



ADOLESCENT HEALTH TASK FORCE MINUTES
Cross-Cutting Issues
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Task Force Members: Barb Bowsher, Donna Breitenstein, Steve Cline, Tamera Coyne-Beasley, Carol Ford, Patti Forest, Michelle Hughes, Sharon Mangun, Steve North, Connie Parker, Kay Phillips, Kristin Rager, Joel Rosch, Tom Vitaglione

Interested Persons and Staff: Heidi Carter, Paula Collins, Dave Gardner, Jennifer Hastings, Mark Holmes, Sarah Langer, Jim Martin, Christine Nielson, Ruth Petersen, Rebecca Reeve, Michael Sanderson, Pam Silberman, Alexandra Sirota, Ilene Speizer, Tara Strigo, Carol Tyson, Yvonne Wasilewski, Berkeley Yorkery

DISPARITIES

*Mark Holmes, PhD, Vice President
North Carolina Institute of Medicine*

The term “disparity” typically applies to racial and/or ethnic gaps in access, outcomes, quality, etc., but may also be used to describe other gaps or inequalities. Healthy People 2010 has a goal to “eliminate health disparities that occur by race and ethnicity, gender, education, income, geographic location, disability status, or sexual orientation.” In addition to these types of disparities, the Adolescent Health Task Force has discussed youth with special health care needs and language disparities. However, for the most part the Task Force has looked at racial and/or ethnic disparities.

A look back at data presented to the Task Force shows that there are disparities by race and/or ethnicity for many of the health topics the Task Force has covered, including injuries; chronic illness, tobacco, and nutrition; substance use; sexual health; mental health; and violence. Which racial and/or ethnic group has poorer outcomes varies by topic.

Disparities are driven by a number of factors including biological, cultural, and confounding factors. Biological factors that influence disparities are relatively limited (e.g. Sickle cell anemia). Cultural differences, such as the types of food eaten and gender norms, also play a role in cultivating and driving disparities. Other factors, such as income and education, are confounding factors.

Confounding factors are those that have a strong relationship with both the independent variable (i.e. the probable effector) and the outcome variable (i.e. the outcome) and thus distort the relationship between the two. For example, when looking at the odds ratios of African-American, Latino, and Asian/Pacific Islanders to whites for likelihood of 11-17 year-olds being overweight, taking into account confounding variables changes the odds ratios. Taking into account both predisposing individual elements (e.g. income, parental education) as well as enabling elements (e.g. transportation, health insurance status, clinic availability), reduces the African-American/white odds ratio by 35%. At the same time, accounting for the same

confounding factors increases the Asian/Pacific Islander/white odds ratio. So while measuring confounding factors is important (so as to understand true levels of disparities), in most cases, confounding factors do not explain away disparities. Disparities usually exist, even when confounding factors are accounted for.

There are several ways the Task Force could address disparities in the report and recommendations:

- Standardized racial/ethnic groups across state agencies dealing with youth and young adults would allow for better data comparisons. Unfortunately, many state agencies are told what categories to report by their federal agency, so changing the categories they use at the state level may not be possible.
- Programs for youth should be available and appropriate for all adolescents, regardless of their race, ethnicity, culture, income, geographic location, etc.
- Guidance should be provided to communities to help them identify evidence-based programs that fit their target audience.

Discussion: There was discussion concerning research showing that even when access and other factors are controlled for, care received may not be the same for all people. Racial, ethnic, and cultural factors influence not only outcomes, but how people are treated when they go to a health care professional for care. Discussion then focused in on other possible drivers of disparities that had not been discussed, including statistical discrimination and early onset of puberty. Finally, the Task Force discussed the structure of the report and how disparities would be included.

SCHOOL-BASED HEALTH CLINICS

*Steve North, MD, Family and Adolescent Medicine
Bakersville Community Medical Clinic*

North Carolina has 55 school-linked and school-based health centers (SLBHC). School-based health centers are located on a school's campus and provide services to students at that school; school-linked health centers are not on a school's campus, but are affiliated with schools in the community and provide adolescent health services and sometimes school-based services. One of the program goals for SLBHC is to improve access to health care for school age adolescents. As such, most of the SLBHC are in middle and high schools.

SLBHCs are sponsored by one of the following: a health department, university, hospital, community health care provider, or other non-profit health care provider in the community. Parents must register their child before he/she can receive care at the SLBHC. In 2007-2008, 24,000 students were registered with the 55 SLBHCs. SLBHCs are overseen by community boards. Most SLBHCs operate as comprehensive care centers, providing preventive care, medical care, nutrition, mental/behavioral health, and health education, although a few provide more limited care. Some SLBHCs are state sponsored while others are independent.

Data from the state-sponsored SLBHCs show that students utilize the SLBHCs for various reasons including: 16% behavioral/mental health visits, 20% preventive visits, 25% medical visits; 36% nursing visits, and 5% for nutritional visits. Of preventive visits, 45% were for risk

assessments, 28% for immunizations, and 27% for well child visits. The top four diagnoses codes for students receiving care in SLBHCs during the 2006-2007 school year were v-codes (which include broad behavioral health issues such as school avoidance, physicals, and contraceptive counseling); symptoms, signs and ill-defined conditions; mental disorders; and diseases of the respiratory system. Services are most likely to be provided by a registered nurse or nurse practitioner.

North Carolina's state-funded centers receive, on average, 30% of their funding from the state. The other 70% comes from a mix of federal and county funds as well as support from community organizations. Some funding comes from billing, but not enough to sustain the centers. In North Carolina, funding for SLBHCs has declined by 10.2% since 2000.

The North Carolina School Health Center Initiative could be strengthened by

- Expanding the scope of the North Carolina School Health Center Initiative to include all schools and students (currently elementary schools are not included).
- Mandating reimbursement for services at state credentialed SLBHCs by all insurers.
- Expanding services to include dental care to students by allowing dental hygienists to perform cleanings and screenings without a supervising dentist on site.

Discussion: The discussion focused on the potential role of tele-medicine in SLBHCs and the need to be able to quantify the impact of SLBHCs on student performance.

Review of Cross-Cutting Recommendations for Schools and Health

The Task Force reviewed draft cross-cutting recommendations for schools and health. Comments and edits were incorporated.