CQC IMPACT REPORT

RELEASED MAY 2016

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.

CQC
California Quality Collaborative
Breakthroughs for Better Healthcare

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Message from the Director

Six years ago, the Affordable Care Act (ACA) sparked sweeping changes to fundamentally change who has access to health insurance and how care is provided. Since then, California has aggressively pursued health coverage expansion and care delivery improvement. Admittedly, reigning in skyrocketing costs played a back seat role to improving access in the ACA. California, however, has not ignored this dynamic by fully embracing managed care and testing new ways to more effectively deliver care.

As the preeminent multi-stakeholder improvement organization in California, CQC assists providers and plans to meet the demands of the current environment. Given the need to rein in costs without compromising quality, you can see a closer tie to CQC's improvement activities to measureable value. Also noticeable is an increasing focus on the harder to treat populations, particularly medically complex patients. And all of CQC's activities incorporate the fundamental belief that systemic changes are needed at the organizational level and building capacity is necessary to sustaining unprecedented transformation.

Each program plays a unique and complementary role to fostering improvement in California. Below are some highlighted accomplishments in the last 12 months:

- Achieved a substantial reduction in total cost of care in the Intensive Outpatient Care Program (IOCP) while improving patient reported engagement and outcomes. **Findings were published in Health Affairs Blog in January, 2016.**
- Expanded IOCP training and development activities from the Commercial and Medicare populations to Medi-Cal Health Homes for Patients with Complex Needs
- Trained 72 professionals in motivational interviewing techniques
- Contributed to the prevention of 9,036 readmissions, resulting in a savings of $86,745,600 over the course of the five-year ARC collaborative
- Launched the Practice Transformation Initiative, based on the success of Advanced Primary Care collaborative, to support 4,800 California clinicians in implementing comprehensive quality improvement
- **Published summary of best practices to manage total cost of care collected from 15 high-performing organizations**.

While CQC achieved great success in 2015, we recognize that much more is needed to meet the goal of better health outcomes and experience at a lower cost. In partnership with many organizations, we will continue to play an important role transforming the way care is provided in California.

Sincerely,

Diane Stewart	Bart Wald, MD
Senior Director	Medical Director

About 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. 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 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.

IMPROVEMENT PRIORITIES

In 2015, the CQC Steering Committee identified three improvement priorities for the next 3 years:

- Aim 1: Build capacity within organizations to reduce **total cost of care**.
- Aim 2: Improve chronic illness care for populations of patients where clinical quality scores are lowest through **practice transformation**.
- Aim 3: Expand the availability of **intensive outpatient management for people with multiple, medically complex conditions**.

HISTORY

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.

2015 IN NUMBERS

In 2015, CQC hosted 33 events, 19 on-site and 14 webinars, reaching over 200 organizations, and more than 1,000 participants!

AIM 1: Total Cost of Care

As Total Cost of Care increasingly becomes part of contract arrangements, organizations can benefit from a roadmap of ordered process changes to address cost of care. CQC will expand on its work to address readmissions to encompass approaches to manage the total cost of care.

Programs:

- Avoid Readmissions through Collaboration (ARC)
- Managing Total Cost of Care Collaborative

Participants:

Avoid Readmissions through Collaboration	Managing Total Cost of Care Collaborative
1. Alameda County Medical Center 2. Alta Bates Medical Center 3. California Pacific Medical Center 4. Chinese Hospital 5. Eden Medical Center 6. El Camino Hospital 7. Marin General Hospital 8. Mills-Peninsula Hospital 9. O'Connor Hospital 10. SF General Hospital 11. Santa Clara Valley Med Center 12. Sequoia Hospital 13. Seton Medical Center 14. St. Francis Memorial Hospital 15. St. Mary's Medical Center 16. St. Rose Hospital 17. Sutter Delta 18. UCSF Medical Center 19. VA Palo Alto Health Care System 20. VA Medical Center San Francisco 21. ValleyCare Health System 22. Washington Hospital Healthcare System	1. Arch Health Partners, CA 2. Brown & Toland, CA 3. Catholic Health Initiative, CO/AK/IA 4. HealthCare Partners, LLC CA 5. HealthPartners, MN 6. Hill Physicians Medical Group, CA 7. Monarch Healthcare, CA 8. Physician Medical Group of Santa Cruz County, CA 9. Physicians of Southwest Washington, WA 10. Prospect Medical Group, CA 11. Sharp Rees Steely Medical Group, CA 12. St. Joseph Heritage Medical Group, CA 13. Steward Health Care Network, MA 14. Torrance Hospital IPA, CA 15. WellMed Medical Group, TX

Avoid Readmissions through Collaboration (ARC)

September 2010–October 2015

Overview

The Avoid Readmissions through Collaboration (ARC) program brings hospitals and their community partners together to prevent readmissions. Spurred by the changing reimbursement environment, hospitals jumped at the chance to learn best practices to reduce the number of patients re-admitted within 30 days of discharge. ARC is led by Cynosure Health and CQC, with funding from the Gordon and Betty Moore Foundation.

Structure

Quarterly face-to-face 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 volunteered to engage more deeply; they received one-on-one coaching in exchange for submitting monthly data on readmissions and patient experience.

ARC cosponsored Annual Readmission Summits with the California Hospital Association and Health Systems Advisory Group, drawing over 400 participants from around the state to learn from national experts and local leaders on successful strategies for avoiding unnecessary readmissions.

In addition, ARC convened affinity groups for pharmacists, chartered a patient advisory committee, and offered webinars with national experts.

Changes adopted by participants

Early on, hospitals focused on internal systems to better prepare patients for discharge. Over time, hospital partnerships with nursing homes, home health, and community agencies multiplied. Some examples of interventions adopted by participating hospitals include:

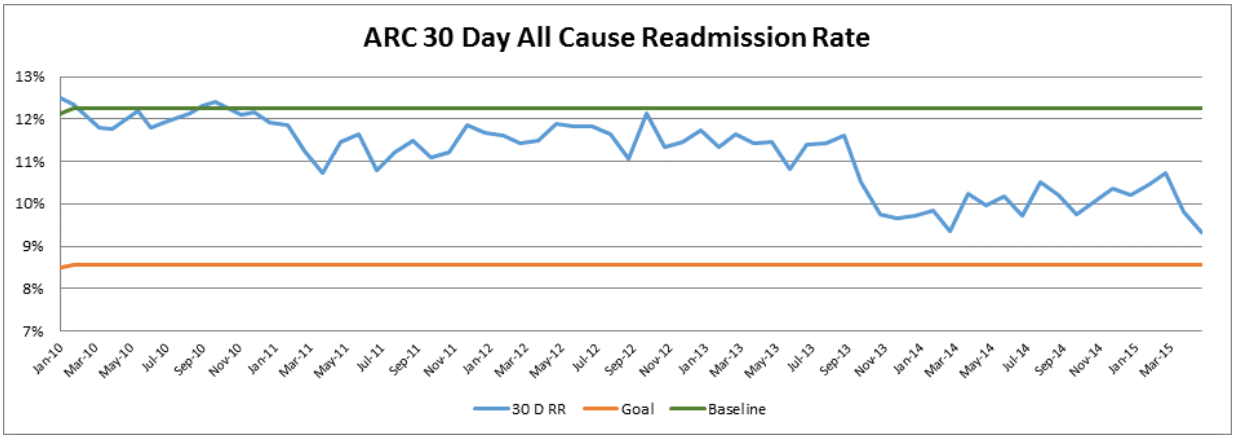
- Integrating pharmacists into the discharge process
- Meeting monthly with nursing facilities to review readmission data and individual patient cases
- Conducting follow-up visits from community agencies in the patient's home
- Targeting patients based on their likelihood of readmission with extra support post-discharge
- Engaging and educating families as caregivers
- Using electronic tools to communicate with multiple agencies and hospitals managing the patient's transition to home

A variety of tools and resources are published on the ARC Website. For more information, click here.

Results

Twenty-five hospitals from the San Francisco Bay Area volunteered to report results on a monthly basis. In aggregate, from January 2010 through December 2014 these hospitals:

- Reduced 30-day all-cause readmission rate by eight percent (statistically significant result)
- Significantly improved the scores on all the HCAHPS care coordination questions
- Prevented 9,036 readmissions, resulting in a savings of $86,745,600



Next Steps/Spread

The successful strategies from this program will be integrated into the CQC programs Total Cost of Care and Practice Transformation Initiative.

Managing Total Cost of Care

Overview

CQC intends to create a "playbook" with ordered steps to both diagnose and address drivers of total cost of care, then use the playbook to spread methods of managing total cost of care across provider organizations. Total cost of care (TCOC) is defined as: Total medical services, inclusive of facility, professional, ancillary, behavioral health and pharmacy, consumed by a general population of attributed patients. The playbook will describe patient management strategies that authentically reduce total cost of care while maintaining or improving quality.

In 2015, CQC conducted interviews with 15 high performing organizations because strategies for managing Total Cost of Care (TCOC) are not well known. Interview findings were published by the California HealthCare Foundation. Based on the interview findings and additional research, CQC is developing a "playbook" which will serve as the basis for a year-long collaborative to help provider organizations implement patient management strategies to measurably reduce total cost of care.

Structure

The 2016 collaborative includes the following components:

- Completion and analysis of a diagnostic survey focused on utilization indicators and contracting structures to determine current performance and inform the selection of participant goals.
- Interviews to better understand the unique infrastructure issues, assets, and challenges for each organization.
- Face-to-face learning sessions that balance structured learning from experts with peer interactions.
- Webinars on promising practices and interventions.
- Customized coaching to support the design and execution of strategies.
- Submission and monitoring of select performance indicators to support data-driven decision making.

The curriculum addresses foundational interventions in the following areas: inpatient and outpatient management; unnecessary emergency department utilization; readmissions risk; and culture of accountability. Depending on the needs of participating organizations, the collaborative might also address imaging utilization, pharmacy costs (e.g. specialty injectables,) ambulatory surgery centers, and out-of-network utilization.

To guide these activities and oversee participant progress, the collaborative will leverage the expertise of faculty advisors. The advisors will guide agenda development for learning sessions, conduct periodic reviews of participant progress, recommend areas for additional coaching support, and lead or facilitate presentations.

Changes adopted by participants

To be determined.

Results

To be determined.

Next Steps/Spread

CQC is in the midst of recruitment for the collaborative. The first learning session is expected to occur in August 2016.

AIM 2: Improving Chronic Illness through Practice Transformation

Medi-Cal expansion and the public exchange brought many previously uninsured adults into the health care delivery system. CQC will build on its experience with population management at the delivery system level and its work with practices through the Advanced Primary Care Collaborative to scale triple-aim improvement for patients in most need.

Programs:

- Advanced Primary Care Collaborative
- Practice Transformation Initiative

Program Participants:

Advanced Primary Care Collaborative:	Practice Transformation Initiative
1. Citrus Valley (NAMM) 2. Clinicas de Salud del Pueblo 3. Memorial Care Medical Foundation 4. St. Joseph Heritage Healthcare	1. Allied Pacific IPA 2. AppleCare Medical Management 3. Central Valley Collaborative 4. Chinese Community Health Care Association 5. Hill Physicians Medical Group 6. Molina Health Plan 7. Molina Medical Group 8. North Coast Health Information Network 9. Palo Alto Medical Foundation 10. Physician Medical Group of San Jose, Inc. (EXCEL MSO) 11. PPN/Centinela (Medpoint Management) 12. Prospect Medical 13. St. Joseph's Hoag Health 14. Sharp Community

Advanced Primary Care Collaborative

June 2015–July 2015

Overview

The Advanced Primary Care (APC) collaborative provides a robust approach and set of resources to support patient-centered medical homes (PCMH) and primary care practice transformation. APC combines training, access to expert faculty, and peer-to-peer learning to transform pilot practice sites within participating physician groups. CQC partnered with UCSF Center for Excellence in Primary Care (CEPC) to plan and deliver content, including training for physician group staff on the skills necessary to redesign workflows at the practice sites.

Structure

1. **Learning Sessions** – CQC convened five in-person learning sessions for all the practice coaches and project teams. Sessions included content on change management, "building blocks" for practice transformation, the model for improvement, and emphasized peer-to-peer support.

2. **Practice Coach Training** – A four-day program delivered by UCSF for APC collaborative participants. UCSF prepared physician group staff to become "practice coaches" – staff who worked directly with pilot practice sites to incorporate proven changes to improve care and create a more efficient practice environment. Training content is based on the Ten Building Blocks of High Performance Primary Care (see picture) which represents the core elements of practice transformation.

3. **Webinars** – CQC convened monthly webinars between the in-person meetings. These webinars allowed participants to dive deeply into topics introduced at learning sessions, share updates on progress and challenges, ask questions of faculty, and engage with peers.

4. **Weekly coaching** – CQC staff met with each team weekly to discuss aims, measures, and testing plans. Weekly calls helped physician groups to stay on track, overcome barriers, and develop confidence to lead the work within their own organizations.

5. **Site visits** – CQC staff also conducted site visits with each team every one to two months to observe practice operations, offer recommendations, and strengthen engagement of others in the organization.

Changes adopted by participants

Participating organizations found that starting with the team-based care building block helped establish strong working relationships within the practice and therefore built a foundation for more extensive changes. Specific changes with that building block, as well as a few others, are listed below:

- Team-based care: 1) Medical Assistants completed visit preparation which includes noting gaps in care and preparing pharmacy refills. 2) Registered Nurses used standing orders and implemented protocols to conduct follow up visits and phone calls for chronic disease patients. 3) "Scrubbed" schedules the day before to shift visits from physicians to nurses or receive a phone call from physician.
- Empanelment: 1) Assigned patients to a physician panel, even if the patient is not part of a managed care plan. This required technological support and engagement of leadership to establish common policies across practice sites.
- Population management: 1) Utilized patient portal messaging to ease anxious, medically complex patients and reduce need for visits. 2) Assigned staff to review gaps in care for patients without scheduled visits.
- Data-driven improvement: Posted results of data analysis and success stories in the office hallways.

Results

All participating organizations completed the Advanced Primary Care Inventory, which measures the status of key practice changes that contribute to improved cost and quality outcomes. The survey was administered three times, at six month intervals. All practice sites improved scores over 12 months. Out of a possible 34 items, improvement on individual items ranged from nine to 23.

In addition, two participating organizations collected and reported additional measures of quality and cost for participating practices. Improvement was reported on clinical screening measures, emergency department visits, and clinician experience (e.g., physicians spending less time at work).

Moreover, the evaluation scores for the meetings and trainings were high. For example, on a five-point scale, 98% of participants rated the learning sessions a four or five on "Would recommend this training to a colleague."

Next Steps/Spread

CQC incorporated lessons from this collaborative into the design of the newly launched Practice Transformation Initiative.

Practice Transformation Initiative

October 2015–September 2019

Overview

As a part of a competitive application process, CQC was one of 29 organizations selected by the Centers for Medicare & Medicaid Services (CMS) to be a Practice Transformation Network (PTN) in the Nation. CQC's goals over the four years are to:

- Improve chronic care measures by 15%
- Reduce unnecessary services 5%, saving $240 million
- Assure that 75% of practices receive patient feedback at least quarterly

CQC partnered with the Center for Care Innovations (CCI) and the Integrated Healthcare Association (IHA) as program partners.

Structure

CQC will recruit 16 Provider Organizations (POs) to participate in PTI. These POs represent a variety of organizational types (e.g., IPA, medical groups), include urban and rural practice sites, and treat Medicare, Medi-Cal, and Commercial patients. The PO team will be trained to work with practices using the Ten Building Blocks of High-Performing Primary Care developed by the Center for Excellence in Primary Care at UCSF. Practice Coaches will also receive Practice Coach training. Following the initial training, quarterly meetings are designed to foster peer-to-peer learning across all the Provider Organizations. POs are expected to submit data quarterly to IHA and share monthly results with clinicians.

Changes adopted by participants

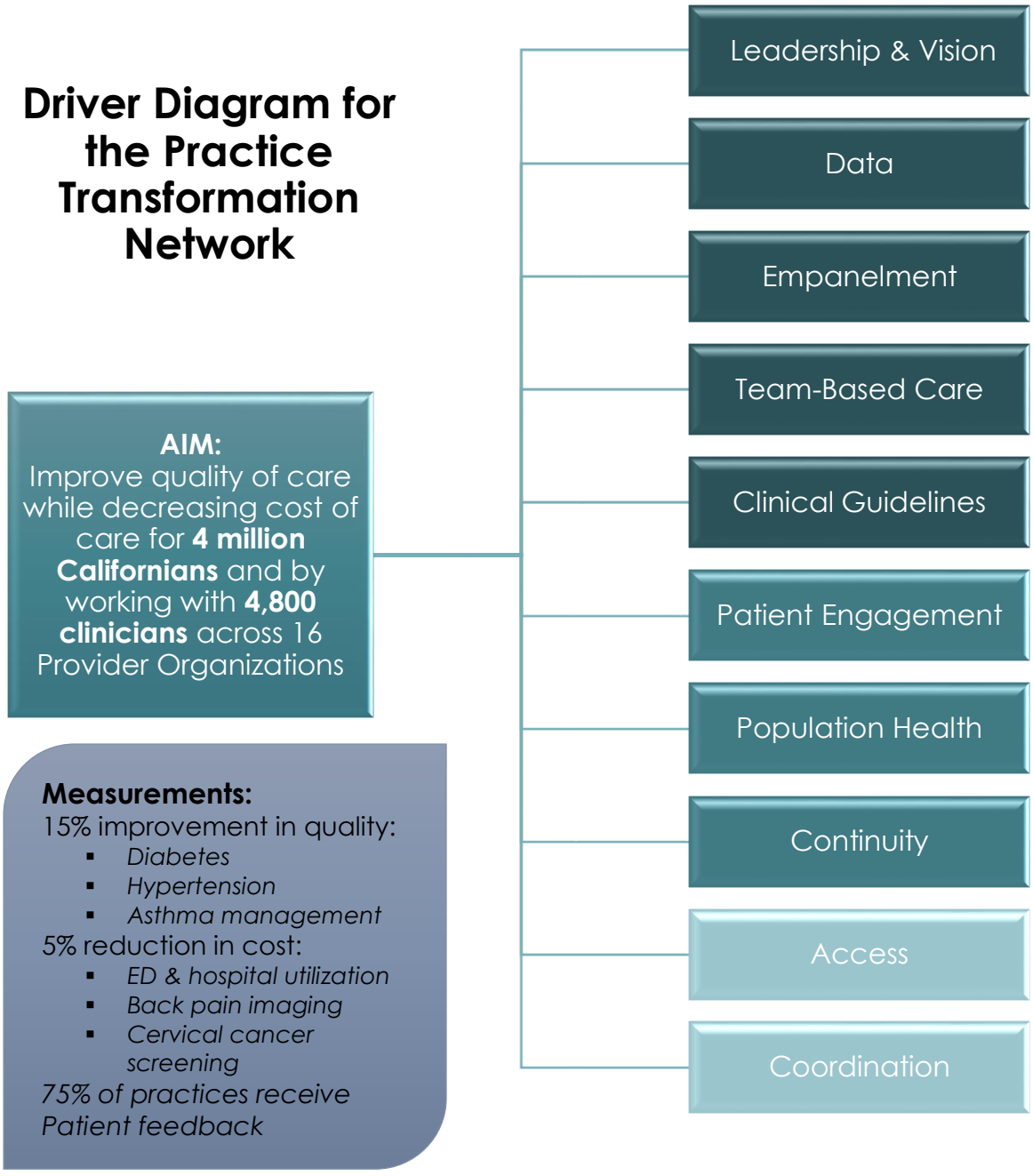
While still early, participating Provider Organizations have already stepped up to make changes. All POs have dedicated resources to lead the practice transformation. Some of the POs have mandated clinician participation in PTI.

Results

- The Practice Transformation Initiative is in the early stages of implementation. Baseline data for the outcome measures were received from 12 enrolled POs by Jan. 31.
- Leadership training for Cohort 1 held March 1-2, 2016.
- First Practice Coaches training held March 22-24, 2016.

Next Steps/Spread

- Cohort 1 trainings to be completed by June 2016.
- Cohort 2 trainings scheduled for May 24-25, 2016.
- Completion of assessment tools to determine the focus of improvement efforts for each practice.



AIM 3: Medically Complex Patients

Within any population, health care spending is 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 use of expensive services. CQC completed a program for Medicare patients – the Intensive Outpatient Care Program – and will expand the availability of intensive outpatient management for people with multiple, medically complex conditions.

Programs:

- Intensive Outpatient Care Program
- Health Homes Program for Patients with Complex Needs

Program Participants:

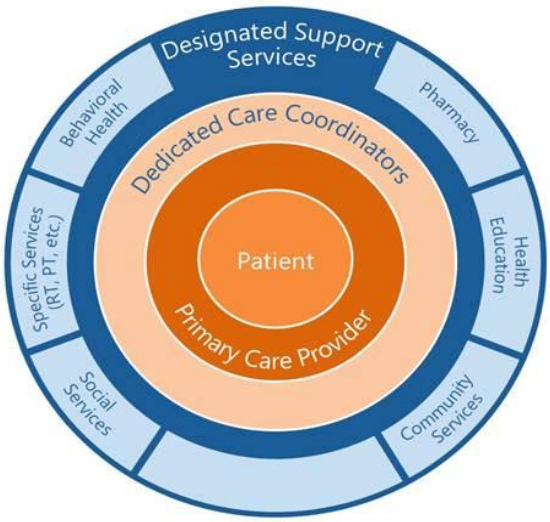
Intensive Outpatient Care Program	Health Homes Program for Patients with Complex Needs
1. Dignity Dignity- Arizona Care Network Dignity Health Medical Foundation – Dominican Dignity Health Medical Foundation – Mercy Medical Group Southern California Integrated Care Network – Ventura Southern California Integrated Care Network – Inland Empire St. Rose Quality Care Network – Las Vegas 2. EPIC Management LP 3. Greater Newport Physicians 4. Palo Alto Medical Foundation 5. PIH Health 6. Santa Clara County IPA 7. Scottsdale Health Partners (AZ) 8. St. Luke's Health System (ID) 9. The Polyclinic (WA) 11. Cigna Medical Group (AZ) 12. John Muir Health 13. Partnership HealthPlan of CA 14. St. Joseph Heritage 15. Sharp Community Medical Group 16. Sharp Rees-Stealy 17. Sutter Health Sutter Medical Foundation (SMF) Sutter Pacific Medical Foundation (SPMF) Sutter Gould Medical Foundation (SGMF)	1. Alliance Medical Center 2. Anthem 3. BAART 4. Collabria Care 5. CommuniCare Health Centers 6. Community Medical Centers, Inc. 7. HealthRight360 8. Hill Country Community Clinic 9. Lifelong Medical Care 10. Marin City Health and Wellness Center 11. Marin Community Clinic 12. Mendocino Community Clinic 13. Mercy Housing California 14. Mission Neighborhood Health Center 15. Mountain Valleys Health Centers 16. North East Medical Services 17. North Coast Clinic Network 18. Open Door Community Clinic 19. Partnership Health Plan 20. Petaluma Health Center 21. Queen of the Valley Medical Center 22. San Francisco Health Network 23. San Francisco Health Plan 24. Santa Rosa Community Health Centers 25. Shasta Community Health Centers 26. Shingleton Medical Center 27. Solano County Health 28. Saint Anthony Medical Clinic 29. St. Helena Family Health Center 30. West County Health Center

Intensive Outpatient Care Program

July 2012–June 2015

Overview

CQC was awarded a three-year Health Care Innovation Award to implement and test the Intensive Outpatient Care Program (IOCP) for Medicare patients across 23 delivery systems in five States. IOCP uses a multidisciplinary team-based approach to address medical, behavioral, and social needs of patients, with care coordinators at the heart of the model. IOCP was first successfully piloted in a commercial population.



Structure

CQC enrolled 15,000 patients in 500 practices across 23 delivery systems in five states. The overall enrollment rate (patients opting in to the program) was 76%, ranging from 33% to 99% among organizations. Enrollment was most successful when the patient's primary care physician referred into or endorsed the program to the patient.

IOCP's "guardrails" (i.e., "must have" elements) distinguish it from other programs for medically complex patients.

The guardrails include:

- Care coordinator (includes nurses, social workers, community health workers, and medical assistants) maintains a close, ongoing relationship with the patient.
- A face-to-face "supervisit" within one month of enrollment where information is gathered with a motivational, open, and flexible approach.
- Monthly, bi-directional communication between the care coordinator and patient.
- Shared Action Plan created with the patient, and working toward at least one goal chosen by the patient.
- Warm handoffs to relevant support services (e.g., home health, behavioral health, transportation, drug assistance programs, food banks, and other community services).
- 24/7 access solution, with communication to care coordinator next business day.

While the IOCP model has similarities to other new models of care, it is the unique combination of these elements that differentiates it from the rest.

All team members received training, but in particular care coordinators had intensive training that helped them develop or sharpen skills in gaining patient trust, maintaining a close relationship, and coaching self-management and behavior change. Motivational interviewing, supervisit tactics, shared action planning, and strategies to build relationships with patients were some of the topics covered. Trainings, usually peer-

to-peer, were directed at organizational leaders as well, and included engaging physicians to participate, managing change, and proving return-on-investment.

Changes adopted by participants

Ninety percent of the participating delivery systems plan to continue key elements of IOCP and integrate it into their population health strategies. Fifteen of the IOCP partners will expand IOCP by including it in their commercial ACO programs. Of special importance, 100% of the participating clinicians indicated continuation of the shared action plan. Practices really liked its patient-directedness and the buy-in it created for self-management.

Results

CQC used several metrics to measure success - changes in patient assessments, utilization, and cost. The Patient Activation Measure, VR-12, and Patient Health Questionnaire results show improvements in patients' engagement in their own care, and in physical and mental health as follows:

- 3.6% increase in patient engagement
- 33% improvement in depression symptoms
- 3.4% improvement in mental health functioning
- 4.1% improvement in physical health functioning

IOCP led to a drop in primary care and specialty physician office visits. Over a 12 month time period, patients with higher risk scores, (i.e., patients that are at a higher risk for future utilization or poor outcomes) had a 21% reduction in total cost of care and a 55% decrease in emergency department visits from the quarter before a patient entered IOCP to the third quarter a patient was enrolled in IOCP.

Program results were published in the Health Affairs Blog in January 2016.

Next Steps/Spread

CQC has partnered with the California Health and Human Services Agency to provide technical assistance and training for delivery system transformation in the Medi-Cal Health Homes for Patients with Complex Needs initiative. This initiative builds upon IOCP best practices and CQC's experience scaling the model in many clinical sites and geographic regions. Numerous discussions are also underway with state and national funders to determine the best ways to spread the IOCP work to additional areas and populations.

Health Homes Program for Patients with Complex Needs

July 2015–January 2017

Overview

CQC is partnering with the California Health and Human Services Agency (CHHS) and the Department of Health Care Services (DHCS) to provide technical assistance and training for delivery system transformation in the Medi-Cal Health Homes for Patients with Complex Needs program (Health Homes Program or HHP). This initiative adapts the Intensive Outpatient Care Program (IOCP) care model and training approach for organizations working with medically complex Medi-Cal patients.

Structure

- Authorized by the Affordable Care Act and California AB 361, the Health Homes Program provides enhanced care management; coordinates care across the full range of physical health, behavioral health, and community-based long term service; and fosters links to community social supports.
- The Health Homes Program will be implemented county by county over 18 months, starting with San Francisco and counties in the North State region in January 2017.
- With CHHS and DHCS, CQC is creating a training plan for the Managed Care Plans (MCP) and Community-based Care Organizations (CCO) participating in Health Homes Program.
- Training for care coordinators, using the train-the-trainer model, will be completed by June 30, 2016. The training is delivered by Primary Care Development Corporation and University of California, San Francisco.
- Practice Transformation Learning Sessions for the project implementation teams and leadership at MCPs and CCOs are set to start in May 2016. They will be offered quarterly.
- Technical assistance will be delivered.

Changes adopted by participants

This is yet to be determined. The training program formally started on April 13, 2016.

Results

A complete training calendar with 14 in-person sessions and 11 webinars was distributed in March 2016.

Next Steps/Spread

The Practice Transformation Learning Sessions and technical assistance will continue through January 2017.

Building Capacity

In addition to programs designed to measurably change the performance of organizations, CQC also offers programs for individuals. Building Capacity programs are a combination of skill-building training sessions and one-day interactive conferences on emerging topics.

Programs:

- Partnering with Patients
- Topics in Healthcare Symposia:

Program Participants:

Partnering with Patients

1. AltaMed Health Services
2. Epic Management LP
3. Humboldt IPA
4. LifeLong Medical Care
5. Los Angeles Christian Health Centers
6. MemorialCare Medical Foundation (MCMF)
7. Olive View
8. Redwood Community Health Coalition
9. Samaritan House Free Clinics
10. Santa Cruz Community Health Centers (SCCHC)
11. Ukiah Valley Medical Center
12. ValleyCare Health System

Topics in Healthcare symposia

1. 24/7 Care at Home
2. 24/7 Hospice
3. Aetna Alameda Health Consortium
4. AltaMed Alvarez & Marsal
5. Anthem
6. Anthem Blue Cross
7. Anthem Medicaid API Wellness
8. AppleCare Medical Management
9. Blue Shield of California
10. Boehringer Ingelheim
11. Brown & Toland Physicians
12. CA Institute for Nursing and Health Care
13. Care Architecture
14. Cedars-Sinai Medical Care Foundation
15. Center for Elders Independence
16. Chinese Hospital
17. Choice Medical Group
18. CHOMP
19. CHWISC.org
20. City of Fremont
21. Clinicas de Salud del Pueblo, Inc.
22. Coast Healthcare Management, LLC
23. Community Health Center Network
24. Community Memorial Hospital
25. COPE Health Solutions Desert Oasis
26. Healthcare Easy
27. Choice Health Plan
28. Epic Care Oncology
29. EPIC Management, LP
30. Facey Medical Foundation
31. Glendale Adventist Medical Center
    Gordon and Betty Moore Foundation
    Health Net, Inc.
32. Health Outreach Partners
33. HealthBegins
34. Heritage Provider Network
35. Hill Physicians Medical Group
36. Home Health Imperial Beach Community Clinic
37. Independence Medical Group
38. Inland Empire Health Information Exchange (IEHIE)
39. Inland Empire Health Plan JP & Associates
40. JSI San Francisco Kaiser Permanente
41. LifeLong Medical Care Los Angeles County Department of Health Services
42. Lumara Health
43. Managed Care Systems, LLC
44. MedPOINT Management
45. Meritage Medical Network
46. Monarch HealthCare MPHS
47. Namm/PrimeCare/Optum Network of Ethnic Physician Organizations
48. North County Health Services
49. Northeast Valley Health Corporation
50. Nursing and Rehab At Home
51. Pacific ENT Associates, Inc.
52. Palo Alto Medical Foundation
53. Partners in Care Foundation
54. PFCCpartners PHE. Inc
55. Physicians Medical Group of Santa Cruz
56. Pinnacle Medical Group
57. PPMSI
58. Primary Provider Management Company
59. Providence Health and Services
60. Regal Medical Group
61. Resolution Care
62. Riverside Physician Network
63. San Francisco Health Plan

Partnering with Patients

October 2013–December 2015

Overview

Partnering with Patients: Motivational Interviewing with Brief Action Planning and Shared Decision Making train patient-facing staff in motivational interviewing - a patient-centered counseling style used to elicit behavior change. Evidence shows that it leads to better health outcomes and more engaged patients. CQC partnered with the Centre for Collaboration, Motivation and Innovation (CCMI) to provide this training. The California HealthCare Foundation made it possible for safety net providers to participate at no cost.

Structure

CQC ran a competitive application process and received 220 applications from 42 organizations. A total of 72 professionals from 12 organizations participated in the program.

The training program was designed with adult learning principles in mind and lessons gleaned from past CQC motivational interviewing programs. The intent of this specific design was to allow for in-person learning, followed by virtual webinars and practice sessions to reinforce skills. Webinar sessions focused on specific topics and included case studies.

Changes adopted by participants

Participants incorporated the use of motivational interviewing skills (e.g., how to identify change talk, ask questions to ensure understanding, engage in action planning) in office visits with patients.

Results

On a scale of one to ten, the average response to "How likely are you to recommend this workshop to your colleagues?" was nine. Written responses on the evaluations were also overwhelmingly positive.

> ***"This has been really great – I love all the time for practice!"***
>
> ***"Time went by fast because I felt focused and engaged during the entire process."***

Topics in Healthcare Symposia

Overview

CQC's Topics in Healthcare Symposia are one-day conferences that focus on key topics of interest to the healthcare community. The Symposia are designed to foster in-depth discussions and networking with colleagues from other organizations. The Symposia attracts a variety of professionals across the spectrum of care delivery.

Structure

Each program is designed as an immersive experience, quickly bringing attendees up to speed on the most relevant issues and considerations. Three to four experts offer their perspective on different aspects of the topic. These experts were discovered through recommendations and participate in a six month planning process to ensure the most crucial elements are addressed. The day also includes a panel presentation. Four programs were held in 2015:

- *Chronic Illness & End-Of-Life Care Through a Palliative Care Lens*, January 14, 2015 (Oakland, CA)
- *Addressing Social Determinants of Health*, March 18, 2015 (Oakland, CA)
- *Improving Medicare Advantage Part D Star Ratings*, June 10, 2015 (Los Angeles, CA)
- *Best Practices from Three Complex Care Management Programs*, September 24, 2015 (Ontario, CA)

Results

Across the board the Symposia rated highly on evaluations:

- On a five-point scale, 100% of participants rated the Medicare Advantage Part D Symposium a four or five for "Would recommend this Symposium to a colleague".
- For the Palliative Care Symposium, 95% of participants rated it as "Excellent" or "Good".
- For the Social Determinants Symposium, 94% of participants rated it "Excellent" or "Good".
- On a five-point scale, 94% of participants rated the Complex Care Management Symposium a four or five for "Overall rating of today's session".

Many participants also included positive written feedback. The following comment epitomizes what was received: **"**Best use of my work day so far this year. Thank you! Presenters were awesome!"

Next Steps/Spread

In 2016, the Symposia topics will align closely with the 2016 - 2018 CQC aims of behavioral health, medically complex patients, practice transformation, and total cost of care.

CQC Steering Committee Members

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Medical Director, Continuum of Care
Sharp Rees-Stealy Medical Group

Jacob Asher, MD
Chief Medical Officer
Anthem Blue Cross

Veenu Aulakh
Executive Director
Center for Care Innovations

Dr. James Cruz, MD
Chief Medical Officer
Molina HealthCare of California

Catherine Dodd, PhD, RN
Director
City and Co. SF Health Service System

Mary Fermazin, MD, MPA
Chief Medical Officer
Health Services Advisory Group

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