



State of California



California Department of Health Services
Medi-Cal Managed Care Division

Medi-Cal Managed Care Adolescent
Collaborative Pilot Survey

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Adolescent Report of Health Visit Pilot Report

Goal of the Collaborative

Medi-Cal Managed Care Division (MMCD) and the participating Medi-Cal Managed Care (MMC) health plans are conducting a statewide Adolescent Health Collaborative to increase the rate of adolescent well care visits and improve the quality of these visits. The HEDIS adolescent well care visit indicator will be used to measure the rate of visits. The second indicator relative to the quality of the visits will be a measurement of the performance of providers in screening and counseling teens on certain risk factors.

Purpose of Pilot

Delmarva Foundation, Inc. (Delmarva) serves as the External Quality Review Organization for the California Medicaid Managed Care Division. Delmarva and MMCD developed the ARHV survey, which is a modified version of a survey tool developed by the Division of Adolescent Medicine at the University of California - San Francisco. The ARHV is designed to collect immediate post-visit information from Medi-Cal adolescents to evaluate the extent to which their provider assessed and counseled them for certain risk behaviors. Delmarva developed protocols and tools to assist MMC health plans and provider sites to collect the surveys. This report will share the results of the pilot, which sought to evaluate the survey process that was completed over a period of 10 weeks (August 26 – October 29, 2004), using the ARHV survey at various high-volume provider sites chosen by a group of volunteer MMC health plans in California.

Pilot Implementation

After a teleconference with all of the MMC health plans to share the intent of the pilot and to review the processes, an invitation was issued for volunteers. Of those MMC health plans who participate in the Adolescent Health Collaborative, three volunteered for the pilot. They were Blue Cross of California, Partnership Health Plan, and San Joaquin Health Plan. Of the four, one health plan choose two provider sites discussed later. The four provider sites included different types of settings: a school health clinic, a Planned Parenthood health clinic, a public health clinic, and a private clinic.

The Pilot Coordinator (Delmarva) called the contact at each MMC health plan to explain the processes, tools, and to provide technical assistance during the pilot. The surveys and instructions for administering them were provided to the three volunteer managed care plans. The MMC health plan representatives then recruited provider sites and commenced with instructions. The same MMC health plan staff provided technical assistance to the provider office staff during the pilot. Provider offices were asked to submit weekly reporting logs of survey activity along with sealed survey responses directly to Delmarva Foundation.

The MMC adolescents were given the surveys upon registration, and were asked to complete the survey, place in a sealed envelope and place it inside a locked box in the office. At the end of each week, provider offices were asked to submit weekly reporting logs of survey activity along with sealed survey responses directly to Delmarva Foundation for analysis. At the end of the pilot period, feedback was provided through two methods: evaluation tools and follow-up telephone calls. Delmarva contacted the MMC health plans several time during the pilot process to solicit limitations and barriers that might have been encountered with the survey process.

A special note of appreciation must be expressed to the three volunteer health plans that participated in this pilot; the clinic/office staff of the four clinics, and the enthusiastic dedication of the three health plan representatives that made this report possible.

Response Rate

Table 1: Adolescent Report of Health Visit – Pilot Response Rate

Plan	Surveys Passed Out	No Response	Responses
Blue Cross	100	60	40
HP of San Joaquin by Site*			
Stagg High School Clinic	56	3	53
Delta Health Care	12	3	9
*HP of San Joaquin- Total	68	6	62
Partnership- Planned Parenthood	8	0	8
Grand Total	176	66	110

Table 1 shows the number of surveys distributed to adolescents who were seen for health visits, number of surveys not returned, and number of completed surveys sent to Delmarva from each provider site.

San Joaquin’s school clinic distributed 56 surveys and had 53 returned for a response rate of 95%. San Joaquin’s second provider site, Delta Health Care, distributed 12, had no response for 3; therefore, had a 75%

response rate. Partnership Plan’s public health model clinic distributed 8 surveys and had 8 returned for a response rate of 100%. Blue Cross’ provider site received 100 surveys; however, information was not collected on how many surveys actually were handed out to Medi-Cal teens completing health visits.

The analysts knew that 40 surveys were completed and mailed to Delmarva. Since no surveys were remaining, an assumption was made that of the 100 delivered to the provider site, that some were distributed, some refused, and possibly some completed but did not put it in the envelope and locked box. The analyst proposed that it is possible that less than 100 surveys were handed out; therefore, the response rate of 40% is the worse case scenario.

The uncertainty of the Blue Cross response rate allows us to say that the response rate in this type of clinic is at least 40%, but it is possibly higher. The response rate for all clinic sites, assuming 100 surveys were distributed at the Blue Cross provider clinic, was 62.5%. Therefore, we can safely say that the total response rate was excellent for teens using this type of process for a survey.

Table 2: Respondents by age and gender

AGE	GENDER			Total
	Male	Female	No Response	
11		1		1
12	2	7	1	10
13	3	7		10
14	3	11	2	16
15	5	13		18
16	6	11	2	19
17	8	18		26
18	1	5		6
19		3		3
20		1		1
Total	28	77	5	110

Table 2 shows that most Medi-Cal adolescents who completed the survey were females of ages 14 to 17 years. The majority of male respondents were 17 years old.

Table 3: Respondents by ethnic background

Ethnic Background	Count
Hispanic/Latino	50
Caucasian	21
Southeast Asian	18

Ethnic Background	Count
African American	14
Other	1
Hawaiian	2
Native American	1
Not Reported	3
Total	110

Table 3 shows that of the total respondents, 46% adolescents reported they were of Hispanic/Latino origin. The second largest reported ethnic background was Caucasian at 19%.

Adolescent Feedback on the Survey Tool

Most of the adolescents thought that the survey tool was not long and easy to complete.

- Ninety-one respondents answered some or all the feedback questions regarding the survey itself. Eighty-six out of 91(94.5%) rated the survey as okay to very easy.
- The majority (70) thought there were enough questions. Seventeen thought there were too many questions and 2 thought there were not enough questions.
- Seventy-four thought the survey did not take long to complete. Twelve respondents did feel the survey did take a long time to complete.
- Eighty-four out of 87 respondents who answered the feedback question regarding understanding the questions said they understood most or all the questions.

Adolescent Responses

Table 4: Adolescent responses to five questions

Survey Question Number	Question Topic	Yes	No	Not Answered	Answered Question	Survey Total
5	Given health questionnaire	72	18	20	90	110
12	Smoking or tobacco use	49	50	11	99	110
16	Drinking alcohol	45	52	103	97	110
21	Drug use	40	53	17	93	110
31	Sex	51	38	21	89	110

Table 4 shows a brief analysis of the responses for five areas. It appears that the adolescents received a health questionnaire to complete. It also appears that their providers did questions about the adolescent's activity surrounding use of tobacco, alcohol, drug, and sex. This would indicate that providers are screening for risk behaviors at these four high-volume provider sites.

MCO Feedback on Survey Process

Locked Boxes

Due to a concern with confidentiality within the provider office, the process called for the MCOs to purchase a locked box to collect the sealed envelopes that contained the completed surveys. All sites had difficulty finding a locked box for this survey. One used a box that could not be locked. One used a locked plastic box. The cost was \$19.00 to \$48.00. One tried a ballot box but the envelope with the survey would not fit through the entry since it was 5 pages and folded to a small envelope.

Recommendation: If the locked box were not considered a necessity for the baseline, then eliminating this hassle would go a long way in making the survey more acceptable to plans and clinics.

Instructions

There were no specific trends found regarding the instructions. One concern voiced was that the provider site/clinic staff needed to have a better understanding of the project. However, after completing the surveys and doing the interviews, it was apparent that clinic staff needed more instructions on how to keep the log and a better explanation of why accounting for all the surveys distributed and not distributed is important for tabulation of the results.

Technical Assistance Required by Provider Sites

All representatives of the plan made weekly contacts either by visits or telephone calls to the sites that seemed to help with understanding.

Incentives Used

One health plan representative took the provider's office staff to lunch and brought them doughnuts on another visit. One site used a bubble pen as an incentive for teens to complete the survey.

No other incentives to provider sites were reported.

One plan thought the survey was too lengthy

Blue Cross staff remained concerned about the length of the survey throughout the pilot.

Provider Site Feedback

- One clinic had non-English speaking teens and could not give them the survey. They felt that the survey should be in Spanish also.
- The timing of the pilot was at a time when there were not many teens coming in for well care or urgent visits.
- The survey questions were applicable to the adolescent and physician encounter and relationship. The survey might be improved if the wording also included other providers such mid-level practitioners.
- One response from a clinic site was very telling: “If we had time to give out the survey, the teen would usually complete it.”
- Clinic staff did not like to put the race of the adolescent on the log sheet. Due to the make-up of the population, the staff felt they might not know the race and they did not want to ask.
- If Medi-Cal health plans want to monitor providers (where there are multiple providers at a site) to see if training improves the performance of providers for screening and counseling, the provider’s name would also have to be on the survey.
- One MMC provider site stated that it was easier to not hand the surveys out to only Medi-Cal teens, that they would rather place a check on the survey tool to denote the insurance category of Medi-Cal.

BC specific

- “The process took too much clinic staff time.” Staff of one clinic commented, “It affected clinic patient flow.” “Very frustrated with the survey.”
- “Survey was too long,” was stated initially by one provider site; however, no comment was made about this perception after several weeks of the pilot.
- “Should not be given to teens that are sick.” “Most resistance because they (adolescents) did not feel like filling out this long survey.”

HPSJ specific

At the Public Health Clinic site (8 surveys distributed), the concern was that most teens came for Sexually Transmitted Disease services and a survey of this kind was not applicable to them and, therefore, not given to them.

Recommendations for Baseline

1. Trim the documentation requirements on the weekly report logs; add columns for tallying surveys handed out, surveys refused, and surveys completed. Add specific weeks of baseline to top of weekly tally sheet and ask provider sites to check corresponding weeks.

2. Omit the locked box. Use the sealed envelopes for the survey.
3. Change the process to give the survey only to teens that are not sick. Also, exclude adolescents who are seen at public health clinics for routine sexually transmitted disease services.
4. Keep the survey length as it based on the adolescent feedback and the wealth of information that can be obtained.
5. Translate the survey into Spanish.
6. Administer the survey using the same post-clinic visit approach with minor revisions, as was used during the pilot.
7. Data collection (receipt of completed, acceptable surveys) may take at least 3 months or more for some provider sites. We recommend that each MCO choose multiple provider sites to reach the desired response rate.
8. Encourage frequent monitoring of provider sites by MCOs.

The information obtained from the pilot of the survey has been very beneficial in planning for the statewide adolescent health collaborative baseline measurement. The use of real time information of screening and counseling practices for this at risk population can be realized through the use of the approach. The three volunteer health plans, their representatives working on this project, and the clinic staff of the four provider sites are to be commended for the time and effort they gave for the pilot and the information it gained to make the survey process better.