DOCUMENT RESUME

ED 444 737 PS 028 826

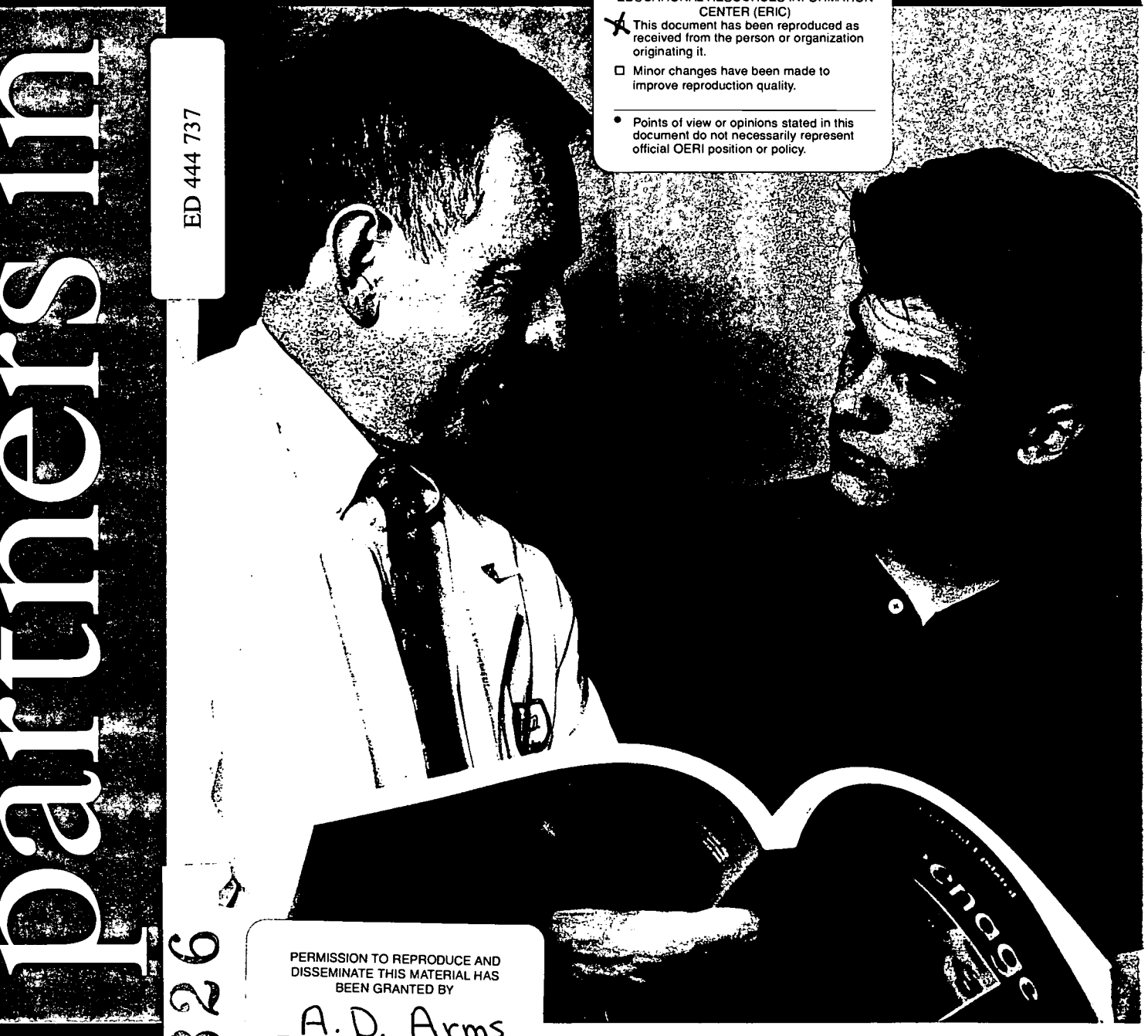
TITLE	Partners in Transition: Adolescents and Managed Care.
INSTITUTION	Children Now, Oakland, CA.
SPONS AGENCY	California Wellness Foundation.; Grant (W.T.) Foundation, New York, NY.; Ralph M. Parsons Foundation, Los Angeles, CA.; Kaiser Foundation, Oakland, CA.
PUB DATE	2000-04-00
NOTE	69p.
AVAILABLE FROM	Children Now, 1212 Broadway, 5th Floor, Oakland, CA 94612; Tel: 510-763-2444; Fax: 510-763-1974; e-mail: children@childrennow.org; Web site: http://www.childrennow.org.
PUB TYPE	Guides - Non-Classroom (055) -- Reports - Descriptive (141) -- Tests/Questionnaires (160)
EDRS PRICE	MF01/PC03 Plus Postage.
DESCRIPTORS	Access to Information; Adolescent Behavior; *Adolescents; Caregiver Child Relationship; Change Strategies; *Child Health; Confidentiality; *Delivery Systems; *Health Maintenance Organizations; *Health Promotion; Health Services; Information Dissemination; Parent Child Relationship; Pediatrics; *Prevention; Program Descriptions; Self Evaluation (Groups)
IDENTIFIERS	*Access to Health Care; Access to Services

ABSTRACT

Noting that managed care organizations face numerous challenges as they respond to adolescents' special health care needs, this report provides the managed care industry with practical information about opportunities for strengthening their health care delivery to adolescents. The report is organized around two goals for health plans. The first goal, facilitate adolescents' access to health care, focuses on policies and systems that can enhance health plans' responsiveness to adolescent members. The second goal, engage teens, parents, and community resources to improve adolescent health, demonstrates the benefits of partnerships to maximize the internal efforts of health plans. The report contains 11 strategies that can help health plans reach these goals. Strategies for Goal 1 include promoting regular preventive health visits; seizing health promotion opportunities; ensuring access to primary caregivers with skills, experiences, and interest in adolescent issues; encouraging the use of multidisciplinary clinical teams; offering comprehensive screening and response for high-risk behaviors; protecting teens' confidentiality; and providing services through specialized adolescent health care centers. Strategies for Goal 2 are to: include adolescents in quality improvement initiatives, help parents and others learn how to support adolescents' health and well-being, participate in community-based health initiatives, and support and disseminate research about adolescent preventive care. Each strategy section also spotlights one or more existing programs and presents outcome data when available. Five appendices include the Managed Care Self-Assessment Tool, clinical preventive service guidelines for adolescents, the Group Health Cooperative parent/teen letter, acknowledgements, and program contacts and other resources. (Contains 148 endnotes.) (KB)

transition

Adolescents and Managed Care



"Our industry plays an ever-greater role in maintaining and contributing to Americans' health—including the wellbeing of our nation's adolescents.

■ Karen Ignagni, *President and CEO, American Association of Health Plans*

Children Now's Managed Care and Adolescent Health Advisory Committee

Children Now assembled the following nationally respected advisory group to help guide us in our Managed Care and Adolescent Health Initiative.

Christina Bethell, PhD, MPH, MBA
Director of Research, Foundation for Accountability

Carmella Bocchino, RN, MBA
Vice President, Medical Affairs, American Association of Health Plans

Claire Brindis, DrPH
Executive Director, The National Adolescent Health Information Center, University of California, San Francisco

Arthur Elster, MD, FSAM
Director, Clinical and Public Health Practice and Outcomes, American Medical Association

Abigail English, JD
Director, Center for Adolescent Health & the Law

Joan Fine, MD, FSAM
Adolescent Medicine Specialist, Pioneer Valley Pediatrics

Karen Hacker, MD
Director of Adolescent Services, Department of Public Health, Boston, MA

David Kaplan, MD, FSAM
University of Colorado Children's Hospital

Jonathan Klein, MD, MPH
Division of Adolescent Medicine, University of Rochester, School of Medicine

John Santelli, MD, MPH
Managed Care Coordinator, Division of Adolescent and School Health, Centers for Disease Control and Prevention

Janet Shalwitz, MD
Adolescent Health Coordinator, San Francisco Department of Public Health

Barbara Staggers, MD, MPH, FAAP
Director, Multicultural Affairs and Division of Adolescent Medicine, Children's Hospital Oakland, CA

Charles J. Wibbelsman, MD, FAAP, FSAM
Adolescent Medicine, Department of Pediatrics, Kaiser Permanente, San Francisco, CA

Donna J. Zimmerman, BSN, MPH
Director, Government Programs, HealthPartners

Children Now gratefully acknowledges The California Wellness Foundation, William T. Grant Foundation, The Ralph M. Parsons Foundation and Kaiser Permanente for generously supporting the production and printing of this report. We would also like to acknowledge The Burton G. Bettingen Corporation, The Clorox Company Foundation, Joseph Drown Foundation, Gap Foundation, William & Flora Hewlett Foundation, Conrad N. Hilton Foundation and The James Irvine Foundation.

partners in transition

Adolescents and Managed Care

About This Project

Children Now's Managed Care and Adolescent Health Initiative aims to increase health plan implementation of strategies that effectively promote adolescent health. Our work is informed by research, consultation with health plan clinicians and administrators and an expert Advisory Committee.

contents

preface

Dear Colleagues:

The number of Americans receiving their health care through managed care organizations has been steadily increasing. With each increase, our industry plays an ever-greater role in maintaining and contributing to Americans' health—including the wellbeing of our nation's adolescents.

But health care providers, including health plans, face particular challenges with adolescents, whose access to care may be impeded by their concerns about confidentiality and privacy, embarrassment about asking questions and trouble with the logistics of getting to and paying for a routine or urgent care visit. Study after study has shown that adolescents under-utilize health care services—even though they need information, guidance and treatment to safeguard them, now and for the future.

As Children Now's report illustrates, many health plans are already taking noteworthy steps to address these challenges and promote adolescents' health. I urge you to examine these examples carefully and consider how they can be applied in your health plan. The American Association of Health Plans (AAHP) has appreciated the opportunity to work with Children Now in the development and dissemination of this report and is here to assist you in your efforts to implement these and other promising practices.

We look forward to working with you as we use our collective expertise to fulfill our commitment to America's adolescents.

Sincerely,

Karen Ignagni
President and CEO
American Association of Health Plans

Dear Colleagues:

Specialists in adolescent medicine have been advocating for the recognition of and comprehensive response to the special health care needs of adolescents. We have researched the origins of unhealthy behavior and biomedical diseases and investigated how to foster teens' healthy choices and development. Many of us have also spent time directly with adolescents and their families, learning about what they need from the health care system and how we can best deliver it.

We still have much to understand, but the model programs in this report demonstrate that our collective experience is being applied successfully in health plans across the country. These promising practices could not be in place if it weren't for the partnerships that are being formed between clinicians and health plan administrators. Both are contributing their knowledge, experience and skills to making teen-centered health care a reality.

But, despite our ongoing efforts, too few teens have access to appropriately designed and delivered screening, preventive counseling and medical treatment. In a startling recent study in the *Journal of the American Medical Association,* researchers found that nearly 20 percent of teens had foregone care they thought they needed, placing them at increased risk of physical and mental health problems. Clearly our work is not done.

Clinicians and health plan administrators alike must continue to promote the need to implement special health counseling and services for adolescents. This report will certainly help us in this effort, as will the continuing work of Children Now.

I am proud to have been a part of the effort to create *Partners in Transition: Adolescents and Managed Care* and I look forward to working with other clinicians, the managed care industry, adolescents and their families to make the vision it sets forth a reality for all adolescents.

Sincerely,

Arthur Elster, M.D.

Arthur M. Elster, MD, FSAM
Director, Clinical and Public Health Practice and Outcomes
American Medical Association

INTRODUCTION

Partners in Transition: Adolescents and Managed Care

It's no wonder that Americans think about adolescents almost exclusively in negative terms. Constant media exposure leaves us believing that most teens are engaging in high rates of unhealthy behaviors, such as cigarette smoking, unsafe sex, violence and drug use. We hear all the time about adolescents who suffer from eating disorders, depression and a profound sense of disconnect from their families, communities and peers. We may be angered, saddened or troubled by this information but regardless: our outlook is negative.

This persistent negativity makes it difficult to consider adolescence for what it *is*: an exciting time of development when careful negotiation of complex situations can lead to immediate and long-term positive results. We need to rethink adolescence, so that we can understand how to foster this period of development, instead of fearing it or dismissing it as intrinsically full of strife. Four basic questions can help us in that process:

- **How should *health* be defined for adolescents?** Measuring health as the absence of biomedical diseases leads to the conclusion that teens are one of the healthiest populations. Yet adolescence is the period when unhealthy behaviors can begin and become habits. Eighty percent of daily adult smokers, for example, first tried a cigarette before they were 18 years old.[2] Adolescents' behavioral choices can also have immediate negative health outcomes: 25 percent of people with HIV contracted the virus when they were teenagers[3] and between 6 and 13 percent of adolescents attempt suicide at least once.[4] Certainly, a teen who smokes, practices unsafe sex or is deeply depressed cannot be considered truly healthy. Moreover, as seen by the strategies in this report, adolescence is a time when healthy behaviors can become life-long habits, but only if teens receive age-appropriate guidance and information. Thus, a teen without the opportunity to learn how to promote his or her health should not be considered truly healthy either.

- **What affects a teen's health?** Teens' physical and mental health history, the health care services they receive and their home, school, peer and community environments may influence their health status.[5] It is also important to remember that the rate of physical, emotional, social and cognitive development during adolescence is second only to infancy.[6] However, teens may develop more slowly or more rapidly than their peers, presenting special challenges. For example, a girl who develops rapidly physically may gain self-confidence, but may not have the cognitive or social abilities needed to navigate sexual pressures. Moreover, research demonstrates that teens with lower family incomes are more likely to engage in certain risky behaviors.[7]

- **Do adolescents want advice from adults?** While a majority of young adolescents turn to their parents for advice on health-related issues, this percentage declines as teens grow older.[8] However, young people say that they want health professionals to help advise them: sixty-five percent of adolescent boys in fifth through twelfth grades said that they want doctors to discuss drugs with them[9]

and a 1995 Children Now poll found that three of four adolescents aged 11 to 17 would trust a doctor "a lot" when looking for guidance on challenging issues such as sex and drugs.[10]

- **Are all teens at equal risk? How does a teen's current behavior affect his or her risk for future unhealthy behaviors?** Most adolescents navigate these years without experiencing a major, long-term problem; however, 25 percent of adolescents are at high risk for drug use, sexually transmitted diseases or other serious health outcomes.[11] This high risk may arise from a variety of factors. Most notably, involvement in one risk behavior itself provides the context for involvement in additional risk behaviors. For example, teens who smoke are more likely to use drugs and drink alcohol.[12] Also, experiences during early adolescence are an especially important determinant of how teens navigate through risk in late adolescence and adulthood.[13]

With this more complex view of adolescence, the developmental tasks presented to teens—such as learning how to take risks safely, solve complex problems and negotiate new types of relationships—are rightfully recognized as being of critical importance. The foundation for this work comes from their early childhood experiences, and the results will guide their approach to their adult responsibilities. Adolescence is a challenging time with profound consequences.

Adolescents should not be alone in struggling to meet those challenges, but an alarming number are. Twenty-one percent of adolescent boys and 13 percent of adolescent girls report that they have "no one" to talk to when they feel stressed, overwhelmed or depressed.[14] Caring adults must become engaged in ensuring that teens have the information, guidance and services they need to enhance their lifelong well-being. With this support, adolescents can fulfill the promise of their boundless energy, limit-

Where Should We Begin?

Health plans are already implementing a range of policies, programs and services to address the unique health care needs of adolescents. Recognizing the complexity of quality improvement initiatives and the need to tailor new programs to a health plan's unique population, Children Now's Managed Care & Adolescent Health Advisory Committee (see the inside cover) suggests that plans begin with two steps:

Step 1. Conduct an internal assessment of adolescent services and infrastructure capacity.

To launch an effective quality improvement initiative, a health plan needs an accurate map of its current services. Important factors to consider in an assessment include adolescents' access and barriers to services, confidentiality and privacy protocols, preventive care guidelines, the quality of primary care and care coordination mechanisms.

Step 2. Assign a clinician or administrator with knowledge and training in adolescent issues to coordinate the quality improvement effort.

Designating an internal champion will demonstrate to clinicians, administrators, members and the community the seriousness of the plan's commitment to adolescents' health care needs. This point person (if assured access to the health plan's medical and health care policy leadership) can not only coordinate the flow of information about adolescent health care, but also be publicly accountable for progress.

less ideas and heart-felt enthusiasm to become our country's next generation of parents, voters, workers and leaders.

Adolescence: A time for investment

There are important efforts underway to improve adolescent health and well-being. Campaigns to prevent teen pregnancy, help teens stop smoking and engage them in nonviolent approaches to problem-solving are among the many initiatives that can be found across the country. But key resources remain untapped and, despite some positive trends, our society still feels the impact of problems that are inadequately addressed:

- The cost to taxpayers of adolescent childbearing is estimated to be $6.9 billion each year for public assistance, health care for children, foster care, criminal justice expenses and lost tax revenue. A conservative estimate of the social cost of teenage pregnancy—loss of productivity, diversion of resources into health care and foster care, and other costs associated with early childbearing—is $8.9 billion per year.[15]

- The annual cost of gunshot wounds of adolescents aged 15 through 19 exceeds $20 billion.[16] Gun shot wounds have nearly matched unintentional motor vehicle accidents as the leading cause of death for boys aged 15 to 19.[17]

- Relative to their population, an analysis of data from 1994 found that adolescents overutilized and improperly used emergency room services, while underutilizing office-based services.[18]

- A 1995 study (in 1992 dollars) conservatively estimated that adolescents 11 to 21 years of age incurred direct annual medical costs of approximately $33.5 billion—or $859 per adolescent—to treat selected preventable health problems.[19]

The United States is in the midst of a period of growth in the adolescent population. In 1993, there were approximately 36 million teens between ages 10 and 19; that number is estimated at 40 million in 2000 and is expected to climb to 43 million by 2020.[20] The challenges described above will only become more acute if we do not devote ourselves to addressing them now.

The special opportunities of managed care

Far from being "just another business," health plans have special opportunities, incentives and missions to promote the health and well-being of our nation's adolescents. Of course, all health care organizations have always had a unique role to play in promoting adolescent health and well-being. But industry trends make clear that managed care has a particularly prominent place in the American health care system. In 1998, 85 percent of Americans and their dependents that had employer-based insurance were enrolled in a managed care plan[21] and 54 percent of all Medicaid enrollees received coverage through managed care in 1998, up from 14 percent in 1993.[22] The new State Children's Health Insurance Program has particularly expanded coverage for teens, and many states have created programs that provide an unprecedented number of adolescents with a managed care medical home. Moreover, one study found that 87 percent of physicians in an urban area had at least one managed care contract.[23]

While "managed care" serves as a catchall term for a diverse array of companies, most managed care organizations (MCOs) share certain characteristics. These characteristics make them ideal partners in efforts to enhance adolescent health and well-being:

1. As *integrated delivery systems*, MCOs bring together a range of health care professionals and services,

potentially enhancing the degree of coordination and continuity in the delivery of care.

2. To maintain their *enrollment rates*, essential in today's marketplace, MCOs have an incentive to be accountable to members' concerns and build "brand loyalty."

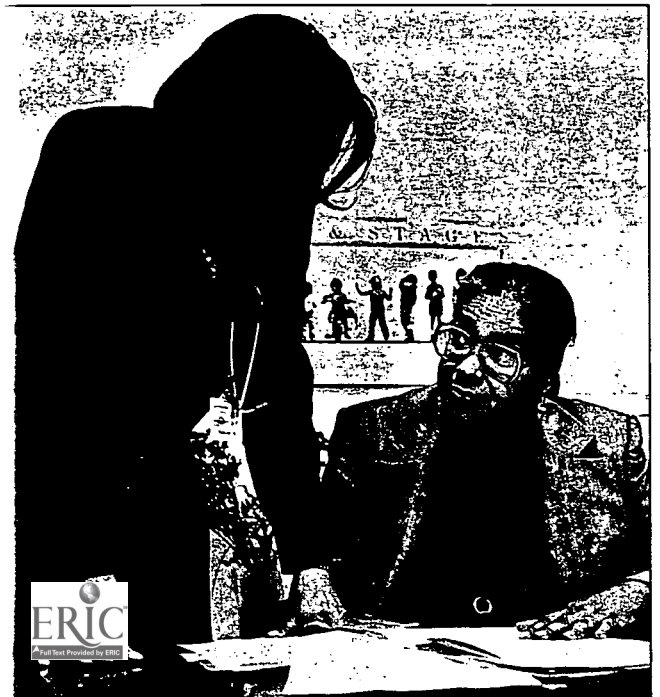
3. The financial structures of capitated MCOs provide an incentive to promote *preventive services*.[24] As they consider the possibility of maintaining members over many years, the opportunities to implement longer-term preventive services become more important.

4. MCO contracts specify a set *benefits package*, facilitating a comparison among managed care plans of their adolescent-specific services.

5. MCOs' membership base creates opportunities to practice population-based *medicine*, in addition to individual patient-based interventions.

6. MCOs are organized to support a range of *quality improvement* activities that can continuously assess and improve their services.

While differences among health plans do exist, particularly in terms of the relationship between clinicians and the plan administration, the common features suggest that health plans may have a special opportunity to promote adolescent well-being. Indeed, some important public and private purchasers of health insurance have already taken steps to promote this role for health plans:



- The Health Plan Employer Data and Information Set (HEDIS) and other performance measurement tools have helped fuel health plan, purchaser and consumer interest in the quality of health care. With these instruments, there is a growing understanding of the important facets of health care quality, such as access to care, patient involvement in care decisions, adherence to practice guidelines and achievement of health outcomes. As described in this report (Strategy 11), HEDIS has recently added a new measure on Chlamydia screening in adolescents and young women, a testimony to the growing recognition of the importance of adolescent health on long-term well-being.

- State officials in Nevada and Michigan now monitor EPSDT (Early and Periodic Screening, Diagnosis and Treatment) compliance and inform plans which children need EPSDT services. EPSDT is a comprehensive children's health care program that is part of Medicaid.[25] Few children receive the full entitlement of EPSDT services, with adolescents being particularly underserved.[26] Following the implementation of these new protocols, 54 percent of the Medicaid children and adolescents enrolled in plans in Nevada and Michigan received all of their EPSDT services, compared to only 19 percent of children in plans where notification and monitoring did not occur.[27]

- The Pacific Business Group on Health (PBGH) is an independent, non-profit coalition of 35 public and private sector purchasers of health care that represents approximately three million employees, dependents and retirees and $3 billion in annual health care expenditures. PBGH contracts with 13

health maintenance organizations (HMOs). During its negotiations with these HMOs, PBGH sets quantifiable quality of care targets. Two percent of the premiums paid to plans rests on their performance on these measures: they only receive this two percent if the targets are met. For example, in 1996, more than half (eight of the thirteen) of the health plans missed the targets for immunizations, leading to a refund to employers of 86 percent of the premium at risk for this performance target.[28]

- The Foundation for Accountability (FACCT), in cooperation with the National Committee for Quality Assurance (NCQA), launched the Child and Adolescent Health Measurement Initiative (CAHMI) to develop new tools for consumers, purchasers and health plans to measure and improve health care quality. Building on research confirming that adolescents are accurate reporters of their health care experiences,[29] one of the instruments created as part of CAHMI is an adolescent survey that measures the preventive services received by teenagers and their experience of the health care system.[30]

How to use this report

Children Now developed this report in order to provide the managed care industry with practical information about opportunities for strengthening their delivery of health care to adolescents. The report is organized around two goals for health plans:

- The first goal, **Facilitate Adolescents' Access to Health Care**, focuses on policies and systems that can enhance health plans' responsiveness to their adolescent members.

- The second goal, **Engage Teens, Parents and Community Resources to Improve Adolescent Health**, demonstrates the benefits of partnerships to maximize the internal efforts of health plans.

The report contains eleven strategies that can help health plans reach these goals.[31] Each strategy also "spotlights" one or more existing programs; outcomes data, when available, can be found under the heading "Benefits and the Bottom Line." Many of the spotlight programs featured in this report come from staff model health plans. Network-model plans can also apply lessons learned from these examples to their institutions.

It is also important to note that although the strategies in this report primarily address preventive care, this focus is not intended to downplay the role of health plans in providing and ensuring teens' access to appropriate management and treatment of clinical conditions. Although not as prevalent as behavior-related health concerns, serious biologically related diseases (such as diabetes mellitus, thyroid disorders, some mental disorders and testicular cancer) may develop during adolescence. Many of the strategies in this report—most notably, engaging parents appropriately and providing access to adolescent medicine specialists—are equally important to consider when seeking to improve clinical treatment for adolescents, as when focusing on the quality of preventive care.

Managed care plans and purchasers of health insurance can consider these goals and strategies a "menu of opportunities." Each managed care plan will develop its own priorities among these (and perhaps other) potential components of adolescent-friendly systems, with much dependent on the priorities of its administrative and medical leaders. Public and private health insurance purchasers also have the ability to influence plan policies and systems during contract negotiations. Children Now intends this report and each strategy to serve not as a ready-made program, but as a catalyst that may lead to the creation of programs tailored to a health plan's particular community.

goal 1.0

Facilitate Adolescents' Access to Health Care

Simply providing adolescents with health insurance is not enough to ensure that they receive the services they need. Adolescents are neither young children whose access to health professionals is solely determined by their parents nor adults who have years of experience in navigating the complex, confusing and even frightening world of medical care. Instead, they may be accompanied by their parents to a clinical visit or may need to make that visit on their own; they may have special concerns about what will happen during the visit or how to follow-up; they may not know their rights or even that health care rights exist.

Adolescents may access health care through a variety of sources. For example, researchers have estimated that teens make 5.2 million visits to family planning clinics and 1.6 million visits to school-based clinics annually.[32] While significant and important sources of health services, these sites are not nearly as prevalent as office-based care: in 1994, teens made an estimated 61.8 million visits. Yet this rate represents a dramatic underutilization of services. Teens' visits comprised 9 percent of all visits, although they made up 15 percent of the population.[33] In light of the known need for teens to receive regular screening, counseling and follow-up, this low visit rate is cause for concern.

The strategies presented in this section focus on primary care, although hospitals and other health care settings could adapt these principles as well. Of course, for many of these strategies to work, adolescents and their families must be familiar with them. Health plans that communicate through teen- and family-friendly materials can help ensure that the promise of their efforts towards promoting adolescent health is fulfilled.

Strategy 1 Endorse and promote regular preventive health visits

Adolescence is a time of rapid change: not only do teens undergo profound physical and emotional development, but their relationships and the risk factors to which they are exposed alter dramatically as well. For example, 13-year-olds are more than three times as likely as 12-year-olds to say they could buy marijuana if they wanted to; almost three times more likely to know a student at their school who sells drugs; and almost three times more likely to know a teen who uses acid, cocaine or heroin.[34] Likewise, although only 9 percent of boys and 4 percent of girls report having first had sexual intercourse before age 13, 60 percent of boys and 62 percent of girls in twelfth grade report being sexually experienced.[35]

Some of the most dramatic changes in behavior occur during the years of early adolescence and can have serious long-term consequences. In one survey, the percentage of students who reported beginning substance use at age 12 or younger was 54 percent for alcohol, 35 percent for cigarettes, 10 percent for marijuana and 2 percent for cocaine.[36] The variable most strongly associated with health risk behaviors of young adolescents is the onset of cigarette use at age 11 years or younger.[37]

These changes bring with them challenges to adolescents' current and future well-being, but also provide an array of opportunities to promote adolescents' health.[38] To meet adolescents' needs during this time, the American Medical Association (AMA), the American Academy of Pediatrics (AAP) and the United States Maternal and Child Health Bureau's Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents uniformly recommend that adolescents receive annual preventive care visits.[39] The American Academy of Family Physicians and the

US Preventive Services Task Force call for a "tailored" periodicity of at least one preventive visit every one to three years.[40]

The AMA's *Guidelines for Adolescent Preventive Services* outlines three goals for preventive care visits:

- identify adolescents who have recently begun, or are considering, health-risk behaviors;
- identify adolescents whose health-risk behavior has escalated to a more serious level; and
- identify adolescents who show signs of early physical or emotional disorders.[41]

Research underscores the benefits of routine preventive care for adolescents. Adolescents are more likely to discuss issues related to sex and sexuality during visits with a physician with whom they have an ongoing, confidential relationship, than when seeing a physician unfamiliar to them.[42] In addition, research suggests that adolescent receptivity to discuss health risk behaviors increases if clinicians address such issues as drugs, alcohol, cigarettes, depression, diet and exercise on repeat occasions.[43]

Health plans now have a direct incentive to provide routine care to adolescents: a measure has been added to the Health Plan and Employer Data & Information Set (HEDIS) that assesses the rate of screening for Chlamydia in young women.[44]

The potential value of routine preventive health care visits will only be realized if adolescents make and keep their appointments. See page 30 for examples of strategies health plans have used to overcome common barriers to adolescent preventive care.

■ Spotlight: Two keys to success: (1) encourage annual preventive visits and (2) target preventive efforts towards every adolescent health plan member

—Medical West Associates, Chicopee, MA

From 1994-97, the Quality Improvement Team at Medical West Associates (at the time, a staff-model HMO in Massachusetts owned by Blue Shield) performed a two-year chart review of pregnant teenagers and found that only one in four (23%; n=74) had been seen in the health center for a well-visit within one year prior to conception. They collected data about the teenagers' pregnancies from the billing and coding departments and confirmed the information by chart review.[45]

The Quality Improvement Team developed a new set of protocols for adolescent medicine that included an annual physical for all teenage members (boys and girls).[46] The new protocol called for each adolescent to be encouraged to make an annual visit, during which time the teen would be asked to complete a confidential reproductive health questionnaire to help clinicians identify pregnancy risk factors. When the questionnaire revealed the presence of such factors, a birth control counselor would meet with the adolescent at the time of the visit for immediate intervention. In addition, to help avoid unintended repeat pregnancies, the obstetrics department instituted a policy to document the teenager's birth control selection on her chart at the 28-week prenatal visit and provide her with the birth control shortly following her child's birth.

As Dr. Joan Fine, Adolescent Medicine Specialist at Medical West, said, "I firmly believe that adolescent pregnancy prevention can be achieved through an interdisciplinary team effort in a managed care setting. Successful reduction of pregnancy rates requires recognition by managed care leadership that adolescent pregnancy is a costly, avoidable condition. It is essential to endorse policy changes consistent with recommended national standards, such as annual preventive visits, for improving adolescent health care, and continually monitor compliance with practice guidelines."

Strategy 2 Seize health promotion opportunities

Regular preventive health care visits (see Strategy 1) can play a key role in promoting the health and well-being of adolescents. However, much can change for adolescents between check-ups, even if teens receive them at the annual rate recommended by the American Medical Association, the American Academy of Pediatrics and others. Teens may face increasing peer pressure to start smoking, use drugs or begin another high-risk behavior.

Beyond routine preventive health visits, there are other opportunities for the health care system to provide guidance and health care services to adolescents. In one study, 81 percent of teens were able to identify the regular provider they would see if they became sick.[47] Another study found that one in four teen girls who learned about a positive pregnancy test result from a clinic had previously gone to a clinic and received a negative pregnancy test result.[48] In some circumstances (and if medically appropriate), these may be powerful opportunities to deliver health promotion messages about key issues.

In addition, adolescents may, over time, see a range of clinicians, such as dermatologists, nutritionists, social workers, sports medicine specialists and others. If these clinicians develop a trusting relationship with a teen, they may be well-positioned to deliver health guidance about a range of important issues or make referrals to other clinicians that teens will see as important to keep.

Health plans can take steps to encourage clinicians to take advantage of these opportunities. For example, as discussed in Strategy 3, some clinicians may not have the skills needed to talk with teens about sensitive issues or may not adequately understand the laws governing adolescents' confidential access to health care services. Health plans can offer clinicians written materials or training about these issues. In addition, some adolescents may not feel comfortable or logistically able to make appointments for preventive or follow-up care. In response, health plans can set policies that expedite laboratory services, facilitate referrals, encourage clinicians to adopt policies that allow for flexible appointment scheduling and take other steps to enhance adolescents' access to care.

■ Spotlight: On-the-spot adolescent pregnancy testing and counseling

—Kaiser Permanente, California

When Kaiser Permanente's Northern California region examined their own and national data on adolescent pregnancy testing, they found compelling reasons to alter then-standard practice. Typically, the majority of Kaiser Permanente's youth members who obtained a pregnancy test within the plan would go to a lab to drop off their urine specimen. If the adolescent did call back the next day, she spoke with a service representative who related the result, but provided no counseling. A review of internal and national data found that[49]

- eighty percent of Kaiser Permanente's adolescent girls who requested a pregnancy test said that they did not want to get pregnant;
- sixty percent of Kaiser Permanente's adolescent pregnancy tests came back as negative, and of this group, 70 percent were

not using hormonal contraceptive methods (which are among the most effective in preventing pregnancy[50]);

- according to a study outside of Kaiser Permanente of adolescents aged 17 and under, 56 percent become pregnant within 18 months after they had received a negative pregnancy test;[51] and
- nationally, among young women 17 and under who had ever conceived, more than one in three had had a prior negative pregnancy test result.[52]

In response, Kaiser Permanente decided to fund an internal Successful Practices Implementation Grant in 1998 to disseminate a new "best practice" to several of their facilities. At these facilities, adolescents seeking a pregnancy test have special priority. They receive on-the-spot pregnancy test results from a counselor who discusses birth control with those who are not pregnant, as well as assure referral for those who are pregnant. Dr. Richard Boise, the project's internal champion, says, "This is an example of a worthwhile, feasible, high impact intervention which has been implemented with minimal funding, primarily for training only. Implementation relied upon caring and committed doctors and nurses in individual facilities recognizing the obvious need to be there for these young people in crisis." As of mid-1999, through a regional training program, a newly created manual and implementation tools (charting forms, questionnaires, etc.), the new protocol had been successfully replicated in 20 facilities in Northern California.

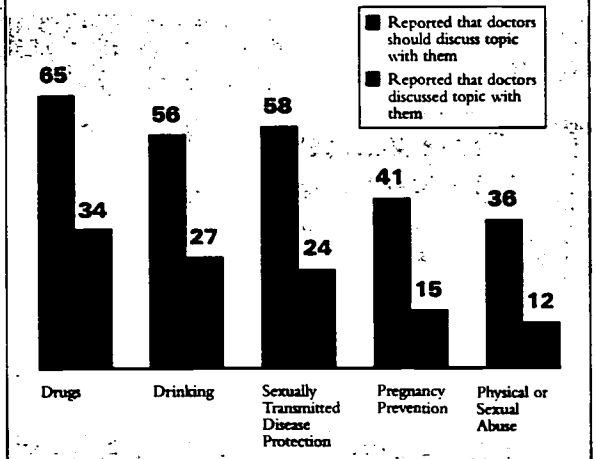
Benefits & the bottom line

- Initial results from an internal study with the new protocol show that, of the group that tested negative and did not previously use hormonal contraceptive methods, 62 percent started to use such methods after receiving counseling.
- Ninety percent of all teens visiting the testing clinic opted to meet with a counselor; of this group, 96 percent found the counseling helpful.
- Providing teens with contraception has the potential to be highly cost-effective, given the high costs of pregnancy and sexually transmitted diseases. For example, one study calculated the private-sector health plan savings from contraceptive use to range from $308 for implants to $946 for the male condom.[53]

Strategy 3 Ensure access to primary caregivers with skills, experience and interest in adolescent issues.

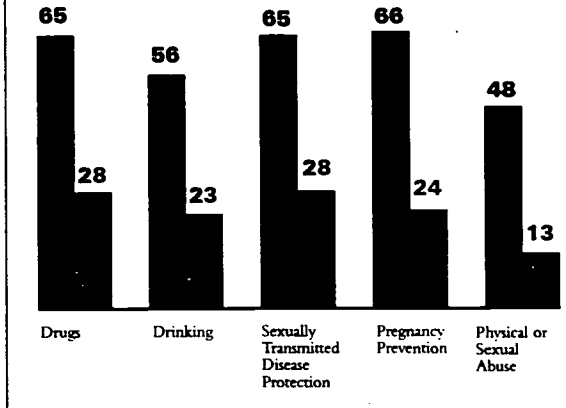
Surveys of adolescents indicate a majority fail to receive the health guidance they expect and want from providers (see boxes opposite page).[54] They also report problems with their relationship with their clinician: thirty-five percent of girls and 21 percent of boys could recall a time when they were too embarrassed, afraid, or uncomfortable to discuss a problem with their doctor or health professional.[55]

Figure 1: Gaps Exist Between What Boys Believe Doctors Should Discuss and What Doctors Have Discussed



The Commonwealth Fund Survey of the Health of Adolescent Girls (1997). Louis Harris and Associates, Inc.

Figure 2: Gaps Exist Between What Girls Believe Doctors Should Discuss and What Doctors Have Discussed



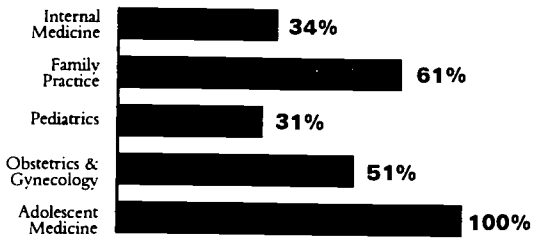
The Health of Adolescent Girls: Commonwealth Fund Survey Findings (1998). Louis Harris and Associates, Inc.

Provider surveys also suggest that many teens may not be receiving the care they need. A 1990 study of pediatricians in New York State found that fewer than half provided anticipatory guidance regarding sexual activity to adolescents and only 14 percent questioned teens about depression.[56] The researchers concluded that most of the surveyed pediatricians "played a small role" in meeting the health needs of adolescents.

Teens fail to receive critical health guidance in part because many providers lack special experience or interest in teen issues. In a survey of HMO practitioners, respondents were asked if they liked to work with adolescents. While every adolescent medicine specialist and 61 percent of family practice physicians responded that they did like to work with teens, only half of obstetricians and gynecologists and a third of internists and pediatricians felt the same way.[57] In this study, researchers theorize that one of the reasons why these physicians do not like to work with adolescents is a lack of relevant knowledge and skills. For example, the majority of internists rated themselves as having poor or fair knowledge and technical competence to deal with eight of ten adolescent health care problems.

Research indicates that providers with skills, experience and interest in adolescent health issues are the most comfortable and capable in serving adolescent patients.[58] They are often preferred by adolescents as caregivers;[59] play a large role in an adolescent's decision to seek care;[60] and promote better patient compliance with treatment protocols.[61] In a recent poll, 87 percent of adolescent boys and 95 percent of adolescent girls said, "It is extremely [to very] important that doctors and nurses know about teen medical problems."[62]

Figure 3: Percent of Physicians in an HMO Setting Who Like Working With Adolescents



Klitsner IN. and Borok GM. (1992.) Adolsecent Health Care in a Large Multispeciality Prepaid Group Practice: Who Provides It and How Are They Doing? *Western Journal of Medicine*. 156(6): 628-632.

Data also show that adolescent members are more willing to discuss sensitive issues with health care providers that demonstrate special knowledge and skills with youth issues.[63] These discussions can lead to life-saving behaviors. Investigators in one random sample found that adolescents who had discussed AIDS with a physician were 70 percent more likely to use condoms.[64]

To strengthen teens' access to providers with appropriate skills, experience and interest, a health plan can 1) increase its supply of such providers and 2) help teens identify and communicate effectively with these clinicians. In an example of the first step, Kaiser Permanente in Northern California provides an annual training on working with adolescent patients for pediatricians and others who work with teens. This training usually covers communication skills, relevant medical content and health plan resources.[65]

In addition to trainings, plans can offer informational materials to providers, such as resource and referral booklets on both the plan and the surrounding community; lectures; newsletters; reading lists and adolescent related articles in newspapers and newsletters. Incentives also may motivate more providers to develop and refine adolescent-specific skills.

Such training and skills-building opportunities are critical not only for physicians, but also for the full team of caregivers who work with teens, including nurses, physician assistants, peer health counselors and health educators, as well as other staff who interact with adolescent enrollees, such as laboratory staff and receptionists.

In addition to increasing its supply of specialized providers, a plan can help teens find and use those caregivers more effectively. Plans, for example, can identify providers committed to working with teens (see spotlight on San Francisco Health Plan below) and distribute that list to enrollee families. A brochure for teen enrollees or teen-oriented Web site, written with the help of teens, could provide information on how to access medical care and health education, topics to discuss with a provider, consent rules and confidentiality protections.[66]

■ Spotlight: Identify, ensure access to and promote providers for youth

—The San Francisco Health Plan in cooperation with the The San Francisco Adolescent Health Working Group

The San Francisco Health Plan (SFHP) provides Medi-Cal (California's Medicaid program) and Healthy Families (California's State Children's Health Insurance Program) coverage for more than 5,000 adolescents between the ages of 12 and 19 in San Francisco. In December 1997, the SFHP decided to make a concerted effort to address the unique needs of their adolescent members. They worked with a community-based adolescent health working group to survey the SFHP primary care network (pediatricians, family practice physicians, general practitioners and internal medicine physicians) to identify those

who wanted to be designated as an adolescent and young adult provider (see survey to the right). These clinicians were listed in the Spring 1998 SFHP provider directory in a special section under the heading "Primary Care Providers & Clinics for Teens and Young Adults." The San Francisco Health Plan estimates that the number of teens who chose a "teen friendly" primary care provider increased by 10 percent from the latter half of 1997 (before the provider directory was published) compared to the same period in 1998 (subsequent to publishing).

The survey also provided the SFHP with information about the comfort level of network clinicians and providers in relating to adolescents. Since conducting the survey, the SFHP has published adolescent-related articles in their newsletter and mailed a local resource directory to the self-selected list of adolescent providers. In the future, the SFHP would like to become more involved in coordinating provider education opportunities related to adolescent issues for physicians in their network.

Strategy 4 Encourage the use of multidisciplinary clinical teams

Many adolescent health care needs bridge more than one medical specialty. For example, mental health concerns, such as eating disorders or depression, can have consequences for a teen's physical well-being and teens engaged in unsafe sexual activity may need counseling and treatment related to sexually transmitted diseases and pregnancy. Moreover, research suggests that a teen engaged in one unhealthy behavior is likely to begin another.[67]

However, individual clinicians may not be well-equipped to provide health care services to multi-need adolescents. In one survey, for example, a majority of internists reported that they had only fair or poor knowledge and technical competence to address eight of ten common adolescent health problems.[68]

Survey For Adolescent Provider Designation

- Do you feel comfortable providing primary care for young people between 12 and 19 years of age?
  ❑ Yes ❑ No ❑ Don't Know
- Do you enjoy seeing young people between 12 and 19 years of age?
  ❑ Yes ❑ No ❑ Don't Know
- Does your practice allow a different amount of time for seeing youth than other patients?
  ❑ Yes ❑ No ❑ Don't Know
- Do you feel confident that you would be able to screen for mental health and substance abuse problems in youth?
  ❑ Yes ❑ No ❑ Don't Know
- Do you have skills to function as part of an interdisciplinary team, incorporating outside agencies and other providers specifically working with youth?
  ❑ Yes ❑ No ❑ Don't Know
- Would you like to be designated as an adolescent provider in our plan's marketing material?
  ❑ Yes ❑ No ❑ Don't Know
- What would make you more comfortable treating adolescents? (Check all)
  ❑ Mailed materials ❑ Case consultation Services
  ❑ Resource list ❑ Other: _____
  ❑ Local CME program
- Approximately what percentage of your patient population is young people between 12 and 19 years old? Please circle one: 1-24, 25-49, 50-74, 75-100.
  ❑ Yes ❑ No ❑ Don't Know
- Any additional comments?
  ❑ Yes ❑ No

Sources: Adolescent Health Work Group in San Francisco, CA and The National Adolescent Health Information Center, University of California, San Francisco. The survey was developed for The San Francisco Health Plan. Please contact Janet Shalwitz at (415) 554-9640 or janet_shalwitz@dph.sf.ca.us.

Many adolescents and clinicians could thus benefit from access to a team of providers representing a range of specialties. In some cases (such as in staff model plans or large group practices), clinicians may already work with a multidisciplinary group of colleagues and may just need advice about how to develop an infrastructure to tap this on-hand expertise. Other clinicians practicing in small group settings might benefit from their health plan playing a coordinating role to create a multidisciplinary environment. The two spotlights described below come from staff-model plans; network-model plans could adapt these services through, for example, a case management program that coordinates the care for adolescents who receive services from multiple clinicians.

■ Spotlight: Multidisciplinary program for pregnant and parenting adolescents

—Harvard Vanguard Medical Associates

In 1991, Harvard Vanguard Medical Associates (then a not-for-profit group practice of 600 physicians providing medical care for 10,000 Harvard Pilgrim Health Care members under age 18) set up a multidisciplinary program for pregnant and parenting teenagers.[69] The collaborative program between obstetrics, pediatrics, mental health and nursing case management brings together clinicians from each of these disciplines to address the physical, psychological and social needs of these multi-need youth. An important component of the program is the inclusion of a social worker who helps keep track of patients and encourages them to come to the group visits. In the past, first-year medical students from Harvard Medical School participated in the program as well.

The adolescents participated in a two-hour integrated medical group visit each week. During the first hour, the members shared their thoughts in an informal discussion about what was going on with their lives. Issues covered during this time included the prospect of motherhood, family and social supports, their relationships with the fathers of their babies, continuing their education and getting medical care for themselves and their babies.

A more formal health class followed the group visit. Topics included giving birth, breast feeding and nutrition, labor and delivery, newborn care, domestic violence, birth control, smoking cessation, prevention of STDs and HIV, substance use, trying to engender empowering habits and connecting the youth together socially and with their clinicians. These highly interactive sessions provided learning opportunities for providers and patients.

Usually, around 20 young women were enrolled in the program at any given point in time, with 10 to 12 attending each week. To help ensure that the participants showed up for the visit, the medical group paid for the member's transportation and provided a snack. Dr. Anita Feins, leader of the project, said, "The program has served as an effective model for conducting group visits and health promotion classes that deal with multiple aspects of a teen's life."

Benefits & the bottom line

- Eighty to 90 percent of the young women involved in the program initiated breast feeding, compared to a national average of 51 percent.[70]
- Anecdotal evidence suggests that the young women in the project had lower rates of premature deliveries and higher birth weight babies and were more prepared for delivery.

■ Spotlight: Multidisciplinary adolescent consultation teams

—Group Health Cooperative of Puget Sound

As a result of an extensive 1989 needs assessment, Dr. Jeffrey Lindenbaum of Group Health Cooperative of Puget Sound (GHC) helped form the multidisciplinary Adolescent Consultation Team (ACT). ACT providers discuss and analyze the needs of high-risk adolescents to improve health care coordination and support primary physicians. The team includes providers from a range of specialties: mental health services, alcohol drug treatment, visiting nurse services, social work, the teen health services director (a pediatrician board certified in adolescent medicine), a registered nurse and a team assistant.

"The program's multiple goals include decreasing utilization, decreasing the number of providers used throughout the system, increasing the involvement of primary care providers, saving money and improving outcomes," says Dr. Lindenbaum. "We've been able to achieve all of them."

The team meets twice a month, reviewing usually eight new and ongoing cases to develop plans and suggestions for the providers of each adolescent. Many of these adolescents have complex medical or psychosocial problems and use GHCs Walk-In Clinic, emergency room (ER), alcohol and drug treatment and mental health services extensively.

Summaries of the ACT discussion and suggestions become part of the patient's chart and are distributed to all involved providers. "ACT provides a simple way to summarize fairly complex cases," says Dr. Lindenbaum. "As part of ACT, we give PCPs (primary care providers) a case review summary of how their patient has interacted with our various systems, including emergency services, mental health, substance use and others. These cases are difficult ones in which a teen may be bouncing around from place

Benefits & the bottom line

- A Group Health Cooperative of Puget Sound analysis has determined that over a six-month review period, ACT saved the health plan over $50,000.[71]
- Of the 29 new cases reviewed by ACT in 1996, six-month pre- and post-review data were available for 20. Of these cases, the average number of visits after six months decreased 29 percent (from 10.55 to 7.45); the average number of specialists used fell 33 percent (from 4.05 to 2.7), and the average number of walk-in emergencies and visits to the ER fell by 43 percent (from 1.15 to 0.65).[72]
- An internal GHC questionnaire revealed that primary care providers felt strongly that ACT reviews were highly appropriate, as were the courses of action suggested to the providers. Eighty-two percent of the responding providers indicated they would refer difficult adolescent cases to ACT in the future.
- An internal survey of providers involved in the care of ACT patients found that ACT's most significant benefits to the providers and their patients/families were reported as: "Help in formulating a plan of action or approach, facilitation of family interactions, fewer patient visits, improved mental health and better coordination of care."

to place; ACT pulls the information together for the providers so we can end the fragmentation. Without ACT, the PCP might not have been aware of all that was happening." The program's RN Coordinator is responsible for contacting the PCP and others as appropriate for follow-up and clarification of ACT suggestions. Resources are furnished to providers and sometimes to adolescents and parents. Resources can include specialist referrals (both internal and external to GHC), community, school and educational services (such as family reconciliation services) and others.

Cases are referred to ACT either through a computer monitoring system (adolescents who see three or more specialists are automatically referred to ACT) or directly from providers (GHC medical staff, nurses, social workers and family practice residents) seeking additional support, advice or a second opinion. Each month around 300 cases are referred for screening and approximately 16 new and ongoing cases receive full team in-depth review and consultation. As a team, ACT meets only with providers, not patients.

The team believes in accountability and understands that demonstrating results could be vital to their continued presence. Each year the ACT team sets goals for themselves and reports on their outcomes in their annual report. Past goals have included reviewing a set number of patients, changing health care service utilization for reviewed patients and staying on budget.

Strategy 5 Offer comprehensive screening and response for high-risk behaviors

Health-compromising behaviors are major threats to adolescent health.[73] Adolescent preventive service guidelines (such as the *Guidelines for Adolescent Preventive Services* and *Bright Futures*, described in Appendix B) recommend that primary care clinicians comprehensively screen adolescents for health-compromising behaviors, further assess those at risk and provide counseling or referral for anticipated or identified problems.[74] Ensuring that these visits meet adolescents' need for confidentiality and privacy would help maximize their effectiveness (see Strategy 6).

In fact, however, adolescents' visits with health care providers frequently fail to include comprehensive preventive screening and follow-up counseling. One 1994 study found that nearly one half of adolescent office visits included no education or counseling, and counseling about key issues such as smoking cessation, HIV and other sexually transmitted diseases and weight reduction occurred less than 3 percent of the time.[75] A poll by MTV found that 57 percent of teens aged 15 to 17 had never discussed sexually transmitted diseases with their health care provider.[76] Another study found that more than 75 percent of college freshmen reported never receiving counseling during adolescence from their primary care provider on 11 out of 15 important topics.[77]

There is also evidence that teens may not be receiving the services they need to follow-up on the results of screening. For example, according to the US Office of Technical Assessment, at least 7.5 million Americans under the age of 18 (12 percent) should be receiving mental health services; fewer than a third of these youth obtain such care.[78]

Time may be an important factor in determining the amount of counseling: the average length of an adolescent health visit is 16 minutes and the time devoted to counseling has been estimated at 2.6 min-

utes.[79] This amount represents a significant increase from an earlier study which found that only seven seconds were spent on counseling,[80] but may still not be enough time, particularly for high-risk teens.

Some plans have addressed the need for longer visits by increasing provider reimbursement for adolescent well-care visits (see page 31). Other options include using multi-disciplinary provider teams during preventive care visits (see Strategy 4) and initial and periodic screening and review of adolescent health risk behaviors and health education needs using a pre-visit assessment form or health educators.

Optimally, plans can tailor care to the preferences of their teen enrollees by offering a variety of screening options. While some adolescents might feel comfortable disclosing personal information to a physician, others may only want to talk with a health educator. Still others may prefer the anonymity of a computer or pre-visit questionnaire to share information about sensitive issues such as exposure to violence, substance use or sexual experience.

■ Spotlight: State-wide adoption of a Medicaid Health-Risk Assessment Questionnaire

—California Medi-Cal (Medicaid)

Medi-Cal, California's Medicaid program, provides coverage to more than 600,000 adolescents through managed care plans. Medi-Cal Managed Care health plans are contractually required to ensure that all new members complete an Individual Health Education Behavioral Assessment within 120 days of enrollment as part of the initial health assessment. All existing members must complete the assessment by their next scheduled health screening exam.

According to Dr. Mary Fermazin, Chief, Department of Health Services (DHS), Office of Clinical Standards and Quality, "The DHS Medi-Cal Managed Care Division, in collaboration with Medi-Cal Managed Care health plans and the Office of Clinical Preventive Medicine, has recently completed development of the "Staying Healthy" Assessment tool." DHS has adopted this tool and is promoting its use by Medi-Cal Managed Care plans and providers of primary care services as a means to fulfill the contractually required individual health education behavioral assessment.[81] The tool was developed in a two-year collaborative process that included reviewing existing assessment forms, consulting with clinicians and administrators and pilot testing the new questionnaires.

In October 1999, approximately 28 Medi-Cal Managed Care Plans began conducting training for their providers on how to fulfill the contractually required assessment and on useful community and plan-specific resources and referrals. By March 1, 2000, providers of primary care services in each plan's network are expected to be using the English and Spanish versions of the "Staying Healthy" Assessment tool, or other approved tool that complies with DHS criteria. DHS is continuing to translate the "Staying

Healthy" Assessment tool into other threshold languages. As these translations are made available, providers will be expected to incorporate them (or other approved tools) into their practice.

The "Staying Healthy" Assessment tool is designed to assist providers in identifying the high-risk behaviors and health education needs of individual plan members and to initiate and document focused health education interventions including counseling, referral and follow-up. The assessment targets issues that are important to teen well-being and that can be influenced by effective interventions. Topics include nutrition, feeling sad, car safety, bicycle safety, guns, tobacco use, alcohol, drugs and sex. Providers are required to review the completed assessment tool and risk reduction plan at least annually with adolescents who have a scheduled visit. "The assessment questionnaires allow providers to efficiently spot health-compromising behaviors and risk-factors," says Dr. Larry Dickey, Chief of California's Office of Clinical Preventive Medicine. "These questionnaires provide important tools for both plans and providers to help them target health counseling and referral services."

Completed forms provide additional information for MCOs to use in health education program planning and quality improvement. For example, plans could use information from the forms to assess the risk factors prevalent in their adolescent population and then better target health education resources and training for their providers and members. Blue Cross of California State Sponsored Programs, which has approximately 75,000 members statewide from age 13 through 19, is one of the plans that will use the questionnaires. According to Dr. Paul Russell, Medical Director, Blue Cross of California State Sponsored Programs, "The state assessment tool will allow us to monitor the interventions given and evaluate how well prevention activities have been integrated into primary health care."

■ Spotlight: Multimedia CD-ROM computer health risk assessments to enhance direct provider/patient communication

—Kaiser Permanente, Hawaii and California Divisions

Multimedia adolescent health risk screening programs integrated with multi-disciplinary health education provider teams provide a low-cost strategy to deliver comprehensive preventive health services to large numbers of adolescents. The Youth Health Provider© (YHP)[82] and The Teen Challenge (TC) program are two CD-ROM-based adolescent health risk assessment tools.

TC and YHP are interactive health education software programs that guide the user through a series of sensitive health- and behavior-related questions. The programs obtain a complete behavioral, psychosocial and health history, identify and prioritize health needs, provide specific health advice, give age-specific anticipatory guidance and show health education video segments about physical and emotional health issues. In addition, they generate printed assessments for the clinician or interviewer and health education materials for the adolescent.

The YHP system can operate in English and Spanish; the TC system will soon be available in multiple languages. YHP also adapts the ethnicity and gender of the characters in the videos to match those of the adolescent, and the program's content (including questions and printouts) can be customized to conform to provider or community standards. Printed feedback for each youth can include community resources and toll-free advice lines. Some topics covered by the software include stress, sexual activity, contraception use, family issues, alcohol use, violence exposure, suicide risk, riding-with or driving under the influence of alcohol, seat belt use and bicycle helmet use.

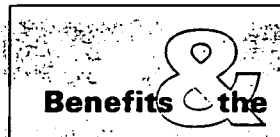
Kaiser Permanente's Hawaii Division's use of the YHP shows that multimedia computer-based health assessment programs can serve as a cost-effective way to conduct risk assessments and deliver adolescent preventive services.[83] The computer can raise difficult topics and help educate the adolescent. The provider then can review the results and talk with the adolescent about identified health-risk behaviors and/or refer the adolescent for additional counseling, behavioral or physical assessments.

"Teens have really accepted the computer as an important part of their visit," says Dr. David Paperny, the Hawaii Division's adolescent specialist. "We now see providers refer teens for computer-assisted evaluations, where before the provider's policy was 'don't ask, don't tell.'" Many teens have said that they prefer the computer because "it is easier than divulging directly to a doctor or nurse."

To assure that teens could identify with the software, both TC and YHP directly involved adolescents to help design the programs. TC used 200 teenagers from Berkeley and Oakland, California to help with the program's content and style. YHP developers used a review panel of teenagers for assessment and multimedia content. Parents and teachers were also involved in the design process.

One potential drawback to utilizing CD-ROM health-risk assessment software is the need for private space for adolescents to perform the assessments. Time limitations in a clinic may also restrict the program to only the highest priority topics.

Before implementing a computerized assessment, it is important to consider how confidentiality will be protected and whether any of the questions might trigger the need for legal intervention, such as filing a mandatory child abuse report. Adolescents should receive clear information about how their answers to the computerized screening tool could be used.



Benefits & the bottom line

- With the YHP, significantly more health risk factors were identified and more anticipatory guidance delivered than with traditional medical visits.
- Adolescent satisfaction with YHP was high. Seventy-one percent liked the CD-ROM-assisted GAPS assessment, while only 3 percent did not. Ninety-two percent felt that the 45-minute (on average, 20-25 minutes with the computer and 20-25 minutes with providers) visit was of a reasonable length.
- In various pilot tests, the YHP research team estimated the net cost per CD-ROM-assisted GAPS assessment between $15-$25 per visit (versus $70 for a typical physician visit).[84]
- The YHP allows Kaiser Permanente's Hawaii division to see twice as many adolescents for consultations in the time it previously took—nearly the entire first half-hour of the consult is bypassed when the computer program is used.
- Similarly, 250 adolescents who used the Teen Challenge CD-ROM health screening tool reported positive feedback:
  - 93 percent found it useful;
  - 84 percent said they would recommend the program to friends;
  - 56 percent said they learned something about themselves and 63 percent said they would make changes as a result of the program;
  - 91 percent said they answered questions truthfully all of the time; and
  - 52 percent said they would have felt less comfortable answering the questions if a health professional had asked them in person.
- Another advantage of the computer-assisted visit is that it can be conducted in alternative sites such as schools. In a YHP pilot study, adolescents preferred the alternative sites over traditional medical settings (60% vs. 2%).

A mobile team of two educators and one nurse with a clerical aide were used in the YHP study.

Strategy 6 Protect the confidentiality of teen members

Confidentiality is one of the most essential and at the same time complex aspects of adolescent health care. It affects how a health plan structures the systems and protocols used to manage the delivery of care, as well as what happens during the care experience. If health plans fail to implement effective confidentiality protections, they risk seriously undermining adolescents' access to care. Yet, at the same time, finding positive, supportive, productive ways to involve parents and teens together in health care decision-making could certainly benefit many adolescents.

Teens place a very high value on confidentiality. One study found that one in four teens would forego care if their parents might find out.[85] Youth want to prevent rumors and embarrassment, avoid retribution from potentially punitive parents and find ways to solve their own problems.[86] In a poll of urban African American youth aged 12 to 18, 71 percent of the boys and 85 percent of the girls (of those who were sexually experienced) said that "it is extremely [to very] important that a clinic promises that no one will find out about the visit."[87]

The risk that their parents may learn about their health care visit creates a particularly significant barrier to care. More than half of boys and more than two-thirds of girls in the survey cited above said that "it is extremely [to very] important that clinics not make you tell your parents about the visit."[88] Another survey found that the most common reason for adolescents to miss receiving needed care was not wanting a parent to know (35%).[89] A third survey found that if parental knowledge of the visit were required, 81 percent of teenagers said they would not seek care for birth control, 83 percent said they not would seek care for drug use and 55 percent would not seek care for depression.[90]

Recognizing the importance of keeping medical information private, a variety of state and federal laws, constitutional provisions and court decisions protect the confidentiality of most medical information.[91] Under most circumstances, a health care provider may not release or discuss confidential medical information about a patient or client without written consent.[92] In addition, all states have statutes that protect adolescents' access to confidential health services by authorizing minors to consent to some of their own care.[93] Generally, when adolescents are legally authorized to consent for care, their permission should also be obtained for disclosure of information related to that care.[94]

Many providers of adolescent health care, however, may need to be more aware and respectful of adolescents' confidentiality needs and rights. A survey of 93 gynecologists revealed that they "did not have a clear understanding of the laws related to teens and confidentiality."[95]

To protect the confidentiality of their teen members, plans can implement several strategies, including: 1) ensuring that every plan information system protects teens' confidentiality; 2) training all health plan providers and staff members about confidentiality measures; 3) providing all teen members opportunities to meet with their providers in private; and 4) educating teens about their confidentiality rights.

1. Plans must ensure that each of their information systems—including procedures for handling medical charts and records, billing and appointment notification systems and electronic files—protects adolescent confidentiality. System-wide protections are critical because other plan priorities, such as documenting medical encounters, can jeopardize teen members' confidentiality.[96] Plans, for example, should take steps to prevent confidentiality breaches such as sending an appointment reminder

or satisfaction survey to a teen's home after a confidential visit, or releasing to parents copayment data that reveal, for example, their teen daughter's confidential visit to obtain birth control.

2. Plans should train not only providers but all health plan staff members who interact with teens about confidentiality laws and plan procedures that protect confidentiality. Employees who respond to member phone calls, for example, must realize that youth have special confidentiality concerns and rights. If health care workers clearly understand confidentiality laws and health plan protocols, they can properly communicate these rights to the adolescent.

3. Whether an adolescent comes alone to a health care provider, or is accompanied by a parent, it is important that at least a part of the encounter include an opportunity for the young person to speak privately with the provider. In one study, most adolescents (80 to 90 percent) said they would find it at least a little helpful to talk privately with a physician about various sexual matters, including fifty-eight percent who said they would find it very helpful to have a private discussion about avoiding AIDS, but only 39 percent had the opportunity to do so.[97]

Youth may not be willing to discuss sensitive health issues with their provider if a parent or other caretaker is present.[98] In a small study of adolescent substance abusers who had seen a physician during the previous year, almost half of the adolescents denied using of drugs when asked by their clinician, predominantly because a parent was present during the discussion.[99]

Many plans, however, do not ensure teens have the chance to meet with their provider in private. A national survey reported that among adolescents who used care, only 58 percent had the opportunity to talk privately with their health professional.[100] Another survey of Texas physicians found that half saw their adolescent patients with parents in the room, prohibiting any opportunity for privacy.[101]

Plans should implement concrete measures to help ensure teens can see providers privately. For example, plans can issue adolescents their own health plan member cards which enable them to go directly to health plan doctors and clinics for care, without the need to have parents make or authorize appointments. Plans also can educate parents about the importance of making sure their teens have the chance to see a provider on their own. In addition, plans can encourage providers to spend some time alone with teens at each visit.

4. Plans should make sure their teen members fully understand their confidentiality rights and how the plan will protect those rights. Research suggests that the more adolescents know about confidentiality protections, the more trust they place in physicians.[102] Plan providers can give adolescents a reader-friendly pamphlet describing confidentiality rules and plan protections at the start of each visit. In addition, plans can send letters to newly enrolled teens explaining services and addressing teens' questions about privacy, confidentiality and sensitive health topics. Plans also can mail similar newsletters to adolescent members on a continuing basis.

■ Spotlight: A multidisciplinary adolescent confidentiality workgroup

—Kaiser Permanente, Northern California

The Regional Health Education Department of Kaiser Permanente's Northern California region convened a multidisciplinary adolescent confidentiality work group in 1998. Work group members came from many departments: the region's Call Center (which schedules appointments and responds to general member questions), health education, medical records, quality and utilization, adolescent clinics and pediatrics. Community groups, such as academic institutions and children's advocacy groups, were also involved. The work group categorized confidentiality concerns as issues associated with training, charting, operational differences among the health plans' different facilities, and other items. The group identified two priority areas: (1) confidential coding of appointment records for adolescents who make their own appointments and (2) protecting confidential health information in medical records.

Within each priority area, the group documented current policies and systems, identified in-progress efforts to address the concerns and developed next steps. The group also created subcommittees to examine issues in more depth and present recommendations to a variety of Kaiser Permanente decision-making bodies. One subcommittee, for example, identified action steps to ensure that all adolescents who make an appointment (either by phone or in person) are asked if they would like their appointment labeled confidential. This prevents appointment reminders and follow-up materials from being sent to their home. These recommendations were accepted and are currently being implemented throughout Kaiser Permanente's Northern California region.

Strategy 7 Provide services through specialized adolescent health care centers

Provider centers that specialize in adolescent health can tailor their services and programs to the unique needs of adolescents. Research has found that such specialized centers can achieve better patient participation and health outcomes. One study compared adolescent health outcomes from comprehensive, interdisciplinary adolescent-centered prenatal clinics to those from "traditional" adult-centered obstetric service. They found that adolescent clinic clients missed fewer appointments (0.96 vs. 2.29), were more likely to have vaginal deliveries (90 vs. 75 percent), had higher birthweight infants (3330g vs. 3084g) and were more likely to attend six-week postpartum exams.[103]

For some youth, having access to a school-based or school-linked site, freestanding adolescent clinic or other alternative service location can increase the likelihood that they will receive care.[104] Specialized adolescent centers can offer services at locations and times that are convenient for teens. This is a critical benefit because simply getting to a clinic or doctor's office can be an overwhelming problem for teens. Many adolescents do not have ready access to transportation, and their school schedule may preclude appointments during the morning and early afternoon. In one survey of 10th graders regarding seeking treatment for a sexually transmitted disease:

- nearly 25 percent thought transportation would be a problem;
- sixty percent said they would not know where to go for treatment; and
- fifty-six percent did not want their parents to know about their visit (and were therefore unlikely to ask for a parent's assistance in getting to a clinic).[105]

In addition, youth often need assurance that their anonymity (knowledge about the visit from their friends, parents or both) will be preserved, especially when seeking services for sensitive issues such as STDs, drug use and depression. (See Strategy 6.) A teen health center can place a special emphasis on educating its clients about their confidentiality rights. Teens also may feel they are less likely to run into a parent or family friend at a teen clinic.

In addition to addressing transportation and scheduling issues and confidentiality concerns, adolescent centers often can focus on other issues of particular importance to teens, including:

- enhanced coordination of care (see Spotlight on page 29);
- longer appointment times (see page 31);
- greater emphasis on follow-up (see Spotlight on page 28); and
- routine parent education about the importance of assuring teens their care will be kept confidential (see Spotlight on page 28).

Many specialized teen health centers are in school-based health clinics. From 1991 to 1998, the number of SBHCs in the US more than tripled from 327 to 1,157, with 37 percent housed in high schools.[106] A national survey of SBHCs found that approximately one in four had a relationship with a MCO, such as serving as a full primary care provider, specialty provider or co-managers of primary care.[107] The types of financial arrangements within these relationships vary.

Research indicates that teens in managed care plans with access to SBHCs enjoy better access to care. In a study[108] of adolescents in managed care plans that compared teens who had access to SBHCs with peers who did not, researchers made the findings below:

- Adolescents with SBHC access had 38 to 55 percent fewer emergency room or urgent care visits than students without SBHC access.
- Adolescents with access to SBHCs were more than ten times more likely than their insured peers without such access to make a mental health or substance abuse visit and 98 percent of these visits occurred at SBHCs.
- Eighty percent of adolescents with access to SBHCs had at least one comprehensive visit versus 69 percent of comparable adolescents without SBHC access. In addition, adolescents with SBHC access were screened for high-risk behaviors at a higher rate.

However, some adolescents believe that the ideal health care center should not be located in a school.[109] One survey found that nearly 70 percent of adolescents would not want their friends to know about certain health concerns[110]—a level of anonymity that SBHCs might find difficult to promise.[111] Also, school-based clinics, when available, are typically located in traditional schools. For high-risk adolescents in alternative schools or not in school at all, school-based clinics may have little relevancy.

Plans may be able to offer the benefits of SBHCs cited above through alternative locations, such as freestanding community-health clinics and adolescent health clinics affiliated with a MCO or other types of partnerships between health plans and schools. Community-based services, such as family-planning clinics and other settings, may also be valuable resources with which health plans can foster effective partnerships.

■ Spotlight: An HMO with freestanding teen health centers

—Kaiser Permanente

In 1955, Kaiser Permanente opened one of the first teen clinics in the country in San Francisco. Currently, the health plan operates more than 20 adolescent health clinics and plans to open more in the future.

In 1986, The Teen and Young Adult Health Care Center of the Panorama City Kaiser Permanente Medical Center (Teen Center) opened in response to the special challenges that exist in providing comprehensive, effective and efficient health care to adolescents. Kaiser Permanente believed that prompt intervention through a constellation of services—including those related to sexuality, reproduction, violent behavior, and emotional and mental health—could prevent serious and costly health consequences, both in terms of dollars and lives.

The Teen Center strives to create an environment that encourages adolescents to seek and accept care, and, as teens get older, assume responsibility for their own health. Facilities, services and staff have all been designed to provide accessible, confidential, comfortable and comprehensive health services. To provide a teen-friendly atmosphere, facilities are separated from general pediatrics and adult medicine and feature youth-oriented art, educational posters and décor. Health education materials that focus on sexuality, drugs, violence and other adolescent concerns are readily available. The Teen Center is staffed by a multidisciplinary team of health care providers that includes physicians specializing in adolescent medicine, nurses with special interest in teens, a health educator and a social worker.

The center also maintains a collaborative program with obstetrics/gynecology (called the Teen OB Clinic) designed to meet the needs of pregnant adolescents. This relationship facilitates medical, educational and psychological services to support pregnant adolescents and helps promote the birth of healthy babies. Each pregnant teen has an appointment at the Teen OB Clinic every two weeks. At one month post-partum, the teen mother receives her final OB examination and also discusses birth control options with a health educator from the Teen Center. The health educator helps the mom schedule a three month follow-up appointment at the Teen Center. If the member fails to keep her appointment, Kaiser Permanente staff promptly follows up with her. The same vigorous tracking of patients is used for adolescents who fail to come to the Teen OB Clinic for their next Depo-Provera injection.

The Teen Center has also developed policies to communicate to parents the importance of private discussions between health care professionals and adolescents. If a parent accompanies a teen to a visit, the parent is given educational materials about the teen clinic, adolescent confidentiality and adolescent health issues. When the teen is called to see a provider, the parent is asked to wait outside. Parents are welcome to speak with a Teen Center physician, social worker or counselor after their teenager's visit.

Benefits & the bottom line

- In a study of pregnant teenagers, Teen Center adolescent members made fewer after hours and urgent care visits and had fewer hospital admissions than similar patients receiving care at traditional facilities.[113]
- Teen Center members were more willing to discuss sensitive issues with their health care providers, compared to teen patients receiving care at other centers.[114]
- A Kaiser Permanente survey completed by more than 2,700 teen and young adult members found that Teen Center patients were significantly more satisfied with their physicians and other providers, the quality of their medical care, and their access to care than were teen patients receiving care at other centers.[115]

■ Spotlight: An MCO contracting and working with school-based health centers

—HealthPartners, Minnesota

HealthPartners is a 800,000-member, consumer governed nonprofit health plan organization, which includes health plans, an integrated health care delivery system of clinics and a hospital and research and medical education programs. HealthPartners has a primary care contractual relationship with Health Start, a nonprofit organization that operates health and social service programs, including school-based health clinics. Health Start delivers primary care services to HealthPartners' adolescent members in state public programs (Medicaid and MinnesotaCare) who choose to use the school-based health centers for care. HealthPartners is also exploring the feasibility of expanding to commercial products through a relationship with a community clinic network. This partnership helps coordinate the care received by adolescents. For example, if an enrollee (student) is seen in the SBHC for an injury, the SBHC sends a copy of the encounter form to the student's HealthPartners clinic. The center also bills HealthPartners, which then reimburses the SBHC for the service.

For confidential or other sensitive-service visits, encounter information is not routinely forwarded from the SBHC, unless a referral for further care is needed from HealthPartners. Centers still get reimbursed for confidential and other sensitive service visits when they bill for them. At the health plan level, all bills for these services are treated as confidential: no statements of service are mailed to the member or member's family.

HealthPartners credits the communication structure between the plan's clinics and the SBHC for creating shared accountability for the student's health care. Other success factors include:

- a single administrative agency (Health Start) linking multiple SBHCs to HealthPartners;
- SBHC ability to meet health plan credentialing and quality standards;
- willingness of the SBHCs to identify the health plan and appropriate clinic or specialist for referrals;
- direct participation of HealthPartners Medical Group physicians in the SBHCs;
- Health Start's relationships with the local HealthPartners' hospital (Regions Hospital) for all members' referrals; and
- high student user and parent satisfaction with SBHC services.

Overcoming

Ensuring adolescents' access to health care services means more than just providing them with health insurance. In addition, it is essential for health plans and health care providers to examine their systems from an adolescent's perspective for barriers that may exist—and develop policies to overcome them. Three common barriers, and possible solutions, are described below.

Barrier 1: Co-payment

Some adolescents who cannot afford pharmacy and office visit co-payments may be unwilling to turn to their parents for help, particularly if they are seeking care for a sexually transmitted disease, pregnancy, depression, drug use or other sensitive health concern. Thus, for these teens, their managed care plan's co-payment policy prevents them from accessing the health care they need.

In the case of adolescents seeking contraception, research suggests that co-payment requirements not only adversely affect the teen, but also may not make sound financial sense for health plans. An actuarial study found it to be cost-effective for health plans to provide all FDA-approved contraceptives to members without charge. For example, based on the cost of oral contraceptives, their failure rate and the cost of pregnancy outcomes, researchers concluded that providing five years of free oral contraceptives to a woman (who would otherwise not use any birth control method) would theoretically save $12,879 and prevent 4.1 pregnancies. The study

Barriers to Providing Health Care to Adolescents

included similar findings for other birth control methods, suggesting that health plans should consider eliminating co-payments at least for contraception for adolescents.

Barrier 2: Inadequate communication about the value of preventive care

Adolescents and their families may not recognize the value of preventive care, be aware of special health plan services for teenagers or be aware of health plan policies (such as confidentiality) that are in place. Without this information, teens may not access the preventive care they need. Several health plans have taken steps in response:

- **Reminders to parents.** Blue Cross and Blue Shield of Maine sends parents of adolescents ages 11 to 13 a reminder about the importance of immunizations, along with biannual preventive care guideline recommendations. These steps contributed to the health plan's recent second-place score in the country on adolescent immunization rates, with over 95 percent immunized.
- **Reminders to clinicians.** Humana Inc. instituted an adolescent immunization reminder system. In addition to sending reminders to parents, the plan provides physicians with a list of their current adolescent patients who need to be immunized.
- **Web site for teens.** Group Health Cooperative of Puget Sound's Web site has a special section for adolescents. One page within the site responds to commonly asked questions by youth, such as: "Can I choose my own doctor?", "Can I see my doctor by myself?" and "How do I make an appointment?" The site also provides a list of health resources tailored to adolescents.

Barrier 3: Clinician reimbursement rates that fail to reflect the time teens need

In capitated systems, clinicians are paid a set amount per month regardless of the cost of the services a patient receives during that time and clinicians operating in a fee-for-service system are paid, in part, per well-care visit no matter how long that visit is. But, adequate time is an essential component of an adolescent-friendly health care system: adequate time to gain adolescents' trust, discuss their current participation in risk behaviors and agree upon healthier options. Researchers estimate that it would take 30 to 45 minutes to conduct an initial medical appointment with a low-risk teenager; that amount increases with higher-risk patients. But, in place of that single appointment, the clinician might be able to treat several non-adolescent patients or might see several teenagers, just not in accordance with practice guidelines.

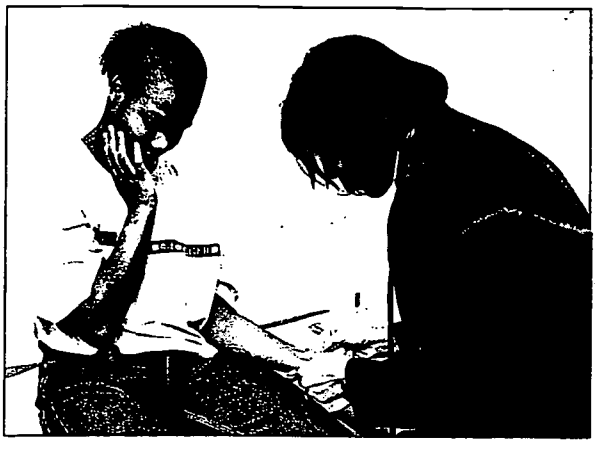
Recognizing the link between payment and clinical practice, Blue Cross and Blue Shield of Maine changed its reimbursement of physicians who see adolescents. "When we looked at the way we were paying physicians, we found that there was no compelling financial reason for them to work harder at getting adolescent patients in the office. So we increased the capitation rate for two age groups, kids ages 7 to 12 and from 12 to 18," says Meredith Tipton, PhD, director of health improvement. "Adolescents are low utilizers of the healthcare system. We now pay physicians more equitably to take care of a population that doesn't need a lot of tests, but needs time to be spoken to and seen in the office. The bottom line is that we wanted our teens to be seen more often."

Engage Teens, Parents and Community Resources in Improving Adolescent Health

Families, schools and communities all have an impact on adolescent health. Some may already have carved a special niche for themselves: perhaps a school has instituted an anti-smoking campaign that has secured the help of local businesses or a group of families may have organized a drug- and alcohol-free party for high schoolers. Others may not have directly worked on a health-related issue, but have a rich and positive history of engaging local youth.

By developing collaborations with parents and community resources, managed care organizations can magnify the impact of their internal efforts to promote adolescent health. Joint projects are never simple, but the examples in this section testify to their potential for powerful results.

When initiating any project, it is essential to remember that the true experts on adolescent health are adolescents themselves. When offered a sincere opportunity, teens can become effective partners in the development and implementation of health care services that are accessible and effective.



Strategy 8 Include adolescents in quality improvement initiatives

Initiatives to improve the quality of adolescent health care services benefit from broad-based involvement. For example, including the range of clinicians and administrators involved in the day-to-day care of adolescent members—pediatricians, adolescent specialists, family practitioners, obstetricians, dermatologists, health educators, mental health providers and others—can offer quality improvement programs technical expertise and help secure widespread support. Parents can also add valuable input about the community's expectations for the health plan. But it is perhaps most important that quality improvement activities include adolescents themselves.

As demonstrated throughout this report, adolescents' concerns about the health care system and health care issues differ substantially from those of younger children or adults. It is also important to remember that adolescents are not a homogenous population; making assumptions about their experiences, values and perspectives may lead to mistaken priorities and unhelpful programs.

The Mount Sinai Adolescent Health Center in New York City, for example, has found it useful to include teens in policymaking, program design, the development of written materials and as waiting room-based Peer Health Educators. From these experiences, the center's director, Dr. Angela Diaz, has realized that "the general health care approach has been to fit teens into a system designed for and by adults. When this approach doesn't work, we end up blaming the teens themselves. When health systems involve teens in the design, maintenance, execution and evaluation of programs, everything works much better."[123]

Certainly, including adolescents in quality improvement initiatives brings special challenges. Few teenagers have ever been asked for their input about

their experiences with health care or other community institutions and may not know "where to start." They may need basic information about the health plan and how it works. Above all, adolescents will need proof that their opinions are valued and that they can expect their participation to make a difference.

One quality improvement activity that would benefit from adolescent involvement is the creation of a common set of principles about how adolescents should experience the health care system. The principles, sometimes known as a Youth Health Bill of Rights, can be used to inform adolescents, their parents and clinicians alike of the health plan's expectations and priorities for adolescent health care. The following version of a Youth Health Bill of Rights was originally developed by the California Adolescent Wellness Collaborative[124] in conjunction with Children Now and amended with suggestions from focus groups of adolescents.

■ Spotlight: The need for information: a survey of adolescent members and adolescent providers

—Kaiser Permanente, Hawaii

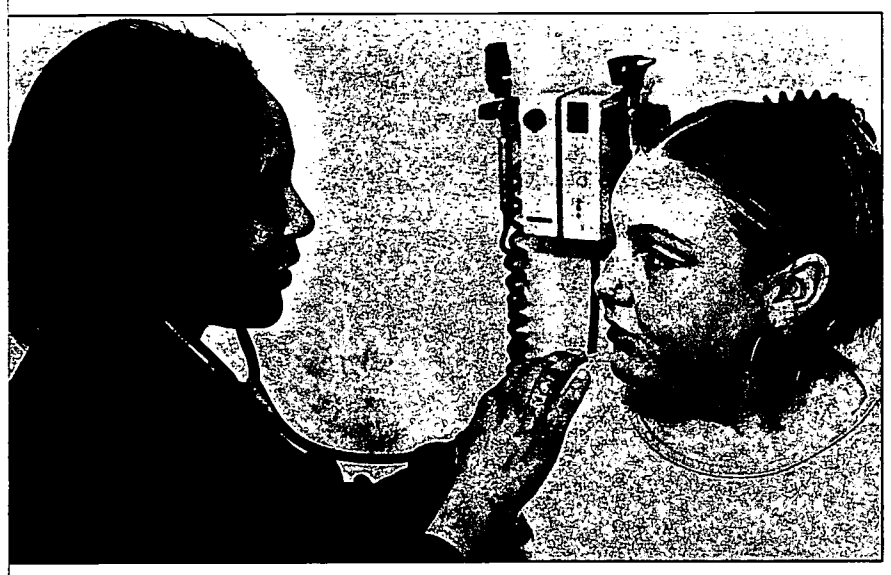
As part of an overall effort to increase health risk prevention services for adolescents, the Kaiser Permanente Hawaii Division surveyed 1,000 young adult members from 14 to 21 years of age; around 750 of the mailed surveys were returned. The Division learned that their youth members wanted information and services related to birth control, safe sex, pregnancy testing, newborn care, and drug and alcohol counseling. According to the adolescents, barriers to care included transportation problems, no time to come in, fear of parents finding out about their medical visits, not knowing where to go, cost and not liking doctors/hospitals. This information was used by the Division to help develop a comprehensive and regional adolescent and young adult preventive services program.

Sample Youth Health Bill of Rights

As a youth interacting with the "Acme" health care system, I have the right:

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

Developed by the California Adolescent Wellness Collaborative. Contact Robert Bates, MD. Adolescent Health Coordinator, 916-657-3069 or rbates@hw1.cahwnet.gov.



■ Spotlight: A health plan's teen advisory council

—Tufts Health Plan

Nicole Dray is only 16 years old, but has the full attention of the pediatricians at Tufts Health Plan in Waltham, Massachusetts—a fact that amazes the high school junior. Ms. Dray is one of 30 adolescents who take part in a Tufts Health Plan advisory committee called the Teen Council. Launched in 1997, the Council is a way for the plan to seek advice on delivering health care to teens from the teens themselves.[125]

Council members come from local high schools and live within a 10-mile radius of the plan. In recognition of their important role, they receive a $30 stipend for each Saturday they participate. The Council meets for three hours on six Saturdays during the year.

During the Council's first year, the teens developed a survey to assess adolescents' satisfaction with the health care system. Only half of the 450 young people who completed the survey felt satisfied or very satisfied with their health care. When Tufts Health Plan read these results, they challenged the Teen Council to help them find ways to improve the plan's services for adolescents.

During the 1997/98 school year, the Council worked with Tufts Health Plan to develop an educational program for physicians and office staff about improving communication with teens. "Our goal is to improve communication between adolescents and health care professionals," says Ms. Dray. "For example, if a doctor doesn't understand the importance of confidentiality, doesn't show respect for adolescents or treats young people like little children, a teen isn't going to tell a physician anything about potential risky behavior or sex. In those situations, the teen just wants the visit to end as soon as possible."

To show providers how to make teens feel more comfortable in health care settings, the teens created humorous skits that portrayed their ideal and worst-case doctor's office visits. After successfully piloting the skits, the Council performed them for physicians and other providers at an evening CME-accredited program. "The skits served as the catalyst for the ensuing discussion on how providers can better work with teens in their office," explained Dr. Michael McKenzie, then the Medical Director of Pediatrics.

During the 1999-2000 school year, the Teen Council will help develop a teen-specific section of the plan's web site that explains issues such as confidentiality and suggests topics that teenagers could discuss with clinicians. "I used to think that I could only talk with a doctor about being sick," says Ms. Dray. "From my work with the Council and talking with physicians, I now know that I could go to a doctor and talk about so much more if I wanted to—like issues related to sex or drugs. It's really important that other teens know this too."

"The Teen Council has helped us see that teens can be very sophisticated and intelligent users of health care when they know what's there for them," says Dr. McKenzie. Dray's experience echoes Dr. McKenzie's comments: "We acknowledge that doctors are busy and may not be able to spend a lot of time with teens," she said. "We're saying that doctors should

find ways and use techniques to make this time as productive as possible. It's rewarding to talk with physicians outside of their office and realize that you have helped them learn new communication techniques. Better communication can save lives."

Strategy 9 Help parents and other caring adults learn how to support adolescents' health and well-being

Popular belief contends that adolescents never listen to their parents nor will even allow their parents to influence them. However, research presents a different picture of parent-teen relationships. For example, one study found that adolescents who feel that their parents show an interest in their activities are less likely to drink alcohol, smoke marijuana and use tobacco.[126] Another survey asked fifth through twelfth graders to identify their most-used source of information about health. For 66 percent of boys and 50 percent of girls the answer was their parents.[127]

However, studies consistently show that parents may not understand teen health issues well enough to provide appropriate guidance and support. Specifically, many parents are unaware of the true health risks their teenagers face. One study of middle school students, for example, found significant differences between adults' perceptions and adolescents' self-reported experiences of carrying a weapon to school; using LSD, cocaine, alcohol, tobacco and marijuana; attempting suicide; and having sexual intercourse. For example, students reported rates of alcohol use nearly 10 times higher than estimated by their parents.[128]

In addition, research suggests that many parents do not know enough about one of the most important issues in adolescent health care—adolescents' legal right to confidential health care services. Researchers in Minnesota tested parents' knowledge of state adolescent health laws; the average score was a dismal 19 percent.[129] Given the overwhelming evidence that most adolescents need an assurance of confidentiality before they will seek medical care (see Strategy 6), this issue is especially important for parents to understand and be able to communicate to their children.

Health plans can help parents and other caring adults provide accurate, sensitive guidance to their teenager about health care issues through a range of venues:

- **Written materials for families.** Health plans can mail teen members and their parents information about adolescent confidentiality laws, special services for teenagers and health care issues of particular importance to adolescents.[130] Health plans can also provide parents with written tips about talking with their teenager and pre-teen about sensitive health care issues. Two examples of these materials are the TLC Kit described on page 36 and Children Now's *Talking with Kids about Tough Issues* parent booklet (see www.talkingwithkids.org).

- **Support for clinicians.** Health plans can encourage clinicians to educate parents about their role in promoting their teenagers' health by providing them with a guide to community resources for parents and handouts to distribute to parents.

- **Classes for parents.** Health plans can provide parents with a forum to discuss the challenges of promoting adolescent health and access to health educators, psychologists and others who can provide expert advice. These classes would be most effective if offered at times convenient to working families and sensitive to cultural competency principles.

However, health plans must recognize that not all youth want their parents' advice, and that not all parents will be supportive of their adolescent. Therefore, it is essential for the health care system to have sound policies and protocols that assure that adolescents can—and do—receive the health care services that they need.

■ Spotlight: Encouraging communication between young adolescents and their parents

—Harvard Pilgrim Health Care

Harvard Pilgrim Health Care provided funding for the Harvard Pilgrim HealthCare Foundation to develop and distribute a Talk-Listen-Care (TLC) Kit, which includes a health education book for teens, brochures for parents, pamphlets for parents and teens and a game to encourage communication between young adolescents (ages nine through 12) and parents about sex and sexuality. The TLC Kit was created by pediatricians, health educators and parents.

The creators of the kit knew it needed to be straightforward and non-judgmental in order to be helpful for parents and their younger adolescents. "Many parents recognize the importance of sex education in the home, but often avoid discussing sex with their children. They may not know what to say. They may feel uncomfortable, or they just may not know how to start," says Dr. Susan Pauker, a practicing physician and Executive Director of the Harvard Pilgrim HealthCare Foundation.

The unique component of the kit is a game that adolescents can play with their parents. It provides a structured forum for parents and their children to talk about what they think and know about issues such as AIDS, homosexuality, racism, drugs, X-rated movies, pre-marital sex, pregnancy and masturbation. "Young adolescents who have learned that they can count on their parents for an honest exchange are more likely to approach a parents to help prevent trouble," says Dr. Pauker.[131]

Originally developed in 1986, the TLC Kit has been updated in response to recommendations from parents, educators, physicians and community groups. Since 1994, more than 50,000 TLC kits have been distributed to families, libraries, schools, shelters and health clinics. In a survey, 77 percent of schools and community agencies reported that they distributed the TLC Kits to parents and 90 percent reported that they were "very satisfied" with it.[132] During the Fall of 1999, the Foundation will produce 40,000 copies of the kit's fourth version (20,000 will be in Spanish).

Tips on positively involving parents in the health care of their adolescent

Jeffrey Lindenbaum, MD, FAAP, FSAM, Director of Teen Health Services for Group Health Cooperative of Puget Sound offers the following suggestions for health plans to encourage parental involvement in their adolescent's health care:

- Do your homework. Send an initial pilot mailing about the importance of adolescent health services to a target age group and then follow up with phone interviews to both parents and adolescents. Plans can also conduct focus groups with teens and parents to find out what information they want and what communications approach works best for them. When Group Health Cooperative of Puget Sound contacted families, they found that almost all parents were in favor of the plan providing health-related information outreach to teen members.
- Be proactive. Just before or at the time of a teen's health maintenance visit, send or give parents a letter about some of the issues that are important to discuss, issues that the provider will bring up with their teen and information on confidentiality.
- Be delicate, but be real. Explain that the health plan understands that parents (as well as the plan) want their teens to have the best possible care while they transition to adulthood. Emphasize to the parents that now is a great time for teens to begin learning how to take more responsibility for their health and how to take care of themselves. GHC's work with parents has been made easier by positioning the plan as an ally with both parents and teens.

(For a copy of the letter Group Health Cooperative's Teen Health Services Department sends to parents of teenagers, see Appendix C.)

Strategy 10 Participate in community- based health initiatives

Across the country, communities have launched public health campaigns to enhance adolescents' awareness of their behavioral choices and offer them resources and support to help them make healthy choices. Indeed, many communities' schools, after-school and recreation centers, churches, law enforcement, public health departments and health care organizations have gained extensive experience in promoting healthier decision-making among young people. Managed care organizations can both benefit from and contribute to these efforts by forming partnerships with community-based organizations.

There are certainly a broad range of issues which health plan-community partnerships could target—adolescent pregnancy, mental health, violence prevention, school-related health, youth self-esteem, neighborhood health and safety, hepatitis B immunizations, and tobacco access are just a small sampling.[133] In addition, partnerships may choose to focus on adolescents' access to care and, in particular, teaching adolescents the skills they need to navigate their managed care organization and the array of resources in their community.

Health plans, community-based organizations and public health agencies can offer different strengths to a health promotion effort. For example, health plans may have expertise in population-health quality improvement efforts (such as improving immunization rates), as well as in gathering encounter data to assess the impact of health promotion initiatives. Community-based organizations may have a rich understanding of the cultural competencies needed to serve local residents and a long-standing history of involving youth in the planning and delivery of services. Public health agencies may have technical expertise to conduct needs assessments and deliver services to at-risk populations.

As the case study below indicates, this mix of skills, resources and expertise can together improve adolescent health outcomes. Moreover, helping to make adolescent health initiatives successful can also enable managed care plans to realize important benefits for their organizations. Not only will healthier adolescents need fewer acute health care services, but also, by learning how to use their managed care plan more effectively, adolescents will become better health care consumers in the long term.

■ Spotlight: School Health Innovative Program (SHIP): Integrating school health and managed care in San Diego

The School Health Innovative Program (SHIP) exemplifies how a community-wide partnership between MCOs and schools can develop shared protocols that help improve the health of students who are in school.[134] SHIP involves representatives from schools (whether or not a school-based or school-linked clinic exists), six local MCOs, a local university, the local public health department, community clinics, a local children's hospital and the local chapter of the American Academy of Pediatrics.

SHIP began by recognizing two facts: (1) adolescents do not receive the preventive health care they need and (2) teens are connected to schools for most of the year. The SHIP partners then identified the foremost problem preventing schools and health plans from working together as poor communication. For example, although school-based services directed many adolescents to see their primary care physician (PCP) for a health care issue, the PCP rarely knew that the school had been involved and subsequently did not share information with the school clinician. SHIP placed much effort into bridging this communication gap to ensure that all of the clinicians seeing a student knew about the care he or she was receiving.

SHIP also discovered that only some students knew their doctor's name, and even fewer knew the name of their health plan. The school nurse often knew neither. As a result, the school referred teens to a provider that the school knew, rather than to the adolescent's PCP or health plan. To solve this problem, SHIP health plans provide the schools with electronic lists of each student's plan and provider. "Bridging this information gap via the health plan and school enrollment data matching has proven to be the cornerstone to everything else we've accomplished," says John Fontanesi, Director of the Center for School Problems in the Department of Pediatrics of Kaiser Permanente.

The program employs a half-time health educator and half-time coordinator, and each health plan has established a school health liaison to assist school nurses. The educator distributes SHIP materials to involved medical practices and community clinics.

The materials describe how providers can work with the schools and include lists of schools in the county, their phone numbers and the name of the school nurse or health contact. The coordinator helps manage the SHIP infrastructure. For example, the coordinator arranges bimonthly meetings with the health plans and the schools to discuss the status and future of the collaboration. The coordinator also maintains five SHIP management committees, four addressing key issues—data/confidentiality, evaluation, health plans and mental health—plus a steering committee. Finally, the coordinator serves as a liaison between health plan data personnel and the schools to manage student information and recruit additional partners to SHIP.

To assure strong involvement in SHIP from the schools, district-level staff from the departments of Management Information Systems, Health, and Billing and Contracts participate in SHIP meetings. Each MCO representative is the CEO or medical director. Such high-level involvement helps to assure quick action from the health plans.

SHIP is self-funded by the school district and health plan third-party reimbursement (primarily Medicaid). Annual administrative costs of approximately $50,000 per year pay for the coordinator and health educator.

The hope among SHIP's participating health plans is that the partnership will provide higher quality care through better collaboration. "The SHIP program is successful because it makes sense. When plans, providers and the schools see that we can successfully work together as a team and our young members get the care they need, each organization is much more willing to cooperate," says Dr. Laura Clapper, Regional Medical Director for Health Net. "By sharing information across organizational lines, the plans, providers and schools are able to see what really happens to these kids and to figure out what really works."

SHIP's Five Overriding Principles

SHIP collaborative partners developed and adhere to the five following principles:

1. Each partner recognizes and respects other partners' institutional goals, how they differ from theirs and where they overlap. Health goals for schools are to keep students healthy so they are available to learn optimally and attend school. For health plans and primary care providers, members need to be kept healthy by delivering care in a cost-effective, coordinated and accessible manner.
2. Collaborative activities maintain principles of confidentiality, parent involvement, preventive care, and continuity of care.
3. The project endorses the "medical home" principle as defined by the American Academy of Pediatrics. A student's health plan, or more appropriately the student's designated health provider, is regarded by SHIP participants to be the optimal medical home, not the school.
4. Collaborative agreements have to be replicable to student populations with varying demographic characteristics and applicable to each school in any one district.
5. To be financially sustainable without grant or governmental funding, aside from Medicaid, each agreement needs to make business sense for MCOs, their providers and schools.

For example, several new SHIP protocols seek to help in asthma management:

- School nurses are notified when a student misses more than four days of school in a 30-day period. The nurse follows up to determine if asthma or another health reason led to the absences. This information is provided to the student's health plan and primary care provider.

- School nurses monitor students' asthma self-care skills and report problems to their plan and provider. By providing regular medical management, this protocol is expected to decrease the number of preventable hospitalizations and missed days of school.

Core SHIP Partners:

- American Academy of Pediatrics; District IX, Chapter 3
- Blue Cross
- Community Health Group
- Community Clinics
- Children's Hospital
- Chula Vista Elementary School District
- Health Net
- Kaiser Permanente
- San Diego County (Health and Human Services & HealthLink)
- San Diego Unified School District
- Sharp Health Plan
- Universal Care
- University of California, San Diego; School Health and Community Pediatrics Division

Strategy 11 Support and disseminate research about preventive care for adolescents

The strategies in this report are based on promising practices from managed care plans and research demonstrating the outcomes, cost effectiveness and member satisfaction that result from their implementation. However, there is much left to be learned about promoting the health and well-being of adolescents enrolled in health plans. The following are just some of the topics that warrant research:

- adolescent health care utilization patterns;
- the topics most amenable to and methods most effective for delivering health counseling to at-risk adolescents;
- effective strategies for using partnerships between health plans and community-based organizations to improve adolescent health; and
- cost-benefit analyses of managed care-based interventions to promote adolescent health and well-being.

Managed care organizations can play an important role in advancing the state of knowledge about these issues. Some health plans currently sponsor or participate in research studies and share their results through venues such as the joint American Association of Health Plans and Agency for Health Care Policy & Research "Building Bridges" annual conference. Indeed, as shown below, health plan-sponsored research can have far-reaching effects on improving the quality of care for adolescents throughout the managed care industry.

Other health plans have been involved with the field-testing of the joint FACCT/NCQA project to develop an instrument for measuring the quality of adolescent health care. This work is providing valuable information not only about how to implement this particular quality survey, but also about developing productive collaborations between researchers and the health plan industry.

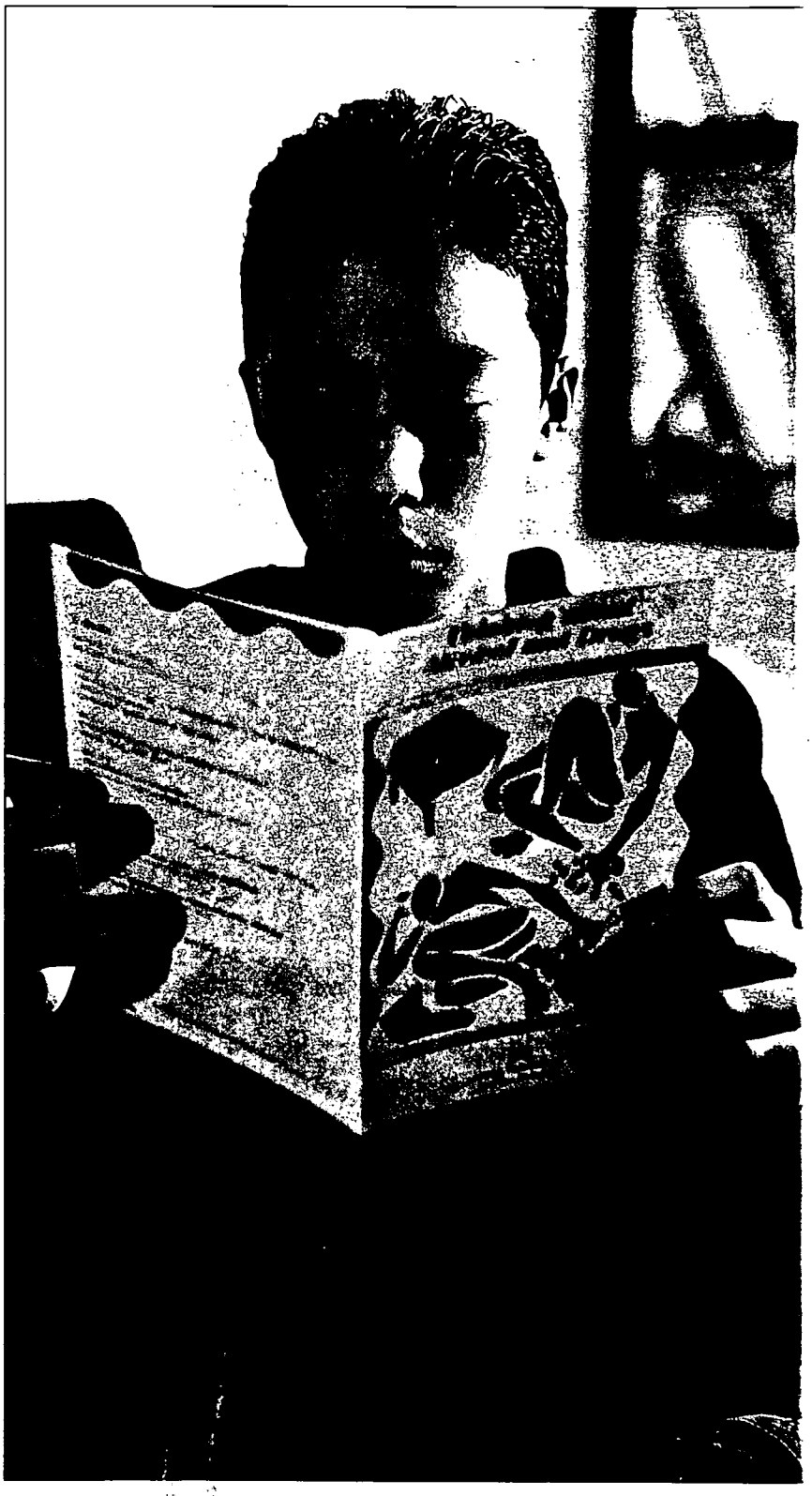
Even health plans that may not have the internal capacity to sponsor research efforts can play an important role. For example, these plans can promote the delivery of evidence-based clinical services, develop and evaluate strategies for disseminating best practices and setting health plan policies based on research findings about co-payments and other factors that influence adolescents' access to care.

■ Spotlight: MCO research helps lead to new Chlamydia HEDIS 2000 measure

—Group Health Cooperative

A 1996 Group Health Cooperative study on the relationship between *Chlamydia trachomatis* and pelvic inflammatory disease (PID) served as a catalyst to include a measure about Chlamydia screening in the Health Plan Employer Data and Information Set (HEDIS).[136] HEDIS, the principal performance measurement tool for managed care, is managed by the National Committee for Quality Assurance (NCQA) and provides a set of standardized measures used to compare health plans.

The Group Health Cooperative of Puget Sound's randomized, controlled study set out to determine if testing for cervical chlamydial infection prevented PID. The study revealed that screening and treating high-risk women (ages 18-34 years) for Chlamydia reduced the risk for PID by more than 50 percent over a 12-month follow-up period. Because Chlamydia displays no symptoms in 70 to 80 percent of infected females and more than 50 percent of infected males, screening is key to detection.[137] The annual financial cost of Chlamydia and its after-effects (PID, ectopic pregnancy, chronic pelvic pain and infertility) in the US amounts to more than $2 billion.[138]



On the day that Group Health Cooperative of Puget Sound's study on Chlamydia was released, the NCQA decision-making body, the Committee of Performance Measurement (CPM), met. "We had been working on a potential measure like this for a long time," says Cathleen Walsh of the CDC. "When the CPM saw this new powerful data and then coupled it with the fact that this work had come out of a managed care setting, the decision to proceed with the Chlamydia measure became much easier."

Now that MCOs will be measured for performing Chlamydia screens for sexually active adolescents ages 15 and older, the next logical area for health plan research on this issue centers on strategies that plans can implement to assure that their adolescent members receive screening. A new study, known as OPTIONS (Outreach Partnership Towards Implementation of Non-Invasive Screening, an Intervention to Enhance Chlamydia Screening in a Managed Care Setting), is aimed at encouraging young women to access screening for Chlamydia in managed care settings. The study, a collaboration between the Centers for Disease Control and Prevention, the National Institute of Health and four MCOs (Health Partners in Philadelphia, Kaiser Permanente's Northern California Division, VIVA Health and Community Care-Health Plus in Birmingham), will test and report on different approaches to raise member awareness of the importance of Chlamydia screening.

conclusion

Partners in Transition

The health of America's teenagers, now and in the future, rests primarily on their behavioral choices. These choices reflect teens' knowledge and attitudes towards health issues, their developmental maturity and the family, school, community and other social contexts in which they live. The choices teens make today can either help prepare them for a healthy adulthood or set the stage for a future riddled with health problems. Moreover, their choices can have an immediate impact on their experience as teenagers—a time of life that should be filled with exploration, learning and growth, but too often seems frightening and dangerous.

This report illustrates some of the ways that managed care organizations can enhance their delivery of care so as to improve the health of their adolescent members. These opportunities include facilitating adolescents' access to health care and engaging teens, parents and community resources in improving adolescent health. Health plans have a tremendous potential to improve the well-being of teenagers, and Children Now hopes that this report will facilitate their engagement in this effort. ■

Appendix A: Managed Care Self-Assessment Tool

National Adolescent Health Information Center

Assuring the Health of Adolescents in Managed Care
A Quality Checklist for Planning and Evaluation Components of Adolescent Health Care

Planning and Evaluating Managed Health Care Components for Adolescents

Components of Adolescent Health Care Delivery

This checklist serves as a tool for planning and evaluating the key components of comprehensive, accessible and coordinated health care for adolescents. It presents six key components, identifies important aspects of each of these components and describes ways these components may be fulfilled. These key components include:

- Access for Adolescents
- Adolescent-Appropriate Quality Services
- Coordination of Services
- Adolescent-Sensitive Authorization and Review Processes
- Coordination with Core Public Health Functions
- Adolescent Participation in the System of Care

Background

With their expanded role in serving the private sector and Medicaid populations, managed care organizations have become essential in assuring the health of adolescents. Comprehensive clinical guidelines developed over the past few years provide managed care organizations with important resources for serving this population. Some managed care organizations are taking this opportunity to systematically plan services that meet the unique health care needs of adolescents.

This checklist was originally prepared by the San Francisco Adolescent and Managed Care Working Group, a group of adolescent health care providers committed to establishing standards of universally accessible health care for adolescent and young adults. The National Adolescent Health Information Center has refined the Working Group's document for use by managed care organizations.

The tool draws upon the American Medical Association's *Guidelines for Adolescent Preventive Services* (GAPS), *Bright Futures*, developed with support form the Maternal and Child Health Bureau and the Health Care Financing Administration, and the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) federal requirements.

Ways Managed Care Organizations Can Use This Document

A managed care organization can use this checklist to review current practices and to develop procedures designed to better meet the needs of adolescents. Although an internal review process by managed care organizations can help gauge the existing level of adolescent health care services, involving providers, public health personnel, and community participants can further enhance the process. Users of this checklist are encouraged to evaluate the six key components in relation to their settings to help establish their own priorities.

Next Steps for Managed Care Organizations

There are many possible ways to use this tool.

- A group of providers, subscribers, adolescent health leaders, and staff can be convened to use this checklist to assess the managed care organization's planning and performance regarding adolescents. This group can identify strengths and areas for improvement in the managed care organization's services to adolescents.
- The managed care organization can designate staff and/or providers to develop expertise and take leadership roles in developing adolescent health care services.
- The managed care organization can seek outside consultants to evaluate service delivery and program planning regarding these components.
- The managed care organization can survey providers about their interests and skills in serving adolescents. Identified providers can be designated as "adolescent-oriented" providers in marketing materials.
- This checklist can be used over time to assess changes in the managed care organization's responsiveness to adolescent health needs.

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

Instructions for Evaluating Your Organization

Following each item is a scale for evaluating the degree the managed care plan fulfills this aspect for adolescents:

None				Complete
1	2	3	4	5
☐	☐	☐	☐	☐

1 No current provision in the plan for this component.
2 Some limited provision of this component in the plan, but not adolescent-specific.
3 Some limited provision of this component in the plan, specifically tailored for adolescents.
4 Fairly complete provisions of this component in the plan, either through general provisions or adolescent-specific services.
5 Comprehensive inclusion of this component in the plan, specifically designed for adolescents

(Note: *EPSDT in the text below indicates Early and Periodic Screening, Diagnosis and Treatment standard.)

	None 1	2	3	4	Complete 5
A. Access for Adolescents					
1. Institute policies and procedures to assure confidential care including:	❑	❑	❑	❑	❑
a) Establish confidentiality policies regarding family planning and reproductive health services, sexually transmitted disease care, substance abuse treatment, and/or mental health treatment, consistent with state and federal law.	❑	❑	❑	❑	❑
b) Establish policies which allow for adolescents to give informed consent consistent with state guidelines.	❑	❑	❑	❑	❑
c) Establish financial policies and procedures for adolescents to enable access to specified confidential services, consistent with state law:	❑	❑	❑	❑	❑
i. limit deductibles to ensure adolescent affordability.	❑	❑	❑	❑	❑
ii. establish procedures in billing and statement of benefits which ensure confidentiality, consistent with state law.	❑	❑	❑	❑	❑
2. **Enable** access to adolescent-oriented providers:					
a) Clearly identify adolescent providers and services in marketing materials. (see below for adolescent provider designation).	❑	❑	❑	❑	❑
b) Establish mechanisms to assure adolescent choice of provider different and independent from other family members and to inform adolescents and family members of this option.	❑	❑	❑	❑	❑
3 Assist adolescents to reduce barriers to access:					
a) Educate adolescents regarding their rights to confidential health care and the meaning of informed consent.	❑	❑	❑	❑	❑
b) Inform adolescents regarding the laws and policies that apply in their state which allow minors to consent to health care, protect confidentiality, and/or otherwise facilitate adolescents' access to care.	❑	❑	❑	❑	❑
c) Educate adolescents and their families on how to access their plan's services (e.g. enrollment procedures and requirements, disenrollment, information lines).	❑	❑	❑	❑	❑
d) Establish an adolescent hotline to provide information to adolescents on how to most effectively enroll and utilize their health plan.	❑	❑	❑	❑	❑
4. Other adolescent-specific policies or procedures designed to facilitate access. Specify:_____	❑	❑	❑	❑	❑
B. Adolescent-Appropriate Quality Services					
1. Implement guidelines for care:					
a) Regular annual comprehensive preventive health care visits with modifications for setting/location and special populations. Specify which:					
• Bright Futures (Maternal and Child Health Bureau)	❑	❑	❑	❑	❑
• Guidelines for Adolescent Preventive Services/GAPS (AMA)	❑	❑	❑	❑	❑
• Put Prevention into Practice (USPHS/DHHS)	❑	❑	❑	❑	❑
• Other_____	❑	❑	❑	❑	❑
• Our own standards	❑	❑	❑	❑	❑

	None 1	2	3	4	Complete 5
b) If the managed care organization has developed its own standards, does it include protocols for:					
Dental	❑	❑	❑	❑	❑
General health problems	❑	❑	❑	❑	❑
Immunizations	❑	❑	❑	❑	❑
Laboratory assessments	❑	❑	❑	❑	❑
Mental health	❑	❑	❑	❑	❑
Physical exams	❑	❑	❑	❑	❑
Referrals	❑	❑	❑	❑	❑
Reproductive health	❑	❑	❑	❑	❑
Risk-screening	❑	❑	❑	❑	❑
Substance abuse screening	❑	❑	❑	❑	❑
c) Reimbursement or capitation rates to enable sufficient staff time to establish rapport and complete comprehensive preventive health visits.	❑	❑	❑	❑	❑
d) Developmentally appropriate and culturally sensitive health education and guidance for adolescents, parents, and other family members, and partners should be provided by personnel skilled in health education.	❑	❑	❑	❑	❑
e) Criteria for referral for those with complex medical problems.	❑	❑	❑	❑	❑
f) Criteria for referral for those with complex mental health problems.	❑	❑	❑	❑	❑
g) Rehabilitation services including outpatient and residential drug treatment.	❑	❑	❑	❑	❑
2. Clearly identify providers with skills working with adolescents:	❑	❑	❑	❑	❑
a) Encourage self-designation as an adolescent primary health care provider by those who are committed to working with adolescents and who have training and skills in care coordination and in providing primary care in reproductive health, metal health, and substance abuse treatment.	❑	❑	❑	❑	❑
b) Identify Board eligible/certified Adolescent Medicine Specialists to serve as primary care providers, subspecialty consultants, and referral sources for primary care gatekeepers.	❑	❑	❑	❑	❑
3. **Establish a quality improvement process** within each provider group to monitor and improve adolescent access, quality of care, coordination, collaboration, and member participation in planning and evaluation.	❑	❑	❑	❑	❑
4. Establish adolescent health resource mechanisms for consultation on adolescent health issues and problems:					
a) Establish user-friendly and systematic access to subspecialty advice and formal consultation, including mental health and substance abuse treatment.	❑	❑	❑	❑	❑
b) Provide up-to-date resources and reference materials which can be available for clinical use where services are provided.	❑	❑	❑	❑	❑
5. Other adolescent-specific policies and procedures to improve quality of adolescent services. Specify:_____	❑	❑	❑	❑	❑

	None 1	2	3	4	Complete 5
C. Coordination of Services					
1. Establish collaboration mechanisms for information about and referral to providers, organizations, and systems dealing with:					
Developmental disabilities	❑	❑	❑	❑	❑
Education/special education	❑	❑	❑	❑	❑
Foster care	❑	❑	❑	❑	❑
Mental health	❑	❑	❑	❑	❑
Probation	❑	❑	❑	❑	❑
Reproductive health care	❑	❑	❑	❑	❑
School based/liked health centers	❑	❑	❑	❑	❑
Social services	❑	❑	❑	❑	❑
Substance abuse	❑	❑	❑	❑	❑
Temporary Assistance to needy Families/TANF (previously AFDC)	❑	❑	❑	❑	❑
Other special issues (e.g. teen pregnancy/parenthood, HIV/AIDS, violence)	❑	❑	❑	❑	❑
Specify:_____	❑	❑	❑	❑	❑
2. Conduct outreach services to inform adolescents, parents, and adolescent-serving agencies about health plan services to encourage entry to services, appropriate referrals, ready communication, continuity, and commitment to care. *EPSDT	❑	❑	❑	❑	❑
3. Implement case-management systems for high-risk adolescents including activities such as transportation assistance, translation, supportive counseling, home/community visits and brokering of services. Clients to be considered for referrals should include: adolescents with HIV/AIDS, multiple sexually transmitted diseases, and/or complex health risks (e.g. homeless and/or runaway adolescents, adolescents waiting for mental health services). *EPSDT	❑	❑	❑	❑	❑
4. Encourage contractual agreements with established essential community providers (such as school-based health centers, local health agencies, family planning clinics, substance abuse treatment programs) for services such as adolescent-specific outreach, health education, case management.	❑	❑	❑	❑	❑
5. Other adolescent-specific policies and procedures to enhance coordination. Specify:_____	❑	❑	❑	❑	❑
D. Adolescent-Sensitive Authorization and Review Processes					
1. Use reviewers with expertise in adolescent health for establishing prior authorization and utilization policies.	❑	❑	❑	❑	❑
2. Use broad definition of "medical necessity" in authorization and review processes. The EPSDT definition includes screening, preventive, diagnostic, and treatment services necessary to address physical, mental, and developmental problems regardless of etiology. *EPSDT	❑	❑	❑	❑	❑

	None 1	2	3	4	Complete 5
3. Other adolescent-specific means to enhance authorization and review processes. Specify:_____	❑	❑	❑	❑	❑
E. Coordination with Core Public Health Functions					
1. Collaborate with public health agencies and other care providers in adolescent epidemiology and surveillance, in the development of adolescent health outcome measures, in quality assurance and in monitoring access and satisfaction. *EPSDT	❑	❑	❑	❑	❑
2. Provide opportunities for input from adolescents, families, and service delivery providers in the managed care organization's policy-making process.	❑	❑	❑	❑	❑
3 Develop a community planning process which includes adolescents, their families, advocates and providers.	❑	❑	❑	❑	❑
4. Monitor quality using adolescent access, satisfaction, health outcomes, system navigation landmarks, and compliance, as well as other indicators, such as chart reviews.	❑	❑	❑	❑	❑
5. Other adolescent-specific means to enhance core public health functions. Specify:_____	❑	❑	❑	❑	❑
F. Adolescent Participation in the System for Care					
1. Involve adolescents in outreach, orientation, marketing, and peer education.	❑	❑	❑	❑	❑
2 Include adolescents in establishing formal mechanisms for consumer input, including surveys, focus groups, and advisory panels.	❑	❑	❑	❑	❑
3. Provide adequate support for adolescent involvement in planning and evaluation through training, guidance, and mentors.	❑	❑	❑	❑	❑
4. Other adolescents-specific means for enhancing participation. Specify:_____	❑	❑	❑	❑	❑

Appendix B: Clinical Preventive Service Guidelines for Adolescents

Several organizations have developed guidelines for preventive adolescent health services. The content of recommended preventive visits for these guidelines usually includes health education and anticipatory guidance for adolescents and their parents, early detection of disease, and assessment of physical growth and psychosocial development.

American Medical Associations' Guidelines for Adolescent Preventive Services (GAPS)

The American Medical Association, with support from the Centers for Disease Control and Prevention, Division of Adolescent and School Health, developed the *Guidelines for Adolescent Preventive Services (GAPS).*[141] The 1994 guidelines are intended to produce a framework for adolescent preventive services within the clinical setting. The recommendations not only address biomedical risks, but also behavioral, social and emotional issues. GAPS recommends an annual preventive services visit for youth ages 11 through 21. The topics covered by the guidelines include, among others: promoting parents' ability to respond to the health needs of their adolescents; adjustment to puberty and adolescence; safety and injury prevention; physical fitness; healthy dietary habits; healthy psychosexual adjustment; preventing negative health consequences of sexual behavior; use of tobacco products; use and abuse of alcohol and other drugs; severe or recurrent depression and suicide; physical, sexual, and emotional abuse; learning problems; and infectious diseases.

Bright Futures

In 1994, the Maternal and Child Health Bureau and the Medicaid Bureau produced *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.*[142] *Bright Future's* (BF) guidelines for adolescent preventive care recommend annual health supervision screening from age 11 through 21 for uncommon biomedical problems and stress screening and counseling for problem behaviors.

US Preventive Services Task Force's Guide to Clinical Preventive Services

The federal government published clinical guidelines to address the uncertainty among clinicians about preventive services. In 1996, the US Preventive Services Task Force (USPSTF) issued the second edition of its report, *Guide to Clinical Preventive Services,*[143] that contains age-specific recommendations to help practitioners prevent medical disorders and health problems. For ages 11 through 24, the Task Force recommends that clinicians counsel adolescents to reduce health-compromising behaviors. The guide, published after four years of evidentiary study, was commissioned by the Office of Disease Prevention and Health Promotion.

The American Academy of Pediatrics

The American Academy of Pediatrics (AAP) has produced the *Clinician's Handbook of Preventive Services,*[144] recommendations for pediatric preventive care for adolescents ages 11 through 21. AAP also sponsors activities including continuing medical education courses, office-based research, conferences and public education initiatives designed to improve the training and clinical practice of pediatricians who provide care for adolescents.

American Academy of Family Physicians[146]

The American Academy of Family Physicians (AAFP) produced revised recommendations for the content of the periodic health examinations for asymptomatic patients ages 13 through 18 in 1994.[147] AAFPs recommendations are based on clinical practice guidelines developed by the USPSTF and from recommendations from the AAFP Commission on Public Health and Scientific Affairs. Interventions, among others, include screening, counseling, and immunizations.

Appendix C: Group Health Cooperative Parent/Teen Letter

Dear Teen and Parent:

We are pleased that _____ has an appointment for a Preventive Care Visit.

Clinic Name:_____ Date:_____
*Provider:_____ Time:_____a.m./p.m.

We would like to tell both of you a little bit more about this upcoming visit and the important roles you each play. This appointment includes what used to be called a *physical exam* as well as a *sports exam*. At the visit, we discuss topics that impact health such as: nutrition, safety, exercise, sexuality, tobacco, alcohol, and other drugs. We review current and past health conditions as well as family health history. We encourage your family to discuss all of these important health topics at home before or after the visit.

It is important for teens to begin to share in decision-making and responsibility for their own health. Spending time alone with the provider allows teens to learn how to do this in a safe way. Therefore, Group Health providers like to spend some time during this visit alone with the teen. Healthcare providers are reliable adults to turn to for information and privacy makes it easier to discuss health concerns honestly and openly. Most of what is said between a teen and their healthcare provider is private. If you have questions about this please ask.

A Message to Teens
To get ready for you visit, **please fill out the enclosed health questionnaire and bring it with you to your appointment.** Feel free to talk with your provider about any of the issues in the questionnaire or any other concerns you have. It is okay to leave a question blank. Even if you leave a question blank on the form, it's still good to bring it up with your provider during your visit.

A Message to Parents
We invite you to share your concerns and questions with your teen's provider in person (at the start or end of your teen's visit) or in writing (before the visit). We understand that it might be hard for you to not be part of the whole office visit with you teen. Teens (and adults) have an easier time sharing information with their healthcare provider in private. Your support helps your teen begin to take responsibility for their own health. We also ask that you let your child fill out the enclosed questionnaire in private. Remember, we are dedicated to helping your teenager stay healthy and safe.

We look forward to seeing you at your upcoming visit!
If you need to cancel or reschedule this visit please call:_____

Your Healthcare Team

*Provider = the skilled healthcare provider (doctor, nurse practitioner or physician assistant) who will conduct the visit.

Acknowledgments

Children Now extends its deepest thanks to the following individuals for their guidance in the development of this report.

Since the inception of this project in 1996, the Adolescent Health and Managed Care Advisory Committee, listed on the inside cover, generously provided advice and guidance. Their expertise and dedication to youth and families provided a constant source of inspiration.

On March 8, 1999, Children Now assembled a respected group of health care industry leaders in Chicago to help us think strategically about this report from the provider, health plan, consumer and purchaser perspectives. Those individuals marked with a ‡ attended this strategic planning meeting.

*In addition to the advisory committee, Children Now appreciates the help of the following people for generously sharing their expertise and time regarding adolescents and the health care system. Those individuals marked with a * also provided feedback to draft versions of the report.*

Roy Behr
Ellen Frawley [formerly]
Jim Margolis
Elizabeth Riel
Greer, Margolis, Mitchell, Burns & Associates

Becky Belangy
Molly Burchell, MD
* Richard Boise, MD
John Edmiston
* John Fontanesi, PhD
* Pat Forman, MPH
Merula Franzgrote, MD
Daniel Fuster, MD
Scott Gee, MD
Maureen Hanrahan, RN
David Lawrence, MD, MPH
Sharon Levine, MD
Allan Mann
* David Paperny, MD
* Linda Rieder, MPH
Valerie Sheehan, MPH
Diane Strum, MD
Scott Thomas, PhD
Randy Watson, MPH
*‡Charles J. Wibbelsman, MD, FAAP
Kaiser Permanente

*‡Christina Bethell, PhD, MBA, MPH
*‡Colleen Peck, MS
The Foundation for Accountability

Gail Bolan, MD
* Romni Neiman
* Dan Wohlfeiler
State of California, Department of Health Services, STD Control Branch

*‡Claire Brindis, DrPH
Charles E. Irwin, Jr., MD
David Knopf, MSW, MPH, LCSW
Elizabeth Ozer, PhD
* Jane Park
National Adolescent Health Information Center University of California, San Francisco

*‡Lorraine Brown, MSPH
Managed Risk Medical Insurance Board

T. Jann Caison-Sorey, MD
Henry Ford Health System

*‡Craig Carlson, MPH
American Association of Health Plans

Laura Clapper, MD
Mark Finch, MD
Health Net

* Angela Diaz, MD
Mount Sanai Hospital

‡ Charlotte Donnelly-Barry
General Motors

Acknowledgments (continued)

Nicole Dray
Teen Council Member
Tufts Health Plan

Jonathan Ellen, MD
* Laurie Zabin, PhD
Johns Hopkins School of Public Health

*‡Arthur Elster, MD
American Medical Association

*‡Abigail English, JD
Center for Adolescent Health & the Law

* Anita Feins, MD
Kenmore Pediatrics

Martin Fisher, MD
North Shore University Hospital, Society for Adolescent Medicine

Tracy Flanagan, MD
* Gloria Thornton, MA, MFCC
The San Francisco Health Plan

* Missy Fleming, PhD
American Medical Association

Beth Gawronski, RN
Blue Choice/Blue Shield of the Rochester Area

*‡Foster Gesten, MD
Office of Managed Care, State of New York

Marcia Griffith, MPH
Charles Marietta, MS
ZAP Asthma Consortium, Inc.

‡ Karen Hein, MD
William T. Grant Foundation

Sue Hennessy
Kaiser/Group Health

Jim Hill
Hill & Company Communications, Inc.

John Hochheimer
National Committee for Quality Assurance

Susan Holtzman, MD
Kenmore Pediatrics

Priya Kamani, MD
Arnold Milstein, MD, MPH
William M. Mercer, Inc.

Peggy Kennedy
* Mitzi Krockover, MD
Humana, Inc.

* John W. Kulig, MD, MPH
New England Medical Center, Society for Adolescent Medicine

*‡Paul Kurtin, MD
Center for Child Health Outcomes
Children's Hospital and Health Center, San Diego

Jennifer Leischow, MPH
Intergroup of Arizona, Inc.

* Jeffrey Lindenbaum, MD, FAAP, FSAM
* Delia Scholes, DS, PhD
Group Health Cooperative of Puget Sound

Charles Marietta, MS
* Jim Rifenberg
*‡John Santelli, MD, MPH
Cathleen Walsh, DrPH
US Centers for Disease Control and Prevention

*‡Patricia MacTaggart, MBA
Center for Medicaid and State Operations
Health Care Financing Administration

Kim Mandosa
Michael McKenzie, MD
Tufts Health Plan

‡ Jacob Moody, MSW
The California Endowment

* Edie Moore
Society for Adolescent Medicine

* Lawrence Neinstein, MD
USC University Park Health Center, USC School of Medicine, Society for Adolescent Medicine

Acknowledgments (continued)

‡ Ed Neuschler, MPP
National Institute for Health Care Management

Maryann O'Sullivan, JD
The California Healthcare Foundation

Michael Rich, MD, MPH
Children's Hospital, Boston

Dick Ridenour
Rivard, Ridenour & Associates

Jabes Rojas
Harvard Pilgrim HealthCare Foundation

*‡Nancy Ross, PhD
Florida Agency for Health Care Administration

Paul Russell, MD
Dawn Wood, MD, MPH
* Valerie Elvine
Dee Warrington
Blue Cross of California State Sponsored Programs

*‡Janet Shalwitz, MD
Department of Public Health
City and County of San Francisco

‡ Laura Sessions Stepp
(guest speaker at the strategic meeting)
The Washington Post

Felicia Stewart, MD
The Henry J. Kaiser Family Foundation [formerly]

* Howard Taras, MD
University of California, San Diego

Joseph Thompson, MD, MPH
Agency for Health Care Policy and Research / Arkansas Children's Hospital

Steven Tierney, EdD
Health Initiatives for Youth

PJ Watters, MD
Group Health Northwest

Bobbie Wunsch, MBA
Health Care Consulting & Management Services

Walter Zelman, PhD
California Association of Health Plans

In addition, Children Now would like to thank the more than 40 health care professionals affiliated with Kaiser Permanente who participated in structured interviews.

Partners in Transition: Adolescents and Managed Care was researched and written by Michael Burgmaier. Additional writing and editing were done by Patricia Freeman and Jessica Reich. Other reviewers included Amy Dominguez-Arms and Lois Salisbury. Shirin Shoai proofread the report, Cheryl Baggeroer served as an intern for this project over the summers of 1997 and 1998, and Geovanny Fernandez and Heidi Taam provided valuable research and administrative support.

Photography:
Steve Fisch

Design:
Demetrio Roldán and Dennis Johnson

Appendix E: Program Contacts & Other Resources

For more information about the programs highlighted in this report, feel free to contact the following experts:

Endorse and promote regular preventive health visits
Joan Fine, MD
Pioneer Valley Pediatrics
123 Dwight Road
Longmeadows, MA 01106
413-567-1031
jsfine@pol.net

Seize health promotion opportunities
Richard Boise, MD
Kaiser Permanente
Adolescent Medicine
3400 Delta Fair Blvd.
Antioch, CA 94509
925-779-5136
Richard.Boise@kp.org

Ensure access to primary caregivers with skills, experience and interest in adolescent issues
Tracy Flanagan, MD
Medical Director
San Francisco Health Plan
568 Howard Street, 5th Floor
San Francisco, CA 94105
415-547-7818
tracy_flanagan@dph.sf.ca.us

Janet Shalwitz, MD
Convenor
Adolescent Health Working Group
c/o San Francisco Department of Public Health
680 8th Street, Suite 210
San Francisco, CA 94103
415-554-9640
415-554-9647 FAX
janet_shalwitz@dph.sf.ca.us

Encourage the use of multidisciplinary clinical teams
Anita Feins, MD
Kenmore Pediatrics
Harvard Vanguard Medical Associates
133 Brookline Ave.
Boston, MA 02215
617-421-8880

Jeffrey Lindenbaum
Director, Teen Health Services
Group Health Cooperative of Puget Sound
Northgate Medical Center
9800 Fourth Ave, NE
Seattle, WA 98115
206-527-7156
lindje1@ghc.org

Offer comprehensive screening and response for high-risk behaviors
California Medi-Cal
Mary Fermazin, MD, MPA
Chief, Office of Clinical Standards and Quality
Medi-Cal Managed Care Division
California Department of Health Services
714/744 P Street
PO Box 942732
Sacramento, CA 94234-7320
916-653-5297
916-657-2069 FAX

David Paperny, MD
1010 Pensacola Street
Honolulu, HI 96814
David.Paperny@kp.org

Pat Forman, MPH
Kaiser Permanente, California Division
Community and Government Relations
1950 Franklin St, 3rd Floor
Oakland, CA 94612
510-987-3095
510-873-5029 FAX
Pat.Forman@KP.org

Protect the confidentiality of teen members
Linda Rieder, MPH
Kaiser Permanente
Pediatric and Adolescent Preventive Healthcare
Regional Health Education
1950 Franklin Street, 13th Floor
Oakland, CA 94612
510-987-4730
510-873-5079 FAX
linda.rieder@ncal.kaiperm.org

Provide services through specialized adolescent health care centers
Daniel Fuster, MD
Kaiser Permanente
13652 Cantara Street
Panorama City, CA 91402
888-778-5000
818-375-2063 FAX

Charles J. Wibbelsman, MD, FAAP
The Permanente Medical Group, Inc.
Teenage Clinic
2350 Geary Boulevard
San Francisco, CA 94115
415-202-3345
415-202-2665 FAX
Charles.Wibbelsman@kp.org

Donna Zimmerman, BSN, MPH
HealthPartners
Director, Government Programs
8100 34th Avenue South
Minneapolis, MN 55440
612-883-5119
612-883-5180 FAX
donna.j.zimmerman@HealthPartners.com

Scott Aebischer, MPH
HealthPartners
Vice President, Network Management
8100 34th Avenue South
Minneapolis, MN 55440
612-883-5585

Overcoming barriers to providing health care to adolescents

Mitzi Krockover, MD
Vice President, Women's Health
Humana Inc.
500 W. Main Street
Louisville, KY 40202
502-580-1501

Jeffrey Lindenbaum, MD, FAAP, FSAM, see Group Health Cooperative of Puget Sound's Multi-disciplinary Adolescent Consultation Teams

Include adolescents in quality improvement initiatives

Angela Diaz, MD
Vice Chair, Department of Pediatrics
Director, Adolescent Health Center
Box 1005
The Mount Sinai Hospital
320 East 94th Street
New York, NY 10128
212-423-2900
212-423-2920 FAX
angela_diaz@smtplink.mssm.edu

David Paperny, see: Offer comprehensive screening and response for high-risk behaviors

Kim Mandosa
Program Coordinator
Tufts Health Plan
333 Wyman St.
Waltham, MA 02454
781-466-9066
781-466-1003 FAX
Kim_Mandosa@Tufts-Health.com

Help parents and other caring adults learn how to support their adolescent's health and well-being

Ralph Fuccillo or Peter Snyder
Harvard Pilgrim HealthCare Foundation (TLC Kit)
185 Dartmouth Street, Floor 11
Boston, MA 02116
617-859-5030

Participate in community-based health initiatives

Howard Taras, MD
Associate Professor
Medical Consultation to Schools (SHIP)
University of California, San Diego
Division of Community Pediatrics
9500 Gilman Drive, Dept. 0927
La Jolla, CA 92093-0927
619-681-0665
619-681-0666 FAX
htaras@ucsd.edu

Support and disseminate research about preventive care for adolescents

Cathleen Walsh, DrPH
Health Scientist
Division of STD Prevention
Centers for Disease Control and Prevention
1600 Clifton Road, NE, MS E-44
Atlanta, GA 30333
404-639-1829
404-639-8607 FAX
cmw0@cdc.gov

Delia Scholes, DS, PhD
Center for Health Studies
Group Health Cooperative of Puget Sound
1730 Minor Abe, Suite 1600
Seattle, WA 98101
scholes.d@ghc.org

RESOURCES

These organizations, and many others, can also serve as resources regarding adolescent health services in managed care organizations:

Advocates for Youth
1025 Vermont Ave
Suite 200
Washington, DC 20005
202-347-5700
202-347-2263 FAX
info@advocatesforyouth.org
www.advocatesforyouth.org

American Academy of Family Physicians
8880 Ward Parkway
Kansas City, MO 64114
816-333-9700
fp@aafp.org

American Academy of Pediatrics
Division of Adolescent Health
American Academy of Pediatrics
141 Northwest Point Road
PO Box 927
Elk Grove Village, IL 60007
847-228-5005
kidsdocs@aap.org
www.aap.org

American Association of Health Plans
1129 20th Street, NW, Suite 600
Washington, DC 20036
202-778-3200
www.aahp.org

Program Contacts and Other Resources (continued)

American Medical Association
515 N. State Street
Chicago, IL 60610
312-464-5570
gaps@ama-assn.org
www.ama-assn.org/adolhlth/adolhlth.htm
(Adolescent Health On-Line)
www.ama-assn.org

Bright Futures
National Center for Education in Maternal and Child Health
2000 15th Street North Suite 701
Arlington, VA 22201-2617
(703) 524-7802
info@ncemch.org
www.brightfutures.org

Center for Adolescent Health & the Law
211 North Columbia Street
Chapel Hill, NC 27514
919-968-8870
info@adolescenthealthlaw.org
www.adolescenthealthlaw.org

Children's Defense Fund
25 E Street, NM
Washington, DC 20001
202-628-8787
www.cdf.org

Families USA
1334 G street, NW
Washington, DC 20005
202-737-6340
www.familiesusa.org

Family Voices
PO Box 769
Algodones, NM 87001
505-867-2368
www.familyvoices.org

The Foundation for Accountability (FACCT)
Child and Adolescent Health Measurement Initiative (CAHMI)
520 SW Sixth Ave., Suite 700
Portland, OR 97204
503-223-2228
www.facct.org

George Washington Center for Health Policy Research
2021 K Street NW, Suite 800
Washington, DC 20006
202-530-2305

National Adolescent Health Information Center
University of California, San Francisco
Division of Adolescent Medicine
Department of Pediatrics and Institute for Health Policy Studies
1388 Sutter St., Suite 605A
San Francisco, CA 94109
415-502-4856
nahic@itsa.ucsf.edu

National Institute for Health Care Management
1225 19th Street, NW Suite 710
Washington, D.C.
202-296-4426
www.nihcm.org

Pacific Business Group on Health
221 Main Street, Suite 1500
San Francisco, CA 94105
415-281-8660
415-281-0960 FAX

The Society for Adolescent Medicine
1916 NW Copper Oaks Circle
Blue Springs, MO 64015
816-224-8010
socadmed@gvi.net
http://cortex.uchc.edu/~sam/

US Centers for Disease Control and Prevention
John Santelli
Division of Adolescent and School Health
US Centers for Disease Control and Prevention
4770 Buford Highway,
Mailstop K33
Atlanta, GA 30341
770-488-3212
jfs8@cdc.gov

Endnotes

Research Methodology

The strategies presented in this report are by no means the only approaches to delivering adolescent health care services, and Children Now welcomes information about other promising programs.

Children Now developed this report using the following research methods:

- a literature search;
- interviews with health care professionals and administrators;
- interviews with adolescent health care advocates; and
- consultation with Children Now's Managed Care & Adolescent Health Advisory Committee.

[1] Ford CA, Bearman, PS, Moody J. (1999). Foregone Health Care Among Adolescents. *Journal of the American Medical Association.* 282(23):2227-2234.

[2] US Department of Health and Human Services. (1994). Preventing Tobacco Use Among Young People: A Report of the Surgeon General. Atlanta: US Department of Health and Human Services, Public Health Service, US Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.

[3] Kirby, D. (1997). *HIV Prevention Among Adolescents.* http://hivinsite.ucsf.edu/akb/1997/09adol/index.html#E.

[4] Garland, AF and Zigler, E. (1993). Adolescent Suicide Prevention: Current Research and Social Policy Implications. *American Psychologist*, 48(2):169-82.

[5] Raphael, D. (1996). Determinants of Health of North-American Adolescents: Evolving Definitions, Recent Findings and Proposed Research Agenda. *Journal of Adolescent Health.* 19(1):6-16. Brindis, CD. (1993). What It Will Take: Placing Adolescents on the American National Agenda for the 1990s. *Journal of Adolescent Medicine*, 14(7):527-30.

[6] Kipke, MD (ed.). (1999). *Adolescent Development and the Biology of Puberty: Summary of a Workshop on New Research.* Washington, DC: National Academy Press.

[7] Lowry, R et al. (1996). The Effect of Socioeconomic Status on Chronic Disease Risk Behaviors Among US Adolescents. *Journal of the American Medical Association.* 276(10):792-797.

[8] Commonwealth Fund Staff and Commission on Women's Health Staff's Analysis of *The Commonwealth Fund Survey of the Health of Adolescent Girls.* As cited in Meyer, JE, et al. (1999). *Improving the Health of Adolescent Girls: Policy Report of the Commonwealth Fund Commission on Women's Health.* New York, NY: The Commonwealth Fund. Califano, JA and Booth, A. (1998). *Back to School 1998: The CASA National Survey of American Attitudes on Substance Abuse IV: Teens, Teachers and Principals.* New York, NY: The National Center on Addiction and Substance Abuse at Columbia University.

[9] Schoen, C, et al. (1998). *The Health of Adolescent Boys: Commonwealth Fund Survey Findings.* New York, NY: The Commonwealth Fund.

[10] Children Now and Kaiser Permanente. (1995). *Campaign for Children's Health and Safety National Poll.* Oakland, CA: Children Now.

[11] Kipke, M. (ed.) (1999). *Risks and Opportunities: Synthesis of Studies on Adolescence.* Washington, DC: National Academy Press.

[12] Califano, JA and Booth, A. (1998).

[13] Carnegie Council of Adolescent Development. (1995). *Great Transitions: Preparing Adolescents for a New Century.* New York, NY: Carnegie Corporation of New York, page 20.

[14] Schoen, C, et al. (1998).

[15] Maynard, RA, ed. (1996). *Kids Having Kids: A Robin Hood Foundation Special Report on the Costs of Adolescent Childbearing.* New York, NY: Robin Hood Foundation.

[16] Children's Safety Network Economics and Insurance Resource Center. (December, 1997). *Childhood Injury: Cost and Prevention Facts.* Landover, MD: National Public Services Research Institute.

[17] Tablulated by the National Center for Injury Prevention Control using data from the National Vital Statistics System, 1997. Thanks to J. Lee Annest, Ph.D., National Center for Injury Prevention and Control, National Center for Disease Control and Prevention.

[18] Ziv, A, Boulet, J, Slap GB. (1998). Emergency Department Utilization by Adolescents: An Analysis of the 1994 national Hospital Ambulatory Medical Care Survey. *Pediatrics.* 101(6):987-994. Ziv, A, Boulet JR, Slap GB. (1999). Utilization of Physician Offices by Adolescents in the United States. *Pediatrics.* 104(1):35-42.

[19] Gans, JE, et al. (1995). The Cost of Comprehensive Preventive Medical Services for Adolescents. *Archives of Pediatrics and Adolescent Medicine,* 149(11):1226-34. Excluded from this $859 direct medical cost estimate are life-time medical costs associated with the condition, the value of lost workdays, losses due to premature death, medical costs in later years that could be attributed to the condition, and other nonmedical costs related to the condition.

[20] Ozer EM, Brindis, CG et el. (1998). *America's Adolescents: Are They Healthy?* San Francisco, CA: University of California, San Francisco, National Adolescent Health Information Center.

[21] Levitt, L, Lundy, J, and Srinivasan, S. (1998). T*rends and Indicators in the Changing Health Care Marketplace: Chartbook.* Menlo Park: The Henry J. Kaiser Family Foundation.

[22] Health Care Financing Administration. *National Summary of Medicaid Managed Care Programs and Enrollment.* (June 30, 1998). www.hcfa.gov/medicaid/trends98.htm.

[23] Bindman AB, Grumbach K et al. (1998). Selection and Exclusion of Primary Care Physicians by Managed Care Organizations. *Journal of the American Medical Association.* 279(9):675-679.

[24] US Centers for Disease Control and Prevention. (1995). Prevention and Managed Care: Opportunities for Managed Care Organizations, Purchasers of Health Care, and Public Health Agencies. *Morbidity and Mortality Weekly Report,* 44(RR-14):1-12.

[25] EPSDT is designed to improve primary health benefits for children with emphasis on preventive care and has been a part of the federal Medicaid program since its beginning in the late sixties. After a Medicaid review in 1989, Congress moved to increase the services of EPSDT through the Omnibus Budget Reconciliation Act. States must now cover regular and periodic exams for all eligible children under the age of 21. They must also provide any medically necessary services prescribed by the exams, even those not covered in a state's Medicaid plan.

[26] Office of Evaluation and Inspections. (1997). *Medicaid Managed Care and EPSDT.* Chicago: US Department of Health and Human Services, Office of Inspector General.

[27] *ibid.*

[28] Schauffler, HH et al. (1999). Raising the Bar: The Use of Performance Guarantees by the Pacific Business Group on Health. *Health Affairs.* 18(2):134-142.

[29] Klein, JD, et al. (1999). Developing Quality Masures for Adolescent Care: Validity of Adolescents' Self-Reported Receipt of Preventive Services. *HSR: Health Services Research.* 34(1):391-404.

[30] See www.facct.org/CAHMI.

[31] Several other organizations have developed recommendations regarding health care services for adolescents children and their families. See Appendix B.

[32] See discussion in Ziv, A et al. (1999).

[33] *ibid.*

[34] Califano, JA and Booth, A. (1998).

[35] Centers for Disease Control and Prevention. (1998). Youth Risk Behavior Suveillance—United States, 1997. *Morbidity and Mortality Weekly Report.* 47(SS-3):70.

[36] DuRant, RH, et al. (1999). The Relationship Between Early Age of Onset of Initial Substance Use and Engaging in Multiple Health Risk Behaviors Among Young Adolescents. *Archives of Pediatrics and Adolescent Medicine,* 153(3):286-91.

[37] *ibid.*

[38] Adolescence is also a time during which many biologically related diseases (such as diabetes mellitus, thyroid disorders, certain mental disorders and testicular cancer) may develop. This report's focus on behavior-related health concerns is not intended to replace or supercede the importance of clinical attention to physical health issues.

[39] Green, M, ed. (1994). *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.* Alexandria, VA: National Center for Education in Maternal and Child Health. Elster, AB and Kuznets, NJ. (1994). *AMA Guidelines for Adolescent Preventive Services (GAPS).* Baltimore, Maryland: Williams & Wilkins.

[40] Elster, AB. (1998). Comparison of Recommendations for Adolescent Clinical Preventive Services Developed by National Organizations. *Archives of Pediatric and Adolescent Medicine.* 152(2):193-198.

[41] Elster, AB and Kuznets, NJ. (1994), page 2.

[42] Schuster, MA, et al. (1996). Communication Between Adolescents and Physicians About Sexual Behavior and Risk Prevention. *Archives of Pediatric and Adolescent Medicine.* 150(9):906-913.

[43] Steiner, BD and Gest, KL. (1996). Do Adolescents Want to Hear Preventive Counseling Messages in Outpatient Settings? *The Journal of Family Practice,* 43(4):375-81.

[44] National Committee for Quality Assurance. *HEDIS 2000 List of Measures.* http://www.ncqa.org/pages/policy/hedis/h00meas.htm.

[45] According to Dr. Fine, the study author, the number of abortions (and hence pregnancy rate) may have been underestimated due to patients going outside the plan for that service. However, the only local abortion clinic did provide data for the study. Miscarriages resulting in hospitalization, emergency room visits or office visits as well as all hospitalizations for delivery were easily identified; however, not all miscarriages necessarily resulted in a medical encounter.

[46] Fine, J. (1998). Adolescent Pregnancy Prevention in a Staff-Model HMO. Poster Session Presentation at the March 1998 Society for Adolescent Medicine Meeting. Atlanta, Georgia. *Journal of Adolescent Health,* 22(2):175.

[47] Klein, JD et al. (1999). Access to Medical Care for Adolescents: Results from the 1997 Commonwealth Fund Survey of the Health of Adolescent Girls. *Journal of Adolescent Health.* 25(2):120-130.

[48] Zabin, LS et al. (1996). Adolescents with Negative Pregnancy Test Results: An Accessible At-Risk Group. *Journal of the American Medical Association.* 275(2):113-117.

[49] Boise, R and Vu, L. (1998). Teen Pregnancy Test Counseling Recommended as Best Practice by TPMG. *The Monocle: Kaiser Permanente Northern California,* 12(6):1-2.

[50] Lee, PL and Stewart, FH. (1995). Failing to Prevent Unintended Pregnancy is Costly. American *Journal of Public Health.* 85(4):479-480.

[51] Zabin, LS, Sedivy, V, and Emerson, MR. (1994). Subsequent Risk of Childbearing Among Adolescents with a Negative Pregnancy Test. *Family Planning Perspectives.* 26(5):212-217.

[52] Zabin, LS, et al. (1996).

[53] Trussell, J et al. (1997). Medical Care Cost Savings from Adolescent Contraceptive Use. *Family Planning Perspectives.* 29(6):248-55,295.

[54] Schoen, C, et al. (1997). *The Commonwealth Fund Survey of the Health of Adolescent Girls.* New Yor, NY: The Commonwealth Fund. Schoen, C, et al. (1998). *The Health of Adolescent Boys: Commonwealth Fund Survey Findings.* New York, NY: The Commonwealth Fund.

[55] Schoen, C, et al. (1997).

[56] Marks, A, Fisher, M, and Lasker, S. (1990). Adolescent Medicine in Pediatric Practice. *Journal of Adolescent Health Care,* 11(2):149-53.

[57] Klitsner, IN, et al. (1992). Adolescent Health Care in a Large Multispecialty Prepaid Group Practice: Who Provides It and How Well Are They Doing? *Western Journal of Medicine,* 156(6):628-32.

[58] Neinstein, LS, Shapiro, J, and Rabinovitz, S. (1986). Effect of an Adolescent Medicine Rotation on Medical Students and Pediatric Residents. *Journal of Adolescent Health Care,* 7(5):345-9. Blum, RW and Bearinger, LH. (1990). Knowledge and Attitudes of Health Professionals Toward Adolescent Health Care. *Journal of Adolescent Health Care,* 11(4):289-94. Blum, R. (1986). Physicians' Assessment of Deficiencies and Desire for Training in Adolescent Care. *Journal of Medical Education,* 62(5):401-7.

[59] Ginsburg, KR, Menapace, AS, and Slap, GB. (1997). Factors Affecting the Decision to Seek Health Care: The Voice of Adolescents. *Pediatrics.* 100(6):922-30.

[60] *ibid.*

[61] Litt, IF and Cuskey, WR. Satisfaction with Health Care: A Predictor of Adolescents' Appointment Keeping. *Journal of Adolescent Health Care*, 5(3):196-200.

[62] Ellen, J, et al. (1998). *Factors Influencing Health Care Seeking for STDs in Adolescents.* APS/SPR/APA 1998 Annual Meeting. New Orleans, LA. May 1-5, 1998.

[63] Borok, G, Klitsner, I, and Fuster, D. (1995). *Adolescent Health Study: Final Report.* Pasadena: Kaiser Permanente, Southern California Permanente Medical Group, Research and Evaluation Department. Interview with Daniel Fuster, MD, Kaiser Permanente. April 27, 1999.

[64] Hingson, RW, et al. (1990). Belief about AIDS, Use of Alcohol and Drugs, and Unprotected Sex Among Massachusetts Adolescents. *American Journal of Public Health,* 80(3):295-9.

[65] Email from Linda Rieder, Kaiser Permanente's Regional Health Education Department. April 4, 1999.

[66] The Kaiser Permanente Northern California Health Education Department has developed such a brochure. For more information, contact Linda Rieder at 510-987-4730.

[67] Califano, JA and Booth, A. (1998).

[68] Klitsner, IN, et al. (1992).

[69] Interview with Anita Feins, MD, Harvard Vanguard. Feins, A and Pressman, A. (1998). Caring for Pregnant Adolescents. *Academic Medicine,* 73(5):573.

[70] Ross Products Division, Abbot Laboratories. (1998). *Mothers Survey.* Note: the statistic refers to women under age 20.

[71] Telephone interview with Jeffrey Lindenbaum, MD. March 22, 1999.

[72] Lindenbaum, J. (1996). *Adolescent Consultation Team 1996 Annual Report.* Seattle, WA: Group Health Cooperative.

[73] Kipke, MD (ed.) (1999).

[74] Hedberg, VA, Klein, JD, and Andresen, E. (1998). Health Counseling in Adolescent Preventive Visits: Effectiveness, Current Practices, and Quality Measurement. *Journal of Adolescent Health,* 23(6):344-53.

[75] Ziv, A et al. (1999).

[76] Kaiser Family Foundation/MTV/TEEN PEOPLE, National Survey of Teens on STDs, conducted March 24-April 14, 1998; Released March 8, 1999.

[77] Joffe, A, Radius, S, and Gall, M. (1988). Health Counseling For Adolescents: What They Want, What They Get, And Who Gives It. Pediatrics, 82(3 Pt 2):481-5.

[78] Saxe, LM, Cross, T, and Silverman, N. (1986). *Children's Mental Health: Problems and Services. Report prepared for the US Congress Office of Technology Assessment.* Durham, NC: Duke University Press. As cited in Gans, JE, McManus, MA, and Newacheck, PW. (1991). *Profiles of Adolescent Health Series, Volume 2: Adolescent Health Care: Use Costs, and Problems of Access.* Chicago, IL: American Medical Association.

[79] Goldstein, EN, Dworkin PH, Bernstein, B. (1999). Time Devoted to Anticipatory Guidance During Child Health Supervision: How Are We Doing? *Ambulatory Child Health.* 5:113-120.

[80] Reisinger, KS, Bires, JA. (1980). Anticipatory Guidance in Pediatric Practice. *Pediatrics.* 66:889-92.

[81] The state identified five different populations (and designed a different questionnaire for each) for which health risk assessments should be conducted: (1) early childhood (ages 0-3); (2) young children (ages 4-8); (3) pre-adolescents (ages 9-11); (4) adolescents (ages 12-17); and (5) adults (18 and over).

[82] Paperny, D and Hedberg, V. (1999). Computer-Assisted Health Counselor Visits: A Low-Cost Model for Comprehensive Adolescent Preventive Services. *Archives of Pediatrics and Adolescent Medicine,* 153(1): 63-7. Paperny, D, et al. (1990). Computer-Assisted Detection and Intervention in Adolescent High-Risk Health Behaviors. *Journal of Pediatrics,* 116(3):456-62. Paperny, D. (1997). Computerized Health Assessment and Education for Adolescent HIV and STD Prevention in Health Care Settings and Schools. *Health Education and Behavior,* 24(1):54-70.

[83] Interview with David Paperny, MD, Kaiser Permanente, Hawaii Division. March 24, 1999.

[84] *ibid.*

[85] Cheng, TL, et al. (1993). Confidentiality in Health Care: A Survey of Knowledge, Perceptions, and Attitudes among High School Students. *Journal of*

the American Medical Association, 269(11):1404-7. Council of Scientific Affairs, American Medical Association. (1993). Confidential Health Care Services for Adolescents. *Journal of the American Medical Association,* 269(11):1420-4. English, A. (1990). Treating Adolescents: Legal and Ethical Considerations. *Medical Clinics of North America,* 74(5):1097-112. Ford, CA, et al. (1997). Influence of Physician Confidentiality Assurances on Adolescents' Willingness to Disclose Information and Seek Future Health Care: A Randomized Controlled Trial. *Journal of the American Medical Association,* 278(12):1029-34. Sigman, G, et al. (1997). Confidential Health Care for Adolescents: Position Paper of the Society for Adolescent Medicine. *Journal of Adolescent Health,* 21(6):408-15.

[86] Council on Scientific Affairs, American Medical Association. (1993). Confidential Health Services for Adolescents. *Journal of the American Medical Association.* 269(11):1420-1424.

[87] Ellen, J, et al. (1998).

[88] *ibid.*

[89] Klein, JD, et al. (1999).

[90] Marks, A, et al. (1983). Assessment of Health Needs and Willingness to Utilize Health Care Resources of Adolescents in a Suburban Population. *Journal of Pediatrics.* 102(3):456-60.

[91] English, A. (1995). Adolescents and HIV: Legal and Ethical Questions. In Quackenbush, M, et al. eds. *The HIV Challenge: Prevention Education for Young People.* Santa Cruz, CA: ETR Associates.

[92] Generally, adolescents who are authorized to legally consent for diagnosis and care for a condition are also the ones who have the right to control the disclosure of information related to that care. English A. Adolescents and HIV: Legal and Ethical Questions, in Quackenbush M et al. (eds.) (1995). *The HIV Challenge: Prevention Education for Young People.* Santa Cruz, CA: ETR Associates.

[93] Gans, JE, ed. (1994). *Policy Compendium on Confidential Health Services for Adolescents.* Chicago, IL: American Medical Association.

[94] English, A. (1995).

[95] Reidel, CW, Scott, CS, and Waxman, A. (1997). Confidentiality and Minors: Poster Presentation. Annual Meeting of North American Society for Pediatric and Adolescent Gynecology. April 7, 1997. As cited in Fine, J. (1998). Adolescent Pregnancy Prevention in Managed Care. *Women's Health Issues,* 8(3):148-58.

[96] Lurie, N. (1997). Studying Access to Care in Managed Care Environments. *Health Services Research,* 32(5):691-701.

[97] Schuster, MA, et al. (1996).

[98] Elster, AB and Kuznets, NJ. (1994). p. 8-9.

[99] Friedman, L, Johnson, B, and Brett, A. (1990). Evaluation of Substance-Abusing Adolescents by Primary Care Physician. *Journal of Adolescent Health Care,* 11(3):227-30.

[100] Klein, JD, et al. (1999).

[101] Purcell, JS, et al. (1997). Interviewing Techniques with Adolescents in Primary Care. *Journal of Adolescent Health.* 20(4):300-5.

[102] Schuster, MA, et al. (1996).

[103] Bensussen-Walls, W and Saewyc, E. (1999). Teen-Focused Care vs. Adult-Focused Care for the High Risk Pregnant Adolescent. Poster Presentation at the Society for Adolescent Medicine March 1999 Conference. *Journal of Adolescent Health.* 24(2):102.

[104] Brindis, CD, et al. (1997). *Improving Adolescent Health: An Analysis and Synthesis of Health Policy Recommendations.* San Francisco, CA: University of California, San Francisco. National Health Information Center. Fisher, M, et al. (1992). School-based Adolescent Health Care. *Adolescent Health Care,* 146(5):615-21. Brellochs, C, et al. (1996). School-Based Primary Care in a Managed Care Environment: Options and Issues. *Adolescent Medicine: State of the Art Reviews.* 7(2):197-206. Santelli, JS, et al. (1995). *Improving Access to Primary Care for Adolescents: School Health Centers as a Service Delivery Strategy.* MCH Policy Research Brief. Baltimore, MD: JHU Child and Adolescent Health Policy Center.

[105] American School Health Association, Association for the Advancement of Health Education & Society for Public Health Education, Inc. (1989). *The National Adolescent Student Health Survey: A Report on the Health of America's Youth.* Oakland, CA: Third Party Publishing Company. As cited in: Gans JE, McManus MA, Newacheck PW. (1991).

[106] Making the Grade National Program Office. (1998). National Survey of State School-Based Health Centers Initiatives, School Year 1997-98 (Revised January 1999). George Washington University: Washington, DC.

[107] Fothergill, K. (1998).

[108] Kaplan, DW, et al. (1998). Managed Care and School-Based Health Centers: Use of Health Services. *Archives of Pediatrics and Adolescent Medicine,* 152(1):25-33.

[109] Bravender, T, et al. (1999). Health Care Preferences of 9th and 12th Graders in Massachusetts. Poster Presentation at the Society for Adolescent Medicine, March 1999 Conference. *Journal of Adolescent Health,* 24(2):141.

[110] Cheng, TL et al. (1993).

[111] Letter to Michael Burgmaier, Children Now from Carmella Bocchino, American Association of Health Plans. March 4, 1999.

[112] Klitsner, IN. (1993). Meeting the Challenge of Adolescent Health Care in a Group Practice HMO. *HMO Practice,* 7(4):151-6. Interview with Daniel Fuster, MD, Kaiser Permanente. March 23, 1999.

[113] Borok, G, Klitsner, I, and Fuster, D. (1995). Interview with Daniel Fuster, MD, Kaiser Permanente, April 27, 1999.

[114] *ibid.*

[115] Ershoff, DH, et al. (1992). Meeting the Special Needs of Adolescents in an HMO Setting. Patient Satisfaction with a Comprehensive Teen Clinic vs. Traditional Primary Care. Presented at the 120th Annual Meeting of the American Public Health Association. Washington, DC. November 8-12, 1992.

[116] Zimmerman, DJ and Santelli, JS. (1998). School and Adolescent Health and Managed Care. *American Journal of Preventive Medicine,* 14(3S):60-6. For those interested in further reading, Zimmerman and Reif have discussed such issues as how SBHCs can work with either staff- or IPA-models and how health centers working in an area with multiple health plans can serve both commercial and Medicaid populations, see Zimmerman, DJ and Reif, CJ. (1995). School-Based Health Centers and Managed Care Health Plans: Partners in Primary Care. *Journal of Public Health Management Practice,* 1(1):33-9.

[117] Klein, JD, et al. (1992). p. 165.

[118] Trussell, J, et al. (1995). The Economic Value of Contraception: A Comparison of 15 Methods. *American Journal of Public Health.* 85(4):494-503.

[119] Moretz, S. (1999). How to Shoot up HEDIS Adolescent Immunization Rates and Boost Care. *Managed Healthcare,* January:40-41

[120] The site is located at http://www.ghc.org/health_info/self/teenheal.html (March 24, 1999).

[121] Marks, A and Fisher, M. (1987). Health Assessment and Screening During Adolescence. *Pediatrics.* 80(1 Pt 2):131-58.

[122] Moretz, Sandy. (1999).

[123] Interview with Angela Diaz, MD, Vice Chair, Department of Pediatrics, Director, Adolescent Health Center, The Mount Sinai Hospital. May 12, 1999.

[124] The California Adolescent Wellness Collaborative is a public and private partnership of professionals and organizations concerned with improving adolescent health in California. For more information, please contact: Robert Bates, MD, Adolescent Health Coordinator, 916-657-3069 or rbates@hw1.cahwnet.gov.

[125] Interview with Michael McKenzie, MD, Assistant Medical Director, Pediatrics, Tufts Health Plan. May 12, 1999 and Nicole Dray, Teen Council Member, May 13, 1999. For more information, see: Cross, M. (1998). Cultivating Better Relationships with Teens. *Healthplan.* 39(3):62-66,68-69,71.

[126] Hansell, S and Mechanic, D. Parent and Peer Effects on Adolescent Health Behavior. In Hurrelman, K and Losel, F. eds. (1990). *Health Hazards in Adolescence.* New York, NY: Walter de Gruyter. p. 43-66. FIND

[127] Meyer, JE, et al. (1999), p. 31.

[128] Young, TL and Zimmerman, R. (1998). Clueless: Parental Knowledge of Risk Behaviors of Middle School Students. *Archives of Pediatric and Adolescent Medicine.* 152(11):1137-1139.

[129] Cutler, EM, et al. (1999). Parental Knowledge and Attitudes of Minnesota Laws Concerning Adolescent Medical Care. *Pediatrics.* 103(3):582-7.

[130] The Northern California Kaiser Permanente Regional Health Education Department has just developed such communication pieces. Contact Linda Rieder at 510-987-4730 for more information.

[131] Kort, C. How to Talk to Kids About the Birds, the Bees and More. *Brookline Citizen*. July 6, 1990.

[132] Harvard Pilgrim HealthCare Foundation. Teen AIDS and Pregnancy Prevention: Summary of Needs Assessment Findings, FY93.

[133] Lurie, N. (1997). Can Managed Care Companies Affect Community Health? *The Bulletin*, 41(SA):10-3.

[134] Taras, H, et al. (1998). The School Health Innovative Programs: Integrating School Health and Managed Care in San Diego. *Journal of School Health,* 68(1):22-5.

[135] Serwint, JR, et al. (1997). Outcomes of Annual Tuberculosis Screening by Mantoux Test in Children Considered to be at High Risk: Results from One Urban Clinic. *Pediatrics*. 99(4):529-33.

[136] Scholes, D, et al. (1996). Prevention of Pelvic Inflammatory Disease by Screening for Cervical Chlamydial Infection. *New England Journal of Medicine*. 334(21):1362-6.

[137] California Chlamydia Action Forum. (1999). *Action Agenda for Chlamydia Prevention and Control in California: A Five Year Plan*. Oakland, CA: California HealthCare Foundation.

[138] *ibid.*

[139] Interview with Cathleen Walsh, Health Scientist, Division of STD Prevention, Centers for Disease Control and Prevention. March 25, 1999.

[140] Hedberg, VA, Klein, JD, and Andresen, E. (1998).

[141] Elster, AB and Kuznets, NJ. (1994).

[142] Green, M, ed. (1994).

[143] US Preventive Services Task Force. (1996). *Guide to Clinical Preventive Services, 2nd ed*. Baltimore, MD: Williams & Wilkins.

[144] American Academy of Pediatrics. (1994). *The Clinician's Handbook of Preventive Services: Put Prevention into Practice*. Elk Grove Village, IL: American Academy of Pediatrics.

[145] American Academy of Pediatrics Committee on Practice and Ambulatory Medicine. (1995). Recommendations for Pediatric Preventive Health Care. *Pediatrics*, 96(2 Pt 1):373-4.

[146] Elster, AB. (1998). Comparison of Recommendations for Adolescent Clinical Preventive Services Developed by National Organizations. *Archives of Pediatrics and Adolescent Medicine,* 152(2):193-8.

[147] American Academy of Family Physicians. (1994). *Age Charts for Periodic Health Examinations*. Kansas City, MO: American Academy of Family Physicians.

[148] Elster, AB. (1998). AAFP indicates American Academy of Family Physicians (data from AAFP); AAP, American Academy of Pediatrics (data from AAP); AMA, American Medical Association (data from Elster and Kuznets); BF, Bright Futures (data from Green, M, ed.); and US Preventive Services Task Force (data from USPSTF).

Children Now is a nonpartisan, independent voice for America's children. Using innovative research and communications strategies, Children Now promotes pioneering solutions to problems facing America's children. Recognized nationally for its policy expertise, up-to-date information on the status of children, and leading work with the media, Children Now focuses particular attention on the needs of children who are poor or at risk, while working to improve conditions for all children by making them a top priority across the nation.

Children Now Board of Directors

Partners in Transition: Adolescents and Managed Care

Oakland
1212 Broadway
5th Floor
Oakland, CA 94612
Tel (510) 763-2444
Fax (510) 763-1974
children@childrennow.org

Los Angeles
2001 South Barrington Ave.
Suite 100
Los Angeles, CA 90025
Tel (310) 268-2444
Fax (310) 268-1994
cnla@earthlink.net

New York
355 Lexington Ave.
11th Floor
New York, NY 10017
Tel (212) 682-1896
Fax (212) 682-3222
children@inch.com

www.childrennow.org

CHILDREN NOW

Printed on recycled paper. 4.2000

U.S. Department of Education
Office of Educational Research and Improvement (OERI)
National Library of Education (NLE)
Educational Resources Information Center (ERIC)

NOTICE

Reproduction Basis

☒ This document is covered by a signed "Reproduction Release (Blanket)" form (on file within the ERIC system), encompassing all or classes of documents from its source organization and, therefore, does not require a "Specific Document" Release form.

☐ This document is Federally-funded, or carries its own permission to reproduce, or is otherwise in the public domain and, therefore, may be reproduced by ERIC without a signed Reproduction Release form (either "Specific Document" or "Blanket").

EFF-089 (3/2000)