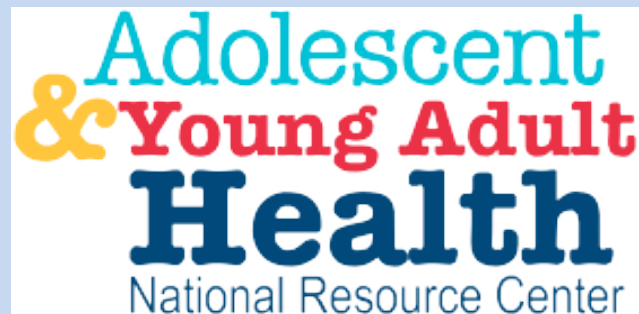
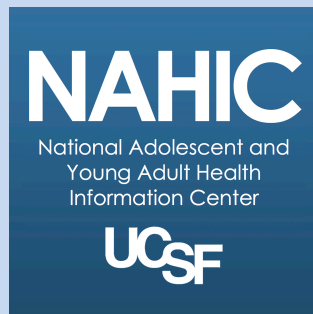


**Adolescent and Young Adult Health National Resource Center
The National Adolescent and Young Adult Health Information Center**

**Improving Access to Health Insurance and
the Quality of Preventive Visits
Among Adolescents and Young Adults:
*A Compendium of State and Local Strategies***



May 2016

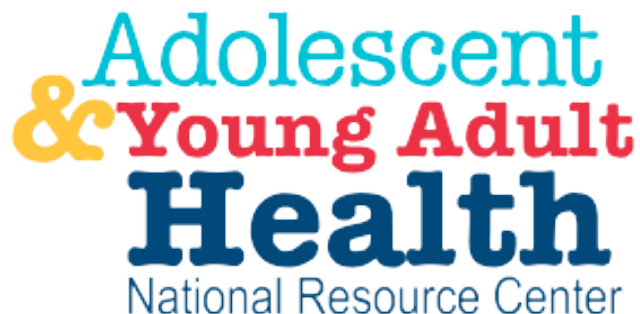
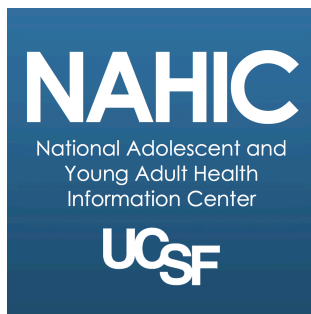
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http://nahic.ucsf.edu/resources/resource_center/



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ACRONYMS

AAPVT	American Academy of Pediatrics Vermont Chapter
ACA	Affordable Care Act
AKAA	All Kids Application Agents
AYA	Adolescent and Young Adult
CHAMP	Child Health Advances Measured in Practice
CHIP	Children’s Health Insurance Program
COYAC	Colorado Youth Advisory Council
DHS	Iowa Department of Human Services
ECHO	Enhancing Child Health in Oregon
Family PACT	Family Planning, Access, Care and Treatment
FPL	Federal Poverty Level
GCI	Get Covered Illinois
Hawk-i	Healthy and Well Kids in Iowa
HFS	Illinois Department of Healthcare and Family Services
IDPH	Iowa Department of Public Health
MCH	Maternal and Child Health
OHA	Oregon Health Authority
OPIP	Oregon Pediatric Improvement Partnership
OPS	Oregon Pediatric Society
QI	Quality Improvement
SBIRT	Screening, Brief Intervention, and Referral Treatment
SMART	Saves Medicaid Access and Resources Together
START	Screening Tools and Referral Training
YHII	Youth Health Improvement Initiative
YPH	Youth Partnership for Health

INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) of 2010 included several provisions to help adolescents and young adults (AYA) obtain health insurance coverage and gain access to key preventive health care services. This document describes state and local strategies that can leverage these provisions. This section provides an overview on the ACA and the potential role it can play in the health and well being of adolescents and young adults.

ACA and Health Insurance

The ACA's provisions to increase health care insurance address both private insurers and public insurance programs. First, states can opt to expand Medicaid up to 133% Federal Poverty Level (FPL) for adults regardless of disability, family status, and other factors that historically limited low-income adults from Medicaid eligibility. In addition, all state Medicaid programs are required to offer coverage for youth aging out of foster care until age 26; historically, many former foster youth lost Medicaid eligibility at age 18. States are also required to provide outreach to Medicaid-eligible vulnerable populations and reduce barriers to enrollment by streamlining application procedures.¹ Secondly, private health plans are required to extend dependent coverage up to age 26, regardless of the individual's financial, marital or educational status. Third, each state is required to have a health insurance exchange ("the Marketplace") for individuals and small businesses to shop for, compare, and purchase health insurance coverage. The Marketplace offers financial assistance through premium credits and cost-sharing subsidies to help lower-income individuals afford health insurance. Fourth, almost all health insurance companies are restricted from denying coverage to individuals based on pre-existing health conditions, such as diabetes, cancer, and mental illness.²

These provisions are especially important for young adults who have had low rates of insurance coverage historically.³ Among AYAs, significant disparities exist in rates of health insurance coverage, particularly among Latino youth and children from mixed-status familiesⁱ. Latino young adults are more than twice as likely as blacks or whites to lack health insurance coverage for an entire year (44% versus 21% and 19%, respectively).⁴ Citizen children with a non-citizen parent are twice as likely to be uninsured as children with citizen parents (40% vs. 18%). Currently, there are an estimated 1.8 million children with a non-citizen parent who are eligible for health insurance, yet remain uninsured.^{5,6}

ACA and Preventive Care

The ACA includes several provisions to promote prevention and wellness, in both the public and private insurance sectors. First, most private health plans—including both employer-based and individual market plans – are required to cover certain preventive services without cost-sharing from recommendations established by four expert medical and scientific entities: the U.S. Preventive Services Task Force ("A" and "B" recommendations); American Academy of Pediatrics/Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents; Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices; and the HRSA guidelines for Women's Clinical Preventive Services. Second, all marketplace plans are required to offer a comprehensive package of services called

ⁱ Refers to a family with members who have different legal status. This includes any combination of legal status, including: a) a non-citizen parent with a child born in the U.S.; and/or b) mixture of citizen and non-citizen siblings.

“essential health benefits,” which includes dental care for pediatric populations (ages 0-18 years), and mental health/substance use disorder services. Essential health benefits must also be provided to adults newly eligible for Medicaid in states that chose to expand their Medicaid program.²

Improving access to preventive care is especially important for adolescents and young adults (ages 10-25), who are less likely to utilize the health care system, yet experience higher rates of largely preventable health problems. Prior to the implementation of the ACA, young adults (age 18-25) had significantly lower past-year health care utilization rates for any health service than other age group. Less than half (48%) of young adults reported receiving a preventive care visit in 2011. The major health issues of adolescence and young adulthood are largely preventable with early identification and intervention; issues include substance use, obesity, sexually transmitted disease, and motor vehicle injury. Many of these problems are also linked to the major causes of morbidity and mortality in long-term adulthood.³

Purpose of Compendium











The purpose of this compendium is to identify best practices related to improving access to health insurance and quality preventive visits among adolescents and young adults. More specifically, the project aims to describe specific strategies and experiences of agencies, cities, communities, and states related to ACA implementation. This document systematically reviews the experiences of selected “top-performing” states in addressing the health needs of adolescents and young adults. In so doing, the authors aim to inform future efforts to assure that eligible AYAs are enrolled in health insurance and receive recommended preventive services. Given the relatively early stage of ACA implementation, results of state and local efforts to address AYAs have not been available in the peer-reviewed literature. Thus, this Compendium aims to fill a gap in existing knowledge of state and community efforts.

Organization of the Compendium

This Compendium presents promising practices across two areas: (1) increasing access to health insurance coverage and preventive visits, and (2) improving the quality of preventive visits. Within each area, the compendium presents identified promising practices according to specific strategies. Symbols are used throughout the document to help the user identify additional characteristics of state and local initiatives (See Box 1). Finally, this Compendium includes an Appendix with resource materials and more specific details on initiatives that are briefly highlighted within each theme.

This is a “work in progress” and we welcome contributions from other states and entities to this compendium. Recognizing the many efforts underway, we welcome additions and resources that may be useful to others as they embark on this important endeavor.

Box 1: Symbols Key

 Collaboration	 Mixed-Immigration Status
 Public-private partnerships	 Use of Media
 Bright Futures Guidelines	 Medicaid Expansion State
 Quality Improvement	 Medical Home
 Special Populations	 School-based health centers

METHODS

In order to develop this compendium, we first identified top-performing states in health insurance enrollment and receipt of preventive care visits among adolescents and young adults (AYAs). Two data sources were used to calculate state-level insurance and preventive visit rates—the National Survey of Children’s Health for adolescents and the Behavioral Risk Factors Surveillance System for young adults. These data sources were used to obtain rates on:

- a) pre- and post- ACA rates of insurance coverage;
- b) pre- and post- ACA rates of past-year preventive visits; and
- c) changes in pre-and post- ACA rates for both insurance coverage and preventive visits.

Based upon these sources of data, a list of 33 top-performers was generated and further refined to ensure broad geographic and demographic representation. We also considered the percent of a state’s population covered by Medicaid using 2013 data from the Kaiser Family Foundation to account for states that had a large Medicaid population.⁷ To provide geographic and demographic variability, the finalist states selected for the project were: California, Colorado, Illinois, Iowa, Oregon, Texas, and Vermont.

Second, guided questions were developed across two areas: improving access to health insurance coverage and preventive visits, and improving the quality of preventive visits among AYAs. Questions asked about previous efforts to improve access to health insurance and quality of preventive care, specific strategies to improve rates, and perceived barriers to care.

Third, maternal and child health stakeholders were recruited from the seven selected states. This involved conducting targeted outreach based on professional knowledge of AYA state-level leaders, for example, State Maternal and Child Health (MCH) Directors, recommendations from the State Adolescent Health Coordinators, and research of state-level young advocacy organizations (e.g., Young Invincibles). Outreach included email invitations to key informants to participate in one-hour telephone interviews, telephone follow up, and reminder emails. Selected respondents were then sent copies of the survey instrument to review prior to telephone interviews. Interviews were scheduled with respondents individually or in groups comprised of up to five individuals working together on AYA related efforts. Due to the nature of the study, the Institutional Review Board at UCSF granted an exempt status.

Fourth, interviews were conducted with twenty-five stakeholders between May and July 2015. Participants included three Title V/MCH Directors, six Adolescent Health Coordinators, four Youth Advocacy Stakeholders, and 12 state and county health employees. Phone interviews followed the written survey instrument, with supplemental probing questions added where appropriate to elicit additional information. Interview information was supplemented with reviews of relevant state and federal government websites, literature reviews, and conference presentation materials.

Fifth, qualitative analysis was conducted upon completion of the interviews. During weekly meetings, researchers reviewed interview data to identify common strategies related to increasing health insurance coverage and preventive visits, and improving the quality of preventive visits among adolescents and young adults in the selected states. The final strategies included in this compendium represent the most commonly used strategies across the selected states.

Cross-cutting themes were identified that were used across states, for example, in the focus on special populations of AYAs. The majority of successful states and local agencies adopted a wide range of strategies concurrently, thus, we incorporated the use of symbols across examples to help users of this compendium identify strategies of interest.

In the following section, we divide the findings by the two major elements of this compendium—strategies adopted to increase access to health insurance coverage and preventive visits, and strategies adopted to improve the quality of preventive visits.

STRATEGIES TO IMPROVE ACCESS TO HEALTH INSURANCE & PREVENTIVE VISITS

Strategy 1: Use Community Agencies and Networks

States and counties have utilized multiple strategies, including building partnerships and networks, to increase health coverage among adolescents and young adults. States with long-established, community-based partnerships were able to make great advancements enrolling eligible adolescents and young adults into public health insurance programs, like Medicaid and the Children's Health Insurance Program (CHIP). Additional information on each initiative can be found in the *Appendix* on page 18.

STATE LEVEL

Illinois

The *Illinois Department of Healthcare and Family Services* (HFS) began utilizing ALL Kids Application Agents (AKAAs) in 2005 to provide statewide outreach and enrollment to all children (up to age 18) regardless of income and immigration status. Under the direction of HFS, AKAAs conducted a multi-pronged outreach and enrollment approach by partnering with five state agencies, public-private entities, and health care organizations. For example, AKAAs partnered with the Department of Employment Security to make applications available to the newly unemployed. In addition, AKAAs partnered with the Illinois Chapter of the American Academy of Pediatrics to incorporate ALL Kids enrollment/application processes into over 40,000 doctors' registration procedures.⁸

Illinois conducted over 275 enrollment events by 2008, and increased ALL Kids enrollment by 33%.

In Illinois, the uninsured rate decreased among young adults (-23%), Latinos (-17%), and African Americans (-30%) between 2013-2014.



In 2013, *Get Covered Illinois* (GCI)—the state's health insurance marketplace—launched a comprehensive consumer assistance and outreach campaign to target Illinois' uninsured population, specifically diverse communities and young adults. First, GCI implemented a public education campaign through print, radio, television, social media, and special events. This included airing 23,000 radio advertisements aimed at African Americans and Latinos, partnering with Univision and Telemundo to host 30-

minute enrollment specials, and holding an educational event for faith-based leaders on promoting coverage in their congregations. In addition, GCI partnered with popular on-line platforms (e.g., [YouTube](#) and [The Onion](#)) to promote health insurance among young adults. GCI utilized a network of 1,200 navigators and 250 community-based organizations to provide one-to-one outreach to hard-to-reach populations. For example, GCI partnered with *A Safe Haven*, an organization that helps individuals overcome addiction and end homelessness, to provide training and part-time jobs to program participants. In 2014, program participants distributed over 20,000 signs in high traffic commercial areas to drive awareness about open enrollment.^{9,10}

STRATEGIES TO IMPROVE ACCESS TO HEALTH INSURANCE & PREVENTIVE VISITS

Strategy 1: Use Community Agencies and Networks

Iowa

Since 2006, the *Iowa Department of Public Health* (IDPH) and the *Department of Human Services* (DHS) have collaborated to increase enrollment and retention of children in Medicaid and the Healthy and Well Kids in Iowa (*hawk-i*) program, Iowa's CHIP. Each agency employed a comprehensive outreach and enrollment strategy. For example, IDPH contracted with 22 local Title V maternal and child health agencies - that serve all of the state's 99 counties—to provide local outreach through schools, faith-based organizations, and health care providers. DHS promoted *hawk-i* through statewide partnerships with the Department of Education's Free and Reduced Meal Program, and the Department of Revenue by requiring all taxpayers to indicate whether dependent children listed on their income tax form had health insurance coverage. Eligible families who indicated 'no' were sent program information along with a *hawk-i* application.¹¹

Iowa enrolled over 36,000 children into *hawk-i* by June 2014; a 69% increase since 2006.

Oregon's outreach program offers over 50 languages with a network of over 800 certified Application Assistants.

Oregon

Oregon Health Authority's (OHA) Community Partner and Outreach Program contracts with 230 partner organizations to provide statewide outreach and enrollment activities. Partner organizations include health care providers, community-based organizations, Tribes, health advocacy groups, and county health departments.¹² Past outreach activities include distributing over 150,000 informational flyers to K-12 students and collaborating with Portland Public Schools to incorporate

insurance questions (e.g., "*Does your child have health insurance? If not, would it be possible for a Community Partner to contact you regarding enrollment?*") in the enrollment packet provided to incoming students.

COUNTY LEVEL

Texas

In 2013, Texas had the highest uninsured population in the nation at 22% compared to 15% in the United States. The most populous county in Texas, Harris County, had over 4 million residents and an uninsured rate of 25%.¹³

In response, twenty-one organizations formed a collaborative partnership called *Enroll Gulf Coast* to coordinate, network, and streamline efforts to efficiently and effectively engage eligible populations in Harris County. Organizations within this collaborative include: a.) *Young Invincibles*, a national youth advocacy organization; b.) *Enroll America*, a health care enrollment coalition with over 4,600 national partners; and c.) the *Houston Department of Health and Human Services*. *Enroll Gulf Coast* has held enrollment events at K-12 schools, colleges, libraries, and other community events (e.g., LGBT Pride Parade).¹⁴

Enroll Gulf Coast's efforts led to the enrollment of 190,000 people during the first open enrollment period in Harris County.

STRATEGIES TO IMPROVE ACCESS TO HEALTH INSURANCE & PREVENTIVE VISITS

Strategy 2: Leverage Opportunities

Strategies put forth by federal health care agencies to increase adolescent well visits include leveraging clinical encounters to promote health insurance enrollment and access to preventive care.¹⁵ This may include using episodic and acute care to provide enrollment assistance, educating parents on the importance of well visits, and converting sports physicals into well visits.

States have utilized innovative strategies to leverage clinical and school-based encounters with adolescents and young adults to improve access to preventive care.

SPORTS PHYSICALS

Vermont     

In 2009, six state-level agencies (*The Vermont Principals' Association, the Vermont Departments of Health and Education, the Vermont chapters of the American Academy of Pediatrics, Family Physicians and School Nurses' Association*) agreed to recommend that middle or high school students participating in sports receive a comprehensive well exam (per AAP/Bright Futures Guidelines) instead of a sports physical.¹⁶ The *Vermont Department of Health School Liaisons* at each of the 12 Local Health offices also worked to inform school nurses at the Middle and High School levels about this recommendation. School Nurses were empowered to educate and engage school personnel, providers, and families in an effort to promote well visits and decrease barriers to access. For example, many school nurses provided outreach to these partners, tried to ensure students are connected to medical homes, educated parents on the importance of well-visits through school communications, and promoted the Bright Futures' periodicity schedule to local providers.

California's Family PACT mostly served clients under the age of 24 (42%) and Latino (64%) in FY 2012.

REPRODUCTIVE HEALTH

California  

The *Family Planning, Access, Care and Treatment (Family PACT)* program provides comprehensive services to eligible, low-income men, women, and adolescents in California. In 2012-2013, *Family PACT* served 1.8 million low-income Californians. Among the patient population in 2012, 79% were uninsured, 24% lacked a primary source of care, and 22% reported Family

PACT being their usual source of care. Moreover, a majority of the adult clients (65-80%), many of whom are young adults, were found to be eligible for January 1, 2014 ACA changes to Medi-Cal (California's Medicaid program) coverage or qualify for subsidized coverage through Covered California (California's Marketplace). Given providers' unique encounter with this uninsured but eligible population, many Family PACT sites screen clients for eligibility (69%), offer education regarding enrollment (77%), refer clients for enrollment assistance (90%), and offer enrollment assistance onsite (56%).¹⁷⁻¹⁹

STRATEGIES TO IMPROVE ACCESS TO HEALTH INSURANCE & PREVENTIVE VISITS

Strategy 3: Focus on Special Populations

Special, or “vulnerable,” populations are groups of people who have systemically experienced greater obstacles to health based on their racial or ethnic group, religion, socioeconomic status, gender, age, or many other characteristics historically linked to discrimination or exclusion. For AYAs, this may include an increase in physical and mental health problems, limited access to health insurance coverage, and a lower rate of preventive care visits. In response, *Healthy People 2020* set an overarching goal “to achieve health equity, eliminate disparities, and improve the health of all groups.”²⁰

Many state agencies and organizations have conducted extensive outreach to reduce health insurance disparities and improve health outcomes for special populations of AYAs, including former foster youth, Latino youth, and homeless youth.

FORMER FOSTER YOUTH

California 

Children Now, a national advocacy organization, launched an outreach campaign in 2013 called [CoveredTil26](#) to ensure all current and former foster youth in California knew they were eligible for Medicaid until age 26. The campaign provided direct outreach, technical assistance, and enrollment support through informational flyers, social media (e.g., [Twitter](#) and [Facebook](#)), and county-specific flyers with contact information for county staff especially trained to work with former foster youth and process applications. Outreach was also provided through Foster Clubs (a national network of 44,406 members and former foster youth), direct service providers, and other state agencies that frequently came into contact with former foster care youth.

Oregon experienced a 14% decline in the percent of Latinos without insurance between 2010-2014.

RACIAL/ETHNIC DIVERSITY

Oregon 

The *Oregon Health Authority* (OHA) partnered with Spanish media outlets and the Mexican and Guatemalan Consulates to promote messages related to health insurance enrollment among Latinos, including mixed-status families. Targeted advertisements ran on Univision and 8 Spanish radio stations to reach over 520,000 Latinos. In addition, OHA staff attended a 3-day soccer tournament with over 10,000 people—mostly Latinos—to promote enrollment and assure mixed-status families that health insurance will not affect their application for citizenship.²¹⁻²³

HOMELESS YOUTH

Illinois 

In 2013, *Beacon Therapeutic*, a non-profit organization that serves at-risk youth and their families, provided outreach and enrollment services to homeless youth at 50 shelters across Chicago. Outreach services were built on a system of peer advocates and incentives (e.g., gift cards and hygiene kits). Two adults and two adolescent peers, who lived in shelters, worked with case managers to recruit and enroll homeless AYAs. Case managers provided follow-up to applicants to ensure they were formally receiving care through medical homes and retained health insurance coverage.²⁴

STRATEGIES TO IMPROVE ACCESS TO HEALTH INSURANCE & PREVENTIVE VISITS

Strategy 4: Engage Youth

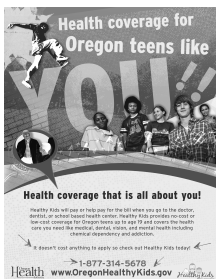
A guiding principle of Positive Youth Developmentⁱⁱ is Youth-Adult Partnerships, which occurs when youth and adults work in tandem to improve programs and policies that affect the lives of youth.²⁵ Research has shown that programs using youth-adult partnerships often demonstrate greater effectiveness, and offer potential benefits not only to youth, but to the adults and organizations that serve them.²⁶ Youth-adult partnerships can vary in their form (e.g., youth advisory boards) and level of shared decision-making (i.e., youth directly impacting the design and delivery of a program or policy). While youth advisory boards may not directly address increasing health insurance enrollment and preventive visits, they play an important role in addressing the legislature and other key stakeholders on the important issues facing youth.

Many state agencies and organizations have utilized youth-adult partnerships to engage youth in outreach and enrollment efforts, while others have raised awareness on the unique health needs of AYAs.

OUTREACH

Texas

In 2015, *Enroll Gulf Coast* partnered with *Young Invincibles* to host a health festival called Rock Enroll Houston to increase awareness about the ACA and provide critical enrollment information to eligible young adults ages 18 to 34. This event provided live music, giveaways, free health screenings, and enrollment assistance to over 2,500 attendees. In addition, young adults were involved in the public relations and entertainment of this event. For example, two youth representatives spoke at the event's press conference to encourage enrollment, and all the live music was performed by young adults ages 18 to 34.^{27,28}



MARKETING

Oregon

In 2011, Oregon Health Authority's (OHA) Youth Advisory group created a teen-friendly flyer to promote health insurance enrollment among AYAs. This flyer was promoted for two years via the OHA website, Planned Parenthood clinics, Federally Qualified Health Centers (FQHCs), and schools. For example, flyers were placed in every student's take home folder across the state. This flyer ended up being "one of the most successful flyers" for OHA because "it did not look like a flyer from the government, so teens related to the message."

POLICY

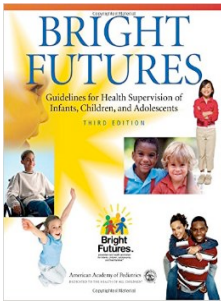
Colorado

In 2008, the State Legislature created the *Colorado Youth Advisory Council* (COYAC) to formally advise and provide policy recommendations to elected officials on issues affecting Colorado youth. Each year, Council members ages 14 to 19 meet with state legislators and subject matter experts to develop a list of formal policy recommendations. For example, in 2014, the Council focused on improving access to mental health services through school systems and school-based health centers (SBHCs).²⁹ This was seen as an important strategy as currently there are 54 SBHCs in Colorado that provided over 103,000 primary care visits to over 31,000 children during the 2012-2013 school year.³⁰

ⁱⁱ Evidence-based approach that guides communities in developing and implementing services, opportunities and supports so that young people can be engaged and reach their full potential.

STRATEGIES TO IMPROVE THE QUALITY OF PREVENTIVE VISITS

Strategy 1: Commitment to Bright Futures Guidelines



The ACA requires private health plans to offer all children certain preventive care services and screenings without cost-sharing. The ACA preventive service provision does not apply to children in Medicaid programs; however, many state Medicaid agencies have adopted Bright Futures as the standard of care for their Early Periodic Screening, Diagnostic, and Treatment programs. As of August 2015, twenty-five state Medicaid agencies have adopted Bright Futures' periodicity schedule.³¹

BUILDING PARTNERSHIPS

Illinois

In 2011, the *Illinois Chapter of the American Academy of Pediatrics* partnered with the *Illinois Department of Healthcare and Family Services*, the state's Medicaid agency, to revise its [Handbook for Providers of Healthy Kids Services](#) to reflect Bright Futures guidelines as the standard of care in Illinois. The two organizations reviewed what was included in the Handbook and determined what needed to be updated regarding promotion and reimbursement to ensure that the Medicaid program was consistent with the Bright Futures guidelines and the ACA.³²

Illinois' adolescent well-visit rate has increased from 41% to 47% since adopting Bright Futures.

Vermont currently has a 47% well-visit rate for adolescents ages 12-21 in Medicaid.

PROMOTING BRIGHT FUTURES TO PROVIDERS

Vermont

In 2008, the *American Academy of Pediatrics Vermont Chapter (AAPVT)* organized a roadshow that travelled to 12 different regions across the state to teach providers about Bright Futures recommendations, which had recently been adopted as the standard of care by Vermont's Medicaid program. Meetings covered a range of topics, including an overview of Bright Future standards,

a discussion on preventive services, and a review of AAPVT's role in the partnership. AAPVT also purchased and distributed Bright Futures guidelines and pocket guides to state practitioners.³²

Oregon

In 2012, Oregon's school-based healthcare state program partnered with the Oregon County Health Information Network to develop an electronic health record system based in Bright Futures guidelines that enables clinicians to better provide preventive care to adolescents in school-based settings.^{33, 34}

During the 2013 school year in Oregon, 32% of patients received a well-care visit from a SBHC.

STRATEGIES TO IMPROVE THE QUALITY OF PREVENTIVE VISITS

Strategy 2: Focus on Medical Homes

The Patient-Centered Medical Home (“medical home”) is an approach to providing comprehensive and continuous preventive care for all individuals. This approach relies on a team of providers (e.g., physicians, nurses, nutritionists, pharmacists, social workers) to meet a patient’s health care needs including access to timely and preventive care.³⁵ Research has shown that pediatric medical homes are associated with increased provision of preventive services for children.³⁶ This includes an increased likelihood of receiving anticipatory guidance, and increased rates of past-year preventive visits.^{37,38} For example, a national study of over 26,000 children ages 0-17 found that care in a medical home was associated with an 11% increase in the receipt of preventive visits.³⁹

As of March 2015, 46 states and D.C. have adopted policies and programs to advance medical homes in their Medicaid and/or CHIP programs.⁴⁰

Vermont

In 2006, *Blueprint for Health* (“Blueprint”) was established as a state-wide multi-payer initiative to improve health outcomes, control costs, and deliver overall better care in Vermont. A core component of Blueprint is implementing the medical home model. The establishment of Community Health Teams, through Blueprint, allows providers to offer enhanced services with the well-care visits, such as care coordination, enhanced nutrition counseling, access to a health coach, and social services when needed. Successes include improved clinical quality on adolescent well-care visits, higher rates of primary care visits, and lower annual per-member health care expenditures relative to comparison groups. For example, Blueprint participants received higher rates of adolescent well-care visits than the comparison group in 2013 (60% vs. 53%, respectively).⁴¹

Vermont has 121 Blueprint providers operating as medical homes to over 514,000 patients as of December 2013.

In 2012, 45% of Colorado children in Medicaid/CHIP had an identified medical home compared to 41% in 2007.

Colorado

The Colorado Medical Home Initiative began in 2001 in response to the Title V/ MCH national outcome measure, *all children will receive comprehensive coordinated care within a Medical Home*. This initiative is a systems-building effort that brings together over 40 representatives from various sectors (e.g., government, health providers, and policy-makers) to build a sustainable system that delivers quality health care, including access to

preventive visits, for all children in Colorado. The Initiative was formally expanded through 2007 legislation (SB 07-130) that established medical homes for all children in Medicaid/CHIP.^{42,43}

Illinois

In 2006, the *Illinois Department of Healthcare and Family Services* implemented the Primary Care Case Management Program founded on the Medical Home concept called Illinois Health Connect. Between 2007-2010, Illinois Health Connect saved the state \$531 million in healthcare costs. In response, the Illinois Legislature passed a series of Medicaid reforms called Saves Medicaid Access and Resources Together (SMART) Act of 2012. The SMART Act required 50% of Medicaid recipients be enrolled in a medical home by 2015.⁴⁴

In 2012, 29% of Illinois children ages 0-17 in Medicaid/CHIP had a medical home; a 45% increase since 2007.

STRATEGIES TO IMPROVE THE QUALITY OF PREVENTIVE VISITS

Strategy 3: Quality Improvement

Quality improvement (QI) “consists of systematic and continuous actions that lead to measureable improvements in health care services and health status of targeted patient groups.”⁴⁵ This involves using well-defined measures to collect practice-level data, implementing evidence-based strategies, and monitoring implementation to ascertain whether change has occurred. Successful QI projects can produce a range of benefits, including: a) improved patient health outcomes that involve both process outcomes and health outcomes; b) improved efficiency of managerial and clinical processes; and c) avoided costs associated with process failures and poor outcomes.

Vermont

The *Youth Health Improvement Initiative* (YHII) began in 2001 to support pediatric and family practices with improving preventive services delivery for youth ages 8-18. Between 2010-2011, YHII worked with 12 practices to improve the rate of several screening procedures linked with an adolescent well-care visit, including screening for Chlamydia among sexually active patients under the age of 21. Strategies included establishing protocols for delivering confidential results, implementing processes for obtaining sexual histories from patients, and implementing practice-wide screening changes.

Youth Health Improvement Initiative increased rates of chlamydia screening from 11% to 70% across 12 Vermont practices.

CHAMP increased rates of adolescent depression screening from 32% to 97% across 17 Vermont practices.



In 2012, the *Child Health Advances Measured in Practice* (CHAMP) project began to increase the efficiency, economy, and quality of care provided to Medicaid-eligible children and families. In 2013, CHAMP conducted a QI project across 17 practices and 28 providers to increase rates of depression screening and follow-up among adolescent patients. Strategies included increasing utilization of validated screening tools, administering the Patient Health Questionnaire (PHQ-9)—a nine

question diagnostic tool to screen for depression—at all adolescent well visits, and improving communications and connections with local mental health services.⁴⁶

Oregon

The *Oregon Pediatric Society* (OPS) is the state chapter of the *American Academy of Pediatrics*. In 2008, OPS established a statewide initiative to promote the highest standard of care and practice change in primary care settings called Screening Tools and Referral Training (START). In 2013, START began the Adolescent Health Project to increase use of the Screening, Brief Intervention, and Referral Treatment (SBIRT)—a developmentally appropriate tool that is consistent with *Bright Futures*—for depression and substance use screening within the context of the adolescent well-visit. By October 2014, all enrolled clinic sites reported using standardized tools to screen for depression among all adolescent patients; 25% screened consistently prior to the project.⁴⁷

START trained over 1,130 primary care providers and 1,500 health care workers in Oregon as of 2014.

STRATEGIES TO IMPROVE THE QUALITY OF PREVENTIVE VISITS

Strategy 4: Capacity-Building

Capacity-building is “the development of sustainable skills, organizational structures, resources and commitment to health improvement in health or other sectors, to prolong and multiply health gains many times over. This involves not only providing skills and awareness, but also creating channels, by means of partnerships, policy and leadership, through which this learning can be transferred into sustainable action.”⁴⁸

States have engaged in building the capacity of providers to improve the quality of preventive care that they deliver to adolescents.

DEVELOPING MATERIALS

Vermont    

In 2007, the *Vermont Department of Health*, in collaboration with the *American Academy of Pediatrics Vermont Chapter* and the *Vermont Academy of Family Physicians*, developed a web-based Provider’s Toolkit to offer providers an organized compilation of current standards and materials of preventive health supervision and health screening for children and adolescents based on Bright Futures recommendations. The toolkit offers multiple ways to access information, including a Search by Age and Search by Screening Topic/Service.⁴⁹

TRAINING PROVIDERS

Oregon      

The *Oregon Pediatric Improvement Partnership* (OPIP) is a public-private partnership dedicated to improving the health of children and youth in Oregon. Since its establishment in 2010, OPIP has led several projects focused on implementing Bright Futures elements related to developmental screening, adolescent screening, and anticipatory guidance. For example, OPIP’s Enhancing Child Health in Oregon (ECHO), a medical home learning collaborative, engages providers in medical home transformation. Since 2011, ECHO sites have received trainings and webinars on the implementation of SBIRT.⁵⁰

Texas  

The state’s EPSDT program, *Texas Health Steps*, offers over 50 free online Continuing Medical Education modules on pediatric and adolescent health-care topics for providers and other health professionals. The modules are also available (*and free!*) to anyone in the general public. The adolescent health modules cover health screening, substance use, behavioral health, nutrition, confidentiality, and depression screening with SBIRT. Links to these modules can be found in the *Appendix* on Page 18.⁵¹

NEXT STEPS

We would like to extend a special thanks to the 25 Title V/ Maternal and Child Health stakeholders who participated in this project. This compendium would not have been possible without your insights, wisdom, and continuing commitment to improving the health and well being of adolescents and young adults.

It is our hope that the body of resources and strategies presented in this compendium can assist other states as they seek additional ways to assure that eligible AYAs are enrolled in health insurance and receive the preventive health care services built into the Affordable Care Act of 2010. We also hope this compendium will provide valuable insights to the 38 states who have chosen National Performance Measure 10 as part of their 2015 Title V Block Grant Program—percent of adolescents (ages 12-17) with a preventive medical visit in the past year.

Given the relatively early stage of ACA implementation—and lessons learned are still emerging—the compendium will be updated periodically as new information and resources become available.

STRATEGIES TO IMPROVE ACCESS TO HEALTH INSURANCE & PREVENTIVE VISITS

APPENDIX

Bright Futures

The Bright Futures initiative was launched in 1990 by the Maternal Child Health Bureau, in partnership with the Centers for Medicare and Medicaid Services, to improve the quality of health promotion and preventive services for children from infancy through age 21. A core feature of Bright Futures is the *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, a comprehensive set of health supervision guidelines; the third and most recent edition was released in 2008. Another important tool produced by Bright Futures is the periodicity schedule, which is a schedule of screenings and assessments recommended at each well-child visit from infancy through age 21.

Enroll Gulf Coast

In 2013, twenty-one organizations formed a collaborative partnership called *Enroll Gulf Coast* to coordinate, network, and streamline efforts to efficiently and effectively engage eligible populations in Harris County. Organizations within this collaborative include *Young Invincibles*, *Enroll America*, and the *Houston Department of Health and Human Services*. Representatives from each partner organization are divided into five working groups. This includes:

- *Operations*: Provides review, guidance, and oversight
- *Logistics*: Plans, sets up, and coordinates events
- *Administration*: Monitors budget, decision-making, and organizational activities
- *Intelligence*: Collects enrollment data
- *Marketing*: Coordinates promotional materials

During the first open enrollment effortⁱⁱⁱ, *Enroll Gulf Coast* hosted over 430 enrollment events at local libraries, town hall meetings, and other community events that led to the enrollment of 190,000 eligible individuals in Harris County.

Family Planning, Access, Care and Treatment (Family PACT)

The *Family Planning, Access, Care and Treatment (Family PACT)* program is Medi-Cal's family planning program that provides comprehensive family planning services to eligible low-income men, women, and adolescents. Reports from 2012 found that a majority of clients are ages 20 and over (82%); Latino (59%); and uninsured (79%). In addition, a majority of adult clients (65-80%) were found to be eligible for the 2014 ACA provisions to Medi-Cal coverage or qualify for subsidized coverage through Covered California. Given providers unique encounter with this uninsured but eligible population, many Family PACT providers began screening clients for public and private insurance eligibility (69%), offering education on enrollment (77%), referring clients for enrollment assistance (90%), and offering onsite enrollment assistance (56%).

Illinois Department of Healthcare and Family Services

In 2005, Illinois became the first state to extend health coverage to all children, regardless of income and immigration status with the passage of *Covering ALL KIDS Health Insurance Act*. In response, HFS launched a massive outreach campaign to promote ALL Kids to families with eligible children.

ⁱⁱⁱ First enrollment period occurred between October 1 2013 through March 31 2014

Illinois utilized a multi-pronged outreach and enrollment approach to reach eligible children and their families.

- *Information Request Cards:* Outreach staff disseminated information at malls, sporting and community events to promote the ALL Kids program. Staff also passed out information request cards. Families that completed the cards were sent enrollment applications by mail.
- *Targeted outreach through state agencies, including:*
 - *Department of Employment Security:* Applications made available to the newly unemployed.
 - *Department of Professional and Financial Regulation:* Applications made available to those who were self-employed or owned a small business.
 - *Department of Human Services:* Applications sent to those enrolled in a DHS program, and those who received state grants.
 - *Department of Commerce and Economic Opportunity:* Outreach to small business owners.
 - *Department of Revenue:* Outreach to self-employed and licensed professionals.
- *Public-private partnerships:*
 - *Malls:* Coupons given to families who enrolled at application events at 12 malls across the state.
 - *Pharmacies:* Applications made available at CVS Pharmacy.
 - *Grocery Stores:* Enrollment events conducted at popular supermarkets in the Chicago area.
- *Health Care System:*
 - *220 Hospitals:* In partnership with the Illinois Hospital Association, ALL Kids enrollment/application process was incorporated into admission processes
 - *40,000 Doctors:* In partnership with Illinois Chapter of the American Academy of Pediatrics, ALL Kids enrollment/application process was incorporated into registration processes
 - *8,000 Nurses:* Partnered with Illinois Nurses Association and the Illinois Association of School Nurses to enroll eligible children into ALL Kids.

By 2008, outreach staff had conducted over 275 enrollment events in supermarkets, malls, schools, and other venues throughout the state. These efforts resulted in over 200,000 newly enrolled children into ALL Kids; a 33% increase since 2005. Of the newly enrolled children, over 60,000 (30%) would not been eligible for healthcare in the absence of the 2005 expansion.

Iowa Department of Public Health & Department of Human Services

Since 2006, Iowa's Department of Public Health (IDPH) and Department of Human Services (DHS) have collaborated to increase enrollment and retention of children in Medicaid and the Healthy and Well Kids (*hawk-i*) program, Iowa's CHIP.

Each agency employs a comprehensive outreach and enrollment strategy, including:

- *Iowa Department of Public Health (IDPH):* Contracts with 22 local Title V maternal and child health agencies that serve all of the state's 99 counties to provide the statewide

structure for targeted outreach. Hawk-i outreach coordinators provide Presumptive Eligibility determinations, which allow children eligible for Medicaid and *hawk-i* to have immediate coverage while their application processes. Outreach coordinators also collaborate with various entities to promote *hawk-i*, including:

- *Schools*: Collaborate with school nurses to ensure informational materials are available on campus. In FY2014, an outreach coordinator in Eastern Iowa was able to complete Presumptive Eligibility applications during school registration for children without health insurance.
 - *Faith-Based Community*: Collaborate with local ministerial associates and churches. For example, in FY2011, one coordinator in Southeast Iowa provided education and information to over 300 churches in their service area.
 - *Medical Providers*: Collaborate with local medical and dental providers to disseminate program information. Some outreach coordinators are able to partner with Iowa's 1st Five Healthy Mental Development to educate medical providers on the *hawk-i* program. 1st Five coordinators educate health providers in the early detection of social-emotional and developmental delays in children from birth to age five. While the focus of 1st Five is the first five years of life, most pediatric providers see children of all ages, or are family physicians and see patients of all ages.
 - *Diverse Ethnic Populations*: Partner with and provide outreach to multicultural and diverse populations. For example, in FY2014, one outreach coordinator worked with a local meat packing plant to set up a booth onsite during the lunch hour to provide *hawk-i* information to employees, who are primarily Bosnian and Hispanic.
- *Department of Human Services (DHS)*: Promotes the *hawk-i* program through a comprehensive outreach campaign, including:
- *Free and Reduce Meal Program*: Partnered with the Department of Education to require public schools to share household information of eligible students receiving free or reduced price meals who have expressed interest in learning about the *hawk-i* or Medicaid programs. In FY 2011, for example, 47,000 households received a postcard with information on how the family can request an application.

As of June 2014, there are over 36,000 children enrolled in *hawk-i*; a 69% increase since 2006.

Youth Partnership for Health (YPH)

Colorado has championed youth engagement models since 2000 with the establishment of the *Youth Partnership for Health (YPH)*. Funded by the Colorado Department of Public Health and the Environment (CDPHE), YPH consists of youth ages 14-19 who are responsible for providing feedback and recommendations to CDPHE programs, practices and policies that affect the health and well-being of young people statewide. Some issues YPH has helped address in Colorado include: substance use/abuse, teen motor vehicle safety, mental health, and HIV/STD prevention. As of November 2012, Colorado has 102 unique youth advisory boards/councils.

STRATEGIES TO IMPROVE THE QUALITY OF PREVENTIVE VISITS

APPENDIX

Child Health Advances Measured in Practice

In 2012, the *Child Health Advances Measured in Practice* (CHAMP) project began to increase the efficiency, economy, and quality of care provided to Medicaid-eligible children and families. CHAMP is a QI and research initiative of VCHIP in partnership with the *Vermont Department of Health*, the *American Academy of Pediatrics Vermont Chapter*, and the *Vermont Academy of Family Physicians*. Past projects have focused on immunizations, adolescent depression screening, and healthy weight and nutrition. To date, 40 practices—95% pediatric—have participated in CHAMP’s annual QI projects.

Past successes include increasing rates of adolescent depression screening from 32% to 97% across 17 practices and 28 physicians in 2013. Practice teams completed assessments of their office systems to support adolescent mental health services at the beginning and end of the project using the AAP’s *Mental Health Practice Readiness Inventory*. Significant advances were in developing and routinizing office systems to support enhanced mental health services for adolescents. This included a) increasing utilization of validated screening tools; b) administering the PHQ-9 at all adolescent well visits; and c) improving referral rates, follow-up visits, and treatment planning for patients identified with depression.

In addition, CHAMP increased increasing the percent of children^{iv} with up-to-date immunization series from 62% to 73% across 24 practices and 35 physicians in 2012. Strategies included contacting all patients who were overdue for vaccinations, reviewing immunization status at each patient visit, and flagging patient records before a visit for those who were due for vaccinations.

Oregon Pediatric Improvement Partnership

The *Oregon Pediatric Improvement Partnership* (OPIP) is a public-private partnership dedicated to improving the health of children and youth in Oregon. Since its establishment in 2010, OPIP has led several learning collaboratives, provided practice and health system-based facilitation, and supported the development and dissemination of policy briefs. For example, OPIP has conducted consultations and trainings to improve the quality of adolescent well-visits. Topics have included operationalizing privacy and confidentiality practices, developing adolescent transition policies, strength and risk behavior screening for adolescents, and identifying referral sources.

Links to OPIP materials on adolescent well-visits:

- Webinar (2014): [*Enhancing Adolescent Well-Visits: Getting Them In, Setting the Stage, and Implementing Strength & Risk Screening Tools*](#).
- Brief (2015): [*The Value of the Adolescent Well-Visit*](#).
- Brief (2015): [*Policy and Practice-Level Strategies to Improve Adolescent Well-Visit Rates*](#).

OPIP’s [*Enhancing Child Health in Oregon*](#) (ECHO), a medical home collaborative, began in 2011 in partnership with the Oregon Rural and Practice-Based Research Network. Eight primary care

^{iv} Includes ages 0-13

practices participated in this three-year project. Learning sessions focused on care coordination, behavioral and mental health integration, and children/youth with special health care needs. For example, ECHO sites received trainings and webinars on the implementation of the Screening, Brief Intervention, and Referral Treatment (SBIRT); a developmentally appropriate tool that is consistent with *Bright Futures Guidelines*.

Links to OPIP materials on medical home transformation:

- Webinar (2015): [Depression Screening and SBIRT for Adolescents: Practical Considerations for Implementing the CCO Incentive Metrics](#).
- Brief (2015): [You've Screened for Depressions, Now what? Considerations for Follow-Up for Youth Identified At Risk](#).

Oregon Pediatric Society

The *Oregon Pediatric Society* (OPS) is the state chapter of the *American Academy of Pediatrics*. In 2008, OPS established a statewide initiative to promote the highest standard of care and practice change in primary care called [Screening Tools and Referral Training](#) (START). This initiative works in partnership with medial clinics and local community agencies serving children and adolescents to enhance collaboration and coordinated care for Oregon's youth. As of 2014, START has trained over 1,130 primary care providers and 1,500 health care workers.

In 2013, START began the Adolescent Health Project to increase universal screening, brief interventions, and referral to treatment (SBIRT) for depression and substance use within the context of an adolescent well-visit. By November 2013, START trained 173 providers across four clinics and five SBHCs, as well as 14 'tag on' clinics.

Texas Health Steps

The state's EPSDT program, *Texas Health Steps*, offers over 50 free online Continuing Medical Education (CME) modules on pediatric and adolescent health-care topics for providers and other health professionals; the general public may also access the courses.

Adolescent health modules are listed below:

- [Health Screening](#)
- [Substance Use](#)
- [Identifying and Treating Young People with High-Risk Behaviors](#)
- [Interpersonal Youth Violence](#)
- [Consent and Confidentiality](#)
- [Behavioral Health: Screening and Intervention](#)
- [Effective Asthma Management at School](#)
- [Introduction to Screening, Brief Intervention, and Referral to Treatment \(SBIRT\)](#)
- [Management of Overweight and Obesity in Children and Adolescents](#)
- [Motivational Interviewing](#)
- [Nutrition](#)
- [Preventing Unintentional Injury: 5 to 12 Years](#)
- [Preventing Unintentional Injury: 13 to 18 Years](#)
- [Transition Services for Children and Youth with Special Health-Care Needs](#)

Youth Health Improvement Initiative

The *Youth Health Improvement Initiative* (YHII) began in 2001 to support pediatric and family practices with improving preventive services delivery for youth ages 8-18. YHII began in partnership with state agencies and private health insurance companies, including: *Vermont Department of Health*, the *Department of Vermont Health Access*, and *Blue Cross/Blue Shield*. Past projects have included increasing immunization rates, improving adolescent depression screening, and promoting healthy weight. In total, YHII has worked with 69 pediatric practices to improve the quality of care for AYAs.

Past successes include increasing the rate of Chlamydia screening of sexually active patients under the age of 21 from 11% to 70% across 12 practices. This project involved recruitment, baseline data collection, a daylong learning session, and monthly quality improvement activity recording in a 10-month intervention period. Strategies included establishing protocols for delivering confidential results to patients, implementing processes for obtaining sexual histories from patients, and implementing practice-wide screening changes (e.g., reminders/alerts, training support staff to alert provider if screening is needed).

Vermont Blueprint for Health

Established in 2006, Blueprint for Health (“Blueprint”) is a statewide multi-payer initiative created to improve health outcomes, control costs, and deliver overall better care in Vermont. One core component of Blueprint includes implementing patient-centered medical homes (PCMHs). As of December 2013, there are 121 primary care providers operating as medical homes serving over 514,000 patients in Vermont. This same year, 2013, an evaluation found multiple positive impacts on clinical quality, utilization, and cost when comparing Blueprint participants to Comparison Groups. For example, Blueprint participants with commercial insurance had an increased rate of adolescent well-care visits than Comparison groups (59.8% vs. 53.2%, respectively). In addition, Blueprint participants had lower per-member health care expenditures relative to comparison groups with a per-person savings of \$586 per commercially insured adult, \$386 per commercially insured child, \$447 per adult Medicaid enrollee, and \$200 per pediatric Medicaid enrollee.

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