IMPACT REPORT 2016

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CQC
California Quality Collaborative
Breakthroughs for Better Healthcare

Executive Summary

Dear Colleagues:

Despite the uncertainty of changes that a new administration and Congress in Washington, D.C. will make to health care in 2017, the California Quality Collaborative (CQC) remains focused on advancing the quality and efficiency of health care in California. As the preeminent, multi-stakeholder, quality improvement organization in California, CQC assists providers and plans to meet the demands of the current health care environment. CQC's activities incorporate the fundamental belief that patient outcomes can improve when systems of care are redesigned for quality and efficiency at multiple levels — delivery system, practice, and clinician.

In 2016, CQC programs focused on four aims:

Aim #1: Building the capacity of provider organizations to manage total cost of care

Aim #2: Improving chronic illness care for populations of patients where clinical quality scores are lowest

Aim #3: Expanding the availability of intensive outpatient care management for people with multiple, medically complex conditions

Aim #4: Advancing primary care provided by independent and solo physicians

We also continued to offer capacity building and professional development opportunities for providers through the CQC's Topics in Healthcare Symposia, which this year expanded on ideas issuing forth from CQC programming.

This 2016 CQC Impact Report details many of the accomplishments of these programs in the pages that follow, including these highlights:

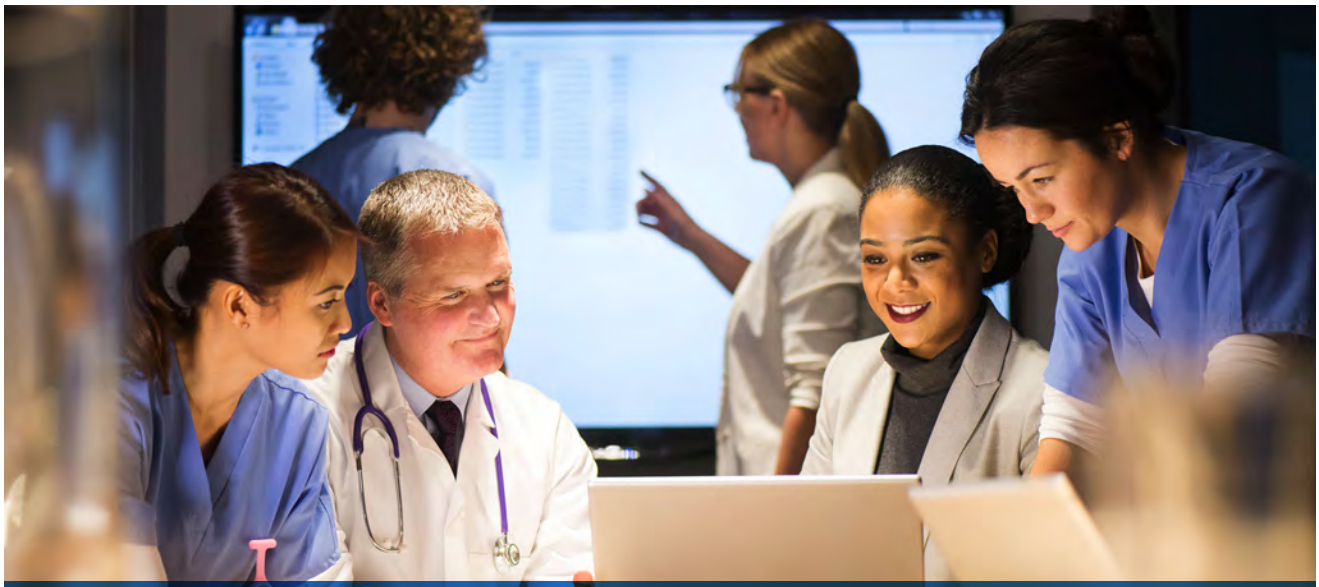
- A Total Cost of Care Action Community pilot program was launched with the goal of improving care outcomes for patients while reducing health care costs. (Aim #1)
- Thirteen delivery systems and 3,036 clinicians enrolled in our Practice Transformation Improvement initiative to improve Triple Aim measures of improved patient care experience, reduced cost of care, and improvements in population health. (Aim #2)
- CQC translated lessons from our Intensive Outpatient Care Program (IOCP) into technical assistance for 55 organizations serving Medi-Cal's medically complex populations in preparation for the Health Homes Program. We also released the IOCP toolkit, which offers guidance based on learnings from our three-year, 23 delivery-system CMS Innovation Award. Findings from IOCP hit the national stage in a Health Affairs blog. (Aim #3)
- Four health plans joined forces to create a quality improvement effort aimed at raising the care standards for independent health practitioners. The program offers rigorous data feedback for providers and intensive on-site coaching. (Aim #4)
- And finally, we welcomed three new health plan members in 2016: LA Care, SCAN Health Plan, and Molina Healthcare.

Although 2016 was full of achievements for CQC, we recognize that the ambiguity of potential changes in store for health care practice in the months ahead can be a source of strain. CQC plans to stay the course in supporting care transformation in California.

Sincerely,

Diane Stewart
Senior Director

Bart Wald
Medical Director



Aim 1 Managing Total Cost of Care

Total cost of care (TCOC) efforts are aimed at supporting affordability, reducing inefficiencies and highlighting cost-saving opportunities by examining the total cost of medical services utilized by a given patient population. Taking a TCOC approach has, at its core, the goal of improving care outcomes for patients while bringing down health care costs.

As TCOC increasingly becomes part of contract arrangements, provider organizations can benefit from a roadmap of ordered process changes to address the cost of care. In 2016, CQC developed the Total Cost of Care Action Community as a new program to explore patient management strategies that can reduce TCOC and improve quality across the health care sector.

Overview

The Total Cost of Care Action Community was created to support provider organizations in diagnosing and addressing the drivers of high health care costs and inefficiencies within their respective practices. It consists of learning sessions, webinars, peer networking, and dedicated practice coaches to support participants. The program has been designed to share successful interventions and support actions that reduce cost and utilization while maintaining or improving care quality.

The Action Community will be piloted in 2017 with provider organizations. Focus areas for action will be identified by examining current performance metrics and existing "pain points" in a particular payer population (e.g., Commercial, Medicare Advantage, Medi-Cal Managed Care). Data on measures of hospital and emergency department utilization will be collected throughout the program and shared with participants.

Changes Adopted by Participants

We anticipate participants will choose TCOC strategies that target better inpatient and outpatient care coordination while addressing specific cost centers (e.g., imaging, ambulatory surgery centers).

Results

- The Total Cost of Care Action Community program structure was developed and initial outreach to provider organizations has begun.
- A best practice guide on TCOC — Managing Cost of Care: Lessons from Successful Organizations — was published on the California Health Care Foundation website.

Next Steps

CQC is recruiting participants. The program will launch by June 30, 2017.

Participants

To be determined.

Aim 2 Practice Transformation

An unprecedented number of Californians have gained health care coverage through Medi-Cal expansion and the public insurance exchange. The growth in health care access, while positive, can put greater strain on the care delivery system to deliver high-quality health care and patient outcomes at a manageable cost. CQC has continued to build on its experience with population health management at the delivery-system level and its work with primary care practices through the Practice Transformation Initiative to scale Triple Aim improvement for patients in greatest need.

Overview

The Practice Transformation Initiative (PTI) was created to help clinicians advance the quality of their practices, lower healthcare costs, and improve the health of patients. The goals over the life of the four-year initiative are to:

- Demonstrate an average 15% quality improvement across PTI's clinical quality measures (e.g. blood pressure control measures, asthma medication uptake, and various clinical tests for patients with diabetes).
- Save $242 million by reducing utilization measures at least by 5%.
- Ensure that 75% of clinicians receive regular feedback from patients about their personal care experience.

2016 Attendee Estimates for CQC On-Site Events

800 Unique Attendees
250 Unique Organizations

Program Totals: On-Site Events & Webinars

25 Medically Complex
5 Building Capacity
14 Practice Transformation

CQC is partnering with the Center for Care Innovations (a health care improvement consultancy) and the Integrated Healthcare Association (for data collection) to execute the program over four years.

CQC has recruited 15 provider organizations to participate in PTI. These participants represent a variety of organizational types (independent practice associations, medical groups, and health plans), geographical locations (urban, suburban, and rural practice sites), and payer mix (Medicare, Medi-Cal, and commercial). Participants hire practice facilitation coaches who are trained by PTI to work with practices using the 10 Building Blocks of High-Performing Primary Care developed by the Center for Excellence in Primary Care at the University of California San Francisco. Quarterly convenings are designed to foster peer-to-peer learning and provide comprehensive technical assistance,

Aim 2 Practice Transformation

including individualized improvement advising for each organization, virtual learning sessions, a data results portal, and an online community.

Participants are expected to submit 12-month data reports on a quarterly basis and share monthly results with clinicians. In November, the Integrated Healthcare Association launched the PTI Data Results Portal which helped provide greater data visualization at three levels: organization, practice, and clinician.

Changes Adopted by Participants

Initial practice improvements include the co-location of physicians and team members with whom they work closely, nursing protocols for common patient care needs, and standing orders for missing labs.

Results

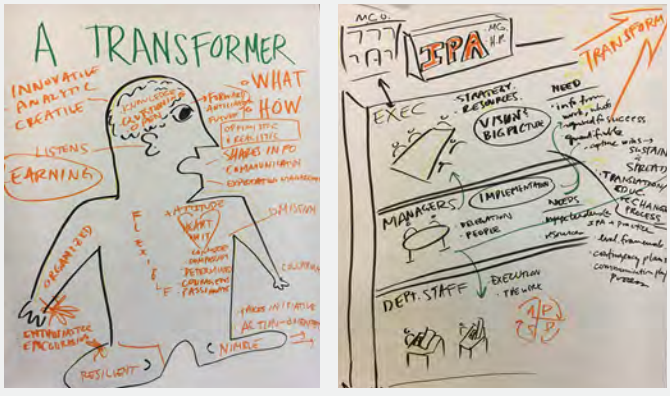
- A complete baseline data set was collected from all participants.
- Monthly results across 12 clinical quality measures were collected from 3,036 clinicians.
- Fifty practice coaches were hired and trained.

Next Steps

- Our 2017 learning sessions will include quarterly in-person learning sessions, monthly webinars, and two in-person trainings for practice coaches.
- Additional provider organizations will be onboarded into the program.
- Progress on changes happening within practices and the subsequent impact on measure results will be monitored and shared.

Practice Transformation Participants

1. Allied Pacific IPA
2. AppleCare Medical Management
3. Central Valley Collaborative
4. EPIC Management
5. HealthCare Partners
6. Hill Physicians Medical Group
7. MedPOINT Management
8. Molina Health Plan
9. Molina Medical Group
10. North Coast Health Improvement & Information Network
11. Palo Alto Medical Foundation
12. Physicians Medical Group of San Jose
13. Prospect Medical Group
14. Riverside Physician Network
15. St. Joseph Hoag Health
16. Sharp Community Medical Group
17. Sutter Pacific Medical Foundation



A graphic facilitator was used during a PTI learning session to illustrate qualities for leading transformation.

Aim 3 Intensive Outpatient Care Management

The vast majority of health care spending is often concentrated among a small population of patients who use a disproportionately large number of services. Intensive outpatient support has been shown to improve care and reduce the use of more expensive in-patient services.

CQC developed the Intensive Outpatient Care Program (IOCP), beginning in 2012, with the goal of expanding the availability of intensive outpatient management for people with multiple, medically complex conditions. The IOCP embeds care coordinators in physician practices to teach medically complex patients how to manage their conditions while ensuring seamless transitions among multiple providers and services.

In 2016, CQC developed two new programs under the IOCP initiative to assist provider organizations seeking to strengthen outpatient care models that can better support high-need, high-cost patients:

- Health Homes Program — focused on provider organizations serving Medi-Cal patients
- Building Care Solutions — focused on provider organization serving Medicare patients

HEALTH HOMES PROGRAM

Overview

CQC contracted with the California Health and Human Services Agency and the Department of Health Care Services to adapt the Intensive Outpatient Care Program care model and training approach and apply it within organizations working with medically complex Medi-Cal patients. By expanding the IOCP model to a larger cohort in 2016, CQC is helping to proactively support delivery-system transformation in advance of the implementation of the Medi-Cal Health Homes for Patients with Complex Needs program (Health Homes Program), rolling out in July 2017.

In 2016, CQC offered training for the first wave of managed care plans and provider organizations participating in the Health Homes Programs, including:

- Training for care coordinators and managers of care coordinators delivered by Primary Care Development Corporation and University of California, San Francisco. Training was completed by June 30, 2016.
- Training for leadership teams to redesign processes that identify and manage high-need, high-cost Medi-Cal patients. CQC led a series of two Practice Transformation Learning Sessions for the project implementation teams from May to September 2016.

Aim 3 Intensive Outpatient Care Management

Changes Adopted by Participants

Training sessions provided a venue for managed care plans and provider organizations to plan for the Health Homes Program together. Implementation teams learned best practices for leading change, supporting multi-disciplinary care teams, integrating behavioral health, and strengthening financial sustainability. Care coordinators learned techniques for engaging patients, applying principles of trauma-informed care, and integrating a person-centered approach to psycho-social assessment.

Results

- Seven Medi-Cal managed care plans and 43 provider organizations attended training sessions in 2016.
- Training attendees represented 26 California counties.
- Ratings for the training sessions from the three training audiences — care coordinator, managers of care coordinators, and implementation teams — were excellent:
  - + Nearly 100 percent of survey respondents rated the care coordinator training as "relevant to their work and well organized."
  - + About 90 percent of managers of care coordinators rated the quality of the course and faculty either a four or five on a 5-point scale (with five being most satisfactory).
  - + About 90 percent of implementation team audiences rated the quality of the course and faculty either a four or five on a 5-point scale.

Next Steps

The Health Homes Program was completed in January 2017. CQC provided the Department of Health Care Services a summary of training materials, lessons learned, and a guidebook to support future technical assistance.

Health Homes Program Participants

1. Abode Services
2. Alliance Medical Center
3. Anthem
4. BAART
5. Cal Optima
6. Central California Alliance for Health
7. Collabria Care
8. CommuniCare Health Centers
9. Community Medical Centers, Inc.
10. Community Solutions
11. County of Monterey Clinic Services
12. County of Santa Cruz Health Centers Agency
13. Dignity Health
14. ePath
15. Encompass Community Services
16. Fairchild Medical Clinic
17. Gardner Family Health Center
18. Golden Valley Health Center
19. Health Plan of San Mateo
20. HealthRight360
21. Hill Country Community Clinic
22. Institute on Aging
23. Lifelong Medical Care
24. Livingston Community Health
25. Marin City Health and Wellness Center
26. Marin Community Clinic
27. Mendocino Community Clinic
28. Mission Neighborhood Health Center
29. Mountain Valleys Health Centers
30. Natividad Medical Center
31. North East Medical Services
32. Northeastern Rural Health Clinic
33. Open Door Community Clinic
34. Partnership Health Plan
35. Peninsula Healthcare Connection
36. Petaluma Health Center
37. Ravenswood Family Health Center
38. Queen of the Valley Medical Center
39. San Francisco Health Network
40. San Francisco Health Plan
41. Salud Para La Gente
42. Santa Clara Family Health Plan
43. Santa Cruz Community Health Centers
44. Santa Rosa Community Health Centers
45. Shasta Community Health Centers
46. Shingletown Medical Center
47. Saint Anthony Medical Clinic
48. St. Helena Family Health Center
49. The Health Trust
50. West County Health Center

Aim 3 Intensive Outpatient Care Management

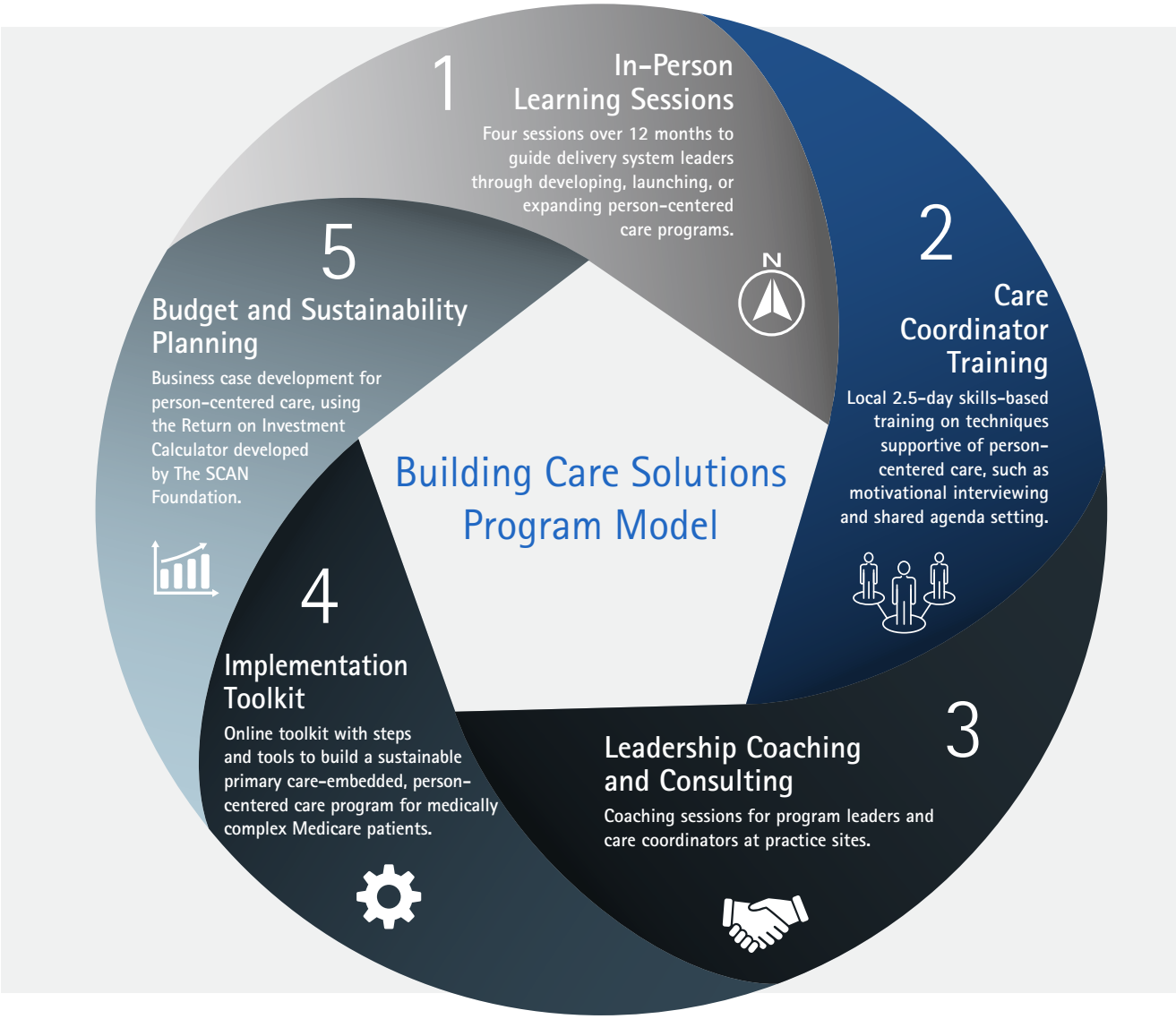
BUILDING CARE SOLUTIONS

Overview

With funding from The SCAN Foundation, CQC began planning a program known as Building Care Solutions for Older Adults with Complex Needs for provider organizations serving the medically complex Medicare population. The program builds on the IOCP model where care coordinators build strong relationships with patients and engage them in managing their care while keeping them safely at home. Financial planning is integrated into the program to support the financial sustainability of provider organizations.

Building Care Solutions uses a collaborative model with three clusters of provider organizations working together to improve care for their senior population. Recruiting is underway and it is expected that provider organizations from multiple states will join as participants.

The program model is as follows:



Aim 3 Intensive Outpatient Care Management

Changes Adopted by Participants

Program participants will sharpen patient identification and engagement techniques and develop multi-disciplinary teams to support patients with complex medical, behavioral, and social needs.

Results

- Based on continued learnings from participants, significant updates were made to the IOCP Toolkit, adding more implementation resources. A revamped Toolkit was published in December, 2016.
- The updated IOCP Toolkit was included in a national online resource — The Playbook: Better Care for People with Complex Needs

Next Steps

- Building Care Solutions will launch its first collaborative in April, 2017, in Los Angeles, with two additional collaboratives to follow.
- Care coordinator training will begin after the launch of the first collaborative, including techniques to improve patient engagement.

Building Care Solutions Applicants

Several groups have already submitted letters of interest and are planning to join the program:

1. EPIC Management
2. Jewish Family and Children's Services of San Francisco, the Peninsula, Marin, and Sonoma Counties
3. Regal Medical Group
4. Riverside University Health System
5. Salinas Valley Memorial Hospital System

Aim 4 Advancing Independent Practices

Despite the spread of managed care models and payment changes brought on by the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, there remains a portion of physicians in California who operate independently, without strong connections to independent physician associations. These physicians face unique challenges amid the shifting health care landscape. CQC is tailoring its quality improvement expertise to meet the needs of these physicians.

Overview

Covered California requires participating health plans to implement a quality improvement program for independent clinicians (i.e., those not affiliated with an independent practice association or medical group). With support from CQC, four health plans (Blue Shield of CA, Anthem, Health Net, and Molina) teamed up in 2016 to create a single program — Advancing Independent Practices — to engage lower-performing independent practices in quality improvement strategies. Using a statewide, multi-payer claims database, CQC identified geographic clusters of lower-performing clinicians on diabetes measures. CQC then developed a quality improvement program for a subset of the lower-performing clinicians that combines data feedback with intensive on-site coaching support to raise the quality of care these providers give.

Changes Adopted by Participants

Program participants will develop databases of patients with chronic conditions that practice staff can use to proactively manage patients.

Results

- To date, geographic clusters of lower-performing clinicians on diabetes measures have been identified in Southern California.

Next Steps

- Share the model with three to five solo practices to learn more about their needs and motivation to engage in the technical assistance program.
- Identify a quality improvement partner who will offer practice coaching support.
- Develop a value proposition to encourage greater independent clinician participation.
- Recruit up to 200 independent clinicians in Southern California by April 30, 2017.

Building Capacity

Overview

CQC's Topics in Healthcare Symposia are one-day conferences that focus on key topics of interest to the health care community. The Symposia are designed to foster in-depth discussions and networking with medical group, health plan and clinic staff participants. Experts offer their perspective on various aspects of the topic at hand. The Symposia attract a variety of professionals from across the care delivery spectrum.

In 2016, the Symposia topics explored themes from the CQC work described above, including:

- Improving Behavioral Health Access, Coordination & Data for the Medi-Cal Population: A Health Plan Perspective, January 25, 2016 (Ontario, CA)
- Practice Transformation in California, October 5, 2016 (Oakland, CA)
- Medically Complex Patient Care: Best Practices Symposium, November 15, 2016 (Los Angeles, CA)

Results

- Over 175 professionals participated in the 2016 Symposia.
- Program feedback for Improving Behavioral Health was extremely positive. Feedback included comments such as:
  - + "The organizers were great. So nice, well-organized, good time keeping."
  - + "Topics were helpful — thank you!"
- For Practice Transformation in California, 90 percent of the survey respondents replied that the symposium met their learning objectives.
- For Medically Complex Patient Care, 100 percent of survey respondents rated it as "Excellent" or "Good".

Next Steps

In 2017, CQC will host two symposia. A Total Cost of Care symposium will be held in the spring and the second topic is in development.

Speakers in 2016 included:

Improving Behavioral Health Access, Coordination & Data for the Medi-Cal Population

Peter Currie, PhD, Senior Director of Clinical Transformation and Integration; Senior Clinical Director of Behavioral Health, Inland Empire Health Plan

Jennifer Clancy, MSW, Jen Clancy Consulting

Marc Avery, MD, University of Washington

Tom Riley, Cal Capitol Group

Sandra Pisano, PsyD, Manager of Behavioral Health, AltaMed Health Services

Practice Transformation in California

Dr. Lance Lang, Covered California

Dr. Ashby Wolfe, Centers for Medicare & Medicaid Services (CMS)

Sunday Marquez, MPH, Sharp Community Medical Group

Crystal Eubanks, MS, Pacific Business Group on Health

Medically Complex Patient Care — Best Practices Symposium

Brad Gilbert, MD, MPP, CEO, Inland Empire Health Plan – Keynote

Lee Suyenaga, CEO, Central Health Medicare Plan and MSO

Neil Solomon, MD, FACP, Co-Founder/Chief Strategist/ CMO, MedZed, LLC

Nina Vaccaro, Chief Operating Officer, CCALAC

Stefany Almaden, PhD, RN, Sr. Director, Clinical Member Services, LA Care Health Plan

Diane Factor, Executive Director, Worker Education Resource Center

Bridget Hogan Cole, Executive Director, Institute for High Quality Care

Erin Westphal, Program Officer, The SCAN Foundation

Scott Heimer, Project Manager, Sharp Rees-Steely Medical Centers

Lisa Payne Simon, Senior Advisor & Consultant

Margie Powers, Director, Pacific Business Group on Health

Building Capacity Participants

1. Building Capacity Participants
2. Allied Pacific
3. AltaMed Health Services
4. Andrew Flowers Inc.
5. Anthem Blue Cross
6. ArborMetrix
7. Blue Shield of California Foundation
8. Boehringer-Ingelheim
9. Cal Capitol Group
10. California Quality Collaborative
11. CalOptima
12. Community Clinic Association of Los Angeles County
13. Center for Care Innovations
14. Central Health Medicare Plan and MSO
15. CHOC Foundation
16. Clinicas de Salud del Pueblo
17. Community Health Systems, Inc
18. COPE Health Solutions
19. County of San Bernardino
20. Cozeva
21. CSH
22. Cynosure Health
23. End-to-End Analytics
24. EPIC Management, L.P.
25. Forster Private Hospital
26. Health Net of California
27. Health Plan of San Mateo
28. Heritage Provider Network
29. Hill Physicians
30. Hospital Association of Southern California
31. Health Services Advisory Group
32. Inland Empire Foundation for Medical Care
33. Inland Empire Health Plan
34. Institute for High Quality Care
35. Integrated Healthcare Association
36. Jen Clancy Consulting
37. LA Care Health Plan
38. LMT & Associates Consulting
39. LSN Health Strategy
40. MedPOINT Management
41. MedZed, LLC
42. Merck
43. Molina Healthcare
44. Peer Health Exchange
45. Pinnacle Medical Group
46. Planned Parenthood
47. Regal Medical Group
48. Riverside University Health System
49. San Bernardino County Department of Behavioral Health
50. Sharp Community Medical Group
51. Sharp Rees-Steely Medical Centers
52. St Joseph Heritage
53. St. Anthony Medical Clinic
54. Sutter-PAMF
55. SynerMed
56. The SCAN Foundation
57. The WellPoint Companies, Inc.
58. UC Berkeley
59. UC San Francisco
60. UCSF Benioff Children's Hospital Oakland
61. UnitedHealthcare
62. University of Washington
63. Worker Education Resource Center

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MOLINA HEALTHCARE

Health Net

L.A. Care HEALTH PLAN

CAPG The Voice of Accountable Physician Groups

scan HEALTH PLAN

PBGH PACIFIC BUSINESS GROUP ON HEALTH

UnitedHealthcare

Boehringer Ingelheim

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

NestléHealthScience Where Nutrition Becomes Therapy

Bristol-Myers Squibb