Highlights
Chapter X – Accessing Health Care

Adolescence is a time when youth begin making independent choices concerning their own health and health care. Their experiences will have lifelong effects on their health choices and adult health status, so it is important that the care they receive is timely, appropriate, easily accessible and affordable.

Colorado Trends

Health insurance is vital to adolescents' access to and use of health care services. More than one in 10 Colorado adolescents are not insured.

- About 92,600 (13.8%) Colorado youth ages 7 to 17 are uninsured.
- About 11,000 (20.6%) Colorado adolescents age 18 are uninsured.
- Young adults ages 18 to 24 are the group in Colorado least likely to be insured. This age group comprises only 9.6 percent of Colorado's total population, but 19.1 percent are uninsured.
- While 12 percent of Colorado youth ages 0 to 17 living in families at all income levels are uninsured, 23 percent of Colorado children living in families with incomes below 200 percent of the federal poverty level are uninsured.
- Colorado's white non-Hispanic youth are the least likely to be uninsured (11.4%); Hispanic children and youth are the most likely to be uninsured (29.4%).

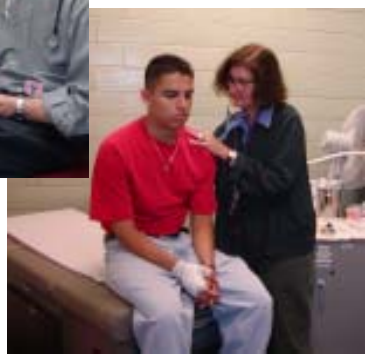
2000 Objectives

Progress Report

There were no objectives for improving access to health care published in the *Adolescent Health in Colorado, 1997* report.

Best Practices

- ***Parents*** – Strategies for parents include making preventive health care a priority, and taking children for regular check-ups and immunizations; establishing open lines of communication with adolescents to talk about health; and being an advocate for adolescent health at school and in the community.
- ***Schools*** – Schools can support student health by working on the eight school components identified by the Centers for Disease Control: health education, physical education, health services, nutrition services, health promotion for staff, counseling and psychological services, healthy school environment and parent/community involvement. Schools can also institute a program of health instruction for students, and serve as hosts for community providers to locate their physical and mental health services within school walls.
- ***Community Health Care Providers*** – Providers can make their services "teen friendly" by promoting regular preventive health visits; seizing health promotion opportunities; ensuring access to primary caregivers with skills, experience and interest in adolescents; offering comprehensive screening and counseling for high-risk behaviors; protecting the confidentiality of their teen patients; and teaching parents and other caring adults how to support adolescent well-being.



2010 Objectives

Reduce Uninsurance Rates

- By 2010, reduce the proportion of children aged 7 to 17 who are uninsured to 6.8%, from the 2001 estimated baseline of 9.0%
- By 2010, reduce the proportion of youth aged 18-24 who are uninsured to 15.6%, from the 2001 estimated baseline of 20.7%
  Source: Colorado Household Survey (2001); U.S. Census Bureau (2000)

Increase Access to Health Care Services

- By 2010, increase the proportion of Medicaid-eligible teens 10 to 14 years old who receive a comprehensive health exam to 50.0%, from the 2001 baseline of 38.2%
- By 2010, increase the proportion of Medicaid-eligible teens 15 to 18 years old who receive a comprehensive health exam to 50.0%, from the 2001 baseline of 33.8%
  Source: Colorado Department of Health Care Policy and Financing, 416 Medicaid Report

Increase Access to School-Based Health Centers

- By 2010, increase the proportion of school-age children and youth who have access to comprehensive physical and mental health services offered by school-based health centers to 15%, from the 2000 baseline of 8.7%
  Source: Colorado Department of Public Health and Environment

Websites

American Academy of Pediatrics
www.aap.org

Annie E. Casey Foundation
www.aecf.org

Association of Maternal and Child Health Programs
www.amchp.org

Bright Futures
www.brightfutures.org

Center on Budget and Policy Priorities
www.cbpp.org

Center for Health and Health Care in Schools
www.healthinschools.org

Center for Health Services Research and Policy
www.gwhealthpolicy.org/chsrp

Center for Law and Social Policy
www.clasp.org

Center for Reproductive Rights
www.crlp.org

Children Now
www.childrennow.org

Colorado Association for School-Based Health Care
www.casbhc.org

Colorado Child Health Plan *Plus* (CHP+)
www.cchp.org

Colorado Coalition for the Medically Underserved
www.ccmu.org

Colorado Indigent Care Program
www.chcpf.state.co.us/cicp/cicpindex.html

Colorado Medicaid
www.chcpf.state.co.us

Colorado Office of the State Auditor
www.state.co.us/gov_dir/audit_dir/audit.html

Colorado Works Program
www.cdhs.state.co.us/oss/CWP/cwphome.html

The Commonwealth Fund
www.cmwf.org

Covering Kids
www.coveringkids.org

Future of Children
www.futureofchildren.org

Kaiser Commission on Medicaid and the Uninsured
www.kff.org

National Adolescent Health Information Center
www.youth.ucsf.edu/nahic

National Assembly on School-Based Health Care
www.nasbhc.org

National Center for Education in Maternal and Child Health
www.ncemch.org

National Center for Health and Health Care in Schools
www.healthinschools.com

National Center for Youth Law
www.youthlaw.org

National Conference of State Legislatures
www.ncsl.org

National PTA
www.pta.org

Office of Juvenile Justice and Delinquency Prevention
www.ojjdp.ncjrs.org

Policy Information and Analysis Center for Middle Childhood and Adolescence
www.youth.ucsf.edu/policycenter

Society for Adolescent Medicine
www.adolescenthealth.org

State Children's Health Insurance Program (SCHIP)
www.cms.hhs.gov/schip

Urban Institute
www.urban.org

Chapter X
Accessing Health Care: Maintaining Healthy Adolescents

Adolescence is a time when youth begin making independent choices concerning their own health and health care – physical, mental and dental. Their experiences can have lifelong effects, so it is important that the care they receive is timely, appropriate, easily accessible and affordable.

Because most adolescents are generally physically healthy, we tend to take their health for granted. However, adolescents *do* have particular health needs. Adolescent health concerns include skin conditions, weight and nutrition, vision concerns,[1] dental and orthodontia concerns (see Chapter VIII), conditions of the spine, reproductive issues,[2] common viral diseases such as infectious mononucleosis and meningitis and access to immunization services.[3] They also commonly need services for mental health, substance abuse and social development issues (see Chapters II and V).

Health promotion and injury prevention services are critical during this phase of development. Most premature death and illness in the United States is related to six categories of behavior:

- Behavior resulting in unintentional or intentional injury (including suicide attempts and completions)
- Use of alcohol and other drugs
- Tobacco use
- Sexual behaviors contributing to sexually transmitted infections and unintended pregnancy
- Inadequate physical activity
- Poor dietary habits

These behaviors are commonly initiated during adolescence. Unfortunately, if not prevented, these behaviors initiated during adolescence often extend into adulthood and have serious consequences for long-term health status. Virtually every early death in adolescence is preventable, and many adult chronic health conditions find their genesis in these preventable adolescent risk behaviors.[4]

Prevention Pays

Health economists estimate that every year the US spends $33.5 billion on *direct medical costs* (e.g., hospital, doctor care, drugs) for preventable adolescent illness associated with just six areas: teen pregnancy, sexually transmitted infections, alcohol and other drug problems, motor vehicle injuries, other unintentional injuries and outpatient mental health visits. These experts also estimate that it would cost only about $4.3 billion (or $203 per person) annually to provide adolescents and young adults (ages 10-24) with a comprehensive package of health and dental services such as that recommended by the American Academy of Pediatrics.[5]

If adolescents have a regular source of health care – a "medical home" – they are more likely to receive preventive services. A medical home, as opposed to an emergency room, is a place where a person forms a relationship with a health provider and feels comfortable enough with the health care system to access care in a timely and appropriate manner.[6] Because teens are changing so rapidly in

This chapter explores the following:

- Health insurance, including a "thumbnail sketch" of how welfare reform and the state children's health insurance program have impacted health care systems for adolescents
- Barriers adolescents face in accessing health care
- Successful strategies and best practices to improve access to meaningful health care.

Separate chapters address access to mental health (Chapter II) and dental health (Chapter VIII) care services.

their physical, social and emotional development, health experts recommend that adolescents (up to age 21) have an annual, routine preventive visit.[7] These regular visits to a health practitioner are opportunities to detect potential health problems early on, especially if there is a family history of poor health or chronic disease. Equally as important, they offer opportunities for preventive counseling to the adolescent and his or her family.

However, adolescents are the group of children who are least likely to be insured and most likely to "under-use" primary and preventive health services. They face substantial barriers in entering and using the health care system, often missing opportunities to improve their health. The major barrier is cost. Other factors impeding access include geography and lack of transportation, a shortage of providers trained in adolescent specialties and limited provider participation in subsidized care.[8]

Health Insurance: The Key To Health Care Access

Health care is expensive; without health insurance (public or private), youth are much less likely to receive health services in a medical home. Thus, health insurance is vital to adolescents' access to and use of health care services. More than one in 10 Colorado adolescents are not insured.

- About 92,600 (13.8%) Colorado youth ages 7 to 17 are uninsured.
- About 11,000 (20.6%) Colorado adolescents age 18 are uninsured.
- Young adults ages 18 to 24 are the group in Colorado *least* likely to be insured. This age group comprises only 9.6 percent of Colorado's total population, but 19.1 percent of its uninsured. (See Figure 1.)[9]
- Colorado ranks 35th (out of 50 states, plus the District of Columbia) in the proportion of adolescent girls (ages 13 to 18) who are insured.[10]

If you are a child or adolescent in Colorado, having health insurance *and* access to care are primarily functions of income.[11] (See Figure 2.)

- Twelve percent of Colorado youth ages 0 to 17 living in families *at all income levels* are uninsured.
- Only five percent of children ages 0 to 17 living in families *with incomes greater than 200 percent of the federal poverty level* (FPL) are uninsured.
- Twenty-three percent of Colorado children living in families *with incomes below 200 percent of FPL* are uninsured.[12]
- Colorado's white non-Hispanic children and youth are the least likely to be uninsured (11.4%); the proportion of uninsured African American children is slightly higher (13.3%). Hispanic children and youth are the most likely to be uninsured (29.4%).[13]

Coloradans' Uninsurance Status by Age, 1997-1999

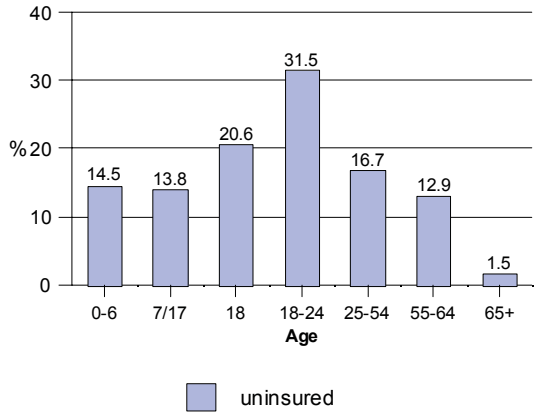


Figure 1: *Source: 2001 Colorado Health Data Book*, Chart 8, Colorado Coalition for the Medically Underserved (2001)

Uninsurance Rates for Children by Family Income Level, Colorado 1997-1999

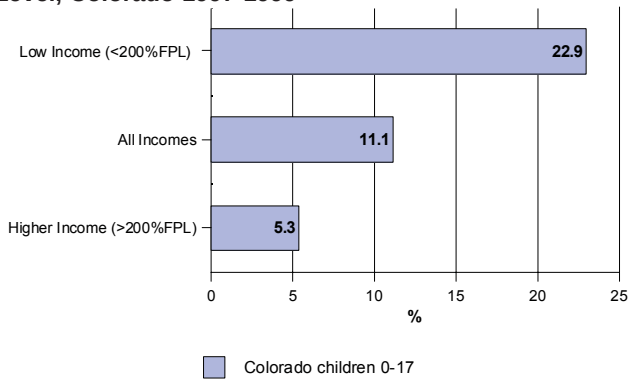


Figure 2. *Source: 2001 Colorado Health Data Book*, p. 46, Colorado Coalition for the Medically Underserved (2001)

Recent data from the American Academy of Pediatrics indicate that Colorado is losing ground in terms of the percentage of all children who are covered by insurance. For example, the Child Health Plan *Plus* continues to enroll an increasing number of children. However, the number of undocumented children and youth in Colorado is increasing as well. Demographers at the Colorado Department of Public Health and Environment do not anticipate improvement in the percentage of uninsured children in the next few years because undocumented children are not eligible for any kind of publicly subsidized health insurance.[14]

Medicaid: Comprehensive Health Coverage for Children

Children in very low-income families are eligible for Medicaid, the federally funded insurance program that covers medically necessary health care services. Within Medicaid is a set of preventive services referred to as EPSDT. EPSDT (Early and Periodic Screening, Diagnosis and Treatment) is a comprehensive set of physical and mental health services, including preventive care, screening, well child visits, vision care and dental care. However, many eligible adolescents are not enrolled in Medicaid, and the percent of those who are enrolled and actually receive preventive services through EPSDT remains low.

In the days prior to welfare reform, children in a family receiving public cash assistance were automatically entitled to health care under Medicaid. When a family's income increased, they would often lose their welfare benefit as well as Medicaid coverage, making independence from welfare very difficult for many families.

Two important pieces of federal legislation have altered the context in which children are covered by publicly funded health insurance coverage.

- The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA – welfare reform)[15] created the Temporary Assistance for Needy Families (TANF) program. In Colorado, the program is called "Colorado Works."
- The State Children's Health Insurance Program (CHIP or SCHIP)[16] allowed states to create new health insurance programs for low-income children. Colorado's program is the Child Health Plan *Plus*.

Perhaps most importantly, welfare reform severed the link between eligibility for cash assistance and eligibility for Medicaid. Low-income families can receive Medicaid even if they do not qualify for Temporary Assistance for Needy Families (TANF). This step increases the likelihood of families becoming self-sustaining, as health insurance is seldom offered through low-wage jobs, and individual coverage is increasingly expensive.

SCHIP: Expanded Health Insurance for Children

On the heels of federal welfare reform, Congress created the State Children's Health Insurance Program (SCHIP), the largest expansion of children's health benefits since Medicaid. Under SCHIP, the federal government provides matching funds for states, which are higher than the Medicaid match. The program expands health insurance coverage for low-income children who are ineligible for Medicaid, up through age 18. Medicaid is an entitlement program, and states must provide required services to specific populations, without regard to the desire of state policymakers to limit or redesign the program. In contrast, the federal SCHIP legislation gave states the flexibility to design a program that best fit their needs with regard to eligibility, outreach, enrollment, benefits, cost-sharing and state budget limitations.[17] Colorado's program is the Child Health Plan *Plus* (CHP+).

Medicaid and SCHIP Enrollment

Medicaid and the Child Health Plan *Plus* (CHP+) are the two major sources of publicly subsidized health insurance for Colorado's children and adolescents. In Colorado, Medicaid and CHP+ are separate programs.

- As of December 31, 2001, Medicaid had enrolled 34,758 younger adolescents (ages 10-14) and 23,648 older adolescents (ages 15-19).
- As of January 31, 2002, there were 38,816 children enrolled in CHP+; 10,070 were teens between the ages of 13 and 18.

These programs have dramatically increased access to health insurance. However, teens still face barriers to accessing the actual services they need.

Quick Definitions

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 replaced Aid to Families with Dependent Children (AFDC) with Temporary Assistance for Needy Families (TANF), fundamentally changing access to public benefits for low-income families by eliminating the federal guarantee for benefits. States now have greater flexibility and responsibility to administer the program. Colorado's program is "Colorado Works."

Medicaid is a federally funded program that funds medically necessary health care services for low-income families and individuals. Historically, families who qualified for welfare automatically received Medicaid. Federal welfare reform law now requires that financially eligible, low-income families with children can receive Medicaid, irrespective of their eligibility for welfare benefits (i.e., TANF).

State Children's Health Insurance Program (SCHIP or CHIP) provides health insurance to children in low-income families who are not eligible for Medicaid. The 1997 federal legislation allows states to expand Medicaid and/or create new health insurance programs for low-income children. Colorado's version is the Child Health Plan *Plus* (CHP+).

Accessing Health Care Services

Barriers to accessible health care for youth primarily revolve around outreach, income-related eligibility, a shortage of providers, lack of comprehensive services, developmental appropriateness of services and confidentiality.

Outreach

While enrollment of adolescents has increased in health insurance programs, local providers and advocates must make special efforts to reach adolescents. Certain barriers persist.

- While outreach targeted in schools has met success, many adolescents are not in school. Targeted outreach is needed to teens with special health care needs, teens in alternative education, home-schooled teens, juveniles being released from incarceration, adolescents in foster care and homeless or runaway youth.
- Marketing efforts should reach parents and legal guardians. In 2001, the CHP+ program lowered its relatively high monthly premium rate and simplified the joint application for Medicaid and CHP+.[18]
- Many families attach a "stigma" of public assistance to Medicaid and do not wish to enroll.[19]
- Undocumented persons and many legal immigrants are not entitled to benefits under either Medicaid or CHP+. Studies have indicated that many immigrant families with *eligible* children have not enrolled their children out of fear of potential immigration issues.[20]

Enrollment/Eligibility

Eligibility, which differs according to publicly funded programs, is confusing and depends primarily on family income and age of the child. As of 2002, some of the guidelines follow.

- To be eligible for CHP+, a child must be found ineligible for Medicaid. In most cases, Medicaid eligibility is determined at the local county level, while CHP+ is a centralized program, which increases the importance of coordination between the two programs.[21]
- Adolescents under 21 are financially eligible for Medicaid if the annual family income is 100 percent of, or below, the federal poverty level (FPL). If the adolescent is older than 18, the family's income must not exceed 36 percent of the FPL. Pregnant adolescents, regardless of age, are eligible for Medicaid if the family income does not exceed 133 percent of the FPL. Colorado also applies an "assets test," and families with assets above $2,000 plus the value of one car may be disqualified.[22]
- Adolescents, ages 18 and younger, are eligible for CHP+ if the annual family income is between 133 and 185 percent of FPL, and the child is not covered by employment-based insurance and does not qualify for Medicaid.[23]

Shortage of Providers

- Medicaid reimbursements in Colorado are still low relative to the real cost of delivering care, and some communities in Colorado do not have adequate numbers of health care providers who will accept Medicaid patients.[24]
- Some areas of the state lack providers willing to serve children under the Child Health Plan *Plus*, which uses the same managed care plans as those contracting with Medicaid.[25]

Comprehensive Services

Insurance benefit packages should include elements critical for adolescent health care, such as coverage for preventive medical, dental, mental or substance abuse care and treatment. Because adolescent physical health problems often are intertwined with behavioral issues, services must provide counseling for prevention and be coordinated with and linked to follow-up care.[26]

Medicaid and Colorado's CHP+ benefit package provide basic coverage for most adolescent health needs.

- Colorado is one of the few states that include full reimbursement for "well teen" checkups with the anticipatory guidance and counseling recommended for adolescents by the American Academy of Pediatrics and the American Medical Association.[27]
- CHP+ covers all prenatal visits for pregnant teens and includes a dental benefit (see Chapter VIII).
- CHP+ covers neurologically based mental illness to the same extent as medical conditions. Care is time-limited for all other mental or behavioral health services.[28]
- CHP+ likewise limits coverage for outpatient substance abuse coverage (30 outpatient visits per diagnosis) and coverage of inpatient care is not available.
- Many of Colorado's children with special health care needs use Medicaid and CHP+ to obtain primary and many specialty care services. Coverage for coordination of services is important so that providers can help families negotiate complex health and social services for children with chronic conditions or special health care needs.[29]

Private insurance plans vary greatly in the level of benefits, especially preventive services, for which adolescents qualify.

Confidentiality

Numerous studies document that many adolescents are reluctant or unwilling to seek medical care without the assurance of confidentiality. In a recent national survey of almost 7,000 adolescent girls, nearly one-third had missed a medical appointment for needed care. "Not wanting a parent to know" was the most common reason for missing care for both girls and boys. Adolescents may seek confidentiality as part of the normal process of developing autonomy, from a desire for maturity, as a way to protect reputation or self-esteem, or due to fear of hostile or abusive reactions from parents.[33]

Both initial consent for care and subsequent notification of care having been given raise concerns about confidentiality.

State legislatures engage in a complex balancing act. The rights of parents to make health decisions for their children are balanced against the public health benefit of facilitating adolescents' confidential access to health care, especially for sensitive services. If adolescents delay access to services out of fear of parent notification, they may jeopardize their own health or the health of others. On the other hand, parental involvement may be beneficial and facilitate ongoing attention to an adolescent's health problems.[34]

In Colorado, there is no "one law fits all ages" guidance with regard to parental consent, notification or confidentiality for adolescents. Different subjects are treated individually.

- **Consent for medical, dental, and related care**. Generally, minors under age 15 cannot consent to hospital, medical, dental, emergency health and surgical care for themselves without parental consent. An emancipated minor over age 15 who is living separate and apart from his or her parent(s) or legal guardian, and is managing his or her own financial affairs, regardless of the source of his or her income, or any legally married minor may consent to services without prior parental permission. Colorado Revised Statutes (CRS) 13-22-103(1)[35]
- **Minor parents.** A minor who is a parent may give consent for medical, dental and related care for his or her own child. CRS 13-22-103(3)
- **Contraceptive services.** Colorado law permits adolescents to access "all medically acceptable contraceptive procedures, supplies and information" regardless of age or marital status. CRS 25-6-102(1) However, a minor under the age of 18 cannot legally consent to sterilization without parental consent. CRS 25-6-102(6)[36]
- **Prenatal care.** Colorado law is silent as to the circumstances under which a minor can seek access to prenatal care[37]

- **Access to sexually-transmitted disease (STD) services, including human imuno-deficiency virus (HIV).** Minors may consent to confidential testing and treatment for STDs and HIV without the prior consent or later notification of a parent or guardian. CRS 25-4-402(4), (6)[38]
- **Parental involvement in minors' abortions.** In Colorado (as of this report's publication), health care providers are not required to notify a parent before a minor may obtain an abortion.[39]
- **Tattooing and piercing.** Body art or piercing requires prior parental consent before being performed on a minor. CRS 25-4-2103
- **Mental health care.** A minor 15 years or older, with or without the consent of a parent or legal guardian, may consent to receive mental health services to be rendered by a facility or a professional person and may make voluntary application for hospitalization. CRS 27-10-103 (2), (3.1)
- **Substance abuse**. A minor can consent to examination or treatment for addiction to or use of drugs without the consent of or notification to the minor's parent(s) or legal guardian. *Source:* CRS 13-22-102

Best Practices: Broadening Support For Adolescent Health

This section describes some promising strategies for broadening support for improving adolescent health care.

Parents, health providers, schools and organizations serving youth can work together on a "game plan" for improving adolescent health.

Parents

Strategies for parents include:

- Making preventive health care and education a priority for the family by taking children for regular check-ups and immunizations
- Establishing open lines of communication with adolescents to talk about health
- Supporting school policies on health issues
- Being an advocate for adolescent health at school, at work and in the community[40]

Strategies for health care providers include:

- Endorsing and promoting regular preventive health visits
- Seizing health promotion opportunities
- Ensuring access to primary caregivers with skills, experience and interest in adolescents
- Encouraging the use of multidisciplinary clinical teams
- Offering comprehensive screening and response for high-risk behaviors
- Protecting the confidentiality of teen patients
- Providing services through centers that tailor their services to the unique needs of adolescents and achieve better patient participation and health outcomes
- Listening to adolescents
- Helping parents and other caring adults learn how to support adolescent well-being
- Participating in community-based health initiatives
- Supporting and disseminating research about preventive care for adolescents[41]

Schools

Schools are a natural setting in which to identify uninsured students and reach out to their families to enroll their children in Medicaid and CHP+. A common set of strategies has emerged:

- Incorporate outreach into regular school meeting or events
- Piggy-back on routine school mailings
- Create new referral mechanisms, using the school lunch program or emergency contact forms
- Implement presumptive eligibility, in which state-authorized entities, such as schools, can temporarily enroll children in health coverage if they appear eligible
- Enable on-site eligibility determination, in which local Department of Human Services staff members are out-stationed in the school district.[43]

At the national level, the Division of Adolescent and School Health at the National Center for

Chronic Disease Prevention and Health Promotion champions these health promotion strategies for school-age children:

- Employ models where health activities, messages and services are coordinated among eight school components: comprehensive health education, physical education, health services, nutrition services, health promotion for staff, counseling and psychological services, healthy school environment and parent/community involvement.[44]
- Institute a planned, and sequential program of health instruction for students in grades K through 12. Parents, health professionals and other concerned community members are involved in the design of the program. The curriculum, delivered by trained teachers, addresses a range of categorical health problems at developmentally appropriate ages. School programs include activities that help young people develop the skills they need to avoid behavior that places their health at risk.[45]

Colorado has 176 school districts and several options for increasing health in schools.

Colorado Comprehensive Health Education Act of 1990

This act "encourages every school district to provide a planned, sequential health education program in grades pre-K through 12." Parental and community involvement in the program is stressed. Parents/guardians have the right to exempt a child from the health education program. Local advisory councils are encouraged, representative of the norms and values of the community.[46]

Colorado School Health Services Program

More than 90 percent of Colorado school districts participate in the School Health Services Program, which began in 1997 (also known as the School Medicaid Reimbursement Program). Any public school district or Board of Cooperative Educational Services (BOCES) can participate, once they have conducted a health needs assessment; sought and received community input; submitted and received approval for a Local Services Plan from the Colorado departments of Education and Health Care Policy and Financing; and received a contract to claim funds. School districts may receive the federal government's match (50 percent) of the cost to the district of health services provided to Medicaid-enrolled children. The state passes the funds to the contracting school district, which then can use the funds for new or expanded health services for any student or group of students.[47]

It Yourself

Is your school district participating in the School Health Services Program? Check it out at www.chcpf.state.co.us/school/schooldist.html.

School-Based and School-Linked Services

If adolescents are reluctant or unable to access health care services, why not bring the services to them? This is what school-based and school-linked health centers (SBHCs) do.

During the 1999-2000 school year, there were over 1,300 school-based health centers across the United States.[48] SBHCs emphasize prevention and early intervention by offering basic medical services, mental health and substance abuse services and health promotion activities. School-based (or school-linked) health centers support the mission of schools – to help students learn. Students miss less school seeking needed health services, and are better able to concentrate when health and mental health problems are resolved or under control.

Research studies have shown that SBHCs:

- Reduce the use of expensive emergency room care and reduce overall Medicaid expenditures, while increasing use of preventive well child/ adolescent services[49]
- Educate parents about the CHP+ program, and the importance of preventive health care
- Improve immunization rates
- Reduce behavioral health risks among vulnerable students
- Help students stay in school, be promoted and graduate
- Engage a broad local community constituency in health planning for children[50]
- Play a vital role in linking students to mental health services[51]

SBHCs in Colorado have experienced significant growth. During the 2000/2001 school year, there were 40 SBHCS in Colorado, up from

just 13 in 1994, located in schools with high proportions of low-income, uninsured children.

All Colorado school-based health centers involve parents and community to ensure local support.

- Parents, school officials and local health care providers determine the scope of services.
- Parents sign detailed consent forms before students may use these services.
- Abstinence from sexual activity is stressed as the best pregnancy prevention method; availability of family planning services for teens is locally determined.[52]

Does your school district have a school-based health center? Look it up at www.casbhc.org/locate.htm.

Communities

Enrolling Teens in Health Insurance

Despite serious efforts to enroll children in Medicaid and CHP+, an estimated seven million who are eligible are not enrolled. Much has been learned about successful outreach strategies.[42]

- Develop innovative out-stationing of eligibility technicians in clinical and school settings.
- Use technical tools, such as software, for tracking insurance status.
- Address language and cultural differences.
- Enlist neighborhood residents and community health workers who can speak to other parents from their own experiences, and assist in outreach.
- Ensure a "user-friendly" atmosphere in places and processes for enrollment.
- Form outreach "collaboratives" among state and local agencies.
- Participate in community events.
- Use local media and marketing.
- Provide scholarships for payment of application fees and premiums.

Services Tailored to Teens

Regardless of the type of health insurance, adolescents need services that meet their particular needs. "Adolescent-friendly" care:

- Provides an appropriate mix of benefits and services
- Assures provider competency with sexual orientation, language, culture, and appropriate developmental approaches
- Offers teen-friendly locations and hours of operation.
- Assures confidentiality

Adolescents are the age group least likely to use the health care system.

- They may not seek care voluntarily if they are uncomfortable with the provider. Many health care providers are not trained to deal with adolescents in general, much less adolescents with health risks such as mental health, substance abuse, homelessness, sexual identity

What Does a School-Based Health Center Offer?

Medical services	Mental health and substance abuse services	Health promotion and education services
• Physical exams • Immunizations • Care for acute illness and injury • Care for chronic conditions such as asthma • Preventive dental care	• Identify problems early • Reduce the stigma of getting help • Reduce school suspensions for problem behavior • Improve academic participation	• Teach health consumer skills • Encourage avoidance of health risks that affect learning • Provide an ideal venue for tobacco prevention and cessation programs

or those transitioning out of the foster care or juvenile justice systems.[30]

- Adolescents often "enter" the health care system through the emergency room door, seeking care for their immediate problem. Health care providers therefore often miss the opportunity to inquire about other health-related issues.[31]
- Adolescents often will only seek health care or follow-up care if the location and hours are convenient.[32]

Involving Youth

Experts in youth development agree that if youth do not take part in health decisions, efforts to improve their health are less effective. Communities across the country are experimenting with ways to include youth in planning around health.

- A national child advocacy organization has proposed a "Youth Health Bill of Rights." This statement can be used to inform adolescents, parents and health care providers of expectations and priorities for adolescent health care.[53]
- A major foundation has funded youth movements against tobacco use. The goal is to engage youth in community action against tobacco use and foster meaningful youth-led tobacco prevention activities. Through this funding, the Colorado Department of Public Health and Environment's State Tobacco Education and Prevention Partnership (STEPP) supports youth coalitions across the state.
- The Youth Partnership for Health, funded by the Colorado Department of Public Health and Environment's Division of Prevention and Intervention Services for Children and Youth, is a group of adolescents from the state who meet monthly to discuss health issues that are important to them. These youth have researched issues, conducted surveys and made presentations to various staff and advisory councils.

End Notes

1. Health experts recommend eye exams every one to two years during adolescence because myopia (nearsightedness) generally develops during late childhood and early adolescence. K Soren, "The adolescent years," in *Complete Home Medical Guide*, 3rd rev. ed., Columbia University College of Physicians and Surgeons (1995).
2. Ibid. This includes for girls: pelvic examinations and discussions about sexually transmitted infections for sexually active girls, instruction on breast self-exams, and issues around menstruation; for boys, it includes examinations for penis and scrotum abnormalities and discussions about sexually transmitted infections for sexually active boys. For both girls and boys issues include discussions about abstinence, sexual activity and contraception.
3. Ibid. Recommended immunizations include tetanus and diphtheria booster, Hepatitis B and tuberculosis if the young person is exposed to high-risk adults. Recently there has been discussion about vaccination for college-bound youth against meningitis. Maryland requires incoming college dorm students to be vaccinated for meningitis or sign a waiver declining the vaccine. California requires that colleges and universities inform students about meningococcal vaccine and document that that they have done so. Centers for Disease Control and Prevention, "Meningococcal disease and college students: Recommendations of the Advisory Committee on Immunization Practices," *MMWR* 49(RR07): 11-20 (2000).
4. Centers for Disease Control and Prevention, "Youth risk behavior surveillance – United States, 1997," *MMWR* 47(SS-03) (1998).
5. MJ Park et al., *Investing In Clinical Preventive Health Services for Adolescents*, Policy Information and Analysis Center for Middle Childhood and Adolescence and National Adolescent Health Information Center, University of California, San Francisco (2001).
6. A Ziv, JR Boulet and GB Slap, "Emergency department utilization by adolescents in the United States," *Pediatrics* 101(6): 987-994 (1998); KM Wilson and JD Klein, "Adolescents who use the emergency department as their usual source of care," *Archives of Pediatrics and Adolescent Medicine* 154(4):361-365 (2000); S Ryan et al., "The effects of regular source of care and health need on medical care use among rural adolescents," *Archives of Pediatrics and Adolescent Medicine* 155(2):184-190 (2001), AC Beal, J Ausiello and J Perrin, "Social influences on health-risk behaviors among minority middle school students," *Journal of Adolescent Health* 28(6):474-480 (2001); JD Klein and KM Wilson, "Delivering quality care: Adolescents' discussion of health risks with their providers," *Journal of Adolescent Health* 30(3):190-195 (2002).

7. For example, the American Academy of Pediatrics and the American Medical Association. M Green and JS Palfrey, eds., *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* (2nd ed., rev.), National Center for Education in Maternal and Child Health (2002).
8. P Newacheck et al., "Adolescent health insurance coverage: Recent changes and access to care," *Pediatrics* 104(2):195-202 (1999), C Schoen et al., *The Health of Adolescent Boys: Commonwealth Fund Survey Findings*, The Commonwealth Fund (1998); CA Ford, PS Bearman and J Moody, "Foregone health care among adolescents," *Journal of the American Medical Association* 282(23): 2227-2234 (1999); Children Now, *Partners in Transition: Adolescents and Managed Care* (2000) ; JD Klein et al., "Access to medical care for adolescents: Results from the 1997 Commonwealth Fund survey of the health of adolescent girls," *Journal of Adolescent Health* 25(2): 120-130 (1999).
9. B Yondorf, *2001 Colorado Health Data Book: Insurance, Access and Expenditures*, Colorado Coalition for the Medically Underserved (2001). Data sources in Yondorf's report define children and youth as ages birth to 17; 18-year-olds are defined as adults.
10. RB Gold and A Sonfield, "Expanding eligibility and improving outreach under CHIP," *The Guttmacher Report on Public Policy* 4(3): 6-9 (2001).
11. Yondorf, *2001 Colorado Health Data*, see note 9.
12. According to the 2001 US Department of Health and Human Services poverty guidelines, a family unit with the following annual income is considered to be in poverty (at the Federal Poverty Level): $15,020 for a family of 3; $18,100 for a family of 4; and $21,180 for a family of 5. *Federal Register* 67(31) (February 14, 2002). The State of Colorado began using these guidelines for Medicaid, CHP+ and the Colorado Indigent Care Program on July 1, 2002.
13. Yondorf, *2001 Colorado Health Data*, p. 57, see note 9.
14. Colorado Department of Public Health and Environment, Maternal and Child Health grant proposal 2002.
15. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), (Pub. Law No. 104-193), 1996: Title 42, Chapter 7.
16. Balanced Budget Act of 1997, Pub. Law No. 105-33, 111 Stat. 251 (1997), Title IV, Subtitle J, State Children's Health Insurance Program, §§ 4901-49223.
17. HB Fox , MA McManus, and SJ Limb, *Access to Care for S-CHIP Adolescents*, Kaiser Commission on Medicaid and the Uninsured (2000); National Conference of State Legislatures, Health Policy Tracking Service, *Mental Health Coverage in Title XXI Plans* (1999); L Ku, F Ullman and R Almeida, *What Counts? Determining Medicaid and CHIP Eligibility for Children*, Urban Institute (1999); T Brown, *The Impact of the State Children's Health Insurance Program (SCHIP) on Title V Children with Special Health Care Needs Programs – Updated Edition*, The Association of Maternal and Child Health Programs (2000)
18. J Tilly and J Chesky, *Recent Changes in Health Policy for Low-Income People in Colorado*, The Urban Institute (2002).
19. J Stuber et al., *Beyond Stigma: What Barriers Actually Affect the Decisions of Low-Income Families to Enroll in Medicaid?* Center for Health Services Research and Policy at George Washington University (2000).
20. Undocumented immigrants are not eligible for CHIP regardless of their date of entry into the United States. However, many children and adolescents in immigrant families – both documented and undocumented – were born in the United States and therefore are U.S. citizens and eligible for CHIP. Immigrants who arrived in the United States after August 22, 1996 (the enactment date of the welfare reform bill) and who are not eligible for federal health programs must wait for five years before receiving Medicaid or CHIP benefits. See, generally, ER Brown et al., "Access to health insurance and health care for immigrant children," in DJ Hernandez, ed., *Children of Immigrants: Health, Adjustment, and Public Assistance*, Washington DC: National Academy Press (1999); L Ku and S Blaney, *Health Coverage for Legal Immigrant Children: New Census Data Highlight Importance of Restoring Medicaid and SCHIP Coverage*, Center on Budget and Policy Priorities (2000).
21. See references cited in note 20. See also Colorado Office of the State Auditor, *Children's Basic Health Plan, Department of Health Care Policy and Financing, Performance Audit* (Audit No. 1225A) (2000).
22. V Smith, E Ellis and C Chang, *Eliminating the Medicaid Asset Test for Families: A Review of State Experiences*, Kaiser Commission on Medicaid and the Uninsured (2001).
23. Yondorf, *2001 Colorado Health Data*, p. 71, see note 9; see also Colorado Child Health Plan *Plus, Information for Parents Seeking Health Insurance for Their Children* (no date).
24. See discussion in Chapter II on mental health and Chapter VIII on dental health.
25. Tilly and Chesky, *Recent Changes*, see note 18; see also Colorado Department of Public Health and Environment, Maternal and Child Health grant proposal, see note 14.
26. Fox et al., *Access to Care*, see note 17.
27. Ryan et al., "The effects of regular source of care," see note 6; A English, "Special populations of children need special attention by CHIP programs," XIX *Youth Law News 6*, National Center for Youth Law (1998).
28. Colorado Child Health Plan *Plus*, *CHP+ Benefits Booklet* (2001).
29. See, e.g., I Hill, AW Lutzky and R Schwalberg, *Are We Responding to Their Needs? States' Early Experiences Serving Children with Special Health Care Needs under SCHIP*, The Urban Institute (2001). P Newacheck et al., "Access to health care for children with special health care needs," *Pediatrics* 105(4): 760-766; BA Stroul et al., "The impact of managed care on mental health services for children and their families" and HB Fox and MA McManus, "Improving state Medicaid contracts and plan practices for children with special needs," *The Future of Children* 8(2) (1998).
30. See, e.g., the following references, broken down by subject: Age: LE Conard, JD Fortenberry and DP Orr, "Pharmacists' attitudes and practices with adolescents," *Journal of Adolescent Health* 30(2): 93-94 (2002); Foster Care: DW Nelson, "Gratified but not satisfied on foster care independence," *AdvoCasey* 3(2), Annie E. Casey Foundation (2001); HN Taussig, RB Clyman and J Landsverk, "Children who return home from foster care: A 6-year prospective study of behavioral health outcomes in adolescence," *Pediatrics* 108(1): e10 (2001); Gender: J Gilliam, *Young Women Who Have Sex with Women: Falling through Cracks for Sexual Health Care*, Advocates for Youth (2001); Race/Ethnicity: Advocates for Youth, *Effective HIV/STD and Teen Pregnancy Prevention Programs for Young Women of Color* (2001); Transition: RW Blum et al., "Transition from child-centered to adult health-care systems for adolescents with chronic conditions: A position paper of the Society for Adolescent Medicine," *Journal of Adolescent Health* 14:570-576 (1993); Juvenile Justice: JJ Cocozza and K Skowyra, "Youth with mental health disorders in the juvenile justice system: Issues and emerging responses," *Juvenile Justice* 7(1): 3-14, Office of Juvenile Justice and Delinquency Prevention (2000); Youth with Special Health Care Needs: LA Smith, PH Wise and NS Wampler, "Knowledge of welfare reform program provisions among families of children with chronic conditions," *American Journal of Public Health* 92(2): 228-230 (2002).
31. See, e.g., JW Noell and LM Ochs, "Relationship of sexual orientation to substance use, suicidal ideation, suicide

attempts, and other factors in a population of homeless adolescents," *Journal of Adolescent Health* 29(1): 31-36; Advocates for Youth, *Lesbian, Gay, Bisexual, and Transgender Youth: At Risk and Underserved* (1998); N Seiler, *TANF and Teen Parents with Disabilities*, Center for Law and Social Policy (2001).

32. CD Brindis et al., *Improving Adolescent Health: An Analysis and Synthesis of Health Policy Recommendations*, National Adolescent Health Information Center (1997).
33. See Klein et al., "Access to medical care," see note 8; see also, e.g., Klein and Wilson, "Delivering quality care," see note 6; AV Marcell et al., "Male adolescent use of health care services: Where are the boys?" *Journal of Adolescent Health* 30(1): 35-43; The Center for Reproductive Rights (formerly the Center for Reproductive Law and Policy), *Restrictions on Young Women's Access to Abortion Services* (2002) and *Parental Consent and Notice for Contraceptives Threatens Teen Health and Constitutional Rights* (2001)
34. Notwithstanding confidentiality requirements in law, the Society for Adolescent Medicine position paper on confidentiality includes the statement: "Blind adherence to absolute confidentiality, or absence of confidentiality (in deference to parental wishes), is neither desirable nor required by ethics or law." "Confidential health care for adolescents: A position paper of the Society for Adolescent Medicine," *Journal of Adolescent Health* 21:408-415 (1997).
35. See generally, H Boonstra and E Nash, "Minors and the right to consent to health care," *The Guttmacher Report on Public Policy* 3(4):4-9 (2000).
36. The Alan Guttmacher Institute, *State Policies in Brief (as of January 1, 2003): Minors' Access to Contraceptive Services*.
37. The Alan Guttmacher Institute, *State Policies in Brief (as of January 1, 2003): Minors' Access to Prenatal Care.*
38. The Alan Guttmacher Institute, *State Policies in Brief (as of January 1, 2003): Minors' Access to STD Services*.
39. The US 10th Circuit Court of Appeals has ruled that a Colorado law (CRS 12-37.5-104) requiring minors to notify a parent before getting an abortion is unconstitutional. The law does not have an exception allowing doctors to perform abortions necessary to protect a pregnant teenager's health. The case is Planned Parenthood of the Rocky Mountains *v.* Owens, No. 00-1385, 107 F. Supp.2d 1271 (D. Colo. 2000), affirmed April 19, 2002 by the US 10th Circuit Court of Appeals.
40. See, e.g., National PTA, *Healthy Children, Successful Students: Comprehensive School Health Programs (no date)*.
41. Children Now, *Partners in Transition: Adolescents and Managed Care* (2000). *Partners in Transition* provides an overview of the barriers that prevent teens from receiving the health care they need and spotlights health plans from across the country that have successfully addressed them. The report includes eleven strategies, each of which is illustrated by a model program. See also National Adolescent Health Information Center, *Assuring the Health of Adolescents in Managed Care: A Quality Checklist for Planning and Evaluating Components of Adolescent Health Care* (1998).
42. S Silow-Carroll et al., *Reaching Out: Successful Efforts to Provide Children and Families with Health Care,* Community Voices: Healthcare for the Underserved, WK Kellogg Foundation (2002).
43. DC Ross and M Booth, *Enrolling Children in Health Coverage Programs: Schools Are Part of the Equation*, Covering Kids and the Center on Budget and Policy Priorities (2001).
44. Division of Adolescent and School Health, *Coordinated School Health Program* (2002).
45. Ibid.
46. Colorado Department of Education, *Comprehensive Health Education* and *The Colorado Comprehensive Health Education Act: The Law and Guidelines* (no dates).
47. Colorado Department of Health Care Policy and Financing and Colorado Department of Education, *School Health Services Program: Program Description* (2001) CRS 26-4-531.
48. See, generally, the Center for Health and Health Care in Schools, *School-Based Health Centers – Background* (no date); National Assembly on School-Based Health Care, *Partners in Access: School-Based Health Centers and Medicaid – Policies and Practices* (2001).
49. See, e.g., DW Kaplan et al., "Managed care and school-based health centers: Use of health services," *Archives of Pediatrics and Adolescent Medicine* 152(1): 25-33 (1998). For an extensive bibliography on school-based health, from the National Center for Health and Health Care in Schools, go to: http://www.healthinschools.org/sbhcs/biblio.asp.
50. Colorado Association for School-Based Health Care, *What is a School-Based Health Center?* and *1999 Annual Report*.
51. The National Center for Health and Health Care in Schools, *Children's Mental Health Needs, Disparities and School-Based Services: A Fact Sheet* (no date).
52. CASBHC, *What is a School-Based Health Center?*, see note 50.
53. Ibid.