Between Two Worlds: Adolescents and our Health Care System
The Centene Corporation
Alliance for Health Reform
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ED HOWARD: Okay. Why don't we try to get started? My name is Ed Howard. I'm with the Alliance for Health Reform and on behalf of Senator Rockefeller, Senator Blunt, and our Board, I want to welcome you to this program today on the Special Health Needs of Adolescents in America.

There are 42 million people in the United States between the ages of 10 and 19. That's the common definition of adolescence, but by no means the only one, as you are about to hear as the briefing goes on. Most of these people are healthy, so those with health problems often get overlooked by policy makers and the public, but just consider there are 4 million people between 10 and 18 who are uninsured. Twenty percent of adolescents have a diagnosable mental health disorder and there are major gaps in the training given to health professionals in the often unique challenges presented by meeting adolescent health needs. And one particularly interesting aspect of this is the transitioning adolescents from pediatric to adult medical care are unreimbursed and therefore often neglected.

So, today we're going to take a look at the health and healthcare related needs of adolescents. Some of the challenges facing public and private programs seeking to respond to them, and we're going to take a look at some examples of promising efforts to do just that.

We're very pleased to have, as co-sponsors of today's briefing, the Centene Corporation which operates health plans for Medicaid beneficiaries and others in, gee, it's almost 20 states now.

A couple of housekeeping items. You'll see on the screen a hash tag if you want to Tweet about this hearing. The hash tag Team Health. If you need Wife there are instructions on the screen and on your table about how to connect for that purpose. In your packets there are a bunch of background materials. There's a sheet that lists a bunch of other background materials. There's biographical information on our speakers. There are copies of the slides they're going to be using so you can follow along. All of that is also on our website, allhealth.org. There'll be a video of this briefing on that website tomorrow, we hope; shortly thereafter, if not, and then a couple of days after that we'll have a transcript available for you to take a look at. At the appropriate time you can ask our panel a question by filling out one of the green question cards in your packets, or you can come to one of the microphones that you see in the audience. And at the end of the briefing we appreciate your filling out the blue evaluation form in your packet. If you're on a congressional staff we're particularly interested in your responses. Senator Rockefeller always said that our primary mission was to help the members of Congress get educated by educating the staff. So what you need is what we want to try to deliver and we'd appreciate your filling that out. And as a way of incenting you to fill that out and, actually you don't have to be on a congressional staff to be part of this, normally about a fourth of you take the trouble to fill out the evaluation form. If that number rises to 35% the Alliance will donate $50 to support the Adolescent Health Center at the

Children's National Health System here in D.C. and if 50% of you complete the evaluation, the donation to Children's will be $100. At the bottom of that slide—I hope you can read it better than I can on the confidence monitor—is the URL where you can go to get more information about the Adolescent Health Center and, for that matter, make a donation yourself in the giving season.

Before we get to the program, I ask your indulgence and the indulgence of the panelists as well, there are a couple of items I want to get to before we start so that no one's going to miss them. First, the lead organizer of the Alliance's preparation for this briefing is Deanna Okrent, our Senior Policy Associate, seated immediately in front here. She's been with the Alliance for going on 8 years now. During that time she's been our go-to staffer on issues involving the elderly particularly, not surprising given her background as a former official at the White House Conference on Aging—not the one coming up, but the previous one. She's written issue briefs and chapters of our sourcebook through the reporters, among other documents. This is Deanna's last briefing as a member of the Alliance staff and I want to take a minute to recognize her substantial contribution to our success over the last 8 years. Now, I'm pleased to say that we're not losing Deanna's skills altogether. She's agreed to take on a number of writing assignments for us over the next 6 months, an arrangement that's going to allow her and her husband, Chuck, to take those long biking trips and the even longer visits to grandchildren that she's been trying to fit in among her work duties over the last couple of years. Deanna, thank you so much for all your good work over the last period. [Applause]

Bear with me just one minute more. There's one other person for whom this is the last Alliance briefing, and that's for someone who's been with the Alliance for even longer than Deanna has, Senator Jay Rockefeller. Most of you know he's retiring at the end of this Congress, after 30 years of serving the people of West Virginia and the rest of us in America. Can't take the time to recite his achievements in healthcare or health policy but I have to note that the Alliance was basically his idea. As Chairman of the so-called Pepper Commission in the late 1980s he saw how his congressional colleagues struggled with the complexities of healthcare and health policy issues in a reform context and he actually convinced me and some others to help him form a bi-partisan, evidence-based entity to help members and their staffs understand the healthcare system and proposals to change it, and then he worked to make that entity succeed, including serving as Chairman of the Board for about 15 years. Now his hard work and his tenacity on health issues have triggered a whole lot of improvements in the healthcare system, particularly for vulnerable populations—the poor, children, frail elders, many more. And I should say that in one of his last acts as Honorary Co-Chairman, he recruited his successor, a Democrat to team with Republican Senator Roy Blunt to make sure you'll be able to continue to count on the Alliance for even handed policy information. As of January, the Alliance's Democratic Honorary Co-Chair will be Senator Ben Cardin of Maryland and, in your packets, there's a release that we issued when Senator Cardin's election to that position was announced. So we turn a page on a chapter in Alliance history and salute the

man who was the key to there even being an Alliance history, Senator Jay Rockefeller. Thank you, Senator Rockefeller. Yes, you may applaud. [Applause]

And, thank you all for enduring all of that boilerplate before we hear from the panel that we have recruited to edify us today, and it is an outstanding one. We're going to start on my far left with Dr. Leslie Walker. Dr. Walker is the Chief of the Division of Adolescent Medicine at Seattle Children's Hospital, and Professor and Vice Chair of Faculty Affairs in the Department of Pediatrics at the University of Washington School of Medicine. She's a pediatrician, as you may have inferred, a past president of the Society for Adolescent Health and Medicine, and a frequent contributor to the work the Institute of Medicine on adolescent health, and she's agreed to give us a start by presenting an overview of adolescent health needs. Dr. Walker, thank you for joining us.

LESLIE WALKER: Thank you very much. It's great to be here today to really participate in this dialog. So, let's get started defining what an adolescent is, what optimal health looks like, and how it is supported.

The Society for Adolescent Health and Medicine, the only multidisciplinary health organization dedicated solely to adolescent health, defines adolescence biologically and behaviorally to include those between the ages of 10 to 24 years. Those 18 to 24 years might be better called young adults, however, they're still undergoing scientifically confirmed changes in their brains, bodies, and behaviors that will not be completed until just beyond 24 years of age, making them deserving of specific attention when we look at this developmental period.

I want to spend a few minutes creating a vision of what it means to be a healthy adolescent accessing healthcare. Let me tell you about Crystal. She was a 16-year-old adolescent living in Seattle, which means that she went to a public high school with a full service school-based health clinic. In addition to physical health providers, it's comprehensively equipped with behavioral health support such as mental health counselors and a substance abuse therapist that's connected to the integrated federally qualified health center that runs the school-based clinic. This is important for Crystal because depression and substance dependence runs in her father's side of the family, so when Crystal's grades started to slip and she started to feel very anxious, her friend who goes to the school clinic told her to go to talk to a counselor there, and talking with the counselor confidentially it was clear that she wanted and needed her parent's support. Her mother and father were called to the clinic and resources for the whole family were recommended and given. Since her high school clinic was connected to a primary care clinic, her pediatrician was alerted when her combined health chart was updated. After getting comprehensive help at the school-based health center her grades improved and she stopped isolating from family and friends. Because her parents had been to an evidence-based drug prevention program, they knew their daughter's difficulties could lead to her trying easy solutions like drugs. They stepped up their monitoring and clear messages about their views on drug use and her health, so when an acquaintance handed

her a marijuana edible at lunch to ease her stress she turned it down. She graduated strong with skills to manage her mild anxiety disorder and she was on her way to being the first person to graduate from college in her family and hoped one day to be a counselor like the one that had helped her.

Compare that now to David, an 18-year-old adolescent who lives in rural Washington. David also had depressed mood and anxiety that emerged in high school. Unlike Crystal, David's school did not have a school-based health clinic on campus and, although there was high drug use in his school, drug counselors were not on campus and no prevention program for parents existed. David told his friend, too, that he was feeling stressed with dropping grades and panic attacks that he was feeling on the basketball court. His friend told him he read on the Internet that marijuana and alcohol could help with stress and sleep. David tried it and for a moment it seemed to help, but with his family history of drug dependence he was soon off to a new world where he spent his days wanting to get high. He was also having more panic attacks and consequently stopped playing basketball altogether. Pretty soon he no longer had energy or motivation to get up for class. His mom tried to get him to the doctor, worried about possible drug use, mood changes, and missing school but there were not any adolescent training providers in his clinic and no integrated behavioral services or telemedicine links, so no one ever talked to him alone. There were no confidential adolescent-friendly screening forms, and in the presence of his mom he denied drug use and mood issues. The doctor gave him some information on sleep hygiene and recommended coming back for immunizations and a checkup a few months later. David dropped out of school that year and after getting arrested a few times for possession of drugs he no longer had a dream of being a Navy Seal. He still has panic attacks; he gets high daily now and lives at home. He rarely sees his old friends anymore. He doesn't know life could be different. His mother doesn't know there could be help and his doctor doesn't know he has a treatable condition because David never went back for follow-up. Even if his doctor had known of his behavioral health condition there were no resources for drug use or mental health care for adolescents in their rural community. David has not yet been back to get his immunizations or a checkup and now he's too old to go back.

These stories are not unique. With the population of adolescents continuing to grow in the U.S. there is inequitable access to appropriate care across the country. At a time of accelerated development, initiation of potentially harmful health behaviors, and at a time where the right interventions can change the trajectory of a person well into adulthood, we have fragmented services.

So adolescent-focused behavioral health is a necessary component of adolescent medical services, anxiety and depression and substance abuse dramatically increase in adolescent and young adult ages. As you can see here more than 20% to 30% of all adolescents need ongoing services, even more need short-term help, and less than 10% of them get the recommended substance abuse services that they need, and much less than 50% of those that need care for depression and anxiety get that needed care. Without addressing these

types of concerns in adolescence we are assured of continued preventable mortality and morbidity in adolescence and continued morbidity into later adulthood.

In 2009, I was part of an Institute of Medicine Committee that published findings on adolescent healthcare missing opportunities. The report recommended a strategy for healthy adolescents, highlighting development matters, community matters, timing and skill matter, and policy matters. In November of this year, another Institute of Medicine Committee produced findings on young adults age 18 to 26, and this report, investing in the health and well being of young adults, we recommended actions that capitalized on the health opportunities that still exist at that age to change the trajectory of a young adult for a brighter, healthier future.

While there have been best practices for a while showing a way to address the complex web of services needed for optimal healthcare, a study recently came out in the Journal of the American Medical Association led by Dr. Laura Richardson, showing evidence that behavioral health services can be successfully integrated into primary care sites with superior results to regular care. With 42 million adolescents currently in the country, and growing, we have a severe shortage of health providers who have specific training in adolescent healthcare and development, and training in how to successfully transition adolescents to adult healthcare systems as they age out of the pediatric system. For example, in pediatrics the training only has one month of required adolescent health education and three years of training, and that's one of the disciplines that has the most training. Almost half of teens who see a primary care provider are not provided private, confidential time, even though it is a recommended standard of care. Repeated studies have found that teens many times do not disclose serious health concerns without privacy and confidentiality and they are more likely to forego care. With a majority of pediatric providers, they want to screen and care for this age group but not all providers have been trained to manage a confidential visit with the teen and they don't have the time to do so. There is one multidisciplinary program in the country that is dedicated to education in adolescent health: the HRSA-funded Maternal and Child Health Leadership Education and Adolescent Health program that trains 5 different disciplines together. They are only in 7 sites in the country.

In addition, adequate reimbursement for adolescent health visits is needed because they involve time with the parent and teen together and time with the teen alone. Also critical is a gap where less than 10% of high schools in the U.S. have a school-based health center on site, and this slide shows where they are.

For those that have opportunities to get care where they need it and want it and how it should be delivered there is still a need for integration of services so that regardless of where a teen or young adult goes for care it is linked to an extended medical home with trained providers. It is not uncommon that one teen may need multiple services: chronic disease care, mental health care, substance abuse care; and these three systems of care are not now integrated.

In summary, transition to adulthood must be valued and supported as a critical time to ensure health along the life course. To deliver effective adolescent care development matters, community matters, needs and equity matter, skills matter, and policy matters. Adolescent healthcare must not only be affordable but accessible, appropriate, equitable, and accountable. With this I would recommend implementing integrated physical and behavioral health medical home models specific to adolescent and young adult population including school-based health centers, continued and sufficient support for the adolescent health to lead a national agenda to improve the health and well being of adolescents and young adults, and develop and implement specific research, informed benchmarks, and recommendations for physical and behavioral health quality in adolescent health. Also, increased resources and training for adolescent health providers focused on adolescent and young adults and healthcare transition, support for continued research with ready access to findings that promote evidence-based prevention and treatment guidelines for adolescents and young adults, and last, equitable availability of appropriate services in communities across the country.

ED HOWARD: Thanks very much, Dr. Walker. Excellent beginning, and now we're going to turn to Jenny Kenney who is the co-director of and a Senior Fellow in the Health Policy Center at the Urban Institute. She's an economist; she's a nationally known expert on Medicaid and CHIP, among other topics. She's a former Alliance for Health Reform panelist; I'm pleased to say—

JENNY KENNEY: I finally got asked back.

ED HOWARD: [Laughter.] And, Jenny is going to highlight some of the challenges and priorities in securing access and coverage for this population. Jenny, welcome back.

JENNY KENNEY: Thank you. I want to thank the Alliance and Centene for sponsoring this event. It focuses on such a critical developmental period in the life cycle that has profound implications for health trajectories in adulthood. I also want to thank Leslie for laying such a great foundation for today's discussion.

I'm going to use the time I have to focus on financial access to coverage and care for adolescents and close with a few remarks about the year ahead where a number of policy changes are possible in the landscape that could affect both younger and older adolescents.

I'm going to start with a reminder about the powerful link between coverage and access to care. Survey after survey finds much greater barriers—cost barriers—to care for the uninsured versus the insured. These estimates are courtesy of Leslie from a Commonwealth paper by Sarah Collins and you see lower cost barriers to care reported among the adolescents who were continuously covered, or young adults who were continuously covered but much higher barriers—cost barriers—among those who are

uninsured with over half of this particular age group, which was 19 to 29, reporting that they had skipped or gone without needed treatment or care because of cost concerns.

Wow. That is light. [Laughs.]

ED HOWARD: My apologies.

JENNY KENNEY: The ever disappearing Affordable Care Act. [Laughter.] So this slide focuses on the Affordable Care Act, which, as we all know, was passed in 2010 and was designed to reduce uninsurance through accommodation of a Medicaid expansion for adults with incomes up to 138% of the federal poverty level, Medicaid expansion to children who had been in the foster care system up through age 25, an expansion of dependent coverage to allow young adults up to age 25 to remain on or be enrolled in their parents' coverage, new subsidies for the population between 138% and 400% of the federal poverty level accompanied by a set of market reforms in the nongroup market, new investments in outreach and enrollment aimed at getting more eligibles enrolled, and an individual mandate that includes penalties for noncompliance.

Since we'd already achieved historical lows in uninsurance rates among the population below age 18, the ACA coverage provisions were really designed to target uninsurance among not only adults, but it also extended federal CHIP funding through fiscal year 2015 and included maintenance of eligibility requirements on Medicaid and CHIP coverage for children through 2019. In 2012, before these major coverage provisions were implemented there were an estimated 8.7 million uninsured between the ages of 10 and 24 with over 80% concentrated in the 19 to 24 age group. The high concentration of the uninsured in the 19 to 24 age group derived at that point in time from the much higher rates of uninsured in that age group relative to the younger adolescents aged 10 to 18, and while, as you can see here, there is an income gradient in the uninsured rate for both younger and older adolescents, it's much more pronounced among the 19- to 24-year-olds where those with incomes below 200% of the federal poverty level being 25 percentages points more likely to be uninsured than those with incomes above 400% of the federal poverty level.

This graphic depicts how coverage changes across the adolescent age spectrum. Going from age 10 to age 24 you see that the risk of being uninsured increases with age, with particularly large jumps when kids turn 18, 19, and 20. If you look at the ends of the age spectrum in this group you see 24-year-olds being four times as likely to be uninsured as 10-year-olds back in 2012. And underneath this pattern with respect to uninsurance across the age spectrum you see that it's driven by very different rates of public coverage, coverage through Medicaid and the Children's Health Insurance Program wherein 40% of the 10-year-olds relied on Medicaid of CHIP for coverage in 2012 compared to just 14% of the 24-year-olds.

Not surprisingly, given the uninsurance pattern that we observe across the age spectrum as kids go from 10 to 24, as they grow older and pass into young adulthood their rates of unmet health needs also rise in a pronounced way. And when we look historically, in the last several decades going back to 1984 when Medicaid expansions were initiated for children, going through the creation of the Children's Health Insurance Program in 1997 you see really dramatic declines in the uninsured rates among the 10- to 17-year-olds that live below the federal poverty level. Those rates were 32.8% in 1984 compared to 13.1% in 2012. In contrast, over the same time period, the uninsured rate for 18- to 24-year-olds living below the federal poverty level stayed above 30% in all these years. So this gives the historic sweep of why, when we look in 2012 before the first open enrollment period to Affordable Care Act, why the coverage profile is so much different for young versus older adolescents.

But I want to draw your attention to the more recent period and you do see the 18- to 24-year-olds and non-poor 18- to 24-year-olds gaining coverage between 2010 and 2012 and that's precisely when the dependent coverage provisions were implemented. They actually wanted, with the earlier ACA coverage provisions, to be implemented and other research has documented that over a million young adults gain coverage due to the dependent coverage expansions. But keep in mind that they really benefited the young adults who were fortunate enough to have parents who themselves have coverage that could include the children, the young adults.

When we look at the more recent period, 2013 to 2014, we do have some early data from the Urban Institute's Health Reform Monitoring Survey which suggests that the uninsurance differential between older and younger adolescents may be narrowing. This graphic shows that the uninsured rate among the 18- to 24-year-olds fell from 22% to 18.4% between mid-2013 just before the first open enrollment period the Affordable Care Act was implemented and mid-2014. In contrast, we don't see meaningful change for the 10- to 17-year-olds over that same time period and while this is a national picture we'd expect to see different patterns according to whether the states have expanded Medicaid or not, given what we're observing for the entire non-elderly population.

Beyond age and income where you live matters too. Among younger adolescents, uninsured rates are found under 5% so the younger adolescents in many of the Northeast states have uninsured rates that are under 5%, but interestingly, low prevalence of uninsurance among the younger adolescents is not limited to the Northeast. You have states like Alabama and Iowa that have also achieved very low uninsured rates in this particular demographic; in contrast you have states like Texas, Nevada, and Alaska where, for this younger adolescent group, the uninsured rates are over 15%. But when you look at the older adolescents across the board, in each and every state, you see higher uninsured rates for the 18- to 24-year-olds than for the 10- to 17-year-olds. Only Massachusetts and D.C., back in 2012, had an uninsured rate for the older age group that was below 10%, and fully 11 states had uninsured rates that were above 30% for this older demographic. As I said, we're starting to see drops in the uninsured rate for this

older adolescent group but the difference is, while narrowing will certainly not be eliminated anytime soon.

So let me close by focusing on the year ahead. As I said at the outset, it's a year full of a lot of uncertainty on the policy front. First and foremost, how many additional states will implement the Medicaid expansion? Right now we're at 28 plus D.C. Today there's news that Tennessee has a plan. A couple of other states in the Northwest are proposing to expand Medicaid, at the same time there's a possibility that some states that have expanded that Medicaid may roll that expansion back. Arkansas has to re-up every year and so we'll be watching that with great interest. There's a lot of question about how much additional enrollment Medicaid programs will attract, how close to reaching full participation they'll be, and, importantly, whether they'll be able to meet the increased demand. Second, the pending Supreme Court decision slated to be handed down in June 2015 could mean that no federal subsidies are available in the states that have not established a state-based exchange for marketplace coverage. This would affect consumers in over 30 states and would especially hit hard in states that have not expanded Medicaid, since that's the only new financial assistance available to the uninsured in those states. Third, while I focused on the uninsured and affordability issues due to lack of coverage, it's really important to keep in mind that affordability poses problems for those with ESI, Employer Sponsored coverage, and marketplace coverage as well. The growing prevalence of high deductible plans for those with employer sponsored insurance, and the out-of-pocket spending burdens faced by many, particularly lower income individuals and families with marketplace coverage may keep some of these older adolescents with coverage from getting the care that they need in a timely way. Fourth, and finally, the future of the Children's Health Insurance Program is up in the air. If Congress fails to act, no new federal funding will be available after October 1, 2015. Given the high cost of dependent coverage facing many low income families and the rules governing who is eligible for marketplace subsidies and how those subsidies are structured, the elimination of CHIP would almost certainly increase the number of 10- to 18-year-olds who lack coverage and raise the financial barriers to care for many who switch from CHIP to a different type of coverage.

So, with that, I'll close. Thank you.

ED HOWARD: Thanks very much, Jenny. I should say, by the way, that a couple of months ago we did a briefing about the CHIP program that contained a lot of background information on what the actual legislative situation is. That's an actively pursued topic of conversation among the leadership with responsibility in Congress for these things, so we will be trying to keep you up to date on the CHIP reauthorization and funding bundle over the next couple of months.

Meantime, we're going to turn to Tamara Smith. She's the CEO of the YWCA in the National Capital Area where she has led the YW to put a major emphasis on social justice and women's economic empowerment issues. And today she's going to highlight for us

some of the strategic partnerships that are important to connecting teens with the resources for them in their communities. Tamara, thank you so much for coming with us.

TAMARA SMITH: Thank you. Good afternoon everyone, and I'd also like to thank the Alliance and Centene for hosting this briefing today, and I'm honored to be with my fellow panelists, Leslie, Jenny, and Victoria, who bring extensive expertise in research and policy as well as in innovative and effective healthcare delivery system models.

I've worked in the D.C. area for the last 30 years in the healthcare sector and now in the nonprofit sector so I have seen the benefit of the increased coverage from the Affordable Care Act as well as from local legislation to increase insurance. I've seen the increase in number of school-based adolescent and health programs as well as more collaboration in public-private healthcare and non healthcare sector around population-based solutions to improving health.

So, my objective today is really to talk about one of the programs of the YWCA of the National Capital Area. It's called our Empower Girls Program and we believe it's made a difference in the overall health and well being of adolescent girls. Empower Girls is a 9-month program that operates every other Saturday during the school year with a curriculum of about 14 modules that focus on nutrition, healthy relationships, exercise, academic skills building, mentoring, self esteem building, anti bullying, violence prevention, STEM career exploration, and college readiness. We've partnered with many organizations: Department of Energy, Howard University, University of Maryland School of Engineering, Women's Cyberjutsu, and others to support our STEM career exposure as well as providing access to strong role models. I'll talk about why that's important.

We've also collaborated with Children's National Medical Center, United Methodist Women, The Links, and others who have helped us develop curriculum as well as provided expertise in the area of developing healthy lifestyles, anti bullying, and healthy relationship curriculum. A specific curriculum we developed was called "Fighting Back," and it's a peer to peer curriculum that teaches peers about healthy relationships, how to avoid sexual exploitation, and how to self advocate. Each of our program participants is matched with a near-peer mentor, usually a college-aged student or a young professional. A typical program day includes a start with breakfast, checking in on how the week's been, any issues the students and young girls have experienced, and then followed by an in depth conversation on the topic of the day, followed by luncheon speaker, role model interaction, 45 minutes of exercise, and then a wrap up and evaluation. It's really a comprehensive program that focuses on creating health awareness, providing skills, putting exercise and a health component into the program.

All of our mentors, in particular, have training to recognize signs of abuse, neglect, behavioral issues. They talk with their mentees each week and they build relationships of trust with their girls and oftentimes with their parents. If problems are identified we work

with our social worker and our leadership team to refer our girls to needed programs and services in the community.

All of our participants complete a survey at the beginning and the end of the program to assess their social skills, leadership skills, confidence and self esteem levels. What's important is that we actually collect data and this shows some of the data that we collected that looks at teens and near teens. It's a little difficult to read, but basically we're testing what their social skills are at the beginning of the program, how well they interact with their peers, what kind of self esteem they have, what their leadership skills are like how well they work with groups, as well as how well they can plan and how well they can problem solve. And we absolutely see a difference from the beginning of the program to the end of the program, just because of the skills building that we're doing, the mentoring that we're doing, and the information that we're sharing.

We've been operating the Empower Girls program for about 4 years now. Our program participants have stayed in school—no dropouts. Seniors have gone on to college, no teen pregnancies, and their feedback show that their level of confidence, self esteem, ability to communicate with their peers, and their ability to self advocate really has improved. Recently we had a senior who was fighting with her mother, who was kicked out of the house during the school year and found housing with another relative. She told her mentor and us that if it had not been for the Empower Girls program and the support of her mentor she would've never finished school, would never have been able to apply to college and then go on to college. You've heard from the experts, I think the slide was before, showed a little bit about the issues facing adolescents: risks for depression, obesity, poor self esteem, they're victims of peer bullying, they're victims of poor health habits, partner violence, at risk for substance abuse, engage in risky behavior, and are often witnesses to domestic violence in their own homes. How many of you know that the average age of a young woman involved in sex trafficking and transactional sex is 13? That's a 6th or 7th grader. So we know that community based programs like Empower Girls, and many others, provide mentors, role models, problem solving skills, and life changing programs that can even be life saving. There's a handout in your packet from one of the school-based health programs, Charlotte Hagar, and she talks about the number 1 deterrent of teen pregnancy is a young person having a mentor, having somebody to talk to. It's so critical in their ability to work through the challenges in things that they face on a day to day basis.

My second objective today is to talk about my personal story. Why is this panel discussion important in our ability to develop more integrated health and community-based programs so important? Why? And I'll talk a little bit about a two-generation program—is it important?

Six years ago I joined the YWCA. I left a 25-year successful career in healthcare. I was CEO of a local Medicaid Managed Care Plan. One of our plan participants was a mother of four girls. She had a history of substance abuse, behavioral health issues, she was a

high school dropout, she was unemployed, and she was living with her children in an abandoned home. The father of the girls was terminally ill. In a state of despair and with no sense of hope she did the unthinkable. She killed her four girls. That was a life changing moment for me. I made a commitment that I would use my time and talent to make a difference in the lives of women and girls. And I realized that there were thousands of girls in this city and in this region who needed more than just health coverage. She had health coverage. They need support. They need problem solving skills. They need education. They need role models, mentors and, most of all, they need hope, things most of us that are educated, who have strong families, professional support systems, take for granted.

So, I'm actually excited to be here today because the work that we're doing together is important and I want to briefly share some exciting work using a two-generation model that the YWCA is implementing with College Success Foundation and the Washington Area Women's Foundation. It's a partnership that will result in the development of a two-generation program and it will talk about and develop programs for both adolescents and their female caregivers. The program will support academic preparation, college readiness, workforce readiness, employment placement support, as well as mentoring and life skills development, health information, and behavioral health support, as well as case management for both girls and adults.

As you can imagine, both adults and teens face many of the same issues: substance abuse, depression, violence, chronic illness, and lack of life skills. Research has shown that parents and caregivers that have an education, employment opportunities, an ability to support themselves and their families, as well as their children, they'll be more successful and better able to sustain their economic future and overall well being. One of the keys to success for the two-generation program is really building more partnerships, working with both community providers, government and local funders, social service organizations, and community-based providers. We each bring expertise, and you've heard from many of them today, but we have to work together to really develop comprehensive and integrative programs that help our teens and our parents be successful.

So, I'm hopeful about the future. I'm hopeful that the overall health and well being of our teens and their parents and caregivers can move forward because it'll be through collaborations and information sessions like this where we become much more educated about the needs of our communities. Thank you for the opportunity to be here and I look forward to your questions.

ED HOWARD: Thanks very much, Tamara. Can I just ask a couple of quick factual questions? What are the ages of the girls in Empower Girls' program?

TAMARA SMITH: The ages range from 1st grade to 12th grade, so we have the elementary school girls, the middle school girls, and then the high school girls. The majority, 50%, are the teenage girls that are between 13 and 18.

ED HOWARD: And what's the scope of the program? How many girls have you been able to, um –

TAMARA SMITH: Serve.

ED HOWARD: —serve. Thank you very much. You know all those technical terms.

TAMARA SMITH: A little less than 100 over the past few years. You know, they come back every year. We're at a community-based site at our facility. Next year our plan is to go actually into the schools to reach more and to be in a school-based program as well.

ED HOWARD: Okay. Thanks very much. Victoria Ward is batting cleanup for us today. She is the Bronx Regional Director of Psychosocial Services at the Institute for Family Health of Greater New York. She's responsible for delivering behavioral health services at six federally qualified health centers in the Bronx. She's not only an administrator, she's a hands-on social worker who's been actually delivering behavioral healthcare in a range of settings for years, and teaching others how to do it. She's going to bring us today some insight into how an FQHC can successfully integrate behavioral health and primary care. Vicky thanks for coming.

VICTORIA WARD: I have a big mouth but I'm going to try with the mic, too. So, I wanted to echo my fellow panelists and thank Centene and the Alliance for having me, and also thank my fellow panelists for their important contributions. So I am with the Institute for Family Health. You know, I think we were invited today to kind of give an example of an integrated care setting. You've heard from my fellow panelists that integrated care is really an effective way in which to serve our adolescent population.

So, a little bit about the Institute. It's the largest Federally Qualified Health Center network in New York State so we have about 20 some odd practices throughout New York City as well as the mid-Hudson Valley of New York, that's why it's called Greater New York. And I say 20 some odd because we're expanding rapidly and so two could open today and then I would be wrong, so I'm just saying 20 some odd centers, four of which are school-based health centers that are also integrated and seven of which are Article 31 outpatient mental health centers that are co-located with primary health centers.

So some of the things that the Institute is well known for are one, our innovation in use of health information technology to better serve our patients, and the other would be, you know, our integration, not only delivering the care but also going out into the nation and

training other programs to start implementing integrated care. So, we'll get into that right away.

Integrated care, at the very basic level, just needs a coordination of care. The primary and medical care with the behavioral health and with the idea that often medical issues and behavioral health issues happen at the same time. With that there are many different models of integrated care so I wanted to go over a few of those with you just to get you familiar.

So, co-located care is really just physical sharing of space between primary care and behavioral health. It doesn't necessarily mean that they're collaborating so sometimes the term co-located care is misused in implying that it's integrated care when that's not necessarily the case. In fact, I'm aware of a few different organizations that have co-located care, which is better than separated care, but the integration and the collaboration and coordination isn't necessarily there, so we don't want to take that for granted.

Collaborative care is usually used interchangeably between integrated care and coordinated care, so collaborative care is what we're speaking of when we're talking about different healthcare providers and disciplines working together to treat the same patient. I'm going to skip down to multidisciplinary care. In hindsight I would've flipped that on the slide but, oh well. So, multidisciplinary care is kind of the next step up where you have, again, what I was speaking of in terms of collaborative care, you have different disciplines working to treat the same patient. They often do share the health record of the patient, they're able to see each other's notes, they're able to consult and have case conferencing around the patient's treatment, but in multidisciplinary care what you also have is there's still that hierarchy in terms of the different disciplines and usually one discipline is making the sole decision in the patient's care which is particularly the primary care provider.

The next up above that is interdisciplinary care. Here you have everything with multidisciplinary care but, in addition, you have kind of that shared decision making among disciplines so that everyone is working together to decide, you know, what are our main goals for treatment for this patient. Here you have use of a shared care plan and, again, use of the patient record and interdisciplinary care is a little bit of a step up from multidisciplinary care. And then you have transdisciplinary care which we feel is the most sophisticated of the integrated care models, and this is what the Institute practices.

Everything that I just described about interdisciplinary care, however, in addition, what happens is that the disciplines are cross trained, not necessarily so that the disciplines can provide the care of other disciplines that may or may not be appropriate, but more so for each discipline to kind of know what the other discipline is doing and what we find is there is an anticipation of needs when that happens. So if I'm working with a patient in terms of behavioral health and I know that primary care is focusing on these aspects I can prep the patient for that or talk about attendance at the medical appointment, or schedule

the next medical, so there's a little bit more of an anticipation of needs in terms of working together. And transdisciplinary care is, there are less boundaries between the disciplines which is nice. So those are some examples of some models.

So really, integrated care is the most ideal kind of form or setting for adolescents. I don't want to belabor the issue. Thankfully, I have the luxury of going last, so my panelists have given you a lot of data on how adolescents are more likely to receive primary care, not only because of access but because of insurance, and also obviously stigma. There's also, it's well documented in your packets as well as by my colleagues in terms of prevalence of comorbidity, you know, so for example, obesity and depression, you know there's a lot of comorbidity between medical and mental health needs. And also, the early onset of behavioral health issues, so that's also in your packet as well, just in terms of how many, many mental health disorders kind of start to present symptoms in adolescence. So, those are some of the reasons why integrated care would just be the best model for our adolescents.

One of the things that really help in integrated care is the use of an electronic health record and so, again, I had spoken about sharing of the patient's health record and if it's electronic then that's really what we really strive for in integrated care settings. With the use of electronic health records, of course, it also means that providers can go into the system and look at notes and labs and, you know case conference and consult in that way but above that, because it's electronic, there are so many other things that we can do. So, for example, we use patient and provider portals. So what that is, ours is My Chart, My Health, and this is a way in which patients can login, be on the Internet, be at a secure portal to access their health record. They can schedule appointments; they have direct contact with their providers through electronic communications that's confidential. They can access their labs and different parts of their medical record. The other thing that we have is Institute Link, which is our community portal. Right now we have about 120 organizations that are participating in Institute Link. These are community based organizations so, and particularly with adolescents, we're talking about foster care programs, preventative services, community outreach programs, a program like YWCA that Tamara spoke of—they're logged in, they go through a training, they cover all their bases in terms of consents. They can also access the record and they can access the medication list, the problem list, which is all the diagnoses, they can access, again, they can communicate with providers electronically and things like that, and that's really helped with integration even for the organizations that, or for the patients who seek services outside of the organization.

The other thing to remember is, as we know, our adolescent folks are very tech savvy, so they love this kind of way in which they can incorporate technology into their care. We do have an app for the smart phones that the adolescents love. They have direct access to their providers and we know, you know, when the adolescents are more supported and feel like they're more connected they're more likely to access care and continue to access care and build those relationships.

Just briefly, your regional and information exchanges, we can have data uploaded to our electronic health record about any patient hospitalizations that our patients may have, any outside providers, and what happened at those services, and also it's a very interesting or optimal way for quantifiable health outcomes so we're really able, using electronic health record and the data that we can export from that, we can really track to see are our patients getting better. So, for example, we have a very sophisticated depression registry where we track their depression scores through the PHQ9, which I'm sure most of you know is the standardized tool for that, and we're able to really see are these scores getting better and we track and trend that information.

The other thing is that since we provide care in rural and urban settings, so New York City as well as the mid-Hudson Valley, which is more rural, we have first hand kind look at the disparities in access to care, which has already been talked about. And we'll use eating disorders as an example, so we know that to treat eating disorders you need a very integrated system. You know you need primary care working with mental health. We need the weights monitor, we need nutrition monitored, and those types of things, and so what we've found—and I just did a layman's search in New York City just to kind of see what would come up, and at least 10 reputable programs came up in New York City in terms of the Renfrew Center, which I'm sure most of you are familiar with, and really great programs, and in Ulster County all that comes up is individual psychotherapists, you know, private practice, which is really not going to be the best in terms of integrated care.

So just to wrap up, integrated care really does bridge the gap. It's a one-stop shop. It kind of increases the access, however, I wanted to leave you with the fact that changes are needed in order to increase the likelihood that integration kind of expands and particularly with our billing standards. So right now there's a fee for service model. What that means is we get one payment for a day of service regardless of how many licensed professionals our adolescents see, or our patients in general see. So, for example, if I have an adolescent who's seeing the primary care provider, a nurse who was triaged before the primary care provider, then they come up to see me for a behavioral health visit. They see the psychiatrist for their medications. That's four licensed professionals who have seen that patient and we're only getting one bill, we're billed for one service. So that's really a deterrent for a lot of organizations to be able to do this. We're fortunate enough to supplement with grant funding and since we're federally qualified we get federal dollars, but, you know, that's really going to be kind of a deterrent to others to really be able to do this.

And with that, I thank you.

ED HOWARD: Thank you Vicky. Let me just follow up on what you were just talking about with respect to payment. What share, if any, of your payments are coming from what folks are calling value-based systems as opposed to fee for service?

VICTORIA WARD: So, what I know is that we get a bundled payment as an FQHC, so it's a little unfair for me to talk about it because we get grant funding as well as that bundled payment, so I'm not – I don't know how it would look for others, but I do know that most others have the fee for service model too, which again is a deterrent to really bringing people together because if I'm in a different organization then I'm getting billed for my behavioral health service and then the primary care is getting billed as well. So that's really what we've found has been the biggest deterrent to integration.

ED HOWARD: And you say changes are needed. Is the basic change the need for a change in payment?

VICTORIA WARD: Yes. I would say primarily from our anecdotal perspective that's what we feel would be best. We go around and train other organizations throughout the nation and this is often what they bring up to us as a barrier.

ED HOWARD: Very good. Thanks very much.

Great presentations from the panel. Let me just remind you that we do encourage you to Tweet. As you can see the Teen Health hash tag, and encourage you to fill out the evaluation form before you have to go.

There are microphones that you can use to ask a question now. If you do use those microphones I'd ask you to identify yourself and your institutional affiliation, if there is one. And I would appreciate it if you have a question that you don't want to bother getting up for, if you would use one of the green question cards and send it forward.

Okay. Let me start, while folks are getting their questions written and their nerve up to stand up, Vicky talked about the difference between the care in the rural setting and care in the city and I was reminded of what Dr. Walker had talked about in trying to deliver services to David, as opposed to the previous example. Are there lessons to be learned in the kind of cross pollinization or the techniques used by Vicky's organization in trying to reach folks like that?

LESLIE WALKER: I think one of the things – we have a lot of rural communities that we serve in about four states including Alaska and Alaska, especially around this time, people can't come even if they could fly they can't get out, so telemedicine, I think, is one of the main ways we've been – one of the things we've used to even do behavioral health. We're actually trialing it out in our adolescent division with eating disorders, because many of those kids need to be seen weekly and there's no way you can fly from a very rural place weekly, and we're trying that out to see how well that works even with eating disorders because these kids need help, and their outcomes are very different if they don't get an evidence based way of treatment.

JENNY KENNEY: We also use telemedicine and it's interesting because of Skype, you know, adolescents are way more receptive to and at ease with this form of treatment than our adult population, which is interesting, but yes, telemedicine is really necessary for the rural communities.

ED HOWARD: Yes, go right ahead.

FLORENCE FEE: First of all, thank you so much to the panel for an excellent discussion. My name is Florence Fee, I'm with No Health Without Mental Health. I have two questions. Firstly for Dr. Walker, your institution, the University of Washington, has a really outstanding program called the AIMS Center, Advancing Integrated Mental Health Solutions, and they have been a real pioneer in developing the collaborative care model which is an intervention in primary care that includes the patient, the PCP, the care manager, and the psychiatric consultant working off a common electronic health record to integrate physical and behavioral health for adults across a variety of medical settings. So my question to you, Dr. Walker, was have you worked with the AIMS Center at the University to see if that could be applied in the Adolescent Center, and then just quickly, I have a question for Victoria, are you aware of any studies that show the comparison between the effectiveness of collaborative care, integrating physical and behavioral health, in rural FQHC's that have trouble accessing behavioral health versus the effectiveness of referring those same patients to specialty behavioral health via telemedicine? Thank you.

LESLIE WALKER: Yes. I touched on it very briefly, but you do have one of the articles in your packet that was from a group that was started by Dr. Laura Richardson, that's exactly what she did. She worked with the AIMS, some of the investigators there, and developed the same model looking at primary care sites for adolescents and integrating behavioral health, and she did show that depression was decreased and it was superior to regular care. And the thing that was interesting about that is that this was in a closed loop system called Group Health, it's kind of like Kaiser if you're familiar with Kaiser, so that all the kids did already have access to mental health, but it wasn't integrated. There wasn't a collaborative model and somebody there in the primary care setting. And so she brought that additional collaborative heath model into a closed system, and those kids had superior depression remission to the kids that just had regular care, even though those kids had access somewhere in the building. Because it wasn't right there in primary care it made a difference. So she's one of the first people that's shown that in adolescent health it. And the article is in your packets from the *Journal of the American Medical Association*. She's continuing to do work there as well.

VICTORIA WARD: And I also just got back from training the AIMS in motivational interviewing. We've been working with the AIMS Center as well and we trained them in the collaborative care model and things like that, so I'm very familiar with that work. In terms of the question about efficacy of the rural FQHC versus telemedicine, what I would just say is without data right in front of me is that anecdotally we always default to the

FQHC and we actually use the telemedicine at the FQHC if we aren't able to bring those patients in due to transportation. That's another huge thing in rural settings is lack of public transportation and things of that nature. So I would say that because we use FQHC as the default and we use telemedicine kind of as the exception to the rule I would say that the data is probably more in favor of FQHC in the rural settings and, you know, if you approach me after I can give you my card. We could definitely give you more information on that—more data.

ED HOWARD: Okay. We have a couple of questions that have come forward on cards about the school-based health centers and there was a slide showing the penetration of various geographical breakdowns of those. First of all, how do these centers get funded; secondly, how do you plan to integrate mental behavioral health services in school-based programs, and not only where does the money come from, but how are providers paid? What kind of reimbursement payment is used? A whole bundle of questions, it seems to be quite an effective technique. Why is it not more widespread?

LESLIE WALKER: Money is an issue. In Seattle, in Seattle proper there's a levy that the citizens have voted so that money goes directly and it's a very secure system for the school-based health centers there, so every public school in Seattle has a full service school-based health center, and full service means a provider that can give medications, can put birth control methods, long acting reversible control contraceptives. They can treat medical conditions. But, you know, actually nationally a big part of school-based health centers is, and the reason people go, is for mental health. They usually have some sort of counselor there if it's a comprehensive center. It's much beyond having a nurse. This is a full – you can walk in and get your healthcare. For some kids, this is their primary care provider to be able to go to their school-based health centers. But I do think, you know, there is a lot of concern about how is it funded.

Each individual—you know, in different places it's done differently where you might have an FQHC, doing the work, we have, like our hospital has one of the school-based health centers in Seattle, so there's a lot of partnership usually with it; an outside healthcare group in the school, but the school-based health centers actually are separate. A teacher can't go and get a kid's records and what's happening to their health. It's a separate system which is very important as well for confidentiality for kids.

VICTORIA WARD: So, usually it is the larger organizations that kind of—you know, we have four. We have one in Harlem, two in lower Manhattan, and one actually up in the rural area, and just like Leslie had said, there is a social worker embedded to be able to provide the behavioral health services. But, yes, to get around the funding again it's these larger organizations—hospitals or large FQHC's that are able to kind of come in and provide the care. That's basically it.

ED HOWARD: Okay. Yes, ma'am.

AUDIENCE MEMBER: Thank you. I'm Peggy McManus with the National Alliance to Advance Adolescent Health, and I have two questions. First one is for Jenney Kenney. Do you have any estimates of the proportion of the increase in uninsured that might happen if CHIP is not passed among the 10- to 18-year-olds?

JENNY KENNEY: We're working on updating analysis that we did a couple years ago right now, so in the first part of 2015 we'll have updated estimates. But, Peggy, I'd have to go back and look and you're raising a really good question about whether we actually have separate estimates for that age group. That's something we could do that I don't know that we've planned to do, so.

AUDIENCE MEMBER: It would be great if you could. Ten- to 14, 15 to 18. And a question for Leslie, for the issue of private time with adolescents, which you raise, is a really important issue and one that is not widely available. I'm wondering if SAM or the AP is planning on doing any kind of educational efforts or outreach efforts to really make that a more widespread target of improvement. Thank you.

LESLIE WALKER: I know the Society for Adolescent Health and Medicine does have a grant to try to help promote preventive services, you know, outside of our organization, because most people that would go to an adolescent health conference already would know that private time is essential for kids, but there is some push to try to make that more possible for people. I think a lot of people would like to do it but they tend to not know how to do it and how to integrate it and how to get it covered if a team discloses something at the last minute when they have a full clinic. I think there's a lot of logistical issues that people feel constrained with if they haven't had training on how to do it in a smooth and efficient way.

ED HOWARD: Yes, Mary.

AUDIENCE MEMBER: Hi, I'm Mary Tierney. I'm a pediatrician and in my past I ran the Early and Periodic Screen Diagnosis and Treatment Program. I'm very interested in finding out if any of you have worked with the school nurse programs, not the school based health centers, and if you have what are lessons learned, barriers, good things that happened, and what worked and what didn't.

ED HOWARD: And can I ask whoever would like to respond to that to first take 30 seconds or whatever you need to describe the important differences between school based health centers and the school nurse program. We'll see if we can get them from them, if not we'll get—

AUDIENCE MEMBER: Yes, I mean, usually there is not like someone that is an independent practitioner who can write prescriptions and do all that. It's oftentimes the school nurses that take care of the youngsters.

ED HOWARD: And it's decidedly not a separate system.

AUDIENCE MEMBER: No, and oftentimes it's funded by the schools themselves, and, you know, the school system, like in the district with the superintendent of schools, not always. It's very nebulous.

LESLIE WALKER: With this – I've seen it work very well where there's a school based health center and a school based nurse and they're co-located in the same area, which is wonderful. Not every kid that has access to a school based health center will sign up to go. You know, the majority of kids, it's wonderful if you can get 60% of the kids signed up in the school based health center. I haven't heard of a situation where 100% of the kids were signed up, so in a good situation if a child gets sick or has worries or needs some support they might be told go to the school nurse, and then the school nurse can either, you know, maybe they need to just go home or, you know, it's something fairly straightforward, maybe not. And if it's not, being able to get them signed up or referred if they're already signed up to the school-based health center for further help, I mean, that's the ideal way I've seen that work. I've also seen it where they're, you know, the systems are always—I'm not seeing them together. They usually are funded separately, so, you know, in a difficult situation they're not co-located and they're not working together necessarily. But I think over time, you know, the years that we've had now with both systems working together it seems to me I've seen more groups working well together than I've seen difficulties.

ED HOWARD: Anybody else? Yes, sir.

AUDIENCE MEMBER: Hi. My name is Adam Swanson with the National Council for Behavioral Health. As was established earlier today, most adolescents exhibit a serious mental illness before the age of 25. Miss Smith, my question is for you. I'm curious about, if any, what type of training you do with faculty in your organization outside of the licensed clinical social worker, and then, on the back end, once you recognize that you have some type of behavioral health condition, how are you building partnerships with other community based organizations, and can you speak a bit about that?

TAMARA SMITH: Sure. It's a great question. I think I mentioned a partnership with Children's National Medical Center, and I would say that more of these partnerships are absolutely critical because we are not the individuals with expertise in the behavioral health issues, so those behavioral health providers training our mentors and our staff around recognizing problems and signs of issues and then our being able to develop a list of community based resources where we can refer our young girls to support, so it's the partnerships that are critical to help train our staff to recognize problems, it's the partnerships that are critical for us to be able to refer our girls out. We do have a clinical social worker that we do work with but, I mean, they're not doing actual treatment. They're just going to help with that referral process.

ED HOWARD: Several of you have focused on the school based health centers in—oh, I'm sorry. Go right ahead.

AUDIENCE MEMBER: Melanie Zanona with CQ. Jenny mentioned some of the big policy issues in healthcare next year, but I'm wondering about the effect of some of the issues that were not acted on this year in Congress such as the Medicaid Doctor Pay Parity program or anything else that you thought might have been acted on this year but wasn't.

JENNY KENNEY: You probably know more than I do but it sounds like the Medicaid fee bump may still be taken up in early 2015. I don't know what the prospects are but for those who don't necessarily follow Medicaid that closely, in 2013 and 2014 with federal funding Medicaid fees for primary care services were raised to Medicare levels in every state but that was a 2-year time limited policy and the Kaiser Family Foundation surveyed states a couple months ago and I think maybe 15 states said they anticipated— 13 or 15 states—anticipated maintaining the higher level or some boost to the Medicaid fees with state dollars. There were a number of states that said no, they weren't going to be using state funds to do that, and then a good number that said they hadn't really made up their mind. I think one of the challenges is that the evidence about the impact of those changes is really challenging to establish given the time frame.

ED HOWARD: And by that you mean, among other things, that a lot of states actually didn't implement it anywhere close to the time period when it was available?

JENNY KENNEY: That's right. The federal regs came out very close to the end of 2012 and it was a complex policy to implement because it also had to be implemented, not just in fee for service but in the managed care setting, and there were issues about identifying the physicians who could qualify and whatnot. So, while the information that's available indicates that all states have implemented, but that's absolutely right. It didn't happen on January 1, 2013.

ED HOWARD: Yes. Go right ahead.

AUDIENCE MEMBER: Hi. My name is Suzanne Mackey. I'm with the School Based Health Alliance and I just wanted to thank you all for incorporating school-based health centers so much into this briefing. And just to add a little bit to some of the questions earlier about how school-based health centers are funded, I think that was what the question was around, so about 30% of the 2500 school-based health centers nationwide are sponsored by FQHC's and so they do benefit from the enhanced rate and all the things that come with being an FQHC, but that means that 70% don't have access to that, so they're sponsored by health departments, medical centers, hospitals, nonprofits, so that's a big challenge because even though a number of states do put in state funding for school-based health centers there is no dedicated federal funding for school-based health centers, and that's something that we've been trying to work on for a long time. And

then, in terms of billing, most of our centers, the vast majority of them, are billing Medicaid and whether it's fee for service or in a lot of states where it's pretty much all managed care, but there are a lot of services that they provide that they do not get paid for and so there's a big gap there. So, thank you so much.

ED HOWARD: Well, stay there for a second if you would. I'd love to be able to draft expertise because, as I said, we have a couple of other questions related to this. One of them is what's being done in the schools to detect the warning signs of mental health and substance abuse?

AUDIENCE MEMBER: In school-based health centers?

ED HOWARD: In school-based health centers, well, yes, by school-based health centers or, I guess, by school nurses or any other means, but if you've got 2,000 of these things, presumably they're doing some of this.

VICTORIA WARD: Well, I think it's a mix. We get referrals to our school-based health centers from teachers directly. We get it from the nurse who does a little bit of triaging and then with our electronic health record and we have a battery of assessments that are at our fingertips, they're standardized and they're a way in which to assess things very quickly in terms of do these referrals really pan out? Are there significant mental health issues at work here, and go from there. But I think it's a mix of different referral sources. Parents can come in, identify things, though that's less likely to happen. Those are the different ways in which those things are identified.

ED HOWARD: Are there privacy, special privacy concerns in that context?

VICTORIA WARD: Yes. I mean, especially in our non school-based health centers we have definitely made sure that we were able to acknowledge that anyone 12 and above can access confidential care for reproductive health and things of that nature which a lot of teens prefer to keep confidential. We have blocks on our portals so that parents can't get access and in the school-based health center it's very similar. So unless we have the consent from the patient that treatment is protected. It's protected, as Leslie said, from the teachers and the staff if the patient doesn't prefer etcetera, etcetera.

ED HOWARD: Leslie.

LESLIE WALKER: Also, one of the things that I think that's helpful too when you have school-based health centers in the perfect sense, I mean, you know, it's all across the country. There's, you know, 2500 or so, so there's probably many different ways of doing this, but some of the things I've seen at different centers that's nice is they don't just wait for kids to come into the clinic but they go out. People in the clinic can go out and do teaching, you know, screening. When I was here at Woodson High School, which is here in Washington, D.C., when I used to work here, they had a whole assembly where

they would go out and talk about things and get kids, you know, aware of depression or violence, how to manage those things, another way to draw them into the clinic or at least just to have kids that need some help and are looking for it to find a way to get that help. So I think it doesn't have to just be in a clinic, when you have that expertise in the school, in the best sense, that can work with the school system as well to give the teachers and the administrators some support.

ED HOWARD: Does that comport with your members' experience?

AUDIENCE MEMBER: Yes. Absolutely. I mean, in order for the centers to remain sustainable financially they need to go out and let the students know that they're there and be active. So it really is about a partnership between the schools and the students and the families. It doesn't work unless that's all there.

ED HOWARD: Okay. Well, thank you very much. And this question actually comes on the heels of these school-based centers and that is that insurance coverage, school-based practices are all important reaching adolescents who are in school living with parents, however, we've defined adolescents as including people up to 24 or, in some cases, 26. What can be done to reach those 18- to 24- or 26-year-olds who are not in school living on their own? How do you encourage them to seek treatment or care with or without insurance coverage?

TAMARA SMITH: I can speak to that.

ED HOWARD: Tamara.

TAMARA SMITH: I could speak to you for a moment. We have a program for young women, young adults 18 to 24. It's really in our adult literacy and workforce readiness program, but many of those in that category of individual, low income, may not have finished school, be out of school and looking for opportunities to finish their education and find employment. And so, it's through programs like that and there are many other adult programs that reach that 18- to 24-year-old population, and I think it's the assessments that we do. We do behavioral health assessments; we match them with case workers just to really understand what their health issues are, and be able to, again, refer and direct them to the services in the community.

LESLIE WALKER: The other thing I would add, just so people know, there are some school-based health centers that take people in their community, not just the kids that are in school, so the kids that are out of school could still access the school in their community with a school-based health center. Not all of them do that, but some do and some will even see people in the community, not just kids that age. So, again, having that be a nexus in a community for people to get healthcare is an exciting possibility.

The only thing I think, it's hard to access kids once they're out of school, but people are looking at how we can do that with social media, you know, doing that in an employment setting. There's many ways people are looking now to try to really identify how do we get the kids that aren't in school and the young adults aware that they can sign up for coverage, aware that there is care, and that they can get help. I think it's an ongoing issue we have to really work on.

ED HOWARD: Jenny.

JENNY KENNEY: I was just going to say, from the poor young adult-adolescents, we know that they can be reached at pretty high rates through other family members who are already enrolled in Medicaid, through SNAP, the food assistance program, and so that there's some pretty efficient ways to reach out and identify those who are in this target population. Getting them to enroll is a different matter.

VICTORIA WARD: Right, and community health, I mean, one of the things that we have to do is go out into the community in some way. So it may not be schools, we do community health fairs right on the street in the communities. We do it on a Saturday, give a lot of, you know, provide free food and things like that, particularly for the low income areas, to attract them, engage them and so those are some of the things that we have to do in order to really get the message out in addition to Facebook and things like that.

ED HOWARD: Very good. Do you see up on the screen, by the way, a reminder about the evaluation and what's riding on whether or not you fill it out? So, we're almost out of scheduled time. We have a bunch of questions. I want to try to get to a few of them while we're finishing up here. Please pull out those forms and fill them. And I've got a question, a quick one I hope, for Jenny. Why are the uninsured rates in D.C. and Massachusetts so much lower for older young adults than in other states? I think I know half the answer to that question.

JENNY KENNEY: So, of course, Massachusetts expanded introduced health reform in the late part of the last decade and provided expanded access to Medicaid and subsidies for coverage and Massachusetts already had lower than average uninsured rates because it has a higher employer sponsored insurance base, but we absolutely saw gains in coverage for this age group and other non elderly adults following that expansion. The District, interestingly, while it didn't have a comprehensive health reform effort like Massachusetts, has kind of in a quiet way, expanded Medicaid in advance of the Affordable Care Act and so if you're a young adult, if you're in the District of Columbia, you're more likely to have access to affordable coverage than young adults living elsewhere.

ED HOWARD: Okay. Very good, thank you. We'll try to squeeze in a couple of questions before we adjourn this program. One of them has to do with foster care, and I

know a couple of you have referenced this in your remarks and there were some materials as well. First of all, have the ACA changes in coverage for foster care kids who age out dealt satisfactorily with the problems that we're presented by that policy, and then, also, how much of what was mentioned can be, as this questioner phrases it, lifted up and used to develop integrated health records for this population?

JENNY KENNEY: So, on the first question I did a quick scan of experts on this topic and to this point we don't have hard data on how effective the expansion of Medicaid to the former foster care youth has been connecting them with coverage. There is information out, surprisingly, that the implementation of this is uneven across the country and some states have greater success at reconnecting with these young people. My understanding is that there's some research in progress right now that might speak to this, but I think it's a really important topic that probably hasn't gotten as much attention as is needed.

ED HOWARD: Leslie.

LESLIE WALKER: I would underscore, you know, there are a lot of great practices, best practices that you heard mentioned here but we need a lot more research on what the evidence base is for a lot of things that are happening both with integrated care with adolescents and young adults in particular. So I think there's a lot of best practices that could be lifted up and implemented or tried and piloted in other places. But we do need to continue to do some research to find out the most effective of the best practices.

ED HOWARD: Okay. Alright. We've got, as Karnak used to say, the last question. Do any of your programs work specifically with young people who identify as LGBTQ? If so, what are the key components of the wellness for this population and do you collect data about sexual orientation or gender identity to help assess disparities for this group?

VICTORIA WARD: We have actually a very big LGBTQ community in the Institute that's actually been nationally renowned in terms of really being able to establish protocols for people who identify as such. So, part of our assessment is asking about sexual orientation and things like that. We also use a culturally informed assessment tool in our intake process, really getting at what are the aspects of your identity that have been a challenge throughout your life and what may have been a barrier to receiving care? So, we're really asking up front about those questions. Then, having said that, we have people, providers, who self identify and are willing to, if requested, are willing to provide care. We have a huge program that serves the HIV-related population and so the LGBTQ Committee works very closely with that program to ensure screenings and things of that nature. But also, it's really just about making sure that we're pairing patients up with providers with whom they feel comfortable to disclose and address their concerns. So that's something that we've presented on throughout the nation over the last couple of years.

JENNY KENNEY: And we have general screening that's actually recommended nationally that every kid—we see maybe about 12,000 or so kids, or have visits a year, and all of them are asked just generally, it's on the general screening form, what their orientation is. We also have a transgender health clinic looking at, you know, how can you be healthy transgender, do you need hormones, how to help the family understand and support their child during that process. And I think there are, across the country, there are clinics that are beginning to have clinics like that. I think just in general the healthcare system is beginning to accommodate and understand that there are differences and disparities in health for kids and adults who identify differently than what historically people have been trained to expect.

ED HOWARD: Okay. Well, with one more plea to help us evaluate these programs and make them better for you, let me just say it's been a really educational session for me, and I want to thank you for asking some very good questions. I want to thank our friends from Centene for allowing us to put this program together and helping us to put it together. And I want to ask you to join me in thanking our panel for a wonderful, wonderful description of the issues and some possible solutions.

[Applause]