

Factors Associated with Sexual Health Care Access and Utilization Among Black  
Youth in King County: A Qualitative Pilot Study

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## **Abstract**

### Factors Associated with STI Testing Utilization Emergency Departments Settings Among Black Youth: A Qualitative Study

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Chlamydia and Gonorrhea infections most commonly affect 15–24-year-olds and can cause significant and permanent health problems if left untreated. Confidentiality concerns, stigma, and inaccessible services have been cited as barriers to sexual health care among youth. There are also racial and ethnic disparities among Black youth who also have the highest rates of Chlamydia and Gonorrhea infections, even when accounting for similar sexual behaviors. Our team recently conducted a large quantitative analysis that showed 20% of Black youth with Medicaid received Chlamydia and Gonorrhea testing in an emergency department, even though prior studies suggest that receiving sexual health services in these settings is not ideal. To better understand the barriers and facilitators that lead to emergency departments utilization for Chlamydia and Gonorrhea testing among Black youth, our team will conduct a qualitative analysis based on the Health Belief Conceptual Model. However, prior to implementing a larger qualitative study, a pilot study will be conducted to identify and address potential issues which could compromise the success of the larger study.

For our pilot study, we recruited two youth who received Chlamydia and/or Gonorrhea testing in a pediatric emergency department or urgent care within the past year. After completing the interview, these youth gave feedback on best practices for study recruitment and perceptions of the interview guide design. Overall, there were two primary issues identified during the pilot. The first included difficulty with recruitment, likely due to starting with an overall small sample frame, but mistrust of the health care system among Black youth, particularly with regards to research needs to be explored. We also encountered problems regarding protecting the anonymity of youth whose multiple intersectionalities could be compromised given our small population size. The team will expand our sample size across multiple hospital systems to ensure confidentiality and anonymity is maintained. Among the pilot study participants, they reported no concerns regarding the survey design, understanding of questions, or length of interview. Results from this pilot will be used to improve our study design and methodology prior to initiating the larger qualitative study.

## **Introduction**

Pilot studies are a type of feasibility study that have historically been used in quantitative research, but more recently have become useful to researchers conducting qualitative research as a means to identify and correct problems which could compromise the acceptability and delivery of a larger research study.<sup>1</sup> A well-executed pilot can assure methodological rigor, which can result in high quality research that can be published for the benefit of the relevant community.<sup>2</sup>

Our team plans to conduct a qualitative study that seeks to understand the experiences of Black youth in King County, WA who have received testing for the two most common bacterial sexually transmitted infections, *Chlamydia trachomatis* (CT) and *Neisseria gonorrhoea* (GC), in emergency department settings.<sup>3</sup> However, prior to initiating a larger qualitative study, our team has conducted a pilot study. Given the small population of Black youth in King County, and the importance of conducting this study efficiently and without harm, the purpose of piloting this study was to identify any unanticipated weaknesses and problems in our recruitment strategy and interview design. Additionally, piloting this study will allow the team to create solutions for any unanticipated problems that may occur, while also refining the research team's qualitative research skills.

## **Background**

### ***STI Disparities***

Youth and young adults aged 15-24 account for about half of the 26 million new sexually transmitted infections (STI) that occur annually in the US.<sup>4</sup> CT and GC are the two most common bacterial STIs in the US, and unlike some STIs, CT/GC infections are easily treated with timely and appropriate testing and access to antibiotics.<sup>3</sup> Untreated CT/GC infections can affect quality of life and can also lead to significant and permanent complications including pelvic inflammatory disease, chronic pelvic pain, increased risk of HIV infections, ectopic pregnancy, urethritis, and infertility.<sup>5,6</sup> Many CT/GC infections are asymptomatic so an individual may not be aware that they have CT/GC.<sup>7</sup> If an individual is symptomatic, the symptoms typically have a quick onset and may include pain and/or discharge at the genitourinary site, causing a youth to seek immediate medical attention.<sup>8,9</sup> Also, unlike many other STIs, CT/GC is typically performed with a quick urine test which can be performed in almost any medical setting.<sup>10</sup> Additionally, medical providers don't need additional training or staff to treat CT/GC infections as the recommended antibiotics for CT/GC infections are generally inexpensive and widely available.<sup>11</sup> For these reasons, and because CT and GC have specific and routine screening recommendations for youth, our study will focus primarily on the testing of these two STIs.<sup>11</sup>

There are many biological, psychological, and accessibility issues experienced by youth that contribute to their higher burden of STIs.<sup>12</sup> Commonly cited barriers to STI care among youth include the lack or absence of education around STI testing and treatment, the lack of available adolescent friendly testing spaces and services, shame and judgement from medical providers, and concerns about confidentiality.<sup>13</sup> These barriers disproportionately affect Black youth who have the additional burden of systemic, institutional, and cultural racism that further limits access to equitable sexual health care while also perpetuating harmful racial stereotypes

and biases that lead to medical mistrust and foregone care.<sup>14</sup> It is therefore not surprising that Black youth have the highest rates of CT/GC infections. According to the Centers for Disease Control (CDC), in 2018, the rate of reported CT cases among Black females aged 15–19 years was 4.5 times the rate among White females in the same age group, while the rate of GC among Black females aged 15–19 years was 8.8 times the rate of White females in the same age group.<sup>15</sup> Similarly, among males aged 15–19 years, the rate of reported CT cases among Blacks was 9.1 times the rate among Whites.<sup>15</sup> According to the CDC, “it is important to understand that these higher rates are not caused by ethnicity or heritage, but by social conditions that are more likely to affect minority groups.”<sup>15</sup> One study entitled, “What Racism Has to Do with It: Understanding and Reducing Sexually Transmitted Diseases in Youth of Color” sought to explain STI disparities by identifying sexual risk factors within the framework of racism.<sup>14</sup> The study explains how structural racism (with examples of housing segregation and criminal justice system policies), interpersonal racism (including provider implicit/explicit bias and discrimination), and cultural racism lead to added sources of stress and inaccessible health care which may lead to downstream issues such as substance abuse and worse mental health outcomes.<sup>14</sup> These downstream issues often lead to riskier sexual behaviors, which then increases an individual’s chances of contracting a STI, while also decreasing their ability to receive effective testing and treatment.<sup>14</sup> Ideally, interventions that seek to decrease inequities in STI and sexual health care for Black youth will acknowledge and address the upstream effects of systemic, cultural, institutional, and interpersonal racism.

### ***Prior Research***

This impetus for conducting our qualitative study began in 2022 as the study team sought to identify where youth receive CT/GC testing and if testing locations varied by an individual's race and/or ethnicity? To evaluate this question, the study team analyzed claims data from 2019 using the IBM MarketScan database. This database includes approximately 7 million Medicaid beneficiaries from 10 to 12 unidentified states.<sup>16</sup> Our study analyzed the number of visits in which a combined CT/GC test was ordered among 13–21-year-olds who were enrolled and had at least 1 claim during the study period. Overall, we analyzed over 418,000 CT and GC tests. Our results showed that across all races and ethnicities, youth were most likely to have their STI testing ordered at medical offices. However, the study also highlighted that an alarming 19.6% of the almost 200,000 tests ordered among Black youth occurred in emergency department (ED) settings. Prior studies have shown that youth who receive CT/GC testing in an ED are more likely to experience over and/or under treatment of their infection, become lost to follow up, and receive inadequate counseling and education services.<sup>17</sup> Studies have also shown that there are racial and ethnic disparities among youth who receive STI care in ED settings. For example, non-White adolescent females are more likely to undergo STI testing in the ED than White adolescent females.<sup>18</sup> Although testing for STIs like CT and GC are important, these tests should be ordered based on recommended screening and testing guidelines, and not on an individual's race. Studies have consistently shown that Black youth receive STI testing more than White youth as a direct result of provider biases and our society's tendency to over-sexualize Black youth.<sup>19</sup>

### ***King County, WA demographics and STI Disparities***

King County is the most populous county in Washington State, and Black youth account for 8% of all youth under the age of 24 in King County.<sup>20,21</sup> Despite King County and Washington State's more progressive laws regarding sexual and reproductive healthcare (Washington State was one of the first in the US to initiate a chlamydial screening program), there are still significant disparities in CT/GC rates among Black youth.<sup>22,23</sup> CT and GC infection rates among Black youth in King County are similar, or worse than national rates. In 2019, rates of reported CT cases among Black youth aged 13-24 was 5.0 times higher than White youth of the same age.<sup>23</sup> Similarly, rates of reported GC cases was 9.5 times higher among Black youth than White youth.<sup>23</sup> While there are currently several different initiatives within King County and Washington State that aim to identify and address sexual health disparities among youth, it is unclear if and how Black youth's experiences in accessing sexual health care in an area where they make up only 8% of the population is being centered in these discussions.<sup>24</sup>

### ***Limitations in STI Research and the Need for a Pilot Study***

With regards to research, President Obama once stated "smaller communities in particular can get lost, their needs and concerns buried in a spreadsheet."<sup>25</sup> This can be particularly true when conducting sexual health research among historically marginalized groups and youth. STI research has many limitations.<sup>26</sup> For example, STI research involving large survey data such as The Youth Risk Behavior Surveillance System and Washington State's Healthy Youth Survey are often incomplete, lacking important information about sexual and reproductive health, and can have low response rates.<sup>26</sup> STI research involving claims or electronic health records data often lacks context at the individual level, i.e., was the youth sexually active, was the test ordered as

part of recommended screening or for symptomatic testing. Claims and electronic health record data may also lack complete race, ethnicity, preferred language, and gender identity data. Despite these limitations, data is still needed to inform policy and funding for interventions that seek to decrease STI disparities.

### ***Health Belief Model***

Given the multifactorial forces that contribute to STI disparities among Black youth, our team will use the Health Belief Model (HBM) to help clarify and interpret how these forces influence the ways in which youth access sexual health services. The HBM was first developed in the 1950s by public health experts who sought to understand how and why some individuals or communities utilize certain health services.<sup>27</sup> The HBM hypothesizes that health behaviors often depend on multiple factors, including perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy.<sup>27-29</sup> Specific to our population of interest, the HBM proposes that preventative care like CT/GC screening and medication adherence are more likely to be followed if a youth understands: 1) they are susceptible to getting CT/GC 2) An untreated CT/GC infection can develop into serious health problems 3) The benefits of understanding how to access STI testing quickly and efficiently is beneficial to their overall sexual health and 4) Feel empowered to access and advocate for their own sexual health.<sup>30</sup> Ultimately, the HBM suggests that youth will be more likely to take ownership and follow screening recommendations with regards to their sexual health if they receive cues and reminders which will be used in future implementation studies based on the results of our qualitative study.

Using the HBM, our study will seek to understand the perceptions and experiences of Black youth based on the following primary variables: 1. barriers and facilitators associated with ED utilization for CT/GC testing compared to other health care settings 2. experiences and satisfaction with receiving sexual health care in the ED compared to other health care settings, and 3. perceived needs at the ED, hospital system, and community levels that could decrease barriers to care and ultimately be used as interventions and implementation strategies that seek to decrease STI disparities among Black youth.

## **Methods**

### ***Participants and Recruitment for larger qualitative study***

Our qualitative study will recruit Black youth aged 15-24 who have received a CT or GC test at a Seattle Children's Hospital ED or Urgent Care (UC). Our justification for picking this population included: 1. These are youth who may not have access to primary care or school-based care if they are seeking STI testing in an emergency setting and 2. These are youth who are likely sexually active and are accessing sexual health care, which wouldn't be guaranteed in a random community sample. To start, the research team utilized Adaptx software which allowed the team to stratify de-identified electronic health records data by location type, patient race, age, diagnosis, and lab test ordered. From Adaptx, de-identified medical record numbers that were associated with a CT and/or GC test ordered within the preceding year were then evaluated directly in the electronic health record. Potential participants met inclusion criteria if they had at least one CT and/or GC test ordered from January 2022 – March 2023, identified as Black or African American (including multiple races), had a personal and confidential phone number

listed in the electronic health record and whose CT/GC test was not associated with a visit documented to have occurred as a result of a sexual assault or other trauma. These youth were excluded as to not perpetuate or reintroduce harm.

Our study aimed to conduct semi-structured, in-depth, one-on-one interviews via Zoom. If a potential participant met inclusion criteria, the youth was contacted via telephone. After it was determined that the primary investigator was talking to the correct person, the details of the study were explained, and the youth was asked about their willingness to participate. For youth who were willing to participate, a meeting time was arranged based on the participant's availability, and a link to a secure University of Washington Zoom meeting was provided via text or email (participant's preference). For individuals who declined to participate, they were thanked for their time and no further communication was initiated.

For the larger qualitative study, our team will seek to complete 15-20 interviews. For the pilot study, our team sought to complete 2-3 interviews.

### ***Interview Guide***

In keeping with the HBM, interview questions were created to understand participants' experiences and perceptions in both utilizing the ED for STI testing, but also to understand potential barriers and facilitators that explain the utilization of other STI testing locations such as primary care offices, school-based health centers, STI clinics, etc. For the pilot, the interview guide consisted of 4 sections: demographics, general health care access, sexual health care access, and perceived needs and areas for improvement (see appendix A). With the exception of

demographics, questions were semi-structured so that the question could be modified based on an individual's response. The interview was designed to take 30-45 minutes. For the pilot interviews, participants not only completed the interview, but at the completion of the interview, they were also asked to share their thoughts on the length, wording, and formatting of the interview guide.

### ***Ethical Considerations***

This study was approved by the University of Washington Institutional Review Board (IRB) with additional reliance from the SCH IRB. In Washington State, youth over the age of 14 can legally receive STI testing and treatment without an adult's consent; however, for research purposes, youth under 18 years old cannot participate in research without a waiver of parental permission which was obtained from the UW IRB for our study. Additionally, because the population of Black youth is small in King County and the study included not only confidential information, but sensitive and HIPAA protected medical information, special consideration would need to be undertaken to ensure that a participant's identity and privacy were maintained. For their time and participation, youth who complete the interview would receive a \$100 Tango gift card.

### **Analysis**

For the larger study, we will use thematic analysis to identify and interpret patterns highlighted in participant interviews.<sup>31</sup> All interviews will be recorded and transcribed verbatim. An inductive approach will be used to code themes based on similar patterns of responses. Two members of the study team will code the data, then use an iterative approach to compare, modify, and revise

codes as needed. Similarly, the coded data will be used by the study team to identify pertinent themes.

### **Pilot Results and Discussion**

Results of our pilot testing showed several pitfalls and areas of concern that the study team can improve prior to initiating the larger study. One primary area of concern was around recruitment. One reason why we decided to recruit from electronic health records data in ED and UC settings, was because we wanted to capture youth who were sexually active and who may not have consistent health care. Since we recruited our pilot participants from the same sample frame as our large qualitative study, the process for determining our sample population was concurrent. Once we used Adaptx software to define our sampling frame, we found that 30 Black youth had been seen for a CT/GC test in the 15-month study period. As our study aimed to recruit 15-20 participants, we continued with the IRB process to see how many of the 30 youth would meet inclusion criteria. After evaluating electronic health records data for inclusion criteria, it was determined that 21 youth met inclusion criteria. Amongst the 21 youth who were contacted, 8 did not answer the phone. Of significant concern is that among the 21 who met criteria to be invited to participate in the study, 6 phone numbers (28.6%) were answered by parents or guardians. Although the study team had prepared a generic script for this scenario, the fact that the youth's phone number was listed as personal brings into question the youth's ability to receive confidential testing in ED and UC settings as any results or follow up would be communicated via the parent's phone number. Of the remaining youth who did answer the phone, 4 youth agreed to participate, but were then unreachable after the initial contact with the study team. 2 of the youth agreed to participate in the interview and were recruited for the pilot study.

One question that arose prior to initiating the study was around conducting the interviews among participants with whom the primary investigator (an adolescent medicine physician) has treated medically in the past or may treat in the future. Although the IRB didn't prohibit contact between care providers and study team participants, the team sought to provide transparency among potential participants and to clearly communicate that participating or refusing to participate in the study would not affect past, present, or future clinical care. Among the 2 youth who participated in the pilot study, both were prior patients of the interviewer with one participant stating in the middle of the interview, "Wait, I know who you are. You took care of me while I was in the hospital last Christmas". Until the participant said this, the interviewer did not remember the participant, but again reiterated that participating in the interview would not affect the patients present or future care from the provider. However, among both pilot participants, having a prior clinical relationship seemed to make the participants feel at ease to answer questions more openly and honestly.

At the conclusion of both interviews, participants were asked to also give their perspectives on the acceptability and feasibility of the study. The participants were asked about the length of the interview and the understandability and conciseness of the questions. Although the interview was designed to take 30-45 minutes, the interview amongst a participant who was 16 years old lasted 20 minutes, while the other participant who was 21, had more to say which led to an interview time closer to 50 minutes. After completing the pilot study, changes to the interview guide included asking participants about their initial reasons for visiting the ED, as well as who initiated CT/GC testing, the youth, or the medical provider. Both youths stated that they went

into the ED for other non-STI related concerns, but specifically requested STI testing during their ED encounter because of the convenience of already being in a medical setting and the difficulty with making an appointment with their primary provider outside of typical clinic hours. Additionally, because of the difficulty with recruiting from our pre-stated sample frame during the pilot, the study guide was amended to ask participants about their thoughts on recruitment; both for the larger qualitative study, and for any future interventions that will be conducted based on the results of the qualitative study. Both participants felt like social media could be a useful recruitment tool. Additionally, one participant highlighted the importance of having youth be the lead of the study, particularly for any potential interventions.

Lastly, a significant concern that arose during the pilot was around how to protect a participant's confidentiality and anonymity while also being able to relay the profound and powerful experiences that these youth described during their interview. During one of the pilot interviews, a participant disclosed an encounter in which they requested STI testing in the ED while being seen for a different medical concern. The participant disclosed that they had a physical disability and after asking for STI testing, this individual was questioned relentlessly about their "ability to even engage in penetrative intercourse". The youth went on to describe how ableist this encounter was and how she was unlikely to receive testing in this setting in the future. The study team plans to address issues around confidentiality and anonymity by expanding our sample population to include to 2 other hospital systems within King County, the University of Washington Medical Center ED and Harborview Medical Center ED. When a participant shares a past experiences, this information will not include identifiers or specific locations. Our study

team will also consider blinding participants and/or changing specific details to protect study participants.

### **Conclusion and Future Steps**

Overall, conducting a small pilot of this study prior to initiating the larger study has provided the study team with useful information that will allow us to conduct a more efficient and thoughtful study. The results and subsequent changes that will come about as a result of this pilot will be used to guide our qualitative study, and ultimately future interventions that seek to improve access and decrease disparities for Black youth seeking sexual health care in King County.

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## Appendix A

### Opening Script/Ice Breaker

Thank you for agreeing to participate in this study. My name is Claudia Douglas I am an adolescent medicine doctor and a researcher at the University of Washington and Seattle Children's Hospital. I provide care for youth looking for sexual health services like as STD (infections transmitted through sex) testing and treatment. I understand that there are often issues that teens face when seeking these services, such as wanting to keep your sexual health information private, the location and timing of healthcare offices (i.e., only open 8-5), and costs. For these reasons, teens may seek these sexual health care in places like emergency departments (ED) or urgent care (UC) settings. The goal of this study is to gain a better understanding of barriers and issues that teens (particularly Black teens) face when accessing STI testing and treatment. The results of this study will be used to inform future projects that provide better STI services to teens in Seattle and the surrounding areas.

I am going to ask you to share some of your thoughts and opinions about your experiences with seeking health care. I will not assume anything about your past experiences. Feel free to use whatever words you feel comfortable using to explain your experiences. If I don't understand something, I will ask. Also, if you don't feel comfortable answering a question, just tell me – "I want to skip that question". If at any point during the interview you want to stop, just let me know and we will end the interview.

I also want to reiterate that if you have received health care from me in the past, or if you end up seeing me for care in the future, your participation in this survey will not impact your past, present, or future care.

Before I begin the interview, are there any questions about the consent form or any of the information that I just shared with you?

*[List of prompts that facilitator may use during interview:*

- *...(silence)*
- *Uh-huh*
- *Ok*
- *Echo (repeat back) what they said in a slightly different way*
- *Tell me more*
- *Can you tell me something about...*
- *We have learned from talking to other people that...*
- *Can I ask you some more about...*
- *What's going on there?*
- *That sounds really difficult]*

**\*START RECORDING\***

## ○ **Demographics**

*I will start the interview by asking basic questions about who you are.*

- Would you please tell me how old you are?
- Are you currently in school?
  - If so, what type of school (private, public, religious, home, other) and what grade are you in?
- What is your race?
- What is your ethnicity? (May need to explain)
- What zip code or neighborhood do you live in (may need to give example of areas i.e. South Seattle, North Seattle, other?)
- What zip code or neighborhood is your school located?

## ○ **General Health Care Access**

*Next, I am going to ask you questions about your experiences with receiving general health care*

- If you were not feeling well with something like a sore throat or stomach pains and you needed to see a doctor or get medical care, tell me about where you typically go for your healthcare? (*PROMPT*: school based clinic, primary care office, ED, UC, multiple places?)
- In what neighborhoods or cities are these healthcare locations located?
  - If in different area/neighborhood than school or home, tell me about your reasons for getting care at this place?
- What do you like about going to the places you mentioned in the last question?
- Is there anything that you don't like about the places you mentioned in the last question?
- If you mentioned that you use school-based clinics for general care (like a sore throat or stomach pain), can you tell me about your experiences with getting general medical care at school? (*include the following prompts as examples*)
  - What do you like about your school based clinic? Is there anything that you don't like?
  - Tell me where you would go if you needed general care outside of school hours (i.e., nights, weekends, summer)
- Tell me about your experiences with going to the emergency department or urgent care when you have a health problem that is maybe not an emergency (like a sore throat or stomach pains)? (*include the following prompts as examples*)
  - Tell me about your reasons for going to an emergency department or urgent care center for care? (i.e. can be seen the same day, like the providers, no charge, 24 hour services are more convenient, location of ED/UC)

## ○ **Sexual Health Care Access**

*Next, I am going to ask you questions about your experiences with receiving sexual health care in the ED/UC and other places*

- Have you ever had a STI test in an ED or UC (If youth is unsure, explain what the tests are)
    - If yes, what hospital system and locations were the test performed?
  - Tell me about your reasons for going to the ED or UC for your STI test (as opposed to another location like primary care clinic, planned parenthood, school-based clinic, etc.)? (i.e., PCP availability, location, concerns about confidentiality, costs, other)
  - Tell me about any experiences that you have had with receiving STI care (i.e., testing and treatment) in your school-based clinic? (*include the following prompts*)
    - (skip if youth has not had test at school) If you have never used your school-based clinic for STI testing, why? (i.e., not aware of services, inconvenient hours, confidentiality concerns, other)
  - What are your experiences with receiving STI care at any of the following locations (i.e., testing and treatment at other locations: (*include the following prompts as examples*)
    - Planned Parenthood
    - King County STD clinic
  - Can you tell me about any negative experiences you have had when accessing sexual health care (i.e., stigma, racism, communication issues) and how this has impacted or changed the way you have accessed STI testing or treatment?
- **Communication Around Results, Treatment, and Follow Up**
- For the ED/UC visit/s in which you received a CT/GC test, tell me about the primary reason/s that you went to the ED/UC? (i.e. what were your symptoms)
  - Did the ED/UC provider offer the CT/GC test, or did you ask for it? Tell me about any pushback you received if you asked for a CT/GC test?
  - After you went to the emergency department to get STI testing, explain how the results of your test were communicated with you? Who called you and what did they say?
    - Did you feel like all of your questions were answered and was there any other questions/concerns that you had that did not get answered?
  - Were you prescribed STI medications (Azithromycin, Doxycycline, or Ceftriaxone) during your ED/UC visit (before you knew your test results)? Or, did you receive STI medications after your ED/UC visit?
    - Did you experience any issues with getting your STI medications (costs, pharmacy was out, transportation issues, other) or taking your medication?
  - If you had a positive test from your ED/UC visit, tell me about your experiences with 3 month follow up testing (explain what 3 mo follow up testing is)? (*include the following prompts as examples*)
    - If you did not get 3 month follow up testing, can you explain why not (i.e., I was not told that I needed to be re-tested in 3 months, I did not know where to get testing, I forgot about the follow up testing, something else)
- **Needs/Areas for Improvement**

*This last section will ask you for your opinions on how access to STI testing and treatment can be improved. If you can think of any instances where your friends/peers have mentioned thoughts around improving STI care, feel free to include that information as well.*

- Give me examples of anything that could have made your visit to the ED/UC for STI testing better? *(include the following prompts as examples)*
  - What about the communication from the ED/UC after your STI test?
- If you could design the perfect space where youth could receive STI testing and treatment, what would that space look like? *(include the following prompts as examples)*
  - Where would it be?
  - What would it look like (a traditional “doctor’s office” or something different)?
  - What is important to you about the type of people who would work in this space (would they have the same race or ethnicity as you, be a certain age or gender, other)?
- Some places have tried different options to make STI testing easier for adolescents, what are your thoughts on the following (will explain how point of care (POC) testing works): *(include the following prompts as examples)*
  - POC testing kits sent to your home
  - POC tests performed in ED
  - POC test that can be picked up in community settings (i.e., rec center, gyms, etc.)
  - Mobile clinics?
  - Something else?
- **Ending**
  - Before we end, is there anything that you would like to add with regards to anything that we have discussed today?

*Thank you so much for participating in this interview. If you would like, I would be happy to discuss the general results of this study once the study is completed.*

*If yes: verify contact information to relay results*

*If no: thank participant again and end interview*