THE CAPITOL FORUMS
On Health & Medical Care

DOES NEW JERSEY NEED TO RENEW ITS COMMITMENT TO THE HEALTH OF OUR CHILDREN AND ADOLESCENTS?

PART II
10 - 18 YEARS OF AGE - SAFETY NET?

Background information
for

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DOES NEW JERSEY NEED TO RENEW ITS COMMITMENT TO THE HEALTH OF OUR CHILDREN AND ADOLESCENTS?

PART II - 10 TO 18 YEARS OF AGE - SAFETY NET?

ISSUE: Is there need to renew our commitment to the health care safety net for all — particularly children and adolescents — or are the changes that are taking place as a result of market forces sufficient to provide health care to New Jersey's citizens? Should the recommitment (if any) *come in the form of a subsidized insurance program for kids or as a tax dollar initiative* to "beef up" the service delivery capacity of community-based agencies? Or, should there be a coordinated combination of both subsidies and increased funding?

Health care for adolescents is the focus of this second part of the Capitol Forums series on health care issues for children and adolescents in New Jersey. There is growing support for an effort to provide health insurance to some or all of the nation's ten million uninsured children. It is estimated that over three million of these children are eligible for, but are not receiving Medicaid, and seven million are from families in which one or both parents work. With the changes to Supplemental Security Insurance (SSI) through welfare reform, children taken off the SSI rolls will also lose their Medicaid eligibility. Many of these children, who are at high-risk for physical and emotional disorders, comprise some of the most vulnerable members of our society and depend upon "safety net" providers for their health care. Who should take the leadership to ensure that the safety net — threatened by funding cutbacks, reduced support from the Federal government and a disadvantaged position in competitive health care marketplace — remains intact?

INTRODUCTION

The subject of adolescent health care is one which is broad in scope and complex in nature. Historically, there is no "system," per se, of health care for adolescents. Health care to adolescents is delivered through a network of various categorical programs — some community-based, some school-based; some preventive care, some primary medical care; some education-oriented, others designed for outreach; some focused on a "single-issue," such as teen violence, others on a cluster of mental health issues (depression; eating disorders) — which form a type of patchwork. The lack of coordination and service integration among these programs raises access issues for adolescents, whose health needs are varied and cut across health, mental health, health education and social welfare issues.

This issue brief will continue our analysis of access to health care to our children and youth by focusing on adolescents. It will identify the factors which make adolescent health care needs "different" from those of younger children and adults and discuss barriers to care and strategies to improve access to care for New Jersey's almost 1.9 million (1995) children and adolescents under the age of 18.

OVERVIEW: NATIONAL PROPOSALS AND STATE RESPONSES

In a recent report released by the New York City Public Advocate, it was found that the number of children and adolescents without health insurance has increased twice as fast as the number of adults (*The New York Times*, February 25, 1997). Public Advocate Mark Green

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Capitol Forums on Health & Medical Care

League of Women Voters of New Jersey Education Fund

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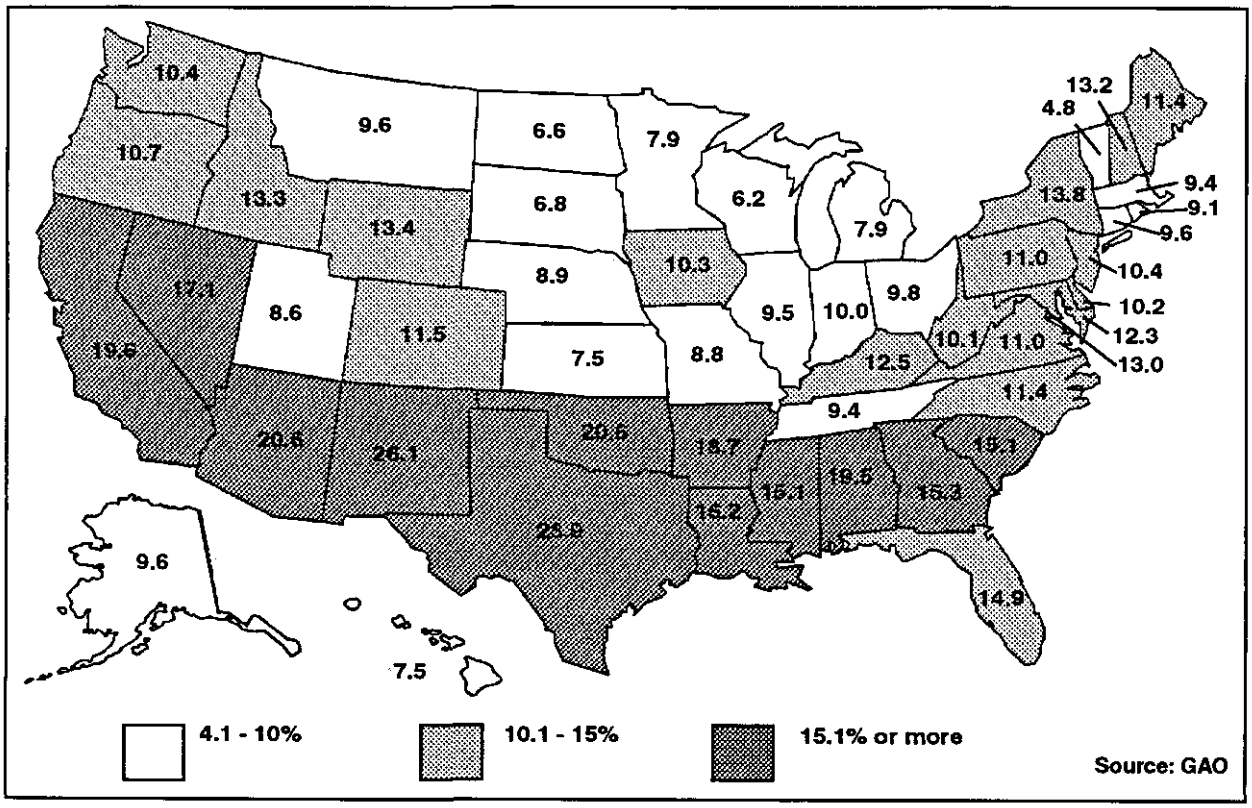
observed: "This is a crisis that is growing exponentially. But unlike kids being shot on the streets, the rising uninsured rates among kids and working families is a quiet crisis that is too easy to overlook."

The issue of providing adequate health care for our children and adolescents is being addressed across the country. National proposals range from Senators Kennedy and Kerry's proposal to establish a subsidy program to help working families purchase private health insurance for their children to the far-reaching goal of Representative Stark's proposal to mandate all group health plans and insurers to make coverage available for dependents and other individuals under the age of 21. A group led by Senator Thomas Daschle and Representative Richard Gephardt is sponsoring "Families First," a broad proposal

PERCENTAGE OF UNINSURED CHILDREN, BY STATE, 1994



The chances of being uninsured are about 40 percent higher for a person under the age of 18 than for an adult. Nationally, research indicates that children were less likely to be covered by insurance as they got older. Table 2 shows that in 1993, rates of non-coverage increased from 12 percent for children under age 6, to 17 percent for children between the ages of 12-17.

Table HC 3.1 PERCENT OF CHILDREN NOT COVERED BY HEALTH INSURANCE

	1987	1988	1989	1990	1991	1992	1993	1994
All Children	13	13	13	13	13	12	14	14
Age 0-5	-	-	13	-	-	-	12	-
Age 6-11	-	-	13	-	-	-	13	-
Age 12-17	-	-	14	-	-	-	17	-
Race/Ethnicity								
White	-	-	13	-	-	-	13	13
Black	-	-	17	-	-	-	16	17
Hispanic	-	-	30	-	-	-	26	28
Family Structure								
Two Parent	-	-	11	-	-	-	12	-
Single Female Headed	-	-	16	-	-	-	14	-
Single Male Headed	-	-	24	-	-	-	22	-

Source: Data for 1989 and 1993 produced by Child Trends, Inc., based on data from the March 1990 and current Population Surveys. Data for 1994 produced by Child Tends, Inc., based on unpublished tables supplied by the U.S. Bureau of the Census. Data for other years provided by U.S. Bureau of the Census based on analyses of March Current Population Surveys for 1988, 1989, 1991, 1992, and 1993.

aimed at families and children that also includes "kids-only" health insurance to create access for all children and youth to affordable health insurance. Currently, the Republican side has not offered any alternative plans (*George Washington University Newsletter*, January 1997).

On the federal level, the insurance model — offering subsidies to families to purchase health insurance — is the more favored model than the model to increase expansion or eligibility in already-established programs, such as Medicaid. Retiring Senator Sam Gibbons of Florida, however, has introduced such a bill, which would create a Children's Health Insurance Trust Fund that would be patterned after the Medicare Insurance Trust Fund.

In many ways, these Federal plans resemble the types of plans states have been experimenting with and developing over the past several years, partly because of the absence of direction offered by the Federal side.

The February 1997 Capitol Forums Issue Brief on children's health care discussed how as a matter of the "Devolution Revolution," it has fallen to the states to develop plans to meet the health care needs of their growing numbers of children and adolescents who experience multiple barriers to affordable and appropriate health care. By 1995, some 14 states had already established state-funded children's health insurance programs to subsidize the purchase of private insurance policies that generally offer more limited benefits than Medicaid (Ibid). In 24 states, it is the strategy to encourage public-private partnerships, with private sector organizations offering children-only insurance policies to some 250,000 children across the country (Ibid).

In analyzing the trend in several states to address the problem by enacting child insurance expansions, the February 1997 Issue Brief presented different models, including insurance subsidy models (such as Children First in New Jersey); the provision of additional funding to safety net providers that care for the poor and uninsured; or expanding programs by extending eligibility limits such as Medicaid expansion models or like HealthStart in New Jersey, which provides an expanded benefits package to Medicaid-eligible pregnant women and infants. Florida's Healthy Kids program provides another model which approaches the problems of access to health care by making greater efforts on outreach and enrollment — the program uses schools to enroll uninsured children. Each of these models affects the health care of our "older" children, aged 10 to 18, in different ways.

The state of New York has implemented an expansion of its Child Health Plus (CHPP) to cover children up to age 19. The CHPP expansion, which is expected to cover a total of 251,000 children (somewhat less than half of the state's uninsured children and youth), will be financed by a new 18.8 percent private payer surcharge (*George Washington University Newsletter*, January 1997). Although in-patient benefits will be added to this program which already provides out-patient benefits, the CHPP excludes mental health, substance abuse and alcohol treatment services.

In the state of Wisconsin, Governor Tommy Thompson proposed his Wisconsin Works program as part of the state's efforts towards implementing welfare reform. In working with the Hudson Institute, a nonprofit public policy think tank in Indiana, Thompson and a team of welfare reform staff built in child and health care subsidies to families earning up to 165 percent of the federal poverty level into the Wisconsin Works program. The subsidies will no longer be connected to public assistance but will be treated as "employment-supporting" programs for low-income working parents. The program's child and health care subsidies do not have time limits attached to them (*Public Welfare*, Spring 1996).

ADOLESCENT HEALTH ISSUES

In the February 1997 Issue Brief on children's health care, Professor Sparer noted that one of the reasons that there is growing support for providing health insurance to our nation's children is that "children, especially young children, are a deserving group". This statement is particularly significant when adolescent health and health care is added to the equation. Culturally, adolescents are not viewed, for the most part, as a "deserving" group; their transition to adulthood is often rife with "behavior" problems which are categorized as "rebellious, non-compliant and attention-seeking." Meeting their health and mental health care needs poses a set of complex problems.

The Children's Medical Security Plan (CMSP) in Massachusetts — the state-funded children's health insurance program — expanded in 1996 to include children up to age 18. While costs for Fiscal Year 1997 were projected at $40.96 per child per month, the program's health benefit coordinator acknowledged that "the expansion will drive up costs because adolescents have different health care needs" (Id).

The health care needs of adolescents **do** differ from those of children and adults. Many adolescents engage in risky behaviors that may have "harmful, even fatal, consequences for themselves and others" (Harvey and Rauch, 1996). The major causes of adolescent mortality (injury, homicide and suicide) have a behavioral basis, which require preventive health services. Currently, adolescent health care is crisis-oriented; yet, research continues to

find that in order to be effective, programs for adolescents must provide comprehensive coordinated care, available at a single site, which focuses on health promotion, illness and injury prevention and education about good health habits. In general, adolescents do not seek out health care services; consequently, provision of preventive and educational services must be through consistent outreach and coordinated information and referral services.

While the commonly held belief is that adolescence is a time of good health, the U.S. Office of Technology Assessment estimates that one in five adolescents suffers from at least one serious health problem (1995). In an analysis of adolescent health care, Dr. Gail Slap at the University of Pennsylvania summarized that adolescents are at particularly high risk for unintentional pregnancy, sexually transmitted diseases (STDs), injury, violence, suicidal behavior and substance abuse (1995). In the age group ranging from 15-24 years of age, injury causes 4 million person-years of lost work - the single-most costly American health problem. Similarly, injury and violence cause 76 percent of deaths and account for a significant share of chronic illness and disability in adolescents (Ibid).

The Child Welfare League of America, using data looking at indicators of health, sketched a portrait of a high school graduating class of 40 students in the year 2000 : thirty-six would have used alcohol, eight tried cocaine, seventeen marijuana, eleven would be unemployed, fifteen living in poverty, six would have run away from home, eight would not even have graduated, but dropped out, two would have given birth and one would have committed suicide (Hein, 1993).

According to the Department of Health and Senior Services' 1996 *Healthy New Jersey 2000 Update*, the leading problems influencing the health and well-being of adolescents in New Jersey are: unintentional injury, sexual and physical abuse, violence, homicide, suicide, unintended pregnancy, sexually transmitted diseases and addiction (alcohol, tobacco, marijuana and cocaine). Adolescent pregnancy is a primary public health issue that affects the health, educational, social and economic future of both mother and child.

Adolescent Pregnancy - A Complex Problem with No Easy Answers

Adolescent pregnancy rates are 3 to 10 times higher in the United States than those documented among industrialized nations of Western Europe. This health problem among our young girls is associated with a high number of individual and societal costs. However, recent studies have shown that the root causes for adolescent pregnancy cut across many issues, and the reduction of adolescent pregnancy cannot be limited to family planning education. The foremost factor affecting adolescent pregnancy is poverty: forty percent of American teenage girls live near or below poverty income levels, and these individuals account for 6 of 7 births to teenage mothers (Journal of the American Medical Association, July 24/31, 1996). At the same time, access to contraceptives remains limited. Only 15 percent of health insurance plans cover the most effective contraceptive methods and two-thirds do not cover birth control pills (Ibid). Another disturbing statistic that emerges when the issue of adolescent pregnancy is scrutinized is the role played by adult males in childbearing by adolescents. In a 1995 study, it was found that of 46,511 marital and unwed births to school-aged girls in California, 71 percent were fathered by men whose mean age was almost 23 years of age (almost five years older than the mother). These and other statistics are sobering and underscore the challenge and complexity of remedying just one of countless adolescent health problems. Cooperative strategies must be developed with families, communities, health care providers, policy makers and politicians to target the root causes of the social problem to reach a viable solution. An example of a successful coordinated program is the adolescent services program at New Jersey's Pinelands Regional High School. The state is currently exploring replicating the program in other schools based on the decline in adolescent pregnancy rates at the school. The Pinelands program documented a decline in adolescent pregnancy from 20 per year prior to the program to 2 per year post-program (Healthy New Jersey 2000 Update, 1996).

The *Healthy New Jersey 2000 Update* identifies as a significant barrier to its goal of improving the health of New Jersey's adolescents the fact that many adolescents do not have health insurance and do not have access to appropriate and regular sources of primary health care. New Jersey mirrors the national problem that economically disadvantaged urban minority and rural adolescents are at highest risk for hurting themselves and others by engaging in risk-taking behaviors (*Healthy New Jersey 2000 Update* 1996; Harvey and Rauch, 1996; Durlak 1995). Poverty is directly related to the growing rates of teen pregnancy, sexually transmitted diseases, addiction, violence-related injuries and deaths, and contact with the criminal justice system (Ibid).

DELIVERY SYSTEM AND ACCESS ISSUES FOR ADOLESCENTS

The provision of adolescent health care is fragmented and not well-coordinated: state programs are administered across several Departments — including Health, Human Services, Education; and community-based services are offered through various private and public provider orga-

nizations (Reference is made to Appendix II, "Overview of New Jersey's Health and Medical Programs for Children and Adolescents"). The primary reasons for this fragmentation include that historically, there were financial disincentives to provide preventive care; categorical funding sources created "single problem" programs, such as alcohol abuse or teen pregnancy, rather than integrated services, leaving already resource-drained safety net providers competing for reduced dollars; adolescent discomfort and mistrust with the health care system and provider inexperience with working with adolescents.

Although research study after study indicates that a comprehensive, integrated approach has the best chance of helping youth avoid negative behaviors and outcomes, administrative and fiscal barriers act as blocks to such coordinated programs. When is the "right time" to consider re-structuring the service delivery system to allow for access to appropriate services for this vulnerable population? In the current environment in which funding reductions are threatening the existence of our community providers, many of whom are providers of last resort, should change be considered at the delivery system level, rather than at the insurance subsidy level? Just as in New Jersey, state government leaders recognized the detrimental effects a fragmented delivery system was having on the senior population and has now "put under one roof" programs for its elderly, is the same restructuring necessary for programs for children and adolescents, which currently cut across the Departments of Health; Human Services (including Divisions of Mental Health and Hospitals; Youth and Family Services; Medicaid; Family Development; Developmental Disabilities); Education, Labor, Insurance and various components of the juvenile justice system?

Research on adolescents indicates that early intervention is critical in working with at-risk adolescents. Early adolescence — that is, between the ages of 10 and 15 — is a formative time in the development of positive behaviors and activities. There appear to be three critical risk antecedents for early adolescents: poverty, neighborhood environment and family environment. Two risk markers — or warning signals for more significant problem behaviors in adolescence — are poor school performance and involvement with child protective services and foster care systems (Resnick and Matheson, 1992). Problem behaviors in this population include: early practice of sexual behavior; truancy from school; running away from home; early use of tobacco, alcohol and other drugs. Risk outcomes which may extend from these behaviors are teen pregnancy and teen parenthood; school dropout; criminal behavior; AIDS and other sexually transmitted diseases (STDs); physical and sexual abuse and various morbidity and mortality conditions, such as accidents, suicide and homicide. It is estimated that as many as half of today's adolescents run a moderate to high risk of experiencing school failures or participating in early sexual activity, alcohol and drug use and criminal behaviors (Id).

Traditional services for at-risk adolescents often address only a single risk marker or outcome, such as teen pregnancy, substance abuse or school failure (Id.) The single-problem focus has limitations: the programs focus only on the problem, rather than the "whole person"; it is difficult to coordinate with other agencies when the single-problem program does not have the resources to address the other problems being experienced by the client; the adolescent client gets "lost" in the system, which s/he is not skilled at negotiating in the first place and also may be resistant to cooperating with.

A service integration model is one in which several service agencies coordinate their efforts to address the full range of service needs presented by youth and families in an efficient manner. The model would include case intake and evaluation, a coordinated service plan based on the needs identified; institutionalized interagency linkages that ensure referrals and follow-up on service referrals. Barriers to service integration for adolescents are significant. They include professional orientation, administrative procedures, eligibility rules and the categorical nature of funding. Service agency staff are trained in narrow, specialized traditions (such as mental health or criminal justice services) and do not move easily into interagency coordination. Categorical public and private funding also drives single-issue programs, as legislatures and policy makers structure programs to address specific problem areas (Id.)

In an Urban Institute study focused on service integration program models, nine programs across the country were evaluated. They included one mentoring program (using positive adult role models in working with at-risk youth); one focused on a geographically defined community; one operating exclusively in the schools; three operating in the schools and community and three that were community-based. Although study findings showed that service integration models best served the adolescent population, whether they were school-based or community-based, or a combination of both, all of the programs continue to struggle for their existence and with the problems of categorical funding and with the fact that several agencies were competing for the same dollars to develop similar programs.

SCHOOL-BASED PROGRAMS — INSURANCE AND SERVICES

The model of Florida's Healthy Kids program enhances access to insurance for this vulnerable popula-

tion by offering School Enrollment Based Health Insurance. The goals of the program are to create a comprehensive insurance product for school children and to facilitate the provision of preventive care for children. Coverage is offered to families with children enrolled in schools, since research indicates that about two-thirds of the uninsured are in households with children of school age. The model is based on the traditional employer-based insurance model, where the employer is the policy holder and the employee as certificate holder can cover spouse and children; with school enrollment based health insurance, the school district is the policy holder, the student is the certificate holder and parents and siblings are covered under his/her insurance plan. A sliding scale is used to identify the family's contribution towards premium payments. Currently, families are contributing 37 percent of the medical costs for the program. Co-pays are also required for some services, such as prescriptions and glasses. The balance of funding comes from local funding sources (18 percent) and state appropriations (45 percent). While the current enrollment is at approximately 20,000 children in nine counties, 1997 plans include expansion into seven new counties and 47,520 children (Healthy Kids - Florida. Annual Report. 1996). One expansion also being considered is to include over 100,000 preschool children throughout the state.

The role of the schools is critical in this model. They serve as the central institution within communities, creating relationships between the local project, community leaders and area business groups. The school-based health center (SBHC) model, which is in place throughout the country, offers a multi-disciplinary team to provide a full array of health services, including primary and acute care, psychological services and treatment for substance abuse. Located on-site in the schools themselves, SBHCs aim to increase access to health care services for students, which is a critical issue for adolescent health care. For example, in 1990, the American Medical Association found that at least 7.5 million youths under age 18 needed mental health services, but fewer than one-third will receive treatment (*Advances*, Fall 1996). When counseling services such as groups on depression or self-harm are made available in school settings, adolescents are more likely to attend because the setting is familiar and non-threatening (Durlak, 1995).

Typically, adolescents under-utilize primary preventive health care services; therefore, outreach is a critical component of any coordinated adolescent health care system. In a recent longitudinal study of school-based programs, it was found that voluntary, in-school groups covering a variety of issues — including depression, substance abuse and addiction, physical abuse, STDs and HIV/AIDS — had a significant positive impact on the adolescents who attended. Concurrent research found that the most effective type of program involved school-based program services, extracurricular activities and corollary programs to educate and engage parents and the community (*Journal of the American Medical Association*, August 21, 1996). The Robert Wood Johnson Foundation's national program "Making the Grade," focuses on helping state-community partnerships increase the availability of school-based health services. In their outcome studies, all evaluations agree in the area of access, school-based centers have a positive impact and do increase access to health care (Advances, Fall 1996).

The New Jersey School-Based Program (SBYSP), implemented over 10 years ago, is an example of a state wide effort to place comprehensive services for adolescents in or near secondary schools. The program is administered and funded through the Department of Human Services, and it is currently in operation in 30 school districts (with 42 program sites). While most of the programs offer primarily supportive services, mental health, employment training and substance abuse couseling, there are a few cases where the program includes primary medical care services, such as the program in operation at the high school in Plainfield, New Jersey

NEW JERSEY - CURRENT STATUS, FUTURE DIRECTIONS

As part of its public health agenda, the state of New Jersey recognizes the need: "to enhance adolescents' access to health services; to strengthen the linkages and infrastructure among the Departments of Education, Human Services and Health to increase the effectiveness of existing primary and preventive health services and the School Based Youth Services Programs; and to collaborate to develop models of health care delivery that include school-based and community-linked approaches." (*Healthy New Jersey 2000 Update*). (Reference is made to Appendix II, "Overview of New Jersey's Health and Medical Programs for Children and Adolescents.")

During the past year, the Department of Health and Senior Services (DHSS) has brought together all of the players at the state governmental level who are involved in programs for adolescents. As with almost every state across the country, New Jersey's programs are shaped by categorical funding sources so that most are focused on single problem issues - such as teenage pregnancy, substance abuse, or AIDS. As a means to "coordinate" health and social services for adolescents, DHSS has organized a working team, beginning with its intra-departmental programs such as Substance Abuse, STDs, AIDS; suicide; homicide; violence; teen parenting; and communicable diseases, and branching out to include advisors from the other Departments, including Human Services (DYFS,

Medicaid, Mental Health), Education, Labor, and representatives from the juvenile justice system.

The Department of Health and Senior Services is also currently completing a profile of New Jersey's adolescents, which assesses their health and mental health status and identifies issues associated with providing primary and supportive services to adolescents. The state is looking at ways to incorporate Service Integration models for adolescent services, in order to remedy access problems that exist in the fragmented delivery system.

In an effort to coordinate adolescent health care services statewide, the Division of Medical Assistance and Health Services (Medicaid), in consultation with the Department of Health and Senior Services, implemented teen-directed family planning services in July 1995. The program offers a separately reimbursed package of services to Medicaid recipients under the age of 21 years old who are served through Family Planning Clinics and Federally Qualified Health Centers in the state. The teen-directed services include an intake process, risk behavior assessment and evaluation, preventive health education and counseling services covering a broad range of issues, from contraception to violence prevention, and case management services including referral to other appropriate services. The service package incorporates the recommended clinical preventive services for adolescents included in the American Medical Association's "Guidelines for Adolescent Services" and the Maternal and Child Health Bureau's "Bright Futures: National Guidelines for Health Supervision of Infants, Children and Adolescents." In a period of just over a year, approximately 5,000 teens were served through the program.

The program works on the model of reaching the teenage client when s/he makes contact with a service agency for medical assistance. The service package "is intended to reduce the number of adolescent pregnancies. . .to diminish risk-taking behaviors and to improve adolescent health outcomes" (*Newsletter*, Department of Human Services, August 1995). DHSS is also implementing a tracking system to collect and analyze outcome data to evaluate the effectiveness of the program.

CONCLUSION

The transition from childhood to adulthood — from dependence to autonomy — is marked with challenges and frustrations. In the current environment of the health care "revolution," the status of adolescents, whose health care services have traditionally been crisis-oriented and rife with barriers to access, is most vulnerable. While there are countless programs throughout the state which provide much-needed services in a effective and efficient manner, their existence is threatened based on the realities of a competitive market and reduced public funding support. As with our children, we must remember that with our adolescents, when we ensure their health and safety, we are ensuring the future for everyone.

QUESTIONS FOR DISCUSSION

• Should the state either expand Medicaid, or develop some other program, in an effort to provide health insurance to the state's uninsured children and adolescents? Are insurance expansions the best way to improve the health needs of the uninsured?

• How will welfare reform impact on the health of New Jersey's children and adolescents?

• Do the health needs of young children and their older counterparts require separate strategies? If so, what are the relevant differences?

• Across the country, several states have scaled-down their once-ambitious health reform plans--whether in the form of insurance expansions, employer mandates, managed care iniatives or universal coverage--and have shifted to an incremental approach. What is New Jersey's position regarding its responsibility, during this time of dynamic transition in the health care environment, to assure a minimun level of health care to its citizens, especially children and adolescents?

• According to a recent U.S. General Accounting Office study of six state-and privately-funded children's health insurance programs, **limited** evidence was found to suggest that such programs "increase the likelihood that children would get the care that they needed; reduced inappropriate emergency room use in some cases; and/or increased children's use of preventive services." Is it too soon to tell, or are early indicators suggesting that the insurance subsidy model is not an appropriate strategy in handling the problem of the enormous numbers of uninsured children and youth?

• The health care revolution — with its emphasis on reduced spending and the spirit of competition — may well have a negative effect on the health care safety net, a significant piece of which is the Medicaid program. What are New Jersey's strategies for supporting its safety net providers who meet the health care needs of its high-risk and vulnerable adolescents?

• As the loosely-knit "safety net" grows thinner, what are the options regarding "who pays?" for care. Throughout the country, the safety net providers themselves are paying for some portion of the care provided to those who are uninsured and under-insured. The Congressional Budget Office reported that in 1995 hospitals and physicians provided an estimated $28 billion in uncompensated care, up from $20 billion in 1991 (Rovner, 1996). With limitations on cost-shifting and competitive market practices such as discounting, hospitals will find it more difficult in the future to provide such levels of uncompensated care. How will these gaps be filled?

• Across the country, states are expanding their Medicaid eligibility limits to provide services to children. As states move towards expanding these programs to the adolescent population up to age 18, policymakers raise concerns about increase costs associated with serving this population based on the reality that their health care needs are different from those of children and adults. How will we balance the great need to serve our adolescents and the drive to reduce health care spending?

• Preventive health care and health education are prominent features of an adolescent health care system, both of which are at the core of population-based public health activities. What priority will New Jersey, which is in the process of "re-structuring" its public health system, place on adolescent health care?

• In the field of mental health, it is well-established that mental illnesses are treatable, and with successful diagnosis and treatment, most children and adolescents with mental illnesses can lead productive lives. Positive outcomes result from early intervention and well-coordinated treatment plans. What is New Jersey's commitment to develop outreach to ensure that its children and adolescents are evaluated and treated at the onset of mental illness, rather than to delay treatment and intervention until the care becomes much more costly?

• Under Title IV-B of the Social Security Act, new legislation was introduced to promote family strength and stability, enhance parental functioning and to improve the delivery of preservation and support services to vulnerable children and families. New Jersey's five-year plan for its Family Preservation and Support Services (FPSS) Initiative, developed and coordinated through the Department of Human Services, includes a commitment to coordinate supportive services for families, which are community-based, in areas outside the traditional child welfare system — housing, mental health, health, education, job training, substance abuse treatment and child care. How will the FPSS affect New Jersey's high-risk adolescents?

• Healthy New Jersey 2000 Update includes in its recommendations to "evaluate managed care trends and their impact on adolescent health outcomes." How can we best use managed care's emphasis on preventive medicine with our adolescents, who so require comprehensive, coordinated preventive care to identify potential problems before they develop into full-blown health problems or self-destructive behaviors?

• The issue of "aging-out" of programs when an individual reaches age 19 raises multiple problems. How do we deal with "transitioning" these individuals from health and human services programs once they chronologically pass the age limit set for program participation?

• Demographers project that by 2020, the growing population of the elderly in our country will be paralleled by the shrinking population of adolescents. In 1980, the percentage of children under 17 years of age was estimated at 30 percent of the total U.S. population, and will be less than 20 percent by the year 2020, when the percentage of elderly population will far exceed it. What are the public policy implications of this skewed balance, especially when our country's youth are confronted with such complex health, mental health and employment problems?

• Program evaluation research, supported by reliable data, is critical in identifying which program models for adolescents "work" and which do not. As with most health care issues, the collection and analysis of reliable data is, at best, fragmented and must be pieced together from different data sources. What is New Jersey's commitment to establishing empirical data sources to best evaluate the programs and collect and analyze outcome data for state-funded adolescent health care?

APPENDIX I

NEW JERSEY HEALTH AND MEDICAL PROGRAMS FOR CHILDREN AND ADOLESCENTS

This overview summarizes the key health and medical programs for children and adolescents administered by the state of New Jersey. Included are various "cross-over" programs that offer social support, mental health, nutritional services and insurance coverage to these groups.

State-wide, there are a multitude of outreach, intervention and prevention programs and services for children and adolescents (with varying levels of service needs) at regional, county and local levels. These services are provided in communities through publicly and privately funded agencies, religious and civic organizations (such as Catholic Charities; Jewish Family Service; Planned Parenthood; Red Cross; United Ways); county and local health departments, local family service agencies, community nursing services, community mental health centers and special education programs in the school districts. For example, county and local health departments may provide a broad range of services such as childhood immunization clinics, dental health services, lead screening and sexually transmitted disease (STD) clinics to members of their communities. A Department-by-Department summary follows.

DEPARTMENT OF HEALTH AND SENIOR SERVICES

• Newborn Screening Program (hearing/biochemical, i.e., sickle cell, PKU)

• Birth Defects Registry: State law mandates reporting of children, birth to age one, with a birth defect to Special Child and Adult Health Services.

• Maternal and Child Health Consortia Oversees and monitors regional maternal, perinatal and child health service delivery networks. Provides education and promotes total quality improvement.

• HealthStart [in conjunction with Medicaid] Pregnant women and children - provides an enhanced package of Medicaid benefits to eligible pregnant women during pregnancy and for 60 days following delivery or the date the pregnancy ends. Children up to the age of two are also eligible for enhanced health services.

• Healthy Mother, Healthy Babies Initiatives in cities with high rates of infant mortality, adolescent pregnancy, including special outreach programs to adolescents.

• Childhood Lead Poisoning Prevention. Provides screening, follow up and education, medical referral and environmental investigation services.

• Special Supplemental Nutrition Program for Women, Infants and Children (WIC) Provides monthly vouchers to purchase food. 1997 budget book indicates that approx. 260,000 pregnant women and children were served under WIC in 1995.

• Communicable Disease Control for infants and children entering school (Rubella; Measles; Mumps; Polio, Diphtheria), provides immunizations for low income uninsured and underinsured children.

• Health Access New Jersey: The Access Program and Children First For access to health insurance coverage for qualified uninsured children. 1995 enrollment for Health Access reached 22,000; by the end of 1996, through attrition, enrollment was at 16,696. Currently, there are 1,548 children under the age of five (5) who are covered and 4,120 covered children between the ages of 6 and eighteen (6 - 18). In the FY 1997-98 proposed budget, $5 million is dedicated to the Children First program. It is estimated that 5,000 children will be covered by the program and an estimated 2,300 children will be from families transitioning from the AFDC economic assistance program.

• Prevention Oriented Health Program provides home visiting services through local health departments for at risk families to promote wellness, safety and parenting skills.

Funding sources for programs include various Federal block grants: Maternal and Child Health Block Grant; Preventive Health Block Grant; Drug Abuse and Mental Health Block Grant; as well as other state and Federal funds.

Within the Department of Health, the key programs for children and youth are situated in various Divisions and Offices. For example, the Division of Family Health Services is comprised of Community Health Services (administers state and federal funding support and technical assistance for the provision of preventive and primary health care services); the Early Intervention Program (EIP) (maintains system of services for infants and toddlers (birth to age 3) with developmental delays or disabilities offering comprehensive coordinated multidisciplinary services); Maternal and Child Health and Regional Services provide Maternal and Child Health Consortia oversight and primary and specialized perinatal services.

Specific programs and services are administered through discrete units. Special Child and Adult Health Services through the Specialized Pediatric Services Program supports a network of providers for access to quality, multidisplinary comprehensive health/medical care for children with disabilities, birth defects and chronic illness. Special Child and Adult Health Services, in cooperation with the local Boards of County Freeholders, funds 21 county based case management units. Their mission is to assist families of children with special health care needs identify and access comprehensive services needed by their child. Each year, more than 10,000 children with special needs are identified through the SCAHS Special Needs and Birth Defects Registries. More than 15,000 families receive SCAHS case management services.

In January 1997 the Department announced the formation of a 31-member Blue Ribbon Panel on Black Infant Mortality, comprised of community members, health experts and social services representatives, to examine the problem of black infant mortality and to find ways to reduce the state's high rate of black infant deaths. In 1994, New Jersey's state-wide infant mortality rate was 7.7 deaths for every 1,000 live births; the rate for blacks was 16.6, which is 2.8 times higher than the rate of 5.9 for whites. The national black infant mortality rate was 15.8 in 1994. Healthy New Jersey 2000's goal is a black mortality rate of 11.0 by the end of the decade.

The Department's programs for children and adolescents also include immunization programs; Sexually Transmitted Disease Control program; Alcohol, Drug Abuse and Addiction Prevention Services; Alcohol and Drug Treatment and Rehabilitation Services. Grants provided for violence-prevention, family counseling (for adolescents), rape prevention education and date/acquaintance rape (with hotlines and counseling services.)

There are 20 state-funded agencies that provide confidential family planning health and education services to adolescents at 60 sites throughout the state.

DEPARTMENT OF HUMAN SERVICES

Division of Medical Assistance and Health Services (Medicaid)

• "Regular" Medicaid Program (health program for the poor whose incomes and resourcesare equal to or below the limits established for the program)

• Medically Needy Program (for pregnant women and children; aged blind and disabled. For individuals whose incomes are too high to qualify for the regular Medicaid program.)

• New Jersey Care (for pregnant women and children under age 13; also aged, blind and disabled eligibles)

• Medicaid Expansion Programs, including: Maternal and Child Health Expansion to Age 6 and 133 percent of poverty.
Expansion to Age 13 and 100 percent of poverty
Expansion to 185 percent of poverty for infants birth-one year and pregnant women.

'• New Jersey Care 2000 - the state's mandatory Medicaid managed care program. Has enrolled more than 340,000 Medicaid beneficiaries in 13 commercial HMOs and the state's Garden State Health Plan.

• HealthStart — Since 1987, in conjunction with the Department of Health and Senior Services, provides an enhanced package of Medicaid benefits (including case management services) to eligible pregnant women and children (up to two years of age).

• Medicaid Model Waiver Programs I, II and III - home and community-based waivers for blind or disabled children and adults.

• ABC Program - home and community-based services for medically fragile children under the care and supervision of the Division of Youth and Family Services (which administers the program).

• Home and Community-Based Services Waiver for Persons with Traumatic Brain Injuries To provide community alternatives for brain injured individuals currently in nursing facilities. Client population to be served is primarily young adult and ambulatory, with cognitive, behavioral and physical deficits which require supervised and supported care.

• AIDS Community Care Alternatives Program (ACCAP) Designed for individuals who are diagnosed as having AIDS or children under five (5 years of age) diagnosed as HIV positive who, without home services, would need institutional care.

DEPARTMENT OF HUMAN SERVICES

School Based Youth Services (SBYSP)

In Healthy New Jersey 2000, the goals for the end of the decade include "strengthen the linkages and infrastructure among the Departments of Education, Human Services and Health for primary and preventive health services and comprehensive school health education."

School Based Youth Services (SBYSP), currently in 42 sites state-wide, are coordinated through a collarborative partnership between the Department of Human Services, local school boards and their communities. The program links the education and human services systems together in a "one-stop shopping" site for youth. Currently, over 20,000 students are served annually through the programs.

SBYSP operates in urban, rural and suburban school districts with at least one site per county; the program is expanded from secondary school settings to elementary and middle schools. Each site provides health care, mental health and family counseling, job and employment training and substance abuse counseling. Additional services may include teen parenting education, day care, tutoring and family planning hotlines.

DEPARTMENT OF HUMAN SERVICES

Division of Youth and Family Services (DYFS)

The primary responsibility of DFYS is receiving, responding to and investigating allegations of suspected child abuse and neglect. DYFS also provides preventive and supportive social services to families where child maltreatment has been substantiated and/or where family disorganization requires intervention, either by direct provision of services or through referral to community providers. Protective services and family support services are delivered by a state-wide network of 32 local District Offices. DYFS provides assessment and evaluation of families to determine appropriate services, foster care placements, adoption services and case management. The Division also operates a 24-hour hotline to receive reports of suspected child abuse and neglect.

Child care programs coordinated through DYFS and the Division of Family Development (DFD):

1. Title IV-A At-Risk Child Care Program.

At-risk is defined as working low-income families whose income is at or below 200 percent of the FPL. This program provides child care assistance to low-income working families who might otherwise be vulnerable to welfare dependency.

2. Child Care and Development Block Grant Program - provides low and moderate income families with child care assistance.

Division of Family Development (DFD)

The Division of Family Development administers various programs including: Aid to Families with Dependent Children (AFDC) - Temporary Assistance to Needy Families (TANF); Work First NJ; General Assistance; Food Stamps; Supplemental Security Income Program; JOBS; Child Support Enforcement; Home Energy Assistance and Emergency Assistance. Recent federal legislation under Title IV-B of the Social Security Act — Family Preservation and Support Services — aims to promote family strength and stability, enhance parental functioning and protect children through a program providing family preservation and support services. In recognition of a fragmented delivery system of services in child welfare and the vulnerability of high-risk families, DFD has designed a five-year plan to implement the Family Preservation and Support Services Initiative, taking into consideration the broader factors of poverty, unemployment and homelessness as threats to the integrity of the family.

Division of Mental Health and Hospitals

The Division of Mental Health and Hospitals oversees, monitors and administers mental health services for New Jersey citizens, including children and youth, through the state and country psychiatric hospital systems and through community mental health centers. The Division purchases community mental health services through contracts with 127 not-for-profit provider corporations, which provide 575 discrete mental health programs. Program services include: outpatient, group home services, case management and family support services.

Division of Developmental Disabilities

The Division of Developmental Disabilities oversees, monitors and administers programs and services, both institutional and community-based, for children, youth and adults with developmental disabilities. Under the Family Support Act (1993), the Division developed the Family Support Program to create a system of family support to serve the individual with a disability and the individual's family. Program services include: cash subsidies, counseling and crisis intervention, day care and personal assistance services.

DEPARTMENT OF HUMAN SERVICES

Catastrophic Illness in Children Relief Fund

The Catastrophic Illness in Children Relief Fund was established by legislation to provide financial assistance for families whose children have experienced an illness or condition which is not otherwise covered by insurance, State or Federal programs, or other source. The Commission which administers this dedicated trust fund operates from the Office of the Commissioner of Human Services.

APPENDIX II: A TALE OF TWO COUNTIES

According to the most recent report from the Association for Children of New Jersey and data collected from the U.S. Department of Health and Human Services' *Trends in the Well-Being of America's Children and Youth*, there are vast variations in the status of New Jersey's children and youth from county to county, region to region. Summarized below are profiles of Hunterdon County, ranked second to the top when compared to New Jersey's state rate for various indicators of health and well-being, and of Camden Country, ranked 20th of 21 when compared to the other counties.

NEW JERSEY STATE FACTS

Per Capita Personal Income 1993.....$26,876
Population Under 18 Years Old 1992.....1,799,462
Percent Non-White.....32%
Percent of Children Living with Single Parent.....19%
Percent of Children Living Below Poverty Level.....11%
Births in 1993.....117,830

TRENDS IN CHILD WELL-BEING

Indicator	Kids Count 1993 Book	Kids Count 1994 Book	Kids Count 1995 Book	State Three Year Average
Low Birth Weight - percent of all live births	7.5	7.3	7.6	7.5
No Prenatal Care - percent of all live births	1.3	1.4	1.4	1.4
Infant Mortality Rate - per 1,000 live births	8.8	8.3	8.4	8.5
AFDC Benefits - per 1,000 children	128	127	120	125
Food Stamp Benefits - per 1,000 children	153	155	154	154
Birth to Teens - per 1,000 teens (15-19)	40	39.7	38.4	39.4
Child Death Rate - per 10,000 children (1-14)	2.5	2.6	2.4	2.5
Teen Death Rate - per 10,000 teens (15-19)	5.8	5.8	5.8	5.8
Juvenile Arrest Rate - per 1,000 children (10-17)	115	110	115	113
Juvenile Commitment Rate - per 1,000 teens (13-18)	1.8	2.1	2.3	2.1
Child Abuse - per 1,000 children	NA	4.6	3.7	*4.2
Family Problems - per 1,000 children	NA	9.1	12.9	*11
Out-of -Home Placement Rate - per 1,000 children	4.5	4	4.6	4.4

HEALTH INDICATORS (1991, 1992, 1993)
AFDC AND FOOD STAMP INDICATORS (1993, 1994, 1995)
ARREST INDICATOR (1992, 1993, 1994)
COMMITMENT INDICATOR (1992, 1993, 1994)
CHILD ABUSE AND FAMILY PROBLEM INDICATORS (1993, 1994)
OUT-OF-HOME PLACEMENT INDICATOR (1993, 1994, 1995)
**TWO YEAR AVERAGE*

Source: Kids Count. New Jersey 1995. State and County Profiles of Child Well-Being. The Association for Children of New Jersey. 1995.]

CAMDEN COUNTY COMPOSITE RANK #20

Per Capita Personal Income 1993.....$22,388
Population Under 18 Years Old 1992.....133,067
Percent Non-White.....31%
Percent of Children Living with Single Parent.....24%
Percent of Children Living Below Poverty Level.....16%
Births in 1993.....7,976

Indicator of Child Well-being	State Rate	County Rate	Percent Worst/Better Than State	1995 County Rank
Low Birth Weight 1993 - percent of all live births	7.6	8.6	13% worse	20
No Prenatal Care 1993 - percent of all live births	1.4	1.4	same as state rate	16
Infant Mortality Rate 1993 - per 1,000 live births	8.4	10.5	25% worse	17
Child AFDC Rate 1995 - per 1,000 children	120	191	59% worse	18
Child Food Stamp Rate 1995 - per 1,000 children	154	233	51% worse	18
Birth to Teens 1993 - per 1,000 teens (15-19)	38.4	58	51% worse	17
Child Death Rate 1993 - per 10,000 children (1-14)	2.4	3.1	29% worse	19
Teen Death Rate 1993 - per 10,000 teens (15-19)	5.8	6.8	17% worse	13
Juvenile Arrests 1994 - per 1,000 children (10-17)	115	114	1 % better	11
Juvenile Commitments 1994 - per 1,000 teens (13-18)	2.3	5.4	135% worse	21
Child Abuse (Sub. Cases) 1994 - per 1,000 children	3.7	3.8	124% worse	20
Family Problems 1994 - per 1,000 children	12.9	16.6	29% worse	16
Out-of -Home Placement 1995 - per 1,000 children	4.6	7.5	63% worse	20

Indicator of Child Well-being	Kids Count 1993	Kids Count 1994	Kids Count 1995	Three Year Average
Low Birth Weight	7.9	8.3	8.6	8.3
No Prenatal Care	1.6	2	1.4	1.7
Infant Mortality Rate	11.6	11.9	10.5	11.3
Child AFDC Rate	211	204	191	202
Child Food Stamp Rate	240	237	233	237
Birth to Teens	61	63.3	58	60.8
Child Death Rate	3.4	3.5	3.1	3.3
Teen Death Rate	6.8	8.1	6.8	7.2
Juvenile Arrests	99	112	114	108
Juvenile Commitments	4.5	6	5.4	5.3
Child Abuse (Substantiated)	NA	9.1	9.3	8.7
Family Problems	NA	15.8	16.6	16.2
Out-of -Home Placement	7.4	5.9	7.5	6.9

Source: Kids Count. New Jersey 1995. State and County Profiles of Child Well-Being. The Association for Children of New Jersey. 1995.]

HUNTERDON COUNTY COMPOSITE RANK #2

Per Capita Personal Income 1993.....$31,545
Population Under 18 Years Old 1992.....25,941
Percent Non-White.....3%
Percent of Children Living with Single Parent.....8%
Percent of Children Living Below Poverty Level.....3%
Births in 1993.....1,462

Indicator of Child Well-being	State Rate	County Rate	Percent Worst/Better Than State	1995 County Rank
Low Birth Weight 1993 - percent of all live births	7.6	5.8	24% better	5
No Prenatal Care 1993 - percent of all live births	1.4	.2	86% better	2
Infant Mortality Rate 1993 - per 1,000 live births	8.4	2.7	68% better	2
Child AFDC Rate 1995 - per 1,000 children	120	14	88% better	1
Child Food Stamp Rate 1995 - per 1,000 children	154	19	88% better	1
Birth to Teens 1993 - per 1,000 teens (15-19)	38.4	10.5	73% better	3
Child Death Rate 1993 - per 10,000 children (1-14)	2.4	1.7	29% better	5
Teen Death Rate 1993 - per 10,000 teens (15-19)	5.8	6.2	7 % worse	12
Juvenile Arrests 1994 - per 1,000 children (10-17)	115	42	63% better	1
Juvenile Commitments 1994 - per 1,000 teens (13-18)	2.3	.4	83% better	4
Child Abuse (Sub. Cases) 1994 - per 1,000 children	3.7	2.3	38% better	5
Family Problems 1994 - per 1,000 children	12.9	6	53% better	3
Out-of -Home Placement 1995 - per 1,000 children	4.6	1.6	65% better	4

Indicator of Child Well-being	Kids Count 1993	Kids Count 1994	Kids Count 1995	Three Year Average
Low Birth Weight	4.6	5.2	5.8	5.2
No Prenatal Care	.2	.1	.2	.2
Infant Mortality Rate	4.7	4	2.7	3.8
Child AFDC Rate	16	15	14	15
Child Food Stamp Rate	22	22	19	21
Birth to Teens	11	7.5	10.5	9.7
Child Death Rate	2.4	3.3	1.7	2.5
Teen Death Rate	4.6	4.8	6.2	5.2
Juvenile Arrests	50	35	42	42
Juvenile Commitments	.1	.1	.4	.2
Child Abuse (Substantiated)	NA	1.7	2.3	2
Family Problems	NA	5.2	6	5.6
Out-of -Home Placement	1.2	2.8	1.6	1.9

Source: Kids Count. New Jersey 1995. State and County Profiles of Child Well-Being. The Association for Children of New Jersey. 1995.]

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