Improving the Health of Adolescents Through Improving Access to Care

LEAH/State MCH Adolescent Health Professionals

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Access: What do we mean?

- “ the timely use of personal health services to achieve the best possible health outcomes” - *Institute of Medicine 1993*

A tool for improving the health of adolescents

A framework for understanding where we are and where to direct our efforts

Access: *5 dimensions:*

1. **Affordability** *(ability to pay for all needed services)*
2. **Availability** *(provider's skills match adolescents need)*
3. **Accessibility** *(geographic proximity)*
4. **Accommodation** *(meet the needs and constraints of adolescents)*
5. **Acceptability** *(adolescent's attitudes towards provider/system)*

Penchansky, R et. al. Medical Care; 19(2) 1981

“these five As of access form a chain that is no stronger than its weakest link”

McLaughlin CG and Wyszewianski, L; Health Services Research; 37(6) 2002

Measuring Access (1):

- Specifically (rates of insurance, physicians trained in adolescent health…)

or

- Functionally (perceptions of adolescents or families about unmet needs for care due to cost, accessibility……)

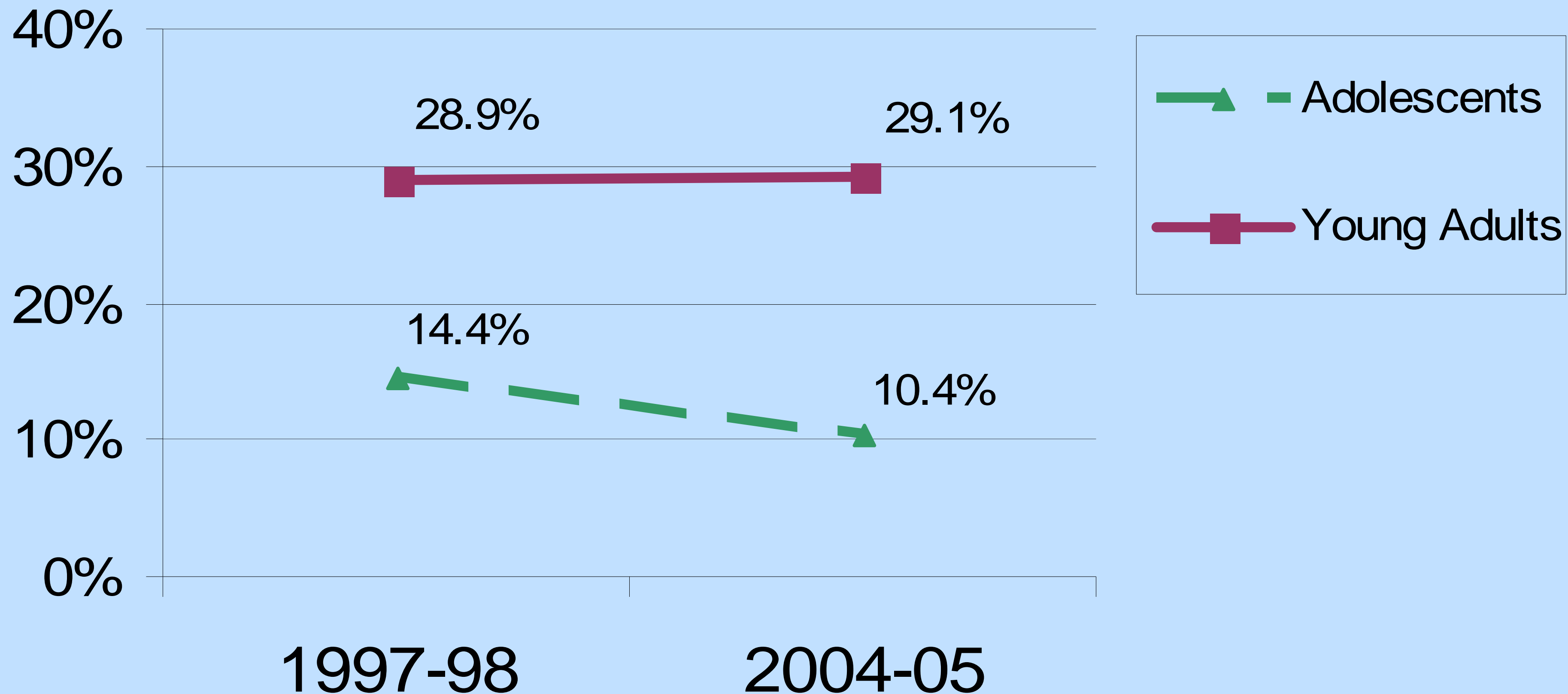
Measuring Access (2):

- **Affordability**
  - Insurance coverage, benefit package, co-payments, underinsurance
- **Availability**
  - % providers trained in adolescent health
- **Accessibility**
  - Located where adolescents are
  - On bus line?

Measuring Access (2):

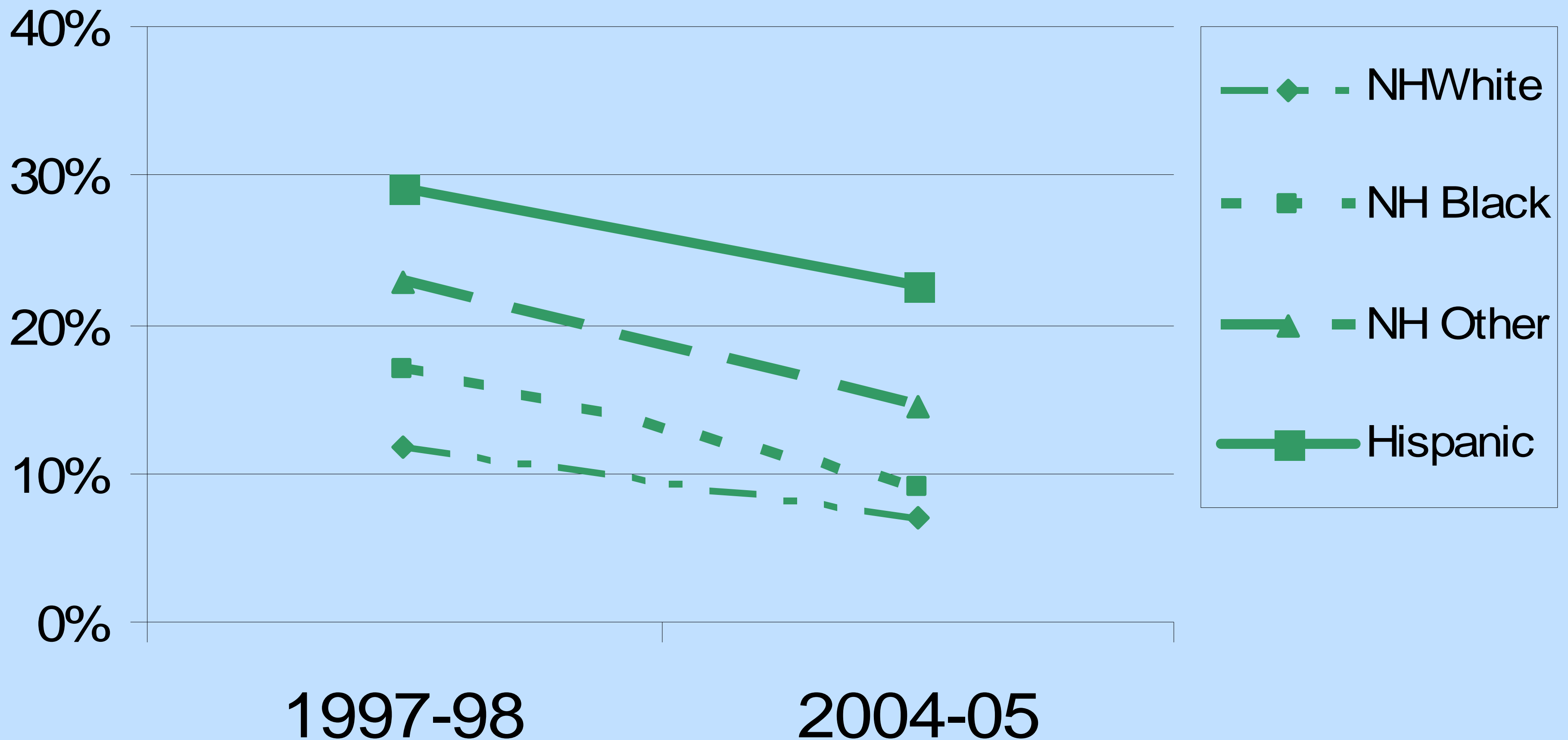
- **Accommodation**
  - Convenient hours
  - Drop in visits
- **Acceptability**
  - Comfortable with the providers and clinic setting
  - Confidentiality
  - Developmentally sensitive

Affordability: Uninsurance Among Adolescents and Young Adults



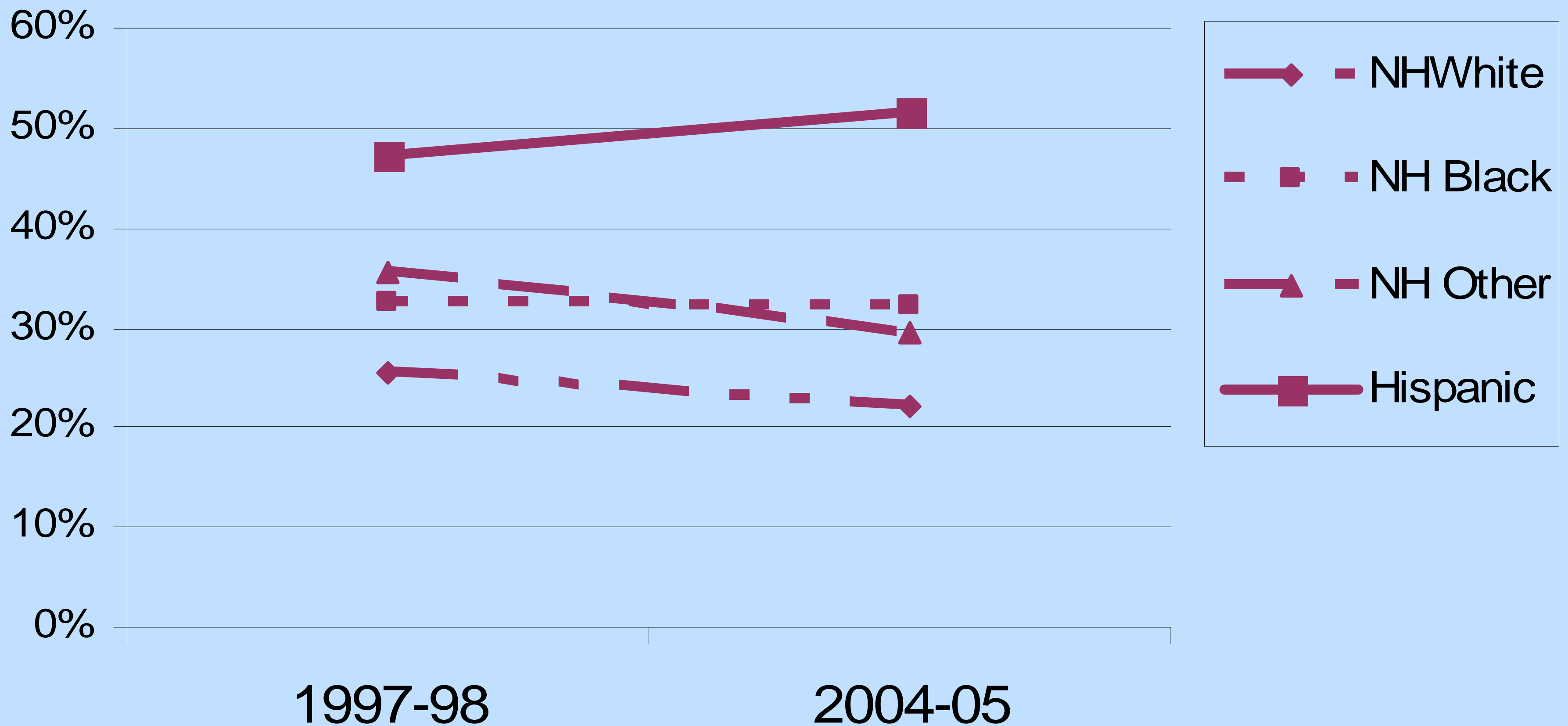
Source: National Health Interview Survey, pooled 1997-98 and 2004-2005

Affordability: Uninsurance among Adolescents by Race/Ethnicity



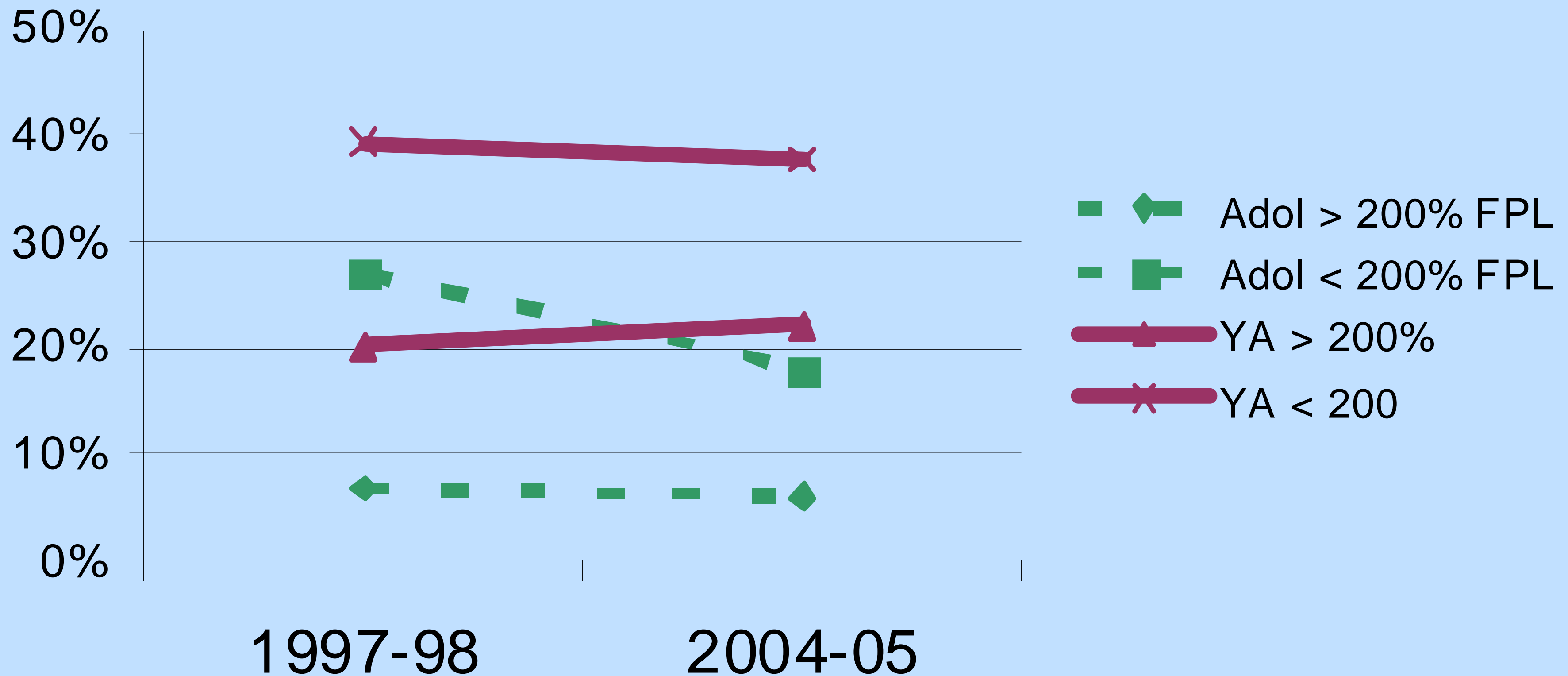
Source: National Health Interview Survey, pooled 1997-98 and 2004-2005

Affordability: Uninsurance among Young Adults



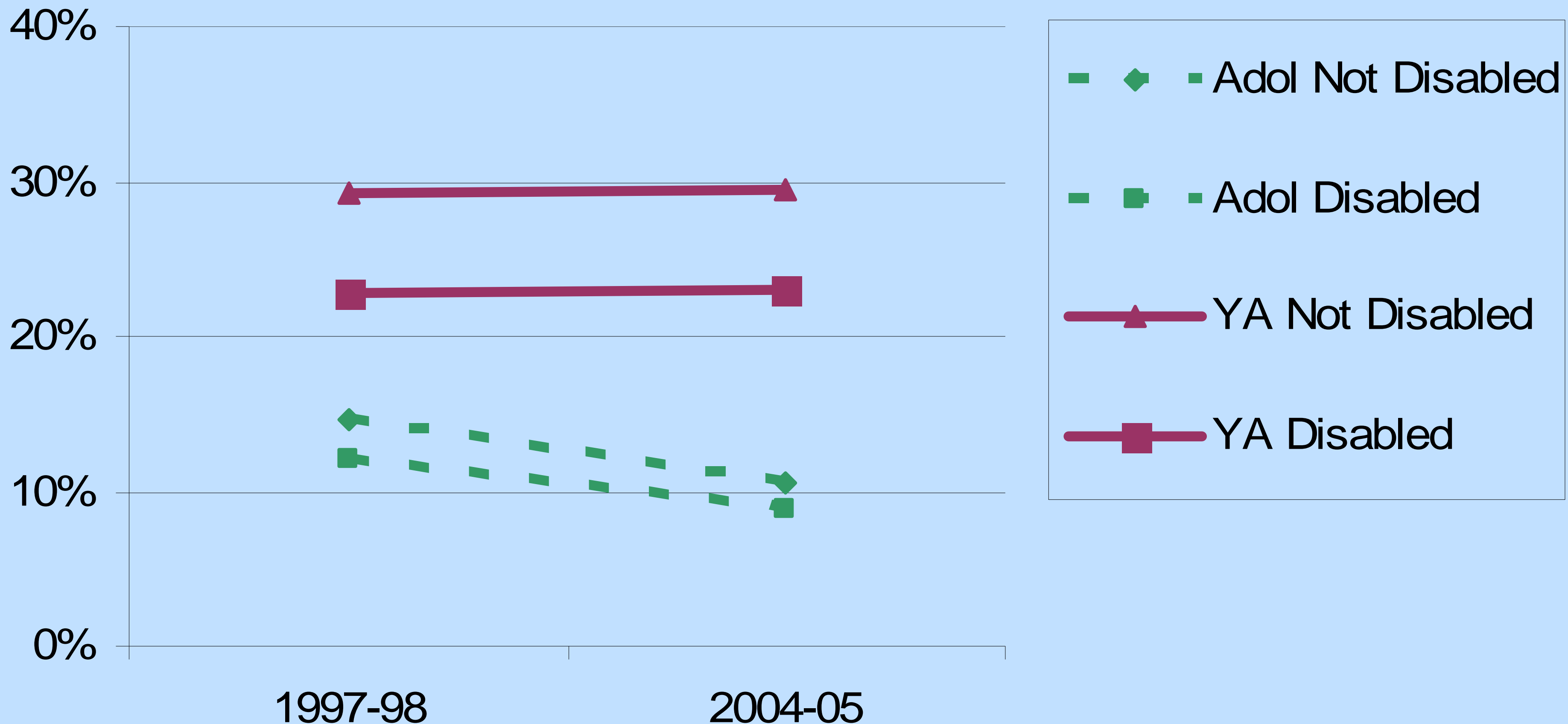
Source: National Health Interview Survey, pooled 1997-98 and 2004-2005

Affordability: Uninsurance among Adolescents and Young Adults by Poverty



Source: National Health Interview Survey, pooled 1997-98 and 2004-2005

Affordability: Uninsurance among Adolescents and Young Adults by Disability



Source: National Health Interview Survey, pooled 1997-98 and 2004-2005

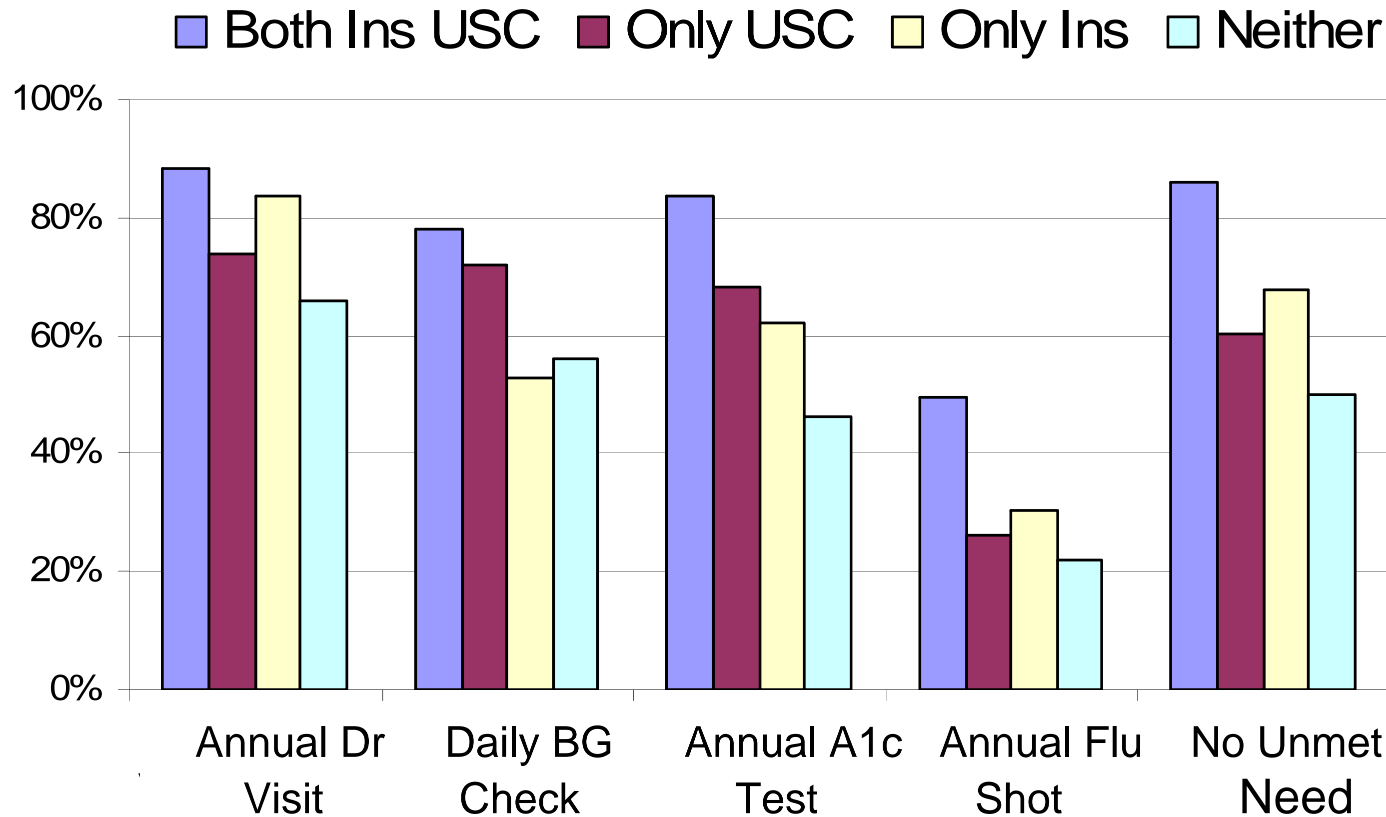
Key Points: Affordability

- Declining rates of uninsurance since 1997 (SCHIP effect?)
  - Most notable decline for low income
  - Positive effect for adolescents
- Some changes among groups of young adults
  - Increase in uninsurance rate among those >200% FPL and Hispanic youth

Access and Quality of Diabetes Care for Young Adults

- Testing the contribution of insurance and having a usual source of care to quality of care
- Young Adults 18-24 with self-report of diabetes onset prior to age 18
- National survey data (Behavioral Risk Factor Surveillance Survey, BRFSS)
- Self-report of quality of care

Access and Quality of Diabetes Care for Young Adults



Source: Behavioral Risk Factor Surveillance Survey, pooled 2000-2005
Young Adults 18-24 reporting diabetes onset prior to age 18

Children with special health care needs (CSHCN) – Access to care

Conducted by the National Center for Health Statistics.

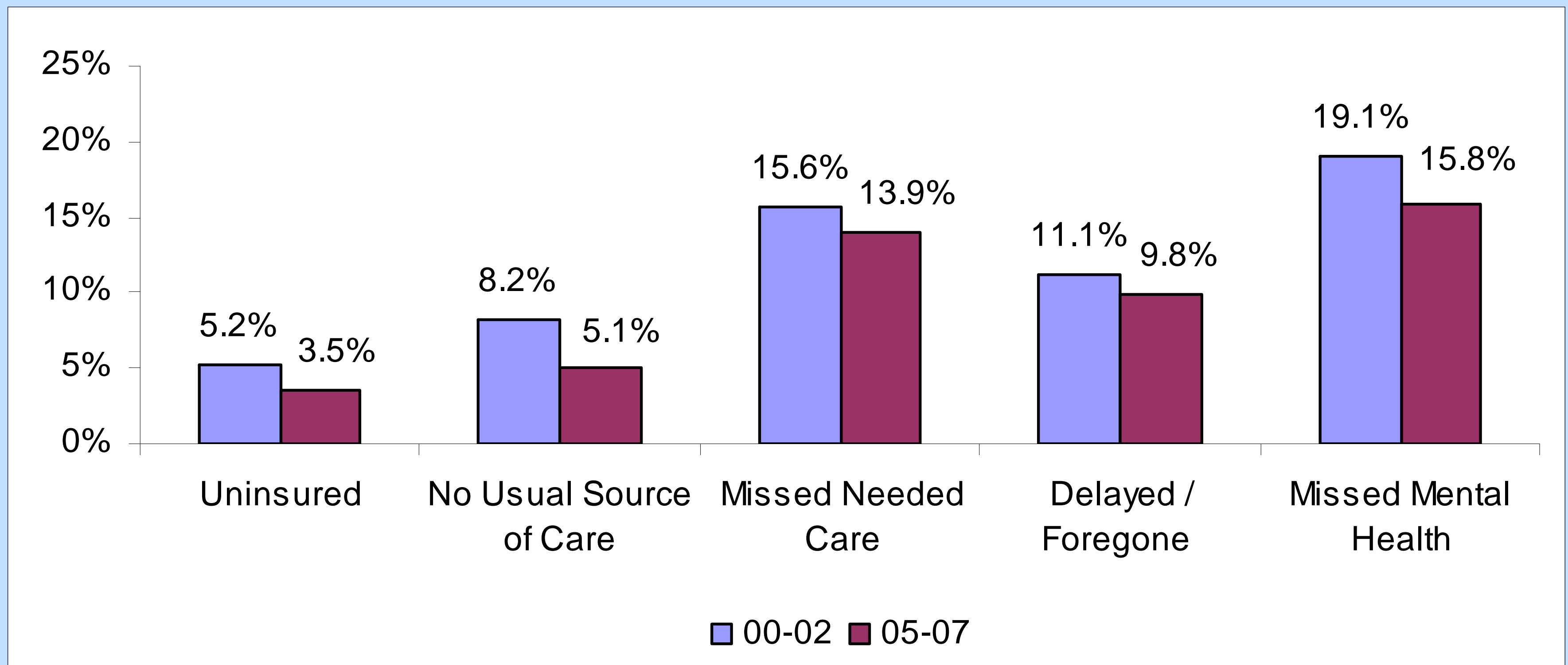
- 2000-2002
- 2005-2007

Includes measures of resources to access care and realized access for ALL 50 states.

- Health insurance coverage, usual source of care
- Missed needed care, delayed or forgone care, missed mental health care.

* Please see handout accompanying slides

CSHCN – Access to care, United States, 2000-2002 and 2005-2007



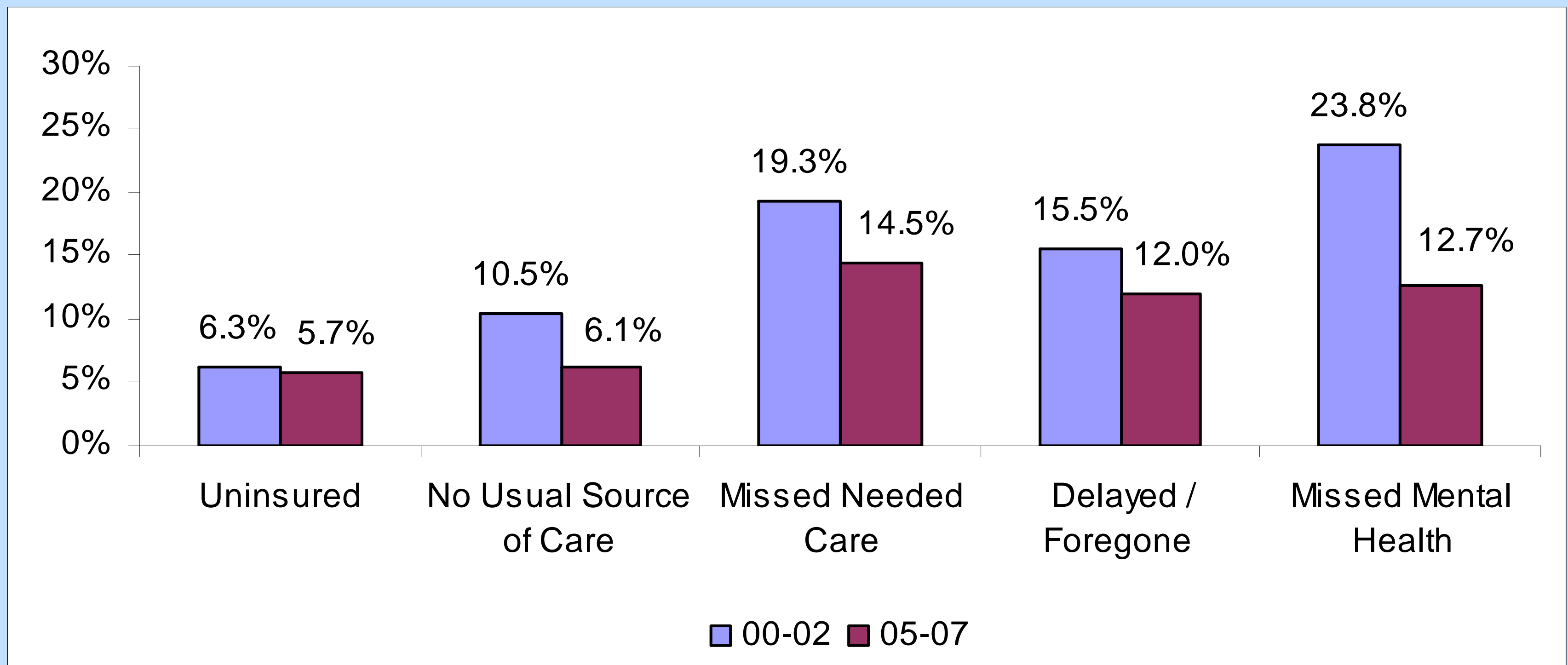
CSHCN – Access to care, by state, 2000-2002 and 2005-2007

Among adolescents with special health care needs, states with no improvement or increased rates of:

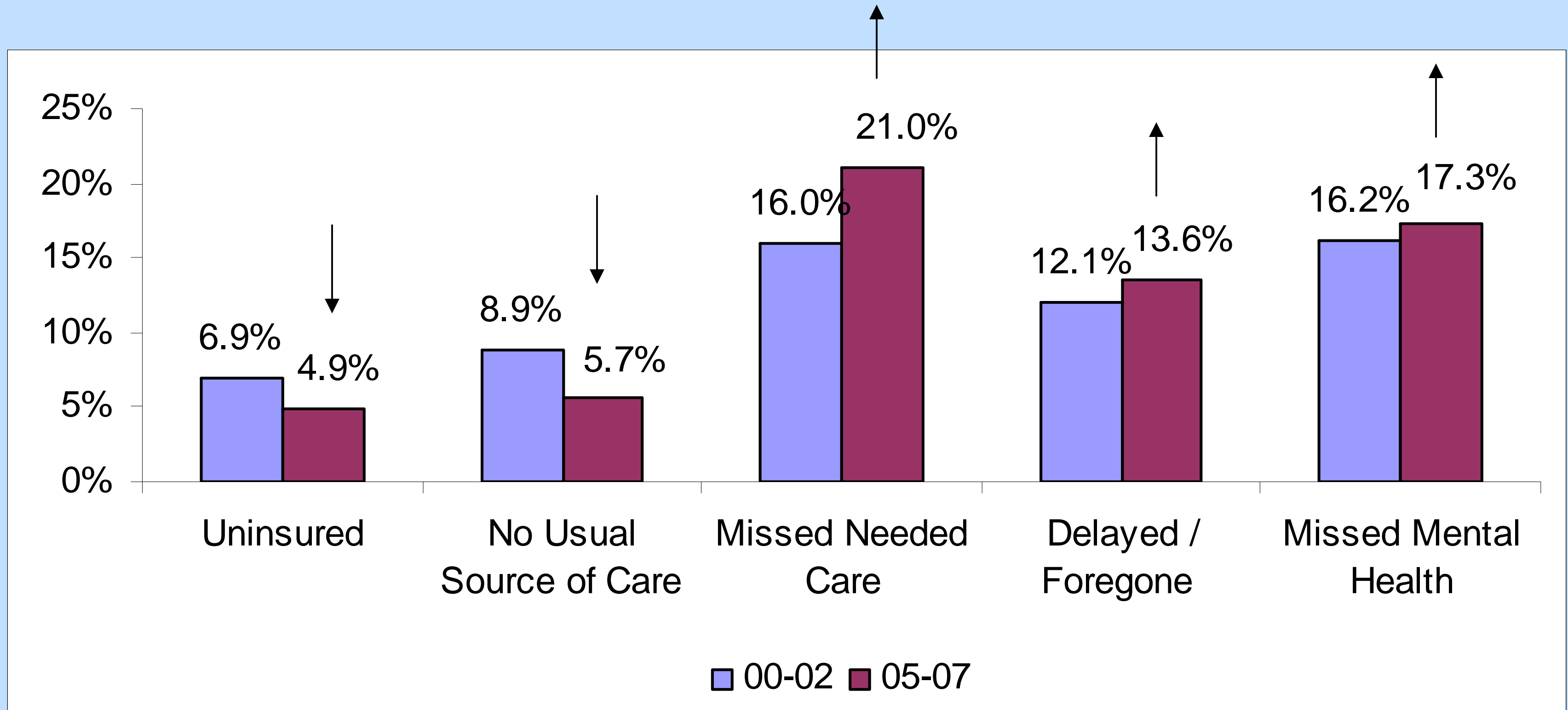
- Uninsurance rate – 10 states
- Missed needed care – 20 states
- Delayed or forgone care – 18 states
- Missed needed mental health care – 21 states

→ Pattern across state not always what you would expect…

Expected pattern: Access to care, Oregon, 2000-2002 and 2005-2007



Paradoxical pattern: Access to care, Florida, 2000-2002 and 2005-2007



Summary: Access to Care

- Insurance plays critical role
  - SCHIP has improved coverage rates for children and adolescents
  - Young Adults are most likely to be uninsured
- Insurance is <u>insufficient</u> to achieving universal access

Still many questions

- Are the trends in access similar for adolescents with and without SHCN?
- Are these trends in realized access different among minority and low income groups?
- Why don’t realized access (unmet needs) always follow potential access (insurance and usual source of care)?

Questions (continued)

- What role does the type of insurance or benefit package play in realized access?

Moving ahead

- Clearly efforts to increase coverage have worked for the targeted populations
- Yet the improved coverage exacerbates the divide between adolescents and young adults, how do we address this?
- Access is clearly multidimensional: efforts directed to providers, youth and systems are effective and should be pursued simultaneously