The National Evaluation of the
CHIPRA Quality Demonstration Grant Program

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How are CHIPRA Quality Demonstration States working to improve adolescent health care?

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Adolescents typically experience dramatic physical changes, usually become more independent decisionmakers, and often engage in risky behaviors. As a result, they require health services tailored to their unique needs. Several CHIPRA quality demonstration States are working with participating providers to enhance their ability to deliver such services and improve the overall quality of health care for adolescents. Specifically, North Carolina and Utah are facilitating adolescent-focused quality improvement (QI) collaboratives for primary care practices, and Colorado and New Mexico are providing support and coaching to school-based health centers (SBHCs) serving adolescents.[1] This *Evaluation Highlight* describes barriers these States encountered in their efforts to improve care for this population, identifies strategies to address these barriers, and suggests actions States could take to enhance adolescent health care.

KEY MESSAGES

- States are encouraging primary care practices and SBHCs to expand screening of adolescents for a variety of health and behavioral risk factors and to counsel or refer adolescent patients as needed.
- Perceived shortages of mental health professionals in some areas have made some primary care providers hesitant to screen for mental health conditions. To overcome this, States are attempting to make primary care providers in rural areas more aware of local mental health providers by bringing them together at events and compiling lists of area mental health resources, for example.
- SBHCs often employ mental health professionals and thus have more capacity than traditional primary care practices to engage and counsel adolescents regarding depression, anxiety, stress, difficult peer relationships, and other issues prevalent among this population.
- Providers sometimes have difficulty ensuring adolescents' confidentiality when treating sensitive conditions for a variety of reasons, including providers not carving out time during visits for confidential one-on-one discussions and insurers' tendency to mail Explanation of Benefits statements home.
- Questionnaires that assess adolescents' risks and strengths can collect sensitive information to help providers prioritize topics to discuss during office visits. Electronic tablets are an innovative tool for collecting such information.

The CHIPRA Quality Demonstration Grant Program

In February 2010, the Centers for Medicare & Medicaid Services (CMS) awarded 10 grants, funding 18 States, to improve the quality of health care for children enrolled in Medicaid and the Children's Health Insurance Program (CHIP). Funded by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), the Quality Demonstration Grant Program aims to identify effective, replicable strategies for enhancing quality of health care for children. With funding from CMS, the Agency for Healthcare Research and Quality (AHRQ) is leading the national evaluation of these demonstrations.

The 18 demonstration States are implementing 51 projects in five general categories:

- Using quality measures to improve child health care.
- Applying health information technology (IT) for quality improvement.
- Implementing provider-based delivery models.
- Investigating a model format for pediatric electronic health records (EHRs).
- Assessing the utility of other innovative approaches to enhance quality.

The demonstration began on February 22, 2010 and will conclude on February 21, 2015. The national evaluation of the grant program started on August 8, 2010 and will be completed by September 8, 2015.

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Background

Although adolescents are a relatively healthy patient population, they experience mental and physical changes that can put them at risk for developing new conditions and engaging in unhealthy behaviors with significant consequences. Meanwhile, providers have relatively few opportunities to screen, counsel, and treat adolescents, since adolescents underuse outpatient care and preventive services.[2,3] When adolescents do seek care – such as for a sports physical or a vaccine – busy providers do not always take the opportunity to screen and treat them for other issues or to counsel them without their parents present about risky behaviors.[4]

Clinicians who meet with adolescents without a parent present – which is recommended by the American Academy of Pediatrics (AAP)[5] – are more likely to provide counseling about risky behaviors.[6] Risky behavior is common among adolescents: 42 percent of high school seniors report having drunk alcohol in the past month, 17 percent report having smoked cigarettes, and 25 percent report using illicit drugs,[7] while only 60 percent of sexually active teens report using a condom the last time they had intercourse.[8] Adolescents also may suffer from mental illnesses. In 2011, 16 percent of youth contemplated suicide, 13 percent went as far as making a plan about how they would do it, and 8 percent actually attempted suicide.[8] Among children who commit suicide, only one in three has a diagnosed mental health condition, and only one in four is in treatment for it.[9]

A lack of confidential time for clinician-patient discussions may also contribute to a disconnect between what adolescents want to discuss with their providers and what they actually end up talking about. According to a national survey, youth most want to talk about drugs, sexually transmitted infections (STIs), and smoking, yet providers most often talk to them about less sensitive topics such as diet, weight, and exercise.[10] Moreover, despite the fact that the most prevalent risk factor adolescents report is feelings of "high stress," providers generally do not engage in routine, systematic screening for behavioral health problems and tend to underdiagnose such conditions.[11,12] For hurried clinicians who already feel stretched thin, the length of time they believe is needed to uncover and address more complicated, sensitive issues can be a barrier to engaging in conversations about them.

> "Doc[tor]s can see 40-50 kids a day — [for] 10-minute visits. For a physical for an adolescent, if you did all the [things recommended in the AAP's] Bright Futures [guidelines], that would take 2 - 2½ hours or so. But you're lucky if you have 15 minutes, and that's if people are on time. … It's a challenge."
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> —North Carolina Pediatrician, April 2012

For this *Evaluation Highlight*, we drew information from: interviews with State staff and consultants, health care providers in participating practices and SBHCs, and other stakeholders; and final operational plans, semiannual progress reports, and other materials prepared by the States.[13]

Findings

States are encouraging providers to screen adolescents more comprehensively.

CHIPRA quality demonstration States are employing a variety of techniques to encourage more comprehensive screening of adolescents for mental health issues and risky behaviors.

North Carolina and Utah are offering participating primary care practices ongoing Webinars on general QI strategies and specific adolescent care guidelines.

Utah's two successive year-long collaboratives are focused on diagnosing and treating mental health conditions prevalent in adolescents. The State is coupling these with semiannual in-person meetings, a practice coach, and a consulting psychiatrist.

Meanwhile, North Carolina's 18-month collaborative, which has concluded, focused on a variety of adolescent-specific care guidelines and issues such as:

- Conducting routine screening to identify risk and resiliency factors and strengths in an adolescent's life (such as involvement in extracurricular activities, good academic performance, friendships).
- Measuring body mass index (BMI).
- Using motivational interviewing to counsel patients about topics like losing weight.
- Engaging in screening, brief intervention, and referral to treatment for at-risk substance abusers and patients with depression and anxiety disorders.
- Setting up a system to remind patients about annual checkups and immunizations.

Colorado and New Mexico are collaborating on a CHIPRA quality demonstration project aimed at increasing how often SBHCs deliver services in line with the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program for a variety of conditions, including obesity, depression, and STIs. SBHCs are trying

new approaches (described below) to assess their progress toward adopting the patient-centered medical home model of care and seeking to increase adolescents' engagement in their care and use of SBHCs. Helping them in these efforts are consultants with expertise in QI and youth engagement, who offer assistance through site visits, Webinars, and telephone calls. For example, coaches help SBHCs pull medical charts and calculate quality measures, analyze medical records for visit completeness, and set goals for practice improvement.

Demonstration States encountered a number of barriers to improving care for adolescents.

Barriers to improving care include some providers' hesitation to discuss mental health, a lack of one-on-one provider-adolescent conversations, and payer policies that put adolescents' confidentiality at risk.

Some primary care providers in some regions of grantee States hesitate to screen for mental health conditions. Interviewees indicated that some doctors feared "opening Pandora's box" when it came to discussing mental health. They worried that doing so would raise issues that could take a long time to discuss and that they did not feel well-equipped to address. Other primary care providers were hesitant to screen for mental health conditions out of a concern that once they identified a problem, a perceived lack of mental health providers (especially in rural areas) could prevent them from ensuring adequate treatment was delivered. This sometimes led to a "don't ask, don't tell" approach to mental health conditions. By contrast, in SBHCs in Colorado and New Mexico, the presence of mental health providers on staff facilitated primary care providers' regular screening of adolescents for mental health issues.

Providers do not always carve out time during appointments for private conversations with adolescents. In North Carolina, State staff found that some primary care providers did not reserve time in their appointments with adolescents for discussions without parents present, thereby decreasing opportunities for discussions about sensitive topics like depression and risky behaviors like unprotected sex or alcohol or drug use.

Providers cannot always guarantee teens' privacy. Providers' inability to assure teenagers full confidentiality was often cited as having a chilling effect on what topics providers brought up during visits. In one State, providers sometimes avoided inquiring about sexual activity and testing for STIs, since insurers would mail an Explanation of Benefits statement to beneficiaries' homes if the testing occurred, creating the possibility that a parent could find out about the delivery of a sensitive, confidential service.

Assuring adolescents' confidentiality is complicated by the fact that different States allow minors to consent to different types of services (for example, contraceptive prescriptions, testing for STIs, or prenatal care) without a parent or legal guardian's permission. In some States, certain types of minors can make decisions about all aspects of their own health care (for example, married or emancipated minors in California). Once providers educate themselves about which services an adolescent can consent to without a parent's permission in their State, a further hurdle is determining a system to segment information about the receipt of these services in a patient's record; many practices and electronic health record (EHR) vendors have not yet determined how to do this.[14,15,16,17]

Demonstration States developed key strategies to improve care for adolescents.

Strategies to improve care include encouraging providers to assess patient risk using questionnaires and educating providers about mental health resources and confidentiality laws.

Encouraging practices to adopt a patient screening questionnaire. All four of the States featured in this *Evaluation Highlight* are encouraging providers to adopt adolescent questionnaires to identify issues that merit discussion during visits. These questionnaires can be administered orally by a provider (using, for example, the AAP's Bright Futures guidelines[5]) or completed in writing by a patient in the waiting room (using the American Medical Association's Guidelines for Adolescent Preventive Services questionnaire[18]). Studies show that questionnaires uncover more adolescent substance abuse problems than relying on clinicians' "impressions" alone[19] and are preferred by adolescents over in-person interviews with clinicians.[20] Reviewing adolescents' written questionnaire responses also gives clinicians a structured way to engage adolescents in a discussion about sensitive topics, including those that make the clinician uncomfortable. Questionnaires can ask

about a range of health risk factors and strengths (such as in North Carolina) or focus only on mental health issues (as in Utah). Efforts to increase the use of screening questionnaires are aided in North Carolina by the State's Medicaid fee schedule, which reimburses providers $8.14 each time they administer such a questionnaire.

Encouraging providers to load patient questionnaires onto tablets. Colorado and New Mexico have outfitted participating SBHCs' waiting rooms with tablet computers and loaded them with a questionnaire that screens for health risk and resiliency factors. SBHC providers see the tablet format as a tool for adolescent engagement that is "fun" and "cool" and, thus, potentially effective in achieving higher rates of screening. Once completed by students, survey responses are reviewed with students confidentially by SBHC staff and added to students' medical records. These surveys have revealed a high prevalence of stress (44 percent), symptoms of depression (25 percent), and sexual activity (57 percent) among students ages 14-19. These findings have helped shape and refine participating SBHCs' approaches to providing both behavioral and physical health services to their patients. Aggregated survey data are sent to the SBHC staff on a quarterly basis and used to assess student population needs. In addition, a survey regarding students' experience with health care services is also administered annually on a tablet.

> "With the adolescent population, the most important thing a provider can do is annually assess risk behaviors in order to identify concerns early and work in partnership with the youth to address any health concerns."
>
> —Colorado SBHC QI Coach

Educating providers about confidentiality laws. To overcome primary care providers' hesitation to discuss sensitive topics with adolescents, North Carolina's QI collaborative educated participating practices about confidentiality laws governing their State and encouraged providers to enter into formal confidentiality agreements with their adolescent patients.

Connecting primary care and mental health providers. At in-person meetings, Utah's QI collaboratives have had local mental health professionals give "elevator speeches" to participating primary care practices that succinctly summarize the services they offer, during a session they call "speed resourcing" (a play on the "speed dating" concept). Utah staff have also compiled a comprehensive list of area mental health resources and partnered each of their participating practices with a local child psychiatrist who visits once a month to provide information, suggestions, and advice on patient cases.

Engaging providers with interactive dramatic exercises. At Utah's in-person collaborative meetings, the State has used "forum theater," an interactive exercise in which actors play out clinical scenarios involving practice staff and a patient. Audience members suggest ways to improve the interaction, and actors then re-act the scenario using the audience's tips. For example, in one scenario, a father brought his son in for a sports physical, and the practice staff had to find a way to incorporate screening for mental health issues into the visit.

> "Our nurses and front desk [staff] always think pediatric visits mean vaccinate – but here you have 14- and 15-year-old [teen moms] coming in for an exam, and we don't think "vaccinate." We're changing that culture and identifying and flagging. We did our first [immunization] audit in December and we were at 0 percent, meaning 0 percent of these teens were up to date with their shots. We're up to 22 percent, which is huge when you go from 0 percent."
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> — Utah Health Care Provider, May 2012

Offering practices maintenance-of-certification (MOC) credit. Many CHIPRA demonstration States, including North Carolina and Utah, have arranged for professional boards to offer providers MOC credit for attending QI collaborative meetings and Webinars, completing plan-do-study-act (PDSA) cycles (documenting a change the practice made that was aimed at improving quality),[21] and submitting progress reports and small-denominator quality measure data. States have found MOC credit to be an effective way to recruit practices and ensure ongoing participation.

Results in some States suggest increases in the use of recommended care processes.

After pursuing the strategies described here, CHIPRA quality demonstration States reported observing some encouraging increases in the rate at which participating providers engaged in recommended care processes.

North Carolina. By the end of North Carolina's QI collaborative, 87 percent of participating practices had adopted a comprehensive adolescent screener into their standard practice, up from

43 percent at the beginning of the collaborative. The State's collaborative is now an online course that family physicians and pediatricians from any State can access for free and use to earn MOC credit.

> "The first week [we began administering a mental health screening questionnaire], we had some amazing stories – families coming in … with big smiles on their faces. [Yet] you find all kinds of things when you get the [questionnaire] back that you wouldn't have seen or heard about just [by] asking "Is everything OK?" …That feedback was amazing for us."
>
> — North Carolina Pediatrician, April 2012

Utah. Utah increased the rate at which participating practices screened adolescent patients for mental health conditions, from 3 percent at the beginning of their first collaborative to 75 percent of adolescent patients by the end. Among patients with identified mental health issues, 73 percent had visits scheduled to treat the identified mental health condition, up from 57 percent at the beginning of the collaborative.

Colorado and New Mexico. As a result of pursuing projects of longer duration, data collection is still ongoing in Colorado and New Mexico, where participating SBHCs have implemented the tablet-based student health questionnaire and routinely administer it. These States will compare data across grant years to determine if clinical practice, adoption of the patient-centered medical home model, and youth engagement improve once their efforts are fully implemented.

Conclusions

The CHIPRA Quality Demonstration States profiled here are working to improve adolescents' health care by educating practices and SBHCs about how to screen adolescents for sensitive health issues in a confidential manner, encouraging them to strengthen linkages to mental health care, and using new training approaches to engage providers. These targeted efforts to increase screening worked in the short term in North Carolina and Utah. These States and participating practices are now exploring whether and how to sustain these gains.

Implications

Based on lessons learned in the four States highlighted here, other States interested in improving adolescents' health care could:

- Exclude information about sensitive services from Explanation of Benefits statements mailed to Medicaid/CHIP beneficiaries' homes, as many States have already done, to preserve adolescents' privacy (if possible within State law and policy).[22]
- Reimburse providers for administering adolescent health risk assessment questionnaires and engaging in private consultations with adolescents regarding their responses.
- Clarify State and Federal privacy rules for providers, EHR vendors, patients, and their parents or legal guardians to increase their awareness of which services providers should discuss confidentially with adolescents (without a parent present) and how to segment this information in patients' records.
- Develop and maintain lists of mental health resources and distribute these to primary care practices. Consider introducing these providers to each other through in-person meetings and encouraging collaboration with mental health professionals and their integration into primary care practices.
- Sponsor expert-led Webinars on how to improve care for adolescents and archive these Webinars online so practices can view them at convenient times.[23,24,25,26] Urge State specialty societies to offer MOC credit to physicians who watch these Webinars and document completion of QI homework.

Endnotes

1. In addition to these four States, other CHIPRA States are working to improve care for adolescents as part of broader efforts to improve care for *all* children served by participating practices.
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26. Envision New Mexico. Videos. Available at: http://envisionnm.org/index.php/videos.

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Use the tabs and information boxes on the Web page to:

- Find out about the 51 projects being implemented in 18 demonstration States.
- Get an overview of the projects in each of the five grant categories.
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