svidler, L., Lowry, S. & Henke, R., "Interview Survey of Adolescents in Foster Care in Los Angeles County Regarding Sexual and Reproductive Health Communication and Access to Resources: Findings From 2021," National Center for Youth Law: 2022

6 UCSF Bixby Center for Global Reproductive Health . (2019, May 16). Changing the Conversation: Shared Decision-Making in Reproductive Health. Innovating Education in Reproductive Health. https://www.innovating-education.org/2016/04/changing-the-conversion-shared-decision-making-in-reproductive-health/

7 SisterSong, Inc. (n.d.). Reproductive Justice. Sister Song. https://www.sistersong.net/reproductive-justice

8 Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. Am J Prev Med. 1998;14(4):245-258.

9 Burns, B., Phillips, S., Wagner, H., Barth, R., Kolko, D., Campbell, Y., & Landsverk, J. (2004). Mental Health Need and Access to Mental Health Services by Youths Involved with Child Welfare: A National Survey. Journal of the American Academy of Child & Adolescent Psychiatry, 43(8), 960–970. https://doi.org/10.1097/01.chi.0000127590.95585.65

10 Stein, B. D., Zima, B. T., Elliott, M. N., Burnam, M. A., Shainfar, A., Fox, N. A., & Leavitt, L. A. (2001). Violence Exposure Among School-Age Children in Foster Care: Relationship to Distress Symptoms. Journal of the American Academy of Child & Adolescent Psychiatry, 40(5), 588–594. https://doi.org/10.1097/00004583-200105000-00019

11 Foundation Trust. (2020, September 21). The Complexity of Racial Trauma. Complex Trauma Resources. http://www.complextrauma.org/complex-trauma/the-complexity-of-racial-trauma/.

12 Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

13 2021 Disparity Indices by Ethnicity, Allegations, accessed May 2022. https://ccwip.berkeley.edu/childwelfare/reports/DisparityIndices/STSG/r/rts/s

14 Courtney, M. E., Okpych, N. J., Charles, P., et al. (2016). Findings from the California Youth Transitions to Adulthood Study (CalYOUTH): Conditions of youth at age 19: Los Angeles County Report. Chapin Hall at the University of Chicago.

15 Putnam-Hornstein, Cederbaum, et al., California's Most Vulnerable Parents: Adolescent Mothers and Intergenerational Child Protective Service Involvement, USC Children's Data Network, 2013.

16 How the Child Welfare System Works. How the Child Welfare System Works - Child Welfare Information Gateway. (n.d.). Retrieved August 11, 2022, from https://www.childwelfare.gov/pubs/factsheets/cpswork/

17 CCWIP Reports. Children in Foster Care, Retrieved May 2022, University of California Berkeley Child Welfare Indicator Project. https://ccwip.berkeley.edu

18 CCWIP Reports. Children in Foster Care, Retrieved May 2022, University of California Berkeley Child Welfare Indicator Project. https://ccwip.berkeley.edu

19 Courtney, M. E., Okpych, N. J., Charles, P., et al. (2016). Findings from the California Youth Transitions to Adulthood Study (CalYOUTH): Conditions of youth at age 19: Los Angeles County Report. Chapin Hall at the University of Chicago.

20 CCWIP Reports. Children in in Foster Care, Los Angeles, Retrieved May 2022, University of California Berkeley Child Welfare Indicator Project. https://ccwip.berkeley.edu/childwelfare/reports/PIT/MTSG/r/ab636/s

21 https://www.clccal.org/resources/foster-care-facts/#:~:text=Many%20children%20in%20California's%20foster,lacked%20strong%20and%20supportive%20relationships.

22 California Welfare and Institutions Code, § 16000.1 (2003); California Welfare and Institutions Code, § 16001.9(a) (2019); California Department of Social Services, 2016; Social Security Act, 2011.

23 California Department of Social Services, 2016, 2021

24 42 U.S.C. §§ 671(a)(16), 675(1)(C)).

25 Welf. & Inst. Code, §§ 16010(b), 16501.1(g)(14).

26 California Department of Health Care Services, Health Care Program for Children in Foster Care. https://www.dhcs.ca.gov/services/HCPCFC/Pages/ProgramOverview.aspx.

27 California Foster Youth Sexual Health Education Act, 2017, Welf. & Inst. Code 16501.1(g)(20), (g)(21)

28 CDSS, All-County Letter 16-88, California's Plan for the Prevention of Unintended Pregnancy for Youth and Non-Minor Dependents (2016)

29 Santelli, J. S., Klein, J. D., Song, X., Heitel, J., Grilo, S., Wang, M., Yan, H., Kaseeska, K., Gorzkowski, J., Schneider, M., Dereix, A. E., & Catallozzi, M. (2019). Discussion of potentially sensitive topics with young people. Pediatrics, 143(2), e20181403. https://doi.org/10.1542/peds.2018-1403

30 Grilo, S. A., Catallozzi, M., Santelli, J. S., Yan, H., Song, X., Heitel, J., Kaseeska, K., Gorzkowski, J., Dereix, A. E., & Klein, J. D. (2019). Confidentiality discussions and private time with a health-care provider for youth, United States, 2016. Journal of Adolescent Health, 64(3), 311-318. https://doi.org/10.1016/j.jadohealth.2018.10.301

31 Ford, C. A., Millstein, S. G., & Halpern-Felsher, B. L. (1997). Influence of physician confidentiality assurances on adolescents' willingness to disclose information and seek future health care. JAMA, 278(12), 1029. https://doi.org/10.1001/jama.1997.03550120089044

32 Sexual and Reproductive Health Care for Foster Youth: Minor Consent Law in California, National Center for Youth Law, 2017 available at: www.teenhealthlaw.org

33 Altshuler, S. J. (2003). From Barriers to Successful Collaboration: Public Schools and Child Welfare Working Together. Social Work, 48(1), 52–63. https://doi.org/10.1093/sw/48.1.52

34 Palinkas, L. A., Fuentes, D., Finno, M., Garcia, A. R., Holloway, I. W., & Chamberlain, P. (2014). Inter-organizational collaboration in the implementation of evidence-based practices among public agencies serving abused and neglected youth. Administration and Policy in Mental Health and Mental Health Services Research, 41(1), 74-85. https://doi.org/10.1007/s10488-012-0437-5

35 CDSS, ACL 16-82, "REPRODUCTIVE AND SEXUAL HEALTH CARE AND RELATED RIGHTS FOR YOUTH AND NON-MINOR DEPENDENTS (NMD) IN FOSTER CARE", 2018

36 National Center for Youth Law. (2020). The California Child Abuse and Neglect Reporting Act: Reporting rules for mandated reporters. Teen Health Law. https://teenhealthlaw.org/wp-content/uploads/2020/04/CANRA-ReportingRulesforMandatedReporters.pdf

37 National Center for Youth Law. (2020). The California Child Abuse and Neglect Reporting Act: Reporting rules for mandated reporters. Teen Health Law, citing California Penal Code 11166(a)(1) and People ex rel. Eicheberger v. Stockton Pregnancy Control Medical Clinic, Inc., 249 Cal. Rptr. 762, 769 (3rd Dist. Ct. App. 1988)

38 Gudeman, R., & Monasterio, E. (2014). Mandated Child Abuse Reporting Law: Developing and Implementing Policies and Training (Rep.). Oakland, California: Cardea Services. http://fosterreprohealth.org/wp-content/uploads/2018/04/Gudeman-Monasterio-Mandated-Child-Abuse-Reporting-Law-GUIDE-20140619.pdf

39 Peterson, S. (2018, May 25). Complex Trauma. The National Child Traumatic Stress Network. https://www.nctsn.org/what-is-child-trauma/trauma-types/complex-trauma.

40 National Research Council and Institute of Medicine. (2009). Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities. Washington, DC: The National Academies Press. https://doi.org/10.17226/12480.

41 Ginwright, S. (2019). Community Well-Being and Resilience. In The Future of Healing: Shifting From Trauma Informed Care to Healing Centered Engagement. IIRP Europe. https://www.iirp.edu/news/2019-iirp-europe-conference-community-well-being-and-resilience.

42 Youth Research & Evaluation eXchange (YouthREX). (2021). From Trauma-Informed Care to Healing-Centered Engagement: A Youth Work Teach-In with Dr. Shawn Ginwright [Video file]. https://youtu.be/NxTSIlWUeg8

43 Courtney, M. E., Charles, P., Okpych, N. J., Napolitano, L., & Halsted, K. (2014). Findings from the California Youth Transitions to Adulthood Study (CalYOUTH): Conditions of foster youth at age 17. Chapin Hall at the University of Chicago.

44 Latzman, N. E., & Gibbs, D. (2020). Examining the link: Foster care runaway episodes and human trafficking. OPRE Report No. 2020-143. Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

45 Bartlett, J., & Steber, K. (2019, May 9). How to Implement Trauma-informed Care to Build Resilience to Childhood Trauma. Child Trends. https://www.childtrends.org/publications/how-to-implement-trauma-informed-care-to-build-resilience-to-childhood-trauma

46 Davis, M., & Hristic, A. (2021, April 30). TIO Resources: Foundations of Trauma Informed Care. Trauma Informed Oregon. https://traumainformedoregon.org/resource/foundations-trauma-informed-care/.

47 Bartlett, J., & Steber, K. (2019, May 9). How to Implement Trauma-informed Care to Build Resilience to Childhood Trauma. Child Trends. https://www.childtrends.org/publications/how-to-implement-trauma-informed-care-to-build-resilience-to-childhood-trauma.

48 Marcell, A. V., & Burstein, G. R. (2017). Sexual and reproductive health care services in the pediatric setting. Pediatrics, 140(5), e20172858. https://doi.org/10.1542/peds.2017-2858

49 Sexual and reproductive health care: A position paper of the society for adolescent health and medicine. (2014). Journal of Adolescent Health, 54(4), 491-496. https://doi.org/10.1016/j.jadohealth.2014.01.010

50 The American College of obstetricians and gynecologists. (2017). Counseling adolescents about contraception. Obstetrics & Gynecology, 130(5). https://doi.org/10.1097/aog.0000000000002393

51 Klein, D. A., Paradise, S. L., & Landis, C. A. (2020). Screening and counseling adolescents and young adults: A framework for comprehensive care. Am Fam Physician, 101(3), 147-158.

52 Klein, David, Paradise, Scott, Landis, Corinne, Screening and Counseling Adolescents and Young Adults: A Framework for Comprehensive Care, Am Fam Physician. 2020 Feb 1;101(3):147-158. https://www.aafp.org/afp/2020/0201/p147.html

53 Hagan, J. F., Shaw, J. S., & Duncan, P. M. (2017). In Bright futures: Guidelines for health supervision of infants, children, and adolescents (pp. 731–820). chapter, American Academy of Pediatrics.

54 Henderson, J. A. (2021, May 7). Breast Examination Techniques. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK459179/.

55 Allen, D., Hunter, M. S., Wood, S., & Beeson, T. (2017). One Key Question®: First Things First in Reproductive Health. Maternal and Child Health Journal, 21(3), 387–392. https://doi.org/10.1007/s10995-017-2283-2

56 Gomez, A., Arteaga, S.,, Ingraham, N., Arcara, J., & Villasenor, E. (2018). It's Not Planned, But Is it Okay? The Acceptability of Unplanned Pregnancy Among Young People. Women's Health Issues. 28-5. https://doi.org/10.1016/j.whi.2018.07.001; Arteaga, S., Caton, L., Gomez, A. (2018). Planned, unplanned, and in-between: the meaning and context of pregnancy planning for young people. Contraception. doi:10.1016/j.contaception.2018.08.012

57 Centers for Disease Control and Prevention. (2021, June 11). Learn About PrEP. Centers for Disease Control and Prevention. https://www.cdc.gov/hiv/clinicians/prevention/prep.html.

58 Tanner, M. R., Miele, P., Carter, W., Valentine, S. S., Dunville, R., Kapogiannis, B. G., & Smith, D. K. (2020). Preexposure Prophylaxis for Prevention of HIV Acquisition Among Adolescents: Clinical Considerations, 2020. MMWR. Recommendations and Reports, 69(3), 1–12. https://doi.org/10.15585/mmwr.rr6903a1

59 Miller, E., & Weimann, C. (2020). Adolescent relationship abuse including physical and sexual teen dating violence. In M. Torchia (Ed.) UpToDate. Retrieved June 15, 2021. https://www-uptodate-com.ucsf.idm.oclc.org/contents/adolescent-relationship-abuse-including-physical-and-sexual-teen-dating-violence.

60 Olsen, E. O. M., Vivolo-Kantor, A., & Kann, L. (2017). Physical and Sexual Teen Dating Violence Victimization and Sexual Identity Among U.S. High School Students, 2015. Journal of Interpersonal Violence, 35(17-18), 3581–3600. https://doi.org/10.1177/0886260517708757

61 Walls, N. E., Atteberry-Ash, B., Kattari, S. K., Peitzmeier, S., Kattari, L., & Langenderfer-Magruder, L. (2019). Gender identity, sexual orientation, mental health, and bullying as predictors of partner violence in a representative sample of youth. Journal of Adolescent Health, 64(1), 86-92. https://doi.org/10.1016/j.jadohealth.2018.08.011

62 American College of Obstetricians and Gynecologists. (2013). ACOG Committee Opinion no. 554: Reproductive and Sexual Coercion. Obstetrics and gynecology, 121(2 Pt 1), 411-415.

63 Katz, C. C., Courtney, M. E., & Sapiro, B. (2020). Emancipated foster youth and intimate partner violence: An exploration of risk and protective factors. Journal of Interpersonal Violence, 35(23-24), 5469-5499. https://doi.org/10.1177/0886260517720735

64 PettyJohn, M. E., Reid, T. A., Miller, E., Bogen, K. W., & McCauley, H. L. (2021). Reproductive coercion, intimate partner violence, and pregnancy risk among adolescent women with a history of foster care involvement. Children and Youth Services Review, 120, 105731. https://doi.org/10.1016/j.childyouth.2020.105731

65 USPSTF. (2018, October 23). Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: Screening. Recommendation: Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: Screening | United States Preventive Services Taskforce. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening.

66 Miller, E. (2017). Prevention of and Interventions for Dating and Sexual Violence in Adolescence. Pediatric Clinics of North America, 64(2), 423–434. https://doi.org/10.1016/j.pcl.2016.11.010

67 Miller, E., & Weimann, C. (2020). Adolescent relationship abuse including physical and sexual teen dating violence. In M. Torchia (Ed.) UpToDate. Retrieved June 15, 2021. https://www-uptodate-com.ucsf.idm.oclc.org/contents/adolescent-relationship-abuse-including-physical-and-sexual-teen-dating-violence.

68 Latzman, N. E., & Gibbs, D. (2020). Examining the link: Foster care runaway episodes and human trafficking. OPRE Report No. 2020-143. Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

69 Wilson, B.D.M., Cooper, K., Kastanis, A., & Nezhad, S. (2014). Sexual and Gender Minority Youth in Foster care: Assessing Disproportionality and Disparities in Los Angeles. Los Angeles: The Williams Institute, UCLA School of Law.

70 Zapata, L. B., Tregear, S. J., Curtis, K. M., Tiller, M., Pazol, K., Mautone-Smith, N., & Gavin, L. E. (2015, August). Impact of contraceptive counseling in clinical settings: A systematic review. American journal of preventive medicine. Retrieved August 11, 2022, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4608447/#:~:text=For%20the%20purpose%20of%20this,achieve%20a%20reproductive%20health%20goal

71 HEEADSSS 3.0: The psychosocial interview for adolescents updated for a new century fueled by media. Contemporary Pediatrics. (n.d.). Retrieved August 11, 2022. https://www.contemporarypediatrics.com/view/heeadsss-30-psychosocial-interview-adolescents-updated-new-century-fueled-media

72 Centers for Disease Control and Prevention. (2020, February 26). Overview. Centers for Disease Control and Prevention. Retrieved August 11, 2022. https://www.cdc.gov/preconception/overview.html

73 Courtney, M. E., Okpych, N. J., Charles, P., et al. (2016). Findings from the California Youth Transitions to Adulthood Study (CalYOUTH): Conditions of youth at age 19: Los Angeles County Report. Chapin Hall at the University of Chicago.

74 Centers for Disease Control and Prevention. (2021, June 11). Learn About PrEP. Centers for Disease Control and Prevention. https://www.cdc.gov/hiv/clinicians/prevention/prep.html.

75 McNicholas C, Madden T, Secura G, Peipert JF. The contraceptive CHOICE project round up: what we did and what we learned. Clin Obstet Gynecol. 2014 Dec;57(4):635-43. doi: 10.1097/GRF.0000000000000070. PMID: 25286295; PMCID: PMC4216614.

76 Centers for Disease Control and Prevention. (2022, June 3). Prep. Centers for Disease Control and Prevention. Retrieved August 11, 2022. https://www.cdc.gov/hiv/basics/prep.html

77 Tydén, T., Verbiest, S., Van Achterberg, T., Larsson, M., & Stern, J. (2016, November). Using the reproductive life plan in contraceptive counselling. Upsala journal of medical sciences. Retrieved August 11, 2022, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5098497/

78 Khalesi, Z. B., Simbar, M., Azin, S. A., & Zayeri, F. (2016, June 25). Public Sexual Health Promotion Interventions and Strategies: A qualitative study. Electronic physician. Retrieved August 11, 2022, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4965198/#:~:text=Sexual%20health%20promotion%20is%20the%20process%20by%20which%20individuals%20achieve,and%20unwanted%20pregnancies%20(4)

79 Klein, D. A., Paradise, S. L., & Landis, C. A. (2020, February 1). Screening and counseling adolescents and young adults: A Framework for Comprehensive Care. American Family Physician. Retrieved August 11, 2022, from https://www.aafp.org/pubs/afp/issues/2020/0201/p147.html

80 Marcell, A., Bell, D., & Joffe, A. (2012). The Male Genital Examination: A Position Paper of the Society for Adolescent Health and Medicine. Journal of Adolescent Health, 50(4), 424–425. https://doi.org/10.1016/j.jadohealth.2012.01.002

81 Elisseou, S., Puranam, S., & Nandi, M. (2018). A novel, trauma-informed physical examination curriculum. Medical Education, 52(5), 555–556. https://doi.org/10.1111/medu.13569

82 Marcell, A.V. and the Male Training Center for Family Planning and Reproductive Health (2014). Preventive Male Sexual and Reproductive Health Care: Recommendations for Clinical Practice. Philadelphia, PA: Male Training Center for Family Planning and Reproductive Health and Rockville, MD: Office of Population Affairs.

83 Weingartner, L. A., Noonan, E., & Holthouser, A. (2019). In The eQuality toolkit: practical skills for LGBTQ and DSD-affected patient care (pp. 31–34). essay, Kentucky Publishing Services.

84 Albertson, K., Crouch, J. M., Udell, W., Schimmel-Bristow, A., Serrano, J., et al. (2018). Caregiver perceived barriers to preventing unintended pregnancies and sexually transmitted infections among youth in foster care. Children and Youth Services Review, 94, 82–87. https://doi.org/10.1016/j.childyouth.2018.09.034 ; See also Harmon-Darrow, C., Burruss, K., & Finigan-Carr, N. (2020). "We are kind of their parents": Child welfare workers' perspective on sexuality education for foster youth. Children and Youth Services Review, 108, 104565. https://doi.org/10.1016/j.childyouth.2019.104565; Ross, C., Kools, S., & Laughon, K. (2020). "It was only me against the world." Female African American adolescents' perspectives on their sexual and reproductive health learning and experiences while in foster care: Implications for positive youth development. Children and Youth Services Review, 118, 105463. https://doi.org/10.1016/j.childyouth.2020.105463

85 Macapagal, K., Bhatia, R., & Greene, G. J. (2016). Differences in healthcare access, use, and experiences within a community sample of racially diverse lesbian, gay, bisexual, transgender, and questioning emerging adults. LGBT Health, 3, 434–42. https://doi.org/10.1089/lgbt.2015.0124

86 Taylor, A., Reyes, F., Evans, C., R, J., Cortez, J., & Gomez, A.-G. (2021, August). Telling our own stories - RHEP foster youth. Telling Our Own Stories. Retrieved August 12, 2022, from https://fosterreprohealth.org/wp-content/uploads/2021/09/Telling-Our-Own-Stories.pdf

87 Butler, A., Creating Safer Spaces for LGBTQ Youth: A Toolkit (2020). http://www.advocatesforyouth.org/wp-content/uploads/2020/11/Creating-Safer-Spaces-Toolkit-Nov-13.pdf

88 McKenney, K. M., Martinez, N. G., & Yee, L. M. (2018). Patient navigation across the spectrum of women's health care in the United States. American journal of obstetrics and gynecology, 218(3), 280–286. https://doi.org/10.1016/j.ajog.2017.08.009

89 Welf. & Inst. Code 16501.1(g)(20), (g)(21).

90 California Dept of Social Services All-County Letter 18-61. (2018). New Mandates regarding Case Plan Documentation and Training reelated to Reproductive and Sexual Health Care Needs and Rights of Foster Youth. https://www.cdss.ca.gov/Portals/9/ACL/2018/18-61.pdf

91 California Dept of Social Services All-County Letter 16-88. (2016). California's Plan for the Prevention of Unintended Pregnancy for Youth and Non-minor Dependents (NMDs) in Foster Care. https://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2016/16-88.pdf

92 Gudeman, R. (2019). California minor consent and confidentiality laws. National Center for Youth Law. http://teenhealthlaw.org/wp-content/uploads/2019/08/2019CaMinorConsentConfChartFull.pdf

93 Gudeman, R. (2019). California minor consent and confidentiality laws. National Center for Youth Law. http://teenhealthlaw.org/wp-content/uploads/2019/08/2019CaMinorConsentConfChartFull.pdf

94 California Dept. of Social Services. (n.d.). Know your sexual and reproductive health rights. https://www.cdss.ca.gov/portals/9/fmuforms/m-p/pub490.pdf

95 California Dept of Social Services All-County Letter 16-82. (2016). Reproductive and sexual health care and related rights for youth and non-minor dependents (NMD) in foster care. https://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2016/16-82.pdf

96 All County Information Notice No. I-06-20 New Resources For Case Management Workers For Documenting, Protecting And Sharing Reproductive And Sexual Health Information For Youth And Non-Minor Dependents (NMDs) In Foster Care. California Dept of Social Services. (2020, January 6). https://www.cdss.ca.gov/Portals/9/Additional-Resources/Letters-and-Notices/ACINs/2020/I-06_20.pdf

97 Schulman, M. (2019, November). Assistance tool November 2019 - trauma-informed care implementation ... Trauma-Informed Care: Implementation Resource Center. Retrieved August 12, 2022, from https://www.traumainformedcare.chcs.org/wp-content/uploads/Make-Your-Pitch-for-TIC-TA-Tool_111819-1.pdf

98 Peterson, S. (2018, March 27). Introduction. The National Child Traumatic Stress Network. https://www.nctsn.org/trauma-informed-care/secondary-traumatic-stress/introduction.

99 Mathieu, F. (2021, January 26). Signs & Symptoms of Empathic Strain and Secondary Traumatic Stress. Tend Academy. https://www.tendacademy.ca/signs-and-symptoms-of-compassion-fatigue-and-vicarious-trauma/

100 Lieberman JA, Stuart MR. The BATHE method: incorporating counseling and psychotherapy into the everyday management of patients. Prim Care Companion J Clin Psychiatry 1999;1:35–8.doi:10.4088/pcc.v01n0202pmid:http://www.ncbi.nlm.nih.gov/pubmed/15014693

101 American Academy of Family Physicians. (n.d.). Tips on Building Doctor/Patient Relations. aafp.org. https://www.aafp.org/dam/AAFP/documents/medical_education_residency/fmig/tips_relationships.pdf

102 Cane, P. M. (2020, June 30). Capacitar Emergency Kits of Best Practices. Capacitar International. https://capacitar.org/capacitar-emergency-kits-to-download/

103 Cane, Ph.D., P. M. (2005). CAPACITAR Emergency Response Tool Kit. Capacitar. Retrieved August 11, 2022, from https://dsamh.utah.gov/pdf/2019%20Trauma%20Academy/Capacitar%20Trauma%20Toolkit.pdf

104 Ahrens, Spencer, Bonnar, Coatney, and Hall, 2016

105 Taylor, A., Reyes, F., Evans, C., R, J., Cortez, J., & Gomez, A.-G. (2021, August). Telling our own stories - RHEP foster youth. Telling Our Own Stories. Retrieved August 12, 2022, from https://fosterreprohealth.org/wp-content/uploads/2021/09/Telling-Our-Own-Stories.pdf

106 Taylor, A., Reyes, F., Evans, C., R, J., Cortez, J., & Gomez, A.-G. (2021, August). Telling our own stories - RHEP foster youth. Telling Our Own Stories. Retrieved August 12, 2022, from https://fosterreprohealth.org/wp-content/uploads/2021/09/Telling-Our-Own-Stories.pdf

107 Same-visit contraception: A toolkit for family planning providers. Same-Visit Contraception: A Toolkit for Family Planning Providers | Reproductive Health National Training Center. (2020, March). Retrieved September 8, 2022, from https://rhntc.org/resources/same-visit-contraception toolkit-family-planning-providers

108 Luther, S. (2020). University Center for excellence in developmental disabilities. Sex and Medicine: The Imperative for Medical and Mental Health Providers to Address Sex and Sexuality. Retrieved September 8, 2022, from https://www.ohsu.edu/university-center-excellence-development-disability/past-events#section-1218721

109 Same-visit contraception: A toolkit for family planning providers. Same-Visit Contraception: A Toolkit for Family Planning Providers | Reproductive Health National Training Center. (2020, March). Retrieved September 8, 2022, from https://rhntc.org/resources/same-visit-contraception-toolkit-family-planning-providers

110 Phone room guidance on emergency contraception. PICCK: Partners in Contraceptive Choice and Knowledge. (n.d.). Retrieved August 11, 2022, from https://picck.org/wp-content/uploads/2022/01/PICCK-Phone-Room-Guidance-on-Emergency-Contraception.pdf

111 U.S. Department of Health and Human Services. (2020, September 24). Pre-Exposure Prophylaxis (PrEP). National Institutes of Health. https://hivinfo.nih.gov/understanding-hiv/fact-sheets/pre-exposure-prophylaxis-prep.

112 Chang, Kimberly S. G.; Lee, Kevin; Park, Terrence; Sy, Elizabeth; and Quach, Thu (2015) "Using a Clinic-based Screening Tool for Primary Care Providers to Identify Commercially Sexually Exploited Children," Journal of Applied Research on Children: Informing Policy for Children at Risk: Vol. 6: Iss. 1, Article 6. Available at: http://digitalcommons.library.tmc.edu/childrenatrisk/vol6/iss1/6

113 Committee on Gynecologic Practice American Society for Reproductive Medicine (2019). ACOG Committee Opinion No. 762 Summary: Prepregnancy Counseling. Obstetrics & Gynecology, 133(1), 228–230. https://doi.org/10.1097/aog.0000000000003014

114 McKenney, K. M., Martinez, N. G., & Yee, L. M. (2018). Patient navigation across the spectrum of women's health care in the United States. American journal of obstetrics and gynecology, 218(3), 280–286. https://doi.org/10.1016/j.ajog.2017.08.009

115 What is the plan-do-check-act (Pdca) cycle? ASQ. (n.d.). Retrieved August 11, 2022. https://asq.org/quality-resources/pdca-cycle

Thank you.