AmeriHealth Caritas™

District of Columbia

Addendum Three:

Minor Rights

to the AmeriHealth Caritas District of Columbia Provider Manual

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Version One

Adolescents continue to be the least frequent users of health care services of any age group. In general, adolescents see providers in brief, specific problem-related visits that do not result in adequate prevention and education-oriented care.

The barriers to health care commonly associated with adolescents, in addition to the lack of insurance coverage, include lack of experience navigating the health care system, doubts about privacy and confidentiality of services, inconveniently located services, scheduling or appointment problems, fragmentation of services, co-payment requirements, transportation, and the perception that primary care providers are hesitant to discuss sensitive issues such as sexuality or emotional concerns. These factors affect all adolescents regardless of economic status, but can be more extreme for many low-income adolescents.

Key Components of an Adolescent-Specific Health Care Model

Many health services are already organized to attract and treat adolescents in a high quality manner. Age-appropriate preventive care is the starting point, and experience has shown that in the absence of certain key elements of health care service delivery, clinical care for the adolescent will not be effective and many adolescents will not seek it out.

These certain key elements include:

- confidentiality,
- consent,
- an adolescent-friendly environment,
- the staff, hours and scheduling,
- getting to know the patient,
- health education and prevention,
- coordination with other health and social service providers, and
- outreach.

A. Confidentiality

The issue of confidentiality is of utmost importance for adolescents and should be taken very seriously. For a variety of reasons, many adolescents feel unable to share their need for medical services with a parent or guardian. Fear that a visit will be reported prevents many adolescents from accessing services and obtaining needed care. The laws regarding confidentiality of services for adolescents need to be fully understood by all staff and explained accurately to both patients and parents or guardians.

Confidentiality should be discussed during the first visit with the patient as well as with the parent or guardian. It is important to clarify to both the adolescent and the parent that all information obtained during the medical visit will remain confidential with the exception of any information deemed harmful or life threatening to the adolescent or others.

After the initial encounter with both the parent or guardian and adolescent, the parent should be asked to leave the room, with the adolescent's permission. Re-emphasizing the confidentiality policy to the adolescent at this point can serve to ease the adolescents' discomfort.

Putting these recommendations into effect should include:

- A written policy on confidentiality and a separate policy on parental consent requirements, in the language spoken by patients and their parents or guardians, should be available in every waiting room and specifically given to all new patients and their parents or guardians at the time of the first visit.
    - Posting adolescent-friendly signs regarding the confidentiality policy in the waiting room and in each examination room will emphasize the point.

B. Consent

There are clear written guidelines which govern the medical and non-medical services that require parental consent. Federal and state laws are shaped by decisions of the Supreme Court. In the District of Columbia the following consent privileges prevail. In DC a minor is generally considered to be someone under the age of 18.
All minors (age 12 and older) *can* consent for/*do not* require a parent's permission for:

- Contraceptive services
- STI/HIV services
- Prenatal care
- Adoption for their child
- Medical care for their child
- Abortion services
- Outpatient counseling for alcohol and drug abuse
- Outpatient mental health services

Disclosure Requirements for Mental Health Information

While minors of any age can seek mental health treatment without parental consent, minors between 14 and 18 can only have mental health information disclosed if both the minor and his or her parent or guardian authorizes a disclosure; if a minor is under 14, only a parent or legal guardian can authorize any disclosure. This rule does not hold true if a minor did not obtain parenteral consent prior to seeking mental health treatment, in which case the consent of the minor is enough for disclosure.

- A minor *may not* decide to drop out of school.

Consent requirements, like confidentiality requirements, should be covered in all staff training sessions.

C. Staff

First Impressions Matter

Receptionists should understand that adolescents are frequently nervous or reluctant about seeing a provider, and should set a tone of welcome. They can offer written policies on confidentiality and consent to reassure adolescents. Nurses and lab technicians can take a few extra minutes to explain first time tests.

Specialized Staff

Assigning a dedicated or particular staff person to operate adolescent clinics and other adolescent services would encourage adolescents to develop an ongoing relationship with health care providers, which would in turn promote continuous use of health care services and develop a pattern of preventive health care maintenance. Ideally, an adolescent patient should have at least one provider who knows all their health issues, and can coordinate care.

All health care providers involved in an adolescent's life (physicians, social workers, nurses, psychologists, psychiatrists, counselors, dentists) should be prepared to discuss risky behaviors, observe potentially negative patterns of behavior and provide the necessary education and referrals to encourage changes of behavior.

Staff Training

All the staff that a client encounters needs to be aware of the psychosocial issues that surround many adolescent problems.

Continuing training for all staff should include information and educational materials on issues and topics relevant to adolescent health such as adolescent development, consent for services, confidentiality, sexually transmitted diseases, reproductive health and contraception, mental health and depression, suicide ideation, sexual orientation, physical and sexual abuse, violence, and community referral sources for teen services.

Beyond the factual information, training should concentrate on how to work with adolescents in building trust, rapport, respect, cultural sensitivity, and a healthy provider-patient relationship.

Culturally Appropriate Staff

Staff diversity in terms of race, ethnicity, and gender that reflects the patient population also provides another avenue to connect with adolescent patients. It builds another level of trust and confidence in the services offered. By implementing staff diversity, service providers will be effective in reaching adolescents and providing health services in the least threatening manner.

Doctors who Care about Adolescents

The physician must have knowledge of other resources to offer during clinic visits. Many adolescent concerns call for other professionals (e.g. mental health professionals, social workers, nutritionists) that should be available for consultation.

D. Hours and Scheduling

In order to reach out to adolescents, there may need to be appointment times set aside for them. Because of school schedules and after-school activities, adolescents often require appointments outside of normal clinic hours, such as late afternoons, evenings, and weekends. Scheduling teen clinic hours a few afternoons or evenings a week or on Saturdays would carve out specific times for adolescents to access the health facility.

E. Getting to Know the Patient

Initial Visit

A conversation about confidentially and consent should be had when both the adolescent and parent or guardian are in the room, and again emphasized when the teen is alone. Finally, at the end of the visit it is generally helpful to bring the parent and patient together again for any concerns or questions.

Patient History

The interview is not only the primary vehicle for assessing the health and risk factors of the teen, but is also serves as a means of building rapport and a relationship between the clinician and the teen. Also, time should be allowed with all new adolescent patients for a complete medical and family history. Some providers find that this is easier to accomplish by means of a preprinted form filled out in private.

There are several teen-specific history-taking techniques available, the most common being in the "HEADSS" format. This guideline is designed to review important adolescent-specific concerns, behaviors and risks, and is meant to cover the topics from least-to-most-sensitive, for the patient's comfort:

H: Home (relationships in the home and exposures, i.e. smoking, pets) & habits
E: Education, employment, exercise (and nutrition)
A: Activities (i.e. extracurricular, athletic), associates, alcohol, abuse (and violence)
D:Diet, drugs (tobacco, alcohol, other), depression
S: Safety, sexuality & sexual activity, suicide

Breaching these topics in the form of open-ended questions is often more effective than asking direct questions without particular definitions, such as "Are you having sex? Do you use drugs?"

F. Health Education and Prevention

An ongoing component of a health visit ought to be at least a brief conversation aimed at increasing the adolescent's knowledge of good health practices and available resources. In national research studies, adolescents report that many doctors do not provide any counseling or education in their visits. Very few discuss pregnancy or STI prevention. Opportunities are lost

to reassure adolescents about normal physical and psychosocial changes and advise them about what to expect. Teaching young people to do routine breast and testicular exams can establish good lifetime patterns. Exploring school progress, mental health or depression, and gender identity can often open up topics of great concern to adolescents who may have no other adults with whom they can confidentially discuss such matters.

Whether or not a patient brings up topics of concern, providers can have on hand written material on common issues such as nutrition, reproductive health, exercise, and emergency contraception. Emphasizing health education during the visits is vital and can help to reduce or eliminate the burden of preventable diseases in the long-term.

G. Outreach

Word of mouth is still the most effective form of outreach. Ask your adolescent patients to tell their friends about your practice. Providers can also let adolescents know they are welcome by making available inexpensive written summaries of services, costs of services, and appointment procedures, which can be distributed at health fairs, schools, neighborhood organizations and churches.

Establishing a collaboration or referral network with community-based organizations can play a major part in outreach efforts. Reaching out to adolescents through established and trusted relationships makes the information about services available in an atmosphere in which adolescents are comfortable.

H. Self –Assessment/Quality Improvement

Health care systems in general are not often geared toward the special needs of adolescents. Providers should regularly review all aspects of their services to ensure that they are doing everything possible to meet the needs of young people.

ACCESS TO HEALTH CARE

A. Paying for Health Care

Medicaid

In Washington, DC federal insurance is provided through Medicaid. Medicaid insures 60 percent of District children through the Early and Periodic Screening, Diagnosis and Treatment program (EPSDT). The EPSDT is the child health component of Medicaid that covers all youth under the age of 21. Through EPSDT, children are to receive periodic, comprehensive history and physical exams, and screening for mental, developmental, dental, vision, and hearing abnormalities. Health care practitioners are required to keep a web-based medical records system to keep track of the immunization records and other important health records of the children covered by Medicaid, for better continuity and coordination of care.

SCHIP

The State Children's Health Insurance Program (SCHIP) was created to respond to the large number of uninsured children nationally. In Washington, DC, SCHIP is also known as the DC Healthy Families Insurance Program, and is aimed at children under age 19 and pregnant women who do not qualify for Medicaid and whose families cannot afford insurance. SCHIP includes coverage for legal immigrant children and pregnant women. Individuals covered by SCHIP are entitled to the full range of medical services, including reproductive health and family planning services.

Title X

Title X is a federal grant program that provides family planning and preventive health services. As such, Title X funding can be used toward contraceptive services and related counseling, STD/HIV prevention education, counseling, testing, and referral, and pregnancy diagnosis and counseling. It is often used to offer family planning services to those individuals who are not eligible to receive such services through Medicaid itself.

Title V

Title V ensures health services for all women and children. Although separate from Medicaid, Title V funding can be used to implement the EPSDT program for children, as well as other Medicaid services. It can also be used towards providing children with special needs and disabilities with healthcare services not already covered by Medicaid. Although the District's Income Maintenance Administration has enrolled an impressive number of children, recruiting immigrant children and covering older adolescents present many challenges.

B. Special Considerations

Access for Immigrants

Fear of being deported can make immigrants reluctant to complete applications for public programs even for their children who are citizens. Legal immigrants may also be reluctant to apply for SCHIP, fearing that use of a public benefit will adversely affect their application for permanent residence or citizenship. The Immigration and Naturalization Service (INS) and the Department of Justice (DOJ) released guidelines in 1999 clarifying that immigrants who receive non-cash assistance programs such as Medicaid, SCHIP, Women, Infants and Children (WIC), immunizations and prenatal care will not be subject to deportation or "public charge" status that would negatively impact their chance for citizenship. In addition, the U.S. Department of Health and Human Services has officially indicated that states may not deny benefits to otherwise qualified legal alien children under SCHIP programs

Older Adolescents

The SCHIP program covers young people through the age of 18. Single adolescents of age 21 and older are not eligible to continue Medicaid coverage unless they have a child. Efforts to establish good health habits of prevention and the trusting relationship of a medical "home" are thus thwarted when young people age out of Medicaid and are unlikely to have access to employer-sponsored or private health care.

REGULATIONS ON REQUIRED REPORTING

- All individuals involved in the care or treatment of youth are mandatory reporters. These include:
  - physicians
  - nurses
  - dentists
  - medical examiners
  - psychologists
  - mental health professionals
  - chiropractors
  - social service workers
  - school officials
  - teachers
  - counselors
  - day care workers
  - law enforcement officers or administrators (DC Law§ 2-1352)

- Mandatory reporters are required to report any case in which there is evidence of the following:
  - Mental, physical or sexual abuse
  - Neglect
  - Suicidal or homicidal ideation or threats
  - Gun shot or knife wounds
  - Reportable communicable diseases
  - Child sex abuse, formerly known as statutory rape

- Child sex abuse is defined as a young person under the age of 16 being in a sexual relationship, consensual or not, with a person four or more years older than him/her.
  - To report a case in the District of Columbia, call the DC Child and Family Services Agency (CFSA)'s 24-hour hotline at (202) 671-SAFE (7233).
    - You will need to provide all available information, including, but not limited to:
      - The name, age, sex, and address of:
        - The child who is the subject of the report
        - Each of the child's siblings
        - The parents or other persons responsible for the child's care
        - The nature and extent of the abuse, if known
        - Your name, occupation, contact information, and any actions that you've taken concerning the child
        - Any other information that may be helpful (DC Law§ 2-1352)

Working with adolescents is a specialized matter. Some of the problems that adolescents face include reproductive health needs, abuse by adults, suicidal thoughts, and substance abuse. These topics are difficult to discuss and can even lead to legal complications. When these problems are not addressed, however, the results are costly: teen pregnancies, STDs, suicides, violence, and chronic adult health problems.

Health care providers cannot be the only “first responders,” but they stand in a critical position to make a difference.