

Statewide Collaborative
Quality Improvement Project
All-Cause Readmissions Remeasurement 1 Report
June 2014 – June 2015

Managed Care Quality and
Monitoring Division
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Commonly Used Abbreviations and Acronyms

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

- ◆ **ACR**—all-cause readmissions
- ◆ **CFR**—Code of Federal Regulations
- ◆ **CMS**—Centers for Medicare & Medicaid Services
- ◆ **DHCS**—California Department of Health Care Services
- ◆ **EQRO**—external quality review organization
- ◆ **FFS**—fee-for-service
- ◆ **HEDIS®**—Healthcare Effectiveness Data and Information Set¹
- ◆ **HSAG**—Health Services Advisory Group, Inc.
- ◆ **MCMC**—Medi-Cal Managed Care
- ◆ **MCP**—Medi-Cal managed care health plan
- ◆ **MY**—measurement year
- ◆ **NCQA**—National Committee for Quality Assurance
- ◆ **Non-SPD**—Non-Seniors and Persons with Disabilities
- ◆ **PCP**—primary care physician
- ◆ **PDSA**—Plan-Do-Study-Act
- ◆ **QIP**—quality improvement project
- ◆ **SMART**— Specific, Measurable, Achievable, Relevant, Time-Bound
- ◆ **SPD**—Seniors and Persons with Disabilities

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 health 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) requires each Medi-Cal MCP to conduct two QIPs that DHCS must approve and DHCS's external quality review organization (EQRO) must validate.

The statewide Medi-Cal Managed Care (MCMC) collaborative project serves as one of the two required QIPs for full-scope MCPs. The second QIP may 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. SCAN Health Plan is the only specialty MCP that elected to participate in the statewide collaborative QIP.

In June 2011, DHCS 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. 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. Additionally, as part of the process, the collaborative developed specifications for an *All-Cause Readmissions (ACR)* measure. The *ACR* measure is a modified version of the National Committee for Quality Assurance's (NCQA's) *Plan All-Cause Readmissions* Healthcare Effectiveness Data and Information Set (HEDIS[®]) measure, which is more applicable to the Medicare rather than Medicaid population.

Summary of Collaborative Quality Improvement Project Activities

The collaborative held four conference calls during the June 2014 through June 2015 reporting period to discuss topics to support the MCPs in their statewide collaborative QIP activities. DHCS and HSAG also held technical assistance calls by telephone with individual MCPs.

MCPs submitted their Remeasurement 1 results for the *ACR* statewide collaborative QIP to HSAG for validation in September and October 2014. DHCS made a decision that each MCP with a QIP that did not achieve a *Met* validation status on the annual submission would be required to submit a Plan-Do-Study-Act (PDSA) cycle related to the *ACR* topic rather than to resubmit the QIP for validation until a *Met* status was achieved. The decision was made in part

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

because DHCS is transitioning to a new EQRO contract beginning July 1, 2015, and in part because of DHCS's focus on rapid-cycle improvement strategies as a way to increase the likelihood of positive member health outcomes.

Twenty-eight QIPs (representing 14 MCPs) did not achieve a *Met* validation status. Except for the specialty MCP, the MCPs with QIPs that did not achieve a *Met* validation status initially submitted the SMART (Specific, Measurable, Achievable, Relevant, Time-Bound) objective and Plan portion of the PDSA cycle for DHCS and HSAG review and approval. After implementing a small test of change for three months, the MCPs submitted the Do, Study, and Act portions of the PDSA cycle. HSAG provided feedback and recommendations to each MCP about its PDSA cycle.

Changes in Eligible Population

In June 2011, DHCS began mandatory enrollment of Medi-Cal-only Seniors and Persons with Disabilities (SPD) members of non-COHS (county-organized health system) counties into Medi-Cal managed care. The enrollment was completed by May 1, 2012. As the SPD population often has greater and more complicated health care needs than the non-SPD population, the influx of the SPD population into MCMC likely resulted in higher overall readmissions rates for measurement year (MY) 2012 (the QIP baseline rates) than the MCPs would have experienced had the enrollment of SPD members not occurred. Many MCPs reported that they had to allocate additional resources toward care coordination and care transition services to help prevent readmissions for this high-need population. MCPs also reported an increased need to develop processes for coordinating with PCPs, specialty providers, and other community resources to ensure meeting the complex needs of SPD members.

Outcomes

Most QIPs had no significant change in their *ACR* rates from baseline to Remeasurement 1. Six MCPs had QIPs with a statistically significant decrease in their total *ACR* rate and SPD *ACR* rate at Remeasurement 1, meaning that in MY 2013 significantly fewer MCMC beneficiaries (aged 21 years and older) were readmitted due to all causes within 30 days of an inpatient discharge when compared to MY 2012. The SPD *ACR* rate decreased significantly for one additional MCP. Finally, the *ACR* statewide collaborative QIP SPD rate decreased significantly at Remeasurement 1 when compared to the baseline rate. Two MCPs had QIPs with a total *ACR* rate and SPD rate that increased significantly from baseline to Remeasurement 1, meaning that in MY 2013 significantly more MCMC beneficiaries (aged 21 years and older) were readmitted due to all causes within 30 days of an inpatient discharge when compared to MY 2012. Four MCPs had QIPs with total *ACR* rates that increased significantly from baseline to Remeasurement 1, and one MCP had a QIP with an SPD rate that increased significantly at Remeasurement 1.

While no change occurred in the statewide readmissions total rate from baseline to Remeasurement 1, the results show that, collectively, the QIPs were successful at reducing readmissions for the SPD population. This suggests that, overall, the MCPs are successfully meeting the health care needs of their SPD members, resulting in a reduction in readmissions for individuals in this population.

Lessons Learned

DHCS and HSAG conducted two technical assistance calls in February and May 2015, wherein MCPs shared lessons learned in the implementation of the *ACR* statewide collaborative QIP. HSAG compiled the results following the technical assistance calls and found common themes among the lessons learned identified by the MCPs.

While some MCPs did not achieve statistically significant improvement in reducing their readmissions rates, the majority of the MCPs experienced residual successes as a result of the *ACR* statewide collaborative QIP. Multiple MCPs identified that they successfully:

- ◆ Built strong partnerships with external organizations (i.e., hospitals, skilled nursing facilities, federally qualified health centers, county health centers, etc.) to work toward the same goal of reducing readmissions.
- ◆ Created collaborative synergy among internal departments to integrate various strategies rather than working in silos.
- ◆ Implemented interventions directly tied to the barrier analysis for a more targeted approach rather than deploying numerous unrelated strategies all at once.

The MCPs also identified key challenges to address with future interventions. Similar challenges that MCPs collectively acknowledged included:

- ◆ Having inaccurate member contact information for post-discharge outreach efforts, especially for members who are homeless. Some solutions that the MCPs are already implementing include:
 - Engaging members while they are still admitted in the hospital to obtain better member contact information after they are discharged.
 - Hiring administrative staff or promotoras to research member contact information.
 - Obtaining alternative contact information from members.
- ◆ Not capturing timely admission and discharge data, resulting in inaccurate information being used when conducting interventions. MCPs reported working to improve the quality of data collection from hospitals.

- ◆ Lack of understanding of the data, resulting in ineffective analysis and evaluation of implemented strategies.
- ◆ Lack of behavioral health agency partnerships to ensure adequate provision of resources for members with mental and behavioral health needs.
- ◆ Limited program eligibility criteria, resulting in fewer members having access to transitions of care services. Several MCPs reported expanding eligibility criteria to allow more members to participate in transitions of care services.

Recommendations and Next Steps

During the reporting period, DHCS made a decision to end the *ACR* statewide collaborative, effective July 1, 2015. The decision was based on the following factors:

1. The QIP was not achieving the desired outcomes.
2. DHCS's focus for quality improvement strategies changed to a rapid-cycle approach, which was not the focus when the collaborative was initiated.
3. DHCS's current EQRO contract is ending June 30, 2015, providing an opportunity for DHCS, with input from the MCPs and the EQRO, to determine the best approach for implementation of QIPs.

As reducing readmissions continues to be a priority for DHCS, the MCPs were instructed to continue to work on reducing readmissions as part of their quality improvement efforts. Additionally, the MCPs are required to report the *ACR* measure as part of DHCS's External Accountability Set.

HSAG recommends the following to DHCS regarding collaborative QIP efforts:

- ◆ Consider identifying a statewide, mandated topic for all MCPs rather than forming a statewide collaborative. Identifying a statewide, mandated topic will allow for each MCP to drill down and determine MCP-specific barriers to address using rapid-cycle improvement strategies to pilot small changes rather than implementing one large transformation. Performing small tests of change requires fewer resources and allows more flexibility to make adjustments throughout the improvement process. By piloting on a smaller scale, MCPs have the opportunity to determine the effectiveness of several changes prior to expanding the successful interventions to a larger scale.
- ◆ Require MCPs to include in their quality improvement efforts internal and external stakeholders and decision makers who can actively participate in the quality improvement processes. Including these individuals will increase the potential for the development of feasible quality improvement strategies with the greatest chance for success.

Medi-Cal Managed Care Background

DHCS administers California's Medicaid program (Medi-Cal) through its fee-for-service and managed care delivery systems. During MY 2013, DHCS contracted with 23 full-scope MCPs and three specialty MCPs throughout California in all 58 counties to provide health care services to more than 6 million beneficiaries enrolled in MCPs.³

Note: During the measurement period, MCMC expanded into several new counties and DHCS contracted with a new MCP. The new counties were not added to the *ACR* statewide collaborative QIP; and, given that the collaborative QIP was already well underway and the new counties and MCP would not have reportable data until MY 2014, the new MCP did not join the statewide collaborative and the new counties were not added.

Quality Improvement Project Requirements

QIPs are a federal requirement. 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 CFR, at 42 CFR 438.240.⁴

DHCS requires each of its contracted Medi-Cal MCPs to conduct two DHCS-approved QIPs and that each QIP be validated by the 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 may 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. Only one specialty MCP elected to participate in the statewide collaborative QIP.

Managed Care Health Plans Participating in the *All-Cause Readmissions* Statewide Collaborative QIP

Table 2.1 lists the MCPs participating in the *ACR* statewide collaborative QIP, including the counties. Note that for MY 2013, Health Net Community Solutions, Inc., added San Joaquin County to the QIP; and Health Plan of San Joaquin added Stanislaus County to the QIP. For

³ *Medi-Cal Managed Care Enrollment Report—December 2013*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: January 22, 2015.

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

these two counties, the MY 2013 rates were considered baseline rates, rather than Remeasurement 1 rates, since MY 2013 was the first year the MCPs reported rates in these counties.

**Table 2.1—Managed Care Health Plans Participating in the
*All-Cause Readmissions Statewide Collaborative QIP***

MCP Name	Counties
Alameda Alliance for Health	Alameda
Anthem Blue Cross Partnership Plan	Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, San Francisco, Santa Clara, Tulare
CalOptima	Orange
CalViva Health	Fresno, Kings, Madera
Care1st Partner Plan	San Diego
CenCal Health	San Luis Obispo, Santa Barbara
Central California Alliance for Health	Merced, Monterey/Santa Cruz
Community Health Group Partnership Plan	San Diego
Contra Costa Health Plan	Contra Costa
Gold Coast Health Plan	Ventura
Health Net Community Solutions, Inc.	Kern, Los Angeles, Sacramento, San Diego, San Joaquin, Stanislaus, Tulare
Health Plan of San Joaquin	San Joaquin, Stanislaus
Health Plan of San Mateo	San Mateo
Inland Empire Health Plan	Riverside/San Bernardino
Kaiser North	Sacramento
Kaiser South	San Diego
Kern Family Health Care	Kern
L.A. Care Health Plan	Los Angeles
Molina Healthcare of California Partner Plan, Inc.	Riverside/San Bernardino, Sacramento, San Diego
Partnership HealthPlan of California	Marin, Mendocino, Napa/Solano/Yolo, Sonoma
San Francisco Health Plan	San Francisco
Santa Clara Family Health Plan	Santa Clara
SCAN Health Plan (Specialty MCP)	Los Angeles/Riverside/San Bernardino

Purpose of the *All-Cause Readmissions Statewide Collaborative QIP*

The *ACR* 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.
- ◆ DHCS’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, DHCS 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 ACR statewide collaborative QIP. Results of the survey were used by a small workgroup to develop the Guiding Principles for the new collaborative. Collaborative members had an opportunity to revise and edit the Guiding Principles before finalizing and adopting them for the new collaborative.

Topic Rationale

The topic rationale was developed by a small workgroup and then shared with the collaborative. The collaborative approved the rationale, and all MCPs agreed to include the approved language under the “Topic Rationale” heading in their QIPs.

The hospital readmissions topic was chosen because hospital readmissions are common and costly. Research by the workgroup found that in recent years policy makers had highlighted readmissions as a target area providing an opportunity to improve quality of health care and reduce costs. While the early focus centered on Medicare patients, states were also 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 readmissions rates were higher than commercial readmissions rates.⁵

The workgroup determined that the Medi-Cal population is uniquely vulnerable to poor outcomes in the transition from hospital to home due to poor health literacy and language barriers. Additionally, while all members are assigned a PCP, most members have no established relationship with their assigned PCP. Additionally, Medi-Cal beneficiaries may have poor understanding of red flags (i.e., when to ask for help) or how to manage medication changes.

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 readmissions rates that ranged from 4.3 percent to 12.6 percent. Two of the four MCPs compared their SPD rates with their non-SPD rates and found that SPD members' readmissions rates were 2 to 8 percentage points higher. Initiation of the *ACR* statewide collaborative QIP provided a standardized methodology for reporting readmissions by all MCPs through the collaborative-developed *ACR* measure.

DHCS required that each MCP calculate an overall Medi-Cal readmissions rate, a readmissions rate for the SPD population, and a readmissions rate for the non-SPD population as well as address any disparities identified through barrier analysis with targeted interventions. Addressing hospital readmissions among Medi-Cal beneficiaries with disabilities is of even more concern as published in the December 2010 brief by the Center for Health Care Strategies, Inc. (CHCS),⁶ which noted that the rate of readmissions among Medicaid beneficiaries with disabilities may be different than that of other beneficiaries as a result of state-level policies, type of chronic illness, and a greater level of multi-morbidity.

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 no readmissions measure existed specific to the Medicaid population and that the existing standardized measures were primarily disease-specific and geared toward the Medicare population. After several meetings, the workgroup decided on a modified version of the NCQA *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. DHCS required that the measure be

⁵ 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: April 28, 2015.

⁶ 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.

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 software vendors and MCPs to calculate the rates. The 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.

Purpose and Scope of the Remeasurement 1 Report

The purposes and scope of this report are to summarize activities related to the *ACR* statewide collaborative QIP for the June 2014 through June 2015 reporting period, report on the Remeasurement 1 outcomes, and provide analysis of the outcomes in comparison to the baseline rates. Additionally, the report will provide a summary of the next steps for the collaborative and the MCPs' continued efforts to reduce hospital readmissions.

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 *ACR* 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 *ACR* 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 *ACR* 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 midcourse corrections, resulting in significant resource/cost savings.
- ◆ Second, the ability to determine the impact of the *ACR* 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 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 *ACR* statewide collaborative QIP make to the project participants?

Answering 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 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 *ACR* 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 3.1—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.	<ul style="list-style-type: none"> ◆ 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.	<ul style="list-style-type: none"> ◆ EQRO log of QIP submission dates

Collaborative Project Improvement

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 3.2—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 <i>Met</i> validation scores for the design and implementation stages of their QIPs.	◆ QIP validation scores ◆ EQRO qualitative analysis of barriers and interventions
3. Medi-Cal MCPs will report valid <i>ACR</i> 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 evaluation⁷ across all sectors of government programs and policies. TDE consists of three steps designed to ensure 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.⁸

The ideal process for using a program evaluation theory model is to develop the theory, ensure that 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 created by the workgroup.

⁷ Donaldson, S. I. (2002). Theory-driven program evaluation in the new millennium. *Evaluating social programs and problems* (pp109-141) Mahwah, NJ.

⁸ 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 evaluations of the interventions are documented as interim measures, and the outcomes of these measures will determine the effectiveness of the MCPs' improvement strategies.

Impact Outcomes

Table 3.3—Merit and Worth Outcome Measures

Long-Term Outcomes	Measures
1. Medi-Cal MCPs will achieve a statistically significant decrease in their <i>ACR</i> rates between the baseline and remeasurement period.	♦ Activity IX validation results for statistically significant improvement
2. Medi-Cal MCPs will achieve <i>Met</i> 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 Baseline Report—June 2013–May 2014*, HSAG reported on results for the oversight and compliance measures collected during the June 2013 through May 2014 reporting period. The current report provides results for the oversight and compliance measures collected during the June 2014 through June 2015 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 meetings facilitator/co-facilitator and minute-keeper
- ◆ EQR log of QIP submission dates

Collaborative Partner Participation

Collaborative Technical Assistance Calls

All MCPs participated on all collaborative calls according to the Guiding Principles. While two MCPs were not able to have representation at one meeting each, DHCS followed up with the MCPs to ensure that they received all information discussed during the calls. DHCS-approved meeting agendas were distributed prior to each meeting, and DHCS 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, DHCS and HSAG co-facilitated the meetings. Most meetings included time for one or more MCPs to share their QIP activities, successes, and lessons learned. At the request of DHCS, HSAG documented minutes and identified action items for timely follow-up. DHCS disseminated the minutes to all MCPs. Calls were held in August and November 2014, and in February and May 2015. Topics discussed included:

- ◆ Guidance regarding meeting all QIP requirements to ensure a successful QIP submission, including documentation of PDSA cycle information.
- ◆ Presentations by MCPs on:
 - Outcomes and QIP data analysis.
 - Lessons learned in the implementation of the ACR statewide collaborative QIP. (See Section 7 of this report for a summary of the lessons learned as reported by the MCPs.)
- ◆ The transition plan for the ACR statewide collaborative.

Timeliness of Remeasurement 1 Submissions

HSAG tracked all QIP Remeasurement 1 submissions and compared its log with DHCS to ensure accurate documentation of the submissions. Remeasurement 1 submissions (with ACR rates for CY 2013 and Activities I through IX) were due September 30, 2014. Sixteen MCPs (representing 30 QIPs) submitted by the due date; however, seven MCPs (representing 17 QIPs) were provided an extension and submitted in October 2014. Note that two QIPs were only assessed for Activities I through VIII because the QIPs had not yet progressed to the Outcomes stage and only baseline data were submitted.

Timeliness of Plan, Do, Study, Act Cycle Submissions

During the reporting period, DHCS made a decision that each MCP with a QIP that did not achieve a *Met* validation status on the annual submission would be required to submit a PDSA cycle related to the QIP topic rather than to resubmit the QIP for validation. The decision was made in part because DHCS is transitioning to a new EQRO contract beginning July 1, 2015, and in part because of DHCS's focus on rapid-cycle improvement strategies as a way to increase the likelihood of positive member-health outcomes.

DHCS provided a PDSA Cycle Worksheet for MCPs to submit; and HSAG, with input from DHCS, developed a review process and feedback form. DHCS instructed the MCPs to focus on a small test of change for the PDSA cycle. The PDSA process allowed for MCPs to implement rapid-cycle strategies and determine quickly if the interventions were effective or not. Once an MCP determined the interventions' effectiveness, the MCP could make a decision to adopt, adapt, or abandon the interventions. The MCPs required to implement a PDSA cycle could target the entire eligible population in all counties, identify a subset population (in one or more counties), target providers, or focus on a systemic problem. While the majority of MCPs with a QIP that did not achieve a *Met* validation status were required to submit a PDSA cycle, DHCS made some exceptions based on DHCS and MCP priorities.

HSAG tracked all PDSA submissions and compared its log with DHCS's information to ensure accurate documentation of the submissions. MCPs were initially required to submit the SMART objective and Plan portion of the PDSA cycle. MCPs had varied due dates for the submissions, and all MCPs submitted timely. All MCPs were instructed to implement the Do, Study, and Act portions of the PDSA cycle and submit their findings to DHCS and HSAG by April 30, 2015. All 13 MCPs required to submit a PDSA cycle submitted the Do, Study, and Act information by April 30, 2015.

5. COLLABORATIVE PROJECT IMPROVEMENT—PROCESS MEASURES' RESULTS

In the *Statewide Collaborative Quality Improvement Project All-Cause Readmissions Baseline Report—June 2013–May 2014*, HSAG reported on results for the process outcome measures collected during the June 2013 through May 2014 reporting period. The current report provides results for the process outcome measures collected during the June 2014 through June 2015 reporting period.

To determine the collaborative's progress toward achieving process outcomes related to the Remeasurement 1 reporting period, HSAG assessed the following:

- ◆ Completion date of QIP milestones against the timeline targeted due dates.
- ◆ QIP validation scores.
- ◆ EQRO validation of performance measures—final audit report.

Collaborative Timeline

DHCS 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 Outcomes/Remeasurement 1 stage and the status of each milestone.

Table 5.1—Completion Status for All-Cause Readmissions Statewide Collaborative Components During Outcomes/Remeasurement 1 Stage

Milestones	Targeted Due Date	Status
MCPs undergo performance measure audit.	March–June 2014	Complete
MCPs submit QIP with Remeasurement 1 data (CY 2013).	September 30, 2014	Complete
QIP validation.	October–November 2014	Complete
EQRO's first remeasurement report.	May 2015	Complete (Report delayed until June 2015 to allow for inclusion of all PDSA cycle information.)

QIP Validation Scores

HSAG's validation of the initial QIP submissions resulted in 19 QIPs (representing 11 MCPs) achieving a *Met* validation status and 28 QIPs (representing 14 MCPs) achieving a *Partially Met* validation status. Note: Of these, Anthem Blue Cross Partnership Plan had one QIP that achieved a *Met* validation status and eight QIPs that received a *Partially Met* validation status, and Health Net Community Solutions, Inc., had two QIPs that achieved a *Met* validation status and five QIPs that received a *Partially Met* validation status.

Table 5.2 depicts a summary of the validation status for the *ACR* statewide collaborative QIP Remeasurement 1 submissions.

**Table 5.2—Summary of Validation Status for
All-Cause Readmissions Statewide Collaborative QIP Remeasurement 1 Submissions**

Validation Status	Annual QIP Submission
<i>Met</i>	19
<i>Partially Met</i>	28
<i>Not Met</i>	0
Total QIPs	47

Assessment of Validation Results for Annual QIP Submissions

Table 5.3 provides the aggregate percentages for each QIP activity within the CMS protocols for the annual *ACR* statewide collaborative QIP submissions.

**Table 5.3—Aggregate Validation Results for
All-Cause Readmissions Statewide Collaborative QIP Annual Submissions*
(23 MCPs, 47 QIP Initial Submissions)**

QIP Study Stage	Activity	Aggregate Percentage of Applicable Elements		
		<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>
Design	I. Appropriate Study Topic	100%	0%	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)	Not Applicable	Not Applicable	Not Applicable
	VI. Accurate/Complete Data Collection**	99%	1%	1%
Design Total		100%	0%	0%
Implementation	VII. Appropriate Improvement Strategies**	73%	15%	11%
	VIII. Sufficient Data Analysis and Interpretation	82%	17%	1%
Implementation Total		76%	16%	8%
Outcomes	IX. Real Improvement Achieved	44%	0%	56%
	X. Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		44%	0%	56%
Overall Percentage of Applicable Evaluation Elements Scored <i>Met</i>		80%		
Percentage of QIPs with a Validation Status of <i>Met</i>		40%		

* 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 two *ACR* statewide collaborative QIP annual submissions and Activities I through IX for 45 submissions. The MCPs met 100 percent of the requirements for all applicable elements within Activities I through IV, which was expected since common language was provided to the MCPs for these activities. In previous submissions, MCPs had difficulty meeting all requirements for Activity VI; however, the MCPs improved upon documentation of their processes for collecting data, resulting in the MCPs collectively meeting 99 percent of the requirements for all applicable elements within this activity.

MCPs demonstrated opportunities for improvement related to the Implementation stage (Activities VII and VIII), with MCPs collectively meeting only 76 percent of the requirements for all applicable evaluation elements within the stage. The following are issues identified for the QIPs that did not fully meet the requirements for Activity VII:

- ◆ The MCPs did not indicate if any factors threatened the internal or external validity of the findings.
- ◆ The MCPs included no interpretation of the findings.
- ◆ The MCPs did not provide accurate or clear data.
- ◆ The MCPs did not identify statistical differences between the baseline and Remeasurement 1 data or identify factors that affected their ability to make comparisons between the two measurement periods.
- ◆ The MCPs provided no interpretation of the success of the study.

Activity VIII assesses whether or not the barrier analysis is adequate to identify barriers to improvement, the MCP has developed appropriate improvement strategies, and the timeline for implementation of interventions is reasonable. The area with the most opportunity for improvement within this activity was related to MCPs not providing documentation regarding the success of the implemented interventions and/or how the interventions were standardized or monitored.

Activity IX assesses the likelihood that the reported improvement is “real” improvement, to verify if the QIP has achieved significant improvement and if reported improvement in processes or outcomes of care is actual improvement. During the reporting period, 45 *ACR* statewide collaborative QIPs progressed to Activity IX. Of these 45 QIPs, six achieved statistically significant improvement over baseline.

HSAG’s validation results suggest that the interventions that many MCPs are implementing are not effective. Although the MCPs report conducting new causal/barrier analyses, HSAG found that many MCPs are not evaluating each intervention. Without a method to evaluate the effectiveness of interventions, the MCPs are limited in their abilities to make informed decisions regarding revising, standardizing, or discontinuing improvement strategies, ultimately limiting their ability to be successful at achieving positive outcomes in subsequent measurement periods.

Assessment of Validation Results for Annual QIP Resubmission

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. As indicated previously, during the reporting period DHCS made a decision to require that all MCPs except SCAN Health Plan implement a PDSA cycle for *ACR* statewide collaborative QIPs that did not achieve a *Met* validation status on the initial submission. In its initial QIP submission, SCAN Health Plan met 100 percent of the requirements for all applicable evaluation elements for the Design stage; and the scores remained *Met* after HSAG's review of the resubmitted QIP. SCAN Health Plan had deficiencies in its documentation of the Implementation stage in the initial QIP submission; and the MCP corrected all deficiencies in the resubmission, meeting 100 percent of the requirements for all applicable evaluation elements within this stage. SCAN Health Plan's *ACR* statewide collaborative QIP study indicator did not achieve statistically significant improvement over baseline, resulting in only 50 percent of the requirements for all applicable elements being met for Activity IX.

Review of Plan-Do-Study-Act Cycle Submissions

Thirteen MCPs were required to submit a PDSA cycle for their *ACR* statewide collaborative QIP. DHCS and HSAG held technical assistance calls with the MCPs, collectively and individually, to ensure that the MCPs had understanding of the PDSA cycle submission process and requirements. DHCS provided a PDSA Cycle Worksheet for MCPs to submit; and HSAG, with input from DHCS, developed a review process and feedback form. The MCPs initially submitted the SMART objective and Plan portion of the worksheet. Most MCPs had to resubmit revised worksheets before HSAG provided approval for the *ACR* PDSA cycle implementation.

SMART Objective

In the SMART objective for the PDSA cycle, the MCPs were required to clearly define the purpose of the PDSA cycle, include a target for the interim outcome, and specify the change that would be tested. The SMART objective was to include an end date for the cycle. While HSAG identified no single issue across all MCPs when reviewing the SMART objectives, the following were issues identified for at least some of the MCPs' *ACR* PDSA cycles:

- ◆ The SMART objective was not documented.
- ◆ The change to be tested was not documented in the SMART objective.
- ◆ The SMART objective did not include a narrowed focus.
- ◆ The SMART objective included an incorrect end date for the cycle.
- ◆ The SMART objective did not include a relevant target for the interim outcome.

Plan

In the Plan portion of the PDSA Cycle Worksheet, the MCPs were required to specify the change to be tested, a prediction for what will happen and why, the plan for implementing the change, and the plan for data collection. In this phase, the MCPs were required to answer the following questions: Who will be performing the change? What is being tested? When will the change occur? Where will the change occur? While HSAG identified no single issue across all MCPs when reviewing the Plan portion of the worksheets, the following were issues HSAG identified for at least some of the MCPs' *ACR* PDSA cycles:

- ◆ The change(s) to be tested were not clearly identified and/or fully described.
- ◆ The current/baseline rate was not provided.
- ◆ A narrowed focus was not identified, or the focus of the PDSA cycle appeared broad.
- ◆ A complete prediction was not provided.
- ◆ The data collection process was not fully described.

Do, Study, Act

In the Do, Study, and Act phases of the *ACR* PDSA cycle, the MCPs implemented the change being tested, collected data, completed analyses, summarized what was learned, and determined whether the change would be adopted (kept), adapted (modified), or abandoned (stopped). While HSAG identified no single issue across all MCPs when reviewing the Do, Study, and Act portions of the worksheets, the following were issues HSAG identified for at least some of the MCPs' *ACR* PDSA cycles:

- ◆ Not enough detail was provided in the Do section regarding whether the test was carried out as planned.
- ◆ Unexpected delays occurred and/or insufficient time existed in the PDSA cycle to demonstrate success.
- ◆ Insufficient number of staff were assigned to complete all tasks for the PDSA cycle.
- ◆ MCP staff changes resulted in no tracking of results.
- ◆ External partners did not complete agreed-upon tasks and activities, causing no results.
- ◆ Underreporting of results existed due to claims lag and/or data collection issues.
- ◆ Members declined and/or psychosocial barriers prevented participation in the change.
- ◆ MCPs planned to adopt a change without supporting data.

As a result of the PDSA cycle:

- ◆ Three MCPs met or exceeded their goal.

- ◆ Seven MCPs did not meet their goal; however, one of the MCPs saw some improvement.
- ◆ Three MCPs were not able to determine if their goal was met.

All but one MCP summarized what was learned as a result of the PDSA cycle. Regarding whether to adopt, adapt, or abandon the change:

- ◆ Six MCPs indicated they plan to adopt the change.
- ◆ Five MCPs indicated they plan to adapt the change.
- ◆ One MCP indicated plans to both adopt and adapt the change.
- ◆ One MCP indicated plans to abandon the change.

Some MCPs indicated plans to adopt changes without evidence that the test of change was successful; however, MCPs should only adopt a change after results of the PDSA cycle demonstrate that the change was successful.

Performance Measure Validation

As part of the 2014 NCQA HEDIS Compliance Audit™⁹ process, HSAG reviewed and approved 23 MCPs' source codes, either internal or vendor created, for the ACR statewide collaborative QIP measure. All MCPs produced valid and reliable rates for CY 2013. HSAG produced MCP-specific final audit reports that were distributed to MCPs and DHCS in July 2014.

Baseline and Remeasurement 1 *All-Cause Readmissions Rates*

Table 5.4 includes CY 2012 and 2013 ACR rates and shows the comparison between the baseline rates (CY 2012) and Remeasurement 1 rates (CY 2013). Please note the following when reviewing the rates in Table 5.4:

- ◆ 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 from Anthem since the MCP no longer provides Medi-Cal services in these counties.
- ◆ The rates of the specialty MCP participating in the ACR statewide collaborative have been included in the weighted averages. Therefore, the weighted averages presented in this report may vary slightly from previously reported data, which do not include the specialty MCP's ACR rate in the weighted averages.

⁹ NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

The following key applies to Table 5.4:

Symbol	Definition
*	HSAG calculated statistical significance testing between each SPD, non-SPD, and total rate using a Chi-square test.
**	The MCP did not report an <i>All-Cause Readmissions</i> rate for this time period.
↔	The Remeasurement 1 rate was not significantly different from the baseline rate.
▲	Denotes significant <i>improvement</i> in performance, as indicated by a significant decrease of the 2013 rate from the 2012 rate.
▼	Denotes a significant <i>decline</i> in performance, as denoted by a significant increase in the 2013 rate from the 2012 rate.
Not Comparable	A rate comparison could not be made because data were not available for both populations.
S	Since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Table 5.4—Baseline and Remeasurement 1 *All-Cause Readmissions* Rates

MCP Name and County	Population	Baseline (MY 2012) Rate	Remeasurement 1 (MY 2013) Rate	2012–13 Rate Difference*
Statewide (rates are weighted averages)	SPD	17.04%	16.27%	▲
	Non-SPD	9.35%	9.18%	↔
	Total	14.43%	14.16%	↔
Alameda Alliance for Health—Alameda County	SPD	15.86%	19.54%	▼
	Non-SPD	10.47%	13.64%	▼
	Total	14.66%	17.42%	▼
Anthem Blue Cross Partnership Plan—Alameda County	SPD	15.98%	19.74%	↔
	Non-SPD	9.84%	10.91%	↔
	Total	14.67%	18.16%	▼
Anthem Blue Cross Partnership Plan—Contra Costa County	SPD	23.00%	19.78%	↔
	Non-SPD	8.89%	S	↔
	Total	18.62%	17.30%	↔
Anthem Blue Cross Partnership Plan—Fresno County	SPD	16.79%	16.18%	↔
	Non-SPD	10.55%	10.68%	↔
	Total	13.83%	14.38%	↔
Anthem Blue Cross Partnership Plan—Kings County	SPD	19.82%	S	▲
	Non-SPD	11.84%	S	↔
	Total	16.58%	8.43%	▲

MCP Name and County	Population	Baseline (MY 2012) Rate	Remeasurement 1 (MY 2013) Rate	2012–13 Rate Difference*
Anthem Blue Cross Partnership Plan— Madera County	SPD	17.31%	S	↔
	Non-SPD	2.50%	S	↔
	Total	10.87%	8.63%	↔
Anthem Blue Cross Partnership Plan— Sacramento County	SPD	15.52%	13.26%	↔
	Non-SPD	7.85%	8.70%	↔
	Total	12.63%	11.83%	↔
Anthem Blue Cross Partnership Plan— San Francisco County	SPD	15.35%	17.38%	↔
	Non-SPD	6.56%	S	↔
	Total	14.19%	16.67%	↔
Anthem Blue Cross Partnership Plan— Santa Clara County	SPD	14.47%	16.33%	↔
	Non-SPD	12.43%	6.88%	↔
	Total	13.74%	13.75%	↔
Anthem Blue Cross Partnership Plan— Tulare County	SPD	15.70%	12.83%	↔
	Non-SPD	7.83%	8.22%	↔
	Total	11.70%	10.59%	↔
CalOptima—Orange County	SPD	18.82%	16.83%	▲
	Non-SPD	11.35%	10.83%	↔
	Total	16.69%	15.22%	▲
CalViva Health—Fresno County	SPD	12.30%	15.39%	▼
	Non-SPD	7.69%	7.78%	↔
	Total	10.64%	13.10%	▼
CalViva Health—Kings County	SPD	12.69%	8.57%	↔
	Non-SPD	5.00%	S	↔
	Total	10.31%	7.92%	↔
CalViva Health—Madera County	SPD	14.04%	16.36%	↔
	Non-SPD	7.41%	S	↔
	Total	10.81%	13.40%	↔
Care1st Partner Plan—San Diego County	SPD	17.35%	16.90%	↔
	Non-SPD	8.65%	8.64%	↔
	Total	15.64%	15.57%	↔
CenCal Health—San Luis Obispo County	SPD	16.54%	14.96%	↔
	Non-SPD	6.70%	6.71%	↔
	Total	13.49%	12.28%	↔

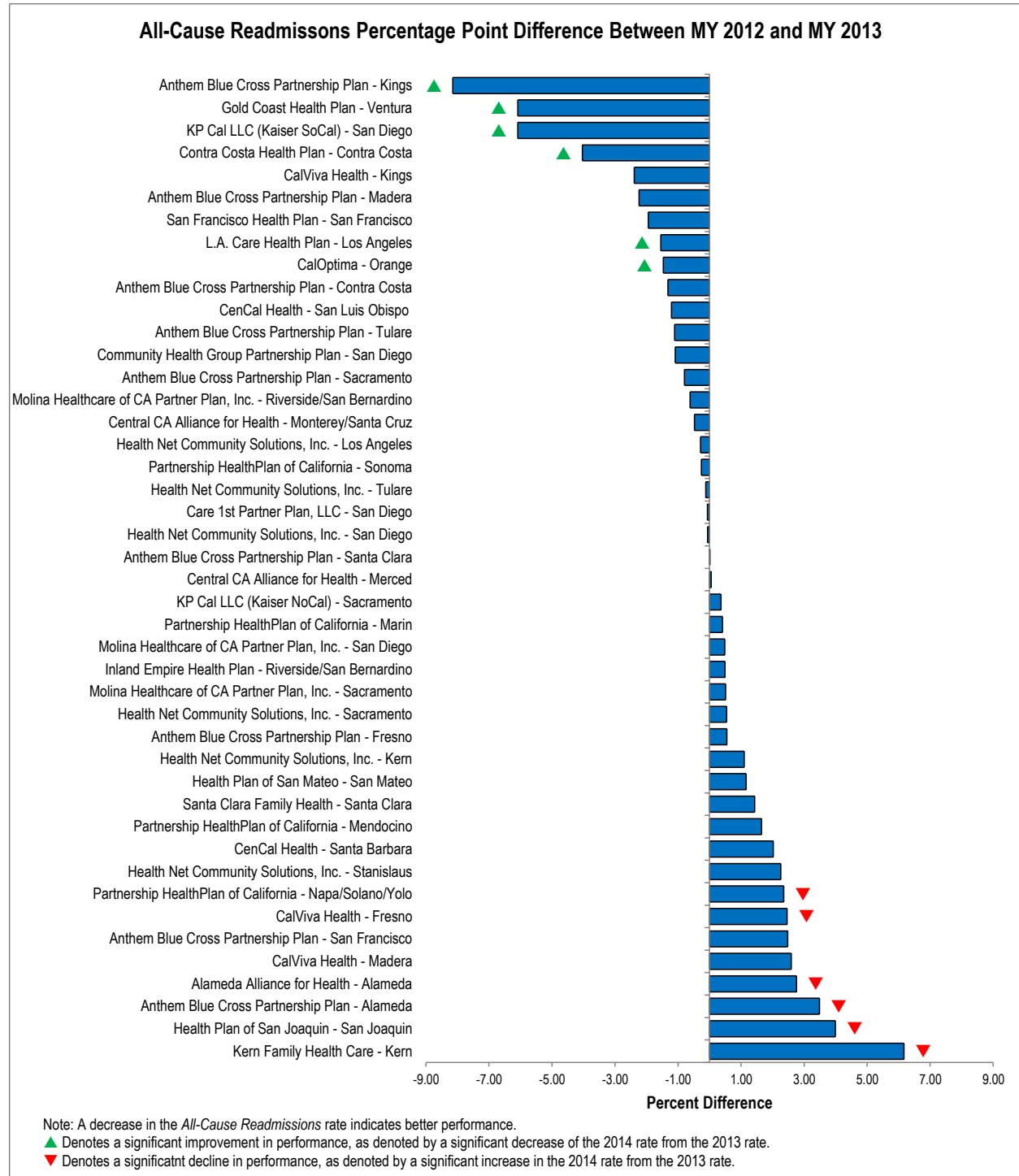
MCP Name and County	Population	Baseline (MY 2012) Rate	Remeasurement 1 (MY 2013) Rate	2012–13 Rate Difference*
CenCal Health—Santa Barbara County	SPD	13.88%	16.41%	↔
	Non-SPD	5.54%	7.29%	↔
	Total	11.13%	13.15%	↔
Central California Alliance for Health—Merced County	SPD	14.40%	15.78%	↔
	Non-SPD	9.86%	8.00%	↔
	Total	12.73%	12.78%	↔
Central California Alliance for Health—Monterey and Santa Cruz Counties	SPD	14.47%	13.89%	↔
	Non-SPD	7.78%	7.69%	↔
	Total	12.06%	11.58%	↔
Community Health Group Partnership Plan—San Diego County	SPD	17.03%	14.88%	↔
	Non-SPD	10.79%	10.38%	↔
	Total	14.37%	13.28%	↔
Contra Costa Health Plan—Contra Costa County	SPD	19.48%	14.13%	▲
	Non-SPD	12.72%	9.53%	↔
	Total	16.99%	12.95%	▲
Gold Coast Health Plan—Ventura County	SPD	23.16%	15.06%	▲
	Non-SPD	11.32%	9.53%	↔
	Total	19.17%	13.08%	▲
Health Net Community Solutions, Inc.—Kern County	SPD	11.72%	12.18%	↔
	Non-SPD	7.36%	9.35%	↔
	Total	10.40%	11.50%	↔
Health Net Community Solutions, Inc.—Los Angeles County	SPD	14.16%	13.40%	↔
	Non-SPD	7.58%	6.53%	↔
	Total	11.93%	11.64%	↔
Health Net Community Solutions, Inc.—Sacramento County	SPD	14.03%	13.70%	↔
	Non-SPD	6.02%	9.16%	↔
	Total	12.15%	12.69%	↔
Health Net Community Solutions, Inc.—San Diego County	SPD	17.88%	17.37%	↔
	Non-SPD	9.38%	7.87%	↔
	Total	15.96%	15.90%	↔

MCP Name and County	Population	Baseline (MY 2012) Rate	Remeasurement 1 (MY 2013) Rate	2012–13 Rate Difference*
Health Net Community Solutions, Inc.— San Joaquin County	SPD	**	25.00%	Not Comparable
	Non-SPD	**	0.00%	Not Comparable
	Total	**	18.60%	Not Comparable
Health Net Community Solutions, Inc.— Stanislaus County	SPD	10.12%	13.24%	↔
	Non-SPD	5.66%	S	↔
	Total	8.71%	10.97%	↔
Health Net Community Solutions, Inc.— Tulare County	SPD	15.86%	12.77%	↔
	Non-SPD	5.79%	9.62%	↔
	Total	11.86%	11.74%	↔
Health Plan of San Joaquin—San Joaquin County	SPD	13.75%	13.65%	↔
	Non-SPD	6.27%	6.86%	↔
	Total	7.07%	11.06%	▼
Health Plan of San Joaquin—Stanislaus County	SPD	**	15.88%	Not Comparable
	Non-SPD	**	8.67%	Not Comparable
	Total	**	13.11%	Not Comparable
Health Plan of San Mateo—San Mateo County	SPD	13.28%	16.78%	▼
	Non-SPD	19.24%	11.52%	▲
	Total	14.52%	15.68%	↔
Inland Empire Health Plan—Riverside and San Bernardino Counties	SPD	16.95%	17.37%	↔
	Non-SPD	9.82%	9.67%	↔
	Total	14.24%	14.73%	↔
Kaiser North—Sacramento County	SPD	17.05%	17.24%	↔
	Non-SPD	11.63%	12.14%	↔
	Total	15.71%	16.07%	↔
Kaiser South—San Diego County	SPD	20.74%	11.41%	▲
	Non-SPD	6.67%	11.46%	↔
	Total	17.51%	11.42%	▲
Kern Family Health Care—Kern County	SPD	17.07%	18.74%	↔
	Non-SPD	6.27%	11.62%	▼
	Total	8.77%	14.94%	▼

MCP Name and County	Population	Baseline (MY 2012) Rate	Remeasurement 1 (MY 2013) Rate	2012–13 Rate Difference*
L.A. Care Health Plan—Los Angeles County	SPD	19.69%	18.44%	▲
	Non-SPD	10.99%	9.19%	▲
	Total	17.05%	15.50%	▲
Molina Healthcare of California Partner Plan, Inc.—Riverside and San Bernardino Counties	SPD	18.15%	16.27%	↔
	Non-SPD	9.17%	8.46%	↔
	Total	14.65%	14.03%	↔
Molina Healthcare of California Partner Plan, Inc.—Sacramento County	SPD	14.68%	15.39%	↔
	Non-SPD	9.02%	7.34%	↔
	Total	13.20%	13.71%	↔
Molina Healthcare of California Partner Plan, Inc.—San Diego County	SPD	17.65%	17.07%	↔
	Non-SPD	9.37%	8.52%	↔
	Total	14.45%	14.93%	↔
Partnership HealthPlan of California—Marin County	SPD	18.83%	17.72%	↔
	Non-SPD	3.70%	S	↔
	Total	16.04%	16.45%	↔
Partnership HealthPlan of California—Mendocino County	SPD	10.68%	13.24%	↔
	Non-SPD	8.03%	S	↔
	Total	9.81%	11.46%	↔
Partnership HealthPlan of California—Napa, Solano, and Yolo Counties	SPD	15.67%	16.98%	↔
	Non-SPD	6.84%	7.48%	↔
	Total	13.25%	15.60%	▼
Partnership HealthPlan of California—Sonoma County	SPD	15.38%	14.00%	↔
	Non-SPD	7.01%	9.54%	↔
	Total	13.05%	12.79%	↔
San Francisco Health Plan—San Francisco County	SPD	18.08%	17.88%	↔
	Non-SPD	7.59%	5.69%	↔
	Total	15.81%	13.86%	↔
Santa Clara Family Health Plan—Santa Clara County	SPD	16.54%	18.25%	↔
	Non-SPD	8.26%	8.29%	↔
	Total	13.77%	15.20%	↔
SCAN Health Plan—Los Angeles, Riverside, and San Bernardino Counties	SPD	14.10%	10.07%	▲
	Non-SPD	0.00%	27.40%	↔
	Total	14.06%	12.37%	↔

Figure 1 depicts the percentage point difference between MY 2012 and MY 2013 for each MCP county that reported rates for both years.

Figure 1—Percentage Point Difference between MY 2012 and MY 2013



Since the *ACR* statewide collaborative QIP had not yet progressed to the Outcomes stage, in the *Statewide Collaborative Quality Improvement Project All-Cause Readmissions Baseline Report—June 2013–May 2014*, HSAG reported on its assessment of interim outcomes during the June 2013 through May 2014 reporting period. The current report provides results for merit and worth outcome measures collected during the June 2014 through June 2015 reporting period.

To determine the collaborative’s progress toward achieving merit and worth outcomes, HSAG assessed Activity IX validation results for statistically significant improvement. For MCPs with QIPs that achieved statistically significant improvement from baseline to Remeasurement 1, HSAG also assessed whether or not the MCP conducted evaluation of the interventions to determine the interventions’ effectiveness. Activity X, which assesses for sustained improvement, was not evaluated because the *ACR* statewide collaborative QIP had not progressed to the point where sustained improvement could be assessed.

Changes in Eligible Population

In June 2011, DHCS began mandatory enrollment of Medi-Cal-only SPD members into Medi-Cal managed care. The enrollment was completed by May 1, 2012. As the SPD population often has greater and more complicated health care needs than the non-SPD population, the influx of the SPD population into MCMC likely resulted in higher overall readmissions rates for MY 2012 (the QIP baseline rates) than the MCPs would have experienced had the enrollment of SPD members not occurred. Many MCPs reported that they had to allocate additional resources toward care coordination and care transition services to help prevent readmissions for this high-need population. MCPs also reported an increased need to develop processes for coordinating with PCPs, specialty providers, and other community resources to meet the complex needs of SPD members.

MCP-Specific Outcomes

Most QIPs had no significant change in their *ACR* rates from baseline to Remeasurement 1. The following six MCPs had QIPs with a statistically significant decrease in their *ACR* rates at Remeasurement 1, meaning that in MY 2013 significantly fewer MCMC beneficiaries (aged 21 years and older) were readmitted due to all causes within 30 days of an inpatient discharge when compared to MY 2012:

- ◆ Anthem Blue Cross Partnership Plan—Kings County
- ◆ CalOptima—Orange County

- ◆ Contra Costa Health Plan—Contra Costa County
- ◆ Gold Coast Health Plan—Ventura County
- ◆ Kaiser South—San Diego County
- ◆ L.A. Care Health Plan—Los Angeles County

The SPD *ACR* rate for the QIPs of the MCPs listed above also decreased significantly at Remeasurement 1 when compared to the baseline rate. Additionally, the SPD rate for SCAN Health Plan's QIP decreased significantly at Remeasurement 1. Finally, the *ACR* statewide collaborative QIP SPD rate decreased significantly at Remeasurement 1 when compared to the baseline rate.

The following six MCPs had QIPs with a statistically significant increase in the *ACR* total rate at Remeasurement 1, meaning that in MY 2013 significantly more MCMC beneficiaries (aged 21 years and older) were readmitted due to all causes within 30 days of an inpatient discharge when compared to MY 2012:

- ◆ Alameda Alliance for Health—Alameda County
- ◆ Anthem Blue Cross Partnership Plan—Alameda County
- ◆ CalViva Health—Fresno County
- ◆ Health Plan of San Joaquin—San Joaquin County
- ◆ Kern Family Health Care—Kern County
- ◆ Partnership HealthPlan of California—Napa/Solano/Yolo counties

Three MCPs had QIPs with a statistically significant increase in the *ACR* SPD rate at Remeasurement 1:

- ◆ Alameda Alliance for Health—Alameda County
- ◆ CalViva Health—Fresno County
- ◆ Health Plan of San Mateo—San Mateo County

While no change occurred in the statewide readmissions total rate from baseline to Remeasurement 1, the results show that, collectively, the QIPs were successful at reducing readmissions for the SPD population. This suggests that, overall, the MCPs are successfully meeting the health care needs of their SPD members, resulting in a reduction in readmissions for individuals in this population.

Analysis of Interventions

In the *Statewide Collaborative Quality Improvement Project All-Cause Readmissions Baseline Report—June 2013–May 2014*, HSAG provided detailed information on the interventions being implemented by the MCPs. As indicated in the baseline report:

- ◆ 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 that members receive needed medications and follow up with their primary care physicians (PCPs). Additionally, some MCPs are using interactive voice response calls or are calling members directly to assess members' needs and to ensure that members have a follow-up appointment scheduled with their PCP.
- ◆ The Medi-Cal population is the target for most 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 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.

When submitting the Remeasurement 1 information, some MCPs reported making changes to their interventions. The modifications were generally enhancements to the discharge process rather than new interventions. Modifications included the following:

- ◆ Placing staff on-site at the hospital.
- ◆ Increasing follow-up efforts post discharge to ensure that members are seen by their PCP.
- ◆ Identifying staff members to conduct medication reconciliation and to ensure that members understand their medication regimen.
- ◆ Having a staff member schedule the follow-up appointment with the PCP.
- ◆ Adding more detailed information to the discharge instructions.

Impact of Interventions on Outcomes

Based on the timing of the intervention modifications, which in most instances was at the end of 2013 or early- to mid-2014, it is unlikely the changes impacted the Remeasurement 1 results.

When assessing the interventions of MCPs with positive outcomes (i.e., statistically significant improvement from baseline to Remeasurement 1 in the total readmissions rate), only two of the MCPs (CalOptima and Kaiser South) conducted evaluation of their QIP interventions.

- ◆ CalOptima determined that its transitions of care intervention, which included coaching, had some impact on reducing readmissions. The program was implemented in April 2013; and while the evaluation of the intervention showed a lower readmissions rate after implementation of the program, the improvement was not statistically significant.
- ◆ Kaiser South's evaluation found that members completing their post-discharge follow-up appointment with their PCP and those receiving pharmacy services bedside in the hospital had lower readmissions rates than did members who did not attend their follow-up appointment and members who did not receive the pharmacy services bedside.

As the interventions were similar across all MCPs, it is difficult to determine with certainty what led to a statistically significant improvement for some MCPs but not for all. With continued emphasis on rapid-cycle improvement strategies and on a more narrowed focus for improvement efforts, moving forward, the MCPs should be better able to identify which interventions are effective and which are not.

DHCS and HSAG conducted two technical assistance calls in February and May 2015, wherein MCPs shared lessons learned in the implementation of the *ACR* statewide collaborative QIP. Each MCP presented about one to two significant successes as well as one to two areas for improvement. HSAG compiled the results following the technical assistance calls and found common themes among the lessons learned identified by the MCPs.

Significant Successes

While some MCPs did not achieve statistically significant improvement in reducing their readmissions rates, the majority of the MCPs experienced residual successes as a result of the *ACR* statewide collaborative QIP. Multiple MCPs identified that they successfully:

- ◆ Built strong partnerships with external organizations (i.e., hospitals, skilled nursing facilities, federally qualified health centers, county health centers, etc.) to work toward the same goal of reducing readmissions.
- ◆ Created collaborative synergy among internal departments to integrate various strategies rather than working in silos.
- ◆ Implemented interventions directly tied to the barrier analysis for a more targeted approach rather than deploying numerous unrelated strategies all at once.

Areas for Improvement

Based on evaluating the results of the *ACR* statewide collaborative QIP, the MCPs identified key challenges to address with future interventions. Similar challenges that MCPs collectively acknowledged included:

- ◆ Having inaccurate member contact information for post-discharge outreach efforts, especially for members who are homeless. Some solutions that the MCPs are already implementing include:
 - Engaging members while they are still admitted in the hospital to obtain better member contact information after they are discharged.
 - Hiring administrative staff or promotoras to research member contact information.
 - Obtaining alternative contact information from members.

- ◆ Not capturing timely admission and discharge data, resulting in inaccurate information being used when conducting interventions. MCPs reported working to improve the quality of data collection from hospitals.
- ◆ Lack of understanding of the data, resulting in ineffective analysis and evaluation of implemented strategies.
- ◆ Lack of behavioral health agency partnerships to ensure adequate provision of resources for members with mental and behavioral health needs.
- ◆ Limited program eligibility criteria, resulting in fewer members having access to transitions of care services. Several MCPs reported expanding eligibility criteria to allow more members to participate in transitions of care services.

Recommendations and Next Steps

During the reporting period, DHCS made a decision to end the *ACR* statewide collaborative, effective July 1, 2015. The decision was based on the following factors:

The QIP was not achieving the desired outcomes.

1. DHCS's focus for quality improvement strategies changed to a rapid-cycle approach, which was not the focus when the collaborative was initiated.
2. DHCS's current EQRO contract is ending June 30, 2015, providing an opportunity for DHCS, with input from the MCPs and the EQRO, to determine the best approach for implementation of QIPs.

As reducing readmissions continues to be a priority for DHCS, the MCPs were instructed to continue to work on reducing readmissions as part of their quality improvement efforts. Additionally, the MCPs are required to report the *ACR* measure as part of DHCS's External Accountability Set.

HSAG recommends the following to DHCS regarding collaborative QIP efforts:

- ◆ Consider identifying a statewide, mandated topic for all MCPs rather than forming a statewide collaborative. Identifying a statewide, mandated topic will allow for each MCP to drill down and determine MCP-specific barriers to address using rapid-cycle improvement strategies to pilot small changes rather than implementing one large transformation. Performing small tests of change requires fewer resources and allows more flexibility to make adjustments throughout the improvement process. By piloting on a smaller scale, MCPs have the opportunity to determine the effectiveness of several changes prior to ramping up on a larger scale and expanding the successful interventions to a larger population.
- ◆ Require MCPs to include in their quality improvement efforts internal and external stakeholders and decision makers who can actively participate in the quality improvement processes. Including these individuals will increase the potential for the development of feasible quality improvement strategies with the greatest chance for success.

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 applied to Medicaid populations.

All-Cause Readmissions (ACR)

Medi-Cal Managed Care – Statewide Collaborative Quality Improvement Project

FINAL Specifications Revised 11/26/13 - Modified from HEDIS^{®10} 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 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.
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Index Admission Date	The IHS admission date.
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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.
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Index Readmission Stay	An acute inpatient stay for any diagnosis with an admission date within 30 days of a previous Index Discharge Date.
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Index Readmission Date	The admission date associated with the Index Readmission Stay.
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¹⁰ 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	<p>An acute inpatient discharge on or between January 1 and December 1 of the measurement year.</p> <p>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.</p> <p>The organization should follow the steps below to identify acute inpatient stays.</p>

Administrative Specification

Denominator	The eligible population.
Step 1	<p>Identify all acute inpatient stays with a discharge date on or between January 1 and December 1 of the measurement year.</p> <p>Include acute admissions to behavioral healthcare facilities. Exclude nonacute inpatient rehabilitation services, including nonacute inpatient stays at rehabilitation facilities.</p>
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	<p>Exclude stays for the following reasons.</p> <ul style="list-style-type: none"> • 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 (SPD) 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
12/2012 Update - Removed aid code 65.					
65	Disabled Substantial Gainful Activity/Aged, Blind, Disabled-Medically Needy, IHSS			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

Appendix C. All-Cause Readmissions Timeline

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 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 analyses and planned interventions grids 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.	Complete
	QIP validation.	October–November 2014	HSAG conducts validation of plan Remeasurement 1 QIPs.	Complete
	EQRO's first remeasurement report.	May 2015	Report completed June 2015 to allow for inclusion of PDSA cycle results.	Complete
Outcomes/ Remeasurement 2	Health plans undergo performance measure audit.	March–June 2015		Complete
	Plans submit QIP with Remeasurement 2 data (CY 2014).	September 2015	HEDIS 2015.	N/A
	QIP validation.	October–November 2015	HSAG conducts validation of plan baseline QIPs.	N/A
	EQRO's final remeasurement report.	May 2016		N/A

Appendix D. All-Cause Readmissions Logic Model

