REDUCING HOSPITAL READMISSIONS ▸ IMPROVING CHRONIC CARE ▸ BETTER MANAGEMENT FOR COMPLEX PATIENTS

Impact 2011

Each year, CQC offers programs to improve clinical quality, patient experience and cost of care to nearly 1,000 leaders and staff from 300 organizations providing health care to an estimated 6.5 million Californians. CQC offers expert training and peer-to-peer learning via a combination of teleconferences, one-day on-site sessions and year-long intensive programs. During 2011, CQC focused on improving chronic care, the Medicare Star quality measures, care for medically complex patients and reducing hospital readmissions. Programs brought together clinicians, staff and executives from physician groups, health plans and community agencies around a shared goal of improving patient care in California.

▸ REGIONAL LEARNING NETWORKS ▸ IMPROVING CARE FOR MEDICARE PATIENTS ▸

CQC
California Quality Collaborative
Breakthroughs for Better Healthcare

Reducing Hospital Readmissions

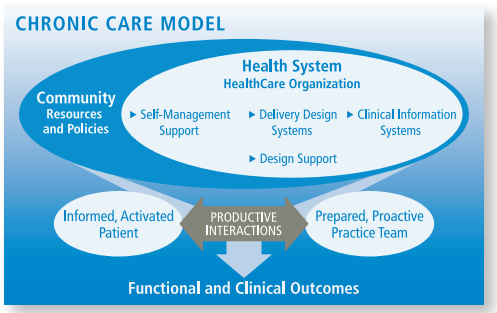
Why: A 2010 brief released by the National Priorities Partnership estimates that preventable hospital readmissions account for $25 billion of wasteful health spending.[1] Preventable readmissions can negatively impact patients' quality of life and often reflect an absence of care coordination and information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

How: CQC partnered with Cynosure Health and the Gordon and Betty Moore Foundation to offer an Avoid Readmissions through Collaboration (ARC) program that brought together California hospitals and their partners in the community to prevent readmissions. In 2011 ARC:

- Hosted quarterly on-site learning sessions in Oakland for 52 hospitals and hospital partners to understand existing evidence-based models to reduce readmissions.
- Led participants through a self-assessment and 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 their facility to spread change.

Results: With 18 months worth of data available, hospitals participating in the program have already reduced their average rate of readmissions from 13 percent to 11 percent – a 15 percent decrease – preventing admissions for 300 patients per month.

Next Steps: ARC will continue in 2012 with the goal of reducing 30 and 90-day readmission rates by 30 percent by 2013.



Improving Chronic Care

Why: Cardiovascular disease and diabetes represent the first, third and seventh leading causes of death in the United States.[2] Although there are widely accepted care guidelines for diabetes and heart disease, gaps between recommendations and the care provided persist. In California, 2011 reporting year data from the Integrated Healthcare Association's (IHA) P4P program for over 200 physician groups shows a wide variation in performance for the comprehensive diabetes care measures. Optimal diabetes care performance ranged from zero to 60 percent, indicating that even in the best groups, just over half of patients with diabetes received optimal care.

How: CQC developed an intensive 15-month Chronic Care Collaborative to assist provider organizations to measurably improve diabetes and heart disease measures for patients in areas of California with the poorest data outcomes. In 2011 CQC:

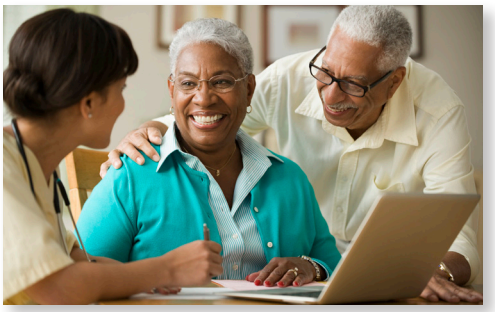
- Hosted four on-site meetings for participants from five physician groups, caring for 250,000 patients, to implement multiple changes based on the Chronic Care Model.
- Trained participants on implementing and leveraging data systems to identify and act on gaps in care, evidence-based practices to improve diabetes and heart care, and techniques to engage physicians in change.
- Supported groups as they implemented pilot tests and spread changes in their networks through bi-weekly coaching calls and two on-site visits to each provider group.

Results: The participating groups nearly doubled the number of patients meeting blood pressure targets, and closed the gap by 20 percent for seven of the eight target measures for diabetes and heart disease. These improvements in chronic care impacted more than 13,000 patients with diabetes.

Next Steps: In 2012 CQC expanded this work by launching the Compass Program, an ambitious collaborative to improve key chronic care measures that appear on multiple measure sets for both Medicare and commercial populations.

I am especially proud that this is a collaborative approach with the physician organizations, health plans, CQC and community advocacy partners. It is an open exchange of real problems and real solutions. Each group can point to an improvement related to quality and/or service as a result of CQC.

— Howard Saner, CEO, Riverside Physician Network



Better Management for Complex Patients

Why: The average per capita spending for patients living with four chronic conditions is 10 times higher than those without a chronic condition.[3] While much is known about how to care for patients with one chronic condition, less is known about how to manage high-cost patients with multiple and complex chronic conditions.

How: CQC partnered with the California HealthCare Foundation (CHCF) to convene a Complex Care Management Action Community, comprised of eight leading California organizations that are working to redesign and improve care for patients with multiple chronic conditions, limited functional status and psychosocial needs, who account for a disproportionate share of health care costs and utilization. In 2011 CQC and CHCF:

- Facilitated peer learning among eight organizations to share and test improvements in care that lead to better health outcomes at lower cost.
- Compiled learning on common changes across participating organizations, including strengthening approaches to risk stratification of patients, developing more robust measurement strategies, improving care transitions, tightening care coordination through improved communication and redesigning care team models.

Results and Next Steps: CQC developed a comprehensive toolkit to spread the Action Community learning to other organizations in California in 2012. The toolkit is available for download on CQC's website (www.calquality.org).

1 *Compact Action Brief: A Roadmap For Increasing Value in HealthCare. Preventing Hospital Readmissions: A $25 Billion Opportunity*. National Priorities Partnership, November 2010.
2 Healthy People 2020 website – www.healthypeople.gov
3 *Care management of patients with complex health care needs*. By Thomas Bodenheimer, MD, MPH and Rachel Berry-Millett, BA. Robert Wood Johnson Foundation Research Synthesis Project Report No. 19, December 2009.

Regional Learning Networks

Why: Publicly reported measures of clinical care and patient experience for organizations in Riverside and San Bernardino Counties (AKA the Inland Empire), have historically lagged far behind state averages.

How: CQC continued to host the Inland Quality Collaborative (IQC), an effort started in 2007 which brought together Inland Empire physician groups, health plans and the California Association of Physician Groups to improve patient care for the 1.5 million commercial patients living in the Inland Empire. Throughout this program CQC:

- Hosted quarterly on-site sessions for physician groups, health plans and community agencies in the region to foster peer-to-peer exchange of ideas and approaches to improve patient care.
- Sponsored one-day training sessions on aspects of quality improvement.
- Sponsored dinner sessions among health care executives on the case for care improvement.
- Facilitated regional conferences showcasing efforts to improve patient care.

Results:

- Progress was tracked using the following IHA P4P measures: HbA1c testing, HbA1c control, LDL testing and LDL control in coronary artery disease.
- Data shows improvement in the Inland Empire outpaced all but one region in the state, improving care for 700,000 patients.

Next Steps: Now that the many Inland Empire groups have reached or surpassed the state mean on key measures, the IQC has been sunsetted and Inland groups are joining state-wide programs offered by CQC.

The nature of the job is that everyone needs something done now; it's easy to be frantic and less intentional. To have someone tutor you through a vision helps … CQC's Action Community helped to keep us moving forward with a plan, and to be less reactive, more proactive and intentional.

— Maria De Lima, MD, High Desert Medical Group

Improving Care for Medicare Patients

Why: The Centers for Medicaid and Medicare Services (CMS) introduced quality measures for Medicare Advantage health plans in 2007, and created financial incentives for improved performance. Only one California health plan achieved the highest rating, five stars, in 2011. Although Star ratings are reported at the health plan level, measurement reflects an aggregation of plan and physician organization performance. Because every group's performance impacts the final score and physician organizations are reimbursed based as a percentage of health plan revenue, the ideal improvement strategy is a collaborative effort.

How: CQC rapidly launched the Meteor Program, which assisted physician groups in improving performance on key Medicare Star measures for 2011 during the last six months of the year. In 2011 CQC:

- Worked with 12 physician groups to strengthen approaches to patient and physician outreach to close care gaps within six months.
- Offered a robust curriculum, focused on the role of centralized functions in coordinating bidirectional data exchange with plans to generate gap or exception reports, physician outreach and engagement, member outreach to close gaps through phone calls or reminder letters and group-sponsored senior wellness clinics.
- Hosted two in-person meetings and offered coaching calls by CQC staff throughout the program.

Results: The Meteor approach demonstrated that individual groups can improve quality performance within just six months with a focused, centralized effort by the group staff.

- Coast Healthcare Management improved osteoporosis management in women with a fracture at each of its three IPAs and improved from a one-star to a three-star rating on this measure.
- Alta Bates Medical Group reached a five-star rating for breast and colorectal cancer screenings.
- High Desert Primary Care improved Star ratings by implementing birthday card reminders and comprehensive visits at a dedicated wellness center.
- Choice Medical Group and PrimeCare Riverside improved multiple Star measures through outreach and education of PCPs, augmented member outreach and a senior health and wellness center.

Next Steps: In 2012 CQC expanded this work by launching the Compass Program, an ambitious collaborative to improve key chronic care measures that appear on multiple measure sets for both Medicare and commercial populations.

California Quality Collaborative would like to acknowledge the following organizations for supporting the program in 2011:

- Anthem Blue Cross
- Blue Shield of California
- Boehringer Ingelheim
- California Association of Physician Groups
- California HealthCare Foundation
- Cigna
- Gordon and Betty Moore Foundation
- Health Net
- Novo Nordisk
- Pacific Business Group on Health
- Robert Wood Johnson Foundation
- SCAN Health Plan
- United Healthcare

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