

# Creating Healthy Opportunities: Conversations with Adolescent Health Experts



An Interview with Angela Diaz, MD, MPH, Conducted by Karen Brown  
A PROJECT OF THE PARTNERS IN PROGRAM PLANNING FOR ADOLESCENT HEALTH (PIPPAH) INITIATIVE

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# Author and Interviewee Biographies

### KAREN BROWN

Karen Brown is a public radio reporter and freelance writer who specializes in health care. Her work frequently appears on NPR and in national magazines and newspapers. She has also produced several radio documentaries on mental health topics, including childhood bipolar disorder, siblings of the mentally ill, and post-traumatic stress disorder. She has won numerous national awards, including the Edward R. Murrow Award and Daniel Schorr Journalism Prize, as well as journalism fellowships, most recently the 2008-09 Kaiser Media Fellowship in Health. Her work is featured online at [www.karenbrownreports.org](http://www.karenbrownreports.org).

### ANGELA DIAZ, MD, MPH

Angela Diaz, is the Jean C. and James W. Crystal Professor of Pediatrics and Community Medicine at Mount Sinai School of Medicine and Director of the Mount Sinai Adolescent Health Center in New York, NY and Director of the Mount Sinai Adolescent Health Center, a unique program of free, integrated, interdisciplinary primary care, reproductive health, mental health, and health education for teens. She is President of the Children's Aid Society. Dr. Diaz has been a White House Fellow, a member of the FDA, and a member of the Board of the New York City Department of Health and Mental Hygiene. She reviews grants and serves on advisory panels

for the NIH and the CDC and has received several NIH grants. In 2003, she chaired the National Advisory Committee on Children and Terrorism. In 2008, she was elected to the Institute of Medicine. Dr. Diaz is active in public policy and advocacy and has conducted many international health projects in Asia, Central and South America, Europe and Africa.

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### PROFILE:

# Angela Diaz

PROFESSOR AND VICE CHAIR, DEPARTMENT OF PEDIATRICS  
AT MOUNT SINAI SCHOOL OF MEDICINE



*"I think the health care system in the US was created for adults, by adults. And then we try to fit teenagers into that system, and it really doesn't work for them. And then we call them non-compliant and hard to reach."*

Dr. Angela Diaz believes the first step to keeping teenagers healthy is understanding their culture, but not necessarily 'culture' as we usually think about the word.

"There is a culture of adolescence that in my opinion is stronger for adolescents than the race and ethnicity culture," Diaz says. "And if you understand adolescents and how to work with them, it almost doesn't matter, the color of the kid, or the class of the kid."

Diaz runs the Mount Sinai Adolescent Health Center in Lower East Harlem, New York City. Ninety-one percent of her clinic's patients are teenagers of color, most of them Latino or African-American. Diaz says practitioners and policy makers who want to help these kids should start with their developmental stage, not their sociological or racial background.

"I think the health care system in the U.S. was created for adults, by adults. And then we try to fit teenagers into that system, and it really doesn't work for them. And then we call them non-compliant and hard to reach," says Diaz, who is also President of the Board of the Children's Aid Society of New York, as well as a member of the Institute of Medicine. "If you understand the culture of adolescence and the developmental journey, and you work with them on that basis, I think they are the greatest health care consumers."

That said, Diaz fully acknowledges the uphill health battle facing her mostly low-income clientele when compared with middle class teenagers in other parts of the city and country – a problem she blames mostly on lack of access to health care and health insurance.

Mount Sinai caters to teenagers living in poverty, because that is the population

that most needs help, Diaz says, and in New York City, poverty is closely correlated with minority status. These factors can often predict whether an adolescent is getting the health care she needs. Diaz says African American teenagers are 40 percent more likely to be uninsured than their white counterparts, and Latinos are 300 percent less likely to have health insurance than white teenagers. That's where the disparity starts, with alarming consequences for the health and welfare of those populations.

"People who do not have insurance, or money to pay, have to prioritize food and shelter over health. They don't get any kind of prevention. They don't get any kind of real health education, such as teaching them how to take care of themselves. And they don't go to the doctor early, before something happens. When they are very sick, they will go to an ER, where the care by design is to take care of the immediate problem, not necessarily the whole person."

Not surprisingly, minority teens have higher rates of diabetes, obesity, and heart disease than whites, and these conditions then continue into adulthood. Teen birth rates among Latino and African American youth ages 15 to 17 are 83 and 64 per 1000, respectively – more than two times those of their Caucasian counterparts, according to the Federal Interagency Forum on Child and Family Statistics. "When you look at the charts of the rates of teen pregnancy, African American and Latino teens are way up there in terms of teen pregnancy compared to whites," Diaz says. "But this difference can be reduced by providing access to good care." Good care, she says, involves strong relationships with

providers, easy access to a doctor's office, reproductive information on demand, and basic primary care.

That's what her program aims to provide. The most basic way is both simple and obvious: offer health care for free. Even though a quarter of her patients do have Medicaid, and a smaller percentage have private health insurance, the majority are uninsured, and that means the Center privately raises 10 million dollars a year to make sure that no teenager is turned away for lack of money. "We will not charge them a penny," Diaz says. "And if they need to come a hundred times per year, they will come a hundred times per year. It does not matter. If they need to get whatever work up, the top of the line quality medicine, they will get that."

Once a teenager arrives at the Center, mostly due to word of mouth among peers,

of these issues, but in many cases, Diaz will bring in professionals from the outside to consult.

Diaz is quick to point out that her center goes beyond what people consider traditional health care – to create partnerships with other disciplines. One of the key partnerships is with the legal profession. Because so many of the Center's patients live in poverty, they often find themselves in need of a legal advocate, but unable to navigate the law on their own. So when a social worker from Diaz's clinic (there are 25 social workers on staff) stumbles upon a problem she can't solve on her own, the legal partners are brought in.

"For example, if a kid has asthma, the doctor or social worker may be writing to the landlord that there's a trigger in the apartment," Diaz says. "But the landlord often won't respond, so the kid

doing their part, the health practitioners are helping their teen patients with the social or emotional implications of living in an immigrant community. This is one aspect of 'cultural competency' that Diaz considers key to promoting health for teenagers.

"I think immigration is traumatic," Diaz says. "Even though you are coming to this country for a better life, and for economic or for religious freedom or whatever, it's really traumatic. You are leaving what you are familiar with, your friends, your family, your school, your community, and then placed in a completely different environment."

Diaz is herself an immigrant from the Dominican Republic; she arrived in New York City as a teenager, lived in poverty with a single mother, dropped out of high school at one point, and relied on the Mount Sinai Adolescent Health Center to

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or referrals from schools and community programs, he will find himself the center of attention, Diaz says. She only hires staff who honestly like teenagers, and who understand the developmental urge to experiment, take risks, and connect with peers. Although the Center encourages parental involvement, its staff is always willing to see a teenager alone, confidentially if necessary (as permitted under New York law). Diaz considers the promise of confidentiality one of the reasons that teenagers trust the Center and keep coming back.

Another reason, Diaz says, is the Center's integrated approach, which she calls the "under one roof" model. That means teenagers may arrive at the Center with one simple health issue, but they will stay there for a comprehensive health evaluation that includes everything from mental health and reproductive health, sex education and nutrition, HIV prevention, or drug treatment, to counseling for victims of rape, incest, domestic abuse, or sexual exploitation. The Center does have full-time staff that can handle many

keeps getting triggered with asthma. But if a lawyer gets involved, the landlord is much more likely to respond."

On the flipside, some of her patients find themselves in trouble with the law and in need of legal defense. Diaz considers this an extension of her patients' health care, especially when a young person is arrested for a minor infraction, such as drug possession or school truancy, but faces life-long consequences. "If you can help a kid not end up with a criminal record," she says, "you are helping them stay whole."

Diaz says the legal partners will also take on cases to help teenagers stay in high school (she notes that youth of color have much higher drop-out rates than whites), or help them get financial aid for college. Dropping out of school is a predictor of poor long term health, Diaz points out.

Lawyers may also help with immigration or refugee status, securing the rights of a family to stay in America and obtain social services. And while the lawyers are

help get her life back on track. So it's not much of a stretch for Diaz to understand the challenges of many of her patients. However, she says most staff members are not immigrants, nor people of color. While she would like to have more practitioners of color – as role models for minority teens – she considers it much more important to have staff who are culturally competent, who respect and understand the teenagers they treat. And in the case of immigrant families, much of this understanding revolves around their relationship with family.

"Once the teenager is here for a while, the culture of that teenager and the expectations at home, and what the kids are going to get exposed to in school, and in the community, are not always in sync," Diaz says. "So you need to make sure that you help that young person or the family understand and communicate better, to be back in the same wavelength."

Diaz believes that improving family relationships does more than promote harmony at home; it improves teen health.



Take a teenager who comes from a strict Catholic family or community where she is told premarital sex is a sin. “How do you help that kid... get the help that they need to prevent the negative consequences?” Diaz says. “Because they do have the sex, but they don’t want to tell anyone because they think they are going to be judged for doing something wrong.”

Which is why treating teenagers without judgment is another tenet of Diaz’ health care philosophy – one that she drills into the medical residents who come to train at Mount Sinai in adolescent health. Sometimes that’s a hard lesson to teach, especially when a teenager is coming in for a third pregnancy, having failed to heed the clinician’s previous warnings.

“We are here to help teens, not to mandate, and this is part of adolescent development – to experiment. What we have to do is really create a safe environment around them, whether they try drugs or they try sex or they try whatever. What we really need to do is help them feel connected to a place where they can always come for help. Even the rare teen who comes with a third-time pregnancy, I will try to prevent the fourth one.”

Diaz works with populations others have given up on, including teens involved in the sex trade or addicted to drugs. But she insists her positive youth development approach can work with all teenagers, at clinics that are less comprehensive than hers, as long as administrators put a few key concepts in place. For example, she urges clinics to:

- stay open during the hours that suit a teenager’s schedule, such as evenings and weekends;
- hire staff willing to listen closely to adolescents’ needs;
- respect patient confidentiality within the confines of each state’s parental notification laws; and
- involve teenagers in their own care (e.g., asking teenagers what sort of birth control they are most likely to use, as opposed to telling them which type they should use).

Diaz has also instituted a peer mentoring program, where she trains adolescents to reach out to their friends with health education, and sometimes, to edit the very surveys the clinic sends out to teenagers.

But Diaz says individual clinics can only do so much without support from policy makers and legislators. On this topic, she always comes back to access – an issue that disproportionately affects young people of color. According to the National Alliance to Advance Adoles-

they should be eligible for health care, plain and simple.

If more teenagers had access to government-sponsored insurance, she believes many more health centers would have the resources to focus on the neediest adolescents. Instead, Diaz says, the health care financing in this country works against programs that take more time to engage vulnerable patients, or that follow an integrated, interdisciplinary model. That's true even for insured populations, since most insurance payors only reim-

IV and antibiotics that they have to get... there is no question as to which approach ends up saving money.”

As it stands, she says, the only way a program like Mount Sinai Adolescent Center can operate is through constant fundraising by administrators like Diaz – a highly skilled practitioner who, she points out, would much rather be seeing teen patients in her office.

On a societal level, Diaz would like to see more medical students specialize in adolescent health, and she'd like

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cent Health, about a quarter of all Latino teenagers and 11 percent of black teenagers are uninsured, compared to only eight percent of white adolescents. And the majority – 72 percent – of uninsured teenagers of color live in low-income households, compared to just 49 percent of the white population.

This disparity is a main reason that Diaz believes legislators need to make sure that every adolescent, into their early 20s, has health insurance. For state-administered programs, like Medicaid, the application process needs to be much simpler because she believes the mounds of paperwork and bureaucracy families are forced to navigate become major obstacles to health care.

“The forms and the requirements are just total barriers,” Diaz says. “For example, they ask parents to produce pay stubs. Well, not necessarily all these parents are working in circumstances that they can produce a pay stub. They want leases, but sometimes these people are paying for a room in somebody else's apartment.” For some programs, Diaz says, teenagers are required to produce immigration papers or Social Security cards, tasks that often derail the entire process of getting into the Medicaid program. She wants legislators to make Medicaid or other insurance programs an automatic default for all teenagers; if they can prove their age,

burse a very small amount per visit, and may not pay for all preventive services or for the time it takes to connect low-income teens with legal, psychological, educational, or other services. She'd like to see that dramatically shift.

“If [policy makers] invest in the front end, in...prevention and wellness, in primary health care and creating a medical home, you can reduce unwanted pregnancies, sexually transmitted infections, and many of the chronic illnesses that develop in adolescence, like obesity or high cholesterol, and diabetes,” Diaz says. “To give you an example, when a kid comes here, we screen them for sexually transmitted infection[s]. Let's say that we find that they have Chlamydia. We give them the pills and a glass of water and they take it here in front of us. We know that they are treated, and then ask them to bring their partner or partners here for treatment. It's a public health approach. Compare that to a kid who has gotten Chlamydia and doesn't know it because they don't have access, they have not been screened, they have not been tested. And, then [they are] sent to an ER with pelvic inflammatory disease, which has spread to their uterus and their tubes and sometimes their ovaries, so that they have to be admitted [to the hospital] at that point. So you have the expensive ER, the expensive inpatient unit, the expensive

to see more minorities enter medical fields, both to improve the overall cultural competency of the health profession, and to become role models for teenagers of color. In the meantime, she believes those who already work in adolescent health and welfare need to become louder, and more unified, advocates. That could mean forming one institution, with representatives from medical, legal, and social disciplines, that is dedicated to furthering adolescent health issues – from juvenile justice reform to health education in public school to reproductive rights. She says the struggling economy makes that type of advocacy all the more urgent.

“Whenever there is not enough money, what gets cut is the money for social services,” Diaz says. “So I'm hoping that the people in charge of the country, the leadership, really take a broader view of what's important.” ■