

Program Evaluation of Milwaukee's Sexually Transmitted Disease Clinic

by Danielle T. Jones, Brenda Parker, Scott Scrivner

Sexually transmitted diseases (STDs) present a formidable social, health, and economic problem for our nation. More than 65 million U.S. citizens are currently living with STDs, and an additional 15 million become infected with one or more STDs each year, including 3.5 million teenagers (CDC, 2000). Health risks associated with STDs include pain, increased susceptibility to other diseases, blindness, and even death. Women are at special risk of infertility, pregnancy problems, cervical cancer, premature births, and infant deaths. Estimated annual health costs associated with STDs total \$17 billion (Institute of Medicine, 1997). Among these costs, STDs that go untreated generate the highest social and economic cost, as initial complications become more severe and the disease is spread to others.

Milwaukee has a sizable population of STD-infected individuals and thus must contend with the health effects and associated costs. Milwaukee ranks among the top twenty cities for rates of STD infection, (see Table 1) nearly double the average rate for cities with populations larger than 200,000 people. For example, the national rate for chlamydia is 382 cases per 100,000; in Milwaukee it is 838 cases per 100,000. Milwaukee Health Department staff believe that one explanation may be that Milwaukee more accurately detects and reports STD cases. Relative standing aside, the absolute rates indicate that there is a sizable population of STD infected individuals in Milwaukee.

As a means of providing treatment and guarding against the spread of STDs within the city, the Milwaukee Health Department operates a free, community-based sexually transmitted diseases clinic. As the city's only free provider of STD diagnostic and treatment services, the clinic is part of an effort to address problems locally related to the aforementioned national STD problem, and serves to minimize the adverse health and financial impacts for the city and its residents. The city maintains this free clinic as a means of serving city residents who have limited access to health care because they are uninsured, underinsured, or have few resources with which to purchase care. Data indicate that approximately 22 to 26 percent of Milwaukee residents lacked health insurance at some point in 1999 and 7 to 9 percent were never insured during the year (Wisconsin DHFS, 2000). The most current data available suggest that in 1995 approximately 16 percent of Milwaukee families had income below the poverty threshold (Census, 1995). Although these estimates do not capture other needy populations, such as the underinsured or those living near the poverty threshold, there is clearly a large population with limited access to health care.

By providing care to this population, the city is able to identify and treat cases that would otherwise go undetected. In the absence of such a clinic, this population would be systematically underdiagnosed and undertreated, and as a result the city would not be able to approach the current rate of success in reducing infection in the city. Members of the untreated population would not only generate private and public costs directly related to their disease, but would also spread STDs to other populations. By treating needy individuals, the city is able to reduce directly the STD-infected population and reduce the risk of future

epidemics. Motivated by similar arguments, the Institute of Medicine and the U.S. Centers for Disease Control (CDC) have declared that local communities are best equipped to understand and contain STD epidemics, and that public STD clinics are the cornerstone of an equitable and efficient STD elimination strategy. This is particularly important in Milwaukee, an urban center with a concentrated black population, a demographic group that has reported STD rates up to 30 times greater than the white population.

This report evaluates the effectiveness of the clinic in meeting its goal of providing care to populations with limited access to care. The qualitative approach used in this report was chosen because of the clinic’s complicated organizational structure, multiple funding sources, and limited program participation and outcomes data. With this methodology in mind, we focused principally on two topics: the completeness with which the clinic adheres to guidelines for the treatment of STDs; and the extent to which STD clinics in Baltimore and Cincinnati use effective practices that could be successfully adopted by the Milwaukee clinic.¹ These cities were chosen because they are considered to be model urban clinics by the CDC, and because they have demographic characteristics similar to Milwaukee—specifically large black populations and high poverty rates—and relatively high STD morbidity rates.

Table 1: Comparative Demographic and STD Morbidity Rates, 1999

Demographic and Poverty Information	Milwaukee	Cincinnati	Baltimore
Overall Population	628,000	364,000	736,000
Black Population as Percentage of Total	30.5%	37.9%	59.2%
Poverty Rate	21.6%	23.4%	21.2%
Poverty Rate for Black Population	41.2%	38.3%	27.1%
Morbidity (rate per 100,000)			
Gonorrhea	535.7	332.1	948.6
Syphilis	18.2	11.4	145.8
Chlamydia	838.1	498.9	818.8

Source: Authors’ tabulations from data provided by the Wisconsin DHFS, the U.S. Centers for Disease Control, and the United States Census Bureau.

The evaluation results that follow suggest that the Milwaukee STD Clinic measures up to expectations of quality and guidelines for service, and compares well with Baltimore and Cincinnati clinics in service delivery. The strengths of the clinic’s performance are described in the “Report Card” included in the body of this report (see Table 4). At the same time, the clinic could benefit from a series of programmatic improvements that would strengthen its service delivery. These improvements are described in the recommendations sections of the report, and include “smart practices” (denoted by a ★ symbol) of other clinics as practical examples. Implementation costs of smart practices are not monitored by

¹ A detailed description of the methodology used is presented in Appendix A.

Baltimore and Cincinnati clinics and are not available. However, we intentionally considered and included practices that appear to be low-cost and appropriate for the current or future activities of the Milwaukee STD Clinic.

National Standards for STD Clinics

This evaluation uses the collection research already available on effective STD clinic practices to develop a set of standards to use in the analysis of the Milwaukee clinic. Standards fall in four primary categories: basic services and accessibility, diagnosis and testing and treatment, patient counseling, and partner notification. Although other components of STD clinic service delivery are addressed in this report, these four constitute the base of the Milwaukee STD Clinic evaluation. Guidelines for each category summarize current (1990-present) research on effective practices and include standards that should be met by public STD clinics to ensure that they are providing thorough and effective services for clients. The standards do not encompass every element of STD service provision, but rather provide a set of key benchmarks by which clinics can assess general performance and consider areas for improvement. In subsequent sections these standards are used to evaluate the performance of the Milwaukee STD Clinic.

Basic Services and Accessibility

Basic clinical STD services should be readily available to all adolescents and adults, according to the United States Advisory Committee for HIV and STD prevention. These services should be accessible without fees or with only nominal fees, available at least five days a week, and advance appointments should not be required. Patients should receive services on the day they arrive at the clinic, and if same-day service is impossible, clients should be referred to quality services elsewhere (USAC Recommendations, 1998). Clinics should be aware of language and multicultural issues relevant to their clientele to ensure appropriate communication and service delivery. Consistent with the theme of providing care to all needy populations, staff should be well trained to work with a variety of special populations, including adolescents and abused women and children; and information about other social services should be available to clients. Appropriate time should be spent with each client; the CDC 1991 guidelines recommend 20 minutes for males and 40 minutes for females.

Research has shown that same-day service, low cost, privacy concerns, convenient location, and expert care are primary reasons that clients attend public STD clinics (Celum et al., 1995). STD patient-provider interactions have been found to be problematic and even counterproductive on many occasions. Over 25 percent of patients in a recent survey indicated that their privacy was not preserved in interactions with clinical staff, a concern likely to create disincentives to make return visits (Aral and Wasserheit, 1999). Additionally, patients expect to be examined in a timely fashion, and excessive waiting times or early clinic closures tend to distance patients from the delivery system.

The Institute of Medicine (1997) recommends that all public STD clinics review and attempt to enhance the quality and extent of services provided to clients, and the CDC suggests that each clinic have a quality assurance team that periodically reviews STD clinic performance. Such periodic evaluations should be made with the intention of maintaining access to care for target populations and ensuring that no unintentional obstacles to care exist.

Diagnosis, Testing and Treatment

Testing is a critical component of STD treatment because of the high prevalence of undetected STDs. The CDC provides general recommendations for testing as part of its comprehensive treatment guidelines and recommends that these technical testing guidelines be obtained and adhered to by all STD clinics (CDC, 1998). Additionally, clinical diagnostic services should be updated whenever possible, particularly in public clinics. In all cases, STD test results should be held in strict confidentiality. In cases of HIV testing, the clinics should obtain informed consent of clients before testing, and offer the option of anonymous HIV testing. Anonymous testing (testing information is not documented in client's record) has been used widely and effectively and may offer important benefits for the health of individuals and the public, such as earlier entry into medical care. Some persons who would otherwise not be tested may seek anonymous HIV testing and learn their HIV status (CDC, 2000).

The CDC publishes a set of STD treatment guidelines that are updated every three to five years. The most recent set of guidelines was published in 1998, and its 150 pages contain general prevention suggestions, as well as detailed medical instructions for diagnosis and treatment for all common sexually transmitted diseases. These guidelines include new treatments for herpes, pelvic inflammatory disease, and genital warts, revised evaluation techniques for urethritis and syphilis, and expanded sections concerning STD treatment for certain populations, including pregnant women and infants (CDC, 1998). Developed by a committee of international experts, the CDC publication is considered the "gold" standard for STD treatment, particularly for public STD clinics. Viable clinics need to be aware of updates in guidelines and adhere to the standards set by the CDC, although adaptation of guidelines may occur for unique patient or clinic circumstances. Particular attention should be given to providing single-dose therapy, in which the full course of treatment is provided in one dose as opposed to a several day regimen, whenever possible (Institute of Medicine, 1997). Clear and accurate records of client concerns, symptoms and treatment are essential for clinics to monitor CDC guideline attainment and gauge their overall performance.

In its comprehensive 1997 report, *The Hidden Epidemic: Confronting Sexually Transmitted Diseases*, the Institute of Medicine suggests that public clinics need to become more involved in supporting long-term management of chronic viral STD infections. Staff, for example, should discuss the long-term nature of the diseases, options for suppression and relief of symptoms, and other strategies for self-care. Examples include how to suppress recurrent genital herpes, manage cervical dysplasia, and how to manage early hepatitis B infections (Institute of Medicine, 1997). For long-term disease care, staff need to inquire about insurance status and provide referrals or information related to public insurance where appropriate.

Patient Counseling

A 1990 study of STD clinic services found that 28 percent of public STD clinic clients did not receive any information regarding prevention during their visit, and that minimal counseling was provided (Roter et al., 1990). Busy clinic staff may at times give partner notification or other duties a higher priority than patient counseling (Institute of Medicine, 1997). Both the Institute of Medicine and CDC, however, recommend counseling as an important part of patient care for each clinic visit. Recent research has confirmed the value of counseling in preventing future STDs among clients (Institute of Medicine, 1997).

Among public STD clinic patients, those who receive a series of individual counseling sessions based on CDC recommended techniques are significantly more likely to adopt certain protective behaviors and less likely to acquire new STDs in the six months following counseling than are those who received only educational messages. Even brief counseling (two twenty-minute sessions) can increase risk-reduction behavior as well as STD incidence and can be conducted in busy public STD clinic setting (Kamb et al., 1998). Important factors in the provision of counseling are the use of interactive rather than didactic methods and the use of personalized risk reduction plans. Counselors do not need to have significant experience in counseling if quality control measures are in place; current clinical staff can provide counseling. Whenever possible, clients should return to the same counselor for repeated sessions; this helps the client feel secure, reduces misunderstanding, and promotes the likelihood of effective risk reduction (Compendium of HIV Prevention Interventions).

The CDC describes effective risk reduction sessions as those that:

- Emphasize confidentiality;
- Begin with assessment of the specific HIV/STD prevention needs of the client;
- Identify appropriate goals and objectives of clients, utilizing written protocol;
- Use skill-building exercises designed to meet specific needs of clients;
- Include negotiations with the client on recommendations for changing and sustaining behavior changes as appropriate to their situation. Identifying specific, not general behavioral changes is recommended;
- Enable and/or motivate participants to initiate and/or maintain behavior change independently;
- Enhance abilities of participants to access appropriate services; and
- Use open-ended questions rather than direct questions when conducting risk-assessment and counseling activities.

STD counseling providers should refrain from using counseling sessions as means for data collection and be wary of lengthy sessions. If completing paperwork is necessary, it should be done at the end of the session or by staff that do not participate in the counseling activities. Risk-assessment instruments in the form of checklists can be detrimental to effective counseling because they may cause counselors to use directed questions, limit eye contact, and miss verbal or nonverbal cues. The emphasis on information provision may also cause counselors to miss prevention opportunities and cause clients to lose interest in the counseling session. Counselors should also limit the extent to which they discuss theoretical rather than personalized risks because doing so may shift the session away from actual risk discussions and toward comfortable but irrelevant topics (CDC, 2000).

Partner Notification

Partner notification is an essential component of STD treatment and prevention, because only by notifying those who have had sexual contact with an infected person can the further spread of STDs be eliminated (CDC guidelines, 1998; Institute of Medicine, 1997; Health Canada, 1998). Specific partner notification activities include interviews, field visits to locate and notify contacts, treatment, verification of a contact, and documentation of activities, among others. The 1998 CDC guidelines provide general information about the necessity of partner notification for specific STDs, but little information on how to

implement such practices most effectively. The last CDC publication to provide explicit partner notification instruction was published in 1985. The Institute of Medicine, CDC, and other organizations recognize that current partner notification activities are largely inadequate, and that the research on partner notification practices is scant (Institute of Medicine, 1997; Macke et al., 1998). In the absence of comprehensive and current guidelines regarding partner notification, a set of general principles and best practices must be constructed from the STD literature and recent research on this topic. Current operating practices from “model” clinics can provide further guidance.

At minimum, clinics should follow practices in the CDC treatment guidelines, attempting to notify partners for all relevant STDs. Certain STDs have specific partner notification policies. Sexual contacts of chlamydia patients from the past 60 days need to be notified for efficient disease suppression or elimination (Zimmerman et al., 1999). Additionally, efforts must be made to ensure that male and female partners are notified equally, as research has shown that partners of female clients are not always contacted (Institute of Medicine, 1997). Also, attempts to identify sex partner networks should be made when possible. Communities and clients should help design partner notification activities, and collaborative approaches to partner notification should be considered. Accurate and complete record keeping, as well as technologically updated notification systems will aid in the partner notification process.

When staff resources are not available to notify partners directly, agencies must teach clients the skills to inform their partners. To be effective, this teaching may require the use of non-directive counseling approaches that incorporate clients’ values and choices (Landry and Forrest, 1996). Over two-thirds of public clinics report using patient referral (alone or with provider contact) for partner notification; quality standards for counseling patients who conduct referrals need to be developed (Macke, 1998). Finally, studies have shown that computer and technology use improves the timeliness of partner notification (Macke et al., 1998).

Overview of Milwaukee STD Clinic and Clientele

Milwaukee’s Central Health Clinic provides treatment exclusively for STDs. This clinic is both the only free clinic and the only city-operated STD clinic in Milwaukee. It is located downtown at 700 West Michigan Street and is situated on a major bus line that allows clients easy access from other areas of the city. The clinic is open five days a week and offers some evening hours on some days. Hours are Monday and Thursday from 11:00 to 8:00 p.m., and Tuesday, Wednesday, and Friday from 8:00 to 4:00 p.m. The clinic is designed to serve all citizens in the Milwaukee area who lack access to care or the means to pay for care, or have other concerns, such as desire for the anonymity.

The clinic provides care for major sexually transmitted diseases including chlamydia, gonorrhea, and syphilis. It does not provide treatment for HPV (also known as genital warts), herpes,² Hepatitis B,³ or HIV, but does offer referral information to other local clinics for these services. For patients with HIV, confidential testing, counseling, and referral services

² The clinic does provide prescriptions for antivirals to clients with severe cases, but clients must pay to have them filled.

³ Note that the clinic provides Hepatitis B vaccinations for any 18-year-old who requests this service. The clinic does not provide vaccinations for younger children because of state regulations requiring parent consent. Vaccinations are not provided to those older than age 18 because the clinic receives no funding that covers the expensive three-dose process for those older than age 18.

are an integral part of clinic operations. Hepatitis B testing is also available to clients who consent. The clinic also provides partner notification services designed to inform partners of those with STDs of the risk of infection and to identify the clinic as a treatment source.

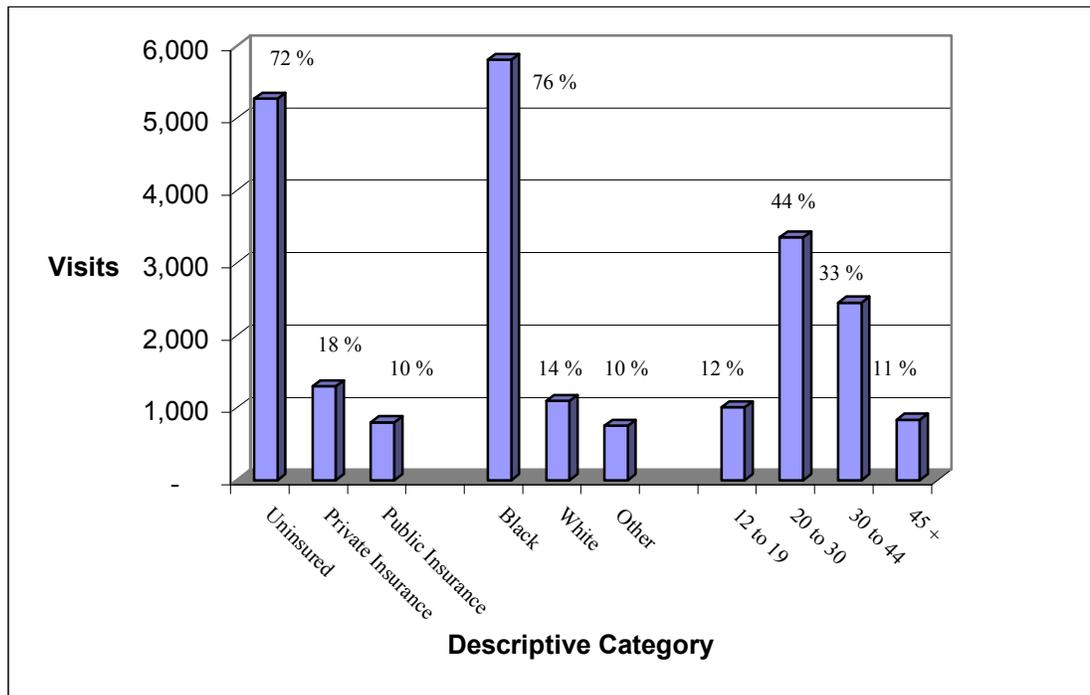
In the calendar year 2000, clients made 7,658 visits to the clinic, and of these approximately 95 percent were made by Milwaukee residents.⁴ The caseloads are disproportionately composed of males (66 percent) compared to females (34 percent). The majority of those who visit the clinic are African American (76 percent), with white clients (14 percent) and other races (10 percent) making up the remaining portion of the caseload. Visitors are most likely to be in their twenties. Slightly less than half (44 percent) of those who visit the clinic are between the ages of 20 and 30, and another 32 percent of all clients are between the ages of 30 and 45. Teenagers make up an additional 13 percent, and clients over the age of 45 represent approximately 11 percent. Table 2 illustrates visits by selected descriptive characteristics.

More than two-thirds (69 percent) of the caseload reports being uninsured at the time of the visit—this demonstrates the clinic’s role as a source of care for those who might otherwise lack access to care. Clients with private insurance in the form of fee-for-service or HMO plans make up 17 percent of the caseload, and clients with Medicaid or other public insurance make up an additional 10 percent. Note that 4 percent of clients did not report information on availability of health insurance.

Although the clinic is designed to serve Milwaukee residents who lack adequate access to care, these data indicate that some clients fall outside of these explicitly targeted groups. Clinic and Health Department staff, however, noted that providing treatment to those who have limited access to health care or live outside city limits (but who nevertheless visit the city) is an important step in managing rates of infection within the city. To the extent that these populations might otherwise receive no care and continue to spread STDs in the city, providing service to them is an important element of STD reduction in Milwaukee. The STD Clinic receives funding from a variety of sources, including the City of Milwaukee, the State of Wisconsin, and grants from federal agencies such as the CDC. This poses some complications for clinic operation. First, each funding source imposes different requirements and priorities. The federally funded project to eliminate syphilis, for example, provides funds for syphilis tracking, treatment, and partner notification which cannot be used to treat other STDs and which must be accounted for separately. Second, individual staff members are wholly funded from one particular source, and have different accountability systems. For example, disease intervention specialists who notify potentially infected partners of those with STDs are entirely funded by state and federal sources. These specialists work within the clinic, but have their own state-employed supervisor and priorities determined by state staff and legislative decisions, such as the Wisconsin law that requires mandatory contact of HIV-infected individuals. Some clinic employees are paid wholly by the city while others are paid wholly by the state or federal government. These factors can inhibit collaborative and strategic planning and limit the oversight of the City of Milwaukee on some clinical matters. The clinic is currently searching for a manager who will fill a vacant position designed to

⁴ Note that clients may make multiple visits to the clinic, and therefore the descriptive statistics for visitors may differ somewhat from those for total visits. We do not anticipate that this difference substantively affects the general portrayal of clinic visitors presented here. Data on the total number of *patients* seen was not available for analysis.

Table 2: Visits to Milwaukee STD Clinic by Insurance Status, Race, and Age: Jan 2000 – Dec. 2000



Source: Authors' tabulations of clinic visit data.

provided oversight for daily operations and serve as a quasi-supervisor to all. Because of the disparate funding sources, complications with clinic management are likely to persist after such an individual is hired.⁵ A summary of clinic employees and their funding source is provided in Table 3.

The clinic's 2000 budget from combined sources was \$1.7 million, which funds the services described in this report, outreach and prevention efforts undertaken by the clinic, and ensures adequate clinic supplies and facilities. Additionally, each year the clinic sub-grants subcontracts with local clinics, spending approximately \$50,000 to provide STD services that the Milwaukee clinic cannot provide—such as extended HIV and Herpes health care. The clinic's budget varies each year depending on the number of special projects and grants, and budget data available to us was not always explicit in nature. In discussing budget issues with other STD clinics, we found that relatively lax budgetary procedures and complicated accounting systems are a common problem. Of the three clinics we examined, Milwaukee's was able to provide the most accurate data related to budget.

⁵ A commonly used method for addressing the problem of paying staff using funds from different sources involves pooling the funds and allotting each employee a salary from this pool rather than from any single source. The structure currently in place is, however, an artifact of federal and state funding restrictions and cannot be altered without new legislation.

Table 3: STD Clinic Staff by Position Type and Funding Source

Position	Funding Source
Clinic Medical Director	City
Nurse Practitioner	Federal
Public Health Nurse Supervisor	City
Public Health Nurse (x5)	City
Milwaukee DIS Program Manager	Federal
Milwaukee DIS 1 st Line Supervisor	Federal
Disease Information Specialist (x5)	State
HIV Partner Referral Staff (x2)	State
Public Health Educator II	City
Medical Laboratory Technicians (x2.5)	City
Laboratorians (x3)	1 State, 2 City
Office Assistant II	City
Office Assistant III	State
Office Assistant III	City

Source: Clinic staffing data provided by Dr. Swain.

Assessment Of Milwaukee STD Clinic Compared To National Standards: Findings And Recommendations

The evaluation team compared the performance of the Milwaukee STD Clinic to the national standards previously described. Our findings are detailed below in two parts: a *Clinic Report Card* (Table 4) and a written description of the clinic’s performance. The report card provides an abbreviated and simplified picture of the quality of Milwaukee’s services in four areas: basic services and accessibility, testing diagnosis and treatment, counseling, and partner notification. The descriptions that follow outline the criteria for report card grades and provide descriptions of clinic services, including strengths and areas of improvement. Note that this evaluation did not explore the extent to which technical procedures are correctly implemented. Therefore, the following items are not included: an assessment of the skill with which diagnoses are made; technical content of protocols; and testing content and execution.

Basic Services and Accessibility: Strengths and Recommendations

Milwaukee’s central health STD Clinic is widely accessible to city residents as it is located downtown and situated on a major bus line that allows clients from all areas of the city access to the clinic. The clinic’s extended evening hours also represent an excellent

Table 4: Report Card for the Milwaukee STD Clinic

<i>CATEGORY</i>	<i>GRADE</i>
<p>BASIC SERVICES AND ACCESSIBILITY</p> <p>Low-cost, confidential, and professional care is provided to underinsured Milwaukee citizens, resulting in nearly 8,000 clinic visits per year. The clinic facilities are accessible by public transportation, well kept, and designed to facilitate effective clinician-patient interactions. However, the newly designed walk-in system still results in patients being turned away regularly, as well as days of very low demand. No evaluation system is in place.</p>	A-
<p>TESTING, DIAGNOSIS AND TREATMENT</p> <p>Diagnosis and treatment protocols are regularly updated, single-dose therapy and presumptive treatment provide efficient client treatment, and test results are returned quickly and always remain confidential. Diagnosis, testing, and treatment are tracked through a computerized record-keeping system. The clinic does not, however, promote a continuum of health care by establishing patient-clinician relationships, and is not interconnected to a larger system of comprehensive health care.</p>	A
<p>PATIENT COUNSELING</p> <p>Personal risk assessments are made for all clients, and counseling is offered. However, there appears to be variation in the extent and quality of counseling services.</p>	B-
<p>PARTNER NOTIFICATION</p> <p>Confidentiality is maintained for individuals with HIV or syphilis while several attempts by telephones or home visits are made to reach infected partners. Computerized systems enhance the efficiency of partner notification. Infected persons with other diseases are given information about the clinic and the disease and are encouraged to notify partners about their risks. The clinic does not, however, give priority these referred partners when they visit the clinic and they must therefore wait through the same line as those who may not be infected.</p>	B+
<p>OVERALL GRADE</p>	B+

effort to increase accessibility. The clinic is open to all citizens in the Milwaukee area, and its free services keep it accessible to the poorest members of the community.

Clinical facilities are excellent. The waiting room, though sparsely furnished, is clean and comfortable. Educational materials are available, and a television displays related prevention videos. Warning signs and the presence of a security guard indicate that disorderly behavior will not be tolerated in the waiting room.

Nurses have two spaces in which they interact with clients: an examination room and an office with no medical equipment where counseling and conversation may take place. Nurses report that the office setting helps clients to feel more comfortable and less apprehensive in describing their problems and receiving counseling. The office space also makes it convenient for nurses to enter information into the clinic's computerized charting system so that accurate client information may be reviewed during any subsequent visits. Both the examining room and office spaces contain many positive prevention messages—in multiple languages. Although staff reports that few of their clients do not speak English, the clinic has made provisions for these clients by the use of AT&T's Language Line interpreter

service. This service allows clinic staff to dial into a bank of interpreters who can provide translation services for nearly any language. The staff reported that this system works well for them and clients.

The clinic's traditional reservation-based client intake and processing system was redesigned in August 2000. The new intake approach works on a first-come, first-served for both morning and afternoon segments. On a given Tuesday, for example, when the clinic opens at 8:00 a.m., clients waiting in line are assigned numbers based on their position in the line, and seen in that order by available staff. The clinic then continues to admit clients until the morning session is full. Those clients who arrive after all available slots have been filled are told to return for the afternoon session or to try again another day. If the session does not fill up, walk-ins may continue to be seen until 11:30, the time of the last appointment. At 11:30 the doors to the clinic are locked and no new clients are admitted until the afternoon session begins at 12:30.

The clinic adopted the walk-in system to address difficulties with the appointment-based system, specifically the high incidence of no-shows. The clinic had not been able to operate at capacity because of an inability to determine what percent of the scheduled caseload might actually arrive on any given day. The new system is well received by staff, and allows scheduling to align with clinical resources available each day (for example, if a staff member is sick, the clinic can adjust the number of patients it can serve). It has allowed the clinic to serve a greater number of patients: approximately 20-40 clients can be seen each day in the Milwaukee clinic. The daily capacity is affected, however, by the gender-mix of the caseload on a given day, as more time is needed for female clients. The Milwaukee clinic allots at least thirty minutes to each client, depending on gender, exceeding the national CDC recommendation minimum of twenty minutes per client.

Clinical staff pay close attention to both informing clients that services are confidential and carry out procedures to ensure that confidentiality is maintained. Each client is told that although the clinic uses names for the purpose of record keeping, no information will be released without his or her consent. Clients are called by number, not name while they are in the clinic. The consulting and clinic rooms have doors that are closed at all times when a nurse is with a client.

Our recommendations range from logistical matters to budgeting to evaluation strategies for the clinic.

Adjust Clinic Schedule to Meet Patterns of Demand

The walk-in system brings about variations in daily caseloads-- some days are very busy and clients must be turned away, while on other days there is very low attendance. Staff noted that caseloads vary considerably but they could not determine any patterns.

In order to facilitate an exploration of utilization patterns, clinic staff provided data on the daily number of clinic visitors and the number of visitors turned away from the time that the walk-in system was implemented in August 2000 through February 2001. These data indicate that, on average, the clinic had a total of 39 daily visitors, of which 6 were turned away because of lack of capacity. The average daily turnaway rate was approximately 14 percent.⁶ Although useful for developing a rudimentary sense of the level of service

⁶ The daily turnaway rate is defined as the number of clients that were denied service divided by the total number of visitors on a given day. Also note that the average of daily turnaway rates (14 percent) will nearly always differ from the result of dividing the average of daily

provided, these aggregate level descriptive statistics conceal more interesting patterns in daily utilization.

As illustrated in Table 5, daily utilization data suggest that the clinic faces unusually large demand for services on Monday mornings, when the average of number of turnaways is approximately 6—nearly twice that for other weekday morning sessions. Visits and turnaways are relatively stable across other days and sessions, although Thursdays and Fridays have marginally lower average numbers of turnaways for both morning and afternoon sessions. The data unfortunately do not provide the information needed to examine whether those turned away return on another day or for the afternoon session on the same day.

Table 5: Average Number of Clinic Visitors, Number Turned Away, and Turnaway Rate, by Day, August 2000 – February 2001

Utilization	Weekday				
	Monday	Tuesday	Wednesday	Thursday	Friday
Average Number of Turnaways					
Morning Session	6.4	3.1	3.5	3.0	2.7
Afternoon Session	2.4	2.5	2.2	1.8	2.3
Daily Total	8.8	5.6	5.7	4.8	5.0
Average Number of Visits					
Daily Total	44.2	37.2	37.8	39.8	38.0
Average Turnaway Rate					
Daily Rate	19.1%	14.1%	14.2%	11.1%	13.1%

Source: Authors' tabulations of clinic utilization data.

While, on average, some clients are turned away each day, an examination of individual daily observations indicates that for some sessions no clients are turned away. On one of these slow days, there may be few visitors to the clinic. For example, during the evaluators' March 16, 2001, site visit, the clinic saw approximately 10 clients. Such attendance leaves clinic staff with a considerable amount of extra time.

We recommend that the clinic adjust its schedule to meet the observed attendance patterns more appropriately. Demand for services in STD clinics around the country is greatest on Monday mornings, and this appears to be the case in Milwaukee also. We suggest that the clinic extend its hours on Monday, specifically to include early morning hours so that more clients could be seen in the morning. The attendance data suggest that the clinic could close early on Thursday or Friday to balance the extended Monday schedule; the demand for services seems comparably low on these days. Alternatively, the clinic may wish to have

turnaways by the average daily visitors (15 percent). To illustrate, consider a case for only two days—one with 61 visits and 1 turnaway and another with 17 visits and 11 turnaways. Average visits and turnaways remain at 39 and 6, but the average of the two daily turnaway rates is approximately 33 percent.

more staff available on Mondays and less on Thursdays or Fridays. The staff could also attempt to smooth out the distribution of visits by informing clients that Mondays are a busy time and that they are more likely to be seen promptly on other days. Any of these adjustments would maximize service delivery to patients and minimize “down time” for clinical staff. Even with this system, there will still be occasions of or low clinic attendance. We recommend that the clinic plan other activities for staff time during these days (e.g., staff meetings, training, prevention efforts, or evaluation and quality control activities).

★ **Consideration:** The Baltimore Druid Clinic is implementing a new treatment and prevention effort called the Ujima van. This van will be serving city districts with high STD morbidity for five afternoons and evenings (3 p.m.-8 p.m.). This will be a full-service STD clinic on wheels, providing exams, medications, counseling, partner notification services, lab results from the previous week’s exams and prevention information. The Ujima van is a convenient way for people in neighborhoods with the most need to receive services and information. This effort, however, would require a substantial investment.⁷ It represents an innovative method of increasing access to care and can be used to target areas of particularly high STD infection. It also illustrates the type of activity for which federal grant funds may become available. Because this activity represents a non-trivial expenditure, we recommend that clinic staff conduct a follow-up evaluation of the long-term success of this new activity in Baltimore.

We also considered the establishment of a fee-for-service system. Currently the clinic receives no insurance or client reimbursement for its services. While this allows the clinic to retain its complete accessibility policy, its free status, and the protection of client confidentiality, it may also strain clinical resources. The evaluation team investigated two possibilities to address the lack of reimbursement: collection of public insurance and a fee-for-service model. Of utmost concern in our analysis below is the maintenance of client trust and privacy (and thus continued use of clinical services), a low marginal effort and efficiency of reimbursement system, and measurable economic benefits after costs were assessed.

Clinic visit data indicate that approximately 27-31 percent of clients report having public or private insurance. In recognition of this fact, we examined the feasibility of implementing a billing system that would collect reimbursement from public insurance. We felt that this alternative would yield certain income and incur a low start-up cost. With only one source to bill and an efficient and free billing system available from the state, staff time required would be small. This alternative, however, proved problematic. First, Medicaid policy representatives from the state and federal government informed the evaluation team that the clinic could not bill Medicaid unless it also billed private insurance companies—allowable Medicaid charges are determined by the usual and customary charges made to those who do not have Medicaid, which is zero in this case. The clinic could receive reimbursement from Medicaid if it also billed privately insured patients, but that poses the risk of violating client privacy, a serious concern of Milwaukee Health Department staff. The collection of reimbursement from private insurance companies would also complicate the billing system because—unlike for Medicaid—no single mechanism or software could be used to perform all billing functions. Thus, demand on staff time would be high. Even if the clinic were willing to assume these risks and bill private and public insurance, another barrier

⁷ Baltimore staff were unable to provide cost estimates for this service.

is presented by the Medicaid system in Wisconsin—most Wisconsin Medicaid clients are enrolled in Medicaid HMOs, with which the STD Clinic is not affiliated and therefore would not be an authorized care provider.⁸ For these reasons, we do not recommend that the clinic implement a health insurance based billing system at this time.

Another alternative with potential to recover a portion of service costs is a fee-for-service system. This would involve imposing a minimal charge for patients who receive services at the clinic. We recommend that patients pay a minimum of \$3 and a maximum of \$7 per visit to the clinic, based on the number of services received. This fee schedule is based on recommendations in the literature and practices observed at other clinics. This amount could be paid in installments for those clients with extremely limited resources, and those who could not or would not pay should not be forced to do so.

★ **Smart Practice:** The Cincinnati STD clinic charges \$3 for each of three possible services: examination, laboratory use, and provision of medication. Clients who receive all three services owe a total of \$9. Clients unable to pay the total fee are asked to contribute at least \$3 toward the examination. The rest of the fee is tracked through a running tabulation of fees, and the next time the person attends the clinic, he or she is asked to pay for current and past STD services to the extent possible. No bills are sent to the person's home and, if he or she is unable to pay for any of these services, the services are still rendered. Christopher Payne, the Cincinnati clinic data specialist, states that most of the visits to the clinic end with the patient paying at least the minimum \$3 service fee for the examination. According to the Cincinnati clinic data, from January 1 to April 10, 2001, a total of 8,879 payments were made to the Cincinnati clinic. Revenue from 7,155 payments of the minimum fee of \$3 resulted in \$21,465. Another 754 payments of \$9 were made by individuals, resulting in \$6,786 in revenue. Cincinnati clinic staff observed that these payments have not deterred people from seeking clinic services and do not appear to have an appreciable impact on the total number of visits.

Based on the 7,658 visits to the made to the Milwaukee clinic in the year 2000, Table 6 includes a matrix of estimated gross revenues resulting from the imposition of a fee system under varying assumptions of fee amount and success in collection. Charging fees would increase the clinic's annual income from \$11,000 to \$53,000 depending on the number of fees collected and the magnitude of the fee. This could result in an increase of as much as 3 percent of the total budget. Although Cincinnati staff could not quantify their collection rate, they noted that the vast majority of clients pay the requested amount. We provide estimates for three assumptions under which at least half of visits result in a payment. We also assume, based on the effects observed in the Cincinnati clinic, that there will be no decline in the number visits to the clinic. Implementation and operating costs are not included in these estimates, but given that the existing intake structure would not have to be modified to accommodate such as system and additional time devoted to collection would be extremely small, we anticipate very low start-up costs.

⁸ Clinic visitors who are enrolled in Medicaid but do not visit their HMO provider presumably do so out of concern for confidentiality, though other factors such as convenience of location and timeliness of diagnosis and treatment may also play a role.

Table 6: Estimated Gross Revenues from the Nominal Fee per Visit under Selected Fees and Collection Rates

Collection Rate	Fee		
	\$3	\$5	\$7
100 %	\$ 22,974	\$ 38,290	\$ 53,606
75 %	\$ 17,231	\$ 28,718	\$ 40,205
50 %	\$ 11,487	\$ 19,145	\$ 26,803

Source: Authors’ tabulations from clinic visit data and assumed fees and collection rates.

Fee income would be a relatively stable source of revenue and would not come with the reporting requirements that accompany grant funding. Ideally, this increased funding would enhance the clinic’s prevention and outreach efforts or be used to implement other recommendations described in this evaluation.

Seek grant funding

The clinic currently has no mechanism through which newly available requests for proposals or grant opportunities may be developed. The CDC maintains a listing of new opportunities on its website, and the clinic is urged to monitor this site on a biweekly or monthly basis. Because staff have Internet-connected computers and the site is extremely well organized this activity would take only minutes and could be conducted during days with small caseloads. Once hired, the new clinic manager could share responsibilities for grant writing with staff at the Health Department.

Re-evaluate the clinical time allocated for each client

The clinic has established time allocations for patients that exceed the CDC recommendations CDC recommends 20 minutes for men and 40 minutes for women; Milwaukee STD Clinic allocates 30 minutes for men and one hour for women. Although the Milwaukee time allocations are generous, clinicians do not always use the time allotted. As the data above demonstrate, the clinic often turns clients away because of scheduling concerns. A change in time allocation would allow the clinic to see more patients than it currently accommodates. This increased capacity must be balanced against the loss of interaction time with clients.

Conduct a client survey

Key questions included in a client survey might include: “Have you ever delayed visiting the clinic or not visited at all because you were worried that you would have to wait for a long time?” and “Did staff answer all of your questions about STDs?” or “Are you likely to practice safer sex because of your visit today?” A general question, such as “What could we do to make your visit more pleasant?” might also be helpful. Undertaking a survey is one step in the continuous improvement process that should be applied to the new walk-in system.

Establish a Quality Assurance Team and Systematic Evaluation Process

Medical Director Geoffrey R. Swain, M.D., ensures that clinical guidelines for medical treatment are updated and improved annually, and the head clinic nurse reviews patient records daily. Systematic approaches to assessing and improving overall clinic services appear to be limited. Head Nurse Beth Schuelke described improvement measures as a trial and error approach: “We just see what works.” The CDC recommends that each clinic have a quality assurance team that regularly reviews clinical procedures. This team should include the medical director, clinic manager, clinical supervisor, Disease Intervention Specialist supervisor, clerical supervisor, and ideally an outside evaluator and fiscal management representative. The quality assurance team should observe staff/client interactions regularly, investigate and update laboratory procedures, and ensure that a mechanism for receiving and managing client complaints is in place, among other duties. Although including an outside evaluator and fiscal representative may not be feasible, using a more structured approach to evaluation is likely to yield improved results in clinic management and services and will result in little or no increase in operating costs.

Testing, Diagnosis and Treatment: Strengths and Recommendations

The clinic operates according to an extremely detailed set of protocols developed by the Medical Director. These protocols closely follow the official CDC guidelines but have been adapted by Dr. Swain and clinic staff to meet particular clinic-specific needs where appropriate. Staff reported that the protocols are modified on a continuing basis, and that Dr. Swain incorporates the most current and effective means of STD treatment. One staff member referred to this document as “The Nurses’ Bible” and commented that the clinic is in line with the most current recommended procedures as a result of Dr. Swain’s efforts to keep the protocols up to date. Staff is also kept abreast of up-to-date techniques via training sessions conducted at the CDC regional training center in Cincinnati, Internet coursework, and in-house training sessions.

Nurses assess and treat clients according to protocol. Single-dose therapy is usually provided, and the clinic maintains a lab facility to ensure timely delivery of test results. The laboratory allows the clinic to provide test results for some diseases, such as syphilis, while the client is still at the clinic. Many results, however, are not available until the next day or slightly longer. If this is the case, clinicians can provide presumptive treatment, in which clients are treated before test results are obtained, for clients following clinic protocols. Dr. Swain reported that data indicate that the clients who are presumptively treated have substantially higher rates of disease than those who are not treated presumptively.

Notifying patients of test results is an important component of clinic services. If patients do not phone or visit the clinic for results, the clinic makes several attempts to contact patients whose test results are positive to ensure treatment. This is problematic, as patients do not always give accurate information because of privacy concerns or for other reasons. Clinic nurses work closely with clients to confirm phone numbers and encourage honest exchange of information so that they may be reached when results are available. Patients are given a written notice with the clinic’s phone number so that they may easily contact the clinic. HIV test results, however, cannot be given over the phone; personal contact is required, which allows the clinic to provide counseling, collect information about client partners, and treat the patient.

The clinic uses a computerized record-keeping system to track patient visits and progress. We examined printouts of a small sample of approximately 30 client cases and found the information generally to be complete and organized. Each day, the head clinic nurse reviews each file to ensure that appropriate clinic procedures were followed and that necessary forms are present for each file. If necessary, the nurse will make changes or work with appropriate staff to improve procedures. This quality check is an important part of clinic management. This, coupled with the attention given to continuing education for clinical staff, suggests that the clinic is in full compliance with the majority of the guidelines in this area.

The clinic fully meets the guidelines with respect to confidentiality and consent for testing, but does not provide anonymous testing (in which test results are not recorded in a client's file). Clinic staff feel that providing this service is inconsistent with their commitment to notifying partners and providing HIV services. Anonymous testers cannot be contacted for support services. It is unclear whether the lack of anonymous testing deters clients; it may be that many do not know the difference between confidential and anonymous testing.

Our recommendations include improving the records system of the clinic, ensuring consistency in counseling and treatment from one visit to another, and considering joining forces with another clinic.

Make Full Use of the Computerized Patient Tracking System

Client records did not always include full information and so were not as useful as they might have been. Specific symptoms were not always reported (although a field for listing symptoms does exist in the computer record), and clinic staff seldom reported the specific nature of the problem and steps taken to alleviate the problem. Records with even very limited information are more likely to facilitate appropriate and efficient follow-up care and assure more accurate quality control in the daily review of client files. The clinic's excellent tracking system is already in place, and efforts should be made to use it to full capacity—especially when doing so involves limited additional effort. We suggest making better use of the symptom and notes fields by including two or three sentences. This effort would add considerable value to the record system and would require minimal effort to implement.

Ensure that returning clients visit the same clinical nurse whenever possible

Currently, clients are randomly assigned to clinical nurses according to scheduling convenience, and the clinic offers little support to patients with long term STD morbidity. Many clients are, however, returning to the clinic for follow-up services or because of repeated exposure to STDs. Arranging for clients to visit the same clinician repeatedly can assure more accurate treatment, aid in the identification of other health problems, and facilitate prevention efforts. With repeated interactions, clinicians and patients can establish a more trusting relationship, which may facilitate client behavioral changes and better care.

★ **Smart Practice:** Researchers at the Baltimore clinic found that the patient-physician relationship is important for motivating patients to engage in healthy lifestyles. The Baltimore clinic participates in a major initiative for the treatment of HIV-infected individuals that is based on the patient-physician relationship. The clinic encourages long-term treatment for patients with HIV by offering longitudinal care. Longitudinal care consists of clinical visits, medicine, personal counseling, and arrangements for that individual to

receive future care outside the clinics. An important aspect of this system is the patient-physician relationship. A person receiving HIV treatment at this clinic is seen by the same physician every time he or she comes to the clinic. These physicians are HIV specialists who also work at the Johns Hopkins University HIV and AIDS clinic. A part of the service arrangements made by the social workers is to ensure that clinic patients receive future treatment at the Hopkins clinic. According to Hogan (2001), patients who were able to continue care outside of the Baltimore clinic with the same physician were more likely to continue proper maintenance of their condition than those who did not have the same physician.

Consider sharing a location with a comprehensive public health clinic

The STD Clinic treats several specific STDs, but not all. For example, it does not treat herpes or HPV or deal with other health issues of clients. However, patients often have long-term and multiple health needs. They also may lack access to preventive care, according to clinic staff. Some young women have the misperception that an STD exam meets their need for an annual Pap smear and pelvic exam. While it may not be efficient for the clinic to provide these services, we recommend that the STD Clinic collocate with a general health clinic. This would allow clients to receive a broader array of services in one visit and allow medical staff to work more closely together to address public health care problems more holistically. We make this suggestion in light of the clinic's current search for a new location.

★ **Smart Practice:** The Baltimore and Cincinnati STD clinics are located in health buildings that offer a variety of services, such as family medicine, men's health, and dental services. According to clinic staff, the shared location increases the likelihood that people will seek STD services when they have other health needs. Also, being in the same location as their general health care facility may decrease the stigma of attending the clinic, as a client could be attending the clinic for a wide variety of health needs.

Patient Counseling: Strengths and Recommendations

As already noted, the clinic schedule allows 30 minutes for male clients and one hour for female clients, which generally offers clinicians ample time to hold a brief counseling session. The clinic provides some counseling for all clients as part of its general treatment and service provision. Head clinical nurse Beth Schuelke indicated that counseling is an important priority for the clinic. During each patient visit, clinical staff conduct a risk assessment. This questionnaire allows clinicians to gain a sense of client behavior as long as the patient provides honest information. This information is entered into the computer, and can lead into a discussion between clinician and staff about behavior and risk reduction. Clinicians employ various additional counseling methods. Some staff described attempts to establish a relationship with the client that facilitates client question asking. They also reported using a personalized counseling technique based on the particular details of the client's situation. Because some clients seemed in a hurry, other clinicians used an approach that involves distributing literature and answering specific questions that the client might then ask, focusing on the issues that brought the client to the clinic.

Our recommendation in the area of patient counseling is that the clinic enhance its efforts to emphasize personalized and client-centered counseling techniques. Interviews with clinic staff suggest that content and quality of counseling varies within the clinic.

Use Non-Didactic Counseling Methods

Traditional risk behavior assessments, used frequently by the clinic, have been found less effective than open-ended questions—they may cause clinicians to miss important cues or prevention opportunities, or the client to lose interest or feel threatened. The clinic should ensure that all staff are trained in effective, non-didactic counseling methods described in the guidelines section, and to ensure that staff follow these methods uniformly. The recommendation for clients to visit the same clinician whenever possible could aid in these counseling efforts. Ongoing review of counseling practices, including periodic staff observations can help the clinic be more effective in its counseling and prevention efforts. A useful technique for implementing change in this area might involve including suggested counseling techniques in the clinic protocols, which all clinicians refer to during patient treatment.

Partner Notification: Strengths and Recommendations

The Milwaukee STD Clinic focuses its intensive partner notification efforts primarily on two sexually transmitted diseases: syphilis and HIV. The clinic focuses on these diseases because of a current syphilis elimination project grant (part of a national CDC effort), and because of a law that requires that all HIV-positive Wisconsin citizens be notified of their status in person. Currently five staff work on partner notification efforts. When a client is diagnosed with syphilis or HIV, he or she immediately meets with partner notification staff within the clinic. These staff, also known as Disease Intervention Specialists (DIS), ask clients to identify at-risk sexual partners. In the case of syphilis, partners within the past 60 days are identified as they may be infected and are at risk of transmitting the disease to others; HIV positive clients must list partners for a lifetime. During this interview, clients are informed that clinic staff will contact all partners, but that the client's confidentiality will be retained during this process. STD Clinic staff takes this role very seriously. As one member explained, "I tell clients that some people when informed of HIV contact will go through their address book and call everyone they've had sex with and blame that person [for HIV transmission]. They will lie and say that a clinic person gave them your name. Do not fall into this trap. I will not give out your name no matter what."

Partner referral staff make several attempts to contact infected partners and to ensure that they receive testing and treatment. Staff generally make six or seven attempts to contact partners, by phone and in person. This may mean going to into neighborhoods and knocking on doors. Once individuals are contacted, they are encouraged to get treatment. If they refuse, two or three additional attempts are made to ensure their treatment. If a client maintains that he or she has been treated, the appropriate doctor or clinic is called to verify the treatment. The clinic maintains a computerized system to track partner referral, a system that few clinics have in place. This system allows clinical staff to respond to client calls efficiently and for any staff member to help a client, a strategy recommended in recent studies about partner notification.

The clinic also emphasizes partner notification for clients diagnosed with other STDs, such as gonorrhea or chlamydia. Clinic nurses encourage clients to get partners into the clinic for treatment (through direct conversation or anonymous notice of risk), and explain that re-infection is a risk if partners remain untreated. Clients are given an "urgent notice" to provide to their partners. This notice indicates that someone they have had sexual contact with has recently been diagnosed with an STD, and provides clinic information and hours if the

partner wishes to seek treatment. Clients also receive fact sheets about the disease to pass along to their partner. Clinic staff seemed uncertain of the percentage of partners who are informed and seek treatment when client notification is relied upon, but indicate that clients often seem motivated by fear of re-infection to inform partners and encourage their treatment. Clinical data indicates that, in 2000, 1057 (13.8%) of the 7,658 visits to the clinic were made in regard to concerns about contact with an infected partner. It is not clear how many of these client visits are the cause of a patient referral.

Our recommendations include offering more greater counseling efforts aimed at helping patients inform partners themselves; establishing ways for partners to visit the clinic sooner rather than later; and even offering pagers or cell phones to staff to facilitate partner notification efforts.

Provide enhanced counseling and support for clients to notify partners

Increasing the use of counseling specifically designed to address the problem of partner notification will increase the likelihood of actual notification by easing patient anxiety about the topic.

★ **Smart Practice:** In Baltimore's Druid Clinic, social workers and DIS staff work carefully with patients who will be notifying their partners of infection. They give each client the opportunity to role-play the conversation with his or her partner. This interpersonal tool helps build confidence in clients and prepares them for potential questions from their partner.

Implement a "fast track" for referred partners who wish to visit the clinic

The clinic currently operates on a first-come, first-served basis. This means that a client with known exposure to a disease and a client with potential symptoms are prioritized in the same manner. This method of service delivery distributes waiting times equally among visitors, but is not efficient in terms of disease reduction goals. Clients with known exposure have higher morbidity rates, while many clients with symptoms may receive negative test results. We recommend that the clinic implement a partner priority system, in which referred partners receive treatment before other clients. This will ensure that clinic time is utilized most efficiently and may serve to increase attendance among referred clients. Care must be taken to evaluate patterns of attrition in the waiting room if such a system is implemented. If, for example, non-referred visitors are more likely to become frustrated and leave before being seen, further refinements may need to be made.

★ **Smart Practice:** At the Baltimore STD Clinic, infected clients are given special referral cards to pass along to their partners. Persons holding these cards or individuals brought in by DIS staff are placed at the top of the line and have the shortest waiting time. This fast-tracked treatment is an advertised benefit given to individuals who come to the clinic after being contacted by a partner or DIS. According to Terry Hogan, the clinic's training center coordinator, the STD Clinic staff believe that the fast tracking is an important tool for encouraging those who are at risk of having and spreading the four diseases to receive treatment.

★ **Smart Practice:** In Cincinnati, clients who have been referred by infected partners are exempted from the standard fee of \$3-\$9 that is usually collected from clients.

Supply pagers or cellular phones to partner notification staff

Because the partner notification staff spend time in the field, they often aren't in the office much to receive calls. Missed phone calls may mean a missed opportunity to treat an

infected client. As DIS partner notification supervisor explains, “A client may be coming down from a heroine high and actually be lucid for a six-hour period and willing to be treated. If we miss the call, the next day he might be on a drug high again and then unreachable for days.”

Conclusion

Our evaluation suggests that the City of Milwaukee is actively addressing the need for quality care and containment of sexually transmitted diseases through its STD Clinic. The clinic provides STD diagnosis, treatment, and counseling services to approximately 8,000 uninsured or underinsured visitors each year. Without these crucial services, infected individuals would likely contribute to the spread of STDs, and experience severe health consequences resulting from untreated diseases. The clinic is not only a necessary point of service, but also delivers a message that the City of Milwaukee is concerned about local health and about its vulnerable populations.

This message is confirmed by the professional and high-quality services provided to patients at the clinic. Clients can expect the attentive care of a clinic nurse, a thorough examination and confidential testing; an accessible, clean, and efficient facility; and single-dose and (usually immediate) treatment utilizing up-to-date methods. The clinic’s open-door policy ensures that clients will be treated regardless of ability to pay, and that confidentiality will be strictly upheld. Well-organized, computerized records track client’s clinical histories.

The clinic also encourages changes in high-risk behavior and works to limit the spread of STDs. All clients are asked about their safe-sex practices and are provided information about preventing further STD exposure. The clinic contacts sexual partners of infected clients, devoting staff-intensive resources to notifying and treating these infected partners, while at the same time protecting the confidentiality of the original patient. Computerized monitoring systems and persistent efforts lead to high rates of success in the partner notification process.

The clinic’s record of service, though good, still leaves room for improvement. The implementation of several recommendations would enhance the clinic’s organizational viability and services to clients. A revised clinic schedule would reduce the number of clients who are turned away; a fee-based system and attention to grant opportunities could boost clinic revenues with little associated cost; and ongoing evaluation of services would strengthen the level and knowledge of care provided. Additionally, ensuring that clients repeatedly visit the same nurse and that meticulous records are kept could strengthen clinician’s understanding of patients and improve provider-patient relationships; and locating itself within a general health clinic would meet broader health needs of patients. In the area of counseling, the use of consistent, patient-centered, and interactive methods would more likely produce behavioral changes in clients and ultimately aid in prevention efforts. Finally, prioritizing the treatment of partners of infected clients and providing cellular phones to field staff who contact these partners could enhance communication with and treatment of this high-risk population. These strategies could be implemented with relatively low costs, yet could have considerable positive impact.

These findings represent the evaluation team’s assessment of the clinic as it currently operates. Beyond the scope of this report, but closely related to the evaluation findings, is the topic of advocacy. Our findings suggest that to truly address the STD epidemic, the Milwaukee Health Department may need to assume an even greater advocacy role—by

serving as a model, a convener, and an educator in the community. Advocacy requires commitment, time, and resources. It demands that clinic staff work intensively with each client to develop relationships and encourage behavioral changes; and that the clinic utilize every feasible opportunity for improved services and prevention. It suggests that Milwaukee needs to look at a community-wide and collaborative approach to STD education prevention, a smart practice adopted by many cities around the country. An expanded advocacy role may be met with ambivalence because of its demand for changes in current practice or additional resources and time. However, this evaluation report indicates that Milwaukee Health Department has a solid framework of services to build upon, and a large number of dedicated staff. These assets can aid Milwaukee in surpassing its current—and considerable—achievements in STD care and prevention.

Appendix A: Methodology

The evaluation process used to inform our research findings was primarily qualitative and took place over a three-month period. The scope of the evaluation was limited by our time frame, and therefore involved two principal components. We first researched and identified a set of professional standards related to the delivery of services by public STD clinics. The standards convey practices recommended by the U.S. Centers for Disease Control and the Institute of Medicine, the leading national experts in STD treatment and prevention. Standards also include recommendations based on findings from current medical and public health research efforts. The evaluation team then assessed the practices of the Milwaukee STD Clinic according to these national benchmarks. Results of this assessment include the evaluation of standard attainment and identification of superior practices used by the Milwaukee STD Clinic, as well as recommendations for ways by which the clinic could better meet national guidelines.

The second component of this research strategy involved the investigation of STD clinics in Baltimore and Cincinnati. This effort was designed to identify effective models for service delivery or smart practices that might be adopted by the Milwaukee STD Clinic. While the first component of our research provided a baseline for services and evaluation in specific areas, this analysis was designed to identify practices that evolved outside of, or simply exceeded, the existing guidelines. As requested by our project officer at the Milwaukee Division of Budget and Management, the emphasized models and practices focus on service and prevention, and could largely be implemented in a budgetarily neutral manner.

The data in this report are derived from a variety of sources, including current literature, interviews with Milwaukee Health Department and STD Clinic staff in Milwaukee, Baltimore, and Cincinnati; observations conducted at the Milwaukee clinic; and materials and data provided by staff from Milwaukee, the Baltimore and Cincinnati training centers, and the Centers for Disease Control. Specific information on smart practices was obtained via a site visit to the Baltimore clinic and several conference calls with staff at the Cincinnati clinic. A complete list of sources, including individuals who were interviewed, can be found in our reference section.

References

Interviews

Char Crabb, Wisconsin HIV Partner Referral Project
Steve Dunagan, Disease Intervention Specialist, Milwaukee STD Clinic
Seth Foldy, Milwaukee Health Department
Teri Hogan, Baltimore CDC Training Center
Irma Kalsey, Milwaukee STD Clinic
Mary McCaron, Milwaukee STD Clinic
Bruce Miller, Center for Disease Control
Christopher Payne, Cincinnati Clinic Data Specialist
Beth Schuelke, Milwaukee STD Clinic
Debbie Tripp, Cincinnati CDC Training Center,
Geoffrey R Swain, Milwaukee Health Department and STD Clinic
Amy Reichenbach, Milwaukee Health Department

Observational Site Visits

Milwaukee STD Clinic, 16 March 2001
Baltimore STD Clinic and CDC Training Center, 15 March 2001

Cited Sources

Aral, S. and J. Wasserheit (1999). STD-related health care seeking and health service delivery. K. K. Holmes et al. (eds.) *Sexually Transmitted Diseases*. (3rd edition) New York: McGraw-Hill. pp.1295-1306

Aral, S. and T.A. Peterman (1998). Do we know the effectiveness of behavioral interventions? *The Lancet* . 351(Supp. 3): 33-36.

Artz, L. et al. (2000). Effectiveness of an intervention promoting the female condom to patients at sexually transmitted disease clinics. *American Journal of Public Health*. 90(2): 237-44.

Celum et al., (1995) "Patients attending STD clinics in an evolving health care environment: demographic, insurance coverage, preferences for STD services etc." *Sexually Transmitted Diseases* 23 (2): 28-37.

Centers for Disease Control (2000). *Revised Guidelines for HIV Counseling, Testing, and Referral*. Atlanta: Centers for Disease Control.

Center for Disease Control (1999). *STD Surveillance 1999*. Atlanta: Centers for Disease Control.

Centers for Disease Control (1998). *1998 Guidelines for Treatment of Sexually Transmitted Diseases*. Atlanta: Centers for Disease Control.
www.cdc.gov/wonder/prevguid/p0000480/p000480htm. 20 February 2001.

Centers for Disease Control (1998b). *HIV prevention through early detection and treatment of other sexually transmitted diseases—United States Recommendations of the Advisory Committee for HIV and STD Prevention*. Atlanta: Centers for Disease Control.

Centers for Disease Control (1995). *Guidelines for Health Education and Risk Reduction Activities*. Atlanta: Centers for Disease Control.
www.wonder.cdc.gov/wonder/prevguid/p0000389 1 February 2001

- Conlon, R. (1998). Introducing technology into the public STD clinic. *Health Education and Behavior* 24(1): 12-19
- Chernesky, M. (1999). Laboratory services for sexually transmitted diseases: Overview and Recent Developments” in K. K. Holmes et al. (eds.) *Sexually Transmitted Diseases*. (3rd edition). New York: McGraw-Hill. pp. 1281-94.
- Decosas, J. and V. Pednault (1996). Preventing sexually transmitted disease through individual- and population based public health approaches: Social and political implications. *The Journal of Infectious Diseases*. 174 (Supp. 2): S248-52.
- Department of Health and Family Services, Wisconsin (2000). *Wisconsin Health Insurance Coverage 1999*. Madison, Wis.: Bureau of Health Information, September 2000.
- Gorbach, P. et al. (2000). To notify or not to notify: STD patients’ perspectives of partner notification in Seattle. *Sexually Transmitted Diseases*. 27(4): 193-200.
- Health Canada., (1998) *Highlights of Canadian Guidelines for Sexually Transmitted Diseases*. Ottawa: Health Canada. www.hc-sc.ca/hpb/lcdc/bah. 21 February 2001.
- Holmes, K. et al. (eds.) (1999). *Sexually Transmitted Diseases*. (3rd edition). New York: McGraw-Hill.
- Holtgrave, D. et al. (1995). An overview of the effectiveness and efficiency of HIV prevention programs. *Public Health Reports* 110 (2): 134-54.
- Institute of Medicine (1997). *The Hidden Epidemic: Confronting sexually transmitted diseases* Washington, D.C.: National Academy Press.
- Kamb, M. et al. (1998). Efficacy of risk-reduction counseling to prevent human immunodeficiency virus and sexually transmitted diseases: A randomized controlled trial,” *Journal of American Medical Association* 28 (13): 1161-67.
- Laudry, D. and J.D. Forrest (1996). Public health departments providing sexually transmitted disease services. *Family Planning Perspectives*. 28: 261-66.
- Macke, B. et al. (1996) Partner notification in the real world: A four site time-allocation study. *Sexually Transmitted Diseases* 25 (10): 561-68.
- Macke, B., H. Keenan, and W. Kassler (1998). Partner notification strategies for sexually transmitted diseases. *Sexually Transmitted Diseases*. 25 (8).
- Oxman, G. and L. Doyle (1995) A comparison of the case-finding effectiveness and average costs of screening and partner notification. *Sexually Transmitted Diseases*. 23 (1): 51-7.
- Thomas, J.C. et al. (1998). Lay health advisors: Sexually transmitted disease prevention through community involvement. *American Journal of Public Health*.. 88 (8): 1252-53.
- Thomas, J.C. et al. (1999). The social ecology of syphilis. *Social Science and Medicine*. 48: 1081-94.
- U.S. Census Bureau. (2001). 2000 Statistical Abstracts. www.census.gov/prod/2001pubs/statab/sec01.pdf 13 April 2001.
- Zimmerman-Rogers, H. et al. (1999). Establishing partner notification periods for patients with chlamydia. *Sexually Transmitted Diseases*. 26(1): 49-54.

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