Adolescent Champion Model

An Innovation Station Promising 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:	Promising Practice	Primary/Preventative Health Care Adolescent Health National Performance Measures: **NPM 10:** Adolescent Well Visit **NPM 11:** Medical Home **NPM 12:** Transition National Outcome Measures: **NOM 16.2:** Adolescent Motor Vehicle Death **NOM 16.3:** Adolescent suicide **NOM 17.2:** Well-functioning System of Care for CSHCN **NOM 22:** Adolescent vaccination (HPV, Tdap, MCV4) **NOM 25:** Access to Health Care
Date Submitted:	12/17/2018	

Practice Description

The goal of the Adolescent Champion Model is to improve services for adolescent patients at clinical practices across the country. The model brings together youth-serving clinical providers in a community of practice to execute practice improvement through PDSA cycles over an 18-month intervention.

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]

As a response to this need, the Adolescent Health Initiative at Michigan Medicine developed the Adolescent Champion Model. The model is a multifaceted approach to improving adolescent-centered care in primary care settings. The Adolescent Champion model has been shown to yield statistically significant improvements in provider and staff knowledge and attitudes around adolescent confidentiality and minor consent, provider and staff attitudes around health center climate related to adolescent-centered care, and adolescent patient satisfaction with services provided at the health center.[xiii]

Practice Foundation

The Champion Model, 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 process 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 core components of the model include:

1. Baseline and year-end data collection of adolescent patient satisfaction surveys, staff and provider knowledge and attitude surveys, and patient-level quality data (3 months prior and 3 months post-intervention)
2. Development of interdisciplinary Champion Team at each site
3. Development of a Community of Practice among a cohort of co-located primary care health centers including two in-person summits
4. Completion of an Adolescent-Centered Environment Assessment Process (ACE-AP) to identify opportunities to improve the health center's environment, policies, and practices related to adolescent patient care
5. Participation in provider and staff training and professional development opportunities related to adolescent-centered care
6. Certification as an adolescent-centered environment for clinical sites that meet criteria

Practice Activities

Core Component	Activities	Operational Details
Data Collection	• Adolescent patient satisfaction • Staff and provider knowledge and attitudes • Clinic information including adolescent HEDIS quality measures	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 initial summit.
Development of Champion Team	• Sites identify interdisciplinary team to participate in project	Each site identifies a team that consists of a provider, clinic manager, and 2-3 other dedicated staff members
Development of a Community of Practice among a cohort of sites	• Participation in two in-person summits with other participating sites	Champion Teams come together for two in-person events to share best practices, share challenges and solutions, and learn key information such as state minor consent and confidentiality laws.
Completion of ACE-AP process	• Baseline, year-end assessment	Champion Teams complete baseline and year end assessment with AHI coach. Sites develop implementation plan based on results and data collected to work on throughout process. Sites participate in ongoing check-in calls with coach.
Participation in provider and staff training opportunities	• Core contents/Sparks	Champion teams lead Spark Mini trainings on topics related to adolescent-centered care at their sites. Teams also participate in 3 distance learning Core Content modules.
Certification	• Sites that meet all certification requirements become Certified Adolescent Centered Environments by AHI	AHI Coach will determine eligibility.

Evidence of Effectiveness (e.g. Evaluation Data)

Four cohorts of health centers in Michigan and Wisconsin have completed the Adolescent Champion model. Pilot study results, published in the Journal of Pediatrics, highlight how the model successfully drove change. Adolescent patients' perceived experience with both their provider and the health centers overall significantly improved from baseline to year-end across every survey measure, and this improvement was consistently sustained at one-year follow-up. For example, adolescents noted an improvement in their provider asking about physical and mental health ($p<0.001$), explaining things in a way they could understand ($p<0.001$), increased honesty with their providers ($p=0.004$), and improved knowledge of confidential health services ($p<0.001$).

Providers and staff improved attitudes and practices around caring for adolescents, including improved knowledge of minor confidentiality laws ($p<0.001$), increased approval of these laws ($p<0.001$), increased percent of well visits with time alone with the adolescent ($p=0.001$), and increased use of a confidential risk screening tool ($p<0.001$). The requirement of needing to fulfill maintenance of certification (MOC) activities for physician licensure was utilized to help

implement practice-based QI processes. Published results from AHI's complimentary customized MOC Part IV project increased confidential time with patients during well visits, ($p=0.001$), increased frequency in which minor consent laws are explained to patients($p<0.001$), and improved provider confidentiality assessment scores ($p<0.001$). Finally, by the end of the of the intervention, according to self-assessment, over 90% of Champion sites had implemented the following: screening for STIs following national guidelines, creating a standardized workflow for reviewing immunizations, routinely screening for behavioral health symptoms, encouraging adolescents to receive the HPV vaccination, screening for overweight and obesity, prioritizing annual well visits, and counseling patients on nutrition.

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Replication

At the time of writing AHI has worked with 61 health centers on the Champion Model across Arizona, Colorado, Michigan, Texas, and Wisconsin, reaching over 300,000 adolescents, to improve their care of adolescents and young adults (ages 12 - 25).

Section II: Practice Implementation

Internal Capacity

A cohort of 4-10 clinical sites is needed to replicate the model. Sites must be in the same state and close enough to convene for two in-person summits. Each site need a dedicated team of 3-5 personnel committed to working 1-4 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 Champion Teams partner with personnel at the clinical site who are not on the team as well as with youth-serving resources in the community.

Practice Cost

Cost of Champion Model implementation varies based on factors such as number of participating clinics, availability of local organization to share coordination efforts, travel expenses, and availability of local clinical consultant. Please contact AHI (information below) for details on pricing.

Practice Timeline

Practice Timeline				
Phase	**Description of Activity**	**Date/Timeframe**	**# of hours needed to complete/ oversee activity**	**Person(s) Responsible**
Baseline Data Collection	Collection of 50 adolescent patient satisfaction surveys	3 months	2 hours total	Champion Team, key data collection point person
	Collection of staff and provider knowledge and attitude surveys			
	Collection of Clinic information tool including adolescent HEDIS measures and quality data			
Implementation	Participation in Summits	Twice over course of intervention	7-14 hours total	Champion Team
	Completion of Core Contents and Spark Mini Trainings	12 months	6 hours total	
	Completion of ACE-AP process	12 months	0-2 hours per month over 12 months	
Year-end Data Collection	Collection of 50 adolescent patient satisfaction surveys	3 months	2 hours total	Champion Team
	Collection of staff and provider knowledge and attitude surveys			
	Collection of 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	Champion Team

Resources Provided

For more information, visit http://www.umhs-adolescenthealth.org/improving-care/adolescent-champion-model/

Lessons Learned

Clinics participating in the Champion Model 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 1-4 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 2 Summits and 2 check-in calls throughout the 18-month process
- Willingness to complete key program activities including Core Content Modules and Spark Trainings

Next Steps

N/A

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

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