Adolescent-Centered Environment Assessment Process

An Innovation Station Emerging Practice

Purpose: This document is intended to support MCH professionals to implement a practice found in Innovation Station. This resource provides the information needed to replicate the practice and is divided into two sections: the first section provides a high-level overview of the practice while the second section describes how to implement the practice. For additional information on any of the content provided below, please reach out to the practice contact located at the bottom of this document.

Section I: Practice Overview

Location:	National	**Title V/MCH Block Grant Measures Addressed**
Category:	Emerging Practice	Primary/Preventative Health care National Outcome Measures: **NOM 16.2:** Adolescent Motor Vehicle Death **NOM 16.3:** Adolescent Suicide **NPM 17.2:** Well-functioning System of Care for CSHCN **NOM 22:** Adolescent Vaccination **NOM 25:** Access to Health Care
Date Submitted:	12/10/2018	

Practice Description

The goal of the Adolescent-Centered Environment Assessment Process is to improve services for adolescent patients at clinical practices across the country. The ACE-AP is a facilitated, comprehensive self-assessment tool and improvement process that includes customized resources, recommendations, technical assistance, and implementation plans using Plan, Do, Study, Act (PDSA) improvement cycles.

Purpose

Adolescent patients access primary care services at lower rates than any other age group despite increased risk for morbidities and mortalities due to behaviors such as substance use, sexual activity, interpersonal violence, and suicide.[i] While these high risk behaviors are common among adolescents, less than 20% receive recommended screening and counseling on them from their healthcare providers.[ii,iii] Moreover, while adolescents have healthcare needs and developmental characteristics that differ from other age groups, they remain the most likely to be uninsured[iv,v,vi] and the least likely to access primary healthcare compared to other age groups.[vii] Adolescents have reported being reluctant to seek out health services due to their apprehension regarding provider compliance with confidentiality as well as the sensitivity and respectfulness of providers and staff.[viii] Research has shown that provider perspective and behavior influences the satisfaction of their adolescent patients and the likelihood that

adolescents will continue seeking healthcare treatment.[ix] Concurrently, national surveys of physicians, nurses, social workers, and other health professionals have identified gaps in self-perceived skills, competencies, and training related to adolescent health.[x,xi,xii]

The ACE-AP intervention draws from a larger more complex evidence-based intervention developed by AHI, the Adolescent Champion Model, which includes intensive in-person trainings and greater time commitment. The Champion model requires a cohort of 4-10 co-located health centers and may not be feasible for practices due to limited budgets, staff time, or geographic location.

In response to these barriers, AHI developed a single, scalable, low-cost component of the model, the ACE-AP. The ACE-AP can be facilitated remotely and done by a single health center which may not be located near other health centers such as in a rural community.

Practice Foundation

The ACE-AP, was developed and framed around proven evidence-based interventions and best practices in the care of adolescents. AHI used the World Health Organization's definition of Adolescent Friendly Health Services, summarized as services that "meet the needs of young people in this age range sensitively and effectively and are inclusive of all adolescents" as an initial framework, and then went a step further to use the term "adolescent-centered" to indicate that youth were also consulted in the development and execution of the process. The tool is informed by evidence-based guidelines from the United States Preventive Services Task Force (USPSTF), the American Association of Pediatrics (AAP), the American Association of Family Physicians (AAFP), and the Society for Adolescent Health and Medicine (SAHM).

Core Components

The ACE-AP is a facilitated, comprehensive self-assessment tool and improvement process that includes baseline and year-end data collection, ACE-AP self-assessment, implementation planning and execution, and customized support and technical assistance using Plan, Do, Study, Act (PDSA) improvement cycles. The ACE-AP utilizes a 75-indicator self-assessment tool that measures health center environment, policies, and practices in 12 key areas of adolescent- centered care:

1. Access to Care
2. Adolescent Appropriate Environment
3. Confidentiality
4. Best Practices & Standards of Care
5. Reproductive & Sexual Health Clinical Practices
6. Mental Health Clinical Practices
7. Nutritional Health Clinical Practices
8. Cultural Responsiveness
9. Respectful Treatment
10. Adolescent Engagement & Empowerment
11. Parent Engagement

12. Community Engagement and Outreach

Practice Activities

Core Component	Activities	Operational Details
Baseline Data Collection	• Adolescent patient satisfaction • Staff and provider knowledge and attitudes • Clinic information including adolescent HEDIS quality measures	Clinical sites collect up to 50 adolescent patient satisfaction surveys, staff and provider knowledge and attitude surveys and patient-level data over the three months prior to the baseline ACE-AP self-assessment.
Baseline ACE-AP self-assessment	• Complete baseline ACE-AP self-assessment with AHI ACE-AP coach and interdisciplinary clinic team	Clinical sites form an interdisciplinary team consisting of a provider, clinic manager, and 1-3 other clinic personnel committed to the project. Team schedules baseline meeting with AHI ACE-AP coach to complete baseline guided self-assessment.
Implementation planning and execution	• Complete implementation plan based on data collection and ACE-AP self-assessment	Interdisciplinary team works with AHI ACE-AP coach to develop implementation plan based on data collected and ACE-AP results. Coach offers resources and strategies to facilitate implementation over the year.
Customized support and technical assistance	• Check in with AHI ACE-AP coach throughout year to receive technical support and guidance of implementing adolescent-friendly changes to clinic	Interdisciplinary team executes implementation plan, checking in with AHI ACE-AP coach throughout process. Team also has mid-year PDSA check-in meeting to review progress and update implementation plan.
Year-end ACE-AP reassessment	• Complete year-end ACE-AP self-assessment with AHI ACE-AP coach and interdisciplinary clinic team	Interdisciplinary team completes ACE-AP reassessment at year end.
Year-end data collection	• Adolescent patient satisfaction • Staff and provider knowledge and attitudes • Clinic information including adolescent HEDIS quality measures	Interdisciplinary team completes second round of data collection over final three months to show progress and identify more areas of improvement for future.
Certification	• Sites that meet all certification requirements become Certified Adolescent Centered Environments by AHI	The AHI ACE-AP coach will determine eligibility

Evidence of Effectiveness (e.g. Evaluation Data)

The ACE-AP process is still undergoing rigorous evaluation though initial results are promising in all areas of data collection including adolescent patient satisfaction, staff and provider knowledge and attitudes and patient-level quality data.

Replication

The ACE-AP process has been executed across several states and types of health center sites. To date the ACE-AP has been replicated in Michigan, New Hampshire, Washington, DC, Nevada, Wyoming, Alaska, Mississippi, Iowa, and Illinois. Sites that have implemented the model include Federally Qualified Health Centers, Title X Clinics, School-Based Health Centers, and Primary Care Practices.

Section II: Practice Implementation

Internal Capacity

Clinical sites need a dedicated team of 3-5 personnel committed to working 0-2 hours/month over 18 months on the project. The team must include one provider and one health center manager or administrator. Other team members can include medical assistances, front desk staff, or other staff members dedicated to improving adolescent services at their site.

Collaboration/Partners

Successful team's partners partner with personnel at clinical site who are not on the team as well as with youth-serving resources in the community.

Practice Cost

Budget			
Activity/Item	**Brief Description**	**Quantity**	**Total**
AHI Consultation Fee	Cost covers all resources and technical assistance provided to implement ACE-AP process over 18 months in one health center.	1	$7,500
		Total Amount:	$7,500

Practice Timeline

Implementation of the ACE-AP process is spread over an 18-month period.

Practice Timeline				
Phase	**Description of Activity**	**Date/Timeframe**	**# of hours needed to complete/ oversee activity**	**Person(s) Responsible**
Baseline Data Collection	Collect 50 adolescent patient satisfaction surveys	3 months	2 hours total	Interdisciplinary team, key data collection point person
	Collect staff and provider knowledge and attitude surveys			
	Collect clinic information tool including adolescent HEDIS measures and quality data			

Implementation	Complete baseline ACE-AP	12 months	0-2 hours per month over 12 months	Interdisciplinary team
	Implement changes using PDSA cycle			
	Complete year-end ACE-AP			
Year-end Data Collection	Collect 50 adolescent patient satisfaction surveys	3 months	2 hours total	Interdisciplinary team
	Collect staff and provider knowledge and attitude surveys			
	Collect clinic information tool including adolescent HEDIS measures and quality data			
Certification	Clinics that meet requirements become certified Adolescent-Centered Environments	1 hour call	1 hour	Interdisciplinary team, AHI Coach

Resources Provided

For more information, visit www.umhs-adolescenthealth.org/improving-care/ace-ap/

Lessons Learned

Clinics participating in the ACE-AP process have the most success when they have key institutional factors in place prior to starting. In particular, it is best if sites have the following capacity prior to beginning:

- Interest in improving care for adolescent patients (ages 12-21)
- Willingness to commit up to 2 hours per month to the project
- Ability to assemble a team that consists of (at least) a provider, practice manager and 1-3 other key staff members (such as an MA, social worker, or nurse) to support the project
- Ability to collect approximately 50 youth surveys from adolescent patients ages 12-21 (survey will be provided)
- Ability to survey all health center staff and providers on knowledge and attitudes on state minor consent laws as well as perceptions of youth friendliness at their clinic (survey will be provided)
- Ability to provide clinic-level patient outcomes data including adolescent-specific quality (HEDIS) data on chlamydia screening, HPV vaccination, well visit, and depression screening
- Commitment to regular, ongoing communication with ACE-AP coach
- Willingness to participate in check-in calls throughout the 18-month process

Next Steps

AHI is in the process of evaluating the effectiveness of the model using rigorous evaluation methods. AHI also plans to adapt the resource for behavioral health practices as well as practices providing specialty care.

Practice Contact Information
For more information about this practice, please contact: (734) 998-2009 adolescenthealth@umich.edu

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