

Meeting the Challenges of Risk Screening in Michigan's School Based Health Centers

The Michigan Department of Community Health oversees the Child and Adolescent Health Center (CAHC) program which provides funding and administrative oversight to 70 school-based and school-linked health centers across the state. Michigan has the fourth largest school-based health center program in the country, with centers located in medically underserved areas in order to care for the state's most vulnerable children and teens.

Carrie Tarry is the Manager of the Adolescent and School Health Unit for the Michigan Department of Community Health. In this role, Carrie oversees many programs including teen pregnancy prevention, health education, coordinated school health, school nursing and the CAHCs.

These school-based and school-linked health centers (CAHCs) are primary care settings, located either within or close to a school. In addition to managing physical health, the centers offer a wide continuum of health-related screenings and services such as: mental health care, dietary guidance, health education and risk reduction, oral healthcare, and insurance enrollment assistance. Carrie likes to say "Anything you can get in a pediatrician's office you are able to get at a school based health center, plus more."

In Michigan, State-funded CAHCs are required to administer a risk screening on all patients by the third visit that the teen makes to that center. This is a state-based rule for the CAHCs and it is also a best practice recommendation and guideline nationally. Initially, the majority of CAHCs used a risk screening called GAPS (Guidelines for Adolescent Preventive Services) to fulfill this requirement. Developed by the American Medical Association, the GAPS survey was one of the few risk screenings available at the time that was specifically tailored to adolescents. However, GAPS presented a number of challenges.

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The GAPS screening was very long and paper based. This made the process burdensome on both the teen taking the screening, and also for the health professional whose job it was to go through the results with the young person. Once the risk screening session was completed, the results would then go into a patient chart – and that was where it stayed until the patient came into the center again. No data could be reviewed, combined, or grouped to help the center understand their patient needs without undergoing a time intensive data entry process. The CAHC could not look at patterns or risk trends across teens accessing their centers, and the state could not look across their funded CAHCs to determine trends.

Access to the data was especially important to the state of Michigan – particularly the ability to review data across multiple CAHCs. Carrie says "We ran the school-based health center program for 15 years and never had risk data about the teens accessing care. We could not report on their overall risks or the progress that we were making in changing behaviors. We could not compare our CAHCs or help them match their programs to the needs of their teen patients."

State-wide Adoption of a Data-driven Survey for Better Assessment and Care

Jennifer Salerno was a Nurse Practitioner and Director at the University of Michigan Health System, responsible for all of the school-based health centers operated by UM. In order to address the challenges of the existing risk screening process and to better meet the needs of the health centers in her care, Jennifer took the initiative to build a new survey tool altogether. This new screening, called RAAPS (Rapid Assessment for Adolescent Preventive Services) was shorter, has since been validated, and touches on all relevant risk domains recommended by the Centers for Disease Control for screening behaviors in teens that contribute most to morbidity and mortality.

Shortly after Jennifer began using RAAPS at her sites, she showed a marked increase in risk identification, improvement in the quality of the counseling for the survey recipients, and an ability to analyze data and produce reporting that was unprecedented. This success sparked immediate interest from the other Michigan school-based health centers.

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As mentioned above, the data is critically important to the state, particularly the ability to look across multiple centers. Carrie explains “We had 60+ centers identifying risk factors and no way to collect, consolidate, and report the data on those adolescent populations. We didn’t have any population data because it was all sitting in patient charts. We wanted to paint a clear picture for ourselves and the CAHCs about what the needs are of the teens accessing these centers. We wanted to be able to look at data for differences between rural and urban centers, for regional differences – like between the Upper Peninsula and Detroit, for race/ethnicity differences, and income disparity differences. We immediately saw the value of the data.”

So in 2009 the state of Michigan supported a pilot project for 9 CAHCs. They offered to pay for the Year 1 RAAPS license, start-up fees, and a laptop or handheld device for teens to complete the survey. The plan was for the state to pay for RAAPS at the pilot sites for the first year to show the CAHCs how cost effective the system was and to demonstrate the overall value to the centers. Then, going forward, the center would pay the annual license fee directly. With the RAAPS survey, the CAHC could see what was really going on in their center and use the data to establish need, apply for grants, and tailor programs to their actual teen population needs (rather than guessing).

Of the pilot program, Carrie adds “We hoped to get better data and paint a picture of the needs of the teens coming into our school-based health centers and better understand how to develop and tailor our services for them. We wanted to know: are we directing programming to the highest risks and are we able, through risk reduction counseling, to change those risks over time?”

In 2010, 11 more CAHCs were included in the pilot project and in 2011 all CAHCs were offered the opportunity to participate – with a total of 56 centers participating by the end 2011. The state contracted with RAAPS for all implementation and support. RAAPS used web based training to get everyone up and going, with site set-up and troubleshooting led by Jennifer and her team. As a key metric of the pilot, the RAAPS team reported on the number of surveys that were completed at each CAHC to the state of Michigan consulting team. If there was a center that wasn't completing many surveys or not entering data on time, the state consultants would gently nudge the centers to comply.

Then the state took the RAAPS pilot a step further – looking at ways to incorporate motivational interviewing into the pilot. This technique was employed to tailor the post-RAAPS risk reduction counseling in a way that teens would respond to more positively. Each pilot site sent their health professionals through a two day “MI” training. The state paid for the training with the goal of providing a more comprehensive and effective approach to risk reduction in teens being seen in the CAHC’s.

Added Benefit: Improved Communication Leads to Better-fit Programs

Like all RAAPS customers, the State of MI was trying to improve the reliability of the survey responses, the consistency of questions and counseling from professional to professional, the consistency of approach and data from health center to health center, and the reporting and analysis of the data. They feel that the RAAPS pilot has enabled them to accomplish all of these goals.

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One key benefit of RAAPS comes from the electronic delivery.

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And the state is using this newly gathered data, on the "real issues" teens are struggling with, to tailor program offerings. Carrie explains "We wanted to make sure that centers direct their programs towards the needs of the patients coming into the center. If most teens are saying that they have depression or that they need sexual health information – we wanted to ask the centers 'Do you have programs around those areas?'" Carrie states that the number of centers who actually use RAAPS is a testament to the support of the product.

When asked about other benefits of the RAAPS system, Carrie says: "The reports are the most valuable to us at the state. We recently presented risk data from RAAPS to the Medicaid staff at the Michigan Department of Community Health. The data was aggregated by factors like – Medicaid versus private insurance – versus no insurance. Our Medicaid staff were fascinated by the data. We have a huge focus on disparities and how disparities play out in seeking health care, quality of life, and chronic disease. We are trying to set up a pilot with The Michigan Association of Health Plans around getting private Medicaid doctors to use RAAPS in their practice to improve the health of their adolescent patients."

Of the pilot overall, Carrie says: "This was a great investment for the State of MI. RAAPS is a great system that is conducive to adolescents, quick to complete, and comprehensive in what it tells us. Each health center can identify the most pressing issues of their patients and then deal with those issues in a very focused way. Risk screening help teens open up about issues they are struggling with, and then enable the clinician to have a conversation around those needs and connect them to the right support. We meet teens where they are at and get them the support they need. RAAPS is high quality, the company is easy to work with, and the price is right. What else can we ask for?"

Finally Carrie hopes that RAAPS is used even more on a national basis, saying: "It would be huge for school-based health centers across the country to have aggregate data on the teen populations we serve and to be able to show the differences we are making in changing their risky behaviors over time. Getting more comparative data on a national level would be icing on the cake."