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Department of Health Care Policy and Financing

ADOLESCENT WELL CARE QUALITATIVE STUDY

Final Report

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1. Acknowledgements

We wish to express our thanks and appreciation to the following individuals and organizations who contributed to the project as participants in the Colorado Medicaid Quality Improvement Committee (QuIC). While the names of the 21 Medicaid providers interviewed are confidential, their insights and recommendations are particularly appreciated. Their knowledge and experience in caring for adolescents on a daily basis are essential to understanding how to improve practices.

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Introduction

The Colorado Department of Health Care Policy and Financing (CDHCPF) administers the Colorado Medicaid program, which finances care for approximately 48,000 adolescents from 12 to 21 years of age. Adolescents are a unique population with health concerns and needs that present challenges in both access to care and health care delivery. This report describes a qualitative study of adolescent care conducted in 2002 by CDHCPF and Colorado Medicaid health plans.

According to the National Center for Health Statistics, adolescents aged 10 to 19 years old make up approximately 14 percent of the total U.S. population in 1999 and numbered about 40 million[1]. Eighty percent of these teenagers self-reported very good or excellent health, 10 percent have limitations caused by a chronic disease or disability, and approximately 20 percent experience a mental or behavioral health disorder. However, 70 percent of adolescent morbidity/mortality is the result of participation in risky behaviors, and this rate has not declined in the last 20 years. In fact, in 2000 nearly one in three adolescents reported engaging in multiple risky behaviors[2].

Annual well care visits are necessary if adolescents are to receive appropriate counseling and guidance on behavioral risks. Yet, research shows that adolescents have lower rates of health care utilization than both younger and older persons, despite their health issues[3]. A 1994 study of utilization[4] showed adolescents as under-represented in office visits: adolescents 11 to 21 years old made 9.1 percent of total office visits but represented 15.4 percent of the U.S. population.

CDHCPF and its Medicaid Quality Improvement Committee (QuIC) initiated this qualitative study with the goal of understanding more about the current environment for adolescent care for Colorado Medicaid clients. The study included the Colorado Medicaid PCP Program (PCPP), unassigned Fee-for-Service (FFS) program, and the Colorado Medicaid HMOs: Colorado Access, Rocky Mountain Health Plans, Community Health Plan of the Rockies, Kaiser Permanente and UnitedHealthCare of Colorado.

Study Objectives

There were three main objectives of the QuIC study:

- To provide a baseline assessment of the infrastructure of each Colorado Medicaid health plan in order to establish expectations for future planning,
- To assess a sample of providers to understand what is taking place at provider offices regarding adolescent care and to identify strengths and opportunities for improvement, and
- To provide CDHCPF with an overall assessment of Colorado Medicaid health plans, including plan-to-plan comparisons.

It was recognized that, as is usual in a qualitative study of this nature, the use of small sample sizes would preclude being able to project results to the Colorado Medicaid population as a whole. While a broader study based on these results may be considered in future, the goal of the current study was exploratory and was designed to provide richer information than could be gained from a quantitative study alone.

NOTE: Names of plans and other relevant organizations are identified using acronyms frequently throughout this report. For their meanings, see the list of acronyms "*10.* Glossary" on page 46.

Methodology and Sampling

Three complementary approaches were used to gather information for the study: (1) self-assessment of health plan practices which relate to adolescent care, (2) use of a series of provider interviews to investigate provider experiences and best practices, and (3) medical record review of a sample of adolescent records. This study included 21 providers in total, three from each plan. The small sample size of providers may not be representative of Colorado Medicaid providers as a whole.

Health Plan Self-Assessment

An assessment of the policies, procedures and services of each Colorado Medicaid health plan was completed to understand how current practices affected adolescent members. The National Adolescent Health Information Center (NAHIC) self-assessment tool was used as a model and was edited using feedback from QuIC. The NAHIC tool was considered by QuIC to reflect "best practices." Four areas were chosen: (1) access to care for adolescents, (2) adolescent-appropriate quality services, (3) coordination of services, and (4) adolescent participation. Each health plan was requested to submit a completed self-assessment and supporting documentation with examples of how criteria were met.

Provider Interviews

Each of the seven Colorado Medicaid health plans/programs selected providers with the highest volume of adolescent well care visits in 2001. Three providers from each network were interviewed using an interview guide developed from Society for Adolescent Medicine (SAM) criteria. The 21 interviews (each lasting 20 minutes) addressed provider use of clinical practice guidelines, effective approaches to making services more convenient for adolescents, processes to assure the adolescent of the confidentiality of services, coordination with behavioral health and community organizations, and the question of how providers address diversity, including children with special health care needs. Finally, the interviewer asked each provider for one recommendation to improve the care of Medicaid adolescents in Colorado. All results (shown in "*12.* Appendix B: Final Results") are as reported by the providers. Their information was not validated as part of this study.

Medical Record Review

For each of the 21 providers, medical records of five adolescents were reviewed at the time of the provider interview with the exception of Kaiser Permanente. The medical records were reviewed at Kaiser Permanente's Regional Office utilizing their computerized medical record system. These adolescents had made an annual well care visit to the provider in 2001 and were sampled by the health plans using HEDIS® 2002 adolescent well care specifications. This study did not require an independent audit of the health plan sample and data were accepted as submitted; as a result, some adolescents submitted had no well care visit. The medical record review tool was developed by identifying the common elements of the most widely recognized guidelines on adolescent care, including the American Medical Association Guidelines for Adolescent Preventive Services (GAPS); the Maternal and Child Health Bureau Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents (MCHB); the American Academy of Family Physicians; the U.S. Preventive Services Task Force guideline Putting Prevention Into Practice (PPIP); and requirements of Colorado's Early and Periodic Screening, Diagnosis and Testing (EPSDT) Program. Medical records were abstracted to determine the degree to which the provider documented the essential components of the adolescent well care visit. A sample of records was re-abstracted by a supervising nurse reviewer and 96.5 percent of items matched, exceeding the 95-percent accuracy standard.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). The Health Plan Employer Data and Information Set (HEDIS) comprises a set of performance measures widely used in the managed health care industry.

Health Plan Self-Assessment Results

This evaluation was conducted to identify current strengths and opportunities for improvement for health plans related to adolescents' experiences with the plan. In this baseline study, self-assessment results show that, in the four areas reviewed, health plans do not currently customize policies, procedures and practices to serve the unique needs of adolescents. This is not to say that they do not apply to adolescents or meet their basic needs, but that in only a limited number of cases is there evidence that current practices have been designed or adapted with the needs of adolescents in mind. A notable exception was identified: one provider in Colorado Access' network offered excellent examples of policies, procedures and practices designed to address adolescent needs and meet the NAHIC "Best Practices" standard. These were the provider's policies, procedures and practices and were not used by the health plans for all adolescent members. The health plans had their own separate corporate policies. Nonetheless, the materials provided by Colorado Access for this study are recognized in this report as "Best Practices."

Colorado Access and Community Health Plan of the Rockies scored significantly higher on the self-assessment because they actively solicit feedback and/or participation from adolescents.

Summary of Self-Assessment of Adolescent Health Care

SUMMARY	ALL PLANS	ALL HMOS	ROCKY MTN	CHPR	CO ACCESS	UNITED	KAISER	PCPP	FFS
ACCESS TO CARE FOR ADOLESCENTS	54.6%	55.6%	53.7%	51.8%	59.3%	57.4%	N/R	53.7%	51.9%
ADOLESCENT APPROPRIATE QUALITY SERVICES	72.7%	75.7%	70.8%	70.8%	84.7%	76.4%	N/R	66.6%	66.6%
COORDINATION OF SERVICES	54.0%	59.8%	62.1%	57.6%	66.7%	53.0%	N/R	42.4%	42.4%
ADOLESCENT PARTICIPATION	50.0%	58.3%	33.3%	66.6%	100%	33.3%	N/R	33.3%	33.3%
OVERALL SELF-ASSESSMENT	**57.8%**	**62.4%**	**55.0%**	**61.7%**	**77.7%**	**55.0%**	**N/A**	**49.0%**	**48.6%**

Note: N/R = No Response. N/A = Not Applicable. Kaiser Permanente did not participate in the self-assessment component of the study.

For each answer, one point was assigned when information relevant to adolescents was not available for review (the minimum score), two points were assigned when general information relevant for all members was available and three points were assigned when adolescent specific information was available (the maximum score). This resulted in a total maximum score of 198 points (100%) and a minimum score of 66 (33.3%). In this table, scores are summed for each category, weighted equally and shown as percentages of the total possible scores. None of the health plans scored greater than 80 percent on the overall self-assessment category (in **bold**), two health plans received positive results with room for improvement (between 60 and 79 percent) and four health plans scored less than 60 percent, which reflects a priority for improvement.

Provider Practices

Summary of Medical Record Review Findings

ELEMENTS IN EACH MEDICAL RECORD	ALL PLANS	ALL HMOS	ROCKY MTN	CHPR	CO ACCESS	UNITED*	KAISER	PCPP	FFS
RECORDS REVIEWED	99	69	15	15	15	9	15	15	15
PHYSICAL EXAMINATION									
COMPREHENSIVE EXAM	93	63	15	14	14	5	15	15	15
BLOOD PRESSURE	83	54	12	7	13	7	15	14	15
BODY MASS INDEX	88	59	14	13	12	5	15	14	15
VISION TEST	64	38	11	2	10	3	12	11	15
HEARING TEST	21	9	3	0	6	0	0	6	6
ORAL EXAM	89	59	12	14	13	5	15	15	15
TOTAL PERCENTAGE FOR PHYSICAL EXAMINATION	74%	68%	74%	56%	76%	46%	80%	83%	90%
HEALTH EDUCATION									
NORMAL DEVELOPMENT	56	28	5	5	4	1	13	13	15
DIET & PHYSICAL ACTIVITY	63	35	7	6	5	3	14	13	15
HEALTHY LIFESTYLES	56	28	5	1	6	1	15	13	15
INJURY PREVENTION	51	24	5	0	3	1	15	13	14
TOTAL PERCENTAGE FOR HEALTH EDUCATION	57%	42%	37%	20%	30%	17%	95%	87%	98%
RISK SCREENING AND COUNSELING									
EATING DISORDERS	57	34	7	6	4	2	15	8	15
SEXUAL ACTIVITY	47	25	3	2	5	3	12	9	13
ALCOHOL USE	55	31	7	3	4	5	12	11	13
DRUG USE	53	30	7	1	6	4	12	10	13
TOBACCO USE	66	42	7	4	8	8	15	10	14
ABUSE	40	22	4	1	1	1	15	6	12
SCHOOL PERFORMANCE	51	31	7	1	5	3	15	5	15
DEPRESSION OR SUICIDE	43	28	5	2	5	1	15	3	12
TOTAL PERCENTAGE FOR RISK SCREENING AND COUNSELING	52%	44%	39%	17%	32%	38%	93%	52%	89%
PERCENTAGE OF TOTAL ELEMENTS POSSIBLE									
TOTAL PERCENTAGE	60%	52%	50%	30%	46%	36%	89%	70%	91%

* United submitted an incorrect sample resulting in a lower number of reviewed records.

A total of 99 adolescent records were reviewed. The table shows the number of records where the provider documented important elements covered on the adolescent visit. For each plan, the final percentage for medical record review was calculated by summing the number of elements which were documented in all medical records and dividing by the total possible elements. For example, 18 elements were evaluated for each of the 15 medical records yielding a total possible score of 270. If 124 of the possible 270 elements were documented in the medical record review, the overall score would be 46 percent. The combined total scores across all plans for comprehensive exams, blood pressure, body mass index, and oral exams were above 80 percent. Scores for vision tests, guidance on diet and physical activity, and tobacco use were between 60 and 79 percent, while scores for hearing tests, guidance on normal development, healthy lifestyles, injury prevention, eating disorders, sexual activity, alcohol and drug use, abuse, school performance, and depression or suicide were below 60 percent and offer opportunities for improvement.

During the provider interviews, all providers identified ways in which they addressed quality, accessibility, confidentiality, coordination and flexibility. The examples offered ranged from formal, documented practices to informal procedures. Two-thirds of the 21 providers used a clinical practice guideline of their own design. Some were familiar with GAPS, PPIP, EPSDT, and Bright Futures guidelines and incorporated these into their procedures for completing exams, while others referred to their training and education as the foundation for their procedures for completing adolescent exams. Fifteen providers had written tools to capture all or part of the well care exam components and four of these incorporated a "teen" survey or questionnaire at the time of the adolescent well care visit. All physicians were interested in finding out about tools used by others and tools accepted as standard in the community.

Overall

Strengths

- The providers interviewed clearly sought to serve adolescents well. On average, they had 18 years' experience serving adolescents and more than 40 percent of the adolescents they served were Medicaid clients. All providers were interested in contributing their knowledge and experience to efforts to improve care for adolescents.
- Based on this study, providers with Kaiser Permanente and the unassigned Fee-for-Service (FFS) program appeared to document components of a comprehensive adolescent well care visit more than others.
- Colorado Access was most active in soliciting adolescent feedback and participation.
- Community Health Plan of the Rockies identified in its provider directory the age range a provider would work with.
- Rocky Mountain Health Plans had comprehensive case management and referral protocols to coordinate care with the full range of services needed. While not related specifically to adolescents, they have the benefit of an adequate structure in place to make access easier when needed.
- UnitedHealthCare of Colorado provided a number of excellent examples of adolescent-specific outreach, using the "Healthy You" newsletter.
- A network provider/subcontractor of Colorado Access and Rocky Mountain Health Plans had policies and procedures on Adolescent Confidential Health Care and Informed Consent.

Opportunities for Improvement

- All plans should develop specific policies, procedures and programs to assure adolescents of confidential care.
- All plans should ensure that adolescents have access to ID cards. Without their own card, adolescents may experience barriers when accessing care from a provider without their parents' knowledge.
- Medical record documentation of encounters with providers can be improved. There was a lack of documentation for hearing and vision testing, health education and anticipatory guidance, screening and counseling related to risky behaviors, sexual activity, depression or suicide, and abuse.

Conclusions and Recommendations

The results of this preliminary study indicate that Colorado Medicaid and the managed care health plans are at an early stage in developing adolescent-friendly practices to promote adolescent well care. From an adolescent perspective, they appear to be treated the same as other children or as other adults, but in few areas are their concerns and needs addressed directly. However, through participation in this study, Colorado Medicaid and the health plans have shown a commitment to improvement in this area, and the study has identified important areas for improvement in both access to care and the adolescent's experiences during a visit to a provider. The providers interviewed were, without exception, willing to participate in the study and clearly committed to finding opportunities to improve care.

We recommend that CDHCPF and the health plans that participate in QuIC:

- Share and discuss examples of "Best Practices" identified in this report to set expectations and inform future interventions.
- Include the HEDIS® Adolescent Well Care Visit indicator in the required list of monitored Medicaid measures to track improvements in access to care over time.
- Review all materials targeted to members and look for opportunities to make them more adolescent-friendly. For example, references to the "Family Doctor" in member materials could imply to adolescents that they cannot, or should not, have a different doctor from the rest of the family.
- Create opportunities for adolescent participation in development of policies, procedures and resources.
- Create materials to explain confidentiality consistent with state laws and distribute these materials to adolescents and physicians.
- Involve the provider community in initiatives to develop adolescent friendly interventions.
- Identify adolescent-oriented providers in provider directories.
- Issue separate Medicaid ID cards to adolescents to encourage individual physician selection.
- Encourage physicians to address components of a comprehensive well care exam when adolescents come in for a sports physical.
- Continue to support EPSDT outreach efforts to ensure that periodic adolescent exams are being performed.
- Introduce an incentive for adolescents to come in for preventive visits. One California health plan, CalOPTIMA, has had remarkable success with this approach, increasing HEDIS rates substantially. The health plan gives a gift certificate to the teen with documentation of a well care visit. It also issues a teen newsletter and has a provider recognition program for those providers who show outstanding performance with adolescent members[5].
- Collaborate with physicians to develop age-specific educational information that can be given to the adolescent or parent at the time of the adolescent well care visit.

The Colorado Medicaid Program managed by the Department of Health Care Policy and Financing (CDHCPF) seeks to improve the care of its Medicaid clients by coordinating quality initiatives through its Quality Improvement Committee (QuIC). This committee is a collaboration among these organizations:

- Colorado Department of Health Care Policy and Financing (CDHCPF)
- Medicaid managed care organizations for Colorado
- Colorado community health care organizations
- Health Services Advisory Group, Inc. (HSAG), in its role as the External Quality Review Organization (EQRO) for Colorado Medicaid

In the fall of 2001, QuIC agreed that adolescent well care was an important area for a focused study.

Adolescent health is not generally regarded as a priority for our health care system, in part because adolescence is viewed as a time of health and vigor. This notion may have held some truth in the past. Yet recent studies show that contemporary American adolescents must deal not only with rapid physical growth and hormonal changes, but also with peer pressure to participate in a wide range of risky behaviors. Research shows that many, if not most, causes of adolescent mortality and morbidity result from these risky behaviors. Unintentional injury, homicide, suicide, pregnancy, sexually transmitted disease, and substance abuse are some of the common health events that bring adolescents to visit health care professionals.

Nationally in 1999, half of all high school students reported they were sexually active, reflecting a decrease of 8 percent between 1991 and 1999[6]. In Colorado, teen birth rates have been steadily falling since 1992, from 13.6 per 1,000 teens aged 10 to 17 years in 1992 to 11.7 per 1,000 in 1998[7]. Although birth rates are falling, teenagers are still disproportionately infected by sexually transmitted diseases. Chlamydia is the most common sexually transmitted disease in the U.S. and the most frequently reported in Colorado[8]. In 1999, Colorado had 10,708 tests positive for chlamydia, 75 percent of the positive cases were from women and 39 percent were from teens aged 15 to 19 years. Gonorrhea in Colorado increased 52 percent in the period 1995 to 2000[9]. In 2000, 24 percent of positive cases in Colorado were in teens in the age range of 15 to 19 years. Women in this age group had the highest age-group-specific rate (338 per 100,000 population), which was dramatically higher than the overall rate in Colorado (71.8 per 100,000 population).

The most recent Colorado data shows that 34 percent of high school students report regular use of tobacco products[10]. Smoking has also been shown to be associated with other risky behaviors. Patterns of alcohol use among teens are similar: half of high school students reported alcohol use in the previous 30 days[11]. Marijuana is the most commonly used illicit drug among high school students. In 1999, 47 percent of high school students reported previous use of marijuana.

Substance abuse may be driven by adolescents' attempts to cope with mental health issues, which are clearly on the rise. In 1999, 25 percent of female adolescents and 14 percent of male adolescents reported that they had seriously considered or attempted suicide. In 2001, the U.S. Surgeon General released a National Action Agenda for Children's Mental Health outlining problems. The National Action Agenda, an outgrowth of the 1999 Surgeon General's Report on Mental Health, is founded

on the belief that the nation is at the precipice of a public crisis in mental health for children and adolescents.

Research indicates there are many adolescents who are engaging in risky behavior. During discussions at the QuIC meetings, a question was raised as to what guidelines physicians are using to help identify adolescents who are at risk. The most widely recognized practice guidelines which specifically address adolescent care are the American Medical Association's *Guidelines for Adolescent Preventive Services* (GAPS); the Maternal and Child Health Bureau *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* (MCHB); and guidelines from the American Academy of Pediatrics. These guidelines all recommend an annual adolescent well care visit. In addition, the American Academy of Family Physicians (AAFP) and U.S. Preventive Services Task Force recommend at least one preventive-care visit every one to three years. Annual well care visits are essential if adolescents are to receive appropriate counseling and guidance on behavior risks. However, research shows that adolescents have lower rates of health care utilization than both younger and older persons, despite the health issues described above[3]. In a 1994 study of utilization of physician offices, adolescents aged 11 to 21 years old made 9.1 percent of the total office visits but represented 15.4 percent of the U.S. population, indicating that adolescents are under-represented in office visits[4]. The most recent national Medicaid HEDIS® statistics show that, in 1999, on average only 28 percent of Medicaid-enrolled adolescents had an annual well care visit[12].

Study Goal

The goal of this study was to understand the environment for adolescent care in Colorado Medicaid.

The study included the Colorado Medicaid PCP Program (PCPP), unassigned Fee-for-Service (FFS) program, and the five Colorado Medicaid HMOs: Colorado Access, Rocky Mountain Health Plans, Community Health Plan of the Rockies, Kaiser Permanente, and UnitedHealthCare of Colorado.

Study Objectives

There were three main objectives of the QuIC study:

- To provide a baseline assessment of the infrastructure of each Colorado Medicaid health plan in order to establish expectations for future planning,
- To assess a sample of providers to understand what is taking place at provider offices regarding adolescent care and to identify strengths and opportunities for improvement, and
- To provide CDHCPF with an overall assessment of Colorado Medicaid health plans, including plan-to-plan comparisons.

It was recognized that, as is usual in a qualitative study of this nature, the use of small sample sizes would preclude being able to project results to the Colorado Medicaid population as a whole. While a broader study based on these results may be considered in future, the goal of the current study was exploratory and was designed to provide richer information than could be gained from a quantitative study alone.

Literature Review

Health Services Advisory Group reviewed current research literature[13] on adolescent health care to help identify key reasons that adolescents continue to have such low rates of physician visits compared to other age groups. Using criteria selected by the Society for Adolescent Medicine for evaluating adolescent access to health care services, the literature review identified research findings in these categories: availability, visibility, quality, confidentiality, affordability, flexibility and coordination.

Reasons that adolescents under-utilize health care services vary by gender, age, ethnicity and geographic location. One issue that concerns many adolescents is confidentiality. Seventy percent of adolescent morbidity/mortality is the result of participation in risky behaviors, and nearly one in three adolescents report that they engage in multiple risky behaviors[14]. Not surprisingly, most adolescents do not want their parents to know about their behavior regarding contraception and pregnancy, testing and treatment for sexually transmitted diseases, violence, substance abuse, or mental health concerns. As a result, concerns about confidentiality may dominate the older adolescent's decisions about whether or not to seek care and compromise the ability of younger adolescents to discuss these issues in the presence of their parents. Research shows that between 17 and 25 percent of adolescents have skipped care because of concerns that their parents might find out[15]. Confidentiality may therefore be considered an area with significant potential to effect change in adolescent utilization of health care services.

Availability

Providers play a key role in addressing preventive services for adolescents. In 1993, Igra et al[16] found that adolescents who seek care do not always receive the care defined by the national guidelines. There are no statistics to show the number of primary care physicians who follow the national guidelines for preventive care, and only a few studies have addressed the barriers that physicians must overcome to provide preventive services. Barriers reported by physicians include issues around reimbursement rates, time constraints, the emphasis on "acute" care versus preventive care, lack or limitation of training, and confidentiality and parental consent.

Visibility

The Society for Adolescent Medicine defines *visibility* of health care services as those that are "recognizable, convenient and ...[that] do not require extensive or complex planning by adolescents or their parents." Teenagers usually have limited or no experience navigating our complex medical system. Those who are motivated to make a solo visit to a doctor for the first time must be able to identify which primary care physician to visit, how to get there (transportation needs), and how to pay. Convenience is key. Any time a teen must plan and schedule a future appointment with a physician or clinic, chances decrease that the visit will take place. Young adults usually don't have experience in planning and scheduling on a daily basis; so scheduling a health care visit will compete with many other priorities including school, work and social life (not necessarily in that order). This explains the success of school-based health centers and adolescent clinics where unscheduled and walk-in visits or extended hours are available. Using focus groups of 9th-graders, researchers[17] investigated issues impacting adolescents' decisions to seek care. Several issues were identified which related to the adolescents' desire to navigate the health care system independently: teens want to be able to go on their own, they want visits and testing to be anonymous, they want their own medical card, and they need to be able to make appointments easily.

Quality

The Society for Adolescent Medicine identifies *quality* as providing a basic level of service to all youth, with adolescents satisfied with the care they receive. Many studies show that the primary reason that adolescents access care is for treatment of acute conditions—not to address behaviors that are considered high-risk. There appear to be two issues for discussion. The first is the fact that adolescents feel they have needs that are not being addressed during physician office visits. The other is that of foregone care, where adolescents have not sought care for conditions that require it. Even when adolescents are able to access care, not all of them receive the recommended screening and anticipatory guidance to prevent illness and injury and to promote safe health habits. Appropriate care and guidance are critical to ensuring that adolescents maintain emotional and physical well-being. In a 2001 study[18] of adolescent outpatient care, well care, and sexual health assessments, researchers found that sexual health assessment was infrequently documented in the medical records of teenagers enrolled in Medicaid-managed care.

Confidentiality

Confidentiality plays a key role when adolescents are determining whether or not to seek health care services. This issue is a major deterrent to accessing care. Adolescents are reluctant to include their parents in certain health care decisions, and providers are reluctant to provide care without parental consent. This dilemma is especially true for adolescents seeking care for sexually transmitted diseases, mental health issues, drug and alcohol abuse, contraception and pregnancy. Adolescents with health insurance may not seek care because they are afraid the reason for the visit will be included on the billing statement, giving their parents access to that information. In a Practice Guideline issued in 1999, the American Academy of Pediatrics notes the primary reason that adolescent girls do not get contraceptives or family planning is because of confidentiality concerns[19]. Recommendations are made that pediatricians' offices have clearly defined policies and procedures to address waiver of confidentiality, guidelines for reimbursement for services, medical records access, appointment scheduling, and disclosure of information.

Affordability

The Society for Adolescent Medicine states that it is critical for adolescents to have access to insurance programs that provide both preventive and other services designed to promote healthy behaviors and decrease morbidity and mortality. However, eligibility for Medicaid does not always mean that individuals will enroll. In 1996, one-third of uninsured adolescents aged 13 to 18 years were eligible for Medicaid but were not enrolled in the program[20]. In Colorado, before 2000, children from families earning less than 100 percent of the Federal Poverty Level (FPL) were covered by Medicaid until aged 15 years, but after reaching 16 years old only those from families earning less than 39 percent of the FPL were eligible. This earning limitation is slowly changing, as required by Federal law. In 2000, 16-year-olds became eligible for Medicaid at 100 percent FPL, and by October 1, 2002, all children under age 19 will be covered in families earning up to 100 percent of the FPL. A benefit available to all Medicaid-eligible children is the EPSDT program; ensuring periodic doctor visits at regular intervals and coordination for other eligible services. Colorado's Children's Health Insurance Program (CHIP), a federal and state partnership, covers children under the age of 19 in families that earned too much to qualify for Medicaid but not enough to pay for private insurance (up to 185 percent FPL).

Flexibility

The Society for Adolescent Medicine model recommends that decisions regarding services, providers and delivery sites consider the cultural, ethnic, and social diversity among adolescents. Risky behaviors vary considerably for different populations, and substance abuse rates are often higher for minority populations. A report from the National Association of Social Workers[21] summarizes adolescent health issues for different ethnic groups. American Indian youth overall have the worst health indicators of any racial or ethnic group, with motor vehicle death and suicide rates three times that of the general population, and the highest substance abuse rates compared with other ethnic groups[22]. Hispanic and African American adolescents are less likely to smoke than their white counterparts. However, cigarette smoking among Hispanics and African Americans has increased after several years of substantial decline in the 1990s[23]. Ethnic minority youths are the hardest hit by the HIV/AIDS epidemic[24], comprising 84 percent of new HIV infections in young people between the ages of 13 and 19. Minority adolescents also have disproportionate rates of sexually transmitted diseases and unintended pregnancies. Among high school students, African Americans and Hispanics are less likely to report regular participation in physical activity than white individuals. This puts African Americans and Hispanics at increased risk of ailments—such as diabetes, obesity, and cardiovascular disease—related to physical inactivity[25].

Coordination

The Society for Adolescent Medicine emphasizes the importance of the providers' role in ensuring coordinated care for adolescents. Even when adolescents are able to access a provider, they may not receive recommended health screening and preventive services. Adolescents are more likely to visit providers for problems associated with a sore throat, cough, acne or an injury, which means visits are inclined to be brief and problem-oriented and care is often fragmented. The opportunity to conduct a thorough health assessment, provide preventive services such as immunization, and provide anticipatory guidance is often missed. To eliminate the many barriers that adolescents face when accessing health care services, a multifaceted approach is needed that will ensure that adolescents' physical and psychosocial health care needs are being met.

Self-Assessment

An assessment of the policies, procedures and services of each Colorado Medicaid health plan was completed in order to understand how current practices affected adolescent members. The National Adolescent Health Information Center (NAHIC) self-assessment tool was used as a model and was edited using feedback from QuIC. The tool was in the form of a quality checklist to be used by managed care health plans for planning and evaluating components of adolescent health care. The San Francisco Adolescent and Managed Care Working Group, a provider body interested in establishing a standard of care for adolescents and young adults, had developed the tool. The NAHIC tool was considered by QuIC to reflect best practices.

Four areas were included in the final study self-assessment tool: access to care for adolescents, adolescent-appropriate quality services, coordination of services, and adolescent participation. One section (adolescent-sensitive authorization and review processes) of the NAHIC tool was eliminated and two sections were combined (coordination with core public health functions and coordination of services). QuIC agreed to weight each of the final four areas equally when calculating the final self-assessment score.

The NAHIC tool used a five-point scale to evaluate the degree to which the managed care plan fulfilled each aspect for adolescents. Scoring relied on subjective judgment, and so it was decided to score the Colorado study tool more objectively: either the criteria were met and evidence could be provided, or the criteria were not met. Consequently, health plans were asked to complete the self-assessment, check each statement that applied, and provide supporting documentation to HSAG.

The final tool was distributed to plans on April 17, 2002 for return to HSAG by June 5, 2002.

The final results of the self-assessment were compiled by HSAG by reviewing answers and comparing to documentation provided. A star rating system was used to score and report final results with each star indicating:

 Adolescent-specific information was available (three points were assigned)

 General information was available for all members and not adolescent-specific (two points were assigned)

 Information relevant to adolescents was not available for review (one point was assigned)

Results are shown in Appendix B, page 71.

All health plans were credited with  for question 11, quality improvement processes which address adolescent issues, because of their participation in this study.

Provider Interview

Sample Selection

Each of the seven Colorado Medicaid health plans/programs selected providers with the highest volume of adolescent well care visits in 2001. First, HEDIS® criteria were used by each plan to identify adolescents with well care visits (see data specification in Appendix A, page 68). For each adolescent, the health plan identified the provider of service. These were ranked by number of adolescents served in 2001, and a list of the top 20 providers was sent to HSAG. HSAG created a master set of these providers and identified overlaps between networks. Where a physician was listed in more than one network, that physician was assigned to the network where he or she had served the highest number of adolescents. HSAG initially identified five providers for each network and asked the health plan to confirm these for use in the study. Three providers in each network (21 in total) were interviewed; the remainder was an over-sample to account for physicians who might have been unavailable during the interview period. Of the 21 final interviewees, 14 were MDs, one was a Physician Assistant, three were Nurse Practitioners, two were Registered Nurses and one was the office manager. Providers were located in different areas of Colorado including Aurora, Brighton, Cedaredge, Colorado Springs, Delta, Denver, Grand Junction, Greeley, Lakewood, Pueblo, and Westminster.

Notification of Providers

Providers selected for interview received written notice thirty days in advance of the site visit and a follow-up telephone call to schedule the visit date. They were given notice that the medical records of five adolescents would also be reviewed during the visit. A follow-up letter fourteen days in advance of the site visit confirmed details of the appointment and attached a list of names and identification details of eight adolescents (which included three over sample).

Interview Guide

A semi-structured interview guide was developed using the Society for Adolescent Medicine (SAM) criteria for evaluating adolescent access to health care services: quality, visibility, confidentiality, coordination and flexibility. The 21 interviews (each lasting 20 minutes) addressed provider use of clinical practice guidelines, effective approaches to making services more convenient for adolescents, processes to assure the adolescent of the confidentiality of services, coordination with behavioral health and community organizations, and a discussion of how providers addressed diversity, including children with special health care needs. For each topic, providers were invited to discuss how they addressed the key issues and to identify any best practices. Finally, the interviewer asked each provider for one recommendation to improve the care of Medicaid adolescents in Colorado. Overall, the intent was not to evaluate individual provider performance, but rather to identify current approaches and allow providers the opportunity to voice their opinions on the issues. The interviewer used a checkbox to capture the frequency of specific approaches and then made notes on the additional areas discussed immediately after the meeting.

The provider notification letters and final interview guide are included in Appendix A, beginning on page 53.

Medical Record Review

Sample Selection

Medical records of five adolescents were reviewed during each provider interview visit. These adolescents had each made an annual well care visit to the provider in 2001 and were sampled by the health plans using administrative data and the HEDIS® 2002 adolescent well care specifications. Initially, CDHCPF expressed interest in selecting a stratified sample of adolescents by age; however, there were too few adolescents with well care visits to support a stratified sample design.

HSAG randomly selected eight adolescents from the plan's HEDIS® numerator. This study did not require an independent audit of the health plan sample and data were accepted as submitted. As a result, some adolescents submitted from United Healthcare of Colorado had no well care visit. Investigation showed that United appeared to use the HEDIS® denominator (the eligible adolescents) incorrectly for the sample, rather than the adolescents with a well care visit from the numerator.

Medical Record Review Tool

The medical record review tool was developed by identifying the common elements of the most widely recognized clinical practice guidelines on adolescent care, including the American Medical Association Guidelines for Adolescent Preventive Services (GAPS); the Maternal and Child Health Bureau Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents; the American Academy of Family Physicians; the U.S. Preventive Services Task Force guideline Putting Prevention Into Practice (PPIP) and requirements of Colorado's Early and Periodic Screening, Diagnosis and Testing (EPSDT) program. Reviewer instructions for the medical record review tool were based on HEDIS® AWC medical record review criteria used by HSAG in HEDIS® audits. QuIC members reviewed and commented on the medical record review tool and the instructions before they were finalized.

Children with Special Health Care Needs (CSHCN)

CSHCN were identified in either of two ways. A table of ICD-9 codes and conditions was included with the tool instructions. In addition, CDHCPF staff identified all children in the sample who were SSI-eligible, making SSI eligibility apply to children, rather than parents, and assigning it for those with disabilities.

Reliability

A registered nurse abstracted records on site. Data were captured on paper using the medical record review tool with adolescent-identifying information pre-filled. The findings were reviewed with on-site staff to ensure that all available information was captured.

The completed tool was then returned to the HSAG office for data to be keyed into an electronic version of the tool. The electronic version of each record was electronically downloaded into a Microsoft Excel database for analysis. The project analyst then compared results in the database with the paper record. A sample of medical records was re-abstracted by a supervising nurse reviewer with the result that 96.5 percent of items matched, exceeding the 95 percent accuracy standard.

The final version of the medical record review tool and instructions are included in Appendix A, page 47.

Limitations

Sample Sizes

This small qualitative study was designed to provide in-depth information on the current practices related to adolescent well care in Colorado Medicaid, but results should not be considered representative of Colorado Medicaid as a whole. The self-assessment component captures information from Colorado Medicaid managed care plans except for Kaiser Permanente, and so does not completely represent practices across the state. The medical record review component targeted only 15 adolescents in each network and cannot be considered representative of all Colorado adolescents who made a well care visit. Finally, the provider interviews targeted those serving the highest volume of adolescents, per HEDIS® specifications. Because of these small convenience samples, we cannot know the extent to which the results are typical of other Colorado Medicaid providers. Consequently, any comparison between plans is illustrative and cannot be assumed to be representative.

Data Completeness and Accuracy

The selection of adolescents and providers who met study criteria relied on the accuracy and completeness of health plan reporting. However, this approach was problematic in some areas.

Colorado Access providers were identified at the clinic level rather than the individual physician level. The adolescents selected had received care at the clinic in 2001, but the individual *physician* was not available from the plan's administrative data. Consequently, in one case the physician who was interviewed was not actually the physician who cared for the adolescents at the clinic in 2001, since he was new to the practice as of May 2002. As a result, this provider may have had less insight into the practices of the clinic.

UnitedHealthCare of Colorado incorrectly submitted the HEDIS® adolescent well care denominator (age-eligible adolescents) rather than the numerator (those adolescents who made a well care visit per administrative data). Consequently, 15 adolescent records originally selected for review were not available either because they did not have an adolescent well care visit, or because the provider identified was the provider auto-assigned to them rather than the provider they had made a visit to. As a result, nine medical records were reviewed for United Healthcare rather than 15 for the other plans.

The study data specifications did not request information from plans on which ICD-9 codes or CPT codes caused the visit to meet the HEDIS® adolescent well care criteria. If this information had been available, additional analyses would have been possible. For example, a high percentage (approximately one-third) of adolescent visits appear to have been visits for sports physicals. Providers also indicated that they would like a different code to charge for counseling and health guidance in addition to the well visit. This appears to indicate that they may not be completing a full adolescent well care physical because this is not being reimbursed when identified with a sports visit code.

All interviews were planned as face-to-face discussions in the provider office. However, in two cases, the provider was called away and the interview had to be rescheduled and completed by telephone.

Provider interviews identified current practices; however, these were not validated independently.

Self-assessment findings in table format are included in Appendix B, page 71.

This evaluation was conducted to identify current strengths and opportunities for improvement for health plans related to adolescents' experiences with the plan. In this baseline study, self-assessment results show that, in the four areas reviewed, health plans do not currently customize policies, procedures and practices to serve the unique needs of adolescents. This is not to say that they do not apply to adolescents, or meet their basic needs, but that in only a limited number of cases is there evidence that current practices have been designed or adapted with the needs of adolescents in mind. A notable exception was identified: one provider in Colorado Access' network offered excellent examples of policies, procedures and practices designed to address adolescent needs and meet the NAHIC "Best Practices" standards. These were the provider's policies, procedures, and practices and were not used by the health plans for all adolescent members. The health plans had their own separate corporate policies. Nonetheless, the materials provided by Colorado Access for this study are recognized in this report as "Best Practices."

Summary of Self-Assessment of Adolescent Health Care

SUMMARY	ALL PLANS	ALL HMOS	ROCKY MTN	CHPR	CO ACCESS	UNITED	KAISER	PCPP	FFS
ACCESS TO CARE FOR ADOLESCENTS	54.6%	55.6%	53.7%	51.8%	59.3%	57.4%	N/R	53.7%	51.9%
ADOLESCENT APPROPRIATE QUALITY SERVICES	72.7%	75.7%	70.8%	70.8%	84.7%	76.4%	N/R	66.6%	66.6%
COORDINATION OF SERVICES	54.0%	59.8%	62.1%	57.6%	66.7%	53.0%	N/R	42.4%	42.4%
ADOLESCENT PARTICIPATION	50.0%	58.3%	33.3%	66.6%	100%	33.3%	N/R	33.3%	33.3%
OVERALL SELF-ASSESSMENT	**57.8%**	**62.4%**	**55.0%**	**61.7%**	**77.7%**	**55.0%**	**N/A**	**49.0%**	**48.6%**

Note: N/R = No Response. N/A = Not Applicable. Kaiser Permanente did not participate in the self-assessment component of the study.

For each answer, a score of one (the minimum), two, or three (the maximum) points was assigned. One point was assigned when information relevant to adolescents was not available for review. Two points were assigned when general information relevant for all members was available. Three points were assigned when adolescent-specific information was available. This resulted in a total maximum score of 198 points (100%) and a minimum score of 66 (33.3%). In this table, scores are summed for each category, weighted equally and shown as a percentage of the total possible score. None of the health plans scored at or above 80 percent on the overall self-assessment category (in **bold**). Two health plans received scores between 60 and 79 percent, and four health plans scored less than 60 percent.

Colorado Access and Community Health Plan of the Rockies scored significantly higher on the self-assessment because they actively solicited feedback and/or participation from adolescents.

Numbered paragraphs below indicate the specific question on the self-assessment tool, which can be found in Appendix A, page 47.

Access for Adolescents

1. Confidential Care

The self-assessment tool asks plans to confirm that, "There are policies and procedures to assure confidential care, including confidentiality policies regarding family planning and reproductive health services, sexually transmitted disease care, substance abuse treatment, and/or mental health treatment, consistent with state and federal law."

According to the Alan Guttmacher Institute*, in Colorado minors may independently consent to:

- Testing and treatment for STDs, explicitly including HIV testing and treatment
- Placing their child for adoption (for minors who are parents)
- Medical care for their children (for minors who are parents)
- Receive contraceptive services (in the following circumstances)
    - When a physician believes there is a probable health hazard
    - When a minor is married
    - When a minor is a parent
    - When a minor is pregnant
    - When a minor has been referred by a professional such as a physician or a clergyman.

Only the network provider/subcontractor for Colorado Access and Rocky Mountain Health Plans had comprehensive policies and procedures that were adolescent-specific, stating it "…will provide confidential health care to un-emancipated minors (age 18 and younger) when requested for the following conditions…" UnitedHealthCare of Colorado had confidentiality policies, which included minors, related to mental health and substance abuse only. Others referenced general policies that did not specifically mention adolescent confidentiality issues.

2. Informed Consent

"There are policies that allow for adolescents to give informed consent consistent with state law." The network provider/subcontractor for Colorado Access and Rocky Mountain Health Plans had an informed consent policy that discussed adolescents in detail. It stated that, "Under 18 years of age, a minor can give consent under any of the following circumstances:" (and then listed the circumstances).

In all other cases, general member rights and responsibilities statements were referenced, such as "you have the right to be seen by a family doctor who will give you the care that you need."

* State Policies in Brief: Available at http://www.agi-usa.org/pubs/spib.html (August 2002).

3. Access to Adolescent-Oriented Providers

"Adolescent providers and services are clearly identified for adolescents and their families."

Pediatricians are routinely identified in most provider directories. However, this is not considered adequate information for adolescents, who do not view themselves as children. Community Health Plan of the Rockies specifically references in the provider directory the age groups that the provider targets. In addition, Colorado Access has a section in the provider directory for adolescent medicine specialists.

4. Adolescent Choice of Provider

"There are mechanisms to assure adolescent choice of provider different and independent from other family members and to inform adolescents and family members of this option."

Community Health Plan of the Rockies uses the terminology "family doctor" throughout the member handbook. This may send an unintended message that there is one doctor per family, causing adolescents to wrongly believe that they cannot have a separate doctor from parents and siblings.

Other plans do not specifically address adolescents, although there is general information in the handbook explaining that it is possible to change doctors. It is not clear, however, whether the average adolescent would have ready access to the handbook if it were sent to the head of household and not to the individual member.

5 – 6. Assist Adolescents to Reduce Barriers to Access

"Adolescents are educated regarding their rights to confidential health care and the meaning of informed consent."

There was no information in any health plan materials submitted specifically targeting adolescents and their rights to confidential care and the meaning of informed consent. General materials were available to explain enrollment, disenrollment etc. The general member handbook received from one of the health plans did not explain how to enroll, but this information may have been available in other materials that were not submitted.

For adolescents to access the system under confidential circumstances, they may need to obtain their own individual Medicaid ID card. HSAG staff contacted Maximus, the enrollment broker, to discuss how ID cards are assigned. The enrollment broker did not know the answer and referred us to CDHCPF. The state employee was able to confirm that ID cards are issued to the family, listing one physician. The card identifies all family members assigned to that physician. If an adolescent were to try to get confidential services in the current Medicaid system, they are likely to experience difficulty because they would be asked to present a Medicaid ID card that they do not have. This may discourage the adolescent from making a visit at all.

Adolescent-Appropriate Quality Services

7. Guidelines for Care

All plans identified EPSDT guidelines as the main source of guidelines on adolescent care. Since these are not adolescent-specific, credit was given for general information. UnitedHealthCare of Colorado was the only plan to show evidence that information from the guidelines is available to adolescent members: the preventive care guidelines are clearly shown in the "Healthy You" newsletter. All plans received credit for benchmarks using the guidelines and evaluation of cost, quality and outcomes. EPSDT participation rates must be reported to the Centers for Medicare & Medicaid Services showing participation by age group (including adolescents) and credit was given for an EPSDT study completed with QuIC in 1997. Credit was given for this study in the absence of any other evidence; however, this study is now five years old and should now be considered out of date.

8. Managed Care Guidelines

Again, based on EPSDT requirements, all plans were given some credit for having guidelines that encompass a range of necessary services for adolescents. However, health plans did not always check these categories. For example, Rocky Mountain Health Plans and Community Health Plan of the Rockies did not check that they had dental-care protocols.

9 – 10. Culturally Sensitive Materials for Adolescents, Parents and Families

HMOs have general member materials that explain translation services and show sensitivity to cultural barriers and physical accommodations. Member handbooks identify the availability of outpatient rehabilitation services and drug treatment services. No information was available for PCPP or FFS networks. No adolescent-specific information was found.

11. Quality Improvement Processes

By virtue of their participation in this study, all plans were credited with having a quality improvement process that addresses adolescent issues.

Coordination of Services

12. Collaboration Mechanisms

Most health plans identified care coordinators who were responsible for maintaining connections to a range of services. Only Rocky Mountain Health Plans checked connections to the probation system. None identified adolescent-specific processes.

13. Outreach

Generally, outreach information provided was targeted to the head of household (parents) but did not directly address adolescents. However, UnitedHealthCare of Colorado provided excellent examples of adolescent and parental outreach directly related to issues of concern to adolescents: the *Healthy You* newsletter has addressed teen checkups, chlamydia, condoms, screening guidelines and eating disorders. Quarterly issues routinely address a new area of interest to adolescents. Only the Fee-for-

Service and PCP programs include outreach to state agencies. All plans are required to participate in EPSDT and have access to outreach coordinators.

14 – 16. Identifying and Working with High Risk Adolescents

Only Colorado Access specifically identified links to school-based health centers (including the Denver Health system).

Adolescent Participation

17 – 18. Mechanisms to Obtain Feedback from Adolescents

Colorado Access has facilitated enrollment in a summer camp for youth with diabetes. In 2002, Colorado Access is conducting an analysis of health care needs of individuals, including youth members, with mental and physical health comorbid diagnoses.

The network provider/subcontractor for Colorado Access and Rocky Mountain Health Plans is focusing on teen pregnancy through the Teen Pregnancy Outreach Advisory Board and is working with families through its Consumer Advisory Council.

Community Health Plan of the Rockies does state in its Member Handbook that they solicit suggestions from all members, which would include adolescents.

6. Provider Interview Findings

The provider interview findings in table format are included in Appendix B, Table 18.

All providers reported ways they addressed quality, accessibility, confidentiality, coordination and flexibility, the examples offered ranged from formal documented practices to informal verbal procedures. Where clinics had their own tools and resources, physicians provided copies of the materials used. Some were more comprehensive than others and many of the offices were in the process of updating or creating new forms. Physicians were always interested in finding out what tools others were using and what was accepted as the community standard.

Demographics of Provider Sample

Of the 21 providers interviewed, on average 22 percent of their patients were adolescents aged 12 – 21 years and 41 percent were Medicaid clients. Most providers had substantial experience working with adolescents, on average 18 years, and for each network this ranged from seven years (UnitedHealthCare of Colorado) to 26 years (PCPP).

Provider Use of Clinical Practice Guidelines

CDHCPF and QuIC members were interested in gaining an understanding of what criteria or framework physicians and physician extenders used to complete a comprehensive exam for adolescent Medicaid clients. There are multiple clinical guidelines available for reference at the national, state, and health-plan-specific level. There was no direct reference to the differences between clinical guidelines when discussing this topic with the provider. The impression of the interviewer was that providers use the same framework for well visits for all adolescents that they examine.

- Fifteen of the 21 providers used their own clinic-specific tool to document the adolescent well care visit.
- Six providers had age-specific health education materials and distributed these to the adolescent and/or parent at the visit.
- Many providers were familiar with GAPS, PPIP, EPSDT, and Bright Futures and incorporated parts of these guidelines in their clinic tool. Others referred to their medical education and training as the foundation for how they completed an adolescent well visit.
- Four providers used a "teen" survey or questionnaire that was completed before the visit with emphasis on identifying risk behavior.
- Two providers were in the process of redesigning their tools.
- Four providers did not have any formal tools.
- Overall, providers were interested in finding out what other physicians were using.

Visibility and Accessibility

The literature review findings indicate that it was very important to adolescents to be able to walk in for an appointment, to have extended office hours, and for providers to be available, if needed.

- Fourteen of the 21 offices would accommodate walk-ins.
- Eleven offices had hours after 5:00 p.m. Monday through Friday. Thirteen offices had hours on Saturday and three had hours on Sunday.
- Some offices have formal outreach programs in place to remind parents and adolescents to come in for well care exams, sports physicals, and health maintenance. One office sends out reminder and birthday cards to adolescents.
- With the after-hours on-call system, all physicians would be available by pager or phone. One physician stated that if he was concerned about an adolescent, he will make sure that the adolescent knows how to reach him, if needed.
- Kaiser Permanente had "Teen Exam" rooms that were designed specifically for adolescents.
- Three offices use Children's Hospital for after-hours calls and triage.
- Six offices offer their patient's access to an Advice Line; while not specific to adolescents, is a resource to answer questions for adolescents.
- Three physicians have Teen Clinics in place. One has been in place for many years and does outreach to 250 providers through bi-monthly newsletters regarding their adolescent services. The second clinic has been in place for two years and the third was recently started in 2002.

Confidentiality

The literature review findings indicate that confidentiality plays a key role in whether or not adolescents seek care. This is particularly true for adolescents who seek care related to sexually transmitted diseases, contraception and pregnancy, mental health, and substance abuse issues.

- Eighteen providers mentioned that they explained confidentiality verbally during the visit. Two physicians did not discuss confidentiality. One of these physicians reported feeling uncomfortable discussing confidentiality because of not knowing if there were recent changes in the state laws regarding confidentiality. No information was captured for one physician.
- Eleven providers said they offered or incorporated private time with the adolescent at the visit. The adolescent's age, circumstances, and parental consent influenced if this was needed or not.
- Providers reported that they respected the adolescents' decisions regarding what should be communicated to the parents, unless there was danger to themselves or others.
- One physician mentioned that adolescents would ask about what would and would not be documented in the medical record and that the answer directly impacted what the adolescent would share with the physician.
- Many physicians emphasized the importance of building trust with adolescents.
- Many providers were unsure if their office could ensure confidentiality through billing and notifying the member of test results. Many providers refer the adolescent to the local health

department or to Planned Parenthood because it is free and confidential, and these organizations do not bill clients for their services.

- One physician chose to use a sealed envelope for information that was regarded as highly confidential and this was used to ensure that no one else in the office had access to the information. Another provider at the teen clinic stated that clinic policy dictated that no information would be disclosed without consulting the provider or office manager.
- Five providers discussed their processes for maintaining confidentiality of lab services and for billing. Three of the physicians stated they would work with the adolescent but did not address the specifics of how the specimen and billing would be handled. Other physicians mentioned the use of a sliding scale for payment or waiving the co-payment. This would mean a bill would not be generated. One office asks the teen to call for lab results so it is not necessary to send the results to his or her home. Another office codes the office visit as "confidential" and the office staff knows how to handle billing and sending the specimen to the lab. No name is placed on the bill or on the lab specimen. Arrangements are coordinated with the adolescent on obtaining the results.

Coordination with Behavioral Health and Community Organizations

In the majority of cases, adolescents seek care for acute care conditions and the opportunity for health screening and preventive services can be missed. The primary care provider has the greatest opportunity to identify potential problems, initiate the appropriate referrals and make recommendations for change. Their role is to manage and coordinate all aspects of the care required and to set treatment goals. To do so, communication between health care providers and community organizations must be in place.

- No written referral criteria were identified for when an adolescent needs to be referred to a mental health provider or for substance abuse services. Providers said that they rely on self-referral by adolescents for these services, unless they are a threat to themselves or others.
- Several providers were concerned about the difficulty of getting an adolescent to see a mental health provider who specializes in adolescents and were concerned that, once the adolescent is in the system, there is difficulty with communication between providers. This is especially a challenge for rural providers, where the specialist travels to the area to see/evaluate patients.
- Outreach efforts with community organizations appear to be in place. It depended where the physician was located as to the level of involvement and type of organization. Many of the providers work with adolescents who have behavior problems (e.g., ADHD or ADD), so there is communication with the schools. Many physicians work with foster care.
- Eight offices had designated staff to coordinate these services.
- All referrals are done electronically at Kaiser Permanente making it easier to initiate the process.
- Two clinics/offices have group visits for adolescents that focus on education for smoking, weight management, etc.
- Kaiser Permanente has a designated person to work with children with special health care needs to coordinate care and identify resources. Kaiser Permanente also has a designated person who works with pregnant adolescents on the economic and social aspects of becoming a parent.

Diversity and Children with Special Health Care Needs

Findings of the literature review indicate that addressing issues of diversity is critical to ensuring adequate care. The health care system is being asked to serve a more diverse group of patients, and risk behaviors and risk for health conditions vary considerably among different populations.

- Multilingual services appear to be generally available. Many of the office staff and physicians who work with the Hispanic population speak Spanish. Many times, the member will bring a family member along with them to the appointment if they do not speak English or have difficulty understanding it.
- When working with Children with Special Health Care Needs, the emphasis was on allowing additional time at the appointment and coordinating efforts between organizations and caregivers. Several providers mentioned that it is difficult to know what resources are available. One physician's office who works with a high volume of children with special health care needs provides the following resource book to her patients: *Start Here: A Guide to Resources and Services for Families of Children with Disabilities 2001* by the Colorado Developmental Disabilities Planning Council. This information was shared with several of the offices that did not know about this resource book.
- Several physicians mentioned the concern about the high number of teenage pregnancies. Some have tried outreach educational efforts within their community but have experienced a low participation rate. Planned Parenthood was mentioned as a community resource that can offer education and prevention and has close ties with the community. One physician put the emphasis on the social and cultural considerations that have to be taken into account in order to have an impact on reducing the number of teenage pregnancies.

Comments from Providers

Overcoming Access Issues

Providers described general recommendations that they felt might improve **access to care** for Medicaid adolescents. These include:

- Increase public awareness and education about who is eligible for Medicaid. Providers believe that those who may qualify often do not understand the process for gaining eligibility and go without coverage.
- Two providers stated that there is an urgent need to increase opportunities to get adolescents in for preventive care. Many times help is needed much earlier and often not available, or the need is not identified, until the adolescent is in the legal system due to problems with the law.
- Several providers emphasized the need to build a relationship with the adolescent and viewed a well care exam as an opportunity to do so.
- Make it easier for adolescents to identify providers who specialize in caring for, and like to work with, adolescents.

- Design the process to allow adolescents to come in alone for preventive care, taking into consideration the state laws around parental consent requirements, and make the process easier on the adolescent and parent or caregiver.
- Two physicians commented that it is great to see Medicaid patients because they know that the patients can access the necessary service/care needed.

General Care of the Adolescent

Many providers also discussed general theoretical care of adolescents, which impact all adolescents. For example, how society relates to children. These providers believe that specific skills should be taught to children at a young age in order to prepare them to deal with the issues of normal growth and development during adolescence. Providers also emphasized the impact of changes in social structure and the need to understand culture and how it relates to adolescent behavior. They believe that adolescents need coaching to learn skills to help them cope with stress, conflict, change and anxiety, to prepare them for independence and to enable them to deal with the normal stresses of life in a healthy manner. Providers discussed:

- Gaining a greater understanding of the social and cultural issues that prevent adolescents from seeking care, identifying opportunities to get them to come in and, if risk behavior is identified, understanding how to eliminate or reduce the risk.
- Providing lifestyle counseling to prevent problems, starting at an early age. One physician stated there is a difference between adolescents who have goals and adolescents who do not have goals.
- Using "Health Peers" in schools that adolescents can go to for information and who can direct them to community services or provide support. Adolescents trust their peers more than they trust adults, making it more convenient for them to access information through other adolescents. Confidentiality would need to be addressed.
- Redesigning the process or benefits to increase accountability of parents to get kids (adolescents) in for preventive care. This particular office calls the parents or responsible person to make an appointment for preventive services, but many times the appointment is a no show.
- Providing free confidential reproductive health care for all adolescents through 19 years of age. A recommendation was made to review the current authorization requirements for contraceptives to determine if changing the requirements would help reduce the number of teenage pregnancies. Many times adolescents will come into the office and request a newer method of birth control. The provider has to explain to the adolescent that in order to get this particular type of birth control, the adolescent needs to try alternatives first. The adolescent may or may not want to try these other methods and there is an increased chance that the adolescent will become pregnant. However, the opportunity for prevention occurred at the initial visit when the adolescent was very interested in trying a specific type of birth control.

General Recommendations from Providers

Providers also gave general feedback when invited to make recommendations. They include:

- Offer education and information on lifestyle/parenting skills to the parents of adolescents.
- Develop a billing code to be used for counseling and health guidance in addition to the well visit.
- Evaluate current enrollment materials and communication methods used with Medicaid families and identify areas that could be simplified.
- Provide incentives for adolescents to come in for health care services.
- Offer transportation assistance if needed.
- Have a list of preferred providers for adolescents in the provider directory.
- Include the PCP name on the membership card and provide the adolescent with his or her own card.
- Educate adolescents on the state laws regarding confidentiality.
- Redesign the process to encourage adolescents to come in for preventive care and have access to, and communication with, behavioral health providers.

The complete medical record review findings in table format are included in Appendix B, Tables 20-23, pages 92-95.

Demographics of Adolescent Sample

A total of 99 adolescent records were reviewed. The average age of all adolescents was 14 years, consistent across all health plans. By gender, the average age of young women in the study was 14 years except for Community Health Plan of the Rockies (15 years) and UnitedHealthCare (13 years). For young men, the average age was 14 years except for Fee-for-Service (FFS), PCPP and Colorado Access (15 years) and Community Health Plan of the Rockies (13 years).

Overall, gender was balanced since 53 of the 99 adolescents in the sample were female, and for the HMOs, 37 of 69 were female. Rocky Mountain Health Plans and Community Health Plan of the Rockies also had balanced gender samples. However, in the Fee-for-Service sample there were almost three times as many males than females (4 females, 11 males). UnitedHealthCare of Colorado and Kaiser Permanente had twice as many females as males in the study, and PCPP had four times as many females as males (12 females, 3 males).

Twenty-three of the 99 adolescents were children with special health care needs (CSHCN). However, Community Health Plan of the Rockies and UnitedHealthCare of Colorado had no CSHCN clients in the study sample.

Physical Examination

	All Plans	All HMOs	Rocky Mtn	CHPR	CO Access	United*	Kaiser	PCPP	FFS
Records Reviewed	**99**	**69**	15	15	15	9	15	**15**	**15**
Physical Examination									
Comprehensive Exam	**93**	**63**	15	14	14	5	15	**15**	**15**
Blood Pressure	**83**	**54**	12	7	13	7	15	**14**	**15**
Body Mass Index	**88**	**59**	14	13	12	5	15	**14**	**15**
Vision Test	**64**	**38**	11	2	10	3	12	**11**	**15**
Hearing Test	**21**	**9**	3	0	6	0	0	**6**	**6**
Oral Exam	**89**	**59**	12	14	13	5	15	**15**	**15**
Total Percentage for Physical Examination	**74%**	**68%**	74%	56%	76%	46%	80%	**83%**	**90%**

* United submitted an incorrect sample resulting in a lower number of reviewed records.

A total of 99 adolescent records were reviewed. The table shows the number of records where the provider documented important elements covered on the adolescent visit. The combined result for all plans was scored at greater than 80 percent on the following four components of the physical examination: comprehensive exam, blood pressure, body mass index, and oral exam. Overall, the plans scored between 60 and 79 percent on the vision test; however, the total for all health plans on the hearing exam was less than 60 percent, which indicates room for improvement.

Overall, results are positive for four of the six indicators. However, one area of concern regards vision tests and hearing tests. The providers who were interviewed indicated that they believe hearing tests are routinely done in the schools, but there is no evidence in the medical record of this expectation. Results by plan appear to indicate that results for Community Health Plan of the Rockies and UnitedHealthCare of Colorado show the greatest opportunities for improvement.

Health Education and Anticipatory Guidance

	ALL PLANS	ALL HMOS	ROCKY MTN	CHPR	CO ACCESS	UNITED*	KAISER	PCPP	FFS
RECORDS REVIEWED	**99**	**69**	15	15	15	9	15	**15**	**15**
HEALTH EDUCATION									
NORMAL DEVELOPMENT	**56**	**28**	5	5	4	1	13	**13**	**15**
DIET & PHYSICAL ACTIVITY	**63**	**35**	7	6	5	3	14	**13**	**15**
HEALTHY LIFESTYLES	**56**	**28**	5	1	6	1	15	**13**	**15**
INJURY PREVENTION	**51**	**24**	5	0	3	1	15	**13**	**14**
TOTAL PERCENTAGE FOR HEALTH EDUCATION	**57%**	**42%**	37%	20%	30%	17%	95%	**87%**	**98%**

* United submitted an incorrect sample resulting in a lower number of reviewed records.

These results show that three of the four health education components are not being regularly documented as part of the adolescent well care visit. In this area there again appears to be a substantial difference between Kaiser Permanente, Fee-for-Service and PCPP, and the other managed care plans.

Screening Risky Behavior and Counseling

	ALL PLANS	ALL HMOS	ROCKY MTN	CHPR	CO ACCESS	UNITED*	KAISER	PCPP	FFS
RECORDS REVIEWED	**99**	**69**	15	15	15	9	15	**15**	**15**
RISK SCREENING AND COUNSELING									
EATING DISORDERS	**57**	**34**	7	6	4	2	15	**8**	**15**
SEXUAL ACTIVITY	**47**	**25**	3	2	5	3	12	**9**	**13**
ALCOHOL USE	**55**	**31**	7	3	4	5	12	**11**	**13**
DRUG USE	**53**	**30**	7	1	6	4	12	**10**	**13**
TOBACCO USE	**66**	**42**	7	4	8	8	15	**10**	**14**
ABUSE	**40**	**22**	4	1	1	1	15	**6**	**12**
SCHOOL PERFORMANCE	**51**	**31**	7	1	5	3	15	**5**	**15**
DEPRESSION OR SUICIDE	**43**	**28**	5	2	5	1	15	**3**	**12**
TOTAL PERCENTAGE FOR RISK SCREENING AND COUNSELING	**52%**	**44%**	39%	17%	32%	38%	93%	**52%**	**89%**

* United submitted an incorrect sample resulting in a lower number of reviewed records.

On average, only 52 percent of records show documentation of screening and counseling for risky behavior and only one of the eight risk screening and counseling indicators is documented more than 60 percent of the time. In addition, less than half the records document screening and counseling related to sexual activity (47 percent), depression or suicide (43 percent) and abuse (40 percent).

If lack of documentation in these areas is matched by a lack of attention to these issues this indicates an important issue for CDHCPF and QuIC to address. This finding is consistent with the research literature, which indicates that screening for risky behaviors is not routinely completed. However, it should be noted that Kaiser Permanente results and the Fee-for-Service results again appear to be better than others. Kaiser Permanente uses an electronic medical record so easier methods of documenting the visit may influence these results.

Children with Special Health Care Needs

Of the 23 adolescents with special health care needs, nine were female and 14 were male. These children were identified administratively, using SSI eligibility codes provided by CDHCPF. Of the managed care plans, Rocky Mountain Health Plans had six CSHCN, Colorado Access had five and Kaiser Permanente had three. No obvious differences in the care of these children have been identified from the medical record review.

Testing

TESTS	ALL PLANS	ALL HMOS	ROCKY MOUNTAIN	CHPR	CO ACCESS	UNITED*	KAISER	PCPP	FFS
TOTAL SAMPLE	**99**	**69**	15	15	15	9	15	**15**	**15**
TESTING									
CHOLESTEROL – AT RISK	**9**	**5**	1	3	0	1	0	**2**	**2**
CHOLESTEROL – NUMBER TESTED	**2**	**1**	1	0	0	0	0	**0**	**1**
TB – AT RISK	**5**	**3**	0	0	1	0	2	**0**	**2**
TB – NUMBER TESTED	**4**	**2**	0	0	1	0	1	**0**	**2**
STDS – SEXUALLY ACTIVE	**12**	**9**	2	1	3	2	1	**1**	**2**
STDS – NUMBER TESTED	**8**	**5**	0	1	2	1	1	**1**	**2**
HIV – SEXUALLY ACTIVE	**15**	**9**	2	1	3	2	1	**1**	**5**
HIV – NUMBER TESTED	**9**	**4**	0	1	1	1	1	**0**	**5**
PAP – FEMALE SEXUALLY ACTIVE	**7**	**6**	1	1	2	1	1	**1**	**0**
PAP – NUMBER TESTED	**5**	**4**	0	1	1	1	1	**1**	**0**
URINALYSIS AT RISK	**74**	**45**	15	9	8	6	7	**14**	**15**
URINALYSIS NUMBER TESTED	**37**	**15**	4	1	2	4	4	**11**	**11**
HEMATOCRIT – FEMALE OR AT RISK	**32**	**23**	5	5	4	2	7	**7**	**2**
HEMATOCRIT – NUMBER TESTED	**12**	**7**	0	2	2	2	1	**4**	**1**

* United submitted an incorrect sample resulting in a lower number of reviewed records.

The table above shows two types of information for each recommended test. The first line shows the total number of adolescents who were at risk. The second line shows the number of adolescents who were at risk and where documentation in the medical record shows they were correctly tested. Of the seven tests shown, two show the majority of adolescents at risk were not tested – cholesterol and hematocrit for females. Urinalysis has the same number being tested as not being tested; the others are mostly tested when required. Conclusions for individual plans cannot be made given the small numbers.

I. Colorado Access

Colorado Access provided materials that were developed by Denver Health, part of the Colorado Access network. However, these applied to only 25 percent of Colorado Access adolescent members and so were not included in scoring for Colorado Access. Denver Health materials are discussed separately in this report.

Self-Assessment

Colorado Access achieved the highest self-assessment score at 77.7 percent, including the top score in all four categories. Strengths were in adolescent participation (100 percent) and in adolescent appropriate quality services (84.7 percent). Adolescent health physical exam checkup forms used by the Colorado Access network providers include all elements of guidelines for care. There are, however, some opportunities for improvement in coordination of services and in access to care for adolescents. Colorado Access policies and procedures on confidential care are more limited than the benchmark materials developed by its provider, Denver Health. Educational materials from Colorado Access do not cover adolescents' right to confidential care and the meaning of informed consent.

Provider Interviews

Colorado Access providers were identified at the clinic level rather than the individual physician level. The adolescents selected had received care at the clinic in 2001, but the individual *physician* was not available from the plan's administrative data. Consequently, in one case the physician who was interviewed was not actually the physician who cared for the adolescents at the clinic in 2001, since he was new to the practice as of May 2002. As a result, this provider may have had less insight into the practices of the clinic.

Medical Record Review

While Colorado Access has promoted provider use of checkup forms for adolescents, the medical record review indicates that these are not consistently completed for key elements of adolescent care. For example, school performance is an element on the checkup form but was only completed in five out of the 15 records reviewed. Injury prevention was documented in only three out of 15 records. It is not known if issues are not being addressed, or are addressed but not documented.

Eighteen elements were evaluated across 15 medical records making a total possible score of 270. Colorado Access providers documented 124 of these elements, 46 percent of the total.

Recommendations

- Adopt Denver Health policies, procedures and practices related to adolescent care throughout the Colorado Access network.
- Increase provider awareness of the 13 to 21 year old Child Health Check-Up Tracking Form to ensure all elements of health education and risk screening and counseling are being completed and are documented.

II. Community Health Plan of the Rockies

Self-Assessment

Overall, Community Health Plan of the Rockies (CHPR) was the second highest scoring plan in the self-assessment, at 61.7 percent. This score was greatly improved by positive results for adolescent participation since CHPR encourages members to make suggestions for improvement and notifies members of the right to attend meetings of the Consumer Advisory Board. CHPR was the lowest scoring plan on access to care for adolescents. While scores were positive in one area (the plan specifically references in the provider directory the age groups that the provider targets), the materials provided no information on how to enroll. The member handbook is directed to members who have already enrolled and explains enrollment policies but not procedures on how to enroll. Materials submitted did not include policies and procedures to assure confidential care or educational materials on the meaning of informed consent.

Provider Interviews

CHPR providers were concerned about the need to assure confidentiality, and suggested adolescents have their own ID card separate from other family members.

Medical Record Review

Eighteen elements were evaluated across 15 medical records making a total possible score of 270. CHPR providers documented 82 of these elements, 30 percent of the total. This was the lowest documentation rate by providers for the plans/programs evaluated and indicates a priority for physician education.

Recommendations

- Review member materials' references to the "Family Doctor" and consider updating with terminology that supports individual choice of physician.
- Consider implementing separate welcome calls to adolescents to ensure they are aware that they may choose a separate physician from the rest of the family. This would also provide an opportunity to educate adolescents on confidential care.
- Communicate to providers the importance of addressing and documenting all aspects of adolescent care covered in the medical record review since these are based on national guidelines.

III. Kaiser Permanente

Self-Assessment

Kaiser Permanente did not participate in the self-assessment component of the study.

Provider Interviews

Kaiser Permanente providers recommended making it easier for adolescents to find providers by having a list of preferred providers for teenagers.

Medical Record Review

Eighteen elements were evaluated across 15 medical records making a total possible score of 270. Kaiser Permanente providers documented 240 of these elements, or 89 percent of the total. This score far exceeded the other managed care plans although it did not exceed the 91 percent rate for Fee-for-Service providers.

Recommendations

- Make it easier for adolescents to find providers who like to work with adolescents by creating a list of preferred providers for teenagers.

IV. Rocky Mountain Health Plans

Self-Assessment

Rocky Mountain Health Plans scored 55 percent on the overall self-assessment, indicating there are a number of opportunities to introduce policies, procedures and practices to meet the unique needs of adolescents. While general information for members is clearly available, this could be tailored to be more adolescent friendly. On-line provider directories included adolescent medicine specialists; however, these were not identified as such in the *2002 Medicaid Provider Directory* so it is unclear if these are available to Medicaid members. One of the four physicians was listed in the directory as a pediatrician, but with no indication of specialty. Rocky Mountain Health Plans has clear guidelines for identification and care of adolescents with special health care needs, which incorporate EPSDT requirements. Rocky Mountain Health Plans case management services coordinate with a wide range of agencies involved with adolescent care, including foster care and probation systems.

Provider Interviews

Overall, providers offered very positive comments about Rocky Mountain Health Plans. One recommended offering parents more education and information on lifestyle/parenting skills and suggested that the membership card identify the name of the PCP for the member, in addition to the name of the plan.

Medical Record Review

Eighteen elements were evaluated across 15 medical records making a total possible score of 270. Rocky Mountain providers documented 136 of these elements, 50 percent of the total.

Recommendations

- Ensure adolescents are informed of the option to choose their own provider.
- Complete provider training on guidelines for adolescent care.
- Communicate to providers the importance of addressing and documenting all aspects of adolescent care covered in the medical record review since these are based on national guidelines.

V. UnitedHealthCare of Colorado

Self-Assessment

UnitedHealthCare of Colorado scored 55 percent on the overall self-assessment, indicating some strengths but also a number of opportunities to introduce policies, procedures and practices that address the unique needs of adolescents. The plan has high quality communication materials, with topics relevant to Medicaid members and available in Spanish. Outreach to adolescents and their parents on teen-related issues using the *Healthy You* newsletter was exceptional. The communications presented in the newsletter spoke clearly and directly to teens, covered appropriate topics (eating disorders, use of condoms, chlamydia, checkups for teens) and used photos and graphics of adolescents. The plan scored second highest in providing adolescent appropriate quality services. EPSDT guidelines for teens were communicated to members via the *Healthy You* newsletter. The policy that was provided on confidentiality for minors noted that release of personal health information must be authorized by the custodial parent or legal guardian, except for substance abuse and mental health records. It did not discuss the adolescent's right to confidential care for family planning and reproductive services, sexually transmitted disease care or detail the circumstances in which adolescents may receive confidential care consistent with state law. While there were some mechanisms for referral to social services, substance abuse and mental health services, mechanisms to coordinate services with a wide range of agencies that can assist adolescents in need are not yet in place. There was no evidence of adolescents being asked to provide feedback or to participate in health plan initiatives.

Provider Interviews

One of the three providers interviewed recommended creating an incentive for adolescents to come in for preventive visits. This approach has shown positive results for other health plans.

Medical Record Review

For the study sample, UnitedHealthCare of Colorado incorrectly submitted the HEDIS® adolescent well care denominator (age-eligible adolescents) rather than the numerator (those adolescents who made a well care visit per administrative data). Consequently, 15 adolescent records originally selected for review were not available, either because they did not have an adolescent well care visit, or because the provider identified was the provider auto-assigned to them rather than the provider the adolescent had visited. As a result, nine medical records were reviewed for this plan compared to 15 for the other plans. Eighteen elements were evaluated across these nine medical records making a total possible score of 162. UnitedHealthCare of Colorado providers documented 58 of these elements, 36 percent of the total.

Recommendations

- Develop adolescent specific communications on rights to confidential care for family planning, reproductive services and sexually transmitted disease care.
- Set goals to increase care coordination and collaboration mechanisms with essential services for adolescents, including foster care, probation, and school-based clinics.
- Communicate to providers the importance of addressing and documenting all aspects of adolescent care covered in the medical record review since these are based on national guidelines.
- Extend the welcome letter and member information directly to the adolescents with their ID card.

VI. Primary Care Physician Program

Self-Assessment

The Primary Care Physician Program scored 49 percent on the self-assessment part of the study, less than the five HMOs but marginally higher than the Fee-for-Service program. The only difference between PCPP and Fee-for-Service identified from the submitted materials was in the Access to Care dimension, which related to policies that allow adolescents to give informed consent consistent with state law. For the PCPP program, these are identified in CDHCPF Staff Manual Volume 8 (8.730) Family Planning Services.

Provider Interviews

The providers who were interviewed for the Primary Care Physician Program averaged 26 years experience working with adolescents and had a much larger percentage of Medicaid adolescents (approximately 34 percent) when compared to providers of other plans/programs. They advocated increasing the accountability of parents to get adolescents in for preventive care. Providers recognized the value of Medicaid because members have the ability to receive all necessary health care services. One provider suggested promoting the idea of "health peers" in schools who adolescents could go to for information. These health peers could then direct teens to appropriate community services and supports. Providers also emphasized that adolescents are concerned about confidentiality and must be reassured this will be respected.

Medical Record Review

Eighteen elements were evaluated across 15 medical records making a total possible score of 270. PCPP providers documented 189 of these elements, 70 percent of the total. This was the highest score for the managed care plans but did not exceed the Fee-for-Service total of 91 percent.

Recommendations

- Review policies and procedures related to issuing Medicaid ID cards to the family to enable adolescents to receive their own cards.

VII. Recommendations for All Plans

- Share and discuss examples of Best Practices identified in this report to set expectations and inform future interventions.
- Include the HEDIS® Adolescent Well Care Visit indicator in the set of routinely monitored Medicaid measures in order to track improvements in access to care over time.
- Review all materials targeted to members and look for opportunities to make them more adolescent-friendly. For example, references to the "Family Doctor" in member materials could imply to adolescents that they cannot, or should not, have a different doctor from the rest of the family.
- Create opportunities for adolescent participation in development of policies, procedures and resources.
- Create materials to explain confidentiality consistent with state laws and distribute to adolescents and physicians.
- Involve the provider community in initiatives to develop adolescent-friendly interventions.
- Identify adolescent-oriented providers in provider directories.
- Issue separate Medicaid ID cards to adolescents to encourage individual physician selection.
- Encourage physicians to address components of a comprehensive well care exam when adolescents come in for a sports physical.
- Extend outreach calls to welcome new members to include adolescents as well as the head of household. This will provide opportunities to explain to adolescents their rights to confidential care and the opportunity to choose a different physician from the rest of the family.
- Introduce an incentive for adolescents to come in for preventive visits. One California health plan, CalOPTIMA, has had remarkable success with this approach, increasing HEDIS rates substantially. The health plan gives a gift certificate to the teen with documentation of a well care visit. It also issues a teen newsletter and has a provider recognition program for those providers who show outstanding performance with adolescent members[5].
- Collaborate with physicians to develop age-specific educational information that can be given to the adolescent or parent at the time of the adolescent well care visit.

9. References

[1] MacKay et al, 2000. MacKay AP, Fingerhut LA, Duran CR. *Health, United States, 2000: with Adolescent Health Chartbook*. Hyattsville, Maryland: National Center for Health Statistics.

[2] Shenkman E, Slap G, Irwin CE, Klein JD, Santelli J. (2000) *Adolescent Health Care and Health Services Research: Proceedings of the Second Annual Meeting of Child Health Services Researchers*. Report to Agency for Healthcare Research and Quality. Washington, DC: Health Systems Research.

[3] Irwin CE, Brindis C, Holt KA, Langlykke K, editors. (1994) *Health Care Reform: Opportunities for Improving Adolescent Health*. Arlington, VA: National Center for Education in Maternal and Child Health

[4] Ziv A, Boulet JR, Slap GB (1999) "Utilization of Physician Offices by Adolescents in the United States." *Pediatrics* Vol 104 No 1(July): 35-42

[5] Daly D.M., Nguyen, H.T., et al (2002) "Improving the rate of adolescent well care visits: Case study from a Medicaid managed care plan." Provider Operations, CalOPTIMA.

[6] American Medical Association. *Healthy Youth 2010, Supporting the 21 Critical Adolescent Objectives.* Available at: http://www.ama-assn.org/ama/pub/category/1943.html.

[7] Boulder County Civic Form, 2001. "Indicators – People: #10 Teen Birth Rate." From *Quality of Life in Boulder County: A Community Indicators Report*. Available at: http://www.bococivicforum.org/indicators/people/10.html

[8] Dahan B, 2001. *Sexually Transmitted Diseases in Colorado Surveillance Report: 1999*. Colorado Department of Public Health and Environment, Division of Disease Control and Environmental Epidemiology.

[9] Dahan B, 2001. *Sexually Transmitted Diseases in Colorado Preliminary Surveillance Report for 2000*. Department of Public Health and Environment, Division of Disease Control and Environmental Epidemiology.

[10] CDPHE, 3/9/00. Colorado Department of Public Health and Environment. *Comparison of Colorado Progress and Goals with National Goals: State Performance Measure 6: Teen Tobacco Use*.

[11] CDPHE, 3/9/00. Colorado Department of Public Health and Environment. *Comparison of Colorado Progress and Goals with National Goals: State Performance Measure 1: Teen Alcohol Use*.

[12] NCQA, 2000. *National Medicaid Results for Selected 2000 HEDIS and HEDIS/CAHPS Measures: Measure Adolescent Well-Care Visit*.

[13] Health Services Advisory Group, Inc. (2002) "Adolescent Well Care Literature Review" Report to Colorado Department of Health Care Policy and Financing.

[14] Shenkman et al, 2000. Shenkman E, Slap G, Irwin CE, Klein JD, Santelli J. *Adolescent Health Care and Health Services Research: Proceedings of the Second Annual Meeting of Child Health Services Researchers*. Report to Agency for Healthcare Research and Quality. Washington, DC: Health Systems Research.

[15] Ford et al, 1997. Ford CA, Millstein SG, Halpern-Felsher BL, Irwin CE, Jr. "Influence of Physician Confidentiality Assurances on Adolescents' Willingness to Disclose Information and Seek Future Health Care." *JAMA* 278(12): 1029-1034.

[16] Igra et al, 1993. Igra V, Millstein SG. "Current Status and Approaches to Improving Preventive Services for Adolescents." *JAMA* 269(11): 1408-1412.

[17] Ginsburg et al, 1995. Ginsburg KR, Slap GB, Cnaan A, Forke CM, Balsley CM, Rouselle DM. "Adolescents' Perception of Factors Affecting Their Decisions to Seek Health Care." *JAMA* 273(24): 1913-1918.

[18] Lafferty et al, 2001. Lafferty WE, Downey L, Shields AW, Holan CM, Lind A. "Adolescent Enrollees in Medicaid Managed Care: The Provision of Well Care and Sexual Health Assessment." *Journal of Adolescent Health* 28(6): 497-508.

[19] Felice et al, 1999. Felice ME, Feinstein RA, Fisher M, Kaplan DW, Olmedo LF, Rome ES, Staggers BC. "American Academy of Pediatrics Committee on Adolescence: Contraception in Adolescents." *Pediatrics* 104(5 Pt 1): 1161-1166.

[20] Selden et al, 1998. Selden TM, Banthin JS, Cohen JW. "Medicaid's Problem Children: Eligible But Not Enrolled." *Health Affairs* 17(May-Jun): 192-200.

[21] Clark S, 2001. *Adolescent Health, Practice Update*. National Association of Social Workers. Vol 2(3).

[22] Clayton et al, 2000. Clayton S, Brindis C, Hamor J, Raiden-Wright H, Fong C. *Investing in Adolescent Health: A Social Imperative for California's Future.* University of California at San Francisco: National Adolescent Health Information Center.

[23] US Public Health Service, 1998. U.S. Public Health Service. *Surgeon General's Report on Tobacco Use Among U.S. Ethnic/Racial Groups*. Washington, DC: Office of the U.S. Surgeon General.

[24] Centers for Disease Control and Prevention (2000) *HIV/AIDS Surveillance in Adolescents*. Atlanta, GA: National Center for HIV, STD and TB Prevention.

[25] Centers for Disease Control and Prevention (2000) *Strategies for Participation in Physical Activity and Sports in Young People*. Atlanta, GA: National Center for Chronic Disease Prevention and Health Promotion.

Acronyms	
AAP	American Academy of Pediatrics
ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
AFDC	Aid to Families with Dependent Children
AMA	American Medical Association
AWC	Adolescent Well Care
CDHCPF	Colorado Department of Health Care Policy and Financing
CHIP	Colorado Children's Health Insurance Program
CHPR	Community Health Plan of the Rockies
CSHCN	Children with Special Health Care Needs
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
EQRO	External Quality Review Organization
FFS	Fee-for-Service
FPL	Federal Poverty Level
GAPS	Guidelines for Adolescent Preventive Services
HEDIS®	Health Plan Employer Data and Information Set
HMO	Health Maintenance Organization
HSAG	Health Services Advisory Group, Inc.
NAHIC	National Adolescent Health Information Center
MH/SA	Mental Health/Substance Abuse
MRR	Medical Record Review
PCPP	Primary Care Physician Program
PPIP	Putting Prevention Into Practice
QuIC	Quality Improvement Committee
SAM	Society for Adolescent Medicine
SBHC	School Based Health Center
SSI	Supplemental Security Income
TANF	Temporary Assistance to Needy Families

Health Plan Self-Assessment Tool

SOURCE	QuIC ASSESSMENT CRITERIA	VALIDATION CHECKLIST	DESK REVIEW DOCUMENTATION REF:
	Access for Adolescents – 25 percent		
Standard A: **Access for Adolescents** NAHIC A.1.a	Confidential care 1. There are policies and procedures to assure confidential care, including confidentiality policies regarding family planning and reproductive health services, sexually transmitted disease care, substance abuse treatment, and/or mental health treatment, consistent with state and federal law.	☐ Family planning and reproductive services ☐ Sexually transmitted disease care ☐ Mental Health/Substance abuse treatment ☐ Consistent with state and federal law	
NAHIC A.1.b	Informed consent 2. There are policies that allow for adolescents to give informed consent consistent with state law.	☐ Informed consent by adolescents	

SOURCE	QuIC ASSESSMENT CRITERIA	VALIDATION CHECKLIST	DESK REVIEW DOCUMENTATION REF:
NAHIC A.1.c NAHIC B.2.a	Enable access to adolescent-oriented providers 3. Adolescent providers and services are clearly identified for adolescents and their families: Adolescent primary health care providers are those who are Board certified or Board eligible and/or who have training and skills in care coordination and in providing primary care in reproductive health, mental health and substance abuse, growth, and development. If behavioral health services are carved out, adolescents are provided with clear information on how to access these providers and services, if necessary.	☐ Process for adolescents to identify providers with adolescent training and/or skills ☐ Care coordination ☐ Reproductive Health ☐ Mental Health ☐ Substance Abuse	
NAHIC A.2.b	Adolescent choice of provider 4. There are mechanisms to assure adolescent choice of provider different and independent from other family members and to inform adolescents and family members of this option.	☐ Adolescent choice independent of family ☐ Adolescents informed of this option	
Standard A: Access for Adolescents NAHIC A.3.a	Assist adolescents to reduce barriers to access: 5. Adolescents are educated regarding their rights to confidential health care and the meaning of informed consent.	☐ Education materials on adolescents' right to confidential care ☐ Education materials on the meaning of informed consent	
NAHIC A.3.c	6. Information is available for adolescents and their families on how to access their plan's services (e.g. enrollment procedures and requirements, disenrollment, information lines).	☐ Enrollment procedures ☐ Special requirements ☐ Disenrollment ☐ Information lines	

SOURCE	QuIC ASSESSMENT CRITERIA	VALIDATION CHECKLIST	DESK REVIEW DOCUMENTATION REF:
	Adolescent Appropriate Quality Services		
Standard B: Adolescent Appropriate Quality Services NAHIC B.1.a	Guidelines for Care 7. Adolescent care guidelines have been implemented* and communicated to providers and members and include regular annual comprehensive preventive health care visits with modifications for setting/location and special populations. Eg. Bright Futures (MCHB), GAPS (AMA), Put Prevention into Practice (USPHS/DHHS), EPSDT, local standards * ***Implementation*** *of Guidelines refers to active dissemination with strategies to overcome barrier. JAMA 1999 282(15)1459*	☐ Guideline selected ☐ Distributed to all appropriate providers ☐ Available to members ☐ Provider training completed ☐ Benchmarks established ☐ Evaluation of impact on cost, quality, outcomes	
Standard B: Adolescent Appropriate Quality Services NAHIC B.1.b	8. If the managed care organization has developed its own guidelines, it includes protocols for:	☐ Dental ☐ General health problems ☐ Health guidance ☐ Immunizations ☐ Laboratory assessments ☐ Physical exams ☐ Referrals ☐ Reproductive health ☐ Risk-screening ☐ Substance abuse screening ☐ Mental health	

SOURCE	QuIC ASSESSMENT CRITERIA	VALIDATION CHECKLIST	DESK REVIEW DOCUMENTATION REF:
NAHIC B.1.d	9. Culturally sensitive health education and guidance materials are available for adolescents, parents and other family members.	Materials address: ☐ Physical barriers ☐ Cultural barriers ☐ Linguistic barriers ☐ Personnel skilled in health education are available	
NAHIC B.1.g	10. Rehabilitation services are available, including outpatient and residential drug treatment If behavioral health services are carved out, adolescents are provided with clear information on how to access these services, if necessary.	☐ Outpatient Rehab ☐ Residential drug treatment	
Standard B: Adolescent Appropriate Quality Services NAHIC B.3	11. There is a quality improvement process to monitor and improve adolescent access, quality of care, coordination, and collaboration.	☐ Evidence of a quality improvement process which addresses adolescent issues	

SOURCE	QuIC ASSESSMENT CRITERIA	VALIDATION CHECKLIST	DESK REVIEW DOCUMENTATION REF:
	Coordination of Services – 25 percent		
Standard C: **Coordination of Services** NAHIC C.1	12. Collaboration mechanisms exist for information about and referral to providers, organizations, and systems dealing with:	☐ Developmental disabilities ☐ Education/special education ☐ Foster care ☐ Probation ☐ Reproductive health care ☐ School-based/linked health centers ☐ Social services ☐ TANF (AFDC) ☐ Other issues (e.g. pregnancy, HIV/AIDS, violence) ☐ Substance abuse ☐ Mental health	
NAHIC C.2	13. Outreach services are used to inform adolescents, parents, and adolescent-serving agencies about health plan services to encourage entry to services, appropriate referrals, ready communication, continuity, and commitment to care. *EPSDT	☐ Adolescent outreach ☐ Parental outreach ☐ Agency outreach	
Standard C: Coordination of Services NAHIC C.3	14. There are specific criteria and processes in place to identify adolescents who are high risk . Appropriate case management services are available for all high-risk adolescents.	☐ Criteria to designate high risk adolescents ☐ Processes used to identify and case manage high risk adolescents ☐ Range of appropriate case management services are available	

SOURCE	QuIC ASSESSMENT CRITERIA	VALIDATION CHECKLIST	DESK REVIEW DOCUMENTATION REF:
NAHIC C.4	15. Contractual agreements have been made with established essential community providers (such as school-based health centers, local health agencies, family planning clinics, substance abuse treatment programs) for services such as adolescent-specific outreach, health education, case management.	Network includes: ☐ SBHC ☐ Local health agencies If contracted, services include: ☐ Family planning clinics ☐ Substance abuse treatment programs	
NAHIC C.5	16. Other adolescent-specific policies and procedures are available to enhance coordination: There are mechanisms to facilitate adolescent access to mental health and substance abuse services and this has been communicated to the adolescents.	☐ Other adolescent specific policies and procedures to enhance coordination	
	Adolescent Participation in the System		
Standard F: Adolescent Participation in the System for Care NAHIC F.2	17. There are mechanisms in place to obtain feedback from adolescents.	☐ Examples are available showing that adolescents have been asked for feedback	
Standard F: Adolescent Participation in the System for Care NAHIC F.4	18. Other adolescent-specific means for enhancing participation are available.	☐ There is evidence of interventions designed to encourage adolescent participation	

Physician Letters

May 2, 2002

«First_Name» «Middle_NameInitial» «Last_Name», «Professional_Credentials»
Attention: «Office_Manager»
«Practice_Name»
«Street_Address», «Suite»
«City», «State», «Zipcode»

Dear Dr. «Last_Name»:

Colorado Medicaid and the five HMOs who serve Colorado's Medicaid clients are conducting a **qualitative study of adolescent health care** to gather information on the current environment for adolescent care in Colorado. You have been identified as a provider who serves a high number of adolescent members of [*Health Plan or Program Name]*, and we are contacting you to request your assistance in gathering information about how your office interacts with and serves these adolescents.

Health Services Advisory Group, the External Quality Review Organization (EQRO) for the Colorado Medicaid program, will be implementing the study. There are two components of the physician site visit. The first is a **20-minute interview with you, or a designated physician extender** at your office, and a **review of five medical records** of adolescents who made a well care visit in your practice in 2001. We will call your office in the next few days to schedule a time for our reviewer to meet with you.

Study tools have been developed with input from adolescent health specialists and pediatricians and focus on important elements of adolescent care. The interview will cover a brief discussion of clinical practice guidelines, and your views on how to make services to adolescents accessible, confidential and sensitive to the needs of a diverse population. The medical record review covers age-appropriate preventive health care services: physical exam, health education and anticipatory guidance, screening risky behavior and counseling and tests. All information gathered for the study will be kept confidential.

We look forward to the opportunity to work with you on this study of adolescent health care, your perspective as a physician is critical to our understanding of current practices. Should you have any questions about the study, please feel free to contact our reviewer, Janet Lucchesi RN, EQRO Project Manager, at 303-755-1912 ext. 103. Thank you.
Sincerely,

Emad Alkhoudairy
EQRO Contract Manager

Health Services Advisory Group, Inc.
Confidentiality Statement
Colorado Medicaid Adolescent Well Care Study

During our visit we will complete an on site medical record review of five medical records of adolescents who made a well care visit in your practice in 2001. When we confirm the visit date, we will identify the adolescents who have been randomly selected for review and send them to you in advance. We would appreciate your cooperation in making these records available on the day of the visit.

All abstracted and copied medical record information will be kept confidential and will be used only for purposes of the contract with CDHCPF. The Medicaid client's application for Medicaid coverage and your agreement with the Medicaid program provide for the release of medical record information to CDHCPF or its designee (Staff Manual Volume 8 – Medical Assistance, 8.100.82); **thus, a separate authorization for release of information is not necessary for this review request.** HSAG is authorized as the designated representative of CDHCPF, and providers are required to allow review of medical records by HSAG upon request (Staff Manual Volume 8 – Medical Assistance, 8.079.86). If you have questions, please call Janet Lucchesi RN, MHS (303) 755-1912 ext. 103.

Date

Contact Name
Business Name
Street Address, Suite Number
City, State, Zipcode

Dear [Contact]:

This letter is to **confirm my appointment with you at your office on [insert date and time**]. The purpose of my visit is to complete the interview and medical record review for the qualitative study of adolescent health care by Colorado Medicaid and the HMOs who provide care to Medicaid adolescents.

The interview will not take more than 20 minutes and will be followed by a review of the medical records of five adolescents who made a well care visit to your practice in 2001.

A list of adolescents who have been identified for medical record review is enclosed. Your cooperation in making these records available on the day of the visit is appreciated.

All information gathered for the study will be kept confidential.

I have also enclosed a copy of the original letter from Colorado Medicaid introducing the study and requesting your assistance. Should you have any questions about the study prior to the visit, please feel free to call me at (303) 755-1912 ext. 103.

Sincerely,

Janet L. Lucchesi, RN, MHS
Manager Colorado EQRO
Health Services Advisory Group, Inc.

Enclosures

Health Services Advisory Group Inc.
Medical Record Identification
Colorado Medicaid Adolescent Well Care Study

The following eight Medicaid clients have been identified as patients in your practice and their medical records have been randomly selected for review. We would appreciate your cooperation in making these records available on the day of our visit, DAY AND DATE INSERTED Five of these eight charts will be reviewed during the visit.

1. Name
   Medicaid ID
   DOB

2. Name
   Medicaid ID
   DOB

3. Name
   Medicaid ID
   DOB

4. Name
   Medicaid ID
   DOB

5. Name
   Medicaid ID
   DOB

6. Name
   Medicaid ID
   DOB

7. Name
   Medicaid ID
   DOB

8. Name
   Medicaid ID
   DOB

All abstracted and copied medical record information will be kept confidential by the EQRO and will be used only for purposes of the contract with Colorado Medicaid. The Medicaid client's application for Medicaid coverage and your agreement with the Medicaid program provides for the release of medical record information to Colorado Medicaid or its designee (Staff Manual Volume 8 – Medical Assistance, 8.100.82); **thus, a separate authorization for release of information is not necessary for this review request.** HSAG is authorized as the designated representative of Colorado Medicaid, and providers are required to allow review of medical records by HSAG upon request (Staff Manual Volume 8 – Medical Assistance, 8.079.86). If you have questions, please call Janet Lucchesi RN, MHS (303) 755-1912 ext. 103.

Medical Record Review Tool and Instructions

Client name:	*Provider name:*
Client ID:	*Provider ID:*
Client DOB:	*Provider Type:*
Gender:	*Plan name:*
Age in 2001:	*Abstractor:*
2001 visit on:	*Review date:*

Guideline	Present	Absent
Physical Examination		
1. Comprehensive Exam (once at 12-14 years, once at 15-17 years, once at 18-21 years)	☐	☐
2. Blood Pressure	☐	☐
3. Body Mass Index	☐	☐
4. Vision: objective test at 12, 15, 18 and subjective at other ages	☐	☐
5. Hearing: objective test at 12, 15, 18 and subjective at other ages	☐	☐
6. Oral exam	☐	☐
Health Education and Anticipatory Guidance		
7. Normal Development	☐	☐
8. Diet and Physical Activity	☐	☐
9. Healthy Lifestyles	☐	☐
10. Injury Prevention	☐	☐
Screening Risky Behavior and Counseling		
11. Eating Disorders	☐	☐
12. Sexual Activity	☐	☐
13. Alcohol use	☐	☐
14. Drug use	☐	☐
15. Tobacco use	☐	☐
16. Abuse	☐	☐
17. School Performance	☐	☐
18. Depression/Suicide	☐	☐

Tests	At risk	Tested	No
19. Cholesterol (if positive family hx of CD or hyperlipidemia)	☐	☐	☐
20. TB (if high risk living conditions, incarcerated or exposed)	☐	☐	☐
21. STDs GC, Chlamydia, Syphilis & HPV (if sexually active)	☐	☐	☐
22. HIV (if notes indicate high risk)	☐	☐	☐
23. Pap Smear (if sexually active or over 18 years old)	☐	☐	☐
24. Urinalysis (routine for EPSDT)	☐	☐	☐
25. Hematocrit or Hemoglobin (if menstruating female,	☐	☐	☐
Children With Special Health Care Needs		**Yes**	**No**
26. Documented Title XIX child with special health care needs		☐	☐

Comments:

Identification Information

The information in the following boxes will be pre-filled with the client and provider information that was received from the health plans and state. At the time of the medical record review the information should be compared to the office chart for accuracy and corrections noted.

If the medical record is not available for review enter "Not Available" under client name.

a) Verify the client name matches the medical record

b) Verify the client ID by using the client's Medicaid ID

c) Verify the client date of birth

d) Verify the client gender

e) Verify the client's age as at December 31, 2001

f) Enter the date of well care visit

g) Verify the Provider name

h) Verify the Provider ID by using the provider's Medicaid Number

i) Select the Provider Type using the drop down menu:

OB/GYN,
Family Practice,
Pediatrician,
Internal Medicine,
Physician Extender,
Adolescent Medicine, or
General Practitioner.

j) Select the health plan name using the drop down menu:

Colorado Access
Community Health Plan of the Rockies;
Fee-for-Service (FFS)
Kaiser Permanente;
Primary Care Physician Program (PCPP)
Rocky Mountain HMO;
United Health Care of Colorado

k) Complete your name as the abstractor.

l) Enter the date the review was completed.

For the medical record review, any adolescent visit during 2001 calendar year counts.

Physical Examination

Check box as present only if documented in the medical record, else check as absent.

1. **Comprehensive Exam (once at 12–14 years, once 15–17 years, once 18-21 years).**
   A complete head to toe assessment or general multi-system exam that includes assessment of: ***skin, head, eyes, ears, nose, throat, teeth, nodes, heart, lungs, abdomen, external genitalia, extremities, spine/neuro.*** It is often difficult to draw the line between a complete and incomplete exam. The guideline to use when trying to determine a complete physical exam is whether or not at least 75 percent of head to toe assessment is documented. If so, check box as 'present'. If not, check 'absent'. If there is no evidence of a comprehensive exam in the 2001 year, look for physician notation of "no change" or other indication of the exam being current.

2. **Blood Pressure**
   Record as 'present' if a current or prior blood pressure reading is documented.

3. **Body Mass Index**
   Check the record to determine if the adolescent is overweight or at risk to become overweight. If the provider states body mass index BMI, weight WNL (within normal limits), or records the adolescent is over or under weight, this is acceptable. A record of both height and weight are acceptable, but not either alone.

4. **Vision**
   Subjective vision screening is a verbal or written verification from the member, parent, guardian or provider regarding the adolescent's vision. At age 13, 14, 16, 17, 19, 20, 21 this is appropriate. **Objective** vision screening is done using one of the following tests and should be completed at age 12, 15, & 18: Snellen, Unilateral cover test, Tumbling E test, HOTV – wall chart consists of only H's, O's, T's, and V's., Allen Card Test (using flash cards containing commonly used figures.) **or** Documentation of the word "eye exam" Credit would also be given it the provider attempted to complete the screening but the adolescent was uncooperative or unable to complete it.

5. **Hearing**
   Subjective – a verbal or written verification from the adolescent, parent, or provider regarding the adolescent's hearing. This is acceptable for ages 13, 14, 16, 17, 19, 20, 21. ***As soon as the provider documents a method used by which she or he assessed the patients hearing it becomes an objective hearing screen.*** **Objective**: If the provider documents 'turns head to sound' or 'hearing appears to be normal' would be acceptable. Documentation of Audiometric Testing, Impedance Testing. If the member is unable to complete these tests, the whisper or bell ringing tests is acceptable. Objective testing should be done at 12, 15, & 18. Credit would also be given it the provider attempted to complete the screening but the member was uncooperative or unable to complete it.

6. **Oral Exam**
   The physician documents that the oral cavity was checked or the status of the adolescent's teeth. If the provider documents inspection of mouth, teeth and gums it would qualify as a dental screen. If the provider mentions HEENT, it would verify that she or he has inspected the mouth.

Health Education and Anticipatory Guidance

See list of age appropriate anticipatory guidelines at the end of this document. It will be acceptable if the provider has documented "anticipatory guidance" or "ant. Guide" to cover 7 – 10 as being present.

7. **Normal Development**
   There is evidence that the adolescent received guidance on what to expect as normal physical, psychosocial, psychosexual development for his or her age.

8. **Diet and Physical Activity**
   There is evidence in the record that the adolescent received guidance on the importance of a healthy diet and physical activity.

9. **Healthy Lifestyles**
   There is evidence in the record that the adolescent was educated on the benefits of cleaning teeth, no smoking, responsible sexual behavior etc.

10. **Injury Prevention**
    There is evidence in the record that the adolescent was given information on age specific injury prevention, such as, the use of helmets, seat belts, driving, or weapons.

Screening Risky Behavior and Counseling

It will be acceptable if the provider has documented "negative risks ID" or has "positive for ETOH, pot, etc" to cover 11 – 18. Adolescent questionnaires can also be used as evidence of screening for risky behaviors.

11. **Eating Disorders**
    Documentation of evaluation on behaviors to determine if any problems with eating disorders and obesity.

12. **Sexual Activity**
    Counseling provided on responsible sexual behaviors, including abstinence, how to prevent STD's, HIV, and birth control methods. Acceptable if documentation states positive or negative sexual activity and use of birth control.

13. **Alcohol use**
    Provider has documented positive or negative ETOH use or exposure to other adolescents who consume alcohol.

14. **Drug use**
    Provider has documented positive or negative drug use or exposure to other adolescents who use drugs. Documentation assessing the adolescent's use of alcohol/drug(s), prior use of, cessation of, decreased use of, etc. is acceptable. ***If the provider documents discussion/education of alcohol/drug abuse, it would qualify for anticipatory guidance (healthy lifestyles).***

15. **Tobacco use**
    Documentation assessing the adolescent's use of tobacco (including chewing tobacco), second hand exposure, prior use of, cessation of, decreased use of, etc. is acceptable. ***If the provider documents discussion/education of tobacco habit/use/exposure it would qualify for anticipatory guidance(healthy lifestyles).***

16. **Abuse**
    Provider documents positive findings or concerns regarding physical, emotional, and psychosocial abuse and takes appropriate action.

17. **School Performance**
    Documentation to support how the adolescent is doing in school. Acceptable would be "no problems in school" or a statement by the adolescent that "like or dislike school".

18. **Depression/Suicide**
    Documentation of depression risk assessment, counseling and discussion of signs or symptoms of depression or risk of suicide.

Tests

Where children were not tested for the following conditions, the reviewer should check for indications of risk criteria. If there is no documented risk criteria, 'at risk' will be blank.

19. **Cholesterol**
    At Risk: Provider documents a positive family history of CAD or hyperlipidemia.
    Tested: A cholesterol or lipid profile or SMA 22 is ordered or drawn.

20. **TB for high risk, exposure**
    At Risk: Provider documents at risk due to high risk because of living conditions, incarcerated, or exposed to high TB area.
    Tested: Notes show Mantoux tuberculin skin test was administered.

21. **STD's (GC, Chlamydia, Syphilis & HPV)**
    At Risk: If sexually active, then screen for STD's.
    Tested: Notes show positive or negative for screening of STD's with the appropriate test ordered.

22. **HIV**
    At Risk: Notes indicate if high risk for HIV.
    Tested: Documentation of recommended screening, or a consent to screen.

23. **Pap Smear**
    At Risk: Recommended if sexually active or over 18 years old
    Tested: Provider documents that the Pap smear was completed or scheduled, or if a well women exam completed is acceptable or documentation of the status.

24. **Urinalysis**
    At Risk: Routine for EPSDT.
    Tested: Documented u/a completed with results of leukocytes. The chart may indicate "neg. U/A" and this is acceptable since the test should be completed once during adolescence between 12-21 years of age.

25. **Hematocrit or Hemoglobin**
    At Risk: All menstruating adolescent women, required annually.
    Tested: Documentation that an Hct or Hgb was ordered either separately or included in CBC or a result of a finger stick is acceptable.

Children with Special Health Care Needs

26. **Children With Special Health Care Needs**

The first page of the medical record will document primary diagnoses. If any are categorized as Title XIX children with special health care needs (see table below) check 'yes', or if there is evidence of enrollment in Colorado's Health Care Program for Children with Special Needs (HCP) check 'yes'.

ICD-9 Codes	Conditions
042	HIV/AIDS
142, 147, 155, 158, 170-171, 189, 190-192, 196, 197, 200-208	Malignant neoplasms
237	Benign neoplasms
250, 277	Genetic endocrine disorders (diabetes & cystic fibrosis)
282	Hereditary hemolytic anemia (inc. sickle cell)
292-296, 299	Organic mental illness and psychoses
300-302, 306-310, 312-316	Neurotic and non-psychotic mental disorders (includes ADD, ADHD, and developmental delay)
317-319	Mental retardation
330-331, 343-344	Cerebral degeneration and other paralytic syndromes
345	Epilepsy
359	Muscular dystrophy
369, 389	Blindness and hearing loss
394-396	Disorders of the mitral and aortic valves
493-494	Asthma and bronchiectasis
580-581, 584-589	Structural and functional disorders of the kidney
714	Rheumatoid arthritis
741	Spina bifida
744-747, 749-751, 754, 758	Congenital anomalies
765-766, 770-771	Perinatal conditions
800-803, 806, 940-949	Head, thorax, and spine fractures and burns
995.5	Child Abuse

Anticipatory Guidelines by Age

12 – 13 Years

Traffic safety
Water safety
Sports safety
Firearm safety
Good health habits and self-care
Sex Education
Academic activities
Social interactions
Good parenting practices
Dental care

14 – 15 Years

Traffic safety
Water safety
Sports safety
Firearm safety
Good health habits and self-care
Counseling regarding sexual activity
Pregnancy prevention
Social interactions
Educational activities
Good parenting practices
Dental care
Nutrition

16 – 17 Years

Traffic safety
Water safety
Sports safety
Firearm safety
Good health habits and self-care
Counseling regarding sexual activity
Pregnancy prevention
Social interactions
Educational activities
Good parenting practices
Dental care
Smoking, alcohol, drugs

18 - 19 Years

Traffic safety
Water safety
Sports safety
Firearm safety
Good health habits and self-care
Counseling regarding sexual activity
Pregnancy prevention
Social interactions
Educational activities
Plans for the future
Dental care
Smoking, alcohol, drugs

20 - 21 Years

Traffic safety
Water safety
Sports safety
Firearm safety
Good health habits and self-care
Counseling regarding sexual activity
Pregnancy prevention
Social interactions
Educational activities
Plans for the future
Dental care
Smoking, alcohol, drugs
Physical activity

Provider Interview Guide

20 MINUTE DISCUSSION OUTLINE	DOCUMENT
Demographics • Percentage of patient population between 12 and 21 years old • Percentage of Adolescent Medicaid patients • Length of time serving adolescent patients	 _____ percent _____ percent _____ years
Quality • Use of clinical guidelines for adolescent preventive services	☐ GAPS ☐ Bright Futures ☐ CO EPSDT ☐ PPIP ☐ Health plan guideline ☐ Colorado standardized guideline ☐ None
Visibility/Accessibility • Effective approaches the practice has used to make services more convenient for adolescents	☐ Use of open-access, walk-in clinics ☐ Group visits for adolescents ☐ Weekend, after school and/or evening hours ☐ Adolescent hotline ☐ Other:
Confidentiality • Processes to assure the adolescent of the confidentiality of services	☐ Confidential billing processes for adolescent visits ☐ Resources and materials used to communicate with adolescents re right to confidentiality ☐ Consent forms ☐ Other:

20 MINUTE DISCUSSION OUTLINE	DOCUMENT
Coordination • Processes to coordinate with behavioral health and community organizations, such as health agencies, educational system and the justice system.	☐ Referral criteria and coordination with behavioral health services ☐ Referral criteria and coordination with substance abuse services ☐ Processes to coordinate with community organizations ☐ Designated coordinator on staff ☐ Other:
Flexibility • Meeting the needs of a diverse group of adolescents including children with special health care needs	☐ Multilingual services available, including patient education resources in appropriate languages ☐ Support for children with special health care needs ☐ Support or resources for adolescents who are parents and/or are pregnant ☐ Other:
Wrap Up What one recommendation would you make to improve the care of Medicaid Adolescents in Colorado?	

Data Specifications

Overview	The Colorado Medicaid adolescent well care study will include a provider assessment component. Providers with a high volume of adolescent patients will be interviewed (three from each Medicaid HMO, PCPP and unassigned FFS) and, for each provider, five medical record reviews completed for adolescent patients who made a visit in 2001. Small over-samples of providers and adolescents will be made to ensure 3 providers and 15 adolescents are included for each HMO and Program, taking into consideration overlap of networks and availability of providers and medical records. This document provides outline data specifications and steps to identify providers and adolescents for each HMO, PCPP and unassigned FFS.
Summary Process HMO, PCPP, FFS	1. Identify adolescents with an AWC visit per HEDIS 2002 admin spec 2. For all adolescents in step 1, identify provider/s and date/s of service 3. For all providers in step 2, sort by number of adolescents with visit 4. Submit to HSAG data on top 20 providers and counts of adolescents 5. HSAG selects 5 providers per program for CDHCPF & QuIC approval 6. Each HMO, PCPP & FFS will randomly select 8 adolescents for each of these providers and send information re 40 patient records to HSAG.
Provider Selection	HSAG will select five providers per network, using the information provided and taking into consideration overlap of networks. CDHCPF and QuIC will review and approve the selection. Only three providers with the highest volume will be visited. The remaining physicians will be an over-sample to account for vacation, difficulties scheduling etc.
Adolescent Selection HMO, PCPP, FFS	For each of the five providers identified above, HMOs, PCPP and FFS will assign a random number to their adolescent patients in the HEDIS numerator, and randomly select 8 adolescents for medical record review. If there is more than one AWC visit for an adolescent, the latest visit date meeting HEDIS AWC criteria will be selected for review. CDHCPF and HMOs provide requested data elements to HSAG.
Data Submission 1	One record per provider, twenty provider records in one file by March 28
Data Submission 2	One record per adolescent, forty member records in one file* by April 26 (*Both files may be submitted by March 28 if this is more convenient – in this case a random sample of 8 adolescents for <u>each</u> of the 20 providers is requested , 160 in total). Electronic file format, <u>together with printout</u> of records: dbase IV, Excel, Word table formats, or comma delimited file.
Send to	Anna Scott, MBA PAHM, Project Manager, Health Services Advisory Group, Inc. 301 East Bethany Home Road, Suite B-157, Phoenix, Arizona 85012

Adolescent Criteria	Member Level Data (Medicaid HEDIS 2002 Admin Specification)
Product Line	Medicaid
Age(s)	Adolescents 12 – 21 years as of December 31, 2001
Continuous Enrollment	Continuously enrolled in 2001
Allowable Gap	No more than one gap in enrollment of up to 45 days during 2001. If enrollment is verified monthly, the member may not have more than one month gap in coverage (i.e. member whose coverage lapses for 2 months (60 days) is not considered continuously enrolled.)
Target adolescents	Adolescents who meet the eligible population criteria (above) and for whom **administrative data** shows at least one comprehensive well-care visit with a primary care practitioner or an **OB/GYN** practitioner during 2001. The PCP does **not** have to be the practitioner assigned to the member. An adolescent is considered to have received a comprehensive well-care visit if s/he had a claim/encounter with a primary care practitioner or OB/GYN practitioner with one of the codes listed below (Table U4-A from HEDIS).
CPT codes	99383 - 99385, 99393 – 99395
ICD-9-CM codes	V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9
Notes	Internal or state-specific codes, or other transaction data not cited above that denote an EPSDT well-child visit are acceptable. Preventive services may be rendered on the occasion of visits other than well-care visits. If the specified codes are present, these services count, regardless of the primary intent of the visit. Visits to school-based clinics with practitioner types that would be considered as primary care practitioners may be counted if documentation that a well-care exam occurred is available in the administrative system before December 31, 2001 (entries made retroactive to the measurement year are not counted). The primary care practitioner does not have to be the practitioner assigned to the member.
Provider Criteria	All practitioners who completed a comprehensive well-care exam during calendar year 2001 for any Medicaid-eligible adolescent identified above. High volume practitioners will be targeted. The HMO provider population should be sorted according to the number of adolescent patients who received at least one comprehensive well-care visit in 2001 using the above HEDIS criteria.

Provider Record	Twenty provider records requested for sample frame (high volume)		
Field one	plan_name	Health Plan/Program Name	
Field two	prov_id	Unique Provider ID	
Field three	awc_count	Count* of patients in 2002 HEDIS AWC Total	
Field four	early_count	Count of patients in 2002 HEDIS 12-14 yrs	
Field five	mid_count	Count of patients in 2002 HEDIS 15-17 yrs	
Field six	late_count	Count of patients in 2002 HEDIS 18-21 yrs	
Field seven	prov_name	Provider Name	
Field eight	prov_grp	Provider Group Practice	DBA name
Field nine	prov_type	Provider Type	PCP, OB/GYN, other
Field ten	prov_add1	Provider Office Address 1	
Field eleven	prov_add2	Provider Office Address 2	
Field twelve	prov_city	Provider Office City	
Field thirteen	prov_zip	Provider Office Zip (5)	
Field fourteen	prov_phone	Provider Office Telephone (10)	
Field fifteen	Prov_fax	Provider Office Fax (10)	

* sort provider records by the awc_count field, report top twenty, inc zero
use primary office address, not billing address

Member Record	Eight adolescent records requested for each provider in sample frame		
Field one	plan_name	Health Plan/Program Name	
Field two	prov_id	Unique Provider ID	associated with AWC visit**
Field three	last_name	Adolescent last name	
Field four	first_name	Adolescent first name	
Field five	client_id	Unique Member ID	Medicaid number xnnnnnn
Field six	client_dob	Member date of birth	mm/dd/yy
Field seven	visit_date	AWC visit date 2001**	mm/dd/yy

** if more than one visit meets HEDIS AWC criteria, select the latest date

12. Appendix B: Final Results

Self-Assessment Results

Table 1—Summary of Self-Assessment of Adolescent Health Care

SUMMARY	ALL PLANS	ALL HMOs*	ROCKY MOUNTAIN	CHPR	COLORADO ACCESS	UNITED	KAISER*	PCPP	FFS
1-6 ACCESS TO CARE FOR ADOLESCENTS	54.6%	55.6%	53.7%	51.8%	59.3%	57.4%	N/R	53.7%	51.9%
7-11 ADOLESCENT APPROPRIATE QUALITY SERVICES	72.7%	75.7%	70.8%	70.8%	84.7%	76.4%	N/R	66.6%	66.6%
12-16 COORDINATION OF SERVICES	54.0%	59.8%	62.1%	57.6%	66.7%	53.0%	N/R	42.4%	42.4%
17-18 ADOLESCENT PARTICIPATION	50.0%	58.3%	33.3%	66.6%	100%	33.3%	N/R	33.3%	33.3%
OVERALL SELF-ASSESSMENT SCORE	**57.8%**	**62.4%**	**55.0%**	**61.7%**	**77.7%**	**55.0%**	**N/A**	**49.0%**	**48.6%**

* N/R = No Response. N/A = Not Applicable. Kaiser Permanente did not participate in the self-assessment component of the study so these results include only the four HMOs, PCPP and FFS programs.

Each answer was assigned one point (★), two points (★★), or three points (★★★) with a total maximum score of 198 points (100%) and a minimum score of 66 (33.3%). In this table, scores are summed for each category, weighted equally and shown as a percentage of the total possible score.

Table 2—Access to Care – Confidentiality

	ALL PLANS	ALL HMOs*	ROCKY MOUNTAIN	CHPR	COLORADO ACCESS	UNITED	KAISER*	PCPP	FFS
1. SCOPE OF PLAN/PROGRAM POLICIES AND PROCEDURES TO ASSURE **CONFIDENTIAL CARE**									
FAMILY PLANNING & REPRODUCTIVE SERVICES	★	★	★	★	★	★	N/R	★	★
SEXUALLY TRANSMITTED DISEASE CARE	★	★	★	★	★★	★	N/R	★	★
MH/SA TREATMENT	★	★★	★	★	★★	★★	N/R	★	★
CONSISTENT WITH STATE AND FEDERAL LAW	★★	★★	★★	★★	★★	★★	N/R	★★	★★
2. HAS ESTABLISHED POLICIES WHICH ALLOW ADOLESCENTS TO GIVE INFORMED CONSENT CONSISTENT WITH STATE LAW									
POLICIES ALLOW ADOLESCENT INFORMED CONSENT CONSISTENT WITH STATE LAW	★	★	★	★	★	★	N/R	★★	★

* N/R = No Response. Kaiser Permanente did not participate in the self-assessment component of the study so these results include only the four HMOs, PCPP and FFS programs.

Key: ★ information was not available; ★★ general information for all members was available; ★★★ adolescent specific information was available. Aggregate results for All HMOs and All Plans are calculated by averaging the results and rounding to the nearest whole number.

Table 3—Access to Care – Adolescent-Oriented Providers

	ALL PLANS	ALL HMOS	ROCKY MOUNTAIN	CHPR	COLORADO ACCESS	UNITED	KAISER*	PCPP	FFS
3. ADOLESCENT PROVIDERS AND SERVICES ARE CLEARLY IDENTIFIED FOR ADOLESCENTS AND THEIR FAMILIES, IN THE FOLLOWING AREAS:									
PROVIDERS WITH ADOLESCENT TRAINING AND/OR SKILLS	★★	★★★	★★	★★★	★★★	★★	N/R	★★	★★
CARE COORDINATORS	★★	★★	★★	★★	★★	★★	N/R	★	★
REPRODUCTIVE HEALTH	★★	★★	★★	★★★	★★	★★	N/R	★★	★★
MENTAL HEALTH	★★	★★	★★	★★	★★★	★★	N/R	★★	★★
SUBSTANCE ABUSE	★★	★★	★★	★	★	★★	N/R	★★	★★
4. ADOLESCENT CHOICE OF PROVIDER									
ADOLESCENT CHOICE INDEPENDENT OF FAMILY PCP CHOICE	★★	★★	★★	★	★★	★★	N/R	★★	★★
ADOLESCENTS ARE INFORMED OF THIS OPTION	★	★	★	★	★	★★	N/R	★	★

*N/R = No Response. Kaiser Permanente did not participate in the self-assessment component of the study so these results include only the four HMOs, PCPP and FFS programs.

Key: ★ information was not available; ★★ general information for all members was available; ★★★ adolescent specific information was available.

Aggregate results for All HMOs and All Plans are calculated by averaging results and rounding to the nearest whole number.

Table 4—Access to Care – Adolescent Education

	ALL PLANS	ALL HMOS	ROCKY MOUNTAIN	CHPR	COLORADO ACCESS	UNITED	KAISER*	PCPP	FFS
5 – 6. ADOLESCENT EDUCATION ON HOW TO ACCESS THE SYSTEM									
EDUCATION MATERIALS ON RIGHT TO CONFIDENTIAL CARE	★	★	★	★	★	★	N/R	★	★
EDUCATION MATERIALS ON MEANING OF INFORMED CONSENT	★	★	★	★	★	★	N/R	★	★
EDUCATION ON HOW TO ENROLL	★★	★★	★★	★	★★	★★	N/R	★★	★★
EDUCATION ON SPECIAL REQUIREMENTS FOR ADOLESCENTS/FAMILIES	★★	★★	★★	★★	★★	★★	N/R	★★	★★
EDUCATION ON HOW TO DISENROLL	★★	★★	★★	★★	★★	★★	N/R	★★	★★
INFORMATION LINES ARE AVAILABLE FOR ADOLESCENTS	★★	★★	★★	★★	★★	★★	N/R	★★	★★

* N/R = No Response. Kaiser Permanente did not participate in the self-assessment component of the study so these results include only the four HMOs, PCPP and FFS programs.

Key: ★ information was not available; ★★ general information for all members was available; ★★★ adolescent specific information was available.

Aggregate results for All HMOs and All Plans are calculated by averaging results and rounding to the nearest whole number.

Table 5—Adolescent-Appropriate Quality Services

	ALL PLANS	ALL HMOS	ROCKY MOUNTAIN	CHPR	COLORADO ACCESS	UNITED	KAISER*	PCPP	FFS
7. PRACTICE GUIDELINES FOR ADOLESCENT CARE									
ADOLESCENT CARE GUIDELINES HAVE BEEN SELECTED	★★	★★	EPSDT	EPSDT	EPSDT	EPSDT	N/R	EPSDT	EPSDT
GUIDELINES SENT TO ALL APPROPRIATE PROVIDERS	★★	★★	★★	★★	★★	★★	N/R	★★	★★
CARE GUIDELINES ARE AVAILABLE TO MEMBERS	★★	★★	★★	★★	★★	★★★	N/R	★★	★★
PROVIDER TRAINING ON GUIDELINES HAS BEEN COMPLETED	★★	★★	★	★	★★	★★	N/R	★★	★★
BENCHMARKS HAVE BEEN ESTABLISHED USING GUIDELINES**	★★★	★★★	★★★	★★★	★★★	★★★	N/R	★★★	★★★
EVALUATION OF COST, QUALITY AND OUTCOMES DONE**	★★★	★★★	★★★	★★★	★★★	★★★	N/R	★★★	★★★

* N/A = No Response. Kaiser Permanente did not participate in the self-assessment component of the study so these results include only the four HMOs, PCPP and FFS programs.

** These categories were checked for all plans using EPSDT guidelines even if the plan did not complete this on the self assessment. EPSDT participation rates must be reported to Centers for Medicare & Medicaid Services, showing participation by age group (including adolescents) and an EPSDT study was completed in 1997.

Key: ★ information was not available; ★★ general information for all members was available; ★★★ adolescent specific information was available.

Aggregate results for All HMOs and All Plans are calculated by averaging results and rounding to the nearest whole number.

Table 6—Plan/Program Guidelines

	ALL PLANS	ALL HMOS	ROCKY MOUNTAIN	CHPR	COLORADO ACCESS	UNITED	KAISER*	PCPP	FFS
8. WHERE THE PLAN/PROGRAM HAS ITS OWN GUIDELINES FOR ADOLESCENT CARE, THEY INCLUDE THE FOLLOWING PROTOCOLS:									
DENTAL	★★	★★	★★	★★	★★★	★★	N/R	★★	★★
GENERAL HEALTH PROBLEMS	★★	★★	★★	★★	★★★	★★	N/R	★★	★★
HEALTH GUIDANCE	★★	★★	★★	★★	★★★	★★	N/R	★★	★★
IMMUNIZATIONS	★★	★★★	★★	★★	★★★	★★★	N/R	★★	★★
LABORATORY ASSESSMENTS	★★	★★	★★	★★	★★★	★★	N/R	★★	★★
PHYSICAL EXAMS	★★	★★★	★★	★★	★★★	★★★	N/R	★★	★★
REFERRALS	★★	★★	★★	★★	★★★	★★	N/R	★★	★★
REPRODUCTIVE HEALTH	★★★	★★★	★★★	★★★	★★★	★★	N/R	★★★	★★★
RISK SCREENING	★★	★★	★★	★★	★★	★★★	N/R	★★	★★
SUBSTANCE ABUSE SCREENING	★★	★★	★★	★★	★★	★★	N/R	★★	★★
MENTAL HEALTH	★★	★★	★★	★★	★★★	★★	N/R	★★	★★

*N/R = No Response. Kaiser Permanente did not participate in the self-assessment component of the study so these results include only the four HMOs, PCPP and FFS programs.

Table 7—Developmentally Appropriate and Culturally Sensitive Services

	ALL PLANS	ALL HMOS	ROCKY MOUNTAIN	CHPR	COLORADO ACCESS	UNITED	KAISER*	PCPP	FFS
9. DEVELOPMENTALLY APPROPRIATE AND CULTURALLY SENSITIVE HEALTH EDUCATION AND GUIDANCE MATERIALS ARE AVAILABLE FROM THE PLAN FOR ADOLESCENTS, PARENTS AND FAMILY MEMBERS									
MATERIALS ADDRESS PHYSICAL BARRIERS	★★	★★	★★	★★	★★	★★	N/R	★	★
MATERIALS ADDRESS CULTURAL BARRIERS	★★	★★	★★	★★	★★	★★	N/R	★	★
MATERIALS ADDRESS LINGUISTIC BARRIERS	★★	★★	★★	★★	★★	★★	N/R	★	★
PERSONNEL SKILLED IN HEALTH EDUCATION ARE AVAILABLE	★★	★★	★★	★★	★★	★★	N/R	★	★
10. INFORMATION ON HOW TO ACCESS REHABILITATION SERVICES IS AVAILABLE, INCLUDING OUTPATIENT AND RESIDENTIAL DRUG TREATMENT									
OUTPATIENT REHABILITATION SERVICES AVAILABLE	★★	★★	★★	★★	★★	★★	N/R	★★	★★
RESIDENTIAL DRUG TX SERVICES ARE AVAILABLE/ACCESSIBLE	★★	★★	★★	★★	★★	★★	N/R	★★	★★
11. QUALITY IMPROVEMENT PROCESSES ADDRESS ADOLESCENT ISSUES									
QUALITY IMPROVEMENT PROCESS ADDRESSES ADOLESCENT ISSUES	★★★	★★★	★★★	★★★	★★★	★★★	★★★	★★★	★★★

* N/R = No Response. Kaiser Permanente did not participate in the self-assessment component of the study so these results include only the four HMOs, PCPP and FFS programs.

Key: ★ information was not available; ★★ general information for all members was available; ★★★ adolescent specific information was available.

Aggregate results for All HMOs and All Plans are calculated by averaging results and rounding to the nearest whole number.

Table 8—Coordination of Services

	ALL PLANS	ALL HMOS	ROCKY MOUNTAIN	CHPR	COLORADO ACCESS	UNITED	KAISER*	PCPP	FFS
12. COLLABORATION MECHANISMS EXIST FOR INFORMATION AND REFERRAL TO PROVIDERS, ORGANIZATIONS AND SYSTEMS DEALING WITH:									
DEVELOPMENTAL DISABILITIES	★★	★★	★★	★★	★★	★	N/R	★	★
EDUCATIONAL/SPECIAL EDUCATION	★★	★★	★★	★★	★★	★	N/R	★	★
FOSTER CARE	★	★★	★★	★	★★	★	N/R	★	★
PROBATION	★	★	★★	★	★	★	N/R	★	★
REPRODUCTIVE HEALTH	★★	★★	★★	★★	★★	★	N/R	★	★
SCHOOL BASED/LINKED HEALTH CENTERS	★★	★★	★★	★★	★★	★	N/R	★	★
SOCIAL SERVICES	★★	★★	★★	★★	★★	★★	N/R	★	★
TANF (AFDC)	★	★★	★★	★	★★	★	N/R	★	★
OTHER ISSUES E.G. AIDS, VIOLENCE	★★	★★	★★	★★	★★	★★	N/R	★	★
SUBSTANCE ABUSE	★★	★★	★★	★★	★★	★★	N/R	★	★
MENTAL HEALTH	★★	★★	★★	★★	★★	★★	N/R	★	★

* N/R = No Response. Kaiser Permanente did not participate in the self-assessment component of the study so these results include only the four HMOs, PCPP and FFS programs.

Key: ★ information was not available; ★★ general information for all members was available; ★★★ adolescent specific information was available.

Aggregate results for All HMOs and All Plans are calculated by averaging results and rounding to the nearest whole number.

Table 9—Outreach

	ALL PLANS	ALL HMOS	ROCKY MOUNTAIN	CHPR	COLORADO ACCESS	UNITED	KAISER*	PCPP	FFS
13. OUTREACH SERVICES TO INFORM ADOLESCENTS, PARENTS, AND ADOLESCENT-SERVING AGENCIES ABOUT HEALTH PLAN SERVICES									
ADOLESCENT SPECIFIC OUTREACH	★★	★★	★	★	★★	★★★	N/R	★	★
PARENTAL OUTREACH	★★	★★	★★	★★	★★	★★★	N/R	★★	★★
AGENCY OUTREACH	★	★	★	★	★	★	N/R	★★	★★

* N/R = No Response. Kaiser Permanente did not participate in the self-assessment component of the study so these results include only the four HMOs, PCPP and FFS programs.

Key: ★ information was not available; ★★ general information for all members was available; ★★★ adolescent specific information was available. Aggregate results for All HMOs and All Plans are calculated by averaging results and rounding to the nearest whole number.

Table 10—Managing Care of High Risk Adolescents

	ALL PLANS	ALL HMOS	ROCKY MOUNTAIN	CHPR	COLORADO ACCESS	UNITED	KAISER*	PCPP	FFS
14. CRITERIA AND PROCESSES AVAILABLE TO IDENTIFY ADOLESCENTS WHO ARE AT HIGH RISK AND PROVIDE APPROPRIATE SERVICES									
CRITERIA EXIST TO DESIGNATE HIGH-RISK ADOLESCENTS	★★	★★	★★	★★	★★	★★	N/R	★	★
PROCESSES TO IDENTIFY AND CASE MANAGE HIGH-RISK ADOLESCENTS	★★	★★	★★	★★	★★	★★	N/R	★	★
APPROPRIATE CASE MGT SERVICES ARE AVAILABLE FOR TEENS	★★	★★	★★	★★	★★	★★	N/R	★	★
15. CONTRACTS WITH ESSENTIAL COMMUNITY PROVIDERS FOR ADOLESCENT SPECIFIC OUTREACH, EDUCATION, CASE MANAGEMENT									
SCHOOL BASED/LINKED HEALTH CENTERS	★★	★★	★	★★	★★★	★	N/R	★★	★★
LOCAL HEALTH AGENCIES	★★	★★	★★	★	★★	★	N/R	★★	★★
FAMILY PLANNING CLINICS	★★	★★	★★	★★	★★	★★	N/R	★★	★★
SUBSTANCE ABUSE TREATMENT PROGRAMS	★★	★★	★★	★★	★★	★★	N/R	★★	★★
16. ADOLESCENT SPECIFIC POLICIES AND PROCEDURES TO FACILITATE ACCESS TO MHSA SERVICES									
OTHER ADOLESCENT SPECIFIC POLICIES AND PROCEDURES ARE COMMUNICATED TO TEENS	★★	★★	★★	★★	★★★	★	N/R	★	★

* N/R = No Response. Kaiser Permanente did not participate in the self-assessment component of the study so these results include only the four HMOs, PCPP and FFS programs.

Key: ★ information was not available; ★★ general information for all members was available; ★★★ adolescent specific information was available. Aggregate results for All HMOs and All Plans are calculated by averaging results and rounding to the nearest whole number.

Table 11—Adolescent Participation in the System for Care

	ALL PLANS	ALL HMOS	ROCKY MOUNTAIN	CHPR	COLORADO ACCESS	UNITED	KAISER*	PCPP	FFS
17-18. MECHANISMS TO OBTAIN FEEDBACK FROM ADOLESCENTS									
ADOLESCENTS HAVE BEEN ASKED FOR FEEDBACK	★★	★★	★	★★	★★★	★	N/R	★	★
INTERVENTIONS TO ENCOURAGE ADOLESCENT PARTICIPATION	★★	★★	★	★★	★★★	★	N/R	★	★

* N/R = No Response. Kaiser Permanente did not participate in the self-assessment component of the study so these results include only the four HMOs, PCPP and FFS programs.

Key: ★ information was not available; ★★ general information for all members was available; ★★★ adolescent specific information was available.

Aggregate results for All HMOs and All Plans are calculated by averaging results and rounding to the nearest whole number.

Provider Interview Results

Table 12—Demographics of Provider Sample

	ALL PLANS	ALL HMOS	ROCKY MOUNTAIN	CHPR	COLORADO ACCESS	UNITED	KAISER	PCPP	FFS
TOTAL PROVIDERS	**21**	**15**	3	3	3	3	3	**3**	**3**
PERCENT OF PATIENTS AGED 12 – 21 YR	**21.7%**	**18.4%**	28.3%	20.0%	17.5%	8.3%	17.7%	**33.8%**	**29.2%**
PERCENT MEDICAID ADOLESCENTS	**41.1%**	**43.5%**	46.7%	65.0%	40.0%	31.7%	15.0%	**26.4**	**40.8%**
AVERAGE YEARS SERVING TEENS	**18**	**18**	18	20	20	7	23	**26**	**12**

Note: Four providers in total had some missing answers (i.e. they could not make an estimate) and so averages reflect only those who answered. The data presented in this table is taken from the demographics portion of the provider interview (page 66).

Table 13—Provider Use of Clinical Practice Guidelines for Adolescent Preventive Services

QUALITY	ALL PLANS	ALL HMOS	ROCKY MOUNTAIN	CHPR	COLORADO ACCESS	UNITED	KAISER	PCPP	FFS
TOTAL PROVIDERS	**21**	**15**	3	3	3	3	3	**3**	**3**
GAPS	**4**	**2**			1	1			**2**
BRIGHT FUTURES									
PUTTING PREVENTION INTO PRACTICE	**2**	**2**		1		1			
COLORADO EPSDT	**2**	**0**						**1**	**1**
COLORADO STANDARD GUIDELINE	**2**	**1**		1				**1**	
HEALTH PLAN GUIDELINE	**2**	**1**					1		**1**
CLINIC'S OWN GUIDELINE	**14**	**10**	3	1	2	2	2	**3**	**1**
NONE USED	**1**	**1**		1					
COMMENTS	American Academy Blue Book (for sports physicals) was also mentioned. Several use Teen Health History intake checklist.								

The number of providers using each guideline is shown in the table. Multiple responses are included.

Table 14—Provider Practices to Make Services More Convenient for Adolescents – Self Reported

VISIBILITY & ACCESSIBILITY	ALL PLANS	ALL HMOS	ROCKY MOUNTAIN	CHPR	COLORADO ACCESS	UNITED	KAISER	PCPP	FFS
TOTAL PROVIDERS	**21**	**15**	3	3	3	3	3	**3**	**3**
OPEN ACCESS/ WALK IN CLINICS	**14**	**10**	3	2	3	1	1	**1**	**3**
GROUP VISITS FOR ADOLESCENTS	**2**	**2**					2		
WEEKEND, AFTER SCHOOL, EVENING HOURS	**13**	**10**	2	2	1	2	3	**2**	**1**
ADOLESCENT HOTLINE	**0**	**0**							
OTHER	**0**	**0**							
COMMENTS	Some clinics have a separate waiting room for adolescents. Some mentioned giving adolescents a direct line to the office and a pager.								

The number of providers using each method is shown in the table. Multiple responses are included.

Table 15—Provider Processes to Assure the Adolescent of the Confidentiality of Services – Self Reported

CONFIDENTIALITY	ALL PLANS	ALL HMOS	ROCKY MOUNTAIN	CHPR	COLORADO ACCESS	UNITED	KAISER	PCPP	FFS
TOTAL PROVIDERS	**21**	**15**	3	3	3	3	3	**3**	**3**
CONFIDENTIAL BILLING PROCESSES	**5**	**3**	2		1				**2**
RESOURCES REGARDING RIGHT TO CONFIDENTIALITY	**4**	**4**			1		3		
CONSENT FORMS	**12**	**7**		2	3	2		**2**	**3**
OTHER									
COMMENTS	Some providers mentioned a concern with protecting their rights/knowing the state laws, not comfortable with verbally explaining the state laws. Would like to be more informed.								

The number of providers who mentioned each approach is shown in the table. Multiple responses are included.

Table 16—Provider Coordination with Behavioral Health and Community Organizations – Self Reported

COORDINATION	ALL PLANS	ALL HMOS	ROCKY MOUNTAIN	CHPR	COLORADO ACCESS	UNITED	KAISER	PCPP	FFS
TOTAL PROVIDERS	**21**	**15**	3	3	3	3	3	**3**	**3**
REFERRAL/COORDINATION WITH BEHAVIORAL HEALTH	**17**	**13**	3	3	2	2	3	**2**	**2**
REFERRAL/COORDINATION WITH SUB ABUSE SERVICE	**17**	**13**	3	3	2	2	3	**2**	**2**
COORDINATION WITH COMMUNITY ORGANIZATIONS	**19**	**14**	3	3	3	2	3	**2**	**3**
DESIGNATED COORDINATOR ON STAFF	**8**	**5**		2	1	2		**1**	**2**
OTHER									
COMMENTS	One provider noted Mental Health Group serves Medicaid members & comes to office at specific time each week. Started 1 year ago. Increases access and integration of care.								

The number of providers mentioning each approach is shown in the table. Multiple responses are included.

Table 17—Serving a Diverse Population

FLEXIBILITY	ALL PLANS	ALL HMOS	ROCKY MOUNTAIN	CHPR	COLORADO ACCESS	UNITED	KAISER	PCPP	FFS
TOTAL PROVIDERS	**21**	**15**	3	3	3	3	3	**3**	**3**
MULTI-LINGUAL SERVICES INC. PATIENT EDUCATION	**17**	**12**	2	3	2	2	3	**2**	**3**
ADDITIONAL SUPPORT FOR CHILDREN WITH SPECIAL NEEDS	**19**	**14**	3	2	3	3	3	**2**	**3**
RESOURCES FOR PREGNANT TEENS & TEENS AS PARENTS	**12**	**11**	3		2	3	3		**1**
OTHER									
COMMENTS	One provider mentioned using Blue Sky – an organization that does assessments on special needs kids and makes referral to MD.								

The number of providers mentioning each item is shown in the table. Multiple responses are included.

Table 18—Provider Recommendations

TABLE 18: WHAT ONE RECOMMENDATION WOULD YOU MAKE TO IMPROVE THE CARE OF MEDICAID ADOLESCENTS IN COLORADO?

FEE-FOR-SERVICE:

1. PROVIDER SUGGESTED ANOTHER CODE COULD BE USED FOR "COUNSELING OR HEALTH GUIDANCE" IN ADDITION TO THE WELL VISIT, SINCE THERE IS NOT ENOUGH TIME TO DO A COMPREHENSIVE EXAM. ALSO ASKED - WHO DOES HEALTH EDUCATION TODAY, SINCE SCHOOLS ARE CUTTING BACK ON PHYSICAL EDUCATION AND HEALTH PROGRAMS.
2. THIS PROVIDER REPORTED AN URGENT NEED TO INCREASE OPPORTUNITIES TO GET ADOLESCENTS IN FOR PREVENTIVE CARE. HELP IS NEEDED EARLIER AND IS OFTEN NOT AVAILABLE TO MANY ADOLESCENTS UNTIL A CRIME IS COMMITTED AND THEY ARE IN THE PENAL SYSTEM.
3. ALL ADOLESCENTS THROUGH AGE 19 SHOULD HAVE FREE, CONFIDENTIAL REPRODUCTIVE HEALTH CARE. RECOMMEND REVIEWING AUTHORIZATION REQUIRED FOR NEW BIRTH CONTROL METHODS TO ALLOW TEENS TO USE NEW FORMS OF BIRTH CONTROL (PATCH). **IT'S TOO HARD TO GET AUTHORIZATION**, SO TEEN DOESN'T USE ANYTHING, BECOMES PREGNANT AND THEN DROPS OUT OF SCHOOL.

ROCKY MOUNTAIN HEALTH PLANS:

1. PROVIDER COMMENTED THAT ROCKY MOUNTAIN HEALTH PLANS IS EXCELLENT. NO SPECIFIC ISSUES WITH MEDICAID.
2. WOULD LIKE TO SEE THE ADOLESCENTS WHO ARE **ELIGIBLE** FOR MEDICAID **RECEIVE** MEDICAID. THIS PROVIDER NOTED A LACK OF PUBLIC AWARENESS AND EDUCATION. NEED TO USE CLEARER, SIMPLER LANGUAGE TO EXPLAIN THE PROGRAM
3. RECOMMEND OFFERING PARENTS MORE EDUCATION AND INFORMATION ON LIFESTYLE/PARENTING SKILLS. SUGGEST ALSO THAT THE MEMBERSHIP CARD IDENTIFY THE NAME OF THE PCP FOR THE MEMBER; NOW IT ONLY IDENTIFIES THE NAME OF THE PLAN

COMMUNITY HEALTH PLAN OF THE ROCKIES (CHPR):

1. GAIN A GREATER UNDERSTANDING OF SOCIAL AND CULTURAL ISSUES THAT PREVENT ADOLESCENTS FROM SEEKING CARE. IDENTIFY OPPORTUNITIES TO GET THEM TO COME IN AND, IF RISK BEHAVIORS IDENTIFIED, HOW TO ELIMINATE OR REDUCE RISK. COMMENT: WONDERED IF ADOLESCENTS WHO DO NOT SEEK CARE HAVE PARENTS OR CAREGIVERS WHO ALSO DO NOT SEEK CARE.

TABLE 18: WHAT ONE RECOMMENDATION WOULD YOU MAKE TO IMPROVE THE CARE OF MEDICAID ADOLESCENTS IN COLORADO?

2. BE ABLE TO ASSURE CONFIDENTIALITY, TO ALLOW TEENS TO COME IN WITHOUT PARENTAL CONSENT. IDENTIFY A BILLING CODE FOR HEALTH GUIDANCE AND IDENTIFICATION OF RISKY BEHAVIORS & COUNSELING TO REIMBURSE FOR ADDED TIME SPENT. ADOLESCENT IS PLACED ON MEMBERSHIP CARD FOR ENTIRE FAMILY, IT WOULD BE MUCH BETTER FOR ADOLESCENTS TO HAVE OWN ID CARD.

3. RECOMMEND EDUCATION TO ADOLESCENTS TO ALLOW THEM TO COME IN BY THEMSELVES FOR PREVENTIVE CARE WITH PARENTS CONSENT, CREATING ACCOUNTABILITY AND RESPONSIBILITY FOR THEIR OWN HEALTH. PARENTS WORK AND HAVE DIFFICULTY GETTING TO PHYSICIAN OFFICE - THAT'S A BARRIER.

COLORADO ACCESS:

1. PROVIDER CONCERNED ABOUT THE NUMBER OF ADOLESCENTS WHO ARE NOT COMING IN FOR CARE. EMPHASIZED IT WAS EXTREMELY IMPORTANT TO BUILD RELATIONSHIPS WITH ADOLESCENTS. ADOLESCENTS WITH CHRONIC CONDITIONS ARE SEEN MORE OFTEN BECAUSE RELATIONSHIPS ARE BUILT, SO ISSUES ARE ADDRESSED MORE.

2. PROVIDERS NEED TO CONSIDER SOCIAL STRUCTURE CHANGES THAT HAVE OCCURRED, I.E., PARENTS WORKING, LATCH-KEY KIDS, SELF-EDUCATION. OFFER EVENING CLINIC HOURS, OFFER CLASSES IN BIRTH CONTROL, SEXUALLY TRANSMITTED DISEASES, OBESITY, ETC.

3. FIND WAYS TO MAKE IT EASIER FOR ADOLESCENTS TO HAVE ACCESS TO, AND COMMUNICATION WITH, BEHAVIORAL HEALTH PROVIDERS. WE NEED LIFESTYLE COUNSELING FOR KIDS FROM AN EARLY AGE TO PREVENT PROBLEMS.

UNITEDHEALTHCARE OF COLORADO:

1. THIS PARTICULAR CLINIC IS PLEASED TO SEE A MEDICAID CLIENT BECAUSE THEY CAN ACCESS THE NECESSARY SERVICE/CARE NEEDED. THE MAJORITY OF ITS CLIENTS HAVE NO HEALTH CARE COVERAGE.

2. TEENS NEED ASSISTANCE IN DEVELOPING PARENTING SKILLS (CULTURAL/SOCIAL CHANGE REQUIRED). WE NEED TO RECOGNIZE THAT ADOLESCENTS MIMIC WHAT THEIR PARENTS DO – NOT ALWAYS A GOOD THING!.. NEED TO LOOK AT HOW ADOLESCENTS RECEIVE INFORMATION AND TARGET COMMUNICATIONS MORE APPROPRIATELY.

3. RECOMMEND SOME TYPE OF INCENTIVE FOR ADOLESCENTS TO COME IN FOR HEALTH CARE SERVICES – ESPECIALLY PREVENTIVE & ACUTE CARE. IT WOULD CREATE AN OPPORTUNITY TO BUILD A RELATIONSHIP OR AT LEAST "BREAK THE ICE," SO THE ADOLESCENT WOULD SEE THE PHYSICIAN AS A RESOURCE.

TABLE 18: WHAT ONE RECOMMENDATION WOULD YOU MAKE TO IMPROVE THE CARE OF MEDICAID ADOLESCENTS IN COLORADO?

KAISER PERMANENTE:
1. RECOMMEND MAKING IT EASIER FOR MEDICAID ADOLESCENTS TO COME IN FOR SERVICES -- HAVE TRANSPORTATION ASSISTANCE AND LET ADOLESCENTS KNOW WHEN THEY CAN ACCESS SERVICES WITHOUT PARENTS. CURRENTLY ALLOWED TO SEEK CARE WITHOUT PARENTAL CONSENT FOR SEXUALLY TRANSMITTED DISEASES AND BIRTH CONTROL - SHOULD ALSO INCLUDE ACUTE CARE.
2. RECOMMENDS MAKING IT EASIER FOR ADOLESCENTS TO FIND PROVIDERS WHO LIKE TO WORK WITH ADOLESCENTS. HAVE A LIST OF PREFERRED PROVIDERS FOR TEENAGERS.
3. MANY ADOLESCENTS STRUGGLING. FOR MEDICAID, NUMBER MAY BE HIGHER BECAUSE OF LIMITED RESOURCES. RECOMMENDATION: FIGURE OUT WAY TO ASSIST ADOLESCENTS WHO DON'T HAVE GOALS - CAREER COUNSELING COULD OFFER MODEL. PROVIDER SEES A DIFFERENCE BETWEEN ADOLESCENTS WHO HAVE A GOAL AND THOSE WHO DO NOT.
PRIMARY CARE PHYSICIAN PROGRAM (PCPP):
1. REDESIGN THE PROCESS OR BENEFITS TO INCREASE ACCOUNTABILITY OF PARENTS TO GET ADOLESCENTS IN FOR PREVENTIVE CARE. PROVIDER SEES A LACK OF COMPLIANCE WITH PARENTS NOT BRINGING KIDS IN. THIS OFFICE CALLS TO SCHEDULE VISIT AND FOLLOW-UP ON IMMUNIZATIONS AND CARE. PROVIDER ASKED IF MEDICAID SENDS REMINDERS RE PREVENTIVE CARE.
2. WE NEED MORE EDUCATION AND EMPHASIS ON TEACHING CHILDREN SKILLS TO DEAL WITH CHANGE, STRESS, CONFLICT, ANXIETY, SO ADOLESCENTS KNOW HOW TO HANDLE IT WHEN THESE INSTANCES OCCUR. MEDICAID IS STILL THE BEST SYSTEM FOR ACCESSING THE HEALTH CARE SYSTEM - MEMBERS HAVE THE ABILITY TO OBTAIN ALL SERVICES.
3. SUGGESTED "HEALTH PEERS" IN SCHOOLS THAT ADOLESCENTS CAN GO TO FOR INFORMATION – DIRECT THEM TO COMMUNITY SERVICES OR PROVIDE SUPPORT. THIS ROLE PREVIOUSLY DONE BY SCHOOL NURSE. BASED ON TRUSTING PEERS INSTEAD OF ADULTS. BRIDGES THE GAP. GIVE EDUCATION WHERE THE ADOLESCENTS ARE - RECOGNIZE CONCERN ABOUT CONFIDENTIALITY.

Medical Record Review Results

Table 19—Demographics of Adolescent Sample

TOTAL SAMPLE	ALL PLANS	ALL HMOs	ROCKY MOUNTAIN	CHPR	COLORADO ACCESS	UNITED	KAISER	PCPP	FFS
TOTAL SAMPLE	**99**	**69**	15	15	15	9	15	**15**	**15**
AVERAGE AGE[1]	**14**	**14**	14	14	14	14	14	**14**	**14**
SPECIAL NEEDS[2]	**23**	**14**	6	0	5	0	3	**4**	**5**
FEMALE ADOLESCENTS	ALL PLANS	ALL HMOs	ROCKY MOUNTAIN	CHPR	COLORADO ACCESS	UNITED	KAISER	PCPP	FFS
TOTAL FEMALE	**53**	**37**	8	7	6	6	10	**12**	**4**
AVERAGE AGE[1]	**14**	**14**	14	15	14	13	14	**14**	**14**
SPECIAL NEEDS[2]	**9**	**6**	4	0	1	0	1	**2**	**1**
MALE ADOLESCENTS	ALL PLANS	ALL HMOs	ROCKY MOUNTAIN	CHPR	COLORADO ACCESS	UNITED	KAISER	PCPP	FFS
TOTAL MALE	**46**	**32**	7	8	9	3	5	**3**	**11**
AVERAGE AGE[1]	**14**	**14**	13	13	15	14	14	**15**	**15**
SPECIAL NEEDS[2]	**14**	**8**	2	0	4	0	2	**2**	**4**

[1] Age calculated as at December 31, 2001 [2] Children with Special Needs were identified administratively using SSI eligibility codes

Table 20—Physical Examination Documentation

PHYSICAL EXAMINATION	ALL PLANS	ALL HMOS	ROCKY MOUNTAIN	CHPR	COLORADO ACCESS	UNITED	KAISER	PCPP	FFS
TOTAL SAMPLE	**99**	**69**	15	15	15	9	15	**15**	**15**
FEMALE - MALE	**53** **46**	**37** **32**	8 7	7 8	6 9	6 3	10 5	**12** **3**	**4** **11**
COMPREHENSIVE EXAMINATION	**93**	**63**	15	14	14	5	15	**15**	**15**
BLOOD PRESSURE	**83**	**54**	12	7	13	7	15	**14**	**15**
BODY MASS INDEX	**88**	**59**	14	13	12	5	15	**14**	**15**
VISION TEST	**64**	**38**	11	2	10	3	12	**11**	**15**
HEARING TEST	**21**	**9**	3	0	6	0	0	**6**	**6**
ORAL EXAM	**89**	**59**	12	14	13	5	15	**15**	**15**
TOTAL PERCENTAGE FOR PHYSICAL EXAMINATION	**74%**	**68%**	74%	56%	76%	46%	80%	**83%**	**90%**

Table 21—Health Education and Anticipatory Guidance Documentation

HEALTH EDUCATION	ALL PLANS	ALL HMOS	ROCKY MOUNTAIN	CHPR	COLORADO ACCESS	UNITED	KAISER	PCPP	FFS
TOTAL SAMPLE	**99**	**69**	15	15	15	9	15	**15**	**15**
FEMALE - MALE	**53** **46**	**37** **32**	8 7	7 8	6 9	6 3	10 5	**12** **3**	**4** **11**
NORMAL DEVELOPMENT	**56**	**28**	5	5	4	1	13	**13**	**15**
DIET & PHYSICAL ACTIVITY	**63**	**35**	7	6	5	3	14	**13**	**15**
HEALTHY LIFESTYLES	**56**	**28**	5	1	6	1	15	**13**	**15**
INJURY PREVENTION	**51**	**24**	5	0	3	1	15	**13**	**14**
TOTAL PERCENTAGE FOR HEALTH EDUCATION	**57%**	**42%**	37%	20%	30%	17%	95%	**87%**	**98%**

Table 22—Documentation of Screening Risky Behavior and Counseling

RISK SCREENING	ALL PLANS	ALL HMOS	ROCKY MOUNTAIN	CHPR	COLORADO ACCESS	UNITED	KAISER	PCPP	FFS
TOTAL SAMPLE	**99**	**69**	15	15	15	9	15	**15**	**15**
FEMALE - MALE	**53** **46**	**37** **32**	8 7	7 8	6 9	6 3	10 5	**12** **3**	**4** **11**
EATING DISORDERS	**57**	**34**	7	6	4	2	15	**8**	**15**
SEXUAL ACTIVITY	**47**	**25**	3	2	5	3	12	**9**	**13**
ALCOHOL USE	**55**	**31**	7	3	4	5	12	**11**	**13**
DRUG USE	**53**	**30**	7	1	6	4	12	**10**	**13**
TOBACCO USE	**66**	**42**	7	4	8	8	15	**10**	**14**
ABUSE	**40**	**22**	4	1	1	1	15	**6**	**12**
SCHOOL PERFORMANCE	**51**	**31**	7	1	5	3	15	**5**	**15**
DEPRESSION OR SUICIDE	**43**	**28**	5	2	5	1	15	**3**	**12**
TOTAL PERCENTAGE FOR RISK SCREENING AND COUNSELING	**52%**	**44%**	39%	17%	32%	38%	93%	**52%**	**89%**

Table 23—Testing Documented in Adolescent Medical Record

TESTS	ALL PLANS	ALL HMOS	ROCKY MOUNTAIN	CHPR	CO ACCESS	UNITED*	KAISER	PCPP	FFS
TOTAL SAMPLE	**99**	**69**	15	15	15	9	15	**15**	**15**
TESTING									
CHOLESTEROL – AT RISK	**9**	**5**	1	3	0	1	0	**2**	**2**
CHOLESTEROL – NUMBER TESTED	**2**	**1**	1	0	0	0	0	**0**	**1**
TB – AT RISK	**5**	**3**	0	0	1	0	2	**0**	**2**
TB – NUMBER TESTED	**4**	**2**	0	0	1	0	1	**0**	**2**
STDS – SEXUALLY ACTIVE	**12**	**9**	2	1	3	2	1	**1**	**2**
STDS – NUMBER TESTED	**8**	**5**	0	1	2	1	1	**1**	**2**
HIV – SEXUALLY ACTIVE	**15**	**9**	2	1	3	2	1	**1**	**5**
HIV – NUMBER TESTED	**9**	**4**	0	1	1	1	1	**0**	**5**
PAP – FEMALE SEXUALLY ACTIVE	**7**	**6**	1	1	2	1	1	**1**	**0**
PAP – NUMBER TESTED	**5**	**4**	0	1	1	1	1	**1**	**0**
URINALYSIS AT RISK	**74**	**45**	15	9	8	6	7	**14**	**15**
URINALYSIS NUMBER TESTED	**37**	**15**	4	1	2	4	4	**11**	**11**
HEMATOCRIT – FEMALE OR AT RISK	**32**	**23**	5	5	4	2	7	**7**	**2**
HEMATOCRIT – NUMBER TESTED	**12**	**7**	0	2	2	2	1	**4**	**1**

* United submitted an incorrect sample resulting in a lower number of reviewed records.