Statewide Collaborative Quality Improvement Project

All-Cause Readmissions Baseline Report

June 2013 – May 2014

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

June 2014

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Commonly Used Abbreviations and Acronyms

Following is a list of abbreviations and acronyms used throughout this report.

- **CFR**—Code of Federal Regulations
- **CMS**—Centers for Medicare & Medicaid Services
- **COHS**—County Organized Health System
- **CP**—commercial plan
- **DHCS**—California Department of Health Care Services
- **EQRO**—external quality review organization
- **FFS**—fee-for-service
- **GMC**—Geographic Managed Care
- **HEDIS®**—Healthcare Effectiveness Data and Information Set[1]
- **HSAG**—Health Services Advisory Group, Inc.
- **LI**—Local Initiative
- **MCMC**—Medi-Cal Managed Care program
- **MCP**—managed care plan
- **MMCD**—Medi-Cal Managed Care Division
- **NCQA**—National Committee for Quality Assurance
- **Non-SPD**—Non-Seniors and Persons with Disabilities
- **PCP**—primary care physician
- **QIP**—quality improvement project
- **SPD**—Seniors and Persons with Disabilities
- **TPM**—Two-Plan Model

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires that all states operating a Medicaid managed care program ensure that their contracted managed care plans (MCPs) conduct quality improvement projects (QIPs) in accordance with the Code of Federal Regulations (CFR), at 42 CFR 438.240.[2] The California Department of Health Care Services (DHCS), Medi-Cal Managed Care Division (MMCD), requires each Medi-Cal MCP to conduct two QIPs that MMCD must approve and MMCD's external quality review organization (EQRO) must validate.

The statewide Medi-Cal Managed Care program (MCMC) collaborative project serves as one of the two required QIPs for full-scope MCPs. The second QIP can be an individual QIP or small-group collaborative involving at least four MCPs. Although not contractually required to participate in collaborative QIPs, specialty MCPs may choose to participate in the collaborative if the topic is applicable to their Medi-Cal population and approved by DHCS. Senior Care Action Network Health Plan (SCAN) is the only specialty MCP participating in the statewide collaborative QIP.

In June 2011, MMCD met with its EQRO, Health Services Advisory Group, Inc. (HSAG), and its contracted MCPs to discuss a new collaborative QIP. The result of these discussions was a QIP focused on reducing readmissions to acute care hospitals due to all causes within 30 days of an inpatient discharge among MCMC beneficiaries. Hospital readmissions have been associated with the lack of proper discharge planning and poor care transition. Improving the care transition after hospital discharge has the potential to reduce preventable readmissions while decreasing costs and improving quality of care, leading to improved health outcomes. DHCS contracted with HSAG to conduct QIP validation, an activity mandated by the Centers for Medicare & Medicaid Services (CMS), and to produce reports on the progress and outcomes of the statewide collaborative QIP.

Summary of Collaborative Quality Improvement Project Activities

The collaborative held five conference calls during the June 2013 through May 2014 reporting period to discuss topics to support the MCPs in their statewide collaborative QIP activities, including conducting causal/barrier analyses; prioritizing barriers; developing interventions to address high-priority barriers; evaluating interventions; and applying the Plan, Do, Study, Act (PDSA) cycle.

MCPs submitted their baseline results for the *All-Cause Readmissions* statewide collaborative QIP to HSAG for validation in September and October 2013. Many MCPs struggled with meeting the validation requirements on the first submission of their QIPs. Issues included lack of detailed information about QIP processes and activities, such as the data analysis plan and planned

[2] Balanced Budget Act of 1997. Federal Register/Vol. 67, No. 115, June 14, 2002, 2002/Rules and Regulations, p. 41109.

interventions; lack of routine causal/barrier analyses; no prioritization of barriers; and lack of targeted interventions. While most MCPs had to resubmit their QIPs, all MCPs eventually met the validation requirements for the Design and Implementation stages.

Recommendations

Based on its review of the baseline submissions for the *All-Cause Readmissions* statewide collaborative QIP, HSAG provides the following recommendations to the MCPs:

- Include detailed documentation for all QIP processes and activities (e.g., data analysis plan, planned interventions) when submitting QIPs for validation to enable the EQRO to thoroughly assess if the QIPs are methodologically sound.
- Conduct routine causal/barrier analyses.
- Identify and focus on three to five high-priority barriers, and develop targeted interventions for the high-priority areas to increase the likelihood that improvement strategies will be successful. Additionally, specify which barrier(s) each intervention is designed to address.
- Because interventions implemented through December 31, 2014, have the opportunity to impact Remeasurement 2 outcomes, MCPs should engage in rapid cycle improvement strategies to determine if high-priority barriers have changed and if interventions should be revised, standardized, scaled up, or discontinued. Implementation of rapid cycle improvement strategies will increase the likelihood of positive outcomes.

HSAG recommends that MMCD continue to provide technical assistance to the MCPs, in collaboration with HSAG, to support them in implementing rapid cycle improvement strategies to increase the likelihood of reducing readmissions due to all causes for Medi-Cal beneficiaries.

Next Steps

Collaborative next steps for the MCPs include the following:

- Continue to implement and evaluate interventions, and revise, standardize, scale up, or discontinue interventions, as appropriate.
- Conduct new barrier analyses, and confirm already-existing high-priority barriers or identify new high-priority barriers.
- Collect, report, and submit Remeasurement 1 data in the *All-Cause Readmissions* QIP submissions due to HSAG for validation by September 30, 2014.

HSAG will complete the next *All-Cause Readmissions* statewide collaborative QIP report, including the Remeasurement 1 data and analyses, in May 2015.

Medi-Cal Managed Care Background

In the State of California, the Department of Health Care Services (DHCS) administers the Medicaid Program (Medi-Cal) through its fee-for-service (FFS) and managed care delivery systems. During the 2012 measurement year, DHCS contracted with 22 full-scope MCPs and 3 specialty MCPs operating throughout California in 30 of California's 58 counties, to provide health care services to approximately 4.8-million beneficiaries enrolled in MCPs.[3] Medi-Cal MCP model types participating in the collaborative are described below.

County-Organized Health System

A County Organized Health System (COHS) is a nonprofit, independent public agency that contracts with DHCS to administer Medi-Cal benefits through a wide network of health care providers. Each COHS MCP is established by the County Board of Supervisors and governed by an independent commission.

Geographic Managed Care

In the Geographic Managed Care (GMC) model, DHCS allows MCMC beneficiaries to select from several commercial MCPs within a specified geographic area. The GMC model currently operates in San Diego and Sacramento counties.

Two-Plan Model

In Two-Plan Model (TPM) counties, MCMC beneficiaries may choose between two MCPs; typically, one MCP is a local initiative (LI) and the other a commercial plan (CP). DHCS contracts with both plans. The LI is established under authority of the local government with input from State and federal agencies, local community groups, and health care providers to meet the needs and concerns of the community. The CP is a private insurance plan that also provides care for Medi-Cal beneficiaries.

[3] *Medi-Cal Managed Care Enrollment Report—December 2012.* Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx. Accessed on: June 6, 2014.

Specialty Managed Care Plans

In addition to the full-scope MCPs, DHCS contracts with specialty MCPs to provide health care services to specialized populations.

Quality Improvement Project Requirements

Quality improvement projects (QIPs) are a federal requirement. The Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires that all states that operate a Medicaid managed care program ensure that their contracted MCPs conduct QIPs in accordance with the Code of Federal Regulations (CFR), at 42 CFR 438.240.[4]

DHCS requires each of its contracted Medi-Cal MCPs to conduct two MMCD-approved QIPs and that each QIP be validated by the external quality review organization (EQRO). MCPs must always maintain two active QIPs. The statewide MCMC collaborative project serves as one of the two required QIPs for full-scope MCPs. The second QIP can be an individual QIP or small-group collaborative involving at least four MCPs. Although not contractually required to participate in collaborative QIPs, specialty MCPs may choose to participate in the collaborative if the topic is applicable to their Medi-Cal population and approved by DHCS. Senior Care Action Network Health Plan is the only specialty MCP participating in the statewide collaborative QIP.

Purpose of the *All-Cause Readmissions* Collaborative QIP

The *All-Cause Readmissions* statewide collaborative QIP provides an opportunity to collect data, share knowledge and best practices, and implement changes that will help reduce acute hospital readmissions due to all causes within 30 days of an inpatient discharge for the Medi-Cal population. Hospital readmissions have been associated with the lack of proper discharge planning and poor care transition. Improving the care transition and coordination after hospital discharge may reduce the high rate of preventable readmissions, which in turn would decrease costs and improve overall quality of care, and ultimately lead to improved health outcomes for the Medi-Cal population.

Collaborative Components and Process

During the first collaborative project meeting in June 2011, the roles and the responsibilities for the project were defined as follows:

- HSAG's role—to provide technical assistance, validate the QIPs, and provide input into QIP development.

[4] Balanced Budget Act of 1997. Federal Register/Vol. 67, No. 115, June 14, 2002, 2002/Rules and Regulations, p. 41109.

- MMCD's role—the "owner" of the QIP, responsible for progression of the QIP, solicitation of workgroup participation, meeting planning and facilitation, and ultimate decision making.
- MCPs' role—to participate in the QIP development and conduct the QIP.

The collaborative process incorporated a method that first used workgroups composed of MCP volunteers, MMCD staff, and HSAG staff to develop the collaborative components, which were presented to the collaborative group for feedback and approval. Collaborative components included:

- Guiding Principles.
- Evaluation plan.
- Technical specifications.
- Design stage common language.

In June 2011, MCPs responded to the Hospital Readmissions Collaborative Survey. The purpose of the survey was to obtain input and recommendations from MCPs regarding the collaborative process for the *All-Cause Readmissions* statewide collaborative QIP. Results of the survey were used by a small workgroup to develop the Guiding Principles for the new collaborative. Collaborative members then had an opportunity to revise and edit the Guiding Principles before finalizing and adopting them for the new collaborative.

Purpose and Scope of the Report

The purpose of this report is to summarize activities and progress related to the *All-Cause Readmissions* statewide collaborative QIP for the June 2013 through May 2014 reporting period and inform mid-course corrections that MMCD and MCPs can make to increase the chance of success before the second remeasurement year ends, which is December 31, 2014. Specifically, the report includes the progress of the *All-Cause Readmissions* QIP through the Implementation stage; displays QIP validation findings; displays the historical and baseline readmissions rates, representing calendar year 2011 and calendar year 2012, respectively; and presents conclusions and recommendations for the next stage of the collaborative.

Topic Rationale

The topic rationale was developed by a small workgroup and then shared with the collaborative. The collaborative approved the documentation and agreed to include the following information presented under this heading as part of each MCP's QIP:

Hospital readmissions are common and costly. Research shows that in 2005, nearly one-in-five Medicare patients in the FFS program had readmissions within 30 days of discharge from a hospital stay with an estimated 12-billion dollar annual cost for potentially preventable readmissions.[5] In recent years, policy makers have highlighted readmission as an opportunity to improve quality of health care and reduce costs. The 2007 and 2008 Medicare Payment Advisory Commission reports to Congress pointed to readmission as a marker of poor quality and high cost. The report recommended measuring and reporting disease-specific, 30-day readmissions beginning in 2009. The recommendation also outlined a payment policy that eventually became a provision of the Affordable Care Act, Section 3025, which established the Hospital Readmissions Reduction Program: to reduce payments to hospitals with excess readmissions. Beginning in federal fiscal year 2013, CMS will penalize hospitals with excess readmission ratios for its patients with heart failure, acute myocardial infarction, and pneumonia (and eventually medical and surgical conditions) that are readmitted within 30 days of discharge.[6]

While the early focus centered on Medicare patients, states are now measuring hospital readmissions for Medicaid beneficiaries. Data from the 2007 Healthcare Cost and Utilization Project (HCUP) on all-cause readmissions among non-elderly Medicaid patients revealed that Medicaid readmission rates were higher than commercially insured patients. For instance, the non-obstetric 30-day readmission rate was 10.7 percent compared with 6.3 percent. Of hospitalized study patients from 21 to 64 years of age, at least 1-in-10 had 1 or more readmissions within 30 days after discharge from their first hospital stay. In addition, rates increased with age and the number of co-morbidities. More than half of the readmissions involved an initial stay for circulatory diseases, mental disorders, respiratory and digestive diseases, or alcohol/substance abuse.[7]

[5] MedPAC. Report to Congress: *Promoting Greater Efficiency in Medicare*. June 2007. Available at: http://www.medpac.gov/documents/jun07_entirereport.pdf. Accessed on: June 6, 2014.
[6] Boutwell, AE, et al. An early look at a four-State initiative to reduce avoidable hospital readmissions. (2011).Health Affairs, 30(7), 1272-80.
[7] Jiang, HJ & Wier, LM. (2010). All-cause hospital readmissions among non-elderly Medicaid patients, 2007. Available at: http://www.hcup-us.ahrq.gov/reports/statbriefs/sb89.jsp. Accessed on: June 6, 2014.

Discharge from a hospital is a critical transition point in a patient's care. Incomplete handoffs at discharge can lead to adverse events for patients and avoidable readmissions. Potentially preventable readmissions are readmissions directly tied to conditions that could have been avoided. Hospital readmissions may indicate poor care or missed opportunities to better coordinate care. However, determinants of readmission are varied.[8]

The Medi-Cal population is uniquely vulnerable to poor outcomes in the transition from hospital to home due to poor health literacy, language barriers, and primary care access difficulties. Medi-Cal patients may have poor understanding of red flags (when to ask for help) or how to manage medication changes. Dr. Eric Coleman's research[9] shows that 40 percent of older patients experience a medication discrepancy at the time of discharge. Organizations across the country are focused on hospital discharges as a high-yield opportunity to improve outcomes and reduce costs, with interventions focusing on improving care coordination between hospital, specialist, and PCP; improving patient/family understanding of the patient's conditions and how to manage predictable symptoms; ensuring accurate medication reconciliation; and assisting patients with accessing needed follow-up services.

Prior to initiation of DHCS's formal MCMC collaborative QIP, several MCPs had already begun efforts to measure and address the issues surrounding readmissions. Limited data from four MCPs using various methodologies showed readmission rates that ranged from 4.3 percent to 12.6 percent. Two of the four MCPs' rates for SPD compared with non-SPD members showed that SPD members' readmission rate was 2–8 percentage points higher. The MCMC collaborative QIP provides a standardized methodology for reporting readmissions by all MCPs through the collaborative-developed *All Cause Readmissions* measure.

MMCD required that each MCP calculate an overall Medi-Cal readmission rate, a readmission rate for the SPD population, and a readmission rate for the non-SPD population and address any disparities identified through barrier analysis with targeted interventions. Addressing hospital readmissions among Medi-Cal members with disabilities is even of more concern as published in the December 2010 brief by the Center for Health Care Strategies, Inc. (CHCS),[10] which noted that the rate of readmission among Medicaid beneficiaries with disabilities may be different than other beneficiaries as a result of state-level policies, type of chronic illness, and a greater level of multi-morbidity. The subjects of the study were 941,208 Medicaid beneficiaries with disabilities, in 50 states, between 2003 and 2005. The goal was to identify potential opportunities to improve care

[8] Kangovi, S. & Grande, D. (2011). Hospital readmissions – not just a measure of quality. *JAMA, 306(*16), 1796-7.

[9] Coleman, Eric. Person-Centered Models for Assuring Quality and Safety During Transitions Across Care Settings. Available at: http://www.caretransitions.org/documents/Coleman%20Senate%20Aging%20Testimony%20July%202008.pdf. Accessed on: June 6, 2014.

[10] Gilmer T, Hamblin A. Hospital Readmissions among Medicaid Beneficiaries with Disabilities: Identifying Targets of Opportunity. December 2010. Available at: http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261200. Accessed on: June 6, 2014.

and reduce readmissions. Beneficiaries in the managed care programs were excluded from the study. The CHCS study revealed that among Medicaid members with disabilities:

- The 30-day readmission rate increased from 16 percent to 53 percent within one year.
- Of those readmitted within 30 days, 50 percent did not visit a physician between discharge and readmission.
- The number of readmissions increased with the number of chronic conditions present.
- Readmission rates were particularly high among beneficiaries with mental illness, substance use disorder, skin infections, and infectious disease. Additional conditions with high readmission rates included heart failure, diabetes, and persons with co-morbid cardiovascular and pulmonary diseases.

In another study, a decreased Length of Stay (LOS) for acute hospital inpatient Medicaid beneficiaries receiving rehabilitation care was associated with increased readmissions. The increased readmissions were consistent for Medicaid beneficiaries with disabilities in all rehabilitation impairment categories.[11] Consequently, reducing readmissions and providing the best care to beneficiaries with disabilities is important, especially in the current environment with limited resources.

Study Indicator Development—Specifications and Methodology

After the initial kick-off meeting with the collaborative, a small workgroup was formed to develop the specifications for the statewide measure. The workgroup determined through research of existing, standardized measures that there was no readmission measure specific to the Medicaid population, and the existing standardized measures were primarily disease-specific and geared toward a Medicare population. After several meetings, the workgroup decided on a modified version of the National Committee for Quality Assurance's (NCQA's) *Plan All-Cause Readmissions* HEDIS measure. The HEDIS-like measure was renamed as the *All-Cause Readmissions* measure. The rationale for the changes to the *Plan All-Cause Readmissions* HEDIS measure is provided in Appendix A. Additionally, MMCD required that the measure be reportable for three populations: the MCP's overall Medi-Cal population, the SPD population, and the non-SPD population. MCPs were instructed to discuss the modified specifications as well as the stratification of the data by SPD status with their internal staff members responsible for producing the measure or with their certified software vendors. A test of the specifications by a few volunteer MCPs demonstrated that the specifications could be met by the vendors and MCPs to calculate the rates. The final measure specifications are included in Appendix B.

In addition to the study topic and technical specifications, the workgroup also developed the study question and study population definition.

[11] Kenneth J. Ottenbacher, et.al. LOS and Hospital Readmissions among Persons with Disabilities. American Journal of Public Health. 2000;90:1920–1923.

Project Evaluation Plan Development

In response to a recommendation made at the end of the prior collaborative QIP, HSAG led the development of an evaluation plan for the *All-Cause Readmissions* statewide collaborative QIP to help focus the project and measure various aspects of the project. The purpose of the evaluation plan is to evaluate the *All-Cause Readmissions* statewide collaborative QIP in the areas of oversight and contractual compliance, process, and merit and worth. For a well-constructed evaluation plan, three key questions should be addressed at the beginning of the collaborative project to ensure that each evaluation question can be answered.

Question 1: Were the project/contractual obligations met?

Answering this question is important because it provides MCMC a measure of accountability. It includes the federal and/or State-mandated QIP reporting requirements plus any additional measures deemed important to describe the *All-Cause Readmissions* statewide collaborative QIP.

The project obligations to be evaluated are related to the collaborative Guiding Principles developed by collaborative partners on July 28, 2011, and the DHCS QIP requirements.

Question 2: What improvements can be made to the delivery of the project?

Evaluating delivery of the project is important for two reasons:

- First, data gathered from ongoing monitoring of the project can inform mid-course corrections, resulting in significant resource/cost savings.
- Second, the ability to determine the impact of the *All-Cause Readmissions* statewide collaborative QIP is difficult to assess if there is uncertainty about the fidelity with which the project was implemented. If the QIP failed to have its intended effect on members, was it attributable to failures in delivery (i.e., the QIP was not given a fair chance) or because of substantive issues in conceptualization (i.e., invalid, underlying assumptions in how to develop and implement interventions)? The answer to this question will lead to very different decisions, either (a) improving operations or (b) a complete restructuring of the conceptualization of the QIP.

The project delivery areas to be evaluated are related to the collaborative timeline, the adherence to the CMS protocol for conducting a QIP, and external audit results for producing valid rates.

Question 3: What difference did the *All-Cause Readmissions* statewide collaborative QIP make to the project participants?

To answer this question requires an understanding of the underlying assumptions of the QIP. What are the critical issues that contribute to readmissions? Making the programmatic assumptions explicit is essential because it is these underlying issues that the QIP activities should be trying to change. That is, the identified critical issues are the immediate and interim outcomes that are necessary to produce change in reducing readmissions.

Since it is uncertain whether substantive changes in reducing readmission rates will be observed and sustained over a three-year period, an assessment of the immediate and interim outcomes becomes even more critical in demonstrating the value of the *All-Cause Readmissions* statewide collaborative QIP.

Oversight and Compliance

The collaborative participants developed and agreed on two measures in the area of Oversight and Compliance.

Oversight and Compliance Measures

Table 4.1—Oversight and Compliance Outcome Measures

Implementation Outcomes	Measures
1. Medi-Cal MCPs will participate in the statewide collaborative QIP activities according to the collaborative-developed Guiding Principles.	◆ MCP attendance at collaborative QIP meetings (a minimum of one key member to attend all meetings) ◆ Log of collaborative meeting facilitator/co-facilitator and minute-keeper.
2. Medi-Cal MCPs will prepare and submit their QIPs for validation according to DHCS-identified due dates and requirements.	◆ EQRO log of QIP submission dates.

Collaborative Project Improvement—Process

As part of the evaluation plan, process improvement relates to quality assurance measures and improving the delivery of the project as the collaborative progresses. Three process outcome measures were identified.

Process Measures

Table 4.2—Process Outcome Measures

Process Outcomes	Measures
1. The QIP will be implemented according to the collaborative timeline.	◆ Completion date of QIP milestones against the timeline targeted due dates.
2. Medi-Cal MCPs will achieve *Met* validation scores for the design and implementation stages of their QIP.	◆ QIP validation scores. ◆ EQRO qualitative analysis of barriers and interventions.
3. Medi-Cal MCPs will report valid *All-Cause Readmissions* rates consistent with the collaborative-defined specifications.	◆ EQRO validation of performance measure—final audit report.

Merit and Worth

Critical to understanding the appropriate outcomes to evaluate is first understanding the program theory. Theory Driven Evaluation (TDE) is a valid and widely used approach in evaluation[12] across all sectors of government programs and policies. TDE consists of three steps designed to ensure there is a logical connection between program activities and evaluation. TDE begins by making the assumptions underlying the program explicit. These assumptions are often depicted visually and show the chain of conditions that the program is trying to change. Once the programmatic assumptions are understood, programmatic activities are aligned to them. Finally, indicators and measures are sought to evaluate those conditions being targeted by the program activities. It is the summary of these three steps that is the basis for the logic model.[13]

The ideal process with using a program evaluation theory model is to develop the theory, ensure the Medi-Cal MCPs are targeting the identified issues, and then develop the measures. The evaluation workgroup created a logic model that identified conditions related to readmissions. Appendix D shows the logic model that was shared with the collaborative.

[12] Donaldson, S. I. (2002). Theory-driven program evaluation in the new millennium. *Evaluating social programs and problems* (pp109-141) Mahwah, NJ.

[13] Renger, R., & Titcomb, A. (2002). A three-step approach to teaching logic models. *American Journal of Evaluation*, 23(4), 493-503.

MCPs used the collaborative logic model as the basis for their MCP-specific barrier analyses. Based on the results of their analyses, MCPs developed interventions to address the barriers. The evaluation of the interventions is documented as interim measures, and the outcomes of these measures will determine the effectiveness of the MCPs' improvement strategies.

Impact Outcomes

Table 4.3—Merit and Worth Outcome Measures

Long-Term Outcomes	Measures
1. Medi-Cal MCPs will achieve a statistically significant decrease in their *All-Cause Readmissions* rate between the baseline and remeasurement period.	◆ Activity IX validation results for statistically significant improvement.
2. Medi-Cal MCPs will achieve *Met* validation scores for sustained improvement.	◆ Activity X validation results for sustained improvement.
Immediate/Interim MCP-Specific Outcomes— TBD Dependent on Targeted Barriers	**Measures— TBD Dependent on Targeted Barriers**
1. Example: Medi-Cal MCPs will improve the discharge planning process.	◆ Example: Percentage of members discharged from a facility with a complete discharge plan.

In the *Statewide Collaborative Quality Improvement Project All-Cause Readmissions Interim Report—June 2011–May 2013*, HSAG reported on results for the oversight and compliance measures that were collected throughout the Design stage. The current report provides results for the oversight and compliance measures that were collected during the June 2013 through May 2014 reporting period.

To determine the collaborative's progress toward achieving oversight and compliance implementation outcomes, HSAG assessed the following:

- MCP attendance at collaborative QIP meetings (a minimum of one key member to attend all meetings).
- Log of collaborative meeting facilitator/co-facilitator and minute-keeper.
- EQR log of QIP submission dates.

Collaborative Partner Participation

All MCPs participated on all collaborative calls according to the Guiding Principles, with a minimum of one MCP staff member in attendance for all meetings. MMCD-approved meeting agendas were distributed prior to each meeting, and MMCD documented attendance at the beginning of each call. The meetings followed the agenda and included a facilitator/co-facilitator. At the request of the MCPs, MMCD and HSAG co-facilitated the meetings. Most meetings included time for one or more MCPs to share their QIP activities, lessons learned, and successes. MMCD, HSAG, or a designated MCP documented minutes and identified action items for timely follow-up. Calls were held in July, August, and November 2013, and February and May 2014. Topics discussed included:

- Changes and enhancements to HSAG's QIP validation process and revisions to the QIP Summary Form designed to increase the emphasis on improving QIP outcomes. Changes and enhancements included:
  - Updates to the QIP validation methodology, which place greater emphasis on health care outcomes by ensuring that statistically significant improvement has been achieved before HSAG assesses for sustained improvement.
  - Revisions to the QIP validation scoring process, which was streamlined to make the process more efficient.
- Guidance regarding meeting all QIP requirements to ensure a successful QIP submission.

- Conducting causal/barrier analyses, prioritizing barriers, developing interventions to address high-priority barriers, and evaluating interventions.
- Application of the Plan, Do, Study, Act (PDSA) cycle, including rapid cycle improvement strategies.

QIP Submission Timeliness

HSAG tracked all QIP baseline submissions and compared its log with MMCD to ensure accurate documentation of the submissions. Baseline submissions (with *All-Cause Readmissions* rates for CY 2012 and Activities I through VIII) were due September 30, 2013. Eighteen MCPs (representing 40 QIPs) submitted by the due date; however, five MCPs (representing five QIPs) were provided an extension and submitted in October 2013.

6. Collaborative Project Improvement—Process Measures Results

In the *Statewide Collaborative Quality Improvement Project All-Cause Readmissions Interim Report—June 2011–May 2013*, HSAG reported on results for the process outcome measures that were collected throughout the Design stage. The current report provides results for the process outcome measures that were collected during the June 2013 through May 2014 reporting period.

Collaborative Project Improvement—Process

To determine the collaborative's progress toward achieving process outcomes, HSAG assessed the following:

- Completion date of QIP milestones against the timeline targeted due dates.
- QIP validation scores.
- EQRO qualitative analysis of barriers and interventions.
- EQRO validation of performance measures—final audit report.

Collaborative Timeline

MMCD tracked the completion date of QIP milestones against the timeline targeted due dates. The timeline for the entire project is provided in Appendix C. Below are the key milestones for the Implementation/Baseline stage and the status of each milestone.

Table 6.1—Completion Status for Statewide *All-Cause Readmissions* Collaborative Components during Implementation/Baseline Stage

Milestones	Targeted Due Date	Status
MCPs submit their barrier analysis and planned interventions grid to HSAG	January 31, 2013	Complete
MCPs implement interventions	January–April 2013	Complete
MCPs submit QIP with baseline data (CY 2012)	September 30, 2013	Complete
QIP Validation	October–November 2013	Complete
EQRO Baseline Report	June 2014	Complete

QIP Validation Scores

HSAG's validation of the initial QIP submissions resulted in 16 QIPs (representing 5 MCPs) achieving a *Met* validation status, 28 QIPs (representing 17 MCPs) achieving a *Partially Met* validation status, and 1 QIP (representing 1 MCP) achieving a *Not Met* validation status. DHCS requires that QIPs receive an overall *Met* validation status; therefore, MCPs must resubmit a QIP until it achieves a *Met* validation status, unless otherwise specified. In all, 18 MCPs (representing 29 QIPs) had to resubmit their *All-Cause Readmissions* QIP.

Most MCPs provided the required documentation in their Resubmission 1, with 25 QIPs (representing 14 MCPs) achieving a *Met* validation status and 4 QIPs (representing 4 MCPs) achieving a *Partially Met* status. HSAG and MMCD provided technical assistance to the four MCPs with QIPs that did not achieve a fully *Met* validation status on the first resubmission to ensure the MCPs understood the requirements for each evaluation element. Three of the four QIPs achieved a *Met* validation status at Resubmission 2; however, one QIP did not achieve a *Met* validation status until the third resubmission, which occurred in March 2014.

Table 6.2 depicts a summary of the validation status for the *All-Cause Readmissions* QIP baseline submissions.

Table 6.2—Summary of Validation Status for *All-Cause Readmissions* QIP Baseline Submissions

Validation Status	Annual QIP Submission	Annual QIP Resubmission 1	Annual QIP Resubmission 2	Annual QIP Resubmission 3
Met	16	25	3	1
Partially Met	28	4	1	0
Not Met	1	0	0	0
Total QIPs	45	29	4	1

Table 6.3 depicts the number of MCPs with QIPs that achieved a *Met*, *Partially Met*, and *Not Met* validation status for each type of submission.

Table 6.3—Summary of QIP Validation Status by Number of Managed Care Plans

Validation Status	No. of MCPs' Annual QIP Submission	No. of MCPs' Annual QIP Resubmission 1	No. of MCPs' Annual QIP Resubmission 2	No. of MCPs' Annual QIP Resubmission 3
Met	5	14	3	1
Partially Met	17	4	1	0
Not Met	1	0	0	0
Total No. of MCPs	23	18	4	1

Assessment of Validation Results for Annual QIP Submissions

Table 6.4 provides the aggregate percentages for each QIP activity within the CMS protocols for the annual QIP submissions.

Table 6.4—Aggregate Validation Results for *All-Cause Readmissions* Statewide Collaborative QIP Annual Submissions* (23 MCPs, 45 QIP Submissions)

QIP Study Stage	Activity	Aggregate Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	I. Appropriate Study Topic	99%	0%	1%
	II. Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III. Clearly Defined Study Indicator(s)	100%	0%	0%
	IV. Correctly Identified Study Population	100%	0%	0%
	V. Valid Sampling Techniques (if sampling was used)	NA	NA	NA
	VI. Accurate/Complete Data Collection**	78%	17%	4%
Design Total		**91%**	**7%**	**2%**
Implementation	VII. Appropriate Improvement Strategies**	71%	4%	24%
	VIII. Sufficient Data Analysis and Interpretation	62%	38%	0%
Implementation Total		**68%**	**16%**	**16%**
Outcomes	IX. Real Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
	X. Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**Not Assessed**	**Not Assessed**	**Not Assessed**
Overall Percentage of Applicable Evaluation Elements Scored *Met*		**83%**		
Percentage of QIPs with a Validation Status of *Met*		**36%**		

* The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.

**The activity totals may not equal 100 percent due to rounding.

HSAG assessed Activities I through VIII for all 45 *All-Cause Readmissions* statewide collaborative QIP annual submissions. Activities I through IV received the highest scores, which was expected since common language was provided to the MCPs for these activities. As was true with the Design stage submissions, MCPs had difficulty meeting all requirements for Activity VI. The lower scores in Activity VI were a result of most of the MCPs not providing a description of their data analysis plan and several MCPs not providing documentation of a clearly defined and systematic process for collecting baseline and remeasurement data.

MCPs demonstrated opportunities for improvement related to the Implementation stage, with MCPs only meeting 68 percent of the requirements for all applicable evaluation elements within the stage. Since most MCPs did not provide a data analysis plan, several QIPs received a lower

score for elements in Activity VII related to analysis of the data. Almost half of the MCPs did not document if there were factors that threatened the internal or external validity of the findings, and several MCPs did not provide all required information related to their baseline results, resulting in lower scores for elements within Activity VII. Most MCPs did not provide all required documentation related to barriers and interventions, including the process used to identify the barriers/interventions, how barriers were prioritized, and how interventions will be measured for effectiveness, resulting in lower scores for elements within Activity VIII.

Overall, only 36 percent of the QIPs achieved a *Met* validation status, resulting in 18 MCPs having to resubmit their QIPs.

Assessment of Validation Results for Annual QIP Resubmissions

Table 6.5 provides the aggregate percentages for each QIP activity within the CMS protocols for all annual QIP resubmissions.

Table 6.5—Aggregate Validation Results for *All-Cause Readmissions* Statewide Collaborative QIP Annual Resubmissions* (18 MCPs, 34 QIP Submissions)

QIP Study Stage	Activity	Aggregate Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	I. Appropriate Study Topic	99%	1%	0%
	II. Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III. Clearly Defined Study Indicator(s)	100%	0%	0%
	IV. Correctly Identified Study Population	100%	0%	0%
	V. Valid Sampling Techniques (if sampling was used)	NA	NA	NA
	VI. Accurate/Complete Data Collection**	96%	1%	2%
Design Total		**98%**	**1%**	**1%**
Implementation	VII. Appropriate Improvement Strategies	92%	4%	4%
	VIII. Sufficient Data Analysis and Interpretation	87%	13%	0%
Implementation Total**		**90%**	**7%**	**2%**
Outcomes	IX. Real Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
	X. Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**Not Assessed**	**Not Assessed**	**Not Assessed**
Overall Percentage of Applicable Evaluation Elements Scored *Met*		**95%**		
Percentage of QIPs with a Validation Status of *Met*		**85%**		

* The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.

**The activity totals may not equal 100 percent due to rounding.

HSAG assessed Activities I through VIII for all 34 QIP resubmissions. Of the 34 QIP resubmissions, 29 were first resubmissions; and 25 of these QIPs achieved a *Met* validation status. Four QIPs had to be resubmitted a second time, and three of them achieved a *Met* validation status on the second resubmission. One MCP had to resubmit its QIP a third time; and upon the third resubmission, the QIP achieved a *Met* validation status.

For the resubmissions, MCPs demonstrated strong application of both the Design and Implementation stages. As noted above, since common language was provided to the MCPs for Activities I through IV, it was expected that the QIPs would receive high scores for these activities. Issues resulting in three of the MCPs needing to resubmit their QIPs a second time and one MCP needing to resubmit its QIP a third time included:

- Lack of documentation of the process the MCP used to identify the barriers or interventions.
- Lack of documentation regarding how the MCP will evaluate the interventions for effectiveness.
- Identification of interventions which would not change the readmissions rate.

As indicated above, HSAG and MMCD provided technical assistance to the four MCPs with QIPs that did not achieve a fully *Met* validation status on the first resubmission to ensure the MCPs understood the requirements for each evaluation element. HSAG provided the MCPs with detailed descriptions of what they needed to include in their QIPs so that HSAG could assess if the QIPs were methodologically sound.

Analysis of Barriers and Interventions

As indicated in the *Statewide Collaborative Quality Improvement Project All-Cause Readmissions Interim Report—June 2011–May 2013*, in January 2013, MCPs were required to submit their barrier analyses and an intervention grid to HSAG and MMCD for evaluation. Also as indicated in the interim report, HSAG held individual technical assistance calls with each MCP to discuss the barriers and interventions, with the first call occurring in February 2013 and the last call occurring in June 2013. HSAG provided each MCP with MCP-specific feedback by e-mail. Additionally, HSAG provided general feedback to all MCPs, including that they should:

- Ensure barrier analyses are supported by their MCP-specific data.
- Clearly prioritize the identified barriers.
- Link each intervention to a specific barrier.
- Describe each intervention's targeted population.
- Provide detailed descriptions of all QIP processes.
- Include an evaluation plan for each intervention.

In the QIP submissions, MCPs provided the barrier and intervention information in different formats and included varying levels of detail. Appendix E includes a summary of each MCP's identified barriers and interventions from the annual QIP submissions, including the targets for the interventions. Please note the following regarding the information included in Appendix E:

- Since many MCPs identified multiple interventions, HSAG did not include all interventions for all MCPs. Instead, HSAG included what it determined to be the key interventions being implemented by each MCP to address the priority barriers.
- Based on how MCPs presented the information in the QIP Summary Form, HSAG could not always determine if or when an MCP intended to implement interventions labeled as "planned interventions." In instances where it was not clear whether or when the MCP intended to implement the interventions or when planned interventions appeared to be duplicative of interventions already being implemented, HSAG did not include the information.
- Some MCPs did not align each intervention with a specific barrier or identify the intervention target. In some instances, HSAG was able to determine which barriers the interventions were designed to address and the target for the intervention; however, HSAG was not able to determine this information for all MCPs. Therefore, in some instances, there is no alignment of barriers to interventions; and in other instances, HSAG aligned the barriers and interventions based on its interpretation of the information provided by the MCPs. Additionally, when the target for an intervention was not specified by the MCPs but the target information could be determined from the intervention description, HSAG included it in the summary.

HSAG made the following observations related to the barriers and interventions when reviewing the QIPs:

- Most MCPs made modifications to the barriers and interventions they submitted to HSAG in January 2013; however, most MCPs did not provide detailed documentation of the processes used to modify the barriers and interventions.
- The priority barriers most frequently identified were in the following areas:
  - Discharge process (e.g., process not adequate, no discharge plan developed/provided, members not complying with discharge plan).
  - Transition of care, including lack of adequate coordination of care processes, shortcomings with case/care management processes, and poor communication to primary care physicians (PCPs) about members being discharged from an inpatient stay.
  - PCP follow-up appointments, including appointments not being scheduled, members not attending appointments, and members not having access to a PCP.
  - Medications, including members not filling/refilling prescriptions, members not understanding medication regimens, and members not complying with medication regimens.

- Observations related to the identified interventions include:
  - Interventions designed to impact the discharge process are the most common interventions being implemented by the MCPs, including enhancing discharge processes, implementing transition of care programs, and expanding care/case management programs to include additional diagnoses at high risk for readmissions.
  - Some MCPs are implementing home visits to ensure members receive needed medications and follow up with their PCPs. Additionally, some MCPs are using interactive voice response calls or are calling members directly to assess members' needs and to ensure members have a follow-up appointment scheduled with their PCP.
- Observations related to the target(s) for the interventions include:
  - The Medi-Cal population is the target for most of the member-focused interventions; however, some MCPs are targeting members with specific chronic conditions/illnesses and others are targeting members determined to be at high risk for readmissions.
  - Many of the MCPs are targeting hospitals with their interventions, with some implementing the interventions in select hospitals only (e.g., high-volume, low-performing hospitals), and others implementing the interventions in all participating hospitals.
  - Several interventions target PCPs, specialists, and/or participating physician groups, and several interventions focus on making an impact at the MCP level.

Remeasurement 1 Submission

Beginning in January 2013, MCPs began to implement interventions in an effort to impact the Remeasurement 1 results (HEDIS 2014, CY 2013). The MCPs' Remeasurement 1 submission for the *All-Cause Readmissions* statewide collaborative QIP is due September 30, 2014.

Performance Measure Validation

As part of the 2013 NCQA HEDIS Compliance Audit™[14] process, HSAG reviewed and approved 23 MCPs' source codes, either internal or vendor created, for the *All-Cause Readmissions* statewide collaborative QIP measure. All MCPs were able to produce valid and reliable rates for CY 2012. HSAG produced MCP-specific final audit reports that were distributed to MCPs and MMCD in July 2013.

[14] NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

Historical and Baseline *All-Cause Readmissions* Rates

Table 6.6 includes CY 2011 and 2012 *All-Cause Readmissions* rates. Please note the following when reviewing the rates in Table 6.6:

- The CY 2011 rates were submitted by the MCPs as part of the *All-Cause Readmissions* statewide collaborative QIP Design stage. The rates were submitted as a test run to ensure the MCPs were able to accurately run the rates and perform the appropriate stratifications. While the Design stage rates were audited, the MCPs' first year of reporting presented some data limitations. Some MCPs had challenges with identifying the SPD population using the required aid codes. Similarly, the audit team had difficulty benchmarking the reasonability of rates and validating appropriate capture of SPD members without historical information or other State or national Medicaid benchmarks on readmissions. In addition, SPD members were transitioned into managed care over a period of time, complicating the enrollment numbers for benchmarking purposes for some MCPs. Finally, due to the complexity of measure specifications used to identify index hospitalizations, some miscounting may have occurred. Typically, first-year, untested, measures are not reported or used as strong data points to allow both MCPs and the audit team to gain proficiency with identifying and resolving issues.
- HSAG did not perform statistical testing on the rates; therefore, the reader should exercise caution when drawing conclusions about any variations in the rates from CY 2011 to CY 2012.
- The State and many MCPs experienced significant population growth during CY 2012, including the transition of members within the SPD population. The rates as presented do not take into account population size; therefore, the reader should exercise caution when interpreting variations in rates, numerators, and denominators.
- The SPD, Non-SPD, and MCMC total weighted averages for CY 2012 in this report exclude San Joaquin and Stanislaus counties for Anthem since the MCP no longer provides Medi-Cal services in these counties. Additionally, since SCAN participates in the *All-Cause Readmissions* QIP, SCAN's rates have been included in the weighted averages. Therefore, the weighted averages presented in this report may vary slightly from previously reported data.

Table 6.6—Calendar Year 2011 and 2012 *All-Cause Readmissions* Rates

MCP Name and County	Population	CY 2011			CY 2012		
		Numerator	Denominator	Rate	Numerator	Denominator	Rate
Statewide (rates are weighted averages)	SPD	3,961	24,750	16.00%	11,218	65,818	17.04%
	Non-SPD	3,389	32,767	10.34%	3,176	33,966	9.35%
	Total	7,350	57,519	12.78%	14,394	99,784	14.43%
Alameda Alliance for Health—Alameda County	SPD	179	1,238	14.46%	480	3,027	15.86%
	Non-SPD	67	613	10.93%	91	869	10.47%
	Total	246	1,851	13.29%	571	3,896	14.66%
Anthem Blue Cross Partnership Plan—Alameda County	SPD	26	181	14.36%	108	676	15.98%
	Non-SPD	17	213	7.98%	18	183	9.84%
	Total	43	394	10.91%	126	859	14.67%
Anthem Blue Cross Partnership Plan—Contra Costa County	SPD	9	57	15.79%	23	100	23.00%
	Non-SPD	6	61	9.84%	4	45	8.89%
	Total	15	118	12.71%	27	145	18.62%
Anthem Blue Cross Partnership Plan—Fresno County	SPD	*	*	*	92	548	16.79%
	Non-SPD	*	*	*	52	493	10.55%
	Total	*	*	*	144	1,041	13.83%
Anthem Blue Cross Partnership Plan—Kings County	SPD	*	*	*	22	111	19.82%
	Non-SPD	*	*	*	9	76	11.84%
	Total	*	*	*	31	187	16.58%
Anthem Blue Cross Partnership Plan—Madera County	SPD	*	*	*	9	52	17.31%
	Non-SPD	*	*	*	1	40	2.50%
	Total	*	*	*	10	92	10.87%
Anthem Blue Cross Partnership Plan—Sacramento County	SPD	60	440	13.64%	180	1,160	15.52%
	Non-SPD	47	723	6.50%	55	701	7.85%
	Total	107	1,163	9.20%	235	1,861	12.63%

MCP Name and County	Population	CY 2011			CY 2012		
		Numerator	Denominator	Rate	Numerator	Denominator	Rate
Anthem Blue Cross Partnership Plan—San Francisco County	SPD	15	100	15.00%	62	404	15.35%
	Non-SPD	6	70	8.57%	4	61	6.56%
	Total	21	170	12.35%	66	465	14.19%
Anthem Blue Cross Partnership Plan—Santa Clara County	SPD	18	124	14.52%	44	304	14.47%
	Non-SPD	13	199	6.53%	21	169	12.43%
	Total	31	323	9.60%	65	473	13.74%
Anthem Blue Cross Partnership Plan—Tulare County	SPD	44	317	13.88%	70	446	15.70%
	Non-SPD	37	551	6.72%	36	460	7.83%
	Total	81	868	9.33%	106	906	11.70%
CalOptima—Orange County	SPD	685	3,662	18.71%	1,135	6,030	18.82%
	Non-SPD	486	3,860	12.59%	273	2,406	11.35%
	Total	1,171	7,522	15.57%	1408	8,436	16.69%
CalViva Health—Fresno County	SPD	*	*	*	212	1,723	12.30%
	Non-SPD	*	*	*	75	975	7.69%
	Total	*	*	*	287	2,698	10.64%
CalViva Health—Kings County	SPD	*	*	*	17	134	12.69%
	Non-SPD	*	*	*	3	60	5.00%
	Total	*	*	*	20	194	10.31%
CalViva Health—Madera County	SPD	*	*	*	16	114	14.04%
	Non-SPD	*	*	*	8	108	7.41%
	Total	*	*	*	24	222	10.81%
Care1st Partner Plan—San Diego County	SPD	20	95	21.05%	132	761	17.35%
	Non-SPD	13	147	8.84%	16	185	8.65%
	Total	33	242	13.64%	148	946	15.64%
Central California Alliance for Health—Merced County	SPD	131	785	16.69%	105	729	14.40%
	Non-SPD	45	547	8.23%	42	426	9.86%
	Total	176	1,332	13.21%	147	1,155	12.73%

MCP Name and County	Population	CY 2011			CY 2012		
		Numerator	Denominator	Rate	Numerator	Denominator	Rate
Central California Alliance for Health—Monterey and Santa Cruz Counties	SPD	194	1,134	17.11%	165	1,140	14.47%
	Non-SPD	49	718	6.82%	50	643	7.78%
	Total	243	1,852	13.12%	215	1,783	12.06%
CenCal Health—San Luis Obispo County	SPD	69	400	17.25%	66	399	16.54%
	Non-SPD	16	179	8.94%	12	179	6.70%
	Total	85	579	14.68%	78	578	13.49%
CenCal Health—Santa Barbara County	SPD	88	589	14.94%	87	627	13.88%
	Non-SPD	28	295	9.49%	17	307	5.54%
	Total	116	884	13.12%	104	934	11.13%
Community Health Group Partnership Plan—San Diego County	SPD	18	118	15.25%	252	1,480	17.03%
	Non-SPD	146	1,442	10.12%	118	1,094	10.79%
	Total	164	1,560	10.51%	370	2,574	14.37%
Contra Costa Health Plan—Contra Costa County	SPD	78	458	17.03%	270	1,386	19.48%
	Non-SPD	52	615	8.46%	103	810	12.72%
	Total	130	1,073	12.12%	373	2,196	16.99%
Gold Coast Health Plan—Ventura County	SPD	*	*	*	242	1,045	23.16%
	Non-SPD	*	*	*	60	530	11.32%
	Total	*	*	*	302	1,575	19.17%
Health Net Community Solutions, Inc.—Kern County	SPD	45	280	16.07%	81	691	11.72%
	Non-SPD	33	320	10.31%	22	299	7.36%
	Total	78	600	13.00%	103	990	10.40%
Health Net Community Solutions, Inc.—Los Angeles County	SPD	159	1,500	10.60%	644	4,548	14.16%
	Non-SPD	181	2,417	7.49%	176	2,323	7.58%
	Total	340	3,917	8.68%	820	6,871	11.93%

MCP Name and County	Population	CY 2011			CY 2012		
		Numerator	Denominator	Rate	Numerator	Denominator	Rate
Health Net Community Solutions, Inc.—Sacramento County	SPD	32	305	10.49%	175	1,247	14.03%
	Non-SPD	17	341	4.99%	23	382	6.02%
	Total	49	646	7.59%	198	1,629	12.15%
Health Net Community Solutions, Inc.—San Diego County	SPD	15	124	12.10%	138	772	17.88%
	Non-SPD	22	237	9.28%	21	224	9.38%
	Total	37	361	10.25%	159	996	15.96%
Health Net Community Solutions, Inc.—Stanislaus County	SPD	12	111	10.81%	35	346	10.12%
	Non-SPD	10	148	6.76%	9	159	5.66%
	Total	22	259	8.49%	44	505	8.71%
Health Net Community Solutions, Inc.—Tulare County	SPD	13	100	13.00%	79	498	15.86%
	Non-SPD	16	250	6.40%	19	328	5.79%
	Total	29	350	8.29%	98	826	11.86%
Health Plan of San Joaquin—San Joaquin County	SPD	79	571	13.84%	11	80	13.75%
	Non-SPD	55	689	7.98%	42	670	6.27%
	Total	134	1,260	10.63%	53	750	7.07%
Health Plan of San Mateo—San Mateo County	SPD	362	2,887	12.54%	266	2,003	13.28%
	Non-SPD	24	266	9.02%	101	525	19.24%
	Total	386	3,153	12.24%	367	2,528	14.52%
Inland Empire Health Plan—Riverside and San Bernardino Counties	SPD	398	2,504	15.89%	1,290	7,609	16.95%
	Non-SPD	531	4,818	11.02%	457	4,656	9.82%
	Total	929	7,323	12.68%	1,747	12,265	14.24%
Kaiser–Sacramento County	SPD	99	542	18.27%	89	522	17.05%
	Non-SPD	26	200	13.00%	20	172	11.63%
	Total	125	742	16.85%	109	694	15.71%

MCP Name and County	Population	CY 2011			CY 2012		
		Numerator	Denominator	Rate	Numerator	Denominator	Rate
Kaiser–San Diego County	SPD	34	215	15.81%	73	352	20.74%
	Non-SPD	15	107	14.02%	7	105	6.67%
	Total	49	322	15.22%	80	457	17.51%
Kern Family Health Care—Kern County	SPD	12	70	17.14%	170	996	17.07%
	Non-SPD	158	1,442	10.96%	208	3,316	6.27%
	Total	170	1,512	11.24%	378	4,312	8.77%
L.A. Care Health Plan—Los Angeles County	SPD	829	4,192	19.78%	2,967	15,072	19.69%
	Non-SPD	630	5,416	11.63%	721	6563	10.99%
	Total	1,459	9,608	15.19%	3,688	21,635	17.05%
Molina Healthcare of California Partner Plan, Inc.—Riverside and San Bernardino Counties	SPD	42	302	13.91%	186	1,025	18.15%
	Non-SPD	75	703	10.67%	60	654	9.17%
	Total	117	1,005	11.64%	246	1,679	14.65%
Molina Healthcare of California Partner Plan, Inc.—Sacramento County	SPD	35	181	19.34%	106	722	14.68%
	Non-SPD	20	214	9.35%	23	255	9.02%
	Total	55	395	13.92%	129	977	13.20%
Molina Healthcare of California Partner Plan, Inc.—San Diego County	SPD	45	265	16.98%	177	1,003	17.65%
	Non-SPD	56	524	10.69%	59	630	9.37%
	Total	101	789	12.80%	236	1,633	14.45%
Partnership HealthPlan of California—Marin County	SPD	*	*	*	45	239	18.83%
	Non-SPD	*	*	*	2	54	3.70%
	Total	*	*	*	47	293	16.04%
Partnership HealthPlan of California—Mendocino County	SPD	*	*	*	30	281	10.68%
	Non-SPD	*	*	*	11	137	8.03%
	Total	*	*	*	41	418	9.81%

MCP Name and County	Population	CY 2011			CY 2012		
		Numerator	Denominator	Rate	Numerator	Denominator	Rate
Partnership HealthPlan of California—Napa, Solano, and Yolo Counties	SPD	11	77	14.29%	213	1,359	15.67%
	Non-SPD	282	2,351	11.99%	35	512	6.84%
	Total	293	2,428	12.07%	248	1,871	13.25%
Partnership HealthPlan of California—Sonoma County	SPD	6	47	12.77%	108	702	15.38%
	Non-SPD	140	1,158	12.09%	19	271	7.01%
	Total	146	1,205	12.12%	127	973	13.05%
San Francisco Health Plan—San Francisco County	SPD	27	298	9.06%	198	1,095	18.08%
	Non-SPD	21	223	9.42%	23	303	7.59%
	Total	48	521	9.21%	221	1,398	15.81%
Santa Clara Family Health Plan—Santa Clara County	SPD	72	481	14.97%	199	1,203	16.54%
	Non-SPD	49	710	6.90%	50	605	8.26%
	Total	121	1,192	10.15%	249	1,808	13.77%
Senior Care Action Network Health Plan—Los Angeles, Riverside, and San Bernardino Counties	SPD	*	*	*	149	1,057	14.10%
	Non-SPD	*	*	*	0	3	0.00%
	Total	*	*	*	149	1,060	14.06%

*The MCP did not report *All-Cause Readmissions* rates for this time period.

Since the *All-Cause Readmissions* statewide collaborative QIP had not yet progressed to the Outcomes stage, HSAG could not assess the QIPs' impact on the long-term outcomes; however, HSAG assessed the QIPs for interim outcomes.

Interim MCP-Specific Outcomes

HSAG made the following observations related to the interim MCP-specific outcomes when reviewing the QIPs:

Only three MCPs included interim study indicator results (i.e., the MCPs' calculation of the number of readmissions to determine if their interventions were making an impact.)

- One MCP indicated that based on the time frame for implementing the interventions, it was not able to link the readmissions data directly to the interventions performed. The MCP indicated that it would include the analysis of the data in its next QIP submission.
- One MCP indicated that its analysis of the intervention, which included home visits, did not reveal any change since the number of participants was so low. The MCP indicated that it will continue with the intervention and will reassess after more data are available.
- One MCP reported that its intervention of providing pharmacy education and reconciliation at high-risk readmission patients' bedsides had positive results and that it planned to expand the intervention to other high-risk members.

Only four MCPs provided preliminary intervention evaluation results that they planned to use to assess the effectiveness of their interventions, including:

- The number of members enrolled in case management.
- The number of members indicating an understanding of discharge instructions.
- The number of members that scheduled a follow-up appointment and kept it.
- The number of members compliant with prescription fills.

The remaining MCPs either documented that they planned to evaluate the interventions or documented that the intervention evaluation was completed but did not provide any quantitative results.

Conclusions and Recommendations

All MCPs participating in the collaborative continue to be vested in the *All-Cause Readmissions* statewide collaborative QIP, as demonstrated by each MCP being represented on all collaborative calls held during the review period.

In the *Statewide Collaborative Quality Improvement Project All-Cause Readmissions Interim Report—June 2011–May 2013,* HSAG provided specific recommendations for MCPs to include in their *All-Cause Readmissions* baseline QIP submissions; however, the MCPs did not incorporate many of the recommendations, resulting in many of the MCPs not meeting the requirements for all applicable evaluation elements and having to resubmit their QIPs. Issues leading to the MCPs needing to resubmit their QIPs included:

- Lack of detailed information about QIP processes and activities, such as the data analysis plan and planned interventions.
- Lack of routine causal/barrier analyses.
- No prioritization of barriers.
- Lack of targeted interventions.

Upon receiving feedback from HSAG on the QIP documentation, the MCPs were able to demonstrate sufficient application of the QIP Design and Implementation stages, and the QIPs achieved a *Met* validation status.

Based on its review of the *All-Cause Readmissions* statewide collaborative QIP baseline submissions, HSAG provides the following recommendations to the MCPs:

- Include detailed documentation for all QIP processes and activities (e.g., data analysis plan, planned interventions) when submitting QIPs for validation; this will enable the EQRO to thoroughly assess if the QIPs are methodologically sound.
- Conduct routine causal/barrier analyses.
- Identify and focus on three to five high-priority barriers, and develop targeted interventions for the high-priority areas to increase the likelihood that improvement strategies will be successful. Additionally, specify which barrier(s) each intervention is designed to address.

- Because interventions implemented through December 31, 2014, have the potential to impact Remeasurement 2 outcomes, MCPs should engage in rapid cycle improvement strategies to determine if high-priority barriers have changed and if interventions should be revised, standardized, scaled up, or discontinued. Implementation of rapid cycle improvement strategies will increase the likelihood of positive outcomes (i.e., a decrease in the number of readmissions).

HSAG recommends that MMCD, in collaboration with HSAG, continue to provide technical assistance to the MCPs to support the MCPs in implementing rapid cycle improvement strategies; such support will increase the likelihood of reducing readmissions due to all causes in the Medi-Cal population.

Next Steps

Collaborative next steps include the following:

- Continue to implement and evaluate interventions and to revise, standardize, scale up, or discontinue interventions as appropriate.
- Conduct new barrier analyses and either confirm already-existing high-priority barriers or identify new high-priority barriers.
- Collect, report, and submit Remeasurement 1 data in the *All-Cause Readmissions* QIP submissions, which are due to HSAG for validation by September 30, 2014.

HSAG will complete the next *All-Cause Readmissions* statewide collaborative QIP report, including the Remeasurement 1 data and analyses, in May 2015.

Appendix A. *All-Cause Readmissions* Specification Modification Rationale

Table A.1—*All-Cause Readmissions* Specification Modification Rationale

Traditional HEDIS *Plan All-Cause Readmissions (PCR)* Measure	Medi-Cal *All-Cause Readmissions* Measure	Rationale for Modification
Product Line: Commercial and Medicare only	**Product Line:** Medi-Cal	No HEDIS specification available for Medicaid.
Age Requirement: 18 years and older as of the Index Discharge Date	**Age Requirement:** 21 years and older as of the Index Discharge Date	Resolves issues with California Children's Services (CCS) carve-out for some MCPs.
Continuous Enrollment (CE) Requirement: 365 days prior to the Index Discharge Date through 30 days after the Index Discharge Date.	**Continuous Enrollment (CE) Requirement:** 120 days prior to the Index Discharge Date through 30 days after the Index Discharge Date.	CE requirement was necessary for readmission probability/weighting calculations. Maintaining a one-year CE would eliminate all newer SPDs and other members. Recommend 120 days to allow for MCPs to contact and establish care for new members after enrollment.
Allowable Gap: No more than one gap in enrollment of up to 45 days during the 365 days prior to the Index Discharge Date and no gap during the 30 days following the Index Discharge date.	**Allowable Gap:** None	Aligns with approach to allow MCPs 45 days to contact new enrollees.
Risk Adjustment Weighting: Includes an algorithm for risk adjustment weighting based on surgery, discharge diagnosis, and co-morbidities.	**Risk Adjustment Weighting:** Eliminated	Based on feedback from several Medicaid MCPs and NCQA, the risk adjustment weighting does not produce accurate results when to applied to Medicaid populations.

All-Cause Readmissions (ACR)

Medi-Cal Managed Care Program – Statewide Collaborative Quality Improvement Project

FINAL Specifications Revised 2/21/13 - Modified from HEDIS® Specifications

Note: Plans should follow the most current HEDIS specifications each year and apply the collaborative defined modifications as outlined in this document.

Description

For members 21 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days. Data are reported in the following categories:

1. Count of Index Hospital Stays (IHS) (denominator)
2. Count of 30-Day Readmissions (numerator)

Gray Shading indicates deviation from the HEDIS®[1] specification.

Definitions

IHS	Index hospital stay. An acute inpatient stay with a discharge on or between January 1 and December 1 of the measurement year. Exclude stays that meet the exclusion criteria in the denominator section.
Index Admission Date	The IHS admission date.
Index Discharge Date	The IHS discharge date. The index discharge date must occur on or between January 1 and December 1 of the measurement year.
Index Readmission Stay	An acute inpatient stay for any diagnosis with an admission date within 30 days of a previous Index Discharge Date.
Index Readmission Date	The admission date associated with the Index Readmission Stay.

[1] HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

Eligible Population

Product line	**Medi-Cal**
Ages	**21** years and older as of the Index Discharge Date.
Continuous enrollment	**120** days prior to the Index Discharge Date through 30 days after the Index Discharge Date.
Allowable gap	**None**.
Anchor date	Index Discharge Date.
Benefit	Medical.
Event/ diagnosis	An acute inpatient discharge on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not members. Include all acute inpatient discharges for members who had one or more discharges on or between January 1 and December 1 of the measurement year. The organization should follow the steps below to identify acute inpatient stays.

Administrative Specification

Denominator The eligible population.

Step 1 Identify all acute inpatient stays with a discharge date on or between January 1 and December 1 of the measurement year.

Include acute admissions to behavioral healthcare facilities. Exclude nonacute inpatient rehabilitation services, including nonacute inpatient stays at rehabilitation facilities.

Step 2 ***Acute-to–acute transfers:*** Keep the original admission date as the Index Admission Date, but use the transfer's discharge date as the Index Discharge Date.

Step 3 Exclude hospital stays where the Index Admission Date is the same as the Index Discharge Date.

Step 4 Exclude any acute inpatient stay with a discharge date in the 30 days prior to the Index Admission Date.

Step 5 Exclude stays for the following reasons.

- Inpatient stays with discharges for death
- Acute inpatient discharge with a principal diagnosis for pregnancy or for any other condition originating in the perinatal period in Table 1.

Step 6 Calculate continuous enrollment.

Table 1: Codes to Identify Maternity Related Inpatient Discharges

Description	ICD-9-CM Diagnosis
Pregnancy	630-679, V22, V23, V28
Conditions originating in the perinatal period	760-779, V21, V29-V39

Numerator At least one acute readmission for any diagnosis within 30 days of the Index Discharge Date.

Step 1 Identify all acute inpatient stays with an admission date on or between January 2 and December 31 of the measurement year.

Step 2 ***Acute-to-acute transfers:*** Keep the original admission date as the Index Admission Date, but use the transfer's discharge date as the Index Discharge Date.

Step 3 Exclude acute inpatient hospital discharges with a principal diagnosis using the codes listed in Table 1.

Step 4 For each IHS, determine if any of the acute inpatient stays have an admission date within 30 days after the Index Discharge Date.

Reporting: *Denominator*

Count the number of IHS for the total eligible population.

Reporting: *Numerator*

Count the number of IHS with a readmission within 30 days for the total population.

Quality Improvement Project Reporting Requirements

Plans are required to report on three distinct populations for members enrolled in the plan for each county:

1. Overall readmission rate
2. Seniors and Persons with Disabilities (SPDs) readmission rate*
3. Non-SPD readmission rate

* Seniors and Persons with Disabilities are defined in Table 2.

Table 2: Aid Codes to Identify Seniors and Persons with Disabilities

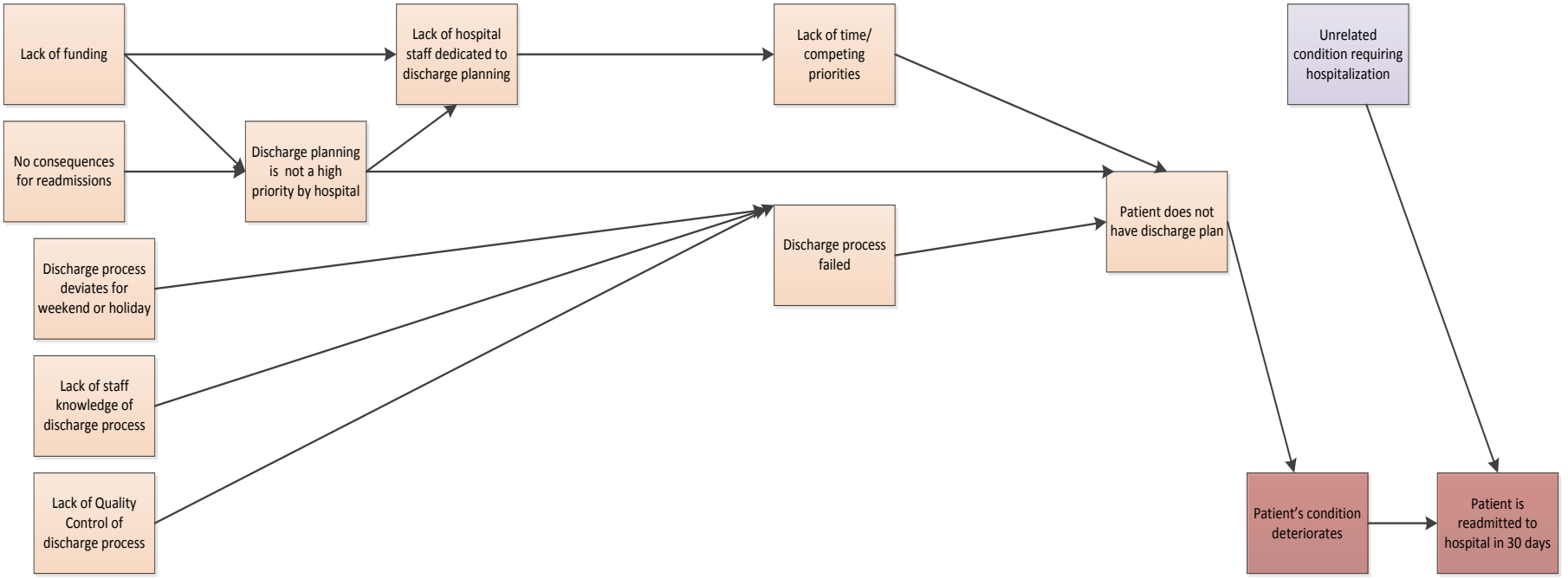
Aid Codes	Aid Code Calculated Desc (E1r)	Two Plan	GMC	COHS-1	COHS-2
10	Aged	X	X	X	X
13	Aged - LTC -SOC			X	X
14	MN Aged	X	X	X	X
16	Pickle-Aged	X	X	X	X
17	Aged - SOC			X	X
20	Blind-SSI/SSP-Cash	X	X	X	X
23	Blind - LTC			X	X
24	MN Blind	X	X	X	X
26	Pickle-Blind	X	X	X	X
27	Blind MN SOC			X	X
36	Disabled Widow/ers	X	X	X	X
60	SSI/SSP Disabled	X	X	X	X
63	Disabled - LTC - SOC			X	X
64	Disabled - MN	X	X	X	X
65	Disabled Substantial Gainful Activity/Aged, Blind, Disabled-Medically Needy IHSS *12/21/12 Update – Removed aid code 65.*			X	X
66	Pickle-Disabled	X	X	X	X
67	Disabled - SOC			X	X
1E	Eligibility for the Aged	X	X	X	X
1H	Aged-FPL Program	X	X	X	X
2E	Eligibility for the Blind	X	X	X	X
2H	Disabled - Federal Poverty Level for the Blind Prog	X	X	X	X
6A	Disabled Ad/Chld Blind	X	X	X	X
6C	Disabled Ad/Chld Disabled	X	X	X	X
6E	Eligibility for the Disabled	X	X	X	X
6G	Disabled - 250 Percent Working Disabled Program	X	X	X	X
6H	Disabled-FPL Program	X	X	X	X
6J	Pending Disability Determination	X	X	X	X
6N	No Longer Disabled Bene in Appeal (Not 6R)	X	X	X	X
6P	PRWORA/No Longer Disabled Children	X	X	X	X
6R	Potential Grandfathered SSI Disabled Children			X	X
6V	DDS Waiver	X	X	X	X
6W	DDS Regional Waiver			X	X
6X	IHO Waiver			X	X
6Y	IHO Waiver - SOC			X	X
C1	OBRA Aged Medically Needy (MN) - Aliens				X
C2	OBRA Aged MN - Aliens - SOC				X
C3	OBRA Blind MN - Aliens				X
C4	OBRA Blind MN - Aliens - SOC				X
C7	OBRA Disabled MN - Aliens				X
C8	OBRA Disabled MN - Aliens - SOC				X
D2	OBRA Aged LTC - Aliens				X
D3	OBRA Aged LTC - Aliens - SOC				X
D4	OBRA Blind LTC - Aliens				X
D5	OBRA Blind LTC - Aliens - SOC				X
D6	OBRA Disabled LTC - Aliens				X
D7	OBRA Disabled LTC - Aliens - SOC				X

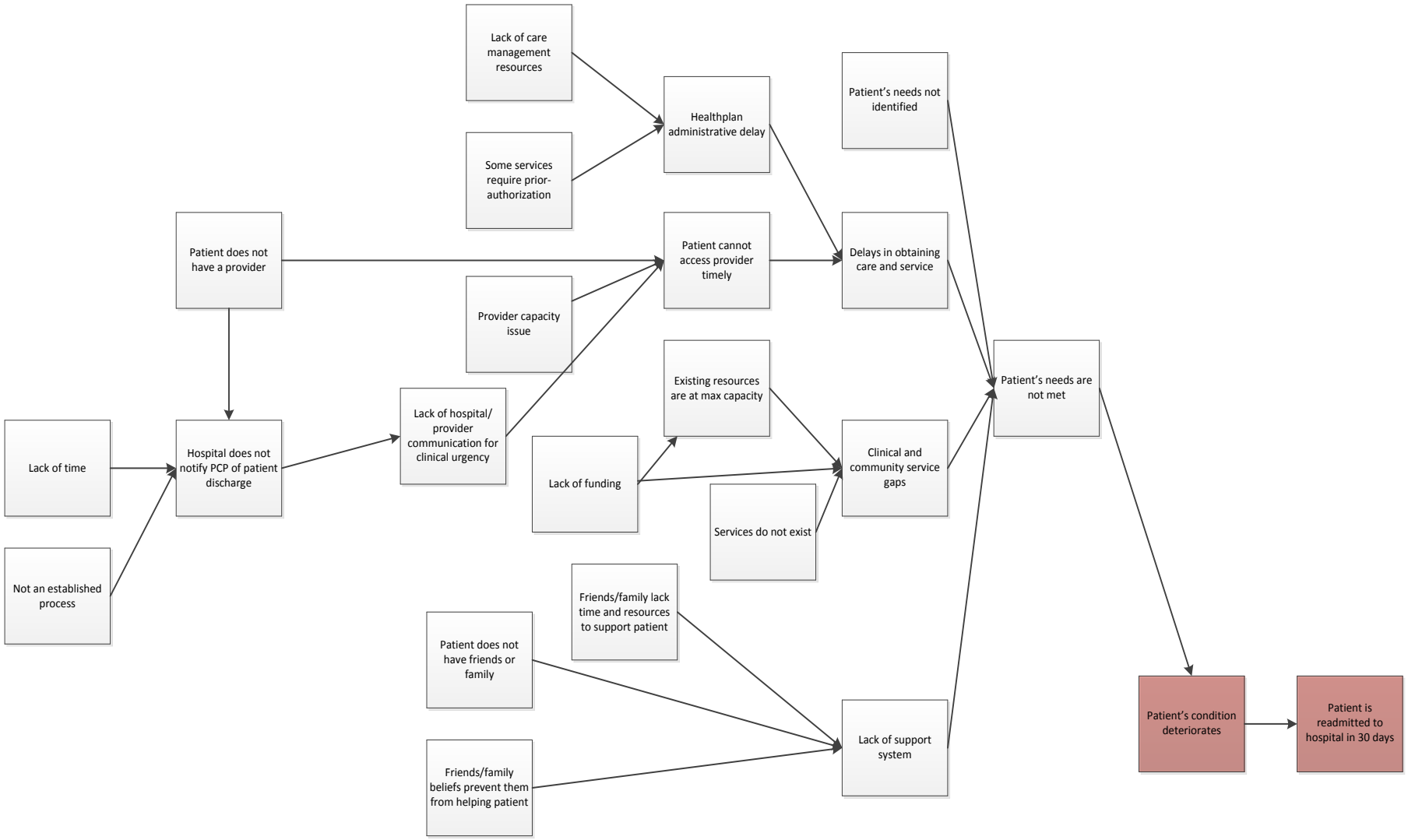
Table C.1—Statewide Collaborative QIP: *All-Cause Readmissions* Timeline
(Revised January 11, 2013)

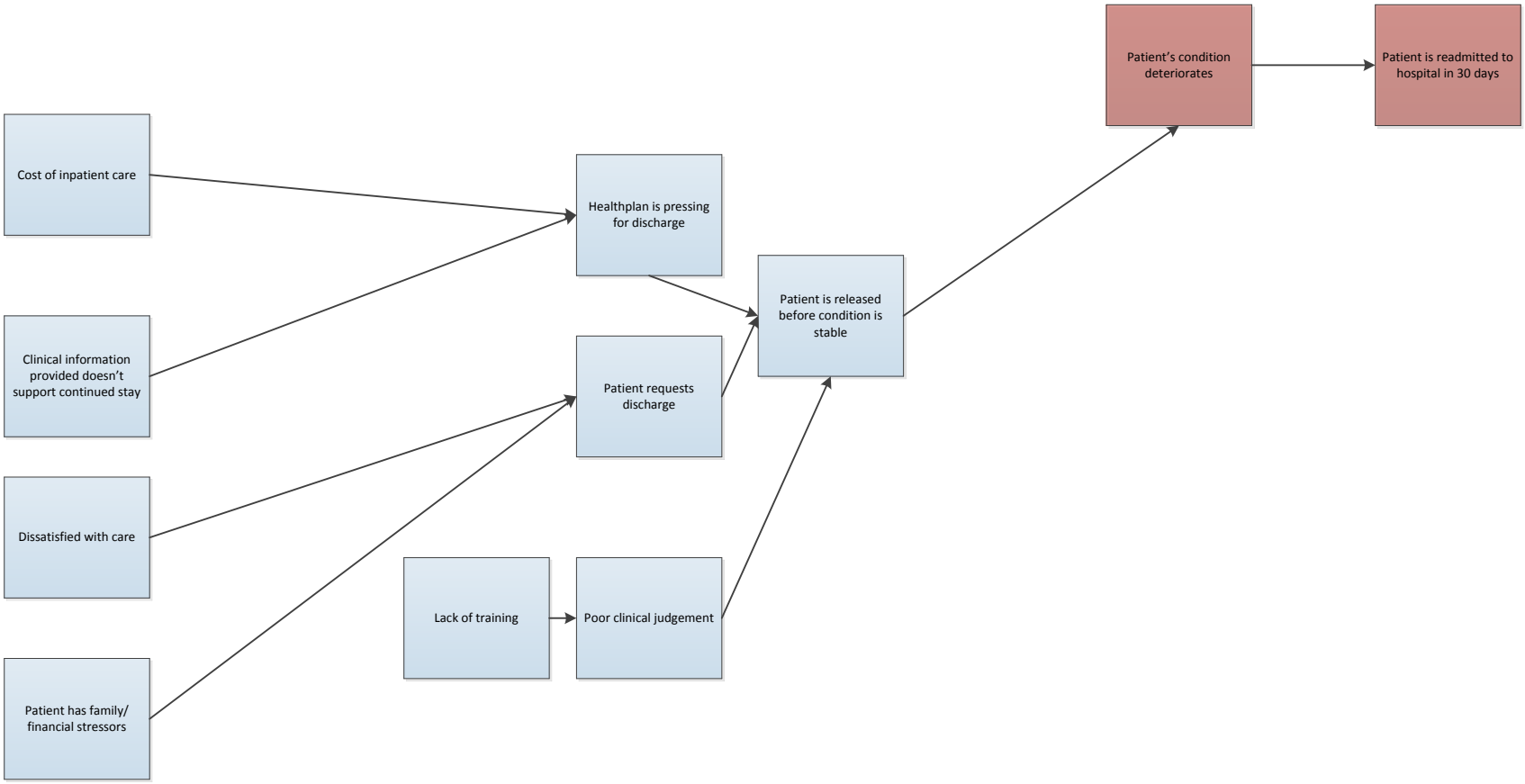
QIP Stage/ Measurement Period	Milestones	Targeted Due Date	Comments	Status
Study Design/ Pre-baseline	Kick-Off Meeting	July 21, 2011	Teleconference; see attached agenda.	Complete
	Finalize Guiding Principles	July–August 2011	Formation of a small workgroup to develop Guiding Principles.	Complete
	Review existing readmission measures and develop draft QIP measure specifications	August 31, 2011	Formation of a small workgroup to review/modify potential readmissions measures.	Complete
	Plan testing of draft measure specifications	August 31, 2011		Complete
	Provide Guiding Principles and draft measure specifications to collaborative for input/comment	September 13, 2011	Discuss measure at September Medical Directors' Meeting.	Complete
	Finalize measure specifications	October 1, 2011		Complete
	Collaborative QIP development	January–February 2012	Development of study topic background, study question, defining the study population and study indicator.	Complete
	Evaluation plan development—Oversight and Compliance	January–February 2012	Small group of subject matter experts to work with HSAG and DHCS on oversight and compliance for evaluation.	Complete
	Collaborative QIP Meeting	March 1, 2012	Provide common language for study design.	Complete
	Plans submit statewide collaborative QIP Proposal	March 30, 2012	QIP activities populated through Activity VI.	Complete
	Plans undergo performance measure audit	March–June 2012	HSAG conducts audit.	Complete
	QIP validation	April–May 2012	HSAG conducts QIP validation of plan project proposals.	Complete

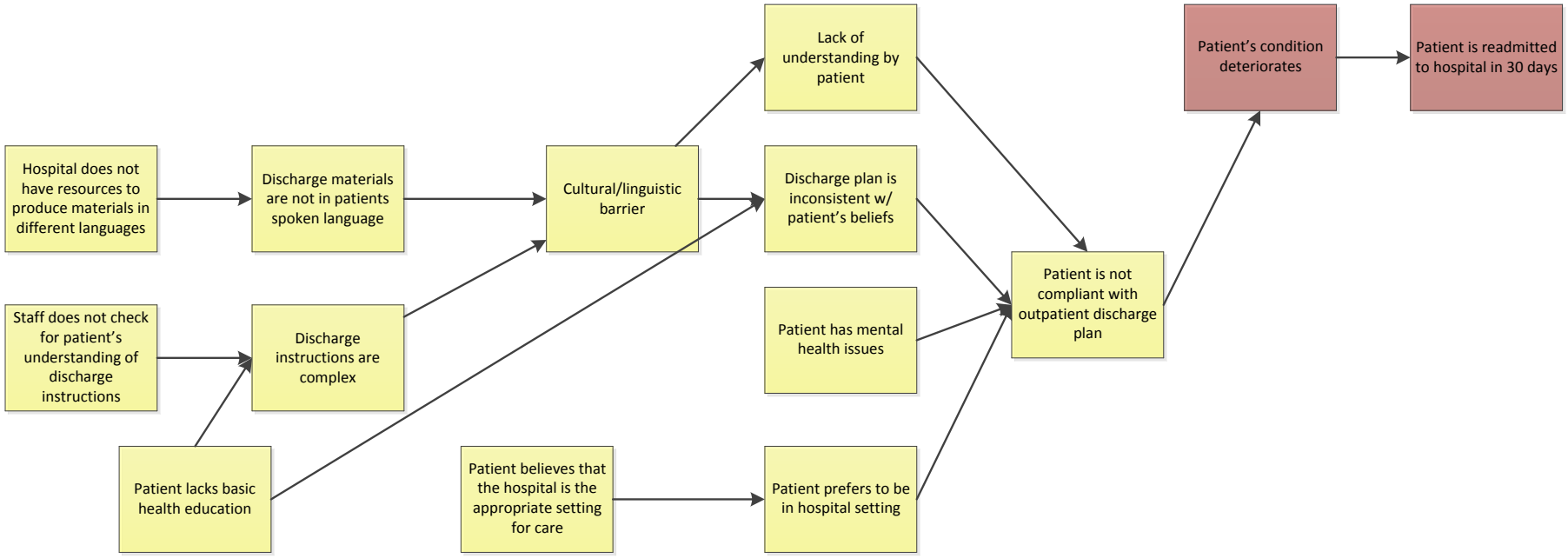
QIP Stage/ Measurement Period	Milestones	Targeted Due Date	Comments	Status
	Evaluation plan development—Logic Model	May–June 2012	Small group of subject matter experts to work with HSAG and DHCS on logic model for evaluation.	Complete
	Plans conduct barrier analysis and design interventions	July–December 2012	Plans develop interventions for January 2013 implementation.	In process
	Plans submit QIP Design stage data	September 28, 2012	HEDIS 2012 (CY 2011 data as historical data = Design stage data).	Complete
	QIP validation	October–November 2012		Complete
	Evaluation plan development	October–December 2012	Small group of subject matter experts to work with HSAG and DHCS on logic model for evaluation.	Complete
	EQRO collaborative interim report	June 2013	Initial report that details the activities of the collaborative through the Design stage.	Complete
Implementation/ Baseline	Barrier analysis and planned interventions	January 31, 2013	Plans submit their barrier analysis and planned interventions grid to HSAG for review.	Complete
	Barrier analysis and intervention feedback with plans	February 2013	HSAG provides technical assistance calls with plans to provide feedback on barrier analysis and interventions.	Complete
	Plans implement interventions	January–April 2013	Plans implement interventions early in 2013 in an effort to impact HEDIS 2014 rates.	Complete
	Health plans undergo performance measure audit	March–June 2013		Complete
	Plans submit QIP with baseline data (CY 2012)	September 30, 2013	HEDIS 2013	Complete
	QIP validation	October–November 2013	HSAG conducts validation of plans' baseline QIPs.	Complete
	EQRO Baseline Report	June 2014		Complete

QIP Stage/ Measurement Period	Milestones	Targeted Due Date	Comments	Status
Outcomes/ Remeasurement 1	Health plans undergo performance measure audit	March–June 2014		Complete
	Plans submit QIP with Remeasurement 1 data (CY 2013)	September 30, 2014	HEDIS 2014. Reflects interventions initiated beginning January 1, 2013.	
	QIP validation	October–November 2014	HSAG conducts validation of plan Remeasurement 1 QIPs.	
	EQRO's first remeasurement report	May 2015		
Outcomes/ Remeasurement 2	Health plans undergo performance measure audit	March–June 2015		
	Plans submit QIP with Remeasurement 2 data (CY 2014)	September 2015	HEDIS 2015	
	QIP validation	October–November 2015	HSAG conducts validation of plan baseline QIPs.	
	EQRO's final remeasurement report	May 2016		


Lack of funding
Lack of hospital staff dedicated to discharge planning
Lack of time/ competing priorities
Unrelated condition requiring hospitalization
No consequences for readmissions
Discharge planning is not a high priority by hospital
Patient does not have discharge plan
Discharge process deviates for weekend or holiday
Discharge process failed
Lack of staff knowledge of discharge process
Lack of Quality Control of discharge process
Patient's condition deteriorates
Patient is readmitted to hospital in 30 days


Lack of care management resources
Some services require prior-authorization
Healthplan administrative delay
Patient's needs not identified
Patient does not have a provider
Patient cannot access provider timely
Delays in obtaining care and service
Provider capacity issue
Existing resources are at max capacity
Patient's needs are not met
Lack of time
Hospital does not notify PCP of patient discharge
Lack of hospital/ provider communication for clinical urgency
Lack of funding
Clinical and community service gaps
Services do not exist
Not an established process
Friends/family lack time and resources to support patient
Patient does not have friends or family
Lack of support system
Patient's condition deteriorates
Patient is readmitted to hospital in 30 days
Friends/family beliefs prevent them from helping patient


Patient's condition deteriorates
Patient is readmitted to hospital in 30 days
Cost of inpatient care
Healthplan is pressing for discharge
Clinical information provided doesn't support continued stay
Patient is released before condition is stable
Patient requests discharge
Dissatisfied with care
Lack of training
Poor clinical judgement
Patient has family/ financial stressors


Hospital does not have resources to produce materials in different languages
Discharge materials are not in patients spoken language
Cultural/linguistic barrier
Lack of understanding by patient
Discharge plan is inconsistent w/ patient's beliefs
Staff does not check for patient's understanding of discharge instructions
Discharge instructions are complex
Patient has mental health issues
Patient is not compliant with outpatient discharge plan
Patient's condition deteriorates
Patient is readmitted to hospital in 30 days
Patient lacks basic health education
Patient believes that the hospital is the appropriate setting for care
Patient prefers to be in hospital setting

Appendix E. *All-Cause Readmissions* Barriers, Interventions, and Targets

All-Cause Readmissions QIPs			
MCP	**Priority Barriers**	**Intervention(s) to Address Barriers**	**Intervention Target(s)**
Alameda Alliance for Health	◆ Members do not receive adequate hospital discharge processes. ◆ Members do not have the ability to manage self-care. ◆ Members receive suboptimal quality of care at provider offices, in the home, or at skilled nursing facilities. ◆ Providers are unaware that Alameda Alliance for Health (AAH) is collecting data for the *All Cause Readmissions* measure. ◆ Providers are unaware of treatment guidelines that AAH supports. ◆ Providers are not complying with treatment guidelines. ◆ Members often forget to refill medications and do not have time to pick up medications every month. ◆ AAH lacks resources to identify/create additional educational materials to support quality improvement initiatives. ◆ AAH lacks resources to support clinical pharmacy improvement activities and quality improvement analysis.	Mobile Medical Examination Services (MMES) conducts home visits. The purpose of the home visit is to: ◆ Assess and compile clinical and diagnostic data from the patient for the purposes of care coordination, disease management, and education. ◆ Provide members with guidance related to specific issues to discuss with the primary care physician. ◆ Identify urgent health problems or health risks. ◆ Optimize the Centers for Medicare & Medicaid Services (CMS) Hierarchical Condition Categories (HCCs) scoring through appropriate documentation of medical records and submission of all relevant ICD-9 diagnostic codes identified during the home visit. ◆ Follow up with members who needed to be readmitted to assess the cause and effect of the readmission.	Medi-Cal members discharged from the hospital who meet the following specified criteria: ◆ Medi-Cal, In-Home Supportive Services, Alliance Complete Care. ◆ Aged 21 years and older. ◆ Exclude obstetrics (OB), elective surgeries, members seen by Healthways, chemotherapy/cancer. ◆ Exclude delegated medical groups until February 1, 2012. ◆ Focus first on members who have had readmissions in the past. ◆ In 2012, include members who were admitted for myocardial infarction, pneumonia, or heart failure. ◆ Utilization Management department to identify additional members who should be seen by MMES.

All-Cause Readmissions QIPs			
MCP	**Priority Barriers**	**Intervention(s) to Address Barriers**	**Intervention Target(s)**
Anthem Blue Cross Partnership Plan	◆ Outpatient transition of care is not supported adequately.	◆ Use a formal process to facilitate safe discharge/transition of patients from one level of care to another.	◆ Medi-Cal members who are likely to have a readmission, which is determined by using a predictive model.
	◆ Patients' needs are not met.	◆ Provide education and counseling for patients and families to enhance active participation in their own care.	
	◆ Patients leave hospital before condition is stable.	◆ Discharge planners assess the patient's family dynamics prior to the time of discharge to identify potential family or financial issues.	
CalOptima	◆ Patients do not have a discharge plan. ◆ Patients are noncompliant with discharge plan. ◆ Patients are released before condition is stable. ◆ Patients have needs that are unmet.	◆ Implemented a transitional care model program based on Eric Coleman's Care Transitions Intervention Program. Members in the target population are invited to participate in the no-cost program which includes a home visit, follow-up calls, and possible referrals. Members who decline a home visit are offered coaching via telephone. ◆ Members who decline participation in the transitions of care program are sent a discharge kit that includes a personal health record, medication lists, a medication pillbox, health education material, and resources.	Transitions of Care Program ◆ Adult Medi-Cal members diagnosed with congestive heart failure (CHF) and end stage renal disease, and discharged from three select hospitals/facilities. Discharge Kit ◆ Adult Medi-Cal members who declined participation in the transitions of care program. ◆ Adult Medi-Cal members diagnosed with CHF and end stage renal disease, and discharged from hospitals/facilities other than the three hospitals/facilities selected for the transitions of care program.

All-Cause Readmissions QIPs			
MCP	**Priority Barriers**	**Intervention(s) to Address Barriers**	**Intervention Target(s)**
CalViva Health	◆ Lack of timely follow-up appointment after discharge. ◆ Patients lack understanding of the importance of taking medications as prescribed (medication adherence). ◆ Patients lack the knowledge of which previously prescribed medications are to be taken regularly after discharge and when to take newly prescribed medications (medication reconciliation). ◆ Patients lack social, emotional, and physical support after discharge (e.g., transportation to follow-up appointment).	◆ Implemented a transitional care model program using the Coleman Care Transition Intervention as the underlying foundation. ◆ Implemented an ambulatory case management program to focus on transition of care and continuity of care. ◆ Interactive voice response (IVR) calls are made to members who are hospitalized for any condition to encourage them to call their providers and/or the Nurse Advice Line for any questions about their care and to set up follow-up appointments with their PCP.	◆ Medi-Cal members
	◆ Hospitals have inadequate discharge plans.	◆ Placed on-site case managers at high-volume hospitals. ◆ Distributed the Agency for Healthcare Research and Quality (AHRQ) Taking Care of Myself Guide to hospitals and providers to distribute to patients prior to discharge.	
	◆ MCPs are not fully aware of the patients' discharge plans and there is a lack of coordinated communication between hospitals, participating physician groups (PPGs), primary care physicians (PCPs), and MCPs.	◆ Placed on-site case managers at high-volume hospitals.	
	◆ Patients with chronic conditions may not be adequately educated about their illness.	◆ Expanded the Disease Management Program and education to include other chronic conditions. ◆ Distributed AHRQ's Taking Care of Myself Guide to hospitals and providers to distribute to patients prior to discharge.	

All-Cause Readmissions QIPs			
MCP	**Priority Barriers**	**Intervention(s) to Address Barriers**	**Intervention Target(s)**
Care1st Partner Plan	◆ Lack of member follow-up after discharge from the hospital. ◆ Lack of providers' notification that their patient was admitted and for what conditions. ◆ Lack of understanding of what medications were changed or prescribed and assurance that member and medication reconciliation will be mailed to the PCP or provider doing the follow-up prior to the appointment with instructions to review, follow up, and record in the member's record.	Discharge Planning ◆ Select hospitals have on-site hospitalist and in-house case management. ◆ Case management and discharge planning start when the member is admitted to any of the select hospitals. ◆ Case manager is assigned, social services goals are set, and a plan is developed to assess triggers for readmission and barriers to prevent another admission. ◆ Assure all members being discharged have a follow-up appointment with their PCP or specialist scheduled within seven days of discharge. ◆ Assure that full medication reconciliation is completed with the PCP within seven days of discharge. Assuring Members Follow Up with PCP ◆ Case manager or coordinator places a reminder call to the member the day prior to the scheduled PCP or specialist follow-up appointment. ◆ Follow-up call is made to member after the PCP or specialist visit to confirm the member was seen and if not, the appointment is rescheduled. ◆ Free transportation is arranged for members who need it.	◆ Select hospitals ◆ Medi-Cal members ◆ PCPs/specialists

All-Cause Readmissions QIPs			
MCP	**Priority Barriers**	**Intervention(s) to Address Barriers**	**Intervention Target(s)**
CenCal Health	◆ Patients lack access to PCPs after hospital discharge.	◆ Implemented a PCP Incentive payment process to reimburse providers for the extra time needed to accommodate access to timely (within 72 hours) appointment for discharged members. ◆ Developed intradepartmental collaboration to facilitate PCP appointment scheduling for members requiring assistance, letter notification for members unable to be reached by telephone, provider services promotion and training of PCPs, and claims reports and payments. ◆ Established readmission agreement with large federally qualified health center (FQHC) PCP clinic system to perform outreach to its members and be incentivized by reducing its readmission rates. ◆ Developed a process (fax/e-mail) to notify PCPs within 24 hours of their members being discharged from hospitals so they can perform outreach and increase access to timely appointments. Discharge summaries are provided to PCPs as part of the process.	◆ PCPs
	◆ Lack of post-discharge care transition and utilization of community resources/support.	◆ Conduct weekly utilization management/case management departmental meetings to discuss high-risk cases and monthly utilization management/case management metrics meetings to discuss readmission rates, community-based resources, and resource voids (homeless, mental health). ◆ Hired one full-time position, a health services representative, to work with community providers and external agencies on behalf of CenCal in matters pertaining to high-risk members. The staff member is based primarily at a high-volume, mid-county hospital.	◆ MCP ◆ A high-volume hospital

All-Cause Readmissions QIPs			
MCP	**Priority Barriers**	**Intervention(s) to Address Barriers**	**Intervention Target(s)**
	◆ Lack of information sharing with PCPs, community resource liaisons, and hospital discharge planners.	◆ Refined the process to identify members discharged from in- and out-of-area hospitals and to monitor cases using Essette case management software.	◆ Medi-Cal members ◆ PCPs ◆ Community liaisons ◆ Hospitals
Central California Alliance for Health	◆ Lack of PCP follow-up care post-discharge within 14 days. ◆ Members with chronic conditions are at higher risk for readmission and have poor outcomes in the transition from hospital to home. ◆ Members' lack of understanding on how to manage medication regimen.	Alliance Telephonic Care Transitions Program ◆ Conduct telephonic assessment post-discharge with all members in Santa Cruz and Merced counties who have a diagnosis of heart failure, myocardial infarction, diabetes, asthma, or pneumonia. The call includes verification of a PCP follow-up appointment within 14 days after discharge, medication inventory, an advanced care plan, and a member satisfaction survey. ◆ A second telephone call is made after the 14-day follow-up appointment to do a medication inventory and assess for any additional needs. Alliance Home Visit Care Transitions Pilot Program ◆ Readmitted members discharged from Monterey County hospitals with a diagnosis of heart failure, myocardial infarction, diabetes, asthma, or pneumonia are visited by a Visiting Nurse Association (VNA) nurse within 72 hours of the hospital discharge. The nurse verifies that the member has a follow-up visit scheduled with his/her PCP within 14 days of the discharge, completes a medication reconciliation, completes an advanced care plan, and conducts a member satisfaction survey. ◆ A second VNA visit after the PCP visit occurs to conduct another medication reconciliation and assess for any additional needs.	◆ Medi-Cal members with a diagnosis of CHF, myocardial infarction, diabetes, asthma, or pneumonia

All-Cause Readmissions QIPs			
MCP	**Priority Barriers**	**Intervention(s) to Address Barriers**	**Intervention Target(s)**
	◆ Lack of PCP follow-up care post-discharge within 14 days. ◆ Lack of MCP notifying PCPs of member inpatient admissions.	◆ Implemented the process to send a fax to the PCP when the member has an inpatient admission. The fax includes the member's 90-day readmission history and a reminder that the member will need a follow-up appointment within 14 days.	◆ PCPs ◆ MCP
Community Health Group Partnership Plan	◆ Members are not getting their discharge medications.	◆ A local pharmacy delivers the medications to the members immediately after discharge or while the member is still at the hospital.	◆ Medi-Cal members with diabetes, asthma, CHF, or chronic obstructive pulmonary disease (COPD) who have had three acute care admissions within a 12-month period and are enrolled in the Multiple Admitters Program (MAP+)
	◆ Members do not understand the post - discharge instructions.	◆ Members have a home health nurse visit within one day of discharge to review post-discharge instructions/medications.	
	◆ Members do not follow up with their PCPs post-discharge.	◆ A complex case management case manager contacts the members to facilitate follow-up with their PCP.	
	◆ Members do not have the resources to provide for non-covered services.	◆ Provide non-covered services that will have a positive impact on a member's condition or to prevent the worsening of an existing condition.	
	◆ The MCP is unable to validate the true risk levels of members telephonically or via mail.	◆ Conduct home visits to engage members and complete a form developed by the case managers to obtain basic information about the members and to assist in coordinating follow-up care post-discharge.	
Contra Costa Health Plan	◆ Lack of care coordination. ◆ Limited care management resources. ◆ Inconsistency in the discharge process. ◆ Patients do not understand how to navigate the health care system.	◆ Established a call center with a nurse available during the week days to assist discharging staff at area hospitals to ensure that all required services and follow-up care are arranged before the patient is discharged. ◆ Implemented having a nurse call all patients discharged from the county hospital to ensure they have all of their care needs met.	◆ Medi-Cal members discharged from the hospital ◆ Discharging staff at area hospitals

All-Cause Readmissions QIPs			
MCP	**Priority Barriers**	**Intervention(s) to Address Barriers**	**Intervention Target(s)**
	◆ Limited care management resources. ◆ Deficiencies in the discharge process. ◆ Patients do not know how to obtain help. ◆ Lack of proactive patient engagement. ◆ Members become weaker as a result of inpatient stays.	◆ Implemented a new initiative to provide a family nurse practitioner to round on members in skilled nursing facilities and be available to go to skilled nursing facilities when a potential need to prevent readmissions is identified.	◆ Medi-Cal members in skilled nursing facilities
Gold Coast Health Plan	◆ The patient is not seen for a follow-up appointment with the physician between discharge and readmission.	◆ MCP staff members call or visit patients 24–72 hours after discharge to ensure the members made/kept their follow-up appointment.	◆ Medi-Cal members discharged from the hospital
	◆ Staff does not check for patients' understanding of discharge instructions. ◆ The discharge plan is inconsistent with the patient's belief. ◆ Discharge instructions are complex. ◆ The patient disagrees with treatment.	◆ MCP staff call or visit patients 24–72 hours after discharge to ask if discharge instructions are understood and to explain the discharge instructions further.	
	◆ Patients do not understand proper use of their medication or do not fill the prescription. ◆ Patients do not have transportation.	◆ MCP staff will call or visit patients 24–72 hours after discharge to ask if the members filled their prescriptions.	
	◆ Patients do not understand proper use of their medication or do not fill the prescription. ◆ Staff members do not check for patients' understanding of the discharge instructions.	◆ MCP staff will call or visit patients 24–72 hours after discharge to ask how medications are taken to see if members understand and are complying.	
	◆ The hospital has limited resources (written materials, educational staff, etc.).	◆ MCP staff will call or visit patients 24–72 hours after discharge to send/provide additional educational material if needed/requested.	
	◆ Assessment of language and/or education barrier.	◆ MCP staff will call or visit patients 24–72 hours after discharge and provide education in a way that addresses language or educational barriers.	

All-Cause Readmissions QIPs			
MCP	**Priority Barriers**	**Intervention(s) to Address Barriers**	**Intervention Target(s)**
Health Net Community Solutions, Inc.	◆ Patients with chronic conditions are high utilizers of health care.	◆ Expanded current disease management program to include COPD, CHF, and coronary artery disease (CAD). ◆ Weekly, the MCP identifies members admitted and discharged from a hospital and the members receive an IVR reminder call advising them to make a follow-up appointment with their PCP within seven days of discharge and to call their PCP or the Nurse Advice Line for any health care needs or questions. ◆ Each week, members discharged from a hospital who have a CHF or COPD diagnosis are sent disease-specific educational materials and a notice advising them to call their doctor for a follow-up appointment with tips to discuss during their follow-up visit.	◆ Medi-Cal members with chronic conditions
	◆ Members lack timely follow-up appointment after discharge.	◆ Implemented the Transition of Care Management program. The MCP uses an advanced analytics program to identify members who are at high risk for readmission, and the high-risk members are contacted by case managers for assessment of their condition and provision of support and education. ◆ Weekly, the MCP identifies members admitted and discharged from a hospital and the members receive an IVR reminder call advising them to make a follow-up appointment with their PCP within seven days of discharge. ◆ Each week, members discharged from a hospital who have a CHF or COPD diagnosis are sent disease-specific educational materials and a notice advising them to call their doctor for a follow-up appointment with tips to talk about	◆ Medi-Cal members ◆ High-volume hospitals, PPGs, and PCPs

All-Cause Readmissions QIPs			
MCP	**Priority Barriers**	**Intervention(s) to Address Barriers**	**Intervention Target(s)**
		during their follow-up visit. ◆ High-volume hospitals, PPGs, and PCPs that participated in a previous survey and requested an educational booklet for patients on what to do when they are discharged from a hospital were sent the booklet along with information on how to order more copies. The MCP also sent a flyer it produced advising members on what to discuss in the follow-up appointment.	
	◆ Members lack understanding of the importance of taking medications as prescribed (medication adherence).	◆ Coordinated a medication adherence program for members diagnosed with hyperlipidemia, hypertension, diabetes, asthma, and COPD. Members who were prescribed medications specific to their conditions but have not had their prescriptions filled are sent reminder letters to have the prescriptions filled or to call their physicians. Providers of members who continue to not have their prescriptions filled after receiving the reminder letter are notified and encouraged to contact their patients. ◆ The MCP plans to coordinate a program to reconcile newly prescribed medications from the hospital with members' other medications once the member is discharged from the hospital. Instructions to members will include medication dosage, frequency, and importance of taking their medications as prescribed. ◆ Weekly, the MCP identifies members admitted and discharged from a hospital and the members receive an IVR reminder call advising them to make a follow-up appointment with their PCP to review their previous and current medications and to ask questions about their care.	◆ Medi-Cal members with a diagnosis of hyperlipidemia, hypertension, diabetes, asthma, or COPD ◆ Providers

All-Cause Readmissions QIPs			
MCP	**Priority Barriers**	**Intervention(s) to Address Barriers**	**Intervention Target(s)**
	◆ PPGs lack an effective program to reduce hospital readmissions.	◆ Developed a program to identify PPGs with high rates of readmissions and ensure the members with high rates of readmissions from these PPGs receive the IVR call and appropriate educational materials. Additionally, notify the PPGs when their patients are discharged to encourage the PPGs to contact the member for a follow-up appointment within seven days of discharge. ◆ Implemented the Transition of Care Management program. The MCP uses an advanced analytics program to identify members who are at high risk for readmission, and the high-risk members are contacted by case managers for assessment of their condition and to be provided support and education.	◆ Medi-Cal members ◆ Providers
	◆ Cultural, age, or gender barriers may be drivers for hospitalizations.	◆ Weekly, the MCP identifies members admitted and discharged from a hospital, and the members receive an IVR reminder call advising them to make a follow-up appointment with their PCP within seven days of discharge. The MCP works with the IVR vendor to use methods found to be successful with specific populations.	◆ Medi-Cal members
	◆ Lack of timely admission and discharge reporting.	◆ Implemented a process to obtain weekly updated lists of members in the disease management program and members admitted and discharged from the hospital to ensure timely interventions are implemented. ◆ MCP sent a provider update to all contracted hospitals reminding them to send admission and discharge information of all Health Net members who are admitted to and discharged from their facilities within 24 hours.	◆ MCP ◆ Hospitals

All-Cause Readmissions QIPs			
MCP	**Priority Barriers**	**Intervention(s) to Address Barriers**	**Intervention Target(s)**
	◆ Members lack knowledge of which previously prescribed medications are to be taken regularly after discharge and when to take newly prescribed medications.	◆ The MCP plans to develop a program to coordinate medication reconciliation among members who have been discharged from the hospital. Members/caregivers will be educated about medication dosage, frequency, side effects and contraindications, and the importance of taking medications as prescribed. ◆ Weekly, the MCP identifies members admitted and discharged from a hospital, and the members receive an IVR reminder call advising them to make a follow-up appointment with their PCP to review their current medications.	◆ Medi-Cal members
	◆ Lack of coordinated communication among providers of health care such as health plan, hospital, PPG, and PCP.	◆ Implemented a process to obtain weekly updated lists of members in the disease management program and members admitted and discharged from the hospital to ensure timely interventions are implemented. ◆ MCP sent a provider update to all contracted hospitals reminding them to send admission and discharge information of all Health Net members who are admitted to and discharged from their facilities within 24 hours.	◆ Medi-Cal members ◆ Hospitals
Health Plan of San Joaquin	◆ Members with behavioral health and/or substance use disorder issues negatively impact the transition of care.	◆ Implemented a transitional care behavioral health intervention program that includes a mental health specialist seeing the members while they are in the acute care setting. Additionally, the mental health specialist joins the nurse practitioner on home visits to follow up with recently discharged members.	◆ Medi-Cal members with behavioral health and/or substance use disorder issues
	◆ Lack of in-home monitoring of high-risk members leads to more readmissions.	◆ Implemented a pilot biometric outreach program which allows for in-home monitoring of high-risk members.	◆ Medi-Cal members identified as high risk

All-Cause Readmissions QIPs			
MCP	**Priority Barriers**	**Intervention(s) to Address Barriers**	**Intervention Target(s)**
Health Plan of San Mateo	◆ Non-SPD members are not receiving notification after discharge about the importance of receiving follow-up care.	◆ Send notifications by mail to non-SPD members within two weeks of discharge that highlight the need for them to contact their PCP for follow-up and include contact information for the MCP's care coordination department.	◆ Medi-Cal non-SPD members
	◆ PCPs are not notified when their Medi-Cal members are admitted or readmitted to a hospital.	◆ Implemented a process to send quarterly reports to PCPs with the highest rates of readmissions.	◆ PCPs with members who have the highest rates of readmissions
Inland Empire Health Plan	◆ Members admitted to the hospital are not identified and PCPs are not notified of the admissions in a timely manner. ◆ The MCP has inadequate staffing in the transition of care department. ◆ There is a lack of identified and targeted interventions for members at high risk of readmissions. ◆ The MCP does not have a home visit program as recommended by the Eric Coleman model that services all areas. ◆ The MCP has challenges addressing the needs of the dual diagnosis members. ◆ There is a higher readmissions rate for members discharged with medication discrepancies.	◆ Developed a process to provide timely notification to PCPs of their members' admissions and discharges, including notification of medications at discharge. ◆ Enhanced the transitions of care program for all lines of business by staffing appropriately, developing an identification process to identify members at high risk for readmissions, developed targeted interventions for members transitioning from one setting to another, and addressing members' behavioral health issues. ◆ Created *Knowmymeds* portal for the MCP and providers to conduct medication reconciliation.	◆ PCPs ◆ MCP ◆ High-risk Medi-Cal members ◆ Transitioning Medi-Cal members

All-Cause Readmissions QIPs			
MCP	**Priority Barriers**	**Intervention(s) to Address Barriers**	**Intervention Target(s)**
Kaiser–Sacramento County	◆ Patients, families, and caregivers lack understanding about health conditions and medications to be taken post discharge.	◆ Transition Care Pharmacist (TCP) in hospital focuses on high-risk patients (defined as those with transition concern) and conducts medication reconciliations and bedside patient education to ensure understanding of current and new medications. Performed by hospital-based pharmacist. Teaching is tailored to patient/family need.	◆ High-risk Medi-Cal members
	◆ Patients, families, or caregivers lack understanding about health conditions and symptoms and when to contact the physician to avoid condition deteriorating.	◆ Registered nurse discharge planner or hospital-based physician calls high-risk patients within 48 hours of discharge to follow up on key items in the plan of care that are essential to keep the patient safely at home. The conversation is tailored to address the member's specific discharge instructions/plan and transition to home.	◆ High-risk Medi-Cal members
	◆ Patients do not consistently have follow-up appointments. Patients/families are unsure what follow-up is needed or who to contact for questions after discharge.	◆ Prior to discharge, Adult Services (Medicine) patients discharged to home have an appointment scheduled within seven days, maximum. The appointment information is included in the printed discharge instructions and a reminder is given to the member based on member preference (i.e., automated telephone call, via e-mail, or via text).	◆ Adult Services Medi-Cal members

All-Cause Readmissions QIPs			
MCP	**Priority Barriers**	**Intervention(s) to Address Barriers**	**Intervention Target(s)**
Kaiser–San Diego County	◆ Patients discharged from hospital often lack an understanding of discharge instructions and medication management, have poor family support, and are uncertain about disease management and signs/symptoms to report.	◆ Established the Bridge Clinic pilot. The clinic is staffed with a physician and social worker offering an enhanced one-hour visit instead of the customary 20-minute visit. Patients are seen within seven days of discharge.	◆ High-risk Medi-Cal members based on a scoring system that factors in hospital length of stay, acuity of admission, comorbidity burden, and the number of emergency department visits within the last six months
	◆ Patients discharged from hospital often do not have a clear understanding of medication management, the disease process, and when it is appropriate to go to the emergency department. High-risk patients may require complex case management. ◆ There is a culture of sending high-risk patients to the emergency department prematurely.	◆ Home health visits are conducted within 24 hours of discharge.	◆ High-risk Medi-Cal members based on a scoring system that factors in hospital length of stay, acuity of admission, comorbidity burden, and the number of emergency department visits within the last six months
	◆ Patients do not have adequate follow-up or support and may not have necessary medication or durable medical equipment after discharge.	◆ Based on risk level, a post-discharge call is made to all high-risk patients to ensure appointments are made, address medication issues, confirm durable medical equipment has been delivered, and confirm that home health has contacted or seen the patient.	◆ High-risk Medi-Cal members based on a scoring system that factors in hospital length of stay, acuity of admission, comorbidity burden, and the number of emergency department visits within the last six months
	◆ Patients go home without medications and many do not appreciate the importance of medications.	◆ Pharmacists provide education and medication reconciliation at the member's bedside prior to discharge. The pharmacists also sell necessary medications and offer medical financial assistance to members who cannot afford their medications.	◆ High-risk Medi-Cal members based on a scoring system that factors in hospital length of stay, acuity of admission, comorbidity burden, and the number of emergency department visits within the last six months

All-Cause Readmissions QIPs			
MCP	**Priority Barriers**	**Intervention(s) to Address Barriers**	**Intervention Target(s)**
Kern Family Health Care	◆ Communication ▪ Lack of standardized process and coordination ▪ Sharing of member information ▪ Pre- and post-medication discrepancies ▪ Lack of prompt discharge follow-up ◆ People ▪ Member education/understanding of discharge instructions ▪ Staffing ◆ Infrastructure ▪ Lack of workflow processes ▪ Different systems/different processes ▪ Connectivity ◆ Environment ▪ Health Status ▪ Access ▪ Socioeconomics ▪ Transportation ▪ Location ◆ Research and Reporting ▪ Best Practices ▪ Benchmarks ▪ Assessment ▪ Reporting ◆ Policies and Procedures ▪ Contracts ▪ Approved Policies ▪ Hospital Collaborative	Implement Comprehensive Transition of Care Pilot Program ◆ Medication Therapy Management ▪ Medication reconciliation ▪ Potential interactions and patient education ◆ Discharge Advocate ▪ Standardize comprehensive discharge planning (assist with arranging appointment, transportation, and durable medical equipment) ◆ Post Discharge Clinic and Home Visit Program ▪ 2–3 day follow-up clinical re-evaluation and additional care coordination ◆ Health Coach ▪ Self-management ▪ Symptom recognition ▪ Post-discharge care plan ▪ Follow-up compliance	◆ Highest-volume hospital with high percentage of Medi-Cal SPD member readmissions

All-Cause Readmissions QIPs			
MCP	**Priority Barriers**	**Intervention(s) to Address Barriers**	**Intervention Target(s)**
L.A. Care Health Plan	◆ SPDs have higher risk for readmissions. ◆ Members in standard delegation for L.A. Care concurrent review have higher risk for readmission. ◆ Existing resources are at maximum capacity. ◆ There are a limited number of staff members dedicated to discharge planning. ◆ There are limited care management resources. ◆ There are administrative delays getting admission and discharge notifications from hospitals. ◆ Hospital does not notify PCPs when members are discharged. ◆ PCPs are unaware of the hospitalization and therefore cannot follow up with the patient. ◆ PCP follow-up appointments are not scheduled. ◆ Members lack transportation. ◆ Members do not have timely access to a provider. ◆ Members do not fill their prescriptions.	Implemented a transition of care program that provides targeted case management and care coordination for members while they are in the hospital through 30 days post-discharge from the facility. The intervention takes a member-centered approach to identifying barriers and coordinating post-discharge care, and brings together an interdisciplinary team. For at-risk patients, this team includes transition of care nurses, care coordinators, social workers, primary care providers, disease management nurses and coordinators, behavioral health specialists, pharmacists, and long-term supports and services specialists. The members are stratified into three categories—high risk, moderate risk, and low risk—and receive different levels of interventions, including: ◆ Prior to discharge of high- and moderate-risk members, the transition of care team will regularly assess the interdisciplinary care plan for updates, ensure the PCP follow-up appointment is scheduled, and notify and connect with the PPG to ensure coordination of care. ◆ Within 24 hours post-discharge of high- and moderate-risk members, the transition of care team will conduct medication reconciliation, assist with scheduling follow-up appointments, identify post-discharge special needs, identify the member's support network, address advance directive needs, and establish member-specific goals and objectives. ◆ Seventy-two hours post-discharge of high-risk members, the transition of care team will	◆ Medi-Cal members at risk for readmission

All-Cause Readmissions QIPs			
MCP	**Priority Barriers**	**Intervention(s) to Address Barriers**	**Intervention Target(s)**
		confirm medication compliance; conduct an initial assessment of internal referrals to long-term supportive services, social service, and disease management; and assure no transportation barriers exist. ◆ Seven days post-discharge: ▪ For high- and moderate-risk members, the transition of care team will assess for needs identified at the follow-up visit; include the caregiver in the post-discharge process, if applicable; assess the need for and establish internal network referrals and notify the member of potential telephone contact by a transition of care team member; assess for medication compliance; address the member's goals and progress; and confirm that needed external services have been completed or remain in progress. ▪ For low-risk members, the transition of care team will make a follow-up telephone call to the members to facilitate post-discharge PCP follow-up. ◆ Fourteen days post-discharge for high- and moderate-risk members, the transition of care team will address initial barriers and secure resolution to barriers (e.g., meals on wheels, pharmacy delivery service), conduct medication reconciliation of initial and changed medications, assure the member was contacted by an L.A. Care team member regarding needed internal services, and address the member's short-term goals and progress toward success. Additionally, the team will ensure that all external follow-up care occurred for high-risk members.	

All-Cause Readmissions QIPs			
MCP	**Priority Barriers**	**Intervention(s) to Address Barriers**	**Intervention Target(s)**
		◆ Thirty days post-discharge for high- and moderate-risk members, the transition of care team will transition the member to complex case management; conduct final medication reconciliation; notify the member that internal referrals for care will continue, if needed; contact the primary caregiver and inform them of the member's status; and review future medical appointments with the member, including giving them a calendar for reference and the PCP/specialist contact information. Additionally, the transition of care team will reassess high-risk members for high-risk factors to determine whether immediate attention is required for any issues.	
Molina Healthcare of California Partner Plan, Inc.	◆ Failed or unsafe discharges.	◆ Inpatient review rounds with the MCP's medical director and utilization management staff to discuss members currently hospitalized. Members are identified for case management prior to hospital discharge.	◆ MCP
	◆ Hospitals provide inadequate discharge plans. ◆ Medications are not adequately reconciled. ◆ Members/caregivers are unaware of discharge instructions from hospital.	◆ The case manager makes a "Welcome Home Call" to the member within 24 hours of discharge. The purpose of the call is to determine that discharge instructions were understood and that the follow-up appointment was made with the PCP.	◆ Dual-eligible members and members with complex needs
	◆ There is finite funding.	◆ Improved budgetary management resulting in cost savings from improved member services management.	◆ MCP
	◆ There is an emphasis on short inpatient length of stay and members being discharged before their conditions are stable.	◆ Health plan care transitions clinicians advocate for the members to ensure appropriate, timely, and safe discharges.	◆ MCP

All-Cause Readmissions QIPs			
MCP	**Priority Barriers**	**Intervention(s) to Address Barriers**	**Intervention Target(s)**
	◆ Care coordination is inadequate. ◆ There is inadequate follow-up of members once they are discharged from an inpatient setting. ◆ Discharge planning is inadequate.	◆ Conduct Interdisciplinary Care Team meetings with the MCP's medical directors and care/case managers to address all aspects of members' health care, including medical, behavioral, and social health needs. Care transition clinicians will communicate discharge plans to physicians and other community service providers to ensure appropriate follow-up care of members after discharge. The MCP will encourage members to be active participants in their own care.	◆ MCP
	◆ There is a workforce shortage.	◆ The MCP will hire five more care/case managers plus community health workers and support staff as needed.	◆ MCP
	◆ Discharged members are not assigned to case managers timely.	◆ The MCP reorganized discharged member assignment to care/case managers to promote timely care coordination and discharge follow-up.	◆ MCP
	◆ PCPs are unaware of patients' issues and case management care plan.	◆ Upon admission to the MCP case management program, there is timely verbal and written communication of member issues, interventions, and medication adjustments to the PCP.	◆ MCP
	◆ Hospitals report workforce shortages, including inadequate discharge planning staff in numbers and quality.	◆ MCP assumes much more responsibility for its members' discharge planning.	◆ Hospitals
	◆ There is finite funding.	◆ The MCP will renegotiate hospital contracts at renewal time.	◆ Hospitals
	◆ There are no consequences for readmissions: Medi-Cal and Medicare pay for unlimited inpatient stays.	◆ Implement value-based, bundled payment system for hospitals at time of contract renewal.	◆ Hospitals
	◆ Discharge planning is not a priority for hospitals.	◆ The MCP assumes responsibility for its members' discharge planning and leads by example.	◆ Hospitals

All-Cause Readmissions QIPs			
MCP	**Priority Barriers**	**Intervention(s) to Address Barriers**	**Intervention Target(s)**
	◆ Hospitals do not notify PCPs of patients' admission or discharge.	◆ MCP notify PCPs of members' admission and discharge and provide discharge plan to the PCPs.	◆ Hospitals
	◆ Hospital does not provide adequate health teaching with patient prior to inpatient discharge	◆ MCP's transition of care coaches assume more responsibility for members' health teaching.	◆ Hospitals
	◆ Patient has no pharmacist contact for medication education prior to discharge.	◆ MCP's transition of care coaches use in-house pharmacy staff to assist in member education regarding medications.	◆ Hospitals
	◆ There is a lack of communication between hospitals and the MCP regarding discharge plans.	◆ MCP case managers initiate and maintain communication with hospital personnel regarding the patients' discharge plans.	◆ Hospitals
	◆ Patients are discharged on the weekend without involvement from the MCP.	◆ MCP has on-call discharge staff available after hours, on weekends, and on holidays to facilitate safe discharges.	◆ Hospitals
	◆ PCPs are unable to see discharged members in a timely manner.	◆ MCP transition of care coaches facilitate timely post-discharge PCP visit.	◆ PCPs
	◆ PCPs are unable to devote sufficient time to members during post-discharge office visits.	◆ MCP transition of care coaches and provider relations staff educate PCPs and their staff regarding the post-discharge visit and division of labor to maximize the PCP's time.	◆ PCPs
	◆ Members lack funds to afford medications and/or costs of other services.	◆ MCP's clinicians work with PCPs to ensure use of the fewest medications and use of generics medications. MCP pharmacy staff members are involved in care and authorize full coverage of required medications if needed.	◆ Members
	◆ Members lack caregiver and/or social support at home.	◆ Care managers arrange for in-home support services so members receive required care in the community. Community health workers are assigned to members to provide social support.	◆ Members
	◆ Members lack transportation for health care purposes. Members do not realize transportation service is a covered benefit.	◆ Care managers, community connectors, or member services staff assist members in receiving all transportation related to health care.	◆ Members

All-Cause Readmissions QIPs			
MCP	**Priority Barriers**	**Intervention(s) to Address Barriers**	**Intervention Target(s)**
	◆ Members are not compliant because of lack of knowledge, cultural barriers, language barriers, and member preferences.	◆ Care managers, community connectors, and member services staff continually educate members regarding their plan benefits, health problems, treatment requirements and options, use of translator services, and use of other support services to optimize recovery and prevent health problems.	◆ Members
	◆ There is a lack of or inadequate community support resources.	◆ Care managers use all available resources to support members in the community and prevent unnecessary inpatient encounters.	◆ Community
Partnership HealthPlan of California	Information/Data Systems ◆ Hospitals and PCPs do not know their readmissions rates. ◆ The MCP has a poor system for identifying high-risk members for the MCP's Care Transition Program. ◆ PCPs are not notified when their patients are hospitalized and when they are notified, the notification is not timely.	◆ Provide quarterly reports to all PCPs showing their readmissions rates and, when requested, a drill down at the patient level. ◆ Increased the number of hospitals reporting readmission rates electronically which reduces delays in the MCP being notified of hospitalizations. ◆ Tested an e-mail notification system with three primary care sites that provided timely alerts of a patient hospitalization. ◆ Pay-for-Performance Program.	◆ PCPs ◆ Hospitals
	Education/Self-Management ◆ The discharge process is inadequate.	◆ Hired a care transition nurse to work in the Sonoma region to reach more members who need these services. ◆ Increased the case load for the care transition nurse by testing and improving the referral system for identifying members at risk for a readmission. ◆ Enrolled the top five patients with the most readmissions within a 12-month period into care transitions and case management.	◆ MCP ◆ Medi-Cal members

All-Cause Readmissions QIPs			
MCP	**Priority Barriers**	**Intervention(s) to Address Barriers**	**Intervention Target(s)**
San Francisco Health Plan	◆ There is a lack of follow-up with patients from clinics and medical groups in the MCP's network.	◆ Implemented a comprehensive pay-for-performance program that assigns points (and dollars) to medical groups and clinics to ensure they are actively working with the MCP's members to decrease readmissions. The MCP contracted with the Center for Excellence in Primary Care to provide intensive training for clinic care managers. The measures are: ▪ Each clinic or medical group will develop a personalized intervention that ensures that patients are contacted within seven days of discharge. ▪ The contact can be in the form of an in-person visit or telephone call by the PCP or a care team member. ▪ The contact may include the following: ▪ Education on red flag symptoms ▪ Medication reconciliation ▪ Medication self-management ▪ Referral services ▪ Scheduling/reminder of post-discharge appointment. ▪ Clinics and medical groups must report findings quarterly as a follow-up to the intervention.	◆ Medical groups and clinics
Santa Clara Family Health Plan	◆ The MCP does not have a sufficient number of case managers on staff to address SPD member needs.	◆ The MCP added additional case management staff to increase the number of SPD members engaged in case management services.	◆ Medi-Cal SPD members
	◆ The MCP's case management processes do not include a defined post-discharge call/outreach process.	◆ Implemented a post discharge call policy and procedure.	◆ Medi-Cal members

All-Cause Readmissions QIPs			
MCP	**Priority Barriers**	**Intervention(s) to Address Barriers**	**Intervention Target(s)**
	◆ The MCP and its contracted hospitals do not have a process to allow the MCP's case managers to review the discharge plan the hospitals provided to each member upon discharge.	◆ Implemented a discharge plan documentation pilot program with Stanford Hospital where upon discharge, the MCP's concurrent review team is responsible to download the electronic discharge plans from Stanford's online system. The discharge plan information is used in the care planning and care coordination processes.	◆ Low-performing hospital with 0 percent of discharge plans provided by the hospital to case management
Senior Care Action Network Health Plan	◆ Patients are confused about discharge instructions. ◆ Patients are confused about medication regimen post discharge. ◆ Patients are not prepared for initial follow-up appointment with usual physician. ◆ Patients are not scheduling timely follow-up care appointments post discharge. ◆ Patients lack transportation. ◆ There are delays/gaps in home health follow-up ◆ There are delays in getting durable medical equipment. ◆ Patients lack support system.	◆ Implemented a care transitions program that includes a multi-media sharing and messaging component where the care transition coaches develop and record individualized video messages that can be sent electronically to the member and/or the member's caregivers. ◆ Implemented a home visit pilot to remove barriers related to readmissions. The home visit helps improve members' understanding of their discharge plans and ensures that they receive needed support services. ◆ The MCP is partnering with skilled nursing facilities and acute care facilities to improve care transition to skilled nursing facilities and reduce readmissions to the acute care environment.	◆ Medi-Cal members ◆ Medi-Cal members identified as frail, vulnerable, and socio-economically challenged without a support system using hospital readmission, emergency room utilization, medication adherence, and high-risk medication case management data