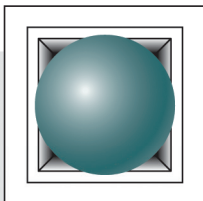


# Structuring Health Care Reform to Work for Adolescents

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Most Americans now place health care reform high on the nation's agenda. While health care reform solutions span a broad spectrum of political thought and rely on different mechanisms for covering the uninsured, certain concepts for restructuring the health care financing and delivery system to be more efficient and effective are gaining traction: placing greater emphasis on prevention, redesigning primary care, changing payment incentives, and relying more on evidence-based research.

The National Alliance to Advance Adolescent Health urges Congress and the new Administration to consider the needs of adolescents, an underserved segment of the population that has had little prominence in the dialogue and yet represents one of our best strategies for realizing cost containment goals. The needs of adolescents are too often ignored because of the perception that they are healthy, when, in fact, adolescents have morbidity and mortality rates twice those of younger children.<sup>1</sup> Our nation's failure to respond more effectively to their increasingly complex physical, mental, and reproductive health needs is reflected in alarming rates of obesity, depression and suicide, post-traumatic stress, drug and alcohol abuse, sexually transmitted diseases, pregnancy – and even school drop out, which can be attributed in part to neglected health problems. What each of these outcomes has in common is that they bear long-term personal and societal costs. That adolescents' health conditions are almost entirely preventable or able to be more effectively managed should qualify adolescents as a primary target for any reform proposal serious about generating cost savings.



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***Focusing on Prevention to Improve Health Outcomes for Adolescents***

As the cornerstone of a high performance health system, prevention is featured prominently in health care proposals. The Federal Employees Health Benefits Plan (FEHBP) is often identified as standard for basic coverage, but Medicaid's EPSDT benefits and additional benefits promulgated by the Secretary to cover services including early detection, disease prevention, and self management often are required as well. In addition, to encourage the use of preventive services, some proposals provide for the elimination of cost sharing for a wide range of preventive interventions and reduced premium charges for enrollees who participate in wellness programs.

Current reform proposals may not have been developed with the adolescent population in mind, but those that call for enhanced preventive benefits and a strong emphasis on self management certainly address the core elements of a more effective and cost-efficient health care delivery system for adolescents. Even Medicaid's EPSDT benefits – which primarily consist of screening services, a physical examination, immunizations, and brief anticipatory guidance – do not usually assure coverage for the interviewing and sustained behavioral counseling interventions that adolescents may require; in fact, only 33 states even provide coverage for an annual preventive health visit during the adolescent period.<sup>2</sup> The needs of adolescents, particularly those from low-income families, are complex and interrelated. The adolescent who is engaging in unprotected sex, for example, might also be overweight and experiencing anxiety. Identifying an adolescent's health concerns and risk factors requires skilled interviewing and the assurance of confidentiality. Helping them to take greater responsibility for reducing risky or unhealthy behaviors requires a health mentoring strategy that adds to their health knowledge, builds on their strengths, and increases their decision-making skills, self-esteem, and self-control. It often also will involve educating and supporting parents and engaging school and community resources. A commercial benefit package, FEHBP, and even most current EPSDT programs cannot achieve the kind of primary care practice changes needed to promote the health and well-being of adolescents.

We recommend that reformers consider an adolescent prevention benefit package that goes beyond improved screening services and a prohibition on cost-sharing to include longer interviews and behavioral health counseling and support services that may be provided at the

annual visit and, as needed, on an ongoing basis. Counseling services would be available in group or individual sessions and also through email, text messaging, or telephone communications. They would also include parent training and supportive counseling. These are services that would be efficiently provided by health educators, nurse practitioners, or social workers as well by physicians in primary care sites.

### ***Building an Adolescent-Centered Interdisciplinary “Health Home”***

Some health reform proposals endorse *the medical home model* for improving the care of patients with chronic conditions – making it more patient-centered, better coordinated, and higher quality primarily through a greater reliance on physician-directed interdisciplinary teams and health information technology. Pilot medical home projects are being promoted and many, primarily established under state leadership, are already underway. The concept has been gaining favorable support from certain health policy and business leaders and is now being viewed by professional medical organizations –including the American Academy of Pediatrics, the American College of Physicians, and the American Academy of Family Physicians – as a means of improving primary care for all patients.

Patient-centered care and the use of interdisciplinary teams and health information technology are needed reforms in primary care for adolescents. As the model is currently constructed, however, it is too medically oriented to address adolescents’ needs for comprehensive, interdisciplinary primary and preventive care. Conceived as a means of improving the care of children and adults with chronic conditions, patient centeredness under the medical home model is meant to engage patients to better manage their chronic conditions, coordination is primarily between primary and specialty care services, and team care is generally limited to the physician and his or her nursing and administrative staff. Almost 20% of adolescents have a chronic physical health, mental health, or substance abuse condition,<sup>3</sup> but a larger proportion presumably are at risk for a chronic condition because of unhealthy behaviors and the stressful and often dangerous environments in which they live. For various reasons, adolescents generally are left, sometimes on their own, to piece together the physical, behavioral, and reproductive health services they may require from different providers who are too often focused on the care of adults or young children. A transformed primary care model for adolescents would be a “health home” in which integrated care was provided by an

interdisciplinary staff that included nurse practitioners, health educators, social workers, and psychologists able to provide comprehensive preventive care, primary care, sexual health services, and mental services on site and to negotiate appropriate arrangements for specialty services such as psychiatric, obstetric/gynecological, and substance abuse treatment.

Health reform proposals that promote the medical home concept should consider what needs to be done to customize it for adolescents. Policies pertaining to primary care provider requirements or payment enhancements should encompass adolescent-centered health promotion and disease prevention activities, as well as chronic care management, to improve the quality and efficiency of primary care. And, pilot projects should test how adolescent-centered models of interdisciplinary care can best be implemented on a broad scale, what features are critical to positive health outcomes for adolescents, and what process and outcome variables can be used to measure success.

### ***Paying for a Better Model of Adolescent Primary Care***

Significant attention from reform advocates is being paid to compensation because of long-standing recognition that current fee-for-service methodologies undervalue primary care and reward volume rather than quality and cost efficiency. While some health care proposals are short on specifics, all call for restructuring payment to better compensate providers for prevention, early detection of problems, and chronic care management. They also call for financial incentives to achieve health care quality measures and improve patient health. More detailed proposals offer ideas for a mix of changes to fee-for-service payment, capitated per member payments for chronic care management, bundled payments for episodes of care, and performance-based incentives.

Implementing new payment approaches to improve delivery system design for all populations, including adolescents, is clearly needed. Yet, adolescents have factored minimally in payment reform demonstration and debates, undoubtedly because obvious and immediate cost-savings are to be found in improving chronic care and disease management. As a result, current proposals have limited applicability to the needs of adolescents. They fail to capture opportunities for promoting innovation in health promotion and disease prevention. Similarly, they

do not sufficiently incentivize adolescent health care providers to redesign their practices to offer comprehensive interdisciplinary models of care to improve health outcomes for adolescents.

In crafting strategies to better align payment with delivery system advancements, we urge reformers to consider the unique primary care needs of adolescents that go beyond chronic care management. To improve adolescent health care delivery, fee-for-service payment systems should compensate primary care providers fairly and payment should be available in primary care sites: for comprehensive health promotion and disease prevention services -- including individual and group preventive counseling, gynecological and testicular exams, mental health therapy, and parent education and support; for the efficient use of services delivered by nurse practitioners, health educators, social workers, and psychologists; and for multiple services furnished on the same day. In addition, consideration could be given to capitated care management fees paid not only for adolescents with chronic conditions but also for those at risk for chronic conditions in order to support appropriate telephone and email communications as well as coordination with schools, parents, and relevant community agencies. Finally, to promote the widespread development of comprehensive adolescent health centers, payers could be required to enter into contracts with providers designated as meeting specified criteria for such centers -- be they hospital outpatient departments, community or school-based clinics, or physician practices -- and to pay them reasonable rates for the services they provide. (Federal grants or loans could finance needed capital improvements and other infrastructure changes.)

### ***Making Evidence-Based Research Work for Adolescents***

Several reform architects look to science to guide providers and consumers in making better informed decisions about health care interventions. Concepts in reform proposals such as *evidence-based practices, demonstrated effectiveness, and comparative effectiveness* have the twin goals of controlling costs by limiting access to proven treatments and of ensuring high quality care by using only those practices with an established track record. In some proposals external review boards would be granted authority to guide reviews and research on the comparative effectiveness of various treatments.

Strict adherence to a rigorous evidence base, however, is likely to be problematic for adolescents. The standard of evidence for some adolescent services is irrefutable. Reproductive

health services, for example, have demonstrated effectiveness at increasing adolescents' use of contraception, reducing adolescent pregnancy, and increasing adolescents' knowledge about sexual and other reproductive health issues.<sup>4</sup> Psychotropic medication and mental health therapy, usually in combination, have well-established efficacy for adolescents with ADHD, bipolar disorder, depression, and anxiety.<sup>5,6,7,8,9</sup> With respect to preventive care, however, the US Preventive Services Task Force, frequently referenced in health reform proposals as the arbiter of evidence-based standards, cites insufficient evidence to recommend screening or counseling of adolescents for alcohol and tobacco use, nutrition and physical activity, obesity, depression, and suicide.<sup>10</sup> Inadequate evidence does not mean these services lack value. Although providers should be expected to draw upon available scientific findings, it is not currently possible to base a system of care for adolescents on evidence-based research. Moreover, desired health status outcomes for adolescents could not be assured in the future if innovation, experimentation, and individualized interventions were restricted by findings from broad population evidence-based studies that failed to account for differences in culture, genetics, environment, and adolescent and parent competencies.

To build an effective, high quality health care system for adolescents, we urge that evidence-based research take account of adolescents' changing and interrelated conditions and health-risk factors. More research needs to be done, especially preventive services research that goes beyond interventions addressing discrete risk factors. As this is an underserved, rather than overserved, population, however, we need to assure that "evidence-based care" is not used as a rationale for curtailing access to creative prevention and treatment approaches for which we have no research. We also need to assure that comparative-effectiveness studies are not used as a way to limit treatment options that could be beneficial for individual or subgroups of adolescents (particularly, but not exclusively, in psychiatry). If an entity on comparative-effectiveness is to be established, the efficacy of adolescent health interventions should not be judged by leaders in adult medicine. It should be determined by a consensus of opinion by expert practitioners in adolescent health.

Health reform offers an important opportunity to strengthen the health care delivery system for adolescents. Policies designed to foster comprehensive preventive services as part of a new model of interdisciplinary primary care would go a long way to assuring that adolescents, particularly those from low-income families, become healthy and productive adults. They are also likely to achieve future cost-savings not only for the health care system but for society as a whole.

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<sup>1</sup> National Center for Health Statistics. *Health, United States 2007, With Chartbook on Trends in the Health of Americans*. Hyattsville, MD: National Center for Health Statistics, 2007.

<sup>2</sup> Fox HB, Limb SJ, McManus MA. *Preliminary Thoughts on Restructuring Medicaid to Promote Adolescent Health*. Washington, DC: Incenter Strategies, 2007.

<sup>3</sup> US Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

<sup>4</sup> Burlew, R, Philliber S. *What Helps in Providing Contraceptive Services for Teens*. Washington, DC: National Campaign to Prevent Teen and Unplanned Pregnancy, 2007.

<sup>5</sup> AACAP. Practice parameter for the assessment and treatment of children and adolescents with attention-deficit/hyperactivity disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*. 2007; 46: 894-921.

<sup>6</sup> Practice parameter for the assessment and treatment of children and adolescents with bipolar disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*. 2007; 46: 107-125.

<sup>7</sup> The TADS Team. The treatment for adolescents with depression study (TADS): long-term effectiveness and safety outcomes. *Archives of General Psychiatry*. 2007; 64.

<sup>8</sup> David-Ferdon C, Kaslow NJ. Evidence-based psychosocial treatments for child and adolescent depression. *Journal of Clinical Child and Adolescent Psychology*. 2008; 37: 62-104.

<sup>9</sup> Walkup JT, Albano AM, Piacentini J, Birmaher B, Compton SN, Sherrill J, Ginsburg GS, Rynn MA, McCracken J, Waslick B, Iyengar S, March JS, Kendall PC. Cognitive-behavioral therapy, sertraline and their combination for children and adolescents with anxiety disorders: acute phase efficacy and safety. *New England Journal of Medicine*. Online ahead of print 2008; 359.

<sup>10</sup> United States Preventive Services Task Force. *The Guide to Clinical Preventive Services, 2008*. Bethesda, MD: Agency for Healthcare Quality and Research, 2008. <http://www.ahrq.gov/clinic/pocketgd08/pocketgd08.pdf>

The National Alliance to Advance Adolescent Health, formerly Incenter Strategies, provides education, research, policy analysis, and technical assistance to achieve fundamental improvements in the way that adolescent health care is structured and delivered in the United States. Its mission is to enhance the physical and emotional well-being of adolescents, especially those who are low income and minority, by improving the health care delivery model for adolescents and achieving the infrastructure changes needed to support it. The National Alliance seeks to promote comprehensive, interdisciplinary models of physical, mental, behavioral, and reproductive health care that incorporate a youth development philosophy and operate in collaboration with schools and other community-based programs. It also seeks to ensure that all adolescents have health insurance coverage for the services they require.

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