



NIHCM  
FOUNDATION

## BRIGHT FUTURES and MANAGED CARE

# Action Brief

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### *Strengthening Health Supervision for Adolescents*

Adolescents have many more opportunities today, but also seem to be facing increasing health problems and risks. Medical conditions are only a piece of health care considerations for adolescents; they also face serious psychosocial and behavioral problems.

NIHCM Foundation sponsored a forum in 1999 on the special issues of adolescent health care. **David Heppel, MD, Director of the Division of Maternal, Infant, Child and Adolescent Health at the U.S. Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau (MCHB)**, welcomed the 90 participants.

The forum was part of the "Bright Futures and Managed Care" series, which NIHCM Foundation is conducting under a cooperative agreement with MCHB. This *Action Brief* summarizes key issues and insights from the forum.

#### Keynote Presentation

##### Speaker

**Claire Brindis, DrPH**, Executive Director, National Adolescent Health Information Center, and Adjunct Professor of Pediatrics, Division of Adolescent Medicine, University of California at San Francisco

**Dr. Claire Brindis** noted that a common perception about adolescence is that it is the healthiest period in life, yet an estimated 20% of adolescents have serious illnesses. Seventy percent of all adolescent deaths and disabilities are due to injury and violence, which have replaced illness as a major cause of death.

Many adolescent morbidities and mortalities relate to preventable illnesses and injuries, including homicide, pregnancy, sexually transmitted disease, motor vehicle accidents and substance abuse. In attempting to identify systems of care that respond to their multiple needs,

adolescents use a variety of systems simultaneously, from hospitals and clinics to family planning centers, safety net providers, and school-based health services.

***We need to intervene early in many adolescent behaviors because many of the problems that we can deal with in adolescence have long-term implications.***

—**Claire Brindis**

**Dr. Brindis** explained that the absence of health insurance and concerns about confidentiality are the major reasons adolescents do not access health care services. Other issues include lack of preventive care, cost, transportation, and ignorance about accessing care.

A fragmented health care system and providers who are not trained to deal with adolescents complicate efforts to assure that teenagers receive the services they need. Managed care offers the opportunity to improve adolescent health through comprehensive, coordinated care on a continuous basis. **Dr. Brindis** encouraged managed care organizations to structure systems that ensure access to age-appropriate and adolescent-focused care.

Adolescents need not only preventive health screenings and care coordination, but also other services, including nutrition, substance abuse and mental health counseling, family planning, and dental, vision, and hearing services.

**Dr. Brindis** outlined specific opportunities to improve adolescent care: (1) educate purchasers and providers regarding adolescents' needs and utilization patterns; (2) engage and inform teens and parents about confidentiality issues; (3) teach teens how to use the system and designate a provider; (4) commit to quality standards to gauge the progress in adolescent health care.

Integrating practice guidelines like Bright Futures and GAPS into adolescent care are critical to assuring the delivery of comprehensive preventive services and improving the health status of adolescents.

## Addressing Unique Issues of Adolescent Health Care

### Moderator

**Dawn Wood, MD, MPH**, Vice President and Medical Director, State-Sponsored Programs, Blue Cross of California

### Presenters

**Linda Juszczak, MS, MPH, PNP**, Division of Adolescent Medicine, North Shore University Hospital

**Angela Diaz, MD**, Director, Adolescent Health Center, Mt. Sinai-NYU Medical Center

**Abigail English, JD**, Director, Center for Adolescent Health & the Law, Advocates for Youth

**Dr. Dawn Wood's** responsibilities include both the Medicaid and State Children's Health Insurance Program (SCHIP) populations in California. In evaluating care, Dr. Wood found that adolescent members of the plan most frequently access health care because of pregnancy. Other major diagnoses include respiratory conditions, in-patient admissions for asthma, and menstrual disorders. Blue Cross of California recognizes the need for coordinated services for adolescents between inpatient and outpatient visits.

The plan is initiating Bright Futures to encourage health education for adolescent members. Bright Futures teaching materials are sent to each physician in Blue Cross' network. The plan has also established a confidential health education and advice line for teens; the 800 number logs approximately 400 calls per quarter.

Developing a uniform mechanism for health risk assessment is the greatest barrier to getting health care information on adolescents. With numerous systems available, **Dr. Wood** encourages health plans, providers, child health advocates and state regulatory agencies to coordinate the use of comprehensive and age-appropriate tools.

### Research on Adolescent Access

**Linda Juszczak** enumerated the complicated issues which current health care systems are struggling to address, such as intentional and unintentional injuries, family and school problems, chronic illnesses, nutrition and fitness problems, oral health problems, AIDS and STDs, mental health problems, substance use, delinquency, and homelessness.

Adolescents also are increasingly likely to be uninsured, with 13% reporting no usual source of care. The rate of an annual doctor's office visits for those 15 to 24 years of age is the lowest throughout the life span.

In contrast, adolescents have two to three more visits per year to school-based health centers than community-wide health center networks or a public hospital system. Prenatal care is the driving force behind use of the community network, while adolescents requiring mental health services are more likely to receive them at a school-based health center.

Pediatricians report an average time for an office visit is 15 minutes, and they can not address the range of services that adolescents need in that short amount of time; moreover, pediatricians may not be comfortable treating adolescent issues. They have concerns about providing sensitive services and being responsive to the needs of this young population.

Adolescents too are concerned that pediatricians do not understand their health care needs and will not provide confidential services. Adolescents also want care that is respectful. They want providers who listen to them and treat them well, take their problems seriously, and are honest with them. As **Ms. Juszczak** noted, these are the same concerns that adults have about health care.

### Motivating Teens to Access Care

From her experience directing a freestanding adolescent health center in New York City, **Dr. Angela Diaz** emphasized that efforts must be made to help develop motivation in adolescents so that they will seek and utilize health care. The health care system also needs to be encouraged to provide relevant services.

***I think that as providers, managed care companies, and health administrators, if we design the right program for teenagers and we make sure they know that we have those services, the adolescents will come to us.***

**–Angela Diaz**

The first step is to realize that most adolescents are not getting pregnant or contracting sexually transmitted diseases. **“I think we need to start thinking about adolescence as a very positive and rewarding stage, not a passage from childhood to adulthood,”** said **Dr. Diaz**. Adolescence spans many years, and tremendous physical, emotional, cognitive and psychological development occurs during this period. It is a crucial period within which lifelong behaviors and health patterns can be shaped.

Health services for adolescents are generally modeled on the services designed by adults for adults and this is not the best model. To assure that adolescents receive care tailored to their needs, **Dr. Diaz** stressed the need for collaboration between families, providers and the health care system to design adolescent appropriate health services and health promotion strategies.

**Dr. Diaz** also encouraged providers to be aware of the confidentiality laws in their state and to make sure that adolescents know their privacy will be respected. If adolescents trust their providers, they will encourage friends, family and others to seek care.

Another key element is to give adolescents a place they feel belongs to them. Along with adolescent-specific health services that they access regularly, adolescents need appointments that meet their schedules. Evening and weekend hours are crucial. Telephone systems tend to be difficult for teenagers, so it is important to assure timely response to phone calls by people who really want to work with them and to assist them in navigating systems.

**Dr. Diaz** has found that an interdisciplinary approach with as many services on-site as possible is best for this population. Her program takes a comprehensive approach with on-site primary care, acute care, and specialty care. Specialists are always available. Physicians also directly connect the adolescent to a social worker when needed.

In designing a program for adolescent health care, **Dr. Diaz** concluded that people working with adolescents need to have the energy and commitment to care for them. Most importantly, they must be well trained so as to be able to assess the specific health problems and risks that affect adolescents and engage them in care.

### ***Understanding Consent and Confidentiality***

Adolescents need access to comprehensive and confidential health services. **Abigail English** noted that although family involvement is positive for many, there are special considerations to accessing care for adolescents who do not have supportive families. **“Laws should not impede but rather should facilitate access,”** said Ms. English.

Parental consent is generally required for minor’s health care, though every state allows minors to give their own consent under specific circumstances. Providers must, however, obtain informed consent. Conversely, the absence of a minor consent statute does not prohibit minors from giving consent.

The main ways in which minors are authorized to give their own permission are based upon status and services.

Every state has laws that address a minor’s status for consent. These groups might include: mature minors; emancipated minors; minors who are married, pregnant or who are parents; minors in the Armed Forces; minors who have attained a specific age or have graduated from high school; and minors who are living apart from their parents even though not legally emancipated (runaways or homeless youth).

Services that minors may give consent might include: reproductive health services such as contraceptive care, pregnancy-related care, and abortion; prevention, diagnosis, and treatment of STDs and HIV infection; care related to a sexual assault and rape; diagnosis and treatment for reportable infectious, contagious, or communicable diseases; substance abuse treatment; and both inpatient and outpatient mental health counseling.

***Relationship of State and Federal law:*** Generally, state law controls consent for health care services, but federal law has played a very important role, especially through the Title X Family Planning Program. It requires confidential services to be available without regard to age and that minors’ financial eligibility must be determined based on their own income rather than family income.

Although protections for the confidentiality of medical information under state law are numerous, applicability to minors is not always clear. Federal protection ranges from the constitutional right of privacy and some specific statutes like Title X, Title V, and Medicaid, to regulations for drug and alcohol programs.

***Integration of Consent, Confidentiality, Enrollment and Payment Issues:*** With the advent of coverage through Medicaid expansions and SCHIP, successful enrollment and outreach efforts can significantly increase the numbers of low-income adolescents joining the ranks of the insured. Many of these adolescents will be enrolled in managed care organizations that traditionally may not have served this population. Targeted efforts are needed to ensure that health plans and providers understand the situation in which minors may consent to services and when information about services for minors should remain confidential.

Issues around payment, in Medicaid, SCHIP and also private insurance, present some significant logistical and practical challenges for managed care organizations and insurers. Scope of services covered, contraceptive coverage, and logistical problems related to consent and confidentiality all need to be addressed in the context of adolescent care. Insurance companies can look to some of the categorical programs, particularly Title X, which have successfully addressed these issues.

**Ms. English** cautioned that there are efforts in a number of states to repeal some of the minor consent laws that have been on the books for 10 to 30 years. Repeatedly, members of Congress have attempted (unsuccessfully) to mandate parental notification for family planning services. Also, statutory rape laws are being enforced more vigorously than in the past. These changes can impose additional responsibilities on providers.

## Improving Health Supervision For Adolescents

### Moderator

**Melissa Koury**, Clinical Quality Improvement  
Department, Highmark Blue Cross Blue Shield

### Presenters

**Missy Fleming, PhD**, Program Director, Child  
and Adolescent Health Program, American  
Medical Association

**Jonathan Klein, MD**, Division of Adolescent  
Medicine, University of Rochester

### Reactors

**Dawn Wood, MD, MPH**, Vice President and  
Medical Director, State-Sponsored Programs,  
Blue Cross of California

**Bradley Bradford, MD**, Chairman, Department  
of Pediatrics, Mercy Hospital of Pittsburgh

**Highmark Blue Cross Blue Shield** has developed and implemented many education programs for its members, with a particular focus on adolescents. On a child's 12<sup>th</sup> birthday, Highmark sends cards directly to the child and includes immunization reminders and other educational information. The plan also uses advertising, such as bus placards, newspaper ads, and playbills, to inform adolescents and parents about various services.

**Melissa Koury** explained that health plans are looking for ways to improve adolescent care. Highmark is investigating the use of Bright Futures as a collaborative approach with providers to deliver high-quality care to child and adolescent members.

### *Guidelines for Adolescent Preventive Services (GAPS)*

The American Medical Association (AMA) developed and released the Guidelines for Adolescent Preventive

Services (GAPS), a comprehensive set of 24 recommendations for adolescent preventive services, in December 1992. GAPS was designed to improve the delivery of clinical preventive services and address leading morbidities and mortalities for adolescents. It fits into a cluster of other national guidelines, along with Bright Futures and the "Putting Prevention into Practice" initiative. GAPS supports implementation by providing training and technical assistance.

As **Missy Fleming** explained, health risks for adolescents are mostly behavioral in nature rather than biomedical. Most adolescents engage in some form of risky behavior, and some in multiple risk activities. **"It's a way to try on adult behaviors, and it's a hallmark of this period," said Dr. Fleming.**

GAPS promotes adjustment to puberty, safety and injury prevention, physical fitness, and parents' ability to respond to their adolescent's health needs. GAPS' recommendations address preventing hypertension, hyperlipidemia, infectious diseases, use of tobacco products, depression and suicide, and physical, emotional and sexual abuse.

GAPS provides a framework for the organization and content of preventive health services including (1) a system to deliver care, (2) screening, (3) health guidance and (4) immunizations. Recommendations address annual preventive service visits for all adolescents that are age and developmentally appropriate and are delivered by physicians with established confidential care policies. GAPS promotes annual screenings and health guidance for both clinical and psychosocial conditions. Other recommendations highlight prophylactic immunizations, including a second MMR vaccine, a Td booster, Hepatitis B vaccine, Varicella vaccine and pneumococcal/influenza vaccine, when indicated.

GAPS is also an algorithm with four sequential steps: Gather initial information; Assess further; Problem identification; and Solutions. Information is gathered through patient visit forms that ask about biomedical information, a trigger questionnaire that helps to structure the clinical interview, and parent/guardian questionnaires and resources. Key solution areas include promoting self-efficacy, overcoming barriers, eliciting commitments to the intervention, and follow-up.

### *Bright Futures Guidelines*

**Dr. Jonathan Klein** noted that most causes of adolescent death and disability are preventable, but there are missed opportunities for prevention. Nearly half of teens do not have a private conversation with their clinician during a visit, because of embarrassment or fear of disclosure. Many teens do not get needed care. Much of

the content that teens desire is not discussed during physician visits.

Bright Futures provides comprehensive, family-centered, community-based guidelines for health supervision from birth through adolescence. Like GAPS, Bright Futures was developed through a consensus and evidence-based process. Input from experts distinguishes these guidelines from others which are strictly evidence-based.

Bright Futures addresses health promotion and disease prevention and provides materials, training, and a series of networking activities to improve prevention for children. It is applicable to all primary care settings. Part of the goal of Bright Futures' activities is a broad awareness and dissemination of the materials to all providers.

Care is tailored under Bright Futures to meet individual needs, with appropriate intervention for teens identified as high-risk. Unlike GAPS, Bright Futures encompasses the entire age range from birth through adolescence. Bright Futures does incorporate much of the GAPS content on teenagers, though it adds information on nutritional recommendations and dental care. **Dr. Klein** noted that Bright Futures has excellent materials that detail how to approach adolescents and ask questions in the clinical setting.

Implementation of guidelines is the key to effective prevention, but research is needed to provide concrete evidence of the impact. Health care providers know less about how to implement prevention guidelines effectively than about the efficacy of specific counseling services. GAPS provides a strong set of implementation materials for improving adolescent preventive services.

Just as there are special issues of accessibility and availability of services for teens, there are quality issues for adolescent care. Even though there is a HEDIS measure for adolescent well visits, it is difficult to know what really happens during the visit. Many adolescent issues cannot be evaluated by chart review or in administrative data. The only way to get that information accurately is to ask the teens. Directly surveying teens, however, is a new measurement for most health plans. The Measuring Adolescent Preventive Services (MAPS) study looked at the validity and reliability of self-report by adolescents. Research showed that teens can report accurately on their care. In fact, adolescents' recall was better than chart review and clinicians' immediate recall.

Other work in terms of preventive care measures include the Youth Risk Behavior Surveillance System (YRBSS) from the CDC, and the Child and Adolescent Health Measurement Initiative (CAHMI) which is a collaborative effort of Foundation for Accountability (FACCT) and the National Committee for Quality Assurance (NCQA)

to develop measures that can be used by consumers. These measures potentially will be used in HEDIS and can also be used for assessment of Medicaid and SCHIP programs, as well as used at the practitioner level.

Bright Futures, GAPS and other guidelines have excellent materials, and **Dr. Klein** suggested that health plans evaluate them in terms of their providers' practices. Many clinicians already use various forms, and they may be resistant to changing their practice unless they see a clear benefit. Evidence that routine screening improves health education and health promotion may encourage physicians to use the screening tools, and they may also then be prepared to address the need for other services.

### *Practitioners' Perspective*

**Dr. Bradley Bradford** noted that pediatricians make prevention a priority. In contrast to the recent past, pediatricians today are comfortable with adolescent-related issues and are beginning to address them.

**Dr. Bradford** believes pediatricians in western Pennsylvania find Bright Futures amenable to their practices because it addresses the continuum within child health supervision. Bright Futures also addresses many of the morbidity issues of adolescents.

***Bright Futures fits within the context of the age span of pediatric medicine in contrast to merely segmenting out specific years.***

**-Bradley Bradford**

Guidelines need to be user-friendly as well as amenable to new technology in use by both providers and children. Bright Futures materials are adaptable to computer technology, and some programs are testing this option. **Dr. Bradford** noted that educating physicians on adolescent issues and having measurable outcomes are necessary for effective implementation.

In California, **Dr. Wood** explained that Medicaid and SCHIP contracts obligate plans to follow AAP guidelines and GAPS. California also requires plans to perform a health risk assessment. She believes using Bright Futures will help Blue Cross meet those requirements.

Providers, however, need an incentive to use Bright Futures because implementation can be time-consuming and costly. During 1999, Blue Cross of California began a bonus program for physicians who participate in its Medical program and implement Bright Futures. Under its contract with the state, Blue Cross must conduct regular audits of participating physicians. Those reviews can also help the plan to evaluate use of Bright Futures.

**Dr. Wood** noted that coding problems can hinder collection of good data on the number of doctors assessing health risk during an adolescent preventive care visit. She hopes that all health plans address better coding and data collection in the future regarding adolescents and if appropriate, partner with organizations and advocacy groups which are also able to influence the process.

## Purchasing Specifications

### Presenter

**Colleen Sonosky, JD**, Assistant Director, Center for Health Services Research and Policy, George Washington University Medical Center

**The Center for Health Services Research and Policy at George Washington University** is developing sample purchasing specifications for pediatric services in managed care contracts, resulting from its “Negotiating the New Health System,” a nationwide study of provisions in Medicaid managed care contracts. **Colleen Sonosky** explained that the purchasing specifications are intended as a tool for states and other interested purchasers to include in their managed care documents.

A series of user guides have been developed, and one guide specific for adolescent services incorporated Bright Futures and GAPS into the specifications. They have been included as the standard of care which can be used for coverage determinations.

## Meeting Teen Needs

### Presenters

**David W. Kaplan, MD, MPH**, Chief of Adolescent Medicine, Children’s Hospital, Denver, and the University of Colorado School of Medicine

**Donna J. Zimmerman, BSN, MPH**, Director of Government Programs, HealthPartners, Minneapolis

**Diana Medlock**, Executive Director, Adolescent Health and Wellness Center, Dayton, Ohio

### School-Based Health Clinics

Meeting the unique needs of teens often requires a non-traditional approach. School-based clinics “go where

teens are,” and are more likely than traditional providers to focus on specific adolescent issues such as mental health, sexuality, and pregnancy.

Considering the range of services that adolescents need, **Dr. David Kaplan** differentiates medical care from health care. Health care is oriented toward prevention, and school-based clinics play a greater role in those services. Dr. Kaplan pointed out that many of the solutions to prevalent adolescent issues, such as injury and pregnancy, reside outside of the purview of medical care.

But when society fails to deal with adolescents’ problems, they often show up in clinical settings. This pattern highlights the need to remove barriers to accessing care. Along with financial issues, transportation problems, and confidentiality concerns, adolescents many times do not know where to go for care.

***The attractiveness of a school-based setting is that it deals with many of the barriers to adolescent care.***

***-David Kaplan***

Because teenagers spend most of their time at school, a school-based setting is an ideal location to provide services. School-based clinics also facilitate the integration of mental health, educational, and social services with medical services. Clinics are easily accessible, and transportation is not an issue. Teens get to know the staff well, and continuity of care is more likely. Adolescent-friendly services can be developed with input from teenagers. School-based care offers the opportunity for early identification and detection of problems. Working parents also find it helpful.

School-based centers do have some limitations in the range of clinical services and continuity when a teen uses more than one source of care. Clinics may have to follow the school calendar and close during the summer. Despite these drawbacks, the number of school-based health centers has risen dramatically, from approximately 100 in 1990 to 1150 in 1998. The number of school-based clinics has increased in every region of the United States.

Research also shows that school-based clinics have been very effective at reaching teens. Students with access to school-based centers are ten times more likely to have made a mental-health or substance abuse visit; 98% of these visits were made at a school-based clinic. Also, students with school-based health center access after hours had an emergency or urgent care visit rate much lower than those students without such access.

### *Managed Care and School-Based Clinics*

**HealthPartners** has two arrangements to deliver care to adolescent members: a direct contract with a group of eight school-based health clinics and a population-based collaboration with the Minnesota Center for Population Health. **Donna Zimmerman** explained that Minnesota is a unique environment in terms of regulatory status and provider relationships which allow health plans to engage in innovative programs.

HealthPartners has been contracting for the past four years with Health Start, a nonprofit program that manages school-based health centers generally serving senior high school students. The school clinics serve as a primary health care provider to HealthPartners' members. Mental health services are included in the primary care agreement, and services do not require preauthorization.

In developing the contract, HealthPartners addressed financing issues, administrative capabilities and confidentiality, as well as physician issues of care coordination. HealthPartners' providers financially at-risk for services needed a link with providers in school-based centers. Health Start was both a community clinic and a Medicaid provider with an established billing and administrative system, so coordinating with primary care providers was not a problem. School clinic providers must meet credentialing criteria and participate in plan quality improvement programs.

Students choose a primary care clinic in HealthPartners' network (HealthPartners-owned or –contracted clinics) as a “medical home.” School-based providers keep that clinic informed about services teenagers receive, and will refer students for additional services.

In addition to its contract, HealthPartners collaborates with the Minnesota Center for Population Health on a consensus-building project. A coalition of hospitals, health plans, provider groups, and state and local public health officials work on improving the health of the population through public/private partnerships. Adolescent health is one of the coalition's priorities.

### *Community-Based Adolescent Clinics*

**The Adolescent Health and Wellness Center** is a free-standing clinic in Dayton, Ohio with a mission to provide for the physical and emotional needs of uninsured adolescents from ages 10 through 19. **Diana Medlock** explained that the school-based clinics in Dayton serve primarily elementary and middle-school children for health checks; the clinics work with the Adolescent Health and Wellness Center for adolescent care, particularly for issues that the schools do not handle such as sexual-ity issues.

The Center provides a full range of primary care services to adolescents including confidential STD diagnosis and treatment, and pregnancy prevention. Nearly 80% of the Center's patients have chosen to be sexually active and the Center stresses the use of birth control and condoms. In spite of this high rate, the pregnancy rate for the Center's patients is 64.6 per thousand, well below the national average of 174.6 per thousand.

A sliding fee scale is essential for all uninsured families to assure access to care. Approximately 60% of the adolescents seeking services are uninsured and 30% are enrolled in Medicaid. For services provided to insured patients, the Center bills the insurance company.

Education and mental health services are important components of the primary care services, and the Center offers one-on-one education to every patient. Every new patient receives a psychosocial assessment from a licensed social worker and annually thereafter. Although the Center currently does not use health supervision guidelines, **Ms. Medlock** expressed interest in training for GAPS or Bright Futures.

## **Preventing Teen Pregnancy**

### **Presenters**

**Paula Hollerbach, PhD**, Senior Research Officer, Research and Evaluation Unit, Academy for Educational Development

**Shelley Evans, MAT**, Associate Director, Center for Adolescent Pregnancy Prevention, Family Health Council, Inc.

### *Effective Prevention Programs*

**Dr. Paula Hollerbach** noted that after years of steady increases, teenage birth rates are down 15% since 1991, and pregnancy rates have fallen to their lowest level in 20 years. The decrease is similar across race and ethnic groups. Birth rates for black and Hispanic teenagers, however, continue to be substantially higher than for other racial groups, with Hispanic teens at the highest birth rate of any other group. Although the overall picture looks optimistic, the incidence of teen pregnancy is much higher in the United States than in many other developed countries.

Another important trend relates to births among unmarried teens. Because of the changes in marriage patterns and birth rates among teenagers, the proportion of births occurring to unmarried teenage women has risen steeply.

Data on the recent developments in teenage birth rates are generally based on three surveys: the National Survey of Family Growth, the National Survey of Adolescent Males, and the Youth Risk Behavior Surveillance Survey, which is conducted in the schools.

Factors affecting declines in teenage birth rates include a decrease in high school students having sexual intercourse and an increase in use of contraceptives. Substantial numbers of sexually experienced students obtain prophylactics from school-based health clinics. Research has shown, however, that providing contraceptives does not appear to hasten or increase the frequency of sexual activity, nor does it markedly increase the use of contraceptives.

The most effective programs to reduce teenage pregnancy appear to be those that are most intensive. Experience suggests that programs must be maintained to continue to produce desired results. Such programs apparently are more successful in reducing the probability of a repeat pregnancy rather than preventing the first.

In order to work, programs must recognize differences in values, roles, and attitudes about sexuality, contraception, and child rearing as those factors vary across ethnic and social groups. Parental involvement and community participation must be incorporated. Moreover, teenagers who participate in volunteer community programs are less likely to become pregnant.

### *Pregnancy Prevention in Managed Care*

**Family Health Council's Center for Adolescent Pregnancy Prevention (CAPP)** is the primary prevention program committed to reducing teenage pregnancy in western Pennsylvania. It strives to increase community awareness of programs associated with teenage pregnancy, encourage and assist parents to take responsibility as the primary sexuality educator of their children, and link teens with resources to help prevent unintended pregnancies. **Shelley Evans** noted that since the project began in 1990, the teen pregnancy rate has dropped 29% in Allegheny County.

CAPP's success is due in large measure to creating partnerships and community coalitions. The public school system, hospitals, YWCA, YMCA, the City of Pittsburgh, community centers, and housing authorities as well as managed care organizations have joined CAPP in a range of activities.

CAPP focuses on four interventions to achieve its goals: (1) Parent and Community Education; (2) Teen Peer Education; (3) Multimedia and Public Awareness Campaign; and (4) Professional Training.

The Parent and Community Education program encourages family communication using "Family Connection" guidebooks. CAPP provides the guidebooks free of charge and trains parents and professionals to use them.

The Teen Peer Education Program uses older adolescents to teach reproductive health, life skills, refusal skills and decision-making skills to other teenagers. Also, high school students are trained to be peer educators in middle schools and through some community centers. Because teenagers are more likely to listen to fellow teens than to adults, health educators know that this program can make a difference. Surveys show that 20% of teens have heard about CAPP's clinical services through peer educators.

The Multimedia and Public Awareness Campaign uses radio stations and television programs to increase awareness and encourage communication between parents and children. The Campaign also distributes resource booklets on issues such as suicide prevention and lists HIV and STD hotlines. Highmark Blue Cross Blue Shield donates mailing services for bulk orders of the booklets.

Other interventions include the "Not Now" campaign, also supported by Highmark Blue Cross Blue Shield, to counsel teens between 10 and 19 after they have a negative pregnancy test, and a "Man To Man" program, through which 11th and 12th grade males work in the clinic and talk to the male partners of girls using the clinic about clinic services or other issues.

CAPP has formed a teen advisory board to provide information about services that teens need, as well as other issues such as input on the physical layout of the clinic. Clinics have become a place to hang out, so resources such as computers are available for creating resumes and searching the Internet. CAPP's model also includes extensive research and evaluation.

As **Dr. Wood** concluded, teenage pregnancy, especially second pregnancy, is an important issue for health plans. Building community coalitions to address adolescent health concerns can help to improve interventions.

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