California Quality Collaborative

*Breakthroughs for Better Healthcare*

***Continuing on the journey of improving health care delivery since 2002.***

# CALIFORNIA QUALITY COLLABORATIVE IMPACT REPORT 2014

RELEASED MAY 2015

*California Quality Collaborative (CQC) is a multi-stakeholder health care improvement organization dedicated to advancing the quality and efficiency of the health care delivery system in California.*

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# About California Quality Collaborative

## WHAT IS CALIFORNIA QUALITY COLLABORATIVE?

The California Quality Collaborative (CQC) is a multi-stakeholder health care improvement organization dedicated to advancing the quality and efficiency of the health care delivery system in California. Based in San Francisco, CQC is administered by the Pacific Business Group on Health, a 501(c)3 nonprofit organization, and guided by a multi-stakeholder steering committee. CQC generates scalable and measurable improvement in care delivery in ways important to patients, purchasers, providers and health plans.

## IMPROVEMENT PRINCIPLES

- Value is best created by improving cost and quality together.
- Performance is a system property; therefore, improvement strategy must be focused at the organization level.
- Improvement is sustainable only when aligned with business models that support cross-institutional integration and quality outcomes.
- Measurement and reporting will be based on the triple aim for improvement in:
    - Improving the patient experience of care (including quality and satisfaction)
    - Improving the health of populations
    - Reducing the per capita cost of health care

## PROGRAMS

Led by national experts in the field, CQC offers a range of health care improvement programs, including:

- **Topic-specific collaboratives** that offer access to national experts and leading physician peer group leaders to facilitate the adoption of best practices in patient satisfaction, clinical care and efficiency.
- **Health care quality improvement training programs** that engage California physician group and hospital leadership teams to manage change across their organizations to achieve evidence-based, patient-centered care.

## PROVEN SUCCESS IN 2014

This report serves to illustrate the success of the California Quality Collaborative in 2014. Started in 2002 under the auspices of the Diabetes CQI Project, the California Quality Collaborative has also been known as the Breakthroughs in Chronic Care Program, illustrating its long-term commitment and history in tackling chronic care issues in California.

# A Message from CQC's Directors

Letter from Diane Stewart, M.B.A., Senior Director, and Lance Lang, M.D., FAAFP, Clinical Director:

*CQC's programs focus on strengthening the capacity within delivery systems to continually improve care for their patients. In 2014, CQC demonstrated improvement on every dimension of the Triple Aim, plus one:*

- Improvements in Health – The **Compass collaborative** helped organizations build systems to better care for patients living with chronic illness. The **Intensive Outpatient Care Program** (IOCP) identified and supported medically complex patients in 23 delivery systems in five states.
- Improvements in Cost of Care – **Avoid Readmissions through Collaboration** (ARC) reduced readmissions in the San Francisco region while the **Take Accountability for Ambulatory Care Transitions** (TAACT) better prepared outpatient providers around the state to help patients leaving the hospital.
- Improvements in Patient Experience and Engagement – CQC has shown that improving health and improving cost of care can also improve the patient experience with care. **ARC** improved hospitalized patients' ratings of care while reducing readmissions, and **IOCP** improved patients' confidence in managing their own care.
- Improvements in Care Team Satisfaction – To address growing concerns about the viability of primary care, the **Advanced Primary Care collaborative** assists medical groups and community clinics to redesign care to improve satisfaction for both patients and their care teams.

*And to keep our stakeholders up-to-date with emerging trends in health care delivery,* ***Topics in Healthcare Symposia*** *offer one-day briefings on topics such as palliative care and social determinants of health. Finally, CQC offered skill-building opportunities through its* ***Lean Certification*** *and* ***Partnering with Patients*** *programs.*

*Physician organizations, community clinics, integrated delivery systems and their health plan partners in California have a long history of leading the nation. Now in this exciting time of health reform, we are showing what accountable care looks like, and what is possible when we work together on behalf of the patients we serve.*

***Diane Stewart, M.B.A.***

***Senior Director***

***Lance Lang, M.D., F.A.A.F.P.***

***Clinical Director***

# CQC Programs

## COLLABORATIVES

- Advanced Primary Care
- Avoiding Readmissions through Collaboration
- Compass (2013–2014)
- Intensive Outpatient Care Program
- Take Accountability for Ambulatory Care Transitions

## CAPACITY-BUILDING PROGRAMS

- CQC Lean Healthcare Certification
- Partnering with Patients (motivational interviewing)
- Topics in Healthcare Symposia

# CQC PROGRAMS

## CQC PROGRAM STATISTICS

| DESCRIPTION | TOTAL |
|---|---|
| **Unique Organizations** | **279** |
| **Attendees (All Sessions)** | **1,818** |
| Attendees (Live Sessions) | 569 |
| Live Sessions | 22 |
| Attendees (Virtual Sessions) | 1,249 |
| Virtual Sessions | 35 |

# Program Summaries

## ADVANCED PRIMARY CARE COLLABORATIVE | JUNE 2014–JUNE 2015

### OVERVIEW

Primary-care transformation develops deeper patient relationships, broader interactions with the health care system, and a team-based approach to delivering care, improving health outcomes and lowering the cost of care. The Advanced Primary Care (APC) collaborative provides a robust approach and set of resources to support primary-care medical homes (PCMH) or primary-care practice transformation in four organizations--one safety-net organization and three multipayor medical groups. This collaborative builds organizational capacity to test an efficient means to promote APC. Given the 24,000 primary-care providers in California, no outside agency can provide the training to all, so CQC is helping practices build their own training capacity. CQC has partnered with the UCSF Center for Excellence in Primary Care (UCSF-CEPC) to train practice coaches and their teams, a core intervention for building capacity in primary care. The APC training content is delivered in both through in-person and virtual meetings. UCSF-CEPC's Ten Building Blocks of High Performing Primary Care are the primary components of the educational content. Peer-to-peer learning and close coaching of teams are key elements of the program.

### STRUCTURE

Because primary-care practice transformation requires culture changes at multiple levels in the organization, several program elements are structured to support the participants:

1. **Practice Coach Training** – CQC's core intervention for building capacity to transform primary care is practice coach training, which includes having Tom Bodenheimer as faculty. Participants rated the training an average of 9 out of 10 (excellent) with many positive comments about knowledgeable trainers who engaged participants in an interactive, hands-on learning environment, supporting peer-to-peer sharing.

2. **Learning Sessions** – CQC will convene four quarterly in-person learning sessions (i.e., collaborative meetings). Sessions focus on four foundational building blocks of advanced primary care: (1) engaged leadership; (2) team-based care; (3) data-driven improvement and (4) empanelment. Additional topics included population management, template of the future and planning for spread. The evaluation ratings were high--98 percent of participants provided ratings of 4 or 5 for "Would recommend this training to a colleague."

3. **Webinars** – CQC convenes monthly webinars between in-person meetings. The agendas are co-developed and presentations are shared between the CQC, UCSF-CEPC and CareOregon teams. These webinars are an opportunity to dive deeply into topics introduced at learning sessions, share updates on how teams are implementing, and ask questions of faculty and peers.

4. **Weekly coaching** – CQC master coaches meet with each team weekly to discuss aims, measures, testing plans and to address barriers.

5. **Site visits** – CQC master coaches conduct site visits with each team every one to two months to observe practice operations, offer recommendations to implement APC strategies and develop relationships with organization leaders and change agents.

## MEASUREMENT

The measurement plan focuses on impact on the "quadruple aim"--patient experience of care, quality outcomes, cost of care and provider satisfaction.

Specific measures include:

- APC inventory – 35-item survey addressing implementation of the 10 building blocks
- Clinical measures – Diabetes and cardiac optimal care measures, other clinical measures (optional)
- Cost/utilization – Hospital utilization (admits and/or days per thousand), ER utilization (visits per thousand), specialty referral rate, cost/efficiency
- Patient/clinician satisfaction – Step Survey (UCSF-CEPC)
- Structural & operational process measures - Standing orders for chronic care developed, percentage of clinic days with huddles, number of visits with RNs

## PARTICIPANTS

- Citrus Valley (NAMM)
- Clinicas de Salud del Pueblo
- MemorialCare Medical Foundation
- St. Joseph Heritage Healthcare

## INTERVENTIONS

Interventions include the implementation of the 10 Building Blocks of High Performance Primary Care.

1. Engaged leadership--including patients--creating a practice-wide vision with concrete objectives and goals

2. Data-driven improvement using computer-based technology

3. Empanelment

4. Team-based care: (a) culture shift--Share the Care, (b) stable teamlets, (c) colocation, (d) staffing ratios adequate to facilitate new roles, (e) standing orders/protocols, (f) defined workflows and workflow

mapping, (g) defined roles with training and skills checks to reinforce those roles, (h) ground rules, (i) communication--team meetings, huddles and minute-to-minute interaction

5. Patient-team partnership: (a) evidence-based care; (b) health coaching; (c) informed, activated patients; (d) shared decision making

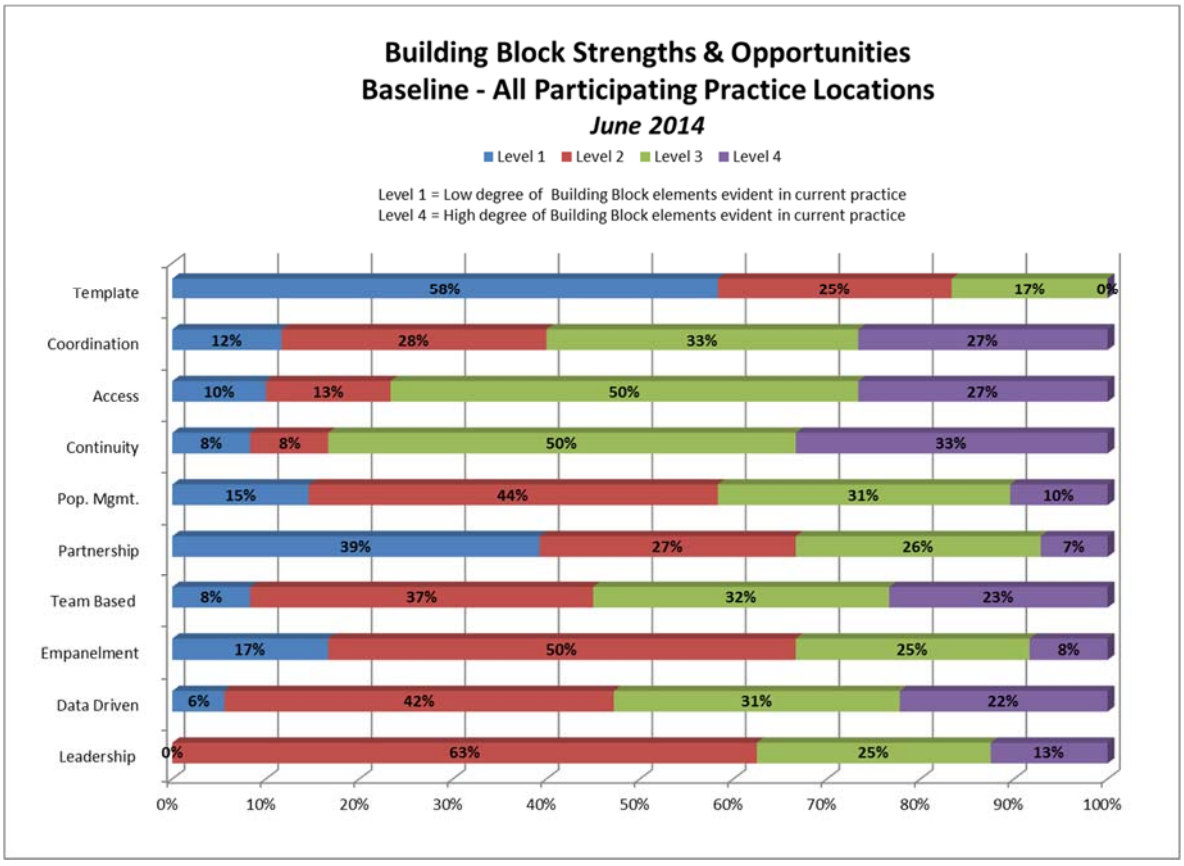
6. Population management: (a) panel management, (b) self-management support (health coaching), (c) complex care management

7. Continuity of care

8. Prompt access to care: (a) weekday hours, (b) nights/weekends, (c) phone access

9. Comprehensiveness and care coordination: (a) within the medical neighborhood, (b) with community partners, (c) with family and caregivers

10. Template of the future--escape from the 15-minute visit: (a) e-visits, (b) phone visits, (c) group visits, (d) visits with nurses and other team members, (e) requires payment reform



# PROGRAM SUMMARIES

## RESULTS

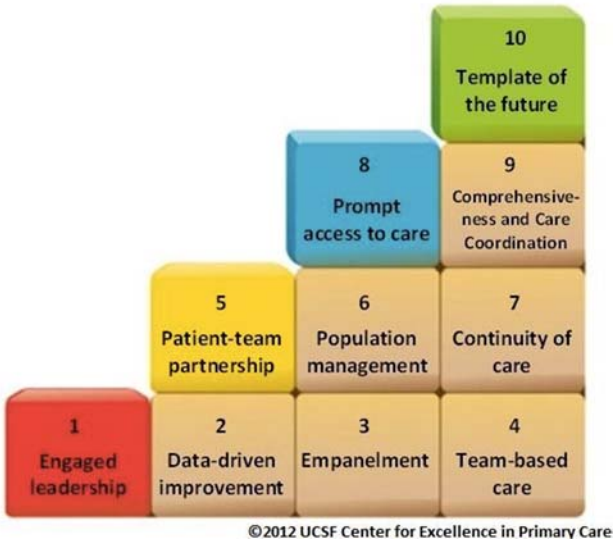
Midway through the collaborative, it is premature to measure quality and cost outcomes. However, the foundational elements of primary-care transformation are steadily being implemented in all sites. Most notably, the ability to measure gaps in quality of care at the panel level is within reach for each site. Also, several aspects of team-based care are being tested at each site, such as expanding medical assistant roles to implement standing orders. The implementation of empanelment, team-based care, engaged leadership and data-driven improvement are foundational to achieving the outcomes that many other advanced primary-care initiatives across the country have accomplished. The Patient-Centered Primary Care Collaborative reviewed 28 publications for its January 2015 "The Patient-Centered Medical Home's Impact on Cost and Quality: Annual Review of Evidence 2013-2014" and concluded that the PCMH model can lead to a reduction in health care costs, inpatient hospitalizations and inappropriate ED utilization.

## LESSONS LEARNED

A detailed assessment of data analytic capability and infrastructure is necessary. Appropriate planning to close any gaps is key to successful implementation of the foundational building blocks. Advanced primary care requires complex change in infrastructure, roles, workflows and behaviors. This takes longer than expected and requires close coaching. Careful selection of practice coaches is key. They must have the skills, attitude and time allotted to be on the ground, hand-in-hand with the teams as they implement changes. Leadership dyads that include both a physician and an administrator are powerful in their ability to guide change in complex organizations.

## NEXT STEPS/SPREAD

At the end of the collaborative, during the last learning session, CQC will teach concepts of spread planning and ensure that each site develops one. The hope is to support all sites during a second year as they implement their spread plans.



## AVOID READMISSIONS THROUGH COLLABORATION | SEPTEMEBER 2010–DECEMBER 2014

### OVERVIEW

The Avoid Readmissions through Collaboration (ARC) program seeks to bring together hospitals and their community partners to prevent readmissions. ARC is a partnership between Cynosure Health and CQC, funded by the Gordon and Betty Moore Foundation.

### STRUCTURE

Quarterly on-site learning sessions in Oakland started as a forum for hospitals and their partners to understand existing evidence-based models to reduce readmissions. A subset of hospitals received one-on-one coaching in exchange for submitting monthly data on readmissions and patient experience.

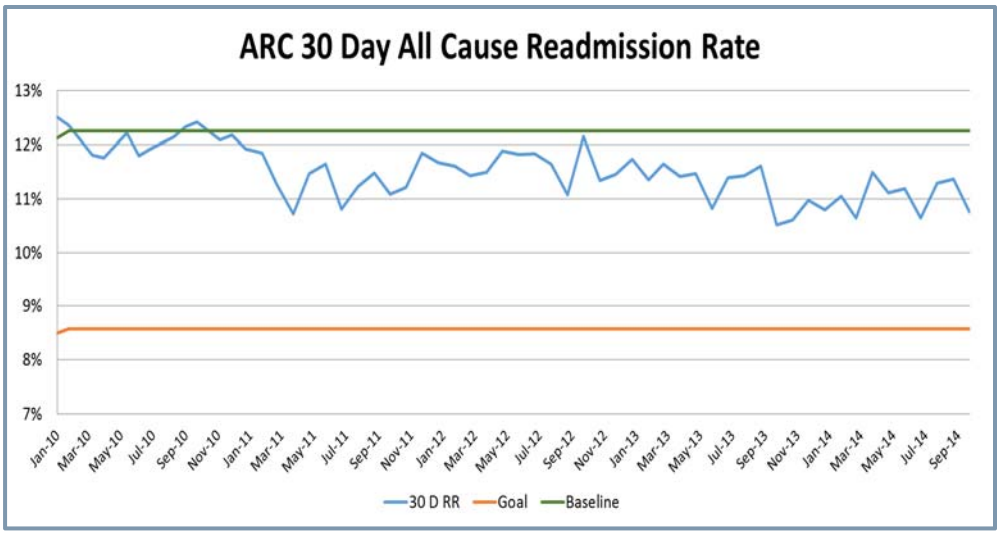
Early on, hospitals focused on internal systems to better prepare patients for discharge. Over time, partnerships exploded between hospitals with nursing homes, home health and community agencies. ARC convened affinity groups for pharmacists, chartered a patient advisory committee and offered webinars with national experts. ARC cosponsored Annual Readmission Summits with California Hospital Association and HSAG, drawing over 400 participants from around the state to learn from national experts and local leaders on successful strategies.

### MEASUREMENT

Participating hospitals submit data monthly on the following measures:

- 30-day all-cause readmission rate.
- 90-day all-cause readmission rate.
- HCAHPS Patient Survey Q23: During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.
- HCAHPS Patient Survey Q24: When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.
- HCAHPS Patient Survey Q25: When I left the hospital, I clearly understood the purpose for taking each of my medications.

# PROGRAM SUMMARIES




## PARTICIPANTS

- Alameda County Medical Center
- Alta Bates Medical Center
- California Pacific Medical Center
- Chinese Hospital
- Eden Medical Center
- El Camino Hospital
- Lodi Memorial Hospital
- Marin General Hospital
- Mills-Peninsula Hospital
- O'Connor Hospital
- SF General Hospital
- Santa Clara Valley Med Center
- Sequoia Hospital
- Seton Medical Center
- SF VA Medical Center
- St. Francis Memorial Hospital
- St. Mary's Medical Center
- St. Rose Hospital
- Sutter Delta
- Stanford Hospital
- UCSF Medical Center
- VA Palo Alto Health Care System
- ValleyCare Health System
- Washington Hospital Healthcare System

## INTERVENTIONS

Some examples of interventions adopted by participating hospitals:

- Monthly meetings with partner nursing facilities to review readmission data
- Integrating pharmacists into the discharge process

- Follow-up visits from community agencies to the patient's home
- Stratifying patients based on their likelihood of readmission, to target extra support post-discharge
- Engaging and educating families as caregivers
- Electronic tools to communicate with multiple agencies and hospitals managing the patient's transition to home

## RESULTS

For the 25 reporting hospitals:

- Eight percent reduction in 30-day all-cause readmission rate
- Over 9,036 readmissions prevented from Jan. 2010 through Dec. 2014, resulting in over $86,745,600 saved in the San Francisco Bay Area
- Improvement in every patient experience measure

## QUOTATIONS

"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."

--Participant, Physician at Marin General Hospital

"Where else can you get this experience? It's like having your own university! I learn something every time."

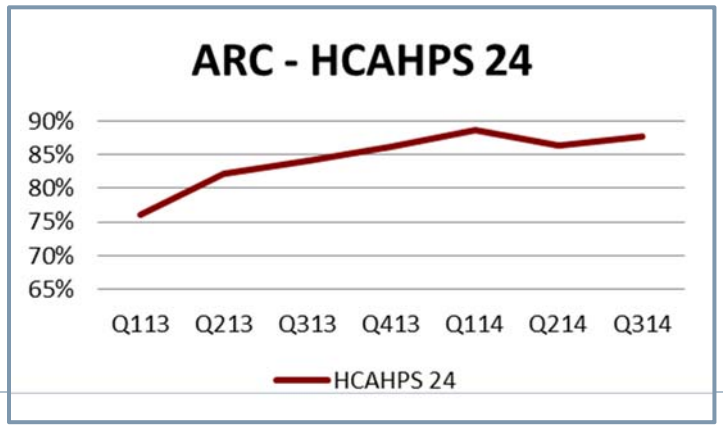
--Participant, Washington Hospital

"When I left the hospital, I had a good understanding of the things I was responsible for in managing my health."

--Patient

## NEXT STEPS/SPREAD

The program will end in 2015.



# COMPASS COLLABORATIVE (II) | OCTOBER 2013–OCTOBER 2014

## OVERVIEW

The Compass program dates back to CQC's initial offering focused on improving care and clinical metrics for commercial HMO patients with chronic disease. In 2013- 2014, the program focused on making changes in fundamental processes to improve performance in Medicare Star ratings, ACO Quality Metrics (Medicare Shared Savings Program / ACO), and P4P for commercial populations. Participating groups encompassed 4,500 primary-care physicians who cared for about 1.6 million patients, of whom 360,000 were commercial, 120,000 were Medicare and 1.2 million were Medi-Cal.

## STRUCTURE

Collaborative participants from 11 medical groups, independent practice associations (IPAs) and Medi-Cal managed care plans attended four in-person learning sessions in 2013 - 2014, participated in monthly webinars on related content, and engaged in coaching calls with CQC staff. Between the learning sessions, groups implemented action plans refined during the learning sessions.

## MEASUREMENT

Data was scheduled to be submitted quarterly on core diabetes measures including:

- A1c > 9.0
- A1c testing
- Blood pressure < 140/90
- Diabetes blood pressure control
- Eye exams
- LDL < 100
- LDL screening
- Nephropathy monitoring
- Optimal Diabetes Care 1
- Optimal Diabetes Care 2

Optional measures included:

- Adolescent immunizations
- Appropriate treatment for people with rheumatoid arthritis
- BMI documentation
- Breast cancer screening
- Colorectal cancer screening
- Controlling blood pressure for patients with hypertension
- Osteoporosis management for

women with a fracture

## PARTICIPANTS

- Affinity Medical Group
- Brown & Toland Physicians
- Choice Medical Group
- Health Plan of San Mateo
- Independence Medical Group
- Inland Empire Health Plan
- Managed Care Systems / Gem Health Care Plan
- MedPoint Management
- MemorialCare Medical Group
- San Diego Physicians Medical Group
- Synermed / Multicultural IPA

## INTERVENTIONS

- Mailing FIT kits for high-sensitivity FOBT testing for colorectal cancer screening
- Use of CPT Category II codes to collect blood pressure, BMI and other key clinical data
- Performance reports and lists of patients to physician offices
- Stratification and outreach to groups of patients, either centralized or practice-based
- Incentive programs for physicians and office staff
- Case management for complex patients with chronic disease
- Retrieved data for core measures while completing HCC chart review
- Use of portable equipment (DEXA Scan for bone density testing)
- Centralized staff dedicated to supporting practice sites

## RESULTS

Only three groups reported results for 2013 and 2014 for comparison, and these data were aggregated. The results are not audited HEDIS results but from registries and electronic health records. Of the three groups reporting data for the full two-year period, one group reported data only for the core diabetes measures and two of the optional measures. The other two groups reported data for all the measures except Controlling Blood Pressure for Patients with Hypertension. Results for the groups reporting included:

- Groups improved minimally or stayed the same on seven of the 16 measures. These included A1c > 9, A1c testing, BMI recorded, breast cancer screening, colorectal cancer screening, LDL < 100 and Optimal Diabetes Care 2.

- Rates decreased for eight of the measures, including adolescent immunizations, asthma control, blood pressure control for diabetics, eye exams for diabetics, LDL testing, nephropathy monitoring, osteoporosis management for women with a fracture and Optimal Diabetes Care 1.
- No groups reported on the measure of blood pressure control for patients with hypertension.

## LESSONS LEARNED

Participating groups shared lessons learned during the improvement cycles. A few are summarized below.

- Strong hands-on QI leadership is a key to improvement.
- Communicate progress and give regular feedback reports to primary-care physicians.
- Provide valid, actionable, real-time data to physicians at the point of care.
- Engage all stakeholders in system redesign, including other departments, as they may have valuable insights.
- Align incentive payment programs.
- Mailing FOBT kits was efficacious but took some coordination to set up programs.
- Changes in health care coverage due to the implementation of the Affordable Care Act caused a significant influx of new patients into the system, especially Medi-Cal. Many of these patients did not previously have coverage. This negatively impacted results for the 2014 reporting year.

## NEXT STEPS/SPREAD

CQC is in the process of defining program priorities and aims for 2015-17. Working with its steering committee and other stakeholders, CQC defined one priority aim--to improve chronic illness care for populations of patients where clinical quality scores are lowest. The achievement for this aim is to show substantial improvement in Medi-Cal clinical quality measures and related Medicare Advantage Star measures. A design team consisting of CQC staff and steering committee members will work to design the chronic care program for 2015 and beyond.

# INTENSIVE OUTPATIENT CARE PROGRAM | JULY 2012–JUNE 2015

## OVERVIEW

The Intensive Outpatient Care Program (IOCP) is a model of care focused on managing high-risk, medically complex patients using a team-based approach with dedicated support of the patient. IOCP emphasizes coordination of care and addresses medical, behavioral and psychosocial needs for patients with chronic illness and comorbid conditions.

## STRUCTURE

PBGH functions as an aggregator and builds clinical and operational infrastructure in partnership with medical groups that provide direct services to patients. PBGH's role includes (1) program management and accountability to CMS for achieving specified metrics, (2) liaison to medical groups, (3) training, (4) organizer of peer-to-peer learning sessions directed at medical group leadership and (5) analysis of program data, either in-house or through subcontractors.

## MEASUREMENT

IOCP reports more than 30 process and outcome measures from a variety of data sources including claims, EHR data, and patient surveys. Claims and EHR measures are reported quarterly with other measures reported more frequently. Examples include:

- HbA1c in control (diabetics)
- Blood pressure in control (CVD and diabetics)
- Lipid control (diabetics)
- Proportion of days covered by therapeutic category
- Annual monitoring for patients on persistent medications
- Shared care/action plan
- Number of Care Manager contacts
- Follow-up after Hospitalization Emergency Department visit
- Patient Experience
- Patient Assessment completion and results
- Patient enrollment/disenrollment
- Admit/Readmit rates
- ED visit rate

- Total cost of patient care

## PARTICIPANTS

- Brown & Toland Physicians
- Cigna Medical Group (AZ)
- Dignity Health (Arizona Care Network, Dominican, Mercy Medical Group, Southern California Integrated Care Network - Ventura and Inland Empire, St. Rose Quality Care Network)
- EPIC Management
- Greater Newport Physicians
- John Muir Health
- Palo Alto Medical Foundation
- Partnership HealthPlan of California
- PIH Health
- Santa Clara County IPA
- Scottsdale Health Partners (AZ)
- Sharp Community Medical Group
- Sharp Rees-Stealy
- St. Joseph Heritage Medical Group
- St. Luke's Health System (ID)
- Sutter Gould Medical Foundation
- Sutter Medical Foundation
- Sutter Pacific Medical Foundation
- The Polyclinic (WA)

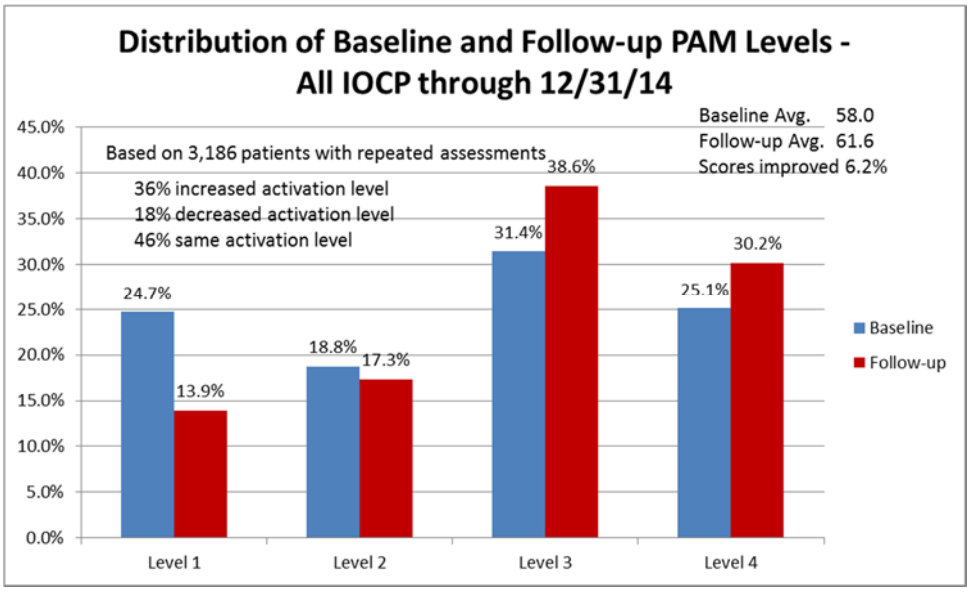
## INTERVENTIONS

- Care managers (including nurses, social workers, community health workers and medical assistants) maintain 1:1 longitudinal relationships with their own patient panel and use standardized assessment tools: the VR-12, Patient Activation Measure and PHQ2/9 depression measure.
- Care coordinators complete a face-to-face "supervisit" within one month of enrollment. This supervisit is done in a face-to-face setting; information is gathered in a motivational, open interviewing style.
- Two-way communication between the care coordinator and patient occurs at least monthly.
- The team works with patients to develop a Shared Action Plan, and works toward at least one patient-defined goal per year.
- The team provides warm handoffs to relevant support services (e.g., home health, behavioral health, transportation, drug assistance programs, food banks and other community services).
- The site must develop a 24/7 access solution for patients to avoid ED visits.

# PROGRAM SUMMARIES

## RESULTS

Patient-reported outcomes continue to be an important indicator of program success. The VR-12 assessment scores show a 4.6 percent improvement in mental health functioning and a 3.9 percent improvement in physical health functioning at one year. IOCP patient PAM scores increased 6.2 percent from baseline to follow-up, with 36 percent of patients showing a higher overall level of patient activation. Patient PHQ scores showed a 32.4 percent improvement from baseline to follow-up.



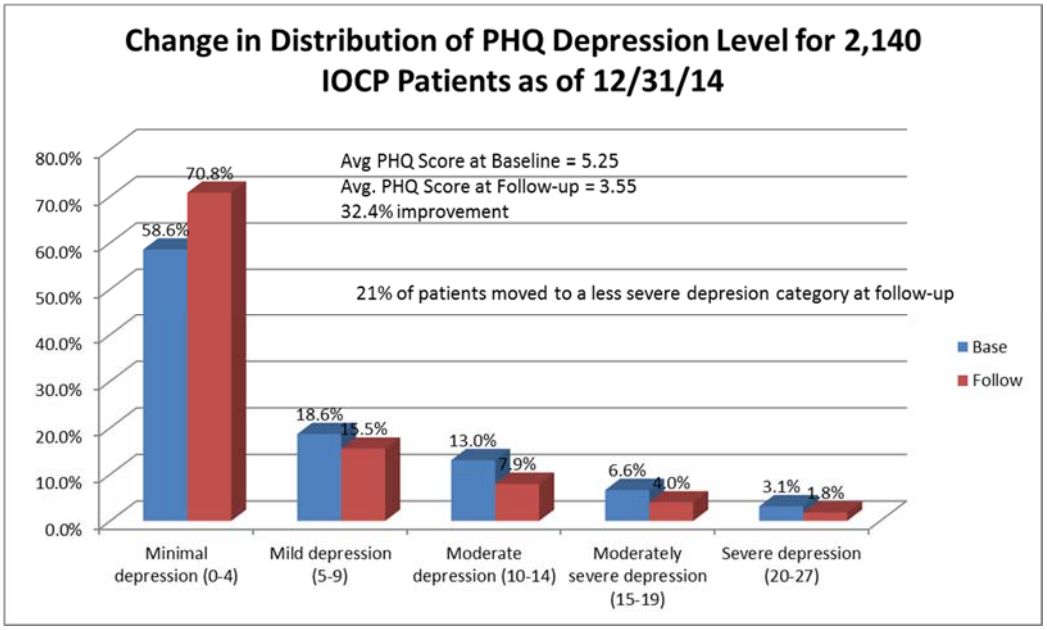

## LESSONS LEARNED

- Executive and clinical champion support is necessary to achieve program success.
- Enlist support for the program and for participants to take an active role in patient engagement.
- Outreach by medical director engagement is a big factor in success.
- Engage office staff as well.
- Model works well when integrated into the entire population strategy for high-risk patients.
- A dispersed provider environment can be challenging (e.g., IPA vs. foundation).

## NEXT STEPS/SPREAD

- Provide support to the medical groups during the transition period that follows the end of the grant.

- Conduct an evaluation of Medicare Advantage outcomes through a partnership with Stanford, as the CMS quantitative evaluation uses only fee-for-service claims. The research design is under development, as CMS approval of the special request was not received until the end of January.
- Support expansion to PBGH Member companies.



## TAKE ACCOUNTABILITY FOR AMBULATORY CARE TRANSITIONS (TAACT) | FEBRUARY 2013–JULY 2014

### OVERVIEW

CQC offered the six-month TAACT collaborative as a means to spread best practices and to help participating organizations develop plans to better manage the transition of patients from inpatient to ambulatory systems in the first 30 days after a hospital stay.

Over the course of the collaborative, participants:

- Assess readiness for implementing a post-discharge improvement plan
- Review available post-discharge readmission resources
- Understand different models for reducing readmissions
- Decide on a model appropriate for their organization
- Identify a pilot team to test, implement 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) defined a change plan for spreading their chosen model widely to achieve scale.

### STRUCTURE

The TAACT collaborative was a series of staggered, six-month collaboratives, regional in focus. The regional cohorts were:

- Cohort A: February 2013–July 2013 – Los Angeles / Orange County
- Cohort B: May 2013–October 2013 – Greater Bay Area / Northern California
- Cohort C: October 2013–April 2014 – Inland Empire / Riverside / Antelope Valley

### MEASUREMENT

The key outcome measure that all participants were expected to report on was 30-day all-cause readmission rate. Additional process measures specific to individual organizations were decided upon based on their reporting capabilities, needs and interest. Some process measures include:

- Percentage of post-discharge clinic appointments kept
- Number of patients receiving a TAACT intervention
- Percentage decrease in ED use among TAACT patient population

# PROGRAM SUMMARIES

Organizations were required to report their data throughout the collaborative on a bimonthly basis and then quarterly for 12 months following the conclusion of the collaborative.

## PARTICIPANTS

Participating groups in the TAACT collaborative represented a spectrum of organizations at various phases of care coordination sophistication. The three cohorts run in 2013 included these organizations:

- Health Net
- Inland Empire Health Plan
- La Clinica De La Raza
- Meritage Medical Network
- Monarch HealthCare
- NAMM – Prime Care Sun City
- PIH Health
- SF Dept. of Public Health
- St. Joe's
- Synermed – Angeles IPA
- Synermed – EH

## INTERVENTIONS

In order for each organization to meet its specific goals, maximize available resources and maintain cultural identity, a variety of interventions have been deployed over the course of the collaborative. Some of these are outlined below:

- Stand-alone post-discharge clinic where patients are seen by a team of caregivers and a provider who is not a primary-care physician
- Virtual care teams who provide primary-care physicians the additional resources needed to address patient needs
- Information exchanges between hospitals and clinics that give clinics the relevant information about their patient's hospital stay
- Use of care transition teams who follow patients from the hospital to the home
- Incorporation of "care transition visits" into clinic practices, separate from follow-up with a primary-care physician

## RESULTS

Success with this program varied widely for the participating organizations. Clinica de la Raza was only able to figure out when its patients were admitted to the hospital, while St. Joseph Health System created a post-discharge clinic to see high-risk patients upon discharge. The level of intervention achieved and the associated data were deeply varied across all participating groups. To that end the data available are not adequate to provide an objective evaluation of the success of this program. Subjectively, the progress each

participating organization made on their individual work plans and the quantity of best practices developed suggests that this program provided great value to its participants and can be considered a success.

## LESSONS LEARNED

While CQC still believe this is a worthwhile endeavor for physician organizations, this program will be sunsetted because of the difficulty for interested organizations to show the ROI for their participation and to show meaningful improvement through measurement. Because of the potential positive impact of this work, CQC will strive to incorporate the key elements and successes from this program into future programs.

## PARTNERING WITH PATIENTS | OCTOBER 2013–DECEMBER 2014

### OVERVIEW

Partnering with Patients: Using Motivational Interviewing for Brief Action Planning and Shared Decision Making commenced in 2013 with five sessions held: 2 in Los Angeles, 1 in San Francisco and 1 in Bakersfield. The Partnering with Patients (PwP) program serves as an introductory course to motivational interviewing for patient-facing clinicians, specifically to be used for clinicians within the context of a 15-minute office visit. CQC collaborated with the nonprofit organization The Centre for Collaboration, Motivation and Innovation (CCMI) to offer the training.

### STRUCTURE

Each training session contained two back-to-back full days of didactic, role-playing time and interactive exercises taught to an audience of 30–90. The two days of in-person training were followed by six months of 90-minute monthly webinars reviewing core concepts covered in the motivational interviewing training. They were designed with adult learning principles and allowed for time between sessions for practice and trial in the patient-facing workplace setting. Three hours of coaching calls per organization were also included.

### MEASUREMENT

After each day of training, CQC distributes an evaluation to understand participant satisfaction in the training to inform the need to adjust future trainings. Also, CQC will examine the effect of motivational interviewing on improvement in Pay-For-Performance (P4P) measures for LDL screening and LDL control and in adherence to medications prescribed for high cholesterol and high blood pressure through examining the following P4P measures:

- Diabetes Optimal Care 1
- Diabetes Optimal Care 2
- HbA1c control < 7.0%
- HbA1c control < 8.0%
- HbA1c control > 9.0%
- HbA1c screening
- LDL-C control < 100 mg/dL
- LDL-C screening
- Monitoring for patients on persistent medications (ACE/ARB, Digoxin, diabetes, overall) – MPM

CQC expects to have results from Measurement Year 2014 in August 2015.

# PROGRAM SUMMARIES

## PARTICIPANTS

Groups that participated in 2014 include:

- Alameda Health System (Hope, Homeless Coordination Office and Care Transitions)
- Arizona State University
- Castro Mission Health Center
- Chinatown Public Health Center
- Community Health Center Network
- Community Health Clinic Ole
- Daughters of Charity Medical Foundation (DCHS)
- Health Net
- LA County Dept. of Health Services
- Maxine Hall Health Center
- Meritage Medical Network
- Miller Children's Hospital - Endocrine Clinic
- Miller Children's Hospital - Long Beach
- MemorialCare Health System
- Mission Neighborhood Health Center
- North East Medical Services
- Open Door Community Health Centers
- Palo Alto Medical Foundation
- Partnership HealthPlan of California
- Positive Health Practice
- Potrero Hill Health Center
- Primary Care Behavioral Health - SF Dept. of Public Health
- Riverside County Health System
- SCAN Health Plan
- SF Community Clinic Consortium
- SF General Hospital
- SF Health Plan
- SF Medical Respite Program
- South of Market Mental Health Community Site
- St. Anthony Free Medical Clinic
- St. Joseph Health
- St. Jude Heritage Medical Group
- Sutter East Bay Medical Foundation
- Sutter Health
- Synermed
- Tom Waddell Urban Health Center
- UCSF Positive Health Program at SFGH
- UCSF Primary Care Services
- UCSF/SFGH Department of Psychiatry
- USF School of Nursing

# PROGRAM SUMMARIES

## INTERVENTIONS

Participants in the program were offered two days (12 hours) of training; fundamental principles of motivational interviewing were taught through presentations, role-playing and exercises with course instructors. Attendees were then offered the opportunity to practice skills in six 90-minute webinars that followed, one per month, for six months. Up to three hours of organization-level coaching with a health coach were also offered.

## RESULTS

Participants gained motivational interviewing skills over the course of two days. Data from the Integrated Healthcare Association (IHA)'s Pay for Performance program will be ready in June 2015. CQC will compare performance in groups' measures from Measurement Year 2013 to 2014 and expects to have results of the measures in August 2015.

## LESSONS LEARNED

With five trainings in 2014, CQC learned that two consecutive days of training was intense for attendees. The inclusion of the six webinars allowed for continuation and feedback for the groups that were able to take advantage of this opportunity. Pre-program work was essential for success, and CQC made efforts to bring managers into conversations in order to support the growth of their direct reports' motivational interviewing skills.

CQC saw better outcomes as teams became larger. Partnering directly with organizations to provide training proved to be more effective and better engaged attendees than if one attendee from a single organization held a training. As a result, CQC's efforts in 2015 will encourage team attendance for its motivational interviewing trainings.

## QUOTATIONS

"I found this workshop to give me skills useful within my role [in quality improvement], even though my role isn't direct patient interaction. Additionally, this workshop would be so powerful for our providers."

--Quality Improvement Project Manager, March 2014

"I think that the training was really comprehensive. The way in which we were able to practice the skills and get immediate feedback [was great]. I loved the [fact that we will have the] ability to come back again through webinars to collaborate, touch base again, see how the training is going and see how the skills are working for us––that is going to be key.

This is my first motivational interviewing course. It was really great. It's easy, it's simple––which is important because we don't have time to do massive, big changes. I like that the small things can have a huge impact--and an immediate impact."

--Katherine Barresi, Case Manager, Partnership HealthPlan of California

## NEXT STEPS/SPREAD

In 2015, CQC will continue to offer the Partnering with Patients Program through a grant from the California HealthCare Foundation, for two training sessions, in Northern and Southern California. Based on the lessons from 2014, the 2015 program will involve a single day of training followed by a period of practice and two follow-up webinars. The second day of training will follow a few months later, followed by two additional webinars, which will reinforce learning.

# TOPICS IN HEALTHCARE SYMPOSIA | JUNE 2014–PRESENT

## OVERVIEW

CQC's Topics in Healthcare Symposia are single-subject programs on topics applicable to medical group, health plan and clinic staff. The symposia allow for in-depth discussions of issues of great concern to population health managers and quality improvement professionals in particular, and the one-day conferences allow attendees to quickly learn about current topics. CQC has brought in community organizers, medical directors, palliative care program directors and nonprofit executive directors, among other professionals, offering diverse perspectives on tough issues to foster lively discussion and learning.

## STRUCTURE

Symposia are partial-day events, starting in the morning and lasting until midafternoon. Two to three speakers, typically for 30–50 minutes each, present a different aspect of the topic. A panel discussion, including an interactive Q&A segment, is moderated by the keynote speaker.

## MEASUREMENT

A post-symposium survey is distributed to attendees to assess satisfaction with the content and materials.

## PARTICIPANTS

Groups that participated in 2014 include:

- Access Medical Group
- Accountable Care Organization - BSCA
- Affinity Medical Group
- AltaMed Health Services
- Alzheimer's Association Orange County Chapter
- American Cancer Society
- AppleCare Medical Group
- Blue Shield of California
- Brown & Toland Physicians
- Care Dimensions
- CareChoices
- CareLink
- CCHP
- Center for Elders' Independence
- Chinese Hospital
- Choice Management
- CHOMP
- CHW Initiative of Sonoma County
- City of Fremont
- Coalition for the Compassionate Care of California
- Coast Healthcare Management
- Community Memorial Hospital
- CSU - Santa Barbara
- Cynosure

# PROGRAM SUMMARIES

- Dignity Health Medical Foundation
- Double Check Consulting
- El Camino Hospital
- El Sol
- Epic Care Oncology
- EPIC Management
- Facey Medical Foundation
- Family Care Specialists
- Glendale Adventist Medical Center
- Good Samaritan Hospital San Jose
- Gordon and Betty Moore Foundation
- Haven Health
- Health Net
- Health Plan of San Mateo
- HealthBegins
- HealthCare Partners
- HealthInsight
- Hill Physicians Medical Group
- Home Health
- Independence Medical Group
- Inland Empire Health Plan
- Johnson & Johnson
- Kaiser Permanente
- Kaiser Permanente - SCPMG
- Kaiser Permanente LA Medical Center
- LA Care Health Plan
- LA County Dept. of Health Services
- LightBridge Medical Associates
- Loma Linda University Medical Center
- MCMG
- MedPoint Management
- Memorial Hospital Sonoma County
- MemorialCare Health System
- Mercy Memorial Home Health and Hospice
- Meritage Medical Network
- Molina Healthcare
- Monarch HealthCare
- MPHS
- NAMM California
- NEHI
- Nursing and Rehab at Home
- Optum Palliative and Hospice Care
- Palo Alto Medical Foundation
- Partners in Care Foundation
- Pathways Home Health & Hospice
- PAVA Hospital
- PIH Health
- PPMSI
- ResolutionCare
- SAC Health System
- SCAN Health Plan
- SCCIPA
- St. Michael CareChoices
- St. Joseph Heritage Medical Group
- St. Jude Medical Group
- Sutter Care at Home

# PROGRAM SUMMARIES

- Sutter Health
- Sutter Health Sacramento Sierra Region
- Synermed
- UC Irvine Health
- UCLA Medical Group
- UCSF
- VAHCS
- ValleyCare Health System
- Veterans Affairs
- Vision y Compromiso
- Washington Hospital
- Wellpoint Foundation
- White Memorial Medical Center

## INTERVENTIONS

A comprehensive list of the two sessions held in 2014 include:

- The Role of Palliative Care in the Readmissions Challenge, June 2014
    - "Palliative Care: Meeting the Readmissions Challenge": Mike Rabow, M.D., UCSF
    - "Automated Remote Monitoring": Jeff Guterman, M.D., LA County DHS
    - "The Role of POLST in Readmissions and More": Judy Citko, J.D., Coalition for Compassionate Care of California
- Leveraging Community Resources to Improve Patient Health, October 2014
    - "Moving Healthcare Upstream: Optimizing Healthcare Value": Rishi Manchanda, M.D., M.P.H., Health Begins
    - "How the Promotores Model Facilitates Access to Health Care in California Communities": Maria Lemus, Vision y Compromiso
    - "Working Together: Implementing a CHW Program in a Medical Group": Ana Rodriguez and Eliethe Reyes, HealthCare Partners Medical Group

## RESULTS

Results can be measured through the comments received via paper evaluations distributed post-session, illustrating the impact of each day-long session. A high-level summary of comments is as follows:

- The Role of Palliative Care in the Readmissions Challenge, June 2014
    - "How would you rate the speakers and presentations?" Out of 29 respondents, 27 (93 percent) rated the overall value of the program as "excellent" or "good" (choices were excellent, good, average, fair, poor); 27 out of 29 also rated the panel discussion as "excellent" or "good" for "format" and "practical value."

      Comments: "Very informative." | "Every presenter was knowledgeable in area of expertise."

- "Given everything you learned at this session, what was the most valuable to you?"

  Comments: "Confirmation that the work we are doing is extremely valuable, and global understanding of challenges and opportunities ahead" | "Hearing experts, questions and learning resources. Citation of resources, networking."

- Leveraging Community Resources to Improve Patient Health, October 2014
  - "How would you rate the speakers and presentations?" Out of 20 respondents, 19 (95 percent) rated the overall value of the program as "excellent" or "good" (choices were excellent, good, average, fair, poor).
  - "What did you learn today that you will take back and apply to your organization?"

    Comments: "Actual implementation of educational classes for diabetes re: diet, numbers, etc." | "Great sharing of annual well visit strategies and incentives." | "CHW Promotora Programs implementation within the health care system in the Inland Empire."

## LESSONS LEARNED

In continuing to improve on each meeting, CQC takes evaluations by attendees seriously, continuously evolving the symposia based on feedback to allow for more actionable education and interactive, collaborative sessions. Although CQC provides rough frameworks for the events, speakers are also involved in their development, allowing symposia to be designed for and by the clinicians and health care professionals who are the intended audience.

## NEXT STEPS/SPREAD

As a part of CQC's pursuit of increasing the quality and efficiency of care in California, CQC continues to offer symposia in 2015, with events planned in January, March, June and September (to be confirmed) in venues across California, attracting statewide attendees. The aim is to continue to attract health care professionals from within medical groups and health plans to allow for continued rich discussion of ideas about current issues and trends, cross-discipline understanding and inspiration.

# CQC LEAN HEALTHCARE CERTIFICATION | MAY 2014–PRESENT

## OVERVIEW

The CQC Lean Healthcare Certification program is an introductory course that teaches the background and basics of Lean, moderately complex tools, and includes a simulation and hands-on exercises. It strives to give participants a solid foundation from which to begin new projects at their organization, or to become an integral part of any performance improvement team using Lean to tackle workplace challenges. The program was codesigned by CQC and Health Care Associates (HCA) faculty, with oversight from UCLA Executive Programs in Health Policy & Management.

## STRUCTURE

The courses in 2014 were comprised of a two-day in-person training session, a webinar, another two-day in-person session, and a final webinar for review of key concepts prior to the certification examination. The exam consists of 100 questions and requires a score of 80 percent for the student to receive certification. The certification exam was created by CQC faculty and was vetted and administered by UCLA Executive Programs in Health Policy & Management. The curriculum for the course follows:

**Day 1**

Introduction to Lean + History and definition of Lean + Lean vs. Six Sigma + Definition and drivers of waste + Performance drivers/benchmarking + *Voice of the Customer* + Improvement project charters + Process flow mapping + Value stream mapping + Value added flow analysis

**Day 2**

Defining process requirements + Productivity measurement and tracking + SIPOCs + Creating a data collection plan + Data collection tools for performance, process time and causal analysis (check sheets, Pareto chart, frequency plot) + Waste assessment worksheet, waste wheel + Workplace arrangements / Spaghetti diagrams + Cycle, efficiency and Takt time calculations

**Webinar**

Data collection tools + Check sheets + Pareto charts + Frequency plot

**Day 3**

Root cause analysis (fishbone, Ishikawa Diagrams / Five whys) + Affinity diagrams + 5S + Quick changeover + Error proofing + Just-in-time principles (continuous one-piece flow, in-process stock, signaling pull, process pulse calculation) + Visual controls + Load leveling, sequencing and service leveling + Control tools (standard work)

**Day 4**

A3 + Lean management system (strategy deployment) project planning/reporting and stakeholder engagement + Leading improvement teams + Leading Kaizen events+ Team facilitation + Storyboards

# PROGRAM SUMMARIES

## PARTICIPANTS

**May 2014**

- Blue Shield of California
- Center for Care Innovation
- Chinese Community Health Care Association
- Health Plan of San Mateo
- Hill Physicians Medical Group
- HPMG
- Indian Health Center of Santa Clara Valley
- Kaiser Permanente
- Physicians Medical Group of Santa Cruz
- PIH Health
- SF Community Clinic Consortium
- SF Health Plan
- SF VA Medical Center
- St. Francis Medical Center
- USF School of Nursing

**November 2014**

- Alameda County Public Health Department
- Blue Shield of California
- Health Plan of San Mateo
- HealthRIGHT360
- Humboldt-Del Norte Foundation for Medical Care
- Kaiser Permanente
- LifeLong Medical Care
- Lucille Packard Children's Hospital Stanford
- Marin General Hospital
- MedPoint Management
- Salinas Valley Memorial System
- SF Health Plan
- St. Francis Medical Center
- Sutter Health
- UCSF-CEPC
- University of Pennsylvania

## RESULTS & MEASUREMENT

At the end of each course, all students complete an evaluation that provides CQC and the faculty with feedback. Both courses in 2014 were rated an average of 4.7 out of 5. The positive feedback from participants in the first two courses in 2014, plus the demand for seats in the class, has resulted in a renewed contract with the trainers from HCA for two additional courses in 2015, with the option of adding an Advanced Lean course and a Lean Management System course.

## LESSONS LEARNED

Based on feedback from participants and from a review of similar course offerings in the California market, CQC has changed the format of the course for 2015. Rather than four in-person days, there will be four 90-minute webinars to begin the course that cover the basic material and which are suitable for the web. They will be followed by two in-person sessions for hands-on/team activities, simulations and more interactive learning modules. This format has allowed a lower cost for the program, making it more competitive.

## NEXT STEPS/SPREAD

The two open courses planned for 2015 will be held in Northern and Southern California in May and October, respectively, each with the capacity to train approximately 35 students. Interested organizations will also have the option to hold private courses on their own campus. Based on interest and capacity, the instructors have offered to provide a leadership course and an advanced Lean course.

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*Also serves on CQC Executive Committee

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