

BLUEPRINT FOR ADOLESCENT AND YOUNG ADULT HEALTH CARE





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CHAPTER 1. MAKING THE CASE FOR ADOLESCENT AND YOUNG ADULT HEALTH CARE

Why Adolescent and Young Adult–Centered Health Care?

Adolescents (aged 10 to 19 years) and young adults (aged 20 to 24 years) comprise approximately 21% of the population of the United States¹—a significant segment of our society with immense promise to contribute to our communities. These young people are at an age of transition when they are developing and adopting healthy or unhealthy behaviors based on their life situations thus far.² Despite their limitless potential to contribute to our society if given the opportunity for a healthy future, frequently, their unique needs are not addressed by the traditional, adult-focused health care model.

The passage of the Affordable Care Act (ACA) of 2010 has stimulated increased interest in medical homes that can comprehensively address health care. For young people, the establishment of a medical home can increase the likelihood of building a trusting relationship with a health care provider and provide valuable insight into how all aspects of health are connected. The importance of consistent, comprehensive care is underscored by evidence that nearly half of young people do not have a medical home and that the resulting lack of coordinated care is linked to failure to diagnose mental disorders at an early age.⁴ However, while the transformation of primary care via the medical home model could greatly benefit

“One of the most important commitments a country can make for future economic, social, and political progress and stability is to address the health and development needs of its adolescents.”³

young people, their unique health care needs have not yet been incorporated into transformation activities.⁵ To date, they have been viewed as a subset of the pediatric population⁶ and discussed largely in terms of the family medical home. The unique factors that relate to the needs of young people and their concerns when seeking care have not been specifically considered. One aim of this blueprint is to help catalyze and inform this discussion.

The Mount Sinai Adolescent Health Center (MSAHC or the Center), with nearly 50 years of experience working with this age group, has long recognized that it is imperative to prioritize the health of young people and ensure access to care that is specific to their developmental needs. In establishing this program, MSAHC has built a model that responds to the need for a health home specifically for young people, has created best practices in adolescent and young adult health services, and is currently developing

the evidence of what works in providing health services to young people.

The health of young people impacts their health and well-being throughout their lifespan.

During adolescence, the responsibility to be healthy begins to shift from caregivers to young people, making it critical to ensure that they have access to health care, education, and the opportunity to develop the skills they need to be productive and make valuable societal contributions.⁷ Health care providers can play a unique role in providing appropriate interventions that encourage young people to become great health care consumers and adopt healthy behaviors. These interventions can be reinforced by educators, advocates, and family to empower young people to thrive physically and emotionally.

Young people experience unique challenges.

Adolescence is a time characterized by a growing need for independence—which

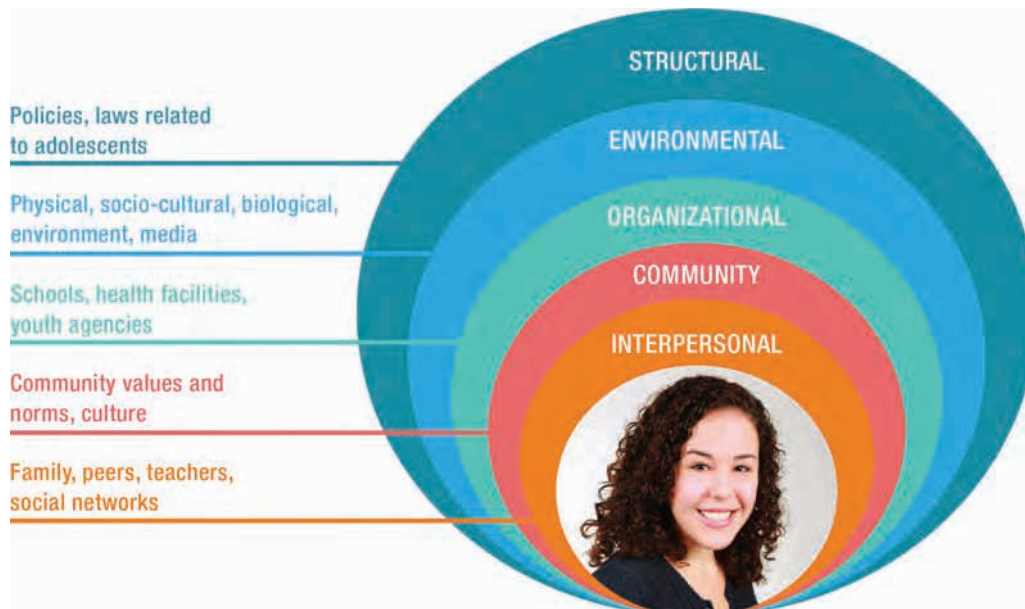
requires experimentation—and is when many adult behaviors are established. The behavioral patterns that evolve during this developmental period help determine young people’s immediate health status and influence their long-term health, including their risk for developing chronic diseases in adulthood.²

Due to this developmental transition, adolescent behavior can be highly influenced by individual, environmental, organizational, and community contexts, illustrated in Exhibit 1. Interpersonal interactions with individuals and groups, including family members, peers, teachers, health care providers, and school personnel, can impact young people’s health and well-being in positive and negative ways. Cultural factors shape interactions and have an impact on the young person and his or her environment.

Young people are impacted by their surroundings—neighborhood, schools, and



EXHIBIT 1. FACTORS THAT CAN BE ADDRESSED WITH ADOLESCENT AND YOUNG ADULT-CENTERED CARE



local resources—as well as structural factors, including policies and laws. With guidance, education, and intervention, even young people who engage in higher-risk behaviors are less likely to experience negative outcomes,* indicating that young people with access to comprehensive health and sexuality education and access to health services and preventive methods can reduce their chances of becoming pregnant or being diagnosed with a sexually transmitted infection (STI).

Adolescent and young adult health has been a field of study for more than 60 years.

Health care providers and researchers have made significant progress in working with and caring for young people. Today, this history and expertise informs a number of established best practices and strategies for adolescent and young adult health; the lessons learned can be implemented as part of the standard of care for young people. This blueprint offers a model of care for young people based on the work of MSAHC in New York City, a program that evolved by developing and building on best practices for working with young people, contributing to the field of adolescent and young adult health for almost 50 years. Today, the MSAHC, which started as a small clinic in a few rooms in a basement, is one of the largest adolescent health centers in the United States.

The Mount Sinai Adolescent Health Center Blueprint for Adolescent and Young Adult Health Care

This blueprint, which represents MSAHC’s innovative adolescent and young adult-centered health care model, is informed by years of practice and lessons learned. Since its inception in 1968, practitioners at the MSAHC have learned through practice and

from young people themselves how best to serve them by designing tailored services and programs that appeal to them and encourage them to seek care. The MSAHC seeks to address the whole young person and understand all of the factors that may impact his or her life, whether interpersonal, organizational, environmental, or structural.

MSAHC serves underserved and at-risk young people aged 10 to 24, regardless of their ability to pay or their insurance status. Confidential, comprehensive, integrated medical, sexual and reproductive health, dental, optical care, behavioral and mental health, prevention and support services are provided by a team of compassionate and competent practitioners with expertise in working with young people. The MSAHC team aims to provide appropriate support at the right time to ensure better health outcomes and to reduce any longer-term negative consequences resulting from harmful behaviors.

This blueprint outlines MSAHC’s gold-standard approach to caring for young people. It includes information and tools that can be replicated to help programs and individuals interested in developing or improving their own youth-centered initiatives and health care services.

Who Should Read the Blueprint?

This blueprint will support any agency, health care provider, or clinical trainee who works with young people or is interested in working with them and understanding their needs. The blueprint can also help support health care agencies, health care providers, child welfare and juvenile justice systems, policymakers, and programs

*For example, results from a school-based survey in 2013 demonstrate that, although 64% of students in the 12th grade reported having sexual intercourse, 53% reported using a condom during their last sexual encounter.⁸

interested in establishing and implementing best practices for adolescent and young adult health, as well as advancing health initiatives designed for young people. It offers a comprehensive model that demonstrates integration of services—primary care and mental health, mental health and substance abuse, and health care and public health. In this respect, the blueprint may be useful for those who inform policies regarding payment, reimbursement, and integration of service delivery and payment, including government officials and those involved in health care reform who wish to learn more about successful strategies to provide high-quality health care to young people at low cost.

How to Use the Blueprint

This blueprint can be applied in a variety of settings and by a diverse range of individuals and agencies. Some users may be thinking of starting an adolescent and young adult program; others may already serve young people but are looking for ways to improve or expand their services or add new elements to improve outcomes for this age group.

What Is Included in the Blueprint?

This blueprint presents a road map for providing health care to young people, based on the MSAHC's philosophy and approach. It is organized into the following chapters, described in Exhibit 2. It can be used as a whole, or readers can identify the sections most relevant to their goals.

While the scale and complexity of the MSAHC model may seem overwhelming, remember that the MSAHC has expanded and evolved over time to meet the needs of young people. The blueprint is intended to provide recommendations on how to implement elements of the program based on users' context, starting point, needs, and interests.



EXHIBIT 2. CONTENT OF MSAHC BLUEPRINT CHAPTERS

Chapter 1. Making the Case for Adolescent and Young Adult Health Care

Chapter 2. Introducing the MSAHC: MSAHC's origins, mission, target populations, and the evolution of the model over time.

Chapter 3. Developing Adolescent and Young Adult–Centered Health Care: Guiding principles, core operating values, and essential elements of the youth-friendly model that is the foundation for MSAHC's overall program.

Chapter 4. Creating an Adolescent and Young Adult–Centered Culture: The MSAHC's staffing approach and how to establish a culture that supports care that is friendly to young people.

Chapter 5. Providing Adolescent and Young Adult–Centered Health Care: Detailed descriptions of MSAHC services and strategies for removing barriers to care for young people, including best practices for creating a welcoming space and using technology to increase retention and engagement.

Chapter 6. Strengthening Adolescent and Young Adult Care With Evaluation and Research: Strategies for evaluation, continuous quality improvement, and innovative research that contributes to the broader field of adolescent health, advocacy, and policy.

Chapter 7. Implementing the Adolescent and Young Adult–Centered Care Model: Tools and recommendations for adopting the strategies used by the MSAHC, including guidance for moving toward adolescent and young adult–centered care, assessing community needs, prioritizing services and programs, and leveraging resources.

Appendices—Tools for Getting Started:

Compilation of online resources, materials, and links, including publications, policy briefs and clinical services resources, and checklists that support work in adolescent and young adult health care.

CHAPTER 2. INTRODUCING THE MOUNT SINAI ADOLESCENT HEALTH CENTER

The MSAHC Mission

The MSAHC works to break down economic and social barriers to health care and wellness for young people by providing vital services—high-quality, comprehensive, confidential, and free—for all who come to the Center. The MSAHC advances adolescent health as a national imperative by serving as a leading center of clinical care, specialized training, and innovative research.

Source: <http://www.teenhealthcare.org/>

Overview of Chapter 2

From nearly five decades of providing health services to young people, the MSAHC has developed best practices for implementing services intentionally designed for young people that are geographically and financially accessible, and focuses on methods that successfully encourage young people to seek and use services. This chapter provides an overview of the MSAHC's mission, model, and history, and describes the young people to whom care is provided.

The MSAHC Mission

The MSAHC focuses specifically on improving health outcomes for young people ages 10 to 24. MSAHC strives to go beyond providing primary medical services to address the whole young person, empowering them to maintain control of their health and, as an educated health consumer, to participate in identifying and obtaining the services that they need.

Through this mission, MSAHC seeks to advance the field of adolescent and young adult health by providing a certified health home for young people that is based on a biopsychosocial, cultural, youth-friendly, health care model. The MSAHC model also takes into account that many health systems have been created by and for adults and are not designed to meet the developmental needs of young people. Exhibit 3 highlights features of the model.

Some of the program characteristics adopted by the MSAHC to facilitate the processes include the following:

- Access to **core services** that truly represent young people's health service needs: physical health care, sexual and reproductive health care, dental care, optical services, behavioral and mental health care, nutrition and wellness services, and health education.

ENVIRONMENTAL
CONTEXT



**EXHIBIT 3. THE MSAHC
MODEL**

**ADOLESCENT-
CENTERED CARE**

- CORE SERVICES**
- Sexual & Reproductive Health Services
- Primary Medical Care
- Behavioral and Mental Health Care
- Health Education
- Optical Care
- Dental Care

**CULTURE AND VALUES SUPPORTING
ADOLESCENT-CENTERED CARE**

Innovative Research/Evaluation | Impact Policy
Specialized Training | Clinical Service Provision
Advocacy | Community Outreach

SPECIALIZED SERVICES

Legal | Wellness | Population-Specific Services

**Commitment
to Principles of
Adolescent Care:**

Safe, Accessible, Confidential, Comprehensive, Integrated,
Easily Navigated, Engaging of Adolescents, Developmentally Tailored,
Personal, Respectful and Culturally Responsive, and Relationship Based

- Provision of specialized services that speak to the needs of young people who may need additional support in addition to core health services (these services are described in detail in Chapter 5).
- Elimination of financial and insurance barriers by providing services free for young people who lack insurance.
- Colocation and integration of as many services as possible to facilitate access and promote continuity of care.
- A holistic approach with the provision of as many services as are needed within a single visit, reducing the burden on the young person to make multiple visits, even when this limits the potential for billing insurance for young people with coverage.
- Development of an organizational culture based on a staff team that is passionate about young people and a foundation of principles that consistently promote a welcoming atmosphere for them, described in Chapters 3 and 4.
- Taking into account the environmental and community factors experienced by the populations of young people who come to the MSAHC, as well as their families, and responding to these factors with appropriate services and methods of service delivery. Developing this

understanding includes taking the time to explore each young person's personal history from the perspective of their family, neighborhood, culture, and unique life experiences, and identifying how their health is affected by each of these contextual factors. The importance of engagement is addressed in this chapter, as well as in Chapter 5.

Whom Does the MSAHC Serve?

The MSAHC serves vulnerable young people ages 10 to 24, as well as any children they have while in care at the MSAHC. The program has evolved to particularly attract and welcome young people who may lack alternatives—for instance those who are uninsured and of low socioeconomic status—so as to increase access to health care for vulnerable individuals; however, care is provided to any young person who seeks it. The Center annually serves close to 10,000 young people. Of this population, 98% are low-income, and almost 90% are young people of color. Their racial and ethnic backgrounds, levels of education, and household situations are extremely diverse; some are in foster care, homeless, sex-trafficked, or refugees, while others have better life circumstances. Regardless, the

Continuity of care at the MSAHC means a continuum of health maintenance, prevention education, acute, and tertiary care. Along with physical exams, immunizations, and screening tests, young people receive health education, anticipatory guidance, and mental health counseling. If they are admitted for inpatient care, the same providers attend to them during and after their hospital stay. No matter the services provided, comprehensive care creates an accessible, welcoming environment that allows young people to gain information, knowledge, and skills they can use to make lifelong healthy decisions.

MSAHC aims to provide a safe, welcoming, nonjudgmental environment in which young people can access high-quality health care. Exhibit 4 includes information about the young people that the Center serves.

Insurance coverage is never a factor in determining which young people are seen at MSAHC. Historically, the majority of those served have lacked insurance coverage of any kind. MSAHC actively fundraises through grant applications and private philanthropy to maintain its ability to serve young people for free. MSAHC works with young people to help them obtain benefits when they may be eligible, but the first interactions when a young person walks into MSAHC are never with a financial status screener or biller. Rather, MSAHC focuses on welcoming the young persons and assuring them they will receive care. No money is ever exchanged. When possible, MSAHC will bill insurance (e.g., Medicaid) but not if an explanation of benefits (EOB) will be sent to the young person’s parent or guardian, generally the primary insurance holder. Similarly, insurance billing never determines how many services a young person can get in one visit; the goal is to do everything needed in the same visit rather than book multiple return visits, even in the event that MSAHC forgoes revenue. Finally, MSAHC offers one standard of care for all-comers—regardless of their financial or insurance status.



With the passage of the ACA, the demographic of young people seeking care at the MSAHC and other clinics focused on young people may change since coverage on parental health insurance until they turn 26 is available to many. Although more young people have insurance, MSAHC may see a greater number of young people who are looking for confidential services and are therefore unwilling to use a parent’s insurance coverage. Although changes in health care policy and legislation may create new trends in the young people seen at the MSAHC, continued awareness and responsiveness to these changes will allow young people to continue to access care designed with their needs in mind.



EXHIBIT 4. WHO MSAHC SERVES

10,000
young people aged 10 to 24 served each year

17
is the average age of young people who received services

70%
have no health insurance

98%
come from low-income families

88%
are Hispanic, African American, or Asian American

80%
are female

15%
are immigrants

3,000
young people access mental health services each year

Who Is the MSAHC?

The exceptional work of the MSAHC is supported and delivered by an interdisciplinary staff of over 100 individuals from diverse backgrounds and disciplines (see Chapter 4 for detailed information about staffing structure, training, and support). A variety of stakeholders also support the MSAHC's ability to serve young people.

The MSAHC staff members are selected based on not only their skill, training, and commitment to working with young people, but on their commitment to the principles for providing care to young people within the biopsychosocial model that the MSAHC has developed. The MSAHC team has a firm belief in caring for young people and their families with compassion, respect, and confidentiality, and builds relationships with those who come to the MSAHC, helping them feel loved, respected, connected, and not judged.

The program is led by a senior administrative team, including Director Dr. Angela Diaz; Medical Director Dr. Anne Nucci-Sack; and Chief Operating Officer and Assistant Director Dr. Ken Peake. This senior team is responsible for hiring, supervising, and mentoring staff; overseeing clinical, research, and general operations; providing direct patient care; fundraising; monitoring the program's budget; and supporting strategic planning.

The MSAHC maintains an advisory board that is invested in the implementation of the Center's mission, composed of 35 men and women representing diverse backgrounds. They bring expertise in areas such as finance, juvenile justice, management, fundraising, and communications, and serve on one or more committees that advance the MSAHC's strategic goals. The advisory board also represents and advocates for the Center among outside constituents and stakeholders (including current and potential donors, media

“That’s the common theme of everybody who works here: ‘If you don’t love teenagers, you won’t last here very long.’”

► Medical Director,
Anne Nucci-Sack, MD

outlets, and political representatives) and carries out fundraising initiatives.

The MSAHC is affiliated with the Mount Sinai Hospital and Icahn School of Medicine at Mount Sinai. In addition to providing services to young people at its facility in upper Manhattan, the program runs school-based health centers in three New York City public high school complexes (the Julia Richman Education Complex, the Bayard Rustin Educational Complex, and the Manhattan Center for Science and Mathematics), and three more will be added in 2016. As part of its relationship with Mount Sinai, the MSAHC also provides training in adolescent medicine via resident and medical student rotations and competitive post-residency fellowships.



The Development of the MSAHC

The MSAHC was established in New York City in 1968 by Dr. Joan Morgenthau, a Mount Sinai pediatrician and a pioneer in the field of adolescent medicine who recognized that young people had unique needs that were not being adequately addressed by the mainstream health care system. One of the most important needs identified was for an adolescent-specific health care facility to deliver services that were private and comfortable, and outside the intimidating façade of a larger hospital setting. A modest service was initiated to serve young people in Harlem and the

Upper East Side of Manhattan. The first services were offered by Dr. Morgenthau and a part-time nurse and social worker who worked a few hours a week out of an apartment complex basement. The resulting Center was the first program devoted to the special health care needs of vulnerable and disadvantaged young people in New York, and one of the first in the United States. The program expanded gradually over the next five decades, and continued to grow as it received grant funding to provide additional services (see Exhibit 5 for more information about the MSAHC leadership and Appendix A for a full chronology of the MSAHC's development).



EXHIBIT 5. THE MSAHC DIRECTORS

Joan Morgenthau, MD **Founding Director** **1968–1982**

Served as Associate Dean for Student Affairs and Professor of Clinical Pediatrics and Preventive Medicine at the Mount Sinai School of Medicine, and Attending Pediatrician at Mount Sinai Hospital.



Leslie Jaffe, MD **Director** **1982–1989**

Former Associate Professor of Clinical Pediatrics at the Mount Sinai Medical Center. Presently serves as College Physician and Director of Health Services, Smith College.



Angela Diaz, MD, Ph.D., MPH **Director** **1989–Present**

Serves as the Jean C. and James W. Crystal Professor in Adolescent Health and Professor of Pediatrics and Preventive Medicine at the Icahn School of Medicine.



CHAPTER 3. DEVELOPING ADOLESCENT AND YOUNG ADULT-CENTERED HEALTH CARE

Adolescent Voices

“And once you come here, you actually feel a little bit more comfortable because you see everyone that’s in your age range, so you—I feel like every time I come, I feel less nervous because I’m like you know what? This hall is filled with a whole bunch of other teenagers going through things who want to ask questions, so I feel less nervous, like at least I’m not the only one.”

► MSAHC Youth

Overview of Chapter 3

MSAHC’s model is based on principles for providing adolescent and young adult-centered care and services. There are two types of principles:

(1) Service principles guide what types of programs and services that are provided.

(2) Operational principles are the foundation for how care is provided to young people.

This chapter outlines both types of principles, including definitions and examples of how they are applied. In developing an adolescent and young adult-centered program or practice, it may be helpful to review these principles and consider which are currently used in your practice, and which could be developed in the future. This blueprint might be helpful in determining which programs or services can be leveraged or offered differently to yield

better results. This chapter also addresses the philosophy behind delivering adolescent and young adult-centered care and building an organizational culture that is geared toward serving young people.

The Foundation of Adolescent and Young Adult-Centered Care

The MSAHC model is centered on the philosophy that all young people have a right to health care that is

- Free of charge
- Confidential
- Adolescent and young adult-friendly
- Developmentally appropriate
- Culturally competent
- Equitable
- High quality

The MSAHC adolescent and young adult-centered care model is unique. It is based on almost 50 years of clinical practice and is consistent with the characteristics of adolescent-friendly health care promoted by the World Health Organization (see Exhibit 6). Research shows that services delivered in a manner that is youth-friendly are likely to lead to increased use of service by young people.¹¹ The MSAHC seeks to deliver on this premise by offering comprehensive services that are easy to access and well integrated to make navigation easy.

To make this philosophy a reality, MSAHC operates on an adolescent and young adult-centered care model with a solid foundation of service and operational principles: service principles for **what** is provided to young people, and operational principles for **how** the care is provided. These service and operational principles are supported by core values that foster the culture needed to support MSAHC’s adolescent and young adult-centered care. Together, the two types of principles support an adolescent-centered organizational culture (see Exhibit 7).



EXHIBIT 6. QUALITIES OF ADOLESCENT AND YOUNG ADULT-FRIENDLY HEALTH SERVICES

Accessible: They can be used by young people.

Acceptable: Young people are willing to use them.

Equitable: All young people are able to obtain them.

Appropriate: Young people need them.

Effective: They are provided in a way that makes a contribution to young people’s health.¹⁰



EXHIBIT 7. PRINCIPLES OF ADOLESCENT AND YOUNG ADULT-CENTERED ORGANIZATIONAL CULTURE



Adolescent and Young Adult–Centered Organizational Culture

The culture at the MSAHC supports youth empowerment and youth involvement; providers and staff take young people seriously, and view adolescence as an exciting and important part of life. They demonstrate this by interacting with the young people who come to the Center in a manner that is responsive and nonjudgmental.

The MSAHC team has worked to build an organizational culture that acknowledges the following:

- The overall culture of adolescence
- The effect of the diverse cultural backgrounds of young people on their health and their health behaviors
- The importance of having each adolescent or young adult feel supported and validated as a person with a unique sense of identity to enhance a positive youth-provider dynamic, dissipate fears, establish trust, and facilitate engagement
- The importance of helping every young person develop competence and a sense of agency in the world

The MSAHC’s organizational culture is operationalized in the selection of staff and the way in which services are developed and delivered. One key criterion for hiring staff is whether they have a passion for working with young people. As they interact with young people, these staff members take the time to learn about and acknowledge the culture that each young person comes from, and their family, community, neighborhood, and other life circumstances. Taking the time to develop this understanding allows providers to give meaning to the health education, counseling, and prevention messages they relay. Familiarity with overall adolescent

“It’s really the idea that you’re approaching a teenager first and recognizing that life is changing for them pretty rapidly, and they’re going through a lot of dramatic stuff, that we try to work with them and meet them where they are and allow them to really understand what’s going on with their health and, hopefully, become a really good partner in their health care.”

► MSAHC Provider

culture also helps the provider to tailor strategies for successful treatment to young people, including offering age-appropriate information, addressing adherence to medications, removing barriers to keeping appointments, and planning transportation to the Center. The importance of building a staff that understands adolescent culture is further addressed in Chapter 4.



Service Principles for Adolescent and Young Adult–Centered Health Care

As mentioned above, **service principles** help to determine the **type of services provided to young people**. The MSAHC’s service principles are listed in the box to the right, followed by a detailed description of each.

Providing a Safe Space

It is important to create a space where young people feel safe, welcome, respected, connected, and not judged. If family members or other people in the young person’s life accompany them when they seek care, these individuals also need to feel welcome and safe. There is an art to establishing a space where young people feel that their needs will be met while maintaining their right to confidentiality. Strategies for creating safety and a feeling of welcome include the following:

- Engaging the entire staff in creating a climate and culture that radiates warmth and welcome to all young people, their families, and companions as soon as they walk through the door.
- Ensuring that every young person has one-on-one interactions with staff so that each can feel familiar and establish relationships with health care providers.
- Conveying the message that what the young people share will be kept confidential, and explaining exceptions to the rule.
- Encouraging young people to feel safe in asking questions about behaviors or issues that they face honestly and directly.
- Creating a physical environment that is warm and that signals that all types of young people are welcome and no subject is taboo.

MSAHC Service Principles

MSAHC services are centered on providing the following:

- Safe space
- Accessibility
- Care that is **confidential, comprehensive, integrated, and easily navigated**
- Care that is equitable: All young people are able to obtain health services regardless of gender, ethnicity, religion, disability, social status, or any other reason
- Care that is high quality and effective
- Transition services to an adult medical home when the young person “ages out” of the MSAHC

Providing a Geographically and Financially Accessible Service

Location

Regardless of the geographic area where health services are located, young people need to be able to get there. Reducing geographic and transportation barriers are key service principles. To increase access to care, it is crucial to identify the modes of transportation used by young people and what is necessary to provide transportation. If a young person needs help with transportation, directions, public transit instructions or tickets, or money

for transportation, it is important to meet these needs. Asking about access to transportation when the appointment is made is an important step in identifying barriers that might not otherwise be apparent. The MSAHC is located on the Upper East Side of Manhattan in New York City, an area that is easy to walk or bike to for those who live nearby, and that can be easily and readily accessed with public transportation from different parts of the city. The MSAHC provides MetroCards for subways and buses if needed. Because of its hospital affiliation, the MSAHC has a free shuttle service to Mount Sinai Hospital for young people who need to go to or come from the hospital, making it easier for them to access specialized care as needed.

Cost

As described on page 7, at MSAHC, money is not exchanged with the patient population and care is provided free of charge to all young people whether or not they have insurance. MSAHC does bill insurance for those young people who have coverage—but only if their confidentiality is not threatened. MSAHC provides as many services as possible in the same visit, even when an insurer will only pay for one service. Insurance revenues and various other funding sources enhance the ability to provide free services. Information about the MSAHC’s current funding is provided in Appendix B.

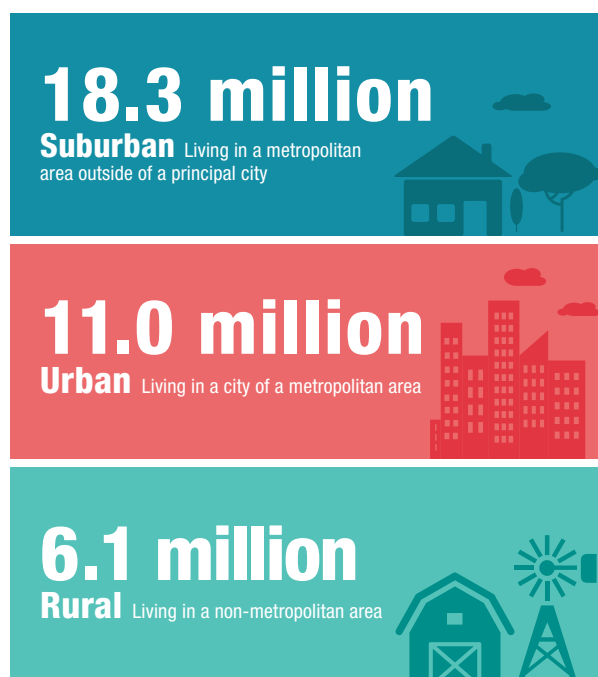
Providing Confidential Care

Confidentiality is the cornerstone of adolescent and young adult health and is highly important to young people seeking health care.¹³

Therefore, it is essential that all members of the health care team understand the laws of confidentiality in their state. The meaning of confidentiality—as well as the limits of

confidentiality for minors—should be explained to each young person the first time they interact with a clinic staff member. Any time a staff member feels that he or she may need to break the young person’s confidentiality or disclose sensitive information, the staff member should let the young person know first, and should explain why.

WHERE ADOLESCENTS LIVE



Offering free services can help to maintain confidentiality because it circumvents the need to bill private insurance. Using private insurance can cause the insurance company to send an EOB to the primary insured on the policy—for many young people, their parent or guardian. Young people in many areas of the country have the right to confidential services (particularly for sexual and reproductive health services). Offering these services for free protects the confidentiality and trust of young people. Staff members who make appointments should address cost issues in advance so that young people can be reassured about receiving free services.

MSAHC's confidentiality practices include the following:

- Communicating openly and honestly about confidentiality and the types of information that can and cannot be kept confidential; this ensures no surprises, enabling the young person to feel in control of when and how his or her information is shared.
- Verifying that the medical provider and all staff involved with providing care are familiar with applicable confidentiality laws that address young people on the federal and applicable state level.
- Ensuring that the staff are competent in communicating laws and regulations, including the protections and the limits of confidentiality, to young people.
- Posting confidentiality laws in understandable and visible ways throughout the clinic.
- Providing vaccinations, contraception, and medications onsite whenever possible, rather than sending young people elsewhere to fill prescriptions. This practice reduces the chance that others will find out that the young person sought health care or received treatment. When treatment cannot be fulfilled onsite, it is important to have seamless referral systems that are youth-friendly and confidential.

MSAHC builds young people's health literacy and competencies in obtaining health care by having them provide informed consent for the services they receive in lieu of seeking parental consent. Providers take the time to discuss with young people, in developmentally appropriate ways, the meaning of the consent process.



Providing confidential care and having young people give informed consent does not mean that MSAHC leaves parents out of the equation. When appropriate and when it is clear that parental involvement will help the young person without putting them at risk, MSAHC helps young people talk to their parents about the issues they are facing. When difficult family interactions are having a detrimental impact on the young person, MSAHC will offer family therapy, part of the array of services available at MSAHC, as a potential solution. Many young people who are initially leery of talking to their parent will, over time, learn to comfortably involve a parent, although many others continue to seek care confidentially. In these ways, MSAHC seeks to promote interaction between young people and their parents or guardian.



EXHIBIT 8. DEFINITION OF COMPREHENSIVE CARE VERSUS INTEGRATED CARE

Comprehensive Care: A range of services appropriate to the common problems in the respective population.¹⁴

Integrated Care: The management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system.¹⁵

Providing Comprehensive and Integrated Care

The service principle of comprehensive care goes hand in hand with that of integrated care. Definitions from the World Health Organization for both types of care are articulated in Exhibit 8. While comprehensive care involves providing multiple services at one site, integrated care involves coordinating services between providers to respond to immediate and long-term needs.

Health care systems in which each part of the body is treated in a different setting can be overwhelming for anyone, but especially for young people who are learning to navigate their health care independently. In many systems, young people with multiple needs may receive primary medical care in one location, and reproductive health, mental health, optical, and dental care in separate locations. It is also hard for different providers to keep track of recommendations, laboratory tests, and medications given by others, especially if they do not all share the information with each other. This fragmentation and lack of coordination makes it difficult for young people to see the connection between all of the multiple factors that influence health and behavior and contributes to failure to access and follow through with care.

To address these barriers, the MSAHC has established a health care environment specifically designed for young people that is based on the following two service principles.

The MSAHC promotes **comprehensive care** by

- Offering as many services as possible in a single location.
- Establishing a clear referral and linkage process to use when a service is not provided onsite, including memoranda of understanding with referral services and having the young person sign a release of records form so that MSAHC can track the services received and follow up, which allows MSAHC to continue to serve as the young person's medical home.
- Providing onsite wellness services and services that enhance the effectiveness of clinical interventions, such as exercise sessions and emotional support to address obesity issues; legal services (e.g., for education and immigration issues); and, for transgender adolescents and young adults, the acquisition of new identity documents once they transition.
- Coordinating same-day, onsite referrals when additional needs are identified to reduce the chance of young people being lost to follow-up.

The MSAHC promotes **integrated care** by

- Maintaining the availability of sexual and reproductive health and mental health services within primary care visits.
- Including wellness assessments, health promotion, prevention, and risk reduction during each encounter with a young person.
- Using assessment interviews and tools that identify a variety of health and intervention needs, no matter the purpose of the visit. For example, health educators use tools to identify needs in areas such as HIV risk reduction, mental health, history of sexual assault and abuse, smoking cessation, and/or substance abuse prevention even when the primary focus of a visit is reproductive health. This allows the coordination of referrals to other onsite services and follow-up.
- Providing care to young parents and their children at the same visit.

Having a comprehensive, integrated model also promotes the holistic provision of responsive health care services addressing different needs that a young person may have. Primary care includes health maintenance as well as acute care; the primary care provider can access tertiary, or specialty care, but can continue to be involved should a young person be hospitalized. As acute problems resolve, the primary care provider supplies continued

wellness intervention. MSAHC secures donations to circumvent payor policies that dictate how many and what type of services can be provided in the same visit enabling the Center to better serve young people.

Providing Easily Navigated Care

Health service centers and programs should be easy for young people to navigate. In creating a physical space designed for them, important elements include that the location is easy to find and enter, including distinct street-level entrances when possible or easy-to-follow signs.

“The goal of transition is to optimize health and assist youth in reaching their full potential. To achieve this goal requires an organized transition process to support youth in acquiring independent health care skills, preparing for an adult model of care, and transferring to new providers without disruption in care.”

- ▶ GotTransition.org, a program of the National Alliance to Support Adolescent Health¹⁶

Transitioning to Adult Health Care Services at MSAHC

It can take 18 months to two years for patients to have a comprehensive physical, immunization updates, contraceptive method chosen (if female), and an insurance product secured prior to aging out of adolescent and young adult health services.

The physical layout of the clinic should be simple and easy to navigate. The MSAHC provides services in a facility designed with young people in mind. The physical layout of the space was created on the basis of feedback shared by young people about the importance of a physical space in which it is easy to find their way around. The different areas of the clinic are color-coded to make it easy to move through—from registration, to having vital signs checked, to meeting with the provider and others. Providers are assigned to specific color areas and flags on the examination room doors are used to communicate when a patient is in the room or with a provider, so that people do not interrupt.

Another aspect of navigating care is flexibility about how young people can seek care. MSAHC maintains an appointment system, but also accommodates as many walk-in visits as possible. For many young people, there are barriers to making and keeping appointments that have to do with their community, people in their lives, and confidentiality concerns. Giving them permission to seek care without an appointment may make it possible for them to receive care that would otherwise not be available.

Services Are Equitable

A vital part of MSAHC’s mission is to ensure that all young people feel welcome and can get the care they need, regardless of gender, ethnicity, religion, disability, social status, or any other reason. For example, while the majority of those who come to MSAHC are lower income, MSAHC does not screen young people to determine whether they have financial resources to afford care elsewhere. The operating assumption is if they are seeking MSAHC services, they have a good reason and a need, which results in young people coming to MSAHC from all five boroughs of New York City and beyond.



Reaching Out to Young People Who Are Particularly Vulnerable

MSAHC provides equitable access to services to all young people who seek them; however, MSAHC recognizes that some groups are especially vulnerable and may find it very challenging to seek out care. For such young people (e.g., those who test positive for HIV, those being sexually exploited and abused, or those who are most vulnerable to risky behavior), MSAHC has targeted outreach strategies and services.

Providing Transition Services to Adult Medical Homes

An important step in providing high-quality adolescent and young adult health care is transitioning young people to an adult medical home as they age out of services. Proactively planning the transition is part of supporting young people in reaching their full potential. It is critical to start transition discussion early.

Many of the MSAHC’s patients do not want to transition to an adult health care provider; this is both an acknowledgment that they value and appreciate the services they receive at the MSAHC and also a challenge, in that they must establish a new medical home to continue health and wellness care

as adults. MSAHC staff support the transition process in several ways:

- The conversation about transition is started between the young person's 21st and 22nd birthday.
- The office staff often serve as health insurance navigators and actively encourage young people to explore options that best fit their needs and situation.
- The medical providers work to find adult medical homes that meet specialized needs and actively link young people to new providers or to maintain services with specialty providers if possible.
- The MSAHC provides assistance in signing up for health insurance through the ACA Marketplace or with employers if this option is available.

The MSAHC Operational Principles for Adolescent and Young Adult–Centered Health Care

Operational principles drive how services are delivered to young people in every aspect of the program. MSAHC's operational principles are listed in the box above and then described in detail.

Adolescent and Young Adult–Driven Health Care

Health services for young people should be designed from the adolescent and young adult perspective to increase their access to and utilization of services.¹⁷ It is important to incorporate young people's voices across the service continuum from conceptualization of services to evaluation, as doing so can increase utilization of services.¹⁸ Young people can provide insight on their needs and factors that facilitate or hinder their health-seeking behavior, and can review materials for cultural and developmental appropriateness.

MSAHC Operational Principles

The MSAHC program and services are provided in a manner that is:

- Driven by young people
- Engaging to young people
- Developmentally tailored and appropriate
- Supportive of one-on-one young person-provider interactions and trauma-informed approaches
- Respectful, nonjudgmental, and without stigma
- Relationship based

The MSAHC has developed mechanisms to integrate feedback from young people directly into the program on a regular basis via the following:

- Informal conversations with providers and staff.
- Patient experience surveys (through a youth advisory board).
- Opportunities to volunteer to participate in research and evaluation activities at the MSAHC (e.g., focus groups, interviews, surveys).
- A youth advisory board that meets with the MSAHC staff to discuss a variety of topics, including the relevance of services offered, clinic operations and procedures, educational materials, and barriers and facilitators to accessing services.

- **SPEEK** (Sinai Peers Encouraging Empowerment through Knowledge), an intensive training and service program that helps young people learn about the health issues that can affect them and bring this knowledge to engaging and educating other young people. They learn how to provide peer education and outreach in the community and facilitate workshops on preventing HIV/AIDS, STIs, and pregnancy.

All of these activities reinforce the MSAHC's mission of empowering young people and teaching them to be educated health consumers. Through their participation, they learn more about the MSAHC's services, develop knowledge of health issues affecting them, and learn leadership and public speaking skills, leading to a greater sense of self-esteem.

Engaging to Young People

When first meeting a young person, it is vitally important to make them feel welcome and comfortable. Because many young people are guarded and ambiguous about trusting and sharing information with someone they have just met, engaging them as partners is an essential first step in connecting them to health services. Simply crossing the threshold of a clinic does not mean that the young person is engaged. MSAHC providers take nothing for granted, and continually strive to strengthen engagement, to build trust, and to open up an ongoing conversation and partnership.

The MSAHC's providers **increase engagement** of young people by

- **Greeting them with a smile** and a handshake, welcoming them, and explaining how care will be provided.
- **Understanding that despite the myth that young people feel invulnerable**, they commonly feel stressed, concerned, and confused when seeking care.
- **Encouraging them to ask any questions** or ask for clarification at any time.

Benefits of a Peer Education Program

- Help address peer pressure and address issues related to teen pregnancy, HIV/AIDS, and STIs
 - Develop youth leaders
 - Offer employment opportunities through street outreach and mapping activities
 - Can be delivered in a variety of formats, such as theater, workshops, one-on-one sessions, or via educational materials
 - Foster an environment where young people and adults work together on a common goal
-
- **Asking directly about their lives**, which gives them permission to talk about their experiences and signals that no topic is off limits.
 - **Setting wide margins** when assessing their risks and respecting their desire not to address an issue at first, unless there is an issue of safety—even though an issue might seem important to the provider—by finding comfortable ways of keeping the issue on the table and returning to it over time.
 - **Presenting a nonjudgmental attitude** about how the young person presents and describes his or her situation and experiences.
 - **Validating the young person's feelings** to help them feel supported in seeking services.

At the MSAHC, providers are trained to demonstrate warmth, compassion, patience, and respect. This approach is critical. Providers must understand that regardless of the lifestyle or behaviors young persons are involved in, it is the providers' responsibility to determine how to best help and serve them. As part of engaging young persons, the provider should give them the message that they do not have to disclose sensitive information until they are ready. They should leave with the feeling and knowledge that the provider will not "give up" on them and that they can return for more help.

Another engagement strategy used by the MSAHC is **normalizing the young person's experience of interacting with medical and other providers**. This is done through the following:

- Explaining that the providers pose the same questions to everyone so that every young person has an opportunity to share what is happening in their lives.
- Relaying the message that history-taking is a routine part of a visit, and that the goal is to help them address health concerns to ensure their well-being, not solely to obtain information for the provider's use.
- Not reacting with shock when a young person trusts the provider enough to start opening up. Young people who are victims of abuse or have experienced violence or engaged in substance abuse may expect shock or disapproval; it is critical for the provider to continue to help them feel safe in sharing and exploring their behavior. The conversation should proceed to probe further in a nonthreatening way.

Developmentally Tailored and Appropriate

Working with young people effectively requires an appreciation for the diverse spectra of maturity, education, health literacy, and communication skills seen



across adolescents and young adults. Meeting young people "where they are" and interacting with them in ways that are comfortable and understandable—while not condescending—is of great importance for providing developmentally tailored care. For greatest effectiveness, conversations with young people should use direct, simple language. Providers at MSAHC have expertise in using the following strategies:

- Communicating with young people in a warm, nonthreatening manner that puts them at ease.
- Using simple, appropriate language to help young people feel comfortable and safe so that they can be honest about their health behaviors.
- Framing health risks in a way that focuses on things that matter to the young person right now, rather than on statistics or long-term health consequences. For example, a discussion about smoking with very young patients might focus on how they access cigarettes and that frequent use can stain their teeth, rather than focusing entirely on the more abstract long-term negative health consequences of smoking.
- Asking young people about their strengths and vulnerabilities to allow them to share issues, challenges, or particular needs from their own perspective, so that resulting intervention and treatment plans are developmentally appropriate for the young person.

One-on-One Adolescent-Provider Interactions

Establishing clear, one-on-one communication is the key component to providing high-quality care to young people. The MSAHC’s priority is to facilitate a one-on-one interaction between the provider and the young person, allowing the young person to speak candidly and to ask sensitive questions that can then be addressed. This approach results in a more thorough, honest health history and allows the provider to develop a more effective treatment plan.¹⁹ Many of the young people seeking care at MSAHC come confidentially without a parent. However, MSAHC recognizes that parents and caregivers can also play an important role in the health care of young people; they can inform care by providing helpful information about their family history or the youth’s birth history. Over time, when appropriate, MSAHC will work with the young person to encourage the inclusion of a parent or caregiver in the care plan; however, the majority of young people continue to seek care on their own.

To achieve ease of communication, MSAHC providers explain the process for the visit to both the young person and any parent or caregiver who may be present. When there is an accompanying caregiver, the provider will always thank them for bringing in the young person and will ask “Why have you brought your child in for care?” The provider will also explain that he or she will need time alone with the young person. Providers review confidentiality policies with the young person and caregiver together so that everyone is clear about the rights of minor clients and confidentiality limits, and providers explain instances in which they would need to involve a parent.

The parent or caregiver is asked to sit in the waiting room during the young person’s exam and is then invited in after the exam is completed and after the provider has talked

privately with the patient. During the one-on-one interaction with the patient, the provider is able to focus on engaging the young person and obtaining a complete history in an environment where the young person may feel more comfortable sharing about sensitive topics and asking questions.

Trauma-Informed Approaches

Events that are life-threatening or that threaten safety, or even witnessing such events, can cause posttraumatic stress disorder (PTSD) or other mental health issues.²⁰ Young people who have had traumatic stress may have trouble trusting others or may experience other difficulties interacting with friends, family, service providers, or realizing their full potential, even if PTSD is not their diagnosis.

It is important to let young people know that the location where they receive their health care is a safe place to talk about their life experiences, including any that have been traumatic. An adolescent and young adult-centered health center can serve as a source of support, even if a young person does not have an immediate or well-defined health care need. Relaying this level of caring is a way to help young people feel connected and to engage them in long-term interventions that lower the long-term harm of experiencing or witnessing traumatic events.²¹



Adopting trauma-informed approaches includes establishing safety in the physical location of the program, providing clear and consistent messages about what will happen during each visit, ensuring that all staff maintain appropriate interpersonal boundaries, and maximizing the young person's choice and control in terms of which services are received, when they are received, and the characteristics (e.g., gender, culture) of the provider(s) with whom they interact.²²

Many young people who come to the MSAHC have experienced trauma on some level. The MSAHC has adopted a number of trauma-informed practices; following are examples:

- Security staff are carefully selected for their ability to interact with young people and relay a relaxed and nonthreatening sense of safety.
- The registration process and steps that follow (triage, having vitals taken, seeing the provider) are clear and organized and the young person is informed about what will happen at each stage of the visit.
- All staff take the time to greet the young person, answer questions, and interact in a warm but professional manner to relay a sense of welcome and safety.
- Providers are trained to build trust over time so that they can identify and explore

traumatic experiences and their impact on the young person's health and well-being.

- Options to address trauma are available onsite and immediately as needed, including crisis intervention, one-on-one psychotherapy, group therapy, and legal services.
- Trauma-specific therapies are considered necessary core competencies for all social workers and psychologists and are supported by ongoing weekly clinical group supervision, and trauma sensitivity training is provided for all staff and providers.

Nonjudgmental and Without Stigma

It is important to serve young people with an open mind and in a nonjudgmental way, regardless of the behavior in which the young person is engaging. Young people should be made to feel comfortable coming back and sharing what is really going on in their lives without the disapproval of the service provider. Adolescents and young adults do not respond well to criticism or judgment and are likely to shut down and not return to a place where they perceive censure. The goal is to open up a conversation that over time can allow the provider and the young person to fully explore and understand the implications of their actions.

Adolescents are particularly sensitive to rude, judgmental, or overbearing attitudes and behaviors on the part of adults. In fact, such attitudes and behaviors can cause adolescents to:

- Leave the clinic before they get the care they need;
- Fail to comply with treatment requirements; and
- Refuse or forget follow-up care.²³

The MSAHC has found that a key step toward establishing a stigma-free environment is the concept of “one service, one clinic.” This means that there is one main entrance to its primary care clinic and one reception area for young people, no matter why they are coming to the Center. As young people register for their appointment and as they are called by the provider, the reason for their visit remains private; to avoid stigma, no one is separated out or isolated. Along with creating a stigma-free environment, it is critical to hire staff who love working with young people and can interact in a nonjudgmental way. Often, individuals who are either trained in adolescent health disciplines or willing to learn how to work effectively with young people are best able to meet young people where they are and listen to what they are saying without making them feel judged. Selecting, training, and supporting staff are addressed further in Chapter 4.

Relationship-Based

Relationships are the foundation of any good patient-provider interaction but young people are especially sensitive to the way adults relate to them and are highly attuned to issues of respect, honesty and genuineness. Research has shown that health care providers should try to improve communication and empower young people during their interactions with them in order to increase adherence to intervention/prevention guidance.²⁴ Without trust, caring, and regard between young persons and their provider, opportunities for maintaining or restoring health are likely to be limited.

There is also evidence that young people who perceive a higher level of trust, mutuality, and empathy in their relationship with health care providers have greater improvements in social skills, including cooperation, self-control, assertiveness, and empathy, than program participants who perceive a lower-

quality relationship with adult providers.²⁵ While more research is needed in this area, these findings underscore the importance of encouraging staff to achieve high-quality relationships with young people, regardless of the specific intervention strategy. Promoting this practice can be an important part of recruitment, training, and supervisory practices in the clinic as well.



MSAHC’s aim is that young people establish lasting bonds with their providers and with the Center. Staff and providers, supported by organizational leaders, prioritize relationship-building from the initial appointment to the ongoing management of health issues or preventive care. Young people are highly social beings and their desire and need to be accepted and feel connected is very strong. This need for connection makes a difference in their willingness to trust, engage in treatment, and listen to health promotion messages, as barriers to a sense of trust and connection can affect health outcomes. At the MSAHC, the actual connection and relationship is considered part of the healing process. To extend the benefits of human connection, MSAHC also offers peer education programs (described in Chapter 5) for young people that increase the network of caring adults and caring peers who may support patients’ health journeys.

CHAPTER 4. CREATING AN ADOLESCENT AND YOUNG ADULT-CENTERED CULTURE

Overview of Chapter 4

Health practitioners who provide care for adolescents and young adults have a special role. Their patients are at a critical time in their lives, and providers must engage them on deeply personal, private, and sensitive psychosocial and health issues. This requires being comfortable with direct questioning without coming across as confrontational. Being skilled in working with young people and their families, and possessing an understanding of issues young people experience, is therefore an essential element in serving young people. This chapter describes how the MSAHC staffs its services in alignment with the principles of adolescent and young adult care that are the foundation of the Center's work.

The MSAHC Supports Multidisciplinary, Team-Delivered Care

Young people have a finely tuned radar for authenticity—or the lack of it. They can sense when staff and health care providers care about them. Young people are also acutely aware when the collective team communicates and functions as a whole, rather than a fragmented group of individuals who each perform only their specific functions in an isolated, generic manner. It is tremendously important for young people to feel that the entire team works together to solve their problems, help them stay safe and healthy, and make them a priority each time they come to the Center. This helps ensure that patients feel invested in their own care.



It is critical to MSAHC that each young person not only feels connected to the individuals they work with, but to the Center as a whole. Over time, although staff members may leave, the MSAHC wants to create relationships with young people that endure over time—sometimes for more than a decade. So teamwork and strong collaboration are critical to caring for young people at the MSAHC. As one young person said, “It is the social worker, the health educator, and the doctor sitting down and working together, putting those pieces together and makes the whole puzzle.” Collaboration also means that providers learn from each other by working closely together to expand their skill sets and provide services outside of their traditional practice areas when working with a young person. The richness of this mix of people highly trained in different disciplines and working together gives individual staff members greater confidence in their ability to identify the different issues experienced by each young person. They are able to go a few steps further because they know that if they are unsure of what to do in a particular situation, they always have access to colleagues with expertise.

Engaging an Adolescent or Young Adult

“What helps me engage the adolescent is to think about when I seek medical care. Personally, I am usually very nervous and anxious. I try to find the balance between asking too many questions or not enough. I want my patients to trust and confide in me without feeling judged. I don't want to see a shocked face if I tell a doctor something out of the ordinary and I like to see some emotion emanating from them if I discuss something of a sensitive nature.

I engage my clients with all of these thoughts in mind. I want them to feel welcomed and safe in my office. I pride myself in not having a 'sterile-looking' exam room. When I ask questions relating to social history, a patient will often ask 'What does that have to do with my sports physical?' I respond that I don't only care if they can physically throw a ball, but that I want to get to know the whole person behind the ball. When I ask sensitive questions and raise sensitive issues, such as when I ask if they have ever been bullied or when I ask about their relationships, friends, and parents, I will often talk about my husband, children, and parents or stories of others, so that they realize that it isn't just them and that they aren't alone. Many times, I have become teary-eyed with them when we find that we have something in common.

Humor is one of my most favorite ways to engage my clients. Humor helps the young person feel less nervous, especially during a GYN exam, which is the most private type of examination ... It helps my patients see a human side of me which ultimately makes them feel comfortable and trusting of me.

There are situations when I feel that I have to wear two hats when engaging a patient. If the young person tells me that she wants contraception, but that she doesn't want her mom to know, I feel that it is my responsibility both as a nurse practitioner and as a mom to provide them with safe and effective decision-making skills that will direct them to make the right choices and decisions.

Lecturing never helps, it merely pushes the young person further into the corner, not wanting to hear anything you have to say. Mutual decision making makes the young person feel much more valued and, in turn, much more accountable for their actions.”

► MSAHC Provider

For example, a physician who learns that a young person is the victim of incest can connect the patient to a mental health provider immediately by introducing the two directly, and in this way coordinate the patient’s physical and behavioral health needs promptly. Multidisciplinary and adolescent and young adult–centered care are inextricably linked at the MSAHC.

In addition to providers (adolescent medicine physicians, pediatricians,

physician assistants, nurse practitioners), the MSAHC employs a variety of staff (including receptionists; registrars; medical assistants; health educators; social workers; psychologists; psychiatrists; nutritionists; dentists; optometrists; IT, finance, and development administrators; and attorneys) who all work together to help young people navigate their care (see Exhibit 9). Team members also facilitate connections and referrals to other services, such as housing, schools, and benefits.



EXHIBIT 9. OVERVIEW OF THE MSAHC PROVIDERS AND STAFF



Staffing From a “Culture of Adolescence” Perspective

The MSAHC model and approach is based on understanding “youth culture” while simultaneously fully appreciating each individual adolescent or young adult’s unique background, circumstances, aspirations, and challenges. Culture refers to some of the distinctive characteristics of adolescents and young adults, including those shaped by developmental factors, and how they relate to society, institutions, and services.

Because adolescents must learn to navigate their world and become independent, they benefit from increased participation in decision making and decreased control from adults with whom they enjoy ongoing stable and supportive relationships.^{26,27} Developmentally, young people have an increasing sense of autonomy and independence, which helps drive this process forward. They also engage in experimentation, which at times can put them at risk, as they lack the experience by which to judge and navigate new situations on their own. The challenge for adults—and for adolescent service providers—is to find ways to be able to allow young people gradual and increasing control over personal decision making while remaining available for advice and guidance when it is sought. This has been described by some as a *learner’s permit*¹⁴ approach because it views adolescence as a period in which the learning process of development requires making mistakes, in addition to experiencing successes, if good decision-making skills are to be cultivated. MSAHC, following this view, delivers and designs services for young people that encourage increasing participation and youth voice in the delivery of care. By

making adolescents partners in their care plan, MSAHC’s providers believe that they have the best chance to keep the conversation open with each young person, thus enabling young people to be honest about their lives and reduce the risks they face.

Understanding youth culture also requires that services be designed to fit well with young people’s experiences. Even as young people begin to navigate health care on their own, they lack the experience to fully assess their own needs or to navigate the many silos



which typify health services.^{28,29} For instance, few young people who have experienced trauma, such as interpersonal violence, show up knowing they may need mental health services. Instead, they may present with a stomach ache, worries about their body, or for a sexual health service concerned about the unintended consequences of a sexual experience. Simply put, most adolescents lack the experience by which to categorize, label, and make sense of their experiences, and so at MSAHC services are highly integrated and offered in one place. Staff are sensitive to the many ways that young people may present and are trained to explore each person’s concerns fully to develop a true sense of why a visit has been made.

Underlying all of this is the recognition that adolescents and young adults are highly concerned about their privacy and can easily feel a sense of shame or stigma when seeking health care. They are keenly aware of the ways in which adult providers relate to them; they value genuineness and are very sensitive to what they perceive to be judgmental attitudes.

The youth-provider dynamic is the most critical aspect in helping to dissipate fears, establish trust, and facilitate engagement. The MSAHC staff members recognize that it is important for adults to view young people as developmentally distinct from both young children and from adults, and to interact with them in a developmentally appropriate way. This approach helps to reduce conflict and disappointment and manage expectations.³⁰

“It’s really the idea that you’re approaching a teenager first and recognizing that life is changing for them pretty rapidly, and they’re going through a lot of dramatic stuff, that we try to work with them and meet them where they are and allow them to really understand what’s going on with their health, and, hopefully, become a really good partner in their health care.”

► MSAHC Medical Provider



Creating and maintaining a culture of adolescence means that besides understanding and supporting the operational and service principles described earlier in this chapter, staff must be willing to deliver care in a manner that validates what is foremost in the mind of each patient. Following is a list of foundational elements for working with young people that help to build relationships. It can be very useful to discuss these elements during interviews with job candidates to ensure that new staff members respect and understand youth-centered culture within the context of providing health care:

- **Ensure privacy and confidentiality.** Staff and providers should demonstrate how information about sensitive issues will be kept confidential and take the time to explain the limits of confidentiality, as well as provide private space to ask personal questions. If young people cannot be assured that their information will be kept confidential and do not understand when it must be shared, they will not talk freely and may even forego care.

- **Communicate with trust and honesty.** Staff and providers must gain the trust of the young people they work with, and they can do this by being honest about what will take place during visits, providing full information, and saying “I don’t know, but I will try to find out” when they are not sure. If young people suspect their provider has not been truthful, they will be reluctant to listen to and follow the provider’s instructions.
- **Establish connectedness.** Besides feeling connected to people and organizations in their life (e.g., family, friends, school, community), young people also need to feel connected to the people who seek to serve them, including their medical providers and clinicians. Staff and providers should not only ask young people how they are now, but should follow up on conversations from the previous visit; this shows patients that they remember them and that what happens in their lives is important.
- **Build resiliency.** In working with young people, it is important to recognize the challenges they have faced, and to help them identify the ways they have coped. By doing this, the provider can validate the patients’ experiences and build their understanding of their ability to adapt to different circumstances and overcome tremendous challenges. One way to build and rebuild this resiliency is to reassess with young people how they managed different situations and how they plan to manage current challenges.
- **Acknowledge freedom.** Young people are no longer children, and want to be acknowledged as young adults with new responsibilities and fewer limits imposed by their families and other authority figures. However, although they are no longer children, they are not yet adults, and will continue to have some limits on their freedom and behaviors. In interacting

Supporting Staff and Providers

MSAHC’s model supports staff and providers to:

- Have short- and long-term positive impacts on young people and families;
- Promote health-enhancing attitudes and behaviors;
- Address issues from a biopsychosocial perspective;
- Reduce fears, correct misconceptions, and provide accurate information;
- Provide young people with the tools they need to be healthy; and
- Serve as role models and mentors.

honestly and directly with them, staff and providers can validate their growing maturity while continuing to provide guidance.

- **Understand group identity and conformity.** Young people often feel compelled to belong to a group during adolescence, and sometimes change their behaviors to be accepted and to conform to group norms. They like to have a sense of belonging, and suffer fears of being left out. Young people’s affiliation with groups that are involved in age-appropriate and affirming activities is positive; however, groups involved in risky behaviors and activities are not in their best interest. Staff

and providers need to be able to show understanding of young people who are experimenting with conformity issues, educate them about risk behaviors, and help them address conflict within families when it occurs.

- **Explore experimentation and inquisitiveness.** The emerging cognitive abilities and new social experiences of young people can lead them to try new things. They may be curious about their bodies, question values and rules shared by adults, and experiment sexually or with drugs and alcohol. Not all experimentation is negative; a young person may decide to try out for a new sports team or start a community service project. Adolescence is characterized by trying on new roles and identities in order to discover and practice new behaviors. The role of staff and providers is to help young people assess what type of experimentation and environments are safe and when experimentation may become problematic.



“This is a period where many of the behaviors are established and therefore can be shaped. I often feel like an artist working with a sculpture. When working with young people, you help shape the sculpture with every turn.”

► MSAHC Medical Provider

- **Address fear.** Young people often experience fear: fear of not being “normal,” not being popular, of not fitting in, not being attractive, not doing things well, being different. Young people who do appear different in certain ways may experience bullying and teasing. Providers must work with young people to help them appreciate their unique attributes without fear, and recognize when harmful effects of bullying need to be addressed.
- **Recognize vulnerability.** Young people may feel vulnerable because of personal experiences (for example with trauma) or negative situations they have witnessed in other adolescents and young adults, among their families, and in their communities. Staff and providers should maintain a warm, gentle approach and relay that the health care site is a safe place to talk through these experiences.
- **Encourage young people to become more knowledgeable.** Young people have a great capacity for learning. They often receive conflicting information from the Internet, the media, their peers, their school, and their family. Staff and providers can play a role in helping them to digest information and determine what is in their best interest.

Selecting the Right Staff Members

The MSAHC care delivery model is based on an adolescent and young adult focus: “I think it is a unique place in that adolescents are the number one priority here.” MSAHC’s staffing structure creates a team of providers who work to follow young people as they grow and interact with different systems to ensure that they receive the services they need. Staff must be receptive to an organizational culture where confidentiality and respect are a priority, and open to the flexibility that young people need, including same-day appointments, walk-in services without an appointment, and Saturday clinic hours.

MSAHC recruits many of its physicians from its own training program (described at the end of this chapter) and receives a good number of applications for open positions from the adolescent medicine community. Although the pool of potential applicants with an adolescent medicine specialty is not large, there are others with foundational experience who can learn to work specifically with young people. For example, pediatricians who have primarily served younger children are often interested in working with adolescents and young adults. For both providers and other staff positions, other good candidates are those who have worked in organizations that serve young people or families.

“I think that what we strive for here is to treat the whole person, not just whatever they’re coming in for and complaining about physically or medically. So it’s not just looking at what the patient is presenting as a problem, but looking at the other things that are going on in their environment: in school, and home, and work, and relationships. And so that’s kind of what we strive for, which I think is unique, as opposed to just going into another health care facility or seeing a private physician that you don’t necessarily get that totally comprehensive care. That’s what we look for, is comprehensive care.”

► MSAHC Medical Provider



Characteristics and Skills of Staff Members Who Deliver Adolescent and Young Adult–Centered Care

- Passion for and commitment to working with young people
- Respect for young people
- Demonstrate empathy, compassion, patience; not judgmental of young people
- Advocate for young people
- Willing to learn and adapt to meet the needs of young people
- Ensure confidentiality and privacy
- Engage in active listening
- Able to communicate with young people, families, and caregivers
- Collaborative and supportive of multidisciplinary approach to young people’s care
- Able to gather health and psychosocial information
- Able to assess young people
- Establish rapport, create a safe and comfortable environment
- Implement a developmental-oriented and appropriate approach
- Initiate conversations about sensitive topics
- Encourage independent access to health care for young people

Considerations When Hiring Staff Members to Deliver Adolescent and Young Adult–Centered Care

- Consider previous training program participants, interns, fellows, volunteers, or individuals who have had experience working in the clinic environment and with your team
- Assess their interests in working with young people: Do they like young people? Do they respect young people?
- Consider their skills and expertise: Will they work well with a team-based approach? Are they collaborative?
- Do they fill a need that has not been addressed in your setting?
- What are the applicant’s personal goals and personal characteristics: How will they fit with the organizational culture and day-to-day workflow?



When selecting candidates for all positions, MSAHC’s interviewing process is extensive and often involves multiple interviews. The initial interview focuses on work experience and how the candidate interacts with young people. Clinicians will go through at least two rounds of interviews that focus on their clinical experience and detailed discussions of challenging cases involving young people. The interviewers make observations such as the following:

- Does the candidate exhibit a compassionate understanding of adolescent development?
- Is the candidate able to talk about young people in a nonclinical way? Following are example questions:
 - If the candidate is asked to share a work experience or present a case involving a young person, do they present it in a way that shows that they see the young patient as a person? Do they recognize them as a young person, rather than relating to them as a child?
 - Does a candidate over-use professional jargon?

- When talking about young people, does the candidate speak respectfully, or does he or she use phrases that consistently refer to young people as “kids,” or say things like “teenagers are so stubborn”?
- Does the candidate speak about young people from a strengths perspective, demonstrating that they see them as people with potential, not only people who make mistakes?

In the final-round stages of the interview process, after a candidate has been vetted clinically, a senior staff member meets with each finalist and explores their work style, the types of organization in which they feel they have thrived or conversely felt too restricted, how they handle workplace conflicts, how they utilize supervision, and what they want to accomplish in the next few years. This goes well beyond asking them to speak about their experiences with young people, as the goal is to get a sound assessment of the fit between the MSAHC environment and the candidate’s personal and professional goals. MSAHC recognizes that a good fit is necessary to retain talented staff over time.

Similar to other adolescent and young adult-centered health care organizations, the MSAHC is a fast-paced, ever-changing workplace where staff may fill multiple roles in order to ensure that each young person gets what he or she needs with a minimum of transitional hurdles. For example, a medical provider may assess and provide treatment to a young person, but also often navigates them through additional services. Frequently, the provider will not only conduct an in-person, warm connection to another in-house staff or provider, but will follow up later to collaborate with the other staff for next steps. Therefore, flexibility is heavily explored because the MSAHC workflow is not routinized but varies based on each young person's needs. Overall, being able to tolerate frequent change is an essential quality. In addition, MSAHC is open during hours that are accessible to young people, and staff members are expected to work evenings and Saturdays.

MSAHC also seeks staff who can think programmatically. Because the challenges faced by young people are ever changing, new strategies to serve young people with complex needs are continually developed. Staff roles and responsibilities change, so MSAHC seeks to recruit people who over time will see beyond the individual patient and help develop new services.

Training and Development of Staff

Providing exceptional adolescent and young adult-centered care requires both unique skills and training. The MSAHC supports staff and providers by offering a variety of training and mentoring opportunities to reinforce and enhance skills in providing care to youth. Additionally, the MSAHC offers specialized training programs for medical and mental health professionals interested in gaining additional expertise in adolescent health.

MSAHC Social Worker Program Development Competencies

Young people require creative approaches to service delivery. Integral to clinical practice with young people and their families is assessing and evaluating programmatic needs with the patient population, service area, and communities served. Therefore, the social worker must be able to accomplish the following:

- Identify unmet psychosocial needs in the client population
- Initiate, plan, and implement programmatic ideas to meet the needs of the patient population
- Use practice-based research and other evaluative approaches
- Collaborate with and take the initiative and engage with the interdisciplinary team in the development of new services

Newly hired staff members are oriented to the team approach that surrounds every job function. As they move through their first days and weeks, other staff members mentor and guide them. Communication mechanisms, usually in the form of group meetings, facilitate the integration of new staff into the day-to-day clinic operation. Each month, there are weekly meetings of providers, case conferences (many of which are multidisciplinary), “huddles” (preclinic meetings) to prepare for specific patients, and all-staff meetings. At these meetings, the MSAHC’s systems of care such as referral systems are addressed, which is an important learning opportunity for new staff. Through constant and consistent communication, staff observe and learn firsthand how the multiple needs of young people are addressed in each visit.

Professional Development

The MSAHC staff and providers have numerous opportunities for professional development, including informal mentoring relationships between more seasoned staff and interns or fellows, which reinforces the MSAHC philosophy and approach to working with young people, the operationalization of principles of care, and the support of learning communities around specific clinical areas of interest. Providers also have the opportunity to attend professional and academic conferences and meetings, as well as pursue teaching and mentoring activities, research, and additional educational degrees.

Professional development is included in many meetings, including the monthly all-staff meeting, during which half of the meeting is devoted to training. Topics such as trauma-sensitivity may be addressed, or leaders in the adolescent medicine field from outside of the MSAHC may be invited to give presentations.



Providers and mental health practitioners are encouraged to conduct research and to participate actively in professional life and knowledge dissemination through presenting at conferences and publishing in journals.

Specialized Training Programs

The MSAHC is affiliated with the Icahn School of Medicine at Mount Sinai and, since the 1970s, has served as a teaching environment for adolescent medicine residents and medical student rotations. The MSAHC uses this opportunity to educate new and future providers by training them to care for young people through demonstrating the principles of care that the MSAHC has operationalized and practiced. The MSAHC training programs have often helped to identify promising providers, and the Center has successfully found key staff through this pipeline. Training opportunities offered include resident and medical student rotations, adolescent medicine fellowships, the Family Therapy Training Program, and a Pre-Doctoral Psychology Internship Program (see Exhibit 10).



EXHIBIT 10. THE MSAHC TRAINING PROGRAMS

Resident and Medical Student Rotation. The Mount Sinai Adolescent Medicine Division provides an educational experience for all levels of medical learners from multiple disciplines at the MSAHC. Adolescent Medicine is a required clinical training experience mandated by the American Board of Pediatrics for residency training and interns from the Pediatric residency training program at Mount Sinai rotate through the MSAHC as a core requirement every four weeks. The focus of this unique experience is the clinical approach to adolescent and young adult care. The rotation promotes competence in the evaluation and assessment of the adolescent or young adult patient in a developmentally and age-appropriate manner. The ultimate goal of this experience is to encourage medical providers in training to be advocates for young people and to be proficient providers of health care to young people.

Adolescent Medicine Fellowship Program. The goal of the Mount Sinai Adolescent Medicine Fellowship Program is to train physicians to serve as leaders in adolescent medicine with a focus on becoming expert clinicians, clinician educators, researchers, and advocates for young people. As clinicians, fellows are trained to provide expert, safe, effective, empathic, and efficient patient-centered care to young people. The training program provides a structure to build the fellows' skills as educators committed to providing comprehensive education to patients, families, interdisciplinary staff, and medical trainees. Adolescent medicine fellows work with and educate resident physicians and medical students. While in fellowship, fellows work on existing and ongoing research projects or develop projects in their areas of interest and expertise.

Family Therapy Training Program. The MSAHC Family Therapy Training Program is a one-year training program available to mental health staff at MSAHC. The program provides an integrative, interdisciplinary approach to training clinicians to conduct family therapy, and hands-on learning through live supervision provided by a team of clinicians.

Pre-Doctoral Psychology Internship Program and Post-Doctoral Training. The MSAHC has an American Psychological Association-accredited Pre-Doctoral Psychology Internship Program in addition to an externship program. Psychology trainees are involved in many facets of the Center, including therapy and psychological assessment services; a dialectical behavior therapy program; a young parent service; transgender health services; trauma-focused cognitive behavioral therapy services; and a project aimed at integrating mental health services into the primary care medical setting. Additionally, MSAHC offers an interdisciplinary training program for post-doctoral students in psychology and social work research.

Masters in Social Work (MSW), Masters in Public Health (MPH), and Masters in Mental Health Counseling Training. The MSAHC trains MSW and Masters in Mental Health Counseling candidates who are in their final year of training. These trainees receive exposure to working within a highly interdisciplinary and integrated health care setting, as well as learning about trauma-focused care. MPH students can also conduct their internships with MSAHC. These internships are limited to students who can make a significant time commitment.

CHAPTER 5. PROVIDING ADOLESCENT AND YOUNG ADULT-CENTERED HEALTH CARE

Overview of Chapter 5

This chapter provides a picture of the services provided by the MSAHC and how they fit together to create an integrated model for adolescent and young adult health care services. Each service is described and key factors to consider in building this element into your program are identified. You can tailor your own model based on your organization or program's core operating principles, the needs of the target adolescent and young adult population that you are serving or would like to serve, and the resources to which you already have access.

Services are classified as “core” and “specialized.” The MSAHC sees the core services as essential parts of integrated care for young people; specialized services are important additions to care that enhance the effectiveness of core services, increase well-being, and also may be based on the unique needs of the youth populations served.

The MSAHC Approach to the Primary Care Visit

The MSAHC's goal for delivering care is to establish a “health home” for each young person by providing comprehensive care from the same providers, whenever possible. Continuity of care is a key factor in engaging and retaining young people in MSAHC's services, and having a designated primary care provider to serve as a knowledgeable and reliable resource can help to build trust over time, especially for young people who have experienced trauma or have had

negative interactions with adults or institutions (e.g., social services and law enforcement).

During the first visit and at all subsequent visits, the medical provider takes great care to engage each young person and build a relationship with him or her, starting with two distinct actions:

- **Personally acknowledging** by calling the young person from the waiting room and offering a handshake as an introduction. This practice sets the tone at the first visit and maintains it upon the young person's return. Research findings emphasize a strong, personal introduction as an important factor in the positive perceptions of young people about their health care, and as a factor that encourages them to return.³¹
- **Drawing the young person out** by asking about his or her interests, finding something about them to compliment, or asking questions about school and other areas of the patient's life. This is done in an effort to recognize the patient's uniqueness and show an interest in him or her as a person.
- **Providing access to care**, regardless of ability to pay.
- **Establishing open, consistent communication** between the youth and the provider team, and the channels available to the young person for maintaining this communication (appointment scheduling, walk-in care availability, how the young person would like the clinic to contact him or her, and how to contact the medical provider with questions).

- **Assuring confidentiality** of services, and explaining limits to confidentiality.
- **Providing comprehensive services.**

MSAHC's Model for Engagement

At MSAHC engagement is viewed through three different, but equally important lenses:

(1) *A consumer lens*: The provider takes seriously how the young person defines his or her own needs and the issues that are most on his or her mind.

(2) *A vulnerability/risk/worries lens*: The provider pays careful attention to any aspect of the young person's situation that the provider feels concerned about.

(3) *A youth development lens*: The provider considers the young person's contributions along with his or her dreams, aspirations, strengths, and coping capacities upon which the service relationship can be built.

When working with adolescent and young adult clients, effective MSAHC practitioners must integrate a view through all three lenses simultaneously to get a complete clinical picture, but it is useful to think about engagement as a process in which there is a sequential shift in emphasis from one lens to the other.

MSAHC practitioners understand that a young person who physically comes through the door has not yet crossed the self-perceived threshold as a client. To achieve trust and mutually define where to begin, the practitioner must understand what the young person wants to talk about and what issues—though important clinically—are initially off

limits. This need must initially be addressed on the young person's own terms. Often the whole point of the first session is to secure a second session.

Once a client begins to talk openly and engagement begins, clinicians can then allow the "vulnerability/risk lens" to focus their assessment. A complete risk assessment involves not only what the provider determines places the client at risk, but also the client's own worries and self-perceived vulnerability, including any behavioral and environmental risk factors. Providers work hard to get both sets of concerns on the table—if not on the first visit, then over time. Done well, a complete risk assessment conducted in a nonjudgmental way serves to



demonstrate the clinician's genuine interest in the client, as well as signal that MSAHC is a safe place to talk about loaded issues—if not now, then later.

As treatment goals and strategies evolve, the youth development lens, which takes into account the young person's strengths and resources, is applied. Successful work with young people requires understanding both current and past coping patterns that serve as a foundation upon which to build.

Providers ask each young person to make a self-assessment of both coping and vulnerabilities. However, MSAHC's theory of help is that the most developmentally

appropriate service model is one that recognizes and builds on young clients' competencies by engaging them as partners in managing their own health and mental health care.

To maximize the atmosphere of engagement that the MSAHC strives to create, other staff members also focus on building relationships and setting a respectful, welcoming tone:

- The registrars are the first people with whom the young person interacts. They warmly greet the young person by name, take the time to explain the registration process to new patients, review insurance information while reassuring the young person that they will be seen regardless of whether they have insurance, assess for confidentiality concerns, and make every attempt to accommodate those who walk in without an appointment or are late for their appointment.
- Health Communities Access Program enrollers educate young people about available coverage for which they can enroll.
- Medical technicians (MTs) greet young people as they begin their medical visit and before they leave the clinic. The MTs perform screenings (e.g., height, weight, vision, blood pressure), order urine testing for pregnancy or STI, and provide support to both the provider and the young person. They ensure that all of the young person's questions are answered, and act as a reassuring presence during the visit.

Guiding young people through their medical visits and the medical system allows them time to synthesize the information and instructions they receive from medical providers, and helps them become confident in taking full control of their health care. Due to the confidential nature of many of the services provided at the MSAHC, many young people are using medical services on their own for the first time. To support these young people, MSAHC staff act as

Motivational Interviewing

Motivational interviewing (MI) is a goal-oriented, client-centered counseling style focused on exploring the pros and cons of changing or not changing behavior. The goal of MI is to resolve ambivalence through increasing the client's awareness of how their behavior may cause problems for them, the consequences they experience, and the risks that they face because of the behavior.

MSAHC staff members receive training in MI techniques, such as asking open-ended questions, providing affirmations, reflective listening, and providing summary statements to the client. These skills are used strategically, while focusing on a variety of topics (e.g., looking back, a typical day, the importance of change, looking forward, confidence about change).³²

health navigators by providing support and understanding of the “next steps”—seeing all of the necessary clinical staff, taking all of the appropriate tests, and scheduling all of the recommended follow-up appointments.

The MSAHC’s Core Services

The MSAHC provides five core services: (1) primary medical care; (2) sexual and reproductive health care; (3) behavioral and mental health care; (4) oral health care; and (5) optical care. Together, these core services form a seamlessly integrated, comprehensive primary care model for young people.

Primary Medical Care

Primary care is the gateway to other core services, as well as specialized services. Besides addressing the reason why the young person came to the clinic, the primary care appointment is an opportunity to screen for other issues. At the first primary care visit, a detailed medical screening

(including a physical, immunization updates, and a health plan for the management of acute and chronic health conditions) is developed and a psychosocial history is conducted. The psychosocial history is used to develop a coordinated treatment that includes both immediate intervention and preventive services, including sexual and reproductive health services, behavioral and mental health care, dental and/or optical care, and health education. The principle of comprehensive care is carried out by providing as many services as possible while the youth is at the clinic, thereby reducing the number of follow-up visits.

Health education is provided during all medical visits, but the MSAHC also provides distinct health education appointments. The MSAHC’s health educators provide counseling that guides young people through HIV testing, contraception, pregnancy options, and sexual risk reduction. They integrate other health issues into risk assessment counseling,

Affiliation With Mount Sinai Hospital and Health System

The MSAHC is a part of the Mount Sinai Hospital and Health System and the Icahn School of Medicine. This relationship provides excellent access to resources, staff, and faculty from seven member hospitals and six hospital affiliates to support the work of the Center. For example, while the MSAHC has a variety of providers and staff available, some young people have specialized needs. Having access to specialists via the Mount Sinai Hospital and Health System allows MSAHC to arrange for provider consults and appointments with various specialists as needed or on a particular consult day so that young people can receive specialized care. The hospital’s eight pediatric specialties include (1) oncology, (2) diabetes and endocrinology, (3) hematology (4) gastroenterology and GI surgery, (5) nephrology, (6) neurology and neurosurgery, (7) pulmonary, and (8) urology.

including mental health, sexual assault, tobacco use, and substance abuse. As with medical visits, health education sessions are entered into the young person's chart. To build trust and ensure continuity of care, young people are assigned to a specific health educator whenever possible.

Throughout the visit, health educators establish a nonjudgmental and safe space to help the young person feel comfortable as they review their answers on standardized risk assessments and provide counseling and referrals related to sexual health and other health issues. The average visit with the health educator lasts 30 to 45 minutes, depending on the needs of the young person. The health educators use motivational interviewing as a key strategy in risk reduction counseling. As the health educator meets with the young person to reinforce and expand on the information relayed by the provider, the health educator's goal is to ultimately empower the young person to make informed decisions that benefit their health.

Sexual and Reproductive Health Services

The young person's primary care provider also provides sexual and reproductive health care. The provision of this care is multifaceted and includes discussion of sexual identity; the young person's perception of him or herself as a sexual person and how he or she makes sexual decisions is equally as important as the physical care. The medical provider takes the time to discuss questions and to help the young person understand his or her own sexual behavior, whatever that behavior may be. Giving the young person their "own" medical provider with whom they can discuss these issues is a priority for ensuring engagement and longer-term positive outcomes.

Sexual and Reproductive Health Service Provision: Best Practices

- Provide counseling and education so that young people understand all of their options.
- Validate the young people in exploring their sexual identity and other factors that may affect their sexual decisions and behaviors.

The MSAHC's Sexual and Reproductive Health Services*

- Routine screening for STIs, including HIV
 - STI treatment for the young person and all identified partners
 - All family planning methods approved by the FDA (birth control pills, patches, rings, injections, IUDs, and Nexplanon)
 - Pregnancy testing as needed, and counseling on pregnancy options if the test is positive.
- * All visits include counseling and education

Young people come to the MSAHC for sexual and reproductive health care for a variety of reasons: they may be thinking of having sex or are already having sex, they may be using a family planning method and not using condoms to prevent STIs, or they may not be using any form of protection. They may have questions about sex and sexuality for which they need answers. No matter how each individual presents to us, sexual and reproductive health services are always discussed in a whole life context, taking into account each adolescent or young adult's unique circumstances and relationships. Providers spend time assessing how able the young person is to make decisions, whether



he or she is in a coercive relationship, is being sex trafficked, is feeling more subtle pressures to have sex, or feels ready to have sex.

The medical providers always spend time talking with young people to find options for self-care that fit with their lifestyles and life situations. For example, in discussing contraception, providers encourage young people to consider factors such as their comfort, lifestyle and experience, need for confidentiality, as well as the effectiveness of various methods. Many young people select long-acting methods of contraception (e.g., Nexplanon or an intrauterine device [IUD]) after identifying their needs for a method that does not require them to remember to take a pill every day, or because they need to keep their use of contraception private. Young people can download an app for contraceptive and appointment reminders. A full inventory of MSAHC's sexual and reproductive health services is included in Appendix C.

Young women are screened for pregnancy upon request or if their last menstrual period is late or abnormal. If the pregnancy test is positive, comprehensive options counseling is provided on the same day, usually by a mental health provider or a health educator.

Options counseling includes assessment of social and family support and of the relationship with the person by whom they became pregnant. Partners are involved in options counseling with the young person's consent. Young people receive assistance and follow-up in connecting to what is needed for whatever choice they make, including post-termination contraception and prenatal care.

Mental and Behavioral Health Services

The MSAHC integrated mental health services directly into the medical setting 25 years ago. The MSAHC's model embraces

the mental health and psychosocial needs of historically underserved, high-risk, and often traumatized young people who have historically been difficult to engage in ongoing mental health services due to numerous stressors and histories of marginalization. This model was developed because MSAHC's primary care medical providers noted that a large percentage of the young people presenting for medical appointments have high rates of trauma and other significant mental health problems, engage in high-risk behaviors, and display unmet psychosocial needs (e.g., depression, posttraumatic stress disorder, anxiety, school problems, family conflicts, risky sexual behavior, housing and food insecurity).

The MSAHC addresses this gap in mental health services for young people in several ways, recognizing that multiple options create multiple opportunities to engage young people in services:

- Young people seeking mental health services or who are referred to them directly can obtain a full spectrum of services by scheduling an intake appointment.
- Young people often self-refer directly to mental health, or are referred through parents and caregivers, or by agencies throughout the community.
- Providers include screening for mental health needs and psychosocial issues during all medical appointments.
- Many young people do not actively seek mental health services, so MSAHC has a

team of mental health professionals fully embedded in the primary care services, so that when a patient seems in need, the medical provider can immediately invite the mental health practitioner into the exam room to begin a process of screening and engagement. Thus, in-clinic mental health services can be put in place immediately. Within the primary care setting, the mental health team also actively scans the clinic roster and waiting areas to identify and greet young people they may have seen previously or who they think should be engaged in mental health, behavioral, or support services—for instance, those who make repeated visits for pregnancy or STI testing but have never been engaged in ongoing counseling, or those they have previously met but have not returned.

- Young people who do not need immediate engagement can be referred to intake for mental and behavioral health services, but most adolescents and young adults benefit by not waiting and being seen immediately when a concern is foremost on their minds.



Why Integrate Medical and Mental Health Services for Young People?

Accidents and suicide, often linked to risky behavior and depression, are leading causes of death for young people. In spite of this, only 20% of adolescents and 10% of young adults who experience mental health disorders receive treatment. A recent study found that outcomes improved by 66% for young people who received integrated medical and mental health care.

Integrated care removes geographic and transportation barriers and reduces the stigma of receiving mental health care. In addition, use of an integrated team, similar to the MSAHC's model (e.g., medical providers, social workers, psychologists, psychiatrists) was found to increase positive outcomes by 73%.³³

Engaging Young People and Mental Health

Because many young people are guarded or ambivalent about trusting and sharing information with someone they just met, engagement is key to connecting them to mental health services.

The MSAHC's mental health providers increase engagement of young people by:

- Greeting them with a smile, welcoming them, and explaining how care will be provided;
- Encouraging them to ask any questions or ask for clarification at any time;
- Presenting a nonjudgmental attitude about how the young person presents and understands their situation and experiences; and
- Validating the young person's feelings to help them feel supported in seeking therapy.

Regardless of the avenue through which each young person enters mental health care, the process of accessing these services begins with an intake interview that usually takes one session (the length may be tailored to the client's individual needs) conducted by a psychologist, licensed clinical social worker (LCSW), or licensed master social worker (LMSW). During the initial intake, the provider assesses the young person's overall mental health and provides referrals to other services as needed. Common issues include exposure to community violence, experiences of abuse, adolescent and young adult parenting, HIV infection, substance use, issues of adjustment to sexual orientation, gender identity issues, PTSD, depression, academic issues, and family issues.

The MSAHC social workers (LCSWs and LMSWs) and psychologists play a key role in both the primary care and mental health clinic settings, providing assessment and case management, ensuring that each young person's needs are addressed, and

confirming that assistance in successfully navigating the available avenues of care is provided. Case conferences are led by a team of licensed social workers, a psychologist, and a psychiatrist. The MSAHC offers a comprehensive and diverse array of treatments, listed in Exhibit 11.

Connecting Young People to Behavioral and Mental Health Services

The following strategies are used to successfully connect young people to behavioral and mental health care.

Immediate Link to Mental Health Services: Within the primary care setting, licensed providers (LCSWs, LMSWs, and psychologists) are present so that when a primary care provider identifies a mental health or psychosocial concern, the young person can be immediately referred to a mental health clinician. A key piece of this strategy is the "warm connection" in contrast to the "cold handoff" of an impersonal



EXHIBIT 11. THE MSAHC'S MENTAL AND BEHAVIORAL HEALTH SERVICES

- Short- and long-term individual, family, and group therapy
- Lesbian, gay, bisexual, transgender, questioning (LGBTQ) support and counseling
- Treatment for complex trauma and PTSD related to trauma exposure (sexual assault, domestic violence, commercial sexual exploitation)
- Alcohol and substance abuse prevention and treatment
- Treatment for self-injurious behavior
- Psychological testing
- Psychiatric evaluation and medication management
- Psychoeducational testing and evaluation of learning disabilities

referral; the primary care provider introduces the young person to the mental health clinician and helps explain the reason for the referral, building on their relationship with the young person.

Following this introduction, the mental health provider conducts a thorough psychosocial assessment with the young person and determines whether there is an issue that can be addressed through psychosocial interventions or case management. However, throughout the assessment the clinician remains acutely aware of the perspectives of the young person, constantly seeking opportunities to engage the adolescent or young adult on his or her own terms. This requires a balancing act between the “rigor” of a complete and prolonged assessment and the need to remain engaged and “relevant” to what is currently on the young person’s mind: that is, finding a place to start. When a need is identified and an agreement made the primary care mental health provider will invite the young person back. Since few young people immediately agree to come for ongoing sessions, mental health services are offered in a very flexible fashion tailored to the young person’s attitude. MSAHC staff often say that “the purpose of the first meeting is to obtain a second one.”

Because mental health services are provided through the medical setting, young people are never “discharged” from their mental health care due to missed appointments. They can be seen by a mental health provider in the medical setting whenever they would like. Inviting the young person to receive mental health services in the primary care setting reduces barriers to care. Primary care mental health providers are specially trained in trauma-informed care and are supervised by a psychologist. Mental health services available in the primary care setting include individual and family therapy, psychiatric medication services, and psychological testing.

Acknowledging the Experience and Effect of Trauma

The MSAHC’s screening for mental health issues includes checking for past or current exposure to trauma during each medical and health education appointment. The population of young people served by the MSAHC have experienced a high percentage of past traumas (e.g., sexual abuse, physical abuse, domestic violence, and commercial sexual exploitation), and the MSAHC seeks to alleviate the long-term deleterious impact of trauma on mental and physical health.

In-Clinic Intervention: If the mental health provider determines that the young person faces barriers that will make it difficult for them to keep appointments (such as homelessness or being sex trafficked), the clinician arranges for the young person to automatically be seen by both the primary care provider and the mental health clinician whenever the young person comes to the center. This strategy is effective because the young person is likely to return to the center for medical care, even if he or she cannot return for mental health care only.

Established Mental Health Services

Following the assessment, the clinician and the young person agree on a follow-up plan to ensure that mental health care can be continued. If the client cannot commit to routine appointments, psychotherapy can be provided in the primary care clinic during medical visits, or on a drop-in basis, as described above. Otherwise, the clinician schedules weekly appointments with the young person.

Sometimes it is beneficial to work with the entire family. Family therapy focuses on communication, understanding each family member's role, and learning how to respond or interact in a positive way. Family configurations are defined as whoever the youth identified as family, whether it is two parents, a single parent, or grandparents; siblings and other relatives are also included.

MSAHC's mental health clinicians offer a variety of therapies based on the presentation of the young person. If youths are given a diagnosis such as depression, adjustment disorder, substance abuse or dependency, anxiety, or PTSD, specific approaches such as trauma-focused cognitive behavioral therapy or dialectical behavior therapy may be used; tools such as the University of California, Los Angeles PTSD reaction index, the Beck Depression and Anxiety Inventories, CRAFFT Screening Test, and the Conners Comprehensive Behavior Rating Scale are used as well (see Appendix D for detailed descriptions). Many MSAHC mental health providers also use evidence-based interventions, including the Seven Challenges, Students Managing Anger and Resolution Together Team (SMARTteam), Strengthening Families, Teen Intervene, and LifeSkills Training (LST) (see Appendix E for links to intervention descriptions) at the MSAHC. However, the engagement of

31% of young people served at MSAHC received mental health services in 2014.

MSAHC's Comprehensive Services: One Youth's Experience

F.V., now 25 years old, first came to the MSAHC to support his sister's participation in the Center's HIV/AIDS program. Following her passing, he sought help through the mental health counseling services at the MSAHC. F.V. has shared that the MSAHC saved him, not only by helping him cope with the loss of his sister, but also allowing him to work through past issues he had been unaware were affecting him. He also found access to an array of comprehensive services he never knew he needed—primary medical care, dental care, and legal support, among others. The understanding and genuine care for his well-being he found at the MSAHC motivated him to move into his own apartment.

the young person is always foremost in the clinician’s mind; diagnoses and therapies are always discussed to ensure he or she is fully informed and educated and becomes a partner in his or her care.

Group Therapy: The MSAHC offers a variety of therapy and support groups, which were developed to meet the needs expressed by the young people who receive care. Specific groups provide support to LGBT young people who are coming out; transgender youths; and survivors of rape, intimate partner violence, and sex trafficking. Other groups are art therapy-based or focus on social skills or the management of emotions. To encourage participation, reduce any potential stigma, and strengthen the feelings of privacy and confidentiality, therapy-focused groups are marketed not



by their therapeutic focus, but based on life situations. For example, a group for young women who are survivors of intimate partner violence may be advertised as a “Ninth Grade Girls Support Group.”

The groups are advertised throughout the clinic on television screens and with fliers. Young people can be referred to group

therapy by any clinician or staff person, or they can self-refer. The clinician facilitating a group will connect with the young people to meet with them, assess their “fit” for the group, and evaluate additional services from which they may benefit.

Comprehensive Psychosocial Assessment and Referral for Additional Services: Mental health clinicians provide comprehensive case management, including collaboration with various agencies such as the Department of Education, Administration for Children’s Services, other welfare agencies, and the court and legal systems.

Specialized Mental Health Services

The MSAHC provides comprehensive psychological testing, using standardized and validated measures to assess cognitive, academic, neuropsychological, and social-emotional functioning. Psychological testing enables diagnosis of learning disabilities that can facilitate educational accommodations and gives providers further diagnostic clarity.

Both primary care and mental health providers frequently consult with one of the Center’s psychiatrists in cases where medication might be an option or where a diagnostic question remains. Comprehensive psychiatric evaluation and medication management is provided. An interdisciplinary team, which includes a psychiatrist and psychologist, reviews the initial plan and progress at least every 3 months for every young person receiving psychosocial services to ensure that services are appropriate and sufficient.

Oral Health Services

The provision of oral care helps prevent young people from developing common dental conditions, such as cavities, gingivitis, and periodontitis. If left untreated, these conditions can lead to pain, tooth loss, and advanced gum disease, interfere with school attendance and productivity, and affect their overall health.

The MSAHC's free dental clinic opened in 2011 after cuts in Medicaid payments for dental services reduced access to oral health care for young people throughout New York City. As with other services, dental services are provided to young people at no cost to address this gap and provide comprehensive care.

Because access to dental care and treatment is severely limited for young people, many have had no access to dental services before coming to the MSAHC and present with a disproportionately high rate of tooth decay. The MSAHC recognizes that oral health services must be a core service available to each young person who receives care at the Center.

Primary care providers and mental health clinicians explain the importance of oral health and refer young people to the dental clinic. They can also self-refer, even if they receive primary care elsewhere. The MSAHC's dental suite has three dental chairs and is staffed by two dentists and an assistant/coordinator.

Routine dental care (including preventive measures such as cleaning teeth, treating with fluoride, filling cavities, applying sealants, and other restorative work) is provided every six months. With access to information about proper oral hygiene, treatment for serious oral health problems (e.g., gum disease), and the use of preventive measures, the MSAHC has seen improved oral and physical health among the population of disadvantaged young people being served.^{34,35}

Optical Services

Young people sometimes do not realize that poor vision may be causing them to do poorly in school. Sometimes, poor school performance may seem to point to behavioral testing to understand the origins of performance issues, when in actuality, vision problems are a greater contributor.³⁶ To identify vision problems, all young people

MSAHC's Ophthalmic Suite

MSAHC collaborated with Cohen's Fashion Optical to establish the Ophthalmic Suite and provide the following services:

- Evaluation and treatment of the functional status of the eyes and visual system
- Assessment of ocular health status using appropriate diagnostic procedures
- Fitting for glasses or contact lenses, as needed
- Emergency screening
- Counseling and education about eye diseases and conditions, including prevention
- Screening of young people with diabetes and other health conditions that can affect the eyes (with appropriate referral and interventions)

receive vision screening at their first primary care visit and then on an annual basis. Young people who screen positive for poor vision are referred to the optometrist for an exam to determine whether they need glasses or other intervention, all provided free of charge. Any young person with any indication of eye disease is referred to an ophthalmologist. The MSAHC works with a private ophthalmologist who donates the services.

The MSAHC's Specialized Services

The MSAHC complements core service offerings with specialized services that address the presenting issues and life experiences of many of the young people who come to the MSAHC. These services are accessible when primary care and mental health providers see the benefit of additional interventions to complement the treatment that happens during medical visits. However, some of these specialized services are unique, and young people may be referred to MSAHC from outside agencies specifically to access them. The MSAHC's specialized services fall into two categories. The first is **enhanced services**, which address issues or situations that can put any young person's health and well-being at risk. These services include legal assistance; violence intervention

and prevention; sexual abuse and sexual assault; obesity and eating disorder education and treatment; and substance abuse treatment. The second category is **population services**, which address the unique needs of specific populations of young people, such as LGBTQ youth, young people living with HIV, and young parents.

Enhanced Services

Legal Assistance

Issues related to immigration, need for decent housing, and homelessness can be especially hard to address for young people, and the MSAHC recognizes that addressing these issues is a way to maximize the effectiveness of health care. The MSAHC operates a legal clinic that is staffed by an attorney and full-time paralegal. Young people can be referred to the legal clinic by any staff person. Generally, young people are referred to the legal clinic for a particular issue, but often the attorney discovers that they are facing multiple issues that must be addressed. Education-related issues are also common areas of concern. Exhibit 12 provides examples of the services provided.



EXHIBIT 12. THE MSAHC'S LEGAL CLINIC SERVICES

- **Legal Advocacy:** Immigration, housing and homelessness, public assistance, Medicaid, Social Security/disability, employment, family law (child support, custody, neglect/abuse, court orders of protection, guardianship), LGBT issues (including identification for transgender young people), finding counsel, criminal case assistance.
- **Educational Advocacy:** College selection and application, financial aid application assistance, special education, access to disability services, course load, and school debt.



The attorney works closely with young people who are referred to the legal clinic as needed. In addition to writing letters, completing documentation, and performing phone advocacy on their behalf, the attorney (or paralegal or law school students interning at the Center) also provide the following services:

- Advocacy for young people, examples of which include addressing problems that have arisen at school, including access to disability services and accommodations to which they are entitled under law; working with government offices to ensure access to food stamps, public assistance, or social security disability benefits; and accompanying young people to fair hearings or housing or family court.
- Referral to public interest or pro bono law firms and not-for-profit agencies for outside counsel and representation.
- Referral to housing services (including the New York City shelter or domestic violence shelter systems and agencies that provide emergency or supportive housing) and referral to vocational and job training programs (including a nonprofit employment agency that offers one-week workshops to educate young people about

the job market, helps them with resumes and interview techniques, and sends them on interviews for the many job referrals the agency gets from participating employers.)

Violence Intervention and Prevention Service

MSAHC provides comprehensive medical and mental health services, preventive education, and criminal justice system advocacy for young survivors of incest, sexual abuse, rape, dating violence, domestic violence, and other forms of criminal victimization. Services include the following:

- Individual, group, and family therapy, along with support groups, to address child physical or sexual abuse, intimate partner violence, rape and sexual assault, human trafficking and commercial sexual exploitation, and witnessing or being the victim of violence or violent crime
- Self-defense and self-assertiveness training
- Community outreach and education about safe dating, violence prevention and intervention
- Training for health and mental health professionals

Nutrition

MSAHC recognizes the importance of addressing nutrition as a major factor in the health of young people. Both primary care and mental health clinicians assess each young person's food security and knowledge of healthy nutrition, and address issues related to nutrition and eating. Depending on the patient's needs, nutrition education may be provided by the primary care provider, or by an integrated team that also includes a mental health clinician and a registered dietician.

Messages and education about general health and nutrition are included as a standard part of primary health care, including information about eating a balanced diet. Throughout National Nutrition Month, clinic televisions play short presentations about various topics related to healthy eating, and activities are held such as quiz games with raffle prizes. The clinic also hosts a Health Day that focuses on nutrition, with a Zumba class and other activities.

For young people with more intensive needs, the primary care clinic provides nutrition therapy. During the first nutrition therapy appointment, a primary care provider assesses the young person's current eating habits, medical history, and family history, and addresses his or her health concerns, goals, and expectations for the future. Young people are provided with appropriate nutrition education based on their readiness to change and individual needs. Follow-up appointments are designed to provide ongoing and continuous support to help the young person reach health- and nutrition-related goals and include check-in, discussion of how they are doing, and further nutrition education. Exhibit 13 provides a list of nutrition issues that can be addressed, with several highlighted in more detail.



EXHIBIT 13. MSAHC NUTRITIONAL SERVICES

- General health and nutrition
- Weight management
 - Obesity, underweight, weight loss (intentional and unintentional)
- Diabetes education
 - Prediabetes, type 2, gestational
- Heart disease
 - High cholesterol, hypertension, high triglycerides
- Eating disorders
 - Anorexia and bulimia
 - Binge eating
- Gastrointestinal disorders
 - Irritable bowel syndrome, Celiac and Crohn's disease, food allergies/sensitivities
- Polycystic ovary syndrome
- Pre/postnatal nutrition
- Pediatric nutrition
- Sports performance
- Auto-immune disorders

Obesity Treatment and Prevention

For young people who are overweight or obese (those with a body mass index of greater than 25 kg/m²), the MSAHC offers the Teen Fit Program, which is facilitated by a registered dietician, a social worker, and an exercise instructor. The goal of the Teen Fit Program is to enhance nutrition and wellness of young people who are overweight by helping to change their lifestyles and improve their health through physical exercise, nutritional education, counseling about positive choices, behavior modification, improved self-esteem, and motivation. The program provides physical activity classes three days a week, nutrition class once a week, a weight loss support group once a week, and a self-esteem group once a week. Prior to starting the group, the young person completes a comprehensive physical exam, and also meets with the nutritionist for an intake and a motivational interviewing assessment. Ongoing support is provided following completion of the program, including weekly, every other week, or monthly nutritional sessions, and access to appointments with the social worker for additional emotional or social support.

Treatment of Eating Disorders

Nutrition therapy is an integral part of the eating disorder treatment and recovery process. The primary role of nutrition therapy is to assist patients in normalizing their eating patterns. Each nutrition session provides counseling on the following:

- Eating adequately to meet the body's daily nutritional needs.
- Developing a balanced relationship with food.
- Listening to and trusting the body's internal cues to determine hunger and fullness.

69% of young people served at MSAHC have received obesity and eating disorder education, treatment, or both.



15% of young people served at MSAHC have been given a diagnosis of obesity (body mass index [BMI] over 30).

The MSAHC uses a comprehensive approach to treat young people with disordered eating. An interdisciplinary team—composed of a nutritionist, a primary care physician, and a social worker or psychologist—works together to support and assist young people in meeting nutritional goals and progressing in recovery. Each individual session is tailored to each young person's unique struggle with food and eating. Young people are scheduled for appointments on a weekly or biweekly basis, depending on their progress. The clinical team communicates regularly and holds monthly case conferences.

Substance Abuse Treatment

MSAHC views substance abuse as a symptom of other underlying issues. Young people who present with substance abuse issues are connected with a mental health clinician, regardless of whether they are ready to formally enter treatment. The mental health clinicians may use psychotherapy or evidence-based interventions, such as the Seven Challenges® (see Appendix E). If the young person does not wish to engage in treatment, the MSAHC team continues to provide primary care and other services to them and address substance abuse with a harm reduction approach (see Exhibit 14), working with them to help them understand their use, why they use, and to try to move them along to use less and eventually stop using.

MSAHC offers an evidence-based intervention, Strengthening Families, which focuses on early intervention and prevention of substance abuse with young people and their families. In this intervention, facilitators work with the young people and their families separately but concurrently and then brings them together so that they can learn to communicate.

Populations With Unique Needs

Lesbian, Gay, Bisexual, and Questioning Youth

Although MSAHC is not advertised as a “gay clinic,” MSAHC takes great care to provide a safe space for lesbian, gay, and bisexual young people—also referred to as “sexually minority youth.” Because the MSAHC has an established reputation for welcoming this population of young people, significant numbers seek comprehensive medical and mental health services at the clinic. To ensure that they are being adequately served, the



EXHIBIT 14. THE HARM REDUCTION APPROACH

Harm reduction is an approach to treating substance abuse that aims at working with the drug user to develop strategies to lower the harm of substance abuse, regardless of whether the user intends to abstain from drug use. Harm reduction is based on the principles that drug users should be treated with dignity and not denied medical or social services because of their drug use.³⁷

MSAHC has added tailored services and activities for this youth population. Since many young people do not identify their sexual orientation when they walk in the door, effectively serving lesbian, gay, bisexual, and questioning young people starts with conducting the initial comprehensive medical and psychosocial history. As mentioned earlier, the history is a respectful conversation that allows all young people the opportunity to share their sexual orientation and identity, as well as their sexual behavior, with no assumptions made in advance by the provider. Medical students and residents receive special training in how to take this history in a sensitive manner, especially when discussing sexual orientation, attraction, and behavior. For young people who share that they are gay, lesbian, or bisexual, the providers are then able to further assess potential medical and mental health needs that may be of specific concern.

All services available at the MSAHC are equally accessible for lesbian, gay, bisexual, and questioning young people. Although many initially come in for STI and HIV testing, the primary care provider ensures that they also receive, at minimum, an annual physical and that their immunizations are updated. Postexposure prophylaxis (PEP) and pre-exposure prophylaxis (PrEP) are available for any young person who is at high risk of acquiring HIV.

The MSAHC has developed tailored mental health services for lesbian, gay, bisexual, questioning, and transgender young people,

including mental health clinicians who, through a “Coming Out” support group, can support young people who are questioning their sexual orientation, having concerns about their family’s acceptance, or struggling with other issues related to coming out.

Transgender Young People

The MSAHC’s comprehensive services are tailored to meet the needs of young people who are transgender, and are based on the work of Dr. Ryan and the Family Acceptance Project (see Exhibit 15). The MSAHC has established transgender health protocols that reflect current standards of care and best



EXHIBIT 15. THE FAMILY ACCEPTANCE PROJECT

The Family Acceptance Project™ is directed by Dr. Caitlin Ryan at the Marian Wright Edelman Institute at San Francisco State University, and was developed by Drs. Ryan and Rafael Diaz in 2002.

The Family Acceptance Project was designed to accomplish the following:

- Analyze parents’, families’, and caregivers’ reactions and adjustment to a young person’s coming out and LGBT identity.
- Develop training and assessment materials on working with LGBTQ children, young people, and families specifically for health, mental health, and school-based providers; for child welfare, juvenile justice, and family service workers; and for clergy and religious leaders.
- Develop resources to strengthen families to support LGBTQ children and adolescents.
- Develop a new model of family-related care to prevent health and mental health risks, keep families together, and promote well-being for LGBT children and adolescents.

Findings are being used to inform policy and practice and to change the way that systems of care address the needs of LGBTQ children and adolescents.³⁸

practices outlined by the World Professional Association of Transgender Health, including hormone therapy, and has seen more than 200 young people who are transgender, along with available family members, since doing so. The MSAHC's primary care providers may also provide specialty care for young people who have a primary care doctor outside of the MSAHC, but need

assistance specifically with medications related to gender transition.

In keeping with the MSAHC model, medical and mental health services go hand in hand in addressing the health needs of transgender adolescents and young adults, who are at higher risk for depression, suicide attempts, substance abuse, and HIV

MSAHC's Care Retention Strategies

The MSAHC uses the following strategies to keep HIV-Positive young people in care:

- Enlist social workers as case managers who maintain contact with young people and ensure that they come in for appointments.
- Use a team approach in providing care, with medical and mental health staff working together to give young people a consistent message about their care.
- Address quality of life issues, including school, finding a job, and relationships.

MSAHC's Project Impact: One Youth's Experience

F.G., 24, has been with the MSAHC for 4 years—he was diagnosed with HIV at 21. Within hours of receiving this life-changing news, he met with a doctor and social worker and applied for insurance. With encouragement from his mentors at the MSAHC, F.G. enrolled as an active member of Project Impact, a program at the MSAHC providing confidential medical and mental health support and resources to young people living with HIV. He graduated a year early from St. John's University on a full academic scholarship, and earned a bachelor's degree in English studies.

He currently works as a client manager in the Global Banking and Markets division of a bank, and is eager to advance in the financial field.

infection. Specifically, along with medical care, the MSAHC provides one-on-one psychotherapy with clinicians who are experienced at working with transgender youths. Family members are included, as appropriate, because MSAHC recognizes that building a supportive family environment is key to improving health outcomes for transgender youth. A transgender support group is facilitated by a psychologist and a licensed social worker with extensive experience working with transgender people. The MSAHC's mental health clinicians can also provide treatment for gender dysphoria (discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth). Treatment for gender dysphoria is often a combination of medical intervention (e.g., hormone therapy) and psychotherapy.

Young People Living With HIV

MSAHC has been treating young persons living with HIV/AIDS since the mid-1980s, and currently provides HIV care to approximately 80 young people of all genders, ranging in age from 16 to 24 years, some of whom were behaviorally infected and some with perinatally acquired HIV. Young people who receive HIV care at the MSAHC include those who tested HIV positive in the clinic and those referred from other agencies.

A diagnosis of HIV is a crisis situation for a person of any age, and especially for a young person. To ensure immediate intervention and to help reduce fear and anxiety, when a young person tests HIV positive, a team of staff—including a primary care provider, two mental health clinicians, a health educator, and a linkage coordinator (who ensures that their services both at MSAHC and elsewhere are well coordinated)—mobilizes to arrange a highly coordinated intervention on the same day that the test result is given. These encounters are well planned and



choreographed to fit the unique situation of the young person, who is introduced to the team and given each team member's contact information. He or she is also assigned to a licensed social worker who acts as both a case manager and as a psychotherapist. But meeting the whole team ensures that the young person feels connected to the group, and knows they will always be able to get immediate help, even when their assigned social worker is not present. The team approach also provides a highly supportive structure for the staff.

Most of those who test positive for HIV have had extraordinarily difficult life circumstances and complicated and challenging family relationships. The team takes a whole-life approach, supporting the young person and those who are important to him or her, both helping them through the hurdles and challenges they face and celebrating achievements and milestones.

Primary medical services include general primary care (physicals, immunizations, growth and development monitoring, STD testing, and sexual and reproductive health care), as well as specialty HIV care (CD4 and viral load monitoring, HIV medication management). An HIV support group meets weekly, and is the oldest continually running support group at the MSAHC.

The health outcomes for young people living with HIV who receive care at the MSAHC are excellent, according to national standards for retention in care, including viral suppression rate, immunization and annual physical rates, and frequency of HIV-related lab work.

Young Parents

Young parents' services at the MSAHC are highly coordinated, multidisciplinary, and designed to provide comprehensive services to young mothers, fathers, and their children within a family-based model. The program consists of dedicated pediatricians who provide primary and sexual and reproductive health care for the parents and well-child care for the children; social workers who perform mental health assessments and help families navigate various psychosocial hurdles, including housing and food insecurity; psychology interns who perform developmental assessments for the children (who are at elevated risk for developmental delays); and a nutritionist who works with each family to promote healthy lifestyle choices. The focus is on providing young parents with the tools to stay healthy, continue to pursue their dreams, and create strong family bonds.

Because the MSAHC's primary care providers are adolescent medicine physicians and board-certified pediatricians, they are able to take care of the medical needs of both the parents and children during the

Teen Parent Nutritional Services

The teen parenting program team includes a nutritionist who assesses the nutritional risk for the teen mother and child and provides nutritional education about topics such as the following:

- Nutrition needs for infants, babies, and toddlers
- Breastfeeding and formula feeding
- Introducing solid foods
- Choking hazards
- Picky eating
- Weight management
- Applying for the Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
- Food intolerance/sensitives
- Postpartum nutrition

same visit, greatly reducing the burden on young parents. They understand that young mothers are at higher risk for many issues, such as repeat pregnancy, intimate partner violence, lack of school completion, and inadequate self-care, especially in regard to mental health. The MSAHC's primary care and mental health providers work to engage these mothers in consistent care and emphasize reliable contraception. During regular visits to the clinic, there is also a focus on timely vaccinations for the children, as well as referrals for routine developmental screening, in accordance with the Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care.

Young parents and their children are seen during the same appointments for comprehensive, ongoing care. This approach minimizes the number of days missed from school and work. Social workers assist young parents with returning to school, preventing another pregnancy, and becoming the best possible parents they can be through parenting classes, support groups, and case management. The social workers also make sure the children receive optimal health and social services; are developing properly; and maximize attachment, bonding, and interactions with their parents. The staff team encourages parents and models how best to interact with their children, including talking and reading to them.

To be able to return to school, young parents must have child care. Many of the young mothers live at home with their parents or with the baby's father's family, who often provide child care. The social workers work with the young mothers in communicating with their own parents, as well as the baby's father, about co-parenting their children.



Utilizing Technology to Deliver Adolescent and Young Adult Health Care

A critical element of delivering adolescent and young adult-centered care is the ability to adapt to meet the needs of young people. Implementing technological advances into service delivery is a key way to adapt and innovate to meet the needs of young people in diverse communities.

MSAHC has learned the importance of integrating the latest technology into care delivery. The MSAHC aims to empower young people to take control and responsibility for their health. As they become more informed consumers of health care and more sophisticated with technology, the MSAHC has responded by creating mobile platforms and building online capability to support young people in making appointments, reviewing lab results, seeking health-related information, contacting a provider, and in adhering to treatments. Today, the MSAHC is able to offer several technology-based systems that promote successful continuity of care and is working to increase its Web presence and build new applications to increase its presence in the youth community.

Text in the City

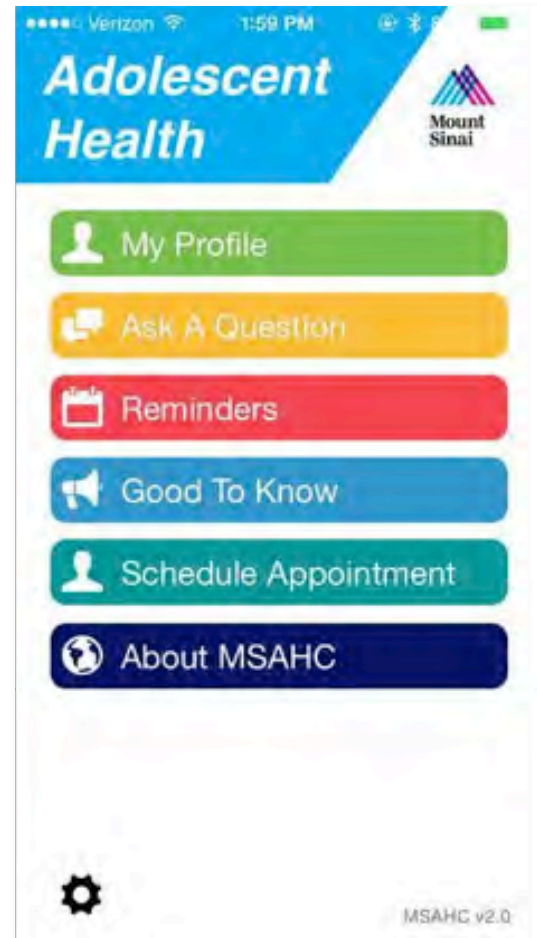
The MSAHC’s Text in the City initiative was a program that allowed young people to anonymously text questions using a short code to medical staff who then respond, to receive weekly health bytes/tips and to set up custom medication reminders. Young people could also opt in to receive text reminders one week and 24 hours prior to scheduled appointments. The initiative’s intent was to increase the frequency of communications with patients by offering personalized, confidential appointment and medication reminders. The platform allowed for four types of communication: (1) anonymous Q&A, (2) medication reminders, (3) appointment reminders, and (4) health education tips. Text in the City’s reach included social media platforms such as Facebook, Twitter, Google+, and Flickr. Text in the City evolved into Health Squad (described below) in 2013.

Health Squad

The MSAHC’s Health Squad is a free mobile health application available on iOS and Android platforms; it can be accessed from the Apple App Store. Health Squad is the second generation of health technology developed by MSAHC for young people. Health Squad is a secure mHealth solution developed with input from young people via focus groups and surveys on functionality, design and logo, and name. Health Squad is available to all young people, not just those served at the MSAHC. The Web site supports communicating with providers, seeking information, and adhering to treatment regimens and referrals.

Using Health Squad, young people can do the following:

- Send messages that qualified MSAHC medical staff respond to within 24 hours via the app. Text messages have SnapChat functionality, so questions and responses can be immediately deleted from the device.



- Schedule medical, dental, and other appointments at the MSAHC; receive automatic appointment notifications one week and 24 hours prior to scheduled appointments; and cancel scheduled appointments.
- Seek health information and adherence support by setting up a profile, custom reminders, and medication reminders. Young people can also opt in to receive weekly health bytes and messages; for example, young parents can receive weekly tips on parenting.
- Access the Health Squad Web site, including links for office hours, locations, and services offered.

My Chart Patient Portal and Mobile App

Currently, Health Squad is part of a pilot where it will appear as a recommended application to all young people age 12 and older with the My Chart Mobile App. Health Squad will appear as a recommended app within the My Chart app; patients can click on the app to open Health Squad if they've already downloaded it. If not, they can download it from the App Store/Google Play. To date, 30% to 35% of patients who received an activation letter from the MSAHC about My Chart activated their My Chart account.

The My Chart Patient Portal was created in 2013. My Chart is a mobile app that patients can download for free on either the iOS or Android platforms. The portal allows young people to send and receive secure, legal communications with their provider regarding

their health; allows the provider to release test results along with notes that young people can view; and allows young people to see upcoming appointments, receive communications such as a doctor's excuse from school, request refills on medications, or view their current list of problems/health concerns. Providers can make referrals that the young person can see, including referrals to health apps that they can click on within My Chart and download to facilitate healthy choices and behavior. In addition to providing easy access to health information, the portal is aligned with the MSAHC's principles. For example, providers can communicate with youths about lab test results that require follow-up, whereas previously a phone call or a postcard would have been necessary, which might have prompted inquiry from caregivers.



CHAPTER 6. STRENGTHENING ADOLESCENT AND YOUNG ADULT CARE WITH EVALUATION AND RESEARCH

Overview of Chapter 6

This chapter addresses how evaluation and research in adolescent and young adult health care (such as the MSAHC's work) can enhance the work of youth services. The MSAHC conducts ongoing evaluation of many different program areas and also seeks opportunities to involve staff and young people in contributing to growth in the field of adolescent health. There are many ways to do this, and suggestions for getting started are included.

Measuring Impact Through Evaluation

Understanding the impact of a program and what services are effective in improving health outcomes for young people is important—important for an individual program and to advance the field of adolescent and young adult health. Evaluation can be used to assess a variety of processes and outcomes, inform program development and improvement, and provide valuable information about program activities and lessons learned to local stakeholders, potential funders, and policy experts. Evaluation stages can include planning, data collection and analysis, dissemination, and improving your program.³⁹

Evaluation Planning. Some programs and staff have greater capacity and funding to implement evaluation activities than others. A comprehensive, large-scale evaluation of all clinic activities is not required to help learn more about the impact of a program or monitor services delivered to a patient population.

Evaluation Considerations

- Work with stakeholders to determine what type of evaluation is needed. What will you do with the data? What do you hope to learn or improve?
- Consider partnering with researchers and/or students from a local university to design evaluations, implement data collection activities, and analyze results.
- Share information learned with stakeholders, staff, and the community to help increase awareness about your program and gain buy-in and support for your program activities and services.
- Evaluation/continuous quality improvement (CQI) resources:
 - <http://www.cdc.gov/healthyyouth/evaluation/pdf/brief1.pdf>
 - https://www.healthit.gov/sites/default/files/nlc_continuousqualityimprovement_primer.pdf
 - <http://www.eval.org/p/cm/ld/fid=51>

Evaluating a small component of a program, such as investigating progress with serving transgender youth, can be meaningful and help to inform continued programmatic activities and practice.

Partnering with an individual evaluator or agency that has evaluation expertise is one way to brainstorm approaches and develop evaluation questions and an evaluation plan to understand the impact of a program. Local evaluation expertise can be found by reaching out to the social sciences or public health departments of a local college or university for expertise from professors or graduate students; via a social science–related professional organization, such as the American Evaluators Association; or by connecting with colleagues or a funding organization to see if they have evaluation contacts. Working with other program stakeholders to determine areas of focus for an evaluation should also be considered.

Data Collection and Analysis. Once a team has been assembled and an evaluation plan has been developed, data can be gathered. Evaluations may collect quantitative or qualitative data, and many use a mixed-method approach that uses both types of data. These approaches are influenced by the environment or community where data are being collected. For example, an exploratory study that aims to learn more about barriers to accessing services among young women may use focus groups or interviews to understand related themes. An evaluation that aims to learn about patients' satisfaction with services provided at a school-based health center can be administered via an online satisfaction survey to students following receipt of services. Analysis of qualitative data may review themes across interviews and focus groups; whereas quantitative data analysis will look at patterns, frequencies, and associations between data points.

Evaluation Approaches

- Assessment
- Process monitoring
- Process evaluation
- Outcome monitoring
- Outcome evaluation
- Impact evaluation
- Cost effectiveness and cost-benefit analysis
- Return on investment activities and practice

Dissemination and Program Improvement. After data have been analyzed and findings are interpreted, they can be shared with a variety of audiences:

- Some findings may be compelling to include in a grant application to garner additional funding for a program.
- Other qualitative findings or case studies can be used to share with stakeholders and prospective funders to educate them on a program's focus and success.
- Findings with statistical significance or broader application may be submitted to peer-reviewed academic journals focused on adolescent and young adult health or a policy brief for dissemination.
- Results from evaluation activities can also be shared as PowerPoint presentations with colleagues and peers during staff meetings or hospital grand rounds.
- Results can also be disseminated using a brief graphical representation (e.g., an infographic) in hard-copy marketing materials (e.g., brochures) or on a Web site promoting a program.

An Independent Outcome Evaluation of the MSAHC

The MSAHC has contracted with an independent consulting firm to conduct an evaluation to determine the effectiveness, appropriateness, and policy implications of the adolescent-centered, holistic, confidential health service delivery model provided by the MSAHC. The evaluation compares 700 young people enrolled in the MSAHC's clinic services with 700 similar young people drawn from the surrounding community who are not receiving the MSAHC's services, and follows both groups over three years. The evaluation includes the following components:

- The **Adolescent Health Survey** is a 20-minute survey that assesses adolescent and young adult health, beliefs about health care, and experiences with health care providers. The survey is administered via CATI every six months for three years.
- **Focus groups and patient interviews** are conducted with participants each year to gather more specific information about treatment-seeking; provide further comparative context for their experiences with health care; and seek input on retention strategies.
- **Provider interviews** with staff members are conducted at the MSAHC to understand the implementation of an adolescent and young adult-centered model and barriers and facilitators to providing care to young people.
- A **rapid assessment process (RAP)** was implemented with young people from the clinic as part of the evaluation. RAP uses intensive team interaction in both the collection and analysis of data to develop a preliminary understanding of a situation from the insider's perspective. A team of five youth advisors were recruited from the clinic and its surrounding community. The team participated in intensive trainings on research methods, protections of human subjects, observation, and data collection.

Data Collection Methods— Quantitative Data

Quantitative data collection gathers information that can be expressed as a number, or quantified. Data can be gathered via paper and pen, telephone, or online survey. Technology such as computer-assisted telephone interviewing (CATI), iPads and tablets, and online survey software (e.g., SurveyMonkey) can help to facilitate data collection.

Data Collection Methods— Qualitative Data

Qualitative data gathers information that can be captured that is not numerical in nature. Data can be gathered via direct observation, focus groups, key informant interviews on the phone, or in person. Videoconferencing and online software can also be used to conduct qualitative data collection.

Evaluation Versus CQI³⁸

Evaluation

- Conducted by evaluators and program managers, not entire staff
- Science-based study of the design, implementation, and impact of public health programs and interventions
- Aimed at justifying a program's merit or worth

Continuous Quality Improvement

- Ongoing data collection for quick feedback and quick cycle improvements
- Utilized for workflow design and process improvement
- Can yield incremental or big change (innovation)

RAP team members were able to serve as evaluation advisors on all aspects of the project, including survey design, design of confidentiality protections, and outreach methodologies, and provided review and input on analyses.

- A **policy analysis** component is also included. The Policy component is comprised of an annual assessment of the MSAHC service delivery and funding streams (health financing briefs) and an annual health policy update on a policy-related topic relevant to adolescent health and evaluation findings.

Continuous Quality Improvement (CQI)

is characterized by an “ongoing effort to achieve improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality services or processes that improve the health of the community or environment.” CQI data collection processes are ideally brief and well-integrated into existing work patterns so information can be gathered and reviewed routinely without disrupting the regular clinic

operations.⁴⁰ CQI can help address the questions “How are we doing?” and “How can we do it better?” Chapter 7 provides additional guidance on conducting CQI.⁴¹

The MSAHC is engaged in CQI of its program and services. It proactively reviews and uses patient data from Epic electronic medical records, and Cerner billing systems to inform clinic practices and programs, and provide information to its funders and stakeholders. A specialized team of researchers and providers at the MSAHC created a questionnaire-based evaluation for all young people who visit the clinic. The evaluation will assess more than 100 variables relevant to adolescent and young adult health, including demographics, living circumstances, scholastic performance, sexual activity, substance use, emotional well-being and resilience, dietary habits, and many others.

Stages or Types of Research Involvement

Collaborating with external entities to recruit research participants:

- At this first stage, a health center may be contacted to assist with recruiting participants for a particular research project. The “recruitment” may be passive in the form of providing information to the targeted population or active in the form of identifying or engaging specific individuals to consider participating in the proposed research project;

Establishing formal partnerships with other organizations and institutions to conduct research:

- At this first stage, a health center may be contacted to assist with recruiting participants for a particular research project. The “recruitment” may be passive in the form of providing information to the targeted population or active in the form of identifying or engaging specific individuals to consider participating in the proposed research project;

Creating a research department to generate own research proposals:

- Formalizing an organizational department with adequate resources to generate research proposals on its own is the third stage of research involvement. Research priorities are identified, proposals developed, and submitted by providers/staff of the health center.

Source: <http://waimanalohealth.org/media/W1siZiIsIjIwMTMvMTEvMTkxMTJfMzBfNTRfOTU2X1doeURvUmVzZWYyY2gucGRml1d/WhyDoResearch.pdf?sha=50f4e438>

Innovative Research

Participation in research can be beneficial to adolescent and young adult health services by advancing their missions; increasing capacity; serving as a recruitment and retention tool for staff; diversifying revenue streams; increasing recognition as an expert resource; encouraging and strengthening local, state, and national partnerships; strengthening proposals or other grant applications; and improving data collection and reporting.⁴¹ Youth directly involved in research activities may feel that they are helping their peers by sharing their opinions and perspectives, or they may find it cathartic to have an opportunity to share information about themselves.

Research activities begin with an idea about a topic of interest and relevant research questions. For example, as a research topic, nurse practitioners may want to explore their patients’ birth control decisions to inform their procedures and outreach. Depending on the

“Community-based participatory research (in health) is a collaborative approach to research that equitably involves all partners in the research process and recognizes the unique strengths that each brings. CBPR begins with a research topic of importance to the community with the aim of combining knowledge and action for social change to improve community (health).”

- W.K. Kellogg Foundation, Community Health Scholars Program⁴²

research capacity of an organization, it may be necessary to pursue partnerships with individual researchers and/or organizations that have experience implementing research studies and expertise in the topic of interest. Participating in the design of a study from the onset can help to ensure that the research is adolescent and young adult-centered and appropriate. For example, it can influence the data collection methods used, timing, and language of instruments. Identifying and securing funding for research activities is also critical to research studies; research partners may be able to help support the development of grant proposals. There are resources to support developing agency research capacity building and implementation available, including <http://www.aapcho.org/resources/db/cbpr-toolkit>.⁴⁴

Addressing Gaps in Young People's Health—MSAHC Research Initiatives

In addition to providing clinical health services to youths, MSAHC is committed to a broader goal of promoting and advocating for adolescent and young adult health care services. Researchers affiliated with the MSAHC are engaged in studies that are relevant to adolescent and young adult health outcomes and resilience. They actively disseminate what they have learned to inform and improve clinical practice and to

impact policymakers to address the needs of adolescent and young adult health. More specifically, MSAHC researchers are investigating critical research gaps in obesity prevention, trauma and resilience, and the impact of vaccines for human papillomavirus (HPV) on young people. Exhibit 16, on the next page, includes information about current research activities at the MSAHC.

Policy

In addition to contributing to research that advances the field of Adolescent Health, MSAHC is committed to impacting local, state, national, and global policies that improve the health of young people. Staff members at MSAHC are involved in a variety of working groups on adolescent and young adult health at the city, state, national, and international level. As part of its evaluation, MSAHC is conducting a **policy analysis** component to help explore policy implications related to adolescent and young adult health concerns, outcomes from the evaluation, and response to the ACA. These studies are being conducted in consultation with experts in adolescent medicine and health policy, including an assessment of MSAHC service delivery and funding streams and health policy updates on a policy-related topic associated with adolescent and young

MSAHC Health Policy Briefs

- <http://healthpolicy.ucsf.edu/Protecting-Adolescent-Confidentiality>
- http://healthpolicy.ucsf.edu/sites/healthpolicy.ucsf.edu/files/documents/MSAHC_HealthPolicyReport_Nov2011.pdf
- <http://healthpolicy.ucsf.edu/sites/healthpolicy.ucsf.edu/files/documents/639265-0-000-04-020%20Mt%20Sinai%20Health%20Brief.pdf>
- <http://healthpolicy.ucsf.edu/improving-health-care-access-and-utilization-under-aca>

adult health and evaluation findings. The most recent policy briefs have explored the impact of the ACA on adolescent and young adult care and patient confidentiality, and the perspectives of young people on the medical home approach for health care.

MSAHC supports its model of free care and implements its programs with funding from public and private grants, fundraising events, individual gifts and Medicaid. Sustaining current funding and identifying new sources of financial support is critical to the continued success of the MSAHC and has implications for other, perhaps less established, programs

offering similar services to young people. MSAHC has partnered with Grantmakers in Health, a nonprofit, educational organization that aims to support communication and collaboration among grantmakers to help strengthen the grantmaking community's knowledge, skills, and effectiveness; to explore the impact of current policies and develop recommendations for funding opportunities to sustain programs that support adolescent and young adult health in ***Policy Options to Facilitate Replication of the Mount Sinai Adolescent Health Center Model of Care***, a companion document to this Blueprint.



EXHIBIT 16. THE MSAHC'S CURRENT RESEARCH ACTIVITIES

Healthy Body. MSAHC researchers conducted a randomized controlled trial to test a behavioral intervention for obesity prevention in adolescents and young adults most at risk for developing obesity. Patients at high risk for obesity were randomly assigned to receive either an educational video control or the Healthy Body program. Participants in the Healthy Body program completed a six-week, group-based intervention designed to empower kids to gain control of their own diet and physical activity habits. From pre- to postintervention, the control group gained body fat and increased in BMI units, while the Healthy Body group lost a small amount of body fat and decreased in BMI units.

Obesity Diagnosis. Using BMI percentile, the currently accepted method of diagnosing obesity, approximately 19% of young people at the MSAHC were found to be obese. Using a brief and simple measure of body fat (bioelectrical impedance analyses), which is a more refined marker of obesity, approximately 25% of young people at the Center were found to be obese. Changes resulting from the ACA have brought about far greater reimbursement for obesity treatment; however, a diagnosis of obesity is necessary for insurance reimbursement. Findings suggest that traditional methods for diagnosing obesity significantly underestimate childhood obesity rates, and thus may also restrict access to treatment for a great number of individuals in need.

HPV. The primary aims of this ongoing study, currently in its eighth year, are to examine the effectiveness of the HPV vaccine in inner-city adolescent and young adult females, and factors related to the prevalence and persistence of cervical, anal, and oral HPV infections. The study focuses on multisite HPV infection in adolescent and young adult females who have received, or plan to receive, the HPV vaccine. Early analyses demonstrate that young people were simultaneously infected with one or more HPV types across a range of body sites: 59% cervical, 57% anal, and 12% oral. A second study is now recruiting young men, as there are very few studies in the literature that focus on HPV in males. For males, vaccination is relatively recent. There are no recommended tests to detect presence of HPV, and many males do not demonstrate or exhibit symptoms of infection.

CHAPTER 7. IMPLEMENTING THE ADOLESCENT AND YOUNG ADULT-CENTERED CARE MODEL: NEXT STEPS

Overview of Chapter 7

The MSAHC has been in operation for almost 50 years and is one of the oldest adolescent and young adult health centers in the country. Any clinic seeking to replicate the MSAHC's adolescent and young adult care model should know it is a steady and sometimes long marathon to build the kind of practice that the MSAHC strives to maintain. In this chapter, steps that both new and established clinics can take to get started in building, redesigning, or expanding their adolescent and young adult-centered care program are outlined and resources that may be helpful are included.

Milestones for Implementing Adolescent and Young Adult-Centered Health Care

The foundation for achieving an adolescent and young adult-centered health care program is a commitment to serving young people. Replicating the MSAHC's level of success in serving young people should start with a leadership decision supported by an organizational plan to foster the principles of providing accessible adolescent and young adult-centered care that involves all staff members and builds on the current service model.

Leadership decision to provide accessible adolescent and young adult-centered care: To adapt or replicate the MSAHC's level of success in serving young people, the first step is a clear, communicated decision to work with young people in a way that is developmentally appropriate. This can originate from clinic leadership or other decision makers who have the authority to consent to change and who can formally commit, on behalf of the organization, to implement changes so that the program will be aligned with the principles of quality adolescent and young adult health care described in Chapter 3.

Commitment to change practices and the clear communication of this intent is the necessary first step in transforming services for young people into adolescent and young adult-centered care.

Organizational commitment to implement the principles of adolescent and young adult–centered care: With the leadership decision to embrace quality adolescent and young adult health care and to implement principles of care, a plan can be developed that outlines the clinic elements that need to change in order to adopt an adolescent and young adult–centered care model. This plan should consider the existing strengths and weaknesses of the practice and seek to implement a model with the fewest barriers to quality care possible. Organizational commitment to the principles of adolescent and young adult–centered care requires a willingness to make changes in policies, procedures, staff training/hiring, and confidentiality practices with minors, as well as changes in types of services and the way staff interact with young people.

Steps to an Adolescent and Young Adult–Centered Health Care Program

Once the decision and organizational commitment to change has been made, the next steps involve moving to action. It is important to understand that there is not one right way to transform, and that the process takes time. With that in mind, some guidance is offered for those interested in replicating MSAHC’s success in reaching and caring for young people. While not every program may be able to implement all aspects of the MSAHC, every clinic serving young people can strive to provide a stronger care model for this important population. The following steps to start an adolescent and young adult–centered care model offer a jumping-off place. To identify which steps are needed and what they will look like for a particular clinic, it may be helpful to review and adapt the diagram of the MSAHC’s model. A template is provided (Appendix F) to help with this task.

Below are summaries of steps and keys for success that also may prove helpful.

Step 1: Communicate Service and Operational Principles of Adolescent and Young Adult–Centered Care to All Staff

A key step in moving toward offering adolescent and young adult–centered health care is to commit to embrace the principles of care described in Chapter 3. It is crucial to demonstrate and communicate this commitment throughout the clinic. A key way to formalize this commitment to the principles is through a structured plan to communicate with staff, provide training in key elements, and follow up with staff and supervisors to obtain feedback on an ongoing basis. Some practical steps for this include the following:

- Elicit feedback and buy-in in an all-staff meeting where the principles are discussed and staff can ask questions; identify how the principles can apply to their daily work; and, through working with leadership, develop a common vision and practical steps to work toward an adolescent and young adult–centered care model.

Sample activity:

Engage staff in articulating why each principle is specifically important to young people and why the principles are so important to optimal care for them.

- Supplement the meeting discussion with brief training sessions on how to bring the principles into action, reinforce learning, and refine skills to provide care focused on young people and their needs. For a small team, the 45-minute training could take place during a breakfast, lunch, or after-work meeting; for larger teams or for teams that are very new to serving young people, a small series of trainings that walk staff members through how to create a culture and service environment that is adolescent and young adult-centered may be most helpful.
- Hire staff members who are in tune with adolescent and young adult-centered care, including those who have past experience and skills in developing trusting and caring relationships with young people, or those who are excited and willing to learn new ways of engaging young people and offering them adolescent and young adult-centered care and services.

Sample activity:

Ask a potential hire to describe how he or she approaches working with young people and to give examples from their past employment. Ask the candidate to describe a time when they really connected with or helped an adolescent or young adult patient. Listen to their responses and gauge their understanding of and ability to embrace an adolescent-centered care approach and adhere to the MSAHC principles for adolescent and young adult-centered care.

Sample activity:

Engage a diverse group of staff to lead some of the discussions, share examples of their experiences of interactions with young people, or raise situations they perceive as challenging for group input and thinking—just be sure to stay focused on how the clinic team can increase the program’s focus on effectively engaging and serving young people.



Step 2: Conduct a Self-Assessment

To set a successful path to improve adolescent and young adult health care using the principles of care in Chapter 3, it is important to not only set the expectation for care through application of the care principles, but to understand where current strengths and weaknesses lie in terms of providing optimal health care to young people. A self-assessment can help clinics and programs critically and objectively look at strengths and gaps in the approach to adolescent and young adult care as it is currently delivered.

One simple step forward is to engage clinic leadership and staff as appropriate, and ask basic questions about the young people that the program serves (or seeks to serve).

It is also important to ask young people about their experiences in the program and their ideas about how to make it more adolescent and young adult-centered without staff members present, so that they can speak candidly. There is no substitute for hearing from the target population and really understanding their ideas and suggestions.

There are existing tools that can be used to conduct a comprehensive self-assessment of your program's current efforts to serve young people. *The Adolescent Friendly Quality Assessment Tools*⁴⁵ are recommended for a holistic assessment, both initially and then for continually monitoring progress toward creating an effective adolescent and young adult-centered health care model.

Self-Assessment Questions

Who are the young people in my service area? What is the sociodemographic profile of adolescents and young adults in my service area?

Are we serving a client base that reflects the community demographic or are we serving a distinct subset of these young people?

What are the presenting health issues or life issues of the young people we currently see in the clinic(s)?

What are the prevalent health disparities among young people in our service area?

Which set of core health and preventive care services do we currently have capacity to provide?

Do we offer the core services recommended in this blueprint? Do we offer these for free, at reduced cost, or at cost to the young person?

Which specialized services do we currently have capacity to provide?

Do we offer the specialized services recommended in this blueprint? Do we offer these for free, at reduced cost, or at cost to the young person?

What are barriers to care for young people in our community? In what ways will we help to remove those barriers for young people?

Consider your geographic location, clinic hours, policies related to confidentiality, costs of services, and scheduling of appointments/walk-in acceptability.

For core or specialized services where there is not capacity to offer the full spectrum of adolescent-centered services, are there partners proximal to our program who could be engaged to create access for the young people we serve?

If our clinic primarily serves children or adults right now, what kind of changes in service type, access, and delivery would be needed to provide comprehensive, adolescent and young adult-centered care?

Consider the changes needed to embody all of the principles of care more fully, to offer the spectrum of services, and to create an adolescent-centered culture in the clinic.

Step 3: Finding Resources for Cost-Effective Free Comprehensive Care

Financial resources have facilitated many improvements in adolescent and young adult health care at the MSAHC. While many of the principles of care for young people center on changing the way services are delivered and have no associated costs, access to flexible financial resources and creative funding sources is needed to move closer to the ideal of providing all services free of charge, adding specialized services, and removing barriers to patient access associated with little or no income and transportation.

Self-assessment results can be used to identify gaps that might be filled. Finding resources to fill them is an important step in setting priorities for fundraising or maximizing billable service revenue to offset nonbillable services. The following is a partial list of strategies for maximizing revenue and identifying additional funding and in-kind resources:

- Screen every patient for eligibility for public insurance, including Medicaid and other medical reimbursement programs (federal and state programs) to ensure revenue generation that may offset costs related to uninsured visits.
 - Provide onsite assistance for applications and support the patient in following through until he or she is approved.
 - Explore your program’s eligibility to become certified to bill public insurance programs that it is not currently certified to bill.
- Track the provision of reimbursable, routine care (e.g., annual physical exams) that benefits the patient and also provides a steady revenue stream.
- Determine the maximum level and amount of services that can be provided within a visit in order to provide as much care as possible to each patient.
- Develop mutual partnerships for referral of patients for services for which your clinic cannot be reimbursed.
 - Work with partner agencies to identify services for which they can bill and your agency cannot, and vice versa, and develop an agreement to mutually refer patients.
- Develop relationships with dental schools and private providers in the community who are willing to see a certain number of patients per month for dental and specialty care.
- Explore private foundation and pharmaceutical company funding for medical equipment, support groups, health education programs, and services for populations with unique needs, such as LGBT young people and adolescent and young adult parents.
 - Private insurance companies, city social services programs, and local businesses may also have funding opportunities that will sponsor a certain quantity of specialized services (e.g., a specific number of nutritional counseling sessions).
- Explore other funding options, including Title X Family Planning grants.
- Develop relationships with pharmaceutical representatives who may be able to provide medication samples and access to the numerous medication scholarship programs. Some clinics maintain a database of drug scholarships for low-income patients. Also, organizations such as Direct Relief (www.directrelief.org) have domestic donation programs for organizations serving the medically indigent that provide medical supplies and medications.

Step 4: Leverage Community Resources

Understanding the resources available in a community is an important step to establish key linkages to partner organizations and providers that also value and practice in a way that is supportive of an adolescent and young adult care model. These linkages may be critical to the success of efforts to work with young people, particularly for those organizations that cannot provide as much free, comprehensive, and integrated care as the MSAHC. Partners who value adolescent and young adult–centered care are crucial.

- Creating a referral network of community providers that are also youth-friendly can help to fill gaps in comprehensive care for young people. This could involve developing new partnerships. For example, if dental or optical services cannot be added to your program, new relationships could be sought with nearby providers.
- If your program cannot become a medical home for young people once they exceed the age limit, consider identifying adult care providers in the area so that warm connections can be made for the transition of young clients to an adult medical home when the time comes.
- Creating memoranda of understanding that are explicit about adolescent and young adult care principles, roles, and responsibilities is one way to transfer values and expectations in organizational and referral partnerships. Annual renewal of the agreement also provides a time to reflect on things that went well and areas of improvement in the referral and linkage partnership.

Use surprise visits or test calls to the desk staff of referral partners to see how they handle adolescent needs for confidentiality, walk-in appointments, and fees for service. The use of “secret shoppers” can give a good picture of what young clients might experience if they take a referral to a partner provider.

- Local professional organizations, businesses, and universities may be able to provide interns to staff legal clinics, dentists willing to volunteer their time, or optometrists willing to provide eye exams and glasses.

Step 5: Establish Key Core Services

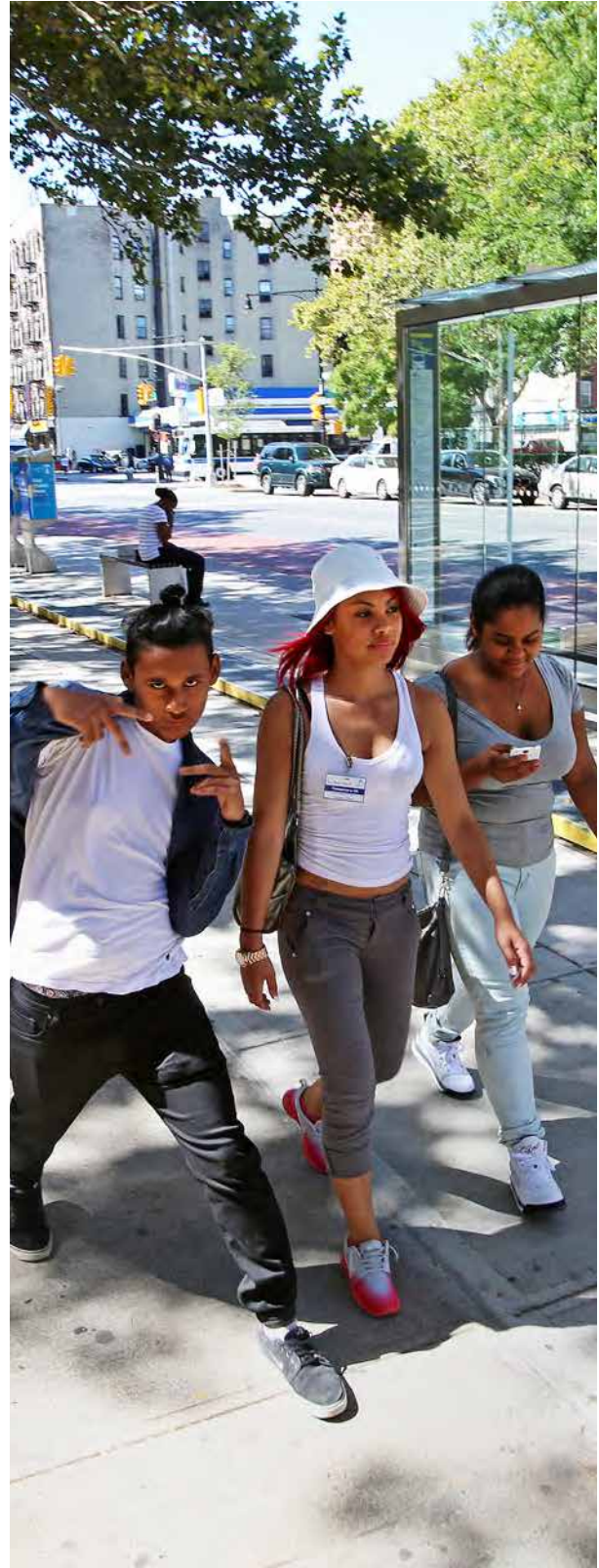
Steps 3 and 4 provide a good picture for maximizing internal program and external community resources to offer adolescent and young adult–centered care. These resources, including what is currently available and what could feasibly be obtained, should be considered when establishing or re-establishing a clinic’s core services.

Consistent with the MSAHC’s service principles, continuing to improve adolescent and young adult care may mean increasing the diversity of services that a clinic is able to offer, as well as those to which it can easily link. Clinics should seek to provide a core set of five services that most young people need at some time during their development: (1) primary care/preventive care, (2) sexual and reproductive health care, (3) behavioral/mental health care, (4) dental care, and (5) optical services. Offering these services onsite, delivered by adolescent and young adult–friendly health care staff and providers, is the fundamental stepping stone to holistic and effective adolescent and young adult care. While all the services described in Chapter 1 are desirable, starting with an initial core set may be the best first step in building a medical home for adolescents and young adults.

This step is inherently unique to each clinic in its journey to realize adolescent and young adult–centered health care. Being creative and using the resources identified in the community may enable clinics to offer these core services directly or in partnership with community providers. It is not necessary to begin providing all core services at once; implementation can be a series of incremental changes, adding a new service for a period of time before adding another.

Step 6: Make a Technology Plan or Road Map

Data systems can be expensive, and they take time to create and refine, but they can be powerful tools for managing the health of young people, as well as for reaching or staying connected to adolescent and young adult patients. Understanding where a clinic is in its technology journey is an important



step in visualizing goals for one year, three years, or five years in the future. This step is explicitly about making a strategic plan for how to use and build technology into adolescent and young adult-centered care; development of a vision for the future and the setting of relevant goals for completion are the primary tasks for this milestone. Below are some key considerations for technology priorities related to engaging young people:

- Invest in an electronic medical records (EMR)/electronic health records system. There are many systems to choose from; shifting to EMR is an investment in the future. Such systems can facilitate care and support team-based care management in powerful ways. These are critical value-added systems to facilitate adolescent and young adult-centered care.
- Patient portals where clients can make appointments, communicate with providers, and check test results are also wise investments for effectively caring for young

people. Patient portals reduce barriers and engage young people in technology with which they are familiar and comfortable. Such portals could also be used to ask satisfaction-related questions to better understand the experiences—both clinical and interpersonal—of young patients.

- Cellular text-based communications and smart phone applications for a clinic might be additional ways to facilitate communication and engage young people in their own health care. While these systems have associated expenses for their development and maintenance, they can be powerful tools for interaction between young people and their providers; they can be used as tools for intervention (such as weight management, physical activity, and smoking cessation), and they can be easily updated to stay current with trends and issues affecting young people.

Step 7: Ensuring Continued Buy-In From Staff and Providers

Once services and procedures are identified, it is time to move to action by beginning implementation and considering how to sustain the services over time. Energy and commitment are needed to maintain the culture and the practices required for adolescent and young adult-centered care to become a reality. A director or manager of clinical care or quality improvement, or even a seasoned office manager or head nurse, can appoint someone to ensure that the clinic can “walk the talk” and deliver on the principles of adolescent and young adult-centered care. This person—an adolescent and young adult-centered care manager—should use a basic list tailored to the clinic services and staff configuration to do regular spot checks; enforce values, practices, and service integration approaches; and make procedural or other enhancements along the journey.



Action Steps for the Adolescent-Centered Care Manager¹⁰

- Work with service providers and other staff members to ensure that all procedures are applied.
- Work with service providers and staff members to determine whether clinic hours can be adjusted (as a pilot or longer-term commitment) to meet the needs of young people.
- Take action to post visible notices about confidentiality for young people, and display lists with details of health services provided—when, for whom, and how much they cost (and if they are offered for free or at low cost, highlight this fact).
- Develop a small brochure or flyer with this information, including clinic hours and contact information, which can be distributed to schools, youth-serving organizations, and referral partners.
- Work with other staff to identify potential key partners proximal to the clinic, meet with these organizations to share how services for young people are being improved, and possibly make plans for involving partners in these efforts.
- Set aside time for youth-friendly staff to conduct outreach to engage young people where they are: schools, job training programs, youth programs, and events.
- Work with clinic staff and providers to ensure that they are aware of policies and recommended procedures specific to young people—especially around confidentiality, privacy, and explanations of benefits (if insurance is involved).
- Work with clinic staff and providers to determine what can be done to ensure both visual and auditory privacy for young people while they are at the clinic.
- Communicate with health care providers and support staff about the importance of being nonjudgmental, and how to relate to young people in a friendly manner—and be watchful for instances where they are not and take appropriate corrective action.
- Find ways to keep waiting times short, and to accommodate walk-in visits.
- Ensure that service providers and support staff work in a team-based care model to integrate services. If referrals are made, they should ensure that all staff use referral systems and follow-up to ensure young people are receiving the care that they need.
- Work with service providers and support staff to elicit feedback from young people served by the clinic, as well as other young people in the community to share ideas and suggestions in designing health services for young people.
- Ensure that staff and providers have tools they need, like comprehensive health and wellness assessment tools and referral partner lists. Also ensure that supervision assessments include adolescent and young adult-centered care principles and practices as part of routine staff performance evaluation.

Step 8: Quality Improvement Cycles

The last step—but a very important one—is to commit to ongoing assessment of the success of the adolescent and young adult–centered care approach. This means engaging the entire team in asking the questions: “Are we successfully ensuring the health and well-being of the adolescents and young adults in our care and in our community?”

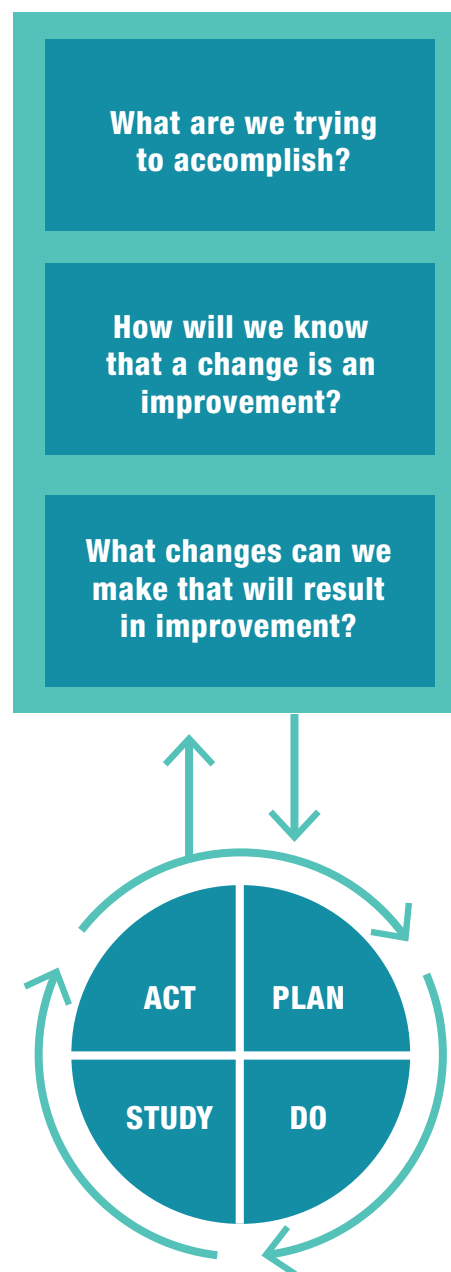
The Institute for Healthcare Improvement (IHI) offers a simple but well tested framework for answering this question (see Exhibit 17); the Plan-Do-Study-Act method of quality improvement is a simple and useful heuristic for how to answer the key questions in the exhibit. The four steps of the method follow:

- (1) Plan:** Focus on planning for implementation of the changes and services needed to embrace adolescent and young adult–centered care. Assess where you are and where you have gaps to fill; make strides to address the gaps; and prepare staff and providers for this shift in the way business is done.
- This process involves both commitment to and communication of your vision (Steps 3 and 4); establishing core services (Milestone Step 5); and planning for technology supports (Milestone Step 6).

(2) Do: Use the plan for making the clinic adolescent and young adult–centered and ensuring staff and providers are ready, willing, and able to follow-through on this care; this phase is about “doing” the work and implementing this approach to care. The adolescent and young adult–centered care manager is key to this process (see Milestone Step 6).



EXHIBIT 17. IHI MODEL



Source: <http://www.ihl.org/>

- There are many steps involved in actually doing the work in new ways; you should expect surprises, challenges, successes, and failures. Like any new approach, program, or service, everything will not always go smoothly. However, “the perfect should not be the enemy of the good,” and you can learn how to improve by examining what you are doing.

(3) Study: Once you have been implementing for a while, use data to examine how well you meet the needs of young people. Are you reaching them with services? Are they coming back for their appointments? Do they feel respected, safe, and heard by your staff? Are they adhering to treatment regimens or engaging in prevention and wellness activities? Some of these data must come from young people themselves, but other data should be part of your normal charting and system data.

- Examining these data regularly can help identify areas for improvement. Sharing the results with your entire clinic management and staff can help reinforce the investment you have made in quality adolescent and young adult care and help to create the next solutions for improving that care.

(4) Act: Make changes that you believe will improve adolescent and young adult-centered care based on the data and success (or failure) of incremental changes.

- Building your clinic to be a model of adolescent and young adult-centered care is likely to be an exercise of “building the plane while you fly it.” That’s OK! This step is all about acting on what you have learned and making real changes that you believe will improve the quality and the delivery of the services.



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TOOLS FOR GETTING STARTED

This appendix offers a variety of resources and tools that can be helpful when creating or modifying an adolescent health program.

- **Appendix A:** Chronology of the MSAHC's Development
- **Appendix B:** MSAHC's Operating Budget
- **Appendix C:** List of MSAHC's Sexual and Reproductive Health Services
- **Appendix D:** Detailed Descriptions of Therapeutic Approaches
- **Appendix E:** Links to Mental Health Intervention Descriptions
- **Appendix F:** Template of MSAHC's Model

APPENDIX A: CHRONOLOGY OF THE MOUNT SINAI ADOLESCENT HEALTH CENTER'S (MSAHC'S) DEVELOPMENT

The MSAHC was established in New York City (NYC) in 1968 by Dr. Joan Morgenthau, a Mount Sinai Hospital pediatrician and a maverick in the field of adolescent medicine. Dr. Morgenthau recognized that adolescents in the community had unique needs that were not adequately addressed by the traditional health care system. One of the most important needs identified was for an adolescent-specific health care facility that was private and comfortable, and outside the intimidating façade of a larger hospital setting. A modest program was initiated to serve young people in Harlem and the Upper East Side of Manhattan in NYC; the first services were offered by Dr. Morgenthau and a part-time nurse who worked a few hours a week out of an apartment complex basement. The result, a program devoted to the special health care needs of vulnerable and disadvantaged adolescents in New York, was one of the first in the United States. The program expanded gradually over the next four decades as grant funding was awarded to provide additional services (see exhibit).

EXHIBIT: THE GROWTH OF MSAHC: 1968–PRESENT

1960s–70s	1968. MSAHC established by Dr. Morgenthau—program focused on substance abuse in young people.
	1971. MSAHC offered extended hours and increased the adolescent specific services offered. Population served increased to 900 youths.
	1972. Adolescent medicine fellowship training program created.
	1976. MSAHC offers medical services, counseling services and family planning.
1980s	1982. Dr. Leslie Jaffe became the program’s second director. School-based health centers were created in two NYC public high schools.
	1984. Health education programs, an HIV/AIDS prevention program, and a STAR program were initiated.
	1989. Dr. Angela Diaz became the program’s third director. The American Medical Association (AMA) named the MSAHC as having the best HIV/AIDS program for adolescents in the country. Parenting program and additional family planning services were added to MSAHC.
1990s–Present	1990. Fee-based services ended; youths were able to access services for free.
	2010. Expansion of MSAHC facility increased space by 5,000 square feet. Dental services were initiated.
	2013. Optical services were established; online and mobile communications with youths were initiated.

In response to a major heroin epidemic in the 1960s and early 1970s, the program applied for and received a grant to prevent substance abuse in youths. This funding enabled Dr. Morgenthau to shift from providing services in a basement to two trailers in a Mount Sinai Hospital parking lot in East Harlem. It also allowed for the addition of new staff; first a social worker was added, followed by drug counselors (individuals in recovery). Although the program focused on preventing and treating substance abuse among youths, Dr. Morgenthau continued to add different components to the adolescent health program and to diversify the services and the staff to address the needs of young people in the community more holistically.

By 1971, the program had extended hours and increased the adolescent specific services offered. The program relocated to a larger facility on East 102nd Street to accommodate the increasing number of youths served as the program expanded to 900. In 1972, Dr. Morgenthau initiated an adolescent medicine fellowship training program for doctors who completed their pediatric training to gain expertise in adolescent medicine. By the late 1970s, the center had three main components: medical service; the counseling service; and family planning, which was largely run by Sinai midwives.

In 1982, Dr. Leslie Jaffe, who started his training in 1976 at MSAHC, and was an attending physician at the MSAHC, became the program's second director. Dr. Jaffe continued to expand the program's funding by pursuing additional grants. Under his leadership, the center hired its first health educator and developed a health education program. A family planning education program was developed soon after. The MSAHC's HIV/AIDS prevention and STAR program were both also initiated during this time, and a street outreach worker was added to the staff. A March of Dimes grant helped to establish a research program to evaluate the effectiveness of peer education to change behavior. In 1989, the AMA named the MSAHC as having the best HIV/AIDS program for adolescents in the country. MSAHC also expanded its reach of services to NYC public schools in the early 1980s. MSAHC created its first school-based health clinics in 1982, one at the Manhattan Center for Science and Math, and a second at Julia Richman High School. Grant awards also helped to establish a parenting program and additional family planning services.

In 1989, Dr. Angela Diaz assumed leadership of the program as its third director. Dr. Diaz has remained the director of the program for the last 26 years. As with her predecessors, Dr. Diaz continued to diversify the services offered by the program, increasing the number of patients served, expanding the grant portfolio, and initiating other philanthropic strategies and event-related fundraising efforts. As the program became more established, providers were able to identify and address barriers to youths seeking services. For example, in 1989, MSAHC charged youths on a sliding fee scale; most patients paid \$9 per visit. The fee was identified as a barrier to care for adolescents and it was discontinued. As the majority of the youths who seek services at MSAHC are underserved and uninsured, the program has made it a priority to maintain the ability to provide high-quality and wellness care to its patients free of charge.

APPENDIX B: MSAHC'S 2016 OPERATING BUDGET

Revenue

Clinic and School Based Health:

Medicaid	3,530,031
School Based Health Medicaid	322,504
Charity Pool	1,598,396
HCRA Allocation	203,950
Contract	54,300
	\$5,709,181

Grants:

Federal	1,003,052
State	1,543,418
City	193,033
	\$2,739,503

Other Revenue

Indirect Grants–Federal	258,933
Teaching Revenue	218,941
Foundations	1,018,337
Individual Giving	773,250
Corporate Giving	40,000
	\$2,309,461

Total Revenue

\$10,758,145

Direct Expenses:

Salary and Fringe	3,681,755
Other Than Personnel Services (OTPS)	790,990
Ancillary	835,792
Billing Costs	176,502

Grant Offset

Federal	1,003,052
State	1,543,418
City	193,033
Indirect Grants–Federal	258,933

Foundations	1,018,337
Other Administrative Expenses	326,472
Teaching	186,567

Total Direct Expenses:

\$10,014,851

Indirect Expense Allocation Charged to MSAHC by Mount Sinai	697,980
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Total Expense

\$10,712,831

Surplus/Deficit

\$45,314

APPENDIX C: LIST OF MSAHC'S SEXUAL AND REPRODUCTIVE HEALTH SERVICES

We feel strongly that any teenager or young adult who needs our services should get them.

Our multidisciplinary health team partners with young people, educates them, and provides comprehensive health services (including sexual and reproductive health services) to help them make responsible decisions and stay healthy.

A well-informed adolescent who has complete information and the right tools and services can make responsible decisions and be a powerful health care consumer with better lifelong health.

Comprehensive Reproductive Health Care Services:

- Gynecological and Complete Reproductive Health Examinations
- Comprehensive Sexuality Education
- Sexual Decision Making
- Family Communication
 - Abstinence Support
 - Family Planning
 - Partner Negotiation
- Sexually Transmitted Infection:
 - Prevention
 - Risk reduction
 - Screening
 - Diagnosis
 - Treatment
 - Talking With Your Family
 - How to Talk With Your Kids
 - Treatment of Partners Regardless of Age
 - HPV Vaccination
- HIV/AIDS

- Prevention
- Risk reduction
- Screening
- Diagnosis
- Treatment
- Talking With Your Family
- How to Talk With Your Kids
- Pregnancy Testing
- Pregnancy Options Counseling
 - Referrals for prenatal
 - Referrals for termination
 - Birth Control services, including contraceptive advice and information
 - Provision of all medically accepted birth control methods, including the following:
 - » IUD
 - » Subdermal
 - » Pills
 - » Patch
 - » Depro Provera
 - » Ring
- Emergency Contraception
- Condom Distribution
- Colposcopy Services
- Breast Examinations

APPENDIX D: DETAILED DESCRIPTIONS OF THERAPEUTIC APPROACHES

Trauma-focused cognitive behavioral therapy (TFCBT). TF-CBT was developed by Drs. Anthony Mannarino, Judith Cohen, and Esther Deblinger. TF-CBT is an evidence-based treatment that has been evaluated and refined during the past 25 years to help children and adolescents recover after trauma. Currently, 14 randomized controlled trials have been conducted in the United States, Europe, and Africa comparing TF-CBT to other active treatment conditions. All of these studies have documented that TF-CBT was superior for improving children’s trauma symptoms and responses. TF-CBT is a structured, short-term treatment model that effectively improves a range of trauma-related outcomes in eight to 25 sessions with the child/adolescent and caregiver. Although TF-CBT is highly effective at improving youth posttraumatic stress disorder (PTSD) symptoms and diagnosis, a PTSD diagnosis is not required in order to receive this treatment. TF-CBT also effectively addresses many other trauma impacts, including affective (e.g., depressive, anxiety); cognitive and behavioral problems, as well as improving the participating parent’s or caregiver’s personal distress about the child’s traumatic experience; effective parenting skills; and supportive interactions with the child. See <https://tfcbt.org/about-tfcbt/>

Dialectical behavior therapy (DBT). DBT is a cognitive-behavioral treatment approach with two key characteristics: a behavioral, problem-solving focus blended with acceptance-based strategies, and an emphasis on dialectical processes. “Dialectical” refers to the issues involved in treating patients with multiple disorders and to the type of thought processes and behavioral styles used in the treatment strategies. DBT has five components: (1) capability enhancement (skills training); (2) motivational enhancement (individual behavioral treatment plans); (3) generalization (access to therapist outside clinical setting, homework, and inclusion of family in treatment); (4) structuring of the environment (programmatic emphasis on reinforcement of adaptive behaviors); and (5) capability and motivational enhancement of therapists (therapist team consultation group). DBT emphasizes balancing behavioral change, problem-solving, and emotional regulation with validation, mindfulness, and acceptance of patients. Therapists follow a detailed procedural manual. See <http://legacy.nreppadmin.net/ViewIntervention.aspx?id=36>

University of California, Los Angeles (UCLA) PTSD Reaction Index. The UCLA PTSD Reaction Index for Diagnostic and Statistical Manual of Mental Disorders (4th ed.) (DSM-IV) is a self-report questionnaire to screen for exposure to traumatic events and assess PTSD symptoms in school-age children and adolescents. The scale assesses the frequency of occurrence of PTSD symptoms during the past month (rated from 0 = none of the time to 4 = most of the time). The items map directly onto DSM-IV intrusion, avoidance, and arousal criteria, while two additional items assess associated features (fear of recurrence and trauma-related guilt). Scoring algorithms permit tabulation of UCLA PTSD-RI total score, and B, C, and D subscale scores. See <http://www.nctsn.org/content/ucla-posttraumatic-stress-disorder-reaction-index-dsm-iv>

Beck Depression and Anxiety Inventories. The **Beck Depression Inventory®—II (BDI-II)** is a widely used 21-item self-report inventory measuring the severity of depression in adolescents and adults. The BDI-II was revised in 1996 to be more consistent with DSM-IV criteria for depression. For example, individuals are asked to respond to each question based on a two-week time period rather than the one-week timeframe on the BDI. The BDI-II is widely used as an indicator of the severity of depression, but not as a diagnostic tool, and numerous studies provide evidence for its reliability and validity across different populations and cultural groups. It has also been used in numerous treatment outcome studies and in numerous studies with trauma-exposed individuals. See <http://www.nctsn.org/content/beck-depression-inventory-second-edition-bdi-ii>

The Beck Anxiety Inventory® (BAI). **The Beck Anxiety Inventory (BAI)** is a widely used 21-item self-report inventory used to assess anxiety levels in adults and adolescents. It has been used in multiple studies, including in treatment-outcome studies, for individuals who have experienced traumas. Although the age range for the measure is from 17 to 80, the measure has been used in peer-reviewed studies with younger adolescents aged 12 and older. See <http://www.nctsn.org/content/beck-anxiety-inventory-bai>

CRAFFT Screening Tool. The CRAFFT is a behavioral health screening tool for use with children under the age of 21 and is recommended by the American Academy of Pediatrics' Committee on Substance Abuse for use with adolescents. It consists of a series of six questions developed to screen adolescents for high-risk alcohol and other drug use disorders simultaneously. It is a short, effective screening tool meant to assess whether a longer conversation about the context of use, frequency, and other risks and consequences of alcohol and other drug use is warranted. See <http://www.ceasar-boston.org/CRAFFT/index.php>

Conners Comprehensive Behavior Rating Scales (Conners CBRS). Conners CBRS is designed to provide a complete overview of child and adolescent concerns and disorders. Those working in the field of child and youth psychology can use the Conners CBRS to assess a wide spectrum of behaviors, emotions, academic, and social problems in today's youths. The Conners CBRS includes the Diagnostic and Statistical Manual of Mental Disorders (5th ed.) (DSM-V), symptom scales, content scales, other clinical indicators, critical items, and impairment items. The age range for this assessment is six to 18 for the parent and teacher forms, and eight to 18 for the self-report forms. See <http://www.mhs.com/product.aspx?gr=edu&prod=cbrs&id=overview>

APPENDIX E: LINKS TO MENTAL HEALTH INTERVENTION DESCRIPTIONS

Seven Challenges. The Seven Challenges is designed to treat adolescents with drug and other behavioral problems. Rather than using prestructured sessions, counselors and clients identify the most important issues at the moment and discuss these issues while the counselor seamlessly integrates a set of concepts called the Seven Challenges into the conversation. The challenges include (1) talking honestly about themselves and about alcohol and other drugs; (2) looking at what they like about alcohol and other drugs and why they are using them; (3) looking at the impact of drugs and alcohol on their lives; (4) looking at their responsibility and the responsibility of others for their problems; (5) thinking about where they are headed, where they want to go, and what they want to accomplish; (6) making thoughtful decisions about their lives and their use of alcohol and other drugs; and (7) following through on those decisions. These concepts are woven into counseling to help youths make decisions and follow through on them. Skills training, problem solving, and sometimes family participation are integrated into sessions that address drug problems, co-occurring problems, and life skills deficits. The Seven Challenges reader, a book of experiences told from the perspective of adolescents who have been successful in overcoming problems, is used by clients to generate ideas and inspiration related to their own lives. In addition to participating in counseling sessions, youth write in a set of nine Seven Challenges Journals, and counselors and youth engage in a written process called cooperative journaling. The program is flexible and can be implemented in an array of settings, including inpatient, outpatient, home-based, juvenile justice, day treatment, and school. The number, length, and frequency of sessions depend on the setting. Counselors with various levels of experience in working with mental health and substance abuse problems are trained in program implementation. See <http://legacy.nreppadmin.net/ViewIntervention.aspx?id=159>

Students Managing Anger and Resolution Together (SMARTteam). SMARTteam is a multimedia, computer-based violence prevention intervention designed for middle school students in grades six through nine (11–15 years of age). SMARTteam is designed to increase students' repertoire of nonviolent, conflict-resolution strategies; their knowledge about what triggers their anger; and their confidence in their ability and intentions to use nonviolent strategies. The program is based on social learning theory as well as a skill-acquisition model that approaches learning as a five-stage process ranging from novice to expert, with learners at each stage having different needs. See <http://nrepp.samhsa.gov/ProgramProfile.aspx?id=89>

Strengthening Families Program (SFP). SFP is a family skills training program designed to increase resilience and reduce risk factors for behavioral, emotional, academic, and social problems in children aged three to 16 years. SFP comprises three life-skills courses delivered in 14 weekly, 2-hour sessions. The Parenting Skills sessions are designed to help parents learn to increase desired behaviors in children by using attention and rewards, clear communication, effective discipline, substance use education, problem solving, and limit setting. The Children's Life Skills sessions are designed to help children learn effective communication, understand

their feelings, improve social and problem-solving skills, resist peer pressure, understand the consequences of substance use, and comply with parental rules. In the Family Life Skills sessions, families engage in structured family activities, practice therapeutic child play, conduct family meetings, learn communication skills, practice effective discipline, reinforce positive behaviors in each other, and plan family activities together. Participation in ongoing family support groups and booster sessions is encouraged to increase generalization and the use of skills learned. See <http://legacy.nreppadmin.net/ViewIntervention.aspx?id=44>

Teen Intervene. Teen Intervene is a brief, early intervention program for 12- to 19-year-olds who display the early stages of alcohol or drug involvement. Integrating stages of change theory, motivational enhancement, and cognitive-behavioral therapy, the intervention aims to help teens reduce and ultimately eliminate their substance use. The program is typically administered in an outpatient, school, or juvenile detention setting by a trained professional in three one-hour sessions conducted 10 days apart. During session 1, an individual session with the adolescent, the therapist elicits information about the adolescent's substance use and related consequences, examines the costs and benefits of the substance use, and helps the adolescent set goals of behavior change, including goals to reduce or eliminate substance use. In session 2, the therapist assesses the adolescent's progress, discusses strategies for overcoming barriers, and negotiates the adolescent's continued work toward meeting goals. Session 3 is an individual counseling session with the teenager's parent (or guardian); this session addresses parent-child communication and discipline practices, and specific ways for the parent to support the child's goals. The third session also includes a brief wrap-up conversation with the parent and adolescent. See <http://legacy.nreppadmin.net/ViewIntervention.aspx?id=287>

Life Skills Training (LST). LST is a school-based program that aims to prevent alcohol, tobacco, and marijuana use and violence by targeting the major social and psychological factors that promote the initiation of substance use and other risky behaviors. LST is based on both the social influence and competence enhancement models of prevention. Consistent with this theoretical framework, LST addresses multiple risk and protective factors and teaches personal and social skills that build resilience and help youth navigate developmental tasks, including the skills necessary to understand and resist prodrug influences. LST is designed to provide information relevant to the important life transitions that adolescents and young teens face, using culturally sensitive and developmentally and age-appropriate language and content. Facilitated discussion, structured small group activities, and role-playing scenarios are used to stimulate participation and promote the acquisition of skills. Separate LST programs are offered for elementary school (grades three through six), middle school (grades six through nine), and high school (grades nine through 12); the research studies and outcomes reviewed for this summary involved middle school students. See <http://legacy.nreppadmin.net/ViewIntervention.aspx?id=109>

APPENDIX F: TEMPLATE OF MSAHC'S MODEL

The following template (based on the MSAHC model) is intended to help agencies as they begin to develop and implement an adolescent and young adult–centered care model.

CORE SERVICES

What services are provided to adolescents and young adults at your agency? Which of these services are considered core services?

Consider the following:

Example Core Services - MSAHC Model	Is this service provided at the agency?	Is this a core service for the agency?	Is this a service the agency wants to provide?
Sexual and reproductive health services			
Primary medical care			
Behavioral and mental health care			
Health education			
Optical care			
Dental care			
Other service:			
Other service:			
Other service:			

CULTURE AND VALUES

What culture and values guide the approach to caring for adolescents and young adults?

Consider the following:

Example Culture and Values - MSAHC Model	Is this service a core value at the agency?	How is this core value reflected in the agency's work?
Clinical service provision		
Impacting policy		
Innovative research/evaluation		
Advocacy		
Community outreach		
Specialized training		
Other culture and values:		
Other culture and values:		
Other culture and values:		

SPECIALIZED SERVICES

Are specialized services offered to adolescents and young adults?

Are specific populations of adolescents and young adults served by the agency? Are services tailored for these populations of adolescents and young adults?

Consider the following:

Example Specialized Services - MSAHC Model	Is this specialized service provided at the agency?	Is this a specialized service the agency wants to provide?
Legal		
Wellness		
Population-specific service (specify):		
Other specialized service:		
Other specialized service:		
Other specialized service:		
Other specialized service:		
Other specialized service:		
Other specialized service:		

PRINCIPLES OF ADOLESCENT CARE

Which principles of adolescent care are important to the agency? Which principles guide service provision? Which principles have not yet been adopted by the agency? Which principles would the agency like to adopt?

Consider the following:

Example Principles of Adolescent Care - MSAHC Model	Is this a core principle to the agency?	How is this principle reflected in the agency's work?
Safe Space		
Accessible		
Confidential		
Comprehensive		
Integrated		
Easily navigated		
Supports transition services		
Adolescent-driven		
Engaging to adolescents		
Developmentally tailored and appropriate		
Relationship based		
One-on-one adolescent provider interaction		
Trauma informed		
Other principle:		
Other principle:		
Other principle:		
Other principle:		
Other principle:		



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