Statewide Collaborative Quality Improvement Project

Reducing Avoidable Emergency Room Visits

Remeasurement Report: January 1, 2008 – December 31, 2008

Medi-Cal Managed Care Division
California Department of
Health Care Services

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Purpose and Scope of Report

The California Department of Health Care Services' (DHCS) Medi-Cal Managed Care Division (MMCD) is responsible for administering the Medi-Cal Managed Care Program and overseeing quality improvement activities that comply with State and federal regulations.

According to the Code of Federal Regulations (CFR) at 42 CFR §438.240, the State must require that its plans conduct performance improvement projects designed to achieve, through ongoing measurement and intervention, significant improvement sustained over time. This sustained improvement must occur in both clinical and nonclinical areas to achieve improved health outcomes and enrollee satisfaction.[1]

To meet federal requirements, the DHCS requires its contracted, full-scope managed care plans, prepaid health plans, and specialty plans to conduct two quality improvement projects (QIPs). For full-scope managed care plans, the DHCS requires participation in a statewide collaborative QIP.

In July 2007, MMCD initiated a statewide collaborative QIP focused on reducing avoidable emergency room (ER) visits among Medi-Cal managed care members. The collaborative defined an avoidable ER visit as a visit that could have been more appropriately managed by and/or referred to a primary care provider (PCP) in an office or clinic setting.[2]

In October 2009, the DHCS released a collaborative baseline report, available on the DHCS Web site,[3] which described the planning process for the collaborative; established the indicators for measurement; presented existing, plan-specific interventions; and introduced the planned statewide collaboration interventions.

Following the baseline report, the DHCS released an interim collaborative report in June 2010, available on the DHCS Web site,[4] which described the collaborative activities conducted since the baseline report. The interim report provided the status of statewide collaborative interventions,

[1] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Vol 3, October 1, 2005.
[2] California Department of Health Services. May 2009. *Baseline Report: Statewide Collaborative QIP on Reducing Avoidable Emergency Room Visits.*
[3] Department of Health Care Services. *ER Collaborative Baseline Report*, August 2008. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx
[4] Department of Health Care Services. *ER Collaborative 2008–2009 Interim Report*, June 2010. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx

initial QIP validation findings, baseline data, collaborative successes and challenges, and recommendations.

The DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to conduct QIP validation, an activity mandated by the Centers for Medicare & Medicaid Services (CMS). The DHCS also contracted with HSAG to produce a remeasurement report on the statewide collaborative QIP.

This remeasurement report describes collaborative activities since the interim report, covering the period of July 1, 2009, through June 30, 2010. In addition, the report summarizes collaborative background information, updates the progress of the collaborative statewide interventions, displays QIP validation findings, presents the first year of remeasurement data, discusses activity related to interim report recommendations, and presents conclusions and recommendations for the remainder of the collaborative.

Summary of Collaborative Quality Improvement Project Activities

Since the interim report, the collaborative:

- Completed implementation of its two targeted statewide interventions: a member health education campaign and a plan-hospital data collaboration pilot.
- Developed both process and outcomes measures for each statewide intervention to help evaluate the effectiveness of short-term and intermediate outcomes.
- Developed a provider survey on the member health education campaign. Plans disseminated the survey and completed data collection while the DHCS aggregated and analyzed results.
- Submitted first-year remeasurement data to the EQRO for QIP validation in October 2009.
- Held a statewide collaborative annual meeting in Sacramento May 11, 2010, when the EQRO provided QIP validation feedback to the plans, the DHCS presented an overview of remeasurement data and provider survey results, the plans presented provider and member interventions, and participants discussed next steps for a member survey.

Summary of Overall Findings

HSAG reviewed a total of 25 statewide collaborative QIP submissions, which represented 21 plans, using a validation protocol to ensure that plans designed, conducted, and reported QIPs in a methodologically sound manner. As a result of this validation, HSAG determined the credibility of the reported results.

HSAG provided each QIP submission with an overall validation status of *Met, Partially Met,* or *Not Met*. The DHCS requires that QIPs receive an overall *Met* validation status; therefore, plans must resubmit a QIP until it achieves a *Met* validation status.

Of the 25 QIP submissions, 9 required a resubmission and 1 required a second resubmission. As of March 31, 2010, all collaborative QIP submissions received an overall *Met* validation status.

Within the QIP submissions, plans operating in multiple counties reported county-level results. Of the 38 county-level results that had baseline and remeasurement rates, 13 showed a decrease in their avoidable ER visits rate. Nine of the 13 decreases were statistically significant. Conversely, the remeasurement data showed an increase in the avoidable ER visits rate for the other 25 county-level rates. Twenty of these increases were statistically significant.

Analysis by plan model type showed differences. Fifty percent of Geographic Managed Care (GMC) county plans showed improvement compared to approximately 30 percent for the Two-Plan county plans and 20 percent for the County-Operated Health System (COHS) county plans. Additionally, for four of the five GMC county plans demonstrating improvement, the results were statistically significant.

Analysis by county did not reveal patterns of improvement or decline.

Plans that improved used a combination of plan-specific interventions targeting members, providers, and systems.

HSAG noted that some plans were inconsistent in reporting their 2007 and 2008 audited *HEDIS® Ambulatory Care—Emergency Department Visits*[5] rate within their QIP for the first indicator. HSAG worked with each of these plans to resolve this issue, when appropriate, to increase the ability to compare plans, report aggregate results, and derive meaningful conclusions. Additionally, three plans incorrectly calculated their avoidable ER visits rate, which, once corrected, may show more favorable results.

[5] HEDIS® refers to the Healthcare Effectiveness Data and Information Set and is a registered trademark of the National Committee for Quality Assurance (NCQA).

Conclusions and Recommendations

HSAG identified several strengths of the collaborative through QIP validation and documented activities. HSAG noted substantial improvement in plans' QIP documentation compared to the prior-year baseline submissions. The plans demonstrated increased proficiency with the CMS requirements for conducting a QIP.

One of the two objectives of the member health education campaign was to increase communication between members and PCPs on appropriate ER use. Based on the provider survey results, providers found the member health education campaign materials helpful in talking with patients about the ER. By providing these materials, the campaign may have increased how frequently providers and patients communicate regarding appropriate ER use. Some plans and providers experienced challenges with having culturally and linguistically appropriate campaign materials for populations that speak a language other than English or Spanish.

Plans overcame early challenges and barriers related to identifying hospitals willing to participate in a data exchange, resulting in the implementation of this intervention by all plans participating in the collaborative.

Thirty-four percent of county-level reported rates for avoidable ER visits decreased. Sixty-six percent of county-level reported rates for avoidable ER visits increased. Neither of the collaborative interventions was fully implemented during the measurement period of January 1, 2008, through December 31, 2008. Therefore, the results of the first remeasurement period reflect plan-specific efforts. Plans implemented the member health education campaign in late spring and summer 2009. Plans had varied timing for the data exchange intervention; however, most did not have agreements in place until late 2008 and into 2009. The second remeasurement period may provide a greater indication of collaborative efforts and the success of statewide interventions.

Plans continued to report challenges with collaborative efforts to reduce avoidable ER visits given many hospitals' direct marketing efforts to increase use of the ER. Other states have initiated or are in the design phases of similar collaborative approaches to reduce avoidable ER visits. Many of these collaboratives are implementing interventions that include the participation of hospitals as collaborative partners. The results from these efforts are pending but once available may provide additional information on the effectiveness of alternative strategies.

As the collaborative continues to progress, with the DHCS and the plans analyzing data from the additional remeasurement years, more information will be available to identify patterns of success and interventions that might have a greater impact on reducing avoidable ER visits.

Based on the first remeasurement period results and additional collaborative documentation, HSAG recommends the following:

- Plans should consider sharing campaign materials translated into other languages among plans to extend the reach of the campaign when possible.
- Plans should explore strategies to sustain successful or promising interventions.
- Plans should implement quality checks and greater oversight of data to minimize errors when reporting rates.
- Plans should report data in a consistent manner to allow for greater comparability across all Medi-Cal managed care reporting units.

Medi-Cal Managed Care Background

The DHCS administers the Medi-Cal Managed Care Program, California's Medicaid managed care program, which serves roughly half of the Medi-Cal population. The other half is enrolled in fee-for-service (FFS) Medi-Cal.

During the first remeasurement year, which reflects data from January 1, 2008, through December 31, 2008, 21 full-scope health plans were operating in 25 counties throughout California, providing comprehensive health services to approximately 3.4 million beneficiaries enrolled in Medi-Cal managed care as of December 31, 2008.[6]

The DHCS administers the Medi-Cal Managed Care Program through a service delivery system that encompasses three different model types: County-Organized Health System (COHS), Geographic Managed Care (GMC), and Two-Plan.

County-Organized Health System

In a COHS model, the DHCS contracts with one county organized and operated plan in a county to provide managed care services to all Medi-Cal beneficiaries in that county, with very few exceptions. Beneficiaries can choose from a wide network of managed care providers. Beneficiaries in COHS plan counties do not have the option of enrolling in fee-for-service Medi-Cal unless authorized by the plan.

During the measurement period for this report, January 1, 2008, through December 31, 2008, the DHCS had contracts with five COHS plans operating in 10 counties.

Geographic Managed Care

In the GMC model, enrollees choose from three or more commercial plans offered in a county. Beneficiaries with designated mandatory aid codes must enroll in a managed care plan. Seniors and individuals with disabilities who are eligible for Medi-Cal benefits under the Supplemental Security Income (SSI) program and a small number of beneficiaries in several other aid codes are not required to enroll in a plan but may choose to do so. These "voluntary" beneficiaries may either enroll in a managed care plan or receive services through the Medi-Cal FFS program.

[6] *Medi-Cal Managed Care Enrollment Report, December 2008*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

During the measurement period for this report, January 1, 2008, through December 31, 2008, the GMC model type was operating in San Diego and Sacramento counties.

Two-Plan

In the Two-Plan model, the DHCS contracts with two managed care plans in each county to provide health care services to beneficiaries. Most Two-Plan model counties offer a locally operated, local initiative (LI) plan and a non-governmental commercial plan (CP). Like the GMC model type, the DHCS requires beneficiaries with designated mandatory aid codes to enroll in a plan, while seniors and individuals with disabilities who are eligible for Medi-Cal benefits under the SSI program and a small number of beneficiaries in several other aids codes can voluntarily choose either to enroll in a plan or remain in the FFS program. As in the GMC model, these "voluntary" beneficiaries may either enroll in a managed care plan or receive services through the Medi-Cal FFS program.

During the measurement period for this report, January 1, 2008, through December 31, 2008, the Two-Plan model was operating in 12 counties.

Purpose of the Collaborative Quality Improvement Project

The DHCS requires each of its contracted Medi-Cal managed care plans to conduct two DHCS-approved QIPs according to federal requirements. Plans must always maintain two active QIPs. For full-scope plans, the statewide Medi-Cal managed care collaborative project serves as one of the two required QIPs. The second QIP can be either an individual or small-group collaborative involving at least three Medi-Cal managed care plans.

MMCD selected reducing avoidable ER visits as the statewide collaborative topic beginning in 2007 in response to utilization patterns and findings from the Institute of Medicine's report, *Emergency Medical Services at the Crossroads*. MMCD also selected the topic to improve member access to primary care while encouraging preventive care, which can avoid or minimize the damaging effects of chronic disease.

The collaborative established a QIP goal of reducing avoidable ER visits by 10 percent for each plan over a three-year period.

Collaborative Components and Process

The collaborative primarily used work groups to conduct QIP activities. The collaborative work groups were multidisciplinary, with participation from medical directors, quality improvement staff, medical policy staff, health educators, and nurse consultants from the State and the plans.

During the QIP design phase, the collaborative used a work group to review literature, analyze data, and discuss the aspects of ER overuse that the QIP would address. The collaborative also developed and initiated a health plan survey, a member survey, and a provider survey. The collaborative used the surveys to obtain information on after-hours access to care, the relationship between health plans and hospitals, provider incentives, plan-specific initiatives previously implemented, members' knowledge of after-hours services, members' reasons for using the ER, members' use of advice lines, and provider availability.

The collaborative partners used survey results outlined in the baseline report along with data analysis and literature review to conduct causal/barrier analysis. The collaborative's statewide interventions were focused on barriers common to all plans and were complementary of plan-specific interventions.

The collaborative continued to use work groups throughout the implementation and first remeasurement phases of the QIP. Work groups focused primarily on developing and launching the member health education campaign, defining and implementing the plan-hospital data collaboration intervention, and defining intervention outcome measures.

Plans were responsible for collecting baseline and remeasurement data and reporting the results in their QIP submission to the EQRO for validation. In addition, plans were accountable for disseminating provider surveys, which solicited feedback on the member health education campaign, along with data collection and data entry.

The collaborative selected two performance measures for baseline and remeasurement reporting, defined in the baseline report as ***Measure I*** and ***Measure II***.

Measure I—HEDIS Ambulatory Care—Emergency Department Visits

Measure I consists of the *HEDIS Ambulatory Care—Emergency Department Visits* measure. This measure reflects emergency department (ED) visits that did not result in an inpatient admission during a specified calendar year.

Plans report rates as the total number of ED visits/1,000 member months. Plans use this measure to derive and calculate the avoidable ER visits rate. While the DHCS requires plans to report ***Measure I*** as part of their QIP submission, the DHCS recognizes that this measure includes ED visits that are beyond the control of the plans. Therefore, the QIP results for this measure are considered informational and are not assessed for improvement.

Measure I reflects the plans' 2008 and 2009 *HEDIS Ambulatory Care—Emergency Department Visits* rate, which covers the measurement period of January 1, 2007, through December 31, 2007, and January 1, 2008, through December 31, 2008, respectively.

HSAG noted some inconsistencies between ***Measure I*** rates reported in the plans' baseline QIP submissions and the plans' reported HEDIS rates. Some plans excluded members younger than 1 year of age, inconsistent with the measure's technical specifications, while other plans ran data at a later date.

Per HSAG's recommendation in the interim report, the DHCS notified plans to follow HEDIS specifications for reporting this measure prior to submitting their QIPs in October 2009. In addition, HSAG implemented a process to check plans' reported QIP rates, both baseline and remeasurement, against the HEDIS reported rates prior to conducting validation to address data discrepancies.

HSAG found that 12 of the 21 plans had inconsistent rates. Six of the plans resolved these discrepancies and indicated that the reasons for the errors varied. Discrepancies, for example, were due to excluding members less than 1 year of age, reporting data inconsistent with the updated baseline year, and using the wrong data source to populate the QIP.

The other six plans could not report rates consistent with their reported HEDIS rates because they refreshed their data after HEDIS reporting and were unable to revert to the previous data set. One plan discovered an error in its HEDIS rate because the plan did not exclude mental health visits consistent with the specifications. The plan then reported the corrected data. Another plan realized that its software vendor excluded denied claims. The plan then corrected the issue and reported the updated rate.

Measure II—Avoidable ER Visits

The collaborative developed ***Measure II***, a HEDIS-like measure, to define the percentage of avoidable ER visits among members older than 1 year of age.

Measure II reflects the number of ER visits that could have been more appropriately managed by and/or referred to a PCP in an office or clinic setting. Appendix A includes the data specifications for ***Measure II***.

The collaborative used ***Measure II*** as the QIP indicator to measure the success of the collaborative. As part of the validation process, HSAG assessed whether plans achieved real, statistically significant improvement between the baseline and remeasurement year using this measure.

Validation review and analysis of plan-reported results found that three plans reported ***Measure II*** inconsistent with collaborative-developed specifications. These three plans may not have excluded members less than 1 year of age before running their avoidable ER visits rates. HSAG requested that these three plans run data again for both their baseline and remeasurement periods as part of their next annual QIP submission in October 2010. These plans' rates are noted within the results tables of this report to provide caution to the reader regarding the accuracy of the results.

Collaborative Statewide Interventions

Since the interim report, the collaborative fully implemented its two statewide interventions and completed development of outcome measures for each intervention.

While the development and implementation of intervention outcome measures are not a standardized component of a QIP, they are necessary to evaluate the efficacy of the interventions. The efforts of the collaborative to collect information on the two statewide interventions will help evaluate the interventions' short-term and/or intermediate impact on the targeted causal barriers. This information will be useful to the collaborative partners when allocating resources for ongoing and future interventions.

Member Health Education Campaign

The collaborative targeted the member health education campaign, "Not Sure It's an Emergency?" as a strategy to address two identified causal barriers:

- Lack of member information on alternatives to seeking care in the ER.
- Lack of communication between members and PCPs on appropriate ER use.

The campaign targeted parents of members 1 to 19 years of age and plan providers. The collaborative determined that this age group showed a high rate of avoidable ER visits for all plans across all ethnic and language subgroups. In addition, the avoidable diagnosis codes related to colds, coughs, and earaches were highest in this age group.

The collaborative identified two objectives for the campaign:

- Increase members' knowledge/awareness of alternatives to using the ER.
- Increase communication between members and PCPs on appropriate ER use.

Campaign materials, available at the DHCS Web site,[7] included an English and Spanish brochure and poster, and a provider tool kit. Plans disseminated initial campaign materials to providers beginning in May 2009, with completion in October 2009.

[7] Department of Health Care Services. *ER Collaborative Baseline Report,* August 2008. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx

Member Health Education Campaign Outcome Measures

The collaborative finalized a cover letter and 10-question provider survey in December 2009 to evaluate process, satisfaction, and short-term outcomes of the member health education campaign. The collaborative targeted providers who received campaign materials. The collaborative also established county response rate goals based on plan membership and the total number of providers, with an overall goal of 440 completed provider surveys across counties. Providers could complete the survey online or fax their responses back to the plan.

In April 2010, the collaborative finalized a five-question member survey to assess whether members received a campaign brochure, saw a campaign poster, and spent time with their provider for an explanation of the materials. For members who had providers discuss the materials with them, two additional questions assessed whether members would be more likely to contact their provider or nurse advice line before going to the ER or if they were worried about their child's earache, sore throat, cough, cold, or flu.

The collaborative directed member surveys to parents of members 1 to 19 years of age who visited a campaign-targeted provider between May 2009 and January 2010. Plans identified members through either claims data or physician contact. Plans could choose several options for survey administration, including interactive voice response, telephone member outreach, during a PCP visit, or another plan-developed method. The collaborative established county response rate goals based on plan membership, with an overall goal of 440 completed member surveys.

HSAG recommended that the outcome measures align with the objectives of the campaign. For example, the collaborative could measure the extent to which parents with children 1 to 19 years of age received materials and/or were more educated about alternatives to using the ER and the extent to which providers and members discussed appropriate use of the ER.

The collaborative considered these recommendations when finalizing both the provider and member surveys. While it was not feasible for the collaborative to administer pre- and posttests and to administer surveys using statistically valid sampling techniques due to limited time and resources, the survey results will provide the collaborative with some data on process outcomes and the short-term outcomes of those surveyed.

Provider Survey Results

MMCD collected and aggregated provider survey results for 519 respondents. Appendix B includes the provider cover letter, survey, and survey results.

The survey included several process- and satisfaction-related questions to assess campaign material distribution and provider receptivity. Most provider respondents indicated that they received the campaign materials through a visit from the health plan's representative or by mail. Providers

displayed the campaign poster primarily in their office waiting room, while a smaller portion displayed the posters in the exam rooms. The most frequent reason respondents cited for not displaying the poster was *limited wall space*.

Most providers distributed brochures to patients by making them available on waiting room counters and in exam rooms, or by having a receptionist distribute them. Approximately 150 respondents indicated that the provider distributed a brochure directly to members or had other medical staff distribute them to members. Only 26 respondents indicated that they did not distribute the campaign materials, citing *brochures not useful for patients*, *limited counter space,* and *other* as the primary reasons.

More than half of the respondents added their name, address, and telephone number to the back of the brochure. About 50 percent of the survey respondents said the health plan contacted them to provide assistance or more materials, or to answer questions. In this group, 82 percent responded that the assistance was either *very helpful* or *helpful*.

Approximately 38 percent of respondents indicated that patients asked questions about use of the ER *sometimes*, while 37 percent indicated *rarely*, followed by responses of *never, often*, and *always*. Approximately 48 percent of respondents indicated that they initiated discussion with their patients about when to use the ER *always* or *often*, while approximately 38 percent said *sometimes*, 10 percent said *rarely*, and 3 percent responded *never*.

Of the survey responses, approximately 74 percent found the campaign poster and brochure helpful in talking with patients about appropriate ER use.

Member Survey Results

Plans have until August 2, 2010, to complete member survey administration, data collection, and submission. Appendix C includes a copy of the member survey.

HSAG will provide member survey results in the next remeasurement report. These results combined with the provider survey data will allow HSAG to better assess the collaborative's impact on the targeted barriers.

Member Health Education Campaign Challenges and Successes

The collaborative has had several successes with the member health education campaign. All 21 plans participating in the collaborative have implemented the member health education campaign. An estimated 7,000 providers across Medi-Cal managed care counties received campaign materials, which represents approximately 67 percent of Medi-Cal managed care providers who see members 1 to 19 years of age.[8] This demonstrates an ongoing commitment from the DHCS and participating plans despite limited resources.

[8] Department of Health Care Services. Health Plan Survey Provider Sample Responses. November 2, 2009.

Based on provider survey results, the survey respondents indicated that most received the member health education campaign materials in person from a health plan representative. This may have increased providers' awareness of the campaign materials, goals for the project, and willingness to participate and use the campaign materials.

While the collaborative produced materials in English and Spanish only, some plans translated materials and made them available to members and providers in additional languages. Some plans translated materials into Armenian, Chinese, Khmer, Korean, Vietnamese, and Tagalog, which extends the reach of the original campaign.

One of the two objectives of the member health education campaign was to increase communication between members and PCPs on appropriate ER use. By producing and distributing materials that providers found helpful in talking with patients about the ER, the collaborative may have increased how frequently providers and patients communicate regarding appropriate ER use.

Collaborative partners also experienced challenges with the member health education campaign. Health education materials were provided in English and Spanish as agreed to by the DHCS and the plans. Although some plans translated materials into additional languages, resources allocated by some plans were insufficient to provide translated materials in all languages needed. This had an impact on reaching all monolingual, non-English speaking, or limited-English-proficient members.

Additional challenges for some plans included a lack of enough resources to print and reprint campaign materials and turnover of staff responsible for implementing the ER campaign.

Plan-Hospital Data Collaboration

The collaborative developed a plan-hospital data collaboration intervention as a strategy to address two identified causal barriers:

- Lack of timely notification from the hospital to the health plan of member ER visits.
- Lack of timely member interventions initiated by the health plan following an avoidable ER visit.

The collaborative identified two objectives for the plan-hospital data collaboration intervention:

- Increase timely exchange of information for members seen in the ER.
- Increase timely interventions initiated by the health plan for members with an avoidable ER visit.

The collaborative is interested in learning what impact timely notification has on the health plans' ability to intervene with members to reduce avoidable ER visits.

The collaborative targeted 21 hospitals for the intervention, one per participating partner plan. Since the interim report, one plan, Western Health Advantage, terminated its contract with the DHCS as of December 31, 2009, which left 20 remaining plans. Implementation began in August 2008 with the expectation that all plans have a data exchange in place by June 1, 2009. All the plans were successful with implementing a process for data exchange with a hospital. The plans varied in terms of the data elements captured and the frequency of the data exchange. Appendix D provides the data elements captured and the frequency of data exchange by plan.

Plan-Hospital Data Collaboration Outcome Measures

The work group developed both process monitoring and outcomes measures. Process measures included information about the initiation of plan contact with a hospital for regular data feeds, the date of the first data feed from the participating hospital, and the start date of member interventions based on data feeds.

In addition, plans will collect and report information on data frequency, data timeliness, data volume, and data completeness. The collaborative will use this information to determine if it met its first objective by measuring if there was an increase in the timely exchange of information from the hospital to the plan.

The work group will measure success with the second objective, increasing timely interventions initiated by the plan with members seen in the ER with an avoidable visit, through a member communications measure. This measure reports the percentage of plan outreach attempts/communications to members originating from the data feeds during the measurement period.

Finally, the work group developed measures to evaluate avoidable ER visit rates from participating and nonparticipating hospitals. Plans will conduct one or more analyses comparing the avoidable ER rates between participating and nonparticipating hospitals, analyzing the rates for participating and nonparticipating hospitals pre- and postintervention, and analyzing the rates for participating and nonparticipating hospitals compared to the total avoidable ER rate.

Appendix E includes the hospital collaboration process and outcome measures.

Plans are collecting data for the six-month periods of January 1, 2009–June 30, 2009, and July 1, 2009–December 31, 2009. Plans will report data for the 2009 calendar year in October 2010 and finish the intervention December 31, 2010, reporting the data in 2011. HSAG will include plans' reported data as part of their October 2010 submissions in the next remeasurement report.

The process and outcome measures for this intervention will allow plans to determine if the intervention was successful and evaluate opportunities to expand the intervention to additional hospitals.

Plan-Hospital Data Collaboration Challenges and Successes

Participating plans were successful implementing the hospital data exchange intervention. Plans overcame early challenges and barriers related to identifying hospitals willing to participate and finding the necessary resources to support the intervention.

Challenges include having the resources needed to sustain the intervention, data issues, and turnover of key hospital point of contacts.

The intervention outcome measures that plans will submit in October 2010 will provide more information regarding the success of the intervention.

Plan-Specific Interventions

In addition to the statewide collaborative interventions, many plans initiated plan-specific interventions to reduce avoidable ER visits. Many plans have had interventions in place for several years, while others have implemented them throughout the initiation of this project. Although the types of interventions varied, the plans included interventions focused on the provider, member, and system.

A discussion of interventions for plans that showed a decrease in their avoidable ER visits rate between the baseline and first remeasurement period is included in the Results section of this report.

Project Timeline

In October 2009, all plans submitted QIPs for validation and reported first-year remeasurement data, which reflect the measurement period of January 1, 2008, through December 31, 2008.

Appendix F provides the ER collaborative QIP timeline in greater detail.

Quality Improvement Project Validation Description

CMS produced protocols for plans to use when conducting QIPs[9] and for EQROs to use when validating QIPs.[10]

CMS protocols include 10 activities, as outlined below, for plans when conducting QIPs. Plans document each activity and report progress annually to the EQRO for validation.

Activity I:	**Select the study topic(s)**
Activity II:	**Define the study question(s)**
Activity III:	**Select the study indicator(s)**
Activity IV:	**Use a representative and generalizable study population**
Activity V:	**Use sound sampling techniques (if sampling is used)**
Activity VI:	**Reliably collect data**
Activity VII:	**Implement intervention and improvement strategies**
Activity VIII:	**Analyze data and interpret study results**
Activity IX:	**Plan for real improvement**
Activity X:	**Achieve sustained improvement**

[9] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. EQR Managed Care Organization Protocol. *Conducting Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities*, *Final Protocol, Version 1.0, May 2002*.
Available at: http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/07_Tools_Tips_and_Protocols.asp

[10] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. EQR Managed Care Organization Protocol. *Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities, Final Protocol, Version 1.0, May 2002*.
Available at: http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/07_Tools_Tips_and_Protocols.asp

With October 2009 QIP submissions, plans completed Activities I–IX, which involved statistical testing for a real, statistically significant decrease in their rates of avoidable ER visits.

The DHCS contracts with HSAG as the EQRO that validates QIP proposals and annual submissions.

The primary objective of QIP validation is to determine each plan's compliance with federal requirements, which include:

- *Measuring* performance using objective quality indicators.
- *Implementing* systematic interventions to achieve improvement in quality.
- *Evaluating* the effectiveness of the interventions.
- *Planning* and *initiating* activities to increase or sustain improvement.

Evaluating the Overall Validity and Reliability of Study Results

A QIP that accurately documents CMS protocol requirements has high validity and reliability. *Validity* is the extent to which the data collected for a QIP measure its intent. *Reliability* is the extent to which an individual can reproduce the study results. For each completed QIP, HSAG assesses threats to the validity and reliability of QIP findings and determines when a QIP is no longer credible. Using its QIP Validation Tool and standardized scoring, HSAG reports the overall validity and reliability of the findings as one of the following categories:

- ***Met***=Confidence in the reported study findings.
- ***Partially Met***=Low confidence in the reported study findings.
- ***Not Met***=Reported study findings that are not credible.

Quality Improvement Project Validation Findings

HSAG reviewed a total of 25 statewide collaborative QIP submissions, which represented 21 plans. HSAG provided each QIP submission with an overall validation status of *Met, Partially Met,* or *Not Met*. The DHCS requires that QIPs receive an overall *Met* validation status; therefore, plans must resubmit a QIP until it achieves a *Met* validation status.

Of the 25 QIP submissions, 9 required a resubmission and 1 required a second resubmission. As of March 31, 2010, all collaborative QIP submissions received an overall *Met* validation status.

HSAG presents a summary of the validation results for baseline through Remeasurement 1 data in Table 5.1. Validation results presented in the table include all plans' final QIP submissions that achieved an overall *Met* validation status. All plans included their entire eligible population; therefore, they did not use sampling techniques.

Table 5.1—Remeasurement 1 Validation Results for the Statewide ER Collaborative QIP (21 Plans; 25 QIPs)

QIP Stages	Activity	Activity Average Rates*		
		Met Elements	*Partially Met* Elements	*Not Met* Elements
Study Design	**I: Appropriate Study Topic**	**95%** (142/150)	**3%** (5/150)	**2%** (3/150)
	II: Clearly Defined, Answerable Study Question(s)	**100%** (50/50)	**0%** (0/50)	**0%** (0/50)
	III: Clearly Defined Study Indicator(s)	**98%** (171/174)	**2%** (3/174)	**0%** (0/174)
	IV: Correctly Identified Study Population	**94%** (48/51)	**4%** (2/51)	**2%** (1/51)
Study Implementation	**V: Valid Sampling Techniques**	--	--	--
	VI: Accurate/Complete Data Collection	**98%** (118/120)	**2%** (2/120)	**0%** (0/120)
	VII: Appropriate Improvement Strategies	**93%** (66/71)	**4%** (3/71)	**3%** (2/71)
Quality Outcomes Achieved	**VIII: Sufficient Data Analysis and Interpretation**	**89%** (170/192)	**10%** (20/192)	**1%** (2/192)
	IX: Real Improvement Achieved	**43%** (41/96)	**0%** (0/96)	**57%** (55/96)
	X: Sustained Improvement Achieved	**	**	**
Overall QIP Performance		**89% (806/904)**	**4% (35/904)**	**7% (63/904)**

* The activity average rate represents the average percentage of elements with a *Met*, *Partially Met,* or *Not Met* finding across all the applicable evaluation elements for a particular activity.
** No QIPs were assessed for this activity.

Based on the final QIP validation results, the plans demonstrated a strong understanding of both the study design and study implementation phases. The percentage of elements *Met* across activities improved compared with the prior-year validation results from plans' October 2008 submissions, except for Activity I, which remained the same at 95 percent.

Plans significantly increased their compliance with the CMS protocol for conducting QIPs in their October 2009 submissions compared to their October 2008 submissions. Sixty percent of QIPs submitted in October 2009 achieved an overall *Met* validation status. No QIPs submitted in October 2008 achieved an overall *Met* validation status.

This suggests that actions taken by the DHCS and plans have resulted in greater compliance. The DHCS allowed plans a transition period after plans submitted QIPs in October 2008. During this

transition period, the DHCS revised its QIP requirements to transition plans to the HSAG QIP Summary Form that supports documentation of all the required activities within the CMS protocols. The DHCS developed a collaborative QIP study question consistent with the CMS protocol for conducting a QIP and made it available to plans for their October 2009 submission. In addition, the DHCS had HSAG provide training to plans on their QIP summary form, validation requirements, and CMS protocols. HSAG provided ongoing technical assistance to the DHCS and the plans. Detailed validation findings are available on the DHCS Web Site at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx.

For future QIP submissions, HSAG has enhanced its validation methodology to ensure that plans provide an accurate rate calculation before the QIP can receive an overall *Met* validation status as part of Activity VI. Under the new methodology, the three plans that incorrectly calculated their rates would receive an overall *Not Met* validation status until the error has been corrected.

While the plans have gained increased proficiency with the CMS protocol for conducting QIPs through improved documentation for both the study design and study implementation phases, achieving full compliance becomes more challenging as QIPs progress to evaluating quality outcomes.

Plans can achieve full compliance in this phase only by demonstrating statistically significant improvement in Activity IX and sustained improvement in Activity X. Plans achieved *Met* scores for only 43 percent of the elements within Activity IX for the October 2009 QIP submissions. Plans could not be assessed for Activity X until they reported results for a second remeasurement period.

Table 6.1 presents the results for ***Measure I***—*HEDIS Ambulatory Care—Emergency Department Visits*. The results were informational and not evaluated for improvement since this rate includes both avoidable and nonavoidable ER visits.

Table 6.1—*Measure I—HEDIS Ambulatory Care—Emergency Department Visits*¥

Plan Name	County	Model and Plan Type*	ER Visits/1,000 Member Months		Informational Change
			Baseline 1/1/07–12/31/07	Remeasurement 1 1/1/08–12/31/08	
Alameda Alliance for Health	Alameda	Two-Plan: LI	47.6 †	39.6 †	↓
Anthem Blue Cross	Alameda	Two-Plan: CP	55.5 †	56.7 †	↑
Anthem Blue Cross	Contra Costa	Two-Plan: CP	51.8 †	52.8 †	↑
Anthem Blue Cross	Fresno	Two-Plan: CP	37.3 †	38.9 †	↑
Anthem Blue Cross	Sacramento	GMC: CP	33.3 †	34.2 †	↑
Anthem Blue Cross	San Francisco	Two-Plan: CP	29.8 †	29.9 †	↑
Anthem Blue Cross	San Joaquin	Two-Plan: CP	35.1 †	36.9 †	↑
Anthem Blue Cross	Santa Clara	Two-Plan: CP	30.3 †	32.6 †	↑
Anthem Blue Cross	Stanislaus	Two-Plan: LI	50.6 †	53.0 †	↑
Anthem Blue Cross	Tulare	Two-Plan: LI	44.0 †	40.0 †	↓
CalOptima	Orange	COHS	36.3	37.4	↑
Care 1st	San Diego	GMC: CP	44.1	39.3	↓
CenCal Health	Santa Barbara	COHS	50.3 †	51.9 †	↑
CenCal Health	San Luis Obispo^	COHS	Δ	Δ	
Central California Alliance for Health	Monterey, Santa Cruz	COHS	60.9	62.1	↑
Community Health Group	San Diego	GMC: CP	23.3	27.0	↑
Contra Costa Health Plan	Contra Costa	Two-Plan: LI	55.1	57.1	↑
Health Net	Fresno	Two-Plan: CP	35.4	39.2	↑
Health Net	Kern	Two-Plan: CP	38.6	41.5	↑
Health Net	Los Angeles	Two-Plan: CP	27.4	29.0	↑
Health Net	Sacramento	GMC: CP	26.6	26.4	↓
Health Net	San Diego	GMC: CP	41.5	43.7	↑
Health Net	Stanislaus	Two-Plan: CP	50.8	53.2	↑

Table 6.1—*Measure I—HEDIS Ambulatory Care—Emergency Department Visits*¥

Plan Name	County	Model and Plan Type*	ER Visits/1,000 Member Months		Informational Change
			Baseline 1/1/07–12/31/07	Remeasurement 1 1/1/08–12/31/08	
Health Net	Tulare	Two-Plan: CP	42.9	41.1	↓
Health Plan of San Joaquin	San Joaquin	Two-Plan: LI	42.3	34.7	↓
Health Plan of San Mateo	San Mateo	COHS	48.1	52.7	↑
Inland Empire Health Plan	Riverside/San Bernardino	Two-Plan: LI	47.4	48.0	↑
Kaiser Permanente—North	Sacramento	GMC: CP	38.9 †	40.2 †	↑
Kaiser Permanente—South	San Diego	GMC: CP	41.7 †	39.5 †	↓
Kern Family Health Care	Kern	Two-Plan: LI	38.9	40.3	↑
LA Care Health Plan	Los Angeles	Two-Plan: LI	31.6	33.1	↑
Molina Healthcare	Riverside/San Bernardino	Two-Plan: CP	36.1	39.9	↑
Molina Healthcare	Sacramento	GMC: CP	33.3	31.9	↓
Molina Healthcare	San Diego	GMC: CP	40.6	39.1	↓
Partnership Health Plan	Napa, Solano, Yolo	COHS	45.0 †	46.8 †	↑
San Francisco Health Plan	San Francisco	Two-Plan: LI	22.8	22.5†	↓
Santa Clara Family Health	Santa Clara	Two-Plan: LI	36.1	35.0	↓
Western Health Advantage	Sacramento	GMC: CP	26.4	30.2	↑

Note: Changes in rates from baseline to Remeasurement 1 are presented for informational purposes only and will be indicated with directional arrows (↑ or ↓).

¥ Table data reflect plan-reported rates via 2009 QIP submissions.

* Model Types: COHS=County-Operated Health System, GMC=Geographic Managed Care, Two-Plan
Plan Types: CP=Commercial Plan, LI=Local Initiative

^ CenCal Health—San Luis Obispo County added in March 2008.

Δ Data not reported in QIP submission.

† Rate reported in QIP differs from the HEDIS rate reported to the DHCS for the same measurement period.

Of the 37 counties that had both a baseline and remeasurement rate, 11 showed a decrease in their ED visits rate while 26 showed in increase. Figure 6-1 shows the absolute change by plan.

Figure 6-1—*Measure I—HEDIS Ambulatory Care—Emergency Department Visits*

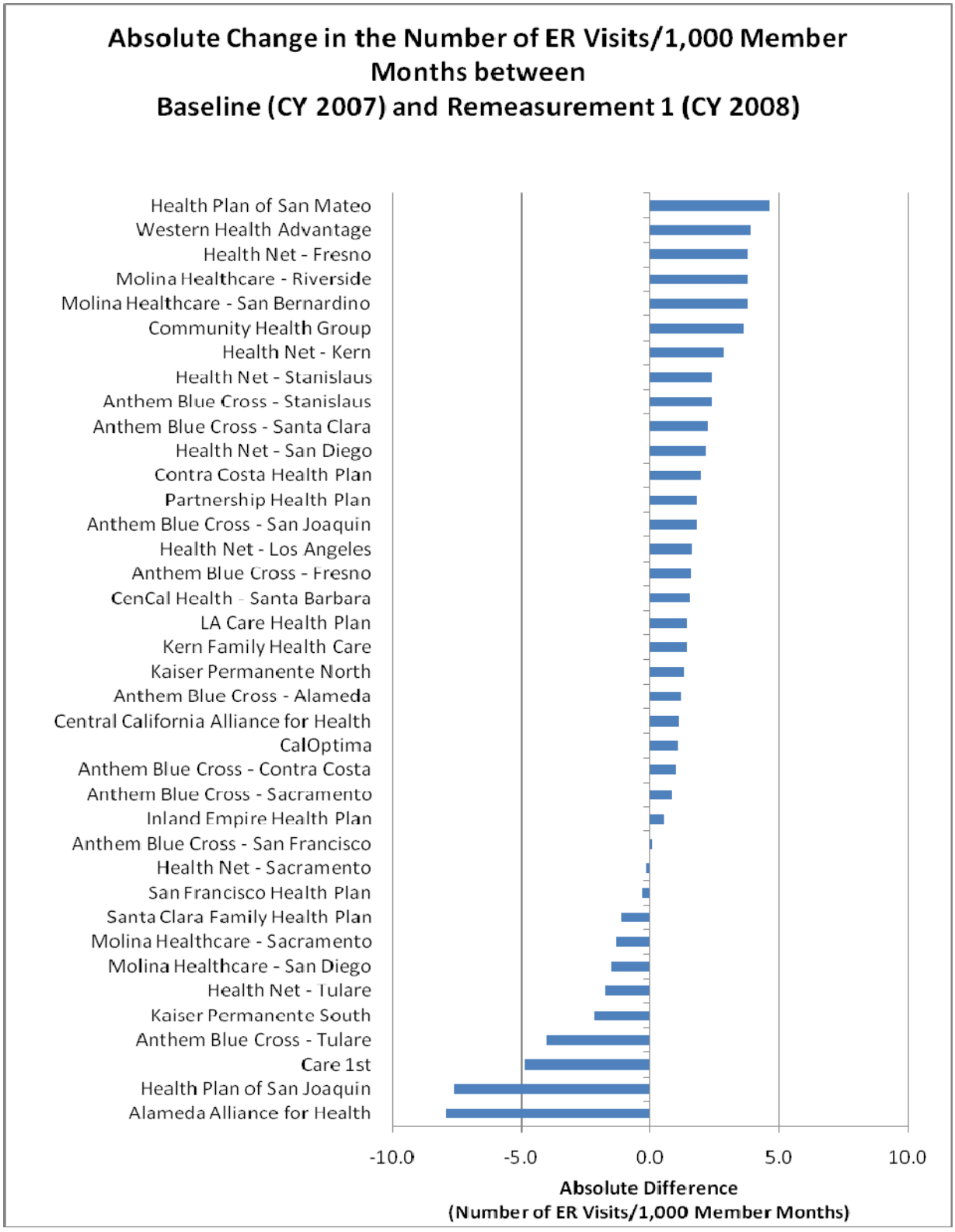


Table 6.2 includes the results for ***Measure II*** and compares the results from baseline to Remeasurement 1. For this measure, a statistically significant decrease in the rate demonstrates improvement.

Table 6.2—*Measure II*—Avoidable ER Visits¥

Plan Name	County	Model and Plan Type*	Avoidable ER Visits as a Percentage of Overall ER Visits		Improvement
			Baseline 1/1/07–12/31/07	Remeasurement 1 1/1/08–12/31/08	
Alameda Alliance for Health	Alameda	Two-Plan: LI	12.1%†	15.0%†	No**
Anthem Blue Cross	Alameda	Two-Plan: CP	18.7%	16.3%	Yes**
Anthem Blue Cross	Contra Costa	Two-Plan: CP	20.9%	17.7%	Yes**
Anthem Blue Cross	Fresno	Two-Plan: CP	16.4%	16.6%	No
Anthem Blue Cross	Sacramento	GMC: CP	17.0%	15.7%	Yes**
Anthem Blue Cross	San Francisco	Two-Plan: CP	16.4%	16.3%	Yes
Anthem Blue Cross	San Joaquin	Two-Plan: CP	18.5%	18.3%	Yes
Anthem Blue Cross	Santa Clara	Two-Plan: CP	17.6%	17.7%	No
Anthem Blue Cross	Stanislaus	Two-Plan: LI	22.2%	21.1%	Yes**
Anthem Blue Cross	Tulare	Two-Plan: LI	21.3%	19.8%	Yes**
CalOptima	Orange	COHS	16.1%	16.7%	No**
Care 1st	San Diego	GMC: CP	13.8%	17.7%	No**
CenCal Health	Santa Barbara	COHS	19.2%	19.6%	No
CenCal Health	San Luis Obispo^	COHS	--	--	--
Central California Alliance for Health	Monterey, Santa Cruz	COHS	23.2%	19.0%	Yes**
Community Health Group	San Diego	GMC: CP	17.9%	16.5%	Yes**
Contra Costa Health Plan	Contra Costa	Two-Plan: LI	16.6%	20.9%	No**
Health Net	Fresno	Two-Plan: CP	17.4%	22.2%	No**
Health Net	Kern	Two-Plan: CP	15.3%	21.5%	No**
Health Net	Los Angeles	Two-Plan: CP	15.5%	21.7%	No**
Health Net	Sacramento	GMC: CP	15.9%	19.0%	No**
Health Net	San Diego	GMC: CP	16.2%	20.5%	No**
Health Net	Stanislaus	Two-Plan: CP	14.5%	23.5%	No**
Health Net	Tulare	Two-Plan: CP	19.4%	22.5%	No**
Health Plan of San Joaquin	San Joaquin	Two-Plan: LI	21.3%	16.7%	Yes**

Table 6.2—*Measure II*—Avoidable ER Visits¥

Plan Name	County	Model and Plan Type*	Avoidable ER Visits as a Percentage of Overall ER Visits		Improvement
			Baseline 1/1/07–12/31/07	Remeasurement 1 1/1/08–12/31/08	
Health Plan of San Mateo	San Mateo	COHS	15.0%	16.2%	No**
Inland Empire Health Plan	Riverside/San Bernardino	Two-Plan: LI	22.8%	20.3%	Yes**
Kaiser Permanente —North	Sacramento	GMC: CP	11.6%	10.8%	Yes
Kaiser Permanente —South	San Diego	GMC: CP	11.5%	13.1%	No**
Kern Family Health Care	Kern	Two-Plan: LI	15.9%	16.9%	No**
LA Care Health Plan	Los Angeles	Two-Plan: LI	16.0%	15.9%	Yes
Molina Healthcare	Riverside	Two-Plan: CP	19.6%	21.6%	No**
Molina Healthcare	San Bernardino	Two-Plan: CP	19.1%	20.9%	No**
Molina Healthcare	Sacramento	GMC: CP	14.5%	16.7%	No**
Molina Healthcare	San Diego	GMC: CP	15.3%	16.2%	No**
Partnership Health Plan	Napa, Solano, Yolo	COHS	17.7%	18.9%	No**
San Francisco Health Plan	San Francisco	Two-Plan: LI	16.3%†	17.0%†	No
Santa Clara Family Health	Santa Clara	Two-Plan: LI	17.1%†	18.5%†	No**
Western Health Advantage	Sacramento	GMC: CP	13.8%	15.1%	No

Note: Improvement in rates from baseline to Remeasurement 1 is indicated by either "Yes" or "No."

¥ Table data reflect plan-reported rates via 2009 QIP submissions.

* Model Types: COHS=County-Operated Health System, GMC=Geographic Managed Care, Two-Plan Plan Types: CP=Commercial Plan, LI=Local Initiative

** Statistically significant difference between baseline and Remeasurement 1 (p value ≤ 0.05).

^ CenCal Health—San Luis Obispo County added in March 2008.

Δ Data not reported in November 2009 QIP submission.

† Rate may have been calculated incorrectly.

Thirteen counties demonstrated improvement, a decrease in the rate of avoidable ER visits, from baseline to Remeasurement 1. For 9 of the 13 counties, the improvement was statistically significant. Conversely, 25 counties reported an increase in the rate of avoidable ER visits, and for 20 plans the decline in performance was statistically significant.

Of the 13 counties that had a decrease in their avoidable ER visits rates, only two showed a decrease in their *HEDIS Ambulatory Care—Emergency Department Visits* rate, which suggests that, at least for this review period, the *HEDIS Ambulatory Care—Emergency Department Visits* rate is not a good indicator of how well the plan is managing avoidable visits. The results also suggest that the avoidable ER visits rate, even with statistically significant decreases, did little to reduce the *HEDIS Ambulatory Care—Emergency Department Visits* rate during the remeasurement period.

Many plans noted in their QIP analysis that external factors, such as the H1N1 flu virus, may have affected their ability to reduce ER visits rates. Nonetheless, many plans hypothesized that their ER visits rates, both avoidable and nonavoidable, would have been higher without the collaborative interventions. A comparison of the rates to national trends may demonstrate the merit of the collaborative interventions in slowing the rate of increase.

HEDIS Medicaid 2008 and 2009 audit means, percentiles and ratios for the *HEDIS Ambulatory Care—Emergency Department Visits* measure showed a mean of 60.9 and 60.2 for the HEDIS 2008 and 2009 years, respectively, which does not support a national increase between baseline and Remeasurement 1. For both years, approximately 78 percent of county rates fell below the national 25th percentile, 48.4 and 48.9 for the 2008 and 2009 reporting years, respectively; 19 percent fell between the 25th and 50th percentile; and 3 percent fell between the 50th and 75th percentiles.[11]

Table 6.3 presents the results for ***Measure II*** by model type.

Table 6.3—*Measure II*—Avoidable ER Visits by Model Type¥

Change in Avoidable ER Visits From Baseline to Remeasurement 1	Model and Plan Type			
	County-Organized Health System N = 5	Two-Plan: CP N = 13	Two-Plan: Local Initiative N = 10	Geographic Managed Care: CP N = 10
Increase	20.0%	15.4%	10.0%	10.0%
Statistically Significant Increase	60.0%	53.8%	60.0%	40.0%
Decrease	0.0%	15.4%	10.0%	10.0%
Statistically Significant Decrease	20.0%	15.4%	20.0%	40.0%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

¥ Table data reflect plan-reported rates via 2009 QIP submissions.
CP=Commercial Plan

Improvement from baseline to Remeasurement 1 differed by model type. Fifty percent of GMC county plans showed improvement compared to approximately 30 percent for the Two-Plan county plans and 20 percent for the COHS county plans. Additionally, for 4 of the 5 GMC county plans demonstrating improvement, the results were statistically significant.

[11] National Committee for Quality Assurance. Medicaid HEDIS Audit Means, Percentiles, and Ratios.

Table 6.4 reports the results for ***Measure II*** by county.

Table 6.4—*Measure II*—Avoidable ER Visits by County[¥]

County	Change in Avoidable ER Visits From Baseline to Remeasurement 1				Total Number of Plans
	Increase	Increase*	Decrease	Decrease*	
Alameda		1		1	2
Contra Costa		1		1	2
Fresno	1	1			2
Kern		2			2
Los Angeles		1	1		2
Monterey/Santa Cruz				1	1
Napa, Solano, Yolo		1			1
Orange		1			1
Riverside		1			1
Riverside/San Bernardino				1	1
Sacramento	1	2	1	1	5
San Bernardino		1			1
San Diego		4		1	5
San Francisco	1		1		2
San Joaquin			1	1	2
San Mateo		1			1
Santa Barbara	1				1
Santa Clara	1	1			2
Stanislaus		1		1	2
Tulare		1		1	2
Total	**5**	**20**	**4**	**9**	**38**

[¥] Table data reflect plan-reported rates via 2009 QIP submissions.
* Statistically significant change (*p* value ≤ 0.05).

Results varied for both small and large counties. Eight counties, or combined counties, were represented by only one plan. For these single-plan counties, only Monterey/Santa Cruz and Riverside/San Bernardino reduced their rate of avoidable ER visits. For the counties with two plans, only the plans in San Joaquin both reported improvement. In counties with five plans, only one plan in San Diego and two plans in Sacramento reported a decrease in the rate of avoidable ER visits.

Table 6.5 reports county-level results for ***Measure II*** for those showing improvement.

Table 6.5—*Measure II*—Avoidable ER Visits—Plans With Improvement

Plan Name and County	Improvement	Statistically Significant Improvement
Anthem Blue Cross—Alameda	✓	✓
Anthem Blue Cross—Contra Costa	✓	✓
Anthem Blue Cross—Sacramento	✓	✓
Anthem Blue Cross—San Francisco	✓	
Anthem Blue Cross—San Joaquin	✓	
Anthem Blue Cross—Stanislaus	✓	✓
Anthem Blue Cross—Tulare	✓	✓
Central California Alliance for Health—Monterey, Santa Cruz	✓	✓
Community Health Group—San Diego	✓	✓
Health Plan of San Joaquin—San Joaquin	✓	✓
Inland Empire Health Plan—Riverside/San Bernardino	✓	✓
Kaiser Permanente (North)—Sacramento	✓	
LA Care Health Plan—Los Angeles	✓	

For the 13 county-level plans showing improvement between baseline and Remeasurement 1, 9 plans had statistically significant improvement. All plans that showed improvement implemented a variety of plan-specific interventions. Most of these plans implemented a combination of member, provider, and system interventions.

The most common member interventions used by these plans included the use of small media (brochures, newsletters, posters, Web site) to educate new and existing members on appropriate use of the ER, provide health tips and information, and explain how to access care. Additionally, these plans used case management and nurse advice lines. Finally, these plans used member input and/or feedback from surveys or focus groups on experiences with after-hours care, ER services, and other aspects of care and services that impact avoidable ER visits.

Plans that demonstrated improvement used provider interventions that solicited provider input and feedback and alerted providers to members who accessed the ER.

Plans with improvement also implemented processes to run and analyze ER data, including frequency and usage reports.

In future QIP submissions HSAG will assess which of these plans showed sustained improvement.

Strengths/Opportunities for Improvement

The DHCS and plans made considerable progress with their ER collaborative QIP since the interim report. Plans fully implemented both statewide interventions. In addition, the collaborative finalized outcome measures for the statewide interventions, including a provider survey to assess one component of the member health education campaign in which the collaborative developed, initiated, collected, and analyzed results. The campaign materials were well received among providers who responded to the survey. The majority of provider respondents found the materials helpful in speaking to members about appropriate use of the ER, which may increase communication between a PCP and member about alternatives to using the ER.

Plans significantly improved their compliance with the CMS protocol for conducting QIPs. Plans have become proficient with the study design and implementation phases of a QIP.

Thirty-five percent of county plans reporting baseline and remeasurement rates for avoidable ER visits had a decrease. Of those, approximately 70 percent showed a statistically significant decrease.

Despite noted improvement among some county plans, many plans showed an increase in their rates. Analysis by plan model type revealed mixed results, with many model types showing relatively the same number of statistically significant increases as statistically significant decreases. Results also varied by county and size of county with no noted trends.

As the collaborative progresses and the DHCS and the plans analyze data from the additional remeasurement years, more information will be available to decipher patterns of success and interventions that might have a greater impact on reducing avoidable ER visits.

One opportunity for plans is to report data in a consistent manner to allow for comparability. Many plans reported HEDIS® ED visits rates that differed from their QIP reported rates. In some cases that variance could have impacted the statistical outcome between baseline and Remeasurement 1. Additionally, the three plans that incorrectly calculated their avoidable ER visits rates will have different results to report once they correct their error.

Next Steps

The collaborative's next steps include the following:

- Complete implementation, data collection, and analysis of member surveys for the member health education campaign.
- Collect and report Remeasurement 2 data and submit QIPs to the EQRO for validation by October 29, 2010.
- Collect and report plan-hospital data collaboration outcome measures data for January 1, 2009–June 30, 2009.

HSAG will complete the next statewide collaborative QIP report, including the second remeasurement year data and analysis, in July 2011. The DHCS's public release of that report is targeted for September 2011.

Appendix A. Data Specifications for Measure II: Avoidable ER Visits

The collaborative defined "avoidable ER visits" as visits with a primary diagnosis that matches the diagnosis codes selected by the collaborative. The collaborative did not select many additional diagnosis codes that could also represent an avoidable ER visit. The rate of avoidable ER visits used in Measure II represents the percentage of all ER visits that match the selected diagnosis codes.

Plans were required to use the following data specifications when collecting baseline data for the avoidable ER visits measure:

- The denominator is determined by the total number of visits from the HEDIS ER measure, excluding infants (less than 12 months of age)
- The numerator represents ER visits containing any of the collaborative-designated primary diagnosis codes (Table A-1)
- The numerator excludes visits for members younger than 12 months of age
- Plans identify the Medi-Cal client index number (CIN), Medi-Cal ethnicity, Medi-Cal language, primary diagnosis, date of service, and Medi-Cal Aid Code.
- Plans calculate and include the age (on the date of service) and total length of plan enrollment (as member months) in their data collection.

The Baseline Measurement Period:

- The 12-month calendar year (January 1, 2007, through December 31, 2007)[A-1]

Numerator:

- Represented by the total number of avoidable ER visits for members 1 year of age or older

Denominator:

- The total number of HEDIS ER visits for members 1 year of age or older per 1,000 member months

Rate:

- The percentage of all ER visits defined as avoidable

[A-1] The baseline measurement period is based on the revised collaborative time frame.

ER Collaborative Avoidable Visits ICD-9 Diagnosis Codes

Medi-Cal ICD–9 Diagnosis Codes for Avoidable ER Visits	ICD-9 Code No Decimal	ICD-9 Code Decimal
Dermatophytosis of body	1105	110.5
Candidiasis of mouth	1120	112.0
Candidiasis	112	112
Candidal vulvovaginitis	1121	112.1
Candidias urogenital NEC	1122	112.2
Cutaneous candidiasis	1123	112.3
Candidiasis – other specified sites	1128	112.8
Candidal otitis external	11282	112.82
Candidal esophagitis	11284	112.84
Candidal enteritis	11285	112.85
Candidiasis site NEC	11289	112.89
Candidiasis site NOS	1129	112.9
Acariasis	133	133
Scabies	1330	133.0
Acariasis NEC	1338	133.8
Acariasis NOS	1339	133.9
Disorders of conjunctiva	372	372
Acute conjunctivitis	3720	372.0
Acute conjunctivitis unspecified	37200	372.00
Serous conjunctivitis	37201	372.01
Ac follic conjunctivitis	37202	372.02
Pseudomemb conjunctivitis	37204	372.04
Ac atopic conjunctivitis	37205	372.05
Chronic conjunctivitis, unspecified	37210	372.10
Chronic conjunctivitis	3721	372.1
Simpl chr conjunctivitis	37211	372.11
Chr follic conjunctivitis	37212	372.12
Vernal conjunctivitis	37213	372.13
Chr allrg conjunctivis NEC	37214	372.14
Parasitic conjunctivitis	37215	372.15
Blepharoconjunctivitis	3722	372.2
Blepharoconjunctivitis, unspecified	37220	372.20
Angular blepharoconjunct	37221	372.21
Contact blepharoconjunct	37222	372.22
Other and unspecified conjunctivitis	3723	372.3
Conjunctivitis, unspecified	37230	372.30
Rosacea conjunctivitis	37231	372.31
Conjunctivitis NEC	37239	372.39
Other mucopurulent conjunctivitis	37203	372.03
Xeroderma of eyelid	37333	373.33
Suppurative and unspecified otitis media	382	382
Acute suppurative otitis media without spontaneous rupture of ear drum	38200	382.00

ER Collaborative Avoidable Visits ICD-9 Diagnosis Codes

	Medi-Cal ICD–9 Diagnosis Codes for Avoidable ER Visits	ICD-9 Code No Decimal	ICD-9 Code Decimal
	Acute suppurative otitis media	3820	382.0
	Ac supp om w drum rupt	38201	382.01
	Chr tubotympan suppur om	3821	382.1
	Chr atticoantral sup om	3822	382.2
	Chr sup otitis media NOS	3823	382.3
	Suppur otitis media NOS	3824	382.4
	Otitis media NOS	3829	382.9
	Ac mastoiditis-compl NEC	38302	383.02
	Acute nasopharyngitis	460	460
	Acute pharyngitis	462	462
	Acute laryngopharyngitis	4650	465.0
	Acute upper respiratory infections of multiple or unspecified sites	465	465
	Acute URI mult sites NEC	4658	465.8
	Acute URI NOS	4659	465.9
	Acute bronchitis	4660	466.0
	Acute bronchitis and bronchiolitis	466	466
	Chronic rhinitis	4720	472.0
	Chronic pharyngitis and nasopharyngitis	472	472
	Chronic pharyngitis	4721	472.1
	Chronic nasopharyngitis	4722	472.2
	Chronic maxillary sinusitis	4730	473.0
	Chronic sinusitis	473	473
	Chr frontal sinusitis	4731	473.1
	Chr ethmoidal sinusitis	4732	473.2
	Chr sphenoidal sinusitis	4733	473.3
	Chronic sinusitis NEC	4738	473.8
	Chronic sinusitis NOS	4739	473.9
	Chronic tonsillitis and adenoiditis	4740	474.0
	Chronic tonsillitis	47400	474.00
	Chronic disease of tonsils and adenoids	474	474
	Chronic adenoiditis	47401	474.01
	Chronic tonsils&adenoids	47402	474.02
	Hypertrophy of tonsils and adenoids	4741	474.1
	Tonsils with adenoids	47410	474.10
	Hypertrophy tonsils	47411	474.11
	Hypertrophy adenoids	47412	474.12
	Adenoid vegetations	4742	474.2
	Chr T & A Dis NEC	4748	474.8
	Chr T & A Dis NOS	4749	474.9
	Cystitis	595	595
	Acute cystitis	5950	595.0
	Chr interstit cystitis	5951	595.1

ER Collaborative Avoidable Visits ICD-9 Diagnosis Codes

Medi-Cal ICD–9 Diagnosis Codes for Avoidable ER Visits	ICD-9 Code No Decimal	ICD-9 Code Decimal
Chronic cystitis NEC	5952	595.2
Trigonitis	5953	595.3
Cystitis in oth dis	5954	595.4
Other specified types of cystitis	5958	595.8
Cystitis cystica	59581	595.81
Irradiation cystitis	59582	595.82
Cystitis NEC	59589	595.89
Cystitis NOS	5959	595.9
Urinary tract infection, site not specified	5990	599.0
Inflammatory disease of cervix, vagina, vulva	616	616
Cervicitis and endocervicitis	6160	616.0
Vaginitis and vulvovaginitis	6161	616.1
Female infertility NEC	6288	628.8
Pruritic conditions NEC	6988	698.8
Pruritic disorder NOS	6989	698.9
Prickly heat	7051	705.1
Lumbago	7242	724.2
Backache NOS	7245	724.5
Disorders of coccyx	7247	724.7
Other back symptoms	7248	724.8
Headache	7840	784.0
Follow up examination	V67	V67
Surgery follow-up	V670	V67.0
Following surgery, unspecified	V6700	V67.00
Follow up vaginal pap smear	V6701	V67.01
Following other surgery	V6709	V67.09
Radiotherapy follow-up	V671	V67.1
Chemotherapy follow-up	V672	V67.2
Psychiatric follow-up	V673	V67.3
Fu exam treated healed fx	V674	V67.4
Following other treatment	V675	V67.5
High-risk Rx NEC Exam	V6751	V67.51
Follow-up exam NEC	V6759	V67.59
Comb treatment follow-up	V676	V67.6
Follow-up exam NOS	V679	V67.9
Encounters for administrative purposes	V68	V68
Issue medical certificate	V680	V68.0
Disability examination	V6801	V68.01
Other issue of medical certificates	V6809	V68.09
Issue repeat prescript	V681	V68.1
Request expert evidence	V682	V68.2
Other specified administrative purposes	V688	V68.8

ER Collaborative Avoidable Visits ICD-9 Diagnosis Codes

	Medi-Cal ICD–9 Diagnosis Codes for Avoidable ER Visits	ICD-9 Code No Decimal	ICD-9 Code Decimal
	Referral-no exam/treat	V6881	V68.81
	Other specified administrative purposes	V6889	V68.89
	Administrtve encount NOS	V689	V68.9
	General medical examination	V70	V70
	Routine medical exam at health facility	V700	V70.0
	Psych exam-authority req	V701	V70.1
	Gen psychiatric exam NEC	V702	V70.2
	Med exam NEC-admin purpose	V703	V70.3
	Exam-medicolegal reasons	V704	V70.4
	Health exam-group survey	V705	V70.5
	Health exam-pop survey (population)	V706	V70.6
	Exam-clinical research	V707	V70.7
	General medical exam NEC	V708	V70.8
	General medical exam NOS	V709	V70.9
	Special investigations and examinations	V72	V72
	Eye & vision examination	V720	V72.0
	Ear & hearing exam	V721	V72.1
	Encounter for hearing examination following failed hearing screening	V7211	V72.11
	Encounter for hearing conservation and treatment	V7212	V72.12
	Other examinations of ears and hearing	V7219	V72.19
	Dental examination	V722	V72.2
	Gynecologic examination	V723	V72.3
	Routine gynecological examination	V7231	V72.31
	Encounter for Papanicolaou cervical smear to confirm findings of recent normal pap smear following initial abnormal pap smear	V7232	V72.32
	Preg exam-preg unconfirm	V724	V72.4
	Pregnancy examination or test, pregnancy unconfirmed	V7240	V72.40
	Pregnancy examination or test, negative result	V7241	V72.41
	Pregnancy examination or test, positive result	V7242	V72.42
	Radiological exam NEC	V725	V72.5
	Laboratory examination	V726	V72.6
	Skin/sensitization tests	V727	V72.7
	Examination NEC	V728	V72.8
	Preop cardiovsclr exam	V7281	V72.81
	Preop respiratory exam	V7282	V72.82
	Oth spcf preop exam	V7283	V72.83
	Preop exam unspcf	V7284	V72.84
	Oth specified exam	V7285	V72.85
	Encounter blood typing	V7286	V72.86
	Examination NOS	V729	V72.9

Appendix B contains the following materials:

- Provider survey introduction letter
- Provider survey
- Provider survey responses

State of California—Health and Human Services Agency
Department of Health Care Services

DAVID MAXWELL-JOLLY
Director

ARNOLD SCHWARZENEGGER
Governor

Appendix B

December 3, 2009

Subject: Avoidable ER Visits: Your Feedback is Needed

Dear Medi-Cal Managed Care Provider:

Earlier this year the Department of Health Care Services in collaboration with our Medi-Cal managed care health plans initiated a health education campaign to reduce avoidable ER Visits among Medi-Cal Managed Care members.

The campaign began May 1, 2009 with distribution of a poster and brochure entitled "Not Sure It's An Emergency". Your feedback is critical to evaluating how effective the materials have been in reducing avoidable ER visits.

We know you have a busy practice. Therefore, we have designed a flexible survey process. The survey may be completed using a web based survey instrument (Survey Monkey), or by fax or mail. A health plan representative will contact you in the near future and will provide additional information about the survey process and timelines.

Thank you in advance for taking the time to help us evaluate the health education campaign to reduce avoidable ER Visits in California.

Sincerely,

Susan McClair

Susan McClair, MD, MPH
Acting Chief, Medical Policy Section

Medi-Cal Managed Care Division
1501 Capitol Avenue, P.O. Box 997413, MS 4404
Sacramento, CA 95899-7413
Phone (916) 449-5000 Fax (916) 449-5005
www.dhcs.ca.gov

ER Provider Survey 2009

ER Health Education Campaign Materials, "Not Sure It's An Emergency? "

Thank you for taking the time to complete this survey. This survey should only take about 5 minutes to complete.

Responses to this survey will be used to assist the Statewide ER Collaborative to evaluate the ER Health Education Campaign that began late spring/early summer 2009.

Your responses to this survey should be in reference to the implementation of the ER Health Education campaign and materials by your medical practice.

Please click "Submit" after completing the survey questions.

Please enter the following information:

Provider Name

Health Plan

City

Please enter the county where services are provided?

1. How did you receive the health education posters and brochures, "Not Sure It's An Emergency?" from the health plan?

Check all that apply.

- ☐ *Electronically*
- *By Mail*
- ☐ *Provider Training/Orientation Session*
- ☐ *Visit from Health Plan Representative*
- ☐ *Health Plan Meeting*
- ☐ *Other*

(Please specify)

ER Provider Survey 2009

2. Where did you display the poster(s)?

Check all that apply.

- ☐ *Waiting Room*
- ☐ *Reception Counter*
- ☐ *Some Exam Rooms*
- ☐ *All Exam Rooms*
- ☐ *Did Not Display*

Other

(Please specify)

2.1. If you did not display the poster(s), please explain why?

(If you did display the poster/posters, please skip to question 3.)

Check all that apply.

- ☐ *Limited Wall Space*
- ☐ *Limited Office Counter Space*
- ☐ *Posters Not Useful for Patients*
- ☐ *Policies Prohibit Display of Posters*
- ☐ *Posters Not Available in Relevant Patient Languages*
- ☐ *Other*

(Please specify)

ER Provider Survey 2009

3. How did you distribute the brochures to your patients?

Check all that apply.

- ☐ *By Receptionist*
- ☐ *By Doctor During Office Visit*
- ☐ *By Other Medical Staff*
- *Available on Waiting Room Counters/Tables*
- ☐ *Available on Exam Room Counters/Shelves*
- ☐ *Did Not Distribute*
- ☐ *Other*

(Please specify)

3.1. If you did not distribute the brochures, please explain why?

(If you did distribute the brochures, please skip to question 4.)

Check all that apply!

- *Limited Counter Space*
- *Not Enough Time to Discuss with Patients*
- *Brochures Not Useful for Patients*
- *Brochures Not Available in Relevant Patient Languages*
- *Other*

(Please specify)

ER Provider Survey 2009

4. Approximately how often did your patients ask questions about the appropriate use of the ER?

○ *Never* ○ *Rarely* ○ *Sometimes* ○ *Often* ○ *Always*

Additional Comments?

5. How often did you initiate discussion with your patients about when to use the ER?

○ *Never* ○ *Rarely* ○ *Sometimes* ○ *Often* ○ *Always*

Addition Comments?

6. How helpful was the poster, *"Not Sure It's an Emergency",* in talking to your patients about appropriate ER use?

○ *Not Helpful* ○ *Somewhat Helpful* ○ *Helpful* ○ *Very Helpful*

Additional Comments?

7. How helpful was the brochure, *"Not Sure It's an Emergency"*, in talking to your patients about appropriate ER use?

○ *Not Helpful* ○ *Somewhat Helpful* ○ *Helpful* ○ *Very Helpful*

Additional Comments?

ER Provider Survey 2009

8. Did you add your name (provider, practice or clinic name), address, and telephone number in the box on the back of the brochure?

- *Yes*
- *No*

8.1. If no, please explain why? *(If yes, please skip to question 9.)*

9. Did the health plan contact you/your office to offer assistance, e.g. to provide more materials, answer questions, etc.?

- *Yes*
- *No*
- *Do Not Know*

9.1. If yes, how helpful was the assistance? *(If no, skip to question 10.)*

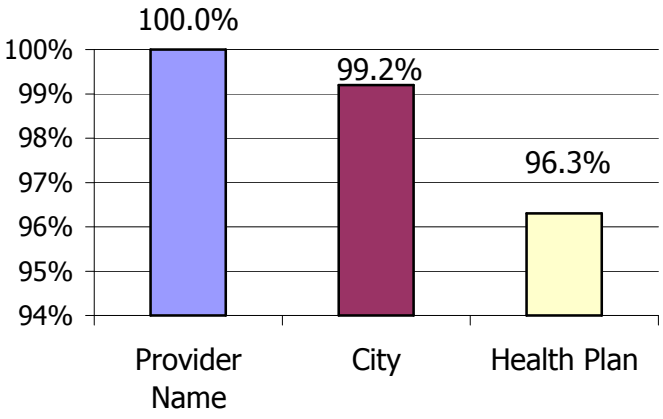
- *Not Helpful*
- *Somewhat Helpful*
- *Helpful*
- *Very Helpful*

Other (please specify)

10. Please provide additional comments or recommendations for improving the ER Health Education Campaign materials below:

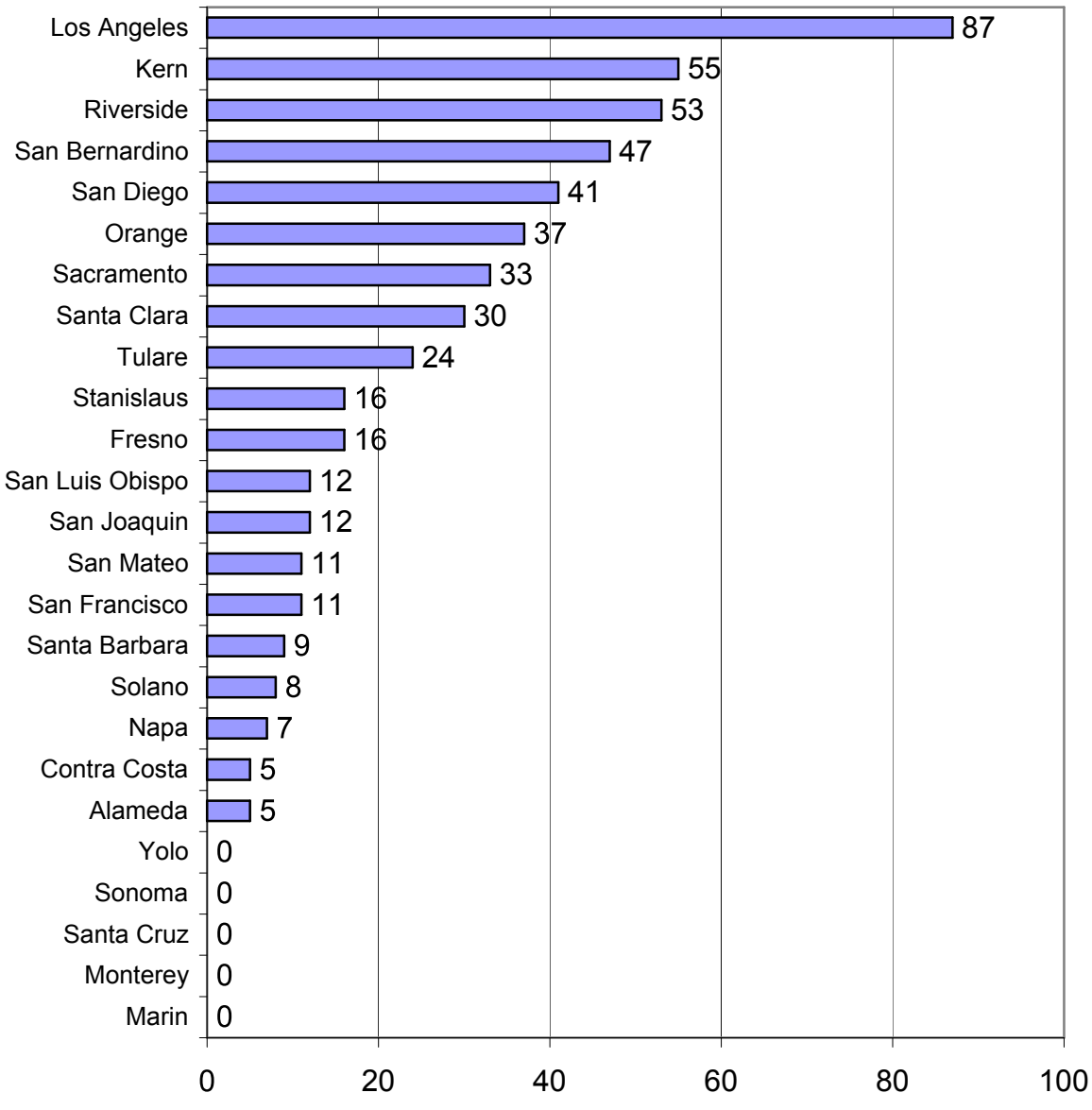
ER PROVIDER SURVEY 2009
Survey Responses

Percent of responders that entered the providers' name, city, and health plan



Answer Options	Response Percent	Response Count
Provider Name	100.0%	519
City	99.2%	515
Health Plan	96.3%	500

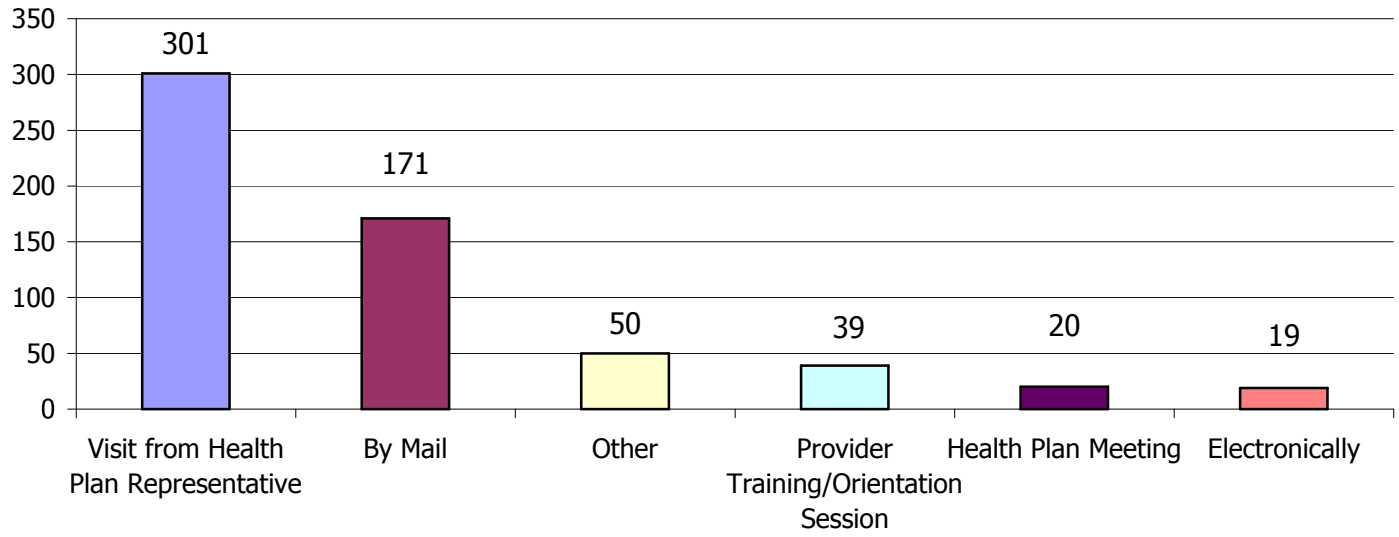
Please enter the county where the services are provided?



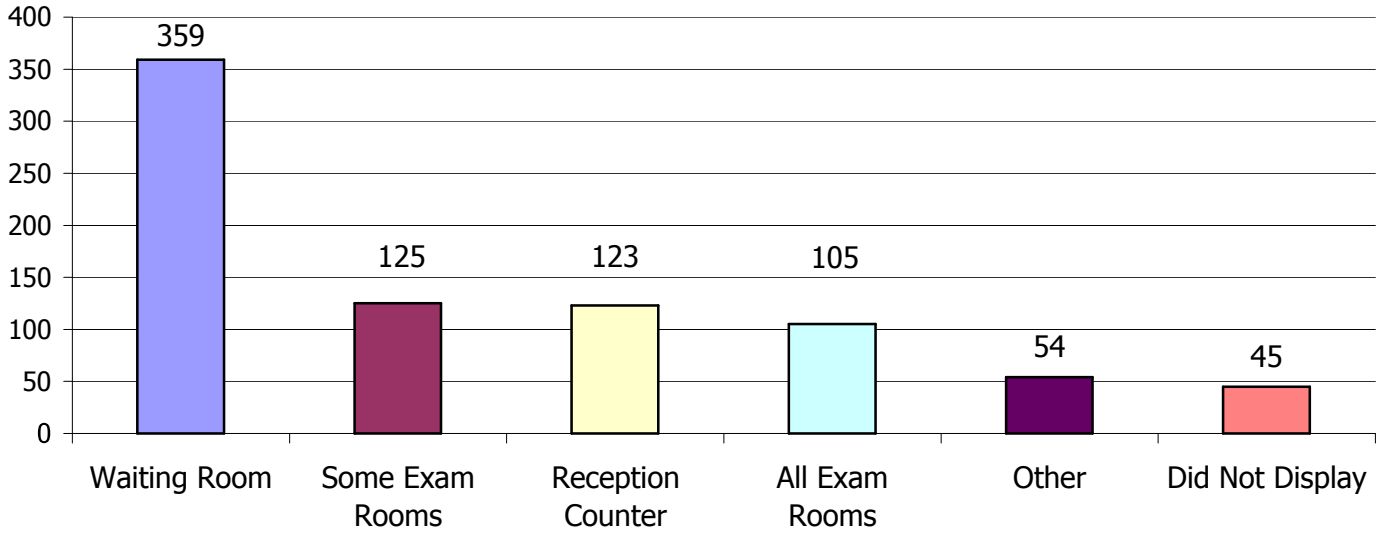
Data Source: Survey Monkey, responses downloaded April 6, 2010

ER PROVIDER SURVEY 2009
Survey Responses

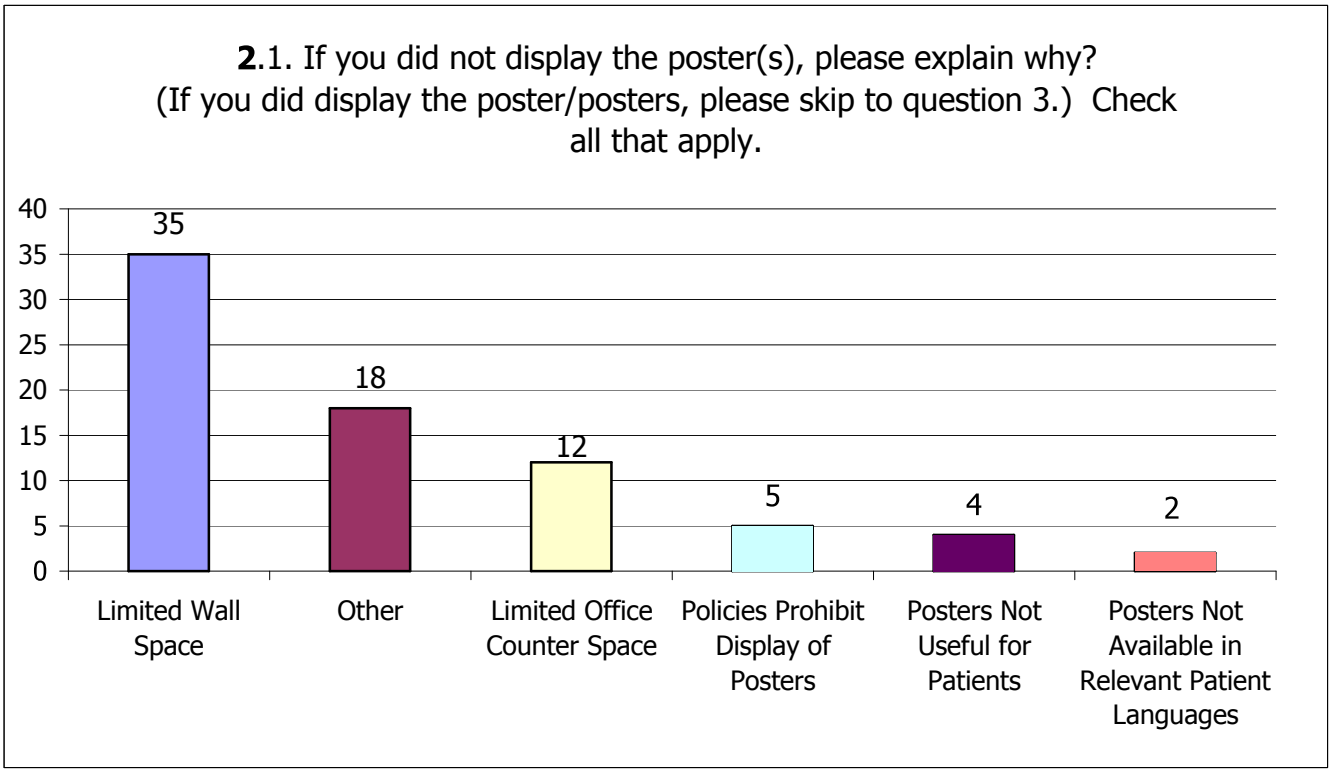
1. How did you receive the health education posters and brochures, "Not Sure It's An Emergency?" from the health plan? Check all that apply.

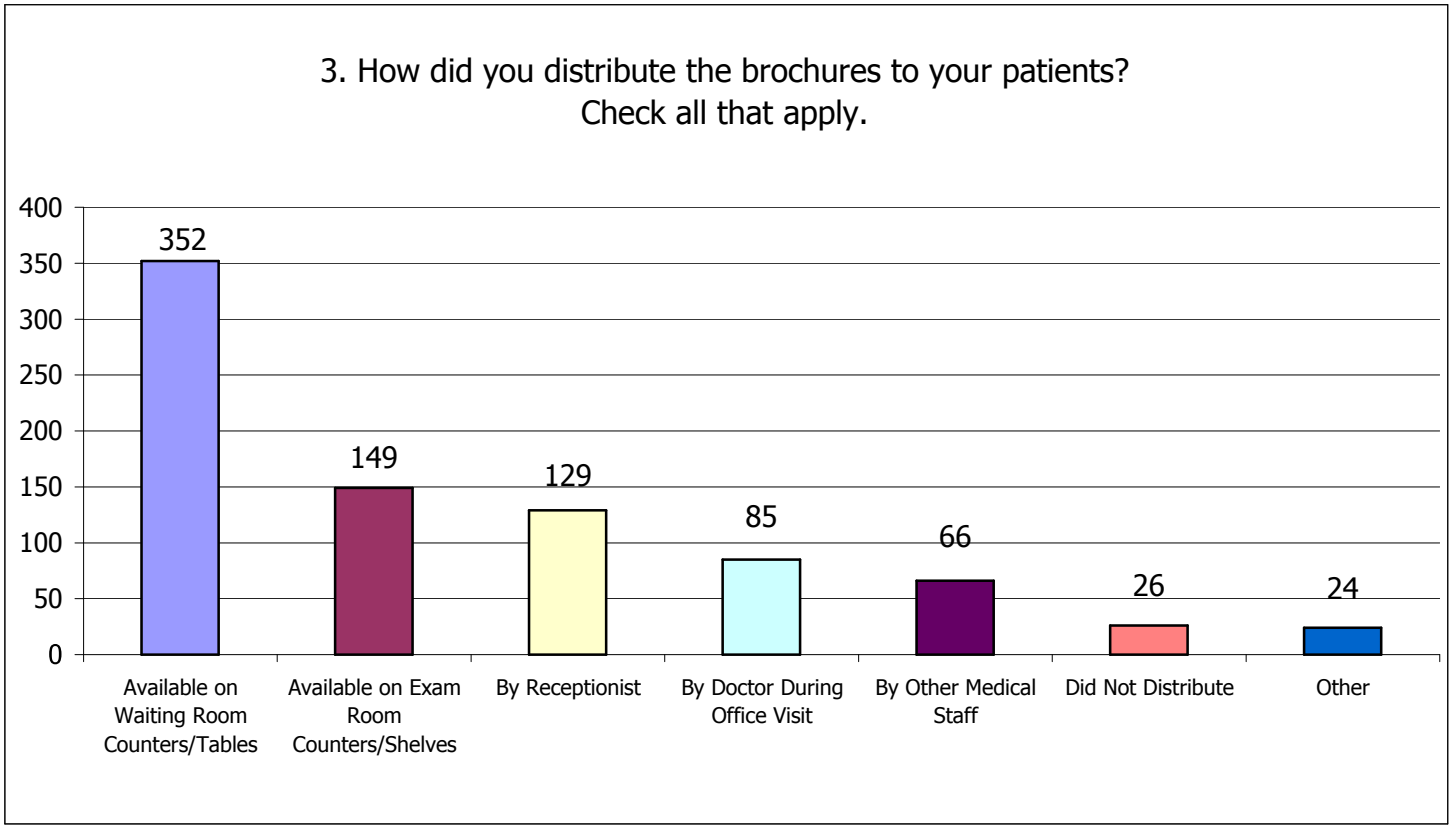


2. Where did you display the poster(s)? Check all that apply.



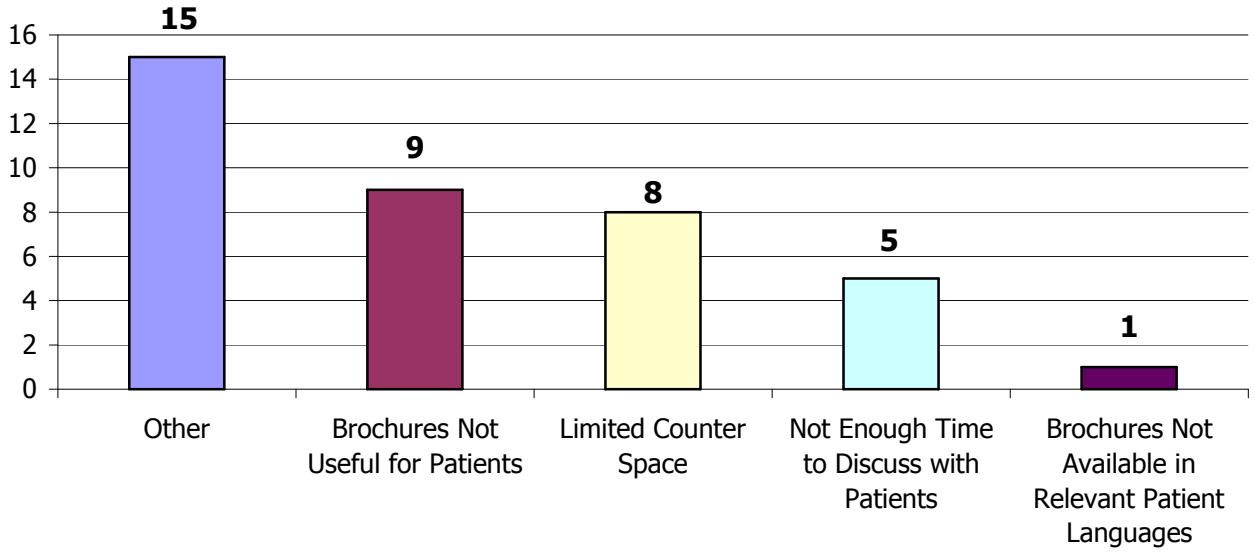
ER PROVIDER SURVEY 2009
Survey Responses



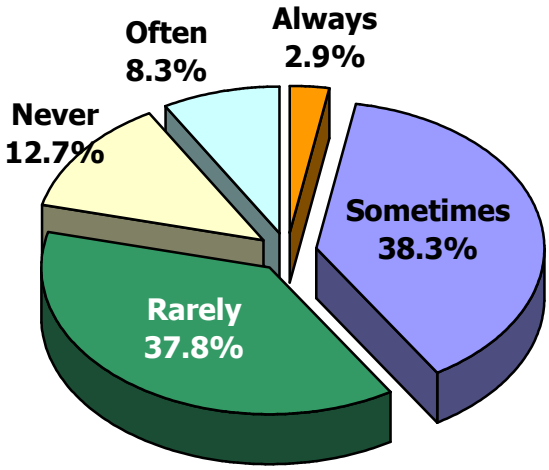


ER PROVIDER SURVEY 2009
Survey Responses

3.1. If you did not distribute the brochures, please explain why? (If you distribute the brochures, please skip to question 4.) Check all that apply!



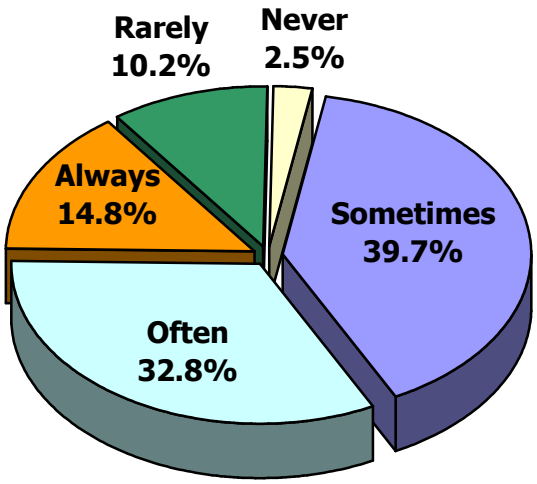
4. Approximately how often did your patients ask questions about the appropriate use of the ER?



Answer Options	Response Percent	Response Count
Sometimes	38.3%	199
Rarely	37.8%	196
Never	12.7%	66
Often	8.3%	43
Always	2.9%	15

ER PROVIDER SURVEY 2009
Survey Responses

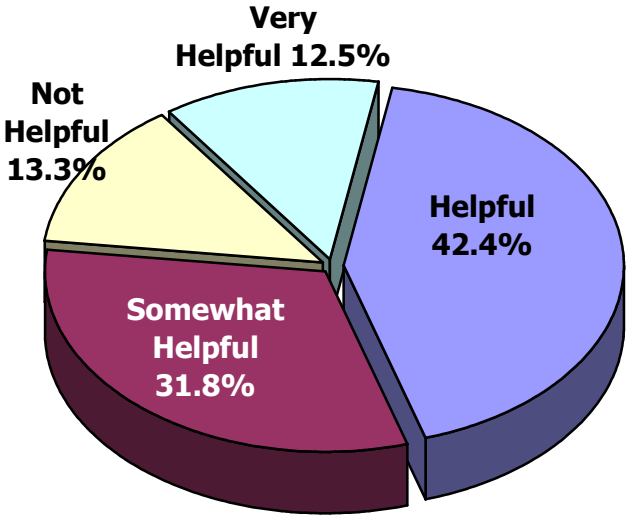
5. How often did you initiate discussion with your patients about when to use the ER?



Answer Options	Response Percent	Response Count
Sometimes	39.7%	206
Often	32.8%	170
Always	14.8%	77
Rarely	10.2%	53
Never	2.5%	13

ER Provider Survey 2009

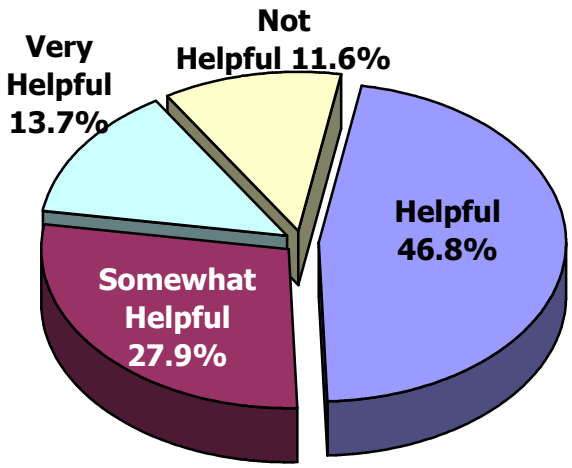
6. How helpful was the poster "Not Sure It's an Emergency", in talking to your patients about appropriate ER use?



Answer Options	Response Percent	Response Count
Helpful	42.4%	220
Somewhat Helpful	31.8%	165
Not Helpful	13.3%	69
Very Helpful	12.5%	65

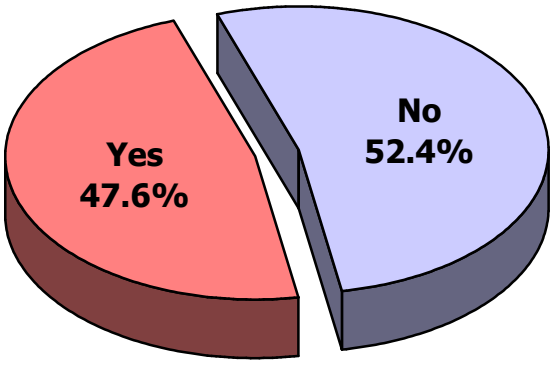
ER PROVIDER SURVEY 2009
Survey Responses

7. How helpful was the brochure, "Not Sure It's an Emergency", in talking to your patients about appropriate ER use?



Answer Options	Response Percent	Response Count
Helpful	46.8%	243
Somewhat Helpful	27.9%	145
Very Helpful	13.7%	71
Not Helpful	11.6%	60

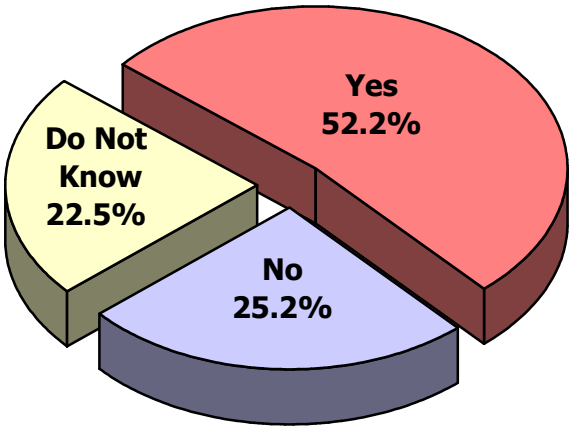
8. Did you add your name (provider, practice or clinic name), address, and telephone number in the box on the back of the brochure?



Answer Options	Response Percent	Response Count
No	52.4%	272
Yes	47.6%	247

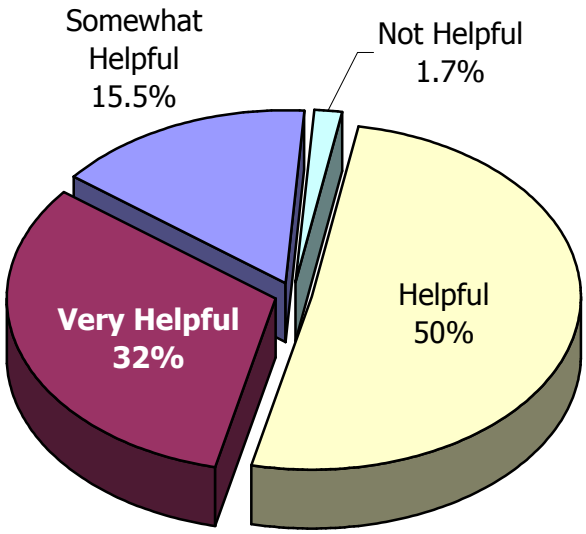
ER PROVIDER SURVEY 2009
Survey Responses

9. Did the health plan contact you/your office to offer assistance, e.g. to provide more materials, answer questions, etc.?



Answer Options	Response Percent	Response Count
Yes	52.2%	271
No	25.2%	131
Do Not Know	22.5%	117

9.1. If yes, how helpful was the assistance? (If no, skip to question 10.)



Answer Options	Response Percent	Response Count
Helpful	50.9%	118
Very Helpful	31.9%	74
Somewhat Helpful	15.5%	36
Not Helpful	1.7%	4

Appendix C contains the following materials:

- Member survey in English
- Member survey in Spanish

Member Survey

Please answer a few questions about your recent doctor visit with (doctor's name here). Your answers will help us improve member services.

1. Did you receive a brochure titled "**Not Sure It's an Emergency**" at your doctor's office?

   Yes **No**

2. Did you see a poster titled "**Not Sure It's an Emergency**" at your doctor's office?

   Yes **No**

3. Did your doctor spend time with you explaining the brochure and/or poster?

   Yes **No**

If you answered "No" to question 3, you are done with this survey!

If your doctor talked to you about using the ER and/or the brochure or poster, please answer the following questions*:*

4. After talking with your doctor:

   - Will you be more likely to call your doctor (or nurse advice line) when you are **not sure about going to the emergency room**?

     Yes **No**

   - Will you be more likely to call your doctor (or nurse advice line) if you are worried about your child's **earache, sore throat, cough, cold, or flu?**

     Yes **No**

Thank you!

For Office Use Only	Survey Number :
Administered in: ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Other (please specify)_____	
How was survey administered? ☐ Interactive voice response ☐Telephone member outreach ☐ At the PCP office ☐ Other	
Time between member office visit & survey administered: ☐ Same day ☐1 week or less ☐ 2-3 weeks ☐4-6 weeks ☐ more than 6 weeks	
Time between PCP receving materials and member office visit: ☐1 week or less ☐ 2-3 weeks ☐4-6 weeks ☐ more than 6 weeks	

ENCUESTA PARA MIEMBROS

Por favor responda a las siguientes preguntas sobre su visita más reciente con su doctor *(doctor's name here).* Sus respuestas nos ayudarán a mejorar nuestros servicios.

1. ¿Recibió usted un folleto titulado "¿**Es Una Emergencia**?" (*Not Sure It's An Emergency*) en el consultorio de su doctor?

   Sí **No**

2. ¿Vio usted un letrero titulado "¿**Es Una Emergencia**?" (*Not Sure It's An Emergency*) en el consultorio de su doctor?

   Sí **No**

3. ¿Tomo tiempo su doctor para explicarle el folleto y/o el letrero?

   Sí **No**

¡*Si contestó **"No"** a la pregunta **3**, usted ha terminado la encuesta!*

Si su doctor hablo con usted sobre el uso de la Sala de Emergencia (ER) y el folleto o el letrero, por favor conteste las siguientes preguntas:

4. Después de hablar con su doctor:

   ¿Es usted más probable de llamar a su doctor o línea de Conserjería Medica si **no está seguro(a) de ir a una sala de emergencia?**

   Sí **No**

   ¿Es usted más probable de llamar a su doctor o línea de Conserjería Medica si usted o su niño(a) tiene un **dolor de oídos o garganta, tos, o gripe?**

   Sí **No**

¡Gracias!

For Office Use Only	Survey Number :

Administered in: ☐ English ☒ Spanish ☐ Chinese ☐ Vietnamese ☐ Other (please specify)_____

How was survey administered? ☐ Interactive voice response ☐Telephone member outreach ☐ At the PCP office ☐ Other

Time between member office visit & survey administered: ☐ Same day ☐1 week or less ☐ 2-3 weeks ☐4-6 weeks ☐ more than 6 weeks

Time between PCP receving materials and member office visit: ☐1 week or less ☐ 2-3 weeks ☐4-6 weeks ☐ more than 6 weeks

Appendix D. Hospital Data Elements Sent to Health Plans

Appendix D presents the hospital data elements sent to health plans.

Health Plan	FAX	Electronic	Frequency	Member ID	First Name	Last Name	DOB	Address	Phone Number	Date of Service	Time of ER Visit	Primary DX	Admit to Hosp	PCP	Other
Alameda Alliance	X		Daily	X	X	X	X	X	X	X	X	X	X	X	Gender, other insurance, acuity of ER treatment, treatment provided, condition upon discharge
Anthem Blue Cross	X		Daily	X	X	X	X	X	X	X	X	X (Admitting diagnosis-presenting complaint)		X	Marital status, ethnicity, language, birth place, next of kin, employer, guarantor
Cal Optima		X Eceda	Daily pending	X	X	X	X	X	X	X		X	X		
Care 1st		X	10 days	X	X	X	X	X	X	X		X			
CenCal		X	Daily aggregated once a week	X	X	X	X	X	X	X	X	X	X	X	Facility name
Central Ca. Alliance for Health		X	Daily	X			X			X		X			

Health Plan	FAX	Electronic	Frequency	Member ID	First Name	Last Name	DOB	Address	Phone Number	Date of Service	Time of ER Visit	Primary DX	Admit to Hosp	PCP	Other
Community Health Group	X		15 days		X	X	X	X	X	X		X	X		Chief complaint with vague diagnosis
Contra Costa Health Plan	X		Daily	X	X	X	X	X	X	X	X	X	X	X	
Health Plan of San Joaquin		Picked up by current review nurse	5 days	X	X	X	X	X	X	X	X	X	X	X	
Health Plan of San Mateo		X	Daily	X	X	X	X	X	X	X	X	X			Discharge diagnosis; language code, IV med admin code
Health Net		X	7 days	X	X	X	X	X	X	X		X		X	
Inland Empire Health Plan				X	X	X	X	X	X	X	X	X			Discharge time
Kaiser Permanente –Sacramento		X	7 days	X	X	X				X		X		X	Age
Kaiser Permanente –San Diego		X	2–3x/week	X	X	X	X		X	X		X		X	Age
Kern Family Health Care		Hospital web site	Daily	X	X	X	X	X	X	X		X	X	X	

Health Plan	FAX	Electronic	Frequency	Member ID	First Name	Last Name	DOB	Address	Phone Number	Date of Service	Time of ER Visit	Primary DX	Admit to Hosp	PCP	Other
LA Care		X	Weekly to monthly (varies)	X	X	X	X	X	X	X	X	X	X	X	Discharge date, discharge time, disposition
Molina Healthcare	X		2 days	X	X	X	X	X	X	X	X	X		X	Method of arrival to hospital
Partnership Health Plan		Electronic claims processing	Varies	X	X	X	X	X	X	X		X		X	Data sent directly to PCP; quality incentive on access and ER
San Francisco Health Plan		FTP updates	Weekly	X	X	X	X	X	X	X	X	X			
Santa Clara Family Health		FTP site	5–7 days	X	X	X	X	X		X	X	X	X		Level of care

Problem:

- Health plans do not receive timely ER member information from hospitals.
- Member and provider education geared to change behavior about the appropriate use of the ER is most effective if performed as soon as possible following use of the emergency room.

Goal:

- Each health plan to establish and maintain a collaborative relationship with at least one hospital for the timely exchange of information for members seen in the emergency room.
- Timely information received by the plans will be used to develop and implement member and provider interventions focusing on the reduction of avoidable ER visits.

Barriers:

- Information is currently shared via claims submissions payment often weeks or months after the visit.
- Hospitals are not motivated to provide timely information on ER visits to plans and PCPs.
- Electronic and other resource barriers exist that prevent timely sharing.

Basic Information Required of Health Plans

- Date of initiation of contact with a hospital for regular data feeds
- Date of first data feed from the participating hospital(s)
- Date of start of intervention with members or providers based on data feeds

Process to Measure Success of Collaboration between Health Plans and Hospitals

1. **Data Frequency** – the percentage of health plans that receive regular ER data feeds from at least one participating hospital during the measurement period.
   - Plans report the frequency of reporting standard that they have arranged with a hospital.
   - Plans report the actual frequency that they receive data feeds during the measurement period (percentage of late reports).

2. **Data Timeliness** – the percentage of ER visits received from the participating hospital(s) within 5, 10 and 15 days of the service date during the measurement period. Plans report a percentage for each time period.

- Numerator = total number of ER visits received from the participating hospital(s) through regular data feeds at 5, 10 and 15 days from the service date
- Denominator = total number of ER visits* received from the participating hospital(s) through the regular data feeds

  Measurement Period: annually; submit with annual QIP status report
  * Total number of ER visits, all ages for the participating hospital.

3. **Data Volume** – the percentage of total plan visits received by the health plan from the participating hospital(s) through the regular data feeds compared to total ER visits for all hospitals.
   - Numerator = total number of ER visits received from the participating hospital(s) through regular data feeds during the measurement period
   - Denominator = total ER visits from the HEDIS ER* measure denominator for the measurement period

     Measurement period: annually, submit with annual QIP status report
     *Total ER Visits for all ages.

4. **Data Completeness** – the percentage of total ER visits received through the regular data feeds compared to ER visits from claims/encounter data received from the participating hospital(s).
   - Numerator = total number of ER visit records received from the participating hospital(s) through the regular data feeds
   - Denominator = total number of ER visit records received from the participating hospital(s) through claim/encounter data

Process to Measure Health Plan Action as a Result of Data Received from Hospitals

5. **Member Communications** – the percentage of member outreach attempts/communications originating from the data feeds during the measurement period
   - Numerator = number of members in the denominator that were provided Qualifying Communication originating from the health plan within 14 days of receiving notice of the member's first Avoidable ER visit during the six month period.
   - Denominator = number of members with Avoidable ER visits reported through the regular data feeds that are received from participating hospital(s) during the six month period

     Measurement period: every 6 months; submit with annual QIP status report.

     Qualifying Communication includes but is not limited to: letters sent; group instruction, individual instruction in person or via telephone. Returned letters (undelivered) and calls to disconnected phone lines do not constitute Qualifying Communication with the member.

Outcome Measures

6. **Avoidable ER Visit Rate (AER Rate) for Participating Hospital(s)**
   - Numerator = total number of avoidable ER visits from claims/encounter data for the participating hospital(s) for the measurement period
   - Denominator = total number of ER visits from claim/encounter data for the participating hospital(s) for the measurement period derived from the denominator for Measure II Avoidable Emergency Room Visits

     Measurement period: annually, submit with annual QIP status report

7. **Avoidable ER Visit Rate (AER Rate) for Non-Participating Hospital(s)**
   - Numerator = total number of avoidable ER visits from claim/encounter data for the non-participating hospital(s) for the measurement period
   - Denominator = number of total ER visits from claim/encounter data for the non-participating hospital(s) for the measurement period derived from the denominator for Measure II Avoidable Emergency Room Visits

     Measurement period: annually, submit with annual QIP status report

8. **Total Plan AER Rate**
   - Numerator = number of total avoidable ER visits from claim/encounter data for the measurement period
   - Denominator = number of total ER visits from claim/encounter data for the measurement period (from the HEDIS measure)

     Measurement period: annually, submit with annual QIP status report

Outcome Evaluation

It is recommended health plans conduct an analysis of one or more of the following and submit with the annual QIP status report:

- AER Rate for participating vs. non-participating hospital(s)
- AER Rate for participating hospital(s) pre and post intervention
- AER Rate for non-participating hospitals pre and post intervention
- Total AER Rate pre and post intervention
- AER Rate for participating hospital(s) vs. Total AER Rate
- AER Rate for non-participating hospital(s) vs. Total AER Rate

Appendix F. Timeline for the ER Statewide Collaborative QIP

Appendix F presents the ER statewide collaborative QIP timeline.

Timeline for the ER Statewide Collaborative QIP