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Improving Receipt and Preventive Care Delivery for Adolescents and Young Adults: Initial Lessons from Top-Performing States

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Abstract *Purpose* Provisions of the Patient Protection and Affordable Care Act (ACA) of 2010 hold promise for improving access to and receipt of preventive services for adolescents and young adults (AYAs). The Title V Block Grant transformation also includes a focus on improving adolescent preventive care. This brief report describes and discusses an inquiry of promising strategies for improving access and preventive care delivery identified in selected high-performing states. *Methods* Two data sources were used to identify top-performing states in insurance enrollment and preventive care delivery: National Survey of Children's Health for adolescents (ages 12–17 years) and Behavioral Risk Factors Surveillance System for young adults (ages 18–25 years). Interviews were conducted with key stakeholders to identify promising strategies related to increasing AYAs' insurance enrollment and receipt of preventive services. *Results* Seven top-performing states were selected: California, Colorado, Illinois, Iowa, Oregon, Vermont, and Texas; 27 stakeholders completed interviews. Four strategies were identified regarding insurance enrollment: use of partnerships; special populations outreach; leveraging laws and resources; and youth engagement. Four strategies were identified regarding quality preventive care: expand provider capacity to serve AYAs; adopt medical home policies; establish quality improvement projects; and enhance consumer awareness of well-visit. States focused

more on adolescents than young adults and on increasing health insurance enrollment than the provision of preventive services. *Conclusions* This commentary identifies strategies and recommends areas for future action, as Title V programs and their partners focus on improving healthcare for AYAs as ACA implementation and the Title V transformation continues.

Keywords Adolescents · Young adults · Preventive care · Affordable Care Act · Title V Block Grant transformation · Well-visit

Significance

The major health issues for adolescents and young adults are largely preventable with early identification and intervention. Provisions of the Patient Protection and Affordable Care Act of 2010 hold promise for improving access to and receipt of quality preventive services for adolescents and young adults (AYAs). A second federal initiative, Title V Block Grant transformation, also includes a focus on improving adolescent preventive care.

This is the first study to identify strategies and recommend areas for future action, as Title V programs and their partners focus on improving healthcare for AYAs as ACA implementation and the Title V Transformation continues.

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Introduction

The major health issues for adolescents and young adults (AYAs) are largely preventable with early identification and intervention. The adolescent health field has long recognized the need for preventive interventions during

adolescence, while more recent efforts have also called for preventive efforts among young adults (YAs) (Institute of Medicine and National Research Council 2014). For example, professional organizations have focused on clinical preventive services since the early 1990s, with major medical organizations endorsing *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* (Hagan et al. 2008). Although there is less professional focus on preventive services for YAs, a study by Ozer et al. (2012) identified evidence-based preventive services for YAs.

Several provisions of the Patient Protection and Affordable Care Act (ACA) of 2010 hold promise for improving access to and receipt of preventive health services for the AYA population. Provisions to expand access to services address both public and private insurance. First, the ACA requires states to expand Medicaid up to 133% Federal Poverty Level (FPL) for children and adolescents; states have the option to expand Medicaid up to 133% FPL for the adult population under age 65, which includes YAs. Second, the ACA requires most private health plans to extend dependent coverage to YAs up to age 26, regardless of the individual's financial, marital or educational status. Third, under the ACA, each state has a health insurance exchange ("The Marketplace") that offers financial assistance to low-income individuals and families.

Several ACA provisions also aim to increase the receipt of preventive services. Starting in 2010, most private health plans were required to cover select preventive services without cost-sharing. These services are drawn from four sets of recommendations: "A" and "B" preventive services recommended by the U.S. Preventive Services Task Force for all adults; the *Bright Futures Guidelines*; CDC's Advisory Committee on Immunization Practices (for all ages); and the HRSA guidelines for Women's Clinical Preventive Services, which includes many services relevant for AYAs. States that choose to expand Medicaid to adults must also offer these services without cost-sharing to newly eligible adults, including YAs.

Additionally, a second federal initiative holds promise for advancing a prevention agenda for adolescents. The Maternal and Child Health Bureau has launched a "Title V Transformation," including significant changes to the National Performance Measures (NPMs) to which states are held accountable. This transformation is guided by the aims of "reducing state reporting burden, and maintaining state flexibility while improving accountability of state Title V programs." Under this system, states are required to choose eight out of 15 NPMs, at least one in each of six population domains, including adolescent health. One adolescent option, NPM #10, calls for increasing the percent of adolescents (ages 12–17) with a well visit in the past year (Kogan et al. 2015).

Implementation of the ACA and NPM #10 is highly dependent on state-level activities. Given the early stages of implementation for both federal initiatives, little research has examined actions taken within states to improve access to and receipt of preventive services among AYAs. In this context, this exploratory study was conducted with an overall study goal of identifying strategies in "top performing" states related to increasing enrollment in insurance and receipt of preventive visits among AYAs. Researchers undertook the study to support state and local action to increase insurance and receipt of a preventive visits among AYAs, and to contribute to the emerging literature on state implementation of the ACA, specifically for AYAs. First, to support state and local action, the authors developed a compendium of strategies identified in the study (Twietmeyer et al. 2016). Second, the authors developed this brief report.

Methods

The exploratory study had two aims: (1) identify states that were top performing in insurance enrollment and preventive care delivery for AYAs; and (2) identify their promising enrollment and delivery strategies across these selected states. For the first aim, two national data sources were used to identify top performing states: the National Survey of Children's Health (National Center for Health Statistics 2012) for adolescents (ages 12–17), and the Behavioral Risk Factors Surveillance System (CDC 2014) for young adults (ages 18–25). Data sources were used to obtain state-level data for the following three parameters for insurance enrollment and preventive care: pre-ACA rates; post-ACA rates; and pre-post change rates. For the second aim, qualitative analyses of stakeholder interviews were conducted to identify promising strategies related to enrollment and preventive care delivery.

For Aim 1, a preliminary list of states was identified through three steps. First, analyses were conducted to determine the three aforementioned parameters. States were then rank-ordered on these parameters for insurance enrollment and preventive visits. Next, states that performed above average on at least one parameter ($n = 36$) were categorized into geographic regions (West, South, Midwest, Northeast).

From these 36 states, 26 "semi-finalist" states were identified through elimination of the lowest performers in each region. From this, the research team used a consensus approach to identify 11 "finalist" states using the following criteria: states that performed above average on more than one parameter (i.e., insurance and preventive visits for AYAs) in each geographic region. Researchers also considered states that were diverse in both population size and

policy characteristics (e.g., Medicaid expansion status and the percent of state population enrolled in Medicaid).

For Aim 2, key stakeholders were selected through targeted outreach based on professional knowledge of AYA state-level leadership; recommendations from Title V State Adolescent Health Coordinators; and information gained from background research on selected states. Telephone interviews were conducted to identify promising strategies with 27 stakeholders from the selected states. Interviewees included MCH/Title V Directors, School of Medicine faculty, State Department of Health staff, and youth advocacy organization staff. Two researchers used a survey instrument that had questions related to current and previous efforts to increase health insurance enrollment and preventive care delivery. Following each interview, both researchers analyzed responses and used a consensus process to identify common themes and strategies. This study received an exempt status from the UCSF institutional review board.

Results

Of the 11 finalist states, 27 stakeholders in seven states participated: California, Colorado, Iowa, Illinois, Oregon, Texas, and Vermont. From the interviews, we identified eight promising strategies for increasing insurance enrollment and improving preventive service delivery among AYAs.

Strategies to Increase Enrollment in Health Insurance

Participant responses were grouped into four strategies: Use of Partnerships; Special Populations Outreach; Leverage Laws and Resources; and Youth Engagement (see Table 1).

Use of Partnerships

All selected states built or established partnerships to increase health coverage among AYAs in public and private health insurance. Two types of partnerships were identified: (a) state entities establishing formal contracts with county government agencies to provide local outreach and enrollment services; and (b) a broader range of entities including governmental departments working with multiple non-governmental organizations. For example, 21 organizations led by the *City of Houston Health and Human Services Department* formed a collaborative partnership in 2013 called *Enroll Gulf Coast* to coordinate, network, and streamline efforts to engage and enroll eligible, yet uninsured populations in Harris County. Partnerships were reported by five states to provide outreach and enrollment

Table 1 Strategies to increase enrollment in health insurance among selected states by adolescents and young adults

	Use of partnerships	Special populations outreach	Leverage laws and resources	Youth engagement
California	X ^c	X ^{c,d,e,f}	X ^c	
Colorado	X ^a	X ^{a,d}	X ^a	X ^a
Illinois	X ^a	X ^{d,g}	X ^a	X ^a
Iowa	X ^a	X ^{a,d}	X ^a	
Oregon	X ^a	X ^{a,d}	X ^a	X ^a
Texas	X ^b	X ^d	X ^a	X ^c
Vermont	X ^a			

“X” indicates efforts reported for adolescent and/or young adult population

^aInformants reported efforts targeting adolescents only

^bInformants reported efforts targeting adolescents and young adults

^cInformants reported efforts targeting young adults only

^dEligible Latinos and mixed-status families

^eFormer foster care youth

^fLesbian, gay, bisexual, and transgender young adults

^gHomeless adolescents

to children and adolescents, while two states used this strategy to reach YAs.

Special Populations Outreach

Six states conducted outreach and enrollment campaigns to reach Latinos and mixed-status families of all ages. “Mixed-status” refers to a family with members who have different legal status (i.e., citizen and non-citizen). For example, the Oregon Health Authority partnered with Spanish media outlets (e.g., Univision) and the Mexican and Guatemalan Consulates to promote health insurance enrollment. Two states focused on specific populations of AYAs: homeless adolescents (Illinois) and former foster youth (California). In California, an advocacy organization spearheaded a campaign to help former foster care youth enroll in Medicaid up through age 26, a provision of the ACA.

Leverage Laws and Resources

Five selected states leveraged opportunities to expand their outreach and enrollment efforts for adolescents through the use of new and existing mechanisms; one state leveraged clinical encounters to enroll eligible YAs. Five of the six states that performed strongly for adolescents received federal outreach and enrollment grants to enroll eligible adolescents into Medicaid and CHIP. For example, a non-profit organization in Illinois received federal funds to provide outreach and enrollment services to homeless adolescents

(<https://www.insurekidsnow.gov/downloads/initiatives/grantssummary-2009.pdf>). In addition, five states that performed strongly among adolescents leveraged policy options (e.g., Express Lane Eligibility) to streamline their enrollment and renewal processes for Medicaid and CHIP (Brooks et al. 2014).

Youth Engagement

Four states developed programs to engage youth as partners in their outreach and enrollment efforts. This strategy was used among three states to partner with adolescents, while only one state partnered with YAs. For example, the Oregon Health Authority (OHA) consulted with a youth advisory council to develop a teen-friendly flyer to promote health insurance among uninsured AYAs. The flyer was used statewide in clinics, schools, Federally Qualified Health Centers, and the OHA website.

Strategies to Increase Receipt and Quality of Preventive Care

Participant responses were grouped into four strategies: Enhance Consumer Awareness of Well-Visit; Expand Provider Capacity to Serve AYAs; Adopt Medical Home Policies; and Establish Quality Improvement Projects. One state focused on increasing the rate of well-visits through consumer awareness efforts, while the remaining states focused on improving the quality of the visit (see Table 2).

Enhance Consumer Awareness of Well-Visit

One state, Vermont, used several strategies to increase awareness among adolescents and parents of the importance of the well-visit. In 2012, the Vermont Department of Health (VDH) conducted focus groups with adolescents, parents, and providers to identify why insured adolescents

were not receiving annual visits. VDH also conducted state-wide trainings of K-12 school nurses to help educate parents on the importance of the preventive visit for children, regardless of sports participation. Nurses subsequently posted educational information on school websites and on a ‘Resources for Parents’ webpage on VDH’s website; nurses also provided individual outreach to adolescents receiving a sports physical check-up to promote a more comprehensive annual well-visit.

Expand Provider Capacity to Serve AYAs

Five states adopted *Bright Futures* in their Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. Three states led provider training initiatives relevant to preventive services. Texas’ EPSDT program offers more than 50 free online Continuing Medical Education modules on pediatric and adolescent health-care topics, such as confidentiality. Several projects of the Oregon Pediatric Improvement Partnership focused on provider training across multiple topics, including developmental screening and anticipatory guidance.

Adopt Medical Home Policies

Four states adopted policies and programs to advance medical homes for children and adolescents, including two states that also focused on the general adult population including YAs. In 2006, Vermont established the *Blueprint for Health*, which implemented medical homes for both publically- and privately-insured populations, including AYAs, as part of a state-wide multi-payer initiative to improve health outcomes, control costs, and deliver quality care. The *Blueprint* initiative led to an increase in the rate of adolescent well-visits. In 2013, commercially-insured *Blueprint* participants received significantly higher rates of adolescent well-care visits than a comparison group with

Table 2 Strategies to increase receipt and quality of preventive care among selected states by adolescent and young adults

	Expand provider capacity to serve AYAs	Adopt medical home policies	Establish quality improvement projects	Enhance consumer awareness of well-visit
California				
Colorado	X ^a	X ^a		
Illinois	X ^a	X ^b		
Iowa	X ^a	X ^a		
Oregon	X ^a		X ^a	
Texas	X ^a			
Vermont	X ^a	X ^b	X ^b	X ^a

“X” indicates efforts reported for adolescent and/or young adult population

^aInformants reported efforts targeting adolescents only

^bInformants reported efforts targeting adolescents and young adults

similar insurance coverage (60% vs. 53%, respectively) (Vermont Department of Health Access 2014).

Establish Quality Improvement Projects

Two states established quality improvement (QI) projects focused on improving preventive service delivery among adolescents; no states reported such activities for YAs. In 2008, the Oregon Pediatric Society established a statewide initiative to promote the highest standard of care and practice in primary care settings called the Screening Tools and Referral Training (START). In 2012, START began the Adolescent Health Project to increase universal screening, brief interventions, and referral to treatment (SBIRT), a developmentally appropriate tool consistent with *Bright Futures* Guidelines. In 2014, START trained 23 clinics and 173 primary care providers and clinic staff on using SBIRT in the context of an adolescent well visit. By October 2014, all enrolled clinic sites reported using SBIRT among all adolescent patients; 25% screened consistently prior to the project.

Conclusion

This study identified strategies and areas for improvement that may be useful, as Title V programs and their partners across the country focus on the health care needs of AYAs in the context of ACA implementation and the Title V Transformation. These findings provide an opportunity for states to adopt specific strategies from top performing states as they seek additional ways to improve health care for AYAs.

We found that leadership on the state and local level, in public and private organizations, played a pivotal role in spearheading efforts to enroll and promote preventive visits among the AYA population. For example, county-level leaders in Texas sought federal enrollment grants to drive enrollment efforts, whereas state-level leadership in Iowa drove statewide enrollment efforts. Overall, initiatives tended to focus more on adolescents than YAs, and health insurance enrollment than delivery of preventive health services. This suggests further support is needed to strengthen the role of public health systems, including linkage to clinical delivery systems, to increase receipt of quality preventive services for AYAs.

In addition, more rigorous evaluations are needed to identify effective strategies to ensure that ACA implementation improves insurance rates and increases receipt of preventive visits as increasing numbers of AYAs are enrolled in insurance plans. For example, effective strategies are needed to promote use of preventive services (e.g., information campaigns about the importance of an annual visit);

strategies in this area should target AYAs, their caregivers, providers, health care delivery systems and insurers.

Similarly, as states fulfill the intent of the Title V Transformation goals and metrics, close monitoring will help assess the states' abilities to fulfill federal intent to improve the delivery of care, as well as ensure that evidence-informed strategies are shared among states.

Several factors limit the conclusions that can be drawn from this research. Descriptive studies like this rely on identifying a comparable set of key stakeholders and decision-makers across the states. We used several recruitment procedures to assure the broadest participant knowledge base, including connecting with State Title V/MCH Directors and in-depth web-based searches to identify state-level programs and directors. However, we were not able to systematically ensure that participants had the same role across the selected states, due to position vacancies, non-responses, and refusals to participate. Additionally, other factors that were not assessed in our research may have contributed to the high rates of insurance and receipt of preventive health care among AYAs. For example, employment rates in selected states might have contributed to increased employer-based insurance coverage among YAs who gained coverage via their parents' plans. Disaggregating between public and private rates of insurance could yield a better understanding of factors that may have contributed to high enrollment figures for each type of insurance program, as well as access to preventive health visits. While other important factors, such as follow-up care, impact health care quality, the identification of promising state-level activities to improve insurance enrollment and preventive visits can benefit other states. Direct causal relationships cannot be determined without further evaluations.

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Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interest.

References

- Brooks T., Miskell S., Artiga S., Cornachione E., & Gates A. (2014). Medicaid and CHIP Eligibility Enrollment, Renewal, and Cost-Sharing Policies as of January 2016: Findings from a 50-State Survey. The Kenry J. Kaiser Family Foundation. Resource document. <http://files.kff.org/attachment/report-medicare-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2016-findings-from-a-50-state-survey>.

- Centers for Disease Control and Prevention. (2014). *Behavioral Risk Factor Surveillance System* [data file]. Retrieved from http://www.cdc.gov/brfss/data_documentation/index.htm.
- Hagan, J. F., Shaw, J., & Duncan, P. (2008). *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* (3rd ed.). Elk Grove Village, IL: American Academy of Pediatrics.
- Institute of Medicine and National Research Council (2014). *Investing in the health and well-being of young adults*. Washington, DC: The National Academies Press.
- Kogan, M. D., Dykton, C., Hirai, A. H., Strickland, B. B., Bethell, C. D., Naqvi, I. et al. (2015). A new performance measurement system for maternal and child health. *Maternal and Child Health Journal*, 19(5), 945–957. doi:10.1007/s10995-015-1739-5.
- InsureKidsNow.gov. (2016). CHIPRA Cycle I Grants. Retrieved from <https://www.insurekidsnow.gov/downloads/initiatives/grantssummary-2009.pdf>.
- National Center for Health Statistics. (2012). *National Survey of Children's Health* [Data file]. Retrieved from <http://childhealthdata.org/learn/NSCH/data>.
- Ozer, E. M., Urquhart, J. T., Brindis, C. D., Park, M. J., & Irwin, C. E. Jr. (2012). Young adult preventive health care guidelines: There but can't be found. *Archives of Pediatrics and Adolescent Medicine*, 166(3), 240–247. doi:10.1001/archpediatrics.2011.794.
- Twietmeyer L., Brindis C.D., Adams S., Park M.J., & Irwin C. E. Jr. (2016). Improving access to health insurance and the quality of preventive visits among adolescents and young adults: A compendium of state and local strategies. Resource document. National Adolescent and Young Adult Health Information Center. <http://nahic.ucsf.edu/compendium/>. Accessed June 1, 2016.
- Vermont Department of Health Access. (2014). Vermont Blueprint for Health 2013 Annual Report. Retrieved from <http://www.leg.state.vt.us/reports/2014ExternalReports/296747.pdf>.