

Workflows that Work:

Integrating Adolescent Risk Screening in Primary, Family and Pediatric Practice

Even with an age-specific, technology-based system like RAAPS – adolescent risk screening presents a unique set of barriers – and these issues can be especially challenging for care providers in primary, family, and pediatric care practices.

With limited appointment times, overwhelming insurance and regulatory requirements, and ever-changing care guidelines, **integrating yet one more change into practice workflow can be both daunting and burdensome.**

Yet, with 75% of all morbidity and mortality in adolescents due to risky behaviors – taking on the challenge of workflow integration is a cause that can, quite literally, save lives.

This case study examines the experience of three very different primary care practices and the providers who have successfully navigated the process of workflow integration with RAAPS, including the best practices and lessons learned along the way to address the unique barriers in adolescent risk assessment.

ADDING ADOLESCENT SCREENING IN A PEDIATRIC CARE SETTING

*“In a busy pediatric practice a lot of our preventive focus revolves around immunizations and building healthy behaviors around nutrition and exercise,” explains **Mari Kay Evans-Smith, MD, FAAP at Pediatric Associates of the Northwest in Portland, Oregon.** “Making the transition to the unique risks associated with the teenage years requires a change in mindset, and a distinctly different process.”*

For Dr. Evans-Smith, the process begins with privacy. When doing adolescent risk screenings, Dr. Evans-Smith knows it’s vital to have her patients separated from their parents/guardians. This privacy increases the adolescent’s awareness that the assessment is confidential and allows her to get more honest, accurate responses. For her patients this separation begins in the waiting room, where parents are asked to remain for the initial portion of the appointment.

Dr. Evans-Smith relies on an experienced Medical Assistant (MA) to bring the adolescent back to the exam room, take vitals, explain the RAAPS process and purpose, and then give them an iPad to take the assessment. Using the RAAPS provider interface, the MA can see when the assessment is complete and prints out a copy of the adolescent’s responses, along with the RAAPS recommended talking points and key counseling messages for Dr. Evans-Smith. In addition, practice-approved resource materials and a list of the risk-specific websites (from the RAAPS system) are prepared for the adolescent.

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Prior to entering the exam room, Dr. Evans-Smith reviews the high-risk responses (prioritized in the RAAPS report) and prepares her discussion strategy. For Dr. Evans-Smith, it's the triage and prioritization from RAAPS that makes the workflow actually "work". *"RAAPS gives me so much more information in a short period of time. I have about 30 minutes with an adolescent during an annual visit. RAAPS gives me an opportunity to triage the conversation, I can focus the conversation to critical topics – because there are so many things we could be talking about."*

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She has also found that using technology – the iPad delivered assessment – opens doors to topics that might not have otherwise been uncovered. ***"It's a stepping stone to sometimes difficult conversations,"*** shared Dr. Evans-Smith. *"A lot of the questions in RAAPS were things we hadn't asked before, and it was surprising how many kids have answered yes to issues like being angry, or carrying a weapon for protection."*

Over time Dr. Evans-Smith has evolved a conversation and intervention style that works best for her and her patients – using a mix of her own risk-specific talking points along with some of the RAAPS messaging suggestions, and the website resources recommended within the system. She shared an example of a young patient who had recently participated in oral sex without the use of a condom. ***"The patient wanted more information on the topic, but that isn't something you can easily 'Google'. In fact, I got the impression she had tried that and was embarrassed with the results. By giving her a specific site I know she can safely learn more, privately, and I can trust the information she's getting."***

Parents are brought back into the appointment after the risk counseling is complete. While a few parents have questions or concerns about being excluded from the conversation, Dr. Evans-Smith finds it is relatively easy to explain the value of allowing teens to have a trusted interaction directly with a physician. *"This age group wants to be heard; they have a lot of questions about their life and their health. They need to be able to talk to someone who is outside of the family who is respectful and will listen."*

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The RAAPS reporting has also been valuable to her practice. According to Dr. Evans-Smith, *"I see a high percentage of adolescents and the RAAPS system allows me to easily share findings about our teen population with the other providers in the practice. Before we didn't necessarily realize how many of our teens were having these specific experiences. **I can easily print out how many of my patients answered positively to different questions, and have shared that information at our meetings so we are all aware of trending or emerging risks in our adolescent population.**"*

When asked about the value of working RAAPS into her daily workflow Dr. Evans-Smith responded, *"It's opened doors with adolescents on really important topics that they wouldn't otherwise bring up. **Bottom line: I really like it; I think it's helped me do a better job.**"*

INTEGRATING ADOLESCENT RISK ASSESSMENT IN AN INTEGRATED CARE MODEL

For Health Partners of Western Ohio – a Federally-Qualified Health Center (FQHC) with seven satellite offices and an integrated care model providing medical, dental, pharmacy, behavioral health, substance abuse, and community outreach services – the “workflow” is a little different than that of the average primary care office.

However, while they have more time for screening teens and more immediately accessible resources for any risks that are identified – they also have significantly more need.

“As an FQHC, we serve a high risk adolescent population – and we serve a high volume of patients. We have screened over 1800 teens since we implemented RAAPS,” explained Director of Pediatric Services Karen Martin, PNP and Dr. Daphne Lindo, DBH, LISW-S.

Dr. Lindo likes using RAAPS because it has questions specific to health risks and behaviors that are areas of concern for their adolescents, and that other screenings don’t cover, such as substance abuse, bullying, LGBT topics, and sexual risks (particularly relevant as Ohio ranks fifth in the country for human trafficking). *“These extra questions help behavioral health providers get more information and make referrals. Plus the kids like using a web-based tool, which makes it easier for providers to get the information they need.”*

Martin adds that RAAPS is very illustrative of the needs of the community, what the kids are thinking and where they’ve been. ***“As adults, we tend to think we know what they want and what they need. When we do RAAPS, the youth is actually telling us what they need in an electronic format that feels safe and natural to them.”***

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Because of their multi-disciplinary resources, the Health Partners FQHC team applies a unique approach with RAAPS delivery and workflow. A health coach goes into the exam room before the medical provider with a mobile kiosk to explain and administer RAAPS. After the assessment is complete, the health coach will discuss lifestyle related risks such as making healthy food choices and wearing their seatbelt. If something from RAAPS indicates a clinical intervention is needed for a risky behavior, a behavioral health provider is immediately brought in to talk with the adolescent (bullying, sexual behaviors, mood, etc.) The pediatric practitioner consults with the care team, and meets with the adolescent to discuss a risk-reduction plan and recommend any additional referrals as appropriate.

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Despite the breadth of resources available within their integrated model, Dr. Lindo and Martin feel that RAAPS has improved the quality-of-care of care for adolescents. ***“Teens know they are not being judged, the questions are unbiased. It has opened up the door to conversations – true discussions. This connectedness is huge.”***

Martin shared the example of a 14 year old who had revealed thoughts of suicide and was admitted to the hospital after meeting with the behavioral health team. *“If we had asked that particular adolescent the same questions verbally they probably wouldn’t have revealed that potentially life-saving information.”*

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RAAPS reporting helps the community outreach efforts as well. Services are focused on high risk issues happening in the home, and programming is targeted to need. Dr. Lindo added, *“Without the reporting we wouldn’t be easily able to identify areas of concern, such as the high percentages of drug use and domestic violence in our population. RAAPS helps us identify increases in a specific area and hone in on underlying issues.”*

For Health Partners adolescent risk assessment is a critical component of an integrated care model, Martin and Dr. Lindo agreed *“It’s not optional to provide exemplary care to our kids.”*

RISK ASSESSMENT IN THE ADOLESCENT MEDICAL HOME

The University of Michigan Adolescent Health Initiative (AHI) was established to help healthcare providers, health centers, health systems, and youth-serving agencies improve their care for adolescents.

For AHI, the best care includes annual adolescent risk assessment using a comprehensive, confidential, standardized instrument. AHI staff spend a lot of time helping providers develop and integrate workflows for new process such as risk assessment, as part of AHI’s Adolescent Champion model. **Lauren Ranalli, MPH is the director at AHI** and likes RAAPS because of its shorter length, and that it still covers a comprehensive landscape. Ranalli adds, *“We work with health centers that use a variety of risk screening tools. With RAAPS, it’s nice to have one brief tool that can address a broad range of risk issues. RAAPS is designed in a way that makes it easy for providers to quickly and easily identify areas that they need to discuss and follow-up with their patients. It’s been vetted by youth and is up-to-date. Plus it’s confidential and technology-based, so youth are engaged.”*

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The University of Michigan Saline Health Center is one of the sites working with the AHI team. **As an Adolescent Champion in AHI’s program, Pediatrician Steve Park, MD, led the process of selecting and integrating RAAPS at the Saline Health Center.**

Over the years, Dr. Park had seen the wide variation in risk assessment among primary care providers – including asking questions orally, sometimes even in front of parents.

To ensure confidentiality for adolescents in the Saline Health Center, a private area in the waiting room was set-up with a kiosk (safe from parental shoulder surfing) for patients to take the RAAPS assessment before their appointment. Once in the exam room, a doctor reviews the results with the patient privately before the parents are brought in for the remainder of the appointment. Dr. Park implemented this approach because studies show adolescents are more likely to be honest with their answers when completing a screening privately and online, compared to answering a provider's questions face-to-face.

According to Ranalli, many of the providers AHI has worked with have identified issues such as depression and eating disorders that hadn't come up in previous encounters. *"Providers will say, 'I guess I wasn't asking the right questions, or asking in a way that they felt comfortable disclosing...I've been seeing this patient for years and it's never come up before.'"*

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The staff at the Saline Health Center has had similar outcomes. *"RAAPS has revealed things that are going on that we wouldn't otherwise have picked up on,"* Dr. Park shared. ***"The office as a whole has experienced a high***

degree of satisfaction from their adolescent patients because they are able to talk to their doctor about things they want to, without their parents around. They trust their provider more now that they can see the office is doing things confidentially."

Getting that parental separation isn't always easy. But according to Ranalli, the issue isn't always the parents themselves – but the lack of training provided to physicians and staff. She explained, *"One of the biggest concerns among MAs and providers is the perception of how this exchange is going to go, the perceived barrier of separating parent from youth."* **AHI recommends developing scripts and having role-playing sessions to help MAs with the process, and also having physicians explain the importance of risk screening to both the parent and patient.**

"You have to be purposeful in terms of how MAs approach and interact with parents," Dr. Park advised. *"Parents will want to know: 'Why are you asking these questions? My child is too young...' or 'I want to know the results of the assessment.' I recommend practices develop a common, agreed-upon language of how to talk to parents so everyone will respond the same way to the questions and objections they will have."*

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Ranalli agreed that a process that is embraced and executed at all levels of the practice is a hallmark of an effective risk screening workflow. When asked what the most important elements of risk assessment with adolescents in a primary care setting are, Ranalli summarized: ***"Using a comprehensive, accessible tool that speaks to teens, and can be done in a confidential manner. The confidential format is critical, and can be one of the biggest opportunities for improvement in primary care settings."***