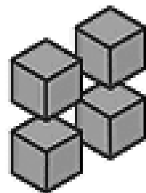
Is the Health Care System Working for Adolescents?

Perspectives From Providers in Boston, Denver, Houston, and San Francisco

Margaret A. McManus
Kandi I. Shejavali
Harriette B. Fox

October 2003



MATERNAL & CHILD HEALTH
POLICY RESEARCH CENTER

ABOUT THE MATERNAL AND CHILD HEALTH POLICY RESEARCH CENTER

The Maternal and Child Health Policy Research Center is a health policy group that provides federal and state policymakers, public health officials, and provider and family organizations with analysis of financing and service delivery developments affecting children and adolescents, with particular focus on those with special needs and those from low-income families. For more information about the Maternal and Child Health Policy Research Center, visit our web site at www.mchpolicy.org.

TO OBTAIN COPIES OF THE REPORT

This report can be downloaded from the Maternal and Child Health Policy Research Center's web site or ordered from:

Maternal and Child Health Policy Research Center
750 17th Street NW, 11th Floor
Washington, DC 20006
Tel.: 202-223-1500
Fax: 202-496-9067
Web site: www.mchpolicy.org

Permission to copy, disseminate, or otherwise use this work is granted as long as authorship is properly attributed.

Acknowledgements

The authors gratefully acknowledge the William T. Grant Foundation whose financial support made this study possible. We are most appreciative of the guidance and encouragement from Karen Hein, whose vision of adolescent assets and system opportunities were critical in our research. We are also deeply indebted to the many public and private health care providers who participated in each of the four study cities. They generously took the time to share their opinions and provide us with valuable information about how the health care delivery and financing system works for adolescents. We want to especially acknowledge several individuals in each city who helped identify key health care providers and furthered our understanding of various policies and programs in their cities: David Kaplan, Paul Melinkovich, Barbara Ritchen, and Ginny Trierweiler in Denver; Jean Emans, Timothy Everett, Karen Hacker, John Kulig, Pauline Sheehan, and Deborah Klein Walker in Boston; Claire Brindis, Sai-Ling Chan-Sew, Janet Shalwitz, and Charles Wibbelsman in San Francisco; and Albert Hergenroeder, Regenia Hicks, and Peggy Smith in Houston. In addition, we wish to thank our project's Advisory Board members for their substantive input throughout the course of our study. They include Joy Dryfoos, a New York-based independent researcher and writer; Abigail English of the Center for Adolescent Health and the Law; Charles Irwin of the University of California at San Francisco; Jonathan Klein of the University of Rochester; Leslie Morris of the National Association of Community Health Centers, and Mark Schaefer of Connecticut's Department of Social Services. We additionally would like to acknowledge Trina Anglin of the Maternal and Child Health Bureau. We are also grateful to Mary Reichman, formerly of the Maternal and Child Health Policy Research Center, who provided valuable research assistance during two site visits.

Table of Contents

I. Introduction 1

II. Methods 3

III. What Are the Most Important Health Problems Facing Adolescents? 5

IV. Preventive and Primary Care 7

Sources of Care 7

What Works 7

Roadblocks 7

Innovative Programs 8

V. Reproductive Health Care 11

Sources of Care 11

What Works 11

Roadblocks 12

Innovative Programs 12

VI. Behavioral Health Care 15

Sources of Care 15

What Works 15

Roadblocks 16

Innovative Programs 18

VII. Conclusions 19

VIII. Recommendations 21

References 24

I. Introduction

Adolescence is a period of great vulnerability. Profound physical, developmental, intellectual, emotional, and social changes take place. Adolescents' ability to negotiate these changes depends in large part on their family and school connectedness. It also depends on other adult and peer support, recreation and work resources, and neighborhood and media influences. Important as well are the health care providers and delivery systems available to respond to their needs.

Although most adolescents are reported to be healthy,[1] the preponderance of evidence reveals that they confront significant health risks: physical and mental health problems, early experimentation with sex and drugs, physical inactivity, overweight and obesity, and substantial stress from school, family, and peer pressures,[2] as shown in Table 1. Adolescents who are low-income, minority, and living in inner cities appear to be at highest risk. In Boston, Denver, Houston, and San Francisco, the four cities we visited for this study, 29% to 33% of high school students reported persistent feelings of sadness, 18% to 36% reported episodic heavy drinking, 20% to 39% reported being sexual active, and 26% to 32% reported being overweight.[3] Nationally, the annual costs of preventable adolescent health problems were estimated in 2002 to be $51.5 billion or $1,152 per adolescent.[4] When associated medical, legal, and lost productivity costs are included, annual costs of preventable adolescent morbidity increased to $830.8 billion.[5]

"Adolescents represent 15% of our nation's population and 100% of our nation's future."

Table 1. Adolescent Health Risk Behavior in Largest U.S. Cities[6]

Health Risk Behaviors[3]	U.S.	New York City	Los Angeles	Chicago	Houston	Philadelphia	San Diego	Dallas	San Francisco	Boston	Denver[7]
Persistent sadness	28.3%	32.5%	35.3%	34.1%	30.2%	32.2%	32.6%	32.4%	28.6%	32.7%	N/A
Physical fighting	33.2	40.5	35.0	40.8	33.9	41.7	33.5	41.0	30.9	33.3	38.2
Weapon carrying	17.4	6.9	12.5	21.2	15.7	12.7	12.3	15.9	8.3	16.4	20.3
Past 30-day smoking	28.5	17.6	14.5	24.7	21.8	15.8	17.1	17.8	13.3	15.4	30.3
Binge drinking	29.9	17.9	21.9	21.4	25.4	13.6	24.3	20.7	13.2	18.1	35.5
Sexually active	33.4	36.6	24.9	40.9	35.9	42.1	26.6	38.8	19.8	36.5	39.0
Perceived overweight	29.2	27.8	31.4	28.6	8.8	27.6	29.3	32.9	32.1	28.4	26.4

> "Health behaviors are established in youth and persist into adulthood."

Adolescents not only confront substantial health risks, their use of health services is also problematic. No other age group, except for young adults, is as likely to be without a usual source of care and have lower ambulatory visit rates. Foregone care is common among teens, especially among those who are older, low-income, uninsured, from minority backgrounds, or involved in high-risk behaviors.[8] Not surprisingly, national expenditure data reveal that per capita health care expenditures for adolescents are low compared to adults — $979 versus $2,870 in 2002. Among racial and ethnic groups, Black adolescents have the lowest per capita health care expenditures, followed by Hispanics ($439 and $627, respectively). Among white adolescents, per capita expenditures total $1,180. For poor adolescents, per capita expenditures averaged only $746 in 2002.[9]

Despite high levels of preventable morbidity and potential cost savings, investment in adolescent health care has been limited. Moreover, few significant reforms have moved beyond the demonstration phase to wide-scale implementation despite numerous national and state policy recommendations calling for improvements in adolescent health care.[10]

The purpose of this report is to offer a comprehensive assessment of how well adolescents in urban areas are being served by the current health care system. We sought the perspectives of health care providers practicing in major U.S. cities and delivering preventive and primary, reproductive, and behavioral health services (including both mental health and substance abuse treatment services) to adolescents in a range of sites. We wanted to know what systems work best for adolescents and what systems are not working well. In addition, we wanted to learn where improvements are needed that could positively influence health outcomes for adolescents. We sought to identify financing and delivery strategies that might be implemented at the local, state, and national levels to achieve a more effective and efficient system of care for adolescents.

II. Methods

This qualitative study, funded by the W.T. Grant Foundation, presents providers' perspectives on how well the health care system is working to serve adolescents in Boston, Denver, Houston, and San Francisco. Our research questions addressed five areas important to adolescents' health:

- their most important health problems;
- their usual sources of care;
- the extent to which preventive and primary care, reproductive care, and behavioral care adequately meet their needs;
- the main organizational, health insurance, managed care, and other factors facilitating or impeding access to these services; and
- community, state, and federal recommendations for organizing and financing an optimal health care system for adolescents.

In all, over 200 health care providers practicing in a range of settings — community health centers, school-based health centers, office-based practices, hospital-based clinics, family planning clinics, community mental health centers, and substance abuse programs — were interviewed between June of 2001 and April of 2002. Each site visit lasted three days and included up to 10 separate group interviews. Following our site visits, additional telephone interviews and data requests were made to clarify or expand on information provided.

The four cities were carefully selected based on their innovative adolescent health care leadership and program initiatives. To select the cities, we consulted with nationally recognized experts and federal officials knowledgeable about adolescent health programs. We also tried to ensure diversity among the cities in terms of geography, demographics, and state health policies. In addition, we took into consideration the likelihood of participation of providers representing different service and organizational perspectives.

Providers were identified initially from the adolescent medicine leadership in each city, who in turn suggested additional clinicians practicing in a variety of settings. We also relied on provider recommendations from state adolescent health coordinators, other state health and mental health officials, and state chapter representatives from the American Academy of Pediatrics and the American Academy of Child and Adolescent Psychiatry. Prior to conducting each site visit, we analyzed city and state-specific information, including demographic data; needs assessment surveys; Medicaid, State Children's Health Insurance Program (SCHIP), and private health insurance policies; confidentiality, consent, and mental health parity laws; managed care and public program arrangements; and special health initiatives. Structured interview forms were developed based on our core set of research questions. They were modified to reflect city-specific background information, but permitted consistent collection of information across sites.

This study attempts to glean from various types of providers what their experiences and challenges have been in serving adolescents ages 13 to 18. Throughout the report, except when we describe innovative efforts, city names are not mentioned. Although the sample size of this study is small and findings should be interpreted with caution, we believe this study provides a unique snapshot of the health care system available to adolescents in urban areas, a disproportionate number of whom are from low-income families and diverse racial and ethnic backgrounds. It is unclear, however, the extent to which these same perspectives apply to providers serving suburban or rural areas, or in urban areas with predominantly middle- and upper-income adolescents.

This report has seven sections. Following the introduction and methods is a summary of providers' perspectives of the most important health problems facing adolescents. The subsequent three sections — on preventive and primary care, reproductive care, and behavioral care — review what providers told us about adolescents' utilization patterns and their usual sources of care, service delivery arrangements that work well, barriers that impede care, and key elements of care that make a difference. We also include innovative examples from each of the cities. The final section in this report, which reflects both the providers' and authors' perspectives, addresses recommendations that pertain to community planning, state Medicaid and SCHIP policies, and federal reforms. Quotes from providers illustrate comments we heard frequently.

III. What are the Most Important Health Problems Facing Adolescents?

The health and well being of adolescents is profoundly shaped by their family and social environment. The health care providers we interviewed painted a disturbing picture of the lives of many adolescents in their cities. Providers reported that the most common adolescent health conditions are indicators of the turbulent world in which they live, rather than signs of inherent medical problems. Moreover, a significant proportion of teens experience a considerable lack of parental involvement in many aspects of their lives, including health care.

In all four cities, behavioral health conditions were cited as serious issues in the adolescent population, more so than reproductive or physical health conditions. Providers described the most pervasive behavioral health conditions experienced by teens as depression, anxiety, and post-traumatic stress syndrome (typically resulting from family or interpersonal violence). Substance abuse, most often, alcohol, marijuana, and tobacco, was also reportedly widespread. The use of club drugs, for example, Ecstasy, was commonly mentioned, mostly among middle- and high-income teens. Providers told us repeatedly about the lack of hope and low self-esteem that characterizes many adolescents' they care for, causing them not to feel good about themselves and prone to making risky decisions. Somewhat less common, but still considered important behavioral health conditions, are attention deficit hyperactivity disorder, eating disorders, and suicidal ideation. Homelessness, particularly in two cities, was also noted as a serious problem among teens.

Reproductive health conditions were described as the second most important category of health problem, according to providers in all four cities. Specifically, sexually transmitted diseases — chlamydia, human papilloma virus, herpes simplex, and trichomoniasis — are seen at disturbingly high rates. Providers attributed these health problems to early and unprotected sexual behavior that often takes place in the context of drinking and drug abuse. Of particular concern to many providers is the earlier age of sexual intercourse occurring among teens. Providers placed some of the blame for teens' sexual behavior on the media's carefree and glamorized portrayal of sex, which contradicts the messages that most parents and educators try to convey about abstinence and sexual responsibility. Teen pregnancy, though the rates are declining, is still considered a major problem.

The physical health conditions that were mentioned as the most important among teens are obesity and asthma. Poor nutrition, lack of exercise, and even lack of sleep were highlighted as typical among teens. Starting with no breakfast, most teens leave for school without lunches; they rely instead on vending machine snacks with high sugar content and on school lunches with high fat content. Providers also expressed concern about injuries, other chronic conditions (mainly diabetes), and tooth decay among adolescents.

When asked about adolescent subgroups with a disproportionate burden of health problems, we were told of differences by income, age, sex, race, and ethnicity. For example, poor adolescents are more affected by asthma than non-poor adolescents. Older adolescents are more involved with drugs than younger adolescents. Males in these cities are more likely than females to have post-traumatic stress syndrome. African Americans are more likely than Asian Americans or other whites to be obese. Hispanics are more likely than non-Hispanics to become teen parents. Overall, minority and low-income adolescents are more adversely affected.

"A strict emphasis on diagnoses misses the fact that health conditions are largely shaped by adolescents' environments."

"The complexities of life stresses that adolescents face are substantial. Their parents have their own problems and often don't imagine that they can affect their kids."

"Acculturation can play a negative role, especially among teens."

The interrelatedness of behavioral, reproductive, and physical health conditions was commonly stressed among providers serving adolescents. They noted that adolescent health problems often occur in concert with other problems and with common risk factors. While adolescents often present with physical symptoms, the problem may actually be behavioral or gynecological. Recurrent headaches, for example, can be a sign of depression, anxiety, or sexual abuse. Depression can be linked with compulsive overeating which, in turn, results in obesity with its multitude of associated problems, including diabetes. Similarly, early sexual activity can be related to substance abuse, which is often accompanied by psychological problems, such as low self-esteem.

The context of teen health problems and the inextricable linkages between them are crucial points to consider in understanding providers' perspectives on how well preventive and primary care, reproductive care, and behavioral health care work for adolescents. Medicalizing adolescent health problems, without giving proper weight to the context in which they arise, does a great disservice to teens and often leads to interventions that are only partially effective.

IV. Preventive and Primary Care

When asked whether preventive and primary care, as it is currently structured, adequately meets the needs of adolescents, providers in all four cities responded that it does not. There are too few teen-friendly sites of care.

Sources of Care

Providers consistently reported that adolescents seldom seek preventive care services; rather, they typically access care only for acute care on an episodic basis, most often on their own. When adolescents do receive preventive care, it is often for a required sports physical, which focuses on safety, orthopedic injuries and physical fitness, and risk of injury from sports. Moreover, providers thought few of their colleagues are actually following the full set of recommended guidelines for preventive care when adolescents do come in for appointments.

In all four cities, sources of preventive and primary care for adolescents vary by insurance status. Privately insured and SCHIP-insured adolescents tend to rely on office-based practices and managed care clinics, while Medicaid-insured and uninsured adolescents are more likely to rely on community health centers, hospital outpatient departments, and, to the extent they are available, school-based health centers. Still, we heard the emergency room is too often the source of primary care for many uninsured youth. Providers also told us that the adolescents least likely to seek preventive and primary care are males, immigrants, Hispanics, gays and lesbians, and youth not in school.

What Works

Whenever we heard that preventive and primary care were adequately meeting the needs of adolescents, it was because services were easily accessible and at least some physical, behavioral, and reproductive services were co-located. Based on our site visits, it appeared that such arrangements were available in many school-based health centers, community health centers and hospital outpatient departments with special teen clinics and multidisciplinary staff arrangements, a few group-model HMOs with special teen programs, and even some mobile services. According to providers, what makes preventive and primary care work for the adolescent population are delivery arrangements that allow walk-ins, extend office hours (late afternoons and evenings), anticipate no-shows, have separate office space for teens, eliminate cost sharing, assure confidentiality, emphasize parent participation, but, most important, have providers that truly care about treating adolescents and have the training to do so.

Other components of high quality preventive and primary care were mentioned as well. We heard about the importance of focusing on adolescents' strengths, not on their pathologies, and of stressing prevention in order to influence adolescent risk behaviors. Also, linking clinical, school, and community health initiatives can be very beneficial. For example, providers in San Francisco noted that significant health benefits have been achieved as a result of community and media strategies to reduce teen smoking and pregnancy. Providers in all four cities also highlighted the importance of supporting community-wide efforts to reduce violence, unemployment, and poverty. By linking youth development programs, such as mentoring, recreational programs, and after-school activities with health programs, they believe that enormous payoffs can be achieved in health as well as in the use of preventive and primary care.

Roadblocks

Various roadblocks, however, stand in the way of assuring the provision of comprehensive preventive and primary care to adolescents.

"Most adolescents do not have a medical home."

"The right type of provider is key in delivering care to adolescents successfully. Such providers must have a tremendous ability to relate to teens, engage them, and be immersed in their world."

"Stereotypes about adolescents keep providers from wanting to serve them."

"If anyone ever did a business plan for an adolescent practice, no physician would ever go into such a practice."

They can be grouped under three main categories: provider availability and organization, insurance and managed care, and parental consent and communication. With respect to providers, we heard in all four cities that pediatricians, particularly those in private practice, are typically more interested in serving younger children. Their offices are seldom set up to handle adolescent patients; they usually do not feel comfortable asking about sexual, behavioral, and other health risks; they lose money when serving adolescents; and they don't have the time to arrange needed behavioral and reproductive referrals. Providers noted that, at the same time, adolescents are often uncomfortable in pediatric settings and many have not yet found an appropriate adult provider interested in serving adolescents. We also heard that many community health centers have not adjusted their administrative or clinical approaches to address the unique needs of adolescents. Adolescents, often on their own, without transportation and without the knowledge of how to navigate the health care system, are at a distinct disadvantage. Predictably, many are lost to follow-up.

Insurance problems present additional challenges affecting providers' ability to deliver preventive and primary care. In all four cities, providers repeatedly complained that reimbursement rates under Medicaid and SCHIP, and, to a lesser extent, private insurance, are not at all sufficient to cover the time necessary to provide preventive and primary care to adolescents. Care coordination, preventive counseling, and diagnostic codes for signs and symptoms (V-codes for billing purposes) are seldom reimbursed by either public or private payers. In two cities, we heard that preventive care for privately insured adolescents is not consistently a covered benefit, and, in one city, that Medicaid's EPSDT periodicity schedule covers preventive care for adolescents only every four years. Even when preventive care is covered, many teens forget their insurance cards, causing administrative inefficiencies and delays in care. Providers were troubled, especially in the cities with the highest rates of uninsurance, that low-income families often do not know what insurance teens are eligible for. They also noted that the lengthy application forms and documentation requirements for Medicaid and SCHIP deter enrollment, and that SCHIP outreach seldom targets adolescents.

In addition, several concerns related to managed care were raised by providers. In all four cities providers reported that they have insufficient time to spend with adolescents because of financial pressures and health plan expectations to see a certain number of patients each day. Another common concern was that school-based health centers are not usually included in managed care networks. Two main reasons were given: plans may perceive either that school-based health centers, even when sponsored by community health centers or hospitals, are not available 24 hours a day, or that they do not have a sufficient number of adolescent enrollees who would seek care at these sites.

Consent issues further inhibit providers' ability to deliver comprehensive preventive and primary care to adolescents. In each city, providers complained that obtaining parental consent for preventive care is a problem, particularly since so few parents accompany their adolescents to care, and a substantial proportion of parents have limited English proficiency.

Innovative Programs

Boston Medical Center, an academic medical center that is part of a public managed care network, has an Adolescent Center with a broad array of support services. The Adolescent Center offers medical and confidential counseling services that address staying healthy; nutrition counseling; sports and employment physical exams; healthy sexuality for young men and women (including a peer leader support program for young men); contraceptives; STD and HIV screening and treatment; prenatal, childbirth, and parenting education classes; other gynecology and endocrine services; as well as surgery, allergy, cardiology, and neurology specialty services. The Adolescent Center also offers numerous special programs. One example is the Lifestyles Program, a multidisciplinary program focused on nutrition education, behavior modification, and weight management. Another is the Teen and Tot Program, a comprehensive program of care, support, and education to meet the needs of pregnant and parenting adolescents and their children. A third is the Adolescent Resource Center. Staffed by college-age volunteers, this peer counseling program offers such

resources as a computer terminal in the waiting room and handouts with information on jobs and job training programs, school and college information, financial aid information. Bilingual social work staff are also available to help with eligibility for benefits, immigration, and family issues. Additional special services at Boston Medical Center include a Family Advocacy Program (providing free legal services), the Child Witness to Violence Project (providing outreach, counseling, and advocacy), the Boston Healing Landscape Project (involving the arts community in countering apathy, commercialism, and violence), the Good Grief Program (offering training, consultation, and crisis intervention in the area of child and adolescent bereavement), Project Health (involving undergraduates in service, mentoring, and reflection), and the Spirituality and Child Health Initiative (examining the role of religion and health and the use of complementary medicine). In 2002, over two thirds of the adolescents served by Boston Medical Center's Adolescent Center were African American, and 13% were Hispanic. Funding for the Adolescent Center comes from the state's uncompensated care pool, Medicaid, SCHIP, private health insurance, and foundation and government grants.

Denver Health, an integrated public health safety net system, includes two Teen Clinics as part of its network of 11 community health centers; 13 school-based health centers in elementary, middle, and high schools operated in partnership with a number of community health providers; and a special reproductive clinic for teens at the public health department. At the Teen Clinics, a broad array of services are furnished — preventive and primary care, gynecological exams, colposcopies, family planning counseling and contraception, STD and HIV testing and counseling, psychological evaluation, individual and family counseling, and referrals for specialty services. The Teen Clinics also offer tobacco cessation, dental care, and maternity care. They are open weekdays and one evening a week for appointments and walk-ins. Denver Health's school-based health centers are in six of the 10 high schools and offer a wide range of services at no cost: preventive and primary medical care; reproductive health care (except contraceptives); mental health services, including individual, group, and family counseling for school-related problems, mental health consultations, and referrals to community mental health resources; substance abuse counseling; education about tobacco use, diet and exercise; and preventive dental care. The Denver Metro Health Teen Clinic, another program of Denver Health, serves female teens, providing routine gynecological care, STD and HIV testing and treatment, pre-conception counseling, pregnancy testing, and contraception, at no cost. Most of the teens using these Denver Health clinics are from low-income families of minority backgrounds. Funding for all Denver Health services comes from the state's indigent care fund, Medicaid, SCHIP, foundation and government grants, and patient revenues.

San Francisco's **Balboa Teen Health Center** is a school-based health center that serves a culturally diverse student body of 1,500 high school students as well as students from other city schools. The following free and confidential services are available year round on a drop-in or appointment basis: treatment for minor illnesses and injuries, sports physicals, immunizations, chronic disease management, reproductive health care, contraception, pregnancy testing, treatment for STDs, mental health counseling, drug counseling, general health education, nutrition counseling, and HIV testing and counseling. Several special programs are offered by Balboa Teen Health Center. The Partner Support Program is a health education program that focuses on reproductive health and decision-making, academic support, and job readiness. Students work in pairs (for example, boyfriend/girlfriend, best friends) with a health educator, starting with regular meetings and sometimes continuing throughout high school. Students decide what issues they want to work on – for example, increasing birth control compliance, communicating with partners and parents, or improving academics. Lunchtime groups are provided weekly as part of this program. Mental health staff also lead weekly groups for a variety of reasons, including depression, a girls support group, and other areas of interest. Additionally, the Health Center's art therapist participates in English as a second language classes and works with youth who are trying to adapt to and make sense of a new country, at the same time identifying those who may need

individualized mental health support. Finally, the Balboa Teen Health Center staff provides support to families and faculty by participating in school meetings on Individualized Education Plans (IEPs); student assistance programs; and Student Success Teams that assist students, families, and teachers to seek positive solutions to maximize students' potential. Balboa Teen Health Center is a cooperative venture of the Department of Public Health, the school district, and the Bayview Hunters Point Foundation. Funding for the Health Center comes from the city's general fund; the state's Office of Family Planning, Department of Mental Health, and Department of Alcohol and Drug Programs; Medicaid; and foundations.

V. Reproductive Health Care

Providers in all four cities reported that although free and confidential reproductive health care is available for teens, the organization and delivery of reproductive care does not sufficiently meet the needs of adolescents. Prevention and education do not receive enough attention; confidentiality protections are not well understood or consistently implemented; and reproductive health care is often disconnected from preventive and primary care.

Sources of Care

The vast majority of adolescents are reticent, even fearful, about talking about sexuality with their primary care providers and having reproductive health examinations. When adolescents seek reproductive care, it is generally for contraceptives, STD/HIV testing, pregnancy testing, or prenatal care and typically on a confidential basis. According to providers, routine gynecological care as part of adolescent well visits is seldom provided.

Providers reported that unlike preventive and primary care, sources of reproductive health care do not vary much by insurance status. Adolescents tend to choose providers based on their perceptions of confidentiality or anonymity as well as on recommendations made by friends. Not surprisingly, we heard that family planning programs and, to a lesser extent, community health centers are often the sites of care for reproductive health examinations, screening for sexually transmitted diseases and pregnancy, family planning counseling, and contraceptives for adolescents. School-based health centers in the four cities offer a limited set of reproductive services due in large part to religious and political considerations. Few pediatric providers provide reproductive health care for various reasons, including the fact that sexually active teens often do not want to be seen by familiar providers. Maternity care services for teens are usually available only in hospital-based clinics or community health centers. According to providers, the adolescents least likely to seek reproductive health care are males, immigrants, Asian Americans, youth not in school, gays and lesbians, and those with chronic illnesses or disabilities.

What Works

It appeared from our site visits that reproductive health care adequately meets the needs of adolescents where a broad array of reproductive services are available on a free and confidential basis and reproductive and primary care is linked in teen-friendly settings. Such arrangements were found in many family planning programs, community health centers and hospital outpatient departments with special teen clinics, and a few group-model HMOs with special teen programs.

Reproductive health care services that work, not unlike preventive and primary care, are ones that offer confidential protections, no cost sharing, a teen-friendly atmosphere, easily accessible sites of care, public transportation, evening hours, and phone-in lines. Providers emphasized the value of education at home, in schools, and in the community to help counter the increasingly negative and persuasive media images portraying sexual promiscuity among youth. In particular, they noted the critical role that families should play in informing their children about sexual development and monitoring their teenagers' activities. Providers also discussed the benefits of schools assuming an active role in education about reproductive biology and effective decision-making skills. Using peer education programs and bringing family planning program staff to schools and community-based organizations to educate students can be very beneficial.

"Being assertive about getting reproductive care is too much of a burden on teens."

"More time is needed during preventive visits with adolescents to discuss sexual development and activity. When teens come in for acute care problems, providers need to raise these issues as well."

Providers repeatedly mentioned the significance of integrating preventive and reproductive care wherever possible, using comprehensive risk assessments and also incorporating at least some mental health and substance abuse counseling to address the psychosocial issues underlying their sexual activity. Self-referral options are particularly important for adolescents who may not be comfortable using their health plan providers for reproductive care. Providers also noted that having a secure source of financing to pay for confidential care — either fee-for-service payments or grant funds (e.g., Title X) — is critical to assuring access.

"Males often have problems communicating with the opposite sex. All too often teens learn from music videos and song lyrics. So many girls think being mistreated is 'the norm.' Many teens don't have real adult role models in their lives."

Roadblocks

Four major problems reportedly impede the delivery of comprehensive reproductive care to adolescents — lack of confidentiality protections, insurance coverage limits, insufficient financing for confidential care, inadequate information for adolescents, and limited provider availability. With respect to confidentiality problems, providers in all four cities stated that most private insurers mail home to parents an "explanation of benefits" for each health care visit and this includes the reason for the visit, the diagnosis, and any laboratory tests. To avoid this violation of confidentiality, providers often refer teens to family planning programs or modify their diagnostic and billing codes. Only in San Francisco and Boston are public financing reimbursement mechanisms available so that providers can be reimbursed for confidential services.

"Insurance information goes home, so providers must either modify the reason for a visit or not bill."

With respect to private insurance problems, the most common complaints expressed by providers concerned copayment requirements for contraceptives and limited or no benefits for contraceptives, particularly oral and injectable contraceptives. In addition, STD screening is sometimes not covered. In the city with the most restrictive reproductive benefits under SCHIP and many private health insurance plans, contraceptives are not covered unless required for a medical condition, and routine gynecological examinations and family planning counseling are not covered at all. In general, providers had relatively few concerns about Medicaid coverage, except that in two of the four cities routine gynecological care is not reimbursed separately from the adolescent EPSDT visit when delivered by primary care providers.

With respect to adolescents' lack of information and knowledge, providers reported that not enough parents teach their children about sexual development and reproductive health care, and schools are providing less and less medically accurate and comprehensive information, focusing almost exclusively on abstinence-only education. As a result, there are serious gaps in what adolescents know, particularly about sexually transmitted diseases. In addition, providers noted that few adolescents know where to go for reproductive health services and what rights they have for confidential services.

With respect to provider availability, we heard that there is a lack of reproductive providers trained to serve adolescents. This problem is especially acute for male adolescents. Many family planning clinics and obstetrician/gynecologist offices have waiting rooms filled with women and magazines for women, which can be very off-putting for adolescent males. Lack of cultural and linguistic competence creates additional challenges in reproductive health care delivery. In one city, for example, public health officials told us that as many as 364 languages are spoken by local teens. Providers in three cities expressed concern over long waits and understaffing at some community health centers. Finally, coordination between schools and community health centers and between office-based practices and family planning clinics is often lacking because many reproductive health services are freestanding and not part of larger organized systems of care.

Innovative Programs

Baylor College of Medicine Teen Clinics in Houston is a network of six clinics in different neighborhoods offering an array of free reproductive and primary care services. One of the clinic sites is the Austin High School, with a student body of 2,400 students, almost all of whom are Hispanic. This clinic offers a wide range of services including preventive medical services, immunizations, sports physicals, treatment of minor acute illness, gynecological care, STD and HIV screening

and treatment, pregnancy testing, prenatal care, postpartum counseling, and some mental health counseling. There are four special programs offered through the Baylor Teen Clinics. The first, the Assets Enhancement Program for Young Women, teaches resiliency skills, including problem-solving strategies to use when teens are faced with difficult choices. It also offers case management services to assist teens in becoming self sufficient in terms of health, education, and career development. The second, the Fatherhood Initiative Program for fathers ages 15-25, consists of peer support and group discussions, case management, parenting classes, job assistance, health education, and parent and child activities. The third, the North East Adolescent Project, using outreach workers, school nurses, and counselors, identifies pregnant teens at area schools and refers them for early prenatal care. Outreach workers also assist pregnant teens in accessing other health services, entitlement programs, and educational programs. They also work with the mother, infant, and family until mutually agreed upon goals are achieved. The fourth, the Best Friends Program, teaches adolescents to be better parents. Using the "Big Sister" concept, volunteers discuss parenting skills and provide information on stress management, baby care, and community resources. Finally, community education programs addressing health care, human sexuality and adolescent pregnancy are offered by Baylor Teen Clinics to schools, churches, and other community sites. The majority of patients served by Baylor's Teen Clinics are low-income and primarily African American and Hispanic. Baylor Clinics are supported through Title V, Title X, and Title XX funds; Medicaid; the state's and the city's health departments; and through foundation and other private grants.

San Francisco's **New Generation Health Center**, a freestanding clinic of the University of California, provides free and confidential reproductive care to young women and men ages 12-24. Reproductive health services include examinations, pregnancy tests and counseling, STD and HIV screening, diagnosis, and treatment, and colposcopy. Also included are education and counseling on sexuality, contraception, pregnancy options, STD and HIV infection, substance abuse, stressful life situations, relationship violence, and peer and family relationships. In addition, New Generation Health Center (NGHC) provides free health education in English and Spanish to local schools and community agencies. Two special prevention programs are available for young men and women. For young men, NGHC offers a peer education program, called R.E.A.L.I.T.Y. (Real Education and Living in Today's Youth), in partnership with two high schools. With the goal of fostering better attitudes about unintended teen pregnancy and early fatherhood, the young men attend a weekly training session for 10 weeks and learn about pregnancy, STD and HIV infection, and other issues, such as violence, along with communication and team-building skills. For a one-year period, male peer educators make classroom presentations and participate in outreach programs. Incentive pay is provided. For young women, ages 12-19, NGHC offers a girls' club, called Independent Creations. With the goal of improving self-esteem, enhancing decision-making, and preventing teen pregnancies, girls participate in a range of activities, such as self-defense classes, drama, dance, arts and crafts, and tutoring. Each girl is matched with a mentor who provides emotional and academic support. NGHC serves a culturally and racially diverse population of mostly female clients, about 15% of whom speak Spanish only. NGHC is funded through the state's Office of Family Planning, Medicaid, and private foundations.

Boston's **Planned Parenthood League of Massachusetts** provides a range of affordable and confidential clinical, education, and advocacy services for children, adolescents, and adults. The reproductive services available include gynecological care, contraception, pregnancy testing and options counseling, pregnancy termination, colposcopy, and STD and HIV screening and counseling. In addition to its clinical services, Planned Parenthood League of Massachusetts offers three special education programs for youth. The first one, called Positive Transitions, is a five-session program for middle-school students. At the outset, a meeting of parents and staff review the curriculum and the importance of age-appropriate comprehensive sex education. The education sessions address self-esteem, reproductive anatomy and physiology, emotional and physiologic changes associated with puberty, healthy relationships, communicating individu-

"We need the media to portray attractive images of youth that are not exploitive."

"It's unclear who is responsible for educating adolescents about sexuality. Parents point to the schools and schools point to the parents."

als' choices, contraception, and HIV. The second program is called Heart to Heart and is offered to high schools students. It addresses myths and facts about sexuality and sexual relationships, effective communication skills, preventing STDs and HIV, accessing health services, negotiating healthy relationships, and understanding protective methods, including postponement of sexual intercourse. The third program, called Health Choices, is a series of group education sessions offered to teens at risk of fathering children, becoming pregnant, or contracting STDs. Based on the Heart to Heart curriculum, this program offers an expanded menu of topic options that are tailored to the individual needs of each group, including men's health and peer pressure. It is commonly offered at various Department of Youth Services and Department of Social Services settings. In fiscal year 2003, about a third of the teens receiving Planned Parenthood's clinical services came from minority groups. The Heart to Heart and Positive Transitions programs were provided to about 6% of Boston's middle and high school students, about half of whom are Black or Hispanic and the majority of whom come from lower income, underserved communities. Funding for the Planned Parenthood League of Massachusetts comes from private donations, grants, Medicaid and private insurance, and client fees.

VI. Behavioral Health Care

By far, health care providers in all four cities were most concerned that mental health and substance abuse treatment services are grossly inadequate to meet the needs of adolescents. The shortage of psychiatrists, psychologists, social workers, and substance abuse counselors trained to serve adolescents is widespread, and has been at a crisis stage for some time.

Sources of Care

Relatively few adolescents who need mental health services receive treatment and even fewer receive substance abuse treatment services, according to providers in all four cities. Those who do obtain care generally have a serious emotional disturbance, are experiencing a crisis, or have been required by schools or courts to participate in counseling. Comprehensive, continuous treatment is consistently unavailable.

Sources of mental health care in all four cities vary by insurance status and condition severity. Generally, providers reported that adolescents covered by Medicaid or SCHIP have better access to a continuum of mental health services than those with private insurance. In addition, they reported that adolescents with the most serious problems, including those in the juvenile justice system, receive better care than those with less serious problems. For many uninsured and most Medicaid-insured adolescents, and, to a lesser extent, SCHIP-insured adolescents, community mental health centers are the main source of outpatient mental health care, but teens usually must have a serious emotional disturbance. For privately insured adolescents in all four cities and SCHIP-insured adolescents in two cities, private behavioral health plan network providers are the most common source of outpatient mental health care. However, we heard that many privately insured teens rely on private mental health providers who are not in plan networks. School-based health centers provide varying amounts of primary mental health counseling to all students, but sometimes because of limited resources, have to triage those with private health insurance to their behavioral health plans. Community health centers, primary care providers, hospital-based clinics, and non-governmental organizations end up being important sources of outpatient mental health care for many adolescents. Sources of inpatient mental health care also vary by insurance source, but overall very few inpatient psychiatric beds are available for either publicly insured or privately insured teens.

Sources of outpatient and inpatient substance abuse treatment do not appear to vary by insurance status largely because services for adolescents are unavailable. However, some schools and non-governmental organizations in the four cities provide limited substance abuse prevention and counseling services.

Adolescents least likely to receive mental health or substance abuse treatment services are immigrants; Asian Americans; males; youth not in school; and those with less severe conditions, learning disabilities, and developmental disabilities. Also, providers told us that adolescents with chronic physical conditions, who predictably experience worse psychological adjustment and higher rates of psychiatric impairment than their healthier peers, seldom receive care.

What Works

Providers told us that where the behavioral health needs of adolescents are met, risks are identified early on, families are involved in treatment, mental health and substance abuse counseling are integrated, and a continuum of services is delivered in a timely manner by well-trained providers. Such optional arrangements are rarely found, however. In our study, we heard about integration achieved by a group-model HMO and by a collaborative between a public behavioral health plan and a public MCO. Less comprehensive, but still noteworthy, a few school-based health centers were offering primary mental health and substance abuse counseling, often through arrangements with community mental health centers or community-based substance abuse programs. For more serious problems, community mental health

"Health insurance coverage of mental health and substance abuse treatment services seems like a non-issue, since currently there are no providers."

"Most teens fall through the cracks."

"The mental health system is driven by failure. An adolescent has to fail repeatedly to get needed services."

"The reconfiguring of mental health services that occurred over the last 10 years has been really problematic. We don't know what providers have experience in serving adolescents and we don't know who has openings."

"We trade on the goodwill of the few psychiatrists there are."

"There is a mismatch between what providers are attempting to accomplish and the billing codes that insurers accept for reimbursement."

centers were providing the broadest array of mental health services, including intensive case management, day treatment, after-school programs, and crisis intervention.

Providers offered many insights about what makes behavioral health services work well for teens — having a single point of access or one phone-in line but multiple sites of care, same-day services, evening and weekend hours, flexible scheduling, longer appointments, after-school programs, and outreach with particular attention to immigrants and others with little or no experience using behavioral health services. Just as with primary and reproductive care, possibly even more so, having the right type of provider — skilled and interested in caring for teens — is key. All commented on the importance of providing mental health and substance abuse treatment at much earlier ages. Providers also noted the value of having adequate numbers of male therapists and more therapists from diverse racial, ethnic, and linguistic backgrounds who understand the cultural and social context in which adolescents experience problems. Greater use of specific interventions, including family therapy, group therapy, care coordination, home assessments and new models of home visiting, peer health education, multi-systemic therapies, and respite care as well as recreational and school supports also makes a difference.

Roadblocks

Providers informed us of numerous barriers that impede the delivery of mental health and substance abuse treatment services to adolescents. By far, provider shortages and inadequate reimbursement rates, interrelated factors, were the two most important. Restrictive managed care policies and arrangements, health insurance benefit limits and cost sharing, inadequate funding and fragmentation of public programs, weaknesses in special education, stigma, parental consent requirements, lack of defined roles for primary care providers, and an overall lack of accountability were also described as major roadblocks.

Severe shortages of mental health and substance abuse providers trained to care for adolescents were reported in all four cities. Child and adolescent psychiatrists are in extremely short supply and, although there are more psychologists and social workers, we were told that few are willing to accept the low rates of reimbursement offered by Medicaid, SCHIP, and even private insurers. We also heard that managed behavioral health panels are too small; typically, adolescents have long waits for appointments and many network providers are not accepting new patients. In addition, mental health providers reported that insurers rarely cover telephone calls to parents, teachers, and primary care providers; team conferences; and care coordination. In addition, we were told that few insurers accept diagnostic codes for psychosocial problems that are not yet considered diagnosable mental disorders. Because of these numerous payment problems, many mental health providers now require payment at the time of service. Providers told us that there are particular difficulties recruiting and retaining qualified providers to practice in urban areas.

In addition to the outpatient mental health shortages, we heard that few inpatient psychiatric and substance abuse beds are available for adolescents and those that exist are often far from families' homes, sometimes even out of state. As a result, teens with mental health crises often wait for extended periods in the emergency room. In one city, many adolescents with serious mental health conditions become "stuck kids" because without adequate community-based treatment programs, they remain hospitalized for extended periods of time. Similarly because of the dearth of substance abuse treatment services in all four cities, many adolescents end up in the criminal justice system. Where there once was a continuum of services with schools, outpatient, inpatient, day treatment, and residential facilities, we were told there is only outpatient and very little inpatient treatment.

Aspects of managed care also present special problems for adolescents seeking mental health care. Providers reported that separate insurance plans for mental health services, referred to as behavioral health carve-outs, create a false dichotomy between physical and mental health services. Coordination between the two systems rarely takes place. Moreover, providers with adolescent expertise are seldom identifiable or available, and school-based health centers, community mental health centers, and hospitals with multidisciplinary clinics do not participate in behavioral health networks. Another managed care concern reported by providers is the use of strict authorization and utilization control policies, which results in many fewer outpatient visits and shorter hospital stays than mental health providers recommend. We heard in two cities adolescents often must be suicidal to obtain inpatient care and those with eating disorders often must have serious medical complications before inpatient care is authorized.

Private health insurance benefit limits and cost-sharing requirements were cited as con-

cerns in all four cities. Lack of coverage for family therapy, case management, neuropsychological evaluations, partial hospitalization, and residential treatment services were also mentioned. In two cities, we heard about coverage exclusions for individuals with certain behavioral disorders, especially conduct disorder and oppositional defiant disorder. In contrast to private coverage, Medicaid offers comprehensive coverage for adolescents, except in one city where outpatient substance abuse treatment services is not covered and inpatient treatment is limited to detoxification only. SCHIP coverage, though more generous than conventional private health insurance plans, still has visit and day limits in two cities — 20 mental health outpatient visits, 20 outpatient substance abuse visits, and inpatient substance abuse coverage only for detoxification. Cost-sharing requirements, in the form of copayments and coinsurance — even nominal amounts — also serve as a barrier to privately insured and SCHIP-insured adolescents accessing mental health and substance abuse treatment services. Providers also noted that mental health parity laws, enacted in all four cities, offer little added protection for adolescents who do not have "biologically based disorders."

In addition to insurance problems, providers reported that public programs are inadequately funded and seriously fragmented. Inadequate funding for prevention, outreach, care coordination, and school-based mental health and substance abuse programs was identified as a persistent problem in all four cities. Providers reported that even funding for community mental health centers is being threatened because of state and county fiscal crises. Providers also mentioned that innovative programs designed for youth are often not sustainable. Also noted is the serious fragmentation in particular, the schism between mental health and substance abuse treatment agencies, which often results in piecemeal care to adolescents. State departments of mental health, developmental disabilities, maternal and child health, substance abuse, and child and youth protective services operate separate agencies and the delineation of roles and responsibilities, according to providers, is confusing and difficult to navigate. Although efforts are being made to improve interagency collaboration at the state and local levels, there appears to be little evidence of this from the perspective of service providers.

Providers also raised concerns about the erosion of special education services for adolescents with mental health conditions. In three cities we heard that because of limited resources, many youth with mental health conditions and educational-related problems are not being identified or are being mislabeled as having behavior problems to avoid providing special education services. Comprehensive assessments of learning problems often do not take place, and, in one city, services called for in Individualized Education Plans (IEPs) are often not provided. Moreover, few efforts are being made to integrate mental health services provided in school-based health centers with special education services.

The role of the primary care provider in delivering mental health and substance abuse treatment services was the subject of much discussion during our site visits. On the one hand, pediatricians and other primary care providers noted that more is being asked of them because of the absence of available mental health professionals, including screening and diagnosis, medication management, and counseling. On the other hand, they acknowledge having limited training and experience in delivering mental health and substance abuse treatment and, even those who are qualified are usually unable to obtain reimbursement for this care because they are not mental health clinicians or participants in behavioral health networks.

The stigma associated with acknowledging mental health or substance abuse conditions is of concern to many adolescents, particularly those from certain cultural backgrounds, such as Asians Americans. Providers mentioned that teens and their families oftentimes do not consider behavioral health problems as "real problems," particularly if they involve substance abuse. Moreover, adolescents are generally reluctant to seek care and few want to go to places called mental health or substance abuse treatment centers.

A related concern is the issue of parental consent. Many youth are afraid of informing their families about their problems. In only one of the four cities are minors explicitly authorized to consent to outpatient mental health care. In the other three cities, adolescents must be of a certain age — 12, 15, or 16 — to consent for care. Providers noted that for many younger teens, this is a serious barrier to care, particularly when there is emotional distress or substance abuse in the family or when the parents do not consent to care or do not follow-up with the provider.

Unlike preventive and primary care and, to a lesser extent, reproductive care, providers concluded that there is an overall lack of accountability with respect to mental health and substance abuse treatment services for youth. Not only are there enormous provider short-

"There is a push to medicalize adolescents' mental health problems for insurance reasons."

"The funding base for behavioral health providers in the public sector involves numerous sources that are constantly changing and all with varying expectations and reporting requirements. This takes important time away from direct services."

ages, there is no continuum of clinical services, no recognition of the unique needs of youth and opportunities for prevention and treatment, no widespread use of effective medications and other therapeutic interventions, no internal mechanisms for coordination among inpatient and outpatient providers or between physical and mental health services, and no data to track receipt of care or health outcomes.

"Learning disabilities are not being picked up and adolescents, especially African American males, are dropping out of school, often ending up with untreated mental health or substance abuse problems."

Innovative Programs

San Francisco's **Kaiser Permanente** is a group model HMO with a teen health clinic that offers — in addition to extensive primary, preventive, and reproductive health services — a wide range of behavioral health services from a multidisciplinary team of psychiatrists, psychologists, and social workers. Mental health services include individual, group, and family therapy and special groups for adolescents — an eating disorder group, a separate group for parents of adolescents with eating disorders, and a group for parents struggling with teens' risk-taking and out-of-control behaviors. Additionally, intensive outpatient and inpatient mental health services are available. Kaiser's substance abuse treatment services for adolescents include an intervention and education program and an intensive outpatient program. The eight-week intervention and education program consists of weekly teen and parent support groups and drug testing. Teens are encouraged to examine how their substance use is impacting their lives and to maintain abstinence. The intensive outpatient program consists of three phases — Phase I, early recovery, lasts a minimum of six weeks; Phase II, ongoing recovery, lasts eight weeks; and Phase III, extended ongoing recovery, lasts four weeks. Each phase consists of several weekly individual, group, and family sessions and attendance at self-help meetings. Completion of each phase depends on the teen's and family's participation, abstinence from substance use, and completion of a self-assessment assignment and home contract. Residential substance abuse treatment services are available as well.

"Primary care providers do not want to ask about behavioral issues if there are no mental health providers to refer to."

Richmond Area Multi-Services (RAMS) of San Francisco is part of a community mental health center network with more than 30 community-based clinics and school-based sites. Its child mental health clinic staff offers psychological assessment; individual, family, and group therapy; consultation to school teachers and staffs, case management; and special wraparound services for Medicaid-insured youth, youth served by school Wellness Centers, and seriously emotionally disturbed youth at risk for out-of-home placement. Wraparound services include tutors, mentors, "shadows" or people who stay with a young person for several hours a day to help him/her emotionally and behaviorally, after-school activities, parent education, respite, and transportation. RAMS services are available in several Asian languages and Russian. At the school-based sites, RAMS provides mental health services and consultation for seriously emotionally disturbed children who are in special education. It also offers a school-based Primary Intervention Program, which is designed to help students identify behavioral health difficulties among their peers and assist them to seek help. Prior to budget cuts, RAMS also offered a Transition Project, which helped youth in 5th and 8th grades transition into middle and high school and also helped newcomer students from immigrant families, and at youth recreation centers, RAMS staff members provided mental health services and programs for teens. Funding for RAMS is provided by San Francisco's city and county public health department, Medicaid, SCHIP, private HMOs, patient fees, and public and private grants.

Denver's **Arapahoe House**, provides a broad array of school- and community-based services to adolescents with substance abuse and other behavioral problems and their families. The school-based program, which operates in 15 high schools and 2 middle schools, includes prevention and education classes, assessment and evaluation, individual and group counseling, family consultation and therapy, and case management. Similar services are available in outpatient programs. In 6 high schools with school-based clinics, substance abuse treatment services are integrated with mental health and physical health services. In addition, Arapahoe House has several other services for adolescents — an adolescent triage center, which is a small adolescent inpatient treatment unit; two adolescent day treatment programs; an adolescent intensive residential treatment program; a residential treatment group home for adolescent girls and boys; and a specialized women's program to assist pregnant women or women who have dependent children with their ongoing substance abuse issues. New Directions for Families offers case management, residential, and aftercare services and has a specialized learning center for children residing with their mothers during treatment. About a third of the adolescents served by Arapahoe House in 2002 were Hispanic and 14% were African American, while just under half were White. Funding for Arapahoe House comes from various sources including private insurance, Medicaid, the state's Alcohol and Drug Abuse Division, and the federal Substance Abuse and Mental Health Services Administration.

VII. Conclusions

This study of provider perspectives in Boston, Denver, Houston, and San Francisco found that preventive and primary care, reproductive care, and behavioral health care services are not well matched to the needs of adolescents. Behavioral health care is the most problematic. Consequently, adolescents — at a critical period in their development — are receiving too little care, too late. Providers have to work too hard to make the system function for adolescents. It is likely that these same conclusions would be found in cities throughout the United States. Even though each of the four cities we visited has many high quality components of care and numerous committed health providers, as evidenced in the innovative programs described in this report, overall their health care delivery systems for adolescents are characterized more by omission than availability and more by fragmentation than efficiency. The shortcomings of the service delivery system appear to derive in large part from the way that public and private financing and managed care systems have evolved over the past few decades.

Health care services that work well for adolescents appear to share common features: caring and qualified providers are easily accessible; families are involved; preventive and primary care, reproductive care, and mental health and substance abuse treatment services are well coordinated; early identification and intervention are emphasized; more time and attention is given to adolescents during each encounter; linkages are made between health and other community supports; and insurance payments are reasonable and flexible grant funds are available. Examples of what works well are most often found in school-based health centers, community health centers and hospital outpatient departments with special teen clinics, and group-model HMOs with special teen programs. Providers believed that where there is collaborative leadership, a "champion" for adolescents, an institutional commitment, and adolescent training infrastructure, a pubic health investment, and high-level political support — particularly as evidenced in San Francisco — the delivery and financing of preventive and primary care, reproductive care, and behavioral health care is vastly improved.

There are also common roadblocks that constitute barriers to quality health care for adolescents, however.

■ Too few teen-friendly sites of care. Most health services, except for school-based health centers and mobile clinics, are difficult for adolescents to access. Unless services are convenient and co-located, the potential for low service utilization and loss to follow-up are predictable. There is also a need to make confidential care more accessible to adolescents who require it. Unfortunately, though, many clinics with special teen programs are not invited to participate in health plan networks.

■ Shortages of providers trained to care for adolescents. There are serious shortages of qualified providers interested in serving adolescents. Behavioral health provider shortages are the most pressing and widespread. Male reproductive and behavioral health providers and providers representing diverse racial, ethnic, and linguistic backgrounds are particularly in short supply.

■ Limited parental involvement and consent. Providers reported that too few parents are involved in supporting their adolescents to stay healthy, obtain health care when needed, and follow through on recommended treatment and referrals. The importance of parental involvement cannot be overestimated. Yet,

when parents are not involved or when adolescents fear their involvement, the process and outcomes of care are compromised unless adolescents are able to consent for care and obtain confidential care.

■ Lack of recognition of the value of preventive care among parents and teens. A large proportion of teens do not obtain timely and ongoing preventive care. They only seek care when sick. Consequently, many opportunities for preventive counseling and health education by qualified providers are lost.

■ Financial disincentives associated with adolescent health care. Insurance is not sufficient to assure appropriate care for adolescents. The amount of uncompensated care provided to insured adolescents – for example, the added time during visits, telephone calls, preventive counseling, care coordination, and multidisciplinary team care, and care that must be kept confidential from parents' insurers — is substantial and far greater than for other insured children or adults. Moreover, compared to younger children, a greater proportion of adolescents are uninsured.

■ Limited public health infrastructure. Except in San Francisco, the public health infrastructure to support planning, prevention, research and demonstration programs, and quality improvements for adolescents is under-funded, not designed to be comprehensive, and largely state-based. There are not at all enough sustained and concerted efforts to reduce behavioral risks among adolescents. The public health system is currently organized to address separate categorical issues, such as smoking, teen pregnancy, or violence. As a result, the small amount of resources available for the public health system has very limited reach.

VIII. Recommendations

This study, based on the perspectives of over 200 health care providers has revealed significant problems for adolescents in accessing appropriate health care services. It has also identified numerous examples of best practices and recommended approaches for improving the preventive and primary care, reproductive, and behavioral health service systems. From these examples and approaches, useful lessons can be drawn to help guide future improvements. The solutions rest in greater integration among the three health service systems and in broader family, school, and community interventions. According to providers, fundamental changes are needed in how health care services for adolescents are financed and delivered.

Based on their recommendations and our own analysis of the current limitations in financing and delivery arrangements in the four cities, we offer a set of suggestions pertaining to community planning, state experimentation with Medicaid and SCHIP, and federal agency supports. The recommendations, therefore, focus on what would help providers improve the delivery of care to adolescents in their cities. Certainly, many other reforms related to work force development and public health interventions are critically important but are not included in this report. We also recognize the resource challenges facing states and localities, and acknowledge that money alone will not eliminate all of the problems that providers reported. Still, however, important opportunities exist to achieve quality improvements and savings for adolescents through the following financing and service delivery reforms.

COMMUNITY COLLABORATIVES FOR ADOLESCENT HEALTH

At the community level, adolescent health collaboratives with public and private representatives could be formed to plan and implement more effective ways to deliver health services to adolescents. Such a collaborative might include clinicians who maintain a leadership role in primary, reproductive, and behavioral care; adolescents and parents who are representatives of the community; employers and public officials who are supportive of youth development activities; and also representatives from youth-serving organizations. These collaboratives could position themselves to work with Medicaid and SCHIP officials, public health managers, health plan medical directors, and employee benefit managers to stimulate improvements in adolescent health care delivery and financing. There are a wide range of activities that members might undertake.

- Examine the range of potential opportunities to integrate and expand preventive, reproductive, behavior health services, and youth development activities.

- Develop a workforce plan to increase the availability of mental health and substance abuse treatment providers trained to serve adolescents, the number of male reproductive and behavioral health providers, and the number of providers from culturally diverse backgrounds.

- Expand the number and financial viability of school-based or school-linked health centers as well as teen programs in community health centers, office-based practices, hospital outpatient departments, managed care clinics, family planning programs, community mental health centers, and substance abuse programs.

- Develop uniform approaches for assuring adolescents' confidentiality, including alternatives to mailing home "explanations of benefits," strategies for sharing medical records, and ways for obtaining parental consent in a timely and efficient manner.

"Money and services should follow the adolescent wherever they receive services."

■ Promote improvements in care coordination focused on assuring adolescents' adherence to treatment recommendations; maintaining communication among primary, specialty, reproductive, and behavioral health services; and linking health, education, and community support services.

■ Develop an outreach strategy, with peer educators and others, to encourage adolescents to use health care services and become active participants in health care decisionmaking, with particular attention directed at adolescents with low utilization patterns, especially males, Hispanics, immigrants, and youth not in school.

■ Create new models of parent outreach and education to support families in dealing with predictable adolescent challenges as well as addressing the needs of adolescents who are experiencing health problems.

■ Expand the availability of school health education programs aimed at promoting self-esteem, healthy relationships, conflict resolution, sex education, physical fitness, and nutrition by involving community health programs.

STATE EXPERIMENTATION WITH NEW MEDICAID AND SCHIP FINANCING APPROACHES FOR ADOLESCENT SERVICES

At the state level, Medicaid and SCHIP officials could experiment with new managed care models to support integrated health services for adolescents. In addition, states, as well as the MCOs they contract with, could explore a variety of reimbursement reforms. Separate from managed care, states could also introduce fee-for-service options to support school-based health centers and teen clinics in performing additional preventive and case management functions.

■ New Managed Care Models. States contracting with MCOs could experiment with alternative managed care models to encourage comprehensive and integrated services for adolescents. For example, they could capitate community-based networks of adolescent health providers capable of delivering and managing primary and specialty health care, reproductive care, and mental health and substance abuse treatment services. In addition, states could capitate shared managed care/school-based health center arrangements where responsibilities for all aspects of care are coordinated. Similarly, states using primary care case management arrangements could experiment with establishing specific provider qualifications for serving adolescents and enhanced case management fees in exchange for implementing specific teen-friendly requirements.

■ Reimbursement Reforms. States contracting with MCOs could adjust their capitation methods for adolescents by modifying their low prior utilization estimates to account for recommended standards of care and levels of adolescent morbidity and behavioral risk. They could also maintain fee-for-service payment options for all confidential reproductive, mental health, and substance abuse treatment services. States using primary care case management programs or fee-for-service arrangements could experiment with reimbursement reforms, including increasing fees for certain evaluation and management services; allowing physicians to bill separately for gynecological examinations on the same day as an EPSDT preventive visit; allowing for same-day billing for physical and mental health services; and adding codes for preventive medicine counseling, telephone calls, and team conferences, for example. In addition, financial incentives could be offered by states and plans to encourage the availability of teen-friendly services and integrated care as well as compliance with recommended treatment guidelines and other quality performance standards.

■ Fee-For-Service Options to Support School-Based Health Centers and Teen Clinics. Separate from managed care, states could experiment with fee-for-service payment arrangements to support key services offered by school-based health centers and other teen clinics offered in hospital outpatient departments, community health centers, and office-based practices. Using the flexibility of the EPSDT benefit, states could cover enhanced preventive services under Medicaid's optional benefit, "diagnostic, screening, preventive, and rehabilitative services." The scope of the preventive services could be defined to include

various services important to adolescents, such as health risk assessments, preventive counseling, mental health and substance abuse counseling, nutritional counseling, and reproductive health education. Also related to EPSDT, states could allow school-based health centers and other teen clinics to obtain fee-for-service payments for providing students and their families information about the availability of EPSDT services, providing or arranging for EPSDT screening services, arranging for referral for needed treatment, and conducting follow-up to ensure that adolescents receive needed diagnosis and treatment. Another fee-for-service option would be to support targeted case management for teens at risk for poor health outcomes or, for example, youth engaged in multiple risk-taking behaviors, pregnant and parenting teens, teens with sexually transmitted diseases, teens with serious chronic conditions, and teens out of school. These fee-for-service payments might be offset by reductions in capitation rates to MCOs.

FEDERAL INTERAGENCY COORDINATING COUNCIL FOR ADOLESCENT HEALTH

At the federal level, a new interagency coordinating council for adolescent health could be established, involving the Centers for Medicare and Medicaid Services, the Health Resources and Services Administration, the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Services Administration, the Department of Education, and the Office of the Secretary of the Department of Health and Human Services. This federal interagency commission, modeled after the Federal Interagency Coordinating Council (FICC) for infants, toddlers, and preschoolers who receive services under the Individuals with Disabilities Education Act (IDEA), could facilitate and help coordinate federal activities related to adolescent health. In addition, with expanded funds, the federal Maternal and Child Health Bureau under its Community Integrated Service Systems (CISS) program could provide support to strengthen state and local systems of care for adolescents, focusing primarily on infrastructure building. Through grants to community adolescent health collaboratives, the Maternal and Child Health Bureau could stimulate and support teen friendly, one-stop shopping service systems; interdisciplinary training; linked clinical, school, and community preventive interventions; new and emerging technologies and state-of-the-art treatment; technical assistance; and services not otherwise insured. Such services could include care coordination, telephone hotlines, crisis intervention, peer education, and health education services. Finally, the Maternal and Child Health Bureau could also evaluate the extent to which health services and funding actually follows the adolescent and is seamless.

References

1 Newacheck PW, Hung YY, Park MJ, Brindis CD, Irwin CE. (2003). Disparities in adolescent health and health care: Does socioeconomic status matter? *Health Services Research*. In press.

2 Ozer EM, Park MJ, Paul T, Brindis CD, Irwin CE. (2003). *America's Adolescents: Are They Healthy?* San Francisco, CA: National Adolescent Health Information Center, University of California, San Francisco; Maternal and Child Health Bureau. (2002). *Child Health USA 2002*. Rockville, MD: Maternal and Child Health Bureau, U.S. Department of Health and Human Services. Committee on Psychosocial Aspects of Child and Family Health, American Academy of Pediatrics. (2001). The new morbidity revisited: A renewed commitment to the psychosocial aspects of pediatric care. *Pediatrics* 108(5):1227-1230.

3 Centers for Disease Control. (2001). *Youth Risk Behavior Surveillance System: 2001 Information and Results, Youth 2001 Online*. Accessed online at www.cdc.gov/nccdphp/dash/yrbs/2001/youth01online.htm.

4 Gans JE, Alexander B, Chu RC, Elster AB (1995). The cost of comprehensive preventive medical services for adolescents. *Archives of Pediatrics and Adolescent Medicine*. 149(11):1226-1234. Converted to 2002 dollars from the original amount of $33.5 billion in 1992, using the U.S. Department of Labor's Bureau of Labor Statistics' Medical Care Consumer Price Index.

5 Hedberg VA, Bracken AC, Stashwick CA. (1999). Long term consequences of adolescent health behaviors: Implications for adolescent health services. *Adolescent Medicine: State of the Art Reviews*. 10(1):137-151. Converted to 2002 dollars from the original amount of $700 billion in 1998 dollars, using the U.S. Department of Labor's Medical Care Consumer Price Index.

6 U.S. Census Bureau (2000). Accessed online at www.census.gov. This list includes the 8 largest U.S. cities, excluding Phoenix (6th largest). It also includes San Francisco, Boston, and Denver the 13th, 20th and 25th largest cities respectively.

7 According to the Youth Risk Behavior Surveillance System, the most recent data available for Denver is from 1995.

8 "Foregone care" is measured by adolescents' response to "Has there been any time over the past year when you thought you should get medical care, but did not?" Ford CA, Bearman PS, Moody J. (1991). Foregone health care among adolescents. *JAMA*. 282 (23): 2227-2234.

9 Newacheck PW, Wong ST, Galbraith AA, Hung YY. (2003). Adolescent health care expenditures: A descriptive profile. *Health Services Research*. 32(6S):3-11. 1997 health expenditures were converted to 2002 dollars by using the U.S. Department of Labor's Medical Care Consumer Price Index.

10 Brindis CD, Ozer EM, Handley M, Knopf DK, Millstein SG, Irwin CE. (1998). *Improving Adolescent Health: An Analysis and Synthesis of Health Policy Recommendations*. San Francisco: National Adolescent Health Information Center, University of California, San Francisco.