

◆ REDUCING HOSPITAL READMISSIONS ◆ IMPROVING CARE FOR COMPLEX MEDICARE PATIENTS◆

Impact 2012

Each year, CQC offers programs to improve clinical quality, patient experience and cost of care to nearly 1,000 leaders and staff from about 300 organizations providing care to an estimated 7 million Californians. CQC offers expert training and peer-to-peer learning through a combination of teleconferences and webinars, one-day on-site sessions and year-long intensive programs. During 2012, CQC's work was focused on reducing hospital readmissions, improving medical group performance on Medicare Star and P4P quality measures, improving care and reducing cost for Medicare patients with complex conditions, and improving care transitions. Programs brought together clinicians, staff, and executives from physician groups, health plans and community agencies with a shared goal of improving patient care while reducing health care costs in California.

◆ IMPROVING MA STARS AND P4P PERFORMANCE FOR MEDICARE PATIENTS ◆ IMPROVING CARE TRANSITIONS ◆

CQC
California Quality Collaborative
Breakthroughs for Better Healthcare

A NOTE OF THANKS

It is with great pleasure that the team at California Quality Collaborative presents our *Impact 2012* report. While 2012 began as a year of uncertainty for the healthcare industry, one thing remained clear: The imperative to reduce total cost of care through improved quality has never been more critical to California or to the nation.

As a multi-stakeholder healthcare improvement leader, CQC is proud of our history of bridging organizations to drive towards improved quality of care. This report highlights the accomplishments we have achieved through our collaborative program efforts in the past year.

I would like to draw attention to the impressive caliber of individuals who have served as faculty of our programs. CQC is fortunate to have the participation of our expert faculty, and I graciously thank each individual who has contributed.

2013 brings a time that requires accelerated improvements at greater scale. CQC remains committed to continuing to partner with our many stakeholders, faculty, sponsors, and program participants to achieve extraordinary results.

Steve Escamilla, MSIE, FACHE
Director
California Quality Collaborative

Reducing Hospital Readmissions

Why: A 2010 brief released by the National Priorities Partnership estimates that preventable hospital readmissions account for $25 billion of wasteful health spending.[1] Preventable readmissions can negatively impact patients' quality of life and often reflect an absence of care coordination and information exchange among providers.

How: CQC partnered with Cynosure Health and the Gordon and Betty Moore Foundation to offer the Avoid Readmissions through Collaboration (ARC) program. ARC brought together California hospitals and community partners to prevent readmissions. In 2012 ARC:

- Hosted quarterly in-person learning sessions in Oakland for 50 hospitals and hospital partners to understand existing evidence-based models to reduce readmissions.
- Led participants through a self-assessment and development of a tailored action plan.
- Facilitated intensive support including coaching and access to planning grants.
- Fostered exchanges among program participants and exposure to new ideas through national experts.
- Empowered participants to be presenters, teachers and champions within each facility to spread change.

Results: With 24 months of data available, hospitals participating in the program have realized an 8% reduction in 30-Day All-Cause Readmission Rate, preventing over 1,400 readmissions over the 2-year life of the program, and resulting in over $10 million in estimated savings.

Next Steps: CQC secured additional funding from the Gordon and Betty Moore Foundation to sustain the progress made in ARC I and to further reduce 30 and 90 day all cause readmissions by the end of 2013. CQC will seek to expand the number of hospitals in data-driven improvement and strengthen relationships with other stakeholders to work with hospitals to improve transitional care between settings.

Improving Medicare and P4P Performance

Why: Provider organizations are challenged with multiple priorities on a daily basis. They strive to provide high-quality, patient-centered care at a low-cost, while also trying to make sense of and address the numerous quality measures to which they are held accountable.

How: The Compass Program is focused on making changes in fundamental processes to improve performance on three sets of measures: Medicare Star ratings, ACO Quality Metrics (Medicare Shared Savings Program / ACO), and P4P for commercial populations. In 2012 Compass:

- Hosted two in-person learning sessions for fourteen medical groups/IPAs.
- Hosted monthly webinars on related topics.
- Facilitated coaching calls with groups to provide support in implementing action plans.

Results: Aggregated data for Compass groups through quarter three of 2012 shows the following promising preliminary results:

- Diabetes A1c >9.0 showed improvement and was almost at the Medicare Advantage (MA) 4-Star cut point.
- Mammography screening is at the P4P 90th percentile and exceeds the MA 5-Star cut point.
- Diabetes blood pressure <140/90 showed a 15.7% increase from baseline.
- Diabetes nephropathy monitoring achieved the MA 4-Star cut point.
- Patients with BMI recorded exceeded the MA 5-Star cut point.
- Treatment of patients with rheumatoid arthritis with DMARD therapy showed a 15.5% increase.

Next Steps: Compass groups will meet in May 2013 and continue work plans and measurement through 2013. A toolkit will be disseminated to share information on interventions, lessons learned, and share resources. CQC is currently planning for Compass II which is slated to start in the Fall of 2013.

"ARC was a great benefit to our program. There were a lot of people doing things, but individually. It allowed us to get specific about our goals as an organization"

Physician – El Camino Hospital

[1] *Compact Action Brief: A Roadmap For Increasing Value in HealthCare. Preventing Hospital Readmissions: A $25 Billion Opportunity.* National Priorities Partnership, November 2010

TAACT
TAKE ACCOUNTABILITY FOR AMBULATORY CARE TRANSITIONS

Improving Ambulatory Care Transitions

Why: Physician organizations play a critical role in reducing avoidable hospital readmissions. Complex patients are leaving the hospital with better discharge plans, but they need an organized team of partners to assure that the plan works … and works every time. CQC offers the TAACT Collaborative to spread best practices in managing the handoff from inpatient to ambulatory systems in the first 30 days after a hospital stay.

How: Through the TAACT Collaborative, participants will follow a six-month journey which includes:

- Assessment of currently existing post-discharge readmission prevention resources
- Understanding of models for reducing readmissions
- Decision on a model appropriate for each organization
- Identification of a pilot team to test and refine the chosen model

By the end of the six-month journey, organizations will have (1) a clear, tested strategy for reducing readmissions; and (2) a defined a change plan for spreading their chosen model widely to achieve scale.

Next Steps: The TAACT Collaborative is a series of staggered, six-month collaboratives that are regional in focus. The regional cohorts are:

- Cohort A: February 2013 – July 2013 – Los Angeles / Orange County.
- Cohort B: May 2013 – October 2013 – Greater Bay Area / Northern California
- Cohort C: August 2013 – January 2014 – Inland Empire/Riverside/Antelope Valley/San Diego
- Cohort D: November 2013 – April 2014 – Central Valley

This collaborative approach represents a significant innovation designed to scale CQC interventions to impact statewide performance.

Target Outcome: Working with the ARC Collaborative, the California Hospital Association and the Heath Services Action Group (California QIO), the target is to fulfill the national Partnership for Patients goal to reduce statewide readmissions by 20%. Each collaborative will set goals for participants in that collaborative.

INTENSIVE OUTPATIENT CARE PROGRAM
PACIFIC BUSINESS GROUP ON HEALTH

Managing Medically Complex Medicare Patients

Why: A relatively small number of Medicare patients with chronic illness and co-morbid conditions consume a large amount of health care resources without experiencing a commensurate improvement in outcomes. Through IOCP, PBGH is applying the lessons learned by several member companies that developed pilot programs providing intensive care management to high risk patients to avoid admissions and readmissions, coordinated care, and teach illness self-management skills.

How: PBGH provides program support and technical assistance to participating organizations. Participants have the opportunity to collaborate through regular leadership trainings, Care Coordinator Academies, and peer support. In addition, they have access to expert clinical faculty. The IOCP program contracts with CQC to provide much of this training. PBGH provides each partner with a stratified high-risk patient list, a real-time performance dashboard, direct access reporting on the entire Medicare population, and quarterly benchmarking across other participating groups.

Results: Goals by July 2015 include:

- Enroll 27,000 Medicare patients
- Improve patient experience by 2-4%
- Improve patient clinical outcomes by 2%
- Lower total cost of care (net of investment) by 5%

The measurement plan includes quarterly feedback measures to the participating organizations on:

- Clinical quality, such as Blood pressure, cholesterol, and HbA1c control
- Cost of care, including Hospital and emergency department utilization

Next Steps: Participating medical groups will begin enrolling patients in May 2013. The second "wave" of medical groups will onboard in summer and fall 2013. Enrollment of the next cohort of patients will begin December 2013 / January 2014. Leadership training is offered quarterly. Three day Care Coordinator Academies to build appropriate skills for IOCP are offered quarterly.

"The collaborative…stressed bringing in people we don't normally involve, like patients and their families, and now we include them in other aspects of work….you can read all you want about evidence-based models, but you can see how to make it real, so it gives folks like us the courage to take this on."

Physician – Marin General Hospital

California Quality Collaborative Program Faculty 2012

- **Alameda County Medical Center** – ARC Team
- **Samer Assaf, MD** – Sharp Rees-Stealy
- **Eva Balint, MD** – Brown & Toland Medical Group
- **Micaela Bazan** – High Desert Primary Care Medical Group
- **Nancy Boerner, MD** – Monarch Health Care
- **Stacey Brenner, MD** – Regal Lakeside & Affiliates
- **Blair Bryson, MD** – Choice Medical Group
- **Chris Cammisa, MD** – Consultant
- **Robert Castillo, MD FAAP** – Epic Management LLC
- **Eric Coleman, MD, MPH** – University of Colorado School of Medicine
- **Ilene Corbett** – Memorial Care Medical Foundation
- **Jeff Critchfield, MD** – UCSF/SFGH
- **Alison Danielczyk** – Monarch Healthcare
- **Erik Davydov, MD** – Facey Medical Group
- **Susan Erlich, MD, MPP** – San Mateo Medical Center
- **Mary Fermazin, MD** – Health Services Advisory Group
- **Alan Glaseroff, MD** – Stanford Coordinated Care & Humboldt-Del Norte IPA
- **Silvestre Hernandez-Mendoza** – Choice Medical Group
- **John Hirshleifer, MD** – Blue Shield of California
- **Kathleen Kerr** – Coalition for Compassionate Care
- **Wendi Knapp, MD** – Palo Alto Medical Foundation
- **Pranav Kothari, MD** – Renaissance Health
- **Marilyn Lettice** – United Family Care
- **Bridget Levich, RN** – UC Davis
- **Carol Levine** – United Hospital Fund
- **Ann Lindsay, MD** – Stanford Coordinated Care
- **George Louie, MD** – Health Net
- **Catherine MacLean, MD** – Anthem Blue Cross
- **Beth Mahler, MD** – Sutter Health
- **Lesley Manson, PhD** – Open Door Community Health Care
- **Marin General Hospital** – ARC Team
- **Vicki Medlen** – NAMM California
- **Kate Meyers** – California HealthCare Foundation
- **Sherry Miller** – Epic Management LLC
- **Joanne Moser** – Torrance Hospital IPA
- **Lisa Nedlan, RN, BSN** – Humboldt-Del Norte IPA
- **Jerry Penso, MD** – Sharp Rees-Stealy
- **David Perrott, MD** – California Hospital Association
- **Kelly Pfeifer, MD** – San Francisco Health Plan
- **Mino Pham, MD** – High Desert Primary Care Medical Group
- **Gail Rusin, MBA** – Integrated Healthcare Association
- **Tomi Ryba, MHA** – El Camino Medical Center
- **St. Francis Memorial Hospital** – ARC Team
- **St. Rose Hospital** – ARC Team
- **Terri Scott, RN, BSN** – Dignity Health
- **Wells Shoemaker, MD** – California Association of Physician Groups
- **Glen Singer, MD** – Managed Care Systems LLC
- **Sunny Singh, MD** – Stanford School of Medicine
- **Rebecca Snakowski** – Monarch Healthcare
- **Andrew Snyder, MD** – Brown & Toland Medical Group
- **Bruce Spurlock, MD** – Cynosure Health
- **Tory Starr, RN** – Alameda County Medical Center
- **Susan Stone, MD** – Healthcare Partners
- **Pat Teske, RN, MHA** – Cynosure Health
- **Betsy Thompson, MD** – Centers for Medicare & Medicaid Services Region IX
- **Cassidy Tsay, MD** – Greater Newport Physicians IPA
- **VA Medical Center San Francisco** – ARC Team
- **VA Palo Alto Healthcare System** – ARC Team
- **Washington Hospital Healthcare System** – ARC Team
- **Mike Weiss, DO** – Monarch Healthcare
- **Terry Winter** – Marin General Hospital
- **Dolores Yanagihara, MPH** – Integrated Healthcare Association

California Quality Collaborative Steering Committee

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California Quality Collaborative Staff

Diane Stewart	Senior Director
Steve Escamilla	Director
Lance Lang	Clinical Director
Amit Karkhanis	Senior Manager
Maj-Britt Llewellyn	Senior Manager
Lydia Paull-Flores	Senior Manager
Cindi Ardans	Project Consultant
Chris Forbes	Project Coordinator

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- Gordon and Betty Moore Foundation
- Pacific Business Group on Health
- Robert Wood Johnson Foundation
- SCAN Health Plan
- United Healthcare

221 Main Street, Suite 1500
San Francisco, CA 94105
415.615.6397

calquality.org