CHIP:

New Opportunities in Adolescent Health Care Delivery

Angela Diaz, M.D., Sharon Edwards, M.D., Wendy P. Neal, M.D., Pamela Ludmer, M.D., Jacalyn Bitterman, M.D., and Anne T. Nucci, M.D.

Abstract

Children's Health Insurance Programs (CHIP), usually targeted to infants, toddlers, and school-aged children, have been expanded to include adolescents. Adolescents need some form of health insurance in order to access needed care. Moreover, programs and services that provide them with health care must be adolescent-friendly, adolescent-focused and adolescent-sensitive, and include specialized training for primary care providers. Translating this philosophy into a successful health care delivery program involves addressing the psychological, institutional and financial barriers that make it difficult for adolescents to access health care. Overcoming these barriers, especially the financial ones, requires that primary care providers advocate for teenagers and take advantage of resources made available for them. CHIP provides a critical opportunity for policy-makers and health care providers to further improve adolescent health care and to more fully integrate adolescents into the health care system.
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The delivery of adolescent health care is at a pivotal stage because of the Children's Health Insurance Program (CHIP) mandate to provide access to adolescent health consumers. CHIP targets families who earn more than is permitted under traditional Medicaid programs—up to 200% of the federal poverty level—but do not have private insurance. It is estimated that CHIP will provide coverage for health care to 3 million previously uninsured children and will identify an additional 660,000 children who are eligible for Medicaid but currently are not enrolled (1). In order for practitioners to take advantage of this resource, implementation of CHIP programs needs to be incorporated into a larger adolescent health care strategy that addresses all the impediments which this population faces, financial and otherwise. Such a strategy must build upon a proactive philosophy toward adolescents as health care consumers and use this philosophy as an impetus for more adolescent-sensitive provider training, more flexible hours, "teen-friendlier" facilities, and outreach. This article will describe a proactive adolescent philosophy, examine three critical barriers to successful adolescent health care delivery, and then evaluate the potential impact of CHIP as a resource for advancing adolescent health care.

Developing a Proactive Adolescent Health Care Philosophy

Unfortunately, many teens facing health problems today do not receive any kind of care. Services for this population need to begin with the adoption of a proactive philosophy toward adolescents with respect to their health care. Many CHIP programs are already targeting young children, infants and toddlers, because these populations have been afforded greater attention both within the medical community and by society. However, adolescents must be treated as a separate age group that is unique and, therefore, not appropriately categorized as either children or adults.

Recognizing adolescents as a distinct group of health consumers necessitates appreciating

From the Division of Adolescent Medicine/Mount Sinai Adolescent Health Center, Department of Pediatrics, Mount Sinai Medical Center, New York, NY.

Address all correspondence to Angela Diaz, M.D., Director, Mount Sinai Adolescent Health Center, 320 East 94th Street, 2nd floor, New York, NY 10128; email: angela.diaz@msnyuhealth.org
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their uniqueness. The physical, mental, emotional, cognitive, reproductive and social changes that they undergo are of a range and intensity that can be likened only to those of infancy. These almost sudden and simultaneous occurrences, often beginning at the end of the first decade of life, leave these young people with vital questions that impact upon their entire future—questions about themselves, their gender, their social identity and their personal values. Health care providers can have tremendous impact as positive role models and as sources of information, as adolescents and their families tackle these issues.

Tied into the period of adolescence is a normal desire to experiment that includes trying different hairstyles, different clothes and even different personalities. Unfortunately, this curiosity can also make these young people vulnerable to a host of behavioral and health disorders, such as alcohol and drug abuse, violence, early unintended pregnancy, sexually transmitted infections and suicide. Approximately one million adolescents in the U.S. become pregnant each year, 85% of these pregnancies unplanned (2, 3). In addition, three million adolescents per year acquire sexually transmitted diseases (4). While the incidence of gonorrhea and syphilis among teens has decreased steadily over the last two decades, contraction of HIV has increased (4). Nearly 25% of adolescents through the age of sixteen report having experienced assault or abuse during the previous year (5). Roughly six million teenagers (or 20%) report that they had been depressed during the previous two weeks, and between 1980 and 1992 the rate of suicide among adolescents increased by 120% (5).

While the vast majority of adolescents ultimately reach adulthood with healthy attitudes and positive life goals, all adolescents can benefit from a relationship with responsible adults, including medical providers who are sensitive to their individual challenges. A proactive philosophy of adolescent health should be based on awareness of the impact we as health care providers can have on easing the challenges associated with adolescence. Effective health interventions must be built around the reality that adolescents do want to live their lives free of violence, sexually transmitted infections, drugs, gangs, untreated illness, depression and suicide.

To increase the chances of adolescents living healthy lives, access to a health care system that works with them to enhance their resiliency and provides them with more comprehensive services than conventional medical treatment is required (5). Programs and services must be adolescent-friendly, adolescent-focused and adolescent-sensitive. Providers must be given opportunities to receive training that includes: communicating effectively with adolescents; asking developmentally appropriate questions; screening for multiple risks; and conveying accurate information regarding confidentiality and consent laws. They also must be allowed to spend more time with these patients in order to develop trusting relationships. Perhaps most important, adolescents themselves must be recognized as an age group that merits our attention apart from other age groups. A proactive adolescent philosophy is, quite simply, one that places value on adolescence.

Components of Adolescent-Sensitive Care

Translating this philosophy into components of a successful program involves recognizing the greatest barriers adolescents face to receiving health care. These barriers are psychological, institutional and financial.

Psychological Barriers

The greatest concern that adolescent patients face when visiting a health center is that "someone might find out [they] have a problem."

There are several explanations for this concern. A majority of health problems that adolescents face have their origins in sociocultural and behavioral factors (6). Teenagers are often embarrassed and ashamed to undergo a pregnancy test or sexually transmitted disease screening, or receive mental health counseling for alcohol and drugs. These are all conditions that they do not want to advertise to their peers. Their shame is compounded by the peer pressures of adolescence, urging them to "fit in" and "be cool." Visiting a health care provider creates a dilemma in that it places a teenager at risk of being ostracized for "doing things differently."

As if social pressures were not enough, parents may compound a teen's concerns. While parents are the most important influences in a teenager's development, teenagers are at a maturity stage in which they are beginning to make their own decisions about their physical, social and reproductive activities. Adolescents must weigh many factors besides parents when making these decisions, including self, peers, teacher, religious representatives and even the media. Visiting a health care provider places

teenagers at risk that their parents may discover their behavior or its consequences. For many teens this risk alone is enough for them to delay seeking preventive health information and/or forgo crucial care.

For health care providers, a proactive adolescent health care philosophy must echo one of the most basic tenets of the medical profession: the patient must come first. In the case of adolescents this means establishing, assuring and abiding by confidentiality rules. Providers should explain from the beginning that the doctor's office is a safe haven in which no information will be shared with parents, peers or any other outsiders. Providers should also explain the exceptions to these rules, e.g., cases in which the adolescent discloses child abuse or is a physical threat to himself/herself or to others. Providers should seek training on how to discuss the confines of confidentiality with their adolescent patients and they should stay informed as to any changes in confidentiality regulating requirements. Providers should also seek every opportunity to emphasize to adolescent patients the importance of sharing their health concerns with their parents and of making parents partners in their health maintenance and/or recovery.

Institutional Barriers

Another reason that patients give for not seeking services is that they simply do not know where to go. For teenagers who are just beginning to develop a sense of independence that sometimes puts them at odds with "adult" institutions, dealing with a large medical facility like a hospital may be perceived as too complex or frustrating.

Even if teenagers attempt to seek care from medical institutions, they may encounter a cold and unfriendly atmosphere and feel that adults do not welcome their presence. These perceptions have some validity, since health care providers work in a medical setting that has been designed by and for adult consumers. To attract teens, we need to reconsider the physical location, structure and atmosphere of the health facilities. This means establishing a separate building, entranceway or wing that only serves teens. Such an area can contain flyers, brochures, and wall hangings that specifically address teen health concerns. Receptionists and other staff can be trained to make teens feel comfortable from the moment their health care begins.

Related to this need to overcome institutional barriers, adolescent care facilities should also seek to develop comprehensive and interdisciplinary services so that teens can seek care for many of their needs under one roof. The Mount Sinai Adolescent Health Center accomplishes this "one-stop shopping" by housing primary care, mental health care, reproductive health and specialty services in one building. Patients who visit the center are seen by primary care providers, health educators and mental health professionals, when necessary, to ensure a comprehensive bio-psycho-sociocultural-spiritual response to a particular need. Also, adolescents seem to like the idea that one place is specifically designed for them.

For medical centers which cannot establish a wide range of in-house services, referral networks should be established with adolescent-friendly facilities or adolescent-friendly providers. Outreach workers or other staff should also be assigned to accompany teens on their first referrals, to ensure compliance and ease their anxieties.

Lastly, a teen-friendly facility should seek to accommodate teenagers at times convenient for them. For adolescents, this usually means after school, evenings and weekends. Outreach efforts should also be directed where teenagers congregate and should include peer outreach workers. Handouts should feature the image of adolescents, rather than adults or younger children, because adolescents often respond most positively to their own age group.

Financial Access

Teenagers, as a group, are the least likely age group to have health insurance (6). While one in five teenagers has a serious health problem, one in seven does not have health insurance (5, 7). One in three adolescents eligible for Medicaid is not enrolled, and private insurance for adolescents is becoming increasingly restrictive (5, 7). As a result, in the past two decades, the number of young people in private health plans who have lost coverage has exceeded the expansion of Medicaid, leaving this nation with the largest percentage of uninsured youths in its census-taking history (8). As of 1997, nearly 11 million young people lacked medical coverage (9). Even when they are insured through their parents' policies, they may fear accessing health care because they don't want their parents to know about the health care services they are obtaining. When the parents receive the explanation of benefits about the

adolescent's visit from the insurance company, the confidentiality will be breached. The situation is further exacerbated for teens from poor communities. These youths are dependent on centers that will treat them for free or for minimal fees.

Overcoming financial barriers involves providers advocating for confidential billing procedures to health insurance companies, and subsidized funding (public and private grants) for those adolescents who cannot afford care, as offered by the Children's Health Insurance Program.

Taking Advantage of CHIP to Improve Adolescent Health

The Children's Health Insurance Program (CHIP) provides a critical opportunity for policy makers and health care providers to further improve adolescent health care and to more fully integrate adolescents into the health care system. There needs to be an intergenerational approach to health care and health care coverage, inasmuch as what affects one group will have an impact on others. Despite enacting Medicaid in 1965, it was not until 1998 that Congress approved extensive legislation to provide health insurance for children in need in America (1). The CHIP legislation authorized $24 billion over five years and $48 billion over ten years, for states to initiate and expand the provision of child health assistance to uninsured, low-income children. Of these funds, 10% were set aside for administration and outreach.

The specific framework for how CHIP funds are to be used is designed by individual states and then submitted to the Department of Health and Human Services (DHHS) for approval. Once a state's plan has been initially approved, future modifications of CHIP are left entirely up to that state. Consequently, training and advocacy on adolescent issues in CHIP plans will need to involve not only health care providers and plan administrators, but state legislators as well.

While financial and other resources available through CHIP can be instrumental in remedying the increasing lack of coverage for young people, guidelines set forth by the DHHS also enable CHIP plans to be used for: (a) developing outreach activities, (b) increasing enrollment, and (c) ensuring the quality and appropriateness of care (10). When applied to a proactive adolescent health care philosophy, these measures make CHIP an even more formidable piece of legislation for revolutionizing adolescent health services.

Health care providers should work with legislators to use media to launch a "teen-friendly" outreach campaign to promote teen health and health care enrollment among the 3 out of 4 persons under 18 who qualify for but are not currently receiving Medicaid. As mentioned above, advertising campaigns are needed that address teens' right to health care and provide them with the initial guidance for seeking it. Some of these campaign efforts could be tested at schools, recreation centers and other teen hangouts. They could be paid for by the 10% of CHIP funding earmarked for outreach and administration. Appropriate staff and youth advocates who conduct these campaigns should be trained in communicating with teenagers and in anticipating the types of concerns that they will have (e.g., confidentiality, filling out applications, finding the right provider, etc.). Legislators can facilitate these types of programs by making adolescent-specific outreach, training and demonstration projects a funding priority.

Providers should also use CHIP to expand outreach to special populations of youths who often have the least access to adequate and proper health care, coverage, and information. Included in this category would be adolescents in correctional facilities, teens in shelters, and "undocumented" youths. Since many of these special populations do not have advocates in the political system, their inclusion in CHIP would depend on the combined efforts of legislators and "safety net" service providers.

In every outreach effort, CHIP providers should be sensitive to the gender and culture of adolescents. Males may be more difficult to engage in health care because they may not understand the benefit of health programs until an emergency / crisis situation arises. On the other hand, females may be resistant to reproductive health care unless it guarantees them a safe and confidential setting. Attractive brochures should publicize the nature and benefits of the health care services being offered. In keeping with a proactive adolescent philosophy, outreach materials need to assure teenagers of their right to confidential services, and they should explicitly state the specific types of services to which adolescents can provide consent. Outreach brochures should also be multilingual, to address the growing number of non-English-speaking uninsured.

In terms of financial barriers to care, CHIP can have even greater impact if adolescents are permitted to self-enroll. Current stipulations provide temporary self-enrollment under the

"presumptive eligibility" clause—through which a teenager may fill out an application for certain types of services (e.g., reproductive health), receive care, and seek parental involvement only after his or her eligibility is corroborated by the state. While presumptive eligibility is essential for guaranteeing immediate provision of care in many circumstances, it is insufficient as a mechanism for ensuring long-term adolescent involvement in the health care system. It would be more effective if parents were invited to participate in care by the teenagers themselves. This could be accomplished by permitting teen self-enrollment and training health care providers to counsel teens on the importance of parental involvement. This would help adolescents receive the services they need and, at the same time, increase the possibility of engaging parents.

The actual enrollment procedures for Medicaid and CHIP programs need to be as straightforward as possible, to avoid overwhelming or confusing the applicants. Simplification of enrollment forms also facilitates adolescents' access to services and helps to ease their initial anxieties about seeking care. Enrollment should take place in community settings such as health services sites, schools, recreation centers and other adolescent-friendly locales. In these settings, eligibility for health care programs could be linked to qualification for other subsidized programs, like school lunches, or even more simply, have all uninsured teens qualify.

A mechanism should also be developed to ensure that coverage is not lost because of sudden disqualification or a need to "switch" program coverage. This is particularly important because Medicaid and CHIP target families whose incomes are subject to considerable fluctuation. Enrollment needs to be guaranteed for a prescribed period of time (e.g., one year or more) regardless of family income fluctuation, with a seamless movement from one coverage program to another, or at least a system that will alert program administrators when loss of coverage is imminent.

Providers should also use CHIP as a basis for advocating for legislators and plan administrators to cover a wider range of health care services that are similar to those mandated by Medicaid. In some states, mental health and substance abuse services are not provided within their plans. In other states health education and counseling are not provided. Under some religion-based managed care plans, adolescents are unable to receive access to contraception and abortion. Adequate health care must be comprehensive and interdisciplinary to ensure health maintenance.

Conclusion

CHIP provides a significant window for improving the health of all people under the age of 19 years. Although CHIP initiatives continue to emphasize younger age groups, it is essential to target adolescents for enrollment, so as not to eliminate the chance of reaching their unmet health care needs. Over the next few years state policy makers and health care professionals should continue to design and redesign plans to actuate the goals of CHIP.

The recommendations presented here highlight the importance of legislators, insurance administrators and health care providers when considering a proactive adolescent health care philosophy in launching CHIP initiatives. When this philosophy is followed by steps to facilitate enrollment and enhance adolescent-appropriate services, CHIP resources can better overcome barriers to adolescent health care and change the landscape for adolescents as consumers in the health care industry. Perhaps health care can then become a truly intergenerational priority in these families, because the health care access of one member of the family will have an impact on the others.

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