State of California

California Department of Health Care Services Medi-Cal Managed Care Division

Adolescent Health Statewide Collaborative Quality Improvement Spread Strategy Report

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DHCS
California Department of HealthCareServices

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Purpose of Collaborative

In January 2004, the California Department of Health Care Services (DHCS), Medi-Cal Managed Care Division (MMCD) established the statewide Adolescent Health Quality Improvement Project collaborative ("the collaborative"). The collaborative formed to support the provision of quality comprehensive preventive and primary healthcare services for adolescents from economically disadvantaged families enrolled in the Medi-Cal Managed Care (MCMC) program.

The goals of the collaborative were to (1) increase annual adolescent well-care visit rates for adolescents, 12-17 years of age, enrolled in the MCMC program, and (2) to improve the quality of comprehensive health services provided to adolescents at the time of their routine and episodic health care visits.

The collaborative used The Healthcare Effectiveness Data and Information Set (HEDIS®)[1] measure for *Adolescent Well-Care Visits* to determine the annual adolescent well-visit rate for each health plan. A modified version of the *Adolescent Report of Well Visit* survey, developed by the Division of Adolescent Medicine, University of California, San Francisco (UCSF), was used to collect post-visit information from adolescents about the content of their comprehensive well-care visit. The targeted age range for this consumer-based survey was extended early in the project to include adolescents who were 11-18 years of age, which allowed for inclusion of all enrolled members in sixth through twelfth grades.

Implementation of a strategy for spread and sustainability of best-practice interventions is a key component of the quality improvement collaborative process. The purpose of the MMCD Adolescent Health Collaborative change "spread" process was to gradually extend project interventions throughout health plan primary care provider networks after the structured collaborative group ended. This report describes each phase of the collaborative project and the timeline and procedures used by plans to implement the collaborative change spread process.

[1] HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA, 2008).

Project Phases

Table 1, below, provides an overview of the strategy used by plans to implement the collaborative project's change spread process.

Table 1: Adolescent Health Quality Improvement Project Spread Strategy Overview

Adolescent Health Quality Improvement Project Spread Strategy Overview
Objectives Established • Increase rate of annual adolescent well-care visits • Improve quality of comprehensive health services provided to adolescents
Phase One • Perform root cause analysis to identify barriers • Identify adolescent medicine faculty consultants • Establish measures and evaluation procedures • Recruit provider sites • Recruit individuals willing to champion change within each participating plan • Identify interventions
Phase Two • Implement pilot • Perform adolescent survey baseline measurement • Implement regional Train-the-Trainer learning sessions • Conduct health plan survey interim measure • Perform adolescent survey re-measurement
Phase Three • Plans spread skills-based learning sessions to other network PCP
Project Completed and Collaborative Disbands • Plans continue spreading the comprehensive adolescent healthcare quality improvement process throughout the network to other/all primary care providers of healthcare services for adolescents

Phase One

The focus of Phase One was improving rates for the *Adolescent Well-Care Visits* HEDIS® measure. Plans individually completed root cause analyses to identify barriers that caused or contributed to the generally low

statewide rates for completion of well-care visits among adolescents. A variety of analytical approaches were used to identify barriers related to adolescent beneficiaries, network providers, internal systems, and community issues. Examples of barrier assessment strategies included hosting face-to-face teen focus groups, facilitating provider discussion groups, and distributing consumer satisfaction and/or service usage surveys to adolescents, parents, and/or providers. Barriers to care identified by root cause analyses formed the basis for developing improvement strategies and implementing plan-specific interventions.

Most plans implemented multi-level interventions such as informing PCPs about reimbursement procedures for annual adolescent well-care visits, publishing articles about adolescent health in provider and member newsletters, sending "reminder" birthday cards to adolescents who had not received a well-care visit during the previous 12 months, and providing incentives (*e.g.,* movie tickets) to adolescents for completing their well-care visit. The intent of each intervention was to increase the number of enrolled adolescents that received an annual comprehensive well-care visit. Other innovative interventions included a "Back-to-School" campaign hosted by CalOptima Health Plan for adolescent members and monthly raffles for a bicycle and helmet donated by local businesses sponsored by Central Coast Alliance for Health for its adolescent members who had completed their annual well-care visit.

Phase Two

Phase Two consisted of several strategies to improve the quality of the comprehensive adolescent well-care visit provided at PCP sites. The first strategy was a nine-week pilot in which three health plans (Anthem Blue Cross of California, Health Plan of San Joaquin, and Partnership Health Plan) volunteered to distribute the 45-question adolescent consumer survey, *Adolescent Report of Well Visit.* English and Spanish surveys were administered to adolescents enrolled in Medi-Cal managed care after their well-visit at four volunteer PCP sites. These sites included a school health clinic, a Planned Parenthood clinic, a public health clinic, and a private practice clinic. Because the results piloting the survey with adolescents enrolled in Medi-Cal Managed Care at these sites were very similar to the results of a previous study conducted by UCSF at Northern and Southern California Kaiser Permanente sites, the survey was deemed an appropriate measure for all enrolled MCMC adolescent members.

In February 2005, plans recruited participants for the project from various practice types and sizes within their provider networks, most of which were high-volume primary care providers of adolescent health services. For this collaborative strategy, plans conducted a four-month statewide baseline measure using the *Adolescent Report of Well Visit* to survey adolescents about the health care they received at each of the participating provider sites. Delmarva, the External Quality Review Organization for the Medi-Cal Managed Care program[2], used a 12-month average of adolescent enrollment data to calculate the number of surveys

[2] Federal law requires each state's Medicaid managed care organization contract with an EQRO to provide independent evaluation as to whether the care and service delivered by Medicaid-contracted health plans meets the federal standards for quality, access, and timeliness.

plans needed to collect in each county from their participating providers. Delmarva analyzed the consumer survey data and provided baseline results to plans and DHCS prior to the rollout of three regional DHCS-sponsored skills-based train-the-trainer learning sessions held in Oakland, Orange, and Los Angeles in September 2005.

For the third strategy, nationally known clinical experts in adolescent health medicine served as faculty consultants and developed the training curriculum and modules for the skills-based train-the-trainer learning sessions. Faculty consultants were Janet Shalwitz, M.D., Adolescent Health Working Group, Inc.; Charles Irwin, M.D. and Elizabeth Ozer, Ph.D., University of California, San Francisco; and Paula Duncan, M.D. University of Vermont School of Medicine, American Academy of Pediatrics, and National Initiative for Children's Healthcare Quality. The underlying theme of the learning sessions was the importance of provider knowledge about and skills with adolescents, and the implementation of adolescent-friendly practices on site. Each plan selected one or more "Champions of Change" to attend the learning sessions. (See Appendix 1: Qualities of an Adolescent Health Champion.)

Didactic presentations included topics such as adolescent growth and developmental phases, assessment of adolescent behavioral risks and practical strategies for adolescent-friendly practices. Skills-based sessions included demonstrations by the faculty team on informing adolescents about confidentiality, conducting interactive interviews, imparting "key" health messages and providing "brief" anticipatory counseling based on assessment of the adolescent's individual positive assets. Champions practiced new skills with a group of youthful actors from the Kaiser Children's Theater - Northern, California who portrayed the role of adolescent beneficiaries.

Adolescent health champions facilitated skills-based continuing education courses or on-site learning sessions for participating providers throughout Fall/Winter 2005/2006. Approximately 350 primary care providers from 130 sites participated in the collaborative project. Additionally, some plans were able to implement the 14-question "postcard" interim survey to assess provider uptake of new skills prior to the *Adolescent Report of Well Visit* re-measurement period in February 2006. However, due to the timing of provider training schedules, some plans were not able to complete the interim postcard survey prior to initiating the survey remeasurement with adolescents. During each survey period (baseline and re-measurement), approximately 1,700 adolescents were surveyed about the healthcare services they received at their routine well-care visits. Additionally, at the conclusion of the remeasurement process, another limitation tied to an unexpectedly high number of disqualified surveys (19%), may have contributed a decrease in reliability of the numbers for some indicators. Results of the survey remeasurement revealed that, although all adolescents enrolled in the Medi-Cal Managed Care program are expected to receive a comprehensive assessment at their annual routine healthcare visits, adolescents reported having received a comprehensive risk screening at a rate of approximately 61 percent.

Phase Three

Phase Three, conducted in 2006-2007, consisted of spreading strategies from the skills-based learning sessions to other network primary care providers who had not participated in the initial collaborative training program. The Institute for Healthcare Improvement defines "spreading a change" as the science of taking a local improvement, intervention, idea or process and disseminating it across a system, which means disseminating the change beyond the pilot site or initial participants (IHI Breakthrough College Series, 2005). During this phase, plans provided the skills-based learning session(s) to a minimum of five additional providers of adolescent health primary care services. The spread process also included a baseline assessment of these providers, re-measurement processes to determine the effectiveness of the learning session intervention with the new providers, and providing data sharing and feedback to providers. The strategic spread plan action steps and timelines are shown in Table 2.

Table 2: Spread Strategic Plan Action Steps and Timelines

Action Step	CDHS	DFMC	Plans	PCPs	Timeline
Determine "spread" strategy/process	✓	✓	✓		Sept/Oct 2006
Disseminate "Spread Strategic Plan" to plans		✓			Nov 2006
Determine criteria/process for selecting other providers			✓		Nov/Dec 2006
Select, notify, and recruit five or more new providers			✓		Nov/Dec 2006
Schedule periodic all-plan teleconferences	✓				Periodic
Perform baseline measurement for one month (*i.e.*, postcard survey, chart review, administrative data analysis, or other), analyze results and provide feedback to providers			✓		Nov 2006-Jan 2007
Conduct Adolescent Health Learning Session(s) with new providers			✓		Nov 2006- Feb 2007
HEDIS® *Adolescent Well-Care Visits* (per usual schedule)			✓		Jan-May 2007
Perform Re-measurement for three consecutive months (*i.e.*, postcard survey, chart review, administrative data analysis, or other), analyze results, and provide feedback to providers			✓		Jan-May 2007
Provider responsibilities • Participate in baseline measure process outlined by plan • Attend provider learning session(s) • Implement learning session strategies on site • Participate in re-measure process outlined by plan				✓	Nov/Dec 2006 Dec 2006/Jan 2007 Dec 2006-Mar 2007 Feb-May 2007

Adolescent Health Collaborative Change Spread Procedure

The change spread module was developed as a collaborative workgroup process that included the DHCS, Delmarva, adolescent health faculty consultants and representatives from each of the health plans. The objective of the module is to provide health plan staff with a practical step-by-step procedure to implement the spread change process with network providers. The module also provides tools for conducting the adolescent health postcard survey and the medical record review. These tools are included under Appendices in the back of the report to facilitate the continuation of this work by health plans.

Change Spread Modules

Appendix 1 – Health Champions

Qualities of an Adolescent Health Champion

Appendix 2 – Spread Procedures

Change Spread Procedures and Frequently Asked Questions

Appendix 3 – Postcard Survey

Information for Providers and Frequently Asked Questions

Adolescent Health Postcard Survey – English

Adolescent Health Postcard Survey – Spanish

Monthly Report of Activity

Appendix 4 – Medical Record Review

Information for Providers and Frequently Asked Questions

Adolescent Health Focused Medical Record Review

Change Spread Evaluation

Delmarva distributed an online survey to all Medi-Cal managed care health plans for evaluation of the change spread strategies that were implemented during the year. (See Appendix 5: Adolescent Collaborative Spread Year – Evaluation Survey.)

Data Findings

The findings below were taken from the online "Spread" Evaluation Survey sent by Delmarva to all Medi-Cal managed care health plans.

Strategic Plan for Quality Improvement Spread

The survey asked various questions regarding elements of effectiveness of the Strategic Plan for Quality Improvement Spread (QI Spread Strategy). Overall, the plans responded positively to the QI Spread Strategy's instructions, design, and tools. However, response to survey questions about the practicality of the QI Spread Strategy's actions steps and timelines rated lower.

Table 3: Summary of Plans' Assessment of Quality Improvement Spread Strategy

Plans' Assessment of Quality Improvement Spread Strategy	Yes
Instructions were clear, understandable and sufficiently detailed	85%
Strategy assisted with developing and implementing spread strategies	65%
Implementation tools were useful and user-friendly	60%
Action steps and timelines were practical for organizing and accomplishing spread plan activities (see Table 2 for steps and timelines referenced)	35%

Using Champions for Quality Improvement Spread

During the spread year, adolescent champions were primarily physicians (~59%) and, more specifically, pediatricians (~28%). Nurse practitioners/registered nurses working with general/family practice physicians (~19% each) were also included as champions for changes.

Adolescent champions were selected from among health professionals within the plan 28 percent of the time. Community clinics, private practice, and county public health agencies provided more than 50 percent of the spread-year champions, possibly indicating the importance of individuals that work closely with adolescents serving as champions for change.

More than half of the spread-year adolescent champions were involved in training sessions, served as quality improvement champions at the practice site, and/or worked directly with adolescents and/or their parents. Champions tended to participate in activities that most affected the champion's own practice or physician group.

The tables that follow provide a detailed breakdown of the plans' responses to specific survey questions about adolescent champions (bolded and in quotations above each table).

"Our selected adolescent health champion(s) for the spread year activities included the following: (Select all that apply.)"

Adolescent Health Champion	% of Survey's 20 Respondents
Pediatrician	28.3%
General / Family Practice Physician	18.9%
Nurse Practitioner / Registered Nurse	18.9%
Health Educator	13.2%
Other	9.4%
Adolescent Medicine Physician	5.7%
Internal Medicine Physician	5.7%
Behavioral /Mental Health Counselor or Specialist	0%
Social Worker	0%

"The adolescent health champion(s) are from the following settings: (Select all that apply.)"

Settings from which Champions were Selected	% of Survey's 20 Respondents
Responding Plan [Managed Care Organization]	27.9%
Community Clinic	20.9%
Private Practice	18.6%
County Public Health Agency	14.0%
Other	7.0%
School-based Clinic	4.7%
University / College / Learning Institution	4.7%
Hospital	2.3%
Mental Health Agency	0%
Retired	0%
Another Plan [Managed Care Organization]	0%

"The adolescent health champion(s) supported our quality improvement project during the spread year in the following ways: (Select all that apply.)"

Quality Improvement Activities of Champions	% of Survey's 20 Respondents
Facilitated/participated in training sessions for participating network providers	17.6%
Served as the champion for quality improvement changes on his/her practice site	15.4%
Worked directly with adolescents and/or their parents	15.4%
Attended Medi-Cal Managed Care Division's 1-day train-the-trainer learning session	12.1%
Served as expert consultant to plan staff on adolescent health issues	8.8%
Served as expert consultant to network providers	7.7%
Worked to develop practice guidelines, referral systems, documentation tools, etc.	6.6%
Advocated for coordination and provision of quality adolescent health services to local healthcare agencies, school groups, community groups, etc.	5.5%
Wrote articles for provider or member newsletter or other publications	4.4%
Other	4.4%
Facilitated/participated in focus groups (provider, adolescent, parent, etc.)	2.2%

Using Learning Sessions for Quality Improvement Spread

The plans offered skill-based learning sessions to new providers during the spread year to increase their effectiveness in providing comprehensive health care to adolescents. High-volume providers of adolescent services and community/public health clinics accounted for over 60 percent of the new providers participating in the learning sessions during the spread year. Professional staff (non-physicians and non-medical directors) members from the plans made up 45 percent of the learning session trainers during the spread year. Almost 88 percent of the learning session trainers were from either the plan or plan's provider network. Trainees attending the learning sessions were fairly evenly split among physicians, non-physician healthcare providers, clinic managers, and front and back office staff.

The spread year survey results showed that topics new providers were most interested in were: confidentiality and minor consent; counseling on key health messages for adolescents; and comprehensive screening and assessment for adolescents (in that order). The format for the training sessions preferred by providers were individual onsite training sessions or sessions with participating providers/groups (during the spread year). Didactic and computerized/electronic training programs were infrequently used as training session formats. Insufficient provider/staff resources and staff scheduling difficulties were identified as the major barrier to conducting training for adolescent healthcare providers.

The tables that follow provide a detailed breakdown of the plans' responses to specific survey questions about learning sessions (bolded and in quotations above each table).

"Which of the following best describes the *majority* of your participating new providers in the adolescent health provider learning sessions during the spread year? (Select up to 3 items.)"

Categories of New Providers Selected by Plans	% of Survey's 20 Respondents
High-volume Providers of Adolescent Services	31.6%
Community or Public Health Clinics	28.9%
Small to Medium-sized Private Practices	18.4%
Staff Model Provider Sites	13.2%
School-based and/or School-associated Health Centers	5.3%
Other	2.6%
University / Learning Institution Clinics	0.0%

"The trainers for our adolescent health provider learning sessions during the spread year included the following:"

Categories of Learning Session Trainers	% of Survey's 20 Respondents
Staff (non-medical director, non-physician) from plan [Managed Care Organization]	45.0%
Medical director or physician from plan [Managed Care Organization]	22.5%
Physician or nurse champion from plan's provider network	20.0%
Adolescent health experts or clinical specialists from local community agencies	7.5%
Medical director, physician, and/or staff from *another* plan [Managed Care Organization]	5.0%
Contracted adolescent health experts or clinical specialists from outside local area	0.0%
Other	0.0%

"Which of the following best describes your adolescent health provider learning sessions during the spread year? (Select all that apply.)"

Categories of Learning Session Attendees	% of Survey's 20 Respondents
Physicians only	18.7%
Non-physician providers	18.7%
Clinic managers	17.3%
Front office staff	17.3%
Back office staff	17.3%
Other	6.7%
Counselors, health educations, etc.	4.0%

"The new providers who participated in the adolescent health provider learning sessions during the spread year were *most* interested/enthusiastic about the following: (Select top 3 items.)"

Topics Generating Interest / Enthusiasm in New Providers	% of Survey's 20 Respondents
Confidentiality and minor consent	28.3%
Brief counseling on key health messages for adolescents	22.6%
Comprehensive screening and assessment for adolescents	11.3%
Office practice redesign for establishing teen-friendly sites	9.4%
Techniques for interactive interviewing with adolescents	7.5%
Receiving local adolescent-specific referral resources	7.5%
Adolescent strengths-based assets assessment	7.5%
Other	5.7%
Using PDSA cycles for site-specific practice quality improvement	0.0%

"Which of the following best describes your adolescent health provider learning sessions during the spread year? (Select all that apply.)"

Format of Learning Sessions	% of Survey's 20 Respondents
One individual onsite session with each participating provider/group	39.1%
One or more training sessions with some of the participating providers/groups	26.1%
Two or more individual onsite sessions with each participating provider/group	17.4%
Computerized/electronic training program	8.7%
No training sessions were held, but education materials were distributed	4.3%
One formal didactic CME training	4.3%
Didactic and/or onsite sessions done collaboratively with other plans	0.0%
Two or more formal didactic CME trainings	0.0%

"We experienced the following barriers in performing the adolescent health provider training during the spread year: (Select all that you experienced.)"

Barriers to Performing Training for the Adolescent Health Provider	% of Survey's 20 Respondents
Insufficient provider/staff resources to implement strategies	23.3%
Difficulty scheduling time with provider/site staff	23.3%
Other	16.3%
Problems with accessing champions to assist with trainings	9.3%
Insufficient plan [Managed Care Organization] resources to conduct trainings	9.3%
Attitude/unwillingness of provider/staff regarding making changes in office practice	9.3%
Lack of provider/site staff interest	7.0%
No barriers experienced	2.3%
Plan [Managed Care Organization] training staff felt unprepared to conduct trainings	0.0%
Lack of plan [Managed Care Organization] support at administrative/management level	0.0%

Methodologies Used to Assess and Communicate Results

Methodologies used by plans to evaluate the content of the comprehensive adolescent well visit were administrative data analyses, focused chart reviews, or brief postcard surveys of adolescents. To inform new providers of their evaluation results, plans shared results with individual providers during site visits and presented aggregate results at meetings with participating providers.

The tables that follow provide a detailed breakdown of the plans' responses to specific survey questions about methodologies and communication (bolded and in quotations above each table).

"What methodology did your plan use to assess the content of comprehensive adolescent well visits prior to and after implementing the adolescent health provider learning sessions during the spread year?"

Methodologies Used by Plans to Assess Adolescent Well Visits	% of Survey's 20 Respondents
Administrative data analyses	33.3%
Focused chart review	29.2%
Postcard survey	25.0%
Other	12.5%

"What methods did you use to inform new providers of their assessment results? (Select all methods used)"

Methods Used by Plans to Inform New Providers of Evaluation Results	% of Survey's 20 Respondents
Shared results with individual providers during site visits	24.1%
Presented summary of results at meeting(s) with participating providers	24.1%
Other	13.8%
Sent information to participating providers electronically	10.3%
Sent hard copies of printed material to participating providers by mail	6.9%
Presented summary of results at general meeting of network providers	6.9%
Disseminated information in provider newsletter or bulletin	6.9%
Did not share assessment results with participating providers	10%

"With the completion of spread year activities, the next steps for my MCO [Managed Care Organization] over the next year will include:"

Next Steps Identified by Plans	% of Survey's 20 Respondents
Developing a plan to assess impact of quality improvement strategies on HEDIS® rates	48.4%
Developing a formal long-term plan to continue to spread the quality improvement strategies taught at the adolescent health provider learning sessions across the provider network	25.8%
Develop a plan to assess whether current participating providers have sustained strategies for working with adolescents members	12.9%
Implementing our formal plan to further spread the adolescent health trainings to other network providers	6.5%
Other	6.5%

Conclusion

The *Adolescent Well-Care Visits* HEDIS rate is currently one of the measures associated with the MMCD pay-for-performance enrollment assignment default algorithm. The implementation of plan-specific interventions that target getting adolescents in for their annual comprehensive well-care visit has been an ongoing part of the MMCD adolescent Health Collaborative project. In the Quality Improvement Spread Survey over 48 percent of the plans reported developing additional strategies to assess the impact that project quality improvement strategies made on their HEDIS rates. DHCS will continue to follow and trend for increasing and sustained improvements through monitoring the annual HEDIS external accountability data set established for the MCMC Program.

Medi-Cal managed care health plans are encouraged to continue the work started during the statewide MMCD Adolescent Health Collaborative in improving the quality of primary care services provided to adolescent members. Several best practices were identified during the project, including the importance of seeking input about the services provided directly from adolescents, providing skills-based training sessions for providers, implementing interventions that promote adolescent-friendly provider sites, providing individual academic detailing learning on sites, use of "champions of change" to promote key strategies, and providing assessment and informational feedback method for providers.

Although the statewide Adolescent Health Project has formally ended, the adolescent health change spread strategy module is included in this report.

Appendix 1
Qualities of an Adolescent Health Champion

Medi-Cal Managed Care
Adolescent Health Quality Improvement Collaborative

Qualities of an Adolescent Health Champion

"If you don't have a project champion, you don't have a project."
(Axiom in project management circles)

Adolescent Health Champions (of Change):

☑ know what is going on in adolescent health, but do not assume everyone else does.

☑ are publicly committed to adolescent health, and inspire others with their dedication and enthusiasm.

☑ are proactive communicators who pull others in ever more closely, constantly soliciting their ideas and hearing their concerns.

☑ promote, support, advocate for and grasp the benefits of providing quality health services to adolescents.

☑ are change managers who act as conduits to the "end-use" community.

☑ have a vision of the overarching MMCD adolescent health project with all its complexities and are able to keep the end result in mind at all times.

☑ are "work-with" people and can lead initiatives that influence others to perform differently and better than expected.

☑ use problem solving, planning, and organizing skills to handle obstacles with patience and understanding, help overcome resistance, clear red tape and neutralize organizational politics, and still carry on championing.

☑ acknowledge the likelihood of being met by silence, confusion, criticism, denial, discord, thoughts of sabotage, easy superficial agreement, deflection – none of which deters them.

☑ do not interfere once they have handed down the work, but are always there – ready to communicate, listen, and support.

☑ are role models for gaining new Adolescent Health Champions.

(**Adapted from: "*Champions Wanted to Drive Training Initiatives*", Moira Kats and Marietta van Rooyen).**

Appendix 2
Quality Improvement Change Spread Module

Medi-Cal Managed Care
Adolescent Health Quality Improvement Collaborative

Quality Improvement Change Spread Procedure

Change Spread Procedure

Each health plan will:

1. Determine criteria/process to identify a minimum of five (5) additional new providers who did not previously participate in the project.
2. Select, notify, recruit and inform the new providers. (Plans may collaborate with shared providers.)
3. Determine an interim measure process to assess content of comprehensive adolescent well visit prior to and after implementing the provider skills-based learning session with new providers.
   a. Conduct a "baseline" assessment for a one-month period *prior to* implementing provider skills-based learning sessions, such as:
      - postcard survey: provide supplies to the provider and site staff (Information for Providers, pre-printed postcard surveys, envelopes, collection container, etc.); or
      - focused chart review: appointment date/time; or
      - administrative data analysis: determine methodology and implement process; or
      - other interim measure.
   b. Conduct interim "re-measure" assessment, using the same methodology used for the baseline measure, over a three-month period after completing the provider skills-based learning sessions.
   c. Collect and analyze baseline and re-measure results, identify areas of interest for presentation, and implement a process for timely presentation of information to providers (Table 2).
   d. Serve as an informational contact resource for providers throughout the spread change process.

Table A2-1: Potential Areas for Postcard Survey Evaluation

Adolescents	Providers	Office Practices
• differences by age • differences by gender • differences by race/ethnicity	• results range(high/low outliers) • strengths(*e.g.*, survey items most covered or documented) • areas for improvement?(*e.g.*, survey items least covered) • differences by provider type • differences by practice type	• use of health questionnaire (*e.g.*, Staying Healthy) • adolescent's private time with provider (without parent)

4. Implement adolescent health skills-based learning sessions with new providers (*e.g.,* CME/CEU courses and/or individual on-site "academic detaining" sessions).
5. Complete Adolescent Well-Care HEDIS® measure per NCQA specifications and DHCS schedule.
6. Continue the comprehensive adolescent health QI spread process throughout the provider network to all primary care providers of healthcare services for adolescents.
7. Continue to survey adolescents regularly about the primary health care services they receive and provide ongoing informative feedback to providers.

Frequently Asked Questions

Why is interim measurement necessary?

The purpose of interim measurement in the quality improvement process is to determine as early as possible whether an intervention is effective or not. Needed adjustments can be made in the intervention prior to the performance of a key measure of significance (*e.g.*, HEDIS®). For this project, the interim measure will be conducted in conjunction with spreading the adolescent health skills-based learning session to additional providers. If interim measure results show that providers are not improving in the performance of the intended standard (completion of annual comprehensive adolescent well care visits), then other interventions (*e.g.*, providing additional user-friendly screening assessment or documentation tools, site staff training) may be implemented prior to conducting the key measure.

Are the timelines for this spread strategy absolute?

No. The timelines listed are general guidelines. Some plans have already assessed their selected providers and were ready to begin provider visits in November 2006, while others have decided to conduct the interim baseline measure and skills-based provider learning sessions at a later time. While plan-specific implementation schedules will vary, plans will have from November 2006 through May 2007 to complete all activities related to this round of spread change strategies. However, all spread interim re-measurement activities must be completed prior to the end of May 2007.

Can plans add other questions to the postcard survey and chart review templates?

Yes. Plans may choose to add other items (*e.g.* BMI, Chlamydia screening) to the interim measurement templates. These tools are designed specifically for use by plans to gather information relatively quickly about an intervention that has been implemented and to assist in organizing feedback for providers about the intervention. Remember to add any additional survey questions to the Spanish survey as well.

Will Delmarva be analyzing the postcard surveys?

No. Neither Delmarva nor DHCS will be analyzing the interim measure data for the adolescent health spread strategy. This module is designed so that plans can collect and analyze their own data. Each plan will collect, analyze and summarize the data, and develop brief reports/presentations for their participating providers for whatever interim measure data collection method is selected for use. If the postcard survey is selected as the interim measure, plans may choose to have providers send the collected surveys directly to the plan or a plan representative may arrange to pick up the surveys on site. ***Do not*** send surveys to Delmarva or to DHCS.

How many postcard surveys need to be collected during the baseline and re-measure processes?

There is no set amount for number of surveys required. Plans may choose to collect 5, 10, or more surveys per month from adolescents for each participating provider. The key point is to collect a sufficient number of surveys to be able to provide adequate information to participating providers.

Appendix 3
Adolescent Report of Health Visit - Postcard Survey

Medi-Cal Managed Care
Adolescent Health Quality Improvement Collaborative

Adolescent Report of Health Visit - Postcard Survey

Information for Providers

Congratulations on being selected for participation in the Medi-Cal Managed Care (MCMC) Adolescent Health Quality Improvement Project. We welcome you as a partner in this statewide collaborative process which addresses the needs of primary care providers in providing quality healthcare services to adolescents. Your participation in the project will include:

1) attending the Adolescent Health Learning Session provided by **health plan name**; and
2) collecting *Adolescent Report of Health Visit* postcard surveys during a one-month period from **ten (10)** adolescents, ages 11-18 years, who are enrolled in the MCMC program and completed a routine well-care or comprehensive episodic care visit within the past **state the timeframe**; and
3) collecting *Adolescent Report of Health Visit* postcard surveys after attending the learning session for consecutive three months, from to **ten (10)** adolescents each month who completed a routine well-care or comprehensive episodic visit during the previous month.

Frequently Asked Questions

What are the dates for this process to begin and end?

The one-month baseline *Adolescent Report of Health Visit* postcard survey collection will begin **(add date)**.
The Adolescent Health Learning Session will be scheduled with you on **(add date)**.
The 3-month re-measurement *Adolescent Report of Health Visit* postcard survey will begin **(add date)** and end **(add date)**.

What will I need to participate in the project?

A "project kit" that has all the materials and instructions will be provided to you. The project kit contains:

1) MMCD *Adolescent Report of Health Visit* Postcard Survey Information for Providers.
2) MMCD *Adolescent Report of Health Visit* postcard surveys in English **and Spanish**.
3) Envelopes that can be sealed – (should equal the number of surveys provided).

4) Monthly Report Sheets.
5) Pre-addressed and pre-stamped envelopes.

Who should the survey be given to?

Give the survey to adolescents, 11-18 years of age, who are enrolled in Medi-Cal Managed Care and have competed a well-care visit.

Do I hand surveys out to adolescents who are too sick to complete the survey?

It is up to the provider's discretion whether to give a survey to an adolescent who comes in for an episodic or urgent care visit. Providers may choose to survey the adolescent if a comprehensive assessment and health counseling was done and if the adolescent is not too ill to complete the survey.

Do I hand surveys out to adolescents who are seen only for sexually transmitted infections in a public health setting?

No, the adolescent needs to have had a health care a visit in which a comprehensive assessment and health counseling/education was done.

What should I do to prepare for survey distribution to adolescents?

Before the health-care visit:

- Identify staff person(s) who will inform/instruct adolescent about completing the survey.
- Determine which adolescents being seen that day should get the survey.
- Write or stamp the name of the provider seeing the adolescent on the survey (if not already done).
- Make sure postcard surveys and a pen/pencil are readily available.
- Set up drop location/container for completed surveys (near the discharge window works best).

What should I say to the adolescent about completing the survey?

After the health-care visit:

- Use a friendly approach to inform the adolescent about the brief survey. *Example:*
  "We are working to improve our care and services to young people. Your healthcare experience is valuable to us in making those improvements. We would like you to complete a brief survey about your health care visit today. This survey is confidential and anonymous. Answer all questions by marking either the "Yes" or the "No" box. It should take about 2-3 minutes."
- Give the postcard survey and a pen/pencil to the adolescent.
- Provide him/her with a private place to complete the survey.
- Instruct the adolescent to answer all questions.
- Remind the adolescent to ask for help/assistance if any questions are not clear.

- Ask him/her to seal the completed survey in the envelope and place it in the designated collection box/receptacle or to hand it to staff.
- Thank the adolescent for his/her assistance. Provide small incentive, if any.

Does the collection box have to be locked?

No. We recommend that it be placed in a confidential place at the end of every day and be returned near the discharge area at the beginning of each office/clinic day.

What is the purpose of the monthly report sheet?

This sheet helps to determine the accuracy of the response rate. There is a section at the bottom of the sheet to tally the number of surveys you hand out and the number of surveys that are refused or not returned by adolescents.

How do I distribute and collect surveys for more than one health plan?

The process is the same, but you will need to make sure the survey handed to the adolescent corresponds to their health plan insurance carrier. Plans may have pre-stamped the survey tool with their plan name. For this reason, only give a pre-stamped survey to an adolescent from the plan in which he/she is an enrolled member. Prior to giving a survey to an adolescent, and if not already done write the plan's name and the name of the provider the adolescent visited that day in the space on back of the postcard survey. As long as each survey is properly labeled, all surveys can be collected in one box/receptacle.

What do we do with the monthly reports and returned surveys?

At the end of the month, open the collection container and count the number of surveys that were returned. Complete the form, and follow the instructions provided by the health plan for routing the sealed survey envelopes back to health plan.

If I have questions and/or need more materials, who do I call?

Someone from the health plan should be contacting you regularly, but do not hesitate to call the health plan request more envelopes, surveys in a specific translation, and/or monthly report sheets, or if you have questions at anytime during the project.

Appendix 3A
Adolescent Health Visit Postcard Survey - English

ADOLESCENT HEALTH POSTCARD SURVEY

◊◊◊◊◊◊ ◊◊◊◊◊◊ ◊◊◊◊◊◊

Help us improve our healthcare services! This questionnaire is about the health care visit you had today.
Circle "Yes" or "No" for *each* question. Your answers are confidential and anonymous.

Your Age _____ Your Sex: (circle one) M F Your Grade (in school) _____ Today's Date _____

Your ethnic background: (Circle all that apply)

a. African American/Black b. Asian/Pacific Islander c. Hispanic/Latino d. White-not Hispanic e. Other_____

1. Did your doctor ask you about information that you put on your health questionnaire?	Yes	No
2. Did you have some time with your doctor *without your parent*?	Yes	No
3. Did your doctor explain to you that there were certain things s/he *would not* tell your parents about?	Yes	No
4. Did your doctor ask if you smoke or chew tobacco?	Yes	No
5. Did your doctor ask if you drink alcohol?	Yes	No
6. Did your doctor ask if you have ever used drugs?	Yes	No
7. Did your doctor ask if you ever had sex?	Yes	No
8. Did your doctor ask you if you use a seatbelt when riding in a car?	Yes	No
9. Did your doctor talk to you about how much physical activity you do?	Yes	No
10. Did your doctor talk to you about eating nutritionally balanced meals?	Yes	No
11. Did your doctor ask you about the important adults in your life?	Yes	No
12. My doctor and I did not discuss some of the above topics because we spent most of the visit discussing one of my questions or concerns.	Yes	No
13. I did not feel comfortable discussing something with my doctor during this visit because_____ _____		
14. [Space reserved for plans to add any question they desire that would help with rapid-cycle improvement.]		

Adapted from survey developed by the Division of Adolescent Medicine, University of California, San Francisco, 2001.

POSTCARD BACK

Provider / Site Name

Appendix 3B
Adolescent Health Visit Postcard Survey - Spanish

ENCUESTA DE SALUD PARA ADOLESCENTES

◊◊◊◊◊◊ ◊◊◊◊◊◊ ◊◊◊◊◊◊

¡Ayúdanos a mejorar nuestros servicios de salud! Este cuestionario es acerca de la visita que tuviste hoy.

Por favor, encierra en un círculo "Si" o "No" a *cada* pregunta. Tus respuestas serán confidenciales y anónimas.

Edad: _____ Tu sexo (circular uno): Masculino Femenino Grado escolar _____ Fecha de hoy: _____

¿Cómo te identificas? (Circula todo lo que te corresponda)

a. Afro-norteamericano o negro b. Asiático/Hawaiano o isleño del Pacífico c. Mexicano o mexicano-americano

d. Blanco no hispano e. Otro (describe) _____

1. Durante tu visita al médico, ¿te hizo preguntas sobre la información que pusiste en el cuestionario de salud?	Sí	No
2. ¿Tuviste tiempo con tu médico sin la presencia de tus padres?	Sí	No
3. ¿Te explicó tu médico que hay ciertas cosas que no le dirá a tus padres?	Sí	No
4. ¿Te peguntó tu médico si fumas o mascas tabaco?	Sí	No
5. ¿Te preguntó tu médico si tomas alcohol?	Sí	No
6. ¿Te preguntó tu médico si alguna vez has usado drogas?	Sí	No
7. ¿Te preguntó tu médico si has tenido relaciones sexuales?	Sí	No
8. ¿Te preguntó tu médico si usas el cinturón de seguridad cuando vas en carro?	Sí	No
9. ¿Te habló tu médico sobre la cantidad de actividad física que realizas?	Sí	No
10. ¿Te habló tu médico sobre comer comidas balanceadas y nutritivas?	Sí	No
11. ¿Te preguntó tu médico sobre los adultos importantes en tu vida?	Sí	No
12. Mi doctor y yo no hablamos sobre algunos de los temas que se mencionan arriba porque pasamos la mayor parte del tiempo de la consulta hablando sobre una de mis preguntas o preocupaciones.	Sí	No
13. No me sentí a gusto hablando con mi doctor durante esta visita porque: _____ _____		
14. [Space reserved for plans to add any question they desire that would help with rapid-cycle improvement.]		

Adapted from survey developed by the Division of Adolescent Medicine, University of California, San Francisco, 2001.

POSTCARD BACK

Provider / Site Name

Appendix 3C
Postcard Survey - Monthly Report of Activity

Medi-Cal Managed Care
Adolescent Health Quality Improvement Collaborative

Adolescent Report of Health Visit - Postcard Survey
Monthly Report of Activity

Provider sites:

1. Complete sections A, B, and C.
2. Section C: Use the tally section to keep count of the number of surveys handed out to Medi-Cal managed care adolescents.
3. Each completed survey should be in a sealed envelope.
4. Place sealed envelopes and this completed report in one self-stamped manila envelope.
5. Send envelope to health plan at the address listed below monthly or as designated by your health plan contact.
6. If you want to change the process in anyway, please call your plan contact to discuss.

XXX Health Plan
Attention: Project Manager
1234 Healthcare Boulevard
Anytown, CA 94000

A. Check the survey period dates this report covers.

___ *(Collection Dates to be added by plan)*

___ *Date*

___ *Date*

B. Name of provider/site where collection occurred: _____.

C. Total number of surveys handed out to Medi-Cal managed care adolescents _____

(Tally Space)

D. Number of surveys collected in the time period marked in Section A: _____

(Note: If you are collecting surveys for more than one plan, surveys must be counted separately for each plan.)

Appendix 4
Adolescent Health Focused Medical Record Review

Information for Providers

Congratulations on being selected for participation in the Medi-Cal Managed Care (MCMC) Adolescent Health Quality Improvement Project. We welcome you as a partner in this statewide collaborative process for addressing the needs of primary care providers in providing quality healthcare services to adolescents. Your participation in the project will include:

1) attending the Adolescent Health Learning Session provided by **health plan name**;
2) scheduling an appointment prior to attending the learning session with **health plan name**, in which a focused baseline review would occur on **ten (10)** medical records of adolescent, ages 11-18 years, who are enrolled in the MCMC program and have completed a comprehensive healthcare visit within the past **state the time frame**; and
3) scheduling monthly appointments for three consecutive months after you have attended the learning session with **health plan name,** in which a focused remeasurement review would occur on **ten (10)** medical records of adolescent, ages 11-18 years, who are enrolled in the MCMC program and have completed a comprehensive healthcare visit during the previous month.

Frequently Asked Questions

What are the dates for chart review to begin and end?

The one-month baseline focused medical record review will begin **(add date)**.
The Adolescent Health Learning Session will be scheduled with you on **(add date)**.
The 3-month re-measurement medical record review will begin **(add date)** and end **(add date)**.

What will I need to do to participate in the chart review?

A reviewer from the health plan will schedule an appointment for the chart review. He/she will need a designated place on site to review records. Ten charts will be needed for the baseline and each of the remeasurement reviews. For the re-measurement review, 10 charts will be needed per month for comprehensive visits on adolescents that have been completed after you attended the skills-based learning session. If a comprehensive visit was completed during an urgent care or other non-routine visit, then these records may also be included in the focused chart review.

If I have questions, who do I call ?

Someone from the health plan should be contacting you regularly, but do not hesitate to call the health plan if you have questions at anytime during the project.
Below is a example of a checklist for an Adolescent Health-Focused Chart Review.

Medi-Cal Managed Care
Adolescent Health Quality Improvement Collaborative

Medi-Cal Managed Care
Adolescent Health-Focused Chart Review

- ☐ Physical examination
- ☐ Immunizations
- ☐ Staying Healthy (or other Behavioral Assessment)
- ☐ Tobacco Use
- ☐ Alcohol Use
- ☐ Sexual Behavior
- ☐ Physical Activity and nutrition
- ☐ BMI calculated
- ☐ BMI grafted
- ☐ Safety (e.g., seatbelt, helmet, violence)
- ☐ Sun exposure
- ☐ Mental health/depression/suicide
- ☐ Positive relationships with adults
- ☐ School participation/performance
- ☐ Participation in healthy activities
- ☐ Responsibilities
- ☐ Chlamydia Screening
- ☐ Health education
- ☐ Anticipatory counseling
- ☐ Confidentiality
- ☐ Referrals made
- ☐ Follow-up of past issues
- ☐ Other
- ☐ Other
- ☐ Other
- ☐ Other

Appendix 5
Adolescent Collaborative Spread Year Evaluation Survey

Health Plan Name: _____

Position of Person Completing: _____

1. **Our selected adolescent health champion(s) for the spread year activities included the following: (Select all that apply.)**
   - **A. Pediatrician**
   - **B. Adolescent medicine physician**
   - **C. General/family practice physician**
   - **D. Internal medicine physician**
   - **E. Nurse practitioner/registered nurse**
   - **F. Health educator**
   - **G. Social worker**
   - **H. Behavioral/mental health counselor or specialist**
   - **I. Other** _____

2. **The adolescent health champion(s) are from the following settings: (Select all that apply.)**
   - **A. Private practice**
   - **B. School-based clinic**
   - **C. Community clinic**
   - **D. County public health agency**
   - **E. Hospital**
   - **F. University/college/learning institution**
   - **G. Mental health agency**
   - **H. Our MCO**
   - **I. Another MCO**
   - **J. Retired**
   - **K. Other** _____

3. **The adolescent health champion(s) supported our quality improvement project during the spread year in the following ways: (Select all that apply.)**
   - **A. Facilitated/participated in training sessions for participating network providers**
   - **B. Served as expert consultant to MCO staff on adolescent health issues**
   - **C. Served as expert consultant to net work providers**
   - **D. Served as the champion for quality improvement changes on his or her practice site**
   - **E. Attended the DHS/MMCD 1-day train-the-trainer learning session**
   - **F. Advocated for coordination and provision of quality adolescent health services to local healthcare agencies, school groups, community groups, etc.**
   - **G. Worked directly with adolescents and/or their parents**
   - **H. Facilitated/participated in focus groups (provider, adolescent, parent, etc.)**
   - **I. Wrote articles for provider or member newsletter or other publication(s)**
   - **J. Worked to develop practice guidelines, referral systems, documentation tools, etc.**
   - **K. Other_____**

4. **How many of the adolescent health champion(s) participating in spread year adolescent health provider learning sessions as trainers/facilitators/consultants also served in this capacity at the initial adolescent health provider learning sessions?**
   - **A. All**
   - **B. 1 – 2**
   - **C. 3 – 4**
   - **D. 5+**
   - **E. None**

5. **How many of the adolescent health champion(s) participating in spread year adolescent health provider learning sessions were new trainers/facilitators/consultants that were trained at the initial adolescent health provider learning sessions?**
   - **A. All**
   - **B. 1 – 2**
   - **C. 3 – 4**
   - **D. 5+**
   - **E. None**

6. Which of the following best describes the *majority* of your participating new providers in the adolescent health provider learning sessions during the spread year? (Select up to 3 items.)
   A. High-volume providers of adolescent services
   B. Small to medium-sized private practices
   C. School-based and/or school-associated health centers
   D. Community or public health clinics
   E. University/learning institution clinics
   F. Staff model provider sites
   G. Other _____

7. The new providers who participated in the adolescent health provider learning sessions during the spread year were *most* interested/enthusiastic about the following: (Select top 3 items.)
   A. Confidentiality and minor consent
   B. Comprehensive screening and assessment for adolescents
   C. Techniques for interactive interviewing with adolescents
   D. Brief counseling on key health messages for adolescents
   E. Adolescent strengths-based assets assessment
   F. Office practice redesign for establishing teen-friendly sites
   G. Receiving local adolescent-specific referral resources
   H. Using PDSA cycles for site-specific practice quality improvement
   I. Other _____

8. The new providers who participated in the adolescent health provider learning sessions during the spread year were *least* interested/enthusiastic about the following: (Select top 3 items.)
   A. Confidentiality and minor consent
   B. Comprehensive screening and assessment for adolescents
   C. Techniques for interactive interviewing with adolescents
   D. Brief counseling on key health messages for adolescents
   E. Adolescent strengths-based assets assessment
   F. Office practice redesign for establishing teen-friendly sites
   G. Receiving local adolescent-specific referral resources
   H. Using PDSA cycles for site-specific practice quality improvement
   I. Other _____

9. The trainers for our adolescent health provider learning sessions during the spread year included the following:

A. Physician or nurse champion from our provider network
B. Our MCO medical director or other MCO physician(s)
C. Our MCO staff (e.g., quality improvement, health education, provider relations)
D. Medical director, physician, and/or staff from *another* MCO health plan
E. Adolescent health experts or clinical specialists from local community agencies
F. Contracted adolescent health experts or clinical specialists from outside of local area
G. Other _____

10. Which of the following best describes your adolescent health provider learning sessions during the spread year?
(Select all that apply.)
A. One formal didactic CME training (e.g., dinner session, formal meeting)
B. Two or more formal didactic CME trainings (e.g., dinner sessions, formal meetings)
C. One individual onsite session with each participating provider/group
D. Two or more individual onsite sessions with each participating provider/group
E. One or more training sessions with some of the participating providers/groups
F. Computerized/electronic training program
G. Didactic and/or onsite sessions done collaboratively with other MCO(s)
H. No training sessions were held, but educational materials were distributed

11. Number of different sites trained during the spread year? _____ (Fill in the number)

12. Total number of attendees at the formal didactic sessions held during the spread year?
_____ (Fill in the number)

13. Which of the following best describes the individuals that attended your provider learning sessions during the spread year? (Select all that apply to the majority of learning sessions provided.)
A. Physicians only
B. Non-physician providers (e.g., nurse practitioners, physician assistant)
C. Back office staff (e.g., clinical)
D. Front office staff (e.g., clerical)
E. Counselors, health educators, etc.
F. Clinic managers
G. Other _____

14. Which of the following best describes the level of participation at your provider learning sessions during the spread year?
(Select all that apply to the learning sessions provided.)

A. All physicians who provide services to adolescents on participating sites attended.
B. At least one physician from each participating site attended.
C. Non-physician providers (nurse practitioners, physician assistant) who provide services to adolescents on participating sites attended.
D. Back office staff (clinical) from the majority of participating sites attended.
E. Front office staff (clerical) from the majority of participating sites attended.
F. Clinic/site managers from the majority of participating sites attended.
G. The majority of sites had *all* staff in attendance (e.g., provider, non-physician providers, front and back office staff, managers).
H. Other _____

15. We experienced the following barriers in performing the adolescent health provider training during the spread year:
(Select all that you experienced.)
A. Difficulty scheduling time with provider/site staff
B. Insufficient provider/staff resources to implement strategies
C. Lack of provider/site staff interest
D. Insufficient MCO resources to conduct trainings
E. Attitude/unwillingness of provider/staff regarding making changes in office practice
F. Lack of MCO support at administrative/management level
G. Problems with accessing champions to assist with trainings
H. MCO training staff felt unprepared to conduct trainings
I. No barriers experienced
J. Other _____

16. Of all the strategies taught, we anticipate that the new practices/practitioners will most likely implement the following strategies:
A. Office redesign practices to promote an adolescent-friendly environment
B. Confidentiality practices
C. Adolescent-focused screening assessment and counseling
D. Strength-based assessments
E. Other _____
F. None of the above

17. What methodology did your plan use to assess the content of comprehensive adolescent well visits prior to and after implementing the adolescent health provider learning sessions during the spread year?
A. Postcard survey

B. Focused chart review
C. Administrative data analysis
D. Other

18. Did you include additional questions/items for analysis on the brief survey or chart review used by your plan?
A. Yes
B. No

19. What methods did you use to inform new providers of their assessment results? (Select all methods used)
A. Did not share assessment results with participating providers
B. Shared results with individual providers during site visits
C. Presented summary of results at meeting(s) with participating providers
D. Presented summary of results at general meeting of network providers
E. Sent information to participating providers electronically
F. Sent hard copies of printed material to participating providers by mail
G. Disseminated information in provider newsletter or bulletin
H. Other

20. With the completion of spread year activities, the next steps for my MCO over the next year will include:
A. Developing a formal long-term plan to continue to spread the quality improvement strategies taught at the adolescent health provider learning sessions across the provider network
B. Implementing our formal plan to further spread the adolescent health trainings to other network providers
C. Develop a plan to assess whether current participating providers have sustained strategies for working with adolescents members
D. Developing a plan to assess impact of quality improvement strategies on HEDIS rates
E. Other _____

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