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CQC
California Quality Collaborative
Breakthroughs for Better Healthcare

2013
IMPACT REPORT

Advanced Medical Management • Affinity Medical Group • Anthem Blue Cross • Anthem Blue Cross Foundation • AstraZeneca Axminster Medical Group • Blue Shield of California • Boehringer-Ingelheim • Brown & Toland Physicians • California Association of Physician Groups • California HealthCare Foundation • Choice Medical Group • Cigna • Cigna Medical Group • Community Health Center Network (Alameda County) • Dignity Health (Arizona Care Network, GEMCare, Dignity Health Medical Foundation – Dominican, Dignity Health Medical Foundation – Mercy Medical Group, Southern California Integrated Care Network – Ventura, Southern California Integrated Care Network – Inland Empire, St Rose Quality Care Network (Nevada), Woodland Clinic) • Epic Management, LP • Gordon & Betty Moore Foundation • Greater Newport Physicians • Health Care Partners • Health Net of California • Health Plan of San Mateo • Independence Medical Group • Inland Empire Health Plan John Muir Health • Lakeside Community Healthcare • La Clinica De La Raza • Managed Care Systems • MedPOINT Management • Memorial Care Medical Group • Meritage Medical Group • Monarch Healthcare • Monarch (MHIPA, Optum Health) • NAMM (Prime Care Sun City, Prime Care Chino) • Pacific Partners Management Services Incorporated (PPMSI) • Palo Alto Medical Foundation • Partnership HealthPlan of California PIH Health Physicians • Regal Medical Group • San Diego Physicians Medical Group • San Francisco Department of Public Health • San Francisco General Hospital & Trauma Center • Santa Clara County IPA (SCCIPA) • Santa Clara Valley Medical Center • SCAN Health Plan • Scottsdale Health Partners (Arizona) • Sharp Community Medical Group • Sharp Rees-Stealy • Sierra Nevada Medical Associates IPA • St. Joseph Heritage Medical Group • St. Joseph Hospital • St. Jude Heritage Medical Group • St. Luke's Health System (Idaho) • St. Mary's Medical Center • Sutter Health (Sutter Gould Medical Foundation, Sutter Pacific Medical Foundation, Sutter Medical Foundation) • Sutter Medical Network • Synermed (Angeles IPA, EHS Medical Group) • The California Endowment • The Polyclinic (Washington) • Torrance Hospital IPA • UCSF Medical Center • UnitedHealthcare

CQC
California Quality Collaborative
Breakthroughs for Better Healthcare

Table of Contents

California Quality Collaborative

California Quality Collaborative (CQC) is a healthcare improvement organization dedicated to advancing the quality and efficiency of health care delivery systems in California. As part of Pacific Business Group on Health, CQC started in 2002 under the auspices of Diabetes Continuous Quality Improvement (DCQI). In 2007, the California Quality Collaborative was established as a program.

CQC generates scalable and measurable improvement in care delivery in ways important to patients, purchasers, providers, and health plans.

Proven Success in 2013

- 370 Medical Groups
- Number of Readmissions Prevented = >6,317
- Cost Savings = >$60,643,200
- Over 1,000 Professionals Trained
- 30 Learning Sessions
- 25 Webinars

*January 2010 - December 2013, via Avoiding Readmissions through Collaboration initiative

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 only sustainable 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:
  - » 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 healthcare improvement programs:

- Healthcare quality improvement training programs engage California physician groups and hospital leadership teams to manage change across their organizations to achieve evidence-based, patient-centered care
- Topic-specific collaboratives 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

Letter from the Interim Director, Cindi Ardans, BSHA, CPHQ

California Quality Collaborative's vision for the future of health and health care in our communities is the delivery of optimal care to patients as a result of redesigned care. We believe the best way to do this is through work which fundamentally adheres to principles of quality improvement and strong commitment to local presence as well as autonomous local leadership that engages, aligns with, and strengthens existing initiatives in our state.

Led by national and state experts in the field, CQC offers a range of healthcare improvement programs. CQC uses the IHI Breakthrough Series Model and the Model for Improvement as a foundation for promoting change in the health care delivery system through these programs. Our skill-building workshops give individuals valuable tools to enhance skills, spread change, and create lasting impact within their organizations.

We believe in supporting collaborative practice transformation that benefits all patients, regardless of payer type.

Thank you to all of you who have been on our healthcare redesign journey so far – we look forward to an exciting 2014 year as we continue to seek new ways to accelerate redesign throughout the care delivery continuum.

Cindi Ardans, BSHA, CPHQ
Interim Director

Letter from the Clinical Director, Lance Lang, MD, FAAFP

As California's preeminent multi-stakeholder improvement organization in the outpatient setting, the value of the California Quality Collaborative is seen in the improved outcomes achieved by those participating in CQC collaboratives.

CQC's programs focus on enabling organizations to achieve the "quadruple aim:" patient centered goals of better health outcomes and better experience at a lower cost, as well as a more satisfying professional experience for care teams through better organization of care.

Examining the results of CQC programs from 2013 is truly exciting; the results illustrate how California Quality Collaborative was able to affect change by supporting organizational planning and disciplined execution. It is thrilling to see organizations progress and excel as they adopt the tools of quality improvement for the benefit of their patient populations.

Physician organizations in California have a long history of leading the nation. Now in this exciting time of health reform, we are demonstrating what accountable care looks like and what is possible through proactive planning and coordination across institutional boundaries.

We hope that you will join us as we stay the course, committed to improvement.

Lance Lang, MD, FAAFP
Clinical Director

Avoid Readmissions Through Collaboration (ARC Program)

OVERVIEW

Avoid Readmissions through Collaboration (ARC) brings together hospitals and their communities to prevent readmissions. ARC is a partnership between Cynosure, California Quality Collaborative (CQC) and funded by the Gordon and Betty Moore Foundation. Given that readmission rates in California are not much better than national norms, ARC's vision was to reduce 30 and 90 day readmission rates by 30% by the end of 2013.

STRUCTURE

Quarterly on-site Learning Sessions in Oakland started as a forum for hospitals and their partners (e.g. medical groups/IPAs, home health, long term care and community agencies) to understand existing evidence-based models to reduce readmissions. The program led participants through a self-assessment to an action plan tailored for their own institution. In addition, ARC convened affinity groups for pharmacists, chartered a patient advisory committee and offered webinars with national experts. ARC co-sponsored the California Readmission Summit with California Hospital Association and Health Services Advisory Group (HSAG), drawing 365 participants from around the state to learn from national and local leaders on successful approaches to reducing readmissions.

MEASUREMENT

The hospitals in the Action Network submit data monthly, including the following measures:

1. 30-Day All-Cause Readmissions Rate
2. 90-Day All-Cause Readmissions Rate
3. HCAHPS Patient Survey: Did hospital staff talk with you about whether you would have the help you needed when you left the hospital?
4. HCAHPS Patient Survey: Did you get information in writing about what symptoms or health problems to look out for after you left the hospital?
5. HCAHPS Patient Survey: 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.

PARTICIPANTS

Participants who are submitting data to the Action Network include:

- Alameda Health System
- Alta Bates Medical Center
- Chinese Hospital
- Eden Medical Center
- ElCamino Hospital
- Lodi Memorial Hospital
- Marin General Hospital
- Mills Peninsula
- O'Connor Hospital
- San Francisco General Medical Center*
- Santa Clara Valley Medical Center
- Sequoia Hospital
- Seton Medical Center
- St Francis Lynwood*
- St Francis Memorial Hospital*
- St Mary's Medical Center
- St Rose Hospital
- Sutter Delta Medical Center
- UCSF Medical Center
- VA Medical Center San Francisco
- VA Palo Alto Healthcare System
- ValleyCare Health System Washington Hospital Healthcare System

* Partial Data

QUOTATION

"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

(ARC Continued)

RESULTS

The 24 hospitals reporting through the Action Network saw:

- **8% reduction in 30-Day All-Cause Readmission Rate across the 18 hospitals**
- **Over 1,400 readmissions "saved" over the 2-year life of the program, resulting in over $10 million in estimated savings**

During the time period of January 2010 - December 2013:

- **Number of Readmissions Prevented = > 6,317**
- **Cost Savings= > $60,643,200**

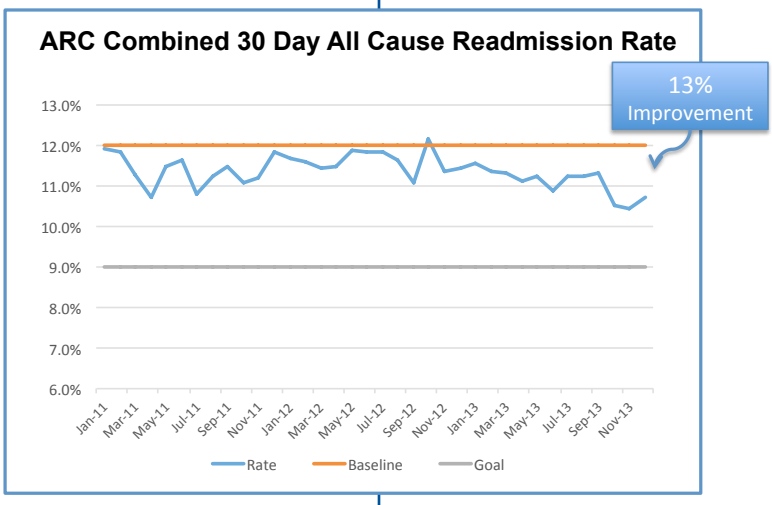
NEXT STEPS

In order to sustain the progress and to further advance the goal of reducing 30 and 90 day all cause readmissions, the Gordon and Betty Moore Foundation will support development of a sustainability plan for continued work in the Bay Area, including a convening of hospital CEOs in Q2 2014.

PROGRAM HIGHLIGHTS

# of Readmissions Prevented = >6,317

Cost Savings =>$60,643,200



QUOTATION

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

– Washington Hospital

Take Accountability for Ambulatory Care Transitions Collaborative (TAACT Program)

OVERVIEW

CQC offers the 6 month Take Accountability for Ambulatory Care Transitions (TAACT) Collaborative as a means to spread best practices and allow organizations the opportunity 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 have (1) a clear, tested strategy for reducing readmissions and (2) a defined change plan for spreading their chosen model widely to achieve scale.

STRUCTURE

The TAACT Collaborative is a series of staggered, six-month long commitments that are 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
- Cohort D: June 2014 – December 2014 – Los Angeles / Orange County

MEASUREMENT

The key outcome measure which all participants report on are 30 day all-cause readmission rates. Additional process measures specific to individual organizations are 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 of decrease in ED utilization among "TAACT patient" population period of twelve months following the conclusion of the collaborative.

Organizations are required to report their data throughout the collaborative on a bi-monthly basis and then quarterly for a period of twelve months.

INTERVENTIONS

In order for each organization to meet their specific goals, maximize available resources and maintain cultural identity, a variety of interventions were deployed during the first three Cohorts. Examples are outlined below:

- Stand-alone post-discharge clinic where patients are seen by a team of caregivers and non-PCP providers
- Virtual care teams who provide PCPs 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 PCP

QUOTATION

"For TAACT … we were really able to find our opportunities for reducing readmissions for our complex patients. The experience of being able to learn together from each other's mistakes and successes are one of the strongest improvement modalities that we have. Pulling local people together is one of the big strengths [of TAACT]."

-Ricki Stajer RN MA CPHQ
Vice President, Care Coordination
PIH Health

QUOTATION

"Making connections with people was a big part of the collaborative. It was great to learn from other organizations – we could borrow ideas from other organizations in the collaborative and make them our own. We had tried [a discharge clinic] a few tries before [the collaborative] and it was missing major components. Being involved in the collaborative allowed us to figure out what to include. Seeing someone talk about a project in the state of California, in your region, where they have the same health plans, up against the same laws and rules as we are, is inspiring."

-Lorrie Baird, Manager
Facilitators at St. Joseph Healthcare

(TAACT Continued)

PARTICIPANTS

The TAACT Collaborative was designed to accommodate a full spectrum of physician organizations at the various phases of care coordination sophistication. Additionally, hospitals pursuing readmissions reduction through post-discharge care coordination were also encouraged to participate. Participants to date include:

- Optum Medical Group
- PIH Health
- St. Joe's
- Synermed – Angeles IPA
- Synermed – EHS
- Health Net
- San Francisco Department of Public Health
- Meritage Medical Group
- La Clinica De La Raza
- Inland Empire Health Plan
- NAMM – Prime Care Sun City

Figure A

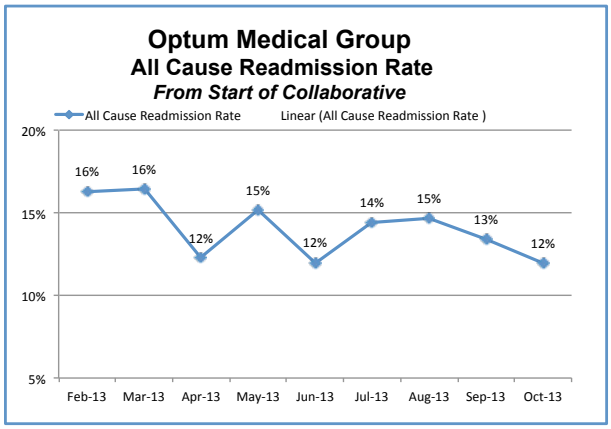
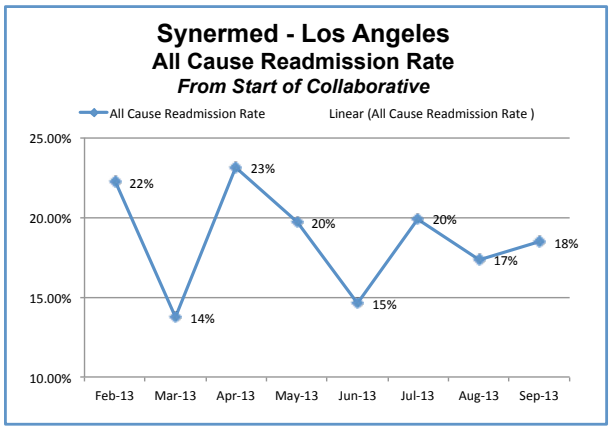


Figure B



RESULTS

While much of the data will come in over the next year and a half, there is some preliminary data from the first cohort that suggests the work done through TAACT has had a positive impact on reducing all cause readmissions. Two charts illustrate the improvements made by two of our larger organizations who participated in Cohort A from February – July 2013.

The first (Figure A) is Optum Medical Group. Through the development and refinement of a virtual-care team model, this group has reduced readmissions from an average of 15% pre-collaborative to an average of 13.9% post-collaborative

The second group (Figure B) is Synermed Angeles IPA. Serving a mostly low-income population, Synermed has focused on providing its patients with follow-up care in a post-discharge care clinic, as well as sourcing and providing their patients with social/environmental resources such as transportation, home care and nutrition.

Intensive Outpatient Care Program (IOCP)

OVERVIEW

In 2012, Pacific Business Group on Health (PBGH) was awarded a $19.1 million grant by the Centers for Medicare and Medicaid Innovation (CMMI) to engage 27,000 predicted high-risk Medicare patients throughout California and Arizona to receive intensive, practice-based care management in partnership with their respective delivery systems, health plans and private purchasers. The Intensive Outpatient Care Program (IOCP) care delivery model uses embedded care managers in high-performing primary care teams to develop close relationships with medically complex patients and deliver highly individualized and accessible primary care based on treatment goals specific to each patient. The goal is fewer emergency room visits, a reduction in avoidable hospitalizations, better mitigation of disease and reduced complications as a result of intensive care management.

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%

STRUCTURE

Through PBGH's CMMI Cooperative Agreement, Physician Medical Groups (PMGs) contracted to establish an intensive outpatient care program within their organization. PMGs hire and train dedicated care coordinators to work with selected primary care practices and manage a panel of high-risk patients each. California Quality Collaborative (CQC) staff leads the development and execution of the collaborative training for PMG leadership teams to support the IOCP implementation. PMGs receive predictive risk scores for their Medicare population and support from clinical experts to adapt the model for their organization and patients.

MEASUREMENT

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

In addition, measures collected and reported on include:

- Patient reported outcomes (Patient Activation Measure, Depression and Health Status)
- Patient experience
- Net program savings

PARTICIPANTS

The PMGs were supported through two "waves" of collaborative implementation. Wave I participants started in the winter of 2012 and the Wave II participants started in the fall of 2013. In addition to California and Arizona, the implementation of the IOCP care model include PMGs in Idaho, Nevada and Washington.

Wave I Participants

- Brown & Toland Physicians
- Cigna Medical Group (AZ)
- John Muir Health
- Partnership HeathPlan of California
- Sharp Community Medical Group
- Sharp Rees-Stealy
- St. Joseph Heritage
- Sutter Health (SMF, Gould, Pacific)

Wave II Participants

- Epic Management, LP
- Greater Newport Physicians
- PIH Health
- Santa Clara County IPA
- Scottsdale Health Partners (AZ)
- St. Luke's Health System (ID)
- The Polyclinic (WA)
- Dignity Health (Arizona Care Network, Dominican, Mercy Medical Group, Ventura Chapter, Inland Empire Chapter, Las Vegas)

INTERVENTIONS

1. By the end of 2013, all of the eight Wave I PMGs officially launched and begun outreaching and enrolling patients for the IOCP.

2. Patient engagement and enrollment was monitored through regular program meetings and weekly status report updates from all the Wave I PMGs. This information is being collected to identify best practices that are disseminated through shared learning groups to develop new ideas and approaches to try in their respective organizations and also, support iterative refinements in the expansion and implementation of the IOCP.

(IOCP Continued)

3. Although there were limitations on data extraction and processing, mitigation strategies to expedite a risk stratified patient list were identified. This has allowed the PMGs that did not have access to other methods for patient identification to benefit from a preliminary patient list.

4. The main repository of materials and resources available to all the participating groups contains various tools and templates ranging from patient selection workflows to shared decision making and action plans. The document is regularly updated to meet the needs of the PMGs.

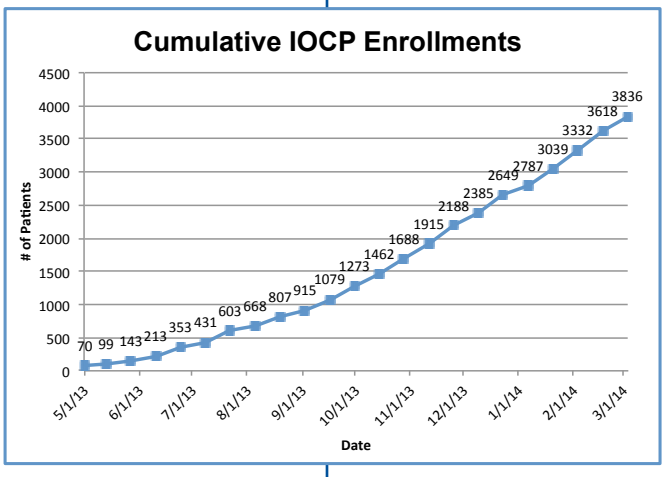
5.Eight new partners have been successfully engaged for the Wave II expansion of the IOCP.

RESULTS

While there are many promising and successful practices, there is no one solution that fits all. For example, the PMGs discovered that patient engagement and enrollment in the IOCP is most successful with physician involvement; however, strategies for engaging physicians to participate in the program vary depending on the relationships at each medical group.

PROGRAM HIGHLIGHTS

Awarded $19.1M
27,000 Medicare Patients
July 2012 - June 2015



Compass Program: Charting Your Course to Excellence for Medicare Star, ACO, and P4P (MAP) Measures

OVERVIEW

Compass is a program with history which goes back to CQC's initial offering focusing on improving care and clinical metrics for patients with chronic disease. In 2012 – 13, the comprehensive and intensive 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 5,300 primary care physicians who cared for about 1.3 million patients, of whom 180,000 were Medicare. Aggregate performance across all participants met or exceeded 20% relative improvement from baseline through September 2013 in nine of twelve measures. Aggregate data showed that the groups either maintained four or five star performance or increased MA stars ratings for measures with lower performance.

STRUCTURE

Collaborative participants from 14 medical groups and Independent Practice Associations (IPA) attended four in-person learning sessions in 2012 - 13, participated in monthly webinars on related content and engaged in coaching calls with CQC staff. Between the learning sessions, at which groups shared information about interventions and how they overcame barriers, groups implemented action plans refined during the learning sessions.

MEASUREMENT

Data was submitted quarterly on core diabetes measures including:

- A1c >9.0
- LDL <100
- Blood pressure <140/90
- Eye exams
- LDL screening
- Nephropathy Monitoring

Optional measures included:

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

PARTICIPANTS

- Advanced Medical Management
- Axminster Medical Group
- Choice Medical Group
- Epic Management, LP
- High Desert Primary Care Medical
- Managed Care Systems, LLP
- MedPOINT Management Memorial
- Memorial Care Medical Care
- Monarch HealthCare
- NAMM/Prime Care Chino
- Regal Medical Group/Lakeside Community Healthcare
- Sierra Nevada Medical Associates IPA
- Sutter Medical Network
- Torrance Hospital IPA

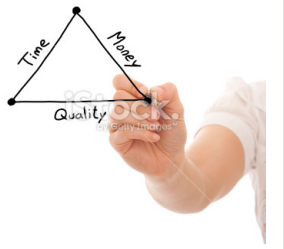
INTERVENTIONS

- Senior wellness centers/clinics and health fairs to augment primary care services
- 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
- Intensive stratification and outreach to groups of patients, either centralized or practice-based
- Performance reports to physician offices
- Incentive programs for physicians and office staff
- Case management for complex patients with chronic disease
- Use of comprehensive annual physical form for seniors to capture key indicators
- Retrieved data for core measures while completing HCC chart review
- Outreach to homebound patients
- Use of portable equipment (DEXA Scan for bone density testing)
- Centralized staff dedicated to supporting practice sites

RESULTS

Participating groups in 2012 - 13 cared for about 20,000 diabetic patients and instituted improvements to increase the percentage of diabetics with blood pressure controlled from 42.7% in 2011 to 63.1% as of September 2013. (Note: 2013 data lack Q4 final collection, so best year over year comparison is for Q3.)

(Compass Program Continued)



RESULTS (CONTINUED)

Extrapolating the impact of a 20% relative improvement in diabetes glucose control will result in prevention of complications, and using the patient population of the participating groups, CQC estimates that these improvements will result in delay/reduction* in complications for ~2,000-4,500 patients resulting in $78 to $89 million in cost savings** the first year the complication is prevented***.

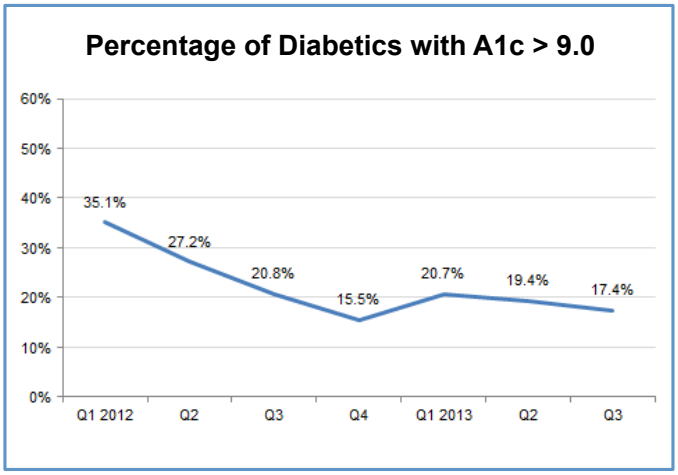
In addition, aggregated data through quarter three of 2013 showed the following results:

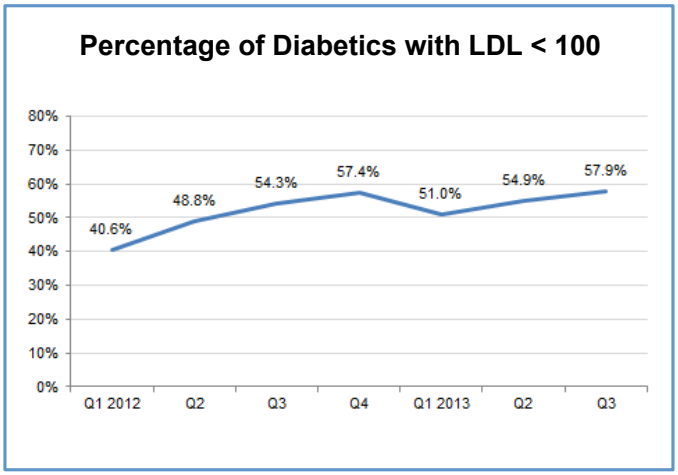
- Groups achieved 20% relative improvement in eight of twelve measures, maintained 4 or 5-Stars in 6 measures, improved Star ratings in 5 measures, and achieved 20% relative improvement in one non-Medicare measure
- Diabetes A1c >9.0 showed surpassed the Medicare Advantage (MA) 4-Star cut point and was nearing the 5-Star cut point with one quarter remaining in the year (graph above)
- Mammography screening is at the P4P 90th percentile and exceeds the MA 5-Star cut point
- Diabetes blood pressure <140/90 showed a 19.6% increase from 2011
- Patients with BMI recorded exceeded the MA 5-Star cut point from a starting point of 1-Star
- Treatment of patients with rheumatoid arthritis with DMARD therapy showed a 22.9% increase from baseline to quarter three of 2013

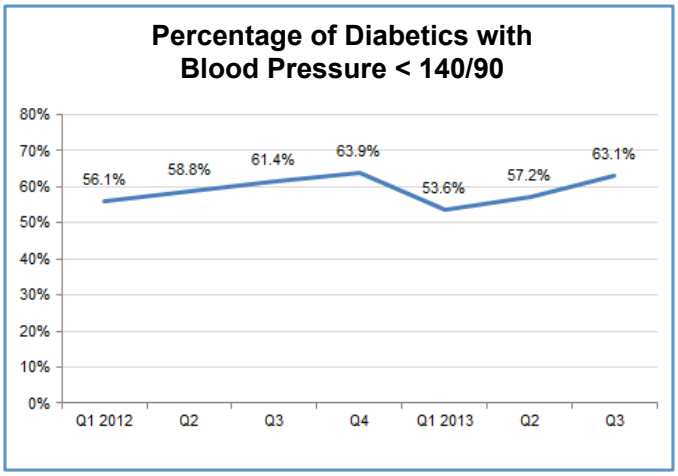
QUOTATION

"Participating in Compass has given GEMCare the discipline to better implement planned changes and follow through on measuring effectiveness, resulting in significant improvement in clinical results."

-Glenn Singer, MD
Senior Medical Director
GEMCare Health Plan







(Compass Program Continued)

LESSONS LEARNED

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

- Senior patients are hesitant to participate over the phone with a stranger, but are more receptive with a senior staff member to allow nurse practitioner assessments and lab draws
- 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
- Vet new programs with PCPs to secure buy-in during development and implementation
- Partner with vendors, ancillary providers, and community organizations where incentives align
- Mailing FOBT kits was efficacious – be sure to assess supply/demand and prioritize
- Recognize champions and high performers
- Align incentive payment programs and include key measures on dashboards
- Ensure regular communication of progress and give regular feedback to PCPs
- Strong hands-on quality improvement leadership is a key to improvement

NEXT STEPS

A new cohort of twelve organizations met for the initial Compass learning session in October 2013. The 2013-14 focus for Compass is improving "optimal diabetes care", a patient-centered measurement of the proportion of patients who meet all clinical targets rather than one test at a time. Participating groups represent over 4,500 primary care physicians who care for 1.7 million patients and 120,000 of whom are Medicare Advantage commercial, SNP or dual-eligible.

NOTES

*Reduction estimates based on results published from the Diabetes Control and Complications Trial and the Epidemiology of Diabetes Interventions and Complications (EDIC) clinical trial.

**From Estimating the cost of complications of diabetes in Australia using administrative healthcare data. Value Health. 2008 Mar-Apr; 11(2): 199-206

***Prevalence of diabetes complications based on State of Diabetes Complications in America - National Health and Nutrition Examination Survey (NHANES) (1994-2004)

PROGRAM HIGHLIGHTS

Groups achieved 20% relative improvement in 8 of 12 measures.

Partnering With Patients: Using Motivational Interviewing for Brief Action Planning and Shared Decision Making

OVERVIEW

Motivational Interviewing is an approach in which a clinician partners with patients with chronic conditions around their priorities to build a plan for needed behavior change. The guiding principle is "ask...don't tell." The style is focused and goal-directed and has been shown to aid patients in creating sustained changes in lifestyle behaviors. Motivational interviewing is considered to be a non-judgmental form of counseling that works with patients who span the spectrum of readiness with regards to change in behavior.

CQC received an Anthem Blue Cross Foundation grant to deliver Motivational Interviewing (MI) training to medical providers, clinical support staff, and healthcare improvement specialists across the state of California through December 2015. The grant initially provided training for medical providers and the support staff of medical groups participating in the ongoing Compass Program but was also offered to other medical groups in California.

The training introduces Brief Action Planning to guide patients in setting short-term goals within the context of a brief office visit and shared decision making to engage patients as a part of the care team.

STRUCTURE

Trainees join a two-day in-person learning session, participate in monthly webinars on related content, and engage in coaching calls with the training staff over the course of 6 months.

PARTICIPANTS

- Blue Shield of California
- COPC Care Management, San Francisco DHP
- Dignity Health
- Epic Management, LP
- Family Health Center SFGH DPH
- Independence Medical Group
- LifeLong Medical Care
- Lyon-Martin Health Services
- Managed Care Systems
- MedPoint Management
- Palo Alto Medical Foundation
- Pinnacle Medical Group
- San Joaquin Community Hospital
- St. Joseph Heritage
- Synermed
- Torrance Hospital IPA

INTERVENTIONS

Deliver training modules aimed at improving the ability of providers to communicate with patients, to improve patient engagement, and to increase self-management.

California Quality Collaborative Steering Committee

Sylvia Gates Carlise, MD, MBA, Managing Medical Director
Anthem Blue Cross

Mark Finch, MD, Lead, Regional Medical Director, Healthcare Services
Blue Shield of California

Neil Solomon, MD*, Vice President for Quality Care System Transformation
Blue Shield of California

Wells Shoemaker, MD*, Medical Director
California Association of Physician Groups

Betsy Thompson, MD, DrPH, Chief Medical Officer, Region IX
Centers for Medicare and Medicaid Services

Jacob Asher, MD, Medical Director
CIGNA

Bruce Spurlock, MD*, President and Chief Executive Officer
Cynosure Health

Tracy Sklar, MBA, MS, Senior Vice President
Dignity Health

Peggy Haines, Vice President for Quality Management
Health Net, Inc.

Mary Fermazin, MD, MPA, Vice President, Health Policy and Quality Measurement
Health Services Advisory Group

Tom Williams, DrPH, MBA*, Executive Director
Integrated Healthcare Association

Helen Macfie, PharmD, Vice President, Performance Improvement
MemorialCare Health System

Elizabeth Haughton, Esq., Vice President, Legal Affairs
NAMM California

David Hopkins, PhD*, Senior Advisor
Pacific Business Group on Health

Dan Osterweil, MD, Medical Director
SCAN Health Plan

Gordon Hunt, MD, MBA*, Senior Vice President and Chief Medical Officer
Sutter Health

Joshua Adler, MD, Chief Medical Officer
UCSF Medical Center and UCSF Benioff Children's Hospital

Eric Book, MD*, West Region Medical Director
United Healthcare Medicare and Retirement

*An asterisk denotes members who are part of the Executive Committee

Many thanks to our CQC program staff.

Diane Stewart, MBA

Lance Lang, MD, FAAFP

Cindi Ardans, BSHA, CPHQ

Amit Karkhanis, MS, MBA, Senior Manager

Maj-Britt Llewellyn, MHA, Senior Manager

Lydia Paull-Flores, MA, Senior Manager

Chris Forbes, Performance Improvement

Jen Burstedt, Marketing Project Management

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Breakthroughs for Better Healthcare

575 Market Street
Suite 600
San Francisco, CA 94105

Questions? Contact us at:
cqcinfo@calquality.org